NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Tuesday 16 December 2025 at 11.15am
online via MS teams

No	Item	Request to	Lead	Enc.
1	Welcome	Note Information	KL	
2	Apologies for Absence:			
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest			A
	Standing items			
5	Minutes of the meeting held in public on the 27 November 2025	Decision	KL	B
6	Actions Log	Decision		C
7	Remaining 26/27 Clinical changes	Assurance	TL	D
8	Planning Submission 2026/28	Assurance	TL	E
9	Any Other Urgent Business (to be notified in advance)		KL	Verb
10	Public Questions *			
11	Close			

*** 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 29 January 2026 10:00am – The Baths Hall, Doncaster Road, Scunthorpe, DN15 7RG

RDaSH nurturing the power in our communities

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Jane Charlesworth, Head of Corporate Assurance		
Meeting	Board of Directors	**Date**	16 December 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 have been amendments to Ms Blake, and Ms Gillatt a declarations of interest as marked in bold.

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 and Director of K Lavery Associates Ltd • Chair ACCIA Yorkshire and Humber Panel • Non-Executive Director at Locala Community Interest Company (and Audit Committee Chair) • Chair of Locala Solutions Ltd
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)**~~ • Director: Bawtry Community Library • Bawtry Mayflower School Governor - Co-opted • **Sponsor: Network Rail** • **Trustee at Rossington Miners Welfare** • **Treasurer at Actie Rosso**

Name / Position	Interests Declared
Richard Chillery, Chief Operating Officer	• Nil
Maria Clark Non-Executive Director	• Lay Examiner for the Royal College of Obstetrics and Gynaecology • School appeals and Chair of the Independent Review Panel, Barnsley MBC • Grant making panel member for the Three Guiness Trust • Solicitor, Taylor Emmet Solicitors • Lay member National Institute of Clinical Excellence (NICE) • Associate Hospital Manager at Leeds and York Partnerships NHS FT and Derbyshire Healthcare NHS FT • Volunteer - Stroke Rehab Services Review, Joined Up Care Derbyshire • Research Ethics Committee Member, Ministry of Defence • NHS England Patient Safety Partner and Patient Advisory Forum member and also a member of the Independent Investigations Review Group. • 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
Dr Diarmid Sinclair, Chief Medical Officer	• Nil
Sarah Fulton Tindall, Non-Executive Director	• Member of the Patient Participation Group at the NHS Heeley Green General Practice Surgery, Sheffield • Age UK Readers' Panel member
Dave Vallance, Non-Executive Director	• Nil
Pauline Vickers, Non-Executive Director	• Independent Assessor for the Business to Business (B2B) Sales Professional Degree Apprenticeship for Middlesex University and Leeds Trinity University • Associate Coach with Performance Coaching International • Managing Director and Executive Coach Insight Coaching for Leaders • Director of Marsh and Vickers Coaching Limited

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 27 NOVEMBER 2025 AT 10.00AM FITZWILLIAM ROOM, ROCKINGHAM PROFESSIONAL DEVELOPMENT CENTRE, ROUGHWOOD ROAD, ROTHERHAM S61 4HY

PRESENT

Pauline Vickers	Non Executive Director (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
Jill Savoury	Interim Director of Finance
Dr Diarmid Sinclair	Chief Medical Officer
Dave Vallance	Non Executive Director

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Philip Gowland	Director of Corporate Assurance / Board Secretary
Dr Jude Graham	Director for Psychological Professions and Therapies
Jo McDonough	Director of Strategic Development
Shabir Pandor	NExT Director
Sarah Dean	Corporate Assurance Officer (Minutes)
James Hatfield	Freedom To Speak Up Guardian

2 members of staff, 1 member of public and 3 Governors were in attendance

Ref		Action
Bpu 25/11/01	**Welcome and Apologies** Mrs Vickers welcomed all attendees to the meeting. Apologies for absence were noted from Mrs Kathryn Lavery, Chair, and Sarah Fulton Tindall, Non Executive Director. Mr Pandor was welcomed to his first meeting, and he would commence the role of NExT director from 1 December.	
Bpu 25/11/02	**Quoracy** Mrs Vickers declared the meeting was quorate.	
Bpu 25/11/03	**Declarations of Interest** Mrs Vickers presented the declarations of interest report and confirmed there had been amendments to Mrs Vickers and to Ms Clark's declarations of interest to the register since the last meeting. Changes to Ms Blake's declarations 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.**	

STAFF STORY		
Bpu 25/11/04	**Staff Story** Ms Holden and Mr Forsyth introduced a video that celebrated the achievement of recruiting 350 volunteers (Promise 3) and included personal stories of volunteers and their contributions to the organisation. It and emphasised the importance of recognising their impact on services and community connection. The video and subsequent discussion illustrated how volunteering had provided structure, confidence, and career pathways for individuals, including those in recovery or seeking new skills, and highlighted the reciprocal benefits for both volunteers and people who were known to services. Mr Forsyth outlined the range of backgrounds that volunteers represented, including age, sexual orientation, and race, and noted that while not all diversity was visible in the video, the organisation was working in this area and was meeting the success measure that has been set. He explained the ongoing efforts to streamline the volunteer recruitment process, aiming for a steady state of 400 volunteers, and acknowledged the need for continual efforts to maintain and grow the programme efficiently. Mrs Vickers noted the intended reflection time later on the agenda.	
STANDING ITEMS		
Bpu 25/11/05	**Minutes of the previous Board of Directors meeting held on the 25 September 2025** **The Board approved the minutes of the meeting held on the 25 September 2025 as an accurate record subject to minor amendment (page 13 Minute Item Bpu 25/09/18 reference to dementia and good quality care).**	
Bpu 25/11/06	**Matters Arising and Follow up Action Log** The Board received the action log and noted the progress updates. All actions noted as 'propose to close' were agreed.	
BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS		
Bpu 25/11/07	**Report from the Quality Committee (QC)** Dr Falk presented the paper and gave the key highlights correcting the final sentence as it actually related to always measures which were discussed and would be presented later on the agenda. The midyear review of the PSIRF approach highlighted the processes in place to ensure oversight of patient safety events and learning. A recent 360 Assurance audit of PSIRF had been undertaken and being finalised to be presented to the Audit committee. An update report was presented on mortality with no concerns for escalation.	

	The effectiveness report was recognised as technically limited and required work to demonstrate quality effectiveness, which would return in January. Mr Lewis raised a point related to PSIRF, and that only around 50% of incident investigations had been fully completed. Mr Forsyth responded that interventions were in place to improve compliance, with Radar expected to help achieve 100%. The learning element, often overlooked, would become embedded in the Radar closure processes. Mr Forsyth confirmed the biannual staffing review assured that current establishments were appropriate using the mental health optimisation tool. **The Board received and noted the report from the Quality Committee.**	
Bpu 25/11/08	**Report from the Audit Committee (AC)** Ms Gillatt presented the paper and provided key highlights. The Deloitte auditors' annual report provided assurance that the Trust's financial statements and value for money arrangements fully comply with national guidelines. The auditors issued an unmodified audit opinion, confirming that the financial reporting and governance processes meet required standards. In addition, Deloitte offered strong commendations to the finance team for their significant progress and improvement. Internal audit progress remained strong. The first half of the year (H1) audits were nearing completion, and action tracking continued to be robust. The H2 audit scopes were being reviewed and finalised by Executives, with action tracking remained at 100%. The AC discussed clinical audit progress with particular attention to shared responsibilities and the need for timely reaudit cycles. Work was ongoing to strengthen these processes. The AC approved action related to medical declarations of interest compliance, to coordinate with the appraisal team to ensure all medical consultants and prescribers completed their declarations of interest, aiming for 100% compliance before the next meeting. Mr Lewis suggested to deescalate the action. He acknowledged the importance of balancing assurance with practicality, particularly in light of job planning priorities. The emphasis would be on integrating declarations into job plans to avoid unnecessary duplication and reduce the sense of being "chased," while maintaining transparency and compliance. Ms Gillatt referred to the strong work on counter fraud and anti bribery measures, including a successful half day session that reinforced organisational awareness and controls. **The Board received and noted the report from the Audit Committee.**	

Bpu 25/11/09	**Report from the Mental Health Act (MHA) Committee** Ms Clark, on behalf of Ms Fulton Tindall, presented the paper and highlighted key points. Consent to Treatment under Sections 3 and 2 achieved a 100% compliance rate for which was an excellent outcome and reflected strong practice. There remained concern with the continuing decline in compliance rates in Rotherham which remained an outlier in Consent to treatment on admission and Section 132 Rights being read within 24 hours. The MHA committee understood that work was underway that seeks to show improvement by March 2026. A key development is the ability to view compliance data at ward level, which would be invaluable for tracking and targeted action. The report provided detailed compliance figures, and while Rotherham showed particular concern, other areas also required attention. Regarding training compliance, there had been a decline in MHA Level 3 mandatory training and only slight improvement in reducing restrictive interventions training, which remain below expectations. **The Board received and noted the report from the Mental Health Act Committee.**	
Bpu 25/11/10	**Report from the People & Organisational Development (POD) Committee** Ms Blake presented the paper and acknowledged that the difficult subjects and range of perspectives shared, provided a deeper understanding of the initiatives currently underway, with some items later on the agenda. The POD included a discussion on the October Open Staff Meetings on racism, reaffirming the commitment to being an anti racist organisation and the importance of coproducing solutions with staff. The Freedom to Speak Up report included the growing number of champions and the success of FTSU Week. The POD emphasised the need for continued Board support and reiterated that detriment for speaking up would not be tolerated. Excellent progress on the apprenticeship levy had been made with near 100% utilisation including innovative courses that demonstrated a holistic approach to patient enrichment, particularly on inpatient wards. In response to Mr Lewis, Ms Holden and Dr Sinclair explained there was no systemic issue with doctors' rotas, supported by proactive monitoring and compliance with national frameworks. **The Board received and noted the report from the People & Organisational Development Committee.**	

Bpu 25/09/11	**Report from the Public Health, Patient Involvement & Partnerships (PHPIP) Committee** Mr Vallance presented the paper and highlighted key points. The PHPIP committee celebrated reaching a major milestone in volunteer engagement, Promise 3, with 351 active volunteers and more volunteers in the onboarding process. Appreciation was expressed to all teams and volunteers involved for their commitment, and improvements in volunteer recruitment processes were noted as making participation easier and more sustainable. Mr Lewis emphasised the importance of sustaining improvements beyond numerical targets, reducing operational strain, and embedding continuous learning. The PHPIP committee welcomed progress on Promise 2, highlighting emerging clarity and proposal for an awareness campaign targeting staff and line managers. Positive developments were also reported for Flourish, particularly in respect of the favourable CQC feedback for core services and Woodfield24, having been assessed as Good. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	
Bpu 25/11/12	**Report from the Finance, Digital & Estates (FDE) Committee** Mrs Vickers presented the paper and highlighted key points. The FDE committee discussed the savings plan, noting the £10 million target and the need for sensitive, inclusive, and collaborative communication and engagement throughout implementation. The estates enabling plan continued to progress with emphasis that the plan must focus on future readiness and quality, not just speed. Consideration was given to outsourcing elements of estates work while maintaining quality and safety standards. External advisors were being appointed to support specifications and commercial aspects. A detailed paper on the estate enabling plan would return to the Board in March 2026. There were significant digital developments including the rollout of SystemConnect in several clinical areas, supporting Promise 14 and reducing four week waits. The system would enable patient self referral and streamlines processes, improving patient experience. Rollout was planned between October and February, with plans for further rollout across all services by April with considerations for digital inclusion. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
Bpu 25/11/13	**Trust People Council (TPC)** Mr Vallance presented the paper and highlighted key points.	

	There was continued focus on organisational culture as a key enabler for delivering the strategy. Plans were in place to cocreate a dedicated session on culture for the January meeting, aimed at clarifying what culture means in practice and ensuring staff feedback was heard and acted upon. The discussion also covered the Trust's commitment to becoming positively anti racist, with progress to be reviewed through the upcoming stocktake in the upcoming agenda item. Ms Clark addressed sickness absence trends and the need for deeper analysis, including links to caring responsibilities and flexible working arrangements. Ms Holden explained a sickness absence deep dive was scheduled with operational teams next week to explore those issues further. Mr Lewis acknowledged that flexible working was well established in some areas but remained challenging in shift based roles. **The Board received and noted the report from the Trust People Council.**	
Bpu 25/11/14	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report. It was noted that the medical education oversight by the Deanery, which had been in place since March, was successfully removed earlier this week. He noted the appointment of Dr Milmore as Director of Postgraduate Medical Education. In addition, the appointment of the Lead Resident role was nearing completion. The NHS medium term financial framework 2026 to 2029 had been issued following the NHS 10 year plan with emphasis on digital innovation. The focus echoed the organisational plans, with work underway to review opportunities for technology to support treatment and reduce administrative burden, such as SystemConnect, and alignment with national policy. Care group delivery reviews in the prior few days saw strong engagement around Care Opinion and evidence of meaningful change, particularly in children's services. Good progress was observed and evidenced regarding CQC readiness, and a substantive discussion on this topic was planned for the January Board meeting. In relation to neurodiversity waiting times, Children's services remained strong and on track to deliver 18 week compliance by 2026 in North Lincolnshire and Doncaster, although prescribing issues in North Lincolnshire remain unresolved. Funding adjustments were planned for 2026, moving resources into Rotherham. Adult neurodiversity pathways remained unresolved, with approx. 6k patients waiting, including 2k for autism assessments. In responding to Mr Vallance, Mr Lewis noted the actions on recurrent demand and supply agreed in September but confirmed there remained no coherent backlog plan to present to the Board. A wider discussion might be required on whether the Trust was best placed to provide this service was the present position persisted. Mr Lewis referred to discussions held at the private Board in August regarding the dysfunctionality of the	

payment regime. Optimism was expressed that South Yorkshire ICB would progress tariff reform. Initial impact assessments suggest a neutral financial position but the changes would give us a basis for growth.

The Trust awards recently held celebrated the success and recognised excellent practice and staff pride, while acknowledging the challenges ahead into 2026.

Mr Lewis asked the Board to endorse the proposal in relation to specialty medical staff ambitions (the SAS-6 – para 3.7). This would support the development of specialty doctors. For example, this moved specialty roles into leadership positions, taking a lead from Dr Mike Seneviratne who was now our associate medical director.

Mr Vallance referred to the importance of amplifying positive messages alongside difficult changes, particularly for recruitment and engagement. Mr Lewis acknowledged the need to maintain staff morale during a period of financial strain and organisational change.

Ms Clark stated her interest in relation to speciality medical staff and advised she sat on the Board of a SAS committee for three years. She declared her support for the proposal, recognising the value this would bring.

Ms Blake acknowledged the large volume of national changes. She referred to the youth advisory council and development with place partners. Mr Lewis explained there had been multiple meetings with the youth advisory group and ongoing work with the childrens care group director to respond to four key points, including waits and employment. Plans include collaboration with the chief executive of City of Doncaster Council and an academy group to prototype a school experience model. Mr Lewis advised place based work was progressing, with strong engagement across three partnerships. The ICB had indicated reduced involvement going forward, and discussions were underway to determine backfill arrangements by April. Funding responsibilities were noted as a potential challenge, requiring alignment with organisational values if costs were shifted.

Dr Graham referenced the continued balance of celebrating achievements with transparency about challenges, ensuring staff and stakeholders remained engaged and informed. Dr Graham requested a further update with regard to eating disorder services. Mr Lewis explained the process to qualify for certain contracts, and work continued with South Yorkshire ICB colleagues, with investment from providers matched by the ICB. Clinical concerns remain that current plans may act as a temporary solution rather than a comprehensive approach. Mr Lewis would present a detailed proposal to the ICB Board in January. Credit was given to Sheffield Health Partnerships University Trust for work on opening up day services across South Yorkshire and progressing inpatient provision proposals.

The Board received and noted the Chief Executive's report and the forward actions it contained, the difficult decisions needed to secure large-scale delivery of our 2025/26 plans.

	The Board endorsed the proposal in relation to specialty medical staff ambitions (the SAS-6 – para 3.7).	
Bpu 25/11/15	**Freedom to Speak Up (FTSU) Guardian six month update** James Hatfield introduced the paper and gave key highlights on the FTSU position between April to September 2025. Inappropriate attitudes and behaviours remained the most reported FTSU concern. James explained there was emphasis on improving how feedback was delivered, ensuring it was constructive and supportive. He noted examples recently led through the Chief Executive, which had been well received. Ms Blake referred to the discussions at the recent POD committee and asked whether James felt there was further action required to support staff wellbeing, learning, and resilience. James replied he would encourage all leaders to increase visibility in their areas and openly speak with staff, with focus on the wellbeing. Mr Lewis noted current FTSU levels were proportionate to peer organisations and questioned when protected characteristic reporting would become available. James advised raising concerns would go live on Radar in December, and anonymised FTSU reporting would also be available. James highlighted other routes to raise concerns through FTSU champions. Mr Lewis voiced a concern over the absence of protected characteristics data from the report. This was discussed and James committed to ensure all future reports did contain this information. Mr Chillery referred to the wider engagement underway through community services redesign and transparent communications. He explained this may evoke anxiety, fear or anger and may lead to an influx of FTSU concerns in quarter 4. Ms Holden referred to discussions at POD and noted only a small proportion of staff had raised concerns to date (24 cases from over 4000 staff), highlighting the need to promote FTSU champions and strengthen line manager visibility to resolve issues early. In response to Mr Pandor, James advised year to date the number of concerns reported were similar to the previous year. Mr Lewis cautioned the trend may increase during the next quarter for the reasons already mentioned. Mr Lewis highlighted the importance of building a culture where people were able to speak up and that there were other forms by which to do so, and not only through FTSU processes such as speaking to the spiritual leaders, line managers and trade unions. He agreed to consider with executive colleagues outside this meeting of a broader culture of speaking up beyond formal FTSU processes.	**SF** **TL**

	The Board received and noted the FTSU update paper on activity from April to September 2025 and acknowledge the supportive behaviours.	
Bpu 25/11/16	**Promise 1 progress and actions** Mr Lewis presented the paper and highlighted the progress made in delivery of Promise 1 but also the remaining ask, which was significant. Peer support was the largest single investment in the past two years and would remain a priority next year. Mr Lewis emphasised the need for Board understanding of peer support, its purpose and benefits before committing further funds. Research showed role clarity and strong relationships delivered mutual benefits, but current coverage varied across services with gaps in role clarity and consistency. Next steps included completing a gap analysis, setting common standards, revising policies, and developing an outcome framework. The approach would shift from trial and error to a structured program over the next six months. Dr Sinclair emphasised the need to measure outcomes for this major investment and leverage research opportunities. Dr Graham advised peer support brought value to care but also governance, procurement, and service design. Mr Chillery acknowledged some challenge and caution remained in embedding peer support within traditional medical models and addressing towards community power. The next steps included developing an outcomes framework focusing on both qualitative and quantitative measures, which captured diverse benefits and clarifying employment models to avoid siloed approaches. Mr Forsyth explained the peer support journey would shortly be presented to Doncaster partners and local authority, emphasising sustainability through integration across organisations and embedding in policy and safety plans. Mr Lewis recognised the importance for clear language and transparency about workforce changes as peer support roles expand. The Board reaffirmed its commitment to concurrent peer support alongside care, recognising cultural and governance challenges and the importance of oversight and celebrating progress. **The Board received and noted the progress made in delivery of Promise 1 and the actions contained**.	
Bpu 25/11/17	**Promise 14 delivering a 4 week wait for all referrals** Mr Chillery presented the paper and highlighted the progress on services achieving the referral to assessment 4 week wait standard. Significant progress had been made, with some services slightly ahead of timetable, but the real focus was on ensuring sustainability. Most services have identified that they have enough supply to meet demands, with the exception of podiatry services. All other services offered some assurance of meeting 4 weeks from March 2026. Mr Chillery confirmed that the mapping of secondary pathways would be finalised in December.	

	Mr Chillery explained the importance of maintaining weekly allocation oversight, and the risks posed by small service teams and potential pathway changes. Key risks in achieving 4 weeks in the next 4 months could include small service vulnerabilities, such as staff sickness and capacity fluctuations. It was acknowledged the community services redesign and demand capacity work would support long term improvements however, it will be a turbulent time of change for community services. Mr Vallance praised the progress in reducing waits, noting reputational benefits, digital support, and the need to evaluate patient experience and service flow. Mr Chillery highlighted Care Opinion and SystemConnect as tools to empower patient feedback, and self management of appointments by patients, confirming their positive impact on communities. In response to Dr Falk, Mr Chillery confirmed the podiatry service had seen a sustained 100% growth in referrals following a successful campaign, which meant the service would not now deliver in timescale, and highlighted the need for two additional posts via investment bids. The recent pathway changes to the PCN health and wellbeing pathway meant they may not achieve in timescale, although work was underway to try to address that. Although wheelchair services met the four-week assessment target, full delivery of some wheelchairs would take 18 weeks. Mr Chillery emphasised that ongoing monitoring and assurance were required to maintain progress and manage capacity. Dr Sinclair questioned whether the shorter waits had started to attract patients from neighbouring trusts. Mr Chillery stated there was no evidence to suggest a shift of being a preferred provider but emphasised the importance of monitoring cross referrals and demand from neighbouring trusts. He stressed that progress must be measured methodically, ensuring secondary waits were also identified and addressed. Mr Lewis felt that the key metric for sustainability would be having all services achieving allocation within one week, creating flexibility to manage spikes. Mr Chillery offered confidence that this would be in place through 2026. **The Board received and noted the progress made in delivery of Promise 14. A further update would be provided to the Board in March 2026.**	
Bpu 25/11/18	**Always Events Planning** Mr Forsyth presented the paper and highlighted the introduction of five Always Measures (AMs) datasets. He reinforced the importance of the initiative as a major cultural and operational shift, designed to ensure real time accountability and improve patient experience. The AMs dataset would drive a major cultural shift to 100% compliance in key areas and enable real time monitoring via dashboards with rapid escalation protocols (24 hours to directorate leaders/teams, up to five	

	days for executive review). Mr Forsyth gave a recent example of Measure 5 and the impact this had in addressing urgent communication needs for a patient with a hypoxic brain injury, demonstrating its practical value. Dr Falk noted that this approach represented a fundamental change from current practices. Mr Lewis referenced previous learnings and reflected on the cultural shift required for successful implementation and sustainability. He emphasised the need for strong local accountability alongside a phased implementation approach in 2026 to test out the AMs. Mr Vallance acknowledged that this would challenge existing organisational norms and test line manager capability but that it was essential for enhancing care quality and improving responsiveness. Ms Blake highlighted the importance of managing carer involvement sensitively and ensuring care assessments delivered meaningful outcomes. Mr Lewis noted that it was clear that Always Events go live would need very careful planning and calibration, and further discussions were needed before those arrangements can be confirmed. **The Board received and noted the Always Events report.**	
Bpu 25/11/19	**Anti Racism stocktake at RDaSH** Ms Holden presented the paper and gave key highlights on the progress toward becoming an anti racist organisation. Drawing on staff open meetings and other material previously shared with the Board she outlined a change of approach, focused on our 557 line managers and their cultural competency as anti racist leaders. She also highlighted work on antisemitism that had been planned since summer 2025. Colleagues, including Dr Falk, voiced concerns about language, noting terms like “global majority” and “BME” as potential microaggressions. Ms Blake stressed the persistence of discrimination across protected characteristics and the importance of maintaining focus despite external pressures. Mrs McDonough acknowledged social media challenges and the organisation’s limited ability to remove harmful posts, while confirming that staff posting or liking discriminatory content would continue to be addressed under policy. Mr Lewis stressed the need for behaviour change, focusing on the skills and accountability of 557 line managers to actively assess and demonstrate cultural competency. Responding to Mr Forsyth, Ms Holden acknowledged the importance of inclusive language and careful framing to avoid offence. She highlighted social media policy challenges, referencing a fitness to practise case and difficulties managing discriminatory posts. She stressed the value of staff sharing experiences while recognising the risk of retraumatisation, with consensus on balancing storytelling with action and ensuring staff feel supported. Ms Holden outlined the ongoing tender and evaluation process for EDI training, which will include antisemitism, and invited	

	Board members to participate in that tender process should they wish to be involved. Mrs Vickers agreed on the need for a clear plan to drive behavioural change, maintain momentum, improve staff understanding, and address behaviours through education, accountability, and robust frameworks. **The Board received and noted the Anti Racism report, acknowledged the approach taken and feedback received, and supported the proposal to undertake targeted unannounced service visits focused on culture from April 2026.**	
Bpu 25/11/20	**Financial plan 2026 to 2027 and workflow workforce changes** Mrs Savoury presented the initial element of the paper, which reaffirmed that the Board approved medium term financial plan, having been reviewed against the published subsequent guidance remained extant. She drew attention to income uncertainties which persisted. The first two years of the three year financial plan must be submitted to NHSE by 17 December, with revisions planned for February following updated national guidance and ICB allocations. To meet tight timelines, the Board were asked to delegate authority for submissions to be jointly signed off by Mrs Vickers (Chair of FDE) and Mr Lewis on behalf of the Board. Mr Lewis confirmed that cash and capital projections required further refinement due to changes in national capital policy, with the most significant differences expected between December and February submissions. The Trust's medium term financial plan assumes a flat cash position and a 1.5% net income uplift. A well developed plan would be submitted to NHSE on 17 December, with confidence in the organisation's planning capability supported by robust financial and workforce triangulation processes: this was grounded in work over some months. Mrs Vickers then asked Mr Lewis to introduce the workforce change element of the paper. He noted the balance between a 4% change, or £6m paybill changes, as relatively modest, and the reality for affected and concerned teams. He reminded the Board of the TPC discussion previously cited which included exploration of support structures. Mr Lewis drew attention to the section of the paper which confirmed the changes planned in backbone services. Recognising changes, where they involved TUPE transfer or role displacement would be subject to consultation, he noted that the scale of change was around 25 roles among just over 600. Overall reductions in corporate costs, including nonpay changes, met the £2m figure set out in the July 2025 plans for 2026/27. He recognised that further changes within the Nursing and Facilities directorate would need to be managed carefully, and that changes in payroll and accounts payable had been subject to much discussion. He praised staff for their engagement in testing ideas and felt confident that the backbone changes were well balanced.	

	He noted the quality safety impact assessment (QSIA) and other processes needed to confirm the schemes, recognising that the executive group had reviewed the corporate schemes together in October. The review process for QSIA would focus most time on the community clinical schemes which were returning to the Board in December: with this paper offering a precis of developing proposals. The adult mental health changes aim to improve productivity and consistency while preserving flexibility, with built in allowances for education, research, and well-being, plus a 5% activity growth buffer. Children's services proposals continued to be refined, with a final version expected shortly following feedback. Adult physical health changes were the most extensive because they seek during 2026 to move the Trust's service model towards neighbourhood team working. This formed part of our Promises but was also national strategy. Mr Lewis recognised the need to future proof services and avoid repeated incremental changes. Mr Lewis drew attention to the conclusion and recommendations emphasising the Board's leadership role over the coming four months. He highlighted a view that the risk lay in implementation from April, which was why work on that will start in January. Dr Falk queried whether skill mix gaps had been factored into the cost base for clinical staffing. Mr Lewis confirmed no changes to inpatient ward staffing levels were included in the current plan, with any adjustments to be considered through the investment fund process only. He assured the Board that safe staffing data did not indicate unsafe levels and stressed the importance of using robust comparisons and evidence-based decisions given variations in financial viability across organisations. Dr Sinclair discussed future service models and noted a likely shift to less specialised teams in mental health and physical health. Dr Sinclair acknowledged potential challenges in managing perceptions of fairness and consistency, with teams such as assertive outreach facing increased scrutiny under national policy. Dr Graham highlighted the need to manage organisational change carefully during a period that also included winter pressures, noting potential short term productivity impacts. The QSIA on 8 December would review backbone and clinical schemes collectively, with attention to smaller professional groups where reductions could affect workforce sustainability. Mr Lewis confirmed that within the plans all clinical professions were impacted. Mrs McDonough highlighted staff concerns about the scale of proposed changes and the need to maintain clear communication of the rationale. She noted productivity gains, including sustaining the four week wait target. The discussion stressed the importance of robust QSIA processes, thoughtful measurement thresholds for 2026/27 implementation, and acknowledged cultural challenges in achieving consistent productivity. Mr Chillery noted that workforce change initiatives were underway across the ICB and praised the care group directors for their efforts in	

	engaging staff throughout the organisation. He explained that the proposed productivity gains were in some ways modest, data driven, and include built in buffers to ensure feasibility. Mr Forsyth highlighted several positive developments already achieved, including implementing the real living wage, maintaining investment in inpatient services, and introducing innovative care models that improve outcomes without additional staffing. He stressed that staff engagement would remain a priority and, while changes were challenging, the overarching aim was to deliver better services while keeping sight of the rationale for transformation. **The Board received and noted the Financial Plan 2026 to 2027 and Workflow Workforce Changes, and noted the work to engage staff and develop ideas for a safe but balanced 2026 to 2027 financial plan.** **The Board delegated submission of the 17 December plan documents to NHS England as outlined.** **The Board recognised the anxiety of colleagues about the scale and pace of change required, and supported the recommended corporate backbone change schemes.** **The Board agreed to review the final shape of patient-service changes at its next meeting on 16 December.**	
Bpu 25/11/21	**CQC Readiness: Well-Led** Mrs Vickers invited colleagues to take the paper as read and opened up for discussion and questions for Mr Gowland. Mr Gowland explained the link and interdependent work related to the four key CQC domains which the Board would be sighted on in January. The Board noted that the report reflected progress over the past six months and introduced how clinical directorates demonstrated compliance against a related maturity matrix. Mr Gowland confirmed that feedback on the provider capability assessment was expected in early December. The external well led review tender closes on 15 December, with the successful bidder due to start before Christmas and provide a draft report by 31 March 2026. The Board discussed the need to ensure confidence in self assessments by reflecting multiple perspectives rather than relying on a single viewpoint. Strengthening triangulation through the directorate maturity matrix and evidence testing was highlighted as essential. **The Board received and noted the update and status of the CQC Readiness Well-Led report and the next steps and planned reporting schedule**.	
Bpu 25/11/22 a	**Integrated Quality Performance Report (IQPR) Incorporating Older Peoples Quality Indicators**	

	Mrs Vickers invited colleagues to take the paper as read and opened up for discussion and questions for Mr Chillery and Dr Sinclair. In response to Mr Lewis, Dr Graham explained that using diagnosis specific length of stay data, overseen by HQTC, would provide more precise and actionable insights by aligning stays with diagnostic categories and national benchmarks. This approach would set realistic patient expectations, identify non clinical delays, and improve collaboration with internal teams and partners to expedite discharge. Clinicians would receive data on their own practice to support accountability and service improvement. Work remained ongoing with regular executive oversight to address clinical challenges and ensure ownership as the process evolves. The Board acknowledged the IQPR had previously been received at Board committee level for scrutiny and challenge. Regarding older people quality indicators, Dr Sinclair explained the further work required to develop the quality indicators including the separation of organic patients had not been negatively impacted by service changes. **The Board received and noted the Integrated Quality Performance Report, incorporating the older people indicators.**	
Bpu 25/11/22 b	**Health Inequalities: Review of IPQR** Mrs Vickers invited colleagues to take the paper as read and opened up for discussion and questions for Mrs McDonough. Dr Falk highlighted concerns about the large volume and complexity of data, questioning how it could be turned into meaningful action and delivery. Mr Lewis agreed and suggested reviewing the format and focus of future reports, with a new reporting format to be confirmed in April. Mr Vallance noted discussions at the PHPIP committee highlighted the need for shorter, more concise papers with clearer data synthesis. He acknowledged the current format was complex and required improvement to present actionable insights. Mrs McDonough stressed the importance of linking performance data to service improvement, confirming plans to refine reporting and ensure data informed decision making. Some metrics, such as splitting adult and older adult populations, remain in development. **The Board received and noted the health inequalities review of the IQPR and noted the comparison of the IPQR data to our local population, against four of the protected characteristics.**	**JMcD**
Bpu 25/11/23	**Promises and Priorities Scorecard** Mrs Vickers invited colleagues to take the paper as read and opened up for discussion and questions for Mr Lewis. Mrs McDonough highlighted the value of the rating league table in showing where objectives were on track, where progress had been made, and where further work was required. She noted the pressure this	

	placed on approximately 557 line managers and raised concerns about how best to support them given competing priorities. Dr Graham agreed the league table format was helpful and it was confirmed that future reports would include directional arrows to show progress. Dr Graham emphasised the interdependencies between some promises and the risks posed by limited investment or support from partners. Mr Forsyth questioned how success would be defined for those promises with vague measures. Ms Holden welcomed the clarity provided by the league table and stressed the need to reinforce the rationale behind the promises, particularly for staff who had joined since the strategy was launched. Ms Blake suggested exploring opportunities for non executive involvement in championing key priorities. Mr Vallance raised challenges in embedding change and implementing real time data. Mr Lewis explained that the league table reflected three implementation approaches: initiatives that required distributed ownership, those needing active driving before becoming business as usual, and centrally deliverable projects. He proposed a comprehensive review in the spring to assess barriers, success factors, and engagement ahead of the Annual Members' Meeting in July. He noted the difficulty of evaluating impact and the need for clarity on success measures and delivery chains. Mr Lewis also highlighted interdependencies across geographies and partnerships and confirmed there was engagement with the ICB to strengthen integrated care. He agreed to explore mapping non executive interests to align with strategic priorities. Mr Lewis agreed to consider non executive directors in championing specific promises, where colleagues' expertise and enthusiasm could add value rather than create formal roles. **The Board received and noted the Promises and Priorities Scorecard and the self assessment provided, augmented by the narrative within the paper. The Board acknowledged the effort across 23 directorates to deliver 28 Promises by the end of 2028, and recognised continued focus on in year delivery of both parts of Promise 14**.	**TL**
Bpu 25/11/24	**Strategic Delivery Risks (SDRs)** Mr Gowland presented the report and reaffirmed the importance of continuing to monitor and address strategic risks through the relevant committees and executive leadership. Progress had been made across several areas, including leadership development programmes, improved data availability, and partnership engagement, particularly with primary care. Those initiatives were designed to strengthen service delivery and support the organisation's strategic objectives, although challenges remained, particularly in relation to workforce capacity and seven day service provision. Mr Gowland highlighted the potential distraction posed by external publications and performance reporting, which could divert focus from the organisation's agreed priorities. Following review of the NHS 10 year	

	plan, the five strategic risks previously identified remain valid. Since the publication of the medium term planning framework, the Board were again asked to consider if there were any additions or changes to the current SDRs and create additional risks. Mr Lewis noted emerging issues such as workforce retention and neighbourhood model implementation may require additional consideration in the coming months. Mrs Vickers referred to the financial medium term planning framework and suggested no further changes to the SDRs. Mr Vallance reflected on discussions at PHPIP committee and its review of the SDR3. Mr Chillery referred to the challenges and opportunities associated with community service redesign, and whilst SDR3 and SDR5 had reference community aspects, they were currently weighted towards primary care and leadership development. Mr Chillery questioned whether they adequately reflected the scale and complexity of the work underway in community services, particularly given the potential disruption posed by forthcoming national GP neighbourhood contracts. Following discussion and whilst no immediate changes were made, there was consensus that by March, when greater clarity on national GP contracts was expected, a review of risk wording and intent may be necessary to ensure alignment with organisational priorities and systemwide developments. **The Board received and noted the update position for each SDR, and confirmed no immediate changes were required to the current five Strategic Delivery Risks.**	
Bpu 25/11/25	**Operational Risk Report** Mr Gowland presented the report and highlighted the key developments made. Recent reviews had highlighted the need for stronger alignment of risk management processes across the organisation. Mr Gowland explained whilst some risks were added recently, further work was required to ensure they were correctly referenced and integrated into the risk framework. This would be a key focus in the coming weeks, with discussions scheduled at the Risk Management Group meeting in December. A more structured approach to operational risk assessment was being developed to provide greater clarity beyond tolerance thresholds and to identify opportunities for improvement. Delivery reviews had revealed that some teams still had no recorded risks and several actions remained overdue. Mr Gowland advised that addressing those gaps would be prioritised to ensure consistency and accountability. Emerging risks, including those related to anti racism and equality, required close monitoring and accurate reflection. In response to Ms Gillatt's query regarding patient care risk (RSK-375), Mr Gowland explained that the identified backlog of DVLA medical review cases in Rotherham related to patients' ability to drive. Eight cases remain outstanding however remedial action was underway and expected to be resolved by next week. Indemnity arrangements had been clarified with the organisation's insurers and processes had been updated to allow suitably qualified staff, not only doctors, to complete DVLA reviews.	

	Mr Lewis noted the two key risks related to medication safety with shared care arrangements for lithium prescribing and medicines information systems (RSK-038 and RSK-083). Dr Sinclair advised progress had been made to enable clinician level prescribing visibility, and the functionality would expand to include team level reporting and cost analysis. This enhancement would support rapid responses to safety alerts and strengthen governance. Full functionality was expected by March. Mr Lewis recommended the Board be kept sighted on those core patient safety risks. **The Board received and noted the operational risk report and noted the revised reporting thresholds based on risk appetite and the planned work to address the extended number of risks that were currently outside of appetite and tolerance.**	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEE)		
Bpu 25/11/26	**Supporting Papers** Mrs Vickers informed the Board of the medical revalidation report for information which was presented as a supporting paper that had previously been presented at people and organisational development committee level for scrutiny and challenge. **The Board received and noted the medical revalidation report for information**.	
Bpu 25/11/27	**Any Other Urgent Business** There was no further business raised.	
Bpu 25/11/28	**Any risks that the Board wishes the Risk Management Group (RMG) to consider** There were no risks identified.	
Bpu 25/11/29	**Public Questions** There were no public questions.	
Bpu 25/11/30	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 : JANUARY 2026

PAPER C – ACTION LOG

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 25/05/20	**CQC Readiness: Well-Led** During quarter 4, a formal, externally commissioned, well led review would take place.	PG	**December 2025:** As previously reported, an externally commissioned review will be commissioned in Q3 and delivered **in Q4 2025/26**.	Propose to close
Bpu 24/11/08	**Report from the Quality Committee** Work was ongoing to develop a management escalation process with agreed parameters for intervention.	TL	**December 2025:** This was discussed within the private Chief Executive's report in September and remains open at this time, with a stated implementation point of January 2026 noted.	Open
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	**December 2025:** The discussion in November did not identify any changes to the SDRs – but it was acknowledge that the review should take place again at the end of Q4.	Open
Bpu 25/09/08	**Report from the People & Organisational Development (POD) Committee** Mr Lewis reflected on violence and aggression and noted the dissonance between the results of the internal audit and staff experiences. Mr Lewis recommended Mr Forsyth and Ms Fulton Tindall created space to explore violence and aggression through the Mental Health Act (MHA) Committee.	SF	**December 2025:** Chief Nurse is providing an update to MH Act Committee meeting in December.	Open
Bpu 25/09/15	**Tackling waits in neurodiversity services** An update would be provided to the Board in November and January.	TL	**December 2025:** the topic will feature as a planned agenda item in the **January 2026** meeting.	Open
Bpu 25/09/17	**Future of Pharmacy Services (Wholly Owned Subsidiary)** The Board would be kept informed regarding who would host the pharmacy service.	TL	**December 2025:** Discussions continue with an expectation of an interim arrangement via the Flourish CiC	Open
Bpu 25/09/21	**Provider Capability Assessment** The Board would receive an update in November 2025 of this process and any feedback received.	PG	**December 2025:** Feedback on the Trust's self assessment is awaited and will be reported to the Board of Directors in **January 2026.**	Open
Bpu 25/09/34	**Public Questions** Mr Lewis agreed to agreed to work with PFG and peer support workers to develop clear interim guidance for	TL	**December 2025:** Note very recently issued to PFG and feedback awaited. Retain item until received with likely close in January 2026.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
	service users seeking neurodiversity services, ensuring they receive accurate information about their options.			
Bpu 25/09/25	**Further update on Community Mental Health Services (Adult)** An improvement programme for community-based services would be developed, and would return to the Board in January and March to outline the approach.	TL	**December 2025:** As recorded at the previous meeting, this topic will feature within the agenda of the Board of Directors meetings in **January and March 2026**.	Open
Bpu 25/09/25	**Further update on Community Mental Health Services (Adult)** The October Time Out would create space to discuss the level of current insight amongst Board members and how they could develop a shared knowledge base through which to support teams with improvement work in the year ahead.	TL	**December 2025:** Given the postponement of the October time out, the matters planned for the session will feature in the next timeout session in **February 2026**.	Open
Bpu 25/09/24	**Estate Plan** An outline case would be presented before the Board in March 2026.	TL	**December 2025:** As recorded at the previous meeting, this topic will feature within the agenda of the Board of Directors in **March 2026**.	Open
Bpu 25/11/15a	**Freedom to Speak Up (FTSU) Guardian six-month update** All future reports to include protected characteristics data.	SF	**December 2025:** Not yet due	Open
Bpu 25/11/15b	**Freedom to Speak Up (FTSU) Guardian six-month update** Mr Lewis agreed to consider with executive colleagues outside this meeting of a broader culture of speaking up beyond formal FTSU processes.	TL	**December 2025:** This will return to the Board in March, including after work within TPC on wider organisational culture.	Open
Bpu 25/11/22b	**Health Inequalities: Review of IPQR** A review of the format and focus of future reports would be undertaken, with a new reporting format to be confirmed in April.	JMcD	**December 2025:** Not yet due	Open
Bpu 25/11/23	**Promises and Priorities Scorecard** Mr Lewis agreed to consider non-executive directors in championing specific promises, where colleagues' expertise and enthusiasm could add value rather than create formal roles.	TL	**December 2025:** Not yet due	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Remaining 26/27 clinical changes	**Agenda Item**	Paper D
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Public Board of Directors	**Date**	16 December 2025

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

The paper follows that to the Board in November, where backbone change schemes 26/7 were agreed and community clinical changes outlined. The paper summarises proposed approval of the schemes developed by care groups and widely engaged upon over the past six weeks.

The overarching risks are associated with implementation in that a proportion of schemes relate to changed behaviour within teams. Implementation planning will commence in January as all changes outlined are proposed to take workforce/budgetary effect from April 2026. The QSIA process suggests some scheme specific KPIs but this will be developed further in coming weeks, again ready for April.

The Board will not wish anyone to be made redundant within this process. The aim is to support redeployment into currently vacant roles or posts arising from the Investment Fund process. The process to do so will be centrally managed. Funding submissions are based on consultation commencing not later than January 26th: delays to execution of the schemes in April are priced at £0.5m per month, which on average salary scales equates to 15 wte. Taking community clinical schemes (together with backbone) we estimate that up to 95 wte are impacted by schemes agreed or due approval: of which two-thirds have staff in post.

Previous consideration (where has this paper previously been discussed?

n/a – but explored within the paper

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE processes of development/review undertaken by Care Grp Directors and QSIA panel

CONSIDER the issues raised by those processes – notably the seven in the cover paper

AGREE to pursuing schemes outlined, delegated minor variation to the Chief Executive

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)	
Digital plan	X
People and teams plan	X
Finance 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.	**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
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
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
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 3							
System / Place impact (advise which ICB or place that this matter relates to)							
Reflects wider ICB financial pressures							
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	Jan 8th
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	Dec 8th
Appendix (please list)							
Annex A – example of productivity analysis output undertaken							
Annex B – QSIA report including anonymised scheme detail (clinical and selected corporate)							
Annex C – discussion of overall vacancy position entering 2026/27							

ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Community clinical schemes – 2026 change management

1. Introduction

1.1 This paper is best read as a follow-on of those before the Board in November, in September, and in July in private. *The obligation to meet our statutory financial duty on a recurrent basis is understood among us all*. Since 2020 that duty has been lost at the Trust, and many colleagues have worked hard since 2023 to move towards restoring that compliance: our underlying deficit has fallen from £16m to just over £5m and in the latest plan to balance in the year ahead, pending contract negotiations which remain ongoing.

1.2 The paper reports on the remaining proposals to alter our workforce configuration in 2026/27. The medium-term financial plan, approved by the Board in September, and considered again in November, provides for approximately £6m of changes to our paybill next year. In approving the approach to RRP in July, and the backbone schemes agreed in November, we have made a start with that plan: this paper outlines approximately £3.7m of further changes, which, subject to due and meaningful consultation, will form the baseline establishment from April 2026. Delays to our paybill schemes beyond that date, will require a further £0.5m of proposals per month: or £1.5m per quarter. *The impetus to move to timetable has this urgency, recognising it is also important to staff colleagues, who experience anxiety and want to end uncertainty*.

1.3 The schemes considered in this paper focus on community clinical services, and roles displaced are in some cases patient-facing. The Board agreed not to make further changes to inpatient clinical care when it met in March 2025, reflecting changes at scale in the prior two years. *Whilst reference will be made to productivity within this paper, that should not be read as a criticism of teams working within the Trust*: on the one hand, we know from the national cost collection that the Trust is comparatively efficient, and in addition teams have worked to patterns of work set by the organisation. Changing those patterns of work will require significant implementation support, both from January in preparing for change, and from April in making those changes a safe reality.

2. **Community clinical service models: an opportunity for change**

2.1 Since October, care group leaders have led working through an analysis of current patient care volumes in community-based teams. This builds on work done to meet our wait time target of four weeks, and work too to ensure, in mental health, that we have care plans consistently in place. This work, aligned to the development of job plans in all clinical professions, has provided a good foundation to understand the strengths and limitations of our data.

2.2 Necessarily **slightly different approaches to analysis have taken place in the five care groups**.

- Children's services have sought to analysis demand and capacity and then generated a series of proposals which remove duplication where they can: this does include change in mental health services but not within Getting Help/Advice. It does involve changes in some physical health services.

- Our physical health care group have worked to consider the neighbourhood future of local healthcare, and to identify opportunities both in out of hours care, and in moving teams into our 4 geographies that better reflected our partnership with general practice.

- Our learning disabilities and forensics directorate are working with less clearcut data, but have, since summer, undertaken a wider review of their services and future – and the proposals that they have put forward arise from that.

- Adult mental health care groups, including work for talking therapies, has followed a common broad approach which is outlined in the next paragraph.

2.3 Management teams started by reviewing the Trust's patient level costing dashboard. This identified differences between cost per contact within each team. Significant work then took place to gather further data and 'verify the opportunity'. This included scrutiny of both data report 071 (activity data, all clinical contacts) and use of health roster (all 'available hours for individual staff members). This work was used to derive a staff level productivity calculation based on face to face contacted per day per staff member, and all contacts per day on the same basis. Annex A includes excerpts from that work to illustrate the output. **It is important to be clear that this data was then carefully weighed within and between teams by our service managers, taking account of annual leave, sickness, and training**. All modelling has been done to account for roles spending 75% of time in patient facing work: retaining time for personal development, leadership, research and wider education.

2.4 **Proposals are not rooted in the full scale of opportunity that this analysis suggests.** That is because we understand there will be potential peaks and troughs in demand, because there are inevitable limitations to data quality and completeness, and because the act of moving to a more 'scheduled' or predicted activity level is a very new endeavour in many teams, much of whose work is not always organised in that manner.

2.5 As outlined in the paper presented to the Board on November 27th, a number of the proposals from teams also seek **to rationalise lead roles at clinical level**. The Trust's management structure at Care Group level remains stable and in line with the outcome of work in summer 2023: directorates likewise are not changing structure, with minor previous removals and additions of role. These changes are at team level and just above – and bring together several professions under fewer full time non-patient facing clinical leaders.

3. Principles behind our changes

3.1 **None of the proposals outlined reduce our capacity to meet patient need (sometimes called demand**). The proposals have been scrutinised for their

congruence with our four-week wait. It is slightly more difficult to do this for what is labelled ‘secondary waits’, predominantly in specialist psychology care – as their mapping concludes at Christmas. But on their face, no scheme worsen those positions, and the Board is aware that an investment fund remains to identify new roles we will need. The Chief Operating Officer has been involved in validating these proposals in their entirety.

3.2 Care Group leaders have confirmed that proposals:

- Retain role balance (the 75/25 outlined above)
- Maintain career progression at directorate or higher level
- **Do not reduce educational placement availability**

As is laid out in Annex B, on the QSIA process, these ideas were also tested by our clinical and patient panel: Drs Sinclair & Graham, Glyn Butcher and Steve Forsyth.

3.3 Of course, removing roles will often mean **others need to work differently**. In so far as that is based on the capacity/volume analysis cited above, the scale of daily/weekly work does not go beyond what is being undertaken by some colleagues presently. One scheme, which looks at speech therapy in learning disabilities, is just testing that assertion.

3.4 It remains our ambition to have **greater consistency between our teams between places**. This has happened over 2025 in children’s services with alignment of the Thrive model. And our work on inpatient care has begun to do the same with ‘standard work’ approaches to how we operate. In community mental health services teams, their structure, and financing start from historically very different places. Most obviously, no assertive outreach team for North Lincolnshire is commissioned by Humber and North Yorkshire. *The proposals narrow but do not eliminate these differences*: the key step is to agree ‘throughput’ volumes of care in common for similar teams. These are shown below.

It will be the delivery of these volumes, as a minimum, which will form the essence of the implementation work referenced in this paper. We know from similar efforts in respectively children’s services and all-age neurodiversity that preparatory work with team leaders and with teams will be needed to be ready for this more disciplined way of working; including ensuring that it is introduced persistently and insistently so that it is fair to all involved. Many staff, in engagement, have welcomed the transparency that this will bring and the sense of peer-to-peer accountability too. Of course, such a data-led approach also means that should demand rise, we have a basis for expansion – introducing a relationship between productivity, staffing and income as we have planned since 2023/4.

	Nursing / SW									AHP								Psychology									
F2F Min Expectation per 7.5 hr day	3	4	5	6	7 (Clinical Leads)	6 Nurse Led Clinic	Clinic Setting (Depo/Cloz/Lith)	8a	8B	OTA	OT5	OT6	OT7	OT8B	B3 Physio	B6 Physio	B7 Physio	CBT	Psych 4	Psych 5	Psych 6	Psych 7	Psych 8a	Psych 8b	Psych 8c	DBT	Duty per day / Locality or Team
CMHT	4		4	3	2	4	10	2	2	4	4	3	2					3	4	4	4	4	3	3	1.5	4	1
Older Adults - Memory	3	4	4	3	3			0.8	2	4	4				4	3	2		4	4	4	4	3	2	1.5	4	1
Older Adults - Functional	4	4	4	3	3			0.8	2	4	4				4	3	2		4	4	4	4	3	2	1.5	4	1
EIP	3	4		3	2						4							3	4	4	4	4	3	2	1.5	4	1
AoS / AoT	3			3	2				2	3	4			2				3	4	4	4	4	3	2	1.5	4	1
PCMH				4	2				2		4							3	4	4	4	4	3	2	1.5	4	1
Perinatal	4	2		3	2			1										3	4	4	4	4	3	2	1.5	4	1
Rehab	3	4		3	2					3	4							3	4	4	4	4	3	2	1.5	4	1
Health & Wellbeing	4	6	4	4	2		12		3	4								3	4	4	4	4	3	2	1.5	4	1

Total Min Expectation per 7.5 hr day	3	4	5	6	7 (Clinical Leads)	6 Nurse Led Clinic	Clinic Setting (Depo/Cloz/Lith)	8a	8B	OTA	OT5	OT6	OT7	OT8B	B3 Physio	B6 Physio	B7 Physio	CBT	Psych 4	Psych 5	Psych 6	Psych 7	Psych 8a	Psych 8b	Psych 8c	DBT	Duty Days / Locality
CMHT	6		6	5	4	6	12	4	4	6	6	5	4					5	6	6	6	6	5	5	3.5	6	1
Older Adults - Memory	6	6	6	5	5			2.8	4	6	6				6	5	4		6	6	6	6	5	4	3.5	6	1
Older Adults - Functional	6	6	6	5	5			2.8	4	6	6				6	5	4		6	6	6	6	5	4	3.5	6	1
EIP	6	6		5	4						6							5	6	6	6	6	5	4	3.5	6	1
AoS / AoT	6			5	4				4	5	6			4				5	6	6	6	6	5	4	3.5	6	1
PCMH				6	4				4		6							5	6	6	6	6	5	4	3.5	6	1
Perinatal	6	4		5	4			3										5	6	6	6	6	5	4	3.5	6	1
Rehab	6	6		5	4					5	6							5	6	6	6	6	5	4	3.5	6	1
Health & Wellbeing		8	6	6	4		14		5	6								5	6	6	6	6	5	4	3.5	6	1

4. What are the changes in summary

4.1 Consistent with our prior practice, it is for the executive leadership, including clinical executives, to primarily scrutinise the detail of individual schemes. Clinical community schemes proposals have been created by Care Group Directors, working with three CG level clinicians, the COO and CEO: this work has then been tested by the CMO, CNO, PPT director and a patient representative. In addition, we have seen proposals discussed by SLTs, explored in CLE, and of course subject to lengthy and widespread engagement. We provide some detail below of proposals, sufficient to understand the changes being taken forward. At Annex B, the QSIA process and arising risks and potential KPIs are set out. There is more work to do on these 'tracking measures', such that a bespoke data report covering the whole programme of change is available from April, **with some data available weekly, and others monthly.**

4.2 Engagement has given rise to significant adaptation and changes to proposals prior to their presentation today. Care Groups have retained records of that adaptation, and it has continued to December 11th. We are choosing to retain a specialist hairdressing function within our hospice, after being unpersuaded of alternative options. We will be expanding art and music therapy into North Lincolnshire. Additional schemes in talking therapies are being finalised to avoid the removal of a specific therapeutic modality. **At the time of writing, I anticipate we will wish to discuss in particular:**

i. Productivity assumptions associated with our CAMHS service
ii. Defunding the separate ARMs pathway in North Lincolnshire
iii. Potential changes in assertive outreach, which appear deliverable, but need to tested against our new engagement/disengagement policy
iv. Sufficiency of therapy cover within our Learning Disabilities service
v. Changes to the safeguarding / child sexual exploitation professional arrangements

vi. Changes to chaperone arrangements out of hours in Doncaster, which again appear deliverable as outlined in the annex: and changes to palliative care out of hours.

vii. Merging the health and wellbeing pathway into CMHTs in Rotherham

The short list above does not relate to employee views: many other schemes attract disagreement. **These are the seven areas where there is a measure of judgement needed, which we suggest make them suitable for the Board to reflect on, based on weighing quality considerations**.

4.3 Teams have continued to evolve schemes over the engagement period. We are confident that those involved understand that their teams may affected, and conversely teams not involved should have that knowledge too. The two slides below provide an overview of what is intended – firstly in terms of clinical coverage, and then in terms of scale of change. WTE calculations are being validated but are shown as broadly accurate.

Scale and scope

There are likely three types of schemes

The majority of schemes in mental health, and most in children's, **focus on productivity**: we will keep short wait times, but analysis shows opportunity to work differently – a proportion (less than a third)of that opportunity is then crystallised as savings related proposal

A set of proposals which aim to move us back towards **some generalism in our care teams** – consistent with the ten-year plan vision for neighbourhood working

In addition, in some areas, **non-patient facing clinical role leads are changing** – where within a team there are profession specific leadership roles: moving to fewer, but without breaching span of control aims

The list below is not exhaustive

Learning disabilities and forensics

- We are considering a series of changes within our learning disabilities teams; including introducing more consistency between our places

Physical health services (adults and children)

- In children's services there are a variety of changes *including* in sexual health, SPOC, school nursing and health visiting
- For adult services, there are changes in out of hours care models, and in how teams are structured to fit to neighbourhoods: we anticipate around 19 roles will be removed

Mental health services (adults and children)

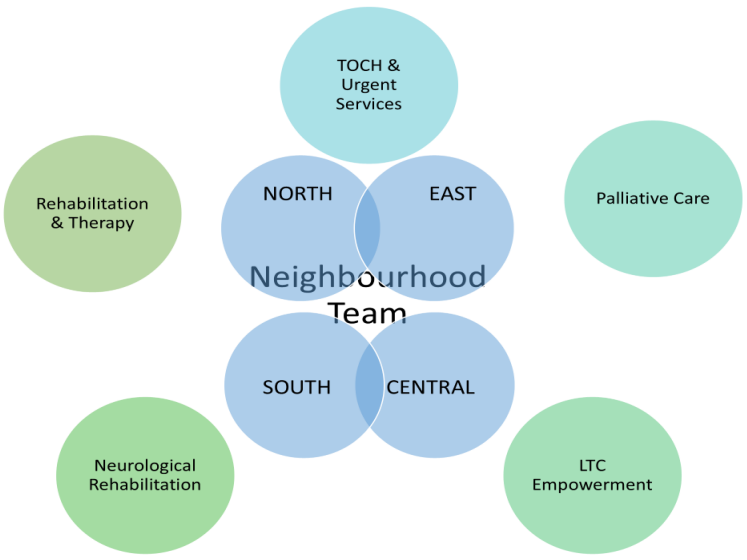
- In children's services there are a variety of changes with some clinical lead roles being restructured: Getting Advice and Getting Help are not affected
- Changes impact some working age community teams, talking therapies and some older adult care (but not in Doncaster)

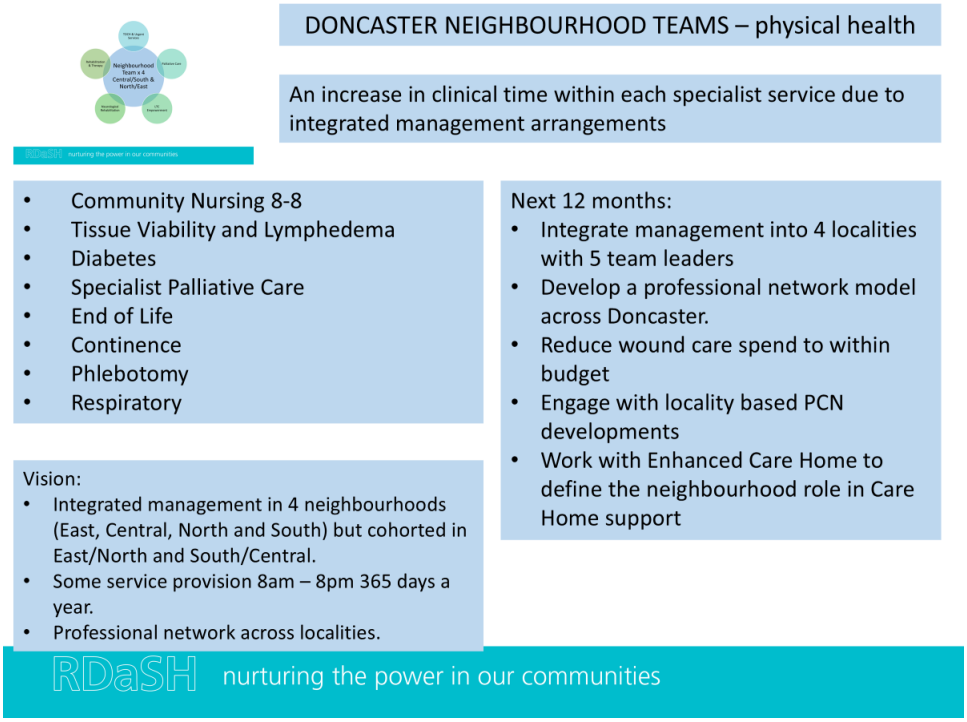
Summary of potential community clinical schemes:
all care group proposals are between 3.4-3.8% of budget (25/6)

Physical health services (adults and children)	Mental health services (adult and children)	Learning disabilities and forensics
• 912k FYE savings are proposed in **adult services. Expected to remove c19.16 roles** of which 4.42 are currently vacant. There are currently 14 'schemes' to achieve this; albeit some do not remove posts but move us closer to a new service model • There are 10 physical health schemes in children's services: saving c394k, with c **7.4 roles affected** of which 0.8 is vacant: changed shift patterns in sexual health is the largest of the schemes proposed.	• Children's service have 4 schemes **removing 2.71 wte** saving 327k: further consideration is being explored in respect of CAMHS productivity scheme which is half of the proposed savings. • Within adult mental health services there are approximately **35.57 posts removed** (of which 9.5 are vacant) • Doncaster: 14.16 (2 vac) saving 629k (4 schemes) • Rotherham savings 8.63 wte (3.6 vac) to save 445k (3 schemes) • North Lincs removes 7.08 posts (0.2 vac) to save 369k (10 schemes) • Trust Talking Therapies removing 5.7 posts (3.7 vac) saving 340k across seven schemes (which may reduce to six) • The total Adult Mental Health proposed saving is £1.783m	• 2 schemes are outlined, saving 349k – all within the Learning Disabilities service for adults (with a line report change in FOLs). These remove c **5.35 roles.** • Changes to art and music therapy will proceed but only having expanded the service to include North Lincolnshire.

4.4 It is recognised that proposals within physical health and neurodiversity, focused largely on the community/LTC directorate go beyond those needed to meet financial duties. These follow from a principle of generalism which care groups and the executive established at the outset of this change work. With the appointment of the community development director on December 19th, we anticipate during 2026/27 exploring how adult mental health services will, similarly, more closely wrap into neighbourhood working. *The physical health proposals for Doncaster reflect a strategic direction which is elegantly summarised within the two slides shown below* arising from a process that Cora Turner has led with considerable integrity and dedication.

By the end of 2026 we will have moved to services as below





5. Work left to do before the Board meets on January 8th

5.1 The focus of attention has been on staff engagement and on appraising the safety of the proposals. **Final validation is now required of protected characteristics of those who will be pooled and of roles likely to be removed by the proposals**. This will be completed over the coming period. Initial indications suggest that there are not obvious discrepancies, recognising that the largest single staff group impacted are within band 3 roles. The removal of a number of band 7 roles, highlighted in the QSIA report, follows from the changes to lead clinical roles specified above, recognising that in addition a number of changes are made to CNS and nurse consultant posts – as we look to focus senior clinical roles more on direct patient care.

5.2 The Board takes seriously our commitment to consider whether older adult services are being disproportionately affected by change. With changes during 2025/26, Doncaster services for older adults have not been included with further proposals for 2026/27: and a minimum of 250k of the investment fund has been pre-marked for older adult admission avoidance/virtual ward proposals. Older adult expenditure in the Trust when compared to working age adults for community services is on a ratio of 1:4. Within the cost proposals in this paper the impact ratio is 1: 7, suggesting it is lower: and noting the intended £250k investment for 26/7. We should recognise nonetheless that: we need to disproportionately consider older adult care, not least given its omission from the Ten-Year Plan mental health priorities.

5.3 The annual Investment Fund process started on November 25th and bids are due by January 16th: recognising pre-commitments to support therapeutic activities, the Real

Living Wage, and neighbourhood working, we have indicated that around £1.8m may be bid for, albeit the budget for 26/27 will anticipate slippage on that. We estimate that perhaps 15 new roles within the Trust may emerge from that process, which would be vacancies available to fill. Of course, with turnover of up to 10%, and an anticipation of some spike as we move towards year end, the vacancy position outlined at Annex C is not a fixed one.

5.4 **The Trust intends to consult employees over a single timetable. This is to ensure fairness in managing vacancy opportunities**. Following representations from trade union partners, rather than one consultation, four groups of schemes will proceed in parallel: learning disabilities, backbone changes, changes in children's services, and changes in adult care service (all age). It has not yet proved possible to agree a timetable leading up to the start of consultation, which we require to be not later than January 26th. Further meetings take place on December 22nd to finalise the partnership work needed during January.

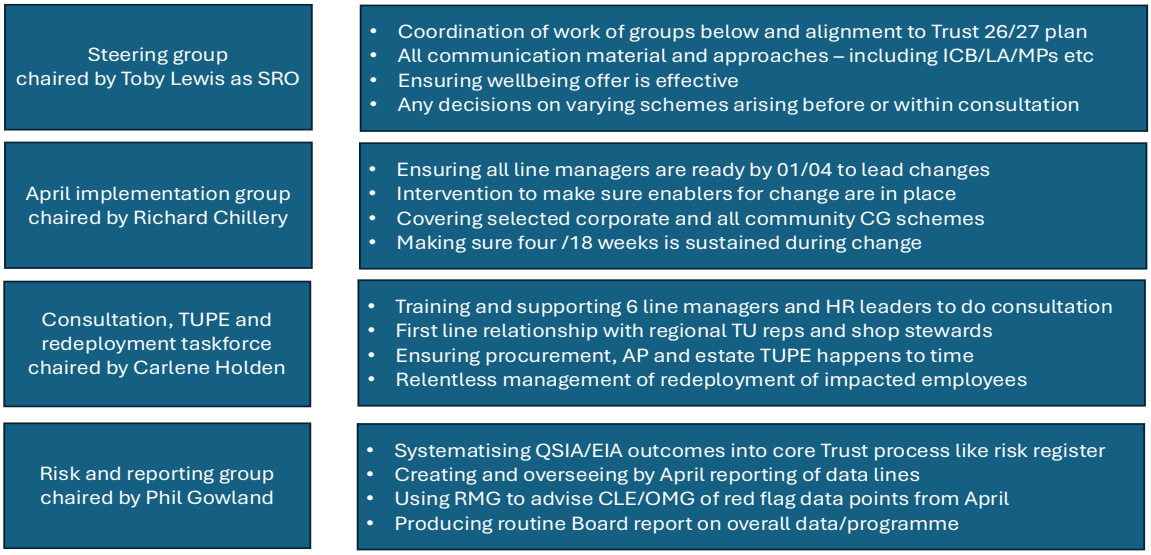
From that date, pre-scheduled one to ones will take place with impacted staff, with selection into roles using criteria (potentially including interview) to take place. Employees displaced by that selection process will then be intensively supported into suitable alternative employment – as the Board is aware that process will operate centrally, without resort to TRAC or multiple applications, and with centrally operated interview panels that remove the discretion of local line managers to make selection decisions in respect of displaced colleagues. We very much hope to have made offers to colleagues for new roles not later than March 31st.

There are a handful of consultative exercises which alter rotas which we suspect will take place outside the timetable described (for bandwidth reasons). The Board is also aware of two probable TUPE consultations, one related to financial change – the second of these, related to estates, cannot feasibly now take place by March and so will follow in Q1. Proceeding the first, for procurement, is contingent on partner sign off of the proposal which takes place later this month.

5.5 For some proposals within the process, only a single individual in a specific role is affected and is due consultation. For others, whilst role/roles are being likely removed, a wider pool of employees may be considered in competition for the resultant smaller number of roles. A process is needed to select from the larger pool those into roles. Recognising both the limitations of interview as a format, and the stress it can create, we are finalising proposed selection criteria, which may operate instead of (for some roles) or in addition to (for all). We expect these to be available to the Board for January 8th, recognising that engagement with trade unions on these criteria will proceed the commencement of consultation. Data validation on the information within those criteria would take place prior to consultation, but employees would also have an opportunity to see and challenge data about themselves.

5.6 **An overall architecture for supporting this process from January is summarised on the slide below**. It separates April implementation, includes a group focused solely on risk and data: and provides an authority structure for key decisions (the steering group, which as SRO I will chair). Before the end of March,

we will agree within the Board on the March 2027 evaluation process for these changes, which we will report in public and publish with our 2026/27 annual report.



6. **The focus of the Board's discussion**

6.1 Bearing in mind the information provided, in addition to prior meetings and papers, including scheme specific briefings of both EG and the non-executive group, it would be helpful if we were to:

- *Consider the sufficiency of processes that have developed the proposals*
- *Discuss any specific schemes from the annex B QSIA tables or from the seven bullet pointed items that the board wishes to debate*

- Recognise further work to do on the tracking data KPIs for schemes, which will be crucial to our implementation work and full year review
- Note the status of development work to commence consultation, recognising that that is better addressed when we meet on January 8th

All of the schemes represent change and risk. Where staff have devoted themselves to patient care and worked in a particular way over time it is right and understandable that many will seek to explain the disbenefits of changes. In taking these steps to better productivity, and in moving into neighbourhoods with more generalised care models, we should, however, recognise we are adapting as the service needs to.

There will be a Hawthorne effect of improving productivity from scrutiny. The bigger risk is that we create merely transactional relationships at work. That would be overreach. Managers and leaders should ensure transparency on performance, including scale and complexity of work. But our colleagues are professionals, working hard, and we want to see innovation. The focus of change proposed in this paper must not block out that light.

Toby Lewis, Chief Executive – December 12th 2025

Annex A: Example output from capacity/demand analysis used for key schemes

Estimating Opportunity

Early Intervention

Rotherham Doncaster and South Humber NHS Foundation Trust

F2F / Day

Directorate	Service Grouping	CC	Cost Centre	Estimated Productivity (F2F/Day)	Weighted Avg. Expected F2F/Da...	Budgeted Clinical WTE	In Post Clinical WTE	Forecast Activity / Week	Required WTE on Shift	Duty Responsi bilities	Uplift for A/L, Sickness & Traini...	Uplift for Vacancy Factor	Budgeted WTE	Identified Variance	Estimated Savings @ B6 (Mid AFC)
Community - Speciality	Early Intervention	Early Interventns in Psychosis	RQ0900	1.2	3.1	18.9	17.1	79	5.2	1.0	8.7	8.9	18.9	-10.0	-£ 476,894
Specialist	Early Intervention	Donc Early Intervention Psych - DE4055	DE4055	0.9	3.0	25.5	23.6	75.3	5.0	1.0	8.4	8.7	25.5	-16.9	-£ 805,858
Community	Early Intervention	NL Early Intervention Team	SS8019	1.7	2.6	8.9	8.4	63.1	4.8		6.8	6.9	8.9	-2.0	-£ 93,311

Total Contacts / Day

Care Group	Directorate	Service Grouping	CC	Cost Centre	Estimated Productivity (F2F/Day)	Weighted Avg. Expected F2F/Da...	Budgeted Clinical WTE	In Post Clinical WTE	Forecast Activity / Week	Uplift for Estimate d Lack of recordi...	Required WTE on Shift	Duty Responsi bilities	Uplift for A/L, Sickness & Traini...	Uplift for Vacancy Factor	Current WTE	Identified Variance	Estimated Savings @ B6 (Mid AFC)
RCG	**Community - Speciality**	Early Intervention	Early Interventns in Psychosis	RQ0900	2	5.1	18.9	17.1	121	120.7	4.8	1.0	8.1	8.3	18.9	-10.6	-£ 505,061
DCG	Specialist	Early Intervention	Donc Early Intervention Psych - DE4055	DE4055	1.9	5.0	25.5	23.6	132	132.0	5.3	1.0	8.8	9.0	25.5	-16.5	-£ 787,851
NLCG	Community	Early Intervention	NL Early Intervention Team	SS8019	3	4.6	8.9	8.4	105	104.8	4.5	1.0	7.8	8.0	8.9	-0.9	-£ 44,000

Annex B – QSIA for CIP Programme Dec 2025

1. Situation and Background

1.1 - What we have learned from previous transformation programmes is that we have a need to consider QSIA for the CIP proposals across the Trust from 3 perspectives (1) single schemes (2) collective schemes that may affect clusters of care pathways (i.e. schemes across specialism, or schemes where there is delivery by a specific staff group – i.e. AHPs) (3) the cumulative impact of all schemes.

1.2 - A request was therefore made for a QSIA panel to sit and review all schemes in one day. To enable this all Directors were requested to produce a consistent data pack for the QSIA conversation and both the Directorate Lead and CEO attended the panel to present. The panel was clinically focussed and consisted of the Chief Medical Officer, Chief Nurse, Director for Psychological Professionals and Therapies and also a Lived Experience Expert. This enabled the focus upon the changes from the 3 perspectives. The outcome of which will be provided in the remainder of this Annex.

2. Assessment

2.1 - Full QSIA checklists for all schemes are presented in section 4 of this document for transparency. Not all items will be expanded upon in this assessment section however, the main risks and benefits concerning quality and safety will be summarised.

2.2 - Specific points of discussion, concerning specific proposals and across Trust proposals -

2.21 – Risks

- Palliative care quality – the proposed change that concerns changing the hospice delivery model with an increased use of Woodfield 24 services. Whilst this will enable the same number of visits to patients and families, there is a potential skill set need considering the complete of this patient group. This risk will be mitigated by training and also supervision from the St Johns hospice service.

- Chaperoning – the changes suggest a reduction or ceasing of chaperones in the physical health directorate. This is based on no incidents occurring in this team related to risk of lone working. Whilst this change is understood, it is accepted that the current use of chaperones may be the reason why there is currently no incidents. In addition, it is understood that chaperones are not always used for safety they may also be for assisting with an intervention, and / or carrying equipment. What has therefore been suggested in the QSIA process is a middle ground concerning reducing the number of chaperoned visits and having a clearer process concerning what would trigger the need for a chaperone visit.

- Children's leadership changes – there are a number of different clinical and managerial leadership changes proposed in the children's care group (i.e. part-time nurse consultant psychiatrist) as single proposals all have risk mitigations, however, as a collective in one care group potentiate a risk in terms of experience and redistributed leadership. For this reason, the CYP Quad team have been asked to explore the collective impact and also display this visually.

- Training/ development time – some of the schemes require training and development of staff in order to relocate workload or change team structures to enhance resilience. Examples of these schemes in the QSIA's include: the enhanced use of Woodfield 24 in palliative care pathways – or the formation of an all age single point of access and the development of staff who may only have worked in either children's or adults pathways. If this change is not progressed in a timely there may

be unintended risks whilst upskilling. This is the type of subject which will be governed by the implementation group which commences work in January.

- AOT proposals – there are proposals for adjustment in the AOT (Assertive Outreach Team) space. This service has been in focus nationally recently concerning the Nottinghamshire Inquiry. In addition we have had an internal focus due to the links with 3 changes over the past 2 years (1) the closure of Emerald and Coral units (2) the rewrite of the patient engagement policy, and the challenges with executing this with a patient group who may not to engage (3) the challenge with out of area placements and the opportunities for pathway connection that the High Dependency Unit (HDU) has. These risks were therefore explored in the QSIA process.

- Learning Disability proposals - From QSIA discussions there has been additional detail to be added into the plans which represents the proposals more completely enabling a more complete picture of the risks and benefits which the plan also brings.

  The current position of the Learning Disability service is that operational and clinical leadership is delivered within profession – so that nursing leadership provides both operational and clinical leadership to nursing, Occupational Therapy leadership provides both operational and clinical leadership to Occupational Therapist – the same for Speech and Language Therapy, Art / Drama Therapy and Physiotherapy.

  The proposal is to remove some posts – creating purely operational posts and centralise the operational functions of the service into these roles – releasing clinical capability from the current clinical leads.

  Whilst this release is beneficial there are overall risks that will need monitoring as the scheme progresses, specifically –

    The reduction in Art / Dramatherapy hours will introduce a risk of increased waiting times for people requiring this intervention. As Art / Dramatherapy is a key intervention in enabling access for people with learning disabilities to access psychological therapies – there is a risk that more people with learning disabilities will not be able to access psychological therapies or will wait longer.

    The move for all the professions to clinical leadership in three places will place additional demand on the posts who currently lead in one or two places. Note that this leadership will also hold a complex caseload across all three places therefore this will increase travel. Robust job planning will account for some of this – however the demands on the individuals in these roles should be recognised as a risk.

    The reduction in Speech and Language Therapy introduces a risk that people with learning disabilities will have less access to assessment and management for complex dysphagia. Aspiration Pneumonia (a consequence of dysphagia) is still the leading cause of death in people with Learning Disabilities

  Because a significant proportion of the work delivered in learning disability services is not face-to-face, it is likely that the data in the service does not reflect the productivity in the service. There is a risk if this data is used to make judgements on the productivity of staff. And therefore data accuracy and activity management must be a part of the change process.

2.22 – Benefits

Neighbourhood focus – Through all of the schemes, and most evident in the physical health directorate change plans is the consistency with the RDaSH Clinical and Organisational Strategy and the NHS 10 year plan's focus upon neighbourhood working. This has multiple benefits and will enable better across organisational working for the benefit of patients and families.

Focus on maintaining clinical placements and supervision capacity - Within all of the schemes proposed there has been a consistent assurance provided that the change plans will not effect the Trusts contractual and higher than contractual offer for practice placements across all non-medical disciplines. This is extremely positive as we know where trainees and students work there is often a higher standard of care and there are specific recruitment and retention benefits also when these aspects are considered.

In terms of the medical capacity, the only placement concern regards where there has been a suggested post removal. This requires more detail and this has escalated linked with this point to both reduce risk, but also ensure future proofing for the service.

Safe staffing focus – where safe staffing levels are nationally set, or advocated, the panel asked of each presenting director whether the proposals would impact upon job plans or safe staffing levels. All who presented had been cognisant of these level, and provided descriptive and numerical data in terms of how safe staffing levels will be maintained.

Focus upon potential redistribution of resources – some of the proposals advocate the change of team makeup and the removal of some roles. Where as in other parts of the care group and wider organisation there is a workforce challenged in terms of similar roles. At the QSIA discussion colleagues not only focussed about quality and safety, they also spoke about the potential for new opportunities for potentially displaced staff, which appeared to be positive in terms of retaining talent.

Improved use of data to drive suggestions - The QSIA proposals collectively had a stronger use of quantitative data. Which supported a more transparent discussion in terms of capacity and demand linked with quality and safety. The qualitative aspects of the impact however still need development.

Focus upon manageable management capacity – in terms of the managerial capacity proposed changes, all of the directorates ensured that the principle of 'not managing more than 10 staff directly' was followed. This not only support managerial 'headroom' and capability, but also ensures consistency in terms of management approach which overall trust risk.

2.3 – Cumulative load reflections

To progress this scale of change, despite of individual mitigations has risks, in terms of capacity to make change, capability and productivity impacts considering for those impacted upon directly. Leaders in the QSIA discussions reflected upon this, and also management strategies / resource which will be needed in terms of the pathway changes, team integration, workforce development and job plan changes. The support for exploring the cumulative impact and also managerial development is considered a positive learning / managerial development.

Detailed workforce analysis is being conducted concerning those potentially affected by the proposed changes. This will analyse effect in terms of professional group, protected characteristics and pay scale. This supports the QSIA and also EIA process. From an initial view of data, there is not an equal effect on all service, this is not necessarily an issue in itself as CIP was not allocated on a proportionate basis, and not all service baselines are resourced richly. However it would be remiss not to note the themes in the collective schemes which are -

- Higher number of B3 and B7 positions proposed to be removed. *Why is this an issue at RDaSH?* These two AfC Band ranges are significant in RDaSH as they are often seen as pivotal career points. The Band 3 is typically a starter point for things like professional training, apprenticeships and also has been a band range where NHSP has been used in the recent past. B7 is typically a level of lower management, or a jump from clinician to advanced practice or consultancy level practice.

- Higher number of therapeutic professionals proposed to be removed, when considering the % Trust staff make up with other professional groups. *Why is this an issue at RDaSH*? This is concerning when there are significant waits for some therapeutically led treatments, and also where length of stay is at times elongated potentially due to the lack of specific therapeutic engagement.

- Older Peoples services appear slightly disproportionally in focus in North Lincolnshire and Rotherham if compared with adult and children's services. *Why is this an issue at RDaSH?* A core part of our Trust strategy is reducing health inequalities, and also focussing on health in older age. We have a further commitment to parity in March 2025, and this issue is addressed in the cover paper.

2.4 - Qualitative and quantitative measures to enable PDSA cycles to monitor change effects

Behind each of the directorate proposals there are recommended measures in terms of quality and safety. They will not all be listed here. For the larger risks discussed through the QSIA process, outlined in section 2.2, there are the following suggested measures which will be used in order to track any changes in terms of quality and safety and enable both learning and also early intervention should the change not progress as anticipated. Below are the suggested areas of success measures and performance indicators for the risks identified in section 2.21.

	Palliative Care Quality – Increased Use of Woodfield 24
Success Measures (outcomes)	- Patients and families report no reduction in quality of palliative care after the model change. - Woodfield 24 Staff feel confident and competent to support complex palliative needs. - Care remains safe, with no increase in clinical incidents or avoidable harm.
KPIs (Measurable Indicators)	- % of staff completing enhanced Woodfield 24 palliative training (target: >95%). - Number of clinical incidents or near misses related to palliative skills gaps (target: zero or downward trend). - Family/carer satisfaction scores from palliative care surveys (target: maintain or improve baseline). - Timeliness of visits (e.g., % visits delivered within planned timeframe).
	Chaperoning Changes in Physical Health Directorate
Success Measures (outcomes)	- Safe patient care continues with no increase in safety incidents following reduced chaperone use. - Clear, consistently followed decision-making framework for when chaperones are required. - More efficient visit scheduling through partnership working with neighbourhood-based services.

KPIs (Measurable Indicators)	- Number of incidents related to lone working or absence of chaperones (target: zero). - % of visits documented with correct chaperone decision recorded (target: >95%). - % of joint visits completed with partner agencies (baseline & improvement target). - Staff compliance with new chaperone protocol (audit score target: >90%).
	Children and Young People leadership changes
Success Measures (outcomes)	- Leadership across the Children's Care Group remains stable, visible, and effective after changes. - Quality, safety, and staff wellbeing not negatively affected by redistributed leadership roles. - CYP Quad team completes and shares a clear visual impact map of leadership capacity.
KPIs (Measurable Indicators)	- Leadership visibility audits (e.g., % of teams reporting regular contact with clinical/managerial leaders). - Staff survey scores on confidence in leadership (target: maintain or improve). - Delivery of CYP Quad leadership impact map by agreed deadline. - Number of quality or safety escalations linked to leadership gaps (target: zero).
	Training and development time for new care models
Success Measures (outcomes)	- Staff demonstrate competence in new skills (e.g., Woodfield 24 competencies, all-age SPA skills). - Safe transition with no incidents linked to skill gaps during implementation. - Training delivered on time, supporting safe service redesign.
KPIs (Measurable Indicators)	- % of staff who complete required training before go-live (target: >95%). - Time taken to deliver full training programme against planned timescale. - Number of incidents linked to insufficient training or transition risks (target: zero). - Competency assessment pass rate (target: 100% or >95%).
	Assertive Outreach Team Proposals
Success Measures	- Service changes do not negatively impact patient engagement or safety. - Learning from the Nottinghamshire Inquiry is demonstrably embedded. - Joined up working across pathways (HDU, community, OOA placements) is strengthened.
KPIs (Measurable Indicators)	- Patient engagement rate (e.g., % of planned contacts completed; target: maintain or improve). - Number of incidents, SIs, or near misses in AOT (target: reduction or zero). - % of staff trained in updated patient engagement policy (target: >95%). - Number and length of out-of-area placements (target: reduction trend). - HDU–AOT pathway connection audit compliance (target: >90%).

3. Potential focus of discussion

3.1 – The Board of Directors consider the benefit of the method used for QSIA, the QSIA panel and also the focus upon the three lenses of potential effect.

3.2 – The Board of Directors has a summary of the main risks and benefits considering both the individual and collective QSIA's conducted. Whilst any change of this scale is not without risk, the board should consider the transparency in terms of the potential, and also intention to have a clear series of progress KPI's related to the changes to individual and collective effect. This will be linked with the 'always measures' and quality and safety delivery plan.

3.3 – The Board of Directors should note that the consideration for further impact assessments were considered with all schemes at the QSIA panel. These impact assessments are: DPIA (Data Protection Impact Assessment, and EIA (Equality Impact Assessment). No schemes were identified as requiring a DPIA. Certain schemes which effect i.e. those living in rural areas, those which require digital access and those that effect people with protected characteristic will require a an Equality Impact Assessment (EIA).

3.4 – The Board Consider the suggested 'success measures' and 'KPI's within the main body of the paper linked to the larger risks and also within the separate QSIA sheets at the end of this pack. These will be finalised before the middle of January and considered at the Quality Committee. They will be further considered at the conclusion of the consultation.

4 QSIA (Summary Feedback Sheets) (☑ = effect X = no effect)

4.1 - Directorate: - Physical Health Care Group Date: 8/12/25 QSIA Panel – CNO / CMO / CPPTO / Lived Experience Expert

What is the change being proposed → QSIA Domain ↓	Proposal 1	Proposal 2	Proposal 3	Proposal 4	Proposal 5	Proposal 6	Proposal 7
1. Patient Safety							
Could the change increase risk of harm to patients?	☑	X	X	X	X	X	☑
Does the change impact on how risk is managed?	☑	X	☑	X	☑	X	☑
Are there risks related to medication?	X	X	X	X	X	X	☑
Are there risks to physical health of the patient?	X	X	X	X	X	X	☑
2 Quality Safety and Effectiveness							
Will this change access to care/ waiting times?	X	X	☑	X	X	X	☑
Will this impact on clinical standards (i.e. NICE adherence)?	X	X	X	X	X	X	X
Does this effect diagnostic accuracy?	X	X	X	X	X	X	X
Does this impact on treatment efficacy?	X	X	X	X	X	X	X
Does this impact on treatment monitoring?	X	X	X	X	X	X	X
3. Patient and Carer Exp3erience							
Will the change impact patient choice?	X	X	X	X	X	X	X
Will the change impact upon care personalisation?	X	X	X	X	X	X	X
Will the change impact on carer support/ involvement?	☑	X	X	X	X	X	X
Will the change potentiate patient / carer complaints?	☑	X	X	X	X	X	X
4. Workforce, culture and Wellbeing							
Does the change increase workload?	☑	X	X	X	X	☑	☑
Will the change alter roles / job plans?	☑	X	X	X	X	☑	X
Does the change create staff risks (i.e. lone working)?	X	X	X	X	X	X	☑
Does the change impact upon training needs?	☑	X	X	X	X	X	X
Does the change impact upon supervisory availability?	☑	X	X	X	X	☑	☑
Does the change impact upon placement provision?	X	X	X	X	X	X	X
Does the change have issues related to retention?	☑	X	X	X	X	X	☑
Will the change effect workforce inequalities?	X	X	X	X	X	X	X
5. Health Inequalities							
Does the change effect protected groups?	X	X	X	X	X	X	X
Does the change affect those in rural areas?	X	X	X	X	X	X	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X	X	X	X	X
6. Legal /Regulatory / Safeguarding							
Are there implications for Safeguarding?	X	X	X	X	X	X	X
Are there MHA or MCA implications?	X	X	X	X	X	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X	X	X	X
7 Dependencies / System Impact (inc Resource)							
Does the change impact on other team's resource?	☑	X	X	☑	X	X	☑
Does the change rely on an external partner?	☑	X	X	☑	X	X	☑
Does the change create any service gaps?	☑	X	X	☑	X	X	☑
Are the system partners supportive? (if applicable)	X	X	X	☑	X	X	☑
8. EIA Monitoring							
Is there a risk of discrimination (in any protected category)?	X	X	X	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X	X	X	X
Will the change restrict patient rights?	X	X	X	X	X	X	X
Will the change impact on staff rights?	X	X	X	X	X	X	☑
9. Impact on Promises (insert promise number)							X
10. Impact on RDaSH 5 (insert 1-5)							X

What is the change being proposed → QSIA Domain ↓	Proposal 8	Proposal 9	Proposal 10	Proposal 11	Proposal 12:	Proposal 13	Proposal14
1. Patient Safety							
Could the change increase risk of harm to patients?	X	X	X	X	X	X	X
Does the change impact on how risk is managed?	X	X	X	X	X	X	X
Are there risks related to medication?	X	X	X	X	X	X	X
Are there risks to physical health of the patient?	X	X	X	X	X	X	X
2 Quality Safety and Effectiveness							
Will this change access to care/ waiting times?	X	X	X	X	X	X	X
Will this impact on clinical standards (i.e. NICE adherence)?	X	X	X	X	X	X	X
Does this effect diagnostic accuracy?	X	X	X	X	X	X	X
Does this impact on treatment efficacy?	X	X	X	X	X	X	X
Does this impact on treatment monitoring?	X	X	X	X	X	X	X
3. Patient and Carer Experience							
Will the change impact patient choice?	X	X	☑	☑	X	X	X
Will the change impact upon care personalisation?	X	X	☑	X	X	X	X
Will the change impact on carer support/ involvement?	X	X	X	X	X	X	X
Will the change potentiate patient / carer complaints?	X	X	☑	☑	X	X	X
4. Workforce, culture and Wellbeing							
Does the change increase workload?	X	X	X	X	☑	☑	☑
Will the change alter roles / job plans?	☑	X	X	X	X	X	☑
Does the change create staff risks (i.e. lone working)?	X	X	X	X	X	X	X
Does the change impact upon training needs?	X	X	X	X	X	X	☑
Does the change impact upon supervisory availability?	X	X	X	X	X	X	☑
Does the change impact upon placement provision?	X	X	X	X	X	X	☑
Does the change have issues related to retention?	X	X	X	X	X	X	X
Will the change effect workforce inequalities?	X	X	X	X	X	X	X
5. Health Inequalities							
Does the change effect protected groups?	X	X	X	X	X	X	X
Does the change affect those in rural areas?	X	X	X	X	X	X	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	☑	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	☑	X	X	X	X
6. Legal /Regulatory / Safeguarding							
Are there implications for Safeguarding?	X	X	X	X	X	X	X
Are there MHA or MCA implications?	X	X	X	X	X	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X	X	X	X
7 Dependencies / System Impact (inc Resource)							
Does the change impact on other team's resource?	☑	☑	☑	☑	☑	☑	☑
Does the change rely on an external partner?	X	X	X	X	X	X	X
Does the change create any service gaps?	X	X	X	X	X	X	X
Are the system partners supportive? (if applicable)	X	X	X	X	X	X	X
8. EIA Monitoring							
Is there a risk of discrimination (in any protected category)?	X	X	X	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X	X	X	X
Will the change restrict patient rights?	X	X	X	X	X	X	X
Will the change impact on staff rights?	X	X	X	X	X	X	X
9. Impact on Promises (insert promise number)							
10. Impact on RDaSH 5 (insert 1-5)							

Any additional questions –

Questions asked –

1. *Will this effect clinical placement capacity* – No- in either Nurses or AHP as there is capacity for all the current and future placement increase of 25% or above if required.

2. *Starter roles* - With the removal of a number of B5 roles, is there a risk in terms of starter roles and newly qualified roles (Typically nurses and AHPs). No problems with recruitment identified, other B5 roles are available.

3. *There is concerns about lone working in terms of the chaperone discussion* – discussed that the staff concerns are acknowledged, and that there is more work that needs doing should this proposal be progressed. Discussed that the risks and incidents do not suggest that there is an issue that needs the level of chaperoning currently used. However there could be an argument that because of the level of staffing and use of chaperones, then the risk is managed which is the reason for the lower risks and issues.

   Discussed that there will be potentially two solutions to mitigate against the risks (expanded below – specifying who needs 2 on a visit and how we work with other organisations i.e. YAS and Woodfield 24 in order to provide the chaperone if required). The need for a chaperone can be for multiple reasons, safety only being one. Others include carrying equipment and also some procedures requiring more than one member of staff.

   Other potential risks were discussed, considering the written concern received as part of the change discussion process. The final risk pertains to the fact that some of the team are early in their career and so many not be experienced in the same way and therefore the 2nd worker supports not only in terms of carrying equipment and supporting interventions that require 2 people – it also means that the experience of the B3 feeds into the consultation and therefore quality of care.

4. *Does the managerial and AHP changes effect Specialism* – SALT and Dietetics have an increase combination in terms of specialism, the similarities are high (i.e. dysphasia work) therefore the risks are low. In addition there are partner Trusts who have specialists in these areas who can be drawn upon in terms of supervision if required.

   The second area examined was wheelchair services - there are issues when discussing wheelchair services and whether they fit better neuro-injury services or empowerment services. These clinical alignments will be explored as the change progresses. The service would be expected to work in a joined up way despite of where in the care group they are line managed and therefore the risk is mitigated.

5. *Interdependency* - There is work that is conducted that is dependant on multi-agency activity i.e. (1) primary care – and care home liaison (2) care home quality – this is a requirement to discuss with the ICB and LA (3) DBTH discharge nurse and physiotherapy – DBTH are conducting their own transformation at this time and therefore any changes made that are partner dependant must also factor this in.

6. *Quality issues* – the main service that is identified as having quality changes is the move of some of the specialist palliative services to Woodfield 24. It was acknowledged that this will affect quality, but that this will be mitigated via a training, development and supervision of the Woodfield 24 team. The quality reduction is not stated to incur risk though.

7. *Managerial capacity* – there is significant managerial change being proposed when the schemes are considered across care group. It was explored whether any of the schemes breech the principles set out in terms of not managing more than 10 people. The answer was not – except wheelchair services which will be on a level with the maximum expected number of people to manage.

8. *Nomenclature* – the naming of clinical leads is an anomaly, the roles called this that are due to be reviewed as part of the process are managerial with very little clinical components.

9. DOCCLA Digital support – you have said there is potentially a risk in terms of the digital monitoring. It was confirmed the funding has been paid for this year, and CEO agreed in the QSIA that this is permanent/concurrently funded from within the PHCG budget allocation.

Comments re any risks of proposals –

- All questions were answered in the QSIA process.
- No additional information was requested from the care group.

Comments were suggested -

- Work on chaperone and lone working – supported by health and safety in N&F and looking at partner working in terms of Woodfield 24.
- Placement team situation to be considered also with L&D as it is only PHN and CYPCG who have the roles internal rather than centralised.
- Ensure future naming is consistent – i.e. managerial or clinical leads
- Non-care group action – action for across trust leads – clinical leads as a name should be looked at accross

4.2 Directorate: - Children and Young People Date: 8/12/25 QSIA Panel – CNO / CMO / CPPTO / Lived Experience Expert

What is the change being proposed → QSIA Domain ↓	Proposal 1	Proposal 2	Proposal 3	Proposal 4	Proposal 5	Proposal 6	Proposal 7
1. Patient Safety							
Could the change increase risk of harm to patients?	X	X	X	X	☑	☑	☑
Does the change impact on how risk is managed?	X	X	X	X	☑	☑	☑
Are there risks related to medication?	X	X	X	X	X	☑	☑
Are there risks to physical health of the patient?	X	X	X	X	X	X	☑
2. Quality and Clinical Effectiveness							
Will this change access to care/ waiting times?	☑	X	X	X	☑	☑	☑
Will this impact on clinical standards (i.e. NICE adherence)?	X	X	X	☑	X	☑	☑
Does this effect diagnostic accuracy?	X	X	X	X	X	☑	X
Does this impact on treatment efficacy?	X	X	X	X	X	☑	X
Does this impact on treatment monitoring?	X	X	X	X	X	☑	X
3. Patient and Carer Experience							
Will the change impact patient choice?	X	X	X	X	☑	☑	X
Will the change impact upon care personalisation?	X	X	X	X	☑	☑	X
Will the change impact on carer support/ involvement?	X	X	X	X	X	☑	X
Will the change potentiate patient / carer complaints?	X	X	X	X	☑	☑	X
4. Workforce, Culture and Wellbeing							
Does the change increase workload?	☑	☑	X	X	X	☑	X
Will the change alter roles / job plans?	X	☑	X	☑	☑	☑	☑
Does the change create staff risks (i.e. lone working)?	X	X	X	X	X	X	X
Does the change impact upon training needs?	X	X	☑	X	X	☑	X
Does the change impact upon supervisory availability?	X	X	☑	X	X	☑	X
Does the change impact upon placement provision?	X	X	X	X	X	☑	X
Does the change have issues related to retention?	X	X	X	X	X	☑	X
Will the change effect workforce inequalities?	X	X	X	X	X	☑	X
5. Health Inequalities							
Does the change effect protected groups?	X	☑	X	X	X	☑	X
Does the change affect those in rural areas?	X	X	X	X	X	X	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X	X	X	X	X
6. Legal / Regulatory / Safeguarding							
Are there implications for Safeguarding?	X	☑	X	X	X	X	X
Are there MHA or MCA implications?	X	X	X	X	X	☑	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X	☑	X	X
7. Dependencies / System Impact (including Resource)							
Does the change impact on other team's resource?	X	☑	X	X	X	☑	X
Does the change rely on an external partner?	X	X	X	X	X	X	X
Does the change create any service gaps?	X	X	X	X	X	X	X
Are the system partners supportive? (if applicable)	X	☑	X	X	X	X	X
8.EIA impacts							
Is there a risk of discrimination (in any protected category)?	X	X	X	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X	X	X	X
Will the change restrict patient rights?	X	X	X	X	X	X	X
Will the change impact on staff rights?	X	X	X	X	X	X	X
9. Impact on Promises (insert promise number)							
10. Impact on RDaSH 5 (insert 1-5)	X	X	X	X	X	X	X

What is the change being proposed → QSIA Domain ↓	Proposal 8	Proposal 9	Proposal 10	Proposal 11	Proposal 12	Proposal 13	Proposal 14
1. Patient Safety							
Could the change increase risk of harm to patients?	☑	X	X	X	X	X	X
Does the change impact on how risk is managed?	☑	X	X	X	X	X	X
Are there risks related to medication?	X	X	X	X	X	☑	X
Are there risks to physical health of the patient?	X	X	X	X	X	X	X
2. Quality and Clinical Effectiveness							
Will this change access to care/ waiting times?	X	X	X	☑	X	X	X
Will this impact on clinical standards (i.e. NICE adherence)?	X	X	X	X	X	X	X
Does this effect diagnostic accuracy?	☑	X	X	X	X	X	X
Does this impact on treatment efficacy?	☑	X	X	X	X	X	X
Does this impact on treatment monitoring?	☑	X	X	X	X	X	X
3. Patient and Carer Experience							
Will the change impact patient choice?	X	X	X	X	X	X	X
Will the change impact upon care personalisation?	X	X	X	X	X	X	X
Will the change impact on carer support/ involvement?	X	X	X	X	X	X	X
Will the change potentiate patient / carer complaints?	X	X	X	X	X	X	X
4. Workforce, Culture and Wellbeing							
Does the change increase workload?	☑	☑	☑	☑	☑	X	X
Will the change alter roles / job plans?	☑	X	X	X	☑	X	X
Does the change create staff risks (i.e. lone working)?	X	X	X	X	X	X	X
Does the change impact upon training needs?	X	X	X	X	X	X	☑
Does the change impact upon supervisory availability?	☑	X	X	X	X	X	☑
Does the change impact upon placement provision?	X	X	X	X	X	X	☑
Does the change have issues related to retention?	☑	X	X	X	X	X	☑
Will the change effect workforce inequalities?	X	X	X	X	X	X	X
5. Health Inequalities							
Does the change effect protected groups?	X	X	X	X	X	X	X
Does the change affect those in rural areas?	X	X	X	X	X	☑	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X	X	X	X	X
6. Legal / Regulatory / Safeguarding							
Are there implications for Safeguarding?	X	X	X	X	X	X	X
Are there MHA or MCA implications?	X	X	X	X	X	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X	X	X	X
7. Dependencies / System Impact (including Resource)							
Does the change impact on other team's resource?	☑	X	X	X	X	☑	☑
Does the change rely on an external partner?	X	X	X	X	X	X	☑
Does the change create any service gaps?	X	X	X	X	X	X	☑
Are the system partners supportive? (if applicable)	X	X	X	X	X	X	☑
8.EIA impacts							
Is there a risk of discrimination (in any protected category)?	X	X	X	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X	X	X	X
Will the change restrict patient rights?	X	X	X	X	X	X	X
Will the change impact on staff rights?	X	X	X	X	X	X	X
9. Impact on Promises (insert promise number)				X		X	X
10. Impact on RDaSH 5 (insert 1-5)				X		X	X

Additional questions asked at the QSIA panel –

Sexual exploitation role – This post was introduced as additional to service spec as good practice. Since the introduction there has been a broader expansion in the wider system which differentiates the need. There have also been changes in system partners awareness and responsibilities in this area – specifically in terms of the police and Barnardo's. There is also in the safeguarding team that provides cross cover. All of these factors act as mitigations for the proposals and minimise risks to quality and safety.

Practice educators – the post proposed to be removed is an educator. This vacancy has not been filled for some time, and there hasn't been access to a place in NL for some time.

Therefore the changes proposed are likely to have minimal impact. However, there is a potential to discuss with the People and OD teams who host the other directorates (apart from P) practice educators (who are not in CYP and PHN Care Group about cross cover and cross working for parity and resilience).

Senior post removal – nurse consultants and medical consultants are currently in post, and also there are proposals for removal. This situation poses a potential across professional risk, a risk for senior supervisory capability and also a risk in terms of clinical leadership coverage, it was therefore understood why they have been put as separate proposals but there is a need also to consider the collective impact of the = B7, B8a and B8b Nurse – as well as a medical consultant. There were discussions in the meeting that there are two 8a ACPs that are also completing training and due to commence in full positions from January 2026, however these are not across all pathways, and provide a difference in terms of seniority and experience, and although they account for low patient contact time, the patients are often complex and therefore there is a potential impact for direct care for patients, and families. As it was difficult to understand the pathway cover, it was requested that for completeness a full leadership 'as is' and 'to be' diagram be presented so that the quality, safety, patient, supervisory and placement implications could be considered.

5-19 scheme – team leader alignment is proposed, to ensure equity as there are different numbers of staff in different teams. In addressing the equity issue, there is an expectation that capacity will be created to focus on the data quality issues and also data handling issues that have been identified as problematic in the service. This in turn should improve service quality.

Bus Driver – the fact that there is currently only one driver, is a risk – however there are opportunities for internal discussion both in terms of volunteer driver opportunities and also opportunities from different care groups should cross cover be considered. This service is not solely an information and health promotion service it is also a service, where clinics run from (i.e. TB clinics). The mobile nature of this effects people who may have inequalities in terms of poverty and travel and also for rural sites or sites / areas not easily accessible by public transport routes, which need to be considered if the reduction is pursued.

Supervision – the reduction in psychotherapy supervision has a potential impact on the post holder who is part time due to a retire and return. Agreed that this risk will be discussed and overcome between the two directors responsible for the services worked across. In terms of the supervision gap this reduction creates, it is specialist and so there is limited capability in the Trust and so to mitigate the care group leads explained that they will look to gain supervision from partnership working with SCH and SWFT – for the child psychotherapy.

5. *Senior nurse supervision*, with the 8b removal the supervision will move to a medical doctor. This has an impact on medical time, specifically where there is another proposal to take out another medical post, and also senior nurse consultants. More information is required to consider this risk.

Job planning and placement capacity in terms of medical provision – this will need reviewing in terms of the propose removal of the 8b nurses and the movement of the supervision. There is also a risk in terms of the placement capacity for doctors and therefore this will impact on the pipeline of doctors in an area that is extremely difficult to recruit to and there has been a premia been in place before. More information is therefore needed to consider the quality and safety impact of the collective proposals.

Other medical issues – (1) Registered educators will need maintaining to ensure training scheme doctors are supported (which will then support pipeline). (2) current placement issues are raised, this will be dealt with outside of this QSIA and CIP process (3) there needs to be a consideration about the potential impact on clinical patient hours if supervision is moved and trainees are allocated to remaining clinicians.

Model fidelity – the WMIM model fidelity has a risk with the proposals. In other parts of the Trust (i.e. core 24, EIT) we do not have full model fidelity to nationally advocated structures, but these services still achieve outcomes. Therefore an internal decision is possible, accepting there may be external attention and increased scrutiny because of the deviation against the standard. This issue was discussed further. The directors recognised that the WMIM team have raised a concern about how this may reflect on their 'outstanding' service rating and therefore how staff feel in terms of working into an "outstanding service".

REQUEST FROM CARE GROUP IN TERMS OF FOLLOW UP INFORMATION FOR QSIA COMPLETENESS –

- Produce a capacity diagram in terms of productivity.

  Clinical Leadership diagram in terms of the posts
- Show proposed job plans for medical members of staff (including cover arrangements).

Comments re any risks of proposals –

Job planning will need looking at in terms of medical staff – this is due to taking on the supervision of non-medical staff and the removal of a post.

Interdependences of the proposed reduction with safeguarding (internal to care group and external and in backbone services i.e. N&F safeguarding cover leave) to be considered.

Discussions with Director for People and OD about where practice educators sit outside of the learning and development team (this is really only with the Children's care group and the physical health care group)

Considerations of the cumulative effect of the leadership (clinical roles) and impact this would have upon leave cover, sickness cover and also general patient needs.

Digital options may be beneficial to explore in terms of economies of scale.

Bus discussions – other care group discussion in terms of shared driving as well as in other services.

4.3 Directorate: - Doncaster MH Community Date: _8/12/25_ QSIA Panel – CNO / CMO / CPPTO / Lived Experience Expert

What is the change being proposed → QSIA Domain ↓	Proposal 1	Proposal 2	Proposal 3	Proposal 4
1. Patient Safety				
Could the change increase risk of harm to patients?	X	☑	☑	☑
Does the change impact on how risk is managed?	☑	☑	☑	☑
Are there risks related to medication?	X	X	X	X
Are there risks to physical health of the patient?	X	☑	☑	X
2. Quality Safety and Effectiveness				
Will this change access to care/ waiting times?	☑	☑	☑	☑
Will this impact on clinical standards (i.e. NICE adherence)?	☑	☑	☑	☑
Does this effect diagnostic accuracy?	X	X	X	X
Does this impact on treatment efficacy?	X	☑	☑	☑
Does this impact on treatment monitoring?	X	☑	☑	☑
3. Patient and Carer Experience				
Will the change impact patient choice?	☑	☑	☑	X
Will the change impact upon care personalisation?	☑	☑	☑	X
Will the change impact on carer support/ involvement?	☑	X	X	X
Will the change potentiate patient / carer complaints?	☑	X	X	X
4. Workforce, Culture and Wellbeing				
Does the change increase workload?	☑	☑	☑	☑
Will the change alter roles / job plans?	☑	☑	☑	☑
Does the change create staff risks (i.e. lone working)?	☑	X	X	☑
Does the change impact upon training needs?	X	X	X	X
Does the change impact upon supervisory availability?	X	X	X	X
Does the change impact upon placement provision?	X	X	X	X
Does the change have issues related to retention?	X	X	X	X
Will the change effect workforce inequalities?	X	X	X	X
5. Health inequalities				
Does the change effect protected groups?	X	X	X	X
Does the change affect those in rural areas?	X	X	X	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X	X
6. Legal / regulatory / safeguarding				
Are there implications for Safeguarding?	X	X	X	X
Are there MHA or MCA implications?	X	X	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X
7. Dependencies / System impact				
Does the change impact on other team's resource?	X	X	X	X
Does the change rely on an external partner?	X	X	X	X
Does the change create any service gaps?	X	X	X	X
Are the system partners supportive? (if applicable)	X	x	x	X
8. EIA Monitoring				
Is there a risk of discrimination (in any protected category)?	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X
Will the change restrict patient rights?	X	X	X	X
Will the change impact on staff rights?	X	X	X	X
9. Impact on Promises (insert promise number)				
10. Impact on RDaSH 5 (insert 1-5)				

Any additional questions –

- *Costings for EI* – discussed that when DCG is compared to internal team (Roth in NL) the cost per patient supported by the service is higher. That said this is the only Trust EI team that has the NCAP status in the organisation in terms of EIT. No national comparisons available by the presenter in the QSIA panel, this made it difficult to see if the staffing model proposed is unaligned with NCAP standards: care group reassurance was offered that the standards would still be met, but documentation is coming.

- *Employment coordinator* – discussed the potential for work being taken up by other agencies. This is the case.

- *Levels of sickness* – the current proposals are partly put forward linked with the current capacity and demand with a higher than Trust level of sickness in the Ei service (approx. double) calculations of need are based on reducing the team sickness rate to the trust target of sickness.

- *Therapeutic reduction* – CBT therapist reduction, and also DBT reduction is proposed. This was questioned as DCG has the lowest rate of psychological workforce per head of population between the two care groups and also there was a 18 month wait for intervention. This is now thought to have reduced to 28 weeks, but that is still outside of the Trust targets, and therefore the proposed reduction risks longer waits for people.

  The therapeutic reduction presented by DCG lacked comparison with other 'like for like' services in the other two adult mental health care groups. This potentiates a post code lottery in terms of treatment availability in different care groups. It was requested that this is clarified before progressing, as there is potentially either a health inequality introduced linked with Doncaster plans or a need to review the capacity and demand in the other two place based services.

- *Primary care* – There is a proposal to remove CAP and psychology from DCG but not from other care groups. Removal is stated to be linked in part to there being no supervisor, rather than whether there is a demand. However, there are psychologists in the wider care group that could be considered. Waiting times in terms of the high level and low-level interventions in the pathway were not made available in the QSIA panel in terms of primary care, which made it difficult to identify the quality and safety impact. As an output of the panel, it was was agreed to reconfirm the wait time impact.

- *AOT* – the current proposal is to reduce the team size. This is consistent with Rotherham, not North Lincolnshire (who do not have a service). The question is that the disengagement care group proposals but not process can be followed by the team and also care planning is important but currently low. This issue requires further information in order to progress the QSIA, especially in light of the Nottingham inquiry findings.

4.4 Directorate: - North Lincolnshire MH Date: 8/12/25 QSIA Panel – CNO / CMO / CPPTO / Lived Experience Expert

What is the change being proposed → QSIA Domain ↓	Proposal 1	Proposal 2	Proposal 3	Proposal 4
1. Patient Safety				
Could the change increase risk of harm to patients?	☑	☑	☑	☑
Does the change impact on how risk is managed?	☑	☑	☑	☑
Are there risks related to medication?	X	X	X	X
Are there risks to physical health of the patient?	☑	☑	☑	☑
Will this change access to care/ waiting times?	☑	☑	☑	☑
Will this impact on clinical standards (i.e. NICE adherence)?	☑	☑	☑	☑
Does this effect diagnostic accuracy?	☑	☑	X	X
Does this impact on treatment efficacy?	☑	☑	☑	☑
Does this impact on treatment monitoring?	☑	☑	☑	☑
Will the change impact patient choice?	☑	☑	☑	☑
Will the change impact upon care personalisation?	☑	☑	☑	☑
Will the change impact on carer support/ involvement?	☑	☑	☑	☑
Will the change potentiate patient / carer complaints?	☑	☑	☑	☑
Does the change increase workload?	☑	☑	☑	☑
Will the change alter roles / job plans?	X	X	X	X
Does the change create staff risks (i.e. lone working)?	X	X	X	X
Does the change impact upon training needs?	X	X	X	X
Does the change impact upon supervisory availability?	X	X	X	X
Does the change impact upon placement provision?	X	X	X	X
Does the change have issues related to retention?	X	X	X	X
Will the change effect workforce inequalities?	X	X	X	X
Does the change effect protected groups?	X	X	X	X
Does the change affect those in rural areas?	☑	☑	☑	☑
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X	X
Are there implications for Safeguarding?	X	X	X	X
Are there MHA or MCA implications?	X	X	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X
Does the change impact on other team's resource?	☑	☑	☑	☑
Does the change rely on an external partner?	X	X	X	X
Does the change create any service gaps?	X	X	X	X
Are the system partners supportive? (if applicable)	X	X	X	X
8. EIA Monitoring				
Is there a risk of discrimination (in any protected category)?	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X
Will the change restrict patient rights?	X	X	X	X
Will the change impact on staff rights?	X	X	X	X
9. Impact on Promises (insert promise number)	X	X	X	X
10. Impact on RDaSH 5 (insert 1-5)	X	X	X	X

What is the change being proposed → QSIA Domain ↓	Proposal 5	Proposal 6	Proposal 7	Proposal 8	Proposal 9	Proposal 10
1. Patient Safety						
Could the change increase risk of harm to patients?	☑	☑	☑	☑	☑	☑
Does the change impact on how risk is managed?	☑	☑	☑	☑	☑	☑
Are there risks related to medication?	☑	☑	☑	X	X	X
Are there risks to physical health of the patient?	☑	☑	☑	☑	☑	☑
Will this change access to care/ waiting times?	☑	☑	☑	☑	☑	☑
Will this impact on clinical standards (i.e. NICE adherence)?	☑	☑	☑	☑	☑	☑
Does this effect diagnostic accuracy?	☑	X	X	☑	☑	☑
Does this impact on treatment efficacy?	☑	☑	☑	☑	☑	☑
Does this impact on treatment monitoring?	☑	☑	☑	☑	☑	☑
3. Patient and carer experience						
Will the change impact patient choice?	☑	☑	☑	☑	☑	☑
Will the change impact upon care personalisation?	☑	☑	☑	☑	☑	☑
Will the change impact on carer support/ involvement?	☑	☑	☑	☑	☑	☑
Will the change potentiate patient / carer complaints?	☑	☑	☑	☑	☑	☑
Does the change increase workload?	☑	☑	☑	☑	☑	☑
Will the change alter roles / job plans?	☑	☑	☑	☑	☑	☑
Does the change create staff risks (i.e. lone working)?	X	X	X	X	X	X
Does the change impact upon training needs?	X	X	X	X	X	X
Does the change impact upon supervisory availability?	X	X	X	X	X	X
Does the change impact upon placement provision?	X	X	X	X	X	X
Does the change have issues related to retention?	X	X	X	X	X	X
Will the change effect workforce inequalities?	X	X	X	X	X	X
Does the change effect protected groups?	X	X	X	X	X	☑
Does the change affect those in rural areas?	X	X	X	X	X	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X	X	X	X
6. Legislation/ Safeguarding						
Are there implications for Safeguarding?	X	X	X	X	X	X
Are there MHA or MCA implications?	X	X	X	X	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X	X	X
7. System Impact / Dependencies				X	X	X
Does the change impact on other team's resource?	X	X	X	X	X	X
Does the change rely on an external partner?	X	X	X			
Does the change create any service gaps?	X	X	X	X	X	X
Are the system partners supportive? (if applicable)	X	X	X	X	X	X
8 EIA Considerations						
Is there a risk of discrimination (in any protected category)?	X	X	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X	X	X
Will the change restrict patient rights?	X	X	X			
Will the change impact on staff rights?	X	X	X	X	X	X
9. Impact on Promises (insert promise number)						
10. Impact on RDaSH 5 (insert 1-5)	X	Yes	Yes			

Additional questions –

ARMS – In terms of the changes there is caseload specification nationally, and the proposals do slightly deviate from this national guidance. Other Trusts in the county have mixed approached and can variate skill set with is what is proposed, and also supported.

OPMH – the service was discussed, and the roles that are in each of the different areas, and what there would be that benefits the patients. There is a need to standardise the roles and also the naming of the roles. This is not a part of the QSIA but will be looked at in the wider community development process.

S*MI Health check* – there is one of the largest per WTE. The question was therefore is there confidence in terms of still meeting the demand of the patients in the time frame needed – yes, based on current DNA data and current increased productivity.

CNS Removal – the patient record data that has been assessed as part of the capacity and demand modelling. What the care group suggest, is that that even with the post removed then this will still generate sufficient capacity to meet the need of the patients entering the service.

OT role – the removal of this post was discussed as it is a post that is a unique (and potentially legacy) post, and is not in any other care group , and therefore there is support to discontinue this, as the work may provide value on an individual basis but it is not an essential part of the work. There is also capacity in terms of some of the OTs picking up the work.

4.5 Directorate: - Rotherham AMH Date: 8/12/25 QSIA Panel – CNO / CMO / CPPTO / Lived Experience expert

What is the change being proposed → QSIA Domain ↓	Proposal 1	Proposal 2	Proposal 3
1. Patient Safety			
Could the change increase risk of harm to patients?	☑	X	☑
Does the change impact on how risk is managed?	☑	X	☑
Are there risks related to medication?	☑	X	☑
Are there risks to physical health of the patient?	☑	X	☑
2. Quality and Clinical Effectiveness			
Will this change access to care/ waiting times?	☑	X	☑
Will this impact on clinical standards (i.e. NICE adherence)?	☑	X	☑
Does this effect diagnostic accuracy?	X	X	X
Does this impact on treatment efficacy?	X	X	X
Does this impact on treatment monitoring?	☑	X	X
3. Patient experience and choice			
Will the change impact patient choice?	X	X	X
Will the change impact upon care personalisation?	X	X	X
Will the change impact on carer support/ involvement?	X	X	☑
Will the change potentiate patient / carer complaints?	☑	X	☑
4. Workforce, Culture and Wellbeing			
Does the change increase workload?	☑	X	X
Will the change alter roles / job plans?	☑	X	X
Does the change create staff risks (i.e. lone working)?	X	X	X
Does the change impact upon training needs?	X	X	X
Does the change impact upon supervisory availability?	X	X	X
Does the change impact upon placement provision?	X	X	X
Does the change have issues related to retention?	X	X	X
Will the change effect workforce inequalities?	X	X	X
5. Workforce, Culture and Well-being			
Does the change effect protected groups?	X	X	X
Does the change affect those in rural areas?	X	X	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X
6. Legislative / Regulatory / Safeguarding			
Are there implications for Safeguarding?	X	X	X
Are there MHA or MCA implications?	X	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X
7. System Impact			
Does the change impact on other team's resource?	X	X	X
Does the change rely on an external partner?	X	X	X
Does the change create any service gaps?	X	X	X
Are the system partners supportive? (if applicable)	X	X	X
8. EIA considerations			
Is there a risk of discrimination (in any protected category)?	X	X	X
Will there be an impact on equality duty?	X	X	X
Will the change restrict patient rights?	X	X	X
Will the change impact on staff rights?	X	X	X
9. Impact on Promises (insert promise number)			
10. Impact on RDaSH 5 (insert 1-5)			

Any additional questions –

Leadership – proposed removal of the team leader in the HWB service. Asked whether there is any inconsistency with other patient care group – it was explained that it is not, as in the other care groups this activity is managed and owned within each of the care group. Additional question was posed as to whether the post conducted any other clinical activity, which needs considering prior pathway change.

AOT – there is a small reduction in this team, and a need for a case load review in this service, consistent with the discussion with Doncaster AMH progress. The Care Group have completed their review which confirms that caseloads are within nationally expected parameters.

Placement landscape – no impact on the AHP or nurses

Supervision capability – there is sufficient supervision capacity

ASK OF THE MANAGEMENT TEAM –

- Calculate the per head population for perinatal in not having the same standard as Doncaster so that there can be consistency. This remains to be completed and will be done in 2025.

- Explore whether the HWB transformation proposed currently is only managerial tasks or if there are any clinical tasks that would effect patient and family experience if this was progressed. The Care Group have responded to this confirming that the removed role is not providing clinical input.

4.6 Directorate: - Talking Therapies Directorate Date: 8/12/25 QSIA Panel – CNO / CMO / CPPTO / Expert by Experience

What is the change being proposed → QSIA Domain ↓	Proposal 1	Proposal 2	Proposal 3	Proposal 4	Proposal 5	Proposal 6	Proposal 7
1. Patient Safety							
Could the change increase risk of harm to patients?	☑	☑	☑	☑	☑	☑	☑
Does the change impact on how risk is managed?	☑	☑	☑	☑	☑	☑	☑
Are there risks related to medication?	X	X	X	X	X	X	X
Are there risks to physical health of the patient?	☑	☑	☑	☑	☑	☑	☑
Will this change access to care/ waiting times?	☑	☑	☑	☑	☑	☑	☑
Will this impact on clinical standards (i.e. NICE adherence)?	☑	☑	☑	☑	☑	☑	☑
Does this effect diagnostic accuracy?	☑	☑	☑	☑	☑	☑	☑
Does this impact on treatment efficacy?	☑	☑	☑	☑	☑	☑	☑
Does this impact on treatment monitoring?	☑	☑	☑	☑	☑	☑	☑
Will the change impact patient choice?	☑	☑	☑	☑	☑	☑	☑
Will the change impact upon care personalisation?	☑	☑	☑	☑	☑	☑	☑
Will the change impact on carer support/ involvement?	☑	☑	☑	☑	☑	☑	☑
Will the change potentiate patient / carer complaints?	☑	☑	☑	☑	☑	☑	☑
Does the change increase workload?	☑	☑	☑	☑	☑	☑	☑
Will the change alter roles / job plans?	X	X	X	X	X	☑	X
Does the change create staff risks (i.e. lone working)?	X	X	X	X	X	X	X
Does the change impact upon training needs?	X	X	X	X	X	☑	X
Does the change impact upon supervisory availability?	X	X	X	X	X	☑	X
Does the change impact upon placement provision?	X	X	X	X	X	X	X
Does the change have issues related to retention?	X	X	X	X	X	☑	X
Will the change effect workforce inequalities?	X	X	X	X	X	X	X
Does the change effect protected groups?	X	X	X	X	X	X	X
Does the change affect those in rural areas?	☑	☑	☑	☑	☑	☑	☑
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X	X	X	X	X
Are there implications for Safeguarding?	X	X	X	X	X	X	X
Are there MHA or MCA implications?	X	X	X	X	X	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X	X	X	X
Does the change impact on other team's resource?	☑	☑	☑	☑	☑	☑	☑
Does the change rely on an external partner?	X	X	X	X	X	X	X
Does the change create any service gaps?	X	X	X	X	X	X	X
Are the system partners supportive? (if applicable)	X	X	X	X	X	X	X
8. EIA Monitoring							
Is there a risk of discrimination (in any protected category)?	X	X	X	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X	X	X	X
Will the change restrict patient rights?	X	X	X	X	X	X	X
Will the change impact on staff rights?	X	X	X	X	X	X	X
9. Impact on Promises (insert promise number)	X		X	X	X	X	X
10. Impact on RDaSH 5 (insert 1-5)	X	X	X	X	X	X	X

4.7 **Directorate**: - Learning Disabilities Directorate. Date: 8/12/25 QSIA Panel – CNO / CMO / CPPTO / Lived Experience Expert

What is the change being proposed → QSIA Domain ↓	Proposal 1	Proposal 2
1. Patient Safety		
Could the change increase risk of harm to patients?	☑	X
Does the change impact on how risk is managed?	☑	X
Are there risks related to medication?	X	X
Are there risks to physical health of the patient?	X	X
2. Quality Safety and Effectiveness		
Will this change access to care/ waiting times?	☑	X
Will this impact on clinical standards (i.e. NICE adherence)?	☑	X
Does this effect diagnostic accuracy?	☑	X
Does this impact on treatment efficacy?	☑	X
Does this impact on treatment monitoring?	☑	X
3. Patient and Carer Experience		
Will the change impact patient choice?	☑	X
Will the change impact upon care personalisation?	☑	X
Will the change impact on carer support/ involvement?	X	X
Will the change potentiate patient / carer complaints?	X	X
4. Workforce, Culture and Wellbeing		
Does the change increase workload?	☑	X
Will the change alter roles / job plans?	X	☑
Does the change create staff risks (i.e. lone working)?	☑	X
Does the change impact upon training needs?	X	X
Does the change impact upon supervisory availability?	☑	X
Does the change impact upon placement provision?	☑	X
Does the change have issues related to retention?	☑	X
Will the change effect workforce inequalities?	?	X
5. Health inequalities		
Does the change effect protected groups?	☑	X
Does the change affect those in rural areas?	☑	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	☑	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X
6. Legal / regulatory / safeguarding		
Are there implications for Safeguarding?	X	X
Are there MHA or MCA implications?	X	X
Is there a risk to personal data? (*if yes see DPIA section)	X	X
Does the change impact on the -CQC getting to good plan?	?	X
7. Dependencies / System impact		
Does the change impact on other team's resource?	☑	X
Does the change rely on an external partner?	X	X
Does the change create any service gaps?	X	X
Are the system partners supportive? (if applicable)	X	☑
8. EIA Monitoring		
Is there a risk of discrimination (in any protected category)?	X	X
Will there be an impact on equality duty?	X	X
Will the change restrict patient rights?	X	X
Will the change impact on staff rights?	X	X
9. Impact on Promises (insert promise number)		
10. Impact on RDaSH 5 (insert 1-5)		

Comments re any risks of proposals –

- The clinical lead changes in LD may impact upon supervisory availability (as the way the proposal reads is that it may take out lead professionals and also supervisors for other practitioners replacing with managers and potentially supervisors who cannot transact a supervisory role due to being a different registered professional)
- Placement provision is often requested in LD services, how will the changes effect placements and how will you mitigate against that?
- AOT to be seen in terms of productivity and engagement considering the Nottingham findings.

4.8 Directorate: - Backbone Directorates Date: 8/12/25 QSIA Panel – CNO / CMO / CPPTO / Lived Experience Expert

What is the change being proposed → QSIA Domain ↓	Proposal 1 Chief Operating Officer	Proposal 2 People and OD Directorate	Proposal 3: Psychological Professional & Therapies Directorate	Proposal4: Strategy and Development changes	Proposal 5 Corporate Assurance Directorate	Proposal 6 - Finance & Estates	Proposal 7 Medical, Pharmacy & Research	Proposal 9 Nursing and Facilities
1. Patient Safety								
Could the change increase risk of harm to patients?	X	X	☑	X	X	X	X	X
Does the change impact on how risk is managed?	X	X	☑	X	X	X	X	☑
Are there risks related to medication?	X	X	☑	X	X	X	☑	X
Are there risks to physical health of the patient?	X	X	☑	X	X	X	X	X
2 Quality, Safety and Effectiveness								
Will this change access to care/ waiting times?	X	X	X	X	X	X	X	X
Will this impact on clinical standards (i.e. NICE adherence)?	X	X	☑	X	X	X	X	☑
Does this effect diagnostic accuracy?	X	X	X	X	X	X	X	X
Does this impact on treatment efficacy?	X	X	X	X	X	X	X	X
Does this impact on treatment monitoring?	X	X	X	X	X	X	☑	X
3. Patient and carer experience								
Will the change impact patient choice?	X	X	X	X	X	X	X	X
Will the change impact upon care personalisation?	X	X	☑	X	X	X	X	X
Will the change impact on carer support/ involvement?	X	X	X	X	X	X	X	X
Will the change potentiate patient / carer complaints?	X	X	X	X	X	X	X	X
4. Workforce, Culture and Wellbeing								
Does the change increase workload?	☑	☑	☑	☑	X	X	☑	☑
Will the change alter roles / job plans?	☑	☑	X	☑	☑	☑	☑	☑
Does the change create staff risks (i.e. lone working)?	X	X	X	X	X	X	X	X
Does the change impact upon training needs?	X	X	X	X	X	X	X	X
Does the change impact upon supervisory availability?	X	X	X	X	X	X	X	X
Does the change impact upon placement provision?	X	X	X	X	X	X	X	X
Does the change have issues related to retention?	X	☑	X	X	☑	X	X	X
Will the change effect workforce inequalities?	X	X	X	X	X	X	X	X
5. Inequalities								
Does the change effect protected groups?	X	X	X	X	X	X	X	X
Does the change affect those in rural areas?	X	X	X	X	X	X	X	X
Does the change risk widening inequalities in access, treatment, and / or outcomes?	X	X	X	X	X	X	X	X
Are there any accessibility risks related with the change (i.e. translation)?	X	X	X	X	X	X	X	X
6. Legislation/ Safeguarding								
Are there implications for Safeguarding?	X	X	X	X	☑	X	X	☑
Are there MHA or MCA implications?	X	X	X	X	X	X	X	☑
Is there a risk to personal data? (*if yes see DPIA section)	X	X	X	X	X	X	X	X
Does the change impact on the -CQC getting to good plan?	X	X	X	X	X	X	X	X
7. System Impact / Dependencies								
Does the change impact on other team's resource?	X	☑	X	X	X	☑	X	X
Does the change rely on an external partner?	X	X	X	X	X	☑	X	X
Does the change create any service gaps?	X	X	X	X	X	X	X	X
Are the system partners supportive? (if applicable)	X	X	X	X	X	☑	X	X
8 EIA Considerations								
Is there a risk of discrimination (in any protected category)?	X	X	X	X	X	X	X	X
Will there be an impact on equality duty?	X	X	X	X	X	X	X	X
Will the change restrict patient rights?	X	X	X	X	X	X	X	X
Will the change impact on staff rights?	X	X	X	X	X	X	X	X
9. Impact on Promises (insert promise number)								
10. Impact on RDaSH 5 (insert 1-5)								

Any additional questions

Psy*chological Professionals and Therapies Directorate* –

- Healthy Hospitals team reduction potentials risk in terms of not only 'stop smoking' services being provided to people who are vulnerable (in terms of physical health and SMI) but also wider lifestyle changes (related to – eating, sleeping, and exercise).
- The success measures are suggested to include - Improved patient access to physical healthcare (movement, diet, smoke-free support); Reduction in inequalities in physical health outcomes for people with SMI.
- The suggested KPIs are: % of physical health checks completed (BMI, BP, bloods, smoking status); % of patients receiving activity/movement sessions weekly; Smoking cessation referral and engagement rates; Compliance with nutrition and hydration standards.
- Will the changes in the Trauma and Resilience team, potential increased burden on the rest of the team in terms of administration. Answer – the solution is most effective in prioritising people who see patients face to face. There may be some complains, however there are also digital and support to ease the administrative burden (i.e. dragon dictation, shorter assessments and records, AI note keeping pilot).

Nursing and Facilities Directorate – It is noted that whilst there are clinicians impacted with these changes, the roles within these teams do not necessarily require to be a clinician/nurse. Also none of the roles are directly linked to clinical contact and do not effectively ever "touch a patient" in that they have no direct patient contact.

- IPC team and Safeguarding Team reductions discussed in terms of potential risks for team cover and organisational cover with a reduced WTE. Capacity and demand has been considered as has comparative size of the team with the organisation (against others) and this WTE is deemed as sufficient.

- <u>Success Measures to monitor the impact for IPC may include</u> - Reduced transmission of infections within RDaSH inpatient services and confidence levels among patients and staff in cleanliness standards.
- <u>KPIs (for IPC)</u> – Hand hygiene compliance rates (target: >95%); % of staff IPC training completed; Rate of healthcare-associated infections (C. diff, flu outbreaks, etc.); Cleaning audit scores (monitored via RADAR).

- <u>Success Measures to monitor the impact for Safeguarding may include</u> – PIPOT panels Attendance at external meetings reduced, attending to statutory functions, MCA and SG reaudit assurance levels and safeguarding training compliance.

- <u>KPIs (for Clinical Effectiveness)</u> – Monitoring of NICE compliance, demonstrable effectiveness shown in audits to improve quality, report to Quality Committee to outline the changes – QC has deferred paper and Audit Committee critical of its listing of audits and absence of effectiveness. Local and national audit compliance. Undertake research and deeper level of audit effectiveness that supports our communities but then is shared nationally and internationally.

Medical, Pharmacy and Research / Corporate Assurance

- Discussion focused on pharmacy provision, distinct from the subsidiary company to replace the private provider. We were reassured that the modest changes, which primarily focus on

bank staff will not impact patient safety. It remains the case that the medication dataset for directorates for 2026/7 is a key step in patient safety.

- Mindful of other safeguarding schemes we discussed potential changes to roles, including medical input. 2 sessions of medical input is the agreed requirement for the envisaged future state.

Annex C – workforce information and possible consultation approach

Introduction

1.1 As with any organisation, change management occurs to support the operational and business needs and has become much more prevalent in the NHS in recent years to manage different contractual arrangements, organisational mergers and financial balance.

1.2 We have an approved Change Management Policy and Procedure which has been in place for a number of years, which is complaint with employment legislation and in part governs the overarching principles of change management application within the Trust. **The approach outlined in this paper is consistent with that: it does apply those principles differently to some recent examples within the Trust. But the approach is situationally appropriate to protect fairness.**

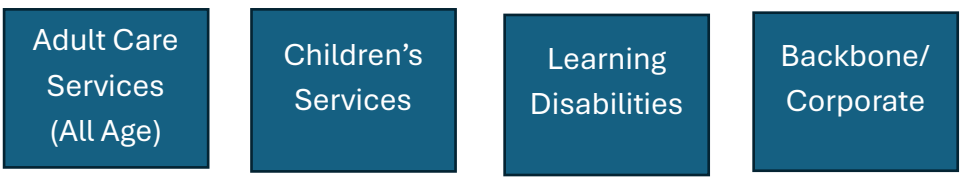
1.3 Alongside the internal policy framework there is also the nationally agreed terms and conditions of service for our non-clinical workforce (Agenda for Change Terms and Conditions) and for our medical workforce (Medical and Dental Terms and Conditions). Within these nationally negotiated and agreed terms and conditions, elements are relevant to change management such as redundancy pay, Section 16 of Agenda for Change Terms and Conditions for example. Furthermore, there are also the ACAS guidance documents linked to consultation and change.

2.0 Change Management Proposal

3.1 We are keen to ensure that our colleagues possibly affected by the proposals are supported by their staff side representatives, have a meaningful consultation but there is timely consultation to manage the length of uncertainty for colleagues.

3.2 Whist the change management principles will be the same for all proposals, it is proposed that we group the schemes into 4 discrete areas. This is to facilitate a meaningful consultation with the affected employees, who may have similar questions and where pooling considerations are more meaningful.

3.3 The proposed 4 schemes as



3.4 In addition to the above schemes, in early 2026/27 there are likely to be a number of TUPE transfer consultations linked to Procurement,

Estates and Accounts Payable. These will be managed as separate consultations as and when they are in a position to progress, the only option to group the consultations would arise if two of more contracts were awarded to the same provider and the timescales align.

4.0 The practicalities

4.1 It is proposed that the change management is supported by a PMO approach and project methodology to remove variations and to facilitate the timetabling of activities. Whilst this has been the approach in RDaSH previously for a change management process (the Aspire contract) this hasn't been the norm, and the scheduling and approach has been more relaxed.

4.2 It is proposed that an opening consultation meeting, mid-point and end point consultation meeting is scheduled for each scheme proposal. The time to be taken for consultation is not yet agreed, recognised different interests. The expectation remains that no more than 30 days will be needed but we may consider a 45 day approach assuming that selection processes from pooling can be completed within that framing.

4.3 A consultation has to be a meaningful consultation, and we are hopeful that by prioritising the meetings and having a dedicated change team, this can be achieved. However, there is the possibility that an extension may be requested, and we would have to assess this at the time: under the structure outlined in the cover paper this would be a decision for the steering committee.

4.5 By having a dedicated change team of six managers, supported by HR colleagues, we are confident that the team can facilitate all of the one to ones in the first two weeks of the consultation. This scheduling also affords management and HR colleagues sufficient time to review and issue the outcome notes following the meetings.

4.6 Whilst a change team hasn't been the norm for RDaSH it allows us to provide additional training for these colleagues prior to commencing the consultation, to provide additional support and supervision during this time period and more importantly allows us to free up their time to focus on this important workstream rather than managing and trying to balance a number of competing priorities.

4.7 The change team would have one hour per one to one to facilitate a meaningful discussion with colleagues, should a group of colleagues wish to access a one to one then obviously more time will be scheduled. The provision of an hours' time is an increase on the norm which has been offered in recent consultations.

4.8 The change team would then summarise their findings, actions and questions to the central team to ensure timely reply to any questions

which they may not be in a position to answer, such as you have proposed X but have you considered Y.

4.9 This approach then allows the latter end of the consultation period to consider any alternative proposals which may be submitted and feedback to colleagues timely. The process for decision making in this regard is outlined within the main paper.

5.0 Suitable alternative employment

5.1 As per the project approach above, should there be a requirement for colleagues to interview for posts in the structure or suitable alternative employment opportunities, then the interviews will be scheduled and will be across the Trust rather than team specific. Again, reducing the distress to colleagues having to apply/be considered for multiple vacancies, whilst they have been performing in a similar role.

5.2 Within our change management policy, for suitable vacancies we would initially look at the current band, one band above and one band below. Should a colleague accept a post on a lower band they will be eligible for pay protection, for a defined period, nor more than two years. But in line with national terms and conditions, should any post of their previous higher band become available during the period of pay protection which negates the pay protection they will be formally offered the role at the higher banding. This supports the organisation in minimising the financial exposure but more importantly provides the opportunity for the colleague to maintain their salary level (and pension provision) in the long term.

6.0 Number of affected colleagues

6.1 Whilst the schemes are currently being finalised and subject to the QSIA process, the likely affected number of colleagues has been confirmed in the main report, to which this paper is an annex.

6.2 This needs to be balanced against the Trust vacancy position of 191.12 WTE vacancies. In addition to the current vacancies we also need to factor in the potential turnover which is c.10%. Therefore, on this basis the number of vacancies by March 2026 is likely to increase by a further 120 WTE, which would increase the overall number of vacancies to 311.12 WTE.

We then have a further 15 posts to potentially add on as part of the investment fund approvals which increases the number to 326.12 WTE. But removing the vacancy factor, the posts in the recruitment process which have already been offered and start dates agreed reduces this by 171.64, which provides c.154.48 WTE vacancies to support the redeployment of colleagues. The suitability of these vacancies for affected colleagues has not yet been finally assessed, but as the schemes are finalised to facilitate the consultation this will be

undertaken. This is the principal matter preventing release of more final and definitive information inside the organisation.

6.3 In addition, we also need to be mindful whilst we will do our upmost to redeploy colleagues, there is a risk that we may not be able to redeploy all colleagues. For colleagues employed on Agenda for Change Terms and Conditions of Service, any redundancy payments would be in accordance with Section 16, based on the following criteria

The redundancy payment will take the form of a lump sum, dependent on the employee's reckonable service at the date of termination of employment. The lump sum will be calculated on the basis of one month's pay for each complete year of reckonable service, subject to a minimum of two years' continuous service and a maximum of 24 years' reckonable service being counted.

For those earning less than £23,000 per year (full time equivalent), the redundancy payment will be calculated using notional full-time annual earnings of £23,000, pro-rated for employees working less than full time.

For those earning over £80,000 per year (full time equivalent) the redundancy payment will be calculated using notional full-time annual earnings of £80,000, pro-rated for employees working less than full time. No redundancy payment will exceed £160,000 (pro-rata).

6.4 Given the schemes are not yet finalised, the potential redundancy liability will be discussed in our Board meeting on January 8th: but it is important to reiterate that we will working to avoid any such. Suitability is a decision made, ideally mutually, based on discussion of individual circumstances albeit ultimately a decision for the employer to reach.

Carlene Holden, Director of People and OD
12th December 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Planning submission 2026/2028	**Agenda Item**	Paper E
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Public Board of Directors	**Date**	16 December 2025

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

We are required to make an initial submission of plans for two years on December 17th, based on material issued to the service in mid-November. A final plan to 2029 is due on February 12th. We do so in the context of one year offer and no multi year financial plan from commissioners.

The paper outlines the material items and focuses on the board assurance statements. These have been previously circulated to Board members for comment. Pauline Vickers will join me in presenting the key items. We are including cash and capital plans which are ahead of wider board confirmation but reflect our discussions in principle in August 2025.

The income submissions reflect our view of what is needed and credible, not the first two versions of ICB offers made: no offer has been received from HNY ICB at the time of writing.

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

n/a – albeit board assurance material circulated December 10

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the proposed board assurance statements outlined

RECOGNISE the oversight of contracting implied within them

DELEGATE to the chief executive pursuit of further clarity on year 2/3 contracting

THANK colleagues in finance, POD & operations for rapid work to populate the spreadsheets

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
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	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
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
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)
SRD 1-5
System / Place impact (advise which ICB or place that this matter relates to)
As per paper

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

Appendix (please list)
n/a

Summary of key points and issues - December 17 2025 submission

1. The documents prepared build on our eight plans, seven of which have had formal board approval during 2025/26. We are clear that plans of any type are there to support delivery of our strategy and its 28 Promises. The Board has a long established 'pecking order' of work, which positions national directions clearly in juxtaposition to the priorities of our patients, carers and communities.

2. The financial plans cover both revenue and capital, and necessarily cash. It is likely that our capital plans in the period under submission may necessitate higher surpluses in subsequent years beyond the planning period. Currently we cannot submit a plan based on a move away from block contracts and other outdated currencies, nor reflecting neighbourhood or IHO contracts, because none of this promised material has been issued to the service. Our capital plans do include the likely land disposals and site redevelopments discussed within the Board but not yet finalised. This reflects dialogue with the chair, shared with the wider Board.

3. Our workforce plans reflect the intentions we have for 2026/27. At this juncture plans beyond that are more broad brush: we recognise a need to live within an affordable pay-bill using substantive colleagues in a fully staffed basis. The Real Living Wage is assumed throughout with uplifts from our investment fund. Our CIP plans assume a continued failure to fully fund national pay awards.

4. The high-profile national sickness target, also a NOF remedial priority for us, is a submitted item. By the planning period end we reach the target national measure of 4.1% based on a reduction in long term sickness. Improvement is slow in 2026/27, not least recognising the likely sickness impact of organisational change.

5. Within our operational plans we indicate compliance with national measures, many of which we have met since 2024 – a major change in culture. This includes the perplexing LOS measure which continues to only 'count' the LOS of patients discharged in the reporting period. We do not commit to improve our recovery rate in Talking Therapies, despite this being a national ask. The ask is not underpinned by research and is counteracted by longitudinal studies on deprived communities and vulnerable patients, whose access we wish to increase.

6. Four assurance statements are suggested below a fully embedded self-rating:

    - The phasing submission: as per comments above
    - The data-driven quality model: in line with our PCA/AGS track record
    - Popn. needs and contracting measures: reflecting apparent disconnect between a broader strategy and contract offers, and a concern over public mental health within population health strategies

    Only the first of these would likely change at February submission.

Maturity Assessment Key	
1. Embedded [Full Assurance]	The action is fully integrated into normal operations. It is standardised, sustainable, and reinforced by policy, leadership, systems, and culture. Continuous improvement is an established norm, and outcomes are consistently positive.
2. Maturing	The action is becoming routine. There are documented processes, growing staff awareness, and increasing consistency across teams. Evaluation and improvement mechanisms may be in place but are not yet fully optimised.
3. Developing	Steps have been taken to introduce and implement this action. There may be informal processes, or isolated examples of good practice, but they lack consistency, coordination, or broad awareness.
4. Not Embedded [No Assurance]	There is little to no evidence that this action has started. If it has, it's ad hoc, inconsistent, or heavily reliant on individuals rather than being supported by systems or structures.

Reference	Category / Area For Assurance	Statement	Response	Commentary
1	Foundational activities	The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning. This includes reviewing demand and capacity analysis.	1. Embedded [Full Assurance]	The Trust's productivity plans are based on demand and capacity analysis undertaken over the last year. We have known gaps (adult neuro and secondary psychology waits). Timescales of national plans place pressure on review, but our assessment relies on foundational work since 2024 across the Board on our plans through to 2028 in 8 domains: quality/safety, people/teams, research/innovation, learning/education, equity/inclusion, digital transformation, estate & finance.
2	Governance and leadership	The board can confirm strong clinical leadership is involved in the development of plans.	1. Embedded [Full Assurance]	Three clinical executives are part of our Board, alongside our clinical NED. Financial plans have been subject to QSIA by those colleagues, and development work by sundry others. Clinical voices remain concerned by omissions from local plans, notably in the fields of dementia, eating disorders and tier 3.5 CYP access. The Trust is actively working to address those gaps.
3	Governance and leadership	The board can confirm processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans.	2. Maturing	The Trust's strategy, Board governance, KPIs and plans fully reflect known knowns in this regard. Public mental health is a limited field and so we are working with LAs to understand how gaps are plugged. In addition, the rating shown reflects a lack of clarity or visibility on how such analysis has informed issued commissioning volumes and proposals to date.

Reference	Category / Area For Assurance	Statement	Response	Commentary
4	Governance and leadership	Robust quality and equality impact assessments (QEIA) are underway or are planned to be undertaken and reviewed by the board to inform development of the organisation's plan.	1. Embedded [Full Assurance]	QSIA/EIA material is complete for all change proposals underpinning these documents, with the exception of emerging plans for digitalisation (AI). The Board reviewed our four part evaluation in December and decisions will be made in February.
5	Governance and leadership	The board is playing an active role in setting direction, reviewing drafts, and constructively challenging assumptions during the plan's development.	1. Embedded [Full Assurance]	The Board approved medium term financial and workforce plans in Q2 25/26, so submissions in this process adapt from those long developed documents. All provider side assumptions have been subject to scrutiny and debate.
6	Governance and leadership	The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	2. Maturing	The Trust has invested heavily in leadership development which contains a QI element. Our PCA submission acknowledges weaknesses in the data-driven 'ness' of our quality approach. For other domains (people, finance etc) this is strong. Improvement capability remains a work in progress with full focus from the Board, in its investment in this area, and its culture work via our Trust People Council
7	Governance and leadership	The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	1. Embedded [Full Assurance]	The Trust has a very developed structure for this with commissioners, provider partners and other key relationships. It is within the work of board committees and has been subject to internal audit assessment. The present transition of some functions was considered vis a viz a lower rating.
8	Plan development	The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	2. Maturing	This is rated as maturing only because of further work needed to ensure our approach to cash and capital is validated in final submission: and because only a one year commissioner forward look has been issued. Our plan is deliverable, the phasing requires mutuality as we left shift

Reference	Category / Area For Assurance	Statement	Response	Commentary
9	Plan development	The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	1. Embedded [Full Assurance]	The Board relies here not only on scrutiny of officers and non-executives but on its prior practice (unamended 25/6 workforce plan because congruent through year). Capital/cash remains a work in progress as national system evolves.
10	Productivity	The board can guarantee that the organisation is fully considering and reflecting productivity opportunities in plans. This should include those identified in national data packs as well as any local opportunities to improve productivity.	1. Embedded [Full Assurance]	The Board has extensive involvement in assessing productivity, which is reflected in our PCA. A 19% patient facing gain 23-25 is testimony to board oversight as is execution of corporate cuts vs 2021 ahead of national plan. The national 24/5 data packs issued late 2025 do not provide a rationale nor robust basis for changes but they have been considered in developing our plans.
11	Risk	The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	1. Embedded [Full Assurance]	The Trust has a clear, documented, audited, and successfully delivered approach. In 25/6 the Trust has assimilated over 1% of risk transfer mid year to the organisation and accepted a 4% risk transfer at planning stage. The underlying financial position has been the basis for financial planning and action since 2024/5.
12	NHS standard contract and commissioning	The board can confirm work is underway to ensure contract values used in planning submissions are aligned across (commissioner and provider) activity and financial plans.	2. Maturing	Contract values have been issued twice in December. The method used does not reflect agreements since September, but Trust officers are working with commissioners to develop a shared understanding and solutions, alongside other providers: taking a cross MHLDA approach
13	NHS standard contract and commissioning	The board can confirm that there is an effective process in place to manage the sign-off of contracts.	1. Embedded [Full Assurance]	The Board has no concerns over the scrutiny and oversight of this process, which has improved markedly having criticised in 22/23 accounts. All contract sign offs have clear scrutiny, and the Board actively engages in any delays.

Reference	Category / Area For Assurance	Statement	Response	Commentary
14	NHS standard contract and commissioning	The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	1. Embedded [Full Assurance]	see prior statement. An internal timetable is in place. And updates as in prior years will be transparent. Mediation and arbitration arrangements remain to be clarified.
15	Workforce	The board can confirm the impact of the 10 Year Health Plan on the workforce is being considered in the development of plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	1. Embedded [Full Assurance]	We considered a much lower rating for this measure. We have been using these shifts for some time in our planning. But the absence of either the neighbourhood contract or IHO detail makes it difficult to connect the journey clinical generalism with our detailed workforce plans. We are confident that the Trust is leading the way in shaping those ideas locally.