NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 25 July 2024 at 10.00am
Scunthorpe United Football Club, Glanford Park, Scunthorpe, DN15 8TD

No	Item	Request to	Lead	Enc.
1	Welcome	Note Information	KL	
2	Apologies for Absence: Carlene Holden			
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest			A
	Patient / Staff Story			
5	Staff story - apprenticeships	Information		Verb
	Standing items			
6	Minutes of the meeting held in public on the 30 May 2024	Decision	KL	B
7	Matters Arising and Follow up Action List including:	Decision		C
	Board Assurance Committee Reports to the Board of Directors			
8	Finance, Digital & Estates Committee	Assurance	PV	D
9	Public Health Patient Involvement & Partnerships Committee	Assurance	DV	E
10	People & Organisational Development Committee	Assurance	DV	F
11	Mental Health Act Committee	Assurance	SFT	G
12	Quality Committee	Assurance	DL	H
13	Audit Committee	Assurance	KG	I
14	Chief Executive's Report (inc. leadership development offer) • Responsible Officer	Information Decision	TL GT	J Ji
15	Trust Response to the Independent Culture Review of the Nursing and Midwifery Council (NMC)	Information	SF	K
16	Strategy Delivery Risks 2024/25: Q1 report	Assurance	PG	L
17	Learning Half Days (LHD): Introduction and pilot learning	Discussion	JG	M
18	Placements in each profession	Information	SF	N
19	Learning and Education Plan	Discussion	JG	O
20	Learning from Deaths	Information	GT	P
21	Clinical and Operational Strategy: Strategic Objective 3	Discussion	JMc	Q

Operating Performance / Governance / Risk Management				
22	EPRR Biannual Update	Assurance	RC	R
23	Integrated Quality Performance Report (IQPR)	Assurance	TL	S
24	Operational Risk Report – Extreme Risks	Assurance	PG	T
25	Risk Management Framework Annual Report	Assurance	PG	U
Supporting Papers (previously presented at Committee)				
26	Accountable Officer for Controlled Drugs Annual Report 2023/24 Safeguarding Annual Report 2023/24	Information	KL	V
27	Any Other Urgent Business (to be notified in advance)		KL	Verb
28	Any risks that the Board wishes the Risk Management Group to consider			
29	Public Questions *			
30	Chair to resolve '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press are excluded from the remainder of the meeting, which will conclude in private.'*		KL	
31	*Minutes of the meeting held on the 30 May 2024 (private session)*	*Decision*	KL	AA
32	*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
33	*Reflections on the Staff Story*	*Discussion*		Verb
34	*Chief Executive Private Update to the Board of Directors Inc Electronic Patient Record (EPR) Update*	*Information*	TL	CC
35	*Humber and North Yorkshire MHLD&A Collaborative Joint Venture*	*Decision*	TL	DD

CORPORATE TRUSTEE				
36	Minutes of the meeting held 25 January 2024	Decision	KL	AAA
37	Reports from the Charitable Funds Committee: • 6 March 2024 • 5 June 2024	Assurance	PV	BBB
38	Charitable Funds Development Update	Decision	JMc	CCC

*** 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 26 September 2024 9:30 am
at The Pavilion, Askern Rd, Bentley, Doncaster DN5 0HU

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Chloe Pearson, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	25 July 2024

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

- The report is presented as a standing agenda item at each meeting to ensure board awareness to any declarations and if needed, actions taken to prevent any conflicts during the business of the Board.
- The report outlines the changes to the register since the last meeting which relates to the removal of Ian Currell and the inclusion of Izaaz Mohammed as the Director of Finance and Estates.

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

Business as usual	x

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

Not applicable

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

The Board is asked to:

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

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

Trust Risk Register							
Board Assurance Framework							
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

BOARD OF DIRECTORS – REGISTER OF INTERESTS

Executive Summary

The Trust and the people who work with and for it, collaborate closely with other organisations, delivering high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. The Trust is committed to maximising its resources for the benefit of the whole community. As a Trust and as individuals, there is a duty to ensure that all dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that the Trust uses the finite resources in the best interests of patients. For this reason each Director makes a continual declaration of any interests they have. Declarations are made to the Board Secretary as they arise, recorded on the public register and formally reported to the Board of Directors at the next meeting. To ensure openness and transparency during Trust business, the Register is included in the papers that are considered by the Board of Directors each month.

Amendments are shown in bold text.

Name / Position	Interests Declared
Kathryn Lavery, *Chair*	• Owner / Director of K Lavery Associates Ltd • Chair ACCIA Yorkshire and Humber Panel • Consultant with Agencia Ltd. • Chair of the Advisory Board Space2BHeard CIC HULL • Non-Executive Director at Locala Community Interest Company
Toby Lewis, *Chief Executive*	• Nil
Richard Banks, *Director of Health Informatics*	• Wife works in administration at Sheffield Children's NHS Foundation Trust.
Richard Chillery, Chief Operating Officer	• Nil
Steve Forsyth, *Chief Nursing Officer*	• Coach at the Gambian National Police Force • Ambassador and Affiliation for WhizzKidz • Non-Executive Director for the African Caribbean Community Initiative

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

Name / Position	Interests Declared
Izaaz Mohammed, *Director of Finance and Estates*	• **Chair of Governing Body – Westmoor Primary School, Church Lane, Dewsbury, West Yorkshire.** • **Trustee of Howlands Community Hub – charity based in Dewsbury which runs arts and crafts sessions for people with learning difficulties and physical disabilities.**
Sarah Fulton Tindall, *Non-Executive Director*	• Member of the Patient Participation Group at the NHS Heeley Green General Practice Surgery, Sheffield. • Age UK Readers' Panel member.
Dr Graeme Tosh, *Executive Medical Director*	• Director of Copdoc NI Ltd. • Director of ADHDEASY Ltd. (not trading at present – dormant status) • Partner is the Director of Kennedy Beach Architects Limited.
Dave Vallance, *Non-Executive Director*	• Nil
Pauline Vickers, *Non-Executive Director*	• Independent Assessor for the Business to Business (B2B) Sales Professional Degree Apprenticeship for Middlesex University and Leeds Trinity University • Associate Coach with Performance Coaching International • Managing Director and Executive Coach Insight Coaching for Leaders.
Dr Richard Falk, *Associate Non-Executive Director*	• Medical Consultancy advice to H I Weldricks Pharmacies (who have a footprint across the RDaSH geographical area).
Rachael Blake, *Associate Non-Executive Director*	• People and Transformation Lead – Jacobs (Global Rail & Transit Solutions Provider) • Elected Member - City of Doncaster Council • Trustee - South Yorkshire Community Foundation • Director - Bawtry Community Library

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 25 July 2024

Staff Story: Apprenticeships

Rotherham Doncaster and South Humber NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 30 MAY 2024 AT 10.00AM UNITY CENTRE, ROTHERHAM, S65 1PD

PRESENT

Kathryn Lavery	Chair
Richard Chillery	Chief Operating Officer
Ian Currell	Director of Finance and Estates
Steve Forsyth	Chief Nurse
Sarah Fulton Tindall	Non-Executive Director
Kathy Gillatt	Non-Executive Director
Carlene Holden	Director for People and Organisational Development
Dawn Leese	Non-Executive Director
Toby Lewis	Chief Executive
Dr Graeme Tosh	Medical Director
Dave Vallance	Non-Executive Director
Pauline Vickers (from 10.57)	Non-Executive Director

Dr Janusz Jankowski, Non-Executive Director, joined virtually.

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Dr Richard Falk (from 10.57)	Associate Non-Executive Director
Philip Gowland	Director of Corporate Assurance / Board Secretary
Jo McDonough	Director of Strategic Development
Jyoti Mehan	NeXT Director
Lea Fountain	NeXT Director
Sarah	Patient Story

3 members of staff, 1 member of the public and 6 governors joined the meeting.

Ref		Action
Bpu 24/05/01 & Bpu 24/05/02	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting, particularly Steve Forsyth, Carlene Holden and Dr Richard Falk as it was their first Board meeting. Apologies for absence were noted from Dr Jude Graham, Director of Psychological Professionals and Therapies and Rachael Blake, Non-Executive Director. Mrs Lavery highlighted that it would be the last Board meeting attended by Mr Currell who would be leaving the Trust over coming weeks and thanked him for his contribution and hard work as Director of Finance.	
Bpu 24/05/03	**Quoracy** Mrs Lavery declared the meeting was quorate.	

Bpu 24/05/04	**Declarations of Interest** Mrs Lavery presented the Declarations of Interest report which outlined the changes to the register since the last meeting relating to Steve Forsyth, Carlene Holden, Rachael Blake and Dr Richard Falk. Entries for Sheila Lloyd, Nicola McIntosh and Justin Shannahan had been removed. **The Board received and noted the changes to the Declarations of Interest Report.**	
PATIENT / STAFF STORY		
Bpu 24/05/05	**Patient Story** Mrs Lavery welcomed Sarah to the meeting who was invited to share her daughter's story and experience with Rotherham Children and Young People Mental Health Service (CAMHS). Sarah is the mother to 3 children with Special Educational Needs (SEN), her daughter was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) through Rotherham CAMHS. Sarah expressed that it had taken 4 years to reach a diagnosis from initial referral, Sarah's daughter was now in secondary education and it had taken her entire junior school education to reach a diagnosis, following assessments for both ADHD and ASD. Sarah's daughter also had social and emotional mental health difficulties and Sarah spoke about the challenges this created in school. Sarah's oldest son had a diagnosis of ADHD and Autism Spectrum Disorder (ASD) and her youngest son had a diagnosis of ASD. Sarah conveyed her belief that the waiting list for an assessment was too long and questioned if RDaSH was working to improve these timescales. She explained that her daughter would be waiting 9-12 months for medication and was waiting to be assigned to the appropriate sensory pathway. In addition, she questioned the mental health support that could be offered for her daughter during this period. Sarah referred to her work in the community with S62 (a collection of peer support groups in the community of Rotherham) and the number of neurodiverse individuals that were being supported, that had not been supported early enough. She questioned the mental health support offered to children following diagnosis, in order to prevent mental health difficulties later on in life. Dr Tosh expressed his apologies on behalf of the Trust for Sarah and her daughters experience, and he noted the 2024 investment made into ADHD and ASD services for adults and children to improve waiting times. He then mentioned the work undertaken to separate neurodiverse diagnosis from a mental health diagnosis. Dr Tosh advised that ADHD was a treatable condition and was uncertain why Sarah's daughter would be waiting for medication following diagnosis, he noted that the Trust was ensuring the necessary clinicians were working on the front line to enable treatment to be prescribed immediately after diagnosis. Sarah felt that medication shouldn't be the only route to treating ADHD, and that other routes of intervention / coping mechanisms should be explored first.	

	Supporting Mr Vallance's comment about support arrangements, Ms Fountain asked if there was any guidance / support offered during the period that Sarah's daughter was waiting for an assessment. Sarah advised that the main source of support was through the voluntary community sector, which didn't help in dealing with the psychological impact. Mr Lewis noted that the Trust was investing approximately £1.5m to improve the waiting list position. With reference to promise 14, excluding neurodiversity, the aim for no young people to be waiting longer than 4 weeks for meaningful intervention through CAMHS services from July 2024. He noted that good progress was being made with this aim, and there was confidence it would be met during Q2. In terms of next steps, Mr Lewis was interested in the pattern of meaningful support being offered whilst people were on the waiting list, highlighting the use of third sector resource to support this. He expressed disappointment that Sarah's daughter had been waiting 9 – 12 months for mediation and agreed to follow this up outside of the meeting. Mr Banks questioned the difference in experiences between face to face and digital assessments. Sarah felt that face to face was the better method as it provided more effective interaction and a better understanding of the patient and their complexities. Mrs Lavery and the Board thanked Sarah for taking the time to speak about her families experience regarding Rotherham CAMHS and noted the intended reflection time later on the agenda.	**TL**
STANDING ITEMS		
Bpu 24/05/06	**Minutes of the previous Board of Directors meeting held on 28 March 2024** **The Board approved the minutes of the meeting held on 28 March 2024 as an accurate record, subject to a minor wording amendment requested by Ms Fulton Tindall under 24/03/11 (Report from the Mental Health Act Committee).**	
Bpu 24/05/07	**Matters Arising and Follow up Action Log** There were no matters arising from the minutes. The Board received the action log and noted the progress updates. All actions noted as 'propose to close' were agreed. **<u>24/03/17 – CEO Report (WRES Data)</u>** Mr Lewis challenged the closure of the paper on WRES and asked that it remained on the log until the Board was satisfied with the meaningful response. This was agreed through the chair.	
BOARD ASSURANCE COMMITTEES		

Bpu 24/05/08	**Report from the Quality Committee** Mrs Leese presented the paper, particularly highlighting the detailed discussion held around safe staffing, and encouraged the Board to read the supplementary paper issued by Mr Lewis which focused on the recent safe staffing 'stock take'. She referred to the discussion held at the last Board following receipt of the safe staffing declaration and the areas of further work required. She provided an update that positive progress was being made to better understand the aggregate data at ward level and what planned safe staffing levels should look like in both ward and community settings. There was continued monitoring at the Quality Committee in respect of Venous Thromboembolism (VTE) assessments, Malnutrition Universal Screening Tool (MUST) assessments, out of area placements, resuscitation compliance and the closure of internal audit actions. The patient safety and complaints reports were deferred to July 2024 as there was a need to ensure the data was fully understood and triangulated across the organisation. In response to Mr Lewis, Dr Tosh confirmed that he was confident in the accuracy of the data contained within the learning from deaths annual report. Ms Gillatt requested to see the key findings and recommendations from the findings of the independent review of Greater Manchester Mental Health NHS Foundation Trust (GMMH). It was agreed that this would be circulated to Board members outside of the meeting. Mr Forsyth provided assurance that contact had been made with the lead investigator from GMMH to ensure the Trust gained a full insight into the report. **The Board received and noted the report from the Quality Committee.**	**SF**
Bpu 24/05/09	**Report from the Commissioning Committee** Mrs Leese presented the paper, which was of the final meeting of the committee. There were ongoing quality & safety issues in respect of the one of the services provided within South Yorkshire and the Committee had continued to have robust oversight of the position. There were now a number of extreme risks on the risk register relating to this area of work. Mrs McDonough provided an updated position, noting that the Trust had worked with NHS England as part of the rapid review of quality at Ellern Mede. NHS England had agreed to escalate this to the next level of oversight through a quality improvement process. The associated governance and monitoring arrangements would continue via the Public Health, Patient Involvement & Partnerships Committee and where necessary in the finance and quality committees. **The Board received and noted the report from the Commissioning Committee.**	

Bpu 24/05/10	**Report from the Public Health, Patient Involvement & Partnerships Committee** Mr Vallance presented the paper and highlighted that progress was being made in respect of the draft Equity & Inclusion and Research & Innovation Plans. He reiterated the importance of 'data insight' especially in terms of equity & inclusion. Mr Lewis referred to the work ongoing to finalise the core data sets on routine patient relevant data by protected characteristics - he emphasised the importance of the Board's role in the review of inequalities data as part of routine reporting and the progress required at pace. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	**RB/JM**
Bpu 24/05/11	**Report from the People & Organisational Development Committee** Mr Vallance presented the paper and highlighted that the Committee had a positive discussion around the transition into the new ways of working and the broader measures in respect of the People and Teams Plan. For accuracy, Mr Lewis requested for the sentence regarding Rotherham exceptional reports in relation to section 136 to be removed. **The Board received and noted the report from the People & Organisational Development Committee.**	
Bpu 24/05/12	**Report from the Mental Health Act Committee** Ms Fulton Tindall presented the paper, highlighting the detailed discussion held in respect of the legislation compliance performance report. The presentation of the data going forward would include real numbers as opposed to percentages and it would be disaggregated by protected characteristics. The Committee would become more focused on the Trust's compliance with the legal obligations for each patient in a given period: this shift in emphasis had been welcomed by the Board as a whole. Compliance with Section 132 rights was ranging between 80% - 85% and there would be focus at the next meeting around the nature/rationale for non-compliance and the associated documentation. Ms Fulton Tindall was pleased to note that a new system had been implemented in April 2024 to provide a more efficient way of recording Section 17 Leave. **The Board received and noted the report from the Mental Health Act Committee.**	

Bpu 24/05/13	**Report from the Audit Committee** Mrs Gillatt presented the paper highlighting that the preparatory work for the annual report and accounts 2023/24 was progressing to plan. The key risks for 2023/24, as per the external auditors, were property valuation, management override of controls and overstatement of trade creditors and accruals. Trust materiality was reported at £4.25m. The interim Head of Internal Audit Opinion had been received with a reduction to limited assurance and conversations were ongoing with 360 Assurance to ensure there was a collective understanding of the assessment methodology and associated conclusions. Mr Lewis commented on the interim opinion received and that the opinion proceeded from internal audit's view that the Board's decision around the management of its Board Assurance Framework (BAF) was mistaken. In addition, it proceeded from the belief that medium and high risk internal audit actions were delivered too late, data validation was ongoing in respect of this. The Annual Governance Statement would fairly represent the disagreement between internal audit's opinion and Mr Lewis's more positive opinion. It was agreed with internal audit that the final opinion would distinguish and more accurately reflect the period of transition through 2023/24 to the new operating model. With reference to the Clinical Audit Plan 2024/25, work was ongoing to ensure there wasn't any duplication with the Internal Audit Plan 2024/25 or more importantly gaps between them. There was an improvement noted in the response to internal audit recommendations, and this would continue to be a key focus area in terms of management oversight. **The Board received and noted the report from the Audit Committee.**	
Bpu 24/05/14	**Report from the Finance, Digital & Estates Committee** Mrs Vickers presented the paper, highlighting the focus on performance against the finance plan at year end. The Trust reported a £3.55m deficit forecast at year end (the original planned deficit was £6.15m). The care groups were on track to underspend on their budgets and the savings plan was on track. The most significant area of challenge was agency spend – new processes, additional controls and oversight would be implemented as part of the Agency Reduction Plan and this would continue to be a key focus area for the Committee. The draft finance, capital and savings plans for 2024/25 had been reviewed and scrutinised by the Committee and would be discussed later on the Board agenda.	

	Work continued to rebase Trust-wide vacancy factors as part of 2024-25 planning to ensure a consistent approach was taken across all areas. Mr Lewis commented that the Trust's vacancy factor historically ranged from 0% - 6% and that 2.5% was the intended vacancy factor over the coming year, in line with organisational workforce plans. The draft Digital Plan was reviewed and additional success measures included with a clinical and cyber security focus. An update was received regarding statutory and mandatory compliance for Estates services as part of the Estate Plan, this was aligned with the draft Capital Plan in terms of emerging risks. The 23/24 Procurement improvement plan would be a focus at the August meeting. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
Bpu 24/05/15	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report. During 2023/24 the coroner issued a regulation 28 report specifically to RDaSH in respect of mental health disengagement. Whilst no responsibility for the death of the young person was found, a significant piece of work had been undertaken around the Trust's disengagement policy – it is important that the clinical audit programme 2024/25 comprehensively included engagement and disengagement behaviours. Mr Lewis stressed the importance of this work given the number of individuals that had disengaged from mental health services, and reflected on the likely outcome of the Nottingham enquiry which may become a systemic issue nationally. The second regulation 28 letter, issued to NHS England, was in relation to eating disorder liaison services and a paper would be issued from the South Yorkshire Mental Health and Autism Collaborative Board on local compliance with the Medical Emergencies in Eating Disorders (MEED) guidance. Mr Lewis expressed that it was extremely difficult to assess compliance with the guidance unless as a health system, there were designated beds for people with an eating disorder that were not entirely focused in a physical hospital – this was an apparent gap in South Yorkshire's provision. Mrs Leese assured the Board that all regulation 28 reports were received at the Quality Committee and confirmed that there would be a review at July's meeting to consider if the work in response was on track. With reference to the investment on reducing waits in ADHD, Mr Lewis congratulated Dr Tosh and Sadie Watkinson-North on the agreement of shared care arrangements in Rotherham. This was real progress and offered the prospect of a maximum 1 year wait for adults over coming	

	months. There was less clarity on the children's waiting time trajectory and this was being discussed further through delivery reviews. Mr Lewis referred to the Trust's staff networks, particularly the success of the Disability and Wellbeing Network (DAWN) and the significant overspend of the new central 'reasonable adjustments' budget. During June, Mr Lewis and Mrs Lavery would be reviewing all of the staff networks and the outcome would be brought back to the Board in due course. This work was linked to the creation of the new Trust People Council which would bring together key staff and representatives to hear the staff voice at a senior level. Mr Lewis noted the concerns regarding the use of Oxevision and that whilst there was now a hugely improved position in terms of consenting practice and recording, this needed to be sustained. There would be a similar focus in respect of the resuscitation concerns highlighted at the last meeting. Mr Chillery provided an update in terms of Oxevision compliance, noting that mental health wards in Doncaster and Rotherham were at 100%, and North Lincolnshire were at 81%. Mr Lewis noted that the Quality & Safety Plan would include the key areas of Trustwide focus and he reconfirmed that he was very reluctant to turn off Oxevision as it was part of the Trust's wider improvement in terms of consent issues. Mr Lewis suggested further reflection on the learning from prior attempts that hadn't succeeded to drive forward the consented use of Oxevision. There was a strong reflection from the care group delivery reviews and crucial role of team leaders and ward managers in driving this forward. Mrs Lavery expressed congratulations regarding the new Trust People Council and staff network arrangements. Ms Fountain shared her congratulations around the overspend on reasonable adjustments and the representation of the Trust's communities and health inequalities. As Executive Sponsor for the DAWN Network, Mrs McDonough highlighted the previous challenges with accessing the right reasonable adjustments and positive progress made in supporting staff. Some issues remained in terms of delays in access which would be rectified as the work progressed. Mr Vallance referenced that around 600 people joined the Trust on a yearly basis with a potential lack of induction and feeling unsupported, he expressed the importance of ensuring there was a shared culture and ensuring staff were 'job ready'. Mr Lewis commented that a range of feedback suggested there was inconsistency in the induction process and noted the further work required to improve the 'job ready' position. The Trust would move back to a face to face induction in the coming months which would include an induction into the communities. Mrs Holden noted that the people promise exemplar site had recently commenced which focused on Trust staff retention. During 2023/24, a quarter of staff leaving the Trust did so with less than 1 years' service.	**TL / KL**

	She reiterated that the Trust's induction programme would be upscaled and improved. Ms Mehan commented that the induction programme was internally focused and encouraged the value of inducting staff into the communities. Mr Lewis agreed. He highlighted the great success in the recruitment of consultant psychiatrists since Christmas and noted Ms Mehan's point in suggesting that the consultant psychiatrists could work with local General Practitioners (GPs) to understand the referral process and ways of working as part of their induction. **The Board received and noted the Chief Executive's report and the forward actions it contained.**	
Bpu 24/05/16	**Change in Responsible Officer** Dr Tosh presented the paper which included a request for the Board's approval in the transition the role of Responsible Officer from Dr Graeme Tosh, Executive Medical Director, to Dr Sunil Mehta, Deputy Medical Director, from the 1 July 2024. **The Board approved the transition of the Responsible Officer to Dr Mehta from 1 July 2024.**	
Bpu 24/05/17	**CQC Preparedness – Well Led Domain** Mr Gowland presented the CQC Preparedness Briefing which focused on the Well Led Domain. The paper set out the ongoing work which supports the ambition of achieving a good rating for well led. The framework proposed in the paper was welcomed by Board members. A further update would be provided to the Board in September to outline the complete self-assessment against the CQC framework, including other aspects of work such as the Code of Governance and next steps in relation to the Good Governance Improvement (GGI) report. Mr Lewis drew attention to the GGI report, reminding the Board that GGI were commissioned to review the new operating model and that they would be returning in December 2024 to provide further feedback on its implementation. The intention of the report was to provide a framework for the re-assessment later in the year although it offered recommendations in the intervening period. The report made seven recommendations, a number of which were linked to the business of the Board, such as the refresh of the Board Assurance Framework and the voice of patients, linked to promise 5 - the remaining recommendations required further reflection in terms of informing a response. Mr Lewis was particularly interested in the outcome of the re-assessment later in the year, at which point the operating model would be fully embedded. Mrs Lavery agreed with Mr Lewis' perspective and reflected on the Board	

	accepting the collective and individual responsibility and moving forward with the new ways of working. Mr Vallance felt that the report was vaguer than expected and referred to the areas of work to take forward as a Board before the next re-assessment by GGI. Mrs McDonough referred to the follow up report and evaluation, questioning if the leadership within the care groups would be engaged as part of the work. Mr Lewis suggested that it would, at a point in time through a separate process. Mr Chillery commented on the need to clarify the purpose and the conduct of meetings, and the support required to ensure people are confident in chairing meetings and holding people to account. Mr Lewis agreed with the point raised, recognising the developmental work required to provide the necessary support. He highlighted the intended 'shift' from an assurance culture to a delivery culture. In response to Mr Vallance, Mr Lewis clarified that the evidence in respect of the Well Led Framework would be collected, a self-assessment would be undertaken in June with an update to the Board in September. **The Board received the CQC Preparedness Briefing – Well Led Domain and agreed the recommendations included in the report.**	**TL**
Bpu 24/05/18	**Constitutional Amendment – Composition of the Membership and Council of Governors** Mr Gowland presented the paper which included the proposal to amend the composition of the membership of the Council of Governors (CoG) within the constitution. Through a series of discussions with the CoG and reviews of the constitution, there are a number of items identified as impacting on governor recruitment. The primary objectives was to ensure the composition of the CoG was achievable and workable in terms of recruitment and flexibility, and representative of the communities the Trust served. Lead Governor Jo Cox thanked the governors involved in the discussions, with particular thanks to Susan Black (Corporate Assurance Officer) for her continued support to the governors. The discussion and consideration around the composition of governors arose from the 2023/24 election process, where the current constitution meant that there more candidates than vacancies in some areas, with no candidates for particular areas. Jo then summarised the proposed amendments that were fully supported by the CoG and included in the paper. The Board was invited to discuss any amendments to that work. From a practical perspective, Mr Gowland suggested that having a staff governor for each care group, and one for corporate / backbone services was preferable to that CoG suggestion of 'clinical' and 'non-clinical' staff.	

	This was actively agreed after discussion, recognising that we needed our arrangements to now reflect our structure. Mr Lewis questioned if there was a limit of 9 partner governors and if there wasn't then he suggested the current seat for the Voluntary, Community and Social Enterprise (VCSE) representation should be maintained. Following discussion, it was agreed that VCSE would retain the partner seat. Mr Lewis was keen to ensure there was sufficient representation to achieve geographical parity where appropriate and asked for this to be considered as part of partner governor recruitment. Mr Chillery and Ms Fountain acknowledged the introduction of youth representation and considered the environment and support required to ensure they could effectively fulfil the role and have a voice. Jo Cox expressed that the governors felt strongly around the introduction of youth representation and felt this was currently a gap, and two youth positions were proposed to enable peer support. Mr Gowland clarified that a suggestion was made from the Children's Care Group that their youth 'patient voice body' could be the source of those seats. **The Board agreed the amendments to the composition of the membership / Council of Governors within the Constitution, including the supplementary proposals made regarding the alignment of staff governors to the organisational structure and VCSE.**	
Bpu 24/05/19	**Leadership Development** Mrs Holden drew attention to the key points, recognising the importance of the Trust's new leadership development offer (LDO). She highlighted the number of individuals across the Trust that came forward to help in shaping the offer, a commercial tender process commenced in February which initially attracted 5 suppliers. A robust presentation day and a competitive dialog process has been undertaken to determine the chosen supplier and this process would be concluded and final supplier(s) chosen in the coming weeks. It was anticipated that the LDO would be launched at the Leaders' Conference in September. Approximately 150 senior leaders would commence the 3 year programme during 2024/25, with a further roll out over the next two financial years. Mrs Holden highlighted the need to ensure there was a consistent approach and application across the Trust footprint, recognising the organisational strategy and promises. Supplementary to the core programme, a number of additional elements would be considered separately, including Restorative, Just and Learning Culture, Team Effectiveness and Development Tool (TED) and a focus on protected characteristics / inclusion of the communities to enable shared learning. Ms Fulton Tindall asked how staff would receive and be engaged with the offer and Mrs Holden advised that a number of working groups had taken place with a range of professions where some colleagues were favourable	

	of leadership development and others not so. Discussions had also taken place via the Education & Learning CLE group and delivery reviews. Mr Vallance emphasised that the success of executive leaders would make the biggest difference through active participation by setting clear expectations, including coaching and mentoring. He encouraged the introduction of quarterly reviews by the executive leaders to ensure active management. Mr Banks referred the wider leadership skills required, and questioned how this would be linked to Trustwide recruitment in terms of expected skill sets for new members of staff. Recognising that the Trust was lacking in terms of line managers induction, Mrs Holden advised that new staff with line management responsibilities would go through a comprehensive programme, and noted the use of job descriptions, portability of MAST training and succession planning. Recognising the significant leadership changes as part of the new operating model, Mr Chillery considered the development of modern matrons and service managers and the need to ensure there was a consistent offer across the organisation in terms of the wider leadership support aside from the programme: although both of the named roles are part of the Top Leaders' Cadre. Mr Lewis noted the importance of viewing the programme as skills development and agreed with Mr Vallance around the Trust's active role in progressing this work forward. He clarified that there would be one leadership development offer for the Trust. Discussion ensued regarding the baseline measures in respect of practical skills and the subsequent transparency around this. Mrs Gillatt recognised the significant investment in people for the 18 month programme and queried the plans in the event of staff dropping out / leavers. Mrs Holden noted that this would be considered and there would be a level of flexibility dependent on individual circumstances. Mr Lewis stated that 40% of leaders worked in corporate services and the work required to ensure staff were prepared for the programme. Mr Vallance offered his support on behalf of Non-Executive Directors to accelerate / amplify the programme and noted he would be joining the programme board. The Board recognised the need to review the wider leadership support to line managers within this financial year, and agreed to revisit the effectiveness of what is being done during Q4 2024/25. **The Board supported proceeding with the leadership development offer in 2024/25 as outlined, subject to receipt of a satisfactory and affordable bid.**	**CH**
Bpu 24/05/20	**Clinical and Operational Strategy: Strategic Objective Two** ***'Create equity of access, employment and experience to address differences in outcome'***	

	Mrs McDonough presented the update, noting that the paper set out the complexities and difficulties associated with the implementation of strategic objective two and its key promises, and the shift required in order to address health inequalities. She highlighted the significant challenge of being able to maintain consistency around clinical standards across the organisation, at the same time as delivering care to meet the needs of local communities, with an impact on health inequalities and narrowing the gap. She then considered the Board's role in driving this ambition forward. In terms of improving community engagement, Mrs Lavery questioned how this would work in terms of digital exclusion. Mrs McDonough noted that work was required to identify ways of engaging with all communities, regardless of digital access. Mrs Leese suggested there was a theme emerging throughout the meeting in respect of patient experience and the difference between the Trust's view and people's journey and experience of the care delivered. She referenced the capacity and capability required to understand and gain insight on whole patient journey, such as poverty proofing, digital access and wait times. Mr Forsyth referred back to the patient story and the need to consider the family / social aspect, as opposed to providing care in isolation. Following on from Mr Falk's comment around engagement with primary care, Mr Lewis referenced promises 7 and 8 and the challenges they posed in terms of the Trust's relationship with local GPs which required a further learning discussion. Mr Lewis then noted the challenges in respect of recognising and responding to specific needs of rural communities (promise 12) and the focus required as a Board to learn and determine the way forward to address this. Mrs McDonough summarised the intention to work with communities to minimise the impact on inequality and the collective focus required from a Trustwide perspective. The Equity & Inclusion Plan would be presented to the Board in due course, where decisions would be made in terms of commitment to resource the plan. **The Board received and noted the report on Clinical and Operational Strategy focused on Strategic Objective Two.**	**JMc**
Bpu 24/05/21	**2024/25 Finance Plan** Mr Currell presented the paper and drew attention to the key points. The paper provided an update on the revised financial plan 2024/25 that was submitted to NHSE at the beginning of May, with an intended deficit	

	of £3.8m. General growth funding of £0.7m had been included in the Trust's South Yorkshire (SY) ICB contract allocation and £0.7m of funding had been allocated to cover additional depreciation charges in line with the national funding model. The Trust so far had not received any Service Development Funding (SDF). Mr Currell referred to the areas of material risk, noting the achievability of the CIP target (£6.7m), the Trust was currently £1.4m short against identified schemes, and the assumed slippage on in year costs of £2.4m. The other key risk was in relation to Adult Eating Disorder Provider Collaborative (AED PC). The Trust's 2024/25 plan assumed a balanced position on the AED activities, with discussion ongoing between the Trust and NHSE on additional funding in 2024/25. This risk has been included in the Trust's plan submission to the ICB and NHSE. Mr Currell referenced the cost pressure reserve (appendix 3) of £3.4m, highlighting the positive plans in place to make a difference to improve patient care, and the funding received for ADHD waiting lists. In response to Ms Gillatt, Mr Currell advised that whilst the Trust had a deficit plan, there were cash reserves in place. Mr Lewis referred to the five areas of material risk and the dependence on the closure of beds which was embedded in the plan. This remained subject to discussions and by the end of July, the Trust would need to conclude which option was to be progressed from October 2024. He then referred to the agency reduction plan, which assumed a £1m benefit from this workstream. He noted the introduction of revised approval mechanisms agreed through the Clinical Leadership Executive. Routinely agency would require agreement from the Care Group Director, relevant clinical executive, and for the next two quarters at least from himself. He acknowledged that it was foreseeable that on occasion clinical advice may be perceived to be being overruled but highlighted his confidence that the 'three ticks' system would bring greater rigour to approvals and to the pace of exiting agency commitments. The expectation is was that Q3 agency will be materially lower than Q1. Mrs Leese sought further clarity around the potential to overrule clinical advice on decisions regarding agency use. Mr Lewis noted that agency would not be utilised without all three 'ticks' being satisfied that every alternative had been exhausted. This was expected initially to be difficult to achieve as existing analysis suggested historic practices had not been as purposive as they now would be. There would however be an assessment and record of the impact of every decision made. Mrs Leese emphasised the importance of ensuring that quality and safety would be fully considered. Mr Lewis drew attention to the mechanisms to do that, and highlighted the harms arising from agency use. Mr Vallance noted the absence of waiting list data at Board level and, referring to the funding received to reduce the ADHD waiting list, sought	

	clarification on the plans in place to address other service waits. Mr Lewis referred to the robust bid process that had taken place, with scrutiny received at the Clinical Leadership Exectuvie (CLE). A number of the bids approved were related to waiting times, however several were not supported due to the absence of numeric and quantified data. Mr Chillery was leading on the process regarding waiting lists. The comparative data on ADHD waiting times would be brought to the Board in Q2. In response to Mrs Vickers and the oversight of the vacancy factor, Mr Lewis noted that the 2.5% vacancy factor applied to directorate level, and the rosters would run in line with the budgeted WTE. This was perhaps the first time that vacancy factors had been coherently used as a tool within the Trust, and we would to evaluate their impact. In response to Mrs Lavery around the national requirement to lower staffing numbers, Mr Lewis referenced the perception that since 2019, the NHS had employed a large number of staff and had not seen the productivity gains. This was not the case for the SY ICB and with the significant reduction in agency use, the Trust would be operating within the spirit of the intention, with the Trust seeking to become fully staffed against its establishment. Mr Lewis wasn't aware of any instruction to the Trust to enforce a 'vacancy freeze' and he advised the Board that such blunt instruments were highly questionable – preferring instead the scrutiny model applied now by Care Groups and Executive Directors. **The Board reconfirmed its support for the 2024/25 Financial Plan noting that the deficit would be exceeded if the AED contract with NHSE was not 'back to back' with the ICB submitted plan.**	**RC**
Bpu 24/05/22	**2024/25 Capital Plan** Mr Currell presented the paper which set out the proposed revisions to the phase 1 Capital Plan agreed at Board on the 28 March 2024 and the proposed phase 2 Capital Plan. The two phases reflected concern to ensure clinical risk was widely considered before making relative choices. The proposed plan for phase 2 totalled £5.6m, and therefore the total capital plan was £6.7m against an allocation of £6.6m. Mr Currell advised that the level of over commitment was manageable in year either through in year bids for additional funding or through the management of slippage and phasing of schemes. The paper also set out the schemes that were not supported at this point in time, drawing attention to the likelihood some will not proceed at all. Mr Currell highlighted the significant schemes as Great Oaks Refurbishment (Phases 3 and 4) and the Mental Health inpatient doors, and the requested that the Board delegated approval of the two related business cases to the Finance, Digital and Estates (FDE) meeting in June. The paper set out the detail of the review of ligature risk and door safety, being undertaken by the Chief Nurse across all inpatient areas. The full	

	cost of this programme could range from £0.5m up to a potential £3.3m. The budget was currently set at £1.9m. The paper outlined a 'door panel' to oversee this work, chaired by the Chief Executive. This would hold and manage the risks being debated and report back to the Board in due course. Mr Forsyth summarised the concerns in relation to the current inpatient doors, noting that the Trust was awaiting a response from the current provider in terms of the identified queries. Mrs Leese was pleased to see a well thought out capital plan and valued Mr Forsyth's expertise and input into the ligature review work. She referenced the ongoing action on the QC action log around the completion and assurance in respect of ligature risk assessment. She then referred to the areas that were not currently prioritised as part of the plan, such as Hazel & Hawthorn wards. Mr Lewis noted that the section of the plan referred to was about not prioritised in 23/24 but agreed for 24/25. Mr Lewis confirmed that there would be a full review of ligature risk by ward, by Q4. Interim assurance would be provided through the QC. **The Board:** - **Approved the revisions to the phase 1 capital plan set out in Appendix 1.** - **Approved the phase 2 capital plan set out in Appendix 2.** - **Approved the prioritised schemes which would be progressed when funding becomes available set out in Appendix 3.** - **Approved delegation of approval of the Great Oaks Phase 3 & 4 business case to Finance, Digital and Estates committee.** - **Approved the recommendations set out in Appendix 5 paragraph 17 regarding the ligature risk and door safety review.**	**SF**
	Mr Currell left the meeting at 14.15.	
Bpu 24/05/23	**Our 28 Promises – success?** Mr Lewis presented the paper which provided a summary of the work undertaken over the last six months to create a working 'finish line' measure for the promises and noted the split over four categories of progress. Mrs Lavery welcomed the paper and noted that 10 promises are now in delivery, which is welcome and perhaps not widely understood. Ms Gillatt questioned if there would be a phase focused on the embeddedness of the promises. Mr Lewis noted the development of the quantifiable success measures that would offer this, alongside an evaluation of how it feels following delivery. Mr Chillery suggested allocating time for the Board to further discuss the promises in depth, it was agreed that this would be allocated to a future	

	Board timeout. He was especially concerned to explore the 'handover' from design to delivery. Mr Vallance queried if the paper was measuring the completion of the task or the intent. Mr Chillery commented that the focus was not solely on the outcome measures, but also how they fit with the other promises. Mr Lewis welcomed the depth of discussion, which he hoped would be ongoing. **The Board received and noted the 28 Promises Update.**	
Bpu 24/05/24	**Productivity** Mr Lewis presented the paper in respect of productivity, recognising the strong support from the South Yorkshire ICB for the Trust to lead work in this area. The paper focused on best use of time in all disciplines and professions. Izaaz Mohammed (incoming Director of Finance) would be leading this work from October. Mr Lewis suggested that the Board returned to this topic within the August timeout. Ms Fulton Tindall commented that the paper was innovative and it provided a positive stance in terms of being efficient and effective. Mr Vallance sought further understanding on the nature of the challenges being faced across the communities and the associated data. Mr Lewis noted that the ICB had agreed to fund some of the work in this space and emphasised his particular focus on the interface with General Practice. There was ample space for the Trust to help release time for others as well as focusing on its own agenda. **The Board received and noted the paper on Productivity and agreed to discuss further at the August Board timeout.** *[DN it has subsequently been proposed to use the October timeout for this work]*	
OPERATING PERFORMANCE / GOVERNANCE / RISK MANAGEMENT		
Bpu 24/05/25	**Board Assurance Framework** Mr Gowland presented the paper which brought together in one place all of the relevant information on the risks to the achievement of the Board's strategic objectives. Following previous discussions in March, the Board spent time in its April timeout to consider the risks further and this paper set out the key Strategic Deliver Risks that would be the Board's focus during 2024/25 - each risk had an assigned risk lead and Board assurance Committee in terms of monitoring, oversight and reporting. The paper included the first draft of key controls and the sources from which the Board would seek assurance on the effectiveness of those controls in mitigating the risk. Mr Gowland referenced the key topics discussed throughout the meeting that featured within the Strategic Delivery Risks, such as challenges in	

	working with diverse populations, addressing health inequalities, primary care and productivity. Mrs McDonough referred to the risk relating to primary care and commented on the Trust's role in working to build an effective relationship with local GPs. Mr Lewis confirmed that this was covered within the risk and requested for the word 'sides' to be amended to 'parties' within the risk description. Mr Vallance referred to the risk assigned to SO4 and questioned the focused view being the NHS Terms and Conditions as the blocker, rather than the Trust's own ability to lead change. Mr Chillery referred to the strong cultural normality around 5-day working and how this would need to be addressed. Ms Gillatt asked if financial stability and culture had been considered as potential risks. Mr Gowland noted the change focus of the strategy and that whilst referred to in the paper, the Board, in its timeout, had agreed that financial stability would not impede on the ability to deliver the strategy. In response to Mrs Vickers, it was greed to circulate the risks that were not included in the final set of strategic risks, with an explanation to where else they are being taken forward. From an operational risk perspective, Mr Gowland clarified that the Boards focus would be on the extreme risks only. In terms of strategic risk, the Board would be sighted on the keys as part of its workplan, and Mr Gowland with the Audit Committee chair would meet with the strategic risk leads 3 times a year to review progress on the actions to mitigate the risks. **The Board received the Strategic Delivery Risks (Board Assurance Framework) Update and supported the proposed risks and their identified lead executive and Board committee.**	**PG**
Bpu 24/05/26	**Integrated Quality Performance Report (IQPR) including Finance Report M12** Mr Chillery introduced the Integrated Quality Performance Report (IQPR) for April 2024, including the Finance Report for Month 12. The 'Big Six' Long Term Plan targets had been agreed for 2024/25. The IQPR contained the fields previously seen by the Board, except some data currently held nationally in the Mental Health Services Data Set (MHSDS) report (this would return to 'normal' in mid-June). Talking Therapies remained below the volume target of 1,915 with actual performance of 1,359, this was a key focus at the recent delivery reviews. There was a sustained improvement in a number of key quality metrics, with a slight downward trajectory in respect of VTE and MUST. This continued to be a key focus at the Quality Committee.	

	There was a positive improvement around Personal Development Reviews (PDRs), the 90% standard had been met (at 91.09%), and a small drop in sickness absence rates from 4.91% to 4.53%. The IQPR was currently under review in order to strengthen it further, and associated feedback was awaited from the care groups. <u>M12 Finance Report</u> Mr Lewis commented on the Better Payment Practice Code, 85.9% of invoices had been paid within the timescale against a target of 95% at the end of March, he requested future reporting separately identified recent month not cumulative performance. **The Board received and noted the Integrated Quality Performance Report (IQPR) April 2024 and the M12 Finance Report.**	**IC**
Bpu 24/05/27	**Operational Risk Report – Extreme Risks** Mr Gowland presented the paper and noted the increase in the number of extreme risks There were currently 5 extreme risks which were all subject to regular review by the respective risk owner and to monthly scrutiny via the Risk Management Group. Mr Lewis requested for future iterations to include the risk target mitigation date and key planned actions. **The Board received and noted the Operational Risk Report – Extreme Risks update.**	**PG**
Bpu 24/05/28	**Board Annual Workplan 2024/25** Mr Gowland presented the proposed Board Annual Workplan for 2024/25. The workplan would, when and where necessary, be added to as matters emerge or escalate during the year that require the Board's attention or decision. In addition, there was an intent to also consider a thematic focus for future Board's meetings – starting in July with an 'Education' focus. Over the coming weeks, proposed topics would be identified. Mr Banks suggested an additional item to be added on an annual basis around cyber security in line with the FDE Committee Terms of Reference and workplan. Mr Lewis confirmed that the enabling plans would be included in the final iteration of the workplan. **The Board agreed the Workplan for 2024/25.**	

SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEES)		
Bpu 24/05/29	Mrs Lavery informed the Board of the following additional reports for information which were presented as supporting papers that had previously been presented at committee level for scrutiny and challenge: • Learning from Deaths Annual Report 2023/24 • Guardian of Safe Working Hours (to 31.03.2024) • Freedom to Speak Up: Q4 (to 31.03.2024) **The Board received and noted the additional reports for information.**	
Bpu 24/05/30	**Any Other Urgent Business** There was no further business raised.	
Bpu 24/05/31	**Chair's Summary (Actions, Decisions, and new risks)** Mrs Lavery gave a brief overview of discussions from the meeting in particular the CQC Preparedness - Well Led update, Leadership Development, constitution amendment, the focus on Strategic Objective Two and the new Strategic Delivery Risks.	
Bpu 24/05/32	**Public Questions** There were no questions raised by members of the public.	
Bpu 24/05/33	The Chair resolved '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press would be excluded from the remainder of the meeting, which would conclude in private.*'	

Rotherham Doncaster and South Humber NHS Foundation Trust

PAPER C – ACTION LOG – BOARD OF DIRECTORS:

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
23/11/2023 CEO Report	**Audit of Practice** Mr Lewis will be coordinating an audit of practice of Oxevision through February which will be shared with the Quality Committee and Board in March 2024	TL	**July 2024:** A verbal report was provided at the last Board and will be provided again. There is now confidence that work on this is embedded within Care Groups.	Propose to Close
Bpu 24/03/17c CEO Report	**Vacancy Summary** Vacancy summary to be provided as an annex to the CEO Report.	TL	**July 2024**: Included within CEO report (Agenda Item 14).	Propose to Close
Bpu 24/03/13	**RIDDOR Information** Ms McIntosh confirmed that recent RIDDOR events would feature in the next related report to POD.	CH	**July 2024**: The paper was presented to POD in June 2024. In future the committee will be specifically asked to assure the Board on the specific actions being taken to prevent recurrence (an annual audit of which will take place).	Propose to Close
Bpu 24/01/15	**EPRR** Mrs Lavery summarised the discussion and asked for a report in July, rather than the proposed September. The Board received the EPRR update report and agreed as amended the recommendations contained in the report.	RC	**July 2024:** EPRR update report to be presented (Agenda Item 23).	Propose to Close
Bpu 24/05/08	**Report from the Quality Committee** Agreed that key findings and recommendations from the findings of the independent review of		**July 2024**: The independent review of GMMH was circulated to Board members.	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
	Greater Manchester Mental Health NHS Foundation Trust (GMMH) would be circulated to Board members outside of the meeting.	SF		
Bpu 24/05/20	**Clinical and Operational Strategy – Strategic Objective Two** Mr Lewis referenced promise 7 and 8 and the challenges they posed in terms of the Trusts relationship with local GPs which required a further learning discussion.	JMc	**July 2024**: We are currently scoping how and what we will deliver under promises 7 and 8. They, and other promises, will require joint working with Primary Care. The Board has recognised that if we do not have this in place there is a risk to us delivering our strategy. This has been developed into one of our Strategic Delivery Risks (SDR) which we will develop actions and mitigation for in the coming months. Report on SDR 3 provides an update, presented under Agenda Item 17. In the meantime, we are recruiting to a new post of Primary Care Strategic Lead to help us improve relationships with Primary Care.	Propose to Close
Bpu 24/05/21	**Financial Plan 2024/25** ADHD Waiting List The comparative data on ADHD waiting times would be brough to the Board in July.	RC	**July 2024**: ADHD waiting list update included within CEO report (Agenda Item 14).	Propose to Close
Bpu 24/05/25	**Board Assurance Framework** Agreed to circulate the risks that weren't included in the final BAF, with an explanation to where else they are being taken forward.	PG	**July 2024:** Report on SDR provides an update, presented under Agenda Item 17.	Propose to Close
Bpu 24/05/27	**Operational Risk Report – Extreme Risks** Future iterations to include the risk target mitigation date.	PG	**July 2024**: Further details provided within the Operational Risks Report, presented under Agenda Item 25.	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/05/15	**Chief Executive's Report** Staff Networks During June, Mr Lewis and Mrs Lavery would be reviewing all of the staff networks to explore what they wish to achieve, the outcome would be brought back to the Board in due course.	TL / KL	**July 2024**: Reflections on those meetings are included within both the public and private CEO reports: details of new sponsor arrangements are in the former.	Propose to Close
Bpu 24/05/15b	**Chief Executive's Report** Local Induction Work ongoing to build an outstanding face to face induction system - A report on progress will be at the Board's meeting in September.	CH	**July 2024:** July 2024: Work is progressing to design a face-to-face induction programme, which is likely to span 5 days. This was discussed at the June CLE meeting and was positively received. A preview will be shared with the Board prior to go-live.	Propose to Close
Bpu 24/05/18	**Leadership Development** The Board recognised the need to review the wider leadership support to line managers within this financial year, and agreed to revisit the effectiveness of what is being done during Q4 2024/25.	CH	**July 2024:** Work is progressing on the Band 5 and the Senior Clinicians development programme, in addition to the LDO. The Board agenda plan for Q4 will include this item.	Propose to Close
Bpu 24/05/20a	**Clinical and Operational Strategy – Strategic Objective Two** Mr Lewis then noted the challenges in respect of recognising and responding to specific needs of rural communities (promise 12) and the focus required as a Board to learn and determine the way forward to address this.	JMc	**July 2024**: Work has commenced on understanding the challenges of our rural communities. Exploratory work being led by our North Lincolnshire Care Group has sought to understand how other parts of the country have addressed the specific needs of rural communities. We have joined the National Centre for Rural Health & Care in order to maintain our collaboration with others. ***Future Board development time will include time for expert briefings on this topic.***	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/01/13a Bpu 24/01/3b Bpu 24/03/13	**Resuscitation Equipment** Mr Lewis was keen to revisit this topic at the next Board for further discussion to understand the challenge and issues on resuscitation equipment.	TL	**July 2024:** Unlike Oxevision, these audits are not yet embedded – oral update to be provided within CEO report item of meeting.	Open
Bpu 24/03/11	**Mental Health Act Committee Report** TAMS Training and impact on compliance with MHA. Dr Tosh noted the planned discussion to address this feedback and also the work with Ms McIntosh to ensure a recent change in the law was actioned, which may result in the TAMs inheriting employee status.	GT CH	**July 2024**: work to recruit to 8 new TAMs and to enrol NEDs within the group as well is in hand and will be visible before the end of July. **July 2024**: Further to an internal working group there are no issues associated with potential National Minimum Wage breaches but further scoping work is being undertaken on associated benefits to address any potential risks	Open
Bpu 24/03/13	**Racist Incidents** Mr Lewis stated the intention for CLE to discuss this matter in April, with a view to agreeing the policy that he had outlined in January at May's CLE.	TL	**July 2024**: This topic featured in the CEO VLOG on the 17 May 2024 and the draft policy referred to previously was discussed at the CLE on 21 May 2024 and is now being consulted on further: it is due for implementation imminently.	Open
Bpu 23/11/15a	**Chief Executive's Report** RCRP data management Consequences from RCRP implementation with annex 3 setting out the planned data focus - yet noting a lack of baseline.	TL	**March 2024:** Update on RCRP impact using this data to return to Board in **September 2024.**	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/03/17	**Chief Executive's Report** WRES data The People and OD Committee were requested to receive a report at its June Committee on WRES that also included additional information drawn from sources such as FTSU, PSIRF and Trade Unions.	CH	**July 2024**: Scheduled to be presented at POD in October 2024. The Board will consider further in **September**.	Open
Bpu 24/05/10	**Report from the Public Health, Patient Involvement & Partnerships Committee** The review to be undertaken (at pace) of inequalities data required as part of routine reporting at Board level.	RB/JM	**July 2024:** Work is underway to scope the data required and our first report on inequalities data will be available for PHPIP and Board **in September**.	Open
Bpu 24/05/15a	**Chief Executive's Report** Response to Regulation 28's To consider progress on actions arising from the two regulation 28s received during 2023. 1) relating to the review of the disengagement policy (from Reg 28 received by the Trust) 2) relating to Eating Disorders Services (from Reg 28 sent to NHS England).	GT	**July 2024:** 1) The Trust is behind with the commitments made, because policy agreement has been delayed. A review of progress with the CEO/COO will take place before the next Board meeting. 2) The MHLDA Board has agreed an approach to the MEED guidance, which is being explored with Acute Federation representatives.	Open
Bpu 25/05/16c	**Chief Executive's Report** Review of the effectiveness / appropriateness of the quality and safety metrics to be used within the Trust's revised IQPR.	SF	**July 2024**: Initial work from Care Groups has been collated, and some first thoughts shared with QC in July: RB/TL/SF meeting next week to consider further.	Open
Bpu 24/05/17a	**CQC Preparedness – Well Led** Mr Lewis clarified that the evidence in respect of the Well Led Framework would be collected, a self-assessment would be undertaken in June with an update to the Board in September.	PG	**July 2024:** As noted in the meeting, Well-Led self-assessment will be presented to the Board of Directors in **September 2024.**	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/05/23a	**Capital Plan 2024/25** Ligature risk and door safety - there will be a full review of ligature risk by ward, by Q4.	SF	**July 2024**: Full review of ligature risk by ward has commenced, to be completed by Q4.	Open

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Digital & Estates Committee	**Agenda Item:**	Paper D
Date of meeting:	19 June 2024		
Attendees:	Pauline Vickers (Chair), Richard Banks, Sarah Fulton Tindall, Carlene Holden, Izaaz Mohammed (deputising), Philip Gowland, Ian Spowart, Victoria Takel (deputising), Rachael Blake.		
Apologies:	Richard Chillery, Ian Currell, Richard Rimmington		
Matters of concern or key risks to escalate to the Board:	**Vacancy and Workforce Reporting** – work is nearing completion to rebase Trustwide vacancy factors as part of 2024/25 planning to ensure a consistent approach is taken across all areas.		
Key points of discussion relevant to the Board:	**Performance against the finance domain of the IQPR** – at Month 2, the Trust had a deficit of £524k (£102k better than plan). From Month 3, there will be a forward view focus undertaken with budget holders including recruitment, CIPs, investment reserve items, and mitigating / recovery plans. **Finance & Savings Plan 2024/25** - show a planned deficit of £3.6m. The plan forms the basis of individual Directorate budgets and includes a savings target of £6.7m. There are five areas of risk including a potential unmitigated pressure circa £1.1m in respect of energy inflation. Plans to mitigate energy inflation are being developed and form part of the Trust's savings plan, with a target to reduce costs to £0.8m. **Capital Plan 2024/25** – noted the revisions to the phase 1 Capital Plan, the phase 2 capital plan and review work that has been undertaken; the prioritised schemes which would be progressed when funding becomes available; the delegation of approval of the Great Oaks Phase 3 & 4 business case to FDE; the recommendations regarding the ligature risk and door safety review. **Audit Recommendations Progress Report** - update provided on the recommendations and action plans underway; Financial Ledger and Reporting 360 Assurance audit opinion - *Moderate Assurance*; IQPR 360 Assurance audit opinion – *Significant Assurance*. In addition, the audit of the DSPT was undertaken by KPMG and provided an overall risk assurance rating of '*partial assurance with improvements required*'. Assured that internal audit recommendations were being managed appropriately.		
Positive highlights of note:	**DPA18/GDPR, IG Incident & DSPT Update Report** – Robust processes in place to support completion of the 2023/24 DSPT submission against all assertions by 28 June 2024 deadline. Noted the robust plans and processes in place to support IG Compliance. **Information Quality Work Programme 2024/2025.** Focus for 2024/25 is the Integrated Quality Performance Report (IQPR) and the introduction of the 'Mighty 9' which are a mix of national and local priority Key Performance Indicators (KPIs). Current methodology to be revised. The work programme will feature 8 specific measures to be reported to FDE.		
Matters presented for information or noting:	**Estates Update.** The future estate plan continues to progress with Shared Agenda, including what shared space is required and how best to provide future clinical models. Capital phases 1 and 2 works noted. Estates service actions are nearing completion following the 2023 patient led assessment of the care environment (PLACE) audit. The estate risk register continues to be reviewed and linked to the capital plans to mitigate and reduce risks.		

Decisions made:	**Business Cases** – the Committee agreed to proceed with **Great Oaks Phase 3 & 4**; the creation of two additional bedrooms, a crisis assessment centre and other associated work including office space. The Committee agreed to proceed with **Waterdale**; the relocation of Children's Services into a central space in Doncaster City Centre, subject to completion of the impact assessment and the Committee requested to be kept informed on progress regarding the issues raised through the Capital Plan update
Actions agreed:	**Finance Report – Month 2**. To be shared with the Committee when available. **Business Case – Great Oaks Phase 3 and 4**; further consideration for safe staffing, IT, training facilities and any impact of Phase 1 patient bedroom door priority work. **Business Case Waterdale** – impact assessment to be undertaken as soon as feasible.

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

Report to the Board of Directors meeting scheduled for 25 July 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper E
Date of meeting:	17 July 2024		
Attendees:	Dave Vallance (Chair), Dawn Leese, Toby Lewis, Dr Graeme Tosh, Carlene Holden, Jo McDonough, Dr Janusz Jankowski.		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	• **Draft Research & Innovation (R&I) Plan**. The five areas of focus will be dementia; ADHD; virtual technology; physical health (nutrition and exercise, obesity); community-based research and innovation. Further development work to the R&I plan continues including the SMART measures and focus on innovation, how investment would improve outcomes, and use of charitable funds for research initiatives. • **Patient Involvement – Promise 5**. Work is in progress how we mobilise and engage our membership and project this summer is developing options to that purpose, which will be presented for agreement within the September Council of Governors. The map of community participation across the organisation expected to be ready by December 2024.		
Positive highlights of note:	• **Promise 8 – The RDaSH 5**. The Trust is committed to identifying five key areas that we want to have an impactful change upon in terms of inequalities. Three of the Five key areas are already in progress (AHCs, dementia, older peoples Talking Therapies). Work continues throughout the summer to mobilise and start shaping delivery.		
Matters presented for information or noting:	• **NHS South Yorkshire ICB**. The committee were presented with Health Inequalities faced by Gypsy Roma Travellers (GRT) with focus on mental health. The presentation addresses a number of Promises within the Trust Strategy and highlights the issue of sustainable funding required to recruit, develop and train trusted link workers as essential to maintain connections to the GRT community and the need to address barriers to accessing support services resulting from lack of address or GP registration. • **Identified Statutory Responsibilities**. An update on Ellen Mede was provided rated as inadequate by CQC, NHSE quality improvement process in place with continued monitoring of implementation with providers and partners.		
Decisions made:	• **Flourish Enterprises**. The Committee received details of three prospective new Directors for Flourish – all were endorsed by the current Flourish Directors. Support was provided by the Committee to their appointment (Subsequent to this support, Kath Lavery, Chair confirmed the appointments on behalf of the RDASH Board of Directors) • **Significant operational risks** to be escalated formally to the Committee for due diligence and completeness.		
Actions agreed:	• **Health inequalities for GRT / Working with Partners**. Update at the next committee from discussions and dialogue between the Trust with SY ICB on funding / investment and GP registration criteria.		

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

Report to the Board of Directors meeting scheduled for 25 July 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper F
Date of meeting:	19 June 2024		
Attendees:	Dave Vallance (Chair), Sarah Fulton Tindall, Carlene Holden, Ian Spowart, Pauline Vickers, Dr Judith Graham, Victoria Takel (deputising) and Kate McCandlish (deputising).		
Apologies:	Richard Chillery, Steve Forsyth, Lea Fountain and Richard Rimmington.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**IQPR: Retention:** The retention rate was over target but with 12-month rolling rate decreasing. The organisation is in phase 2 of the national 12-month people promise exemplar (PPE) programme with implementation started on some work-streams. **Consultant vacancy rates:** Consultant vacancy rates were static, but with two recruits to join, albeit with lengthy notice periods. Recruitment timescales / time to hire were on red this month, due to slow returns of DBS checks and candidates taking time to decide between multiple offers. Work had been done with the care groups to identify ways to drive up the recruitment KPI's. **Appraisals Audit:** This gave a moderate rating and highlighted the quality of the conversations was a challenge. The Trust is undergoing a significant overhaul of its performance management and development (appraisal) framework in 2024/25 and will address the findings and more. An overarching training needs analysis will also be launched this year to identify workforce development needs.		
Positive highlights of note:	**Gender Pay Gap**: The percentage difference in hourly rate (Median) had decreased from 9.64% (March 2023) to 7.10% (May 2024). Benchmarking with neighbouring trusts showed a pay gap difference of 9.6% for the Trust, compared to 9.3% for Sheffield Health and Social Care. Some positive action to address gender pay gaps, including through work with the women's network around culture. **RIDDOR:** There had been a marginal reduction in staff incidents, 5 incidents in Q4.		
Matters for information / noting:	**People Plan:** The final draft would be circulated in advance of the August meeting to allow time for reflection by the Committee. **Guardian of Safe Working Hours:** Increase in Doncaster breaches and inappropriate on-calls. Dr Yusufi had written to the care group medical director and clinical supervisors about inappropriate calls from Cusworth and Windermere wards. Concern expressed about temporary absences by junior doctors where the cross-cover is not available.		
Decisions made:	**IQPR:** To include the RIDDOR data.		
Actions agreed:	**Guardian of Safe Working Hours:** Executive Director of People & OD and Executive Medical Director to agree admin support for GoSWH.		

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

Report to the Board of Directors meeting scheduled for 25 July 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Mental Health Act Committee	**Agenda Item:**	Paper G
Date of meeting:	19 June 2024		
Attendees:	Sarah Fulton Tindall (Chair), Dr Janusz Jankowski, Dr Jude Graham, Toby Lewis, Dr Graeme Tosh.		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	**MHA Compliance and Performance Reports Q1 –** There were 130 detentions during the reporting period (110 people). Concerns were raised in respect of detention admissions paperwork (17 situations needed documentation amendment) consent to treatment (on admission) (58 of 88 cases) (100% at 3 months), Section 132 Rights (88 of 99 times) and Section 17 Leave recording, all of which impacted on the lawfulness of patient detentions in some cases. This would be discussed and challenged further at the care group delivery reviews. MCA Level 3 training was still a challenge in some areas of the Trust, as was Reducing Restrictive Interventions (RRI) training. Issues of staff attendance once places had been booked was having an impact, as well as appropriate levels of staffing to provide the training itself. Both issues are being addressed with the staffing situation expected to improve in the near future. It was noted that there was a theme throughout both reports which continued to identify issues with incorrect Receipt, Scrutiny and Recording. It was noted that pilots are underway to eliminate typing and handwriting, which may assist.		
Key points of discussion relevant to the Board:	**MHA Compliance and Performance Reports Q1** – Building on the last meeting the Committee's key discussion points focused on the levels of both compliance and performance assisted by an enhanced data set and narrative providing an increased understanding of actions and learning. Separating out the reports has helped to have a sharp focus on where we are acting lawfully or unlawfully in terms of the MHA. A key discussion on the Performance Report was the use of Seclusion Suites in terms of the criteria for their use and adhering to Trust policies in respect of the occupants. The continuing challenge of Section 136 Suites was also considered.		
Positive highlights of note:	**MHA Approvals Report (Midlands & East of England) -** The Committee was assured that there is an effective panel membership to fulfil the role, and that the assurance function is operating in a timely and efficient manner. **MHA Patient Feedback –** The Committee noted the progress made and revised approach being piloted to gain feedback from patients who had been detained under the MHA. It was recognised that this was an important, but challenging area. The Committee was pleased to receive a summary of the patient feedback obtained as part of the development process, and noted that it would receive a formal feedback report bi-annually.		
Matters for information:	**Trust Associate Hospital Managers** – Whilst there is still more to do the Committee noted work undertaken and progress made to ensure the process was as effective as possible. TAMs training requirements and compliance were discussed, which would be rationalised outside of the meeting to eliminate those that did not add value to the role. Hearing stand downs were also discussed, with a view to better understand both the reasons and information provided to the Committee.		

Decisions made:	**MHA Compliance and Performance Reports Q1** - The Committee agreed a new emphasis to reach 100% on the compliance elements, to resolve the over 24-hour length of stay in the Trusts Section 136 suites, and to ensure the Trust was working multi professionally on its seclusion arrangements. It also agreed to celebrate areas within the Trust that had achieved 99+% levels of training compliance.
Actions agreed:	

Sarah Fulton Tindall, Non-Executive Director, Chair of the Mental Health Act Committee

Report to the Board of Directors meeting scheduled for 25 July 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper H
Date of meeting:	17 July 2024		
Attendees:	Dawn Leese (Chair), Dave Vallance, Dr Janusz Jankowski, Dr Graeme Tosh, Steve Forsyth, Dr Jude Graham, Richard Chillery, Richard Banks, Dr Richard Falk.		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	**Resuscitation Update** – QC remain concerned around the gaps in compliance with resuscitation equipment audits (via Tendable) and Level 3 training compliance. Resus officer maternity cover currently being explored for the coming year (Mat Leave commenced May 24). **Mental Capacity Act (MCA) Annual Report 2023/24** – The Committee was not assured regarding the consistency of application / compliance with the MCA across the Trust. Action requested for assessment of current performance, compliance data, the associated gaps, level of risk and recovery plan (September 2024 QC). **Complaints Management** – The process for complaints management and compliance with required standards if currently under review. The Committee requested an update on review findings, assessment of risk and recovery plan at September QC.		
Key points of discussion relevant to the Board:	**Integrated Quality Performance Report (June 2024 data)** – Improvement noted in the percentage of VTE assessments completed within 24 hours and the reporting and recording of MUST assessments (performance clinics held and ongoing to ensure consistent delivery). **Draft Quality & Safety Plan –** QC received and the draft plan, further comments to be provided for consideration and inclusion. **Patient Safety Reports –** February to May 2024 reports received and discussed. The Committee noted that work is required to relaunch and enhance the patient safety process in the Trust, including data reporting and the approach to PSIRF implementation. There is currently an independent review in progress to inform this work. **Reduced Ligature Environmental Risk Assessment Audit Results and Action Plans** – 23 actions remain outstanding from the 2023/24 environmental ligature assessment programme, all with mitigations in place and RAG rating in terms of priority. Further update to be received at November QC to ensure delivery against the plan and to understand any outstanding areas of risk. It is noted previous risk assessments did not include the most recent CQC guidance – this has been actioned for the 24/25 audit and commences in July 2024. **Quality Safety Impact assessment (QSIA) –** It was noted that this process was ongoing and that impact assessments are under review. However, there was no evidence of the totality of reviews required or consideration of the cumulative impact. Further update required at September QC. **Patient Experience Report –** The Committee received an update on promise 4 and 5. Future reports need to provide a comprehensive plan for the delivery of promise 4 and information that demonstrates how services are systematically informed and shaped by the patient feedback.		
Positive highlights of note:	**Safe Staffing (ward areas)** – The Committee noted the plans in place, enhanced reporting and oversight on a daily basis to effectively manage safe ward based staffing levels. The outcome of the outstanding MHOST acuity data collection will be received at September QC. **CQC Registration Reporting** - The Committee was assured that the CQC registration requirements were being kept up to date. **Safeguarding Annual Report 2023/24** - The Trust meets its statutory requirements regarding safeguarding adults and children. Ongoing work noted to		

	ensure training requirements are met and sustained. **Accountable Officer for Controlled Drugs Annual Report 2023/24** – The QC was assured that the Trust is meeting its statutory requirements relating to the use of controlled drugs.
Matters for information:	**Measles briefing** – The Committee noted the resilience plans in place to provide a reactive response as required through the Trusts escalation and governance processes. **Nursing Midwifery Council (NMC)** – It was noted that the Trusts response to the independent culture review of the NMC will be received at July's Board of Directors meeting.
Decisions made:	
Actions agreed:	**CQC Enquires Thematic Review** – CQC enquiries and thematic review and response noted. It was agreed that future reporting required strengthening to provide the necessary assurance in relation to statutory CQC compliance. **Patient Safety (PSIRF), Complaints and patient experience –** The Committee will receive a further update on the Trusts approach to PSIRF and complaints management and patient experience at September QC, including associated recovery plans. **Mortality Report -** QC remains assured by the systems and processes in place associated with learning from deaths. The response to the two recent regulation 28 reports, as discussed at the May Board, will be considered at September QC. **Quality Safety Impact assessment (QSIA)** - Further work to do to ensure that review / monitoring of the totality of schemes and the cumulative impact of changes across the Trust.

Dawn Leese, Non-Executive Director and Chair of the Quality Committee

Report to the Board of Directors meeting scheduled for 25 July 2024

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper I
Date of meeting:	5 June 2024		
Attendees:	Kathryn Gillatt (Chair), Dawn Leese, Pauline Vickers, Phil Gowland, Izaaz Mohammed, Steve Forsyth, Kay Meats (360 Assurance), Laura Brookshaw (360 Assurance), Paul Hewitson (Deloitte), Caroline Jamieson (Deloitte).		
Apologies:	Ian Currell.		
Matters of concern or key risks to escalate to the Board:	**Standing Financial Instructions** - Downward trend in respect of the value of single quote / tender waivers – the Committee didn't feel assured regarding value for money and proactive planning in terms of the tender process. This would be a focus area as part of the procurement review.		
Key points of discussion relevant to the Board:	**Annual Report and Accounts 2023/24 –** • External Audit planning update received that focused on the 2023/24 year-end audit work. • Key risks for 2023/24 remain as property valuation, management override of controls and overstatement of trade creditors and accruals. • The Annual Report and Accounts 2023/24 will be formally received for approval at the extraordinary meeting planned for the 27 June 2024*. **Audit Recommendations Progress –** • Currently 8 overdue internal audit actions. The position would be improved during 2024/25 and there would be enhanced oversight of action delivery through corporate and care group delivery reviews, Committees and executive leads. **Internal Audit and Clinical Audit Joint Working –** • Work has been undertaken to ensure there was alignment between the Clinical Audit and Internal Audit plans and mapped alongside the Trusts strategic objectives and promises utilising the three lines of defence model.		
Positive highlights of note:	**Risk Management Framework Annual Report –** • The Committee recognised the improvement in monthly risk review compliance and the progress made in response to the internal audit recommendations. • The Committee noted the refreshed approach taken during 2023/24 resulting in a significant increase in the number of risk, and the establishment of the Risk Management Group which had created a route for key decision making and provided the Trust with a more comprehensive risk profile and a more positive risk culture.		
Matters presented for information or noting:			
Decisions made:	• The Committee agreed the Counter Fraud Functional Standard Return.		
Actions agreed:			

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

Report to the Board of Directors meeting scheduled for 25 July 2024.

* Extraordinary Meeting of the Audit Committee – see over

27 June 2024 – Extraordinary Meeting of the Audit Committee

This meeting took place involving the members of the Audit Committee and several other members of the Board of Directors were in attendance. It was also attended by representatives from Internal Audit (360 Assurance) and External Audit (Deloitte).

The primary focus was the Annual Report and Accounts 2023/24.

The final Head of Internal Audit Opinion was received.

An update and latest position was provided by Deloitte – which noted their current and expected conclusions / opinions, but also the range of work that was, at that time, still to be completed.

The Chief Executive provided a response to the stated position and reflected on the way in which the respective conclusions / opinions would be included and referenced within his Annual Governance Statement (AGS) – part of the Annual Report.

Subject to the completion of work by Deloitte, which in turn was partly reliant upon further submissions or discussions from and with representatives from the Trust, an expected sign off date within the week commencing 8 July was agreed.

The Audit Committee provided its support and approval for the Annual Report and Accounts 2023/24. In doing so, it also agreed to reconvene if anything of significance arose between the meeting date and the final sign off date.

(Post Meeting Note:
The Annual Report and Accounts 2023/24 was signed on 11 July 2024.
The accounts had an unmodified opinion.
The VFM opinion included two significant weaknesses – strategic risk management and timely responses to audit actions.
Submissions to Parliament have been made and the documents are expected to be laid before Parliament in the week commencing 22 July 2024, after which they will be published.)

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	25 July 2024

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

The report highlights the balance of delivery issues and medium-term issues being considered by the senior leadership: implementation of our financial plan and execution of promises relevant changes are highlighted. Work to secure our Fully Staffed ambition and fill our vacancies should be trackable via the newly appended annex.

Key underlying issues of exclusion, including service suitability for people with autism are highlighted. During quarter 2 the intention is to adopt **no** new further new initiatives or areas of focus, but to 'bed down' our agreed changes and ready our teams for the hard work of H2. This will need to be balanced with both continued system financial challenges and the energy generated from autumn by a new government and policy landscape.

Alignment to 23-28 strategic objectives	
SO1. Nurture partnerships with patients and citizens to support good health.	X
SO2. Create equity of access, employment and experience to address differences in outcome.	X
SO3. Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addition services.	X
SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.	X
SO5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X

Previous consideration

Not applicable

Recommendation

The Board of Directors is asked to:

X	**EXPLORE** the patient, people and population issues described
X	**CONSIDER** any matters of concern *not* covered within the report
X	**NOTE** work being done to ensure services reflect the needs of older people in the Trust

Impact

Trust Risk Register	x	Various, including extreme risks cited in other papers					
Board Assurance Framework (SDR)	x	HIE data					
System / Place impact	x	See text					
Equality Impact Assessment	required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	required?	Y		N	X	If 'Y' date completed	

Appendix

Annex 1: CLE summary June & July 2024
Annex 2: Current register of Trust vacancies July 2024
Annex 3: National publications June/July 2024
Annex 4: Board summary of South Yorkshire MHLDA Collaborative Board (July 24)

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report

July 2024

Introduction

1.1 The first report from the Covid inquiry has just been published. This serves to remind all of us of the sacrifices of the pandemic, the ongoing health effects for many, and the failings of **emergency preparedness** identified. Today the Board considers our latest review of EPPR: and there is within that, in my view, a welcome balance between actions needed to secure safety and prepared for adverse events, and compliance with guidance and edicts. The team involved are well aware that the assurance test I shall apply is whether 'Doris', an eponymous member of any one of clinical teams, knows the plan and how to safely respond and evacuate.

1.2 At our last Board meeting, we discussed the cultural opportunity of having many new starters coming into the Trust, as well as the gains to be made if we can successfully reduce those leaving inside a single year. A new annex to my reports shows the **vacancies** we have reconciled to the approved budget. Our savings plans, and our safety ambitions, rest on filling those vacancies. The costs we need to manage out are the cost of agency premiums and the cost of turnover.

1.3 The new government have made clear that they will legislate for a **new Mental Health Act** in the coming Parliamentary session. The clarity this brings is welcome and, in Q3, a detailing briefing of implications will be shared and discussed. We need to consider, and are already considering, potential consequences for our existing bed base and pattern of 'detention', as well as for key improvement programmes such as DIALOG+. Alongside work being done to reflect on assertive outreach and "disengagement", in light of deaths in Nottingham, the new Act will be an important context to much that we do in the next two years, notably in respect of our second, third and fourth strategic objectives.

1.4 As happens each time we meet, the Board's reports are issued before, but the Board meets after, **our Delivery Reviews**. This will again, as in May, offer an opportunity to reflect on delivery, and to consider how we best sequence what we are asking people to focus on. As I promised, resuscitation compliance (identified in QC) and regulation 32 compliance (MHA) both feature. More wide-scale improvement projects, such as our approach to the mental capacity act, will be planned into Q3 or Q4: with the Q2 focus remaining on filling vacancies, inducting new starters, and ensuring that the support offered by backbone teams fits snugly into the work of our clinical directorate leaders. That of course is the context to the restructure of the Nursing and Facilities directorate, which launches on July 24th, and which will take until October to fully implement.

Our patients

2.1 We heard last time about Emily, who had waited far too long for a neurodiversity assessment. The impact of such waits is reflected with increasing clarity in our risk register. The Board determined in September 2023 that these waits, though routine across the NHS, were unacceptable – and clearly a sizeable investment has followed to address them. Good progress is being made. Of course, it will take some time to address multi-year waits, and we also need to tackle issues of medication unavailability, and ensuring that alternatives to medication are available concurrently, or, where clinically indicated, sequentially. The Clinical Leadership Executive (CLE) examined, at its last meeting, **our wider approach to autism**. A series of recommendations for action were accepted, recognising that diagnostic waits are lengthy, and in one part of our population, no service is commissioned. The focus, however, of the renewed autism work is to ensure that those with autism using our wider services, including inpatient mental health admission, are supported in an appropriate manner. Our current self-assessment suggests we have considerable work to do to achieve that ambition.

2.2 Older peoples' services are a critical part of the RDaSH contribution to health and care. Progress with dementia diagnosis pace and reach is contained in the IQPR and, under promise 8, we are seeking to address inequalities of presentation and acknowledgement in some communities. Gemma Graham led CLE through a comprehensive assessment of **wider issues in older people's services and care**, other than dementia. As we explore how we reduce reliance on inpatient admission, and as we seek to retire age-cut off in mental health services (i.e. <65 only in crisis team), there are some critical capabilities we need to develop, including the knowledge and skills of our wider staff teams around ageing and frailty. Learning Half Days, referenced elsewhere on the agenda, will be a key opportunity to develop cross organisational and intra community dialogue in this field.

2.3 Our Children's Care Group remain fully focused on the maximum 4 week wait that we wish to secure in treatment services (**CAMHS**) for young people with mental health needs (excluding neurodiversity). Progress had stalled from our last Board discussion, and senior level engagement is now in place to try and ensure that we can, not only reach this measure, but sustain it. We have to acknowledge that other CAMHS services, locally and nationally, have far longer waits, however, consistent with our promise 14, we are intent to making sure that those, who truly need specialist services, are rapidly able to access them. Rather than offer out of data analysis here, I will provide further detail when the Board meets having conducted the review meeting on Tuesday 25th: 85 children in Rotherham have assessment appointments in coming weeks, which represents the wait list backlog.

2.4 Work at the Trust, and across the collaborative, has, as the Board knows, sought to tackle long waits for, and long stays in, Health Based Places of Safety (**section 136 suites**). It remains highly likely that the ICB will support the required six suites and, meanwhile, we are focused on the 24-hour maximum length of stay that this calculation is rooted in. Our initial data since the project started on July 1st is shown below: 4 of 30 patients 'breached' with a cumulative time loss to the availability of the suites to others of just over 57 hours. This is perhaps encouraging, but clearly

individual patients with specific needs, will always create different situations that need creative and collaborative solutions. Once our dataflow is robust (end of July), we will begin to publicise much more widely, and in real-time, the situation in our three suites, both on our website and among partners at a very senior level.

136 Suite Daily Breach Indicator (Click through for detail)	Mon (01/07/2024)	Tue (02/07/2024)	Wed (03/07/2024)	Thu (04/07/2024)	Fri (05/07/2024)	Sat (06/07/2024)	Sun (07/07/2024)	Mon (08/07/2024)	Tue (09/07/2024)	Wed (10/07/2024)	Thu (11/07/2024)	Fri (12/07/2024)	Sat (13/07/2024)	Sun (14/07/2024)
DONCASTER									4 hrs 39 mins					
NORTH LINCOLNSHIRE	17 hrs 29 mins	5 hrs 53 mins	13 hrs 47 mins					15 hrs 18 mins						
ROTHERHAM														

2.4 I am aware that last time, we discussed again the Regulation 28 letters associated with our care over the last two years. The MHLDA Collaborative Board has approved, for presentation into the wider ICB, an analysis of MEED guidance compliance for **liaison provision for eating disorders care**. This is guidance which operates across acute hospitals, mental health trusts, and others, and seeks to ensure collective efforts are effective and well-structured. The self-assessment shows less than 50% compliance across South Yorkshire, and suggests that, with partners, we need to take steps over the next twelve months to change services. Whilst this work is part of the new Eating Disorders Collaborative, it is important that we do not lose sight of this liaison work, which, among other interdependencies, often involved our liaison psychiatry teams.

<u>Our people</u>

3.1 It is helpful to have further time as a Board to explore our education and learning role and contribution. Apprenticeships are a feature of our annual members meeting, and again of our Board's meeting, as in November last. Work is ongoing meanwhile to finalise **our work experience arrangements.** Our teams are deeply embedded in local schools and colleges and creating a much clearer and more equitable pathway into the Trust, for those seeking to understand our work and their career opportunities, is something we expect to have ready for the autumn term.

3.2 Last time the Board discussed **our leadership development offer**. Discussions with our selected partners are moving at pace, alongside work to ensure that our offer to senior clinicians outside formal leadership roles, and to other employees, as well as first line managers. The Trust Leaders' Conference takes place on September 25th, and we have committed to have this work completed for launch in that room.

3.3 Our changes to **agency authorisation**, discussed last time, have gone live. The grip they offer is leading to real insights into opportunities to work better across and between teams. It is clear too that the enhanced bank offer and support in October from NHS Professionals will assist greatly. Teams have worked hard to reduce agency use from the end of July, and approvals for use beyond October are counted on the fingers of one hand. Of course, agency access remains available in urgent circumstance, although for non-clinical and unregistered roles, it can only be accessed with the most senior authorisation.

3.4 We expect to have our finalised **Anti-Racism plan** available within the CLE-sub space later in August. Again, this is timetabled to be available for the leaders' conference and subsequent Board meeting. Given our own WRES position, feedback from our staff networks, and indeed the considerations arising from the NMC report in today's agenda, it is crucial that our work is comprehensive and authentic. Go-live with our red card scheme is imminent, and we are exploring how external investigators, drawn from global majority backgrounds, may assist our work to assess incidents and complaints between employees.

3.5 Kath Lavery and I have met with each of our **staff/people networks** over recent weeks, in advance of the TPC meeting. Revised executive sponsorship arrangements are being put in place involving Jude Graham, Izaaz Mohammed, Richard Chillery, Jo McDonough, and Steve Forsyth – and each network will have a confirmed leader and deputy in place not later than January. That timescale is reflective of the opportunity created by Learning Half Days to enable our employees to get more actively involved with our networks. Each member of the executive group now has an 'EDI' objective, which forms part of our annual appraisal process.

<u>Our population</u>

4.1 The Board's public health committee benefitted from expert input from among our local Gypsy, Roma and Traveller community at its last meeting. Meanwhile, we are due to commit funding to a variety of health inequalities programmes alongside Doncaster Local Authority. These will include a significant step towards homeless health services, advised through Pathway – a national charity and advocacy organisation with relevant expertise. Both pieces of work highlight the continued challenge registering for general practice care without a home address, despite the clear stipulation that this is not required. This may form a barrier to accessing our services: and we will work with the ICB and others to consider what further steps need to be taken to tackle **this structural exclusion**.

4.2 As part of our work on promise 5, we are reviewing how we work in Care Groups and corporately with **local VCSE organisations**. There are a variety of local touchpoints, including some that formed part of the previous community transformation programmes. I am aware of the commitment to maintain a VCSE voice within the Council of Governors as well. It was, in my view, apparent from our timeout at Rotherham Voluntary Action that our promises resonate deeply with, and rely very much on, the calibre of our work with the sector.

4.3 It is important to again recognise that we have not reported our IQPR with a full suite of **health inequalities data analysis** in place. Material for the Mental Health Act committee was summarised with protected characteristics visible, and this will continue routinely. A set of reports relevant to E&I promises is being developed presently. And a recut of the relevant reports in the IQPR to take account explicitly of HIE is in final development. As a general guide where we are drawing data from Systm1, our data completeness for protected characteristics is strong. Any data pick up that relies on bespoke service specific collection will need further work, which deputy care group directors are taking forward.

Concluding comments

5.1 Both of our Integrated Care Boards submitted deficit plans for 2024/25 of just less than £50m. Trusts in South Yorkshire, including our own, have had our Oversight Framework rating worsened to take account of these deficits (not the approach in the prior year). The year-to-date position in South Yorkshire is also escalated. The Trust position year to date is considered in the IQPR but we expect to return to plan in month 4, and discussions continue over the NHSE Eating Disorders contract. Of greater concern is the Place positions, and resultant lack of certainty of SDF funding for 2024/25. Constructive discussions continue in both Rotherham and Doncaster about how we best ensure that every pound is wisely spent and that decision-hiatus does not take hold. It will be especially important to actively ensure parity of esteem in such considerations, given the understandably dominant focus on some waiting lists for some services: excluding community and in the main mental health services.

5.2 Our financial plans do not yet take account of changes in Out of Area Placement funding arrangements and risk share to bring RDaSH into alignment with other providers in NEY. I would expect over coming weeks to have final proposals in that area, and will attend the August meeting of the FDE to discuss with non-executive colleagues the risk profile proposed for any revised 24/25, 25/26 and 26/27 arrangements: stressing our previously articulated view that we need a strong measure of consistency across RDaSH and therefore between two ICBs, if we are not introduce the appearance of perverse incentives discordant with good clinical care.

5.3 Ending this report in a non-financial domain, Board members are reminded that from October Care Opinion will become our feedback portal with patients. This is an exciting development being rolled out at pace through Q2. The product will provide much wider and more immediate access to both feedback and trend analysis. This has the potential to transform our insight into patient feedback in the Trust and to much more rapidly deploy that feedback into Senior Leadership Teams (SLTs) in care groups, and within spaces like CLE and Delivery Reviews, as well of course as providing visibility to the Board and its quality committee.

Toby Lewis, Chief Executive
19 July 2024

Annex 1

Clinical leadership executive – June 2024 and July 2024

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

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

June	July
Learning Half Day pilot	Autism and sensory suitable care
Apprentice first programme	Medium term bed state / ward closure Oct 24
Working with local primary care	Older people's care
Promises and finish lines	Leadership development offer
July agency implementation	Intellectual / learning disabilities nomenclature

In terms of decisions made, in June we re-agreed changes to agency approval schedules. July's meeting considered a range of discursive items referred to elsewhere in the CEO report and acknowledged decisions made by sub-groups including Equity and Inclusion setting targets within our promises.

There are not specific matters to escalate to the Board, but the CLE meeting informs the report to Board, for which this is an annex.

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

- Our equity and inclusion and research and innovation plans
- Transitional care for children and young people into adult services
- How we best manage time, as part of concerted work to ensure we balance formal meetings/time with staff and teams/development work/change leadership
- How we support our work to meet core CQC standards
- The awards and rewards model for the Trust

Toby Lewis, Chief Executive
19 July 2024

Annex 2 Current vacancy summary

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

Directorate	ESR Vacancies (WTE)	ESR Vacancies (%)	Recruitment in Progress (Posts)
Childrens Care Group Mental Health	-	-	48
Childrens Care Group Physical Health	-	-	14
Doncaster Adult Mental health and LD Acute	44.43	19%	22
Doncaster Adult Mental health and LD Community	11.02	4%	27
Doncaster Adult Mental health and LD Learning disabilities and forensics	17.00	7%	16
North Lincolnshire Adult MH / Talking The Talking therapies	8.96	5%	19
North Lincolnshire Adult MH / Talking The Acute	11.19	9%	9
North Lincolnshire Adult MH / Talking The Community	13.09	12%	13
Doncaster Physical H and Neurodiversity Comm & LTC	22.37	6%	64
Doncaster Physical H and Neurodiversity Rehab	15.26	8%	26
Doncaster Physical H and Neurodiversity Neurodiversity	-	-	14
Rotherham Adult Mental Health Acute	29.25	12%	19
Rotherham Adult Mental health Community	15.32	7%	17
Corporate Assurance	6.52	16%	2
Estates	5.64	8%	3
Finance & Procurement	12.30	25%	6
Informatics	0.78	1%	1
Med, Pharm & Res	14.56	22%	2
Nursing & Facilities	33.12	17%	6
Operations	3.38	7%	7
POD	7.31	7%	6
Strategic Dev	3.14	16%	1
Therapies & PT	1.62	25%	1
TOTAL	**268.72**	**7%**	**343**

Annex 3

National publications/guidance summary – June/July 2024

Forgotten generation: shaping better services for children and young people
(NHS Providers 15/07/2024)

Increasing demand for children and young people's services, and increasing acuity of patients, have been growing concerns among trust leaders in recent years. Trust leaders have told NHS Providers that, due to a unique combination of pressures, services are struggling to keep pace with increasing levels of need. This is resulting in concerns about quality of care and patient safety.

NHS trusts and foundation trusts provide a variety of essential services for children and young people at home, in the community, in hospitals and inpatient settings. These include health visiting, speech and language therapy, audiology, neurodevelopmental services, acute psychiatric inpatient care and paediatric surgery.

NHS Provider's previous work on children and young people's services, which focused on health inequalities (NHS Providers, 2023), community services (NHS Providers and NHS Confederation, 2023) and mental health services (NHS Providers, 2021) has sought to understand and raise the profile of pressures being experienced in this sector. This report builds on these findings to provide a comprehensive view across the provider sector of the state of children and young people's healthcare services in England – across acute, ambulance, community and mental health services. It gives an overview of the challenges facing children and young people in accessing care; shares examples of the local initiatives and progress made by providers and their partners; highlights the national and system-level action needed to further support trusts; and makes a set of recommendations for the government.

https://nhsproviders.org/forgotten-generation-shaping-better-services-for-children-and-young-people

NHS Education Funding Agreement – April 2024 – March 2027
(NHS England 30/05/2024)

The NHS Education Funding Agreement replaces the 2021/24 NHS Education Contract, covering both education and placement providers from 1 April 2024 until 31 March 2027.

The 2024/27 agreement supports non-competitive, equitable activities listed in the Department of Health and Social Care Education and training tariff guidance and NHS Education funding guidance published yearly, regarding:

- education and placements funding
- salary support funding (where not directly commissioned to a provider and where not under a host/lead contract)
- education and training grants for programmes published by NHS England

The NHS Education Funding Agreement will not be used for competitive education and training programmes. NHS England will collaborate with education and training providers through a commercial process to establish the appropriate contract mechanism for all new competitive education and training programmes.

https://www.england.nhs.uk/terms-and-conditions-2/new-nhs-education-contract/

Preparations for an Autumn/Winter 2024/25 flu and COVID-19 seasonal campaign
(NHS England 30/05/2024)

Letter from Steve Russell, Chief Delivery Officer and National Director for Vaccinations and Screening, NHS England

https://www.england.nhs.uk/long-read/preparations-for-an-autumn-winter-2024-25-flu-and-covid-19-seasonal-campaign/

Key principles for ensuring continuous health records of adopted children
(NHS England 04/06/2024)

Letter from Professor Simon Kenny, Dr Amanda Doyle and Dr Claire Fuller about the managing of health records when a child is adopted

https://www.england.nhs.uk/long-read/key-principles-for-ensuring-continuous-health-records-of-adopted-children/

Reporting potential supply disruptions of medical equipment and consumables
(NHS England 06/06/2024)

Guidance for NHS trusts, integrated care boards (ICBs) and NHS England regional procurement or regional Emergency Preparedness, Resilience and Response (EPPR) teams sets out the steps that NHS trusts, ICBs and NHS England regional procurement or regional EPRR teams should take when seeking to report and resolve potential or actual disruptions to the supply of medical equipment and consumables.

https://www.england.nhs.uk/long-read/reporting-potential-supply-disruptions-of-medical-equipment-and-consumables/

Health and care passports
(NHS England 18/06/2024)

Guidance and template to support integrated care systems (ICS) to review existing arrangements for health and care passports (or hospital passports) to address recommendations by the Health Services Safety Investigations Body (HSSIB), and to improve health outcomes for people with a learning disability and autistic people.

https://www.england.nhs.uk/publication/health-and-care-passports/

Children and young people diabetes toolkit
(NHS England 08/07/2024)

This toolkit is designed to support integrated care systems (ICSs) to design, plan, and deliver high-quality treatment and care for children and young adults aged 0-25 years with all types of diabetes.

https://www.england.nhs.uk/wp-content/uploads/2024/07/children-and-young-people-diabetes-toolkit.pdf

Framework for managing the response to pandemic diseases
(NHS England 15/07/2024)

This document provides a framework for NHS England when managing the response to a pandemic. The purpose of the document is to outline the pandemic-specific roles and responsibilities of NHS England, with a focus on the command, control, coordination, communication and governance arrangements for the NHS.

https://www.england.nhs.uk/long-read/framework-for-managing-the-response-to-pandemic-diseases/

Annex 4

South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note – 18 July 2024

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 18 July 2024. The main areas of discussion and subsequent actions are outlined below.

Managing Director Report

National, regional and local developments that impact the work of the Collaborative were discussed.

The Board received an update on the new Mental Health and Neurodevelopment Resource Groups that will replace clustering. A new tool is intended to support systems to plan, benchmark, fund and improve services in an evidence-based way. This is intended to improve parity of esteem with the acute sector.

The Board discussed Parity of Esteem in more detail, including a review of developments since the last discussion on this matter in March 2024. Practical application of the concept was illustrated with examples and the Board agreed this would be shared across the system for wider profile and sponsorship.

It was agreed that the Chief Executives will collectively further develop the Collaborative Board Assurance Framework, which will return to a future session for approval.

Progress was reviewed on a performance scorecard developed by the ICB team and Collaborative. The progressing system scorecard and continuing work to refine the data, and timeliness of that data, was noted by the Board.

Work Programme Update

The paper discussed highlighted from the Collaborative's work programmes including the Collaborative's Clinical and Care Professional Assembly which is now well established with colleagues from across the four Trusts now formally inputting into the Collaborative programmes via bi-monthly meetings. Following the last meeting of the Board in May, progress and key actions were highlighted for the following programmes: Health-based places of safety; eating disorders and neurodiversity.

Board also noted the significant work by Collaborative, Trusts and ICB to analyse the data around out of area placements giving an overarching position. A seven-point action plan including a data dashboard are under development.

STOMP (stopping over medication of people with a learning disability and autistic people)

A paper was provided on STOMP which forms part of the Collaborative's work programme. The context of STOMP is rooted in the broader NHS England agenda to enhance person-centred care and ensure the rights and wellbeing of vulnerable populations. The STOMP initiative seeks to re-dress systemic healthcare inequities by promoting non-pharmacological interventions and person-centred approaches through offering positive behaviour support.

The programme led by the Collaborative comprises a two-phase project plan which is centred in co-production with people with lived experience.

1. Phase one – Secondary Care (up to February 2025) including:

a) Contribution to STOMP training and awareness.
b) Development of robust data collection and monitoring.
c) Development of Easy Read medication information.

d) Scoping of existing non-medication alternatives and development of alternatives and system wide resources – underpinned by person-centred care planning.
e) Undertaking a workforce review across South Yorkshire providers.

2. Phase two – Primary Care interface (from February 2025):

- Broader system discussions with the ICB and partners in primary care to understand STOMP Shared Care protocols throughout South Yorkshire and to clarify further the interface between primary and secondary care.
- This will frame around a systemic approach with plans to explore collaboration with the SY Primary Care Alliance.

Also noted were the successes and challenges with the programme. STOMP represents a cultural shift, and the Board re-affirmed their commitment to STOMP healthcare and to continue to work together and share best practice across the system using a quality improvement model approach.

MEED (Medical Emergencies in Eating Disorders)

The Board were provided with a paper outlining the current position on the implementation of Medical Emergencies in Eating Disorders (MEED) Guidance in South Yorkshire. MEED was developed by the Royal College of Psychiatrists and is non-mandatory but very high profile. The work is part of the broader South Yorkshire Eating Disorders Transformation Programme, and this element is led by the Commissioning Hub.

The paper outlined progression of a system review to understand current provider compliance with the 12 MEED recommendations. The Board agreed the proposed plan which includes further work with partners - including the Acute Federation - on compliance, risk assessment and review of other ICBs, and this work including a proposed SY model is planned to return to Board in November 2024.

Mental Health Investment Standard 2024/25

Following the Board's discussion at the session in May, the joint work between Chief Executives and ICB leaders relevant to SDF and MHIS had progressed: the Board agreed that the updated MHIS calculation now has their endorsement. It was noted that the collective work around growth and efficiencies would continue with updates planned for future Board meetings.

Specialised Commissioning Update

The Board received the routine report from the SYB Specialised Commissioning Provider Collaborative. The paper reported on the key updates from the Adult Secure, CAMHS Tier 4 and Adult Eating Disorders Provider Collaboratives and brought to the attention of the Board items for escalation or risk to the system.

Chief Executive Leadership Arrangements

The Joint Working Agreement agreed by all four Trusts provides that the lead will be reviewed on an annual basis. The Board reviewed the outcome of the decision-making process and approved Toby Lewis's appointment as lead Chief Executive of the MHLDA Provider Collaborative for another 12 months effective from 1 July 2024. This will be reviewed again in 12 months' time on the same basis. The same process for the Chair will now take place, with a decision paper on the agenda for the September meeting.

Sharon Mays, Lead Chair
Toby Lewis, Lead Chief Executive

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	RDaSH Responsible Officer	**Agenda Item**	Paper Ji
Sponsoring Executive	Dr Graeme Tosh, Medical Director		
Report Author	Dr Graeme Tosh, Medical Director		
Meeting	Board of Directors	**Date**	25 July 2024

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

We wish to transition the role of Responsible Officer from Dr Sunil Mehta, Deputy Medical Director, to Dr Diarmid Sinclair, Deputy Medical Director, from the 1st September 2024.

A decision is required and the output needs to be a confirmation letter from Board of Dr Sinclair's appointment.

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

Business as usual.	x

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

N/A

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

The Board of Directors is asked to:

X	**AGREE** the transition of Responsible Officer to Dr Mehta from 1 July 2024.

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

Trust Risk Register							
Board Assurance Framework							
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

RDaSH Responsible Officer

Proposed Change of Responsible Officer for Medical Revalidations

Dr Graeme Tosh
Executive Medical Director

19 July 2024

RDaSH nurturing the power in our communities

Responsible officers have an important statutory role in medical regulation. The successful implementation of revalidation depends to a considerable degree on the competence and skills of those doctors carrying out this role.

Our responsible officer is accountable for the local clinical governance processes in RDaSH, focusing on the conduct and performance of doctors. Duties include evaluating a doctor's fitness to practise and liaising with the GMC over relevant procedures.

They make recommendations to the GMC; but the decision on whether a doctor should be revalidated belongs to the GMC, as the regulator.

Our current Responsible Officer is Dr Sunil Mehta, Deputy Medical Director; Dr Mehta will be leaving the Trust on 3rd September 2024 and I propose that prior to that date the role is transitioned to our other Deputy Medical Director Dr Diarmid Sinclair from the 1st of September 2024.

Dr Sinclair is an experienced consultant psychiatrist and trained appraiser, he has yet to complete the formal training for the Responsible Officer role but this has been discussed with our contact at NHSE and they are happy for him to take on this role and complete training at the next available opportunity. I am informed that this is a common scenario due to the limited places on training available.

For Dr Sinclai to formally commence this role NHS England have asked for confirmation from the Board of his appointment and commencement date, upon receipt they will notify the GMC of the intended change.

I am requesting a decision on this today and an action to write to NHS England to confirm the decision.

Appendix 1 is a sample letter to NHSE.

Graeme Tosh
Executive Medical Director
July 2024

Appendix 1

Rotherham Doncaster and South Humber NHS Foundation Trust

Chief Executive's Office
Woodfield House, Tickhill Road Site,
Tickhill Road, Balby, Doncaster, DN4 8QN
Telephone: 01302 796400 / 07967793306
Text only phone for deaf/hard of hearing:
07771933869

Date

Laura McGinty
Professional Standards Manager (Medical Directorate)
NHS England and NHS Improvement - Northeast & Yorkshire
The Old Exchange
Barnard Street
Darlington
DL3 7DR

england.yh-appraisals@nhs.net

Dear Ms McGinty

Re: Dr _____– Confirmation of Responsible Officer

This letter is to confirm Dr _____ appointment as the Responsible Officer at Rotherham, Doncaster and South Humber NHS Foundation Trust from _____. The RO appointment was approved via the Board of Directors at its meeting in public on _____.

If you require any further information, please do not hesitate to contact me.

Kind regards,

Yours sincerely

CHIEF EXECUTIVE
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	NMC Independent Culture Review	**Agenda Item**	Paper K
Sponsoring Executive	Steve Forsyth, Chief Nurse		
Report Author	Steve Forsyth, Chief Nurse & Carlene Holden, Director of People and Organisational Development		
Meeting	Board of Directors	**Date**	25 July 2024

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

We have chosen to publicly reflect on this report and to act and issue a Trust wide response to our nursing, and wider professionals' workforce, so they know we are with them and supporting them. It will also be important that we review the key recommendations and ensure that there are processes in place which gives a clear message bullying and racism is unacceptable and whistle blowers are able and given opportunities to be free to speak up.

The Trust is accountable to act and review those who are currently under or having concluded, fitness to practice investigation offering compassionate support to them during this period of unease.

The Board is asked to consider and support the recommendations outlined in this report to ensure the Trust acts on the concerns raised in the NMC independent review and creates as a result an open, honest, and supportive culture for those who work for us.

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

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

None.

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

The Board of Directors is asked to:

X	**CONSIDER AND SUPPORT** the recommendations outlined in this report.

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

Trust Risk Register	X	WRES related and retention related risks						
Board Assurance Framework	Na							
System / Place impact	X							
Equality Impact Assessment	Is this required?		Y	x	N		If 'Y' date completed	To be produced after individual case review cited above
Quality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	

Appendix (please list)

None.

NMC Independent Culture Review – Reflection, Accountability and Action

An independent review led by Nazir Afzal, OBE of the NMC's culture published on 9 July 2024 highlighted safeguarding concerns and found that people working in the organisation have experienced racism, discrimination, and bullying. The NMC is one of the world's largest regulators for nursing, midwifery and nursing associates. This review was following a series of disclosures by a whistleblower in 2023, which claimed a 'deep seated toxic culture' was leading to skewed and failed investigations.

A series of reports and investigations have been undertaken:

- In 2008 the DoH published a report following **allegations of racism and bullying and serious concerns around processes to manage the risk** that a nurse or midwife poses to people receiving care.
- In 2012, strategic review of the NMC for the Council for Healthcare Regulatory Excellence found **weakness in governance, leadership, decision making and operational management**.
- The Francis Report (2013), **surfaced concerns relating to the NMC** during their Mid Staffordshire NHS Foundation Trust review.
- From 2016-2019 a range of audits, reviews and reports saw more concerns highlights including the handling of documentation relating to midwives where there was **culture that failed to act with an appropriate level of care and compassion.**

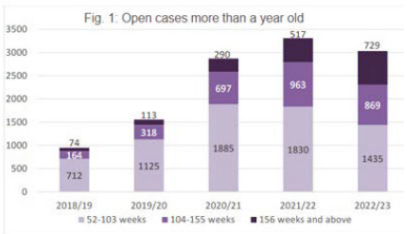
1. Findings

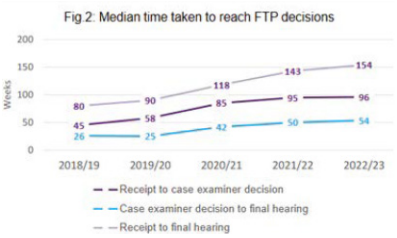
This report will undoubtedly make painful reading to many of our nursing colleagues who believe and trust the NMC are committed to protecting the public and maintaining high standards in nursing and midwifery. The report highlights 4 key themes outlined below:

Safeguarding people involved in our processes.

- The review engaged with over **85%** of staff members. Many felt frustrated that previous reviews into cultural problems within the NMC have failed to deliver the changes needed and they felt their voices have been overlooked.
- Currently, the NMC is trying to get through a huge backlog of Fitness to Practise cases, which is close to **6,000**.
- In all cases, it is taking too long for decisions to be taken and **the delays are having a serious impact** on those that have been referred.
- It is an incredibly slow screening process; the system was not sufficiently attuned to differentiate between serious and minor issues.
- Since 2016, **26** people have died by suicide our suspected suicide and tragically, since April 2023, **6** people have died by suicide or suspected suicide whilst under, or having concluded, Fitness to Practice investigation. Some nurses have been in a Fitness to Practice review for nearly 10 years.

The graphs outline below the backlog.





Culture and regulation entwined.

The independent report is clear about the link between **regulatory performance and culture**. One affects the other and this has created a pressurised environment for our people, which has contributed to **poor behaviours and concerning case outcomes** in some areas. It has seriously undermined our collective efforts to reach quick, fair and safe decisions across all casework.

Key culture findings

- There were directorates with a healthy culture, but there were also a growing number of staff who are trapped in a **dangerously toxic culture** and feel deeply frustrated and upset in their jobs. It's this latter culture that was starting to overwhelm the good work and do enormous damage.
- The reported contained claims of **racism, people being afraid to speak up and nurses accused of serious sexual, physical and racial abuse** being allowed to keep working on wards were all repeated to the reviewers on multiple occasions. Everything the whistleblower documented was corroborated and investigators spoke to many others that had similar experiences. The report remarked that it is remarkable that there have not been more whistleblowers coming forward.
- Evidence suggested that the previous reports showed a **long-standing culture of toxicity** have been validated from the findings throughout the review, more concerningly whilst they have previously been well-contained, there was a concern these are much more widespread.
- Significant increase in the **number of sickness days** at the NMC associated with stress, anxiety and depression relating to the workplace, hundreds of people were deeply unhappy in their jobs, with over **30% signalling** that they felt emotionally drained from their work.
- Evidence of a blame culture, impeding confidence to speak up and clearly demonstrating there is an **openly toxic culture,** that previous was more hidden.
- Some of the findings show there was a risk to public safety due to the strains and pressures to NMC staff, impacting on the registrants.
- The complexity of governance in the NMC has led to **mistrust**, there was little faith in decision making and the duty of candour responsibility for healthcare professionals to be honest when things go wrong has become anathema at the NMC.

An organisation of multiple cultures.

The review has held a mirror up to life at the NMC. At one point, it observes that two people passing each other in a corridor can have very different experiences of working there – some have had **experiences of racism, discrimination, and bullying**.

Senior Leaders commit to doing better.

A failure of senior leadership to rise to the challenges facing the NMC. Culture is shaped by what leaders tolerate. It is clear some people have behaved in completely unacceptable ways that should have been called out and tackled much sooner. This has contributed to colleagues feeling **uncomfortable or even unsafe to speak up, or unconfident that appropriate action will be taken if they do.**

2. NMC Response

Full acceptance of the recommendations, accepting it is a turning point for the NMC and that there is a long way to go.

Safeguarding specific actions include:

- In March the NMC agreed a £30m investment in an 18-month plan to make a step change in fitness to practise, with a clear goal to reach decisions in a more timely and considerate way.
- In February they strengthened the guidance to make decisions on concerns about sexual misconduct and other forms of abuse outside professional practice.

There are further immediate actions being taken to address the findings:

- Appointing an equality, diversity and inclusion (EDI) advisor to the Executive Board to support decision making.
- Work to increase the diversity of the Executive Board.
- The Freedom to Speak Up Guardian is now available to colleagues to raise concerns and get independent support
- Listening circles facilitated by trained professionals for all colleagues to openly discuss issues raised in the report.
- Invested in a partner to improve psychological safety in teams, starting in our Professional Regulation directorate which includes fitness to practise, and registration and revalidation.
- Decompression support to colleagues working on sensitive casework, professional counselling from a trained psychologist.
- Doubling the amount spent on learning and development. An external EDI partner is undertaking a review of our EDI learning and making further recommendations to improve our mandatory training.
- Actively working on a new behavioural framework to support recruitment, development, career progression and performance management, for launch in September.

3. Recommendations for RDaSH

It is imperative as a Board we demonstrate compassionate leadership to our **1,283** nurses, **27** nursing associates, from all backgrounds and disciplines, during this period of anger, anxiety, and distress. RDaSH is required to especially focusing on the **12%** of our nursing workforce from a global majority background given the findings of the report.

This includes upholding and demonstrating our values: **passionate, reliable, caring, and safe, supportive, open, and progressive**. As well as committing to our promises, specifically **promise 26** to become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.

The outcome of this report is likely to impact on wider independent reviews of regulatory bodies, therefore the above actions will include a support offer to nursing, and other

professional groups inclusive of allied health professionals, social workers, and psychological professionals.

There are three key areas RDaSH requires to act on:

1. RDaSH is required to reflect on this report and to act and issue a response to our dedicated nursing and professionals' workforce across all our disciplines, so they know we are with them and supporting them.
2. RDaSH also requires reviewing the key recommendations and ensure that there are processes in place which gives a clear message bullying and racism is unacceptable and whistle blowers are able and given opportunities to be free to speak up.
3. RDaSH is accountable to act and review those who are currently under or having concluded, fitness to practice investigation offering compassionate support to them during this period of unease.

To ensure RDaSH commits to these key areas actions have been identified and summarised below:

Briefing on the NMC Independent Review

A briefing to be sent out to all nursing and professionals by our Chief Nursing Officer and Director of Psychological Professionals by the end of July 2024. This will summarise support processes, freedom to speak up (FTSU) processes, whistle-blowing procedures and sign posting support.

Freedom to Speak Up Process

RDaSH will further strengthen the freedom to speak up guardian role and processes with a push on communications with a narrative on the NMC investigation to support an open and honest culture. Additional drops in will be offered and pop-up clinics.

FTSU Current process update

RDaSH in response to this report has reviewed its current process to ensure our workforce is given opportunities to raise concerns and that they are heard and acted on.

The freedom to speak up guardian has been making regular visits to all inpatient MH unit every 6-8 weeks. As well as this, regular visits have been made to other area in clinical settings such has CMHT and physical health ward. These visits are primarily to increased visibility, identify and breakdown barriers and listen to works concern. Discussion have been had with the inpatient staff team on how to raise concerns through FTSU and to encourage staff to raise concern with anyone within the SLT. The guardian continues to educate the inpatient staff team on available options for raising concerns through FTSU whether that be an open, confidential, or anonymous concern.

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

Confidential concerns- this is another option for staff to raise concerns where the guardian or freedom to speak up champion may be aware of the individual raising the concern name however this would not be shared with anyone outside of this.

Anonymous concerns – this is an option that staff can access through the freedom to speak up intranet page where staff members can raise a concern anonymously by typing their

concern in the FTSU tab. This then is sent to the guardian directly for escalation, the only downside is that the individual would not receive any feedback.

The guardian makes it clear to the individual raising the concern that the only reason confidentiality would be broken is if it is divulged that someone (patient or staff) is in direct harm.

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

Outcome – once an outcome has been reached and steps have been taken be the care group/service to address the concern the guardian will have a conversation with the individual to feedback and the concern will be closed down.

Increasing champions- It has also been noted that not all teams have a FTSU Champion identified within their teams. Work has progressed through the month to identify more FTSU champions and we now have 54 trained FTSU Champions and 51 staff who are keen to access formal training.

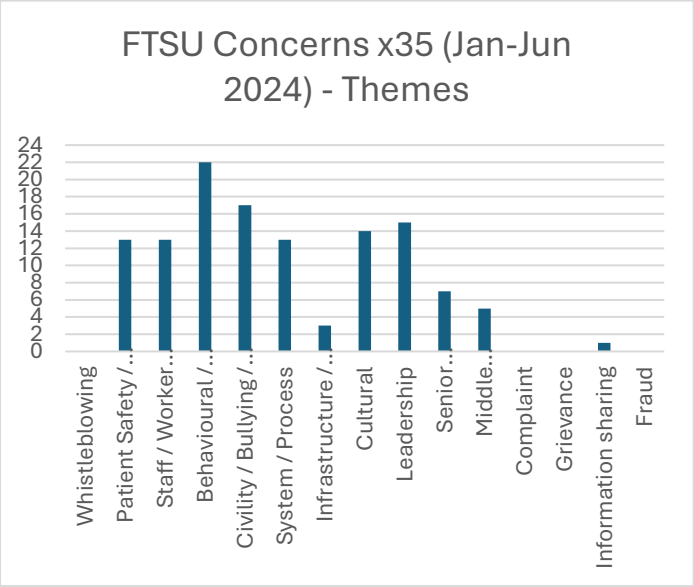
Database – all FTSU concern are recorded in the FTSU database which the guardian and one admin have access to. This records all concerns and include the information below:

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

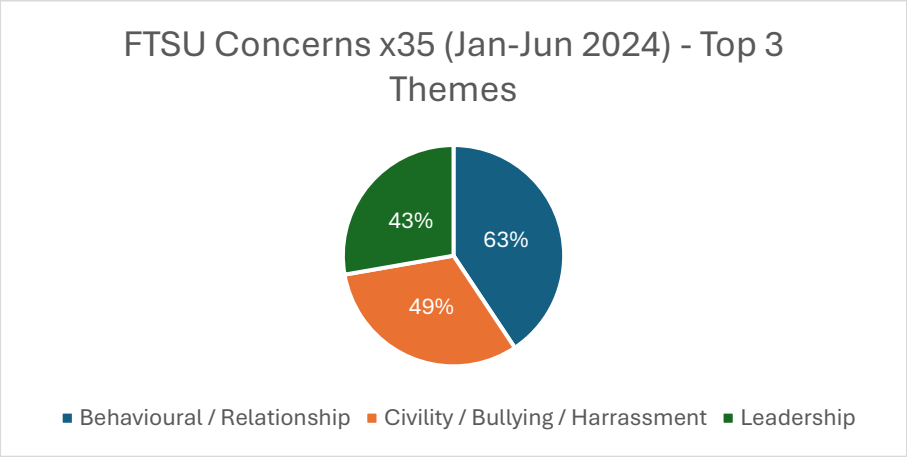
The guardian must report to the NGO (national guardian office) quarterly on the number of concerns coming through to RDaSH, the themes and the profession of the staff raising the concerns.

The guardian has the regular option of meetings with the Chief Executive (quarterly) and the Chief Nurse (monthly) where FTSU agenda and any barriers or areas of concern discussed openly. The guardian also meets once per month with all Care group directors to discuss open concern in their area and any ongoing organisational learning that can be taken from the concerns raised.

FTSU data 01/01/24- 30/06/24



This chart represents the themes of the 35 concerns raised to FTSU from January to June 2024.



This chart represents the percentages of the top 3 themes raised for the 35 concerns brought to FTSU from January until June 2024.

Fitness to Practice Reviews

There are currently **7** colleagues under an NMC Fitness to Practice review, **4** colleagues under a HCPC Fitness to Practice review and **1** colleague under a Social Work England Fitness to Practice review, all at different stages. These cases will be individually reviewed, in light of the findings from the NMC independent review and a tailored support response will be offered depending on need and circumstances.

HR Disciplinaries

As colleagues are aware from Harding review and the more recent NMC review, internal (conduct/capability processes) and professional body cases do have a significant impact on colleagues. In relation to the internal processes, we have taken steps in recent months to detail the length of time our internal investigations are taking, we are committed to reducing the length of time these investigations take for all colleagues. In addition, we are also clear suspension should be a last resort, from August 24 we will have a further 'scrutiny' of all suspensions exceeding 28 days, these cases will be reviewed by the Director of People and OD and a NED on a monthly basis. All of the colleagues are offered support, which we will review as part of the NMC review findings.

Promise 26

RDaSH is prioritising promise 26 to be an active accredited anti racist organisation. This includes understanding lived experience, inclusive recruitment, talent development, EDI champions working across organisations within care groups to be on the ground and the offer wrap around support.

RDaSH requires to have processes in place for colleagues to feel comfortable to speak out about racism and ensure those concerns are acted on without retaliation. Develop their capacity to talk about race and everyday covert racism, set standards of change that challenge everyday racism, get better at acting on the early warning signs of racism, impart the skills that all staff need to get closer to genuine anti-racist practice. We will utilise our alliance group, our EDI champions and incident reporting processes to ensure the Organisation acts in relation to the findings of the NMC report to provide additional support to our colleagues from a global majority background.

Conclusion

The Board of Directors are requested to approve the recommendations outlined in this report to ensure RDaSH acts on the concerns raised in the NMC independent review and creates as a result an open, honest, and supportive culture for those who work for us. An update on this work will be provided at Quality Committee in September 2024.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks 2024/25: Q1 Report	**Agenda Item**	Paper L
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	25 July 2024

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

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

The Board received and discussed a paper at its May 2024 meeting that presented a framework that identified:

- the key Strategy Delivery Risks that will be the Board's focus during 24/25
- a lead executive for each risk and a lead Board assurance Committee
- the first draft of key controls to be put in place and the sources from which the Board will seek assurance on the effectiveness of those controls in mitigating the risk

Since that meeting, executive leads have further developed and refined the five strategic delivery risks such that the paper attached now presents:

- An initial risk score; and a planned target risk score
- Refined and specific actions, controls and planned sources of assurance. Specifically within the individual SDR within the Annex to the paper, the forward plan of actions that are to be completed to mitigate the risks are presented as the 'Controls – What will we put in place to mitigate the risk.'

Work remains ongoing on this to ensure clarity, but also to ensure changes in such are captured throughout the year.

The paper also sets out for the remainder of 24/25 the planned points of reporting (and challenge, scrutiny and oversight) via Committees, Board and through the newly established tri-annual review with the Audit Committee Chair and Director of Corporate Assurance.

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

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

This paper is the latest in a series of papers presented to and discussed by the Board on the topic - Board of Directors in March 2024; Board of Directors timeout session – April 2024; and Board of Directors May 2024.

Recommendation (indicate with an 'x' all that apply and where shown elaborate)								
The Board of Directors is asked to:								
RECEIVE and **NOTE** the progress with the development of the mitigating plans for the five Strategic Delivery Risks								
SUPPORT the individual risk scores assigned to each SDR and the target score and associated time scales (for risk mitigation)								
NOTE the planned next steps and the commencement of new monitoring arrangements via DoCA and AC Chair meetings; Board assurance Committee meetings; and at the Board of Directors.								
Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)								
Trust Risk Register	x							
Board Assurance Framework	x	All						
System / Place impact	x							
Equality Impact Assessment	Is this required?		Y	X	N		If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y	X	N		If 'Y' date completed	
Appendix (please list)								
Individual Strategic Delivery Risk forms are in Annex to the Report.								

Strategic Delivery Risks (Formerly referred to as the Board Assurance Framework)

1. Background

1.1 The Strategic Delivery Risks are those risks that the Board has determined as having most potential to disrupt the delivery of the strategic objectives. These are different from the risks manged via the range of risk registers (operational risks). The latter reflects the challenges to the organisation's functioning on a year by year, week by week basis. It is a live document that will show identification, mitigation and escalation of key risks faced by teams across the organisation. In contrast, the SDRs focus on factors which could interrupt delivery of the organisation's objectives over the medium term. These are also risks that the Board has a unique ability to solve.

1.2 The intention is that the Board is focused on mitigating the likelihood, or more typically the impact, of these factors. Individual executive directors have been tasked with progressing actions to this effect, with a new oversight model in place to support the effectiveness of that work.

2. Strategic Delivery Risks (SDR) 2024

2.1 The paper to the Board in March 2024, reflected the work undertaken with the Executive Group and separately with NED representation during Q4 2023/24. Subsequent to that, the Board undertook further work at its timeout session in April and then received a paper in May 2024. This process resulted in the identification and agreement of five Strategic Delivery Risks – stemming from an initial 40 risks that were initially reduced to 16.

2.2 The five risks, each aligned to a strategic objective are:

- The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities (links to SO1)

- Challenges generating data and / or evidence to support interventions to address Health Inequalities (links to SO2)

- Capacity / Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies (links to SO3)

- Movement to seven-day working is poorly reflected in national terms and conditions and the Trust is therefore unable to shift to new models of care without major retention risk (links to SO4)

- The Trust lacks the cultural capability and competence on wider issues (links to SO5)

The Annex to the paper summarises each of the above, re-written to better articulate the risk faced and presents the refreshed mitigating controls and the expected assurances. It also identifies an initial risk score together with a target risk score and associated timescale.

2.3 Clearly as the shift is complete to the newly formed Strategic Delivery Risks process, there is the need to consider the risks that were included in the previous Board Assurance Framework that are now no longer visible as strategic risk. The Board discussed these within its timeout sessions as part of the rationale for the change in focus and approach this year and agreed for them not to be included.

That said, it is clear that within the SDR there are references to them and / or that there are operational risks that are within the same scope, that remain on the risk registers and subject to regular review and scrutiny – hence nothing has been dismissed or ignored that was previously included:

- SR1 related essentially to the numbers (capacity) of staff at the Trust and the need to ensure sufficiency. Within the attached SDR there is the reference to the aim to move to full establishment within the year following the robust budget setting process and reconciliation of finance and workforce related data.
- SR2 related to quality leadership and culture. Within SDR there are multiple references to the work planned through the year regarding leadership (including the Leadership Development Offer) and to revisions to induction, appraisal, training and the reliance and importance on the staff survey as an assurance mechanism.
- SR3 related to the delivery of the financial plan. An operational risk (F1/24) is in place and is specifically aimed at this (currently scored 3 x 3 = 9)
- SR4 – Partnerships. This very much remains within the SDR with multiple references to the importance of the establishment, development and nurturing of a range of partnerships with colleagues and stakeholders.
- SR5 – Fundamental Standards of Care. The essence of strategic objectives 3 and 4 point towards this but in addition the achievement towards the three other objectives is equally important regarding the quality of care provided by the Trust. Supporting this are a number of operational risks relating to investigations, learning, PSIRF, management of outbreaks and compliance with CQC guidelines.
- SR6 – Governance arrangements. Significant work within 2023/24 and the move to the new operating model addressed a considerable part of the governance related risk. A related operational risk CA4/23 (currently scored 4 x 2 = 8) remains in place
- SR7 – unplanned incident. Operational risks relating to on-call arrangements, evacuation plans and more significantly the Trust's compliance with the national EPRR standards remain in place. (The Board will today as agenda item 22 (Paper S) receive its bi-annual update on EPRR).

2. Next Steps

2.1 Because these are the major strategic risks we face, it is right that mitigating them should consume time and energy among the most senior management. During 24/25 the following actions will be taken:

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

b) BAF risks and the progress on their mitigation will be reported to the Board assurance committees as follows:

SDR	Board Committee	Date of Report presentation			
1	PHPIP	September	November	January	March
2	FDE	August	October	December	February
3	PHPIP	September	November	January	March
4	QC	September	November	January	March
5	POD	August	October	December	February

c) Three reviews will be scheduled where the director of corporate assurance and the audit committee chair meet the responsible director to review progress. These reviews will be purposive and supportive, but also anticipate not just progress of effort and actions, but difference. These will be scheduled for August, November and February and following each a report to the next meeting of the Audit Committee will be made:

d) The Board will receive an update at each meeting throughout the remainder of 2024/25.

2.2 Given the link between the SDR (BAF) and the work of internal audit, especially its Head of Internal Audit opinion work, regular liaison with 360 Assurance will be undertaken through monthly liaison meetings and via a specific piece of work that 360 Assurance will undertake in Q3.

3. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the progress with the development of the mitigating plans for the five Strategic Delivery Risks

SUPPORT the individual risk scores assigned to each SDR and the target score and associated time scales (for risk mitigation)

NOTE the planned next steps and the commencement of new monitoring arrangements via DoCA and AC Chair meetings; Board assurance Committee meetings; and at the Board of Directors.

Philip Gowland
Director of Corporate Assurance
19 July 2024

SO1: Nurture partnerships with patients and citizens to support good health											
What could get in the way? **The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027									
	because	of the leadership's inability to identify, communicate and engage								SF	PHPIP
	then	it will lead to a loss of confidence locally and likely non-delivery of SO1									
Risk Score	Current (July 2024)					Target (March 2026)					
	I	4	L	4	16	I	4	L	2	8	

Controls – What will we put in place to mitigate the risk?	
Stakeholders	• Stakeholder Management Matrix • Roles, Responsibilities, Authority and Capacity of identified leaders to participate • Reporting mechanisms to (CLE Groups, EG and the Board of Directors)
Educating our staff	Leadership Development Offer Component, "Compassionate leadership to unlock community power' – confirmation through delivery report that the cohort of circa 150 have completed this component.(CPD accreditation) – LDO launches September 2024 Induction - Revised induction process to 5-day event that will focus on the introduction to the Trust and its communities. – New induction launches October 2024.
Cultural Shift	Ability of leaders to instigate change; an openness to fail, but learn and improve and ultimately succeed
Representation within our colleagues	A workforce with volunteers, patient safety partners and members that is truly representative of the communities we serve. Understand the current profiles and agree focus of action to address any identified shortfall.

Assurance – How will we know the controls are working?	

	• Internal Audit work on Partnership Governance and Risk management (Q4)
	• Internal Audit work on Patient Experience, Engagement and Inclusion (Q3)
	• PHPIP Report relating to implementation of Stakeholder Management matrix (confirming establishment and fulfilment of expected engagement – especially focusing on the diversity of those with whom we are engaging)
	• PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each PHPIP meeting)
	• Strategy Progress Reports on related (promise) deliverables (multiple promises)
	  ○ Promise 4 (Quality – Quality and Safety Plan)
	  ○ Promise 5 (Board – Quality and Safety Plan)
	  ○ Promise 6 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 8 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 10 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 11 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 26 (POD – People and Teams)
	• IQPR reporting improvements in sickness absence and turnover rates;
	• Improved WRES data
	• Patient and wider community partner feedback
	• Complaints profile

SO2: Create equity of access, employment and experience to address differences in outcome												
What could get in the way? **Challenges generating data and / or evidence to support interventions to address Health Inequalities**	As a Strategic Delivery Risk:										**Lead Exec**	**Board Committee**
	If	we do not execute plans to consistently create, use and respond to data inside our services and with others										
	because	our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities									RB	FDE
	then	this will lead to a lack of precision in how the Trust reshapes services										
Risk Score	Current (July 2024)					Target (March 2026)						
	I	4	L	3	12	I	3	L	2	6		

Controls – What will we put in place to mitigate the risk?	
Data Availability	Health Inequalities – Data relating to Promises. Paper to E&I Group described work towards achieving a baseline position and details of planned further work across a range of data points including the establishment of targets (via Reportal 521 Health Inequalities Dashboard) (Pointed towards health inequality related promises 6, 7, 8, 10, 11, 12 and 17) Data refinement processes – oversight of the portal; removal of underutilised reports will be completed.
Educating our leaders	Digital Needs Survey (to take place in Q2) – understanding what people have fed back, to include reflection of experiences of what is in place, suggestions of what is needed in addition in order to close the gap on the needs identified. Data Saves Lives Campaign (commencing from Q3) – Six key aims of the national campaign including 'Giving health and care professionals the information they need to provide the best possible care' and 'Working with partners to develop innovations that improve health and care'

	Learning Half Days (from Sept 24) – will feature learning opportunities focused on the importance of data and health inequalities.
Making Changes	• Joint Strategic Needs Assessment aligns and informs the planned work • Responding to the health inequalities data; identifying what gaps or shortfalls there are or are perceived to be and developing actions that seek to respond to or address these. Must demonstrate what those 'moves' are, the rationale for them and the impact that they have had for those that use our services

Assurance – How will we know the controls are working?	

	• Health Inequalities – Data relating to Promises. Presented to Equity and Inclusion Group (July 2024)
	
	• FDE Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting from August 2024)
	
	• Strategy Progress Reports on related (promise) deliverables:
	  ○ Promise 6 (PHPIP – Equity and Inclusion Plan)
	  ○ Promise 8 (PHPIP – Equity and Inclusion Plan)
	
	• Revised IQPR and associated Health Inequality measurements / indicators with reporting that confirms that as a result of action there are reductions in the health inequalities

SO3: Expand our community offer, in each of - and between - physical, mental health, learning disability, autism and addiction services.											
What could get in the way? **Capacity/Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	we cannot agree with local GPs and the wider primary care leadership how to coordinate care at PHCT/PCN/neighbourhood level									
	because	there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive								TL	PHPIP
	then	we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.									
Risk Score	Current (July 2024)					Target (March 2026)					
	I	4	L	4	16	I	4	L	2	8	

Controls – What will we put in place to mitigate the risk?		
Stakeholders	• Stakeholder Management Matrix – focus explicitly on Primary care partners such as GP forums, confederations, PCNs • Roles, Responsibilities, Authority and Capacity of identified leaders to participate • GP leadership positions within the Trust's structure	
Regular and well established touchpoints within each of the three places with GP representatives	Doncaster	Complete.
	Rotherham	By Q3 – currently in progress
	North Lincolnshire	By Q3 – currently in progress
Facilitate insight into General practice within …	Board	By Q3 – to complete Physical Health Care Group Medical Director GP Liaison role within the Strategic development Team (appointment to be made by 26 July 2024) In place: Dr Richard Falk – Non-Executive Director Dr Dean Eggitt – GP Partner Governor

		Laura Sherburn – Primary Care Doncaster Chief Executive (route to CLE)
	Care Groups	GP related appointments into Care group structures
	Wider workforce	Through the Leadership Development Offer (LDO) – aim is to skill up our people regarding primary care.
Practical programme of change	Trust Wide	By Q3 this programme will be in place and include programmes focused on referrals and communication; and Roles (DN / PC MH team) By Q1 25/25 – this programme will be delivered / implemented.

Assurance – How will we know the controls are working?	

	• Internal Audit work on Partnership Governance and Risk management (Q4)
	• Internal Audit work on Patient Experience, Engagement and Inclusion (Q3)
	
	• PHPIP Report relating to implementation of Stakeholder Management matrix (confirming establishment and fulfilment of expected engagement – especially focusing on the Primary Care partners
	• PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)
	• Strategy Progress Reports on related (promise) deliverables:
	  ○ Promise 12 (PHPIP - Equity and Inclusion Plan)
	  ○ Promise 15 (PHPIP - Equity and Inclusion Plan)
	  ○ Promise 21 (PHPIP - Equity and Inclusion Plan)
	
	• Feedback mechanisms with GPs confirm strong alignment on Primary and Community MH services and adult and children's community nursing

SO4: Deliver high quality and therapeutic bed based care on our own sites and in other settings										
What could get in the way? **Movement to seven-day working is poorly reflected in national terms and conditions and the Trust is therefore unable to shift to new models of care without major retention risk**	As a Strategic Delivery Risk:								**Lead Exec**	**Board Committee**
	If	Seven day working and other bed based service alterations are not implemented fully								
	because	of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring)							RC	QC
	then	we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.								
Risk Score	Current Score (July 2024)					Target Score (March 2026)				
	I	4	L	3	12	I	3	L	2	6

Controls – What will we put in place to mitigate the risk?	
Service provision (RDASH)	Decisions relating to the need 24/7 for services : We need to understand the current position (create a baseline) – map of services created that confirms current state. This will include 24 hours services (some may not deliver full function such as ward discharges at weekend); extended hours and "normal working" hours. This is across all 23 directorates. This will include current virtual offer or not. Mapping to include potential rational for change and a risk score for impact of extending to 24/7 In Q3 Identify learning from recent similar changes – eg. patient flow / on call Determine the right model and resources for the right delivery function Pilot programme to test the ability, capacity and affordability of proposed changes. Learning points identified. (Pilot – two clinical ; one corporate) In Q4

	Prioritised programme of work developed and agreed aligned to Trust Strategy, so creating a vision for change. This would not be all services - but services which will improve patient outcomes. This will include demand and capacity work to reflect patient need and the voice of the community. This will be a 2–3-year change programme and will be a combination of strategies. We will need change in partners, for example if discharges from wards at weekends what support is available? Consider innovative approaches and choose the proper communication channels. Potential strategies • Co locates with partners who are already 24/7 (i.e. LA, acute, police) or extend hours (GP's) • Expansion of virtual offer and "remote working" • Outsourcing to community partners to abridge to RDaSH services • Offer A Service With A 24/7 Assistant (expansion of virtual; apps?) • Increase self help services - with swift access to advice and support Development of new approach to bid writing for new services that ensures requirement for service provision (and possible expansion) are included
Service provision (others)	Explore how and who other service providers (community and voluntary sector) can contribute / support the delivery or support to our services on a more flexible or longer basis
Staff Engagement	Unions and Staff Side – consultation / engagement processes discussed and agreed Revised ‘standard’ terms and conditions to create opportunity for more flexibility Ensure changes are clinically led. Ensure JD reflects new ways of working. Key will be ensuring this is not felt as an imposition - but support improved patient outcomes. Consider if change can be managed in part through staff turnover and investment as opposed to mass service consultation. Consider workforce models of support - training; enhanced work flexibility; clarity on support and supervision models; safety

Assurance – How will we know the controls are working?	

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

SO5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations												
What could get in the way? **The Trust lacks the cultural capability and competence on wider issues**	As a Strategic Delivery Risk:										**Lead Exec**	**Board Committee**
	If	We do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027										
	because	We do not develop and practice the skillsets required to make change occur									CH	POD
	then	The Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees										
Risk Score	Current Score (July 2024)					Target Score (March 2026)						
	I	4	L	4	16	I	3	L	3	9		

Controls – What will we put in place to mitigate the risk?	
Developing our Leaders	Leadership Development Offer – circa 130 individuals – launch September 2024 Leaders Conference – circa 130 staff as the Top Leaders Cadre – September 2024 Learning Half Days – every member of the Trust – commence on 3 September following pilot in North Lincolnshire and Talking Therapies Care Group First Line Managers Training Scheme – Launch September/October 2024 'Wider leadership' proposals – B5+ / Very Senior Clinicians - Launch September/October 2024 Induction (all new starters) – week long / RDASH and our communities – Launch October 2024 Revised appraisal process developed and implemented – Q4 24/25 People and Teams CLE Group (already established) Education and Learning CLE Group (already established)
Increasing capacity / capability	Fully utilising the apprenticeship levy (delivery of Promise 9) Fully recruiting to all posts – 97.5% by January 2025 Commitment to designated training budget – Budget commitment achieved – demonstrate increase in spending year on year Re- development of the Change function

How will we know the controls are working?	

Assurance	• Internal Audit work on Partnership Governance and Risk management (Q4)
	• POD Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)
	• Strategy Progress Reports on related (promise) deliverables:
	  ○ Promise 9 (PHPIP - Equity and Inclusion Plan)
	  ○ Promise 26 (POD – People and Teams Plan)

Feedback	• Pulse check scores • Staff Survey outcomes • Positive feedback in respect of the Leadership Development Offer including via psychological analysis exercises • Positive feedback from new starter networks • Exit interview data/feedback across the Trust
Impact	• Feedback from stakeholders regarding the approach of the Trust • consistent timely exit and delivery of time bound projects, and achievement of key measures with respect to the wider issues within the Strategy • Reduction in Employee relations cases / matters • Reduction in sickness absence • Reduction in staff turnover (esp within first 12m)

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Half Day Learning	**Agenda Item**	Paper M
Sponsoring Executive	Dr Judith Graham, Director for Psychological Professionals and Therapies		
Report Author	Dr Judith Graham (Director for Psychological Professionals and Therapies), Vicky Clare (Nurse Director – NL &TT Care Group), Jon Rouston (Chief AHP)		
Meeting	Board of Directors	**Date**	25 July 2024

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

The slide deck and attached appendix is provided for Board members to consider the ½ day learning concern and the pilot progressed during Q1 24/25. This should be considered as part of the Learning and Educational Plan and promise 24 of our RDaSH Strategy.

The work described also includes the next phase of the ½ day learning journey where we upscale across the Trust from September 2024, and where we can consider the 2026-27 ambitions related to this programme of work.

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

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

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

Clinical Leadership Executive Group

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

The Board of Directors are asked to:

X	**DISCUSS** the method, and progress described
X	**CONSIDER** any matters of concern *not* covered within the slide deck or appendix
X	**RECOGNISE** the commitment to education and learning leadership highlighted

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

Trust Risk Register							
Board Assurance Framework	X						
System / Place impact	x						
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)

Appendix 1 – Pilot Evaluation

Rotherham Doncaster and South Humber NHS Foundation Trust

Half Day LEARN
Pilot & Full Implementation

Board of Directors
July 2024

Dr Judith Graham BEM QN
Director for Psychological Professionals and Therapies
Chair – Education & learning Group

***Please note this information should be considered alongside of the 3 page learn brief evaluation provided.**

RDaSH nurturing the power in our communities

Aim of the session

Rotherham Doncaster and South Humber NHS Foundation Trust

- To focus upon the ½ day learning sessions and purpose for these (the **WHAT**)
- To share information concerning the 3 month pilot that has been conducted in the Trust regarding the ½ day learning session. (the **PILOT**)
- To share information in terms of the launch of the Trust wide protected ½ days for learning considering the learning from the pilot. (the **'AND WHAT'**)
- To consider work in 2025-27 – in terms of widening the approach consistent with our wider strategic ambitions (specifically:- partnership working, peer support and 24/7 working) - (the '**WHAT NEXT'**)

Rotherham Doncaster and South Humber NHS Foundation Trust

The '**WHAT**'.....

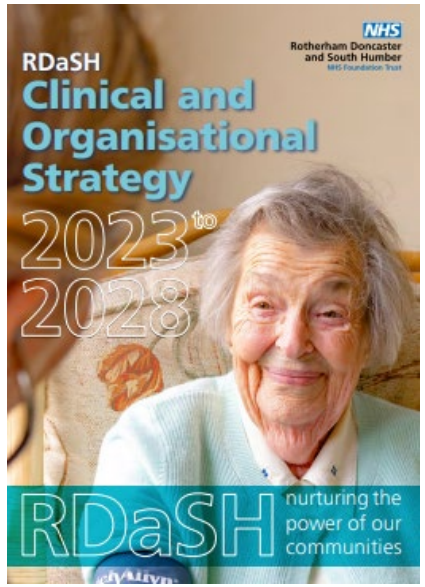
RDaSH nurturing the power in our communities

Strategic Alignment

Rotherham Doncaster and South Humber NHS Foundation Trust

Objective 2 – *Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations*

Promise 4 – Expand and Improve our educational offer at undergraduate and post graduate level; as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan.



With aspects also aligned with:-

- *O1/P3 – Work with over **350 volunteers** by 250 to go the extra mile in the quality of care we deliver.*
- *O1/P4 – put **patient feedback** at the heart of how care is delivered in the Trust encouraging all staff to shape services around individuals diverse needs.*
- *O1/P5 – from 2024 **systematically involve our communities** at every level of decision making in our Trust throughout the year, extending our membership offer and delivering the annual priorities set by our staff and public governors.*
- *O2/P9 – consistency exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focussed on refugees, citizens with learning disabilities, care leavers and those from excluded communities.*
- *O5/P28 – **extend the scale and reach of our research work** every year; creating partnerships with industry and universities that bring investment and employment to our local communities.*

Education and Learning – Strategic Delivery Plan













Individual reflection, mentoring, coaching

Team meetings & supervision

In Partnership with patients & families

Directorate (clinical or support)

In Care Group

With 'Place' Partners

Via clinical and non-clinical Specialism

Trustwide

Through Integrated Care Partnership

Through Positive Practice & Incident

Regional Forums & Partnerships

National Forums & Publications

RDaSH nurturing the power in our communities

RDaSH 'Learn' Events

Rotherham Doncaster and South Humber NHS Foundation Trust

Context and discussion

- Time to learn must be privileged otherwise it will not be prioritised.
- The need to enhance our focus upon becoming a 'learning organisation' is our commitment and core to our quality and safety.
- Learning is something that transcends teams and roles, and should not just be the focus of clinical services.
- Protected time to learn will be introduced, this will enable focus upon a number of different learning opportunities (i.e. MAST, research, team learning meetings, mentorship, Schwartz rounds etc).
- We will link learning with our RDaSH calendar and National celebration days.
- We will use the learning ½ days to connect across specialism as well as focus on place (i.e. older adults)
- We will focus upon developing a programme which is accessible for people who work around the 24 hour period, either paying people who wish to attend the 9-5 Mond/Fri sessions as well as enabling sessions on evenings and weekends.
- The learning will also enable talent management and also talent showcasing, with focussed learning from experts by experience and experts by education.
- As we progress, there will be enhanced opportunities for partnership learning and also to offer some of our leaning activities to be co used with system partners.
- This activity will be overseen via the sub-CLE Learning and Education Group

Branding & Commitment

Rotherham Doncaster and South Humber NHS Foundation Trust

#RDaSHLearn =

- **L**earning,
- **E**ducation
- **A**nd
- **R**esearch/**R**eflection
- **N**etwork(s/ing)

We all learn differently and therefore our learn experiences need to enable different learning experiences.

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The **PILOT…….**

Includes one Care Group = 2 directorates – NL and TT. This is beneficial as this included a 'place based' service and an organisational wide service.

***Please note this information should be considered alongside of the 3 page learn brief evaluation provided. By NL&TT Care Group SLT**

RDaSH nurturing the power in our communities

High Level Outcomes

Rotherham Doncaster and South Humber NHS Foundation Trust

Pilot Parameters defined:-

- MAST training – with focus upon increasing compliance with this dedicated time being prioritised.
- Dates set out for the pilot to enable booking
- Care Group 'Learning' meetings moved into this designated time.
- Communicated expectation of 'Christmas Day Cover' one Wednesday morning per month – releasing all other staff to complete learning.
- A range of activities made available, from a taught programme based around broad themes, to meetings to discuss learning, Schwartz rounds and MAST focussed on site provision.
- Those with ongoing learning commitments defined as not having to participate in programmed sessions to enable those already studying to not receive 'double' study time.
- Self directed learning and professional portfolio reflection permitted as a learning activity.

Results:-

- MAST Compliance:
  - MAST compliance as at 31st March 2024 = 91.10%
  - MAST compliance as at 8th April 2024 = 91.75%
  - MAST compliance as at 2nd May 2024 = 92.04%
- Programme has been very well received by those who have participated in the programmed activities (see attached report)
- The pilot saw increased numbers of people engaging with the protected LEARN time, but it is acknowledged not all participated.
- Facilitator Learning & Feedback (within report)
- System (ESR) Recording issues
- Visible leadership in all care group areas enabled from care group SLT (this in itself provided a learning and leadership connection opportunity)
- Good support was provided from backbone services

Pilot Challenges

Rotherham Doncaster and South Humber NHS Foundation Trust

- Fixed date / time clashes with clinical commitments reducing autonomy of staff.
- Some dates coincided with non-clinical e.g. partnership meetings.
- Supporting people to have the permission to take time to learn was challenging, and has taken trust and encouragement. Some people declined to partake.
- Room space is required in order to provide facilitated courses.
- Significant project manager and admin time was required to book sessions and rooms, register and record learning.
- Significant leadership time is needed to progress this programme of work.
- New learning needs identified are currently being suggested as topics for half day learning – need to ensure that expectations around capacity are realistic.

Pilot Successes

Rotherham Doncaster and South Humber NHS Foundation Trust

- There has been an improved focus on learning with the pilot.
- Set day and time focusses attention on importance of learning and CPD
- Wide communication about the set day and time improves participation and draws out challenges
- Programme of short sessions offers those with limited understanding of CPD offer a chance to 'trial' and then sign up for something more in the future.
- Sitting with care group has meant local autonomy and response to need within the care group. Can be agile to meet new demands.

Rotherham Doncaster and South Humber NHS Foundation Trust

The ‘**AND WHAT**’ ….

RDaSH nurturing the power in our communities

Across Trust Roll Out

Rotherham Doncaster and South Humber NHS Foundation Trust

- From September 2024 the ½ day learning approach will be rolled out across the Trust.
- What this means is that –
  (1) the dates that have been set in the corporate calendar circulated must be planned for
  (2) The prototype approach and learning from the NL pilot, will inform mobilisation for the other 21 directorates in the Trust,
  (3) there will be sessions that are beneficial 'for across Trust/Directorate' attendance – the next slide provides an example of these which will be available via communications.
- In terms of the NL Pilot
  - All learning to be taken into account for next session planning.
  - Planning group established fortnightly.
  - Project Plan in place and followed.
  - 'You said we did' document in production following receipt of colleagues feedback.
  - LEARN menu is being enhanced following feedback.
  - Inclusion / Exclusion criteria is being reviewed.
  - Request for support regarding ESR 'overload' issues.
  - Staff Portal as a digital solution to manage bookings and attendance at the LEARN sessions being explored.

Open learning opportunities….

Topic → / Date ↓	Schwartz Round	'Bite Size' Research Session (Promise 28)	'Autism & Sensory Friendly' (Promise 8)	MAST Sessions (KLOE – SAFE)	Safeguarding Sessions (Promise 7)	Staff Network Event
3/9/24 –PM	Me and my personal development (Face 2 Face Session)	Introduction to research (MS Teams) – TBC	Sensory Awareness (MS Teams)	Face to Face in North Linc's, Rotherham & Doncaster	Human Trafficking effects, detection and reporting (MS Teams) –TBC	Women's Network meeting (Hybrid)
10/10/24–AM	'Look out for your team' – (MS Teams) 'Managing Conflict – (MS Teams)	Publications (MS Teams) –TBC	How to Improve patient experience? (MS Teams)	Face to Face in North Linc's, Rotherham & Doncaster	Persons in a Position of Trust Processes – PiPoT (Face to Face)	LGBTQ+ Network drop in (MS Teams – TBC)
6/11/24-PM	TBC	Research Library Resources (MS Teams) -TBC	Our environments and how to make them sensory friendly (MS Teams)	Face to Face in North Linc's, Rotherham & Doncaster	FGM (MS Teams) –TBC	REaCH Network Drop in (MS Teams – TBC)
12/12/24-PM	'Managing people through change' (MS Teams) 'Identify your career anchor' – Face 2 Face	Joining a research project (MS Teams) –TBC	Deploying the Sensory Friendly resource pack (MS Teams)	Face to Face in North Linc's, Rotherham & Doncaster	Safeguarding Childrens Awareness (MS Teams) –TBC	DAWN Network Drop-in (MS Teams – TBC)
24/1/25-AM	'Personal Effectiveness and Time Management' – MS Teams	Research Governance (MS Teams) –TBC	Sensory Awareness (MS Teams)	Face to Face in North Linc's, Rotherham & Doncaster	Safeguarding Adults Awareness (Face to Face – all localities)	Carer's Network – TBC
13/2/25-AM	TBC	Ethics Approval Processes (MS Teams) –TBC	How to Improve patient experience? (MS Teams)	Face to Face in North Linc's, Rotherham & Doncaster	Childhood Sexual Exploitation (MS Teams) –TBC	Intersectionality Discussion (MS Teams)
26/3/25-PM	'Agile Working' – one session Face 2 Face and one session MS Teams	Research in your area of work – clinical, digital, finance or education	Our environments and how to make them sensory friendly (MS Teams)	Face to Face in North Linc's, Rotherham & Doncaster	Safeguarding and older adults (Face to Face – all localities)	The strength of Diversity (MS Teams)

Roll out (Slide -1/2)

Rotherham Doncaster and South Humber NHS Foundation Trust

Across Trust Progress

- With the prototype that has been presented by the NL&TT senior leadership teams, the expectation is that all directorates adopt this approach starting in September 2024.

Logistical Points

- Links with Medical SPA – the ½ days are SPA time and over the course of a year, clinical work will be reinstituted where that is practicable.
- Payment (for parttime or shift workers) – for discussion in terms of local/ personalised approach and decision linked with job planning.

Roll out (Slide -2/2)

Rotherham Doncaster and South Humber NHS Foundation Trust

- It is appreciated that with the widening of the programme there will be economies of scale in terms of some of the sessions that people from a number of different directorates will want to attend, but this in itself whilst creating networking and across working opportunities will require administrative support and coordination.
- Our workforce policies and processes need to support the mandating of learning. This is aligned with professional body expectations (where applicable) and also CQC requirements.
- Additional LEARN time for facilitators, managers, coordinators and those covering the 'Christmas Day rota's is required to enable learning for these individuals.
- It is suggested that some the staff network activity is revised and moved into the LEARN half day time to enable attendance. Each network to last 1 hour. So not all of the LEARN ½ day would be taken by these.
- The provision of 'place based' MAST courses and OD sessions (such as Schwartz rounds) must be deployed for all of the planned ½ days moving forward, to support directorate access.
- Partner conversations required to manage expectations in terms of meetings (in the similar lines to the GP contact days)
- A booking system which records attendance and preferably enables feedback is required
- The half days are a positive place to enable research training and also research pieces of work (in terms of projects, supported publication etc)

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The '**WHAT NEXT**' … 2025/26/27

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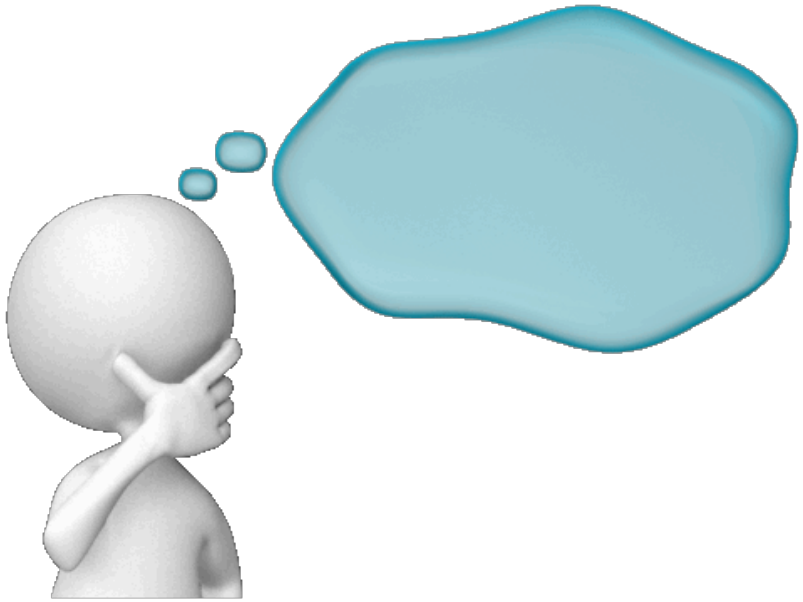
Considerations:-

Rotherham Doncaster and South Humber NHS Foundation Trust

- Greater inclusivity for shift workers
- PSIRF development, enabling enhanced opportunities for learning.
- Increased partnership working enables opportunities for across organisational learning and community investment.
- Our strategic growth of volunteers and peer support workers enables different opportunities to learn, and opportunities to attract people to ‘work with us’.
- We need to review the learning in cycles to ensure matrix working is enabled (i.e. across specialism and place)
- Research plans can be tied into these events.
- BAU planning, will protect this time and prioritise as an essential activity for organisational health
- Staff volunteering options and experience (coaching, visiting, shadowing) with partners is something we could consider once we have embedded the internal culture focussed on learning.
- Considerations for students and people accessing placements

Rotherham Doncaster and South Humber NHS Foundation Trust

Any Questions?



RDaSH nurturing the power in our communities

LEARN dates:

Rotherham Doncaster and South Humber NHS Foundation Trust

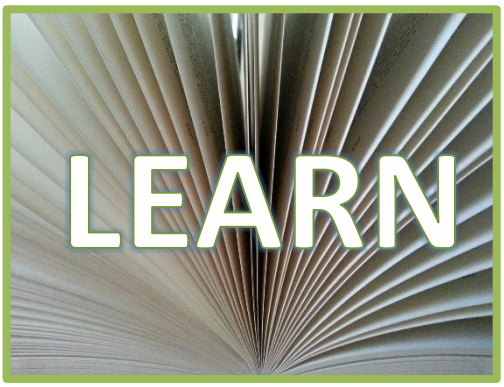
Dates

- Tuesday September 3rd - afternoon
- Thursday October 10th - morning
- Wednesday November 6th - afternoon
- Thursday December 12th - afternoon
- Friday January 24th - morning
- Thursday February 13th - morning
- Wednesday March 26th - afternoon

LEARN stands for:-

#RDaSHLearn =

- **L**earning,
- **E**ducation
- **A**nd
- **R**esearch/**R**eflection
- **N**etwork(s/ing)



North Lincolnshire Mental health and Talking Therapies Care Group

Monthly Learn event
First Wednesday Morning, every month – starting 3rd April 2024

Initial Brief Evaluation

Promise 24 – Expand and improve our educational offer at undergraduate and post graduate level as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan.

AIM

To provide protected time for the whole care group to prioritise their own learning and continued professional development. Each month the Learn session will be mandatory for all staff with the exception of staff providing 'Christmas day' service cover for essential services (this will be rota'd so that all staff have the same opportunities).

3.4.24 – Learning Menu and participation:

Session	Session Description	Venue	Facilitator	Participants (No.)
Data Quality – 3 sessions	These sessions will cover topics such as data entry, data quality, common mistakes that affect how data is captured and how to guides etc.	Via Microsoft Teams	Karen Samuel-Hannan and Natasha Littlewood	9
Learning from Mental Health Act Incidents	This is an opportunity to hear about learning from Mental Health Act incidents and how this applies to your practice.	Via Microsoft Teams	Helen Moran	7
Emotional Intelligence	This 75-minute session will focus on knowledge and understanding of emotional intelligence, how to build self and social awareness and how to use emotions positively.	Via Microsoft Teams	RDaSH Academy	27
Personal Effectiveness and Time Management	This course will cover techniques for managing distractions, how to develop successful habits and how to focus on tasks to make sure they get done.	Via Microsoft Teams	RDaSH Academy	23
Service Improvement and Change Management	This is an opportunity to learn about transformation and service improvement within the Care Group and future planning.	Meeting Room, Great Oaks	Louise Treen and Louisa Redhead	6
Controlled Drugs	Medicines Management with Controlled Drugs including Ordering, Storage, Administration and Destruction.	Meeting Room, Great Oaks	Katie Norton, Senior Pharmacy Technician	6
Focus Group – Caring for Gypsy/Traveller Communities	Leeds GATE is a member-led organisation working to improve quality of life for gypsy and traveller communities.	Via Microsoft Teams	Kari Griffiths, Leeds GATE	10

When does poor care become safeguarding? 2 sessions	**Two sessions are available – attendance will cover Safeguarding Adults Level 3 compliance.**	**Ironstone Centre, Scunthorpe**	**Karen Whitby, Lead Professional Safeguarding Adults**	**11**
Fundamental Skills Training	**This course includes:** • **Taking full A-E assessment including respiration rate, manual and electronic blood pressure, pulse, temperature, blood sugars, neurological observations.** • **Scoring via NEWS2 and clinical judgement.** • **Sharps injuries and safety.** • **Neurological charts.** • **Sepsis signs.** • **Monitoring post fall.**	**Great Oaks**	**Angie Dodd, RDaSH Academy**	**8**

01.05.24 – LEARN Menu and Participation

Session	Session Description	Venue	Facilitator	Participants (No.)
Patient Facing Apps Demo	Patient Facing Apps Project – SystmOne • Explanation of Features and Functionality available to improve digital communications with Patients o Communications Annexe o Sending letters electronically o Inviting patients to book appointments via a link o Information that patients can view online/via app • North Lincs Adult Mental Health and Talking Therapies Care Group project phase commencement o Timescale o Demo sessions o What to expect	Microsoft Teams	Elaine Evans/Paul Crozier	7
DIALOG	David from Clinical Systems will present on the use of DIALOG on SystmOne	Microsoft Teams	David Powell, Clinical Systems	10
Safeguarding	Focus session on case study and actions to be taken from a safeguarding perspective	Ironstone Centre, Scunthorpe	Karen Whitby	0
Organisational Learning Session	A session for shared learning from serious incidents, complaints, patient safety and to identify themes and trends.	Microsoft Teams	Vicky Clare	27
Data Quality	This session will cover topics such as data entry, data quality, common mistakes that affect how data is captured and how to guides etc. Please bring along any queries you may have.	Microsoft Teams	Sam Steeples and Natasha Littlewood	11

Drop in session for ESR	**A member of the Workforce Systems team will be available for staff to drop in for any queries or training required on ESR.**	**Meeting Room, Great Oaks**	**Patrick Reeves and Lisa Booker, Workforce Systems**	**N/A**
IG/DPA processes for Admin staff	**Chrissie and Kerry will give an overview of DPA processes**	**Seminar Room, Great Oaks**	**Chrissie Whittaker**	**9**
Addressing Health Inequalities	**Addressing Health Inequalities – How you can start to understand who is accessing your services** **To help us understand if parts of our community are representative in your services, or if some are under-served, we have created a report to help you with this. The report uses your services data and looks at it through a lens of deprivation and protected characteristics. On 1st May Ray Hennessy, Deputy Director of Strategic Development, will show you a couple of examples and how you can access this for your own service yourself.**	**Seminar Room, Great Oaks**	**Ray Hennessey**	**8**
Completing IR1s (2 sessions)	**Rob will give an overview on completing IR1s on Ulysses, there will be opportunity to ask questions at the end of the session.**	**Microsoft Teams**	**Rob Maginnis**	**16**
Learning from Incidents	**Sharon will present on learning from serious incidents.**	**Seminar Room, Great Oaks**	**Sharon Greensill**	**11**
Cultivating Compassion Circles (3Cs) - Look After Yourself	**We are not super-human, make sense of chaos? Paying attention to the present moment can improve your wellbeing. This includes your thoughts and feelings, your body and the world around you.**	**Microsoft Teams**	**Becky and Kudzai, Improvement and Culture Team**	**19**
Cultivating Compassion Circles (3Cs) - Speaking Candidly & Compassionately	**Is it possible to do both? It sounds easy in theory: speaking to others in a way that is both forthright and caring. Balancing your frankness with empathy is essential when working under pressure**	**Microsoft Teams**	**Becky and Kudzai, Improvement and Culture Team**	**15**
How to manage Tasks on SystmOne	**This session will be an opportunity to see how to manage and action tasks on SystmOne.**	**Microsoft Teams**	**Darryl Nevil**	**18**

In addition to the facilitated face to face and virtual sessions a number of staff used the LEARN protected time to complete MAST / self-guided learning

Compliance overview

MAST compliance as at 31st March 2024 = 91.10%
MAST compliance as at 8th April 2024 = 91.75%
MAST compliance as at 2nd May 2024 = 92.04%

To note – a number of staff completed MAST that had not yet expired which needed to be completed within the coming months. We hope that the protected time at LEARN will ensure that MAST compliance doesn't decrease.

Key Learning points for organisers

Facilitators feedback – April:

- Encouragement required to some colleagues to participate – appreciate culture change and new concept
- Require service manager and team manager support to ensure opportunity fully realised
- Recognise need for champions across teams
- Good buy in from facilitators and wide learning offer in place
- ESR issues while completing e-learning – Query if system overwhelmed
- Support in place from SRO and deputy
- Require 'inhouse' facilitator on all virtual sessions to introduce, communicate 'house keeping' cameras on, record session, general support
- Need to considered staggered start time to accommodate urgent work and morning duties on acute wards
- Need to review inclusion and exclusion criteria and consider pro rata for part time staff, options for NHSTT that limit impact on access targets, options for smaller teams
- Explore use of Eventbrite for bookings and links (automated)
- Explore options for Domestic teams (NLMH and TT)

Facilitators feedback – May:

- Good attendance and engagement throughout the sessions.
- Having a host attending the sessions was helpful for facilitators and helped run the sessions smoothly.
- Timing for some sessions worked as planned (e.g. Patient Facing Apps) but for other sessions more time would be better in the future to allow for questions (e.g. Completing IR1s).
- Some of the facilitators have already been booked and are happy to attend future LEARN events, e.g. Improvement and Culture team, Clinical systems team, ESR team.
- No bookings for Safeguarding this time despite session being tailored to feedback from March. Karen Whitby will continue delivering these in upcoming moths and we will come up with a tailored approach to deliver this to staff that need it.
- In person sessions had a positive experience from the support they received by team with setting up equipment (connecting lap top, screen etc) and provision of refreshments.
- Facilitators would find it useful to have feedback from attendees to improve and tailor their sessions.

- It would be useful to tailor sessions around areas that need improvement across the CG or where there is a specific need (e.g. low compliance, new functions on SystmOne, etc)
- Some sessions require some preparation in advance. This will be incorporated to the LEARN menu which is circulated to staff.
- Having to book on the LEARN sessions instead of having the links available to just turn up, has created challenges.
- ESR crash in April was due to New Financial Year updates and with should not be causing an issue on other months.

Staff Feedback - extract

Positive:

Didn't feel guilty about completing training in preference to other work

I think the idea behind the LEARN event is great, learning new things and self-development is something I am really passionate about

Well prepared and delivered presentation and loved that we broke out into small groups to discuss

I attended emotional intelligence training and felt that it gave me a nice reflective space and a prompt to check in...

It was a great opportunity to stop and LEARN which felt perfect!

I found all content useful. Some was a refresher for me, but I also learned some new skills

Improvement suggestions:

More consideration from clinicians asking for admin to complete things during the protected time

I had two pieces of MAST training I was going to complete, I completed one, but then the system was struggling, and I got the circle of doom

For staff that don't work Wednesdays to have protected time

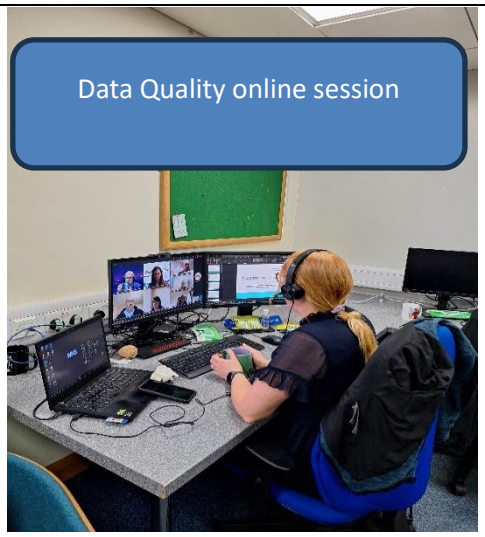
Options to give ideas or request for training sessions, rather than just being given a 'menu' of sessions that don't feel all that relevant.

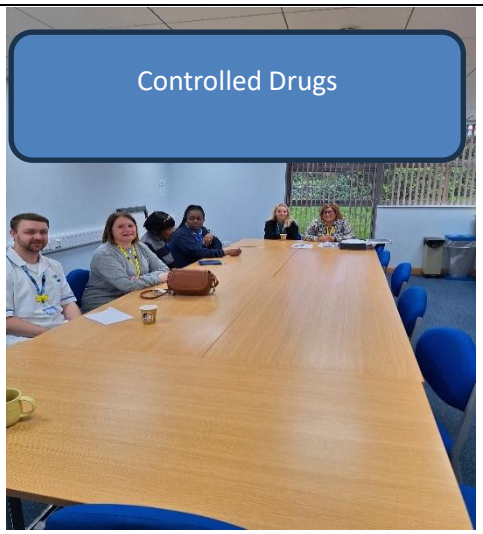
A full morning is a lot to lose in one day for those with heavy work loads

Speaking to leaders within teams to find out what is actually needed would prove to be beneficial

Future Considerations:

General: • Follow up sessions on same topics (i.e. data quality) • More Face to Face sessions • Training in Doncaster and Rotherham for TT colleagues • More training on the services offered at PLACE • Understanding pensions and NHS benefits	**Clinical:** • More specific training for clinicians • Reschedule the cancelled reflective sessions • Protected time to complete professional portfolio • Learning from incidents and CQC visits, audits • Case studies
Admin: • More training specific for admin	**Health and Wellbeing:** • Increase health and wellbeing offer within LEARN
Leadership: • Leadership training • Recruitment and retention, learning from induction	**Teams Training / networking:** • Stalls – networking across teams • Practice development (protected time for teams to come together) • Specific workshops within teams for CPD to ensure we also keep accreditation up to date





Next Steps

- All learning to be taken into account for next session planning.
- Planning group established fortnightly.
- Project Plan on track.
- You said we did document in production following receupt of colleagues feedback.
- Learn menu is being enhanced following feedback.
- Inclusion / Exclusion criteria is being reviewed.
- Request for support regarding ESR ‘overload’ issues.
- We are looking into the use of Staff Portal as a digital solution to manage bookings and attendance at the LEARN sessions.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Placement Landscape	**Agenda Item**	Paper N
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Co-produced authorship – Director for Psychological Professionals and Therapies, Medical Director and CNO		
Meeting	Board of Directors	**Date**	25 July 2024

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

The slide deck updates Board members in terms of the placement landscape currently within RDaSH. This is a complex landscape to consider, specifically when considering the range – from formalised placements with Higher Education Institution to work experience and volunteer placements.

The placement landscape is important when considering our service delivery as it has an impact on patient care, staff experience, prospective new recruits and delivery of our Trust Strategic Objectives.

The amount of placements is only one aspect of the landscape, the Board are asked to consider the quality and potential of our placement landscape particularly when we are actively pursuing an enhanced local offer.

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

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

Not applicable

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

The Board of Directors are asked to:

X	**CONSIDER** any matters of concern *not* covered within the slide deck
X	**RECOGNISE** the commitment to the placement landscape in its totality
X	**NOTE** the obligations of the Trust re: commissioned and non-commissioned training

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

Trust Risk Register	X	Linked to care quality and workforce risks					
Board Assurance Framework	x						
System / Place impact	x	Linked to HEI and educational partnership working					
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)

Rotherham Doncaster and South Humber NHS Foundation Trust

Placement Landscape

Board of Directors
July 2024

RDaSH nurturing the power in our communities

What is a placement ?

DHSC guidelines define a placement as:

- Be a recognized part of the education and training curriculum for the course and approved by the HEI and the relevant regulatory body as appropriate;
- Meet the quality standards of the regulator, the commissioner and HEE;
- Be direct clinical training with an agreement programme, being a minimum of one week;
- Have the appropriate clinical and mentoring support as defined by the regulatory body; and
- Is not workplace shadowing

In addition:

- Simulation, as permissible by the regulator in lieu of face to face clinical experience
- Virtual placements incorporating patient facing experience
- Be supported by an appropriate placement agreement and have defined learning outcomes

Who regulates, and how?

- Professional bodies define expectations for training (i.e. HCPC Standards of Education and Training)
- HEIs are expected to take account all of these frameworks when designing their programme.
- HEIs often contract with several different organisations NHS, Social Care and VCSEs to support students to gain a broad range of experience.
- In some courses there are elective placements which may be completed outside of the UK.
- HEIs are therefore the employer for many of our students on placements (there is an exception in terms of medical)
- Non-medical students must be supernumerary on placement.
- HEIs and professional bodies work together in terms of regulation.
- Occupational Health is provided by the HEI in non-medical.

NHS

Rotherham Doncaster and South Humber

NHS Foundation Trust

How it is funded?

- Certain placements have a funded tariff (i.e. the organisation receives funding for them towards supervision, MAST and other support)
- The funding is via NHSE's Workforce, Training and Education Team (formerly know as HEE).
- HEE merged with NHS on 1/2/23 however there are still processes related to the merger being progressed.
- Training Programme Directors and Heads of Schools are still in place.
- The RDaSH placement team works with non-medical 'health' placements, there is a separate process for medical placements and social work placements.

Professions eligible for tariff funding

Rotherham Doncaster and South Humber NHS Foundation Trust

- Medical (ALL)
- clinical psychologist
- healthcare scientist practitioner training programme (PTP)
- adult nurse
- children's nurse
- dietician
- dual qualification nursing courses
- learning disabilities nurse
- mental health nurse
- midwifery
- shortened midwifery courses
- occupational therapist
- operating department practitioner
- pharmacist - undergraduate
- physiotherapist
- podiatrist
- speech and language therapist

Type of Placement	Original tariff for placement activity in 2023 to 2024	Additional uplift following pay deals	Revised tariff for placement activity in 2023 to 2024 tariff
Clinical	£5,193 plus MFF per full time equivalent (FTE)	3.0%	£5,343 plus MFF per full time equivalent (FTE)
Medical undergraduate (all placements)	£31,937 plus MFF	2.0%	£32,552 plus MFF
Medical postgraduate	£12,398 plus MFF Plus a contribution to basic salary costs. See Annex A. See paragraph 7.9 for further information on separate funding arrangements for study leave.	2.0%	£12,637 plus MFF Plus a contribution to basic salary costs. See Annex A. See paragraph 7.9 for further information on separate funding arrangements for study leave.

Data Collection

Rotherham Doncaster and South Humber NHS Foundation Trust

- Data is submitted by education providers 3 times per year
- Placement providers are now required to review aggregated placement activity based upon data summitted to NHSE Workforce, Training and Education Team (formerly know as HEE). by education providers
- Payment of Non-Medical Education and Training (NMET) Tariff for the indicated reporting period is only be made after validation is received and confirmed
- Placement providers need to ensure their own internal data monitoring systems to be able to review placement activity robustly
- Placement Activity is recorded in hours not student headcount.
- Data is presented as hours undertaken by academic year cohorts, qualification, profession and education provider.

Tariff Use and Monitoring

DHSC guidelines state the following:

- Direct staff teaching time within a clinical placement
- Teaching and student facilities
- Administration costs
- Infrastructure costs
- Education supervisors
- Pastoral and supervisory support
- Health and wellbeing (excluding any OH assessments carried out by the Education Provider)
- Student/trainee accommodation
- In-course feedback and assessment
- Staff training and development relating to their educational role

In addition:

- Should benefit all eligible professional groups, but is not a direct placement fee – scope for the organisation to flex funding
- between groups for short term to support specific objectives
- Transparency at organisational level to ensure awareness of funding use

Monitoring

- Education Contract requires biannual reporting
- While funding does not have to go direct to the service or ward delivering the placement, it is expected – as a total funding stream – be used to proportionately support all eligible learners.
- HEE will be seeking evidence of this and that the Trust can demonstrate transparency internally as to how all eligible professional groups benefit from the investment

Formalised Placement Agreements

Rotherham Doncaster and South Humber NHS Foundation Trust

Nursing Placements

Specialisms:-

- Adult
- Learning Disability
- Mental Health
- Child
- Nursing Associates

AHP & Social Work Placements

AHP

- Occupational Therapy
- Physiotherapy
- Art Therapy
- Podiatry
- Speech & Language
- Dietetics

Social Work

- Undergraduates
- ASYE

Psychological Professionals

- Doctorate in Clinical Psychology (DClinPsy)
- CBT (CBTp, CBTe, CBTpd)
- Forensic Psychology
- Counselling Psychology
- Talking Therapies (HIT, PWP)
- Child Psychotherapies
- Counselling
- Systemic Psychotherapists
- Child Wellbeing Practitioners (CWP)
- Education MHWP
- Mental Health Wellbeing Practitioners (MHWP)

Medical & Pharmacy

Medical

- GP VTS
- Junior Doctors
- Specialist Trainees
- Medical Psychotherapy

Pharmacy

- Pharmacy Technicians
- Pharmacists
- Non-Medical Prescribers

Additional Landscape considerations

Rotherham Doncaster and South Humber NHS Foundation Trust

Other valued people ……..

- Volunteers (Promise 3)
- Peer Support (Promise 1)
- Work Experience (Promise 5&10)
- Advanced Practice & CPD (Promise 24)
- Cadet Programmes (Promise 10)
- Mentee's
- Leadership Graduates
- Graduate Researchers
- Apprenticeships (Promise 9)
- Preceptee and International Recruits (often experienced, but learning needs in terms of new place, specialism, country and potential exams, OSCEs etc)

Cumulative Impact

- On patients and families
- On recruitment and retention
- On supervisor capacity

Ethical Considerations

- Unpaid Placements & Volunteer
- Partner educational establishments entry criteria which may exclude people we are attempting to privilege linked with the results they expect.

Scale of Placements

Rotherham Doncaster and South Humber NHS Foundation Trust

- Nursing –

- Current capacity - 107
- Potential capacity = 736 based on the fair share allocation – 2023/24 date

  * areas state they are at capacity, but based on the fair share allocation model and 2023/24 data we could facilitate c.50% more placements.
  *we are supporting all current placement requests
  *it would be helpful if more nurses could take placements
  * Safe staffing, turnover / induction and sickness is the highest reason for non-expansion
  *digital planner under development with finance will be implemented Q3

- AHP –

- Occupational therapy (120) – 22/23 – 7 OT placements offered, increased in 23/24 – 30 OT placements offered.
- Physiotherapy (63) - 15 placements (tariff funded)
- SALT (18) – N= 7 (tariff funded)
- Dietetics (6) – DBTH arrangements joint hosting placement. (not paid for, but under review)
- Podiatry (11) – n=6 (tariff gained)
- Art & Drama Therapists (9) – n= 3 (no tariff gained)

*Our AHP Approach uses NHSE Fair Share Model

- Social Worker

- Student – 18
- ASYE -10

*Supported by Lead Social Worker rather than placement team.
* non-Health meetings and funding streams

- Psychological Professionals

- Psychologists (N=27)
  - NL work with Hull & Sheffield University works with other sites (*with personalised exceptions)
  - Placement capacity meets requirements, but is impacted with lower numbers of psychologists compared with other organisations.
  - Placement tariff is gained from this but no current placement team psychological professional member

- Psychotherapists (N=variable 20-40)
  - Talking Therapies services host a trainees at PWP & HIT
  - Expansion specific (i.e. systemic and EIT; CMHT)

Medical Staff

Rotherham Doncaster and South Humber NHS Foundation Trust

Placement Information

- Generally two intakes a year - April and August
- After successful completion of the Foundation programme the person is awarded the Foundation Programme Certificate of Completion (FPCC). The person is then able to go on to training in a chosen specialty, or general practice (GP) training.
- Training programmes differ in length and structure according to specialty.
  - general practice lasts three years.
  - other specialties can last 5-8 years.
  - Placements vary in length 4, 6 and 12 months.
- Abbreviations
  - FY – Foundation Year
  - GP – General Practitioner
  - CT – Core Trainee
  - ST – Speciality Training

Numbers

(each year over both cohorts)

- FY 1– N = 22
- FY2 - N= 14
- GPST1 – N = 2
- GPST2 – N = 5
- CT1 – N = 13
- CT2 – N = 5
- CT3 – N = 8
- ST4 – N = 14
- ST5 – N = 1
- ST6 – N = 11

Total = 95 placements per year

NHSE Fair Share Model

Rotherham Doncaster and South Humber NHS Foundation Trust

All healthcare students

- **Potential students on placement** at any one time

= WTE Registered practitioners x 39* (weeks) x 0.5^
= WTERP x 0.375

*taking into account annual leave, training, sickness

^not practical for mentor to have a student 100% time, but 50% reasonable

Equal allocation formula from HEE North West England Physiotherapy Project example:-

- Whole time equivalent (WTE) workforce figures across North West (approx. 2600)
- Calculated % of total WTE practitioners per Trust (e.g. 50 WTE = 2%)
- Total number of placements required across NW as baseline (approx. 1700)
- Using % figure of WTE per Trust minimum quota calculated (2% of 1700 = 34.5)
- Minimum quota equated to 65% of total WTE (physio/student ratio 3:2) 50 staff: 35 students

Using the same example above. If the organisation with 50FTE provided 350 weeks of placement at 35 hours/week for a number of students, then this would translate into = 350 weeks * 35 hours *£2.52/hr = £30,870 annual NMET return

(NB this figure does not include MFF so should be taken as approximate) (MFF = local Market Forces Factor)

Placement facilitation

Rotherham Doncaster and South Humber NHS Foundation Trust

Medical

- There are defined roles DME – Dr Thomas and Dr Seelam
- There is support within the Medical HR function for trainees, GP trainees and higher trainees
- Some tariff is gained
- There are contractual and employment differences between medical and none medical

Placement Team

- 4 people (P/T)
- 1x AHP & 3x Nurses
- Exploring Psychology part time placement team
- Only support non-medical placements. (this includes SNAs, Top Ups, work experience, & T level)
- There is strain with sickness, and part time posts.
- Work has been underway to expand considerations for placements 'beyond nursing'.
- Quarterly meetings are provided to support supervisors

LEMs

- These are Learning and Education Mentors
- All established nurse and AHP placement areas have an LEM (and most have a deputy – for A/L & sickness)
- The amount of the role that is devoted to the LEM role depends on the size of the team and number of students (it is usually a few hours to a day a month)

Discussion Points

Rotherham Doncaster and South Humber NHS Foundation Trust

- How does the Board, and its POD committee, currently know the calibre and educational quality of our placements?
- If we needed to increase placement volumes by a quarter, what changes in approach might be needed?
- What, if anything more, can we do to support local people to train and enter placements?

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Education and Learning Plan	**Agenda Item**	Paper O
Sponsoring Executive	Dr Judith Graham, Director for Psychological Professionals and Therapies		
Report Author	Co-produced authorship		
Meeting	Board of Directors	**Date**	25 July 2024

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

The Education and Learning Plan has been coproduced to enable an understanding of what education and learning mean in respect of the RDaSH Strategy and provide clear and measurable actions for change. There is a specific focus upon strategic promises 9 and 24 as well as a summary of what would constitute success in the future.

Although most Board members have viewed this plan separately in different forums and meetings and contributed to its production, the purpose of presenting this final version at the Board of Directors is to consider the plan in its entirety, discuss the interdependencies of the plan (specifically in relation to the People Plan and Research and Innovation Plan) and to consider the implications of the Plan. The expanded example concerning apprenticeships is included to aid discussions.

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

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

Education and Learning Group; Clinical Leadership Executive; & People and OD Committee

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

The Board of Directors are asked to:

X	**EXPLORE** the people and population issues described
X	**CONSIDER** any matters of concern *not* covered within the plan
X	**NOTE** work being done to develop a coherent Education and Learning plan for the Trust

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

Trust Risk Register							
Board Assurance Framework	x						
System / Place impact	x						
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	TBC – once final version is agreed
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)

Appendix 1 – Apprenticeship considerations (example)

Learning and Education Plan

Six ☑ -

1. Author ☑
2. TL ☑
3. EG ☑
4. CLE and sub
5. Board committee
6. Board

What do we mean by learning and education?

- Learning is a broad concept which encompasses a number of different methods and approaches.
- Learning is an active and continuous process, rather than just a process that has to be time boundaried.
- 4 Pillars of Learning:- Learning to know, Learning to do, Learning to live together, Learning to be.
- Learning is applicable to all roles in RDaSH and enables safety.
- Learning can be gained from examining things that go right and also things that go wrong.
- Learning partnerships also enable accross system growth (i.e. safeguarding partnerships)

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

Current state

Education

Positive

- Small internal training team
- Commissioning for some professionals
- Good use of apprentice tariff
- Advanced Practice supported
- Training included in the recruitment offer
- Good range of placements offered

For Improvement

- Education spend not linked with workforce plan or strategy
- No multi-professional oversight group
- Underused recruitment linked with apprentices
- Lack of cohesive plan for placement increase and recruitment based on return on investment
- Low use of employed subject matter experts (in many fields in the Trust)
- We have the ability to invest in partners and invite partners to learning events

Learning

Positive

- Organisational Learning brief
- Good practice learning groups in some areas.
- Growing learning culture (i.e. daily huddles, PSIRF)
- Supportive reflection (i.e. Post Incident Response Team, Safety Huddles and Schwartz Rounds)
- Educational offer open for some
- Some trained coaches
- Mentoring and reverse mentoring experiences

For Improvement

- A lack of ringfenced time to learn
- A lack of investment for some staff (i.e. ringfenced money for medical, nursing and AHP staff but no other)
- Communication and sharing of learning could increase
- Organisational development activities (i.e. Schwartz, leadership events, time to think events) have low attendance

LEARNING

Individual reflection, mentoring, coaching

Team meetings & supervision

Directorate (clinical or support)

In Care Group

Trustwide

In Partnership with patients & families

With 'Place' Partners

Through Integrated Care Partnership

Through Positive Practice & Incident

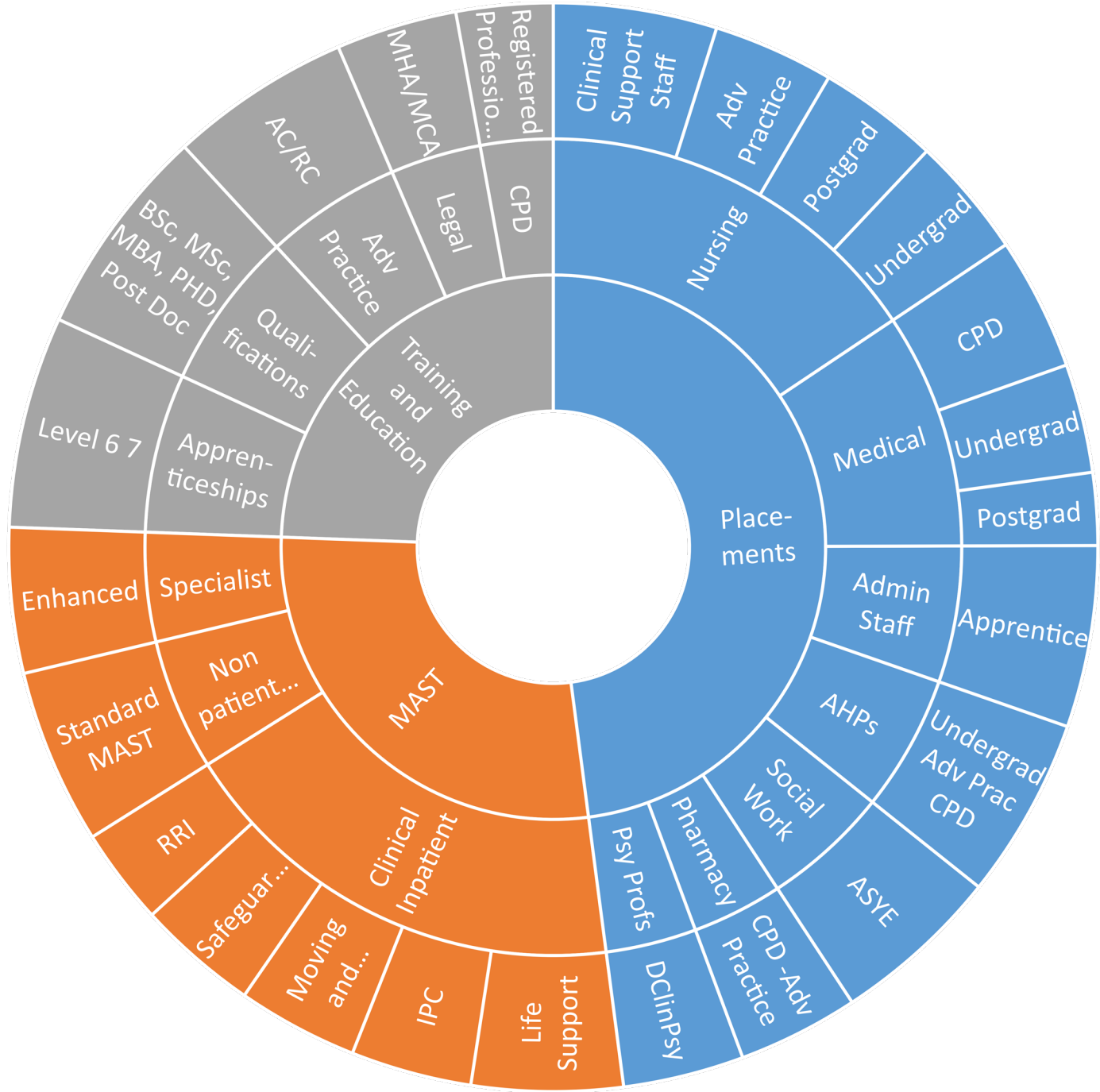
Regional Forums & Partnerships

Via clinical and non-clinical Specialism

National Forums & Publications

EDUCATION

Education


Training and Education
Quali-fications
Appren-ticeships
Adv Practice
Legal
CPD
BSc, MSc, MBA, PHD, Post Doc
AC/RC
MHA/MCA
Registered Professio...
Level 6 7
Placements
Nursing
Medical
Admin Staff
AHPs
Psy Profs
Pharmacy
Social Work
Clinical Support Staff
Adv Practice
Postgrad
Undergrad
CPD
Undergrad
Postgrad
Apprentice
Undergrad Adv Prac CPD
ASYE
CPD -Adv Practice
DClinPsy
MAST
Clinical Inpatient
Enhanced
Specialist
Standard MAST
Non patient...
RRI
Safeguar...
Moving and...
IPC
Life Support

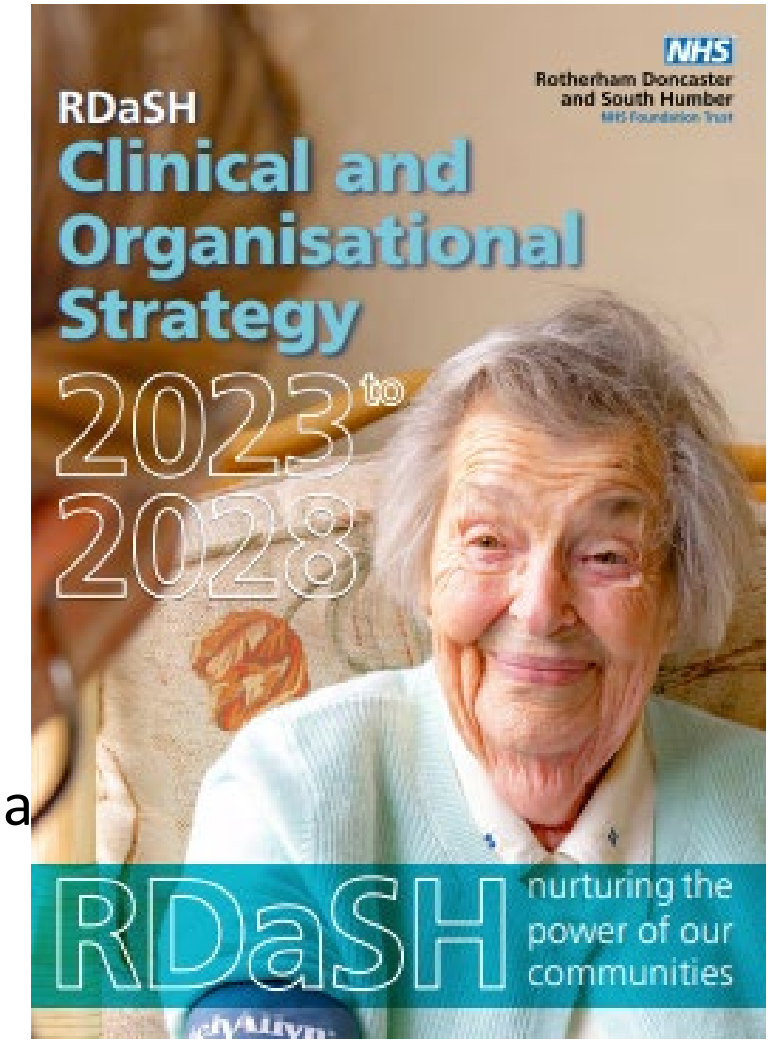
Related strategic promises -

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

- **Promise 9** - Consistently exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.

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

- **Promise 24** -Expand and improve our educational offer a undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan.



Promise 9 - Consistently exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.

Why?

- This is money we will spend and therefore we need to invest in our people (in our organisation and communities)
- We want to be a supportive employer who privileges all. This will be beneficial for the community, for our current ad future workforce and also for the wider health economy.
- Our specified areas of focus take into account public health information and also information from our patients, families and communities.
- This is linked with our 'People Plan' and supports recruitment, retention and growth
- This is linked with our equality and inclusion plan and creates opportunities for some people who have used different parts of our services

What? And How?

- We will review our current expenditure and gap.
- We will reflect upon the population who have accessed apprenticeships through use of our apprentice levy over the past 5 years.
- We will engage our staff and communities and explore how we improve access for excluded communities.
- We will work with education providers to enable better access for people from excluded communities
- We will create enabling opportunities for people to access courses using our levy
- We will monitor, and promote progress to encourage others to join

Promise 24 - Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan..

Why?

- This is money we will spend and therefore we need to invest in our people (in our organisation and communities)
- We want to be a supportive employer who privileges all. This will be beneficial for the community, for our current ad future workforce and also for the wider health economy.
- Our specified areas of focus take into account public health information and also information from our patients, families and communities.
- This is linked with our ‘People Plan’ and supports recruitment, retention and growth
- This is linked with our LIVED plan and creates opportunities for some people who have used different parts of our services

What? And How?

- We will review our current expenditure and gap.
- We will reflect upon the population who have accessed apprenticeships through use of our levy over the past 5 years.
- We will engage our staff and communities and explore how we improve access for excluded communities.
- We will work with education providers to enable better access for people from excluded communities
- We will create enabling opportunities for people to access courses using our levy
- We will monitor, and promote progress to encourage others to join
- Progress more partnership rotational opportunities to meet the requests of our new workforce. (i.e. pharmacy rotations with primary care partners)

LEARNING

The importance of learning

Why?

- Learning is important for improvement.
- Learning is essential in order to deliver excellence
- Learning also supports responsiveness to changes in patient needs and in healthcare.
- To ensure a safe and healthy workplace, mandatory training is vital.
- Structured learning approaches enable systematic approaches to iterative, data-driven improvement.

What and How?

- Through our leadership development programmes
- Through our mandated learning processes
- Through our facilitated processes
- Through structured learning time
- Through communication and learning briefs
- Through safety huddles, incident management and learning meetings
- Through preceptorship & legacy mentors
- Through work with ICB partner and National opportunities

Provider Comparisons - Education

Comparators

- Trusts and Organisations who maximise their Apprenticeship Levy spend - as well as proportionally allocating to protected groups that are not always privileged in terms of education.
- Trusts and Organisations who have progressed multi-professional learning and education opportunities to enable a more significant impact in terms of their spend.
- Trusts and organisations who provide flexible placements to enhance and enable the maximum number of quality placement possible. This will require both the consideration of comparators and also partnering to provide coproduced opportunities – aligned with our wider strategic intentions.

Action(s)

1. To spend 100% of our apprenticeship levy, 10%> ringfenced for refugees, citizens with learning disabilities, care leavers and those from other excluded communities. This will focus upon, but not solely mean enhanced training for peer support workers and our promise to increase this workforce.
2. To create a multi-professional education group panel that providers governance, oversight and support for business cases for education.
3. To ensure all our workforce have a parity of access to education and development opportunities to support their roles.
4. To work with partners to commission across ICB/ Speciality or Regional opportunities that maximise resource and enable access.
5. To ensure we provide over 100% of professional placements (medical, nursing, AHP, psychology, psychotherapy, social work and pharmacy) to support our local growth but also create space and opportunities above and beyond our contract.
6. To develop an advanced practice framework that enables all, not just specific groups. This will include peer support workers and also smaller professional groups.

Metric / Monitoring

1a) Spend Ratio

1b) Spend Allocation
(analysed via protected characteristic)

2) Education and Learning Group minutes & Outbrief

3) Learner feedback & staff survey

4)Learning Events

5a) Placement audits

5b) Placement uptake & feedback

5c) NHSE Educational Review

6) Policy Framework

Provider Comparisons - Learning

Comparators

- We will have comparators related to Learning actions.
- In terms of National Comparators and Partners – Mersey Care will be a key comparator, specifically considering the work they have progressed in terms of just cultures, learning cultures and safety cultures.
- ICB comparators will include ICB partners such as NAViGO in terms of the work they have progressed concerning for example 'out of area placements'
- 'Learning' is a concept that transcends all CQC assessment domains, and is focussed upon most dominantly in terms of the 'safe', 'effective' and 'well-led' domains. Therefore when considering other Trusts and organisations who have an 'outstanding' rating linked with CQC we would consider ELFT and CNT as comparators.

Actions

1. To review all of our learning vehicles in the organisation and ensure an integrated model with multiple, integrated ways to learn which best suit the diversity of our services and partnerships.

2. To build upon the learning processes progressed as part of PSIRF and the daily huddles, ensuring learning is triangulated and shared.

3. To enable a monthly learning ½ day for all in the Trust to commence in Q3 23/24. This will be piloted first in North Lincolnshire. Outputs from this will support personal learning, team learning, and in some cases partnership learning and will link with the learning briefs in terms of shared learning.

4. Schwartz Rounds and Learning activities (i.e. journal club, special interest presentations, research presentations) will be scheduled to coincide with learning time for all to access and to create a learning repository/ library/vault.

5. To develop learning approaches that enable a diverse range of learning styles and levels. This will include enabling learning outside of the 9-5 Monday to Friday working period, coproduced with practice leads such as Matrons.

6. To enable rapid communication of learning to support improvement through clinical learning brief.

7. To align audit process to learning to monitor that the learning is embedded.

8. To ensure that the implementation of DIALOG+ has oversight in regards to education and learning, including system learning from national partners.

Metric /Monitoring

1) Review report

2) PSIRF Implementation review and implementation evaluations

3a) LEARN Pilot Q1 24/25
3b) LEARN Pilot Evaluation Q2 24/25
3c) Trustwide LEARN Q3 24/25
3d) LEARN Yearly Evaluation 26/27

4) OD Reporting tracking Schwartz activity

5) Tracking integrated with actions 3a-3d above

6) Monthly Clinical Learning Brief & CEO Weekly Message

7) Annual Clinical Audit Report

8) Programme plan for Dialog+

Other metrics for Improvement

Education

- Placement Numbers
- Placement Audits
- Course Numbers
- Levy spend
- Placement feedback/experience
- Learner feedback
- Partnership measures
- Recruitment/retention/career advancement
- Mentor and LEM numbers/feedback

Learning

- Risk register
- Trend analysis
- Staff Survey
- Contents of the learning brief
- Uptake of activities (i.e. Schwartz rounds)
- FTSU data
- Workforce (grievance data)
- Audit
- Follow up reflection (survey)

Key changes needed for success

Learning Changes

- Protected time to learn for all by Q3 2024/25
- Commitment to LEARN events from all clinical and backbone services working around the 24 hour period
- Policy reviews and change to align with changes in learning and education
- Communications resource to share learning across and within services
- A diverse resource and learning programme defined which links with our RDaSH learning brief and evidence vault.
- Volunteer and Peer participation in learning
- An audit programme to be developed and defined to ensure a loop closure on learning linked with sustainability.

Educational Changes

- Changed process for training requests
- Recruitment process changes (i.e. to consider apprenticeships and diverse characteristics more prominently in regards to advertisement, selection panels and also talent management)
- Managerial commitment
- Aligned budget oversight (i.e. medical and non medical)
- Commitment to joined up learning
- Learning spaces ‘at place’ rather than centralised in Doncaster
- Combined approaches to medical and non-medical educational investment.
- Dashboard regarding educational spend / usage linked with workforce planning

Support required to deliver

Internal

- Financial review – as budgets are currently separate (i.e. medical)
- Education panel (multi-professional)
- Data (re education, placements, spend, training, reporting)
- Sub-CLE – Education Group
- Workforce – support in diversifying and privileging access for those who are currently disadvantaged
- Safety – PSIRF and related processes
- Communications – sharing learning in different, accessible formats for all staff

Partnerships

Education

- HEIs
- Community Groups
- Apprentice Partners
- Peer & Expert by Experience Partners

Learning

- Exemplar Trusts and Organisations
- Learning Metrics linked with Quality and Safety plan
- ICB , Regional and National partners

RDaSH in 2027

What does the future look like & how will we know we have succeeded?

- We will have spent all of our education budget, and used this in a way that ensures multi-professional learning and privileges previously under represented colleagues.
- We will be able to show a parity of investment in all areas in regards to operational and backbone services.
- Our workforce planning will directly relate to our educational spend and this will be monitored quarterly.
- We will see a better return on investment with our increased student/ trainee placements.
- Our staff survey will reflect better opportunities being offered in terms of staff investment.
- We will have peer support workers and lived experience workers who have undertaken formal training and have CPD ringfenced in the same way that other colleagues and professional groups.
- We will have built the foundation, and culturally changed our commitment to learning. This will then assist in terms of our talent management and recruitment and retention feedback.

Coproduction for this plan

Our People

- RDaSH Staff
- RDaSH Managers
- RDaSH Clinical Supervisors
- Students
- Apprentices
- Learning and Development Team

Our Partners

- HEIs
- Educational Partners
- Patient and Service User Groups
- Professional Bodies / Regulators
- Leadership Academy
- Partner NHS Trusts

Appendix 1 – Implications Example Apprenticeships

Rotherham Doncaster and South Humber NHS Foundation Trust

- Following discussions at two CLE subs meeting (People & Teams and Education & Learning), it has been agreed that all Band 2 and Band 3 vacancies will be advertised as an Apprenticeship opportunity.
- This revised approach will commence no later than 1st September 2024.
- This apprenticeship first approach will enable growth in levy spend, support widening participation of underrepresented communities in our workforce and contribute to the delivery of our Promise 9 objective.
- It is anticipated that most, if not all, Band 2 and Band 3 posts will be advertised as an apprentice opportunity but there is an exceptions process which may apply in a very small number of situations.
- Given this revised approach a task and finish team, initially from the POD Directorate have been working up the principles and considerations for a further discussion and agreement in July/August 2024 at People & Teams and Education and Learning.

- Consideration(s) and Implication(s) – Response to change; governance and oversight; prioritisation; forward planning round (linked with wider educational budget); work with partners.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Learning from Deaths	**Agenda Item**	Paper Q
Sponsoring Executive	Dr Graeme Tosh, Medical Director		
Report Author	Dr Graeme Tosh, Medical Director		
Meeting	Board of Directors	**Date**	25 July 2024

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

This paper highlights the importance of learning from deaths in the Trust and the tragic case which let to the national agenda on improving this; it outlines the processes through which we review every death and seek to learn from these where possible and if appropriate spread that learning across the Trust (and beyond).

In relation to mortality, we need to support individual clinicians to be inquisitive and to learn, corporately we need to identify lessons to be learnt and take appropriate action.

This paper is prepared to supplement the Board's focus on learning and education – and invites you to consider what more we can do to ensure ongoing good governance of mortality and how we implement and evidence learning where we identify potential for improvement.

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

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

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

The Board of Directors are asked to:

X	**NOTE** – The current structures in place
X	**CONSIDER** – How scrutiny of deaths is further developed (team structure/learning half days)
X	**DISCUSS** - the learning to date

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

Trust Risk Register							
Board Assurance Framework							
System / Place impact	x						
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	TBC – once final version is agreed
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)

Learning From Deaths (and the Mortality Process): A summary and Discussion

Dr Graeme Tosh

Executive Medical Director

Background

The death of Connor Sparrowhawk in 2013 resulted in the ‘Mazars Report’ of December 2015 into deaths 2011 to 2015 in the Southern Health NHS Trust.

The report uncovered serious concerns regarding mortality systems management.

A CQC review of how Trusts review and investigate deaths in England (2016) showed that learning from deaths was not being given priority and opportunities for improvements were missed.

As a result, in 2017 the Trust set about developing a new system for monitoring mortality led by the Medial Director and Supported by the Deputy Medical Director and Mortality lead.

This led to the current Learning from Deaths Policy which can be viewed here: https://www.rdash.nhs.uk/policies/learning-from-deaths-policy-the-right-thing-to-do/#1

In scope* Death Reported on Ulysses

Reported by a regulated clinician who, where possible was directly involved in the care.

Summarises the care provided by RDaSH in the lead up to death.

IR1 Reviewed in Mortality Operational Group

MOG is made up of experienced clinicians, at least one psychiatrist and one band 7 Nurse.

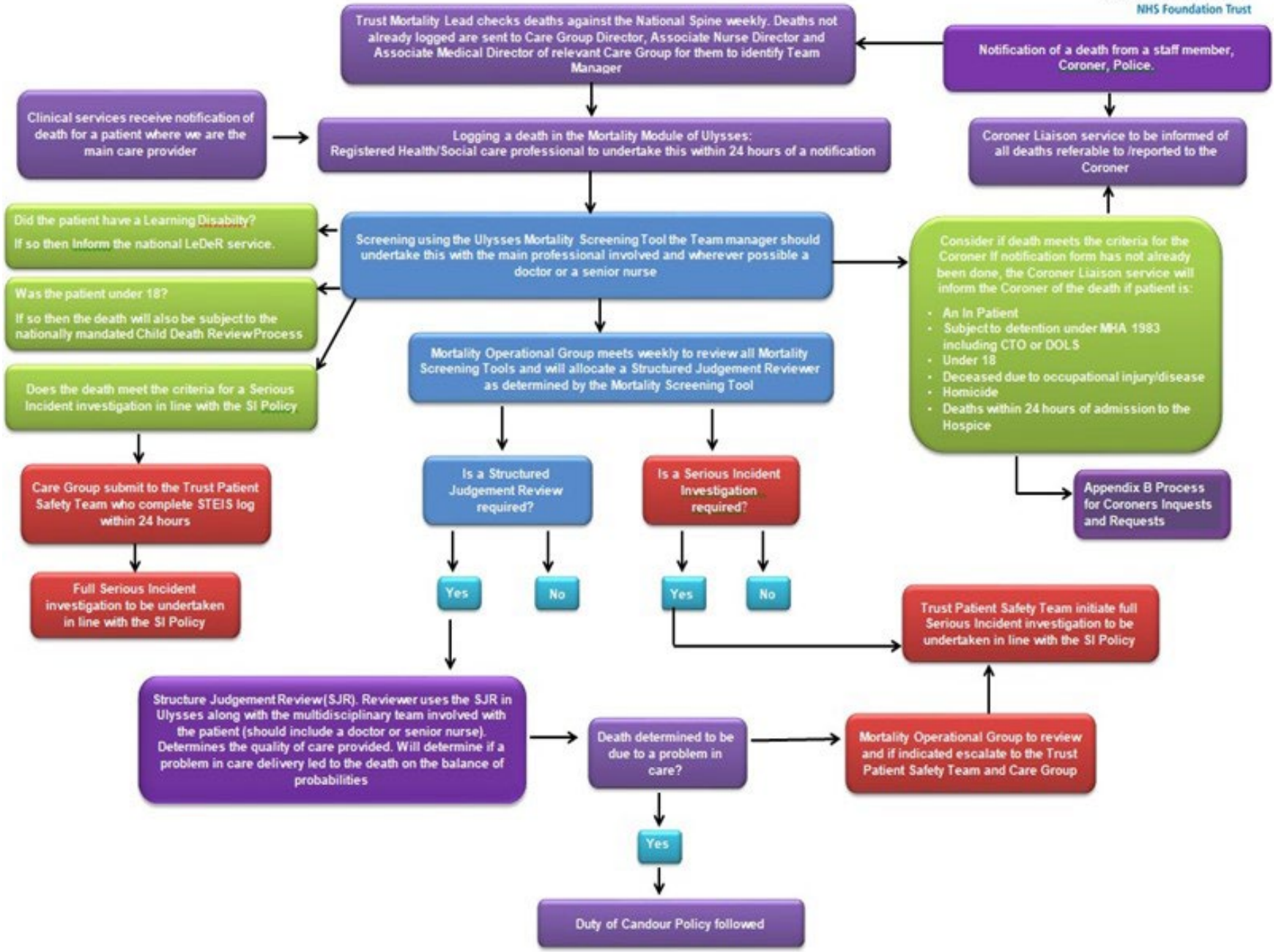
MOG will close the IR1, request more information or escalate to Structured Judgement Review/Serious Incident

MOG outputs are summarised and reported on a 2 monthly basis.

This is a statutory requirement (minimum quarterly) and goes to board via Mortality Surveillance Group, Quality and Safety Meeting and Quality Committee.

Appendix A: Mortality Reporting and Review Process April 2020

Rotherham Doncaster and South Humber NHS Foundation Trust



Mortality Operational Group

Mel Ketton
Band 7 Nurse
Coroners Liaison Lead

Dr Becky Humphries
Consultant Psychiatrist
Medical Lead for Mortality

Kim Gostolo
Band 7 Nurse
Mortality Lead

<u>Responsibilities of MOG</u>

Review all deaths weekly

Request additional information if required

Decide on further investigation (SJR/SI)

RAG rate SJRs

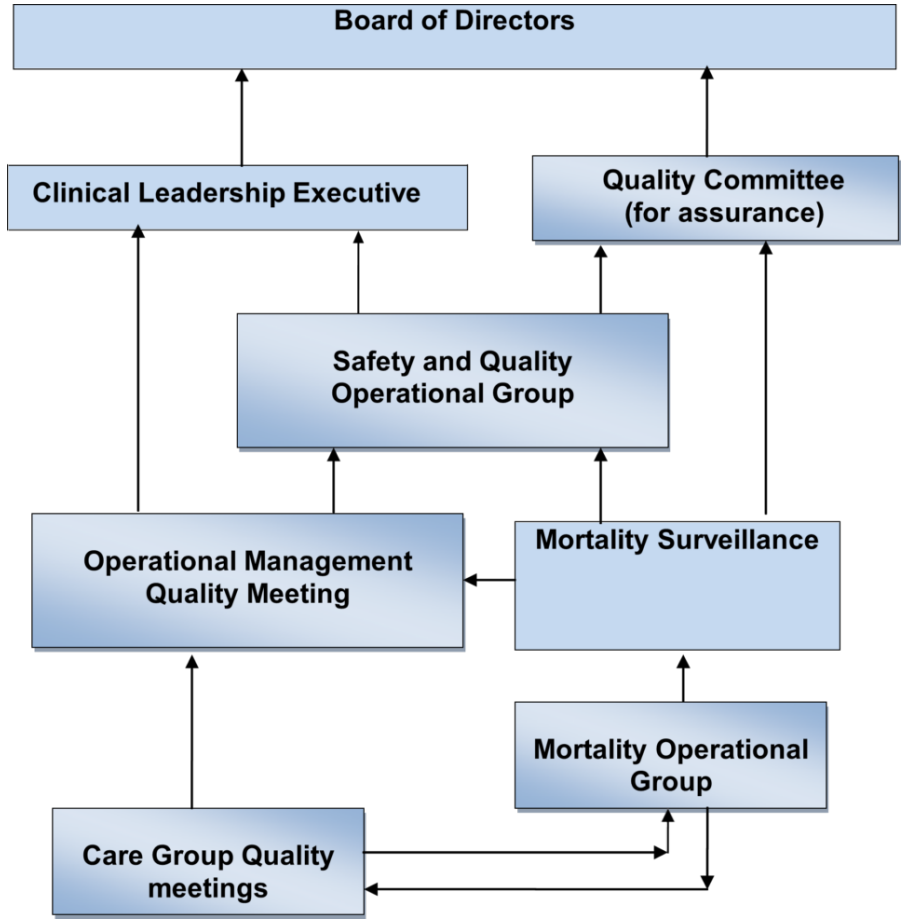
Identify trends and inform MSG

Close or escalate SJRs

<u>MOG reviewed 593 deaths in 2023/24, 62 were escalated to SJRs</u>

Dedicated SJR reviewers (Mel and Kim above) have been instrumental in managing a backlog that emerged through a previous system.

Mortality Governance Pathway



Mortality Surveillance Group

- The MSG meets on a two monthly basis, its key responsibilities are as follows:
  - to review data in relation to trust deaths in line with the learning from deaths policy
  - receive assurance from the care groups and provide assurance to the quality committee and the board of directors that the all deaths are appropriately scrutinised and investigated in keeping with trust and national guidance
  - receive assurance from MOG regarding the trust performance against key performance indicators in relation to mortality management
  - engage with relevant external regional and national bodies contributing to the management and improvement of quality learning in relation to mortality management and bring in relevant knowledge and skills into the organisation both to contribute to organisation learning and to cascade into the care group governance meetings
  - receive and critique the two monthly mortality report
  - act as the central point for identifying trends, gathering of risk information relating to patient deaths and taking action on these.
  - recommend consideration of external reviews of deaths by the Executive Management team where this is deemed appropriate.
  - review relevant policies in relation to mortality surveillance.
  - use mortality data to identify key risk groups or situations for suicide with the aim of targeting those to reduce suicide rates
  - engage with external regional and national bodies contributing to the management and improvement of quality learning in relation to mortality management
  - act as the organisation's expert advisory group in terms of scanning for and digesting national guidance and other relevant documentation

Medical Examiners

- A new statutory medical examiner system is being rolled out across England and Wales to provide independent scrutiny of deaths and to give bereaved people a voice.
- From 9 September 2024 all deaths in any inpatient health setting that are not investigated by a coroner will be reviewed by NHS medical examiners.
- Well in advance of the September deadline, RDaSH have gone active with the local medical examiners' process and it appears to be working well, following discussions Doncaster medical examiner's office will serve as the single point of contact for ME services across the Trust.
- We are in the process of writing an SOP for the application of the Medical Examiner process.

How is Learning from Deaths disseminated?

- MOG to MSG to Care Group Reps
- MSG – Chair's 4 Points
- Clinical Learning Brief
- Direct Service Visits
- Feedback from the National Enquiry into Suicide

- A role for the Mortality Team in the Training half days in future?

Examples of Past Learning from Deaths

- MOG identified that in a number of cases older people were not having their dementia medications reviewed in line with NICE guidance, this led to the discovery of a huge backlog in memory services which was rapidly managed improving safety around prescribing, without MOG this could have gone unchecked.
- MOG observed significant differences in death rates of older people between Rotherham and Doncaster, this was investigated and revealed explained by differences in what was commissioned and ways of working between the different areas.
- Deaths of people under the Doncaster Drug and Alcohol service have led to the rolling out of Naloxone across the area which is expected to have a very real effect on deaths from opiate overdose.
- The National Enquiry into suicide identified that 14% of all suicides happened in the first 3 months after discharge, this has led to improved follow-up processes and a review of the disengagement policy.
- Thematic analysis of National Regulation 28s via MSG has identified common issues which have regularly been disseminated via the Clinical Learning Brief
    - Poor engagement of family
    - Knowledge of novel means of suicide (Sodium Nitrite Overdose)
    - Improving Pressure Ulcer Management

What next?

- Changes in structure require a review of our Learning From Deaths Policy.
- We need to rapidly develop an SOP for working with Medical Examiners.
- Improving/recommissioning our incident reporting system and involving the Mortality team to make it more user friendly to those reporting or reviewing a death.
- The Trust leadership needs to make some important decisions on the future structure of Mortality and Coronial systems, e.g.:
    - Increased legal/paralegal input
    - Devolvement of some responsibilities to care groups
    - Professional oversight of reports to coroner

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Objective 3	**Agenda Item**	Paper Q
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Dr Jude Graham, Director of Psychological Professionals and Therapies Jo McDonough, Director of Strategic Development		
Meeting	Board of Directors	**Date**	25 July 2024

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

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

In this case, the paper recognises our commitment to:

- shift care into communities from our bed based services wherever possible;
- provide more integrated care to our community patients with partners, especially primary care;
- meet the challenging target to reduce the time that patients wait for our care to 48 hours for urgent care and 4 weeks for routine.

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

Previous consideration

n/a

Recommendation

The Board of Directors is asked to:

	RECEIVE and discuss the issues in the paper

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

Trust Risk Register		
Board Assurance Framework	X	See new BAF in papers
System / Place impact	X	Central to partnerships across place

Equality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	September 2024
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

n/a

Rotherham Doncaster and South Humber NHS Foundation Trust

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

Jo McDonough
Director of Strategic Development

and

Dr Judith Graham BEM
Director for Psychological Professional and Therapies

July 2024

RDaSH nurturing the power in our communities

What is the Board being asked?

All Board members have contributed to developing the strategy, and its objectives. We have agreed to use each meeting to re-discuss and explore each of the objectives, in March 2024 we looked at Strategic Objective 1 and in May 2024 Strategic Objective 2. Today we want to look at Strategic Objective 3. This is part not of changing or adapting the specific objectives but having time to consider the real meaning and intent. Colleagues understanding of the objective will evolve, and new ideas will become important or have greater salience.

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

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

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

As a Board we know that keeping people in their own homes wherever possible is the best way to deliver care. They can receive care in their homes whilst sleeping in their own beds, being in familiar surroundings and routines and having their family and carers visiting at any time.

People have the best chance of recovering or having a good outcome of their care if they wait the least amount of time for their care and treatment to start. Waiting for care to start can add additional stress and a deterioration in health for people.

For this Strategic Objective to be successful it is important for people to feel engaged in their care by identifying goals and outcomes that they want to achieve with clinicians. Our clinicians need to be trained in delivering the best evidence-bas
ed care and be able to work with others to focus on both the physical and mental health needs of patients.

We recognise that often patients benefit from talking to people who have experienced the same thing as them. This is why the journey we have started to progress regarding partnering with patient and carer organisations and increasing our lived experience roles is an essential foundation for success. By involving peer support workers, who have lived experience in the recovery process, we unleash the power of communities. We talked about this when we looked at Strategic Objective 1.

Another factor that is essential in progressing this objective is to develop a deeper understanding what it is like to live in all of our neighbourhoods, to help us tailor our services to patients and communities ensuring that there is no discrimination in the delivery of our care. This is the reason that we have made significant progress over the past 9 months to ensure that as a Board Team and wider senior leadership team we have spent time in different parts of our footprint, with patients, carers, staff and partners including a specific focus upon our partnerships at a primary care level.

This objective does not stand alone and must be considered specifically in relation to our increased focus upon inclusion described in objective 2. By considering the cross over in this objective and objective 3 we focus specifically upon ensuring that culturally appropriate services are in place so that all communities feel understood and supported.

There are five Promises that fall under this Strategic Objective, as per table below

Promise No.	Promise	Board committee involvement	CLE group	Which plan the Promise is in
13	Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, children's', or care home.	Quality Committee	Operations Management Group	Quality and safety
14	Assess people referred urgently inside 48 hours from 2025 (or under 4 where required) and deliver a 4-week maximum wait for all referrals from April 2026: maximising the use of technology and digital innovation to support our transformation.	Public Health, Patient Involvement and Partnerships	Operations Management Group	Quality and safety
15	Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs.	Public Health, Patient Involvement and Partnerships	Operations Management Group	Equity and inclusion
16	Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.	Quality Committee	Research & Innovation	Quality and safety
17	Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities.	Public Health, Patient Involvement and Partnerships	Equity & Inclusion	Equity and inclusion

When we explore the challenges cited in this paper a number of themes emerge:

- Home First and integrated neighbourhood teams are constructs that mean different things to different professionals and provoke mixed views or familiarity among our populations. There is work to do to find shared meaning that delivers real change.
- Addressing waiting times and indeed focusing on outcomes in different ways challenge the management paradigm within the Trust and ask us to behave in different ways. There is significant work to do to support this and ensure it is widely adopted among service leaders and others.
- Partnering with education is not traditionally a space in which NHS organisations thrive, and it is easy for such objectives to 'left' to the children's services team: their expertise is acknowledged but we need to ensure that CYP is as much the work of the Trust's most senior leaders as it is local teams – without that appearing an imposition.
- Both promise 16 and 17 requires us to become expert scouts for evidence and best practice from elsewhere. That active searching requires consideration and structure.

(Promise 13) Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, children's', or care home.

This promise must be considered in two parts, firstly that of 'home first; and secondly that of integrated care. A 'home' can mean a different thing to different people. It is a place where a person and/or family live, and most importantly, a place where you feel you belong. The two parts of the definition are important when considering care and health treatment as the provision of treatments in an environment which is not 'home' can have unwanted negative effects in some cases and prolong or complicate discharge and recovery. This is why we are focussing so much effort in terms of enhancing our services with the ethos of 'Home First'. Although we know that the virtual ward is one positive example, we are looking to expand this way of working in terms of our mental health and learning disabilities services as well. We are currently working with partners to identify gaps and barriers that increase the reliance on inpatient services so that wherever possible people will be provided care in their own home, care home or children's home. This involves offering culturally appropriate services which pertain to supporting carers and family members to be empowered in terms of being care partners and also ensure that support is provided by a range of professionals and people including peer support workers and those with lived experience. We are also working on programmes to help people be more digitally confident and have access to technology, this will support people to be able to access community treatments in a way that is less impactful on other aspects of this life (i.e. reducing the travel time to appointments by providing remote access to some treatments – this may be also beneficial to support people to have a reduced impact on work or caring responsibilities).

Where is the challenge?

The perception of the safety of care provision in a hospital is a barrier to providing community-based services in a number of fields. Examples related to this can be the difficulty we saw in launching our Doncaster virtual wards, linked with a need for a proactive partnership approach with acute providers. The issues raised in terms of risk management and care responsibility hindered the use of the virtual bed service a time, and although focussed work has started to remove this barrier, there is still virtual bed availability despite their being challenged actual bed ability within the 'place'.

This perceptual impact is not only isolated to physical health, when a corresponding issue is considered in mental health care and dementia care, the risk of supporting a person in the community balanced with the potential for iatrogenic harm if admission is facilitated is well researched and a local challenge.

One example of the challenge may be considered when utilising admission for people who have experienced complex trauma, sometimes labelled as a personality disorder. The admission facilitates physical risk management in one sense, however due to the nature of both the relational and attachment aspects of a person's experience research shows that negative effects, including increased suicidality and self-injurious behaviours are often the result of long hospital admissions and paternalistic interventions related to the inpatient environment. Yet, when we actively look at people in the RDaSH inpatient mental health bed-base we know we have a number of people currently as inpatients who have this type of experience.

When considering partners, we know that good partnerships are essential in order to provide good community care. However, multiple organisations working together towards a common goal also has its challenges. In summary some of the challenges we face and are trying to lean into and find solutions to include:

- Ceding of power, including sharing of resources and budget with partners to provide enhanced community pathways. This is particularly focussed on the need to decommission some activities in favour of lower-profile but higher volume activities such as home-based rehabilitation.
- Traditionally, people would have to experience a 'step up' into inpatient care to then have an opportunity to 'step down' into community-based care, and there are good examples of this being effective: what we need is a systemic change so that we can 'step in' and help people to live at home and avoid any unnecessary need to be an inpatient in the first place.

In terms of the third challenge listed regarding specialist service availability, we have unique challenges related to our geography and investment in RDaSH, as well as challenges others share in the country related to some underinvested in specialisms. One example that the Board is aware of is the treatment of eating disorders where there has been a lack of investment in community provision, which means people's conditions may deteriorate and then also puts pressure on the demand for eating disorder beds which have been limited in their availability.

(Promise 14) Assess people referred urgently inside 48 hours from 2025 (or under 4 where required) and deliver a 4-week maximum wait for all referrals from April 2026: maximising the use of technology and digital innovation to support our transformation.

We have made good progress in terms of reducing our waiting times in a number of areas, and Board members are well sighted in terms of papers pertaining to 'talking therapies' provision, community mental health care waiting times, perinatal service waiting times. However, we do have specific areas in which we have progressed work but we remain challenged (i.e. autism and ADHD assessment). We therefore aim to ensure that people will wait the least amount of time to be seen and receive care. As well as some of the partnership and adjusted assessment interventions we have progressed, looking to the future increasingly we will adopt the use of digital solutions and technology to support providing care in people's homes, communicate with patients and carers and provide care itself. A strong example of this is the recent introduction of Virtual Reality as part of treatment for Children and Young People's Mental Health services.

Where is the challenge?

We are focussed upon the capacity our services have to provide and also (where appropriate) where we can partner with others in order to extend the capacity, manage service backlogs as well as develop sustainable access, which can also cope with seasonal and predictable variation (i.e. seasonal vaccinations, assessment requests at the start of a school year).

There can also be an emphasis on the 'headline figure' regarding waiting times, and an assumption that once this is achieved then all is concluded. It is why a whole pathway will need continued oversight and vigilance by services so that any potential bottlenecks are not caused

and are mitigated once someone is in treatment (e.g. group therapy is part of someone's treatment pathway and isn't available).

The notion of managing supply, focusing on productivity, and creating team job plans that are capable of matching monthly referral demand (be it internal or external) requires a shift in managerial mindset within the organisation. A strong start to this work during 2024 has been made, but sustaining this effort across a large number of 'activity parameters' will be required.

The first step of course is 48 hour urgency. We need to focus hard on the Friday patient, for whom care needs to be provided by the end of Sunday. We need to complete work to ensure we understand how we are triaging such patients and ensure that we have systems in place which do not depend on patients using higher levels of specialist service (for instance S136) because a more intermediate tier is not available.

(Promise 15) Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs.

The Fuller Stocktake (2022) outlined a new vision for integrating primary care, by bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations. This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

We are starting to see a commitment in our three places to achieve integrated neighbourhood working. Iona Johnson, the Care Group Director for North Lincolnshire, has taken on a role to develop with partners a model of integrated neighbourhood working in South Scunthorpe. Community, NHS and Council partners in Doncaster are also keen to develop integrated neighbourhood working, building upon work that has been undertaken for a number of years. In Rotherham, following a survey of the local community in Maltby and Dinnington, as well as using other data, there is an opportunity to develop joint responses to the challenges faced by communities to better support them.

Where is the challenge?

Whilst the Fuller Stocktake set out a vision for integrated working, there has been a lack of consistency in approach, with a lack of infrastructure and support which has held progress. INTs mean different things to different people and so there is a pervasive risk of declaring things are integrated, when in truth the judge for that parameter has to be the patient.

A next step is to build upon this to have truly integrated working with other organisations, driven by the community and their needs. Some of this may not just mean looking at ways of working, but also shaping pre-existing organisational boundaries. Those boundaries will be structural, but also processes such as data and information sharing. As we get more integrated neighbourhood working, the 'gaps' may not be for us to deliver, it may be that for example the voluntary and

community sector would be better placed to do so. This might mean joining or pursuing resources (i.e. money) to make this happen.

The clearest case of getting this right may lie in older adults' service provision. Yet rarely is that the system's first focus (with the exception of Doncaster Health and Wellbeing Board – and arguably the community first plan in North Lincs – but local authority led). The older adult population in England is increasing faster than any other age group. In the last 40 years, the number of people aged 65 and over has increased by over 3.5 million (a 52% increase), making up around 18% of the population. Our 'place' data suggests an older adult population that is slightly above the national average.

Increased demand on older people's mental and physical health services is therefore inevitable. This concept is important to consider as despite this we are working in a health and care system that is often dominated around the needs of working age adults. It also gives a focus on why this Promise is important: local systems and structures don't work best for people now and demand will increase.

(Promise 16) Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.

When people receive care from our community services, we ensure that they receive the best care possible by providing evidence based, therapeutic care. Some of the changes that we face however are that in some of our services the patient centred goals and outcomes are clearer than others. For example –

- The specific care evidenced as beneficial for people entering our early interventions services. This care pathway includes timelines for engagement, specified interventions for timeframes and also the utilisation of particular PREMs and PROMs
- Talking Therapies – this service has clear time frames and targets in terms of assessment, access, treatment and recovery. There are clear PREMs and PROMs linked with the different diagnostic areas the service is provided for and this enables clear goals and performance comparators 'year on year'.
- Within some of our children's services we have specific age points by which children must be assessed and receive intervention, these are related to developmental outcomes and evidence-based risk periods in terms of factors such as weight, speech, mobility and relational interaction. These pathways, milestones and specific measures are helpful in terms of benchmarking and comparisons.

Where is the challenge?

The challenges in this area are related to both actions required from backbone services and also in terms of direct care services.

When considering examples of backbone service changes we will need to work with our medical team, informatics, finance and performance on key areas such as diagnostic coding, payment by results and reporting.

When considering the changes required to achieve this promise in terms of direct clinical care, there are challenges in terms of care pathways and also KPIs and agreed outcome measures in only certain services we provide. This issue is further complicated when we are pursuing work with partners to co-deliver care because some of our partners do not have the access to recording systems in terms of outcomes and intervention and therefore there are infrastructure, memorandums of understanding and also information governance aspects of change being progressed in order to mobilise the ability to achieve this promise for and with our patients, staff and partners.

Whilst some of the various measures and metrics have been based upon evidence and engagement, we still need to make sure we are focusing upon those that matter to local people. We still need to collaborate to test ideas and suggestions on what people would see as truly meaningful outcomes that would mean they could say if their quality of life is improving, or not.

(Promise 17) Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities.

The services we provide cross a broad range of geographies, which have different levels of inequality. For that reason a 'one size' fits all approach is not suitable to address the outcome required for this promise. Roberta Ratcliffe-Birds, Consultant Clinical Psychologist in the Children's Care Group, is leading on shaping and defining how we will deliver this Promise.

Our children and young people's services have been focussed upon integrated physical and mental health, and reducing inequity for a number of years through progress of programmes of work such as 'future in mind'.

As we progress, new challenges have arisen related to certain events (i.e. educational and developmental impact for children born and schooled in the covid-19 pandemic).

We are focussed upon the expanded delivery of care in neighbourhoods so that we are responding to what the local needs are in those communities. This includes embedding some of our services alongside schools, early years and nursery providers to tackle poor school readiness. Some examples of workers focussed upon this are educational mental wellbeing practitioners and the neurodiversity practitioners referenced in promise 15 above.

Our challenge

We know the size and scale of challenge we need to address: namely how many children and schools we are supporting or could be supporting and what their needs are. We can see examples of very positive work progressed in some of our localities and 'place systems', however we do not feel that we are consistently inclusive or a part of all discussions in all areas concerning 'levelling up'.

Whilst there are easier national definitions of 'school readiness' developed, these definitions do not meet the potential of individuals. For example, if a person had a learning disability they may

not meet all the national criteria of school readiness. We would need to make sure we develop something that meets and allows all children to meet their potential.

We do provide services for 0-5 year olds in Doncaster and North Lincolnshire respectively: these services are valued by people and commissioners. But, we don't provide such services in Rotherham. Our scope to do something for 0-5 year olds in Rotherham would be very limited.

Whilst we have examples of working with others such as nursery providers, for the Promise to be successful this needs to be more systemic.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Mid-term EPRR Report	**Agenda Item**	Paper R
Sponsoring Executive	Richard Chillery, Chief Operating Officer		
Report Author	Victoria Takel, Deputy Chief Operating Officer Katie Speed, EPRR Lead		
Meeting	Board of Directors	**Date**	25 July 2024

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

For the Board to note and then consider:

- Previous position?
  Due to the national "hard reset" on EPRR Core standards the Trust reported in November 2023, 21% "noncompliance". This was in line with all system providers and the ICB.

- What has changed since last time we reported?
  The Trust has developed a 2-year programme of work to achieve compliance by September 2025. The focus for year 1 is 3 core pieces of significant work (see below). We are looking to report 60% compliance in October 2024 for the annual Trust EPRR Core Standard submission.

1. Business Continuity - A new template has been developed in line with ISO22301 international standards for business continuity planning. There is a trajectory for these to be rolled out Trustwide with 100% completion by May 2025. This includes exercising of all plans. Currently 37.5% of 165 plans have been written in line with this trajectory.
2. Temporary Shelter and Evacuation - A new template has been developed for Temporary Shelter and Evacuation plans. The Trust plan and those for Brodsworth, Cusworth and Skelbrooke have been written. There is a trajectory to have Temporary Shelter and Evacuation plans for 100% of appropriate Trust areas, with a programme of testing, by August 2025.
3. A training programme has been developed and launched for on call colleagues, in line with the National Minimum Occupational Standards, which follows a three-year training cycle. Current compliance is as below:

Strategic
On-Call Induction course: 100%
Principles of Health Command: 100%
Block 1 training (CPDMe Introduction): 69% completed or booked.
Tactical
On-Call Induction course: 100%
Principles of Health Command:77%
Block 1 training (CPDMe Introduction): 77% completed or booked.

In addition, 5 exercises have taken place to test readiness to respond to incidents. These cover various scenarios such as evacuation, measles outbreaks, AWOL patient response, prolonged heatwave and data security. Learning from these exercises has been disseminated through the Trust's EPRR group.

- Where will we be by March 2025?

The Trust will have undergone the self-assessment and peer review process for Core Standards compliance and anticipates an increase in compliance from 21% to an anticipated 60%. We will be progressing with of the programme planned for the remainder of this financial year and into Q1 and Q2 of financial year 25/26.

- 99.3% of business continuity plans will be completed and exercised, with the remaining Trust level plan to be completed in May 2025. Work will be ongoing across all areas to ensure staff are fully aware of the plans and their obligations under these.
- 62.5% of evacuation plans will be completed, with the remainder (Amber Lodge and Windermere, and Hazel and Hawthorne) to be completed in May 25 and august 25 respectively.
- Current plans to increase compliance with the Core Standards for EPRR will continue to be worked upon, with self-assessed compliance in March likely to be circa 80%.
- On call colleagues will have completed the first year of their three yearly training cycle, in line with the National Minimum Occupational Standards, with year 2 being launched.

• <u>What is important for the Board to discuss?</u>
  - To note the 2-year EPRR compliance programme and to review the trajectories in this paper.
  - To note the hard work of the EPRR core team and consider if the Board are confident that EPRR has an improving profile within the Trust, with particular reference to the 3 core areas of focus in this financial area.
  - To raise any questions the Board may have in relation to the contents of this paper

-	
SO1: Nurture partnerships with patients and citizens to support good health	
SO2: Create equity of access, employment, and experience to address differences in outcome	
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	
Business as usual	X

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

Request for interim report following previous EPRR Board report. This relates to the EPRR core standards and direct oversight of Board on the annual EPRR trust submission.

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

The Board of Directors is asked to:

	RECEIVE X
	CONSIDER X
	AGREE
	TAKE ASSURANCE

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

Trust Risk Register	X						
Board Assurance Framework							
System / Place impact	X						
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Appendix (please list)

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

Emergency Preparedness Resilience and Response

Mid-Year Board Report

July 2024

RDaSH nurturing the power in our communities

1.0 Introduction

The mid-year report is aimed at giving an update on the EPRR position against the EPRR Core Standards, progress on this year's key areas of work and setting out what will be done before the planned first self-assessment submission to the ICB at the beginning of September 2024. This submission will then undergo a peer review process, with organisations in South Yorkshire working collaboratively to provide these peer reviews. The peer reviews are anticipated to be completed by the end of October 2024, which is when the confirmed submission will be made. As a Trust we have particularly prioritised a major Business Continuity improvement programme, Temporary Shelter and Evacuation planning and testing and the embedding of the National Minimum Occupational Standards for EPRR.

It will also cover the standard reporting items as required by the EPRR Framework and Core Standards set by NHSE.

2.0 Business Continuity Improvement Programme (BCIP)

The Trust BCIP began in January 24 with a pilot team from each Care Group. New and improved templates have been developed to both align to ISO22301 (the international standard) for Business Continuity and to make plans more fit for purpose and user friendly for colleagues. This includes a thorough Business Impact Analysis (BIA) and a Business Continuity Plan (BCP).

Since April 24, this has been rolled out to the wider Trust, and Clinical Directorates are currently writing their plans with progress as follows below. Further details on the timelines and key milestones can be found at Appendix 1.

Phase 1 - Operational (Team level) Planning Summary

- Both Doncaster Mental and Physical Health Care Groups have submitted all their plans for quality assurance approval with the EPRR team. This totals 62 plans. To date approximately 59% of these have been passed through this approval stage with the rest undergoing final refinement.
- All other areas of the Trust are now in the process of creating their BIA and BCP documents. In total there will be 165 team level (operational) plans meaning we are 37.5% complete overall to date with a trajectory to have 100% of plans fully signed off and exercised by May 2025.

Plans will go through a rigorous governance process, including ratification by Directorate Leads and the EPRR Team. Plans that are not fully compliant with the standards are returned to the Care Groups for further refinement in partnership with the EPRR team who provide robust support and guidance. This ensures as far as possible that the plans are fit for purpose and aligned to ISO22301.

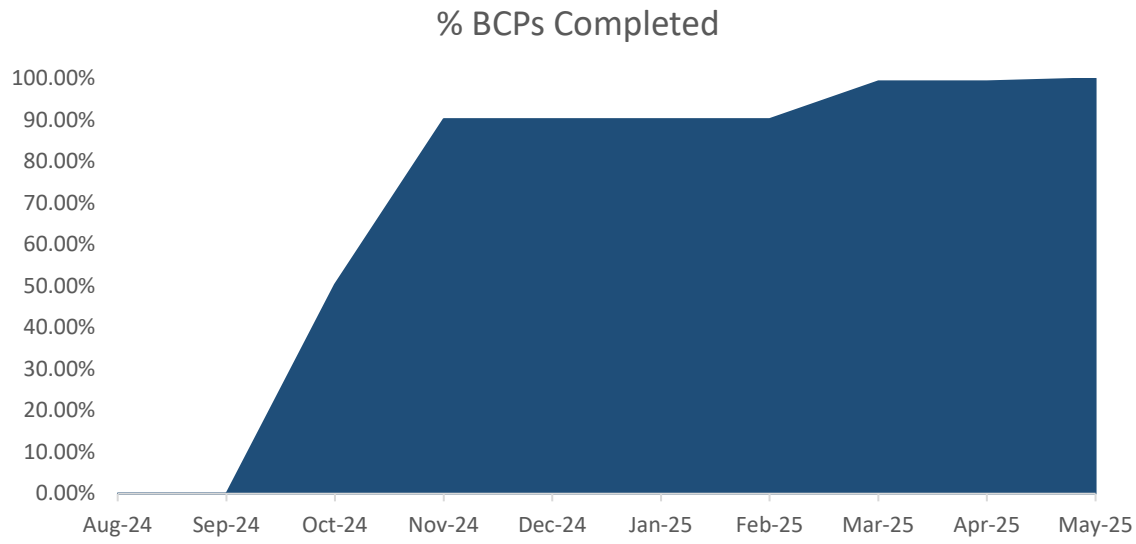
Once a plan is finalised, it will be tested in an exercise at team level or higher to assess its validity and amendments will be made where necessary following testing or any subsequent incident requiring utilization of the plan. Plan authors will be asked to deliver training to their respective teams to ensure everyone knows their role in an incident. This training will be cascaded down through team leaders who will ensure staff at all levels are aware of the plans, where to find them, and what

their roles will be in responding to an incident. This cascade will include walk arounds, 'stop the shifts', and email correspondence. The EPRR team will follow up with spot checks, where they visit clinical areas, talk to staff about their understanding of the plans, and provide some myth-busting and/or further informal training as required. We could consider building this into the developing peer review process.

The outcomes of the EPRR spot checks will be fed into the Trust's EPRR Group monthly for a minimum of six months post plan completion and exercise. This will ensure that further actions can be developed if necessary to support staff to have full understanding of the plans and their roles and responsibilities.

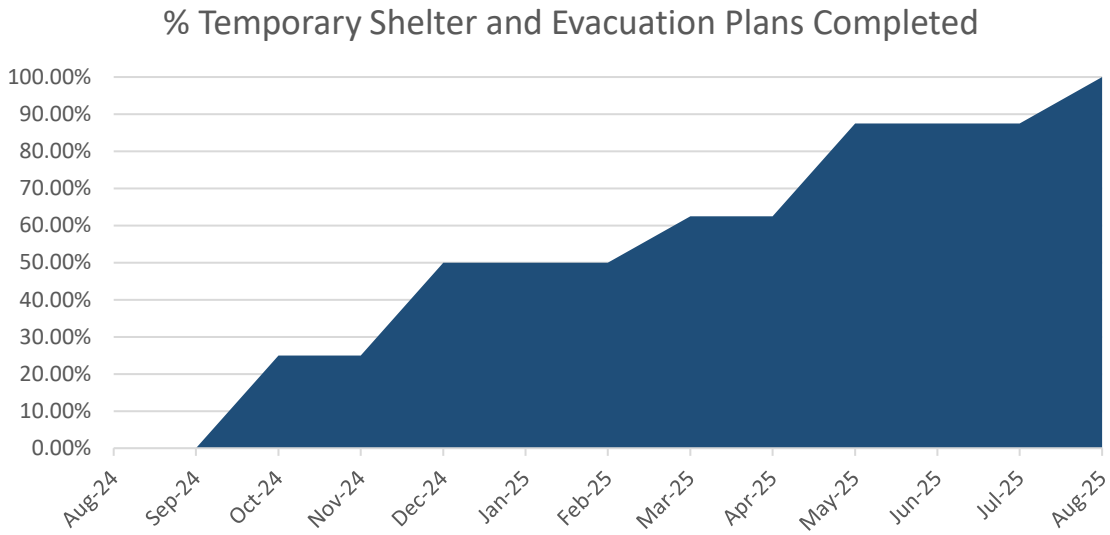
Phase 2 – Tactical (Directorate and Director Level) Plans
Phase 2 of the BCP is scheduled to commence in November 2024. These plans are aimed at summarising the Team plans and provide a Tactical overview of the Directorate area of the Trust. This can be summarised by viewing the diagram at Appendix 2.

Phase 3 – Strategic (Trust Level) Plan.
It estimated that development of the Trust level Strategic plan will commence in February 2025. The graph below demonstrates the planned trajectory for completion and certification of all plans. To be fully completed and certified, all plans need to be exercised which is a requirement that has informed the timescales reflected.



3.0 Temporary Shelter and Evacuation (TSE) Planning

At the time of the last Board report the TSE plans for the Trust were out of date. Since this time, a full project plan (see appendix 3) been developed for the Trust to become compliant with the Core Standard and to ensure that plans are in place and exercised to ensure that the organisation has trained staff who know what to do in the event of an incident which requires activation of the TSE plan. This is a staged approach with timescales reflected in the graph below. Detail of the areas a TSE plan is required for and their associated timescales are visible in table 1.



Brodsworth, Cusworth, Skelbrooke	Oct-24
Trust Plan	Oct-24
Woodlands	Dec-24
Kingfisher, Sandpiper, Osprey	Dec-24
Mulberry and Laurel	Mar-25
Amber Lodge and Windermere	May-25
Hazel and Hawthorne	Aug-25

Table 1

For clarification purposes, these plans do not incorporate Fire Evacuation, the documents for this sit separately under the Estates team Fire Officer. These plans closely interlink so where the Fire Evacuation plan ends (i.e. people are out in the car park), is where the TSE plans begin.

At present the Trust's overarching plan and the pilot ward level plan for Brodsworth, Cusworth and Skelbrooke have been distributed to the relevant teams for specialist input. These will then be finalised and sent out for full consultation by the end of July 2024. Once the pilot has been signed off (estimated date August) and exercised (estimated in September), training and awareness sessions will be held with staff to ensure everyone knows their role in an incident.

The pilot plan will then be used as a blueprint for other Wards across the Trust to create their plans. Further details on when plans are estimated to commence and key milestones are included in Appendix 3.

Finally, due to the specialist nature of the Low Secure Ward, Amber Lodge, the Trust has collaborated with other mental health Trusts across Yorkshire and the Northeast to create a joint escalation plan. This was signed off by all Trusts and issued in June 2024. This is planned to be exercised in the Autumn. It is being led by Leeds and York Partnership NHS Foundation Trust and is currently in very early stages of development. RDaSH will take part in the exercise, but it will not be based on an RDaSH ward evacuation, since the Trust was the subject of the last exercise in 2022.

4.0 National Minimum Occupation Standards (NOS) for EPRR

All colleagues on the Silver and Gold On-Call rota must be trained as a Tactical (Silver) or Strategic (Gold) Health commander and be able to prove their competency against the NOS for EPRR. Clarity has now been received from NHSE on mandatory requirements and the process of training our colleagues has begun. A software package called CPDMe has been purchased to assist with the efficiency and evidence gathering for Commander's training records and mandatory portfolio evidence.

To make the process as efficient as possible for already busy colleagues, the EPRR team have planned training sessions in blocks with multiple times available to help colleagues fit training in around their other responsibilities. Each year Commanders will have to attend two half day training 'blocks' and a full day session. Over the three yearly NOS cycle, this will enable Commanders to meet their competencies and evidence them via the CPDMe portfolio. Further information on training is available in section 5.2.

5.0 Standing Report Items

5.1 Summary of Incidents and Lessons

Since the last Board report, there have been no incidents to note.

Lessons identified from previous incidents continue to be tracked through EPRR Group on the new digitised action log. A full analysis of actions outstanding is due to take place during the next quarter ahead of the Core Standards submission. This will be reported on in the next Board paper.

5.2 Training and Exercises

The following summarises the training compliance to date this year:

Strategic
On-Call Induction course: 100%
Principles of Health Command: 100%
Block 1 training (CPDMe Introduction): 69% completed or booked.

Tactical
On-Call Induction course: 100%
Principles of Health Command:77%
Block 1 training (CPDMe Introduction): 77% completed or booked.

The following exercises have taken place:

Date	Exercise Name	Scenario
18.01.2024	Exercise Decedo	Woodlands evacuation plan test and staff awareness session
27.03.2024	Exercise Surua	Measles outbreak scenario to identify areas for planning and improvement on

		preparedness. The actions from this exercise are currently sitting with Nursing and Quality
16.04.2024	Exercise Masterwork	A no notice nighttime exercise to test the AWOL policy and staff response on Windermere Ward. This also included the six monthly out of hours communications test.
23.05.2024	Exercise Grey Parrot	A multi-agency LRF exercise based on a severe heatwave similar to that of 2022.
10.06.2024	Exercise Irish Setter	Annual exercise for the Data Protection Security Toolkit compliance. The scenario was based on leaking of sensitive information by an employee

A summary of planned exercises for the remainder of the 24/25 financial year can be found at Appendix 4.

5.3 EPRR Team Resource Assessment

In accordance with EPRR Core Standard 5, the Trust must have adequate people resource in the EPRR Team. The current EPRR Manager is due to leave the Trust mid-August. Recruitment to this post has been successful and it is not anticipated that there will be a gap in the team. In addition, the Deputy Care Group Directors have responsibility for EPRR within their roles that provides some added robustness to the function. The Chief Operating Officer has conducted some benchmarking that places this resource in line with that in other organisations within South Yorkshire ICB therefore full compliance is anticipated for this Core Standard in September's Core Standard Assurance submission.

5.4 EPRR Team Budget

Since the last report, the EPRR Team have been allocated a separate budget code and associated budget. This budget is mainly intended to cover the training requirements of the NOS, but also allows expenditure on upcoming expenses such as CBRN/HAZMAT response boxes. The annual non pay budget for 24/25 is £34,100.

5.5 EPRR Core Standards Update and Compliance

The foundation of EPRR is risk and it was identified that the biggest risks to the Trust are business continuity and evacuation. Therefore, it was agreed with the Accountable Emergency Officer and the EPRR Group that these will be the primary focus for this year, alongside the NOS for on call Commanders.

It should be noted that choosing to address our highest risks is not the work that will 'tick the most boxes' and increase the Trust's compliance with Core Standards by the most percentage points due to the time required to ensure that plans are fit for purpose. However, it is the right thing to do for our staff and our patients to ensure we can appropriately respond to incidents and minimise interruptions to service delivery. In line with the rest of South Yorkshire Integrated Care Board, this means that the journey to 'Fully Compliant' is expected to be a two-year programme of improvement.

To recap, following the new 'check and challenge' process with NHSE from September 2023, the Trust was rated as follows:

Compliance Level	Evaluation and Testing Conclusion
Non-Compliant	The organisation is 21% compliant with the core standards they are expected to achieve.

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

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

All Trusts within South Yorkshire ICB experienced a similar drop in compliance level following the September 2023 check and challenge process and are working through a two-year programme of improvement as a region. RDaSH compliance is estimated to increase to 60% during the September 2024 assurance process, with further plans in place to achieve compliance with the remaining outstanding standards during financial year 25/26 to move to full compliance. The increase to 60% was predicted due to the high risk, but complex pieces of work chosen as best to focus on that will have certainly increased resilience and preparedness for the Trust.

To date, additional work above the top three agreed EPRR priorities include:

- EPRR Policy Update
- Adverse Weather Plan full rewrite
- Measles planning and preparedness, including increasing FFP3 FIT testers and increasing/updating people tested.
- Summer preparedness work with local resilience forums
- A review of On-Call procedures and policy, plus implementation
- Digitalising the EPRR risk register, work plan and exercise and training records
- Creation of a mental health trust EPRR Memorandum of Understanding so that in a major incident, the EPRR team can request mutual aid from other peer Trusts.
- Industrial action planning, preparedness and response.
- Facilitated incident debriefs for non EPRR incidents.

A full breakdown of the 34 Core Standards which the Trust is anticipating achieving compliance with in the September 2024 Assurance process is included in Appendix 5. A plan is in place to achieve compliance with the remaining 24 standards in time for the assurance process in financial year 24/25.

6.0 Summary

The Board are asked to note the contents of this paper and be assured that the Trust plan to reach fully compliant with the Core Standards in the next 2 years is on track.

Appendix 1. Business Continuity Improvement Programme Timeline

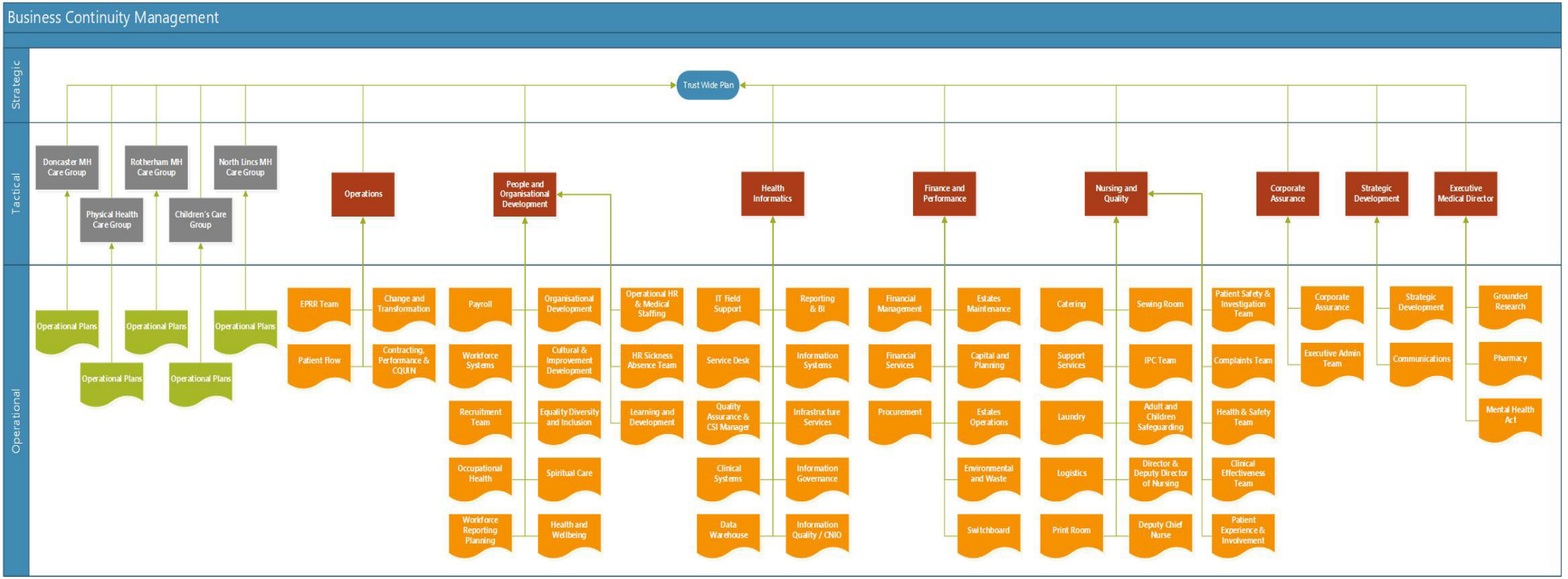
Phase 1

Phase 1 - Local Team/Department Plans									
	Ratifier Check-in One	Start Date	Business Impact Analysis	Business Continuity Plan	Ratifier Check-in Two	Plan Submission Deadline	EPRR Team Review and Feedback Period	Plan Exercise Period	Final Completion and Certification Deadline
Doncaster	13:30 - 14:00 Mon 26/02/2024	1st April 2024	1st April - 12th April (2 Weeks) Workshop Tue 02/04/24 - 10:00	15th April - 26 April (2 Weeks) Workshop Mon 15/04/2024 - 10:00	13:00 - 13:30 Thur 23/05/2024	14th June 2024	17th June 2024 - 19th July 2024 (5 Weeks)	9th September 2024 - 11th October 2024 (5 Weeks)	11th October 2024
Physical Health	09:30 - 10:00 Tue 19/03/2024	15th April 2024	15th April - 26th April (2 Weeks) Workshop Wed 17/04/24 - 09:00	29th April - 10th May (2 Weeks) Workshop Wed 01/05/24 - 09:00	13:00 - 13:30 Mon 10/06/2024	28th June 2024	1st July 2024 - 2nd August 2024 (5 Weeks)	9th September 2024 - 11th October 2024 (5 Weeks)	11th October 2024
Rotherham	11:00 - 11:30 Tue 26/03/2024	29th April 2024	29th April - 10th May (2 Weeks) Workshop Mon 29/04/2024 - 13:30	13th May - 24th May (2 Weeks) Workshop Mon 13/05/2024 - 13:30	09:30 - 10:00 Tue 18/06/2024	12th July 2024	15th July 2024 - 9th August 2024 (4 Weeks)	9th September 2024 - 11th October 2024 (5 Weeks)	11th October 2024
Children's	10:00 - 10:30 Mon 08/04/2024	13th May 2024	13th May - 24th May (2 Weeks) Workshop Wed 15/05/24 - 13:30	27th May - 7th June (2 Weeks) Workshop Wed 29/05/24 - 13:30	09:00 - 09:30 Tue 02/07/2024	26th July 2024	29th July 2024 - 23rd August 2024 (4 Weeks)	9th September 2024 - 11th October 2024 (5 Weeks)	11th October 2024
North Lincs	11:00 - 11:30 Mon 22/04/2024	27th May 2024	27th May - 7th June (2 Weeks) Workshop Tue 28/05/24 - 13:30	10th June - 21st June (2 Weeks) Workshop Tue 11/06/24 - 13:30	10:30 - 11:00 Tue 16/07/2024	9th August 2024	12th August 2024 - 6th September 2024 (4 Weeks)	9th September 2024 - 11th October 2024 (5 Weeks)	11th October 2024
Corporate	N/A	10th June	N/A	N/A	N/A	23rd August 2024	26th August 2024 - 4th October 2024 (6 Weeks)	7th October 2024 - 1st November 2024 (4 Weeks)	1st November 2024

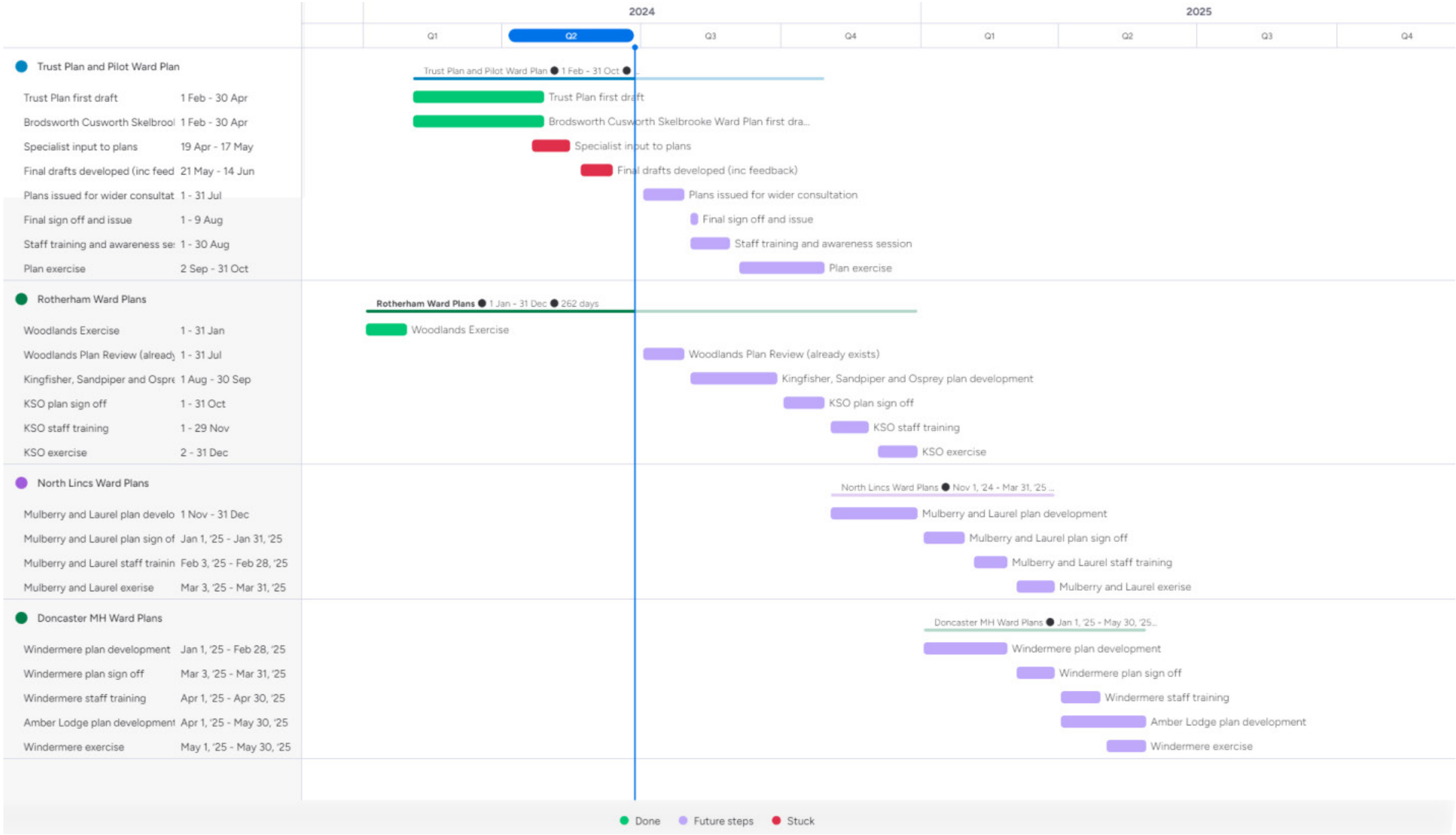
Phase 2 and 3

Phase 2 - Care Group and Directorates/Board					Phase 3 - Trust Wide/Strategic Plan			
Start Date	Plan Submission Deadline	EPRR Team Review and Feedback Period	Plan Exercise	Final Completion and Certification Deadline	Start Date	Plan Submission Deadline	Plan Exercise	Final Completion and Certification Deadline
4th November 2024	17th January 2025	20th January - 21st February 2025 (5 Weeks)	To be Confirmed	21st March 2025	24th February 2025	25th April 2024	To be Confirmed	3rd May 2025
4th November 2024	17th January 2025	20th January - 21st February 2025 (5 Weeks)	To be Confirmed	21st March 2025				
4th November 2024	17th January 2025	20th January - 21st February 2025 (5 Weeks)	To be Confirmed	21st March 2025				
4th November 2024	17th January 2025	20th January - 21st February 2025 (5 Weeks)	To be Confirmed	21st March 2025				
4th November 2024	17th January 2025	20th January - 21st February 2025 (5 Weeks)	To be Confirmed	21st March 2025				
4th November 2024	17th January 2025	20th January - 21st February 2025 (5 Weeks)	To be Confirmed	21st March 2025				

Appendix 2 – Plan Summary



Appendix 3 – Temporary Shelter and Evacuation Timeline



Appendix 4 – Planned Exercises

Airedale Green Sparrow - BC Plan Testing	BC Plan Testing and Verification	10.09.24
Airedale Green Condor - BC Plan Testing	BC Plan Testing and Verification	10.09.24
Exercise Dragon - Tactical Command	Large Scale Tactical Commanders Exercise (Part of Commander Training) - Testing the Trusts Overarching Evacuation Plan and the one specifically for Skelbrooke, Brodsworth & Cusworth Wards	19.09.24
Golden Hind - Reservoir Inundation	Being run be South Yorkshire LRF	24.09.24
Airedale Olive Sparrow - BC Plan Testing	BC Plan Testing and Verification	25.09.24
Airedale Olive Condor - BC Plan Testing	BC Plan Testing and Verification	25.09.24
Airedale Blue Sparrow - BC Plan Testing	BC Plan Testing and Verification	01.10.24
Airedale Blue Condor - BC Plan Testing	BC Plan Testing and Verification	01.10.24
Airedale Red Sparrow - BC Plan Testing	BC Plan Testing and Verification	04.10.24
Airedale Red Condor - BC Plan Testing	BC Plan Testing and Verification	04.10.24
Airedale White Sparrow - BC Plan Testing	BC Plan Testing and Verification	09.10.24
Airedale White Condor - BC Plan Testing	BC Plan Testing and Verification	09.10.24
Swordfish - Tactical Command Exercise (Evacuation)	Large scale Tactical Commanders exercise (Part of Commander Training) - Aim and details of exercise still to be confirmed	15.10.24
Rottweiler - All Command Level Exercise (Cyber-attack)	Large scale exercise to test the Trust response to a Cyber Attack	Feb - March 2025 (Exact Date to be Confirmed)

Appendix 5 – Expected Compliant Standards

The following standards are expected to be assessed as compliant in the September 2024 assurance process.

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

7	**Duty to risk assess**	**Risk Management**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
18	**Duty to maintain plans**	**Protected Individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.

21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
25	**Training and exercising**	**Staff Awareness and Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
26	**Response**	**Incident Co-Ordination Centre**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
30	**Response**	**Situation reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
33	**Warning and Informing**	**Warning and Informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.

34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and re-robe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments

65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR) – June 2024	**Agenda Item**	Paper S
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery – Chief Operating Officer		
Meeting	Board of Directors	**Date**	25 July 2024

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

There is considerable detail both within the report and in the executive summary. The extent and nature of debates within the clinical leadership associated with the use of this report should be a matter of considerable assurance. Individual leaders are deeply engaged with the accuracy and meaning of the core data. A review of that data and items in the IQPR has been largely completed, but there is further work to do quality and safety data. This include safe staffing data reporting where, as this report records, we will alter our national reporting: however, internally the key metric will remain red shift/green shifts as it has been since April 2024.

The finance reports set out two points of deviation: North Lincs Adult MH/TT care group where a phasing issue has seen YTD overspend, and the YTD Trust position which reflects the unsigned Adult Eating Disorders contract the future of which is considered in the CEO's private Board report. Vacancy data is elsewhere in the Board's papers.

It may be helpful to focus discussion on the Top 10 metrics (this year's big six) and how many, with a third of the year gone, we are confident of meeting on a full year basis.

Waiting list data continues to be collated and size of wait list will in due course be added to the IQPR when the data is robust, as outlined in prior papers to the Board since November.

Alignment to strategic objectives	
SO1: Nurture partnerships with patients and citizens to support good health	
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.	

Previous consideration

Clinical Leadership Executive and relevant committees of the Board

Recommendation

The Board is asked to:

X	**NOTE** reported delivery and consider learnings from successful areas of improvement

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

Trust Risk Register	X	O 10/19, O1/23, NQ 12/23, NQ 3/23, DCGMH 1/23, RCG 2/23, NLCG 1/23,POD 2/23, WF 1/20, FP 1/22, TT 3/23, O 1/20,						
BAF (prior)	X	SR3						
System / Place impact	X							
Equality Impact Assessment	Is this required?			N	X	If 'Y' date completed		
Quality Impact Assessment	Is this required?			N	X	If 'Y' date completed		

Appendix (please list)

Integrated Quality Performance Report

July 2024 Review

Data as at 30th June 2024

Final

Contents

1.0 Executive Report

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

The Trust continue to focus delivery on ten key metrics (LTP01-LTP10) on the understanding that all performance is a priority. There remain a number of key performances metrices where there are areas for development and action, these are noted below:

Childrens services continue to perform well achieving the children and young people (CYP) accessing services (OP13a) metric reporting 9,880 against the target of 9,783. Our Children and young people with routine eating disorders seen within 4 weeks has improved month on month from 92.86 % in May to 94.02% in June, slightly below the 95% target. The significant piece of work on data cleansing has resulted in an improvement however this work continues until the 10th July 2024. Is it anticipated once completed this will improve performance above target. (OP15) Urgent cases are seen within 1 week with performance remaining at 100%.

Physical health services continue to perform well against OP08c, OP10c and the major piece of work on the new RTT pathways for physical health in June 2024 has resulted in a significant improvement . At present we are reporting 1 wait over 52 weeks 1 breach is currently been investigated to determine if it is a true wait. To be confirmed by the 14th July. It is also worth noting that the occupancy for our Virtual Ward on the 1st, 15th and 30th of the calendar month has exceeded our 80% occupancy target across all 3 points in the month and our ambition remains to expand our bed base to meet the 130-bed target by the end of March 2025. The one indicator in physical health where there is a deterioration in performance is related to the 2 hour assessment for those in crisis (OP05). At present the root cause of this deterioration is under investigation by the Performance team and the Care Group and is to be completed by the 12th July 2024.

Our Mental Health services continue to experience progress and challenges. In terms of OP13e, the metric in relation to adults and older people accessing community mental health services with 2+ contacts, we continue to achieve the target Trustwide reporting 8,693 against the target of 8,533. However, our Talking Therapies services are experiencing some challenges with performance against reliable recovery (OP03c) seeing a drop in performance to 43.41% in June against the 48% target. This variation may be normal range variation but the service will conduct a fact finding to establish if there is a reason for the deterioration in month. This will determine if immediate actions are required or a monitoring of performance over coming months to establish if this is a trend that requires intervention or is due to a common cause event. Reliable Improvement continued to perform well, reporting 68.72% against the 67% target. The Talking Therapies access rate (OP03) remains below the target (5,414) with actual performance of 3,904. Demand on this pathway continues to remain below the capacity available and some localities continue to report available assessment slots some weeks. It is recommended that the dedicated “Performance Clinic” is reinstated to identify root cause and develop meaningful actions to support with achievement and rectification.

The implementation of the new RTT pathways for mental health (OP08d) has seen an improvement to 79.19% from May where we were reporting performance of 74.48% . Although we are reporting some waits greater than 18 weeks, these are under investigation (to be completed by the end of July) with some likely to be data quality related with patients having been seen but not reflected correctly in the clinical system.

Our focus on inappropriate out of area placements remains an area of significant concern and we are currently reporting 28 individuals placed out of area as at the end of June. A significant improvement programme is emerging for 24/25, lead by a number of the Executive Team.

1.0 Executive Report

The percentage of VTE (QS08) assessments completed within 24 hours (reporting 91.16% in June) along with the number of episodes of seclusion (QS31) receiving and internal MDT assessment (reporting 66.67% in June) have both noted an increase in month based on May performance. Performance Clinics were held on the 18th June in each Care Group with the Director of Nursing. Deep dives were conducted which showed that although assessments are being completed in each care group for every patient they are completed outside of the timescale. The Clinical systems team are developing an alert for patient records to show within 12 hours if the assessment's remain incomplete. Care groups are conducting deep dives and weekly audits which are acted on and continue to feed back to Doctors concerned. For VTE where there is missing information for patients that are transferred from the acute trust already having VTE assessments in place the assessments are being undertaken by RDaSH . Performance clinics are planned mid-July to continue to monitor progress and actions asnd share good practice.

In June on the current metrices for Safer Staffing (QS15) we are reporting that 15/18 wards achieved over 90% "fill rate" measured in hours. If we express this as a percent this equates to 83.33% of how many wards achieved over the 90% fill rate in June measured in hours. The hotspot wards in June are Kingfisher, Hospice & Amber. They all have local plans to improve in place. In August we will move to the reporting for safe staffing to fill rates per ward (how many actual staff have filled the shift) and care hours per patient day, in line with national reporting.

The number of detained patients who abscond from an acute adult and OP inpatient mental health units (QS20) has seen an increase to 4 detained patients absconding in June from the 2 detained patient In May. Following a deep dive two patients were failed to return from section 17 leave at the agreed time rather than absconding from the ward. One patient absconded while being transferred from section 136 to the ward through a door which didn't have the appropriate locking mechanism and was returned to the ward by the Police within the hour. The door lock has been replaced and is now secure and supervision has been provided to the staff member involved in the incident.

The number of episodes of seclusion receiving an internal MDT assessment (QS31) within 5 hours has breached the Trust's 100% target for June. However, upon investigation an increase in performance can be seen to 66.67% (4/6) from the 14.29% in May and 53.85% in April. However, following a deep dive by the Mental Health Act Manager we can report that 83.33% (5/6) patients are receiving an MDT assessment within timescale showing an increase on the previous month of 55% (5/9) patients. The Executive Medical Director and Deputy Medical Director are receiving all information following the deep dive each month and driving clinicians to correctly input the data, although there are still ongoing issues with compliance for medical reviews and inputting the data. The risk is highlighted on the risk register for each Care Group and the Care Groups are sighted on the compliance issues. The Mental Health Act Manager has instructed the Matrons that all audits of episodes of seclusion must be taken through the Mental Health Legislation Monitoring Groups for oversight and actioning and addressing areas of noncompliance. A meeting took place 2nd July 2024 with the DoN's, Chief Nurse, COO and Deputy Medical Director to discuss segregation, use of seclusion/ segregation and the outcome of this is that the Chief Nurse will be discussing with the Executive Medical director and undertake a review of the seclusion policy roles and responsibilities.

From a people perspective it is pleasing to report that we have sustained the performance for the number of our employees receiving a performance and development review (POD18) with performance now at 90.23% and above the 90% target. The year-to-date sickness absence (POD10) % has increased slightly from 5.3% to 5.58%. The new metrics to report the vacancy rate is reported as 7.40% against the target of 2.5%.

1.0 Executive Report

The Trust is reporting a deficit financial position of £434,000 as of the end of June 2024. The adverse position is driven by an overspend of £574k linked to enhanced packages of care (EPCs) within the SY Adult Eating Disorder Provider Collaborative. The position excluding these costs is a year to date underspend against plan of £140k. The Trust has submitted a multi year proposal to NHSE to closer align the contract value with actual spend.

2.0 - Performance – In Focus

Indicators for June 2024/2025 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP01 (N)		People first episode in psychosis started treatment in 2 wks		7/12	58.33%		77.00%	>= 60%	77.00%
OP02 (N)		People completing Talking Therapies moving to recovery		252/548	45.99%		49.00%	>= 50%	49.00%
OP03a (L)	LTP 02 a (i)	People accessing Talking Therapies - Cumulative Annual			1271		3905	>= 5414	3905
OP03c (N)	LTP 02 b	Reliable recovery rate within Talking Therapies		247/569	43.41%		46.00%	>= 48%	46.00%
OP03d (N)	LTP 02 c	Reliable Improvement rate within Talking Therapies		391/569	68.72%		69.00%	>= 67%	69.00%
OP05 (N)		People in physical health crisis assessed within 2 hours		14/34	41.18%		52.00%	>= 70%	52.00%
OP07b (L)	LTP 03 b	Women supported by perinatal MH service (Rolling 12M)			527		527	>= 598	527
OP08c (N)		18 weeks RTT for consultant led Physical Health services		451/468	96.37%		94.00%	>= 92%	94.00%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		123/151	81.46%		79.00%	>= 92%	79.00%
OP10c (N)		Waiting 52 weeks or more for a consultant led PH service			1		1	= 0	1
OP10d (N)		Waiting 52 weeks or more for a consultant led MH service			2		4	= 0	4
OP12 (N)		People discharged from MH inpatients followed up in 72 hrs		52/76	68.42%		80.00%	>= 60%	80.00%
OP13a (N)	LTP 04	People accessing CYP services with >= 1 contact (13mth roll)			9040		9040	>= 9783	9040
OP13b (N)		People accessing CYP services >= 2 contacts and paired score		789/4215	18.72%		19.00%	>= 20%	19.00%

Narrative

OP02 – This month has seen a decline in performance to 45.99%, the service are reviewing the data at individual service level to understand the reasons behind this decline. Investigations to be completed by 21st July 2024.

OP03a – This is a place target however, only includes RDaSH activity reporting 3,905 for the cumulative year to date up until the end of May against a target of 5,414. Ieso are subcontracted to support with Rotherham place activity to deliver 108 for the year.

OP03c – This month has seen a decline in performance to 43.41% It is noted that the Trust continues to perform below the target for the Talking Therapies Access Rate.

OP05 – This month has seen a decline in performance to 41.18% the service are working with performance to understand the reasons behind this decline. Investigations to be completed by 21st July 2024.

OP7b – PLACE TARGET ACHIEVED - This is a rolling 12 month place target for Perinatal and Maternal Mental Health Services. Once RDaSH activity (527) and Maternal Mental Health Service (SHSC) (131) is counted the number of women receiving support is 658 remaining above the March 2025 target of 598.

OP08d – Reporting as per the new RTT pathways which came into effect on the 1st April 2024. Any new breaches >18 weeks will be investigated during the month of July to establish if they are data quality related.

OP10C the 1 breach is currently been investigated to determine if it is a true wait. To be confirmed by the 14th July.

OP10d The 2 breaches over 52 weeks, 2 from June to be re-investigated and 2 from June to be investigated during the month of July to establish if they are data quality related.

OP13a – PLACE TARGET ACHIEVED . A Place target, focus on this metric continues with performance at place (9,880) meeting the 2023/2024 target of 9,783 (RDaSH 9039, Kooth 780/Mind 61).

OP13b –Performance has continued to sustained its performance of last month reporting 19% slightly behind the 20% target.

2.0 - Performance – In Focus

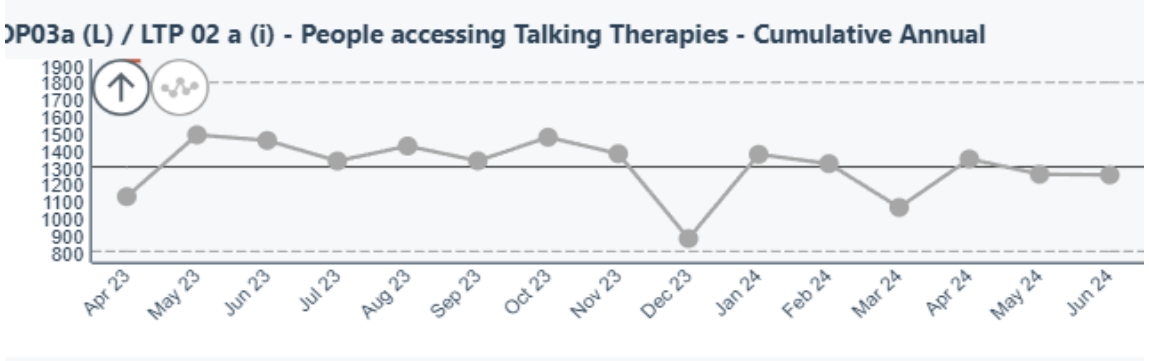
Indicators for June 2024/2025 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP13e (N)	LTP 01 b	CMHT access rate (DW not MHSDS) (>=1 Contact)			8694		8694	>= 7331	8694
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		110/117	94.02%		94.00%	>= 95%	94.00%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		3/3	100.00%		100.00%	>= 95%	100.00%
OP17c (N)	LTP 05 a	The number of active inappropriate adult acute OAPs			29		29	<= 27	29
OP19 (N)		MHSDS score for data quality maturity index (DQMI)		986/1000	98.60%		99.00%		99.00%
OP54a (L)	LTO 06 a (i)	Virtual ward occupancy - on day 1		57/90	63.33%		67.00%	>= 80%	67.00%
OP54b (L)	LTO 06 a (ii)	Virtual ward occupancy - on day 15		61/90	67.78%		56.00%	>= 80%	56.00%
OP54c (L)	LTO 06 a (iii)	Virtual ward occupancy - on day 30		55/90	61.11%		59.00%	>= 80%	59.00%
OP59a (L)	LTP 09 (i)	Waiting List - Adult ADHD			4227		4227	<= 3428	4227
OP59b (L)	LTP 09 (ii)	Waiting List - CYP Neurodevelopment			2452		2452	<= 2341	2452

Narrative

OP14 - Children and young people with routine eating disorders seen within 4 weeks has improved in month from 92.86 % in May to 94.02% in June remaining slightly below the 95% target.
(OP15) Urgent cases are seen within 1 week with performance remaining at 100%.
OP17c The number of inappropriate adult acute OAP's is reported as 28 reporting slightly above the target of 27.
OP54a/OP54b/OP54c – The metrics introduced in April 2024 measure occupancy of the Virtual Ward at 3 points in the calendar month. The service have achieved high occupancy against the 60 available beds and are meeting the 80% occupancy rate across all 3 points in the month. A correction is required to the metrics as there are only 60 available beds at present not 90.
OP59a –The metric measuring performance against the Adult ADHD waiting list trajectory is reporting that we are behind target reporting 4,093 individuals waiting against the target of 3,468. The trajectory in this report has not yet been updated to reflect the revision made due to some incorrect assumptions made to the staff available on the assessment pathway regarding the other workload within the service. At the end of June the revised trajectory states that there should be no more than 4301 waiting for assessment. The actual waiting is 4223 so we are below the revised target.
OP59b This new metric measuring performance against the Children and Young People's Neurodevelopment waiting list trajectory is reporting that we are behind target reporting 2,451 CYP waiting against the target of 2,341. This is primarily due to the delays to recruitment of the additional staffing required to deliver the trajectory.

2.1 Performance In Focus - Exceptions

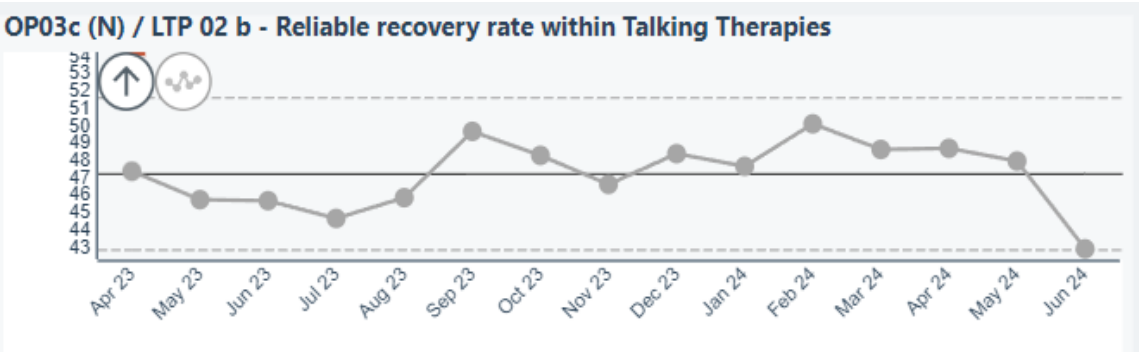


Trend, Reason and Action

OP03a It is noted that the Trust continues to perform below the target for the Talking Therapies Access Rate. The service has undertaken a Supply Analysis to calculate the capacity within the service at each step in the pathway which has identified a number of opportunities for service and pathway improvement. To oversee delivery of these, together with a number of actions already underway to improve performance within the service, a Talking Therapies Weekly Operational Oversight Group has been implemented from w/c 8 July 2024, whose workplan will focus on the following four priority themes:

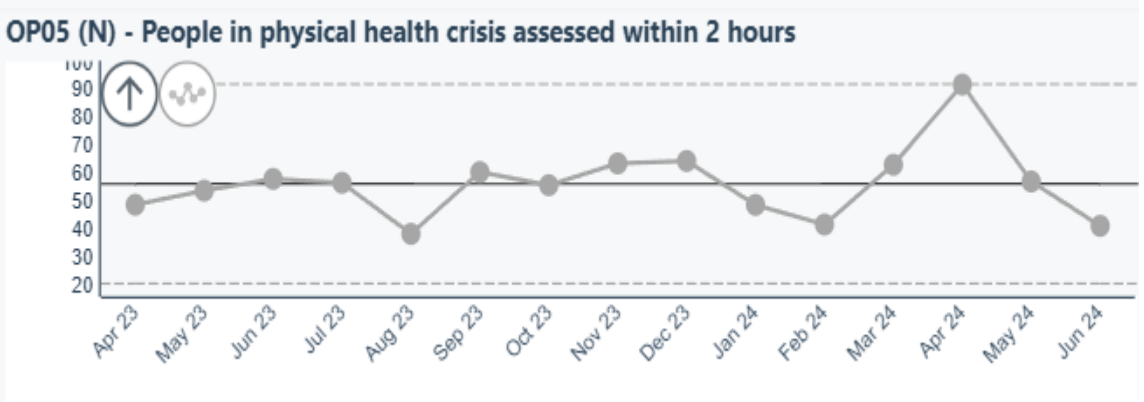
- Marketing
- Partnership and community engagement
- Consistent and evidence based service delivery
- Real time performance forecasting and management

Actions completed by this group and the impact on performance will be reported monthly through the IQPR.



Trend, Reason and Action

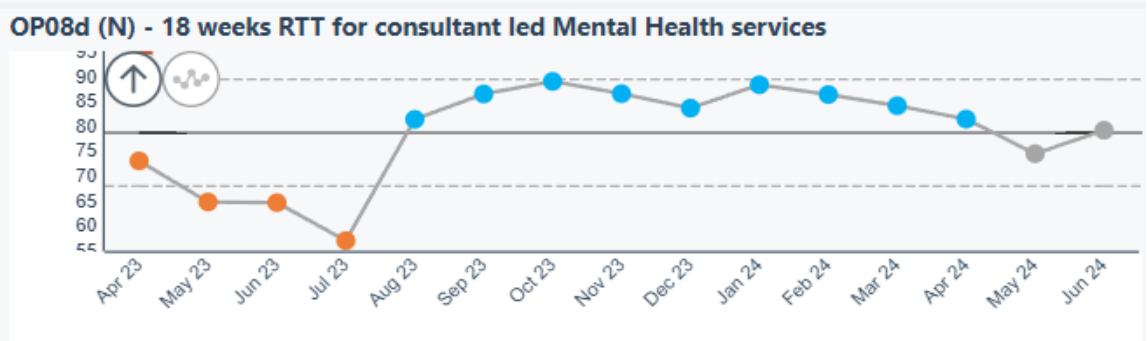
OP03c Performance over the first quarter of the year has seen a month on month deterioration in performance and a significant dip in performance to 43.41% in June. The service are investigating the reason for this underperformance on this metric. The continued deterioration will trigger the requirement for a Performance Clinic to be held with the service to understand the root cause, and to identify actions to mitigate and rectify performance. The date for this performance clinic will be scheduled to take place in July 2024. Reliable Improvement remains above the target of 68%.



Trend, Reason and Action

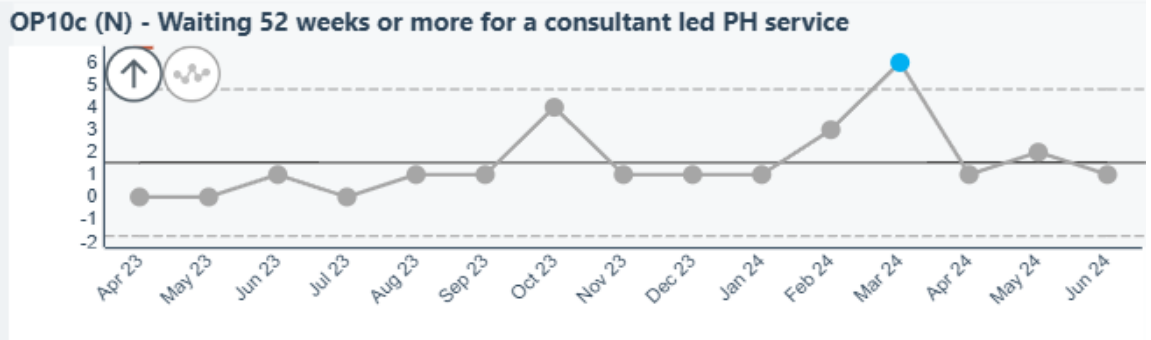
OP05 Performance over the first quarter of the year has seen a month on month deterioration in performance and a significant dip in performance to 41.18% in June (20 breaches). A deep dive is currently taking place to investigate the 20 breaches, this will be completed by the end of July 2024. The continued deterioration will trigger the requirement for a Performance Clinic to be held with the service to understand the root cause, and to identify actions to mitigate and rectify performance. The date for this performance clinic will be scheduled to take place in July 2024.

2.1 Performance In Focus - Exceptions



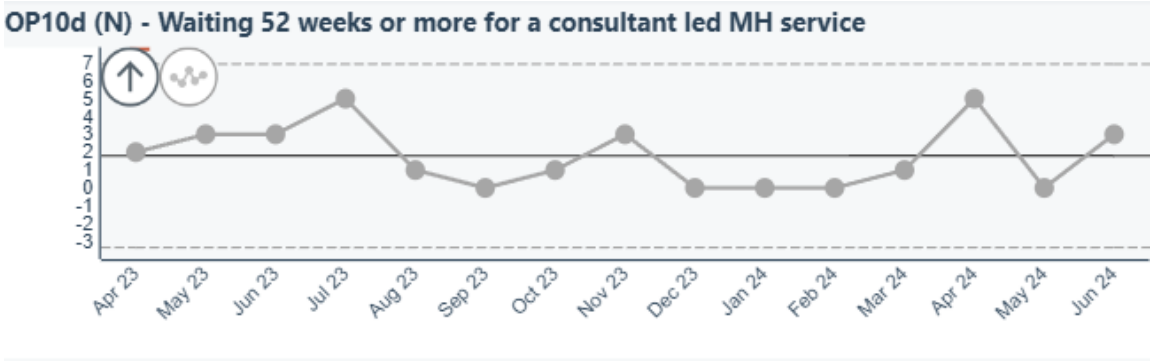
Trend, Reason and Action

OP08d – The Referral to Treatment pathways for Mental Health, a new metric reporting against the newly defined RTT pathways from the 1st April, is reporting an improvement to 79.19% in June from the 74.48% in May but remains below the 92% target. 31 individuals are reported as waiting longer than 18 weeks and these breaches are currently under investigation to determine the reasons behind the waits. It is likely that some of these waits are not true waits but where the clinician has not stopped the clock appropriately and therefore the clinical record will be required to be amended with clarity provided to clinicians on how to record once assessment and treatment has been completed.



Trend, Reason and Action

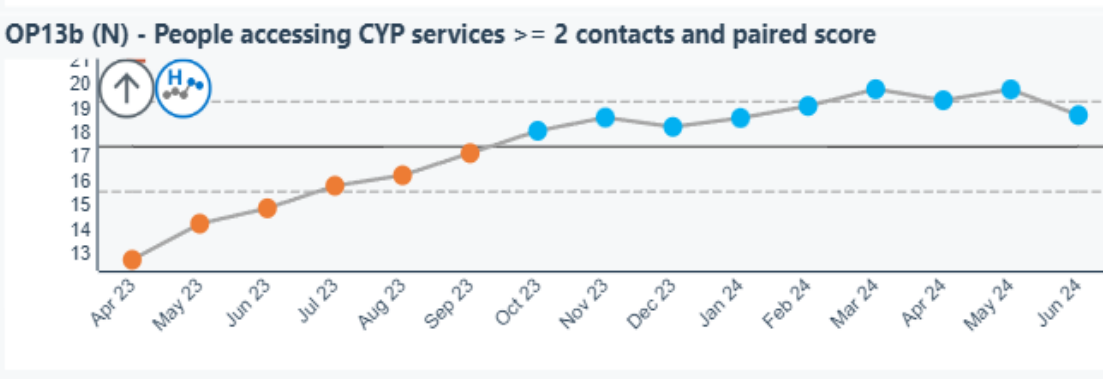
OP10c The report is indicating that there is one patient waiting over 52 weeks in the consultant led physical health service. The wait is currently under investigation to determine if this is a true wait. To be completed by the 14th July 2024.



Trend, Reason and Action

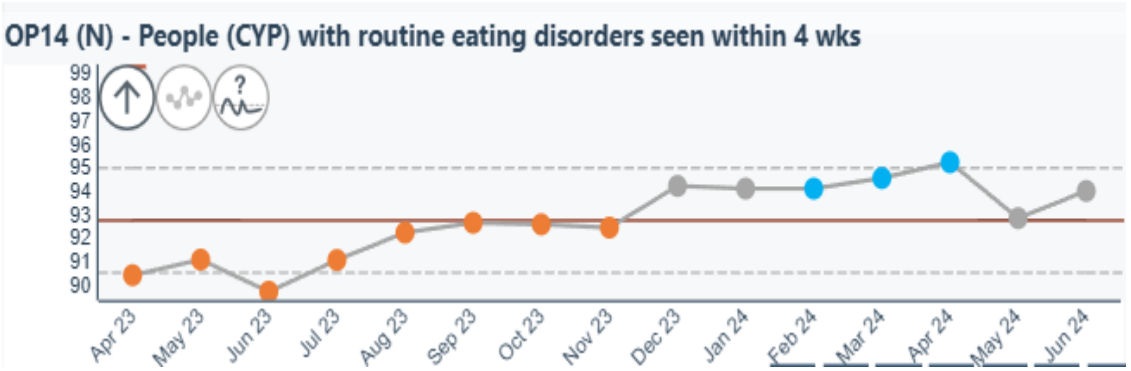
OP10d There are six patients waiting over 52 weeks in the consultant led mental health service. Investigations to determine the reasons behind the waits. Although all 6 breaches are under investigation it has already been confirmed that 2 of the waits are not true waits but are where the clinician has not stopped the clock appropriately and therefore the clinical record will be required to be amended. Additional targeted training will be provided to clinicians on how to record once assessment and treatment has been completed.

2.1 Performance In Focus - Exceptions



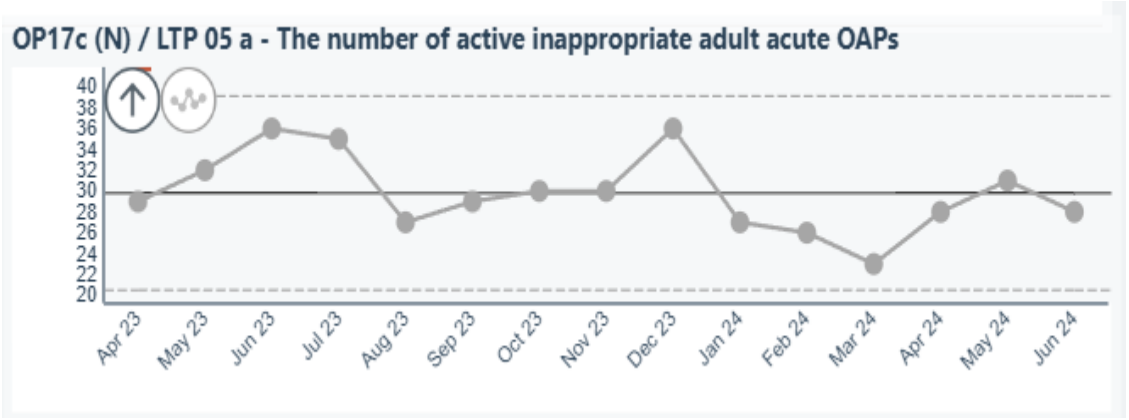
Trend, Reason and Action

OP13b Performance has seen a slight deterioration in performance to 18.72% in June from 19% in May.



Trend, Reason and Action

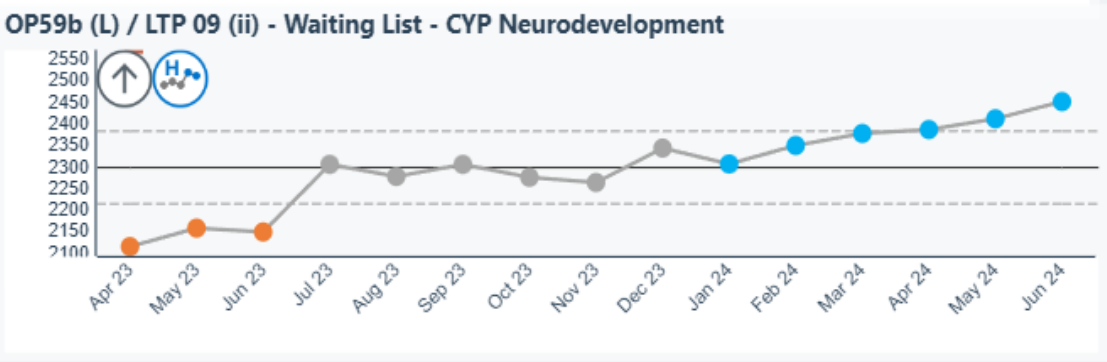
OP14 A focus in June on the clinical recording has seen an improvement in performance to 94.02% in June from 92.86% in May. The service are continuing to validate the 7 remaining exceptions and this will be completed by the 10th July 2024.



Trend, Reason and Action

OP17c The number of inappropriate out of area placements is reported as 28 at the end of the calendar month remaining above the trajectory of 27. A significant improvement programme is emerging for 24/25, led by a number of the Executive Team.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP59b This new metric measuring performance against the Children and Young People's Neurodevelopment waiting list trajectory is reporting that we are behind target reporting 2,410 CYP waiting against the target of 2,335. This is primarily due to the delays to recruitment of the additional staffing required to deliver the trajectory. Recruitment is now progressing with an additional 3 Band 8 Clinical Psychologists due to commence in September and October 2024, 1 Band 7 post has been filled however, 3 are to be re-advertised as we were unsuccessful in recruiting to these posts.

3.0 Quality & Safety In Focus

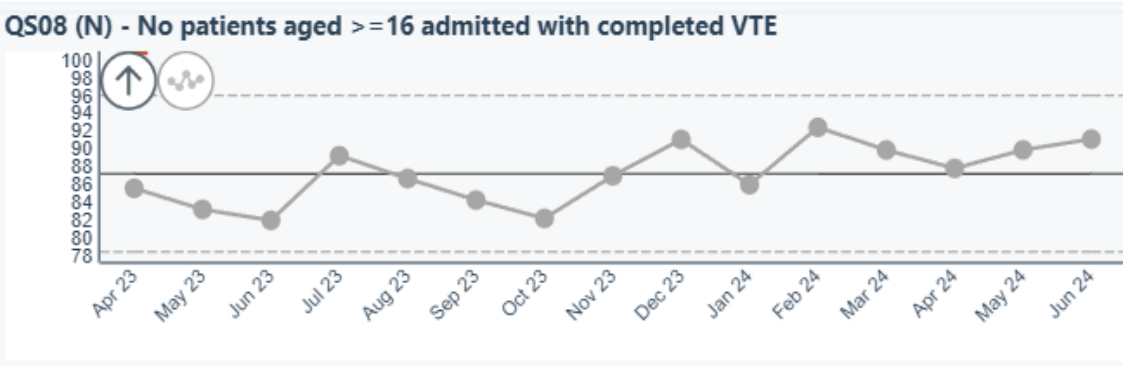
Indicators for June 2024/2025 TRUST — Quality & Safety

Indicator	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS04 (L)	% Patient Safety Alerts completed by the required deadline.	= 100%	100/100	100.00 %		100.00%	= 100%	100.00%
QS05 (N)	Number of MRSA infections (Monthly)	= 0		0	Q1 = 0	0	= 0	0
QS06 (N)	Number of Clostridum difficile infections (Monthly)	= 0		0	Q1 = 0	1	= 0	1
QS07 (N)	Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q1 = 0	0	= 0	0
QS08 (N)	No patients aged >=16 admitted with completed VTE	>= 95%	134/147	91.16%	Q1 >= 95%	90.00%	>= 95%	90.00%
QS15 (L)	No of wards reporting registered staff on nights/days >90%		15/18	83.33%		89.00%	>= 90%	89.00%
QS19 (L)	Number of AWOL's from low secure units (Amber Lodge)			0		0	= 0	0
QS20 (L)	No detained patients absconded acute adult/OP inpatient MH			4		6	= 0	6
QS21a (L)	Physical aggression incidents mod or above to staff (%)		0/0	- nan(ind)		50.00%		50.00%
QS21b (L)	Physical aggression incidents mod or above to staff/pats (%)		1/1	100.00 %		51.00%		51.00%
QS23 (L)	Number of Suspected Suicides (Inpatient Settings)							
QS27 (L)	Ligature incidents mod or above all inpatient areas		3/15	20.00%		11.00%	<= 10%	11.00%
QS29 (L)	Number of racist incidents against staff members			1		9	= 0	9
QS31 (L)	Episodes of Seclusion - Internal MDT within 5 hours		4/6	66.67%		46.00%	= 100%	46.00%
QS36 (N)	Inpatients that have a completed MUST assessment		99/153	64.71%		62.00%	= 100%	62.00%
QS37 (L)	Inpatients commenced with falls assessment in 72 hrs		82/84	97.62%		97.00%	= 100%	97.00%
QS38 (L)	Moderate/High falls requiring a structured review	= 0%	1/2	50.00%	Q1 = 0%	50.00%	= 0%	50.00%

Narrative

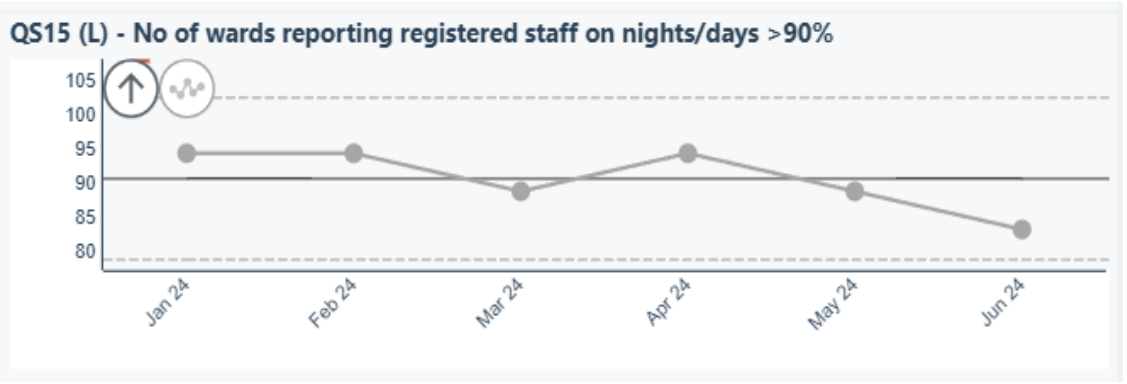
QS08 - The percentage of VTE assessments completed within 24 hours has shown an increase to 91.16% (134/147) in June from the 89.94% in May..
QS15 - Safer staffing has declined to 83.33% in June (15/18 wards) from the 88.89% (16/18 wards) in May.
QS20 – IQPR is reporting 4 detained patients absconding in May from acute adult and OP inpatient mental health units which has breached the zero target.
QS29 – IQPR is reporting a sharp decline in racist incidents with 1 reported in June from the 6 reported in May and 2 reported in April.
QS31 - The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target for June. However, upon investigation an increase in performance can be seen to 66.67% (4/6) from the 14.29% in May and 53.85% in April
QS36 - IQPR is showing an increase to 64.71% (99/153) in May from the decline in April to 59.59% of the % of Inpatients that have a completed MUST assessment
QS37 – IQPR is showing a slight decline to 96.43% in June from the increase in May to 98% of the number of Inpatients receiving a falls assessment within 72 hours. 3 patients didn't receive a falls assessment within 72 hours in June. Upon investigation 2 were missed completely and 1 was completed day 4 post admission.
QS38 –IQPR is reporting that ½ falls at 50%, however following a deep dive one fall is reported as being moderate or above for June which requires a structured review and the trust performance is 100%. Investigations will take place during the month of July to ascertain why the reporting is incorrect. This was a fall which resulted in a fractured arm and is being investigated in line with the After-Action Review process. It was presented to falls panel on the 8th July.

3.1 Quality and Safety In Focus - Exceptions



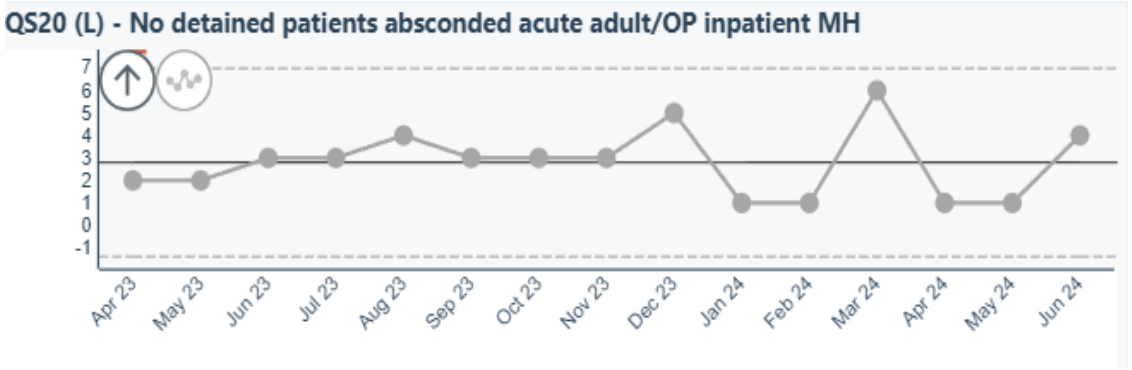
Trend, Reason and Action

QS08 - The percentage of VTE assessments completed within 24 hours has shown an increase to 91.16% (134/147) in June from the 89.94% in May. Performance Clinics were held on 18th June in each Care Group with the Director of Nursing. Deep dives were conducted which showed that although assessments are being completed in each care group for every patient they are outside of the timescale for reporting. The Clinical systems team are developing an alert for patient records to show within 12 hours if the VTE assessment remains uncompleted. Care groups are conducting deep dives and weekly audits which are acted on if the VTE assessment is not fully completed and continue to feed back to Doctors concerned. Where there is missing information for patients that are transferred from the acute trust already having VTE assessments in place the assessments are being undertaken by RDaSH . Performance clinics are planned mid-July to continue to monitor progress and actions asnd share good practice.



Trend, Reason and Action

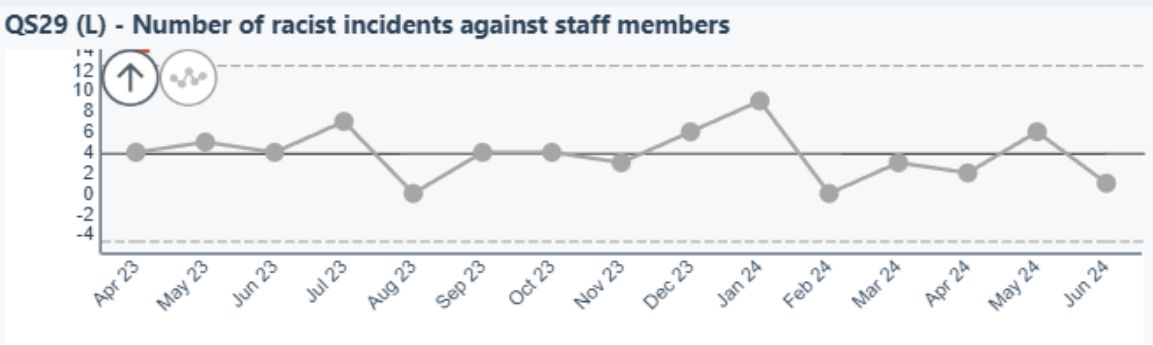
QS15 –In June on the current metrices we are reporting that 15/18 wards achieved over 90% "fill rate" measured in hours. If we express this as a percent this equates to 83.33% of how many wards achieved over the 90% fill rate in June measured in hours. The hotspot wards in June are Kingfisher, Hospice & Amber. They all have local plans to improve in place. In August we will move to the reporting for safe staffing to fill rates per ward (how many actual staff have filled the shift) and care hours per patient day, in line with national reporting.



Trend, Reason and Action

QS20 - – IQPR is reporting 4 detained patients absconding in May from acute adult and OP inpatient mental health units which has breached the zero target. Following a deep dive two patients were failed to return from section 17 leave at the agreed time rather than absconding from the ward. One patient absconded while being transferred from section 136 to the ward through a door which didn't have the appropriate locking mechanism and was returned to the ward by the Police within the hour. The door lock has been replaced and is now secure and supervision has been provided to the staff member involved in the incident.

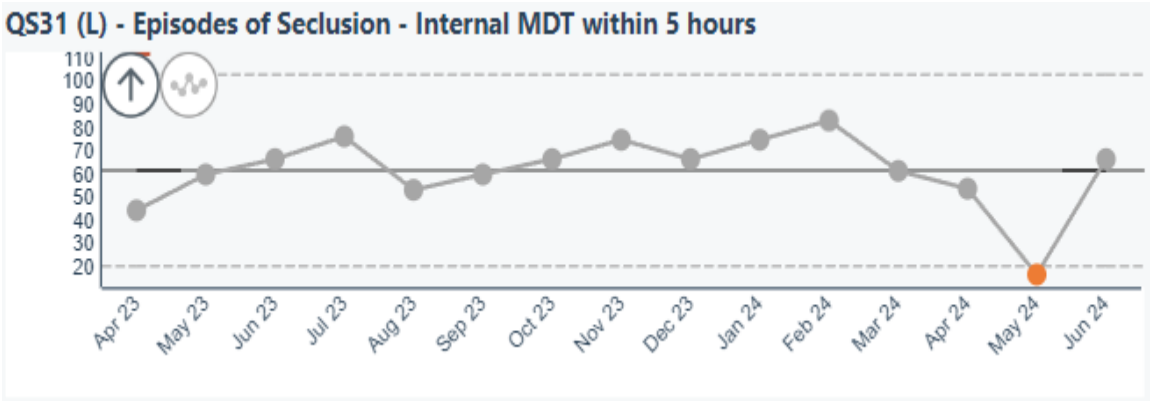
3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

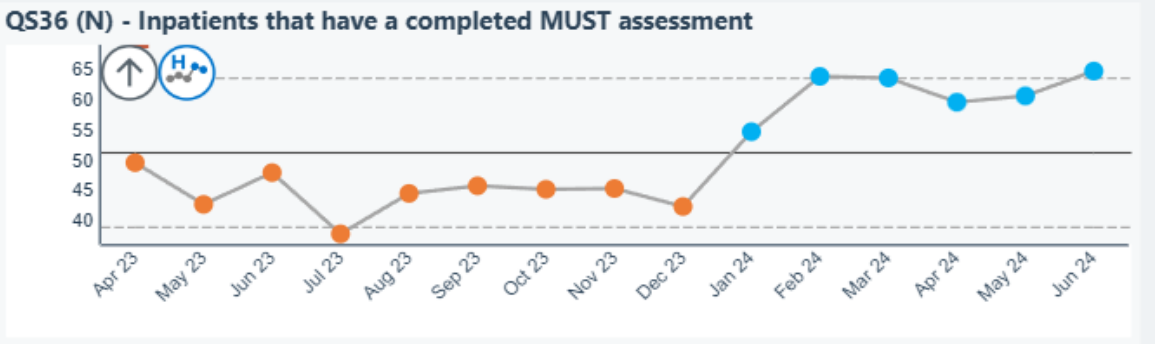
QS29 – Reporting a sharp decline in racist incidents with 1 reported in June from the 6 reported in May and 2 reported in April.

All incidents are discussed at the Daily Incident meetings which has created a greater awareness of reporting incidents. All incidents are reported via IR1 and discussed individually with staff members and warnings are issued where appropriate to patients. At ward level staff are supported by managers and encouraged to discuss issues and to report them to the Police as a hate crime. A revised process known as the 'Red Card' scheme is to be implemented across the Trust and is currently going through the appropriate governance channels.



Trend, Reason and Action

QS31 - The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target for June. However, upon investigation an increase in performance can be seen to 66.67% (4/6) from the 14.29% in May and 53.85% in April. However, following a deep dive by the Mental Health Act Manager we can report that 83.33% (5/6) patients are receiving an MDT assessment within timescale showing an increase on the previous month of 55% (5/9) patients. The Executive Medical Director and Deputy Medical Director are receiving all information following the deep dive each month and driving clinicians to correctly input the data although there are still ongoing issues with compliance for medical reviews and inputting the data. The risk is highlighted on the risk register for each Care Group and the Care Groups are sighted on the compliance issues. The Mental Health Act Manager has instructed the Matrons that all audits of episodes of seclusion must be taken through the Mental Health Legislation Monitoring Groups for oversight and actioning and addressing areas of noncompliance. A meeting took place 2nd July 2024 with the DoN's, Chief Nurse, COO and Deputy Medical Director to discuss segregation, use of seclusion/ segregation and the outcome of this is that the Chief Nurse will be discussing with the Executive Medical director and undertake a review of the seclusion policy roles and responsibilities.



Trend, Reason and Action

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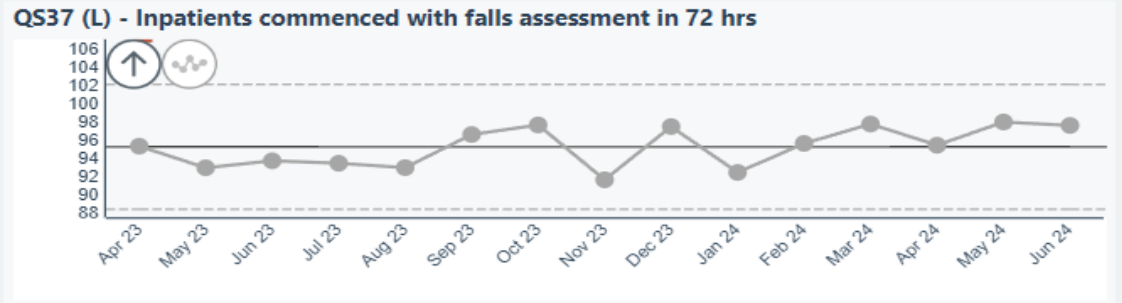
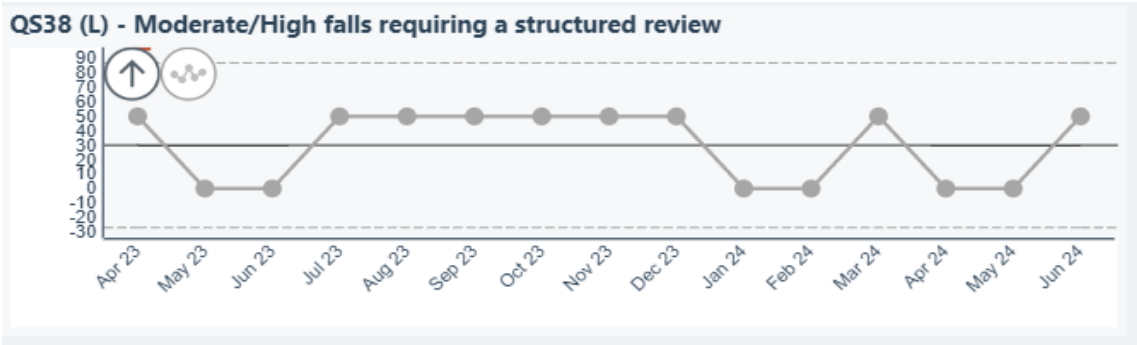


Trend, Reason and Action

QS37 – IQPR is showing a slight decline to 96.43% in June from the increase in May to 98% of the number of Inpatients receiving a falls assessment within 72 hours. 3 patients didn't receive a falls assessment within 72 hours in June. Upon investigation 2 were missed completely and 1 was completed day 4 post admission. Of the 2 which were missed, 1 patient has since been discharged the other remains under our care on Magnolia and this has been alerted to the service for completion. Mental Health Wards are 100% compliant with this KPI.



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4.0 People and Organisational Development – In Focus

Indicators for June 2024/2025 TRUST — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	9.61%		10.00%		10.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	5.58%		5.00%		5.00%
POD15 (L)	Number of Consultant Vacancies	<= 10	16		16		16
POD16 (L)	Qualified nursing vacancies	<= 10%	7.82%		8.00%		8.00%
POD17 (L)	Support worker vacancies	<= 10%	6.64%		7.00%		7.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	90.23%		90.00%		90.00%
POD19 (L)	Individuals completed mandatory/statutory training	> 90%	91.29%		91.00%		91.00%
POD23 (L)	Number of individuals currently suspended from employment		5				
POD24 (L)	Average suspension length in calendar days	<= 150	134		134		134
POD25 (L)	Recruitment completed within 12 weeks	>= 95%	87.65%		88.00%		88.00%
POD26 (L)	Compliance for safeguarding children's training		80.46%		80.00%		80.00%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		81.26%		81.00%		81.00%
POD28 (L)	Total Vacancies		213		213		213
POD29 (L)	Total Vacancy Rate %		7.40%		7.00%	<= 2.5%	7.00%

Narrative

POD10 - In June the year to date sickness absence % increased slightly from 5.3% to 5.58%.

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

POD25 – Performance has dipped to 87.65% remaining below the 95% target. The dip in compliance is due to the availability of candidates returning the HR paperwork. Regular contact is in place with all successful candidates.

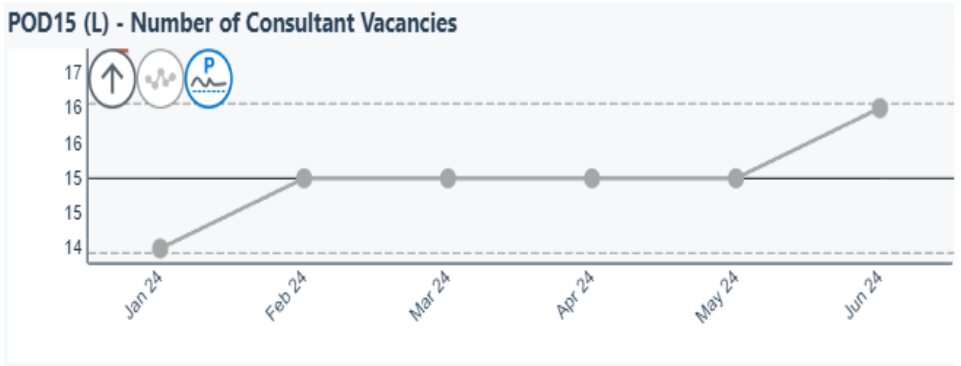
POD26 and POD 27 - Trust Level 1 and 2 (both adult and child are compliant) but level 3 for adult and child are amber. A continuing focus for the CG Directors of Nursing and will continue to be monitored through delivery reviews.

POD29 – this is a new metric this month and is reported as 7.4% against the target total vacancy rate percentage of less than or equal to 2.5%.

4.1 People and Organisational Development - Exceptions

Trend, Reason and Action

In June the year to date sickness absence % increased slightly from 5.3% to 5.58%.



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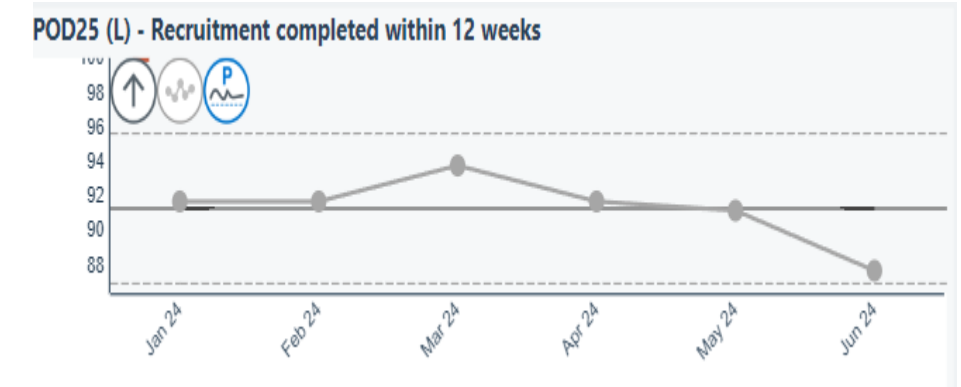

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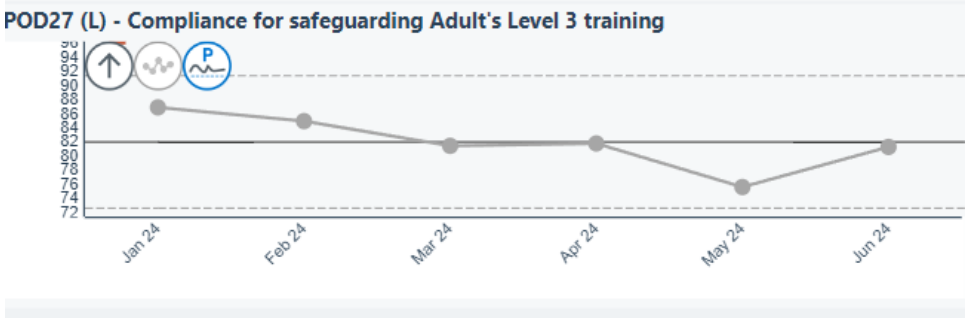

Trend, Reason and Action

POD26 and POD 27 - Trust Level 1 and 2 (both adult and child are compliant) but level 3 for adult and child are amber. This is a focus for the CG Directors of Nursing and will continue to be monitored through delivery reviews

4.0 Finance – In Focus

Indicator	Metric	Target £000	Actual £000	Variance £000
FIN01	Year to date actuals vs budget	- 942	- 1,376	- 434
FIN02	Year to date actuals vs budget - excluding AED	- 942	- 802	140
FIN03	Forecast outturn vs budget	- 3,762	- 3,762	-
FIN04	Annual savings target vs schemes identified	6,622	5,512	- 1,110
FIN05	Agency spend as % of total pay bill - year to date	3.6%	3.3%	-0.3%
FIN06	Year to date capital plan vs spend	1,241	615	- 626
FIN07	Annual capital plan vs forecast spend	7,146	7,146	-

Narrative

FIN01 The position at the end of June is a deficit of £1,376k, £434k adverse compared to the plan. The adverse position is driven by an overspend of £574k linked to enhanced packages of care (EPCs) within the SY Adult Eating Disorder Provider Collaborative.
The position excluding these costs (FIN02) is a year to date underspend against plan of £140k. The Trust has submitted a multi year proposal to NHSE to closer align the contract value with actual spend.

FIN03 – no variance to report at month 3

FIN04 – The value of savings schemes identified for 24-25 is £5,512k, this is £1,110k less than the plan. A savings target of 0.5% has been delegated to each group and a vacancy factor of 2.5% has been applied to staffing budgets. Central schemes such as managing inflation, non pay savings and agency reductions are progressing, with the gap to target to be identified through full year effects of prior savings schemes and additional income opportunities in year.

FIN05 Agency costs at the end of June are 3.3% of the total pay bill. An agency ceiling target has not been set by NHSE, therefore the target for 2023/24 of 3.6% has been provided for comparison purposes. The Trust savings plan assumes a £1m saving linked to agency premium, the Trust must keep agency spend at or below 3.6% of the total pay bill to achieve this.

FIN06 / 07 – The year to date variance on capital is expected to be recovered as key capital projects such as Great Oaks are progressed from Q2 onwards. The capital forecast remains in line with the plan.

Appendix 1`

SPC Icon Description

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(common cause)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
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(blank)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational; Risk Report – Extreme Risks	**Agenda Item**	Paper T
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	25 July 2024

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

The Trust has been engaged for a year in a process to elevate and better tackle risk. Some further risks are emerging through that process. In addition to themes associated with eating disorders and out of area placements, long waits for neurodiversity diagnosis and care are now visible in our risk register. We are also exploring how our risk register connects to that of our ICBs.

The Board is invited to test the sufficiency and grip associated with the risks, following the discussions held at the Clinical Leadership Executive this month.

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

Business as usual.	X

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

Operational Risk Report to Board in May 2024 included reference to five extreme risks; Further to the Risk Management Group (RMG) and Clinical Leadership Executive (CLE) in July 2024, there are now 8 risks scored as 'extreme'

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

The Board of Directors is asked to:

x	**RECEIVE** and note the current extreme risks.

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

Trust Risk Register	x	As detailed in the report
Board Assurance Framework		
System / Place impact	x	O10/19, S2/22, S4/24,

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

Appendix (please list)

None

Rotherham Doncaster and South Humber NHS Foundation Trust

Current Extreme Risks (15 July 2024)

RMG at its meeting on 2 July continued to support the risks previously moderated as 'extreme' in respect of the following (which were reported to, and supported by CLE on 16 July 2024):

O 10/19 – Chief Operating Officer
If the patient flow into and through the Mental Health inpatient units is not improved then the trust will continue to place people in Out of area acute beds impacting on negative patient and family experience, increasing wait times and delivery against National KPIs.

Current Score (I x 3, L x 5 = 15) Target Score (I x 3, L x 2 = 6)

Aiming to reduce this risk in line with the promise 19 (by March 2025).

DCG 11/17 – Care Group Director – Physical Health and Neurodiversity
If the speech and Language therapy service is unable to meet the target for priority one referrals which indicate overt signs of aspiration and high risk of secondary health symptoms, this could lead hospital admission and possibly death.

Current Score (I x 4, L x 4 = 16) Target Score (I x 3, L x 2 = 6)

Exploring options to mitigate the risk by end of October 2024. A review of the waiting list is being undertaken and the demand and capacity work is commencing at the end of August.

S 2/22 – Director of Strategic Development
If there is insufficient funding available or demand exceeds the financial envelope then the Trust will incur a deficit in relation to the provider collaborative and the viability of the collaborative may need to be reviewed.

Current Score (I x 4, L x 4 = 16) Target Score (I x 2, L x 2 = 4)

Deficit is estimated at £1.2m. Discussions remain ongoing with NHSE to determine where the deficit will sit. Likelihood will not change until at least September 2024.

S 4/24 – Director of Strategic Development
If there are insufficient Community Adult Eating Disorder Services in each of the four ICB places, then demand and length of stay for specialist inpatient services will remain high, leading to a poorer experience for patients and an unaffordable model of care.

Current Score (I x 4, L x 4 = 16). Target Score (I x 4, L x 2 = 8)

Proposal for Joint Committee agreed by 2 of 4 Trusts, once agreed a joint committee would run in shadow form until March 2025. Confirmed that investment would be needed nationally, and a business case is being prepared. Possible change to likelihood expected in September 2024.

***S 6/22 – Director of Strategic Development**
If one of the specialist inpatient eating disorders service does not implement the recommended improvements, then there is a risk to patient safety and reputational damage for the collaborative and the Trust as lead commissioner.

Current Score (I x 4, L x 4 = 16) Target Score (I x 3, L x 2 = 6)

The service remains closed to referrals, NHSE have a quality improvement process in place and continue to meet on a monthly basis. Possible change to likelihood expected in September 2024.

***E 4/24 – Director of Finance and Estates**

If a plan to manage 24/25 energy inflation from a forecast of £1.1m to a 24/25 budget of £0.8m is not developed and delivered, then this will have an adverse impact on the delivery of the Trust savings plan."

Current Score (I x 3, L x 5 = 15) Target Score (I x 2, L x 2 = 4)

Exploring estate and whether a reduction is buildings being used is feasible to reduce costs.
Identify other areas of the Estates budget where expenditure can be reduced to manage any inflationary pressure
Identify energy saving initiatives to reduce the level of spend in 24-25

***PCG10/24 – Care Group Director – Physical Health and Neurodiversity**
If the waiting times for assessment of ADHD remain above target, then this will impact on RDaSH patients and their families wellbeing and health outcomes, service delivery, staff health and wellbeing, the delivery of the Trust's Strategic Objective Promise 8 and Promise 14, and the Trust's reputation

Current Score (I x 3, L x 5 = 15) Target Score (I x 3, L x 2 = 6)

Interviews taking place and Awaiting confirmation of Rotherham Shared Care pilot / trial start date. Expectation is that improvement will start to be seen in September 2024.

***PCG9/24 – Care Group Director – Physical Health and Neurodiversity**
If Doncaster and Rotherham patients are left undiagnosed for Autism then this will impact on patients and their families wellbeing and health outcomes, staff health and wellbeing, is in breach of NICE guidance, the delivery of the Trust's Strategic Objective Promise 8 and Promise 14, and the Trust's reputation

Current Score (I x 4, L x 4 = 16) Target Score (I x 2, L x 2 = 4)

Recruitment being undertaken and away day planned end of July to review assessment process and to determine the mitigating actions to be undertaken.

* not previously reported to the Board of Directors

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Risk Management Framework Annual Report 2023/24	**Agenda Item**	Paper U
Sponsoring Executive	Phil Gowland, Director of Corporate Assurance/Board Secretary		
Report Author	Jane Charlesworth, Corporate Assurance Manager		
Meeting	Board of Directors	**Date**	25 July 2024

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

The Risk Management Framework Annual Report provides an overview of the work undertaken during 2023/24 in respect of Strategic and Operational risk.

- Of significance in the year was work aimed at improving the engagement with risk, and the profile and importance of Risk Management. Multiple workshops resulted in a significant increase in number of risks on the registers, enabling the production and use of a more comprehensive risk profile. Risk became a specific point of reference within decision making processes.

- At the year-end the registers contained 237 open risks – a two-fold increase on the position at the end of the previous year.

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

Business as usual	X

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

This Annual Report was received and noted by the Audit Committee on 5 June 2024.
The Audit Committee asked for consideration of risk management within the new induction process for staff.

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

The Board of Directors is asked to:

X	**RECEIVE** and **NOTE** the Risk Management Framework Annual Report
X	**TAKE ASSURANCE** on the delivery against the framework and that the Trust has in place robust arrangements for Risk Management acknowledging that there is further scope for development.

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

Trust Risk Register							
Board Assurance Framework							
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Appendix (please list)

None

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

Risk Management Framework Annual Report 2023/24

Jane Charlesworth
Corporate Assurance Manager

RDaSH nurturing the power in our communities

Risk Management Framework Annual Report

Executive Summary

The Trust refreshed the Risk Management Framework in quarter 4 in line with the new operating model. It defines the management of risks (by all staff) and sets out the respective responsibilities for strategic and operational risk management. The Risk Management Framework Annual Report provides an overview of the work undertaken during 2023/24 in respect of Strategic and Operational risk.

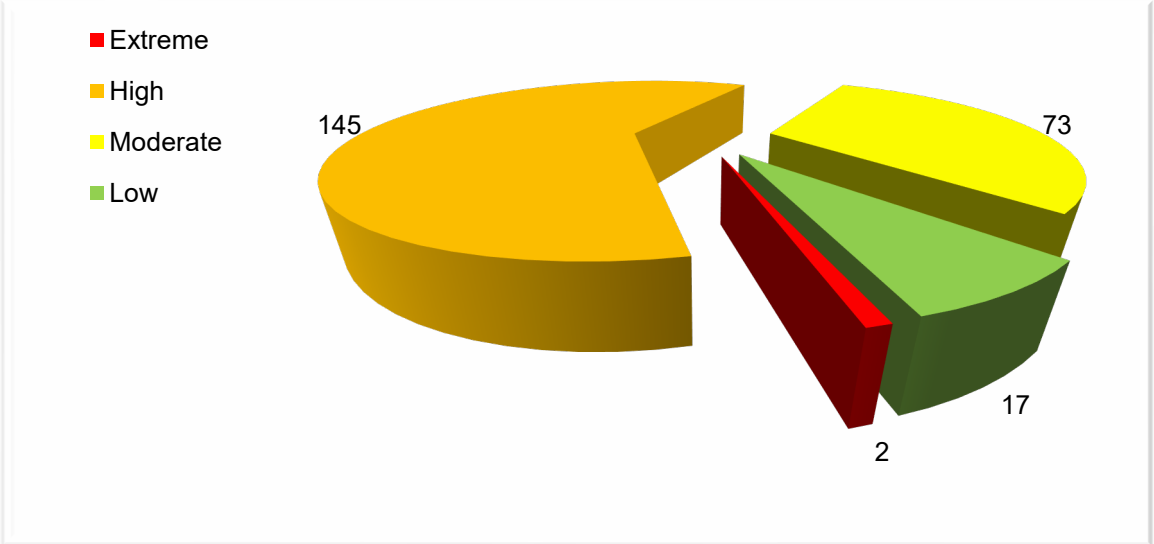
A key piece of work was undertaken in May and June 2023 in the form of risk workshops with key stakeholders that covered:

- Risk vs issues
- Reviewing existing risks -whether they were still relevant
- Focus on identification of risk exploring the different types and each team

These workshops resulted in significant increase in risks being added to the risk registers in term so both live and tolerated risks providing the Trust with a more comprehensive risk profile. In addition, the workshops re-invigored engagement with risk and an improvement in the Trusts risk culture.

Another key development was the introduction of a monthly CLE Risk Management Group with the meeting. The group met three time during 2023/24 and continues to meet on a monthly basis.

During the year 295 new risks were identified, 2 risks re-opened and 238 were mitigated/closed. As at the 31 March 2024 there were 237 open risks. This shows that the Trust continues to be risk aware and in turn responsive to risk.



1. Introduction

The Risk Management Framework provides clear guidance for the management of risks, requiring it on a timely basis and with sound escalation mechanisms.

Implementing and maintaining effective risk management arrangements underpins the Trust's system of internal control which along with the Board Assurance Framework supports the Trust in fulfilling its corporate governance responsibilities.

Within the Trust there are 2 levels of risk:

- **Operational Risk** - these are the identified risks that have the potential to impact on the delivery of business, projects or programme objectives. Operational risks are recorded within risk registers.
- **Strategic Risk** - A Board Assurance Framework is developed in order to identify and record the key strategic risks for the Trust that may impact on the achievement of its Strategic Objectives.

A risk is the chance of something happening that will have an impact on business objectives and this can be in terms of:

- A threat - a possible event we want to try to reduce the chances of occurrence or limit the impact to us if it did happen.

or

- An opportunity - a possible event that we might exploit by taking action which could deliver a benefit or positive effect for our Trust.

The severity of a risk is determined by assessing its' impact and likelihood and subsequently scoring as 'low', 'moderate', 'high' or 'extreme'. The Trust's risk assessment scoring methodology is based on the NPSA matrix whereby the level of risk is assigned using the grid below:

High Risk	Extreme Risk
Low Risk	Moderate Risk

Impact Score		Likelihood Score				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost Certain
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5

2. Accountability Framework and Organisational Structure

During the year the Trust developed and implemented a new operating model. As part of this new model a Clinical Leadership Executive (CLE) meeting and a range of supporting groups were introduced, one of which was a CLE Risk Management Group which commenced in January 2024. In addition, the Terms of Reference of the Board and its committees were restated and refocused in line with new Clinical and Organisational Strategy and the forward

trajectory of the Trust. Following the implementation of the new operating model the risk management framework was refreshed with the following accountability being put in place:

Board of Directors is responsible for:

- taking the lead on the assessment and management of risk and take a strategic view of risks in our Trust.
- ensuring that roles and responsibilities for risk management are clear to support effective governance and decision-making at each level with appropriate escalation, aggregation and delegation.
- determining and continuously assessing the nature and extent of the principal risks that our Trust is willing to take to achieve its objectives – its "risk appetite" – and ensure that planning and decision-making appropriately reflect this assessment.
- assuring itself of the effectiveness of the organisation's risk management framework.

Audit Committee is responsible for:

- understanding our Trust's business strategy, operating environment and the associated risks, taking into account all key elements of the organisation.
- critically challenging and reviewing the risk management framework, to evaluate how well the arrangements are actively working in our Trust.
- critically challenging and reviewing the adequacy and effectiveness of control processes in responding.

CLE Risk Management Group is responsible for:

- ensuring that our Trust is actively identifying and documenting risks in all directorates of the organisation.
- overseeing work to mitigate risks, supporting leaders to do so, where necessary by bringing together expertise across the group.
- taking responsibility for resolving cross-trust risks that are thematic or escalating such concerns for resolution through the Clinical Leadership Executive (CLE) and/or within delivery reviews.
- ensuring that the risk management framework is being implemented effectively and to advise CLE or the Audit Committee where this is not the case.
- ensuring that risks to delivery of the strategy are reflected within the risk register or, where relevant, the Board Assurance Framework.

3. Operational Risk

Each operational risk is allocated a status from the following:

- **Live** - Those risks that are actively being treated and action above and beyond 'Business as Usual' are being taken to reduce the impact and likelihood of the risk occurring.
- **Tolerated** - There are some risks that must remain open as the Trust is unable to implement mitigations that eliminate the risk in its entirety. In these circumstances the Trust may acknowledge that no further action can be taken to mitigate against the risk and decide to tolerate it.
- **Closed** – Fully mitigated and no risk remains.

The graph below shows the level of risk of both open and tolerated risks per register:

Table 1 – Comparative number of risks in 2023 and 2024

Date	Number of Live risks	Number of tolerated risks	Total
31 March 2023	113	91	204
31 March 2024	236	163	399

The above table shows a significant increase in the number of risks identified during the last year compared to the year before and this was instigated through risk workshops held during May and June 2023 with individual risk register owners and senior management teams. Each session sought to clarify and confirm the existing risks remain however the main focus was to explore with each risk register owner their respective 'risk universe' and prompted the consideration of risks of all themes. This was to ensure all areas of the Trust are appropriately represented in the registers and that registers are complete.

Another change in the operating model was the restructure of the care group management that included the introduction of directorates and the care group risk registers have been adapted to be able to allocate each risk to a directorate (when applicable as some risk remains applicable across the care group rather than one directorate).

Tables 2 and 3 overleaf show the movement of risk during 2023/24 and demonstrates that there is regular review, identification, mitigation and closure of risks with good frequency.

Table 2 and 3 – Movement of risk by register and directorate during 2023/24

Care Group Register	Apr-23	Opened	Trans In	Tolerated	Trans Out	Closed	Mar-24	Directorate	Mar-24
Children's Care Group	12	34				19	27	Physical Health	6
								Mental Health	13
								Care Group Level	8
Doncaster AMH & LD Care Group	9	30	1	2	1	7	30	LD & Forensic	3
								Community	9
								Acute	9
								Care Group Level	9
North Lincs AMH & Talking Therapies Care Group	11	18		11	2	3	13	Talking Therapies	1
								Community	2
								Acute	6
								Care Group Level	4
Rotherham AMH Care Group	19	32		13	3	15	20	Community	7
								Acute	8
								Care Group Level	5
Physical Health & Neurodiversity Care Group	12	42	7	4		17	42	Neurodiversity	2
								Community & Long Term Conditions	27
								Rehabilitation	12
								Care Group Level	1

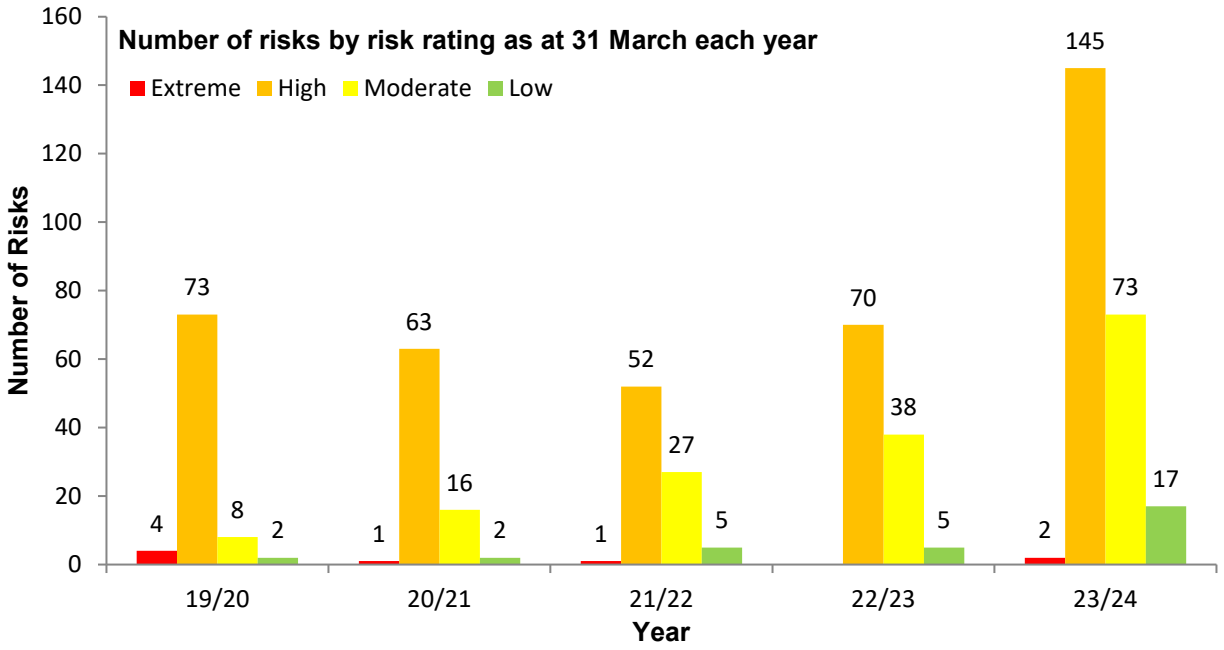
Corporate Directorate Register	Apr-23	Opened	Trans In	Tolerated	Trans Out	Closed	Mar-24
Operations	3	6	4			1	12
Corporate Assurance	1	14		5		1	9
Finance	4	16		5	4	5	6
Estates & Facilities	18	7		8		4	13
Health Informatics	8	24		10		7	15
Medical & Pharmacy	5	31		9		5	22
Nursing & Quality	2	19		4		4	13
People & Organisational Development	3	11		7			7
Strategy	5	11		5		4	7
Psychological Professionals and Therapies	0						0

3.1 Live Risks

Table 4 - Number and level of risk as at 31 March 2024

Register	Extreme	High	Moderate	Low	Total
Children's Care Group		15	10	2	27
Doncaster AMH & LD Care Group		19	6	5	30
North Lincs AMH & Talking Therapies Care Group		5	6	2	13
Rotherham AMH Care Group	1	13	5	1	20
Physical Health & Neurodiversity Care Group		29	11	2	42
Operations	1	9	1	1	12
Corporate Assurance		5	4		9
Finance			5	1	6
Estates & Facilities		8	5		13
Health Informatics		7	5	3	15
Medical & Pharmacy		20	2		22
Nursing & Quality		10	3		13
People & Organisational Development			7		7
Strategy		4	3		7
Psychological Professionals and Therapies					0
Total	2	144	73	17	236

The chart below presents the scoring of risks over the past five years in order to see how the profile of risk scoring has changed.



Throughout the five years the majority of risks are rated as high, in 2019/20 this was significantly so at 84%. In 2020/21 there was a decrease in high rated risks to 77% and

an increase of moderate rated risk up to 20% (from 9% the previous year). The profile continued to shift in the same direction in 2021/22 with 61% of the risk being rated high and moderate rated risks increasing again to 32%. Although the number of risks identified rose substantially in 2023/24 the profile remains similar to 2021/22 as was 2022/23.

Extreme Operational Risks are all the identified risks that are scored 15 or above that have been moderated and agreed. There were 2 extreme risks identified 2023/24:

O 10/19 – Escalating risk relating to inpatient flow and number of out of area placement – moderated and agreed as an extreme rated risk with a risk score of 15.

RCG 5/24 – New risk relating to compensatory rest for junior doctors – moderated in April 2024 and agreed to be a High risk due to the mitigation already put in place at time of moderation.

3.2 Tolerate risks

Table 5 - Number and level of risk as at 31 March 2024

Register	Extreme	High	Moderate	Low	Total
Children's Care Group		1	2	1	4
Doncaster AMH & LD Care Group			3	3	6
North Lincs AMH & Talking Therapies Care Group			5	11	16
Rotherham AMH Care Group			10	4	14
Physical Health & Neurodiversity Care Group			4		4
Operations			1	2	3
Corporate Assurance			4	4	8
Finance			10	8	18
Estates & Facilities		3	6	5	14
Health Informatics			17	4	21
Medical & Pharmacy			14	6	20
Nursing & Quality		1	5	4	10
People & Organisational Development			8	11	19
Strategy			4	2	6
Psychological Professionals and Therapies					0
Total		5	93	65	163

The Risk Management Framework states that no risk will be tolerated with a likelihood of 3 without being moderation and agreed. There were 2 such risks as at 31 March 2024:

FP 12/19 – a high risk (9) relating to the control of ignitions on inpatient wards
S 3/22 – a moderate risk (6) relating to provider collaborative risk sharing

3.3 Fraud Risks

There are number of risks relating to the Counter Fraud and cover the 25 risk areas identified in the Counter Fraud Risk Assessment around Finance, IM & T, Procurement/Assets, Staff, and Patient & Visitors. A review of risk scoring was undertaken with Counter Fraud in May 2022 followed by further clarification and update with the appropriate risk owners.

All the fraud risks are currently classed as 'Tolerated' and a summary overview is shown below.

Table 6 – Summary of the Counter Fraud risks

Finance		Procurements/ Assets		Staff		IM & T		Patient and Visitors	
Subject	Score	Subject	Score	Subject	Score	Subject	Score	Subject	Score
Accounting	3	Staff Corruption	6	Bank & Agency Staff	4	Cyber Crime	6	Overseas Visitors	4
Petty Cash	2	Capital Assets	4	Secondary Working	4	Data Protection	4	Expenses	2
Creditor Payments	6	Estates & Facilities	4	Employment Checks	6	IT Misuse	2	Frequent Service Users	1
Trust Funds	4	External Corruption	6	Expenses	2			Prescription Fraud	4
Salary & Wages	2			Prescription Fraud*	4			ID Fraud	2
				Private Patient Treatment	1				

3.4 Risk Leads

Risk leads are scheduled to review and maintain their risks in a timely manner and to provide an update each month. Care Group risks are scheduled to be discussed at their monthly governance meetings. The table overleaf provides a summary of the reviews undertaken by the risk lead during 2023/24 in comparison to the previous three years. The overall average for the year was 87%, this is a reduction from 2022/23 which was 92%, and there are 4 registers with compliance below 80%. There were a number of changes in risk owners and Corporate Assurance Team has worked and continues to work with all risk owners to emphasise the importance of keeping the risk up to date, providing advice and support throughout the year. The Audit Committee has been informed of this data at each of its meetings.

Table 7 – Percentage review compliance 2023/24 and previous 3 years

Registers	2020/21	2021/22	2022/23	2023/24
Children's Care Group	93%	98%	98%	86%
Doncaster AMH & Learning Disabilities Care Group	93%	80%	71%	88%
Physical Health & Neurodiversity Care Group			96%	92%
North Lincolnshire AMH & Talking Therapies Care Group	86%	93%	91%	100%
Rotherham AMH Care Group	89%	83%	70%	84%
Operations	84%	100%	100%	100%
Corporate Assurance	76%	100%	100%	100%
Finance	100%	100%	97%	76%
Estates	N/A			78%
Health Informatics	99%	91%	89%	98%
Medical & Pharmacy	93%	83%	81%	79%
Nursing & Facilities	94%	100%	89%	86%
People & Organisational Development	63%	100%	100%	81%
Strategic Development	N/A		100%	74%

% = number of reviews / number of scheduled reviews x 100 Green – 80% and above Amber – 60% -80%

3.5 Internal Audit Review

An audit review on operational risk management was undertaken in year which received a Limited audit opinion. Seven recommendations were made and the current status is provided below in Table b.

Table 8 – Recommendations

Recommendations	Current status
1.1 The Risk Management Framework to be updated to: • reflect the revised operating model and changes to roles • include all relevant accompanying guidance in respect of risk management • reference the Risk Form and how this should be used • reference the need to escalate risks which cannot be adequately managed/treated and the relevant governance arrangements.	Completed at time of audit completion
1.2 To develop a risk appetite statement in respect of each strategic risk and guidance on how this should be applied to operational risks.	Overarching statement included with refreshed framework. Work commencement to expand appetite statement and to be discussed at the Risk Management Group.
2.1 The Corporate Assurance Team to put in place a regular deep dive/check and challenge process with risk leads to provide feedback on areas for improvement/development and to review of risk scores, completed actions, controls and risk treatment.	Work has commenced on process and feedback is scheduled to be rolled out in quarter 2.

Recommendations	Current status
3.1 The Trust to review the risks that are identified to tolerate or terminate in the risk registers and ensure that the risk treatment is accurately identified and that these are subject to appropriate authorisation and agreement.	Review undertaken and a monthly check is now in place as part of the moderation reporting to the risk management group.
4.1 The Trust to ensure that the new arrangements being put in place for risk reporting within Care Groups and Corporate Directorates is appropriate to support regular review, moderation and escalation of risks.	Commenced, risks are part of the Delivery Reviews and will become part of the Risk management oversight.
5.1 The Trust to undertake a moderation exercise of all risks added to risk registers as part of the risk workshops to confirm that they are appropriate and consistently scored.	Commenced and progressing through working with risk owners.
6.1 The Trust to review the management information that is required and consider options for obtaining this information directly from Ulysses which reduces the need for manual intervention.	Requirement of management information has been reviewed and manual intervention has been reduced as far as possible. This will be reviewed again when new recording system has been implemented and automation can be introduced.

4 Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) provides the Board of Directors with assurance that appropriate arrangements are established regarding the effectiveness of risk controls in the Trust. These are the controls that have been put in place to mitigate the Trust's exposure to risk in the achievement of its strategic objectives.

The 2021/23 BAF was extended into 23/24 in line with the 2021/23 Trust Strategy and it was until after the launch on the Clinical and Operational Strategy in October 2023 that the revision of the BAF was commenced with the initial outline of potential new strategic risk being presented to the Board of Directors in March 2023. In July 2023 it was agreed to move to exception reporting. The BAF was reviewed and updated by the lead Executive Directors regularly during 2023/24.

5 Monitoring and reporting

Board of Directors received during 2023/24:

- The strategic risk overview in July 2023 and moved exception reporting (until refreshed BAF in place) and received exception reports in September and November 2023.
- initial outline of identified potential strategic risks to the achievement of the objectives within the Clinical and Operational Strategy.
- the operational risk overview including any extreme if applicable received in May (RMF Annual Report), July, September and November 2023.
- Operational risk report detailing current extreme risks received in March 2024 – as per revised terms of reference in place from January 2024.

Quality Committee received and reviewed their respective:

- Strategic risks exception reports in September 2023
- Operational risks including any relevant extreme risks in May, July, September and November 2023 and January 2024 – as per original terms of reference.

Finance Digital and Estates Committee (revised name from January 2024) received and reviewed their respective:

- Strategic risks exception reports in October and December 2023
- Operational risks including any relevant extreme risks in April, June, August, October and December 2023 – as per original terms of reference.

People and Organisational Development Committee received and reviewed their respective:

- Operational risks including any relevant extreme risks in April, June, August, October and December 2023 - as per original terms of reference.

Mental Health Act Committee (revised name from January 2024) received and reviewed their respective:

- Operational risks in May, August and November 2023. – as per original terms of reference.

CLE Risk Management Group received and reviewed:

- Profile data in February and March 2024
- Risk moderation in February and March 2024 (included moderation of two escalating risks suggested as extreme in March).
- Longstanding risks – February 2024
- High Scoring risks – February 2024
- Common risks – March 2024
- Theme Report – Recruitment and Retention in March 2024

6 Summary and future actions

The Risk Management Framework Annual Report 2023/24 demonstrates that the Trust has in place robust arrangements for Risk Management acknowledging there is scope for further development. There was particular focus on risk identification in year resulting in more comprehensive capture of the risks to the Trust.

There is however further work to keep the momentum behind this revised risk culture and for risk management to be proactive with emphasis on recording risk and not issues following the cleansing work undertaken as part of the risk workshops.

Future actions for 2023/24 are to:

- Recruit Head of Risk Management as dedicated resource to further develop risk culture and keep momentum going.
- Continue to work with key individuals to support on the monitoring, review and identification of risks including the review of the risk descriptions with particular focus with risk owners regarding risk reviews.
- Support the further stratification down to directorates within the risk registers
- Review the risk scoring methodology to ensure it remains fit for purpose for the Trust
- Review existing risk appetite and develop for use with operational risks and well as

the strategic risks

- Develop training package identified in the revised Risk Management Framework and commission externa risk awareness training for the current risk leads and the members of the Risk Management Group
- Engage in procurement of new recording system and transition over, including developing easy step guide for users.
- Develop reporting in line with new Risk Management Framework and work toward produce automatic reporting on new system
- Undertake workshops with risks leads and corporate leads to explore whether all risks have been identified.
- Work with Directors fully develop revised BAF and then to ensure that any gaps within the Board Assurance Framework are being addressed, controls introduced assurances being received.