NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 30 January 2025 at 10.00am
Water's Edge, Barton, North Lincolnshire

No	Item	Request to	Lead	Enc.
1	Welcome		KL	
2	Apologies for Absence: Dave Vallance	Note Information		
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest			A
Patient Story				
5	Patient story – Learning Disabilities	Information	SF	Verb
Standing items				
6	Minutes of the meeting held in public on the 28 November 2024	Decision	KL	B
7	Matters Arising and Follow up Actions	Decision		C
Board Assurance Committee Reports to the Board of Directors				
8	Quality Committee	Assurance	RF	D
9	Audit Committee	Assurance	KG	E
10	Mental Health Act Committee	Assurance	SFT	F
11	People & Organisational Development Committee	Assurance	RB	G
12	Public Health Patient Involvement & Partnerships Committee	Assurance	RF	H
13	Finance, Digital & Estates Committee	Assurance	PV	I
14	Trust People Council	Assurance	KL	J
15	Chief Executive's Report • Including the approval of the terms of reference – All Age Eating Disorders Joint Committee	Information/ Decision	TL	K
BREAK				

RDaSH nurturing the power in our communities

16	Promise 14 – inc waiting lists	Information	RC	L
17	25-26 Capital Plan and 25-26 Indicative Revenue Plan	Decision	IM	M
18	Workforce – Staffing Overview (inc Dec 24 vs 24/25 plan and vs Dec 23)	Information	CH	N
19	Promises 3 and 4	Information	SF	O
20	High quality therapeutic care taskforce (HQTC) – further discussion	Information	TL	P
21	<u>Our 8 Plans</u> Digital People and Teams Quality and Safety Equity and Inclusion Finance Estates Research and Innovation Learning and Education	Consider	TL	Q
Operating Performance / Governance / Risk Management				
22	Operational Risk Report - Extreme Risks	Assurance	PG	R
23	Strategy Delivery Risks 2024/25	Assurance	PG	S
24	Promises and Priorities Scorecard	Assurance	TL	T
25	Integrated Quality Performance Report (IQPR)	Assurance	TL	U
Supporting Papers (previously presented at Committee)				
26	Mortality Report Guardian of Safe Working Hours Report	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 28 November 2024 (private session)*	*Decision*	KL	AA
32	*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
33	*Reflections on the patient story*	*Discussion*		Verb
34	*Chief Executive Private Update to the Board of Directors*	*Information*	TL	CC
35	Update on Elizabeth Quarter and Waterdale developments	*Information*	IM	DD

*** 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 27 March 2025 10am at CAST, Sir Nigel Gresley Square, Doncaster.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Chloe Pearson, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	30 January 2025

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

- The report is presented as a standing agenda item at each meeting to ensure board awareness to any declarations and if needed, actions taken to prevent any conflicts during the business of the Board.
- No new declarations have been made.

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

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

Paper presented to each public Board meeting

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

The Board is asked to:

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

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

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

Appendix (please list)

None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

BOARD OF DIRECTORS – REGISTER OF INTERESTS

Executive Summary

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

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

Amendments are shown in bold text.

Name / Position	Interests Declared
Kathryn Lavery, *Chair*	• Owner / Director of K Lavery Associates Ltd • Chair ACCIA Yorkshire and Humber Panel • Consultant with Agencia Ltd. • Chair of the Advisory Board Space2BHeard CIC HULL • Non-Executive Director at Locala Community Interest Company
Toby Lewis, *Chief Executive*	• Nil
Richard Banks, *Director of Health Informatics*	• Wife works in administration at Sheffield Children's NHS Foundation Trust.
Rachael Blake, *Non-Executive Director*	• People and Transformation Lead – Jacobs (Global Rail & Transit Solutions Provider) • Elected Member - City of Doncaster Council • Trustee - South Yorkshire Community Foundation • Director - Bawtry Community Library

Name / Position	Interests Declared
Richard Chillery, Chief Operating Officer	• Nil
Dr Richard Falk, Associate Non-Executive Director	• Medical Consultancy advice to H I Weldricks Pharmacies (who have a footprint across the RDaSH geographical area).
Steve Forsyth, *Chief Nursing Officer*	• Coach at the Gambian National Police Force • Ambassador and Affiliation for WhizzKidz • Non-Executive Director for the African Caribbean Community Initiative • Fellow of the Queens Nursing Institute (QNI).
Philip Gowland, *Board Secretary and Director of Corporate Assurance*	• Wife is Primary Care Strategic Lead employed by RDaSH.
Dr Jude Graham, *Director of Psychological Professionals and Therapies*	• Trustee for the Queens Nursing Institute • Executive Coach – registered and accredited with the European Mentoring and Coaching Council • ImpACT International Fellow for the University of East Anglia.
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.

Name / Position	Interests Declared
Jo McDonough, *Director of Strategic Development*	• Nil
Izaaz Mohammed, *Director of Finance and Estates*	• Chair of Governing Body – Westmoor Primary School, Church Lane, Dewsbury, West Yorkshire. • Trustee of Howlands Community Hub – charity based in Dewsbury which runs arts and crafts sessions for people with learning difficulties and physical disabilities.
Dr Diarmid Sinclair, Chief Medical Officer	• Nil
Sarah Fulton Tindall, *Non-Executive Director*	• Member of the Patient Participation Group at the NHS Heeley Green General Practice Surgery, Sheffield. • Age UK Readers' Panel member.
Dave Vallance, *Non-Executive Director*	• Nil
Pauline Vickers, *Non-Executive Director*	• Independent Assessor for the Business to Business (B2B) Sales Professional Degree Apprenticeship for Middlesex University and Leeds Trinity University • Associate Coach with Performance Coaching International • Managing Director and Executive Coach Insight Coaching for Leaders • Director of Marsh and Vickers Coaching Limited

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 30 January 2025

Patient Story: Learning Disabilities

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 28 NOVEMBER 2024 AT 10.00AM THE CENTRE, BRINSWORTH LANE, BRINSWORTH, ROTHERHAM, S60 5BU

PRESENT

Kathryn Lavery	Chair
Richard Chillery	Chief Operating Officer
Dr Richard Falk	Non-Executive Director
Sarah Fulton-Tindall	Non-Executive Director
Steve Forsyth	Chief Nurse
Kathryn Gillatt	Non-Executive Director
Carlene Holden	Director of People and Organisational Development
Dawn Leese	Non-Executive Director
Toby Lewis	Chief Executive
Izaaz Mohammed	Director of Finance and Estates
Dr Diarmid Sinclair	Interim Medical Director
Dave Vallance	Non-Executive Director
Pauline Vickers	Non-Executive Director

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Lea Fountain	NeXT Director
Philip Gowland	Director of Corporate Assurance / Board Secretary
Dr Jude Graham	Director for Psychological Professions and Therapies
Jyoti Mehan	NeXT Director
Jo McDonough	Director of Strategic Development
Laura Brookshaw	360 Assurance
Jo Cox (v)	Lead Governor
Sarah Dean	Corporate Assurance Officer (Minutes)
Ann Llewellyn (v)	Governor
Ian Spowart (v)	Governor
Nick Skinner	Staff Story
Dr Stephen Kellett	Staff Story
4 members of the public	

Ref		Action
Bpu 24/11/01 & Bpu 24/11/02	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. Apologies for absence were noted from Non-Executive Directors Rachael Blake and Dr Janusz Jankowski. Mrs Lavery gave thanks to Mrs Leese for her work and contributions as Non-Executive Director for the past eight years, as well as Senior Independent Director (SID) and Chair of Quality Committee (QC), noting this was her final Board of Directors meeting. Mr Vallance will succeed Dawn as SID, and Dr Falk as Chair of QC.	
Bpu 24/11/03	**Quoracy** Mrs Lavery declared the meeting was quorate.	

Bpu 24/11/04	**Declarations of Interest** Mrs Lavery presented the Declarations of Interest report which outlined the changes to the register since the last meeting. These related to Mrs Vickers' new interest, Director of Marsh and Vickers Coaching Limited, and Mr Gowland, whose wife was employed within the Trust as Primary Care Strategic Lead. A new declaration of interest was noted for Mr Forsyth regarding his Fellowship of the Queens Nursing Institute (QNI). **The Board received and noted the changes to the Declarations of Interest Report.**	
	STAFF STORY	
Bpu 24/11/05	**Staff Story: Reducing Restrictive Interventions (RRI) Project** Mrs Lavery welcomed Nick and Stephen to the meeting who were invited to share the outcomes of a controlled RRI pilot project undertaken in the Rotherham Adult Mental Health Care Group to improve patient safety through organisational culture on the psychiatric intensive care unit (Kingfisher). Nick had worked within the organisation for a number of years and spoke about his first experiences of restraint on the wards, which he felt were chaotic and unorganised with the patient left feeling frightened and frustrated with no subsequent support. Nick was now the Trust's RRI Training Lead and highlighted the opportunity he had to work directly with the Kingfisher Ward as part of the RRI pilot project to assess how the training was reflected and implemented on the wards. Nick witnessed a culture that needed to change from restraint being the first option. Nick spent time with a member of staff on the ward as an RRI Advocate, to bridge the gap between training and reality, and to effectively implement the training as part of day-to-day practice. This was successful in terms of openness and transparency, improvements were made in terms of incident reporting with a positive change in culture on the ward. Stephen worked on Kingfisher as a Consultant Psychologist and in the Grounded Research Team, he spoke about the use of restraint being difficult for patients and staff and the importance of ensuring there was a culture where restraint was an occasional necessity. In terms of evidencing change, there were 2 stages to the pilot project, the first being to understand what predicts restraint using a regression analysis, the analysis highlighted staff variables which led to the culture change project and the RRI Advocate role to support and coach staff before, during and post restraint. This work was supported by a reflective practice group which was facilitated on the ward on a weekly basis. The controlled pilot project commenced in September 2021 and the data was reviewed for 19 months pre-intervention and 19 months post intervention against a control ward to assess the impact of the project. A comparison exercise was then undertaken with another control ward pre-intervention which highlighted the positive impact of the RRI Advocate, the use of full restraint had reduced by 50%, seclusion was	

	being used less frequently, and a reduction in the use of rapid tranquillisation. Stephen noted that the evidence would be published nationally, including within the British Medical Journal and with other trusts to share evidence and learning around the use of the RRI Advocate role to ensure safe practice and a change in culture to reduce the use of restraint. Mr Lewis referred to the upcoming funding decision on this work, he was interested in Stephen and Nick's reflection in terms of deployment and rolling out the project Trustwide, he suggested a separate discussion to think through the critical success factors to move this forward. Stephen supported each ward having an RRI Advocate that could ensure safe practice, associated learning and to support a culture change. Mr Forsyth referred to the regression model which was utilised in his previous trust and the collaborative approach to RRI in a Psychiatric Intensive Care Unit (PICU). The data was reviewed in hours using a traffic light system which was reduced and sustained to zero. Mr Lewis clarified that there would be a further discussion at the Clinical Leadership Executive (CLE) in February 2025. Dr Graham suggested to review the number of people with attachment issues to assess whether it prolonged the issue. Mrs Lavery and the Board thanked Nick and Stephen for taking the time to speak about the RRI project and experiences and noted the intended reflection time later on the agenda.	
	Stephen and Nick left the meeting 10.25.	
	STANDING ITEMS	
Bpu 24/11/06	**Minutes of the previous Board of Directors meeting held on 26 September 2024** **The Board approved the minutes of the meeting held on 26 September 2024 as an accurate record, subject to a minor wording amendment requested by Ms Fulton Tindall under 24/09/19 (Biannual Report of the Board's Security Champion)**	
Bpu 24/11/07	**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.	
BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS		
Bpu 24/11/08	**Report from the Quality Committee (QC)** Mr Falk presented the paper and noted the conversation in the Committee regarding Rotherham Care Group and the patient safety report. Mr Chillery referred to the care group's delivery review that took place this week where never events and safe staffing levels were rated	

	as good for Rotherham. He noted that the delivery reviews provided an opportunity for additional check and challenge. Mr Lewis clarified that there was no intention to intervene with the Care Group in the next 10 weeks; the Voice Scorecard as taken to Trust People Council (TPC) would provide some softer intelligence in terms of feedback. Work was ongoing to develop a management escalation process with agreed parameters for intervention, by January 2025. Dr Falk highlighted the discussion held with regards to agency staffing and the importance of not becoming complacent, the plan was to liaise with services with previous high agency use to gain their perspective and track any unintended consequences. **The Board received and noted the report from the Quality Committee.**	**RC**
Bpu 24/11/09	**Report from the Audit Committee** Ms Gillatt presented the paper and referred to the key points of discussion, all of which were demonstrating good progress. She noted the response to the external audit recommendations and the low-level areas that the Trust was proposing not to progress with. The Risk Management Framework report was positively received and demonstrated the robust management and oversight of risk. A progress update was received in respect of research governance and a similar piece on education governance would follow at the next meeting. **The Board received and noted the report from the Audit Committee.**	
Bpu 24/11/10	**Report from the Mental Health Act (MHA) Committee** Ms Fulton Tindall presented the paper, highlighting that the Committee was pleased to note the successful Trust Associate Managers (TAM) recruitment process. There were 277 detentions within the Trust during quarter 2 and challenges remained in respect of Documentation Compliance, Consent to Treatment on Admission and Section 132 Rights. The Committee noted that the Trust had acted unlawfully within some of these compliance areas. Ms Fulton Tindall highlighted the positive impact of the new weekly urgent metrics review which contributed to improvements seen in Consent to Treatment and Section 132 Rights. **The Board received and noted the report from the Mental Health Act Committee.**	
Bpu 24/11/11	**Report from the People & Organisational Development (POD) Committee**	

	Mr Vallance on behalf of Ms Blake presented the paper and referred to the key areas. The Committee supported the Acceptable Behaviour Policy. With regards to the Workforce Disability Equality Standard (WDES), Mr Vallance recognised the similar pattern of deterioration to the WRES data in terms of bullying, harassment and abuse by managers and colleagues. This was taken to the Trust People Council for further discussion and work continues to develop a robust action plan. Freedom to Speak Up (FTSU) – The Committee noted the issue around detriment and the Standard Operating Procedure (SOP) that was being developed to address this. James Hatfield (FTSU Guardian) would be providing a FTSU presentation to the new Governors to enhance their understanding. Mr Lewis noted the intent to progress with FTSU SOP and have it in place by the end of December 2024 with a robust process to manage this going forward. **The Board received and noted the report from the People & Organisational Development Committee.**	
Bpu 24/11/12	**Report from the Public Health, Patient Involvement & Partnerships (PHPIP) Committee** Mr Vallance presented the paper, highlighting the open and transparent presentation from Mrs McDonough regarding the concerns on meeting the delivery measures for Promise 8. Further data and understanding of commitment was required to mobilise the organisation for the RDaSH 5. An update on school readiness (Promise 17) was received which proposed what the Trust would do differently and posed questions around capability and next steps in terms of innovation. Mr Lewis clarified that the Board would consider the 8 supporting plans at January's meeting, noting Research and Innovation maybe delayed, but that it would be further consideration of this during quarter 4. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	
Bpu 24/11/13	**Report from the Finance, Digital & Estates (FDE) Committee** Mrs Vickers presented the paper highlighting the key risk around the financial deficit position, linked to the potential shortfall in the funding of the pay award. She referred to the Board's agreement in September (at M7) to submit an updated forecast to NHS England if the shortfall in allocations materialised. Mr Mohammed noted that discussions, including Mr Lewis and ICB partners remained ongoing. Fire safety compliance remained a key area of focus and was currently partially compliant. The Committee requested a further update at the next meeting around the fire safety door inspection programme of work.	

	The Committee approved the conclusion of the procurement arrangements for the Electronic Patient Record (TPP). Mr Banks confirmed the procurement documentation exchange was almost complete. Mr Lewis requested for the underlying financial position to be presented at future meetings to enable the Board to focus on this. Mr Mohammed confirmed that this would be reflected within future reports. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	**IM**
Bpu 24/11/14	**Report from the Trust People Council (TPC), including Terms of Reference** Mr Vallance presented the report which included Trust People Council Terms of Reference for the Board's approval. In response to Dr Falk's query regarding the quorum, Mr Lewis agreed to amend the wording to ensure it was clear that Board members must not form the majority of the quorum. The group received the initial Voice Scorecard which sought to bring together key people data, such as vacancies, with feedback data drawn from FTSU, incidents, and staff survey. Further refinements were planned to the scorecard and this would be utilised in future Committee and Board meetings. Mrs Leese expressed her support for the Voice Scorecard which provided an ability to see the associated staff and patient data. Mr Lewis noted that time was spent at the last delivery reviews to review the first phase results of Care Opinion - this would be a focus at the Board timeout in February 2025. There was a particular focus on ensuring the data was being utilised at all levels of the organisation, initial feedback from teams was so far optimistic and positive with specific recognition to Stuart Green (Patient Experience & Involvement Lead) for driving this work forward. Mr Chillery expressed the importance of recognising where data is missing and ensuring everybody's voices were equally heard. **The Board received and noted the report from the Trust People Council.** **The Board approved the terms of reference for the Trust People Council.**	**TL**
Bpu 24/11/15	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report. The report detailed the current vacancies, Mr Lewis was enthused that approximately 90 new members of staff had joined the organisation over the last 2 rounds of induction.	

Positive progress was being made with regards to flu vaccinations and the goal to reach 3000 vaccinations. The Trust was in a high position nationally and had exceeded last year's numbers.

Mr Lewis attended the last Quality Committee to provide an update on regulation 28 reports issued to the Trust. He reminded colleagues of the report issued to NHS England in relation to the Medical Emergencies in Eating Disorders (MEED) guidance, a paper would be presented from the South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative to the ICB in January 2025 to formally delegate the national guidance or address the substantial non-compliance.

The most recent regulation 28 letter issued to the Trust, which the Board had previously been sighted on, was in relation to the death through suicide of a patient in Rotherham Older Peoples Services. Mr Lewis noted that a response had been issued to the coroner and revised guidance had been issued to staff within Crisis Services to amend the age parameters that most likely two thirds of services had worked with previously. He clarified the responsibility of management to ensure that the age parameters were clear.

With reference to the regulation 28 issued around mental health disengagement, the actions would be implemented, however the intended progress hadn't been made to date. The Trust had taken the opportunity to assess the approach in other areas, given it was a national issue.

Mr Lewis noted the work in relation to the case of Annette, who sadly passed away 10 years ago. He confirmed that the Coroner had recorded that the Trust was contributory negligent to her early death. It was agreed to refresh the action log and re-energise the work signed off by the Board in 2021, with a particular focus on how patients with learning disabilities are viewed they are being cared for within other services.

Mr Lewis referred to the successful position on the transfer to NHS Professionals, meetings continue with partners and the initial data suggested that the majority of the 600 shifts were being filled. There would be a further evaluations undertaken during quarter 1 2025/26.

There were approximately 180 volunteers currently in roles across the Trust with an aim to have 250 by April 2025. Mr Lewis noted that teams were taking on volunteers who hadn't previously been engaged and they were embracing volunteers.

Ms Fulton Tindall was pleased to see the work ongoing around ensuring high therapeutic quality care and suggested for the Board to receive a further update given the importance and the amount of change involved. Mr Lewis noted the discussions held with executive colleagues on the importance of implementing this work and the support for the wards required throughout the year to get it right.

Mr Chillery referred to the achievement with NHS Professionals and the ambition to achieve zero agency use by the end of the year, he linked

	this with the discussion held at the last Quality Committee around remaining curious and the review of persistent lines of enquiry to understand any unintended consequences. There remained a risk on the risk register in relation to Speech and Language Therapy, and he noted that this was a specialised area that NHSP couldn't necessarily provide. Ms Fountain made reference to the medication provision for people diagnosed with ADHD and sought further understanding around the reduction by about 30 appointments per month. Mr Lewis clarified that this was currently affecting the ability to maintain the trajectory. The adult improvement plan, to achieve 4 week waits in 2026, was on trajectory, as well as Doncaster children's services. North Lincolnshire wasn't currently on trajectory, Rotherham had doubled activity over the last 3 months which was encouraging, however the trajectory was more challenging. The revised guidance on medication provision had been considered by the CLE and the Trust was compliant. The Board noted the creation of the Rotherham primary care shared care agreement which would go live in January 2025 and the work required with Rotherham General Practitioners (GP) to support the use of medication that was available nationally. With reference to 1.1 and 1.2 within the report, Ms Holden noted the benefits of discussing the positive feedback from Care Opinion at the last care group delivery reviews, and seeing this being recognised as part of the newly introduced local rewards scheme. Mr Lewis felt that the implementation of Care Opinion would provide real insight and afford the opportunity to preserve and share good practice, as well as identifying the aspects that required change or improvement. **The Board received and noted the Chief Executive's report and the forward actions it contained.**	
KEY MATTERS FOR DECISION OR ASSURANCE		
Bpu 24/11/16	**Care Quality Commission Readiness: Well-Led** Mr Gowland presented the report and reminded the Board of the approach to Well-Led agreed in May 2024. Good Governance Improvement (GGI) would be returning in quarter 4 to provide their input on related work. The paper set out the Well-Led key questions and the current position of the evidenced-based assessment undertaken with a RAG rating, in line with the CQC assessment framework. The assessment was developed with input from a number of colleagues across the Trust and work would continue to collate the necessary evidence over the coming months. He noted the use of Care Opinion and the Voice Scorecard, both referred to earlier in the meeting, as important pieces of evidence and felt that the initial overall assessment was balanced, positive and reflective of the work undertaken on the Trust's the new operating model. The launch of the new Leadership Development Offer (LDO) would further enhance the ability to provide relevant evidence. Mr Gowland suggested to provide a further update on progress in March 2025.	**PG**

	Mrs Lavery found the report helpful, particularly the appendices which provided a view of where the evidence would be collated from. Dr Falk queried if the quality statement criteria and definitions was based on the CQC framework, Mr Gowland confirmed that the template had been completed in line with the CQC framework. Mrs McDonough drew attention to the changes made since the paper was last reviewed and the importance of considering the associated impact. She felt that better linkages could be made within the report, such as the diversity mix of FTSU vs the feedback from the WRES / WDES, and further information included within the sustainability section. Mr Gowland noted the reference within the Shared Direction and Culture around stakeholder feedback and the demographic data being collected and analysed. Mr Gowland welcomed other feedback provided that linked to the way in which the assessment reflected a ward to Board, collective understanding and how the respective 'voices' from right across the Trust would need to be included. Further, that the assessment should develop to include all relevant sources of assurance – and triangulation between them, opportunities for learning and that the associated timescales (to become 'green') needed to be realistic. Developing a common understanding of the assessment would be important for the Board and others and Mr Gowland reiterated his intention to bring a further update to the Board in March 2025. Mr Lewis was keen to be sighted on the parameters of the next GGI review and supported the positive / negative assurance construct. He then commented on the CQC methodology and the real insight required into the broader view of the indicators and the associated evidence. **The Board received and noted the update and status report in respect of the Well-Led key question, the next steps and planned reporting schedule.**	**PG**
Bpu 24/11/17	**Sexual Safety Charter – Action and Results** Dr Graham presented the report which provided an update on the work associated with Sexual Safety and the Sexual Safety Charter in the Trust. She reminded colleagues that the Board signed up to the Sexual Safety Charter during quarter 3 2023/24 and outlined the work undertaken in terms of the baseline assessment and with the national workstreams to develop a consistent policy and training for organisations - this was released at the end of October 2024. Further work was required to improve this area and reference was made to the staff story and that some restraint incidents did relate to sexual safety. The 8 step plan was detailed in the report which was linked to the NHS England findings.	

	In response to Mrs McDonough, Dr Graham advised that the team had liaised with the staff networks and the baseline data collection found that only females were reporting sexual safety incidents over the last 5 years. The planned work included reaching out to males to understand why the reporting wasn't higher. This had been a topic of discussion within the Women's Network and work was ongoing with public health colleagues around sexual safety. Dr Graham informed colleagues that the majority of the incident reports received were from staff of a black minority, this was subsequently discussed at the REACH network and with the spiritual care team to understand further. Mr Mohammed considered how new staff joining the Trust were informed around areas such as sexual safety. Dr Graham and Ms Holden were working on this as part of the Leadership Development Offer and the National Directors Network. Mr Lewis referred to the 149 incidents regarding patients to staff and questioned the realistic aims to address this. Dr Graham noted the zero-tolerance initiative and that this would be unachievable given the circumstances. However, proactively preventing sexual abuse in the workplace and ensuring people were supported to speak up was the aim. Dr Graham noted that some staff had left the organisation due to the experience they had in terms of sexual abuse, which was predominately within inpatient settings. Ms Holden noted the feedback in the staff survey relating to patient to staff incidents and significant work required, 1 in 4 women and 1 in 18 men had been sexually abused, this equated to 849 women and 37 men within RDaSH, however the IR1 system did not demonstrate those numbers. She considered if the approach to tackle racist incidents could be replicated in respect of sexual safety. Dr Sinclair questioned if there was a robust methodology to incorporate students and trainees and felt that this was an underreported area. Dr Graham advised that a robust reporting mechanism for people such as volunteers and students was required, however these were factored in as part of the national process. Mrs Lavery summarised the discussion and a further update would be provided to a future meeting. **The Board received and noted the ongoing workstreams associated with Sexual Safety and the Sexual Safety Charter.**	
Bpu 24/11/18	**An Overview of Research Activity in the Trust** Dr Sinclair presented the paper which provided an overview of research activity in the Trust and how the priorities within the Research and Innovation Plan were beginning to be addressed. The paper also considered the barriers within clinical services to enable the building of R&D capacity and capability.	

	The Grounded Research team had embarked on a project using the Self-Assessment of Organisational Readiness (SORT) tool, this was currently being trialled within the Children's Care Group with potential to identify the learning and apply to other areas across the Trust if successful. Dr Falk spoke about the importance of research and that patients wanted to be involved. He encouraged further development of research within the Trust, noting the income it could generate, the positive reputation and benefits in terms of recruitment and attracting new starters. Dr Falk then referred the Grants and Expressions of Interest (EOI) and queried one of the key reasons declining EOIs being studies were mainly looking for PIC sites, he recognised the opportunity for the Trust to become a PIC site to GP research. Mr Lewis provided a RAG rated response to three aspects of the paper with the consistent delivery of portfolio targets year on year representing a 'green' achievement and he congratulated the team on that success. The 'amber' related to the need for work as an executive team to develop research Trust-wide and move the Trust towards being more 'research-ready'. He then referred to essentially his 'red' area and the six priorities presented in Appendix 1 – which was an honest presentation of the current state in his view. With a couple of exceptions, he felt there was further work required to refine and enhance some of the workstreams in Q4. Dr Sinclair explained that the Trust was in discussions with a research company that undertook psychedelic research - the company were exploring the lease of one of the Trust's buildings in Doncaster to conduct studies. The current models of using psychedelic drugs was in association with assisting therapy, with the appropriate dose. If this aspect of research wasn't undertaken, the likelihood of this being rolled out with a timeframe for patients being able to access would be small. Mr Lewis clarified that a decision would be made in the next 6 weeks and clinical colleagues had expressed their material interest. Mrs McDonough noted the work required to agree the focus for research fundraising, as part of the Trust's charity. Patients and communities were interested in research and would feel motivated to donate to that purpose if the reasoning was clarified. Mrs McDonough, Mrs Vickers and Dr Sinclair agreed to explore this further outside of the meeting. Mr Vallance expressed that research was part of everybody's job role and considered the work required to enable capacity and capability to implement this across the organisation. Dr Sinclair discussed the multiple ways to enable dedicated time for staff to be involved in research. Mr Chillery referred to discussions held regarding staff and need to support our communities to be involved in research, he mentioned the newly developed research facility in Sheffield for Children.	

	Dr Graham noted that sessions were available as part of the learning half days for all staff to gain a further insight and understanding into research and patient ambassadors were involved in the research team. She expressed the importance of helping staff have the identify of being a researcher. Mrs Lavery advised that the Governors were equally interested in research as staff and community representatives. Mr Lewis noted the need to recognise the excellence of Grounded Research could be an inhibiter as well as an enabler. Work was required over the next 6 months to change that. Ms Fulton Tindall suggested including the values of research in job descriptions, Dr Sinclair provided an example where a member of staff accepted a job at RDaSH with research being the deciding factor. A further update would be provided to the Board in due course. **The Board received and noted the overview of progress in Research in the Trust over the last 6 months.**	
Bpu 24/11/19	**Productivity at RDaSH 2025/26** Mr Mohammed presented the paper which provided an overview of the early findings from the Akeso productivity review commissioned by the South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative in September 2024. The review included identifying the potential productivity gains in Older Adult Inpatient Services, Community Mental Health Teams (CMHT) and Children & Young People Services (CYP). Productivity improvements of £3.8m were identified for RDaSH which were detailed within the paper, some of which were aligned to existing workstreams. Data quality was highlighted as a barrier to this work and was driving a number of the variances. Mr Vallance recognised the link to the value for money assessment and felt that an internal arrangements should be in place to determine if value for money was being provided, with consideration as to how this linked with productivity. Mr Mohammed agreed that the two elements should be aligned. Dr Falk raised concerns in respect of the RDaSH geography and the work required with primary care to improve the referral process from primary care into CMHTs and ensure all patients are allocated a service. Mr Lewis requested a further update on this work within the next 6 months. Mrs Leese considered how this information was shared with clinicians and productivity reports were a great opportunity to explore further improvements with clinicians.	**IM**

	Mrs Vickers supported the paper and recognised the joint working opportunity through the Finance, Digital and Estates Committee and the Quality Committee. Mr Gowland drew attention to the inappropriate referrals from primary care and questioned if there were other external influences to address that would support with the Trust's productivity. Mr Mohammed advised that other external influences would be included within the pilot. Mr Lewis pointed out the relevance of DIALOG+ to this work and the purposive nature of how we change clinical time, he agreed to further explore the connectivity between the two workstreams. Mr Lewis then noted the importance of ensuring time was the currency of this work and the focus on clinical time spent with complex patients. **The Board received and noted the progress of the Akeso review and the potential productivity gain identified of up to £3.8m within RDaSH, noting the other productivity work streams the Trust intended to take forward, including how the work will be delivered.**	
Bpu 24/11/20	**Promises 6, 7 and 8 – Accelerating Delivery** Mrs McDonough presented the report which explored the barriers to making progress with Promises 6, 7 and 8 and the ways to accelerate delivery. In terms of Promise 6 – Poverty Proof all services by December 2025, the Trust had worked a partner organisation, Children's North East, to undertake the 3 pilots in North Lincolnshire CAMHS, Podiatry in Doncaster and Early Intervention in Psychosis in Rotherham. The pilots were a success and the teams were positively engaged and feedback was being sourced from patients and the communities. The draft report received for the Podiatry pilot identified opportunities for reducing the impact of poverty on people's ability to access services, including the challenges with regular travel to access care and treatment. Promise 7 – Work had been undertaken to identify all of the Core20Plus5 measures and those that were relevant to RDaSH services. The associated challenges related to the data and information that existed for patient cohorts within our care and primary care. Work was ongoing to resolve this to ensure it was clear which patients fell under the learning disability (LD) service and Serious Mental Illness (SMI) service, for each area. There was a risk of not meeting the December 2024 target for achieving 95% coverage for health checks for those patients with an SMI or LD. Promise 8 – this promise builds on the Core20plus5 measures by focusing more on people with autism, a learning disability or a mental illness, 4 out of 5 areas had been identified to date where we want to reduce inequity. The challenge was identifying the key actions to lead to change and subsequently address the issues. Mrs McDonough and Mr Lewis would be meeting with the 4 areas to address the challenges, some which was around capacity and capability.	

	Mr Chillery referred to Promise 7 and SMI, work was ongoing to meet the RDaSH lists by December 2024 and discussions had been held with the ICB on the wider system work. Mr Lewis emphasised the work required to receive an aggregated view of all SMI and LD patients. With reference to Promise 6, Ms Fountain sought to further understand the barriers for people attending appointments. Mrs McDonough advised that some of the barriers were financial, but others were the availability of appointments, transport and location. The key actions were to support people with these challenges, such as flexibility of appointments, moving services closer to people and transport. Mr Gowland linked this to the Strategic Delivery Risks and recognised the need to ensure leaders had the ability and capacity to have those conversations. Mr Chillery noted the targeted work required to understand what we class as DNA and disengagement for deprived areas, and the link to previous discussions regarding productivity. Mr Lewis recognised the need for further discussion on the approach to poverty proofing and the associated programme of work, and emphasised the need for impactful work and change and not just commenting on inequalities. Mrs McDonough invited Board members and Governors to become part of the Poverty Proofing programme. **The Board received and noted the assessment of work undertaken and learning to date for Promises 6, 7 and 8**.	
Bpu 24/11/21	**Baby Friendly Status** Dr Graham presented the paper which provided an update on the work and workstreams associated with being a 'Baby Friendly' organisation, and the UNICEF Baby Friendly Initiative (BFI). Dr Graham was the Baby Friendly Guardian for the Trust and explained the reason why this work was required, which included the negative advertisements around breastfeeding women and the lack of appropriate facilities being available. She noted that in some local communities that breastfeeding rates were low. In terms of delivery focus, the Trust's baby friendly services were in North Lincolnshire and Doncaster. Dr Graham highlighted that the UNICEF Baby Friendly Initiative (BFI) were recommending the gold accreditation for North Lincolnshire – the final results would be received next week. Work was ongoing with the Doncaster team to prepare its application to 'go for Gold' too. Actions were in place to improve the workplace 'baby friendly offer'. Mr Lewis asked if the Board could provide any useful support to this work, Dr Graham noted the responsibilities from leadership perspective	

	in terms of knowledge and openness, the ability to have active discussions with parents and carers. Mr Chillery acknowledged the praise received for the work undertaken by Dr Graham, and the importance of considering school readiness. Ms Holden linked the discussion to Strategic Delivery Risk 5 and the capacity and capability to develop leaders. The staff survey data identified good results in terms of flexibility working, however deeper dives highlighted that some managers decline flexible working requests, and there was a need to further understand this data. It was suggested that a breastfeeding mum would attend the Board for a future patient story. **The Board received and noted the content of the report and the ongoing workstreams.**	
The Chair on behalf of Board gave a presentation to Mrs Leese. *Mrs Leese left the meeting at 13:30*		
ROUTINE REPORTS		
Bpu 24/11/22	**Operational Risk Report** Mr Gowland presented the report which highlighted the current extreme risks and the high impact / low likelihood risks. There were currently 4 extreme live risks and work continued with the accountable directors to review the risks with monthly scrutiny via the Risk Management Group. In line with the Risk Management Framework, it was important for the Board to be sighted on the high impact / low likelihood risks and work was ongoing to ensure these risks were represented on the risk registers. In terms of high impact and low likelihood, Mrs Lavery referred to the recent water supply issues in Doncaster and the risk of this re-occurring and the associated impact. Mrs Lavery then discussed the risk of flooding being on the risk register, Mr Gowland agreed that this would be considered as a high impact and low likelihood risk. Mr Lewis noted the expectation for all departments to work through their high impact / low likelihood risks by March 2025, Mr Gowland advised the Head of Risk Management was driving this forward and more work would be done to effectively identify these risks. Mr Lewis referred to the ligature risk update due at the Board in March 2025 which linked to 3 of the risks highlighted within the paper. With regards to HI 4/23 around the discontinuation of support for Windows 10 in October 2025, Mr Banks clarified that the mitigation was part of a current Replacement Programme. Mr Mohammed referred to RCG 12/24 regarding the replacement of the Thymatron machines used in the Rotherham ECT, he advised that the procurement process had been finalised and the replacement machines would arrive within the next few weeks.	

	Ms Gillatt considered the management of key system risks, recognising those against the Trust's portfolio. Mr Gowland was engaged with his counterpart at the South Yorkshire ICB who shared their risk register and Board Assurance Framework, an element of this would be introduced as part of the Risk Management Group work around the broader understanding of system risks. Mr Banks referred the South Yorkshire ICB Cyber Security Forum, noting that some risks were generic across health organisations but being responded to with differing mitigations. The group provided a good opportunity for supporting and learning from each other. **The Board received and noted the Operational Risk Report update.**	
Bpu 24/11/23	**Strategy Delivery Risks 2024/25: Q3 Report** Mr Gowland presented the report which focused on SDR 2 and 5, both of which were subject to review at the respective Committee's in October 2024. The paper highlighted the latest position for both risks and noted the revisions in the format to respond to previous commentary to provide clarity where action had been taken, this was now highlighted in bold text. Given the nature of the strategic risks, Mr Gowland noted that progress may be slower than the mitigation of operational risks and referred to pivotal work required to mitigate the strategic risks. Ms Holden referred to SDR 5 and the leadership development offer, noting that there was engagement with community colleagues to develop the programme. The staff survey closed on the 29 November 2024 and the results would provide related data for this risk. In terms of SDR 2, Mr Banks highlighted the opportunity presented through using the learning half days to delivery training and offer support to staff, for both known areas and areas that had emerged through the digital needs survey. Mr Lewis clarified that SDR2 was focused on precise data quality. Mr Lewis noted that the learning development offer would contain an assessment of individuals capabilities and quantified measures would be identified from the first 6 months. Ms Holden noted that a tool would be rolled out to feed into the wider evaluation of the programme. Mrs McDonough referred to the delivery of social value and felt that there wasn't enough knowledge and understanding within the organisation and considered if this could be factored into the leadership development offer. **The Board received and noted the Strategy Delivery Risks 2024/25 report, noting the planned next steps to enhance reporting.**	
Bpu 24/11/24	**Integrated Quality Performance Report (IQPR)**	

	Mr Chillery introduced the Integrated Quality Performance Report (IQPR) for October 2024. With reference to the top 10 areas of delivery – a strong position was reported for adult access services, perinatal, dementia, adult ADHD, virtual ward and talking therapies. Children & Young People (CYP) access remained below the target by 179 children, there was a plan in plan to achieve this by the end of December 2024. Section 136 breaches had improved during November 2024 and this continued to be a key focus area. In terms of safe staffing, there was a decline in safe staffing numbers during October, Mr Forsyth reported the closure of Emerald Lodge had contributed to this and following review, this was now an improving picture. Mr Mohammed provided an update on the financial performance, the position at the end of October 2024 was a deficit of £152k, this was £154k adverse compared to the revised plan. The biggest influence on this included the pay award income accrual of £386k, a change forecast had been submitted to the South Yorkshire ICB. The Trust was on track to deliver the plan this year, with the exception of the pay award. In terms of the delivery of revenue, Mr Lewis advised that this would require 3 of the 6 care groups to deliver their budget, and 3 to deliver better than budget – the final numbers would be confirmed next week. Mr Lewis noted the progress with the capital expenditure plan and confirmed that following a meeting with Mr Mohammed and the Head of Estates, that schemes (IT related) had been brought forward from 2025/26 to recover the current year position. Mr Lewis was now confident that the 2024/25 plan would be achieved. **The Board received and noted the Integrated Quality Performance Report**.	
Bpu 24/11/25	**Promises / Priorities Scorecard** Mr Lewis presented the paper highlighting that the Board received and supported the format at the last meeting. Mr Lewis reiterated the focus on eliminating the plan ‘reds’ going into Q1 2025/26 and was confident that there was an emerging and coherent plan for the majority of those areas. Further work was required to develop a comprehensive plan for Promise 2, this would be a focus area at the Executive Group team away day. Promises 2, 9, 13 and 25 were specifically highlighted in the paper as challenging areas of delivery. Mrs McDonough referred to Promise 27 (achieving net zero) and the anticipated difficulties with moving from red to amber. The current options for achieving this were significant in terms of infrastructure and associated costs. Mr Lewis agreed with the difficulties in delivery, but	

	noted however that it was possible to build a coherent plan that would achieve delivery. In response to Ms Gillatt, Mr Lewis confirmed that the emerging estate ideas would achieve approximately 20% of the net zero and carbon emissions target. There was a need to replace the power system and options for this were being looked into, including potential support from the Government. **The Board received and noted the Promises / Priorities Scorecard update on the work to date and expectations in 2025/26.**	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEES)		
Bpu 24/11/26	**Supporting Papers** Mrs Lavery informed the Board of the following additional reports for information which were presented as supporting papers that had previously been presented at committee level for scrutiny and challenge: • Mortality 6 Monthly Report • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Report 2024 • Guardian of Safe Working Hours • Freedom to Speak Up (FTSU) Biannual update Mr Lewis referred to the discussion held at the last Quality Committee regarding the backlog of Structured Judgement Reviews (SJR) and the importance of distinguishing this between understanding the reasons people had died in RDaSH care vs the wider learning around mortality. Dr Falk discussed that the learning from deaths policy was dependent on the completion of SJRs, and therefore partial assurance had been taken. Dr Graham clarified that the Trust was sighted on all deaths through the incident reporting system reviewed through the daily incident meetings and the Mortality Operational Group. **The Board received and noted the additional reports for information.**	
Bpu 24/11/27	**Any Other Urgent Business** There was no further business raised.	
Bpu 24/11/28	**Any risks that the Board wishes the Risk Management Group to consider** Mr Lewis requested for the three SMI lists to be included in the risk register if not already covered, Mr Chillery agreed to clarify.	**RC**
Bpu 24/11/29	**Public Questions** There were no questions raised by members of the public.	

Bpu 24/11/30	The Chair resolved '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press would be excluded from the remainder of the meeting, which would conclude in private*.'	

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

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/11/16a	**CQC Readiness: Well-Led** Mr Lewis was keen to be sighted on the parameters of the next GGI review and supported the positive / negative assurance construct.	PG	**January 2025:** GGI review including observation opportunities has commenced. Note provided to all Board members regarding the review and associated timescales and the previous GGI report was re-circulated to all Board members.	Propose to Close
Bpu 24/11/28	**Risks that the Board wishes the Risk Management Group to consider** Mr Chillery agreed to clarify if the three SMI lists were included on the risk register.	RC	**January 2025:** Risk (Ref: O5/24) is referred to within the operational risk report (Paper X) on today's agenda and is currently assessed as 'extreme'	Propose to Close
Bpu 24/11/13	**Report from the Finance, Digital and Estates Committee** The underlying financial position to be presented at future meetings to enable the Board to focus on this.	IM	**January 2025:** The underlying position now forms part of standard FDE reporting, and is also reflected within the latest revenue and capital paper before the public Board.	Propose to Close
Bpu 24/11/14	**Report from the Trust People Council - Terms of Reference** Agreed to amend the wording within the TPC terms of reference to ensure it was clear that Board members must not form the majority of the quorum.	TL	**January 2025:** Adjustment made and reported to the TPC meeting held on 29 January 2025.	Propose to Close
Bpu 24/09/21	**Out of Area Placement Risk Share** Mr Mohammed and Mr Lewis to continue negotiations with HNY ICB / North Lincs Place to achieve an equitable OOA placement risk share, in line with the parameters agreed for SY.	IM	**January 2025:** Izaaz Mohammed continues to progress discussion with the ICB in North Lincolnshire to secure parity of agreement, recognising that because the Trust's control total is not within their finances a slightly different risk arrangements may be needed.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/11/08	**Report from the Quality Committee** Work was ongoing to develop a management escalation process with agreed parameters for intervention, by January 2025.	RC	**January 2025:** Relevant executive colleagues met on January 28th to progress the 25/26 'Support and Intervention model' with particular reference to issues of safety. The resultant model will be further considered during February before final issue through the Clinical Leadership Executive membership. It will also be brought into the Quality Committee for awareness in March.	Open
Bpu 24/09/25	**Integrated Quality Performance Report (IQPR)** The new RTT pathways for mental health (OP08d) continues to improve, but remained slightly below the 92% target.	RC	**January 2025:** Paper U IQPR presents the latest data showing in month performance at 74.29% (YTD 81%) with main challenges remaining within North Lincolnshire and Talking Therapies Care Group.	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).	TL	**January 2025:** further to previous update on (2) – now at business case stage with ICB, TL has briefed QC on 1). Actions not yet completed and now due to complete by **March 2025**.	Open
Bpu 24/07/12	**Report from the Quality Committee – MCA compliance** There will be a full review and recovery plan of MCA compliance – recommended to be presented to QC in Q3/Q4.	SF	**January 2025:** This action will be addressed through a paper to the Quality Committee in **March 2025,** after consideration within clinical leadership executive.	Open
Bpu 24/09/19	**Biannual Report of the Board's Security Champion** The final agreement of the role was deferred until later in 2024/25.	PG	**January 2025**: This matter will be re-scheduled for discussion in **March 2025**.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/11/16	**CQC Readiness: Well-Led** Important for the Board to remin sighted and engaged in the progress with the readiness for assessment.	PG	**January 2025:** A further update on progress will be presented in **March 2025**.	Open
Bpu 24/05/23a	**Ligature Risk** Ligature risk and door safety - there will be a full review of ligature risk by ward, by Q4.	SF	**January 2025**: As noted at the previous meeting, a full review of ligature risks by ward has commenced. Upon completion it will be presented to the Board in **May 2025**.	Open
Bpu 24/11/19	**Productivity at RDaSH 2025/26** Concerns were raised in respect of the RDaSH geography and the work required with primary care to improve the referral process into CMHTs. Mr Lewis requested a further update on this work within the next 6 months.	IM	**January 2025:** The SDR reported through PHPIP Committee this month and within the SDR Paper S, refers to the primary care referral process – as a key area of focus. An update, as requested, will feature when the next update on Productivity is received in **Q1 25/26**.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper D
Date of meeting:	22 January 2025		
Attendees:	Dr Richard Falk (Chair), Dr Janusz Jankowski, Steve Forsyth, Dr Diarmid Sinclair, Richard Chillery, Richard Banks and David Vickers. In attendance: Phil Gowland, Laura Brookshaw (360 Assurance), Vicky Clare.		
Apologies:	Dr Jude Graham, Dave Vallance, Maureen Young.		
Matters of concern or key risks to escalate to the Board:	**Resuscitation Update** – Concerns were raised in respect of level 2 and 3 resuscitation training compliance and the potential impact on quality & safety. Further understanding required around patterns of non-attendance and withdrawal from training.		
Key points of discussion relevant to the Board:	**Patient Safety Report, October and November 2024** –The Committee noted the top five patient safety incidents and the work that was ongoing in respect of PSIRF. The importance of ensuring the learning from patient safety incidents was consistently embedded and sustained was noted. **Strategic Delivery Risks Report (SDR4) -** The Committee received the latest position and noted the controls and plans to mitigate any risks to the delivery of high-quality therapeutic bed-based care. **RDaSH Response to the Greater Manchester Mental Health NHS Foundation Trust Independent review** – The Committee noted the baseline position against the five key recommendations identified from the independent review. A further assessment would be undertaken in March 2025 to measure improvement and identify any areas that require further action. **Integrated Quality Performance Report (December 2024 data) –** Continued improvement in the recording of MUST assessments and the number of episodes of seclusion receiving an internal MDT assessment continues to require focus across the organisation. The Committee reflected on the reporting arrangements for the IQPR and the focus on each quadrant at the respective Committees.		
Positive highlights of note:	**Inpatient Safe Staffing, October and November 2024** - The Committee noted the plans in place, enhanced reporting and oversight to effectively manage safe ward-based staffing levels. **CQC Registration Reporting** - The Committee was assured that the CQC registration requirements were being kept up to date. **Patient Experience Report –** The Committee received an update on promise 4 and noted the successful implementation of Care Opinion and the significant improvements made in terms the meaningful feedback from patients and carers.		
Matters for information:	None.		
Decisions made:	None.		
Actions agreed:	**Mortality Report –** The Committee noted the current position in respect of Structured Judgement Reviews (SJR) and the progress with Regulation 28 notices. There will be a further update at the next meeting on the trajectory to address the backlog of SJRs and the alignment with PSIRF.		

Dr Richard Falk, Non-Executive Director and Chair of the Quality Committee
Report to the Board of Directors meeting scheduled for 30 January 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Date of meeting:	4 December 2024		
Attendees:	Kathryn Gillatt (Chair), Pauline Vickers and Dr Richard Falk. In addition: Phil Gowland, Steve Forsyth, Izaaz Mohammed, Matthew Curtis (360 Assurance), Laura Brookshaw (360 Assurance), Sophia Umoh (360 Assurance), Leanne Hawkes (360 Assurance), Carlene Holden, Jill Savoury.		
Apologies:	No apologies were received.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Education Governance Progress Report -** Education governance had been mapped into 3 distinct areas, namely, 1) internal to the trust, 2) operational services and 3) external to the trust. For AC oversight purposes this will be enhanced for the governance and assurance wrap around model and subsequently shared with AC. It was noted that outputs from External Reports feed into Education and Learning Group and the People and Teams group. The approach to CPD spend this year has been through a Training Needs Analysis aligned to RDaSH strategy and promises. **Counter Fraud, Bribery and Corruption Progress -** Summary provided of the counter fraud work. It was noted November was fraud awareness month. One referral was received that did not need criminal investigation but was being followed up through the disciplinary route. Following a review of where the trust sits in relation to the counter fraud functional standards, has resulted in 6 actions being identified and followed up. **Internal Audit Progress Report -** Six reports were issued, 3 resulting in limited assurance, 2 significant and 1 with a split of significant and limited. Follow up audit actions are in a good position with 87% of the high and medium being closed on time and 91% of all risks being closed on time. **RDaSH (Internal Audit) Progress Report** • The internal audit review of the Strategic delivery risks linked to the Head of Audit Opinion had been given a revised date of December 2024 for completion, this was on track. • The high-level procurement risk due September 2024 was still outstanding, reported to be complete by December 2024. Guidance has been developed and would be rolled out following review by 360 assurance. • The overall number of outstanding internal audit recommendations was shown to be decreasing but this was expected to see an increase following the recent issue of a number of reports. **Annual Governance Statement update -** The mid-term statement was received by the Committee, a draft statement would be provided to the meeting in February 2025. Following discussions, it was agreed that the internal audit for data quality would be replaced in the audit plan by waiting list management.		

	Standing Financial Instructions - In the quarter, the company seal had been used once, two losses and compensations had been issued and single quote waivers had reduced significantly. AC were advised that Q4 single source could be expected to increase. AC noted that work is underway as part of procurement and contracting improvement plan which should reduce the need for single source quote waivers. The full impact is not likely to be seen until the 25/26 financial year. **Patient Monies Review -** Benchmarking had been undertaken with other mental health and community trusts around patient monies. A review in quarter 4 would be undertaken of the policy that underpins the management of patient money with any recommendations impact assessed.
Positive highlights of note:	**Risk Management Framework update -** A deep dive of all risks was undertaken by the Head of Risk Management. The maturity assessment had moved on significantly. **Internal Audit Progress Report -** Follow up audit actions are in a good position with 87% of the high and medium being closed on time and 91% of all risks being closed on time.
Matters presented for information or noting:	None.
Decisions made:	**Disposal of zero net book assets -** Approved in principle the disposal of 136 zero net book assets relating to IT equipment and staff lease cars.
Actions agreed:	None.

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

Report to the Board of Directors meeting scheduled for 30 January 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Mental Health Act Committee	**Agenda Item:**	Paper F
Date of meeting:	18 December 2024		
Attendees:	Sarah Fulton Tindall (Chair), Rachael Blake, Toby Lewis, Dr Diarmid Sinclair.		
Apologies:	Dr Janusz Jankowski, Dr Jude Graham.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**MHA Compliance Report, September and October 2024** **MHA Training Compliance** - MHA Level 3 training was a continued challenge in some areas of the Trust (78% Trust wide), as was Reducing Restrictive Interventions (RRI) training (Disengagement 69% and Comprehensive 77%). A further update would be received at the next meeting regarding the plans in place to address this. **Consent to Treatment (at 3 months) – Internal Consent to Psychiatric Medication forms** - The Committee noted that completion of forms stood at 100% for North Lincolnshire, 88% at Doncaster and 86% at Rotherham. It is anticipated that the position would further improve with less agency staff and the development of learning videos for those medics new to the Trust. **Section 132 Rights** – There was fluctuation in compliance with performance decreasing in some areas, particularly in Rotherham in 81 out of 91 cases (84%) and North Lincolnshire, 40 out of 46 cases (87%). The Committee noted that the system for recording was being re-designed to allow for easier recording in SystmOne and reporting. **MHA Performance Report, September and October 2024** **Seclusion of patients** - There was a focus on ensuring the consultant review had been completed within 5 hours of a seclusion episode, and this was achieved in 86% of cases during September 2024 and 60% of cases during October 2024. The Committee was supportive of the approach to work with consultants and junior doctors to address process and communication issues that have been identified and subsequently improve compliance. **Annual MHA Equalities Report 2023/24** – The Committee was pleased to receive the first annual equalities data report. It was agreed to look again at the presentation of the data in order to better understand the main findings and align these with the key focus areas of the Trust, so that we can actively use the data to support our ambitions. Another version of the report would be forthcoming later this year.		
Positive highlights of note:	**MHA Compliance Report** • Of the 308 detentions during September and October 2024, 100% were lawful and 44 required amendments, the majority of which related to spelling errors. None of the required amendments meant that any patient was unlawfully detained at any point. • 100% of detentions were compliant at the point of scrutiny by Matrons and Medics. Consent to Treatment - This was an improving picture particularly in Doncaster and North Lincolnshire due to the introduction of the weekly urgent metrics		

	review undertaken by wards, the Trustwide compliance was 94% (on admission). More work still needs to be undertaken to improve compliance further, whilst achieving consistency across the Trust. The legally required MHA consent to treatment forms were in place for all patients as at the 3-month deadline.
Matters for information:	None.
Decisions made:	None.
Actions agreed:	**MHA Detention Activity** – The Committee noted apparent differences in levels of detention across the three Care Groups. It was agreed that the next report would have a focus on the data to identify and better understand any concerns in respect of significant differences in detaining practice, either by geography, clinician or ward.

Sarah Fulton Tindall, Non-Executive Director, Chair of the Mental Health Act Committee
Report to the Board of Directors meeting scheduled for 30 January 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper G
Date of meeting:	18 December 2024		
Attendees:	Rachael Blake (Chair), Dave Vallance, Pauline Vickers, Carlene Holden, Richard Chillery, Steve Forsyth, Lea Fountain, Richard Rimmington, Ian Spowart.		
Apologies:	Dr Jude Graham, Dr Diarmid Sinclair.		
Matters of concern or key risks to escalate to the Board:	**Staff Incidents, Violence and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Report (RIDDOR) Q2 2024/25 -** There was a particular focus on the sexual and racist incidents and the next steps to address this would be discussed in more detail at the next meeting.		
Key points of discussion relevant to the Board:	**Strategic Delivery Risk 5** – The Committee noted the overview of planned mitigating actions, including the development of the Trusts Leadership Development Officer (LDO), induction programme and full utilisation of the apprenticeship levy and the learning half days. **Integrated Quality Performance Report** – The vacancy rate was reducing, 5.97% (at 30 November 2024) the trust would aim to achieve full staffing (97.5%) by 31 March 2025 balanced with monthly turnover from retirees and leavers. Sickness absence had increased from 5.92% to 6.09% in November 2024 with an increase in short term sickness – data supplied to care groups to identify patterns and take appropriate action. **Guardian of Safe Working Hours report** – Most Exception Reports were for working more hours than scheduled during daytime (10), followed by Breech of Contractual Rest Periods (8) and Excess Hours worked during On-call (4). An amended work schedule will be put in place for new trainees and current trainees to receive back pay. Doncaster had more breaches than previously reported. **NHSP implementation and wider learnings –** Areas of good practice including agency reduction costs and areas for further improvement noted, lessons learnt review including benefits realisation to be presented in April 2025. **Annual Medical Revalidation Feedback 2023/24 –** Summary of data provided, feedback highlighted that 2% of colleagues advised that they wouldn't have the same appraisal again, targeted work required to further understand this data and how improvements could be made to ensure all colleagues have a positive appraisal.		
Positive highlights of note:	• **Gender and Ethnicity Pay Gap** – The gender pay gap had reduced to 4.45, this was a positive comparable from the 7.5 previously reported. • Success of the flu campaign and the wider outreach, the Trust had been noted as the best within the Region.		
Matters for information / noting:	**Partnerships update** – Ongoing engagement with partners as part of the LDO in relation to co-design and participation.		
Decisions made:	None.		
Actions agreed:	**Continuing Professional Development (CPD) Update** - The Committee noted the overview of the CPD spend allocation as at 6 December 202 (currently £321k) with an analysis by protected characteristic. Agreed to undertake a comparison exercise with the previous financial year to the Education & Learning Group.		

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

Report to the Board of Directors meeting scheduled for 30 January 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper H
Date of meeting:	22 January 2025		
Attendees:	Rachel Blake, Dr Richard Falk (Acting Chair), Toby Lewis, Carlene Holden, Jo McDonough, Janusz Jankowski, Diarmid Sinclair		
Apologies:	Dave Vallance, Jo Cox, Jyoti Mehan, Ruth Sanderson.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Gypsy Roma Traveller Community -** Funding has been approved for the Gypsy Roma Traveller link worker for the Children and Young People Services, this would start in quarter 1 2025/26. **Community Involvement Framework -** An update was provided in respect of ongoing work around community involvement. A draft framework was approved for further development. **Health in equalities data -** The data for health inequalities was presented along with the progress made in monitoring measures related to the Equity and Inclusion Plan. New national reporting mechanism are due, and it was acknowledged that work would be needed to accommodate these **Promise 6 - Poverty proofing -** The information from the 3 poverty proofing pilots were received, these were North Lincolnshire CAMHS, Doncaster Podiatry and Rotherham Early Intervention. Insights from the Early Intervention Team pilot in Rotherham were shared and they highlighted the importance of the process, the challenges faced, and the potential solutions to address poverty-related issues for both patients and staff **Promise 21 – Primary Care Networks and hyperlocal -** An update was provided on primary care networks and implementing hyperlocal projects, with an emphasis on the potential for collaboration with GP practices on pilot projects. **CRO/Trust Partnership -** The Committee noted the emerging partnership with a Clinical Research Organisation who are specialists working in Central Nervous System research. **Strategic Delivery Review -** The strategic delivery risk relating to SO1 and SO3 were visited and progress towards lowering the risk scores was noted. It was agreed that there needed to be a clear methodology to demonstrate how risk had objectively been decreased.		
Positive highlights of note:	**Promise 6 – Poverty Proofing -** The poverty proofing paper was well received and there was much enthusiasm for the process.		
Matters presented for information or noting:	None.		
Decisions made:	**Promise 6 - Poverty proofing -** Continuing with the same methodology, the Committee noted the change to the deadline of December 2025 to September 2026.		
Actions agreed:	None.		

Dr Richard Falk, Non-Executive Director and Acting Chair of the Public Health, Patient Involvement and Partnerships Committee

Report to the Board of Directors meeting scheduled for 30 January 2025.

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Digital & Estates Committee	**Agenda Item:**	Paper I
Date of meeting:	18 December 2024		
Attendees:	Pauline Vickers (Chair), Richard Banks, Sarah Fulton Tindall, Carlene Holden, Izaaz Mohammed, Ian Spowart, Rachael Blake, Richard Chillery and Richard Rimmington		
Apologies:	No apologies were received.		
Matters of concern or key risks to escalate to the Board:	The Committee noted continued progress with fire compliance and discussed plans to maintain resilience. The South Yorkshire Fire Service currently undertake informal visits to the Trust to provide advice on areas of focus and will complete an audit of the Trust's fire safety compliance in 2025. The outcome will be reported to the Committee.		
Key points of discussion relevant to the Board:	**Estates Update** – Fire risk assessment backlog reducing, priority given to high-risk areas and capital schemes in place to address remedial works. Slippage in planned work at Great Oaks, however 2025/26 IT projects will be brought forward to mitigate slippage. **Estates Enabling Plan** – Two lease projects underway and expected to be signed off by end of the financial year. **Month 7 Finance Report** – at Month 7, the Trust was £150k off plan, verbal update provided for Month 8 of £270k. This was linked to the Adult Eating Disorder overspend and the pay award shortfall beginning to come through. At month 8 there had been some AED discharges and the year-end forecast was expected to be balanced or a small deficit of approximately £20k. **Strategic Delivery Risk (SDR) Report** – progress noted for the allocated SDR SO2.		
Positive highlights of note:	**Agency expenditure** - Trust was a positive outlier in relation to agency expenditure across South Yorkshire region and ICB were looking how other trusts could apply a similar approach.		
Matters presented for information or noting:	**Draft Finance Enabling plan** – Planned to go forward with scenario one which would put the trust at a £6.2 underlying deficit with the achievement of a balance by the end of 2026/27. **Out of Area Risk Share** – CEO in process of writing up a specification for South Yorkshire. North Lincolnshire required further scoping.		
Decisions made:	No decision were made.		
Actions agreed:	No actions agreed.		

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

Report to the Board of Directors meeting scheduled for 30 January 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Trust People Council	**Agenda Item**	Paper J
Date of meeting:	29 January 2025		
Attendees:	Kath Lavery, Toby Lewis, Carlene Holden, Jacqui Hallam (Womens'), Glyn Butcher (Patient rep), Tinashe Mahaso (REACH), Dr Mike Seneviratne (staff gov), James Hatfield (FTSU), Jennie Gaul (staff gov), Prachi Goulding (staff gov), Simon Mullins (LNC), Laura Wiltshire (Rainbow), Vicki Mitchell (Rainbow), Amanda Ambler (DAWN), Atique Arif (volunteer), Victoria Stocks (staff gov)		
Apologies:	Dave Vallance (Chair), Sue Statter (JLNC), Dr Nav Ahluwalia (Senior doctors committee), Babur Yusufi (GOSWH), Jessica Williams (staff gov), Emma Wilsher (staff gov)		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**Remote working:** Extensive discussion about how the revised framework can better support individuals, teams and services to work flexibly. Recognition that the Trust offers greater flexibility currently than the legislation requires. Appreciation that for some employees working from home is essential for example, for carers' responsibilities. But for others, it may be a refuge. **Leadership training:** Discussion on the Trust's single ringfenced training budget (and its implications for doctors), together with consideration of how to ensure that our leadership training programmes attend to all needs. **Real living wage:** Presentation in support of its intended implementation in April 2025. Helpful discussion about how to narrate the detail and the reasoning for a disproportionate focus on poverty pay. **Staff governors:** Initial conversation about how to buddy and support these important new roles. **Voice scorecard:** Further consideration of data item and presentation to include EDI information. **Carers network:** Brief introduction to fifth network and its intersectionality with other staff groups.		
Positive highlights of note:	Launch of staff carers network on 13th February 2025.		
Matters presented for information or noting:	None		
Decisions made:	Strong collective endorsement for the real living wage.		
Actions agreed:	New format for voice scorecard which supports the diverse readership and co presentation of patient feedback scorecard.		

Kath Lavery, Chair (on behalf of Dave Vallance, Non-Executive Director and Chair of the Trust People Council)
Report to the Board of Directors meeting scheduled for 30 January 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper K
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	30th January 2025

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

The paper summarises work to be ready for 2025/2026, whilst also highlighting key current issues within Q4 of 24/25: your attention to drawn to work within both collaboratives, and to continued progress with cultural and OD interventions to develop the Trust internally, which have been the focus of recent CEO reports. Service changes in crisis and in older people's services are cited.

The Board may wish to spend time on the implications of the wider financial landscape for the Trust's plans, as we move towards implementation of the Real Living Wage in April. We need to ensure that we have the bandwidth and structure to implement in real life changes to out of area placement care, reducing restrictive practices further, and seeing through our promise 14 move to a four week wait, in which CAMHS is leading the way.

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	**APPROVE** delegation of children's and adult eating disorder funding and material decision making to the new Joint Committee outlined at Annex 5

Impact

Trust Risk Register	x	F 3/24 S 6/22, S 2/22, S 4/24, PCG 21/24, NLCG 1/23, RCG 2/23, CCG 17/24, DCG 18/24, RCG 17/23, E 11/24
Strategic Delivery Risks	x	Leadership Development Offer & SDR1, SDR 3 Health Inequalities Data - SDR2
System / Place impact	x	See text, multiple reference to system / place re: financial positions of ICB, potential Joint Venture in HNY, and wider neighbourhood working 'shift'

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 December and January 2025
Annex 2: Current register of Trust vacancies December 2024
Annex 3: National publications December 24/January 25
Annex 4: Board summary of South Yorkshire MHLDA Collaborative Board (January 25)
Annex 5: Proposed terms of reference – All Age Eating Disorders Joint Committee

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report

January 2025

1.1 It should be evident that much of the agenda before the Board today is about getting ready to **start 2025/2026 at the very beginning of Q1**. Consistent with our strategy, agreed in July 2023, we are working in quarters of the year, not on an annualised basis. There is a strong measure of continuity of effort, learning from what has and has not worked, and moving forward determinedly. The capital plan agreed in May 2024 is renewed for the year ahead, we revisit the work done to reduce vacancies and maintain a near-agency free staffing model, and we review updates on our volunteer expansion and patient voice work.

1.2 There are some nuances or point of re-emphasis: for the third meeting in a row, we discussed work to deliver strategic objective four, and within that to re-imagine our bed-base. The **High-Quality Therapeutic Care taskforce starts work on February 12th**. In light of the emergency closure of an older people's ward in Rotherham in early January, this is timely – as the intent to provide three-year clarity on the scale, and shape, of those beds is important to confidence.

1.3 The financial forward look regionally makes a difficult backdrop to these ambitious plans. In 24/25, the Trust, in effect, received no growth funding of any form. This led to a deficit plan, despite successful delivery of our largest ever cost improvement programme (£16m over 18 months). Moving into 25/26, this lack of any funding for growth, **or tariff equivalent adjustment for new costs like NICS or national pay awards in full**, produces a likely near-standstill deficit position for the year ahead, equivalent to just over 1% of turnover. ICB-wide discussions continue about how to best support left-shift policies, match prevalence changes in our population, and deliver wait time reductions that staff want and local people need and deserve.

1.4 It is important to note the moves to local devolution in both North/Greater Lincolnshire and across South Yorkshire. This is accompanied by a welcome focus on worklessness, to which the Trust can contribute in two ways: as an employer able to reach deep into traditionally marginalised communities, including older adults wanting second or third careers, and a provider of services to those out of work. Of note **the SY Mayoral Combined Authority has acknowledged a lack of support for neurodivergent younger adults as a significant barrier to employment** – a description that must be met by a constructive and impactful offer from the local NHS and wider provider partners.

Our patients

2.1 The Trust continues to be at the forefront of work to improve care for **those with eating disorders**. The Trust's children's service has a standout short-wait offer (consistently below four weeks and routinely within days). As a commissioner of adult services, we continue to seek to improve care and provide more community-based care. We welcome the commitment of the ICB to continued investment to 'level up' services, and the development of new services in North Lincolnshire. At Annex 5 are draft terms of reference/schedule to support to the go-live of a delegated Joint Committee of four Trusts and the ICB to create what appears to be the country's first all-age eating disorders pathway commissioning model. The Board has agreed repeatedly, during 2024, that this is a necessary condition for sustained change and is requested to offer formal endorsement for the proposal.

2.2 With the news that the sixth '**health-based place of safety'** suite is now funded in Sheffield, we are well placed to press on with our programme to ensure that S136 suites are open and available, and that no-one resides within one for longer than twenty-four

hours. There is a continued downward trend since the commitment to this goal in July 2024, and we need to ensure that, when the suite is damaged, it can be rapidly refurbished. Throughput in the suite in Barnsley and Sheffield is now subject to the same dataset and monitoring as our own approach and our interdependence is understood.

2.3 The Board discussed **restrictive practices** (RRI) at its last meeting. Analysis of our seclusion suites suggests that average length of use is just above one day, and that there is no spike in use, for example as bed closures occur. The likely rise in use with the move away from out of area placements from July 2025 is acknowledged. The MHA Committee did note some concerns over MDT review, where we have made a subsequent change to policy, which should clarify multi-professional engagement. The wider plan of work to address RRI during 2025/26 will be addressed in my report at the next meeting, as indicated in November.

2.4 The continued expansion of **virtual ward occupancy**, and use of our community based IV service, are perhaps our most significant contribution (other than flu vaccination) to the wider system 'winter' effort. We have again recorded our best ever volume of virtual ward care, and the move to recruit to two community geriatrician roles provides a strong basis for implementing 'step up' care as part of the capability: the key game changing initiative advised to local partners by external review of the service late last year.

2.5 Within this month's delivery reviews, we will again focus on **waiting times for children and young people needing mental health support.** The Trust has invested to reduce to no more than a few weeks neurodiversity diagnostic assessments in 2026, and our other CAMHS services have been seeking to deliver and sustain four weeks for some months. We are certainly on the cusp of doing so, which is welcome, and we will stress-test in Q4 staff and patient perceptions of the experience of using the getting help and getting advice service. This service is perhaps at the forefront of some of the genuine challenges of the promise 14 commitment that we gave – one addressed on a much broader scale within today's papers and expected to be the focus for much of our investment funding going into the year ahead.

2.6 We have spoken extensively about work to improve services for older adults across both our physical and mental health services. Moving to services without birth-date restriction remains a priority for the clinical leadership executive. The implementation of **changes within our crisis services** to create a consistent approach Trust-wide , whilst not without disquiet about pace, was cited by the coroner subsequently for its importance. Monitoring of the workload arising from the changes continues monthly. In these changes, and others to come, we need to make a reality of enhanced support and training to colleagues more used in their practice to supporting working age adults – and Dr Gemma Graham will lead a session with the Board on that subject, as she did with CLE last summer, in February 2025.

Our people

3.1 Recognising our focus on developing our directorates, as managers of today, and liberating care group leaders to focus with the executive and partners of tomorrow, we continue to consider how best to develop those teams. The creation of directorates in late 2023 provides a basis for bringing service teams together at a local level, but also requires those directorates to either work cross-trust (as in learning disabilities and forensics) or to collaborate with peer directorates in different places. For corporate teams, a shift to understanding the needs of all thirteen teams may feel more challenging on occasion than working solely with five care groups. **The intent, and the prize, remains a deeper, broader and more responsive management model – and on that, better reflects the diversity of our services** (only five of the directorates – three in mental health, and two within physical health services contain a bed-base).

3.2 The various leadership development (LDO) programmes that mark 2025 have now started. The first half of our 'LDO' with the top leaders' cadre kicked off in mid-January at the Doncaster Knights rugby club. Programmes to support first line manager, and clinical leaders in thought leadership roles, commence in Q1 25/26. We know that the move to a more responsive leadership model, **including 360-feedback as routine for line managers**, represents another major cultural change in the organisation. This will support the wider work we need to do on employee feedback through the quarterly pulse surveys and the latest 2024 annual staff survey.

3.3 The Trust People Council has been established to provide a real focus on the current and future culture of our organisation. The successful election of **a full suite of staff governors (6)** offers another important voice to that body (and to the council of governors), alongside trade union representatives and those drawn from staff networks. Our staff networks grow again in February with the launch of the carer's network, which is one part of our Promise 2 efforts.

3.4 Whilst the focus of the senior leadership of moving away from the use of agency staffing has been widely discussed, and reviewed, and remains a focus of work, it is important to recognise other major shifts in people-practice. One of those is the intent to ensure that structured and agreed job plans exist annually – and **that 'SPA time' is both protected and purposive**. While that language is traditionally associated with the medical contract, Jon Rouston, Jude Graham and others have been leading work to embed similar disciplines into AHP roles, psychological professionals and roles including nurse consultants. In the main, such SPA time (apart from the element devoted to CPD) will support education, research or leadership, and the transition to these expectations may, understandably, represent a shift – as such the Trust is working closely with neighbouring organisations to compare approaches and paths of change.

3.5 Opening up research to a wider cohort of employees is very much part of our work in the year ahead. The Board reviewed the research arrangements of the Trust last time, as we did education in July, and it is clear there is **more to do to make research accessible to a broader group of professionals**. Both our portfolio practice and our commercial work are significant, and we look forward to collaborating with partners at Sheffield Children's Hospital on their groundbreaking new child health technology centre. Our Children's Care Group are leading the way internally with their focus on multi-professional research – and other teams are seeking to borrow some of their techniques as we make research governance and scaling up part of the mainstream management model for 25/26.

3.6 The clinical leadership executive discussed **sickness absence rates** at its last meeting. We know that these vary among teams, services, and professions. The right approach must prioritise care for the individual, and nothing in this work should be construed as seeking to push people back into work before they are ready. Our focus on reducing turnover and 'turbulence' within teams carries with it an expectation that we support employees over the medium term. It is, however, the case that sickness does drive use of temporary staffing and sometimes places significant pressure onto smaller teams, or shifts. During Q4 the focus is on better understanding our current patterning, before working through the right adjustments to make to try to create a fairer approach over coming months.

Our population and partners

4.1 Over recent weeks, we have completed work at executive and full board level within the South Yorkshire Mental Health LD&A Collaborative. These efforts have been informed by the Care Professionals Assembly, created last year, as well as by active patient and community involvement. The **likely future direction for the collaborative's programme will see greater focus in 2025/26 on dementia care** across South Yorkshire, as we look

to recognise the rising need, and the potential to support both younger adults and older adults with diagnosis and support.

4.2 In Humber and NY, discussions continue about a move to a risk-bearing vehicle for mental health provision across the ICB. Such a proposition will depend on a multi-year funding agreement prior to any go-live proposal, and understandably such important work is taking time. In the meantime, there has been investment to **develop a specialist community rehabilitation service in North Lincolnshire**.

4.3 In terms of our strategy (promises 15/21) and our Strategic Delivery Risks (SDR/BAF), the Trust aims to develop more consistent links with local general practice. This is very much a localised development through our care groups, but with central support through the new primary care liaison manager within strategic development. Whether in terms of ARS roles, or in **delivering the four liaison priorities agreed for 25/26 through CLE**, we need to retain focus on this critical relationship: and to reduce paper-based processes and inter-sectoral handoffs.

4.4 At the latest public health, patient involvement and partnerships committee we discussed again ongoing work, under promise 5, to work better with the third sector. Projects like the charity's small grants programme will help to build relationships. The future structure of **a more strategic relationship with VCSE bodies will vary by place**, and again, like primary care collaboration, will be locally driven with some corporate support (in this case via nursing and facilities).

4.5 Alliances and shared intent continue to matter very much, perhaps especially in making sure that a 'neighbourhood led' NHS is just that. It is welcome, for example, to have strong support from North Lincolnshire Council to develop and secure the Elizabeth Quarter site**, as one part of our Scunthorpe triangle**. Investment in St Nicholas House took place in 24/25, and the Great Oaks redevelopment will be completed during 25/26. When we conduct our team-to-team with the local authority's senior leaders in February, we will then discuss our focus across the district's villages.

Toby Lewis, Chief Executive
January 21st 2025

Annex 1

Clinical leadership executive – December 2024 and January 2025

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.

December	January
Review of CLE functioning	Capital plan 25/26
Project Timepiece (admin support to medics)	Sickness absence YTD – and forward look
HQTC Taskforce	Reducing restrictive practices
Leadership development	Volunteering update
	Cost improvement programme 25/25

In terms of decisions made, in December we focused on how the taskforce would work with Care Groups, yet through directorates. We also explored the clinical leaders' programme which sits alongside the LDO. January's meeting considered the capital programme and work to secure £6m of savings safely across the coming year.

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 (February/March) we will consider, in particular:

- The operating model as we consider GGI's work: notably our CLE subs,
- The trajectories for wait time improvements during 2025,
- How we support our work to meet core CQC standards,
- An update on Care Opinion,
- Our policy and practice approach to both remote working and remodelling PDRs

Toby Lewis, Chief Executive
23 January 2025

Annex 2 Current vacancy summary

This report continues to adapt. It is to be hoped that budget/ESR misalignments have now been resolved in full. At year-end, we will provide a full reconciliation of role growth vs 23/24 outturn and complete the required assessment vs pre 20/21 staffing positions.

Org L4	FTE Budgeted	FTE Actual	FTE Variance		Awaiting Authorisation	Out to Advert	Shortlisting	Interview	Offered	Start Date Given	Total
376 DMHLD Community Services	339.73	321.03	-18.70	RECRUITMENT	6.30	3.10	1.00	1.00	8.70	2.50	22.60
376 DMHLD Learning Disabilities &	191.42	181.23	-10.19		0.80	0.55	1.00	3.00	2.00	1.91	9.26
376 DMHLD Management	10.20	7.80	-2.40		0.00	2.00	0.00	0.00	0.00	0.00	2.00
376 NLTT NHS Talking Therapies	181.29	178.48	-2.81		3.00	0.00	0.00	9.00	7.00	2.00	21.00
376 NLTT Acute Care Services	131.44	119.90	-11.54		5.30	3.80	0.00	5.00	1.00	6.33	21.43
376 NLTT Community Care Services	118.26	103.30	-14.96		1.00	1.70	1.80	0.40	3.51	4.00	12.41
376 NLTT Management	27.18	28.97	1.79		1.00	1.00	0.00	0.00	0.00	1.00	3.00
376 PHND Community & Long Term	406.99	400.07	-6.92		0.00	6.00	0.00	1.45	9.80	2.00	19.25
376 PHND Rehabilitation	318.01	306.83	-11.18		3.80	0.80	1.00	3.24	8.00	3.00	19.84
376 PHND Management	10.00	8.85	-1.15		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 PHND Neurodiversity	43.80	37.73	-6.07		1.00	0.00	0.00	3.00	0.00	0.00	4.00
376 RCG Acute Services	246.48	224.39	-22.09		0.00	1.60	0.00	0.00	10.00	4.40	16.00
376 RCG Community Services	240.46	226.58	-13.88		3.00	1.00	1.40	0.00	7.10	4.20	16.70
376 RCG Management	17.90	14.90	-3.00		0.00	0.00	1.00	0.00	0.00	0.00	1.00
376 Corporate Assurance	30.12	35.36	5.24		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 Estates	45.65	42.17	-3.48		2.00	2.00	0.00	0.00	0.00	0.00	4.00
376 Finance & Procurement	48.54	41.99	-6.55		1.00	0.00	0.00	0.00	0.00	0.00	1.00
376 Health Informatics	75.36	74.24	-1.12		0.00	1.00	0.00	0.00	0.00	1.00	2.00
376 Medical, Pharmacy & Research	46.25	54.60	8.35		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 Nursing & Facilities	171.67	169.18	-2.49		3.73	1.00	0.00	1.00	0.00	1.00	6.73
376 Operations	51.43	45.40	-6.03		0.00	0.00	0.00	0.00	3.00	0.40	3.40
376 People & Organisational	98.89	92.14	-6.75		0.00	0.00	0.00	0.00	0.00	2.60	2.60
376 Strategic Development	19.38	18.56	-0.82		0.00	0.00	0.00	0.00	0.00	1.00	1.00
376 Psychological Professionals and Therapies	6.50	5.00	-1.50		1.50	0.00	0.00	0.00	0.00	0.00	1.50
Total	**3,733.76**	**3,543.06**	**-190.70**		**44.03**	**36.55**	**13.20**	**47.35**	**84.26**	**52.88**	**278.27**

Annex 3: National publications/guidance summary – December 24/January 25

Integrated operational pressures escalation levels (OPEL framework 2024 to 2026
(NHS England, 02/12/2024)

This integrated operational pressures escalation levels (OPEL) framework 2024 to 2026 is for the management of operational pressures across NHS England's providers, including acute trusts, community health, mental health, and NHS 111 services and provides the core parameters that each of these types of provider must use to determine their OPEL.

https://www.england.nhs.uk/long-read/integrated-opel-framework-2024-to-2026/

Flu and COVID-19 vaccinations for eligible frontline health and social care staff
(NHS England 04/12/2024)

https://www.england.nhs.uk/long-read/flu-and-covid-19-vaccinations-for-eligible-frontline-health-and-social-care-staff-2/

Principles for assessing and managing risks across integrated care systems
(NHS England 04/12/2024)

The National Quality Board provides guidance for assessing risks in complex healthcare scenarios. This document outlines principles for managing quality risks within integrated care systems, particularly in rapidly changing environments. It supports the delivery of safe, effective, and personalised care while addressing inequalities across health services.

https://www.england.nhs.uk/long-read/principles-for-assessing-and-managing-risks-across-integrated-care-systems/

NHS education funding guide: 2024-2025 financial year
(NHS England 09/12/2024)

The NHS education funding guide outlines NHS England's funding for learners, educational institutions, employers, and placement providers to support the education and training of professional roles within the NHS for the 2024–2025 financial year.

https://www.england.nhs.uk/long-read/nhs-education-funding-guide-2024-2025-financial-year/

Preparing for a successful spring 2025 Covid-19 vaccination programme
(NHS England 13/12/2024)

Letter from Steve Russell, National Director for Vaccinations and Screening, NHS England.

https://www.england.nhs.uk/long-read/preparing-for-a-successful-spring-2025-covid-19-vaccination-programme/

NHS Activity tracker 2024/2025 – December 2024 Mental health
(NHS Providers, December 2024)

The latest Mental Health Service Dataset (MHSDS) monthly performance data for October 2024, published in December, continues to highlight the increased pressures facing the mental health sector. There were 1.98 million people in contact with mental health services in October 2024, a similar figure to the previous month. Contacts are up by 8.4% compared to a year ago and up by 45% compared to pre-pandemic levels.

https://nhsproviders.org/nhs-activity-tracker-202425/december-2024/mental-health-sector

Annex 4

South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note – 15 January 2025

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 15 January 2025. The main areas of discussion and subsequent action are outlined below.

Managing Director Report

The Board received an overview on national progress with the planning guidance. At this point in time, the full operational planning guidance has not yet been released by NHSE, however, the Mental Health Investment Standard is likely to continue, albeit with some changes. An update on the collaborative work on financial planning was also provided.

Health Inequalities Collaborative Approach

The Board received an overview of current activities being undertaken across the Collaborative to address health inequalities. The majority of the activity is necessarily around different localised priorities (aligned to place plans and local population health). However, there are programmes of work on national initiatives where there is the potential to share learning across the system.

All the Collaborative Trusts in SY are working to ensure implementation of the Patient and Carer Race Equality Framework (PCREF), and the Board supported a suggestion to bring leaders together to share learning and good practice on PCREF and work on other areas of health inequalities. The Board noted that it was necessary to evidence that the work was making a difference.

The Board requested that actions to address and monitor health inequalities in the collaborative programmes of work are made more explicit.

Managing Medical Emergencies in Eating Disorders (MEED)

A proposal for developing a system-wide approach to eating disorders was discussed. The Board was supportive of the proposed model. It was agreed that a business case will be available by the end of February to submit to the ICB for consideration of the proposed model and associated costs as part of 25/26 planning. This will go through the Chief Executives and Eating Disorders Joint Committee as it will need to be considered before the next Provider Collaborative Board. It will then go to March Collaborative Board. Further information will be provided on the engagement and equality impact assessment within the business case.

Eating Disorders Joint Committee

Work continues on the development of the supporting governance for including the terms of reference and supporting documents that will be considered by member trust boards prior to the committee going live in April 2025.

Delivering Our Work Programme

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

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

The system is on track to achieve 7 out of the 8 MHLDA long-term plan goals, however, out-of-area placements are a significant challenge, especially in South Yorkshire, and it's unlikely the planned position will be met.

At the previous meeting the Board requested more assurance on the national measure for the number of autistic people and people with a learning disability in a mental health inpatient setting, so work undertaken to address this was outlined within the report. It appears that the system is now expected to meet the recently amended target of a reduction of 10%.

There is an expectation that the national MHLDA targets will be streamlined next year, however, the Board agreed that it is important that we continue to monitor and review metrics that impact the quality of care provided on a system level basis to ensure oversight and advocacy.

Annual Review of Priorities

The Collaborative Executive teams and Board have met to consider progress to date and to start to plan for next year and beyond. The next steps involve finalising the actions from the Akeso report on productivity, conducting further research, and creating a detailed implementation plan with resources and timelines. MP noted that a more detailed paper will be submitted to the Board in March Board via the Chief Executive Group beforehand**.**

Productivity Review Progress

The productivity review discussed at previous Board meetings has been completed and the report is being finalised. The preliminary outputs were considered by the executive teams in December and planning commenced to realise the productivity and quality benefits identified. Board also noted that plans to develop an Information Improvement Programme, will be included in the 25/26 planning paper that will come to the March Board via the Chief Executive Group.

Inpatient transformation programme

An update on the inpatient policy transformation programme was provided, highlighting progress in areas like the PCREF implementation and sensory environments for neurodiversity. The importance of continuing to track the benefits of transformation programme were noted, especially in light of funding decisions in the upcoming planning process.

Specialised Commissioning Update

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

The Chair noted a formal thank you to Wendy Lowder, who has also held the role of Executive Lead for MHLDA for the ICB. Wendy has been committed to improving MHLDA services and has been a great advocate and valued member of the Collaborative Board. Wendy retires in February, and the new ICB Executive Lead on MHLDA will be Chris Edwards, and we welcome Chris to the Collaborative Board from April 2025.

Marie Purdue, Managing Director, South Yorkshire MHLDA Provider Collaborative

Annex 5

Going live with the all-age Eating Disorder Joint Committee?

1. Contextual reminder

1.1 The prevalence of patients presenting with potential eating disorders continues to rise in the United Kingdom. In the face of these changes, potentially exacerbated in some respects through and after the pandemic, there is not presently a synthesised approach, in the manner of a national service framework. Nor is there ringfenced or allocated funding recognition. Local systems are very much making sense of the situation locally.

1.2 In South Yorkshire, the mental health, learning disabilities & autism collaborative has taken a lead role in seeking to cohere that response. The MHLDA identified all-age eating disorders as one of four priorities in autumn 2023. *The work being done builds on a well-attended professional and patient-inclusive community of practice which has been operating since 2022*.

1.3 In spring 2024, chairs and chief executives supported the creation of vehicle, in shadow form, that was intended to bring into one space the funds distributed through both local and specialised commissioning, to seek to develop joined up transitional pathways, both across age groups, and between specialised and preventive services.

1.4 There are various symptoms of difficulty within current services, but three in particular have motivated action over the last few months:

- the apparently systemic non-compliance of the South Yorkshire system with the MEED guidance, published jointly by relevant royal colleges (where local non-compliance was explicitly identified in a regulation 28 order made in 2023);
- unsustainable use of specialist inpatient practice in private providers for a duration and at a level that cannot be afforded, and likely does not represent good practice;
- significant inequity of service offer, with places other than Sheffield not having adult community teams in place, among other disparities

2. Is a joint committee the answer?

2.1 As partners agreed when we created the shadow JC, the new committee is not a sufficient answer. But it is deemed by Chief Executives a necessary condition. Rather than individual initiatives or projects being progressed in disparate spaces, the JC is intended to allow partners to plan, challenge, commit and change services in a joined-up fashion. This includes both NHS services and partnerships with the voluntary and private sector.

2.2 The shadow joint committee has been meeting since September. It has overseen the co-production of the terms of reference and associated schedules. It has also provided oversight of the MEED response plan,

developed jointly with the acute federation: and provided input to place commissioning of the community eating disorder services. The adult service will operate on a hub and spoke basis from SHSC.

2.3 Moving to a 'live' form represents an important step. Firstly, and most importantly, it confirms that *the five partners are taking shared responsibility for the development of eating disorders services for children and adults locally*. Three providers offer children's ED services, and two adult services. Adult services associated with North Lincolnshire are being developed across South Humber by Navigo.

3. **Does the joint committee fit with other 'developments'?**

3.1 Strategically, it would appear to:

- South Yorkshire ICB is increasingly looking to collaboratives between providers to take on responsibility for system-wide solutions. These changes would represent a first such venture in the MHLDA space, and one that necessarily has to reach beyond provider partners (as MEED illustrates).

- NHSE is delegating, from April 2025, the vast majority of its remaining specialised commissioning responsibility to NEY ICBs, hosted through South Yorkshire. Lee Outhwaite, and others involved, have confirmed that the blending of specialist/general income lines along a pathway is one of several innovations sought by that transition.

3.2 The adult specialised eating disorder service forms a small (50k) part of the wider specialised commissioning hub which also holds a responsibility for some forensic services, and for tier 4 CAMHS. The Joint Committee will change the AED relationship with the hub going forward, but a relationship with RDaSH as the lead commissioner will remain. The hub is a valued service: and increasingly commissioning decisions through the steering group involve the wider collaborative, following changes to the TOR in 2024. Put more directly, the Joint Committee does not destabilise the hub but it does locate strategic leadership for eating disorders elsewhere, with the JC.

3.3 To make the joint committee most effective, it will be important that the four place-teams within the ICB recognise that synthesised role that one ICB voice will play going forward for these pathways. This work will need to be done sensitively and experimentally, as local nuance remains very important, but also because this may not be the only MHLDA service where we need to find a different compromise between place and system.

4. **How does the Joint Committee work?**

4.1 *Nobody moves funding to anyone else*. Partners will bring their own wallet. We do aspire to move money back up the pathway, towards secondary, primary and preventive interventions. But this needs to happen together, and we

should acknowledge that repurposes monies works best without de-commissioning and the creation of stranded cost and expertise.

4.2 The agenda for the Joint Committee will be set by its partner members, including crucially by patient leaders in the room. Accountability for a given service remains with provider Trusts, and the Collaborative's Board will maintain oversight of the work, with the ICB also requiring insight and scrutiny. *The principal work of the JC will be framed by the annual workplan.*

4.3 Careful thought has been given to reaching agreement and managing disagreement. Voting measures are framed very much as a last resort. On the other hand, the vehicle cannot be a talking shop. It both needs to hold itself and providers to account; and to progress service changes to improve quality and manage cost risk. This includes, but is not limited to, creating a different service offer for the most acutely unwell adults.

4.4 Quality governance largely remains as currently structured. Of course, as a committee there will be interest in the safety status and outcome impact of services, but there is nothing in the proposed terms of reference which transfers responsibility from Trusts to the JC. In due course the Collaborative as a whole may seek to share some of the oversight work held presently with the ICB.

4.4 The Joint Committee will serve to keep eating disorder services very much in the spotlight within South Yorkshire. That is part of the aim we have. Of course, awareness of eating disorders needs to be a part of general and wider clinical practice in services like general practice, community mental health teams, and given specialties in acute providers. But the focus offered by the JC is intended to raise a bar of expectation about what can offered to local people.

5. What are Trust's Boards being invited to do?

5.1 *Going live with the joint committee involves delegation to that committee*. Based on feedback from Trust representatives on the JC to date, over some months, we have developed a list of reserved matter or conditions, under which the JC has to re-refer items back to its members' Boards. But we would hope that for all four Trusts, and the ICB, such 'calling-in' of items will be rare.

5.2 Arranging the ICB delegation will take some time in February and early March. Hitherto SY-ICB has not acted as this model requires and so diligence is needed to ensure that the responsibilities sought by the JC are conferred properly. It will considerably assist that process to have all four Boards ready to move, building on the work done by your representatives since late summer 2024.

5.3 Annual review of the workings of the Joint Committee is mandated, and of course partners can seek to review its operation at any point. A chair for the Joint Committee will be appointed from July 2025, in succession to the convening CEO of the collaborative.

5.4 **This is a pathway experiment. Rather than blending eating disorders with other conditions or services, often with which there is little in common, the Joint Committee is based on a theory of change which argues that pathway-based funding and collaboration, may offer, at this time, the best answer to improve quality, access, equity and financial sustainability. The JC is the custodian of that experiment.**

Toby Lewis, Chief Executive, RDaSH - January 20th 2025

South Yorkshire Eating Disorders Joint Committee (SYEDJC)

Terms of Reference

Version	DRAFT 1.7 - Approval
Implementation Date	1 April 2025
Review Date	1 April 2026
Approved By	All Trust boards
Approval Date	[ ]

REVISIONS		
Date	**Reason for Change**	**Author**
2 Jan 2025	Version 1.5 feedback on Reserved Decisions	HD
14 Jan 2025	Version 1.6/7 – for approval	HD

1	Name	**South Yorkshire Eating Disorders Joint Committee (SYEDJC)**
2	General	Capitalised terms have the meaning set out below: "**2006 Act**" means the National Health Service Act 2006 (as amended); **"Agreement"** means the Integrated Working Agreement entered into between the Partners to outline the framework and scope within which the Members of the SYEDJC agree to work in partnership and deliver business collaboratively; "**Chair**" means the chair of the SYEDJC; "**Delegation**" means the terms of any delegation to the SYEDJC including any associated delegation agreement as agreed by the relevant board(s) and appended to these Terms of Reference at Appendix 1 and "Delegated" shall be construed accordingly; "**ICB**" means the NHS South Yorkshire Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated; "**SYEDJC**" means the South Yorkshire Eating Disorders Joint Committee; "**Member**" refers to a member of the SYEDJC listed in paragraph 7; "**Partners**" means the Trusts and the ICB, and "Partner" shall mean any one of them; "**Purpose**" the purpose of the SYEDJC as set out in paragraph 3; "**Trusts**" are the Rotherham, Doncaster and South Humber NHS Foundation Trust,

		Sheffield Children's NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust and "Trust" shall be interpreted accordingly; and "**Work Plan**" means the rolling plan of work to be carried out under the scope of the SYEDJC over a 12-month period (or such longer period as may be agreed by the Trusts). For the avoidance of doubt the Work Plan does not form part of these Terms of Reference and is Annexed to the Agreement and updated when revised by the Partners. All references to legislation are to that legislation as updated from time to time.
3	Purpose	Through delivering its Work Plan, the SYEDJC will be responsible for leading and overseeing the development and implementation of eating disorder services in South Yorkshire within the scope of SYEDJC. The following principles will inform the work of the SYEDJC in delivering the Work Plan: • Ensure that proposals are underpinned by demand and capacity analysis • Ensure that patients, public and stakeholder involvement are at the forefront of the approach and are identified as a core part of the Work Plan • Ensure that clinicians are at the forefront of the development of the envisaged approach through the work of the community of practice • Ensure that the SYEDJC is informed by strategic quality and experience information drawn from across the Partners • Ensure engagement with wider system partners who may be impacted or have the potential to mitigate the impact of any proposed pathway changes • Ensure that programmes of work are resourced to deliver, securing a dedicated team from relevant Trusts and ICB. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations • Ensure that the Work Plan complies with statutory duties and best practice standards in delivering service change • Ensure no detriment to patients within a wider geography, having regard to the broader geographical footprints of some of the Trusts beyond South Yorkshire ICS.

4	Scope	Activities within the scope of the Work Plan, as agreed from time to time by the SYEDJC in accordance with the Agreement shall be within the scope of the SYEDJC. The SYEDJC shall identify the projects and areas it will work on to achieve its Purpose in its Work Plan. The SYEDJC may add and remove projects and areas from the Work Plan from time to time provided that they are linked to the SYEDJC's Purpose.
5	Status and legal basis	The SYEDJC is established by the Partners as a joint committee pursuant to sections 65Z5 and 65Z6 of the 2006 Act in respect of those functions within its scope which are formally delegated by the Partners respectively to the SYEDJC in accordance with paragraph 6 below. The Partners each have the power to arrange for any of their functions to be exercised by each other or jointly with each other under section 65Z5 of the 2006 Act. Where the Partners have arranged for functions to be exercised jointly, they have the power to form a joint committee for this purpose under section 65Z6 of the 2006 Act, and to establish and maintain a pooled fund. The Partners must have regard to the guidance published by NHS England in February 2024 (and any subsequent/replacement guidance) about the exercise of these powers. The Partners will look to work together to ensure wherever possible the South Yorkshire region wide decision-making mechanisms for delegation of specialised services between NHS England the SYICB and the Trusts (that are still developing) do not create any mechanism which prevents or impedes the scope of the activities of the SYEDJC. The Partners have agreed a guiding principle that strategic decisions relating to eating disorder services in South Yorkshire should be made via the SYEDJC where possible (including where it involves children and young person eating disorder services).
6	Decision-Making	The SYEDJC will manage eating disorder decisions in line with the delegations

		made to it by the Partners having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources which may be impacted by the decisions of the SYEDJC. The SYEDJC will look to make decisions in a way that encourages and supports mutual aid between Partners but recognises that it is also likely to need to take decisions which address **long-term capacity/demand** mismatches in services which will require the movement of resources from Partners. • **Decision-making by each Partner Member of the SYEDJC** Where a Member has delegated authority from their Partner organisation to take decisions, they are able to take decisions on behalf of their Partner organisation while sitting on the SYEDJC. Other members of the SYEDJC cannot require a Member to exercise their delegated authority in a particular way. The Partners will work towards having consistency in the levels of delegated authority held by each of the Members when sitting on the SYEDJC. Where the Member does not have delegated authority from their Partner organisation to take a decision which the Partners wish to take in the SYEDJC (outside of the formal delegations to the SYEDJC) then that decision will need to be referred back to the relevant Partner organisation board for determination unless it has been delegated to the SYEDJC as outlined below. • **Decision-making by the SYEDJC as a joint committee** The Partners may formally delegate decision-making to the SYEDJC in relation to particular projects or workstreams within the Work Plan. Such delegations will be in accordance with the guidance given by NHS England. Delegations will be appended to these Terms of Reference and must be delivered in accordance with these Terms of Reference and the Delegation. If there is any conflict between these Terms of Reference and a Delegation, the Delegation will prevail. Where functions of the Partners have been delegated, the SYEDJC acts as a joint committee of the relevant Partners. The process for making decisions in the SYEDJC shall operate through the following stages:

		1. **STAGE 1 – Attempt to reach consensus at SYEDJC** Initially the Members will seek to make decisions through consensus of all Members, with the Members from each Partner seeking to make consensus decisions on behalf of their own Partner organisation. 2. **STAGE 2 – Referral to Dispute Resolution** If consensus cannot be reached between all Members, the matter will be referred to the Dispute Resolution Process under the Agreement (*Clause 4 and Schedule 4*) for resolution. 3. **STAGE 3 – Referral back to the SYEDJC for vote** If the Partners cannot resolve the dispute through the Dispute Resolution Process (prior to referral to arbitration under paragraph 6 of Schedule 4 of the Agreement) then then the matter will be referred back to the next SYEDJC meeting for further discussion and if a consensus decision is still not reached then a vote may be called by any Member present to determine the decision of the SYEDJC. 4. Provided that the decision is not a Reserved Decision (as defined below) and not less than 80% of the Members of the SYEDJC (eligible Members in attendance) including the Member representing from the ICB vote in favour of the decision in the SYEDJC meeting then the decision will be approved as a formal decision of the SYEDJC. 5. **STAGE 4 – If no decision or Reserved Decision referral to arbitration** If the decision is not approved at the meeting (or sits under a Reserved Decision) then in the absence of a consensus decision it will be referred back to independent arbitration under the Dispute Resolution Process at paragraph 6 of Schedule 4 of the Agreement. 6. Reserved Decisions for the purposes of the SYEDJC will be any decision which: a. would be a breach of existing Hub and Lead Provider contractual arrangements for CAMHS (eating disorders) elements of the services; b. falls outside of the scope of the delegations made to the SYEDJC; c. amends the Agreement or these Terms of Reference; d. will require a Partner who has not voted in favour of the proposal to:

		(1) incur material capital expenditure, (2) incur substantial debt, or (3) undertake a material transfer of clinical or non-clinical services or assets, in relation to the adoption of a new model or service (excluding decisions which are in relation to the continuation of existing funding and service models); e. would result in a material transfer of clinical or non-clinical services or assets from a Partner who has not voted in favour of the proposal; f. can reasonably be evidenced to have a "levelling down" impact on the quality of the outcomes for patients which can be delivered by the services from a particular Partner when measured against the level of outcomes being achieved for patients elsewhere in South Yorkshire. If claimed, this impact should be evidenced by the relevant patient outcomes being delivered to patients across South Yorkshire and not simply through changes in the level of budget or workforce being engaged; or g. would have a material adverse impact **on the patient transitions** between eating disorder services provided by the Partners.
7	Accountability	The SYEDJC is accountable to each Partner board
8	Reporting arrangements	The Members from each Partner shall be responsible for ensuring that appropriate reporting is made to their Partner board and, in the case of Members from a Trust, their Trust's Council of Governors, and that feedback from their Partner organisation is fed through to the SYEDJC. The SYEDJC shall submit a summary of the minutes from the SYEDJC Chair to each Partner board meeting in public. The SYEDJC shall ensure that the work of the SYEDJC Sub-Committees is reflected in its own minutes. The SYEDJC shall provide an annual report to the Partners as part of the MHLDA Provider Collaborative annual report. The SYEDJC will provide routine reporting to the Board of the South Yorkshire Mental Health, Learning Disabilities and Autism Collaborative.

9	Membership	The Members of the SYEDJC are: • Chief Executive of Rotherham, Doncaster and South Humber NHS Foundation Trust • Chief Executive of Sheffield Children's NHS Foundation Trust • Chief Executive of Sheffield Health and Social Care NHS Foundation Trust • Chief Executive of South West Yorkshire Partnership NHS Foundation Trust • Designated Executive Lead for MHLDA from NHS South Yorkshire Integrated Care Board Decisions are taken by the Members as set out in paragraph 6 above. The Partners will ensure that their respective Members attend at least 75% of meetings of the SYEDJC.
10	Attendees	The Chair of the SYEDJC may invite such attendees to SYEDJC meetings to provide information or be involved in discussion as the Chair considers appropriate. The Partners acknowledge that the commissioning landscape for eating disorder services is changing, and therefore the Chair may approve changes to standing attendees noted in these Terms of Reference. A representative patient/person with lived experience of the services will be invited to attend all SYEDJC meetings and the Partners will look to take steps prior to SYEDJC meetings to ensure that this representative is able to have meaningful involvement with the group and reflect wider patient views into the SYEDJC. The Partners agree to make any of their officers who are involved in delivery of the Work Plan available to attend the SYEDJC as requested.
11	Deputies	With the permission of the Chair and subject to the minimum attendance requirement set out at paragraph 9 above, Members may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf and count in the quorum. The decision of the Chair regarding authorisation of nominated deputies is final. Such nominations should usually be received five working days before the date of the meetings and should always include a short explanation as to why the nomination of a deputy is necessary.

		The nominated deputy must ensure that they understand the extent to which they are able to take decisions on behalf of their Partner organisation.
12	Chair	The first Chair of SYEDJC (the "**Chair**") from the Implementation Date until 30 June 2025 will be the Chief Executive of RDASH. The Members will elect a replacement Chair from the 1 July 2025 (elected by a simple majority if there is more than one candidate proposed) who will then remain in this position for a period of 12 months from the 1 July 2025 unless otherwise agreed by a majority of the Members. Any subsequent extension to this term or replacement of the Chair will be subject to the agreement of a majority of the Members. Meetings of the SYEDJC will be run by the Chair. The decision of the Chair on any point regarding the conduct of the SYEDJC shall be final. The Deputy Chair of SYEDJC shall be agreed by a majority of the Members. If the Chair is not in attendance, then reference to Chair in these Terms of Reference shall be to the Deputy Chair.
13	Quoracy	As a minimum, one Member from each Partner, or their authorised deputy, must be in attendance for the SYEDJC to be quorate. If any Member of the SYEDJC has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum but may be replaced by an authorised deputy who is not subject to a conflict of interest. Members may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting provided all Members are able to hear and speak to one another.
14	Frequency of Meetings	The SYEDJC will meet at least bi-monthly in private unless otherwise agreed by the Members. Additional meetings may take place as required by giving not less than 7 calendar days' notice in writing to all Members.

		The Chair may call an additional meeting at any time by giving not less than 7 calendar days' notice in writing to Members. Three of the Members may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Members signing the requisition may call a meeting by giving not less than 7 calendar days' notice in writing to all Members specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken. The SYEDJC is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission of the public to meetings of the SYEDJC will be made at the discretion of the Partners. All members in attendance at SYEDJC are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners or in accordance with regulatory and legal requirements on the Partner (including the Freedom of Information Act).
15	Declaration of Interests	If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the NHS England guidance on managing conflicts of interest in the NHS as applicable from time to time. The Chair of the meeting will determine how a conflict of interest should be managed (or the Deputy Chair if the Chair is the Member with the prospective conflict). The Chair of the meeting (or where appropriate the Deputy) may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

16	Support to the SYEDJC	The Lead Officer for the SYEDJC will be agreed by the Members and will be responsible for managing SYEDJC agendas and all governance arrangements for the Work Plan. The SYEDJC will be provided with support initially by RDASH to be amended upon the appointment of the new Chair in July 2025. This will include: • Seeking agenda items from Members two weeks in advance of each meeting; development and agreement of the agenda with the Chair in consultation with the Lead Officer; • Sending out agendas and supporting papers to Members at least five working days before the meeting. • Liaising with attendees invited to SYEDJC meetings under paragraph 10 • Drafting minutes including an updated version of the Work Plan for approval by the Chair within five working days of any SYEDJC meeting. • Distributing approved minutes (including updated Work Plan) to all attendees following within 10 working days of Chair's approval. • Maintaining an on-going list of actions, specifying which Members are responsible, due dates and keeping track of these actions. • Publicising SYEDJC meetings, minutes and associated documents as appropriate • Providing such other support as the Chair requests, for example advice on the handling of conflicts of interest.
17	Authority	The SYEDJC is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires within its remit, from any officer of a Partner. The Partners shall ensure that their officers co-operate fully and promptly with any such request made by the SYEDJC. The SYEDJC is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations provided it ensures that full funding is available to meet the associated costs. The SYEDJC is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it

		considers this is necessary provided it ensures that full funding is available to meet the associated costs. The SYEDJC is authorised to create sub-committees or working groups as are necessary to achieve its Purpose. The SYEDJC is accountable for the work of any such group. The SYEDJC may delegate decision-making to the SYEDJC Sub-Committees in relation to particular projects or workstreams. Such delegations will be in accordance with the guidance given by NHS England and will be appended to the relevant Sub-Committee Terms of Reference.
18	Conduct of the SYEDJC	Members of the SYEDJC will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. The SYEDJC shall undertake an annual self-assessment of its own performance against the Work Plan and these Terms of Reference. This self-assessment shall form the basis of the annual report from the SYEDJC to the Partner Boards.
19	Amendments	These Terms of Reference may only be amended by resolution of each of the Partner boards. Any amendments shall only take effect upon all Partner boards agreeing the change to the Terms of Reference or on such date as all Partner boards agree, whichever is the later.
20	Review date	These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments to the Terms of Reference will be required to be approved by all Partner boards.

APPENDIX 1 – DELEGATIONS

Draft form of delegation for members of the SYEDJC

Annex A: Delegation

1. Context

At its meeting on [DATE], the South Yorkshire Eating Disorders Joint Committee ("SYEDJC") approved a set of work priorities (outlined in the Integrated Working Agreement) to be supported by a workplan (of the matters to be undertaken, together at scale, annexed to the Integrated Working Agreement) over a 12 month period between April 2025 and the end of the 2025/26 financial year.
Broadly, the workplan includes the following issues:

- **[Summarise Workplan key elements]**

To that end, in addition to decision making that may occur through the [name of Partner]'s CEO and [his/her] membership of the SYEDJC, [name of Partner] seeks to delegate the following matters to the SYEDJC to enable the agreed priorities and supporting Workplan to be efficiently and effectively progressed by all Partners through the SYEDJC and to further align the Partners, in accordance with the Integrated Working Agreement.

2. Delegation

In accordance with the Standing Orders (SO), Scheme of Reservation and Delegation (SORD) and Standing Financial Instructions (SFI) of [name of Partner] and pursuant to its statutory powers under section 65Z5 and 65Z6 of the NHS Act 2006:

2.1 The Board of [Partner] hereby resolves to delegate responsibility to the SYEDJC for the carrying on of the following functions (noting that these 'scope' areas are identified as part of the SYEDJC's terms of reference) and to update its governance framework accordingly:

Delegated Functions	Details	Effective Date of Delegation
Eating Disorder Services Functions[1]	Schedule 1	1 April 2025

- Joint exercising of some agreed Partner responsibilities as currently incorporated in the priorities and Workplan under the Integrated Working Agreement, and focused on delivery of eating disorder services[2]

together the "Delegated Functions."

[1] Add in cross reference to any authoritative documents on what functions the ED programmes of work entail if possible.
[2] Note that the ICB will need to confirm the position and agree with NHS England that it can enter this arrangement – it is not technically delegation as the ICB is exercising the functions via the Joint Committee.

2.2 The role of the SYEDJC in exercising the Delegated Functions includes:

- Carrying out any relevant needs and/or opportunities assessment or analysis, including regular reviews of such assessment and analysis, with a view to service improvement and the best discharge of the Partner responsibilities referenced;
- Identifying and assessing what changes are needed to meet any unmet needs or to take advantage of identified opportunities, together with any risks and benefits that they entail and taking into account any necessary public involvement or other engagement processes and any other steps mandated by law or statutory guidance;
- Designing preferred options to meet any unmet needs or to take advantage of identified opportunities, which may include making recommendations as to the proposed way forward,[3] and implementing any such recommendation that is approved;
- Actively managing and overseeing the delivery and performance of any programmes for these purposes;
- Ensuring that it obtains value for money on behalf of [Partner] in any decisions made for these purposes;
- Implementing and overseeing information, reporting and recording requirements in respect of any such programmes of work to ensure progress and evaluate success.

  These matters shall be delegated to the SYEDJC with effect from [1st April 2025] ("the Effective Date of Delegation"), subject to the limits set out below.

2.3 In exercising the Delegated Functions, the SYEDJC shall:

- Notify the Board of [Partner] within [7 days] of any actionable act or omission or purported act or omission by the SYEDJC to properly discharge the Delegated Functions;
- Respond to any requests for information from the public and media on the matters covered by the Delegated Functions, including requests made pursuant to the Freedom of Information Act 2000;
- Provide further information and assistance as required by the [Partner] on any aspect of the SYEDJC's exercise of the Delegated Functions.

3. Limits

3.1 The SYEDJC shall exercise the Delegated Functions in accordance with:

- the Integrated Working Agreement, including the Terms of Reference and agreed Objectives and Collaborative Principles
- all applicable law and guidance and in line with good practice.

[3] We envisage that any contract that is required would be approved by the relevant Partner organisation and could be signed on its behalf by the relevant CEO. Given CEO membership of the SYEDJC, that mechanism should still be an efficient way forward to ensure progress.

3.2 The SYEDJC may not delegate any or all of the Delegated Functions except in relation to operational delivery and implementation.

3.3 The SYEDJC may only exercise the Delegated Functions where:

- [Partner's representative CEO [or Deputy]] are present as part of the quorum of the SYEDJC when making a decision on the Delegated Functions affecting [Partner].
- Special arrangements are made to enable a decision to be taken urgently, when it is not possible for the SYEDJC to meet, which are approved by [[Partner]'s Board].

4. Reporting

4.1 The SYEDJC shall provide a written report to the Trust Board on a monthly basis through the Chief Executive, providing a summary of any decisions made by the SYEDJC on the Delegated Functions and any progress against the Workplan, together with relevant extracts from any minutes of decisions on the Delegated Functions taken at SYEDJC meetings.

4.2 The Trust Board may require one or more members of the SYEDJC to attend a meeting of (or to answer questions from or provide information to) the Trust Board.

5. Accountability and liability

5.1 Accountability and liability for the exercise of the Delegated Functions on behalf of the [Partner] shall remain with [Partner] at all times.

Made on [date] at a quorate meeting of the [Partner] Board held at [location]].

Schedule 1 – Eating Disorder Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 1 *(Eating Disorder Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Eating Disorder Services;

1.1.2 undertaking reviews of Eating Disorder Services in the SYEDJC area;

1.1.3 management of the Delegated Funds (as defined below) in the SYEDJC area;

1.1.4 co-ordinating a common approach to the commissioning of Eating Disorder Services with other commissioners in the SYEDJC area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The SYEDJC is responsible for managing the provision of Eating Disorder Services.

2.2 When carrying out Delegated Functions in respect of Eating Disorder Services, the SYEDJC must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the SYEDJC includes identifying and seeking to address any unmet needs which may be met through the delivery of Eating Disorder Services.

2.4 In respect of integrated working, the SYEDJC must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, the ICB, Local Authorities, Healthwatch, acute and community providers, and other stakeholders;

2.4.2 work with the ICB to co-ordinate a common approach to the commissioning of Eating Disorder Services generally; and

2.4.3 work with the ICB to coordinate the exercise of their respective performance management functions.

Part 2: Specific Obligations

1. Introduction

1.1 This Part 2 of Schedule 1 *(Eating Disorder Services)* sets out further provision regarding the carrying out of the Delegated Functions.

2. Eating Disorder Services Contract Management

2.1 The SYEDJC must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 take on the responsibility for existing services provided pursuant to an Eating Disorder Services Contract, and for commissioning new services;

2.1.3 assume the responsibility for the award of new Eating Disorder Services Contracts; and

2.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the SYEDJC.

3. Transparency and freedom of information

3.1 The SYEDJC must:

3.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the SYEDJC's Area; and

3.1.2 Provide information and assistance as required to support the [Partner] in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Workforce

4.1 The SYEDJC will be responsible for making arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the SYEDJC to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"). Further requirements in respect of workforce may be specified in Mandated Guidance.

5. Finance

5.1 The SYEDJC must comply with such financial processes as required by the [Partner] and the ICB for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

5.2 [Partner] acknowledges that it will provide information to the SYEDJC transparently identifying the funds that are attributable to the Delegated Functions. The SYEDJC acknowledges that in its operations it will look to align the use of the funds from each of the SYEDJC Partners (including [Partner]) and the ICB in respect of the Delegated Functions (the "Delegated Funds").

5.3 Subject to any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England as Mandated Guidance from time to time, ("Mandated Guidance"), the SYEDJC may use the Delegated Funds in the exercise of the Delegated Functions.

5.4 The SYEDJC's expenditure on the Delegated Functions must be no less than that necessary to:

5.4.1 ensure that each of the Partners can fulfil their functions, effectively and efficiently;

5.4.2 meet all liabilities arising under or in connection with any Eating Disorder Services contracts (or elements of wider service contracts relating to Eating Disorder Services) allocated to the SYEDJC in so far as they relate to the Delegated Functions; and

5.4.3 meet national commitments from time to time on expenditure on specific Delegated Functions.

5.5 The Partners acknowledge that they must comply with their statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds by the SYEDJC.

5.6 Without prejudice to any other obligation upon the SYEDJC, the SYEDJC agrees that it must provide:

5.6.1 all information, assistance and support to [Partner] in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

5.6.2 such reports in relation to the expenditure on the Delegated Functions as are set out in Mandated Guidance, or as otherwise reasonably required by [Partner].

6. Complaints

6.1 The SYEDJC will handle complaints made in respect of eating disorder services in accordance with the Complaints Regulations.

7. Commissioning ancillary support services

7.1 The SYEDJC must procure and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the SYEDJC in the effective discharge of the Delegated Functions.

Dated 2025

INTEGRATED WORKING AGREEMENT FOR EATING DISORDERS

Between

(1) NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD

(2) ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

(3) SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

(4) SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST

and

(5) SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

CONTENTS

CLAUSE **PAGE**

Agreement Purpose	To outline the framework and scope within which the Members of the Eating Disorder Joint Committee agree to work in partnership and deliver business collaboratively.
Title	Eating Disorder Joint Committee – Integrated Working Agreement
Description	This agreement outlines the scope and framework through which the partners within South Yorkshire can progress agreed collective business, making timely and effective decisions within key areas of delegated responsibility and accountability through the use of the joint committee and wider collaboration.
Version Control	Version 1-5 – January 2025
Legal Advice	Hill Dickinson LLP
Lead Author	RM
Governance Group Contributors	• Rotherham, Doncaster and South Humber NHS Foundation Trust • Sheffield Children's NHS Foundation Trust • Sheffield Health and Social Care NHS Foundation Trust • South West Yorkshire Partnership NHS Foundation Trust • NHS South Yorkshire ICB
Target Audiences	The primary audience includes the Trust Boards of: □ Rotherham, Doncaster and South Humber NHS Foundation Trust □ Sheffield Children's NHS Foundation Trust □ Sheffield Health and Social Care NHS Foundation Trust □ South West Yorkshire Partnership NHS Foundation Trust and NHS South Yorkshire Integrated Care Board (SY ICB) Additional audiences may include: □ NHS England (NHSE) □ Key stakeholders (within the NHS and outside)
Contact Details	Marie Purdue, Managing Director, South Yorkshire Mental Health, Learning Disabilities & Autism Provider Collaborative Email: marie.purdue@nhs.net

Date 2025

This Collaboration Agreement ("**Agreement**") is made between:

(A) **NHS South Yorkshire Integrated Care Board** of 197 Eyre St, Sheffield City Centre, Sheffield S1 3FG (**"SY ICB"**)

(B) **Rotherham, Doncaster and South Humber NHS Foundation Trust** of Woodfield House, Tickhill Road Site, Tickhill Road, Balby, Doncaster DN4 8QN ("**RDASH**")

(C) **Sheffield Children's NHS Foundation Trust** of Clarkson St, Broomhall, Sheffield S10 2TH ("**SCH**")

(D) **Sheffield Health and Social Care NHS Foundation Trust** of Centre Court, Atlas Way, Sheffield S4 7QQ ("**SHSC**")

(E) **South West Yorkshire Partnership NHS Foundation Trust** of Ouchthorpe Ln, Wakefield WF1 3SP ("**SWYPFT**")

Together the above organisations will be referred to in this Agreement as the "**Members**" and "**Member**" shall be construed accordingly.

INTRODUCTION

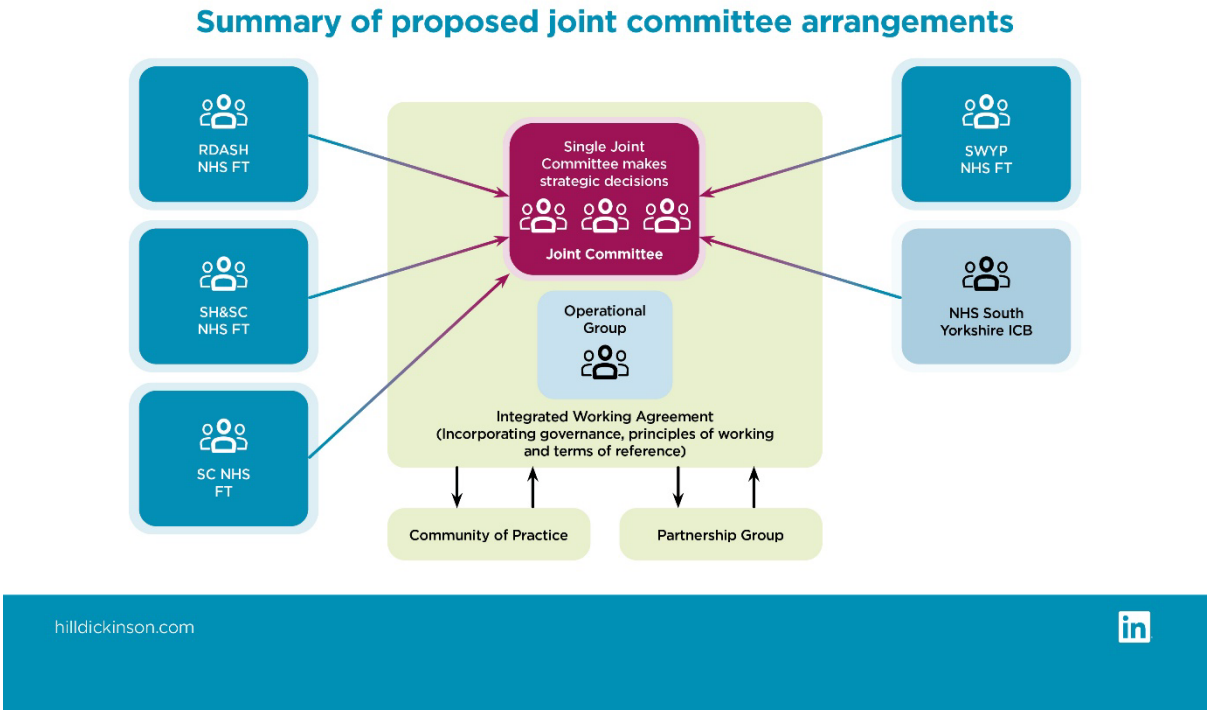
1.1 This Agreement sets out the overarching framework for collaboration between the partners within the South Yorkshire Eating Disorders Joint Committee (**SYEDJC**).

1.2 The Agreement builds upon the work undertaken to develop the SYEDJC to date and sets out:

- the vision, objectives and priorities of the SYEDJC, and
- its joint committee governance structure established in order for the Members to come together to make informed consensus decisions in identified areas.

1.3 The format of the Agreement is designed to work alongside existing services contracts held by the Members such as the NHS Standard Contract (**Services Contracts**). The Agreement does not affect or override any of the current Services Contracts in any way.

1.4 The Agreement can be summarised as follows:



1.5 Some areas of the Agreement will need development around the nature and function of the SYEDJC over time and it is envisaged the Agreement will be reviewed and updated regularly as a result.

BACKGROUND

Policy Context

1.6 The Health and Care Act 2022 (the "2022 Act") established statutory integrated care boards and incorporated new legislative mechanisms to enable further integrated working between statutory partner organisations within integrated care systems.

1.7 The mechanisms set out in the 2022 Act include a new power for provider NHS trusts, as well as integrated care boards and NHS England, to jointly exercise their statutory functions, including through a joint committee.

1.8 The Members intend that the implementation of the SYEDJC will take place in two stages to allow the committee to be formed as well as to take account of the proposed delegation of the relevant functions for eating disorder services from NHS England (Specialised Commissioning) to South Yorkshire ICB for April 2025. The two stages are:

- Shadow form until 31 March 2025 (the Shadow Phase) to allow for preparation of the approach and completion of the documentation; and

- Formally established and delegated functions to the Joint Committee with associated supporting contractual/partnering documents from 1 April 2025 (**Commencement Date**).

1.9 The Members will establish a joint committee pursuant to sections 65Z5 and 65Z6 of the NHS Act 2006, to be known as the SYEDJC through which the Members shall jointly exercise certain of their functions.

1.10 The Members have developed a vision statement for SYEDJC together with goals to which an initial set of priorities for progression have been aligned, as the Members seek to make improvements across the agreed programmes of work.

1.11 This Agreement sets out the overarching governance framework for the Members to work and make decisions together on matters within the remit of the SYEDJC.

OPERATIVE PROVISIONS

Interpretation of the Agreement

1.12 In this Agreement, capitalised words and expressions have the meanings given to them in Schedule 1 (*Definitions and Interpretation*).

1.13 Unless the context requires otherwise, the following applies in this Agreement:

1.13.1 a reference to a "Member" includes its successors or permitted assigns; and

1.13.2 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted over time.

Purpose and Effect of the Agreement

1.14 The Members have agreed to enter into this Agreement as a framework which binds the Members together for integrated working, with the Members agreeing to collaborate with each other and to act in accordance with its terms.

1.15 This Agreement sets out:

1.15.1 the agreed Vision, Intent, Objectives, and Principles of our approach to collaborative working for eating disorders;

1.15.2 the initial Priorities to achieve the Objectives;

1.15.3 the governance structures the Members have established and the programme management arrangements that support collaboration including the Terms of Reference for the SYEDJC;

1.15.4 the respective roles and responsibilities of the Members in relation to their collaboration under this Agreement; and

1.15.5 the general obligations of the Members to work in a collaborative and integrated way. It supplements and operates in conjunction with the Services Contracts between the ICB and NHS England with the Members for the Services. The Services Contracts will set out how each Member will contribute to the provision of the Services.

1.16 Each Member acknowledges and confirms that:

1.16.1 it is empowered to enter into this Agreement; and

1.16.2 each Member shall not be required to take any action pursuant to any provision of this Agreement that causes any of the Members to be in breach of Law, any regulatory obligation or any existing contractual obligation to any third party.

1.17 This Agreement is not an NHS Contract pursuant to section 9 of the National Health Service Act 2006.

1.18 Each Member will perform their respective obligations under their respective Services Contract. The Members acknowledge that the overall quality of the Services will be determined by the collective performance of the Members and agree to work together as described more fully below.

Duration

1.19 The initial term of this Agreement is three years from the Commencement Date, with the option for a one-year extension upon mutual agreement between the Members. Material breach of this Agreement by a Member may constitute grounds for termination of that Member. Where a Member withdraws from this Agreement, the remaining Members agree to work together in good faith to agree the necessary changes so that Services continue to be provided for the benefit of the eating disorder service users.

1.20 This Agreement will be reviewed annually alongside the Terms of Reference for the SYEDJC and will be updated by agreement of all the Members in accordance with clause 10 (*Variation*).

The Vision, Purpose, Objectives and Priorities

1.21 The Members have agreed a vision for the eating disorder pathway in South Yorkshire as:

- To have a South Yorkshire wide approach which supports individuals who have an eating disorder by bringing hope and belief to their recovery journey.
- We will provide help and support to them, their family, and friends so they can help their loved ones recover whilst also looking after their own mental health.
- We will do this by providing a timely and equitable approach that is evidence based, clinically led and patient informed.

1.22 The scope of the SYEDJC builds on the work of each of its Member organisations, focusing initially on a set of areas which are described in the Work Plan.

1.23 The Members have agreed the Purpose of the SYEDJC is:

Through the delivery of its Work Plan, the SYEDJC will be responsible for leading and overseeing the development and implementation of eating disorder services in South Yorkshire within the scope of SYEDJC.

1.24 The Members have identified the following initial Objectives:

1.24.1 **Objective 1 - Improving patient care & experience**

- **Improving access** – supporting recovery & restoration.

- **Quality** – equity & health inequalities through standardisation of care and reduction of unwarranted variance.

- **System resilience & transformation** – new models of care, system strategic developments and a range of enabling priorities at scale such as Digital and Workforce.

1.24.2 **Objective 2 – Best use of resources**

- **Sustainability** - ensuring service productivity, efficiency, and resilience at scale through consolidation where appropriate.

1.25 The Members will agree a Work Plan aligned to achieving the Objectives. The Work Plan will be reviewed regularly and refreshed annually by the Members in the SYEDJC. The full list of initial Priorities is set out in Schedule 3 (*SYEDJC Priorities*), with the collaborative governance process illustrated in Schedule 5 (*Governance*).

1.26 An Executive Lead will be identified for all programmes of work and each Priority within the Work Plan, with a clear role and responsibility in each case.

1.27 The Members acknowledge that the success of their collaboration depends on the collective ability to effectively co-operate, co-ordinate and combine their expertise, workforce, and resources to deliver the Priorities and Objectives of the Work Plan.

Principles

1.28 The Members have identified collaborative principles to underpin working together to deliver the Priorities and the Work Plan as set out in paragraph 3 (Purpose) of the SYEDJC Terms of Reference (the **Principles**).

PROBLEM RESOLUTION AND ESCALATION

1.29 The Members agree to adopt a systematic approach to problem resolution in line with the Principles, the Objectives and Priorities.

1.30 If a problem, issue, concern, or complaint comes to the attention of a Member in relation to the Priorities or any matter within the scope of this Agreement, such Member shall notify the other Members and the Members each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion between the relevant affected Members.

1.31 Save as otherwise specifically provided for in this Agreement, any dispute arising between the Members out of or in connection with this Agreement will be resolved in accordance with Schedule 4 (*Dispute Resolution*).

1.32 If any Member receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier) in relation to the work of the SYEDJC, any response will be agreed by the Members in the SYEDJC and issued by the SYEDJC on their behalf.

OBLIGATIONS AND ROLES OF MEMBERS

1.33 Each Member acknowledges and confirms that:

1.33.1 it will provide to each of the other Members on or prior to the Commencement Date a certified copy of appropriate resolutions approving entry into this Agreement and the SYEDJC delegations to which they are party, duly passed in accordance with the relevant Member's own constitutional requirements;

1.33.2 it remains responsible for its delivery of services in accordance with its Services Contract(s); and

1.33.3 the intention of the Members is to work together with each other and the ICB to achieve better use of resources and better outcomes for the population of South Yorkshire initially in respect of the Priorities and to create a collaborative culture in, and between, their organisations.

1.34 Each Member undertakes to co-operate in good faith with the others and use all reasonable endeavours to avoid unnecessary disputes and will not interfere with the rights of any other Member.

1.35 Each of the Members will inform the SYEDJC as soon as reasonably practicable if it becomes unable to meet any of its obligations at any time and in such case will inform and keep the SYEDJC informed of such issues.

SYEDJC Programme management resource

1.36 The Members have agreed that the SYEDJC will be supported by a programme management office in accordance with paragraph 16 of the Terms of Reference. The PMO will support each Executive Lead or nominee in respect of the work programmes and Priorities within the Work Plan. RDASH will initially provide the PMO whilst its Chief Executive chairs the SYEDJC.

1.37 At least 3 months prior to the start of each financial year, the Members shall agree a budget for the PMO. The Members agree that, unless otherwise agreed by the Members in writing, any and all costs and liabilities attributable to the PMO shall be shared equally between the Members.

1.38 The Members agree that delivery of the Work Plan may require changes in staff resources and as such the Members agree to comply with the principles set out in Schedule 7 (*Management of Change Principles*).

SERVICES

1.39 The Trusts shall provide the Services in accordance with the Services Contracts, Principles and the Work Plan. Each of the Trusts will actively seek ways to continually innovate the provision of the Services to improve the services provided and the outcomes for the Service Users.

1.40 For the purposes of this Clause 6 (Services), where there is any conflict between the duties upon any Member under this Agreement and a Services Contract, the provisions of the Services Contract will prevail unless this Agreement places a higher duty upon that Member, in which case the provisions of this Agreement will prevail.

1.41 Nothing in this Agreement relaxes or waives any of the Members' respective obligations pursuant to any Services Contract.

1.42 Day to day clinical risk remains with those Member organisations who are directly responsible for delivering the Services. This is also the case in relation to any clinical incidents which occur. The limited element of clinical risk in relation to the decision making for the range and adequacy of services commissioned across South Yorkshire will be covered under the delegations of decision making into the SYEDJC.

1.43 Existing Members governance arrangements for assuring the quality of Services provided will continue and will be reported into the SYEDJC by exception. These will include arrangements between the ICB in its commissioning role and Members who are service providers as well as Lead Providers for specialist in-patient beds and providers (delegated to the Commissioning hub).

PAYMENT AND COSTS

1.44 The Members have agreed to pay and be paid in accordance with the mechanisms set out in the Services Contracts in respect of the Services.

1.45 The Members will consider how they may share risk in the delivery of the Services under the Contracts in the future.

1.46 Each Member shall bear its own costs in relation to participation in the SYEDJC and the preparation of and compliance with this Agreement (including in respect of any losses or

liabilities incurred due to their own or their employees' actions), except where the Members agree unanimously that costs in relation to a particular matter shall be shared.

1.47 The Members have agreed to share certain administrative costs associated with the operation of the SYEDJC and/or the role of the PMO.

1.48 Each of the Members severally agrees to inform the SYEDJC as soon as reasonably practicable if at any time it becomes unable to meet any of its financial obligations and in such case inform, and keep the SYEDJC informed, of any course of action to remedy the situation recommended or required by the Secretary of State for Health and Social Care or other competent authority, provided that, to avoid doubt, nothing in this Clause shall in any way fetter the discretion of the Members in fulfilling their statutory functions.

Reporting requirements

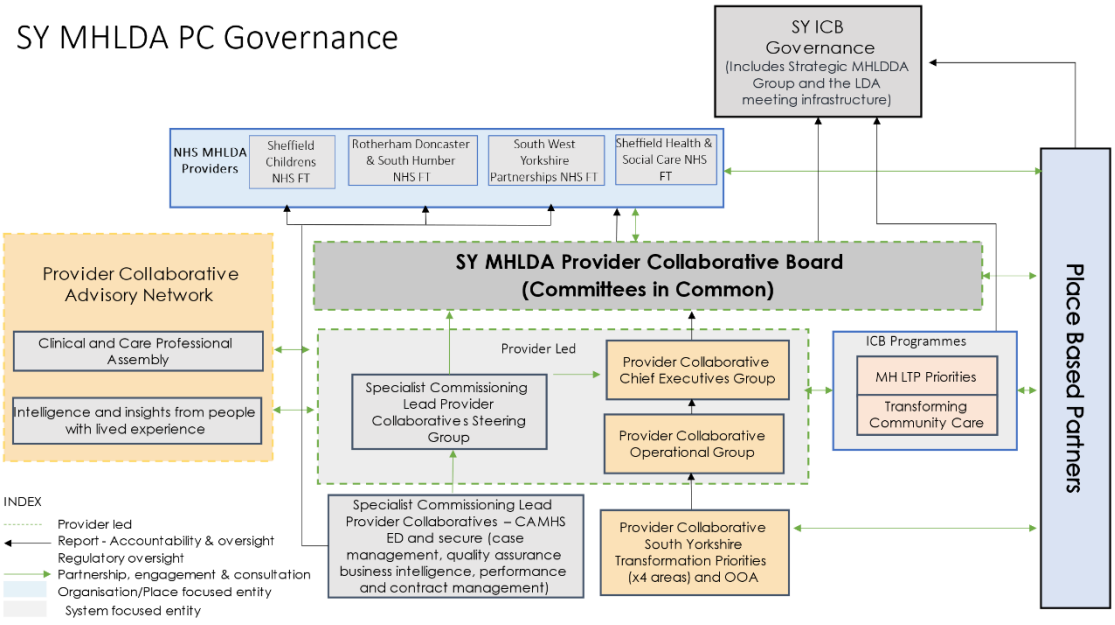
1.49 Each of the Members will, during the Term:

1.49.1 provide to the PMO or to any other Member information in line with the Principles and the Terms of Reference; and

1.49.2 identify and obtain all consents necessary, as may be reasonably required to deliver its obligations under this Agreement limited in each case to the extent that such action does not cause a Member to be in breach of any Law, its obligations under Information Sharing and Conflicts of Interest under this Agreement, including but not limited to the agreed restrictions on sharing Commercially Sensitive Information or any legally binding confidentiality obligations owed to a third party.

GOVERNANCE

1.50 The current governance for the South Yorkshire Mental Health, Learning Disabilities and Autism Provider Collaborative may be summarised as follows:



1.51 The governance arrangements for the SYEDJC comprise:

1.51.1 the SYEDJC under the Terms of Reference;

1.51.2 reporting from and to the South Yorkshire Mental Health Learning Disability and Autism Collaborative Board and South Yorkshire Commissioning Hub where appropriate on progress under the Work Plan;

1.51.3 reporting into the ICB Governance where appropriate (including the Strategic MHLDDA Group and the LDA meeting infrastructure); and

1.51.4 any SYEDJC Programme Boards which may be established by the SYEDJC from time to time to deliver programmes set out in the Work Plan.

1.52 The Members have agreed to establish the Joint Committee (SYEDJC) pursuant to sections 65Z5 and 65Z6 of the NHS Act 2006. When making decisions on functions delegated to it by the Members in accordance with its terms of reference, the SYEDJC is a joint committee of the Members. It has been established by each Member in accordance with their respective governance arrangements.

1.53 The SYEDJC is responsible for leading and overseeing the Members' collaborative approach to the Priorities and working in accordance with the Principles (as set out in its Purpose at paragraph 3 of the Terms of Reference).

1.54 The SYEDJC may establish supporting and/or task and finish groups to take forward programmes in respect of the Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Members. The SYEDJC will have other responsibilities as defined in its terms of reference (set out in Schedule 5 (*Governance*)).

1.55 The Members have each agreed to jointly exercise certain of their functions through the SYEDJC, as set out in the Terms of Reference and as may be updated from time to time through delegations from Member boards. If the Members wish to delegate matters to the SYEDJC, each Member board must approve a completed delegation (using the template delegation set out in the Terms of Reference) in accordance with their standing orders and scheme of reservation and delegation. Where a Member decides to delegate to the SYEDJC for the first time or decides to amend or revoke a previous delegation, either to the SYEDJC or a Chief Executive, the Member will ensure that the other Members are aware and that the matter is brought to the attention of the SYEDJC Chair.

Operational Group

1.56 The Operational Group is responsible for delivery of the Work Plan and assuring the SYEDJC that the Work Plan is being delivered. Its full remit is set out in its terms of reference (set out in Schedule 5 (*Governance*)). The Operational Group is not a committee of any of the Members and operates through authority delegated by the Members to their individual representatives. The Operational Group is accountable to the SYEDJC and will report to the SYEDJC as outlined in its terms of reference. The Operational Group may establish programme boards to take forward the work of the SYEDJC from time to time, and such programme boards shall report to the Operational Group.

Community of Practice

1.57 The Community of Practice is responsible for driving the development and delivery of the clinical priorities for the SYEDJC. Its full remit is set out in its terms of reference (set out in

Schedule 5 (*Governance*)). The Community of Practice is not a committee of any of the Members. The Community of Practice reports to the Operational Group.

Partnership Group

1.58 The Partnership Group is responsible for providing input into the working of SYEDJC and its priorities to other institutions who have a role in eating disorder services pathway. Its full remit is set out in its terms of reference (set out in Schedule 5 (*Governance*)). The Partnership Group is not a committee of any of the Members. The Partnership Group reports into the SYEDJC and the Operational Group.

1.59 The Members will ensure appropriate attendance from their respective organisations at all meetings of the governance groups and that their representatives act in accordance with the Collaborative Principles.

1.60 The Members acknowledge that they each participate in other collaborative arrangements outside of the SYEDJC, including with other providers at a place level. The Members will work together to ensure that the governance arrangements under this Agreement are streamlined and do not unnecessarily duplicate decision-making arrangements in other collaboratives.

INFORMATION SHARING AND CONFLICTS OF INTEREST

1.61 Subject to compliance with all applicable Law (including competition law and obligations of confidentiality (contractual or otherwise)), the Members will provide to each other all information that is reasonably required in order to deliver the Priorities and achieve the Objectives in an honest, open and timely manner.

1.62 The Members will ensure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Law to the extent it is applicable to the Members.

1.63 The involvement of the Members in this Agreement may give rise to situations where information will be generated and made available to the Members which could give them an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Member with a commercial advantage over a separate Member). The Members therefore recognise the need to manage the information referred to in this clause 9.3 in a way which maximises their opportunity to take part in competitions operated by any commissioner by putting in place appropriate procedures, such as appropriate non-disclosure or confidentiality agreements in advance of the disclosure of information.

1.64 Where there are any Patient Safety Incidents or Information Governance Breaches relating to the Priorities, for example, the Members will each comply with their individual Services Contract(s) and work collectively and share all relevant information for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.

1.65 The Members will comply with their obligations under the Data Protection Legislation and the SYEDJC Information Sharing Protocol set out at Schedule 8.

1.66 The Members will disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the delivery of the Priorities in accordance with their own organisation's conflicts of interest policy.

TERMINATION, EXCLUSION, AND WITHDRAWAL

1.67 The Members may resolve to terminate this Agreement in whole where a dispute cannot be resolved in accordance with the Dispute Resolution Procedure.

1.68 A Member may exit this Agreement on giving not less than 6 months' written notice to the other Members.

1.69 Additional providers may become parties to this Agreement on such terms as the Members will jointly agree, acting at all times in accordance with the Principles. Any new provider will be required to agree to the terms of this Agreement and the Terms of Reference before admission.

VARIATIONS

1.70 Any variation of this Agreement will be in writing and signed by each of the Members (or their authorised representatives).

CONFIDENTIAL INFORMATION

1.71 Each Member will keep in strict confidence all Confidential Information it receives from another Member except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Member.

1.72 Each Member will use any Confidential Information received from another Member solely for the purpose of delivering the Priorities and complying with its obligations under this Agreement in accordance with the Principles and for no other purpose.

1.73 No Member will use any Confidential Information received under this Agreement for any other purpose including use for their own commercial gain in services outside of the Priorities or to inform any competitive bid for any elements of the Priorities without the express written permission of the disclosing Member.

1.74 Nothing in clauses 12.6 to 12.7 (inclusive) will affect any of the Member's regulatory or statutory obligations.

Existing Intellectual property

1.75 In order to meet the Purpose and Objectives each Member grants to each of the other Members a fully paid-up non-exclusive licence to use its existing Intellectual Property provided under this Agreement insofar as is reasonably required for the sole purpose of the fulfilment of that Members' respective obligations under this Agreement.

New Intellectual Property

1.76 If any Member creates any new Intellectual Property through the operation of the SYEDJC, the Member which creates the new Intellectual Property will grant to the other Members a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Members' obligations under this Agreement.

Freedom of information

1.77 If any Member receives a request for information relating to this Agreement or the SYEDJC under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004, it shall consult with the other Members before responding to such request and shall have due regard to any claim by any other Member to this Agreement that the exemptions relating to commercial confidence and/or confidentiality apply to the information sought.

COUNTERPARTS

1.78 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression “counterpart” shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Member has executed at least one counterpart.

NOTICES

1.79 Any notice or other communication given to a Member under or in connection with this Agreement shall be in writing addressed to that Member at its address at the head of this Agreement or such other address as that Member may have specified to the other Member in writing, and shall be delivered personally or sent by pre-paid first-class post.

1.80 A notice or other communication will be deemed to have been received: if delivered personally, when left at the address referred to in clause 14.1; or if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second working day after posting.

THIRD PARTY RIGHTS

1.81 A person who is not a party to this Agreement shall not have any rights under or in connection with it.

ENTIRE AGREEMENT

1.82 This Agreement and the Services Contracts constitute the entire agreement between the Members and supersedes all prior discussions, correspondence, negotiations, arrangements, representations, understandings or agreements between them, whether written or oral, relating to its subject matter.

GOVERNING LAW AND JURISDICTION

1.83 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and, subject to Clause 4 (Problem Resolution and Escalation), the Members irrevocably submit to the exclusive jurisdiction of the courts of England.

This Agreement is executed on the date stated above by:

Signed by the CEO for and on behalf of **NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD** .....

Signed by the CEO for and on behalf of **ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST** .....

Signed by the CEO for and on behalf of **SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST** .....

Signed by the CEO for and on behalf of **SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST** .....

Signed by the CEO for and on behalf of **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** .....

SCHEDULE 1 - DEFINITIONS AND INTERPRETATION

The following words and phrases have the following meanings in this Agreement:

Agreement	this collaboration agreement incorporating the Schedules
Associate Member	has the meaning set out in Schedule 10 (*Membership*)
Community of Practice Group	the group of clinical leads established by the Members, the terms of reference for which as at the Commencement Date are set out in Schedule 5 (*Governance*)
Commencement Date	1 April 2025
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information by one of the Members and which that Member properly considers is of such a nature that it cannot be exchanged with the other Members without a breach or potential breach of competition law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Member, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including commercially sensitive information and Competition Sensitive Information
Data Protection Legislation	all applicable Laws relating to data protection and privacy including without limitation the UK GDPR; the Data Protection Act 2018; the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426); the common law duty of confidentiality and the guidance and codes of practice issued by the Information Commissioner, relevant

	Government department or regulatory in relation to such applicable Laws
Dispute	any dispute arising between two or more of the Members in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 4 (Dispute Resolution Procedure) to this Agreement
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Members have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Member by NHS England, the ICB and/or any relevant regulatory body
ICB	NHS South Yorkshire Integrated Care Board
IG Guidance for Serious Incidents	NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at Data Security and Protection Toolkit - NHS Digital
Information Governance Breach	an information governance serious incident requiring investigation, as defined in the IG Guidance for Serious Incidents
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Law	(a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation;

	(b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (c) any applicable judgment of a relevant court of law which is a binding precedent in England; (d) Guidance; and (e) any applicable code in each case in force in England and Wales, and "Laws" shall be construed accordingly
NHS Standard Contract	the NHS Standard Contract as published by NHS England from time to time
Objectives	the objectives for the SYEDJC as set out in clause 3.10, as may be amended from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Operational Group	the delivery group established by the Members, the terms of reference for which as at the Commencement Date are set out in Schedule 5 (*Governance*)
Patient Safety Incident	any unintended or unexpected incident that occurs in respect of a Service User, during and as a result of the provision of the Services, that could have led, or did lead to, harm to that Service User
Priorities	the priorities of the SYEDJC, the initial priorities being those set out in Schedule 3 (SYEDJC Priorities), as may be amended from time to time by agreement of the Members
Programme Management Office or PMO	the programme management office for the SYEDJC, as further described in clause 5.5
Purpose	the Purpose for the SYEDJC as set out in clause 3.8
Senior Responsible Owner or SRO	a Member Chief Executive responsible for the planning and delivery of a work programme pursuant to a Priority
Services	the eating disorder services provided, or to be provided, by a Member to the ICB or NHS England for Service Users pursuant to its respective Services Contract which may include services which are the subject of one or more Priorities
Services Contract	a contract entered into by an ICB and a Member for the provision of Services, and references to a Services Contract include all or

	any one of those contracts as the context requires
Service User	a patient or service user for whom the ICB has statutory responsibility and who receives Services under any Services Contract
SYEDJC	the joint committee established by the Members, the Terms of Reference for which as at the Commencement Date are set out in Schedule 5 (Governance)
Term	3 years from the Commencement Date
UK GDPR	has the meaning given to it in section 3(1) (as supplemented by section 205(4) of the Data Protection Act 2018
Work Plan	the rolling plan of work to be carried out by the SYEDJC over a 12 month period (or such longer period as may be agreed by the Members).

SCHEDULE 2– SOUTH YORKSHIRE EATING DISORDERS JOINT COMMITTEE: CONTEXT AND DEVELOPMENT

All four Members provide some aspect of eating disorder service, and RDaSH functions as the specialised commissioner for adult eating disorders, within the South Yorkshire and Bassetlaw Collaborative Hub model.

There is a consensus on the following concerns:

- Services are not scaled to underlying needs in the populations: those needs are rising (in both South Yorkshire and nationally) and are changing in nature and acuity post pandemic.

- Services in South Yorkshire (notably for adults) are at varied stages of development/investment, with Doncaster and Barnsley in particular having a 'low base' (very small) services with major inequity between parts of the system.

- Workforces vary and often rely on key individuals without established pipelines for succession or development and generalists in various healthcare settings are wary of the client group without expert input.

- Often highly restrictive specialised services consume significant sums and with limited evidence of outcome benefit.

Given this position, eating disorders has been agreed as priority area of work within the SY MHLDA Collaborative, with strong clinical and Integrated Care Board (ICB) involvement. There are four clinical workstreams supported by an established Community of Practice with around 130 people actively involved. Since inception there has been general agreement that it is beneficial to work across age ranges and commissioning divides to improve/reshape services and this is reflected in the approach taken.

Case for change

Concerns about current eating disorder services are documented at local and system level and predominantly fall into the following areas.

- **Harm to individuals** - Some patients are being harmed by the lack of community service provision, resulting in them presenting in a much-deteriorated condition to inpatient care and reducing the likelihood of recovery. The case for the importance of early intervention for eating disorders is well argued. In addition, a lack of joined up care across the patient pathway is leading to patients not receiving the right care at the right time and in very small number of cases this has contributed to patient deaths. The risk to future patient harm remains.

- **Gaps in provision** - The service offer for children and young people is different in each of the four places in South Yorkshire resulting in different therapies offered and differing ability to manage complex patients in the community. For adult services, there are no community services commissioned at all in Doncaster and Barnsley, limited in Rotherham and a large, sometimes cited as over stretched service, provided in Sheffield. There is an acknowledged risk is that with such gaps in care patients will continue to not have their needs met or that residents in Sheffield would have lessened access if funds are diverted to other parts of South Yorkshire. Conversely currently some non-Sheffield residents seek to access services in the city.

- **Regulatory/reputational** - There is no framework in place by which CQC regulation takes place across a collaborative mechanism. We might expect that services would be considered alongside many others in the CQC assessment of ICB collaboration (perhaps distinctively so), and that individual service providers would continue to be regulated for site-based provision.

- **Financial** - The current investment in eating disorder services does not meet the existing demand both in terms of numbers and acuity of patients. The budget for specialist inpatient care is overspent – for adults this was by almost £2m last year – and there is insufficient funding for community services in some places in South Yorkshire and the overall cost of providing the services we do have is increasing.

The concerns above suggests that currently eating disorder services (especially in adults) are not commissioned in a connected way and the supply market is divided by geography, age-group, severity and history.

In summary, the care of people with an eating disorder remains a concern across the Integrated Care System, including on the SY ICB Risk and Issues Register. There is a need to change how we commission and deliver these services to generate a positive impact for individuals and their families/carers.

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SCHEDULE 3 – SYEDJC PRIORITIES

1 The Members have agreed that the scope of the SYEDJC's work will include the following areas, and the Members shall agree Priorities for each financial year and a Work Plan which are aligned to the Objectives and within the broad scope set out in this Schedule 3.

2 The SYEDJC has a work programme which covers the following:

3 It is anticipated that the outputs of this work will largely result in some of the following:

- Clinical care pathways
- Service / clinical standards
- Clinical protocols
- Standard operating procedures
- Strategic business cases
- Target operating models

For the Members, the implications of these outputs are likely to include:

- Business, service & operational processes
- Resource implications including finance, workforce, and materials
- Digital, Data & Technology implications

It is important to recognise that the SYEDJC (which will manage this portfolio of work) will ensure that its PMO governance processes are adhered to, and that these outputs and implications are appropriately identified and documented for discussion, review, and recommendation of any subsequent decision to the SYEDJC.

Decisions made in these areas by the SYEDJC may require commitment of resources (workforce, budgets, materials) and will be restricted to the available annual budget for the SYEDJC.

The SYEDJC can only commit to Priorities beyond this budget if all Members agree to share the resources requested equally between all Members. Commitments beyond the approved budget may require justification and approval by the SYEDJC.

Alignment

The Members agree to share information about their strategic plans, processes, corporate governance, and any other subject they consider relevant in order to ensure alignment and deepen integration between them. The SYEDJC will identify what information sharing and discussions further the Objectives and enable these to take place. This may be through SYEDJC meetings or such other processes as the SYEDJC agrees.

Future ICB delegations

It is proposed that the development of the SYEDJC be flexible as the vehicle within which to receive and manage any appropriate future delegations from the ICB (via Member boards who may then delegate onwards to the SYEDJC, if permitted), with expectations for their management being articulated in a schedule to this Agreement and in line with any delegation agreement between the ICB and Member boards. Each ICB delegation (for the avoidance of doubt including any associated delegation agreement) will be appended to the SYEDJC Terms of Reference.

SCHEDULE 4 – DISPUTE RESOLUTION PROCEDURE

Avoiding and Solving Disputes

1 The Members commit to working co-operatively to identify and resolve issues to mutual satisfaction so as to avoid so far as possible dispute or conflict in performing their obligations under this Agreement. Accordingly, the Members shall collaborate and resolve differences between them in accordance with clauses 4.1-4.4 of this Agreement (*Problem Resolution and Escalation*) prior to commencing this procedure.

2 The Members believe that:

by focusing on the Principles

being collectively responsible for all risks; and

fairly sharing risk and rewards,

they will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with the Priorities.

3 The Members shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement (each a "**Dispute**") when it arises.

4 The SYEDJC shall seek to resolve any Dispute to the mutual satisfaction of each of the Members involved in the Dispute.

5 The SYEDJC shall deal proactively with any Dispute in accordance with the Principles and this Agreement so as to seek to reach a unanimous decision. If the SYEDJC reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Members involved in the Dispute of its decision by written notice.

6 The Members agree that the SYEDJC may determine whatever action it believes is necessary including the following:

if the SYEDJC cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and

the independent facilitator shall:

subject to the provisions of this Agreement, be provided with any information they request about the Dispute;

assist the SYEDJC to work towards a consensus decision in respect of the Dispute;

regulate their own procedure and, subject to the terms of this Agreement, the procedure of the SYEDJC at such discussions;

determine the number of facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

have their costs and disbursements met by the Members involved in the Dispute equally or in such other proportions as the independent facilitator shall direct.

If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 4 and only after such further consideration again fails to resolve the Dispute, the SYEDJC may decide to:

terminate the Agreement; or

agree that the Dispute need not be resolved; or

propose an alternative solution to the relevant Trust Boards.

SCHEDULE 5 – GOVERNANCE

PART 1 - SYEDJC TERMS OF REFERENCE

[To be inserted]

ANNEX A

Template Delegation

[As per the form annexed to the Terms of Reference]

PART 1 - OTHER GROUPS TERMS OF REFERENCE

Operational Group, Community of Practice and Partnership Group

Terms of Reference

SCHEDULE 6 – MANAGEMENT OF CHANGE PRINCIPLES

The Members agree that delivery of the Work Plan may require changes in staff resources and as such the Members will agree principles to comply with to manage these issues which will be annexed below and initialled by the Members for the purposes of identification.

SCHEDULE 7– INFORMATION SHARING PROTOCOL

To be inserted

SCHEDULE 8

Work Plan Template

EATING DISORDERS (ALL AGES) WORK PLAN

1. Population Needs	
2. Scope	
3. Service Model	
4. Finance	
5. Workforce	
6. Interdependencies	
7. Standards	
8. Key Service Outcomes	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 14 – inc waiting lists	**Agenda Item**	Paper L
Sponsoring Executive	Richard Chillery, Chief Operating Officer		
Report Author	Victoria Takel, Deputy Chief Operating Officer		
Meeting	Board of Directors	**Date**	30th January 2025

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

The paper was requested by the Trust Board as an update on the work in relation to Promise 14 with a particular focus on the work to achieve 4 week waiting times by April 2026, across all services.

This paper contains a summary of the real improvements made to waiting times across the Trust, and that now all waits are now true waits. This is supported by the improvement of visibility due to the implementation of new dashboards, reports and improved governance structures and process.

The paper then identifies what that the next stage of this work is required to continue to work towards both elements of Promise 14.

For waiting times this will be a significant piece of work to ensure 85% of services have had robust demand evaluation of their services in achieving a 4 week wait, throughout Q4 of 24/25. This will help inform the current round of investments bid applications for 25/25.

In addition, this paper provides an overview of a proposed workplan to achieve the 48-hour maximum response time to triage urgent referrals. This part of the Promise has had less focus, so less progress to date but with the understanding that scoping is being undertaken currently. This will ensure a robust base line for by the end of Q4 for services in scope and their position in relation to this element of the Promise. An options paper will then be developed to consider next steps, for example a single point of access across the Trust which will initially go to CLE, potentially April 2025.

The use of digital innovations will be part of both elements on delivery of Promise 14.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
SO3. Extend our community offer, in each of and between physical, mental health, learning disability, autism and addiction services	x
Business as usual.	x

Previous consideration

n/a

Recommendation

The Board of Directors is asked to:

x	**NOTE** the report provided and raise issues at its discretion

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

Trust Risk Register	x	Monitored through Waiting List Group, Operational Management Group and Risk Management Group.
Strategic Delivery Risks		
System / Place impact		

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

Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	OOAP prior to decision
Appendix (please list)							
n/a							

Rotherham Doncaster and South Humber NHS Foundation Trust

Promise 14 – Board update

Waiting List Update & Urgent Assessment within 48 hours

Richard Chillery, Chief Operating Officer

January 2025

RDaSH leading the way with care

Introduction

A paper has previously been presented to Board in November 2023 outlining the Trust's waiting list position at that time and setting out 7 action points.

Significant progress has been made since this time, with all the actions achieved. However, there is still further work to be done to ensure that the Trust achieves Promise 14 in its entirety and that we 'assess people referred urgently inside 48 hours from 2025 (or under four where required) and deliver a four-week maximum wait for all referrals from April 2026'. This paper will offer a brief update on the progress made to date, and the next steps required to ensure that waiting times have sufficient oversight, scrutiny and action to meet the obligations set out in the promise.

Progress to date – waiting times

With support from the completed actions referenced above, progress has been made in all Care Groups regarding waiting times. Significant work has been undertaken to increase visibility of waiting lists, with full scoping from Health Informatics, Performance and Care Groups to ensure all waits are now visible with live data refresh daily. This has supported a significant piece of validation work to ensure that all waits recorded are true waits. All waiting lists are scrutinised weekly at Care Group level, with a weekly (interim) waiting list subgroup of the Operational Management Group (OMG) providing oversight of this process and presenting an update monthly to OMG to ensure that progress is maintained.

All Care Groups are expected to have close governance of their waiting lists which will sit within Care Group structures, and the live internal audit which is near to completion on this will help assess this. This robust governance will be key to managing and maintaining a 4 week waits, when achieved and the intensive work by CAMHS is giving us a chance to test our monitoring capabilities, and what the level of work is required.

CAMHS services have been the forerunner for this work and have achieved a maximum 4 week wait in North Lincolnshire and Doncaster, except in cases of patient choice. CAMHS continue to make progress with their waiting times in Rotherham but have demonstrated a gap between supply and demand within Rotherham's Getting Advice service, for which an investment bid has been submitted. The progress made will need to be maintained within the CAMHS services that are already achieving a maximum wait of 4 weeks, through careful monitoring, and further investment may be required to bridge the remaining gap in Rotherham through the investment bid process.

Neurodevelopment services within Children's and ADHD services in adults have received additional non-recurrent investment. Adult ADHD are working towards agreed trajectories to allow achievement of a 4 week wait from April 2026, evidenced in the Trust IQPR and they remain on target. Children's ADHD have been subject to intensive demand and capacity work; and the trajectory to achieve 4 weeks by April 2026 will be agreed during Q4 (24/25).

Progress within our other mental and physical health services is summarised below when compared to 1st April 2024 baseline:

	List Size			Backlog > 4 weeks			Backlog > 18 weeks			52 week breach		
Total for MH Care Groups	3111	1346	-1765	1757	768	-989	653	119	-534	87	0	-87
Total for PH Care Group	1798	1024	-774	1142	650	-492	513	140	-373	263	0	-263
Total Trustwide	4909	2370	-2539	2899	1418	-1481	1166	259	-907	350	0	-350

The number of patients across Mental Health and Physical Health Care Groups has reduced from 2,899 as of April 2024 to 1,418 as of January 2025. This equates to a reduction of 51.09% and is supported by a reduction in the total number of patients on waiting lists of 51.72%. 14 out of 41 services are already able to evidence a 4-week maximum waiting time within this cohort, compared to 4 services as of April 2024. All these services continue to engage with weekly waiting list scrutiny to ensure these wait times are maintained.

Next Steps

Promise 14 – 4 week waiting time

Detailed Supply and Demand modelling needs to be conducted for all remaining services holding waiting lists, with plans to complete a comprehensive demand and supply model for 85% of services by the end of Q4. This is being prioritised based on the services that currently have the longest waiting times. A very basic modelling has been run during Q3 comparing the number of completed episodes against the number of referrals for 100% of services which has further allowed for prioritisation. As a result of this, significant work has already been undertaken within Memory services in Rotherham, leading to significant improvements in wait times in this pathway, and has commenced within Memory services in North Lincolnshire. They are likely to achieve a 4 week wait by April 2025; due to some high intensity waiting list initiative work, in Q4, but have ultimately identified a gap between demand exceeding current supply, and an investment bid has been prepared. If they do achieve this in North Lincolnshire, we will then achieve the mental health RTT performance of 92%+

Once the comprehensive supply and demand modelling is completed, it will allow services to be separated into three distinct categories; those that will be able to achieve a maximum 4-week waiting time from April 2026, those that most likely achieve a 4 week waiting time from April 2026; and those that will be unable to achieve a 4 week waiting time from April 2026 if the status quo is maintained. The latter two categories will receive support from the performance team and other “backbone” teams to work alongside Care Groups to ensure that pathways are evaluated and improved where possible. That all elements of efficiency have been fully explored and implemented upon, with the understanding that all services need to achieve this standard. Some services may require additional investment, with Neurodevelopment and Adult ADHD services being good examples of this, and some other services already have identified gaps through supply and capacity modelling and have submitted investment bids for 25/26.

Areas highlighted for further support

The areas currently highlighted as holding gaps between demand and supply that will prohibit achievement of the maximum wait of 4 weeks from April 2026 are summarised below:

- Memory services in North Lincolnshire currently have a backlog of 233 patients waiting more than 4 weeks for treatment. This accounts for 16.43% of the total number of patients over 4 weeks excluding Children's and Neurodiversity services. They have made significant pathway changes and are on track to achieve a maximum wait of 4 weeks from April 2025, however, will not be able to sustain this improvement without further resource.
- Wheelchair services, Speech and Language Therapy and Stroke Rehabilitation services within the Physical Health and Neurodiversity Care Group currently have a backlog of 137 patients with waits of over 4 weeks, 9.66% of the total referred to above. Like Memory Services, pathway improvement work has been undertaken in all 3 areas, but a gap remains between supply and demand which may require additional resource to address.
- Adult Autism assessment services currently have waits more than 24 months and 1,779 patients on this waiting list. Although pathway improvements have been maximised in this service, the list continues to grow and has increased by 704 patients since December 2023. This service also requires further investment to be able to meet the 4-week maximum waiting time.
- The Getting Advice service within CAMHS has made significant changes to job plans recently to maximise supply, but still has a gap between demand and supply and is unable to make further efficiencies.

All these services have submitted investment bids for investment in financial year 2025/2026 which will allow them to achieve a maximum wait of 4 weeks from April 2026 and these bids will be considered through the approvals process with final confirmation of award no later than 31st March 2026.

Most of the remainder of waits over 4 weeks will be addressed by improving pathways through Q1 and Q2 of financial year 2025/26 to enable achievement of this element of Promise 14 in full across the organisation. Once the detailed supply and demand work is concluded, by the end of Q4, any further outliers will be clearly identified for intensive support.

Promise 14 – Assess People Referred Urgently inside 48 hours from 2025 (or under 4 where required)

Developing a Phased Approach to Action

Although the 4-week element of Promise 14 is progressing at pace, work is also required to enable the organisation to respond to urgent referrals within a 48-hour timescale. This requires several actions to take place during Q4 of 24/25 and Q1 of 25/26. This element of Promise 14 has received less focus than the 4-week element and, as such, is behind where we would like to be.

Referrals have been scoped to identify which services receive referrals graded as ‘urgent’ and those who should receive referrals graded as ‘urgent’ but do not. A standardised process will be developed and rolled out across the organisation prescribing referral categories and how referrals should be logged on SystmOne to ensure that all appropriate services are captured. A baseline of performance against the 48-hour target has also been obtained but requires validation and development into a dashboard to allow for intuitive monitoring at service level to drive improvement. Once this baseline has been fully developed it will be possible to fully confirm which services require pathway redesign, work with referrers on grading, and improvement to triage processes to enable the 48-hour target to be met in full. It is hoped this part of the work will be achieved by the end of April 2025.

As part of this work, both those services that are contractually obliged to respond within 48 hours and all other services that receive referrals graded as urgent, including those not usually considered as urgent care services, will be within scope. However, not all services are currently able to respond to urgent referrals out of hours which currently creates a difficulty with compliance over weekends and bank holidays. To allow achievement of this Promise a significant piece of work needs to occur to fully explore all options for filling this gap, including for example developing the role of our single point of access service for adults, and single point of contact service for children.

Development of this service to allow for 7 day per week triage, with support from clinicians. The clinicians who form part of this triage offer will be able to review patients accepted as being truly urgent post triage to ensure review is available for all patients in urgent need. This will be key to achievement of this element of the Promise. Development of this service is currently being scoped, with current capacity and demand being evaluated to see what developments need to be made from a staffing and technological perspective to allow these single access points to operate as the first point of contact for all urgent referrals received into the Trust. Once this is completed, a paper will be presented at Operational Management Group in March 2025, through to CLE with recommendations.

Technology

Promise 14 clearly articulates that the two objectives discussed earlier in this paper will be achieved by ‘maximising the use of technology and digital innovation to support our transformation’. As such, developments which allow patients great choice over where and when their appointments occur and give the ability to interact with services in different ways are critical to success.

RDaSH are already making strides with the use of technology to allow for improved patient interactions, with SystmOne now having the ability to send patient appointment details through patient’s preferred medium, whether that be letter, text or email. However, there is still significant room for improvement that would support self-referral, increase choice and streamline triage processes. The aim of a further technological solution would be to minimise the administrative burden on clinicians, increase patient choice and ease of access to services, and reduce non-attendance at appointments. There are a number of products available, one of which can integrate directly with our current EPR.

These products operate as ‘Patient Portals’ and offer a total triage online consultation platform that enables communication with patients, improving access and managing demand for services. Patients can access services through apps, our website and via

other more ‘traditional’ methods of communication, such as telephone or face-to-face. All demand is then managed in one screen, capturing category, priority, status, team and or individual. This would be invaluable for triaging and reducing administrative burden on clinicians. Additionally, giving patients greater control over booking and rescheduling of appointments is acknowledged to reduce appointments wasted through non-attendance and improve efficiency. Waiting list validation can also be embedded, and the portal can be used for patient questionnaires prior to attendance to streamline appointments and reduce the amount of time required to be spent with clinicians.

An investment bid has been placed for a ‘Patient Portal’ digital solution and, as with the investment bids detailed above, will be considered through the Trust approvals process.

Conclusion

The Board is asked to note the considerable improvement in waiting list management; and that we now have validation and visibility of all “true waits”. The next stage of the programme is the demand and capacity work, which will concluded with some needing pathway and efficiency work and a limited number of services may will require additional investment. This paper has indicated some of those services and this will be tied into the Trust investment programme.

Less progress has been made on the delivery of triaging of urgent assessments within 48 hours, although work has started. In Q4 we will develop a robust baseline of the services in scope; and then there will be options of next steps which will go to the April CLE, which may include a single point of entry for adults and children, respectively. It is my view investment in some digital infrastructure will support this.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	25-26 Capital Plan and 25-26 Indicative Revenue Plan	**Agenda Item**	Paper M
Sponsoring Executive	Izaaz Mohammed, Director of Finance & Estates		
Report Author	Izaaz Mohammed, Director of Finance & Estates		
Meeting	Board of Directors	**Date**	30th January 2025

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

This paper seeks approval from the Board of Directors for the 25/26 Capital Plan. The capital plan mainly focusses on finishing phase 3 & 4 of the Great Oaks programme (previously approved by the Board in 2024), starting work on the replacement for Hazel & Hawthrone Wards (referred to as the Frailty Centre of Excellence in the paper) and a provision for the development of a High Dependency Unit to support the Trust's ambition to eliminate out of area placements. The total capital plan for 25/26 is £5m, and is based entirely on the Trust's share of the system CDEL.

In the absence of national planning guidance from NHSE the Trust has modelled an indicative 25/26 revenue plan based on the Boards commitment to spend £3m on a cost pressure reserve (which includes paying the Real Living Wage) and deliver a savings programme of £6m. This equates to an underlying deficit of £8.4m (subject to pay award funding resolution for 25/26), which could reduce to an indicative planned deficit of £3.5m if non recurrent deficit support funding and slippage on the cost pressure reserve is included. The former is subject to NHSE planning guidance when this is eventually published, and the latter on the analysis of cost pressures and investment bids during January and February.

Suggested discussion points for the Board are the key areas of capital spend proposed in 25/26, including any excluded categories such as IT, and the work required before the March meeting to work up a draft 25-26 revenue plan, recognising the absence of any planning guidance at the time of writing this paper.

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

Previous consideration

25/26 Capital Plan discussed at CLE 21st January 2025, underlying deficit discussed at various Board and FDE meetings over the past few years.

Recommendation

The Board of Directors is asked to:

x	**NOTE** the movement in the forecast underlying deficit position from £6.2m to £8.4m.
x	**NOTE** the indicative planned deficit of £3.5m for 2025/26, subject to NHSE deficit support funding and cost pressure slippage
x	**APPROVE** the 2025/26 Capital Plan

x	**NOTE** launch of the new clinically informed minor works process that will be launched from February.							
Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)								
Trust Risk Register	x	F 1/24						
Strategic Delivery Risks		n/a						
System / Place impact	x	System financial sustainability						
Equality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	
Appendix (please list)								
None								

2025-26 Capital Plan & Indicative 2025-26 Revenue Plan

1.1 This paper seeks Board approval for the 2025/26 Capital Plan. An update on the Trust's underlying deficit position is provided, and an indicative 2025/26 Revenue Financial Plan is included. This will be refined over the balance of Q4 pending NHSE planning guidance and confirmation from commissioners on income allocations.

1.2 The Board approved a £3.8m deficit revenue plan for 2024/25 in May 2024, the underlying deficit at that point was £6.2m. Since then the Trust has received non recurrent deficit support funding of £3.4m and the confirmation of a AFC pay award of 5.5% which has resulted in a further shortfall of c£1m. NHSE have not published planning guidance or confirmed allocations for 2025/26 at the time of writing this paper, however recent briefings from Julian Kelly and Amanda Pritchard have emphasised the extremely difficult financial year ahead, with many systems seeing a real terms cut in funding.

1.3 The indicative 2025/26 Revenue Plan contained in this paper is based on the key assumptions taken from the Finance Enabling Plan, and reflects information gathered from local and national sources in recent weeks. These assumptions will be refreshed once planning guidance and allocations are confirmed, this is expected to happen in February.

Underlying Deficit

2.1 The 2024/25 plan contained an underlying deficit of £6.2m, down from the £12m+ figure in 2023/24, the reduction driven by the delivery of the highest savings target in the Trust's history of just under £10m. The 2024/25 Plan included £2.4m of planned slippage against the cost pressure and ADHD reserves linked to recruitment lead times. The 2024/25 savings programme includes approximately £0.6m of non-recurrent savings for which recurrent plans are needed to avoid a deterioration in the underlying deficit going into 2025/26. The table below shows the breakdown of the forecast underlying deficit at the end of 2024/25:

In year movement in underlying deficit	**£m**
24/25 Plan (before NHSE deficit support funding)	-3.8
Remove impact of 24/25 non recurrent planned slippage	-2.4
24/25 non recurrent CIP	-0.6
24/25 Closing underlying deficit*	**-6.8**

2.2 *The closing underlying deficit above doesn't include the impact of the additional pay award shortfall resulting from the 2024/25 AFC pay settlement of 5.5% (c£1m). Doncaster Council and the ICB have yet to confirm their funding intentions for this. The impact of a final funding settlement will be reflected in future reports to the Board.

Income & Expenditure Changes

3.1 The tables below set out the impact of anticipated changes to the Trust's income allocations as well as planned changes to expenditure. Tariff uplifts of 3% have been assumed to fund inflation, with a reduction in income of 1.1% for efficiency and a 0.6% reduction linked to a

convergence adjustment. The convergence adjustment is taken off SY ICBs income allocations by NHSE and accounts for the difference between national funding formula calculations and the system's current income. Zero growth is assumed in this version of the plan based on national and local messaging on flat cash settlements for 2025/26. Board members are reminded that although RDaSH did not receive any growth funding in 2024/25, the overall system did. This is a position that must not be repeated, and this has been acknowledged by the ICB CEO and CFO in recent months.

3.2 Key expenditure assumptions include inflationary increases of 3% for pay and non-pay, a commitment to provide for a £3m cost pressure reserve to support the implementation of the Real Living Wage and promises delivery, and a £6m savings target.

25/26 Income Changes	**£m**
25/26 Tariff increase - inflation at 3%	5.8
25/26 Tariff reduction - efficiency at 1.1%	-2.1
25/26 Tariff reduction - SY convergence adjustment at 0.6%	-1.2
25/26 Growth funding - 0%	0.0
Total 25/26 Income Changes	**2.5**

25/26 Expenditure Changes	**£m**
25/26 Inflation - pay & non pay at 3%	-7.1
25/26 Cost pressure reserve	-3.0
CIP at 2.5%	6.0
Total 25/26 Expenditure Changes	**-4.1**

3.3 The annual expected shortfall on inflation funding is shown at £1.3m above (tariff increase of £5.8m less expected inflation cost of £7.1m). The net impact of the assumed income and expenditure movements is a deterioration of £1.6m to the underlying deficit (£2.5m increase in income less £4.1m increase in cost).

2025/26 Underlying Deficit & Indicative Plan

4.1 Taking the forecast closing underlying deficit for 2024/25 of £6.8m and applying the anticipated income and expenditure changes set out in 3.1 and 3.2 results in an underlying deficit of £8.4m for 2025/26. There a 2 material non recurrent items that we can plan for at this stage, these are the continuation of non-recurrent deficit support funding of £3.4m from NHSE, and slippage on the cost pressure reserve of £1.5m. Slippage is assumed at 50% currently, this will need to be refined over the following month in line with spending plans.

24/25 Closing underlying deficit*	**-6.8**
25/26 Income changes	2.5
25/26 Expenditure changes	-4.1
25/26 Underlying deficit*	**-8.4**
25/26 non recurrent slippage - 50% of cost pressure reserve	1.5
Non recurrent NHSE deficit support funding to continue in 25/26	3.4
25/26 Indicative plan	**-3.5**

*excludes impact of further in year pay award shortfall, see 2.2.

4.2 The indicative 2025/26 plan including the 2 non-recurrent items referenced above is £3.5m. This will be updated in over the next two months with confirmed allocation and efficiency information from commissioners.

Capital Plan 2025/26

5.1 Alongside the Revenue Financial Plan, the Board approves the Capital Plan annually. Annual capital spending is constrained by the Capital Department Expenditure Limit (CDEL), this is the maximum amount that can be spent on capital by the DHSC. Each ICB receives an allocation of CDEL and this is shared amongst providers on a fair shares basis. The Trust's expected share for 2025/26 is £5m. In addition to the share of system CDEL, there are some opportunities to bid against targeted national capital programmes. In recent years the Trust has successfully accessed additional capital via these routes to support EPR, mental health ward refurbishments, and urgent and emergency care. No additional capital funding above the share of ICB CDEL is expected in 2025/26.

5.2 The 2024/25 programme has seen slippage on the Great Oaks phase 3 & 4 schemes linked to design, mechanical and engineering elements. The Board approved bringing forward the 2025/26 IT Capital Schemes at the meeting in November to mitigate the slippage and create capacity within the 2025/26 CDEL to complete the Great Oaks schemes. The 2025/26 plan provides for enabling works to progress replacement wards for Hazel & Hawthorne, this was a scheme included in Phase 3 of the 2024/25 capital plan approved by the Board in May and aligns to the Estates Enabling Plan being developed. A figure for the development of a High Dependency Unit has been included to align to the Trust's and MHLDA collaborative's ambition to care for people closer to their homes and reduce out of area admissions.

5.3 The plan has been developed in conjunction with CLE, securing support and approval at the meeting on the 21st January:

Scheme	£m
Complete Great Oaks phase 3 7 4	2.50
High Dependency Unit	1.00
Frailty Centre of Excellence (Hazel & Hawthorne) – Phase 1- enabling works	0.90
Neurodiversity adjustments	0.13
ADHD outpatient unit – Further design and enabling works for alterations to 1 Jubilee	0.10
Maintenance & Compliance	0.10
Medical Equipment	0.10
Fire safety improvement works and compliance	0.05
Contingency for unplanned issues	0.12
Capital Plan 25/26	**5.00**

5.4 Alongside the Capital Plan, a new process for the management of the minor works maintenance budget has been developed. The new group overseeing the use of this budget will consist of clinical and operational senior managers from Care Groups, supported by subject matter experts from Estates, Procurement and Finance. The group will report to CLE via the CLE Finance sub group, with the key focus on how best to spend the c£800k of estates maintenance budget on the most clinically pressing estates issues.

Recommendations

6.1 The indicative revenue plan for 2025/26 and the underlying plan will continue to be refined to reflect NHSE planning guidance and confirmed income allocations from commissioners over the balance of Q4.

6.2 The Board is asked to:

- Note the movement in the forecast underlying deficit position from £6.2m to £8.4m.
- Note the indicative revenue planned deficit of £3.5m for 2025/26 and the assumptions included in arriving at this figure.
- Receive and approve the 2025/26 Capital Plan.
- Note the new clinically informed minor works process to be launched from February.

Izaaz Mohammed, Director of Finance & Estates
22nd January 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Workforce – Staffing Overview (inc Dec 24 vs 24/25 plan and vs Dec 23)	**Agenda Item**	Paper N
Sponsoring Executive	Carlene Holden, Director of People and OD		
Report Author	Carlene Holden, Director of People and OD		
Meeting	Board of Directors	**Date**	30th January 2025

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

The paper provides an update on the work and associated workstreams to become fully staffed by March 2025 (96.7% for 2024/25 and 97.5% for 2025/26) and forecasts the March 2025 outturn position. The objective being to improve our patient care through a consistent workforce, to improve staff health and wellbeing/morale with fewer vacancies and to contribute to the financial challenges by reducing reliance on agency workers. Included in the analysis is a comparison from December 2023 to the December 2024 position to demonstrate progress to date.

The paper details the initial fill rates following the transfer of our internal banks to NHSP on the 21st October 2024. As a reminder bank remains our preferred atypical workforce solution and our continued desire is to remove all agency requirements within the Trust and they remain integral to the Trusts workforce solution.

A hot spot area has been identified as Support Workers/Nursing Assistants and whilst our current overall vacancy rate is 5.5%, against a target of 3.3%, our Support Worker/Nursing Assistants vacancies are currently an outlier at 8.49%. The paper details the current recruitment activity and plans to address this, recognising a significant number of these posts/available shifts are filled by our NHSP flexible workforce.

In addition, NHS England indicated in December 2024 a plan to support Trusts to reduce support and administrative colleagues in 2025/26, the paper details our current position and the growth in recent years, which is lower than the Trust overall growth.

Alignment to strategic objectives	
SO1. Nurture partnerships with patients and citizens to support good health.	x
SO2: Create equity of access, employment, and experience to address differences in outcome	x
SO5. Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x

Previous consideration

n/a

Recommendation

The Board of Directors is asked to:

x	**NOTE** the content of the report, the ongoing workstreams and the current vacancy position
x	**CONSIDER** any matters of concern not covered in the report
x	**RECOGNISE** the local community/sector recruitment programmes and the apprentice events

Impact		
Trust Risk Register	x	POD 5/24 and POD 1/20
Strategic Delivery Risks	x	S05
System / Place impact		n/a

Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Appendix							
Annex A – Current vacancy position							

Rotherham Doncaster and South Humber NHS Foundation Trust

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Workforce – Staffing Overview (inc Dec 24 vs 24/25 plan and vs Dec 23)

1.0 Introduction

1.1 As the Board are aware, we are committed to becoming fully staffed within all 23 Directorates by the end of March 2025. Our focus on vacancies has been relentless, given our high level of vacancies at the start of the financial year and the impact this has on staff morale, health & wellbeing and continuity of patient care.

1.2 Our definition of fully staffed was initially 97.5% (2.5% vacancy factor), but this temporarily increased in year, to support the financial position and has increased to 96.7% (3.3% vacancy factor), reverting to 2.5% from the 1st April 2025. We can report on our vacancies, to an individual post level as the budgeted establishment is recorded on the Electronic Staff Record (ESR – the integrated HR, Payroll & Training system) to facilitate reporting. Any in year budget changes of which there has been many, are also updated on ESR to facilitate accurate reporting.

1.3 Board members will be familiar with the Trust wide vacancy rate, reported via the IQPR, the Trust wide vacancy factor was included this year, to increase oversight, alongside the Support Worker and Consultant vacancy levels. Furthermore, the Chief Executive in his Board report includes a summary of the vacancy position, by Directorate and then the associated recruitment activity.

1.4 Whilst recognising the Trust vacancy position a number of the posts are supported by the atypical workforce, such as bank workers. Following the transfer of our internal banks to NHS Professionals (NHSP) on the 21st October 2024, the paper also details initial fill rates which should be considered alongside the vacancy levels. Whilst bank workers remain a key component of our staffing model, historically due to the high vacancy rates, significantly higher than the vacancy rate in acute Trusts, we have relied on bank workers, who may not necessarily be available at short notice which may then have a detrimental impact on patient care, as demonstrated by patient harm is more likely to occur with staffing plans that minimise the number of nurses rostered in advance as temporary staff may not be available at short notice (Griffiths, et al., 2021). This further supports our commitment to becoming fully staffed.

2.0 Current position

2.1 Our current vacancy position is summarised in Annex 1, which details 190.70 WTE vacancies.

2.2 The budgeted establishment includes all funded posts and includes those posts which were supported as part of the 2023/24 investment round and approved for 2024/25. Alongside the vacancy and budgeted establishment information, an overview of the current recruitment activity is also included. This starts with the approval process, when a post is approved for recruitment up to and including where a start date has been agreed.

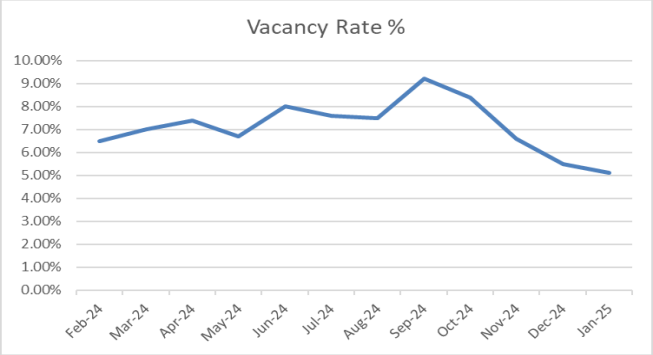
2.3 We operate in a competitive recruitment market, where colleagues may have a choice of a number of employers, therefore, not all posts which have been offered and even where a start date has been agreed will result in an applicant joining the Trust. Based on the current data, we have 190.70 WTE vacancies, and we have 52.88 WTE where the start date has been agreed and 84.26 WTE where the offer has been accepted and the employee is subject to the pre-employment checks prior to the start date being agreed. There are a further 137.14 WTE at earlier stages of the recruitment process.

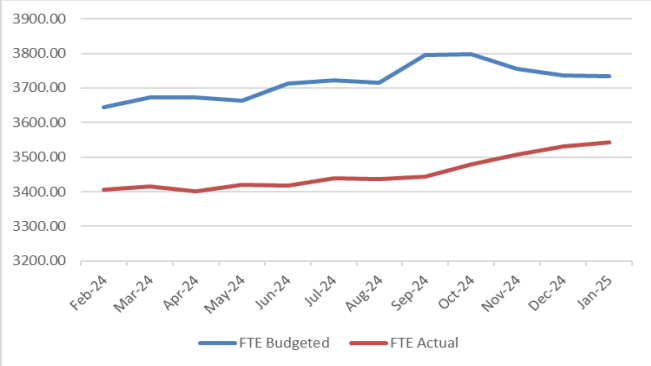
2.4 When looking at the total figures 190.70 WTE vacancies and 234.24 WTE posts at various stages of recruitment (excluding those at the authorisation stage) it appears that we will over recruitment and have a negative-vacancy factor. This is not the case as included within the data is recruitment activity for colleagues who have tendered their resignation, but not yet left the Trust. We encourage managers to undertake timely recruitment to prevent the 'gap' between the previous employee leaving and the new employee commencing.

2.5 In addition to the standard recruitment via Trac, we have implemented local community recruitment programmes to support individuals in our communities and different sectors to apply for our vacancies. This has been further enhanced by 'open day' recruitment events to cover multiple vacancies across the same staff group, initially focussed on administrative and clerical but now expanded to Support Workers, to improve the experience for the applicant and seek to reduce our time to hire. These programmes will continue and be further enhanced in 2025/26.

3.0 Comparison to December 2023

3.1 Given the relentless focus on vacancies and reducing the vacancy gap this year, it goes without saying that our staff in post (SIP) has increased when compared to December 2023. This is not a cost pressure to the Trust as the posts are funded. The following graphs illustrate the progress which we have made over the previous 12 months with the vacancy rate and then a comparison of the SIP and the budgeted establishment.





3.2 Whilst we have focussed on filling all of our vacancies and this remains our commitment, given high levels of vacancy in some staff groups such as AHP and Medical & Dental, we have further focussed on these areas through international recruitment to further enhance the workforce, which also improves the diversity of the workforce, becoming more representative of the communities which we serve. This is reflected in the higher growth in these particular staff groups as demonstrated by the following table:

Budgeted versus Actual

	FTE by Month			
Staff Group	**2023 / 12**	**2024 / 12**	**Variance**	**% Growth**
Add Prof Scientific and Technic	324.75	356.51	31.76	9.80%
Additional Clinical Services	791.95	823.52	31.57	4.00%
Administrative and Clerical	729.21	735.80	6.59	0.90%
Allied Health Professionals	190.46	215.07	24.61	13.00%
Estates and Ancillary	146.11	144.42	-1.69	-1.2%
Medical and Dental	63.10	73.44	10.34	16.00%
Nursing and Midwifery Registered	1,144.79	1,195.18	50.39	4.30%
Grand Total	**3,392.37**	**3,544.95**	152.58	4.50%

3.3 We have not progressed recruitment to all posts/vacancies within the Estates and Ancillary staff group as a review of the Domestic function for non-clinical areas is planned for Q4 2024/25 and it would not be appropriate to recruit to all of the vacancies and then undertake a change management programme. During this period the Trust has maintained the required cleaning standards in all of our clinical areas and have utilised temporary staff as detailed in Section 4.

3.4 As to be expected the SIP growth has predominantly been within our Operational Care Groups which accounts for 135.53/152.58 growth.

4.0 Support via NHSP and other means

4.1 Prior to the transfer to NHSP, the internal banks supported vacancies and short-term demand associated with sickness or increased patient acuity, alongside substantive colleagues who may have worked additional hours.

4.2 Following the transfer to NHSP we have seen our demand for temporary staffing reduce by an average of 8.3% across the staff groups, with the exception of Estates and Facilities where we have seen a significant increase of 16.2% over November/December 2024, but this spike in demand has now reduced.

4.3 We expected to see a reduction in the demand for temporary workers given we are filling our vacancies and in late summer 2024 we closed an inpatient area (Emerald and reinvested in our community services) and these colleagues have been redeployed to other areas. This is further demonstrated with when comparing the bank fill rates in 2023 to 2024 where there is a c.10% reduction in the fill rate. In January 2025 we temporarily closed an Older Peoples ward in Rotherham (Brambles) for a period of three months and this will further reduce our temporary staffing demands due to the ward closure and the redeployment of colleagues.

4.4 We are committed to filling our vacancies and the continued utilisation of bank workers to support temporary demand, instead of agency workers, but in time it is further expected that the demand will further reduce for temporary workers.

4.5 The average fill rates for NHSP in December 2024 across all staff groups equates to 133.11 WTE, recognising this is not all to cover vacancies and some is to support increased patient acuity, this significantly reduces the vacancy gap across the Trust.

5.0 March 2025 predictions

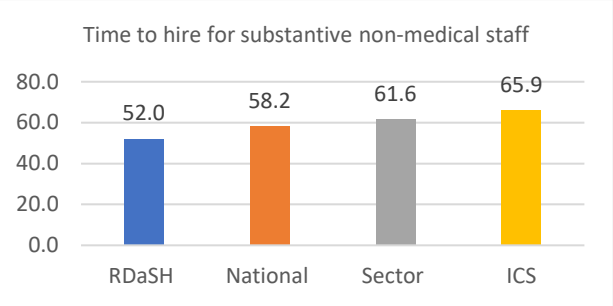
5.1 As part of the vacancy projections and the March 2025 predicted outturn position, it would be easy to take the data in section 2.3 & 2.4 and predict we will achieve the vacancy factor of 3.3% or lower. However, this forecasting would be unreliable due to the variable factor associated with turnover each month, delays in recruitment and applicants changing their mind.

5.2 Whilst we have focussed on retention as part of our People Promise Exemplar work during 2024 and our retention rate is below 10% target, now 9.31%, there remains a seasonal fluctuation associated with turnover in March of each year. On average c.25 colleagues leave the Trust each month, but in March the figure increases and this is figure is directly linked to retirements which more colleagues choose to take at the end of the financial year. Therefore, based on previous data its anticipated that we will have 75-95 colleagues leave during the next three months.

5.3 Assuming all applicants progress with the recruitment (noting the caveats above) and 50% of those currently at interview stage progress to commencing

employment then the predicted vacancies would be 29.86 WTE and a vacancy factor of 0.8%. However this does not factor in the anticipated leavers, c.75-95, based on the 95 figure, with an average of 0.7 WTE worked this would create c.66.5 WTE leavers during Jan – March 25, which increases the vacancies to 96.35 WTE and a vacancy factor of 2.6% Taking a more cautious forecasting approach, assuming 10% of colleagues do not progress with their employment offer, then the vacancies would be 112.44 WTE and a vacancy factor of 3%.

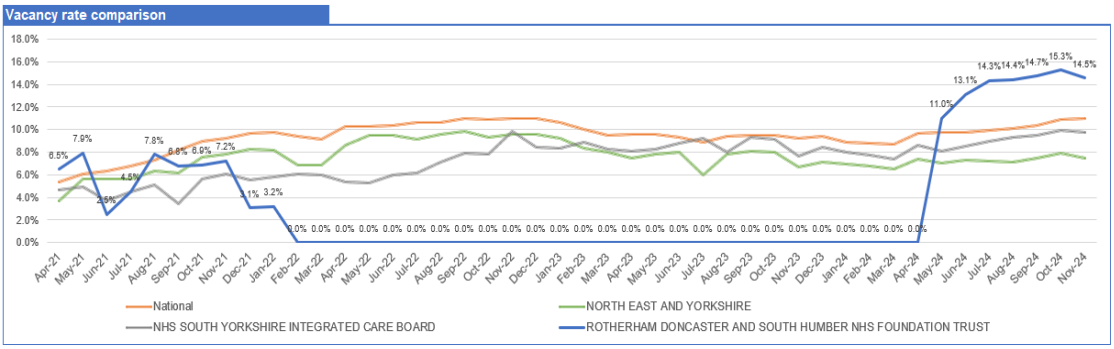
5.4 A further complication is the recruitment lead time, should vacancies not be progressed timely once a colleague has submitted their resignation this will create a delay and may push the recruitment into the new financial year. We actively monitor and report our time to hire via the IQPR. Recognising there are always opportunities for improvement the NHS England National Corporate Services Data Collection 2023/24 detailed below, demonstrates that once the recruitment has commenced, we progress this timely against all comparator groups, but we continually seek to streamline our recruitment processes to further improve, therefore this risk is minimised.



6.0 Areas of focus identified from national returns/intelligence

6.1 *Health Care Support Workers*

Through the IQPR the current vacancy rate for this staff group is 8.49% which has been steadily reducing this financial year. However, when this is compared to the data contained in the NHSE Provider Workforce Return (PWR) the vacancy rate appears to be 14.5%, as detailed below



Following investigations, data quality issues have been identified with the PWR return, where we have over establishments these have not been recorded as a negative vacancy % in the PWR return and as such the vacancy rate has been artificially inflated. This data quality issue will be rectified with the February 2025 PWR return, but it's fair to say the recruitment to our Support Worker/Nursing Assistant roles remains a priority as the vacancy level remains above the current Trust vacancy % and we have further work to do, to reduce it to 3.3% and then 2.5%. A deep dive into these vacancies will be presented to People and Teams in February 2025.

6.2 *Administrative and* Clerical Staff Group

In December 2024, Julian Kelly reported at NHS England Board meeting a plan to support Trusts to reduced support and administrative colleagues in 2025/26. Whilst no further information has been received to date, to clarify the colleagues in scope, the associated timescales and possible target reduction, we have commenced a scoping exercise to understand the administrative and clerical staff groups and the associated growth of these over recent years.

Whilst our data demonstrates growth in this staff group, this in part is balanced against filling of vacancies and historical service growth/new monies. To aid an initial understanding the administrative and clerical SIP at the 2018/19 outturn position was 542.30 compared to currently 735.80, a growth of 193.50 WTE, or 35.6% over the previous 6 years. When compared to the full Trust growth of 973.72 WTE which equates to 38%, therefore admin growth is slightly lower than the overall Trust growth.

It should be noted that a number of roles are categorised as administrative and clerical, such as Call Handlers in our Single Point of Access teams but these roles are hybrid administrative and clinical roles. To ensure all of the posts coded to Administrative and Clerical ('G' occupational codes) a deep dive will be completed in February 2025 to ensure an accurate reporting position.

7. Recommendations

7.1 The Board of Directors are asked to:

1. Note the current vacancy position, the predicted March 2025 outturn position and the potential future national changes linked to administrative and clerical colleagues

2. Recognise the local community/sector recruitment programmes which are underway.

Org L4	FTE Budgeted	FTE Actual	FTE Variance	RECRUITMENT	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total
376 CCG Management	23.23	18.8	-4.43		1.00	0.00	0.00	0.00	1.00	2.00	4.00
376 CCG Mental Health	321.33	305.39	-15.94		6.60	4.70	4.00	13.60	12.20	7.60	48.70
376 CCG Physical Health	278.85	273.9	-4.95		2.00	2.60	2.00	5.66	3.95	2.94	19.15
376 DMHLD Acute Services	233.40	206.27	-27.13		1.00	3.70	0.00	1.00	7.00	3.00	15.70
376 DMHLD Community Services	339.73	321.03	-18.70		6.30	3.10	1.00	1.00	8.70	2.50	22.60
376 DMHLD Learning Disabilities & Forensics	191.42	181.23	-10.19		0.80	0.55	1.00	3.00	2.00	1.91	9.26
376 DMHLD Management	10.20	7.80	-2.40		0.00	2.00	0.00	0.00	0.00	0.00	2.00
376 NLTT NHS Talking Therapies	181.29	178.48	-2.81		3.00	0.00	0.00	9.00	7.00	2.00	21.00
376 NLTT Acute Care Services	131.44	119.90	-11.54		5.30	3.80	0.00	5.00	1.00	6.33	21.43
376 NLTT Community Care Services	118.26	103.30	-14.96		1.00	1.70	1.80	0.40	3.51	4.00	12.41
376 NLTT Management	27.18	28.97	1.79		1.00	1.00	0.00	0.00	0.00	1.00	3.00
376 PHND Community & Long Term Conditions	406.99	400.07	-6.92		0.00	6.00	0.00	1.45	9.80	2.00	19.25
376 PHND Rehabilitation	318.01	306.83	-11.18		3.80	0.80	1.00	3.24	8.00	3.00	19.84
376 PHND Management	10.00	8.85	-1.15		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 PHND Neurodiversity	43.80	37.73	-6.07		1.00	0.00	0.00	3.00	0.00	0.00	4.00
376 RCG Acute Services	246.48	224.39	-22.09		0.00	1.60	0.00	0.00	10.00	4.40	16.00
376 RCG Community Services	240.46	226.58	-13.88		3.00	1.00	1.40	0.00	7.10	4.20	16.70
376 RCG Management	17.90	14.90	-3.00		0.00	0.00	1.00	0.00	0.00	0.00	1.00
376 Corporate Assurance	30.12	35.36	5.24		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 Estates	45.65	42.17	-3.48		2.00	2.00	0.00	0.00	0.00	0.00	4.00
376 Finance & Procurement	48.54	41.99	-6.55		1.00	0.00	0.00	0.00	0.00	0.00	1.00
376 Health Informatics	75.36	74.24	-1.12		0.00	1.00	0.00	0.00	0.00	1.00	2.00
376 Medical, Pharmacy & Research	46.25	54.60	8.35		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 Nursing & Facilities	171.67	169.18	-2.49		3.73	1.00	0.00	1.00	0.00	1.00	6.73
376 Operations	51.43	45.40	-6.03		0.00	0.00	0.00	0.00	3.00	0.40	3.40
376 People & Organisational Development	98.89	92.14	-6.75		0.00	0.00	0.00	0.00	0.00	2.60	2.60
376 Strategic Development	19.38	18.56	-0.82		0.00	0.00	0.00	0.00	0.00	1.00	1.00
376 Psychological Professionals and Therapies	6.50	5.00	-1.50		1.50	0.00	0.00	0.00	0.00	0.00	1.50
Total	**3,733.76**	**3,543.06**	**-190.70**		**44.03**	**36.55**	**13.20**	**47.35**	**84.26**	**52.88**	**278.27**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 3 and 4	**Agenda Item**	Paper O
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Steve Forsyth, Chief Nursing Officer James Waterworth, Volunteer Paula Rylatt, Head of Quality and Promises		
Meeting	Board of Directors	**Date**	30th January 2025

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

The paper allows us to explore what is working and what is not yet working with this 'tranche' of promises, as we look to accelerate timely delivery of strategic objective 1 which is particularly relevant to promise 3, ***350 volunteers by 2025***.

The paper seeks for Board to recognise and celebrate the implementation of promise 4. In particular the report highlights the launch and speed at which care opinion has been embraced by our organisation, care group leaders, teams, individual clinicians, reception staff, our volunteers and what has improved/transpired from this significant change in our patient feedback system/process.

Board is asked to review the promise 3 developments in recruiting people from our community, their demographics but also recognising there is a huge task to support increasing our cohort of people, for us to achieve our first milestone of 250 volunteers by March 2025 and then the further push to 350 by summer 2025. Board are asked to note areas where there remains a challenge in achieving the numbers which were proposed and committed to by the five care groups and thirteen clinical directorates.

Alignment to strategic objectives (indicate with an 'x' which ambitions this paper supports)	
SO1. Nurture partnerships with patients and citizens to support good health.	X

Previous consideration

Clinical leadership executive (CLE)
CLE Quality and safety group
Public Health Patient Involvement and Partnerships Committee

Recommendation

The Board of Directors is asked to:

x	**NOTE** the report provided and the assessment of work undertaken to date, including our learning and actions
x	**AGREE** on acceleration possibilities to get to 350 volunteers and making our feedback translate into meaningful felt change

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

Trust Risk Register		NF 18/24
Strategic Delivery Risks	x	SDR1
System / Place impact	x	Potential impact for VCFSE – unintended consequences

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	

Rotherham Doncaster and South Humber NHS Foundation Trust

Executing our strategy 2023 – 2028: Promises 3 and 4

1. Background

1.1 The Board of Directors have received five papers focusing on each of our Strategic Objectives outlining what the objectives are about and what may be difficult about delivering them. The Board will now receive a new group of papers, November Board of Directors received the first iteration of this with a detailed paper from Jo McDonough, Director of Strategic Development, 'Accelerating Delivery on Promises 6, 7 and 8. This paper seeks to replicate the style of report provided by Jo, igniting the conversation and discussion on strategic objective 1.

Board is to be made aware that internal audit, 360 assurance commence their audit on both promises this month, promise 3 and 4, and this update serves as an update to support their review of our commitment to SO1.

1.2 Building on Jo McDonough's November Board paper, we will focus on a subset of promises to map the road to achievement:

- What is currently being done to deliver the promise and how to get to Amber/Green
- Any potential barriers to delivery
- Anything further action that could be taken.

1.3 These reports will be in addition to the Chief Executive's regular scorecard assessing the progress of implementation of each of the 28 promises in the Strategy.

1.4 This focuses on the rating of the delivery plan as follows: -

- Green – Finalised and agreed.
- Amber/Green – Developed and being refined.
- Amber/Red – Understood but not documented.
- Red – Not constructed yet.

2. Promise 3

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

Success measure	Rating November 2024	Action underway
Have 350 volunteers registered to work with us or have equivalent to that figure volunteering time with us through another body	**Amber green**	Intensive work since summer 2024 mobilising resources and restructure of corporate nursing team to enable dedicated centralisation to maintain level of volunteer recruitment and welfare/pastoral support

Success measure	Rating November 2024	Action underway
For that body of volunteers to reflect the diversity of our populations.	**Amber red**	Concept of plan with varying engagement from VCFSE sector – good links commenced with Sikh, Muslim and voluntary groups including Doncaster Rovers

2.2 Our current position is that we have **197** Volunteers, these people are split between our care groups:

Care Group	No of Volunteers
Backbone - includes Estates and Facilities roles, Chaplaincy, Safeguarding, Patient Engagement and Inclusion (PEI)	37
Children's	27
Doncaster Adult Mental Health and Learning Disabilities Care Group – includes 10 for Aspire	24
Physical Health and Neurodiversity Care Group	37
North Lincolnshire Adult Mental Health and Talking Therapies Care Group	8
Rotherham Adult Mental Health Care Group	7
Unable to allocate to a Care Group	28
Governors	29
Total	**197**

There is significant work that needs to be undertaken with care groups from now until the end of Q4. Care group leaders committed to reach a target per care group that was proposed by each of the five leaders from their respective areas, currently that collective number is 127 short of what they confirmed was achievable. **N.B.** The update to this report will fall between delivery reviews and Board being held, consequently a verbal update on this will importantly be provided by the report author.

So, it is vitally important that we do not achieve a target and miss the point, therefore we have been ensuring that our volunteers reflect our community, the people we deliver care with and ensures promise 26 is a vital construct of our future workforce.

Our successful increase in volunteers over the summer 2024, has seen the following demographic reflection in our volunteer at the various recruitment stages.

- A higher application rate by females than men, with an equal % split of male and female volunteers appointed.

- Our age range is predominately our under 20s and 20-34 with a good representation of volunteers ranging from 35 years upwards.

- We have seen over 240 people from a global majority apply to be a volunteer since the summer, comparably 40 people considering themselves as white British have applied.

- 40% of volunteers appointed confirm having a disability with 45% choosing not wishing to disclose/not stated.

3. Important progress updates on successes and developments

- We have met with the British Red Cross and the use of their volunteers for emergency responses or exercises and to support incidents where required, in clinical areas

- Volunteering is on staff induction day 2. The ambition is to see new volunteers attend part or all staff induction in quarter 4 alongside paid staff.

- The road show events were held and the one stop shop approach was piloted, limited success on this approach.

- Backbone services 2 new volunteers recruited to poverty proofing, 1 to safeguarding and applications coming in for 5 IT admin posts. L&D administration volunteer posts x 2 have been shortlisted and there are pending interviews arranged.

- Academia and work placement organisations continue to request volunteering and placement opportunities.

4. Forward plan quarter 4

4.1 Getting to 250 in just over 60 days will see a push of 10 volunteers per week, in a similar approach to the flu campaign the numbers of volunteers matters!

4.2 Our plan to get **53 volunteers** will be managed weekly with Paula Rylatt, Stuart Green and Steve Forsyth.

4.3 Nursing and Facilities have set up a weekly accountability check in, to get to the first target of our 250 volunteers before the end of the final quarter.

4.4 From now and to run parallel with the aforementioned, it was agreed in Executive Group, 9 January 2025, each of the Executive team directorates will commit to **5 volunteers** to allocate placements, with nearly 40 volunteers already within backbone services, we are certain with Executive commitment and support, alongside a significant increase in the support from Rotherham and North Lincs Care Groups, that the **100 remaining volunteers** that remains for us to recruit and place will reach **350 before the end of the 6 week summer holidays**.

4.5 Full commitment and sign up was offered within the Executive Group.

4.6 This will be managed by the Chief Nursing Officer.

- Recruitment drive for **50 volunteer** administration roles (generic) – offering a peripatetic experience of corporate services for a time limited period 12-16 weeks.
- This will ensure all MAST/orientation and local induction to RDaSH is completed during this time and a “Welcome to the Trust”
- To offer **rotational posts** for volunteers to get a grounding in Backbone and RDaSH services during this time

- As post(s) become available or identified in the Care Groups - volunteers will be allocated in to service areas
- Volunteers can stay in Backbone as well if they wish and the volunteer role is supporting the person

4.7 360 audit will identify in line with the Greater Manchester Report, whilst there in nothing new in what we want volunteers to do, the challenge remains to bring MAST/NHS emails/e-learning up to date for volunteers. We will seek assistance with this from ***Carlene Holden*** to work with the process and align the potential that is seeing volunteers undertake significant MAST hours training.

5. Promise 4: putting patient experience at the heart of how care is delivered in the trust, encouraging all staff to shape services around individuals' diverse needs

Success measure	Rating November 2024	Action underway
Increase by 15% the scale of feedback received in the Trust versus 2024/25 baselines.	**Amber green**	Care opinion launched and being embraced by our community, significant feedback and buy in from all clinical directorates
Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	**Green**	Plan in place 24/25 – successfully being implemented by MHA group
Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.	**Amber red**	We now on a 'push' basis how this can be executed. Work is taking place through 24/25 to test the level of 'pull' from inside DMTs to make this work a reality.

5.1 At the beginning of June 2024, we began the roll out of Care Opinion; this is the direct replacement of YOC (Your Opinion Counts) as our primary feedback, compliments and suggestions platform. Care Opinion was launched across all services in November 2024. Much of our feedback to date is through web based QR codes, though there is an option to offer phone and written feedback as part of this platform. Our contract is for 2 years and currently we have a licence for 450 responders, having 333 at the current position.

5.2 Care Opinion has seen 375 stories told (to 22.1.15). It's flexibility, has allowed local feedback to embed as part of service improvement and change and recognition.

This is a huge success within the Care Groups and our directorates are receiving large numbers of feedback:

Service	Stories
Adult physical health - Community	128
CYP physical health	74
Adult MH Doncaster	42
Neurodiversity	41
Adult MH Rotherham	31
Adult MH North Lincs	28
Addiction team	10

The areas we are targeting to see improvements in care opinion feedback are, learning disability, primary care MH, PICU and talking therapies all localities. These areas have single figures or less feedback.

5.3 The feedback portal has been rolled out to clinical leads, team leads and service mangers as well as Care Group Directors and key people in assurance for performance and quality, with internal colleagues also able to share externally.

5.4 Estates and Facilities also have Care Opinion QR codes as care and the experience of the Trust starts when people visit RDaSH sites. Equally it is about the wrap around experiences of nutrition, laundry as well as parking and grounds.

5.5 As this is a public facing platform for feedback, there are opportunities for, Healthwatch, Commissioners and CQC to have a free monitoring licence which shows “how things are happening” in RDaSH. Healthwatch Doncaster is currently routinely lifting stories out to share on social media.

6. Forward plan quarter 4

- FFT data continues to be gathered monthly for NHS England, via Care Opinion itself.
- The procurement of the new information management system Radar will see the integration of incidents, complaints and PALS data within the first launch module. This triangulation of data will make possible the analysis data trends regarding patient experience.
- Care opinion feedback currently is scrutinised by implementation at our internal process of delivery reviews with each care group. The proposal is that this is channelled through our sub subs, that being Quality & Safety group, that will see a natural transition to the improving patient safety, quality, effectiveness and experience report. With real time feedback rather than last months plus the 15th working day of the month to cleanse data. We can really make a difference and inform our year look back on the real changes that patient feedback has driven, but also enabled us to improve on the good stuff too.
- Another action we are taking is to build in care opinion feedback into our peer reviews, to apply the ‘check and challenge’ litmus test, ensuring feedback brings demonstrable change, that change is known within the team and also, we can see it has been sustained/reviewed/modified.
- We also need to widen our access to monitoring licences, it is great Doncaster Healthwatch have taken this forward, we need our local authorities, VCFSE’s and other community services to join us on this journey.
- Along with this we need to rollout the SMS feature of care opinion, support more ipad’s in clinical areas that have seen significant use of the 10 we have out in the areas with highest levels of feedback.

There is so much more to consider within the learning half days and the leadership development offer, as we move forward with both promise 4 and promise 5, and notably for this paper creating the organisational conditions for a healthy patient feedback culture, alongside the structures that enable

7. Governance

7.1 The finalisation of plans and delivery of these promises is overseen by the Equity and Inclusion Group (sub-group to the Clinical Leadership Executive).

8. Summary

8.1 Promise 3 needs to achieve the key milestone of 250 volunteers before the end of Q4 and then make headway and continue of this momentum to secure 350 volunteers by the end of summer 2025. The demographics of our communities needs representing through the 9 protected characteristics.

8.2 Promise 4 plan is well on track to deliver, our challenge this year in 2025 is to ensure we are ready to demonstrate the changes and achievements in a meaningful quality account, and end of year report to our public demonstrating what we have done less of, more of or changed as a result of our care opinion feedback.

Steve Forsyth
Chief Nursing Officer

January 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	High quality therapeutic care taskforce (HQTC) – further discussion	**Agenda Item**	Paper P
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	30th January 2025

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

Board members, including non-executive colleagues, had sought last time a further discussion on this subject, which is an important one we need to hold in common. The paper is timely because the taskforce starts work on February 12th, with project office support from our Change and Improvement Team. The baseline work on Culture of Care standards will complete by end of March.

Our discussion may wish to focus on the how and 'we' parts of the appended paper, as it is important that the Board has confidence in the authenticity of the way we will do what will be controversial work, or at least have the potential to be so. That work is unambiguously about patient safety, care quality, and employee experience – albeit it comes with financial implications too, which may for some overshadow the wider conversation.

Alignment to strategic objectives (indicate with an 'x' which ambitions this paper supports)	
SO1. Nurture partnerships with patients and citizens to support good health.	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X

Previous consideration

n/a – references previous Board discussions in Q3 24/5 on same topic

Recommendation

The Board of Directors is asked to:

X	**CONSIDER** any specific opportunities or risks associated with the work of the taskforce
X	**NOTE** commencement of the work from February
X	**RECOGNISE** the internal and external concerns that this work is likely to give rise to

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

Trust Risk Register	X	Extreme risk in relation to MH bed flow
Strategic Delivery Risks	X	SDR 4 in relation to 7-day services
System / Place impact	X	OOAP as primary relevant financial risk to both ICBs

Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	Not for this paper
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	Not for this paper

Appendix (please list)

Annex A – NHSE culture of care standards for mental health inpatient settings

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

High quality therapeutic care taskforce (HQTC) – further discussion

Introduction / purpose

1.1 The Trust has 13 clinical directorates, and a minority admit patients into beds and wards for care. Nonetheless, some of our more complex care packages are provided through these wards – and the need to improve the therapeutic care we offer in those spaces was recognised by the Board when we agreed the strategy in summer 2023. We cannot move our Trust's care to good, nor meet the ambitions of our patients, carers and communities, if we do not succeed in that objective, which is variously outlined in promises 18 – 23.

1.2 The focus of September's Board meeting in public was the challenges posed by those promises, the voices of some detained patients from our services, the data and relative efficiency of our wards, and the intent to create a new approach to trying to improve care and introduce more consistent standards. This was further explained in our November Board, noting the Clinical Leadership Executive's (CLE) support for the High Quality Therapeutic Care taskforce, as a time-limited addition to our Operating Model. That taskforce meets for the first time in February.

1.3 **Some colleagues sought further discussion on the aspirations and expectations we had in this area**: mindful for example of the high public profile of bed-based change, the 2019 CQC report which focused attention on adult mental health inpatient care in allocating a Requires Improvement rating to the Trust, and recognising the challenges recognised nationally in providing inpatient mental health care. This paper aims to respond to that appetite but, necessarily, will be in places repetitive. *It assumes Board colleagues have re-familiarised themselves with relevant papers from the prior two meetings, cited above.*

Why we are doing this work?

2.1 The analysis shared with the Board in November 2023, and again in September 2024, confirmed that there was a mismatch between the beds we have in place and the needs of our patients. That mismatch includes:

- We appeared to admit more patients than we would expect to
- A minority of our patients stay with us a very long time, though that proportion is reducing
- We do not have sufficient beds to admit working-age adults needing our care and this, in part, explains our out of area placements
- We devote more beds (and funds) to inpatient provision for older adults than the data suggests is needed
- We comply with gender separation regulations, but often have to offer care elsewhere for patients needing single-gender provision, perhaps notably so for intensive care of female citizens
- Lengths of stay, and patterns of flow, for intensive care are not consistent with the designation and staffing intensity for an intensive care unit.

2.2 The Care Quality Commission rates our inpatient care below the good rating (outstanding for caring) that the Board has agreed is our aim. Whilst many of the recommendations made have been discharged, we do not have significant data points which positively confirm the high quality of our inpatient care.

2.3 Staff/colleagues do not report consistently positively about working in our ward teams: we struggle to recruit to some medical, AHP and psychological professionals' roles, and whilst nursing (registered/unregistered) roles are typically filled, there remains high turnover in places and resort to unsustainable financial premiums in others. As importantly, reports of violence and fear of violence make difficult reading, whether that reflects sexual harms, racism and discrimination, or physical assault.

2.4 In summary terms, clinical experts within the executive may consider our wards safe, but there are not substantial voices – from patients, clinicians, or other leaders – suggesting that they are systematically high quality and therapeutic.

What we will be doing?

3.1 As outlined in multiple CLE discussions, and for the Board, ***we are going to do three simultaneous things***. The implicit theory of change is that all three are needed. In taking the approach outlined, we are rejecting either past, current local, or current national encouragement to have distinct flow and quality projects, or to proceed by pilot/spread. This difference is important, as mental health inpatient improvement work is a national priority and there are myriad initiatives and asks of us to take part.

- creating a **redesign taskforce** which will both prioritise the questions and develop likely solutions, in consultation with others: and report that for approval to CLE.

- putting in place a single '**help squad'** drawn principally from corporate functions, and convened by Jon Rouston, to work inside wards on a programmed basis to support local teams to apply changes successfully

- putting in place, coaching, and supporting **multi-professional ward leadership teams** in all of our ward areas.

3.2 After much discussion and debate, the wards in scope for this work are our eight acute/PICU/forensic wards, and our four (presently three) older adult mental health wards. CLE colleagues felt strongly that community clinicians also needed to participate in the work, as did crisis teams within acute directorates. This is reflected in the approach being taken. But it is important to confirm that the solutions do not lie entirely outside the wards themselves: how those wards work now will sometimes need to change to accomplish improvement in the matters outlined under section 2.

3.3 Changing the work also means changing the workforce. This may mean new skills in existing roles; new roles including delivery of promise 1 on peer support workers; or different responsibilities within roles. We know, for example, that supporting non-medical professionals into RC/AC roles will be essential as scarcity worsens, and a new mental health act brings increased obligations. Our promise to revisit work patterns across seven days is a further consideration.

3.4 The taskforce will spend its first three meetings ensuring that the scope and *sequence* of work meets the most pressing needs faced by patients and staff. For example,

taking forward an estate plan requires that we are clear the future arrangements for intensive care. That service also faces senior cover issues. Likewise, the emergency closure of Brambles, among other dynamics, means that we have given an assurance of clarity about the older peoples' bed base by April 2025. It will be important that time is allocated in early phases to issues which require work over time, as well as those with immediate urgency.

3.5 The commitment we made across the executive was to work with one or two wards to pilot the content and process of an improvement intervention. We need to move to that phase during Q1 of 25/26. It may be that that feels too soon, but there is a greater risk of continued delay in beginning to test necessary changes within our ward areas.

When do we need to do this by?

4.1 The work needs to be largely completed in 2025, and certainly within 2025/2026. That urgency is perhaps best explained as follows:

- while we are working to improve inpatient care, other services will inevitably have less attention. The work, therefore, must have a beginning, middle and an end
- our regulatory improvement work is contingent on change within our wards, and the lack of comprehensive risk-based care planning is the largest single issue in that space
- our ability to staff these spaces with sufficient and experienced clinicians, and colleagues working in teams is unstable
- the functioning of our wards has a very direct bearing on other public agencies locally
- change fatigue is real, rumours rife and hard to counter among shift-based colleagues, and we need to show evidence of good faith to improve patient and staff experiences.

4.2 The work has to be underpinned by a development programme for those in leadership positions. The new first line managers programme starts in coming weeks. We will need to consider whether this is sufficient for the purposes required. If it is not, this will need to be considered on a cross-cutting basis against our 2025/2026 training budget, with work undertaken in Q2 and Q3.

4.3 There is certainly a risk that the need to do, and the trust required to succeed, end up in contest. In February and March, as a taskforce, we want to consider together how best to find the balance for this important work.

How we will do this work?

5.1 As a general guide, the taskforce will focus most time and attention on **what problem it is trying to see solved**. The relatively precise dimensions of that problem, or at least its symptoms, need to be collectively understood. Once this is done, we will consider long list options – and select a preferred and second-best option for consideration. Implementation analysis will vary across two approaches – organisational deployment across a specialty (for example the older peoples' bed base question) or by ward deployment supported through the help team. Even where something appears as organisational deployment, it will typically require behavioural changes at a very local level, and this will need to support to do.

5.2 A data informed perspective, as illustrated in September 2024, will be an important input to the work of the taskforce. But it is not the only identifier of issues: feedback

and professional judgement, published evidential standards, and outcomes sought need to guide our work as well.

5.3 For a proportion of problems, or issues we face, we may seek **an outside-in opinion**. Generally, this will be done through commentary and challenge to the preferred/second best option material. Such outside-in opinion is not about consensus building per se, but rather ensuring that our points of analysis and thinking have not become too narrow. This step, and the wider taskforce will, however, help us to manage myths of pre-decision, or decision making just by executive directors.

5.4 We will look to **communicate as we are going along**. As far as possible we will do that in a form (written/audio) that is replicable so that there are not long chains of misinformation/misunderstanding. Prior to the first taskforce meeting, we will develop a communication cohort of professionals involved in the services covered by this work, and trial how best to narrate the questions, ideas, and progress being made.

Who is we?

6.1 This question is crucial. We have to **hear the voices of our patients and carers** in considering what problems need to be settled in this improvement work. Adopted solutions likewise need to carry public support, and benefit from evaluation after implementation by, and with, our patients. Change will be difficult, and it will be important to build trust that changes made will be subject to impact analysis, and flexible, to further change where promised improvements are not secured in 2026, 2027 and 2028.

6.2 Responsibility for decision making at an operational level will rest with the clinical leadership executive, and with the Board routinely making major strategic decisions on recommendation. As this work will fall principally within the quality domain of our Quality and Safety Plan, **our quality committee will play an oversight role as well**.

6.3 In considering carefully the mix of skills and expertise needed within our taskforce, we have explicitly sourced leaders from a balance of clinical disciplines, drawn from both adult and older adult backgrounds, as well as our learning disabilities and forensics directorate. Indeed, **the majority of attendees are drawn from our directorates**, notably our acute directorates, as we look to hear from, and shape, with those who will be charged with week-to-week implementation.

6.4 It is possible that the outcome recommendations from our work will make changes to the scale or shape of the bed base. It may, for example, invest in Housing Association tenancies in one place, or seek to move services between certain places. We will need to include **relevant statutory and community stakeholders at the formative stage**, as well as in due course in any OSC activity in the summer. We will look to do this with our ICB place directors and Local Authority Chief Executives, recognising that neither can commit their wider organisation to aligning to our suggestions.

6.5 The most complex ‘we’ questions will be **more individual**. As the Board discussed in September, the ostensive legacy position is that individual wards very much operate under the aegis of a ward manager and matron, and individual clinical practice is shaped by clinicians. The move to a more consistent model, that persists even when personnel change, is a shift in ‘who decides what round here’. It does not move RDaSH to a unique or especially unusual position, but it is likely that the transition path will come with some disquiet. The lay explanation of intent to date has been one that

usually makes sense to those listening – 'within one standard deviation of consistent practice'.

What happens next?

7.1 We need in February to finalise a mobilisation plan for the work to be done over the following part of 2025. The final form for that plan must incorporate feedback from the taskforce itself. But it should certainly include seven elements:

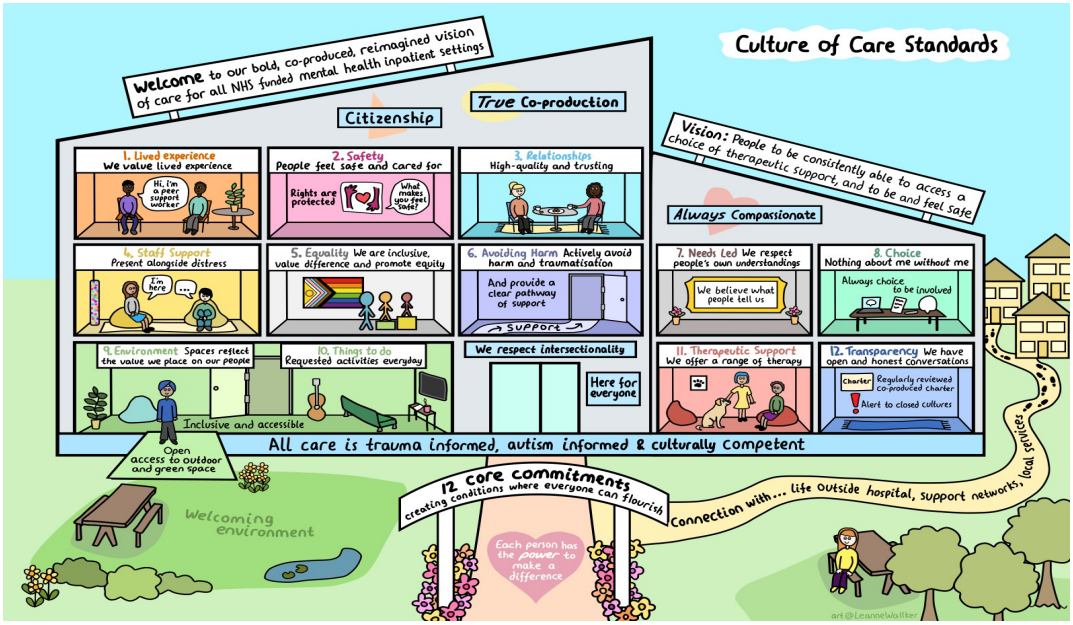
a. **Size/shape proposition:** this sets out the 2028, and before, scale and disposition of currently provided bed-based services at the Trust.
b. **Admission avoidance proposition:** this identifies how we will work, and what we will do differently, to reduce admission rates closer to relevant peer norms
c. **Condition specific length of stay work:** this outlines how we will reduce length of stay safely by reference to best practice expectations for given conditions
d. **Delivering promise 19 (OOAP):** work to tackle first 'inappropriate' out of area placements, and then to relocate placements appropriately cited elsewhere because no service exists locally
e. **Implementing our safety plan in ward environments:** delivering an agreed series of 100% standards on each shift, while contributing to the delivery of CQC core standards
f. **Improving our culture of care self-assessment scores:** supporting multi-professional teams to improve their identified priority areas to support these national standards
g. **Implementing both multi professional leadership teams at ward level and standard work:** bringing a level of consistency to how the wards within given specialist areas work RDaSH wide

7.2 There are five executive members of the taskforce, including the author. Objectives for 2025/2026 will include focus from each in specified areas of this workplan. These objectives will be biased to Q1 and Q2 of the coming year.

7.3 *We will seek at March's Board meeting to offer assurance that we have created the time and manpower to undertake the work outlined in this paper in the months ahead*.

Toby Lewis, Chief Executive
January 22nd 2025

Annex A NHS England Culture of Care standards and local adaptation guide



RDaSH nurturing the power in our communities

Culture of Care (CoC) – Bespoke Approach

(Agreed with Tom Ayres, Director of NCCMH – Royal College of Psychiatrists)

- Culture of Care Baseline assessment – We have agreed a modified approach linked with our Trust strategy and also our commitment to coproduction. Due to this we are in the progress of developing an 'easy read' version of the 'culture of care tool' for use with patient and their families. (PFG are our 3rd Sector partner)
- Older Adults Pilot Baseline (and case study) - Laurel Ward who have been engaged in the CoC coaching will be the pilot ward for the culture of care assessment. Due to the bespoke approach the CoC team have asked for this to be presented at the next quarterly CoC national learning event and be placed as a case study on the futures platform.
- Baseline roll out – after the pilot, and PDSA reflection, the baseline assessment will be rolled out through all of our inpatient areas within Q4 24/25 (see next slide) . This will then result in a ward -based plan and also feed into a Trustwide dashboard with comparisons of each component part of the assessment. (see slide after next)
- Autism/ Sensory Audits – We have a 10 point action plan in terms of 'Autism Friendly' (referenced above). One of the main inpatient aspects of this plan focusses upon environmental changes, after an expert by experience assessment. The changes to the environment are ongoing and are linked with our 24/25 and 25/26 finance and capital plan.
- PCREF – A key part of CoC concerns the implementation of PCREF. Our PSIRF and PCREF plans are interlinked. We are progressing specific actions in terms of anti -racism, bystander training, REaCH Network programmes of work and also recruiting people with lived experience in paid and volunteer roles from different diverse backgrounds, as patient safety experts and 'help team' / QI team members. Our Nursing and Facilities team is currently undergoing a restructure and therefore the joint work between PSIRF and PCREF will be progressed when the restructure is finalised.
- Oversight –Board level ownership. There is a task force that will run from January 2025 to support the 3 strands of therapeutic inpatient work.
- Leadership Development –One of the other rationales for our 'bespoke' programme with CoC, is because of the leadership development programme we have in the Trust, which is working with Virginia Mason, PSC, Mokita.

RDaSH nurturing the power in our communities

[to note the statement here regarding PCREF has subsequently been revised]

Annex B – baseline analysis work Q4 2024/5

*Hospice, Hazel, Hawthorn and Magnolia not included at this time, linked with the nature of care provided

Culture Assessment Plan

Ward	Care Group	Assessment date	Person leading	Patient Perspective Meeting	Patient Perspective Partners	TIC meeting discussion date
Kingfisher (6 bed – Adult PICU)	RCG	Q4	Dr Steve Kellett	Q4	Speakup	Q4
Sandpiper (18 bed acute Adult)	RCG	Q4	Dr Sasha Priddy	Q4	Speakup	Q4
Osprey (18 bed acute adult)	RCG	Q4	TBC suggested Dr I Asquith	Q4	Speakup	Q4
Brambles (15 bed OP acute)	RCG	Q4	TBC suggested Dr I Asquith	Q4	Speakup	Q4
Glade (18 bed OP Acute)	RCG	Q4	TBC suggested Dr I Asquith	Q4	Speakup	Q4
Laurel (13 bed OP Acute)	NL&TT	Q4	Dr Antonia Cooper	Q4	MIND CAB	Q4
Mulberry (17 bed Adult Acute)	NL&TT	Q4	Dr Rebecca Hunter	Q4	MIND CAB	Q4
Brodsworth (20 bed Acute Adult)	DMHLD	Q4	Dr Laura Turner	Q4	PFG	Q4
Cusworth (20 bed Acute Adult)	DMHLD	Q4	Dr Laura Turner	Q4	PFG	Q4
Skelbrooke (6 Bed Adult PICU)	DMHLD	Q4	Dr Laura Turner	Q4	PFG	Q4
Windermere (20 bed OP Acute)	DMHLD	Q4	Dr Kerry Sheldon	Q4	PFG	Q4
Aspire (14 bed Addictions)	DMHLD	Q4	Andrea Vincent suggested Dr Susannah Parker	Q4	Aspire Peer Support	Q4
Amber Lodge (14 bed forensic)	DMHLD	Q4	TBC	Q4	PFG	Q4

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Medium term plans (4 of 8)	**Agenda Item**	Paper Q
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	30th January 2025

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

The route to Board presentation has been long, diverted, and not what we might wish. We have a number of plans which are largely in a form that carries support – but needed to make changes to others to ensure that they describe what we will, and what we won't, be prioritising. The capacity, and capability, issues in devising plans merits discussion outside a Board meeting, as we look to consider how we can address both.

For this meeting, four plans are presented, with one having been considered already in July 2024. The four plans need to hold together as mutually reinforcing: two report through our relatively new PHPIP committee, and one each via POD and QC. The balance of our plans will come back to the Board in March: both the People/Teams and Digital Transformation plans are complete.

The Board may wish to focus on whether we have chosen wisely among the many safety and quality measures we might focus on; and whether we have made sufficient sense of a way forward on innovation. The Equity & Inclusion plan and Learning & Education plan have in common trying to make 'mainstream' work hitherto done by experts and enthusiasts. The summary paper, itself lengthy, tries to narrate what is really intended, and some the enablers and inhibitors, that cut across these plans. It may be a useful 'list' through which to lens assessing the documents themselves.

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 deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X

Previous consideration

Board timeout – October 2024

Recommendation

The Board is asked to:

x	**NOTE** the material presented and raise comments on what is/is it not included
x	**MOVE** to approve final version of these plans at our March meeting

Impact (indicate with an 'x' which governance initiatives this matter relates to)

Trust Risk Register	NA						
Board Assurance Framework	X	The presented plans bear particular on SDR 2 and 4					
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)

Quality & Safety Plan Research & Innovation Plan (to follow) Learning & Education Plan Equity & Inclusion Plan

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Introduction and governance

1.1 The Trust has one strategy. It was never intended that this outlined everything we planned to achieve, nor the organisational enablers needing to develop to deliver it. Instead, our plans were designed to augment the strategy and bring together disparate agendas. They also intended to be the only plans we have. Proposals or ideas or instructions from outside the Trust, typically lower done the agreed pecking order, would be managed where they are to be actioned through assimilation into the plans.

1.2 These complexities may explain the quite tangled and lengthy process of trying to refine plans. At the Board they are not presented for approval but for discussion. We will work from that discussion to agree final form. And add to the four headline plans our enabling plans – estate, finance, people and teams, and digital transformation.

1.3 The plans are uppermost in the role of our Board committees. As such they are an important part of planning our workplans for 2025/26. The six agendas for those meetings need to make sufficient provision for the material within the plans – testing readiness to delivery and Trust-wide progress, whilst also paying attention to execution per group (corporate and our five care groups).

Summary of material – Q&S

2.1 The plan for quality and safety sets out a very distinct approach to these two constructs. One that has been welcomed by senior leadership teams for drawing an important distinction that is meaningful to their work. We have adapted that distinction mindful of an emphasis on PSIRF from our executive clinical leaders, and our Board's commitment to use patient voice at the heart of what we do. In effect this produces a simple 2x2 mindset to our work:

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

2.2 It is important the Board commits to these ideas, not only in themselves, but instead of either a legacy, or another 'outside' list of quality and safety initiatives. In both cases this self-discipline is necessary to retain bandwidth. We have restructured all three clinical corporate functions over time – and in the coming year the nursing and quality functions within nursing and facilities need to work differently and produce new outputs hitherto not seen. The lack of quality and safety synthesis highlighted in recent annual governance statements must be overcoming over coming months: with the new RADAR system providing data to support a revised focus on improvement, coaching, and quantified change.

2.3 The move to lead our quality work with a combination of patient voice and co-constructed outcomes represents a widely held ambition among clinicians and managers. But it also represents a huge change from a focus on input measurement, commissioning models, assurance reports or assessing professional role compliance. Over the last twelve months persistent attempts to develop a new 'language' to support these conversations has proved challenging. It may be that we need to consider how we best develop that share understanding firstly among executive and Board leaders: and then with a wider cohort.

2.4 In the mapping of our promises to our plans, the work to deliver strategic objective 4 is supported through this quality work. That is because we need to be able to embed quality improvement into our work on therapeutic value. Because our ward care is visible, contained, and typically provided to a smaller sub-set of diagnoses, we ought to be able to evidence both the execution of our always events – and improvement in measuring and evaluating outcomes.

Summary of material – R&I

3.1 Our research and innovation plan is likewise closely related to the focus on quality. We think that improving outcomes will require us to both evaluate what we do, understand the factors that are most impactful and amenable to influencing recovery, and take experimental risks in what we do and how we do it. As we operate in a scarcity economy, we cannot build up service models purely based on legacy gold-standard approaches.

3.2 As the Board discussed in November, the clinical leadership executive has identified six research priorities for the Trust. These take us beyond the existing portfolio of NIHR and commercial work progressed through Grounded Research. What is now needed is a cogent proposition for each as to what it will take to use those priorities to recruit and retain clinical experts, and how we will attract trials and other collateral into the Trust.

3.3 Necessarily these ambitions move the Trust to needing its directorates and Care Groups to give focus to research work. This has not identifiably in the

past been the focus of those care groups. Nurturing the confidence, skills, and enthusiasm for our managers and clinical leaders to do this will matter: without a focus in this field our senior staff (of all clinical backgrounds) will ned to look outside the Trust for career variety and indeed to meet core standards expected in some professions of consultant grade posts.

3.4 The innovation work continues to need development. We discussed within Board committee the need to support both incremental and disruptive innovation. To do this we need to be able to both 'buy in' innovation and 'adopt' it from elsewhere. An innovative culture is able to work at pace and with some precision in making choices. It will back some ideas, recognising that perhaps a majority will not succeed. Imbuing those characteristics into a Trust that is simultaneously seeking consistency, more implementation and delivery skills, and a focus on a smaller number of priorities (even if 28 seems a lot), is difficult. But the need to have those skills is one intended to balance our culture. With that in mind, the executive will consider how best to:

- Support newly joined clinicians within the Trust to work to develop novel propositions that might merit consideration (perhaps through a new senior staff learning group..)
- Build from our announced Quality Improvement Poster contest to consider other funding streams we might want in 2027 and 2028 that offer match funding for proposals that come with external support – for example from national bodies…
- Allocate SPA time to innovation projects, either of individuals' own invention, or against a 'key problems list' issued through the clinical leadership executive..

3.5 A crucial enabler of the plan – and other plans – is to introduce during 2025/26 meaningful job planning into our senior clinical roles. In the main, Trust staff do have job plans, but these rarely describe what is in reality done (often people work well in excess of what is documented), and they tend not to come from a prioritisation process that aligns SPA time (excluding CPD) to the material needs of the organisation. The Board is invited to recognise the challenge, and potential contention, that moving to documented job plans on a consistent basis may bring.

3.6 Grounded Research is an asset within RDaSH. The descriptors of change outlined need to be introduced, and developed, without losing what has brought this success. There are three senior leadership roles within the unit, which function within the wider infrastructure of the CMO role and team. With Diarmid Sinclair now appointed, we are considered how best to ensure that the bandwidth offered by those roles is distributed across the extant and new asks of the team. This will include exploring how a network of innovators is developed reaching into all or most clinical disciplines, and with input from our formed but still developing change and improvement team.

3.7 Health services research is not within the current compass of either Grounded Research or RDaSH. But, from dipping our toe into this through work on our leadership development offer, to a much bigger ambition to assess the implementation of our promises and strategy, and its impact on the Trust and within our communities, we do need to change this. An options paper on how we do this, and how we bring expertise from local universities and other partners into the Trust, will be developed. This will run alongside seeking to mobilise the Board's Advisory Council of outside national experts, which we agreed in our 23/24 Operating Model but have held to date from moving forward with.

Summary of material – L & E

4.1 This plan has probably had to most work done on it within the Board. The detail was previously presented – and received strong support. This recognised that education and learning are related but distinct propositions. Our education role in particular is crucial to a pipeline of clinicians in particular able to meet patient's existing and future needs over the next decade or more. Part of the challenge we have, as perhaps all providers do, is that the design of curriculums, and accreditation, is typically rooted in past models of care – and rarely anticipates at sufficient pace the future needs we may have. Whilst relatively modest uptake of digital and simulation capabilities could be used to illustrate this point, so too could the difficulties in recognising an ageing population with a workforce largely not scale to that post millennium transition.

4.2 We could consider that doing our requested educational role well is a sufficient ambition. The Board has heard evidence that that is, typically, how our mentors and supervisors' work is viewed. Post pandemic our nursing placement numbers feel sharply, and we will need to continue to take action to address this. But the quality, as distinct from the quantity, of our offer remains strong. We do need to determine our stance of those in senior clinical roles vis a viz educational mentoring: presently involvement is essential with job descriptions, but sometime optional in practice. If we intend to retain a universalist model, then we need to consider how aptitude is better tested during recruitment and promotion evaluation – and what CPD offer we have for educators.

4.3 In one narrative, the Long-Term Workforce Plan for the NHS imagines a sizeable increase in placements in any number of disciplines. Presently the funding flow into placements and providers from that plan remains very unclear. We had asked colleagues to develop a thought-experiment which modelled what it would take to sizeably grow placements with present patient volumes. This would almost certainly require to make better use of technology as well as moving some educational support into unused clinical hours. This is now, given the uncertain fate of the LTWP, perhaps not a priority for 2025/26. However, given the interest in education, as distinct from research and leadership, very often expressed by newly recruited senior

clinicians, we should not overlook the potential to develop a larger placement base for postgraduate as well as earlier career placements.

4.4 The learning focus to our plan ensures that we create time, funding and impetus behind formal and informal learning among our people and our teams. In 2025 we have made a significant step to support this by making better sense of our training spend and by seeking to create ringfenced learning time. These 'starts' need to build on as we look to ensure that in 2026, they are accessible to, and used by, everyone within RDaSH. As mentioned at the outset of this paper, the risk is that enthusiasts alone have access. As we consider this year our approach to appraisal, we need to make sure that Personal Development Planning is as focused on learning as on career progression, if not very much more so.

4.5 The emphasis on individual and team learning need to be mirrored in our organisational learning model. Within this paper, PSIRF may give rise to some insights from harms, risks, and other experiences. Innovation may offer ideas about improvement drawn from outside and from studies. Our operational model, and theory of change, looks to both see teams reflect local need, and bring consistency to bear. These diverse influences may need some curation as we try and make sure as a Trust we are clear what we are trying to learn, not so much about what to do, as how to do it. The legacy internal focus, which is helpful, on inclusive and engagement, needs to be matched by thoughtful work with our communities about what co-production means. Arguably we presently lack a clear approach to Trustwide organisational learning, albeit we have the features for a typical model increasingly in place.

Summary of material – E&I

5.1 The majority of our promises focus directly or indirectly on equity and inclusion. They reflect three approaches:

- Seeking to ensure mainstream services are accessible/available to all
- Developing bespoke dedicated services for specific needs/characteristics
- Reshaping what the Trust offers away from a 'service' towards nesting capabilities within our communities

5.2 Repeatedly within the Board and committees we have discussed why each of these approaches faces challenge. Our lack of joined-up data is certainly an inhibitor to more assertive action. Of course, our knowledge or, and confidence within, our communities can also limit the effectiveness of what we do. Both ideas feature within our Strategic Delivery Risks (SDRs).

5.3 But the strategy depends on success with all or most of the relevant promises which seek to change access to employment (promise 9), alter the roles we privilege (promise 1), work alongside our communities (promise 5) – and explicitly address patterns of exclusion (promises 6,7, 8, 10, 11 and 12).

5.4 In the main we can describe the symptoms of the problem. We are not always certain that we are treating the principal constraint. So, for example, if we focus on minority ethnic citizens with learning disabilities, we are currently unclear if we have the real registered population locally, and health checks are incomplete; or whether there is a hidden population of need that we need to reach much more effectively. Some of these uncertainties are what we are trying to test through our promise 8.

5.5 The extant E&I plan outlines the work done to date and reminds us of the success measures set. As the Board has discussed, deployment plans to move towards those success measures vary in their:

- Clarity
- Adoption within services and
- Cultural competence

5.6 The 2024 leaders' conference, addressed by Bola Owolabi, provided some impetus to make progress. Programmatic approaches to promise 7 and promise 6 are showing encouraging signs of mobilising teams, including core management teams. These could be a bridge to 'mainstreaming' work on inequalities. But colleagues remain cautious that these are steps from which the Trust will in the future, as in the remembered past, retrench from. We need in addition to recall that knowledge of the importance of health inequalities is not always a core curriculum matter for many of our professions. Making the case to act needs constant attention.

5.7 If we can enter into 2025/26 with more available and intuitive datasets, then we do have a window of attention internally during which executing on many of the strategic objective 2 promises seems possible. As we transition our operational effort increasingly to 'think directorate', this capability to tackle inequalities may be advanced effectively among our care group leaders, as well as among selected executive colleagues.

5.8 Our work to address exclusion among our people goes hand in hand with this patient-facing work. And the sense that we are authentic, committed, and sticking at this, may be more influenced by those personal employment and working life experiences than by evidence of success in other measures. This promise 26 work and the cultural work we need to do, is supported by the People and Teams Plan.

5.9 Of all measures of exclusion faced by our populations, poverty is ever present. Intersectionality within those populations is varied, but a lack of financial agency, manifest either in poor employment, lack of childcare, poor housing, or other exclusion, is the necessary condition for any effort to make lasting change. We probably have work to do to better understand local plans to create economic, educational, and employment opportunity – if we are to anchor our poverty proofing work in the wider work of others.

Next steps and conclusions

6.1 We need to convert the material in the attached plans into a broadly consistent format. Once we have signed off the basic material this is not a particularly cumbersome task. But it will be important to narrating our plans in such a way that they are accessible to senior leaders: and easily understood. In contrast to our promises there is not an aspiration to have them widely recognised across the Trust. They are important documents described a little more detail of what we are trying to do.

As indicated elsewhere there are arguably two exceptions to this idea. The first is the cultural intentions behind our People and Teams Plan (out of scope for today's paper). This needs visibility to respond to the critique that our strategy is too patient focused and insufficiently staff focused. The second is the key ideas within the quality and safety plan. They are needed to re-focus effort onto this pecking order of things, and away from myriad other initiatives or approaches that do not produce the clarity we are seeking in analysing our delivery of safe and high-quality care.

6.2 We need to translate the plans into work accountable directors embrace. The detail of the plans will feed directly into 2025/26 personal objectives. More importantly, it should inform work plans for our committees of the Board. We might reasonably expect that first-line reports in corporate functions also recognise the intentions and instructions offered by the plans. Mapping this translation work is important during Q1 to ensure that we have translated the choices within these plans into our work, *instead* of other priorities. That translation needs an honest assessment within it of the work needed to deliver on the key ideas within our plans – which are, largely, reflected in this paper: subject to additions within our discussion.

6.3 **The Board is invited to comment on the documents, and this paper, and to consider in a fourteen months' time where we might expect to be.**

- To have in place well developed embedded work in our twin safety domains…
- To be evidently progressed with the research priorities agreed through the clinical leadership executive…
- To have broadened and deepened team and individual learning activity, whilst we have developed a recognisable sense of how RDaSH learns..
- To be delivering the overwhelming majority of our E&I promises, with data helping us to make this work mainstream management business…

Toby Lewis, Chief Executive – January 27th 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational Risk Report – Extreme Risks	**Agenda Item**	Paper R
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	30th January 2025

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

The Operational Risk Report presents the update to the Board of Directors on the current extreme rated risks. Each has been subject to review trough the Risk Management Group and reported to the Clinical Leadership Executive (CLE), most recently in January 2025.

Four of the risks were previously included in the report to the Board (and have been maintained at extreme ratings); the paper includes notification of two new extreme risks.

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

Business as usual.	X

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

Risk Management Group (RMG) & CLE have considered the matters within the paper

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

The Board of Directors is asked to:

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

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

Trust Risk Register	x	As detailed in the report						
Strategic Deliver Risks								
System / Place impact	x	O10/19						
Equality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	

Appendix (please list)

None

1. EXTREME RISKS

Since the last report to Board, when the report featured four extreme risks, two new ones have escalated. This report therefore features the six extreme risks on the register.

The RMG continues to support these risks being classified as extreme. These changes had previously been reported to, and supported by, the Risk Management Group (RMG) and the Clinical Leadership Executive (CLE) in January 2025.

1.2. Previously Reported Extreme Risks

O 10/19	Management of Out of Area Placements	**I X L** **3 X 5 = 15**
Description	If the patient flow into and through the Mental Health inpatient units is not improved then the trust will continue to place people in Out of area acute beds impacting on negative patient and family experience, increasing wait times and delivery against National KPIs.	
Accountable Director	Chief Operating Officer	
Updates	The MADE events have been relaunched. Doncaster Adult Acute Pathway MADE completed 13/11/2024. Remaining MADE events booked for Jan/Feb 25. The aim is to reduce this risk in alignment with Promise 19, with a target of achieving this by March 2025.	

PCG 10/24	Implementation of New ADHD Model	**I X L** **3 X 5 = 15**
Description	If patients are left unassessed for ADHD due to capacity not being able to meet demand, then this will impact on RDaSH patients and their family's wellbeing and health outcomes, service delivery, staff health and wellbeing, the delivery of the Trust's Strategic Objective Promise 8 and Promise 14, and the Trust's reputation.	
Accountable Director	Care Group Director – Physical Health and Neurodiversity	
Updates	The waiting list and demand for services continue to grow, with approximately 4,500 patients currently awaiting assessment. We continue to explore opportunities for procuring external ADHD resources and increasing assessment capacity to address the growing demand.	

PCG 9/24	Diagnosis of ASD Patients	**I X L** **3 X 5 = 15**
Description	If Doncaster and Rotherham patients are left undiagnosed for Autism then this will impact on patients and their family's wellbeing and health outcomes, staff health and wellbeing, is in breach of NICE guidance, the delivery of the Trust's Strategic Objective Promise 8 and Promise 14, and the Trust's reputation.	
Accountable Director	Care Group Director – Physical Health and Neurodiversity	
Updates	A six-month trial is underway, running until the end of March 2025, involving CMHT consultant psychiatrists diagnosing patients with support from the Autism Team. However, despite these efforts, the waiting list and demand continue to grow, with 1,676 patients currently awaiting assessment. The situation is being closely monitored, and strategies for managing the waiting list are being considered.	

CCG 3/22	Neuro Waiting Lists	**I X L** **3 X 5 = 15**
Description	If the waiting times for assessment of ASD and ADHD remain above target, this will impact on CYPF, their educational and health outcomes, service delivery, staff health and wellbeing, the delivery of the Trust's Strategic Objective Promise 8 and Promise 14, and the Trust's reputation.	
Accountable Director	Children's Care Group Director	
Updates	Weekly oversight from the Senior Leadership Team (SLT) to ensure progress on the ongoing actions with teams aimed at increasing productivity and refining assessment practices. These efforts are focused on streamlining workflows to improve overall efficiency. Additionally, the implementation of digital offers to help reduce assessment times are being explored, which will further enhance the operational efficiency while maintaining high standards of quality.	

1.3. New Extreme Risks

NLCG 9/24	Failure to Address Crisis Team Improvement Plan	**I X L** **5X 3 = 15**
Description	If the actions in the Rapid Improvement Plan for the Crisis Resolution and Home Treatment Team do not address the identified issues with clinical practice and team culture within the required timeframe, due to the required change taking longer than required, there is a risk that the team will continue to operate below the necessary standards. This may result in harm to patients, increased staff turnover, and challenges in maintaining safe staffing levels.	
Accountable Director	North Lincolnshire Care Group Director	
Actions / Updates	Good progress has been made on the improvement plan, with several actions closed and evidence of change provided. However, ongoing team issues are preventing full completion of some actions, which continues to pose a patient safety risk. A meeting is scheduled to support the assurance process and the risk likelihood may be reduced at the next review.	

O 5/24	SMI Register Duplication Risk	**I X L** **4X 4 = 16**
Description	If there continue to be multiple registers for SMI patients across GP surgeries and RDaSH there is a risk of patients coming to avoidable harm due to being missed and not being offered an annual SMI health check.	
Accountable Director	Deputy Director of Operations	
Actions / Updates	There are discrepancies between the GP, QOF, and RDaSH registers so the Trust is collaborating with GPs to cleanse these registers and consolidate them into a single, accurate position. Efforts are ongoing to ensure that patients placed out of area receive a health check during their placement. Additionally, we are addressing the support provided by our voluntary sector partners to reduce the number of patients declining health checks and improve overall compliance.	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks 2024/25	**Agenda Item**	Paper S
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	30th January 2025

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

The Board has received frequent and regular updates in the year to date on the SDRs and most recently, in November 2024, received a paper that focused on two of those SDRs. This paper has the remaining three SDRs as its focus. This 'rhythm' of regular scrutiny and presentation ensures that the Board remains sighted on the SDRs throughout the financial year.

The three attached SDRs include further detail about the controls in place and those being established and about the assurances already received or that are planned to be received. The discussions at Committee (most recently for these three risks in January at QC and PHPIP) and the discussions with the lead executive and Chair of the Audit Committee have identified broad actions to further enhance the process and the reporting (format) of the management of the risks and have been incorporated into the way that the risks are presented in this paper.

360 Assurance (internal audit) are concluding a review of the Strategic Risk Management process but have indicated a positive conclusion will be reported (significant assurance) – noting the strengthened arrangements in the year and having evidenced routine and robust scrutiny at the Board and Committees.

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, May, July, September and November 2024; and
- Board of Directors timeout session – April 2024;

Specifically, SDR1 and SDR 3 were presented and discussed at the Public Health, patient Involvement and Partnerships Committee; and SDR4 to the Quality Committee.

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 three of the Strategic Delivery Risks (being SDR1, SDR3 and SDR4)								
NOTE the expected positive (significant) assurance from internal audit on Strategic Risk Management.								
Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)								
Trust Risk Register								
Strategic Delivery Risks	x	SDR1, SDR3 and SDR4						
System / Place impact	x	All three SDR in the paper are set within an external (system/place) impact / requirement for engagement.						
Equality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	
Appendix (please list)								
Individual Strategic Delivery Risk forms are in the Annex to the Report.								

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

1. Background

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

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

2. Strategic Delivery Risks (SDR) 2024

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

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

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

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

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

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

2.2 Papers to the Board through to July 2024 included all five of the SDRs. As we progress through the year it is important that the Board of Directors remains sighted on all five, but the scheduling of Committee meetings (at which further scrutiny and oversight occurs) creates an opportunity for the risks to return to the Board in rotation for the rest of the year, affording focus at each meeting on a different cohort of SDR. Hence the Board Report in November focused on SDR2 and SDR5.

2.3 During January 2025, SDR1 and SDR3 were presented and discussed at the Public Health, Patient Involvement and Partnerships Committee; and SDR4 to the Quality Committee. The respective reports from those Committee, included in the agenda packs for today's meeting make reference to this and the latest position in respect of each is attached in the Appendix to this paper.

2.4 Alongside these reporting schedules, the Audit Committee remains sighted on the progress with the overall SDR management (next at February's meeting) and the Chair of the Audit Committee will continue to hold meetings alongside the Director of Corporate Assurance with each of the respective Executive leads.

2.5 The position in respect of each SDR as presented continues to develop and grow but there remains scope to refine the detail of the planned action and assurances. Whilst we have established controls and assurances to support the mitigation of these risks, both remain in the position as stated previously in terms of score (**bold text** in the Appendix indicates 'completion' or 'in place'; other text identified future, planned action or receipt of assurance. Given the strategic nature of the risks this is not unexpected, but the implementation of the controls stated and the receipt of the planned assurances (and the response to current gaps in assurance) will allow us to see the progress and be assured that the risk is not impacting on the delivery of the relevant objectives.

2.6 The appendix records positive progress on mitigating actions for each risk, specifically for SDR1 on immersing our new and current staff within communities; for SDR3 on liaison with primary care colleagues and agreeing areas of focus; and SDR5 with the new High Quality Therapeutic Care task force. It is important to be clear that the assurances we seek align to the controls and confirm that they are making a real difference i.e. mitigating, the risks to the achievement of the strategic objectives.

2.7 This scope for further refinement and adjustment to the format is also one aspect of the feedback from 360 Assurance (internal audit) following its recent review of Strategic Risk Management. A report is to be received imminently from them which provides significant assurance and recognises that the Trust has strengthened its strategic risk management arrangements in the current year and that they have evidenced routine and robust scrutiny of the new SDR at Board and committees.

3. Next Steps

3.1 Actions referred to previously and above will continue on an ongoing basis, namely lead executive work on each risk, scheduled reports to Committee and to the Audit Committee; meetings with lead executives and the Chair of Audit Committee / Director of Corporate Assurance. The Board of Directors will receive a report at each of its meetings – the next meeting in March 2025 will include the year-end position in respect of all five SDRs.

4. Recommendations

The Board of Directors is asked to:

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

NOTE the expected positive (significant) assurance from internal audit on Strategic Risk Management.

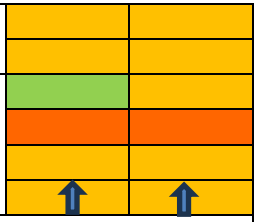
Philip Gowland
Director of Corporate Assurance
24 January 2025

SO1: Nurture partnerships with patients and citizens to support good health										
What could get in the way? **The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities**	As a Strategic Delivery Risk:								**Lead Exec**	**Board Committee**
	If	our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027								
	because	of the leadership's inability to identify, communicate and engage							SF	PHPIP
	then	it will lead to a loss of confidence locally and likely non-delivery of SO1								
Risk Score The controls marked with * will be essential to the target reduction in risk likelihood score.	Current (January 2025)					Target (March 2026)				
	I	4	L	4	16	I	4	L	2	8

Controls – What will we put in place to mitigate the risk? (**Bold text** = complete / in place)	
Stakeholders	**Stakeholder Management Matrix – includes focus explicitly on Primary care partners such as GP forums, confederations, PCNs. Importance of understanding the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; including 'cake' model with two EG colleagues aligned to individual three places to work with relevant care group reps to build relationships and establish progress and create synthesis with information from other sources – Overall oversight in place (Jo McDonough – most recent work via EG in December 2024)**
Educating our staff	**Leadership Development Offer includes, "Compassionate leadership to unlock community power' — LDO launched September 24; Cohort 1 commenced January 2025**; Cohort 2 in April 2025.* **Induction - Revised induction process to 5-day event that will focus on the introduction to the Trust and its communities – New induction launched in October 2024. *** **Learning Half Days commenced September 2024** – *GAP: forward plan to be developed to include related matters linked to this Strategic Delivery Risk and the mitigating actions needed.*

Cultural Shift	Ability of leaders to instigate change; an openness to fail, but learn and improve and ultimately succeed. *The LDO features as learning outcome 2:* Enhance our ability to lead change and deliver improvements *GAP: Clarity over how this will be recorded and reported or evaluated. Lead / date.* Recruitment processes that focus on the appointment based on alignment to the Trust's Values *GAP: Clarity over precisely how we ensure that all recruitment includes this 'test' to ensure appointees have values that align to those of the Trust – lead / date..*
Representation within our colleagues	A workforce with volunteers, patient safety partners and members that is truly representative of the communities we serve – this would include number of as well as diversity and representation within these cohorts.* *GAP: Collation and presentation of related numbers, action plans for increased numbers and analysis of numbers in comparison to our communities – lead / date.* Working in this area to ensure that we: • Understand the current profiles and agree focus of action to address any identified shortfall.*(as above)* • Confirm communication methods (two-way) and frequency to achieve engagement including the engagement **through the Staff Networks** (new Carers Network to launch in February 2025) and via **Trust People Council (TPC) (established from July 24)**

Assurance – How will we know the controls are working?					
Management reporting to Committee or Board or via CLE and its Groups	Strategy Progress Reports on related (promise) deliverables: ○ 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) captured within the Promises and Priorities Scorecard (For each identified measure of success, Plan – confidence of having a plan; L/Hood – of delivery) – see key. PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure.	**Board – September / November 2024 / Jan 25 (shows recent movements** **PHPIP Committee – Nov 24**		Plan	L/Hood
			4		
			5		
			6		
			8		
			10		

	PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing	**PHPIP Committee – Jan 25**	11	
			26	
	PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)	**May 24 / July 24 September 24 / November 24 / January 2025**		
	IQPR reporting improvements in • sickness absence • turnover rates and • complaints;	**IQPR to CLE / Committees and Board (November 2024)**	Sick	5.9%; above target of 5.1%
			T/O	9.5%; below target of 10%
			Comp	
	Improved WRES data	**POD Committee - October 24**	Continues to be area needing concerted focus and action	
	Patient and wider community partner feedback – Care Opinion launched (patients and carers) *GAP: Analysis of responses via Care Opinion including those leading to action – confirmation of method, frequency and lead / date;* Other broader mechanisms to be confirmed	**Care Group Delivery meetings in 2024 featured Care Opinion** Care Opinion within February 25 Board Timeout – analysis, trends, headline, themes. Led by CEO of Care Opinion		
Internal Feedback	Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group) - Cohort 1 launched January 2025 / Cohort 2 launches April 2025 This feedback will secure confirmation that our leaders have the necessary skills and experience linked to the work with our communities, in particular via the following two of the research and evaluation questions.	Research and Evaluation planned outputs (via K Williamson) April and October 2025 and April and September 2026.		

	1b Has the Trust developed compassionate leadership to unlock community power, from the perspective of staff, service users and communities? 3 Has the LDO improved RDaSH Leaders' engagement with each other and the community		
	Induction Feedback and Evaluation - Specific question: *I am able to understand how my role supports the RDaSH Strategic Objectives / Promises and how I can help to Nurture the Power in our Communities.*	**Each cohort – October 2024 November 2024**	**96% Agreed / Strongly Agreed**
	Learning Half Day Feedback and Evaluation	PDSA Review January 2025	
Independent Third-party Assurance	Internal Audit work on Patient Experience, Engagement and Inclusion	Quarter 3 (underway)	Assurance Level (TBC)
	Internal Audit work on Partnership Governance and Risk Management	Quarter 4	Assurance Level (TBC)

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

Risk Score The controls marked with * will be essential to the target reduction in risk likelihood score.	Current (January 2025)					Target (March 2026)				
	I	4	L	4	16	I	4	L	2	8

Controls – What will we put in place to mitigate the risk?		
Stakeholder	**Stakeholder Management Matrix – includes focus explicitly on Primary care partners such as GP forums, confederations, PCNs. Importance of understanding the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; including 'cake' model with two EG colleagues aligned to individual three places to work with relevant care group reps to build relationships and establish progress and create synthesis with information from other sources – Overall oversight in place (Jo McDonough – most recent work via EG in December 2024)**	
Regular and well established touchpoints within each of the three places with GP representatives: • Individual Practices • PCNs • Federations	Doncaster	**Via stakeholder Management Matrix as above** **Via GP Liaison Role – programme of visits established to every practice with touchpoints into PCNs and the local Federations.**
	Rotherham	
	North Lincolnshire	

Facilitate insight into General practice within …	Board	**In place:** **Dr Richard Falk – Non-Executive Director** **Dr Dean Eggitt – GP Partner Governor** **Laura Sherburn – Primary Care Doncaster Chief Executive (route to CLE)** **GP Liaison role (within the Strategic Development Team) commenced (1 November 2024).** *Next step: Appointment to Physical Health Care Group Medical Director of Primary Care / GP – Appointment process re-commences in January 2025*
	Care Groups	GP related appointments into Care group structures (7 / 13 Care Group Directorates are community based – these leaders are especially important in the development and work supporting the mitigation f this risk.)– **2 Medical Leads and the Nurse Director in the Physical Health CG appointed.**
	Wider workforce	Through the Leadership Development Offer (LDO) – aim is to skill up our people regarding primary care. **LDO Launched.** Cohort 1 commenced January 2025; Cohort 2 launches in April 2025.* **Learning Half Days (LHD)** programmed to align to known GP training schedules such as 'Target' in Doncaster (i.e. Wednesday afternoon training sessions across GPS in the city to afford joint training and engagement)
Practical programme of change	Trust Wide	**Agrees programme of change with Primary Care Colleagues that addresses the issues that they raise via other routes, in particular via GP Liaison Role.** **CLE paper – December 2024 identified the four areas of focus (see assurance section below).** *Next Step: Additional small study within one PCN to produce insight before replicating elsewhere. Involves general practice teams and our teams and also considers communication between our teams. Conclusion expected by 30 April, with consideration in CLE in May 2025.*

<table>
<tr><td colspan="4">Assurance – How will we know the controls are working?</td></tr>
<tr><td rowspan="2">Management reporting to Committee or Board or via CLE and its Groups</td><td>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)

captured within the Promises and Priorities Scorecard
(For each identified measure of success, Plan – confidence of having a plan; L/Hood – of delivery)

Paper E (Nov 24 PHPIP) – set out (for P12) – what needs to happen and by when to move to an Amber/Green position against each success measure.

PHPIP Committee – January 2025 – verbal item linked to P21</td><td>Board – September / November 2024; January 2025

PHPIP Committee – Nov 24

PHPIP Committee – Jan 25</td><td><table><tr><td></td><td>Plan</td><td>L/Hood</td></tr><tr><td>12</td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td rowspan="3">15</td><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td>21</td><td></td><td></td></tr></table></td></tr>
<tr><td>PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)</td><td>May 24 / July 24 September 24 / November 24 / January 2025</td><td></td></tr>
<tr><td></td><td>Practical Programme of Change implementation reporting. Four key deliverables agreed by CLE are:
1. Remove any and all practices which prevent our clinical teams within RDaSH making cross referrals or transferring care.
2. Move to simple electronic forms for all referrals, with prompts which ensure that mandatory information is provided:
3. Introduce simple, coherent routes of communication to our clinical teams from primary care, and provide ‘backdoor’ contact models to permit escalation senior clinician-senior clinician for any patients where there is a concern.
4. Audit and justify any practices which tend to pass work or tasks to GPs that could be done by the secondary care team.</td><td>To progress with implementation, likely in sequence as set out on a quarterly basis from April 2025.</td><td></td></tr>
<tr><td>Internal Feedback</td><td>Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group)
Cohort 1 launched January 2025 / Cohort 2 launches April 2025 This feedback will secure confirmation that our leaders have the necessary skills and experience linked to the work with primary care</td><td>Research and Evaluation planned outputs (via K Williamson) April and October 2025</td><td></td></tr>
</table>

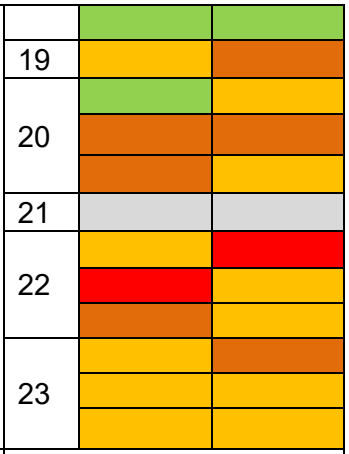
	and other partners in particular via the following research and evaluation question. 3 Has the LDO improved RDaSH Leaders' engagement with each other and the community	and April and September 2026.	
Independent Third-party Assurance	Internal Audit work on Patient Experience, Engagement and Inclusion	Quarter 3 (Currently underway)	Assurance Level (TBC)
	Internal Audit work on Partnership Governance and Risk Management	Quarter 4	Assurance Level (TBC)
	Feedback mechanisms with GPs are established and embedded – these will be used to confirm strong alignment on Primary and Community MH services and adult and children's community nursing. These will include : the 'one important thing' – an ask of every practice on our patch of the one thing that matters most to them about the relationship between them and the Trust; and formal, structured feedback with the Primary Care Networks to help us understand how we are getting on (linked to the Programme of Practical Change – see above)	Identification in Q4 Target of addressing at least 50% of the 'important things' by Q3 25/26 Established during Q4 24/25	

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 The controls marked with * will be essential to the target reduction in risk likelihood score.	Current Score (January 2025)					Target Score (March 2026)				
	I	4	L	3	12	I	3	L	2	6

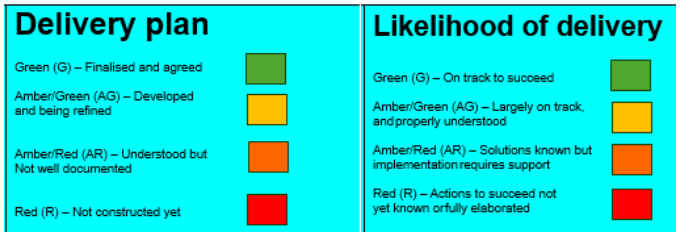
Controls – What will we put in place to mitigate the risk?	
Service provision (RDASH) **Newly established High Quality Therapeutic Taskforce from January 2025 to take forward a range of issues and significantly support the delivery of 7-day therapeutic services within an inpatient and acute context.**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

	services need to align with this new way of working being tested out, for example pharmacy; HTT and AOT services.
Alternative Service provision (others)	Explore how and who other service providers (community and voluntary sector) can contribute / support the delivery or support to our services on a more flexible or longer basis. This will likely be in the form of an options paper to go to CLE in Q1, 2025/26) to consider below. - This may include better provision of the current crisis provision as a potential step down using 2 additional beds in Rotherham to test this - Co locates with partners who are already 24/7 (i.e. LA, acute, police) or extend hours (GP's) - Expansion of virtual offer, AOT and "remote working" - Outsourcing to community partners to abridge to RDaSH services - Future investment in a needed “step down provision” - Offer A Service With A 24/7 Assistant (expansion of virtual; apps?) - Increase self-help services - with swift access to advice and support – enhanced community support and offer for those discharged in first 72 hours
Staff Engagement (linked to necessary change and impact on staff)	• Unions and Staff Side – consultation / engagement processes discussed and agreed (depending on when the pilot is being launched this will go through JCC. This will be RC to lead) * The points below will be discussed at POD in Q4 and will require HR support • Revised ‘standard’ terms and conditions to create opportunity for more flexibility • Ensure changes are clinically led. • Ensure JD reflects new ways of working. • Consider if change can be managed in part through staff turnover and investment as opposed to mass service consultation • Consider workforce models of support - training; enhanced work flexibility; clarity on support and supervision models; safety

Assurance – How will we know the controls are working?					
Management reporting to Committee or Board or via CLE and its Groups	IQPR reporting improvements in • Waiting times • Out of Area Placements • Delays in discharges • Utilisation of talking therapies	**IQPR to CLE / Committees and Board (November 2024)** and Jan 25	Waits		
			OAPs	31.12 15	
			D in D		
			TT		
	Strategy Progress Reports on related (promise) deliverables: This will include all linked to SO3 – Promises 13 to 17, but more specifically those linked to SO4 – Promises 18 to 23 (see grid)			Plan	L/Hood
			18		

	captured within the Promises and Priorities Scorecard that has been presented to the Board of Directors (For each identified measure of success, Plan – confidence of having a plan; L/Hood – of delivery)	**Board – September / November 2024 and January 2025**	
	QC Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)	**May 24 / July 24 September 24 / November 24 / January 2025**	
Internal Feedback	• Staff Survey outcomes (Due Q4 2024/25) • Peer Review process		
External Feedback	• Complaints (reduction in those that relate to access to services) and improved patient feedback • Regulatory Inspection Reports		

Key – re: Promises



ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises / Priorities Scorecard	**Agenda Item**	Paper T
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	30th January 2025

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

The attached annex follows the form used within the Board since September, and which we will use in CLE from April 2025. This report simply updates on any material changes to the estimate made, by using a short paper. This does not repeat considerations on promises 3/4/6/7/8/14 or 18-23 that are the subject of other Board material.

The Board is invited to consider updates here and continue to challenge hard on the capacity and capability needed to secure a step-change in promise delivery in 2025/26 from Q1. One facet of this is the *'precision'* required to move from managers contributing work that "aligns" to a promise – to governing the specific work needed to move the success criteria to delivery.

At March's Board, I will seek to provide an estimate of the position as at July 1st, mindful of our Annual Member's Meeting on July 19th, together with the Promises Report which is the frontend of our annual reporting cycle for 24/25, as it was in 23/24.

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

Previous consideration

n/a

Recommendation

The Board of Directors is asked to:

X	**RECOGNISE** the further feedback on promises 6-8 since November's discussion
X	**CONSIDER** the content updates provided in this paper

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

Trust Risk Register		N/A					
Strategic Delivery Risks		SDR 1/2/3/4/5					
System / Place impact		N/A					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)

Annex 1 – Promises and priorities – delivery plan and delivery self-assessment (current state)

Rotherham Doncaster and South Humber NHS Foundation Trust

Promises and Priorities – January 2025 updates

Context / method next steps

1.1 The format of the annex is as in the prior two reports. In February's timeout we will consider how we transition other Board/Trust reporting for 25/26 to a 'four colour' traffic lights and instil a distinction between planning quality and likelihood of delivery. This move to prospective analysis is increasingly becoming normed/colloquial inside the Trust having been at the core of our delivery review method since late 2023. We agreed to consider the implications of this mindset for our Board 'assurance' mindset effective from April 2025.

1.2 During February PFG are meeting with the author to explore how best to introduce a community feedback/assessment consideration into our promises analysis, mindful of the commitment to have this in place for our annual reporting and Annual Members' Meeting (AMM). That discussion needs to have validity with our governing body, and a proposal on that matter will be before the next Governing Body, as we move to full implementation of Promise 5. We will benefit in so doing from the internal audit review of this promise (alongside 3 and 4); and from use in the coming year of our Community Involvement Framework.

1.3 Over coming Board meetings we will continue to consider specific promises within the workplan. In November, we considered promises 6, 7, and 8. In this January's meeting, we explore 3 and 4, as well as an in-depth look at elements of promise 14. Execution of all elements of **promise 25** is appraised in the Chief Executive's private report to the Board.

1.4 During 25/26 all promises will be considered in this way, noting that strategic objective 2 was assessed in September as being most 'behind', and strategic objective 3 least progressed. HQTC discussions provide an overview of strategic objective 4: and the Public Health, Public Involvement and Partnerships (PHPIP) committee has asked for a final plan for Promise 21 not later than May. In the paragraphs of this report, there is mention of all elements of strategic objective 5 (**emboldened** for ease).

Two monthly update: scoring position

2.1 In the annex, the textual commentary has been changed materially. Where it has been changed, the textbox is greyed. Changes have only been made where there is something new to report. At the last meeting I outlined the intent to tackle next all 'plan reds', and work to conclude that inside Q4 is in hand, notwithstanding the paragraph above about the sole promise where we have not settled on success measures/finish lines.

2.2 Having agreed our approach to anti-racism, the Board in March will test the wider approach being taken within the Trust to **Promise 26.** An agreed success measure for this work was to eliminate our gender pay gap, and the latest assessment has seen that reduce from 11% to just above 4%. That gap should further benefit from implementation of the Real Living Wage from April 2025 – and the impact of that change is presently being analysed.

2.3 In September, this report discussed **promise 27**, and the challenges of meeting the net zero commitment. Last time the Board met, there was some suggestion that planning for delivery might be time-wasted. In reality, we are now successfully building a series of propositions for the investment needed nationally to allow us to change the heat sourcing of our main building sites. On February 12th we host our Climate Adaptation 'day': this will bring together internal and external colleagues to consider how we need, for 2040, to reshape how we deliver care to

meet the inevitable reality of our local landscape. This work will inform, among other things, the development of the Remote Working Framework we will look to adopt in Q1 – itself a key enabler for finalisation of our Estate Plan. We know that our travel and transport approach is journey intensive, and presently car dependent.

2.4 The Board considered our work on research when we last met. In July we explored our education position, as a learning theme for the whole meeting. In 2025/26, delivery reviews with Care Groups will increasingly see a better balance between consideration of service, education, and research, as we seek to make the latter two more equal partners in the management effort. In reality this is dependent on the shift to directorates for day-to-day operational matters, together with the up-skilling of senior leaders across CLE (clinical leadership executive) on the language and levers of both education and research. Delivering **promises 24 and 28**, does require some such broadening of leadership if it is to become truly embedded.

2.5 As an executive group, we continue to try and balance moving forward all promises, with delivering some – and transitioning them to 'business as usual'. Those arguably closest to that state – certainly by July 2025 – are perhaps promises 3, 4, 5, 9, 24, and 25. **Promise 6** may develop that character to time if we can meet the revised schedule of implementation agreed within CLE and shared in my last weekly 'vlog'. As the PHPIP committee outbrief makes clear, the benefit for the audit process was well illustrated by frontline managers' comments at that committee in support of one of the pilot reports. All poverty proofing reports will be published on the Trust's website and retained there – as we work to create accountability loops to implement the changes recommended. Our 2025/2026 annual report will also address the recommendations made in the reports completed by the end of 2025.

2.6 Delivering **promises 14 and 19** are the major operational task of the coming year. They will require support and input from experts across the Board, and from clinical leaders inside our care group SLTs, in particular. Either promise could be executed in a manner which frustrates/risks the real purpose of change. Patient experience must be enhanced by being looked after locally, and therapeutic quality and outcome must not be compromised in so doing. Similarly, in moving to a four-week maximum wait, we cannot create secondary waits, nor create either the practice or impression that 'contact' is being privileged over meaningful assessment and care planning. As a drive to deliver "kicks in" this inadvertent risk arises, and we will consider how best to address it in practice. The CAMHS four-week delivery journey of 2024 – now nearing completion with success will offer a case study from which to draw learning. During Q1 we will consider how to offer an opportunity for frontline clinicians, middle managers, and the Board to explore that 'case study'.

<u>Specific score influencers since the last Board last met (excluding 3-4)</u>

3.1 **Promise 9:** whilst work to fully expend the levy has previously been positively reported, and remains achievable, a recovery plan is due in February from the People and OD directorate. During Q4 a considerable number of high-cost apprentices will need to be commenced, alongside the welcome initiation of our apprentice first work.

3.2 **Promise 11:** part of the challenge of this promise has been marshalling the various interested parties to it and ensuring overwhelming focus on the success measures. A constructive effort to cohere those with an interest, and those needing to lean in has been held. The CLE E&I sub group will see in its May meeting the outcome of that work, which needs to best balance general access to services for veterans and families, together with veteran led peer based services.

3.3 **Promise 13:** work to deliver a community-based clozapine service in all three communities has returned to CLE in January, with clear progress in two of three care groups. We would expect to move to implementation during Q1 25/26.

Conclusion

4.1 It would be especially helpful for Board members to do two things in the discussion:

- Raise any specific promise queries of interest
  (as the lead governor did on promise 10 at COG)
- Comment on whether the level of detail and insight now provided three times is broadly sufficient and suitable for our current needs as a Board.
  (it is recognised that the format/language may not be accessible to all, and we are working through with the help of PFG and others how this might addressed)

Toby Lewis, Chief Executive
22 January 2025

Promises and priorities – delivery plan and delivery self-assessment

Annex 1

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Red (R) – Not constructed yet		Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
1. Employ peer support workers at the heart of every service that we offer by 2027.	Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care.	Red	The developing delivery plan (now CEO owned) needs to supported, and to confirm the so. Specific provision in our Investment Fund for 25/6 has been made for the next steps with this work.	Amber red	The promise is hugely ambitious in number and reach. It is forecast that we can scale up, but are not yet confident of sufficient expansion.
2. Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy.	Achieve Carers Federation accreditation for the work that we do across the Trust.	Amber red	The delivery sequence to do this will be considered in the POD/N&F delivery reviews in February.	Amber green	As an input measure, we are confident that effort will produce compliance/adherence.
	Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Amber green	To a timetable to be confirmed within the HQTC, we will move to a standard access offer across our wards and sites – removing variation.	Amber red	Putting into place what is needed is feasible – what has to be established is that it works – through the eyes of carers…
	Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.	Amber red	We can do more to systematise this. But our plan is likely to be incomplete given self-identification inhibition in early months.	Amber red	This cautious rating reflects the hidden scale of need and the work required to match that with support
	Identify all-age carers that use our services and ensure their rights under the carers act are recognised.	Red	This piece of work is a significant one and may require dedicated resourcing for a fixed term period.	Red	Until the planning work is done it is difficult to meaningfully estimate the LOD.
3. Work with over 350 volunteers by 2025 to go the extra mile in the quality of care that we offer	Have 350 volunteers registered to work with us or have equivalent to that figure volunteering time with us through another body.	Amber green	This is reported elsewhere. Delivery Reviews will focus on upping the numbers of North Lincolnshire and Rotherham Without that plan, we risk missing the point of the measure.	Amber red	Until we are more than a third of the way to the measure (having used 40% of the elapsed time), we need to see a sizeable uptick in take up to go AG.

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	For that body of volunteers to reflect the diversity of our populations.	Amber red	This remains outstanding and the commitment to complete it is contained in the paper before the Board. As yet the plan colour remains unchanged.	Amber green	As with the COG measure which predated the strategy, improvement is very possible against the baseline: proportionality is much more challenging.
4. Put patient feedback at the heart of how care is delivered in the Trust, encouraging all staff to shape services around individuals' diverse needs.	Increase by 15% the scale of feedback received in the Trust versus 2024/25 baselines.	Amber green	We have a deployment plan for Care Opinion, which we believe will improve our reach, pace and analytical capability.	Green	This scale measure we would expect to meet during 2025/26.
	Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	Green	JG has overseen a very clear plan to put this into place in acute settings during 24/25.	Amber green	MHA will continue to support this important qualitative work and there is confidence we can meet the ask.
	Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.	Amber red	It is too early to shift the plan level, but there is an expectation that this will move to amber-green from April.	Amber red	Given that 18 months+ exists, this can be delivered: but the meaningful change means we need to have achieved the push/pull use in mid 2025.
5. From 2024 systematically, involve our communities at every level of decision making in our Trust throughout the year, extending our membership offer, and delivering the annual priorities set by our staff and public governors.	Involve patient and community representatives fully in our board, executive and care group governance .	Green	This work is structured and is in hand: documenting the process of 2024 peer support and creation of 2025 shadow forums will take place in Q3.	Green	Board and CLE changes are in place – CG governance changes planned for Q1 25/26.
	Deliver the Board's community involvement framework in full.	Amber green	Work to refine this is well advanced but final documentation is needed, routed in, VCSE analysis which is presently being finalised.	Amber red	This remains AR until there is a clearer trajectory, which SRO, E&I sub, CLE and PHPIP have confidence in.
	Apply patient participation tests to new policies and plans developed within the Trust .	Amber green	This continues to be an acknowledged oversight and will be addressed in the revised policy of policies over coming weeks.	Green	Getting the required changes into place is not an onerous ask, but does require a structured approach.

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	Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.	Amber green	The proposal on this work will go to the Council of Governors in March.	Green	This work is on track and will be developed.
	Deliver the annual priorities set by our council of governors.	Amber green	Most priorities set with COG are in hand: there is work to do on the digital aid/MH work which needs resourcing.	Amber green	Within 24/25 we would expect to meet the measures we set in 23/24.
6. “Poverty proof” all our services by 2025 to tackle discrimination, including through digital exclusion	All our services to have completed poverty proofing and be able to evidence resultant change (including digital).	Amber green	A revised schedule has been agreed with Care Groups, as is reported within the board committee notes.	Amber green	E&I sub, and CLE, have supported the ‘pre-agreed/indicative’ changes we would expect to make for 25/26 based on initial analysis.
	Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods.	Amber red	Our current plan is to poverty proof. It remains to be established in early 25/26 what other interventions are needed to achieve this measure.	Amber green	The lack of a final timescale for this improvement explains the positive rating – there is time in 2025 to iterate delivery over following months/years.
	Benefits and debt advice access to be routine within Trust services to tackle ‘claims gap’.	Amber green	An initial proposal is almost in place which has strong support among partners: it is likely that this will be dovetailed within DIALOG+	Amber green	There is further work to do to consider scope of coverage but the plan has flexibility to reflect that risk.
7. Deliver all 10 health improvements made in the Core20PLUS5 programme to address healthcare inequalities among children and adults: **achieving 95% coverage of health checks for citizens with serious mental illness and those with learning disabilities from 2024.**	Achieve measured goals for chronic obstructive pulmonary disease (COPD), hypertension, asthma, diabetes, epilepsy, oral health, and children and young people mental health by 2026/27.	Amber green	This plan is at risk of moving towards red because of data and reporting delays. A process across the executive to resolve this in February is in hand.	Green	Teams involve convey confidence within delivery reviews that they can meet these measures over the time period.

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	Achieve learning disability and serious mental illness health check measure in 2024/25 and recurrently.	Amber green	Significant and positive work has taken place over the last two months, on the initial step related to Trust held patient registers. Q1 sees migration to a focus on a single PCN register in both circumstances.	Amber red	Success relies on the Trust changing how we work and who we work with. During Q3 it will become clearer how feasible this is and over what timeframe.
8. Research, create and deliver 5 impactful changes to inequalities faced by our population in accessing and benefitting from our autism, learning disability and mental health services as part of our wider drive to tackle inequality (“the RDASH 5”). (next report will include neurodiversity measure and PCERF)	Increase access to health checks for minority ethnic citizens with Learning Disabilities.	Amber red (reduction)	Presentation to the E&I group illustrated material weaknesses in the delivery chain analysis behind this measure and further work is needed in Q4.	Amber green	Resource to support this work is in place: we now need to see whether we are able to reach those previously excluded.
	Increase diagnostic rates for dementia among minority ethnic citizens.	Amber green (improvement)	Good work has been done to develop a cogent plan based on an understanding of other places. This plan is due in E&I in March to sign off.	Red	This is not simply a supply side change, and clearer influencing strategies need defining to move the LOD assessment.
	Improve access rates to talking therapies among older adults.	Amber green	Teams have worked hard to establish how this can be done and a defined data point is agreed. Executing the plan is commencing and needs ramping up.	Amber red	Movement on the key metric is needed in early 2025 to establish confidence in the work we have done to date
9. Consistently exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.	Achieve the levy requirements in 2024/25 and thereafter.	Amber green (reduction)	A revised plan is needed as outlined within the body of the cover report.	Green	We are meeting our trajectory YTD and expect to do so at year end
	In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Amber green	Work to meet this measure is planned and in part deployed.	Amber red	The scale and sustainability of the work being done needs further stress testing during Q3
	In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Amber red	The timing of this measure remains feasible but further work is needed in 24/25 to cohere our plans	Amber red	The rating reflects the evolving picture of planning outlined

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	In 2026/27 introduce tailored access scheme for people with learning disabilities.	Red	This scheme needs further dedicated work and the right community based partnership. This remains to be planned and is not simply an extension of the schemes above	Amber red	This can be delivered, given not required until 26/27. But schemes elsewhere have sometimes struggled, and we may need to bring forward a trial scheme.
10. Be recognised by 2027 as an outstanding provider of inclusion health care, implementing NICE and NHSE guidance in full, in support of local GRT, sex workers, prisoners, people experiencing homelessness, and misusing substances, and forced migrants.	Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber red	The standards go beyond ourselves and a shared assessment is being documented presently.	Amber red	It will certainly require change to meet the standards, and the homeless health conference in Q3 will be used to kickstart those investments.
	Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.	Red	Data completeness, as well as access itself, makes it very difficult to rate this measure at base. Consideration being given to ‘mystery shopper’ work.	Red	Rating reflects planning gaps identified.
	Specific service offers in place for all or most inclusion health groups by 2027.	Amber red	Plan not yet fully defined, including for refugee groups and sex workers. E&I sub needs to pick up thinking work over remainder of 24/25: this is due in March.	Amber green	Time assists this input metric. Over period possible to put in place what is needed.
11. Deliver in full the NHS’ commitment to veterans and those within our service communities, recognising the specific needs many have, especially for access to suitable mental health and	Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees).	Amber green	Strong planning work has taken place and whilst the reasons for gaps are speculated, the right actions are in place.	Amber green	Over time, with trial and error, we are expecting to close the gap we presently see through a combination of data improvement and better performance.

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trauma responsive services	Introduce peer-led service support offer for local residents.	Amber green	This offer is in place in trial and further expansion is being into place. We'd expect this to be live at full scale during 25/26.	Amber green	This input and effort measure can be met, and is in fact ahead of expectations.
12. Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve.	Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access.	Green	Good connections have been built to help us to think through what the issues and potential solutions may be. Care Group led work at this stage with buy in from other teams.	Amber green	A clear set of intended steps have been defined and agreed in principle through E&I. Further testing needed going into 25/26.
	Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.	Amber red	Not yet meaningfully planned but will be accelerated in the context of the digital transformation plans we have during the balance of 25/26.	Amber red	Rating reflects planning comments made.
13. Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, childrens', or care home.	Deliver over 130 care packages through our physical health virtual ward service.	Green	A strong plan exists, has been peer reviewed, and is being delivered.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Sustain and expand our IV provision in out-of-hospital settings.	Amber green	A little more work might be merited to document the plans and their trajectory, but the component parts of what is needed are well understood.	Green	Services were substantively funded going into 24/25. They are expanding month on month.
	Sustain and expand our Clozapine service in off ward settings.	Amber green	As reported in in the body of the text we need to move forward the plans that Care Groups have developed for 25/26.	Green	This measure can be met when we find released funding to make it happen.

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	Take annual opportunities to transfer services to homecare where safe to do so.	Amber red	In due course we need to find a planning route to go beyond the measures above and establish a broader drumbeat of left shift…	Green	This measure is ours, and others, and will see substantial emphasis in coming years – no doubt.
14. Assess people referred urgently inside 48 hours from 2025 (or under 4 where required) and deliver a 4-week maximum wait for all referrals from April 2026: maximising the use of technology and digital innovation to support our transformation.	Meet four hour wait standard in 2025/26, where it applies.	Amber green	This measure applies in only a handful of defined services. Monitoring suggests room for improvement but strong performance – focus on this is likely to yield delivery.	Amber green	A delivery priority for next financial year.
	Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Red	Planning, visibility and emphasis on this measure is below where it needs to be: delivery review discussion in September to begin to cohere approaches.	Amber red	Comment reflects known unknowns outlined in planning segment.
	Make progress to reduce waiting lists and times and close supply gap in 2024/26.	Amber green	The report before the Board provides a strong basis for considering this key measure and assessed plans by Care Group not at Trust level.	Amber green	The scale of change remains significant. But initial data offers optimism that it could be accomplished.
	Meet 4 week standard from April 2026 across all services.	Amber green	As above	Amber green	As left.
15. Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs.	Support development of integrated neighbourhood teams (INTs) in 2024/5 in all three places.	Red	We have work to do, and partnerships to finalise, to move this goal forward and will not achieve it in 24/25.	Red	As left.
	Restructure Trust services into those INTs during 2025/26.	Red	This rating reflects comment on prior measure.	Amber red	As left.
	Evaluate and incrementally improve joint working achieved through these teams.	Amber red	Planning this work can follow from further definition of the INT plans we have.	Amber green	Once the above measures are met, this item is feasible!

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	Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme.	Amber green	This work was defined in late 23/24 and a monitoring structure established. Indications remains positive that we are on track.	Amber green	As left.
16. Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.	Implement Dialog+ by 2026, collating individual outcomes from that work.	Amber green	The work has started (Sept 24) in the field in training teams, and a well-structured delivery plan exists. We will consider at May's Board our learning and trajectory as this is key to executing this promise over the next two years.	Amber green	This remains a challenging programme and one that can deliver, but will face competition from other priorities.
	Report and improve patient recorded outcome measures (PROMS) supported nationally.	Amber green	We report as we need to. Further clarity is needed about our completeness and whether we are maximising opportunities to go beyond minimum response.	Amber red	An improvement trajectory remains to be understood and defined.
	Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Amber red (deterioration)	Delays and issues with our quality and safety plan have delayed this measure, and we will revisit the balance of top-down/bottom up associated with this measure during the balance of Q4.	Amber red	This has proved a difficult measure to establish despite work on it for over 12 months.
17. Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities.	Narrow the school readiness gap between our most deprived communities and average in each place in which we work.	Amber green (improve)	A strong plan is in place which has been widely praised. The target itself remains very challenging, but the input elements judged most key to execution are in place.	Amber red	Gap narrowing on school readiness has proved elusive: joint working with school is going to be needed to deliver any plan.

Promise		Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	
	Seek to see 80% of children meet their own potential for school readiness by 2028.	Amber green (improved)	As above	Amber red	Improvement in SR has been consistently achieved over recent years, so there is good evidence in support of further improvement.
18. From 2023 invest, support and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery.	Meet guidance obligations from NHS England relevant to the quality of inpatient care, including safer staffing measures where they exist, and fully comply with the Mental Health Act.	Amber green	Current analysis for this measure appears positive. Work to improve MHA compliance is showing promise. We know what to do, we need to do it.	Amber green	With continued focus we have some confidence that this can be met over the balance of the year.
	Implement programme of multi-professional quality improvement across all inpatient services by April 2026 and routinely publish data on the care provided in each environment.	Amber red	The mobilisation plan is required for HQTC before we can further improve this rating. The Board report narrates that this is due in the next eight weeks.	Amber red	Mobilising this work will be a significant endeavour in Q1 25/26, after pilot phases over next two quarters.
	Work with patients and peers to assess the quality of services, including through peer reviews, and ensure that teams are able to act on that feedback and those evaluations.	Green	This work has progressed strongly through 2024/25, including now on an OOH basis. Peer involvement has added greatly to the product.	Green	We do need to be able to show impact from the work done in H1, and this will be reflected in our QA for 24/25.

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19. End out of area placements in 2024, as part of supporting people to be cared for as close to home as is safely possible.	Cease to place patients out of their home district except where that is their choice or in their best interests.	Amber green	We do know what we need to do. The plan gap is resourcing doing it, and securing our delivery chain internally around LOS.	Amber red	The scale of change required remains immense. Substantial improvement is possible, a revised timetable for elimination wil be assessed in Q1 25/26.
20. Deliver virtual care models in our mental and physical health services by 2025, providing a high-quality alternative to prolonged admission.	Deliver over 130 care packages through our physical health virtual ward service working. with partners.	Green	A strong plan exists, has been peer reviewed, and is being delivered.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Introduce and evaluate virtual ward pilot into our mental health services 2024/25.	Amber red	Other priorities have delayed this work, and AOT work has taken primacy. An assessment is being made of how/when this is best mobilised.	Amber red	This rating reflects comments on the left.
	Introduce and evaluate virtual ward pilot within our children's services 2025/26.	Amber red	The intent and commitment to do this is clear from the leadership team – documenting these ambitions needs attention in late Q3 as part of IF process.	Amber green	Evaluation in that time period may not be feasible, but deployment, if funded, will be.

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21. Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents – developing services on a hyper local basis.	There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise.		There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise. However, we have discussed what this needs to include and we would expect to move ratings/measurement forward from May.		There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise.
22. Develop consistent seven day a week service models across our intermediate care, mental health wards and hospice models from 2025 in order to improve quality of care.	Ensure that access to urgent and emergency services is equitably available through Saturday and Sunday (this must include crisis and safe space availability).	Amber green	This is not P14! This measure is mostly met in Trust delivered/commissioned services. The intention is to use the MHLDA programme for 25/26 to influence configuration.	Red	This is rated red to reflect the reality our patients face – where there is substantial variety in non-Trust services which we need to now influence. There is also a fragility to crisis services which needs continued attention.
	Support substantially increased discharge and admission capacity over weekends.	Red	We do not have a defined plan, delivery chain or implementation model in place as yet.	Amber green	There is very substantial executive emphasis on this work and over coming months we'd expect to see change.
	Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services.	Amber red	This is not currently our priority, and we'd anticipate baseline data is scarce. N&F resourcing this work during 25/26.	Amber green	By the end of 2025 this input measure can be met.
23. Invest in residential care projects and programmes that support long-term care outside our wards: specifically supporting expansion of community forensic, step-down and step-up services.	Develop bed-based mental health services within each of our communities by 2028, as additions or alternatives to ward based practice: ideally delivering these services through partner organisations.	Amber green	Good work has taken place to build relationships and this then ties into the bed-plans outlined before the Board. Specific proposals are now being assessed in one of our three places.	Amber red	The challenges to implementation are outlined in another paper and remain significant.
	Expand the scale of our residential forensic rehabilitation service.	Amber green	Work has already taken place with this in mind. Further plan exist in our community teams, with scope for work alongside Cheswold.	Amber green	A 20% expansion has already taken place.- and we now need to consider what more is needed to match need.

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	Establish and support a step-up service for older peoples' care in Doncaster by 2027.	Amber green	Work advancing alongside partners: project resource defined and starts work shortly. Significant place support.	Amber green	This may be an optimistic rating given scale of change: but the pressing need to change gives this natural priority and we have 3 years to deliver.
24. Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan.	Student feedback to reach upper quintile when compared to peers.	Amber green	Strong baseline position, albeit varies annually. Some uncertainty over what drives positivity.	Green	If we retain good infrastructure and support our supervisors with time then performance is expected to be sustained
	Trust workforce plan for 2028 on track to be delivered.	Amber green	Plan, notwithstanding item below, developing well. Fully staffed is year 1.	Amber green	Persistent vacancies are not out principle difficulty (retention exemplar work needs to be effective to sustain seniority within disciplines over time) ie retirement risk.
	Trust meets expectations applied through national Long Term Workforce Plan roll out.	Red	We may pause monitoring of this measure unless the operating plan guidance sheds light on the national future of these plans.	Red	Rating reflects lack of clarity of ask/measure at this stage. May be clarified in 10 year plan (2025)
	NHS England assessment outcomes remain outstanding in all disciplines.	Amber green	Currently strong in all assessed disciplines (latest report just received)	Amber green	No identified reason why assessment outcomes would change over coming period.
25. Achieve Real Living Wage accreditation by 2025, whilst transitioning significantly more of our spend to local suppliers in our communities.	Obtain Real Living Wage Foundation accreditation in first half of 2025.	Green	Engagement started some time ago. Components required all being taken forward and visible within corporate delivery reviews.	Green	For summer 2025 we are confident of achieving accreditation unless external intrusion into our pay plans.
	Pay the Real Living Wage to our own employees from April 2025, or sooner.	Green	We know what needs to be done. Most complex issue is banding reviews of band 2/3 which is needed in Q3/4.	Green	As above.

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	Transfer more of our spend to local suppliers (shift of 25%+ compared to 2023/24).	Amber green	Clear plans developed during 2024. Implementation deadlines are clear and being met.	Green	Measure defined, suppliers aware, procurement on plan with transition by end of Q4.
26. Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.	Implement suite of policies and practice to Kick Racism Out of our Trust.	Green	Clarity across CLE about what we plan to do, first policies change go live in Q3.	Amber green	Practice as well as policy change needed, but visible and compelling start made.
	Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.	Amber red	We have work to do to translate our seven key actions, and wider staff survey response plans, into actionable insights.	Amber red	A complex and longstanding issue, which, as yet does not provide have a clear trajectory to success.
	Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.	Amber green	There is strong commitment to the measures contained in NW accreditation: work needed now to look across excluded groups for relevant assessment tools.	Amber green	These frameworks tend to be input based, not outcome derived. Organisational commitment to compliance is not in question.

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	Tackle our gender pay gap.	Amber green (improve)	Notwithstanding the need for localised plans, it seems most likely that the shift to the RLW will move the position on this measure to compliance.	Amber green (improve)	As left.
27. Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.	Reduce our carbon tonnage by 2000 (and offset balance).	Red	Excellent analysis has established the sheer scale of change/investment needed. Consideration of a route to success is to be considered alongside our forthcoming estate plan.	Red	Estimated £18m investment is not foreseeable, and we are working through what may be possible as an alternate to the heat pump route to gas reduction.
	Agree and deliver specific contribution to local authority climate change plans.	Amber red	Advancing this measure is a matter of time/priorities. Good engagement exists with each LA, and in dour course this work can be documented and reviewed.	Amber green	LA feedback on Trust engagement remains positive, and we are not not doing what is asked. The plan may give rise to a larger ask in time.
	Change service models for patients and staff to reduce travel required by 2027.	Amber red	A plan to achieve this, and to scale ‘this’, is being developed during Q4/Q1. Our ‘remote’ policy and practice will be crucial to success.	Amber green	The implementation of digital care alternatives is a national priority, and we would expect our own and others efforts to intensify in 25-26-27.
28. Extend the scale and reach of our research work every year: creating partnerships with industry and Universities that bring	Meet portfolio study recruitment targets each year.	Green	The Trust is consistently meeting the measures and has a process in place to support engagement where there are shortfalls	Amber green	This is very much a well led measure and we would expect to succeed again in 2024/25

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investment and employment to our local community.	Deliver metrics contained in the Trust's Research and Innovation plan.	Amber red	Significant work is now needed to convert the research priorities we have agreed into a delivery plan owned across Care Groups	Amber red	The 2028 ambitions are deliverable, but a cultural shift is probably needed in how GR/CGs operate together
	Work to further increase the reach of research into excluded communities locally.	Amber green	This is a longstanding programme of work for grounded research. A more detailed delivery plan may be needed going into 25/26. This may include developing a community researchers' programme.	Amber green	This is an input measure which we are confident of sustaining focus on, without too much corporate input

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality Performance Report (IQPR)	**Agenda Item**	Paper U
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Jill Fairbank – Head of Contracting, Performance & CQUIN Victoria Takel – Deputy Chief Operating Officer Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	30th January 2025

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

Whilst the overall position of top ten delivery is consistent with previous reports, time passes on full year delivery. As outlined in the CEO report, we note natural variation in recovery rates. The two commitments where performance improvement or mitigation is needed are CYP access which remains below target by 179 children, and the emerging workforce challenge in perinatal services, owing to sickness absence.

Currently mental health RTT remains at 84.5%. Moving to 92% will not be possible until we resolve the memory services issues in North Lincolnshire, which is possible from Q1, but will 'get worse' through treating the longest waiting patients, before it is resolved.

There is a significant in month increase in hours beyond our 24 hour S136 standard (to 222 hours in October from September's 98). Active work is taking place to achieve this measure, with the opening of the sixth suite from Q4 in Sheffield.

The data herein shows a decrease in ward safer staffing compliance. The data is being rechecked and initial work shows some possible errors. An oral update will be given when the Board meets.

The Trust is reporting a deficit position of £152k at the end of October 2024 (month 7). The month 7 and forecast positions assume that pay award pressures will be funded in full, however, confirmation of this is still pending from the ICB.

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

Previous consideration

Clinical Leadership Executive and relevant committees of the Board

Recommendation

The Board of Directors is asked to:

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

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

Trust Risk Register	X	O 10/19, 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,
Strategic Delivery Risks	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)							
n/a							

Integrated Quality Performance Report

January 2024 Review

Data as at the 31st December 2024

Draft Version 6

Contents

1.0 Executive Report

This report outlines the December 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 several key performances metrices.

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

Physical health services continue to perform well against the new RTT consultant led Physical Health pathways OP08c, OP10c. There is one reported patient waiting over 52 weeks, this is not a true wait. It is also worth noting that this month occupancy within the Virtual Ward continues to exceed the 80% target on the 1st and 30th of the month reporting at 91.67%, and 108.33%. For those people in a physical health crisis (OP05), where patients should be assessed within 2 hours of referral, performance is also above the 70% target reporting at 100% for the month of December.

Within our Children's Services we continue to see all our most urgent children and young people (CYP) in our eating disorder services within 1 week (OP15), and 93.67% of all children within 4 weeks. For CYP accessing our Children and Mental Health Services (OP13a) this place metric was achieved at the end of December reporting 9786 (RDaSH 9,102, Kooth 542, Mind 61 and Healios 81) against the target of 9783.

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 exceed the target Trust wide, reporting 9,937 against the target of 8,533. Talking Therapies services have continued to perform below target in two out of the three targets. For OP03a, the Talking Therapy access target, Performance for December 2024 is in line with the run-rate for the service based on the reduced number of working days in the month (20) compared with previous months (24 and 21), accounting for circa 220 patients when compared to October 2024. This is a positive achievement for the service as the lower capacity and engagement in the month of December usually results in a reduced run-rate for access within the month, but the service has avoided this in 2024. The Reliable Recovery rate (OP03C) is monitored through the weekly Intensive Support process initiated by the Care Group. The Directorate completed a patient level investigation of the causes for reduced Reliable Recovery rates in November 2024 (outcome reported in November 2024 report) and the actions implemented following this continue to be delivered by the Directorate, with an initial improvement in the Reliable Recovery Rate delivered in December 2024 although it is recognised further improvement and more consistent performance is required.

The monitoring of the RTT pathways for mental health (OP08d) have seen a slight overall reduction in performance this month with actual Trust wide validated performance reporting at 74.29% from 79%. Individual Care groups reporting at Rotherham Adults and Older People Mental Health Care group (98.65%) Doncaster and Learning Disability Care Group (97.83%) and North Lincolnshire Talking Therapies Care group (21.82%). The issue within waits in Memory Services in North Lincolnshire continue with the longest wait on this pathway reporting at 37 weeks at the end of December, the Care Group is taking significant action to address issues identified within job plans to increase capacity within the service. Additionally, a multi-assessment centre is being planned for from January 2025 onwards to increase capacity. A full trajectory of RTT recovery within this service will be available by the end of January to chart improvement.

Our metric which reports the number of inappropriate adult acute OAPs at the end of a reporting month (OP17C) has now been aligned to other providers and reports solely the Inappropriate out of area placements. On the last day of December we were reporting thirteen out of area inappropriate placements, five above the target of eight. A multi-staged improvement programme is being developed, led by several of the Executive Team.

The metric measuring availability of our S136 suites and the occupancy hours lost due to breaches within our 3 Section 136 suites is reporting 108 hours lost in the month of December. It is noted that 40 hours were due to estates damage in Rotherham suite and a further 4 non RDaSH patient breaches (2 Sheffield) which totalled 68 hours26 hours of the total relate to RDaSH patient breaches.

1.0 Executive Report

The ADHD and Neurodevelopment pathways in Adults and Children and Young People services continue to be monitored closely against our trajectory to 4 week waiting times targets. Services are currently undergoing transformation as we move all Neurodevelopment services onto a standalone unit in our clinical system and this will disrupt our reporting between now and the start of the new calendar year. Interim measures enable us to manually report across the two units as we manage this transition. For December, our adult's service is reporting 4,913 adults on the waiting list against a trajectory of 5,267. The metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target and is reporting 2,661 CYP waiting against the target of 2,194. This is primarily due to the delays to recruitment of the additional staffing required to deliver the trajectory. The Care Group have redeveloped the trajectory to support with the delivery of the 4 weeks wait and the revised draft has been presented however has not yet been approved.

Targeted action to improve quality and safety across the Trust and primarily with ensuring that patients admitted to our wards receive a VTE (QS08) has dropped very slightly reporting performance of 94.89% against the 95% target. Work continues with improving our performance around all our inpatients receiving a MUST assessment (QS36) with a month-on-month improvement to 79.43% up from 72.67% at the end of November. The addition of an alert to the clinical system has resulted in an improvement of around 6.76% in month. Care groups are conducting daily deep dives and weekly audits which are acted on if the VTE assessment is not fully completed and continue to feed back to doctors concerned. There is a renewed focus on VTE assessments in Junior Doctor's Induction and training across all Care Groups.

The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target reporting a decline to 50% (4/8) from the 60.87% (14/23) for November. The risk continues to be highlighted on the risk register for each Care Group and 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 to ensure that all non-compliance is addressed.

The number of detained patients who abscond from an acute adult and OP inpatient mental health units (QS20) has seen three incidents of patients absconding in December. Following a deep dive the same patient was recorded as two of the instances. The second patient (third incident in month) climbed through fencing on the roof of an inner garden. For all incidents the AWOL procedure was followed and the patients were returned by Police. All incidents have led to the increased monitoring of outside areas by staff. The Trust is reporting three racist incidents (QS29) in month. The Acceptable Behaviour Policy has now launched Trust Wide and in its initial stage of implementation which will create a framework to warn, bar and ultimately exclude carers and patients who abuse employees, students and Volunteers with care Group leaders empowered to apply these sanctions. IR1's are reviewed and actioned when they arise, and staff involved are contacted for support.

From a people perspective the number of our employees receiving a performance and development review (POD18) has been achieved this month with 90.24% of employees having had a review, above the 90% target. The year-to-date sickness absence (POD10) has increased from 6.09% to 6.28%. Adult and child safeguarding compliance (POD26 & POD27) are reporting below the 90% target. Targeted action has taken place with a review of the compliance matrices. The Trust has arranged scheduled bespoke sessions to the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view to targeting individuals in order to improve compliance. The vacancy rate has decreased month on month and is reported as 5.27% form 6% in November against the target of 2.5%. Rotherham Care group and Doncaster Mental Health and Learning Disability Care Group have the highest vacancy rate of 7.4% and 7%, respectively. Trust wide we are reporting 197 vacancies in December and reduction from 224 vacancies in November.

The Trust is reporting a surplus position of £430k at the end of December 2024 (month 9); this is £572k better than planned. This improvement compared to previous months is because £1.1m of non-recurrent funding has been received from NHS England specialised commissioning. This benefit is offset by pressures from the SY Adult Eating Disorder Collaborative and the impact of the pay award. The reported forecast is in line with plan. It assumes the non-recurrent income from NHSE can be used to support the Trust's pay award pressures rather than improving the forecast to a surplus of £1.2m as originally anticipated. Confirmation of whether the ICB will fund the pay award pressures is still outstanding. The forecast assumption is a risk but it is consistent with ICB guidance issued to providers at month 9.

2.0 - Performance – In Focus

Indicators for December 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		15/17	88.24%		89.00%	>= 60%	83.00%
OP03a (L)	LTP 02 a (i)	People accessing Talking Therapies - Cumulative Annual			1112		3721	>= 16939	11405
OP03b (L)	LTP 02 a (ii)	People accessing Talking Therapies - Cumulative Quarterly			1112	Q3 >= 5748	3721		11405
OP03c (N)	LTP 02 b	Reliable recovery rate within Talking Therapies		222/479	46.35%		45.00%	>= 48%	46.00%
OP03d (N)	LTP 02 c	Reliable Improvement rate within Talking Therapies		347/497	69.82%		69.00%	>= 67%	69.00%
OP05 (N)		People in physical health crisis assessed within 2 hours		12/12	100.00%		88.00%	>= 70%	66.00%
OP07b (L)	LTP 03 b	Women supported by perinatal MH service (Rolling 12M)			563		563	>= 598	563
OP08c (N)		18 weeks RTT for consultant led Physical Health services		351/373	94.10%		94.00%	>= 92%	94.00%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		130/175	74.29%		80.00%	>= 92%	81.00%
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			0		0	= 0	0
OP12 (N)		People discharged from MH inpatients followed up in 72 hrs		60/71	84.51%		89.00%	>= 60%	87.00%

Narrative

OP03a – This is a place target however only includes RDaSH activity, reporting 11,405 for the cumulative year to date up until the end of November against a target of 16,939. When compared with activity in the same period last year we are reporting below last year's actual which was 12,026.

OP03b - Quarter to date talking therapies access target for quarter 3 is 3,721 and remained 2,026 below the Q3 target of 5,748.
OP03c – Performance has remained at 46% year to date reporting below the 48% target.

OP5 – Target Achieved

OP7b – PLACE TARGET ACHIEVED -a rolling 12-month place target for Perinatal and Maternal Mental Health Services. Once RDaSH activity (563) and Maternal Mental Health Service (SHSC) (255) is counted the number of women receiving support is 818, remaining above the target of 598.
OP08d – Performance has been validated and we are reporting 45 breaches over 18 weeks, primarily in our North Lincolnshire and Talking Therapies Care Group. Trustwide performance for the month is 74.29% against the 92% target.

OP10c – Reporting 1 breach over 52 weeks which is not a true wait

2.0 - Performance – In Focus

Indicators for December 2024/2025 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP13a (N)	LTP 04	People accessing CYP services with >= 1 contact (13mth roll)			9102		9102	>= 9783	9102
OP13b (N)		People accessing CYP services >= 2 contacts and paired score		725/4555	15.92%		17.00%	>= 20%	18.00%
OP13d (L)	LTP 01 a	Adults accessing community mental health services (DW)			9937		9937	>= 8533	9937
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		77/83	92.77%		93.00%	>= 95%	93.00%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		4/4	100.00%		100.00%	>= 95%	100.00%
OP17c (N)	LTP 05 a	The number of active inappropriate adult acute OAPs			13		13	<= 8	13
OP54a (L)	LTO 06 a (i)	Virtual ward occupancy - on day 1		55/60	91.67%		92.00%	>= 80%	92.00%
OP54b (L)	LTO 06 a (ii)	Virtual ward occupancy - on day 15		44/60	73.33%		73.00%	>= 80%	73.00%
OP54c (L)	LTO 06 a (iii)	Virtual ward occupancy - on day 30		65/60	108.33%		108.00%	>= 80%	108.00%
OP59a (L)	LTP 09 (i)	Waiting List - Adult ADHD			4916		4916	< 5267	4916
OP59b (L)	LTP 09 (ii)	Waiting List - CYP Neurodevelopment			2666		2666	<= 2194	2666
OP60 (L)	LTO07	Dementia Diagnosis rate		7295/9821	74.28%		74.00%	>= 67%	74.00%
OP61a (L)	LTP08a	Place target for SMI		3605/5450	66.15%		66.00%	>= 75%	67.00%
OP61b (L)	LTP08b	SMI Patients having full annual PH check (includes declines)		1220/1376	88.66%		89.00%	>= 95%	89.00%
OP73a (L)	LTP 10 a	Section 136 Breaches – Occupancy hours lost to breaches			108		382		1797

Narrative

OP13a – PLACE TARGET ACHIEVED. A Place target, performance at place (9,786) remaining slightly above the 2024/2025 target of 9,783 (RDaSH 9,102, Kooth 542, Mind 61 and Healios 81). RDaSH activity has increased this month reversing the month-on-month downturn in performance we have seen since April 2024.

OP13b – The CYP access 2 contacts and a paired scored has seen a further deterioration in performance from 16.83% in December to 15.92% in the month of December. This brings YTD performance to 18%, against the 20.00% target.

OP14 - Children and young people with routine eating disorders seen within 4 weeks is reporting 6 breaches in the rolling 12-month period and is reporting 92.77%, just below the 95% target.

OP17c -The number of external inappropriate adult acute OAPs are reporting at 13 at the end of the calendar month.

OP54a/OP54b/OP54c. The Virtual Ward has reported at above 80% occupancy on day 1 and day 30.

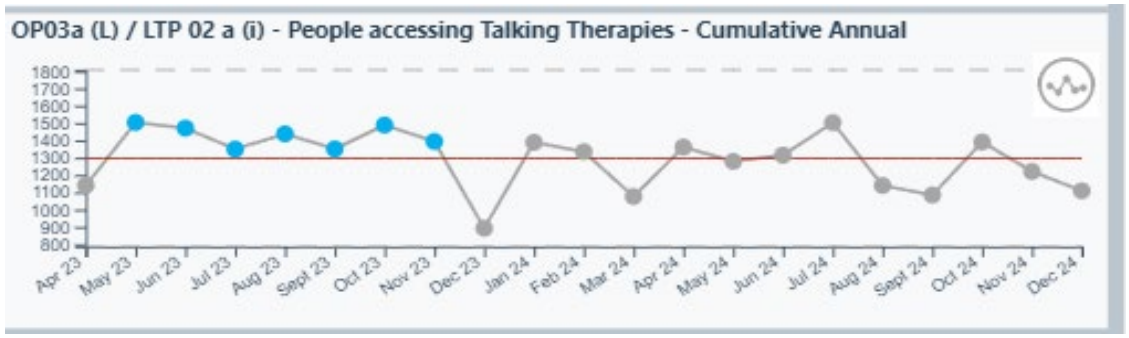
OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target and is reporting 2,666 CYP waiting against the target of 2,194. The Care Group have redeveloped the trajectory to build in nuances that were not already accounted for regarding capacity within the service to support with the delivery of the 4 week wait by April 2026. The revised draft has been presented however has not yet been approved.

OP61a – The metric for individuals receiving an annual health check has been reported for the first time. This metric is the place target measuring 6 checks against the QOF , performance is reported as 67% against the 75% target.

OP61b - The metric measuring compliance against the 8 checks for RDaSH patients is reporting 89%.

OP73a – Increase in month from 57 hours lost in November to 108 hours in December in our S136 suites due to patients staying in the suite over 24 hours, closures, or misuse.

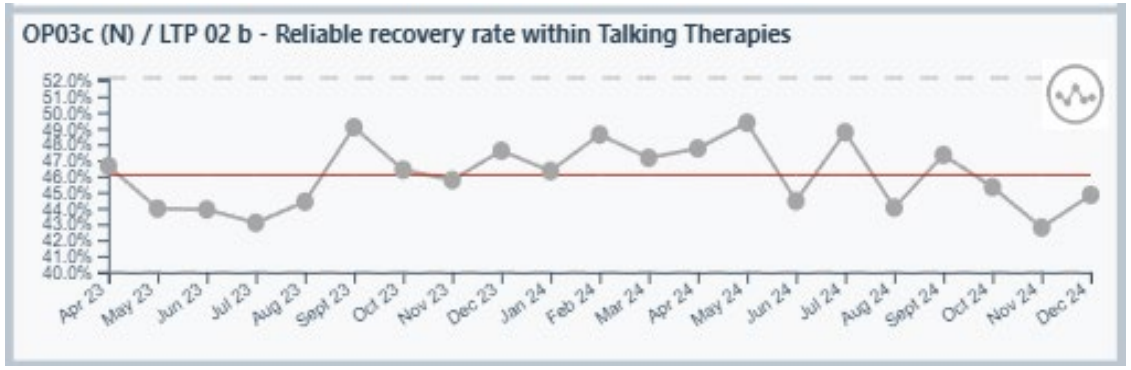
2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP03a The Access Rate Performance for December 2024 is in line with the run-rate for the service based on the reduced number of working days in the month (20) compared with previous months (24 and 21), accounting for circa 220 patients when compared to October 2024. This is a positive achievement for the service as the lower capacity and engagement in the month of December usually results in a reduced run-rate for access within the month but the service has avoided this in 2024.

The service capacity and patient engagement has returned to normal levels during January 2025 and therefore the service is forecast to deliver an increased access rate during quarter 4, 2024/25.



Trend, Reason and Action

OP03c Reliable Recovery is monitored through the weekly Intensive Support process initiated by the Care Group.

The Directorate completed a patient level investigation of the causes for reduced Reliable Recovery rates in November 2024 (outcome reported in November 2024 report) and the actions implemented following this continue to be delivered by the Directorate, with an initial improvement in the Reliable Recovery Rate delivered in December 2024 although it is recognised further improvement and more consistent performance is required.

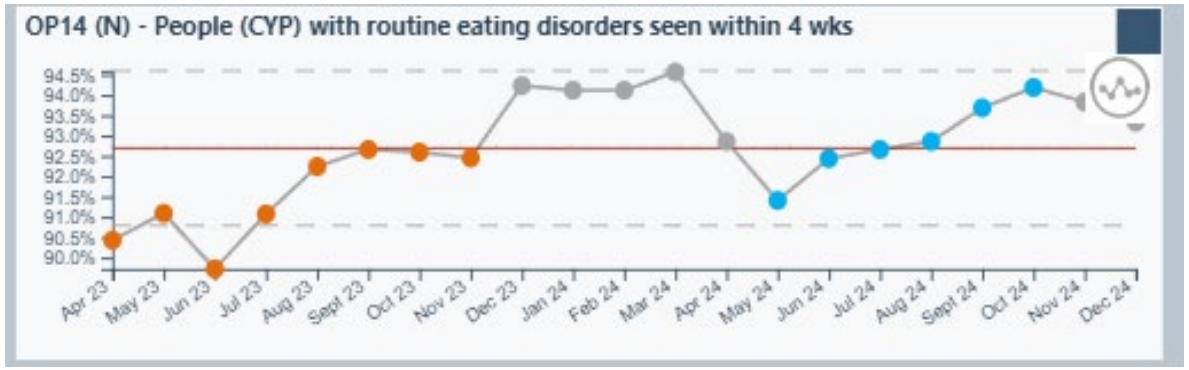
Trend, Reason and Action

OP08d – Performance has been validated, current validated performance is reported as 74.29%, remaining below the 92% target. Individual Care groups reporting at Rotherham Adults and Older People Mental Health Care group (98.65%) Doncaster and Learning Disability Care Group (97.83%) and North Lincolnshire Talking Therapies Care group (21.82%). The issue within waits in Memory Services in North Lincolnshire continue with the longest wait on this pathway reporting at 37 weeks at the end of December, the Care Group is taking significant action to address issues identified within job plans to increase capacity within the service. Additionally, a multi-assessment centre is being planned for from January 2025 onwards to increase capacity. A full trajectory of RTT recovery within this service will be available by the end of January to chart improvement.

2.1 Performance In Focus - Exceptions

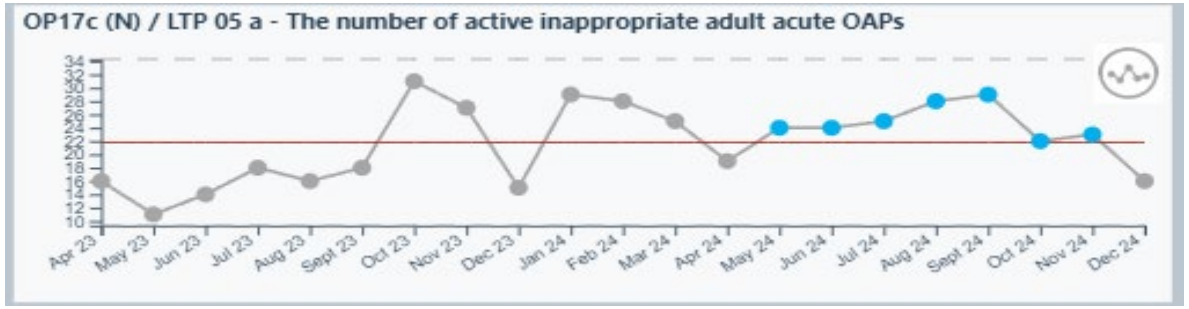
Trend, Reason and Action

OP13b - The CYP access 2 contacts and a paired scored has seen a deterioration in performance in December to 15.92%. CYP do not use a standard tool for recording outcome measures however as a trust we have agreed to implement Dialog+ with CYP planned to see transition to this tool from January – March 2025, will all staff to be trained by April 2025.



Trend, Reason and Action

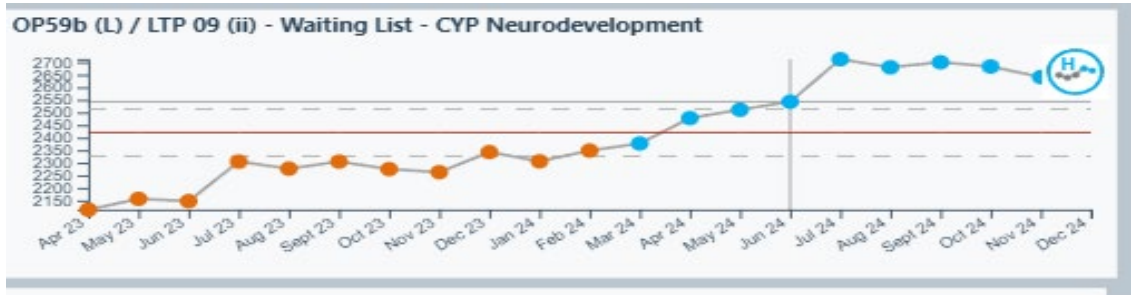
OP14 - Children and young people with routine eating disorders is reporting 6 breaches in the rolling 12-month period. This is a rolling 12-month target with appointments offered slightly over the 4 weeks primarily due to service capacity issues within the April-June 2024 period. Current wait times within this pathway remain below the 4 week wait target.



Trend, Reason and Action

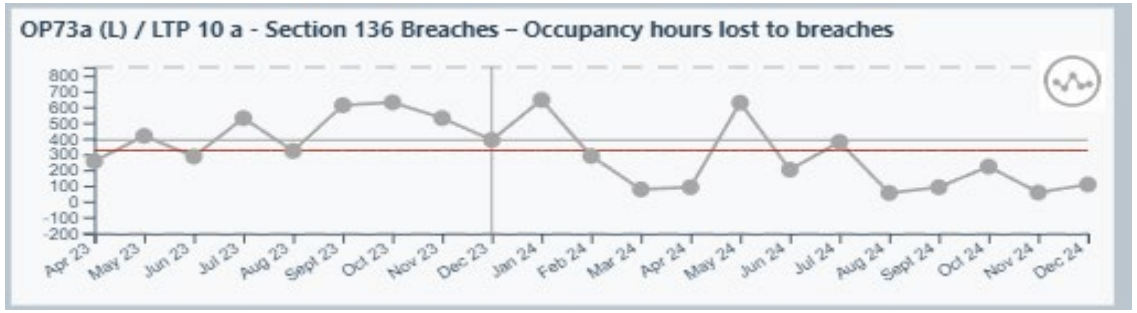
OP17c - The number of inappropriate adult acute OAPs reports the number of inappropriate adult acute OAPs at the end of a reporting month (OP17C) and is reporting 13 out of area inappropriate placements at the end of the calendar month. A task force is to be launched in January 2025 to create focussed actions and drive improvement in flow to support reduction of this number. Internal scrutiny will remain on internal out of area placements at Trust level.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target and is reporting 2,661 CYP waiting against the target of 2,194. This is primarily due to delays to recruitment of the additional staffing required to deliver the trajectory and the need to add in further nuances where capacity is not solely dedicated to new appointments



Trend, Reason and Action

- OP73a – The metric measures the occupancy hours lost due to breaches within our 3 Section 136 suites, 108 hours were lost this month. 40 hours were due to estates damage in Rotherham suite. There were a further 68 hours of breach time attributable to patient stays longer than 24 hours. 4 of these were non-RDaSH patient breaches (2 Sheffield), 26 hours of the total relate to RDaSH patient breaches.

3.0 Quality & Safety In Focus

Indicators for December 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	Q3 = 0	0	= 0	0
QS06 (N)	Number of Clostridum difficile infections (Monthly)	= 0		0	Q3 = 0	0	= 0	1
QS07 (N)	Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q3 = 0	0	= 0	0
QS08 (N)	No patients aged >=16 admitted with completed VTE	>= 95%	130/137	94.89%	Q3 >= 95%	96.00%	>= 95%	93.00%
QS15 (L)	No of wards reporting registered staff on nights/days >90%		16/17	94.12%		92.00%	>= 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			3		6	= 0	19
QS21a (L)	Physical aggression incidents mod or above to staff (%)		10/106	9.43%		5.00%		11.00%
QS23 (L)	Number of Suspected Suicides (Inpatient Settings)	= 0		0	Q3 = 0	0	= 0	0
QS27 (L)	Ligature incidents mod or above all inpatient areas		2/19	10.53%		7.00%	<= 10%	10.00%
QS29 (L)	Number of racist incidents against staff members			3		7	= 0	28
QS31 (L)	Episodes of Seclusion - Internal MDT within 5 hours		4/8	50.00%		57.00%	= 100%	58.00%
QS36 (N)	Inpatients that have a completed MUST assessment		112/141	79.43%		74.00%	= 100%	67.00%
QS37 (L)	Inpatients commenced with falls assessment in 72 hrs		56/71	78.87%		84.00%	= 100%	92.00%
QS38 (L)	Moderate/High falls requiring a structured review	= 0%	0/100	0.00%	Q3 = 0%		= 0%	50.00%

Narrative

QS08 – Reporting a decline to 94.89% (130/137) from 95.21% (139/140) in November.

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

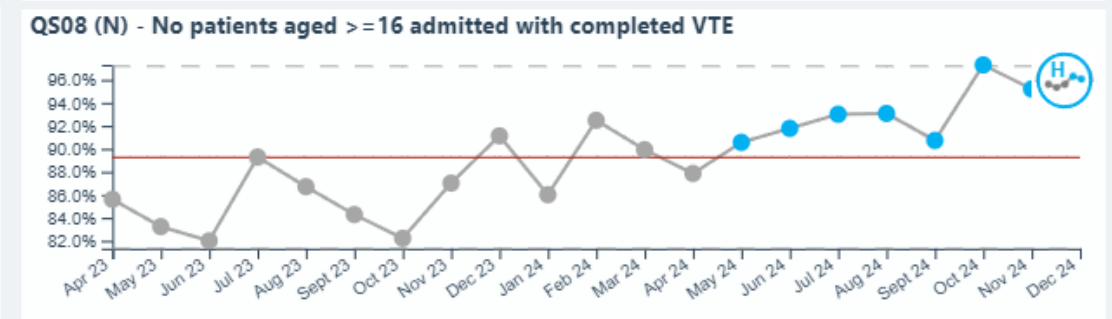
QS29 – Reporting 3 racist incidents in December.

QS31 – Reporting the number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target reporting 50% (4/8) for November.

QS36-- Reporting an increase to 79.43% (112/141) in December from the 72.67% (109/150) in November of the % of Inpatients that have a completed MUST assessment.

QS37 – Reporting a decrease to 78.87% (56/71) in December from the 80.65% (75/93) in November.
for the number of inpatients receiving a falls assessment within 72 hours.

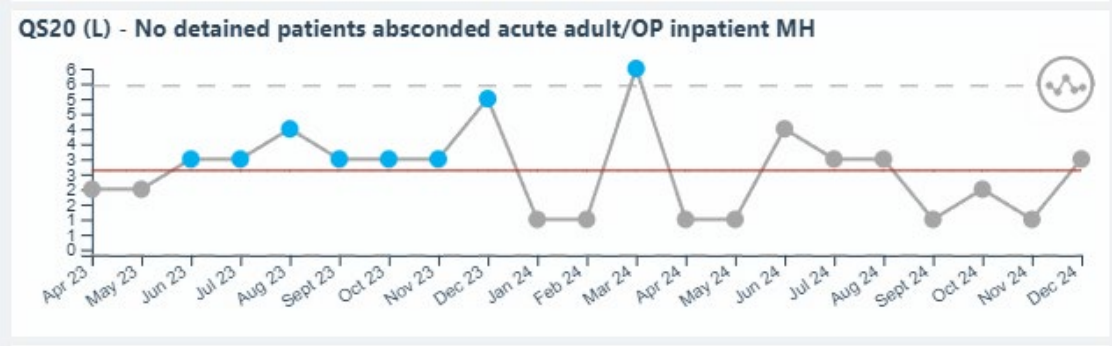
3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

QS08 - The percentage of VTE assessments completed within 24 hours has declined to 94.89% (130/137) from the above 95% target position of 95.21% (139/140) in November.

The alert is now embedded in all inpatient records following a successful trial period so that when retrieved the alert will notify when the assessments are uncompleted to assist with completion within timeframe. There is also an exemption for hospice patients in the last 24 hours of life. Care groups are conducting daily deep dives, weekly audits and exploring transfers with the acute trust which are acted on if the VTE assessment is not fully completed and continue to feed back to Doctors concerned. There is a focus on VTE assessments in Junior Doctor's Induction and training across all Care Groups.



Trend, Reason and Action

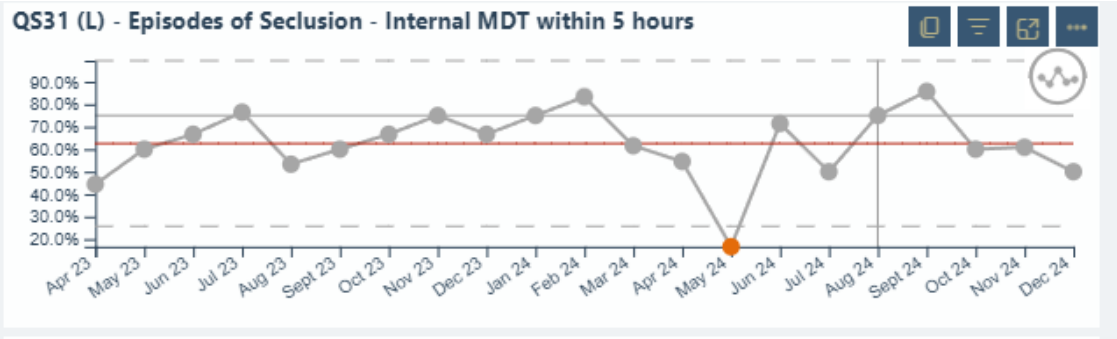
QS20 –An increase to 3 detained patients reported as absconding in December from acute adult and OP inpatient mental health units from the 1 patient in November which has breached the zero target. Following a deep dive the same patient was recorded as two of the instances. Both instances involved scaling the outside area. AWOL procedures were followed, next of kin notified and the patient was returned by the police four hours later. The second patient climbed through fencing on the roof of an inner garden, the AWOL procedure was followed and the patient was returned by Police. All incidents have led to the increased monitoring of outside areas by staff.

Trend, Reason and Action

QS29 – The Trust is reporting an increase to 3 racist incidents reported from the three-month sustained position of 2 racist incidents reported each month from September – November.

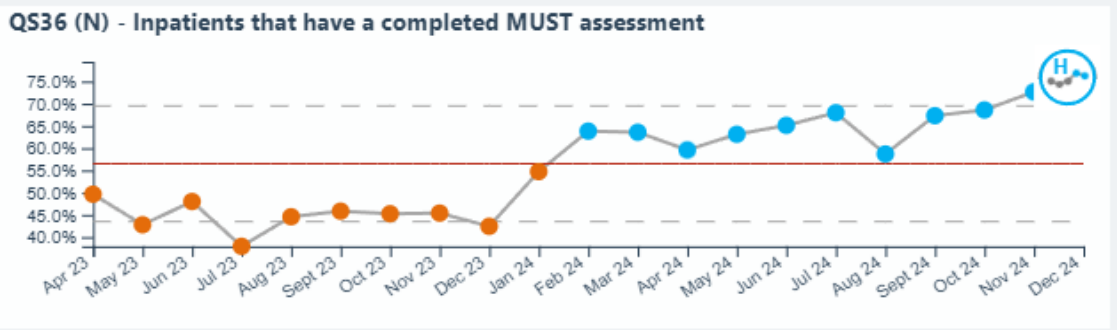
The Acceptable Behaviour Policy has now launched Trust Wide and in its early stages of implementation which will create a framework to warn, bar and ultimately exclude carers and patients who abuse employees, students and Volunteers with care Group leaders empowered to apply these sanctions. IR1's are reviewed and actioned when they arise and staff involved are contacted for support

3.1 Quality and Safety In Focus - Exceptions



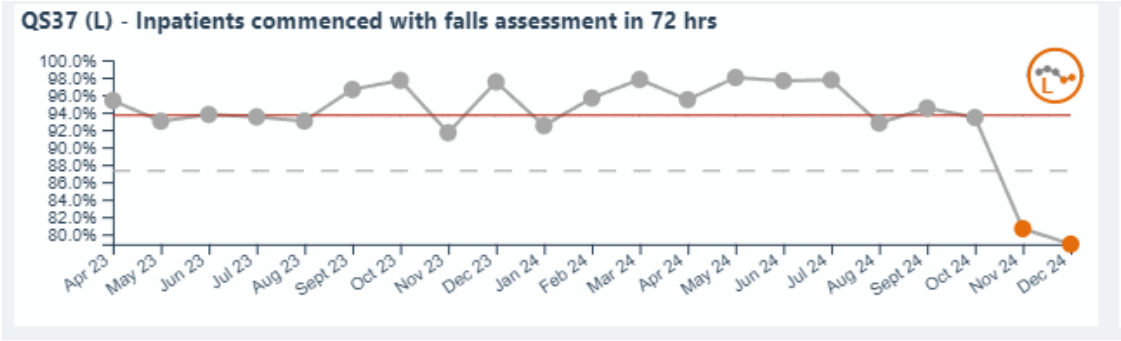
Trend, Reason and Action

QS31 –The number of episodes of seclusion receiving an internal MDT assessment within 5 hours has breached the Trust's 100% target reporting a decline to 50% (4/8) from the 60.87% (14/23) for November. The risk continues to be highlighted on the risk register for each Care Group and 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 to ensure that all non-compliance is addressed.



Trend, Reason and Action

QS36 - Reporting an increase to 79.43% (112/141) in December from the 72.67% (109/150) in November of the % of Inpatients that have a completed MUST assessment. The alert is now embedded in all inpatient records following a successful trial period so that when retrieved the alert will notify when the assessments are uncompleted to assist with completion within timeframe. There is also an exemption for hospice patients in the last 24 hours of life. The Physical Health Care group are exploring recording around patients that are accepted for admission, however, do not arrive on the ward. The data capture is being explored with Clinical Systems Team. Care groups are conducting daily deep dives and weekly audits which are acted on if the MUST assessment remains uncompleted. Daily monitoring is taking place across all care groups.



Trend, Reason and Action

QS37 –A decrease to 78.87% (56/71) in December from the 80.65% (75/93) in November.
As an Organisation we have seen a significant decrease in hip fractures sustained in our direct care , with 1 reported in 2024 against the 8 in 2023.

4.0 People and Organisational Development – In Focus

Indicators for December 2024/2025 TRUST — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	9.31%		9.00%		9.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	6.28%		6.00%		6.00%
POD15 (L)	Number of Consultant Vacancies	<= 10	12		12		12
POD16 (L)	Qualified nursing vacancies	<= 10%	6.36%		8.00%		8.00%
POD17 (L)	Support worker vacancies	<= 10%	8.49%		9.00%		9.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	90.24%		90.00%		90.00%
POD19 (L)	Individuals completed mandatory/statutory training	> 90%	92.24%		92.00%		92.00%
POD23 (L)	Number of individuals currently suspended from employment		1				
POD24 (L)	Average suspension length in calendar days	<= 150	62		62		62
POD25 (L)	Recruitment completed within 12 weeks	>= 95%	98.00%		98.00%		98.00%
POD26 (L)	Compliance for safeguarding children's training		77.46%		77.00%		77.00%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		77.73%		78.00%		78.00%
POD28 (L)	Total Vacancies		197		197		197
POD29 (L)	Total Vacancy Rate %		5.27%		5.00%	<= 2.5%	5.00%

Narrative

POD10 – The year-to-date sickness absence % has shown an increase from 6.09% in November to 6.28% in December. There has been an increase in STS, with the following Directorates all being above 3% for STS in the month of November Rotherham - Acute, Children's - Physical Health, North Lincolnshire - Acute, Community and Talking Therapies, Physical Health and Neurodiversity - Community & LTS and Rehabilitation. The new policy will launch on the 1st April following a period of training for managers. In addition, CLE in January will discuss the sickness absence rates, the revised policy approach and how we support colleagues to maintain attendance.

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).

POD26 and POD 27 - Trust Level 1 and 2 (both adult and child) are compliant but level 3 for adult and child are amber. Reviewed the compliance matrices, scheduled bespoke sessions to the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view to targeting individuals in order to improve compliance.

POD29 – reporting as 5% against the target total vacancy rate percentage of less than or equal to 2.5% with 197 vacancies currently across the trust (reduced from 224). Rotherham (7.4%) and Doncaster Mental Health and Learning Disability Care Group have the highest vacancy rate reporting above 7%.

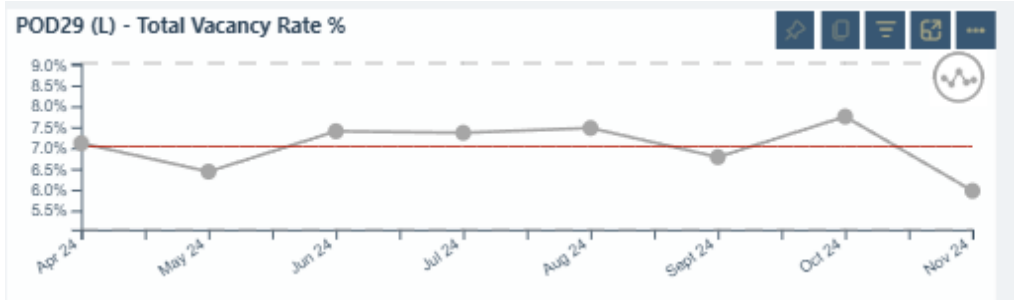
4.1 People and Organisational Development - Exceptions

Trend, Reason and Action

POD10 - The year-to-date sickness absence % has shown an increase from 5.09% in November to 6.28% in December, There has been an increase in STS, with the following Directorates all being above 3% for STS in the month of November Rotherham - Acute, Children's - Physical Health, North Lincolnshire - Acute, Community and Talking Therapies, Physical Health and Neurodiversity - Community & LTS and Rehabilitation. The new policy will launch on the 1st April following a period of training for managers. In addition, CLE in January will discuss the sickness absence rates, the revised policy approach and how we support colleagues to maintain attendance.

Trend, Reason and Action

POD15 –The Trust continues to experience challenges recruiting to Consultant vacancies. We have secured GMC sponsorship and have a pipeline of 12 ST4 doctors to join us through 2024. NHS professionals engagement is assisting with improved medical cover (and reducing significant costs too). 3 Consultant interviews are scheduled for 10th December 2024.



Trend, Reason and Action

POD28 and POD29 - reporting as 5% against the target total vacancy rate percentage of less than or equal to 2.5% with 197 vacancies currently across the trust (reduced from 224). Rotherham (7.4%) and Doncaster Mental Health and Learning Disability Care Group have the highest vacancy rate reporting above 7%.

4.0 Finance – In Focus

Finance

Indicator	Metric	Target £000	Actual £000	Variance £000
FIN01	Year to date actuals vs budget	- 142	430	572
FIN02	Year to date actuals vs budget - excluding AED	- 142	665	807
FIN03	Forecast outturn vs budget	- 348	- 348	-
FiIN04	Annual savings target vs schemes identified	6,622	6,622	-
FIN05	Agency spend as % of total pay bill - year to date	3.6	2.1	-1.5%
FIN06	Year to date capital plan vs spend	- 5,754	- 4,684	1,070
FIN07	Annual capital plan vs forecast spend	- 8,678	- 10,384	- 1,706

Narrative

FIN01 - The position at the end of December is a surplus of £430k, £572k better than the revised plan, which includes NHSE deficit support funding. The improvement in this position is due to non-recurrent £1.1m funding received from NHSE. The enhanced packages of care within the SY Adult Eating Disorder Collaborative continue to be a pressure of £235k along with payment of arrears and the ongoing costs of the pay awards. .

FIN02 - The position excluding the AED costs is a year to date surplus of £665k, which is better than the planned deficit of £70k at M9.

FIN03 - The reported forecast of £348k deficit is on plan. It has been assumed that non-recurrent funding of £1.5m due from NHSE Specialised Commissioning can be used to support the pay award cost pressure rather than being used to forecast a £1.2m surplus as originally expected. Without this funding and if the pay award funding methodology used in previous years is adopted by the ICB, then the Trust expects a full year effect pay award funding shortfall of £2.3m. £1m of this is already assumed in the plan, therefore a further increase of £1.3m to the recurrent deficit on a FYE basis would materialise hence the amber rating. Negotiations continue and the Trust is awaiting confirmation on the pay award funding allocation by the ICB. This is consistent with ICB guidance issued to providers at month 9.

FIN04 - Schemes have been identified in full for the 24/25 savings program. A savings target of 0.5% has been delegated to each group and a vacancy factor of 2.5% has been applied to all staffing budgets. The agency target was held centrally but was allocated to care groups and backbone services in M8. Some of the savings in the forecast are non recurrent, and are being replaced with recurrent schemes as they are identified and developed.

FIN05 - Agency costs at the end of December continue to reduce and are now 2.1% of the total pay bill (2.4% in the previous month). An agency ceiling has not been set by NHSE in 24/25, therefore the target for 2023/24 of 3.6% has been provided for comparison purposes. The trust savings plan assumes a £1.6m saving linked to agency premium, the Trust must keep agency spend at or below 3.6% of the total pay bill to achieve this.

FIN 06 - Capital spend is behind plan year to date by £1.1m. This is due to slippage on projects predominantly relating to Great Oaks. Work is ongoing to bring forward as much spend as possible from the 2025/26 capital plan to mitigate the risk of underspending and losing the funding opportunity.

FIN07 - Despite YTD capital being underspent, we are forecasting an overspend of £1.7m. This is because £2m of potential IFRS16 accounting costs are included in the M12 forecast for the Elizabeth Quarter lease that might have to be recognised in 2024/25. The costs are likely to fall into 2025/26 but it is prudent to recognise the pressure in the forecast so that the ICB and NHSE are aware and funding options can be considered. The proposed accounting treatment is being reviewed by external auditors in January to help clarify which year the cost will be recognised in.

Appendix 1`

SPC Icon Description

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