NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 27 March 2025 at 9.30am
CAST Theatre, Waterdale, Doncaster, DN1 3BU

No	Item	Request to	Lead	Enc.
1	Welcome		KL	
2	Apologies for Absence: Dr Richard Falk	Note Information		
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest			A
Staff Story				
5	Staff story – Adult Neurodiversity Service	Information	CH	Verb
Standing items				
6	Minutes of the meeting held in public on the 30 January 2025	Decision	KL	B
7	Matters Arising and Follow up Actions	Decision		C
Board Assurance Committee Reports to the Board of Directors				
8	Quality Committee	Assurance	DV	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	DV	H
13	Finance, Digital & Estates Committee	Assurance	PV	I
14	Remuneration Committee	Assurance	KL	J
15	Chief Executive's Report (inc Real Living Wage Update Promise 25)	Information	TL	K
BREAK (approx. 11.15am)				

16	2025/26 Financial Plan (including Investment Fund bids)	Decision	IM	L
17	2024/25 Serious Patient Safety Incidents - Learning	Information	SF	M
18	Promise 26	Information	CH	N
19	Older People's Services: proposed changes in 2025/26	Decision	JG	O
20	Trust Bed base – Forward look to 2028	Information	RC	P
21	Health and Safety Update including Ligature Risk Assessment Review	Information	SF	Q
22	Apprentice Levy	Information	CH	R
23	2024/25 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Assurance	SF	S
24	Our Enabling and Delivery Plans	Decision	TL	T
Operating Performance / Governance / Risk Management				
25	Operational Risk Report - Extreme Risks / High Impact – Low Likelihood Risks	Assurance	PG	U
26	Strategy Delivery Risks 2024/25 – Year End Report	Assurance	PG	V
27	Integrated Quality Performance Report (IQPR)	Assurance	TL	W
28	Promises and Priorities Scorecard – Year End Report	Assurance	TL	X
Supporting Papers (previously presented at Committee)				
29	Annual Safe Staffing Declaration 2024/25 Eliminating Mixed Sex Accommodation Annual Declaration Mortality Report Guardian of Safe Working Hours Report	Information	KL	Y
30	Any Other Urgent Business (to be notified in advance)		KL	Verb
31	Any risks that the Board wishes the Risk Management Group to consider			
32	Public Questions *			
	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	
33	*Minutes of the meeting held on the 30 January 2025 (private session)*	*Decision*	KL	AA
34	*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
35	*Reflections on the staff story*	*Discussion*		Verb
36	*Chief Executive Private Update to the Board of Directors (incorporating Cyber Security Update)*	*Information*	TL	CC

*** Public Questions:**

Questions from the public may be raised at the meeting where they relate to the papers being presented that day. Alternatively, questions on any subject may sent in advance and they will be presented to the Board of Directors via the Director of Corporate Assurance. Responses will be provided after the meeting to the originator and included within the formal record of the meeting.

The next meeting of the Board of Directors will take place on Thursday 29 May 2025 10am – venue to be confirmed

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Diane Jeavons, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	27 March 2025

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

- The report is presented as a standing agenda item at each meeting to ensure board awareness to any declarations and if needed, actions taken to prevent any conflicts during the business of the Board.
- There are changes to the register, declared since the last meeting, relating to Mr Mohammed and Mr Forsyth as presented in the attached report.

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 • Director - Bawtry Community Library

Name / Position	Interests Declared
Richard Chillery, *Chief Operating Officer*	• Nil
Dr Richard Falk, *Non-Executive Director*	• Nil
Steve Forsyth, *Chief Nursing Officer*	• Coach at the Gambian National Police Force • Ambassador and Affiliation for WhizzKidz • Non-Executive Director for the African Caribbean Community Initiative • Fellow of the Queens Nursing Institute (QNI). • **Member of Asian Professionals National Alliance** • **Member of British Indian Nurses Association** • **Member of Jabali Men's Network** • **Member of Nola Ishmael Executive Nurses**
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 and 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.

Name / Position	Interests Declared
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.
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 – 27 March 2025

Staff Story - Adult Neurodiversity Service

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 30 JANUARY 2025 AT 10.00AM WATER'S EDGE, BARTON, NORTH LINCOLNSHIRE

PRESENT

Kathryn Lavery	Chair
Rachael Blake	Non-Executive Director
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
Toby Lewis	Chief Executive
Izaaz Mohammed	Director of Finance and Estates
Dr Diarmid Sinclair	Chief Medical Officer
Pauline Vickers	Non-Executive Director
Dr Janusz Jankowski (v)	Non-Executive Director

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Jane Charlesworth`	Head of Corporate Assurance
Lea Fountain	NeXT Director
Philip Gowland	Director of Corporate Assurance / Board Secretary
Dr Jude Graham	Director for Psychological Professions and Therapies
Jo McDonough	Director of Strategic Development
Ann Llewellyn (v)	Governor
Chris Pope	Governor
Ian Spowart (v)	Governor
Vicky Sinclair	Patient Story
Mr and Mrs Greenhalgh	Patient Story
1 member of staff	

Ref		Action
Bpu 25/01/01	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. Apologies for absence were noted from Dave Vallance, Non-Executive Director and Jyoti Mehan, NeXT Director.	
Bpu 25/01/02	**Quoracy** Mrs Lavery declared the meeting was quorate.	
Bpu 25/01/03	**Declarations of Interest** Mrs Lavery presented the Declarations of Interest report which outlined that there were no changes to the register since the last meeting. It was noted that Dr Falk no longer provided medical consultancy advice to H I Weldricks Pharmacies and Rachael Blake was no longer a	

	Trustee for South Yorkshire Community Foundation. Appropriate amendments would be made to the register. **The Board received and noted the changes to the Declarations of Interest Report.**	
	PATIENT STORY	
Bpu 25/01/04	**Patient Story – Learning Disabilities** Mrs Lavery welcomed Vicky Sinclair (Primary Care Liaison Nurse) and Mr and Mrs Greenhalgh to the meeting to share their daughter's story and experience of the care received. Mrs Greenhalgh described her daughter and shared with the board the journey that she had supported her daughter through – including many challenges and involvement with multiple agencies. She shared the more recent events that led to the greater involvement of and support from the Community Learning Disability Team and other professionals. The Community Learning Disability Team, along with occupational therapists, physiotherapists, and social workers, provided extensive supported Amy and her family, helping them navigate her medical challenges and improve her quality of life. Amy's family expressed gratitude for the coordinated care and support they received, particularly from Vicky, highlighting the importance of teamwork and communication among various professionals involved in Amy's care. Amy went into respite at a care home in December 2023 and a decision was then made for her to live there permanently. Mr Lewis thanked Mr and Mrs Greenhalgh for sharing their story and asked what worked so well in terms of the support provided by the teams. Mr Greenhalgh noted that the teams were consistently responsive and helpful, and highlighted the significant support received from Vicky and her coordination of Amy's care. Dr Graham questioned the support provided to Mr and Mrs Greenhalgh as carers, Mrs Greenhalgh referred to Vicky's role in supporting the coordination of care and going above and beyond for Amy's family, as well as the support provided from social services. Mrs McDonough asked if Vicky was still involved in Amy's care at the care home, Vicky advised that she visited Amy when visiting other patients. Since Amy's diagnosis, work was ongoing in North Lincolnshire to develop a dementia pathway for patients with a learning disability with proactive monitoring and a post-diagnostic clinic. This was currently being piloted in North Lincolnshire Adult Mental Health and Talking Therapies Care Group. Vicky advised that learning disability and best interest awareness workshops had been delivered to the Ambulance Service, Mr Lewis noted the work required to ensure this was also delivered to the Fire and Rescue Service.	

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	Mrs Lavery and the Board thanked Mr and Mrs Greenhalgh and Vicky for taking the time to speak about their experiences and noted the intended reflection time later on the agenda.	
	STANDING ITEMS	
Bpu 25/01/05	**Minutes of the previous Board of Directors meeting held on the 28 November 2024** **The Board approved the minutes of the meeting held on the 28 November 2024 as an accurate record, subject to a minor wording amendment requested by Dr Falk under Bpu 24/11/08.**	
Bpu 25/01/06	**Matters Arising and Follow up Action Log** There were no matters arising from the minutes. The Board received the action log and noted the progress updates. All actions noted as 'propose to close' were agreed. Mr Lewis queried when the Board would receive the outcome of the second Good Governance Improvement (GGI) review. Mr Gowland advised that the GGI review and observation opportunities had commenced, the final report would be received during early March 2025. The Board supported Mr Lewis' request to change the due date of the open action regarding Ligature Risk (Bpu 24/11/16), to March 2025.	
	BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS	
Bpu 25/01/07	**Report from the Quality Committee (QC)** Dr Falk presented the paper and referred to the matter of concern regarding level 2 and 3 resuscitation training compliance remaining below target, this was a recurrent theme over a number of meetings. The Committee had discussed the need to understand the patterns of non-attendance and withdrawal from training. Dr Falk recognised the significant improvements made in terms of the other elements of resuscitation practice since the last report. The Committee had received the RDaSH Response to the Greater Manchester Mental Health NHS Foundation Trust Independent review, a further assessment would be undertaken during Q4. The Integrated Quality Performance Report (IQPR) was discussed and there was reflection on the reporting arrangements and focus on the quality & safety quadrant as opposed to the overall IQPR, the Committee felt that further guidance was required by the Board to agree the lens at respective Committee's. Mr Lewis clarified that the Committee should be focusing on the quality & safety and performance quadrants of the IQPR. In terms of mortality reporting, there would be a further update at the next meeting on the trajectory to address the backlog of Structured Judgement Reviews.	

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	Mr Lewis referred to the concerns around resuscitation training compliance and advised that this would be taken forward by the People & Organisational Development Committee as it was fundamentally based on the trust's training arrangements. Mr Lewis wished to discuss the CQC Registration report and its stated assurance outside of the meeting. **The Board received and noted the report from the Quality Committee.**	
Bpu 25/01/08	**Report from the Audit Committee** Ms Gillatt presented the paper and noted the follow up to internal audit actions was in a good position with 87% of the high and medium risks being closed on time and 91% of all risks being closed on time. The Committee received its first report on education governance and would further understand the different components and sources of assurance when it discussed the matter further in April's meeting. Ms Gillatt noted the proactive work ongoing to complete the year-end assessment against the counter fraud functional standard. **The Board received and noted the report from the Audit Committee.**	
Bpu 25/01/09	**Report from the Mental Health Act (MHA) Committee** Ms Fulton-Tindall presented the paper and noted that there were 308 detentions during September and October 2024, all of which were lawful. The Committee was pleased to receive the annual MHA equalities report and it had been 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. MHA Level 3 training was a continued challenge in some areas of the trust, a further update would be received at the next meeting regarding the plans in place to address this. There was fluctuation in compliance for Section 132 Rights, further work was required to ensure this was consistent across the trust. There was a focus on ensuring the consultant review had been completed within 5 hours of a seclusion episode, this hadn't happened in a number of cases. The Committee was supportive of the approach to work with consultants and junior doctors to address process and communication issues that have been identified. Dr Sinclair advised that he had written to junior doctors to outline the expectations. **The Board received and noted the report from the Mental Health Act Committee.**	
Bpu 25/01/10	**Report from the People & Organisational Development (POD) Committee**	

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	Ms Blake presented the paper and noted the positive discussion regarding the NHS Professionals implementation and the areas of good practice and wider learning. The gender pay gap had reduced to 4.45 which was a positive comparable from the 7.5 previously reported. In terms of the guardian of safe working hours report, the Committee was pleased to note that the rota design in Doncaster would be changed to a similar pattern used on Rotherham and North Lincolnshire starting from February 2025. The Staff Incidents, Violence and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Report (RIDDOR) report was received and there was a particular focus on the sexual and racist incidents, the ways by which this would be addressed would be discussed in more detail at future meetings. **The Board received and noted the report from the People & Organisational Development Committee.**	
Bpu 25/01/11	**Report from the Public Health, Patient Involvement & Partnerships (PHPIP) Committee** Dr Falk presented the paper and highlighted the emerging partnership with a Clinical Research Organisation (CRO) and the positive discussion around poverty proofing and enthusiasm for the process. The draft Community Involvement Framework was approved for further development. Mr Lewis noted that the Committee agreed on behalf of the Board, the progression of the terms of the partnership with the CRO who specialised in psychedelic research. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	
Bpu 25/01/12	**Report from the Finance, Digital & Estates (FDE) Committee** Mrs Vickers presented the paper, noting that the trust was a positive outlier in terms of agency expenditure across the South Yorkshire region, and the ICB were looking how other trusts could apply a similar approach. The Committee continued to monitor the progress being made in respect of fire safety compliance and the plans to maintain resilience, reduce backlog assessments and address any high-risk areas. The South Yorkshire Fire Service will undertake informal advisory visits to the trust and they would be completing an audit on the trust's fire safety compliance in 2025. In response to Mr Lewis, Mr Mohammed clarified that the fire safety assessments would be completed by March 2025 and would be included in the health and safety report due to be received by the Board. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	

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Bpu 25/01/13	**Report from the Trust People Council (TPC)** Mrs Lavery presented the paper and highlighted the discussions around remote working and the real living wage. The TPC was pleased to see the new staff governors in attendance at the meeting. **The Board received and noted the report from the Trust People Council.**	
Bpu 25/01/14	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report. The Board was asked to consider and agree the terms of reference for the All Age Eating Disorders Joint Committee, Mr Lewis outlined the intention being (subject to the approval by all four trust's and the ICB) that all parties involved, would oversee investment and disinvestment decisions, ensuring a targeted and equitable approach to service provision across the region. The expectation was that the Joint Committee, over the next year, would focus on creating an upstream offer for families and individuals with eating disorders and reshaping the specialist supply model to target unmet needs, better manage deterioration and reduce reliance on private sector beds. Dr Falk was fully supportive of the collaboration, and queried the risks associated should one of the partners withdraw, Mr Lewis advised that there was no financial risk, however there was some reputational risk. The Joint Committee could carry on if one of the partners withdrew, however wouldn't be able to continue if the ICB withdrew. Ms Blake was pleased to see the meaningful engagement with people with an eating disorder and sought clarity around non-executive involvement. Mr Lewis stated that the only board and non executive involvement would be via the report to the board. He noted it would have been preferable for the paper to more clearly state that on a day to day basis the joint committee would lead on mental health EDA collaborative board as chairs and chief executives. He confirmed that public patients and carers were involved in the individual services and their involvement in the community of practice had been reasonably extensive. Ms Blake then referred to the huge demand on eating disorders and questioned if the new model provided an opportunity for early intervention of support and advice. Mr Lewis advised that this was explicitly the intention of the proposition and by disinvesting in complex care, funds could be released for this purpose - there were two associated risks regarding the allocated pots of money and all members of the Joint Committee would need to be viewed as an accountable body for eating disorders, rather than an institution that provided the service.	

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	Mrs Vickers sought clarity around the trust's visibility around the financial position, Mr Lewis clarified that the trust would remain fully sighted on this. Ms Gillatt praised Mr Lewis for his hard work in progressing this work. Mr Lewis expressed gratitude to Dr Jankowski for his consistent support in this work and drawing attention to the organisations outside of South Yorkshire who could make a positive contribution. **The Board approved the delegation of the children's and adult eating disorder funding and material decision making to the new Joint Committee, recognising the importance of a collaborative approach to enhance service delivery and outcomes for individuals with eating disorders.** Mr Lewis drew attention to the role of the Mayoral Combined Authorities, and noted its likely greater importance and influence in the future. A positive discussion was held with mental health trust chief executives' and the combined authority, particularly around pathways to employment. The South Yorkshire Mayoral Combined Authority had acknowledged a lack of support for neurodivergent younger adults as a significant barrier to employment – this was a significant area of progression. Continued progress was being made in CAMHS services and they were close to achieving the four-week waiting time target. Mr Lewis emphasised the importance of this achievement for children, families, and teachers. Mr Lewis discussed the implementation of SPA time for medical staff, acknowledging the challenges and the need for trust and support in the process. Mr Lewis noted the positive progress with the Elizabeth Quarter development, with the expectation of space available for use by summer. He expressed gratitude to Mr Mohammed, the teams involved and the North Lincolnshire Council for their support. Ms Holden highlighted the reduction in vacancy levels, noting that the organisation has revised its vacancy factor to 3.3%, down from an excess of 8%. This improvement was attributed to better managerial capacity and understanding of vacancy levels. Ms Fountain drew attention to the openness and transparency of complex issues within the report, the attitude taken and desire for inclusivity to the public we serve. **The Board received and noted the Chief Executive's report and the forward actions it contained.**	
Bpu 25/01/15	**Promise 14 – inc waiting lists** Mr Chillery presented the paper which provided an update on Promise 14 highlighting the significant improvement in waiting list validation since	

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	the last report in November 2023 and expressed his thanks to health informatics, performance and the care groups for ensuring all waits were now visible with live data available on a daily basis. A number of services had achieved the four-week waiting time target, which demonstrated hard work undertaken and the effectiveness of the improvements made in service delivery - CAMHS services are the forerunner for this work. Further work was required to ensure all services were achieving a maximum 4 week waiting time from April 2026, this included the completion of demand and capacity analysis to identify services where demand currently exceeds supply and to link investment plans accordingly. An internal audit on waiting list governance within the care groups was currently ongoing. Mr Chillery also discussed the ongoing work to address urgent referrals within 48 hours, including establishing a baseline and exploring options to improve response times. Ms Fulton Tindall commented on the significant improvement in the quality and understanding of data. Dr Falk referred to adult autism assessment services currently having waits more than 24 months and 1,779 patients on the waiting list, Mr Chillery noted that neurodiversity services were the most challenging area in terms of achieving the 4 week wait, adult ADHD had been prioritised as there was an intervention. Further work was required to consider the required investment into autism assessment services. Dr Graham confirmed that support and information was provided to those waiting. Dr Sinclair confirmed to Dr Falk that within the Memory Service, that patients had often received their scan prior to being seen in the service, hence there was no 'second' period of waiting. Mr Banks reflected on the opportunities available for digital solutions to further assist with the work implementing Promise 14. Mr Lewis reflected on the success gained from a small cohort of people stressing the need to get more people involved to ensure that a whole Trust approach was in place. He noted the challenge of sustaining the delivery of the target once it was achieved. Mr Chillery further reflected on the anticipated increase on demand within some services, for example wheelchair services and also reflected on the recently reported waiting times for services such as ADHD and Autism in neighbouring Trusts in the ICB patch. **The Board received and noted the Promise 14 – inc waiting lists update.**	
Bpu 25/01/16	**25-26 Capital Plan and 25-26 Indicative Revenue Plan** Mr Mohammed referred to the Capital Plan within the paper highlighting that core to the £5m plan was the Phase 3 and 4 work at Great Oaks in North Lincolnshire, enabling work associated with Hazel and Hawthorne	

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	wards on the Tickhill Road site in Doncaster and the development of a HDU. No additional capital funding was anticipated from the system. He reminded the Board that funds associated with IT schemes had been brought forward into the current 2024/25 capital plan, in response to the delays on other planned work. Work on sustainability, and reducing emissions, would be part of relevant schemes and there may be opportunities to source funds in support of this type of work. Mr Mohammed noted the additional flexibility afforded through the updated IFRS16 requirements. Mr Lewis confirmed the involvement of Executive colleagues and CLE members in the development of the Capital Plan **The Board approved the 2025/26 Capital Plan; and noted the new clinically informed minor works process to be launched from February.** Mr Mohammed referred to the indicative revenue plan and highlighted the key assumption was £6m savings programme target and a £3m cost pressure reserve; there was an assumption of zero growth from commissioners. Mr Mohammed mentioned that ADHD funding was included in the draft plan contained in the paper, however this was subject to confirmation from the ICB along with confirmation of the amount of deficit support funding. Allocations were expected in February and the plan presented at the March meeting would include the updated figures. As part of the efforts to achieve the £6m target, Mr Lewis detailed the budget cuts, including a 0.5% baseline cut to all of the 23 directorates and the removal of £500k from corporate functions. There was a need to find £1.5m from bed closures from within older people's services. The net position after investment in community-based services was expected to be £1.5 million. An additional £2.5m needed to be found from out-of-area placement budgets, this was part of the effort to balance the budget sustainably while meeting necessary obligations. A further paper would be developed to outline the plan with the assumptions set out in the paper. **The Board noted the movement in the forecast underlying deficit position from £6.2m to £8.4m and the indicative revenue planned deficit of £3.5m for 2025/26 and the assumptions included in arriving at this figure.**	
Bpu 25/01/17	**Workforce – Staffing Overview (inc Dec 24 vs 24/25 plan and vs Dec 23)** Ms Holden presented the paper and provided an update on workforce and vacancy management and associated workstreams to achieve the aim of being fully staffed by March 2025.	

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	Reference was made to the transfer of bank colleagues to NHS Professionals (NHSP). The Trust had been able to secure staff to fill many vacancies through this route. The transfer was part of the effort to reduce agency usage and improve workforce stability. The current position was 190.70 WTE vacancies, Ms Holden discussed the employment journey, including the process of posting vacancies, reviewing applications, and conducting pre-employment checks. It was noted that 53 candidates had start dates agreed, and 85 candidates were undergoing pre-employment checks. A 3.3% vacancy factor was projected by the end of the financial year, considering the current recruitment efforts and expected leavers. The importance of continuous recruitment initiatives and the role of managers in the process was noted. Ms Blake recognised the position in terms of offering alternative employment for people and considered how the trust could further support with community recruitment. In response to Ms Gillatt regarding 'time to hire', Ms Holden advised that the trust was competitive in comparison to other organisations and noted the positives of having a centralised recruitment team. Mrs Vickers noted the importance of tracking the impact of implementing the real living wage. Mr Banks referred to the budgeted vs actuals data and queried if there could be a forecast of actual numbers to the end of 2025. Ms Holden advised that this would be undertaken as part of the workforce return the trust was required to submit annually. Mr Lewis requested further understanding of the 973 posts, being the difference in number to those in 2018/19, to understand if they were new posts or posts that remained vacant. Ms Holden confirmed that a new national workforce system was being procured and would be implemented during 2027 – 2030. **The Board recognised the progress made and note the current vacancy position, the predicted March 2025 outturn position and the potential future national changes linked to administrative and clerical colleagues.**	**CH**
Bpu 25/01/18	**Promises 3 and 4** Mr Forsyth presented the paper and highlighted the successful launch and implementation of Care Opinion across the organisation (promise 4) which was a direct placement of Your Opinion Counts (YOC). Approximately 400 stories had been received through Care Opinion to date which had enabled real time feedback and improved contact with patients and carers, as well as key feedback in terms of service improvement and change.	

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	Mr Forsyth reported on the progress of volunteer recruitment (promise 3), noting the target of 250 volunteers by the end of the quarter 4 2024/25 and the current number of 251 validated volunteers. He emphasised the importance of diversity and the positive impact of volunteers on the organisation. Mr Forsyth was sorry to announce the passing of Mike Valentine, Mike was a retired pharmacist and had volunteered for the chaplaincy department for over 20 years. Mr Lewis drew attention to the 240 people from a global majority that had applied to be a volunteer since the summer, comparably 40 people considering themselves as white British had applied. He noted the importance of reaching the target of 350 volunteers with diversity, and ensuring each clinical service and geography had an equal share of volunteers in 2025/26. **The Board received the report and noted the assessment of work undertaken to date, including the learning and actions.** **The Board agreed acceleration possibilities to get to 350 volunteers and making feedback translate into meaningful felt change.**	
Bpu 25/01/19	**High quality therapeutic care taskforce (HQTC) – further discussion** Mr Lewis presented the paper and drew attention to the key items. He discussed the adoption of the Culture of Care Standards and emphasised the importance of a shared understanding of the problems and the challenges of implementing the new standards within inpatient areas. The high-quality therapeutic care task force would support the mobilisation plan for implementing the standards. The plan would focus on integrating quality and safety, patient flow, and staff experience initiatives – whilst ensuring there was a collective understanding of the various problems. Mr Lewis highlighted the challenges of implementing new standards in inpatient areas, including the need to address variations in practice and ensure consistency across ward areas. He referred to the importance of creating a multi-professional leadership team with representatives from nursing, medical, and allied health professions - this approach aimed to improve collaboration and patient outcomes. Dr Graham recognised the pace of change across the organisation, and highlighted the variation in practice across staffing structures, partnership organisations and resourcing. Various discussions had been held with NHS England around the Culture of Care programme. The benefits this provided for mobilisation, such as integration with Patient Safety Incident Response Framework (PSIRF) and Patient and Carer Race Equality Framework (PCREF) were noted. In response to Ms Fulton-Tindall, Mr Lewis noted that the culture of care baseline assessment would be undertaken by April 2025 which would demonstrate the position in terms of multi-professional working. The	

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	intention was to ensure each ward area had multi-professional ward leadership teams. **The Board noted the commencement of the work from February 2025, considered any specific opportunities or risks associated with the work of the taskforce and recognised the internal and external concerns that this work is likely to give rise to.**	
Bpu 25/01/20	**Our 8 Plans** Mr Lewis presented the paper and acknowledged the delay in their circulation, the paper included four of the eight plans for discussion. The remaining four plans were not ready for approval and would be presented to the Board in March 2025. It was recognised that the Committees of the Board would focus overwhelmingly on the delivery of the plans following final approval, and the respective workplans would need to reset accordingly. <u>Quality & Safety Plan</u> Mr Lewis emphasised the distinction between safety and quality, the safety focus would be on always standards, CQC domains and understanding, investigating, involving and improving care when things go wrong – linked to the PSIRF model. With regards to quality, the focus would be on promise 16 and promise 4 as highlighted in the paper. This approach would reduce the number of assurance reports received against various standards and instead focus on the quality and safety plan metrics. Mr Lewis then discussed how the plan would work operationally, stating that the 'always measures' and safety metrics would be the primary focus for safety. The Board would aim to have more synthesis of its quality and safety position and would take a consistent approach to evaluating safety and quality issues and a more consistent mindset amongst professionals over time. Dr Graham noted the opportunity to reshape the Commtitee agendas and workplans, and highlighted the interdependencies between plans. Mr Lewis referred to the Nursing & Facilities restructure and the opportunity this provided. <u>Research & Innovation Plan</u> There was a need to further develop the research & innovation plan, with a goal to have a conversation about innovation at the leaders' conference in September 2025. The 6 research priorities were outlined in the paper, Mr Lewis recognised the need to bridge the gap between grounded research priorities and trust priorities. Dr Graham noted the other component of grounded research being the psychological observatory and the integration of this within the trust's research team. <u>Learning & Education Plan</u>	

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	Mr Lewis reminded the Board of the agreement of the plan in July 2024, and highlighted the commitment to grow the training budget. He then highlighted the need to focus on organisational learning and the great work and implementation undertaken amongst teams, things that focused on individual and team learning. Regarding organisational learning, there was a question as to whether it was simply the aggregate of individual and team learning or if it was different – a further conversation would need to take place over the next four to six months to agree this. <u>Equity and Inclusion Plan</u> Mr Lewis highlighted the important focus required on the success measures and the associated data sets for delivering the plan - the continued lack of data sets or their incompleteness would hinder the plan's success. There were investment propositions around business intelligence and data analytics to address this issue. Mrs McDonough reiterated that 14 of the 20 promises sat within the equity & inclusion plan and noted the time taken to define what was meant by the success measures. Ms Blake referred to the challenges with ensuring staff had a full understanding of the plan and associated success measures. Discussion ensued around the importance of visualising how the plans / promises fit together, and that it was essential to help people understand the connections between different plans and identify any gaps or inconsistencies. Ms Gillatt suggested working on a visual representation to show how the plans fit together. The Board discussed the challenges with implementing the plans, including the need for a clear narrative, particularly for quality & safety, to guide the organisation and address concerns from staff and regulators. **The Board noted the material presented, the final version of the plans would be presented in March 2025 for approval.**	
OPERATING PERFORMANCE / GOVERNANCE / RISK MANAGEMENT		
Bpu 25/01/21	**Operational Risk Report – Extreme Risks** Mr Gowland presented the paper which highlighted the current position in relation to the extreme risks. Six extreme risks were included, four of which were previously reported and two were new. In terms of out of area placements (O 10/19), this risk remained extreme and was part of a significant work programme taking place over the next year. One of the new extreme risks related to the failure to address the Crisis Team improvement plan in North Lincolnshire, this would be discussed at the next Risk Management Group with a view to potentially reduce the	

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	likelihood score. The second new extreme risk related to SMI register duplication, work was ongoing to cleanse the multiple registers and consolidate them into a single, accurate position. Mr Lewis sought further understanding on the scale of difference between the trust's SMI register vs wider registers. Mr Lewis noted the importance of establishing a process to review and identify emerging risks, such as the response to regulation 28 notices. He asked if there was a risk regarding mental health disengagement on the risk register, Mr Gowland agreed to clarify. **The Board received and noted the Operational Risk Report update.**	**PG** **PG**
Bpu 25/01/22	**Strategy Delivery Risks 2024/25** Mr Gowland presented the report which focused on SDR 1, 3 and 4, all of which were subject to review at the respective Committee's in January 2025. The internal audit review of the trust's strategic risk management process had been finalised, with a positive conclusion of significant assurance, and an acknowledgement of the strengthened arrangements in the year including the routine and robust scrutiny at the Board and Committees. Mr Gowland mentioned the audit recommendations and the need to ensure that controls in place were directly linked to assurance measures, and the need for clearer target risk scores. Mr Chillery noted some of the challenges with plotting actions at this current time, and referred to the introduction of the high-quality therapeutic care taskforce and the associated programme of work that would be impactful but was yet to be agreed. Mr Lewis emphasised the importance of identifying an end point risk score. **The Board received and noted the Strategy Delivery Risks 2024/25 report, noting the planned next steps to enhance reporting.**	
Bpu 25/01/23	**Promises and Priorities Scorecard** Mr Lewis presented the paper which highlighted the progress made on the specific promises and the need to focus on delivery in the coming year. He highlighted the progress on Promise 6 (poverty proofing) since the last update. There was an agreed schedule for poverty proofing across the organisation and discussions had commenced around embedding welfare rights, benefits advice and debt support into clinical pathways and to potentially include this as part of DIALOG+. For Promise 7, annual health checks continued to be a challenging area, and there was a need to address the SMI register issue. Mr Lewis noted the work ongoing around Promise 27 (net zero target), a series of propositions were being developed for the investment needed	

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	nationally to allow us to change the heat sourcing of the main building sites. The trust would be hosting a Climate Adaptation 'day' on the 12 February 2025. For Promise 23 (Invest in residential care projects and programmes that support long-term care outside our wards), one live proposal had been developed which would be considered next week regarding Rotherham. Work was ongoing to develop a Doncaster and North Lincolnshire proposal. In response to Ms Gillatt regarding confidence in delivery, Mr Lewis asked the Board to assume all promises would be delivered by 2028, with the exception of the Promise 27, that may need additional external support. He emphasised that the organisation needed to move into a delivery-based approach for 2025/26. The Board would need to re-engage with the promises in January 2026 to assess progress and make necessary adjustments. Ms Blake referred to a number of promises and the associated work, she drew particular attention to Promise 1 (employment of peer support workers) and queried if the approach was right. Mr Lewis noted the number of bids received for peer support workers and the need to assess this further in terms of the journey to delivery, in March 2025. **The Board received and noted the Promises / Priorities Scorecard update on the work to date and expectations in 2025/26.**	
Bpu 25/01/24	**Integrated Quality Performance Report (IQPR)** Mr Chillery introduced the Integrated Quality Performance Report (IQPR) for December 2024. He referred to the reporting arrangements for the IQPR and the need to focus on each quadrant at the respective Committees. With reference to the top 10 areas of delivery – there was a natural variation in recovery rates and work was ongoing to improve the position. A strong position was reported for the children's access target and there were challenges in the perinatal service due to staff absence, however the trust wide target would likely be achieved. The number of section 136 breaches had improved following the introduction of the 24-hour metric, discussions were required in terms of estates intervention to improve this further. Mr Mohammed provided an update on the financial performance at month 9, the position at the end of December is a surplus of £430k, £572k better than the revised plan. Mr Forsyth clarified that the safe staffing data continued to be reported as per the NHSE and Board requirements. **The Board received and noted the Integrated Quality Performance Report**.	

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SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEES)		
Bpu 25/01/25	**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 Report • Guardian of Safe Working Hours **The Board received and noted the additional reports for information.**	
Bpu 25/01/26	**Any Other Urgent Business** There was no further business raised.	
Bpu 25/01/27	**Any risks that the Board wishes the Risk Management Group to consider** Mr Lewis referred to the discussion under 25/01/21 (operational risk report) and his request to clarify if there was a risk relating to mental health disengagement on the risk register.	
Bpu 25/01/28	**Public Questions** There were no questions raised by members of the public.	
Bpu 25/01/29	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.*'	

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

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
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	**March 2025**. The Trust chair will identify how to implement NED oversight of the three priorities identified in the H&S paper before today's Board meeting (Paper Q).	Propose to Close
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	**March 2025:** The output from a review of ligature risks by ward is included within Paper Q.	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	**March 2025:** The position remains as indicated previously. 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
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	**March 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 and go live during Q1.	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	**March 2025:** Paper W IQPR presents the latest data showing in month performance at 84.50% (from 61.94% in January), a significant improvement but remaining below the 92% target 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	TL	**March 2025:**. The business case for eating disorders (MEED) has been supported by the	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
	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).		collaborative's Board and now needs to be considered within the ICB. It is likely the ICB will continue to non-compliant wit this guidance in 25/6. A revised disengagement approach for the Trust is due in final draft at the end of April 2025 – for deployment in Q2.	
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	**March 2025:** further work in this area is incorporated into our CQC readiness work and should remain an open item through Q1.	Open
Bpu 24/11/16	**CQC Readiness: Well-Led** Important for the Board to remain sighted and engaged in the progress with the readiness for assessment.	PG	**March 2025:** A further update on progress will be presented 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	**March 2025:** As previously noted, an update will feature when the next update on Productivity is received in **Q1 25/26**.	Open
Bpu 25/01/17	**Workforce – Staffing Overview (inc Dec 24 vs 24/25 plan and vs Dec 23)** To further understand the 973 posts that we didn't have in 2018/19 and if these were new posts or posts that remained vacant.	CH	**March 2025:** Work is being undertaken to review the position and the vacancy levels, alongside more recent announcements regarding corporate/backbone areas reducing to staffing levels to the levels which they were pre-pandemic. An update will be provided to the Board in **May 2025**.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 25/01/21a	**Operational Risk Report – SMI Registers** To understand the scale of difference between the Trust's SMI register vs wider registers.	PG	**March 2025:** Analysis of the different registers has been completed and has confirmed that there are differences of circa 2,000 patients between the National PHSMI Register (5,450) and RDaSH Total QOF Register (3,527). Work remains ongoing to work towards a single register containing all relevant people.	Open
Bpu 25/01/21b	**Operational Risk Report – Disengagement risk** To clarify if there was a risk regarding mental health disengagement on the risk register.	PG	**March 2025:** No current risk relating to this matter, but ongoing discussions to capture, record appropriate risk with mitigating controls.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper D
Date of meeting:	19 March 2025		
Attendees:	Dr Richard Falk (Chair), Dr Janusz Jankowski, Dave Vallance, Steve Forsyth, Dr Diarmid Sinclair, Richard Chillery and David Vickers. **In attendance:** Phil Gowland, David Smith, Dr Andrew Heighton.		
Apologies:	Dr Jude Graham, Richard Banks.		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**Strategic Delivery Risks Report (SDR4) -** The Committee received the latest position and noted the plans to mitigate any risks to the delivery of high-quality therapeutic bed-based care, including the development of new models and the newly established high quality therapeutic care taskforce. **Patient Safety Report, December 2024 – January 2025 –** The Committee noted the learning from patient safety incidents, complaints and investigations. The importance of disseminating this learning from Committee from Board to Ward was reiterated. The increase in self-harm incidents was discussed, noting the impact an individual can have on the reported figures. Dr Heighton was in attendance and spoke to the impact on Mulberry Ward of these incidents. The development of a robust complaints management process to ensure that complaints are addressed promptly and effectively was noted. **Annual Safe Staffing Declaration –** Updates were received in respect of the relaunch of MHOST, SNCT and the implementation of Safe Care. The Committee approved the direction of travel for these workstreams and supported the position that the Trust was compliant with national standards, noting the organisation holds a monthly safer staffing meeting to review fill rates against safer staffing levels. The Committee discussed multi professional leadership, highlighting that safer staffing reports on nurses and support workers, but does not include key roles such as Allied Health Professionals, Consultants, Facilities and administrative staff. It was acknowledged that MHOST/SNCT is a supportive tool, but it was made clear that professional judgement and clinical need takes precedent. **Health, Safety and Security Update inc Violence Prevention and Reduction Standard (VPR) –** The progress made on the VPR and Health & Safety action plan was noted, including the prioritisation of urgent estates work required. The Committee felt clarification was required around the future reporting arrangements for the H&S plan, as a number of the allocated work and actions featured heavily with Estates. **Integrated Quality Performance Report (February 2025 data)** – Progress made in VTE assessments and seclusion reviews, the Committee noted the introduction of the new falls assessment target to 12 hours. **Mortality Report –** The Committee noted the current position in respect of Regulation 28 notices and the trajectory to address the backlog of Structured Judgement Reviews (SJR). **Facilities Quality Report** – The Committee noted the improvements in Patient Led Assessments of the Care Environment (PLACE) scores and the immediate action required to address mould in our estates. The Committee debated the legal compliance requirements and resource implications for mandatory food safety training. This will be actioned within education and learning.		
Positive highlights of note:	**Eliminating Mixed Sex Accommodation Annual Declaration** – The Committee was assured that there is a robust process in place to report, monitor and achieve compliance with the National definition of EMSA. **Digital Programme for Safe Quality Care** - Presentation positively received,		

	the Committee felt that the Digital Programme might be of interest to others and that consideration could be given to it being shared more widely throughout the organisation.
Matters for information:	The Committee Chair thanked Prof Janusz Jankowski for his service, dedication and commitment to RDaSH patients, his presence, challenge and expertise will be missed greatly.
Decisions made:	
Actions agreed:	**Clinical Effectiveness Report** – The Committee noted the progress of audits and the need to allocate leads for outstanding NICE baseline assessments.

Dr Richard Falk, Non-Executive Director (Chair of Quality Committee)
Report to the Board of Directors meeting scheduled for 27 March 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Date of meeting:	5 February 2025		
Attendees:	Kathryn Gillatt (Chair), Pauline Vickers and Dr Richard Falk. In addition: Phil Gowland, Steve Forsyth, Izaaz Mohammed, Jane Charlesworth, Jill Savoury, Laura Brookshaw (360 Assurance), Matthew Curtis (360 Assurance), Kay Meats (360 Assurance), Matt Treharne-Clarke (360 Assurance), Caroline Jamieson (Deloitte), Stuart Kenny (Deloitte).		
Apologies:	No apologies for absence received.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Counter Fraud, Bribery and Corruption Progress -** Summary provided of the counter fraud work. The Counter Fraud Functional Standard Return (CFFSR) was in a healthy state, with six components left to complete. **Internal Audit Progress Report -** Three audit reports were issued, strategic delivery risk management (significant assurance), estates helpdesk implementation (limited assurance), and policy management framework (moderate assurance). **Final Accounts Timetable and Plans** • Comprehensive update received regarding annual accounts preparations for 2024/25. The deadline for the submission of the trust, charity and flourish accounts is June 2025 in line with the Annual General Meeting scheduled for July 2025. • One addition was highlighted to the accounting policies in relation to donated assets, recent work identified that St Johns Hospice should be disclosed in the accounts as a donated asset as it is held by RDaSH in trust. Work is ongoing to resolve this, however potential implications could result in a prior year adjustment. • The Committee agreed the 2024/25 going concern assessment, accounting policies updates and the critical judgements/sources of estimation uncertainty disclosures. **Annual Governance Statement update -** There were currently no new or emerging concerns to raise within the scope of the AGS. **Standing Financial Instructions –** Reduced number in the value of losses and compensation payments and single quote waivers. Scope for improvement to avoid duplicative submissions and refinement of the single quote waiver exemption list for certain items**.**		
Positive highlights of note:	**Risk Management Framework update –** The Committee acknowledged the progress made to improve the risk management processes, and the positive feedback received from the strategic delivery risk management review. **Internal Audit Progress Report** • Follow up audit actions are in a good position with 88% of the high and medium being closed on time and 93% of all risks being closed on time. • Positive progress made and continued oversight and encouragement with lead executives around the delivery of actions, particularly as the year-end was approaching. **Finance Development Plan** – The Committee noted the progress made against the plan and the changes made within the finance		

	function, including collaborative working with other organisations and the continued work ongoing to deliver the actions and the ISA260 recommendations.
Matters presented for information or noting:	The potential for a prior year adjustment in the financial accounts 2024/5 relating to the reclassification of St John's Hospice as a 'Donated Asset'. Such a reclassification would only impact the balance sheet and notes to the accounts.
Decisions made:	
Actions agreed:	**Clinical Audit Progress Report** – There would be a further discussion outside of the meeting with the Committee Chair and Chief Nurse to clarify the requirements of the report in terms of governance and assurance.

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

Report to the Board of Directors meeting scheduled for 27 March 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Mental Health Act Committee	**Agenda Item:**	Paper F
Date of meeting:	19 February 2025		
Attendees:	Sarah Fulton Tindall (Chair), Dr Jude Graham, Dr Janusz Jankowski, Toby Lewis, Dr Diarmid Sinclair, David Vickers. In attendance: Dr Nav Ahluwalia, Carlene Holden, Tim Shaw.		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	**MHA Compliance Report Q3 2024-25** **MHA Training and RRI Training Compliance** At February 2025, improvements were seen in all levels of MCA training compliance, with MCA Level 3 compliance standing at 90.41%. RRI compliance was 72.62%. The figures for those out of compliance long term were highlighted as 25 for RRI and 27 for MHA Level 3. The Committee was pleased to receive a paper setting out a new comprehensive approach to address training compliance across the Trust and specific data relating to the above. Central to the new approach would be a significant shift in responsibility from managers to employees from April 2025 to ensure that training is kept up to date, with a range of consequences for non-compliance. A review of MAST against the national review had also been undertaken, this had not changed any requirements to date. **MHA Performance Report Q3 2024-25** **Care Plans** There had been 2 CQC MHA inspection visits since the last report, 1 on Laurel and 1 on Brodsworth. These had resulted in a consistent theme being identified around personalised care planning. This was the sole theme also identified in the Committee's annual thematic analysis of areas for improvement identified during CQC MHA visits to RDaSH during 2024-25. The Committee noted that a review of personalised care planning was underway, this would provide clarity to the board on how the Trust would deliver in this area, including defining what constitutes a personalised care plan.		
Key points of discussion relevant to the Board:	**Hospital Managers Report Quarter 2 and 3 2024-25** The Committee was pleased to learn that Trust support to undertake the Trust Associate Manager role was much improved, including many of them now being able to access their training on ESR, with help offered for those who may need it. The Committee noted that full compliance was still required in respect of training and full completion of both yearly and three annual manager reviews. **MHA Compliance Report Quarter 3 2024-25** There were 477 detentions of which 475 were lawful and 2 unlawful. **Consent to treatment** - consent on admission continues to improve (collectively achieving above 90% compliance, with the Trust wide compliance being 92%) but there is more work to do. There was 1 occasion when consent to treatment at 3 months was not achieved. Consent to Psychiatric Medication also showed improvement. **Section 132 rights** - data in Doncaster and Lincolnshire had achieved over 90% compliance and Rotherham 86%, showing a sustained improvement. A further improvement in data is expected at the June meeting as a result of work underway with the Clinical		

	Systems Team to review the way that Section 132 rights are recorded in SystmOne to allow easier recording and future reporting. **MHA Performance Report Quarter 3 2024-25** **Section 136 Assessments within 24 hours** - there were 2 cases out of 157 where Section 136 assessments were not undertaken in the 24-hour period. **MHA Incidents** - there were 6 MHA Category D (major) incidents. **Seclusion** - 83% of patients had a consultant review within 5 hours in November and 37% in December 2024. The significant difference in percentages was due to the number of episodes – 22 (achieved in 15 out of 18 cases) versus 8 (achieved in 3 out of 8 cases). Adjustments are being made to SystmOne in order to improve the amount of inputting error. **Review of Committee oversight of the MHA Code of Practice and CQC Requirements** An outstanding action to seek a review of the MHA Code of Practice and CQC MHA requirements to ensure that the Committee had oversight of all aspects had identified 4 gaps: • development of a policy for withholding patients' mail • an audit of the process for searching patients • a process for excluding visitors to detained patients • development of a policy for victims. The Committee noted that consideration would be given to an audit for the searching of patients in the Trust's audit programme for 2025/26.
Positive highlights of note:	**MHA and RRI Training Compliance** Positive steps had been taken to improve MHA and RRI training compliance and the expected outcomes were being seen. **MHA Patient and Carer Feedback** The Committee was pleased to receive an MHA Patient and Carer Feedback Report as part of steps to deliver the Trust Strategy Promise 4, The Committee noted a new approach, which attempts to engage those detained under the MHA and includes the development of a versatile semi-structured feedback questionnaire, co-designed with service user partners and peer support workers, which can be used in a range of ways and settings. Feedback achieved to date has identified a number of themes on which action has been taken and the feedback loop closed: • Carer and Family Engagement • Communication • Property loss
Matters for information:	
Decisions made:	None
Actions agreed:	**Blanket Restrictions** - a review of the blanket restrictions data would take place to ensure this was useful for the Committee to monitor and keep oversight.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper G
Date of meeting:	19 February 2025		
Attendees:	Pauline Vickers (Chair), Kathy Gillatt, Carlene Holden, Richard Chillery, Dr Jude Graham, Steve Forsyth, Lea Fountain, Dr Diarmid Sinclair, Ian Spowart.		
Apologies:	Rachael Blake, Dave Vallance, Richard Rimmington		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Audit Recommendations Report:** Implementation of audit actions (2 on Equality Diversity and Inclusion and 3 on Appraisals) are on track. A further audit was expected on mandatory and statutory training with all actions on track. **Strategic Delivery Risk 5** – The next report to the Board in March 2025 would include a refreshed format for all five strategic delivery risks in light of significant assurance and feedback. **Integrated Quality Performance Report:** Sickness absence was on an upwards trajectory currently at 6.28% and a task group would undertake a deep dive. A formal contract with the external provider of occupations health would be put in place to ensure value for money and more useful reporting for managers to drive the work. The new sickness absence policy would launch on 1 April 2025. After emergency closure of Brambles ward and medics' concerns on placements an interim quality review was scheduled to look at all placements. Year-end retirement data - The NHS flexible retirement policy and recent changes in pension regulations meant not as many retirees, leavers in March 2025. The vacancy position 3.3% was close to the 2024/25 target with efforts continuing to manage turnover and improve vacancy rate to 2.5% for 2025/26. **Guardian of Safe Working Hours report:** The hybrid rota model had been adopted in Doncaster. Most exception reports were for contractual rest breaches followed by working beyond contracted hours and issues with support available during service commitments, missing natural breaks and educational opportunities. **Staff Incidents, Violence and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Report (RIDDOR) Q2 2024/25:** 2 road traffic accidents on site were under review with no further police action. The RIDDOR reports show 2 members of staff had fallen out of people's houses while exiting. A review of staff access and egress was taking place. All the staff incidents, and safer staffing incidents were monitored through the Integrated Quality Performance Report.		
Positive highlights of note:	**Partnerships:** The Leadership Development Offer Cohort 1 was launched in January 2025. Cohort 2, due in April 2025, included a greater diverse range of community partners compared to cohort 1, strengthening the organization's community partnerships. Charity bids had been submitted to the March 2025 Charitable Funds Committee highlighted links to the voluntary community and social enterprise sector. **Integrated Quality Performance Report:** Turnover rate was significantly reduced to below 10% and on a downward trajectory. Suspensions were currently at one with zero suspensions expected by the next update.		
Matters for information / noting:	**Trust People Council Update:** addressed remote working concerns about returning to pre-COVID office arrangements. The organisation aimed to maintain a blended approach, ensuring both office and home environments were fit for purpose. The Council emphasized the importance of providing leadership development opportunities across all levels of the organization, including clinical leaders and first-line managers. Addressed concerns with reference to the real living wage and narrowing pay gaps between Bands 1, 2 and 3 and impact on		

	recruitment and retention. Carers network launch was highlighted and reported on a positive initial meeting of the carers network which had provided clarification to ensure consistent application of the carers policy.
Decisions made:	**Annual Revalidation Feedback 2023/24:** was submitted in a new format with additional metrics around case investigators and case managers requested by the NHS England. The intention was to send new colleagues to the case investigator/manager training on recruitment.
Actions agreed:	**Audit Recommendations Report:** to socialise papers such as the score card and annual report to provide context to be covered during governor inductions.

Pauline Vickers, Non-Executive Director and Chair of the People and Organisational Development Committee.

Report to the Board of Directors meeting scheduled for 27 March 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper H
Date of meeting:	19 March 2025		
Attendees:	Dave Vallance (Chair), Dr Richard Falk, Carlene Holden, Jo McDonough, Janusz Jankowski, Cheryl Gowland, Steph Pinnell.		
Apologies:	Toby Lewis, Jo Cox, Joy Bullivant		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**Eating Disorders Collaborative:** The closure of Ellern Mead Moorgate as an eating disorders unit was noted. Relocation of a long-term patient to London from Ellern Mead had resulted in subsequent savings of £600k back into the trust eating disorder fund. Riverdale continues to deliver good care and was working on better management of length of stay and expected discharge dates. Due to the under occupancy in Riverdale, there was a positive budget forecast from the previous £0.5m deficit into a potential surplus. The South Yorkshire wide work continues on eating disorders with the Joint Committee established with a go live in May 2025. **Promise 11, Veterans:** A pilot using positive practise within talking therapy services to improve identification of veterans as a gap was identified in terms of the veterans known to trust based on census data compared to the percentage population. The trust was working to gain accreditation in the veteran AWARE and reaccreditation for the defence employer's recognition schemes which supports the recruitment and retention of veterans in the NHS. **Strategic Delivery Risks, SDR3:** focus was on leadership development offer to build competence in terms of community understanding and engagement in terms of induction with evaluations expected to come from this. Internal audit work on partnerships and promises 3, 4 and 5 will give further evidence and information about actions to mitigate strategic delivery risks.		
Positive highlights of note:	The trust had strong evidence to achieve gold award in the defence employer's recognition scheme.		
Matters presented for information or noting:	**Strategic Delivery Risk, Primary Care Liaison:** the primary care liaison role was focused on building relationships with primary care and addressing key frustrations, highlighting the importance of face-to-face engagement, especially in deprived and rural areas. Three levels of insight were identified from visits; ad hoc interface issues, individual practice frustrations, and common themes aligned to the four CLE priorities across localities. The next steps included promoting the publication of wait times, introducing self-referral for neuro services and working with practices on a streamlined referral process and raising awareness of the range of trust services amongst trust staff and general practice. **Promise 6 – Poverty Proofing and Citizens Advice:** Collaboration with Citizens Advice to provide money and debt advice was a success measure under the poverty proofing promise. The service will be onsite 2 days per week to support patients and staff. The initiative aims to integrate support into clinical pathways and evaluate its effectiveness over 12 months. Work was starting to look at the impact of transport costs noted in some of the poverty proofing reports. Funding of £35,000 from the investment fund was agreed to support some patients, together with the national support through the NHS for transport costs with a need to promote both transport schemes amongst services.		

	Health inequalities data: high DNA rates in deprived areas was highlighted, particularly in Rotherham, which was significantly higher than the average. Work was ongoing with the Chief Operating Officer on analysis and exploring ways to reduce. The transport costs initiative with £35k from the Investment fund and the national NHS scheme would support patients, particularly in deprived and rural areas with guidelines for clinical colleagues. Update on promise 7 showed achievement of the 95% target health checks for people on trust registers. However, a much bigger proportion of people on GP primary care registers required health checks.
Decisions made:	None
Actions agreed:	Ensure the health inequalities data is included in the board pack on a regular basis. Provide a one-page paper on the pathway for the different layers of the service showing actions at different touch points with primary care through to the inpatient services that the trust was commissioning. To update on the completion date for the rural self-assessment and toolkit. To report on the evidence that veterans are receiving expedited access to services with comparison against the benchmarks and or good practice.

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

Report to the Board of Directors meeting scheduled for 27 March 2025.

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Digital & Estates Committee	**Agenda Item:**	Paper I
Date of meeting:	19 February 2025		
Attendees:	Pauline Vickers (Chair), Sarah Fulton Tindall, Carlene Holden, Izaaz Mohammed, Ian Spowart, Richard Chillery, Caroline Britten and Jane Charlesworth		
Apologies:	Richard Banks, Richard Rimmington		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Estates Update** – Estates compliance with regards to fire safety remained an area of focus, with a targeted approach to high-risk areas going forward through 2025 and beyond. All Fire Risk Assessments were due to be completed by the 31st March 2025. **Estates Enabling Plan** – potential funding solutions for the estates enabling plan were outlined and discussed, including land disposal, system capital allocation, national programmes, and off-balance sheet schemes. **Month 9 Finance Report and Month 10 verbal update** – the month 10 position was a surplus of £495k, £678k better than plan. The key change during the last month was the receipt of £1.3m year to date of additional non-recurrent funding from NHSE. SY ICB had reduced the Trust's income allocation by £0.8m linked to depreciation funding, this risked the delivery of the forecast year end surplus of £0.5m, however other mitigations were being sought in M11 & M12. Capital spend was forecast to overspend by £1.7m against the original plan. This was due to the IFRS 16 impact of the Waterdale and Elizabeth Quarter lease agreements, however additional IFRS16 allocation had been secured from NHSE and would be reflected in the M12 reporting. **Draft Finance Plan 2025-2026 Update (including Savings Programme)** – the 25/26 underlying deficit position ranged between £7m - £10m dependant on ICB funding confirmation. The capital plan for 25/26 was £5m based on a fair shares allocation of core system capital from SY ICB. Work will continue to develop the draft financial plan with a revised submission to be presented to Board in March 2025.		
Positive highlights of note:	**General Data Protection Regulation, Information Governance, and Data Security and Protection Toolkit (GDPR, IG, DSPT) Update** - robust processes in place to support completion of the DSPT submission against all fifteen assertions by June 2025 deadline. A baseline submission was made to NHSE in December 2024. Noted the robust plans and processes in place to support IG Compliance. **Clinical Coding Audit** – assured that robust processes were in place to facilitate the accurate application of clinical coding. The Trust had achieved the required attainment level of 'High Assurance' on the DSPT. The report positively highlighted the achievement of quality in clinical coding undertaken across the organisation. **Internal Audit Plans, Reports and Recommendations Report** - assured that internal audit recommendations were being managed appropriately.		
Matters presented for information or noting:	**Strategic Delivery Risk (SDR) Report** – progress noted for the allocated SDR SO2.		

Decisions made:	No decisions were made.
Actions agreed:	**Estates Enabling Plan** – to produce a communications plan for wider public relating to the future estate plans.

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

Report to the Board of Directors meeting scheduled for 27 March 2025.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Remuneration Committee	**Agenda Item**	Paper J
Date of meeting:	28 November 2024		
Attendees:	Kathryn Lavery, Dr Richard Falk, Sarah Fulton-Tindall, Kathryn Gillatt, Dave Vallance, Pauline Vickers, Lea Fountain, Jyoti Mehan Meeting also attended in part by Toby Lewis and Philip Gowland		
Apologies:	Dawn Leese, Rachael Blake and Dr Janusz Jankowski.		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	The Committee undertook to review the remuneration paid to the Executive Group members in line with national guidance and received an update in respect of the recruitment of the Chief Medical Officer.		
Positive highlights of note:	n/a		
Matters presented for information or noting:	n/a		
Decisions made:	Agreement of the Very Senior Managers pay award for 2024/25 with foreseeable prospect of no or very limited uplift in 25/26 (notwithstanding action below)		
Actions agreed:	Very Senior Managers salary structure to be reviewed in Q1 2025/26 with due regard for benchmarking data: bearing in mind the likelihood of national guidance in coming weeks.		

Kath Lavery, Chair of the Renumeration Committee

Report to the Board of Directors meeting scheduled for 27 March 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**	27 March 2025

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

The paper summarises work undertaken over the final quarter of 2024/25: with the Trust reducing vacancies to their lowest known level, meeting its financial duties, and making some, but not yet enough, progress with our promises. The overwhelming focus on promises 14 and 19 operationally will be critical to H1 – alongside our 'make or break' focus on the health inequalities work to which we committed in 2023.

The Board may wish to spend time on the initial results of the staff survey, against the backdrop of substantial system and organisational change outlined. The transition to 'think directorate' is cited, as we try to devolve more day-to-day responsibility to local teams, even as the financial challenges faced by both local ICBs create expectations of standardisation at a large-population level. Work on Neighbourhood Health represents a potential way forward for our community-based services, as we look to re-introduce 'generalism' in care models which have moved for some time towards sub-specialisation.

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

Previous consideration

Not applicable

Recommendation

The Board of Directors is asked to:

X	**EXPLORE** the patient, people and population issues described
X	**CONSIDER** any matters of concern *not* covered within the report
X	**NOTE** the results of the 2024 staff survey and work planned as a result

Impact

Trust Risk Register	x	F3/24, NQ 1/24, NQ 5/23, NF 1/25, S 4/24, E 9/24, T 3/24, T 8/24, T 10/24, T 11/24, PCG 14/24, PCG 18/24, DCG 1/24, DCGMH 5/23, DCGMH 6/23, DCG 3/25, DCG 14/20, DCGP 2/22, POD 3/24, HI 18/24, RCG 2/20, RCG 17/23, RCG 8/24, O 8/19, O10/19
Board Assurance Framework (SDR)	x	Primary care contract changes - SDR 3 Health Inequalities Data - SDR2
System / Place impact	x	See text, multiple reference to system / place re: financial positions of ICB – alongside potential structural adjustments

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 February and March 2025
Annex 2: Current register of Trust vacancies February 2025
Annex 3: National publications February/March 2025
Annex 4: Staff survey 2024 summary report

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report

March 2025

1.1 The financial reset of the NHS cannot now be overstated. **Both local ICBs have £100m+ underlying deficits** and forward estimates of national funding no longer assume that pay awards or other national changes will be wholly newly funded. At the same time, the removal of preventive health objectives from both the planning guidance and now the GP contract, may create an impression that the left shift suggested by Darzi will take some time to follow through as policy and practice – one assumes through the Ten-Year Plan due this spring.

1.2 In establishing our own approach to 2025/2026, we are **implicitly reinforcing certain values and promises that are the foundation for our work**. With the move to the Real Living Wage in April, our continued tackling of agency waste, and in our support for flexible working, we are making clear that *the Trust will not have a low pay model*; even when faced with difficult financial choices. Whilst headcount reduction over the medium term is unavoidable, the roles we have will be paid justly. Similarly, I would suggest, we have committed within promise 14 to *a short wait approach to patient safety*. If, over time, it is suggested that this aim should be slackened, we may need to consider whether long-wait services are ones that we should continue to provide. Encouragingly, presently, local commissioners articulate an understanding that delays in children's mental healthcare, neurodiversity waits, or the availability of home treatment services all prevent 'failure-demand' in the balance of the health, care and justice system.

1.3 The Trust will enter 2025/2026 with **the lowest number of vacancies** (annex 2) in its recent history. This creates the potential to deliver our "fully staffed" position. That position is about the conditions necessary to provide safe care, team dialogue, quality improvement, and execution of our promises. Work on sickness and turnover (or turbulence) needs to seize on that potential – as will our move during 2025/2026 to a new PDR framework routed in local objective setting. For staff survey respondents, who challenge the quality, not the quantity, of historic appraisals, this may be a welcome shift. It is also one that needs to feed into our training approach (the only ringfenced, growing budget).

1.4 The Board in this meeting is asked to reconsider **the scope to go further than the deficit plan agreed in January**. With now two years of no "growth" in funding, even for population need, our recently extensive cost improvement work has not brought us to financial balance. Within the private papers are some possible routes to balance, recognising that financial reform in health services comes in one of only two ways – finding lower cost ways to provide good care or ceasing to provide some things. We continue to work to create a three-year plan for local mental health services, and to embed our community teams within integrated neighbourhood teams. Both offer a better structure to thinking about cost and value – and financial sustainability.

Our patients

2.1 Implementing **an RRI advocacy role in each ward team** will be part of the Q1 work of our care group senior nurses, overseen through the HQTC. This follows from the Board's discussion on violence and on reducing restrictive practices in November. At the same time, we are making changes to our RRI training to ensure that we improve the effectiveness of that training and target it to those who most need it. A protocol for data collection and reporting of incidents of violence was agreed by the Clinical Leadership Executive in February, and should come into effect from April 1st, overseen through the Chief Nurse.

2.2 The paper on serious incidents, before the Board today, reflects a wider emphasis on improving patient safety and learning. The legacy PSIRF policy, agreed with the Board in December 2023, will need some revision, as we seek to embed different forms of reviewing harms and incidents. The closure of Ulysses with the transition to RADAR should provide a clean edge for investigation of new reported incidents, as we also work to ensure all investigations and complaints, from 2024/2025 (pre-1.1.2025) and before, are expedited and concluded. A series of RADAR dashboards (six) will be in place from May, which ought to offer easier visibility of overall policy compliance – allowing the Board and senior committees **to focus more clearly on learning and change**.

2.3 Within the clinical leadership executive, we have continued to work to set priorities for **transitional care**. In this case, the transitions from children's services into adult care. Our three mental health care groups for adults have established workstreams with the Children's Care Group for delivery in the coming year. As one of two local Trusts that offer mental healthcare, to both children and adults, this should be an area of continued quality focus – including working through how we support whole households after or during diagnosis or detention.

2.4 Doncaster's UEC Board continues to offer tentative support to the transitional beds proposed by our physical healthcare team to **better support discharge from Doncaster Royal Infirmary**. Recognising the risk that step-down beds become an extension of time away from home, initial analysis suggests that they could make a valuable contribution to the care pathway of adults, as we develop ideas intended to improve care for those acutely unwell this coming winter.

2.5 The ostensibly successful **launch of Care Opinion** has been subject to discussion within the Board and CLE. There remain services where adoption is not yet sufficient, but the bigger immediate focus is on thematic analysis of the stories told – and supporting local team leaders to share and discuss individual stories within their teams, including within Learning Half Days. Our quality account for 2024/2025 will benefit hugely from the feedback patients are giving us about what matters to them.

2.6 Since the Board last met, we have started **our High Quality Therapeutic Care taskforce**. The baseline culture of care assessments are nearing completion, but the work of the Taskforce in Q1 will rest heavily on progress to reduce length of stay to support our Out of Area Placements commitment, and work within our three clinical executive functions to progress the safety element of the Quality and Safety plan. Reducing tendable audit time,

and replacing this with key measures, will be an important step, facilitated, but not delivered, via RADAR implementation.

Our people

3.1 *'Think directorate'* represents an important transition in our organisation's development moving into the new public sector year. It is one we need to consistently reflect on within our Board committees and meetings. In essence, 13 directorates now lead our clinical services, necessarily the aggregation of a variety of service teams. Increasingly, the Directorate Management Teams (DMTs), who lead those services, need to see their resources in common. Care Group senior leadership teams (SLTs) will work to consider the challenges faced in the future, where managing today will be led at directorate level. Corporate functions, for most matters, will work with these directorates to a much greater degree than in the past. As we reach almost the half-way mark in the structure's duration, that we established in 2023/2024, we will revisit, in late summer, what the trajectory of required improvement will need to be for the balance of 2025/2026. Think directorate resets expectations in longstanding roles, like service manager and matron, and reinforces aspirations for newly created lead roles from early 2024. It is a key step in **a more devolved, delegated and distributed leadership approach**.

3.2 The Trust's **2024 staff survey results** are annexed to this report, as those in 2023 were in early 2024/2025. At a Trust level, and with over 2200 respondents, we remain *above a 7.0 rating for our engagement score, 7 being classified as a good score.* A drop in both morale and in engagement is combined with lowering score for work flexibility and learning, in spite of much work in both areas (perhaps after September 2024). Consistent with the prior paragraph, our analysis and action – and most importantly conversational meaning – will be found at directorate level. As we begin to ready our organisation for much more routine use of feedback (Care Opinion, 360-degree for leaders etc), we need to retain a local focus on what the survey tells us and promote heavily the quarterly Pulse Survey as a tracking tool. We will seek to confirm in May, as a Board, for the staff survey, as we have for CQC ratings, what our aim truly is over the period to 2028.

3.3 In summer 2024, NHS England, and the former Health Education England, provided a very positive assessment of education across the Trust. During 2025/2026, we will undertake a similar exercise in relation to our social workers. We are **meeting with the postgraduate medical deanery in late March** to review the forward look for medical placements, which we have expanded over the last two years. It is recognised that the trainee experience of changes in community rehabilitation (Goldcrest/Emerald) and short notice changes in older peoples' care, may have been sub-optimal, and revisions to the governance of medical education will be taking place to ensure better alignment within our decision making structures.

3.4 In all of our clinical professions, we continue to advance implementing **meaningful job planning** during 2025/2026. This focuses first on ensuring that SPA time is protected and achieved: but also, that that time is used for the research, education and leadership purposes of the Trust. Among AHPs, we expect to have concluded this work in Q2. Nursing and psychological professionals' timescales will be confirmed shortly. Whilst work among medical staff began last summer, for reasons known to the Board in prior discussions, the pace has been mixed, and it makes sense to ensure that the choices

made are meaningful. Colleagues work hard and it is important that APAs, where agreed, reflect that accurately. At the same time, for core Pas, the introduction of employer choices, alongside employees', into how time is spent may take a little time to embed. We will work to ensure that, by early autumn 2025, all of our consultants have a job plan consistent with our promises, and the increase in care volumes needed to meet national and local expectations.

3.5 The Board will consider this month, **our latest update on Promise 26**. This builds on conversations within the Trust People Council about protected characteristics beyond ethnicity or religion and, of course, takes account too of the Board's important conversation about ageism in February. Our 7-point plan in racism needs greater grip, and over coming weeks we will consider how that is best achieved. Implementation work to put in key changes to investigative, disciplinary and recruitment processes is advancing, and not later than the end of April, we would expect to have timelines for each. Likewise, the first audit review by Phil Gowland of the Acceptable Behaviour Policy is due shortly, with recommendations for the year ahead.

3.6 Considerable work has been completed over recent weeks, to be ready to implement **the Real Living Wage in April**. In addition to the build of revised payroll arrangements for all affected, and explanations for colleagues of how the uprating works overtime, we have needed to finalise the approach to the longstanding national band 2/3 recognition dispute. In March, we have made these changes, including meeting back pay expectations. Of course, the Board will recognise ongoing challenges to those decisions, which may take place during the coming financial year.

<u>Our population and partners</u>

4.1 Work with partners continues to be **overshadowed by the NHS-wide financial position**. In addition, to reassertion of a 'commissioning role' is bedding down locally, with the issue of ICB commissioning intentions (these are closely informed by the collaborative's priorities). We continue to expect to be able to implement a specialist community rehabilitation service in North Lincolnshire, albeit the single year funding proposal issued to us is problematic. Given commitment across the system to tackle out of area placements, it will be important to make upfront investments to accomplish change. With new leadership in Humber and North Yorkshire, we are working to better understand the profound differences in service historically commissioned across the six places and chart a course to address those unwarranted differences via something labelled the 'core offer'.

4.3 An initial review of our work with general practice, since the inception of the liaison role, has taken place and that shows both encouraging engagement with primary care, and strong endorsement for the four priorities that CLE agreed for 2025/2026. **The new interim general practice contract** clearly introduces some challenges for us, with its ostensive removal of disease registers, and lower priority for annual health checks. We will work through with local primary care leaders how we wish to approach these issues, which remain important to us, and indeed to our promises.

4.4 In January, I confirmed our signature on the Elizabeth Quarter development in Scunthorpe, and it looks probable that over coming days we will sign the final arrangements for our new CAMHS unit in **Waterdale in Doncaster**. We need to recognise that, in parallel with this

‘health on the High Street’ work, we are withdrawing from leases in a range of community buildings held with CSP. This is why our SHAPE work within the strategic development team is important, as we look, during Q1, to target the transfer of services into genuine community venues.

4.5 It is very encouraging that our work to deliver promises 5, 4 and 3 is progressing well (with a positive audit report due). All necessarily involve developing better and more structured relationships with local VCSE partners – noting **the contribution of our Charity’s Community Grants work** to those relationships – and in addition to moving to 350 volunteers as rapidly as possible, we will commence more structured conversations with our Care Group teams about how this VCSE connection moves forward during the spring. Implementing our revised ‘partnering’ model will be a major change for the executive too in the early part of 2025/2026, but it will leave us with a broader base of strategic leadership locally, less focused on individuals, and consistent with our intent around Well-Led.

Toby Lewis, Chief Executive
March 21st 2025

Annex 1

Clinical leadership executive – February 2025 and March 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 agenda items explored are listed below. Any member can list an item on the agenda. Minutes and the action log are available to any Board member on request through Lou Wood.

February	March
Older adult bed base in 25/26	Vacancies as at March 2024
RADAR implementation	Serious incidents 24/25 review
Care Opinion so far	Approaches to promise 14 on urgent care
Priorities in 25/26	DIALOG+
Reducing restrictive interventions	CLE meeting effectiveness
Reconfirmation of CLE subs	Older adult bed base and community changes

In terms of decisions made, in February we discussed at length older peoples' care and continued closure of the Brambles Ward in Rotherham. We also explored the choices made by Care Groups about where to focus 'transitional care' improvement effort in 25/26. March's meeting considered cost pressures and investments going into 25/26, mindful of the wider NHS financial position.

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 (April/May) we will consider, in particular:

- The segment 3 priorities among our promises
- The trajectories for wait time improvements during 2025,
- How we support our work to meet core CQC standards,
- Our policy and practice approach to both remote working and remodelling PDRs

Toby Lewis, Chief Executive
21 March 2025

Annex 2

Current vacancy summary

This Board has separately had reported the position as against a 'pre-Covid' establishment figure. This report summarises extant vacancies. Our 2.5% target, amended to 3.3% in year, is now more commonly understood as <100 vacancies. With offers made and accepted this remains achievable going into April.

Org L4	FTE Budgeted	FTE Actual	FTE Variance
376 CCG Management	23.23	21.80	-1.43
376 CCG Mental Health	315.33	321.09	5.76
376 CCG Physical Health	278.85	283.99	5.14
376 DMHLD Acute Services	233.30	199.44	-33.86
376 DMHLD Community Services	339.63	325.92	-13.71
376 DMHLD Learning Disabilities & Forensics	191.34	181.33	-10.01
376 DMHLD Management	10.20	8.80	-1.40
376 NLCG NHS Talking Therapies	183.14	186.21	3.07
376 NLCG Acute Care Services	131.43	115.80	-15.63
376 NLCG Community Care Services	116.26	108.90	-7.36
376 NLCG Management	27.38	27.14	-0.24
376 PHND Community & Long-Term Conditions	406.99	397.56	-9.43
376 PHND Rehabilitation	317.41	309.42	-7.99
376 PHND Management	10.20	9.85	-0.35
376 PHND Neurodiversity	45.80	40.73	-5.07
376 RCG Acute Services	246.48	226.08	-20.40
376 RCG Community Services	241.47	233.79	-7.68
376 RCG Management	17.90	15.90	-2.00
376 Corporate Assurance	30.12	28.36	-1.76
376 Estates	45.65	40.97	-4.68
376 Finance & Procurement	49.54	39.99	-9.55
376 Health Informatics	76.36	75.84	-0.52
376 Medical, Pharmacy & Research	46.25	54.52	8.27
376 Nursing & Facilities	177.00	166.40	-10.60
376 Operations	52.43	49.20	-3.23
376 People & Organisational Development	95.94	91.15	-4.79
376 Strategic Development	19.38	20.56	1.18
376 Psychological Professionals and Therapies	5.00	5.00	0.00
Total	**3,734.01**	**3,586.73**	**-147.28**

Annex 3:

National publications/guidance summary – February 2025/March 2025

Update on 2025/26 planning round
(NHS England, 06/03/2025)

Letter from Amanda Pritchard and Sir James Mackey.

https://www.england.nhs.uk/long-read/update-on-2025-26-planning-round/

It's time to prioritise mental health
(NHS Providers 04/03/2025)

Blog by Saffron Cordery, interim Chief Executive at NHS Providers, says it is time to give mental health the priority it deserves.

https://nhsproviders.org/news-blogs/blogs/its-time-to-prioritise-mental-health?utm_campaign=2005446_Start%20the%20week%20-%2010.03.25&utm_medium=email&utm_source=NHS%20Providers%20%28Main%20account%29&dm_i=514F,16ZEU,13CDJQ,4W47L,1

Invest to change: the capital needs of community services
(NHS Confederation and NHS Providers both have details on their websites, 11/03/2025)

The results of a survey by the Community network show the scale of under-investment in NHS community services.

The report highlights views of a range of leaders in the community health services sector on the condition of their organisations' facilities and digital systems; the impact these have on patient care and staff productivity; and the consequences for integrated working.

https://www.nhsconfed.org/publications/invest-change

https://nhsproviders.org/community-network-invest-to-change

Various indicators point to a deterioration in population mental health – likely contributing to rising disability benefit caseloads
(Institute of Fiscal Studies, 12/03/2025)

A new IFS report released today, funded by the Joseph Rowntree Foundation and the Health Foundation, finds a range of evidence that mental health has worsened since the pandemic.

Mental health conditions now account for over half of the rise in disability benefit claims among working-age adults since the pandemic, new research reveals.

The Institute for Fiscal Studies (IFS) reports a 900,000 increase in disability claims, with 500,000 attributed to mental health issues like depression and anxiety.

https://ifs.org.uk/news/various-indicators-point-deterioration-population-mental-health-likely-contributing-rising#:~:text=A%20new%20IFS%20report%20released,benefit%20claims%20for%20mental%20health.

https://ifs.org.uk/sites/default/files/2025-03/IFS%20report%20-%20The%20role%20of%20changing%20health%20in%20rising%20health-related%20benefit%20claims%20final_0.pdf

Independent mental health homicide review into the tragedies in Nottingham
(NHS England, 05/02/2025)

Letter from Claire Murdoch CBE and Dr Adrian James.

https://www.england.nhs.uk/long-read/independent-mental-health-homicide-review-into-the-tragedies-in-nottingham/

Green plan guidance
(NHS England, 04/02/2025)

Updated guidance to help NHS organisations develop robust plans to support world-leading patient care, save money and minimise waste – continuing the NHS' journey to achieving net zero. Refreshed green plans should be approved by the organisation's board or governing body, published in an accessible location on the organisation's website and shared with NHS England by 31 July 2025.

https://www.england.nhs.uk/publication/green-plan-guidance/

Principles for using digital technologies in mental health inpatient treatment and care
(NHS England, 07/02/2025)

The principles for digital technologies help clinicians consider whether use of a digital technology is the most appropriate, effective and least restrictive method of caring for, or treating, a patient in inpatient mental health settings. These principles guide all NHS funded services.

https://www.england.nhs.uk/long-read/principles-for-using-digital-technologies-in-mental-health-inpatient-treatment-and-care/

Experience of care improvement framework
(NHS England, 18/02/2025)

This is guidance to support providers in their work to improve the patient experience of care. It is an update of the original version (2018, formerly the Patient experience improvement framework) and includes links to relevant strategy, policy and good practice documents.

https://www.england.nhs.uk/long-read/experience-of-care-improvement-framework/

Exploring the role of senior medical leadership in mental health providers in England
(NHS Confederation, 28/02/2025)

Findings in the report result from a survey of more than 40 medical directors across England working in mental health settings, accompanied by four in-depth focus groups, and provide an important current perspective and insight into the role of medical leaders within mental health in the new system landscape.
https://www.nhsconfed.org/publications/senior-medical-leadership-in-mental-health-providers

Guidance on neighbourhood multidisciplinary teams for children and young people
(NHS England, 19/02/2025)

This guidance outlines the principles and core components that underpin all neighbourhood multidisciplinary teams for children and young people. It should be read alongside the 2025/26 priorities and operational planning guidance and the Neighbourhood health guidelines 2025/26, which sets out the six core components of neighbourhood health models. One of these components is the neighbourhood multidisciplinary team (MDT). This guidance provides further details for this core component, specifically for children and young people.

https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/

Neighbourhood health – case studies of good practice
(NHS England, 05/03/2025)

These case studies provide examples of existing good practice that forms the foundations of neighbourhood health. They should be read alongside the Neighbourhood health guidelines 2025/56. Currently, there are no known examples of systems delivering all the initial 6 core components of neighbourhood health (detailed in appendix 1 of the Neighbourhood health guidelines) in a coordinated, consistent way or at sufficient scale to support the necessary improvements in health and system efficiency. For 2025/26, NHS England asks all systems to consider how they can increase the consistency, integration and scale in delivering health and care to adults, children and young people with complex health and social care needs who require support from multiple services and organisations. As in the example of 16-year-old Justina, this should include implementing any necessary reasonable adjustments (as required by the Equality Act 2010 and supported by the reasonable adjustment digital flag). This will accommodate the needs of people with disabilities, improving their health outcomes and experience of health and care services, and reducing their risk of premature mortality.

https://www.england.nhs.uk/publication/neighbourhood-health-case-studies-of-good-practice/

Annex 4: Staff survey 2024 summary report

Staff Survey 2024 Results

1. Introduction

The NHS staff survey is carried out on an annual basis between September and November for all applicable substantive employees. Our comparator group is Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts. A total of 57% of the Trust's staff surveyed completed their 2024 questionnaire, which is an increase of 4% in comparison to the 2023 response rate. The CQC median response rate for our comparator group (50 Trusts) was 54%, therefore we were 3% higher.

2. Summary of scores

The staff survey comprises the 7 People Promise themes plus staff engagement and morale – providing nine areas in total. The following infographic summaries our results for the 2024 survey across all 9 areas.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.58	6.34	6.93	6.50	5.83	7.05	7.11	7.02	6.27
Best result	7.90	6.83	7.31	6.72	6.37	7.34	7.48	7.49	6.66
Average result	7.55	6.35	6.94	6.40	5.93	6.83	7.15	7.07	6.20
Worst result	7.03	5.98	6.18	5.86	5.11	6.27	6.78	6.32	5.46
Responses	2205	2205	2183	2185	2104	2193	2204	2211	2208

Key: *Our results - Navy blue bar, Best result – Green line, Average result – Light blue bar, Worst result – orange line*

Overall, the Trust has seen a decrease in results against each of the people promise themes when compared against the 2023 scores. All 2024 people promise theme scores remain aligned with the average comparator scores, with 4 scoring slightly above and 5 slightly below the comparator average (between 0.1 and 0.01 lower). To provide context, nationally within our benchmarking group the average score has reduced for 7 of the areas, stayed the same for one and slightly improved for one, therefore the Trust results are not an outlier.

The staff survey results have been shared with our management teams, based on the Trust taxonomy and are available at Trust, Group and Directorate level.

When analysing the results we are also identify any changes which are classed as statistically significant, of which we have two areas – We each have a voice that counts and Staff Engagement.

Appendix B: Significance testing – 2023 vs 2024

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2023 and 2024*. For more details, please see the technical document.

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.63	2011	7.58	2205	Not significant
We are recognised and rewarded	6.41	2013	6.34	2205	Not significant
We each have a voice that counts	7.06	1989	6.93	2183	Significantly lower
We are safe and healthy	6.57	1992	6.50	2185	Not significant
We are always learning	5.95	1917	5.83	2104	Not significant
We work flexibly	7.09	2002	7.05	2193	Not significant
We are a team	7.17	2006	7.11	2204	Not significant
Themes					
Staff Engagement	7.19	2014	7.02	2211	Significantly lower
Morale	6.37	2015	6.27	2208	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

3. Areas of Improvement based on last years action area

Our 2024 results have seen key improvements which are summarised below

Our 2024 scores are notably better than the comparator average for the diversity and equality sub score, with an overall reduction of 0.8% of employees experiencing discrimination at work from a manager/ team leader or other colleague.

3.1 Discrimination

This was an area of focus following the 2023 survey and reflects the work undertaken over the past 12 months to address workplace discrimination, promote inclusion within the workplace and our commitment to becoming an anti-racist organisation (Promise 26)

3.2 Sexual Safety

Sexual safety at work has been a key priority for RDaSH over the past year and the 2024 results have shown an increase in the number of employees reporting unwanted behaviour of a sexual nature in the workplace from patients/ service users, their relatives or other members of the public, something which we predicted in our previously circulated board papers.

4. Areas of Focus for 2025 – Collective Trust actions

4.1 Discrimination

Colleagues have reported higher levels of disability discrimination. 2024 saw the implementation of a centralised reasonable adjustment budget to support those with disabilities in the workplace, our DAWN network will be asked to support in the further exploration of this area. This is further reflected in the Promise 26 paper.

A high number of colleagues also reported discrimination citing the reason as 'other'. This was also highlighted during the 2023 survey. As an organisation we need to understand what colleagues are indicating when they state they have experienced discrimination on the grounds of "other". Work has been ongoing to explore this with our staff network groups and we have seen a slight improvement against our 2023 score, however this remains higher than our comparator average. All of our networks will be asked to further explore the other category to provide insight into how we can address this.

4.2 Appraisals

This people promise is made of 2 elements; development and appraisals and has seen a slight decline in results from 5.93 in 2023 to 5.83 in 2024.

In relation to appraisals, the Trust has scored lower than our comparator average, with a reduction in staff feeling that their work is valued by the organisation. The number of colleagues reporting having had an appraisal in the last 12 months remains high at 89.4%, which indicates that whilst appraisals are taking place, their value is not being recognised.

Work is required to support managers to provide a meaningful appraisal process, where career development is discussed and encouraged. The introduction of the First Line Manager Development Programme should support in equipping line managers with the skills required to conduct a meaningful appraisal process and support individual and team development. Additionally, a review of our Trust appraisal process has commenced which aims to create a more meaningful and structured process.

Furthermore, it is anticipated that the introduction of monthly learning half days in September 2024 will demonstrate the organisations commitment to learning and to developing our workforce.

5.0 Next Steps

The staff survey results have been shared with all Directors, to commence the sharing and engagement with colleagues. Each Directorate will be asked to identify a small number (two or three) actions which they wish to focus on this year.

As part of this, centrally we will develop a 'You said and Collectively We Did' communications campaign prior to the launch of the 2025 Staff Survey to try to close down the feedback loop to colleagues.

In addition, the Trust has identified three areas of focus which we will look to collectively address, specifically

Appraisals
Disability Discrimination
Learning

These are alongside the areas which each of our 23 Directorate will identify.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	2025/26 Financial Plan (including Investment Funds bids)	**Agenda Item**	Paper L
Sponsoring Executive	Izaaz Mohammed, Director of Finance & Estates		
Report Author	Izaaz Mohammed, Director of Finance & Estates, and Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	27 March 2025

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

The Board and its committees have consistently considered the underlying deficit of the Trust, notwithstanding better-than-plan delivery of the in-year I&E plan in both 23/24 and now in 24/25. The scale of that deficit remains subject to month 12 changes in income from the ICB, developing income / cash support assumptions for 25/26, and unclear funding of pay awards nationally and from local authorities. The recommendation remains to submit in March a deficit position in line with our February submissions.

The paper summarises key known unknowns and recognises the challenging nature of in-year full year delivery of our Out of Area Placements plan. Contained within the Chief Executive's private report to the Board are an initial list of "difficult choices" that may be required to move the Trust to recurrent balance. These are not, at this time, recommended in view of the potential quality issues arising and the importance of developing a consistent approach to service delivery across the system. Considerable derogation of national norms and policy would be required to move forward some of these proposals, probably necessitating Trust and NHS England discussions with the CQC.

A pre-meet with the chair, SID and FDE chair will take place after issue of these papers to provide private scrutiny of the recommendations from the CEO and Director of Finances & Estates contained herein. We note previous examples of Trust submissions being varied at local or regional level and confirm that any Trust submissions will be direct: any variance of these submissions will be escalated immediately to NHS England.

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

January 2025 Board of Directors and February 2025 FDE– Draft 25/26 Plan

Recommendation

The Board is asked to:

x	**CONFIRM** cash releasing savings of £7.8m in year subject to conclusion during April of the requisite QSIA process.

x	**NOTE** reliance on the preferred option outlined in other Board papers associated with the 25/26 mental health bed base.
x	**NOTE** reliance on the agreed approach to OOAP 'inappropriate' funding developed in Q3 with the place directors of Rotherham and Doncaster.
x	**ACKNOWLEDGE** failure to agree similar arrangements in North Lincolnshire, escalating that matter to the acting CEO/chair/incoming regional director during April 2025.
x	**RECOGNISE** and **AGREE** that the difficult choices proposals cannot yet be deployed as a route to financial balance in 2025/26.

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)								
Trust Risk Register		F 1/24						
Board Assurance Framework		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)
Assessment against NHSE Oversight Framework segment 3 exit criteria.

2025-26 Financial Plan

1.1 This paper builds on the January Board discussion on the 25/26 Financial Plan. Since the January meeting, NHSE have published planning guidance for the year ahead, and the Trust has started to receive income allocation information from some of its commissioners. This paper provides an update on the underlying and in year plan based on that guidance and ongoing discussions with our funders.

1.2 The Trust is required to submit a final version of the plan to NHSE on the 27th March. Although this is being described as a final version, the reality is that there remains a national deficit of £6bn based on the February submissions, and with the incoming NHSE leadership describing a need for a "fundamental reset" of the financial regime, further submissions in April / May are highly likely.

1.3 To enable a submission on the 27th March, this paper outlines the updates to the Trust's underlying deficit (24/25 closing underlying deficit of £8.4m vs £7m based on the delivery of the 25/26 plan) and an in year deficit plan of £4.4m. A refresh of the medium-term financial plan will then follow in April to factor in final income settlements as well the route to financial balance in 26-27.

Underlying Deficit

2.1 The 24/25 plan contained an underlying deficit of £6.2m, down from the £12m+ figure in 23/24, the reduction driven by the delivery of the highest savings target in the Trust's history of just under £10m. The 24/25 Plan included £2.4m of planned slippage against the cost pressure and ADHD reserves linked to recruitment lead times. Along with the planned slippage in 24/25, the Trust has seen a defund of depreciation funding by SY ICB of £0.8m and a shortfall on pay award funding from Doncaster Council of £0.8m. These figures deteriorate the underlying deficit, along with £0.6m of non-recurrent savings in 24/25. 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
Local Authority shortfall on pay award funding	-0.8
Removal of depreciation funding by SY ICB	-0.8
24/25 Closing underlying deficit	**-8.4**

Income & Expenditure Changes

3.1 The tables below set out the impact of changes to the Trust's income allocations as well as planned changes to expenditure. Tariff uplifts of 4.15% have been passed to providers to fund inflation, with a reduction in income of 2% for efficiency. Mental Health Investment Standard (MHIS) growth of 2.22% has been assumed on the Trust's SY ICB mental health income. This aligns to the information received from SY ICB, however some differences

remain, mainly on the size of the out of area placement budget that the Trust will inherit, and the recurrent nature of £1.8m of ADHD / ASD funding the Trust received in 24/25. The Trust's figures include this income, whereas the ICB has badged this as non-recurrent and removed it from initial contract offers. Negotiations continue, and the submitted deficit will grow by £1.8m if this income does not flow through to the final contract offer. HNY ICB have not provided the Trust with a contract offer at the time of writing this paper, the planning assumptions are based on 24/25 outturn income, adjusted for inflation and efficiency. No assumed MHIS incorporation is factored in from HNY ICB.

3.2 Key expenditure increases based on the planning guidance include a total pay cost increase of 4.72% of which 2.8% is for an indicative pay award and the remainder to cover NI changes and incremental drift. The Board's commitment to fund cost pressures at £3m to support the implementation of the Real Living Wage and promises delivery, and £7.8m of cash releasing saving are also included. Finally, an expenditure budget to match the anticipated income for SY out of area placements is included at £7.5m. The planned pay expenditure includes the impact of the pay award shortfall for 25/26 linked to the national calculation vs actual cost.

25/26 Income Changes	**£m**
25/26 Tariff increase - inflation at 4.15%	8.9
25/26 Tariff reduction - efficiency at 2%	-3.9
25/26 defund - ADHD / ASD funding removed by SY ICB	tbc
Transfer of SY OAP budget to RDaSH	7.5
Transfer of NL OAP budget to RDaSH	tbc
25/26 Growth funding - 2.22% SY ICB MH spend only	2.4
Total 25/26 Income Changes	**14.9**

25/26 Expenditure Changes	**£m**
Inflation - pay & non pay	-10.7
Cost pressure reserve	-3.0
SY OAP expenditure before CIP	-7.5
NL OAP expenditure before CIP	tbc
CIP target - cash releasing	7.8
Total 25/26 Expenditure Changes	**-13.4**

3.3 The annual expected shortfall on inflation funding is included in the numbers above. The net impact of the assumed income and expenditure movements is an improvement of £1.5m to the underlying deficit (£14.9m increase in income less £13.4m increase in cost).

2025/26 Underlying Deficit & Indicative Plan

4.1 Taking the forecast closing underlying deficit for 2024/25 of £8.4m and applying the anticipated income and expenditure changes set out in 3.1 and 3.2 results in an underlying deficit of £7m for 25/26. There a 2 material non recurrent items that we can plan for at this stage, these are non-recurrent deficit support funding of £2.4m from NHSE (a reduction of £1m on the sum received in 24/25), and slippage on the cost pressure reserve of £1m. In

addition to this a £0.8m risk reserve has been created which recognises the fact that the out of area placement savings scheme may take the first quarter of 25/26 to start delivering.

24/25 Closing underlying deficit	**-8.4**
25/26 Income changes	14.9
25/26 Expenditure changes	-13.4
25/26 Underlying deficit	**-7.0**
CIP risk reserve	-0.8
25/26 non recurrent slippage	1.0
NHSE deficit support funding (reduced by £1m from 24/25)	2.4
25/26 Indicative plan	**-4.4**

4.2 Including the 2 non-recurrent items referenced above, the risk arising for 25/26 is £4.4m. Some indications suggest that cash support will be maintained in 25/26 but not beyond. Commissioners have not indicated a desire to defund neurodiversity waiting times.

Savings Programme 25/26

5.1 The 25/26 plan includes planned cash releasing savings of £7.8m. This consists of 6 areas that are set out in the table below, of which 4 will deliver from the 1st April 2025. These are the closure of an older adult ward, removal of the non-pay reserve up to the value of energy cost inflation, 0.5% cuts to all budgets, and £0.5m of additional cuts to corporate budgets. This means that savings identified and ready to action from budgets on the 1st April total £4.3m of the £7.8m target.

5.2 The balance of £3.5m will be delivered through increased corporate productivity against new funding streams (HDU and community rehab service overheads) and reducing out of area placement spend. The plan assumes an OOAP budget transfer of £7.5m from SY ICB. No budget transfer is currently assumed within the plan for North Lincolnshire. Information and access to key individuals within HNY ICB has been extremely difficult to obtain, with even basic opening income allocation information for 25/26 not received by the Trust at the time of writing this paper. Despite this, a budget of £7.5m+ presents a sizeable opportunity to realise savings and still recycle funding to develop additional capacity within our existing inpatient settings, although the effort required to do so can't be underestimated. This work is critical to the deliverability of the 25/26 financial plan.

5.3 All budget reductions will be actioned from the 1st April 2025 and phased in equal 12ths, except for the OOAP cuts which will deploy from month 4. Conversely a position of year-to-date balance, or surplus in the year will mean the Trust is delivering the savings programme, albeit with non-recurrent substitutions if recurrent reductions in OOAPs have not taken place in line with the £3m target.

5.4 In addition to the budget cuts of £7.8m, non-cash releasing efficiencies of £4.8m are included in the 25/26 plan submission. This relates to the increased productivity the Trust plans to deliver in reducing waiting lists and treating more patients, within the same resources. This productivity gain has been calculated using nationally verified cost collection data for the relevant services.

Savings scheme description	£m
Out of area placement reduction	3.0
Close an older adult ward	1.5
Non pay - only fund FYE of energy inflation	1.2
Reduce all directorate budgets by 0.5%	1.1
Margin on new developments - HDU / Community Rehab	0.5
Additional cuts to corporate directorates	0.5
Total cash releasing savings	**7.8**
Additional activity planned within existing budgets	4.8
Total efficiency included in the 25/26 plan	**12.6**

Cost Pressures

6.1 The Board pre-committed in 2023, and reasserted in November 2024 and January 2025, our move to being a Real Living Wage employer. Payment will be made in April 2025. Separate to this, in March 2025, we concluded longstanding work on band 2/band 3 job description discrepancies, and, like other local Trusts, paid back-pay and revised pay scales. Taken together, these changes mean that the largest workforce caring for our inpatients, those people who keep infection low and patients safe, and our valued administrative staff are now paid the right wage, and a salary above the economy's basepoint. Our pay scales will continue to track the Real Living Wage which is announced each November for the following year.

6.2 The Clinical Leadership Executive has overseen a second year of our 'single process' of considering cost pressures and investments. For this second year, we were very conscious of Board focus on VFM against our promises and accordingly, for the £2m of potential spend, we have focused on four areas: promise 1 and peer support workers (consistent with the culture of care national programme and other guidance), strategic objective two and our commitment to health inequalities (notwithstanding other available funds held with partners), promise 14 and especially a four week maximum wait guarantee in order to improve trust and confidence and address failure demand elsewhere, and the need to meet other pressures and commitments. Bids made totalled £10.5m. Consistent with our financial plan submitted at the end of February 2025, and considered by the Board in January, we have assumed 50% PYE spend for the portion of funds outwith the RLW, which will be clearly be a FYE.

6.3 With assurance from Richard Chillery and Victoria Takel there is confidence that the proposed investment in promise 14 is consistent with what is required to move services to the measure in time. There are two known exceptions: neurodiversity services where delivery will occur in 2026 as a whole, and adult autism services where a system wide discussion is needed about what is the NHS offer (noting that in North Lincolnshire there is no commissioned offer of any kind). These assumptions contain *substantial productivity assumptions*, which we need to work harder to 'hardcode' into our financial plans and submissions. In particular, there is an expectation of cogent job planning at the Trust with a rigour and mutuality not seen before. Secondly, we know we need to change clinical administrative systems because we cannot deliver a four week wait, without a one-week turnaround in decision making (our access policy mandates three week's headroom for

patient choice). And we have to consistently publicise our wait, with local GPs, not only to take the risk of rising referral, but also to subject our data to the sunlight of other's opinions.

6.4 Promise 1 remains, despite debates over promises 19 and 27, a very challenging measure, perhaps our hardest. CLE has requested Chief Executive oversight of the 24/25 and 25/26 spend. It is plain that we cannot meet the promise if we do not reserve these funds, *but a more mandated and centralised work programme is needed now*, of the kind that is prospering for promise 3. During Q1 the promise will be 'handed back' to CNO leadership to deliver the clinical integration into teams that is needed to secure the real patient care benefit this scaling up demands.

6.5 Izaaz Mohammed has led consideration of the other bids. Funding proposals focus on the commitment given by the Board in 2021/22 to clinical administrative support to consultant teams. There is developmental work in 25/26 needed to ensure that other expert consultants have support in place, but, in the short term, as we look to maximise the patient care opportunity of 7.5 DCCs, we are planning to support consultant roles with these posts.

6.6 Finally, our health inequalities bids focus disproportionately on the work Dr Gemma Graham has led on BME access to dementia diagnosis. The acknowledged national discrepancy in access to treatment is a feature of local services too. Building on work done in Bradford we want to develop our services. There is also funding provision to respond to access issues raised in our initial poverty proofing work.

6.7 The Board needs to consider affordability, but it should take confidence from the process entered into during Q4. In 24/25 that process demonstrated that it could contain other costs, whilst moving monies to meet real clinical needs. The same process has been undertaken for 25/26 and is critical to both maintaining momentum and retaining engagement with the hard and difficult choices we face. Cross referencing of bids to our risk register has taken place: as has an active search for 'missed bids' implied by that risk register.

Cost Pressure Bids 25/26		
Care Group / Backbone Directorate	**Description**	**£**
Trustwide	RLW & B2/B3	1,000,000
North Lincolnshire & TT	Memory Service	260,000
Trustwide	Project Timepiece	235,000
Health Informatics	Data warehouse and power BI	180,000
Trustwide	Dementia of people from minority communities	145,000
Physical Health & ND	Neuro rehab PT/OT	123,500
Doncaster AMH & LD	Health checks for YP transitioning to adulthood	108,000
Physical Health & ND	Enhanced Care Home Team OT/PT	97,500
North Lincolnshire & TT	Community Clozapine Initiation	97,000
Children's	Peer Support Workers	95,000
North Lincolnshire & TT	Systemic Family Therapy	84,000
Physical Health & ND	McMillan Peer Support	64,000
Doncaster AMH & LD	Crisis & Home Treatment Peer Support (2 x PSWs)	63,000
North Lincolnshire & TT	Talking Therapies Peer Support	57,000
Health Informatics	Informatics, patient portal	55,000
Physical Health & ND	Community PT	52,000
North Lincolnshire & TT	Peer Support (Acute Directorate)	38,000
Doncaster AMH & LD	Perinatal Bid (Doncaster) (1 B4)	36,000
PP&T	Half day learning co-ordinator	36,000
Trustwide	Mitigating DNAs / WNBs due to transport affordability (note: not taxis)	35,000
Children's	Zone 5-19 Peer Support	32,000
Doncaster AMH & LD	EIP Peer Support - Doncaster	31,667
Rotherham	EIP Peer Support - Rotherham	31,667
North Lincolnshire & TT	EIP Peer Support - North Lincolnshire	31,667
Physical Health & ND	Cardiac Rehabilitation Peer Support	25,000
Total Cost Pressures		**3,013,000**

Difficult Choices – Plan B – Financial Balance

7.1 In 2023/24, in facing the underlying deficit of the Trust from 22/23 (variously estimated between £10-16m, despite notional in year breakeven), the intention was to make changes and cuts to return to I&E balance in 25/26. The lack of any income gain in 24/25 and 25/26 has prevented achievement of that aim. The segmentation section of this paper refers.

7.2 The proposed deficit in 25/26 will not be agreed externally. Moreover, we anticipate allocation of ICB liabilities, for which we have argued. As a Trust leadership we have sought the clarity of leadership responsibility which moves effort away from triplicated work at system, place and collaborative. Existing place plans, in so far as they are visible, offer no clear actions to address demand, but our work to deliver a reduction on out of area placements will require collective action at place. The system work we need to do works alongside acute hospitals to assist with left shift, notably in the last year of life, and in avoiding admissions or arrival at ED. As a collaborative, there is a cast-iron commitment to deliver a 24-hour S136 standard in advance of the new Mental Health Act which removes police custody as an option, and to tackle together out of area placements. Long promised project support with this work may be challenged by new reductions in operating costs for ICBs.

7.3 Appended to the Chief Executive's private report to the Board, are emerging possibilities to move the Trust to an underlying breakeven position. These are not recommended for approval during March. There are three reasons for that pause: firstly the bandwidth to deliver the out of area placement quality and financial changes must be considered paramount; secondly, as yet the Board is unclear the full scale of deficit after potential apportionment of the ICB wide ask; and finally, some of the proposals, in part, move the Trust well outside quality and safety norms within the NHS. Brokerage with the CQC, other professional regulators, and NHS system bodies, would need to be undertaken before the Board could adopt some of the proposals outlined. In effect a contained 'live experiment' about patient outcomes and safety would need to be created to test these changes. The Chief Executive will lead a brief discussion on these options intended to create a 'pecking order' between them in three tiers: possible but needs further work (green), potentially significantly harmful but may need to be considered (amber), and last resort under obligation (red).

7.4 This paper does not yet benefit from consideration of all ideas set out by the incoming CEO for NHS England, Jim Mackey. This may create additional possibilities, albeit possibly not 'in year'. Furthermore, the Trust met with regional and ICB colleagues in late February to consider the sectoral productivity data assessment. Regrettably, the analysis pitched to the Trust made little sense, requiring 60% of all beds and half of Talking Therapy services be cut. Revised data is being urgently sought, for the Trust and wider collaborative, notwithstanding a lack of clarity within NHS England about who owns or can speak to this officially issued information. The Talking Therapies opportunity is over and above current Trust plans but may require derogation of the national operating model for the service: identifying who can agree this variation is being urgently pursued.

Alignment of the Plan to the NHS Oversight Framework

7.5 The NHS Oversight Framework is the mechanism used by NHSE to segment providers and ICBs based on the level of support needs across the themes of quality of care, access and outcomes, preventing ill-health and reducing inequalities, people, finance and use of resources and leadership and capability. In August 2024 the Trust was notified of a move from segment 2 to segment 3. The change was directly linked to the Trust's deficit plan for 2024/25 and the ICB wide deficit (it was applied to all SY hosted Trusts).

7.6 The four standard finance exit criteria for segment 3 provider organisations in 24/25 are as follows:

- **2024/25 Performance** – meet annual financial plan requirements for revenue and capital.
- **Recovery and sustainability** – realistic plan for achieving future in-year financial balance and year on year improvement in underlying financial position.
- **Cost improvement and productivity** – robust planning of cost improvement and productivity schemes, delivered at the level required to support achievement of financial plans and recovery.
- **Governance and control** – robust governance, systems and processes in place.

7.7 Each criteria has several measures which are used to determine whether a provider has met the required standard or not. A table showing the Trust's progress against each measure is included in appendix 1.

7.8 With the recent news of the government's plan to abolish NHSE, and the requirement for ICBs to cut costs by 50%, the future of the oversight framework and the ability of NHSE and ICB to administer the scheme remains unknown. If the existing definitions and criteria remain, then the Trust would expect to continue to be categorised within segment 3 due exclusively to the fact the 25/26 plan doesn't demonstrate planned in-year financial balance. This is despite the Trust substantively meeting the other measures contained within the criteria.

Plan Delivery and Risks

9.1 As referenced earlier in the paper, £4.3m of savings are ready to transact from budgets from the 1st April, with each Care Group and backbone directorate receiving a 25/26 Budget Book outlining the total budget reflecting the impact of CIP and cost pressure reserves, including any PYE control total linked to planned slippage. The CEO and Director of Finance & Estates will meet with each Care Group and Executive Director in April to review the Budget Book and complete sign off. Any further changes to the plan resulting from ICB income changes, or allocation of the system deficit will be held centrally, as will pay award funding and OOAP budget, with the former allocated to budgets once the pay award is paid later in the year.

9.2 The OOAP reduction scheme is the single biggest scheme within the savings programme and will need the appropriate bandwidth to enact the work being undertaken within the High Quality Therapeutic Care Taskforce. This monitoring will take place within delivery reviews and the Finance Group.

9.3 The deficit plan of £4.4m assumes ICB / Place plans don't double count savings contained within the Trust's savings programme. Assurance has been provided by SY ICB leaders that this isn't the case, however without sight of coherent Place plans the risk cannot be ruled out at this stage. The system draft plan for the February submission to NHSE contained a £107m deficit, although this is expected to reduce in the March submission. The residual system gap is likely to be allocated to providers, the basis of which remains a work in progress by the ICB, but in our view must contain a future funding model with a significantly smaller acute sector. A proposal excluding this would not meet the size of the financial challenge facing the system.

9.4 The ICB has adopted the 24/25 income outturn as the starting point for the 25/26 plan. Aligned to this approach, the Trust has assumed continuation of £1.8m of neurodiversity funding which it received in 24/25 in arriving at the 25/26 plan. <u>This income has not been confirmed within the income allocations received in recent days, and if confirmation is not received prior to the 27th March submission, then the Trust's deficit will worsen by £1.8m.</u>

9.5 A pay award funding gap of £0.8m for 24/25 remains, linked to services funded by Doncaster Council. Discussions are underway with council leadership on their funding plans for this gap and a similar shortfall in the 25/26 plan. Ultimately the gap will need

to be funded or will require the services we deliver to live within the funding envelope, this could provide an opportunity to improve the underlying and in year deficit position. 24/25 NHS pay award funding covered in year costs, but is short of recurrent estimates by £0.8m. A gap of over £1m arose from 23/24 pay awards.

9.6 Based on comments briefed by Jim Mackey, the provider equivalent of the ICBs 50% cuts is likely to be focussed heavily on bringing workforce numbers back to pre-pandemic levels, with a particular focus on growth in admin roles. The Trust has seen its total contracted WTE numbers grow from 2,955 in March 2020 to 3,572 in March 2025, an increase of 617 (21%). Admin roles have seen similar % growth, with actual numbers increasing by 128, from 618 to 745. The growth in admin roles is spread across several backbone and care group directorates. Further analysis will take place in April to understand which specific teams this growth relates to and how it aligns to MHIS and SDF investments made since 2020. As previously indicated to the Board, there is concern that many admin roles are not especially accurately coded in this position.

9.7 Despite setting a deficit plan, the organisation's cash position remains healthy going into 25/26, with an average balance of approximately £30m. This means that the Trust will continue to meet its cash obligations without the need for additional cash support and ensure suppliers, particularly local ones, are paid promptly. If the Trust continues to set a deficit plan for multiple years, then this will lead to an inevitable depletion of the cash balance, therefore the route to recurrent balance as set out in the medium-term finance plan will be key to ensuring cash levels are maintained.

Recommendations

The Board is asked to:

10.1 **CONFIRM** cash releasing savings of £7.8m in year subject to conclusion during April of the requisite QSIA process.

10.2 **NOTE** reliance on the preferred option outlined in other Board papers associated with the 25/26 mental health bed base.

10.3 **NOTE** reliance on the agreed approach to OOAP 'inappropriate' funding developed in Q3 with the place directors of Rotherham and Doncaster.

10.4 **ACKNOWLEDGE** failure to agree similar arrangements in North Lincolnshire, escalating that matter to the acting CEO/chair/incoming regional director during April 2025.

10.5 **RECOGNISE** and **AGREE** that the difficult choices proposals cannot yet be deployed as a route to financial balance in 2025/26.

Izaaz Mohammed, Director of Finance & Estates
and
Toby Lewis, Chief Executive
14th March 2025

Assessment against NHSE Oversight Framework segment 3 exit criteria			
Criteria	**Measurement**	**Rating**	**Comments**
2024/25 Performance – meet annual financial plan for revenue and capital.	Revenue financial plan position delivered.		Forecast for 24/25 is a surplus of £0.5m, £0.8m better than plan.
	Capital plan delivery meets agreed plan allocation.		Achieved
	CIP target achieved.		Achieved
	ERF plan and associated productivity improvements delivered.		Forecast to achieve ERF target for 24/25.
	Provider to demonstrate cash management reflects best practice to minimise support requests.		No cash support requests submitted in year, and cash balance of £30m+
	Workforce WTE and interim staffing costs controlled within plan levels.		Reduction of agency costs from £7.5m in 23/24 to £3m in 24/25.
Recovery and sustainability - realistic plan for achieving future in-year financial balance and year on year improvement in underlying financial position.	Multi-year recovery plan (MTFP) developed that aligns with organisation plans for service change and improvement trajectories. Plan must demonstrate significant year-on-year improvement in underlying sustainability, be agreed with ICB and aligned to system plans. To be produced to meet national timelines or by November 2024, whichever is earliest.		This is in place, although has not been discussed with ICB.
	2024/25 normalised exit run rate significantly improved from 2023/24 exit run rate.		Normalised RR similar to 23/24
	2025/26 operational plan demonstrates in-year financial balance or demonstrates delivery of improvement trajectory to achieve in-year financial balance at pace set out in recovery plan and agreed with ICB. Plan is realistic when considered against key benchmarks and indicators including levels of delivery risk.		2025/26 plan does not demonstrate in year balance as it is a deficit plan. The plan is realistic when considered against benchmarks and indicators (productivity opportunity packs, national cost collection data, peer CIP %, NHSE planning guidance).
Cost improvement and productivity - robust planning of cost improvement and productivity scheme, delivered at the level required to support achievement of financial plans and recovery.	2024/5 efficiency and associated productivity plans established and delivered, meeting or exceeding planned % for recurrent savings.		Achieved
	Pro-active use of models, tools, benchmarking and best practice to establish robust multi-year CIP and productivity plans that enables recovery and sustainability, both internally and with system partners.		Akeso commissioned work, plus use of productivity packs and cost collection information
	2025/6 efficiency and associated productivity plans established that will improve sustainability in line with MTFP, and reflect operational plan requirements. Plans are realistic when considered against key benchmarks and indicators including levels of delivery risk.		£xxm of total efficiency included in the 25/26 plan, of which £7.8m is cash releasing.
	Provider to demonstrate that sound governance and PMO processes are in place, including effective risk management and mitigation.		QSIA process in place and refreshed for 25/26.
Governance and control - robust governance, systems and processes in place.	Provider to demonstrate organisational ownership and commitment to financial delivery.		All Care Groups and Backbone directorates on track to hit budget in 24/25 and plans in place to deliver 25/26 budget.
	Embedded and robust challenge and reporting processes that provide maximum possible expenditure control in place, with evidence that those are contributing to reduction in expenditure run-rate.		Regular reporting via I&I process to ICB, with enhanced controls in several domains.
	Evidence of organisation compliance with financial governance and control best practice, including existing or new requirements established by NHSE /ICB.		Regular reporting via I&I process to ICB, with enhanced controls in several domains.

Addendum to the 25-26 Financial Plan paper (public)

1.1 The system financial position remains deeply troubling. A notional balanced plan is due for submission in coming days. It has not been possible to have sight of nor verify double counting within that plan. It does not yet contain the palpable left shift we need as a system.

1.2 However, since the submission of the 25-26 Financial Plan paper to the Board last Friday, re-stating a planned deficit of £4.4m, discussions have continued with SY ICB on funding differences and the residual risk items referenced in that paper. Equally positively we have had confirmation of agreed HNY ICB income assumptions and have signed the contract variation to create North Lincolnshire's first Community Rehabilitation service.

1.3 These SY-ICB discussions have focussed on 3 material issues:

- Agreeing a consistent income start point for the basis of the 25/26 plan.
- Securing additional funding by ensuring consistency in how funding is allocated between the ICB and providers in respect of out of area placement and
- Allocation of the residual system gap: in this Trust and others.

A consistent starting point & additional funding

2.1 Notwithstanding an agreed methodology across the system to use 24/25 income outturn as the starting point for the 25/26 plan, the Trust saw a reduction of £1.8m from outturn in the contract offer from SY ICB (the initial offer was even more divergent). This posed a continued risk of growing the planned deficit if not rectified.

2.2 In addition to the difference on the starting point, the original suggested MHIS funding proposed by the ICB was problematic. The proposal treated budgets held by the ICB materially differently when applying funding uplifts, compared to those held by providers. The Trust led in proposing an alternative model of distribution which ensures equity and consistency across the system.

2.3 Authors have met with the SY ICB DoF, CEO, and Deputy CEO in recent days to tackle issues cited, as well as those of concern to them, including legacy non-recurrent income. These discussions have resulted in writing in a revised income offer, which improves the prior offer by £3.8m recurrently.

2.4 Recognising the approach taken by funders and the efforts of partners to improve their own positions, we have revisited our own financial plans. If we eliminate all feasible contingencies and other provisions for risk, we can offer an improved position that, together with these income changes, moves the Trust's planned deficit for 25/26 to £1.3m. Critically this requires timely delivery of all extant CIP plans before the Board, including those agenda'd today: and removes scope to slip OOAP delivery beyond Q2.

Residual system gap and a route to a balanced plan

3.1 The ICB has calculated the apportionment of the residual system deficit for each provider, which it plans on delegating in 25/26, rather than holding centrally as has been the case

since 22/23. The methodology used doesn't necessarily align with the Trust's suggested approach, which favoured allocations based on the medium term left shift model; recognising too the failure to provide any investment in non-acute care in 24/25 (a primary deficit driver for the Trust). However, under the method applied, our share of the ask is the joint smallest at £1.3m. The chair, Chief Executive and DoFE have discussed with others the inevitability of assimilating the system deficit – and acceptance in principle is the recommendation.

3.2 The ICB has committed to cover half of this gap via non recurrent funding in 25/26, with the other half offset recurrently with additional savings on ICB held specialist out of area funding, specifically related to the establishment of a High Dependency Unit (HDU) at RDASH in 25/26 from mid-year. This would see demand side benefit taken by the Trust, but no risk transfer in year.

3.3 The Trust has now received formal correspondence from the ICB CFO and Place Directors confirming commitment to the points raised in 3.1 and 3.2 (as at 5pm 26/3/25).

Recognition of unresolved issues

4.1 In addition, we have worked through a short list of mutually agreed unresolved issues. This is twofold:

- The first relates to H2 funding for a second community geriatrician post, in addition to the transfer of funding for the first which TUPEs to the Trust from DRI on the 1st April. This is crucial to the city's HWBB priority around ageing, and central too to our work to reimagine the connection between physical and mental health for older people (an issue also relevant to the Woodlands site in Rotherham covering elsewhere on our agenda).

- The second is in relation to the transfer of the CYP autism service from DRI, where we have been working with ICB partners to bring equity to the neurodiversity offer across our places. This is becalmed presently by disinvestment questions with DBTH and investment issues with the Trust: a sum of over £2.5m, with urgency given the ostensive stop to services that has latterly been instituted.

The expectation is of intensive work by the place directors, ICB CFO and Trust CEO to settle these matters in the next ten days.

To note

5.1 The AED Provider Collaborative contract previously agreed with NHSE novates to SY ICB on the 1st April. This contract includes the same base funding as 24/25 uplifted for inflation, as well as an additional clause which funds the actual costs of a high-cost patient (c£1.2m in 24/25).

5.2 Included below is a bridge from the original deficit of £4.4m to the balanced plan, an updated savings plan to reflect the additional non-recurrent funding from SY ICB, and an

updated assessment against the NHSE segment 3 exit criteria to reflect the submission of a balanced plan.

Izaaz Mohammed, Director of Finance & Estates
&
Toby Lewis, Chief Executive
26.03.25

	£m
25/26 plan per Board paper	**-4.4**
Reduction in non recurrent SY ICB income	-1.8
Additional recurrent income secured from SY ICB	3.8
Removal of contingency from original plan	1.1
SY ICB Additional non recurrent funding in 25/26	0.7
ICB plan adjustment to breakeven - Specialist OAP savings	0.7
Revised 25/26 Plan	**0.0**

Savings scheme description	**£m**
Out of area placement reduction	3.0
Close an older adult ward	1.5
Non pay - only fund FYE of energy inflation	1.2
Reduce all directorate budgets by 0.5%	1.1
Margin on new developments - HDU / Community Rehab	0.5
Additional cuts to corporate directorates	0.5
Additional non recurrent funding from SY ICB	0.7
Total cash releasing savings	**8.5**
Additional activity planned within existing budgets	4.8
Total efficiency included in the 25/26 plan	**13.3**

Criteria	Measurement	Rating	Comments
2024/25 Performance – meet annual financial plan for revenue and capital.	Revenue financial plan position delivered.		Forecast for 24/25 is a surplus of £0.5m, £0.8m better than plan.
	Capital plan delivery meets agreed plan allocation.		Achieved
	CIP target achieved.		Achieved
	ERF plan and associated productivity improvements delivered.		Forecast to achieve ERF target for 24/25.
	Provider to demonstrate cash management reflects best practice to minimise support requests.		No cash support requests submitted in year, and cash balance of £30m+
	Workforce WTE and interim staffing costs controlled within plan levels.		Reduction of agency costs from £7.5m in 23/24 to £3m in 24/25.
Recovery and sustainability - realistic plan for achieving future in-year financial balance and year on year improvement in underlying financial position.	Multi-year recovery plan (MTFP) developed that aligns with organisation plans for service change and improvement trajectories. Plan must demonstrate significant year-on-year improvement in underlying sustainability, be agreed with ICB and aligned to system plans. To be produced to meet national timelines or by November 2024, whichever is earliest.		This is in place, although has not been discussed with ICB.
	2024/25 normalised exit run rate significantly improved from 2023/24 exit run rate.		Normalised RR improved when compared to 23/24
	2025/26 operational plan demonstrates in-year financial balance or demonstrates delivery of improvement trajectory to achieve in-year financial balance at pace set out in recovery plan and agreed with ICB. Plan is realistic when considered against key benchmarks and indicators including levels of delivery risk.		2025/26 plan demonstrates in year balance, with a total efficiency target of £13.2m, and £8.4m of cash releasing savings.
Cost improvement and productivity - robust planning of cost improvement and productivity scheme, delivered at the level required to support achievement of financial plans and recovery.	2024/5 efficiency and associated productivity plans established and delivered, meeting or exceeding planned % for recurrent savings.		Achieved
	Pro-active use of models, tools, benchmarking and best practice to establish robust multi-year CIP and productivity plans that enables recovery and sustainability, both internally and with system partners.		Akeso commissioned work, plus use of productivity packs and cost collection information
	2025/6 efficiency and associated productivity plans established that will improve sustainability in line with MTFP, and reflect operational plan requirements. Plans are realistic when considered against key benchmarks and indicators including levels of delivery risk.		£13.3m of total efficiency included in the 25/26 plan, of which £8.5m is cash releasing.
	Provider to demonstrate that sound governance and PMO processes are in place, including effective risk management and mitigation.		QSIA process in place and refreshed for 25/26.
Governance and control - robust governance, systems and processes in place.	Provider to demonstrate organisational ownership and commitment to financial delivery.		All Care Groups and Backbone directorates on track to hit budget in 24/25 and plans in place to deliver 25/26 budget.
	Embedded and robust challenge and reporting processes that provide maximum possible expenditure control in place, with evidence that those are contributing to reduction in expenditure run-rate.		Regular reporting via I&I process to ICB, with enhanced controls in several domains.
	Evidence of organisation compliance with financial governance and control best practice, including existing or new requirements established by NHSE /ICB.		Regular reporting via I&I process to ICB, with enhanced controls in several domains.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	2024/25 Serious Patient Safety Incidents – Learning	**Agenda Item**	Paper M
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Angie Nisbet, Interim Associate (NHSP)		
Meeting	Board of Directors	**Date**	27 March 2025

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

This paper tabulates the key issues with each PSII since 1 April 2024, it is important that Board and our public have absolute awareness and insights, with the detail of these most serious patient harms that have led to a person's death or the highest severity of harm. Revised governance for PSIIs will be in place from April 2025 and conclusion of all 24/25 PSII is overseen by Chief Nursing Officer, newly reporting into directorate delivery review, where a remedial action plan has been agreed.

Our learning from the PSIIs completed to date is set out, with the available data. Improving our data, reporting by directorate is a priority going forward with Richard Banks and our implementation of RADAR, this will ensure, going forward into Q1 & Q2 that our Patient Carer Race Equality Framework commitments are fully understood and reflected in the learning we undertake.

Board should discuss whether the actions outlined to address each learning is realistic, achievable and will be sustainable. So not just to share the incidents which have led to the most serious of harms, that we as a board discuss the learning, noting any changes to service delivery, clinical practice and processes as a result of the actions and findings from the incidents detailed within this paper.

Concern remains over the learning model within the organisation for safety. We will continue to embrace Patient Safety Incident Response Framework (PSIRF), our Quality & Safety (Q&S) plan and Learning Half Days (LHD) to ensure there is a systematic approach to learning from After Action Reviews (AAR), swarm huddle, Multi-Disciplinary Team (MDT) huddles and PSIIs. From May, escalation of key learnings from PSIIs will form part of the delivery review cycle, in addition to work through the organisation's **quality and safety plan**.

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

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

Clinical Leadership Executive 18 March 2025:

- Key learning extracted from benzodiazepine prescribing – **Action** for Chief Medical Officer to ensure there is a clinical process to flag, above British National Formulary prescribing including dosage and combination prescribing (by prescriber, team, directorate).
- **Reflections** on the Regulation 28 issued (details within this report) and the subsequent service change, CLE members acknowledging this was the right change in service pathway for people 65 and over, to ensure access to mental health crisis provision did not age discriminate.
- **Risk assessments** discussed the need to update risk assessments before and after leave period, irrespective of Mental Health Act status – ensuring essential pre leave records are completed.
- **Acknowledgement** into the improvements and sustained attainment of Oxevision care planning compliance, noting the recommendations within this report.
- **Promise 7** to ensure physical health and mental health are given the equivalent attention and priority, especially in relation to a person within our care who is deteriorating (National Early Warning Score) and ensuring diagnostic overshadowing is challenged, utilising the taught element of the Oliver McGowan mandatory training.

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

The Board is asked to:								
X	**NOTE** the lessons learned from PSII concluded year to date							
X	**NOTE** the intention to include 12 months' work for 24/25 quality account - due shortly							
X	**DISCUSS** the outlined actions in response to the learnings and consider comprehensiveness							
Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)								
Trust Risk Register	X	NQ 5/23, NQ 8/24						
Board Assurance Framework	X							
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	

Patient Safety Incident Investigation (PSII) Update

This paper describes five distinct updates:

1) Serves the Board with an update in respect of PSIIs investigated 1 April 2024 – 31 December 2024.
2) Provides a breakdown of PSIIs by care group, incident type, gender split and by age of the person harmed/deceased.
3) Learning from each PSII during period in 1)
4) PSIRF went operational 1 January 2024 – reports outstanding PSIIs during this period and learning from those PSII completed
5) Outstanding investigations under Serious Incident Framework (pre 31 December 2023)

PSII position 1st April 2024 to 31st December 2024

13 SIIs reported between 1st April 2024 to 31st December 2024.

- 5 finalised and signed off.
- 1 QA stage.
- 7 remain under investigation.

The status of the eight ongoing investigations can be found in the table below.

PSII number	Date logged	Care Group	Type of incident	Status	Target closure date
2024/ 9562	20/11/2024	DAMH+ LD	Suspected suicide	Potentially an MDT Review of clinical records completed and contact with team manager. This patient had one contact with SPA that was managed appropriately and within the timescales expected.	04/04/2025
2024/ 9561	20/11/2024	RAMH	Suspected suicide	Investigation underway. Report required by 31/03/2025 for the coroner.	31/03/2025
2024/ 9560	20/11/2024	NLAMH+ TT	Suspected suicide	Potentially an AAR. Very limited contact (one telephone call).	30/04/2025
2024/ 9559	20/11/2024	DAMH+ LD	Patient fracture arm	Investigation completed; several lines of key enquiry emerged. Meetings arranged during April with care groups and key back bone services to establish learning outcomes and actions. Timescales currently within 6 months since reported on STEIS.	25/04/2025
2024/ 8654	15/10/2024	DAMH+ LD	Suspected suicide	Joint TOR being finalised with DMBC and DBTH. The aim is to complete the PSII during August. Next progress meeting with DMBC and DBTH 30th April 2025.	31/08/2025
2024/ 8656	15/10/2024	RAMH	Review of care, treatment and transfer	Investigation ongoing, meeting planned with Matron in April 2025. Timescales currently within 6 months since reported on STEIS.	25/04/2025
2024/ 7457	29/08/2024	NLAMH+ TT	Suspected suicide	Prioritised to be completed by the end March.	31/03/2025
2024/5229	18/05/2024	RAMH	Suspected suicide	Prioritised to be completed by the end March.	31/03/2025

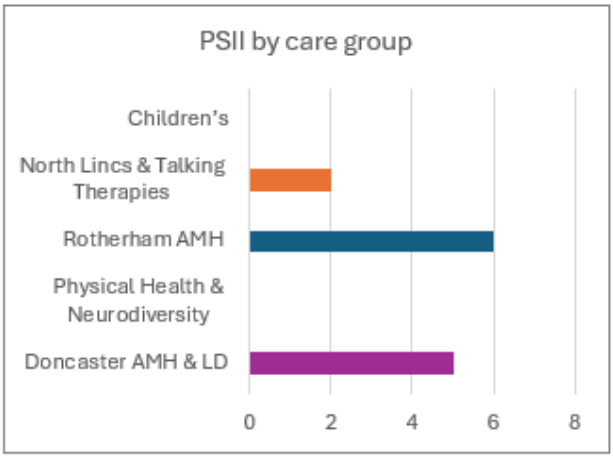
Analysis of data for PSII reported between 1 April 2024 to 31 December 2024

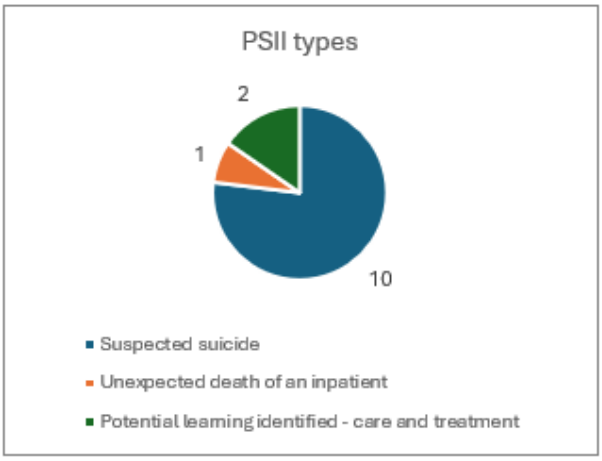
Rotherham MH and Doncaster MH & LD were the highest reporting care groups, with 6 and 5 PSIIs reported. The highest type of PSII reported was suspected suicide. One unexpected death of an inpatient was identified as a PSII due to care and an opportunity for learning identified.

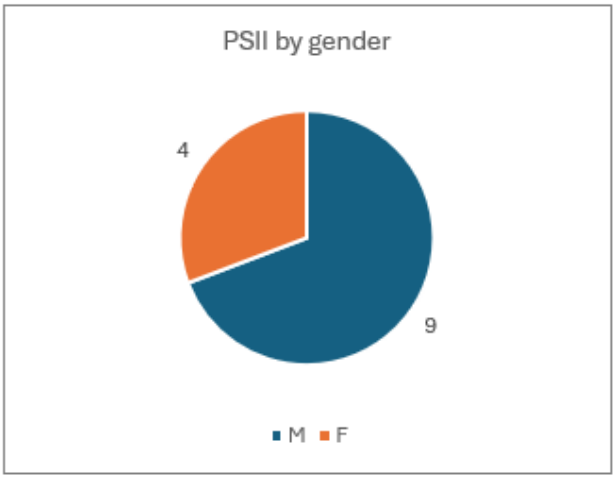
The highest age group of patients reported is 46 to 55 years, correlation with age and incident type, suspected suicides, it is a comparator to the data within the national confidential enquiry into suicide and safety in mental health, which identifies the highest risk age group of suicide is 45 to 54 years.

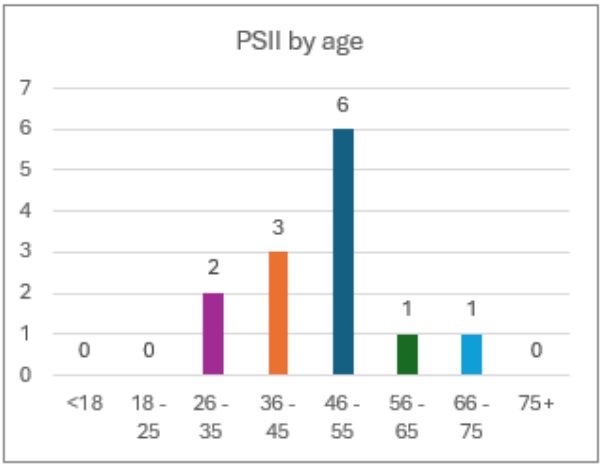
69% of the patients involved within the PSIIs were male.

As we embed PCREF and the work being undertaken in the Equality and Inclusion Committee, we have work to do going into 25/26 to understand the protected characteristics of the patients who come to harm in our care, where there is learning and also those staff that are involved in the persons care.









Learning from PSIIs 1 April 2024 to 31 December 2024

PSII	Learning identified
2024/ 4279	PSII report is in its final draft, the recommendations are summarised below: **<u>Observation/Oxevision Findings:</u>** Clear information on the function of oxevision, has been circulated to all inpatient ward staff. This is because at the time staff did not follow the Trust's physical observation policy. All patients on an inpatient ward should be physically checked minimum of hourly intervals by a staff member, unless an individualised care plan states it is not therapeutic to do so. The Trust is moving to the new oxe-academy online training for the use of oxevision. This is a certified course, and compliance will be mandatory for those required to use it. Compliance will be monitored with the support of the learning and development team. The use of oxevision has been reviewed as part of the Trust's supportive observations policy and in line with the national review of oxevision. All inpatient leadership teams receive a monthly report of the oxevision usage. This is to aid the identification of any increased use or reliance on the system. The Trust is implementing a monthly audit that will monitor staff compliance with supervision and training around oxevision. The audit will be completed, and data circulated to ward leadership teams, Care Group leadership teams and Nursing and Facilities for corporate oversight. The Trust has scoped processes utilised in other Trusts to support a review of standard operating procedure for oxevision. The Standard Operating Procedure (SOP) is due to be presented at the National Director of Nurses forum in Q3 2024 for approval - **complete**. **<u>Medicines Management:</u>** The Trust recognises that its prescribing of clonazepam has increased. Clonazepam is approximately twenty times stronger than diazepam. Additional training around clonazepam has been provided to medical staff to highlight the dose equivalence and to consider switches to other medications such as diazepam when withdrawing this medication to allow for more gradual reductions. **Since this incident, Clonazepam use in Rotherham inpatients has significantly reduced. At a ward level, Kingfisher has had no supplies between July to November 2024 and for Sandpiper there has been use, however it is in general decline. Reported by Chief Pharmacist, 3 January 2025.** **<u>Physical Health Monitoring</u>** The lack of robust and holistic care for patients with complex comorbidities between physical health and mental health providers is acknowledged within this investigation. This is all our responsibility to address locally, with the participation of other agencies. The findings of this investigation are to be shared with our Integrated Care Board (ICB) and importantly with our physical health trusts and patient safety teams. This will be needed to provide the opportunity to learn, develop shared protocols and improve communication relating to potential biases, to what is **diagnostic overshadowing**. **A meeting between RDaSH, Rotherham District General Hospital, Sheffield Teaching Hospitals and ICB clinical leads is being planned into Q1 25-26.**

PSII	Learning identified
	All inpatient areas are to conduct audits that ensure appropriate and individualised physical health care plans are in place, and these are to be reviewed as a minimum weekly as part of the Multi-Disciplinary Team meeting and patient reviews.
2024/ 4896	It is important for service users to **ALWAYS** be heard and listened to and empowered by providing information and explanation of how they can access services and prioritise their recovery. The Crisis Practitioner spent time explaining to the patient the various options available to him to access services that were geared towards promoting his recovery.
2024/ 5228	Patient demonstrated forward planning until the time of her death. Actively seeking out support to address the distress she was experiencing; this indicating that she experienced a crisis that then diminished her ability to see a way forward. **Contributory factors** Patient was suffering from chronic eczema and was prescribed steroidal medication, to which she believed was having an adverse reaction. She presented with physical symptoms that were having a significant impact on her daily life and her ability to care for her two children. The level of distress associated with these symptoms are likely to have contributed to an escalation of crisis alongside life stressors in terms of returning to work after a significant absence, and commencing new treatment for a recent diagnosis of ADHD. **Good Practice** The ADHD service was very responsive to the patients' needs and demonstrated good multi-agency working and communication.
2024/ 9565	The PSII report highlighted the need for clarity of roles & responsibility when a patient is in an A&E department, and leaves before assessment by the MHLT, and the patient is known to the crisis team.
2024/ 9566	The PSII report demonstrated good partnership working between YAS and the crisis team which needs to be reflected in all our teams to ensure handoffs do not lead to poor care pathways and increase risk to patients.

PSIIs reported between 1st January 2024 and 31st March 2024

The Trust went live with PSIRF 1 January 2024. There was a total of 10 PSIIs reported between 1 January 2024 and 31 March 2024. Of these five are closed and 5 remain ongoing. The status update of the five ongoing PSIIs can be found in the table below.

PSII number	Date logged on STEIS	Care Group	Type of incident	Status	Target closure date
2024/3400	31/03/2024	RAMH	Suspected suicide	Final version under QA	31/03/2025
2024/2126	22/02/2024	PH+N	Unexpected death	Finalising	31/03/2025
2024/2123	22/02/2024	NL+TT	Suspected suicide	Awaiting sign off	31/03/2025
2024/2121	22/02/2024	DAMH+LD	Suspected suicide	Final version under QA	31/03/2025
2024/125	04/01/2024	NL+TT	Unexpected death	Final version under QA	31/03/2025

Learning from PSIIs 1st January 2024 and 31st March 2024

PSII	Learning identified
2024/3403	Implement processes to ensure patient's electronic records and pre-leave paper records consistently reflect pre leave information such as time of departure, expected return time, if family are aware of leave and clothing description. Revise Trust wide policy to include guidance around acceptable timeframes for staff to establish contact when an informal patient does not return to the ward from expected leave. Specify a time for informal patients to return if on day leave and agree steps to be taken when this does not happen including contacting a family/carer member.
2024/3400	RDaSH was issued a Regulation 28 report to prevent future deaths. The Reg 28 report asked the Chief Executive and interim Medical Director to consider a review of crisis provision, the crisis provision for people 65+ years, and to ensure General Practice is aware of service available. From 3 December 2024, the crisis service extended its service provision and became accessible for all age groups.
2024/3401	Recommendations include establishing a standard operating procedure for duty workers and ensuring carer's have a carer support plan. A Coroner inquest took place 17 December 2024 and recommendations included an audit of the extension of crisis support for all ages to review progress.

Serious Incidents (SI) reported pre-31st December 2023

There are four remaining SIs ongoing, the status update of the ongoing SIs can be found in the table below.

SI number	Care Group	Type of incident	Status	Target closure date
2023/11556	DAMH+ LD	Sexual Safety	Awaiting information from Matron to complete. Updates required following feedback.	31/03/2025
2023/11295	DAMH+ LD	Slips/trips/falls meeting SI criteria	Tabletop review booked to agree final version and sign off.	31/03/2025
2023/6283	RAMH	Disruptive/ aggressive/ violent behaviour meeting SI criteria	First draft planned 21/03/2025, for Trust sign off.	31/03/2025
2021/4316	PH+N	Abuse/alleged abuse of adult patient by third party	SBAR completed and awaiting sign off.	31/03/2025

Summary/Recommendations

This report notes the progress to date in respect of investigating and closing PSII and SI. This work will continue in 25/26

The Board are asked to:

NOTE the lessons learned from PSII concluded year to date

To include 12 months' work for 24/25 in the year end quality account (due shortly)

DISCUSS the outlined actions in response to the learnings and consider comprehensiveness

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 26	**Agenda Item**	Paper N
Sponsoring Executive	Carlene Holden, Director of People and Organisational Development		
Report Author	Carlene Holden, Director of People and Organisational Development		
Meeting	Board of Directors	**Date**	27 March 2024

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

The paper provides an update on the work and workstreams associated with Promise 26, and focusses on the wider aspects of Promise 26 as the antiracism work was covered in a separate paper in September 2024.

The paper reflects on the current position both within the Trust and nationally and details the initial 10 point action plan, which is in addition to the 7 point anti racism plan which was developed in 2024.

The initial 10-point action plan will be reviewed and refined during Quarter 1 2025/26 via our networks, engagement events and the Trust People Council.

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
ISO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X

Previous consideration

Not applicable

Recommendation

The Board of Directors is asked to:

x	**NOTE** the content of the report and the ongoing workstreams
x	**CONSIDER** any matters of concerns not covered in the report
x	**NOTE** the staff survey results associated with Promise 26

Impact

Trust Risk Register							
Board Assurance Framework (SDR)	X	SO5					
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	X	If ‘Y’ date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If ‘Y’ date completed	

Appendix (please list)

N/A

PROMISE 26

1.0 Introduction

1.1 As we are aware Promise 26, in part, focuses on becoming an anti-racist organisation by 2025 and we considered a paper in September 2024's meeting on our approach and 10-point action plan to achieve this. We recognise though that Promise 26 is much broader than becoming an anti-racist organisation and covers our approach to all elements of fighting discrimination and promoting inclusion, to truly improve the working conditions for our colleagues, providing an environment whereas a Trust we are not neutral in our approach to discrimination.

1.2 Whilst we recognise the promises are bold and ambitious, Promise 26 lies at the heart of the organisation to improve the working conditions and experiences for our colleagues to engage them to thrive in the workplace and offer excellent patient care without the fear of discrimination. The purpose of this paper is to build on the paper presented in September 2024 to cover our ambitious strategy in this area.

1.3 The initial plan has been developed through the support of our networks, network chairs and SRO's and will form a key part of our delivery objectives in 2025/26. Through the staff networks, staff engagement, Trust People Council and in the autumn the annual Staff Survey in which we will hear from colleagues whether our approach is having an impact. Whilst our anti-racist approach was accelerated due to the racist riots we experienced in the summer of 2024, we do not have an accelerant for the wider aspects of Promise 26, but this does not dilute our energy, commitment, and passion to address all aspects of discrimination within RDaSH. During Q1 2025/26 we will further refine our initial 10-point plan to ensure that it focuses on the key areas and the areas of need identified by the majority of colleagues rather than a select few.

1.4 As a Trust we have been clear on our values and **we will not accept nor tolerate discrimination** in the workplace, but this does not remove the distress our colleagues have experienced and continue to experience. We are determined that this must act as a platform to further amplify our work on Promise 26 to make a positive difference in this area. With the staff survey results for 2024 we have some positive improvements associated with racial discrimination, those colleagues experience discrimination at work from their manager or colleagues has improved from 1 in 5 to 1 in 7 which demonstrates our approach is having an impact. Whilst acknowledging we still have further work to do as racial discrimination remains an issue within our workplace (1 in 7 is an unacceptable level), albeit our improvement compared to our comparator groups is much greater.

1.5 The detailed work associated with the promise is being taken forward through the People and Teams sub-group of CLE.

2.0 Current position and reflections

2.1 As with any effort to create and embed change, actions are needed in a variety of domains. However, the concern is to **avoid too many actions** that can distract from full implementation of the most significant steps, which help to address 80% of the problem. We have five Staff Networks within the Trust and therefore believe a sensible approach for 2025/26 is to ask each of the five networks to focus upon a few priority areas, thus ensuring maximum effort and focus on the identified areas of need.

This will provide the Trust with an initial 10-point action plan to explore during Q1 2025/26 and then refine where necessary. It is envisaged that we will utilise a Plan Do Study Act (PDSA) business planning cycle to review our success or not, in quarter four (Q4) to then agree the priority areas for 2026/27. Whilst the ideal being to ultimately remove the need for any action plans or concerted effort in this area, this is not realistic. Therefore, our approach will be integral to the Trust ways of working and the development of our culture, becoming intrinsic to the way we do things at RDaSH. This will reman an area of focus as the Trust, the NHS and wider society changes – we will adapt our areas of focus to reflect the needs of the Trust.

2.2 As with racism, we have policies to address allegations of discrimination, but as highlighted by our 2024 staff survey results, **not all concerns are being escalated via the policies** and we must address this to see a change in the Trust. We have a number of colleagues reporting discrimination in the 'other' category, (31.9% of respondents) which is higher than that of our comparator group, we need to understand what colleagues are categorising as other and this will be an action for all of the networks and wider staff engagement events – if we don't understand the issue/concern, then how can we look to address it.

2.3 As highlighted in September 2024, a key approach and strategy for supporting managers is our development programmes, with the Leadership Development Offer (LDO) and the Mandatory first line manager training which commences in April 2025, which provides our managers with a solid foundation to understand discrimination and our approach to addressing it. **Our middle managers are key to the success** of these interventions as they have the most influence and impact upon our colleagues. They have a significant influence on the delivery of Trust initiatives, and by engaging with these colleagues in striving for the best working conditions for their teams this will have a significant impact on our success measures.

We do not turn a blind eye at RDaSH or look the other way, but we need all colleagues to feel empowered and engaged with this approach. As a reminder our manta being, '**if you walk by it, you stand by it'** and this is not an acceptable approach for any colleagues, leaders or managers.

2.4 In October 2024 we launched the new five-day induction which includes a space for new **RDaSHians to explore their expectations, and ours**: this includes discussions about Active Bystander behaviours and how we can work together at local level to set clear expectations for how we respond and behave and how we address micro-aggressions. However, due to our direct approach some colleagues may decide RDaSH is not the place they wish to work, which is to be anticipated and expected. Most colleagues will welcome this approach, recognising some anxiety in navigating this journey but with the support in place we can and will improve the working conditions of colleagues. The People and Organisational Development Committee and the Trust People council have an instrumental role in holding us to account in this area.

2.5 Whilst we recognise that NHS England are developing a Management and Leadership Framework, which may or may not include an EDI objective or specific training/competencies, we have an understanding of the issues we are experiencing and have **chosen to take action now rather than waiting for any national or regional policy directive**. Obviously, should a national policy or regional policy directive be received we will consider this alongside our Trust approach, but we remain committed to the delivery of our twenty-eight promises by 2028 and therefore action is required now.

2.6 This is the second year we have had a dedicated reasonable adjustments budget to support colleagues in the workplace and for the second year we have exceeded the budget allocation. In the main the budget is spent on digital solutions to support colleagues and whilst this has been well received by colleagues our disability discrimination levels reported via the annual staff survey has slightly increased. The DAWN network will support us in exploring this issue to understand how we can further support colleagues to address the discrimination they face, it may be that an increased focus is required on physical equipment or changes to the job/working patterns, to name a few.

3.0 Initial 10-point action plan

3.1 As previously stated we have five staff networks, recognising we have already agreed a 7-point action plan for our approach linked to becoming an anti-racist organisation which is fundamental to the ReaCH network.

3.2 As a reminder we currently have the following networks within the Trust

- ReaCH – Racial Equality and Cultural Heritage Network
- DAWN– Disability and Wellbeing Network
- Rainbow Network
- Women's Network
- Carer Network – this is our newest network, launched in February 2025.

3.3 This paper focusses in the main on the initial action points for the four networks other than the ReaCH network given we have previously had a detailed discussion and debate on the priorities for the organisation to achieve its desire to become an anti-racist organisation.

3.4 The suggested areas of focus for each of the networks is as follows

Network	Area of Focus
DAWN	1. Actively raise awareness of long-term conditions through speakers with lived experience and promote reasonable adjustments for colleagues and line managers, providing peer support. 2. To explore the 20024 Staff Survey results and the 18.84% reported levels of disability discrimination (slightly increased from 2023 – 18.7% and above the peer group average of 13.43%) to understand what we need to undertake as a Trust to address (reduce) the disability discrimination which our colleagues are reporting.
Women's	1. To explore and understand the gender pay gap and ways to help close (and eliminate) the gap. 2. Flexible working and the intersectionality of the various networks and the importance of addressing overlapping issues such as flexible working, gender pay gap, and carers' responsibilities.
Carers	1. Providing peer support, bringing in guest speakers, raising awareness, and reviewing relevant trust policies. A focus on the importance of supporting unpaid carers and encouraging them to declare their status on the electronic staff record. 2. Working and supporting concerns about colleagues struggling with caring responsibilities and health issues – refining our policies and procedures to support colleagues.
Rainbow	1. To increase awareness and visibility across the Trust by increasing the number of colleagues attending the Rainbow badge training to ensure equal representation across our 23 Directorates. 2. Increase integration with other Trusts, voluntary agencies and LGBTQ+ communities to ensure a wider system of support and activation. This will include both social engagement opportunities and also opportunities for raising the awareness of LGBTQ+ issues and concerns, which will include PRIDE activity across the system.
All	1. To understand the other discrimination reported via the 2024 Staff Survey and shape the Trust response 2. To review the 2024 Staff Survey results in totality and review the proposed actions via the networks.

4.0 What does success look like?

4.1 We are keen to ensure that the work in this area does make a difference to address the challenges rather than producing an action plan which has limited impact. We have seen the impact of our approach to becoming an antiracist organisation and whilst we do not wish to dilute our approach in this particular area, we are eager to spread our focus and impact to all areas of discrimination and the intersectionality.

4.2 The success measures alongside the refinement of the initial 10-point action plan will be explored in Quarter One 2025/26.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Older Peoples Services: proposed changed in 2025/26	**Agenda Item**	Paper O
Sponsoring Executive	Toby Lewis, Chief Executive Officer		
Report Author	Dr Judith Graham, Director for Psychological Professionals & Therapies, Dr Diarmid Sinclair, Chief Medical Officer and Steve Forsyth, Chief Nursing Officer		
Meeting	Board of Directors	**Date**	27 March 2025

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

This Older Adults paper is presented to the Board of Directors for two reasons: (1) to explore and decide upon a recommendation, considering the selected option (2) to discuss and agree upon a set of KPI thresholds that we need to achieve over the coming year, related to the option selected.

The rationale for the paper being considered at Board level is that (1) if the option is selected to reopen the Brambles Ward there will be a significant deficit in the Rotherham Care Group budget which effects the Trust overall financial position; (2) if there is a decision to potentially to progress a change in the geographical delivery of older peoples services this will require Board Consideration and public consultation.

This paper is a central piece of work associated with the High-Quality Therapeutic Care Taskforce leading changes to improve inpatient care, which is associated with SO3 & SO4 in our Trust Strategy. In brief the paper advocates for a change in care provision which will enhance community support for older people with mental health difficulties and dementia; align bed base services in a way that ensures equity and standardise pathways and to enable local delivery. The annex is provided as the background and options appraisal which shows the coproduction and rational for the option selected.

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.	
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.	

Previous consideration

Executive Group; HQTC meeting (Feb and March 2025), CLE Meeting (Jan, Feb & March 2025)

Recommendation

The Board of Directors is asked to:

X	**NOTE** the change in service model outlined in the preferred option
X	**RECOGNISE** the move to mixed provision is the less common option nationally & regionally
X	**AGREE** to reconsider the success of the change against the cited KPIs and other measures of impact in March 2026
X	**ACKNOWLEDGE** that any move to a separate specialist bed-based model would likely be contingent on statutory consultation

Impact

Trust Risk Register	x	Ref – OOA Placements Ref – Emergency temporary closure of Brambles Ward Ref – Medical vacancies
Board Assurance Framework (SDR)	x	HQTC Health Inequalities – reference older people - SDR2
System / Place impact	x	The paper recognises the impact of services across Trust footprint over different places and considers this in the options. Dependent upon option selected, system and place consultation may be required.

Equality Impact Assessment (EIA)	required?	Y	X	N		If 'Y' date completed	Included with the Paper – Annex 4
Quality Impact Assessment (QSIA)	required?	Y	X	N		If 'Y' date completed	Included with the paper – Annex 5

Annex
Annex 1: - Options Appraisal Paper – contributed to via HQTC and CLE. Annex 2: - Considerations from Rotherham Care Group SLT Annex 3: - OP Board Paper Environmental Considerations (Paper previously served at CLE March 2025) Annex 4: - EIA Annex 5: - QSIA

Older Peoples Service Change Paper

Situation

This paper concerns the proposes a three-site mixed ward model for older people's service at RDaSH, with an enhanced community care provision. This proposal is aligned with our Trust Strategy, with specific focus on Strategic Objectives 2 and 3.

Background

This paper is the result of extensive work and consultation with a number of stakeholders in the Trust and has been a core item of focus in the initial work of the High-Quality Therapeutic Care (HQTC) Group.

Annex 1 provides the background detail regarding the changes required in older people's services at RDaSH and the rationale as to why this work has commenced at this time. Thanks is offered here for all the senior clinical and managerial experts that have taken time to contribute to considering the issue with all the complexities, ethical, financial and care considerations – many of the contributors are named in Annex 1, and also the 4 options that were generated and considered prior to this final option being proposed are also detailed.

Assessment

The following section will be presented considering –

- The scale of admission and discharges
- The clinical rational for the selected 'mixed ward'
- The rational for increasing the community care opportunity to support older people and specifically people with dementia at home.

Admissions and Discharges

What we know is that admission rates and occupancy rates have varied across our Trust for some time. However, prior to the emergency closure of Brambles, Older Peoples occupancy levels have been consistently below 70% across the Trust for months. The length of stay in Rotherham has been longer than in all other Trust older peoples bed bases and also the admission rate per head of population is higher in Rotherham, than Doncaster and North Lincolnshire. Therefore, the following 3 data modelling tables are provided in terms of a forward view regarding occupancy levels dependent upon whether length of stay in Rotherham can be reduced in line with the wider Trust.

Model (a) - If Brambles were to remain closed: At 90% occupancy, accounting for Older Adult demand from Rotherham ICB patients, with current median LoS and 0OAPS Rotherham has a deficit of 4.4 Older Adult's beds. When taking the rest of the Trust's Older Adult bed base into account, the organisation has a surplus of 8.2 Older Adult beds. Based on an average weekly admission rate of 2.12 patients, 2.12 patients need to be discharged from Rotherham Older Adult beds per week.

Please see table below for the modelling in terms of this option (a):-

Rotherham	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance** (100% occupancy)	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Brambles	0	0	0	0	0	0	0	0.0	0.0	0.0
Glade	15	65	110	5475	607	6543.0	-1068.0	-2.9	-4.4	-5.2
North Lincs	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance - Current LoS**	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Laurel	13	53	58	4745	470	2604	2141	5.9	4.6	3.9
Doncaster	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance - Current LoS**	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Windermere	20	35.5	108	7300	202.7	3631.3	3668.7	10.1	8.1	7.1

Model (b) - If Brambles were to remain closed: At 90% occupancy, accounting for Older Adult demand from Rotherham ICB patients, with median LoS reduced to 50 days and 0 OAPS Rotherham has sufficient Older Adult's beds. When taking the rest of the Trust's Older Adult bed base into account, the organisation has a surplus of 12.7 Older Adult beds. Based on an average weekly admission rate of 2.12 patients, 2.12 patients need to be discharged from Rotherham Older Adult beds per week.

Please see table below for the modelling in terms of this option (b):-

Rotherham	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance (100% occupancy)**	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Brambles	0	0	0	0	0	0	0	0.0	0.0	0.0
Glade	15	50	110	5475	607	4893.0	582.0	1.6	0.1	-0.7
North Lincs	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance - Current LoS**	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Laurel	13	53	58	4745	470	2604	2141	5.9	4.6	3.9
Doncaster	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance - Current LoS**	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Windermere	20	35.5	108	7300	202.7	3631.3	3668.7	10.1	8.1	7.1

Model (c) - If Brambles were to remain closed: At 90% occupancy, accounting for Older Adult demand from Rotherham ICB patients, with median LoS reduced to 55 days, admissions reduced by 10% (0.92 admissions avoided per month) and 0 OAPS Rotherham has sufficient Older Adult's beds. When taking the rest of the Trust's Older Adult bed base into account, the organisation has a surplus of 12.7 Older Adult beds. Based on an average weekly admission rate of 2.12 patients, 2.12 patients need to be discharged from Rotherham Older Adult beds per week.

Please see table below for the modelling in terms of this option (c):-

Rotherham	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance** (100% occupancy)	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Brambles	0	0	0	0	0	0	0	0.0	0.0	0.0
Glade	15	55	99	5475	607	4838.0	637.0	1.7	0.2	-0.5
North Lincs	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance - Current LoS**	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Laurel	13	53	58	4745	470	2604	2141	5.9	4.6	3.9
Doncaster	**Beds**	**Median LoS (days)**	**Annual admissions**	**Bed days available** (100% occupancy)	**Leave Days**	**Bed days required**	**Variance - Current LoS**	**Bed variance** (100% occupancy)	**Bed variance** (90% occupancy)	**Bed variance** (85% occupancy)
Windermere	20	35.5	108	7300	202.7	3631.3	3668.7	10.1	8.1	7.1

Clinical Rationale

There are several clinical factors that have been considered as a part of this options appraisal, and that advocate the option presented. There is a reference list of national publications used to inform the case, and the following points are listed to highlight the key points of clinical consideration as highlighted by our older people's expert consultant psychiatrists and consultant psychologists: -

Mixed wards (meaning wards that support older adults who have both functional and organic mental health diagnosis) - Different research, national drivers, expert opinion and data informs whether a mixed (functional and organic) ward for Old Age psychiatry is desirable, or whether separate functional wards, and separate dementia wards, might be preferred.

The World Health Organization[1] detail, in diagnosing dementia, how "Impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation" with support of patients having management of mood problems, and dementia. All such in-patients with such cognitive change will have mood problems (by definition, to attract a diagnosis of dementia), similarly in-patients with severe mood problems will have change in cognition and, "it is very unlikely that the sufferer will be able to continue with social, work, or domestic activities, except to a very limited extent."

What this means for us at RDaSH: The World Health Organization explains how patients presenting with dementia, or functional illness, will have an overlap in symptoms and presentations. Therefore, this advocates the 'mixed ward' approach we are advocating.

RCPsych "Acute inpatient mental health care for adults and older adults" [2] similarly supports managing dementia and functional mental illness together, "Here we should be striving for needs based, not diagnosis-based care and treatment…we also need to empower and enable clinicians to work with us to understand our needs as a whole person before agreeing a course of actions to keep us well." The emphasis is on "Holistic assessment" but recognises, "There may be occasions, based on clinical judgement, when it is appropriate to admit an older adult to a general adult ward (e.g. because they are well known to staff there)" or admission avoidance through home treatment by a crisis service[3, 4].

***What this means for us at RDaSH*:** RCPsych acute inpatient pathways support a mixed dementia and functional approach and supports an approach of Old Age psychiatry patients being managed in an "all age" pathways using General Adult psychiatry beds when this advantages the patient, which is the approach we are advocating for in this proposal.

RDaSH agreed through the Clinical Leadership Executive that we would use the national RCPsych accreditation standards[5]. These RCPsych in-patient quality standards describe how, "2.2.4 Patients have a comprehensive mental health assessment . . . a diagnostic assessment of depression, dementia, and delirium," which supports opportunity for mixed functional and organic assessment and expertise, on the ward.

What this means for us at RDaSH: RDaSH quality standards (using RCPsych accreditation standards) supports a mixed functional and organic in-patient offer, to support comprehensive and holistic assessment and management of older people's needs.

The NHS England mental health implementation plan[6] describes how, "*Given the limited number of specialist OPMH staff in a given locality . . . areas will need to expand and deploy their OPMH workforce flexibly . . . this will mean that the same OPMH staff may be working across a range of care settings*," supporting an Old Age psychiatry workforce skilled at working with functional and organic patient needs.

Rather than assessment and transfer or handover of care, continuity of care is stated as important in older adults, further supporting a mixed functional and organic ward. Locally in RDaSH the mixed functional and organic ward (i.e. Windermere Lodge and Laurel Ward) meets the RDaSH and NHS England target of ". . . *a reduction in length of stay for all services to the current national average of 32 days (or fewer)."* This is not currently achieved in Rotherham, which is a part of the rational to change.

What this means for us at RDaSH: Workforce competencies and metrics of patient outcomes are supported by a mixed functional and organic ward.

The Equality Act 2010[7] defines "age" as a protected characteristic, the RCPsych "Suffering in silence: age inequality in older people's mental health care" [8] details concern of age discrimination. The RCPsych supports a need for one holistic service offer and explicitly states, "Any attempt to sub-divide services for older people by diagnosis poorly reflects patients' experiences," noting how, "Separating dementia and other mental health services for older people is unhelpful and was described in the National Dementia Strategy as a 'false dichotomy' (Department of Health, 2009)."

What this means for us at RDaSH: The Royal College states, in limiting discrimination and in advantaging Old Age psychiatry patient care, that functional and organic illness is managed together, rather than separated. This supports the suggestion of a move to a mixed ward approach in the Trust.

Frailty models have been considered, basing care needs on frailty (rather than on functional or organic diagnosis). The RCPsych paper "Frailty: Ensuring the best outcomes for frail older people" [9] supports how, "frailty has been operationalised as a risk index . . . including disability, diseases, physical and cognitive impairments, psychosocial risk factors, and geriatric syndromes (e.g. falls, delirium, and urinary incontinence)" (Xue, 2011)."

Additionally, Old Age psychiatry is defined by the RCPsych in "Criteria for old age psychiatry services in the UK" [10] and noted, "Extensive consultation was undertaken during their development and the principle that older people have access to dedicated, specialist old age services for functional illnesses and dementia is widely supported," rather than separating these services.

What this means for us at RDaSH: Frailty models include cognitive impairment and delirium, to include organic psychiatric disorders, in frailty models of Old Age psychiatry. This supports a mixed functional and organic ward approach.

Providing just a dementia services, and offering an "all age" functional services was appraised by the Royal College with a survey[11] finding, "87% of respondents thought that ageless services were *bad or very bad*". Regional experiences in Leeds and York Partnership Foundation Trust, were that they generated "*ageless*" services for functional patients, then retracted back to "*all age*" services, then returned ack to "*age specific*" services.

What this means for us at RDaSH: Some regional and national experiences support retaining functional psychiatric care of older people with an Old Age psychiatry service, which is a supporting factor to the proposal made. It is recognised however that a larger number of older peoples wards in the country still have a functional and organic ward separation, and that a neighbouring Trust SWYPFT have recently completed a consultation and decided to move from a mixed ward provision to a separate ward provision.

Current wards offer individual rooms, so patients can access toilets and shower in their own room, and sleep in their own room (and not in a bay, or open ward area, with others). This supports eliminating mixed sex accommodation[12] obligations with same sex accommodation requirements being, "*Patients should not normally have to share sleeping accommodation with members of the opposite sex, should not have to share toilet or bathroom facilities with members of the opposite sex, should not have to walk through an area occupied by patients of the opposite sex to reach toilets or bathrooms (this excludes corridors), women-only day rooms should be provided in mental health inpatient units*."

What this means for us at RDaSH: Any of the proposed options can retain support of patient privacy, dignity, and RDaSH single sex accommodation obligations, including the mixed ward proposed.

RDaSH "Clinical and organisational strategy 2023 to 2028" [13] states that, "Patients will . . . be cared for a bed-based service local to where they live," and in contrast to some statements that clarify "where possible" this is unambiguous in not having such a condition. Further, RDaSH Promise 19 [14] is to, "End out of area placements in 2024." Rather than being out of Trust, for the strategic statement and promise to state care will be local to where they live, this requires local Old Age psychiatry bed based services.

What this means for us at RDaSH: Old Age psychiatry in-patient care (whether from RDaSH or using local care homes or Virtual Ward or alternative models) requires bed-based service offers in each of the Rotherham, Doncaster and North Lincolnshire localities.

As feedback has been obtained in terms of this options appraisal, all of our clinical care groups have stated their preference for place-based wards. Over two thirds of colleagues consulted as part of this options appraisal process (including all North Lincolnshire and Doncaster clinical and managerial staff) have expressed preference for a mixed ward model in each RDaSH geographical place. This proportional preference is one of the core reasons that this option is being advocated.

*There have been some concerns re the mixed ward model from Rotherham care group colleagues – which are summarised in Annex 2.

Carers detail difficulty in managing hospital visits outside of their locality, patients are impeded in testing out leave to their home and locality if placed in a bed out of their locality. RDaSH has signed up to John's Campaign [15] and supports carers staying with people living with dementia. Taxi costs have also been seen to be excessive, out of locality.

What this means for us at RDaSH: Carer support and patient community activities, and own home, are supported by local bed-based offers.

Admission to a bed base service can be distressing and can at times worsen a person's mental state, specifically in terms of people with dementia. However, the risk of remaining without an adequate support package at hoe is often the mitigating factor that prompts admission.

What this means for us at RDaSH: With the option advocated, funds and staffing will be released. Except for the savings that have been ringfenced by the Rotherham Care Group SLT – the remaining monies will not be used for savings, instead these will be used to invest in our 24-hour community services for older people in each locality, which will then increase the community options, with the aim of reducing the iatrogenic harm that can come from inpatient services being the only options in terms of risk management.

<u>Workforce Implications</u>

Any of the recommendations bring with them workforce/staffing implications, with differing implications. Given the recommendation for the one ward model based in the Rotherham locality, this would result in a change management process for Rotherham colleagues. The colleagues affected by the change management process would differ based on whether option 2a or 2b was progressed.

Irrespective of the option, the Trust will comply with our change management consultation processes and seek to minimise any anxiety which affected colleagues may face as a result of the change management process.

Any consultation would be for a minimum of a 30-day period and the Trust would seek to redeploy all colleagues to suitable alternative employment opportunities within the Trust, recognising the additional posts which will be available as part of the community investment.

Recommendation

The evidence base, national drivers, regional and local experience, and clinical presentation of old age psychiatry patients, supports care by specialist older adults' teams, in the closest place to home as possible.

On balance, determinants and outcomes are supported by a "Get It Right First Time" and "one stop shop" approach of a holistic single ward in-patient offer that can support both functional and organic aspects of old age mental health presentations – this is the rational for progressing a mixed ward across the whole RDaSH footprint.

Within option (2) that is advocated, readers will see a 2a – one ward remaining in a general hospital site in Rotherham (2b) one ward but moving to swallow nest with other acute wards (which is aligned with the model in NL and Doncaster) and 2c a one ward mixed option again, but with environmental changes.

At this stage the 'one ward' option is all that is being recommended. The movement to Swallownest Court and / or environmental changes can be considered as a 'next step' option should be this mixed 'one ward' per geographical area be agreed. An environmental options paper was produced by the Chief Nursing Officer, and was presented in Annex 3 of this paper, that supports discussions.

KPI's and monitoring –

As with any change we will monitor the effect of the change. We will monitor and review in a defined period the following 6 KPI's:

(1) Length of Stay (LoS)
(2) occupancy levels
(3) patient feedback
(4) carer / family feedback
(5) out of area / out of trust placements
(6) inappropriate internal trust placements

*Inappropriate would be where the patient would be cared for in Rotherham if there was a bed, rather than a patient who is from Rotherham who would not be cared in Rotherham due to other factors even if there was an available bed in the Rotherham locality.

As the work involves 2 strands –
(1) a single mixed ward model in each locality, (this is a primarily Rotherham focussed change)
(2) an enhanced community offer for older people across the Trust.

There are two KPI plans on the following pages that also link with the QSIA and EIA assessments for the change. Page 9 then details the monitoring routes and expected escalation through directorate, care group and executive routes consistent with other similar forms of care delivery in the Trust. Other KPIs linked with routine monitoring that will be considered include:-

- EDD identified within 72hrs of admission
- 90% compliance with EDD set – EDD may change with MDT review
- Any changes in prescribing by prescriber, ward, patient specific not limited to but: benzodiazepines, hypnotics, sedatives
- Restraint use changes – duration and amount to understand by personal characteristics and diagnosis
- Number of transfers to acute general hospital for physical health deterioration

KPI plan - Strand 1 – a single mixed ward model in each locality, (this is a primarily Rotherham focussed change)

Key Performance Indicator	Impact identified	Action required/explanation if none taken	Lead responsible for overseeing actions	Timescales	Costs (where applicable)
Reduce the risk of admission for Rotherham older people, aiming for admission rates (per head of population aligned with wider Trust)	Increased community provision for older people in care group	• Monitor Community Caseload and enhanced community provision use • Monitor admission rates (trustwide comparators) • Monitor Length of Stay (LoS) • Monitor caseload	Community Matron & Service Manager	9 months with evaluation entered at 12 months	Not applicable, expected as part of routine work
Ensure that the environment is the best it can be to cater for the needs of a mixed functional and organic patient cohort. Ensuring that the environmental standards adhere to Royal College recommendations.	Increased risk in terms of mixed occupancy, with previously being a separate functional and organic provision	• Environmental risk assessment • Monitor patient incidents • Spend time with Doncaster and NL inpatient leads who both moved from a separate to mixed ward provision.	Inpatient Matron and Service Manager	9 months with evaluation entered at 12 months	Not applicable, expected as part of routine work.
Ensure all staff are skilled to work with a patient group with mixed functional and organic needs. And Monitor staff experience of change	Improve staff knowledge base and confidence in working on mixed ward	• Training needs analysis – discussion with staff • Delivery of training sessions in handover and on half day learn sessions. • Inclusion of subject matter experts from backbone services (i.e. adjusted RRI for people with cognitive impairment) • Staff pulse surveys	Inpatient Matron and Service Manager Rotherham. For education & pulse – older people's specialists in Care Group/Trust & POD colleagues	3 months with existing staff, then integrated into new starter induction	Time costs – training would be expected by internal older people's specialists Time from L&D trainers
Ensure that admission lengths and treatment efficacy is aligned with other older peoples wards in RDaSH.	Current LoS is outside of the Trust average. This impacts on patient progress.	• Work to be undertaken with other similar wards in RDaSH to explore actions and efficacy of treatments that support the reduced length of stay. • Consultant Peer support to align treatment provision and focus on length of stay	Inpatient Matron and Service Manager. Rotherham OP Consultant Psychiatrist and Consultant Psychologist	With immediate effect Monitored by directorate delivery reviews	Not applicable, expected as part of routine work.
Ensure that carers and family members are informed of the change and supported with any impact of the change that occurs, whilst work on enhanced community support and reduced LoS is progressing.	Potential carer support impact if bed is unavailable in Rotherham and patient is moved to NL or Doncaster	• Individual Carer Assessment • Travel support plan • Communication support plan (i.e. via IPAD as used in some of the Doncaster rehab wards) • Carer experience	Inpatient Matron and Service Managers in all sites	With immediate effect With summary and review in care group business meetings.	There may be costs in terms of supported travel costs or device costs.
Ensure that patients are informed of the change and supported with any impact of the change (i.e. inpatient admission in other RDaSH facility) that occurs, whilst work on enhanced community support and reduced LoS is progressing.	Patient experience of mixed inpatient ward	• Via patient Via ward meetings • Via discharge questionnaires • Via Care Opinion • Out of area placement monitoring	Inpatient Matron and Service Manager Rotherham. Support from N&F backbone patient experience team & patient flow team.	With immediate effect With summary and review in care group business meetings and delivery review.	Not applicable, expected as part of routine work

KPI Plan 2 - an enhanced community offer for older people across the Trust.

Key Performance Indicator	Impact identified	Action required/explanation if none taken	Lead responsible for overseeing actions	Timescales	Costs (where applicable)
Improve the Older Peoples Community resource as including resources on weekends and evenings.	Increased community provision for older people (across trust)	• Monitor admission rates • Monitor caseload • Monitor contacts	Community Matron & Service Manager	9 months with evaluation entered at 12 months	Not applicable, expected as part of routine work
Improve understanding and experience of people with different diverse characteristics, in terms of older people's services.	Access and service use differs in terms of diverse characteristics meaning enhanced services may be felt more by some than others.	• Monitor use of inpatient and community older peoples service provision by protected characteristic. • Ensure that information is analysed and monitored at care group level and through the E&I sub-CLE meeting • Compare different geographical locality data to work together to target any gaps or share any positive practice	Community and inpatient matrons and service manager. Informatics teams re report	In Q1 25/26 then ongoing for 12 months	Not applicable, expected as part of routine work
Increase staff knowledge base and ability to work with older people in the community and utilise other community assets that may support admission avoidance.	Improved staff knowledge base and partnership working.	• Training needs analysis – discussion with staff • Delivery of training sessions in handover and on half day learn sessions. • Joint working with local authority partners in each 'place' • Review of crisis bed use and exclusion /inclusion criteria for resource. • Consider wider community enhanced care packages that could be made available to improve the community offer • Consider 'virtual ward' approach for OP services	For education – older people's specialists in Trust Joint work between service leads and locality local authority partners Discussions with other 'virtual ward' provision in the Trust in PHCG	In Q2 25/26 then ongoing for 6 months	Time costs – training would be expected by internal older people's specialists Time from L&D trainers
Improve patient experience of community mental health support (considering learning from patient feedback, complaints, compliments and also investigations and coroners' inquiries)	Positive / Improved patient experience of enhanced community provision	• Work with patient engagement partners • Work to define patient feedback mechanisms needed via care opinion and other feedback mechanisms • Ensure all community staff regularly seek feedback from patients • Ensure all patient experience data related to older people's community services is collated and feeds into this work.	Care group clinical and managerial teams. Support from N&F backbone patient experience team. Care opinion resource	With immediate effect With summary and review in care group business meetings and delivery review.	Not applicable, expected as part of routine work
Improve staff cover in community older people's services and monitor staff experience.	Improved staff experience of enhanced community model, with increased career opportunities.	• Via staff / team meetings and 1:1s • Via pulse survey • Via changes in working arrangements and community service provision • Via increased use of OP Talking Therapies Treatments	Clinical Leads and Service Managers Support from POD backbone services re pulse check.	With immediate effect. With summary and review in care group business meetings and delivery review.	Not applicable, expected as part of routine work

The table below provides the arrangements that are put in place to monitor and review the positive and adverse impacts of the two plans –

How will the impact of the service changes be monitored?	• Daily via clinical teams • Via care group directorate governance • Via trustwide delivery reviews • Patient and staff experience monitoring
What is the frequency of monitoring?	• Daily – clinical team • Monthly care group governance • Bimonthly – delivery reviews • Annual review of change • Patients experience monitoring reports (N&F) • Staff experience pulse checks and survey (POD)
How will the monitoring results be used and where they will be published?	• Directorate minutes • Delivery review data and out briefs • Clinical Leadership Executive (CLE) updates • Patient Experience reports – Q&S sub-CLE group • Staff Experience reports – P&T sub-CLE group
Who will be responsible for reviewing monitoring results and initiating further action where required?	• Matrons & Service Managers at a delivery level • Quadrumvirates at a Care Group level • Joint work between N&F and Care Groups • Joint work between POD and Care Groups
Who else have been consulted to consider change and review?	• Engagement with staff side colleagues • Engagement with internal and external stakeholders via HQTC taskforce • Engagement with clinical and managerial leads through Clinical Leadership Executive.

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ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Trust Bed Base – Forward Look to 2028	**Agenda Item**	Paper P
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	27 March 2025

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

There have been several Board discussions regarding the RDaSH bed base, including the closure of 2 wards in the last 2 years to then reinvest in assertive outreach services in the communities of both Rotherham and Doncaster. We will also be discussing at this March 2025 Board the older adult mental health service provision.

The focus of this paper is the adult mental health inpatient provision (i.e. 5 wards), so excluding older adult and PICU. We have provided a series of bed modelling scenarios' which if we remain at current level of admissions; length of stay, occupancy rates and delays in discharge then we need 19 more beds than we have on any given day.

We discuss in more detail through the modelling and a broad outline of the intensive work required address the complex matter of length of stay (LoS). This would be a key lever to create more capacity (reflected in an increased number of discharges) to suggest we can then meet the demand for adult mental health inpatient need within our current bed base. However, we note some of the risks in achieving this outcome.

Even with a significant amount of work towards reducing LoS we will certainly not be able to close any of the current adult mental health wards for the period of the current Trust Strategy.

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

SO.4 SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other setting	x

n/a

Recommendation

The Board is asked to:

x	NOTE that there will be no further ward closures in adult mental health for at least the period of the Trust Strategy
x	NOTE national policy imperatives to reduce LOS in acute mental health.
x	RECOGNISE ongoing work to that end.
x	RECEIVE regular tracking data against our occupancy, bed days and average LOS (potentially IQPR)

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

Trust Risk Register		n/a					
Board Assurance Framework		SO4					
System / Place impact	x	Note discussions on OOAP					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	OOAP prior to decision

Appendix (please list)
Appendix 1 Bed Modelling

Trust Bed Base – Forward Look to 2028

Introduction

Throughout the Board's discussions in 2024/25, there have been regular conversations about the RDaSH bed base, including a significant discussion in September 2024. Additionally, numerous conversations about the bed base have taken place in other forums, such as the Clinical Leadership Executive, several of the Board sub committees and the now established High-Quality Therapeutic Care Task Force (HQTC). This paper continues this dialogue.

Over the past two to three years there have been significant strategic decisions about ward environments. For example, the successful closure of Emerald in October 2024 for reinvestment in community assertive outreach teams in Doncaster, as part of the national and RDaSH "home first" strategy. This was similar in 2023/24 with the closure of Goldcrest, in Rotherham for the same objective. This is alongside intensive discussions with both ICBs about investing in "local" specialist inpatient facilities such as a High Dependency Unit (HDU), ABI (Acquired Brain Injury) unit, Supported Living in partnership with the VCSFE, Specialist Rehabilitation and Eating Disorder services.

In today's Board meeting, there is another paper to separately address the emerging model for Older Adult care, including recommendations on the bed base, as we look to align ways of better supporting older age patients. Likewise, PICU provision will be explored late in Q1 2025/25, so this papers focus is primarily the adult mental health bed base (five wards).

We have previously had Board papers presented on the development of the High-Quality Therapeutic Care Task Force (HQTC) which started in February 2025. The task force's primary focus is RDaSH Strategic Objective 4: "Deliver high-quality, therapeutic bed-based care on our own sites and in other settings". A key measure for this work, alongside improving patient outcomes, is the reduction of out-of-area placements (Promise 19), which will be again discussed in more detail at the May 2025 Board meeting.

While HQTC will discuss the bed offer, we must recognise that this "think tanks" remit is much broader and will be focusing not only on the quantity (i.e. bed base) but also on the quality of care. It is imperative we focus on the quality of personalised care for every single patient, alongside the "flow" of patients and the fiscal management of the inpatient provision.

This paper will set out some broad parameters for the RDaSH bed base using bed modelling scenarios; aligning to other RDaSH Promises. However, the primary intention

will be ensuring we do have sufficient inpatient provision for those times when people need a high-quality inpatient bed, within a *therapeutic milieu*.

The key variable within the bed modelling in this paper will be adjustments to Length of Stay (LoS). We have agreed in RDaSH we measure LoS as the difference in days between the start date and end date of inpatient spells. This is monitored at discharge, taking the median LoS for each inpatient area separately.

In the paper we will have three scenarios which have an increasing ambition regarding LoS. This is followed with a brief outline of some work that will need to be undertaken regarding LoS, however, it is prescient to say that LoS is a multi-faceted and complex issue, which will require a significant systems and cultural change. This means it is both a people and process change that is required and an important element will be the **clinical** engagement and leadership for this piece of work.

The timing of this paper also considers the "NHS 2025/26 priorities and operational planning guidance" – and while a reduced set of metrices one of the national priorities' states, "improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds" (page 7). We will be reporting against this metric, and it may become an 11th metrices to join the RDaSH "top 10". It is worth noting there has been national feedback on the way NHSE have defined LoS and so this may change.

Finally, as a Board we need to attend to the anxiety that closure of wards can create in both staff, patients, partners and community and with the closure of two wards in two years, to date, then the narrative can potentially become skewed by this system anxiety. In the conclusion we need to clearly state the intent on the bed base for adult mental health for the remaining period of the Trust Strategy.

Discussion

The Clinical Leadership Executive discussed our bed model in July 2024, and subsequently at Board in September 2024 with a paper, titled, "26 September 2024 - Our Future Bed-Based Care Arrangements – Update."

It relevant to remind the points in this paper in paragraph 4.3 which states:

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

- *We will have fewer older peoples' beds within our bed base in future* (on the March Board agenda)
- *Unless we can reduce our admitting rate and LOS, we would need more acute beds, but*
- *The implication of meeting closer to average rates of admission and LOS would make it possible to accommodate out of area placements without additional beds*

- *We need further discussion and debate about the role of PICU beds within our organisation before we can determine how many beds we need, where they might be, and how gender / safety is best managed."* (Emerging discussions in the HQTC with support from the Provider Collaborative)

Previously the bed modelling based on the 23-24 data showed that if all things remained equal (admission rates, occupancy rate and LoS) there is an ostensive deficit for working age adults' inpatient provision (22 beds on a given day).

We have now updated the previously bed modelling with the most recent 24/25 data and we have then devised 3 bed modelling scenarios, focusing specifically on adult mental health wards, which you can refer to in **Appendix 1**

We are modelling on a **projected 92% occupancy rate**. The national target is 85% which feels ambitious as for adult mental health wards nationally it stands consistently at between 98-100% occupancy, which is the case for RDaSH. The 92% (or below) feels a balance between the two occupancy rates but the move from 100% to 92% will still have to be achieved through the reduction of LoS, a reduction in admissions or a combination of the two.

Scenario A – At a 92% bed occupancy, current admission rates and *current LoS* for adult mental health then we are at a deficit of any given day of 17.4 beds. This is a small improvement on the data presented in September 2024.

Scenario B – At 92% bed occupancy, current admission rates but we significantly *reduced LoS to 32 days maximum* (the national benchmark). Noting Mulberry are already at 22 days, this would lead to a break-even position across all 5 adult mental health wards. It is worth considering the other variables of admissions and bed occupancy rates in this scenario.

Scenario C – If we reduced admissions in Rotherham and North Lincolnshire to the ONS national average of 2.14 per 100k ONS residents and reduced LoS by 5 days in Doncaster (on two wards) we would again achieve a break-even position.

We have also done some basic modelling which will need further work but if we consider that we essentially need 3 more discharges, per week, across the 5 wards in total this would mean we achieve the 32-day median LoS.

I do want to add a point of caution that the bed modelling is just a way of articulating what could be achieved, but in turn do not want to oversimplify what needs to be happen, particularly in terms of the mental health environment. Tackling LoS on wards generally and on mental health wards has been a national issue for many years.

Addressing Length of Stay

As part of the wider HQTC programme, we are planning to run a programme of work around LoS, which will need to address both cultural change alongside systems and process change, including work with partners. This will need to be clinically led, with a particular emphasis on the emerging multi-professional leadership model at the acute ward level, where medical colleagues will play a central role.

The aim of the approach is to develop safe interventions to reduce LoS, while improving care in acute mental health settings and fostering a positive change among staff. Success will be measured by reduced LoS, fewer clinically ready for discharge (CRFD) patients occupying beds, and more clinical time dedicated to therapeutic interventions but these success measures need to be formerly identified by teams.

Overview/approach

A key principle is that all ward environments should operate consistently, ensuring uniformity in processes and therapeutic care. We will need to ensure that this is enshrined in SOP's and policy, along with the leadership and a therapeutic environment on the wards.

All this work on LoS (and other work in this domain) across the adult mental health wards will need an approach of "one Trust". We will want a patient accessing and leaving a ward in North Lincolnshire for it to feel the same as a ward in Rotherham. This means we will operate the beds, similarly as one Trust (or even one hospital..) but the wards are situated at Place to ensure people can be cared for as close to home as possible, but there is some flexibility to adjust when required.

Key objectives will be:

- Plan for discharge from the start – This will mean that from outset there is a clear purpose for admission, not just "for risk". This will need to be diagnostically led. Clear EDD in place within 24hrs of accepting admission of patient and define protocol for how the EDD is met avoiding delay and involve patients and their families in discharge decisions, early on.
- Embed multidisciplinary team review/ consistent working across the teams - including input everyday (current variation in approach) daily reviews with task focused ward teams. Each daily bed round is approximately 45 minutes in length, with a longer more in-depth meeting held each Friday with the full MDT and CRAC team present to discuss complex cases and have team ownership of risk. We need to ensure community teams are reaching into the ward, in effect seamlessly integrated when <u>their</u> patients are receiving inpatient care.
- Establish systems and processes consistently – PIPA/MDT/EDD Planning – a key element of this will be a DASHBOARD and digital process – so daily oversight.

This will include Trust wide as well to be able to look at variations. Visual management tools at ward level are key to this programme.

- Consider implementing Red – Green bed days - 'Red and Green Bed Days' are a visual management system; this is now established in several larger mental health Trusts (eg Cheshire & Wirral; LSCFT) – there is variable feedback for effort verses impact so will need an options review.
- Focus on purposeful and safe discharge with partners - review local CRFD process; Place MADE events and complex CRFD Trust wide process – to develop a Trust wide standardised approach. This will need wider partner engagement (consider alignment to Align to Statutory Guidance on Discharge from mental health inpatient settings (DHSC January 2024))
- Operating discharges over 7 days per week (currently 4.5 days) will be a key recommendation and action required. We admit 7 days per week, often into a leave bed over weekends and so we correspondingly need to be able to discharge 7 days. We will need to work with partners; RDaSH community teams, the wards and VSCFE to be able to achieve this safely.
- Work on the right care, right time, first time ethos. Encourage a supported 'Home First Approach – Promise 13 (connect to other workstreams). We need to be supporting more patients in the community. Do we enhance other community teams such as Home Treatment Teams who can support patients in and out of inpatient settings. This will link with admissions work led by Dr Sinclair and will require active systems working as we move to supporting more complex patients within the community.

How will we go about this? We will most likely need to start on one ward and test an approach to LoS, which is developed in advance. This will need to have a "visiting team" (is this the HTQC help team?) who will need to be very present for a minimum of 4 weeks to embed and learn. This will need to include senior clinicians, perhaps overseen by clinical executive who can support the teams to work differently on the ward. They will need clinical seniority to bring in challenge and clinical rigour. We will need a "receiving team" from the ward which will likely be the acute directorate leadership team, who will then continue to implement and mobilise the learning for changes required.

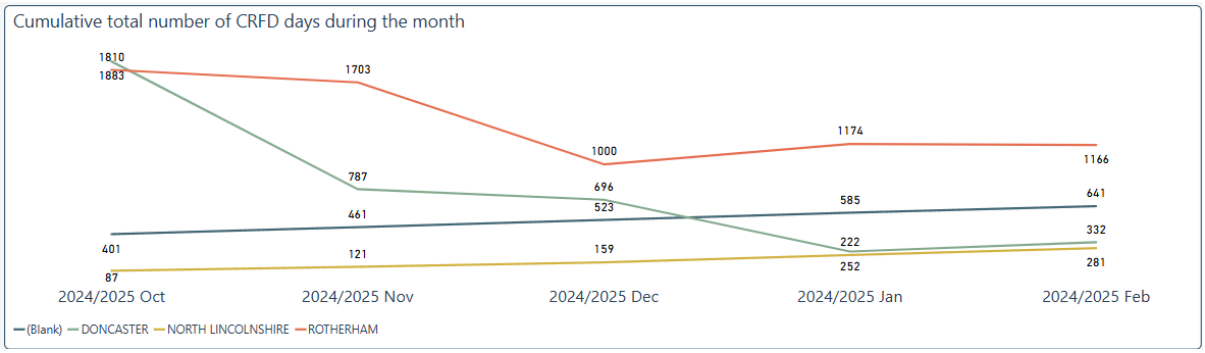
The key will be sustaining any improvements and for these reasons I would anticipate this is a 12-month programme before business as usual to embed different ways of working.

Clinically Ready for Discharge (CRFD)

This is when someone is deemed clinically (medically) optimised on a ward and so can then return to the community, wherever that is, for their treatment or care. There is

clear research that the longer people who are deemed CRFD remain on the ward (delayed CRFD) can then be clinically retrogressive. This also means someone remains in a bed, whose recovery is better placed in the community and is a bed which could be used for someone in an acute mental health presentation.

This has been a focus of the COO, Flow Team and Directors of Nursing and we have seen some improvement. This includes setting up a monthly Complex CRFD forum, which started in October 2024, with a focus on those patients while CRFD but have a complex discharge which is often needing a placement which is not easily available. This forum is with a senior manager from the 3 local authorities, chaired by the COO.



Rotherham - Decrease in number of CRFD bed days lost by 35.6% from 1,810 in October 2024 to 1,166 in February 2025.

Doncaster - Decrease in number of CRFD bed days lost by 82.4% from 1,883 in October 2024 to 332 in February 2025.

North Lincolnshire - Increase in number of CRFD bed days lost every month from October 2024 to February 2025 with 87 and 281 days lost respectively.

While progress has been made, particularly in Doncaster, there is still a way to go. Housing, or lack of it, has often been cited as a key issue alongside access to placements and Care Home provision, particularly in Rotherham and then availability of social workers.

Conclusion

There has been substantial operational work undertaken to improve the number of discharges in the last year, such as a CRFD forum with all three Local authorities. The Patient Flow team are also working more closely with community teams to consider any safe alternatives to admission and have developed a risk prioritisation tool, but its early days.

However, to bring about a significant change in LoS we will need a determined clinical focus on how patients enter and leave the ward, and the therapeutic intervention they receive. I have emphasised this this will need to be clinically led but there is concern

that, with acute care medical vacancies, and leadership gaps within the disciplines, delivery of LoS reductions sustainably may prove challenging.

We also need to note other risks to this ambition. There is a significant amount of Capital Work this year in the wards, through the door replacement programme, and in North Lincolnshire through the Great Oaks Capital Programme three and four. The latter will reduce the bed base for potentially six months. For example, if Mulberry moves to Laurel ward, temporarily, then this will be a reduction of four adult mental health beds. An additional risk lies in the disparity between the funding arrangements for South Yorkshire and Humber and North Yorkshire Integrated Care Boards (ICBs). As RDaSH is anticipated to hold the funding the OAP for South Yorkshire patients from April 2025 this has to date not been agreed with HNY. We will conduct LoS work on all our wards, systematically but not the risks these different funding arrangements bring in.

I think it is clear from the data, we currently need more adult mental health beds if things remain the same (admissions, LoS and high occupancy). Even with significant work that is anticipated including LoS, we will be able to just about meet demand for inpatient beds. This means we will not be able to close any more adult mental health wards within the period of the current Trust Strategy ending in March 2028.

Potentially as we work to drive down OAPs we may need to consider some interim measures of some temporary additional beds locally, as we work to both repatriate the current 25 people in inappropriate OAPs and ensure other patients remain locally, unless there is a clinical imperative for an OAP. This will be explored in the May Board paper.

The Board is asked to:

NOTE national policy imperatives to reduce LOS in acute mental health.
RECOGNISE ongoing work to that end.
RECEIVE regular tracking data against our occupancy, bed days and average LOS.
NOTE that there will be no further ward closures in adult mental health for at least the period of the Trust Strategy.

Appendix 1

Bed Modelling - Scenario A

Current position based on FY 24/25 data.

Adult Mental Health

Rotherham	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Sandpiper	18	34	184	6570	471	5785	785	2.2	72	41	2952	-2.1	-3.6
Osprey	18	31	180	6570	396	5184	1386	3.8					

North Lincs	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Mulberry	17	22	246	6205	687	4725	1480	4.1	79	27	2133	-1.8	-3.1

Doncaster	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Brodsworth	20	57	139	7300	789	7134	166	0.5	94	43	4042	-9.1	-10.7
Cusworth	20	48	156	7300	735	6753	547	1.5					

Backing Data

		Median LoS	Leave days	OAPs
Sandpiper 24/25	Admissions 184	34	471	72
Osprey 24/25	Admissions 180	31	396	
Mulberry 24/25	Admissions 246	22	687	79
Brodsworth 24/25	Admissions 139	57	789	94
Cusworth 24/25	Admissions 158	48	735	

Bed Modelling - Scenario C

Admissions reduced in Rotherham and North Lincs to ONS National Average of 214.72 per 100k ONS resident. LoS reduced by 5 days in Doncaster.

Adult Mental Health

Rotherham	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Sandpiper	18	34	113	6570	471	3371	3199	8.8	72	41	2952	10.2	8.7
Osprey	18	31	113	6570	396	3107	3463	9.5					

North Lincs	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Mulberry	17	22	210	6205	687	3933	2272	6.2	79	27	2133	0.4	-1.0

Doncaster	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Brodsworth	20	52	139	7300	789	6439	861	2.4	94	43	4042	-5.1	-6.7
Cusworth	20	43	156	7300	735	5973	1327	3.6					

Bed Modelling - Scenario B

Current position based on FY 24/25 data but with LoS reduced to 32 days maximum across areas with higher LoS.

Adult Mental Health

Rotherham	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Sandpiper	18	32	184	6570	471	5417	1153	3.2	72	41	2952	-1.1	-2.6
Osprey	18	31	180	6570	396	5184	1386	3.8					

North Lincs	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Mulberry	17	22	246	6205	687	4725	1480	4.1	79	27	2133	-1.8	-3.1

Doncaster	Beds	Median LoS (days)	Annual admissions	Bed days available (100% occupancy)	Leave Days	Bed days required	Variance - Current LoS	Bed variance (100% occupancy)	OAPs 24/25	LoS	Bed days required	Remaining bed variance (0 OAPs)	Bed variance (92% occupancy)
Brodsworth	20	32	139	7300	789	3659	3641	10.0	94	43	4042	7.2	5.6
Cusworth	20	32	156	7300	735	4257	3043	8.3					

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	**Health and Safety Update including Ligature Risk Assessment Review**	**Agenda Item**	Paper Q
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer and Izaaz Mohammed, Executive Director of Finance and Estates		
Report Author	Christopher Pym, Matron – Practice Development & RRI Jill Cross, Health and Safety Lead Shaun Doyle, Fire Safety Officer		
Meeting	Board of Directors	**Date**	27 March 2025

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

The Board discussed 23/24 the Health and Safety annual update in September 24. This report flagged concerns about progress and governance within the health & safety annual report. This paper seeks to outline what has been done since October. Encouragingly, we expect to have no fire safety risk assessments outstanding from April. All ligature assessments have now been completed, and no major capital issues have been identified requiring funding from April 2025. Health and safety work now reports to the CLE sub-group focused on risk management. This provides monthly oversight of actions, issues, and resolutions.

Looking ahead to the 25/26 year the Board should be sighted and clear on the proposed areas of focus including our water safety plan, air ventilation quality/safety and food safety reports. In addition, the continuation of work to enhance our lone working policy and to further support the improved reporting culture and response to violence and aggression to staff. Our Appropriate Behaviour Policy will be further embedded. The Board should discuss and reflect on these plans and areas of focus in seeking confidence in the grip and direction for the forthcoming year in this important area.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
Business as usual	X

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

Data has been presented throughout the year to sub subs of CLE: H&S Forum -> CLE -> POD

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

The Board of Directors is asked to:

X	**RECOGNISE** work done since October 2024 – with approximately six months intensive improvement yet required
X	**NOTE** advice that there remain no major capital dependent ligature or other safety steps
X	**ACKNOWLEDGE** the unresolved issue of staff safety and security and agree to discuss this further in May 2025
X	**TEST** whether sufficient executive grip is in place over these matters

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

Trust Risk Register	X	FP 7/23, FP12/19, FP24/23, NF 22/24, NQ 1/20, NLCG 11/23, RCG 1/24, RCG 13/24, FP 23/23, HI 19/24, FP 15/23, FP 18/23, NF 12/24					
Board Assurance Framework							
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

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

Rotherham Doncaster and South Humber NHS Foundation Trust

Health and Safety Update including Ligature Risk Assessment Review

Report Authors:

Jill Cross
Health and Safety Lead

Christopher Pym
Matron – Practice Development & RRI

Shaun Doyle
Fire Safety Officer

March 2025

1. Introduction

This report articulates how the organisation, through delegated responsibility to the Chief Nursing Officer, via the Chief Executive is legally compliant in relation to health and safety, fire and security, under the Health and Safety at Work Act (1974) and associated regulations. The Trust must comply, to reduce the risk of harm to employees, patients, and other visitors in the workplace.

The 2023/24 annual report for health and safety highlighted areas which required focus and targeted actions to address areas of risk to our compliance.

2. Assessment – Health and Safety

2.1. Governance and escalation

A significant review of the structure within the governance escalation within RDaSH was undertaken by the Chief Executive. The result has improved the visibility across the organisation, specifically at Clinical Leadership, where members have clear line of sight from ward to board, on matters relating to H&S, via the Risk Management Group.

2.2. Health and Safety

Positive recordings on compliance with health and safety training (96.9%) must be noted. Alongside commitment that all H&S inspections are scheduled to be completed by the end of March 24.

2023/4 year annual report identified from health and safety inspections, the following:

- **H&S Risk assessments**
  In some areas these were not always available. Data has been compiled from inspections and shared with Care Group Leads for oversight and action. Feedback is now provided to the Health, Safety and Security Forum.

- **Training**
  Some activities require additional training, mandatory fire, health and safety, including safe use of oxygen. Inspections identified that some areas were not trained.

- **Oxygen training**
  A proposal has been made to develop a competency booklet for oxygen training awareness and signed off by manager as read and understood.

- **Triangulation of Health and Safety, Security and Fire**
  The Fire Safety Advisor now submits a fire safety paper to the Health, Safety and Security Forum and contributes information to reports such as this (**see below 3.3**).

- **Violence Prevention & Reduction standard**
  Since the beginning of January there has been attention to the standard to provide a framework for reporting, governance and leadership of preventing violence and aggression within the organisation. There is an agreed reporting structure through the patient safety, POD report and through our sub–CLE Safety and Quality group.

  Since the appointment of the trust lead for VPR there has been engagement within the care groups to focus on themes and trends, advice and review of complex management in care and particularly focus of supporting colleagues and patients when the patient is either secluded or segregated.

  At the beginning of March 25, the 360-audit assurance commenced an audit with a scope of the VPR benchmarking.

  This month, our VPR Lead, Chris Pym has met with an external security management specialist who has reviewed the VPR benchmarking tool kit against us. Positive observations have been noted with a reporting structure in place and nominated board lead.

- **Non-Executive Director for staff safety and security champion update**
  The Board in September 2024 agreed the three priorities in relation to the NED staff safety and security champion:

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

  Work has not stalled and continued throughout the year enhancing our lone working policy, to this point we have seen risks scores improve. As an example the estates staff lone working risk has been removed due to the mitigation and adequate controls put in place.

  We have also worked with people safe to trial the additions to our use of our 250+ lone working devices already existing within our clinical areas. This includes the use of their app which is being trialled by myself, and the new 4g ID badge is piloted for 20 RDaSH staff in different teams.

  Finally, Dr Graham has been instrumental in the launch of the appropriate behavioural policy. As such we have seen a continued reporting culture in relation to violence and aggression in staff and it should be noted there has been a specific focus 24/25 on racial assaults.

2.3. Fire Safety

All fire risk assessments (c120) are scheduled to be completed by the end of March 25. The Trust continues to work closely with South Yorkshire Fire & Rescue Service for advice and guidance in areas of fire safety and will review the frequency of fire risk assessments in 25/26 to reflect building risk and guidance from the fire service on best practice. Assessments carried out in 24/25 show high compliance with

evacuation procedures, fire drills, signage, fire alarms, suppression systems, management of dangerous substances, and fire door inspections. The three areas of focus which demonstrate partial compliance are fire compartmentation, fire damper testing and fire hydrant testing.

Although the Trust has addressed most fire compartmentation improvements via capital budgets in recent years, some further work is required in the 1960s building stock which includes Hazel, Hawthorne & Magnolia wards. The board approved the 25/26 Capital Programme in January, and this included the continuation of fire safety works to improve compartmentation in these areas.

The Trust has a small number of ventilation ducts that house dampers, and there is a need for more routine testing of these. The Estates department is working to a May 2025 timescale to move all planned preventative maintenance (PPM) on to the new estates maintenance system, and this testing will form part of the regular testing carried out by the maintenance team. External support from specialist contractors is also being sourced to support the work of the in-house team.
Fire hydrant testing is another area which will be addressed through better management of PPM via the maintenance system and is already being progressed.

In addition to the informal support and visits conducted by South Yorkshire Fire & Rescue in 24/25, the Trust is expecting a more formal assessment of its fire safety in 25/26. Reporting on the fire safety improvements mentioned above will be reported via the Estates & Sustainability group into CLE.

Emergency lights
Annual testing of the lights indicated the need for some remedial work. The work is currently being addressed by external contractors via the Estates Maintenance Team. It is proposed that all in/outpatient areas, high risk areas (laundry, commercial kitchen, workshops, stores) and buildings with more than two floors be tested monthly. All other small single storey buildings to be tested every three months. This is to be recommenced as a part of PPM.

2.4. Security

Last year's annual report highlighted a lack of awareness of the lockdown policy and arrangements in some areas. Work has been undertaken and is on-going to ensure that lockdown drills are carried out, with the support of the Security Advisor. Compliance levels are currently around 99% for the two-year lockdown procedure discussion and 70% for a physical drill that should be undertaken every five years.

There have been two reports of vehicles stolen, as well as suspicious activity seen, including theft of property from vehicles and the removal of car number plates in Doncaster. There are also reports of excess speed and vehicles being driven the wrong way around the one-way system at Doncaster main site. Two traffic accidents have occurred resulting in two employees being injured. An investigation is being undertaken to review the traffic management and security arrangements.

3. Ligature assessment update

In 2024 the organisation responded to the planning and implementation of positive change and improving patient safety, the environmental part of this included compliance in our ligature risk reduction programme:

- A clear projection/schedule of ligature risk assessments in all patient areas.
- A governance structure to enable oversight and follow-up of ligature outstanding actions.
- High priority risk assessment in patient areas relating to ward bedroom, bathroom doors and dispenser units.
- A review of the 'Ligature Risk Reduction' policy and inclusive of the CQC ligature point assessment from the CQC single assessment framework: safe environments published 2023.
- Appointment of designated lead for Ligature work plan – Chris Pym. This position has a strong link with operational support with respect to reducing restrictions, risk assessment and care planning, involving our communities, patient and families. With close attention to *promise 4, putting patient feedback at the heart of how care is delivered in the trust, encouraging all staff to shape services around individuals' diverse needs*. This is currently undertaken via multimodal feedback received from peers, volunteers, care opinion and incidents (IR1s).

4.1. Bedroom doors

In 2024 a comprehensive audit of inpatient doors was conducted to review the suitability of existing anti ligature doors installed at the Trust as part of capital projects over recent years. This audit concluded that the existing (recently fitted) anti-ligature doors were suitable and provided sufficient mitigation against ligatures and barricades. The doors also include digital fob access. The 24/25 capital programme has continued to replace bedroom doors for the remaining wards, with Kingfisher due to be completed by March 2025, and Windermere to be completed in Q1 of 25/26. Mulberry and Laurel wards will be installed during the Great Oaks Phase 3 & 4 refurbishment works.

4.2. Bathroom doors

Our current saloon doors were fitted to ensuite areas. However, due to their design, these came with problems. People leaning on them and falling, repetitively coming loose and then left in the bedroom, which caused privacy and dignity issues.

The board decided to replace the en-suite saloon doors with an alternative, this was due to their robust design and anti-ligature compliance. Amber, Cusworth, Brodsworth, Windemere, Skelbrooke, Kingfisher, Sandpiper, Osprey, Mulberry, Laurel, Brambles and Glades, all received new en-suite doors to replace the existing saloon doors. The work started September 2024. **All areas that were identified are complete (we have submitted a joint award submission for our design and rollout across all our inpatient wards).**

4.3. Dispensers in patient rooms

Following a ligature risk review in clinical areas, the team escalated the concern in the Environment Risk in Clinical Areas group (ERICA) the fixed anchor points. This is where soap, towel and tissues dispensers were screwed to walls and posed a significant ligature risk. All of these have now been replaced with the Yewdale magnetic back plate in the Trust Mental Health Acute wards. Older adults remain unchanged at this stage and the risk controls are mitigated via the ligature risk assessments.

January 2025, Chris Pym conducted a further review, specifically Amber Lodge. The outcome being, an investment bid to remedy ligature points in relation to fixed anchors was approved, work commences and the schedule of work will be completed by the end of April 2025.

Note the assessment of risk and ligature risks, be it fixed anchor points or otherwise, is dynamic and will be assessed in the moment of an incident, as part of regular handover checks, weekly ward audits, matron spot checks, observational feedback from staff, patients, carers, other professionals, through to the formal ligature risk assessment, ***this is not static and should not be read as such.***

4.4. Outstanding actions – Garden spaces

In Q3 we received an anonymous concern regarding the garden spaces at Swallownest Court, Rotherham Care Group. In response to this the site was assessed and support to the care group facilitated by estates and backbone services. This resulted in investment into the areas highlighted. Addressing the specific anonymous concern of the elevated fencing within courtyards. A new anti-climb fence has been ordered to address the two areas of identified risk, which has been managed and mitigated over many years by risk assessment and staff observation.

4.4.1 Kingfisher

The fencing currently has a cloaking that was fitted historically on the outside of the lower part of the fence. From assessment this should have been fitted on the inside and extended to the top of the fence. This would reduce the currently known and mitigated risks. The cloaking was fitted to preserve privacy and dignity of patients, as the area would otherwise be visible from a public walking path, where there have been previous incidents reported of items being thrown at patients and abusive language directed at staff and patients.

Current mitigation - The garden area is open to all patients to access fresh air and supportive of reducing restrictive practice. When patients utilise the outside space, this area is always monitored by a member of staff.

4.4.2 Shared Garden area

This area is currently locked due to risks associated with absconding (high). Replacement anti climb fencing has been ordered and manufactured, with work being completed in April 2025.

5. Recommendations

Health & Safety

- The Board are asked to note the information, positive action taken and safety management arrangements in place to monitor legal compliance.

- A review of traffic management and security arrangements at Tickhill Road is recommended.

Ligature

- Ongoing monitoring and review of dynamic environmental ligature risks that are both fixed and non-fixed ligature assessments.
- Ligature risks were previously reported to ERICA/Harm free Care Group. There is a review being undertaken to rationalise meetings. Ligature assessments and risks are given scrutiny within the Health and Safety Group, which escalates risks to RMG which reports to CLE.
- Windermere: an operational plan is devised with the care group leadership and estates to provide a project plan for bedroom door installation.
- **Woodlands** – Glade ward will need to be a review of door replacement.
- **Garden spaces at Swallownest Court** – There is a working action group focusing on outside spaces in mental health wards.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Apprenticeship Levy	**Agenda Item**	Paper R
Sponsoring Executive	Carlene Holden, Director of People and Organisational Development		
Report Author	Carlene Holden, Director of People and Organisational Development		
Meeting	Board of Directors	**Date**	27 March 2025

Suggested discussion points

In May 2024 the Board discussed the apprenticeship levy, and significant changes to our recruitment work took place from autumn 2024 to try and increase our uptake. This moved the Trust away from a legacy focus on high-earner apprenticeships, to a more balanced focus across grades and professions. The move to 'apprentice first' has had mixed success but shows some promise. Unfortunately, we will not meet the levy in full for 2024/25.

This paper focuses on the steps needed in coming weeks to increase uptake among existing employees and to require recruitment of people to apprentice-dependent roles. The promise is now subject to enhanced scrutiny to support quantified changes in delivery and ensure that we meet our commitments. Consistent with our values we will be sharing some elements of our levy with VCSE partners – and will update the Board in May on our work to create access programmes relevant to this promise, over and above work done to deliver betterment through making our existing approaches more inclusive.

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 to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Business as usual	X

Previous consideration

Not Applicable

Recommendation

The Board of Directors is asked to:

x	**NOTE** the work done in 24/25 to deliver the promise and progress in supporting lower banded roles into training
x	**RECOGNISE** the step up needed between April and July to deliver promise 9 during 2025/26
x	**ASK** the Board's POD committee to track progress against an expectation of significantly increased apprenticeship take up in Q1 and Q2
x	**NOTE** the work being done by the Director of People & OD and Chief Executive to develop the four structured access programmes for vulnerable groups outlined in our success measures

Impact

Trust Risk Register							
Strategic Delivery Risks	X	SO1, SO2, SO5					
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

Not Applicable

ROTHERMAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Apprenticeship Levy update

1.0 Introduction

1.1 Our work to exceed the Apprenticeship Levy has been progressed this year with an increased focus in May 2024 we discussed a revised recruitment approach, Apprentice First to further increase our levy spend but more importantly to support our lower banded colleagues in accessing the levy and improving their career opportunities.

1.2 Our commitment to exceed our Apprenticeship Levy spend is a Trust Promise – Promise 9 in which we are committed to exceeding our levy spend by 2025, disappointingly this will not be achieved in 2024/25 financial year.

1.3 The purpose of this paper is to update on progress during 2024 and our plans for 2025/26 to further increase our levy spend and to deliver on Promise 9. This paper also links with Paper X (Promises and Priorities Scorecard – Year End Report) which is also on the agenda and summarises progress against all the promises.

2.0 National Context

2.1 Nationally the landscape and framework are changing, with the government announcement the Apprenticeship Levy will be replaced by Skills and Growth Levy which will be overseen by the newly formed Skills England who will ensure training aligns with current skills gaps.

2.2 While apprenticeships are an invaluable route to developing skills and gaining qualifications, they are not always the best fit for everyone. For example, a colleague in the middle of their career who wants to improve their data and digital skills may prefer to take a short training course instead of spending one or more years doing an apprenticeship and previously this wasn't an option via the levy. Many industries, including Health, called for the Apprenticeship Levy to change so employers could fund other types of training, such as shorter, modular courses focused on upskilling and reskilling staff, in addition to apprenticeships. It is hoped that the new levy will address some of these challenges.

2.3 The new scheme will launch April 2025 and whilst the full changes and guidelines haven't yet been published, there have been recent announcements, indicating the future strategy will include:

- Shorter Apprenticeships (from August 2025): The minimum duration will be reduced from 12 months to 8 months, allowing learners to qualify faster while maintaining quality.

- Functional Skills Reform (from February 2025): Employers will now decide whether adult apprentices (19+) need to complete Level 2 English and maths.

2.4 We anticipate this will have significant benefits to widening participation in apprenticeships however we need to be mindful that professional regulators may still insist on these base level qualifications.

2.5 As part of the new scheme we understand the following will also apply

- Flexible 'Growth and Skills Levy' Ability spend up to 50% of their levy contributions on non-apprenticeship training.
- Transfer unused apprenticeship levy funds over to another business to pay for apprenticeship training and assessments has increased from 25% to a maximum of 50%. Transferring levy funds is a way of supporting partners across systems to allocate funds that support communities and staff. Levy transfer also ensures that any unspent funds that are due to expire are distributed in place rather than returned to treasury.

3.0 Current Position

3.1 We are forecasting a 73% spend on our levy entitlement for 2024/25, which is above the national 55.5%[1] average spend. Within our ICB footprint the highest levy spend sits with Barnsley Hospital at 84%. However, ultimately, we are aiming high and have committed to fully spending our levy, moreover we aspire to be exemplar in this space, we have identified ways to increase our levy spend to make up the 27% underspend in 2025/26.

3.2 The following table provides an overview of the current financial position in relation to the Apprenticeship Levy.

Current Funds in Levy	Levy budget for 2024/25	Actual Spend Q1 – Q3	Projected spend Q4	Planned total spend	Levy underspend
£1,432,763	£750,618	£418,478	£131,247	£549,725	£200,893

3.3 Table 1: Levy financial position 2024/25 taken from Digital Apprenticeship Service (DAS) Account and Levy Financial Data report for NHS England.

3.4 The levy budget is determined by our pay bill. Our reduced vacancies and annual national pay award, our move to the real living wage in April 2025 directly influences and increases the levy budget. The trust wide levy budget for 2025/26 is expected to be at least equal to this year (£750,617) but will be higher due to the reasons already stated.

3.5 Following the launch of Apprentice First in September 2024, to date 20 colleagues have accepted a post with an apprentice first opportunity. This has

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

supported our move from historically utilising the levy on level 7 qualifications to increasing our spend on level 2 and 3 qualification. However, as the level 2 and level 3 qualifications have a lower financial costs we need to support more learners in these qualification to achieve the same levels as supporting level 7 qualifications – therefore colleagues accessing the levy needs to increase to achieve our objective to maximise the levy spend. We are exploring access programmes relevant to this promise, associated with our recruitment to deliver betterment by making our existing approaches more inclusive. This will include the developed of four structured access programmes for vulnerable groups as outlined in our success measures.

4.0 Forecasting 2025/26

4.1 Assuming all the predicted apprenticeships happen at the times we have estimated, without losing existing apprentices we would spend £636,908, leaving an underspend of £113,175.

4.2 Therefore, we have agreed several actions at the March Education and Learning group to ensure a continued focus in this area alongside increased scrutiny to support quantified changed in the delivery to meet our commitments.

5.0 Plans agreed for 2025/26 to address the underspend

5.1 Auditing Existing Academic Attainment

5.1.1 When we launched the Apprentice First approach in September 2025, we encouraged managers to have similar conversations with existing colleagues to prevent a two-tier workforce, with new recruits having access to the levy and longstanding colleagues possibly not being aware of this opportunity. This approach hasn't been consistently applied across our workforce and therefore we have agreed to undertake a scoping exercise for Band 2, 3 and 4 colleagues in Q1 2025/26 to understand which colleagues would be eligible to access an apprenticeship levy qualification and their desire to complete a qualification. This will then allow a targeted approach to support these colleagues to commence a qualification and possibly complete their qualification earlier, given the changes to the length of levy qualifications.

5.1.2 Whilst we have increased the number of colleagues in the lower bands accessing the levy, there is a clear opportunity to further increase this as only 10% of the current Band 3 workforce and 2.3% of the Band 2 workforce have either completed or are currently undertaking an apprenticeship levy qualification.

5.2 Average Turnover and Vacancy Rates

5.2.1 Based on the apprenticeship First approach and possible turnover in 2025/26 we anticipate as a minimum a further 12 colleagues would commence as a new recruit joining the Trust supported by the Apprentice First approach.

5.3 Levy Transfers

5.3.1 Within the reforms there is the option to transfer a larger proportion of our levy to those organisations who do not have access to their own levy or have utilised all their available levy, in 2024/25 we haven't transferred any of our levy. Given our commitment to nurturing the power in our communities we have agreed to consider transferring c£56k of our levy to VCSE or other organisations to further enhance our local communities. This doesn't pose a risk to RDaSH as if we exceed all our levy spend in year from an internal perspective, we have historical levy budget which is available to support this commitment.

5.4 Clinical Expansion

5.4.1 Clinical expansion and growing our own workforce are a key area which we need to focus upon, more so given North East and Yorkshire received the lowest number of university applications for Nursing courses in previous years, which will impact on available supply in three or four years (dependent upon the course length). If we recruit and train from our local communities those colleagues are more likely to remain in our employment. Therefore, we are working with Directorates to identify clear plans linked to workforce planning, levy and training spend to ensure we maximise local supply and have a workforce which has the skills which we need in the changing landscape.

5.5 Growth and Skills Levy

5.5.1 In the current financial year, we have exceeded our training budget spend, this hasn't been achieved previously. As part of our proactive work, we have a Training Needs analysis and on the basis that we are likely to exceed our training budget spend again next year, we will look to maximise the opportunities that the new levy provisions will support to further enhance training opportunities which aren't deemed as non-apprenticeship training.

5.6 Appraisal/PDR Changes

5.6.1 As we significantly review our approach to PDR/Appraisals in 2025/26 we will strengthen the training discussions as part of this framework to support colleagues' development, again this should have a positive impact on the levy spend.

6.0 Levy spend projections in 2025/26

6.1 Based on the predicted levy allocation of £750,617, recognising this will be higher given the changes detailed in 3.4 we have identified a potential underspend of £113,709, but based on the proposed workstreams within this paper the predicted underspend/surplus reduces as follows:

Predicted Underspend		£113,709
Review of current academic attainment – based on 10 colleagues (5 X Business Admin, 5 X Customer Service Specialist)	£45,000	£68,709
New Joiners as HCSW – 12 colleagues (6 X Band 2 and 6 X Band 3)	£72,000	-£3,291
Levy Transfers - 7.5%	£56,296	-£59,587
Growth and Skills Levy – 15%	£112,592	-£172,179

7.0 Recommendations

7.1 The Board of Directors are asked to:

1. Note the work done in 24/25 to deliver the promise and progress in supporting lower banded roles into training

2. Recognise the step up needed between April and July to deliver promise 9 during 25/26

3. Ask the Board's POD committee to track progress against an expectation of significantly increased apprenticeship take up in Q1 and Q2

4. Note work being done by the CEO and Director of People and OD to develop the four structured access programmes for vulnerable groups outlined in our success measures.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	2024/25 - Reporting of Injuries, Diseases, and Dangerous Occurrences (RIDDOR)	**Agenda Item**	Paper S
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer and Carlene Holden, Director of People and Organisational Development		
Report Author	Jill Cross Health and Safety Lead Christopher Pym Matron – Practice Development/ RRI Rachel Millard Interim Nurse Director - Backbone		
Meeting	Board of Directors	**Date**	27 March 2025

Suggested discussion points

RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents to the Health and Safety Executive (HSE).

From April 24 to March 25 there were **10 incidents** recorded where staff members have been injured. 9 were RIDDOR reported, with similar numbers reported in previous years.

Whilst there has been a noted theme of staff falls; these have happened in different circumstances that does not highlight a specific theme.

All staff were supported by local management and had regular work contact whilst they were absent from work.

Alignment to strategic objectives	
Business as usual	X

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

People and Organisational Development Committee

Recommendation

The Board of Directors is asked to:

x	**TAKE ASSURANCE** on the process of reporting and monitoring compliance with the RIDDOR.

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

Trust Risk Register		Not Applicable
Strategic Delivery Risks	x	S01 and S02
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)

Not Applicable

REPORTING OF INJURIES, DISEASES, AND DANGEROUS OCCURRENCES (RIDDOR)

1.0 Introduction

1.1 RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents to the Health and Safety Executive (HSE).

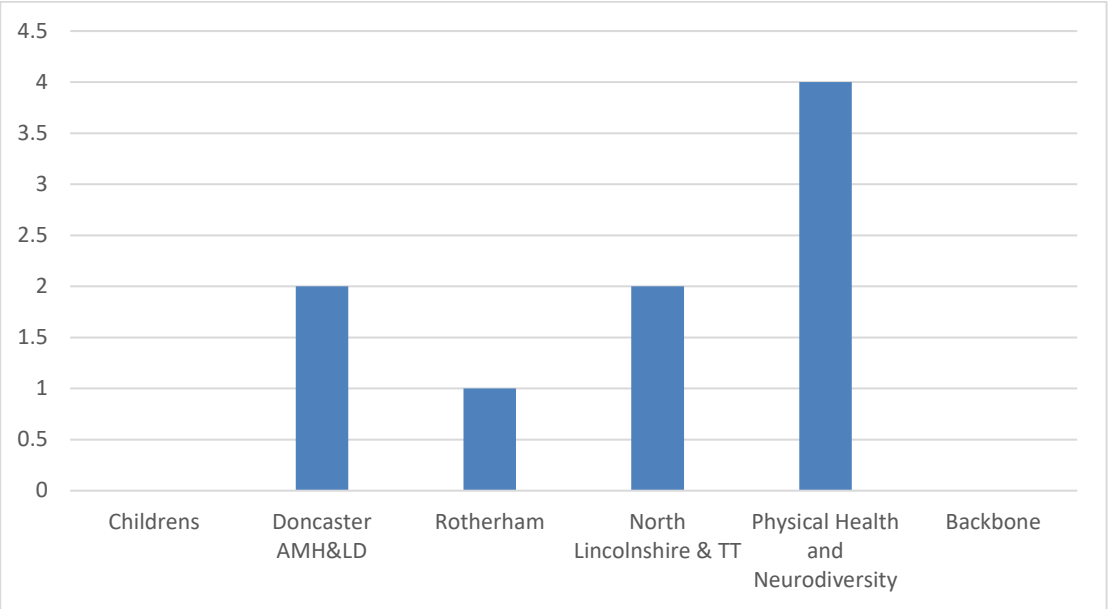
1.2 From April 24 to March 25 there were **10 incidents** recorded where staff members have been injured. 9 were RIDDOR reported and 1 did not meet the criteria for RIDDOR following analysis.

2.0 Analysis

The following table details 9 RIDDOR reported cases for the period 1st April 2024 to March 2025.

Incident date	Cause	Location	RIDDOR reason
01/04/2024	A patient shook an employee vigorously whilst staff were delivering personal care. Staff suffered whiplash.	Magnolia Lodge	Over 7-day absence
22/04/2024	A patient punched an employee in the face then in the back of the head. A second member of staff was then also punched in the face. Both employees suffered concussion.	Mulberry House	Over 7-day absence
26/04/24	An employee turned around in a small space and fell, causing a fractured femur.	New Beginnings	Specified injury fracture.
10/06/2024	Whilst checking on a patient who had recently been assessed in the 136 suite an employee was punched in the face.	Skelbrooke Ward	Over 7-day absence.
07/12/2024	Employee slipped on wet floor.	Osprey Ward	Over 7-day absence. Fractured elbow
16/09/2024	Employee struck to the head causing concussion.	Mulberry House	Over 7-day absence.
07/12/2024	Employee fall leaving patient property.	Community Unplanned Nursing	Over 7-day absence. Sprained ankle.
18/12/2024	Employee fall outside patient's house. Fractured wrist.	North Community	Over 7-day absence.
12/03/2025	Employee reported falling down a step whilst at a patient's home.	Community Planned Nursing	Currently being reported due to fractured ankle.

2.1 The following graph details the prevalence of the RIDDORs against the Trusts taxonomy.



2.2 The most frequent cause is injury from a fall. However, there is no thematic correlation between the reasons for the falls.

2.3 The average length of absence for all of the cases, apart from the last two equates to 82 days absence, with a range of 8 days to 281 days. It is imperative that our line managers explore with colleagues reasonable adjustments to facilitate a return to work early, possible in a different or adjusted role whilst they recover from the injury.

2.4 Three of the incidents occurred in the Physical Health and Neurodiversity Care Group – Community and Long Terms Conditions Directorate and all occurred at patient's homes. On one occasion the employee left a patient's property in a hurry when the patient became irate and tripped over a step, another employee working in the early hours of the morning fell downstairs when descending in the dark after being unable to find a light switch. The third incident involved an employee falling when leaving a property by missing their footing, stating "it was an accident, no one else was involved." They suffered a fractured wrist.

2.5 There was another slip incident on a Rotherham ward when the floor was wet after mopping, but there was no signage to indicate this. The fall caused a fractured elbow. The Domestic who had mopped the floor was provided with refresher training.

2.6 The other incident involved an employee at Great Oaks being struck on the head by a patient with a walking stick, causing concussion and more than 7 days absence from work.

2.7 When comparing the 9 incidents to previous year, whilst the organisation has grown in size, the number of RIDDOR's year on year has remained fairly static, with 10 incidents in 2023/24 and 11 incidents in 2022/23. This indicates that the measures and learning which we are taking from the incidents are being applied.

2.8 At the time of writing the report we have two litigation claims from colleagues associated with the incidents experienced during 2024/25.

3.0 Conclusion

3.1 Whilst there has been a noted theme of staff falls; these have happened in different circumstances that does not highlight a specific theme.

3.2 RIDDOR incidents and any learning from these are discussed at the Trust's Health, Safety and Security Forum.

3.3 Learning is shared within the Trust twice weekly patient safety huddles.

3.4 All staff should be supported by local management and had regular work contact whilst they were absent from work.

3.5 The Health and Safety team have been collaborating with Sheffield Health and Social Care Trust. They are currently in the process of analysing several elements, including staff safety, security management and the trusts experiences where safety themes have arisen from incidents. This will enable future reporting to include comparators with other organisations. In addition, we will seek to explore with both NHS and non NHS Trusts how we may be able to further mitigate the risk posed to our community colleagues when navigating patients homes, often in the dark and possibly in unknown surroundings. It may be that deliver companies can offer some further insight and learnings into this area, whilst recognising we are human and irrespective of the level of intervention and risk management strategies we will never eliminate all of the risks which are workforce face.

3.6 The Board are asked to take assurance on the process of reporting and monitoring compliance with the RIDDOR.

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 27 March 2025

24 - Our Enabling and Delivery Plans

Paper T – to follow

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational Risk Report	**Agenda Item**	Paper U
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	27 March 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) during March 2025. Whilst a number were included in the last report to the Board, the paper outlines both the mitigation (i.e. moderated away from extreme) and identification of others (i.e. new extreme risks) – demonstrating a live and active approach.

The report also returns to the topic of high impact / low likelihood risks on the register – important risks that could have a very large impact, albeit at present their likelihood of occurrence is low.

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.
x	**RECEIVE** and **NOTE** the High Impact/ Low likelihood risks

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

There are now six extreme risks on the register. At the last board meeting, we reported a total of six extreme risks. Since then, one risk has been de-escalated, while another new risk has been escalated to extreme status.

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)

1.1. De-Escalated Extreme Risks

NLCG 9/24	Failure to Address Crisis Team Improvement Plan	**I X L** **4X3 = 12**
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	
Updates	The risk has been de-escalated from extreme to high following the completion of several key safety and quality actions. Clear plans are in place to address the remaining actions, which have been reviewed by the Care Group DoPP, DoN, and the Improvement Plan Lead.	

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	Patient flow has refreshed the PIPA format for OAP to improved management and coordination. Daily meetings and the awaiting admissions list are actively being used to manage demand. Additionally, a cohort of seven individuals from North Lincs has been moved to Magna House, Sleaford, where North Lincs clinicians are carrying out targeted face-to-face discharge planning.	

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	There are currently 4970 patients on the waiting list. Over the past month, several staff members have completed training, leading to the development of a new model based on the increased number of competent staff available to conduct assessments. Productivity management has now been implemented to ensure consistency and improve capacity. The growth of the waiting list has slowed over the past two months, though there have been some staffing changes. Additionally, a new workshop for executive functioning groups will be trialled in April to expand treatment options for patients, utilizing existing capacity.	

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	The waiting list has now reached 1,887 and continues to grow. A new assessment template has been introduced to streamline processes and reduce the time spent on record-keeping. Newer staff members are increasing their productivity as they gain more confidence in assessing and diagnosing. The service is currently awaiting the outcome of an investment bid, which, if successful, will help expand capacity to better manage demand.	

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	The trajectory continues to be managed through regular reviews and performance monitoring. However, it is potentially off track for Q1 2025/2026 due to ongoing staff vacancies. The service is currently	

	awaiting sign-off on the trajectory, particularly regarding additional staffing and a potential digital offer, as current resources remain insufficient to meet the demand in North Lincs and Rotherham.

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 Operation	
Updates	Recruitment has been completed for Project Support Officer posts, who will work alongside GP surgeries to cleanse registers. Additionally, Launchpad has been rolled out across the Trust, with positive feedback received from initial implementation.	

New Extreme Risk

DCGMH 6/23	Medical Staffing	**I X L 5X 3= 15**
Description	Due to the inability of the care group to recruit and retain enough medical staff and the emergence of new vacancies, particularly within the acute directorate there is a risk that patient care and safety will be compromised. Additionally, the limited availability of consultant psychiatrist functions (including Responsible Clinician roles and meeting legal professional requirements) may result in a lack of clinical leadership across the care group, further impacting the quality of clinical care.	
Accountable Director	Care Group Director – Doncaster	
	The risk has now been escalated to extreme due to the lack of applicants for the OPMH consultant post, coupled with the ongoing sickness of the substantive consultant and the potential for practice restrictions pending an OH assessment. Discussions within SLT have confirmed that the risk level has increased, necessitating a higher score.	

2. High Impact, Low Likelihood Risks

The following high-impact, low-likelihood risks continue to be presented for the Board's strategic oversight. Each risk carries a major to severe potential impact (rated 5 out of 5) and a likelihood of rare to unlikely (rated 1 or 2). High-impact, low-likelihood risks hold particular significance because, despite being rare, they have the potential to cause severe harm to operations, patient care, and reputation if left unmanaged. Their infrequency means they can be overlooked, making it essential to maintain strategic oversight and proactive mitigation measures to protect the trust from potentially catastrophic outcomes.

HI 16/24	**Loss of Data Centres**	**5 x 2 = 10**
Description	If the Trust's data centres are lost simultaneously, there is a risk that critical Trust services will fail, which may result in significant disruptions to patient care, compromised data access, and potential harm to the Trust's operations and reputation.	
Accountable Director	Director of Health Informatics	
HI 16/24	**Loss of gas supply**	**5 x 1 = 5**
Description	If an extended gas outage occurred on the inpatient estate, there is a risk that patient care would be disrupted, which may result in significant impacts on service delivery, particularly in inpatient buildings, potentially compromising patient safety.	
Accountable Director	Director of Finance and Estates	
NF 21/24	**Highly Transmissible and Impactful Pandemic**	**5 x 1 = 5**
Description	If a highly transmissible and impactful pandemic emerges and the Trust's pandemic preparedness and response plans are insufficient, there is a risk that the Trust will be unable to effectively manage patient care demands and protect staff, which may result in overwhelmed healthcare services, compromised patient outcomes, and operational disruptions	
Accountable Director	Chief Nurse	
E 12/24	**Electricity Outage**	**5 x 2 = 10**
Description	If an extended electricity outage occurs on the estate, there is a risk that patient care will be disrupted, which may result in severe impacts on inpatient buildings, including compromised safety, and operational challenges.	
Accountable Director	Director of Finance and Estates	
HI 17/24	**Data Breach**	**5x 2 = 10**
Description	If disgruntled employees or employees acting by accident or with malicious intent cause a significant data breach, there is a risk that sensitive information will be compromised, which may result in regulatory penalties, financial loss, reputational damage, and potential harm to patient and staff privacy.	
Accountable Director	Director of Health Informatics	
E 6/24	**Water outage**	**5 x 2 = 10**
Description	If an extended water outage occurred on the estate, there is a risk that patient care would be disrupted, which may result in significant impacts on service delivery, particularly in inpatient buildings, potentially compromising patient safety and hygiene standards.	
Accountable Director	Director of Finance and Estates	

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NLCG 11/23	**Absence of Ligature alarms on Inpatient Bedroom and Bathroom Doors on Laurel Ward**	**5 x 2 = 10**
Description	If there continues to be no ligature alarms on the bedroom and bathroom doors on the inpatient wards, then there is an increased risk of a patient trying a ligature to the door and there being no alert to staff therefore increasing the risk of serious/ catastrophic self-harm though a suicide attempt.	
Accountable Director	North Lincolnshire Care Group Director	
RCG 1/24	**Ligature Risk in Kingfisher Ward**	**5 x 2 = 10**
Description	If the Care Group doesn't replace the current doors on Kingfisher Ward, including the S136 suite, to address the identified ligature risk, there is a risk of serious or catastrophic self-harm through a suicide attempt, which may result in harm to patients and significant legal and reputational consequences for the Trust.	
Accountable Director	Rotherham Care Group Director	
MP 3/22	**Ligature Alarms**	**5 x 2 = 10**
Description	If ligature alarms continue to be absent on bedroom and bathroom doors in inpatient wards, there is an increased risk that staff will not be alerted to a patient attempting to use a ligature on these doors. This may result in serious or catastrophic self-harm, including potential suicide attempts, without timely intervention.	
Accountable Director	Executive Medical Director/Chief Nurse	

The High-impact, low-likelihood (HI/LL) risks included in this report are exclusively those rated at the highest impact level (5). Other risks rated 4 x 1 or 4 x 2 risks or those that might seem HI/LL in nature but are not currently scored as such, are not detailed here. Some of these appear on the EPRR risk register, which follows national guidelines requiring worst-case scenario scoring for events like pandemics or large-scale infrastructure disruptions.

Based on the latest evaluation and at this time, we are confident that all critical high-impact, low-likelihood risks have been identified, are actively monitored, and are being managed with appropriate controls. This ensures continued alignment between our strategic oversight and the ongoing work to protect the organization’s operations, patient care, and reputation. The ongoing evaluation of the risk environment will continue to identify any further risks within this sphere.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks 2024/25	**Agenda Item**	Paper V
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	27 March 2025

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

The Board agreed a revised approach to the management of five newly agreed strategic risks at the beginning of the 24/25 year and has frequently received updates on the progress with the mitigation of those risks (directly and via its Committees). The revised approach was subject to internal audit review during Q3, with the final conclusion of *significant assurance* being received.

At the end of the first year in operation, the Board is invited to reflect on the progress in the twelve months of this new approach, mindful of the positive conclusion by internal audit, to ensure it remains focused on the right risks and to consider whether the forward plan of work remains robust in order that during the year, expected reductions in risk score are achieved. With a necessary increased frequency of reporting in this first year, and the establishment of a robust process, it is proposed that during the next year, reporting is reduced to better allow for progress to be made in the intervening periods. This reflects the strategic nature of the risks, meaning the work to mitigate is rightly at a different pace to that associated with operational risks.

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 January 2025
- Board of Directors timeout session – April 2024;

SDRs are assigned to individual Board Committees and each Committee has received an update throughout 2024/25 at each of its meetings

Recommendation (indicate with an ‘x’ all that apply and where shown elaborate)							
The Board of Directors is asked to:							
ACKNOWLEDGE the development in the year of the Strategic Delivery Risk process and **RECEIVE** the positive (significant) assurance from internal audit.							
NOTE the next steps outlined in the report and **AGREE** to the proposed new reporting process for 25/26.							
NOTE the year end position with respect to each of the five Strategic Delivery Risks							
Impact (indicate with an ‘x’ which governance initiatives this matter relates to and where shown elaborate)							
Trust Risk Register							
Strategic Delivery Risks	x	SDR1, SD2, SDR3, SDR4 and SDR5					
System / Place impact	x	All SDR in the paper are set within an external (system/place) impact / requirement for engagement.					
Equality Impact Assessment	Is this required?	Y		N	X	If ‘Y’ date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If ‘Y’ date completed	
Appendix (please list)							
Individual Strategic Delivery Risk forms are in the Annex to the Report.							

Strategic Delivery Risks (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 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 introduced in 24/25 to support the effectiveness of that work.

2. Strategic Delivery Risks (SDR) 2024/25

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 throughout the year (at each meeting) have featured the five SDRs and respective Committees have also received frequent reports on progress with mitigation. Furthermore, the Audit Committee has remained sighted on the progress with the overall SDR management at each of its meetings and the Chair of the Audit Committee has held meetings, alongside the Director of Corporate Assurance, with each of the respective Executive leads.

2.3 The Trust's new approach to strategic risk management was subject to an internal audit review in Q3 by 360 Assurance. At the end of its review, the overall conclusion was that there was significant assurance that *there is a generally sound framework of governance, risk management and control designed to meet the objectives of the system under review, and controls are generally being applied consistently*. Internal

Audit also noted that, *the Trust has strengthened its strategic risk management arrangements in the current year and we have evidenced routine and robust scrutiny of the new SDR at Board and committees.*

2.4 Whilst positive in its overall conclusion the auditors have made three recommendations to the Trust – the main one referring to the format of the SDR report, specifically that the links between the controls and the assurances should be more direct / strengthened; that actions should be SMART and that there should be clearer version control. The other two recommendations pointed towards the five risks, with a recommended opportunity to reflect and ensure they remained as the strategic delivery risks; and to updates required in the Risk Management Framework to accurately reflect the new approach to strategic risk management. The Trust agreed with the three recommendations and to completing actions in response by 31 July 2025.

2.5 With reference to the main recommendation, a first draft of a new format has been developed and will be subject to further discussion with the lead Executive Directors, to ensure it is clear in its presentation of the action and related assurances. Importantly the revision in format will not solely be used as a presentational enhancement, more an opportunity to really push the thinking about what we are doing to mitigate the risks and how we will know they are working.

By way of example, within a number of the risks the Staff Survey is quoted as a source of assurance – but we must refine the process to ensure that we are more specific about the individual questions that directly link to the strategic delivery risk – it cannot be used as a catch all assurance.

Similarly, the Leadership Development Offer will in the broadest sense, 'develop our leaders', but through some of the specific modules, there will be very direct development in the areas associated with the Strategic Delivery Risks, e.g. The module, Compassionate leadership to unlock community power, links directly to SDR1

We will seek to clarify whether we have recorded all controls – or where we have more to implement, we will identify them as current gaps in control. We will confirm that all current controls remain valid and relevant. Equally once we conclude on all controls we will seek to confirm the relevant assurance mechanism or identify a gap in assurance.

By way of a simple pictoral representation we will shift as below:

Current format

Controls 1 2

Assurances 1 2

New format

Control 1	Assurance 1		
Control 2			Gap in Assurance 2
		Gap in Control 3 (new control)	Gap in Assurance 3

The requirement for SMART actions (and identifying those that will reduce the risk score) and version controls within the reports will also be addressed.

2.6 The Board of Directors will recall the staged process through which it identified and agreed the five strategic risks – the risks that most significantly could impact on the ability of the Trust to deliver its Strategy (and its strategic objectives). Essentially a 'long list' of some forty plus risks were initially identified and subsequently reduced in number to the final five. The second audit recommendation seeks to afford the opportunity for the Board to review the risks and to ensure they remain those that most significantly could impact on the ability of the Trust to deliver its strategy (and its strategic objectives) Whilst opportunistic to consider the risks, the process of identification was robust and comprehensive and the five risks were identified against the long term delivery of the strategy, that is to say they were the most significant and they were expected to take time and effort to address.

2.7 Next steps in response to internal audit (output to next Board in May 2025)

- The Trust will respond to the recommendations through the development of a revised format to present the Strategic Delivery Risks.
- The Board of Directors should take the opportunity to consider if there are other or additional risks, but be mindful of the robust and comprehensive process through which it identified the current five strategic delivery risks.

2.8 The work above will be part of the work undertaken in Q1 with the respective lead Executives and through a further series of meetings between that lead Executive and the Chair of the Audit Committee and Director of Corporate Assurance.

2.9 During 24/25 the reporting of progress to Committee and the Board of Directors has been at each meeting to reflect the new approach being understood and becoming embedded. It is noted that the progress with mitigation in the period between meetings can be limited, given the expected time and effort needed to address strategic risks. It is recommended that the reporting frequency is adjusted in 2025/26 to afford more time tackling the risks, for the meetings with lead executives and Audit Committee chair to occur and for there to be meaningful progress made on controls and related assurances. SDR reports would be received at every other Committee and Board meeting throughout the year.

2.10 The year end position in respect of each SDR is presented in Appendix 1.

3 Recommendations

The Board of Directors is asked to:

ACKNOWLEDGE the development in the year of the Strategic Delivery Risk process and RECEIVE the positive (significant) assurance from internal audit.

NOTE the next steps outlined in the report and AGREE to the proposed new reporting process for 25/26.

NOTE the year end position with respect to each of the five Strategic Delivery Risks

Philip Gowland, Director of Corporate Assurance
20 March 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 (March 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 launched 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 / March 25** **PHPIP Committee – Mar 25**		Plan	L/Hood
			4	Imp	
					Imp
				Imp	Imp
			5		
				Imp	
				Imp	
			6		
			8		Det
					Imp
					Imp
			10		

	PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing	**PHPIP Committee – Jan 25**	11		
			26	Det	
				Imp	
				Imp	Imp
	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 (March 25)**	Sick	6.41%; above target of 5.1%	
			T/O	9.29%; below target of 10%	
			Comp		
	Improved WRES data	**POD Committee - October 24**			
	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 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. 1b Has the Trust developed compassionate leadership to unlock community power, from the perspective of staff, service users and communities?	Research and Evaluation planned outputs (via K Williamson) April and October 2025 and April and September 2026.			

	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	Assurance Level (TBC)
	Internal Audit work on Partnership Governance and Risk Management	Quarter 4	Assurance Level (TBC)

<table>
<tr><td colspan="12">SO2: Create equity of access, employment and experience to address differences in outcome</td></tr>
<tr><td rowspan="4">What could get in the way?

Challenges generating data and / or evidence to support interventions to address Health Inequalities</td><td colspan="7">As a Strategic Delivery Risk:</td><td colspan="2">Lead Exec</td><td colspan="2">Board Committee</td></tr>
<tr><td>If</td><td colspan="6">we do not execute plans to consistently create, use and respond to data inside our services and with others</td><td colspan="2" rowspan="3"></td><td colspan="2" rowspan="3"></td></tr>
<tr><td>because</td><td colspan="6">our leaders lack the time, skills or diligence to see through specific changes or are distracted by ‘wider system’ priorities</td></tr>
<tr><td>then</td><td colspan="6">this will lead to a lack of precision in how the Trust reshapes services</td></tr>
<tr><td rowspan="2">Risk Score</td><td colspan="6">Current (March 2025)</td><td colspan="6">Target (March 2026)</td></tr>
<tr><td>I</td><td>4</td><td>L</td><td>3</td><td>12</td><td></td><td>I</td><td>3</td><td>L</td><td>2</td><td>6</td><td></td></tr>
<tr><td colspan="12">Controls – What will we put in place to mitigate the risk?</td></tr>
<tr><td>Data Availability</td><td colspan="11">Health Inequalities – Reportable Data Sets of data relating to Promises. Identify a baseline position and detail planned further work across a range of data points including the establishment of targets (via Reportal 521 Health Inequalities Dashboard) (Pointed towards health inequality related promises 6, 7, 8, 10, 11, 12 and 17)

Data refinement processes – oversight of the portal; removal of underutilised reports will be completed. Focus on data quality.</td></tr>
<tr><td>Educating our leaders</td><td colspan="11">Digital Needs Survey (completed in Q2)

Data Saves Lives Campaign (Launched 26 November 2024) – The campaign will localise the six key aims of the national campaign including ‘Giving health and care professionals the information they need to provide the best possible care’.

The aim is to convey the message colleagues will be supported in discharging their responsibilities with data and also encouraged, through greater understanding of the benefits to the organisation and to them professionally. Series of posters have been distributed and the first of a series of three Vlogs has been launched too (December 2024)

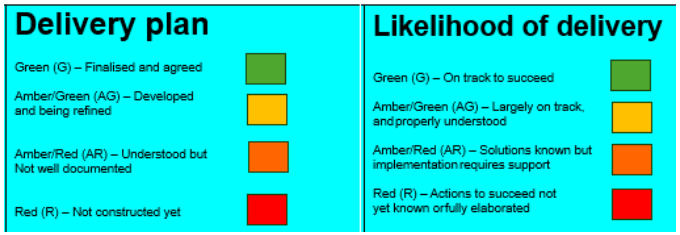
Key messages in December including Improving trust and transparency; Accurate and timely recording of data / Knowledge is Power; The benefits of using the Yorkshire & The Humber Care Record; How data flows through the system/organisation. An ‘Ask me anything’ session took place in January 25.</td></tr>
</table>

	Learning Half Days (ongoing from Sept 24) – feature learning opportunities focused on the importance of data and health inequalities. **Specific related events to date:** **October 2024** • **establishing mental health and community use cases associated with the use of the Yorkshire & The Humber Shared [clinical] Record.** **November 2024** • **New personalised care visualisation (20 attendees in total). The personalised care visualisation is a new development for PROMs and 4ww** • **Saving events in SystmOne (14 attendees in total). Accurately recording both clinical consultations of different types, as well as administration events** • **Communicating with patients digitally (40 attendees in total). This covered all of the patient-facing applications.** • **use of health inequalities data for frontline staff.** **Jan 2025: SMI physical heath checks new visualisation overview (joint session with Change & Transformation)** **Feb 2025: shared care records, patient care access considerations (joint session with Information Governance);** **SystmOne roadmap 25/26**				
Making Changes	Joint Strategic Needs Assessment aligns and informs the planned work Responding to the health inequalities data; identifying what gaps or shortfalls there are or are perceived to be and developing actions that seek to respond to or address these. Must demonstrate what those 'moves' are, the rationale for them and the impact that they have had for those that use our services				
Assurance – How will we know the controls are working?					
	Revised IQPR and associated Health Inequality measurements / indicators with reporting that confirms that as a result of action there are reductions in the health inequalities	**Clarification of cohorts of data linked to Promises, collection tools and reporting – progress reports to Equity and Inclusion Group (July 2024 and September 2024) and to PHPIP Committee (November 2024)**	Outstanding work to complete baseline position for some indicators.		
	Strategy Progress Reports on related (promise) deliverables: ○ **Promise 6 (PHPIP – Equity and Inclusion Plan)**	**Board – November 2024 (Promises and Priorities Scorecard)**	Promise 6	Plan Imp	L/Hood

	○ **Promise 8 (PHPIP – Equity and Inclusion Plan)** **(For each identified measure of success (3 for each Promise) there is a RAG rating based on Plan – 'confidence of having a plan'; and L/Hood – 'of delivery')**				
			8		Det
					Imp
					Imp
	FDE Strategic Delivery Risk Report relating to the oversight and management of SDR2	**FDE – August and October 2024** **Board – March 2024, May 2024, July 2024 and November 2024**			
Data Quality	**Sources of assurance on DQ – internal and externally provided**	**Information Quality Programme and reports (to FDE) (April, June and October 2024)** Kitemarking **Internal Audit report of IQPR** Internal Audit report on Waiting Lists (Due Q4 24/25) **Audit on Clinical Coding** (Feb 25)			**The Committee received and noted the Information Quality Work Programme 2024/25 and that a structured and demonstratable process was in place. Focus remained on the Integrated Quality and Performance Report (IQPR) which measured national and local priority Key Performance Indicators (OP13d, OP54a,b,c), and remedial action continued to develop data quality.** **Significant Assurance** **The Committee was assured by the Clinical Coding Audit Report that robust processes are in place to facilitate the accurate application of clinical coding.**

Internal Feedback	Learning Half Day Events with Feedback and Evaluation	Overall LHD Evaluation - PDSA Review January 2025	
	Leadership Development Offer	All participants will be subject to assessment of capabilities and quantified measures will be in place to assess and show improvement after 6m.	
	Digital Needs Survey outcomes and Data Saves Lives campaign outcomes / assurances.	**Digital Needs Survey (completed in Q2)** **Data Saves Lives Campaign (Launched 26 November 2024)**	**– Summary outcome reports provided to Digital transformation Group and used to inform both the Data Saves Lives programme (see below) and also considerations for both bespoke and broader training, particularly associated with aspects around the requirement to interface with our electronic patient record, SystmOne.** Feedback mechanism and evaluation

Key – re: Promises



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 (March 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*
	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
PHPIP Committee – March 2025, presentation GP Liaison role and work to date</td><td>Board – September / November 2024; January 2025

PHPIP Committee – Nov 24

PHPIP Committee – Jan 25 / March 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	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 (March 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	27 YTD, against target 2
			D in D	
			TT	14291 YTD; against

<table>
<tr><td rowspan="3"></td><td></td><td></td><td colspan="3">target of 20565</td></tr>
<tr><td>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)

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)</td><td>Board – September / November 2024 and January 2025</td><td colspan="3"><table>
<tr><td></td><td>Plan</td><td>L/Hood</td></tr>
<tr><td rowspan="3">18</td><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td>19</td><td></td><td></td></tr>
<tr><td rowspan="2">20</td><td></td><td></td></tr>
<tr><td>Det</td><td></td></tr>
<tr><td></td><td></td><td>Det</td></tr>
<tr><td>21</td><td></td><td></td></tr>
<tr><td rowspan="3">22</td><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td rowspan="3">23</td><td></td><td>Imp</td></tr>
<tr><td>Imp</td><td></td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>QC 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 colspan="3"></td></tr>
<tr><td>Internal Feedback</td><td>Staff Survey outcomes (Due Q4 2024/25)
Peer Review process</td><td></td><td colspan="3"></td></tr>
<tr><td>External Feedback</td><td>Complaints (reduction in those that relate to access to services) and improved patient feedback
Regulatory Inspection Reports</td><td></td><td colspan="3"></td></tr>
</table>

Key – re: Promises

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

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

SO5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations											
What could get in the way? **The Trust lacks the cultural capability and competence on wider issues**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	We do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027									
	because	We do not develop and practice the skillsets required to make change occur								CH	POD
	then	The Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees									
Risk Score	Current Score (March 2025)					Target Score (March 2026)					
	I	4	L	4	16	I	3	L	3	9	

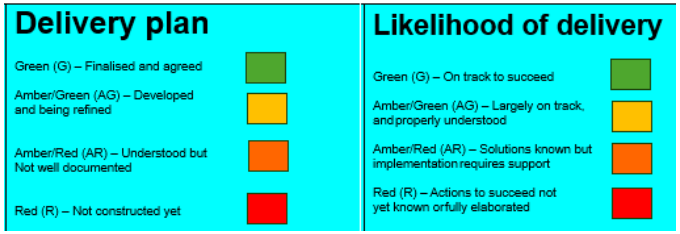
Controls – What will we put in place to mitigate the risk?	
Developing our Leaders	**Leadership Development Offer – circa 130 individuals – launched September 2024 and commenced in two streams in January and April 2025.** Importantly this includes up to 15 community leaders in the cohorts too, allowing for immersive conversations and discussions about the respective communities. **Leaders Conference – circa 130 staff as the Top Leaders Cadre – Event took place in September 2024** **Learning Half Days for every member of the Trust commenced in September 2024.** **Induction (all new starters) – RDASH and our communities – Launched 28 October 2024** First Line Managers Training Scheme – Launches April 2025 'Wider leadership' proposals – B5+ / Very Senior Clinicians Revised appraisal process developed and implemented – Q4 24/25 **People and Teams CLE Group and Education and Learning CLE Group – established and meeting regularly**

Increasing capacity / capability	Fully utilising the apprenticeship levy (delivery of Promise 9) Fully recruiting to all posts – 97.5% Commitment to designated training budget – demonstrate increase in spending year on year **Re-development of the Change function**

How will we know the controls are working?					
Assurance	Internal Audit work on Partnership Governance and Risk Management	Quarter 4	Assurance Level (TBC)		
	POD Strategic Delivery Risk Report relating to the oversight and management of SDR5	**FDE – August and October 2024** **Board – March 2024, May 2024, July 2024 and November 2024**			
	Strategy Progress Reports on related (promise) deliverables: ○ **Promise 9 Apprentice Levy (PHPIP - Equity and Inclusion Plan)** ○ **Promise 26 Anti-Racism (POD – People and Teams Plan)** **(For each identified measure of success (3 for each Promise) there is a RAG rating based on Plan – 'confidence of having a plan'; and L/Hood – 'of delivery')**	**Board – November 2024 (Promises and Priorities Scorecard)**		Plan	L/Hood
			9		Det
				Det	
				Det	
			26	Det	
				Imp	
				Imp	Imp
Feedback	Pulse check scores	Refreshed approach commences in Q4 (24/25)			
	Staff Survey	**Launched September 2024 ends November 2024;** Results and Analysis in Q4			
	Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group) - **Cohort 1 launched January 2025** / Cohort 2 April 2025 This feedback will secure confirmation that our leaders have the necessary skillsets linked to the partnership work	From Quarter 2 (25/26)			

	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**	
	Exit interview data/feedback across the Trust			
Impact (external)	Feedback from stakeholders regarding the approach of the Trust	'Voice' Scorecard Care Opinion		
	Consistent timely exit and delivery of time bound projects, and achievement of key measures with respect to the wider issues within the Strategy – inc the delivery of 'social value' and implementation of P25 where the use of local suppliers will contribute.	Definition (and measurement) of Social Value, demonstrating 'increase / improvement'		
Impact (Internal)	Reduction in Employee relations cases / matters			
	Increased year on year Training Budget			
	IQPR reporting improvements in • vacancies • sickness absence staff • turnover (esp within first 12m)	**IQPR to CLE / Committees and Board**	Vacancies	3.81% against a target of 3.3%
			Sick	6.41%; above target of 5.1%
			T/O	9.29%; below target of 10%

Key – re: Promises



ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	IQPR – February 2025	**Agenda Item**	Paper W
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	27 March 2025

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

It is anticipated that 7 of the "Top 10" will deliver the end of year target which we will confirm in the May Board. Unfortunately, we must note that for the first time adult ADHD has dropped below its trajectory, and this will be the case for some time. The diagnostic suggests this is about additional demand for treatment slots; the impact of national shortage of medication and the 6-month training lag for staff.

For quality and safety, we can consider the improvement in seclusion reviews (100%) which needs to be sustained. There is an increase in moderate or above ligature events (21.43%), although this is down to 3-4 specific patients with repeat attempts of self-harm. This metric can be monitored through the Quality Committee. For Falls we will be moving to a new measure of 12 hours, which will be in place form the 1st April. We will rely on a manual count for February and March, which was 98% for February.

From a people perspective it is a green rag rating for individual professional vacancies, with an improvement in the Trust wide vacancy factor of 3.81% (set against the 3.3% target set). This equates to 141 vacancies. Sickness remains stable at 6.41% with the launch of the health & well being policy In April. We have seen a small improvement in the PDR rates to 87.49 but remains below the 90% target.

The Trust is reporting a surplus position of £1,151k at the end of February (month 11); this is £1,437k better than planned. The improvement is due to non-recurrent £1.4m funding received from the NHSE Specialised Commissioning contingency as well as pay inflationary funding received in month from North Lincolnshire Local Authority and NHSE Education. This benefit is partially offset, however, by a reduction in ICB income of £645k following the clawback of YTD depreciation funding. The reported forecast is £892k better than plan with a forecast surplus of £544k.

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

Business as usual.	x

Previous consideration

Clinical Executive Leadership; Quality Committee;

Recommendation

The Board 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		O 10/19, O 1/20, O 4/24, NQ 1/20 NQ 8/24, NQ 3/23, NLCG 1/23, NLCG 5/24, NLCG 10/24, F 3/24, NLCG 11/23, RCG 1/24, RCG 3/23, CCG15/24, CCG 3/22, PCG 28/24, PCG 10/24, DCGP 2/22, PCG 23/24
Board Assurance Framework		n/a
System / Place impact	x	

Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	
Appendix (please list)							

Integrated Quality Performance Report

March 2025 Review

Data as at the 28th February 2025

Contents

1.0 Executive Report

This report presents the performance data for February 2025 across operational efficiency, quality, workforce, and financial metrics.

The Trust remains dedicated to delivering excellence across ten key performance indicators (LTP01–LTP10), recognizing the priority of all aspects of performance. Several key performance metrics continue to be closely monitored.

Performance Highlights and Areas for Improvement:

Children and Young People (CYP) Services: The CYP Eating Disorder Service (OP15) continues to meet its one-week target for urgent cases, with 93% of all CYP cases being seen within four weeks, demonstrating strong service performance. Additionally, access to Child and Adolescent Mental Health Services (OP13A) has consistently met its target over the last three months, with 9,838 CYP accessing services, slightly surpassing the target of 9,783. Breakdown of access rates is as follows: RDaSH (9,168), Kooth (528), Mind (61), and Healios (81).

Physical Health Services: Performance against the new RTT consultant-led pathways (OP08c) has seen a deterioration this month reporting at 88.64% impacted by the relatively small numbers in essence there are 5 breaches over 18 weeks across the services within the Doncaster Neurological Service. Four breaches relate to appointments offered but patient declined or failure to contact patient to arrange convenient appointment. The one remaining breach the assessment has been completed however treatment is yet to commence.

However performance against the 52 week wait target has been maintained with zero patients waiting over 52 weeks for treatment. (OP10c). Virtual Ward has consistently reported occupancy above the 80% target, with 91.67% on February 1st and 118.33% on February 28th. Performance for patients requiring assessments within two hours of referral (OP05) exceeded the 70% target, reaching 89.66% in February.

Adult and Older Adult Mental Health Services: The Trust continues to exceed the target for adults accessing community mental health services with two or more contacts (OP13d), supporting 10,027 adults compared to the target of 8,533. This reflects effective engagement and care provision, crucial to alleviating pressures on inpatient services and promoting recovery in the community.

Talking Therapies Directorate: While February's access rate appears to have decreased compared to January, the chart does not account for the number of working days per month. The daily access rate for 2024/25 shows a gradual and sustained increase in the number of patients entering treatment. There is still significant work to be done to embed and sustain this change, with a forecasted capacity target of September 2025 based on trainee completion dates. For reliable recovery, February 2025 performance was 47.43%, a decrease from January's 49.01%, but still reflecting sustained improvement compared to earlier in the year.

Mental Health RTT Pathways (OP08d): Performance has significantly improved, particularly in the North Lincolnshire locality, where validated Trust-wide performance reached 84.67% in February, compared to 61.94% in January. Breakdown by care group:

- Rotherham Adults and Older People Mental Health Care Group: 98.94%
- Doncaster and Learning Disability Care Group: 97.06%
- North Lincolnshire Talking Therapies Care Group: 70.31%

The ongoing initiatives in North Lincolnshire's Memory Services are positively impacting performance and patient outcomes, especially in light of the growing demand for dementia and related care. Further improvement is anticipated to be visible in the March data as this metric accounts for all breaches seen within month.

Inappropriate Adult Acute OAPs (OP17C): There were 27 inappropriate out-of-area placements in February, exceeding the target of 2. A multi-phase improvement program is in development, led by the Executive Team.

1.0 Executive Report

Section 136 Suite Availability: A total of 91 hours were lost in February due to occupancy-related breaches. The opening of a third 136 suite in Sheffield is being closely monitored for its impact throughout Q4 and has showed a demonstrable decrease in the numbers of Sheffield patients presenting to RDaSH suites since implementation. 71 hours were attributable to non-RDaSH patients in month.

Neurodevelopmental Services: February saw a deterioration in the number of adults waiting for an Adult ADHD assessment, with 4,992 individuals waiting compared to a trajectory of 4,721. Recruitment challenges and delays in system implementation have impacted the trajectory. A new service delivery model has been designed to improve efficiency, and a revised trajectory for compliance with the four-week target is under review. The CYP Neurodevelopmental waiting list stood at 2,850 against a target of 2,085, largely due to recruitment delays. A new trajectory has been presented for this service but is awaiting approval.

Quality and Patient Safety: The Trust continues to prioritize quality and patient safety, exemplified by a 99.22% compliance rate for VTE assessments (QS08), exceeding the 95% target. Additionally, the Trust has achieved a 100% target for internal MDT assessments during seclusion episodes, ensuring patients in seclusion receive appropriate clinical oversight. However, performance on MUST assessments has declined to 79.39%. A deep dive revealed that 56.52% (13/23) of assessments for admissions in month were completed outside the required timescale. Alerts have now been embedded in inpatient records to notify when assessments are due, and the Physical Health Care group is exploring recording practices for patients accepted for admission but not arriving on the ward.

Absconded Patients (QS20): Two patients absconded from acute adult and older people's inpatient mental health units in February. One patient was on leave and failed to return; appropriate action was taken, and the patient was returned to the ward by the police.

Racist Incidents: Four racist incidents were reported in February. One involved a patient in Rotherham who had been in seclusion for two months. Staff had reduced the number of incident reports due to the high volume of incidents, but this has been addressed with the team. The Trust continues to encourage all colleagues to recognize and report unacceptable behaviour. The Acceptable Behaviour Policy has been launched Trust-wide and continues to support staff in reinforcing zero tolerance. During Race Equality Week (February 3rd–7th), the Trust pledged to implement anti-racist recruitment practices, provide anti-racist training, and commit to a Doncaster-wide anti-racism message in 2025.

Workforce Development: The percentage of employees receiving a performance and development review (PDR) has increased to 87.49%, reflecting improved support for staff development, feedback, and engagement. However, the year-to-date sickness absence rate has risen slightly from 6.26% to 6.41%. A revised policy will be launched in April, following manager training. The Trust has discussed strategies to support attendance through CLE meetings.

Safeguarding Compliance: Adult and child safeguarding compliance (POD26 & POD27) is currently below the 90% target. Targeted actions, including bespoke sessions for the half-day LEARN event calendar, are underway to improve compliance. Any non-compliance will be shared with Directors of Nursing for targeted improvements.

Vacancy Rate: The vacancy rate decreased from 162 to 141 vacancies in February, currently standing at 3.81% against a target of 3.3%.

Finance : The Trust is reporting a surplus position of £1,151k at the end of February (month 11); this is £1,437k better than planned. The improvement is due to non-recurrent £1.4m funding received from the NHSE Specialised Commissioning contingency as well as pay inflationary funding received in month from North Lincolnshire Local Authority and NHSE Education. This benefit is partially offset, however, by a reduction in ICB income of £645k following the clawback of YTD depreciation funding. The reported forecast is £892k better than plan with a forecast surplus of £544k. This assumes that the non-recurrent funding from the NHSE Specialised Commissioning contingency of £1.5m will offset the depreciation funding clawback, pay award income pressures and other cost pressures, rather than improving the forecast to a surplus of £1.2m as originally anticipated. All care groups and backbone services were set control totals earlier in the year to deliver the plan; after a great deal of effort across RDaSH, most are forecast to achieve their control total and work continues in the small number of directorates where this isn't yet the case.

2.0 - Performance – In Focus

Indicators for February 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		19/19	100.00%		88.00%	>= 60%	83.00%
OP03a (L)	LTP 02 a (i)	People accessing Talking Therapies - Cumulative Annual			1318		2883	>= 20565	14291
OP03b (L)	LTP 02 a (ii)	People accessing Talking Therapies - Cumulative Quarterly			1318	Q4 >= 4093	2883		14291
OP03c (N)	LTP 02 b	Reliable recovery rate within Talking Therapies		240/506	47.43%		48.00%	>= 48%	47.00%
OP03d (N)	LTP 02 c	Reliable Improvement rate within Talking Therapies		350/525	66.67%		68.00%	>= 67%	68.00%
OP05 (N)		People in physical health crisis assessed within 2 hours		26/29	89.66%		90.00%	>= 70%	66.00%
OP07b (L)	LTP 03 b	Women supported by perinatal MH service (Rolling 12M)			575		575	>= 598	575
OP08c (N)		18 weeks RTT for consultant led Physical Health services		39/44	88.64%		80.00%	>= 92%	70.00%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		221/261	84.67%		74.00%	>= 92%	80.00%
OP10c (N)		Waiting 52 weeks or more for a consultant led PH service			0		0	= 0	0
OP10d (N)		Waiting 52 weeks or more for a consultant led MH service			0		0	= 0	0
OP12 (N)		People discharged from MH inpatients followed up in 72 hrs		59/67	88.06%		90.00%	>= 60%	88.00%
OP13a (N)	LTP 04	People accessing CYP services with >= 1 contact (13mth roll)			9168		9168	>= 9783	9168
OP13b (N)		People accessing CYP services >= 2 contacts and paired score		699/4719	14.81%		15.00%	>= 20%	18.00%
OP13d (L)	LTP 01 a	Adults accessing community mental health services (DW)			10028		10028	>= 8533	10028

Narrative

OP03a – This is a place target however only includes RDaSH activity, reporting 14,291 for the cumulative year to date up against a target of 20,565. When compared with activity in the same period last year we are reporting below last year's actual which was 14,754.

OP03b - Quarter to date talking therapies access target for quarter 4 is 2,883 and is above the target to date of 2,728.

OP03c – Performance has remained at 47% year to date reporting below the 48% target, the February position is reported as below the target at 47.43%

OP7b – PLACE TARGET ACHIEVED -a rolling 12-month place target for Perinatal and Maternal Mental Health Services. Once RDaSH activity (575) and Maternal Mental Health Service (SHSC) (255) is counted the number of women receiving support is 830, remaining above the target of 598.

OP08c – Reporting 5 breaches over 18 weeks, performance reported as 88.64%

OP08d – Performance has been validated and we are reporting 40 breaches over 18 weeks, primarily in our North Lincolnshire and Talking Therapies Care Group. Trustwide performance for the month is 84.50% from 61.94% in January, a significant improvement but remaining below the 92% target.

OP13a – PLACE TARGET ACHIEVED. A Place target, performance at place (9,852), exceeding the target of 9,783 (RDaSH 9,168, Kooth 542, Mind 61 and Healios 81).

OP13b – The CYP access 2 contacts and a paired scored has seen a further deterioration in performance from 14.81% in January to 14.16% in the month of February. This brings YTD performance to 18%, against the 20.00% target.

2.0 - Performance – In Focus

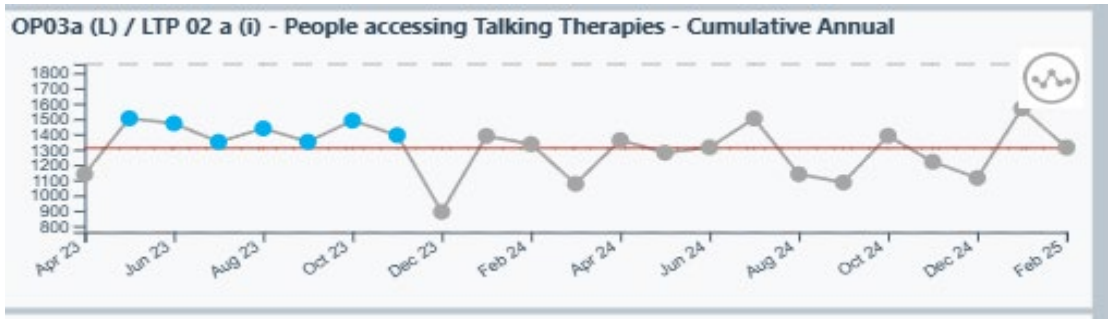
Indicators for February 2024/2025 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP13d (L)	LTP 01 a	Adults accessing community mental health services (DW)			10027		10027	>= 8533	10027
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		79/84	94.05%		93.00%	>= 95%	93.00%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		3/3	100.00%		100.00%	>= 95%	100.00%
OP17c (N)	LTP 05 a	The number of active inappropriate adult acute OAPs			27		27	<= 2	27
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		42/60	70.00%		70.00%	>= 80%	70.00%
OP54c (L)	LTO 06 a (iii)	Virtual ward occupancy - on day 30		71/60	118.33%		118.00%	>= 80%	118.00%
OP59a (L)	LTP 09 (i)	Waiting List - Adult ADHD			4992		4992	< 4721	4992
OP59b (L)	LTP 09 (ii)	Waiting List - CYP Neurodevelopment			2850		2850	<= 2085	2850
OP60 (L)	LTO07	Dementia Diagnosis rate							
OP61a (L)	LTP08a	Place target for SMI		3735/5490	68.03%		68.00%	>= 75%	68.00%
OP61c (N)	LTP08c	Patients with SMI having full annual physical health check		2566/3527	72.75%		73.00%	>= 95%	73.00%
OP73a (L)	LTP 10 a	Section 136 Breaches – Occupancy hours lost to breaches			91		134	= 0	1911

Narrative

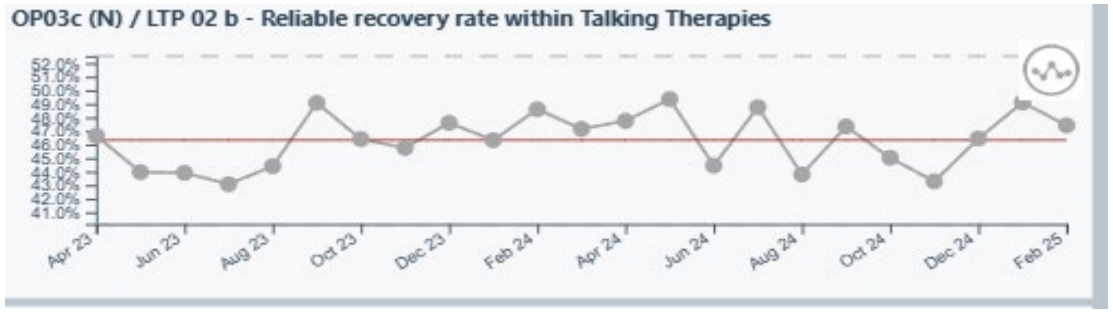
OP14 - Children and young people with routine eating disorders seen within 4 weeks is reporting 5 breaches in the rolling 12 month period and is reporting 94.05% just below the 95% target.
OP17c -The number of external inappropriate adult acute OAPs are reporting at 27 at the end of the calendar month.
OP54a/OP54b/OP54c. The Virtual Ward has reported at above 80% occupancy on day 1 and day 30 however remains below the occupancy on day 15 reporting 70%.
OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 4,992 adults waiting for assessment against the target of 4,721.
OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target actual for February is 2,850 CYP waiting against the target of 2,085. 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 and is the national place target measuring 6 checks against the QOF , performance is reported as 68% against the 75% target for year end.
OP61C – The new metric reported for the first time is measuring the RDaSH performance against the QOF with declines excluded. Performance is reported as 72.75% against the 95% target.
OP73a – Increase in month from 48 hours lost in January to 91 hours in February 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

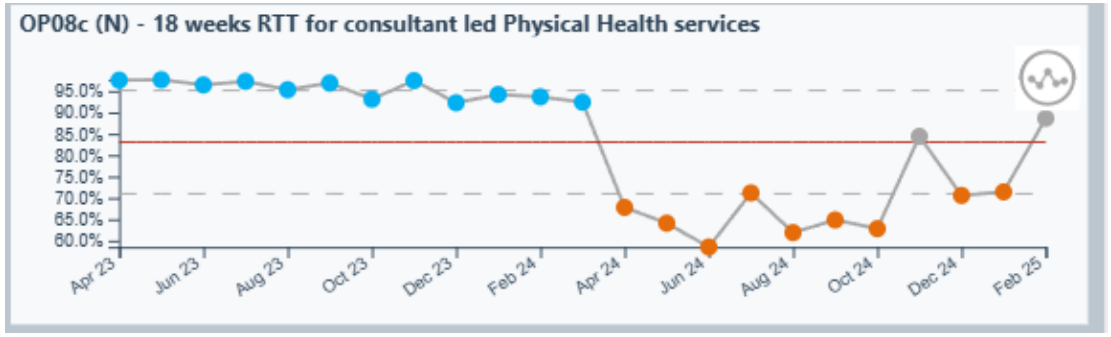
OP03a The Access Rate Performance for February 2025 appears to have reduced when compared to January 2025 based on the current presentation of data in the chart, however, the reporting doesn't account for the number of working days per month. Reporting based on the daily access rate for 2024/25 to date demonstrates that the service is starting to see a gradual and sustained increase in the number of patients entering treatment: There remains a significant number of further actions to embed and sustain this change whilst also further building capacity and demand to deliver the target. The current forecast for when capacity will reach the required level based on trainee completion dates is September 2025.



Trend, Reason and Action

OP03c Performance for February 2025 was 47.43% which was a reduction from the position in January 2025 of 49.01% but does however demonstrate sustained improvement from the year to date position and the period during summer when performance was consistently significantly below target.

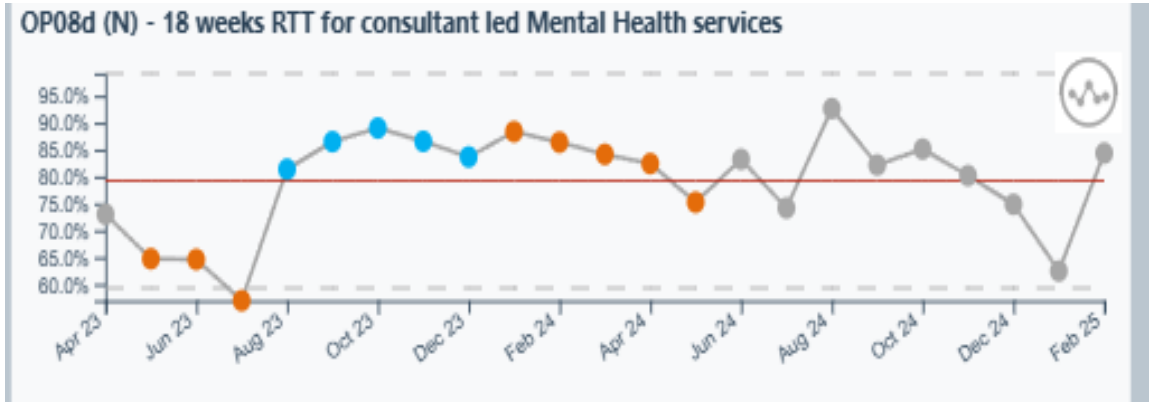
The breakdown between services for February 2025 shows that the Doncaster and North Lincolnshire services both delivered the target whereas the Rotherham service saw a reduction in performance having previously been delivering the target for the year to date. This reduction for Rotherham is therefore not considered to be trend and is therefore forecast to return to above target in March 2025 together with the Trust-wide position.



Trend, Reason and Action

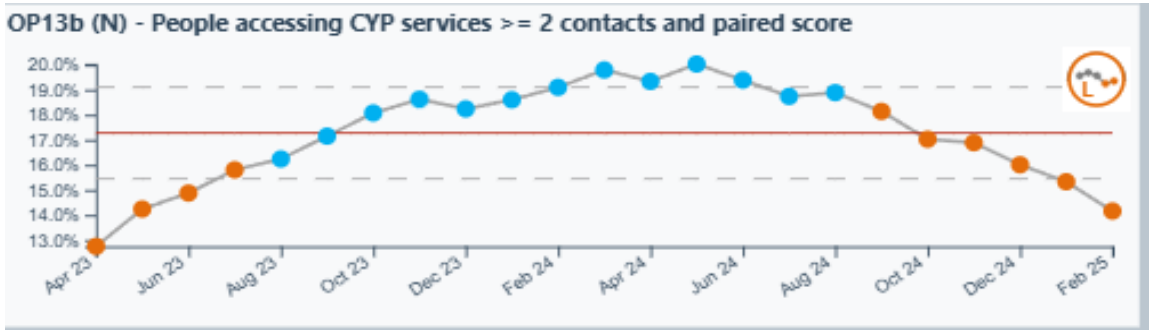
OP08c – Performance on physical health RTT pathways (OP08c) has seen a deterioration in performance, with validated Trust-wide performance reported at 88.64%. There are 5 breaches over 18 weeks in our Doncaster Neurological Service. This is unusual for the service and the breaches are attributable to patients who did not attend their appointment or patient choice for appointment time and date.

2.1 Performance In Focus - Exceptions



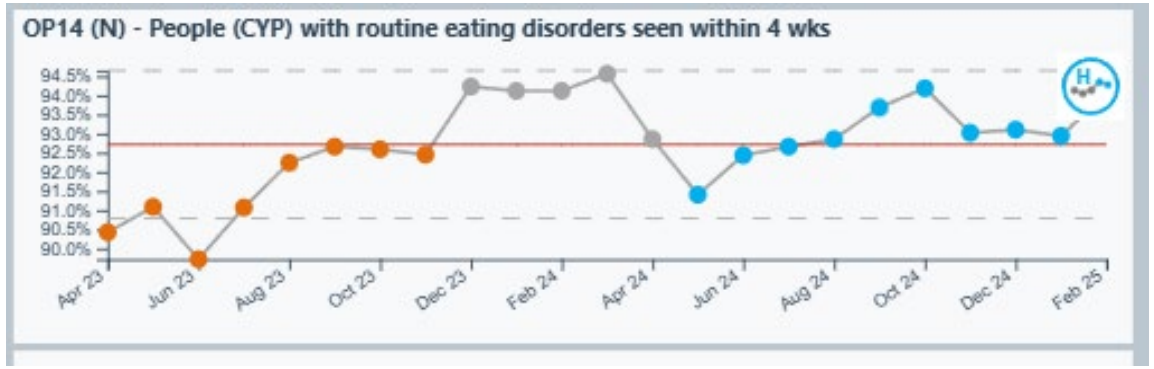
Trend, Reason and Action

OP08d – Performance on mental health RTT pathways (OP08d) has seen the anticipated upturn in performance, with validated Trust-wide performance reported at 84.67%. Performance by care group is as follows:
Rotherham Adults and Older People Mental Health Care Group: 98.94%
Doncaster and Learning Disability Care Group: 97.06%
North Lincolnshire Talking Therapies Care Group: 70.31%
The ongoing challenge in North Lincolnshire's Memory Services showed significant improvement through February, but all breaches seen by the service in month still report as breaches. Further improvement is expected to be visible in the March IQPR.



Trend, Reason and Action

OP13b - The CYP access 2 contacts and a paired scored has seen a deterioration in performance in December to 14.81%. 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 5 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.

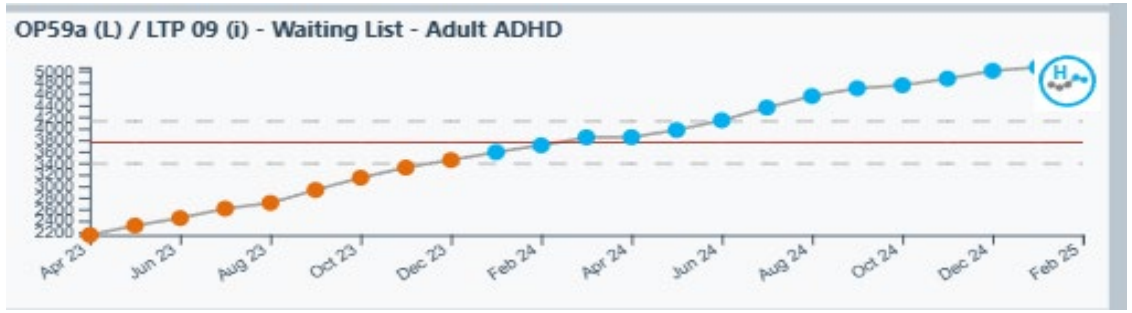
2.1 Performance In Focus - Exceptions

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 27 out of area inappropriate placements. A task force has 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.

Trend, Reason and Action

OP54b - This metric measuring virtual ward occupancy on the 15th day of the calendar month. Although occupancy on the 1st and 30th of the month is reported above the target, for day 15 occupancy remains at below at 70%.



Trend, Reason and Action

OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 4,992 adults waiting for assessment against the target of 4,721. The trajectory is currently in redevelopment as a number of assumptions used to inform the original trajectory have not been possible to translate into practice in the original timescales due to issues in recruitment, implementation of new systems etc. A new model of service delivery has been designed to maximise efficiency and will help inform changes to the trajectory.

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 actual for February is 2,850 CYP waiting against the target of 2,085. 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.

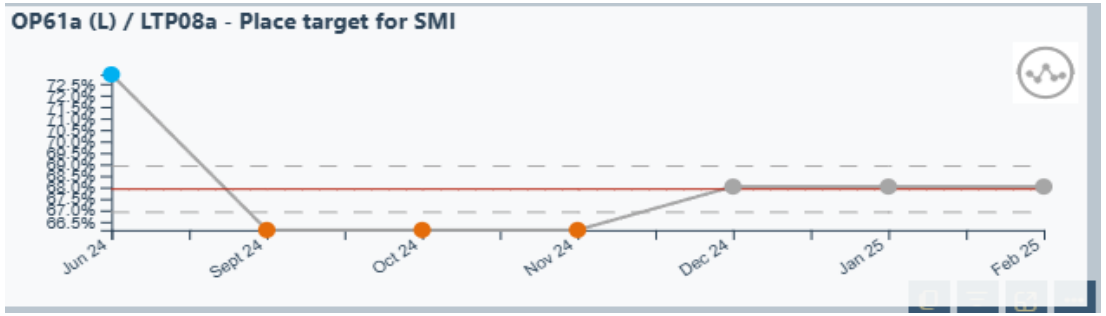
Trend, Reason and Action

OP73a – the metric measures the occupancy hours lost due to breaches within our 3 Section 136 suites, 90 hours were lost this month.

Doncaster had 3 patient breaches, 20 hours of which were non-RDaSH patients, also 1 ward closure which accounted for 2.5 hours

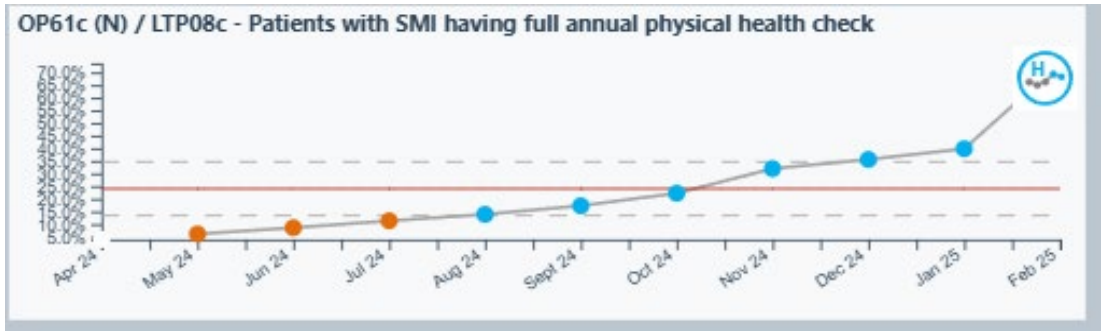
Rotherham had 3 patient breaches, 2 were not RDaSH patients and accounted for 48 hours also 1 ward closure of 12 hours.

North Lincs had 2 RDaSH patient breaches accounting for 2.5 hours.



Trend, Reason and Action

OP61a - The metric for individuals receiving an annual health check and is the national place target measuring 6 checks against the QOF , performance is reported as 68% against the 75% target for year end.



Trend, Reason and Action

OP61C - OP61C – The new metric reported for the first time is measuring the RDaSH performance against the QOF with declines excluded. Performance is reported as 72.75% against the 95% target. This is part of Phase 2 of the work ongoing for Promise 7 to demonstrate 95% coverage of annual healthchecks for individuals with SMI against the QOF that RDaSH has visibility of. Alongside this, work is ongoing to validate the RDaSH QOF visibility against GP registers which will increase the overall numbers and give a true reflection of all SMI patients eligible for the hgealthchecks within the community.

3.0 Quality & Safety In Focus

Indicators for February 2024/2025 TRUST — Quality & Safety

Indicator	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS01 (L)	Overall CQC rating (1 outst, 2 good, 3 improv, 4 inadequate)			3		3	= 2	3
QS02 (L)	Employee Opinion Survey Results for Safety Culture							
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	Q4 = 0	0	= 0	0
QS06 (N)	Number of Clostridum difficile infections (Monthly)	= 0		0	Q4 = 0	0	= 0	1
QS07 (N)	Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q4 = 0	0	= 0	0
QS08 (N)	No patients aged >=16 admitted with completed VTE	>= 95%	128/129	99.22%	Q4 >= 95%	98.00%	>= 95%	94.00%
QS15 (L)	No of wards reporting registered staff on nights/days >90%		15/16	93.75%		91.00%	>= 90%	90.00%
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			2		4	= 0	24
QS21a (L)	Physical aggression incidents mod or above to staff (%)		2/108	1.85%		2.00%		8.00%
QS21b (L)	Physical aggression incidents mod or above to staff/pats (%)		0/108	0.00%				51.00%
QS23 (L)	Number of Suspected Suicides (Inpatient Settings)	= 0		0	Q4 = 0	0	= 0	0
QS27 (L)	Ligature incidents mod or above all inpatient areas		3/14	21.43%		21.00%	<= 10%	12.00%
QS29 (L)	Number of racist incidents against staff members			4		10	= 0	39
QS31 (L)	Episodes of Seclusion - Internal MDT within 5 hours		13/13	100.00 %		75.00%	= 100%	61.00%
QS36 (N)	Inpatients that have a completed MUST assessment		104/131	79.39%		82.00%	= 100%	70.00%
QS37 (L)	Inpatients commenced with falls assessment in 72 hrs		3/74	4.05%		33.00%	= 100%	81.00%
QS38 (L)	Moderate/High falls requiring a structured review	= 0%	0/100	0.00%	Q4 = 0%	50.00%	= 0%	50.00%

Narrative

QS20 - A sustained position of 2 detained patients reported as absconding in February from acute adult and OP inpatient mental health units.

QS27 - Reporting 21.43% for February against the Trust target of 10% for the number of ligatures incidents graded as near miss, moderate or above in all inpatient areas**.**

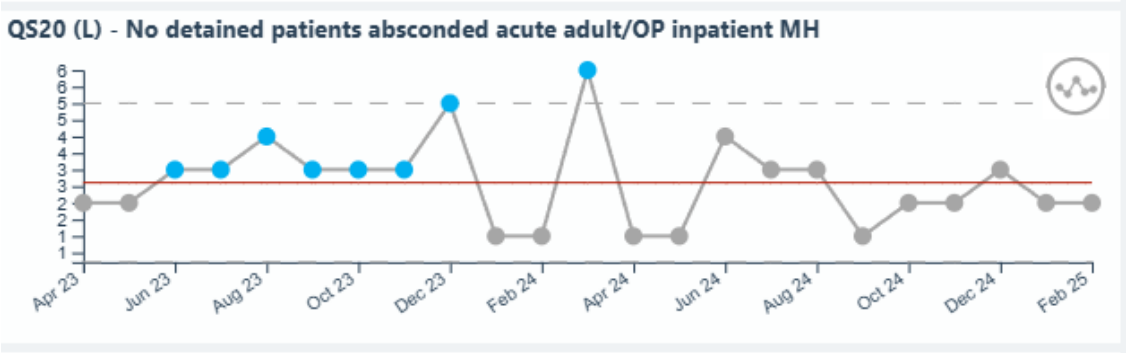
QS29 –A slight decrease to 4 racist incidents in February from the 5 reported in January.

QS31 –The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting an increase In February to 100% (13/13) for this metric from the 70% (7/10) for January.

QS36 - Reporting a decrease in February to 79.39% 104/131 from the 84.62% (143/169) in January of the % of Inpatients that have a completed MUST assessment.

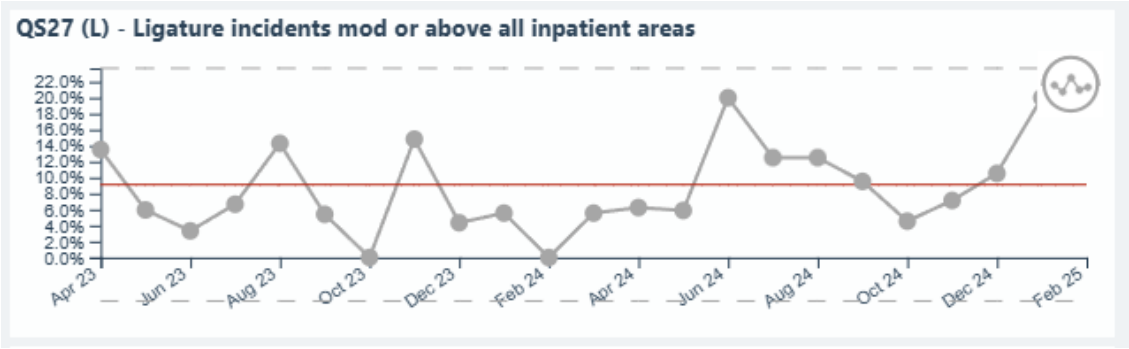
QS37 – Reporting a significant drop in month due to the introduction of a new template introduced to lower the target to 12 hours. This has interrupted reporting until April 2025. A manual audit has evidenced 98% compliance.

3.1 Quality and Safety In Focus - Exceptions



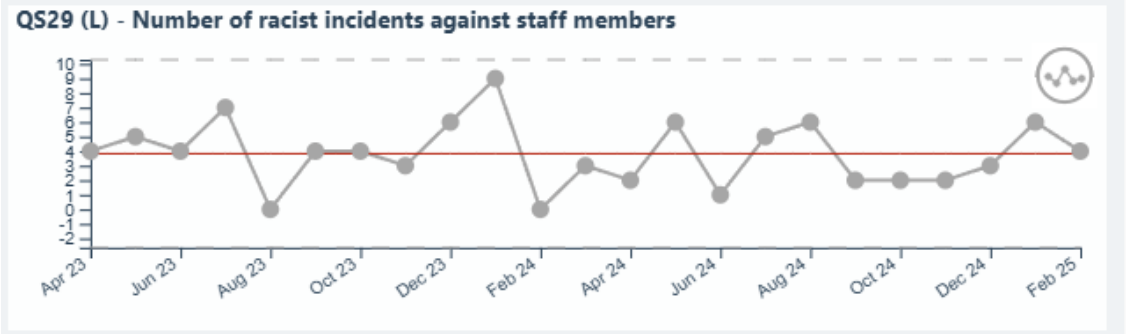
Trend, Reason and Action

QS20 – A sustained position of 2 detained patients reported as absconding in February from acute adult and OP inpatient mental health units. Following a deep dive 1 patient was on leave and failed to return all appropriate action was taken and the patient was returned to the ward by the police. The 2nd Patient is detained under section 3, and only had S17 leave for periods of 15 minutes to go outside in the grounds and failed to return. All appropriate action was taken and the Police were contacted. Following a review from this point unescorted leave was agreed with the Consultant , as the patient benefited from the time away from the ward.



Trend, Reason and Action

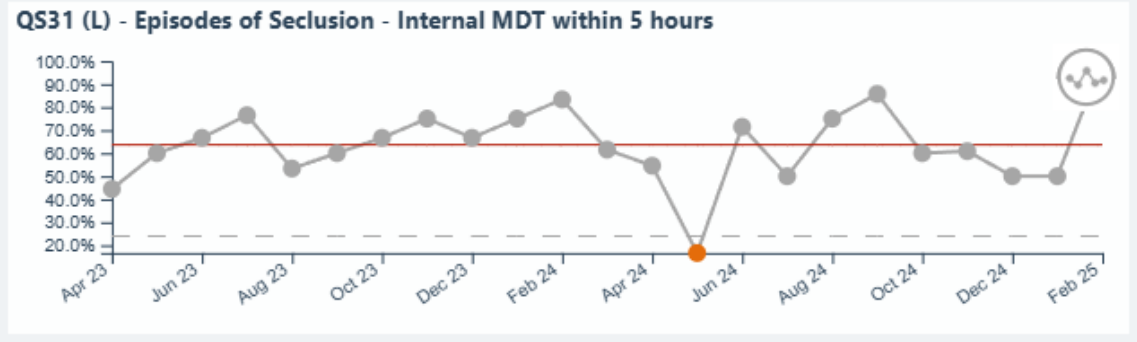
QS27 – Reporting 21.43% for February against the Trust target of 10% for the number of ligatures incidents graded as near miss, moderate or above in all inpatient areas and is reflective of the acuity of the patients during this time as a deep dive established 3 patients with repeated incidents.



Trend, Reason and Action

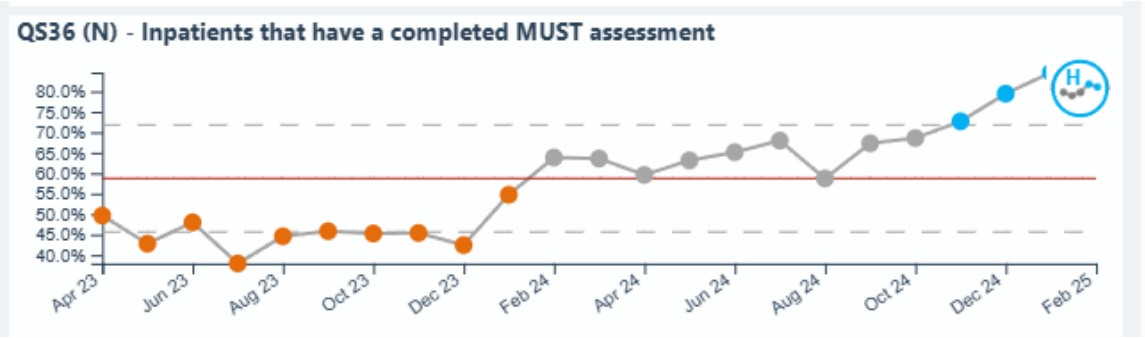
QS29 – The Trust is reporting a decrease to 4 racist incidents in February from the 5 reported in January. In Rotherham one patient has been in seclusion for 2 months and staff have reduced the amount of IR1's that are being completed due to the high volume of incidents. This has been addressed with the team and we continue to encourage all colleagues to recognise and report all unacceptable behaviour. The Acceptable Behaviour Policy has now launched Trust Wide and continues to be used to support colleagues and re-enforce zero tolerance. IR1s are reviewed and actioned when they arise and staff involved are contacted for support. RDASH committed to Race Equality week 3rd-7Th February working together with organisations across Doncaster Place. During Race Equality week we pledged that in 2025 we will: use anti-racist recruitment practices in our organisation, provide anti-racist training for our workforce and commit to a Doncaster–wide anti-racism message.

3.1 Quality and Safety In Focus - Exceptions



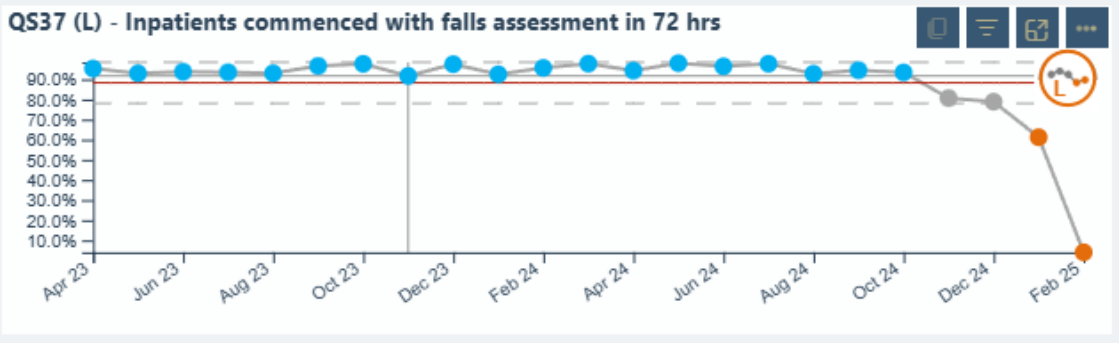
Trend, Reason and Action

QS31 –The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting an increase In February to 100% (13/13) for this metric from the 70% (7/10) for January. To continue to improve the consistency and embedding into services recording changes are being made to the seclusion visualisation on System 1 to allow a pop-up message to appear giving instructions to the Doctors in what circumstances the review should be completed that has been selected. 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 a decrease in February to 79.39% 104/131 from the 84.62% (143/169) in January of the % of Inpatients that have a completed MUST assessment. Following a deep dive within Care groups it has been established that 56.52% (13/23)were completed outside of timescale. The alert is now embedded in all inpatient records 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 in terms of this being an exception. Must has been included in the admission checklist and is being led with daily oversight by the inpatient ward managers.



Trend, Reason and Action

QS37 – Reporting a significant drop in month due to the introduction of a new template introduced to lower the target to 12 hours. This has interrupted reporting until April 2025. A manual audit has evidenced 98% compliance.

4.0 People and Organisational Development – In Focus

Indicators for February 2024/2025 TRUST — **Human Resource**

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	9.29%		9.00%		9.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	6.41%		6.00%		6.00%
POD15 (L)	Number of Consultant Vacancies	<= 10	9		9		9
POD16 (L)	Qualified nursing vacancies	<= 10%	6.12%		6.00%		7.00%
POD17 (L)	Support worker vacancies	<= 10%	4.72%		4.00%		8.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	87.49%		87.00%		87.00%
POD19 (L)	Individuals completed mandatory/statutory training	> 90%	92.38%		92.00%		92.00%
POD23 (L)	Number of individuals currently suspended from employment		1				
POD24 (L)	Average suspension length in calendar days	<= 150	19		19		19
POD25 (L)	Recruitment completed within 12 weeks	>= 95%	98.48%		98.00%		98.00%
POD26 (L)	Compliance for safeguarding children's training		80.26%		80.00%		80.00%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		80.30%		80.00%		80.00%
POD28 (L)	Total Vacancies		141		141		141
POD29 (L)	Total Vacancy Rate %		3.81%		4.00%	<= 3.3%	4.00%

Narrative

POD10 – The year-to-date sickness absence % has shown a slight increase from 6.26% in January to 6.41% in February. The new policy will launch on the 1st April following a period of training for managers. CLE in January discussed the sickness absence triggers, the revised policy approach and how we support colleagues to maintain attendance, this will be supported by a deep dive into sickness absence via People and Teams and also a revised focus on the OH support.

POD18 –The Trust continues to experience challenges maintaining PDR compliance and there has been a small improvement from 86.81% to 87.49%.

POD26 and **POD 27** - Trust Level 1 and 2 (both adult and child) are compliant but level 3 for adult and child are amber. The compliance matrices have been reviewed, bespoke sessions have been scheduled on the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view to targeting individuals to improve compliance.

POD29 – reporting as 3.81% against the target total vacancy rate percentage of less than or equal to 3.3% (2024/25) with 141 vacancies currently across the trust (reduced from 162).

4.1 People and Organisational Development - Exceptions

Trend, Reason and Action

POD10 - The year-to-date sickness absence % has shown a slight increase from 6.26% in January to 6.41% in February. The new policy will launch on the 1st April following a period of training for managers. CLE in January discussed the sickness absence triggers, the revised policy approach and how we support colleagues to maintain attendance, this will be supported by a deep dive into sickness absence via People and Teams and also a revised focus on the OH support. Within the region, we are also seeing an increase in sickness absence levels, whilst this benchmarking data isn't yet available via the national systems through our networks this is a known position
.

Trend, Reason and Action

POD18 –The Trust continues to experience challenges maintaining the PDR compliance and there has been a small improvement from 86.81% to 87.49%. A new appraisal framework will be launched in 2025/56 and this should further improve our position and the quality of PDRs.

Trend, Reason and Action

POD28 and **POD29** - reporting as 3.81% against the target total vacancy rate percentage of less than or equal to 3.3% (2024/25) with 141 vacancies currently across the trust (reduced from 162).

4.0 Finance – In Focus

Finance				
Indicator	Metric	Target '£000	Actual '£000	Variance '£000
FIN01	Year to date actuals vs budget	- 286	1,151	1,437
FIN02	Year to date actuals vs budget - excluding AED	- 286	1,205	1,491
FIN03	Forecast outturn vs budget	- 348	544	892
FIN04	Annual savings target vs schemes identified	6,622	6,622	-
FIN05	Agency spend as % of total pay bill - year to date	3.60%	1.70%	-1.9%
FIN06	Year to date capital plan vs spend	7,316	6,203	- 1,113
FIN07	Annual capital plan vs forecast spend	8,214	10,792	2,578

Narrative

FIN01 - At the end of February the year to date (YTD) position is a £1,151k surplus, this is £1,437k better than the revised plan, which includes NHSE deficit support funding. The current position includes non-recurrent £1.4m funding received from the NHSE Specialised Commissioning contingency. Further improvement in the YTD position has been seen in month 11 due to pay inflationary funding received from North Lincs Local Authority and NHSE Education. This is partially offset, however, by a reduction in ICB income of £645k following the clawback of YTD depreciation funding.

FIN02 - The year to date deficit on the AED costs is £54k, the position excluding the AED costs is a year to date surplus of £1,205k. The overspend has significantly reduced compared to earlier months.

FIN03 - The forecast outturn for the trust at month 11 is a surplus of £544k, which is £892k better than planned. This assumes that the non-recurrent funding from the NHSE Specialised Commissioning contingency of £1.5m will offset the depreciation funding clawback of £703k, pay award income pressures and other cost pressures, rather than improving the forecast to a surplus of £1.2m as originally anticipated by the ICB. All care groups and backbone services were set control totals earlier in the year to deliver the plan; after a great deal of effort across RDaSH, most are forecast to achieve their control total and work continues in the small number of directorates where this isn't yet the case.

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. £0.8m of the savings in the forecast are non recurrent and the 25/26 target will increase by this amount if recurrent savings are not identified by year-end.

FIN05 - Agency costs have significantly slowed on earlier in the year and at the end of February the are 1.7% of the total pay costs of the Trust (1.8% 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.

FIN 06 - Agency costs have significantly slowed on earlier in the year and at the end of February the are 1.7% of the total pay costs of the Trust (1.8% 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.

FIN07 - Despite YTD capital being underspent, the Trust is forecasting an overspend of £2.5m. This is because £2m of IFRS16 accounting costs are included in the M12 forecast for the Elizabeth Quarter lease that will be recognised before year-end when the contract is signed. It has been confirmed that NHSE will increase the Trust's capital CDEL limit to cover the additional lease costs for year-end. The £0.5m overspend balance is because the plan monitored by NHSE has not been increased to include funding received from them earlier in the year.

Appendix 1`

SPC Icon Description

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises and Priorities Scorecard	**Agenda Item**	Paper X
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	27 March 2025

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

The scorecard reflects on work done to firm up plans and to move towards delivery. The picture remains one of high potential, with 2025/26 very much the make-or-break year. We need to set higher expectations of ourselves on precision and on pace, recognising the hard work of many across the Trust to make Care Opinion, volunteering, poverty proofing or research activity part of the leadership work that they do. At a time of NHS uncertainties, the clarity of our promises represents a real benefit to colleagues, patients, carers and communities.

The report recognises that promises 7-12 need faster work in coming months; with a strong delivery plan needed for promise 1, 2, 14 and 19 in particular. It is very encouraging that, since the Board last met, 360 Assurance have reported with significant assurance on work to 'govern' promises 3, 4 and 5.

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

Previous consideration

Considered in each board meeting from September 2024

Recommendation

The Board of Directors is asked to:

X	**CHALLENGE & CONFIRM** current state assessments outlined for success measures
X	**NOTE** the critical success factors for early 25/26 improvement outlined
X	**RECOGNISE** the segmentation of promises' relative priority agreed with CLE
X	**CONTINUE** to focus Board time on testing the depth and pace of change required

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

Trust Risk Register	X	Various (notably relating to wait times and neuro)					
Board Assurance Framework	X	Relevant to all five SDR items					
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)

Annex A - delivery plan / likelihood of delivery scorecard

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Promises and priorities scorecard – March 2025

Introduction

1.1 This standardised update report provides information on work to define, plan and deliver our promises. Over recent Board meetings, we have considered progress with promises 3, 4, 6, 7 and 8. That cycle continues with consideration of promises 9 and 26. This detail follows the previous process of Board consideration of each strategic objective: **information which will be important in feeding back our work to local people in July**.

1.2 There remains work to do to mobilise all promises and **to target that action at the success measures that we adopted last summer**. That is why the report's annex is organised around those success measures. For example, in exploring promise 26, we might note the intention to tackle the gender pay gap, which is progressing strongly; whereas our work on apprentices has not yet benefitted from targeted support to access and sustain employments for the priority populations that we agreed.

1.3 Measures of confidence need to be built to test promise delivery. It is helpful, for example, to have internal audit validation of work on promises 5, 4 and 3. But **we have further to go to use patient feedback/opinion to test promise delivery** – alongside models of organisational assurance. As we move to execute promises 14 and 19, that patient experience test will be especially important, and we are working with our children's care group to apply this thinking to their early-adopter work on CAMHS 4 week waits. If, as is probable, in tackling out of area placements, we hold more people (and risk) in community settings for a defined period, we need to understand the impact of that change on those patients, and their households, as well as on our bed base and budget plans.

1.4 The reports looks forward into the coming year, whilst also exploring how we expect to end 2024/25 - our first full year of seeking to move the promises.

Governing delivery in 25/26

2.1 Promise delivery is currently considered in both CLE sub-groups, and within delivery reviews. This will continue in the year ahead but be augmented by a more structured use of Clinical Leadership Executive (CLE) time to support promise delivery. This is intended to make 'mainstream' delivery of key promises, perhaps especially against objectives 1 and 2. Care Groups, in considering their plans for the year ahead, are exploring the balance of leadership within their own SLTs, and that within directorate DMTs: both promises 3 and 6 are typically being led at that directorate level, and delivery of promise 4 is team leader led in most parts of the Trust.

2.2 That more structured approach will be framed around the Trust's planning guidance that we issued to CLE in February. That sought to segment the promises we have, recognising that a small group (segment 4) will develop more cautiously in the year ahead, but that we need to use that headspace to drive more rapid and consistent execution of other segments. The segmentation split is tabulated overleaf.

Promise 25 is not contained within a segment, on the basis that delivery is centralised and will be completed during Q1 25/26 – assuming accreditation is achieved from the Real Living Wage Foundation.

	Description	Selected promises
Segment 1 – mainstream	Business as usual	3, 4, 5, 24, 26, 28 – requires attention across year
Segment 2 – persist	Collective focus to move forward	1, 2, 6 18, 20, 22, 23 – focus of HQTC
Segment 3 - make or break	Promises that we need to secure in year	7, 8, 9, 10, 11, 14, 19,
Segment 4 – nurture	Progressed but gently	12, 13, 15, 16, 17, 21,27

2.3 CLE will spend focused time on promises contained in segment 2. This looks to mobilise cross group working to move those promises forward. We will review done within other settings on segment 4 at mid-year. For example, for promise 27, we would expect that timing to support us to have made palpable progress with the various funding bids we intend to submit in relation to estate/net zero funding. Or substantial movement on promise 16 relies on deployment of the DIALOG+ tool across our services – a change due to be delivered during 2025.

2.4 Segment 3 promises need concerted work among care group, operational and executive leaders over coming months. This builds on work done to understand and move forward annual health checks, supports investment made in BME dementia diagnosis, but also recognises that some delivery will come from both attention to detail at pace (for instance older adult talking therapies access) or through focused work on administrative processes and data, such as the coding of veterans and veterans' families using Trust services.

2.5 CLE will also receive routine reports from our HQTC work to delivery promises 18-23. Our efforts to, for example, reduce length of stay to support promise 19, will necessarily rely on both virtual ward options (promise 20) and a focus on seven-day working (promise 22). Impact from investments in promise 23 will need to be driven.

2.6 A number of promises continue to lack a delivery plan (despite the intent to complete this work in Q4). The gaps are:

- Promise 1 on peer support workers
- Promise 2 on carers
- Promise 10 on inclusion health
- Promise 15 on integrated neighbourhood teams and
- Promise 21.

We will report at the Board's next meeting on the trajectory to close these gaps.

Execution during 24/25

3.1 Over the course of the year, we have made progress with the majority of promises. Stronger achievement is visible for objectives 1 and 5 than for the objectives we set on inequalities, community first, and our high quality therapeutic care commitment. These are necessarily more diffuse and distributed and need to the application of leadership attention outlined above.

With the overwhelming NHS focus on finance moving into the year ahead, there is a risk that the need to 'kick on' highlighted below is not possible at the pace needed. Conversely, our fully staffed position, leadership development time, and increasing clarity of expectation may serve to help us to move rapidly now to delivery.

3.2 **Strategic objective 1:** Delivery is in two parts; because promises 3, 4 and 5 are seeing strong progress, measured in data we track, and in the feedback of others, notwithstanding the developments highlight above. Both our carers network (promise 2) and peer support workers (promise 1) are starts with much broader pieces of work that need more systematic planning in coming weeks.

3.3 **Strategic objective 2:** We have not fully delivered promise 9, but the Board will see increasing evidence of this work as we aim to reshape our workforce offer. This includes work with veterans and homeless citizens, bringing people into employment as well as expanding our service offer. Baseline work in support of promise 6 and 12 is taking place across the Trust, and a huge mobilisation has taken place to support delivery of more annual health checks than ever before (if not yet enough to deliver our phase 2 ambitions). The expectation of delivery of the RDaSH 5 is clear to those involved, but these projects continue to require significant attention: each has been reviewed with the CLE sub and will now feature in the relevant delivery review of for that care group on a routine basis. Promise 7 is, in effect, stayed pending resolution of material data issues, albeit Trust level data against all bar one measure is now reportable.

3.4 **Strategic objective 3:** The Board is familiar with implementation work now starting for promise 17 on school readiness. It is recognised that an outcome datapoint for this work will not be available routinely. Data flow for promise 16 needs further development in support of the IQPR, but a proxy measure of use of DIALOG+ tool has been discussed within CLE. Likewise, the urgent care work we need to do within Promise 14 has been conceptualised – and investments made to support the 'elective care'/productivity changes designed to deliver promise 14 as a whole. All three care groups now have community clozapine delivery plans to support promise 13, and the expansion of the community IV services continues. The Trust is deeply involved in work in both ICBs to consider how best to support integrated neighbourhood team working.

3.5 **Strategic objective 4:** The new contract with South Yorkshire Housing, is, we'd hope, the first of several to deepen the relationship between local providers and the Trust as part of implementing promise 23. Virtual ward remains solely a physical health construct, albeit we want to expand it to support both adult/older adult MH, and children's services. In moving forward personalised care plans, shorter bed based length of stay, and admission/discharge across weekends, the Trust will move closer to delivering these promises within this objective – at best in 24/25 we have

socialised these ideas; albeit deployment of DIALOG+ will help us, if well used, to improve the calibre of our care planning, which will be critical to CQC outcomes.

3.6 **Strategic objective 5**: We have work to do moving into the coming year, to make both education (promise 24) and research (promise 28) a routine part of the local management language and obligation. In delivery reviews in March and May, each care group will be discussing their training plans and then their research work. These teams have put considerable time into being ready for promise 25 implementation, in particular by ensuring roles that should properly be band 3 posts are adjusted before year-end. Adaptation planning associated with promise 27, and work to tackle perceived and actual discrimination among line managers (promise 26) has started to be planned bottom up.

Conclusion

4.1 By half way through 25/26, we ought to have high expectations of delivery across the majority of our promises, including: promise 3, 4, 5, 7, 9, 10, 11, 13, 14, 18, 19, 23, 24, 25, 26, and 28. Promises 6, 8 and 12 have longer delivery horizons but need to be on track at this point. The annex sets out what half year delivery requires of us, and in the majority of cases it is continued improvement from current state.

4.2 Nine promises sit outside that expectation: either with major implementation challenges to be faced, or with the involvement of partners requiring a pace-of-trust approach. None are undeliverable. Even the much-discussed promise 27 follows well from a revised capital regime as we look to move away from gas fuelled energy and to tackle our business mileage model.

4.3 The strategy was never intended to be easy. It is itself a mechanism to change the focus of what leaders pay attention to. To follow this through, we need to see some systemic change in Q1 and Q2 in the dataflow we have, supporting inequalities and therapeutic care objectives. And skills and behaviours being practiced inside the LDO need to be helping to improve the prevision of planned actions in areas like promise 8, 9 and 10.

4.4 The Board may wish to consider whether:

- It is sufficiently sighted on promise delivery, 2 years into a 5-year programme
- We could do more to make delivery feel feasible in ‘bite sized chunks’
- How we celebrate and give profile to progress to build both bravery and trust

4.5 Colleagues are positively encouraged to seek specific detail inside and outside the Board meeting on promises of particular interest or concern.

Toby Lewis, Chief Executive
March 17th 2025

Promises and priorities – delivery plan and delivery self-assessment

Annex 1

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
1. Employ peer support workers at the heart of every service that we offer by 2027.	Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care.	Amber red (improved)	We have a baseline understanding of our current position, and a credible plan for inpatient coverage: establishing how community coverage is achieved will need us to broker 'sharing' agreement between service teams to become affordable	Amber red	This work will require the focus learnt on promises 3 and 6 in recent weeks if we are to purposefully introduce PSWs at twice or more the scale of neighbouring Trusts: the next few months will set a critical platform for a 26-28 funded plan of growth
2. Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy.	Achieve Carers Federation accreditation for the work that we do across the Trust.	Amber red	Assessing the trajectory for this application was delayed from February to May owing to pressure of other work, so no change to planned rating.	Amber green	As an input measure, we are confident that effort will produce compliance/adherence. The positive 'aura' created by the Carers Network will help – as will the impetus to improve flexible working arising from the staff survey.
	Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Amber green	There is now an understanding that we will have 'a common' Trust-wide approach' to this. Implementation planning will follow via HQTC in Q1.	Amber green (improved)	Carer feedback will be critical, as we implement a new approach – and gather insight into what works (critical too with changes to MHA)
	Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.	Amber red	We would expect plans to move this forward to be developed via our new network over coming weeks.	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 rating has not changed (and may not be wholly enabled either by DIALOG+). We need to build a dataflow that permits each contact to assess/refer, simply.	Red	Until the planning work is done it is impossible to meaningfully estimate the LOD.

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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	There continues to be enthusiasm and energy: but maintaining that (with personnel changes) and managing drop-out rates will require continued effort.	Amber green (improved)	Until we hit 350 in October, we have to remain cautious. Considerable effort has been expended to move towards 250 – and impetus needs to sustain.
	For that body of volunteers to reflect the diversity of our populations.	Amber green (improved)	The January Board paper indicated progress in this regard, with changes in age/ethnicity profile apparent. There remains work to do to reach across all protected characteristics.	Amber green	There is now clear focus on this aim, and with more people entering volunteering on a career-development pathway there is a route apparent to delivery.
4. Put patient feedback at the heart of how care is delivered in the Trust, encouraging all staff to shape services around individuals' diverse needs.	Increase by 15% the scale of feedback received in the Trust versus 2024/25 baselines.	Green (improved)	Both via Care Opinion, and bearing in mind other routes, we can see that the scale of feedback we have in place will continue to expand.	Green	This scale measure we would expect to meet during 2025/26.
	Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	Green	The pilot for this work has proved successful and has been assessed by the Board's MHAC: we now need to sustain the work over time.	Green (improved)	We will track this work in the Q&S sub-committee of CLE – and expect to see changes as a result of the feedback received.
	Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.	Amber green (improved)	Most directorates can evidence how this feedback is influencing their work: we need to ensure all 13 can do so when Delivery Reviews occur in May.	Amber green (improved)	Recognising that feedback is not all about 'change' – we need to be able to evidence a small number of meaningful impactful changes in our 25/26 Quality Account.
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 continues and has been evaluated for further improvement. The remaining step planned is to create communities of practice among those involved, for example through our shadow CLE.	Green	As the work continues, the need to ensure accountability from representatives back to the local community will grow. The route and agency through which to do that remains to be established.

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	Deliver the Board's community involvement framework in full.	Green (improved)	This CIF has broad support (and is now approved) but needs operationalisation plans to deepen with Care Groups, supported by a revised VCSE register (due next week).	Amber red	This remains AR until there is a clearer trajectory, which SRO, E&I sub, CLE and PHPIP have confidence in.
	Apply patient participation tests to new policies and plans developed within the Trust .	Amber green	This continues to be an acknowledged oversight and will be addressed in the revised policy of policies over coming weeks.	Green	Getting the required changes into place is not an onerous ask, but does require a structured approach.
	Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.	Green (improved)	Council of Governors has approved the approach, but there is a need for Nursing and Facilities to now systematically deploy it in Q1.	Green	We now have to expand active membership, recruiting in tandem with our volunteering and VCSE partnering work.
	Deliver the annual priorities set by our council of governors.	Amber green	Most priorities set with COG are in hand: there is work to do on the digital aid/MH work which needs resourcing.	Amber green	Within 2025 we would expect to meet the measures we set in 23/24.
6. "Poverty proof" all our services by 2025 to tackle discrimination, including through digital exclusion	All our services to have completed poverty proofing and be able to evidence resultant change (including digital).	Green (improved)	Directorate level deployment is agreed and a revised 'approach' is being taken learning from pilots. There is a good 'buy in' now from those involved.	Amber green	It will be important before July 2025 to be able to evidence real changes from the 24/25 deployment – with funding for the transport changes put into place.
	Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods.	Amber red	Our current plan is to poverty proof. It remains to be established in early 25/26 what other interventions are needed to achieve this measure.	Amber green	The lack of a final timescale for this improvement explains the positive rating – there is time in 2025 to iterate delivery over following months/years.
	Benefits and debt advice access to be routine within Trust services to tackle 'claims gap'.	Amber green	Teams have begun to describe how this will be integrated within their DIALOG+ deployment: more detail is needed on how patients will experience this access before the plan goes green.	Amber green	There is further work to do to consider scope of coverage but the plan has flexibility to reflect that risk.

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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	The last report flagged a concern of this plan deteriorating owing to data reporting gaps: there is confidence that this can be resolved.	Green	Teams involve convey confidence within delivery reviews that they can meet these measures over the time period.
	Achieve learning disability and serious mental illness health check measure in 2024/25 and recurrently.	Amber red (deteriorated)	There has been some fantastic work done to move this measure forward. However, the gap from our/PCN registers is sizeable and GP contract changes may have an impact on partner engagement and on our approach.	Amber red	For SMI registers it is apparent we do have the scope to do this work. This is less clear for LD registers (where the GP listed popn is significantly larger). We need to resolve in Q1 a trajectory to achieve coverage *or revise our aim.*
8. Research, create and deliver 5 impactful changes to inequalities faced by our population in accessing and benefitting from our autism, learning disability and mental health services as part of our wider drive to tackle inequality (“the RDASH 5”). (next report will include neurodiversity measure and peri-natal MH)	Increase access to health checks for minority ethnic citizens with Learning Disabilities.	Amber red	There is not yet a cogent plan to address this (and the investment fund bid proved unaffordable). A reset of approach needs to be undertaken considering what can be achieved (and what problem we are trying to solve)	Amber red (deteriorated)	The LOD has deteriorated in view of the plan being unaffordable, and the wider challenges for this AHC approach outlined under promise 7 reporting.
	Increase diagnostic rates for dementia among minority ethnic citizens.	Amber green	A strong proposal to make progress with this is funded for 25/26, rooted in evidence from elsewhere. We need to ensure all 3 memory services are engaged with the Rotherham led work.	Amber red (improved)	The LOD is improved based on a emerging and coherent plan. As waits for diagnosis reduce, we have capacity to reach into communities and work at pace (as we evidenced in NL).
	Improve access rates to talking therapies among older adults.	Amber green	There is a plan (to increase access by 1500 slots). A combination of data-mining among exists caseload and new referrals exists – there	Amber green (improved)	The tangible plan, and clear clinical commitment, exists to make this happen – what is now needed is measurable

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			remains some doubt over whether the grip needed is in place (which is also a broader TT concern for the care group).		change over Q1/2 to reinforce confidence in our ability to deliver.
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	A paper on this work is before the March Board: we have not met the measure in 24/25 (unexpectedly) – and have work to do to build up mid career and apprentice first approaches to scale.	Amber green (deterioration)	We remain confidence of meeting the measure in 25/26 but need to see an upswing in enrolment during Q1 to be confident after falling short in 24/25.
	In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Amber red (deterioration)	Work has been done in both spaces (hence AR not red); but it falls short of a tailored access approach, which will be presented in the April delivery review.	Amber red	Whilst there are differences between these three ambitions they currently have in common delivery doubts based on a lack of oversight and cogent approach. This is being urgently addressed – as schemes exists elsewhere and deploying them to the Trust is entirely possible with focus in Q1.
	In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Red (deterioration)	The schemes implied by the measure are not yet in place. Connections exists to develop this and present it to the April delivery review.	Amber red	
	In 2026/27 introduce tailored access scheme for people with learning disabilities.	Red	Learning from what is above, we need to start work now on the scheme for twelve months hence. Working with our ID/LD teams, we need to consider how best we can establish a targeted programme.	Amber red	
10. Be recognised by 2027 as an outstanding provider of inclusion health care, implementing NICE and NHSE guidance in full, in support of local GRT, sex workers, prisoners, people experiencing homelessness, and	Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber red	There remains a need to systematically compare our position to the standards; likely best done at a place level. This taking time to organise. It is most developed in Doncaster. It remains the intent to have this work ready for May's CLE sub.	Amber red	It is possible to meet the standards in time, with rapid use in 25/26 of the funds set aside with partners. This will require concerted work to make 'mainstream' services available, as well as to develop specialied services.

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misusing substances, and forced migrants.	Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.	Red	This access plan will rest on ensuring mainstream services thresholds for exclusion are changed in theory and practice: initial discussions to this effect have begun. A more organised and concerted approach will be needed (with new resource in place to move this forward).	Red	Until a baseline plan is in place it is not possible to offer a more optimistic view of changes needed – nor how much resistance in practice could be experienced in developing TIC models in this field.
	Specific service offers in place for all or most inclusion health groups by 2027.	Amber red	The Trust has invested in GRT specialist service support. Service offers for sex workers and those experiencing homelessness are developing – there remains work to do in considering how best to ensure refugee access.	Amber green	Most inclusions health groups can benefit from revised access arrangements, and some element of specialised support, over the next two years. But only if organisation and emphasis is stepped up in Q1.
11. Deliver in full the NHS' commitment to veterans and those within our service communities, recognising the specific needs many have, especially for access to suitable mental health and trauma responsive services	Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees).	Amber green	Strong planning work has taken place and whilst the reasons for gaps are speculated, the right actions are in place.	Amber green	Over time, with trial and error, we are expecting to close the gap we presently see through a combination of data improvement and better performance.
	Introduce peer-led service support offer for local residents.	Amber green	This offer is in place in trial and further expansion is being into place. We'd expect this to be live at full scale during 25/26.	Amber green	This input and effort measure can be met, and is in fact ahead of expectations.

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12. Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve.	Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access.	Green	Good connections have been built to help us to think through what the issues and potential solutions may be. Care Group led work at this stage with buy in from other teams.	Amber green	A clear set of intended steps have been defined and agreed in principle through E&I. Further testing needed going into early 25/26.
	Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.	Amber red	Not yet meaningfully planned but will be accelerated in the context of the digital transformation plans we have during the balance of 25/26.	Amber red	Rating reflects planning comments made.
13. Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, childrens', or care home.	Deliver over 130 care packages through our physical health virtual ward service.	Amber green (deteriorated)	A strong plan exists, has been peer reviewed, and is being delivered. However, national funding and narrative is now uncertain for virtual ward services.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Sustain and expand our IV provision in out-of-hospital settings.	Amber green	We need to agree a final plan with the Care Group, and crucially with DRI, for the service's further growth.	Green	Services were substantively funded going into 24/25. They are expanding month on month.
	Sustain and expand our Clozapine service in off ward settings.	Green (improved)	Both Doncaster and Rotherham AMH have service plans internally: with a successful Invest Fund bid agreed for North Lincs.	Green	Funding, some centrally pumped, much recycled in now in place to move these services forward in H1 25/26
	Take annual opportunities to transfer services to homecare where safe to do so.	Amber red	In due course we need to find a planning route to go beyond the measures above and establish a broader drumbeat of left shift…	Amber Green (deteriorated)	This measure is ours, and others, and will see substantial emphasis in coming years – no doubt.

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14. Assess people referred urgently inside 48 hours from 2025 (or under 4 where required) and deliver a 4-week maximum wait for all referrals from April 2026: maximising the use of technology and digital innovation to support our transformation.	Meet four hour wait standard in 2025/26, where it applies.	Amber green	This measure applies in only a handful of defined services. Monitoring suggests room for improvement but strong performance – focus on this is likely to yield delivery.	Amber green	A delivery priority for next financial year.
	Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Amber red (improved)	Thinking about routes to success has taken place and CLE is moving to define what this promise in practice means.	Amber red	Until we commence implementation it is too early to be confident we do not have glitches, notably in relation to MDT decision making
	Make progress to reduce waiting lists and times and close supply gap in 2024/26.	Green (improved)	Strong consistent work has taken place to understand our waiting lists and demand/supply in relation to waits themselves. Investments reflect only areas where productivity cannot meet the measure.	Amber green	Delivery relies on both supply side change and some stability in demand, both across a year and by month (as a proxy for four weeks). We will use 25/26 to identify difficulties with that assumption.
	Meet 4 week standard from April 2026 across all services.	Amber green	There is increasing confidence that this measure could be met: the cultural shift doing so requires is not inconsiderable and weariness with the ask will need to managed.	Amber green	Neurodiversity remains the greatest single challenge to the measure, and adult ADHD services are very substantially behind the agreed trajectory going into Q1.
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	Positively, the Trust is at the forefront of 'neighbourhood health' conversations across the ICB: but a cohered plan remains elusive (and we cannot plan alone). We might reasonably expect the Ten Year Plan to again reemphasis the requirement.	Red	Time passes and 26/27 is the earliest feasible delivery date now for restructure. There remains some enthusiasm to shift services onto neighbourhood settings on a pilot or targeted basis.
	Restructure Trust services into those INTs during 2025/26.	Red	This rating reflects the lack of a plan – our community based teams, in the main reflect PCN groupings – not neighbourhoods.	Amber red	Discussions over children's services less well developed than for adults: will require a move towards generalism

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					which may not be easy to lead professionally.
	Evaluate and incrementally improve joint working achieved through these teams.	Amber red	Planning this work can follow from further definition of the INT plans we have.	Amber green	Once the above measures are met, this item is feasible!
	Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme.	Amber green	This work was defined in late 23/24 and a monitoring structure established. Indications remains positive that we are on track.	Amber green	Needs a clear frame of year end analysis in ‘washing up 24/25’.
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	Training has progressed mostly well. Uptake is more mixed. 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	To succeed we need the new directorate team in N&F to clearly prioritise this objective and will need to structure the development of these measure and embed them within the IQPR.	Amber red	This has proved a difficult measure to establish despite work on it for over 12 months.

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17. Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities.	Narrow the school readiness gap between our most deprived communities and average in each place in which we work.	Amber green	A challenging plan exists, which has strong support from across corporate functions and is led through the Children's Care Group.	Amber red	Gap narrowing on school readiness has proved elusive: joint working with school is going to be needed to deliver any plan. This feels feasible, if difficult, in Doncaster and North Lincs.
	Seek to see 80% of children meet their own potential for school readiness by 2028.	Amber green	Establishing this data feed is taking time and requires collaboration across a number of teams inside and outside the Trust. Annual data is feasible as we look to stem a deteriorating position.	Amber red	It is much easier to be confident of the inputs than the results in this field: the Trust has developed and is implementing a clinically led hypothesis which may transpire to make a difference.
18. From 2023 invest, support and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery.	Meet guidance obligations from NHS England relevant to the quality of inpatient care, including safer staffing measures where they exist, and fully comply with the Mental Health Act.	Amber green	Current analysis for this measure appears positive. Work to improve MHA compliance is showing promise. We know what to do, we need to do it – with Q1 25/26 seeing some better real time data available to teams, for instance in relation to S17.	Amber green	With continued focus we have some confidence that this can be met over the balance of the year.
	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	Baseline data is being put into place. But it is taking time to agree how to accomplish change inside each ward. Medical engagement remains a significant challenge to implementing this plan, albeit among acute psychiatrists there is some enthusiasm.	Amber red	Mobilising this work will be a significant endeavour in 25/26, after pilot phases over next two quarters.

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	Work with patients and peers to assess the quality of services, including through peer reviews, and ensure that teams are able to act on that feedback and those evaluations.	Green	This work has progressed strongly through 2024/25, including now on an OOH basis. Peer involvement has added greatly to the product.	Green	We do need to be able to show impact from the work done, and this will be reflected in our QA for 24/25.
19. End out of area placements in 2024, as part of supporting people to be cared for as close to home as is safely possible.	Cease to place patients out of their home district except where that is their choice or in their best interests.	Amber green	We do know what we need to do. The plan gap is resourcing doing it, and securing our delivery chain internally around LOS. Executive time is being spent in April refining that approach with a view to presenting it to CLE and the Board in May.	Amber red	The scale of change required remains immense. Substantial improvement is possible, a revised timetable for elimination will be assessed in Q1 25/26. Our general 25/26 plans assume sizeable change from July 2025.
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.	Red (deteriorated)	AOT work has taken primacy. An assessment is being made of how/when this is best mobilised. It may be that it can support the LOS work referred to under Promise 19.	Amber red	This rating reflects comments on the left.

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	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 – but a tangible plan to trial this is not yet visible and did not come forward within planning for 25/26. Discussions will continue with the CCG.	Amber red (deteriorated)	Evaluation in that time period may not be feasible, but deployment, if funded, will be.
21. Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents – developing services on a hyper local basis.	There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise.		There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise. 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	This will be an important part of our work on promise 19, and efforts to reduce LOS. We do not have a defined plan, delivery chain or implementation model in place as yet but need to have such for May.	Amber green	There is very substantial executive emphasis on this work and over coming months we'd expect to see change.

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	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	We have made a start in Rotherham, and are trying to define final work packages elsewhere. Turning these opportunities into bed flow that impacts acute care needs further grip.	Amber green (improved)	Strong buy in from clinicians and partners – and work can be taken forward within the auspices of HQTC. Will need diligent oversight to avoid atrophy.
	Expand the scale of our residential forensic rehabilitation service.	Green (improved)	Work has already taken place with this in mind. Further plan exist in our community teams, with scope for work alongside Cheswold.	Amber green	A 20% expansion has already taken place.- and we now need to consider what more is needed to match need.
	Establish and support a step-up service for older peoples' care in Doncaster by 2027.	Amber green	Work advancing alongside partners: project resource defined and starts work shortly. Significant place support.	Amber green	This may be an optimistic rating given scale of change: but the pressing need to change gives this natural priority and we have 3 years to deliver.
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.		We may pause monitoring of this measure unless the operating plan guidance sheds light on the national future of these plans.		Rating reflects lack of clarity of ask/measure at this stage. May be clarified in 10 year plan (2025)

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	NHS England assessment outcomes remain outstanding in all disciplines.	Amber green	Currently strong in all assessed disciplines (latest report just received). Social work assessment due in 2025.	Amber green	No identified reason why assessment outcomes would change over coming period, albeit some emerging concerns among postgraduate medical education.
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 have completed the work on both back pay and RLW for implementation to the timetable agreed with the Board.	Green	As above.
	Transfer more of our spend to local suppliers (shift of 25%+ compared to 2023/24).	Amber green	Clear plans developed during 2024. Implementation deadlines are clear and being met but some supply chain issues to resolve in Q1.	Green	Measure defined, suppliers aware. Food and travel most challenging areas to execute, albeit both consistent with P27 agenda.
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.	Amber Green (deteriorated)	The agreed plan has had difficulty being deployed, and audit review criticised the diversity of approaches taken. This is largely addressed but rapid action is needed in Q1.	Amber green	Practice as well as policy change needed, but visible start made and weaknesses caught in time.

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	Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.	Amber green (improved)	Some positive movement within the 2024 staff survey results when compared to 2023 and to peers. Further work needed to deliver in 2025 survey on which the success measure will be based.	Amber red	A complex and longstanding issue, which, as August 2024 illustrated, is subject to events beyond the Trust. We have work to do to build trust and confidence among BME colleagues.
	Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.	Amber green	There is strong commitment to the measures contained in NW accreditation: work needed now to look across excluded groups for relevant assessment tools.	Amber green	These frameworks tend to be input based, not outcome derived. Organisational commitment to compliance is not in question.
	Tackle our gender pay gap.	Amber green (improved)	Notwithstanding the need for localised plans, it seems most likely that the shift to the RLW will move the position on this measure to compliance.	Green (improved)	We are increasingly confidence of delivering this measure moving into 2025/26.
27. Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.	Reduce our carbon tonnage by 2000 (and offset balance).	Amber Red (improved)	Excellent analysis has established the sheer scale of change/investment needed. Consideration of a route to success is to be considered alongside our estate plan.	Red	Estimated £18m investment is not entirely foreseeable, and we are working through what may be possible as an alternate to the heat pump route to gas reduction.

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	Agree and deliver specific contribution to local authority climate change plans.	Amber red	Advancing this measure is a matter of time/priorities. Good engagement exists with each LA, and in due course this work will need to be documented and reviewed.	Amber green	LA feedback on Trust engagement remains positive, and we are doing what is asked. The plan may give rise to a larger ask in time.
	Change service models for patients and staff to reduce travel required by 2027.	Amber red	A plan to achieve this, and to scale 'this', is being developed during Q1. Our 'remote' policy and practice will be crucial to success. A positive climate adaptation day has moved forward thinking inside teams as well as at corporate level.	Amber green	The implementation of digital care alternatives is a national priority, and we would expect our own and others efforts to intensify in 25-26-27.
28. Extend the scale and reach of our research work every year: creating partnerships with industry and Universities that bring investment and employment to our local community.	Meet portfolio study recruitment targets each year.	Green	The Trust is consistently meeting the measures and has a process in place to support engagement where there are shortfalls	Amber green	This is very much a well led measure and we would expect to succeed again in 2024/25
	Deliver metrics contained in the Trust's Research and Innovation plan.	Amber red	Significant work is now needed to convert the research priorities we have agreed into a delivery plan owned across Care Groups	Amber red	The 2028 ambitions are deliverable, but a cultural shift is probably needed in how GR/CGs operate together
	Work to further increase the reach of research into excluded communities locally.	Amber green	This is a longstanding programme of work for grounded research. A more detailed delivery plan may be needed going into 25/26. This may include developing a community researchers' programme.	Amber green	This is an input measure which we are confident of sustaining focus on, without too much corporate input