NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 25 September 2025 at 10.00am
CAST Theatre, Waterdale, Doncaster, DN1 3BU

No	Item	Request to	Lead	Enc.
1	Welcome			
2	Apologies for Absence: Rachael Blake, Dr Richard Falk, Pauline Vickers	Note Information	KL	
3	Quoracy (One third of the Board; inc. one NED and one ED)			
4	Declarations of Interest			A
Staff / Patient Story				
5	Patient story	Information		Verb
Standing items				
6	Minutes of the meeting held in public on the 24 July 2025	Decision	KL	B
7	Matters Arising and Follow up Actions	Decision		C
Board Assurance Committee Reports to the Board of Directors				
8	Finance, Digital & Estates Committee	Assurance	SFT	D
9	People & Organisational Development Committee	Assurance	DV	E
10	Quality Committee	Assurance	DV	F
11	Mental Health Act Committee	Assurance	SFT	G
12	Public Health Patient Involvement & Partnerships Committee	Assurance	DV	H
13	Audit Committee	Assurance	KG	I
14	Chief Executive's Report	Information	TL	J
15	Emergency Preparedness, Resilience and Response *	Decision	RC	K
BREAK (11.30)				

16	Tackling Waits in Neurodiversity Services	Information	TL	L
17	Audit Committee – Workplan *	Information	PG	M
18	Future of Pharmacy Services (WOS)	Decision	IM	N
19	Older Peoples Quality Indicators *	Decision	DS	O
20	Acceptable Behaviour Policy Implementation	Information	PG	P
	LUNCH BREAK (13.00)			
21	Our 8 Plans: Research and Innovation	Decision	DS	Q
22	Provider Capability Assessment	Decision	PG	R
23	Medium Term Financial Plan *	Decision	IM	S
24	2026 to 2027 Savings Programme	Decision	IM / TL	T
25	Estate Plan	Information	IM	U
26	Further update on Community Mental Health Services (Adult)	Information	TL	V
	Operating Performance / Governance / Risk Management			
27	• Integrated Quality Performance Report (IQPR) • Health Inequalities – Review of IQPR		TL	Wi Wii
28	Strategy Delivery Risks		PG	X
29	Operational Risk Report *		PG	Y
30	Promises and Priorities Scorecard *		TL	Z
	Supporting Papers (previously presented at Committee)			
31	Mortality Report	Information	KL	Pack B
32	Any Other Urgent Business (to be notified in advance)		KL	Verb
33	Any risks that the Board wishes the Risk Management Group to consider			
34	Public Questions *			
35	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	
36	*Minutes of the meeting held on the 24 July and 28 August 2025 (private session)*	*Decision*	KL	AA
37	*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
38	*Reflections on the patient story*	*Discussion*		Verb
39	*Chief Executive Private Update to the Board of Directors*	*Information*	TL	CC
40	*Cyber Security*	*Assurance*	RB	DD
41	*Insights*		TL	EE

***Paper to be managed via questions only**

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

The next meeting of the Board of Directors will take place on Thursday 27 November 2025 10am - Rotherham

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**	25 September 2025

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

The report is presented as a standing agenda item at each meeting to ensure board awareness to any declarations and if needed, actions taken to prevent any conflicts during the business of the Board.

There have been no new (or changes to previous) declarations of interest in the period since the last meeting.

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

Paper presented to each public Board meeting

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

The Board is asked to:

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

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

Business as usual	x

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

Business as usual	x

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

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

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

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

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

Appendix (please list)

None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

BOARD OF DIRECTORS – REGISTER OF INTERESTS

Executive Summary

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

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

Amendments are shown in bold text.

Name / Position	Interests Declared
Kathryn Lavery, Chair	• Owner / Director of K Lavery Associates Ltd • Chair ACCIA Yorkshire and Humber Panel • Chair of the Advisory Board Space2BHeard CIC HULL • Non-Executive Director at Locala Community Interest Company
Toby Lewis, Chief Executive	• Nil
Richard Banks, Director of Health Informatics	• Wife works in administration at Sheffield Children's NHS Foundation Trust.
Rachael Blake, Non-Executive Director	• People and Transformation Lead – Jacobs (Global Rail & Transit Solutions Provider) • Director - Bawtry Community Library • Bawtry Mayflower School Governor - Co-opted
Richard Chillery, Chief Operating Officer	• Nil

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

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

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 25 September 2025

Item 5

Patient Story

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 24 JULY 2025 AT 10.00AM ENTERPRISE SUITE, THE ARC, 2 LICHFIELD AVENUE, SCUNTHORPE, DN17 1QL

PRESENT

Kathryn Lavery	Chair
Richard Chillery	Chief Operating Officer
Maria Clark	Non-Executive Director
Dr Richard Falk	Non-Executive Director
Steve Forsyth	Chief Nurse
Sarah Fulton Tindall	Non Executive Director
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

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Lea Fountain	NeXT Director
Philip Gowland	Director of Corporate Assurance / Board Secretary
Sarah Dean	Corporate Assurance Officer (Minutes)
Cheryl Gowland	Primary Care Strategic Lead
Emma Stables	Senior Clinical Nurse Specialist, Infection Prevention and Control

2 members of staff and 1 Governor were in attendance

Ref		Action
Bpu 25/07/01	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. Apologies for absence were noted from Rachael Blake and Dave Vallance, Non Executive Directors, Dr Jude Graham, Director for Psychological Professions and Therapies and Jo McDonough, Director of Strategic Development.	
Bpu 25/07/02	**Quoracy** Mrs Lavery declared the meeting was quorate.	
Bpu 25/07/03	**Declarations of Interest** Mrs Lavery presented the declarations of interest report which outlined that there were changes to the register declared since the last meeting that included the additional declarations for Maria Clark and the removal and an additional declaration for Rachael Blake. Clarification relating to Ms Clark declarations of interest were noted. **The Board received and noted the changes to the Declarations of Interest Report.**	

STAFF STORY		
Bpu 25/07/04	**Staff Carer Story** Mrs Lavery welcomed Emma Stables, supported by Cheryl Gowland, to share her own experience of being a carer whilst working within the organisation, and the challenges she had faced managing her work and life balance. Mrs Lavery referred to material shared prior to the Board meeting. Support was offered to anyone who needed or was distressed by the agenda item. Emma talked about the care she provides to several family members and shared some photographs of her family to provide some context to the people she referred to. Emma spoke about how she managed the caring responsibilities with other family members whilst they maintained professional caring roles themselves. Emma spoke about the increased support required as their loved ones grew older or at times when they suffered a deterioration in health and the additional challenges then of attending medical appointments and fitting that in within the working day. Sadly, Emma's son passed away three years ago from pneumonia and sepsis and Emma spoke briefly about her bereavement and the impact this had on her work life. Emma highlighted the fact that sometimes staff were expected to take annual leave to support loved ones that they are caring for appointments, when leave was often even more important for carers to provide some much needed respite and to avoid taking periods of sickness. Emma felt that due to her increasing caring responsibilities the better option for her was to reduce her hours at work, rather than asking for time off at challenging times. Emma acknowledged that was not an option for everyone. Emma felt fortunate that in her role as a clinical specialist there was an option to work more flexibly around her caring responsibilities but realised that this was less of an option for patient-facing, ward-based clinical staff. Emma talked about the importance of the Carers Network and the support for colleagues who had additional caring responsibilities outside of the workplace. It was acknowledged most members were admin or specialist role colleagues, not ward based colleagues, and further engagement work continued to reach out and promote the Carers Network. Mr Lewis reflected on the outpour of love which came from Emma's story. Ms Fulton Tindall reminisced of caring for her parents whilst able to manage a balanced work life, and the importance of having a supportive manager and organisation. Mr Chillery stated the story highlighted how caring responsibilities affected lots of people and need to recognise as an employer to create flexibility and right roles to be able to lessen the stress and burden on colleagues. Mrs Lavery stated the matter was raised at the recent Trust People Council and how ward based staff could be supported. Mr Forsyth recognised the supportive team in which Emma was part of, and was aware ward based colleagues often changed roles in non ward environments to fit around their caring responsibilities. There would be	

	intention to discuss later on the agenda on the carers delivery plan and how staff would be supported with caring responsibilities. Ms Holden questioned whether there was anything retrospectively different which could have supported Emma further. Emma confirmed compassion, caring and understanding of colleagues personal circumstances needed to be taken account. When Emma's son passed away she received a standard letter from her manager which did not feel supportive or understanding even though Emma had a very supportive and compassionate manager. Ms Holden acknowledged the negative impact Emma experienced and responded the bereavement policy had since changed where colleagues would be entitled to up to two months leave under the circumstances, which is separate to sickness absence. Mrs Lavery and the Board thanked members for taking the time to listen to Emma's story and noted the intended reflection time later on the agenda.	
	Emma and Cheryl left the meeting	
	STANDING ITEMS	
Bpu 25/07/05	**Minutes of the previous Board of Directors meeting held on the 29 May 2025** **The Board approved the minutes of the meeting held on the 29 May 2025 as an accurate record subject to wording amendment requested by Mr Lewis under Bpu 25/05/13 (Chief Executive Report).**	
Bpu 25/07/06	**Matters Arising and Follow up Action Log** There were no other matters arising from the minutes. The Board received the action log and noted the progress updates. All actions noted as 'propose to close' were agreed.	
	BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS	
Bpu 25/07/07	**Report from the Quality Committee (QC)** Dr Falk presented the paper and gave the key highlights. There was a concerning observation arisen and a theme from other committees for education on substance misuse management for people with comorbidity. There may be opportunity to incorporate substance misuse education into learning half days. There was no use of agency staff during April and May to support inpatient safe staffing and fill rates had been maintained at acceptable levels. The quality safety impact assessment (QSIA) highlighted the themes and impacts from the savings programme, and the committee were assured a structured approach was being taken to assess and monitor quality and safety. A retrospective audit of QSIAs would be undertaken to ensure all schemes had been appropriately assessed. Ms Holden	

	advised there would be a retrospective review of directorate budget sign off which may reflect the QSIA process and any learning would be shared. The committee were provided with an overview of work to deliver Promise 16 relating to personalised care and move to the use of patient reported outcome measures (PROMs). The work highlighted the areas for focus and importance of training and organisational culture change. A refined set of 'Always Measures' (AMs) would be implemented as part of the foundational elements of the Quality and Safety Plan and linked to strategic objectives. The AMs would be reviewed and adjusted based on feedback and implementation outcomes. **The Board received and noted the report from the Quality Committee.**	
Bpu 25/07/08	**Report from the Audit Committee** Ms Gillatt presented the paper and confirmed there were no matters of concern or areas to escalate to the Board. Good progress and positive team working was noted regarding the annual report and accounts for 2024 to 2025. The head of internal audit opinion had given significant assurance, an improvement from limited assurance in the previous year. An overview of the procurement arrangements and future plans to improve the function was highlighted, and timeline for an alternative delivery model. The review would include single quote waiver process and policy to ensure they were relevant and best practice. **The Board received and noted the report from the Audit Committee.**	
Bpu 25/07/09	**Report from the Mental Health Act (MHA) Committee** Ms Fulton Tindall presented the paper and highlighted key points. The MHA compliance during April and May showed there were 288 detentions, 1 of which was unlawful. There had been positive improvements made regarding training compliance for reducing restrictive interventions, the Section 136 assessments undertaken within timeframe, and reduction in the number of MHA incidents. Ms Holden stated it was good to see training compliance rates continued to improve across all areas and confirmed there had been great effort from the learning and development team to address culture and support colleagues to improve compliance. There had been a refresh of the annual MHA equalities report with focus on ethnicity, and whether people were disproportionately detained under the MHA compared to the population. Analysis indicated detention rates for the black community were higher than the white community, this reflected the national picture. Mr Forsyth stated it was a significant	

	concern to note that many people detained would also experience the criminal justice system. Mr Lewis confirmed work was underway to better understand those findings. Issues remained relating to seclusion for a patient to have an independent consultant review within 5 hours particularly during weekends. A robust action plan was being developed with Dr Sinclair to improve compliance and job planning reviews. Dr Falk noted there had been 1 unlawful MHA detention and questioned whether there had been any specific learning from that. Dr Sinclair advised the detention was made by an external consultant and work was underway with local authority partners on receipting of patients with appropriate completed MHA paperwork. With regards to blanket restrictions, Mr Lewis highlighted the changes implied were substantial changes to process, policy and governance arrangements, and would expect to conclude by the end of September. **The Board received and noted the report from the Mental Health Act Committee.**	
Bpu 25/07/10	**Report from the People & Organisational Development (POD) Committee** Mrs Vickers, on behalf of Ms Blake, presented the paper and highlighted key points. There would be new exception reporting on the guardian of safe working hours which would be implemented from September. Racist incidents had seen an increase, potentially due to the implementation of Radar that provided more accurate detail whether staff felt the incident was racial or discriminatory. Consultation had been made with the REACH network. Mr Chillery stated it was good to see data was being shared with networks and triangulated to understand qualitative information. The people and teams plan continued to progress with good progress on a self rostering pilot at the hospice as part of the future flexible working arrangements. Consideration for acute areas was needed and how flexible working could be managed, this was also being explored with the carers and women's network, noting the theme from the trust people council. Mr Lewis explained the CEO report also provided further detail on seven-point action plan in response to part of Promise 25 on anti-racism and wider discrimination, noting there would be an audit of the Appropriate Behaviour Policy in practice. **The Board received and noted the report from the People & Organisational Development Committee.**	

Bpu 25/07/11	**Report from the Public Health, Patient Involvement & Partnerships (PHPIP) Committee** Dr Falk, on behalf of Mr Vallance, presented the paper and highlighted key points. He confirmed there were 286 active volunteers (target is 350 by October) and noted challenges faced including cultural barriers, uptake and retention of volunteers. Positive progress had been made against delivery of the research and innovation plan and promise 28. The trust was successful to host the regional ethnic minority research inclusion network and Dr Kellett from the Rotherham care group had become a Professor, a positive step towards enhancement that would attract staff to research. A self assessment was undertaken in 3 areas against the patient, carers, race equality framework (PCREF). Partnership working continued to be strengthened, noting internal audit significant assurance on partnership governance arrangements and development of a partnership scorecard. The development of health inequalities reportable data continued to be refined and verified against delivery of a number of promises. Mr Lewis referenced the first fundamental Aspire partnership report which showed strong performance from the alcohol and drug service. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	
Bpu 25/07/12	**Report from the Finance, Digital & Estates (FDE) Committee** Mrs Vickers presented the paper and highlighted key points. At Month 2, there was a £597k deficit (better than plan). The delivery of the out of area placement (OOAP) savings target would take effect from 1 July and was key to delivering the 2025 to 2026 financial plan. At month 2, there were nine directorates not compliant with their respective budgets and remedial action had been taken to support them. Mr Lewis advised he was satisfied those areas which had deviated from financial plans would be resolved, and confirmed budget delegation would be removed in respect of two care groups by the end of July until they were in a financially stable position and this would be hoped by end of October. The medium term financial plan had been refreshed to include assumptions and level of cost improvement programmes (CIP) required to be delivered to reach an underlying balance. Whilst the plan assumed a £1m shortfall for the pay awards, this could be higher once funding arrangements were known in August. An overview of the procurement arrangements and future plans for an alternative delivery model were noted as above (Item Bpu 25/07/08).	

	The information quality work programme was a positive highlight and demonstrated a structured process was in place to address data quality. The data security and protection toolkit (DSPT) final submission had been completed since the last committee. Mr Banks confirmed the DSPT 360 assurance audit report had also been completed with all achievements being met. Mr Chillery referred to the key assumptions related to achieving the OOAP target and delivery of Promise 19, and confirmed it was a fluctuating position with 8 people who were OOA. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
Bpu 25/07/13	**Remuneration Committee** Mrs Lavery presented the paper and highlighted key points. The national arrangements for very senior manager (VSM) colleagues terms and conditions framework had been revised. The new framework would no longer include claw back arrangements for the Chief Executive's salary. The committee accepted the recommended national VSM pay award for 2024 to 2025. **The Board received and noted the report from the Remuneration Committee.**	
Bpu 25/07/14	**Report from the Trust People Council (TPC)** Mrs Lavery presented the paper and highlighted key points. Feedback from the carers network and disability and wellbeing network (DAWN) was shared related to reasonable adjustments, flexible and remote working. These would be explored further to understand the barriers and parameters as noted earlier (Item Bpu 25/07/10). The engagement, culture and feedback from members was positively received with real debate and many contributions. Dr Falk referenced the further work with managers to understand barriers to flexible working as well as kindness. The Board discussed compassionate leadership and cultural change and acknowledged it was an area of ongoing development. Mr Lewis referred to the TPC to have an equal and diverse range of staff voices including those on behalf of trade unions, noting a BMA representative had positively contributed to the TPC. **The Board received and noted the report from the Trust People Council.**	
Bpu 25/07/15	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report	

The Board were asked to approve the refreshed Green Plan 2025 to 2028 which was previously supported at the PHPIP committee. The updated plan outlined the strategic approach to reducing the carbon footprint of services and estates to align with the NHS ambition to achieve net zero. Mr Lewis reminded members the subject would be discussed at the next Board time out session relating to abolition of energy related grant schemes and potential joint venture proposal.

The new NHS Oversight Framework had been developed to support system performance and improvement, noting the organisation was rated as a 3. This continued to be an evolving situation and Mr Lewis stated that core scores would have given a rating of 2 (better).

The CQC had confirmed it no longer held ratings at a Trust level (previously rated as required improvement), and the outcome of recent acute visits was to follow shortly.

The annual members meeting (AMM) was held in July alongside the first children and young peoples AMM, with considerations to explore, following feedback from young people and their carers.

There would be an audit of the seven point plan as part of promise 25 to address anti racism and discrimination (item Bpu 25/07/10). Good progress had been made against delivery of the plan, noting the changes made where complaints were investigated by someone from a global majority background. There would also be changes made to the interview panel process.

Waiting times would begin to be published on the website from the end of July. This work had been coproduced in partnership with local GP colleagues to provide transparency and reduce pressures. Mr Forsyth noted Care Opinion was a mechanism for direct patient feedback and response relating to waiting times.

There were no specific matters to escalate from the clinical leadership executive (CLE) but Mr Lewis drew attention to the items explored during June and July as well as those to consider in August and September.

There were five RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable incidents during quarter 1.

The NHS 10 year plan had been published with focus on neighbourhood health, and the Board would spend time in its August time out to consider further.

Regarding the children and young peoples AMM, Mr Mohammed reflected on Board members creating space to develop and enhance relevant and appropriate skills and knowledge, and stated he welcomed the planned future board time out session to spend dedicated time with children's services.

	In response to Dr Falk and implementation of the NHS 10 year plan, Mr Lewis confirmed engagement with the primary care networks had commenced and partnerships continued to be developed with primary care and GP partners. Coproduction work would be required to consider clear and effective neighbourhood working and outcomes. Mr Chillery noted the importance of partnership working to include voluntary and community services as well as primary care partners. Ms Clark noted waiting times would be published and raised a concern whether this could be distressing for some patients. Mr Lewis responded as part of promise 14 and deadline of April 2026, there had been significant investment and work to reduce waiting times which would be measured in weeks. Mr Lewis confirmed this work, alongside work across the South Yorkshire ICB would be brought back to the Board in September. In response to Ms Gillatt query relating to the Green Plan, Mr Lewis advised environmental measurements and qualitative descriptives were reported within the Trust Annual Report. **The Board supported submission of the Trust's update Green Plan**. **The Board received and noted the Chief Executive's report and the forward actions it contained.**	**TL**
Bpu 25/07/16	**Older People's Quality Indicators paper** Dr Sinclair presented the paper and gave key highlights. Following the closure of an older adult ward in Rotherham earlier in the year, the Board had made the decision to move from a traditional function to a mixed functional and organic older adult ward. Although this model was a minority position nationally, it had successfully been implemented across Doncaster and North Lincolnshire. There would be different patient environments, designs and staffing make ups to consider as part of the model. The Board were reminded that a Regulation 28 notice was issued in September 2024 following concerns about the lack of crisis team provision for people aged over 65. The new arrangements for over 65s who required crisis support came into effect at the end of last year. There was a need to implement and track meaningful mental health quality indicators for older adults, to monitor the impact of the changes made, be able to benchmark older people services against the working age services to identify differences in care and outcomes, and develop towards data informed services. The quality indicators had been split broadly into two categories for inpatient and community, and Dr Sinclair drew attention to the domains created to measure against accessibility, effectiveness, safety, patient experience and CQC self assessment ratings. Mrs Lavery referred to the Board's previous discussions and decision relating to older peoples services, and the importance of having the quality indicators to be able to evidence and assure the changes made were effective and safe. In response to Dr Falk, Dr Sinclair advised the	

	quality indicators would have a wide remit of safety and care domains to be able to assure the changes in model had not caused harm. The Board discussed the development of the data, monitoring and escalation arrangements. Mr Lewis explained an assessment would be taken, with monitoring to become part of the high quality therapeutic care taskforce (HQTC), safety and quality plans and delivery reviews, with any concerns for escalation to the quality committee. A formal review of the older peoples quality indicators would be undertaken in September 2026, to allow time to develop and implement service development. Dr Falk expressed his interest to become part of those developments. Mr Chillery referenced the inpatient quality indicators proposed, and suggested there may be disproportionate compared to community quality indicators noting that the majority of patient care was provided in the community. Dr Sinclair agreed to explore developing the community quality indicators further. Ms Gillatt referred to disengagement and safe care. Mr Lewis noted there was intended time to discuss the subject during its private meeting. There was a substantial programme of work for safe care planning in community mental health services underway linked to promises and recommendations, and next steps would be provided to the Board at its meeting in September. The Board discussed other measures to consider as quality indicators, and Dr Sinclair agreed to explore people measures such as turnover and MAST. Mr Chillery advised the older peoples mental health services in North Lincolnshire were trialling virtual ward and would be opportunity to test and apply those quality indicators. **The Board received and noted the Older People's Quality Indicators paper.** **The Board supported the quality indicators as a current baseline, with the intention to compare the indicators against other relevant providers (noting the intent to also make comparison to working age services). The quality indicators would continue to be refined, and a progress report would be provided to the Board at its next meeting in September.**	**DS** **DS**
Bpu 25/07/17	**Promise 24: Education at RDaSH** Mrs Lavery invited colleagues to take the paper as read and opened up for discussion and questions for Ms Holden to respond. Mr Lewis recognised the educational journey to support and upskill the workforce and leadership teams over the year. Mrs Lavery noted the improvement made in utlising the apprenticeship levy, and acknowledged further plans to continue with focus on supporting local partners. Mr Mohammed referred to levels of apprenticeships and equity of workforce, with the shift to support lower level qualifications rather than senior and higher paid colleagues.	

	Ms Gillatt explained the Audit Committee had oversight of educational governance, both internally and externally, and welcomed the paper as additional oversight and assurance of educational investment, resources and its effectiveness. Mrs Vickers reflected on earlier discussions on flexible working and how this needed to be integrated with educational plans. Ms Clark highlighted the importance of raising awareness of educational opportunities, noting from a recent inpatient peer review conversation there were some colleagues who were not aware. Ms Holden responded the educational plan had been on an improvement journey during the previous year, with twelve key areas of focus to reflect, learn from and implement changes. Ms Holden agreed there would also be cultural change with managers in the learning space. A training needs analysis review had been undertaken which had been refined and revised approach embedded. The organisation had not exceeded the apprentice levy, but this was improving and had seen an improvement in MAST training since creating learning half days with focus on compliance. Managers had more understanding and increased ownership on individuals whether they were compliant or not. The development of training dashboards for managers was readily available and would include placements and specialisms, and in September there would be focus on education dashboards at delivery reviews. There were two national changes that would support the apprentice spend related to functional skills requirements and shorter courses. Discussions had commenced with volunteers and community partners to enable learning spaces and educational spend opportunities. There had been changes in clinical roles career pathways such as allied health professionals (AHP) able to access the apprentice levy. There had also been a shift in continuing professional development (CPD) allocation which had historically been ringfenced for nursing and AHP professionals. Ms Holden advised the paper was also taken with the learning update which detailed the learning structure and the four pillars of learning for individual and systemic learning and education. **The Board received and noted the update in respect Promise 24 and education at RDaSH, aligned with Promise 9.**	
Bpu 25/07/18	**Learning update** Mrs Lavery invited colleagues to take the paper as read and opened up for discussion and questions for Mr Lewis. Mr Gowland questioned the *change needed in some corporate teams*, and whether this was large scale change. Mrs Lavery acknowledged the positive action taken to protect time for learning with the creation of half learning days. Mr Chillery referred to what had been learnt so far and supported the approach of progressing using PDSA (plan, do, study, act) cycles to constantly learn and improve. Ms Holden referred to the positive outcomes and important insight it provided which could be adopted in other areas for development.	

	Mr Lewis responded the paper focused on two areas since the education and learning plan was launched. The first was to understand what had been learnt so far, and secondly how learning was triangulated and shared. Mr Lewis drew attention to learning half days, what had been learned from feedback, the challenges faced and areas for development. There would be rolled out during quarter 2 and 3 with an adjusted model of learning for 24 hour community and inpatient services. The learning model would continue to be implemented and changed to be able to support triangulated learning, how that would be communicated in an accessible way and embed as good practice. **The Board received and noted the learning update paper.**	
Bpu 25/07/19	**Productivity at RDaSH** Mrs Lavery invited colleagues to take the paper as read and opened up for discussion and questions for Mr Mohammed. Mrs Lavery stated the paper was clearly articulated and queried how productivity would be sustained across the organisation. Dr Falk supported the method of measurement of productivity and having clear understood definitions of productivity which would focus on high quality care for patients. Mrs Vickers agreed and referenced learning from cost improvements and ability to benchmark against internal performance to inform and measure productivity. Regarding unpicking block contracts, Dr Sinclair acknowledged the potential this would create towards productivity improvements. Mr Chillery stated national guidance on productivity was in its infancy, and the trust had already made progress in creating the methodology and definition of productivity relevant to the organisation. The Board noted the programme of work would be developed to make productivity improvements in each care group. Case studies would be created to demonstrate how productivity had impacted following changes made. Mr Mohammed confirmed pilots had commenced in Rotherham and physical health teams, and initial results had shown an improvement in engagement across teams as well as productivity. Data was available through dashboards to support productivity and provide insights. Mr Mohammed referred to national productivity tools, and the organisation continued to engage with peer organisations and wider networks. The trust was able to benchmark national cost collection information and performed well compared to nationally. Mr Mohammed reminded colleagues a £4.8m target for productivity improvements was included in the 2025-2026 financial plan, with the 26/27 plan likely to include cash releasing savings stemming from this work. Mrs Lavery noted the ambition to achieve promise 14 (4 week wait) was the primary driver towards delivery of productivity improvements, and acknowledged the progress made in creating a method for embedding the productivity improvement requirements into the existing delivery work.	

	The Board received and noted the update in respect of productivity at RDaSH. **A further update on delivery of productivity work would be presented to the Board in January 2026**.	**IM**
Bpu 25/07/20	**Promise 2 Carers Delivery Plan** Mrs Lavery invited colleagues to take the paper as read and opened up for discussion and questions for Mr Forsyth. With regards to the success measures of the carers delivery plan and in particular measure 4, to identify all age carers that use services, Mr Lewis questioned whether there was a clear understanding of why carer assessments were not completed. Dr Falk recognised the plan resonated with the always measures (AMs) and delivering personalised care, as part of the overall quality and safety plan, with work underway to produce clear guidelines for all staff to show the process of recognising and signposting for carers assessments. Ms Fulton Tindall noted the low number of staff who were declared as carers, and what plans were to identify and better support carers in the workforce for the future. Regarding national statistics of people providing unpaid care and following feedback from the children and young peoples AMM, Ms Holden questioned whether carers felt integral to the decision making process and how young people in services were also recognised as carer providers. Mr Forsyth agreed to explore how young people in services providing caring responsibilities were being recognised. Mr Forsyth responded that there was a mixed and complex situation to recognising and supporting carers from both patient and staff perspectives. Factors to consider included cultures, aging populations, and consultation with those of lived experienced had took place. The carer delivery plan had since been strengthened with focus on carer support, how the voices of parents, carers, family and friends and staff with caring responsibilities would be listened to and be involved. There were good areas of carer engagement to learn particular from children and young people services. Mr Forsyth noted several workstreams would support delivery of the carers plan such as AMs and delivery of personalised care (discussed under Item Bpu 25/07/07). The measures of success would continue to be monitored and other methods of feedback considered to enhance carer support. **The Board received and noted the Promise 2 Carers Delivery Plan, and an update on its implementation would be provided to the Board in November.**	**SF** **SF**
Bpu 25/07/21	**Promise 14 – Delivering a 4 week wait for all referrals** Mr Chillery presented the paper, which provided a progress update on the management of waiting lists. A trajectory had been set detailing the number of services anticipated to meet the four week waiting time by October 2025, December 2025, and March 2026. The trajectories were essential to deliver against Promise	

	14's to deliver a four week maximum wait for all referrals from April 2026. Mr Chillery highlighted it was important to note that sustained or sudden increase in referral volumes or unforeseen changes, such as sickness in small teams may impact projections, this had already been seen in a small number of services including podiatry. Mr Chillery advised there were some pathways at higher risk for achievement due to the scale of improvement work required regarding community mental health teams and learning disabilities services in Doncaster. An update on the neurodiversity position for adults and children would be provided to the Board in September. Significant work had been undertaken to ensure visibility of clinical pathways to provide visibility and detailed focus to waiting lists. The focus has been a focus on referral waiting lists and further work is ongoing with a small number of secondary waits, to enable targeted support and intervention. There was planned time to discuss with CLE in August regarding secondary waits for some therapy pathways. In response to Ms Clark, Mr Lewis confirmed there was no intention to publish secondary waits but we would want to ensure visibility and action on these waiting lists. Mrs Lavery gave thanks for the open and honest report, and acknowledged the enormous work that had been produced to date on addressing wait times and overall, a positive picture. Ms Fulton Tindall stated it provided an honest insight on waiting times. Regarding waits, Dr Falk queried whether this had impacted on the podiatry service. Mr Chillery replied that the care group had recognised the podiatry service could struggle to meet trajectory should demands be sustained. This was due to the significant increase in referrals following a health promotion work undertaken the previous Q3, rather than secondary waits. Mr Chillery explained although the service had responded quickly to the change, an investment bid may be required should the demand be sustained. Mr Lewis summarised there was ongoing effort in data and performance collection, alongside demand and supply, for services to be able to make decisions about offering appointments inside a week of referral. Mrs Lavery noted the timetable of delivery outlined within the report, and recognised the identified non-compliant services and timetable for further review. Work would continue to define secondary waits, recognising that the commitment made by the Board must be the one which patients experience. **The Board received and noted the update relating to Promise 14 to deliver a 4 week wait for all referrals**.	**RC**
Bpu 25/07/22	**CQC Readiness our next steps** Mr Forsyth presented the paper and gave key highlights. The CQC readiness programme continued to progress following the Board's review of the CQC self assessment across the four domains of safe, caring, effective and responsive. The aim would be to achieve and	

	sustain 'good' rating across all domains, with ambition to achieve 'outstanding' by 2026. Mr Forsyth explained the next steps planned and areas of focus. Quality peer reviews would be extended across community areas in addition to inpatient areas. A time to show (share and shine) event would be hosted to help services showcase the work they were doing to improve services and learn. Care group and directorate evidence folders would be checked and challenged for consistency. Mr Forsyth drew attention to the key milestones which remained between July and November to be able to achieve a 'good' rating. It was noted a delivery plan had been shared with directorates with focus areas which required improvement. Mr Lewis confirmed scrutiny would be undertaken at care group delivery reviews, and Mr Forsyth would reflect on how the process supported services to generate positive and reflective scrutiny and challenge. In response to Mr Mohammed and from feedback in care group delivery reviews, Mr Forsyth advised evidence folders would be built upon, standarised and become consistent, with digital solutions to support services and ensure benchmarking against the CQC four domains. Mr Forsyth explained staff engagement and communications would continue to be promoted, noting the support in place of staff booklets and as it being part of staff inductions. Mrs Lavery summarised the proposed action plans and timescales proposed for delivery, and confirmed the Board were content with those. **The Board received and noted the CQC readiness paper and next steps.**	
Bpu 25/07/23	**Plans for Approval:** • **People and Teams Plan** Ms Holden introduced the People and Teams Plan, emphasising its importance for the organisation. The plan focused on team and leadership development at all levels, aiming to harness the energy of leaders to drive sustainable changes. Ms Holden highlighted the need to measure success through 10 key metrics for each directorate, which would help track progress and ensure that the plan was effectively enabling changes within the organisation. The focus areas in the plan included employees, students, and bank workers. Ms Holden explained governance arrangements and oversight of the plan would be through the CLE People and Teams Group, POD Committee, and Board, and a crucial role to drive the plan forward to ensure successful implementation. • **Digital Enabling Plan** Mr Banks introduced the Digital Enabling Plan, and highlighted its focus on data availability and quality. The plan aimed to improve how data was used to facilitate interactions with patients and staff.	

	The plan included specific success measures that would be monitored through the CLE Digital Transformation Group starting in August. These measures would help track the progress and effectiveness of the plan. In response to Mrs Vickers, Mr Banks advised the plan was strongly aligned with the NHS 10 year plan. The plan's key strengths included digital inclusion, human-centred design, data and intelligence, and partnerships. These areas aligned with the NHS priorities and demonstrated the plan's maturity and innovation. Mr Banks acknowledged the link between the future digital plans and projects and the Trust's future capital plan for 2026 to 2028 and the input he would make to that broader process. **The Board received and approved the People and Teams Plan and Digital Enabling Plan. Delivery oversight of these plans would be given to their respective Board Committee from Quarter 2, in line with their already agreed terms of reference.**	
Bpu 25/07/24	**Integrated Quality Performance Report (IQPR)** Mr Chillery introduced the Integrated Quality Performance Report (IQPR) for June 2025. There had been a slight increase in sickness absence versus target, with recent benchmarking data showing that sickness levels benchmarked high compared to other similar Trusts. The 5.5% vacancy figure reflected the increase in establishment linked to significant changes in community rehabilitation services and also the development of the High Dependency Unit. Improvements had been seen in the access rates to talking therapies and children and young people services, although both were still below target. There remained a focused improvement plan on achieving the target for severe mental illness (SMI) annual health checks, including register consolidation and the introduction of blood test machines for key services. Although racist incidents had seen a drop in reporting, this had been identified as an area of underreporting due to the implementation of Radar system. The financial position was £38k better than plan at Month 2. During June there were 7 OOAP (compared to 25 last year) and Mr Chillery recognised that position had increased to 8 at present although significant effort and change continued to reduce the number of OOAP. **The Board received and noted the Integrated Quality Performance Report**.	
Bpu 25/07/25	**Health Inequalities Review of IQPR** Mr Lewis, on behalf of Mrs McDonough, presented the paper which provided an analysis of the IQPR data through a health inequalities lens. The analysis focused on four protected characteristics of ethnicity, deprivation, age and gender, and highlighted a significant number of	

	services do not fully reflect the communities that they serve in relation to at least one protected characteristic. It was proposed that the CLE Equity and Inclusion Group would review the data, to better understand local need of patients with different protected characteristics. It would also need to understand any variances in provision versus community population, and consider how to provide targeted, culturally appropriate services. Mr Lewis gave thanks to the health informatics team for their efforts in producing the health inequalities data pack (as part of Agenda Pack B). Dr Falk recommended to streamline and refine the report, with future focus on significant health inequalities data so not to be distracted on less significant numbers or percentages. Mr Lewis acknowledged the health inequalities data would continue to be developed and refined to have meaningful data. **The Board received and noted the health inequalities review of the IQPR, and supported the next steps contained within the paper.**	
Bpu 25/07/26	**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. Of particular note were the number of plans assessed as 'red' and 'amber red' on likelihood of delivery. There were clusters of plans that although different in their measures and plans, had common themes and were key to delivery of promises. An example was promise 9. The Board would receive a progress update against delivery of Promise 1 (peer support) in September. There was real commitment from all care groups to deliver Promise 3 (volunteers), noting validation of data was ongoing and confidence of what was required to be able to deliver to expand volunteer numbers and increase diversity was growing. Mrs Lavery referred to promise 22 and highlighted the importance of a seven day service for patient care, noting that the current service levels differ significantly between weekdays and weekends. Mr Lewis acknowledged the challenges and advised a gap analysis would be undertaken over the coming months to help identify the necessary steps and resources required for implementation. This would consider the feasibility, resource requirements, and potential impact on staff and patients. **The Board received and noted the Promises / Priorities Scorecard update on the work to date and expectations in 2025/26.**	
Bpu 25/07/27	**Board and Committee reporting August 2025 to March 2026** Mr Gowland presented the paper.	

	The forward plans had been developed for board and its committees, and Mr Gowland highlighted the importance of consistent oversight and planning. There was need to ensure that all committees were aligned, that any additional topics were regularly covered, to ensure that they were working towards common goals and addressing relevant topics effectively. Mr Gowland confirmed the key focus for the committees would be on four roles of statutory compliance, plan delivery, partnership duties and matters delegated by the Board. There was intent to continue a thematic focus for future Board meetings, noting July's theme of 'education'. A programme to create a rolling update would be introduced to ensure that attention was always four or five meetings in advance, to include the Audit Committee. The Board discussed the benefits of having a rolling update in advance so that members could collaborate, what key topics may have been missed, overlooked or duplicated, and confirmed its support to receive the update in advance. Mr Gowland confirmed that Emergency Preparedness, Resilience and Response (September 25) and Cyber Security (March 2026) would be included to the forward plans. **The Board received and noted the Board and Committee reporting arrangements for the remainder of the financial year**.	
Bpu 25/07/28	**Strategic Delivery Risks (SDRs)** Mr Gowland presented the report, reminding the Board of the revised approach taken within the last year to strategic risk management with enhanced reporting and oversight through its committees. The SDRs continued to be strengthened and understating what gaps remained, with regular engagement with executive leads, as well as tri-annual reviews with Ms Gillatt as the Audit Committee Chair and Mr Gowland. There would be intention to review the SDRs in light of the NHS 10-year plan, the output from that would be presented at the next meeting. Mr Lewis cautioned some plans and targets for delivery may shift following this review. **The Board received and noted the Strategy Delivery Risks report, noting the planned next steps to further refine and enhance plans to mitigate those risks and the intended review of SDRs following the publication of the NHS 10 year Plan.**	
Bpu 25/07/29	**Operational Risk Report** Mr Gowland presented the paper which highlighted the current position in relation to the extreme risks. There had been a shift in operational risk management with the use of risk appetite statements and	

	implementation of the new radar system. The change aimed to improve the identification and management of risks. The use of risk appetite statements helped define the level of risk the organisation was willing to accept. The approach would ensure that risks were managed within acceptable limits. The new Radar system was being used to track and manage risks more effectively, and provided a comprehensive view of risks and helped develop clear mitigation plans. Mr Gowland emphasised the need to address risks that were outside of the defined appetite. Clear mitigation plans were required to manage these risks and ensure they would not impact the organisation's objectives. A total of five risks were previously reported to the Board as extreme. Following the recent recalibration of risk scores across the organisation, three of these risks now sat outside of appetite levels but remained within tolerance limits, which indicated they were managed but still required close monitoring. There were two risks which remained outside of tolerance levels pending further mitigation or resolution. Scrutiny would be undertaken through the Risk Management Group (RMG), noting the higher number that remained outside tolerance and required focused attention. In response to Mr Lewis's question about categorisation, Mr Gowland confirmed that the RMG would review all as part of its next meeting to ensure they were appropriate. **The Board received and noted the Operational Risk Report update, including extreme risks. The Board noted the updated risk appetite levels and the planned work to address the extended number of risks that were currently outside of appetite and tolerance.**	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEE)		
Bpu 25/07/30	**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: • Accountable Officer for Controlled Drugs Annual Report 2024 to 2025 • Health, Safety and Security Annual Report 2024 to 2025 • Mortality Report • Guardian of Safe Working Hours Report **The Board received and noted the additional reports for information**.	
Bpu 25/07/31	**Any Other Urgent Business** There was no further business raised.	
Bpu 25/07/32	**Any risks that the Board wishes the Risk Management Group (RMG) to consider**	

	• Independent review of seclusion and work ongoing to conclude and is this captured in our risk register. • Net zero and ability to record carbon, and whether the organisation was able to accurately record its carbon position.	
Bpu 25/07/33	**Public Questions** Mr Lewis addressed a public question that was raised at AMM about dairy allergies, emphasising the importance of ensuring patient safety and proper communication about dietary restrictions. Dr Sinclair agreed to provide an update relating to staff awareness for alternative dairy free medication.	**DS**
Bpu 25/07/34	The Chair resolved '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press would be excluded from the remainder of the meeting, which would conclude in private.*'	

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

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 25/05/22	**Integrated Quality Performance Report (IQPR)** Neurodevelopmental Services for people waiting for ADHD assessments: Mr Lewis suggested the Board spend time at the next meeting to understand the complexities in achieving the trajectory.	RC	**September 2025**: Paper L provides a further update in respect of ADHD/neurodiversity position.	Propose to Close
Bpu 25/01/21b	**Disengagement risk** Mitigation of the identified disengagement risk is dependent upon the revised Engagement and Disengagement Policy.	PG	**September 2025**: The Engagement and Disengagement Policy was approved by CLE on 16 September 2025.	Propose to Close
Bpu 25/07/16	**Older People's Quality Indicators paper** The community quality indicators would be developed further, noting they may be disproportionate compared to inpatient quality indicators (noting that most patient care was provided in the community).	DS	**September 2025**: Paper O provides a further update in respect of Older People's Quality Indicators.	Propose to Close
Bpu 25/07/16	**Older People's Quality Indicators paper** Other measures to be explored as quality indicators, including people measures such as turnover and MAST.	DS	**September 2025**: Paper O provides a further update in respect of Older People's Quality Indicators.	Propose to Close
Bpu 25/07/20	**Promise 2 Carers Delivery Plan** Mr Forsyth agreed to explore how young people in services providing caring responsibilities were being recognised.	SF	**September 2025**: Young people are supported by the children's care group and appropriate request for young persons carer and safeguarding considered. This is recorded on SystmOne with a specific read code for audit purposes. We are increasing awareness with always measures proposed, training and use of the coding in SystmOne training.	Propose to Close
Bpu 25/07/21	**Promise 14 – Delivering a 4 week wait for all referrals** An update on the neurodiversity position would be provided to the Board in September.	RC	**September 2025**: Linked to action above - Bpu 25/05/22. Paper L provides a further update in respect of ADHD/neurodiversity position.	Propose to Close
Bpu 25/07/33	**Public Questions** Mr Lewis addressed a public question that was raised at AMM about dairy allergies, emphasising the	DS	**September 2025**: Allergies are enquired about on admission as part of the clerking process to our inpatient areas. In services where we prescribe we	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
	importance of ensuring patient safety and proper communication about dietary restrictions. Dr Sinclair agreed to provide an update relating to staff awareness for alternative dairy free medication.		also enquire about allergy status. We have access to medicines information that list excipients (any component of a medicine that isn't the active ingredient) for the medications we prescribe. Our electronic prescribing system automatically alerts where there is a known allergy to the active compound but it would require a manual check of excipients.	
Bpu 25/05/13	**Chief Executive's Report** To consider an organisational response to the guidance *Leading for all: supporting trans and non-binary healthcare staff* through the appropriate staff networks to understand what the changes, if any, mean towards the end of July.	TL	**September 2025:** An update is provided within the CEO report, Paper J.	Propose to Close
Bpu 25/07/15	**Chief Executive's Report** As part of promise 14 and deadline of April 2026, there had been significant investment and work to reduce waiting times which would be measured in weeks. Mr Lewis confirmed this work, alongside work across the South Yorkshire ICB would be brought back to the Board in September.	TL	**September 2025**: Paper L provides a further update in respect of ADHD/neurodiversity position.	Propose to close
Bpu 25/07/19	**Productivity at RDaSH** A further update on delivery of productivity work would be presented to the Board in January 2026.	IM	**September 2025**: As recorded, an update to be provided **in January**. Members of the finance team delivered a presentation on the Trust's work in this domain at the HFMA national productivity & efficiency conference in September. The Trust has been put forward as the mental health productivity host by NEY and SYICB for the upcoming productivity pilots.	Propose to close
Bpu 24/09/21	**Item amended at July Board** A detailed QSIA and EIA document will be developed during June, and a material risk entered onto the risk register. It is suggested that this action replaces the former entry and responsibility transfer to the CEO and COO.	TL / RC	**September 2025:** This is overdue and will be addressed in advance of October's RMG meeting	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 24/11/08	**Report from the Quality Committee** Work was ongoing to develop a management escalation process with agreed parameters for intervention, by January 2025.	TL	**September 2025:** This is discussed within the private Chief Executive's report: it should remain open at this time.	Open
Bpu 25/05/24	**Strategic Delivery Risks (SDRs)** There would be an intended review of SDRs following the publication of the NHS 10 year Plan, to be presented to the Board in September.	PG	**September 2025:** In July 2025 reference was made to the publication of the ten-year plan and its possible impact on the SDRs – whilst further supporting guidance is awaited, we will pause the assessment of whether there is a need to revise the SDRs. Within the update paper on the agenda today there are limited references (particularly SDR3) to recent national guidance such as the ten year plan.	Open
Bpu 25/05/20	**CQC Readiness: Well-Led** During quarter 4, a formal, externally commissioned, well led review would take place. Mr Lewis requested a subset of leaders should be agreed to oversee this work.	PG	**September 2025:** As previously reported, an externally commissioned review will be commissioned in Q3 and delivered **in Q4 2025/26**. Board requested to confirm subset through the chair.	Open
Bpu 25/07/20	**Promise 2 Carers Delivery Plan** An update on the implementation of the carers delivery plan would be provided to the Board in November.	SF	**September 2025:** As recorded, an update on the implementation of the carers delivery plan to be provided **in November.**	Open

Matters Arising

1. Through the implementation of the **PSIRF Policy** the need to make minor amendments to Appendix One of the PSIRF Policy has been identified – this policy was approved by the Board of Directors in May 2025. The minor changes will better and more accurately show how deaths in St Johns Hospice and acquired pressure ulcers in the community are investigated – the relevant and updated appendix is attached for approval, with the amendments highlighted.

2. **Flourish CIC: Appointment of Director**. The Board of Directors reserves the power to appoint Directors to Flourish. Following a recent recruitment campaign the Directors of Flourish have identified and recommend for appointment Mrs Kelly Milanese – a process that included the Shareholder Representative Philip Gowland (RDASH Director of Corporate Assurance) who also supports the recommendation for appointment. This was reported to Kath Lavery, Chair on 29 August 2025 and details provided of the process and of the candidate and Kath provided her support – this is reported to the Board in line with the reserved power. Mrs Milanese is an globally experienced, HR leader with extensive experience within telecommunications, digital and financial services and with roots locally within Doncaster and indeed the NHS. She joins Jade Dyer, Paul Wilkin, Rod Barnes and Steve Gillman as the Directors of Flourish.

Appendix 1 – PSIRF Policy summary – guide to decision making

(This matrix is not designed to be restrictive and cannot provide an exhaustive list of directions. It is instead to provide guidance on a suitable response. If the considered opinion is that a different response from the one above would be more suitable, then deviation from the above is permissible. In some limited cases the system issues may be so poorly understood that a PSII may be the most suitable approach. Some incidents will directly affect RDaSH, but will not be our incidents, for example transfer of a patient into RDaSH services with incorrect medicines. In these cases, the service-to-service processes should be used, where we assist other organisations with their learning)

Suggested learning response - Death (any complicating factors may increase the type of response needed, therefore this should be considered as a minimum)

SWARM	After Action Review (AAR)	Multidisciplinary team (MDT) Review	PSII - internal	PSII - external	Structured Judgement Review (SJR)

Incident type	Area (typical – not restricted to)	SWARM	AAR	MDT Review	PSII Internal	PSII External	PSII SJR	Agencies to brief	Other Comments
Expected Death – in expected time (where the local team feel there is a learning opportunity)	Community or inpatient	X							Mortality form and review at MOG & by medical examiner – for all of these incident types
Expected death with unexpected factors	Community or inpatient	X	X					If Inpatient – CQC	
Stillbirth or pregnancy loss	Community or inpatient	X							
Death of a person with LD	Community or inpatient				X		X	LeDeR	
Unexpected death of a Child in community	Community				X			Safeguarding	
Death with drug/ alcohol comorbidity	Community or Inpatient				X			If Inpatient – CQC	
Suspected Suicide	Community or Inpatient	X (For community suspected suicide - if system factors are not well understood then any of these responses would be appropriate)			X (if it is death of an inpatient or 3+ failed contacts with services)			If Inpatient – CQC & ICB	Please also note that this process is neutral to coroner or police process, who may have their own investigation which we may be involved with but wouldn't change or delay our internal process
Unexpected Inpatient Death	All RDaSH inpatient areas				X			CQC, ICB	
Unexpected community Death	Community			X					
Inpatient Homicide	Inpatient setting					X			
Community Homicide	Community service				X				

Death related to medication error	Community or Inpatient				X				

Suggested Learning Response: - (this is a suggested matrix with examples; it is not exhaustive AND, any complicating factors may increase the type of response needed, therefore should be considered as a minimum only)

SWARM	After Action Review (AAR)	Multidisciplinary team (MDT) Review	PSII - internal	PSII - external	Structured Judgement Review (SJR)

		Physical Harm (examples)			Psychological Harm (examples)			Comments / persons involved
Inappropriate Behaviour								
Sexual Safety	Verbal	Sexual threat & Touch	Sexual Assault	Rape	Harassment	Threat and behaviours such as exposure	Persistent Threat	Criminal Investigation, RIDDOR, POD Team
Violence and Aggression	Verbal	Physical assault with minimal injury, requiring first aid	Physical Assault requiring hospital treatment. Injury is non-permanent	Attempted homicide or injury resulting in permanent damage/injury	Harassment	Threat of harm	Persistent Threat accompanied with behaviours such as stalking / following	Criminal Investigation, RIDDOR, Health and Safety Team
Other inappropriate behaviours	Discriminatory Language/Racism	Vandalising/Throwing and / or damaging equipment	Significant damage to personal or Trust property					Police contact, Health and Safety Team involvement
Prescribing	Recording error	Dose error (form, dose, rate, timing) – too low/high – minimal side effect	Dose error – moderate side effects experienced requiring treatment	Dose error – severe side effects / permanent	Side effects			Reporting via the 'Yellow Card' BNF/NICE scheme – includes VAPE
Administration	Wrong time administered or medication given without current prescription	Drug administered to wrong patient – low harm	Drug administered to wrong patient – moderate harm	Dose error – severe side effects / permanent				Please note specific trust process for reporting insulin errors
Other medication	Medication theft (including police report)	Needlestick (injury may vary)	Adverse drug reactions	Overdose or nonprescribed medication	Unable to gain medication			MHRA Reporting "Yellow Card"
Missing Person								

Patient (informal)	Leave ward without discussion	Leave ward, resulting in self-injury						Family/ significant other notification
Patient (detained)	Returned – had leave but the leave breeched the prescribed S17 time	Absconding from inpatient ward – may be connected to any of these harm categories and MDT review should follow including family						Mental Health Act reporting & family notification
Staff	Not returned at time agreed from visit							Counter fraud may be a consideration
		Physical Harm (examples)			Psychological Harm (examples)			Comments / persons involved
Patient Care and Treatment								
Pressure Sore This said inpatients only previously	Risk identified without the ability to adhere to safety advice	Reddening to the skin, physical assessment & mobility assessment		(Grade 3+) - Moderate to severe (AAR/SWARM) (amend from subject to SJR process	There may be a number of psychological side effects related to a pressure sore (i.e. social isolation, embarrassment related to odour); these should be assessed on an individual basis.			
Falls (inpatient only)	Slip or trip with no injury	Slip or trip with mild harm – this said previously with no significant injury	Slips, trips or falls resulting in moderate or severe harm – this said subject to SJR process	Slips, trips or falls resulting in death (SJR or PSII)	There may be several psychological side effects related to a fall; (i.e. shame, PTSD) these should be assessed on an individual basis.			NAIF report if an inpatient
VTE	Assessment identifies issues but no physical need	Assessment identifies issues, but physical complications seen due to lack of adherence to guidance re proactive intervention, may fall into any of these harm categories. Also, may be suitable for AAR, MDT Review or SWARM dependant on level of harm and context.						Consider specific VTE policy and assessment requirements
Other Examples								
Data Breech	Information governance will advice upon the questions in SWARM				There may be a number of psychological side effects related to a data breech (i.e. fear of sensitive information been known; safeguarding issues etc); these should be assessed on an individual basis.			Data Protection; Information Commissioner
Mental Health Act Breech	i.e. second opinion not completed in time frame							Mental Health Act Office, CQC in some circumstance

Infection control – hospital acquired infection or outbreak	See related policy / process within the infection control manual						Infection control team, Health and Safety. National reporting.

Rotherham Doncaster and South Humber NHS Foundation Trust

Report Title	Finance, Digital & Estates Committee Report	**Agenda Item**	Paper D
Meeting	Board of Directors	**Date**	25 September 2025
Date of meeting:	20 August 2025		
Attendees:	Pauline Vickers (Chair), Sarah Fulton Tindall, Carlene Holden, Izaaz Mohammed, Richard Banks, Ian Spowart, Richard Chillery and Richard Rimmington		
Apologies:	Rachel Blake.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Financial Performance Report:** Month 3 deficit position of £716k, £24k better than plan, with the trust remaining ahead of plan at month 4 with a favourable variance of £11k. £1m of additional funding secured from ICB to support appropriate out of area placements, this remains within the budget year to date but will require close monitoring to ensure this position is maintained and the £3m CIP delivers. The provision of a high dependency rehabilitation unit is due to go live from 1 October 2025, the trust is expected to finalise the details of the cost per case tariff with SY ICB over the coming weeks. **Digital Enabling plan:** On track with progress having been made on developmental and business as usual work. Challenges include the increasing pace and complexity of reporting requirements, financial pressures and competing priorities whilst balancing innovation and governance. **Artificial intelligence pilot and governance**: Pilot programme developed for clinical settings focussed on ambient voice technology. There are products being piloted and evaluations are planned to assess impact on staff time, patient experience and cost effectiveness.		
Positive highlights of note:	**Cyber security:** The trust has the lowest cyber risk score in the region and continues to maintain high benchmarking score for Microsoft Defender for Endpoint. **Finance Performance Report:** As part of the better payment practice code standard, the trust is paying 95% of suppliers within 30 days, in line with the target.		
Matters presented for information or noting:	**Medium Term Finance Plan, 2026 to 2027 savings plan development**: Savings overview provided with information on the schemes identified linked to the medium-term finance plan. Further analysis to be presented at the August Board development session, and a final programme will be presented to the Board of Directors in September 2025 for approval.		
Decisions made:	**Contract approval process for planned spend:** Proposal was agreed, renewals of existing contracts which remain within the original Board approved contract values would not need to be re-approved by Finance Digital and Estates committee each time. Any increase above the original Board approved values would be subject to Standing Financial Instructions limits.		
Actions agreed:	**National cost collection exercise**: Detailed review to be undertaken to scrutinise ward level data as part of Productivity Pilots planned over the balance of the year. **Artificial intelligence**: Focus groups to include staff who are less enthusiastic about digital and to consider whether governors could contribute.		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	People and Organisational Development Committee Report to Board	**Agenda Item:**	Paper E
Meeting	Board of Directors	**Date**	25 September 2025
Date of meeting:	20 August 2025		
Attendees:	Rachael Blake (Chair), Dave Vallance, Pauline Vickers, Carlene Holden, Lea Fountain, Ian Spowart, Steve Forsyth Richard Chillery, Richard Rimmington, Phil Gowland.		
Apologies:	Dr Jude Graham		
Matters of concern or key risks to escalate to the Board:	**Nursing and Midwifery Profile review Band 4-9** The review of 120 to 130 job descriptions poses possible financial risks due to potential banding changes leading to increased pay costs (an increase in banding – but the levels of change experienced with the Band 2-3 review is not anticipated) in addition to the 3.6% pay award which was not fully funded. Financial modelling and regional collaboration with the South Yorkshire steering group to share best practice and assess the financial risk was underway and will be shared with the CEO. The committee also noted the significant resource diversion required for the review, the impact on managers and HR staff, and the potential for unrest among affected staff which required board awareness **Workforce race equality standard (WRES) 2025** and **Workforce disability equality standard (WDES) 2025.** Both reports identified ongoing issues with bullying and harassment, and a decrease in staff engagement scores among disabled colleagues. The Acceptable Behaviours policy review was also referenced to understand the impact or not of the new approach. The new Radar system had seen an increase in reporting of racist incidents, and this may also come through in the 2025 staff survey results.		
Key points of discussion relevant to the Board:	**People and Teams Plan – 10 key priority areas** The ten key areas have been identified and they will now be reported at Directorate level to the committee to focus attention on areas of good practice and those requiring further work/intervention. **People Promises Theme report** The intention was to have one data set on the electronic staff record (ESR) system which included volunteers and peer support workers to help build a true picture and provide a robust overview of the priority areas. A broader analysis on protected characteristics would then be provided to allow comparison between the trust workforce and local demographics. **Integrated Quality Performance Report:** **Recruitment** metric had reduced from 12 weeks to 8 weeks, causing a dip in reported performance, with the challenge of meeting the proposed target of 6 weeks, given the standard 8 week notice period for colleagues at Band 5 level. **Vacancies** had increased slightly, partly due to new investment and trust wide service developments such as the community rehabilitation service in North Lincolnshire and the high dependency unit located in Doncaster. Initiatives through open days and working with job centres and partners had been undertaken to reduce barriers to the application process.		
Positive highlights of note:	**Consultant vacancies** Are reducing with positive recruitment efforts resulted in applications with further interviews taking place in August 2025. **Learning and Development Report** apprenticeship levy promise was on track to exceed its usage target for the year, with only £35k of the £800k budget left to spend for the remainder of the financial year. The apprenticeship team had worked closely with operational managers to promote the levy, focusing on upskilling the current workforce and acting as a springboard for future development. **Internal Audit Progress Report** on 'violence and aggression against staff' had received overall rating of significant assurance.		
Matters for	None		

information / noting:	
Decisions made:	Agreed that active bystander training for the board would be considered as part of board development days however to note some board members had already attended the training through the leadership development offer.
Actions agreed:	None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Quality Committee Report to Board	**Agenda Item**	Paper F
Meeting	Board of Directors	**Date**	25 September 2025
Date of meeting:	17 September 2025		
Attendees:	Dave Vallance (Deputy Chair), Maria Clark, Steve Forsyth, Dr Diarmid Sinclair, Richard Chillery, Richard Banks, Dr Jude Graham, Hannah Hall, and David Vickers.		
Apologies:	Dr Richard Falk (Chair)		
Matters of concern or key risks to escalate to the Board:	**Ligature Report**. Committee was assured of the processes in place relating to ligature risk assessments, remedial action plans and estates response. The report highlighted the importance of learning from incidents and national alerts to inform changes in practice, demonstrated by our learning from the death of a patient in 2022, evidence of learning and sustained actions contributed to the Coroner accepting our recommendations and completed actions at inquest this week. Outdoor spaces have been reviewed by our CNO, and a new design template for our outdoor spaces is being introduced, and will be deployed in areas by April 2027 **Mortality Report May and June** During the months of May and June, there were a total of 90 deaths reported in the Trust. A recent coroner inquest highlighted the organisations policies were compliant with national and local recommended practices. The backlog of SJRs has been reduced, with priority given to high-risk cases. The remaining backlog consists mainly of low-risk, historical cases. The full report is to be presented to the Board in September 2025 in Agenda Pack B.		
Key points of discussion relevant to the Board:	**Patient Safety Escalations** The committee was assured that appropriate systems and processes are in place for such escalations. **Internal Audit Recommendations** Two audit recommendations linked to the review of Promises 3, 4 and 5 are due by 31 December 2025 and are on track for delivery. **Integrated Quality Performance Report (Aug 2025 data)** The committee noted stable overall performance in August, despite an in-month decline in some metrics likely due to seasonal factors. RTT remained strong, but new Length of Stay data highlighted challenges on wards especially in PICU to meet the 32 day target. The data highlighted there were no out of area placements from Doncaster. VTE and seclusions assessments remain on track, with a small reduction in MUST and Falls assessments. Talking Therapies access targets were not met, though a 12% annual increase was projected. There has been an improvement in S136 breach hours, but staffing issues persisted. There has been an increase in ligature incidents and one suspected inpatient suicide. There continued to be a number of racist incidents being reported and challenging environment for staff. Targets for waiting lists in ADHD and neurodiversity within CAMHS will not be met by March, and a paper is to be presented at board to address capacity and demand.		
Positive highlights of note:	**Patient Experience Report** Care Opinion captured 1,465 stories told by members of the public, patients and family members. The Committee was given an update of all works within Care Opinion, PALs and complaints to ensure the Trust delivers timely complaint responses. The complaints team has been restructured to provide more personalised support, including direct contact rather than relying solely on written communication.		
Matters for information:	**Strategic Delivery Risk 4** The Committee received an update on Strategic Delivery Risk (SDR4), noting progress in delivering the strategic objective, particularly through HQTC's support and reductions in impact areas such as OAPS. The core challenge remained in achieving cultural change among staff to adopt flexible working practices, which has seen limited but positive progress through the delivery of new services such as Community Rehab		

Decisions made:	None.
Actions agreed:	**Research Partnership Risk Assessments and Patient Inclusion:** Committee members to submit questions and input to the research subcommittee for detailed response. **Pressure Ulcer Incidence Review:** Undertake a thematic review under PSIRF to compare the incidence of new community-acquired pressure ulcers with other organisations and report findings to the committee. **Patient Experience Report Enhancement:** Extend the patient experience report for the next quality committee to include specific examples of service changes and improvements made because of patient feedback and complaints. Future mortality reports are required to include a clear summary at the front, highlighting key findings and compliance status.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Mental Health Act Committee Report to Board	**Agenda Item**	Paper G
Meeting	Board of Directors	**Date**	25 September 2025
Date of meeting:	20 August 2025		
Attendees:	Sarah Fulton Tindall (Chair), Maria Clark, Toby Lewis, Dr Diarmid Sinclair, David Vickers. In attendance: Carlene Holden.		
Apologies:	Dr Jude Graham.		
Matters of concern or key risks to escalate to the Board:	Rotherham remains an outlier in compliance with a noticeable decline seen in Consent to treatment on admission and Section 132 Rights, where the latter has not achieved over 79% compliance in the last 3 reports.		
Key points of discussion relevant to the Board:	**MHA Compliance Report (June and July 2025)** There were 316 detentions, of which 1 was unlawful. **Consent to treatment** Consent to treatment on admission Trust wide remains compliant at 92%, although this varies across geographies. Consent to treatment at 3 months showed 100%. Consent to psychiatric medication has been fluctuating over the last few reports with Doncaster at 83%, Rotherham 88% and North Lincolnshire 100% in the latest report. **Section 132 Rights** Whilst compliance with Section 132 Rights was starting to show a sustained improvement. The current compliance rates are a mixed picture with Rotherham at 79%, Doncaster 98% and North Lincolnshire 96%. **MHA Performance Report (June and July 2025)** **Mental Health Act Incidents** There were 6 MHA incidents during this reporting period, none of which were classified as major, which is an improvement on recent reports. The learning is that all incidents are now logged on the Radar system for each ward or area they occur, rather than under the Mental Health Act Office. There were 3 Mental Health Act medication incidents. **Community Treatment Orders** There was 100% compliance noted with respect to Community Treatment Orders. **Blanket Restrictions** There were 3 new blanket restrictions 2 remain open, associated with the locking of laundry and sensory rooms. **Seclusion** A mixed picture was reported in respect of Seclusion and patients being seen within the 5-hour target, June was reported at 91% and July 77%. Work continues to progress on timely independent reviews		

	being undertaken where patients are in seclusion for an extended period. **Mental Health Act and Reducing Restriction Intervention Training Compliance** Overall, MHA Training shows an improvement at all levels but there was still more work to do. At ,31 July 2025, 132 staff remain outstanding on MHA Level 3 compared to 170 previously and 74 remain outstanding on RRI training compared to 82 last time. Of the 74, 46 are booked on the training. Discussions continue with managers, through Senior Leadership Teams, the Education and Learning and Operational Management Groups to improve compliance. The data would continue to be monitored monthly. **CQC MHA Inspections Reports** There had been 2 CQC inspections undertaken over the reporting period, 1 on Amber Lodge and the other on Skelbrooke Ward. There had been no specific themes identified, and action plans are in place. The Committee would receive an update at the next meeting.
Positive highlights of note:	**Section 136** Much progress has been made in respect of Section 136 suites. There had been **no** suite closures during the reporting period. Of the 83 patients detained under Section 136 all were assessed within 24 hours. North Lincolnshire has been performing consistently over the last few reports at 100% in respect of Consent to psychiatric medication and Consent to treatment at both admission and 3 months.
Matters for information:	None
Decisions made:	None
Actions agreed:	None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Public Health, Patient Involvement and Partnerships Committee Report to Board	**Agenda Item**	Paper H
Meeting	Board of Directors	**Date**	25 September 2025
Date of meeting:	17 September 2025		
Attendees:	Dave Vallance (Chair), Maria Clark, Jo Cox, Joy Bullivant, Toby Lewis, Jo McDonough, Dr Diarmid Sinclair, Carlene Holden. In attendance: Phil Gowland		
Apologies:	Dr Richard Falk		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**10 Year Plan – Neighbourhood Working** The paper outlined the current thinking in relation to neighbourhood working, aiming to integrate it into traditional models by April 2026, with further board discussions planned for January 2026. The committee will continue to monitor progress and act as a focal point for neighbourhood working within the trust. Committee discussion included the need for strong partnerships, the definition of neighbourhoods, the challenges of integrating services, the importance of community and staff engagement, and the need for clarity and precision in future plans and pilots. **Promise 10 - Inclusion Health – Homelessness** The paper highlighted the trust's new focus on homelessness and inclusion health, detailing the establishment of a specialist homeless health team in Doncaster and plans to address intersectionality and data challenges, with suggestions for future collaboration and research. **Eating Disorders Collaborative** The Committee received an update on the specialist inpatient eating disorders service - and the development of the MEED pathway, with outline of forthcoming investments and timelines for service improvements expected from October and November 2025, aiming to provide comprehensive support across South Yorkshire. **Equity and Inclusion Promises - Data Report** The Committee now receives routine data reports on progress on Promises related to the E&I plan. The paper highlighted ongoing disparities in service access and outcomes for deprived and marginalised groups, the impact of interventions such as the travel fund and Citizens Advice partnership. While some measures show early signs of improvement, others remain static, prompting the committee to focus on assurance whilst further action is underway to embed data driven performance management across the trust. **Health Inequalities Data** – the Committee received mandated health inequalities data, a requirement from NHSE, to be presented to the Board in September 2025.		
Positive highlights of note:	**Promise 28 and Research and Innovation Plan – innovation** The research and innovation plan focused on the development of the 'big six' research areas, the need for cultural change to support innovation, the importance of inclusive language, and the role of thought leaders and community engagement in driving innovation across the trust. The plan will be presented for approval at the September 2025 Board.		
Matters presented for information or	**Strategic Delivery Risks Report – SDR1 and SDR3**		

noting:	An update was provided on the two strategic delivery risks relevant to the Committee and were informed of the changes to the SDR report. In September 2025, the Board will receive the latest update position and will be considering the five SDRs currently in place, in light of the publication of the NHS 10 Year Plan. **Internal Audit Progress Report** The Committee noted the progress made against eight recommendations from recent internal audits, three have been completed and five are on track to delivery.
Decisions made:	None
Actions agreed:	None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Audit Committee Report to Board	**Agenda Item**	Paper I
Meeting	Board of Directors	**Date**	25 September 2025
Date of meeting:	6 August 2025		
Attendees:	Kathryn Gillatt (Chair), Pauline Vickers and Dr Richard Falk. In addition: Phil Gowland, Jill Savoury, James Cooper, Leanne Hawke (360 Assurance), Laura Brookshaw (360 Assurance), Matthew Curtis (360 Assurance), Caroline Jamieson (Deloitte),		
Apologies:	No apologies 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 -** The risk assessment work had been significantly progressed with all fraud risks reassessed within quarter 1. Monthly training continues to be delivered via half-day learning days. **RDaSH Response to ISA260 Report** Fifty-eight recommendations had been addressed or tolerated by management. Of the nine remaining, four were partially addressed and five not yet addressed. Progress reports would be provided to a future meeting. **Patient Monies Review** The trust was an outlier in providing this service and was now considering looking at whether the service was appropriate and to clarify whether the trust had a statutory duty to provide this, noting the current legal advice was unclear.		
Positive highlights of note:	**Internal Audit Progress** Two audit reports were issued; Violence and Aggression Against Staff; and the Data Security and Protection toolkit audit, both which gave significant assurance. Recommendation outturn at 95%. **Risk Management Framework -** The transfer of risk management to the new Radar system now incorporated the risk appetite framework and tolerance levels. Risks from all 23 directorates would feature in the next round of delivery reviews in August and September 2025. Internal Audit review on risk management was underway.		
Matters presented for information or noting:	Trust-wide arrangements for raising concerns		
Decisions made:	**RDaSH Response to ISA260 Report** Agreed for a regular progress report on older recommendations and items with significant judgment to be noted on the committee forward plan.		
Actions agreed:	As noted above in respect of the Patients Monies Review.		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper J
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	25 September 2025

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

The scale of improvements being achieved at mid-year hopefully is distilled within this report and provides an impressive basis for the upcoming leaders' conference: whilst a segment 3 rating is disappointing, the Trust would, without the deficit support override, be ranked 14 among 61 peer organisations. The Trust is well placed to submit plans outlined in the planning framework by NHS England having had a co-produced consistent direction for over two years: and the medium-term financial model is well trailed internally, if demanding in 26/7.

The opening of the Rehabilitation High Dependency Unit (Phoenix) in October marks another milestone of change, with up to sixteen people returning to local care from out of area placement. We continue to explore with commissioners whether a second unit in early 2026/27 is their preferred way forward. Providers within the MHLDA are formally suggesting to commissioners that they should co-lead such a major strategic shift, as work to reduce spend in the private sector gathers pace locally.

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

Aspects of annexes considered in private Board in August 2025

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

EXPLORE the patient, people and population issues described

CONSIDER any matters of concern not covered within the report

NOTE the changes to eating disorder care and improved service equity in Annex 5

RECONFIRM support for the changes in service provider proposed under annexes 6/7

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Alignment to the plans: (indicate those that this paper supports)	
Estate plan	X
Digital plan	X
People and teams plan	X
Finance plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X
Research and innovation plan	X

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

People risks

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

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

SDR 1 and 3

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

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

Appendix (please list)

Annex 1: CLE summary August and September 2025
Annex 2: Current register of Trust vacancies August 2025
Annex 3: National publications August/September 2025
Annex 4: YTD to 31/08 RIDDOR
Annex 5: Outbrief from All Age Eating Disorders Joint Committee
Annex 6: MHLDA update
Annex 7: Summary of procurement KPIs sought through agreed change proposals
Annex 8: Proposed timetable for estate maintenance supplier changes

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report

September 2025

1.1 September has already seen our community rehabilitation service launch in North Lincolnshire, and it was a pleasure to welcome clinical leaders to discuss that at the Board timeout in August – and to hear their testimony to the support for innovation and risk they feel they have received. On September 22nd we launch our annual staff survey drive, focusing on the Board's priority that all 23 directorates seek to reach some key performance measures. On the same day, noting we are ahead of the JCVI timetable, we start **our "Deja Flu 3000" campaign**, aiming at least to repeat the last two years' campaigns, which have been the largest in Trust history.

1.2 At the time of writing, it remains unclear whether the Trust will receive £1.8m of **deficit support funding** pledged to us in the approved annual plan**.** This receipt rests on ICB-wide performance measures. Receipt of these monies drive an Oversight Framework Override, which drops our segment from 2 to 3. Within my report, I provide greater detail of other measures rated 3 or below, noting that in 2026/27, we will not have deficit support funding, albeit there is no commitment that the league table measures will stay the same!

1.3 The Board had time to explore the **Ten-Year Plan** when it met in August. The general consistency of the document with our 2023/28 strategy drives the recommendation that it would be premature mid-year to amend our BAF (SDR). The development of revised GP contracts nationally has the potential to reduce our SDR 3 risk next year. Both Doncaster and Rotherham have had Neighbourhood Bids chosen among the first wave of 43 approved – and we continue to align with partners in North Lincolnshire to develop those neighbourhoods, which the Board has discussed previously in some detail. Our work on rurality and promise 12 matters to that as, of course, does the investment in estate within Scunthorpe.

1.4 The **private Board meeting held in August** considered a number of commercially confidential service proposals. The information sought to reconfirm approval to proceed is outlined in annexes to this report, and in one separate paper about the future of pharmacy care from Q1 2026/27, where we propose to develop a subsidiary company during the following year.

1.5 Our focus on promise 5 remains, and the latest Governing Body meeting provided further demonstration of the benefits of such inclusion, with a commitment to proceed now at pace with Martha's Law proposals from early 2026. **The creation of the shadow-CLE structure**, to bring patient representatives together, in addition to having people within our key decision-making committees, has been slightly delayed, and will now go live from November, two months later than planned.

Our patients

2.1 The start, during October, of the new rehabilitation **High Dependency Unit** (Phoenix ward: Trust-wide, but base at Tickhill Road) represents a significant step to improve care locally. Unlike some of our other work to tackle out of area placement of

patients, this service is being created to acknowledge that, over many years, a cohort of patients were looked after a long way away, and often in private provision, because of the lack of a local service. Importantly, length of stay will be restricted to one year, which underscores the need to ensure next step support is in place from day one. Whilst the Trust is not taking demand-side financial risk in the manner we have since April 2025 for other out of area placements, we will bear the full cost of any stays beyond two years. With investment from NHS England to refurbish the prior Coral ward, the Rotherham Care Group will run this Trust-wide service.

2.2 During 2024/25, we ended a sustained period of poor response times to complaints, and limited evidence of learning from them. The Board agreed in May 2025 on the future approach to PSIIs (patient safety incident investigations) too. After one quarter of the year, a review of **learning from complaints** year to date points to trends for improvement relating to wheelchair services, neurodiversity and community mental health services.

2.3 Annex A, as always, connects the work of the clinical leadership executive (CLE) with the work of this Board. The revised **engagement/disengagement policy** has been a material feature of work this year: approval of the final document provides for rollout of not only a more stringent approach (implied by the Calcorane case review), but also one where data on delivery is collated and scrutinised. We will do that initially using Q4 (Jan-Mar 2026) data, and I would expect the deployment of this policy to feature in both the audit and clinical audit plans for 2026/27. The policy now is an all-age mental health document, with a parallel 'physical' health policy due with CLE in December to be read alongside the revised access policy that we agreed in 2024.

2.4 The Board has consistently discussed our work on promise 26 and, within that, efforts to tackle racism within the Trust. The current societal discord over migration, patriotism, and public symbols, reanimates that discussion and it is important to recognise the seepage-impact on staff, the behaviour of patients and carers, and the wellbeing of employees, perhaps especially those asked to visit patients at home. In that context, it is timely to discuss **the Acceptable Behaviour Policy** we agreed over a year ago, and how, among other work, we invigorate the use of clear boundary setting in support of our people. Prachi Goulding, a staff governor, published a vlog last week, which sought to convey how directly linked racism-patient harms can be.

2.5 October sees the launch of **our therapeutic activities programme** within our mental health wards. This long-planned and exciting development also responds to subsequent acute-services concerns, expressed by the Care Quality Commission. A mix of ward-led and externally supported activities, across seven days, is the minimum expected standard. Work to learn as we go, to audit, and to improve on this matter will continue over the coming six months. This work forms part of the HQTC programme that the Board is well aware of, and the outcome of that programme will be externally reviewed later in 2026, some months after its conclusion.

2.6 We have been discussing, for some time, how constructively to respond to the Supreme Court judgement over the interpretation of rights within **the Equality Act**. The Trust typically does not have single sex spaces, but there is interest in the matters arising and conflicting views over response. We agreed earlier this summer to take time to consider the issues arising: we have now stood down our legacy 'patient trans equality policy' recognising that we will reserve women's lounges for biologically defined women. Our toilets are in the main multi-gender but, where they are gender defined, the ruling's outcome will also apply. We are reviewing our environments between now and the end of 2025 to establish whether we have any areas where there is no access to a multi-gender toilet, with a view to ensuring this is provided for those who do not identify with their biological gender. In the absence of NHS wide guidance, we will respond in this vein to enquiries from the Equality and Human Rights Commission. A revised policy covering these approaches will be finalised over coming weeks in the normal manner. In the meantime, we continue to work sensitively to offer a personalised response as issues arise.

2.7 48 of 81 services will reach **a maximum wait of 4 weeks** at the end of September: this one, less than we had aimed for, but considerably more than half that number at the end of June. Mindful that the 'last few' will be challenging to achieve in Q4, we are working to improve on the target of 59 for the end of December, outlined when the Board last met. In particular, we are seeing betterment in our community mental health teams consistent with that 'go faster': delivery reviews in September are exploring both the demand and supply we have, mindful that ongoing caseloads and assessments remain crucial. Wait times are now visible within our website each month, and it is encouraging to see PCNs and others publicising that to their colleagues, given that the changes are, in part, intended to reduce general practice workload advising patients how long they may expect to wait.

Our people

3.1 65 entries have been received in our widely publicised **first annual Quality Improvement Poster contest**, which reaches a conclusion on September 30th. The contest is part of our work to support localised, evidenced, experimental change inside the organisation. It is hugely encouraging to see a range of submissions, from resident doctors, senior clinicians across all professions, and from managers too. The posters will tour our sites in coming months, before the 2026 contest is launched in February – targeting a hundred submissions – testifying to the depth of ambition among colleagues to improve care and workplace experiences.

3.2 The clinical leadership executive continues to focus on supporting colleagues who are unwell and away from work, as well as support in the workplace. National **sickness absence rates** are 5.6% (5.2% for our peer group). In RDaSH, our sickness rates have risen over the last four years, and in August was 6.5% (cumulative YTD 6.1%). About 1.5% of our position is under 28 days absence, whilst the balance of 4.3% of longer-term: it is unevenly distributed across teams and directorates and individual 'clinics' exploring the issues involved and remedies, if any, are taking place through Q3 (Oct-Dec), led by Carlene Holden and her team.

3.3 At the time of writing, we have 293 registered volunteers, with three dozen recruited and waiting due clearance. This provides **a confidence that Promise 3 will be met during October.** Five of our six groups have reached the minimum threshold of fifty roles intended to ensure a broadening and deepening of volunteering as a core practice within the Trust as a whole. There is much to learn about delivery from the work done to meet this mark since late 2023, and the evaluation work in Q4 2025/26 will create an opportunity to focus on qualitative benefits and how they might best be sustained.

3.4 We continue to move, as reported in July, towards **cogent job plans** for medical staff that reflect the assessed needs of our patients. It is important to recognise that a similar process, designed to both ensure patient-facing volume, and to protect learning and development time, is in hand for nurse consultants, AHPs at band 7 and above, and psychological professionals. In all professions, this will serve to 'protect' clinical professionals against unwarranted pressures, because difficult choices about time allocation should be being clinically informed but held by the institution through its management. That this is a huge change for the Trust and should not be understated.

3.5 The Board has discussed apprenticeships on a number of occasions over the past two years, and when we did not achieve levy spend in full in 2024/25, we agreed a revised plan for 25/26. Encouragingly, estimates for this year do suggest we will meet the spend expectation and now need to focus renewed attention on the five pillars of additional **support to traditionally excluded communities set out in Promise 9.**

3.6 Since the Board met last, Trusts have had sight of the **10 Point Plan for Resident Doctors**, issued by DHSC. Resident doctors are a crucial group of clinical colleagues for our patients and future, and the latest national training analysis suggests that their view of the Trust remains positive and comparatively very much so as against peer providers. The recruitment of our next Director of Postgraduate Medical Education is a key hire in succession to Nikki Thomas. Initial review of the ten-point plan suggests that the Trust is compliant already with the requests made, albeit with some work to ensure rota availability is consistently achieved to the time-horizons outlined. Carlene Holden will complete her review and advise the Board in November of any discrepancies: the senior lead role will be out to advert before October 4th. We are meeting with the Posgraduate Dean in October 2025 to follow up our session from March 2025 – and ensure there remains confidence in the oversight we have of medical education, given our strong commitment to ensure all senior roles play their part as educators.

3.7 In common with Board members, we should recognise **the understandable anxiety** about forward funding and consequent change that is felt by many inside the organisation. However analytical the route to decisions, there is a daunting scale (4%) to change, with no certainty that unbundled block contracts will offer recognition for the productivity gains we seek. Our commitment to doing this work, publicly and transparently is, for some, reassuring, and for others, amplifies anxieties: in the face of that conflict, we need to stick to the timetable set out when we met in August,

reaching a consultative formal stage in Q4 2025/26, thus maximising the time of effective change in the following year, and keeping, as shallow as possible, the cuts required.

Our population and partners

4.1 Whilst engagement among medical colleagues remains mixed, as we have discussed as a Board before, it is welcome to see a major **expansion of medical leadership bandwidth from the coming month**. Drs Heighton and Seneviratne join the central CMO team, whilst Dr Allen, a Sheffield GP, has taken on the medical director role in Physical Health and Neurodiversity, and Dr Hendry, the care group MD role in Rotherham. The postgraduate role cited above joins the care group MD role in Doncaster, as the remaining very senior gaps that we are carrying.

4.2 Colleagues will recall the CYP Annual Members' Meeting held in July and, of course, subsequently, our council of governors has discussed transitional care arrangements for younger adults. Discussions continue with members of **our Youth Advisory Council about their priorities**, but initial discussions suggest a focus in four areas: waiting times consistent with promise 14, career support and job awareness, influence and volunteering, and how we tackle, with partners, endemic bullying within schools. The intention is for the first Council of 2026 to be a youth-takeover and these themes may be used to shape that event.

4.3 The Board has long supported work to try and tackle the poor quality of **eating disorders care** often available, or indeed unavailable, locally. We diverted commissioner funds to expand the Navigo offer in Grimsby and connect it to the benefit for local people in North Lincolnshire. Annex 5 outlines how the new adult community teams in South Yorkshire start work in October, and also that the committee has decided to end the inequity that denied Doncaster residents to the eating disorder day hospital in Sheffield.

4.4 Our third **leaders' conference** takes place next week: this in North Lincolnshire. We welcome Dr Andy Knox, a GP leader from the North-West, with an established reputation in the field of inequalities and quality improvement. That complements the innovation theme for the conference, where we will have chance to consider how best to balance a delivery mindset that introduces more consistency into how we work, with the opportunity to benefit from insurgent, disruptive ideas drawn from our own teams, and from best practice elsewhere. With all attending now embedded within the leadership development offer this balancing act is one we are well-placed to consider – and something vital to really seizing the neighbourhood working opportunity which, by its nature, is experimental and adaptive.

Toby Lewis, Chief Executive
19th September 2025

Annex 1

Clinical leadership executive – August and September 2025

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

August	September
Introduction of mandated employee obligations (MAST, appraisal, policy)	Policy management
Remote working considerations and review governance	Promise 14 – responding to urgent referrals
Timetable and rollout plans for HQTC work	Sickness absence – and new clinics to support improved oversight
Policy in relation to complex ongoing care after four week wait met	2026/27 financial plans for the Trust
	Year one review of acceptable behaviour policy implementation (promise 26)
	Engagement/disengagement policy

In terms of decisions made, we have confirmed the policy management arrangements and supported alterations to urgency triage protocols developed to support our 48 hour wait promise within Promise 14: these will go live from February 2026.

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

Over the next two meetings (October/November) we will consider, in particular:

- Delivery plans in relation to segment 3 promises
- Development and communication in relation to plan B work
- Work to support the 'getting to good' deadline in November
- Implementation of the outcome of HQTC test bed site
- Neighbourhood working and NHS ten-year plan
- 2026/27 changes to our appraisal model

Toby Lewis, Chief Executive
19 September 2025

Annex 2: Current register of Trust vacancies August 2025

The overall Trust vacancy rate on 31st August is 5.7%. The overall workforce vacancy rate for Mental Health and Community Hospitals within North East and Yorkshire on 31st March 2025 is 6.9% and 9.0% across the NHS for this sector.

Org L4	FTE Budget	FTE Actual	FTE Variance		Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total
Total	3767.91	3551.32	-216.59		36.56	29.00	20.82	37.56	47.55	32.11	204.30

The Backbone vacancy rate on 31st August is 4.0% which has increased from 2.8% at the end of July which is attributed to Nursing & Facilities and People and OD, but a number of these vacancies have been progressed.

Org L4	FTE Budget	FTE Actual	FTE Variance	Recruitment	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total
376 Corporate Assurance	29.09	25.76	-3.33		0.05	0.00	0.00	1.00	0.00	0.00	1.05
376 Estates	43.18	43.18	0.00		1.00	0.00	0.00	1.35	0.00	1.00	3.35
376 Finance & Procurement	42.99	41.37	-1.62		0.00	0.00	0.00	0.00	0.00	1.00	1.00
376 Health Informatics	75.46	74.12	-1.34		0.00	0.00	0.00	1.00	0.00	1.00	2.00
376 Medical, Pharmacy & Research	50.27	53.59	3.32		0.20	0.00	0.00	0.00	0.00	0.00	0.20
376 Nursing & Facilities	170.31	161.20	-9.11		0.50	0.00	0.64	0.00	2.11	0.00	3.25
376 Operations	51.08	49.13	-1.95		0.00	1.00	1.40	0.00	1.00	0.00	3.40
376 People & Organisational Development	90.25	82.47	-7.78		0.43	0.00	2.00	1.00	0.00	0.00	3.43
376 Strategic Development	20.25	19.56	-0.69		0.00	0.00	0.00	0.00	0.00	0.00	0.00
376 Psychological Professionals and Therapies	12.50	11.40	-1.10		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	**585.38**	**561.78**	**-23.60**		**2.18**	**1.00**	**4.04**	**4.35**	**3.11**	**3.00**	**17.68**

The Clinical Directorate vacancy rate on 31st August is 6.1% which is the same as the July figure which includes the investment for Community Rehabilitation in North Lincolnshire and Talking Therapies and HDU in Rotherham.

Org L4	FTE Budget	FTE Actual	FTE Variance	Recruitment	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total
376 CCG Mental Health	357.21	337.37	-19.84		6.00	9.80	0.00	7.20	1.00	5.60	29.60
376 CCG Physical Health	297.66	279.87	-17.79		1.00	1.00	0.00	2.71	1.60	1.80	8.11
376 DMHLD Acute Services	230.44	208.64	-21.80		1.00	1.00	1.00	2.00	0.00	2.00	7.00
376 DMHLD Community Services	347.70	336.52	-11.18		5.80	2.60	0.00	1.00	3.00	1.48	13.88
376 DMHLD Learning Disabilities & Forensics	189.55	181.81	-7.74		0.00	1.40	0.00	0.00	1.80	1.00	4.20
376 NLCG NHS Talking Therapies	182.94	182.77	-0.17		2.00	0.00	0.00	1.00	4.00	1.00	8.00
376 NLCG Acute Care Services	140.48	127.03	-13.45		1.75	2.00	6.50	1.00	3.00	0.00	14.25
376 NLCG Community Care Services	158.40	133.20	-25.20		1.80	0.00	3.00	1.40	2.75	7.40	16.35
376 PHG Community & Long Term Conditions	416.24	403.69	-12.55		2.80	1.20	0.00	3.00	2.60	4.00	13.60
376 PHG Rehabilitation	320.95	307.55	-13.40		2.00	2.30	0.00	2.00	6.00	5.53	17.83
376 PHG Neurodiversity	42.66	42.89	0.23		0.80	0.00	0.00	0.00	1.00	0.00	1.80
376 RCG Acute Services	247.79	208.61	-39.18		0.85	1.10	6.68	10.05	19.40	2.00	40.08
376 RCG Community Services	250.51	239.57	-10.94		2.80	4.00	0.00	3.20	0.00	0.00	10.00
Total	**3,182.53**	**2,989.52**	**-193.01**		**28.60**	**26.40**	**17.18**	**34.56**	**46.15**	**31.81**	**184.70**

Annex 3: National publications/guidance summary – August/September 2025

NHS oversight framework – NHS trust performance league tables process and results
(NHS England, published 09/09/2025)

As part of its commitment to transparency and improvement, NHS England launched a new interactive dashboard under the NHS oversight framework 2025/26.
The dashboard provides a view of how NHS trusts are performing in key services including urgent and emergency care, elective services, mental health and more.
https://www.england.nhs.uk/long-read/nhs-oversight-framework-nhs-trust-performance-league-tables-process-and-results/

Non-acute hospital trust league table: https://www.england.nhs.uk/long-read/non-acute-hospital-trust-league-table/

Planning framework for the NHS in England
(NHS England, published 08/09/2025)

This framework is intended as a guide for local leaders responsible for shaping medium-term plans. It provides clarity on roles and responsibilities within the context of the new NHS operating model outlined in the 10 Year Health Plan. It sets out core principles and key planning activities, which should be adapted based on local needs and circumstances.
https://www.england.nhs.uk/long-read/planning-framework-for-the-nhs-in-england/

Graduate guarantee for newly qualified nurses and midwives
(NHS England, published 12/08/2025)

Letter from Duncan Burton, Chief Nursing Officer for England, NHS England, and Elizabeth O'Mahony, Chief Financial Officer, NHS England, regarding the Government's Graduate Guarantee — that every newly qualified nurse and midwife in England will have the opportunity to apply to join the health and social care workforce.
https://www.england.nhs.uk/long-read/graduate-guarantee-for-newly-qualified-nurses-and-midwives/

Actions to tackle sexual misconduct in the NHS
(NHS England, published 20/08/2025)

Letter from Duncan Burton, Chief Nursing Officer for England; Dr Claire Fuller, National Medical Director, NHS England; and Professor Meghana Pandit, National Medical Director, NHS England.
https://www.england.nhs.uk/long-read/actions-to-tackle-sexual-misconduct-in-the-nhs/

Assessing provider capability: guidance for NHS trust boards
(NHS England, published 26/08/2025)

These documents will support NHS boards in assessing their organisation's capability on an annual basis against a range of expectations across 6 areas. Trusts must return this completed self-assessment and associated evidence underpinning it (for example, a board paper) to their regions by **5pm on Wednesday 22 October**.
https://www.england.nhs.uk/long-read/assessing-provider-capability-guidance-for-nhs-trust-boards/

Enhanced therapeutic observation and care: developing a local policy
(NHS England, published 28/08/2025)

This guide is designed to support Trusts develop and implement their enhanced therapeutic observation and care (ETOC) policy. Trusts should create ETOC policies that are living documents, enabling ongoing implementation and continuous improvement that responds to local needs. The information in this guide is applicable to all clinical settings.
https://www.england.nhs.uk/long-read/enhanced-therapeutic-observation-and-care-developing-a-local-policy/

Getting the basics right for resident doctors: 10 Point Plan
(NHS England, published 29/08/2025)

The 75,000 resident doctors working across the NHS are the backbone of the service – but too often they are let down on basic issues like payroll errors, poor rota management, lack of access to rest facilities and hot food, and unnecessarily repeating training. Supported by our commitment to staff under the 10 Year Health Plan for England, NHS England is setting out 10 ways in which we are improving resident doctors working conditions over the next 12 weeks.
This plan sets out actions for NHS England and individual trusts. To ensure meaningful progress, it will be formally incorporated into the new NHS Oversight Framework.
https://www.england.nhs.uk/long-read/10-point-plan-to-improve-resident-doctors-working-lives/

Guidance and role specification: Senior lead for resident doctor experience
(NHS England, published 15/09/2025)

This guidance for NHS trusts sets out the responsibilities and expectations of the senior lead for resident doctor experience (SLRDE) and provides a sample role specification to assist in appointing to the role.
https://www.england.nhs.uk/long-read/guidance-and-role-specification-senior-lead-for-resident-doctor-experience/

Campaign to vaccinate all frontline healthcare staff
(NHS England, published 04/09/2025)

This letter explains that the staff flu vaccination campaign is a national priority and sets out next steps to support leaders and their teams to deliver a high impact programme this year.
https://www.england.nhs.uk/long-read/for-urgent-action-campaign-to-vaccinate-all-frontline-healthcare-staff/

Towards a new co-investment model: what is next for NHS public-private partnerships?
(NHS Confederation, published 07/09/2025)

Insights and learning from NHS private finance initiatives in England and abroad, and recommendations on what any future model should look like.
https://www.nhsconfed.org/publications/towards-new-co-investment-model

Transforming the NHS estate to enable a neighbourhood health service
(NHS Confederation, published 16/09/2025)

This briefing explores the issues affecting the shift to neighbourhoods and what it will take to overcome them. Informed by discussions with NHS leaders, it considers the challenges of transforming estates and how to improve the process.
https://www.nhsconfed.org/system/files/2025-09/Transforming-NHS-estate-enable-neighourhood-health-service.pdf

Annex 4: RIDDOR

Since 1st April 2025 there have been **7** RIDDOR reportable incidents resulting in employee injury.

Incident date	Cause	Location	RIDDOR reason
03/04/2025	An employee slipped on a wet floor in the hub area and suffered a knee injury.	Brodsworth Ward (Doncaster AMH Acute Directorate)	Over 7-day absence
22/04/2025	A Community Healthcare Assistant suffered shoulder pain and a trapped nerve after applying compression bandages to a bariatric patient's legs.	Community Long-Term Conditions	Over 7-day absence
30/04/2025	A Community Partner (volunteer) suffered a hip fracture after falling up steps at an offsite Trust event.	AES Seal New York Stadium	Member of the public taken to hospital
06/05/2025	A patient hit an employee causing bruising and psychological harm.	Mulberry House (N Lincolnshire Acute Directorate)	Over 7-day absence
11/05/2025	Patient pushed over by an employee.	Brodsworth Ward (Doncaster AMH Acute Directorate)	Hospital treatment
04/08/2025	Domestic carried a vacuum cleaner upstairs and suffered back strain.	Facilities (Nursing and Facilities Directorate)	Over 7-day absence
11/08/2025	An employee fell in a hole on grass in the ward garden and twisted their ankle.	Magnolia Lodge (Physical Health Rehabilitation Directorate)	Over 7-day absence

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

- An incident in the 136 suite in North Lincolnshire involved a number of employees being assaulted by a patient. At staff changeover, the patient punched an employee, the alarm was sounded and employees responding were also assaulted.

- There was no requirement for the domestic colleague to carry a vacuum cleaner upstairs as there was already one available on that floor. Improved communication about the location of cleaning equipment in different venues should result in reduced manual handling injuries.

- The hole in Magnolia's garden was due to a rotted tree root and has since been filled.

Annex 5

South Yorkshire Eating Disorders Joint Committee (SYEDJC)
Meeting note – 8 September 2025

The South Yorkshire Eating Disorders Joint Committee (SYEDJC) met on 8 September 2025. The main areas of discussion and subsequent actions are outlined below.

Inpatient care development

Following previous presentations, the SYEDJC discussed an update paper on the future provision of inpatient care for adults with eating disorders, including learning from other national providers. The work done, which this time focused on adults, was well received and impressive – and it was clear the synergies that it could offer across the pathway. Committee requested that sole site/age separation were subject to specific risk assurance analysis; and agreed to review the updated financials/mobilisation plan in November 2025. Further papers outlining options for children and young people, including transitionary care, are due at future meetings later in 2025.

Medical emergencies in eating disorders (MEED)

A proposal to fund enhancements to local MEED pathways was discussed, which re-highlighted the non-compliance with the MEED guidance published by the Royal College of Psychiatrists, and the high level of clinical risk for this cohort of patients. The Committee approved the redistribution of existing adult eating disorder funding to offer a more robust and consistent approach. The final two-phase implementation plan will be discussed to a conclusion at the October meeting. Work to ensure patients and community leaders are sighted on the changes are under way. The proposal presently does not assume a rationalisation of acute presentation sites, but discussions continue with acute Trust clinicians to explore the best practice we need to apply.

Adult community development

The Committee discussed options to enable equitable community day service provision for adults across South Yorkshire in line with the ambition of the Joint Committee to level-up care across South Yorkshire. A move to all-place access was agreed with effect from October 1, which aligns with the introduction of ICB funded community teams in all places – provided through SHSC. A proposal to expand and relocate services over time will be considered alongside the inpatient proposal later in 25/26. Waiting times will be added to the JC KPI scorecard recognising some adverse impact as all four places use the service.

Communications plan

A programme communications plan was reviewed and agreed. The plan outlines methodology for communicating with health and care professionals and people with lived experience regarding progress against the four key areas of the SYEDJC workplan. The communications plan will launch in October 2025.

Risk log

The SYEDJC reviewed the system-wide risk log which aims to enable oversight across provision of services. A number of risks relating to agenda items, namely inpatient care, MEED and involvement, were identified and are to be revised and/or added to the log. Further work on the experience of patients aged 17-19 will be considered in light of the risk log.

Data dashboard

The Committee reviewed a developing data dashboard. The dashboard aims to show performance and quality metrics across pathways including age transitions. The Committee discussed the need to focus on patient access and outcomes with further updates planned for the November meeting.

Annex 6

South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note – 10 September 2025

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 10 September 2025. The main areas of discussion and subsequent action are outlined below.

Service Development Funding (SDF) and the Mental Health Investment Standard (MHIS) – action carried forward from previous meeting

It was noted that the process to include providers in the SDF and MHIS decision making process had not been sufficiently robust in previous years. This has not been resolved, despite actions undertaken following the previous meetings. Members of the Board therefore requested that the ICB Executive Lead for MHLDA works with providers in September/October to agree a process that will be presented to the November Board, ahead of the 26/27 planning round.

Managing Director Report

The Board received an overview of recent national and local developments, with a specific focus on the recent NHS 10 year Plan: Fit for the Future.

Forensic Services

The Board considered initial plans for developments in forensic services. It was proposed that an assessment of need will be undertaken, similar to one previously conducted in West Yorkshire. The Board supported this work, noting that the approach would take a whole system approach, including consideration of low secure and community elements, ensuring that a 'left shift' towards community care is central to the strategy. The Collaborative team will support the work to provide additional resource, and a more detailed paper will be provided in November.

Out of Area Placements (OAP) programme (Mental health complex, acute and PICU placements)

An updated position on the Out of Area Placements (OAPs) programme was provided to the Board with an overview of the positive progress to date. An outline of next steps was provided, mindful of the need to cohere this work with the System Efficiency Board workstream, (Toby Lewis is the senior Responsible Officer for OAPs, in his role as the Collaborative Coordinating CEO). Board was updated on recent discussions with the ICB where it was agreed that the Collaborative focus will remain on Mental Health OAPs and care arising from s117 commitments.
The Board considered the risk to the system of increasing annual expenditure on out of area placements, not covered in local trust budgets, and the importance of provider leadership in addressing the issue.

Report from Eating Disorders Joint Committee (EDJC)

The Board received an update from the EDJC which included progress on developing an NHS offer for future provision of inpatient ED care, plans to enhance funding of care for medical emergencies in eating disorders (MEED) and positive progress with implementing a strengthened, more equitable, South Yorkshire offer for community ED services for adults with a hub and spoke model.

Members of the Board commended the progress on this programme and the strong inclusion of lived experience voice.

Delivering Our Work programme

The scope of the Collaborative work programme was reviewed at a Collaborative Board strategic development event in August, following announcement of ICB funding changes. Changes have been made to the programme workplan to reflect the outcomes of these discussions. Productivity programmes have been paused (however this work continues in individual organisations) and following ICB discussions, the ADHD and autism projects are more specific and time limited, with clear areas of Collaborative responsibility.

In all the other programmes, progress is as planned with no current escalations. Better integration of digital and innovation work into the programme will be reflected in future highlight reports.

The associated **performance scorecard** was presented as a separate paper. It was agreed that Members of the Collaborative will undertake a deep dive into the data used to measure length of stay and will work with ICB colleagues to further investigate the implications of research evidence on reliable recovery rates in deprived communities.

Specialised Commissioning Update

The Board received the routine report from the SYB Specialised Commissioning Provider Collaborative Partnership Steering Group and there were no items for escalation.

Marie Purdue, Managing Director, South Yorkshire MHLDA Provider Collaborative

Annex 7: Summary of procurement KPIs sought through agreed change proposals

The Board discussed arrangements to merge our procurement service with others ready for 2026/27. We agreed in principle that this should be progressed subject to consideration of the key performance indicators which would either wish to:

- Not see decline versus current or
- See improvement in over time

The director of finance and estates is recommending the following indicators form the basis for the SLA we would ask of a revised supplier:

- Percentage of non-pay expenditure with local suppliers (as per our promise 25)
- Identification of and veto over suppliers not paying the Real Living Wage
- Number of Single Quote Waivers raised due to lack of time for a procurement process
- Number of Single Quote Waivers raised
- Time taken to raise orders from inception to completion
- Procurement timetables met to satisfaction of contractee
- Spend via a purchase order as a percentage of total non-pay spend
- Percentage completion of the procurement work plan
- Percentage of spend covered by formal contracts
- Number of procurement related issues raised in internal/ external audits
- NHS Procurement Standards accreditation level (1, 2 or 3)

Annex 8: Possible timetable for estate maintenance supplier changes

Description	By When
Identify and appoint a procurement specialist to assist in writing the tender.	30th September 2025
Appoint a contractor to conduct a detailed asset verification exercise across the RDaSH estate.	30th September 2025
Compile the tender paperwork and engage in any pre-market testing	31st October 2025
Board reconfirmation to proceed	27th November 2025
Asset verification completed	30th November 2025
Issue ITT on the procurement portal	8th December 2025
Commence competitive dialogue and hold interviews with interested parties	12th January 2026
Tender closes	19th January 2026
Evaluation of bids and further supplier interviews (if required)	26th January 2026
Inform successful supplier	2nd February 2026
Successful supplier completes asset verification and issues final contract price.	16th March 2026
Change management paper in relation to any affected colleagues presented at JCC (this will be a TUPE process)	25th February 2026
TUPE consultation ends	27th March 2026
New contract is live from 1st May 2026, with colleagues TUPE across to new supplier from the same date.	1st May 2026

The Board is reminded that this proposal, which it agreed in principle in August, is unrelated to finance or savings: there is no expectation of financial benefit. The proposal relates to operational safety of staff and patients and the need for a robust and well managed service across the entirety of our estate.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Draft Submission	**Agenda Item**	Paper K
Sponsoring Executive	Richard Chillery, Chief Operating Officer		
Report Author	Andrew Hayter, EPRR Manager		
Meeting	Board of Directors	**Date**	25 September 2025

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

The previous submission of the Core Standards was confirmed as "non-compliant" for the 2024/25 financial year (FY). However, the Trust's compliance score had improved to 67%, a notable increase from the FY 2023/24 score of 21% following the national EPRR hard "re-set". For context, only a small number of Trusts nationally continue to achieve a rating of *Substantially Compliant* (89%). The assurance rating thresholds are as follows:

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

We anticipate evidencing full compliance with 52 standards (up from 35 in October 2024), partial compliance with 6 standards, and having no non-compliant standards. This year's submission is expected to increase the Trust's compliance rate from 67% to **89.7%,** moving the organisation from *non-compliant* to "***substantially compliant".*** The EPRR team and all Directorates are to be commended on a significant amount of work this year with a focus on Business Continuity (BCP) and Evacuation plans, with testing of these and up to date polices and procedures.

The final validated position will be reported into the November Trust Board orally through the CEO report.

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

Directorate delivery review

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the progress made to date, and the risks remaining to achieving full compliance

APPROVE submission, delegating to Chief Operating Officer such amendments as per review suggest are necessary

Alignment to strategic objectives (indicate those that the paper supports)	
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	X

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

People risks			
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X

Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks			
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
n/a							
System / Place impact (advise which ICB or place that this matter relates to)							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
EPPR core submission							

Rotherham Doncaster and South Humber NHS Foundation Trust

Emergency Preparedness Resilience and Response

Preliminary EPRR Core Standards Statement of Compliance

Richard Chillery, Chief Operating Officer

September 2025

RDaSH nurturing the power in our communities

Annual Core Standards Compliance

Background

1.1 The NHS England Core Standards for EPRR are the minimum requirements commissioners and providers of NHS funded services must meet. In 2025/26 there are 58 separate core standards that are applicable to RDASH. These are divided into 10 domains.

1. Governance
2. Duty to assess risk.
3. Duty to maintain plans.
4. Command and Control
5. Training and Exercising
6. Response
7. Warning and Informing
8. Cooperation
9. Business Continuity
10. CBRN/HAZMAT

1.2 Each domain has a varying number of sub standards, each of which has several criteria associated with them which must be attained and evidenced.

1.3 The assurance process for 2025/26 will be a similar process to that used by the South Yorkshire ICB EPRR team in financial year 2024/25. The assessment process this year, which is a mix of self-assurance and informal check and challenge assessment by the ICB, will need to meet a detailed set of criteria to comply with each standard, requiring multiple pieces of documented and recorded evidence. The process included an all year-round informal series of 'mini submissions' throughout the year to allow the ICB to comment on evidence completed to allow any adjustments prior to formal submission later in the year.

1.4 To enable achievement of the CBRN standards, Trusts across SYICB are being supported by Yorkshire Ambulance Service (YAS) who are also conducting stand alone assessments of Trust's compliance. However, this is being undertaken by a single YAS specialist and will not take place for mental health or community Trust's this year due to pressure on that resource. A self-assessment of that domain will be undertaken. Without this specialist input from YAS, this means

RDaSH will be unable to achieve our remaining (6) non-compliant standards accounting for 10.3% of the overall compliance rating.

1.5 The Trust will take part in an informal 'check and challenge' by SYICB EPRR team on 23rd October, followed by a final submission by the Trust which must be received by the ICB on **31st October 2025**. Due to the timing of Trust Boards as with previous years we are submitting the DRAFT findings of the Trust submission in September and will be followed up verbally at November Board, with the outcome.

Trust Position against the 2024/25 EPRR Core Standards

2.1 EPRR Core Standard compliance assurance rating thresholds are as follows:

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

2.2 In FY 24/25, the Trust had a validated full compliance for 39 out of 58 applicable standards. This equated to a core of 67%, following the ICB assessment and so deemed "non-compliant" which was reported into the September and November 2024 Boards.

Core Standard Position After Check and Challenge				
Number of Standards	Fully Compliant	Partially Compliant	Non-Compliant	Do Not Apply to MH Trusts
67	39	19	0	9

Proposed Trust Position against the 2025/26 EPRR Core Standards

3.1 The anticipated compliance rating for financial year 2025/2026 is **89.7%,** with an improvement from 39 fully compliant standards in 24/25 to **52** in 25/26.

Compliance Level	Evaluation and Testing Conclusion
Substantially Compliant	The organisation is self-assessed as 89.7% compliant with the core standards they are expected to achieve.

Core Standard Position After Check and Challenge				
Number of Standards	Fully Compliant	Partially Compliant	Non-Compliant	Do Not Apply to MH Trusts
67	52	6	0	9

3.2 This sees the Trust's compliance raising from last year's 67% to 89%, an increase of 22%. This is again a significant improvement on last year's compliance and would see the Trust achieving a rating of 'substantially compliant' for the first time.

*A breakdown of the standards and their proposed compliance rating is included in: Appendix 1. Details of the work conducted by the EPRR team to enable this submission are included in: Appendix 2.

Key Actions in 2024/25

4.1 During 2024/25, significant progress was made to strengthen the Trust's resilience and work towards compliance with ISO 22301 and the EPRR Core Standards.

Business Impact Analysis (BIA) and Business Continuity Plans (BCP)

5.1 A major focus has been the review and enhancement of our BIA and BCP processes.

- Refreshed Documentation: All documentation templates were redesigned and fully aligned to ISO 22301.
- Comprehensive Updates: All of the 132 BIAs and BCPs across the Trust have been updated. A rolling programme of team-by-team review for annual update is ongoing, with each plan formally signed off by the EPRR Team prior to publication.
- Audit and Assurance: A new annual audit process has been introduced to ensure staff are familiar with the requirements of their plans and can respond effectively to any business continuity incident.

Evacuation Planning

6.1 The Trust undertook a full review of its twelve site-specific evacuation plans.

- Collaborative Development: Updates were made following direct consultation with affected clinical and non-clinical areas to ensure plans are practical and locally owned.
- Testing and Exercising: Annual testing is now in progress, incorporating a range of approaches; in-person table-top and live exercises, virtual/online testing, and unannounced drills - to validate plans and staff readiness.

Policy and Compliance

7.1 Several Trust-wide policies were reviewed and updated to ensure alignment with ISO 22301 and to demonstrate full compliance with the NHS EPRR Core Standards.

7.2 These actions collectively strengthen the Trust's ability to maintain safe and effective services during disruptions, provide assurance to regulators and commissioners, and support a culture of preparedness across all services.

Next Steps

8.1 The process for submission this year has been led through the EPRR team on an ongoing basis, with the team submitting evidence to the ICS EPRR team, throughout the year when Standards have been turned 'green'. To this point, the Trust has approved evidence for 79.31% of Core Standards.

8.2 Evidence for core standards 46, 47, 48, 50, 51 and 53 are being finalised ahead of the draft submission deadline. The official draft submission to South Yorkshire ICB will take place on 23rd October 2025 when the Trust will meet with the ICB to work through evidence on all 'green' standards. This will be followed by a final submission, with the accompanying evidence, on 31st October 2025.

Potential Risks

9.1 The biggest risks to the submission are some of the previously discussed CBRN standards which we have endeavored to continue, despite the delays in review for Mental Health Trusts within South Yorkshire. This is a minimal risk to the Trust as the focus of these standards is to ensure that all Trust buildings can respond appropriately if a member of the public attends seeking help and treatment for exposure to hazardous materials. These standards are more rigorous for acute Trusts. The remainder of these CBRN standards will become the focus for improvement in 2026.

9.2 Core Standard 53 'Assurance of Commissioned Providers/Suppliers' is also a risk, which requires 100% of all the Trusts suppliers to have ISO22301 compliant Business Continuity Plans for their organisation. This means that the approximately 1,300 suppliers for the Trust need their business continuity plans audited to ensure that their plans align to ISO22301. Because of the scale of this requirement, the Trust is taking an incremental approach to this, with all new suppliers expected to comply with this and a 'dip sample' approach being taken

to the current existing suppliers throughout 25/26 and 26/27 to provide further evidence. This approach was agreed with the ICB.

9.3 Notwithstanding those risks and the difficulty in fully achieving all CBRN Core Standards, it is still the aim for FY 2026/7 to improve on the proposed 89% and extend the level of compliance, as far as possible during the next financial year.

Plans for 26/27

10.1 As well as fully complying with YAS to achieve compliance with the remaining CBRN standards, maintaining compliance with already achieved standards will form a significant part of the ongoing work plan for the EPRR team, for which they have several internal KPIs. This includes:

- Exercising of BC plans (at least 1 exercise per plan per annum)
- Supplier Audits (5 dip samples per month)
- BC audits (3 per month)
- Review and refresh annually all BC plans (14 plans per month)
- Evacuation plan review and refresh for all inpatient areas.
- Winter planning exercises
- 2 Live BC Exercises
- CBRN/IOR Training to nominated Reception Staff

10.2 The emphasis needs to remain on testing of said plans, with accompanying training and policy frameworks to ensure staff and services have the capability to manage potential unexpected scenarios and incidents to maintain safety.

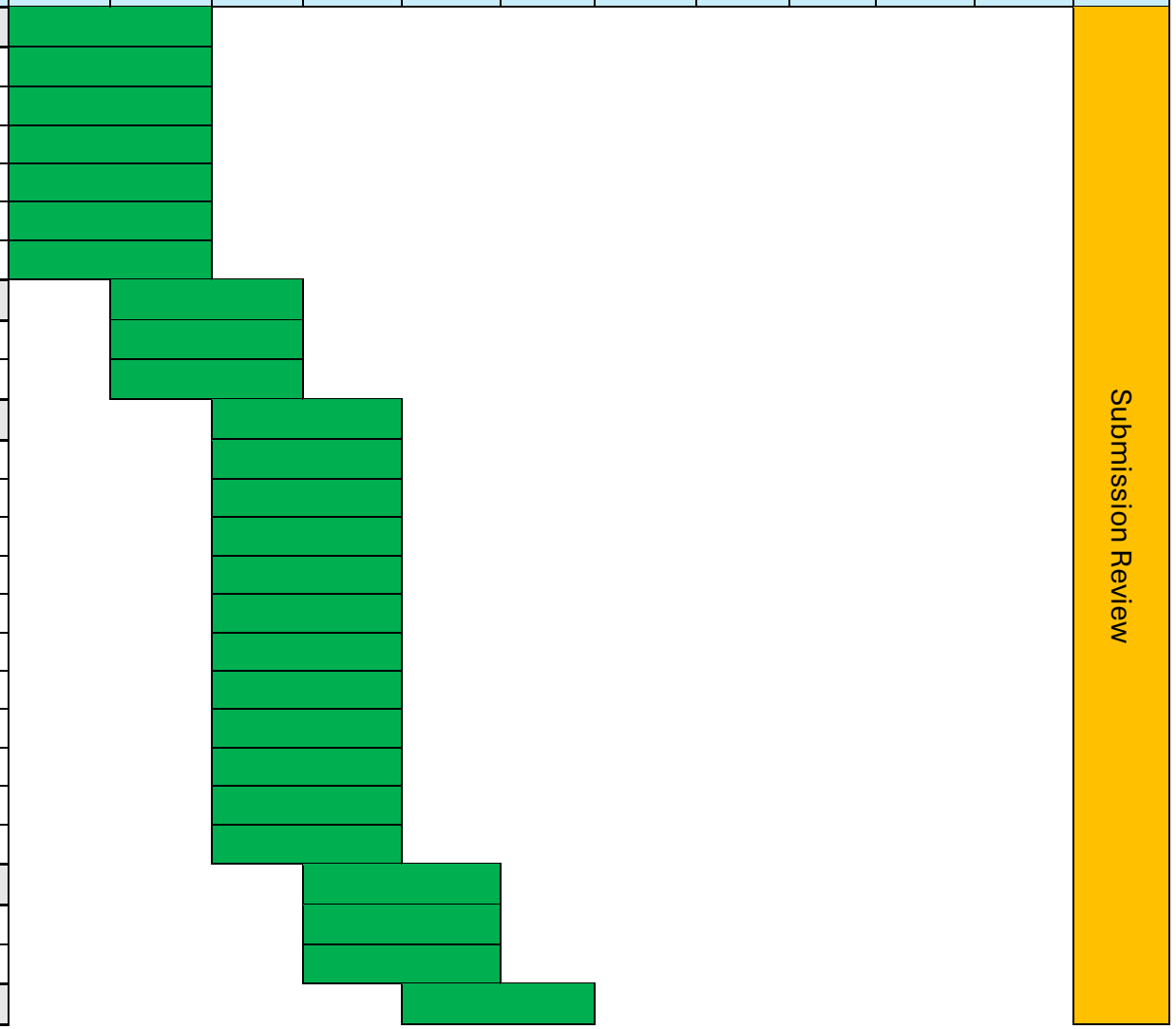
10.3 The Board need to note that there is potential for the Core Standards to change next year, as advised by the ICB. It is likely that some of this will be subject to the changes being made within the ICBs and NHSE, so there continues a degree of uncertainty.

Conclusions

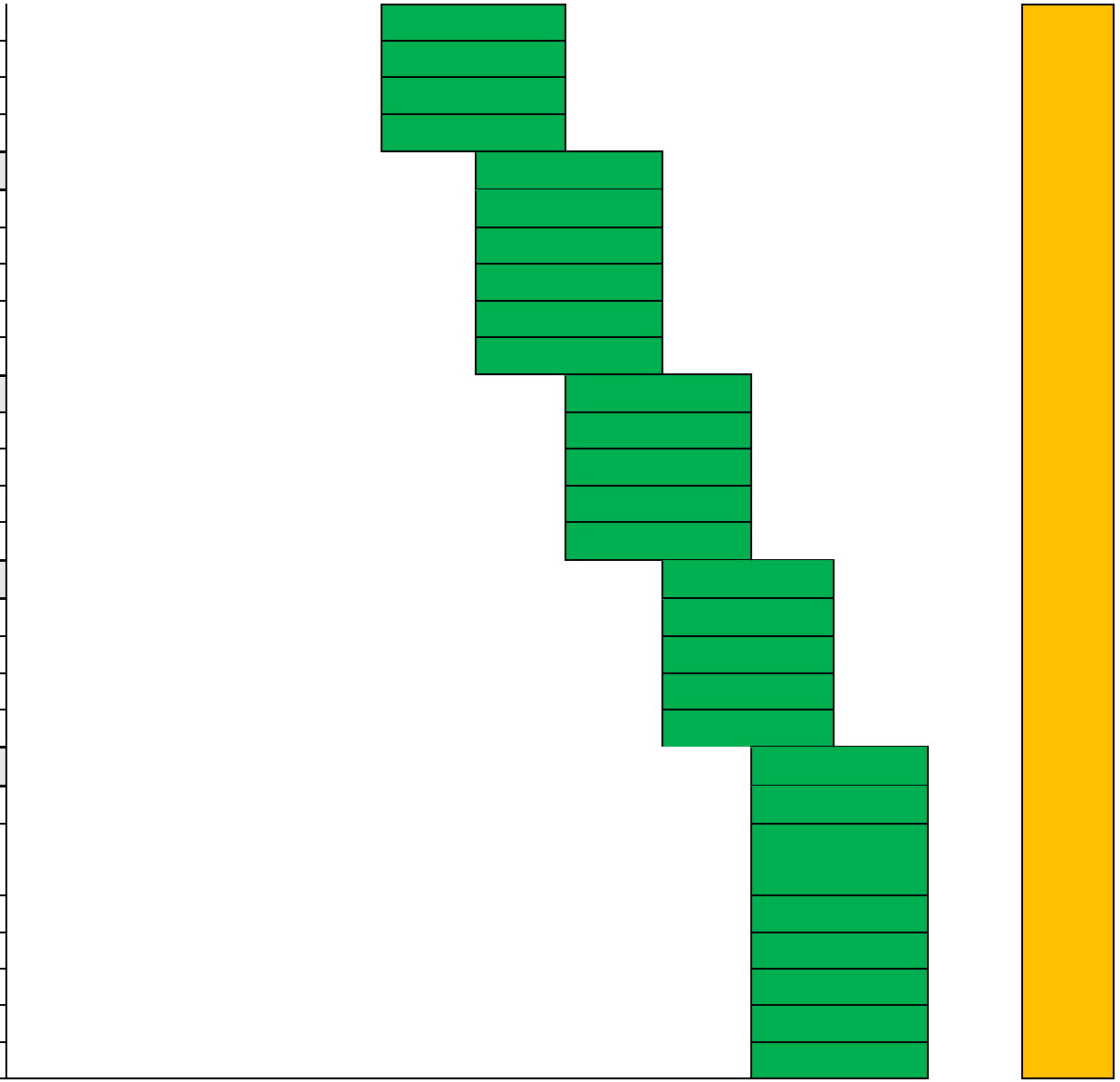
- The Board of Directors is requested to accept the Trust's projected EPRR Core Standards statement of compliance for 25/26.
- It is also requested that the Board receive this board update with a recommendation for a further brief update in Q1 26/27 (May) to allow for ongoing evidence of compliance (as noted in the Core Standards).
- The Board notes the proposed broad EPRR plans for 26/27.

Appendix 1

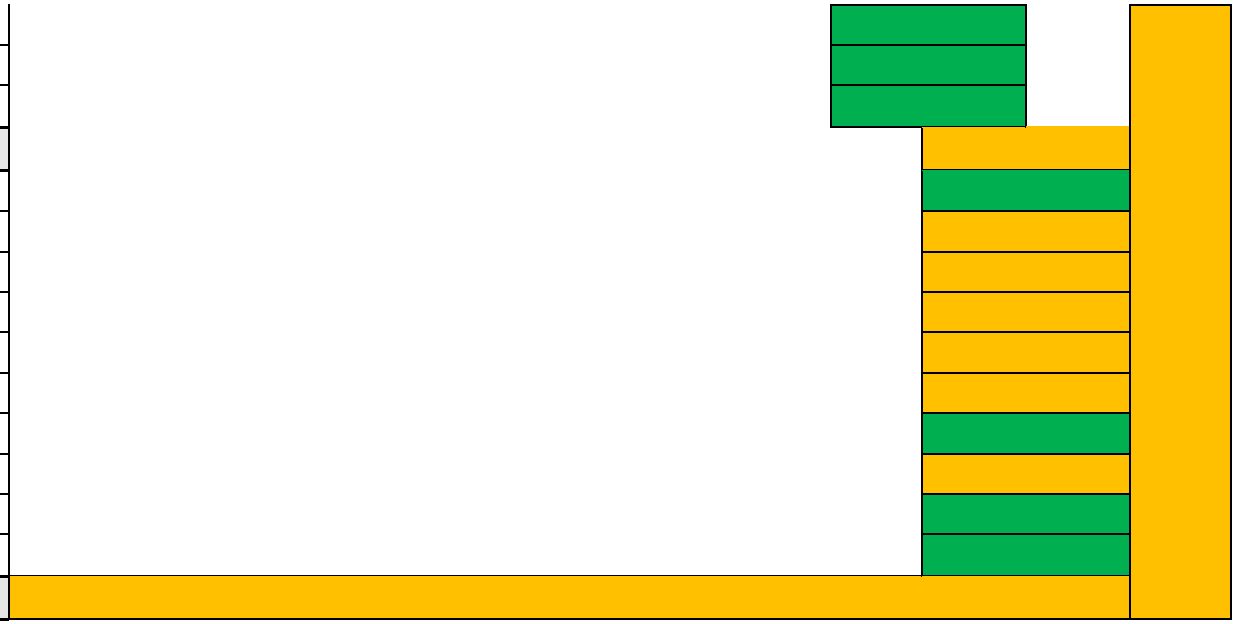
Tasks	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Governance												
Senior Leadership												
EPRR Policy Statement												
EPRR Board Reports												
EPRR Work Programme												
EPRR Resource												
Continuous Improvement												
Duty to Assess Risk												
Risk Assessment												
Risk Management												
Duty to Maintain Plans												
Collaborative Planning												
Incident Response												
Adverse Weather												
Infectious Diseases												
New and Emerging Pandemics												
Countermeasures												
Mass Casualty												
Evacuation and Shelter												
Lockdown												
Protected Individuals												
Excess Fatalities												
Command and Control												
On-Call Mechanism												
Trained On-Call Staff												
Training and Exercising												



EPRR Training
EPRR Exercising and Testing Programme
Responder Training
Staff Awareness and Training
Response
Incident Coordination Centre (ICC)
Access to Planning Arrangements
Management of Business Continuity Incidents
Decision Logging
Situation Reports
Warning and Informing
Warning and Informing
Incident Communication Plan
Communication with Partners and Stakeholders
Media Strategy
Cooperation
LHRP Engagement
LRF/BRF Engagement
Mutual Aid Arrangements
Information Sharing
Business Continuity
BC Policy Statement
Business Continuity Management Systems (BCMS) Scope and Objectives
Business Impact Analysis/Assessment (BIA)
Business Continuity Plans (BCP)
Testing and Exercising
Data Protection and Security Toolkit
BCMS Monitoring and Evaluation



BC Audit
BCMS Continuous Improvement Process
Assurance of Commissioned Providers/Suppliers BCPs
HAZMAT and CBRN
Governance
Hazmat/CBRN Risk Assessments
Specialist Advice for Hazmat/CBRN Exposure
Hazmat/CBRN Planning Arrangements
Equipment and Supplies
Equipment - Preventative Programme of Maintenance
Hazmat/CBRN Training Resource
Staff Training - Recognition and Decontamination
PPE Access
Exercising
Assurance and Continuous Improvement



Appendix 2 – Annual EPRR Update

Key Highlights

1. **Yorkshire and Humber Wide Mental Health Trust and Other Collaboration**

An informal group of the EPRR leads across all mental health and community trusts exists to provide peer support and share information. Following the changes to the EPRR Core Standards, this group has become critical and has become formalised with an agreed Terms of Reference. The group aim is to share best practice amongst peers and to promote the unique differences of mental health and community trusts, especially where guidance and standards are acute focused.

The group is working collaboratively and proactively to share fully compliant processes and documentation in a move to work smarter and share workload for core standards. Indications from the group suggest that RDaSH will perform extremely well in Core Standard compliance this year compared to its peers across the region.

2. **Doncaster Royal Infirmary**

DBTH has historically not maintained a suitable evacuation plan for a large-scale emergency. The RDaSH EPRR Team have helped develop this plan towards the end of 2024 which in turn allowed the individuals from the RDaSH EPRR Team to develop as part of their degree level training.

Further to this an MOU has been developed to outline the Trust's commitment to assisting DBTH during such an event or during a mass casualty event which would require DBTH to discharge up to 20% of its patients. This MOU is a key part of the Trusts evidence of collaboration for our 2024/25 Core Standard submission.

3. **Updated EPRR Policies and Procedures**

Significant policy and guidance documents that have been reviewed, written and published include:

- Road Fuel Emergency Plan
- Major Incident Plan
- Pandemic Plan

These continue to play a significant part in the Trust's readiness to respond to emergencies and its compliance of Core Standards. Planning for the 2026/27 assessment includes ongoing reviews of EPRR policy and the new RADAR system provides the ability to track their status and how they impact on risk mitigation on the desktop.

4. **Evacuation**

The Trust has now in place evacuation plans for all in-patient areas. These have been the focus of the EPRR team for the end of 2025 and through the first half of 2026. These

plans were jointly developed by the EPRR Team and key team members of the individual units and have been exercised for each site to ensure they are fit for purpose and allow any changes that may have been captured as part of that testing and learning prior to publication. These plans can be found on the Trust's intranet site.

5. **Training and National Occupational Standards**

There are several Core Standards that refer to colleague training and competence. These include CS10 incident response, CS20 On-Call mechanism, CS21 Trained On-Call Staff, CS22 EPRR training, CS24 responder training, CS25 staff awareness and training, all of which we are compliant against.

The EPRR Team have developed a Training Needs Analysis for all commander roles to align to National Occupational Standards (NOS) and continues to provide all Commanders with access to their required training which includes a mix of online courses and in person training.

Principles of Health Commander (PHC) Training

As part of the Core Standard mentioned above, NHSE have developed a mandatory training course for all On-Call staff and incident commanders. There are two levels of PHC training required of all 'Health Commanders' and those on call: Tactical (Silver) and Strategic (Gold). NHSE put on monthly courses for each of these. The whole course must be attended to gain the certificate which is valid for three years and then the course must be reattended.

As of September 2025, the Trust training compliance rates are shown in the table below. The EPRR team are tracking training to ensure those that require updated mandatory training are prompted and are provided with access.

Course	**Percentage of Staff Completed**
Tactical PHC	100%
Strategic PHC	100%

On-Call Induction Training

Following the Trust On-Call Managers review, a half-day Induction Training course was developed to ensure that all colleagues receive a base level of training on both Trust-out-of-hour calls received and EPRR incident response. Input was delivered by the EPRR Team, Patient Flow and the Mental Health Act Manager. These continue to be delivered throughout the year where demand requires it.

Loggist Training

The Trust has an obligation to provide trained loggists to commanders during response to an incident. NHSE has set the standard for loggist training and for the accreditation of trainers delivering. The EPRR Team did not hold those qualifications and in the interim employed the qualified TRFT EPRR Team to deliver the first course in July 2025 using a reciprocal arrangement where RDaSH EPRR team will deliver training for TRFT in return. Since that date the Trust's EPRR team have now qualified to deliver Loggist training and

a program will be developed in Q4 of 25/26 to increase numbers of Loggists within the Trust and maintain their competence.

Internal Gold/Strategic Commander Training

In August 2025 training was delivered to Commanders to inform on-call managers about the refreshed online resources available to them for out of hours enquiries and response to an incident. The update to the resources was a significant piece of work for the EPRR Team and the training provided commanders an opportunity to explore these and key elements within those tools such as communications, evacuation and business continuity response.

Media Training

It is a mandatory requirement for all Strategic Commanders to receive media training as part of National Occupational Standards. The Trusts Communication Team secured the services of Capital Media to deliver this in spring of 2025. This training covered all aspects of dealing with the media during and after an incident including interviews for television.

Training Plans 2025/26

The EPRR team have full core standard compliance in regards training requirements and will continue to maintain this status maintaining focus towards exercising during 2025/26. The ERR Team will continue to develop and deliver internal training for

Exercises

External Exercises

Exercise Blue Hammer and Blue Phantom

These exercises took place in September 2025 at the Fire & Rescue Training Centre in Shefield and were an ICB led multi-agency tabletop evacuation exercise of Doncaster Royal Infirmary (DRI).

The need to evacuate DRI is on SYICB risk register and any large-scale emergency requiring an evacuation would have a significant impact on health provision across the region. Attendees on both days were required to explore how their service would support the large-scale evacuation of hundreds of patients and provide feedback to develop local policies further.

Internal Exercises

Evacuation Exercises

Several table-top evacuation exercises have been undertaken at in-patient units within the trust as part of the development of their specific evacuation plans. It has also included a ‘live’ walk through of Physical Health evacuation arrangements in regards access to their proposed temporary shelter, testing communications, access to keys and validation of access codes and fobs.

Next Steps

Plans to undertake a live Trust wide business continuity exercise are being developed with the intent to deliver this in February 2026. This will test and develop the trust’s ability to respond and recover from a national power outage.

7. **Incident Response and Lessons**

Onyx Centre Incident

In July 2025 a patient threatened to shoot a member of staff at the Onyx Centre at the Tickhill Road site. Very quickly staff were able to lock down the unit and raise the alarm to Tactical and Strategic commanders. Communications internally were directed to at risk areas at the site and additional buildings were placed lockdown until SY Police Firearms Officers attended scene to secure the individual who was later placed onto the Trust's care.

The incident identified good practice, in particular the initial response which benefited from recently undertaken lockdown training. A debrief was held and all good practice and any learning was discussed at the EPRR Group.

Forrest Gate Incident

A patient in attendance for an appointment made a threat to stab a member of staff with a knife. The staff calmly handled the situation and alerted all staff in the area. Again, a lockdown was implemented quickly and efficiently, again learning from Lockdown training and previous incidents ensured this was safely and effectively undertaken. The individual was apprehended by Police and a full debrief was undertaken

Section 3 – Business Continuity

As part of the BC process, 162 departments requiring BCPs have been reduced to 142 through a process of merging plans and removing those that no longer exist following re-structure. An offer to support those developing plans online has proven popular amongst teams with limited BCMS understanding and, at the time of writing this report, 93% have been completed and the remaining are under review with the support of the EPRR Team. These will be completed by the end of September.

The BCP Review process has been designed and a program of 14 reviews per month are being undertaken by the EPRR Team. The review takes the form of an online meeting with the author and team members to review the BIA and then the BCP before resubmission. An element of training is undertaken also to support the department in future assessment of BC risk.

BC Exercises will take the form of virtual access to a system on Monday.com which allows the department undertaking an exercise to hold the event during a business or team meeting. The result of the exercise is automatically sent back to the EPRR Team to review and score. This allows the EPRR Team to prioritise support to those teams that require it.

BC Audits commenced early October and there will be 5 'live' audits undertaken per month along with several 'ghost audits which will be online accessed audits. The Live audits will see the EPRR Team attending sites to undertake a 'show and tell' type audit. Staff will be questioned and BCP elements will be triangulated. On conclusion the EPRR Team will provide a report to the Department Lead to give assurance on the status of their preparations for BC.

Section 5 – EPRR Risk Management

As part of strategic processes, the Trust assesses the risk it faces from nationally identified risks which are found on the National Risk Register. These risks are replicated within the Community risk register, held by the Local Resilience Forum (LRF) and the EPRR team use this information to present these risks to the Trust with an associated rating of likelihood and impact.

These risks are now recorded on the Trusts RADAR system to allow all managers a clear view of the risks faced by the trust and inform any work in relation to business continuity to be undertaken to meet the challenges that these risks pose.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Tackling waits in neurodiversity services	**Agenda Item**	Paper L
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis - Chief Executive, Jude Graham – Director of Psychological Professions, Richard Chillery – Chief Operating Officer & Victoria Takel – Deputy COO		
Meeting	Board of directors	**Date**	25 September 2025

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

This paper builds on challenge in the July Quality Committee in relation to the stickiness of long waits in neurodiversity services, despite emphasis since 2023 and considerable Trust-generated investment. It outlines the path forward and trajectory required, recognising the further financial challenges that this could give rise to. One of our four areas of focus (adult wait backlog) does not yet have a fully worked out solution: and this needs continued attention by those who have authored this paper.

Considerable clinical leadership attention has been paid to revisiting the service models of these services. There is a clear view on what needs now to happen. Not all staff involved agree with this way forward, and this paper is written on the basis that we need now to implement at pace those changes, recognising that this may mean that some colleagues choose to work in other parts of RDaSH or the NHS, as we move to a "booked clinic" model of delivery, with clear expectations of individual clinicians, teams and managers. The alternatives to this, including disbanding this service, are considered, but not recommended at this time if the preferred option can proceed effectively in Q3.

Previous consideration

n/a

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

CONSIDER the issues raised and problem analysis outlined

RECOGNISE the suggested difficult choices cited, notably in relation to clinical productivity

DELEGATE to the Chief Executive and colleagues the expedited actions outlined

AGREE to receive an update on progress at November and January Board meetings

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X

Alignment to the plans: (indicate those that this paper supports)	
Estate plan	X
Digital plan	X
People and teams plan	X
Quality and safety plan	X
Equity and inclusion plan	X

Trust Risk Register

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	**X**
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X

Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
n/a							
System / Place impact (advise which ICB or place that this matter relates to)							
Both ICBs now recognise the urgency of changing the status quo							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	Given nature of recommendations
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Introduction and purpose

1.1 This paper is intended to ensure all Board members have insight into the challenges to providing the right services for patients seeking a diagnosis, treatment and support in our CYP and adult neurodiversity services. It is drafted mindful of wider Board discussions in July about delivery of Promise 14, where there is confidence that the vast majority of services will meet the measure of four weeks that we have set as our quality standard from April 2026.

1.2 It is understood that long waits for neurodiversity services, and huge rises in recognised need and demand, are a national issue. In many ways, waits in our services compare favourably to others. However, this is of no real comfort or use to the child or adult waiting locally. A series of national taskforces and reports have been published, and continue, to try to outline how the NHS may better respond to need but there is no credibility in us simply awaiting their final determination, whilst school years and opportunities of employment are deferred – and recognising the considerable cross-over of neurodiversity diagnoses with our wider service portfolio.

1.3 The paper concludes by setting out intended actions over coming weeks to move the services we operate into a more effective state, acknowledging that this will require the most rapid feasible application of organisational policies and procedures, which will be overseen directly by the Director of People and Organisational Development and Chief Executive. Whilst during 2025/26 the services will continue to led through our two relevant care groups, consideration is being given to whether that that needs to change for 2026/27.

Local context

2.1 Humber and North Yorkshire ICB do not have a finalised commissioning strategy for these services. Joint work alongside the place team in North Lincolnshire continues to tackle specific local issues not considered in detail in this paper. In particular, there remains urgent work to be done to establish:

- Whether an adult autism service should be commissioned in North Lincolnshire, given that it is in neighbouring parts of the ICB

- Who will replace the medication/treatment offer that NLAG have ceased to provide, as at Q1 25/26, and which in essence means that children and young people locally are being diagnosed (by RDaSH) but are not then offered NICE approved treatment of any kind: this matter

has been escalated to the joint ICB/Local authority commissioning committee.

2.2 The clarity of position in South Yorkshire is in many ways similar. However, through the Mental Health, Learning Disabilities and Autism Collaborative we have worked with partners to develop a 2026/27 proposal for change. That proposal has been supported formally by the provider-included System Leaders' Executive and will go now to the ICB Board for consideration. The proposal in summary would:

- Create a level playing field of quality standards and service delivery models between all suppliers available to local patients and GPs in the Right to Choose (RTC) framework, including both NHS and private providers.
- Introduce a tariff model for both diagnosis and treatment support which would be volume related: a significant change from the present mix of block contracts and volume funding that pertains.
- Introduce a consistent LES-funded approach to shared care with primary care across South Yorkshire, which, among other benefits, will ensure neurodiversity services have 'flow' of patient in, and out, or services.
- Review what service should be provided in all four places for adult autism, recognising that funding pressures may require monies to be biased towards CYP neurodiversity and adult ADHD.

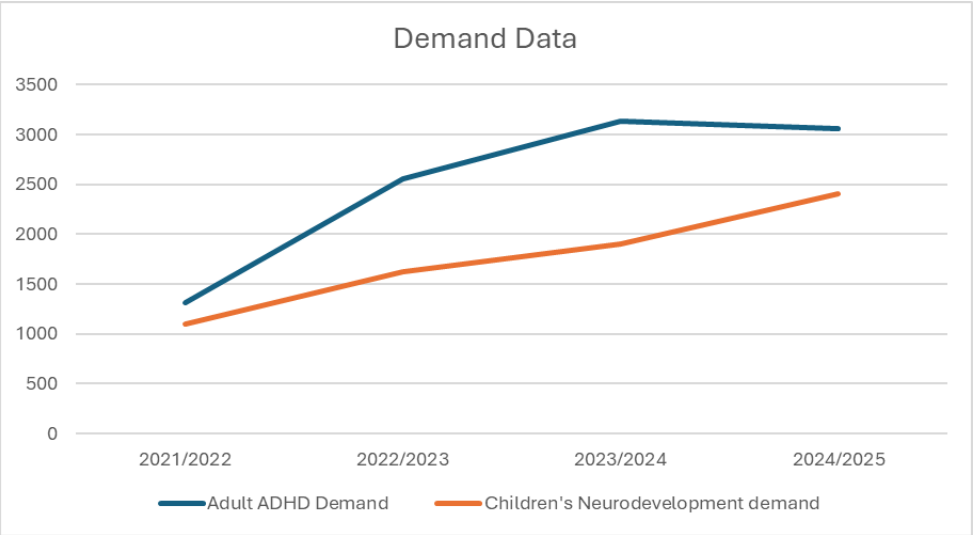
2.3 We cannot consequently yet be wholly confident about the commissioning arrangements for 2026/27, which is the primary concern of this paper. But we can have some confidence that there is a shared intention to invest to improve services. Of course, that can only come, in the case of South Yorkshire, if we can continue to reduce other expenditures to reinvest in this priority area of service. It needs to be recognised that this is not yet a priority area of service in national guidance.

<u>Understanding service demand</u>

3.1 The graph below illustrates the considerable increase in recorded referrals received over the last five years: it has increased by 118% for Children's neurodiversity services and 132% for Adult ADHD services since 2021/2022.

The current waiting lists we hold are very sizeable as follows:

- number of children waiting for assessment currently at **2,916**
- **5,124** adults are waiting, with 2,106 people needing annual review and/or a course of treatment.



3.2 Those waiting with us are among 30,000 people waiting for neurodiversity services in South Yorkshire as a whole. Whilst our typical wait time is now 18 months for CYP and just over two years in adult services, system-wide over 7,000 people have waited more than two years locally, and understandably there is concern to prioritise their needs.

3.3 System-wide the monthly referral numbers are larger than the monthly supply provided, and the rise in referrals over this decade means that the considerable wait list is not being reduced – in fact the gap means it is routinely added to.

<u>Changing our services to match demand and reduce waits</u>

4.1 The Board determined in Q2 2023/24 to invest in 2024/25 and thereafter to address this unacceptable position, both in terms of quality and equity. Over the last 18 months, intensive work has taken place in our three place-based CYP services, and we have sought to develop a Trust-wide adult neurodiversity service. In April 2025 we also took on the contract for CYP autism services in Doncaster, creating similitude of services in our footprint, with the exception, importantly, of the treatment pathway in North Lincolnshire outlined above.

4.2 We have invested in expanding clinical teams and have also made strategic long-term and short-term use of digital modes of delivery, and outsourced suppliers. The longstanding gap for adult services in Rotherham in relation to shared care was tackled, albeit the considerable and extended issues of medication supply have been an issue for all our teams.

4.3 We have now completed, *hence this paper*, a review of our supply models, barriers to delivery, and re-analysis of demand vs supply, recognising:

- continued rising referral rates

- some difficulties adopting shared care

- understanding the complexity of caseloads and training cycle of new recruits

4.4 If we optimise our supply, which is discussed below, we remain still slightly short of anticipated demand.

(i) For children's services we have a backlog waiting, but we know that we can tackle those over the next twelve months in North Lincolnshire and in Doncaster: 1,800 patients remain on the Rotherham backlog – and the solution to that issue will be from Q1 26/27 to repurpose use of digital technologies to focus on Rotherham residents. The approximately £600k cost involved prevents us concurrently addressing backlogs in all three places.

(ii) Having addressed our backlog we have a recurrent gap of 269 referrals to 225 supplied slots across children's services monthly. Using funding already provided into Children's Services we believe that we can meet this annual gap: but will not able to match any continued demand rise.

(iii) For adult services the recurrent position analysis suggests that the service can deliver 140 assessments per month against a referral rate of 163. For treatment the supply is 1,062 against a projected demand of 981. This means currently that the service has a projected shortfall of 23 assessments per month and a surplus of 81 treatments. By altering how we deploy our workforce we can therefore match demand and supply.

(iv) *We do **not** yet have a completed supply solution to the adult backlog. As this is the largest single feature of the issues faced, finding that solution is now our priority, and it is almost certain it has to involve partnering with another supplier – options and costs for this are being finalised. Given probable changes to commissioning of autism services, we will develop distinct options for ADHD and autism. The potential costs involved are inevitably daunting, and it seems unlikely that we can meet our four-week pledge in this service before the end of 2027.*

4.5 We are currently working to establish that the supply outlined above is affordable under the likely tariff model that is being proposed by commissioners. We had deliberately not done this analysis in advance of the proposal to the ICB to avoid a conflict of interest. It is possible it will create some cost pressures to us for 26/27 which will need to be considered in contracting and commissioning discussions ahead: we are clear from headline figures we will not see a large dividend. But the funding model is adopted can provide a way to approach continued referral growth.

Implementing changes to deliver this supply model

5.1 Experiments in changes to the supply arrangements have persisted over the 18-month period and are live currently. This is providing increasing insight into the changes needed to deliver the first three of four objectives outlined above. What is needed is outlined as precisely as possible recognising that it would not be appropriate to discuss here individual performance or compliance issues.

5.2 We know that for face to face care the availability of rooms is a persistent issue. Our expanded use of digital solutions has to date mitigated some of the difficulty, but it cannot defray all of it. We need know to ensure:

- Use of additional rooms in St Nicolas House by exiting other occupants, or misuse of clinical space within the Elizabeth Quarter building when it opens in November: the former is preferred.

- Full and extensive use, both for adults and CYP care, of the new facility we have created at Bentley, which opens in November, as a neurodiversity centre.

- Space solutions in Rotherham remain challenging, but the plans outlined here do not rely on additional space: if we can take forward some of our explored solutions for space in the borough that would considerably assist with efficiency and staff deployment.

5.3 As the cover sheet summary explains we are adopting a 'booked clinic' model both for assessment and treatment. What comes with that approach is that issues such as staff deployment, annual leave management, and personal productivity come to the fore. In implementing changes this year, some teams have found that change more acceptable than others. We are satisfied, with clinical advice, that the intended model is both safe and deliverable – and well within the compass of what might be delivered in another similar service. As such a capability review as necessary for individuals will take place to support choices with them about whether the new service model is one that they wish to continue working within. It is important to distinguish this from engagement about whether to change the service model. Naturally reasonable reasonable adjustments for individuals can be made, but these have to be consistent with the overall capacity of service our patients need.

5.4 Specifically within adult services, we are needing to make changes to roles and potentially to leadership structures, as well as to ensure that all leaders involved in the service are able rapidly to implement the now mandatory ways of working that sit behind this paper. In particular, we will need to move to seeing:

- eight rather than seven assessments per clinician in a full week and to

- ensuring treatment and prescribing work is conducted by all qualified professionals rather than concentrated among a smaller number (with preceptorship periods reduced in line with guidance)

5.5 The Board will appreciate that improvements, notably on the adult service side, have not moved at the pace one might reasonably expect. As such the COO, director of psychological professions, Chief Executive and Care Group Director will review before October 9th what changes in management arrangements will be needed during October to ensure that the recurrent solution outlined is adopted. In the very short term, the management of sickness absence in the team will be centralised within the expert resource of our HR function to ensure that operational improvement necessities and compassionate support for employees are clearly distinguished.

Conclusion

6.1 We have in place the foreseeable funds and resourcing to achieve waits measured in weeks (by which is meant the wait would be reasonably labelled in weeks because it is short) from late in 2026 in CYP services. The work to do this has been considerable, among executive leaders and the service teams. The impetus to deliver must not slacken as we move into 2026.

6.2 We will have “one more go” at making changes in adult services during Q3 to offer a model that is both safe and scaled to monthly demand. If that does not succeed, we should consider again in late Q4 whether to cease to provide this core service.

6.3 We have to, distinct from 6.2, develop a trajectory to deliver the tackling of the backlog as a one-off cost. We have of course sort to do this before: that may disinterest funders in doing this, and the consequent treatment model does not come without cost or resource needs. When we consider our forward financial plans before December, we need to be explicit about how this topic will be addressed as it is a material sum.

Toby Lewis, Chief Executive
18th September 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Audit Committee reporting – October 2025 to March 2026	**Agenda Item**	Paper M
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	25 September 2025

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

This paper follows from the forward plans presented in July of the Board and its committees. The scheduled attached outlines the planned agenda items for the Audit Committee through to the end of the financial year, ensuring the key components within the terms of reference are covered. Any variation (addition or deletion) to these schedules should be minimal during the year.

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

None.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and **NOTE** the work schedule for the Audit Committee for the remainder of the financial year.

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

Business as usual	X

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

N/A

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

None

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

None

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

Appendix (please list)

Appendix 1 - Planned agendas for Audit Committees through to the end of the financial year 2025 – 2026

Audit Committee reporting – October 2025 to March 2026

1. Background

The Trust's Operating Framework provides structure and clarity of role for the Board and its committees, as set out in each respective terms of reference. Key focus for the committees would be on four roles: statutory compliance, plan delivery, partnership duties and matters delegated by the Board. The duties for the Audit Committee are different and are in line with NHS Audit Committee Handbook with a small number of additional 'trust-specific' matters included.

2. Situation

Previous committee agendas were developed against a workplan but through a frequent set of meetings that focused very much on the next meeting only. This paper looks beyond the next meeting, in this case to the end of the financial year to afford a clearer forward plan of work.

3. Future Reporting

In order to reduce the time spent undertaking these planning meetings and to plan for the forthcoming Audit Committee meetings, giving all members maximum notice of agenda items, the schedules set out in Appendix 1 outline the planned agenda items (excluding the standing items) through to the end of the financial year.

Any variation to this schedule should be minimal during the year. A programme to create a rolling update will be introduced to ensure that attention is always four or five meetings in advance.

It is acknowledged these workplans may, when and where necessary, be added to as matters emerge or escalate during the year that require the Board's attention or decision. These may be unplanned matters, but they may also be current matters that need to continue based on current work

4. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the work schedule for the Audit Committee for the remainder of the financial year.

Philip Gowland, Director of Corporate Assurance
18 September 2025

Appendix 1

Audit Committee: Forward Plan

October 2025	
Item	**Lead**
Internal Audit and Counter Fraud Tender Outcome	Phil Gowland
Counter Fraud, Bribery and Corruption Report	360 Assurance
Internal Audit Progress Report	360 Assurance
Audit Recommendations Report	Phil Gowland
Annual Audit Letter	Deloitte
Risk Management Framework Update	Phil Gowland
Annual Governance Statement In-Year Update	Phil Gowland
Declarations of Interest Report	Phil Gowland

December 2025	
Item	**Lead**
Counter Fraud, Bribery and Corruption Report	360 Assurance
Internal Audit Progress report	360 Assurance
Audit Recommendations Report	Phil Gowland
External Audit Plan	Deloitte
Risk Management Framework Update	Phil Gowland
Standing Financial Instructions Q2	Phil Gowland
Education Governance Report	Carlene Holden

February 2026	
Item	**Lead**
Counter Fraud, Bribery and Corruption Report	360 Assurance
Internal Audit Progress report	360 Assurance
Audit Recommendations Report	Phil Gowland
External Audit Progress Report	Deloitte
Clinical Audit Report	Steve Forsyth
Clinical Coding Audit Review	Richard Banks
Annual Report and Accounts: Timetable and Plans Statement of Changes to Accounting Policies	Simon Sheppard
Risk management framework update	Phil Gowland
Standing Financial Instructions Q3	Phil Gowland
Annual Governance Statement Update	Phil Gowland
Research Governance Report	Diarmid Sinclair

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Future of Pharmacy Services	**Agenda Item**	Paper N
Sponsoring Executive	Izaaz Mohammed, Director of Finance & Estates		
Report Author	Izaaz Mohammed, Director of Finance & Estates, Will Holroyd, Senior Programme Manager		
Meeting	Board of Directors	**Date**	25 September 2025

Suggested discussion points (two or three issues for the meeting to focus on)
The private Board considered the matters addressed by this paper when we met in August. The paper doesn't replay the various options discussed in August, but sets out the key patient, clinical, and operational benefits of the proposed option to establish a central pharmacy centre in Doncaster, serving the Trust as a whole: ending the use of a private sector provider that we inherited in 2024. It is recognised that there may be difficulty with achieving the Subsidiary Company structure in time, and that is being considered weekly now, with work-around options for an interim period. The likely terms and conditions for that vehicle are explored within the private Board papers – and mimic existing arrangements that the Trust has operated in its community interest company (CiC) since inception over a decade ago.
Previous consideration (where has this paper previously been discussed – and what was the outcome?)
Discussion on companies and pharmacy dispensing options (August private Board).
Recommendation (delete options as appropriate and elaborate as required)
The Board is asked to:
NOTE the decision to cease external pharmacy services from 2026/27
NOTE the clinical, patient and service benefits outlined of the proposed model.

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

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Performance risks			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
External and partnership risks			
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
N/A
System / Place impact (advise which ICB or place that this matter relates to)
SY ICB – system financial sustainability

Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	Before November BOD meets
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	

Appendix (please list)

Future of (some) Pharmacy Services at RDaSH

1. Introduction

1.1 The Board considered (in private) the rationale for taking the currently outsourced pharmacy dispensing provision in-house in August. This paper builds on those discussions and sets out the key benefits of the proposal.

2. Context

2.1 The Trust has an inhouse Pharmacy department employing 16.59 WTE staff with a £1.22m budget, providing clinical services to inpatient wards and community teams. Medicines supply and dispensing have long been outsourced, with Lloyds Pharmacy delivering the service until its exit from the NHS market in February 2025. The contract has since novated to Rowlands Pharmacy. Rowlands are not a Real Living Wage employer and have confirmed they will not adopt this standard, conflicting with the Trust's Promise 25 commitment.

2.2 The contract with Rowlands ends in April 2026, and the Trust intends to exit the arrangement due to the volatility of the outsourced market, limited operational control, the opportunity for greater efficiency in-house, and misalignment of the current supplier with the Trust's promises. Following a period of engagement with clinical teams, we are proposing that supply and dispensing be brought in-house from April 2026. The likely delivery mechanism for this service will be through a subsidiary company: no TUPE to that company from existing NHS staff is envisaged. This change will include the establishment of a central dispensary hub at 1 Jubilee Close, Tickhill Road, enabling more reliable access to medicines, including for weekend discharges and community services.

3. Benefits of the chosen model

3.1 There are many clinical benefits of the central hub in-house model. Establishing a Trust-led function which is services via a central hub will create a more reliable and responsive medicines supply chain, directly supporting safe and effective clinical practice. Medicines will be supplied consistently and on time to inpatient wards and community teams, reducing the risk of interruptions to treatment. Ward-based pharmacy staff will be better supported to focus on medicines optimisation, patient safety checks, and clinical advice, rather than chasing stock or managing shortfalls.

3.2 The centralisation of stock management enables stronger governance, reducing variation across sites and improving compliance with regulatory standards. It will also provide the pharmacy team with greater visibility of prescribing trends and usage patterns, supporting more proactive medicines management. This model will allow the Trust to rapidly adapt to medicines shortages, ensuring that clinicians have alternative products available quickly and safely.

3.3 Patients will experience quicker and more reliable access to medicines compared to the managed service provision. This includes reduced delays in receiving discharge or leave medication, which will support more timely discharges and help avoid delayed

discharges. Shorter turnaround times will improve patient flow through wards and reduce frustration for patients and families waiting for medicines to be ready.

3.4 The central hub will also strengthen the Trust's ability to support patients in the community by ensuring that community teams have access to the medicines they need on a predictable and consistent basis. This reliability will help maintain continuity of care. Patients will also benefit from improved self-administration programmes, as ward-based pharmacy teams will have more time to prepare and educate patients, building confidence in managing their medicines safely at home. Together, these improvements enhance the patient experience, reduce delays, and contribute to better overall health outcomes.

3.5 From a service perspective, the central hub model introduces consistency, efficiency, and financial sustainability. Centralising procurement and supply enables the Trust to achieve savings through national NHS procurement frameworks, reducing drug spend and freeing up resources to reinvest in patient care. Removing reliance on an external contract eliminates associated management costs and strengthens local control over medicines supply.

3.6 The hub model will streamline logistics by consolidating ordering and distribution, making processes more predictable and reducing duplication of effort across sites. Oversight of stock at a single point enhances governance, minimises waste, and ensures medicines are used more effectively. Improved discharge processes, enabled by ward-based dispensing, will also reduce length of stay pressures and contribute to more effective patient flow, aligning with wider Trust objectives on efficiency and bed management.

4. Operational management of the new service and mobilisation

4.1 The preferred option is to establish a subsidiary company able to operate this new service. We have considered seeking to do this via our current Flourish vehicle: on balance the likely final proposal will seek instead to create a bespoke mechanism. We are working through how to host new recruits in the intervening period, given that a subsidiary company will come with some equivalent benefits to NHS employment models, but not all.

4.2 A project management structure has been put in place to oversee the various personnel, regulatory, commercial, clinical safety and estate matters that need to carefully sequenced. It has not been possible over the last four weeks to fully cohere those threads in time for this Board meeting, and accordingly we will use a small part of the October meeting to sign off on that finalised mobilisation plan.

Recommendations

The Board is asked to:
NOTE the decision to cease external pharmacy services from 2026/27
NOTE the clinical, patient and service benefits outlined of the proposed model.

Will Holroyd, Senior Programme Manager
& Izaaz Mohammed, Director of Finance & Estates
19th September 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Older Peoples Mental Health Quality Indicators	**Agenda Item**	Paper O
Sponsoring Executive	Dr Diarmid Sinclair, Chief Medical Officer		
Report Author	Dr Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	25 September 2025

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

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

Following the papers presented to the Board in March and July 2025, this is a third iteration of the Older Peoples Mental Health quality indicators to be used for assessment at Trust and place level. The expectation for these agreed metrics will be to allow comparison over time for Older Adult services but also to allow for comparison to working age services to ensure that there is parity between the two. Data will be shared at Board level in November 2025, March 2026 and July 2026, with a view to a formal review of progress in September 2026. This is slightly longer than the timescale outlined when the Board met in March to permit time for implementation of change and some shared learning.

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

March and July 2025 Board paper and decision relates.

Recommendation (delete options as appropriate and elaborate as required)

The Trust Board is asked to:

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

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	x
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	x
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	x

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

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

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

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

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

Measuring Mental Health Quality Indicators in Older Adults

1. Why It Matters

1.1 Understanding and improving the quality of mental health care for older adults is more critical now than ever. In April 2025 the Trust Board took the decision to close of one of our dedicated older people's wards. We have now moved to a mixed-diagnosis model across all older adult mental health inpatient services within the Trust.

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

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

1.4 In September 2024 the Trust was issued a Regulation 28 notice by His Majesty's Coroner over the death of a patient, and concerns over whether crisis access was suitably available for people over the age of 65. It was apparent that the three different geographies of the Trust had taken different approaches to this historically with North Lincolnshire providing equitable access to over 65s but this was not the case in either Doncaster or Rotherham. New arrangements for over 65s requiring crisis team input came into effect in December 2024.

1.6 In September 2025 building works commenced in North Lincolnshire at the Great Oaks site. This has led to a temporary reduction in bed numbers with some of the Older Adult beds being reprovisioned as virtual ward beds as opposed to traditional inpatient beds. The Board discussed the clinical oversight of this necessary experiment at its timeout in August.

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

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

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

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

Compare Functional and Organic patient outcomes: We have moved to a model where we no longer have specialist organic and functional inpatient beds but rather a mixed inpatient provision. It will be important to compare outcomes between functional and organic patients so that we can determine if they are achieving equity of access.

Drive Data-Informed Service Development: Good data enables good decisions. By collecting, analysing, and acting on quality metrics, we can ensure that services for older people are not only reactive but also proactive in anticipating needs, allocating resources, and designing care pathways that work.

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

It is important to be clear what we are viewing the datasets against and why, as the annexes of the original paper to the Board set out.

(1) we want to be confident implementation of the blended or mixed ward has been effective, and we would expect to be demonstrated by the end of 2025. This is routine management, and would ordinarily report through our Quality and Safety CLE sub group, and delivery reviews. It would be escalated if necessary.

(2) we want to test the success of older adult services against anticipated outcomes, particular for those admitted primarily with dementia – comparing the performance of the three units against one another but also against reasonable expectations of a specialised service for that purpose

2.3 The decision of the Board in 2025 was clear that the alternative to a mixed model, given the economics of healthcare across North Lincolnshire and South Yorkshire, would be relocating services, after due public consultation onto a single site, as in the Trust across South West Yorkshire. If we are to not have to take that step we have to be satisfied that we are providing a high quality alternative through our more localised model.

3. Inpatient Indicators

Accessibility:

Awaiting admission > 24 hours:

Number of Older Adult patients confirmed as requiring admission waiting longer than 24 hours to be admitted

Bed Occupancy:

Older Adult Bed Base bed occupancy percentage

Out of area:

Number of inappropriate out of area placements for Older Adult patients

Clinically ready for discharge:

Number of patients that are clinically ready for discharge

Effectiveness:

Length of stay:

Average duration of admissions per ward

Readmission rate:

Percentage of patients admitted to a ward shortly after discharge (within 30 days)

Clinical outcomes:

PROMs and other clinical tools

Discharge destination:

Number of patients being discharged to their usual place of living

Safety:

Incident reports:

Frequency of events such as falls, self-harm, suicide attempts, incidents of violence and aggression and mortalities

Venous Thromboembolism (VTE) assessment:

Percentage of patients with a completed VTE assessment within 16 hours of admission

Malnutrition Universal Screening Tool (MUST):

Percentage of patients with a completed MUST assessment within 24 hours of admission

Grab Bag Checks:

Number of Daily Grab bag check not completed on Radar

Medication incidents:

Rates of prescribing errors and administration errors

Restrictive practice:

Number of incidents of rapid tranquilisation, segregation and seclusion

72 hour follow-up:

Percentage of patients having follow up within 72 hours of discharge

Safe Staffing Levels:

Number of shifts without safe staffing levels

Staff sickness:

Rolling average of staff sickness

Staff turnover:

Rolling average over 12 months

Staff turbulence:

Rolling average over 12 months

MAST Compliance:

Number of staff who are not fully compliant with MAST training

Patient experience:

Complaints:

Number of complaints

Feedback:

Number of care opinion and themes from feedback about Older Adult inpatient services. Any qualitative feedback will also be synthesized

MHA rights:

Percentage of detained patients that have their rights read on admission

Other measures:

CQC self-rating:

Self rating over CQC inspection domains

MCA for medication:

MCA completed for Psychiatric medication and Physical Medication

4. Outpatient Indicators

Accessibility:

<4 hours wait for emergency referrals:

Number of Older Adult patients not seen within 4 hours of an emergency referral

<48 hours wait for urgent referrals:

Number of Older Adult patients not seen within 48 hours of an urgent referral

4 week wait for routine referrals:

Number of Older Adult patients not seen within 4 weeks of a routine referral

Crisis referrals:

Number of Older Adult patients taken onto Crisis Team caseload

DNA rate:

Percentage of appointments where the patient did not attend

Dementia diagnosis rate:

Percentage of patients in a locality with a recorded diagnosis of dementia compared to expected prevalence

Talking therapies:

Number of Older Adults accessing NHS talking therapies

Effectiveness:

Care plan completion:

Percentage of patients with a personalised care plan completed

Hospital admission rate:

Percentage of patients admitted to a mental health ward whilst under an Older Adults Team

SMI Checks:

Percentage of patients with SMI that have had an annual health check completed

Clinical outcomes:

PROMs and other clinical tools

Safety:

Incident reports:

Frequency of events such as falls, self-harm, suicide attempts, incidents of violence and aggression and mortalities

Medication incidents:

Rates of prescribing errors and administration errors

Staff to patient ratio:

Number of patients per member of staff for Older Adult teams that hold caseloads

Staff sickness:

Rolling average of staff sickness

Staff turnover:

Rolling average over 12 months

Staff turbulence:

Rolling average over 12 months

Disengagement:

Number of patients discharged due to disengagement

MAST Compliance:

Number of staff who are not fully compliant with MAST training

Patient experience:

Complaints:

Number of complaints

Feedback:

Number of care opinion and themes from feedback about Older Adult inpatient services. Any qualitative feedback will also be synthesized

Other measures:

CQC self-rating:

Self rating over CQC inspection domains

5. Recommendations

The Trust board is asked to agree the quality indicators and the intention to compare the indicators over timer periods but also to compare against working age services. It will be important that we can determine whether quality of care for those with organic diagnoses is comparable to peers using a different delivery model.

Dr Diarmid Sinclair, Chief Medical Officer

19 September 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Implementation of the Acceptable Behaviour Policy	**Agenda Item**	Paper P
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	25 September 2025

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

As we agreed when we launched the Acceptable Behaviour Policy, we have reviewed take up and use. A short survey was undertaken to assess the awareness, understanding of and use of the policy. This sought feedback from service managers and team leaders across the Trust. Included in this paper is the report summarising the work that was presented to CLE on 16 September 2025. CLE supported and added to the recommendations it contained: there was a strong sense that a re-launch was now needed to ensure more routine use of this consequential policy.

The environment that we operate in continues to provide challenges of racism for colleagues and the behaviours outlined in the policy continue to occur – incidents and anecdotal reporting supports this. The recent communication from the Chair to all colleagues, and content within the CEX Report, both talk to this point further. That noted, the policy is not solely about racism, and arguably the perception that it is may be inhibiting as much as enabling.

The use of the policy (certainly at the 'higher' more formal level) is low. The survey responses give an indication of the awareness, confidence or otherwise that colleagues have in applying the policy. Whilst modest in scale the survey is insightful and points towards the potential need for further promotion or education of the policy (to raise awareness); to support to colleagues to utilise it and to feel empowered to do so; and to ensure reporting (of the use of the policy) occurs on a consistent and timely basis.

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

Clinical Leadership Executive – 16 September 2025

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and **NOTE** the outcome of the survey to assess the implementation of the Acceptable Behaviour Policy

NOTE and **SUPPORT** the planned actions to raise further the awareness and use of the Policy, as appropriate, across the Trust.

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

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

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

People risks			
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Patient care risks			

Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
N/A
System / Place impact (advise which ICB or place that this matter relates to)
N/A

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

Appendix (please list)
Implementation of the Acceptable Behaviour Policy – CLE paper : 16 September 2025

Rotherham Doncaster and South Humber NHS foundation trust
Board of Directors

Acceptable Behaviour Policy Implementation – September 2025

1 Introduction

1.1 In light of escalating challenges and a deterioration in the environment in which we deliver services, the Trust undertook to implement a policy aimed at establishing a set of principles and procedures for the recognition of discrimination and abuse that could arise in connection with the services and activities provided by the Trust, and the way by which the Trust would respond.

1.2 The Acceptable Behaviour Policy was launched at the 2024 Leaders Conference (September) to provide a framework and guidance for all employees and others within the organisation who could be exposed to aggressive, threatening discriminatory behaviours so that they are better supported and equipped to avoid and minimise the risks of such behaviours.

2 Implementation – Progress

2.1 Twelve months on from implementation the environment in which we operate continues to provide significant challenge; perhaps even more than it did at that time. In order to ascertain how well the policy has been implemented a survey of colleagues from across the Trust was undertaken. Colleagues were asked a series of questions linked to their awareness, understanding and use of the Policy over the last twelve months.

2.2 A commentary and observations were reported to the CLE in September 2025 alongside three recommendations. The report – attached at Appendix One – showed great awareness to the policy and that it had been used (to its fullest sense) in the year on a number of occasions. Responses suggested that there was scope for further promotion and of the need for additional opportunities to discuss and ensure all colleagues were clear on its applicability to a range of scenarios. Given the change in environment and the reported incidents there were likely more occasions in which the policy should have been used – the actions agreed will support and empower colleague to take the necessary and appropriate action n response to situations – likely then resulting in an increase in the number of formal actions taken in line with the policy.

3 Action

3.1 The recommendations made to and supported by CLE in September 2025 were focused in three key areas and these will be progressed during Q3:

- Refreshed launch of policy – with additional FAQ in support to clarify intentions around use. This would be via several routes – intranet, team cascade and discussion or facilitated LHD events. Equally the use of LHD to show learning and examples of where the use of the policy has been impactful and necessary, no matter what type of action that was used. All aimed at improving awareness and understanding and to give confidence in its use. (Further to CLE an easy read version of the Policy has been produced and will be shared as part of this relaunch work)

- Review of the reporting mechanisms to ensure timely awareness to its use – how can we best understand its use, without the need for a survey – the monitoring

arrangements refer to reporting in Care Grous but also at CLE Groups, but at present there isn't a mechanism for such to occur.

- Consideration to the way by which RADAR functionality and reporting summaries could be used to identify possible behaviours that warrant action via the policy. This would seek to ensure that where behaviours occur and are reported as incidents, that we use this policy if applicable.

4 Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the outcome of the survey to assess the implementation of the Acceptable Behaviour Policy

NOTE and SUPPORT the planned actions to raise further the awareness and use of the Policy, as appropriate, across the Trust.

Philip Gowland
Director of Corporate Assurance
19 September 2025

Appendix One

Rotherham Doncaster and South Humber NHS foundation trust

Clinical Executive Group – September 2025
Implementation of the Acceptable Behaviour Policy

Background

The Acceptable behaviour policy was launch at the Leader Conference in September 2024 after being authorised by the Clinical Leadership Executive Group. The policy is available at acceptable behaviour policy.

Policy: Purpose

The purpose of this policy is to provide standards for the management of unacceptable behaviours of all types that are of a discriminatory or abusive nature.

Policy: Aims

The policy aims are to establish the principles and procedures for the recognition of, response to and treatment of discrimination and abuse that could arise in connection with the services and activities provided by the Trust.

It provides a framework and guidance for all employees and others within the organisation who could be exposed to aggressive, threatening discriminatory behaviours so that they are better supported and equipped to avoid and minimise the risks of such behaviours.

Audit

This audit is designed to review how the policy has been implemented, how many times it has been applied and any findings or changes required to its adoption, application, use or fitness for purpose.

Audit Process

The audit relied on an online survey of all Service Managers and team Leaders across the Trust to establish if and how they had used or applied this policy in their areas.

In addition, reporting via Ulysses and RADAR was also reviewed to establish the range and number of related incidents. This was used as a broad comparator / context only (not any direct link or statistical analysis) to understand the proportions of incidents versus the number of actions in line with the policy.

Outcomes of the survey and data are reported below.

Audit Results

From the survey of Service Managers and team leaders the key headlines are:

37 responses were received covering services in each clinical Care group and clinical Directorate

Prior to receiving the survey 84% of respondents were aware of the Policy (16% or 6 individuals were not) and those that were aware, they had been made so via a variety of routes including:

- Care group (team / clinical leads) dissemination
- Original consultation process
- Via the Intranet
- Via colleague
- HR advice

The Policy lists the behaviours (e.g. discrimination, abusive behaviour, violence, harassment, assault, antisocial behaviour) that it seeks to address and 54% (20) of the respondents said they had witnessed or had reported to them behaviours of this type during the last year.

Whilst 10 of those 20 confirmed that in each case they reported the incidents on to Ulysses / Radar, the other 10 respondents only confirmed that a proportion were reported; explaining that they didn't report them (all) because:

- *Didn't think it was 'reportable'*
- *Reporting it could be detrimental to the relationship with the patient*
- *It's a part of the job ….. expected to tolerate it*
- *Haven't received support when reported things before so why would it be different reporting as an incident*
- *Didn't have access to the system*

Respondents were able to confirm that other routes were (also) used to raise concerns / report matters – such as via Staff Network groups, HR, FTSU, Staff Side, H&S reps.

Where respondents hadn't used the policy it was mainly because they hadn't witnessed any incidents that warranted it – however, some highlighted not being aware of it or it not being clear / not shown how to use it as their response.

Key actions as stated in the Policy are listed below with the number of instances used according to the respondents (we asked for the respondents to be very precise in their responses to the actions shaded; for the unshaded responses respondents were more general and it may be that the actual number is higher than that stated):

Action	Number
Consultation or discussion with the patient, service user, carer, relative, or visitor to highlight unacceptable behaviours and minimise or dispel potential incident	43
Escalation to manager for intervention	38
Manager to liaise with relevant safety team (in the Nursing and Facilities Directorate), to identify appropriate response and support with reported incident.	24
Use of a verbal warning by service manager	8
Issue of an unacceptable behaviour letter	8
Issue of a warning letter (e.g. yellow card)	4
Expulsion or exclusion from trust premises and, withdrawal of clinical services (permanent basis via red card)	1
Report to South Yorkshire or Humberside Police for criminal investigation and consideration of prosecution	6

For context there were over 1000 incidents recorded on Ulysses or Radar in the last 12 months where the descriptor is around disruptive or destructive behaviour or linked to physical or verbal abuse, racism or sexual abuse – that could, in some cases, be referring to behaviours that warrant some action in line with this policy. That said, we aren't able to comment or drawn a conclusion as there will be repeating incidents and the total number of incidents reported here includes all levels of harm – hence this figure is provided as an indicative / contextual figure only.

Observations / Commentary

There is relative good awareness to the Policy although it is clear that there could be more work in this area and especially work to ensure that colleagues see it as applicable to perhaps a broader range of circumstances (or perhaps to ensure they don't see it as not

applicable) – the comments about tolerance and impact are worthy of greater consideration and response and link to the work ongoing regarding Active Bystander. We need to empower colleagues to take action in response to the behaviours of others where it is not acceptable.

Total number of related incidents might suggest that there should be more use of the Policy. This would need further review and analysis. This would mean the scope for use (and therefore the need for action) is currently lower than it might expect to be. We should consider how the daily/weekly review of incidents at a team, directorate, care group and corporate level has the potential to identify situations and incidents in which this policy may be appropriate.

Reporting linked to the policy and the use of the actions may need further consideration – there was an expectation that the survey would only identify a small number of the key actions, in particular the use of red cards – and indeed it did. Anecdotally there was therefore an awareness to the number of these actions, but there may need to be a more confident and accurate (and timely) way by which any such action is routinely reported to enable the Care group SLT / CLE / EG to be aware of such.

There is use of alternative routes when taking matters forward – all others included in the policy have been utilised. As above, we should consider actions to ensure that where these alternative routes are taken, the potential use of the policy should be considered.

Via data and anecdotal evidence we know that there are many and increasing challenges to our colleagues in terms of the behaviours outlined in the Policy. This perhaps signals that one year on from launch the importance of this policy is even greater. Whilst the results of this survey give some assurances and confidence, it also provides scope for further work on dissemination, on understanding embedding and empowerment to utilise the policy.

Recommendations

Refreshed launch of policy – with additional FAQ in support to clarify intentions around use. This would be via several routes – intranet, team cascade and discussion or facilitated LHD events. Equally the use of LHD to show learning and examples of where the use of the policy has been impactful and necessary, no matter what type of action that was used. All aimed at improving awareness and understanding and to give confidence in its use.

Review of the reporting mechanisms to ensure timely awareness to its use – how can we best understand its use, without the need for a survey – the monitoring arrangements refer to reporting in Care Grous but also at CLE Groups, but at present there isn't a mechanism for such to occur.

Consideration to the way by which RADAR functionality and reporting summaries could be used to identify possible behaviours that warrant action via the policy. This would seek to ensure that where behaviours occur and are reported as incidents, that we use this policy if applicable.

Philip Gowland - Director of Corporate Assurance
Jayne Booth – Deputy Director OD

11 September 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Research and Innovation Plan	**Agenda Item**	Paper Q
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Dr Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	25 September 2025

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

The plan is one of eight that create the suite we hold as a Board: in this case the plan routes through our Public Health, Patient Involvement and Partnerships committee. Aspects of the plan relating to research are already deploying, as we look to make research routine management business inside our care groups.

The innovation theme of the plan launches as our leaders' conference on September 30th. It reshapes responsibility and seeks to develop QI methods and wider innovation approaches more consistently across the Trust on the back of the VMI work within our LDO. The plan notes an intent to position innovation as a core business question where currently we often have profiled risk.

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

The plan has been discussed with the PHPIP committee twice, and the Board once

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

APPROVE the plan as finalised

RECOGNISE the research priority given to the Big Six

RECOGNISE the change in approach to innovation that the plan implies for the Trust

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

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

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X

Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

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

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

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

Appendix (please list)

R&I Plan 2025 – 2028 – final version

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Purpose/introduction

1.1 The plan is with the Board for approval as a summary of our intentions between 2025 and 2028 in this key area of work. Research has to be central to our work on quality, because we know that research driven organisations deliver better care. It is central to our people and teams plans, as a key differentiator in why work here? We are actively taking the steps to create time for senior clinicians from all disciplines to be research active.

1.2 The plan speaks to the tension, or balance, between a programmatic delivery mindset that we have sought to create since 2023 – and emergent disruptive bottom-up innovation, which is part of the culture of the plan. As senior leaders we will need to hold that tension and balance it well.

Considerations for the Board

2.1 The Trust's Board and Governors have very actively supported research work, most recently with the adoption of the partnership with Clerkenwell. But we have to acknowledge that our research strengths presently, both in terms of management and the clinical body, rest deeply on a narrow group of people. As such we have exposure to turnover and turbulence. The Board may wish to consider how this can be addressed over time and set some expectations for future development.

2.2 Innovation, and research, will come with failures. Projects that do not succeed. We need to consider how as a Board we celebrate and profile that. Our culture of accountability cannot be one where we do not 'tolerate' not succeeding. We recognised this when we launched the strategy, and clearly some promises are behind, but we learn and keep going. We need to ensure that we face in one direction where teams do all that can be done, try, and a proposition falls short.

2.3 The opportunity cost of this work in the short term can be distracting. That can lead to it being set aside, and with a busy 2026/27 that is perhaps a heightened risk. However, as we establish core consistency to many clinical services, we then need to 'kick on' through innovation. So the year ahead is a chance to capability and capacity build.

2.4 The plan sets out:

- a big six focus for research and

- three areas of specific innovation focus (quality metrics, productivity and neighbourhoods)

The Board is asked to ensure it is comfortable with those choices.

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

Research & Innovation (R&I) Plan 2024-2028

DRAFT FOR APPROVAL

Our Research & Innovation (R&I) Plan

Rotherham Doncaster and South Humber NHS Foundation Trust

- This Plan sets out our ambition to improve the lives of those in our communities through high quality research and innovation, often “dreaming big” to face the challenges of those in our communities with mental and physical healthcare needs.
- Care we deliver today is a consequence of the R&I that has gone before, the R&I of today is informing the care of tomorrow.
- RDaSH has a strong tradition of R&D that can harness the best of what is available to help us deliver evidence-based patient care: innovation is less well established so this plan is a shift.
- This Plan is co-produced with our communities, our patient research ambassadors and our teams and importantly sets out how it will deliver our promises 2023-2028.

Q: Why should we do Research & Innovation (R&I)?

A: R&I Active organisations have:

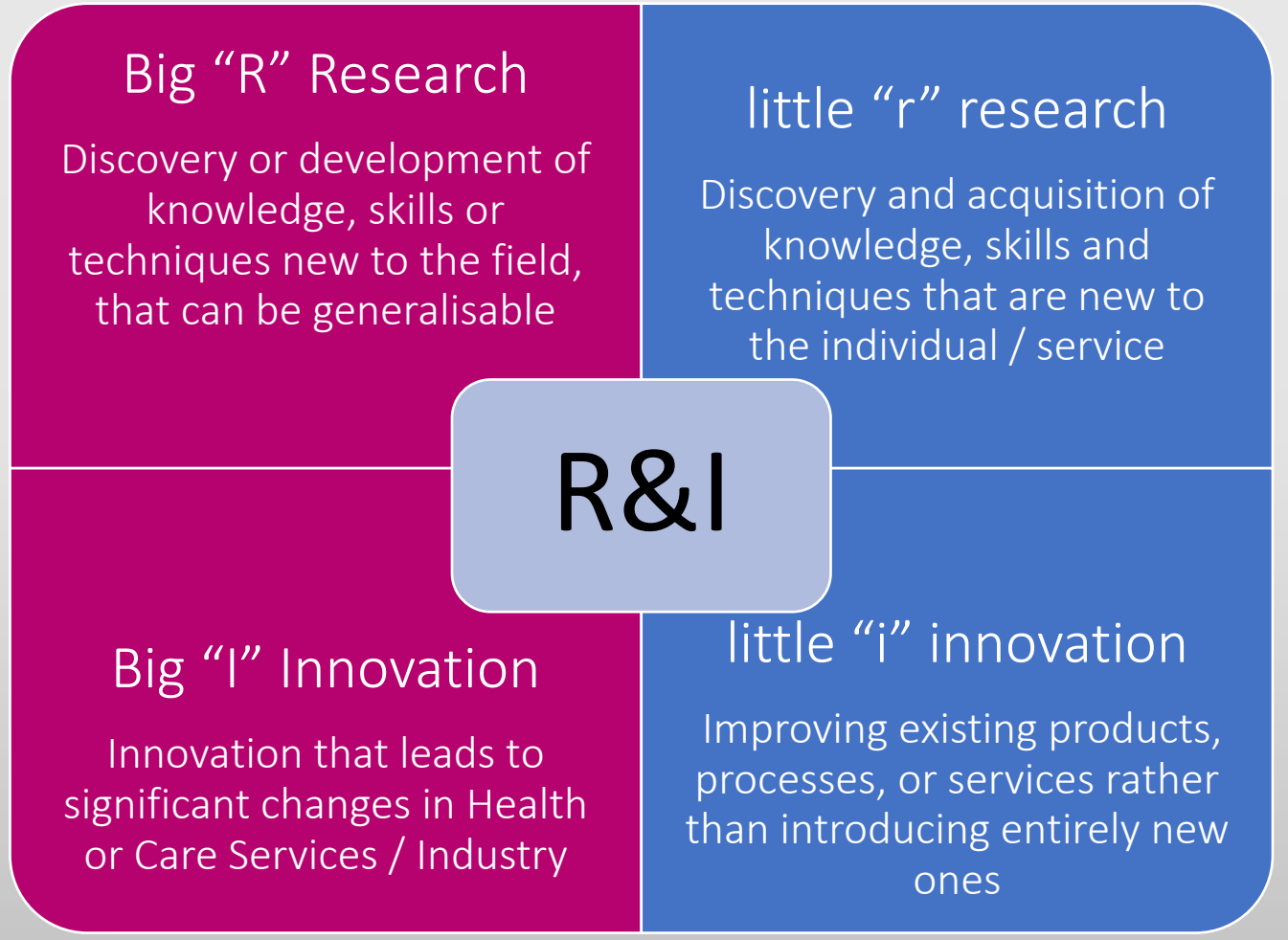
- Patients with more confidence in staff Jonker L, et al, 2019
- Reduced Mortality Jonker L, Fisher J, 2017
- Transformed health through innovation Academy of Medical Sciences, 2019
- Higher Medical recruitment Rees MR, Bracewell M, 2019
- Improved clinical care & reduced cost of healthcare Medical Schools Council, 2022

Key definitions

"Big" R&I - must involve Grounded Research

The attempt to derive generalisable or transferable new knowledge to answer questions with scientifically sound methods, including:

- Trials of new drugs, devices or technologies.
- studies that aim to generate hypotheses/ideas.
- studies that aim to test hypotheses/ideas.
- descriptive studies.



"little" r&i is primarily conducted within Care Groups

Service Evaluation

Designed and conducted solely to define or judge current care.

Clinical Audit

Designed and conducted to produce information to inform delivery of best care.

Quality / Service Improvement

Designed to improve health services, systems, processes.

From here to there: research

Rotherham Doncaster and South Humber NHS Foundation Trust

Right now - here

- The Trust has an established R&D function, which we want to nurture and support. This has enabled us to lead locally on portfolio and commercial trial work in our sectors.
- But our research activity is insufficiently distributed across our Care Groups and professions. This means we lack breadth despite our depth.
- Our innovation 'start up' and deployment work is nascent and under-developed and lacks rigour or system.

Future success - there

- We need to retain those outstanding results and develop succession plans for key researchers and individuals within our system.
- Research activity will become part of how we work as a Trust in all our Care Groups, and then within our directorates: and this means change for those involved in leading those functions.
- We need to 'design into' our work both incremental and disruptive innovation, building out from enthusiasm internally and bringing outside-in ideas into rapid deployment.

From here to there: innovation

Rotherham Doncaster and South Humber NHS Foundation Trust

Right now - here

- Through our grounded research team, several innovative projects and technologies have been piloted within specific parts of the Trust
- A significant number of leaders have some core skills in QI techniques relevant to innovation and improvement work
- A sustained and sizeable appetite for QI exists within the organisation, across all professions, and illustrated both through posters, submissions to journals and practical improvement work

Future success - there

- We have to develop an expectation of leading-edge innovation in approaching core clinical and pathway difficulties we face: as outcome and productivity expectations escalate at pace
- It needs to become simpler and faster to bring innovation into the organisation, without too many barriers beyond those obviously justified by safety and fairness
- We need a clear and culturally accepted route to scaled adoption of proven innovation within each of our six groups, and then Trustwide

Key Promises

Rotherham Doncaster and South Humber NHS Foundation Trust

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

What's success? Leverage skills, local partnerships, with community groups and academic partners, to commission work to gain rigorous and independently garnered opinion of outcomes that matter to local people, and to evaluate the success of services in delivering real change for communities in the outcomes important to them.

What does this really mean?
•High-quality, personalised, meaningful care for people who use our services •A shift away from rigid, arbitrary and inequitable CPA classification, enabling the same access to care for all people who use our services •Patients in charge of their own care, enabling patients to identify what is important to them using 3 patient rated outcome measures (PROMs); Dialog, ReQoL-10 and Goals Based Outcomes •The use of Dialog+ as the therapeutic intervention, building on what patients have identified their needs are in the Dialog scale, to build the patients care plan •An increase in patient satisfaction scores, identifying an improvement with all elements of a patient's life •Closer working with Place partners and voluntary organisations in communities, enabling the delivery of holistic, needs based care and support •A named key worker for people accessing services who will be the most appropriate person for that person at that time

Current 2024 state?
•Requirement of training for all staff in the new way of delivering care. Phase 1 teams (primary care mental health hubs) completed and should be working in the new way •Potential to train partners – discussions taking place •4 workstreams set up to enable the progression of different elements with representatives from across the trust, ensuring staff are part of the change: •Clinical practice, policy and culture •Workforce, training and culture •Partnership, system interface and culture •Digital, systems and reporting •Clinical Assurance Group in place led by SRO and with GP representative •Launchpads developed by Clinical Systems Team with input from clinical staff. Go-live 1 September 2024 •Policy written and consultation complete. Being presented to next CPRAG. Led by Head of Information Quality •Communications completed and shared including leaflets, vlogs, PROMs user videos, ask me anything sessions, Trust Matters updates, team presentations, internet and intranet pages updated regularly •Alignment to regional and national guidance and neighbouring organisations

What will we do first?
•Development of full training plan for staff by small team of Practice Educators (recruited 12months ft) •Training delivery for Phase 2 and Phase 3 teams including community teams (p2), inpatients (p3) and children's (p3) •Working with Human Resources to identify current Care Coordinator job roles within the Trust and what the change will mean to these staff (links to key worker) •Working with clinical and corporate staff within workstreams to enable culture change adopted •Clinical practice workstream in place ensures clinical staff are part of the change in clinical practice (and are not being done to) •Work with our partners at Place including Primary Care, VCSE partners, housing providers to enable holistic care for people who identify these requirements

Key Promises

Rotherham Doncaster and South Humber NHS Foundation Trust

Promise 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.

What's success? Strong, trusted partnerships locally, regionally, nationally, and internationally with Industry, Academia, other NHS organisations, Research enabling networks (e.g. National Institute for Health and Care Research (NIHR) Clinical Research Network (CRN), Health Innovation Networks (HIN) and Integrated Care Boards (CBs)) and communities with a 3-fold increase in investment / income from R&I activity to bring employment opportunities for the local community.

What does this really mean?	Current 2024 state?	What will we do first?
• Several formal academic partnerships • Increased breadth of Industry partnerships (tech / pharma / SMEs). • Large collaborative projects (e.g. multi-centre trials). • More commercially sponsored clinical trials running simultaneously. • Multi-disciplinary (MDT) and expert team to support R&I agenda. • More research active clinicians / services across the Trust. • Strong links into communities to shape R&I agenda. • Range of opportunities in R&I for employment, apprentices, volunteers & students.	• 1 formal partnership with University of Sheffield. • Industry partnerships limited in psychological health in the main. • Small number of large-scale projects. • 3 commercially sponsored clinical trials currently running. • MDT with R&I expertise, lacking expertise in key areas of commercialisation, intellectual Property (IP) and regulatory. • Pockets of excellence in services, lack of medics to deliver R&I. • Established patient & public groups, without formal community working arrangements. • Employed R&I team and 12 Patient Research Ambassadors, but limited students & no apprentices.	• Formalise more academic partnerships & scope out University Hospital status. • Actively build links to industry partners in other fields, e.g. nutrition. • Recruit an R&I Manager to assist with industry liaison activities and strengthen regulatory expertise. • Build strategic partnerships with Pharma to win more commercial clinical trial contracts. • Garner commercialisation, IP and regulatory expertise from external partners, e.g. NIHR HealthTech Research Centre, Medipex. • With Trust funding for R&I community contributors, develop a strategy of engagement across communities. • Create opportunities for student placements, apprentices and grow internal talent & expertise.

Key Focus areas

The R&I activity across the Trust, communities and with external partners will remain broad and varied, the Trust will focus on some key areas for growth across our Care Groups and with community, industry, academic and NHS partners: **Our Super Six**. The areas are aligned with national clinical importance and the Clinical & Organisational Strategy and will enable us to translate R&I findings into practise.
For more detail refer to the R&I Plan Deliverables document.

Priority research areas	Including	Future success measures
Healthy Ageing	Dementia Research & Innovation.	Capability to deliver dementia clinical trials embedded within clinical services, via infrastructure and partnership building, e.g. Brain Health Centres where care and R&I is co-offered to patients.
Neurodiversity	ADHD Research & Innovation.	Vibrant research portfolio in ADHD and other neurodivergent conditions, embracing innovative ideas and creating a validated outcome measure to evidence benefit to patients of new treatments/technology.
Harnessing Technology	Extended Reality (XR), Virtual Reality (VR), Digital Platforms, Artificial Intelligence (AI), Software as a Medical Device (SaMD), Virtual Wards	Successful relationships with Industry, funders, research networks, services and patient groups to bring technology solutions to patients/services
Interface between physical and mental health	Nutrition, ASD, exercise, obesity, multiple long-term conditions, home-first solutions.	Holistic mental and physical health R&I solutions developed to extend lifespan of patients and increase quality of life
Community-based Research & Innovation across the lifespan of our citizens.	Poverty Truth Commissions, early years Research & Innovation, Heath inequalities focus, un-met needs assessment.	Active R&I portfolio across life-span from early years to elderly nurturing power in communities, e.g. via creation of Poverty Truth Commissions, involvement of veteran and ethnic minorities communities
Health Services Research	Corporate services, Strategy implementation, anti-racism issues, Leadership Development Offer	Delivery and implementation of Health Services research and evaluation & improvement of local health services

Enabling Themes

Rotherham Doncaster and South Humber NHS Foundation Trust

To underpin the Super-Six and other areas of R&I across the organisation and with communities and partners six **Enabling Themes** have been identified, aligned with the 5 Strategic Objectives and 28 Promises embedded in the Clinical and Organisational Strategy 2023-2028.
For more detail refer to the R&I Plan Deliverables document.

Enabling theme	Future success measures	Strategic Objective (SO)
Public Involvement and Community Engagement (PICE)	Developed PPIE/EDI Strategy; Engagement with underserved communities; Offering R&I in people's homes/community setting; Active Community partner networks; Poverty Truth Commissions set-up	1: Nurture partnerships with patients and citizens to support good health. 2: Create equity of access, employment and experience to address differences in outcome. 3: Extend our community offer, in each of - and between - physical, mental health, learning disability, autism and addiction services. 5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.
Systemising Innovation	Agreed definition /model/paradigm for innovation (outside of formal R&I grants) Innovative ideas from services identified, assessed, and potentially implemented; Innovation system/model aligned with Q&S Plan	5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.
Workforce development	Training fellowships/Academy; Early access to research careers; Research & Innovation ready workforce; Attract and retain Clinical Academics, Utilisation of Volunteers and Apprenticeships	1: Nurture partnerships with patients and citizens to support good health. 2: Create equity of access, employment and experience to address differences in outcome. 5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.
Stakeholder management	R&I expertise across the pathway; Leverage support from R&I Networks; Engaged Primary Care Networks / ICBs in R&I; Effective communication plan	2: Create equity of access, employment and experience to address differences in outcome. 3: Deliver high quality and therapeutic bed-based care on our own sites and in other settings. 5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.
Financial growth	Commercial portfolio; Accurate financial forecasting; RDaSH led grants / projects; NIHR Portfolio funding	5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.
Process development	Robust governance processes; Inspection readiness / confidence; Well developed IT systems for R&I tracking and delivery; Continued development of Clinical Research Facility	5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.

Systematising innovation

- We are focused on 2026/27, and particular 2027/28, seeing the Trust's culture adapt to become more obviously innovative in mentality: testing ideas from outside (either in our communities or among peers) within the Trust
- To this end, we want to refine skills, protect time, celebrate success and risk, and shift the language within our operating model towards innovation
- We will focus the effort initially on our productivity pilots, quality measures, and neighbourhood health work, recognising that these are priorities shared by many leaders and clinicians
- Corporate deputies and clinical thought leaders will be asked to offer leadership in inculcating innovation into all parts of our 23 directorates

Giving prominence and emphasis to innovation will include from 2026

- Quality improvement contests
- Skills and sharing with Learning Half Days
- New consultants' group with access to the Board
- Introducing Innovation Fellowships into the Trust from 2027
- Using rapid deployment models to introduce test bed sites, based on learning from HQTC
- Substituting innovation for risk in our management discourse

Innovation models

There are all sorts of models and paradigms for thinking about innovation. It may be that over time we need to normalise one, recognising they often indistinct. Most usefully the branches of incremental and disruptive innovation; and how we should consider how we nurture both. Perhaps especially in the domain of neighbourhood health all four 4Ps are considered – where work on quality measures and productivity chooses a smaller range, of equal value

PARADIGM	PROCESS	POSITION	PRODUCT
Re-imagining the way we think about health: that is our community power offer. e.g. Promise 5 about migrating that paradigm shift to be one our staff as individual practitioners find meaningful.	What are our core processes and how do we make them leaner and more effective? e.g. can we move to common processes, can we prize time as the currency – yet can we allow people to disrupt that norm?	Altering our place in the eyes of others e.g. can the Trust make meaningful the integration of mental and physical health – and consequently reposition ourselves in, for instance, North Lincolnshire	New stuff / old stuff reframed: e.g. How can we as RDaSH meet emerging need: most clearly framed in terms of pathways to employment for those with enduring mental health conditions?

Tidd and Bessant: Four Ps model (2021)

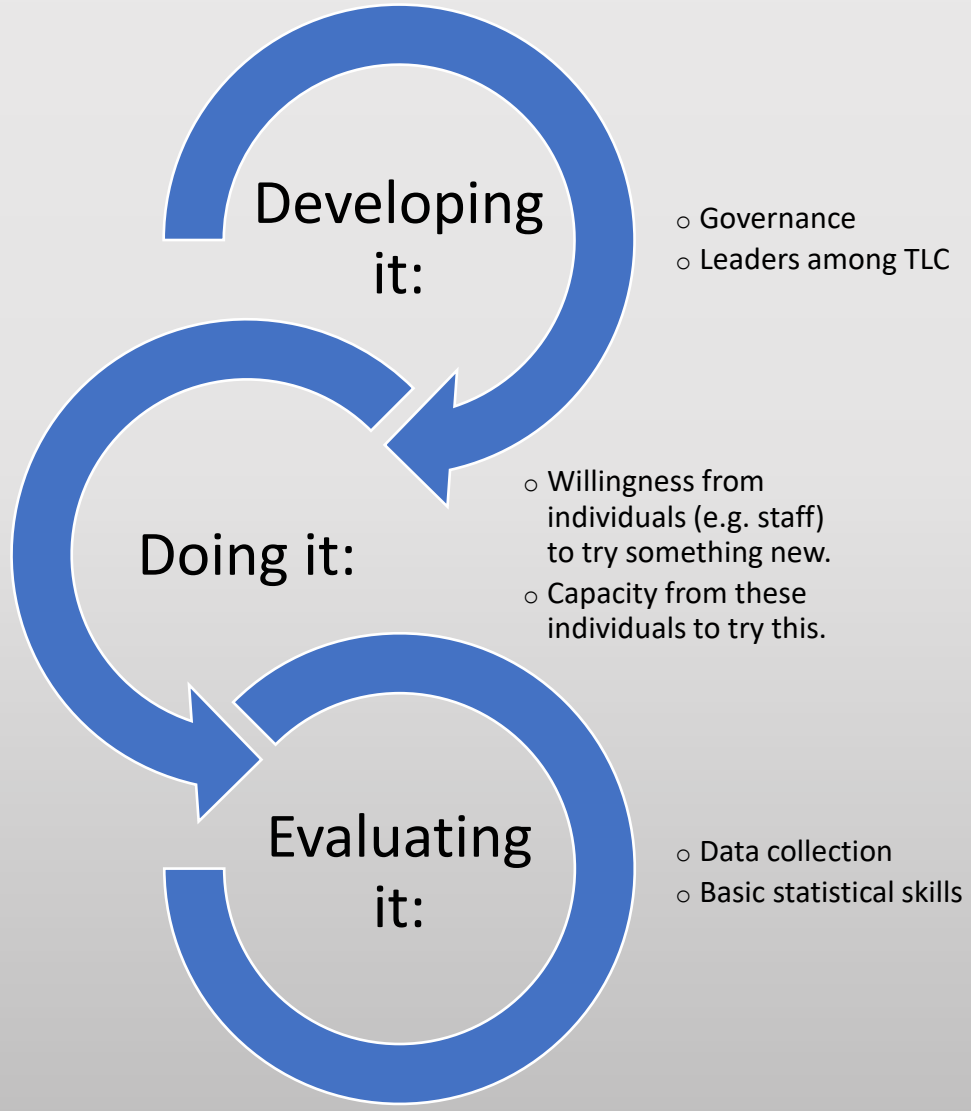
Innovation – *Trying something new and different*

Arguably all research is innovation, whereas not all innovation is research. As an organisation we need to understand the drivers and barriers to being innovative or trying something new and different. This will Care/Group led, with support from a range of parts of the Trusts, including Change and Improvement, OD and Culture, Grounded Research, and Health Informatics

Through our thought leaders and clinical leaders' programmes, as well as the new consultants' club, we will look to share core skills relevant to this agenda.

QI methods training will form part of 26/27 expectations within the LDO, building on the A3s each leader has been asked to develop and report in 25/26

Aligned to our group communities' of practice, from Q1 2026/27 we will begin to review the scale of innovation and testing within each group, likely inviting our three adult MH CGs to work together as a network on this



Timeline of success

Rotherham Doncaster and South Humber NHS Foundation Trust

P = Promise

P28: ½ Day R&I Training & Directorate reports to R&I Group
P28: Appoint R&I Manager
P16: Collate current services outcomes
P13: Add PRAs to volunteer network
P4: Develop a strategy of engagement with R&I Community Contributors
P24: Leverage access to NIHR career development and opportunities & offer R&I Internships, apprentices, student placements and postgraduate training schemes

P28: Strategic appointment of Professorships
P28: Strategic partnerships with Industry, e.g. with Clinical Research Organisations (CROs): IQVIA, Parexel, PPD
P7: Broaden relationship with NIHR Health Determinants Research Centre (HDRC) network and LA partners across patch
P3: Double R&I Volunteers/PRAs to 25
P28: Embed research & innovation into clinical practice.

2024 2025 2026 2027 2028

Engage others in R&I Plan Delivery:

- Corporate services
- Pharmacy
- St John's Hospice
- Mental Health Act
- Community Groups
- Staff & Patients
- Board/NED/Governors

P3: Use volunteers and staff to scope innovation ideas from services and patients, e.g. innovation cafes / innovation fellowships
P28: Form strategic partnerships with Universities
P28: 3-4 commercially sponsored clinical trials
P16: Focus groups with communities/patients around outcomes important to them
P7: Actively pursue leadership and delivery of public health and health services studies

P16: Evaluate the success of services in delivering real change for communities in the outcomes important to them
P26: In partnership with EMRI provide R&I cultural competency training, reverse mentorship and a language and dialects programme across teams
P27: Play active role in delivering the NHS net-zero targets, based on new ways of working
P28: Evaluate (and recalibrate) if increased R&I investment has brought employment opportunities to the community.

P16: Improvement of outcomes for patients

P28: Increased breadth of Industry partnerships (tech / pharma / SMEs)

P28: Scoping of University Hospital Status & NIHR Infrastructure (CRF/BRC)

Where does Grounded Research (GR) fit in?

NHS Rotherham Doncaster and South Humber NHS Foundation Trust

The Team - The Grounded Research (GR) mantra is "Inspire, Deliver, Together". The team provide the governance and legal framework around the Trust's "Big R&I" Research and Innovation (R&I) and is a multi-disciplinary team, e.g. doctors, nurses, psychological therapists and wellbeing practitioners, pharmacists and allied health professionals (AHPs), governance specialists, administrators and communicators.

Facilities - The Grounded Research Hub and community Clinical Research Facility has been designed with input from the local community, our staff and our patients, because we want our environment to be safe, welcoming and inclusive for everyone. It is an established, dedicated R&I facility within an existing NHS Trust infrastructure. Visit us at 2 St Catherine's Close, Tickhill Road Hospital, Doncaster, DN4 8QN.

Portfolio of work - The R&I projects GR currently governs include national NIHR Portfolio studies (involving partnerships with academia, Care Groups and other NHS organisations), Innovation projects in AI and Health Technologies, Commercially sponsored Clinical Trials of drugs, student projects (e.g. PhD/MSc/DClinPsy), and observational or survey research projects. Please contact the Research Governance team for expert advice on R&I governance, ethical and regulatory advice. GR also currently holds the register for service evaluations in the Trust.

Patient & Public Involvement and Engagement - The name Grounded Research was chosen as it embodies our intention to offer inclusive research that is grounded in our communities, that makes a positive difference to people's lives and works for all, through involving patients and the public in all aspects of the R&I journey, from concept to dissemination.

Key contacts

Get in touch and you will be directed to a member of the Grounded Research team to help you:

General enquiries: rdash.groundedresearch@nhs.net
Research Governance team: rdash.research-gov@nhs.net
Service evaluations: rdash.service.evaluation@nhs.net

Grounded Research | Psychological Health Observatory | Centre for Nutrition & Behaviour

People we will work with

Collaboration is the corner stone of R&I and we cannot deliver this Plan without engaging others to achieve our promises, such as:

- Community groups across all three localities e.g. Dementia groups, People Focused Group, Cultural centres, Places of worship, e.g. Mosques & Temples, Andy's man club, Family Hubs, Staff, apprentices and volunteers across all levels, empowering front line people to engage in R&I.
- The National Institute of Health and Care Research (NIHR) and Regional Research Delivery Network (RRN)
- NIHR Infrastructures, e.g. Sheffield HealthTech Research Centre (RDaSH lead the Mental Health cross-cutting theme), Doncaster Health Determinants Research Centre, the UK Clinical Research Facility Network and other local Clinical Research Facilities.
- R&I Networks, e.g. The Yorkshire and Humber Health Innovation Network, Integrated Care Boards (ICBs) R&I networks.
- The NIHR Ethnic Minority Research Inclusion Network.
- Universities nationally.
- Research councils, e.g. Engineering and Physical Sciences Research Council, Innovate UK, UK Research & Innovation
- Charities and funders.
- Local Trust partners via Provider Collaboratives.
- Other NHS organisations and Primary Care regionally and nationally.
- Industry partners, pharmaceutical companies, Small to Medium Enterprises (SMEs) and start-up companies.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Provider Capability Assessment	**Agenda Item**	Paper R
Sponsoring Executive	Kath Lavery, Chair and Toby Lewis, Chief Executive		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	25 September 2025

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

The publication of a Provider Capability Framework is an important piece of a revised yet still emerging regulatory framework for NHS providers. It aligns to the Insightful Board guidance and links to the relatively recent introduction of segmentation and league tables within the sector. We anticipate it being used 'later in the year' as an additional criteria alongside segmentation: its alignment with the CQC well led material, and indeed Trust ratings is being clarified.

The initial requirement of the Trust is to undertake a self-assessment by 22 October 2025. This paper provides the Board of Directors with the first version of this and seeks to receive support for the overall positive position it presents; for the supporting evidence and commentary referred to and to approve the final stage of the process (further refinement of the self-assessment and evidence – but with no expectation of varying the ratings for the criteria) before submission. Delegation of final sight is proposed.

The standard we have suggested using is us/peers, rather than ourselves/perfection, and we rely heavily in GGI review, auditors comments, and other feedback to arrive at a positive conclusion. The suggested amber-green in relation to patient quality of care reflects our own discussions in regard to the Quality and Safety Plan and the revised, and still evolving, governance we are applying internally.

Previous consideration

Not previously discussed elsewhere.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and **NOTE** the changes to the regulatory environment including the new requirement for the Trust to be assessed against a Provider Capability Framework.

RECEIVE, **NOTE** and **REVIEW** the initial self assessment presented in the paper against the Provider Capability Framework

DELEGATE approval of the final self-assessment to the Chair, Vice Chair, Chief Executive, and Director of Corporate Assurance in order that the Trust achieves the submission requirement deadline of 22 October 2025 and to **RECEIVE** an update in November 2025 of this process and any feedback received.

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

Business as usual	X

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

No direct link	

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

External and partnership risks

Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X

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

N/A

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

Part of the assessment itself

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

Appendix (please list)

Appendix 1: Supporting Information relating to the Provider Capability Assessment Framework

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
BOARD OF DIRECTORS

Assessing provider capability: guidance for NHS trust boards

1. Introduction and background

1.1 Recent national guidance has enhanced the regulatory approach and scrutiny of the Trust, alongside all other NHS providers. As part of the NHS Oversight Framework (NOF), NHS England will assess NHS trusts' capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust.

1.2 As a key element of this work, NHS boards have been asked to assess their organisation's capability against a range of expectations across 6 areas derived from another recently published guidance document, *The insightful provider board*, namely:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

1.3 These will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability.

1.4 This results in a relatively sizeable shift in the regulation / scrutiny of the Trust and the table below usefully depicts the change and the synergy / relationship between a number of related matters.

Old Requirements vs NHS Capability Assessment

Previous Requirement	What It Covered	New Capability Assessment	Key Change
Foundation Trust Provider Licence Self-Certifications	Annual board self-certifications on governance, compliance systems, and resource availability. Required evidence + explanation if non-compliant.	Annual **self-assessment across 6 domains**: strategy, quality, people & culture, access, productivity, finance. Boards must give evidence, highlight gaps, and describe mitigating actions.	Broader scope (all trusts, not just FTs). From yes/no compliance → maturity-based capability with ratings (Green → Red).
Governance Statement (Annual Report)	Statement on risk management, internal control, and governance arrangements, linked to audit.	Can be reused as evidence for the capability self-assessment.	Consolidation: governance statement still exists, but capability assessment is now the **primary formal declaration**.
NHS Oversight Framework Segmentation	NHSE placed trusts into oversight categories based on performance and risk.	Segmentation remains, but **augmented by "capability rating"** (Green/Amber-Green/Amber-Red/Red) reflecting board/management confidence.	Adds a formal judgement of **board capability and grip**, not just organisational performance.
CQC Well-Led Review	External regulatory review of governance and leadership.	Still applies, but regional oversight teams **triangulate with the self-assessment**. Boards must align evidence with both CQC and NHSE expectations.	Creates a **dual lens** (CQC external + NHSE internal oversight). Risk of duplication unless integrated.
Ad hoc Oversight (regulator requests, peer reviews)	No standardised self-assessment cycle; interventions varied by region.	**Annual cycle** with template, evidence, capability rating, and explicit in-year "no surprises" reporting.	Makes self-assessment **structured, mandatory, and recurring**. Boards must disclose material in-year changes.

Source: Mason Fitzgerald

2. Summary of the capability assessment cycle

2.1 The self-assessment process which will take a number of stages across the year:
NHS trust boards carry out an annual self-assessment against the 6 domains in The Insightful Provider Board and:

- highlight any areas for which they consider they do not meet the criteria, the reasons why and the actions being taken or planned then, within 2 months
- submit the completed self-assessment template to their regional oversight team with supporting evidence

Oversight teams review the self-assessment and:
- triangulate this with other information including the trust's recent operational history and track record of delivery and third-party intelligence (see below) as necessary to develop a holistic view of capability
- assign a capability rating to the trust

Oversight teams will discuss the capability rating with the NHS trust and consider, in the round, the principal challenges the organisation faces, prioritising issues and the actions needed – for example, monitor something more closely, request follow-up action(s) and/or refresh the capability rating to reflect concerns if necessary.

Oversight teams will, across the financial year, use the capability assessment to inform oversight, for example where:
- risks flagged in the self-assessment are a concern (for example, inability to make 1 or more certifications), or
- annual self-assessments do not tally with oversight team's views or information from third parties, or
- subsequent performance/events at the trust or third-party information are a cause for concern such that elements of the self-assessment are no longer valid and, in order to assess 'grip', teams may wish trusts to review the basis on which they made the initial assessment.

3. RDASH Self-Assessment

3.1 The self-assessment attached presents a positive response across the six domains and is aligned to other related documentation, assessment and assurance. It utilises the scoring mechanism included in Appendix 1: Supporting Information relating to the Provider Capability Assessment Framework

3.2 Recognising that there is ongoing work across all areas, the self-assessment scores 'green' against all but one of the sub criteria, that being *5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.(Quality of Care).* With respect to this criteria a rating of 'amber/green' is assigned. This correlates with the position reported to Board of Directors, Quality Committee and within the Chief Executive's Annual Governance Statement in the Trust's Annual Report 2024/25.

3.3 The initial self-assessment is due to be submitted by 22 October 2025. Whilst this paper has been prepared for today's meeting - to ensure the Board are sighted on the requirements and on the initial response - there will likely be further work undertaken in the period before submission that develops and enhances the response and the evidence. <u>There is no anticipated change in the ratings for the individual criteria</u>. Therefore, with no planned Board meeting, it is recommended that the Board of Directors delegates authority to the Chair, Chief Executive, Director of Corporate Assurance and Vice chaire to complete the work and approve the final submission; and to report the final position to the Board of Directors in November 2026 together with any feedback received by that date.

4. Recommendations

4.1 **The Board of Directors is asked to :**

RECEIVE and **NOTE** the changes to the regulatory environment including the new requirement for the Trust to be assessed against a Provider Capability Framework

RECEIVE, NOTE and **REVIEW** the initial self assessment presented in the paper against the Provider Capability Framework

DELEGATE approval of the final self-assessment to the Chair, Vice Chair, Chief Executive, Director of Corporate Assurance. In order that the Trust achieves the submission requirement deadline of 22 October 2025 and to **RECEIVE** an update in November 2025 of this process and any feedback received.

The self-assessment

I. Strategy, leadership and planning

Self-assessment criteria and rating	1.The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners			
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
Are the trust's financial plans linked to and consistent with those of its commissioning integrated care board (ICB) or ICBs, in particular regarding capital expenditure? Are the trust's digital plans linked to and consistent with those of local and national partners as necessary? Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?	Our strategy and plans (financial, clinical, public health etc) do reflect those of aligned partners. The Trust has a very widely understood and specific Clinical and Operational Strategy 2023 – 2028: whose five objectives reflect the priorities of our communities. The 28 Promises are widely understood by both patients and our staff: and are increasingly used by commissioners themselves in contracting with us.	The Strategy and Plans, whilst purposefully focused on the Trust, its services, its colleagues and those people that use the services and the wider community, align to objectives of system partners and related local and national plans on specific topics (for example NHS Digital) – with the 10-year plan reaffirming some of the intentions already in place within our strategy and plans The Trust has developed its financial plans (and future forward plans) aiming to get to a break-even position; and has done so very conscious of its position and contribution to the wider, system / ICB financial plans (see also criteria 16)	1 / 8 plans still to formally approve as at submission date (estate plan) – not material Is there an argument that HNY ICB 'blueprint' strategy not acknowledged (or indeed accepted)?	Clinical and organisational Strategy 2023-28 RDASH Plans Annual Report 2024/25 Delivering our Promises including patient led version Details of promises incorporated into contracts CQC well led review – acute services (good rating) Capital plan reconciliation
	2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England.			
Is the trust currently complying with the conditions of its licence? Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?	The Trust is compliant with all licence and regulatory requirements and is not subject to any enforcement actions from NHS England.			

	3. The board has the skills, capacity and experience to lead the organisation.			
Are all board positions filled and, if not, are there plans in place to address vacancies? What proportion of board members are in interim/acting roles? Is an appropriate board succession plan in place? Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?	The Board has all positions filled at the present time – none of which are interim or acting roles, with respective individuals clear on accountabilities and responsibilities, which were redefined in 2023/24. Succession planning is in place and the refinement of that explicitly features in the objectives of the CEO and Chair: over the past two years there is good evidence of managing succession, with a balance of external hires and internal promotions. The organisation is committed to diversity in its leadership and can evidence positive results in that direction over the past four years. Skills audit and self assessment of Board undertaken and discussed – turning into practical actions during 2025	Board Development sessions undertaken on bi-monthly basis (including with ICB chair/CEO – and involving NHS Providers for digital board work) Robust FPPT process in place (audited in 24/25 with significant assurance) Annual PDR process is in place for all Board members – and clearly evidenced in remuneration committee minutes Chair, Chief Executive, Director of People and OD and Director of Corporate Assurance leading the processes around succession planning of all including skills audits (pointed to future development) – with the Trust purposeful supporting leadership development and the creation of a Deputy Executive Group to provide experience to potential future leaders.	Eight week gap with changeover of Director of Finances & Estates	Board of Directors page on public board of directors FPPT Board development specification and programme 2024/25 Leadership development offer curriculum Scope for well led review (to be undertaken Q4) Rem Co minutes etc.
	4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.			
Is the trust contributing to and benefiting from its NHS trust collaborative? Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system? Can the board evidence that it is making a positive impact on the	The Trust Chief Executive is the convening CEO for the South Yorkshire MHLDA: members and partners assessment of contribution shows results in respect of eating disorders and urgent mental health need. Majority of collab SROs drawn from RDaSH.	Trust has a clear partnering model, which is part of Board and its committees' terms of reference. Audit review shows strong assurance on the meaningfulness of the Trust's approach to partnering.	More challenging relationship with HNY ICB. Contribute to HNY MH Collaborative, recognising that that vehicle has its challenges. Work very closely with south Humber NHS	Trust can evidence: - involvement - impact - humility Trust can evidence partnering is whole Board business not

wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?	GP partnership increasingly strong, and good evidence of Board engagement with primary care. ICB level engagement with other Board members.	Very positive feedback consistently from VCSE and local authority partners for the Trust's presence, impact and commitment to working together with a purpose.	partners on international recruitment and peer aid for shared issues.	simply CEO or a designated executive.

II. Quality of care

Self-assessment criteria	5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.			
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
The trust can demonstrate and assure itself that internal procedures: ○ ensure required standards are achieved (internal and external) ○ investigate and develop strategies to address substandard performance ○ plan and manage continuous improvement ○ identify, share and ensure delivery of best practice ○ identify and manage risks to quality of care There is board-level engagement on improving quality of care across the organisation. Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients. Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community.	There are cogent answers to all of these lines of enquiry. And considerable evidence of Board consideration of capability in this field, and action. The amber-green rating reflects two principal areas for improvement: - we know we have clinical performance issues that need to improve - our shift from assurance to data (both Q types) needs six months further to mature The transfer of services onto a community footing is evident in various ways including our virtual ward: but at Board level	Board engagement with quality and safety and the reality of care is demonstrated in a range of ways that include: - delivery reviews - peer reviews - frontline visits - patient stories - open meetings Informal timeout sessions have been used to collate board insight into quality and safety in our Trust – and shift to 13 directorates is rebalancing that focus across all facets of clinical service (physical/mental, adults/CYP)	Implementation of RADAR represents a major opportunity: do we have a clear trajectory for analytics use?	Quality and Safety Plan Annual governance statement Paired outcomes data Evidence libraries for getting to good strategy Quality Account 2024/25 CQC Provider and Inspection Reports IQPR

Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust. Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.	by the closure of 23% of our inpatient wards since 2023 and reinvestment into community based services. Learning half days represent a distinctive model through which to foster QI			
	6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.			
Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience? Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities? Is the board satisfied that it receives timely information on quality that is focused on the right matters? Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this? How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance? Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?	There is strong evidence to support a positive assessment for all these key lines of enquiry: including… - comparative data use - protected characteristics - timely datasets - patient feedback at the heart of what we do - patient involvement in service evaluation - board skills audit - use of complaints as learning tools (now – less strong before 2025) The Trust utilises Care Opinion as a key source of feedback from patients. Reporting mechanisms are in place with open access to all colleagues to read. But the Board can also demonstrate other tools being used recognising the exclusionary bias from one source.	Care Opinion stories now at 1,664 in number (less than a year active) and demonstrable progress with ensuring responses provided (78% to last 100 stories) Reading and learning encouraged by wider colleagues and within directorates – with directorates challenged via Delivery review process on numbers and responses and learning and celebration of good practice 'Check and Challenge / contribution via patient partners on our progress with promise delivery The patient voice and community are represented in decision making within governance structure in line with Promise 5 of the Trust Council of Governors and the inclusion of patient and carers representative provides an avenue for feedback and challenge in respect of service delivery.		Care Opinion website reporting

III. People and culture

Self-assessment criteria	7. Staff feedback is used to improve the quality of care provided by the trust.			
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where here is scope for improvement? Does the board engage with staff forums to continually consider how care can be improved? Can the board evidence action taken in response to staff feedback?	Diversity analysis is a core feature of the Board's work, and of its committees, and improvements in WRES data reflect effort put in. There is a clear audit trail of engagement including but not limited to: - investment in reasonable adjustments - focus on LHDs as time to learn - development of non-patient facing time for senior clinicians - training ringfenced and development of advanced training plans The Board has a dedicated staff sub committee (TPC) focusing on the culture of the Trust, where the overwhelming majority of members are from bands 8 and below – and where protected characteristic diversity is well reflected. Staff feedback is collated via the Staff Survey and via Trust People Council and our Staff networks and is used to inform	Staff Survey responses have increased; with plans developed in response at Directorate level to respond to the issues raised. WRES and WDES analysis shows improvements but with further work evidently needed. Training spend and Apprenticeship Levy are analysed by protected characteristics Trust People council and Staff networks well established and routinely provide for engagement opportunities with staff, union reps and staff governors. Peer Reviews are undertaken by Board reps and provide an interface for staff feedback and their voice to be heard Monthly Backbone emails from CEO; Trust wide drop in sessions and a weekly VLOG from CEO all afford engagement and feedback opportunities and provide the opportunity for two way communication and discussion	Enhanced Pulse Check	Staff Survey Report Trust People Council Minutes WRES and WDES reports Evidence (samples) of communication to staff and links to communication via RDASH YouTube channel

	action and to improve quality of care and the employee experience.			
	8. Staff have relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels			
Does the trust regularly review skills at all levels across the organisation? Does the board see and, if necessary, act on levels of compliance with mandatory training?	The Board is very focused on mandatory training and in the last twelve months has complete a full review of inclusions and made changes – and has now altered how MAST is reported to ensure those who miss part of their MAST are not counted as compliant. The Board holds a dedicated education and learning Trust Board meeting, and more widely can evidence a consistent focus on skills and learning. Training access has been expanded over the past two years	From joining the Trust and attending the comprehensive 5 day induction programme (including trust and local induction, immersion in or communities, and time to fulfil MAST requirements) the Trust continues to support staff through multiple development schemes including the leadership Development Offer and the First Line Managers scheme. Succession planning is in place within most teams/services Trust wide Training Needs Analysis launched 2024/25 identifies the needs from the Trust to ensure our resources are appropriately and routinely used to develop colleagues. MAST reported via IQPR to Board each time, also reviewed at POD Committee Job Planning work through medical staff but now on a broader footing seeks to ensure capacity and clarity is provided with respect to colleagues and their work		IQPR Reports (inc MAST) Induction, LDO, First Line Managers Programmes Learning from the TNA to cover all 23 Directorates and staff groups Job Plan Report
	9. Staff can express concerns in an open and constructive environment.			

Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience? Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required? Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns? Is there a safe reporting culture throughout the organisation? How does the board know? Is the trust an outlier on staff surveys across peers?	Robust process(es) in place utilised on increasing frequency with demonstrable evidence of action in response Links back to criteria 7	Multiple opportunities on a trust wide level for engagement with staff affording the opportunity for open and constructive debate. Including the Trust People Council, chaired by NED and attended by Chair and CEX (with union reps, staff governors and the FTSU Champion amongst other representatives) Detriment SOP has been launched FTSU Guardian well established within the Trust with reach across the organisation and to the Board. Sexual safety – online reporting tool Robust complaints process that involves highest level of the Trust in response	Given league table data vs peer group how are we weighting FTSU staff feedback vs other criteria here	Staff Survey FTSU Bi-Annual Reports to Board of Directros

IV. Access and delivery of services

Self-assessment criteria	10. Plans are in place to improve performance against the relevant access and waiting times standards.			
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement	The Trust meets operating guidance standards consistently since 2023 (except OOAP): and meets RTT routinely. But our drive goes much further.	Progress on achieving this promise has been substantial and a majority of services will deliver it by the planned deadline in April 2026. The Board is aware of those services that are unlikely or will not achieve this. Important to stress that standards are examined on the basis of	Discussion on two hour standard for community nursing?	Waiting times Board Paper (July 2025)

	The Trust has committed (Promise 14 (part b) to deliver a 4-week wait for all referrals from April 2026; a promise that exceeds national standards. Waiting times across all services are know and continuously measured and scrutinised – with from July 2025 all waiting times published n the Trust's website.	local services – not aggregated to Trust level.		
	11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients.			
The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place.	Information available to identify the variations and the Board receives at each meeting an analysis via a HI lens of its IQPR. The focus of the Board on inequalities is evidenced through the content of papers and the strategy itself. The Board has a dedicated public health board sub committee meeting every eight weeks.	Service data presented by protected characteristic and deprived area can be broken down to clinical directorate level (from Sept 2025). We also report data by some protected characteristics and deprivation for the 14 promises which sit under our Equity and Inclusion Plan. The Equity and Inclusion Group (sub to CLE) oversees the action related to delivering the 14 E&I promises and monitors performance data as well as progress against actions on a bi-monthly basis. This data is also reported to the Sub-Committee of the Board – Public Health Patient Involvement and Partnerships.	Actions are in place to make key changes to our provision and narrow inequalities gaps e.g. RDaSH 5, Citizens Advice support, Travel Fund, Poverty Proofing work, School Readiness additional work, Rurality assessments and plans and homeless health. Further work is required to see if the actions taken start to make a difference to the communities affected, shown via the data. The key measures are: - Improve representation of communities in our patient referrals - Improve attendance of appointments for patients from a deprived area and	Equity and Inclusion Plan Promises Data Reports IQPR HI data RDaSH 5 plans Poverty Proofing programme, findings and actions Pilot Rurality assessments.

			some ethnic communities; - Improve outcomes for patients from deprived areas and those with protected characteristics; Ensure that waiting times are equitable across all patients groups.	
	12. Appropriate population health targets have been agreed with the integrated care board.			
Is there a clear link between specific population health measures and the internal operations of the trust? Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?	We have developed our data suite and baselines working closely with Local Authority Public Health teams and used national public health datasets, along with data from ICBs. This has been used to develop our Strategic Plan and 28 promises, and the supporting Equity and Inclusion Plan. Our strategic plan is in line with the strategies of both of our ICBs which focus on improving the health of their populations.	The Trust's strategic plan with 28 promises strongly addresses population health and aims to reduce health inequalities. The supporting Equity and Inclusion Plan sets out plans for deliver the 14 promises it covers, along with success measures for each. These have been informed by population health information and data from our three places. Our data also has contributed to our self-assessment against the Patient and Carer Racial Equality Framework which is now being driven forward with a supporting action plan. Service data presented by protected characteristic and deprived area can be broken down to clinical directorate level (from Sept 2025). Teams across the Trust have been involved in a range of developments to address/improve population	We have more to do to embed the use of health population data to drive actions in every team across the organisation. More needs to be evidenced that actions being taken are improving the health of our population. This will take a long time, could be a decade or even generational in terms of life expectancy and health life years. However, a number of success measures/proxy measures have been developed to monitor progress.	Neighbourhood health profiles. JSNAs. Equity and Inclusion Plan Promises Data Reports IQPR HI data RDaSH 5 plans Poverty Proofing programme, findings and actions Pilot Rurality assessments.

		health. In fact, for some teams this is their primary focus such as Health Visiting. Other teams are specifically involved in key pieces of work to reduce inequalities and improve population health for some specific communities such as our RDaSH5: - To increase number of older adults referred to Talking Therapies - To increase the number of people from an ethnic minority background referred to our perinatal services and dementia services People with a learning disability from an ethnic minority community having their annual healthcheck.		

V. Productivity and value for money

Self-assessment criteria	13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.			
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to: ○ review its performance against peers ○ identify and understand any unwarranted variations ○ put programmes in place to reduce unwarranted negative variation.	The Trust is leading on Productivity and Value for Money in the mental health and community provider sector, with the best National Cost Collection index score in 202425, demonstrating the efficient use of resources to deliver high quality care. The	The Trust benchmarks well against peers and has achieved the best NHS National Cost Collection measure of all Mental Health & Community Trusts with a score of 85. This demonstrates that the Trust's cost of delivering activity is 15% lower than the national average.	Although the work on productivity has progressed in a number of directorates, there is more work to do to ensure all directorates are using the available dashboards and implementing learning from this information and	National Cost Collection Report VFM Conclusion Deloitte I&I Controls Assessment

The trust's track record of delivery of planned productivity rates.	Trust has embraced digital solutions in progressing productivity pilots in directorates and is working with NHSE to develop mental health specific solutions in this space.	The Trust has led the way in developing power BI dashboards for costing data to be used in productivity pilots across the Trust, and is awaiting confirmation on whether our bid to be the Mental Health productivity host for NEY region has been successful. Our 25/26 CIP programme includes a c£4m productivity scheme, which is focussed on the Trust's promise to reduce waits to 4 weeks across its services. Performance against this is monitored via FDE committee. As well as the work on productivity, the Trust received a clean VFM conclusion following the 24/25 annual audit by Deloitte.	changes made elsewhere by peers.	

VI. Financial performance and oversight

Self-assessment criteria	14. The trust has a robust financial governance framework and appropriate contract management arrangements.			
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data. Have there been any contract disputes over the past 12 months and, if so, have these been addressed? [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and	A robust framework is in place with the Board of Directors in its financial governance role having its Finance, Digital and Estates Committee. Budget delegation via annual sign off process with CEX and DoF ensures all directorates are clear on their responsibility.	The Trust has undergone an external assessment undertaken by Deloitte on behalf of SY ICB and NHSE on the organisations financial governance and controls across key areas of spend. The Trust's controls have been assessed as being either "enhanced" or "strong" in 9 out of 11 areas.	The 2 areas of deemed to have "standard" levels of controls from the external assessment were the provision of a PMO function and absence monitoring. Work to progress these areas will continue over the balance of 25/26.	Annual Financial Plan Internal Audit Plan Deloitte I&I Controls Assessment

show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?		Internal Audit undertakes a number of financially related audits on a rolling programme; with annually the External Auditors providing additional assurances regarding the system of control, management of key risks, delivery of value for money and the production of the annual report and accounts. Staffing and Financial systems are aligned to ensure consistency of reporting in operational costs; and whilst support via bank (NHS Professionals) continues to be supported and utilised agency use has reduced significantly to minimal limits (and the achievement of its eradication is imminent)controls etc ?		
	15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes.			
Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?	The Trust has a Quality and Safety Impact Assessment (QSIA) process that is routinely utilised to measure the impact of financial considerations on patient care and outcomes.	The Trust, in dealing with differing requirements and 'asks' has developed a pecking order of considerations of which at its top is patient safety – demonstrating a desire not to compromise patient safety. Supported additionally by an averse risk appetite in respect of patient safety. Financial performance is routinely monitored (in addition to that by budget holders, directorate SLT and through delivery reviews) through the Finance, Digital and Estates Committee and by the Board of Directors – with supporting narrative articulating the	Staff wellbeing harms evident and discussed during change management?	

		rationale for any performance not in line with plan. Rigorous budget setting process is supported by regular and robust budget management via individual responsibility and collectively within directorates with scrutiny provided via delivery reviews. Where necessary, budget delegation has been temporarily removed where additional management control was deemed necessary to ensure corrective action was taken.		
	16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.			
Is the board contributing to system-wide discussions on allocation of resources? Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?	The Trust engages fully with system partners across ICB and Place to support the optimal use of resources and to contribute to the delivery of the relevant financial outturn plans. The Trust has returned monies to other system partners in order to support collective balance. The Trust has taken on over £15m of demand side risk in order to better balance the ICB/Trust position.	The Trust sets its plan in conjunction with its system partners, with CEX and DoF involvement at system planning and resource allocation discussions throughout the year. RDaSH has met all its financial obligations over several years, achieving the required level of CIP and control totals. The CEX is the system lead on the reduction of out of area placements.		SLE and SEB minutes and attendance FCEDG minutes

Key to ratings applied:

Green	High confidence
Amber green	Some concerns or areas that need addressing
Amber red	Material issue needs addressing or failure to address major issues over time.
red	Significant concerns arising from poor delivery, governance and other issues.

Appendix 1: Supporting Information relating to the Provider Capability Assessment Framework

Inability to make a positive self-assessment

The board may not be able to make a positive self-assessment either because it considers the risks in a specific area are too great or its organisation is already manifestly failing in a specific area (for example, delivering on access targets). In these situations – and in line with the 'no surprises' ethos – in the self-assessment template boards should provide:

- the reasons why a positive self-assessment cannot be made against specific criteria and the extent to which these have been outside the trust's control to address (for example, industrial action, system-wide factors)
- how long the reasons have persisted
- a summary of any mitigating actions the trust has taken or is taking
- if not already shared with oversight teams, a high-level description of trust plans to address the issue, how long this is likely to take and KPIs or other information the trust will use to assess progress

Oversight teams will use this information to form their view of the overall capability of the trust and tailor their oversight relationship with it.

Material in-year changes

In addition to the annual self-assessment, if the board becomes aware in-year of a significant change to its ability to meet any of the self-assessment criteria – for example, an external report reveals material quality risks or an unforeseen cost will affect its financial performance – it should inform the oversight team along with the actions it is taking to address the issue. Such in-year changes will likely inform the ongoing regulatory relationship with the NHS England region.

The NHS provider trust capability rating

Regional oversight teams will review the trust's submitted self-assessment and consider the statements and evidence. Using a range of considerations, including the historical track record of the trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the trust's capability rating and share this with it, including the rationale for the rating.

Rating: Green

- High confidence in management.

Indicative criteria

- No concerns evident from the self-assessment or subsequent performance.
- No concerns arising from third-party information.
- High confidence in the trust's ability to deliver on its priorities based on track record over past 12–24 months.

Rating: Amber–green

- Some concerns or areas that need addressing.

Indicative criteria

- After discussion with the trust, some concerns emerging across more than 1 domain, but these as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS.
- Trust has prepared plan(s) to address any problems with associated timeframe for delivery.
- Historical issues/track record mean NHS England does not (yet) have full confidence in the board.

Rating: Amber–red

- Material issue needs addressing or failure to address major issues over time.

Indicative criteria

- Issues with self-assessment or subsequent issues across multiple domains.
- Failure to deliver on agreed plans to address a material issue.

- Potentially in breach of licence.

Rating: Red

- Significant concerns arising from poor delivery, governance and other issues.

Indicative criteria

- Material or long-running concerns at the organisation that management has been unable to grip.
- NHS trust in breach of licence or likely to be.

Third-party information

As set out in the NHS Oversight Framework, third-party information relating to the organisation's governance and risk profile, staff morale and quality of care provided may inform NHS England's view of NHS trust capability. We expect that where **trusts receive information that impacts on their self-assessment** they should share this with NHS England. Relevant third parties include:

- **other bodies with regulatory responsibilities**, where concerns can reflect weaknesses in internal governance and systems of internal control and oversight – including the Information Commissioner, Human Tissue Agency and NHS Blood and Transplant
- **professional representative bodies,** reflecting issues with working conditions, staff morale, operating culture and safety – including the General Medical Council, Nursing and Midwifery Council and Royal Colleges
- **patients and the public,** reflecting issues in areas such as patient experience and culture via groups like Healthwatch
- **staff information,** reflecting issues in internal culture and inability to speak up, for example via staff survey or whistleblowers
- **integrated care board partners,** covering areas like the trust's willingness to collaborate and deliver shared goals
- **other NHS England teams,** reflecting knowledge from central programmes like quality, cyber assurance or digital maturity
- **relevant oversight groups,** including joint strategic oversight groups (JSOG) and system and regional quality groups
- **other sources** as relevant to the NHS trust, including coroners, Parliamentary Health Service Ombudsman, local government and Social Care Ombudsman, Ofsted, the trust's internal and external auditors and even the police

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Medium Term Financial Plan	**Agenda Item**	Paper S
Sponsoring Executive	Izaaz Mohammed, Director of Finance & Estates		
Report Author	Izaaz Mohammed, Director of Finance & Estates		
Meeting	Board of Directors	**Date**	25 September 2025

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

Our medium-term financial plan, also referred to as the Finance Enabling Plan, is one of our eight plans: a crucial enabler to our investment work, and the delivery of our agreed 2023-2028 strategy. It has been discussed in various places over the past 18 months, most recently at the August Finance, Digital & Estates Committee. The national planning framework requires us to submit a plan by December very much in the spirit of this document.

The attached plan sets out the route to underlying balance after accounting for deficit support removal, as well as providing indicative savings targets and income growth (margin) requirements between 26/27 and 29/30. The Board is familiar with the possible sources of CIP in the first of those years, and recognises that, given our relative efficiency compared to peers, levels of CIP cannot be sustained at that level credibly in following years. Income/margin growth is not assumed to be wholly from NHS funders.

Cash and capital is outlined, mindful of finalisation of the digital and estate need implied by our other plans.

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

Finance, Digital and Estates Committee 20 August 2025

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE & DISCUSS the key assumptions contained within the financial plan.

NOTE the requirement to identify £10m of savings in 26/27 and the income growth needed to sustain underlying financial balance.

APPROVE the medium-term financial plan, recognising routine reporting against these assumptions will then become part of how FDE operates

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Alignment to the plans: (indicate those that this paper supports)	
Estate plan	X
Digital plan	X
People and teams plan	X
Finance plan	X
Quality and safety plan	X
Education and learning plan	X
Research and innovation plan	X

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

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

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

N/A

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

SY ICB – system financial sustainability

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

Appendix (please list)

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Medium term financial plan

Introduction

1.1 The plan is submitted for approval alongside other plans, recognising that it will iterate as assumptions are mandated from elsewhere. Our financial reporting has changed since 2023, with a focus on eliminating the legacy deficit developed during the pandemic period. Restoring financial balance can be achieved in 2026/27, one year later than we originally hoped – a reality explained by both the flat funding position adopted by our main funder in 2024/25, and the continued gap each time a national pay ward is made.

1.2 Three main conclusions can be drawn from the material here:

- The Trust's healthy cash position underscores the going concern recognising that we will wish to commit to investments some of these monies, once the regulatory environment permits a more local model of decision making.
- The Trust continues to make significant savings. Beyond 2027, it is not immediately evident where those savings would be taken from without service closures needing to be considered: backbone and inpatient changes are moving to a conclusion, and planned focus on community services in 2026 will then close that opportunity.
- The Trust has grown care volumes by 19%. Initial draft national analysis of unpicking our work suggests a fair share income formula would grow the Trust's income by around £22m. That is unrealistic, and the income within this plan assumes no gain or losses from the process of unbundling.

Considerations for the Board

2.1 Moving to tracking our financial position against the MTFM is a cultural shift for all involved. It will require focus on income inside our groups from April. And different reporting mentality from April 2026 at Board and elsewhere. It will be important for staff confidence that we have stability in our reporting over the medium term, as that will help to reinforce the importance of these figures, and challenge the view that they "move around".

2.2 The Trust has moved to directorate level focus in 2025/26. 21 of 23 directorates are in budget YTD, which suggests a level of grip and control which is fairly exceptional. The Deloitte analysis of our control regime testifies to that to, as does our pay position being within budget (the only such Trust in the ICB). It will be important that the necessarily quite centralised model of change management associated with the 2026/27 ask does not unsettle that local leadership strength which has been carefully built over the last 18 months.

2.3 Diversifying our funders and income sources is an important implication of this MTFM. The Board will need to consider what resources and skills may be needed to assess market opportunities for this, recognising that the sums indicated for 26/27 already have delivery plans well advanced.

RDaSH Finance Enabling Plan 2026-2030

Izaaz Mohammed

Director of Finance & Estates

RDaSH Finance Enabling Plan

- The RDaSH Finance Enabling Plan has been presented and discussed at FDE Committee and the Trust Broad on several occasions in the past 12 months.

- The aim of the plan is to provide medium term planning assumptions and indicative income, expenditure and savings figures to enable the Trust to reach recurrent balance.

- This refresh of the enabling plan reflects the balanced 25/26 plan the Trust submitted to NHSE in March, and sets out the required level of additional income and savings needed to reach recurrent balance from 2026/27.

- An update on the underlying deficit is included, as well as a 4 year forward look on key revenue and expenditure lines.

- The emerging capital & funding plans that will support the Estate Plan will be reflected once fully developed.

Underlying position

- RDaSH's underlying deficit in 2022 stood at approximately £16m. In the subsequent 3 years, the Trust has focussed on delivering budget cuts that have been the highest the Trust has seen in recent years. This has included closing 3 wards, reducing agency spend down from £9m to a handful of posts, and disproportionately targeting savings in corporate services.

- This work has ensured that the Trust's underlying deficit has reduced materially, and would be eliminated completely, if not for unfunded national pay awards which result in an annual shortfall of between £1m-£1.8m.

- The Trust submitted a balanced 2025/26 plan in March. This includes non recurrent items such as deficit support funding of £2.4m, slippage on cost pressures and investments of £1m, and the Trust's share of additional income from NHSE to achieve a balanced plan (£0.65m).

- In addition to these non recurrent items, the Trust anticipates a further shortfall on pay award funding of £1.3m. This is linked to the final pay award agreed by the government being higher than the figure Trust's were asked to base their 25/26 plans on back in March 2025.

Underlying position

Bridge - 25/26 Plan to Underlying Deficit - with deficit support removal	£m
25/26 Plan	0.0
remove NHSE deficit support funding	-2.4
remove non recurrent slippage on cost pressure reserve	-1.0
remove non recurrent income from NHSE to support plan delivery	-0.7
include likely impact of pay award funding gap from revised pay award	-1.3
25/26 Forecast Closing Underlying Deficit	**-5.4**

Bridge - 25/26 Plan to Underlying Deficit - without deficit support removal	£m
25/26 Plan	0.0
remove non recurrent slippage on cost pressure reserve	-1.0
remove non recurrent income from NHSE to support plan delivery	-0.7
include likely impact of pay award funding gap from revised pay award	-1.3
25/26 Forecast Closing Underlying Deficit	**-3.0**

- The tables above set out the underlying deficit position the Trust is expected to finish the 2025/26 financial year with.
- The key variable remains the timing and scale of the removal of deficit support funding by NHSE.
- Further guidance on this is expected in the autumn, however it would be prudent for the Trust to plan based on full removal in 2026/27 at this stage.

Planning Assumptions
26/27 to 29/30

Key assumptions used in the plan

- Directorate budgets in recurrent balance in 25/26 with no centrally held CIP, and all schemes delivered recurrently.
- Out of Area Placement deal agreed with SY ICB in October 2024 (inappropriate placements) and August 2025 (appropriate placements) remains in place.
- Deficit support funding of £2.4m is removed by NHSE from 2026/27.
- Cost Pressure / Investment Reserve is the **only** route to additional funds for directorate budgets, “additional” in year income received will be held centrally / offset against any central risk reserve.
- Vacancy factor remains at 2.5% for all directorates.
- Capital spend remains at a similar level to 25/26. Any decisions taken by the Board which impact on revenue or cash over and above this level will need to be reflected in the plan.

Income & expenditure assumptions

- Income inflation - ICB and NHSE contracts at 4.83%, LA contracts 0% - in line with 25/26.
- Tariff efficiency – ICB and NHSE of 2%, LA contracts at 0% - in line with 25/26.
- Convergence efficiency – 0% - in line with 25/26.
- Annual cost pressure reserve of £3m.
- Pay award shortfall continues each year, linked to national calculation which disadvantages mental health, community, and ambulance trusts.
- Cash releasing CIP needed to balance - £7.5m in 26/27 (£2.8m after 26/27).

Income & expenditure assumptions

- The Trust has received varying levels of income growth from commissioners in recent years, ranging from £4.2m in 25/26, £0 in 24/25 and £2m in 23/24.

- To achieve recurrent balance, we will need to find ways of growing our income base whilst keeping cost growth in line with inflation.

- 26/27 will see a savings requirement which is unsustainable if replicated over multiple years.

- Rather than include assumptions for growth funding based on historic funding patterns which are difficult to predict, the plan instead provides an overall income target figure which must be achieved to keep savings requirements at modest levels from 27/28 onwards.

Summary I&E

Category	Description	25/26 Underlying	26/27	27/28	28/29	29/30
Income	*Patient Care Income - NHS*	£214.5	£223.8	£232.7	£241.9	£251.3
Income	*Patient Care Income - Non NHS*	£26.1	£26.1	£26.1	£26.1	£26.1
Income	*Other Income*	£10.7	£10.7	£10.7	£10.7	£10.7
Total Income		£251.2	£260.6	£269.5	£278.7	£288.1
Pay	*Sub & Bank*	-£202.9	-£211.1	-£215.9	-£224.9	-£234.2
Pay	*Agency*	£0.0	£0.0	£0.0	£0.0	£0.0
Pay	*Tariff Efficiency*		£4.2	£2.2	£2.2	£2.3
Pay	*Additional Efficiency*		£1.8	£0.0	£0.0	£0.0
Pay	*Pay Growth*		-£2.5	-£2.5	-£2.5	-£2.5
Total Pay		-£202.9	-£207.6	-£216.3	-£225.2	-£234.4
Non Pay	*Depreciation*	-£6.6	-£6.6	-£6.7	-£6.7	-£6.8
Non Pay	*Premises*	-£8.8	-£8.8	-£8.9	-£8.9	-£9.0
Non Pay	*Supplies & Services*	-£8.9	-£9.0	-£9.0	-£9.1	-£9.1
Non Pay	*Transport*	-£2.2	-£2.2	-£2.2	-£2.2	-£2.2
Non Pay	*Other*	-£21.7	-£21.8	-£20.9	-£21.0	-£21.1
Non Pay	*Drugs*	-£3.2	-£3.2	-£3.2	-£3.2	-£3.2
Non Pay	*Net Finance Costs*	-£2.3	-£2.3	-£2.3	-£2.3	-£2.4
Non Pay	*Tariff Efficiency*		£1.1	£0.5	£0.5	£0.5
Non Pay	*Additional Efficiency*		£0.5	£0.0	£0.0	£0.0
Non Pay	*Non Pay Growth*		-£0.5	-£0.5	-£0.5	-£0.5
Total Non Pay		-£53.6	-£52.9	-£53.2	-£53.5	-£53.8
Underlying Surplus/(Deficit)		**-£5.4**	**£0.0**	**£0.0**	**£0.0**	**£0.0**

Key plan figures

Summary of changes to underlying position					
Tariff / cost changes	**26/27**	**27/28**	**28/29**	**29/30**	**Context**
Tariff uplift	£10.4	£10.8	£11.2	£11.7	Tariff uplift - Inflation funding applied to the Trust's NHS contracts.
Tariff deflator	-£4.3	-£4.5	-£4.7	-£4.8	Tariff deflator - Funding reduced by this figure to account for expected savings.
Pay inflation	-£8.1	-£8.4	-£8.7	-£9.0	Pay inflation - Cost of pay awards and incremental drift.
Non pay inflation	-£0.3	-£0.3	-£0.3	-£0.3	Non pay inflation - The amount that NHSE expect non pay costs to increase by.
Cost pressure reserve	-£3.0	-£3.0	-£3.0	-£3.0	Cost pressure reserve - Funds promise delivery and any material cost pressures.
Net tariff inflationary pressure	**-£5.4**	**-£5.4**	**-£5.4**	**-£5.5**	
CIP delivery required	£7.5	£2.8	£2.8	£2.9	Higher level required in 26/27 to reach recurrent balance.
Growth funding / margin target	£3.3	£2.6	£2.6	£2.6	Income margin / growth needed above any figures included in the CIP programme to achieve balance.
Total CIP / margin impact	**£10.8**	**£5.4**	**£5.4**	**£5.4**	
Total impact to underlying	**£5.4**	**£0.0**	**£0.0**	**-£0.1**	

Growth funding / target margin

- The finance enabling plan is predicated on the Trust growing its income base (after inflation funding) by £3.3m in 26/27, and then £2.6m every year thereafter.

- There are 2 main ways in which this may materialise:
  - **Growth funding** - Secure growth funding from our commissioners, with no further cost commitments other than those already included within the £3m cost pressure reserve. The Trust has successfully negotiated this in the past (23/24 and 25/26) by securing Mental Health Investment Standard (MHIS) funding, without committing to new spend outside of Board approved plans.

  - **Grow commercial / cost per case income** – The Trust would need to enter into commercial agreements that provide a margin of the values shown above. The % target margin will vary based on the type of commercial arrangements the Trust enters; however a 10% margin should be a minimum expectation when considering options, with commercial research activity attracting up to a 90% margin.

Cash & Depreciation

- Based on the assumptions outlined in this model, cash balances will range between £25m - £33m from 26/27 to 29/30.
- This ensures the Trust can continue to pay its suppliers and staff in a timely manner, without the need for additional cash support from NHSE.
- Cash balances could be subject to change should the Trust spend more on capital than it currently does, without corresponding cash receipts from any disposals.
- Any reduction in cash levels will also have an impact on the level of interest income the Trust receives; this currently averages at £1.8m per year.
- Depreciation ranges between £6.6m and £6.8m in the current model, current NHSE finance rules remove the impact of any favourable or adverse variance on depreciation from the Trust's operational control total.
- No material changes to the Trust's DHSC loan, PFI and Public Dividend Capital payments are expected over the life of the finance plan.
- Although a more detailed table is provided on the following page, this will need to be refreshed once the Trust's funding model for the Estate Enabling Plan is finalised in Q4.

Summary Cashflow

	26/27	27/28	28/29	29/30
Cash and cash equivalents - opening balance	**33.4**	**31.3**	**29.3**	**27.2**
Operating surplus/(deficit)	2.3	2.3	2.3	2.3
Depreciation and amortisation	6.6	6.6	6.7	6.8
Net cash generated from / (used in) operations	**8.9**	**8.9**	**9.0**	**9.1**
Cash flows from investing activities				
Interest received	1.8	1.8	1.8	1.8
Purchase of property, plant and equipment and investment property	(6.6)	(6.6)	(6.7)	(6.8)
Net cash generated from/(used in) investing activities	**(4.8)**	**(4.8)**	**(4.9)**	**(5.0)**
Cash flows from financing activities				
Public dividend capital received	1.0	1.0	1.0	1.0
Movement in loans from the Department of Health and Social Care	(0.4)	(0.4)	(0.4)	(0.4)
Capital element of lease liability repayments	(1.3)	(1.3)	(1.3)	(1.3)
Capital element of PFI, LIFT and other service concession payments	(1.4)	(1.4)	(1.4)	(1.4)
Interest on DHSC loans	(0.1)	(0.1)	(0.1)	(0.1)
Interest element of lease liability repayments	(0.1)	(0.1)	(0.1)	(0.1)
Interest element of PFI, LIFT and other service concession obligations	(1.6)	(1.6)	(1.6)	(1.6)
PDC dividend (paid)/refunded	(2.3)	(2.3)	(2.3)	(2.3)
Net cash generated from/(used in) financing activities	**(6.2)**	**(6.2)**	**(6.2)**	**(6.2)**
Increase/(decrease) in cash and cash equivalents	**(2.1)**	**(2.1)**	**(2.1)**	**(2.1)**
Cash and cash equivalents - closing balance	**31.3**	**29.3**	**27.2**	**25.2**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	2026/27 Savings Programme	**Agenda Item**	Paper T
Sponsoring Executive	Izaaz Mohammed, Director of Finance & Estates		
Report Author	Izaaz Mohammed, Director of Finance & Estates		
Meeting	Board of Directors	**Date**	25 September 2025

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

The paper reminds Board colleagues of ongoing discussions since March 2025 about the route to financial sustainability: a position made more salient by the change to operating guidance which penalises Trust services by discounting the agreed Deficit Support Funding for 2025/6. Change schemes totalling £3.7m were approved in July, covering key areas such as non-pay inflation, reducing utilities / rates / and mobile phone use, seeking commercial income opportunities, and 26/7 approaches to RRP payments.

This paper outlines work to be done over the coming ten weeks to crystallize a similar, if not slightly larger scale, of change focused on altering ways of working, reducing establishments, and consulting some employees about redeployment into other roles. Uncertainty is disconcerting, but if we are to involve leaders at directorate level, and teams affected we need to engage directly and soon.

The paper assumes a single RDaSH wide consultative process for change during Q4 in order both to ensure fairness for staff affected, and to ensure high quality management processes are in place and coordinated.

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

Plan B discussed at March Board (public/private), July Board (private), August Brd timeout

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE the requirement in the Long-Term Financial Model to identify £10m of savings and deliver £7.5m in year to achieve underlying financial balance.

NOTE & DISCUSS the progress made to date in identifying the schemes and indicative values to meet the £10m target.

DISCUSS the key elements of work needed to have a fully worked up plan for each scheme by the end of Q3, including the delivery infrastructure to achieve the target savings.

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

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

People risks

Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	**X**
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
SDR 4							
System / Place impact (advise which ICB or place that this matter relates to)							
SY/HNY ICB – system financial sustainability							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	Will be needed at end of Q3
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							

2026/27 Savings Programme Development

1. Introduction

1.1 The financial history, and delivery of savings schemes, is outlined in the Medium-Term Financial Plan which comes to the Board this month. Over recent years we have made significant savings. This has led us to meet, for example, the corporate overhead reduction target for Trusts before it was due. We are a Trust whose comparative data (using existing measures) suggests relative efficiency in the use of resources. However, in the main, our major savings initiatives have been nested or contained: Goldcrest ward (23/4), Emerald (24/5), Brambles (25/6), facilities (25/6) – only agency (24/5) and out of area placements (25/6) have spread across the organisation *at scale*.

1.2 The savings programme for April 2026 to March 2027 focuses on a significant change to our cost base, whilst acknowledging the need to find income gains from an increasing range of funders. Sustaining financial balance after 2027 is important, rather than one heave to achieve no underlying deficit. Public board papers, committee reports, and briefings to JCC/TUs, have drawn attention to the underlying deficit for some time. Whilst we might see no surprise therefore in the requirements of this paper, we should recognise the extent to which within the organisation people may have discounted the reality of the forward challenge – more so because our approach has previously been more contained.

1.3 **The label plan B needs a reminder:** we entered 2025/26 anticipating setting, with regret, a deficit budget. We worked with ICB funders to find a balanced plan. That relied on a transfer of risk from the ICB to the Trust, which the Board accepted. Our plan for 2025/26 was nonetheless a high risk one, and remains so, in that it required a sizeable transformation of out of area placements to succeed, as well as the creation of a new service: our Phoenix Ward facility. The thinking outlined in this paper was therefore developed in anticipation that a mid-year or late year plan revision or recovery may be required.

1.4 **It remains however an apposite label.** That is because a material part of the financial challenge in 2026/27, in effect the delta, or step up from savings scale in 2024/25 and 2025/26, lies in needing to plan for the failure of the wider NHS system to address two structural funding flow failings – 1) fully funding pay awards negotiated nationally but distributed according to a pay-bill/turnover ratio which does not reflect our position, nor the wider sectors; and 2) gaps in growth funding to reflect population demography or expectations of a left shift. What is outlined here is a plan b substitute for that continued omission.

1.5 The Board has discussed (in private) the development of the 26/27 Savings Programme in July and August, this paper sets out the output of that work and considers the things that need to be in place from January 2026 to enable delivery of the £10m target.

1.6 We will work on developing and agreeing the detail behind each scheme over Q3 with CLE, Care Groups and Directorate Teams, with a plan ready to consult upon meaningfully from January 2026. That timing matters, because as this paper outlines the shallower cut to services, corporate or clinical, is achieved if we maximise the proportion of 2026/7 during which savings are live. The Medium-Term Financial Model suggests a cash out efficiency requirement in 26/27 of £7.5m. We know that there will be some part year effect and lead times to contend with in delivering this level of saving, therefore a target of £10m of schemes is recommended for 26/27 to mitigate this – and if need be contribute to a savings ask roughly half that size in the succeeding two years.

2. Delivery planning

2.1 Some of the schemes covered within this paper, follow from those in the plan B1 material agreed with the Board in July. They are specific projects that can show a yield if delivered, albeit they carry a variety of risks, including testing management bandwidth. There is no assumption that all RRP payments will cease early in 2026/27, but having concluded job planning during 2025, and recognising that we have not set, and should not set, a 10 PA ceiling, we would expect to write to all benefitting from such RRP payments outlining the sunset arrangements that will apply.

2.2 The table below provides a snapshot summary of a possible programme for the year that follows. From that list *the following were agreed in July* (B1) and should be reconfirmed at this Board meeting:

- No delegated non pay inflation (IM)
- Commercial income flowthrough (IM)
- Rates / utilities / mobile phone etc (IM)
- Remove legacy ward RRP from Q4 25/6 (CH)
- Scale back Doncaster PH services to budget (TL)

26/27 Savings Programme

	£m		
Scheme Description	**Saving FYE**	**Expected in year delivery**	
Alter and reduce some community staffing models	3.00	2.25	75%
No delegated non pay inflation	1.60	1.60	100%
Maximum change digital option for clinical admin	1.15	0.58	50%
Changes to corporate functions	1.00	0.90	90%
Commercial income flowthrough	1.00	1.00	100%
Rates / Utilities / Mobile Phone reductions	0.50	0.50	100%
Productivity - cash out	0.50	0.12	25%
Remove RRP from some / all medical roles	0.40	0.20	50%
Remove all legacy ward RRP	0.30	0.30	100%
Scale back services to Doncaster Public Health budget	0.30	0.30	100%
Service workforce changes (LD&F)	0.25	0.13	50%
Total Savings	**10.00**	**7.87**	**79%**

2.3 The further detail outlined within this paper then discusses the considerations with the balance of the proposed programme. This **recognises the Board's commitment not to make further ward closure proposals** in 2026 or 2027, and to retain the localised inpatient model now being delivered until 2028. This is an important confidence building measure, and one that reflects the idea that whilst there are undoubtedly length of stay benefits to be realised, we are not yet operating at 92% occupancy: and the acuity of those within our wards ought, if we succeed with quality improvement work, to rise.

2.4 In headline terms the detail herein focuses therefore on how we can:

- Continue work since 2023 to spend more of each pound on direct patient care: the whole of our programme cannot come from **backbone services**. But some of it must – and colleagues have been working through potential changes with that in mind. Whilst no final decisions are proposed here, we are confident that for November's Board we will have specific proposals on which, subsequently, to consult. These consultation may vary in form, as some proposals may involve transfer of responsibilities and therefore operate with a TUPE premise.

- We spend around a third of the Trust's turnover on **community-based teams**; in adult and children's services, within mental health and physical healthcare. Whilst the left shift and move to neighbourhoods is a priority for us that cannot come with a ring-fence of status quo service models. We know we have varied approaches inside the Trust geography, and we need to find the right balance of generalist and specialist provision.

- Areas of service where **we need to determine the future service model**, as external analysis appears to suggest that we have a relatively expensive service model. The Trust's costings team have done detailed, and award winning, work on the apportionment of our costs and this gives rise to a number of Key Lines of Enquiry. As colleagues within the clinical leadership executive remarked these discrepancies may reflect costing models, which is why the expectation is that only some of these projects will offer opportunities for safe change.

- **Optimising the use of digital technologies**, including in the administration of clinical services. There is some understandable reticence about the pace of change in this field, in advance of a demonstrated AI or other digital intervention on which we can rely. It is clear that from 2027 we will need to be operating with a different headcount in this area (it is a major area of workforce growth since 2019) but we have not yet got a product demonstrated in the field; and we know that we have clinicians doing their own administration (and we

wish to cease that). As such the pace of change implied in this plan may need to be tempered but not paused entirely.

2.5 **During October and early November, executive colleagues and Care Group leaders will work <u>together</u> to develop the ideas outlined in this paper**. This will replace bottom-up CIP development in our directorates, who will instead be asked to:

- Consume any non-pay inflation considerations
- Address any further incremental drift
- Manage proposed cost pressure submissions to the Investment Fund

[Based on mid-year positions, we do expect to grow the yield from backbone schemes to a slightly larger sum that first thought, which may helps us to manage the fourth bullet outlined above]

In working up proposals to alter community provision, we will consider in particular three lines of enquiry:

- The productivity and throughput achieved in our best performing community services
- Differences between teams operating in different geographies
- The implications of teams assimilating a 4% workforce change in each team, which is broadly what the sums involved imply

We will agree some principles, which, in line with the Board's previous discussions make clear that investments to deliver our promises are not to be reversed out of funding unless the promise can be shown to be delivered in a similar manner.

2.6 **Delivery reviews with corporate teams will be used in October to assess the major schemes to meet the backbone changes outlined**. This was indicated to corporate directors in mid-August and will allow the Board to be confident of a further significant portion of the 2026/27 savings programme. Changes will not be simply evenly shared functions – having previously established that the estate maintenance function will change for non-financial reasons, and that the digital capability of the Trust needs some protection (a position now indicated nationally given analogue to digital aspirations in the 10YP).

2.7 Schemes will not be based on pay re-banding. Pay protection invalidates such proposals and the wellbeing consequences of such changes is prohibitive. Nor will we approach change with vacancy freezes. Instead, **our implementation model will be based on maximum flexibility to move roles inside our organisatio**n thus protecting services and jobs where we can. The scale of headcount change is estimated at between 100-150 roles: significant but one that illustrates that the vast majority of RDaSHians will not need to move role to rebalance our finances and services.

Discussion of potential schemes in more detail

3. Reduce roles / redesign work within community teams (£3m)

3.1 This scheme is based on developing a HQTC equivalent programme for community-based teams to reduce unwanted variation and set team staffing based on a consistent case load level, using demand and capacity modelling to inform this.

3.2 The work will likely begin in Q4 to give us time to work through the HQTC changes, ensure there is sufficient bandwidth to engage with this work meaningfully, and deliver the £3m savings assumed in the draft 26/27 savings programme numbers. The table below sets out the budget & WTE in scope per Care Group based on current workings. This information will need to be refined during the implementation of the scheme to determine which areas remain in scope and which ones are covered in other aspects of the savings programme. This currently suggests a reduction in budget of about 3.5%.

Care Group	Budgeted WTE	Total Budget
Childrens	427	21,635,919
Doncaster MH & LD	370	20,448,736
North Lincs & TT	127	7,059,302
Physical Health & ND	472	23,813,911
Rotherham	192	12,023,023
Total	**1,588**	**84,980,891**

Community CIP Target	**3,000,000**

% of total budget	**3.5%**

The apportionment in the table above is not the intended targets – as we need to map teams first. This work will take place during Q3, aided by the end of September completion of work to identify line managers across RDaSH and embed them into ESR. We would hope not later than mid-November to be clear the most likely change scale by community-based directorate.

3.3 At this inception stage this work will be led by seven senior managers working together (COO, CEO, 5x CGDs), with three clinical leaders drawn from our CLE team, and patient voice from the outset. A launch session is being diaried with a view to exploring where the opportunities may lie, and any areas we wish to prohibit from the outset. As with other work in this paper, there is not an expectation that change will be proportionate between Care Groups, as starting points demonstrate some lumpy costs/historic investments.

4. Long term changes to reduce clinical admin costs (£1.15m)

4.1 This scheme recognises the legacy growth in clinical administrative roles but is mindful of the investment decision associated with project Timepiece. The table below includes all B2-B7 admin & clerical posts coded to Care Groups within ESR and their associated cost. This suggests a £1.15m reduction is the equivalent to a 10% cost reduction. This may feel daunting but what it illustrates is that only by large-scale workflow redesign can we deliver the financial gain, and other benefits, sought. That is why continued reflection is needed about the enablers for change at such scale – and the timing of such a project.

Care Group	Contracted WTE	Total Budget
Childrens	76	2,560,530
Doncaster MH & LD	89	2,949,037
North Lincs & TT	48	1,633,413
Physical Health & Neurodiversity	76	2,551,583
Rotherham	52	1,726,040
Total	**341**	**11,420,602**
Clinical Admin CIP Target		**1,150,000**
% of total budget		**10.1%**

4.2 The proposal is a productivity one. We need to work through what volume of work is reasonably expected from roles that are similar, and what conditions are necessary for the new norm to be met. Between 2021 and 2024 the Trust had a project which was arguably in a similar area. Lessons need to be learnt from that project's scope drift and difficulty, but it also means some important data and connections may be in place. Inevitably our work on digital enablers, estate enablers, first line managers and remote working all intersect with this scheme.

4.3 During Q3 we will work to do two things in particular:

- Understand the roles outlined in the table above, comparing scope of roles between teams
- Continue to test technologies which could allow transactional tasks to be part-replaced, recognising that clinical administration is a specialist function that often fills in the gaps – and cannot be simply replaced by AI

4.4 A structure for this work will be established which includes very senior managers from each of our five care groups, working alongside senior clinicians from corporate functions. The timescale for the work will be tight, even if subsequent implementation is slower than before – this recognises the need for clarity for staff, and the past history of 'inclusive projects' which did not

necessarily see benefit from the time taken.

5. Changes to corporate functions (£1m+)

5.1 Since 23/24, the savings made by the Trust have deliberately disproportionately reshaped corporate services, resulting in RDaSH being on track to achieving the NHSE target of reducing corporate cost growth by 50% from 2026/27. Whilst this is good news and puts us ahead of peers in this space, there are more opportunities to realise savings, and grow the portion of RDaSH £ which is spent on patient facing services.

5.2 Previous efforts in reducing corporate costs have largely focussed on removing posts that have been held vacant for 6-12 months. This 26/27 plan is focussed on more material changes, which will end some functions, and reshape others. This is not based on reallocating work, but on making choices to stop some forms of work. This paper outlines timings for final draft proposals from executive directors at the end of October. But we know we are likely to see that include: payroll function changes to meet peer costs; changes to some contracting functions; alternations within the finance team; and changes to audit and some other corporate clinical functions.

5.3 In addition to these cost-related choices, the Board is being asked to agree some other changes that relate to operational functionality. This includes changes in pharmacy, in procurement and in estate maintenance. The basis for these changes is different to those covered in the prior paragraph.

6. Changes arising from peer cost comparison

6.1 The Trust as a whole is ostensibly relatively cost-efficient when compared to some peers. That statement reflects the index of costing used nationally, where RDaSH is arguably the most VFM mental health and community provider in England. However, we know that some services stand out distinct from that pattern. Those teams have been advised of their positioning and between September and November's Board we will work with those teams to understand the basis for this high-cost discrepancy.

6.2 That work will then allow us to hone choices about where to concentrate the productivity gains programme highlighted within this savings programme. This may involve some roles being disestablished or not filled. But it may also relate to costs for consumable and non-pay services. We need to recognise that the Trust through the pandemic appears to have accepted a number of previously pass through costs as block lines, especially in physical health services: this position is not consistent with national policy of funding flows, and needs to be reconsidered as we move towards 2026/27 contracting.

7. Recommendations

The Board is asked to:

- Note the requirement in the Medium Term Financial Model to identify £10m of savings and deliver £7.5m in year to achieve underlying financial balance.

- Note and discuss the progress made to date in identifying the schemes and indicative values to meet the £10m target.

- Discuss the key elements needed to have a fully worked up plan for each scheme by the end of Q3

Izaaz Mohammed

Director of Finance & Estates

19th September 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Estate Plan Update	**Agenda Item**	Paper U
Sponsoring Executive	Izaaz Mohammed, Director of Finance & Estates		
Report Author	Izaaz Mohammed, Director of Finance & Estates		
Meeting	Board of Directors	**Date**	25 September 2025

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

This paper sets out the four areas of work in relation to the Estate Plan that will be progressed in H2 to enable an outline business case to be brought before the Board in March 2026.

These are:

- Identify Rotherham estate options
- Identify a funding model
- Develop visuals for a future Health Village on the THR site
- Develop the business case for a Heat Network on the THR site

Engagement with external partners such as NHSE, SYICB, Doncaster LA, Homes England, HNDC and others will be key in progressing these workstreams, with support from a specialist estate development advisory firm being explored.

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

At various Board and FDE committee meetings over the past 12 months, most recently at the August private Board meeting.

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE the areas of work outlined in the paper that need to be progressed over H2 to bring an outline case before the Board in Q4.

DISCUSS any areas not outlined in the paper that Board members feel should be incorporated into the H2 work plan.

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

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	**X**
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
N/A
System / Place impact (advise which ICB or place that this matter relates to)
SY ICB – system financial sustainability

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

Appendix (please list)
Annex 1 – Current THR Site

Annex 2 – Future THR Site (one option for)
Annex 3 – Rotherham Planned Retained Estate (probable)
Annex 4 – North Lincs Planned Retained Estate (confirmed)

Estate Plan Update

1. Introduction

1.1 The Board has discussed the development of the Estate Plan in public and private at several points over the past 12 months. The discussion at the August Board Development session included detailed information on the current estate occupied by the Trust in Rotherham, Scunthorpe and Doncaster, and the funding considerations over the next 3 years to enable the delivery of the plan.

1.2 Our Estate plan is focussed on delivering on 3 key aspects:

- Better spaces for our people and teams.
- Improving productivity in what do by separating patient facing space from other areas, including the provision of education and research space.
- The provision of high quality and therapeutic patient appropriate spaces, for example around dementia and neurodiversity accessibility.

1.3 This paper doesn't aim to summarise or restate the content and discussion from the August development session, but rather outlines what is left to do to move the Estate Plan to an engagement phase with colleagues, patients and partners from early 2026. This work is explored in further detail in the paper, and can be broadly categorised as follows:

- Identify Rotherham estate options
- Identify a funding model
- Develop visuals for a future Health Village on the THR site
- Develop the business case for a Heat Network on the THR site

2. Rotherham Estate

2.1 The Rotherham chapter of our Estate Plan is the one that contains the most unknowns at this stage on alternative accommodation which the Trust might look to move in to. We know that capacity to see more patients in our non-inpatient services across Rotherham has been one of the reasons for slower progress on productivity and waiting list reduction work.

2.2 Leased properties such as Kimberworth Place, Badsley Moor Lane and Centenary Clinic offer poor quality spaces for our colleagues and patients, with Trust owned Ferham Clinic requiring some minor works investment to improve the useability of some clinic spaces. An Elizabeth Quarter type solution for Rotherham to address these issues could potentially be the Riverside building. This building is used by Rotherham Council, SY ICB and other partners, and owned by the local authority. The Trust previously discussed the potential for taking on the ground floor library space, and this is being explored further with the newly appointed council CEO who has indicated a decision in December 2025.

2.3 There isn't an abundance of high-quality leasable space within Rotherham, so more work is needed to identify potential interim and alternative solutions at this stage. An initial mapping of community assets has been completed in Rotherham and this information will be reviewed and used in discussions with local partners to identify potential solutions. In all scenarios we will adopt the strict distinction of patient facing space from employee spaces which is being applied to the Elizabeth Quarter design.

2.4 Work cited under the above two paragraphs cover Talking Therapies, Children's Services, LD provision, and Adult Mental health care.

2.5 RDaSH inpatient space in Rotherham is housed across Swallownest Court and Woodlands. Acute adult inpatient and PICU services are delivered out of Swallownest Court, with wards undergoing a full refurbishment in recent years. There is vacant space within this building resulting from the closure of a ward 2 years ago (Goldcrest). This could accommodate a future additional High Dependency Rehabilitation Unit with modest capital investment if the Trust and ICB reach agreement on this over the balance of 25/26: this obviously relies on the initial success of the Phoenix Ward when it opens in October.

2.6 Entrance in to and around Swallownest is confusing and no provision of a catering space exists on the site. These aspects would benefit from some capital investment in the future, and in the case of a catering facility the potential to partner with a local or national supplier to deliver basic amenities for colleagues and people visiting Swallownest Court.

2.7 The Woodlands is a purpose-built older adult in patient unit which is situated at the back of The Rotherham Foundation Trust Hospital site on Moorgate Road. The unit is approximately 15 years old and is sited on land which is owned by TRFT and leased to RDaSH on a 99-year lease. With the decision to close Brambles ward in March, the building now houses The Willows ward which provides both functional and organic older adult mental health care. There is lots of potential to utilise the space at Woodlands in a more efficient way, and a future medium-term solution might include the use of the space by partners such as Rotherham Hospice and TRFT. Discussions to do this have stalled over the summer months and now need to be reinvigorated.

3. Funding Models

3.1 The Board has previously discussed a route to funding the Estate Plan through CDEL and land sale receipts over a 3-year period. Whilst this is the current working version of the funding model, other options are also being explored, and these must be firmed up and reviewed in detail over the balance of Q3.

3.2 Based on the high-level plans explored to date, the capital funding requirements of the Estate Plan range between £35m-£40m. Assuming current levels of system CDEL (£7m per year) continue over the 3 year period, this leaves around £14m-£19m to find from other sources such as land sales, system capital brokerage, or non CDEL funding models.

3.3 Further guidance on private finance initiatives linked to neighbourhood health centres is expected later in 2025. This may provide part of the solution to squaring off any

financial gap from CDEL and land sales alone, however the Trust is working with external partners to look to alternative arrangements such as managed service and pay as you go options in addition to this.

3.4 The Trust will need to engage with NHSE, the Valuation Office Agency and its external auditors over Q3 to confirm the current market value of the land, confirm the audit requirements that the Trust must meet to recognise land sale receipts over multiple years, and obtain confirmation from NHSE that RDaSH can retain the proceeds of any sale to reinvest in more capital spend. There are recent local examples of other NHS Trust's being allowed to do exactly this, so this remains very low risk.

3.5 Sale and leaseback of land will form a key component of any future build project. The Trust will need to engage with potential interested parties over the next quarter to explore options and work through any regulatory and audit approvals needed to make this happen.

3.6 We are in the process of appointing a healthcare advisory service which specialises in NHS estate development, management service provision and procurement to lead this element of the work. They will report directly to the CEO in October and November, and then the incoming CFO from December.

4. THR Health Village

4.1 The overall size and potential scale of development on the Tickhill Road site is best demonstrated by physically walking around the site, an approach we have taken with several partners in recent months.

4.2 We do however need to ensure that prior to any meaningful engagement with colleagues and patients, we are able to provide some visuals of what the future site may look like. This element of the work will focus on engaging with an architect to develop plans which show a Health Village on the THR site that incorporates a step up frailty facility, education and research accommodation, space for backbone services, amenities and community space including a cafe, parkland, play area, gym and pharmacy.

4.3 A similar visual will also be created for the Swallownest Court site, and any other Rotherham Estate which the Trust agrees to develop in the Estate Plan.

5. Energy Centre & Heat Network

5.1 The Trust's Green Plan sets out 5 priorities:

5.1.1 Estate Decarbonisation – Targeting a 500-tonne annual reduction in gas emissions through building rationalisation and capital projects, despite funding challenges.

5.1.2 Business Mileage – Aiming to cut emissions by 200 tonnes annually by optimizing route planning, increasing electric vehicle use, expanding charging

infrastructure, and promoting sustainable travel schemes.

5.1.3 Digital Transformation – Leveraging digital tools to reduce paper use by 20%, expand virtual care pathways, and procure low-carbon IT hardware with net zero supplier requirements.

5.1.4 Food Waste Reduction – Reducing waste from 137 to 30 tonnes annually via smarter inventory management, portion control, sustainable menus, and food redistribution partnerships.

5.1.5 Climate Adaptation – Preparing all services for climate impacts through benchmarking, adaptation planning, staff education, and supplier engagement.

5.2 The Estate needs to ensure that it supports the delivery of the Green Plan, especially in relation to priority 1 – estate decarbonisation. Reliance on gas to power our buildings uses 1,896 carbon tonnes per year, which is approximately 53% of our total emissions. Reducing our need for fossil fuels like gas provides an opportunity to make a significant reduction on our emissions.

5.3 In addition to this, our current services on to the THR site are routed through the area which would form part of the land disposal needed to fund the estate plan. Therefore the estate plan development gives us the opportunity to build an energy centre on the retained land, with a focus on renewable and sustainable energy use that also helps us meet our Green Plan goals.

5.4 Initial work will focus on the development of a Heat Network, using Heat Pumps as an energy centre on the Tickhill Road site. A heat network (district or communal heating) is a system of insulated pipes that delivers heat from a central source to multiple buildings or individual flats/offices. Instead of each building relying on individual gas boilers or heat pumps, heat is generated at scale and distributed, allowing the use of low-carbon and renewable sources such as heat pumps, waste heat from industry, data centres, or energy from waste plants.

5.5 RDaSH is exploring the potential to decarbonise its estate through the development of a heat network delivered via a Public-Private Partnership (PPP) model. To test this opportunity, we are undertaking a high-level assessment to examine the best route to take that could attract private investment and deliver long-term, low-carbon heat supply.

5.6 We are working with an organisation, HNDC, with expertise in this area to define the steps to completing an outline business case and securing funding. HNDC Ltd is a specialist heat network consultancy supporting the development of low-carbon, commercially viable schemes across the UK.

6. Next steps and recommendations

6.1 Several annexes are included alongside this paper which set out the retained properties within North Lincolnshire and Rotherham, as well as an indicative disposal and development map of the THR site.

6.2 Progress against the four areas outlined in this paper will be reported through the FDE committee, with an update to the Board in March. This timescale will enable the Trust to be able to meaningfully engage with colleague from Q1 26/27.

6.3 The Board is asked to:

6.3.1 Note the areas of work outlined in the paper that need to be progressed over H2 to bring an outline case before the Board in Q4.

6.3.2 Discuss any areas not outlined in the paper that Board members feel should be incorporated into the H2 work plan.

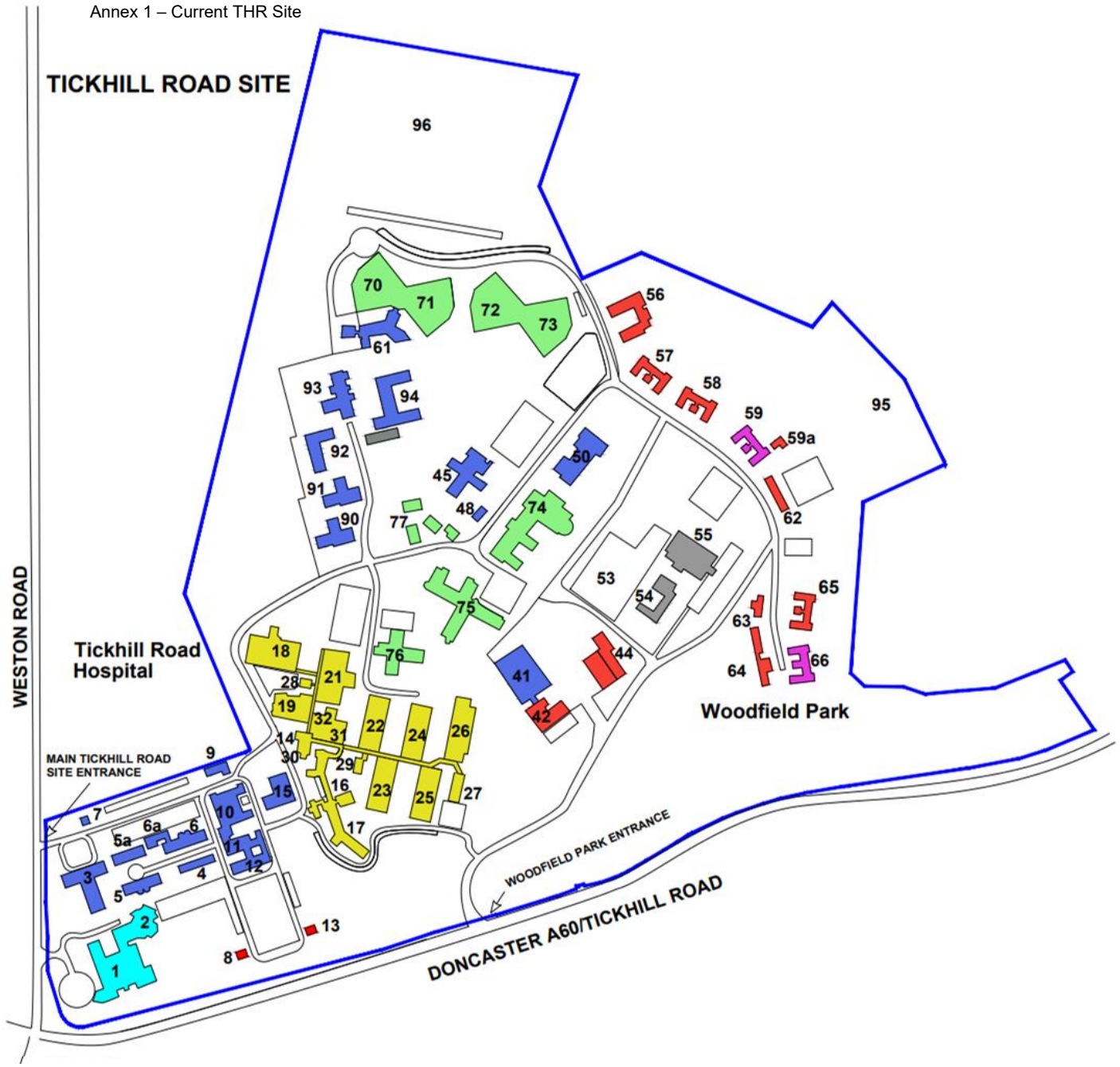
Izaaz Mohammed

Director of Finance & Estates

16th September 2025

Annex 1 – Current THR Site

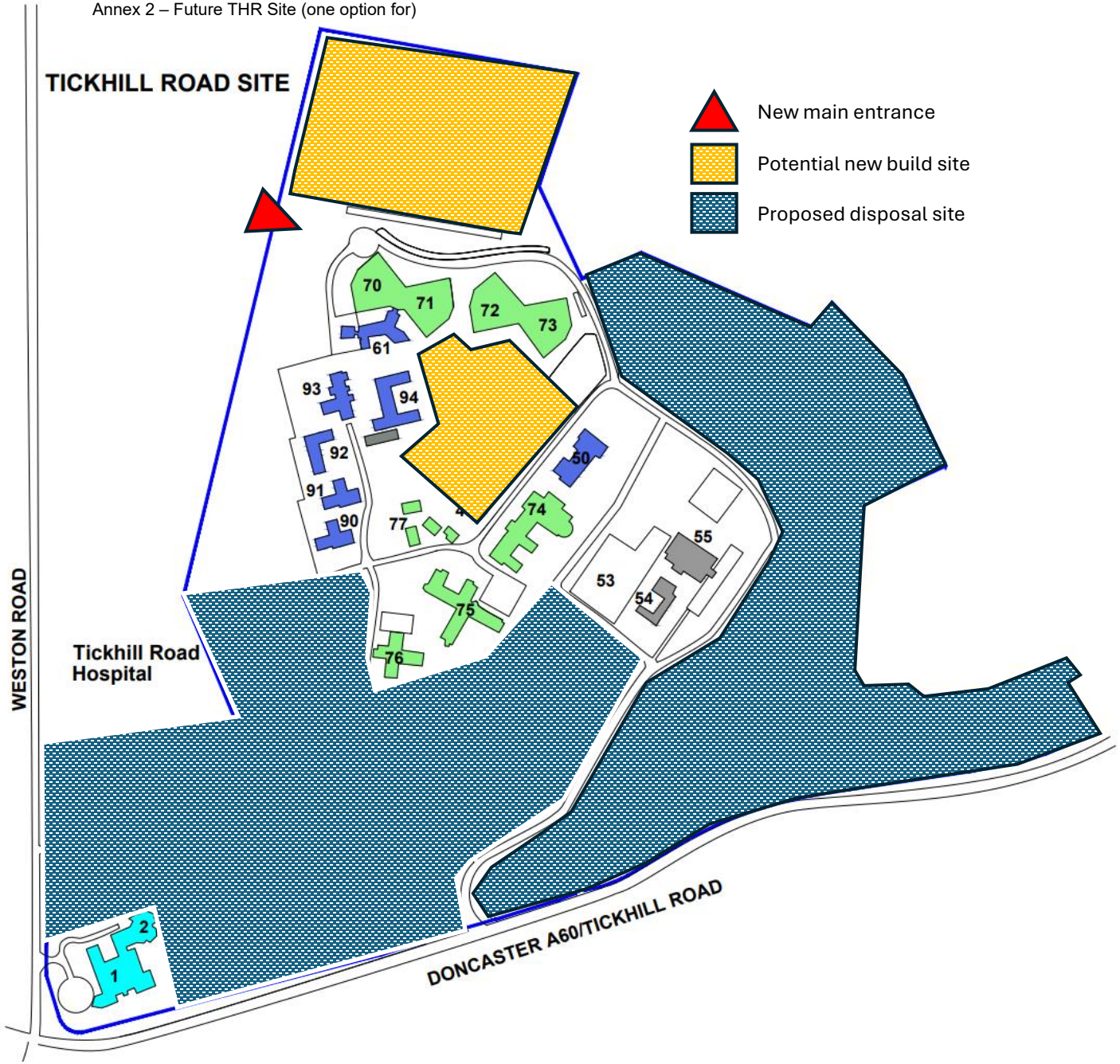
Current Tickhill Road Site



1	St. John's Hospice
2	St. John's Information and Support Centre
3	Forest Gate
4	Blossom Lodge
5	Meadow View
5a	Crystal Building
6	Sewing Room
6a	Rosewood Lodge
7	Security Cabin
8	57 Tickhill Road
9	Rose Lodge
10	Print Services
11	Food and Drink Cafe
12	Woodfield House
13	59 Tickhill Road
14	Well Bean Cafe
15	Laundry
16	Chapel / Spiritual Care Centre
17	Honeysuckle Lodge
18	Former Elm Ward
19	Evergreen
21	2 Jubilee Close
22	Hawthorn Ward
23	Hazel Ward
24	Holly Lodge
25	Maple Lodge Wheelchair Services
26	Magnolia Lodge
27	NROT Neurological Rehabilitation Outreach Team
28	IT Training Room
29	Store
30	Main Entrance / Reception
31	Physiotherapy Department
32	Occupational Therapy Department
41	Main Stores/Estates Workshops
42	Walnut Lodge - Yorkshire Ambulance Service
44	Woodfield Leisure and Squash Club
45	Onyx Centre
48	Amethyst Lodge
50	Diamond Activity & Therapeutic Services
53	Flourish - Walled Garden
54	Old Stable Block
55	St Catherine's House/Café Flourish
56	Cherry Tree Court
57	Oak Tree Lodge
58	Park Lodge
59	Almond Tree Court
59a	Woodbury Court
61	Skelbrooke Ward
62	Kale Lodge
63	Sorrel Lodge
64	Community Hall & Bergamot Centre
65	Hyssop Court
66	Chestnut View
70 - 71	Cusworth / Brodsworth
72 - 73	Coniston Lodge / Windermere Lodge
74	Opal Centre
75	Amber Lodge
76	1 Jubilee Close
77	PFI Bungalows
90	1 Catherine's Close
91	2 Catherine's Close
92	3/4 Catherine's Close
93	Sapphire Lodge
94	Coral Lodge
95	Wadworth House Land
96	Loversall Land

Annex 2 – Future THR Site (one option for)

Future Tickhill Road Site



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~~4~~	~~Blossom Lodge~~
~~5~~	~~Meadow View~~
~~5a~~	~~Crystal Building~~
~~6~~	~~Sewing Room~~
~~6a~~	~~Rosewood Lodge~~
~~7~~	~~Security Cabin~~
~~8~~	~~57 Tickhill Road~~
~~9~~	~~Rose Lodge~~
~~10~~	~~Print Services~~
~~11~~	~~Food and Drink Cafe~~
~~12~~	~~Woodfield House~~
~~13~~	~~59 Tickhill Road~~
~~14~~	~~Well Bean Cafe~~
~~15~~	~~Laundry~~
~~16~~	~~Chapel / Spiritual Care Centre~~
~~17~~	~~Honeysuckle Lodge~~
~~18~~	~~Former Elm Ward~~
~~19~~	~~Evergreen~~
~~21~~	~~2 Jubilee Close~~
~~22~~	~~Hawthorn Ward~~
~~23~~	~~Hazel Ward~~
~~24~~	~~Holly Lodge~~
~~25~~	~~Maple Lodge Wheelchair Services~~
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~~32~~	~~Occupational Therapy Department~~
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~~42~~	~~Walnut Lodge - Yorkshire Ambulance Service~~
~~44~~	~~Woodfield Leisure and Squash Club~~
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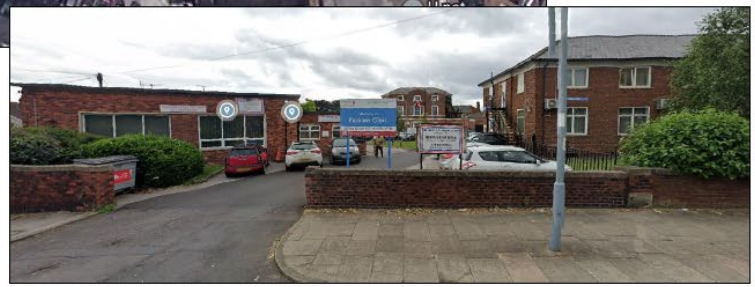
74	Opal Centre
75	Amber Lodge
76	1 Jubilee Close
77	PFI Bungalows
90	1 Catherine's Close
91	2 Catherine's Close
92	3/4 Catherine's Close
93	Sapphire Lodge
94	Coral Lodge
95	Wadworth House Land
96	Loversall Land

Annex 3 – Rotherham Planned Retained Estate (probable)

25. FERHAM CLINIC

Key Information	
Age (year built)	1960
Address	149 Kimberworth Road, Rotherham, S61 1AJ
Tenure	RDaSH
Services provided	Adult Mental Health and Talking Therapies- Outpatients and Team Base
Building size ($GIAm^2$)	909.11
Land size (hectares)	0.29
Condition rating	B
Cost to repair	£368,145



27. SWALLOWNEST COURT HOSPITAL

Key Information	
Age (year built)	1992/2011
Address	Aughton Road, Swallownest S26 4TH
Tenure	RDaSH
Services provided	Adult Mental Health in-patients and team base.
Building size (GIAm^2)	4990.59
Land size (hectares)	2.66
Condition rating	B
Cost to repair	£944,390

Annex 3 – Rotherham Planned Retained Estate (probable)

28. WOODLANDS

Key Information	
Age (year built)	2011
Address	Rotherham General Hospital, Moorgate Road
Tenure	RDaSH own the building, land is on a long lease from RFT
Services provided	2 Elderly inpatient wards and community teams. And 1 Decant Ward
RDaSH occupied space (m^2)	3454.52
Condition rating	B
Cost to repair	£711,050

36. GREAT OAKS

Key Information	
Age (year built)	2005/2011
Address	97A Ashby High Street, Scunthorpe DN16 2JX
Tenure	RDaSH
Services provided	Adults in-patients/outpatients and community teams - 35 beds
Building size (GIAm^2)	3293.09
Land size (hectares)	1.52
Condition rating	B
Cost to repair	£386,800

39. ST NICHOLAS HOUSE

Key Information	
Age (year built)	1988
Address	Shelford Street, Scunthorpe, DN15 6NU
Tenure	RDaSH
Services provided	CAHMS
RDaSH occupied space (m^2)	811.92
Condition rating	B
Cost to repair	£252,060

Annexe 4 – North Lincs Planned Retained Estate (confirmed)

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Further update on community mental health services (adult)	**Agenda Item**	Paper V
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	25 September 2025

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

This paper follows from, and assumes some knowledge of, matters discussed in July in the private section of the Board about quality of care in some of our community mental health services. The paper identifies important work to improve outcomes and patient experience, and of course is drafted mindful of other papers on future service scale, investment and savings required.

There is no Board decision to make, but the information involved likely shapes to a 'taskforce' style approach to re-design and improvement during 2026 – which may cover more services than are considered here. In contrast to HQTC, we are seeking now to complete the analytical and issue-identification work in advance of taskforce formation. We will shape this work further over coming weeks and look to ensure we have clearly in place the management bandwidth for this work ready for Q1 2026/27.

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

n/a

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the update on thinking regarding improvements for patients

RECOGNISE the synergy between this work and our wider neighbourhood working agenda

DISCUSS the level of current insight among Board members and how we can develop a shared knowledge base through which to support teams with improvement work in the year ahead

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
SDR 1 and 3
System / Place impact (advise which ICB or place that this matter relates to)
Overlap to system financial plan likely draft for 2026/27

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Further update on community mental health services

1.1 This paper outlines a series of issues. It is presented to underscore the need to approach them in a coherent manner, together, because otherwise service leaders and staff members will experience multiple potentially conflicting improvement agendas. There are highly likely more issues than those listed, both ones that offer encouragement about services, and areas of concern.

1.2 In the period to 2023, nationally and locally, a programme of community mental health 'transformation' was undertaken. This came with investment, and importantly involved extensive co-design work with VCSE, primary care and patient partners. Partners' experiences of this work varied and leaves mixed memories of our willingness to listen and to change – and as we move into further neighbourhood re-design, we need to recognise that legacy.

1.3 In different places our adult community based mental health teams work very differently. What is in place is the output of different investment and commissioning decisions over many years. In some ways, these differences shape to local circumstances, albeit we should not be misled to think all variation of population health led. In the main the commentary offered here relates to our community mental health teams (adult and older adult), assertive outreach services, home treatment teams, and early intervention psychosis services. By extension liaison and crisis teams are not included, forming part of our acute directorates alongside inpatient care.

Waiting times for access / service scale

2.1 Through our work on promise 14 we continue to try to achieve a four-week maximum wait for access. Since the Board last discussed these waits in July, we have seen improvements in waits and the timeliness of delivery of this standard, with increasing confidence that the measure can be met across all services covered by this paper – and largely in early 2026. With delivery reviews taking place before the Board, the most up to date position can be discussed if need be.

2.2 Clearly, the services discussed here do not only receive referrals through primary care partners, but, in some cases entirely, take work from other parts of our mental health system. In ensuring that we meet promise 14, it will be important that access for one 'stream' does not defray access for others. We know through work within the High-Quality Therapeutic Care taskforce that we must ensure that any patient admitted who needs access to community-based care not only needs to obtain that but to have a key worker involved in handover and review. During Q3 we will finalise the dataset through which to

analyse our practice, as there appear variations, which the 'standard work' approach to inpatient flow is exposing.

2.3 As is discussed below, we also need to consider the underlying caseloads supported through these teams. These are typically subject to some guidance and guidelines nationally, often derived through professional consensus. As we move more decisively towards use of the DIALOG+ tool, it will also be possible to consider those caseloads against the actual clinical role our teams are playing in the support and recovery of patients: this is likely to be a more refined assessment of workload than 'listed' numbers.

2.4 The final part of the picture is the experience and skills within our teams. Turnover (exit) and turbulence (movement) is tracked, and whilst we have substantially reduced vacancy rates over the last two years, we are building a 'rich picture' currently of each of these community teams to understand the skill mix and professional experience brought together within each.

National review of assertive outreach services (AOS)

3.1 Further to the Calocane enquiry outcome, the Board has spent considerable time discussing the lessons that we need to draw from what happened. There has to be a recognition that harms and errors could happen here, as elsewhere. Work reported within our Board papers consider our approach to both engagement/disengagement and out of area placements – two key findings in that work.

3.2 NHS England published a set of key lines of enquiry to ICBs and Trust in 2024 and subsequently have sought assurance against those standards. Through Richard Chillery, working with our three community directorates under AMH Care Groups, progressing the standards and assessment has been led through service manages and consultant psychiatrists, with their teams. Recognising that we host AOS in Doncaster and Rotherham, and there are some variations, our latest standard return (June) is amber for most measures among the list below, with the exception of 'clear and effective information sharing protocols are in place' where we have further improvement (current state red) – as a system – to achieve:

- Strengthened partnership working
- Effective systems in place to provide assurance of safe staffing
- Arrangements in place to ensure equitable access
- Key worker and caseload management is fully in place
- Multi-agency coordination outside core hours
- Individuals have a care plan in place
- Effective assessments of local services

For measures related to hearing about patient experience and views, we have self-assessed as good – consistent with wider Trustwide work.

Accordingly of the pre-populated assurance statements allowed, we have declared “we have started to make progress in improving our intensive and assertive community care, however, are still unable to provide full assurance that we can fully meet the need of this population group.”

3.3 Nationally the focus is solely on AOS assessment. In approaching issues of safety, community-based care, and indeed Board assurance, we wish to take a wider view across the services considered within this paper. We will continue to work with the ICB to ensure we engage with the national process, but will use the wider infrastructure outlined in this paper to take forward the issues arising. The Board may be concerned by the absence of an AOS offer for patients in North Lincolnshire, and in responding to commissioning intentions for 2026/27 from Humber and North Yorkshire ICB, we will seek clarity on the compliance of that position with more recent national operating guidance.

Independent review of a specific patient’s care

4.1 In February and March 2025 we discussed circumstances associated with a specific patient’s care within community based mental health services. That patient is no longer under the care of our teams, and we have completed the independent review we commissioned in spring 2025: the outcome of the review has been shared with family members and efforts made to share them with the patient concerned. A domestic homicide process is also ongoing, to which the Trust is contributing, which aligns with this review.

4.2 Our independent review concludes that there are important lessons to be learnt to improve services from the care we provided, as well as examples of good practice. The seven recommendations cover the following areas:

a) Staff understanding of autism
b) Weak care planning and a lack of multiagency support
c) The mental capacity process, including the more nuanced approach needed for people with neurodiverse needs
d) How part time consultant staff coordinate their work together
e) Incomplete carers’ assessments and
f) Commissioners discharge of their CTR responsibilities

4.3 The wider process of partners’ investigations is likely to conclude in the early part of 2026. The Trust has consistently engaged with other agencies including NHS England and relevant ICBs to ensure that there is proportionate awareness of this case, and it may be that the review we have done and the DHR will be followed next year by other processes of enquiry.

Our independent enquiry was not to forestall the actions of others but to ensure rapid insight locally.

4.4 *There is no obvious basis for considering that the recommendations would only apply to the one team or pathway involved*. Our approach will need to assume similar weaknesses may be apparent in similar Trust services.

- We already have in place processes to seek to alter our care planning to be more patient-led, though implementation of DIALOG+. The training and implementation of that work has to be mindful of this report.
- We have a clear commitment to reshape and rescale our use of carers' assessments through Promise 2, and that deployment likewise has to be mindful of this report
- We are reviewing, alongside job planning, areas of the Trust where part time roles, or formal job shares, are in place to put documents into operation that describe the joint working of professionals
- A review of our use of the Mental Capacity Act has been taking place this summer, and an implementation plan for improvement is due in the October delivery review of the Nursing and Facilities directorate and
- We have an extant plan for neurodiversity training, initially among ward -based staff, and are reviewing now how we can support that at larger scale across community teams in 2026/27

This more "widespread" approach in no way denies the specific harms or reality of the case reviewed: however, it does learn from previous salient patient safety incidents that applying improvement work solely to a name or specific example of harm is not always as emotionally engaging as can be assumed in the moment.

Care planning and DIALOG+ rollout

5.1 In 2024 the clinical leadership executive agreed a two-year programme of training and deployment of the DIALOG+ tool, including as a replacement for the Care Programme Approach (CPA). This work has progressed well and training uptake has been positive. We decided to include children's services in the rollout, which some other Trusts have not, and that engagement and co-shaping if progressing well. Given our focus on transitional care this consistency will be important in the future. It may be helpful during Q3 to consider DIALOG+ more generally as a Board; as it lies at the heart of work to tackle inpatient improvements in care too – and is the likely basis, through paired outcome data, for much of our quality work within the Quality and Safety Plan, with that element being a focus for our insights and innovation discussions.

5.2 The first priority has been to ensure that patients that meet a CPA threshold have either a CPA or Dialog+ plan. At the time of writing we have reduced to 6 (Rotherham) and 14 (Doncaster) the number of patients still missing either. There is a further group of patients (2,829) who do not meet the threshold for CPA and do not currently have a defined care plan. Weekly tracking is in place to rapidly resolve the status of these patients during Q3 and early Q4.

5.3 The need for this work gives rise to significant learning about the management culture that we need to support inside community services, and the level of data-driven clarity needed to operate caseloads, service flow, and measure outcomes with the precision we intend. We will include measures relevant to these issues in the revised quality and safety section of our IQPR, which is being scoped to final form during October.

No wrong referral?

6.1 Board members will recall our intention to seek to improve the referral experience of patients, and of GPs in particular. We commissioned work, which has been delayed in concluding, from Primary Care Doncaster to map and understand patterns of rejection, cross referral and other blockages in primary care facing mental health services for adults. This work is intended to inform a 'best fit' assessment of where patients need to be supported that works across RDaSH, rather relying on GP mastery of sub-specialised services at the Trust.

6.2 In support of this idea, and the problem behind it which was vivid in our 2024 annual members' meeting with the Board, we are working through developing an AI capability to better route referrals based on textual understanding of underlying symptoms and patient story. This work is complex and is unlikely to reach maturity before 2027, but it has both face validity and considerable promise.

Disengagement/engagement policy

7.1 The majority of patients within our adult and older adult mental health work are supported through the teams considered in this update paper. Accordingly, their work will be *especially impacted* by the now approved and policy referred to in the Chief Executive's report. Colleagues will recall this follows from a 2023 PFD report locally, as well as from national insights from difficulties elsewhere. Despite that prominence, there has not been a consistent template or approach nationally and considerable has gone on led through RDaSH to try to develop the new approach we will take. That includes a core performance dataset, which will be used for the first time to consider the implementation baseline in Q4 25/26.

7.2 DNA reporting in the Trust has been overhauled, and this does mean that it should be very straightforward for clinicians and managers to visualise patients who have not attended for care as expected. The policy sets clear expectations and timescales, with professional judgment at its heart, about how we will respond in those circumstances. The policy takes account of revised national guidance into the use of risk assessments, for example referred to in recent publications regarding reducing suicide risk (Staying Safe from Suicide).

The improvement journey 2026

8.1 It is important to be explicit that there is tremendous and high-quality work being done with patients in all of the teams involved in this paper. We know that from the 2024 Community Mental Health patient survey where we were considered to have performed above expectations, and that datapoint is prominent in our national league table assessment. We would hope that a focus on what works less well, including less consistently, can be replaced later in 2026/27 with a focus on outcomes of care.

8.2 Notwithstanding that acknowledgement there is cause for concern in the variability of approach to key working practices and pathways indicated in this paper, but also in the limited oversight in place through data of how consistently we are applying agreed approaches. Building on learning from the work on promise 14, on care planning and in assessing AOS services we need to construct a programme of consistent improvement for 2026. That must include implementation of the recommendations from the independent review.

8.3 During Q3 we know we will have to make difficult choices about the scale, shape and size of community services, including teams within this paper. It is not the case that the difficulties relayed present a case to not take that step. Whilst there are elements of workload issues contained herein, the majority of issues outlined reflect working practice difficulties.

8.4 Working with our care groups, the author and Chief Operating Officer are considering how best to develop a taskforce style improvement programme for community-based services from April 2026, which needs to take account of neighbourhood health, and within that possible team geography changes too. **We will return to the Board in January and March to outline the approach. A report on intended implementation of work in relation to the independent review will go to the Quality Committee in November.**

8.5 In undertaking some of this work to date, we have paired with colleagues in South -Yorkshire Mental Health Trust, which has added to our insight. It had been the intention to work across the whole MHLDA Collaborative in South Yorkshire, but the funding changes made by the ICB have led to a de-

prioritisation there of this work – accordingly we will continue alongside SWYMHT and also explore whether insights from Navigo could add value to how we are working.

Toby Lewis, Chief Executive
17th September 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality & Performance Report (Mth 5 YTD)	**Agenda Item**	Paper Wi
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	25 September 2025

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

There are no material deteriorations since last discussed with the Board eight weeks ago, and there are some areas of improvement, including continued success with S136 access and sustained delivery of RTT. We are working with MHLDA partners on issues relating to Talking Therapies' recovery.

The IQPR has some new LOS metrics included, and mindful of the indicator used for the national league table now, we will continue to iterate what measures we use, recognising our overriding intention to see bed use reduce, but potentially higher acuity patients stay with us – meaning raised average LOS: 48% of our patients stay beyond 32 days. More generally we are finalising alignment of the IQPR with the league tables and anticipate improvement not later than Q4 in our 2 hour community access measure.

There has been an increase in the number of ligatures graded as near miss, moderate or above in all inpatient areas to 14.29% (target 10%) (QS27). Upon deep dive it is due to two patients with repeated ligature attempts. Ligatures were identified and removed by staff during appropriate security checks.

There is continued improvement in PDR levels, with the sustained focus. However, an area of concern is the high level of sickness absence levels which is above target (5.79% vs 5.1%), with RDaSH as an "outlier". The care group with the highest sickness absence rate is RCG at 8.55%.

The Trust is reporting a deficit position of £426k at the end of August (month 5); this is £6k better than planned and we have seen an improvement in the number of directorates overspent, which now stands at 2 (not 6). This is qualified by a number of cumulative risks related to the deficit position of the ICB; unfunded Agenda for Change pay settlement at 3.6% instead of the planned 2.8%, the ICB funding 50% of appropriate out of area placement activity and the possibility of liabilities arising from the band 4 to 9 national nursing job profile exercise. These risks will be monitored and factored into the forecast as appropriate: all feature in our national reporting return monthly.

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

Clinical Leadership Executive and relevant committees of the Board

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE reported delivery and consider areas of under achievement

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

SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X

SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			X
Alignment to the plans: (indicate those that this paper supports)			
People and teams plan			X
Finance plan			X
Quality and safety plan			X
Equity and inclusion plan			X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	X
External and partnership risks			
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X
Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)			
System / Place impact (advise which ICB or place that this matter relates to)			

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

Appendix (please list)

Integrated Quality Performance Report

September 2025 Review

Data as at the 31st August 2025

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1.0 Executive Report

Performance Report – Year End July 2025

This report outlines performance across our Top Nine and the key metrics which relate to operational efficiency, quality, workforce, and financial metrics for the month ending August 2025.

Performance Highlights and Areas for Improvement

Top Nine

the Trust has prioritised delivery of nine key metrics in 2025/26. Monthly Performance Clinics continue to provide enhanced oversight and a targeted approach to performance management. Tailored improvement plans, along with weekly performance monitoring and forecasting enables the Trust to successfully achieve several key targets, including those for Children and Young People's Access (T901) Out of Area Placements (T904) Dementia Diagnosis (T906) Perinatal Services Access (T907b), Access to Individual Placement Support for North Lincolnshire (T908), and we are on target to achieve the % number of services meeting the 4WW for the end of Q2 (LTP03).
However, there are some metrics where we continue to require intervention.

In our **Talking Therapies service** (T903a,b,c) The Access Rate performance is 7,252 for the year-to-date position against a target of 9,374. We are reporting that there are an additional 655 people accessing the service when compared to the same period last year however, we are forecasting that we will not achieve the 2025/26 target. At the current trajectory, we are predicting to see an increase in approximately 2,000 access contacts for the full year effect from 2024/25, which is a 12% increase. The service are looking to increase service operational hours to improve accessibility and have commenced with recruitment of volunteers to support with pre-calling individuals in advance of appointment sin order to support with reducing the DNA' rates from October onwards. The number of people achieving Reliable Recovery (T903c) has seen a dip in performance to 44.88% when compared to the 48% target. Our focus on increasing access has resulted in more patients accessing the service with a lower caseness (score at the start of treatment). This means there is less opportunity to increase the improvement score throughout their treatment which is resulting in a decrease in the overall reliable improvement score. We want to ensure the service is accessible to all, however, appreciate this is having a direct impact on target achievement. In tandem the increase in access rates also has a negative consequence for Reliable Improvement rates as individuals commence in the service with a lower caseness.

The metric measuring the occupancy hours lost due to breaches within our 3 **Section 136 suites** (T905) has seen 35 hours lost this month this has reduced from 99 hours in July. Our North Lincolnshire suite has had 2 patient breaches of 7 and 10 hours. The 7 hour breach was a Doncaster patient. 17 hours were lost due due to safe staffing concerns across the Trust out of hours. Rotherham suite had 1 patient breach of 1 hour.

The final metric introduced this month is the **length of stay of our inpatients** where the target is 32 days. Our baseline position from this month is 123 days and is primarily impacted by RC annual leave and a reduced level of discharges in the first two weeks of August (2 for Rotherham) compared to previous months and compared to the to Trustwide target of 16 discharges per week (3 per ward)" to Trustwide target of 16 discharges per week (8, Doncaster, 6 Rotherham & North Lincs, 3) A ward consistency pilot has commenced with a plan to roll out Trustwide by November 2025 along with job planning to confirm RC cover arrangements for periods of leave.

1.0 Executive Report

Children and Young People (CYP) Services

The number of CYP receiving at least one clinical contact within a rolling 12-month period one of our Top 9 achieving metrics continues to exceed the target of 9,424.

The Children's Eating Disorder Service continues to perform strongly. It achieved 100% compliance with the target to see the most urgent cases within one week (OP15) across the full year and saw 94.19% of referrals within four weeks (OP14), slightly below the 95% target. The five breaches occurred 1 in May 2025 2 in March 2025, 1 in Jan 2025, and 1 in Nov 2024 and were due to carer- or parent-initiated appointment cancellations. The service remains committed to offering appointments within the target period wherever possible.

Physical Health Services

Physical Health Services continue to demonstrate consistently robust performance. Both 18-week referral-to-treatment metrics (OP08b and OP08c) for AHP-led and consultant-led services exceeded the 92% target, with all patients treated within 18 weeks. Notably, there are no patients waiting over 52 weeks for treatment (OP10c).

The Virtual Ward (LTP06), which enables care at home as an alternative to hospital admission, experienced a slight decline in occupancy rate for the second consecutive month on day thirty of the calendar month. This was due to discharges occurring either on or before that day and we may anticipate some seasonality and its likely this will once again rise as we move to the winter period. The Urgent Community Response service seeking to assess patients in 2 hours (OP05) is currently under review due to reporting discrepancies with national reporting. A task and finish group are meeting daily with escalation to the COO to confirm the discrepancy and to ensure targeted action is taken to address.

Adult and Older Adult Mental Health Services

These services continue to perform well across all metrics. The Trust consistently exceeds the 18-week referral-to-treatment target (OP08d), underscoring its commitment to timely, high-quality care and there are no individuals waiting longer than 52 weeks in these services.

Neurodevelopmental Services

The adult ADHD assessment waiting list currently stands at 5,447 individuals, exceeding the trajectory target of 4,918 (OP59a). This variance is due to several assumptions underpinning the original trajectory not materialising as expected, including recruitment challenges and delays in implementing new systems. The Care Group, in collaboration with the Performance Team, is revising the trajectory to better reflect operational constraints. A draft is in development and will be presented for approval by the CEO and COO.

The CYP neurodevelopmental waiting list includes 5,067 individuals, compared to a target of 2,353. This list increased by approximately seven hundred children in April 2025 due to the transfer of cases from the Doncaster Royal Infirmary Autism Service. A revised trajectory is currently under development for this pathway as well and will be presented for approval by the CEO and COO.

Quality and Patient Safety

Overall, there has been a slight deterioration in several metrics that has been noted for the month of August. There has been an increase in the number of ligatures graded as near miss, moderate or above in all inpatient areas to 14.29% (target 10%) **(QS27)**. Upon deep dive it is due to two patients with repeated ligature attempts. Ligatures were identified and removed by staff during appropriate security checks as per the policy and least restrictive approaches have been taken by staff. Therapeutic work to de-escalate and manage these two patients has been implemented the directorates supported by the trusts Reducing Restrictive Intervention Lead. Monitoring of this metric and the detailed learning will be provided to, and monitored by the Patient Safety Operational Group (Sub Quality and Safety Group)

1.0 Executive Report

Sadly, and unrelated to the metrics within **QS27**, there has been 1 suspected suicide of a patient in inpatient care in the month of August **(QS23).** This patient was not detained under the Mental Health Act and was utilising leave that does not need to be authorised as in accordance with section 17 at the time of the incident. Following agreement within the Learning from patient safety events group (LFPSE) and using the patient safety incident response approach (PSIRA), this case will be reviewed by a patient safety incident investigation (PSII). The family and staff team involved have been well supported during this time. The learning from this incident will be reported in line with the PSIRA in due course and oversight via Quality and Safety Group.

Safer Staffing (QS15)
The number of wards reporting registered staff below 90% for the month of August is below target at 87.5% (14/16 wards), which is the same as in July, this may be in part, due to summer holiday period affecting fill rates, but also, due to some rostering changes whilst we awaited the merger of the Brambles and Glade wards rosters from 1st September to form the Willows.

Racist Incidents (QS29)
Reporting a sustained position of 17 racist incidents reported in August. On RADAR we can now report on the question 'does this incident include racial/discriminatory abuse?' which means staff can report the incident under the main category and still report the racial abuse which means we are now seeing a more accurate picture of our racial abuse incidents. The next steps are to understand and trends from this data and any learning identified and shared.

Falls Assessments (QS37)
This new metric measures the proportion of patients receiving a falls assessment within 12 hours of admission. This month we have seen a decrease to 79.76% (67/84) from 90.29% (93/103) in July of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission. There is a focus on the support required in the Mental Health Care Groups for staff to start the assessment within 12 hours and oversight via the patient safety oversight group and to Quality and Safety Group.

Workforce Development

The percentage of employees receiving a performance and development review (PDR) has increased from 91.06% to 91.80% continuing to exceed the 90% target.

TRUST RETENTION RATE (POD09)

The trust retention rate on a rolling 12 month remains above the 10% target. The trust retention rate on a rolling 12 month remains above the 10% target. Turnover in June and August did not follow trend and was considerably higher. Highest turnover for Apr – Aug 25 – resignation, Registered Nurses - Physical Health & Neurodevelopment.

1.0 Executive Report

SICKNESS (POD10)

The Sickness Absence % is above target (5.79% vs 5.1%), The care group with the highest sickness absence rate is RCG at 8.55%. Children's Care Group and Backbone Services remain under the trust target. This is still an improving position compared to the previous financial year. The approach and compliance continues to being monitored given the launch of the new policy on the 1st April 2025. Areas of focus, both to celebrate and those of concern will continue to be reviewed at Group level meetings. Actions to reduce sickness absence levels have been agreed and progress against these is reported via People and Teams Sub CLE with a more detailed conversation at CLE in September 2025.

RECRUITMENT (POD25)

The recruitment KPI has breached, this is primarily down to the National reporting requirements which have been reduced to 8 weeks (previously 12 weeks) hence the reduction in performance.

Safeguarding Compliance (POD 28/29)

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. Given the move in the Autumn to increased employee responsibility should help further improve this position

Vacancy Rate: The vacancy rate increased from 209 to 219 vacancies in July, currently standing at 5.82%. against a target of 2.5%. Whilst the vacancy factor has increased, the establishment has increased to reflect two significant development, Community Rehabilitation and also the High Dependency Unit, which don't 'open' until September and October 2025. The budgeted establishment is included in advance to facilitate recruitment. The Directorates with the highest level vacancy factor are receiving additional support and oversight to ensure recruitment to the vacancies.

Finance

The Trust is reporting a deficit position of £426k at the end of August (month 5); this is £6k better than planned. Within this position, there are variances compared to budget and 2 of the 23 directorates are overspent. Where overspends occur, the directorates are at risk of losing decision making autonomy and the budget being returned to the control of the Chief Executive.

The forecast is to breakeven in line with the plan. This assumes that all £2.4m deficit support funding will be received in year, however, the Q2 to Q4 funding is dependent on the South Yorkshire system achieving its' **combined** financial targets. The ICB have paid over the Q2 funding despite not receiving the allocation from NHS England so there is a risk this could be clawed back; RDaSH may lose planned funding of £1.8m and be unable to achieve breakeven at year-end. Other emerging risks are the Agenda for Change pay settlement at 3.6% instead of the planned 2.8%, the ICB funding 50% of appropriate out of area placement activity and the possibility of liabilities arising from the band 4 to 9 national nursing job profile exercise. These risks will be monitored and factored into the forecast as appropriate.

2.0 - Performance – In Focus

Indicators for August 2025/2026 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP01 (N)		People first episode in psychosis started treatment in 2 wks		19/20	95.00%		98.00%	>= 60%	91.00%
OP03b (L)	T903a	People accessing Talking Therapies - Cumulative Quarterly			1314	Q2 >= 3955	2866		7252
OP03c (N)	T903b	Reliable recovery rate within Talking Therapies		263/586	44.88%		46.00%	>= 48%	46.00%
OP03d (N)	T903c	Reliable Improvement rate within Talking Therapies		406/605	67.11%		67.00%	>= 67%	67.00%
OP05 (N)		People in physical health crisis assessed within 2 hours		6/12	50.00%		66.00%	>= 70%	69.00%
OP07b (L)	T907	Women supported by perinatal MH service (Rolling 12M)			587		587	>= 574	587
OP08b (L)		18 wks RTT for AHP led Physical Services		277/285	97.19%		96.00%	>= 92%	98.00%
OP08c (N)		18 weeks RTT for consultant led Physical Health services		50/52	96.15%		96.00%	>= 92%	96.00%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		175/175	100.00%		100.00%	>= 92%	99.00%
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		68/73	93.15%		90.00%	>= 80%	92.00%
OP13a (N)	T901	People accessing CYP services with >= 1 contact (13mth roll)			10016		10016	>= 9424	10016
OP13b (N)		People accessing CYP services >= 2 contacts and paired score		834/5675	14.70%		15.00%	>= 20%	14.00%

Narrative

OP03b – Reporting 7,252 for the year-to-date position against a target of 9,374. When compared with activity in the same period last year (6,597) we are reporting 655 above last year's actual.

OP03c – Performance reported as 44.88% for August, a further increase on previous month however remains below the 48% target.

OP03d – Performance reported as 67.11% for August, an increase from 66.94% in July, year to date target improves to 67% against the 67% target.

OP05 – Performance reported slightly below the 70% target at 69%, targeted action is in place to identify the reporting discrepancies between local and national reporting. Daily meetings are in place with escalation to the COO.

OP13b – The CYP access 2 contacts and a paired scored has deteriorated slightly to 14.70% in August from 14.8% in July.

2.0 - Performance – In Focus

Indicators for August 2025/2026 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP13d (L)		Adults accessing community mental health services (DW)			10538		10538	>= 8533	10538
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		81/86	94.19%		94.00%	>= 95%	94.00%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		1/1	100.00%		100.00%	>= 95%	100.00%
OP17c (N)	T904	The number of active inappropriate adult acute OAPs			11		11	<= 21	11
OP54c (L)		Virtual ward occupancy - on day 30		45/60	75.00%		75.00%	>= 80%	75.00%
OP59a (L)		Waiting List - Adult ADHD			5447		5447	< 4918	5447
OP59b (L)		Waiting List - CYP Neurodevelopment			5067		5067	<= 2353	5067
OP60 (L)	T906	Dementia Diagnosis rate		7287/9755	74.70%		75.00%	>= 67%	75.00%
OP61c (N)		Patients with SMI having full annual physical health check		2601/3674	70.79%		71.00%	>= 95%	71.00%
OP73a (L)	T905	Section 136 Breaches – Occupancy hours lost to breaches			35		134	= 0	218
OP77c (L)	T902a	Mean Spell LOS Current Inpatients (Internal Beds/Month-End)			123		123	<= 32	123
OP77d (L)	T902b	% Inpatients Spell LOS > 32 Days (Internal Beds/Month-End)		106/220	48.18%		48.00%		48.00%
OP78 (L)	T908	Number of people accessing Individual Placement Support	>= 50		63		63		63
OP80 (L)	T909	% Services meeting 4 week wait target at end of month		44/81	54.32%	Q2 >= 59%	54.00%		54.00%

Narrative

OP14 – The metric measuring over a 12 month rolling period is reporting at 94.19% slightly below the 95% target. (Breaches occurred in 1 in May 25 2 in March 25, 1 in Jan 25, and 1 in Nov 24)

OP54c – Occupancy on the virtual ward dropped from 76.67% in July to 75.00% on day 30 in August remaining below the 80% occupancy target for the second consecutive month.

OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 5,447 adults waiting for assessment against the target of 4,918. The Care Group are redeveloping the trajectory to build in nuances that were not already accounted for regarding capacity within the service.

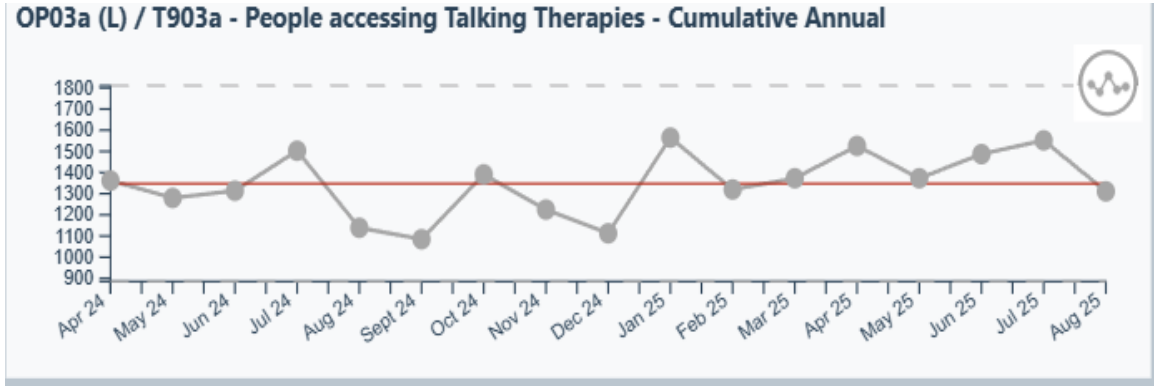
OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target actual with 5,067 CYP waiting against the target of 2,353. The Care Group is redeveloping the trajectory to build in nuances that were not already accounted for regarding capacity within the service and to incorporate the children and young people received from Doncaster Royal Infirmary who were waiting on the Autism Assessment list (700).

OP61c – The metric is measuring the RDaSH performance against the QOF Performance is reported as 70.79% for August against the 95% target.

OP73a – There have been 35 occupancy hours lost within the section 136 suites for the month of August 2025 reduced from 99 hours in July.

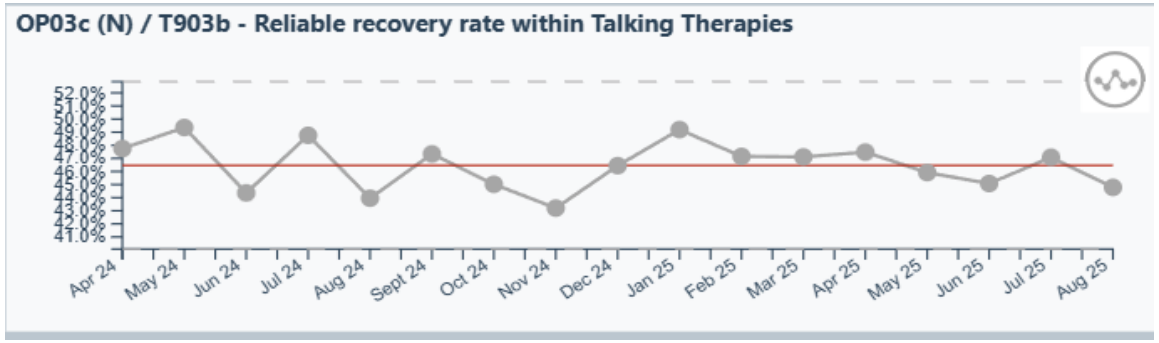
OP77c - The new metric reporting the mean length of stay for patient who remain on the wards is reported for the first time this month. Performance is reported at 123 days against the target of 32 days.

2.1 Performance In Focus - Exceptions



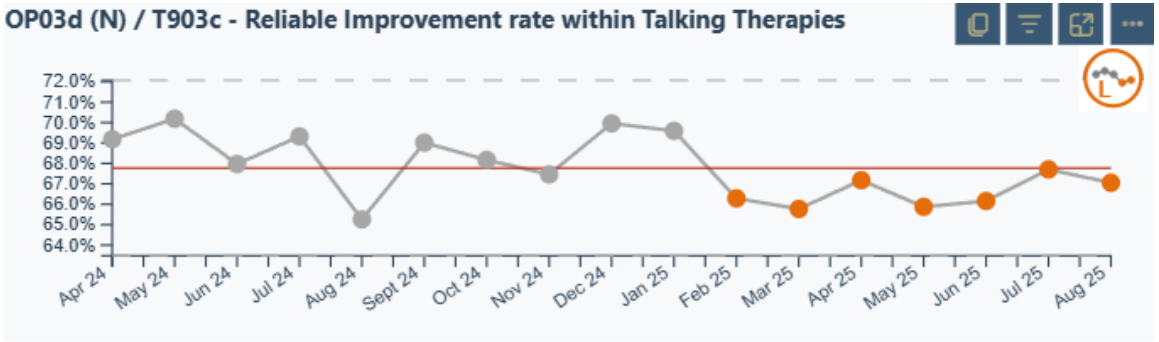
Trend, Reason and Action

OP03b The Access Rate performance is 7,252 for the year-to-date position against a target of 9,374. We are reporting that there are an additional 655 people accessing the service when compared to the same period last year. Not forecasting to achieve the 2025/26 target, however, at the current trajectory, we are predicting to see an increase in approximately 2,000 access contacts for the full year effect from 2024/25, which is a 12% increase. The service are looking to increase service operational hours to improve accessibility and have commenced with recruitment of volunteers to support with pre-calling individuals in advance of appointment sin order to support with reducing the DNA' rates from October onwards.



Trend, Reason and Action

OP3c The teams focus on increasing access has resulted in more patients accessing the service with a lower caseness (score at the start of treatment). This means there is less opportunity to increase the improvement score throughout their treatment which is resulting in a decrease in the overall reliable improvement score. We want to ensure the service is accessible to all, however appreciate this is having a direct impact on target achievement. Further work and discussion to take place. It is also recognised that our North Lincs locality is lower than the other 2 localities, so a deep dive will be undertaken to understand this variance.



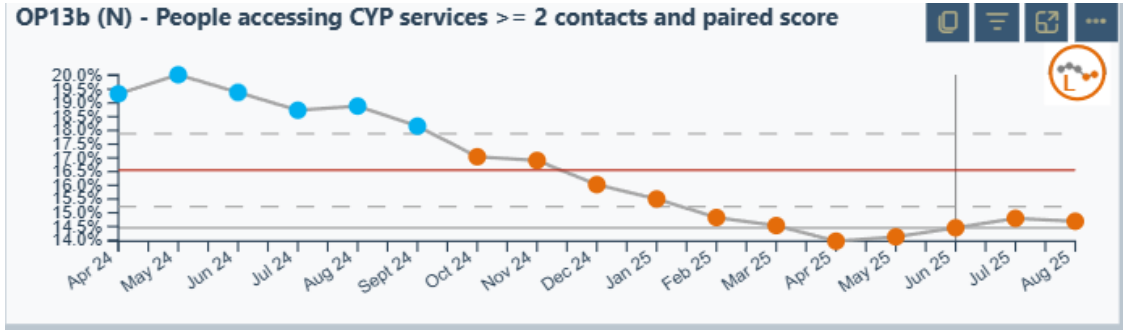
Trend, Reason and Action

OP0dc – The teams focus on increasing access has resulted in more patients accessing the service with a lower caseness (score at the start of treatment). This means there is less opportunity to increase the improvement score throughout their treatment which is resulting in a decrease in the overall reliable improvement score. We want to ensure the service is accessible to all, however appreciate this is having a direct impact on target achievement. Further work and discussion to take place.

2.1 Performance In Focus - Exceptions

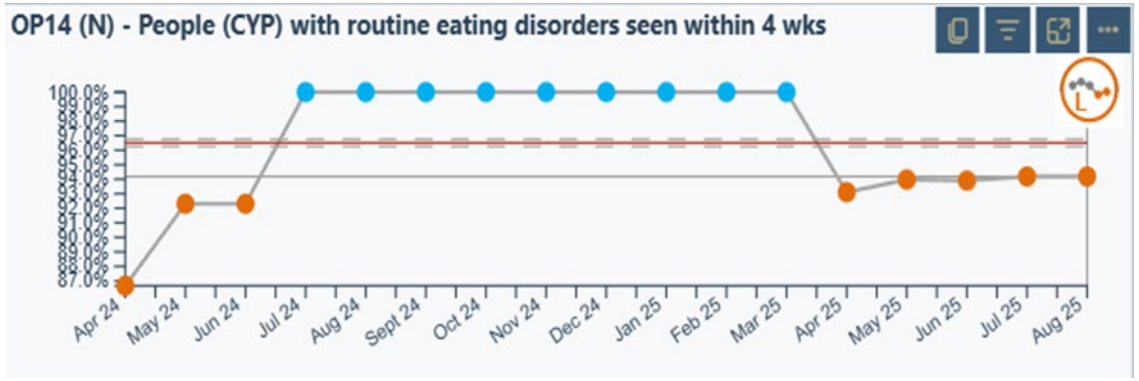
Trend, Reason and Action

OP05 - The metric is currently under review due to reporting discrepancies with national reporting. A task and finish group are meeting daily with escalation to the COO to confirm the discrepancy and to ensure targeted action is taken to address.



Trend, Reason and Action

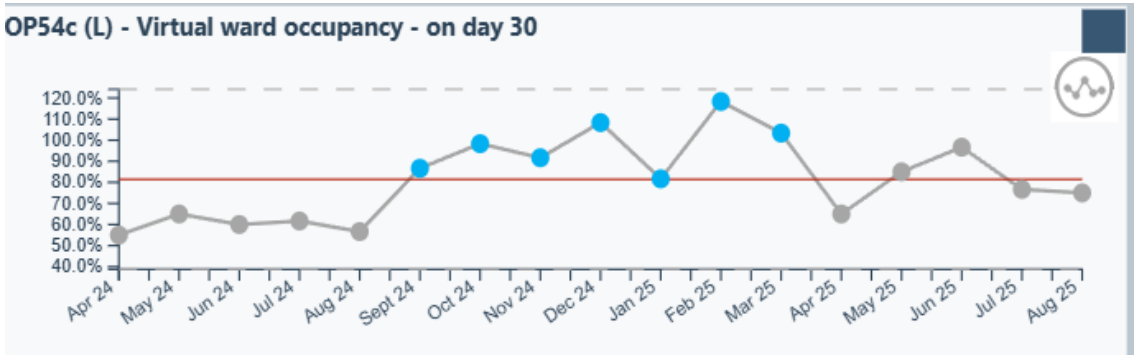
OP13b - The CYP access 2 contacts and a paired scored has seen a slight deterioration in performance in August. It is noted that the services do not use a standard tool for recording outcome measures however as a trust we have agreed to implement Dialog+ with CYP in the process of transitioning across to this.



Trend, Reason and Action

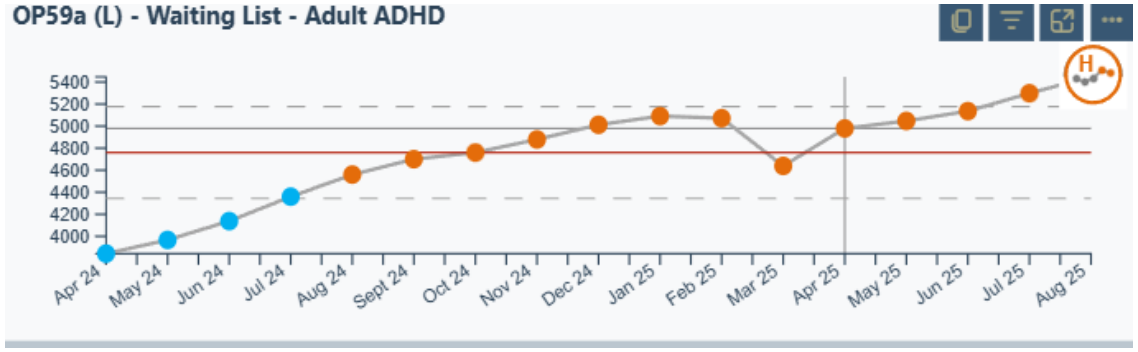
OP14 - Children and young people with routine eating disorders is reporting 5 breaches (2 in March 2025, 1 in January 2025, 1 in Nov 2024 and 1 in May 2024) in the rolling 12 month period. This is a rolling 12 month target with appointments offered slightly over the 4 weeks due to patient choice and cancelled appointments. Current wait times within this pathway remain below the 4 week wait target.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

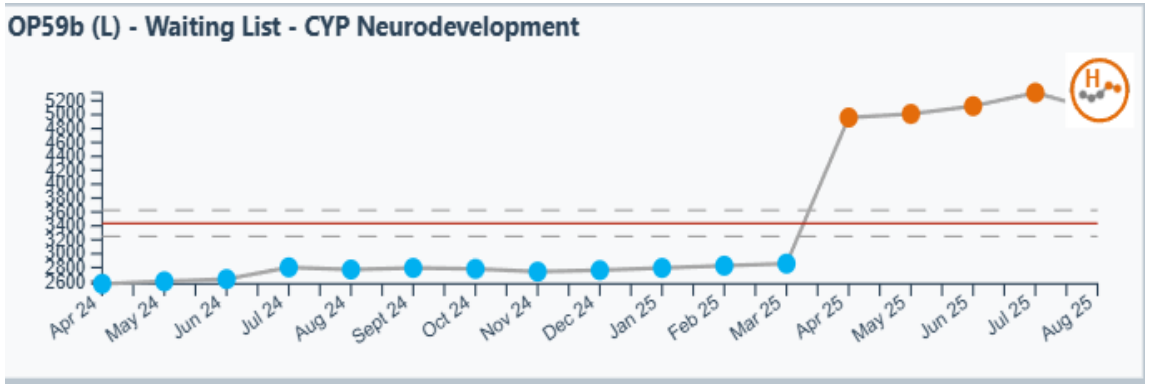
OP54c – Occupancy for the Virtual Ward on the 30th of the month is reported slightly below the 80% occupancy target. This reduction was due to discharges prior to and on the 30th of the month.



Trend, Reason and Action

OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting at 5,447, above the target of 4,918.

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. The migration of data is now completed. Weekly performance meetings are in place and further diary management processes are being enacted in September 2025.

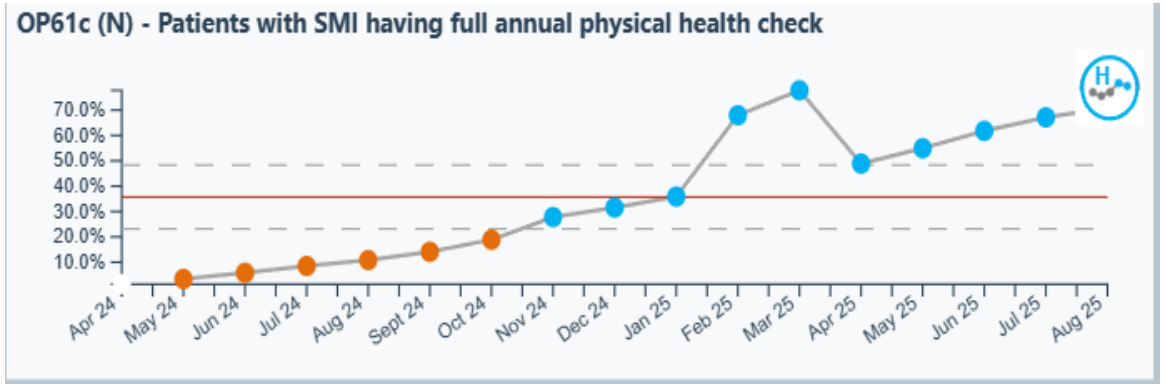


Trend, Reason and Action

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting at 5,067 above the projected target of 2,353.

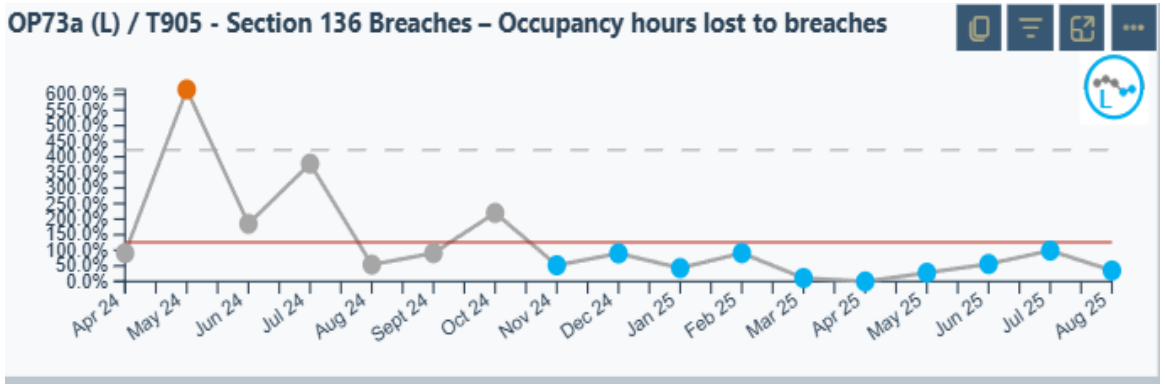
The Care Group have redeveloped the trajectory to build in the additional Autism service recently transferred from Doncaster Royal Infirmary (approximately 700 children and young people) in addition to adding nuances that were not already accounted for regarding capacity within the service.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP61C– Reporting against the QOF for the place target. Graph indicates performance against the SMI checks for Promise 7 OP61c, reporting 70.79% Trustwide. Improvement initiatives are in place which include a continuing focus on declines across all 3 Care groups and register consolidation which is underway with an end date of September 2025. To support blood test compliance all Care groups are to receive a POC machine which will support easy access to blood tests for patient eligible for these health checks and improve compliance. The impact of this is expected to show by Q3 25/26 however a performance clinic is scheduled with Care Groups prior to the end of September 2025 to ensure a continued focus.

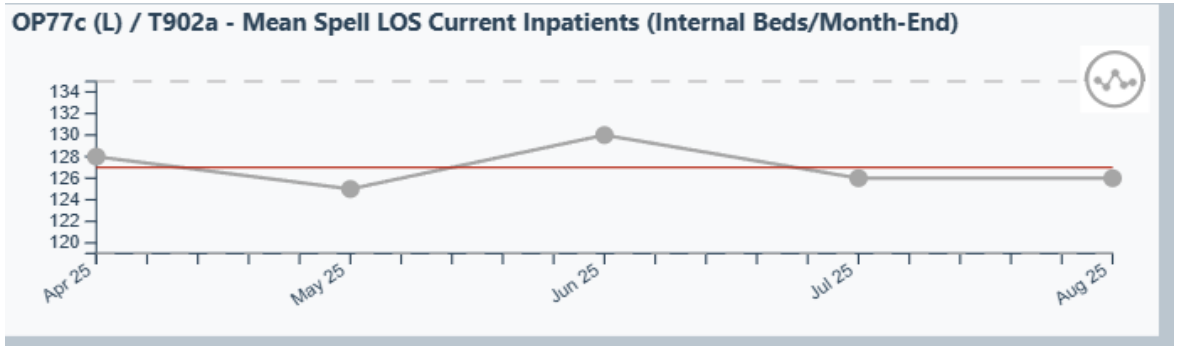


Trend, Reason and Action

OP73A—the metric measures the occupancy hours lost due to breaches within our 3 Section 136 suites, 35 hours were lost this month.

N Lincs suite has had 2 patient breaches of 7 and 10 hours. The 7 hour breach was a Doncaster patient. 17 hours was closure due to safe staffing concerns across the Trust out of hours.

Rotherham suite had 1 patient breach of 1 hour.



Trend, Reason and Action

OP77c – Increase in mean LoS through August, particularly in Rotherham Care Group. RC annual leave has been a contributing factor for this with less discharges in the first two weeks of August (2 for Rotherham) compared to previous months and compared to Trustwide target of 16 discharges per week (roughly 3 per ward). Ward consistency pilot has commenced with a plan to roll out Trustwide by November 2025 along with job planning to confirm RC cover arrangements for periods of leave.

3.0 Quality & Safety In Focus

Indicators for August 2025/2026 Trust	Quality and Safety							
Indicator	Metric	Target		Value	QTD Target	QTD Actual	YTD Target	YTD Actual
QS05	Number of MRSA Infections (Monthly)	0		0	0	0	0	0
QS06	Number of Clostridum difficile infections (Monthly)	0		0	0	0	0	2
QS07	Number of gram-negative bloodstream infections (Monthly)	0		0	0	0	0	0
QS08	Bi patients >= 16 admitted with completed VTE	>= 95%	147/152	96.71%	>= 95%	97%	>= 95%	96%
QS15	No of wards reporting registered staff on nights/days >90%		14/16	87.50%		88%	>= 90%	97%
QS19	Number of AWOL's from low secure (Amber Lodge)			0		0	0	0
QS20	No of detained patients absconded acute adult / OP inpatient MH			0		5	0	8
QS21a	Physical agression incidents mod or above to staff (%)		2/63	3.17%		9%		10%
QS21b	Physical agression incidents mod or above to staff/pats (%)		0/63	0.00%		2.00%		2%
QS23	Number of Suspected Suicides (inpatient settings)	0		1	0	1	0	1
QS27	Ligature incidents mod or above all inpatient areas		3/21	14.29%		19%	>=10%	15%
QS29	Number of racist incidents against staff members			17		17	0	65
QS31	Episodes of seclusion - Internal MDT within 5 hours		16/17	94.11%		80.00%	100%	85.00%
QS36	Inpatients that have a completed MUST assessment		124/154	81.17%		83.00%	100%	83.00%
QS37c	Inpatients commenced falls assessment in 12 hrs		67/84	79.76%		85.00%	100%	81.00%

Narrative

QS15 -The number of wards reporting registered staff below 90% for the month of August is below target at 87.5% (14/16 wards) although it is worth noting the improvement in performance.

QS23 -Sadly reporting 1 suspected suicide in inpatient care in the Month of August whilst on leave from Osprey Ward.

QS27 –The number of ligature incidents graded as near miss, moderate or above in all inpatient areas has breached the 10% target for August with 14.29% (3/21) reported.

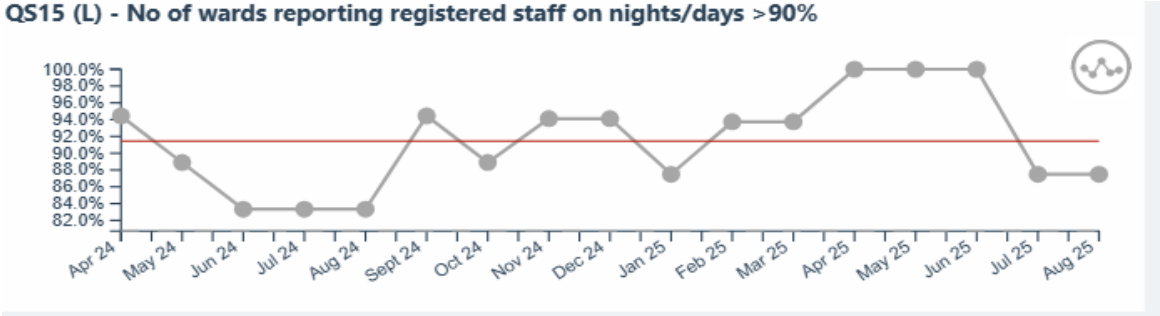
QS29-Reporting a sustained position of 17 racist incidents reported in August.

QS31 -The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting an increase to 94.11% (16/17) in August from the 61.54% (8/13) reported in July.

QS36 – Reporting a decrease in August to 81.17% (124/154) from 84.39% (146/173) reported in July of the % of Inpatients that have a completed MUST assessment.

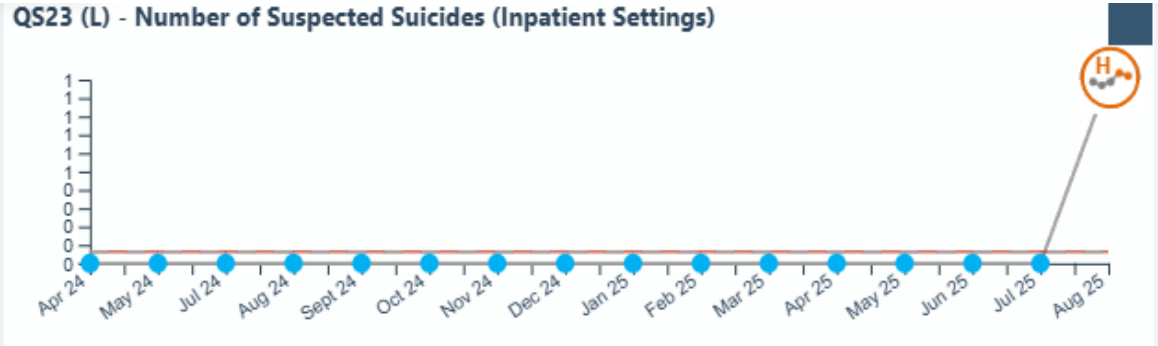
QS37- This metric has decreased to 79.76% (67/84) from 90.29% (93/103) in July of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission.

3.1 Quality and Safety In Focus - Exceptions



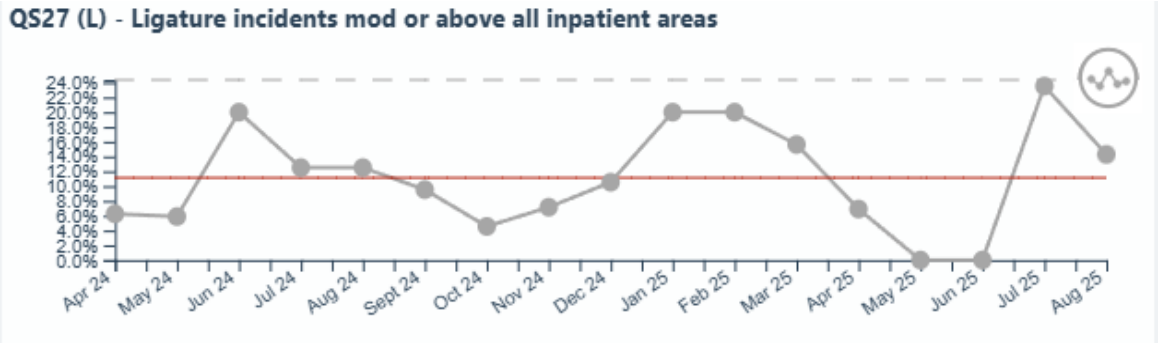
Trend, Reason and Action

QS15 – The number of wards reporting registered staff below 90% for the month of August is below target at 87.5% (14/16 wards), which is the same as in July, this may be in part, due to summer holiday period affecting fill rates, but also, due to some rostering changes whilst we awaited the merger of the Brambles and Glade wards rosters from 1st September to form the Willows.



Trend, Reason and Action

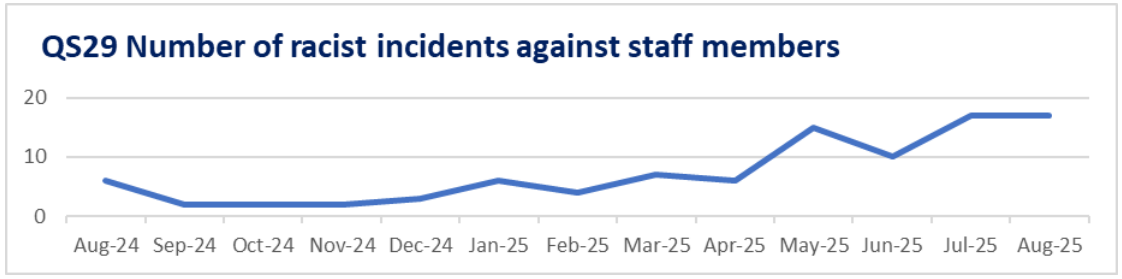
QS23 - Sadly, and unrelated to the metrics within **QS27**, there has been 1 suspected suicide of a patient in inpatient care in the month of August **(QS23).** This patient was not detained under the Mental Health Act and was utilising leave that does not need to be authorised as in accordance with section 17 at the time of the incident. Following agreement within the Learning from patient safety events group (LFPSE) and using the patient safety incident response approach (PSIRA), this case will be reviewed by a patient safety incident investigation (PSII). The family and staff team involved have been well supported during this time. The learning from this incident will be reported in line with the PSIRA in due course and oversight via Quality and Safety Group.



Trend, Reason and Action

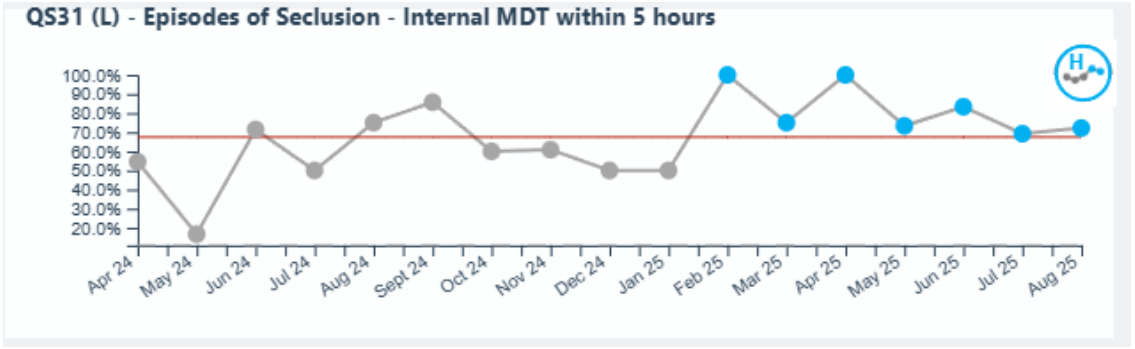
QS27–The number of ligature incidents graded as near miss, moderate or above in all inpatient areas has breached the 10% target for August with 14.29% (3/21) reported. Upon deep dive it is due to two patients with repeated ligature attempts. All ligatures were identified and removed by staff during appropriate security checks as per the policy. Lease restrictive approached have been taken by staff.

3.1 Quality and Safety In Focus - Exceptions



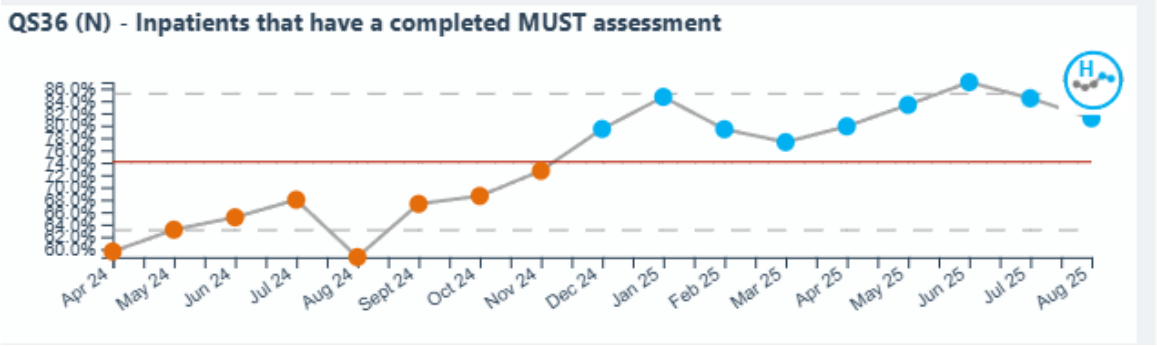
Trend, Reason and Action

QS29 –Reporting a sustained position of 17 racist incidents reported in August. On RADAR we can now report on the question 'does this incident include racial/discriminatory abuse?' which means staff can report the incident under the main category and still report the racial abuse which means we are now seeing a more accurate picture of our racial abuse incidents. The next steps are to understand and trends from this data and any learning identified and shared.



Trend, Reason and Action

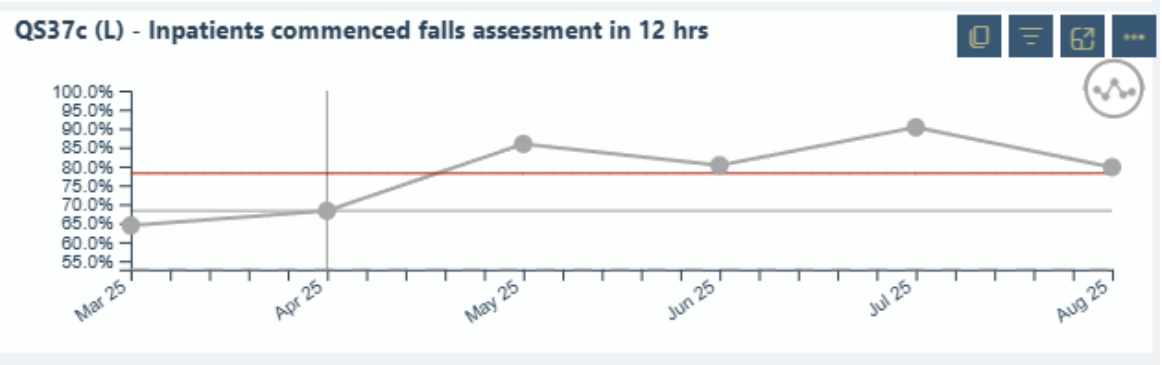
QS31 -The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting an increase to 94.11% (16/17) in August from the 61.54% (8/13) reported in July. The changes have been implemented to the seclusion visualisation on System 1 to allow a pop-up message to appear giving instructions to the Doctors in what circumstances the particular 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. There have been two instances of data recording errors this month which have been rectified at source.



Trend, Reason and Action

QS36 –Reporting a decrease in August to 81.17% (124/154) from 84.39% (146/173) reported in July of the % of Inpatients that have a completed MUST assessment. The MUAC templated has been implemented to include step 4 completion to ensure this is clearer. MUST has been included in the admission checklist and is being led with daily oversight by the inpatient ward managers and is planned to be discussed in PIPA. In North Lincs several patients have refused to be weighed on admission one due to their level of distress and one who felt it was unfair to be weighed. All MUST assessments have now been completed within 72 hours.

3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

QS37 –This new metric measures the proportion of patients receiving a falls assessment within 12 hours of admission. This month we have seen a decrease to 79.76% (67/84) from 90.29% (93/103) in July of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission. There is a focus on the support required in the Mental Health Care Groups for staff to start the assessment within 12 hours and oversight via the patient safety oversight group and to Quality and Safety Group.

4.0 People and Organisational Development – In Focus

Indicators for August 2025/2026 TRUST — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	10.50%		11.00%		11.00%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	5.79%		6.00%		5.00%
POD15 (L)	Number of Consultant Vacancies	<= 10	9		9		9
POD16 (L)	Qualified nursing vacancies	<= 2.5%	7.25%		7.00%		7.00%
POD17 (L)	Support worker vacancies	<= 2.5%	5.48%		5.00%		5.00%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	91.80%		92.00%		92.00%
POD19a (L)	Individuals completed mandatory/statutory training	> 90%	94.81%		95.00%		94.00%
POD23 (L)	Number of individuals currently suspended from employment		1				
POD24 (L)	Average suspension length in calendar days	<= 150	62		62		62
POD25a (L)	% recruitment completed in 8 wks [Advert to checks complete]	>= 95%	57.64%		58.00%		73.00%
POD26 (L)	Compliance for safeguarding children's training		92.95%		93.00%		93.00%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		91.60%		92.00%		92.00%
POD28 (L)	Total Vacancies		219		219		219
POD29 (L)	Total Vacancy Rate %		5.82%		6.00%	<= 2.5%	6.00%

Narrative

POD09 – Total retention rate on a 12 month rolling period is reporting 10.50% and remains above the 10% target.

POD10 – working days lost to sickness is reporting 5.79% against the 5.1% target.

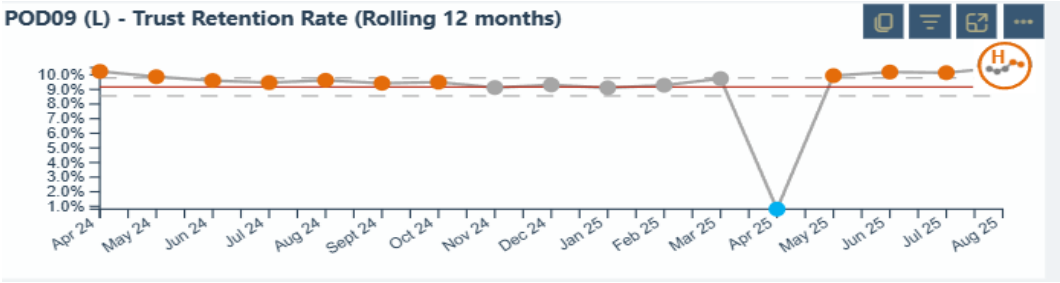
POD16-17 – Reporting as 7.25% and 5.48% against the revised target of 2.5% for both qualified and support worker vacancies. A clear trajectory is in place to deliver the 2.5% vacancy factor across staff groups and roles.

POD25a – Recruitment completed in 8 weeks is below target reporting 57.64%. This is due to a national reporting change – the National reporting requirements have been reduced to 8 weeks (previously 12 weeks) hence the reduction in performance.

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

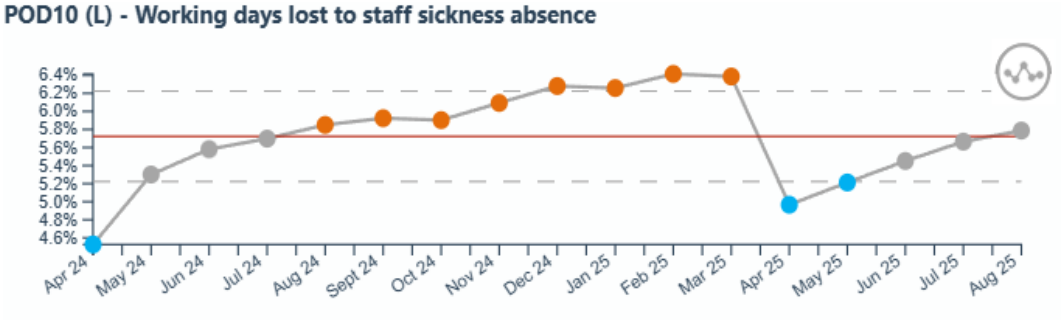
POD29 – reporting as 5.82% against the target total vacancy rate percentage of less than or equal to 2.5% with 219 vacancies currently across the trust

4.1 People and Organisational Development - Exceptions



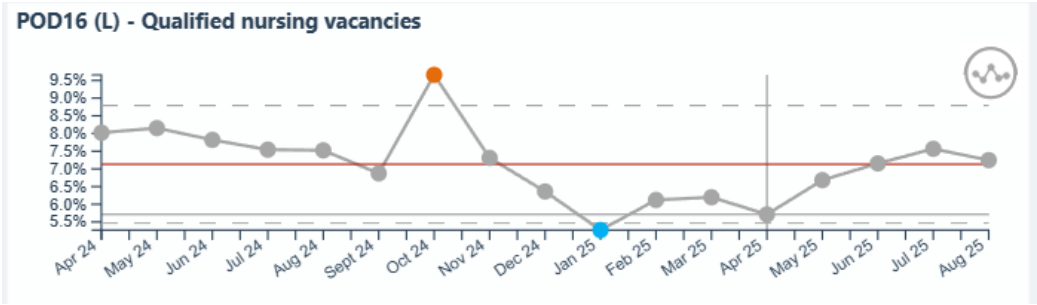
Trend, Reason and Action

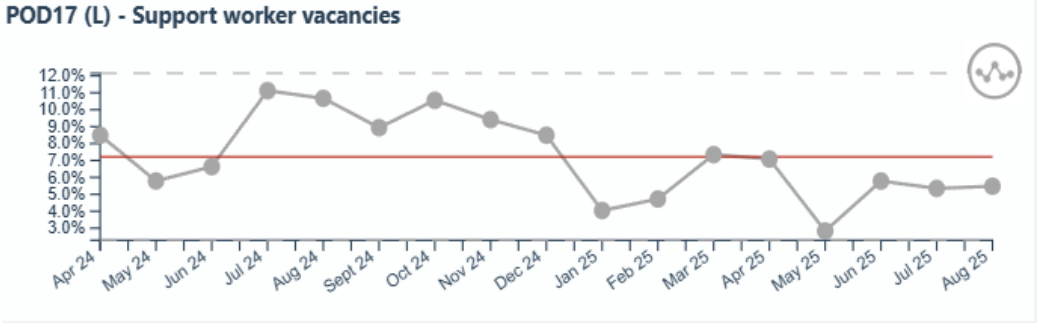
POD09 – The trust retention rate on a rolling 12 month remains above the 10% target. Turnover in June and August did not follow trend and was considerably higher. Highest turnover for Apr – Aug 25 – resignation, Registered Nurses - Physical Health & Neurodevelopment



Trend, Reason and Action

POD10 – The Sickness Absence % is above target (5.79% vs 5.1%), The care group with the highest sickness absence rate is RCG at 8.55%. Children's Care Group and Backbone Services remain under the trust target. This is still an improving position compared to the previous financial year. The approach and compliance continues to being monitored given the launch of the new policy on the 1st April 2025. Areas of focus, both to celebrate and those of concern will continue to be reviewed at Group level meetings. Actions to reduce sickness absence levels have been agreed and progress against these is reported via People and Teams Sub CLE with a more detailed conversation at CLE in September 2025

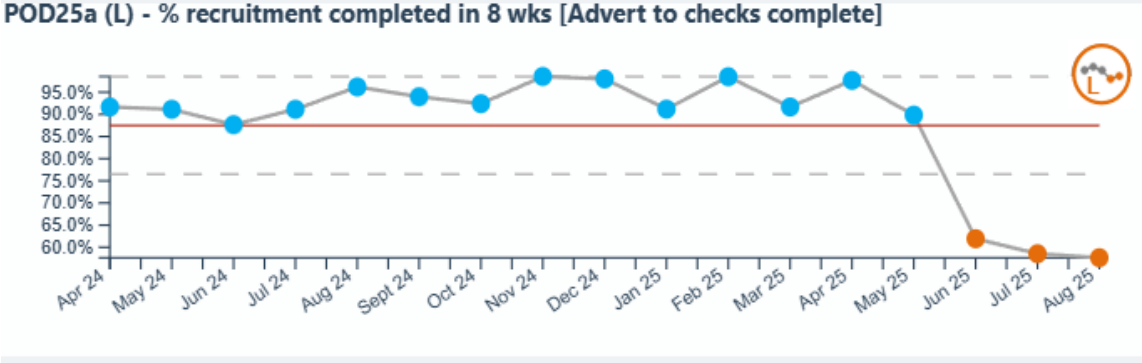




Trend, Reason and Action

POD16/17 Reporting against the revised target of 2.5% for both qualified and support worker vacancies. Data includes newly commissioned services and it is anticipated that once vacancies have been filled for these services then the Trust will be on target to deliver the 2.5% vacancy factor for qualified nursing and support worker vacancies. Hard to fill qualified nurse vacancies were identified and support provided by the recruitment to resolve

4.1 People and Organisational Development - Exceptions

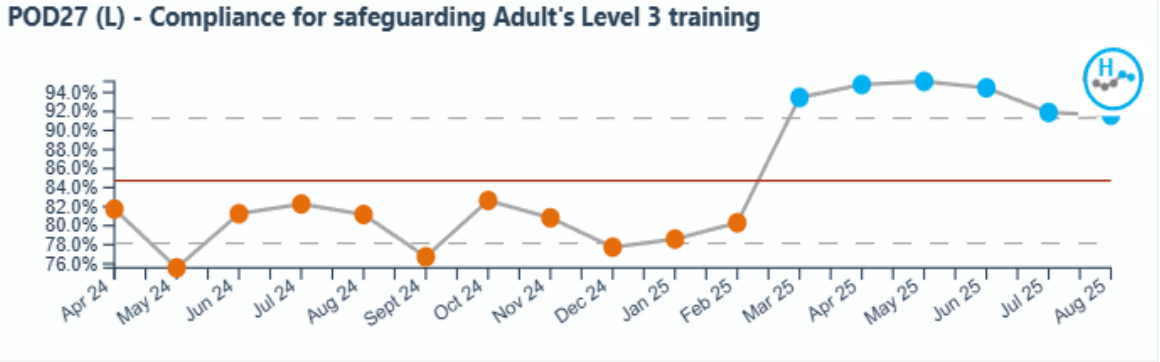


Trend, Reason and Action

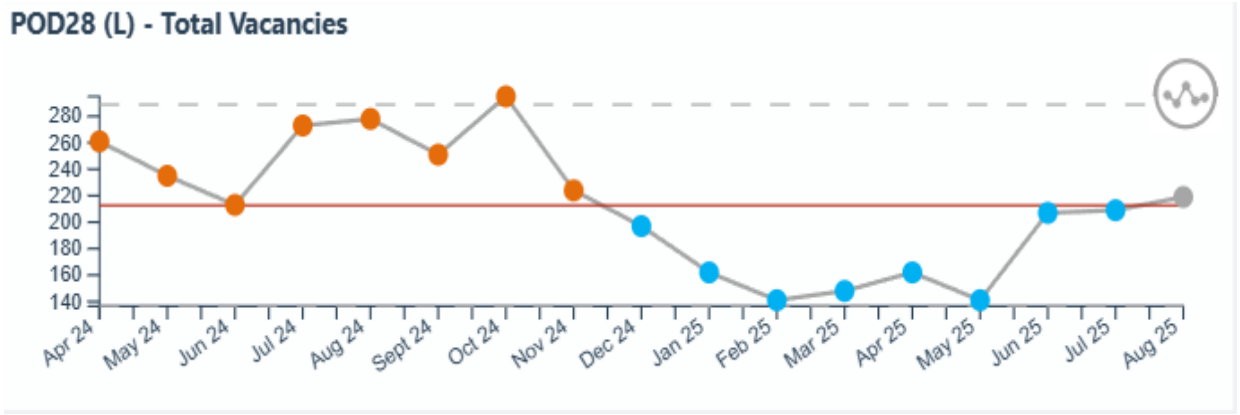
POD25 The recruitment KPI has breached this month this is primarily down to the National reporting requirements which have been reduced to 8 weeks (previously 12 weeks) hence the reduction in performance.

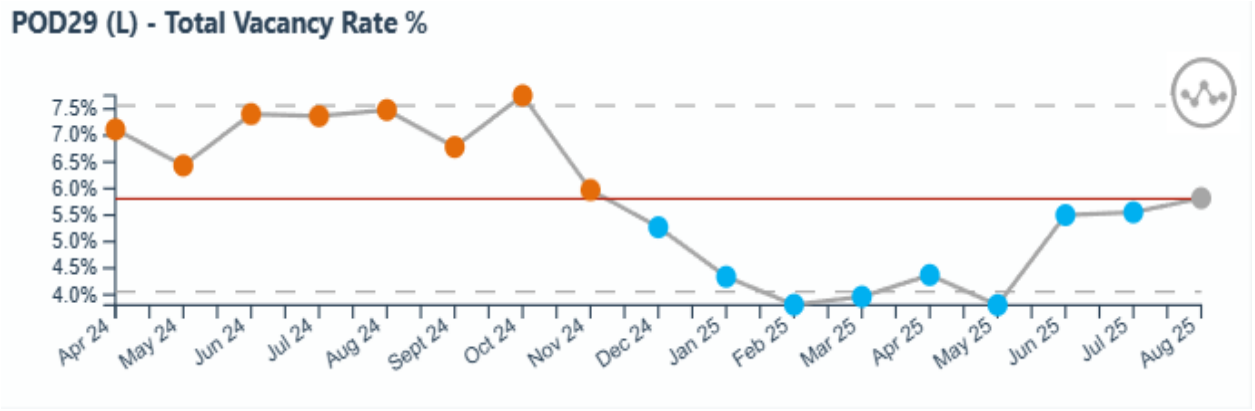
Trend, Reason and Action

POD26/27 Trust Level 1 and 2 (both adult and child) are compliant but level 3 for adult and child are amber. The compliance matrices have been reviewed, bespoke sessions have been scheduled on the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view to targeting individuals to improve compliance. Given the move in the Autumn to increased employee responsibility should help further improve this position



4.1 People and Organisational Development - Exceptions





Trend, Reason and Action

POD28 and POD29 - The vacancy rate increased from 209 to 219 vacancies in July, currently standing at 5.82%. against a target of 2.5%. Whilst the vacancy factor has increased, the establishment has increased to reflect two significant development, Community Rehabilitation and also the High Dependency Unit, which don't 'open' until September and October 2025. The budgeted establishment is included in advance to facilitate recruitment. The Directorates with the highest level vacancy factor are receiving additional support and oversight to ensure recruitment to the vacancies.

4.0 Finance – In Focus

Finance				
Indicator	Metric	Target	Actual	Variance
FIN01	Year to date actuals vs budget	(432)	(426)	6
FIN02	Forecast outturn vs budget	0	0	-
FIN03	YTD savings target vs schemes identified	4787	4775	(12)
FIN04	Annual savings target vs schemes identified	13,254	13,254	-
FIN05	Agency spend as % of total pay bill - year to date	1.57%	0.37%	(1.2)%
FIN06	Year to date capital plan vs spend	2,412	1,341	(1,071)
FIN07	Annual capital plan vs forecast spend	9,764	9,764	-
FIN08	No of directorates compliant with budget - year to date	23	21	91.3%
FIN09	No of directorates compliant with budget - forecast	23	20	87.0%
FIN10	***Directorates not compliant with budget - YTD:***			
	Rehabilitation	(1,112)	(1,162)	(50)
	Neurodiversity	(9,744)	(9,780)	(35)
FIN11	***Directorates not compliant with budget - Forecast:***			
	North Lincs Acute	(8,987)	(9,210)	(223)
	Talking Therapies	(9,265)	(9,326)	(61)
	Community & Long Term Conditions	(2,669)	(2,815)	(146)

Narrative

FIN01 – At M5 the year to date (YTD) position is £6k better than planned. Within this position, there are variances compared to budget with 2 directorates showing overspends as reported at FIN10

FIN02 - the forecast at M5 is to breakeven in line with the plan. This assumes that all £2.4m deficit support funding will be received in year, however, the Q2 to Q4 funding is dependent on the South Yorkshire system achieving its' combined
financial targets. The ICB have paid over the Q2 funding despite not receiving the allocation from NHS England so there is a risk this could be clawed back; RDaSH may lose planned funding of £1.8m and be unable to achieve breakeven at year-end.

Other emerging risks are the Agenda for Change pay settlement at 3.6% instead of the planned 2.8%, the ICB funding 50% of appropriate out of area placement activity and the possibility of liabilities arising from the band 4 to 9 national nursing job profile exercise. These risks will be monitored and factored into the forecast as appropriate.

FIN03/4 - Schemes have been identified in full for the 25/26 savings program and the forecast is to achieve the plan. At M5 however, the savings are behind plan by £12k relating to an underachieved non-recurrent scheme to date, this is now expected to catch up over the remainder of the year. A savings target of 0.5% has been delegated to each directorate and taken out of budgets. An additional £500k of savings have been identified from backbone services and removed from budgets. The out of area savings target of £3,000k has been adjusted against the out of area cost centre. There are no centrally held savings targets in 25/26.

FIN05 - Agency costs have reduced significantly since July 2024. The nominal target contained in the IQPR references the 24/25 outturn and is provided for comparison purposes only. YTD costs are significantly below this amount and are forecast to continue to be so for the remainder of the year. Currently YTD agency costs are 0.37% of the total pay bill for the Trust. Three agency locums are working in the trust and have end dates in Sept, October and January.

FIN06 & FIN07 Capital spend is behind plan year to date by £1,071k. Spend has accelerated over the last 2 months as expected, however, with £1,021k of costs incurred. This will accelerate more quickly now the Great Oaks works have commenced. The forecast is that capital funding will be used in full by year-end.

FIN08/please note these figures are draft as budgets are being adjusted to account for pay awards that were paid in August and maybe subject to change. 25/26 budgets were agreed and signed off on the basis that all directorates would manage their budgets and not overspend. (* The exception being Doncaster acute which has a permitted overspend to M6 due to the continued need for agency medics while substantive recruitment processes are completed). At M5, 2 directorates are not compliant, this has improved by 1 since M4. Where overspends occur, the directorates are at risk of losing decision making autonomy and the budget being returned to the control of the Chief Executive.

FIN09/11 - these figures are draft as budget adjustments are in process. The Trust is currently forecasting break even for year end, however, 3 directorates are currently showing deficits from the initial work though of the M5 forecast outturn. Finance colleagues will work with Care Group colleagues to validate the assumptions in the forecasts and where necessary support them to develop mitigations to recover the position. Drugs pressures highlighted at M4 have reduced significantly, although there is still insufficient assurance over the values and work is ongoing with pharmacy colleagues to validate this.

Appendix 1`

SPC Icon Description

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Health Inequalities – Review of IPQR	**Agenda Item**	Paper Wii
Sponsoring Executive	Joanne McDonough, Director of Strategic Development		
Report Author	Ray Hennessy, Deputy Director of Strategic Development		
Meeting	Board of Directors	**Date**	25 September 2025

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

The Board is being asked to receive the latest analysis of our IQPR data for 2025/26 that has been analysed through a health inequalities lens. The overall conclusion from the analysis is again that a number of our services do not fully reflect the communities that they serve in relation to at least one protected characteristic, and that follow-up activity will be undertaken to see if in some cases this is to be expected or is an issue. Work is underway to:

- Improve the data completeness of ethnicity status in our patient records;
- Research national evidence in relation to health inequalities and access to health care to compare our performance.

We need to complete this work before the end of 2025/26. Changes to protected characteristic coding in services are a key enabler of action in 2026/27.

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

Not previously discussed elsewhere.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE - the comparison of the IPQR data to our local population, against four of the protected characteristics.

CONSIDER – any other conclusions that can be drawn from the data.

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

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

People Risk	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Patient care risk	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
External and partnership risks	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

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

SDR 2

System / Place impact (advise which ICB or place that this matter relates to)							
Wider population health plans							
Equality Impact Assessment	Is this required?			N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?			N	X	If 'Y' date completed	
Appendix (please list)							
Refer to Agenda Pack B							

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

IQPR Data reviewed through a Health Inequalities Lens

Jo McDonough
Director of Strategic Development

and

Ray Hennessy
Deputy Director of Strategic Development

September 2025

RDaSH nurturing the power in our communities

1.0 What is the Board being asked?

1.1The Board is being asked to receive the analysis of our 2025/26 year to date IQPR data that has been analysed through a health inequalities lens, and to note that further work will take place to better understand and improve our position where this has been identified.

2.0 Background

2.1 The Board were informed that there is a requirement for the NHS to publish a core set of data, up to and including Board level. This is reflected in NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006) published in 2023

2.2 At its July meeting, the Board received an analysis of the IPQR for 2024/25 viewed through a lens of four protected characteristics: namely ethnicity, deprivation, age and gender. Feedback from the Board about this analysis has been reflected in the current report. In addition, work is being undertaken by Grounded Research to understand the national picture and evidence base in relation to health inequalities and access to services which, when complete, will be presented along side our data.

3.0 Analysis and conclusions

3.1 The IQPR for 2025/26 up to end August has been analysed through the lens of four protected characteristics: namely ethnicity, deprivation, age and gender.

3.2 As a reminder, the overall 'denominator' is based upon our population. For the four characteristics analysed, the table below breaks this down.

Local authority	20% most deprived	% aged 18 to 64	% aged 65+	%female	%male	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	White	Other ethnic group
Doncaster	41%	59.8%	19.4%	50.4%	49.6%	2.9%	1.2%	1.5%	93.1%	1.2%
Rotherham	36%	59.1%	19.6%	51.0%	49.0%	5.3%	1.1%	1.4%	91.0%	1.1%
North Lincolnshire	21%	58.0%	22.0%	50.7%	49.3%	3.3%	0.5%	1.1%	94.3%	0.8%
TOTAL	34%	59.1%	20.1%	50.7%	49.3%	3.9%	1.0%	1.4%	92.7%	1.1%

4.0 Conclusions

4.1 The analysis undertaken leads us to draw the following conclusions, which are similar to the 2024/25 data analysis:

- A significant number of our services do not fully reflect the communities that they serve in relation to at least one protected characteristic;

- Patients from an ethnic minority are inappropriately over-represented in some of our mental health services e.g. assessment for psychosis, in-patient services (given higher numbers of 72 hour follow-ups) and we are secluding more patients from an ethnic minority population;

- Some services are seeing more patients from a deprived area than the population, e.g assessment for psychosis, talking therapies, 72 hour follow-up mental health which could be seen as positive. However, it is not clear that we understand why and whether this is by accident or design. We also don't know whether services meet their needs?

- Some services are seeing more patients from a deprived area than the population which might indicate this as a concern? For example, more people from deprived areas are inappropriately placed in out of area mental health placements and more are experiencing episodes of seclusion;

- For a number of services we cannot draw a robust conclusion in relation to ethnicity because the data about patients' ethnicity is not as complete in our patient records. This affects around 7,000 records on the IPQR where the person's ethnicity is 'not stated' or 'not known'. Historically, the Trust took a decision to use the ethnicity from the GP shared record due to quality and primary referral initiation. Whilst that has remained the case, it would not stop the Trust asking someone about their ethnicity and updating our records accordingly. Work is underway to improve data completeness for this protected characteristic.

5.0 Further analysis

5.1 The detailed data is provided in the data pack in Part B of the Board pack. As requested at the July Board meeting, both the numbers of people as well as the percentages are included in the pack. Below is a summary of the analysis for those services where there is reasonable variation in representation in our services compared to the population, under or over representation. It also shows where variation is in relation to one or two protected characteristics or up to four. The analysis shows a similar pattern overall that was seen when the 2024/25 data was analysed.

5.2 Analysis of the data is represented in the table overleaf.

Table 1 - Analysis of IQPR data – Variation to population and protected characteristics

Variation	**High**	Physical health crisis assessment – more males than females, more people from deprived areas. 18 weeks RTT for consultant led MH services – fewer people from deprived areas and fewer males are referred. 18 weeks RTT for AHP led PH services – more females than males, higher proportion of people from deprived areas. People accessing CYP services with more than one or more than two contacts more over 16 young females than males having or more than two contacts, more young people from deprived areas. Virtual Ward occupancy – no person from a minority community received the virtual ward service. Gender variations regarding virtual ward occupancy on days 1, 15 and 30. Adult ADHD waiting list - more females than males on ADHD waiting list, more from deprived areas. CYP Neurodevelopment waiting list - more males than females on CYP Neurodevelopment waiting list, more from deprived areas. People having annual health checks – more from minority communities, more from deprived areas.	First episode of psychosis assessments – more people from minority backgrounds, from deprived areas and males are being assessed for their first episode of psychosis. People accessing talking therapies – females make up around two thirds of the people accessing talking therapies. More people from more deprived areas accessing talking therapies. Fewer older adults are accessing talking therapies. There is also a lower per cent of people completing talking therapies moving to recovery from deprived areas, ethnicity and older adults, when compared to the per cent of referrals. 18 weeks RTT for consultant led PH services – more males than females are being referred to the service, fewer people from minority communities and fewer from deprived areas (noting small numbers) receiving a consultant led PH service in 52 weeks. MH discharge follow-up in 72 hours – suggest higher level of follow-up for people from minority backgrounds, people from deprived areas also make up almost half of the follow-ups, more males than females having MH discharge follow-ups. Adults accessing community MH services – more females than males, higher from deprived areas, fewer older adults. CYP with eating disorders seen within 4 weeks – fewer people from lower deprived areas are referred, referrals mostly females, all people are white. Inappropriate out of area – more people from minority backgrounds, more people from deprived areas and more males than females are placed inappropriately out of are for their mental health care. Episodes of Seclusion – More people from minority backgrounds, more from deprived areas and more males than females are experiencing episodes of seclusion.
		Low (variation in 1-2)	**High (variation in 3-4)**
	Variation in number of protected characteristics		

5.3 There may be more variation than shown in some services because the data is incomplete in patient records, mainly in relation to ethnicity. These services are:

- Physical health crisis assessment;
- 18 weeks RTT for consultant led MH services;
- MH services including CMHTs;
- People accessing CYP services with more than one contact or more than two contacts;
- Women supported by perinatal mental health (in this case, address / postcode may also not be properly recorded);
- 18 weeks RTT for AHP led PH services;
- 18 weeks RTT for consultant led PH services;
- Virtual ward occupancy;
- Adult ADHD waiting list; and
- CYP Neurodevelopment waiting list.

6.0 Next steps

6.1 A range of actions will be overseen by the Equity and Inclusion Group and reported into the Public Health Patient Involvement and Partnership Committee (which reports into the Board). This includes to:

- address the data gaps where a person's ethnicity is not known or not stated;
- use the review by Grounded Research, identify which services where a variation against our local population is expected and those where we may be an 'outlier' requiring further action;
- provide targeted, culturally appropriate services.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks	**Agenda Item**	Paper X
Sponsoring Executive	Philip Gowland, Board Secretary and Director of Corporate Assurance		
Report Author	Philip Gowland, Board Secretary and Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	25 September 2025

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

The Board continues to receive update reports on the Strategic Delivery Risks, ensuring awareness to the progress on mitigating those five risks, that it felt had the biggest opportunity to disrupt the delivery of the Strategy.

The Board previously acknowledged that the publication of the NHS 10-year plan may impact on which risks were included in the SDR. Initial considerations did not immediately highlight the need for change but the Board will await the publication of further guidance documents in Q3, before confirming the need for any change in SDRs.

Whilst the current five SDRs remain, the paper sets out the progress made with respect to controls and assurances for each including the considerations (and slight adjustment) to the timeframes for achieving the target scores.

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

Each Board of Directors meeting includes this agenda item and relevant Committees receive updates on their allocated SDR – see Committee Reports to Board.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and NOTE the update position for each SDR.

NOTE the intended review of SDRs following the full consideration of the NHS 10 year Plan and the expected additional guidance documentation

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

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

People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X

	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
	Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks	Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
	Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

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

SDR1, SD2, SDR3, SDR4 and SDR5

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

All SDR in the paper are set within an external (system/place) impact / requirement for engagement.

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

Appendix (please list)

Individual Strategic Delivery Risk forms are in the Annex to the Report.

Strategic Delivery Risks

1. Background

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

1.2 The Board is focused on mitigating the likelihood, or more typically the impact, of these factors. Individual executive directors have been tasked with progressing actions to this effect.

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

- The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities (links to SO1)
- Challenges generating data and / or evidence to support interventions to address Health Inequalities (links to SO2)
- Capacity / Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies (links to SO3)
- Movement to seven-day working is poorly reflected in national terms and conditions and the Trust is therefore unable to shift to new models of care without major retention risk (links to SO4)
- The Trust lacks the cultural capability and competence on wider issues (links to SO5)

2. Strategic Delivery Risks

2.1 The Board of Directors will recall the staged process through which it identified and agreed the five strategic risks – the risks that most significantly could impact on the ability of the Trust to deliver its Strategy (and its strategic objectives). Essentially a 'long list' of some forty plus risks were initially identified and subsequently reduced in number to the final five. Whilst opportunistic to consider the risks in-year, they are not expected to change frequently – albeit circumstances may change to the extent that this is required. The recent Internal Audit highlighted this and suggested this was considered by the Board of Directors and with the recent publication of significant guidance documents like the NHS 10-year plan, this process has commenced. Initial considerations do not suggest a need for immediate change but importantly there are more related guidance documents expected. For this reason the Board will afford itself time in H2 2025/26 to fully consider if there needs to be a change to the five SDRs, whilst referencing these documents and changes in the current SDRs if appropriate – for example within SDR3.

2.4 Review and monitoring work will continue through

2.4.1 Individual executive leads and additional collective sessions with all leads.
2.4.2 Board Committees (all SR have been presented to Committees in August and September 2025)
2.4.3 the tri-annual reviews with Executive leads by the Audit Committee Chair and Director of Corporate Assurance (planned for Q3).
2.4.4 Board of Directors

2.5 The current position in respect of each SDR is presented in Appendix 1. Of note in the progress within the Appendix is:

SDR1: The updates focus on the planned feedback and evaluation of the stated means by which we are developing our leaders – this will be internally generated evaluation and analysis in respect of the LDO, but also independent assurance via 360 Assurance (internal audit) in respect of the induction process. This will give us an insight into the abilities of colleagues to work differently and work with our communities – the key next steps will then be to demonstrate the changed ways of working are impactful on service delivery and that we have colleagues (staff, members, patients, carers, volunteers and peers that are representative of those communities)

SDR2: The Board of Directors, in receiving the IQPR in July 2025 (and again in September), also had additional information about Health Inequalities appended to it and, in a separate report, received the analysis of the IQPR data through a health inequalities lens. The use of this analysis and data across the Trust will determine the success in mitigating this risk – it is important to have the data, but more so to use it to enact change and improvement.

SDR3: Further appointments into senior leadership roles of colleagues with primary care experience have been made recently (Physical Health CG). National guidance in support of the NHS 10 year plan and neighbourhood working; and possibly via new national contracting arrangements, will provide direction and expectation for all involved that supports the delivery of the associated objective (and mitigation of this SDR). The progress may be subject to different approaches and momentum in our three places which may require us to consider this risk at a level that recognises or acknowledges this.

SDR4 Essentially there is progress on the work being done or planned to do, to achieve the seven day approach consistently and incrementally across the services – this includes new service specification and design that have been established with this risk in mind, with clarity over expected working practices and patterns built in (hence reducing the likely challenge of inflexibility or resistance – essentially, colleagues are clear from the outset.) This is limited to a small number of services but is indicative of the way forward – the greater challenge will come from the need to make large ‘change’’ within existing services. Related work via HQTC and in wards towards consistent (across wards and across seven days) processes also help achieve this objective. Nationally driven work on neighbourhood working will also help and support if systems move forward collectively to provide services on a broader seven day footing.

SDR5: There is great interdependence with the progress and actions stated above in respect of SDR1 – namely the development of colleagues through induction, LDO and other development processes – albeit the emphasis in this SDR on their ability ‘to

make change occur’. Evaluative information and analysis (internal and third party) is due in the coming months on progress within these schemes.

3 Recommendations

The Board of Directors is asked to:

RECEIVE and **NOTE** the update position for each SDR.

NOTE the intended review of SDRs following the full consideration of the NHS 10 year Plan and the expected additional guidance documentation

Philip Gowland, Director of Corporate Assurance
19 September 2025

SO1: Nurture partnerships with patients and citizens to support good health										
What could get in the way? **The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities**	As a Strategic Delivery Risk:								**Lead Exec**	**Board Committee**
	If	our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027								
	because	of the leadership's inability to identify, communicate and engage							SF	PHPIP
	then	it will lead to a loss of confidence locally and likely non-delivery of SO1								
Risk Score	Current (July 2025)					Target (July 2026)				
	I	4	L	3	12	I	4	L	2	8

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Stakeholders: Stakeholder Management Matrix – includes a range of stakeholders; Important to understand the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; including 'cake' model with two EG colleagues aligned to individual three places to work with relevant care group reps to build relationships and establish progress and create synthesis with information from other sources.	In part, the outcome of the Internal Audit work on Partnership Governance and Risk Management is appropriate (significant assurance). The recommendations made in the report and due by 31 August 2025 have now all been implemented.
Educating our Staff: Leadership Development Offer includes, 'Compassionate leadership to unlock community power' — Both cohorts now launched.	Feedback loop: (Gap)Research and Evaluation planned outputs (via K Williamson). Of particular relevance is the response to two questions: *1b Has the Trust developed compassionate leadership to unlock community power, from the perspective of staff, service users and communities? and 3 Has the LDO improved RDaSH Leaders' engagement with each other and the community* Baseline data is available for the two cohorts and the initial data points have been shared at the June LDO Steering Group. Further detailed analysis planned for October 25 to January 26. All participants within the LDO are undertaking a 360 degree LEIPA assessment. Cohort 1 virtually all done / Cohort 2 later in the year. This will provide direct insight

	and feedback to the individual participants and the Trust is exploring whether there is any opportunity for very high level cumulative data to be made available too. Capability and Capacity of Leaders (resultant post LDO) – discussions planned (by March 2026) to review the impact of the course on the cohorts that have taken part.
Educating our Staff: Induction - Revised induction process; 5-day event that includes a focus on introducing colleagues to the Trust and its communities.	Feedback loop: Induction is fast approaching one year in place. Approximate numbers are 50 pm hence to date around 500 people have undertaken this. Evaluation of induction asks for participants to respond to the question, *'I am able to understand how my role supports the RDaSH Strategic Objectives / Promises and how I can help to Nurture the Power in our Communities.* (Gap) *The evaluation will be presented in the Autumn following the anniversary of the new Induction programme alongside the 360 Audit on this topic including local inductions (due October 2025)* Additional independent feedback provided by commissioned 'mystery shopper' for the Day 1, Day 2 and Day 5 elements of the induction to the DoP&OD.
Educating Our Staff: Learning Half Days (Gap) *forward plan to be developed to include related matters linked to this Strategic Delivery Risk and the mitigating actions needed.*	(Gap) – agreed mechanism needed for capturing the outcome and evaluation of activities that feature within the LHD programme. *Discussion at the Education and Learning meeting in June 2025, paper to CLE in June 2025 and a paper to Board in Mach 2025. This will be further enhanced following the appointment of the coordinator and the development of the learning library alongside the trialling of different delivery models for inpatient areas.*
Cultural Shift: Ability of leaders to instigate change; an openness to fail, but learn and improve and ultimately succeed.	The LDO features as learning outcome *2: Enhance our ability to lead change and deliver improvements (Gap)* As per the point above there is work outstanding to clarify the feedback and evaluation of the participants in this regard. The LDO providers have now also included a question as part of the evaluation questionnaires to capture the views and ratings of Line Managers who also have delegates on the programme. January 2026
Cultural Shift: Recruitment and appraisal processes that focus on the appointment based on alignment to the Trust's Values	*(Gap)* Confirmed process to ensure processes effectively include this 'test' to ensure colleagues have values that align to those of the Trust *This will be explored via Trust People Council and also the annual Staff Survey – 'Voice Scorecard'.* In addition new triangulating report on Employee Relations cases, FTSU and Complaints - presented to POD (August 2025) further supporting analysis in this area.
Representation within our colleagues: A workforce with volunteers, patient safety partners and members that is truly representative of the communities we serve – this would include number of as well as diversity and representation within these cohorts.	*(Gap)* Collation and presentation of related numbers, action plans for increased numbers and analysis of numbers in comparison to our communities. *We are currently in the processing of recording our volunteers on ESR to support the production of the demographic data, which will then be analysed against the current workforce data and also the ONS*

	Improved WRES data: the WRES report was reviewed and approved by the POD Committee in August, whilst some areas have improved we have also seen a decline in others WDES data: not improving as much as WRES – Discussed at POD, and will be again through the DAWN network and Combined Staff Network to identify actions Increased understanding of the related demographics of our staff and also then in subsets such as those using the apprenticeship levy; local recruitment, etc. Further work needed to ensure we are representative
Engaging our communities – seeking feedback Care Opinion launched (patients and carers)	Care Group Delivery meetings in 2024 and May 2025 featured Care Opinion and Care Opinion within February 25 Board Timeout Led by CEO of Care Opinion. Council of Governors in June 2025. (Gap) Overarching analysis of responses via Care Opinion including those leading to action – Update to Board in September 2025 within the Chief executive's Report
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 4 (Quality – Quality and Safety Plan) o Promise 5 (Board – Quality and Safety Plan) o Promise 6 (PHPIP – Equity and Inclusion Plan) o Promise 8 (PHPIP – Equity and Inclusion Plan) o Promise 10 (PHPIP – Equity and Inclusion Plan) o Promise 11 (PHPIP – Equity and Inclusion Plan) o Promise 26 (POD – People and Teams)	Via Promises and Priorities Scorecard – routine report to Board of Directors PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure. PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing Board of Directors – March/May 2025 – Promise 26
PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)	Most recent July 2025
Independent Third-party Assurance	Internal Audit work on Patient Experience, Engagement and Inclusion – Significant Assurance Internal Audit work on Induction – 25/26 audit plan (*Gap*)report due by 30 September 2025.

SO2: Create equity of access, employment and experience to address differences in outcome											
What could get in the way? **Challenges generating data and / or evidence to support interventions to address Health Inequalities**	As a Strategic Delivery Risk:									**Lead Exec**	**Board Committee**
	If	we do not execute plans to consistently create, use and respond to data inside our services and with others									
	because	our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities								RB	FDE
	then	this will lead to a lack of precision in how the Trust reshapes services									
Risk Score	Current (July 2025)					Target (March 2026)					
	I	4	L	3	12	I	4	L	2	8	

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Data Availability: Health Inequalities – Reportable Data Sets of data relating to Promises. Identify a baseline position and detail planned further work across a range of data points including the establishment of targets (via Reportal 521 Health Inequalities Dashboard) (Pointed towards health inequality related promises 6, 7, 8, 10, 11, 12 and 17)	Revised IQPR and associated Health Inequality measurements / indicators with reporting that confirms that as a result of action there are reductions in the health inequalities. In July 2025 the IQPR had supplementary information included and the Board of Directors received an analysis of the IQPR data through a health inequalities lens (separate paper) and agreed that CLE Equity and Inclusion Group would review the data to better understand local needs of patients with protected characteristics.
Data Quality	Information Quality Programme and reports to FDE noted structured and demonstratable process was in place. Kitemarking – (Gap) Current position Internal Audit report of IQPR (Significant Assurance) Internal Audit report on Waiting Lists (Significant Assurance – waiting list management / Limited Assurance – waiting list validation) Audit on Clinical Coding (Feb 25) FDE assured by the Clinical Coding Audit Report that robust processes are in place to facilitate the accurate application of clinical coding.
Educating our leaders: Digital Needs Survey (completed in Q2)	Summary outcome reports provided to Digital transformation Group and used to inform both the Data Saves Lives programme and also considerations for both bespoke and broader

Data Saves Lives Campaign (Launched 26 November 2024) – 'Giving health and care professionals the information they need to provide the best possible care'. Series of posters have been distributed and series of three Vlogs launched (December 2024) Key messages in December including Improving trust and transparency; Accurate and timely recording of data / Knowledge is Power; The benefits of using the Yorkshire & The Humber Care Record; How data flows through the system/organisation. An 'Ask me anything' session took place in January 25. Learning Half Days (ongoing from Sept 24) – feature learning opportunities focused on the importance of data and health inequalities.	training, particularly associated with aspects around the requirement to interface with our electronic patient record, SystmOne. Post Data Saves Lives Campaign, 'business as usual' plan agreed. Incorporates Q3/Q4 evaluation and identifies changes and enhancements to systems training offer. (Gap) Identification of key responses from colleagues to the educational efforts to demonstrate learning and great understanding. Board Timeout June 2025 – NHS Digital Board session facilitated by NHS Providers. Specific related events to date: October 2024: establishing mental health and community use cases associated with the use of the Yorkshire & The Humber Shared [clinical] Record; November 2024 : New personalised care visualisation (20 attendees in total). The personalised care visualisation is a new development for PROMs and 4ww / Saving events in SystmOne (14 attendees in total). Accurately recording both clinical consultations of different types, as well as administration events / Communicating with patients digitally (40 attendees in total). Use of health inequalities data for frontline staff: Jan 2025: SMI physical heath checks new visualisation overview (joint session with Change & Transformation) / Feb 2025: shared care records, patient care access considerations (joint session with Information Governance); SystmOne roadmap 25/26
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 6 Poverty Proofing (PHPIP – Equity and Inclusion Plan) o Promise 8 Inequalities (PHPIP – Equity and Inclusion Plan)	Via Promises and Priorities Scorecard PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure. PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing PHPIP Committee – July 2025 - paper on promises data presented. Committee now assured with the progress made and the dashboard now in place.
FDE Strategic Delivery Risk Report relating to the oversight and management of SDR2	

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

Risk Score	Current (July 2025)					Target (July 2026)				
	I	4	L	3	12	I	4	L	2	8

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Stakeholders: Stakeholder Management Matrix – includes a range of stakeholders; Important to understand the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; including 'cake' model with two EG colleagues aligned to individual three places to work with relevant care group reps to build relationships and establish progress and create synthesis with information from other sources.	In part – the outcome of the Internal Audit work on Partnership Governance and Risk Management is appropriate (significant assurance) – report noted some further work which has now been completed. Gap – implementation of the 'cake' model being planned from October 25.
Regular and well established touchpoints within each of the three places with GP representatives – Via GP Liaison Role – programme of visits established to every practice with touchpoints into PCNs and the local Federations. : • Individual Practices • PCNs • Federations	Feedback mechanisms with GPs are established and embedded – these will be used to confirm strong alignment on Primary and Community MH services and adult and children's community nursing. Engagement (differing levels) with circa 90% of practices. Initial survey how practices rate the current level of integration, collaboration and partnership with RDaSH of practices identified score of 2.52 (out of 5) – Gap repeat (May 2026) to assess future progress
Facilitate insight into General practice within:	

1. Senior individuals: via Dr Richard Falk – Non-Executive Director / Dr Dean Eggitt – GP Partner Governor / Primary Care Doncaster Chief Executive (route to CLE) / GP Liaison role (within the Strategic Development Team) / Ben Allen and Matt Hodgson 2. *Care Groups:* GP related appointments into Care group structures (7 / 13 Care Group Directorates are community based – these leaders are especially important in the development and work supporting the mitigation of this risk.)– 3. Wider Workforce: A: Through the Leadership Development Offer (LDO) – aim is to skill up our people regarding primary care. LDO Launched. Cohort 1 commenced January 2025; Cohort 2 launched in April 2025. B: Learning Half Days (LHD) programmed to align to known GP training schedules such as 'Target' in Doncaster (i.e. Wednesday afternoon training sessions across GPS in the city to afford joint training and engagement)	PHPIP Committee – March 2025, presentation GP Liaison role and work to date and Board Timeout – April 2025. GP Liaison role and work to date Recent closure of a gap - A*ppointment to Physical Health Care Group of Medical Director (Ben Allen) and Matt Hodgson, Lead Medic.* (Gap) Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group) Cohort 1 launched January 2025 / Cohort 2 launched April 2025 This feedback will secure confirmation that our leaders have the necessary skills and experience linked to the work with primary care and other partners in particular via the following research and evaluation question. *Has the LDO improved RDaSH Leaders' engagement with each other and the community* Research and Evaluation planned outputs (via K Williamson) April and October 2025 and April and September 2026. LHD – primary care knowledge and understanding – needs to be purposefully built into this programme of learning.
Responding to Neighbourhood Health The ten-year plan seeks to compel primary care to collaborate on either a neighbourhood or community multi-specialty provider contract. Whilst both are yet to be published this may provide a framework to ensure primary care leadership work is enhanced helping to address our risk. Conversely it could create conflict/transactional behaviours. **Our current controls are deep involvement in:** - Decision making bodies as they evolve at place - Direct work with the Self-Care GP Federation in North Lincs (for clarity we are also working closely with Rotherham Fed which includes Doncaster East PCN, and with the various Doncaster leadership groups	(Gap) ability to assess the contracts vs current vs future plan because of a lack of visibility of either the implementation plan for the ten year plan or the primary care contracts

Practical Programme of Change: Agreed programme of change with Primary Care Colleagues that addresses the issues that they raise via other routes, in particular via GP Liaison Role. CLE (Dec 24) identified four areas of focus + additional fifth subsequent. 1. Remove any and all practices which prevent our clinical teams within RDaSH making cross referrals or transferring care. 2. Move to simple electronic forms for all referrals, with prompts which ensure that mandatory information is provided: 3. Introduce simple, coherent routes of communication to our clinical teams from primary care, and provide 'backdoor' contact models to permit escalation senior clinician-senior clinician for any patients where there is a concern. 4. Audit and justify any practices which tend to pass work or tasks to GPs that could be done by the secondary care team. 5. Waiting time information – Providing up to date waiting time information and making it simple to patients to find out their place in queues to reduce purely administrative appointments in primary care.	(Gap) Comprehensive action plans and reporting mechanism to ensure agreed timescales are achieved and have the intended benefits. Action 5: Progress made through publication of waiting list information on the public website since end of July 2025. Action 2: This work is in development and will be advanced by year end. Action 3: this stalled but the completion of job planning work in Q3 for psychiatry/psychology roles will allow us to consider how it can best be approached.
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 12 Rurality (PHPIP - Equity and Inclusion Plan) o Promise 15 Neighbourhood teams (PHPIP - Equity and Inclusion Plan) o Promise 21 Hyper Local (PHPIP - Equity and Inclusion Plan)	Via Promises and Priorities Scorecard Paper E (Nov 24 PHPIP) – set out (for P12) – what needs to happen and by when to move to an Amber / Green position against each success measure. PHPIP return to this in Nov 25: E&I received an update in Sept. PHPIP Committee: Planned for January 2026 – Integrated Neighbourhood Teams and Hyperlocal PHPIP Committee – January 2025 – verbal item linked to P21 and plan to return to this in Jan 26.
PHPIP Strategic Delivery Risk Report relating to the oversight and management of SDR3	Most recently at July 2025's meeting.

SO4: Deliver high quality and therapeutic bed based care on our own sites and in other settings												
What could get in the way? **Movement to seven-day working is poorly reflected in national terms and conditions and the Trust is therefore unable to shift to new models of care without major retention risk**	As a Strategic Delivery Risk:										**Lead Exec**	**Board Committee**
	If	Seven day working and other bed based service alterations are not implemented fully										
	because	of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring)									RC	QC
	then	we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.										
Risk Score	Current Score (July 2025)					Target Score (September 2026)						
	I	4	L	3	12	I	4	L	2	8		

Controls – What will we put in place to mitigate the risk?	Assurance – How will we know the controls are working?
Staff Engagement (linked to necessary change and impact on staff) Unions and Staff Side – consultation / engagement processes with union and staff side reps to discuss and agree. (This will likely include revised 'standard' terms and conditions to create opportunity for more flexibility, changes to JDs to reflect new ways of working.) Consider workforce models of support - training; enhanced work flexibility; clarity on support and supervision models; safety	(Gap) Comprehensive mechanism for collation and reporting of feedback gained via: ○ Staff Survey ○ Pulse Check ○ Peer Reviews ○ Consultation responses ○ Responses via Unions and Staff Side ○ And an associated set of Employee Relations indicators That will help us understand the impact that the changes are having / how they are being received and responded to. Ongoing work - There are opportunities via TPC and OMG about developing and implementing greater flexibility within staff shifts The implementation of the consistent handover process includes a consultation process involving 170 staff and staff side.
Service provision (RDASH)	

Newly established High Quality Therapeutic Taskforce from January 2025 taking forward a range of issues and significantly support the delivery of 7-day therapeutic services within an inpatient and acute context. Data • Base line developed of number of discharges in relation to days of the week, and timing of discharges by wards • "live" Flow Dashboard in place Enhance the Current Offer • enhanced discharges during weekdays using current infrastructure - includes using EDD's more consistently and appropriately • weekly meetings with senior nurses to review EDD (Q2) • complex CRFD forum with the 3 Local Authority Partners and 2 ICB Developing New Models • To ensure therapeutic discharges 24/7 are part of the inpatient improvement programme "the middle bit" (Q3 onwards) • Consider Pilot programme on one ward to test the ability, capacity and affordability of proposed changes.	HQTC: has progressed a number of meaningful measures and actions to create consistency across all wards – these include activities being available 7 days per week; visiting times consistent and across the 7d week; MDT meetings, Care planning and ward handover – consistent and across 7 days. New services are developed with the seven day process in mind – for example the new HDU and Community Rehab Unit; Recent service developments in PH Care Group such as IV and Phlebotomy are 7 day services started in the last 12m Further opportunities are being considered that extend and support the seven day approach such as the extension to medical on call to support discharge at the weekends and extend CAMHS psychiatry to do crisis assessment for young people; In line with promise 14 (part a) patients can access trust (selected services) at anytime to manage appointments; and in line with promise 14 (part b) we will advance to be able to respond to urgent referrals within 48 hours; Work in respect of promise 1 (peer support workers0 and promise 3 (volunteers) will also contribute to the development of seven day working and consistency across all days. Work aligned to promise 21 (Neighbourhood Working) will improve this too IQPR reporting improvements in • Waiting times – greater awareness and regular oversight of waits. Now published (31 July 2025) on website. • Out of Area Placements – reducing in number (at 09/09/25 10 inappropriate (9 NL / 1 R) • Delays in discharges (at 09/09/25 18) • Length of stay metric to be introduced (Mean of patients on the ward) percentage of patients over 32 days (48% in August) • Utilisation of talking therapies And via 'live' Flow dashboard – distributed on a daily basis to senior staff across the Trust

Service provision - Alternative (others) Explore how and who other service providers (community and voluntary sector) can contribute / support the delivery or support to our services on a more flexible or longer basis. (Gap) This will need 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	The commissioning of support via VCSE partners such as PFG are being completed on the basis of them being
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: This will include all linked to SO3 – Promises 13 to 17, but more specifically those linked to SO4 – Promises 18 to 23	Promises and Priorities Scorecard – Board of Directors each meeting P19 Out of Area Placements – Board of Directors May 2025
QC Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk	

SO5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations										
What could get in the way? **The Trust lacks the cultural capability and competence on wider issues**	As a Strategic Delivery Risk:								**Lead Exec**	**Board Committee**
	If	We do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027								
	because	We do not develop and practice the skillsets required to make change occur							CH	POD
	then	The Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees								
Risk Score	Current Score (July 2025)					Target Score (March 2026)				
	I	4	L	3	12	I	4	L	2	8

Developing our Leaders	
Induction (all new starters) – RDASH and our communities – Launched 28 October 2024	September's induction was the eleventh since its launch meaning circa 600 staff have now progressed via this induction. Evaluation of induction asks for participants to respond to the question, *'I am able to understand how my role supports the RDaSH Strategic Objectives / Promises and how I can help to Nurture the Power in our Communities.* (Gap) The evaluation will be presented in the Autumn following the anniversary of the new Induction programme and this will be alongside the 360 Audit on Induction (due by end of September 2025) Independent feedback report also due August 2025.
Leadership Development Offer – circa 130 individuals inc 15 community leaders; Two cohorts are now underway	Leadership Development Offer Feedback and Evaluation (via Education and Learning CLE Group) (Gap) - This feedback will secure confirmation that our leaders have the necessary skillsets linked to the partnership work

	LEIPA Response (that includes self assessments and 360 degree feedback from circa 10 colleagues to each member of the LDO) – Cohort 1 virtually all done / Cohort 2 later in the year Initial evaluation – will be reported to the LDO Steering group Research Evaluation – facilitated by Kevin Williamson, will follow
Leaders Conference – circa 130 staff as the Top Leaders Cadre – September 2025. Learning Half Days for every member of the Trust commenced in September 2024. First Line Managers Training Scheme – Launched April 2025 'Wider leadership' proposals – B5+ / Very Senior Clinicians Revised appraisal process (Gap) People and Teams CLE Group and Education and Learning CLE Group – established and meeting regularly	Leaders Conference will focus on 10 year plan and understanding of it and implications for us (Gap) Other mechanisms of feedback from leaders to demonstrate their increased competence and confidence regarding making change occur and adding social value. Capability and Capacity of Leaders – TL/RC and CH (31 July 2025) – (Gap) outcome and forward plan.
Increased Capacity Fully utilising the apprenticeship levy (delivery of Promise 9) Fully recruiting to all posts – 97.5% Commitment to designated training budget – demonstrate increase in spending year on year Re-development of the Change function - complete	May 2025: 80% utilised in 24/25; Forward plan developed to increase spend including levy transfer to community partners within 25/26. Sept 2025: Current vacancies in CEX Report Annex (204wte – increase from circa 100 wte due to inclusion of two large new teams) 2025/26: Ringfenced training budget in place again.
Feedback Mechanisms From stakeholders regarding the approach of the Trust	Gap – structure, frequency of collation of related feedback mechanisms including: o Staff Survey / Pulse Check o 'Voice' Scorecard o Care Opinion Reduction in Employee relations cases / matters
Consistent timely exit and delivery of **time bound projects**, and achievement of key measures with respect to the wider issues within the Strategy – inc the delivery of 'social value' and implementation of P25 where the use of local suppliers will contribute.	P25 – Real Living Wage accreditation received in July 2025.

Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: o Promise 9 Apprentice Levy (PHPIP - Equity and Inclusion Plan) o Promise 26 Anti-Racism (POD – People and Teams Plan)	Promises and Priorities Scorecard P9 – Apprenticeships – March 2025 P26 – Board of Directors March / May 2025
Independent Third-party Assurance	Internal Audit work on Induction – H1 Audit within the 25/26 audit plan Reporting of findings will be by 30 September 2025 (draft indicates significant assurance)
POD Strategic Delivery Risk Report relating to the oversight and management of SDR5	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational Risk Report	**Agenda Item**	Paper Y
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	25 September 2025

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

This report provides an update to the Board of Directors on the current operational risk profile, reflecting the organisation's embedding of reporting risks in relation to defined appetite and tolerance levels. It continues to align with the updated Risk Management Framework and refreshed risk appetite categories and levels, which were approved by the Board of Directors in May 2025. These developments demonstrate the Trust's strengthened approach to risk oversight and the increasing consistency and clarity in risk assessment and reporting.

We continue to fine tune the processes introduced through the updated Risk Management Framework, particularly in how risks out of tolerance are moderated and escalated for appropriate oversight. The recent round of delivery reviews has provided a more consistent picture of directorate risk profiles and is helping to surface themes across the organisation. This is strengthening the link between local risk ownership and Board-level oversight, with escalation pathways becoming clearer and more embedded.

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

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

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and **NOTE** the operational risk report

NOTE the revised reporting thresholds based on risk appetite and the planned work to address the extended number of risks that are currently outside of appetite and tolerance

Alignment to strategic objectives (indicate those that the paper supports)	
Business as usual	x

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

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

People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	128
Patient care risk	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	220 / 292
External and partnership risks	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	152 / 158

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

Not applicable

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

Not applicable

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

Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Appendix (please list)							
None							

1. Overview

1.1 Operational risk reporting to the Board has shifted from a focus on extreme-rated risks to a clearer alignment with the Trust's defined appetite and tolerance levels. This approach ensures that reporting reflects the full risk framework rather than a single rating threshold.

1.2 From this month, the Board report presents only those risks sitting outside tolerance, following moderation through the Risk Management Groups. This provides assurance that directorates are actively managing risks within appetite or tolerance and that only those requiring escalation for Board oversight are highlighted.

1.3 The use of the RADAR risk management system is supporting this approach by providing greater visibility and consistency in how risks are categorised, moderated, and escalated. The focus is now on strengthening assurance over escalation pathways and ensuring that the Board has sight of those areas where risks remain beyond acceptable thresholds.

1.4 This change continues to embed the updated Risk Management Framework approved earlier this year, reinforcing a more disciplined and transparent approach to oversight, escalation, and decision-making at Board level.

2. Current Operational Overview

2.1 The operational risk profile now reflects a sharper focus on risks in relation to appetite and tolerance, with reporting to the Board limited to those that sit outside tolerance following moderation through the Risk Management Groups. This ensures that oversight is concentrated on areas of greatest residual exposure while providing assurance that risks within appetite and tolerance are being actively managed at directorate level.

2.2 The RADAR system is now fully operational and has replaced Ulysses across the Trust for the recording and monitoring of risks. All services have been onboarded, with staff able to enter, update, and view risks in real time. This provides greater transparency of risk across care groups and corporate services and strengthens the consistency of how risks are captured and reported

2.3 As at the latest review, there are 310 risks recorded on RADAR. The distribution against appetite and tolerance is as follows:

- Within Appetite (Green): 114 risks (36.7%)
- Within Tolerance (Amber): 179 risks (57.7%)
- Outside Tolerance (Red): 17 risks (5.5%)

Compared with the position reported to the Board in July (318 total risks, with 61 outside tolerance), the overall volume of risks has reduced slightly while the number outside tolerance has fallen more sharply. This reflects both targeted mitigation and the outcomes of moderation through the Risk Management Groups. The increase in risks within appetite (from 95 to 114) suggests stronger control in several areas, while those within tolerance but above appetite remain broadly stable. The details of the 17 risks currently outside tolerance are included in the table below

ID	Description	Category	Appetite Level / Upper Tolerance Limit	Impact	L/Hood	Current score	Directorate
RSK-375	Due to the absence of a medic to complete DVLA driving report requests for the memory service, resulting in a backlog since September 2024, there is a risk that patients may either continue driving when unfit or be prevented from driving when capable, which may result in unsafe driving on the roads, reduced quality of life for patients, and reputational damage to the Trust.	Patient Care Risk - Clinical Safety	Averse 6	4	3	12	Rotherham Community Mental Health Directorate
RSK-152	Due to insufficient capacity to meet the demand for ADHD assessments, there is a risk that patients will remain unassessed, which may result in compromised wellbeing and health outcomes for patients and their families, adversely affect service delivery and staff wellbeing, jeopardize the Trust's ability to meet Strategic Objective Promises 8 and 14, and damage the Trust's reputation.	External and Partnership Risk - Delivering Our Promises	Low Tolerance 10	3	5	15	Neurodiversity Directorate
RSK-158	Due to insufficient capacity to meet demand for Autism assessments in Doncaster and Rotherham, there is a risk that patients will remain undiagnosed, which may result in compromised health outcomes, negative impacts on patient and family well-being, and staff health and well-being. This also constitutes a breach of NICE guidance, threatens the Trust's ability to deliver Strategic Objective Promises 8 and 14, and damages the Trust's reputation.	External and Partnership Risk - Delivering Our Promises	Low Tolerance 10	3	5	15	Neurodiversity Directorate
RSK-103	If ligature alarms are not installed on bedroom and bathroom doors in inpatient wards, there is a risk that staff will be unaware of a patient attempting self-harm, which may result in serious or catastrophic injury, including suicide, before help can arrive.	Patient Care Risk - Clinical Safety	Averse 6	5	2	10	North Lincolnshire Acute Mental Health Directorate

ID	Description	Category	Appetite Level / Upper Tolerance Limit	Impact	L/Hood	Current score	Directorate
RSK-221	If all food handlers in the Trust do not receive the required food safety training (a legal requirement), there is a risk of food safety incidents, such as food poisoning or allergic reactions, which could harm patients and staff and expose the Trust to legal and reputational risks.	Patient Care Risk - Clinical Safety	Averse 6	5	2	10	Nursing & Facilities Directorate
RSK-038	Due to the absence of a robust process to assure the Trust that lithium prescribing and drug-monitoring responsibilities are being met with partner organisations, there is a risk that patient safety will be compromised, which may result in clinical harm, reputational damage, and failure of the Trust to meet its accountability obligations.	Patient Care Risk - Clinical Safety	Averse 6	3	3	9	Medical, Pharmacy & Research Directorate
RSK-044	Due to the absence of a reliable method for identifying and monitoring patient discharges resulting from disengagement, there is a risk that patients may be discharged inappropriately without adequate support, which may result in harm to themselves or others.	Patient Care Risk - Clinical Safety	Averse 6	3	3	9	Medical, Pharmacy & Research Directorate
RSK-083	If the Trust lacks a single, authoritative source of information on medicines use, there is a risk that individual prescribers, teams and care groups will be unable to interrogate prescribing and cost data, which may result in suboptimal clinical and budgetary decisions and weaker professional oversight.	Performance Risk - Information Governance	Averse 6	3	3	9	Medical, Pharmacy & Research Directorate
RSK-183	Due to the absence of a dedicated community forensic service, there is a risk that clinical pathways for adult mental health will be insufficient to meet the needs of forensic service users or individuals with extreme challenging behaviours, which may result in inappropriate care, increased	Patient Care Risk - Clinical Safety	Averse 6	3	4	9	Doncaster Community Mental Health Directorate

ID	Description	Category	Appetite Level / Upper Tolerance Limit	Impact	L/Hood	Current score	Directorate
	safety risks to patients, staff, and the public, and reputational harm.						
RSK-360	Due to the absence of a long-term plan for consultant-psychiatrist support to supervise CPN non-medical prescribers in the Enhanced Care Home Team, there is a risk that residents with complex mental-health conditions will receive inadequate assessment, diagnosis and management, which may result in inappropriate medication, unmet psychological needs, deterioration in health, and increased hospital admissions.	Patient Care Risk - Clinical Safety	Averse 6	3	3	9	Rehabilitation Directorate
RSK-119	If the Trust does not continue to invest in the tools and resources needed to maintain a good cyber security posture, there is a significantly increased risk of a successful cyber-attack, which may result in loss of access to clinical and administrative functions, data loss, financial loss, and reputational damage.	Performance Risk - Digital Infrastructure & Cyber Security	Low Tolerance 10	4	3	12	Health Informatics Directorate
RSK-189	If Trust financial performance is not in line with the agreed plan, there is a risk that service delivery will be compromised, commissioners and NHS England may lose confidence, and the Trust's reputation and sustainability could be adversely affected.	Financial Risk - Financial Planning, CIP & Sustainability	Low Tolerance 10	4	3	12	Finance & Procurement Directorate
RSK-196	Due to the potential for the Trust or any of its business-critical system providers to be subject to a successful cyber-attack, there is a risk of major disruption to services, which may impact patient care, compromise corporate operations, and result in significant operational delays and reputational damage.	Performance Risk - Digital Infrastructure & Cyber Security	Low Tolerance 10	4	3	12	

ID	Description	Category	Appetite Level / Upper Tolerance Limit	Impact	L/Hood	Current score	Directorate
RSK-202	Due to the absence of a structured framework for Advanced Clinical Practitioners and non-medical consultants, there is a risk that training, supervision, competence evidence and remuneration will be inconsistent, which may result in unsafe practice, pay inequity and increased patient-safety incidents.	People Risk - Capability and Performance	Low Tolerance 10	4	3	12	Nursing & Facilities Directorate
RSK-291	Due to the continued use of multiple registers for SMI patients across GP surgeries and RDaSH, there is a risk that some patients will be missed and not offered an annual SMI health check, which may lead to avoidable harm and compromised patient care.	Patient Care Risk - Clinical Safety	Averse 6	4	2	8	Operations Directorate
RSK-354	Due to insufficient specialist falls service assessment capacity, there is a risk that access to assessment and treatment will be delayed and inappropriate acute hospital admissions will occur, which may result in reduced responsiveness, poorer patient outcomes, and lower service quality.	People Risk - Capacity	Low Tolerance 10	3	4	12	Rehabilitation Directorate
RSK-382	Due to the occupational-therapy kitchen being located outside the ward airlock and along a key-code corridor, there is a risk that incidents in the kitchen will go undetected or receive delayed response, which may result in serious harm to patients or staff.	Patient Care Risk - Clinical Safety	Averse 6	4	2	8	Rotherham Acute Mental Health Directorate

2.4 Of the 17 risks currently outside tolerance, the most significant include two relating to ADHD services, which as the Board is aware (see IQPR paper) remain a substantial challenge for the Trust. There are also risks linked to workforce capacity in key clinical areas, which continue to place pressure on service delivery. These highlight areas of exposure that require focused attention from management and continued oversight from the Board.

3. Conclusion

3.1 The current profile shows that the majority of operational risks are either within appetite or tolerable with active management, with only a small proportion sitting outside tolerance. Compared with the position reported in July, there has been a marked reduction in the number of red risks, providing assurance that escalation and mitigation processes are starting to take effect.

3.2 The move to reporting through appetite and tolerance continues to provide clearer visibility of where operational risks align with the organisation's capacity and where targeted intervention is still required. The moderation of risks through the Risk Management Groups is supporting more consistent escalation and is beginning to strengthen assurance over how directorates manage risks.

3.3 The remaining out-of-tolerance risks highlight areas where exposure remains beyond what the organisation deems acceptable and will therefore require continued focused attention from management and oversight from the Board.

4. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the operational risk report

Philip Gowland
Director of Corporate Assurance
18 September 2025

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises Scorecard at Sept 2025	**Agenda Item**	Paper Z
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	25 September 2025

Suggested discussion points

This paper *continues to indicate that delivery of our promises by 2028 is possible*. In 2025 we expect to have two fully delivered – promises 25 and then 3. The appended report notes a further eleven where we need to consider more carefully as a Board what constitutes final success. For the first time, success measures for Promise 21 are scored as others are.

The utility of this scorecard cannot simply be for the Board, albeit hitherto it is the Board and CLE who have seen it. The covering paper outlines how the report will change in a few weeks, with *a new league table*, in part to better galvanise colleagues in the wider leadership, notably where there is a need to focus on delivery data – promise 1, 2, 7, 8, and so on, while there remains time to amend and adjust our approach.

Neighbourhood health is prominent at promises 15 and 21 in our work – and the delivery of the HQTC work in coming months is critical too to 2025/26 success including for promises 18 and 19. Within September delivery reviews we are seeking to shift left on the trajectory of Promise 14, with more specialties and teams than the projected 57 succeeding in December. The *new Promise 14 scorecard*, which we will use in CLE from October each month, will ensure collective visibility of the backlog of waiters, the referral assumptions, and other key indicators in the journey to April 2026.

As the promises are the key measure of our clinical and organisational strategy, it is helpful to have robust challenge not only to the self-assessment but to progress: *we should be demanding of ourselves* about the pace of delivery.

Previous consideration	
N/A – albeit future pre-Board circulation from November 1 is outlined	
Recommendation (delete options as appropriate and elaborate as required)	
The Board of Directors is asked to:	
NOTE the self-assessment provided, augmented by the narrative within this paper	
DISCUSS specific updates offered in the report itself – with a focus next time on Promises 1 and 2	
NOTE celebrations held in July for Promise 25 and intended in October for Promise 3	
Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Alignment to the plans: (indicate those that this paper supports)	
Estate plan	
Digital plan	
People and teams plan	X
Finance plan	
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X

Research and innovation plan			X
Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	**X**
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
SDR 1, 2, 3, 4 and 5							
System / Place impact (advise which ICB or place that this matter relates to)							
Work to improve wait times and tackle inequalities and popn. health issues							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Annex 1 – September 2025 promises scorecard							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Latest Promises Update

Purpose and introduction

1.1 This month marks a year since we started reported promises' progress, or position, using a four colour, two assessments model. This month we retain the same format – but November we plan to make three changes:

- List every promise "measure" in league table order from green to red
- Circulate the assessment at the start of November to all CLE subs
- Present the outcome of that month's circulation into the Board

There are two aims to that **change of focus and pace**:

- It much more widely shares how we are doing (as there is evidence from the LDO that this work has not travelled)
- It draws into focus the 86 measures we have

1.2 In November's Board we particular want to form *a shared view of eleven key Promises* that, arguably, have less definitive delivery measures and which might therefore pass under the radar – those being:

i. Promise 4 (patient feedback)
ii. Promise 5 (community involvement)
iii. Promise 7 (CORE20+five)
iv. Promise 11 (veterans' health)
v. Promise 13 (home first)
vi. Promise 16 (patient outcomes)
vii. Promise 20 (virtual ward models)
viii. Promise 22 (seven-day care)
ix. Promise 23 (residential care)
x. Promise 24 (education)
xi. Promise 28 (research)

Key updates from July and August

2.1 We are on the cusp of delivering Promise 3. We have **over 300 validated volunteers in place** and five of six groups have reached fifty or more volunteers in post. Dedicated focused work has been needed over the last four weeks to move forward cogently, which bears criticism of approaches prior to that. This may imply that a more grippy approach is needed where delivery reaches across a number of corporate functions, as well as where it requires execution across clinical services. We are looking to publicise widely through October the benefits being felt from the volunteering work – and thank you support for both volunteers and line managers has been organised.

2.2 **Promise 14** was extensively covered in our July Board meeting and will be a major focus in January too. The work to deliver success in part explains the growth in throughput outlined elsewhere in the Board papers. We now have a scorecard that describes the supply needed every month on current referral volumes to deliver the promise, forming a foundational view about what we need to sustain as service models and staffing arrangements change. 48 services expect to enter the second half of the year complying with the standard, more than half of the services that we report. CLE has agreed a go-live data on February 2026 for the urgent care part of this promise.

2.3 With **Promise 21**, we have now chosen measures, and the report for the first time tests where we are with them. This work will be core for our new 'cake' meetings which bring together corporate and care group leaders by place to consider how effectively we are leveraging our efforts at a local level in North Lincolnshire, Doncaster and Rotherham. Within this promise, and promise 15, we need to consider carefully what we mean by an integrated neighbourhood team, given narrow definitions offered nationally.

2.4 As indicated at the start of 2025/26 we are gradually working to make education and research (**promises 24 and 28) core business for the management processes that we have**. This means, for example, that they form part of delivery reviews. The relative immature nature of care group SLTs engagement with this work will be addressed as we move through the balance of the year – and again forms part of the Think Directorate discussions we need to have. Change of course must also come from the relevant corporate teams, supported Care Group leaders to lead in this space.

2.5 Our Board committee on public health, discussed the approach being taken to Promise 10 over the balance of 25/6 and into 26/7. The launch of our homeless health team is well-advanced, and mapping processes will shortly conclude on our existing reach for **other Inclusion Health** groups. The delivery plan for the promise incorporates both our clinical audit and internal audit programmes for 2026/7, as part of a clear effort to ensure this work is mainstream business.

2.6 The Board considered a paper on **Promise 2 relating to carers** when it met in July. There is no doubting the energy associated with the new carers network. But what needs to be considered in November is the current volume of carers' assessments, and the trajectory of improvement associated with our commitment to take every feasible step. The likelihood is that that success requires a transformation of scale in our referrals for assessments, and we need to map out the sequencing of change by place for the following five quarters.

2.7 **Promise 1** on peer support workers was due to come before the Board this month. It will instead come in November. In the meantime, work led by Jude Graham and Jon Rouston has established partnership in all three places to support PSWs within our mental health wards. We know that our investments for 2025/26 into new teams like our physical health community teams are

being well-received. What is crucial is to establish our forward trajectory for the promise to move PSWs into “all teams”.

Areas of concern

3.1 The chair rightly celebrated the initial **Clozapine** community project in Rotherham this summer in the latest edition of Trust Matters. The clinical leadership executive had agreed in March that both RCG and the Doncaster care group could proceed this work from existing resources, whilst North Lincolnshire received investment to make progress. Concern is now apparent about the pace of progress, and Jude Graham has kindly agreed to review what is going awry, and this work is a key aim within our promises – a step towards shifting care into our communities.

3.2 The **Community Involvement Framework** was approved earlier this year. It is perhaps the most complex part of Promise 5. Implementing the framework requires us to be present in our communities at a scale not presently visible, managerially. As we move to put into place our delayed partnering arrangements, we have work to do in Q3 to ensure that our approach truly reflects this framework. The Promises Team within the Nursing and Facilities directorate has a specific role to play in this work – in helping us to understand our voluntary sector connections as a Trust.

3.3 It will be apparent from the discussion on the acceptable behaviour policy, and from reviewing the IQPR, that we have cause for concern over progress with **Promise 26**. The 7-point anti-racism plan is making good progress and in 2026 we will introduce new rules in relation to all recruitment processes. But the experience of black and minority ethnic / global majority colleagues remains not the one we state we need and want to see. Reflecting after the leaders’ conference we need to consider what more or what deeper implementation support we need to have in place to really shift the dial.

Conclusion

4.1 The ten-year plan has reinforced and not interrupted the drive within our Trust to deliver on these promises. As we discussed in July, some now feature in our contracts with commissioners. Increasingly the promises feature within our delivery review cycle, as teams strive to ‘mainstream’ execution of ambitions like more older people within our talking therapies services (promise 8) or work to begin to tackle school readiness (promise 17).

4.2 We set out to do something amazing. Whilst timescales within the plan are not always being hit, the possibility of delivering the vast majority remains. But the next 15 months need to see laser-like focus on the measures themselves. We need to keep our ambition and the integrity of our review high, rather than falling into the trap of saying ‘we’re there – ish’ at this point.

Toby Lewis, September 22nd 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	The trajectory-based plan is being developed, overdue but required by E&I sub, and BOD, for November. This will inform Investment Fund 26/7 and 27/8. Peer Hub of Excellence launches 24/09/25 as key support to underpin effort. Work needed to be support peer led orgs beyond Doncaster.	Amber red	Recruitment is not the only marker of success – work now needed to build an evidence base for the conditions of effectiveness – including within physical health and older adult services less traditionally used to PSW roles than working age MH.
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	Self-assessment baseline overdue and required with E&I sub group for November meeting.	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	The opening hours and patient/carer handbook launched. We now need to structure an evaluation of access needs with carers and begin to test whether those changes are more effective for advocates and carers’ access to improve.	Amber green	Carer feedback will be critical, as we implement the new approach – and gather insight into what works (critical too with changes to MHA). We have not delivered until that feedback is available.
	Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.	Amber green	The plan presented to the Board, which was previously considered through CLE, sets out some of the actions needed to move forward with this – it is work which has a broad and enthusiastic support among local leaders.	Amber green	This cautious rating reflects the hidden scale of need and the work required to match that with support: concern that our approach to flexible and remote working needs work.

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	Identify all-age carers that use our services and ensure their rights under the carers act are recognised.	Amber green	Whilst the 'always measure' is a useful intention, we have not yet completed a meaningful analysis of what stands in the way of ideal practice (and therefore do not have a cogent delivery plan).	Amber red	This remains an exceptionally challenging measure and the heart of Promise 2. Concerted work through 2026/27 will be needed to make a reality of this commitment.
3. Work with over 350 volunteers by 2025 to go the extra mile in the quality of care that we offer	Have 350 volunteers registered to work with us or have equivalent to that figure volunteering time with us through another body.	Green	The process for recruiting and onboarding volunteers is now mostly optimised, and appears replicable at pace. We need to sustain this and move beyond 400 postholders to account for attrition.	Green	We need not only to achieve but to sustain, and we know that volunteers leave as well as join. Truly achieving this promise is best assessed in March when we have met the measure for six months.
	For that body of volunteers to reflect the diversity of our populations.	Green	Some validation of data this increased diversity is still needed as we now have over 300 postholders on ESR – report imminent.	Green	There is now clear focus on this aim, and with more people entering volunteering on a career-development pathway there is a route apparent to delivery.
4. Put patient feedback at the heart of how care is delivered in the Trust, encouraging all staff to shape services around individuals' diverse needs.	Increase by 15% the scale of feedback received in the Trust versus 2024/25 baselines.	Green	Both via Care Opinion, and bearing in mind other routes, we can see that the scale of feedback we have in place will continue to expand.	Green	This scale measure we would expect to meet during 2025/26. We need to ensure there is spread across the Trust's services for this to be valid.
	Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	Green	The pilot for this work has proved successful and has been assessed by the Board's MHAC: we now need to sustain the work over time.	Green	We will track this work in the Q&S sub-committee of CLE – and expect to see changes as a result of the feedback received. Examples of those changes are needed in the final six months of 25/26.

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
5. From 2024 systematically, involve our communities at every level of decision making in our Trust throughout the year, extending our membership offer, and delivering the annual priorities set by our staff and public governors.	Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.	Green	Directorates have provided good evidence of use of feedback and of Care Opinion: in the three acute adult MH, rehab and children's mental health directorates we have more work to do to expand use and make documented use of alternatives.	Amber green	Recognising that feedback is not all about 'change' – we need to be able to evidence a small number of meaningful impactful changes in our 26/27 Quality Account. **A draft of that evidence will be tested within our CQC work due in November 2025.**
	Involve patient and community representatives fully in our board, executive and care group governance .	Green	This work continues and has been evaluated for further improvement. The remaining step planned is to create communities of practice among those involved, for example through our shadow CLE (delayed launch to November)	Green	As the work continues, the need to ensure accountability from representatives back to the local community will grow. The route and agency through which to do that remains to be established.
	Deliver the Board's community involvement framework in full.	Green	This CIF has broad support (and is now approved) but needs operationalisation plans to deepen with Care Groups, supported by a revised VCSE register (now received).	Amber red	This remains AR until there is a clearer trajectory, which SRO, E&I sub, CLE and PHPIP have confidence in.
	Apply patient participation tests to new policies and plans developed within the Trust .	Green	This continues to be an acknowledged oversight and will be addressed in the revised policy of policies over coming month – building on current pilot with PFG.	Green	Getting the required changes into place is not an onerous ask, but does require a structured approach.
	Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.	Amber Green	This was launched within the annual members' meeting. We will use the N&F delivery review in October to test plans for delivery, which are currently giving cause for concern.	Amber green	We now have to expand active membership, recruiting in tandem with our volunteering and VCSE partnering work.
	Deliver the annual priorities set by our council of governors.	Amber green	Most priorities set with COG are in hand: there is work to do on the digital aid/MH work which needs resourcing.	Amber green	Within 2025 we would expect to meet the measures we set in 23/24.

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6. “Poverty proof” all our services by 2025 to tackle discrimination, including through digital exclusion	All our services to have completed poverty proofing and be able to evidence resultant change (including digital).	Green	Directorate level deployment is agreed and a revised ‘approach’ is being taken learning from pilots. There is a good ‘buy in’ now from those involved.	Amber green	This will be a focus within the Leaders’ Conference in late September as a stimulus to change – also covered in September delivery reviews with CGs.
	Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods.	Amber red	The data is not shifting, albeit it is now readily available. Part of Strategic Objective 2 tracker: implementation of AI tool may assist us to make progress but this remains to be determined.	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’.	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	Increasing uptake welcome, and visible, with some concerns over Doncaster service access emerging. Consistent focus needed to deliver and reach into older adults to be determined.
7. Deliver all 10 health improvements made in the Core20PLUS5 programme to address healthcare inequalities among children and adults: **achieving 95% coverage of health checks for citizens with serious mental illness and those with learning disabilities from 2024.**	Achieve measured goals for chronic obstructive pulmonary disease (COPD), hypertension, asthma, diabetes, epilepsy, oral health, and children and young people mental health by 2026/27.	Green	This now moves to green with the consistent data flow and ability for the E&I group to track progress, with strong evidence we are succeeding.	Green	Teams involve convey confidence within delivery reviews that they can meet these measures over the time period.
	Achieve learning disability and serious mental illness health check measure in 2024/25 and recurrently.	Amber red	This rating reflects the position in terms of Learning Disabilities. As the IQPR illustrates for Serious Mental Illness, we have and continue to make progress against our joined-up QOF measure. Focus of work with the LD&F management team, with new DMT in place.	Amber red	For LD, we need to resolve in Q3 a trajectory to achieve coverage *or revise our aim.* For SMI, there is confidence we can go beyond what is currently being achieved, and materially intervene to

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					improve physical health status among the SMI population.
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	The LOD has deteriorated in view of the plan being unaffordable, and the wider challenges for this AHC approach outlined under promise 7 reporting.
	Increase diagnostic rates for dementia among minority ethnic citizens.	Amber green	A strong proposal to make progress with this is funded for 25/26, rooted in evidence from elsewhere. We need to ensure all 3 memory services are engaged with the Rotherham led work.	Amber red	The LOD is improved based on a emerging and coherent plan. As waits for diagnosis reduce, we have capacity to reach into communities and work at pace (as we evidenced in NL).
	Improve access rates to talking therapies among older adults.	Green	We have reviewed plans to act (and increase by over 1000 the number of older adults using the service annually) within the latest delivery review (the service is managed cross Trust). There is a cogent stepped plan through the balance of 25/26 to meet the goal.	Amber green	A big step up is needed in October in the volume of older adults in services to meet the trajectory developed by the service. There is sufficient capacity exists to shift the dial towards 12% coverage.
9. Consistently exceed our apprentice levy requirements from 2025, and implement from 2024	Achieve the levy requirements in 2024/25 and thereafter.	Amber green	The Board has received the plan of action for this measure: It is now being enacted. It is clear we will	Amber green	This is moving to a green rating, as only 40K remains to be identified and booked, which is a

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specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.			expand our levy spend beyond 24/5 outturn but we need to see over 100k committed on band 4 roles to meet our 830k goal.		huge step from 24/5 outturn: 830k of levy spend being identified with shift from high banded roles..
	In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Red	We will review the plans in the October 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 Q3.
	In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Red	We review the plans in the October delivery review.	Amber red	
	In 2026/27 introduce tailored access scheme for people with learning disabilities.	Red	Learning from what is above, we need to start work now on the scheme for twelve months hence. Working with our ID/LD teams, we need to consider how best we can establish a targeted programme.	Amber red	
10. Be recognised by 2027 as an outstanding provider of inclusion health care, implementing NICE and NHSE guidance in full, in support of local GRT, sex workers, prisoners, people experiencing homelessness, and misusing substances, and forced migrants.	Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber green	Plan of action presented to Public Health, Patient Involvement and Partnerships Ctte of BOD – work to do to embed that across teams so too early to confirm shift to greener rating for the plan.	Amber red	This will require concerted work to make ‘mainstream’ services available, as well as to develop specialised services. Baseline mapping due to take place in Q4 25/6.
	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	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

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			be needed (with new resource in place to move this forward).		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. Board focus on prisoners needs to be reflected in plans.	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 H2.
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 H2 25/26.	Amber green	As part of Promise 1 work, need to confirm that arrangements are in place for the Trust to support relevant peer led groups and to connect that work to service evaluations.
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 2026, building on the two pilot sites.

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	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: we need to describe a standard village offer before the end of 2025/26.
13. Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, childrens', or care home.	Deliver over 130 care packages through our physical health virtual ward service.	Amber green	A strong plan exists, has been peer reviewed, and is being delivered. We are exploring further winter expansion plans which would assist with this model.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Sustain and expand our IV provision in out-of-hospital settings.	Amber green	We need to agree a final plan with the Care Group, and crucially with DRI, for the service's further growth. The protocols for service use have now been signed off with help from CNO.	Green	Services were substantively funded going into 24/25. They are expanding month on month.
	Sustain and expand our Clozapine service in off ward settings.	Green	Both Doncaster and Rotherham AMH have service plans internally: with a successful Invest Fund bid agreed for North Lincs.	Green	The first Rotherham community patient has used the service. **CLE will explore in October progress across all three places.**
	Take annual opportunities to transfer services to homecare where safe to do so.	Amber red	In due course we need to find a planning route to go beyond the measures above and establish a broader drumbeat of left shift…this is a focus for one of the leaders' conference workshops.	Amber Green	This measure is ours, and others, and will see substantial emphasis in coming years – with DHSC focus on frail elderly patients and M-LTCs.
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:	Meet four hour wait standard in 2025/26, where it applies.	Amber green	Incorporated within 48 hour monitoring, and a focus aligned to the league table measures used by DHSC (they use a different metric) – to be incorporated within IQPR.	Amber green	We appear on current data to be largely delivering this promise. We have some to do to understand the problem we need to solve to make this consistent.

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maximising the use of technology and digital innovation to support our transformation.	Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Amber red	Signed off success measures and timetabling at September CLE: work to do over coming four months to be ready for routine monitoring and action.	Amber red	Initial RAG compliance assessment shared with CLE, and work to do within some services to comply ‘on Fridays’.
	Make progress to reduce waiting lists and times and close supply gap in 2024/26.	Green	Strong consistent work has taken place to understand our waiting lists and demand/supply in relation to waits themselves. Investments reflect only areas where productivity cannot meet the measure.	Amber green	Delivery relies on both supply side change and some stability in demand, both across a year and by month (as a proxy for four weeks). We will use 25/26 to identify difficulties with that assumption.
	Meet 4 week standard from April 2026 across all services.	Amber green	There is increasing confidence that this measure could be met: the cultural shift doing so requires is not inconsiderable. Delivery reviews provide data backed evidence of the remaining work to do.	Amber red	There are three groups of services: neurodiversity; those who will meet the measure; and those in the balance. **It is the in the balance group where we need to make changes to succeed.**
15. Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs.	Support development of integrated neighbourhood teams (INTs) in 2024/5 in all three places.	Amber red	It is broadly positive that the ten-year plan places such emphasis on this space. The emerging challenge is to ensure that we work as neighbourhoods not place. During Q3, realistically, it should be possible to review the scale of changes needed in our teams to move from current to future state. This will be important to wider work to reform how community teams work and the balance of generalism and specialism.	Amber green	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		Amber red	

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	Evaluate and incrementally improve joint working achieved through these teams.	Amber red	Planning this work can follow from further definition of the INT plans we have.	Amber green	Once the above measures are met, this item is feasible!
	Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme.	Amber green	This work was defined in late 23/24 and a monitoring structure established. Indications remains positive that we are on track.	Amber green	Needs a clear frame of analysis. **This will be documented over coming weeks.**
16. Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.	Implement Dialog+ by 2026, collating individual outcomes from that work.	Amber green	We are moving from training to use and support teams to doing: led by Jude Graham. A rollout plan of support is in place. The scale of change involved is substantial.	Amber green	This remains a challenging programme and one that can deliver, but will face competition from other priorities at a local level, albeit corporate leadership and support is now defined.
	Report and improve patient recorded outcome measures (PROMS) supported nationally.	Amber green	We report as we need to. Further clarity is needed about our completeness and whether we are maximising opportunities to go beyond minimum response.	Amber green	An improvement trajectory remains to be understood and defined, but data is beginning to be shared to build it.
	Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Amber red	This forms part of our Q&S plan but may take us into 2026/27.	Amber red	We need to reserve development time in Q4 to put in place the agreed data flows to enable delivery to be feasible in the following year.

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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 red	Establishing this data feed is taking time and requires collaboration across a number of teams inside and outside the Trust. Annual data is feasible as we look to stem a deteriorating position.	Amber red	It is much easier to be confident of the inputs than the results in this field: the Trust has developed and is implementing a clinically led hypothesis which may transpire to make a difference.
18. From 2023 invest, support and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery.	Meet guidance obligations from NHS England relevant to the quality of inpatient care, including safer staffing measures where they exist, and fully comply with the Mental Health Act.	Amber green	Current analysis for this measure appears positive. Work to improve MHA compliance is showing promise. We know what to do, we need to do it – with Q1 25/26 seeing some better real time data available to teams, for instance in relation to S17.	Amber green	With continued focus we have some confidence that this can be met over the balance of the year.
	Implement programme of multi-professional quality improvement across all inpatient services by April 2026 and routinely publish data on the care provided in each environment.	Amber green	We have completed test-site on Sandpiper and are now engaged in a ten-week rollout to be live across all of our wards by November at the very latest. A second culture of care appraisal is underway.	Amber red	Mobilising this work will be a significant endeavour in 25/26, after pilot phases over next 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	The plan of action is widely understood. Success will come from sustained effort to avoid OOAP choices, and the work to return people current locations. The steps needed to deliver (for inappropriate OOAP) are in place.	Amber green	This is an improved rating consistent with late Q1/early Q2 delivery. *Moving to zero may not be achievable.*
20. Deliver virtual care models in our mental and physical health services by 2025, providing a high-quality alternative to prolonged admission.	Deliver over 130 care packages through our physical health virtual ward service working. with partners.	Green	A strong plan exists, has been peer reviewed, and is being delivered.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes as does the new willingness of DRI clinicians to support non-admitted patients through the model.
	Introduce and evaluate virtual ward pilot into our mental health services 2024/25.	Amber green	We have agreed to develop a pilot proposition in North Lincolnshire older adult care, as part of implementing the Phase ¾ changes. By November 2025 we'd expect to be better able understand what it will take to do this at greater scale.	Amber green	Clearly the timescale has passed, but it remains possible to deliver this measure within 25/26 **at least on one site.**

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	Introduce and evaluate virtual ward pilot within our children's services 2025/26.	Red	The intent and commitment to do this is clear from the leadership team – but a tangible plan to trial this is not yet visible and did not come forward within planning for 25/26. Discussions will continue with the CCG.	Red	Evaluation in that time period may not be feasible, but deployment, if funded, will be.
21. Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents – developing services on a hyper local basis.	Fulfil our commitment to support a community-first model working alongside partners in South Scunthorpe: focusing first on those with serious mental illness.	Amber green	This remains the focus of neighbourhood proposition in North Lincolnshire: work to be done to ensure that all partners are focused on the same success measures and changes in ways of working.	Amber red	Delivery difficulties over time (18m+) suggest that improvement in outputs/outcomes may not be straightforward to execute.
	Contribute actively to the city-wide Thrive programme within Doncaster, using a liberated method to ensure that duplication and handoffs of care are reduced.	Amber green	Engagement from the Trust remains strong but project still largely LA led/held. Intention to blend this work with Neighbourhood work may offer a route to different impact in coming months.	Amber green	Need to find an agreed success measure as the 'method' denies benefits of KPIs. Work with Families First shows promise in that regard.
	Implement anticipatory preventive care models supported within the Rotherham Place programme, where possible using such approaches to reduce demand for secondary care.	Amber green	A positively viewed programme which is at the heart of the neighbourhood planning in borough. Need to extend this work into Care Homes if it is to impact patterns of use/need in our services.	Amber red	Rating reflects concern that focus is not with patients likely to end up in RDaSH services: work to be done to model care home option as part of neighbourhood planning.
	Understand and act on local research into patterns of referral, cross referral and best fit services for mental health in adults and older adults linked to general practice.	Amber red	Commissioned work from PCD, which is delayed presently: important to understand the patterning before we begin to make changes to service flows.	Amber red	Work needed to scale and shape the project, which will form part of the Community HQTC work, outlined within the Board papers.

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	Consistently integrate our community mental health offer with that provided by voluntary sector organisations, sharing training, data and expertise to improve outcomes.	Amber red	This work links to the item above: we do plenty of signposting,but need to make that a more systematic offer tied to our investments in peer support workers within these teams made since 2024.	Amber red	Once data flow work completed, and armed with shift to DIALOG+ we can assess the scale of transfer/shared care with VCSE partners.
22. Develop consistent seven day a week service models across our intermediate care, mental health wards and hospice models from 2025 in order to improve quality of care.	Ensure that access to urgent and emergency services is equitably available through Saturday and Sunday (this must include crisis and safe space availability).	Amber green	This is not P14! This measure is mostly met in Trust delivered/commissioned services. The intention is to use the MHLDA programme for 25/26 to influence configuration.	Red	This is rated red to reflect the reality our patients face – where there is substantial variety in non-Trust services which we need to now influence. **There is also a fragility to crisis services which needs continued attention.**
	Support substantially increased discharge and admission capacity over weekends.	Amber green	This will be an important part of our work on promise 19, and efforts to reduce LOS. As outlined above the actions needed to make progress are understood: deployment has commenced.	Amber green	There is very substantial executive emphasis on this work and it remains a key measure of our route to 92% moving into 2026.
	Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services.	Amber red	N&F delayed completing this work by other priorities: now due to for issue in time for October delivery review.	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-	Develop bed-based mental health services within each of our communities by 2028, as additions or alternatives to ward based practice: ideally delivering these services through partner organisations.	Amber green	We have made a start in Rotherham, and are trying to define final work packages elsewhere. Turning these opportunities into bed flow that impacts acute care needs further grip.	Amber green	Strong buy in from clinicians and partners – and work can be taken forward within the auspices of HQTC. Will need diligent oversight to avoid atrophy.

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down and step-up services.	Expand the scale of our residential forensic rehabilitation service.	Green	Additional capacity will open by October – and a wider review of role and function is underway.	Green	A 20% expansion has already taken place.- and we now need to consider what more is needed to match need.
	Establish and support a step-up service for older peoples' care in Doncaster by 2027.	Amber green	Work advancing alongside partners: project resource defined and starts work shortly. Significant place support. We did not obtain national funding but are next step is to bring all partners together at Tickhill Road under the auspices of the HWBB.	Amber green	This may be an optimistic rating given scale of change: but the pressing need to change gives this natural priority and we have 2 years to deliver.
24. Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan.	Student feedback to reach upper quintile when compared to peers.	Amber green	Strong baseline position, albeit varies annually. Some uncertainty over what drives positivity.	Green	Latest data shows Trust among top five nationally.
	Trust workforce plan for 2028 on track to be delivered.	Amber green	Plan, notwithstanding item below, developing well. Fully staffed is year 1.	Amber green	Persistent vacancies are not our principle difficulty (retention exemplar work needs to be effective to sustain seniority within disciplines over time) ie retirement risk.
	Trust meets expectations applied through national Long Term Workforce Plan roll out.		We may pause monitoring of this measure unless the operating plan guidance sheds light on the national future of these plans.		Rating reflects lack of clarity of ask/measure at this stage. May be clarified in 10 year plan (2025)
	NHS England assessment outcomes remain outstanding in all disciplines.	Amber green	Currently strong in all assessed disciplines (latest report just received). Social work assessment due in 2025.	Amber green	No identified reason why assessment outcomes would change over coming period, albeit some emerging concerns among postgraduate medical education which we will test in October.

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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: next data review with finance team at October delivery review.	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	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 red	This rating is deteriorated based on staff feedback during Q2 25/26. We have to intensify efforts in coming months to have consequence.
	Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.	Amber green	Some positive movement within the 2024 staff survey results when compared to 2023 and to peers. Further work needed to deliver in 2025 survey on which the success measure will be based. However, there are some adverse indications in our recent quarterly HR data.	Amber green	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.

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	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. Submissions for NW accreditation at Bronze Level planned for Q3 and 4.	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.	Green	Notwithstanding the need for localised plans, it seems most likely that the shift to the RLW will move the position on this measure to compliance.	Green	We are increasingly confidence of delivering this measure moving into 2025/26.
27. Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.	Reduce our carbon tonnage by 2000 (and offset balance).	Amber red	Excellent analysis has established the sheer scale of change/investment needed. Consideration of a route to success is to be considered alongside our estate plan.	Red	Clear route to success identified for 2028, but path to get there is a narrow one with multiple dependencies..
	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.

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
	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. Our 'remote' policy and practice will be crucial to success. 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. The Trust is now hosting EMRI, which further contributes to our aspirations.	Amber green	This is an input measure which we are confident of sustaining focus on, without too much corporate input