NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 29 January 2026 at 10.00am
The Baths Hall, Doncaster Road, Scunthorpe, DN15 7RG

No	Item	Request to	Lead	Enc.
1	Welcome		KL	
2	Apologies for Absence:	Note Information		
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	SF	Verb
Standing items				
6	Minutes of the meeting held in public on the 27 November 2025	Decision	KL	B
7	Matters Arising and Follow up Actions	Decision		C
Board Assurance Committee Reports to the Board of Directors				
8	Quality Committee	Assurance	RF	D
9	Audit Committee	Assurance	KG	E
10	Mental Health Act Committee	Assurance	SFT	F
11	People & Organisational Development Committee	Assurance	RB	G
12	Public Health Patient Involvement & Partnerships Committee	Assurance	DV	H
13	Finance, Digital & Estates Committee	Assurance	PV	I
14	Trust People Council	Assurance	DV	J
15	Chief Executive's Report	Information	TL	K
16	Learning from Prevention of Future Deaths (PFD) Reports	Information	DS	L
BREAK				

RDaSH nurturing the power in our communities

17	Training Needs Analysis (TNA) 2026/27	Information	CH	M
18	CQC Readiness – Self-Assessment	Information	SF	N
19	Neurodiversity Waits Update	Information	TL	O
20	Financial Plan 2026/27 to 2028/29	Decision	TL / SS	P
21	Promise 2 – Carers Plan: Forward Look to 26/27	Information	SF	Q
22	Well-Led – Externally Commissioned Developmental Review	Information	PG	R
23	Promise 5 – Making it Real	Information	TL	S
Operating Performance / Governance / Risk Management				
24	Integrated Quality Performance Report (IQPR)	Information	TL	T
25	Promises and Priorities Scorecard	Information	TL	U
26	Strategy Delivery Risks	Information	PG	V
27	Operational Risk Report	Information	PG	W
Supporting Papers (previously presented at Committee)				
28	Mortality Report	Information	KL	X
29	Any Other Urgent Business (to be notified in advance)		KL	Verb
30	Any risks that the Board wishes the Risk Management Group to consider			
31	Public Questions *			
	Chair to resolve '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press are excluded from the remainder of the meeting, which will conclude in private.'*		KL	
32	*Minutes of the meeting held on the 8 January 2026 (private session)*	*Decision*	KL	AA
33	*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
34	*Reflections on the patient story*	*Discussion*		Verb
35	*Chief Executive Private Update to the Board of Directors*	*Information*	TL	CC

*** Public Questions:**

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

The next meeting of the Board of Directors will take place on Thursday 26 March 2025 Doncaster

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Jane Charlesworth, Head of Corporate Assurance		
Meeting	Board of Directors	**Date**	29 January 2026

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

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

There have been amendments to include declarations from Mr Sheppard and Dr Rumit Shah, as marked in bold.

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

Paper presented to each public Board meeting

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

The Board is asked to:

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

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

Business as usual	x

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

Business as usual	x

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

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

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

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

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

Appendix (please list)

None

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

BOARD OF DIRECTORS – REGISTER OF INTERESTS

Executive Summary

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

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

Amendments are shown in bold text.

Name / Position	Interests Declared
Kathryn Lavery, Chair	• Owner and Director of K Lavery Associates Ltd • Chair ACCIA Yorkshire and Humber Panel • Non-Executive Director at Locala Community Interest Company (and Audit Committee Chair) • Chair of Locala Solutions Ltd
Toby Lewis, Chief Executive	• Nil
Richard Banks, Director of Health Informatics	• Wife works in administration at Sheffield Children's NHS Foundation Trust.
Rachael Blake, Non-Executive Director	• Director: Bawtry Community Library • Bawtry Mayflower School Governor - Co-opted • Sponsor: Network Rail • Trustee at Rossington Miners Welfare • Treasurer at Actie Rosso •

Name / Position	Interests Declared
Richard Chillery, Chief Operating Officer	• Nil
Maria Clark Non-Executive Director	• Lay Examiner for the Royal College of Obstetrics and Gynaecology • School appeals and Chair of the Independent Review Panel, Barnsley MBC • Grant making panel member for the Three Guiness Trust • Solicitor, Taylor Emmet Solicitors • Lay member National Institute of Clinical Excellence (NICE) • Associate Hospital Manager at Leeds and York Partnerships NHS FT and Derbyshire Healthcare NHS FT • Volunteer - Stroke Rehab Services Review, Joined Up Care Derbyshire • Research Ethics Committee Member, Ministry of Defence • NHS England Patient Safety Partner and Patient Advisory Forum member and also a member of the Independent Investigations Review Group. • Voluntary member of the Research Ethics Committee, University of Sheffield • Voluntary Board member (non-voting) College of general Dentistry • Honorary fellow of the Royal College of Surgeons of England • Rental property, Sheffield
Dr Richard Falk, Non-Executive Director	• Nil
Steve Forsyth, Chief Nursing Officer	• Coach at the Gambian National Police Force • Ambassador and Affiliation for WhizzKidz • Non-Executive Director for the African Caribbean Community Initiative • Fellow of the Queens Nursing Institute (QNI). • Member of Asian Professionals National Alliance • Member of British Indian Nurses Association • Member of Jabali Men's Network • Member of Nola Ishmael Executive Nurses
Kathryn Gillatt, Non-Executive Director	• Non-Executive Director at the NHS Business Services Authority and Chair of the Audit and Risk Committee
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
Dr Rumit Shah, Associate Non-Executive Director	• **Chair of Doncaster LMC** • **General Practitioner Hatfield Health Centre** • **Doncaster Lead for Primary care provider alliance** • **Beckingham medical services Ltd**
Simon Sheppard, Director of Finance and Estates	• **Wife is a Specialist Respiratory Nurse at Sheffield Children's Hospital.**
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 – 29 January 2029

Item 5

Patient Story

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 16 DECEMBER 2025 AT 11.15AM VIA MS TEAMS

PRESENT

Kathryn Lavery	Chair
Rachael Blake	Non Executive Director
Richard Chillery	Chief Operating Officer
Maria Clark	Non Executive Director
Dr Richard Falk	Non Executive Director
Steve Forsyth	Chief Nurse
Sarah Fulton Tindall	Non Executive Director
Kathryn Gillatt	Non Executive Director
Carlene Holden	Director of People and Organisational Development
Toby Lewis	Chief Executive
Jill Savoury	Deputy Director of Finance
Simon Sheppard	Director of Finance and Estates
Dr Diarmid Sinclair	Chief Medical Officer
Dave Vallance	Non Executive Director
Pauline Vickers	Non Executive Director

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Philip Gowland	Director of Corporate Assurance / Board Secretary
Jo McDonough	Director of Strategic Development
Shabir Pandor	NExT Director
Jane Charlesworth	Head of Corporate Assurance (Minutes)

7 members of staff and 3 Governors were in attendance

Ref		Action
Bpu 25/12/01	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. Apologies for absence were noted from Dr Jude Graham, Director for Psychological Professions and Therapies.	
Bpu 25/12/02	**Quoracy** Mrs Lavery declared the meeting was quorate.	
Bpu 25/12/03	**Declarations of Interest** Mrs Lavery presented the declarations of interest report and confirmed there had been amendments to Ms Blake and to Ms Gillat's declarations of interest to the register since the last meeting. **The Board received and noted the changes to the Declarations of Interest Report.**	
	STANDING ITEMS	
Bpu 25/12/04	**Minutes of the previous Board of Directors meeting held on the 27 November 2025**	

	The Board approved the minutes of the meeting held on the 27 November 2025 as an accurate record.	
Bpu 25/12/05	**Matters Arising and Follow up Action Log** The action log was considered. It was noted that most actions were carried forward from November, with three new actions added. One action relating to the appointment of a Well Led partner was proposed for closure, as the procurement process was nearing completion. This was agreed.	
Bpu 25/12/06	**Remaining 26/27 Clinical changes** Mr Lewis introduced the paper outlining the remaining clinical changes for 2026–27. He explained that the proposals were relatively modest and proportionate in aggregate, these were significant changes for all involved. The Board has discussed in November the intention to focus on productivity changes and also changes which tilted delivery towards generalism. There also were changes outlined which altered the number of clinical leaders at team level, removing non-patient facing time. The paper was presented on the same basis as the parallel backbone paper in November but was accompanied by QSIA material across the full programme of work. Outlining the QSIA process, Mr Forsyth confirmed it included five standards: appreciative challenge, multidisciplinary involvement, dynamic assessment with data checks, use of a standardised tool covering ten domains, and recommendations for ongoing monitoring. Dr Sinclair added that the vast majority of the queries raised during the QSIA process had been resolved following further information from care groups. Ms Gillatt sought assurance on monitoring and early warning systems, and it was confirmed that thresholds of concern would be defined to trigger intervention if required. Mr Lewis clarified to Mrs McDonough that the panel did not operate a pass or fail system, but he confirmed that some schemes had been withdrawn prior to it or altered as a reflection of it. Illustratively he mentioned the hospice hairdressing scheme which would now not proceed. Mr Lewis emphasised that while risks had been assessed, successful implementation would depend on strong leadership and support for behavioural change across teams. He highlighted that these changes were not radical innovations but material adjustments to improve efficiency and sustainability. Ms Fulton Tindall queried preparations for adaptive leadership and support for managers during implementation given the behavioural change required. Mr Lewis confirmed that a dedicated implementation group, led by Mr Chillery, would focus on readiness and support for team leaders. That would work from January to be ready for April, when schemes go live.	

	Mr Vallance asked about the impact on treatment efficacy and preventative work. Mr Forsyth noted that generally the ongoing impact of schemes would be considered against thresholds of change viewed through key performance indicators (KPIs). Mr Lewis noted that preventive impacts were considered in the QSIA process too but noted that these changes were not in themselves a left shift. Ms Holden raised two key questions, regarding Band 3 workforce impact and inferred references to TUPE transfers. Mr Lewis clarified that only two TUPE transfers were planned (procurement and estates). He felt that reference may be being made to out of hours palliative care where no TUPE situation would arise. He agreed that the impact of change did differ by band and role and committed to analysing societal impact using staff postcodes. Ms Blake requested a positive framing of KPIs and inclusion of geographical equity alongside protected characteristics which was agreed and noted that there would checkpoints in respect of KPIs, likely at the Quality Committee in January and certainly at the Board in March. With respect to the proposed changes in safeguarding, chaperoning, and assertive outreach, Mr Lewis assured Mrs Vickers and the Board that KPIs would track these areas and that assertive outreach changes would not impact on maintaining compliance with national guidance. Mr Lewis drew the Board's attention to the seven highlighted schemes within the paper. • The CAMHS Medical Staffing proposal was to operate with the same number of doctors as current but noted this was fewer than the establishment. He emphasised the need for further detail and assurance before agreeing to proceed due to the scheme's significance and complexity. • The At-Risk Mental State (ARMS) Pathway in North Lincolnshire, previously funded as an investment, was proposed to be integrated into general teams • Assertive outreach changes in Rotherham and Doncaster focus on workflow redesign and reducing handover periods, with staff involvement acknowledged. He recognised that the profile of AOT meant it was right that the Board understood was proposed. • Physiotherapy adjustments in Learning Disability Therapies were considered acceptable however the speech and language therapy changes required further review due to potential clinical risk. • Reduction in medical input and disestablishment of child sexual exploitation posts was proposed with responsibilities redistributed across the safeguarding team. • Alterations to chaperone arrangements and change to specialist palliative care services within Physical Health services would represent significant practical and cultural change, with the QSIA panel influenced by management team's analysis of impact which was detailed and considered. • The integration of Health and Well-Being Pathway into CMHT structures in Rotherham had no material risks identified but was	

	understandably opposed by some of those involved. This would move the Trust into a more consistent position across RDaSH. Responding to Dr Falk regarding GP engagement and whether it could be relied upon, particularly in relation to morale and its potential influence on wider service delivery requirements such as seven day working, Mr Lewis confirmed that no schemes were being implemented that transferred work to GPs and stressed the need to avoid this occurring inadvertently. He noted that some GP groupings had already been briefed on the proposed changes and outlined a process scheduled for the first three weeks of January to engage partners on changes, focusing on neighbourhood physical health initiatives and the health and well-being pathway. Mr Lewis concluded that it was too early to determine the level of GP support and clarified that there was no dependency on GPs within the current proposals. Mrs Vickers questioned whether HR and other teams had the skills and capacity to manage Q4 changes and how they would be supported. Mr Lewis confirmed staff would not be expected to balance their day job with change work, explaining that a small group of managers and HR staff would be identified to work exclusively on this change and consultation process. He acknowledged potential gaps and committed to bringing in additional expertise where needed. Mr Lewis noted the cultural shift toward closer management could lead to varied reactions, including sickness absence, and stressed that readiness, including policies and processes, must be in place by April, as success depends on maintaining projected sickness rates, certainly from Q2. **The Board received and noted the processes of development and review undertaken by Care Group Directors and QSIA panel. The Board considered the issues raised by those processes and seven schemes set out in the paper.** **The Board agreed to pursuing schemes outlined and delegated minor variation to the Chief Executive.** **A private meeting would be held in January to finalise details of consultation and selection and to consider the overall capacity and capability to take this forward amid all of the other priorities the service faces.**	
Bpu 25/12/07	**Planning Submission 2026/28** Mr Lewis presented the planning submission, covering financial, workforce, and operational considerations. He reminded Board colleagues of the Trust's MTFM from September as well as other relevant planning documents. He made the following comments: • A balanced financial plan for 2026 to 2027 and from 2027 to 2028 would be submitted without deficit support, although a gap between income expectations by the Trust, with very modest growth, and the ICB initial offer, existed. The true gap currently was estimated at £3.6m, recognising that CVs and the HDRU sums were in addition to that.	

	• Capital submissions did now reflect the phasing of land sale and receipt, which the Board had accepted as the right planning submission, notwithstanding that the outline business case was due for consideration later in 25/26. • Operational delivery showed further improvement on current positions, including for out of area placements, albeit the forward improvement was modest as we needed to stabilise what had been achieved. There was not an intention to offer to see improvement in clinical outcomes in talking therapies given the inequalities faced by those we were seeking to improve access from. Mr Lewis also noted ongoing confusion over the reporting of neurodiversity patients which would not be resolved for the 17th December submission. • Board members would recognise the challenge posed by sickness, and it was only towards the end of the planning period that the Trust was indicated with external bodies might see as compliance (at 4.1%). Scenario modelling and contingencies were discussed, with the main financial contingency being improved performance in out of area placements. Mr Lewis responded to Mr Pandor and confirmed that the existing 2023-28 strategy would be submitted if required in February with suitable annotation, as the December submission did not mandate a separate clinical strategy. Mr Lewis noted that a more assertive negotiating approach may be necessary in early January due to the absence of contract offers for years two and three, and the lack of any information from colleagues in Humber and North Yorkshire. Mr Vallance questioned whether we were overstating our assurance on the improvement capability within the organisation. Mrs Lavery recognised the challenge offered also over email between Board members. Having discussed this with colleagues she understood that the strong majority view retained the assurance as presented. **The Board received and noted the proposed board assurance statements outlined, and recognised the oversight of contracting implied within them.** **The Board delegated to the chief executive pursuit of further clarity on year 2/3 contracting, with recognition of thanks to colleagues in finance, people and organisation development, and operations for rapid work to populate the spreadsheets.**	
CLOSING ITEMS		
Bpu 25/12/08	**Any Other Urgent Business** There was no further business raised.	
Bpu 25/12/09	**Public Questions**	

	There were no public questions.	
Bpu 25/12/10	**Close** Mrs Lavery thanked members of the Board for their engagement and contributions and confirmed that a further private meeting would be held in January to address outstanding details.	
Next Meeting - Thursday 29 January 2026 at 10.00am The Baths Hall, Doncaster Road, Scunthorpe, DN15 7RG		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
BOARD OF DIRECTORS : JANUARY 2026

PAPER C – ACTION LOG

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 25/05/20	**CQC Readiness: Well-Led** During quarter 4, a formal, externally commissioned, well led review would take place.	PG	**January 2026:** As previously reported, an externally commissioned review has been commissioned and will be delivered in Q4. Item on today's agenda provides the latest position.	Propose to Close
Bpu 25/09/17	**Future of Pharmacy Services (Wholly Owned Subsidiary)** The Board would be kept informed regarding who would host the pharmacy service.	TL	**January 2026:** The Trust and Flourish Enterprises have agreed an approach to enable this matter to progress and the recruitment to posts has commenced. Parallel work to establish the new Wholly Owned Subsidiary is also underway. Whilst proposing to close this action, the Board will receive a further update in May to confirm the new service is open.	Propose to Close
Bpu 25/09/15	**Tackling waits in neurodiversity services** An update would be provided to the Board in November and January.	TL	**January 2026:** item on today's agenda provides the latest position.	Propose to close
Bpu 25/09/25	**Further update on Community Mental Health Services (Adult)** The October Time Out would create space to discuss the level of current insight amongst Board members and how they could develop a shared knowledge base through which to support teams with improvement work in the year ahead.	TL	**January 2026:** Given the postponement of the October time out, the matters planned for the session will feature in the next timeout session in **February 2026**.	Propose to close
Bpu 25/09/08	**Report from the People & Organisational Development (POD) Committee** Mr Lewis reflected on violence and aggression and noted the dissonance between the results of the internal audit and staff experiences. Mr Lewis recommended Mr Forsyth and Ms Fulton Tindall created space to explore violence and aggression through the Mental Health Act (MHA) Committee.	SF	**January 2026:** The Board will consider a full year analysis of staff experience of violence and aggression at its final meeting of the year.	Open
Bpu 24/11/08	**Report from the Quality Committee** Work was ongoing to develop a management escalation process with agreed parameters for intervention.	TL	**January 2026:** This remains work in progress with the intention to ratio any intervention against scorecards for wards and community teams.	Open
Bpu 25/11/22b	**Health Inequalities: Review of IPQR** A review of the format and focus of future reports would be undertaken, with a new reporting format to be confirmed in April.	JMcD	**January 2026**: Three separate reports which focus on E&I Promises actions, E&I Promises data and the IQPR through a Health Inequalities Lens have been reviewed and a new combined report has been	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
			developed. This has been received and reviewed by the E&I Group and PHPIP and is on the Board agenda today. A new monthly HIE-IQPR format will come to **March**'s Board meeting.	
Bpu 25/09/21	**Provider Capability Assessment** The Board would receive an update in November 2025 of this process and any feedback received.	PG	**January 2026:** NHS-NEY have indicated that this will be received this week.	Open
Bpu 25/09/34	**Public Questions** Mr Lewis agreed to agreed to work with PFG and peer support workers to develop clear interim guidance for service users seeking neurodiversity services, ensuring they receive accurate information about their options.	TL	**January 2026:** Guidance has been issued and feedback is due at the first meeting of our communities' leadership executive.	Open
Bpu 25/11/15	**Freedom to Speak Up (FTSU) Guardian six month update** Mr Lewis agreed to consider with executive colleagues outside this meeting of a broader culture of speaking up beyond formal FTSU processes.	TL	**January 2026**: This item will be considered to a proposed conclusion in the **March** CEO report, mindful that we are targeting a move to over 80% employee confidence by March 2027 in line with TOC discussions in October 2025.	Open
Bpu 25/11/23	**Promises and Priorities Scorecard** Mr Lewis agreed to consider non-executive directors in championing specific promises, where colleagues' expertise and enthusiasm could add value rather than create formal roles. This would be explored further, potentially through the Vice Chair and executive leads, to map interests and align them with key strategic areas.	TL	**January 2026:** This item is unprogressed and overdue.	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	**January 2026:** As noted previously, the discussion in November did not identify any changes to the SDRs – but it was acknowledged that the review should take place again in Q4 and so remains open until the **May 2026** meeting.	Open
Bpu 25/09/25	**Further update on Community Mental Health Services (Adult)** An improvement programme for community based services would be developed, and would return to the Board in January and March to outline the approach.	TL	**January 2026:** As recorded at the previous meeting, this topic will feature within the agenda of the Board of Directors meetings **March 2026**.	Open
Bpu 25/09/24	**Estate Plan** An outline case would be presented before the Board in March 2026.	SS	**January 2026:** As recorded at the previous meeting, this topic will feature within the agenda of the Board of Directors in **March 2026**.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Quality Committee	**Agenda Item:**	Paper D
Date of meeting:	21 January 2026		
Attendees:	Richard Falk (Chair), Maria Clark, Steve Forsyth, Dr Diarmid Sinclair, Richard Chillery, Richard Banks, Dr Jude Graham, Hannah Hall, and David Vickers.		
Apologies:	None		
Matters of concern or key risks to escalate to the Board:	**Integrated Quality Performance Report:** Quality and safety results were largely positive, though safer staffing and MUST compliance had declined, and reported racist incidents had increased, indicating areas requiring continued oversight. Rotherham remains an outlier in several metrics. Whilst none of these are critical in nature, the committee looks forward to improvement in due course.		
Key points of discussion relevant to the Board:	**Patient Safety Escalations** The committee was assured that Patient safety escalations for Oct and Nov 2025 had been considered in depth and learning identified. The specifics around leave were discussed and Dr Sinclair agreed to assist in developing the policy further. **Promise 16** The move to personalised care had advanced through increased use of DIALOG+, ReQoL-10 and Goals-Based Outcomes, with staff training reaching high levels and the transition away from the Care Programme Approach remaining on track for completion by March 2026. Data systems had been strengthened to monitor PROMs usage and care-plan compliance, though further work was still required to refine paired-outcome reporting and ensure consistent adoption across services. The programme had begun shifting into business-as-usual, with Care Groups assuming leadership of implementation supported by the Change and Improvement team. **Promise 22** Work on Promise 22 had progressed, with weekend access to crisis and urgent mental health services improved through extended Safe Space provision, expanded crisis support for older adults and better access to Section 136 suites. Reductions in out-of-area placements were achieved through strengthened flow management. However, seven-day discharges remained significantly constrained by workforce, cultural and system-wide barriers, and full implementation of seven-day working continued to be limited despite phased developments. **Internal Audit Recommendations PSIRF Final Report:** The committee noted the moderate assurance opinion from 360 Assurance. It was recognised that the audit had been undertaken soon after the policy had been implemented and as such the report was largely pleasing. The expectation is that a future report would be tending towards significant assurance.		
Positive highlights of note:	**Patient Experience Report:** The reports showed that patient experience feedback had remained strongly positive, with over 2,000 Care Opinion stories received and more than 80% of October and November submissions rated positively. Learning from complaints centred on improving communication, record-keeping, assessment quality and family involvement, demonstrating how patient feedback continued to shape service improvements. The improvement in complaints performance from last year was marked and welcomed. **National Report Benchmarking Summary Briefing**. Committee was assured of continued progress against the GMMH independent review recommendations, with stronger patient-voice processes, more stable staffing, and improved governance. Estates and cleanliness oversight had advanced but still required more consistent audit completion, and key training gaps and staff-engagement issues remained. Overall, the Trust showed clear improvement while recognising several priority areas that still needed focused action. **Integrated Quality Performance Report** The committee noted that the falls		

	risk assessment target (QS37) had been fully met for the first time.
Matters for information:	None
Decisions made:	None.
Actions agreed:	None

Dr Richard Falk, Non-Executive Director (Chair of Quality Committee)
Report to the Board of Directors meeting scheduled for 29 January 2026.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Date of meeting:	3 December 2025		
Attendees:	Kathryn Gillatt (Chair), Dr Richard Falk, Pauline Vickers. In addition: Phil Gowland, Jill Savoury, Laura Brookshaw (360 Assurance), Matt Treharne-Clarke (360 Assurance), Stuart Kenny (Deloitte), Lewis Swann (360 Assurance), Steve Forsyth, Shaida Khan		
Apologies:	Maria Clark		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**Counter Fraud Progress Report**. Strong progress against work plan. November's Fraud awareness campaign reached over 2,000 client staff, improving reporting culture. **Counter Fraud investigations.** The Committee noted ongoing investigations into complex fraud cases. While progress is being made, these cases highlight vulnerabilities in timesheet and secondary employment controls. Training on new legislation (*Failure to Prevent Fraud*) will be delivered to strengthen governance. **Internal Audit**: **Operational Risk Management** audit received significant assurance confirming a mature framework and effective oversight. **Internal Audit: PSIRF** audit moderate assurance. The refreshed policy aligns with national guidance, but learning responses were inconsistently evidenced. Improvements are underway, and the Committee noted that Quality Committee oversight of Radar system embedding will provide additional assurance. **Risk Management Framework**. The Committee welcomed the maturity of risk reporting and suggested a more exception-based reporting to focus on overdue actions and assurance gaps and alignment with strategic priorities. **External Audit Recommendations**. ISA260 actions were in progress, including improvements in annual leave accrual using ESR data. **MCA Action Plan.** Most actions were green, two amber. The committee agreed additional oversight and re-audit to strengthen assurance.		
Positive highlights of note:	**Operational Risk Management audit** significant assurance reflecting strong governance culture. **Fraud awareness campaign**, was successful improving engagement and transparency and reporting culture **Collaborative approach** across committees and directorates was driving improvements.		
Matters presented for information or noting:	Standing Financial Instructions Q2 2025/26		
Decisions made:	Supported internally led MCA re-audit in Q4 and supported the inclusion in forward plan for 2026/27 of a follow up. Supported finance audit scope to include budget setting, reporting, and monitoring.		
Actions agreed:	Arrange training on "Failure to Prevent Fraud" for committee and board members.		

Kathryn Gillatt, Non-Executive Director, Chair of the Audit Committee.
Report to the Board of Directors meeting scheduled for 29 January 2026.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	Mental Health Act Committee	**Agenda Item:**	Paper F
Date of meeting:	17 December 2025		
Attendees:	Sarah Fulton Tindall (Chair), Maria Clark, Toby Lewis, Dr Diarmid Sinclair, David Vickers. In attendance: Steve Forsyth		
Apologies:	Dr Jude Graham		
Matters of concern or key risks to escalate to the Board:	Rotherham remained an outlier and the Committee reaffirmed its understanding that work is underway that seeks to show improvement by March 2026. MHA and RRI training compliance remains a concern for the Committee, with a particular focus on MHA Level 3 and RRI.		
Key points of discussion relevant to the Board:	**MHA Compliance Report (October and November 2025)** There were 278 detentions, with 2 identified as unlawful, due to inadequate medical recommendations and delays in scrutiny. Compliance at the point of medical scrutiny was 98%.There were 38 sets of detention paperwork requiring minor amendments, an improvement from 52 previously. Work is underway by the Medical Director to improve timeliness and reduce future errors. **Consent to treatment on admission and psychiatric medication** compliance had remained high generally in the mid 80% to 91% rang. Rotherham had shown improvement, rising from 73% to 85%, **Consent to treatment at 3 months** 100% compliance at Doncaster, 28% Rotherham and North Lincolnshire required no forms. **Section 132 rights** being read within 24 hours had remained at variable compliance, with Rotherham at 76%, Doncaster at 95%, and North Lincolnshire at 87%. (presentation to be adjusted next meeting) **Section 17 leave** audit indicated that post leave reviews were completed less frequently than expected. The Committee understood that this was regarded as an 'always' measure for the Trust. **Section 23** one discharge occurred without complete paperwork, which was noted as unusual. **MHA Performance Report (October and November 2025)** **Mental Health Act Incidents** The number of MHA incidents had risen to 8 during the reporting period, a rise from 4 incidents during the previous reporting period, 4 of which occurred at Sandpiper, Rotherham. One patient was discharged without Section 23 paperwork, and there were no MHA medical incidents. **Blanket Restrictions** 2 new blanket restrictions were introduced, one related to an individual patient and another concerning estates, both have since been closed. **Seclusion** showed a slight reduction on previous performance related to every patient being reviewed by a Consultant Psychiatrist within 5 hours, 91.7% in October and 83.3% in November. **Absence Without Leave (AWOL)** There were no absconding incidents despite report categorisation errors. **MHA policies** Out of 25 procedural documents, 7 had been adopted with 10 in date and 8 overdue for review, though no harm or legislative changes were identified. **Mental Health Act and Reducing Restriction Intervention Training Compliance** Progress on mandatory training compliance remained below the level		

	expected for MHA level 3 (October 2025 78.37%) and RRI (October 78.15%). Plans were underway through the Education and Learning Group to develop both a plan and a more proactive approach to improve compliance, before being presented to the Board in January. **CQC MHA Inspections** there were 4 visits during the reporting period. Persistent themes identified across inspections include estates issues, risk assessments, and care planning.
Positive highlights of note:	**Community Treatment Orders** There was continued 100% compliance with respect to Community Treatment Orders in respect of Consent to treatment and Section 132 rights. **Section 136 Suites** all 66 patients were assessed within 24 hours. However, it was also noted that all 3 suites experienced closures, totalling 14 occasions, compared to 2 previously, primarily for repurposing to manage operational pressures. **Blanket Restrictions** the first biannual report on blanket restrictions outlined the definition and governance arrangements for both short term and longer term applications. It was recommended that laundry rooms should be treated as health and safety restrictions due to ligature risks and mixed sex ward rather than blanket restrictions.
Matters for information:	**Reducing restriction interventions** During July to September, 418 incidents of violence and aggression were reported, including restraint, racism, and seclusion. The Committee was pleased to receive its first report on reducing restrictive interventions. A further iteration would be presented to the Committee at its next meeting.
Decisions made:	None.
Actions agreed:	**Blanket Restrictions** Mr Forsyth agreed to review the proposed 28 day timeframe against legislative requirements and consider whether adjustments were needed including thresholds and consistency of application. **Reducing Restriction Interventions** Future reports to articulate strategic aims, actions, and outcomes, and include analysis of repeated restraint, duration, protected characteristics and demographic factors.

Sarah Fulton Tindall, Non Executive Director, Chair of the Mental Health Act Committee
Report to the Board of Directors meeting scheduled for 29 January 2026.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee:	People and Organisational Development Committee	**Agenda Item:**	Paper G
Date of meeting:	17 December 2025		
Attendees:	Rachael Blake (Chair), Richard Chillery, Steve Forsyth, Carlene Holden, Richard Rimmington, Ian Spowart, Pauline Vickers. In attendance: Laura Brookshaw, Phil Gowland, Kim Shilomboleni, Leanne Young		
Apologies:	Dr Jude Graham and Dave Vallance		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Staff Survey and pulse update, 2025 campaigns** Initial staff survey results showed a 49.3% response rate, an 8% decrease from 2024. The results will be analysed, once available comparing them with previous years, People Promise themes and sector averages. **Integrated quality performance report (IQPR) and the top ten measures** Retention rate currently 10.5% and expected to rise in Q4 due to a spike in retirements at the end of the year and a small number of colleagues securing posts outside of the Trust in advance of change management, though the position may worsen before stabilising into the next financial year. Modelling based on retirements and other factors was being used to monitor trends. Sickness absence remained high with two thirds of cases long term. Additional manager training was underway, and a further deep dive in February to review cases and explore options for returning staff to meaningful work. Vacancy rates were unlikely to change significantly in Q4. Mandatory training compliance was positive. **Strategic Delivery Report (SDR5)** There remained ongoing work with leaders such as first line management training and leadership development offer focusing on a cohort of 555/7 line managers and aligning development activity with this group. Additional initiatives include establishing the multiprofessional leadership team development programme and clinical leaders training programme being developed with roll out in 2026. **Trust People Council (TPC)** The TPC discussed antiracism, the impact of long term sickness, and human factors linked to organisational change, focusing on support for affected staff and bystanders, alongside plans for further development and staff side engagement. Efforts to ensure representation from both medical and non-medical staff side members continued.		
Positive highlights of note:	**Real living wage (RLW) annual update and next steps** The RLW rises by 6.7% from 1 April 2026. Expected changes for the 2026/27 national Agenda for Change (AfC) pay award are around 2.5% (effective from April 2026). **Training needs analysis (TNA) 2026 to 2027 plans** TNA represented all care groups and backbone services, with work continuing to finalise a fully costed plan for presentation to the Education and Learning Group and the Board in January. Proactive planning was underway for the 2027/28 with dates scheduled for September 2026 to ensure timely delivery of the TNA in future years. **Internal Audit Recommendations** There were four open internal audit actions all on track for completion (violence and aggression against staff and Trust induction audits)		
Matters for information / noting:	**Resident doctors Industrial Action 17 December until 22** Approximately 41% of the workforce participated and consistent with previous strike periods. There was no impact on services with all shifts covered and contingency plans ensured continuity to operate effectively and safely.		
Decisions made:	None		
Actions agreed:	**IQPR** Members considered the Top 10 reporting measures from the People and Teams Plan. A proposal would be developed on which measures should be		

	reported on a rolling basis and suggested grouping of measures to improve efficiency and focus.

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

Report to the Board of Directors meeting scheduled for 29 January 2026.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	**Agenda Item**	Paper H
Date of meeting:	21 January 2026		
Attendees:	Dave Vallance (Chair), Joy Bullivant, Dr Richard Falk, Jo McDonough, Carlene Holden, Dr Diarmid Sinclair, Maria Clark, Jo Cox, Toby Lewis In attendance: Oliver Blake (360 Assurance), Phil Gowland, Steph Pinnell		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Promise 8 (RDaSH 5)**. Overall, actions are progressing on each of the 5, albeit with different levels of rigour, and we are seeing limited changes in the Promise Success Measures in what are still early days. The Committee supported the recommendation to inject a more robust planning approach to achieve the outcomes. Data development, aligned to the Equality and Inclusion Plan, had progressed, supporting clearer oversight of delivery. Partnership roles with the voluntary and community sector in relation to dementia had been established and were in the process of being implemented across place. For perinatal services, a more clearly defined problem had been identified to inform initial actions to improve referrals for women from black and asian backgrounds. Improvements were noted in Talking Therapies, with a small increase in referrals and treatment uptake among adults, alongside ongoing work on health checks for people with a learning disability and the development of autism friendly environments. The Committee recognised the importance of meaningful engagement rather than tokenistic contact, and the need to integrate cultural competency training into organisational planning. **Promise 11 veterans**. Progress of work in relation to serving the Armed Forces Community highlighted improvements in data capture and understanding, while recognising ongoing challenges around data completeness and engagement. Plans were in place to sustain momentum through continued data development, partnership working and targeted actions - to include development of a Peer Support role and training across the organisation. **Promise 15**. Updated thinking on the delivery of Promise 15 and progress on neighbourhood pilots was noted alongside the planned developments in physical health neighbourhood models – set against a backdrop of complexity in developing approaches across different services and geographies. It highlighted the national focus on neighbourhood working as both supportive and challenging, suggesting that a clearer direction could be agreed during quarter one of 26/27, with additional management capacity. A further update would be provided in May. **Promise 21: delivering success.** The report highlighted confidence in delivering the hyper local elements during 2026 to 2027, with sufficient focus to support measurable progress despite some lack of clarity in the measures. It emphasised the importance of joint working with general practice and the voluntary, community and social enterprise sector, referenced the relevance of SDR3 and the development of a shadow Community Leadership Executive, and outlined plans to clarify executive ownership through objective setting. The report acknowledged potential frustration with progress, noting the value of more time bound milestones led by local leaders, and set out an intention to use innovation to support smaller scale,		

	locally driven improvements, supported by changes in leadership and the strategic development function. **Strategic delivery risks: SDR1 SDR3**: Noted the ongoing workforce development activity under SDR1, with further independent assurance still required, and positive progress under SDR3 through a working group addressing next steps for the CLE five primary care priorities. The report also highlighted revised appendices reflecting 360 Assurance feedback.
Positive highlights of note:	**Equity and Inclusion (E&I) Plan**. Efforts to align the E&I plan with health inequalities data and quality measures, aiming for a more coherent approach to tracking progress and identifying areas needing further action. Progress against the plan noted that most Promises had advanced through planning and action stages, although it was too early to evidence impact through data. Future reports would continue to bring action and activity together along with reporting changes in data. **Adult Eating Disorders Collaborative**. The report summarised progress within the Adult Eating Disorders Collaborative, highlighting the quality position of the South Yorkshire inpatient provider, the current and forecast financial position, activity and occupancy levels, and the work of the Joint Committee. While progress had been made, further improvement was required in care transitions, reducing inpatient lengths of stay and strengthening physical health monitoring, with eating disorders remaining a priority for 2026 and 2027.
Matters presented for information or noting:	None.
Decisions made:	None.
Actions agreed:	**Data Consistency and Terminology**: Concerns about inconsistent terminology regarding race and ethnicity in reports and the need for standardised language, - agreed an executive and board level action to formalise terminology and ensure clarity in targets and data interpretation. **External Support for Learning Disability Work:** Explore engaging external expertise to support the team in progressing work on learning disabilities, given current lack of progress.

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

Report to the Board of Directors meeting scheduled for 29 January 2026.

Rotherham Doncaster and South Humber NHS Foundation Trust

Committee:	Finance, Digital and Estate Committee	**Agenda Item:**	Paper I
Date of meeting:	17 December 2025		
Attendees:	Pauline Vickers (Chair), Carlene Holden, Richard Banks, Rachael Blake, Jill Savoury, Maria Madgwick, Richard Chillery, Phil Gowland, Ian Spowart, Sarah Fulton Tindall, Laura Brookshaw and Richard Rimmington		
Apologies:	None.		
Matters of concern or key risks to escalate to the Board:	**Month 8 Finance Report.** A year to date surplus of £544k was reported with a breakeven forecast, though risks remain around HDRU income and deficit support funding. HDRU occupancy is low (6 of 16 beds), creating a £1m income risk. Capital plans include £2m for the Waterdale lease, with a funding bid decision due in January and subsequent refurbishments expected in 2027 to 2028. The underspend is driving a higher than planned cash balance. **Trust Procurement Function Development.** The merger of the procurement team with Sheffield expected to have final sign-off shortly. This will enable the next phase of work to structure the combined team, align processes, and begin consultation and TUPE arrangements. **Medium Term Finance Plan: 2026/27**. Updated assumptions in the Finance Enabling Plan and an increased in year CIP requirement to be £10m (previously £7.5m). Income allocations remained uncertain and subject to negotiation. Capital and cash plans were under development and scheduled to align with the Estates Plan in Quarter 4.		
Key points of discussion relevant to the Board:	**Health and Safety Act Compliance: Air Quality, Legionella, Fire Safety.** The committee was presented with an improving position on estates compliance. Significant progress had been made on fire safety compliance, with further work planned for Quarter 1 2026.		
Positive highlights of note:	**Strategic Delivery Risk Report.** There were increased examples of purposeful data use across the organisation and it was emphasised that clarity had been achieved on priorities, with safety critical work remaining the foremost focus, followed by strategic objectives. **Ambient Voice Technology: Update and Results from Pilot.** The pilot had demonstrated that the trust could benefit from wider investment in this solution. Further results were still being collected to inform procurement decisions to begin in Quarter 4, with a potential contract award and rollout in Quarter 1 of the next financial year.		
Matters presented for information or noting:	**Internal Audit Progress Report.** Two audit recommendations remain in progress, with significant progress made. The estates helpdesk system reporting action was overdue and was expected to be finalised by March.		
Decisions made:	No decisions were made.		
Actions agreed:	None		

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

Report to the Board of Directors meeting scheduled for 29 January 2026.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Trust People Council	**Agenda Item**	Paper J
Date of meeting:	28 January 2026		
Attendees:	Dave Vallance, Kath Lavery, Glyn Butcher (Patient rep), Cheryl Gowland (Chair of Carers Network), Carlene Holden, Toby Lewis, Tinashe Mahaso (Chair of REACH Network), Amanda Ambler (Chair of DAWN Network), Atique Arif (Volunteer rep), , Victoria Takel (Chair of Womens' network), Vikki Mitchell (Co-Chair of Rainbow Network), James Hatfield (FTSU), Dr Simon Mullins (JLNC Staff Side Chair), Jennie Gaul (Staff Governor), Prachi Goulding (Staff Governor), Victoria Stocks (Staff Governor),		
Apologies:	Dr Nav Ahluwalia (Senior doctors committee), John Whitehall (Unison Steward/JCC Staff Side Chair), Laura Wiltshire (Co-Chair of Rainbow Network), Emma Wilsher (Staff Governor), Dr Babur Yusufi (Guardian of Safe Working Hours), Jessica Williams (Staff Governor), Mike Seneviratne (Staff Governor)		
Matters of concern or key risks to escalate to the Board:	Verbal update to be provided, where applicable, given the timings of the meeting.		
Key points of discussion relevant to the Board:	As agreed at the October TPC, the January 2026 TPC meeting was a in-person development session to focus on the culture within the organisation and to hear the voice/feedback/reflections from all of our TPC members. The development session builds on the work of the People and Teams Plan, and the feedback from colleagues to reflect on the culture which they wish to me part of, specifically • Caring, Supporting, Fair and Equitable culture for all: we want staff to treat patients with respect, care and compassion, so all leaders and staff must treat their colleagues with respect, care and compassion • Climate that supports equality, diversity and inclusion: celebrate the diversity and different thoughts, perspectives and views • Climate that supports 'nurturing the power of our communities': encouraging learning and innovation, working alongside those within services and in neighbourhoods • Collective leadership: where staff at all levels are empowered as individuals, within and between teams to act to improve care within and across health and care organisations and systems – 'leadership of all, by all and for all' The development session focussed on the positives and negatives and then the routes and barriers to the delivery of the four points detailed above.		
Positive highlights of note:	Verbal update to be provided, where applicable, given the timings of the meeting.		
Matters presented for information or noting:	Verbal update to be provided, where applicable, given the timings of the meeting.		
Decisions made:	Verbal update to be provided, where applicable, given the timings of the meeting.		
Actions agreed:	Verbal update to be provided, where applicable, given the timings of the meeting.		

Dave Vallance, Non-Executive Director and Chair Trust People Council
Report to the Board of Directors meeting scheduled for 29 January 2026.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper K
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	29 January 2026

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

This report continues to narrate the year we are (25/6) and plans for following years, with the NHS planning round continuing against a submission deadline of February 12th. We anticipate ending the financial year in a break-even position, albeit with an underlying deficit, and the report reminds the Board of arrangements for employee consultation, now starting on February 2nd.

The challenge of balancing present/future, finance/quality, our promises/national plans – and other nuances – is reflected in the report. It is timely to remind ourselves of the Board's approved pecking order for choice-making. Work to deliver our four-week wait continues and CLE is now considering the 'secondary wait' position against an aim to ensuring no care waits beyond 18 weeks (a further upside vs national plans).

During February, we expect to make choices in respect of AI and it may be helpful to confirm how the Board wishes to be sighted, briefed or involved in those decisions, further to the workshop held in December.

Previous consideration (where has this paper previously been discussed?)

The preparatory CLE discussions are considered in annexes: as are partnership deliberations.

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 progress being made towards 12/02 revised national plan submission

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 December 2025 and January 2026
Annex 2: Current register of Trust vacancies – as at time of issue
Annex 3: National publications December 25/January 26
Annex 4: YTD to 31/12 RIDDOR
Annex 5: Outbrief from All Age Eating Disorders Joint Committee - January
Annex 6: Outbrief from South Yorkshire MHLDA Board meeting – January

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report - January 2025

1.1 We discussed in November the possibility in Q4 of **very largely delivering in full our 2025/26 plan, despite the high level of ambition that it contained**. Reductions in out of area placement care are especially welcome, as are four week waits: for both, the sustainability challenge in 2026 should be recognised, as it is for Promise 3 which we met in, and from, October 2025. But it is also important to note and privilege too, the smaller-scale changes, like the recent expansion of our IV services preventing DRI admissions, work to finally put consistent community clozapine care into place across RDaSH, and the virtual ward mental health pilot we discussed in October as a Board. Investment bids are considered elsewhere in the Board's papers with that balance in mind: with a focus on Promise 1 as expected.

1.2 The four-week wait deadline of April, and the promise, is framed in terms of sustainability and is concentrating final changes to processes. From February, we will be reporting in parallel, the one-week decision wait for allocation and appointment. **Likewise, in February, we begin to consistently report our Urgent Care wait time promise within Promise 14**: as the National Oversight Framework reports, we meet the national urgent care wait measures relevant to this Trust's portfolio.

1.3 We need to acknowledge that we did not meet our 3000 ambition in terms of **flu vaccination**. At the time of writing, we completed 2556 jabs with a coverage of 63.1%, which represents a top 10 finish when compared to other NHS Trusts. This is the third year of consistently high vaccination coverage @RDaSH – recognising that our 'second half' was again a tail-off and will be the focus of reflection for the 2026 campaign. Our highest performing directorates were Learning Disabilities and Forensics (Doncaster AMH&LD care group) and Community and Long Term Conditions (Physical health and neurodiversity care group), Operations directorate and Corporate assurance directorate.

1.4 Approximately 200 colleagues among our staff teams are potentially impacted by **the management of change consultation**. The Board has approved changes which remove 95 roles, which currently have 62 postholders in them. Consultation will start on February 2nd, one week later than hoped, but a timetable still consistent with redeployment taking place in March, which is our primary goal. Work on KPIs arising from the approved QSIAs, seen by the Board, continues ready for implementation from April.

1.5 **The planning cycle** is consuming considerable time and attention. Whilst it is superficially a three-year discussion, in practice ICBs have not been able to offer any income clarity beyond March 2027. This is difficult, as it militates against the left-shift that the public and staff are working towards: clarity on the MHIS and on the 6%+ community investment expectation are matters that have been raised in our assurance discussions. We do expect to submit a revised plan with the provider/commissioner income gap narrowed, but at this stage have indicated that contract signature conclusions will take to March to reach collaboratively.

Our patients

2.1 Wait times continue to be reduced, which is welcome. **The Trust is consistently delivering the national RTT measure for both physical and mental health services**. Our monthly website update on progress towards four weeks provides confidence we can deliver by the end of March, except in podiatry, as discussed in November's Board, and in neurodiversity. Whilst adult neuro waits are elsewhere on the Board's agenda, waits for children continue to reduce sharply, and we do not expect, after August 2026, to have any young person waiting over two years (104 weeks). Discussions continue with ICB funders over their investment plans, and tariff arrangements, as the significant progress made for young people since 2024, in the main, reflects self-generated investments from within other RDaSH budgets.

2.2 Our commitment to investing in North Lincolnshire was very evident at the opening event for **the Elizabeth Quarter development** on January 8th. Whilst the facility is a regeneration step for the local authority, and a tremendous boost for our teams, it will be very important that it is fully used. At July's Board, we will consider data on room use from April 2026 onwards, to test whether we are maximising the space's potential to see patients at scale, whether that is in groups or in individual therapy sessions. By June, we will both have completed the rebuild work for Great Oaks and opened our Crisis Assessment Team services (CATs), which will offer our first open access facility, in line with national policy, to transform urgent care in mental health.

2.3 We have reduced memory waits consistently over the last twelve months, albeit rising demand will always place these, under-invested in services, under some pressure. The importance of rapid diagnosis is evident from talking with carers and with GPs. One element of this process is **the DVLA-assessment of driving capacity, which can be associated with a diagnosis**, and which clearly can also bring isolation and loneliness. The service backlog for this assessment in Rotherham is now resolved, and the risk management group has been asked to ensure that, in all three places, we have coherent pathways at pace to support decision making.

2.4 Waits for **wheelchair services in Doncaster** continue to be a focus of improvement work. The service has the potential to deliver the initial four week wait, not later than March. However, obviously receiving the chair takes a little longer with adaptation and customisation. This we intend to do inside a further 14 weeks. Likewise, for repairs, our service needs to be rapid and, in summer 2025, owing to sickness, was not. We have indicated to commissioners that the funding model for wheelchair provision does need to reflect the scale and pace of need and cannot continue to be applied as a block contract with no invested growth since 2022 or before.

2.5 I indicated, when the Board last met, that we were moving to organise RCPsych accreditation for *all of our mental health wards in Q3 2026/27*. That is on the basis of successful conclusion to our HQTC efforts, which started in February 2025. **There remains significant work to be done to consistently have in place MDTs, 7-day therapeutic activities, and consistent use of DIALOG+**. The switching-off of CPA access from April will assist with the last ambition, and the arrival of new technology into all our wards will help with the first. From the start of March, our safer staffing

processes (daily huddles) will focus too on whether the 7-day activities are happening because,, whilst each ward has committed to the timetable, it is operational pressures which are offered as the explanation for their cancellation – it is important to be explicit that activities do not rely on dedicated posts or roles for that purpose, but are a core expectation of the multi-professional team funded within each ward.

Our people

3.1 Work continues to document and define **our wellbeing framework for 2026** and beyond. This work seeks, in line with discussions, especially within the Trust People Council, to ensure basic standards of wellbeing are consistently met. We know that the legacy offer of support, including physical activity, is well-regarded but we want to ensure, for example, that every employee has a base, that those working remotely are doing so safely, and that core line management and supervision support is always delivered.

3.2 Recognising that **our sickness absence trajectory** to 4.1% is due to return to the Board for discussion in March, there remains work to do to improve the position in a minority of directorates where sickness remains very high. The first step is to deliver consistently our policy of support for employees; a second focuses on much more rapid return to daily work for colleagues on long-term sick absence with stress-related concerns, even if that return is into a third sector placement; and a third re-imagines the right way to support colleagues who feel unable to work owing to their disagreement with Trust policies or practices. We need to honestly reconsider how we support those who are unwell and ensure that processes like Fit Notes and occupational health advice are used to aid best practice management of ill-health.

3.3 We continue to make **good progress with recruitment, including for senior doctors**. The last public Board meeting agreed the SAS6 policy. Among consultant staff, our focus remains on concluding job planning, the policy having been agreed by all parties in November 2025. We have 46 consultant postholders now, which is ostensibly the largest figure in the history of the Trust and, of course, that group now includes general practitioners, older adult physicians and paediatricians, as well as psychiatrists. Completing work to recruit into medical leadership roles remains a priority by June, with the CMO team fully staffed, but gaps in CGMD and a handful of medical lead roles at directorate level.

3.4 Whilst our Training Plan comes to the Board separately on the agenda, for the first time, and reinforces the investment in training that we make across all professions, **it is clear that a more robust and insistent, and consequential, approach is now needed to some elements of mandatory training compliance**, specifically RRI and MHA level 3: annual non-compliance (including in 25/6) with these obligations will prevent employees obtaining incremental progression for 2026/27 unless fulfilled by May 31st 2026, and will also be a consideration in any revalidation applications. The provision of sufficient capacity has been assured all year, but do not attend levels have failed to reduce. For ward nurses, this will be improved by a revised approach to rostering from Q1 2026/7, where training time will be specifically scheduled in monthly rosters.

3.5 During February, we are due to make choices about **our future AI investment detail, and selection choices between the ambient pilots used during 2025**. These are important decisions, with a variety of capital costs and license obligations to be set against capital. The emphasis on this area of policy from central government could not be clearer; and our reliance on these tools to change how we work in readiness for 2027 likewise. We know from work done over the last twelve months that it takes time for employees to get used to and train with these tools, and we need to have frank conversations about where these technologies are replacing paid hours of work.

3.6 Our approach to job planning overall incorporates not only medical roles but also posts in other professions. Above band 7, the intention is to have job plans in place for the end of March to support colleagues with role clarity, and to align to both our productivity work and drive to **ensure senior clinicians are able to see complex patients with the majority of their working week**: supervision, and wider research and educational activities are then a smaller, but crucial function, of up to 25% of time. Our 2026/27 audit programme, through 360 Assurance, will include a sample audit across AHP, nursing, psychological professions and medical teams of the delivery of, and governance of, those commitments.

.**<u>Our population and partners</u>**

4.1 The opening of the Elizabeth Quarter underscores **the significant partnerships we rely upon with local authorities**, for children's service, adult care, and as fellow 'anchor' institutions. Work continues to seek to conclude a health proposal in Waterdale in central Doncaster. Pride in Place investments nationally in each LA may create additional traction in coming weeks and months, including within Rotherham where our future estate plans are deeply contingent on expanding service offers in the town, recognising the fixed point of Swallownest Court base. During 2026/27, we expect to begin to fully utilise our Woodlands facility on the Rotherham Hospital site with a variety of potential relocations into the building being considered for decision in late summer.

4.2 The first meeting of the Community Leadership Executive (shadow CLE) will take place in March. Among other gains sought from this body will be a central focus to **our collaboration with key local VCSE bodies**. Given our commitment (in promise 21 for example) to building some community relationships, and after last year's Your Hearts and Minds grant's programme, there is more to do to ensure that, not only do we develop strong alliances with significant local organisations, but that the scope and scale of that work reflects the full diversity of our patients groups: we have to be able to work well with larger organisations, like MIND, as well as with smaller local groups. There is a real opportunity to align the Trust's neighbourhood working more coherently with the sector and, over coming months, we need to find the bandwidth to do just that.

4.3 We continue to work to build a cogent relationship with **the regional team at NHS NEY**. The regional blueprint was published in autumn 2025, and as ICBs change, from spring 2026, it will become clearer how this triangle will work in practice locally. We have hosted the regional mental health team in recent weeks to discuss both

national policies as they are, and how to ensure that missing areas of focus, notably dementia and eating disorders, remain local priorities. We expect shortly to receive the outcome of regional scrutiny on the Provider Capability Assessment: and attended a review of the initial plan submissions made by the Trust in mid-December.

4.4 It seems inevitable that the re-energising of 'strategic commissioning' will lead from 2026/27 to **an increasing tendency to "contractual" behaviours**. We have been working, for some time, to develop outcome-based commissioning proposals, to sit alongside volumes, and other measures, and replace wholesale, the current 'specifications of input', which dominate how we are contracted. There is strong partner support for this initiative, but it will take much of this year to evolve a revised position and, until it is clearer who has what roles within the ICBs, it is premature to conclude we can easily move in this desirable direction. The risk is that instead what matters is narrow documented ideas, many of them over five years old: the Board was clear in 2023 that it did not want to simply 'do what is contracted' and I assume that remains our view, given the expertise asymmetry between ourselves, our communities and those charged with commissioning services.

4.5 In April, our longstanding executive leader for health informatics, **Richard Banks, will retire from the NHS** – having worked for over two decades at RDaSH. Richard's team will move under the operational function, albeit being retained as a distinct directorate. Information governance will transfer under the corporate assurance function. Jo McDonough's retirement in December will then move the executive group down to eight roles, not ten: with strategic development in the main becoming the chief executive's directorate in order to move forward at pace key projects, including those relating to partnerships. Both colleagues will leave us with our thanks for their service, dedication and achievements.

Toby Lewis, Chief Executive
20 January 2026

Annex 1

Clinical leadership executive – December 2025 and January 2026

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.

December	January
Estate plan stocktake	Organisational change planning
Delivery of our 26/27 financial plan	4-week wait and 18-week wait progress
Progress with HQTC at ward level	Investment bidding submissions
Further consideration of weekend working	26/27 operational planning/priorities

In terms of decisions made, we have continued to focus on support to managers and others leading organizational change: recognizing that that is a dominant feature of leader's time in the present moment.

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

- Execution of transitional care plan for young adults across services
- Neighbourhood working and NHS ten-year plan/MTPF
- Being ready for Always measure implementation during Q1
- Considering how implementation of the Engagement/disengagement policy is proceeding
- Exploring our outcome framework for, and other actions in relation to, peer support (which the Board discussed in November)

Toby Lewis, Chief Executive
21 January 2025

Annex 2: Current register of Trust vacancies October 2025

The overall Trust vacancy rate on 16 January 2026 is 5.1%.

Org L4	FTE Budget	FTE Actual	FTE Variance		Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total
Total	3757.74	3566.78	-190.96		30.91	27.75	17.24	30.55	40.82	16.10	163.37

The Backbone vacancy rate on 16 January is 6.3% which has increased by 0.7% from November 2025 (5.6%), which is attributed to Nursing & Facilities and People and OD

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	26.91	-2.18		0.05	0.00	0.00	0.00	0.00	0.00	0.05
376 Estates	45.18	44.78	-0.40		1.75	0.00	0.00	0.00	0.00	0.00	1.75
376 Finance & Procurement	42.99	40.37	-2.62		1.00	0.00	0.00	0.00	1.00	0.00	2.00
376 Health Informatics	79.59	73.17	-6.42		1.00	0.00	0.00	0.00	1.00	0.00	2.00
376 Medical, Pharmacy & Research	51.03	50.02	-1.01		0.00	0.00	0.00	1.00	0.00	1.00	2.00
376 Nursing & Facilities	171.24	158.16	-13.08		0.77	0.00	0.00	0.00	6.68	0.00	7.45
376 Operations	51.08	50.40	-0.68		0.00	1.00	0.00	0.00	1.00	0.00	2.00
376 People & Organisational Development	90.08	80.27	-9.81		2.00	0.60	1.00	1.00	1.00	0.00	5.60
376 Psychological Professionals and Therapies	21.37	20.09	-1.28		0.00	0.20	0.00	0.00	0.00	0.00	0.20
376 Strategic Development	20.25	19.56	-0.69		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	**601.90**	**563.74**	**-38.16**		**6.57**	**1.80**	**1.00**	**2.00**	**10.68**	**1.00**	**23.05**

The Clinical Directorate vacancy rate on 16th January is 4.84% which has reduced by 1.2% since November 2025.

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	343.06	338.67	-4.39		0.00	2.00	1.00	2.00	4.00	2.00	11.00
376 CCG Physical Health	283.97	283.61	-0.36		0.00	0.00	0.00	0.00	0.60	0.00	0.60
376 DMHLD Acute Services	230.44	208.56	-21.88		1.00	4.70	0.00	0.60	3.00	1.00	10.30
376 DMHLD Community Services	346.11	329.15	-16.96		3.00	1.80	1.00	1.80	1.00	0.80	9.40
376 DMHLD Learning Disabilities & Forensics	189.19	179.19	-10.00		0.70	0.60	0.00	2.00	2.00	1.60	6.90
376 NLCG Acute Care Services	138.33	124.43	-13.90		1.40	3.05	4.90	2.00	3.70	1.00	16.05
376 NLCG Community Care Services	155.27	140.07	-15.20		3.70	1.40	1.04	3.50	1.04	1.00	11.68
376 NLCG NHS Talking Therapies	190.09	183.65	-6.44		0.40	3.00	1.00	5.00	1.00	2.00	12.40
376 PHND Community & Long Term Conditions	418.24	399.27	-18.97		0.00	2.00	1.00	1.00	2.80	1.80	8.60
376 PHND Neurodiversity	42.66	40.55	-2.11		0.00	0.00	0.00	0.00	0.60	0.00	0.60
376 PHND Rehabilitation	322.57	311.91	-10.66		3.24	2.00	1.50	2.60	1.00	1.00	11.34
376 RCG Acute Services	251.69	232.82	-18.87		1.00	4.60	4.80	3.35	7.80	1.50	23.05
376 RCG Community Services	244.22	231.13	-13.09		9.90	0.80	0.00	4.70	1.60	1.40	18.40
Total	**3,155.84**	**3,003.04**	**-152.80**		**24.34**	**25.95**	**16.24**	**28.55**	**30.14**	**15.10**	**140.32**

It should be noted that there are four change management schemes which have been identified across the Trust as part of our Cost Improvement Programme for 2026/27 and therefore our vacancy numbers are likely to increase in February and then reduce in March when we redeploy affected colleagues into these vacancies.

Annex 3: **National publications/guidance summary – December 2025/January 2026**

Eating disorder services for children and young people: National guidance
(NHS England, published 20/01/2026)

This guidance is for integrated care boards (ICBs) and providers of eating disorder services and sets out how to design collaborative, integrated services that support all children, young people, and their families and/or carers.

https://www.england.nhs.uk/long-read/eating-disorder-services-for-children-and-young-people-national-guidance/

NHS finance business rules from 2026/27: guidance for integrated care boards and NHS trusts
(NHS England, published 16/12/2025)

This guidance sets out the finance business rules for integrated care boards (ICBs) and NHS trusts and foundation trusts ('NHS trusts') that will apply from 1 April 2026. The finance business rules include relevant statutory financial duties and other financial policy requirements set by NHS England and the Department of Health and Social Care (DHSC) that apply to ICBs and NHS trusts, as well as setting out how the impact of surpluses and deficits are managed in future years.

https://www.england.nhs.uk/publication/nhs-finance-business-rules-from-2026-27-guidance-for-integrated-care-boards-and-nhs-trusts/

Mental health bill receives Royal Assent
(Department of Health and Social Care, 18/12/2025_

Patients with severe mental illness are to be better protected thanks to landmark new legislation. The new Mental Health Act has received Royal Assent, meaning it is now law. It will reform the outdated Mental Health Act of 1983, which provides the legal framework to detain and treat people in a mental health crisis who are at risk of harm to themselves or others. The modernised act will implement urgent reforms which experts have been calling for almost a decade, bringing mental health care into the 21st century and empowering patients to take charge of their treatment. It will support NHS staff to provide more personalised care for those who need it.

https://www.gov.uk/government/news/mental-health-bill-receives-royal-assent-revolutionising-care

https://www.legislation.gov.uk/ukpga/2025/33/enacted

An update on actions to prevent sexual misconduct in the NHS
(NHS England, published 05/12/2025)

https://www.england.nhs.uk/publication/an-update-on-actions-to-prevent-sexual-misconduct-in-the-nhs/

Building an evidence-based approach to mental health care
(NHS Providers, published 19/12/2025)

In this blog, by Emily Gibbson (Policy Officer Mental Health, NHS Providers), it highlights the importance of sound data for good mental health services.

https://nhsproviders.org/resources/building-an-evidence-based-approach-to-mental-health-care

Annex 4:

YTD to 31/12 RIDDOR

Since 1st April 2025 there have been **12** RIDDOR reportable incidents resulting in employee injury.

Incident date	Cause	Location / Directorate	RIDDOR reason
April			
03/04/2025	An employee slipped on a wet floor in the hub area and suffered a knee injury.	Brodsworth Ward (Doncaster 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.	Patient's home (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
May			
06/05/2025	A patient hit an employee in the face causing severe bruising and psychological harm.	Mulberry House (N Lincolnshire Acute Directorate)	Over 7-day absence
11/05/2025	A patient was pushed over by an employee. The following day they were transferred to an external facility (planned transfer) where they complained of leg pain. On attending A& E a hip fracture was discovered.	Brodsworth Ward (Doncaster Acute Directorate)	Member of the public taken to hospital
0 incidents in June and July			
August			
04/08/2025	A Domestic pulled their back when carrying a vacuum cleaner upstairs.	Facilities (Nursing and Facilities Directorate)	Over 7-day absence
07/08/2025	An employee fell in a hole in the garden and twisted their ankle.	Magnolia Lodge (Physical Health and Learning Disabilities)	Over 7-day absence
0 incidents in September			
October			
06/10/2025	An employee fell after being accidentally struck by a confused patient. Hip injury sustained.	Osprey Ward (Rotherham Acute Directorate)	Over 7-day absence
09/10/2025	Patient objected to receiving a depot injection and struck an employee in the face. Bruising and concussion.	Mulberry House (N Lincolnshire Acute Directorate)	Over 7-day absence

14/10/2025	A gardener was loading a lawn mower via a ramp into the back of a van and slipped and fell.	Gardeners / Grounds (Estates)	Specified injury - - knee fracture
14/10/2025	An employee felt back pain after moving bins around the bin compound.	Facilities (Nursing and Facilities Directorate)	Over 7-day absence
0 incidents in November			
0 incidents in December			
January			
09/01/2026	An employee tripped on uneven paving resulting in a twisted ankle and grazed hands.	Facilities(Nursing and Facilities Directorate)	Over 7-day absence

Annex 5

South Yorkshire Eating Disorders Joint Committee (SYEDJC)
Meeting note – 12th January 2026

The South Yorkshire Eating Disorders Joint Committee (SYEDJC) met on 12th January 2026. The main areas of discussion and subsequent actions are outlined below.

Medical emergencies in eating disorders (MEED) – communication with acute trust

Actions are progressing well with the proposal for Phase one of the MEED development and members of the committee finalised the expected funding and confirmed the configuration of the medical and MEED practitioner roles.
Phase one is an adult service development as funding can be freed up from an existing contract and Phase 2 will be all age and designed to align with the modernisation of the intensive community and inpatient services. The committee emphasised the need for the developments at both phases to ensure clear access to, and provision of, services for 16 and 17 year olds.

A requirement for funding of a second phase of changes from October 2026 is still under review by the ICB and remains crucial in implementing a sustainable change.

Physical Health Monitoring

Initial baselining work indicates that commissioning and practice is variable across South Yorkshire for physical health monitoring for eating disorders. A workshop with primary and secondary care colleagues and commissioners is being planned for February to review the current position and recommend best practice. Work will then need to be undertaken to understand the implications that this has for training and capacity, including any associated costs. This will include understanding how this links to effective neighbourhood based care.

Adult community development

The committee received an update that referrals continue to flow from Barnsley, Doncaster, and Rotherham, indicating successful expansion of community eating disorder services. Recruitment to key roles within the team have been successful. Some patients from across South Yorkshire are still having appointments in Sheffield, however, there will be an incrementally increased presence in clinics in Barnsley, Doncaster and Rotherham by the end of March. The service will be fully functional as planned by April 2026 in all four places. The Committee requested that a briefing on the service be provided to clinical teams to highlight the excellent progress to date and clarify any remaining clinical or operational queries.

Inpatient care development

Updates were provided on the inpatient development for both adults and Children and Young People. Both of these consider the required bed base but also the need

to start to develop intensive community services over time with clear integration with community and MEED services.

The adult inpatient feasibility case is progressing really well, and this should support a decision about progression to implementation by March 2026, as planned. Work on feasibility for inpatient Children and Young People services is ongoing, and a project initiation document was presented to the committee for review with ambitious timescales to develop a business case by March 2026, with subsequent scrutiny and governance, including by the provider.

In response to a request from the Committee at the December meeting, advice had been sought from the ICB quality team to ensure that the Commissioner was content in principle with separating the adult and child provision and was content in principle if the physical location for adult services was potentially separate from some other services. The initial feedback is that this is acceptable alongside appropriate mitigation including clarity about access to developmentally appropriate care and safe and effective transitions. ICB colleagues will support ongoing quality impact assessments.

The committee were sighted on the risk to the development if capital funding was not available to support the changes. Capital bids to NHSE have been coordinated by the providers and have been prioritised by the ICB in two different funding pots. The committee was updated on early advice around procurement and informed that a paper would be presented to EDJC by March 2026, noting that this will need to be considered alongside appropriate measures to manage any potential conflicts of interests.

Avoidant/Restrictive Food Intake Disorder (ARFID)

Progress on this workstream continues, however, a paper on the system will now be considered in February 2026, with a more detailed paper in March 2026. This allows for more time to engage with a wider range of stakeholders to help to inform the development of a pathway from early intervention through to meeting the needs of people who would benefit from specific and targeted support.

Annex 6

South Yorkshire Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Board meeting – Meeting note: 14th January 2026

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 14 January 2026. The main areas of discussion and subsequent action are outlined below.

Planning and Mental Health Investment Standard (MHIS)

Members of the Board discussed current planning challenges. Members highlighted a previous commitment by the Integrated Care Board (ICB) representative to ensure MHLDA Collaborative involvement in the planning process, particularly in the application of MHIS. It was agreed the existing system planning group would now include the Collaborative coordinating chief executive on behalf of the Collaborative. Disappointment at the level of MHLDA growth funding was highlighted, noting the context of a difficult national funding position.

Future of the MHLDA Collaborative: Ways of Working

A presentation on future ways of working was provided to the Board for discussion. It was noted that trust leaders were delivering the work of the Collaborative alongside many other priorities, including significant neighbourhood developments. Much of this work was rightly routed through place partnerships.

It was agreed that the collective focus of the MHLDA Collaborative needed to remain on the key priority programmes and retain the existing focus on delivery and outcomes. However, it is also important to ensure a forum for collective sector voice and space to lead reform.

Given the important and changing role of the ICB, this will be further considered with ICB colleagues in a dedicated workshop in the Summer, when long term roles, responsibilities and relationships have been clarified.

Forensic Service Future Development Programme Plan Update

Following a detailed paper in November, the Board received an update on the forensic service development programme plan. A project group has now been established with wider partners and initial data analysis for South Yorkshire & Bassetlaw is progressing to plan.

Following analysis, workshops will be delivered with existing providers, other service specialists and people with lived experience to further develop potential opportunities and create delivery plans, with a focus on the needs of different groups of people requiring forensic services. It was noted that community provision will be addressed as an area in its own right as opposed to being one element of each of the other pathways.
The members of the Board noted the progress with this programme of work and supported the proposed plan high-level next steps.

Next Steps: 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, noting the continued need to focus particularly in the area of complex OAPs where the forecast expenditure for the full financial year could exceed £20 million.

RDASH has recently opened an inpatient unit to provide local high dependency mental health rehabilitation care, with associated community pathways. Learning is being collated to share on the process and in particular the interface with existing ICB processes, to inform future developments.

Plans were shared on next steps for reviews of care for people with complex care needs and for those with an acquired brain injury.

The paper was positively received noting the potential for huge benefits financially but more importantly for the individuals requiring the services.

Eating Disorders

A paper was presented on progress with the eating disorders programme. This is being implemented as planned with considerable progress on the planned left shift in eating disorders care and community development.

There is a continued focus on meeting the needs of people experiencing a medical emergency in eating disorders (MEED) and progress continues with partners to use redirected funding for phase one work to address non-compliance with MEED guidance. Board noted the requirement for system wide support of phase two, which continues to be a challenge.

Given the timing of the South Yorkshire Eating Disorders Joint Committee (EDJC) meeting on 12th January, the usual out brief was not available however a verbal summary was provided, and the out-brief will be circulated to all of the EDJC member Boards.

Highlight Report

An update was also provided on progress to deliver three ADHD and Autism actions that are under shared leadership with the ICB: tariff proposals for ADHD/Autism, shared care for ADHD and autism support for adults.

Health Inequalities

Members of the Board noted that whilst consideration of health inequalities ran through all of the programmes in various ways, it should be considered using a proactive approach to equalities impact assessment. Local best practice will be reviewed and considered at the next board to agree a robust and consistent approach within the Collaborative programmes.

Marie Purdue, Managing Director,
South Yorkshire MHLDA Provider Collaborative

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Learning from Prevention of Future Deaths (PFD) Reports	**Agenda Item**	Paper L
Sponsoring Executive	Dr Diarmid Sinclair, Chief Medical Officer		
Report Author	Dr Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	29 January 2026

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

This paper looks at Prevention of Future Death reports issued nationally and locally from 2023 until 2025 by Coroners.

Suggested discussion points:

- Whether the key national PFD themes align with the Trust's identified quality and safety risks and associated workstreams and whether we can adequately evidence such changes to the communities we serve.
- The adequacy of Trust arrangements for learning from both local and national PFDs.
- That actions arising from the locally issued PFDs have been tracked, changed practice and systems embedded as well as evaluated.

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

Not applicable

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the national themes arising from Prevention of Future Deaths reports including Continuity of Care, Risk Assessment, Staffing, Communication, Learning and implementation of policies

NOTE that the Trust is actively progressing actions plans for PFDs that have been issued to the Trust and has systems in place to review national PFDs to proactively take action within the Trust

NOTE the intention to repeat this analysis looking at PFDs that have been issued again in quarter 4 in 26/27

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)	
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			
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
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
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
N/A
System / Place impact (advise which ICB or place that this matter relates to)
This paper reflects on matters from within and outside of the Trust's geographical footprint as opportunities for learning.

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
BOARD OF DIRECTORS

1. Purpose of the Paper

1.1 The purpose of this paper is to present learning from a national review of **Prevention of Future Deaths (PFD)** reports issued by coroners, with a particular focus on mental health–related deaths. The paper summarises the key themes raised by coroners, considers their relevance to RDaSH, and outlines the implications for the Trust's ongoing approach to quality, safety, and learning.

2. Background and Context

2.1 Under Regulation 28 of the coroners (Investigations) Regulations 2013, coroners have a statutory duty to issue a Prevention of Future Deaths report where they believe that action should be taken to prevent further deaths. These reports are addressed to organisations or individuals who may be in a position to take such action.

2.2 There is a national database of PFD reports which is publicly accessible. This is available on the judiciary website for free and there is also a tool with more reporting functionality the Preventable Deaths Tracker.

2.3 An analysis has been undertaken of this database for PFDs published between 2023 and 2025, focusing specifically on the "Coroner's Concerns" section of each report. This section sets out, in the coroner's own words, the matters that they believe create a risk of future deaths if not addressed.

3. Summary of Findings from National Database

Theme	Number of PFDs
Follow-up / continuity of care	166
Risk assessment & monitoring failures	165
Staffing / resourcing problems	107
Communication failures	82
Policy / procedure clarity issues	66
Record keeping / documentation failures	65
Training / staff competence	50

3.2 There were 180 reports identified for the period. There are more than 180 PFDs by theme in the table above because it is very common for a Coroner to find not only a single problem in care but rather a number of issues.

3.3 The most frequently occurring themes relate to continuity of care, risk assessment and monitoring, staffing and capacity pressures, communication between teams, and the gap between written policy and operational practice. In most cases, multiple themes are present within the same report, reinforcing the view that preventable deaths usually arise from a combination of factors rather than a single point of failure.

4. Continuity of Care and Transitions

4.1 The most prominent concern raised by coroners relates to continuity of care, particularly at points of transition. These include discharge from inpatient care, step-down from crisis services, and transfer between teams or pathways. Coroners frequently describe situations in which individuals were known to services but experienced delays in follow-up, were not allocated promptly to a worker, or were passed between teams without clear ownership.

4.2 In several reports, coroners note that these transition points coincided with periods of heightened vulnerability. The absence of timely contact or clear responsibility was therefore seen as materially increasing the risk of harm. A recurring narrative is that care did not stop entirely, but that it became diffuse, with no single service clearly accountable for next steps.

4.3 RDaSH has several work streams that align to these concerns. Firstly, we are committed through Promise 19 to eliminating out of area placements. By preventing patients going out of area it is easier to ensure continuity of care. Additionally, because of work being progressed through HQTC it will become a standard part of the inpatient and community schedule to attend inpatient MDTs to prevent there being problems with continuity of care. Work on Promise 14 ensures that patients are seen in a timely manner by the correct service.

5. Risk Assessment and Monitoring

5.1 A further consistent theme is the treatment of risk assessment as a static process rather than a dynamic one. Coroners often acknowledge that risk assessments had been completed but raise concern that they were not revisited when circumstances changed, new information emerged, or warning signs became apparent.

5.2 In a number of cases, coroners highlight that professionals relied on historical assessments or assumptions, rather than actively re-formulating risk in light of new evidence. This led to missed opportunities to intervene or to escalate care. The concern expressed is not about the existence of risk tools, but about how they are used in practice and whether they meaningfully inform decision-making.

5.3 The Trust is currently looking at its policies in relation to the national guidance to not use risk stratification tools and not to group people in low, medium and high risk categories. Some policies have already removed reference to this such as the Engagement/Disengagement policy.

6. Staffing, Capacity and Decision-Making

6.1 Coroners also frequently refer to staffing pressures and capacity constraints. This includes delays in allocating key workers, high caseloads limiting timely contact, and decisions being made by staff without sufficient supervision or oversight.

6.2 Importantly, coroners tend to frame these issues as foreseeable organisational risks rather than individual failings. In several cases, they note that systems appeared to rely on informal assumptions about who was responsible, or

whether staff were available, rather than having robust mechanisms to ensure continuity and oversight.

6.3 RDaSH is committed to being fully staffed. We make use of the nationally recognised MHOST tool to monitor our staffing levels taking into account patient acuity and needs. As part of HQTC work is being undertaken to understand the number of patients are unallocated within teams to try and ensure that patients are allocated prior to discharge.

7. Communication and Information Sharing

7.1 Failures in communication between teams are another recurring theme. Coroners describe situations in which information was shared but not acted upon, emails or alerts did not prompt reassessment, or teams operated with different understandings of risk and responsibility.

7.2 These concerns often relate less to the mechanics of communication and more to how information is interpreted and owned. Coroners frequently identify a lack of shared understanding between services, leading to gaps in care that were not immediately visible to any single team.

7.3 RDaSH uses a single clinical system across its range of services. This allows information to be shared across inpatient and outpatient services. The system also allows for information sharing where other providers use the system also such as primary care. In addition work is also being progressed rolling out DIALOG and DIALOG+ which will lead to patients having a single care plan which sets out who is responsible for what.

8. Documentation, Learning and Governance

8.1 Concerns about documentation and record-keeping appear in a significant proportion of reports. Coroners highlight missing or incomplete records of key decisions, a lack of documented rationale for risk judgements, and the absence of written records of debriefs or learning discussions following serious incidents or deaths.

8.2 In many cases, coroners explicitly link poor documentation to a failure of organisational learning. Where decisions are not clearly recorded, they cannot be reviewed, challenged, or learned from. This limits the ability of organisations to improve systems and prevent recurrence.

8.3 RDaSH has implemented a new PSIRF approach refreshing the previous implementation. There is a regular group for sharing key learning from patient safety incidents from across the Trust. These incidents include not only mortalities but also other types of incidents as well.

8.4 RDaSH has also launched Learning Matters which is used to share key learning from incidents, complaints, reviews and improvement work across the Trust, helping staff understand what has happened, why it matters, and what is being done differently as a result.

9. Policy, Practice and Operational Clarity

9.1 Finally, coroners frequently comment on the gap between written policy and operational reality. In some cases, staff and managers giving evidence were unable to clearly explain referral thresholds, escalation routes, or service responsibilities. This lack of clarity was itself identified as a risk, particularly where staff were required to make high-stakes decisions under pressure.

9.2 When policies are being reviewed we are taking the opportunity to ensure that what is being proposed is necessary, proportionate and achievable. An example of this is the new Engagement/Disengagement policy where the policy was sent for further wider consultation to ensure that all aspects of the policy could be implemented.

10. Summary of national PFDs

10.1 The themes identified through this analysis are highly relevant to RDaSH and reflect known national risks within mental health services. They align with areas of focus within the Trust's quality and safety agenda, including crisis care, transitions between services, workforce capacity, and learning from serious incidents and deaths.

11. Local PFDs issued to RDaSH

11.1 The Trust has received two Regulation 28's Prevention of Future of Future Deaths in recent years, one in 2023 and one in 2024.

May 2023

Follow-up / continuity of care – No effective follow up following discontinuing of antipsychotic medication

Communication and information sharing – Failure to work with the drug and alcohol service that was involved in the patient's care

Action plan	Current progress	Status
Reframe the disengagement policy as an engagement policy and increase monitoring of disengagement	Policy ratified in September 2025 Audits of effectiveness are yet to be completed	
Send out a learning brief related to the death	This was completed in December 2023	
Introduction of RDaSH app to facilitate better staff communication and ready access to policies	This was completed in December 2023	
Introduction of learning half-days creating the time and space for local teams to discuss changes that they wish to make and to reflect on Trust-wide changes	These were introduced in 2025	
Policies to be recorded on RADAR with staff having to acknowledge that they have viewed the policy	Cohorts of staff still to be finalised alongside the exact policies for each cohort	

September 2024

Follow-up / continuity of care – No access to Crisis services for those aged over 65 years

Communication and information sharing – Primary Care and 111 not aware of the inability to provide service to over 65s.

Action plan	Current progress	Status
Crisis Teams to accept referrals from older adults as well as working age	All 3 localities provide access to over 65s	
Communicate the change in crisis team provision to Primary Care partners	This has been completed in November 2024	
Improvements to Trust induction programme including local induction	New Trust induction was rolled out in November 2024	
Promise 14: urgent wait time of 48 hours for response, and four weeks for routine care	On track to be implemented in April 2026	
Digitally enabled support for patient-led booking, and cancellation, of appointments	All SystmOne units are set up ready with the capability for patient-led online booking and cancellation of appointments	
Trust's Equity and Inclusion Group to review age-specific policies	This remains in progress	
Support colleagues in managing older adult presentations via education as part of learning half days	Learning half days were introduced in 2025 Specific analysis of attendance to be undertaken to ensure attendance by CMHT and CRHT cohorts	

12. Prevention of Future Deaths issued to other agencies but involving RDaSH patients

12.1 The following cases involved patients that were known to RDaSH and that a PFD was issued but that the PFD was issued to other agencies such as the ICB as opposed to RDaSH itself.

July 2023

Follow-up / continuity of care – lack of joined up care between physical and mental health services in relation to someone who had an eating disorder

Follow-up / continuity of care – lack of transition between child and adult services

Follow-up / continuity of care – no established MEED pathway at DRI

RDaSH is the South Yorkshire lead for the provider collaborative. In this role we have been supporting a phased, system-wide approach to improving the management of medical emergencies in eating disorders. In Phase 1, funding has been reprioritised

to strengthen acute liaison and clinical leadership, including additional consultant medical time at each acute site, dedicated adult eating-disorder hub leadership, and new MEED (Management of Eating Disorders) practitioner capacity across the four adult receiving hospitals. Alongside this investment, acute trusts are required to meet a set of core standards by July 2026, covering designated wards, trained nursing and therapy staff, protected CPD and case-review time, named consultant responsibility, and participation in shared, pseudo-anonymised data for collaborative learning

In parallel, wider system changes are underway to strengthen eating-disorder care across the pathway. These include the roll-out of community-based adult teams in all four geographies, expansion of a South Yorkshire–wide community day service, and the development of potential specialist inpatient units, supported by prioritised capital investment. Phase 2, planned for confirmation by April 2026 and implementation by September 2026, will further expand medical capacity, consider rationalisation of acute sites if appropriate, and extend MEED provision into children and young people's services following pathway review. Together, these actions represent an initial but credible step towards safer, more consistent and collaborative eating-disorder care across South Yorkshire

December 2025

Risk Assessment and Monitoring - concerns that the prescribing regime in primary care did not identify potential addiction and drug seeking behaviour or review medications with a view to checking they are actually required.

We have access to a shared record for patients using SystmOne. For patients whose GPs that do not use this system we still have access to the summary care record which allows us to see what medications patients are being prescribed.

Our Aspire Drug and Alcohol service has prepared a learning brief on commonly abused prescription drugs to share with our primary care colleagues.

13. Recommendations:

The Board of Directors is asked to

NOTE the national themes arising from Prevention of Future Deaths reports including Continuity of Care, Risk Assessment, Staffing, Communication, Learning and implementation of policies

NOTE that the Trust is actively progressing actions plans for PFDs that have been issued to the Trust and has systems in place to review national PFDs to proactively take action within the Trust

NOTE the intention to repeat this analysis looking at PFDs that have been issued again in quarter 4 in 26/27

Dr Diarmid Sinclair, Chief Medical Officer

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Training Needs Analysis (TNA) 2026/27	**Agenda Item**	Paper M
Sponsoring Executive	Carlene Holden, Director of People and Organisational Development		
Report Author	Carlene Holden, Director of People and Organisational Development and Clare Almond, Interim Deputy Director of HR and Learning		
Meeting	Board of Directors	**Date**	29 January 2026

Suggested discussion points

The Training Needs Analysis (TNA) has been developed taking explicit learning from previous years and now represents the diversity of our services and staff groups, to further enhance our most valuable asset, our colleagues, over the next 12 months. The TNA also aligns training requirements linked to the delivery of the Organisational Strategy, our Promises and the national workstreams associated with neighbourhood health and digital first. Recognising the changes this will bring for our colleagues. The Board are asked to focus on the new developments for 2026/27 as detailed in Section 4 of the paper

The paper also details a revised approach to a small number of Mandatory and Statutory Training Courses (MAST) and the accountability of colleagues to ensure they are complaint and up to date and the associated consequences for extended and/or repeated non-compliance, which has been an area of focus at the Mental Health Act Legislation Committee.

Whilst the TNA has been developed across all our 23 Directorates further work is required in January and early February to refine and where applicable standardise the approach whilst ensuring the commitment is within the financial envelope, recognising this has been increased by a further £75k for 2026/27 from the Investment Fund.

Previous consideration

TNA – Education and Learning
ILS, RRI and Mental Health Act Level 3 and above – Education & Learning and also Mental Health Act Legislation Committee (in part)

Recommendation

The Board of Directors is asked to:

NOTE: The TNA represents a step change in approach, addressing known frailties in process from previous years and providing a robust, inclusive and transparent evidence base for investment in learning and development

CONSIDER : The new training which is being commissioned in 2026/27

RECOGNISE: The improvements made in response to learning from previous years

NOTE: The revised approach for a small number of MAST courses and the management of compliance

Alignment to strategic objectives	
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
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:	
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
Trust Risk Register			
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
Patient care risks			
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	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			
All SDR make reference to the development of leaders, which is an element of this TNA			
System / Place impact			

Equality Impact Assessment	Is this required?	Y				If 'Y' date completed	To be completed as part of prioritisation/moderation process
Quality Impact Assessment	Is this required?			N		If 'Y' date completed	
Appendix							

1. Overview

1.1 This paper provides assurance to the Trust Board regarding the robustness, consistency and inclusivity of the Trust-wide Training Needs Analysis (TNA) process for 2026/27. The TNA has been developed taking explicit learning from previous years, especially the 2025/26 process and represents a significant maturation of approach, moving from separate Directorate-led submissions to a single focusing primarily on Nursing and psychological Professional requirements, coordinated Trust-wide analysis across all staff groups and disciplines.

1.2 The 2026/27 TNA has been informed through engagement with Care Groups, Backbone services, Professional Leads and Medical Education, ensuring that the identified training needs reflect the breadth of the Trust's workforce and services. The process supports statutory obligations, professional development and workforce planning.

1.3 Whilst we receive various funding streams to support the education and development of our workforce, and whilst maintaining the fidelity of the funding streams and stipulations, we take the approach based on inclusivity, and rather than allocating via the separate funding streams, reviewing our priorities and needs and then aligning the funding associated with these priorities.

1.4 Given the changing landscape within the NHS, the focus on Neighbourhood Health and the introduction of AI the TNA and this paper also considers how we can develop our colleagues, our most valuable asset, to maximise our ability in those areas for future years.

2. Background and Context

2.1 The Trust recognises that a skilled, capable and well-supported workforce is fundamental to the delivery of high-quality care. A systematic and well-governed Training Needs Analysis is therefore essential to ensure targeted investment in learning and development, effective use of ring-fenced training budgets (our only protected budgeted in the Trust) and equitable access to training opportunities.

2.2 The development of a timely and robust TNA has previously been identified as an area for improvement. The 2026/27 TNA process has therefore been intentionally redesigned to address historical challenges, including variability in approach, limited visibility of Trust-wide demand, uncertainty in procurement volumes and inconsistent feedback to Groups.

2.3 This work also supports delivery of **Promise 24 – Expand and improve our educational offer**, alongside broader workforce, succession and talent planning priorities.

3. Learning from Previous Years

3.1 The 2026/27 TNA explicitly takes learning from earlier iterations of the process. Key improvements include:

- **Trust-wide scope:** The TNA is a single Trust-wide analysis rather than a collection of isolated Directorate returns (previously focussed on Nursing and Psychological Professionals), enabling identification of common themes, economies of scale and shared priorities.
- **Standardised methodology:** A consistent TNA template has been used across all Directorates, improving data quality, comparability and assurance.
- **Inclusive input:** For the first time, the process has formally incorporated input from Professional Leads and Medical Education, ensuring that non-clinical and medical training needs are captured alongside clinical and professional development requirements.
- **Improved funding alignment:** Greater emphasis has been placed on identifying the most appropriate funding routes (CPD, Apprenticeship Levy, central People Development budget) and maximising utilisation of available funds whilst maintaining the fidelity of the separate funding streams.
- **Procurement readiness:** Aggregation of Trust-wide demand addresses previous challenges in procuring and commissioning training due to uncertainty around numbers of places required. This also allows the procurement of multiyear training provision which, provides economies of scale. In future years this is a further area of improvement – to look to work with neighbouring Trusts to procure joint training, which is delivered locally but by purchasing in 'bulk' we can achieve savings to then further increase the training which we can support.
- **Feedback and transparency:** Clearer mechanisms are being established to ensure Directorates receive feedback on what training is approved, commissioned and delivered. This also supports the holding to account of individuals and Directorates, there is a shared responsibility to attend the training given it has been commissioned on shared requirements.

4. Overview and output of the TNA Process

4.1 The TNA was undertaken through structured engagement with:

- Education and Learning representatives
- Backbone Deputy Directors / Service Leads
- Professional Leads
- Medical Education colleagues

4.2 Support was provided through one-to-one sessions, workshops and facilitated discussions led by the Interim Deputy Director of HR and Learning and Interim Head of Learning and Development.

4.3 The TNA captures learning requirements aligned to professional development, service improvement and organisational priorities. Mandatory and statutory training remains out of scope.

4.4 The training needs identified across the Trust to date are categorised as follows:

- Digital Skills: Increased need for training in electronic patient record systems, artificial intelligence and data interrogation, analysis and how to use data to inform decision making. This also includes digital literacy training to ensure colleagues have the core fundamental skills.

- Leadership Development: Demand for structured leadership programmes for emerging leaders which are being met through the Leadership Development Offer (LDO), First Line Management programme currently, with plans to expand the development offer via an internally developed and facilitated Multi Professional Leadership teams and Clinical Leaders which are currently under development. The draft TNA will be further scrutinized to ensure sufficient focus is placed on line management development, given our focus on the '555' Line Managers within the Trust as being an influential group and instrumental in delivering the Trust priorities whilst maximizing colleague experience.
- Specialist Clinical Skills:
- Core Skills:
- Continuous Professional Development (CPD): Staff request clearer CPD pathways.
- Mandatory and Statutory Training requirements are out of scope of the TNA of the process.

4.5 Identified needs have been collated into a costed Directorate-level analysis (minimum and maximum costs), providing a clear evidence base for prioritisation and decision-making.

4.6 Forecasting across the organisation continues to demonstrate a wide range of training requirements, reflecting the diversity of the workforce and the complexity of service delivery. Current requests span essential IT skills, digital capability building, and emerging AI upskilling, alongside operational needs such as forklift training and specialist clinical or therapeutic development including psychological interventions, exercise-based group facilitation, and gendered intelligence training.

4.7 Across each group, an average of around 100 distinct training needs have been identified, with some consistency of request across the Groups which support the 'bulk' purchasing approach.

4.8 This year's TNA is very distinct with the breadth of training courses which have been requested, historically we have commissioned physical health upskilling courses (primarily for colleagues in the Physical Health and Neurodiversity Care Group), conferences, motivational interviewing, trauma informed care and post graduate/masters level qualifications which remain a feature in this year's TNA

4.9 However, this year, as part of the TNA, we will be commissioning a wide range of development/training opportunities to upskill colleagues in preparation for new ways of working associated with the Organisational Strategy, our Promises and the NHS 10 year plan.

4.10 The TNA is categorised at three levels

1) Organisational Level
2) Team/Role Level
3) Individual Level

4.11 Whilst we will continue to commission training as detailed in 4.8, this year we will commission training in the following areas, which is a significant step change from previous years

- Bespoke physical health observations for colleagues in Metal Health Wards
- Customer service skills for our Backbone colleagues
- Tai chi – to enhance our therapeutic offer
- Trauma Therapy Yoga skills - – to enhance our therapeutic offer
- Cultural humility
- Writing Board Reports/Business cases
- Carbon aware decision making
- Cross system working
- Influencing without authority
- Digital skills – covering IT literacy, digital decision making, data quality and AI literacy
- Team building
- Resilience – working in a changing environment/landscape
- Line Manager development – focussing on our '555' Line Managers and how we can ensure they have the skills to perform in their roles and support their team members to thrive.
- 360 degree facilitation skills linked to the revised Appraisal Framework launch in 2026/27

4.12 This above list is in addition to specific individual training refresher training which is required to maintain competency in role.

4.13 Further learnings have been identified for the 2027/28 TNA and whilst this remains an interactive process, the learnings identified to date have been implemented for the following years TNA.

5. Funding streams

5.1 Current position

We received two dedicated funding streams to support the training and development of our colleagues, in addition to the apprenticeship levy. These are

- Continuing Professional Development c.£480k
- Central People Development Support c.£60k

In addition to the Apprenticeship Levy we also have the Multi-professional Education and Training Investment plan which was previously used by Health Education England (HEE) and NHS England to decide how education and training resources are allocated across different professions and nor does it include the individual CPD allowance available to Medical Consultants.

We manage these as a collective budget for the Trust whilst maintaining the fidelity of the individual funding pots.

5.2 Our collective training spend has increased year on year, for the previous two years, which you would expect given our commitment to training and developing our colleagues. The training budget is the only ring-fenced budget within the Trust, we need to ensure that the spend is maximised to deliver our needs and for 2026/27 we have course requests (before prioritisation) which exceed our available budget. We have committed to

growing our collective training spend and to deliver on this commitment £75k from the Investment fund allocation for 2026.27 will be allocated to supporting training expenditure across the Trust.

6. Assurance on Governance and Oversight

6.1 Governance of the TNA process sits with the Education and Learning Group, with clear accountability through to Trust Board. The training budget remains the only ring-fenced budget within the Trust, providing further assurance regarding protection of investment in workforce development. Following the prioritisation of the training requests at the February Education and Learning meeting this will be reported via the People and Organisational Development Committee in February 2026.

6.2 The process supports national reporting requirements, including CPD spend, and aligns with procurement and social value principles, including consideration of local training providers where appropriate.

7. Next Steps

7.1 The following actions are now underway to ensure the TNA is prioritised, moderated and operationalised effectively:

- **Care Group prioritisation sessions:** Dedicated sessions have been held with Care Group colleagues to review, prioritise and rationalise training requests against service need and available funding.
- **Moderation of training/prioritisation requests:** The **Education and Learning Meeting in February** has been repurposed to focus specifically on the moderation of training requests. This session will include representation from:
  - Care Groups
  - Professional Leads
  - Medical Education
- **Funding alignment:** Training requests will be mapped to the most appropriate funding stream (CPD, Apprenticeship Levy or central People Development budget).
- **Procurement and commissioning:** Subject to approval and moderation, procurement activity will commence to ensure training provision is in place from April 2026.
- **Ongoing monitoring:** Progress against procurement, spend and delivery will be monitored through the Education and Learning Group and reported via established governance routes.

8. ILS, RRI Training and Mental Health Act Level 3 and above

8.1 As the Board is aware from the out brief reports from the Mental Health Act Legislation Committee, we have been reviewing training compliance via this committee for a small number of courses. Whilst it is recognised that all mandatory and statutory training courses support effective and safe patient/colleague care we have a specific interest in a small number of courses. As we move to a framework where all colleagues must be fully complaint with their MAST requirements by the end of the given financial year and where they are not then this will have consequences in future years,

linked to our broader discussions about PDR, Policy Reading and MAST we have agreed that for ILS, RRI and Mental Health Act Training Level 3 and above we will take immediate additional action to improve compliance.

8.2 Colleagues will be notified that attendance is compulsory (which in essence is the case for all MAST training) but they will receive an individual letter to confirm this, copied to their manager to then discuss in supervision in which the manager will confirm this is a reasonable management instruction. They will be booked onto the relevant training courses (dates confirmed in the letter) and they will have one opportunity to change the dates for personal reasons. Should they then not attend the training (accepting a small number of valid reasons for non-attendance will exist) then this will be progressed via the Personal Responsibility Framework as a conduct issue. If there is then a repeat issue this will be escalated to the Disciplinary Policy, where a higher-level sanction, including dismissal will be considered. This will form part of the reporting suite to the Education and Learning Group and with a summary overview to the Mental Health Act Legislation Committee.

8.3 Whilst it's disappointing that we find ourselves in this position with a small number of colleagues, action is required to address this. This approach will be implemented and reviewed in the first six months of 2026/27 and if unsuccessful further consideration will be given to schemes in operation in private sector and NHS Professionals for example where colleagues are restricted from accessing shifts/work due to their non-compliance.

9. Recommendations

9.1 The Board is asked to note the Trust-wide Training Needs Analysis for 2026/27 represents a step change in approach, addressing known frailties in process from previous years and providing a robust, inclusive and transparent evidence base for investment in learning and development.

9.2 The Board is provided with assurance that the TNA process is well-governed, informed by broad stakeholder input (including Professional Leads and Medical Education), and supported by clear next steps to ensure prioritisation, affordability and delivery.

9.3 The Board is asked to note the revised position for the MAST training outlined in section 8.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	CQC Readiness – Self Assessment	**Agenda Item**	Paper N
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Steve Forsyth, Chief Nursing Officer Jim Cooper, Deputy Chief Nursing Officer Roshanne Bottomley, Backbone Nurse Director		
Meeting	Board of Directors	**Date**	29 January 2026

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

This paper provides the Board with a comprehensive update on progress within the Trust's CQC readiness programme, building on the self-assessment reviewed in May 2025 and subsequent targeted improvement activity. It reinforces the interdependency of the four quality domains (Safe, Effective, Caring and Responsive) alongside the Well-Led key question, and sets out progress against agreed action plans aimed at achieving at least a *Good* rating across all services, with an ambition for *Outstanding* in Caring by 2026. Overall, the Trust's internal self-assessment, as of January 2026, indicates significant improvement, with most directorates now rated *Good* across all domains.

As we move into Q1, the formal reviews of the evidence libraries commence (again, as they did at the start of the CQC readiness launch), the Board has been invited to observe this scrutiny and interrogation with our Chair keen to hear, see and test this for herself. This second detailed review of the improved and consistently applied/structured library vaults will provide confirmation of the detailed evidence plans in this paper (appendix 2), supporting the work undertaken over the last three quarters. Our CQC delivery plan is 80% there, in our goal with all staff "becoming every day is a CQC day", this cultural shift is tangible.

Suggested discussion points for the Board

- **Ratings:** Does the Board have confidence that the internal self-assessment aligns with how the CQC is likely to view services, particularly where organisational definitions of *Good* and *Outstanding* have been applied? The detail here is for the board to consider the evidence vaults that each Directorate has opened to all staff and which was discussed in November delivery reviews.
- **Residual RI areas:** Are the remaining *Requires Improvement* ratings (notably in acute responsiveness, staffing and pathways) sufficiently prioritised, resourced and time-bound to deliver improvement within agreed timescales?
- **Sustainability of improvement:** How is the Trust ensuring that recent improvements (e.g. PSIRF, Dialog+, safer staffing, 7-day activities) are embedded and sustained beyond inspection readiness?
- **Forward trajectory:** Is the proposed transition from CQC readiness to the Quality and Safety Plan for 2026/27 robust enough to maintain continuous improvement rather than inspection-driven compliance?

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

This paper has been provided via the intensive work undertaken via the CQC readiness group that is a sub sub of the CLE reporting structure.

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

DISCUSS whether there are any unmentioned or under-discussed items that the Board considers have to be addressed in the self-assessment

CONFIRM a process for inspecting evidence files between March 2026 and June 2026, returning to re-examine the self assessment in lieu of that in July 2026.

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)	
Estates plan	X
Digital Plan	X
Education and Learning Plan	X
Equity and Inclusion Plan	X
Quality and safety plan	X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)	

Patient care, people and external 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
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	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
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)							
Implicitly linked to all SDRs							
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)							
Appendix 1 CQC self-assessment process and current ratings Appendix 2 – Updated Self Ratings by Directorate as at January 2026							

CQC Readiness

1. Introduction

1.1. This paper provides the Board an update on the work undertaken within our CQC readiness programme. The Board are reminded of the four domain (safe, caring, responsive and effective) submissions that were discussed up until the end of Q4 in 23/24, and those papers presented within Q1 of 25/26. It is stressed the importance of recognising the Well-Led key question (being posed via Mr Gowland in a separate paper) as one of the five key questions, also appreciating the interdependency across the other key questions, with them each, also considering well-led related matters.

1.2. In May 2025, the board reviewed our initial self-assessment across the four domains along with a triangulated view, and the subsequent actions plans proposed to achieve a 'Good' rating across all domains, with an ambition to achieve 'Outstanding' for Caring by 2026. This paper provides an update on the progress against those plans, provides an updated triangulated internal assessment of the ratings provided and sets out the clear expectations of the work to be undertaken between now and the end of Q2 26/27.

2. CQC Inspections and Ratings

2.1 The Trust last underwent a full formal assessment (formerly known as inspection) by the Care Quality Commission (CQC) in 2019. With a subsequent action plan and internal audit concluding in June 2023. A CQC action plan was last presented to the Quality Committee in May and July 2022 and subsequently, a review was undertaken by 360-assurance against the CQC action plan from June 2023.

2.2 In May 2025, the CQC undertook an unannounced assessment of the acute wards for adults of working age and psychiatric intensive care units.

2.3 A final report was published on the CQC website in December 2025 (report dated 30 July 2025). The themes identified within this report were cleanliness in our therapy kitchen at Swallownest court, unfounded concerns regarding medicines management arrangements at the Tickhill Road site and the lack of activities available to patients, and delays in respect of occupational therapy assessments. The ratings from the 2020 and 2025 assessments are listed in table one of this document.

2.4 There were some notable positive findings from the report. Staff developed holistic, care plans informed by a comprehensive assessment. Staff had a good basic knowledge of the Mental Health Act and Mental Capacity Act. Overall, they discharged their responsibilities well. Risk assessments were detailed, up-to-date and person-centred. Staff we spoke with knew the patients well. They understood how to engage with them and mitigate against individual risks.

2.5 There were a range of quality improvement initiatives in place. Staff and managers could describe how they worked collaboratively to improve the quality of care for patients. Staff treated patients with compassion and kindness and understood the individual needs of patients. We observed positive interactions between staff and patients on all wards.

2.6 An action plan is in situ, but these actions have already been in train for some time. For instance, our High Quality Therapeutic Care (HQTC) Taskforce has progressed our work on activities being available 7 days a week, with this being expressed as a core offer, rather than an optional addition and going forward will be a key part of our daily staffing escalations.

2.7 Our Board paper in March 26 will articulate our work to develop safer staffing beyond nursing, which will encompass our plans to increase our non-nursing workforce, against our own internal safer staffing levels, in the absence of national guidance on such.

2.8 Finally, we undertake regular audits within our therapy kitchen, to evidence its continued cleanliness and immediately remedied the one cooker in the OT kitchen that required a clean.

2.9 Table 1 details the ratings for all trust services, including the revised ratings for the acute mental health wards and PICUs. Ratings for all other service groups and for the trust remain unchanged. Arrows show the direction of any change and the previous rating from February 2020.

Table 1: Current CQC Ratings (from Feb 2020 and July 2025)

	Safe	Effective	Caring	Responsive
Trust Wide	RI	RI	Good	Good
Community Health Services for Adults	RI	RI	Good	Good
Community Health Services for Children and Young People	Good	Good	Good	Outstanding
Community health inpatient services	Good	Good	Good	Good
Community end of life care	Good	Good	Good	Good
Hospice services for adults	Good	Good	Good	Good
Acute Wards for adults of working age and psychiatric intensive care units **(July 2025)**	RI	RI ⇩ (Good in 2020)	Good	Good
Long-Stay or rehabilitation mental health wards for working age adults	RI	RI	Good	Good
Forensic inpatient or secure wards	RI	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good
Community-based mental health services for adults of working age	RI	RI	Good	Good
Mental health crisis services and health-based places of safety	Good	Outstanding	Good	Outstanding
Specialist community mental health services for children and young people	Good	RI	Good	Good

Community-based mental health services for older people	Good	Good	Outstanding	Good
Community-based mental health services for people with a learning disability or autism	Good	Good	Good	Good
Substance misuse services	Good	Good	Good	Good

3. Self-Assessment Process

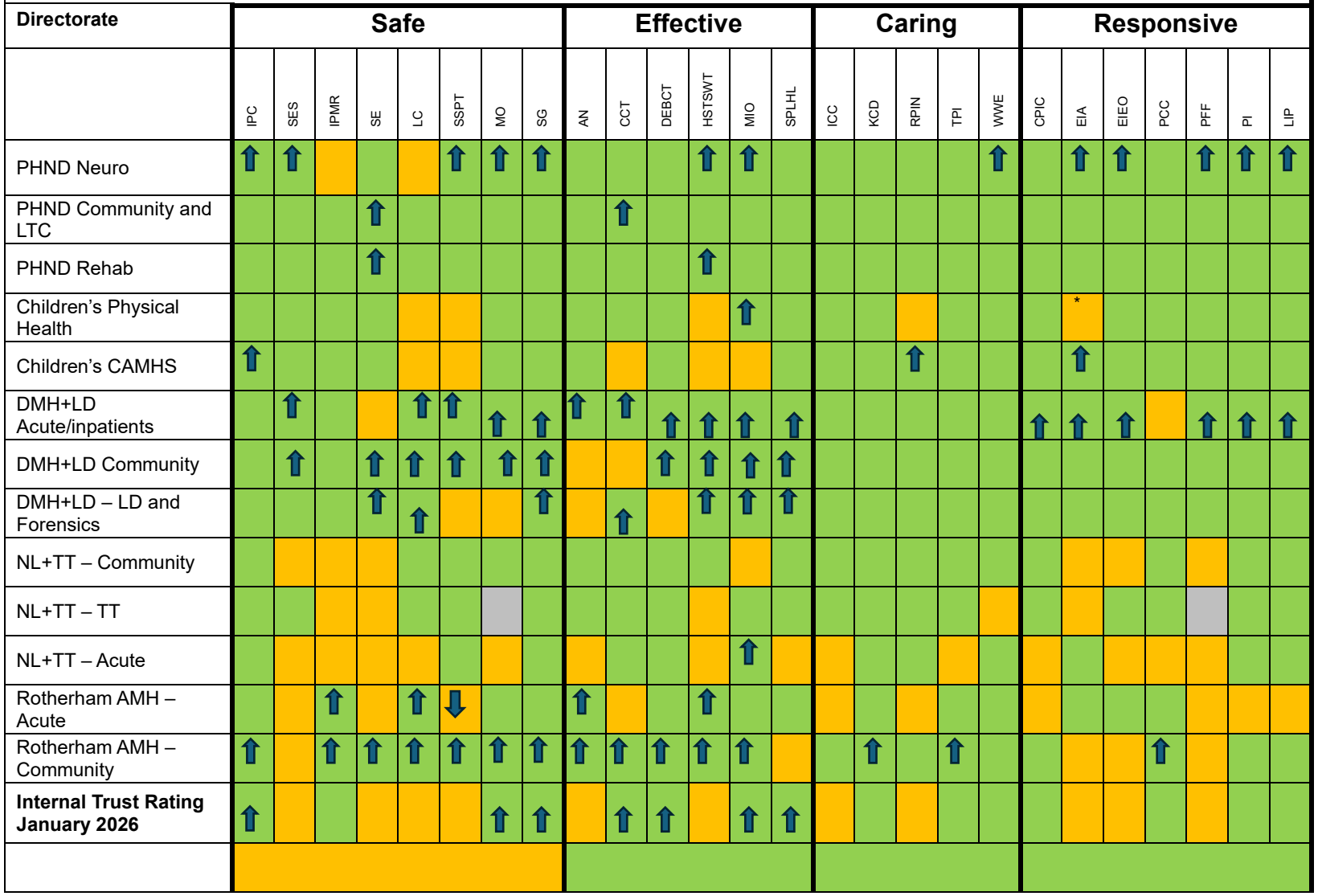
3.1 The Trust has developed a framework using CQC guidance and gathered information from a range of diverse sources to provide a basis for a continuous, developmental self-assessment against the CQC quality statements for safe, caring, effective and responsive.

3.2 In May 2025, the Board reviewed services rated RI or below across several localities and specialties. Since that time, targeted improvement activity has been undertaken, aligned to CQC domains and informed by internal quality governance, peer review and directorate oversight. A Trust–wide approach to CQC readiness has been maintained, with consistent governance via our CQC readiness group, directorate/care group governance and quality meetings and care group delivery reviews. The work described in this paper reflects progress as of January 2026 and incorporates evidence presented through the care group delivery reviews.

3.3 There was also some thought given to those standards identified by the Trust as an organisational target, versus the likely viewpoint of the CQC upon inspection. It was agreed that for non-urgent referrals within scope of the referral to treatment target (18-week target), that having the longest person/waiter at 18 weeks or less was considered good, with the achievement of a 4 week wait considered outstanding. Similarly, a mandatory training compliance rate of 90% or higher is good, and 95% defined as outstanding.

3.4 Table two shows the current self-assessment ratings by directorate for each of the quality statements, with arrows showing the direction of change since the initial May 2025 self- assessments.

Table 2: self-assessment ratings as at January 2026



4 Rotherham Acute Mental Health Care Group

4.1 Since June, a range of actions have strengthened safety across Rotherham services, progressing areas of requires improvement to good. An example of this is increased safeguarding supervisors, with 13 now identified across the care group. Progress continues to be made with reducing waiting lists and having an increased focus on physical health for people with severe mental illness in the community directorate. The care group continues to progress areas from requires improvement to good, as highlighted in appendix 3.

4.2 There are some successes to note within Rotherham including the identification of IPC champions at all sites, supported by regular matron IPC walkarounds and the development and implementation of a community IPC audit tool. PSIRF resources are now shared via a dedicated MS teams channel and there is a positive increase in the culture of incident reporting, with trends reviewed monthly at matron and directorate level and learning from incidents shared through team meetings and care group communications.

4.3 Within the community directorate, further work is required to finalise job planning within adult locality services to achieve a consistent good within the safe and effective staffing domain. Within the acute directorate, there is renovation works required to the Kingfisher ward to ensure a consistently safe environment. Additionally, to meet the safe systems, pathways and transitions domain, work is required across the acute directorate to ensure a multi-disciplinary approach to proactively manage a patient's admission and reduce their length of stay. Finally, there is an ongoing action plan following a review of the Willows, which suggested that whilst the work is ongoing, that the safe systems, pathways and transitions domain was lowered from a good to requires improvement. Planned for completion in Feb 2026.

4.4 Since our last assessment, there has been improved flow within community teams, reducing waiting lists and Integrated Referrals Meetings providing senior oversight of delays to care. There has been work in partnership with supported accommodation services to strengthen rehabilitation pathways and reduce out-of-area placements Within the community directorate, improvement is required in the triage processes, the home treatment offer for older adults and ensuring clear pathways for urgent referrals out of hours.

4.5 There is further work required to finalise a good rating within the effective domain. Within the acute directorate, further work is required to ensure that consent to care and treatment is completed 100% of the time. Within the community directorate, there is further work required to develop physical health clinicals for people with SMI. Work on pathway integration remains ongoing, with a clear trajectory and monitoring arrangements in place.

4.6 There has been work to improve the patient and carer information leaflets within the acute directorate, alongside the implementation of weekly community meetings, matron weekly walkarounds and further work as detailed earlier around Dialog+. This is currently being evaluated before confirming a good rating for the providing information domain.

4.7 Further work is required within the Rotherham acute directorate including the development of multi-professional leadership teams, the delivery of key training sessions including managing the deteriorating patient, relational security and staying safe from suicide, with all teams planned to complete this training by the end of April 2026.

4.8 Within the acute directorate, there are weekly patient feedback sessions to strengthen the implementation of Dialog+, which has identified further work to confirm a rating of good within this domain.

5. Doncaster Acute Mental Health and Learning Disability

5.1 Since the self-assessment in May, there has been substantial work to progress from areas of requires improvement to good. An example of this is in learning disabilities and forensics regarding consent and capacity. The directorate now has MCA champions, an MCA audit has been undertaken with a subsequent action plan and all actions have been completed. In addition, feedback from the MCA champions will be embedded into the quality meeting by the end of February 2026.

5.2 The care group continues to raise the remaining requires improvement quality statements to good. The evidence reported via delivery reviews supports a position of good. In line with other care groups, the acute wards are working towards the Royal College of Psychiatry accreditation standards and are in the early stages of benchmarking against standards. This will continue into 2026/27. The learning disability services have already benchmarked against the standards and are working towards achieving accreditation. The directorate quads have direct ownership of this process with 6 weekly meetings with care group SLT to maintain oversight of progression.

5.3 There are further works planned within the Windermere ward to replace the doors, which is predicted to be completed by the end of 2026. Upon completion this will support the acute directorate to achieving a good rating within the safe environments' domain. There is ongoing work within the Learning Disabilities and Forensics directorate to ensure processes are in place to oversee medicines management, Similarly there is work to define the Danes Court 2-year pathway, which will complete by the end of Q4 25/26, supporting the directorates achievement of good within the safe systems, pathways and transitions domain.

5.4 There is further work required to embed Dialog+ across the care group, with the implementation of a new process to ensure the allocation of a named worker for each patient by the end of March 2026. Within the Learning Disabilities and Forensics directorate, further work is required to ensure that FACE risk assessments are consistently completed.

6. North Lincs Acute Mental Health and Talking Therapies

6.1 In June 2025, selected elements of NL&TT were identified as Requires Improvement, primarily linked to variability in responsiveness, pathway clarity and consistency of governance rather than fundamental safety or quality concerns. In November 2025, it was identified that Talking Therapies were already achieving Good, but that the Acute and Community Directorates had several actions that needed to be implemented to achieve Good.

6.2 In the acute directorate, there is evidence of improvement within the safer staffing domain, with improved check and challenge of rosters, increasing PDR and supervision compliance. Virtual ward staffing remains a concern due to high levels of sickness within the Laurel Ward, which has been added to the directorate risk register. Actions plans are in place with consistent Ward/Team Managers in place and now expected to be at Good by February 2026.

6.3 Dialog+ implementation requires further work within the acute directorate, with an anticipated improvement to good for the safe systems, pathways and transitions domain by April 2026 for the acute directorate, and February 2026 for community.

6.4 There is further work required to ensure monitoring processes are in place to respond to and close incident reports in a timely manner, as within our PSIRF framework and ensuring we have robust processes in place to learn from patient safety events.

6.5 Finally, within the community directorate, there needs to be an improvement in the compliance in safeguarding training, to sustain a good for the Safe domain, this improvement is expected by March 2026. There is a wider piece of cultural work ongoing within the directorate around proactively completing training, and personal responsibility for own learning needs.

6.6 Within Talking Therapies directorate, there is further work to embed PSIRF and ensure that patients are actively involved in managing risks. This includes ensuring communication with the patient and their General Practitioner, and a reduction in the number of repeat assessments undertaken for patients.

6.7 Finally, there is further work required to support the embedding of peer support workers within the care group.

7. Children's Care Group

7.1 In April, both the Mental Health and Physical Health Directorates within Children's Services self-assessed as Good overall, including Safe, Caring and Effective. The Responsive domain was identified as RI, largely linked to access and waiting time standards under Promise 14.

7.2 There is further work required to embed the PSIRF framework within the care group, alongside work to strengthen transition pathways from children's services to adult care. Within the CAMHS directorate, there is further work required to robustly implement consent and parental consent processes, alongside ensure the embedding of Dialog+. Finally, within the Physical Health directorate, there are improvements needed to reduce wait times within the neurodiversity and continence services.

8. Physical Health and Neurodiversity

8.1 Since June, a range of actions have strengthened safety across Doncaster Physical Health and Neurodiversity services, although some work remains to progress to Good in all areas, as detailed in Appendix 3. The use of the PSIRF approach and incident reporting in general has increased, showing a reporting culture, and embedding of PSIRF. There has been improved communication with patients who are waiting to improve their experience, alongside improvements to staff communication, including weekly team leaders meetings to ensure the cascade of information to staff in a consistent, timely manner.

8.2 Within the neurodiversity directorate, there is further work required to embed care plans, safety plans and risk assessments to achieve a good in the involving people to manage risks domain. There is also work to develop the directorates implementation of PSIRF, which is behind its counterparts within the care group.

9. Summary and forward look into 26/27

9.1 The paper provides the Board with a detailed update on the progress made during the 2025-26 year and has identified the work that must continue to ensure our services provide the best care possible and remain diligently prepared for a future CQC inspection.

9.2 Within the closing quarter of 25/26, we will see the achievement of good across most of those directorates who have not yet achieve this standard across all the quality statements, with work for some into 26/27 to either close the gap or maintain the level.

9.3 As we move into Q1, formal reviews of the evidence libraries will commence, and the Board may wish to discuss the potential for non-executive directors to lean into this process as it commences. This will provide confirmation of detailed evidence to support the work undertaken over the last 9 months, alongside continued ratification of the self-assessment ratings provided.

9.4 We will work within Q1/Q2 of 26/27 to translate our evidence bases and scoring within our CQC readiness programme into preparedness to seek accreditation by the Royal College of Psychiatrist, of which we will seek to arrange for September or October 2026.

9.5 Finally, we will transition our CQC readiness programme, into its overarching plan, the Quality and Safety plan, to ensure that we continue to progress in all elements of this plan, as we move into year two of its delivery.

Steve Forsyth

Chief Nursing Officer

Appendix 1 details the self-assessment process and current ratings for each of the 13 directorates following the self-assessment process discussed above; arrows show direction of change since May 2025. Further detail of the outstanding RI areas and priority areas for further improvement by directorate is detailed within appendix 2.

Directorate Self-Assessment Update summary				
Directorate	**Safe**	**Effective**	**Caring**	**Responsive**
PH Neurodiversity	Good ↑	Good ↑	Good	Good ↑
PH Community and LTC	Good	Good	Good	Good
PH Rehabilitation	Good	Good	Good	Good
Children's Physical Health	Good	Good	Good	RI
Children's Mental Health	Good	Good	Good	Good ↑
DMH+LD Acute/inpatients	Good ↑	Good ↑	Good	Good ↑
DMH+LD Community	Good ↑	Good ↑	Good	Good
DMH+LD – LD and Forensics	Good ↑	Good ↑	Good	Good
NL + TT Community	Good ↑	Good	Good	Good ↑
NL + TT - TT	Good	Good	Good	Good
NL+TT - Acute	RI	Good ↑	Good	RI
Rotherham AMH - Acute	RI ↑	Good ↑	Good	RI ↑
Rotherham AMH – Community	Good	Good ↑	Good	Good
Internal Rating Jan 2026	Good ↑	Good ↑	Good	Good ↑

Appendix 2 – Updated Self Ratings by Directorate as at January 2026: table shows detail only for those criteria remaining not at Good

	Overall Rating	**SAFE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
PH+N ND	Good	Involving people to manage risks	• Risk assessments not consistently evidencing the patient voice and patient involvement in production of plans • Improve explicit recording of consent	• Assessments have patient voice throughout them, the history taking and the impact of their symptoms on daily life. • Co-produced risks assessments. • Shared decision making around medication/treatment and the risks are clearly recorded. • Safety measures in regard to physical health checks being mandatory to ensure it is still safe to prescribe. • Informed consent clearly recorded. • Encouraging ownership of self-management and risks plans.	• Care plans, safety plans and risk assessments to be shared with patients in the format of their choosing. • Audit of risk plans/safety plans. • Prescribing audits. • Consent audits. • Increase confidence in the use of self-management and risk plans.
		Learning Culture	• Further work to embed the PSIRF approach which is clinician led	• Complaints responses in line with current policy, learning from complaints evident. • PSIRF approach to be progressed to reach full potential (reliant on the Matron role to mature further). • Increase in care opinions being received and respond to. • PSIRF report includes all directorate incidents, there has been an increase in incident reporting and learning responses, but still more work to do. • ADHD training attendance.	• Implement the Matron role • PSIRF implementation to progress further to reflect the same as the other two directorates – more self-sufficient with the learning responses being progressed.
PH+N – C+LTC	Good	• All criteria rated as Good			
PH+ND Rehab	Good	• All criteria rated as Good			

	Overall Rating	**SAFE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
CCG PH	Good	Learning Culture	• Further work to embed the PSIRF		• Ongoing work to embed PSIRF and formalise learning responses
		Safe systems, pathways and transitions	• Strengthen and improve transition processes		• Ongoing work with adult care groups to continue to strengthen and improve transition between services
CCG CAMHS	Good	Learning Culture	• Further work to embed the PSIRF		• Ongoing work to embed PSIRF and formalise learning responses
		Safe systems, pathways and transitions	• Strengthen and improve transition processes		• Ongoing work with adult care groups to continue to strengthen and improve transition between services
DMHLD Acute	Good	Safe environments	• Windermere door replacement	• Added to risk register	• Windemere door replacement is part of Trust wide scheme and is due to commence July 2026 and be completed by the end of 2026.
DMHLD Comm	Good	• All criteria rated as Good			
DMHLD LD+Fo	Good	Safe systems, pathways and transitions	• Danes Court 2-year Pathway to be defined and implemented	• Work commenced on reconfiguration of Danes Court Pathway defined by DMT. • Danes' Court 6th Bedroom restriction removed.	• Danes Court 2-year Pathway to be defined by the end of March 2026
		Medicines optimisation	• Directorate Medicines Management Meetings	• Directorate Medicines Management meetings to be commenced by end of Q4	• Directorate Meds Management Meeting feedback to be fed into Quality meeting and be business as usual by end of March 2026

	Overall Rating	**SAFE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
NL +TT - Comm	Good	Safe and effective staffing	•	• Recruitment practices – checks and experience • No agency nurse use	• Community safer staffing
		Involving people to manage risks	•	• PSIRF – shared learning, commitment • Freedom to speak up champions • Safeguarding training and supervision • Duty of candour • Medicine optimisation linked to guidelines and protocols	• Being proactive around training not going out of date • Colleagues taking responsibility for learning needs • Risk assessments – updated timely • Evidence of patient voice in care planning and risk management
		Safe environments			
NL+TT - TT	Good	Involving people to manage risks		• Recruited to full capacity of clinical roles • IPC Compliant • Safeguarding training and supervision • Risk assessments completed at every contact with patient and documented on systmone • Freedom to speak up champions • Duty of candour • Active learning through Bespoke offer/ Learn/ Clinical Skills for Step 2 Team • Regular interface meetings with Secondary Care and PCN teams • PHQ9 Risk question done at every clinical appointment	• Ongoing admin capacity/ recruitment issues • PSIRF training to be shared wider • Community venues to be vetted more for lone working • Sharing safety plan with patients • Support for admin and other non-clinical staff in managing risk from patients • Duty system for risk escalation queries • Sharing safeguarding supervision dates
		Safe environments			
NL + TT Acute	RI	Safe and effective staffing		• Recruitment practices – checks and experience • No agency nurse use	

	Overall Rating	**SAFE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
		Involving people to manage risks		• Freedom to speak up champions	• Evidence of patient voice in care planning and risk management
		Safe environments		• Low average length of stay • Low CRFD • Daily PIPA meetings • Daily Safety metrics	• Band 6 leadership level • Record Keeping
		Learning Culture		• PSIRF • IPC compliance • Safeguarding training and supervision • Sharing of learning	• Being proactive around training not going out of date • Colleagues taking responsibility for learning needs
		Medicines optimisation		• Medicine optimisation linked to guidelines and protocols	
RAMH Acute	RI	Safe and effective staffing	• To ensure all services meet the safer staffing levels for each shift	• Twice weekly staffing meetings led by matron or service manager • Matron and service manager check and challenge meetings for each monthly rota period • To ensure vacancies are advertised, short listed and interviews taking place in a timely manner for each service • Managing and supporting staff within sickness absence/occ health/flex working policy	• To use safe care polit to review current acuity and safe staffing levels (Will be completed by April 26) •
		Safe environments	• Kingfisher environment including 136 suite to be fit for purpose. • Management of banned items on the ward and concerns around illicit substances being brought on the wards by patients, visitors.	• Estates acknowledgement around support and work to be progressed with. • Individualised care plans in place around the management of contraband/banned items on the inpatient wards and reactive dog searching when required • Review of visitors process and development of quick/easy read guides for the process at SNC	• Meeting to be held w/c 19/1/26 between Estates and the care group to agree next steps. 136 suite requires new doors and flooring. Kingfisher requires new flooring and the ward decorating. Work should be complete by April 2026. • Monthly routine random visit of dog searching from the end of January moving forwards.

	Overall Rating	**SAFE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
		Safe systems, pathways and transitions	• Ongoing work across all inpatient areas for patient flow • Review of Willows process from admission to discharge	• Some improvements across some areas ie Willows. • Action plan embedded with SLT oversight	• 7 day of admission review meet to be held weekly between matron, ward lead, housing, social care where required and patient flow co-ordinators to proactively discuss any potential barriers from treatment to discharge so next steps are taken much earlier than 15-day escalation. (These meetings will commence on 19/1/26). • Action plan for Willows ongoing, due to be completed by end of Feb 26.
RAMH Comm	Good	Safe and effective staffing	From May self-assessment: • Job planning and review of capacity and demand within Adult Locality Services to improve efficiency		• Still in progress

	Overall Rating	**EFFECTIVE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
PHND – ND	Good	• All criteria rated as Good			
PHND C+LTC	Good	• All criteria rated as Good			
PHND	Good	• All criteria rated as Good			

	Overall Rating	**EFFECTIVE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
Rehab					
CCG PH	Good	How staff, teams and services work together	• Strengthen and improve transition processes		• Ongoing work with adult care groups to continue to strengthen and improve transition between services
CCG CAMHS	Good	Consent to care and treatment	• Consent to care and treatment		• Work ongoing to robustly implement consent and parental consent.
		How staff, teams and services work together	• Strengthen and improve transition processes		• Ongoing work with adult care groups to continue to strengthen and improve transition between services
		Monitoring and improving outcomes	• Implement and embed Dialog+		• Ongoing work to robustly embed Dialog+ and using dataset to evidence outcome measures
DAMHLD Acute	Good	• All criteria rated as Good			
DAMHLD Comm	Good	Assessing needs	• Dialog+ training to support patient focussed care planning • Dialog+ care plans demonstrate patient engagement and voice • FACE Risk Assessments	• All training completed • Dialog+ Care Plan compliance 50% • FACE Risk Assessments compliance • CPA	• Dialogue care plan to be completed for all patients once they have received a gateway assessment and have been allocated a named worker by the end of March for in-area patients
		Consent to care and treatment	• Consent to treatment • MCA Audit action plan	• MCA Audit • Community MCA champions	• MCA champion updates to be feed into Quality Meeting by the end of February 2026. • All MCA Audit actions to be completed by June 2026.
DAMHLD LD+For	Good	Assessing needs	• Dialog+ training to support patient focussed care planning • Dialog+ care plans demonstrate patient engagement and voice	• Dialog+ training almost complete across the Directorate • Flow Chart developed by Quod for implementation. • Engagement with experts by experience to raise awareness	• Dialog+ training to be completed by end of March 2026 • Personalised Care Plan compliance on the inpatient wards and Danes Court to be fully compliant by the end of April

	Overall Rating	**EFFECTIVE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
				• Amber Lodge, Diamond & Danes Court Care Plan compliance 100% • Community Care Plan compliance 78.9% compliant • Radar Care Records Audit for Danes Court	
		Delivering evidence-based care and treatment	• FACE Risk Assessments	• Out of scope Teams defined • Manual calculation of FACE risk assessment compliance 74%	• Work with Clinical Systems Teams to update reporting parameters and cleanse data by the end of February
NL +TT - Comm	Good	Monitoring and improving outcomes		• Attendance in multiprofessional CRFD meetings to work together • Audit-teams engaged and process for learning • Research - links with grounded research • NICE – links with centralised system for the trust and working on baselines of core guidance. • Reducing barriers in accessing the right pathway of treatment • Embracing research and innovation – Flow, MCI research	• RADAR - rolling out training and information • Dialog + • 4 week wait to be consistent across teams • Local working instructions for teams • Improving relationships with gatekeeping services - timely manner – clinical effective interventions • Clinical supervision recorded on staff portal - % increase in compliance required. • Mental capacity Act – response in accordance to assessment (recent audit suggest improvement needed) action plan being developed.
NL+TT - TT	Good	How staff, teams and services work together		• Assessments conducted for all patients • Outcome measures completed at every clinical appointment • Regular data monitoring of outcome measures • Consent to care and treatment followed • Follow NICE evidence-based treatments and as per Talking Therapies Manual	• Communicate outcome of assessment to GP and patient as gold standard • Minimise patient having multiple assessments within service • Caseload management within Counselling modality

	Overall Rating	**EFFECTIVE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
				• Use of step-up meetings to move patients between Step 2 and Step 3 • Regular supervision and caseload management embedded	
NL +TT Acute	Good	Assessing needs	• Daily PIPA meetings • Mental Health Act Section 132 Rights		• Our out of area patient numbers • Record keeping
		How staff, teams and services work together	• Attendance in multiprofessional CRFD meetings to work together •		• RADAR - rolling out training and information • Local working instructions for teams • Early Discharge work by HBT • Virtual care home reviews
		Supporting people to live healthier lives		• Low CRFD • Short average length of stay- Mulberry • QNWA accreditation Mulberry • QNOAMHS accreditation outcome pending – Laurel	• Care Plans not being shared in Partnership with patient •
RAMH Acute	Good	Consent to care and treatment	• Consent to care and treatment to be in place for all inpatient admissions within 24 hours.	• Weekly audit • Review within admission checklist for nursing/medic teams	• Communication with out of hours colleagues around ongoing work required to meet the standards for these to be 100% for each inpatient admission. To be 100% by February 2026.
RAMH Comm	Good	Supporting people to live healthier lives			• Increased focus on physical health for people with severe mental illness, including development of clinics. Further work to go.

	Overall Rating	**CARING**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
PHND ND	Good	• All criteria rated as Good			
PHND C+LTC	Good	• All criteria rated as Good			
PHND Rehab	Good	• All criteria rated as Good			
CCG PH	Good	Responding to people's immediate needs	• Improve waiting times for neurodiversity and continence services.		• Waits for neurodiversity and continence still in progress to improve.
CCG CAMHS	Good	• All criteria rated as Good			
DAMHLD Acute	Good	• All criteria rated as Good			
DAMHLD Comm	Good	• All criteria rated as Good			
DAMHLD LD+For	Good	• All criteria rated as Good			
NL +TT - Comm	Good	• All criteria rated as Good			

	Overall Rating	**CARING**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
NL + TT - TT	Good	Workforce Wellbeing and Enablement	• Responding to care opinion and PEQ patient feedback in a timely manner • Patient choice a part of treatment offered within service and how whether video or face to face for example • Patients treated with kindness, compassion and dignity • Learn events • Regular supervision and management support		• Team and Service Away days • Wellbeing champions • Promotion of Freedom to speak up
NL +TT - Acute	Good	Independence, choice and control	• Patient and carer feedback • Oxevision • Advocacy • Carer sessions-Laurel • Patient experience meetings		• Supervision quality • Band 6 and band 7 development • Personalised care plans • MDT preparation • Inpatient environment
		Treating people as individuals	• Activities • Staff meetings • Reflective practice		• Older adult crisis response
RAMH Acute	Good	Independence, choice and control	• Ensuring all required care plans and patient pathways are person centred • That the 7-day activity timetable on the wards is embedded into each service	• Weekly dialog check and challenge meetings with ward leads • Volunteers across all inpatient services to support with activities • Discussed in the weekly community meetings and patient led with activities being planned	• Weekly patient feedback sessions between matron, a patient from each ward and a representative from the nursing team • MPLT teams to be established within the wards to lead on the embedding of 7-day activity timetable
		Responding to people's immediate needs	• Identified training need for staff to meet the needs of the patients across older adult and working age services	• Online and available training support sessions completed by teams.	• Further bespoke training planned in for the next 3 months covering the deteriorating patient, relational security and staying safe from suicide training for all teams to complete by end of April 2026.

	Overall Rating	**CARING**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
RAMH Comm	Good	• All criteria rated as Good			

	Overall Rating	**RESPONSIVE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
PHND ND	Good	• All criteria rated as Good			
PHND C+LTC	Good	• All criteria rated as Good			
PHND Rehab	Good	• All criteria rated as Good			
CCG PH	RI	Equity in access			• Waits times
CCG CAMHS	Good	• All criteria rated as Good			
DAMH+LD Acute	Good	Person-centred care	• Dialog+ training to support patient focussed care planning	• All training completed • Care plan compliance 100% • Dialog+ Care Planning commenced • NC records audit	• Dialog+ care plan compliance to be 100% by the end of March • Quality record Audits to be completed February 2026

	Overall Rating	**RESPONSIVE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
DAMH+LD Comm	Good	• All criteria rated as Good			
DAMH+LD LD+For	Good	• All criteria rated as Good			
NL + TT - Comm	Good	Equity in access		• Care opinion –feedback being sought from all teams	• Peer support workers – not established despite going through a tender – needs embedding • 4 week waits across the service
		Equity in experiences and outcomes	• Volunteers being key members of the team – involvement in projects, recruitment and service improvement		• Safety metric – to make contact 72hrs post
		Planning for the future		• RAADS – improving the wait for a diagnostic assessment and treatment in the memory service. • Reviewing incidents in accordance with the PSIRF framework. • OLM – sharing practice together from lessons	• PSIRF to be embraced and responsibility taken by all staff at the times of incidents to follow process. • Learning how to share learning with colleagues across the care group and trust. In various formats.
NL + TT - TT	Good	Equity in access	• Care opinion • Recognition of Equality act • Use of interpreters • Patients and quality at heart of delivery of service • Use of translated materials • PEQ (patient experience questionnaire) feedback		• Peer support workers – not established despite going through a tender – needs embedding • 4 week waits across the service • PSIRF to be embraced and responsibility taken by all staff at the times of incidents to follow process. • Learning how to share learning with colleagues across the care group and trust. In various formats. • Being better bedded in communities

	Overall Rating	**RESPONSIVE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
					• OOH working • Consistent use of therapy contract
NL + TT - Acute	RI	Care provision, integration, and continuity		• Increased Care opinion feedback on inpatient • Patient experience meetings on wards • Carer meetings Laurel ward	• Care opinion feedback across full directorate • Preceptorship
		Equity in experiences and outcomes		• Advocacy • Laurel end of life care	• One to one time with patients • Care Home discharge planning
		Person-centred care		• Daily PIPA meetings • Partnership working	• Partnership work in developing care plans
		Planning for the future	• QNWA accreditation Mulberry • QNOAMHS accreditation outcome pending - Laurel • Audit program in place • Improved meal menu		• Education sessions for staff • Record Keeping
RAMH Acute	RI	Care provision, integration, and continuity			
		Planning for the future	• To ensure dialog is embedded	• Daily PIPAs • Timely MDTs at least once weekly for each patient	• Embed dialog and reduction of unnecessary care plans from 7th Feb 26.
		Providing information	• Ensuring patients and carers have full information around our services	• Reviewed patient and carer information leaflets.	• To review the effectiveness of the changes through carers evenings feedback, patient feedback in MDTs, community meetings and feedback on care opinion.
		Listening to and involving people	• Ensuring the voice of patients and carers is at the centre of their time with services.	• Weekly community meetings • Review and change to progress around 7-day activity planners for the wards • Matron weekly walk rounds including 1:1 time with patients on each ward to get their feedback on services, their	• To review the possibility of volunteers to the ward reception areas that will focus on patient feedback through care opinions. • Quality audit to commence from Feb 26 led by ward leads and overseen by matron.

	Overall Rating	**RESPONSIVE**			
Directorate			**Priority areas for improvement**	**Evidence to support**	**Further work to progress**
				understanding of their dialog and risk management plans. • All dialog plans to be person centred and written by the patient wherever possible	• Any peer review audits carried out within RDASH are actioned planned and actions achieved in a timely manner. That these reviews are shared amongst the team for team and patient involvement in areas for improvement and that improvements are sustained.
RAMH Comm	Good	Care provision, integration, and continuity			
		Equity in access		• Clear pathways for urgent referrals across all sites. All services have an OOO reply and/or voicemail to signpost to crisis services • Work to address equity of access identified through leadership oversight • Achieving 4 week wait	• Review and improvement of triage processes in progress • Home treatment offer for older adults in development • Neighbourhood working is underway – Rotherham chosen for pilot
		Equity in experiences and outcomes	From May self-assessment as actions: • Feedback from volunteers to be used to improve services and service delivery • Establishing equity in experiences and outcomes across the community directorate	• Clear pathways for urgent referrals across all sites. All services have an OOO reply and/or voicemail to signpost to crisis services • Work to address equity of access identified through leadership oversight • Achieving 4 week wait	• Planned further use of volunteers to improve services and service delivery • Review and improvement of triage processes in progress • Home treatment offer for older adults in development • Neighbourhood working is underway – Rotherham chosen for pilot
		Planning for the future			• Review and improvement of triage processes in progress • Home treatment offer for older adults in development • Neighbourhood working is underway – Rotherham chosen for pilot

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Neurodiversity waits: update	**Agenda Item**	Paper O
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Cora Turner, Care Group Director (PHND) Richard Chillery, Chief Operating Officer Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	29 January 2026

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

This paper builds on the four-part paper from September which covered adult/CYP waits and both the recurrent supply and backlog supply positions. The paper notes a positive position on CYP waits and requests a full trajectory for all three places at the March Board meeting.

There is progress to report on the recurrent position for adult neurodiversity and the operational plan implements that from April 2026.

Previous consideration (where has this paper previously been discussed?)

September 2025 Board paper on same topic

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

ACKNOWLEDGE work across the ICB's providers to try to develop a level 'paying' field for neurodiversity tariffs and quality standards

NOTE the outlined route-map on prescribing wait harms in North Lincolnshire

CONSIDER the progress summarised on adult neurodiversity since October

RECOGNISE the lack of a backlog plan and funding for adult neurodiversity waiters

ASK the Risk Management Group to review neurodiversity risks mindful of this paper at its next meeting

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)	
Finance plan	X
Quality and safety plan	X

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

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X

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)							
NA							
System / Place impact (advise which ICB or place that this matter relates to)							
Outlined within paper							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	Will be needed if March decision required (para 4.2)
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							

Rotherham, Doncaster and South Humber NHS Foundation Trust

Updating on efforts to improve and eliminate neurodiversity waiting times

Contextual reminder

1.1 In September the Board discussed a detailed paper which explored both adult and CYP (children and young people) pathways and considered both recurrent supply to meet demand monthly and the backlog of people awaiting diagnosis and treatment. The paper was necessary because, whilst we will largely meet our four-week wait time for almost all Trust services, despite considerable virement of funds inside RDaSH since 2023, we are not yet meeting that goal for those waiting in these pathways. We are working to state clearly when we will and can.

1.2 The Trust has been at the forefront of work to see if locally we can develop a more sensible planning and funding model for neurodiversity services. Presently this work is focused on South Yorkshire residents, but we would hope that a similar model might be developed for those in North Lincolnshire. Put simply the model seeks to introduce baseline clinical standards for all providers (NHS and other, under Right to Choose (RTC)). It also seeks to introduce a level 'paying' field: where all suppliers receive the same tariffs for care. This would end the absurd position whereby private RTC providers receive a fee for service with no contract limit, while NHS suppliers have a block contract regardless of need or activity. National work is catching up with this local drive but currently proposes a tariff which cannot meet foreseeable cost and may be applied not to NHS Trusts.

1.3 Most of this paper focuses on adult services. That is because the prior paper suggested that analysis and assurances from our children's care group and operational corporate team offered confidence that we would reach a wait reasonably in weeks in Doncaster and North Lincolnshire in the second half of 2026: and that no one in Rotherham would be waiting over 2 years by August 2026. Meeting the new national 104 week (aka 2 year) wait time is not the limit of our ambition given the significant developmental harms of such delay. But these waits would represent a transformation from 2022 and be better than any neighbouring peers. The tariff model would ensure that if we see patient choice we would be able to invest to grow further. **At our March 2026 Board meeting final 2026/27 CYP neuro wait trajectories will be presented** (in both September and November the CCG reaffirmed its position to the executive in delivery reviews)**.** *At the end of this paper, I update on the appalling prescribing delay in North Lincolnshire which we covered in September and which we discussed on January 8th too. The Board may wish to establish the risk register coverage for this item on the separate paper.*

Adult neurodiversity improvements

2.1 In September, we outlined that plans existed to seek to move adult neurodiversity care to monthly supply/demand balance. We acknowledged then that no funded plan to eliminate the backlog exists and undertook to return to that discussion during Q4

2.2 The Board recognised the need to make immediate changes in leadership arrangements within adult neurodiversity services. These ambitions have experienced some delays and

frustrations but are moving forward. However, by April a credible senior leader will need to be in place to lead the service, as the current arrangements rely on the Care Group Director whose time is needed across a range of issues, and from April will need to be focused on implementation of our neighbourhood changes, among other issues. Positively we have also almost completed implementation of changes in the clinical leadership structure within the adult service.

2.3 Progress has been made in securing sufficient clinical space to offer the services needed. Specifically, from February 1st, the new Trust Neurodiversity Centre in Bentley (which was the Emerald ward we closed in 2024) will see its first patients. Together with the use of Ferham Clinic in Rotherham, The Elizabeth Quarter in Scunthorpe and the Opal Centre at Tickhill Road we no longer believe that, even in a five-day daytime basis, we have a material space constraint. Should that arise, we may need to consider extended day or weekend working.

2.4 Progress has also been made in trialling the higher throughput per clinician model outlined in September. Reasonable adjustment work with staff will be completed by the end of January 2026. All staff have used AI technology to complete documentation following these assessments. From February all Band 6 assessors will have 7 assessment appointments booked in as standard practice, while we continue to explore whether 8 is feasible and practical.

2.5 We have long promised local GPs that we would accept self-referrals without primary care triage. This is now in place, from 1 January 2026, for adult ADHD. In addition, an in-service screening tool is now being used for ADHD which gathers material information prior to appointment booking with the aim of both improving the appointment experience and reducing DNA rates, which remain high.

2.6 The above changes open the prospect of meeting monthly demand. However, there are two remaining barriers:

- We have treatment waits, including those who have been diagnosed elsewhere and are simply waiting to start care
- We have an exit block in that shared care agreements are both locally varied and partial in application

It is recognised that the ICB wide work outlined in the introduction does intend to introduce cross-system LES protocols for shared care, but there is uncertainty over timing and adoption. The shared care arrangements for Doncaster, North Lincolnshire and Rotherham remain inconsistent, with Rotherham practices only accepting shared care for one treatment medication. The other treatments remain under the RDaSH service. Doncaster and North Lincolnshire do accept a wider range of patients under shared care and have lower long-term caseloads within our services as a result.

2.7 Analysis shows we have 942 people waiting on treatment only. We have accepted the need to make Q4 non-recurrent investment to commence treatment for 400 of those people

before the start of April. This is a significant further step to try to address the position we face. **From April we will then be:**

- Providing 173 assessments per month (which meets demand)
- And 957 treatment slots

This is an-balance position if we can reduce to a 10% DNA rate overall, and if we can put into place a maximum six-month treatment regimen within our service. The latter will require consistent attention and work.

2.8 It is recognised that the outlined way forward retains risks and dependencies. But it suggests that our best-case position, and our plan, see us delivering from April 2026 a balanced position.

Our backlog: aka humans waiting too long

3.1 We currently have just over 8000 people waiting in the service. Of these around 6,000 are awaiting an ADHD service, starting with a diagnosis and potentially including medication. The balance are people who are seeking an autism diagnosis. This is a difficult area. A diagnosis can be validating and important, and it can act to avoid overshadowing of other needs or bias within a care plan. Conversely, the NHS offers no treatment nor intervention after the diagnosis. We continue to work with commissioners on whether it would be both safe and sensible to contact our patients awaiting ASD diagnosis with a view to transferring their support to a third sector support provider. We are concerned at piecemeal commissioning models across place which do not scale to the size of need, and note that no adult autism support model of any form is commissioned within North Lincolnshire.

3.2 We do not have a supply model established to diagnose 6,000 people waiting ADHD assessment. We estimate that a minimum of around £4.5m of commissioner investment will be needed at tariff to address this backlog. In effect a backlog service, presumably jointly between ourselves and another provider would be needed to transact this, recognising the treatment needs that would then arise and shared care thereafter. If the tariff model is approved by the ICB, our intention is to:

- Approach partner providers to develop a plan in principle about how, over 18 months, this might delivered.
- Seek funding solutions for the non-recurrent costs involved.

Concluding comments

4.1 Not having a solution is frustrating for all involved: albeit the progress made in recent weeks is notable. At present the service focus needs to be on delivering the changes for April outlined above. As such we are taking forward the key steps outlined in this paper as follows:

a) recurrent delivery from April is led by Cora Turner, supported clinically by Dr Jude Graham

b) seeking to agree a coherent delivery model for adult autism is being led by the author working with the ICB

c) Richard Chillery and Simon Sheppard have been asked during March and April to establish a partnering specification for what we would need to tackle to ADHD model on the basis outlined above.

4.2 As indicated at the outset of this paper, for CYP prescribing in North Lincolnshire we know the backlog solution, and have priced and validated it. Faced with young people in our service who are in limbo, and those in paediatric services on waits with no clear end point, the reality is that funding needs to be directed either to RDaSH or to another provider. Our analysis suggests that, as against the published rates of private providers, our proposition is competitive. We do after all offer a prescribing service in Doncaster and Rotherham. We would of course refer to any other provider is instructed. We have made a final contract offer to Humber and North Yorkshire ICB and indications are that NHS NEY requires resolution to that by February 6th. If agreed there is a lead time to mobilisation which would take us to July 1st but could be transacted having been candid with those waiting that an end is in sight. If for some reason, no solution is in place before March, the Board will asked to choose between two options: proceeding to provide care without funding and deviating our submitted plan for 2026/27 and beyond or closing the service to referrals and directing existing waiters to Right to Choose providers. There can be no rational basis for considering that choice necessary as it would require the explicit derogation of NICE guidance by the ICB: as well as being at 180-degree variance to the recently published NHSE strategy.

Toby Lewis, Chief Executive

January 22nd 2026

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Financial Plan 2026/27 to 2028/29	**Agenda Item**	Paper P
Sponsoring Executive	Simon Sheppard, Director of Finance and Estates		
Report Author	Simon Sheppard, Director of Finance and Estates Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	29 January 2026

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

The Board of Directors is aware from the 8 January 2026 meeting that the Trust submitted a draft 2026/27 financial plan of breakeven. This paper updates the Board on the key assumptions, provides a high-level bridge from the 2025/26 plan to the exit underlying position and finally to the draft 2026/27 plan. The recommendation remains **to submit a breakeven plan** on 12 February 2026 as part of our final planning submission.

The paper provides further details regarding the **key aspects of the financial plan** for 2026/27 which are worthy of a brief discussion.

- Cost Pressures
- Cost Improvement Programme
- Income assumptions, particularly with the South Yorkshire Integrated Care Board (SYICB) and Humber & North Yorkshire Integrated Care Board. For consistency, with regards SYICB, this analysis identifies the assumptions across the 3 key "buckets" – income associated with the High Dependency Unit: outstanding contract variations from 2025/26: and finally the level of assumed growth income.

Unlike the draft submission in December, the final plan requires a **submission for 3 years** – 2026/27 to 2028/29. The paper provides a summary of the respective annual positions inclusive of the key assumptions. At this stage the Board of Directors is receiving this for the Income & Expenditure plan only with the Capital Plan to follow at the March 2026 Board of Directors meeting.

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

Presentation to Executive Group on 15 January with the assumptions and position supported

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the cost improvement target of £10m in 2026/27 and £5.3m in 2027/28 and 2028/29

CONSIDER the latest income position regarding South Yorkshire Integrated Care Board and Humber & North Yorkshire Integrated Care Board

RECOGNISE the 2025/26 exit underlying position and the movement to a breakeven underlying position in 2026/27

DELEGATE authority for the final submission to the Chief Executive and Chair of the Finance, Digital and Estate Committee

AGREE the submission of a break-even Income and Expenditure plan for 2026/27, 2027/28 and 2028/29

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)			
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
Business as usual			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
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	x
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	x
Patient care risks			
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			
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)			
The financial plan is particularly relevant to the South Yorkshire ICB and to a lesser extent Humber and North Yorkshire ICB.			

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)

Financial Plan 2026/27 to 2028/29

1. Introduction

1.1. The Board of Directors and its committees have consistently considered the **underlying deficit of the Trust**, notwithstanding better-than-plan delivery of the in-year Income & Expenditure plan in 2023/24 and 2024/25. Also, a forecast breakeven position in 2025/26 despite the loss of Quarter 4 deficit support funding (£0.6m) as a consequence of the South Yorkshire Integrated Care System forecasting an adverse position to plan. This paper provides the Board of Directors with an update on the underlying deficit as we exit 2025/26.

1.2. The paper provides further details regarding the **key aspects of the financial plan** for 2026/27 which are worthy of a brief discussion.

- Cost Pressures
- Cost Improvement Programme
- Income assumptions, particularly with the South Yorkshire Integrated Care Board (SYICB) and Humber & North Yorkshire Integrated Care Board. For consistency, with regards SYICB, this analysis identifies the assumptions across the 3 key "buckets" – income associated with the High Dependency Unit: outstanding contract variations from 2025/26: and finally the level of assumed growth income.
- Budget principles and sign off process

1.3. Unlike the draft submission in December, the final plan requires a **submission for 3 years** – 2026/27 to 2028/29. The paper provides a summary of the respective annual positions inclusive of the key assumptions. At this stage the Board of Directors is receiving this for the Income & Expenditure plan only with the Capital Plan to follow at the March 2026 Board of Directors meeting.

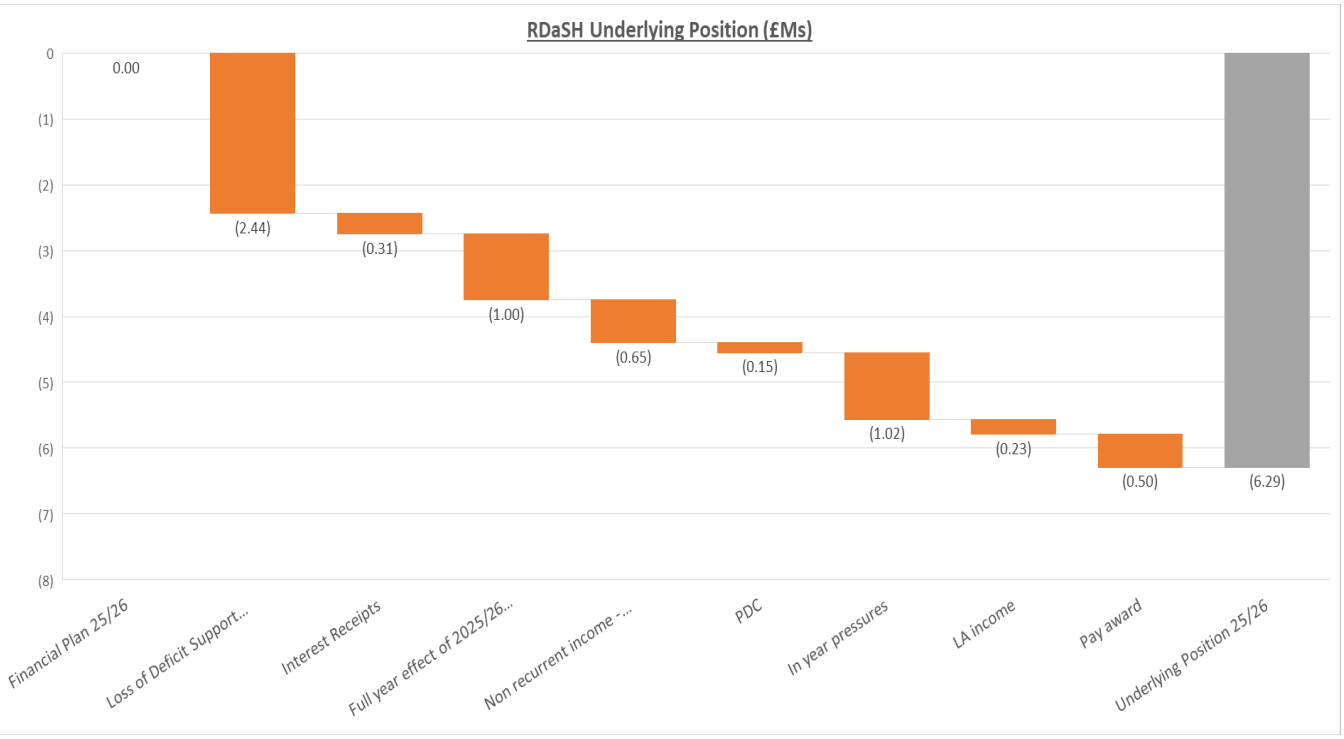
1.4. Finally, the Board of Directors, noting the final submission is at noon on the 12 February 2026, is asked to approve the delegated authority for the final submission to the Chief Executive and Chair of the Finance, Digital & Estates Committee based on the assumptions within this paper.

2. Underlying Deficit

2.1 The Board of Directors will be aware that in 2022/23 the underlying deficit of the Trust was in excess of £16m. This reduced to £12m in 2023/24 and the closing position at the end of 2024/25 was a deficit of £8.4m.

2.2 It is pleasing to note that the exit underlying deficit position for 2025/26 is a reduction to £6.3m. (shown in Chart 1 – bridges from the 2025/6 breakeven financial plan)

Chart 1 – Bridge from the 2025/6 Plan to the Underlying Deficit



2.3 The key drivers of the bridge from the 2025/26 financial plan shown above include:

- Loss of national deficit support funding, £2.44m
- Full year effect of the cost pressures from 2025/26, £1.02m
- Non recurrent income in 2025/26, £0.65m
- Recurrent cost pressures in 2025/26, £1.02m

2.4 The underlying position as we exit 2026/27, with the 2026/27 financial plan described later in the paper, will be a breakeven position. This reflects the stretching yet realistic level of cost improvement in 2026/27.

3. 2026/ 27 Income & Expenditure Changes

3.1 Table 1 sets out the impact of changes to the Trust's income allocations as well as planned changes to expenditure from national planning metrics. Tariff uplifts of 2.03% have been passed to providers to fund inflation, with a reduction in income of 2% for efficiency.

3.2 Key expenditure increases based on the planning guidance include a total pay cost increase of 2.10%. Please note that this reflects a nominal 2% for pay included in 2026/27 allocations, and then a 0.1% for pay drift. The pay cost estimate does not pre-judge the outcome of the pay review body process, which once known will be then reflected in revised percentages.

Table 1 - NHS Cost Uplift for Planning – 2026/27

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.10%	71.31%	1.49%
Drugs	0.58%	2.37%	0.01%
Capital	1.66%	4.44%	0.07%
Other	2.20%	19.66%	0.43%
Unallocated CNST	0.52%	2.22%	0.01%
Total			**2.03%**

3.3 The financial implications at a Trust level of the national assumptions are:

Table 2 – National Planning assumption impact

	£m
2026/27 tariff increase @ 2.03%	4.5
2026/27 tariff reduction – efficiency @ 2%	(4.2)
Pay inflation	(4.3)
Non-Pay inflation	(1.1)
Net change	**(5.1)**

3.4 With a net £5.1m pressure, before any cost pressures, the Trust would require a CIP of £5.1m just to stand still. With an underlying deficit as described in section 2 this level of CIP is not realistic. The Board of Directors is aware, as previously reported, the CIP target for 2026/27 is £10m (4% of turnover). This will be covered later in the paper.

4. 2026/27 Underlying Deficit to 2026/27 Financial Plan

4.1. This section will take the Board of Directors from the 2025/26 exit underlying deficit to the 2026/27 financial plan.

4.2. Taking the exit underlying deficit for 2025/26 of £6.3m and applying the anticipated income and expenditure changes set out in section 3.3 increases our deficit to £11.4m before any CIP, cost pressures or income growth.

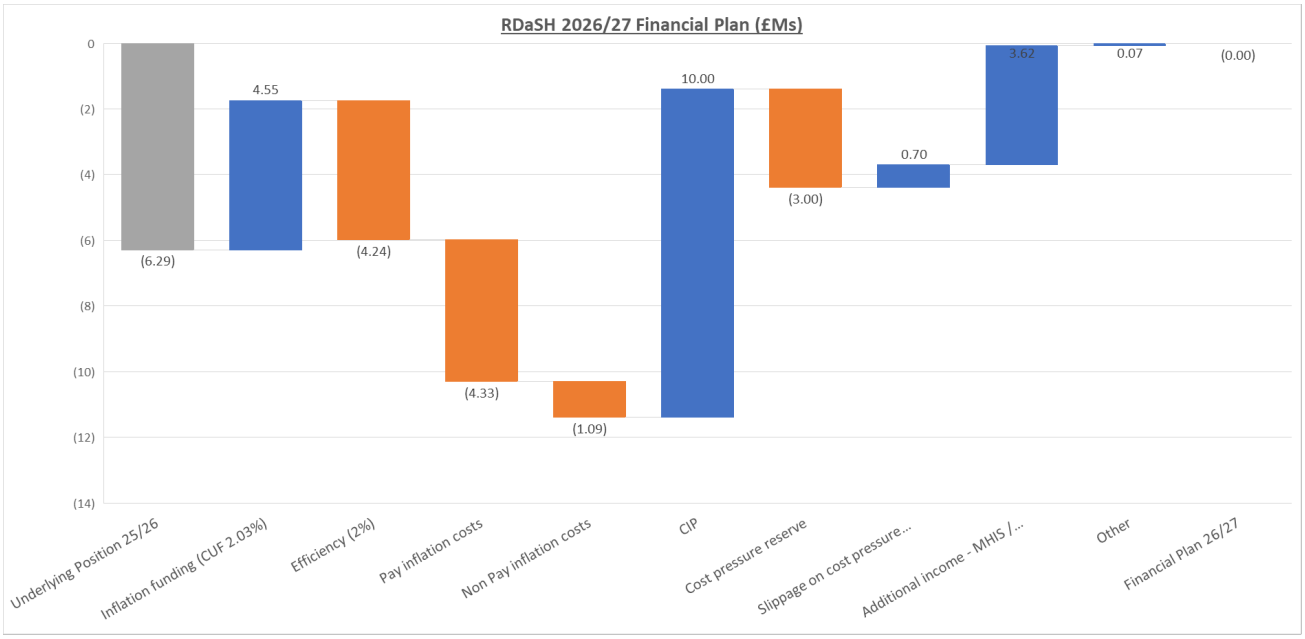
4.3. The final changes are to reduce the £11.44 deficit to a breakeven plan are:

- Cost Improvement Programme of £10m split £1.25m income, £5.90m pay and £2.85m non pay
- Cost pressure allocation of £2.3m
- Income Growth / Mental Health investment of £3.6m

The above 3 areas are covered in further detail later in the paper.

4.4. Chart 2 graphically shows all the changes from the underlying deficit position.

Chart 2 – Bridge from the 2025/6 exit Underlying Deficit to 2026/27 Financial Plan



5. Cost Improvement Programme 2026/27

5.1 The 2025/26 plan included planned cash releasing savings of £7.8m. For 2026/27 this target is £10m which reflects 28% increase to the 2025/26 target

5.2 The £10m target is summarised against the following themes which the Board of Directors are familiar with. It is likely that the mix between the schemes will change slightly prior to budget sign off, but the £10m target will remain intact.

Table 3 – 2026/27 cost improvement programme

	£m		
Scheme Description	**Saving FYE**	**Expected in year delivery**	
Alter and reduce some community staffing models	3.75	3.19	85%
No delegated non pay inflation	1.60	1.60	100%
Maximum change digital option for clinical admin	0.50	0.25	50%
Changes to corporate functions	1.50	1.43	95%
Commercial income flowthrough	1.25	1.25	100%
Rates / Utilities / Mobile Phone reductions	0.50	0.50	100%
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%
Other various	0.75	0.98	131%
Total Savings	**10.85**	**10.00**	**92%**

5.3 As we go through the 2026/27 it will be important we monitor both the in-year performance but also the recurrent full year effect value. The latter will help support the medium-term financial position.

5.4 All budget reductions will be actioned from the 1 April 2026 and phased appropriately (most will be from 1 April 2026). This will help to support not only the submission of a balanced plan but also a realistic monthly profile.

6. Cost Pressures

6.1. Consistent with our prior and annual practice, the Medium-Term Financial Model (MTFM) has included a planned full year effect (FYE) and part year effect (PYE) investment for 2026/27. This is now widely acknowledged inside the Trust as the sole pathway to covering new or unavoidable costs. It should be considered alongside the previously reported "business rules" agreed annually with the Clinical Leadership Executive: these are clear about corporately managed risks, and about the local management of non-pay inflation and incremental drift.

6.2. For 2026/27 PYE spend is higher than in prior years by around £0.3m in the plan. This recognises the full year cost of the Real Living Wage (£0.7m), announced in November, but paid here from April with no backdating. It also is required because we hope to redeploy some displaced colleagues from our consultation into new long-term roles and we cannot do that with mid-year start dates.

6.3. As in prior years, the clinical leadership executive (CLE) is forming a view on priorities, and the Board is being asked to sign off on that. However, it is evident, with a large number of high quality bids that we will need until February's CLE to conclude this process. **Accordingly, the Board is invited to offer any guardrails to the discussion, recognising those outlined below which reflect prior Board discussions**.

6.4. The Board agreed in March 2025 that a precept of not less than 250k would be reserved for older adult mental health admission avoidance work. Bids to that value are being appraised. Board members will recall that in the equity analysis of cuts served on December 16th, the changes being made were lower for older adults than might be proportionate, and this investment further accentuates that positive emphasis.

6.5. The bid invitation document noted a number of in-year decisions made from future budgets. Those reduce the FYE pot to £1.8m, and include:

- Management capacity for neighbourhood transition (operations)
- Real Living Wage as above
- Leadership capacity to take forward the existing and future HDRUs as a key clinical improvement project and core profit line within our portfolio
- Therapeutic activities funding for ward PSWs and for 'Netflix' in our wards
- Expanding our training budget (75k)
- Clinical leadership for both adult and children's social work functions

6.6. Of these perhaps only the last has not explicitly been cited within the Board over the prior six months. It reflects advice on the best way to develop our 80+ social work workforce as key contributors to our clinical and organisational strategy.

6.7. At CLE on 20 January 2026, we discounted a proportion of bids on the lead advice of the Chief Executive and deputy director of strategic development. In total £2.3m of bids, from £6.8m, were set aside. In the main these bids have no foreseeable prospect of being preferred to those being considered. This thinning out process is intended to allow collective focus over the next three weeks. That timeline is critical because by February 24th we have to have in place banded job descriptions for funded roles that can be considered by redeployees from March 3rd.

6.8. As we have discussed within the Board since May 2023, most recently in November 2025's Board meeting in public, we remain concerned about inpatient staffing models. The concern is about the multi-disciplinary staffing, including psychological professionals and some Allied Health Profession (AHP) roles. We are content over core safe staffing for nursing (no bids having been submitted related to the mHost outcome) and over PSWs (see above). There are likewise concerns over administrative staffing, and confirmation is awaited over job planned medical cross cover. Bids of £1.2m were received in relation to benchmarking upwards for psych profs/AHPs. This is not an affordable figure, even over the medium term. However, we are working to identify the 3-400k of priorities we might have, should our contingency be able to manage this change: doing so would need to be directly tied to changes in ward throughput.

6.9. Taking the above two paragraphs together the bids to be considered is halved. The steer offered to CLE foresees an eventual focus in four areas:

- Promise 13/20: Older adult admission avoidance incl. MH virtual ward
- Promise 14: Wait times in podiatry (from Q3)
- Promise 1: Peer support workers, perhaps especially in neurodiversity, transitional eating disorders and adult care within Rotherham (from Q2)
- Promise 14/10Y Plan: Ensuring that the Crisis Assessment Service (open access) project in Scunthorpe is a substantial success

6.10. We need to ensure we also evidently support promises 2 and 6, visibly acting on the poverty proofing reports our staff and partners have worked so diligently to develop.

6.11. Prior to decision, our usual cross reference to the risk register will be completed, both to establish that no mitigation plans presume funding that is unacknowledged in this round. Bids have already been sifted for risk register references and this is reflected in the summary of priorities outlined above.

6.12. Buy-in to the outline above within the clinical leadership executive was notable, with a distinct shift from prior year's emphasis on advocating for one's own bids, to a recognition of the priorities of the Board and strategy. That is also reflected in the calibre of bids being improved this year. Mindful of best value from investments during Q2 2026/27 we will revisit the promised gains from the 2023-2025 funded bids to establish delivery and look for further optimisation, remembering that one funded prior bid is defunded in the CIP plan for 2026/27 (North Lincs ARMs).

7. Contractual Income Discussions

7.1. Section 4.3 and chart 2 shows that the current plan for 2026/27 assumes a £3.6m income growth margin assumption regarding South Yorkshire Integrated Care Board (SYICB). The Board of Directors is reminded that the draft planning submission did contain a sizeable gap between offered income and required income.

7.2. This has three key components:

- The ICB contract with us for the **HDRU on a cost-per-case** basis they had not included that within our income offer, but we require that income to balance our financial plan. The ICB have confirmed the cost-per-case agreement and this narrative will be reflected in the final contract.
- The ICB erroneously omitted a series of **agreed contract variations**, largely already enacted, from their offer – and also did not show the cost of our IT provision to local general practice (despite not having given notice on this).
- There is no agreement with the ICB about the application of the **MHIS**, nor clarity on how the ICB proposes to invest the required minimum 6% community services growth visible in allocations. Both would form a basis for our expectation of 1-1.5% growth in funding vs 25/6 outturn.

7.3. Discussions continue at an Executive Director level; The Board of Directors will be updated on the latest position at the meeting on the 29 January 2026.

7.4. In addition to SY ICB the Trust is in communication with Humber and North Yorkshire (HNY) ICB. We have taken the initiative to make a contract proposal to the HNY ICB for North Lincolnshire services for children and adults as we had not at the draft plan submission stage, and still haven't, received a contract offer.

7.5. The financial proposal takes account of the rehabilitation service that was commissioned in 2025/26 on a full year basis. It also includes the medication service for ADHD for children and young people that has been being discussed. The Trust is unable to continue to accept diagnosis only referrals after April 1st in the event that a medication service, resourced to address the 2025/26 accumulated backlog is commissioned. Just over half of the cost cited is for medication and the Trust will willingly contract on a pass-through basis for these costs.

7.6. We confirmed that we need to conclude contract discussions not later than February 6 2026.

8. Budget Setting Principles and Budget Sign Off

8.1. There are very clear, and consistently applied budget principles, to support the sign off of the budgets during February 2026. These include:

- Directorate budgets in recurrent balance in 2025/26 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 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.

8.2. Board members are aware that annually a process of local budget sign off takes places. This culminates in 23 reviews with the CEO and Director of Finance & Estates. Last year that process concluded in May 2025, albeit was largely completed in March. For 2026/27, it will be completed in February 2026 – this allows the finance function to focus hard in March on making sure every line of local budgets reflects accurately these decisions including the monthly profile. This is intended to reduce to almost none in year budget movements between teams. It then allows the audit process to consume April and early May.

8.3. Directorate reviews start on 05 February and conclude on 13 February. A reserve half day for any teams where budget sign off is not achieved will occur in week beginning 16 February. Sign off is by the care group or executive director, but in the case of our five care groups and 13 directorates, Directorate Management Team (DMT) service managers will attend for a second-year to ensure that they understand and can contribute to discussions of risk and an understanding of local flexibility.

8.4. In the main, at directorate level, there is virement flexibility between teams, and it is important not to under-estimate how novel that was last year and remains this year for this Trust, where prior to 2023, budget ownership was highly centralised, and managers regarded budgets as fixed at a literal lateral entry level.

8.5. Questions for these reviews have been issued and consider issues of delivery and clinical risk. We also consider bank spend and changes, accurate application of rostering allowances including for training time, and ward based budgetary flexibilities to include delivery of High Quality Therapeutic Care (HQTC) agreed actions. Outcome letters will be issued not later than 28 February, and likely much sooner, and these will be shared in due course with Board members.

8.6. For 2026/27 whilst the focus remains on accountability for cost budgets – with income budgets and the Out of Area Placement (OOAP) budget held centrally, alongside reserves – we will run ‘dummy’ or shadow activity accounts and income apportionment. Drafts of these are being finalised to the timetable above, but with ‘go live’ from 1 April 2026. For 2027/28 we might expect activity allocations in particular to be a live matter even if block contracting prevents a fully apportioned income model.

9. Financial Plans 2027/28 to 2028/29

9.1. The final submission on the 12 February requires a submission of the financial plan for 2027/28 and 2028/29 in addition to the 2026/27 draft plan submission.

9.2. Building on the 2026/27 plan, which has been described in detail in this paper, we have been consistent in the assumptions modelled for future years. Namely, national efficiency/inflation rates, cost pressures, cost improvement and income.

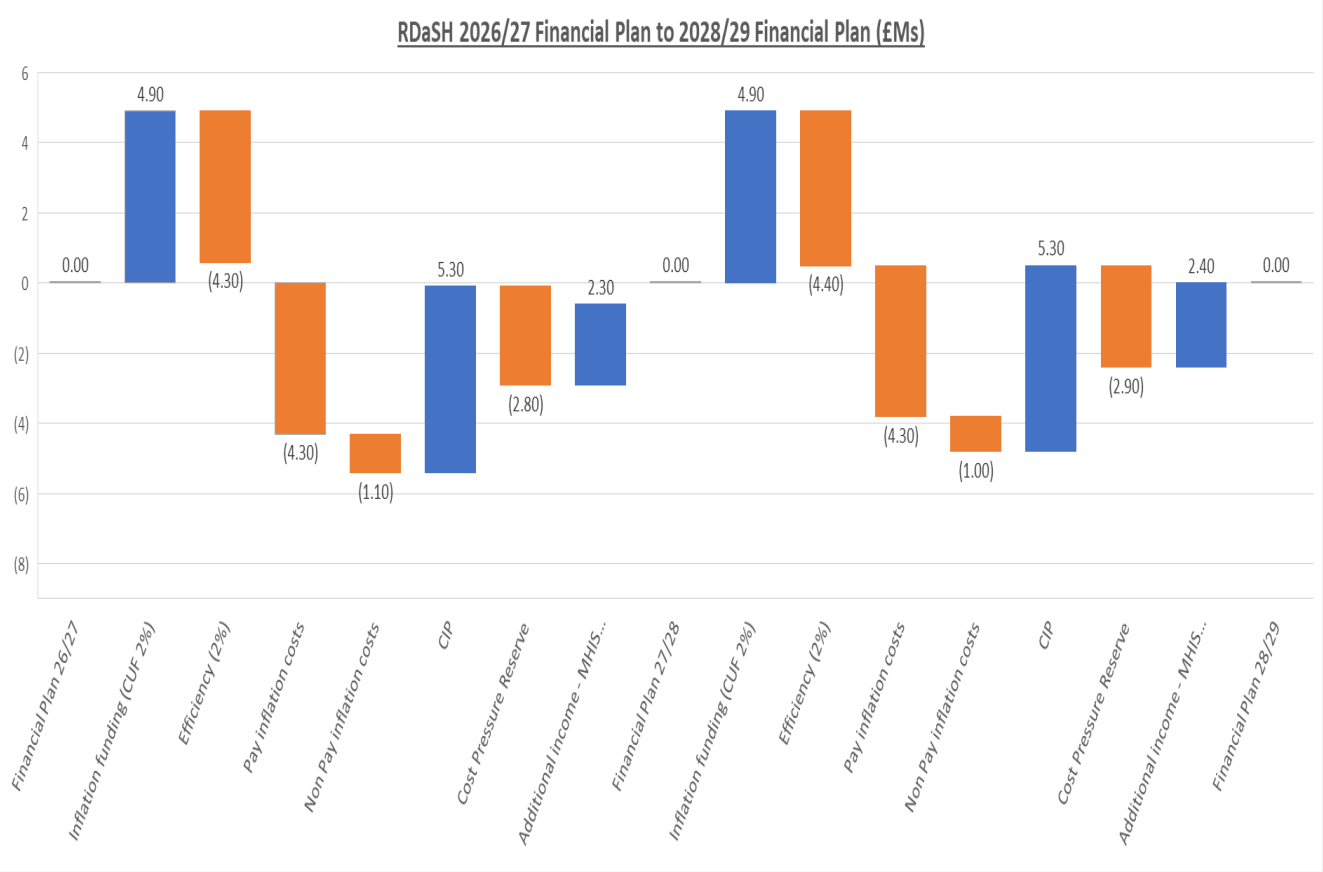
9.3. The inflationary impact is shown below as well as the other key assumptions:

	2027/28 £m	2028/29 £m
2026/27 tariff increase @ 2%	4.9	4.9
2026/27 tariff reduction – efficiency @ 2%	(4.3)	(4.4)
Pay inflation	(4.3)	(4.3)
Non-Pay inflation	(1.1)	(1.0)
Net change	**(4.8)**	**(4.8)**
Cost Reserve	(2.8)	(2.9)
Cost Improvement	5.3	5.3
Income Growth Margin	2.3	2.4
Financial Plan	**0.0**	**0.0**

9.4. The key points to note are these assumptions still support a cost pressure reserve of just under £3m in each year, with the requirement to generate £7.6m/£7.7m from CIP and income growth margin.

9.5. To put 2027/28 to 2028/29 into context, the £7.6m/£7.7m challenge is 56% of the level required in 2026/27. Despite a relatively lower target it is vital the Trust starts to scope, define and then implement medium to long term savings plans. Ideally these need to start in 2026/27 to ensure the recurrent full year effect is realised from 1 April 2027.

Chart 3 – Bridge from the 2026/27 Plan to 2027/28 & 2028/29 Financial Plans



10. Recommendations

10.1. The Board is asked to:

NOTE the cost improvement target of £10m in 2026/27 and £5.3m in 2027/28 and 2028/29

CONSIDER the latest income position regarding South Yorkshire Integrated Care Board and Humber & North Yorkshire Integrated Care Board

RECOGNISE the 2025/26 exit underlying position and the movement to a breakeven underlying position in 2026/27

DELEGATE authority for the final submission to the Chief Executive and Chair of the Finance, Digital and Estate Committee

AGREE the submission of a break-even Income and Expenditure plan for 2026/27, 2027/28 and 2028/29

Simon Sheppard, Director of Finance & Estates
and
Toby Lewis, Chief Executive
29 January 2026

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 2 – Forward look to 26/27	**Agenda Item**	Paper Q
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Steve Forsyth, Chief Nursing Officer Cheryl Gowland, Primary Care Strategic Lead Amanda Ambler, Promises Practitioner		
Meeting	Board of Directors	**Date**	29 January 2026

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

The Board will recall the four success measures and key milestones associated with our promise to our carers in promise 2. This is supported with the regular CEO promises update paper and the paper presented by the CNO to the Board in July 25.

This paper details the work undertaken in the last six months. Whilst there are some real achievements, the cultural shift to embed our commitment to carers needs a significant reset.

The key to the paper is detailing the plan, explaining the areas of the delivery chain, which we need to now nail down in the last quarter of this year and into quarter one; impacting on how we bankrupt our local authorities, by monumentally increasing the referrals of people, who are carers in our communities.

To finish, the Board will want to note the successes in this paper, which include standardised visiting hours for carers, development of SystmOne carers data collection (as part of the always measures dashboard), increase in ESR staff declarations and significant growth of the carers network.

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

The paper is collated from the workstreams that include: HQTC, Equality & Inclusion Group, the carers network workplan and the organisational approach to supporting carers as per the Care Act 2014 and the Carers Leave Act 2023.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECOGNISE the work to be done from April to embed this work and the wider always measure within all 13 directorates.

DISCUSS whether the delivery chain is sufficiently understood to create a coherent plan by which to ensure the required behavioural change.

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
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)	
People and teams 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

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 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			
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 were 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)

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

Promise 2 – Forward look to 26/27

"Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy."

1. Introduction

1.1. The Trust is progressing towards a consistent, organisation-wide approach to identifying and supporting all-age carers across Doncaster, Rotherham and North Lincolnshire, strengthening compliance with the Care Act (2014) ahead of our internal January 2027 target. Strong multi-agency partnerships have been established, joint staff training is underway, and system improvements, such as SystmOne carer flagging and shared reporting, are being developed. Engagement with staff and carer groups is ongoing to better understand barriers and lived experience, and accessible information that will include easy-read materials and digital support. This work underpins readiness for Carers Federation Accreditation and enhances safeguarding, data quality, and future service planning across the Trust.

2. Success Measure 1: Identify All-Age Carers Using Our Services

2.1. Since August 2025, we have made strong progress in establishing strong multi-agency partnerships. The Trust has built effective operational and strategic relationships across all three local authorities:

2.2. In Doncaster, we have embedded working with the carers wellbeing service; active attendance at the carers strategic oversight board; collaboration with the young carers lead.

2.3. In Rotherham, we are participating as a partner with Rotherham Council in the new 2026–2030 carers strategy. We also have an improved understanding of the multiple VCSE providers offering carer support.

2.4. In North Lincolnshire, we are active partners of the carers in partnership board. We have strong joint working agreed with commissioners and support services and have been invited into the development of their 2026–2030 Carers Strategy. These partnerships support consistent identification, referral pathways, and signposting across the Trust's footprint.

2.5 **Staff Process Development & Training** - Joint training has been developed with Doncaster and North Lincolnshire; the carers awareness sessions have been scheduled bi-monthly on our Learning Half Days from December 2025. Further stakeholder collaboration is planned to include bitesize training videos, which we are developing with the Carers Action Group in Doncaster. The training is also included into the First Line Manager training package.

2.6 **Operational Recording & Visibility** - Work has been undertaken with IT/Data Warehouse to create SystmOne carer flags, which will significantly improve our internal reporting. We have been working collaboratively with our local authorities to understand referral tracking and develop shared reporting approaches to improve communication between Carers and services.

2.7 **Understanding Barriers & Lived Experience** - We acknowledge that further work is planned and are working and being visible with both the Carers and Young Carers groups in all 3 localities, to understand referral barriers and assessment experiences. We will work with stakeholder groups to discuss the 'what worked well' and 'what could have been improved upon'. To ensure we gain all areas of feedback we are attending the service team meetings to gather qualitative insight from a colleague perspective and identify what we can do to help them advise, refer, signpost and action effectively.

2.8 **Accessible Information Development** - We are collaborating with CHAD in Doncaster to develop an easy-read booklet for young and adult carers, this is planned for February 2026. Joint work with Doncaster to create a "digital café" model to support form completion, which will cover plans for simple, accessible guides covering rights, support and assessment processes.

2.9 Delivering this programme does four things;

1. strengthens compliance with the Carers Act,
2. supports safeguarding duties,
3. underpins our readiness for Carers Federation Accreditation and
4. improves the Trust's understanding of its carer population — informing future planning, service design and workforce development.

3. Success Measure 2: Improve carer access to inpatient areas and provide flexible, safe, and timely access for carers. Provide flexible, safe, and timely access for carers.

3.1 As part of the work chaired by the CEO, the HQTC has delivered and achieved consistent visiting times across all our hospitals and wards. This seemingly small change is significant for carers when visiting their family and friends. To support our carers, we have also worked with Care Opinion to create a specific barcode to obtain carer and patient feedback for people who are currently in our hospital wards.

3.2 In this quarter, quarter 4, we will undertake a thematic analysis of carer and patient feedback, and stakeholder engagement events will inform a set of recommendations for improved inpatient access. Key risks include VCSE capacity, balancing safety with access expectations, and achieving consistent ward-level implementation. Strengthening carer access will enhance patient experience, support safeguarding duties and ensure alignment with national best practice for carer involvement in mental health inpatient settings.

4. Success Measure 3 - Support Unpaid Carers in Our Workforce

4.1 We are strengthening support for unpaid staff carers by increasing visibility, improving access to resources, and building manager capability around flexible working and wellbeing. The Carers Network has expanded significantly from

single figures, under 10 to now, in excess of 60 members. This is supported by bi-monthly meetings, a dedicated Teams channel and mailbox, and the launch of virtual coffee drop-ins.

4.2 Staff awareness is improving through a new intranet resource hub, Trust-wide communications and an active events programme. Through this, we have seen an increase in ESR carer declarations, with a rolling ESR banner and new guidance being incorporated into the Carers Information Booklet; the intended outcome being to increase declarations by 100% in Q3 2026.

4.3 Manager support is being strengthened via confidence surveys, carer awareness modules and regular HR involvement, while co-production has been embedded into policy processes following the recent review of the Patient & Carer Information Policy. There is further work to do on this, and our planned next steps include launching a video campaign, expanding the speaker programme, and integrating carer-identification prompts into HR touchpoints. Some constraints relate to ESR functionality and increased administrative demand, but overall progress supports retention, advances EDI objectives, and provides essential evidence for Carers Federation Accreditation.

5. Success Measure 4 - Achieve Carers Federation Accreditation (QSCS)

5.1 The Trust is progressing toward Carers Federation Accreditation (Quality Standard for Carer Support) by working through the required eight criteria covering policy, workforce, training, data, partnerships and operational processes. Achieving accreditation will strengthen the Trust's external reputation, support the NHSE People Plan priorities, and embed a consistent, high-quality approach to recognising and supporting carers.

5.2 Key foundations are now in place, with the initial accreditation meeting having taken place in June 2025, followed by a development planning meeting in September 2025 confirming all accreditation requirements. As a result of this a full gap analysis has been undertaken, and the first draft Trust-wide Development Plan was presented to CLE in October 2025 and the E&I group in November 2025, with regular quarterly updates.

5.3 Risks remain around earlier procurement delays and the ongoing need for sustained cross-Trust engagement and evidence collection across multiple departments. Some areas will require some acceleration for us to meet the deadline of December 2026, particularly in relation to standardisation and partnerships to ensure there is consistency across our Care Groups and across our three geographical localities.

5.4 As part of the delivery chain, the below provides a summary for each of the 8 criteria to provide an update to the Board:

5.4.1 <u>Carers Policy & Strategic Commitment</u>
Although good foundations have been made in this area there remain some key gaps around governance to ensure our success. These include:

All relevant policies require review to embed carer identification & support principles.

5.4.2 Identification of a [Carer] Governor representative link and delivery of relevant carer awareness training
Final approval of Carer Champion role description
EDI alignment and new Equality & Inclusion policy to be completed

5.4.3 Designated Members of Staff
We can report that a Carers Lead and [2] Carer Champions have now been identified from within the Promises Team who provide dedicated capacity to supporting Teams in the identification and support of carers. Structured reporting mechanisms are in place to highlight progress and escalation points in relation to the delivery of Promise 2 through Equity and Inclusion Group and Board of Directors through their forward plan.

Staff Training

5.5 Over recent months we have developed carer specific information in our Safeguarding training. Care awareness is also included as part of the 5-day induction programme for new employees to the Trust. This also includes promotion of the Staff Carers Network. Carer awareness training has been developed and is delivered as part of the Learning Half Day each month. This is promoted to all staff via the Staff App. Carer-awareness training is being further developed in partnership with Doncaster Carers Action Group. We recognise that appropriate training is crucial for successful accreditation.

Information, Identification & Accessibility

5.6 The functionality within S1 (SystmOne) has been developed to allow the recording of carer information including identification and access to a carers assessment where appropriate. There is still further development of work required to ensure that carers are proactively identified and supported appropriately as early as possible. We want to ensure that reasonable adjustments guidance is extended to carers. This data will enable us to identify which clinical teams are routinely recording this and where additional support or awareness raising may be required. This is also promoted via carer awareness training for staff as part of the learning half days, and the plan is to include this training in the first line manager's programme. This work is currently underway to ensure full implementation across the organisation.

Ongoing Practical Support

5.7 Our well-being passport now includes a carers element and staff (including managers) are encouraged to support colleagues to complete this. We acknowledge that broader practical support pathways need development, so we will involve carers in all discharge and transition processes. It is acknowledged that further evidence will be required in this area to ensure successful accreditation.

Promote Health & Wellbeing

5.8 Carer support groups are in place in each of our communities, and these are promoted to those carers that have been identified. For our staff carers we have, as mentioned, established a network and have RDaSH health and

wellbeing champions who promote access to local support where appropriate. Further work around the documentation of shared decision-making remains outstanding but will form part of our wider work around early identification and needs assessments of our carers. Early identification work (including needs assessments) will also ensure that we capture carer eligibility for appropriate health checks/vaccinations. We acknowledge that work around recording and reporting of carers may need acceleration in order to secure accreditation by December 2026. This work is currently underway.

Partnerships

5.9 Over recent months we have developed strong multi-agency relationships across all three localities. We can report active engagement with local authority and VCSE partners, including collaboration in Rotherham and North Lincolnshire on local carers strategies. Strong relationships with partners ensure that we can build on and share good practice and avoid duplication of efforts when supporting ‘our’ carers. Work is considered strong in this area, but coordination and documentation require strengthening.

Data Collection & Carer Involvement

5.10 Care opinion as we acknowledge has been a huge success for patients and our staff responders and is monitored well. However, further work is required around the development of broader data/feedback systems including carer satisfaction surveys, and to ensure regular feedback loops are fed into governance meetings to be heard and acted upon.

5.11 The Trust is making progress and demonstrating a strong commitment to the success of accreditation by December 2026. We are in a strong position in terms of muti-agency partnerships, growing our carer networks and our engagement processes. However, a significant amount of work is still required to further develop robust mechanisms around early identification and support of carers and ensuring we have a comprehensive portfolio of evidence to support the delivery of the plan. This work is ongoing and with focused action and some acceleration in some areas we are on a realistic trajectory to successfully achieve accreditation in the time we have.

6. Breaking down barriers

6.1. As detailed in 5.6, we have developed our digital templates to record carer information with S1. Further development of the template is underway to ensure that additional carer information is captured, enabling us to identify and proactively contact and support carers as early as possible and where appropriate. This will include capturing carers demographic data and undertaking (and recording) a carer needs assessment (particularly where a formal assessment is not required) to identify relevant risk factors and areas of support upon contact for the carer.

6.2 It is clearly easier to identify those carers who attend appointments with patients or who are already known to teams, but this leaves a gap for those carers who are currently not known to us. Without data sharing agreements in place with our Local Authority partners, we are unable to gather important information captured as part of a formal carers assessment, which relies on carers sharing the information themselves or by undertaking a separate carer needs assessment on contact.

6.3 In order to develop our relationships robust mechanisms in which we can identify carers early and provide a comprehensive offer of support (where appropriate), we have submitted a funding bid via the investment process to increase our peer support worker carers role, linked to promise 1, that will engage with our communities that our services cannot reach, due to the structure and design of our service pathways and those we exclude.

6.4 The Carers Support function will act as a point of contact, reducing confusion and ensuring carers are linked to appropriate services such as respite care, financial advice, and mental health support as early as possible. This will also ensure that carers are signposted and receive access for formal carers' assessments where appropriate and as soon as possible on their journey. Our plan is to work with our local authorities to outline a trusted carers assessment approach that mirrors that of other types of funding assessments based on needs.

6.5 If the bid is not successful, then we need to continue to progress and keep building on our current offer to ensure carers are proactively identified and supported. To create organisational change, we need to work with our clinicians and clinical teams to ensure they proactively ask whether the person in front of them has a carer or is indeed a carer themselves. This is not a simple yes/no answer but should follow an appreciative inquiry approach. As we know, cultural and generational factors may mean individuals do not identify themselves as carers and therefore do not access the support available to them, including carers’ assessments.

6.6 There is some crossover from Promise 2 to other Promises within our organisational strategy. Promise 7 commits to addressing healthcare inequalities in adults and children particularly around access to annual health checks for people with an SMI or a learning disability. Promise 8 is providing equal access across our autism, learning disability and mental health services as part of our wider work to tackle inequality.

6.7 We know that carers often coordinate appointments, notice early signs of deterioration and influence behaviour including timely access to health services, they are therefore key partners in improving uptake of annual health checks. We want to ensure carers are equal partners by extending our offer of reasonable adjustments to carers and not just our patients wherever appropriate. We want to work closely with our clinical teams to ensure that carers are routinely involved in care planning, discharge planning, etc wherever appropriate. Through robust recording of carer information, dedicated support and outreach into the communities themselves we can work with carers, particularly those from global majority communities, people who are black

and/or brown, who do not identify as white, including our Gypsy Roman Traveler (GRT) community.

6.8 PCREF supports RDaSH in evaluating the impact of equitable partnership working and demonstrates mutual benefits and shared decision-making particularly with our under-represented racial and ethnic communities. We want to ensure that carers are encouraged to more routinely access mechanisms such as care opinion and carer surveys to continually monitor satisfaction levels and alert us to areas of concern as early as possible. This links back to the importance of robust recording mechanisms in order that we can identify our carers and record appropriate demographics in order to proactively engage with those across all of our communities, including those outlined above.

7 Next Steps

7.1 Create a culture of inquisitively changing the way we have historically worked with an action plan, create buying in, ownership and focus on caring and compassionate employer relations with our promise of delivery.

7.2 Secure via Education and Learning subgroup, the inclusion of carer awareness training as part of our new RDaSH inductees on our induction and importantly for our ward and community leaders, included as part of the first line management training. This is also being included as an integral part of Promise 16 and always measure 1 – care planning and dialog + training.

7.3 The MPLT, Multi Professional Leadership Team training framework, that is a creation of HQTC, will be coproduced with Carlene Holden and CNO to ensure there is a specific carer focus, linked to creating the cultural change required for promise 1, PSW and the continued improvements we are making linked to volunteers (Promise 3).

7.4 Continue to work with our digital teams to implement a Trust-wide carer referral system that links ESR as part of the carer re-coding IT system.

7.5 Undertake a benchmarking exercise within Q2 of 26/27 with key stakeholders in preparation for our Carers Federation accreditation.

8 Recommendations

The Board of Directors is asked to:

RECOGNISE the work to be done from April to embed this work and the wider always measure within all 13 directorates.

DISCUSS whether the delivery chain is sufficiently understood to create a coherent plan by which to ensure the required behavioural change.

Steve Forsyth
Chief nursing Officer

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Well-Led – Externally Commissioned Developmental Review	**Agenda Item**	Paper R
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	29 January 2026

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

The most recent update to the Board of Directors in relation to Well-led was in November 2025. That demonstrated the continued collation of evidence in support of the stated position and highlighted progress with the Environmentally Sustainable criteria; it also introduced the correlation to work ongoing under the banner of Think Directorate.

The paper also confirmed that the Trust was undertaking a tender process to appoint an external partner to undertake a Well-led review in Q4. This has been completed, with the contract awarded to The Value Circle and the process has now commenced, with an intention to report the draft dings to the Board at its meeting in March 2026. This paper provides an update on their proposed work including a timetable for the next few months, with Board members involved either through direct interview and engagement or during the observations carried out by TVC (the first of which is via today's meeting of the Board of Directors)

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

Board of Directors has received updates on the topic of Well-Led regularly through 2024 and 2025, most recently in November 2025.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the contract award and the commencement of the external review by The Value Circle in line with the timeline.

PARTICIPATE within the review through the interview and observational processes being deployed by The Value Circle.

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)	
Business as usual	x

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

Patient care risks			
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	x
External and partnership risks			
Legal and 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)							
Leadership and the respective abilities of our leaders is a fundamental part of the Well-led review. All SDR risks, perhaps to varying degrees, are linked to the abilities of our leaders and hence are of relevance to this review.							
System / Place impact (advise which ICB or place that this matter relates to)							
Reputation, Partnership, Workforce							
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. The Value Circle – external review timeline							

Rotherham Doncaster and South Humber NHS Foundation Trust
Well Led – Externally Commissioned Developmental Review

1. Introduction

1.1 The Board received in November 2025, the fourth in a series of papers that focused on the Well-Led key question, a part of the overall CQC's single assessment framework. Board members will be aware of the complementary and parallel work (also presented on today's agenda) that links to the other four CQC key questions.

1.2 Previous papers presented the compliance with the Well Led requirements, via a self-assessment. These had continued to demonstrate increased confidence in this area with the establishment of supporting evidence. They also referred to the Trust's intention to commission an external well-led review in Q4 – to provide the Board with an independent review and assurance on the stated position and evidence. This paper primarily focuses on the arrangements in place for that review and the progress made in recent weeks.

2. Well Led Framework Externally Commissioned Review

2.1 **Requirement**: Foundation Trust's are strongly encouraged (in the Code of Governance) to "*Carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years"*

2.2 The Trust previously commissioned a review by the Office of Modern Governance in 2022 and whilst not a formal Well-led review, also engaged Good Governance Improvement in 2024 on related matters. To ensure that the Trust continues to respond to the Code of Governance expectations and to provide the Board with an independent view on our more recent work, we have completed a tender process and appointed The Value Circle to work with us in the coming months and to deliver an independent review of Well-led at the Trust.

2.3 **Appointment:** The appointment followed a tender process and was overseen by Pauline Vickers, Non-Executive Director and Vice Chair / Senior independent Director and Philip Gowland, Director of Corporate Assurance / Board Secretary. The appointment was made after the receipt of competitive bids and a formal review and presentation by four firms.

2.4 **Work Plan and Timetable:** The review will feature a range of interviews, desktop reviews of evidence and observations at a number of meetings across the Trust. The Board of Directors and other key individuals within our Care groups and in specific roles such as the Freedom to Speak Up guardian will be involved.

2.5 Appendix 1 is the work plan and timeline produced by The Value Circle, which Board members will note has a key delivery point at the March Board of Directors meeting of draft findings with the intention that the Trust and The Value Circle work together then on the response and actions to the findings in April and May 2026. Interviews and Observations commence from today with the Value Circle observing the Board meeting; observations at the next round of Committee meetings, Council of Governors are now scheduled and individuals will shortly receive invitations for focused interviews over the coming weeks. The Value

Circle will also extend their observations and interviews with focus groups and with a number of external partners. The submission of a comprehensive suite of documentation to The Value Circle has commenced.

2.6 The Value Circle are aware of the Trust's recent submission of the Provider Capability Assessment, details of which have been provided to them, and that we expect a response from the Regional team imminently. This PCA will be used by The Value Circle as one of the supporting pieces of evidence.

2.7 **Progress**: The Director of Corporate Assurance will lead the review on behalf of the Trust and ensure that the Chair and Chief Executive are regularly updated on progress. The Board of Directors will, at its next meeting in March 2026, receive an update and draft findings.

3. Recommendations to the Board

The Board of Directors is asked to:

NOTE the contract award and the commencement of the external review by The Value Circle in line with the timeline.

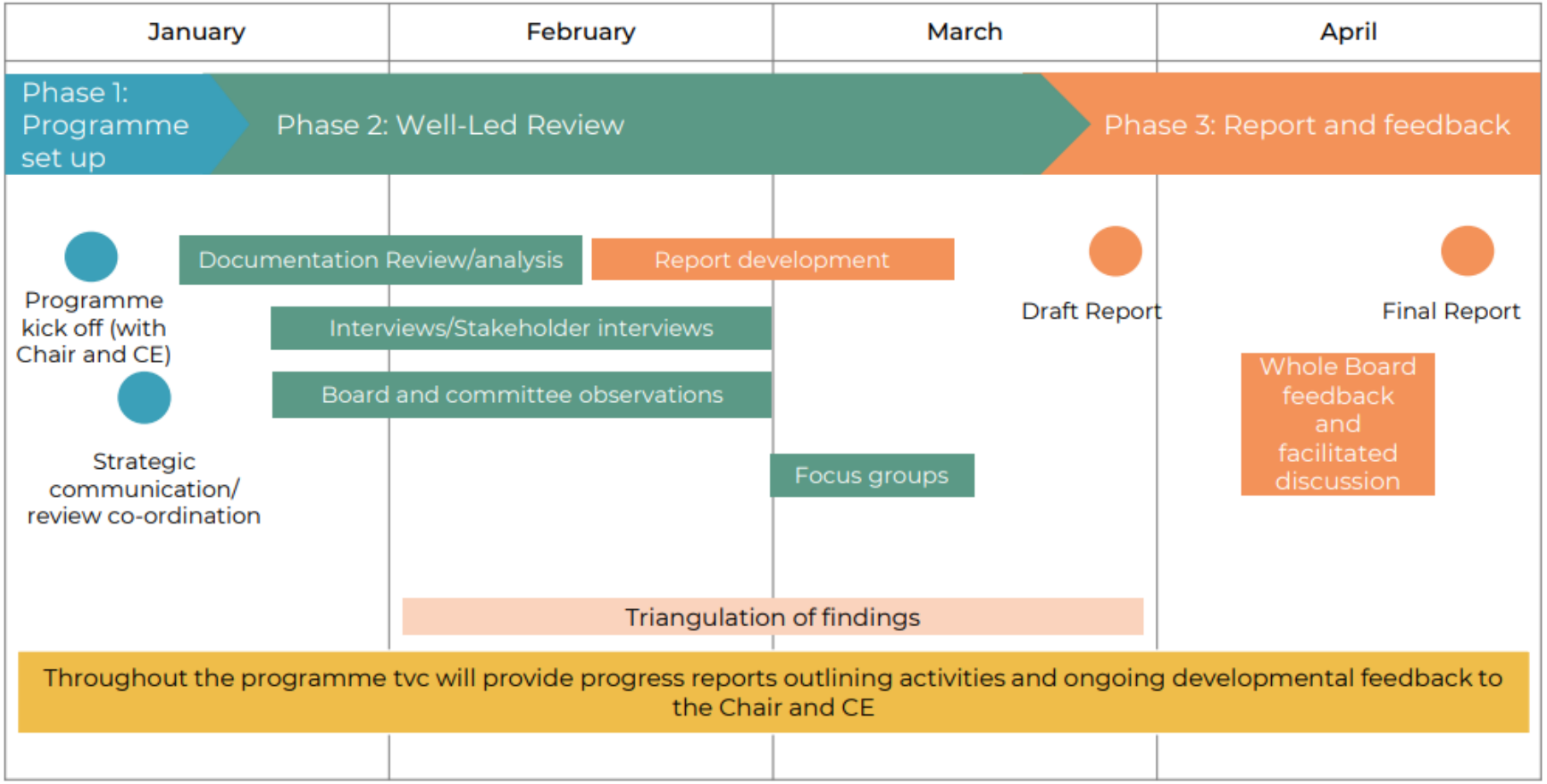
PARTICIPATE within the review through the interview and observational processes being deployed by The Value Circle.

Philip Gowland
Director of Corporate Assurance
22 January 2026

APPENDIX 1

Programme overview (January 26 – April 26)

Below sets out an indicative 4-month timeline outlining the key programme deliverable between January and April 2026.



ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 5: making it real	**Agenda Item**	Paper S
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	29th January 2026

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

This paper narrates the sharing of power. Before we launched our strategy in 2023, the Board spent many hours discussing and considered our own comfort with that intention. Sharing power, recognising the power in others, ceded power and space, all play into our mission as an organisation. It is a step of will and humility. But it also requires some very practical actions to experiment, to build trust and to change.

The ask of the Board is to review what is provided here and to again discuss that sharing of power. As the NHS sees aspects of top-downery reassert themselves, and as expectations of Board leadership come into sharp focus it is important and timely that we re-discuss our commitment to this, even if we are discussing 1%s of changes in tone, style or behaviour – starting with our own.

Previous consideration (where has this paper previously been discussed?)

n/a – albeit a variety of papers to PHPIP committee in 2025

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

CONSIDER what we wish to do differently in 2026/27 to support the Promise

RECOGNISE the establishment of the shadow CLE (Communities' Leadership Executive)

EXPLORE how we would know if our Community Involvement Framework was being delivered

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
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			
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			
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
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
SDR 1							
System / Place impact (advise which ICB or place that this matter relates to)							
Na							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Annex A – the Board's approved Community Involvement Framework (agreed via PHPIP Jan 24) Annex B – summary of our peer work used with partner agencies (credit Dr Jude Graham & Glyn Butcher)							

ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Reminder

1.1 Promise 5 is a corner piece in the complex jigsaw of our promises, and it is certainly the essential component of a mission to nurture the power in our communities. It may perhaps be viewed through two lenses:

- Who is 'in the room' when decisions are made
- Which rooms do we choose to show up within

At the 2025 annual members meeting I reflected feedback that almost the crucial part of what is seen as radical changes in the Trust over recent years, is a view that we do now "show up": and I hope a sense that that is to serve others not solely to advance our own perceived interests.

1.2 However, it would be a mistake to read this introduction and consider that the paper is about what we do well. This has to be a moment to recognise how nuanced, hard, and emergent this work is, and how our efforts to be, ourselves, consistent and authentic about it need to be redoubled yet reflective, and the leaders who are seeking to that need to grow in number – both as we recruit and turnover postholders, and through the development we have invested in with the LDO.

Doing what we said we would do

2.1 If trust is a significant part of the conversation, delivering on what we said that we would do feels important, even if sometimes those are our measures rather than shared ones. In this regard we have some work to do in the first six months of 2026 to catch up and definitively conclude work for three of our success measures are outlined below:

- **Apply patient participation tests to new policies and plans developed within the Trust:** this has started in respect of policies, albeit it will need to become routine not bespoke. We are launching, see discussion below, our shadow CLE very shortly, and ordinarily key plans and frameworks within the Trust will route through that body, or move in addition through our Governing Body (now fully populated) where that would be more appropriate. Phillip Gowland has responsibility for the policy aspect outlined, and Kelly Hicks/Toby Lewis are nurturing the shadow-CLE.
- **Deliver the annual priorities set by our council of governors:** the majority of aspects of these priorities have progressed well and overlap considerably with the promises, which we agreed subsequently. In particular, our work on volunteering and on annual health checks are in line with the focus sought by the council. The exception is our offer to 'kitemark' some digitally delivered tools and support for patients in the mental health space and try and direct those safely waiting to those tools

(as distinct from the many alternates). The next step is to identify who might lead and do that thinking.

- **Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27:** considerable work was done in 2024/5 (second half) and the new membership offer was launched at the 2025 AMM. Over the last 7 months it is not clear that has been followed through in a structured manner, and meetings with the deputy CNO are taking place to ensure that this progresses: these plans are due for review at the February delivery review of the N&F team. The difficulty arises if trust with our 800+ members has been damaged in the hiatus.

Two-way street

3.1 Attached as annex A to this paper is the Community Involvement Framework we agreed in early 2025. The important facet of this is the 80/20 split of leaning in as against bringing people into our spaces. Our success measures included the commitment to **deliver the Board's community involvement framework in full**.

3.2 We know that peers and the wider community are ever more closely involved with how RDaSH operates. For example:

- Peers form part of senior level interview panels consistently, albeit this needs to be expanded to senior clinical hires over the coming year
- Patients sit within our CLE and its sub-groups, and governors sit within our Board committees – the largely now populated and active governing body is a further step change.
- In some care groups this corporate 'vibe' has resonated and similarly patients play a prominent role in their work, but there is more to do to co-produce a set of expectations as an organisation.
- Increasingly we are indicated an unwillingness to contribute to 'strategic spaces' in the health and care system where patients are not visibly in the room from the outset, albeit it is, through this clear, how countercultural this is in some areas.

3.3 What is far less developed, and certainly less visible, is our 80% lean-in contribution and where we choose to deploy that. The Board understands that we set out to cull the vast number of time commitments arising from NHS 'system' working and to release some of that new time into engagement with the VCSE, wider community and primary care sector. This month we have begun to host internal sharing meetings between corporate and care group colleagues by place, with the aim of trying to first understand and then explore those places and where the Trust might be useful. This is a change that will never be urgent, but it is overwhelmingly important: notwithstanding

successful progress on NHS-style goals and gains, like short waits, that cannot substitute for showing up in these spaces and doing so in the right spirit. Our LDO time has been intended, in part to build confidence and understanding of the skills needed to do this – and we know from that work the journey still to travel.

3.4 Perhaps a key milestone in that journey is to better understand 'what's out there' and to see how to seize opportunities that present. As we have done through our charitable grants and the work to create peer support networks and relationships. However, a structured approach will be needed if we to avoid aligning with community-based leaders who fit with us, rather than those best rooted in communities we work with, and perhaps especially those we do not yet work with. By June our shape-mapping has to identify those influencers, and, in addition to seeking to draw people into our orbit, we need to join theirs. Increasingly it feels as if the mapping we need is mapped by others for us, rather than trying to chart this ourselves, albeit our register of VCSE partners is now in place.

<u>Making this effective for all involved</u>

4.1 Our final success measure aims to **'involve patient and community representatives fully in our board, executive and care group governance**'. We touch above on how that is progressing. But the Board wants our changes to be meaningful not tokenistic. Jude Graham has kindly worked with peers to evaluate some of the feelings and experiences from those we are working with. The table below may seem very practical, and it is, but it is also about creating a level that allows everyone to be and feel effective in their contribution. Whilst it is positive that feedback from many involved has been positive, the actions needed to be better are there to be considered, and we would trust habitualised.

What's working well?
- Feeling welcome by chairs and all in the meeting. - Being able to access meetings in person or remotely. - Introductions to all, including new people and deputies. - Inviting contribution on specific matters, is helpful, especially if people attending are anxious.
What's not working well?
- The papers for meetings are still too long. - There is no 'easy read' or quick read for many meetings, which makes them difficult to access and navigate. - Too many things being scheduled in a meeting meaning some people cannot contribute to discussions.

- Abbreviations being used too much without explanations.

- Too much time taken in terms of presenting papers verbally in the meeting, potentially because some people have not read the paper before the meetings. This doesn't give much time for discussion.

- Some people cannot attend the meetings consistently and would like to potentially double up.

- Some people do not feel confident to speak in the meeting.

What could we do better?

- Not all chairs complete pre-briefs or debriefs, but it has been asked that it is consistently applied and therefore factored into chairs diary as part of the corporate assurance meeting booking processes.

- A pre-brief or equivalent process could provide the space to pre-submit questions if people feel anxious to speak in the meeting.

- Print minutes for people who require this. As some people said that they have not got the facility to print, and so sometimes they come without papers, or they spend a lot of money in paper and ink.

- Provide devices – laptops or small tablets to be able to read papers and linked documents. These have not been asked to be expensive, some tablets are less than £150. These could be returned if people leave the meeting.

- Abbreviations list with each paper / meeting.

- Easy read / quick read versions issued as well as full papers – this enables people to read which ever version most suits their wishes and abilities.

- Presenters to present the papers as 'read' and not speak about the paper for more than 2 minutes to enable discussion.

Other comments

- Some people who volunteer or join meetings to undertake these roles have never worked in or experienced our services. And have asked to shadow service visits or peer reviews or place assessments to enable their contribution.

- Some people have said that the meetings they are assigned to are not within their area of knowledge or experience and therefore a request has been made for a different matching process.

4.2 The development of the shadow CLE has taken some time, and we now expect to meet first in March 2026. Terms of reference have been considered by the clinical leadership executive (Oct 25), and the ambition from that conversation was very clear. In particular, the shadow CLE will aim to set an agenda, as well as to respond to our agenda – and it will be critical that senior leaders respond positively to that, as it may seen, and should be seen, as

disruptive. From initial discussions with potential members of this body it is clear that issues of care plan ownership, and weekend working, will feature in early discussions – pushing us and potentially faster in that space. The terms of reference include the ability to 'summon' senior leaders into the shadow CLE to answer questions and be held to account.

4.3 In principle the shadow CLE will likely be dubbed CoLE: our communities' leadership executive. This narrates where its power comes from, whereas the shadow appellation implies a following on that is not consistent with what it was evident CLE want and seek. Starting in 2026, we will need to nurture and develop the role, the space and those involved. But looking forward to 2028 and the renewal of another strategy, it is hard not to be excited about the opportunity for this body to really drive the evolution of our thinking. Resourcing and supporting the CoLE sits in a number of spaces and prior to launch I will document who is offering and enabling this meeting to be impactful, and, as per the table, for the meeting to be in a language and form that reflects its participants.

Discussion items

5.1 Consistent with the introduction to this paper, the community powered organisation we seek to be starts, but does not stop, with our own behaviours and approaches. **The Board needs to renew a conversation**, which can be developed further in informal time in April, about how we work and what we wish to do differently to the purpose of sharing power. That conversation is not unique to our communities, there is some crossover with our teams of staff: but unless we are explicit about the communities element the colleague coproduction may be the default.

5.2 The CIF is simply a framework for what we are trying to achieve. **How will we know how it going, and are we the right judge?** In 2025 we published a community led review of promise delivery, alongside our annual report. We will undoubtedly do the same in 2026. But the 80/20 must be tested for whether it is happened, what outcomes from that, and how we need to adapt to make more of a contribution.

5.3 We have set out to make tackling inequalities, and opening up our organisation to the wider community, routine management behaviour. We need to consider how our management processes, like audit, trajectory setting, planning to respond to care opinion, can be shared endeavours with our communities, and how our first thought when building capacity might be to lean out and buy in, not to employ ourselves. **This investment model (starting with what's strong) is a shift and the Board could play an insistent role in making it happen: how might we do that?**

Toby Lewis, January 22nd 2026

Annex A: RDaSH Community Involvement Framework

Community Involvement Framework

We want to:	
• work within our communities routinely, at neighbourhood/hyper local level	
• start with what is strong locally	
• be consistently considered in how we work and support others	
• stand alongside peers and partners	
To do this we will strive to:	
Draw in others to our work inside the Trust (20%)	**Lean into** the work of others where they are: supporting existing structures, networks, individuals and organisations (80%)
Policy development Committees and other forums Senior recruitment decisions Decisions made about service design Choices about what to prioritise	Use neighbourhood spaces for our work Prioritise conversations at place and neighbourhood level Join others' forums in preference to hosting our own Be open to organisations of different sizes and traditions – sharing data, skills, and funds wherever possible Support partnership efforts, working with all stakeholders: with an intentional bias towards seldom-heard residents and groups Recruit students, volunteers and staff from our local communities, creating opportunities for all Invest our funds locally, working with bodies who share our social values Offer time for our leaders and clinicians to immerse themselves within our communities
Success will be measured through our formal governance structures, ensuring we have achieved and sustained a quantity of change	**Success will be measured through feedback loops from individuals and partners, collected on a consistent basis from 2025 – 2028.** In addition we will publish data demonstrating (we intend) increased investment of time, money and skills within our local community against a 23/24 baseline.

Annex 2

Peer Support

Glyn Butcher

Director PGF & Peer Support Worker

Dr Jude Graham BEM

Director for Psychological Professionals and Therapies - RDaSH

Contents

- Background
- Progress
- Variety of peer support roles
- Peer and Volunteer
- Peer and governance
- Issues and learning
- Next peer ….. Peer Support Framework

Background

RDaSH Strategic Promise 1 – which is = Employ peer support workers at the heart of every service that we offer by 2027.

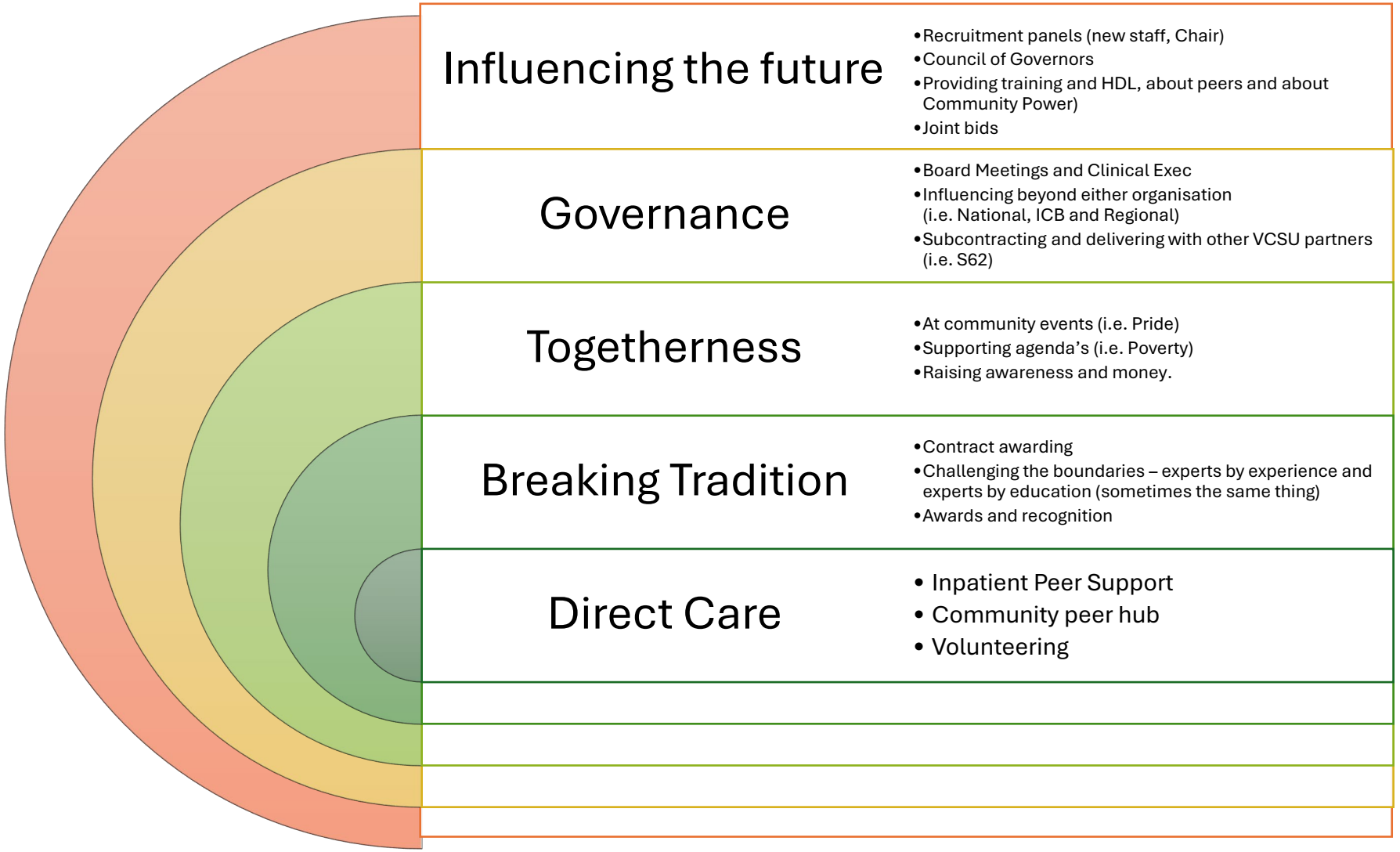
This must be understood in the context

- Promise 5 (the influence of lived experience connected to Trust governance) as these two promises are linked to an overall lived experience approach / framework.

Peer support, delivered by trained workers with lived experience of mental health difficulties is a recognised part of NHS mental health provision (NHSE 2023). In RDaSH we have had a small number of peer support workers employed in the organisation, primarily in children's mental health and adult learning disabilities service.

This paper will focus upon our progress to date with 'lived experience' influence and roles, performance and outcomes related to lived experience and as such the development of a 3-part Peer Support Framework.

Influence through layering



Progress

- – In 2023 we had 3 employed paid peer support workers in the organisation, all in children and young people's care group. Our other peer support roles in the organisations that were volunteer roles, in aspire substance misuse and some mental health services.
- Since the launch of our strategy, we have not only expanded our peer support partnerships with place community partners (i.e. S62, 'Better You', Family Lives and Patient Focussed Group). We have also actively worked in the High-Quality Therapeutic Care (HQTC) taskforce to ensure peer support workers on all 11 of our inpatient mental health and learning disability wards at RDaSH.
- In addition to this, there have been expansion of peer support roles in our Early Interventions in Psychosis Teams, Peri-natal services, and through the development of lived experience and peer support roles in the mental health rehabilitation pathways through the investment bids in 24/25. Our current position is

Name of Directorate (and Locality if applicable)	Number of Peer Support workers
Children's Mental Health Directorate	4
Children's Physical Health Directorate	1
Rotherham Mental Health Community Directorate	7
North Lincolnshire Community Directorate	5
Total	17

Variety of Peer Support & Lived Experience Roles

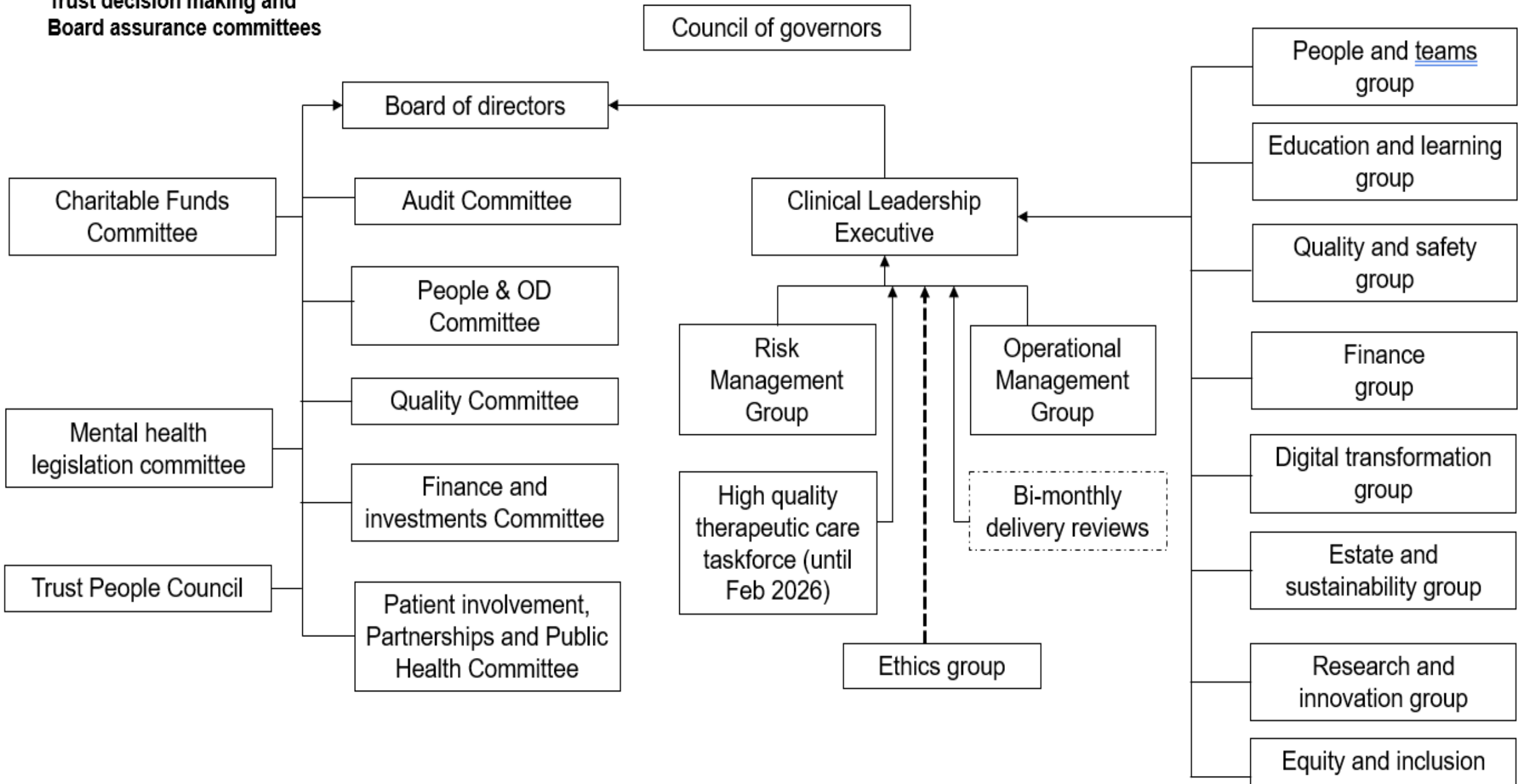
Volunteer

- Volunteer
- Paid roles

All staff influence

RDaSH 2024 and beyond

Trust decision making and Board assurance committees



Governance Meeting Attendance & Contribution

Meeting	Total Number of meeting	Number attended
Committees (Governor's attendance)		
Finance Digital and Estates Committee (2 x Gov)	12	9
Mental Health Act Committee (1 x Gov)	6	6
People and OD Committee (2 x Gov)	12	10
Public Health Patent Involvement and Partnerships Committee (2 x Gov)	12	5
Quality Committee (2 x Gov)	11	10
CLE Groups (Patient Representative attendance)		
Digital Transformation Group	6	4
Education and Learning Group	11	7
Equity and Inclusion Group	6	6
Estates and Sustainability Group	6	1
Finance Group	6	3
People and Teams Group	6*	1
Quality and Safety Group	6	5
Research and Innovation Group	6	5
Risk Management Group	12	5
Operational Management Group	10	7

Learning from first year of lived experience

What's working well?

- Feeling welcome by chairs and all in the meeting.
- Being able to access meetings in person or remotely.
- Introductions to all, including new people and deputies.
- Inviting contribution on specific matters, is helpful, especially if people attending are anxious.

What's not working well?

- The papers for meetings are still too long.
- There is no 'easy read' or quick read for many meetings, which makes them difficult to access and navigate.
- Too many things being scheduled in a meeting meaning some people cannot contribute to discussions.
- Abbreviations being used too much without explanations.
- Too much time taken in terms of presenting papers verbally in the meeting, potentially because some people have not read the paper before the meetings. This doesn't give much time for discussion.
- Some people cannot attend the meetings consistently and would like to potentially double up.
- Some people do not feel confident to speak in the meeting.

What could we do better?

- Not all chairs complete pre-briefs or debriefs, but it has been asked that it is consistently applied and therefore factored into chairs diary as part of the corporate assurance meeting booking processes.
- A pre-brief or equivalent process could provide the space to pre-submit questions if people feel anxious to speak in the meeting.
- Print minutes for people who require this. As some people said that they have not got the facility to print, and so sometimes they come without papers, or they spend a lot of money in paper and ink.
- Provide devices – laptops or small tablets to be able to read papers and linked documents. These have not been asked to be expensive, some tablets are less than £150. These could be returned if people leave the meeting.
- Abbreviations list with each paper / meeting.
- Easy read / quick read versions issued as well as full papers – this enables people to read which ever version most suits their wishes and abilities.
- Presenters to present the papers as 'read' and not speak about the paper for more than 2 minutes to enable discussion.

Other comments

- Some people who volunteer or join meetings to undertake these roles have never worked in or experienced our services. And have asked to shadow service visits or peer reviews or place assessments to enable their contribution.
- Some people have said that the meetings they are assigned to are not within their area of knowledge or experience and therefore a request has been made for a different matching process.

A lot is happening...@RDaSH

- Progress Leadership Development and Leaders ability to speak to the benefit and contribution of lived experience and peer support.
- Development / coproduce education and learning sessions for Learning Half Days (LHD) in terms of MDT case studies, boundaries, confidentiality and outcomes.
- Named worker involvement.
- Named activities with patients and carers.
- Access to Trust email address (and therefore weekly, and monthly briefings) and Electronic Patient Record (EPR)
- Relevant supervision (not general, but focussed on lived experience)
- Clear escalation processes (i.e. safeguarding, risk escalation, managing distress)
- Involvement of peer support workers in team meetings.
- Involvement of peer support workers in transformation, redesign and improvement programmes.
- Recording activity of peer support workers, and viewing this alongside non-peer support worker colleague data, to demonstrate impact.
- Inclusion of peer support workers in Directorate and Care Group recognition activity (i.e. awards)
- Organisational policy inclusion of peer support alongside other more traditional MDT roles.
- Equality Impact Assessments and Quality Impact Assessments, being supported by peer support and experts by experience.
- Career progression for people with lived experience.

Progress in Key Areas

- Activity and Access
- Experience and Satisfaction
- Patient outcomes
- Workforce
- Service Quality
- Equality an Diversity
- Culture and Inclusion (expanded on next slides)

Dashboard

1. How many people we supported	2. Access to Peer Support
People supported this month: _____	New people referred: _____
Total meetings or contacts: _____	Waiting time for first contact (days): _____
Average contacts per person: _____	People waiting: _____
How many contacts were face-to-face: _____	Did Not Attend (DNA) rate:_____
3. Outcomes – How people feel	**4. Experience of the service**
People feel better / more hopeful: _____	Friends and Family Test rating: _____
Wellbeing improved: _____	
People reached their goals: _____	Care Opinion feedback: Positive/ Negative
Crisis contacts reduced: _____	
A&E visits reduced: _____	Good feedback themes: _____
Hospital admissions reduced: _____	
Average time in hospital (days): _____	MDT (team) satisfaction: _____

Outcomes

- – In 2023 we had 3 employed paid peer support workers in the organisation, all in children and young people's care group. Our other peer support roles in the organisations that were volunteer roles, in aspire substance misuse and some mental health services.

- Since the launch of our strategy, we have not only expanded our peer support partnerships with place community partners (i.e. S62, 'Better You', Family Lives and Patient Focussed Group). We have also actively worked in the High-Quality Therapeutic Care (HQTC) taskforce to ensure peer support workers on all 11 of our inpatient mental health and learning disability wards at RDaSH.

- In addition to this, there have been expansion of peer support roles in our Early Interventions in Psychosis Teams, Peri-natal services, and through the development of lived experience and peer support roles in the mental health rehabilitation pathways through the investment bids in 24/25. Our current position is

Difference in Peer and Lived Experience

Issues and Resolution

What we invest (Inputs)	What the service does (Activities)
• Lived experience workforce (Peer Support Workers, Lived Experience Leads) • Training programmes (peer-specific, induction, safeguarding, trauma-informed training) • Supervision structure (lived experience supervision anf line management) • Funding and staffing establishment • Clinical team support and MDT integration • Policies: peer support framework, EDI, safeguarding. • Digital tools and workspace for peers to use • Co-production capacity and time enabled • Partnerships with VCSE and community organisations	• Provide 1:1 peer support intervention • Co-facilitate recovery groups and wellbeing groups • Support goal setting and recovery planning • Deliver hope-based, strengths-based conversations • Use lived experience to role model recovery and self-management • Provide support in community and inpatient settings • Signposting to community resources and social inclusion opportunities • Co-production of service improvements • Engagement with families/carers where appropriate • Training staff teams in lived experience approaches • Collecting outcome measures and feedback

Outcomes and measurable activity (Output)	Short- and Medium-Term Changes
Full explanation provided in paper above and Annex 3 & 4. Examples: • Number of individuals receiving peer support • Number of peer support sessions delivered • Number of groups co-facilitated • Number of recovery stories or co-produced resources • MDT meetings attended • Care plans co-developed • Number of co-production events/projects • Staff teams trained in peer support principles • Recorded wellbeing or recovery measures completed	For Service Users • Increased sense of hope, control & recovery • Improved confidence, self-efficacy, and self-management • Reduced loneliness/social isolation • Increased engagement with care • Faster transitions and reduced DNAs For Staff & Teams • Improved team culture & recovery orientation • Reduced stigma towards lived experience • Improved communication between services • Better relationships between service users and clinicians For the Peer Workforce • Increased job satisfaction • Clearer role identity and development • Reduced burnout due to supportive supervision

Long-Term Impact	What must be true for this to work (Assumptions)
• Improved recovery outcomes • Reduced use of crisis and urgent care pathways • Better transitions from inpatient to community care • Enhanced patient experience across services • Increased community connection and independence • Strengthened co-production culture • Sustained lived experience leadership across the organisation • Contribution to NHS commitments for personalised care and workforce diversification	• Peers receive high-quality training and supervision • MDTs value and integrate peer roles • Clear boundaries and safeguarding expectations • Trust culture supports lived experience leadership • Services commit to co-production and continuous improvement External Factors • Workforce shortages and funding constraints • Community resource availability (VCSE) • National NHS policy (e.g., personalised care, trauma-informed approaches) • Social determinants of health • Digital access

Next Steps.....

Any Questions?

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR) – January 2026	**Agenda Item**	Paper T
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	29 January 2026

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

This month we do not include the Health Inequalities background analysis: this will return in March after consideration of format and clear Insights conclusion.

Delivery against the Top Nine priorities has strengthened, notably the 4-week wait, improving from 32% at Q1 to 70.9% in December, while a small reduction of what was expected in December, we are anticipating all services to be on track to achieve compliance by April 2026. Children and Young People, Physical Health, and Adult Mental Health services continue to perform strongly, with high compliance against access standards and no 52-week waits. Talking Therapies access remains significantly below plan (12,885 YTD vs 16,939 target) and is not forecast to recover in 2025/26 despite year-on-year growth equating to 12.64%.

Quality and safety performance is largely positive, with no ligature or suspected suicide incidents and improved falls risk assessment compliance. We have again seen an increase in reported racist events (18 in December, up from 12), and while concentrated around a small number of patients, this is only what is reported so necessitating ongoing workforce safety and culture interventions. From a workforce perspective, PDR and mandatory training compliance remain high, vacancies are reducing, following the work in December to align budgets with ESR. Vacancy rate remains elevated at 5.14% vs 2.5% target. Sickness absence remains high at 6.59% vs 5.1% target, with a notable increase in short-term sickness and stress/anxiety now accounting for 42.4% of absences.

Financial performance is stable, with a £485k YTD surplus and a breakeven forecast but this is highly dependent on vacancy slippage and one-off mitigations. HDRU (phoenix) income shortfall remains a significant unresolved risk due to lower-than-expected ICB placements, directly impacting savings delivery. This means our savings programme is £201k off plan, with recovery not expected in-year.

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

Relevant committees of the Board

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE reported delivery and consider areas of under achievement against our year end commitment

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)							
Na							
System / Place impact (advise which ICB or place that this matter relates to)							
Largely incorporates commissioned and instructed national standards							
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

January 2026 Review

Data as at the 31st December 2025

Contents

1.0 Executive Report

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 December 2025.

Performance Highlights and Areas for Improvement

Top Nine

The Trust has prioritised delivery against nine key performance metrics in 2025/26. Monthly Performance Clinics continue to provide enhanced oversight and a focused approach to performance management. Tailored improvement plans, alongside weekly performance monitoring and forecasting, are supporting achievement against several key targets. These include **Children and Young People's Access (T901), Out of Area Placements (T906), Perinatal Services Access (T907b) and Dementia Diagnosis (T906).**

Significant progress has been made in relation to the **4-week wait (4WW, T909)**, with the percentage of services meeting the standard increasing from 32% at the end of Q1 to 70.89% by the end of December. Although the Q3 target was not fully achieved, further improvement is anticipated in Q4. It should be noted that Adult ADHD and Autism services, as well as Children and Young People's neurodiversity services, are included within this metric; therefore, Physical Health and Children's services will not achieve 100% compliance. All other care groups remain on track to achieve the standard by April 2026. Ongoing delivery is supported through a continued focus on achievement, monitored via the weekly waiting list meeting.

Within the top nine, there are some metrics where we continue to require intervention.
In our Talking Therapies service (**T903a,b,c) Access Rate** performance stands at 12,885 year-to-date, against a target of 16,939. This represents an increase of 1,474 accesses compared with the same period last year (11,411). While the service is not currently forecasting achievement of the 2025/26 target, year-to-date performance reflects a 12.65% increase compared with 2024/25. To support further improvement, the service is developing long-term conditions pathways in North Lincolnshire to ensure equitable access across the Trust. Work is also underway to embed physical activity within mental health services, in partnership with Sport England, with Doncaster acting as a trailblazer site. Additionally, in Rotherham, community venues are being explored to increase face-to-face capacity **Reliable Recovery** performance reached 49.48% in December, exceeding the 48% target, though year-to-date performance remains slightly below target at 47.91% following reduced Q1 and Q2 results. A known data quality issue affecting cross-site patients has been corrected, with further improvements ongoing. Weekly clinician-level outcome monitoring continues and is reviewed in supervision sessions. Additional analysis is underway for patients receiving fewer than four interventions or ending treatment early to identify opportunities to improve outcomes. Year-to-date performance is expected to exceed 48% within Q4. The **Reliable Improvement** across the cohort of individuals receiving treatment within our Talking Therapies Services remains above the 67% target demonstrating that talking therapy has made a real, measurable difference to a patient's mental health.

The metric for occupancy hours lost due to breaches within our three **Section 136 suites (T905)** is currently inaccurate because the report duplicates breaches when a suite is re-purposed. The Informatics team is working on a fix, and data quality issues are expected to be resolved by Friday, 16th January 2026. For this month, the actual breaches total 94 hours lost:

- Doncaster Suite: 35 hours (21 hours from two suite re-purposed, 14 hours from one suite closure)
- Rotherham Suite: 35 hours (26 hours from two re-purposed, 9 hours from one extended Section 136 due to access)
- North Lincolnshire Suite: 24 hours (one suite closure). Action is being taken by the DCGD to review suite restrictions (led by NL) and improve how this data is captured and monitored.

The metric measuring the number of people accessing individual placement support has remains below the target of 90 individuals, reporting 83 at the end of December (up from 72 as at the end of November). Recruitment has completed however the employment specialists are required to complete training prior to taking on a full caseload, scheduled to complete January 2026.
The final metric this month is the **length of stay of our inpatients** where the target is 32 days. Our position from this month is 59 days (up by 1 day from 58 days). It is noted that a focus is required in all three localities to ensure timely discharge of patients when clinically appropriate. Rotherham remains an outlier for long LoS, but North Lincolnshire has seen a significant increase this calendar year.

1.0 Executive Report

Children and Young People (CYP) Services continue to deliver strong performance. The number of CYP receiving at least one clinical contact within a rolling 12-month period remains one of our top nine metrics, exceeding the target of 9,424 with a reported figure of 10,914. The Children's Eating Disorder Service also demonstrates excellent results. It achieved 100% compliance with the target to see the most urgent cases within one week (OP15) throughout the year. For the four-week waiting time standard, 93.54% of CYP were seen within four weeks, with nine breaches recorded during the 12-month rolling period (4 in Dec 2025, 1 in Nov 2025, 1 in May 2025, 2 in March 2025, and 1 in Jan 2025). Of these breaches, eight occurred despite appointments being offered within the four-week timeframe, as parents/carers either cancelled, rearranged, or opted for later appointments. The remaining breach in December 2025 was outside the four-week wait due to service capacity constraints over the Christmas period.

Physical Health Services continue to deliver consistently strong performance. Both 18-week referral-to-treatment standards (OP08b and OP08c) for AHP-led and consultant-led pathways exceeded the 92% target, with all patients treated within 18 weeks. Importantly, there are no patients waiting longer than 52 weeks for treatment (OP10c).

The **Virtual Ward** (LTP06), which supports care at home as an alternative to hospital admission, reported occupancy well above the 80% threshold on 30 December, reaching 95%. This represents a notable improvement against the downward trend observed over the previous five months.

Adult and Older Adult Mental Health 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.

The Neurodevelopmental Services continue to experience long waits with the adult ADHD assessment waiting list currently standing at 6,005 individuals, an increase from 5,893, and remains above the trajectory target of 5,267 (OP59a). This variance reflects a number of assumptions within the original trajectory that have not materialised as anticipated, including ongoing recruitment challenges and delays in the implementation of new systems. The Care Group is working closely with the Performance Team to revise the trajectory so that it more accurately reflects current operational capacity. A draft revised trajectory is presented for approval. The CYP neurodevelopmental waiting list comprises 4,756 individuals, a reduction from 4,812, but continues to exceed the target of 2,249. The list increased by approximately 700 children in April 2025 following the transfer of cases from the Doncaster and Bassetlaw Trust Autism Service. A revised trajectory for this pathway is also developed in draft and presented for approval.

Quality and Patient Safety
Overall, continued improvement has been observed across several key quality and safety metrics. There were no reported incidents of ligature (QS27) or suspected suicide (QS23). In addition, for the first time, the Trust has exceeded the target for falls risk assessment compliance, with 95.89% of inpatients receiving a falls assessment within 12 hours of admission, exceeding the 95% target.

Safer Staffing (QS15)
In December, 88.24% of wards (15 out of 17) reported registered staff levels above the 90% threshold, which remains below the target. Kingfisher Ward experienced locally managed rostering issues. Laurel Ward was impacted by maternity leave and sickness absence; staffing was supported through redeployment from Mulberry Ward.

MUST Assessment (QS36)
A three-month downward trend continues in the completion of MUST assessments, reducing to 82.17% (129/157) in December from 84.97% (147/173) in November. MUST has now been embedded into the admission checklist. Compliance is subject to daily oversight by inpatient ward managers and is reviewed through PIPA (Mental Health), Board Rounds (Physical Health), and Care Group Governance Meetings.

1.0 Executive Report

Workforce Development
The percentage of employees receiving a performance and development review (PDR) remains above the 90% target for the third consecutive month reporting 90.50% along with the completion of mandatory and statutory training which is reported at 95.04%.

Trust Retention (POD09)
The trust retention rate on a rolling 12 month remains above the 10% target. Turnover for December was 10.32% Turnover remains above normal trend. All Care groups are reporting turnover rates above trust target, with the exception of Doncaster MH and LD who are reporting 9.1% and Children's who are reporting 9.5%. North Lincs MH and TT are the highest reporting 11.2%.

Sickness (POD10)

The Sickness Absence % is above target (6.59% vs 5.1%), LTS sickness has remained static at 5% since July 25 however STS has slowly increased since June 25 and significantly jumped from 2% to 2.7% in the last month. This time last year December was 7.11% and 12 months was 6.33% however the issue last year was LTS which increased from 4% to 5.2%. Top reason for sickness continues to be Anxiety/Stress - however this was 35.8% for Jan - Dec 24 and 42.4% for Jan - Dec 25

Recruitment (POD25)
The recruitment KPI continues to breach, this is primarily down to the National reporting requirements which have been reduced to 8 weeks (previously 12 weeks) hence the reduction in performance, whilst the recruitment KPI's have deteriorated the Trust position remains strong - this has been recognised by the Civica Benchmarking Awards 2025 with the Trust winning the Time to shortlist award.

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.

Vacancy Rate (POD16/17(

The vacancy rate decreased from 216 to 193 vacancies in December, currently standing at 5.14%. against a target of 2.5%.. All of the care Groups have reviewed the vacancies to ensure accuracy. Finance and HR are undertaking a further review to ensure the positions are fully aligned. For 2026/27 budgets – budget sign off is expected in February and as such any changes required for 2026/27 will be made in advance of the commencement of the financial year.

Finance
At M9, the year to date (YTD) position is a surplus of £485k; this is £537k better than planned. The main drivers for this are vacancies at a higher level than the planned 2.5%. This is masking pressures, however, in other areas such as reduced interest rate income and increased drugs and secure transport costs

The forecast is too breakeven in line with the plan. This assumes that £1.8m deficit support funding will be received in year, which is £0.6m less than plan as NHSE have confirmed funding will be withheld as the overall South Yorkshire position is forecast to be worse than plan. It is still possible to forecast breakeven though as £0.2m unexpected industrial action funding has been confirmed and recruitment to vacancies is not happening as quickly as previously thought. The significant risk that emerged during M7 relating to the HDRU still remains as the ICB have not placed as many patients as expected in the service resulting in a loss of planned income. Urgent action from Executive and operational colleagues continues to resolve this

2.0 - Performance – In Focus

Indicators for December 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		17/17	100.00%		92.48%	>= 60%	92.44%
OP03a (L)	T903a	People accessing Talking Therapies - Cumulative Annual			1236		4094	>= 16939	12885
OP03b (L)	T903a	People accessing Talking Therapies - Cumulative Quarterly			1236	Q3 >= 5748	4094		12885
OP03c (N)	T903b	Reliable recovery rate within Talking Therapies		287/580	49.48%		50.13%	>= 48%	47.91%
OP03d (N)	T903c	Reliable Improvement rate within Talking Therapies		419/603	69.49%		68.89%	>= 67%	67.73%
OP05 (N)		People in physical health crisis assessed within 2 hours		34/42	80.95%		76.81%	>= 70%	86.08%
OP07b (L)	T907	Women supported by perinatal MH service (Rolling 12M)			623		623	>= 574	623
OP08b (L)		18 wks RTT for AHP led Physical Services		207/241	85.89%		88.34%	>= 92%	94.39%
OP08c (N)		18 weeks RTT for consultant led Physical Health services		44/45	97.78%		98.59%	>= 92%	98.47%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		190/190	100.00%		99.25%	>= 92%	99.22%
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		80/90	88.89%		87.63%	>= 80%	90.06%
OP13a (N)	T901	People accessing CYP services with >= 1 contact (13mth roll)			10914		10914	>= 9424	10914
OP13b (N)		People accessing CYP services >= 2 contacts and paired		903/5874	15.37%		15.89%	>= 20%	15.36%

Narrative

OP03a – Reporting 12,885 for the year-to-date position against a target of 16,939. When compared with activity in the same period last year (11,411) we are reporting 1,474 above last year's actual.

OP03c – Performance reported as 49.48% in December above the target of 48%. Year to date performance remains slightly below the 48% target, reporting 47.91%.

OP13b – Reporting 15.37% in December below the 20% target.

2.0 - Performance – In Focus

Indicators for December 2025/2026 TRUST — Performance

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP13e (N)		CMHT access rate (DW not MHSDS) (>=1 Contact)			10869		10869	>= 7331	10869
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		81/90	90.00%		92.79%	>= 95%	93.54%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		0/100	0.00%			>= 95%	100.00%
OP17c (N)	T904	The number of active inappropriate adult acute OAPs			6		6	<= 13	6
OP54c (L)		Virtual ward occupancy - on day 30		57/60	95.00%		95.00%	>= 80%	95.00%
OP59a (L)		Waiting List - Adult ADHD			6005		6005	< 5267	6005
OP59b (L)		Waiting List - CYP Neurodevelopment			4747		4747	<= 2194	4747
OP60 (L)	T906	Dementia Diagnosis rate		7551/9891	76.34%		76.37%	>= 67%	75.54%
OP61c (N)		Patients with SMI having full annual physical health check		2869/3772	76.06%		76.06%	>= 95%	76.06%
OP73a (L)	T905	Section 136 Breaches – Occupancy hours lost to breaches			97		542	= 0	761
OP77c (L)	T902a	Mean Spell LOS Current Inpatients (Internal Beds/Month-End)			59		59	<= 32	59
OP77d (L)	T902b	% Inpatients Spell LOS > 32 Days (Internal Beds/Month-End)		61/116	52.59%		52.59%		52.59%
OP78 (L)	T908	Number of people accessing Individual Placement Support	>= 90		83		83		83
OP80 (L)	T909	% Services meeting 4 week wait target at end of month		56/79	70.89%	Q3 >= 80%	70.89%		70.89%

Narrative

OP14 – The metric measuring over a 12-month rolling period is reporting at 93.54%, below the 95% target. 9 Breaches in the 12 month rolling period (occurred: 4 in Dec 25, 1in Nov 25. 1 in May 25 2 in March 25, 1 in Jan 25)

OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 6,005 adults waiting for assessment against the target of 5,267. 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 4,747 (down from 4,759) CYP waiting against the target of 2,194. 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 76.06% (up from 70.32%) against the 95% target.

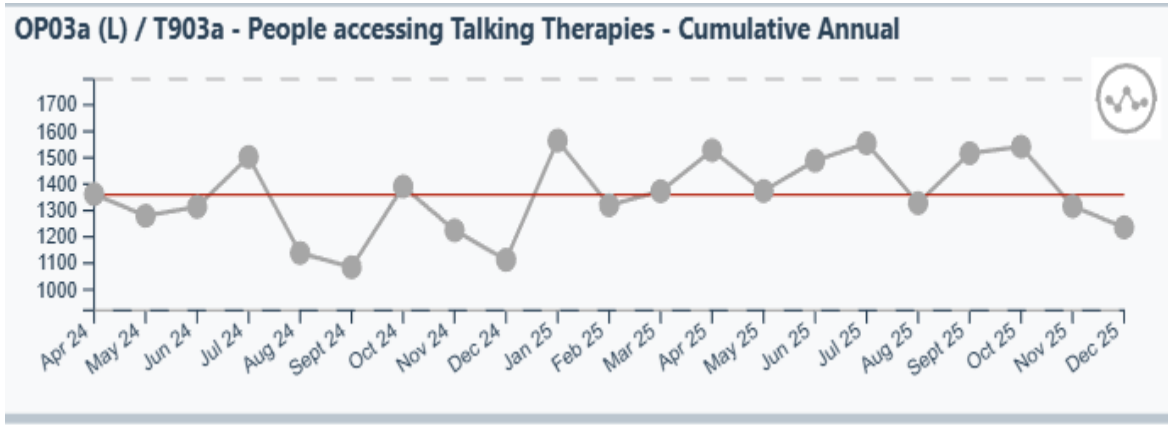
OP73a – the metric measures the occupancy hours is currently duplicating the breaches for when the suite is repurposed and work is underway to resolve the reporting issue. Exceptions outlined in pack.

OP77c - The metric reporting the mean length of stay for patient who remain on the wards is reporting a 59 day mean length of stay against the target of 32 days.

OP78 – IPS in North Lincolnshire remains below the 90 target reporting 83 due to delays in recruitment.

OP80 – The 4WW position reporting against the end of December target is reporting 70.89%

2.1 Performance In Focus - Exceptions

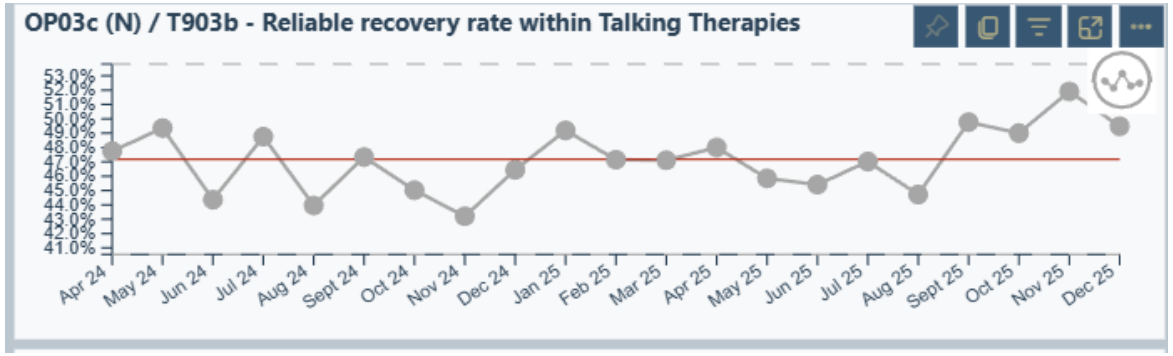


Trend, Reason and Action

OP03a - Access Rate performance stands at 12,885 year-to-date, against a target of 16,939. This represents an increase of 1,474 accesses compared with the same period last year (11,411).

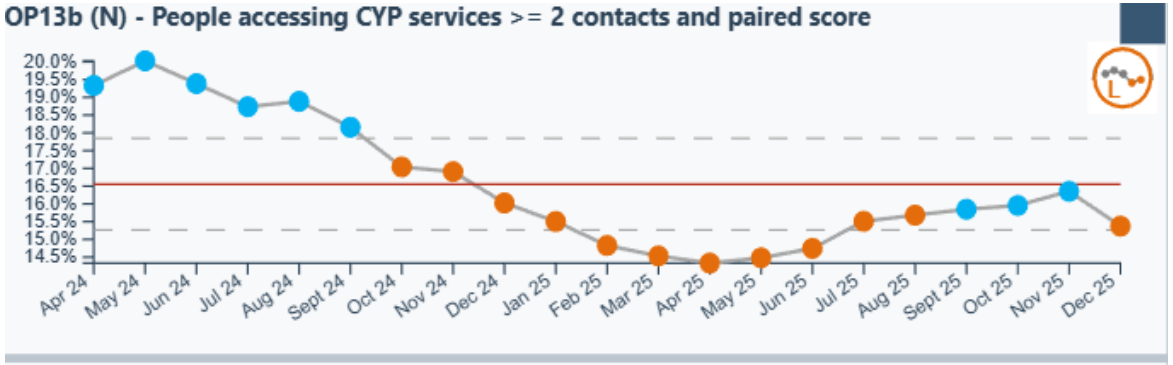
While the service is not currently forecasting achievement of the 2025/26 target, year-to-date performance reflects a 12.65% increase compared with 2024/25.

To support further improvement, the service is developing long-term conditions pathways in North Lincolnshire to ensure equitable access across the Trust. Work is also underway to embed physical activity within mental health services, in partnership with Sport England, with Doncaster acting as a trailblazer site. Additionally, in Rotherham, community venues are being explored to increase face-to-face capacity.



Trend, Reason and Action

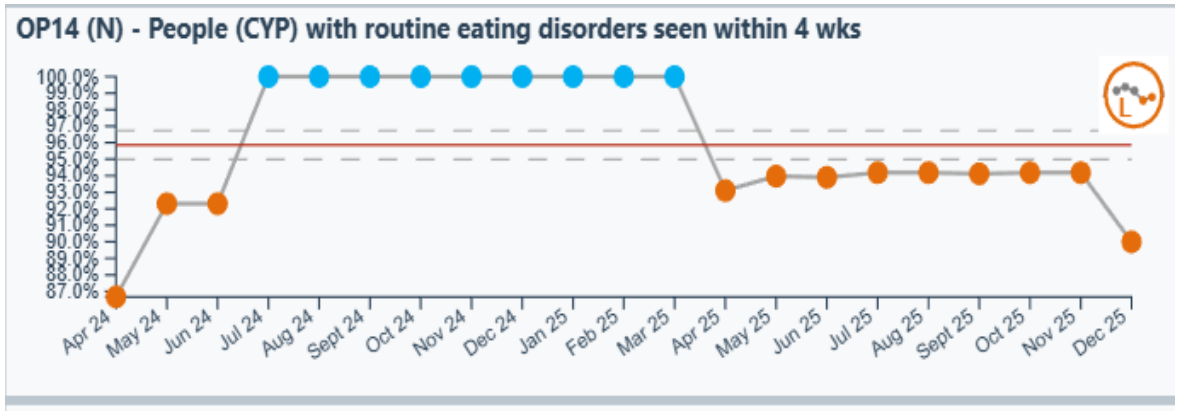
OP3c - Reliable Recovery performance reached 49.48% in December, exceeding the 48% target, though year-to-date performance remains slightly below target at 47.91% following reduced Q1 and Q2 results. A known data quality issue affecting cross-site patients has been corrected, with further improvements ongoing. Weekly clinician-level outcome monitoring continues and is reviewed in supervision sessions. Additional analysis is underway for patients receiving fewer than four interventions or ending treatment early to identify opportunities to improve outcomes. Year-to-date performance is expected to exceed 48% within



Trend, Reason and Action

OP13b - The CYP access 2 contacts and a paired scored has seen a slight deterioration in performance in December. 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.

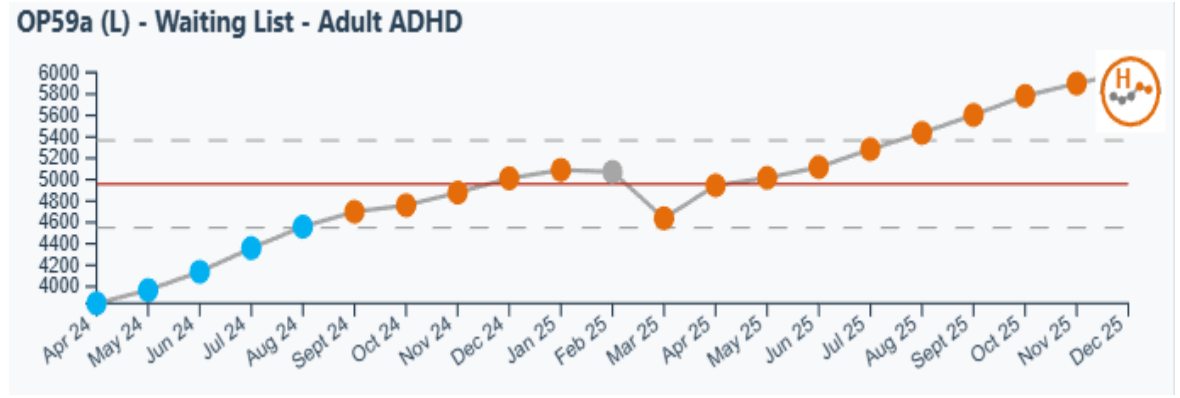
2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP14 - Children and young people with routine eating disorders is reporting 9 Breaches in the 12 month rolling period (occurred: 4 in Dec 25, 1in Nov 25. 1 in May 25 2 in March 25, 1 in Jan 25)

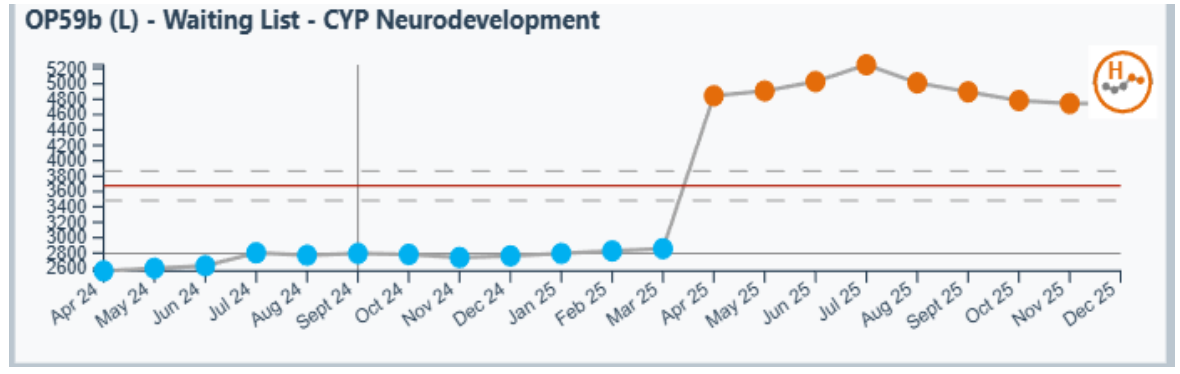
8 of the 9 breaches appointments were offered within the 4 week timescale however parents/carers either cancelled and rearranged or opted to take an appointment outside of the 4 weeks. 1 breach has taken place outside of the 3 week wait in December 25 due to service capacity over the Christmas period.



Trend, Reason and Action

OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting at 6,005 (up from 5,893) at the end of the reporting and remains above the target of 5,267.

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.

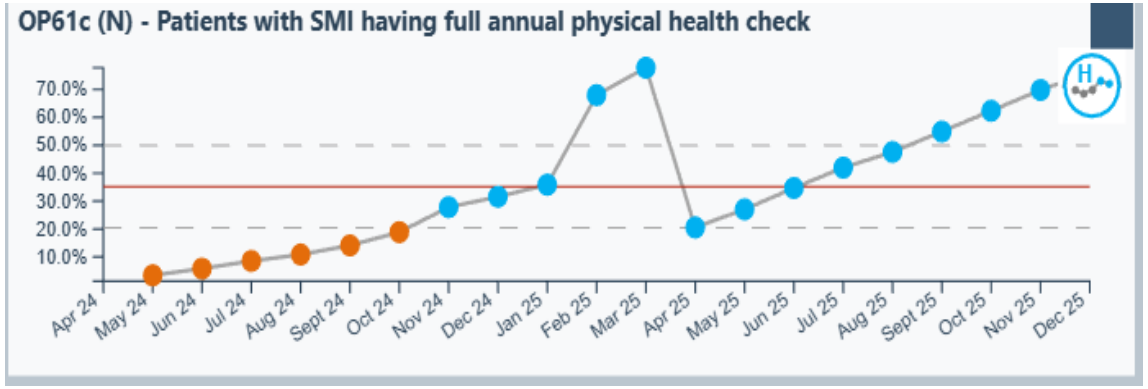


Trend, Reason and Action

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting at 4,747 (down from 4,759) at the end of the calendar month however, remains above the projected target of 2,194.

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.

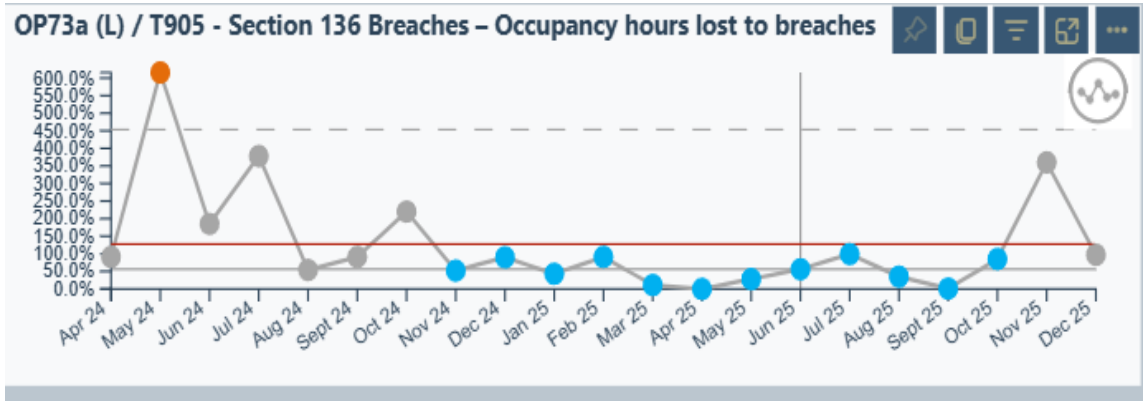
2.1 Performance In Focus - Exceptions



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 76.06% (up from 70.32%)

Improvement initiatives are in place which include a continuing focus on declines across all 3 Care groups, embedding POC machine blood testing, and support from peer support workers to support access. SMI compliance and actions for improvement have been scrutinised at OMG in November and will be re-presented by Care Groups at January's meeting to ensure improvement in all three care groups.

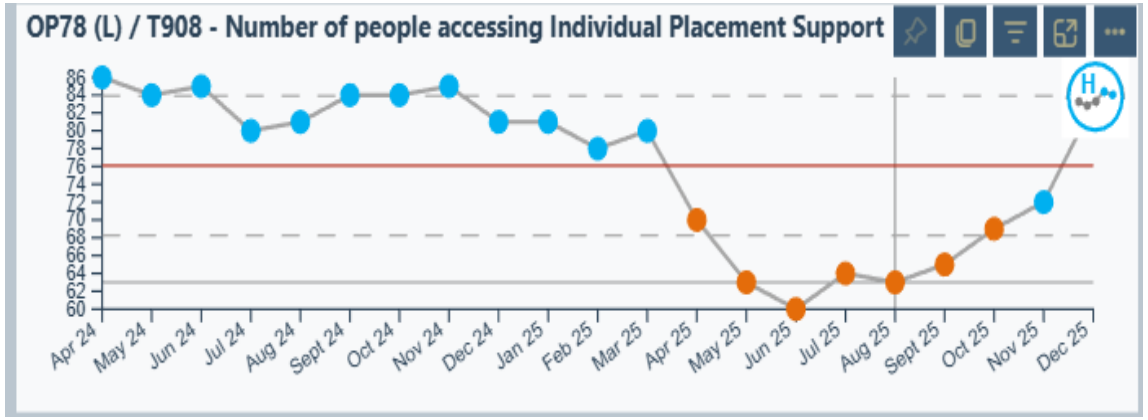


Trend, Reason and Action

OP73A—The metric for occupancy hours lost due to breaches within our three Section 136 suites (T905) is currently inaccurate because the report duplicates breaches when a suite is re-purposed. The Informatics team is working on a fix, and data quality issues are expected to be resolved by Monday, 16 January 2026. For this month, the actual breaches total 94 hours lost:

•Doncaster Suite: 35 hours (21 hours from two suite re-purposed, 14 hours from one suite closure)

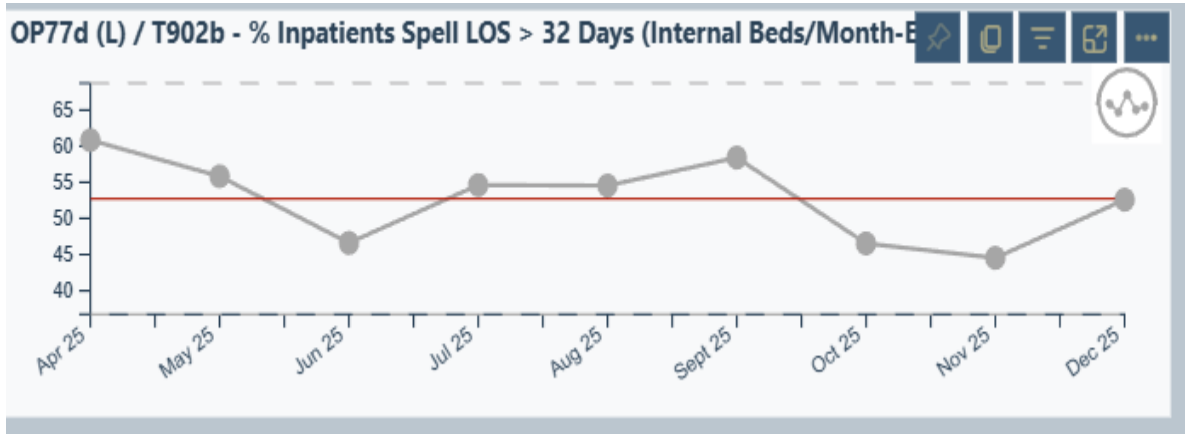
•Rotherham Suite: 35 hours (26 hours from two re-purposed, 9 hours from one extended Section 136 due to access) North Lincolnshire Suite: 24 hours (one suite closure). Action is being taken by the DCGD to review suite restrictions (led by NL) and improve how this data is captured and monitored.



Trend, Reason and Action

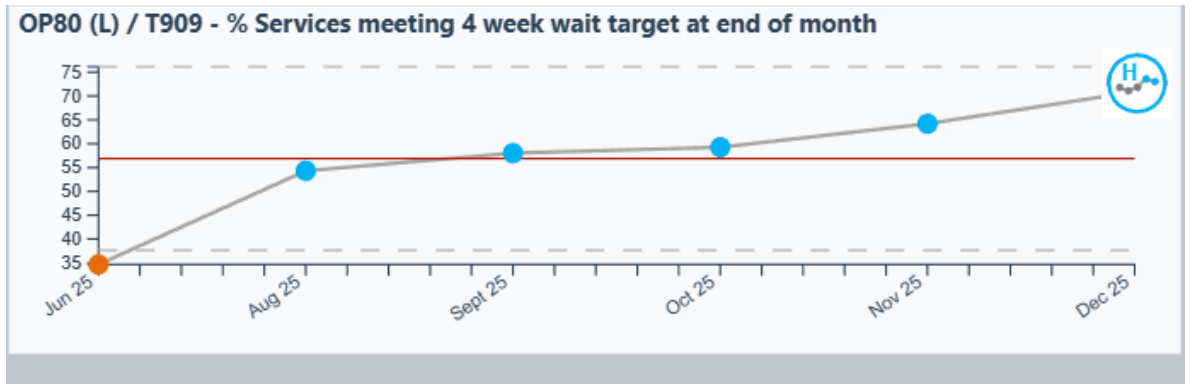
OP78 / T908 The metric measuring the number of people accessing individual placement support has remains below the target of 90 individuals reporting 83 at the end of December (up from 72 as at the end of November). Recruitment has completed however the employment specialists are required to complete training prior to taking on a full caseload scheduled to complete January 2026.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP77d – Our position from this month is 59 days (up from 58 days in previous month). It is noted that a focus is required in all three localities to ensure timely discharge of patients when clinically appropriate. Rotherham remains an outlier for long LoS, but North Lincolnshire has seen a significant increase this calendar year.



Trend, Reason and Action

OP80 - We have made significant progress from 32% of services at the end of Q1 to 70.89% of services at the end of December with 56 of our services meeting the 4 week wait target. It is noted that a number of Care groups have services where they have a small number of patients over the 4 WW with appointments planned during the next few weeks and some cancellations in December by attendees have led to a number of services just missing the Q3 target. Each of the Care groups continue to focus with oversight provided at the weekly waiting list meeting to ensure the delivery of the 4 week wait for all services excluding Adult ADHD and Autism and CYP neurodiversity by the end of March 2026.

3.0 Quality & Safety In Focus

Indicators for December 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
QS08	Bi patients >= 16 admitted with completed VTE	>= 95%	142/154	92.21%	>= 95%	93%	>= 95%	95%
QS15	No of wards reporting registered staff on nights/days >90%	>=90%	15/17	88.24%		91%	>= 90%	93%
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		13	0	22
QS21a	Physical agression incidents mod or above to staff (%)		21/323	6.50%		8%		8%
QS21b	Physical agression incidents mod or above to staff/pats (%)		6/323	1.86%		2.04%		3%
QS23	Number of Suspected Suicides (inpatient settings)	0		0	0	1	0	1
QS27	Ligature incidents mod or above all inpatient areas			0.00%		19%	>=10%	15%
QS29	Number of racist incidents against staff members			18		49	0	170
QS31	Episodes of seclusion - Internal MDT within 5 hours		7/7	100.00%		70.00%	100%	78.00%
QS36	Inpatients that have a completed MUST assessment		129/157	82.17%		84.29%	100%	83.41%
QS37c	Inpatients commenced falls assessment in 12 hrs		70/73	95.89%		89.37%	100%	84.03%

Narrative

QS08- The percentage of VTE assessments completed within 24 hours has declined to 92.21% (142/154) from the 94.71% (161/170) reported in November.

QS15 – The number of wards reporting registered staff below 90% for the month of December is below target at 88.24% (15/17 wards).

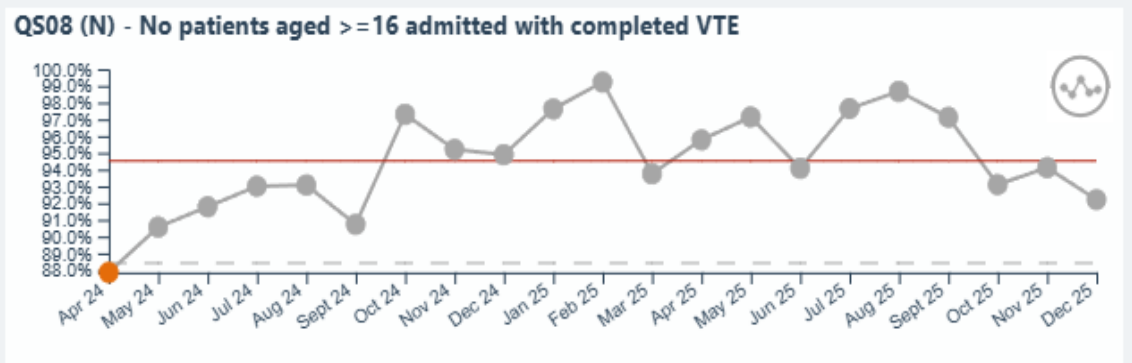
QS29 – Reporting an increase to 18 racist incidents reported in December from the 12 reported in November.

QS31 –The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting an increase to 100% (7/7) from the 66.67% reported in November.

QS36 - Reporting a three month decline to 82.17% (129/157) in December from the 84.97% (147/173) in November and 86.30% reported in October of the % of Inpatients that have a completed MUST assessment.

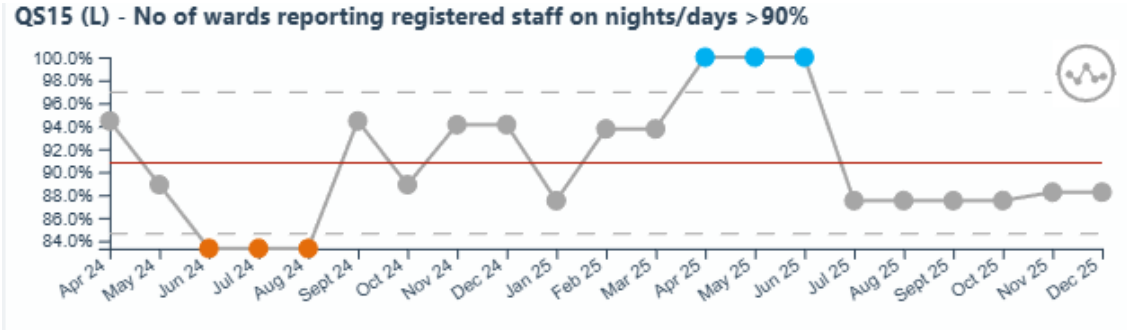
QS37 –This metric is showing an increase to 95.89% (70/73) from the 83.33% (75/90) reported in November of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission.

3.1 Quality and Safety In Focus - Exceptions



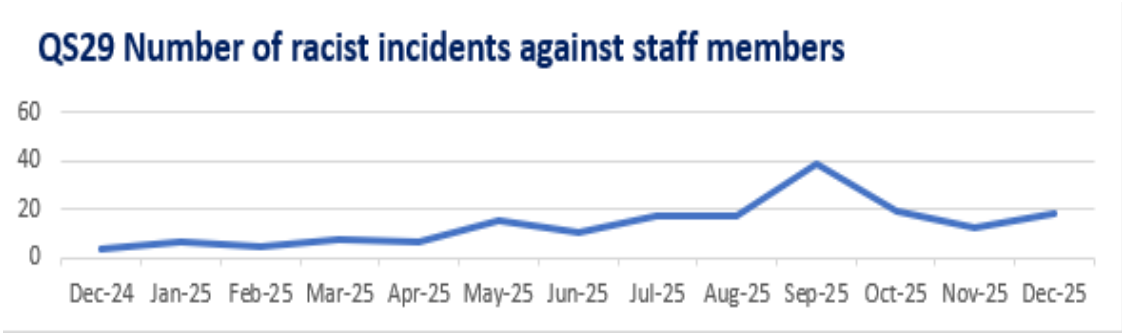
Trend, Reason and Action

QS08- The percentage of VTE assessments completed within 24 hours has declined to 92.21% (142/154) from the 94.71% (161/170) reported in November. There will be ongoing monitoring in all Care Group during January to ensure there is an improvement, and any learning can be addressed more promptly with feedback to individual clinicians and any actions to learn from each delay is implemented. The recent three-day Doctor's strike may have impacted on the compliance.



Trend, Reason and Action

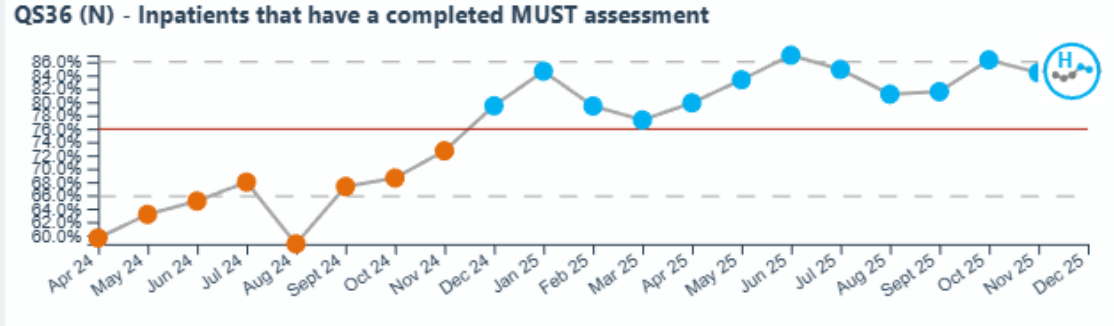
QS15 – The number of wards reporting registered staff below 90% for the month of December is below target at 88.24% (15/17 wards). Kingfisher ward experienced issues with the rostering that have been managed locally, this relates predominately to above tolerance to leave arrangements. Laurel Ward experienced maternity leave and sickness that impacted on staffing, the ward was supported by staff on Mulberry Ward.



Trend, Reason and Action

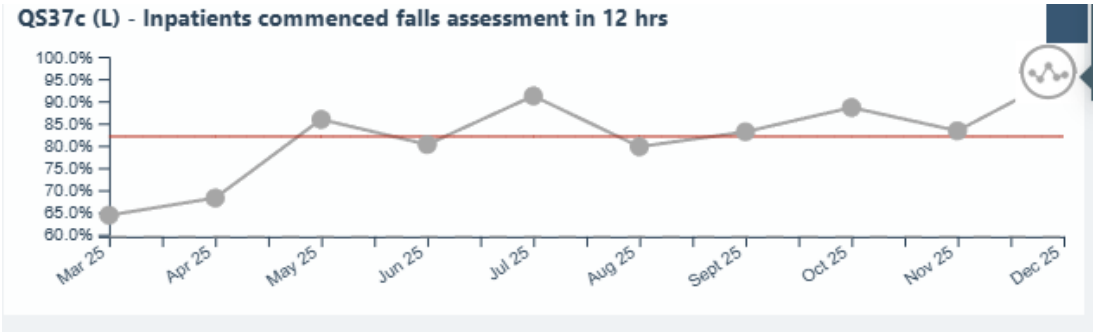
QS29 – Reporting an increase to 18 racist incidents reported in December from the 12 reported in November. One patient who is responsible for a high number of incidents is in the Rotherham Care group. Improvement and Culture are supporting the Care Group and a bespoke space and time out is available to support staff. All Care Groups are continuing to follow the acceptable behaviour policy where appropriate.

3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

QS36 - Reporting a three month decline to 82.17% (129/157) in December from the 84.97% (147/173) in November and 86.30% reported in October of the % of Inpatients that have a completed MUST assessment. MUST has been included in the admission checklist and is being led with daily oversight by the inpatient ward managers and is to be discussed in PIPA (Mental Health), Board Round (Physical Health) and at the Care Group Governance Meetings.



Trend, Reason and Action

QS37 –This metric is showing an increase to 95.89% (70/73) from the 83.33% (75/90) reported in November of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission. We have reached the aspirational target of 95% by the end of Q3 and we are looking to retain and maintain this in Q4 and throughout the next financial year.

4.0 People and Organisational Development – In Focus

Indicators for December 2025/2026 TRUST — Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	10.32%		10.32%		10.32%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	6.59%				
POD12 (L)	Number staff who have had an annual flu vaccination		2521		2521	= 0.7	2521
POD15 (L)	Number of Consultant Vacancies	<= 10	8		8		8
POD16 (L)	Qualified nursing vacancies	<= 2.5%	6.04%		6.59%		6.86%
POD17 (L)	Support worker vacancies	<= 2.5%	6.58%		6.92%		5.80%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	90.50%		90.50%		90.50%
POD19a (L)	Individuals completed mandatory/statutory training	> 90%	95.04%		94.76%		94.57%
POD23 (L)	Number of individuals currently suspended from employment		0				
POD24 (L)	Average suspension length in calendar days	<= 150	0		0		0
POD25a (L)	% recruitment completed in 8 wks [Advert to checks complete]	>= 95%	62.36%		60.04%		66.82%
POD26 (L)	Compliance for safeguarding children's training		93.55%		93.55%		93.55%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		97.49%		93.68%		93.24%
POD28 (L)	Total Vacancies		193		193		193
POD29 (L)	Total Vacancy Rate %		5.14%		5.14%	<= 2.5%	5.14%

Narrative

POD09 – Total retention rate on a 12-month rolling period is reporting 10.32% and remains above the 10% target.

POD10 – working days lost to sickness is reporting 6.59% against the 5.1% target.

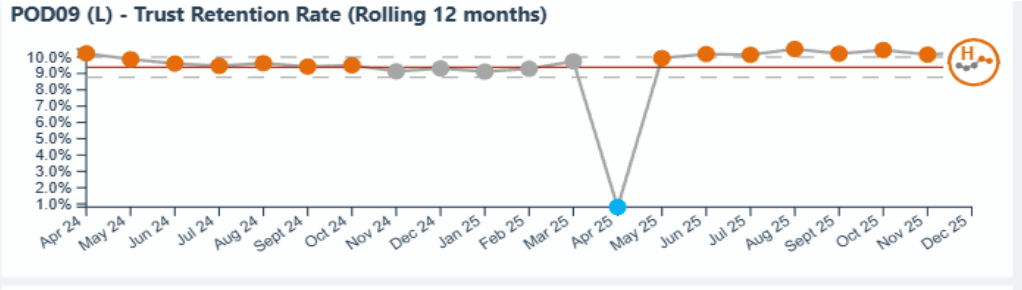
POD16-17 – Reporting as 6.04% and 6.58% against the revised target of 2.5% for both qualified and support worker vacancies

POD25a – Recruitment completed in 8 weeks is below target reporting 62.36%. 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 5.14% against the target total vacancy rate percentage of less than or equal to 2.5% with 193 vacancies currently across the trust

4.1 People and Organisational Development - Exceptions

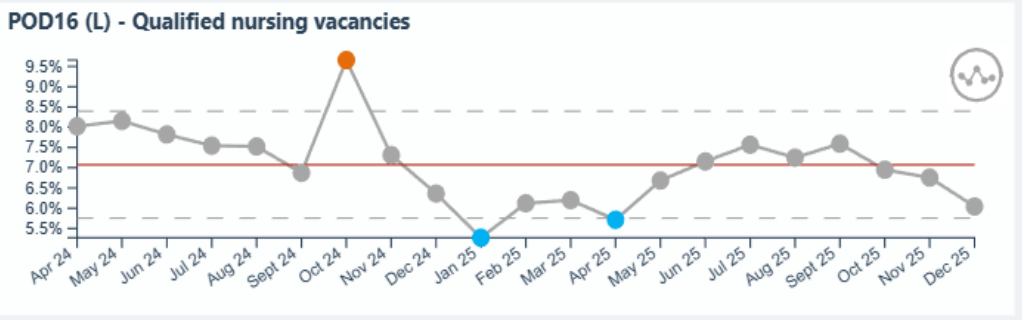


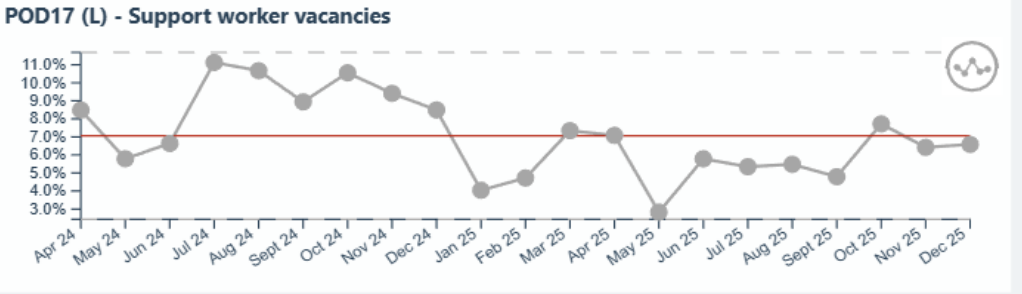
Trend, Reason and Action

POD09 – The trust retention rate on a rolling 12 month remains above the 10% target. Turnover for December was 10.32% Turnover remains above normal trend. All Care groups are reporting turnover rates above trust target, with the exception of Doncaster MH and LD who are reporting 9.1% and Children's who are reporting 9.5%. North Lincs MH and TT are the highest reporting 11.2%.

Trend, Reason and Action

POD10 –The Sickness Absence % is above target (6.36% vs 5.1%), LTS sickness has remained static at 5% since July 25 however STS has slowly increased since June 25 and significantly jumped from 2% to 2.7% in the last month. This time last year December was 7.11% and 12 months was 6.33% however the issue last year was LTS which increased from 4% to 5.2%. Top reason for sickness continues to be Anxiety/Stress - however this was 35.8% for Jan - Dec 24 and 42.4% for Jan - Dec 25

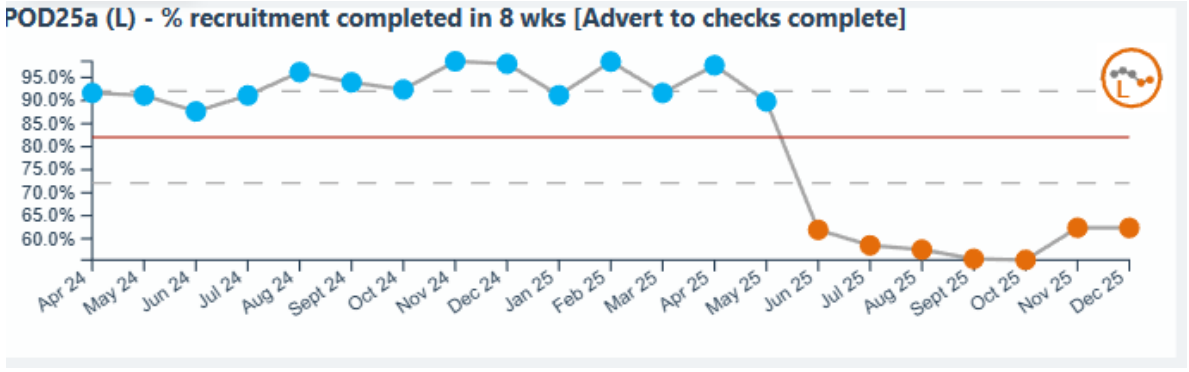




Trend, Reason and Action

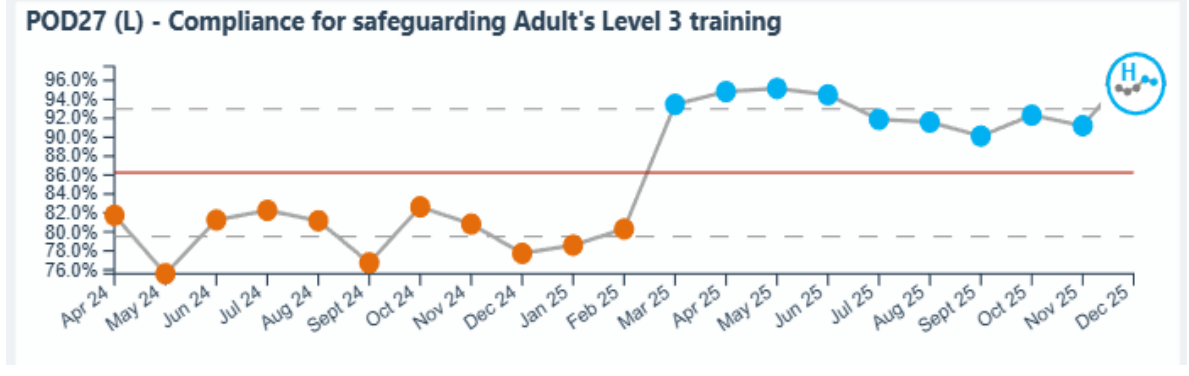
POD16/17 Reporting against the revised target of 2.5% for both qualified and support worker vacancies. All of the care Groups have reviewed the vacancies to ensure accuracy. Finance and HR are undertaking a further review t ensure the positions are fully aligned. For 2026/27 budgets – budget sign off is expected in February and as such any changes required for 2026/27 will be made in advance of the commencement of the financial year.

4.1 People and Organisational Development - Exceptions



Trend, Reason and Action

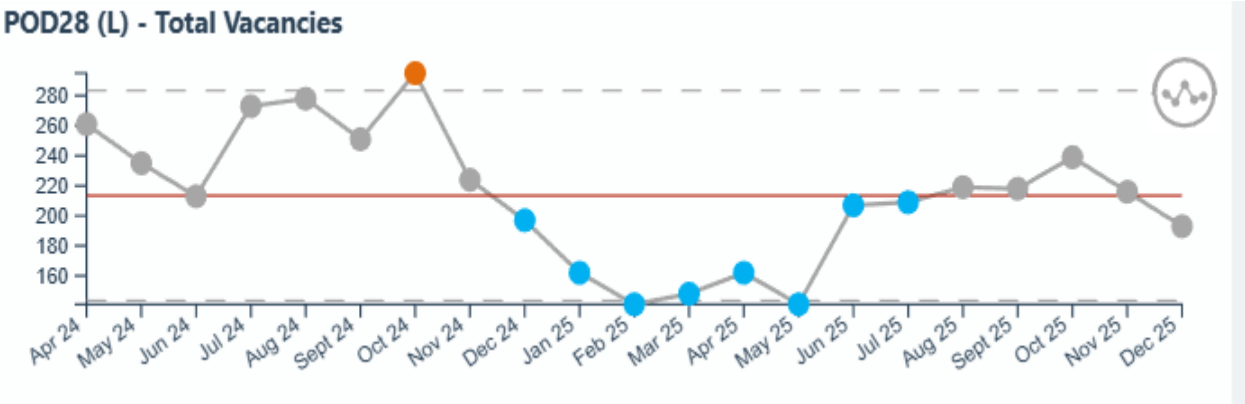
POD25 The recruitment KPI continues to breach primarily down to the National reporting requirements which have been reduced to 8 weeks (previously 12 weeks) hence the reduction in performance. whilst the recruitment KPI's have deteriorated the Trust position remains strong - this has been recognised by the Civica Benchmarking Awards 2025 with the Trust winning the Time to shortlist award.

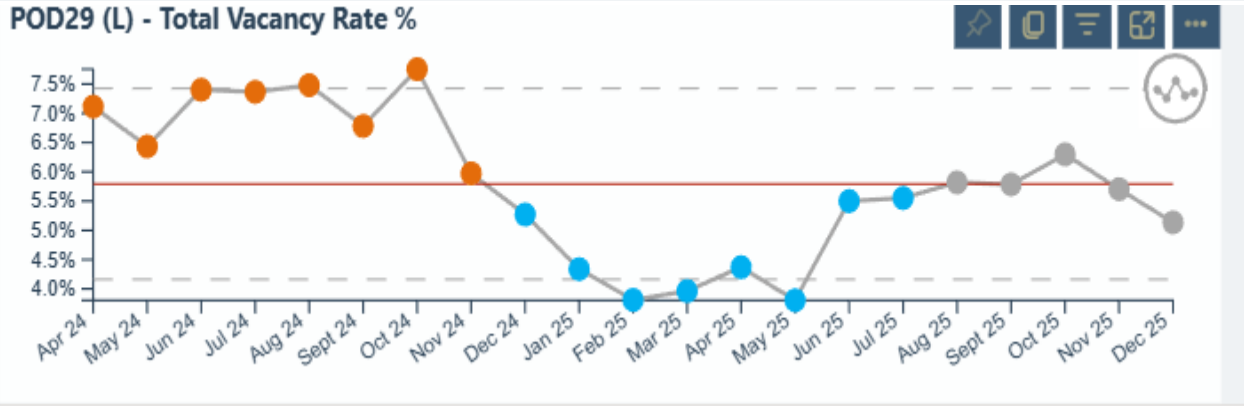


Trend, Reason and Action

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 decreased from 216 to 193 vacancies in December, currently standing at 5.14%. against a target of 2.5%. All of the care Groups have reviewed the vacancies to ensure accuracy. Finance and HR are undertaking a further review t ensure the positions are fully aligned. For 2026/27 budgets – budget sign off is expected in February and as such any changes required for 2026/27 will be made in advance of the commencement of the financial year.

4.0 Finance – In Focus

Finance				
Indicator	**Metric**	**Target**	**Actual**	**Variance**
FIN01	Year to date actuals vs budget	(52)	485	537
FIN02	Forecast outturn vs budget	0	0	-
FIN03	YTD savings target vs schemes identified	9728	9559	(169)
FIN04	Annual savings target vs schemes identified	13,254	13,053	(201)
FIN05	Agency spend as % of total pay bill - year to date	1.57%	0.39%	(1.2)%
FIN06	Year to date capital plan vs spend	6,534	4,774	(1,760)
FIN07	Annual capital plan vs forecast spend	9,764	9,845	81
FIN08	No of directorates compliant with budget - year to date	23	22	95.7%
FIN09	No of directorates compliant with budget - forecast	23	22	95.7%
FIN10	***Directorates not compliant with budget - YTD:***			
	Neurodiversity	(2,004)	(2,016)	(12)
FIN11	***Directorates not compliant with budget - Forecast:***			
	Neurodiversity	(2,672)	(2,702)	(30)

Narrative

FIN01 At M9 the year to date (YTD) position is £537k better than planned. The main drivers for this are vacancies at a higher level than the planned 2.5%. This is masking pressures, however, in other areas such as reduced interest rate income and increased drugs and secure transport costs.

FIN02 - the forecast at M9 is to breakeven in line with the plan. This assumes that £1.8m deficit support funding will be received in year, which is £0.6m less than plan as NHSE have confirmed funding will be withheld as the overall South Yorkshire position forecast to be worse than plan. It is still possible to forecast breakeven though as £0.2m unexpected industrial action funding has been confirmed and recruitment to vacancies is not happening as quickly as previously thought. The significant risk that emerged during M7 relating to the HDRU still remains as the ICB have not placed as many patients as expected in the service resulting in a loss of planned income. Urgent action from Executive and operational colleagues continues in an attempt to resolve this.

FIN03/4 Schemes have been identified in full for the 25/26 savings program; the forecast is to achieve £201k less than the plan. At M9, the savings are behind plan by £169k, this relates relates to overhead income not received for the HDRU. This is not expected to be recovered by year-end hence the forecast of not achieving plan.

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 0.39% of the total pay bill for the Trust. Only one agency locum remains in the Trust in the Doncaster Care Group and is expected to end in March 2026.

FIN06 & FIN07 Capital spend is behind plan year to date by £1,760k. Spend is accelerating now the Great Oaks and HDU works have started on site. The forecast is that capital funding will be used in full by year-end. Spend exceeds the original plan by £81k as additional funding has since been confirmed for electric vehicles charging points and cyber. Funding has been requested from NHSE to enable the Waterdale lease to be signed in 2025/26; we are awaiting approval.

FIN08/FIN10 25/26 budgets were agreed and signed off on the basis that all directorates would manage their budgets and not overspend. At M9, 22 of 23 directorates are underspending. The Neurodiversity Directorate is overspent by £12k YTD, however, this is a permitted overspend as it is caused by factors outside of the Directorate's control. Hence, the indicator is green.

FIN09/11 - The Trust is currently forecasting break even for year end. Only, the Neurodiversity Directorate is forecast to overspend (£30k) but this is a permitted overspend and hence the indicators are green.

Appendix 1`

SPC Icon Description

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises and Priorities Scorecard	**Agenda Item**	Paper U
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	29 January 2026

Suggested discussion points

The league table is again presented. As we look to shift focus to the success measures for our promises, we have asked all Clinical Leadership Executive members to review it in detail across their leadership teams before March: this is part of a determined effort to ensure that through 2026/27 this league table becomes not just a reference point for the full Board but a visible measurement across the senior leadership of the Trust, recalling that, in *our 7 point pecking order (see annex A)*, promises sit above national policy in prioritisation because our focus is with our communities.

The Board focuses this month on Promises 2 and 5. This continues our routine consideration of at least one promise each time we meet. It is however different to our intended focus, which was to be 18-23 and promise 17, which will now come in March and May respectively.

This cover report addresses a number of issues and also profiles annex C which is a report provided to the Public Health, Patient Involvement and Partnerships committee.

Previous consideration

N/A

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the latest self-assessment provided, augmented by the narrative within this paper

ACKNOWLEDGE the effort across 23 directorates to deliver 28 Promises by the end of 2028

RECOGNISE continued focus in the first half of 2026 on both parts of Promise 14

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
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 A – The Board's agreed organisational 'pecking order'
Annex B – January 2026 promises scorecard or league table
Annex C – latest detailed assessment of data associated with inequalities related promises

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Latest Promises Update

Purpose and introduction

1.1 We have 86 success measures that try to provide 'finish lines' for the promises in our clinical and organisational strategy. The league table continues to assess against each. Over time we will aggregate those at promise level once again, having disaggregated them in this phase of change to generate focus.

1.2 Of course, both the promises and the success measures, then aggregate to our five strategic objectives, and overall mission. Strategic objective 1 is perhaps the best advanced on delivery, recognising the inherent difficulties and pace will vary between the five: promises 26 and 27 are acting as a drag on strategic objective 5. Promises 20, 21 and 22 likewise hold back strategic objective 4, where progress on 18, 19 and 23 is evident. It remains relevant to look back at the 'what's difficult' papers for each objective we considered at the board throughout 2024.

1.3 This paper is a very summarised commentary on some key elements of the success measures since we last met. In reality over that eight-week period the combined impact of the planning round and organisational change development has overshadowed concerted progress, which in reality will begin to find salience again from April.

Year of peer support?

2.1 The Board is sighted on progress with promises 3, 4 and 5. A paper on the latter is before the meeting this month. Sustaining those successes will be important as it is for 4 week waits and out of area placement improvements, educational excellence, and trial enrolment. Promise 2 is before the Board today, as it was in July, mindful of the complexity of delivering our always measures, and with carers' assessments forming a key feature of both initiatives.

2.2 On Friday January 31st our latest Listening Live vlog is published, this time with Kelly Hicks, who established PFG sixteen years ago. She offers powerful feedback on the Trust, our partnering behaviours with the local community, and on the work that leaders across RDaSH are spearheading since the Board agreed that community power was our focus. But she also amplifies how peer support is the lead indicator for that relationship, and we discussed peer support workers in some detail in November. 2026 has been described as our year for peer support, and of course that is not intended to imply the focus is temporary: what is intended to recognise is that we cannot deliver Promise 1 during the lifetime of the strategy unless over the coming twelve months we see a step change in three aspects:

- The number of peer support workers within RDaSH service pathways
- The meaningful day to day connection between those PSWs and our MDTs
- A shift in the mindset of some teams in relation to the potential and the contribution of peer support

Getting gritty on health inequalities?

3.1 Annex C is a report that was provided elsewhere – into our executive led CLE sub, and into the Board's public health committee. It illustrates that we do now, in most cases, have the data to hand to measure what we are trying to change. Moreover, that data is increasingly analysable by directorate, in line with our aim to make work on health inequalities the day job for our local leaders, not a sidebar project for enthusiasts.

3.2 The report also lays bare that despite intense effort and commitment, progress is not always being seen. The work is inherently experimental and so some false starts are to be expected and celebrated. We know that to address exclusion in perinatal mental health, we will need to work differently with local midwives and with our and other's health visitors; as well as to build trust within key communities who see such services as potentially punitive. We can evidence the work being done to create dementia diagnosis pathways accessible to black and minority ethnic citizens, but we need that work to show scaled growth in the year ahead.

3.3 In coming weeks we 'go live' with important changes relevant to promises 10 and 11. Building on November's Armed Forces event, the Trust is an early beneficiary of NHS England funded training to be delivered via our LHDs in the months ahead. On the back of this and other work, we have to raise the profile and understanding among our teams of Op Courage and Op Restore. Vacancies for our homeless health team are also now funded and available and will form part of roles into which we look to recruit before the start of 2026/27.

Before year end?

4.1 Recognising the bandwidth issues highlighted in the introduction to this paper, there are nonetheless areas of important anticipated progress in the remaining ten weeks of the year.

a) Promise 22 has a success measures related to a full evaluation of existing weekend provision. This is a significant piece of work and Steve Forysth has confirmed that it will be presented to CLE in March 2026.

b) February is go-live for intensive monitoring and support work associated with the urgent care dimension of Promise 14. There will

be non-compliant services moving into Q1 but the preparatory work done will provide a strong basis for analysis and improvement.

c) Switch off of the Care Programme Approach on April 7th, will considerably assist our work to drive use of DIALOG+, and within that deployment of the paired outcome measures. Not only are these are key step on Promise 16, they are central to our Quality and Safety Plan, and we understand may become a NOF measure in due course.

d) Whilst concluding our long march to be first NHS Trust ever to poverty proof every service, which concludes in September 2026, we will make investment fund decisions to support a number of the actions arising from the reports to date.

Toby Lewis, 23rd January 2026

Annex A **The RDaSH Board pecking order**

Board members will recall previous agreements to the seven-point pecking order, intended to guide what is focused on when there is too much to do. It is reissued here, noting that new elements like the ten-year plan, the NOF, reasserted commissioning behaviours, make it even more crucial that we have clarity. All of the listed new elements are at 3 or below.

1. Safety critical work: i.e. *immediate/imminent* safety issues

2. Work to deliver **our promises** and strategy

3. National work defined and instructed in the planning guidance (bear in mind much of such guidance is suggestion)

4. Work to execute the Eight Plans approved by the Board for RDaSH (quality and safety, education and learning, equity and inclusion, people and teams, research and innovation, MTFP, estate enabling, digital transformation

5. Local Place plan priorities (these plans remain extant albeit we expect with alterations in the ICB they will change in the coming year)

6. Local care group priorities

7. Other national, regional or professional initiatives

Promises and priorities

Annex B, Board January 2026

Top third

Promises and priorities – delivery plan and delivery self-assessment

Promises & 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 or fully elaborated	Comments on likelihood of delivery
Promise 2 - Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	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.**
Promise 3 - 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.**	Amber 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.
Promise 3 - 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 350 postholders on ESR – and have sustained that for much of January..	Green	Data shows more global majority and more male volunteers than our wider staff base, and likewise more younger and older (65+) volunteers.
Promise 4 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	There continues to be progress and we want to test this growth by area, albeit it is important where responses are high we do not push for continued growth. **There is more work to be done in a handful of directorates.**
Promise 4 - 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 –** a start on that has been made in delivery reviews
Promise 5 - 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 CoLE**	Amber 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. **We also**

Promises & 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
				have significant work to do to make sure everyone's contribution is supported and valued.
Promise 6 - 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: **there are investment bids being considered to grow the service in response to need.**	Amber green	Increasing uptake welcome, and visible, with continued concerns over Doncaster service access emerging. Consistent focus needed to deliver and **reach into older adults to be determined.**
Promise 7 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.
Promise 9 - 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. Our plans include sharing our levy with community groups for the first time	Green	This is moving to a green rating, as only 8K remains to be identified and booked, which is a huge step from 24/5 outturn: 830k of levy spend being identified with shift from high banded roles..
Promise 13 - Sustain and expand our IV provision in out-of-hospital settings.	Amber green	We need to agree a final plan with the Care Group but positively **the protocols for change are now in place and first expanded cohort of patients will be looked after in February.**	Green	**As part of agreeing activity levels for 2026/27 we will seek to estimate the potential for growth in this area as we look to support patients to avoid hospital admission where safe to do so.**
Promise 13 Take annual opportunities to transfer services to homecare where safe to do so.	Amber red	Moving into 2026-27 and 2027-28 we need to be perhaps more intentional about our plans and shift, in line with national guidance to do so	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.
Promise 14 - 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: **we will know more moving into Q1**

Promises & 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 or fully elaborated	Comments on likelihood of delivery
Promise 14 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). In planning for 26/27 we have sought to allow a 5% growth buffer. December saw some slippage – **which we are confident of catching up during Q4.**
Promise 14 - Meet 4 week standard from April 2026 across all services.	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 green	This rating, possibly wrongly, excludes Neurodiversity services, albeit we have trajectories to reach waits <18 weeks by 2027 for CYP but not adult services.
Promise 16 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.
Promise 18 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.	Amber Green	We do need to be able to show impact from the work done, and **this will be reflected in our QA for 25/26.**
Promise 23 Expand the scale of our residential forensic rehabilitation service.	Green	**Additional capacity is now open and a patient moves into that capacity during February.**	Green	A 20% expansion has already taken place.- and we now need to consider what more is needed to match need as part of a wider review of LD&F.
Promise 24 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.
Promise 24 Trust workforce plan for 2028 on track to be delivered.	Amber green	Plan, notwithstanding item below, developing well. Fully staffed is year 1. And in year 2 we need to restore ourselves to that position.	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)

Promises & 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
Promise 24 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.
Promise 25 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	We achieved accreditation in July 2025: and the plaque has now arrived. It is a key manifestation of our values to pay the RLW. **We will pay the growth in 2026/27.**
Promise 25 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.
Promise 26 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 completing an assessment of whether our workforce changes deteriorate our achievement of the GPG. This work will be done in good time for the annual report.**
Promise 28 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 2026/27.

Middle third

Promises and priorities – delivery plan and delivery self-assessment

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
Promise 1. Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care.	Amber green ↑	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 launched 24/09/25 as key support to underpin effort. **Work needed to be support peer led orgs beyond Doncaster and in 26/27 we expect to see significant growth with S62.**	Amber green ↑	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. **The framework to do so was agreed by the board in November.**
Promise 2 Achieve Carers Federation accreditation for the work that we do across the Trust.	Amber red	**Self-assessment baseline overdue being finalised in Q4**	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.
Promise 2 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.
Promise 4. 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.**
Promise 5 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. The Board paper (Jan 26) speaks to this.**

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 or fully elaborated	Comments on likelihood of delivery
Promise 5 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. **It is due to be fully in place by the end of Q4.**
Promise 5 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	We need to resource the remaining missed priorities, as outlined within our Board paper. This may extend delivery to the summer.
Promise 6 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 was a focus within the Leaders' Conference in late September as a stimulus to change – confidence and energy to change needs more work.
Promise 7 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	It feels unlikely we will meet this measure in LD in 25/6. For SMI, there is confidence we can go beyond what is currently being achieved, and materially intervene to improve physical health status among the SMI population.
Promise 8 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	As waits for diagnosis reduce, we have capacity to reach into communities and work at pace (as we evidenced in NL).
Promise 8 Improve access rates to talking therapies among older adults.	Amber 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. **We need to understand whether in 26/27 our second try will work better.**	Amber red ↓	A big step up was needed in Q4, which was missed in Q3 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. Right now our miss of this measure is cause-unknown.

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
Promise 8 – Neurodiversity – ensure ward teams and environments are truly suitable for the patients that we serve	Amber green	Cogent training plans have been built and will be further embedded in the TNA for 26/7. The estate change needed need reconsideration and confirmation before end of January.	Amber green	This measure can be delivered in 2026, and we then need to work to sustain it, and test its 'meaningfulness.
Promise 8 Tackle exclusion of BME and other GM groups from peri-natal mental health services	Amber green	Teams are working hard to understand the problem and build a response to it. It may lie in midwifery referral, but our performance will also improve with better coding.	Amber red	This is a nationwide challenge, so it would be premature to regard it as one we can simply rapidly address. It will require multi-agency effort. PHPIP heard that there is a need to pick up the pace of connection to the delivery chain outside the Trust.
Promise 11 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.
Promise 11 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. We expect this work to include an externally hosted peer worker, which we understand is imminent.
Promise 12 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.

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
Promise 13/20 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 red ↓	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes. Unfortunately currently that is not job planned or in place and work by the CGMD is seeking to change that.
Promise 13 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.	Amber red ↓	We have work to do – to be considered at Feb CLE – to make sure this is in place in all 3 areas by June 2026: we promised October 2025 and did not deliver.
Promise 13 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.**
Promise 16 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.
Promise 18 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. Our RI rated relates to therapeutic activities and it is that that we need to fully embed. **We will be repeating our culture of care assessment in coming weeks.**

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
Promise 18 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	The HQTC programme is well understood albeit there is work to do at ward level to ensure that there is both visibility and buy in.	Amber green	**The ward scorecard is in final development and will be ready for demo at the Board in March. This will be used (patient facing and business facing version) to give a line of sight between and up/down through 2026/27.**
Promise 19 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	We continue to deliver but also are experiencing 'winter' pressures – in 2026 concerted work in North Lincolnshire will be needed. *Moving to zero may not be achievable.*
Promise 21 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 green ↑	The team involved report positively on progress and we will be looking in Q1 to provide a more definitive final assessment of work begun in 2024.
Promise 21 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.
Promise 21 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.

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
Promise 21 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	**Now data flow work is completed, and armed with shift to DIALOG+ we can assess the scale of transfer/shared care with VCSE partners. This forms part of neighbourhood work to be led by Iona Johnson.**
Promise 22 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.**
Promise 23 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.
Promise 23 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.
Promise 25 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 chair 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.

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
Promise 26 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, is subject to events beyond the Trust. We have work to do to build trust and confidence among BME colleagues. **The move to being anti-racist has to be manifest in how our 555 line managers operate.**
Promise 26 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.
Promise 27 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 28 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
Promise 28 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 26/7. 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

Lower third

Promises and priorities – delivery plan and delivery self-assessment

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
Promise 2 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 but a draft delivery plan is before the Board,	Amber green ↑	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.
Promise 5 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 red	This was launched within the annual members' meeting. Progress since has been difficult to see and work is going on to get a cohered plan that links members and governors and clearly ensures members receive what we have promised.	Amber red ↓	We now have to expand active membership, recruiting in tandem with our volunteering and VCSE partnering work. This work is in major delay and is being reviewed at the Feb delivery review.
Promise 6 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 red	It is evident how challenging this is proving to be. But there remains basic work to do on reminders/timing adjustment and other interventions, with CCG leading the way with adaptation
Promise 8 Increase access to health checks for minority ethnic citizens with Learning Disabilities.	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)	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.
Promise 9 In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Red	The leadership team are exploring models elsewhere to finalise a plan for RDaSH for 26/27	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 once bandwidth is identified.
Promise 9 In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Red	There is work going on in this space but we have agreed it needs a revised approach and plan.	Amber red	

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
Promise 9 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	
Promise 10 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 Committee 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.
Promise 10 Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.	Red	This access plan will rest on ensuring mainstream services thresholds for exclusion are changed in theory and practice: initial discussions to this effect have begun. A more organised and concerted approach will be needed (with new resource in place to move this forward).	Red	Until a baseline plan is in place it is not possible to offer a more optimistic view of changes needed – nor how much resistance in practice could be experienced in developing TIC models in this field.
Promise 10 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.

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
Promise 12 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.
Promise 14 Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Amber green ↑	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'. This rating may rapidly improve in coming months.**
Promise 15 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 Q1, 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 red ↓	Time passes and 26/27 is the earliest feasible delivery date now for restructure. There remains some enthusiasm to shift services onto neighbourhood settings on a pilot or targeted basis.
Promise 15 Restructure Trust services into those INTs during 2025/26.	Red		Amber red	
Promise 15 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. This work was considered with the PHPIP committee on that basis.	Amber green	Once the above measures are met, this item is feasible!
Promise 16 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 half way 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.

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
Promise 17 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. Implementation to date is strong – the challenge is huge!	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.
Promise 17 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.
Promise 20 Introduce and evaluate virtual ward pilot into our mental health services 2024/25.	Amber red	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.**
Promise 20 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.
Promise 21 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, has now been received (3/1/26): 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.

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
Promise 22 Support substantially increased discharge and admission capacity over weekends.	Amber red ↓	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 but the issues are proving very sticky, hence the lowered plan rating.	Amber red	There is very substantial executive emphasis on this work and it remains a key measure of our route to 92% moving into 2026: it may require commencement of the Comm-HQTC to connect up services and build confidence to succeed
Promise 22 Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services.	Amber green ↑	N&F delayed completing this work by other priorities: now due in March	Amber green	By the end of 202/6 this input measure can be met.
Promise 26 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 Q3 25/26. We have to intensify efforts in coming months to have consequence. The Board will again discuss racism when we meet in May to understand what has happened since November.
Promise 27 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.
Promise 27 Change service models for patients and staff to reduce travel required by 2027.	Red ↓	A plan to achieve this, and to scale ‘this’, is delayed in 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 red ↓	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.

Annex 3

Rotherham Doncaster and South Humber NHS Foundation Trust

Progress Report on Equity & Inclusion Plan

Position and Next Steps

Ray Hennessy, Deputy Director of Strategic Development

January 2026

RDaSH nurturing the power in our communities

1. What is the Group being asked?

1.1 The Equity & Inclusion Group and PHIPP Committee have previously received reports on work that has been undertaken to report on performance on health inequalities both via the promises under our Equity and Inclusion Plan and by reviewing the IQPR through a health inequalities lens. This report brings those two datasets and progress narrative together to review:

- Promises under E&I plan and their success measures;
- Work undertaken to date;
- Progress against success measures;
- Work planned going forward under E&I plan and areas highlighted via IQPR through a health inequalities lens.

It seeks to begin to answer the 'So What' question of – is any of our work making any difference in relation to health inequalities?

2. Equity & Inclusion Plan Promises Covered

2.1 The Equity and Inclusion Plan incorporates half the Trust's Promises. In terms of Progress against these Promises they are overseen by different Clinical Leadership (CLE) Sub-Groups. Not all the Promises overseen by PHIPP are outlined here. The focus is on most of those that are part of Strategic Objective 2 'create equity of access, employment, and experience to address differences in outcome'.

3. Summary Position of Promises

3.1 Promise 6 - "Poverty Proof" all our services by 2025 to tackle discrimination, including through digital exclusion.

Success measures

- *All our services to have completed poverty proofing and be able to evidence resultant change (including digital)*
- *Benefits and debt advice access to be routine within Trust services to tackle 'claims gap'*
- *Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods*

3.1.1 Success Measure 1 - All our services to have completed poverty proofing and be able to evidence resultant change (including digital)

By end November 2025, some 867 people (vast majority who were staff) have received poverty proofing training. By the end of Quarter 3, 92 0f 134 services have been audited as part of the Poverty Proofing Programme. A revised programme has been set to poverty proof all services by September 2026 due to the scale of work required. Quarter 3 of 25/26 report are being drafted, and all other reports have been completed and published on the Trust website. Whilst each report has findings and recommendations relating to the service-specific audits, analysis shows that there were some recommendations that were Trust wide or themes for services to address. Progress on those recommendations are shown below.

Trust Wide Recommendations: Progressing

- **Translation/Interpreter service** - The previous service was deemed unreliable and not for fit for purpose by staff who use it. A new and more responsive service has been in place since September 2025;

- **Staff awareness** - provide a basic level of benefits training across the whole Trust, to empower staff to have financial conversations. Bitesize sessions are being held on Learning Half Days, delivered by Citizens Advice;
- **Travel** – a travel fund process to pay for travel is in place, though take-up has been low so far, with 100 bus passes issued to date.

Trust Wide Recommendations: Next areas of focus

- **Prescription costs** - advise patients about the HC2 form and how to fill it in effectively. Advise that patients who are paying for prescriptions whilst their HC2 form is being processed, should keep their receipts to be reimbursed. Compose a list of organisations that serve our areas who provide free prescription delivery services and add this to the Trust website, and make staff aware. Information about the scheme is on the website and need to make sure staff are aware of this. We will need to see which pharmacies provide a free prescription service and add this to the website also.
- **Food provision** - it would be ideal to have an RDaSH pantry (much like we do for staff) that colleagues are able to collect from to distribute to patients, particularly for those housebound patients who have minimal support. We will be looking to partner with external organisations to see how and what we can establish regarding referrals to foodbanks. We will also be submitting an outline bid as part of this year's Investment Fund.
- **Café and food provision** - as part of a wider piece of work, RDaSH needs to think about food provision which offers value for money to patients, staff and visitors. There should be a warm, nutritious offering which is available beyond current café opening hours.

Service Recommendations: Progressing

- **Flexible appointments** - to (continue to) offer flexibility in appointments for example home visit, video, or telephone if appropriate. To (continue to) offer appointments that are flexible around work arrangements, families, carers to ensure no extra cost is incurred. Some of this will be addressed through the rollout of SystmConnect, where patients can request a specific appointment.
- **Routine financial conversations** – make financial conversations a routine part of someone's appointment and document on SystmOne. This is embedded in Dialog+ for our mental health services.
  Avoid making assumptions or carrying out a visual assessment in place of asking the right questions. Children's North East will be providing this on Learning Half Days in 2026/27.

Service Recommendations: Next areas of focus

- **Providing information to patients** – each service should compose a list of supporting organisations, charities and ways of minimising their healthcare costs. These lists should be distributed to patients electronically, or in a leaflet where necessary.
- **Volunteer driver scheme** - create a pool of volunteer drivers to help people attend appointments. Identify people who would benefit from such a scheme.
- **Advocacy** - identify advocacy services that could provide support for patients/carers. Make sure staff and people know about them. Look at how peer support could play a role in supporting people within the service.

Whilst there has been progress in addressing some of these recommendations, including other service recommendations, the pace of the changes will be a focus in 2026. A Poverty Proofing Community of Practice (CoP) was established in December 2025, with representatives of each service poverty proofed having attendees invited. The CoP will:

- Be a place of learning and accountability: what have you done with your recommendations so far? What is going well? What isn't?
- Over the next 18 months, look to every service to provide an update which can be given to Equity & Inclusion CLE Sub-Group.

3.1.2 Success Measure 2 - Benefits and debt advice access to be routine within Trust services to tackle 'claims gap'

We have introduced a dedicated benefits and debt advice arrangement with our three place Citizens Advice organisations since April 2025. A simple referral process is in place for people (including staff), and up to November 2025 this showed the following take up and benefits.

Place	People Supported	Potential Income Gains	Debt write-offs and other
Rotherham	192	171,000	35,000
Doncaster	175	134,000	
North Lincs	69	222,000	16,000
Total	**436**	**527,000**	**51,000**

SystmOne is updated where a patient has been referred, so this can be followed up.

There has been continued promotion of the service internally and externally (e.g. in the last three editions of Trust Matters, which includes case studies).

3.1.3 Success Measure 3 - Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods

The method of reporting this measure was changed in 2025/26, and therefore the target will need to be revised.

(data as at 2nd January, 2026)

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
Promise 6 - Poverty proof all our services by 2025 to tackle discrimination, including through digital exclusion.													
⊟Sustained reduction in service attendance gap in lower decile neighbourhoods	7%	3.82%	3.92%	3.49%	4.26%	4.13%	3.81%	4.03%	4.09%	4.05%	3.81%	0.16%	3.95%
Total DNA contacts	---	32440	2886	2569	3001	3189	2602	2848	3002	2835	2748	1	25681
Total contacts	---	849722	73701	73606	70432	77211	68279	70583	73355	70046	72037	643	649893
⊟Reference figures for the remaining decile neighbourhoods		2.28%	2.42%	2.17%	2.40%	2.31%	2.11%	2.25%	2.26%	2.22%	2.31%	0.00%	2.27%
Total DNA contacts	---	23451	2158	2012	2213	2248	1811	2089	2094	2009	2004	0	18638
Total contacts	---	1029919	89103	92742	92394	97357	85710	92741	92854	90352	86795	866	820914

The data shows that more people from deprived areas are not attending their appointments versus those from non-deprived areas. So far this year, DNAs have increased overall in deprived neighbourhoods and remain about the same in other neighbourhoods which leads us to conclude that the early work undertaken on trying to support patients with the cost of travelling to their appointments is not yet leading to a reduction in DNAs. Of course, travel cost may not be the only reason why patients are not attending their appointments but our poverty proofing work suggests that it is a major factor for some..

The Strategic Development Team will work with the respective (13) directorates to:

- Look at their data, to see how this varies with the Trust's overall position and similar services;
- Work / talk through some questions of what they could consider doing to reduce DNAs:
    - These will be based strongly around Poverty Proofing recommendations, that are similar to those used in other Trusts looking at their DNAs;
    - How the productivity data is being used to focus upon people that regularly DNA.

Get clarity and capture how they will use the data as part of business planning. The end goal will be to have met with all Directorates by the end of March.

In addition, as part of the project where patients will be able to book appointments, we will be looking to send text reminders not just about the appointments but also to let us know if they are struggling to attend e.g due to the affordability of travel (and see how the Travel Fund can help overcome this problem).

3.2 Promise 7 – Deliver all ten health improvements made in the Core20Plus5 programme to address health inequalities among children and adults; achieving 95% coverage of health checks for citizens with serious mental illness and those with learning disabilities from 2024.

Success measures

- *Achieve LD and SMI health check measure in 24/25 and recurrently*
- *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*
- *Increase access to CAMHS from C&YP from under represented ethnic groups, age, gender and deprivation.*

3.2.1 Success Measure 1 -Achieve LD and SMI health check measure in 2024/25 and recurrently

The data regarding health checks for people with a severe mental illness (SMI) or learning disability is a work in progress. This is because there is a project underway to align our registers with those of GPs. The result of this means that there can be fluctuations when people are added to our data. As an example, the total number of people with a SMI in 2024/25 was 3,671 and this is now 3,754. As at December 2025, 78.24% of patients with an SMI and 80.79% of those with a learning disability had received their annual healthcheck.

(data as at 2nd January, 2026)

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
⊟Adults with a severe mental illness active at month end receiving a health check (work in progress)	95%	64.22%	77.84%	76.95%	76.71%	76.41%	75.37%	75.66%	75.39%	76.44%	78.24%
Total with a health check in place	---	2357	2901	2865	2869	2853	2821	2823	2833	2885	2937
Total with a severe mental illness	---	3671	3727	3723	3740	3734	3743	3731	3758	3774	3754
⊟Adults with a learning disability active at month end receiving a health check (work in progress)	95%	73.99%	78.35%	77.84%	77.48%	75.52%	75.76%	75.83%	76.86%	80.16%	80.79%
Total with a health check in place	---	916	1006	994	998	984	978	982	990	1022	1043
Total with a learning disability	---	1238	1284	1277	1288	1303	1291	1295	1288	1275	1291

SMI Healthchecks - Each of our three places have weekly arrangements in place to review performance, focus and follow-up on DNAs. Peer support workers are proving effective in reducing DNAs as well. Specific clinics for healthchecks are in place, including some evening clinics in Doncaster. Point of Care Devices have been introduced over the last few months which enable clinicians to test patient's cholesterol levels.

Learning Disability Healthchecks – Work includes the ongoing maintenance of accurate data reporting, supported by weekly data huddles to address data quality issues and monitor compliance. Forward planning appointments to maximise service capacity and minimise unutilised slots. Continued alignment of service and GP registers to ensure data consistency and completeness. Development of accessible communication materials, including easy-read letters and pre-assessment questionnaires, to enhance patient engagement and understanding.

3.2.2 Success Measure 2 - 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

Following discussions at Equity & Inclusion Group, a focused set of activity was agreed against this success measures.

The metrics for Children and young people were agreed as:

- All children and young people with an intellectual disability or autism diagnosis being seen by a specialist epilepsy nurse within 4 weeks.

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
⊟Work to a locally agreed metric of all children and young people with intellectual disability or autism diagnosis being seen by a specialist epilepsy nurse within 4 weeks.	4 Weeks	90.00%		100.00%			100.00%		100.00%		100.00%		100.00%
Total seen within 4 weeks of referral	---	9		1			1		1		1		4
Total referrals	---	10		1			1		1		1		4

This year, all four children or young people with an intellectual disability or autism were seen within 4 weeks.

- Reduce Was Not Brought (WNB also known as DNA in adult services) from deprived areas to 7% (both physical and mental health)

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
⊟Reduce Was Not Brought (DNA) from deprived areas to 7%	7%	6.45%	7.72%	5.74%	6.38%	5.99%	7.52%	4.38%	4.10%	3.97%	4.82%		5.55%
Total DNA contacts	---	2263	244	192	234	238	174	142	142	139	156		1661
Total contacts	---	35070	3159	3347	3666	3971	2313	3244	3462	3501	3238		29901
⊟Reference figures for the remaining decile neighbourhoods		4.78%	5.35%	5.38%	5.48%	4.54%	5.58%	3.55%	3.17%	3.75%	4.82%	0.00%	4.58%
Total DNA contacts	---	2366	244	243	295	262	190	178	157	192	217	0	1978
Total contacts	---	49549	4560	4516	5383	5773	3407	5021	4956	5116	4498	3	43233

The definition of WNBs changed and therefore the target needs re-visiting. In 2024/25, WNBs from deprived areas were 6.45% and for other areas 4.75%. WNBs had been showing are lower in deprived neighbourhoods and other neighbourhoods overall in 2025.

For adults, there are two other metrics that are being finalised with Physical Health Directorate for reporting and progress updates. These are:

- Cancer awareness events; and
- Onward referrals to primary care following blood pressure checks Caseload.

3.2.3 Success Measure 3 - Increase access to CAMHS from C&YP from under represented ethnic groups, age, gender and deprivation

The metric agreed was

- Increase the number of referrals from children of a black background by 10%

(data as at 2nd January, 2026)

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
⊟Increase number of referrals from children of a black background by 10%	10%	1.89%	2.49%	1.59%	1.97%	1.83%	2.41%	1.86%	1.58%	1.65%	2.11%	0.00%	1.90%
Total black background child referrals	309	279	28	24	30	29	16	23	24	22	29	0	225
Total child referrals	---	14729	1125	1513	1520	1581	665	1238	1516	1331	1373	1	11863

To note, the target will be 309 by 2027/28 (i.e. a 10% increase on 2024/25). Based upon current performance, we may not achieve an increase in the number of people referred when compared to 2024/25.

This work responds to evidence showing that Black young people are disproportionately represented in adult mental health services while remaining under-represented in children's services. The programme aims to strengthen early access, prevention, and equity of experience through targeted, culturally responsive approaches. The programme is

being delivered as a Quality Improvement (QI) initiative, supporting structured learning, measurable improvement and sustainable change.

Data, Insight and Baseline Development

Key foundations have been established to support evidence-based improvement:

- Core reports (521, 597 and 681) have been identified to monitor access and ethnicity data.
- Work is underway to ensure consistent access to data and improve data literacy across teams.
- Improving the accuracy of ethnicity recording at referral is a key priority.
- A baseline is being established to measure progress, with an initial ambition of a 10% improvement in access, progressing toward population-level representation.

Understanding Barriers to Access

Key barriers identified through data review, professional insight and engagement include:

- Cultural stigma and generational beliefs around mental health.
- Limited awareness of available support and how to access it.
- Inconsistent recording of low-level or informal contacts.
- Workforce pressures affecting continuity and engagement.

These insights are informing both immediate actions and longer-term system improvement.

Engagement with Young People, Families and Communities

- A workshop with young Black people has been delivered, providing insight into lived experience, trust, and service accessibility.
- Services are reviewing how low-level mental health support requests are identified, recorded and responded to.
- Engagement with parents and families is underway to better understand stigma and cultural barriers to help-seeking.

Workforce, Partnerships and Representation

- Collaboration with community and voluntary sector partners is developing, including work through With Me in Mind.
- Opportunities to strengthen representation through peer support roles are being explored.
- A locality-based approach is being adopted to ensure responsiveness to community need.

Next Steps and Assurance

- Strengthen data quality and reporting consistency.
- Continue community and family engagement activity.
- Support services to implement targeted improvements.
- Monitor progress through the QI framework and report outcomes through established governance routes.

3.3 Promise 8 – Research, create and deliver five 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”)

Success Measures

- *Improve access rates to talking therapies among older adults*
- *Increase diagnostic rates for dementia among minority ethnic citizens*
- *Increase access to health checks for minority ethnic citizens with Learning Disabilities*

- *Tackle exclusion of BME and other Global Majority groups from peri-natal mental health services*
- *Neurodiversity – ensure ward teams and environments are truly suitable for the patients that we serve*

3.3.1 Success measure 1 - Improve access rates to talking therapies among older adults

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
⊟Talking Therapies – Target 12% people over 65 accessing TT	12%	6.86%	7.37%	7.09%	7.90%	6.35%	8.31%	7.40%	7.51%	6.99%	8.56%		7.46%
Total referrals from people over 65	3100	1644	141	132	176	148	150	177	163	135	148		1370
Total referrals	---	23959	1912	1862	2228	2330	1804	2391	2170	1932	1729		18358

Analysis by the service reports that in terms of numbers, by this time last year (April 2024- Dec 2024) we had 1178 Older Adults referrals. The current cumulative is that this year (April 2025 - Dec 2025) we have had 1370 Older adult referrals versus a target of 3100.

The areas of focus going forward are:

- Working with Physical Health Care Group to target older adults, including pilot work happening on Hazel and Hawthorn Wards. Also, contacting patients via text on the Physical Health caseload;
- Roll out of Long Term Conditions Service for all three places;
- Work with care homes;
- Work with older adult community groups;
- Increasing GP referrals.

Work to date is not yet showing a significant increase in referrals for older adults.

3.3.2 Success Measure 2 - Increase access to health checks for global majority citizens with Learning Disabilities

(data as at 2nd January, 2026)

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
⊟Adults from minority communities with a learning disability active at month end receiving a health check (work in progress)	95%	46.37%	45.26%	44.91%	42.46%	42.66%	41.26%	42.51%	41.32%	40.97%	43.10%	42.07%	
Total with a health check in place	---	129	129	128	121	122	118	122	119	118	125	122	
Total with a learning disability from minority communities	---	279	285	285	285	286	286	287	288	288	290	290	

People with a learning disability from a global majority background are significantly less likely to have had their annual health check compared to those who are white – c 42% versus 81%. In addition, this position is not improving during 2025/26.

The Plan will be reviewed and refreshed by the service in February 2026.

3.3.3 Success Measure 3 - Tackle exclusion of BME and other Global Majority groups from peri-natal mental health services

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
⊟Increase number of referrals from people of a black background to the Perinatal Service by 10%	10%	2.47%	2.08%	6.67%	0.00%	4.23%	0.00%	4.11%	6.56%	1.85%	8.00%		3.78%
Total black background perinatal referrals	---	17	1	3	0	3	0	3	4	1	4		19
Total perinatal referrals	---	689	48	45	62	71	39	73	61	54	50		503

19 people from a black background referred so far in 2025/26, which is more people than whole of 2024/25, and equates to 8% of referrals versus a target of increasing by 10%. With investment, suggest target increase of 10% is modest and may want to look at again (i.e. this has already been achieved).

The service are:

- Investigating the referral process from midwives, who inputs the referral onto system one and who documents ethnicity
- Engaging with midwives and health visitors (via Trusts) to find out why they are not referring people from a global majority background;
- Undertaking ongoing data quality work within team;
- Continuing to meet as a steering group;
- Inducting the Engagement and participation worker;
- Investigating DNA data through the lens of ethnicity;
- Piloting advanced care planning via the lens of ethnicity – link into Nursing & Facilities /Change and Transformation Team.

3.3.4 Success Measure 4 - Increase diagnostic rates for dementia among minority ethnic citizens

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
⊟Dementia Referrals from minority communities	TBC	3.73%	4.36%	2.94%	1.81%	3.67%	2.57%	3.36%	4.29%	2.42%	5.45%		3.41%
Total minority community dementia referrals	---	137	14	9	6	13	7	12	14	7	14		96
Total dementia referrals	---	3676	321	306	331	354	272	357	326	289	257		2813
⊟Dementia Patients from minority communities (distinct patients)	TBC	3.74%	4.13%	3.00%	1.83%	3.86%	2.63%	3.17%	4.08%	2.50%	5.51%		3.39%
Total minority community dementia patients	---	135	13	9	6	13	7	11	13	7	14		93
Total dementia patients	---	3611	315	300	328	337	266	347	319	280	254		2746

93 people from a global majority referred by 7th Nov. If average monthly trend continues, then the year end is likely to be similar to the total of 135 seen 2024/25.

To the end of March, the focus will be:

- Getting research role recruited to, so will have a person with a focus to support the Promise, including on the diagnosis data;
- Establishing engagement and liaison roles funded and agreed in partnership with community organisations:
    - Rotherham: 'You Asked, We Respond', VCS based in Rotherham and has community links;
    - North Lincolnshire: Carers Support Service, VCS based in NL with community links;
    - Doncaster: Alzheimer's Society, who we deliver the community service in partnership with the Trust already.
    - All are or will look to recruit from local communities.
- Developing work plans for each place in collaboration with the VCS organisations we are partnering with.

From March onwards:

- Delivering place work plans.
- Develop a culturally sensitive training programme.
- Various community work and engagement activity.
- Working with initial GP practices in neighbourhoods with high global majority population.

3.3.5 Success Measure 5 - Neurodiversity – ensure ward teams and environments are truly suitable for the patients that we serve

Some of the RDaSH specific activity includes:

- Waiting list reduction in children's services
- Waiting list reduction in adult services
- Training – 'beyond the basics'
- Partnership exploration with CHAD in terms of Oliver McGowen

- Bespoke training regarding ward-based staff at the Q3 Health Care Support Workers conference

3.6 Promise 10, Inclusion Health – Be recognised by 2027 as an outstanding provider of inclusion health care, implementing National Institute for Health and Care Excellence (NICE) and NHS England (NHSE) guidance in full, in support of local Gypsy, Roma Travellers (GRT), sex workers, prisoners, people experiencing homelessness and misusing substances, and forced migrants.

Success Measures

- *Meet standards set out in published guidance issued by NICE (date) / NHSE (date)*
- *Internal audit confirms access rates being met and feedback from specific communities corroborates that insight*
- *Specific service offers in place for all or most inclusion health groups by 2027*

3.6.1 Success Measure 1 - Meet standards set out in published guidance issued by NICE (date) / NHSE (date). Internal audit confirms access rates being met and feedback from specific communities corroborates that insight

Initial baseline mapping is due to take place in Q4 2025/26 against standards and guidance.

3.6.2 Success Measure 2 - Specific service offers in place for all or most inclusion health groups by 2027

Following the Doncaster Homelessness mapping and workshop event in 2025, a Doncaster Homelessness Mental Health Service is being established for an initial period of 18 months. This will look to support people who are homeless or have a history of being homeless in Doncaster, over 18, with a persistent and ongoing Mental Health need, and people who struggle to access or receive support from mainstream mental health services. The Service is in the process of being set up and should be live by April 2026.

3.7 Promise 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 response services.

Success Measures

- *Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees)*
- *Introduce peer-led service support offer for local residents*

3.7.1 Success Measure 1 - Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees)

The data has been analysed further to show two metrics: the number of referrals who were veterans, and the number of individual veterans referred (distinct patients). This is because some veterans are referred into different and multiple services more than once. (data as at 2nd January, 2026)

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
Promise 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 response services.													
⊟Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees)	3.89%	2.87%	3.13%	2.99%	2.63%	2.41%	2.44%	2.26%	2.48%	2.64%	2.32%	1.58%	2.58%
Total veteran referrals	---	12120	1177	1113	1014	1033	950	907	971	946	814	5	8930
Total referrals	---	421997	37551	37242	38590	42804	38898	40124	39217	35834	35035	316	345611
⊟Achieve priority access to services for veterans (distinct patients)	3.89%	1.98%	2.08%	2.06%	1.99%	1.68%	1.70%	1.62%	1.79%	1.83%	1.68%	1.22%	1.82%
Total veterans	---	3521	311	316	314	300	280	282	289	271	238	2	2603
Total patients	---	178202	14939	15344	15788	17904	16502	17388	16188	14772	14132	164	143121
⊞Total veteran population percentage breakdown - 3.89%													

Using distinct patients, we still have a long way to go in veterans in services being more reflective of our population and the year to date is a lower % than last year. There have been discussions with services on identifying and recording veteran status on patient records, so that we meet our commitments more fully under Promise 11. However, we cannot assume that every veteran requires one of our services at all times.

A Workshop was held in Rotherham in 2025 to specifically focus upon this Promise and a range of actions were agreed.

Over the next 6-12 months we will:

- Make appropriate changes to SystmOne so we can record if a child is the member of a family with Armed Forces;
- Make appropriate changes to SystmOne so that if someone is a veteran it is flagged on the home page of their record (no need to look through various notes);
- Arrange Veterans Covenant Healthcare Alliance training to be delivered to RDaSH exec team, and build it into our induction programme and Learning Half Days;
- Share service information/referral and contact details for Op Courage;
- Share information of all third sector organisations which support the Armed Forces Community;
- Continue to strengthen our partnerships and networks and foster collaborative working.

Actions for RDaSH colleagues:

- Continue to promote the importance of "asking the question" *(have you or any members of your family ever served in the Armed Forces?)* within your service area;
- Talk about our commitment to the Armed Forces Community in an upcoming team meeting.

What will also be a focus is not just recording veteran status, but ensuring there are processes to expedite veterans for priority access. Also, what this would look like when services are achieving their for week wait.

3.7.2 Success Measure 2 - Introduce peer-led service support offer for local residents

We are looking to partner with a VCS organisation who has specific experience in peer support for veterans. Subject to further discussion in January, we would expect to have this starting at the beginning of 2026/27.

3.8 Promise 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.

Success Measures

- *Use rural health and care proofing toolkit (NCforRH) to identify needs and potential solutions*
- *Increase digital and outreach service solutions to village communities, starting in North Lincolnshire*

3.8.1 Success Measure 1 - Use rural health and care proofing toolkit (NCforRH) to identify needs and potential solutions

The three initial pilot rural proofing audits (Winterton in North Lincolnshire, Dinnington in Rotherham, and Moss & Fenwick in Doncaster) were completed, and follow-up meetings held with participants. North Lincolnshire Care Group have agreed capacity to take additional rural proofing audits forward, and address the agreed actions from the pilots. Given the higher rurality in North Lincolnshire, our work will be focused there.

3.8.2 Success Measure 2 - Increase digital and outreach service solutions to village communities, starting in North Lincolnshire

There will be an initial focus upon Winterton, based upon the Rural Toolkit. The actions agreed to take forward are:

- Community facilities available in Winterton that mental health services could be provided from;
- Establish people in Winterton get information about mental health services from?
- Recruit more additional volunteer drivers;
- Work with GP practices to increase attendance and reduce stigma for attending;
- Link with Lincolnshire Rural Services Network;
- Work with GP Practice to see non-practice Talking Therapy clients (to make a local offer more visible and viable).

As there is a variation in the respective places on the size and % of the rural population, this is broken down and reported per place (data as at 2nd January, 2026)

	Target	Previous Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Current Year Total
Promise 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.													
⊟Percentage of referrals from rural areas compared to rural population - Doncaster	14.48%	12.40%	13.21%	11.96%	12.42%	13.60%	14.49%	13.81%	12.95%	13.10%	13.41%	8.77%	13.23%
Total rural area referrals	---	45095	4386	3890	4170	5080	4969	4791	4405	4081	4120	27	39919
Total referrals	---	363539	33202	32513	33587	37340	34301	34684	34016	31160	30721	308	301832
⊞Doncaster rural area population percentage breakdown - 14.48%													
⊟Percentage of referrals from rural areas compared to rural population - North Lincolnshire	44.37%	31.33%	31.44%	29.78%	29.84%	33.77%	34.43%	32.13%	31.57%	32.31%	32.96%	50.00%	32.15%
Total rural area referrals	---	7276	541	526	586	853	828	800	615	570	532	1	5852
Total referrals	---	23221	1721	1766	1964	2526	2405	2490	1948	1764	1614	2	18200
⊞North Lincolnshire rural area population percentage breakdown - 44.37%													
⊟Percentage of referrals from rural areas compared to rural population - Rotherham	9.47%	8.84%	7.44%	9.12%	7.40%	8.39%	8.37%	7.48%	7.42%	7.56%	7.53%	0.00%	7.85%
Total rural area referrals	---	1906	128	158	134	157	137	136	142	130	116	0	1238
Total referrals	---	21571	1720	1732	1810	1871	1636	1817	1914	1719	1541	4	15764
⊞Rotherham rural area population percentage breakdown - 9.47%													

Comparing the first quarter of this year to the previous year in terms of the per cent of referrals, North Lincolnshire and Doncaster has seen a slight increase in the numbers of people referred to our services from rural communities whereas Rotherham has decreased slightly.

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

Success Measures

- *Narrow the school readiness gap between our most deprived communities and average in each place in which we work*
- *Seek to see 80% of children meet their own potential for school readiness by 2028*

3.9.1 Success Measure 1 - Narrow the school readiness gap between our most deprived communities and average in each place in which we work

A more detailed paper for this Promise appears elsewhere on the agenda. An extract is below.

Local data indicates a marked decline in developmental outcomes between early toddlerhood and school entry. At 2–2.5 years, 87.6% of children in Doncaster and 86.3% in North Lincolnshire meet expected developmental milestones. By school entry, this reduces to 67.2% in Doncaster and 66.8% in North Lincolnshire, with provisional 2024 data indicating a further reduction to 64.7% in North Lincolnshire. These indicators reflect different measurement points and tools; they are used here to describe the trajectory and the size of the developmental 'drop-off' prior to school entry.

3.9.2 Seek to see 80% of children meet their own potential for school readiness by 2028

A more detailed paper for this Promise appears elsewhere on the agenda.

4. IPQR Health Inequalities Analysis and Action – Contribution of these Promises

4.1 At its September, October, and November meetings the Trust Board received and considered an analysis of the IPQR data through a health inequalities lens (similar reports have been presented to the E & I Group). In November, this analysis was supplemented by national research undertaken by Grounded Research. Without repeating the detail here, this showed that a significant number of services do not fully reflect the communities we serve (e.g. protected characteristics, deprivation). Also, some parts of our community are over-represented in some parts of our services. This could be positive for (e.g. referrals from people living in deprived communities into mental health services) or requiring further attention (e.g. black males are over represented as experiencing seclusion).

The work of some of the Promises described in this report will be directly attributable to help address some of the health inequalities people may experiencing.

Promise	Contribution (and which protected characteristic)
6 Poverty Proofing	Reduction in DNAs / WNBs of people from deprived communities (who are more likely to DNA / WNBs). This is for all services. (focus upon deprivation)
7 Core20PLUS 5	Healthchecks for people with a severe mental illness or learning disability (focus upon disability) Increase take up of mental health services by children of a black background (focus upon ethnicity)
8 RDaSH 5	Improve access rates to talking therapies among older adults (focus upon age) Increase diagnostic rates for dementia among minority ethnic citizens (focus upon ethnicity) Increase access to health checks for minority ethnic citizens with Learning Disabilities (focus upon ethnicity and disability) Tackle exclusion of BME and other Global Majority groups from peri-natal mental health services (focus upon ethnicity)
12 Rural	Close the gap in people from rural communities accessing services
17 School Readiness	Focus on children in experiencing deprivation (deprivation)

5. Next Steps

- Over the next three months, there will be sessions with clinical directorates to look at the data and work through actions where improvements to performance can be made in relation to the promises in the E&I plan.
- Actions identified in this paper will be implemented.
- Update reports will be provided by Promise leads.
- Work will commence on improving the data completeness of the ethnicity of our patients in services where this is poor.
- Regarding ethnic minority communities being over-represented on the IPQR such as seclusion, this will be looked into by Mental Health Legislative Committee and reported to the Board via the existing governance arrangements.

OTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks	**Agenda Item**	Paper V
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	29 January 2026

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. Whilst taking account of recently issued national guidance and maintaining that the five risks remain the focus of SDR work, the Board will in May 2026, consider again the delivery of its Strategy and assess the risks associated with delivery.

The paper sets out the progress made with respect to controls and assurances for each and this month the format has been refreshed to more clearly articulate the work completed and its impact, and to show what further controls and assurances are required. This refresh responds to feedback from internal audit (360 Assurance).

The progress with mitigation remains measured, particularly given the strategic nature of the risks, with importance on the development of leaders across the Trust (all SDRs), and external relations, particularly primary care, of significance to the mitigation.

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 t**he update position for each SDR.

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. Internal Audit has highlighted this and suggested this was considered by the Board of Directors. With the recent publication of significant guidance documents like the NHS 10-year plan, and during meetings the Board has considered this, with no changes suggested or made to date. It will repeat this formally at its meeting in May 2026.

2.2 With respect to the SDRs, review and monitoring work continues through

2.2.1 Individual executive leads and additional collective sessions with all leads.
2.2.2 Board Committees (all SR have been presented to Committees in December 2025 and January 2026)

2.2.3 the tri-annual reviews with Executive leads by the Audit Committee Chair and Director of Corporate Assurance.
2.2.4 Board of Directors

2.3 The current position in respect of each SDR is presented in Appendix 1. Of note in the progress within the Appendix is:

SDR1 and SDR5: There is interdependence in the work underway to address the two risks primarily with respect to the investment and development of our leaders and colleagues – to both work with our diverse communities (SDR1) and to make change occur (SDR5). Vitally, feedback from those colleagues about the impact and effectiveness of the various programmes and their increased confidence is key to mitigating the risks. In addition, for SDR1, to confirm that we have colleagues (staff, members, patients, carers, volunteers and peers) that are representative of those communities) When referring to our leaders, the initial groupings of those undertaking the Leadership Development Offer (circa n150) are now added to via different schemes aimed at First Line Managers and Multi Professional Teams. This increases the number we seek to support to be better able to respond to the issues within these risks. The feedback from them, to confirm their increased confidence is pivotal to the mitigation of these risks.

SDR2: The risk requires very much a two-point response to the elements of 'do we have the right data available?' and 'can we understand it, use it and make decisions/take action based on it? There is increased availability and assurance on quality of that data and 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 – examples being where we have started to better use HR data, waiting times data, finance data, clinical quality to drive improvement in performance and care.

SDR3: Appointments into senior leadership roles of colleagues with primary care experience are important and offering insight as expected. Dr Shah joining as an Associate NED is another example of this. National guidance in support of the NHS 10-year plan and neighbourhood working; and new national contracting arrangements, provide direction and expectation for all involved with within them, support to 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.) The Quality Committee in January had particular focus on P22 and neighbourhood working. Related work via HQTC and in wards towards consistent (across wards and across seven days) processes also help achieve this objective. Of note – 7-day activity schedules and consistent shift patterns are progressive achievements. 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 and greater partnership working will likely need to underpin further changes ‘as a system’ where there is reliance on others.

2.4 The recasting of the information into the revised format usefully questions the full content and executive leads will look to ensure that where necessary, additional controls, assurance and actions needed are identified and included in the future reports.

3 Recommendations

The Board of Directors is asked to:

RECEIVE and **NOTE** the update position for each SDR.

Philip Gowland, Director of Corporate Assurance
23 January 2026

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	

<u>Current controls</u> – what do we have in place to mitigate the risk?	**Current assurance/performance – how do we know the controls are working?**	**Gaps in assurance/performance – what else do we need to know?**
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.	The regular meetings taking place will afford the opportunity to assure on their effectiveness – CLE need to become aware of their progress and impact. The first 'place meeting', focusing on North Lincolnshire, took place on 20.01.26 and will help shape future meetings on other places in the coming months.
Educating our Staff: Leadership Development Offer includes, 'Compassionate leadership to unlock community power' — Both cohorts now launched.	Baseline data is available for the two cohorts and the initial data points have been shared at the June LDO Steering Group.	LDO feedback - Further detailed analysis planned. 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*

		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. Important within the above to establish in advance what outcome will be deemed 'positive' or satisfactory – 100% scores of confidence may be unachievable or unnecessary to be 'positive' but a target of 85%, for example, maybe our aim in the first instance to demonstrate initial impact.
Induction (all new starters) – RDASH and our communities – Launched 28 October 2024 November's induction was the thirteenth since its launch meaning circa 650 staff have now progressed via this induction. Evaluation of induction asks for participants to respond to questions such as, *'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*	Internal Audit – Induction: Significant Assurance Evaluation of induction presented in the Autumn to People and Teams CLE Group	Potential changes to the induction process based on the feedback being collated via a number of routes – direct from participants and via the Induction and Widening Participation Manager.
Educating Our Staff: Learning Half Days	Discussion at the Education and Learning meeting in June 2025, paper to CLE in June 2025 and a paper to Board in March 2025.	Robust forward plan to be developed to include related matters linked to this Strategic Delivery Risk and the development of a learning library
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 Remains* 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	Triangulating report on Employee Relations cases, FTSU and Complaints - presented to POD (August 2025) further supporting analysis in this area.	Further development of a 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'.
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.	Collation and presentation of related numbers, action plans for increased numbers and analysis of numbers in comparison to our communities – staff, patients, volunteers, members – understanding how representative we are in different cohorts. And using this within recruitment, decision making (e.g. change processes) 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	
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. 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)	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	

○ Promise 8 (PHPIP – Equity and Inclusion Plan) ○ Promise 10 (PHPIP – Equity and Inclusion Plan) ○ Promise 11 (PHPIP – Equity and Inclusion Plan) ○ Promise 26 (POD – People and Teams)	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 – significant assurance.	
<u>Future controls/assurances</u> – what key actions do we have planned to further mitigate the risk?	**Anticipated milestones**	**Progress *(note these will transfer in year to current controls/assurances as appropriate)***
LDO Research and Evaluation planned outputs (via K Williamson) including assessment against expected levels of achievement.	Next reports April and September 2026.	
Consideration of any changes to the induction process to reflect on feedback	In readiness for April 2026 onwards.	

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

Current controls – what do we have in place to mitigate the risk?	**Current assurance/performance – how do we know the controls are working?**	**Gaps in assurance/performance – what else do we need to know?**
Educating our leaders: Digital Needs Survey (completed in Q2) 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.	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 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. 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	Identification of key responses from colleagues to the educational efforts to demonstrate learning and great understanding.

Learning Half Days (ongoing from Sept 24) – feature learning opportunities focused on the importance of data and health inequalities.	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	
Data Availability: Do we have the data we need to make change?	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. From 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. PHPIP Committee – receives and discusses the Health Inequalities - Promises Data Set Report at each meeting; this for example will refer to DNA rates for deprived areas v rates for other areas; number of referrals for veterans) – this allows for purposeful and specific action to respond to the key messages. Progress has been achieved with more to complete.	Continue to develop the suite of data available.
Data Availability: Other: Do we have the data we need to make change?	Examples of where we have developed improved data to make change: Promise 14 delivery (48hr assessment / 4 week wait) – Report to Board to include progress update at November Board meeting. July 2025 – Position regarding 4 weeks waits. Waiting times published on the Trust website.	System Connect – Introduction of more standardised two-way communications options with patients, with potential to reduce DNAs, thereby supporting shorter waits, project due to complete in Feb 26. Neighbourhood working may drive other asks for different cuts our data, aiding understanding of inequalities of access.

Data Quality Is the data we use and make decisions on, 'quality data' with completeness, accuracy, timeliness etc underpinning it?	Information Quality Programme and reports to FDE noted structured and demonstratable process was in place. Completeness of ethnicity data – September Board reported Kitemarking – utilised within the IQPR against individual indicators 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.	Clinical Coding Audit due to be received in February 2026
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) FDE Strategic Delivery Risk Report relating to the oversight and management of SDR2	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.	Ongoing delivery of the E&I Plan and related Promises
<u>Future controls/assurances</u> – what key actions do we have planned to further mitigate the risk?	**Anticipated milestones**	**Progress *(note these will transfer in year to current controls/assurances as appropriate)***

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

<u>Current controls</u> – what do we have in place to mitigate the risk?	**Current assurance/performance – how do we know the controls are working?**	**Gaps in assurance/performance – what else do we need to know?**
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.	The regular meetings taking place will afford the opportunity to assure on their effectiveness – CLE need to become aware of their progress and impact. The first place meeting, focusing on North Lincolnshire, took place on 20.01.26 and will help shape future meetings on other places in the coming months.
Practical Programme of Change: Agreed programme of change (5 priorities) with Primary Care Colleagues. 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:	Latest assessment with CEO / DoSD / DCOO / Contracting / GP Liaison clarified progress and next steps planned – with 1 - 4 largely looking to identify and progress with pilot sites and agree action inc test and learn with primary care partners. Re: 5 – waiting times are now routinely published on the trust website.	The working group will meet again in February 2026 to confirm progress and to clarify reporting mechanism to ensure agreed timescales are achieved and have the intended benefits.

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.		
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. **Our current controls are deep involvement in:** - Decision making bodies as they evolve at place - Direct work with the Safecare 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	PHPIP Committee – January 2026 included discussions relating to Neighbourhood Health and the way forward for the Trust and partners. Change proposals in community settings (consultation from Feb onwards) in part look to respond to the forward look and aims of Neighbourhood working.	Trust continues to digest and seek to understand the full implications of the ten year plan and its impact and the required work with partners. for the Trust
GP Liaison role – key aim to establish regular touchpoints within each of the three places with GP representatives; programme of visits established to every practice, to PCNs and to local Federations.	Feedback mechanisms with GPs are established and embedded. Engagement (differing levels) with circa 90% of practices. Initial survey (May 2025) of how practices rate the current level of integration, collaboration and partnership with RDaSH of practices identified score of 2.52/5 (out of 5)	Need to understand how and if the last 12m has increased or improved the reputation, level of engagement and responsiveness in the eyes of the GPs? If previously the 'score' was 2.52/5, what would satisfactory progress look like?
Facilitate insight into General practice within: 1. *Senior individuals*: via Dr Richard Falk – NED and Dr Rumit Shah - ANED Dr Dean Eggitt – GP Partner Governor PCD CEX (route to CLE) GP Liaison role (see below) 2. *Care Groups:* GP related appointments into Care group structures e.g. Ben Allen and Matt Hodgson	PHPIP Committee – March 2025, presentation of GP Liaison role and work to date; Board Timeout – April 2025. GP Liaison role and work to date.	LDO Feedback and Evaluation (via Education and Learning CLE Group) – to secure confirmation that our leaders have the necessary skills and experience linked to the work with primary care and other partners in particular the answer to "*Has the LDO improved RDaSH Leaders' engagement with each other and the community?"*

3. Wider Workforce: increased awareness via LDO and via LHD, some of which are scheduled to align to known GP training schedules such as 'Target' in Doncaster (i.e. PM on Wednesdays)		LHD – primary care knowledge and understanding – needs to be purposefully built into this programme of learning
PHPIP Strategic Delivery Risk Report relating to the oversight and management of SDR3	PHPIP assured on progress and frequency of reporting	Continued to be scheduled for review to ensure continued oversight
<u>Future controls/assurances</u> – what key actions do we have planned to further mitigate the risk?	**Anticipated milestones**	**Progress *(note these will transfer in year to current controls/assurances as appropriate)***
The 'Place Partnership Reviews' (aka 'cake' meets) will be scheduled on a monthly basis	Meetings commenced in January 2026 (NL focus) Others follow on monthly basis.	
LDO Research and Evaluation planned outputs (via K Williamson)	Next reports April and September 2026.	
Repeat the survey of GP practices to establish the increase or improvement in reputation, level of engagement and responsiveness.	May 2026	

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	

<u>Current controls</u> – what do we have in place to mitigate the risk?	**Current assurance/performance – how do we know the controls are working?**	**Gaps in assurance/performance – what else do we need to know?**
Service provision (RDASH) High Quality Therapeutic Taskforce (est Jan 25) 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	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. Progress towards 7d admissions and discharges has been made and is also including our local partner organisations too. 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	

• 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.	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 workers) 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 on website. • Out of Area Placements – number (at 13/1/2026) 16 inappropriate (7 NL / 4 R) (with D maintaining zero) • Delays in discharges (at 13/1/26 17) • Length of stay metric introduced (Mean of patients on the ward) percentage of patients over 32 days • 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. 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 seven-day services	Further consideration of the alternatives 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?)
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. Consider workforce models of support - training; enhanced work flexibility; clarity on support and supervision models; safety	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. Broad engagement with staff during the implementation of 7dpw activities.	Comprehensive mechanism for collation and reporting of feedback gained via: o Staff Survey o Pulse Check o Peer Reviews o Consultation responses o Responses via Unions and Staff Side o 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.
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 P22 Seven Day services – PHPIP Committee January 2026 presented tangible progress in improving weekend access to urgent and crisis mental health services and in reducing out-of-area placements and length of stay through better demand, capacity and flow management. IQPR data – Length of Stay; Patients who remain on the ward over 32 days.	P22 progress: Full seven-day working—particularly weekend discharges—remains limited due to workforce, system and cultural constraints. Further phased development, system alignment and completion of a formal quality and safety risk analysis are required to deliver the full benefits of the Promise.
QC Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk	Each meeting in 2025/26	
<u>Future controls/assurances</u> – what key actions do we have planned to further mitigate the risk?	**Anticipated milestones**	**Progress *(note these will transfer in year to current controls/assurances as appropriate)***
P22 - Further phased development, system alignment and completion of a formal quality and safety risk analysis are required to deliver the full benefits of the Promise.		

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

<u>Current controls</u> – what do we have in place to mitigate the risk?	**Current assurance/performance – how do we know the controls are working?**	**Gaps in assurance/performance – what else do we need to know?**
Induction – Launched 28 October 2024	Internal assurance via periodic induction feedback to People and Teams CLE; next due in Autumn. External assurance – significant assurance from internal audit; received September 2025.	Further internal assurance anticipated via an independent colleague and via the newly appointed Induction and Widening Participation Manager.
Feedback from our colleagues	Staff Survey – primary source of feedback from colleagues internal to the Trust. from stakeholders 'in-year' and without formal structure Open Staff meetings (Autumn (200+ attended) – additional sessions from 2026. Headlines / reoccurring themes shared within EG / Pulse Check – underway quarterly – more work to do in generating responses…and Care Opinion (staff point of view within teams)	Staff survey results due Q4 - for the first time the results will be stratified not only by CG, directorate and teams but will identify 'new starters' as a cohort – link to impact of induction.
Monthly **learning half days** – commenced September 2024	Internal assurance/performance – pending	Action 1. Need to develop mechanisms of feedback from leaders to demonstrate their increased competence and confidence

		regarding making change occur and adding social value, with the colleagues on these stated programmes being the audience
Leadership development offer	Circa 130 individuals inc 15 community leaders; Two cohorts are now underway. LDO steering group Nov 2025 – received the latest evaluation perspective. Emerging insights from facilitators to challenges experienced. More to be done to understand the impact of this programme for our leaders.	See action 1.
Wider learning opportunities, including: Leaders Annual Conference First Line Managers Training Scheme 555 Line Managers	Leaders Annual Conference – circa 130 staff as the Top Leaders Cadre. First Line Managers Training Scheme – Launched April 2025 555 Line Managers – focus on development and communication channels.	Future learning opportunities planned: Clinical Leaders Training Programme (2026) MPLT – Multi Professional Leadership Team development programme (2026) See also action 2.
Increased capacity; including: • Use of 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	Apprentice levy: Nov 25: 99% utilised to date in 25/26; Forward plan included levy transfer to community partners within 25/26. Purposeful aim to Ability to support in final months before year end achievement. Full recruitment: Nov 25: Current vacancies in CEX Report Annex (223 FTE) Training Budget: 2025/26: Ringfenced budget in place again with utilisation of 100% or more anticipated. Internal audit significant assurance on MAST – received April 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)	Promises and Priorities Scorecard P9 – Apprenticeships – March 2025 P26 – Board of Directors March / May 2025 Voice Scorecard Report to the Trust People Council	

○ Promise 26 Anti-Racism (POD – People and Teams Plan) Trust People Council People and Teams CLE Group and Education and Learning CLE Group – established and meeting regularly POD Strategic Delivery Risk Report relating to the oversight and management of SDR5 to POD Committee	Each meeting throughout 25/26	
<u>Future controls/assurances</u> – what key actions do we have planned to further mitigate the risk?	**Anticipated milestones**	**Progress *(note these will transfer in year to current controls/assurances as appropriate)***
1. Further **developments to internal feedback mechanisms** – particularly from leaders		
2. Revised **appraisal process**	During 26/27	The change to the appraisal process will identify and respond to the need to create learning opportunities for each colleague.
3. Planned **Promise 26 audit**	Q4 25/26	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational Risk Report	**Agenda Item**	Paper W
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	29 January 2026

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

This report updates the Board on the Trust's current operational risk position, with reporting now firmly embedded against our agreed appetite and tolerance levels. This month, the focus is on those risks that remain outside tolerance following review and moderation through the Risk Management Group, giving a clearer picture of where Board oversight is most needed. We have also included an expected resolution lead time for each out-of-tolerance risk.

This is intended to give a better sense of how quickly improvement is likely to be seen, recognising that actions and controls take time to embed and do not always have an immediate effect. This assessment is based on the current position of controls and planned actions and is not fixed. It will be updated as progress is made and as further assurance is gained.

Together, these changes help the Board see not just where risk exposure sits today, but how it is expected to move over time. They reflect a shift from simply having the framework in place to using it in a way that strengthens assurance and supports better oversight and decision making.

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 risk	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	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Appendix (please list)							
None							

1. Overview

1.1 Operational risk reporting to the Board has evolved from a focus on extreme-rated risks to a clearer alignment with the Trust's defined appetite and tolerance levels. This ensures that reporting reflects the full risk framework and provides a more balanced view of exposure across all directorates.

1.2 This month's report presents those risks that remain outside tolerance, following moderation through the Risk Management Group. This focus provides assurance that directorates are actively managing their risks within appetite or tolerance and that only those requiring escalation for Board oversight are highlighted.

1.3 Through the RMG, we continue to further develop and refine the moderation process, focusing on improving the consistency of challenge, the quality of supporting evidence, and the accuracy of appetite alignment. This iterative improvement ensures the process matures month by month and reflects good practice in operational risk governance.

1.4 These continued improvements demonstrate the maturing of the risk management framework, ensuring the Board receives clear, evidence-based assurance on operational risks that sit beyond acceptable thresholds.

2. Current Operational Overview

2.1 This month's report reflects the fact that the rolling approach to reviewing out-of-tolerance risks is now established and working as intended. Rather than revisiting every risk each month, the focus remains on those areas where assurance is most needed, allowing time for actions to take effect and for progress to be meaningfully assessed.

2.2 This approach was introduced to strengthen assurance while avoiding unnecessary repetition in monthly reviews. Controls and mitigating actions often require time to take effect and reviewing every risk each month can lead to limited new insight. The rolling cycle allows sufficient time for actions to embed and for changes in exposure to be meaningfully assessed, ensuring that discussion remains focused and evidence informed.

2.3 A pre-moderation session is also held ahead of each RMG meeting to review risk scores and appetite alignment. This enables the RMG to concentrate its main discussion on the adequacy and impact of mitigations rather than on recalibrating scores.

2.4 A key area of focus this period has been how we capture risks that are emerging from ongoing change activity across the Trust. It is important that risks linked to change are identified early rather than appearing later when impacts are already being felt. To support this, the risk onboarding form has been updated to include a specific question asking whether the risk relates to a change process. This will help strengthen visibility and oversight of change related risks from the outset.

2.5 As at the latest review, there are 328 risks recorded on RADAR. The distribution against appetite and tolerance is as follows:

- Within Appetite (Green): 119 risks (36%)
- Within Tolerance (Amber): 180 risks (55%)
- Outside Tolerance (Red): 29 risks (9%)

Compared to the previous reporting position (314 risks in total), there has been a net

increase of 14 risks across the Trust. The proportion of risks within appetite has remained broadly stable (37% to 36%), while those within tolerance have reduced slightly (57% to 55%). The number of risks outside tolerance has increased from 19 to 29, reflecting the identification and moderation of emerging risks, particularly those linked to ongoing change activity, rather than a deterioration in existing controls. The current out-of-tolerance risks are listed in **Appendix 2**.

2.6 A total of nine (9) risks that were reported as out of tolerance in the previous Board report have now improved and no longer sit outside tolerance in this month's position. These risks are therefore not included in the current out-of-tolerance list and are presented in **Appendix 1**, reflecting their movement into either tolerance or appetite.

2.7 As set out last month, resolution lead time was introduced to provide an indication of when improvement was expected for risks sitting outside tolerance. Of those nine risks, four (4) were assessed as having a short-term resolution lead time and have progressed as expected within the three-month period. The remaining five (5) were originally assessed as longer-term risks, with resolution expected to take six months or more. However, controls have embedded more quickly than anticipated, and risk exposure has reduced sooner, with these risks now also sitting within tolerance

3. Conclusion

3.1 This month's report shows a clearer and more mature picture of operational risk across the Trust. Reporting is now firmly focused on those risks that remain outside tolerance, with improved visibility not only of current exposure but also of the expected direction of travel as controls and actions embed.

3.2 Appendix 1 shows that several risks previously reported as out of tolerance have now reduced to within tolerance or appetite, providing early evidence that moderation and management actions are working. The introduction of resolution lead time has added a forward-looking dimension to assurance, helping distinguish between risks that require immediate attention and those where progress is being made but time is still needed.

3.3 The remaining out-of-tolerance risks continue to receive focused oversight through the Risk Management Group and will be kept under review until sufficient assurance is gained that exposure has reduced to acceptable levels. Alongside improved capture of risks arising from change activity, this provides the Board with a more complete and balanced view of both current risk exposure and emerging pressures.

4. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the operational risk report

Philip Gowland
Director of Corporate Assurance
21 January 2026

Appendix 1- Downgraded Out of Tolerance Risks (No longer Out of Tolerance)

Reference	Description	Category	Resolution Lead Time	Current score	Appetite Level/ Upper Tolerance Limit	Region
RSK-194	Due to potential non-delivery of the savings programme, existing cost pressures, care group service overspending, and pay award settlements, there is a risk that the financial plan will not be achieved. This may result in increased scrutiny, additional interventions from NHS England, and the Trust potentially moving into Segment 4 oversight.	Financial Risk - Financial Planning, CIP & Sustainability		12	Low	Finance & Procurement 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		12	Low	Nursing & Facilities 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		10	Averse	Nursing & Facilities 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		12	Averse	Rotherham Community Mental Health Directorate
RSK-382	Due to the occupational-therapy kitchen being located outside the ward air-lock 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		8	Averse	Rotherham Acute Mental Health 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	Patient Care Risk - Clinical Safety		9	Averse	Doncaster Community Mental Health Directorate

Reference	Description	Category	Resolution Lead Time	Current score	Appetite Level/ Upper Tolerance Limit	Region
	inappropriate care, increased safety risks to patients, staff, and the public, and reputational harm.					
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		12	Low	Rehabilitation Directorate
RSK-405	Due to NCAP data from MHDS and IT systems not capturing DIALOG frequency correctly, there is a risk that team data is recorded inaccurately, which may result in false performance levels being reported.	Performance Risk - Information Governance		9	Averse	Rotherham Community Mental Health Directorate
RSK-418	Due to the national targets for Reliable Recovery and Reliable Improvement in NHS Talking Therapies continuing to rise through to 2029, there is a risk that the service may not meet the required trajectory, which may result in reduced compliance with national standards, potential reputational damage, and diminished outcomes for service users.	External and Partnership Risk - Regulatory		9	Averse	Talking Therapies Directorate

Resolution Lead Time **3 to 6 months**

Resolution Lead Time **6 months +**

Appendix 2 - Out of Tolerance Risks (Currently Out of Tolerance)

Ref	Description	Category	Resolution Lead Time	Current score	Appetite Level	Region
RSK-507	Due to increased levels of staff absence and limited availability of supervisors, non-medical prescribing supervision compliance within the Doncaster 0 to 5 team is currently low. There is a risk that prescribing practice is not regularly appraised or discussed in the appropriate forum, which may result in safety and quality concerns not being identified, escalated, or addressed.	Patient Care Risk - Clinical Safety		9	Averse	Children's Physical Health (CYP) Directorate
RSK-498	Due to delays in recruitment of WAVE 14 staff in line with nationally recommended MHST staffing models, there is a risk that WAVE 14 for Doncaster and Rotherham With Me In Mind will be unable to enter mobilisation in January 2026 to deliver the service. This may result in reputational damage, staff unable to access paid for university places, no data to flow into the WAVE 14 MHST data set and review of contract delivery by commissioning team.	People Risk - Capacity		12	Low	Children's Mental Health (CAMHS) Directorate
RSK-497	Due to the removal of four WTE Education Mental Health Practitioners from the With Me In Mind Doncaster budget, there is a risk that there is insufficient EMHP capacity within the team to meet demand, which may result in secondary waiting lists developing within the service and a negative impact on performance against the Mental Health Support Team data set.	Performance Risk - Capacity & Demand Management		12	Low	Children's Mental Health (CAMHS) Directorate
RSK-481	Due to Hazel and Hawthorn wards not having continuous medical cover and SystmOne electronic transcribing requiring two sources of evidence, including labelled boxed medication, there is a risk that when patients are transferred from the acute trust with missing medicines the ward is unable to confirm and administer the required medications in a timely way, which may result in missed doses and patient deterioration.	Patient Care Risk - Clinical Safety		8	Averse	Rehabilitation Directorate

Ref	Description	Category	Resolution Lead Time	Current score	Appetite Level	Region
RSK-477	Due to 3 x staff leaving the team and ongoing staff sickness in AOT and the potential for additional staff absences, there is a risk that patient care and continuity will be impacted, 4-week wait targets will not be met, staff wellbeing and retention will decline, and MAST compliance will remain low.	Patient Care Risk - Clinical Safety		12	Averse	Rotherham Community Mental Health Directorate
RSK-455	Due to a lack of staff, limited availability of supervisors, sickness, and time taken for team meetings, safeguarding supervision compliance within the Neurodiversity Directorate is currently low. There is a risk that safeguarding issues are not raised or discussed in the appropriate forum, which may result in safeguarding concerns remaining unresolved or unreported and reduced assurance that the team is working safely.	Patient Care Risk - Clinical Safety		9	Averse	Neurodiversity Directorate
RSK-445	Due to significant staffing shortages in community psychology work-force, there is a risk of compromised patient care though increased waiting times for treatment, as well as burden and further staff sickness in wider psychological workforce.	Performance Risk - Capacity & Demand Management		12	Low	Rotherham Community Mental Health Directorate
RSK-181	If there is no appropriate AHP clinical leadership across the directorates in our mental health care groups, there is a risk that AHPs will be under represented within services in decisions which affect the strategic direction of the service and the care of patients. This may result in difficulties with employee satisfaction, recruitment and retention, sickness absence, as well as lack of therapeutic environment.	People Risk - Capability and Performance		12	Low	Psychological Professions & Therapies Directorate
RSK-154	If colleagues do not respond to requests for internal audit actions, Board and committee papers, or contributions to statutory reports, there is a risk that the Corporate Assurance Team will be unable to fulfil governance requirements, which may result in weakened oversight, delays in assurance processes, and reputational or regulatory consequences.	External and Partnership Risk - Legal & Governance		9	Averse	Corporate Assurance Directorate
RSK-141	If alternative accommodation for Kimberworth Place is not secured, there is a risk that staff will experience overcrowding and difficulty finding suitable workspace, which may result in reduced productivity, heightened stress, and poorer wellbeing.	People Risk - Well-being & Retention		12	Low	Children's Mental Health (CAMHS) Directorate

Ref	Description	Category	Resolution Lead Time	Current score	Appetite Level	Region
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		10	Averse	North Lincolnshire Acute Mental Health 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		9	Averse	Medical, Pharmacy & Research Directorate
RSK-508	Due to staff turnover and maternity leave, staffing within Rotherham Getting Advice will reduce from January 2026 to one point zero WTE Band four and two point zero WTE Band six, there is a risk that this reduction in capacity will lead to not being able to maintain promise 14 (4 week wait) and also the increased pressure will have further impact on staff wellbeing in the team, which may result in increased pressure on remaining staff, further sickness or turnover, and young people not accessing the service in a timely way.	People Risk - Capacity		12	Low	Children's Mental Health (CAMHS) Directorate
RSK-476	If anti ligature doors are not installed on Windermere, 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		10	Averse	Doncaster Acute Mental Health Directorate
RSK-474	Due to the absence of an agreed funding arrangement for the provision of complex equipment and high-cost consumables for patients in the community, there is a risk that the Trust will incur unfunded expenditure, as these items are being purchased without a defined budget, which may result in financial pressure for the organisation and an unsustainable cost burden for the service.	Financial Risk - Financial Planning, CIP & Sustainability		12	Low	Community & Long Term Conditions Directorate

Ref	Description	Category	Resolution Lead Time	Current score	Appetite Level	Region
RSK-473	Due to the lack of a clear process for how complex equipment and consumables should be provided for patients discharged from acute settings, Community Nursing staff are required to spend time sourcing and purchasing equipment, there is a risk that this reduces the service's capacity to provide timely and appropriate patient support, which may result in delays in care, limited oversight of equipment use, and missed clinical issues.	Performance Risk - Capacity & Demand Management		12	Low	Community & Long Term Conditions Directorate
RSK-468	Due to a lack of available funds or knowledge on how to secure funding for decarbonisation initiatives, there is a risk that the Trust will not meet its Green Plan targets, impacting sustainability commitments and regulatory expectations.	External and Partnership Risk - Regulatory		9	Averse	Strategic Development Directorate
RSK-460	Due to multiple monitoring platforms collecting different data, lack of a central reporting system, and limited engagement from prescribers, there is a risk that governance oversight of non-medical prescribers is ineffective, resulting in an inability to accurately identify all active prescribers or provide assurance on compliance, training, and safe prescribing practices across the Physical Health and Neurodiversity Care Group.	Patient Care Risk - Clinical Safety		9	Averse	Community & Long Term Conditions Directorate
RSK-459	Due to the potential unavailability of complex equipment, lack of staff knowledge on its use, absence of a confirmed process for responsibility, and no financial agreements in place, there is a risk that specialist equipment provided by the community nursing service (e.g., ventilators, cough assists, suction machines) may not be maintained, serviced, repaired, or replaced in a timely manner, which could lead to delays and significant implications for patient safety.	Patient Care Risk - Clinical Safety		12	Averse	Community & Long Term Conditions Directorate
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		9	Averse	Rehabilitation Directorate

Ref	Description	Category	Resolution Lead Time	Current score	Appetite Level	Region
RSK-220	If waiting times for ASD and ADHD assessments remain above target, there is a risk that children and young people will receive delayed diagnoses, which may result in poorer educational and health outcomes, increased strain on the service and staff, failure to meet Strategic Objective Promises 8 and 14, reputational damage, and additional unfunded financial pressure on the Care Group.	External and Partnership Risk - Delivering Our Promises		15	Low	Children's Physical Health (CYP) Directorate
RSK-208	Due to the current skill mix on mental health wards, specifically the proportion to registered to under-registered, which is a lower number of registered nurses on shift than national guidance recommends, there is a risk that patients will receive inadequate care and RMNs will be unable to fulfil their legal duties under the Mental Health Act or perform essential clinical and safety tasks, which may result in patient or staff safety incidents, MHA breaches, and staff fatigue or sickness due to increased pressure.	People Risk - Capacity		12	Low	Nursing & Facilities 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		12	Low	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 financial sustainability could be adversely affected resulting in additional interventions by NHSE/ DHSC.	Financial Risk - Financial Planning, CIP & Sustainability		12	Low	Finance & Procurement Directorate

Ref	Description	Category	Resolution Lead Time	Current score	Appetite Level	Region
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		15	Low	Neurodiversity 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		12	Low	Health Informatics Directorate
RSK-108	Due to existing qualified podiatry vacancies and impending maternity leave within the Podiatry team, there is a risk that the service will be unable to offer some patients an appointment within a 4-week timescale. This may result in patients experiencing deteriorating foot conditions that could lead to infection, sepsis, loss of limb and potential death.	People Risk - Capacity		16	Low	Community & Long Term Conditions 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		9	Averse	Medical, Pharmacy & Research 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		9	Averse	Medical, Pharmacy & Research Directorate

Resolution Lead Time **3 to 6 months**

Resolution Lead Time **6 months +**