**Rotherham Doncaster and South Humber NHS Foundation Trust**


**Council of Governors**


**11 March 2026**


Pack B INDEX


This pack contains additional supplementary documents and information that will support Governors understanding and awareness to a range of topics that are mentioned within the main Papers for the COG Meeting. This month they are:

**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.

.**Our population and partners**

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

**ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST**

**Latest Promises Update**

<u>Purpose and introduction</u>

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.

<u>Year of peer support?</u>

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 <u>instructed</u> 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<br>Green (G) – Finalised and agreed<br>Amber/Green (AG) – Developed and being refined<br>Amber/Red (AR) – Understood but Not well documented<br>Red (R) – Not constructed yet | Comments on delivery plan | Likelihood of delivery<br>Green (G) – On track to succeed<br>Amber/Green (AG) – Largely on track, and properly understood<br>Amber/Red (AR) – Solutions known but implementation requires support<br>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** |

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| | Green | | Amber green | **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** |

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| 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) |

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| 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

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| 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.** |

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| 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.<br><br>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.<br><br>There is sufficient capacity exists to shift the dial towards 12% coverage. Right now our miss of this measure is cause-unknown. |

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| 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.<br><br>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. |

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| 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.<br><br>**We will be repeating our culture of care assessment in coming weeks.** |

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| 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.<br><br>*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. |

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| 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. |

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| 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.<br><br>**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

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| 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 | |

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| 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. |

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| 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.<br><br>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. |

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| 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. |

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| | Green (G) – Finalised and agreed<br><br>Amber/Green (AG) – Developed and being refined<br><br>Amber/Red (AR) – Understood but Not well documented<br><br>Red (R) – Not constructed yet | | Green (G) – On track to succeed<br><br>Amber/Green (AG) – Largely on track, and properly understood<br><br>Amber/Red (AR) – Solutions known but implementation requires support<br><br>Red (R) – Actions to succeed not yet known or fully elaborated | |
| 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.<br><br>Our 'remote' policy and practice will be crucial to success.<br><br>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. |

# 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.<br><br>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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**Integrated Quality Performance Report** The committee noted that the falls | | |

| | risk assessment target (QS37) had been fully met for the first time. |
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| 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: | 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.<br>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.<br><br>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)**<br>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.<br>**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%,<br>**Consent to treatment at 3 months** 100% compliance at Doncaster, 28% Rotherham and North Lincolnshire required no forms.<br>**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)<br>**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.<br>**Section 23** one discharge occurred without complete paperwork, which was noted as unusual.<br>**MHA Performance Report (October and November 2025)**<br>**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.<br>**Blanket Restrictions** 2 new blanket restrictions were introduced, one related to an individual patient and another concerning estates, both have since been closed.<br>**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.<br>**Absence Without Leave (AWOL)** There were no absconding incidents despite report categorisation errors.<br>**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.<br>**Mental Health Act and Reducing Restriction Intervention Training Compliance**<br>Progress on mandatory training compliance remained below the level | | |

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| | 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

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| **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.<br>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.<br>**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.<br>**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.<br>**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).<br>**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.<br>**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. |
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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<br>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.<br>**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.<br>**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.<br>**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, | | |

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| | locally driven improvements, supported by changes in leadership and the strategic development function.<br>**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.<br>**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.<br>**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

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|---|---|---|---|
| **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**

<u>Reminder</u>

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 <u>we do now "show up":</u>  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.

<u>Doing what we said we would do</u>

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.

Making this effective for all involved

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. <br><br> - Being able to access meetings in person or remotely. <br><br> - Introductions to all, including new people and deputies. <br><br> - 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. <br><br> - There is no 'easy read' or quick read for many meetings, which makes them difficult to access and navigate. <br><br> - Too many things being scheduled in a meeting meaning some people cannot contribute to discussions. |

- Abbreviations being used too much without explanations.

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### 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.

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- 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%) |
| Choices about what to prioritise<br><br>Decisions made about service design<br><br>Senior recruitment decisions<br><br>Committees and other forums<br><br>Policy development | Offer time for our leaders and clinicians to immerse themselves within our communities<br><br>Invest our funds locally, working with bodies who share our social values<br><br>Recruit students, volunteers and staff from our local communities, creating opportunities for all<br><br>Support partnership efforts, working with all stakeholders: with an intentional bias towards seldom-heard residents and groups<br><br>Be open to organisations of different sizes and traditions – sharing data, skills, and funds wherever possible<br><br>Join others' forums in preference to hosting our own<br><br>Prioritise conversations at place and neighbourhood level<br><br>Use neighbourhood spaces for our work |
| **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.**<br><br>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. |

# 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.

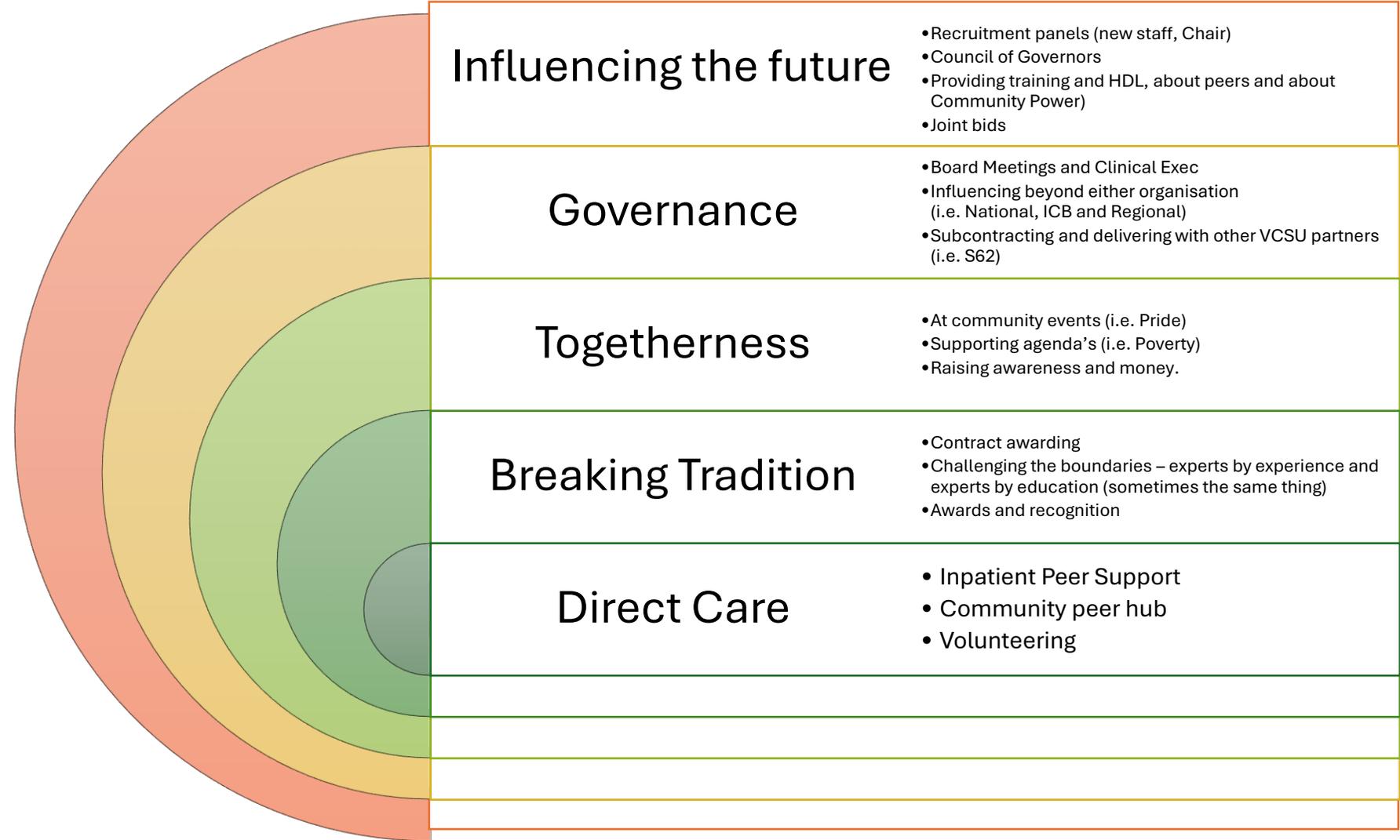This must be understood in the context

- 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

**Influencing the future**
- Recruitment panels (new staff, Chair)
- Council of Governors
- Providing training and HDL, about peers and about Community Power)
- Joint bids

**Governance**
- Board Meetings and Clinical Exec
- Influencing beyond either organisation (i.e. National, ICB and Regional)
- Subcontracting and delivering with other VCSU partners (i.e. S62)

**Togetherness**
- At community events (i.e. Pride)
- Supporting agenda's (i.e. Poverty)
- Raising awareness and money.

**Breaking Tradition**
- Contract awarding
- Challenging the boundaries – experts by experience and experts by education (sometimes the same thing)
- Awards and recognition

**Direct Care**
- Inpatient Peer Support
- Community peer hub
- Volunteering

# 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**

Council of governors

Board of directors

Charitable Funds Committee

Audit Committee

People & OD Committee

Mental health legislation committee

Quality Committee

Finance and investments Committee

Trust People Council

Patient involvement, Partnerships and Public Health Committee

Clinical Leadership Executive

Risk Management Group

Operational Management Group

High quality therapeutic care taskforce (until Feb 2026)

Bi-monthly delivery reviews

Ethics group

People and teams group

Education and learning group

Quality and safety group

Finance group

Digital transformation group

Estate and sustainability group

Research and innovation group

Equity and inclusion

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# 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.

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**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

People supported this month: _____

Total meetings or contacts: _____

Average contacts per person: _____

How many contacts were face-to-face: _____

## 2. Access to Peer Support

New people referred: _____

Waiting time for first contact (days): _____

People waiting: _____

Did Not Attend (DNA) rate:_____

## 3. Outcomes – How people feel

People feel better / more hopeful: _____

Wellbeing improved: _____

People reached their goals: _____

Crisis contacts reduced: _____

A&E visits reduced: _____

Hospital admissions reduced: _____

Average time in hospital (days): _____

## 4. Experience of the service

Friends and Family Test rating: _____

Care Opinion feedback: Positive/ Negative

Good feedback themes: _____

MDT (team) satisfaction: _____

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# 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.

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Difference in Peer and Lived Experience
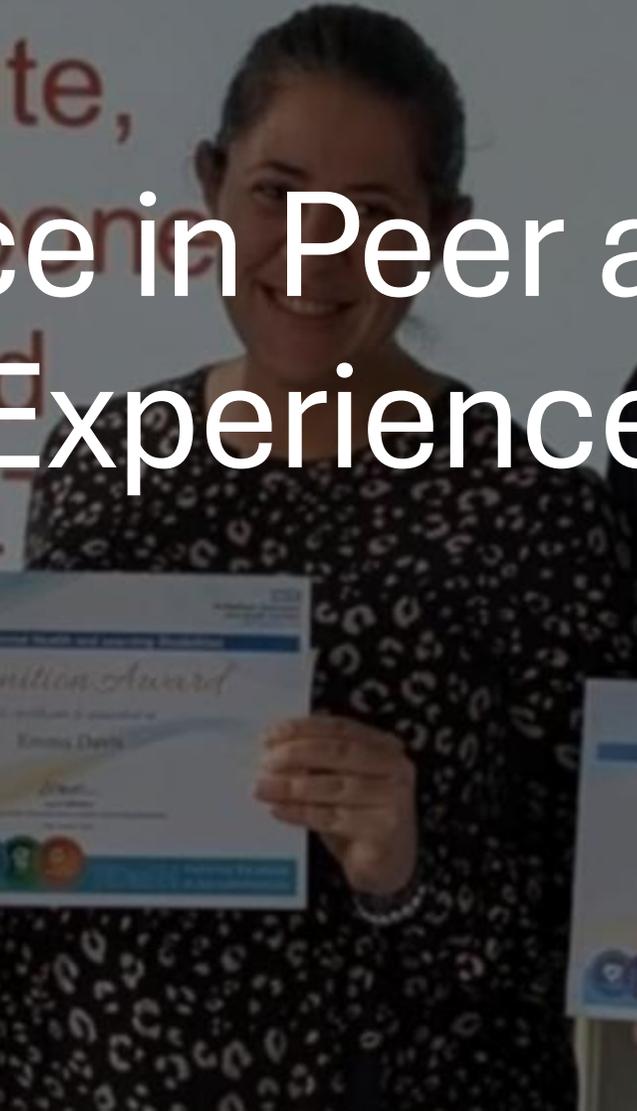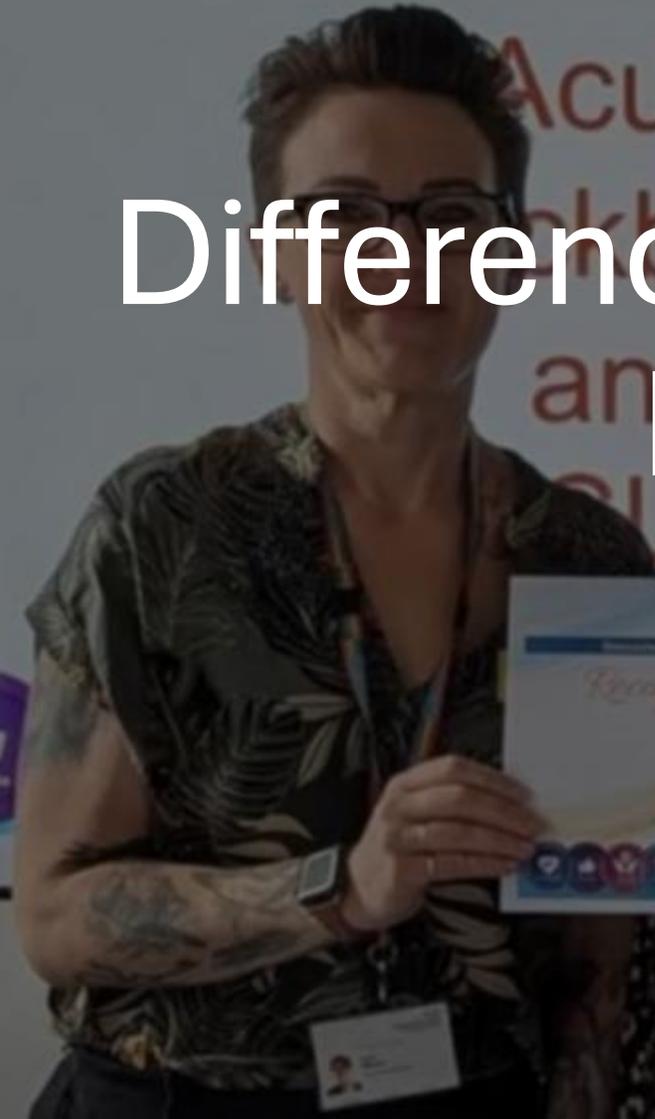
# Issues and Resolution

## What we invest (Inputs)

- 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

## What the service does (Activities)

- 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.** | **For Service Users** |
| | •      **Increased sense of hope, control & recovery** |
| **Examples:** | •      **Improved confidence, self-efficacy, and self-management** |
| •      **Number of individuals receiving peer support** | •      **Reduced loneliness/social isolation** |
| •      **Number of peer support sessions delivered** | •      **Increased engagement with care** |
| •      **Number of groups co-facilitated** | •      **Faster transitions and reduced DNAs** |
| •      **Number of recovery stories or co-produced resources** | **For Staff & Teams** |
| •      **MDT meetings attended** | •      **Improved team culture & recovery orientation** |
| •      **Care plans co-developed** | •      **Reduced stigma towards lived experience** |
| •      **Number of co-production events/projects** | •      **Improved communication between services** |
| •      **Staff teams trained in peer support principles** | •      **Better relationships between service users and clinicians** |
| •      **Recorded wellbeing or recovery measures completed** | **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 | • Peers receive high-quality training and supervision |
| • Reduced use of crisis and urgent care pathways | • MDTs value and integrate peer roles |
| • Better transitions from inpatient to community care | • Clear boundaries and safeguarding expectations |
| • Enhanced patient experience across services | • Trust culture supports lived experience leadership |
| • Increased community connection and independence | • Services commit to co-production and continuous improvement |
| • Strengthened co-production culture | **External Factors** |
| • Sustained lived experience leadership across the organisation | • Workforce shortages and funding constraints |
| • Contribution to NHS commitments for personalised care and workforce diversification | • Community resource availability (VCSE) |
| | • National NHS policy (e.g., personalised care, trauma-informed approaches) |
| | • Social determinants of health |
| | • Digital access |

# Next Steps...........

# Any Questions?