

AGENDA

BOARD OF DIRECTORS

Thursday 28 May 2026 at 9.30am

Riverside House, Main Street, Rotherham, S60 1AE

No	Time	Item	Request to	Lead	Enc.
1	09.30	Welcome		Kath Lavery, Chair	A
2		Apologies for Absence: Dr Diarmid Sinclair	Note Information		
3		Quoracy (One third of the Board; inc. one NED and one ED)			
4		Declarations of Interest			
		Standing items			
5	09.32	Minutes of the meeting held in public on the 26 March 2026	Decision	Kath Lavery, Chair	B
6		Matters Arising and Follow up Actions	Decision		C
6.1		Workplace Violence and Aggression	Information	Steve Forsyth, Chief Nurse	Verbal
		Board Assurance Committee Reports to the Board of Directors			
7	09.35	Quality Committee	Assurance	Richard Falk, NED	D
8		Audit Committee	Assurance	Kathy Gillatt, NED	E
9		Mental Health Act Committee	Assurance	Maria Clark, NED	F
10		People & Organisational Development Committee	Assurance	Sarah Fulton Tindall, NED	G
11		Public Health Patient Involvement & Partnerships Committee	Assurance	Rachael Blake, NED	H
12		Finance, Digital & Estates Committee	Assurance	Pauline Vickers, NED	I
13		Trust People Council	Assurance	Dave Vallance, NED	J
		Operating Performance / Governance / Risk Management			
14	10.05	Strategy Delivery Risks	Information	Philip Gowland, Director of Corporate Assurance	K
15	10.15	Operational Risk Report **	Information	Philip Gowland, Director of Corporate Assurance	L
16	10.30	Integrated Quality Performance Report (IQPR)	Information	Toby Lewis, Chief Executive	M
17	10.40	Promises and Priorities Scorecard **	Information	Toby Lewis, Chief Executive	N
18	10.50	Organisational Change Key Performance Indicators	Information	Steve Forsyth, Chief Nurse	O
19	11.00	Chief Executive’s Report	Information	Toby Lewis, Chief Executive	P
20	11.15	Energy Feasibility Study – route to Full Business Case	Decision	Jo McDonough, Director of Strategic Development	Q
BREAK 11.30 (15 mins)					

No	Time	Item	Request to	Lead	Enc.
21	11.45	Sickness Absence	Information	Carlene Holden, Director of People and OD	R
22	12.10	2025-26 serious patient safety incidents – learning update	Information	Steve Forsyth, Chief Nurse	S
23	12.35	Well led – externally commissioned developmental review **	Information	Philip Gowland, Director of Corporate Assurance	T
Patient Story					
24	12.45	Patient Story	Information	Steve Forsyth, Chief Nurse	Verbal
LUNCH 13.10 (30 mins)					
25	13.40	Culture Work	Information	Toby Lewis, Chief Executive / Carlene Holden, Director of People and OD	U
26	14.05	Staff Survey **	Information	Carlene Holden, Director of People and OD	V
27	14.20	Freedom To Speak Up bi annual update **	Information	Steve Forsyth, Chief Nurse	W
28	14.30	Older Adults Indicators	Information	Dr Andrew Heighton, Deputy Medical Director	X
29	14.45	Board and Committee workplans	Decision	Philip Gowland, Director of Corporate Assurance	Y
30	14.55	Fit and Proper Person Test **	Decision	Philip Gowland, Director of Corporate Assurance	Z
Supporting Papers (previously presented at Committee)					
31	15.00	Establishment Review Paper for Safer Staffing and Annual Declaration Report Mortality Report: Jan and Feb 2026	Information	Kath Lavery, Chair	Agenda Pack B
Closing Items					
32		Any Other Urgent Business (to be notified in advance)		Kath Lavery, Chair	Verbal
33		Any risks that the Board wishes the Risk Management Group to consider			
34		Public Questions *			
35		Chair to resolve <i>‘that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press are excluded from the remainder of the meeting, which will conclude in private.’</i>		Kath Lavery, Chair	
36	15.00	Minutes of the meeting held on the 26 March 2026 (private session)	Decision	Kath Lavery, Chair	AA
37		Matters Arising and Follow up Action List (private session)	Decision		BB
38		Reflections on the patient story	Discussion		Verbal
39		Chief Executive Private Update to the Board of Directors	Information	Toby Lewis, Chief Executive	CC
40	15.05	Well Led – externally commissioned developmental review	Discussion	Philip Gowland, Director of Corporate Assurance	Verbal

* Public Questions:
Questions from the public may be raised at the meeting where they relate to the papers being presented that day. Alternatively, questions on any subject may sent in advance and they will be presented to the Board of Directors via the Director of Corporate Assurance. Responses will be provided after the meeting to the originator and included within the formal record of the meeting.
**Paper to be managed via questions only
The next meeting of the Board of Directors will take place on Thursday 30 July 2026 in Barton upon Humber

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	Agenda Item	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Phil Gowland, Director of Corporate Assurance Diane Jeavons, Corporate Assurance Officer		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
The report is presented as a standing agenda item at each meeting to ensure board awareness to any declarations and if needed, actions taken to prevent any conflicts during the business of the Board. Amendments to the declarations from Kath Lavery, Rachael Blake, Maria Clark, Kathy Gillatt and Pauline Vickers, are marked in bold.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
Paper presented to each public Board meeting			
Recommendation (indicate with an 'x' all that apply and where shown elaborate)			
The Board is asked to:			
x	RECEIVE and note the Register of Interests.		
Alignment to strategic objectives (indicate those that the paper supports)			
Not applicable			
Alignment to the plans: (indicate those that this paper supports)			
People and teams plan			X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	
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.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	

Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
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.	
Strategic Delivery Risks (indicate those that this paper supports)			
Not applicable			
System / Place relevance (advise whether it is national, regional or local)			
Equality Impact Assessment	Is this required?	Y	N x If 'Y' date completed
Quality Impact Assessment	Is this required?	Y	N x If 'Y' date completed
Appendix (please list)			
None			

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

BOARD OF DIRECTORS – REGISTER OF INTERESTS

Executive Summary

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

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

Amendments are shown in bold text.

Name / Position	Interests Declared
Kathryn Lavery, Chair	• Owner and Director of K Lavery Associates Ltd • Chair ACCIA Yorkshire and Humber Panel • Non-Executive Director at Locala Community Interest Company (and Audit Committee Chair) • Chair of Locala Solutions Ltd • Chair – Barnsley Estates Partnerships (LIFTCo) • Chair – Doncaster Estates Partnerships (LIFTCo)
Toby Lewis, Chief Executive	• Nil
Rachael Blake, Non-Executive Director	• Director: Bawtry Community Library • Bawtry Mayflower School Governor - Co-opted • Sponsor: Network Rail • Trustee at Rossington Miners Welfare • Treasurer at Active Rosso • Trustee at Doncaster Citizens Advice Bureau • Member of the Labour Party
Richard Chillery, Chief Operating Officer	• Nil

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

Name / Position	Interests Declared
Carlene Holden, Director of People and Organisational Development	• Governor and Vice-Chair at Brighter Futures Learning Partnership Trust – Hungerhill School, Doncaster
Jo McDonough, Director of Strategic Development	• Nil
Shabir Pandor NEXt Director	• Son is a GP in West Yorkshire • Son in law is GP in West Yorkshire • Daughter is a PCN Pharmacists in West Yorkshire • Wife works in a GP practice as an administrator • Member of The Labour Party, Co-operative party and Y&H Co-op Party Council • Member of Trade Unions (Unite, UNISON and GMB) • Corporate Member of the Chartered Institute of Housing
Dr Rumit Shah, Associate Non-Executive Director	• Chair of Doncaster LMC • General Practitioner Hatfield Health Centre • Doncaster Lead for Primary care provider alliance • Company Director at Beckingham Medical Services Ltd
Simon Sheppard, Director of Finance and Estates	• Wife is a Specialist Respiratory Nurse at Sheffield Children's Hospital.
Dr Diarmid Sinclair, Chief Medical Officer	• Nil
Sarah Fulton Tindall, Non-Executive Director	• Member of the Patient Participation Group at the NHS Heeley Green General Practice Surgery, Sheffield • Age UK Readers' Panel member
Dave Vallance, Non-Executive Director	• Nil
Pauline Vickers, Non-Executive Director	• Independent Assessor for the Business to Business (B2B) Sales Professional Degree Apprenticeship for Middlesex University and Leeds Trinity University • Executive Coach with Performance Coaching International • Managing Director and Executive Coach Insight Coaching for Leaders • ~~Director of Marsh and Vickers Coaching Limited~~

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 26 MARCH 2026 AT 10.00 AM THE LEGACY CONFERENCE CENTRE, SHAW WOOD WAY, DONCASTER, DN2 5TB

PRESENT

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

IN ATTENDANCE

Richard Banks	Director of Health Informatics
Dr Jude Graham	Director for Psychological Professions and Therapies
Philip Gowland	Director of Corporate Assurance / Board Secretary
Shabir Pandor	NExT Director
Dr Rumit Shah	Associate Non Executive Director
Sarah Dean	Corporate Assurance Officer (Minutes)

Jocelyn Flower Social Worker – for the Staff Story

3 members of staff, 2 governors and 2 members of public

Ref		Action
Bpu 26/03/01	Welcome and Apologies Mrs Lavery welcomed all attendees to the meeting. Apologies were noted from Mrs McDonough, Director of Strategic Development. Mrs Lavery noted two public questions had been received from Glyn Butcher on behalf of PFG and that the Chief Executive would respond to these through the HQTC item later in the meeting. Mrs Lavery explained that from the next meeting in May, the Board's start time would be 9.30 am and after minutes, action log and committee reports the Board would consider risk (both operational and strategic), the IQPR and Promises papers, and then before lunch, the Chief Executive's Report, the patient / staff story and one substantial item, before completing the agenda after lunch. The overall meeting time would still end at 4 pm. Mrs Lavery noted that, after 26 years of service, this meeting marked Mr Banks's final attendance at the Board, and affirmed the Board's appreciation for his very significant contribution over that time.	

Bpu 26/03/02	Quoracy Mrs Lavery noted the meeting was quorate.	
Bpu 26/03/03	Declarations of Interest Mrs Lavery presented the declarations of interest report and confirmed there had been amendments to Mr Pandor's and Ms Blake's declarations of interest to the register since the last meeting. Ms Gillatt informed the Board that she had accepted a role as an independent member of the audit committee for Cafcass (under the Ministry of Justice umbrella). The Board received and noted the changes to the Declarations of Interest Report.	
STANDING ITEMS		
Bpu 26/03/04	Minutes of the previous Board of Directors meeting held on the 29 January 2026 The Board approved the minutes of the meeting held on the 29 January 2026 as an accurate record.	
Bpu 26/03/05	Matters Arising and Follow up Action Log <u>Reducing Restrictive Interventions (RRI) Advocates</u> Mr Lewis queried whether the commitment to have RRI advocates in place by April was realistic, noting the issue had been ongoing for since March 2025. Mr Forsyth acknowledged the delays but confirmed that recruitment and preparations were now sufficiently advanced to expect advocates to be operational by the end of June 2026. The Board received the action log and noted the progress updates. All actions noted as 'propose to close' were agreed.	SF
BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS		
Bpu 26/03/06	Quality Committee (QC) Dr Falk presented the paper and gave the key highlights from the QC. QC had provided support on two matters – firstly for the key performance indicators (KPIs) relating to post proposal service redesign, which was aligned with items later on the agenda; and secondly for the planned inclusion of therapeutic activities within the safe staffing reporting in recognition of their clinical importance and their tendency to be dropped in periods of pressure. Dr Falk addressed three areas of concern. 1. The potential data burden associated with the new KPI framework, although substantial reassurance had been received at QC from Dr Graham and Mr Forsyth. 2. Radar task volume and the number of tasks generated risked creating reminders that staff might begin to ignore. 3. Pressure ulcers, which had surfaced significantly the previous year and continued to require monitoring.	

	Regarding Radar task burden, Mr Lewis expressed concern that constant reminders risked desensitising staff, and he asked that the issue be taken through the action log for further refinement within the delivery review process. The Board received and noted the report from the Quality Committee	TL
Bpu 26/03/07	Audit Committee (AC) Ms Gillatt presented the paper which contained no escalations to the Board. She explained that the internal audit programme had demonstrated strong progress with the implementation of recommendations particularly positive. There were no accounting policy issues requiring immediate escalation, and the clinical coding audit review had shown strong performance. Ms Gillatt explained ongoing work to improve transparency around single source waivers and financial instruction compliance. Ms Gillatt noted the moderate assurance rating for the safe staffing audit and the commentary regarding the differential between inpatient and community based staffing in the audit. Regarding the safe staffing audit, Mr Lewis emphasised that the Trust would not be developing an independent community staffing tool because no such tool existed nationally and doing so was not feasible or standard practice. The action plan behind the audit would be amended, and Mr Forsyth would take responsibility for this update. Dr Graham reflected on national context on the widespread absence of community acuity tools, noting that work was underway across several organisations to develop a national approach. The Board received and noted the report from the Audit Committee.	SF
Bpu 26/03/08	Mental Health Act Committee (MHAC) Ms Fulton Tindall presented the paper and highlighted key points from the MHAC. The MHAC noted ongoing concerns about the decline in RRI and MHA Level 3 training compliance, which in January were 75% and 76.3% respectively. The Committee noted that the personal consequences approach for non-compliance for mandatory training had been adopted. Progress on RRI and blanket restrictions work was welcomed, with further updates expected at the next meeting. The Committee also noted the early stages of the revised MHA implementation programme, including February work on detention changes planned for 2027 within the wider 10-year programme, and recognised associated resource and expectation pressures. It was confirmed that Ms Clark would take over as Chair of the MHAC from its next meeting. The Board received and noted the report from the Mental Health Act Committee.	

Bpu 26/03/09	People & Organisational Development Committee (PODC) Mr Vallance, on behalf of Ms Blake, presented the paper and gave key highlights from the PODC. Staff Safety including violence and aggression would be received later on the agenda. Mr Lewis noted that actions cited within the report had since been resolved. The appointment of the Resident Doctor Lead role was recognised, which forms part of the national 10-point plan. Responding to Ms Gillatt query related to mandatory training, Mr Lewis reminded the Board that the Trust's approach differed from most NHS organisations which counted each individual training component, with the Trust instead required staff to complete all required training to be considered compliant. Letters would be issued to all staff not fully compliant as at 30 April, and formal consequences for those without a credible plan would follow in June. He acknowledged that certain training categories, including MHA Level 3, RRI training and Immediate Life Support, had been longstanding areas of weakness and that the shift to a more stringent compliance model was essential for safety. The Board received and noted the report from the People & Organisational Development Committee.	
Bpu 26/03/10	Public Health Patient Involvement & Partnerships Committee (PHPIP) Mr Vallance presented the paper to be taken as read, and highlighted there were no matters for escalation from the PHPIP. The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.	
Bpu 26/03/11	Finance, Digital & Estates Committee (FDE) Mrs Vickers presented the paper and highlighted key points from the FDE. The estate plan was noted to be presented later on the agenda. The Trust remained on course to meet its financial obligations and Mrs Vickers highlighted the month 11 surplus position of £654k. Negotiations regarding 26/27 income continued, and progress had been made in digital investments, information governance and clinical coding. Thanks were given to Mr Banks for his contribution to compliance improvements prior to his forthcoming departure. Mr Lewis sought clarification regarding a figure in the report referring to a reduction in underlying deficit from £16m to £6m. Mr Sheppard agreed that the update was erroneous, clarifying that the underlying deficit was expected to be £6.3m at year end (31 March 2026), a significant improvement from £16m in 2023, with an underlying break even position projected for the following year (2026 to 2027), and agreed that the report would be amended for accuracy. POST MEETING NOTE: report subsequently amended. Mr Sheppard updated the Board on the confirmation and receipt of deficit support funding in quarter 4 and explained that although cash had	

	been received, it was not available for general expenditure. He also confirmed that CDEL cover was in place for the Waterdale development prior to contract signature. The Board received and noted the report from the Finance, Digital and Estates Committee. Dr Falk reflected on the committee highlights reports presented. Mrs Lavery agreed to review the format with Mr Lewis outside the meeting and to consider improvements to committee reporting, escalation, and access to committee minutes, to support greater insight, cross referencing and informal communication. POST MEETING NOTE: the format of Board outbriefs has been amended to ensure only escalations are orally presented to the Board, allowing more time for questions. In addition, the non- executive meeting will be used to ensure cross committee discussion between chairs. Any Board member can ask to have sight of papers and minutes from any meeting.	KL
Bpu 26/03/12	Remuneration Committee (RemCo) Mrs Lavery presented the paper and highlighted key points from the Committee. The Board received and noted the report from the Remuneration Committee.	
Bpu 26/03/13	Chief Executive's Report Mr Lewis drew attention to the key items within his report. The Trust's position within the National Oversight Framework remained stable (2, with a financial override to 3) but the future of the national process lacked clarity and predictability. Mr Lewis cautioned that the absence of clear national metrics from April 2026 made future segmentation difficult to anticipate, and impossible to be confident plans were consistent with a segment 1 or 2 rating, which was our agreed aim. He noted good progress with work to reshape older adult care in Doncaster and development of the proposal for the frailty centre of excellence ('Pond Project'), into the summer. Work continued to align local stakeholders despite varying priorities and organisational changes at Doncaster Royal Infirmary. There would soon be a relaunch of Lio (previously known as Oxevision) training in light of new national guidance, emphasising the consent processes in inpatient mental health settings. Mr Lewis noted that while Lio remained controversial and subject to national scrutiny, the Trust remained committed to its safe and ethical use. Mr Lewis drew the Board's attention to Palantir, noting that some organisations, including the BMA, had appealed for a pause in the migration of providers onto the Federated Data Platform. He assured the Board that Palantir usage within the Trust was limited to non-patient data, and a specific governance arrangement had been instituted for any proposed expansion.	

The Communities' Leadership Executive (CoLE) recruitment process was taking place, with strong engagement across Rotherham, Doncaster and North Lincolnshire. There had been 34 applicants, and interviews were scheduled for the following week. Membership of the expected 16-person executive would be confirmed, with informal meetings planned for April and formal commencement from May.

Dr Graham asked whether wider system level barriers risked undermining the Trust's ability to deliver, citing the Secretary of State for Health's announcement on new recovery programmes for underperforming trusts. Mr Lewis confirmed the Trust remained high performing but highlighted the Mental Health Investment Standard and associated funding flows as continuing system challenges, while noting the intended introduction of pass-through activity in community physical health contracts as a positive step. Mr Banks asked about the impact of North Lincolnshire and Goole (NLAG), and Hull NHS trusts entering special measures, and Mr Lewis explained that given their merged model, the situation was unusual but reinforced the need for strong engagement with NLAG, particularly for the crisis centre and children's neurodiversity services.

In relation to Lio, and in response to Ms Clark's question on whether consent was the only area of concern, Mr Lewis explained that although national debate had raised ethical questions about continuous monitoring, the Trust had already determined that Lio would be used as a harm reduction tool. The priority was now to strengthen consent processes and ensure that monitoring was withdrawn promptly when consent was removed. Dr Graham noted that research and evidence supported this approach, demonstrating that assistive technologies could reduce bias and enhance both staff and patient confidence.

Mr Vallance and Ms Blake referred to Annex 8, noting that although the 5-year pattern was acknowledged, we should all wish to understand why there was such variance between longer standing and more recently hired employees. Mr Lewis clarified that the five-year reference was intended to avoid assuming the results were solely a consequence of change management, as directorate level data showed both improvements and declines. Further analysis would return in May alongside culture related work.

Responding to Ms Gillatt, Mr Lewis confirmed that the main forward financial risks remained the HDRU, energy costs and the community pharmacy scheme – as described in his private CEO report. Mr Lewis highlighted wider system pressures, including significant savings requirements across ICBs and in particular South Yorkshire's £130m challenge, which included a substantial unresolved gap, and reiterated that the Trust had declined to submit a plan with unidentified savings, unlike neighbouring organisations. He noted that although the ICB faced uncertainty, 3 year allocations still indicated growth for community and mental health services, dependent on acute care changes being delivered. He did not consider the Trust at greater financial risk than the previous year, though flexibility had reduced due to energy pressures, HDRU requirements and reliance on non recurrent savings. Mrs Vickers confirmed that the FDE Committee would continue close monitoring.

	With respect to neurodiversity, Mr Lewis reported two positive developments with £1.2m secured for children and young people's services in North Lincolnshire, with communications to affected families planned for May and clinical work due to begin in July. He also highlighted improved adult assessment performance from April. He noted, however, that medication backlogs remained a significant concern, particularly for children and young people, where an earlier issue had been resolved only for a further problem to emerge. Given the prior Board discussions, he acknowledged that this was unacceptable and confirmed that contingency funding would be used to clear the backlog, with work underway to prevent recurrence. Mr Lewis also confirmed priority pathways for young people transitioning to adult services and noted the medium-term aspiration for a dedicated transitional team. The Board discussed governance in identifying and escalating risks, including underestimation of likelihood scores, and noted a neurodiversity waits and volumes scorecard would feature in future reports throughout 2026 to 2027. Attention was drawn to the research evidence cited in the annex to the report, which sought to challenge the 'overdiagnosis' commentary. Options to strengthen capacity, including collaboration with community pharmacies for stable adult patients, were being explored. Mr Lewis noted that 6,000 adults remained on the waiting list, and that a decision needed to be made in Q1 over the future of the autism pathway. The Board received and noted the Chief Executive's report and the forward actions it contained, and noted the progress being made in tackling unacceptable wait times for neurodiversity care.	TL
Bpu 26/03/14	Promise 14 – Delivering a 4 week wait for all referrals Mr Chillery presented the paper and acknowledged the significant achievement in delivering a 4 week wait. The organisation's operational focus had already begun to shift from solely meeting the 4 week wait for all referrals to embedding the 1 week turnaround standard, which required services to notify patients of their proposed appointment within 7 days of referral. Mr Chillery described the 1 week standard as crucial not only for operational flow but for patient experience, noting the quality benefits for patients and reductions in complaints, explaining that patients often needed time before confirming their first appointment. Mr Chillery advised there were around 40 patients still required scheduling before the end of March, with arrangements in place for early April, and outlined the development of SystemConnect to further enhance patient communication and pre booking options. There was emphasis on the need to sustain performance through continued central oversight due to the fragility of smaller teams and impact of staff sickness, with the next priority focused on validating and reducing secondary waits. Dr Graham noted the strong engagement of clinical teams embracing the 4 week waits, the potential of productivity and reducing did not attend and was not brought (DNAs and WNBs),	

	reduction in complaints about waiting times and positive feedback from GPs alongside other wider system benefits, and referenced ongoing work on demand and capacity, including potential investment bids such as podiatry. Dr Sinclair referred to the work around disengagement, confirming that evidence of timely assessments and associated care planning would be essential to ensure the 4 week standard remained meaningful. Responding to Ms Blake, Mr Chillery confirmed that the podiatry service had not met the 4 week standard due to a 100% increase in referrals, and explained that although investment had been secured and recruitment was under way, the new posts would not take effect until the summer. He advised that a detailed trajectory would be provided once the additional staff were in place. The Board received and noted the report and the considerable progress in delivery of access waits to 4 weeks, the next steps for 2026 to 2027, particularly in relation to secondary waits and explored any risks that may impact on supply and demand. A report would return to the Board in July.	RC RC
Bpu 26/03/15	Trust-Wide Learning from Patient Safety and Experience Reports (April 2025 – March 2026) Mr Forsyth presented the paper and gave key highlights. The report outlined triangulated organisational learning, patient safety and the ongoing development of the Trust's learning culture during the period. The introduction and embedding of Radar had markedly improved the Trust's ability to capture, analyse and act on safety related intelligence, supporting transparency, follow through and shared accountability. Mr Forsyth noted that nearly 8,500 incidents had been recorded, over 2,000 learning responses completed and more than 150 good care events identified, demonstrating positive practice and strengthening staff confidence in reporting. Incident reporting had increased, including a peak in November, and Mr Forsyth stressed that this should be interpreted as a sign of greater openness and a maturing safety culture rather than a deterioration in care. He highlighted several tangible improvements arising from learning workstreams, including sustained 100% compliance with falls assessments in quarter 3 and significant estates improvements, with over 300 environmental issues resolved following peer review ward visits. Connected improvements were noted, referencing Promise 14 and the impact of reducing wait times for assessment and treatment. Dr Graham and Ms Gillatt reflected on how learning was becoming more embedded in everyday practice and questioned whether the organisation had reached a point where learning was shaping behaviours and service design from the outset rather than relying on retrospective corrective actions. They noted positive indications, including improvements linked to recent leadership development programmes and the active bystander training, which had strengthened staff awareness of values based behaviours. Mr Forsyth agreed that	

	fostering a proactive learning mindset would be essential to sustaining progress. Mr Lewis highlighted the need for further improvement in the timeliness and quality of incident closures on Radar. Mr Forsyth reported that learning responses were taking between 8 and 25 days to upload and that more than 300 tasks remained open, reflecting increased reporting volumes and slower closure rates in some directorates. He confirmed that this would be monitored monthly by the Patient Safety Oversight Group. Mr Lewis emphasised the importance of ensuring that tasks were closed with meaningful learning rather than under operational pressure. Further discussion highlighted the importance of communication with patients and carers. Mr Vallance noted that many complaints and care opinion themes related not only to clinical issues but to communication, clarity of expectations and the emotional impact of waiting, and encouraged a more patient centred approach to communication design. Ms Blake added that effective communication also supported wider system benefits by reducing anxiety, improving engagement and preventing repeated contacts across services. In response to Ms Gillatt's question on how learning was being supported through leadership development, Mr Forsyth referred to work with the Virginia Mason Institute to strengthen problem solving, reflective practice and the use of improvement methodologies. Mr Chillery added that senior leaders were participating in learning sets examining waiting list risks, medication review pathways and early warning triggers, demonstrating that learning was now shaping wider operational practice. Mrs Lavery invited members to review Care Opinion to gain further insight in how patient feedback was being received and responded to. The Board received and noted the key themes and learning from the Trust-wide review of patient safety and experience report, and recognised the progress made in embedding PSIRF, the improving reporting culture and responding to patient feedback.	
Bpu 26/03/16	HQTC taskforce closure report Dr Graham and Mr Lewis presented the paper and gave key highlights. The HQTC inpatient taskforce had brought together multi professional staff, social care partners and people with lived experience in a way not previously achieved in the Trust. Dr Graham explained that this breadth of involvement was central to shaping outcomes that reflected clinical expertise, therapeutic practice and the perspectives of those who had received inpatient care. The taskforce had delivered measurable improvements, including strengthened therapeutic activity, increased engagement in care planning and more consistent MDT processes, alongside qualitative improvements in patient and carer experience. Although focused on mental health wards, learning had been shared across physical health and substance misuse services, with autism and sensory friendly developments already adopted in the neurorehabilitation unit. Dr Graham added that the work had created the foundations for more precision based care, with clearer alignment between diagnosis,	

	expected length of stay and discharge planning, while maintaining clinical autonomy in complex presentations. Mr Lewis emphasised the transformative impact of lived experience involvement and confirmed that the next phase of community redesign would include a lived experience co-chair. He highlighted the significant cultural shift involved in moving to multi professional leadership teams on wards, replacing the traditional model where ward managers held primary responsibility. Leadership would now be shared across professions, supported by training. He confirmed that consistent daily 2pm MDTs were essential to the model and that while most wards were compliant, a small number required improved reliability. Responding to questions raised in advance of the meeting by Glyn Butcher, Mr Lewis confirmed that the final wards would adopt the 2pm MDT structure the following week and that alternative care planning approaches for patients for whom Dialog+ was unsuitable, including those with dementia, would be completed in early April, with implementation in May and June. He drew attention to the next step actions in the paper and stressed the need to maintain momentum as the programme moved from the taskforce phase to sustained operational delivery. Dr Falk and Ms Fulton Tindall welcomed the shift to interdisciplinary working, with professions contributing to a shared therapeutic approach rather than task orientated. Dr Graham highlighted the need for careful application of diagnosis led models, noting that presentations such as acute stress reactions could evolve. Mr Chillery stressed the importance of strengthening discipline around the purpose of admission, noting that successful inpatient transformation required consistent decision making across system partners and that some avoidable admissions continued to be driven by wider system pressures, making collaborative work with commissioners and acute trusts essential. Mr Lewis advised that the Board should focus on its strategic role, particularly oversight of diagnosis-led, length of stay work throughout 2026, which would become the primary area for scrutiny in the coming months. Mrs Lavery noted the maturity and scale of the work and recognised that the time taken reflected the complexity of inpatient care and the depth of cultural change required. The Board expressed strong support for the direction of travel and agreed that further reports would be brought back as the next phase progressed. The Board received and noted the HQTC taskforce closure report, and recognised the work done by colleagues to try and bring consistency to inpatient adult/older adult mental healthcare since February 2025. The Board acknowledged the current state assessment which indicates more work to do over coming months, and accepted the forward governance outlined and agree to receive a further report in November.	
Bpu 26/03/17	Workplace Violence and Aggression: Staff Safety and Incident Trends (April 2025 – March 2026)	

	Mr Forsyth presented the paper on workplace violence and aggression. The paper highlighted the seriousness and frequency of incidents across the Trust. Mr Forsyth illustrated the scale of the issue, noting that the equivalent of every person in the room would have been assaulted within the past week, with around 1,000 assaults recorded each year, predominantly in inpatient mental health services. Although many incidents were categorised as low or no harm, staff reported significant psychological impact and a tendency to normalise aggression as part of the job in high risk settings. An 18% reduction in harm between quarters 1 and 2 was noted but interpreted with caution. Mr Forsyth emphasised the need for sustained improvement aligned to the quality and safety plan, the people plan and the education and learning plan, and highlighted risks associated with skill mix, lone working and inconsistent risk assessment in physical health and community services. Mrs Vickers stressed the importance of actively offering support, as staff who normalised aggression were often the least likely to seek psychological help. Dr Graham outlined existing post incident processes, including immediate operational debriefs, the post incident learning loop and psychologically informed group sessions, while noting the need for greater consistency across teams. With respect to community services and lone working, Mr Chillery reported that around a quarter of violent incidents occurred in patients' homes and that double staffed visits did not reliably reduce risk and could, in some cases, escalate it. He confirmed the procurement of additional lone worker devices and strengthened pre visit risk assessments, particularly in physical health and overnight community nursing, and noted that district nursing teams operated with 3 staff at night to provide flexible support. Mr Forsyth added that there was no evidence linking reduced out of area placements to rises in inpatient violence and that recent peaks were associated with a small number of highly unwell patients. Ms Blake raised questions about staff support, Board visibility and consequences for perpetrators, suggesting that the "no harm" category should be reconsidered given the impact of racial or verbal abuse. Mr Vallance highlighted the need to recognise the effect on family members concerned about staff safety. The Board discussed whether current recommendations were sufficient and the importance of reinforcing a culture where violence was not treated as an accepted part of the job. Mrs Lavery referenced learning from ambulance services, including structured decompression, team debriefing and targeted psychological support, and encouraged further cross service learning. Mr Forsyth acknowledged that the 4 recommendations in the paper addressed only part of the challenge and emphasised the need for alignment across the Trust's quality and safety, people, and learning plans, alongside the HQTC programme. In responding to Mr Lewis' question he agreed to reflect on the impact of the discussion held before finalising the action plan. The update on this would be considered a matter arising at the next Board meeting.	SF

	The Board received and noted the Workplace Violence and Aggression report across the Trust and had opportunity to consider the impact on staff wellbeing and operational delivery. The Board recognised the progress made and the areas requiring further action. The proposed recommendations would be refined to strengthen prevention, support, and governance.	
<i>Jocelyn Flowere joined the meeting at 1.00pm</i>		
STORY TO BOARD		
Bpu 26/03/18	Staff story Mrs Lavery welcomed Jocelyn Flower, known as Joss, a social worker who worked across HDRU and Amber Lodge in Doncaster, who gave her story on social working. Joss joined in 2006 and explained her career journey across RDaSH and her time at Wathwood Hospital and described the values of social work and colleagues experiences of practising within an NHS Trust. Joss highlighted the value of MDTs, lived experience, peer support, partnership with voluntary organisations and listening closely to families and carers. She spoke passionately about social work as a vocation rooted in trauma awareness and advocacy, noting that social workers were often overlooked within MDTs despite their important role in supporting people whose lives had been shaped by significant adversity. She described her work with individuals with learning disabilities, those discharged after long secure stays and those with limited family networks, emphasising the need to see people beyond diagnostic labels and to maintain a focus on identity, humanity and recovery. She encouraged greater integration of social work within MDTs and explained how shadowing across professions helped build understanding of roles. Increased social work presence on wards was helping to rebalance responsibilities previously carried by medics, and she described the distinct expertise social workers bring in advocacy, safeguarding, cultural understanding and community connection. Mr Chillery and colleagues agreed that social work should be recognised as a core part of MDTs rather than an adjunct to a medical model. Dr Shah noted inconsistent social work input into primary care MDTs, despite its importance for people with dementia and those living in care homes. Joss advised that capacity within the trust had grown and that previous pilots placing social workers in primary care had produced strong results but required sustained investment. The Board acknowledged the importance of strengthening interdisciplinary working, ensuring that social work skills were fully utilised and continuing to build a culture where all professional voices were equally valued. Mrs Lavery and the Board thanked her for a powerful and insightful presentation, and noted the intended reflection time later on the agenda.	
<i>Joss left the meeting at 1.30pm</i>		
Bpu 26/03/19	Next steps on community mental health services for adults Mr Lewis noted that this paper was a follow on from the discussion held in September.	

	Risk and complexity in community mental health services remained high and the paper therefore focused on next steps, including plans to mobilise a fully participatory, patient involved transformation programme. He noted persistent issues with care planning, with too few patients having active, up to date plans and limited uptake of Dialog+. He also highlighted longstanding problems with caseload management and outflow, with many patients remaining on caseloads for extended periods, reducing capacity and sustainability. Mr Lewis observed that the Board had not previously examined community mental health performance in detailed operational terms and that team leaders were often more familiar with accreditation measures than with core metrics such as caseload size, activity, engagement and throughput. Annex A within the report set out basic operational information to be provided to teams, creating a baseline and enabling leaders to work to clearer parameters from Q2. Mr Lewis noted clear links between this work and the organisational change programme, given the overlap in affected teams. He reiterated concerns raised in September that current community arrangements did not yet meet an acceptable standard and encouraged reflection on how this aligned with recent CQC self-assessments rating community services as “good”, including what “good enough” should mean in practice. He concluded that, as demonstrated by the significant progress on 4 week waits, community teams could achieve rapid improvement with the right support. While optimistic, he stressed that current evidence did not show consistent delivery of high quality care planning and that substantial further work was needed as the improvement programme began. Mr Vallance noted that the paper set out a clear direction for community mental health work, with further detail on outcomes to be developed as the programme progressed. Dr Graham welcomed the inclusion of an enabling workstream to ensure community roles were designed as high quality and achievable from the outset. Mr Forsyth asked how the programme would strengthen the no wrong door approach, given the absence of new funding for neighbourhood mental health teams and the need for clearer referral thresholds. Mr Lewis agreed that supporting teams to define what made their roles manageable would be valuable and could be incorporated into the programme. He noted that pressures varied by locality, with North Lincolnshire lacking wider system infrastructure and therefore placing greater demands on Trust teams. He reported improving relationships with the local authority and opportunities for greater involvement in the work. He cautioned that national investment was often directed at creating new services rather than strengthening core teams, which risked adding structures without resolving underlying pressures. A key decision in the coming year would be whether some additional teams should be consolidated into larger, more sustainable community mental health teams. Mr Lewis stressed the need for central oversight of thresholds and referral criteria, as teams currently applied inconsistent parameters. This would support a more reliable no wrong door approach and reduce inappropriate rejections.	

	He proposed that the Board receive an early update in July on pathway development, followed by a fuller assessment in January 2027. Dialog+ care plan coverage should also form part of ongoing oversight, as current levels did not meet an acceptable standard of care. The Board endorsed this approach. Dr Shah noted that work had already begun with primary care, including co designed referral forms in Doncaster South aimed at reducing rejection rates. The Board agreed to receive a further progress update in July and a detailed position in January. The Board received and noted the next steps on community mental health services for adults, and the focus on ensuring that all patients have a timely and up to date DIALOG+ based care plan. The Board recognised the step up in accountability outlined within the paper, and had opportunity to consider how best the Board as a whole may be sighted on progress during 2026 to 2027.	TL
Bpu 26/03/20	Estate Plan - route to Full Business Case (FBC) Mr Sheppard presented the paper: the Board was asked to note and approve the estate plan as the basis for progressing to a FBC in July, with a separate energy options business case scheduled for May. The plan covered all geographical areas, with Rotherham identified as the immediate priority, in the context of past concluding investments in North Lincolnshire, and more complex plans for the Tickhill Road site. T his included advancing the Riverside option to replicate the Elizabeth Quarter and Waterdale facilities and retaining neighbourhood locations wherever possible. Detailed work in Rotherham would continue through April and May. For the Tickhill Road site, Mr Sheppard stressed the need to stabilise the design early, as the FBC would be extensive and could not be repeatedly amended. Effective change control would therefore be essential. He highlighted the financial overview and confirmed that the FDE Committee would scrutinise the detail between April and June. He also noted the alignment between the estates and digital plans, including the U curve capital investment profile. Mr Sheppard advised that the Trust did not have the internal capacity to deliver a programme of this scale and would commission external specialist support through formal procurement, with funding already included in the 2026 to 2027 capital plan. Mr Lewis emphasised that the Board must be confident in both digital investment and advisory capacity, as the Trust could not afford to progress major estate changes only to revisit them later. Mr Vallance asked whether potential redevelopment of the St John's site might affect the business case. Mr Lewis confirmed that the hospice would remain in place and the current planned future footprint had been designed to protect its position. Any wider redevelopment options would be considered only once a development partner was secured and would not alter the present case. In response to Ms Gillatt, it was noted that retained land allowed scope for future expansion and that future proofing	

	would be addressed through detailed clinical and operational engagement, including recent work on future capacity assumptions. Mr Sheppard confirmed that best case and worst case scenarios, risks and benefits would be fully reflected in the FBC. He also addressed concerns about digital cost volatility, noting that some replacements were essential due to expiring contracts and operational risk, and early procurement using recent capital funding provided some protection against market fluctuations. The Board discussed land disposal, noting that significant land would be sold to fund the redevelopment. Mr Lewis confirmed that only land no longer required would be sold and the proceeds used to fund the new estate. The Trust would not control future use of sold land beyond planning conditions, and regulatory approval would require demonstrating that the Trust could replenish its cash position over time. The Board acknowledged that the programme would not deliver like for like replacements and would require service redesign supported by specialist expertise. The Board received and noted the estate plan and route to full business case (FBC), and noted the forthcoming paper on site energy options due May 2026. The Board had opportunity to consider the key questions cited and note the FBC content list outlined, and recognised the focus on Rotherham options over the next 8 weeks. The Board delegated pre scrutiny of the financial estimates to the Finance, Digital and Estate committee, noted the budgeted engagement of advisors and capacity in Q1, and accepted the paper as suitable Outline Business Case calibre sufficient to proceed to next stage.	
Bpu 26/03/21	Organisational Change Go Live Mr Lewis introduced this paper which reflected on the Q4 change programme and sought Board assent to proceed to implementation. Mr Lewis advised that redeployment processes and trial periods would continue into April, and that early indications remained consistent with the estimates shared with the Board in January. The programme had proceeded to plan and that implementation now represented the most challenging phase, as responsibility would transfer from the senior design group to operational teams, some of whom had not been fully involved in earlier design work. Training and development had therefore been prioritised to support leaders through the transition. Mr Lewis confirmed that the steering group would continue to oversee delivery until the end of April, after which the programme would move into business as usual monitoring. He emphasised the need for close tracking of quality-KPIs throughout the year to identify any early issues requiring adjustment. Work was underway to ensure managers had reliable and timely data to support decision making. Mr Lewis noted key clinical risks relating transition of patients between key workers, which were being closely managed.	

	In response to questions from Mr Vallance, Mr Lewis clarified the productivity expectations, explaining the distinction between the overall organisational requirement and team specific levels agreed in December. He noted that some variation across localities would need to be levelled, particularly in North Lincolnshire, but confirmed that all expectations were within safe and achievable margins based on extensive data triangulation. Mr Sheppard welcomed the comprehensive approach to monitoring, noting it would support organisational learning and strengthen readiness for future changes to activity based funding models. Mr Chillery highlighted the importance of sustaining engagement, recognising that the programme had been undertaken with care but that staff nonetheless experienced uncertainty. He also noted the value of moving ahead at pace, respecting staff feedback that they were ready to implement the new structures. Mr Vallance noted the 'above and beyond' approach outlined, which was far more extensive in terms of safety governance than he had experienced previously at the Trust. The Board noted the ongoing efforts to achieve redeployment where that can be delivered in a timely manner, and recognised the key performance indicators being adopted to track safety risks. The Board endorsed the recommendations to proceed now with scheme implementation to largely conclude in Q1.	
Bpu 26/03/22	Capital Plan 2026 to 2028 Mrs Lavery invited colleagues to take the paper as read and opened up for discussion and questions for Mr Sheppard, to consider the capital plan for approval noting its alignment with the previously agreed revenue plan and the estate plan. In response to Mr Lewis's question of why planned capital expenditure exceeded the allocation, Mr Sheppard explained that the NHS operates a "use it or lose it" capital regime, and programmes often underspend due to unavoidable delays. Setting a plan slightly above the allocation ensures the Trust can fully utilise available funding and respond quickly if additional national capital becomes available later in the year. The proposed plan exceeded the allocation by £1.3m, which is consistent with national guidance and previous Board practice. Expenditure would be monitored monthly and adjusted later in the year if necessary to avoid overspend. Mr Lewis agreed this was a prudent and well managed approach. The Board received, noted and approved the capital plan for 2026 to 2027.	
OPERATING PERFORMANCE / GOVERNANCE / RISK MANAGEMENT		
Bpu 26/03/23	Strategy Delivery Risks (SDRs) Mr Gowland presented the paper and gave key highlights.	

	A concerted effort with executive leads would be undertaken to ensure all relevant information relating to the highlighted SDRs were appropriately reflected in the scores from May. Mr Gowland observed that several actions were likely to extend beyond the stated dates, not due to failure but because they had only recently been initiated and further work was required for inclusion in the next iteration. Progress had been made against the objectives, and the risks continued to represent the most significant threats to delivery of the organisational strategy. Mr Gowland noted the discussions throughout the meeting had reflected all of the principal risks, with specific reference made to staff development activity, HQTC discussions, and leadership matters. Data and the organisation's use of data were identified as a substantial theme of earlier papers demonstrating they lay at the heart of Board business. Mr Gowland referred to the increasing volume of data now available and triangulation of data sources, including comparisons with staff surveys and incident trends. It was acknowledged that work remained to be done to strengthen the organisation's ability to operate in a data led manner, although progress had been noted. Mr Gowland highlighted the appointment of the Community Development Director as a positive step in managing the risks relating to neighbourhoods and primary care. It was noted that forthcoming survey results and the evaluation of LDO would support the organisation in responding to risks relating to staff experience and readiness for change. Progress was considered steady due to the scale and complexity of the risks, however none of the risks were believed to be escalating. Mr Lewis reflected on recent discussions through the CLE and HQTC meetings concerning 7 day working, including discussions on what activity should be delivered independently and what should be undertaken collaboratively with partners. He emphasised active management of the risks was evident across the organisation, and that the concept of strategic risk could be difficult for staff to interpret unless it was clearly connected to active management and operational use. Mr Chillery noted that some SDRs were complex and that expectations and timescales might require adjustment to set realistic expectations, recognising they did not operate at the same pace as operational risks. Mr Gowland reflected that the target risks and timescales might benefit from refresh, as earlier assumptions regarding delivery pace had proved optimistic. It was also suggested that certain developments had not yet been fully incorporated into the register and that the May refresh would provide an opportunity to demonstrate progress with clearer milestones to support expectation management (open action Bpu 25/05/24). Mr Lewis confirmed that responsibility for risk scoring rested with the Executive lead. Mrs Lavery acknowledged the debate regarding the refresh of the strategic risk register, and agreed to receive an updated position on each strategic risk at the next meeting. The Board received and noted the Strategic Delivery Risk report.	

Bpu 26/03/24	Operational Risk Report Mr Gowland presented the report, noting the continuation of the revised approach to operational risk reporting. The risks that remained outside the agreed tolerance threshold were highlighted and required increased attention. Although the report provided details and authorship, Mr Gowland noted that work on risks linked to organisational change remained important, particularly in relation to change management processes. He recognised the need to stay alert to additional risks arising from such change and to ensure alignment with ongoing KPI work. The Risk Management Group (RMG) intended to continue monitoring these matters and to ensure they were clearly reflected in future reports. Mr Vallance drew attention to staffing risks, noting significant pressures, including a vacancy rate of around 6.5%. He asked whether risks would reduce as posts were filled. Ms Holden explained that the position varied, as some risks related to sickness absence hotspots while others resulted from changes within the service portfolio. She noted that several risks needed refreshing to ensure accuracy, particularly in respect of dates and tolerance status. Dr Falk queried specific risks, including those linked to prescribing, which appeared to fall within tolerance. Mr Gowland suggested that current categorisation influenced how risk levels were assessed and that some subjectivity remained. He agreed that refining categorisation would support more accurate assessment and ensure risks were aligned with appetite and tolerance levels. Mr Lewis referred to RSK-038 (lithium prescribing and monitoring) and confirmed that Dr Sinclair would provide a briefing at the next Quality Committee meeting, given earlier discussions with clinical leads and the complexity of the issue in practice. Ms Blake raised the length of risk resolution timescales, noting that some extended beyond 6 months, and suggested that clearer explanation of the differences between short delays and significantly longer timelines would be helpful. Mr Gowland agreed to note the revised reporting thresholds based on the organisation's risk appetite and the planned work to address the volume of risks outside tolerance. Mr Lewis emphasised the need for clearer actions, mitigation progress and expected timescales, noting that narrative updates should go beyond restating the risk and should confirm what had been done, what remained outstanding and the anticipated timeframe for resolution - some delays were acceptable but significantly extended ones required closer review. Mr Gowland explained the RMG would continue to oversee those risks outside tolerance. The Board received and noted the Operational Risk Report. The Board noted the revised reporting thresholds based on risk appetite and the planned work to address the extended number of risks that are currently outside of appetite and tolerance.	DS
Bpu 26/03/24	Integrated Quality Performance Report Mr Chillery introduced the Integrated Quality Performance Report (IQPR) for March 2026 review (data as at 28 February 2026).	

	The non urgent care 2 hour standard was accurate, but discrepancies arose once submitted externally. The matter had been raised with NHSE so the differences in data could be resolved, although a response was expected to take at least two weeks. Mr Chillery expected this issue to be addressed further at the next meeting with NHSE. Performance appeared to show unused virtual ward capacity, although in reality the Trust had cleared beds early to support system partners over the weekend, and that performance overall remained consistently strong. Mr Chillery clarified section 136 was already a priority throughout the current year and into the next financial year. He added that achieving zero was unlikely, as some section 140 cases would continue to arise and not all were attributable to the Trust. Mr Chillery stressed that improvements in length of stay were essential to reducing unnecessary section 140 use and that ward capacity and flow were central to this. were planned to support maintenance work. The section 136 suite remained a priority, supported by work to improve length of stay. In response to Dr Falk's question about whether all places of safety could be excluded before applying section 140, Mr Forsyth explained that section 136 suites were the designated places of safety. Although the law allowed other locations, such as a child's placement, this was not common practice nationally. Mr Lewis agreed that section 140 had increasingly been used to expedite admissions, which was inappropriate, and stressed the need to ensure correct use of the provision. He reiterated the aim to improve length of stay and reduce section 136 over-stay hours: our success had been a key system achievement which should not be sacrificed. Mr Forsyth noted that issues raised at the previous Board regarding the presentation of safer staffing data had now been resolved, with the narrative clearly explaining the red and green elements. The Board received and noted the Integrated Quality Performance Report, and recognised that separate Board and CEO level oversight of neurodiversity delivery would apply from April 2026, acknowledging the slower than necessary improvement position.	
Bpu 26/03/25	Promises and Priorities Scorecard Mrs Lavery invited questions for Mr Lewis. With reference to the statement on the cover sheet (in bold) regarding the 'lowest third' Ms Blake asked whether certain measures were inherently difficult or had simply lacked resource. Mr Lewis explained that some issues were complex but moving toward solutions, while others, such as developing a homeless apprenticeship scheme, had stalled due to limited capacity. He noted that most measures in the middle third were achievable with collective effort, and that focusing on them would improve delivery while allowing the Board to identify and prioritise the genuinely difficult areas. Dr Falk supported this approach and asked whether all promises carried equal weight. Mr Lewis confirmed they did, although the success measures varied in complexity. He agreed that the executive team	

	would focus over the next 4 months on shifting the middle group, with the Board retaining 2 years to address the most challenging items. Mr Vallance raised concerns about sustainability, noting overreliance on senior executives to resolve issues that should sit within the wider organisation. He highlighted limitations within the 555 line managers capability framework and the need for more consistent and resilient processes. Mr Lewis agreed and clarified that bespoke services had proven harder to implement than standardised approaches. He confirmed the need to build capability so progress did not depend on executive intervention. Mrs Lavery supported adopting a more structured approach, separating the middle and lower groups to improve focus, while noting that progress this year had been slower than planned. The Board received and noted the latest self assessment provided and work being done to make sense of urgent care, relevant to promises 14 and 22. The Board had considered how it could stimulate impact on Promises 8-10-11-12, and recognised the focused effort needed on Q1 on elements of Promise 9.	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEE)		
Bpu 26/03/26	Mortality Report and the Guardian of Safe Working Hours Report Mrs Lavery informed the Board of the mortality report and the Guardian of Safe Working Hours report for information which was presented as a supporting paper that had both previously been presented at committee level for scrutiny and challenge. The Board received and noted the Mortality report and Guardian of Safe Working Hours report for information.	
CLOSING ITEMS		
Bpu 26/03/27	Any Other Urgent Business There was no further business raised.	
Bpu 26/03/28	Any risks that the Board wishes the Risk Management Group to consider Mr Lewis referred to the forthcoming reflection Mr Forsyth had agreed to undertake on workforce violence and aggression, and asked that RMG should take account of the points raised and whether any risks to consider.	SF
Bpu 26/03/29	Public Questions Mrs Lavery confirmed two public questions had previously been addressed (Item Bpu 26/03/16). There were no further public questions.	
Bpu 26/03/30	Close The Chair resolved 'that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press would be excluded from the remainder of the meeting, which would conclude in private.'	

Next Meeting - Thursday 28 May 2026 at 10.00am, Riverside, Rotherham

DRAFT

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 25/09/25	Further update on Community Mental Health Services (Adult) An improvement programme for community based services would be developed, and would return to the Board in January and March to outline the approach.	TL	May 2026: The Workplans included in today's papers identify opportunities in the timeout session of August 2026 and the formal Board meeting in January 2027 to return to this topic.	Propose to Close
Bpu 26/03/05	Matters Arising - Reducing Restrictive Interventions (RRI) Advocates Mr Lewis queried whether the commitment to have RRI advocates in place by April was realistic, noting the issue had been ongoing for since March 2025. Mr Forsyth acknowledged the delays but confirmed that recruitment and preparations were now sufficiently advanced to expect advocates to be operational by the end of June 2026.	SF	May 2026: RRI advocates have been identified for all AMH inc PICU / OPMH wards, Rotherham HDRU (Phoenix), Doncaster LD (Amber) and physical health rehab (Magnolia).	Propose to Close
Bpu 26/03/07	Audit Committee (AC) Regarding the safe staffing audit, the Trust would not be developing an independent community staffing tool and the action plan behind the 360-assurance audit would be amended.	SF	May 2026: The Report was discussed at the Audit Committee in April. Further discussions with 360 Assurance have re-set and reconfirmed the responses and amended the action plan for the audit outcome.	Propose to Close
Bpu 26/03/11	Reports to Board Mrs Lavery, with Mr Lewis, agreed to review the format and consider improvements to future committee reporting to the Board, including matters for escalation, and the broader access to committee minutes; that would support insights, cross referencing and informal communication.	KL	May 2026: A revised 'report to Board' is now in use, rationalising the points included; full copies of minutes are all available via the corporate assurance team; the use of the NED monthly meetings will facilitate relevant discussion and informal communication relevant to Committee reporting.	Propose to Close
Bpu 26/03/13	Chief Executive's Report A further update for neurodiversity care would return to the Board in May.	TL	May 2026: Contained within CEO annex: a further discussion on the future adult ADHD and adult autism services will take place on July 2026.	Propose to Close
Bpu 26/03/24a	Operational Risk Report Dr Sinclair to provide a briefing at the next Quality Committee meeting in relation to RSK-038 (lithium	DS	A comprehensive update was provided by Dr Sinclair at Quality Committee on 20 May 2026.	Propose to close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
	related) given previous discussions with clinical leads and the complexity of the issue in practice.			
Bpu 26/03/17 & Bpu 26/03/28	Workplace Violence and Aggression: Staff Safety and Incident Trends (April 2025 – March 2026) and any risks that the Board wishes the Risk Management Group to consider Mr Forsyth had agreed to undertake reflections on workforce violence and aggression, to take account of the points raised and whether any risks to consider. The update on this would be considered a matter arising at the next Board meeting.	SF	May 2026: The actions to be taken will be orally presented to the Board meeting.	Propose to Close
Bpu 25/11/15	Freedom to Speak Up (FTSU) Guardian six month update Mr Lewis agreed to consider with executive colleagues outside this meeting of a broader culture of speaking up beyond formal FTSU processes.	TL	May 2026: In light of the staff survey position, and the comments contained in the TVC report, this matter remains under discussion and will be considered further in July and September .	Open
Bpu 25/11/22b	Health Inequalities: Review of IPQR A review of the format and focus of future reports would be undertaken, with a new reporting format to be confirmed in April.	JMcD	May 2026: A new high level, shorter reporting format will be provided to Board providing an analysis of the IQPR via a health inequalities lens. The first version of this report will come to the July meeting of the Board.	Open
Bpu 26/01/23	Promise 5 – Making it Real A dedicated time out session in June for the Board to revisit and align on its understanding of power sharing, and to explore how we would know if our Community Involvement Framework was being delivered.	TL	May 2026: This topic, ‘power in our communities’, is scheduled to be included in the Board’s timeout session in June 2026 .	Open
Bpu 26/03/06	Quality Committee (QC) Regarding Radar task burden, Mr Lewis expressed concern that constant reminders risked desensitising staff, and he asked that the issue be taken through the action log for further refinement.	TL	May 2026: This should remain open as discussions continue. We would expect to conclude in July . RADAR more generally is included on May care group delivery reviews.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 26/03/14a	Promise 14 – Delivering a 4 week wait for all referrals Regarding the podiatry service, a detailed trajectory would be provided once the additional staff were in place.	RC	May 2026: Update on the recruitment to podiatry staffing • Interviews (2 x band 5) – mid May • 2 internal staff (grow our own) currently in training will qualify in August 26 • Applicants to the above may be external students also due to qualify in August – opportunity to identify candidates. Trajectory information as noted will follow once staffing confirmed.	Open
Bpu 26/03/14b	Promise 14 – Delivering a 4 week wait for all referrals A progress report would return to the Board in July.	RC	May 2026: Workplan paper included in today's papers confirms a final plan on 14 week waits will be included in September's Board meeting.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Quality Committee	Agenda Item	Paper D
Committee Chair	Dr Richard Falk, Non-Executive Director		
Lead Executive	Steve Forsyth, Chief Nursing Officer		
Date of meeting:	20 May 2026		
Attendees:	Richard Chillery, Maria Clark, Hannah Hall, Dr Diarmid Sinclair, Dave Vallance		
Matters of concern or key risks to escalate to the Board:	Lithium Prescribing and Monitoring: The Committee received an update on an open Board action from January 2026 concerning lithium prescribing and monitoring in shared care. It was identified that shared care arrangements lack clarity. As an interim measure, a manual lithium register has been piloted in one locality, identifying approximately 130 patients prescribed lithium across the Trust. Six actions are in progress, with a planned completion by the end of July, to strengthen shared care processes and introduce more reliable monitoring arrangements. The adequacy and pace of these actions are being reviewed by the Risk Management Group, with consideration of escalation and potential re-scoring of the risk. Since the introduction of the new incident reporting system, two cases of inadequate monitoring and one case of lithium toxicity have been identified, reinforcing the need for urgent improvement. Safer Staffing Annual Report and Establishment Review: The Committee reviewed the annual inpatient nursing establishment review for 2025/26. The review confirms that all wards are meeting required staffing levels to support safe care, based on established acuity and workforce tools, and a compliance declaration is presented for Board approval. However, the review also highlights that the skill mix on inpatient wards remains below national recommendations owing to sickness absence and vacancies. Mitigations are in place, including roster management improvement and scrutiny, use of nursing associates, twice-daily staffing huddles, redeployment between wards, and the introduction of the SafeCare e-rostering acuity tool, which enables real-time monitoring and responsive adjustments. The Board is asked to approve the safer staffing declaration and to note the continued focus on improving registered nurse availability, overnight.		
Key points of discussion relevant to the Board:	Incident Management: A significant increase in outstanding incident follow-up actions (an much better visibility of same) since the introduction of the RADAR incident reporting system. While the quality of completed investigations remains good and reporting levels are high, delays in closing incidents and actions risk weakening organisational learning and oversight. This matter is being managed by delivery reviews. Mortality Review: The latest mortality review did not identify any concerning trends or clusters. Learning from individual cases has focused on strengthening physical health care and documentation within mental health services. Actions arising from coroner feedback (<i>PFD issued – regulation 28 in relation to the death of Delwyn Preece</i>), including improvements to leave documentation and monitoring, have been implemented and the matter is considered at the Board in the Chief Executive's report. In addition, the committee considered, in particular:		

	• incident management • patient safety trends • potential approaches to always measures, a delayed implementation from 25/26 at the heart of the Q&S Plan • the IQPR

The intention of the Q2 revised IQPR patient safety metrics is to ensure that all 14 clinical directorates feature in the work of the quality committee.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	Agenda Item	Paper E
Committee Chair	Kathryn Gillatt, Non-Executive Director		
Report Author	Phil Gowland, Director of Corporate Governance		
Date of meeting:	8 April 2026		
Attendees:	Kathryn Gillatt (Chair), Pauline Vickers, Dr Richard Falk		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	Counter Fraud Bribery and Corruption Progress Report: demonstrated increased referrals and investigations, evidence of a strengthening anti-fraud culture reflecting improved staff awareness, with discussion focusing on proportionality, learning and embedding organisational controls. Approved the Draft Annual Counter Fraud Plan 2026/27. Internal Audit Progress Report: confirmed significant assurance for Strategic Delivery Risk Management and a moderate assurance outcome for safer staffing, noting strong inpatient arrangements and developing community frameworks. Approved the Draft Internal Audit Plan 2026/27 and amendments to audit scheduling, including deferral of one audit into 2026/27 without undermining overall assurance. Interim Head of Internal Audit Opinion 2025:2026: confirmed a position of significant assurance for 2025/26, supported by strong implementation of high/medium risk actions. Clinical Audit Progress Report: confirmed broad delivery of the programme with measurable quality improvements; concern was raised regarding the prolonged delay in completing the rapid tranquillisation audit. External Audit Plan for the 2025/2026 annual Report and Accounts: provided assurance on scope, key risks and readiness for year-end Risk Management Framework: highlighted increasing maturity, with requests to strengthen thematic insight and reporting clarity of mitigation impact. Education Governance Report: highlighted positive external feedback and the need for clearer outcome-focused assurance. Apprenticeship levy utilisation exceeding 100 per cent for the first time.		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Mental Health Act Committee	Agenda Item	Paper F
Committee Chair	Maria Clark, Non-Executive Director		
Report Author	Dr Diarmid Sinclair, Chief Medical Officer		
Date of meeting:	22 April 2026		
Attendees:	Rachel Blake, Dr Jude Graham, Dr Diarmid Sinclair, David Vickers.		
Matters of concern or key risks to escalate to the Board:	Mental Health Act and Reducing Restrictive Interventions Training Compliance Data Analysis The paper reported that compliance with Mental Health Act Level One training remained consistently high across the Trust and had been sustained at over 90%. Compliance with Mental Health Act Level Two training continued to improve and reached over 95% by March 2026, reflecting the better use of protected learning time. In contrast, compliance with Mental Health Act Level 3 training remained below expected levels despite improvement to just under 80%. Attendance issues and staff booking training far in advance while remaining out of date were identified as continuing challenges. Compliance with reducing restrictive interventions training declined further to just over 76%, despite ample training capacity being available. The discussion confirmed that the issue related primarily to operational pressures and engagement rather than access to training. Clear expectations were reinforced that all mandatory training requirements applied consistently across services, with strengthened oversight and escalation mechanisms in place.		
Key points of discussion relevant to the Board:	Blanket Restrictions Biannual Report The paper described the trust position on the use and oversight of blanket restrictions and reported that 39 relevant incidents were recorded during the reporting period, predominantly within a small number of acute inpatient wards. The most frequent cause was the discovery of illicit substances, resulting in proportionate and time limited ward safety actions. No new medium or short-term blanket restrictions had been introduced since the previous report. Reducing Restrictive Interventions The paper presented restraint, seclusion, and violence and aggression data for January and February 2026. The number of restraint incidents increased between the 2 months, influenced by patient movement and the inclusion of additional wards in reporting. A small number of patients accounted for a significant proportion of restraint activity, and in each case escalation actions were undertaken, including specialist review and placement changes, after which incidents reduced. No prone restraint was used during the period. The number of seclusion episodes remained stable, although a rise was noted in the following month. Incidents of violence and aggression increased, with most resulting in no or minor harm. Concerns were raised regarding variability in documentation quality and post incident physical health monitoring. Mental Health Act Compliance Report The paper confirmed that the Trust processed 409 detentions during the quarter. Two unlawful detentions occurred due to documentation errors, both of which were identified promptly and addressed. Amendments were required on a minority of detention papers, mainly for minor administrative issues. Medical scrutiny compliance remained very high. Performance in assessing capacity to consent to medication at admission varied by locality, with stronger performance in Doncaster		

than in other areas. At the statutory 3 month point, all required consent to treatment forms were in place, although completion of internal capacity documentation remained inconsistent. Compliance with informing patients of their rights under Section 132 was lower in Rotherham compared with other localities, and further work was underway to improve both practice and reporting accuracy. Section 17 leave processes had been revised during the period and discharge requirements were met in all cases.

Mental Health Act Performance Report

The paper provided an overview of Mental Health Act activity and performance. Detention rates were highest in Doncaster, reflecting service demand and patient flow. Section 136 activity was monitored closely, with occasional temporary closures of assessment suites due to operational reasons. One under 18 admission to an adult mental health bed occurred, alongside a small number of admissions to acute general hospitals. There were no absences without leave from low secure services, no medication related Mental Health Act incidents, and strong compliance with seclusion medical review standards. Several Mental Health Act policies remained overdue for review, and recruitment to a specialist management role was underway to address this. The recent legislative changes to the Mental Health Act were noted as having long term implications requiring ongoing strategic oversight.

Care Quality Commission Mental Health Act Inspections Highlight Report

One inspection took place at Sandpiper Ward, where 12 concerns were identified, most of which were addressed within agreed timescales. Remaining actions related primarily to estates works and an ongoing serious incident investigation. Across inspections during the year, recurring themes included environmental standards, maintenance delays, quality of risk assessments and care planning, access to food and drink, advocacy, therapeutic activities, and communication with families and carers.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	People and Organisational Development Committee	Agenda Item	Paper G
Committee Chair	Sarah Fulton Tindall, Non-Executive Director		
Lead Executive	Carlene Holden, Director of People and Organisational Development		
Date of meeting:	22 April 2026		
Attendees:	Richard Chillery, Carlene Holden, Steve Forsyth, Dr Jude Graham, Ian Spowart, Dave Vallance, Pauline Vickers.		
Matters of concern or key risks to escalate to the Board:	Nothing to escalate		
Key points of discussion relevant to the Board:	Integrated Performance and Quality Report and Top Ten Measures The report showed continued pressure across key workforce measures. Retention and sickness absence remained above target (as expected), with vacancies significantly exceeding the agreed threshold and expected to persist into H1 due to organisational change. The Committee discussed the importance of triangulating a range of data to have a clear picture of workforce capacity on a given day, such as: vacancies; sickness; bank and agency information. It was noted too that annual leave, bank holidays and school holiday periods also compounded workforce availability and that a piece of work to bring all these elements together would equip the 555 to manage these things. Appraisal compliance dipped slightly and recruitment performance fell below the revised national standard following changes to reporting requirements rather than local process failure. Internal Audit Progress Report The report confirmed that audit follow up arrangements remained effective overall, with most actions appropriately tracked. Three actions sat within the committee remit, two of which were overdue. The most notable risk related to delays in updating the incident management policy and completing elements of the trust induction review, with dates scheduled to complete the work. Staff Survey Results Update Initial results indicated a continued year on year decline against peer benchmarks, despite remaining above wider national averages. Variation was evident by directorate and length of service, with newer staff reporting more positive experience than longer serving colleagues. Continued success in flexible working was noted. Gender Pay Gap Report The report confirmed statutory compliance and demonstrated a sustained reduction in the overall gender pay gap. However, the medical gender pay gap widened due to small workforce changes, highlighting fragility at senior levels. Ethnicity pay data showed a narrowing gap in favour of staff from ethnic minority backgrounds and disability data showed no current adverse pay impact. The key risk related to under representation of women in the highest paid consultant roles and the impact of the nationally determined clinical excellence awards and potential reputational impact, whilst recognising this isn't within the Trust's control.		

	Staff Incidents and Reporting of Injuries Diseases and Dangerous Occurrences Regulations Report

	Reported incidents of violence and aggression reduced compared to the previous quarter but remained concentrated within inpatient services, driven by a small number of patients. Racist incidents reduced but continued to present a risk to staff safety and experience. Racism incidents saw a reduction by 27 in quarter 3 with 11 incidents reported in quarter 4. It was noted that Rotherham was the highest reporter of incidents and that focused work on racism-related incidents in Rotherham was planned. Several reportable injuries highlighted weaknesses in environmental controls previously marked as resolved. Claimed staffing shortages increased, reinforcing the link between workforce pressure and safety risk.

	Freedom to Speak Up Six Month Update

	The report demonstrated that Freedom to Speak Up arrangements were embedded with volumes comparable to peer organisations. Patient safety and workforce wellbeing remained the dominant themes, while bullying and harassment concerns reduced. A small increase in anonymous cases suggests the effectiveness of this new initiative.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health, Patient Involvement and Partnerships Committee	Agenda Item	Paper H
Committee Chair	Rachael Blake, Non-Executive Director		
Lead Executive	Jo McDonough, Director of Strategic Development		
Date of meeting:	20 May 2026		
Attendees:	Dave Vallance, Joy Bullivant, Richard Chillery, Jo Cox, Dr Richard Falk, Steve Forsyth, Carlene Holden, Toby Lewis, Dr Rumit Shah, Dr Diarmid Sinclair.		
Matters of concern or key risks to escalate to the Board:	The Committee noted that there is slow progress on certain inequalities related promises, notably promise 8, 9, and 10: a focus on this through risk registers and delivery reviews is needed.		
Key points of discussion relevant to the Board:	Promise 2 Unpaid Carers Progress had been made in developing a consistent approach to identifying and supporting carers, supported by new systems for early identification, referral and recording. Partnership working with local authorities had strengthened, with plans for shared reporting from 2026 to monitor take up and outcomes. Development of peer support roles and increased support for staff carers were noted. Work was progressing to achieve accreditation by December 2026. Patient Carers Race Equality Framework Improvement had been seen following a second assessment, although most areas remained in development. 21 areas required further work to reach a stronger standard by October 2026, and 4 areas remained not started and had been escalated. Strengthening data use, partnerships, community engagement and staff awareness was identified as key to progress. Promises and Health Inequalities Data Report Data showed limited improvement between 2024 and 2025, with inequalities in access and outcomes continuing. Some progress was evident in specific areas, but targets had not been met and some groups remained underrepresented. A different reporting approach will be applied to distinguish: action/progress, action/no progress, inaction/ no progress. Aspire Partnership update The partnership remains strong, but there is a need for further focus on ensuring engagement between drug and alcohol services and the wider Trust, and on meeting a financial plan consistent with maintaining the contract beyond term. Simon Sheppard is taking on the SRO role. Draft Rotherham Plan 2026 2036 A decade of opportunity The committee agreed to endorse this broad local authority plan for the borough, recognising that the Trust's work in Rotherham will continue to be defined by its own published strategy. Internal Audit Report Health Inequalities Significant assurance had been provided, confirming that governance, risk management and controls were generally sound. Overall arrangements were robust with minor improvements required. The committee noted that this judgment referred to governance not to delivery.		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Finance Digital and Estates Committee	Agenda Item	Paper I
Committee Chair	Pauline Vickers, Non-Executive Director		
Lead Executive	Simon Sheppard, Director of Finance and Estates		
Date of meeting:	22 April 2026		
Attendees:	Pauline Vickers (Chair), Rachael Blake, Richard Chillery, Carlene Holden, Simon Sheppard, Sarah Fulton Tindall, Ian Spowart		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	Briefing on the final terms of the Waterdale lease 25 year lease was signed on 31 March 2026; with funding confirmed as previously reported to Board including £5.2 CDEL with refurbishment via the Trust's capital funds, NHS England and City of Doncaster funding. Also, as discussed with Board, the head lease has break clauses at 1 year (and 3 years under a defined circumstance). The risk profile remained very low, reflecting the level of investment in Doncaster city centre, the expected timescales for any potential political change and the low probability of legal challenge and emphasised the importance of being risk aware. Month 11 Financial Performance Report Draft pre-audit year-end position would be £646k surplus – thereby delivering the income and expenditure plan, capital plan (small agreed overspend), cost improvement plan and the better payment policy compliance (paying our suppliers within 30 days). 2026 to 2027 Financial Plan Submission of a breakeven plan for 2026 to 2027, with all directorate budgets approved and loaded to the financial ledger in April. The plan includes cost pressures and a challenging cost improvement programme alongside agreed income assumptions. Key risks related to safe delivery of the pharmacy scheme, uncertainty of income linked to service activity (high dependency unit), pay and non-pay inflation particularly regarding utilities. Medium Term Financial Plan including underlying position Continued improvement in the underlying financial deficit over several years was noted (from £16m to £6.3m for the end of 2025 to 2026 financial year), with break even position at the end of 2026 and 2027. The Committee discussed the impact of national assumptions and internal efficiencies required to sustain this position alongside the potential opportunity from deconstructing block contracts to ensure appropriate funding for activity delivered Trust Procurement Function Development Progress continues towards a shared procurement function with early engagement and planning completed and further approval required through Sheffield Health Partnership University NHS Foundation Trust's Board meeting at the end of May 2026. Risks related to delays in governance, staff uncertainty during transition and maintaining service continuity. The current timeline showed the transfer taking place in July 2026. Estate Enabling Plan Supporting the integrated overview of the estates programme, a detailed project plan was being developed working back from Board approval of the full business case in summer 2026, with external capacity being sought to support its preparation alongside a Trust core		

	team. The programme would be delivered through a series of workstreams, including agreement of the site boundary and therefore the land to be retained, progression of sale and leaseback transactions with legal support, further development of the frailty centre proposals, and a specific focus on Rotherham to unlock elements of both the Tickhill Road and wider Doncaster estates.

Health and safety statutory compliance

This paper had provided assurance on compliance with statutory health and safety requirements, noting improvements in assurance processes and completion of key assessments. All fire risk assessments had been completed by the end of March 2026 with ongoing actions monitored by the Head of Estates.

Cyber security

This paper, received at Board in March 2026, confirmed strong performance in responding to national security alerts, completion of system upgrades and progress in strengthening monitoring and supplier assurance; with additional investment planned to strengthen these controls further.

Trust Standing Financial Instructions and Scheme of Delegation Annual Review

This paper had confirmed that the annual review had been completed with only minor amendments required to the transfer of roles following the retirement of the Director of Health Informatics.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Trust People Council	Agenda Item	Paper J
Committee Chair	Kath Lavery Chair		
Lead Executive	Carlene Holden Director of People and Organisational Development		
Date of meeting:	06 May 2026		
Attendees:	Navjot Ahluwalia, Amanda Ambler, Atique Arif, Glyn Butcher, Jennie Gaul, Prachi Goulding, Cheryl Gowland, Iona Johnson, James Hatfield, Toby Lewis, Tinashe Mahaso, Simon Mullins, Kim Shilomboleni, Susan Statter, Jessica Williams, Laura Wilshire.		
Matters of concern or key risks to escalate to the Board:	Trust Culture Discussion A paper was received and accepted which followed the TPC away day in January: broadly the positive and negative facets of culture resonated with members. Some emphasised the importance of the latest staff survey results and pressed for a 'board response', with other colleagues favouring further work on diagnosis, difference and a sustained less reactive response: which recognised the diversity of the organisation and the key role of middle management in the solution. The focus of the Board on culture, and the involvement of networks, trade unions and others was welcomed. <i>This is a key risk rather than an escalation.</i>		
Key points of discussion relevant to the Board:	In addition to the culture work, and some comments on the staff survey 2025, the focus was again on the Remote Agile Hybrid Working Policy which is due to launch before mid-summer. The paper outlined the intention to remake our approach. A series of archetypes for flexible, agile and remote working would be finalised: line managers would predominantly need to be on site. The organisation would be investing to ensure that home working met with Health and Safety legislation. The approach would allow managerial discretion but within clear annualised parameters. Importantly the final proposal will be aimed at ensuring those entering the workplace now view the Trust as leading-edge for their jobs and careers. There was a strong welcome within TPC for this, vociferously from medical staff attendees. Colleagues welcomed efforts to ensure that shift-based workers and others had equitable access to policies including flexible working. It was recognised that a move to not codify long term contractual changes is a different approach to what some are used to and will need during the six-month transition period careful support and introduction.		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks	Agenda Item	Paper K
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
The Board continues to receive update reports on the Strategic Delivery Risks, ensuring awareness to the progress on mitigating those five risks, that it felt had the biggest opportunity to disrupt the delivery of the Strategy. Previously there has been consideration of whether any other risk should replace or be added to the current five; indeed the TVC Well-Led Developmental Review report on today’s agenda makes suggestion for a finance related risk to be considered. The Board is today asked to confirm the SDRs to be its focus throughout 2026/27. For each SDR, and following the latest tri-annual review with the Audit Committee chair and Director of Corporate Assurance, the latest position is presented, with revised actions and timescales to reach the stated target mitigation date – see Appendix 1. It is important that progress is monitored routinely and via the respective Committees and to the Board during the year (at frequencies presented in the Board and Committee Workplan paper on today’s agenda). Significantly, it is increasingly clear that there is a contrast across the SDRs with large aspects within our gift to develop our staff, but also the ability of others – our external partners and stakeholders – to help and support the way forward, although there are as reported challenges within this aspect too. In considering the paper, Directors should cross refer this update with papers on the agenda including the Staff Survey, Promises and Priorities Scorecard, Well Led Developmental Review and Culture work.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
Each Board of Directors meeting includes this agenda item and relevant Committees receive updates on their allocated SDR – see Committee Reports to Board.			
Recommendation (delete options as appropriate and elaborate as required)			
The Board of Directors is asked to:			
RECEIVE and NOTE the update position for each SDR; and .			
CONFIRM the strategic delivery risks relevant for the remainder of the 2026/27 year.			
Alignment to strategic objectives (indicate those that the paper supports)			
SO1: Nurture partnerships with patients and citizens to support good health	x		
SO2: Create equity of access, employment, and experience to address differences in outcome	x		
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	x		
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	x		
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x		
Alignment to the plans: (indicate those that this paper supports)			
Digital plan	x		
People and teams plan	x		
Quality and safety plan	x		
Equity and inclusion plan	x		
Education and learning plan	x		

Research and innovation plan				X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)				
People risks	Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
	Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
	Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
	Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Patient care risk	Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
	Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
	Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
	Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks	Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
	Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks	Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
	Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
	Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X
Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)				
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1				X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services				X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.				X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.				X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets				X

required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees							
System / Place impact (advise which ICB or place that this matter relates to)							
All SDR in the paper are set within an external (system/place) impact / requirement for engagement.							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Individual Strategic Delivery Risk forms are in the Annex to the Report.							

Strategic Delivery Risks

1. Background

- 1.1 The Strategic Delivery Risks are those risks that the Board has determined as having most potential to disrupt the delivery of the strategic objectives. These are different from the risks managed via the range of risk registers (operational risks). The latter reflects the challenges to the organisation's functioning on a year by year, week by week basis. It is a live document that will show identification, mitigation and escalation of key risks faced by teams across the organisation. In contrast, the SDRs focus on factors which could interrupt delivery of the organisation's objectives over the medium term. These are also risks that the Board has a unique ability to solve.
- 1.2 The Board is focused on mitigating the likelihood, or more typically the impact, of these factors. Individual executive directors have been tasked with progressing actions to this effect.
- 1.3 The five risks, each aligned to a strategic objective were agreed back in 2024 and have periodically been reflected upon to ensure they continue to be the organisations strategic risks – in this meeting the Board should take the opportunity to reconsider them again and to confirm the SDR for 2026/27; the SDRs are as below:
 - The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities (links to SO1)
 - Challenges generating data and / or evidence to support interventions to address Health Inequalities (links to SO2)
 - Capacity / Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies (links to SO3)
 - Movement to seven-day working is poorly reflected in national terms and conditions and the Trust is therefore unable to shift to new models of care without major retention risk (links to SO4)
 - The Trust lacks the cultural capability and competence on wider issues (links to SO5)

2. Strategic Delivery Risks

- 2.1 With respect to the SDRs, review and monitoring work continues through
 - 2.2.1 Individual executive leads – as a result of the changes in the Executive Group from 1 April, SDR2 will now be led by Richard Chillery, COO and SDR4, by Dr Jude Graham, Director of Psychological Professionals.
 - 2.2.2 The tri-annual review meetings with executive leads, the audit committee chair and the Director of Corporate Assurance (most recently in May 2026)
 - 2.2.2 Board Committees
 - 2.2.3 Board of Directors; most recently in March 2026
- 2.3 The current position in respect of each SDR is presented in Appendix 1. Of note in the progress within the Appendix is:

SDR1 and SDR5: Work to deliver against Strategic Objectives 1 and 5 and to mitigate these risks has multiple synergies. By focusing on power-sharing, inclusive leadership, and a partnership ethos, the Trust not only nurtures better relationships with patients and communities, but it also strengthens every domain of its leadership and governance. The recent work has focused on the impact of LDO and induction as key points of change with colleagues, but broader training sometimes via LHD, including active bystander and community immersion will be impactful too. Future work with the 555 should target this community engagement too. These mean our colleagues are better placed to engage and respond to our communities and we should continue to reach out (and go) into those communities and use their input through the new formed Community Leadership Executive (CoLE), representation at CLE and its sub groups and through the involvement of volunteers and carers to take forward the related work mitigating these risks.

SDR2: The availability and use of data sits at the heart of this risk and there continues to be work on both strands providing meaningful, quality data to our colleagues in order that they can better and more informed decisions. Availability of health inequalities data being a key one, with marked progress in the last six months and a recent internal audit on this topic acknowledging progress being made, which links back to the availability of data supporting the progress made. System Connect and its expanding use and functionality is also acknowledged as a key next action in this area. Efforts to continue to ensure data quality standards are high remain in place.

SDR3: The national context remains in some flux, without a neighbourhood contract or left shift funding model. Each geography nationally has been asked to define neighbourhood geographies and that process poses at least two irresolvable issues. Firstly, such boundaries may not map to real human geography, but also in many cases it will not map to PCNs. The former reinforces an NHS-only approach to neighbourhood health, the latter raises risks over the contract when issued, which many GPs will have assumed with good evidence will be routed through them.

In response our focus at RDaSH is to get the basics right, as defined through delivery of the five priorities we agreed. 2026 needs to see a shift in referral processes and access to advice from senior clinicians. Iona Johnson and Cheryl Gowland are focused in this space and the community powered healthcare taskforce may offer some additional drive to support that work. The GP survey, and Cheryl's work since coming into post is about individual practice perceptions, and in addition to the overall opinion score, it will be interested to examine how labile respondents are versus their prior year assessment.

We might expect it will take us deep into this year to see the position, and our score, move, as we look to see one or more of our places truly changing. We need to consider how best, notably in North Lincs and Doncaster, we move closer to an IHO position, which is what commissioning bodies indicate they wish the Trust to aspire to.

SDR4: Full seven-day working—particularly weekend discharges—remains limited due to workforce, system and cultural constraints and matters such as job planning and the ways of working of our system partners will continue to challenge the ability to progress. Flow through and quality of care on in patient wards progresses with the lowest ever number of out of area placements occurring now. Developments and future developments such as the 24/7 mental health centre in North Lincolnshire (from October) do demonstrate progress in this area.

- 2.4 Within the recent reviews with the Audit Committee Chair and Director of Corporate Assurance, the executive leads were reflective of the progress to date, the future actions and the point at which they felt that the mitigation of risks would impact on the risk score. Whilst this has been done previously it was clear this time that all still had work to do / time to go and hence each has extended the time by which they felt the risk would be reduced – broadly speaking to the two aligned risks SDR1 and SDR5 may be achieved ‘earlier’ and by the end of the calendar year, but the others, for different reasons, probably need longer and therefore it may be nearer the end of the financial year in March 2027 by which we will have made sufficient progress.

3 Strategic Delivery Risks

- 3.1 As the Trust’s Clinical and Organisational Strategy was launched, the Board of Directors took the opportunity to consider the risks to its achievement – the strategic risks that might genuinely stop progress. Work in timeout sessions and in formal meetings concluded that there would be five such risks – one aligned to each strategic objective. Those chosen were the result of a process that started with over 40 initial risks.
- 3.2 At various points in time since, there has been cause to reflect or suggestions from others about whether the five were indeed the key five or whether there should be more. Indeed, the TVC authored report on today’s agenda reflects on whether there should be a financial position based risk included, something that has also been raised by others in the past.
- 3.3 With specific reference to the finance based strategic risk, the Board did, in its first set of possible risks, consider that topic and decided that it would not be one of the SDRs – in part recognising that our SDR is against our strategy, rather than a summary of the entire institutional operating environment. That noted, we are a going concern and our liquidity raises no risks to needing to borrow to meet operational expenditure. As such the only way in which a “finance SDR” would be relevant is if we consider that our annual 1% investment return for the strategy may not be realisable, recognising that as time carries on the need to invest at this level before 2028 reduces. We could of course revisit our whole approach to the Strategic Delivery Risks and revert to broad thematic context as risks. However, given the time spent in 2023 and then again in 2024, that is not recommended.
- 3.4 With this in mind and as the Board reaches essentially a mid-point within the life of the current Strategy it is timely to consider the SDR and it is recommended to reaffirm the five current SDRs or to change the risks that are considered as the SDR. Whilst finance has been mentioned, that is not to say that it is the only one for consideration. The Board may identify and suggest others too. What is important is that the consideration takes place and that there is clarity within the SDR work for the remainder of the year.

4 Recommendations

The Board of Directors is asked to:

RECEIVE and **NOTE** the update position for each SDR; **and** .

CONFIRM the strategic delivery risks relevant for the remainder of the 2026/27 year.

Philip Gowland, Director of Corporate Assurance
20 March 2026

SO1: Nurture partnerships with patients and citizens to support good health										
What could get in the way? The Trust’s inability to work effectively with a diverse population using diverse methods and create alignment between the Trust’s agenda and that of the patients and communities	As a Strategic Delivery Risk:								Lead Exec	Board Committee
	<i>If</i>	our ‘changed ways of working’ with the diverse population (inc excluded communities) are not delivered by 2027								
	<i>because</i>	of the leadership’s inability to identify, communicate and engage							SF	PHPIP
	<i>then</i>	it will lead to a loss of confidence locally and likely non-delivery of SO1								
Risk Score	Current (March 2026)					Target (December 2026)				
	I	4	L	3	12	I	4	L	2	8

Current controls – what do we have in place to mitigate the risk?	Current assurance/performance – how do we know the controls are working?	Gaps in assurance/performance – what else do we need to know?
Stakeholders: Stakeholder Management Matrix – includes a range of stakeholders; Important to understand the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; Place based meetings now occur monthly – March will be the third in the series and will focus on Rotherham (previous meetings on North Lincs and Doncaster) – attendees are two EG colleagues and relevant care group reps; purpose to discuss progress with building relationships and establish progress and create synthesis with information from other sources.	In part – the outcome of the Internal Audit work on Partnership Governance and Risk Management is appropriate (significant assurance) – All actions complete. The regular meetings taking place as 'place partnerships reviews' afford the opportunity to assure on their effectiveness – CLE need to become more aware of their progress and impact.	Confirm the (form of) flow of outcome within the organisation
Stakeholders: Community Leadership Executive (CoLE) New body (15 members) of community representatives has been established. This will provide community based feedback, be involved in decision making and holding to account, provide strategic input and facilitate communication and develop partnerships; and build capacity and help co-production.	First meeting took place in May 2026	

Educating our Staff: Leadership Development Offer includes, 'Compassionate leadership to unlock community power'	Baseline data established. (commencement of programme) As Cohorts complete the programme additional feedback and analysis to be undertaken.	LDO feedback - Further detailed analysis planned. Of particular relevance is the response to two questions: <i>1b Has the Trust developed compassionate leadership to unlock community power, from the perspective of staff, service users and communities?</i> and <i>3 Has the LDO improved RDaSH Leaders' engagement with each other and the community</i> Capability and Capacity of Leaders (resultant post LDO) – discussions planned (by March 2026) to review the impact of the course on the cohorts that have taken part. Important within the above to establish in advance what outcome will be deemed 'positive' or satisfactory – 100% scores of confidence may be unachievable or unnecessary to be 'positive' but a target of 85%, for example, maybe our aim in the first instance to demonstrate initial impact.
Induction (all new starters) – RDASH and our communities – Launched 28 October 2024 November's induction was the thirteenth since its launch meaning circa 650 staff have now progressed via this induction. Evaluation of induction asks for participants to respond to questions such as, <i>'I am able to understand how my role supports the RDaSH Strategic Objectives / Promises and how I can help to Nurture the Power in our Communities</i>	Internal Audit – Induction: Significant Assurance Evaluation of induction presented in the Autumn to People and Teams CLE Group	Changes to the induction process based on the feedback being collated via a number of routes – direct from participants and via the Induction and Widening Participation Manager – to be deployed over the Summer of 2026.
Educating Our Staff: Learning Half Days	Discussion at the Education and Learning meeting in June 2025, paper to CLE in June 2025 and a paper to Board in March 2025.	Robust forward plan to be developed to include related matters linked to this Strategic Delivery Risk and the development of a learning library
Cultural Shift: Ability of leaders to instigate change; an openness to fail, but learn and improve and ultimately succeed.		The LDO features as learning outcome 2: <i>Enhance our ability to lead change and deliver improvements</i> Remains work outstanding to clarify the feedback and evaluation of the

		participants in this regard. The LDO providers have now also included a question as part of the evaluation questionnaires to capture the views and ratings of Line Managers who also have delegates on the programme. Quantitative measures to be determined.
Cultural Shift: Recruitment and appraisal processes that focus on the appointment based on alignment to the Trust's Values	Triangulating report on Employee Relations cases, FTSU and Complaints - presented to POD (August 2025) further supporting analysis in this area.	Further development of a process to ensure processes effectively include this 'test' to ensure colleagues have values that align to those of the Trust <i>This will be explored via Trust People Council and also the annual Staff Survey – 'Voice Scorecard'.</i> From July 2026 all interview panels for roles B7 and above will be constructed to ensure diversity within the panel.
Representation within our colleagues: A workforce with volunteers, patient safety partners and members that is truly representative of the communities we serve – this would include number of as well as diversity and representation within these cohorts.	Collation and presentation of related numbers, action plans for increased numbers and analysis of numbers in comparison to our communities – staff, patients, volunteers, members – understanding how representative we are in different cohorts. And using this within recruitment, decision making (e.g. change processes) Improved WRES data: the WRES report was reviewed and approved by the POD Committee in August, whilst some areas have improved we have also seen a decline in others WDES data: not improving as much as WRES – Discussed at POD, and will be again through the DAWN network and Combined Staff Network to identify actions	
Engaging our communities – seeking feedback Care Opinion launched (patients and carers)	Care Group Delivery meetings in 2024 and May 2025 featured Care Opinion and Care Opinion within February 25	

	Board Timeout Led by CEO of Care Opinion. Council of Governors in June 2025. Overarching analysis of responses via Care Opinion including those leading to action – Update to Board in September 2025 within the Chief executive's Report	
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: ○ Promise 4 (Quality – Quality and Safety Plan) ○ Promise 5 (Board – Quality and Safety Plan) ○ Promise 6 (PHPIP – Equity and Inclusion Plan) ○ Promise 8 (PHPIP – Equity and Inclusion Plan) ○ Promise 10 (PHPIP – Equity and Inclusion Plan) ○ Promise 11 (PHPIP – Equity and Inclusion Plan) ○ Promise 26 (POD – People and Teams)	Via Promises and Priorities Scorecard – routine report to Board of Directors PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure. PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing Board of Directors – March/May 2025 – Promise 26	
PHPIP Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk (each meeting)	Most recent July 2025	
Independent Third-party Assurance	Internal Audit work on Patient Experience, Engagement and Inclusion – Significant Assurance Internal Audit work on Induction – 25/26 audit plan – significant assurance.	
<u>Future controls/assurances</u> – what key actions do we have planned to further mitigate the risk?	Anticipated milestones	Progress (note these will transfer in year to current controls/assurances as appropriate)
The 'Place Partnership Reviews' (aka 'cake' meets) will be scheduled on a monthly basis	Meetings commenced in January 2026 March 2026 meeting focused on Rotherham; previous ones likewise on North Lincolnshire and Doncaster.	Need to clarify reporting process to CLE

LDO Research and Evaluation planned outputs (via K Williamson) including assessment against expected levels of achievement.	May 2026	
Consideration of any changes to the induction process to reflect on feedback	In readiness for July 2026 onwards.	

SO2: Create equity of access, employment and experience to address differences in outcome

What could get in the way? Challenges generating data and / or evidence to support interventions to address Health Inequalities	As a Strategic Delivery Risk:						Lead Exec	Board Committee		
	<i>If</i>	we do not execute plans to consistently create, use and respond to data inside our services and with others								
	<i>because</i>	our leaders lack the time, skills or diligence to see through specific changes or are distracted by ‘wider system’ priorities						RB (RC from 1 June 2026)	FDE	
	<i>then</i>	this will lead to a lack of precision in how the Trust reshapes services								
Risk Score	Current (March 2026					Target (March 2027)				
	I	4	L	3	12	I	4	L	2	8

Current controls – what do we have in place to mitigate the risk?	Current assurance/performance – how do we know the controls are working?	Gaps in assurance/performance – what else do we need to know?
Educating our leaders: Digital Needs Survey (completed in Q2) Data Saves Lives Campaign (Launched 26 November 2024) – 'Giving health and care professionals the information they need to provide the best possible care'. Series of posters have been distributed and series of three Vlogs launched (December 2024) Key messages in December including Improving trust and transparency; Accurate and timely recording of data / Knowledge is Power; The benefits of using the Yorkshire & The Humber Care Record; How data flows through the system/organisation. An 'Ask me anything' session took place in January 25.	Summary outcome reports provided to Digital transformation Group and used to inform both the Data Saves Lives programme and also considerations for both bespoke and broader training, particularly associated with aspects around the requirement to interface with our electronic patient record, SystmOne. Post Data Saves Lives Campaign, 'business as usual' plan agreed. Incorporates Q3/Q4 evaluation and identifies changes and enhancements to systems training offer. Board Timeout June 2025 – NHS Digital Board session facilitated by NHS Providers. Specific related events to date: October 2024: establishing mental health and community use cases associated with the use of the Yorkshire & The Humber Shared [clinical] Record; November 2024: New personalised care visualisation (20 attendees in total). The personalised care visualisation is a new development for PROMs and 4ww / Saving events in	Identification of key responses from colleagues to the educational efforts to demonstrate learning and great understanding. TNA 2026/27 inclusive of data and digital related matters and these link directly to the outcomes of the Data Saves Lives campaign the recommended actions resulting from it.

Learning Half Days (ongoing from Sept 24) – feature learning opportunities focused on the importance of data and health inequalities.	SystmOne (14 attendees in total). Accurately recording both clinical consultations of different types, as well as administration events / Communicating with patients digitally (40 attendees in total). Use of health inequalities data for frontline staff: Jan 2025: SMI physical health checks new visualisation overview (joint session with Change & Transformation) / Feb 2025: shared care records, patient care access considerations (joint session with Information Governance); SystmOne roadmap 25/26	
Data Availability: Do we have the data we need to make change?	Revised IQPR and associated Health Inequality measurements / indicators with reporting that confirms that as a result of action there are reductions in the health inequalities. From July 2025 the IQPR has supplementary information included and the Board of Directors received an analysis of the IQPR data through a health inequalities lens (separate paper) and agreed that CLE Equity and Inclusion Group would review the data to better understand local needs of patients with protected characteristics. PHPIP Committee – receives and discusses the Health Inequalities - Promises Data Set Report at each meeting; this for example will refer to DNA rates for deprived areas v rates for other areas; number of referrals for veterans) – this allows for purposeful and specific action to respond to the key messages. Progress has been achieved with more to complete.	Continue to develop the suite of data available with an intent (Board Action Log March 20260 to progress this work in April 2026. A range of actions will be overseen by the Equity and Inclusion Group including • Directorate level work to address the data gaps where a person's ethnicity is not known or not stated; • Ensuring that directorates are aware of and managing improvements in the measures of success for the Strategic Objective 2 metrics that focus upon health inequalities. • Implement plans under RDaSH 5 (which are focused at communities that have been under served) and Poverty Proofing. • provide targeted, culturally appropriate services. • Review further the research findings from the IQPR health inequalities analysis, and determine areas of focus / action that will be taken in 2026.
Data Availability: Other: Do we have the data we need to make change?	Examples of where we have developed improved data to make change: Promise 14 delivery (48hr assessment / 4 week wait) – Report to Board to include progress update at November Board meeting.	System Connect – Introduction of more standardised two-way communications options with patients and self-referral, with potential to reduce DNAs, thereby supporting shorter waits; Significant additional work pointed to this implementation from June 2026 onwards which moves from 'basics' to significantly greater

	July 2025 – Position regarding 4 weeks waits. Waiting times published on the Trust website. March CLE – neighbourhood data March 2026 – Sickness absence March 2026 – Staff Survey responses cut and analysed via different aspects including length of service.	functionality consistently used across the teams. Neighbourhood working may drive other asks for different cuts our data, aiding understanding of inequalities of access and prompting actions to target or prioritise.
Data Quality Is the data we use and make decisions on, 'quality data' with completeness, accuracy, timeliness etc underpinning it?	Information Quality Programme and reports to FDE noted structured and demonstratable process was in place. FDE February 2026 – latest three indicators in the 26/27 workplan, confirmed Data quality outcome of • 'High Assurance' for OP61c Patients with SMI having full annual physical health check; • 'High assurance' for QS31 Episodes of seclusion – internal MDT within 5 hours; and • 'Moderate Assurance' for OP73a Section 136 breaches – occupancy hours lost to breaches. Completeness of ethnicity data – September Board reported Kitemarking – utilised within the IQPR against individual indicators Internal Audit report of IQPR (Significant Assurance) Internal Audit report on Waiting Lists (Significant Assurance – waiting list management / Limited Assurance – waiting list validation) Audit on Clinical Coding (Feb 26) FDE assured by the Clinical Coding Audit Report that robust processes are in place to facilitate the accurate application of clinical coding.	Final two indicators in the 25/26 workplan to complete and report in June 2026 are: OP59a Waiting list – adult ADHD OP59b Waiting list – CYP neurodevelopment Internal Audit – ESR and Finance Ledger reconciliation underway (ensuring single source of the truth' for staff related data.
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: ○ Promise 6 Poverty Proofing (PHPIP – Equity and Inclusion Plan)	Via Promises and Priorities Scorecard PHPIP Committee: Nov 24 – Paper E: P6, P8, P10, P11 – what needs to happen and by when to move to an Amber/Green position against each success measure.	Ongoing delivery of the E&I Plan and related Promises

○ Promise 8 Inequalities (PHPIP – Equity and Inclusion Plan) FDE Strategic Delivery Risk Report relating to the oversight and management of SDR2	PHPIP Committee – January 2025 – received a report on Promise 6 – Poverty Proofing PHPIP Committee – July 2025 - paper on promises data presented. Committee now assured with the progress made and the dashboard now in place.	
Future controls/assurances – what key actions do we have planned to further mitigate the risk?	Anticipated milestones	Progress (note these will transfer in year to current controls/assurances as appropriate)
Final two indicators in 25/26 DQ Workplan	June 2026	
HI analysis and reformatted IQPR	July 2026	
Internal Audit – ESR/Finance reconciliation	May 2026	
Conclusion of System Connect work	May 2026	

SO3: Expand our community offer, in each of - and between - physical, mental health, learning disability, autism and addiction services.

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

Risk Score	Current (May 2026)					Target (March 2027)				
	I	4	L	3	12	I	4	L	2	8

Current controls – what do we have in place to mitigate the risk?	Current assurance/performance – how do we know the controls are working?	Gaps in assurance/performance – what else do we need to know?
Stakeholders: Stakeholder Management Matrix – includes a range of stakeholders; Important to understand the dynamic at 'place' but also directly with local authorities. For each relationship clarity over Roles, Responsibilities, Authority and Capacity of identified leaders to participate; Place based meetings now occur monthly – March will be the third in the series and will focus on Rotherham (previous meetings on North Lincs and Doncaster) – attendees are two EG colleagues and relevant care group reps; purpose to discuss progress with building relationships and establish progress and create synthesis with information from other sources.	In part – the outcome of the Internal Audit work on Partnership Governance and Risk Management is appropriate (significant assurance) – All actions complete. The regular meetings taking place as 'place partnerships reviews' afford the opportunity to assure on their effectiveness – CLE need to become more aware of their progress and impact.	Confirm the (form of) flow of outcome within the organisation
Practical Programme of Change: Agreed programme of change (5 CLE priorities) with Primary Care Colleagues. 1. Remove any and all practices which prevent our clinical teams within RDaSH making cross referrals or transferring care. 2. Move to simple electronic forms for all referrals, with prompts which ensure that mandatory information is provided:	Latest assessment with CEO / DoSD / DCOO / Contracting / GP Liaison clarified progress and delivery plan has been agreed. Priorities 1 to 4: largely looking to identify and progress with pilot sites and agree action inc test and learn with primary care partners. Detailed delivery plan seeks to make	The working group will confirm progress and clarify reporting mechanism to ensure agreed timescales are achieved and have the intended benefits. As noted, we expect this work to be concluded during 26/27, and to be a more prominent part of operational

3. Introduce simple, coherent routes of communication to our clinical teams from primary care, and provide 'backdoor' contact models to permit escalation senior clinician-senior clinician for any patients where there is a concern. 4. Audit and justify any practices which tend to pass work or tasks to GPs that could be done by the secondary care team. 5. Waiting time information – Providing up to date waiting time information and making it simple to patients to find out their place in queues to reduce purely administrative appointments in primary care.	substantial progress on these four priorities by 31 July 2026 – with some follow up, stakeholder satisfaction and feedback work planned during Q3 2025/26 Priority 5 – waiting times are now routinely published on the trust website.	change, alongside changes to our AARs offer in the coming months.
Responding to Neighbourhood Health The ten-year plan seeks to compel primary care to collaborate on either a neighbourhood or community multi-specialty provider contract. Our current controls are deep involvement in: - Decision making bodies as they evolve at place - Direct work with the Safecare GP Federation in North Lincs (for clarity we are also working closely with Rotherham Fed which includes Doncaster East PCN, and with the various Doncaster leadership groups	PHPIP has received, as has the Board, recent papers on Promise 15 and 21: in Doncaster we have a clear neighbourhood response within our Physical Health Services. We are working with one PCN to try and develop an 'integrated physical and mental health' approach, which would be a prototype for the Trust.	Whilst continuing to understand the full implications of the neighbourhood guidance (17/03/26), and awaiting the resolution of the ongoing debate or dispute regarding the GP neighbourhood contract, the Trust and partners will be determining and agreeing what the neighbourhoods will be, but it is currently unlikely that defining a neighbourhood team will be possible during 2026.
Community Development Director role – new Director role within Operations; managing GP Liaison role (below) Four priority areas: Primary / Secondary Care interface; Delivery of neighbourhood health; community services transformation; and family first national programme. This will facilitate multiple other opportunities for progress with community partners and introduces a pivotal, resource / skill set / colleague to ensure this objective is achieved.		This is a new role and will help to establish clearer controls across much of this work.
GP Liaison role – key aim to establish regular touchpoints within each of the three places with GP representatives; programme of visits established to every practice, to PCNs and to local Federations.	Feedback mechanisms with GPs are established and embedded. Engagement (differing levels) with circa 90% of practices. Initial survey (May 2025) of how practices rate the current level of integration,	2026 survey has closed and outcomes are being reviewed – headline might be uneven progress across all GPs; and whilst progressive some of the original concerns remain for some. Further analysis will drive next steps during 26/27.

	collaboration and partnership with RDaSH of practices identified score of 2.52/5 (out of 5)	
Facilitate insight into General practice within: <i>Senior individuals:</i> via Dr Richard Falk; Dr Rumit Shah – NED / Assoc NED GP Partner Governor Michael Shaw PCD CEX (route to CLE) GP Liaison role (see above) <i>Care Groups:</i> GP related appointments into Care group structures e.g. Ben Allen and Matt Hodgson <i>Wider Workforce:</i> increased awareness via LDO and via LHD, some of which are scheduled to align to known GP training schedules such as 'Target' in Doncaster (i.e. PM on Wednesdays) <i>Lunch Collab</i> – monthly opportunity with a RDASH team meeting primary care colleagues to discuss the team, roles, waits, referrals, support. (five sessions to date 100+ primary care colleagues have attended)	PHPIP Committee – March 2025, presentation of GP Liaison role and work to date; Board Timeout – April 2025. GP Liaison role and work to date. Board Timeout – April 2026. Update on GP liaison within broader understanding primary care session Individual meeting evaluation undertaken.	LDO Feedback and Evaluation (via Education and Learning CLE Group) – to secure confirmation that our leaders have the necessary skills and experience linked to the work with primary care and other partners in particular the answer to <i>“Has the LDO improved RDaSH Leaders’ engagement with each other and the community?”</i> LHD – primary care knowledge and understanding – needs to be purposefully built into this programme of learning Key relationships with general practice will be built by clinicians at the Trust; there are a range of challenges to the internal relationships with clinicians at the moment that need to be resolved to ensure this work progresses.
PHPIP Strategic Delivery Risk Report relating to the oversight and management of SDR3	PHPIP assured on progress and frequency of reporting	Continued to be scheduled for review to ensure continued oversight
Future controls/assurances – what key actions do we have planned to further mitigate the risk?	Anticipated milestones	Progress (note these will transfer in year to current controls/assurances as appropriate)
The 'Place Partnership Reviews' (aka 'cake' meets) will be scheduled on a monthly basis	Meetings commenced in January 2026 March 2026 meeting focused on Rotherham; previous ones likewise on North Lincolnshire and Doncaster.	Need to clarify reporting process to CLE
LDO Research and Evaluation planned outputs (via K Williamson)	Next reports April and September 2026.	
Repeat the survey of GP practices to establish the increase or improvement in reputation, level of engagement and responsiveness.	Survey closed 30 April 2026	Analysis will drive next steps in 26/27

SO4: Deliver high quality and therapeutic bed based care on our own sites and in other settings

What could get in the way? Movement to seven-day working is poorly reflected in national terms and conditions and the Trust is therefore unable to shift to new models of care without major retention risk	As a Strategic Delivery Risk:									Lead Exec	Board Committee	
	<i>If</i>	Seven-day working and other bed-based service alterations are not implemented fully										
	<i>because</i>	of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring)									RC (JG from 1 June 2026)	QC
	<i>then</i>	we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.										
Risk Score	Current Score (March 2026)					Target Score (March 2027)						
	I	4	L	3	12	I	4	L	2	8		

Current controls – what do we have in place to mitigate the risk?	Current assurance/performance – how do we know the controls are working?	Gaps in assurance/performance – what else do we need to know?
Service provision (RDASH) High Quality Therapeutic Taskforce (est Jan 25) taking forward a range of issues and significantly support the delivery of 7-day therapeutic services within an inpatient and acute context. Data - Base line developed of number of discharges in relation to days of the week, and timing of discharges by wards “live” Flow Dashboard in place Enhance the Current Offer - enhanced discharges during weekdays using current infrastructure - includes using EDD’s more consistently and appropriately	HQTC: has progressed a number of meaningful measures and actions to create consistency across all wards – these include activities being available 7 days per week; visiting times consistent and across the 7d week; MDT meetings, Care planning and ward handover – consistent and across 7 days. Progress towards 7d admissions and discharges has been made and is also including our local partner organisations too. New services are developed with the seven-day process in mind – for example the new HDU and Community Rehab Unit; Recent service developments in PH Care Group such as IV and Phlebotomy are 7-day services started in the last 12m Further opportunities are being considered that extend and support the seven day approach such as the extension to medical on call to support discharge at the weekends and extend CAMHS psychiatry to do crisis assessment for young people; In line with promise 14 (part a) patients can access trust (selected services) at anytime to manage appointments; and in	Inpatient HQTC Stocktake Report to Board of Directors in November 2026

• weekly meetings with senior nurses to review EDD (Q2) • complex CRFD forum with the 3 Local Authority Partners and 2 ICB Developing New Models • To ensure therapeutic discharges 24/7 are part of the inpatient improvement programme “the middle bit” (Q3 onwards) • Consider Pilot programme on one ward to test the ability, capacity and affordability of proposed changes.	line with promise 14 (part b) we will advance to be able to respond to urgent referrals within 48 hours – to be completed in Q1 26/27 (and Q2 for PH services); Work in respect of promise 1 (peer support workers) and promise 3 (volunteers) will also contribute to the development of seven day working and consistency across all days. Work aligned to promise 21 (Neighbourhood Working) will improve this too – recent appointed Community Development Director will aid this. IQPR reporting improvements in • Waiting times – greater awareness and regular oversight of waits. Now published on website. • Out of Area Placements • Delays in discharges • Length of stay metric introduced • Utilisation of talking therapies And via ‘live’ Flow dashboard – distributed on a daily basis to senior staff across the Trust	
Service provision - Alternative (others) Explore how and who other service providers (community and voluntary sector) can contribute / support the delivery or support to our services on a more flexible or longer basis. Increase self-help services - with swift access to advice and support – enhanced community support and offer for those discharged in first 72 hours	The commissioning of support via VCSE partners such as PFG are being completed on the basis of them being seven-day services Further consideration of the alternatives will need to consider below. - This may include better provision of the current crisis provision as a potential step down using 2 additional beds in Rotherham to test this - Co locates with partners who are already 24/7 (i.e. LA, acute, police) or extend hours (GP's) - Expansion of virtual offer, AOT and "remote working" - Outsourcing to community partners to abridge to RDaSH services - Future investment in a needed “step down provision” - Offer A Service With A 24/7 Assistant (expansion of virtual; apps?)	-

Staff Engagement (linked to necessary change and impact on staff) Unions and Staff Side – consultation / engagement processes with union and staff side reps to discuss and agree. Consider workforce models of support - training; enhanced work flexibility; clarity on support and supervision models; safety	Ongoing work - There are opportunities via TPC and OMG about developing and implementing greater flexibility within staff shifts The implementation of the consistent handover process includes a consultation process involving 170 staff and staff side. Broad engagement with staff during the implementation of 7dpw activities.	Comprehensive mechanism for collation and reporting of feedback gained via: ○ Staff Survey ○ Pulse Check ○ Peer Reviews ○ Consultation responses ○ Responses via Unions and Staff Side ○ And an associated set of Employee Relations indicators That will help us understand the impact that the changes are having / how they are being received and responded to.
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: This will include all linked to SO3 – Promises 13 to 17, but more specifically those linked to SO4 – Promises 18 to 23	Promises and Priorities Scorecard – Board of Directors each meeting P19 Out of Area Placements – Board of Directors May 2025 P22 Seven Day services – PHPIP Committee January 2026 presented tangible progress in improving weekend access to urgent and crisis mental health services and in reducing out-of-area placements and length of stay through better demand, capacity and flow management. IQPR data – Length of Stay; Patients who remain on the ward over 32 days.	P22 progress: Full seven-day working—particularly weekend discharges—remains limited due to workforce, system and cultural constraints. Further phased development, system alignment and completion of a formal quality and safety risk analysis are required to deliver the full benefits of the Promise.
QC Strategic Delivery Risk Report relating to the oversight and management of this strategic delivery risk	Each meeting in 2025/26	
Future controls/assurances – what key actions do we have planned to further mitigate the risk?	Anticipated milestones	Progress (note these will transfer in year to current controls/assurances as appropriate)
P22 - Further phased development, system alignment and completion of a formal quality and safety risk analysis are required to deliver the full benefits of the Promise.		

SO5: Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations

What could get in the way? The Trust lacks the cultural capability and competence on wider issues	As a Strategic Delivery Risk:								Lead Exec	Board Committee	
	<i>If</i>	We do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027									
	<i>because</i>	We do not develop and practice the skillsets required to make change occur								CH	POD
	<i>then</i>	The Trust’s strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees									
Risk Score	Current Score (March 2026)					Target Score (December 2026)					
	I	4	L	3	12	I	4	L	2	8	

Current controls – what do we have in place to mitigate the risk?	Current assurance/performance – how do we know the controls are working?	Gaps in assurance/performance – what else do we need to know?
Induction – Launched 28 October 2024	Internal assurance via periodic induction feedback to People and Teams CLE; next due in Autumn. External assurance – significant assurance from internal audit; received September 2025.	Further internal assurance anticipated via an independent colleague and via the newly appointed Induction and Widening Participation Manager.
Feedback from our colleagues	Staff Survey – primary source of feedback from colleagues internal to the Trust. from stakeholders 'in-year' and without formal structure Open Staff meetings (Autumn (200+ attended) – additional sessions from 2026. Headlines / reoccurring themes shared within EG / Pulse Check – underway quarterly – more work to do in generating responses...and Care Opinion (staff point of view within teams) Ask, Talk , Influence – meetings started in April 2026; undertaken monthly as a team brief to all RDASHians.	Staff survey results show usefully differences in responses based on the time that staff have worked at the Trust; those having been less than 5 years being more positive.
Monthly learning half days – commenced September 2024	Internal assurance/performance – pending	Action 1. Need to develop mechanisms of feedback from leaders to demonstrate their increased competence and confidence regarding making change occur and

		adding social value, with the colleagues on these stated programmes being the audience
Educating our Staff: Leadership Development Offer includes, 'Compassionate leadership to unlock community power'	Baseline data established. (commencement of programme) As Cohorts complete the programme additional feedback and analysis to be undertaken.	LDO feedback - Further detailed analysis planned. Of particular relevance is the response to two questions: <i>1b Has the Trust developed compassionate leadership to unlock community power, from the perspective of staff, service users and communities? and 3 Has the LDO improved RDaSH Leaders' engagement with each other and the community</i> Capability and Capacity of Leaders (resultant post LDO) – discussions planned (by March 2026) to review the impact of the course on the cohorts that have taken part. Important within the above to establish in advance what outcome will be deemed 'positive' or satisfactory – 100% scores of confidence may be unachievable or unnecessary to be 'positive' but a target of 85%, for example, maybe our aim in the first instance to demonstrate initial impact.
Wider learning opportunities, including: Leaders Annual Conference First Line Managers Training Scheme 555 Line Managers	Leaders Annual Conference – circa 130 staff as the Top Leaders Cadre. First Line Managers Training Scheme – Launched April 2025 555 Line Managers – focus on development and communication channels.	Future learning opportunities planned: Clinical Leaders Training Programme (2026) MPLT – Multi Professional Leadership Team development programme (2026) See also action 2.
Stakeholders: Community Leadership Executive (CoLE) New body (15 members) of community representatives has been established. This will provide community based feedback, be involved in decision making and	First meeting took place in May 2026	

holding to account, provide strategic input and facilitate communication and develop partnerships; and build capacity and help co-production.		
Increased capacity ; including: • Use of the apprenticeship levy (delivery of Promise 9) • Fully recruiting to all posts – 97.5% • Commitment to designated training budget – demonstrate increase in spending year on year	Apprentice levy: Overused in 25/26 with levy transfers including to community colleagues. Full recruitment: Current vacancies in CEX Report Annex and within change management process with aim of reducing total number to less than 100 at any one time. Training Budget: 2026/27: Ringfenced budget in place again with utilisation of 100% or more anticipated. Internal audit significant assurance on MAST – received April 2025. Compliance of colleagues on MAST and PDR – May letters to 421 / 157 colleagues respectively – follow up due early June 2026.	2026/27 TNA Approved and to be implemented.
Management reporting to Committee or Board or via CLE and its Groups – specifically in relation to related Promises: ○ Promise 9 Apprentice Levy (PHPIP - Equity and Inclusion Plan) ○ Promise 26 Anti-Racism (POD – People and Teams Plan) Trust People Council People and Teams CLE Group and Education and Learning CLE Group – established and meeting regularly POD Strategic Delivery Risk Report relating to the oversight and	Promises and Priorities Scorecard P9 – Apprenticeships – March 2025 P26 – Board of Directors March / May 2025 Voice Scorecard Report to the Trust People Council Each meeting throughout 25/26	

management of SDR5 to POD Committee		
<u>Future controls/assurances</u> – what key actions do we have planned to further mitigate the risk?	Anticipated milestones	Progress (<i>note these will transfer in year to current controls/assurances as appropriate</i>)
1. Further developments to internal feedback mechanisms – particularly from leaders		
2. Revised appraisal process	During 26/27	The change to the appraisal process will identify and respond to the need to create learning opportunities for each colleague.
3. Planned Promise 26 audit	Q4 25/26	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational Risk Report		Agenda Item	Paper L
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance			
Report Author	Philip Gowland, Director of Corporate Assurance			
Meeting	Board of Directors	Date	28 May 2026	
Suggested discussion points (two or three issues for the meeting to focus on)				
This report provides the Board with an update on the Trust's current operational risk position, with reporting continuing to be aligned to the agreed risk appetite and tolerance levels. This period reflects an improved position, with a notable reduction in the number of risks sitting outside tolerance, representing a positive direction of travel following the sustained oversight applied through the Risk Management Group. The report also provides a more detailed update on the risks associated with the Trust's change management programme, reflecting progress in how these risks are being identified, recorded and monitored across care groups and directorates. Whilst specifically highlighted for the purposes of the report today – given links to other papers and the timing of reporting - these risks are but one category within the risk management work. A reminder that expected resolution timeframes are not fixed. They are based on the current assessment of control effectiveness and planned mitigation, and will be refined as actions progress, controls embed, and further assurance is obtained.				
Previous consideration (where has this paper previously been discussed – and what was the outcome?)				
Risk Management Group (RMG) & CLE have considered the matters within the paper				
Recommendation (delete options as appropriate and elaborate as required)				
The Board of Directors is asked to:				
RECEIVE and NOTE the operational risk report				
Alignment to strategic objectives (indicate those that the paper supports)				
Not applicable				
Alignment to the plans: (indicate those that this paper supports)				
Estate plan				X
Digital plan				X
People and teams plan				X
Finance plan				X
Quality and safety plan				X
Equity and inclusion plan				X
Education and learning plan				X
Research and innovation plan				X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)				
People risks				
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.		X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.		X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.		X

Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
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 (indicate those that this paper supports)			
Not applicable			
System / Place relevance (advise whether it is national, regional or local)			
Some risks do have links to other partners and to the system / commissioners			
Equality Impact Assessment	Is this required?	Y	N
Quality Impact Assessment	Is this required?	Y	N
Appendix (please list)			

1. Overview

- 1.1 Operational risk reporting continues to focus on alignment to the Trust's defined appetite and tolerance levels, providing a clearer and more meaningful view of risk exposure across all directorates.
- 1.2 This report presents those risks that remain outside tolerance following moderation through the Risk Management Group. This maintains a clear line of sight on where risk exposure exceeds acceptable limits and where Board oversight and challenge are most required.
- 1.3 The moderation process continues to develop through the Risk Management Group, with ongoing focus on improving the consistency of challenge, the quality of evidence supporting risk scores, and the accuracy of appetite alignment. This is helping support a more consistent and evidence informed approach to risk oversight across the organisation.
- 1.4 Alongside this, work continues to strengthen how risks associated with organisational change are identified, recorded, and monitored across the Trust. This is intended to ensure that transformation activity is supported by appropriate controls, clear oversight, and timely escalation where needed.

2. Current Operational Overview



■ Within appetite (green) ■ Within tolerance (amber) ■ Outside tolerance (red)



- 2.1 The rolling approach to reviewing out of tolerance risks continues to operate as intended. The focus remains on those areas where assurance is most needed, allowing sufficient time for actions to take effect and for progress to be meaningfully assessed.
- 2.2 A pre-moderation session continues to be held ahead of each Risk Management Group meeting to review risk scores and appetite alignment. This allows the group to direct its attention to the adequacy and effectiveness of controls and mitigations,

rather than recalibrating scores during the meeting itself.

2.3 As at this reporting position, there are 366 risks recorded on RADAR. The distribution against appetite and tolerance is as follows:

- Within Appetite (Green): 132 risks (36%)
- Within Tolerance (Amber): 207 risks (57%)
- Outside Tolerance (Red): 27 risks (7%)

2.4 The position this period reflects a meaningful improvement in the Trust's overall risk profile. Compared to the previous reporting period (360 risks in total), there has been a net increase of 6 risks. More significantly, the number of risks sitting outside tolerance has reduced from 42 to 27, a reduction of 15 risks and a 36% improvement on the previous position. Risks within tolerance have increased from 186 to 207, reflecting movement of previously escalated risks back within acceptable thresholds. The proportion of risks within appetite has remained stable at 132.

2.5 The Board is asked to note this positive direction of travel. The reduction in out-of-tolerance risks reflects the sustained oversight applied through the Risk Management Group over the previous quarter and the effectiveness of targeted actions against escalated risks. While 27 risks remain outside tolerance and continue to require close oversight, the overall trajectory is one of improving control. The current out-of-tolerance risks are listed at **Appendix 2**.

2.6 A total of 20 risks that were recorded as out of tolerance in the previous Board report have now moved back within tolerance in this reporting period. The Board is asked to note this as a positive outcome, reflecting the effectiveness of controls and actions progressed since the last report. Two examples are highlighted below.

2.7. Risk 481, which related to the inability to confirm and administer required medications in a timely way when patients are transferred from acute settings to Hazel and Hawthorn wards due to missing medicines and transcribing requirements, is no longer outside tolerance. This is due to the improved assurance on the controls currently in place

2.8. Risk 208, which captured the risk arising from the proportion of registered to unregistered nurses on mental health wards being below national guidance recommendations, has also moved back within tolerance.

2.9. The 20 risks that have moved back within tolerance remain on the risk register and continue to be monitored through the relevant care group governance arrangements. These risks are presented in **Appendix 1**.

2.10 Of the 27 risks currently sitting outside tolerance, RSK-152 and RSK-220, and RSK-038 are considered the most significant on the Trust's risk register.

2.11 Both RSK-152 and RSK-220 relate to unacceptable waiting times for ADHD and neurodevelopmental assessments and carry a current score of 15, the highest of any risk in the out-of-tolerance position. They have remained extreme or out of tolerance for quite some time.

2.12 Their significance is not simply a function of their score. These risks describe children, young people and adults waiting extended periods for assessments that

are often pivotal to understanding their own health, behaviour and daily functioning. A delayed or absent diagnosis does not pause the difficulties a person is experiencing.

- 2.13 The Board is asked to note that these risks have remained at this level for a sustained period. Progress is being made and the controls in place are acknowledged. The Board may wish to satisfy itself that the current trajectory is on track to deliver a material improvement in the position over the coming months.
- 2.14 RSK-038 relates to lithium prescribing and monitoring across shared care arrangements. There remains a gap in the Trust's ability to provide assurance that required blood monitoring and clinical review is being consistently completed for all patients prescribed lithium, particularly where responsibility is shared with partner organisations. The core concern is one of ambiguity, arrangements where it is unclear who holds monitoring responsibility create a risk that patients fall through the gap unnoticed.
- 2.15 A snapshot audit was attempted but proved unfeasible due to system limitations. The focus has therefore shifted to establishing a prospective solution. North Lincolnshire has begun developing a manual register to track patients and their monitoring requirements, and if this approach proves effective, the intention is to replicate it across Doncaster and Rotherham as an interim measure while a longer-term digital solution is developed.
- 2.16 The Board is asked to note this risk and the progress being made, while recognising that robust assurance is not yet in place.

3. Change Management

- 3.1 Since the last report, the programme of work to identify, record and monitor risks associated with the Trust's change management programme has progressed. There are now 29 risks recorded on RADAR that relate directly to change management activity, representing a significant increase from the small number in place at the previous reporting position.
- 3.2 These risks have been identified through two routes: centrally, through the Risk Management Group and central steering committees; and directly from Care Group Directorates, where leads have been engaged to identify risks specific to their schemes. This dual approach is strengthening the completeness and consistency of risk identification across the programme.
- 3.3 Of the 29 recorded risks, 12 are process-level risks that relate to the change programme. These capture the risks associated with managing a large-scale, trust-wide programme of change, including workforce impacts, capacity to deliver, staff engagement and the cumulative effect of multiple concurrent schemes. The remaining 17 are scheme-specific risks, recorded against individual change schemes within directorates.
- 3.4. Scheme-specific risk recording continues to develop across the active change schemes. While 17 scheme-specific risks have been formally recorded to date, a number of schemes do not yet have a risk recorded against them. Work is ongoing to address this, with Care Group Directors continuing to be supported in identifying and articulating risks as schemes progress and their impacts become clearer.

- 3.5 Oversight of change-related risks sits within the Risk Management Group, which has dedicated time within each meeting to review emerging risks from the programme. This ensures that risks identified between reporting cycles are captured and addressed in a timely way, and that the cumulative risk exposure from the programme is visible at a governance level.
- 3.6 The Board is asked to note the progress made in building a more complete picture of change-related risk, and to take assurance that the oversight mechanisms are in place to manage these risks as the programme continues to develop.
- 3.7 The Board is asked to note that a separate paper on this agenda addresses the Key Performance Indicators associated with the Trust's change management schemes. The two papers should be read in conjunction, as the performance position presented in that report and the change-related risks captured within this one together provide a more complete picture of the Trust's current change management exposure

4. Conclusion

- 4.1 This report reflects a more positive risk position than at the previous reporting period. The reduction in out-of-tolerance risks represents a direct result of sustained oversight through the Risk Management Group and the progressive implementation of controls and mitigating actions across care groups and directorates. The Board is asked to take assurance from this direction of travel.
- 4.2 While the overall trajectory is one of improvement, the Board is asked to note that a small number of risks have newly escalated into the out-of-tolerance position this period. These are subject to active oversight and the risks that remain outside tolerance continue to require focused and sustained attention going into the next reporting cycle.
- 4.3 Progress in building a more complete picture of change-related risk is also noted. The foundation is now in place for more systematic oversight of the risks associated with the scale of change the Trust is currently managing.

5. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the operational risk report

Philip Gowland
Director of Corporate Assurance
15 May 2026

Appendix 1- Downgraded Out of Tolerance Risks (No longer Out of Tolerance)

Ref	Description	Category	Resolution Lead Time	Current score	Region
RSK-154	If colleagues do not respond to requests for internal audit actions, Board and committee papers, or contributions to statutory reports, there is a risk that the Corporate Assurance Team will be unable to fulfil governance requirements, which may result in weakened oversight, delays in assurance processes, and reputational or regulatory consequences.	External and Partnership Risk - Legal & Governance		9	Corporate Assurance Directorate
RSK-181	If there is no appropriate AHP clinical leadership across the directorates in our mental health care groups, there is a risk that AHPs will be under represented within services in decisions which affect the strategic direction of the service and the care of patients. This may result in difficulties with employee satisfaction, recruitment and retention, sickness absence, as well as lack of therapeutic environment.	People Risk - Capability and Performance		12	Psychological Professions & Therapies Directorate
RSK-445	Due to significant staffing shortages in community psychology work-force, there is a risk of compromised patient care though increased waiting times for treatment, as well as burden and further staff sickness in wider psychological workforce.	Performance Risk - Capacity & Demand Management		12	Rotherham Community Mental Health Directorate
RSK-477	Due to 3 x staff leaving the team and ongoing staff sickness in AOT and the potential for additional staff absences, there is a risk that patient care and continuity will be impacted, 4-week wait targets will not be met, staff wellbeing and retention will decline, and MAST compliance will remain low.	Patient Care Risk - Clinical Safety		12	Rotherham Community Mental Health Directorate
RSK-481	Due to Hazel and Hawthorn wards not having continuous medical cover and SystmOne electronic transcribing requiring two sources of evidence, including labelled boxed medication, there is a risk that when patients are transferred from the acute trust with missing medicines the ward is unable to confirm and administer the required medications in a timely way, which may result in missed doses and patient deterioration.	Patient Care Risk - Clinical Safety		8	Rehabilitation Directorate
RSK-497	Due to the removal of four WTE Education Mental Health Practitioners from the With Me In Mind Doncaster budget, there is a risk that there is insufficient EMHP capacity within the team to meet demand, which may result in secondary waiting lists developing within the service and a negative impact on performance against the Mental Health Support Team data set.	Performance Risk - Capacity & Demand Management		12	Children's Mental Health (CAMHS) Directorate
RSK-503	If no GP trainee is allocated to the hospice between February 2026 and August 2026 due to maternity leave and accrued leave, there is a risk that day to day medical cover will be reduced, which may result in increased workload for existing medical staff and reduced capacity to support admissions during periods of planned or unplanned absence. There are also less doctors to cover the out of hours on-call.	Patient Care Risk - Clinical Safety		10	Community & Long Term Conditions Directorate

Ref	Description	Category	Resolution Lead Time	Current score	Region
RSK-507	Due to increased levels of staff absence and limited availability of supervisors, non-medical prescribing supervision compliance within the Doncaster 0 to 5 team is currently low. There is a risk that prescribing practice is not regularly appraised or discussed in the appropriate forum, which may result in safety and quality concerns not being identified, escalated, or addressed.	Patient Care Risk - Clinical Safety		9	Children's Physical Health (CYP) Directorate
RSK-548	Due to the current Physiotherapy Lead finishing in post on 30 January 2026, there is a risk of a gap in physiotherapy provision across the acute inpatient wards while recruitment to the vacancy is ongoing. This may lead to reduced or delayed physiotherapy input, particularly within Swallownest Court inpatient wards, which could adversely affect patient flow, patient care and outcomes, and patient safety.	Patient Care Risk - Clinical Safety		8	Rotherham Acute Mental Health Directorate
RSK-558	Due to the sustained reduction in clinical capacity—from an established 3.2 FTE to the current 2.0 FTE, with a further drop to 1.4 FTE expected by March 2026—it is a risk that the team will be unable to meet service demand. This may lead to delays in assessment and intervention, reduced therapeutic input, and a heightened likelihood that the mental health and wellbeing of children in care will deteriorate because the service cannot operate at the required staffing levels.	People Risk - Capacity		12	Children's Mental Health (CAMHS) Directorate
RSK-562	Due to the increased demand for suction machines and limited staff training in their use and maintenance, there is a risk that patients may not have access to a calibrated or functioning suction machine or may receive incorrect advice on its use which may result in ineffective secretion management leading to aspiration, serious harm, or death.	Patient Care Risk - Clinical Safety		9	Community & Long Term Conditions Directorate
RSK-569	If the implementation of PROMs and DIALOG+ care planning is not fully achieved across children's mental health services, there is a risk that care planning will be inconsistent and outcomes will not be systematically captured, which may result in inability to demonstrate equitable, safe and effective care, reduced quality assurance, and potential non compliance with clinical standards and regulatory expectations.	Patient Care Risk - Learning and Oversight		12	Children's Mental Health (CAMHS) Directorate
RSK-208	Due to the current skill mix on mental health wards, specifically the proportion to registered to under-registered, which is a lower number of registered nurses on shift than national guidance recommends, there is a risk that patients will receive inadequate care and RMNs will be unable to fulfil their legal duties under the Mental Health Act or perform essential clinical and safety tasks, which may result in patient or staff safety incidents, MHA breaches, and staff fatigue or sickness due to increased pressure.	People Risk - Capacity		12	Nursing & Facilities Directorate
RSK-360	Due to the absence of a long-term plan for consultant-psychiatrist support to supervise CPN non-medical prescribers in the Enhanced Care Home Team, there is a risk that residents with complex mental-health conditions will receive inadequate assessment, diagnosis and management, which may result in inappropriate medication, unmet psychological needs, deterioration in health, and increased hospital admissions.	Patient Care Risk - Clinical Safety		9	Rehabilitation Directorate

Ref	Description	Category	Resolution Lead Time	Current score	Region
RSK-457	If demand continues to outstrip capacity in the planned Community Nursing service, patient visits or elements of care may be deferred resulting in delays in care delivery, compromised patient safety, and poor patient experience. Staff may also suffer with increased fatigue, poor job satisfaction and presenteeism or absenteeism.	Performance Risk - Capacity & Demand Management		12	Community & Long Term Conditions Directorate
RSK-494	Due to an overspend on wound care products within Planned Community Nursing, there is a risk that available financial resources are insufficient to sustain planned service delivery, which may result in reduced continuity of care, pressure on service quality, and poorer patient outcomes and experience.	Financial Risk - Financial Planning, CIP & Sustainability		15	Community & Long Term Conditions Directorate
RSK-527	Due to the absence of a clear system for identifying and monitoring high risk patients following the end of CPA, there is a risk that patients with complex needs are not consistently recognised or prioritised, which may result in gaps in support, reduced oversight, and increased risk to safe and effective care delivery.	Patient Care Risk - Clinical Safety		9	Doncaster Community Mental Health Directorate
RSK-555	Due to a reduction in training related income, there is a risk the established £320k CIP target will not be achieved, which may result in the directorate not being able to deliver a positive year end budget position.	Financial Risk - Financial Planning, CIP & Sustainability		12	Talking Therapies Directorate
RSK-561	Due to patients with highly complex needs, who are on community caseloads but not receiving care for their most complex conditions directly from the team, lacking comprehensive care plan with clear escalation pathways being available on SystmOne, delays or inappropriate responses to issues such as broken equipment, consumables provision, or changes in condition can occur. The impact includes increased clinical risk, potential breaches in duty of care, heightened anxiety for patients, carers, and staff, and possible reputational and regulatory consequences.	Patient Care Risk - Clinical Safety		12	Community & Long Term Conditions Directorate
RSK-575	Due to ongoing sickness absence and unfilled medical vacancies, caused by delays or challenges in recruiting to vacant posts and limited availability of alternative medical cover, there is a risk that inpatient wards and non-bed-based services within the Acute Directorate will not have sufficient medical staffing, impacting timely patient care, potentially prolonging admissions, delaying assessments, and affecting clinical safety.	Patient Care Risk - Clinical Safety		9	North Lincolnshire Community Mental Health Directorate

Resolution Lead Time 3 to 6 months

Resolution Lead Time 6 months +

Appendix 2 - Out of Tolerance Risks (Currently Out of Tolerance)

Ref	Description	Category	Resolution Lead Time	Current score
RSK-044	Due to the absence of a reliable method for identifying and monitoring patient discharges resulting from disengagement, there is a risk that patients may be discharged inappropriately without adequate support, which may result in harm to themselves or others.	Patient Care Risk - Clinical Safety		9
RSK-141	If alternative accommodation for Kimberworth Place is not secured, there is a risk that staff will experience overcrowding and difficulty finding suitable workspace, which may result in reduced productivity, heightened stress, and poorer wellbeing.	People Risk - Well-being & Retention		12
RSK-487	Due to staff sickness and leave resulting in a shortage of staff within the South Admin Hub and Primary Care Hub at Swallownest Court, with the South Admin Lead role currently covered by the Operational Support Manager, there is a risk that administrative capacity is insufficient to support routine service activity, which may result in delays to administrative processes, increased pressure on remaining staff, and further sickness absence.	People Risk - Well-being & Retention		12
RSK-570	Due to ongoing antisocial behaviour, the presence of rough sleepers, and environmental hazards such as urine, human faeces, cannabis odour and drug paraphernalia (including used needles) within the Parishes Multistorey Car Park in Scunthorpe - used by staff based at Elizabeth Quarter; there is a risk that staff may feel unsafe when travelling between the car park and the office. This may lead to increased anxiety, reduced wellbeing, negative impacts on staff health, potential needlestick injury, reluctance to attend the workplace and possible effects on staff attendance and overall service delivery.	People Risk - Well-being & Retention		12
RSK-576	Due to a lack of available clinical rooms within the North Lincolnshire locality at St Nicholas House, there is a risk that the service will be unable to deliver the neurodevelopmental pathway as planned, which may result in delays to appointments, inability to meet the 4 week waiting time trajectory, and reduced access to timely care for children and young people.	Performance Risk - Capacity & Demand Management		12
RSK-590	Due to the inadequate and unsafe paper-based system for recording medication, there is a risk that further medication errors and transcribing errors will occur. This may result in people being administered the wrong medication, leading to significant clinical safety concerns and potential harm.	Patient Care Risk - Clinical Safety		9
RSK-038	Due to the absence of a robust process to assure the Trust that lithium prescribing and drug-monitoring responsibilities are being met with partner organisations, there is a risk that patient safety will be compromised, which may result in clinical harm, reputational damage, and failure of the Trust to meet its accountability obligations.	Patient Care Risk - Clinical Safety		9

Ref	Description	Category	Resolution Lead Time	Current score
RSK-083	If the Trust lacks a single, authoritative source of information on medicines use, there is a risk that individual prescribers, teams and care groups will be unable to interrogate prescribing and cost data, which may result in suboptimal clinical and budgetary decisions and weaker professional oversight.	Performance Risk - Information Governance		9
RSK-086	If the Care Group does not review the continence-products contract with Procurement support, there is a risk that current cost pressures and future financial risks will remain unknown and unmanaged, which may result in significant financial impact on the Care Group.	Financial Risk - Financial Planning, CIP & Sustainability		12
RSK-108	Due to existing qualified podiatry vacancies and impending maternity leave within the Podiatry team, there is a risk that the service will be unable to offer some patients an appointment within a 4-week timescale. This may result in patients experiencing deteriorating foot conditions that could lead to infection, sepsis, loss of limb and potential death.	People Risk - Capacity		20
RSK-119	If the Trust does not continue to invest in the tools and resources needed to maintain a good cyber security posture, there is a significantly increased risk of a successful cyber attack, which may result in loss of access to clinical and administrative functions, data loss, financial loss, and reputational damage.	Performance Risk - Digital Infrastructure & Cyber Security		12
RSK-152	Due to insufficient capacity to meet the demand for ADHD assessments, there is a risk that patients will remain unassessed, which may result in compromised wellbeing and health outcomes for patients and their families, adversely affect service delivery and staff wellbeing, jeopardize the Trust's ability to meet Strategic Objective Promises 8 and 14, and damage the Trust's reputation.	External and Partnership Risk - Delivering Our Promises		15
RSK-189	If Trust financial performance is not in line with the agreed plan, there is a risk that service delivery will be compromised, commissioners and NHS England may lose confidence, and the Trust's reputation and financial sustainability could be adversely affected resulting in additional interventions by NHSE/ DHSC.	Financial Risk - Financial Planning, CIP & Sustainability		12
RSK-196	Due to the potential for the Trust or any of its business-critical system providers to be subject to a successful cyber attack, there is a risk of major disruption to services, which may impact patient care, compromise corporate operations, and result in significant operational delays and reputational damage.	Performance Risk - Digital Infrastructure & Cyber Security		12

Ref	Description	Category	Resolution Lead Time	Current score
RSK-220	If waiting times for ASD and ADHD assessments remain above target, there is a risk that children and young people will receive delayed diagnoses, which may result in poorer educational and health outcomes, increased strain on the service and staff, failure to meet Strategic Objective Promises 8 and 14, reputational damage, and additional unfunded financial pressure on the Care Group.	External and Partnership Risk - Delivering Our Promises		15
RSK-459	Due to the potential unavailability of complex equipment, lack of staff knowledge on its use, absence of a confirmed process for responsibility, and no financial agreements in place, there is a risk that specialist equipment provided by the community nursing service (e.g., ventilators, cough assists, suction machines) may not be maintained, serviced, repaired, or replaced in a timely manner, which could lead to delays and significant implications for patient safety.	Patient Care Risk - Clinical Safety		12
RSK-463	Due to the age and size of the two Aspire buildings and the potential for further deterioration requiring compliance with safety standards, there is a risk that repair or replacement costs will be very high, leading to significant financial pressure on the Doncaster Community Mental Health Directorate.	Financial Risk - Financial Planning, CIP & Sustainability		12
RSK-468	Due to a lack of available funds or knowledge on how to secure funding for decarbonisation initiatives, there is a risk that the Trust will not meet its Green Plan targets, impacting sustainability commitments and regulatory expectations.	External and Partnership Risk - Regulatory		9
RSK-473	Due to the lack of a clear process for how complex equipment and consumables should be provided for patients discharged from acute settings, Community Nursing staff are required to spend time sourcing and purchasing equipment, there is a risk that this reduces the service's capacity to provide timely and appropriate patient support, which may result in delays in care, limited oversight of equipment use, and missed clinical issues.	Performance Risk - Capacity & Demand Management		12
RSK-474	Due to the absence of an agreed funding arrangement for the provision of complex equipment and high-cost consumables for patients in the community, there is a risk that the Trust will incur unfunded expenditure, as these items are being purchased without a defined budget, which may result in financial pressure for the organisation and an unsustainable cost burden for the service.	Financial Risk - Financial Planning, CIP & Sustainability		12
RSK-476	If anti ligature doors are not installed on Windermere, there is a risk that staff will be unaware of a patient attempting self-harm, which may result in serious or catastrophic injury, including suicide, before help can arrive.	Patient Care Risk - Clinical Safety		10

Ref	Description	Category	Resolution Lead Time	Current score
RSK-508	Due to staff turnover and maternity leave, staffing within Rotherham Getting Advice will reduce from January 2026 to one point zero WTE Band four and two point zero WTE Band six, there is a risk that this reduction in capacity will lead to not being able to maintain promise 14 (4 week wait) and also the increased pressure will have further impact on staff wellbeing in the team, which may result in increased pressure on remaining staff, further sickness or turnover, and young people not accessing the service in a timely way.	People Risk - Capacity		12
RSK-526	Due to sustained shortages in specialist dysphagia trained staff and lack of service resilience, there is a risk that people with learning disabilities who require dysphagia assessment and intervention do not receive timely and safe care, which may result in aspiration pneumonia, choking and avoidable harm, as well as widening inequalities in access to communication support and deterioration in quality of life.	People Risk - Capacity		12
RSK-540	Due to a number of patients across community teams not having an up to date care plan in place, there is a risk that the Trust is unable to provide assurance that care is being delivered safely and effectively, which may result in gaps in coordination, unclear responsibilities, and increased risk to patient safety.	Patient Care Risk - Clinical Safety		9
RSK-547	Due to the main entrance door to Sandpiper Ward not always securing correctly, there is a risk this could cause the controlled ingress system activation while doors remain unsecured on both Sandpiper and Osprey, and restricting safe entry and exit. This may result in the risk of patients leaving the ward unnoticed and being out of staff sight, patient absconson (AWOL), and impact patient safety.	Patient Care Risk - Clinical Safety		9
RSK-559	Due to staffing shortages within the Routine Assessment Pathway PCN, there is a risk that clinical capacity will be insufficient to meet demand, which may result in delays to assessments, increased waiting times from referral to first appointment, failure to meet the 4 weeks wait standard, and deterioration in patient experience and outcomes.	Performance Risk - Capacity & Demand Management		15
RSK-593	Due to incorrect anti pick sealant being used within patient bedrooms, there is a risk that the sealant may create a ligature point, which may result in patients using it for self-harm and causing serious harm or death.	Patient Care Risk - Clinical Safety		12

Resolution Lead Time 3 to 6 months

Resolution Lead Time 6 months +

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR)	Agenda Item	Paper M
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
From July the IQPR metrics and format will change: both to reflect revised NOF approaches and to collapse the performance segment into the quality one. April performance has largely continued the patterning seen since the start of 2026. • Our internal 4-week access standard is largely being as at the end of March but pressures on delivery in Children's Services were notable: treating long wait podiatry patients will temporarily depress the AHP RTT performance (not reportable externally). • Length of stay remains above mean average LOS aims, and occupancy is above plan. The pattern of lost HBPOS time discussed in the March Board persists. • There remains month on month variation in some quality metrics including MUST and ligature incidents, and staffing compliance reporting will be further improved with Safe-care being introduced. • We are seeing some sickness improvements (5.4% in month), whilst turnover has increased: the vacancy position is considered in the Chief Executive's report annex. • At this early stage of the year, the M1 year to date financial position is £21k better than plan. Agency spend is YTD over plan and we will end this month with four roles in post not the planned two: notwithstanding that all 24 directorates are presently operating inside both their budgets and their control totals.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
Relevant committees of the Board and the Clinical Leadership Executive			
Recommendation (delete options as appropriate and elaborate as required)			
The Board of Directors is asked to:			
NOTE continued delivery of promise 14 in respect of planned care			
NOTE further improvements in out of area placements			
RECOGNISE that without length of stay reductions, notably in Rotherham, we cannot meet our agreed aims for inpatient care quality improvement			
Alignment to strategic objectives (indicate those that the paper supports)			
SO2: Create equity of access, employment, and experience to address differences in outcome			x
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings			x
Alignment to the plans: (indicate those that this paper supports)			
People and teams plan			x
Finance plan			x
Quality and safety plan			x
Equity and inclusion plan			x
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	x

Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	x
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	x
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	x
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
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.	
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 (indicate those that this paper supports)			
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services			X

If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.							X
System / Place relevance (advise whether it is national, regional or local)							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Appendix (please list)							
Appendix 1 - SPC icon description							

Integrated Quality Performance Report

May 2026 Review

Data as at the 30th April 2026

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1.0 Executive Report

This report summarises performance against the Trust's Top Nine metrics and key indicators of operational efficiency, quality, workforce and finance for the month ending 30th April 2026.

Work is underway to agree a refreshed set of priority metrics for 2026/27, to be implemented from July and aligned across quality, people and finance in support of the Trust's strategic priorities. Until then, reporting continues against the 2025/26 Top Nine. Monthly Performance Clinics remain in place, providing strengthened oversight and targeted performance management. Overall, a number of core standards remain below target, reflecting sustained demand and ongoing capacity pressures across key pathways.



Top Nine

The **four-week wait standard** is reporting at 83.13%, below the 94% target. Most services remain compliant, with breaches concentrated in a small number of areas, primarily due to workforce capacity pressures. This is most notable in Children's Services, where sickness absence has impacted delivery, and in Physical Health Services, where podiatry continues to experience extended waits due to increased demand. Additional resources have been approved and recruitment is underway to improve capacity.

Talking Therapies (T903a) access is reporting at 1,403 year to date against a target of 1,915, representing a reduction of 115 individuals compared to the same period last year. Improvement actions include the development of long-term condition pathways in North Lincolnshire to support equitable access, embedding physical activity within mental health services in partnership with Sport England, and targeted support for people aged 65 and over within the Physical Health and Neurodiversity Care Group. In-reach support to intermediate care inpatient wards is also in place. Despite reduced access, both **Reliable Recovery** and **Reliable Improvement** remain above target, demonstrating sustained positive outcomes. Weekly clinician-level outcome monitoring continues, with further analysis underway to understand early treatment endings and opportunities to improve access and outcomes.

Operational flow remains a key pressure, with **mean length of stay** increasing to 67 days against a target of 32 days, reflecting delays in discharge across all localities. **Occupancy hours lost within Section 136 suites** totalled 290 hours in April, largely due to suite repurposing and patients remaining in suites pending bed availability. This includes 79 hours in Doncaster, 104 hours in Rotherham and 106 hours in North Lincolnshire. These pressures reflect system-wide capacity constraints rather than quality or safety concerns, noting that the North Lincolnshire position does not yet fully reflect the impact of further suite restrictions.

Children and Young People (CYP) Services continue to perform strongly, with 11,705 CYP receiving at least one clinical contact in a rolling 12-month period, exceeding the target of 9,444. The Children's Eating Disorder Service received no urgent referrals in April. Performance against the four-week standard for routine referrals is 91.67%, below target, reflecting seven breaches over the rolling period. Six patients were offered appointments within four weeks, with delays arising from cancellations or later appointment choices, and one breach occurred in December 2025 due to reduced Christmas capacity.

Physical Health Services continue to perform well overall; however, the 18-week referral-to-treatment standard for AHP and consultant-led pathways (OP08b) has deteriorated to 83.33% against a 92% target, driven by sustained increased demand within podiatry. Investment has been approved to recruit additional staff, with recruitment ongoing. There are no patients waiting over 52 weeks (OP10c), and the Virtual Ward has met the 80% occupancy target.

Adult and Older Adult Mental Health Services continue to perform well across all metrics, consistently exceeding the 18-week referral-to-treatment standard (OP08d), with no patients waiting longer than 52 weeks.

In our **Neurodevelopment services** the Adult ADHD waiting list has reduced month on month but remains high at 6,248 (OP59a). Performance remains below target due to assumptions within the original trajectory not materialising, including recruitment challenges and system delays. A revised trajectory has been developed with the Performance Team and is presented for approval. The CYP neurodevelopmental waiting list has also reduced to 4,122 but remains above target, following a significant increase in April 2025 linked to the transfer of cases from Doncaster and Bassetlaw Teaching Hospitals. A revised trajectory for this pathway is also presented for approval.

1.0 Executive Report



Quality and Patient Safety

Overall performance across quality and safety metrics continues to improve, with ward staffing levels at 100%. Key areas of escalation include:

VTE Assessments (QS08) Performance has improved to 92.86% following alignment with NICE guidance and reduced assessment timeframes. Ongoing monitoring is in place, with missed assessments recorded on Radar from May.

Patients Absconding from acute adult/older adult MH wards (QS20) Two patients absconded in April from acute adult and older adult inpatient mental health units. One patient absconded from an acute ward via the garden while detained and was safely returned by police on the same day to the PICU ward. The second patient exited the ward after pushing past a staff member but returned following staff prompting. All incidents are reviewed through Swarm huddles to support learning and identify any required improvements.

Ligature incidents moderate or above (QS27) An increase at Mulberry House this month is related to two patients experiencing significant distress. Positive Behaviour Support (PBS) plans and keeping safe plans are in place to support risk management and ongoing care.

Seclusion (QS31) Performance has improved, with 93.75% of episodes (15/16) receiving an internal MDT assessment within five hours, up from 80% (20/25) in March. System changes have been implemented to support compliance, including enhancements to the seclusion visualisation in System 1. These provide real-time prompts to guide clinicians on the appropriate timing and type of review required. The associated risk continues to be monitored through Care Group risk registers. The Mental Health Act Manager has also reinforced expectations that all seclusion episode audits are reviewed through Mental Health Legislation Monitoring to ensure oversight and learning.

MUST Assessment (QS36) Performance decreased in April to 78.06% (110/143), down from 85.62% (131/153) in March. Following a detailed review of all patients, a Performance Clinic was held with ward managers in Doncaster Mental Health Care Group. As a result, compliance has improved, with the approach now being rolled out across North Lincolnshire and Rotherham

Falls Assessments (QS37c) Performance has improved to 95.38% (62/65), up from 92.95% (66/71) in March, for patients receiving a falls assessment within 12 hours of admission. Of the three assessments not completed within timescale, all related to Hawthorne Ward. Two were completed late, and one related to a re-admission where the assessment was not recorded as a review. This has been addressed.

People

Workforce Development The percentage of employees receiving a performance and development review (PDR) sits at 93.19% and the completion of mandatory and statutory training has remained above target and is reported at 95.50%. Letters have been issued to approximately 450 staff who are not fully 'green' on all of their training matrix asking them to make sure that everything is up to date by the end of June 2026. In addition colleagues who do not have a PDR recorded for 2026/27 have received an individual letter with an ask that they complete their PDR by the 1st June – therefore compliance is expected to increase in the coming months

Trust Retention (POD09) The trust retention rate on a rolling 12 month remains above the 10% target at 11.08%. As predicted, the turnover for April remained high with 40 staff leaving the Trust compared to 35 last April. It is anticipated that the turnover will remain high for H1 as the change management programme completes.

Sickness (POD10) The sickness absence % is above target (5.40% vs 5.1%), which has decreased from 6.69%. Monthly sickness absence appears to have peaked in January 2026 at 7.60%. March and April 2026 sickness rates have continued to trend downwards. Quarterly LT sickness review clinics have been scheduled for all areas and these will be chaired by the Director of People and OD. In the intervening months, the HR team will also facilitate local review meetings

1.0 Executive Report



Recruitment (POD25b) During February to April 2026 the Trust has filled 107 vacancies. The average time to hire from vacancy approval to final offer letter across the 107 vacancies was 39 working days compared to the NHS England target of 40 working days.

Safeguarding Compliance (POD 28/29) Trust Level 1 and 2 (both adult and child) are compliant but level 3 for adult and child are amber. The compliance matrices have been reviewed; bespoke sessions have been scheduled on the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view to targeting individuals to improve compliance.

Qualified and Support Worker Vacancies (POD16 & POD17) Vacancies for these cohort remained above the 2.5% target reporting 8.19% and 9.19%. Vacancies are being reviewed on a weekly basis to support displaced colleagues, but this is expected to cease in May 2026. We expect vacancies to remain high for Q1, as we recruit to the vacancies and also have a slight increase in our turnover. We will then focus our efforts in achieving the vacancy factor across the Trust.

Vacancy Rate. The vacancy rate increased from 238 to 283 vacancies, currently standing at 7.48%. against a target of 2.5% however the budgeted establishments in ESR have not been changed and will be updated in May 2026. Vacancies are being reviewed on a weekly basis to ensure appropriate posts are held or released in line with the change management process. We expect vacancies to remain high for the early part of Q1, as we have held a number of posts to support colleagues who are displaced. Once we have concluded the change management programme we will advertise any remaining vacancies with the intention to achieve the 2.5% vacancy factor during Q2 as this is dependent upon applicants notice periods. There are 53 vacancies which are currently being advertised a further 115 in the recruitment process and 82 vacancies in authorisation

Finance

At this early stage of the year, the M1 year to date financial position is a deficit of £41k, which is £21k better than planned and the forecast is to breakeven. All 24 directorates are managing within their budgets; this is positive but it is likely to become increasingly difficult as the number of vacancies reduces over the coming months.

2.0 - Performance – In Focus

Indicators for April 2026/2027 TRUST						Performance			
Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP01 (N)		People first episode in psychosis started treatment in 2 wks		11/12	91.67%		91.67%	>= 60%	91.67%
OP03a (L)	T903a	People accessing Talking Therapies - Cumulative Annual			1403		1403	>= 1915	1403
OP03c (N)	T903b	Reliable recovery rate within Talking Therapies		346/696	49.71%		49.71%	>= 48%	49.71%
OP03d (N)	T903c	Reliable Improvement rate within Talking Therapies		513/723	70.95%		70.95%	>= 67%	70.95%
OP05a (N)		People in physical health crisis assessed within 2 hours		22/28	78.57%		78.57%	>= 70%	78.57%
OP05b (N)		Suppression Numbers: People in PH crisis assessed in 2 hours		20/30	66.67%		66.67%		66.67%
OP07b (L)	T907	Women supported by perinatal MH service (Rolling 12M)			628		628	>= 574	628
OP08b (L)		18 wks RTT for AHP led Physical Services		235/282	83.33%		83.33%	>= 92%	83.33%
OP08c (N)		18 weeks RTT for consultant led Physical Health services		18/18	100.00%		100.00%	>= 92%	100.00%
OP08d (N)		18 weeks RTT for consultant led Mental Health services		243/243	100.00%		100.00%	>= 92%	100.00%
OP10c (N)		Waiting 52 weeks or more for a consultant led PH service			0		0	= 0	0
OP10d (N)		Waiting 52 weeks or more for a consultant led MH service			0		0	= 0	0
OP12 (N)		People discharged from MH inpatients followed up in 72 hrs		75/92	81.52%		81.52%	>= 80%	81.52%
OP13a (N)	T901	People accessing CYP services with >= 1 contact (13mth roll)			11705		11705	>= 9424	11705
OP13b (N)		People accessing CYP services >= 2 contacts and paired score		896/6451	13.89%		13.89%	>= 20%	13.89%

Narrative

OP03a – Reporting 1,403 year to date against a target of 1,915. When compared with activity in the same period last year (1,518) we are reporting 115 below last year's actual.

OP08b – 18 Weeks AHP led services is reporting below the 92% target.

OP13b - The CYP access 2 contacts and a paired scored has seen a deterioration in performance in April to 13.89% from 15.31% in March. It is noted that the services do not use a standard tool for recording outcome measures however as a trust we have agreed to implement Dialog+ with recently transitioning across to this.

2.0 - Performance – In Focus

Indicators for April 2026/2027 TRUST						Performance			
Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP13d (L)		Adults accessing community mental health services (DW)			11859		11859	>= 8533	11859
OP14 (N)		People (CYP) with routine eating disorders seen within 4 wks		77/84	91.67%		91.67%	>= 95%	91.67%
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		0/100	0.00%		0.00%	>= 95%	0.00%
OP17c (N)	T904	The number of active inappropriate adult acute OAPs			8		8	<= 30	8
OP54c (L)		Virtual ward occupancy - on day 30		63/60	105.00%		105.00%	>= 80%	105.00%
OP59a (L)		Waiting List - Adult ADHD			6248		6248	< 4184	6248
OP59b (L)		Waiting List - CYP Neurodevelopment			4122		4122	<= 2329	4122
OP60 (L)	T906	Dementia Diagnosis rate		7403/9909	74.71%		74.71%	>= 67%	74.71%
OP61a (L)		Place target for SMI		3775/5385	70.10%		70.10%	>= 75%	70.10%
OP61c (N)		Patients with SMI having full annual physical health check		2929/3935	74.43%		74.43%	>= 95%	74.43%
OP73a (L)	T905	Section 136 Breaches – Occupancy hours lost to breaches			290		290	= 0	290
OP77c (L)	T902a	Mean Spell LOS Current Inpatients (Internal Beds/Month-End)			67		67	<= 32	67
OP77d (L)	T902b	% Inpatients Spell LOS > 32 Days (Internal Beds/Month-End)		65/113	57.52%		57.52%		57.52%
OP78 (L)	T908	Number of people accessing Individual Placement Support	>= 10		87		87		87
OP80 (L)	T909	% Services meeting 4 week wait target at end of month		69/83	83.13%	Q1 >= 35%	83.13%		83.13%

Narrative

OP14 – The metric measuring over a 12-month rolling period is reporting at 91.67% in April, below the 95% target. 7 breaches in the 12 month rolling period (occurred: 1 in Mar 26, 2 in Dec 25, 2 in Nov 25 and 2 in October)

OP15 – there were no urgent referrals received in month requiring to be seen within 1 week.

OP59a – The Adult ADHD waiting list trajectory is reporting that there are 6,248 (down from 6,317) adults waiting for assessment against the target of 4,184. The Care Group are redeveloping the trajectory to build in nuances that were not already accounted for regarding capacity within the service.

OP59b – The Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target actual with 4,122 (from 4,365) CYP waiting against the target of 2,329. The Care Group is redeveloping the trajectory to build in nuances that were not already accounted for regarding capacity within the service.

OP61c – The metric is measuring the RDaSH performance against the QOF. Performance is reported as 74.43% (down from 76.35%) against the 95% target.

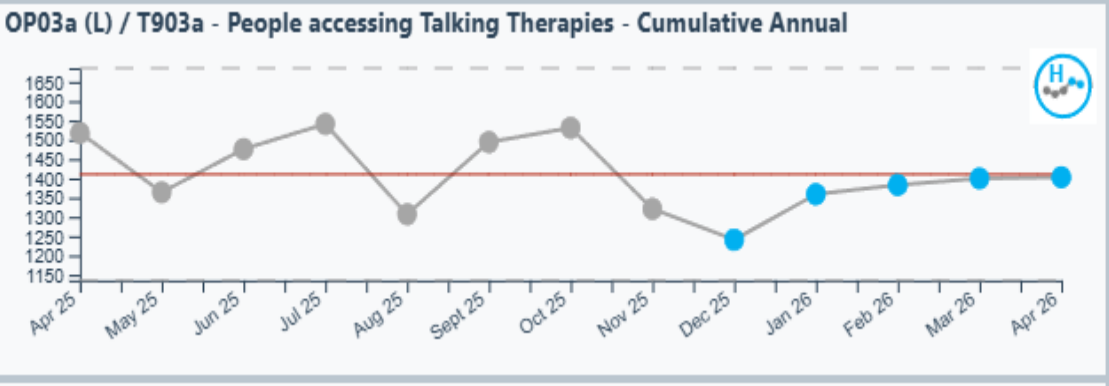
OP73a – The number of occupancy hours lost in the month of April is 290 hours.

OP77c - The metric reporting the mean length of stay for patients who remain on the wards is reporting a 67 days (up from 58 days) mean length of stay against the target of 32 days.

OP78 – IPS in North Lincolnshire remains below the 120 target reporting 87 due to delays in recruitment and maternity leave during last year.

OP80 – The 4WW position reporting against the end of April target is reporting 83.13% against the target of 94%.

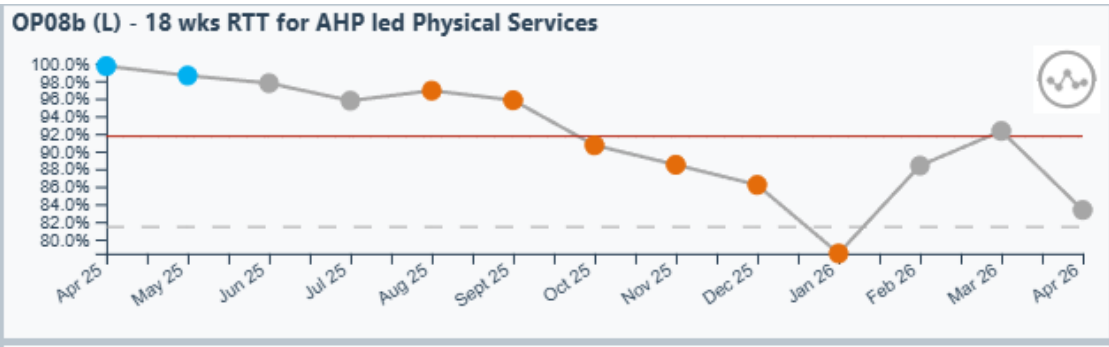
2.1 Performance In Focus - Exceptions



Trend, Reason and Action

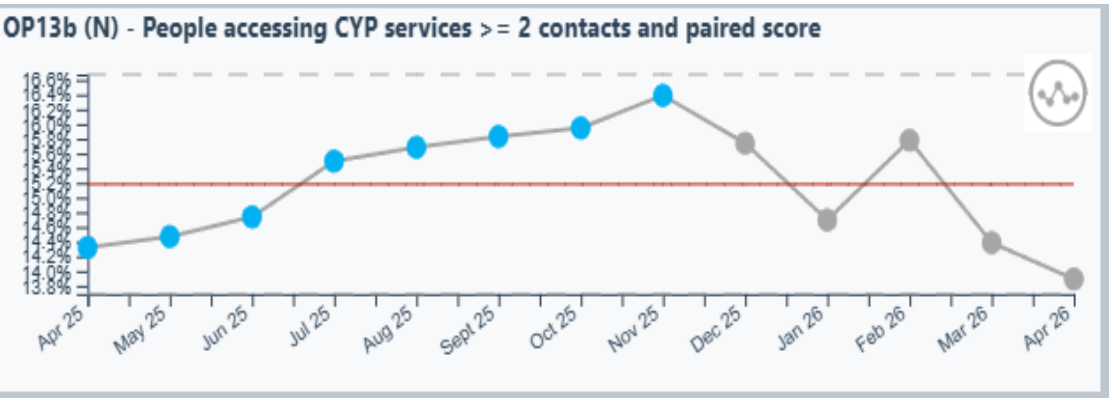
OP03a - Reporting at 1,403 year to date against a target of 1,915, representing a reduction of 115 individuals compared to the same period last year.

To support improvement, the service continues to develop long-term conditions pathways in North Lincolnshire to ensure equitable access across the Trust. Work is also progressing to embed physical activity within mental health services, in partnership with Sport England, with Doncaster acting as a trailblazer site. Targeted support has been provided to patients aged 65 and over within the Physical Health and Neurodiversity Care Group, alongside in-reach support to intermediate care inpatient wards.



Trend, Reason and Action

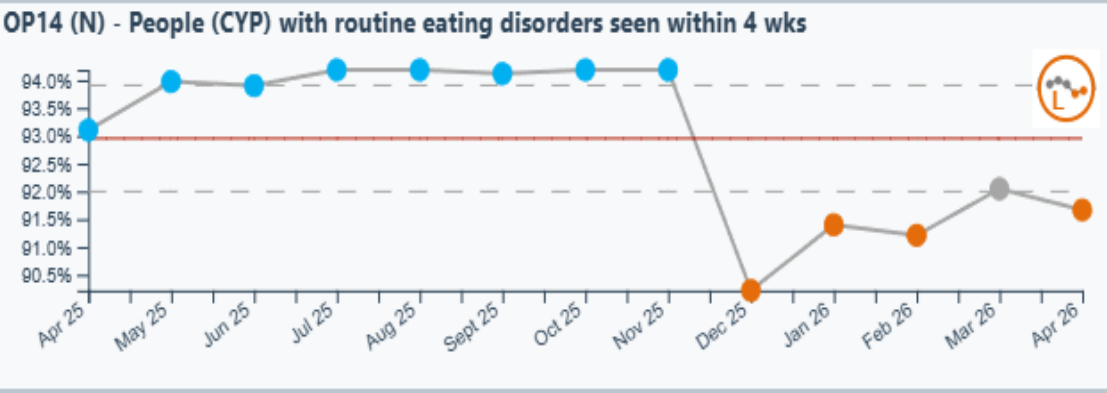
OP08b - Podiatry services are currently experiencing prolonged extended waiting times driven by increased demand. Approval has been secured through the 2025/2026 investment bid process to recruit additional staff to strengthen capacity and reduce delays with recruitment ongoing.



Trend, Reason and Action

OP13b - The CYP access 2 contacts and a paired scored has seen a further deterioration in performance in month. It is noted that the services do not use a standard tool for recording outcome measures however as a trust we have agreed to implement Dialog+ with CYP with recent transition across to this. To enable a paired outcome score to be generated, patients must be first placed on the outcome measurement tool, but then also followed up on this, therefore early improvement is likely to be seen in Q2 26/27.

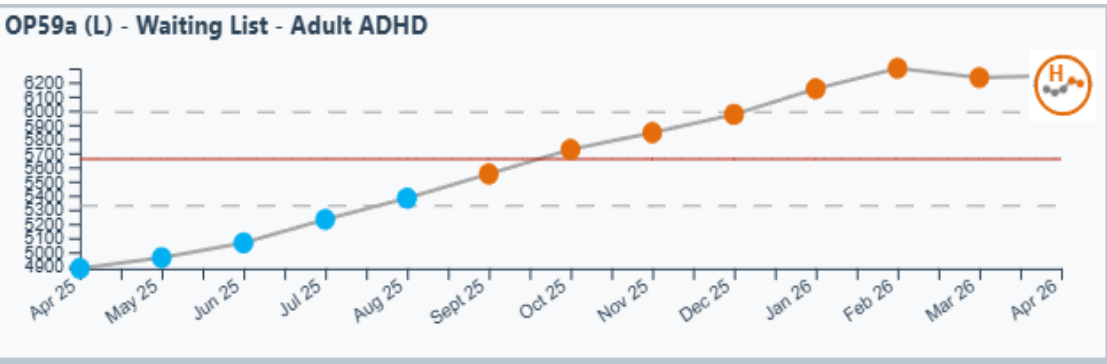
2.1 Performance In Focus - Exceptions



Trend, Reason and Action

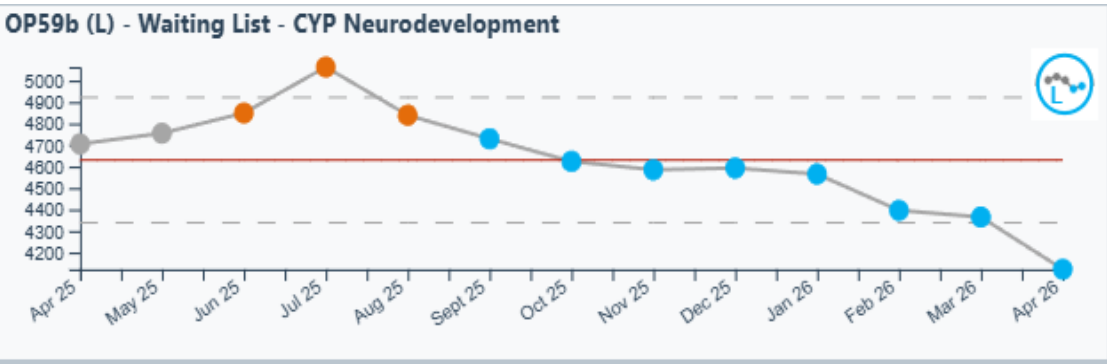
OP14 - The metric measuring over a 12-month rolling period is reporting at 91.67% in April, below the 95% target. Seven breaches in the 12 month rolling period (occurred: 1 in Mar 26, 2 in Dec 25, 2 in Nov 25 and 2 in October)

Of the seven breaches, six patients were offered appointments within the four-week timescale; however, appointments were cancelled or rearranged by parents/carers, or appointments outside the four-week window were chosen. One breach occurred outside the four-week standard in December 2025, attributable to reduced service capacity over the Christmas period.



Trend, Reason and Action

OP59a - This metric measuring performance against the Adult ADHD waiting list trajectory is reporting that there are 6,248 adults waiting for assessment against the target of 4,314. The service has put in place a revised triage protocol from January 2026 and has instigated a pre assessment information pack which is sent out to people prior to assessment to gain essential information to enable an efficient assessment. This, along with work on allocation and rota management has led to a stepped increase in the number of assessment and treatment appointments available. Approximately 600 people on the list are waiting for treatment instigation. From April 2026 the Trust Board has requested the service focus on delivering capacity for 173 assessments monthly. This is being monitored locally within the Care Group.

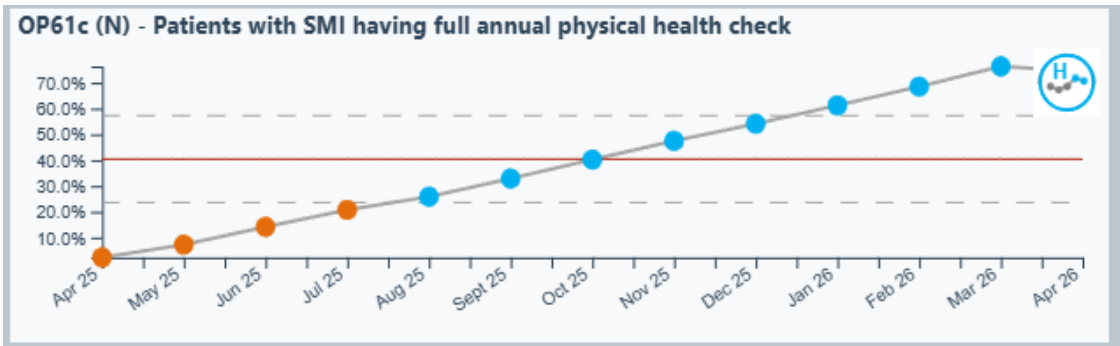


Trend, Reason and Action

OP59b - This metric measuring performance against the Children and Young (CYP) People's Neurodevelopment waiting list trajectory is reporting against the proposed target actual with 4,122 CYP waiting against the target of 2,329.

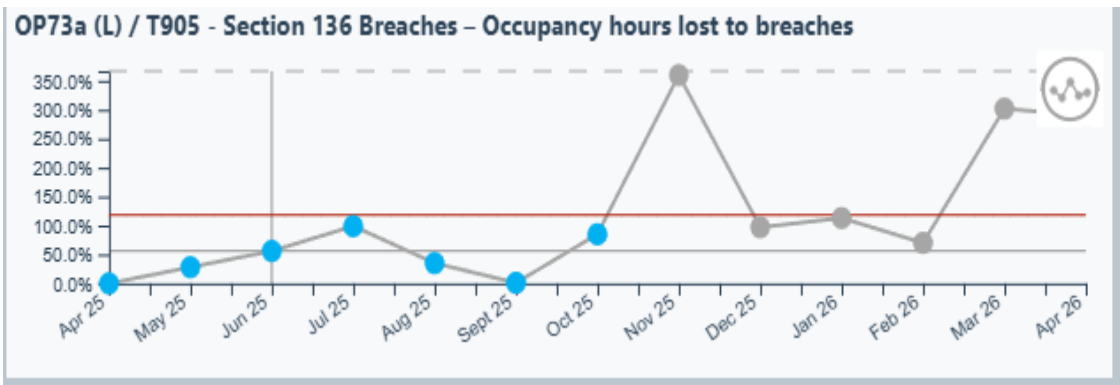
The Care Group have redeveloped the trajectory to build in the additional Autism service recently transferred from Doncaster Royal Infirmary (approximately 700 children and young people) in addition to adding nuances that were not already accounted for regarding capacity within the service.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

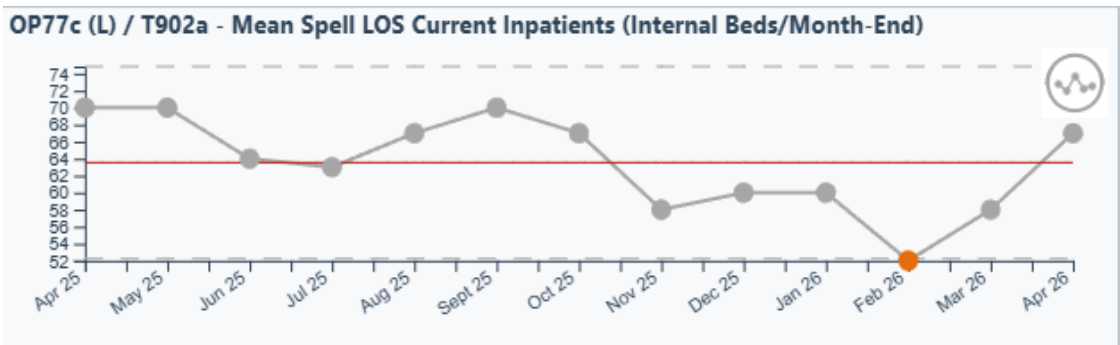
OP61C—Reporting as 74.43% (down from 76.35%) against the 95% target. Improvement initiatives are in place which include a continuing focus on declines across all 3 Care groups, embedding POC machine blood testing, and support from peer support workers to support access. SMI compliance and actions for improvement have been scrutinised at OMG in November and will be re-presented by Care Groups at January’s meeting to ensure improvement in all three care groups.



Trend, Reason and Action

OP73A—the metric measures the occupancy hours lost due to breaches within our 3 Section 136 suites, 290 hours were lost this month. Performance have reviewed and reporting the following to be true breach hours :

- Doncaster 79 hours
- 1 x repurposed suites S140 – 71:48 hrs
- 2 x 24 hr breach -(1 x breach 02:51, 1 x breach 04:53.)
- Rotherham 104 hours
- X 3 Repurposed suites S140 – 104 hrs (76:43 hrs, 21:00 hours and 06:47 hours)
- North Lincs – 106 hrs
- X 1 repurposed suites S140 – 52:39 hrs
- X 3 24hr breach - (1 x breach 08:15, 1 x breach 29:34, 1 x breach 16:30)



Trend, Reason and Action

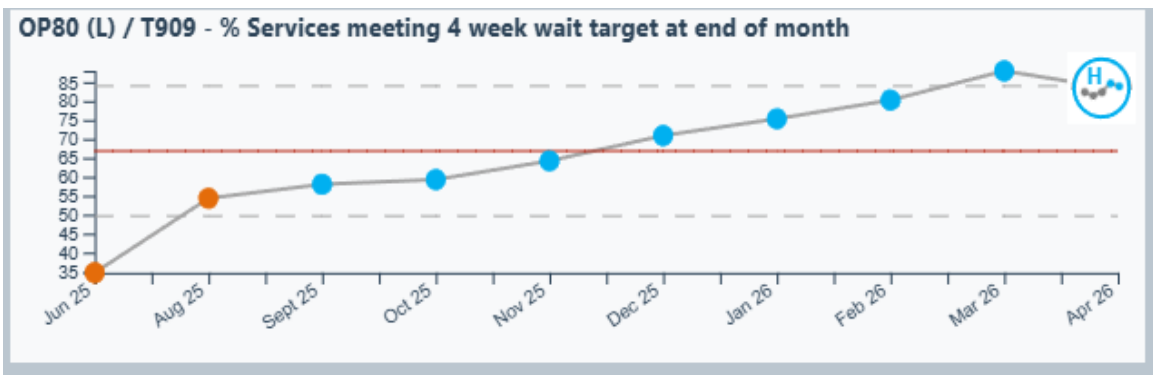
OP77C— Our position from this month is 67 days (increased from 58). It is noted that a focus is required in all three localities to ensure timely discharge of patients when clinically appropriate. Rotherham remains an outlier for long LoS, but North Lincolnshire has seen a significant increase this calendar year, but a reduction through March and April.

2.1 Performance In Focus - Exceptions



Trend, Reason and Action

OP78 / T908 The metric measuring the number of people accessing individual placement support has remains below the target of 120 individuals reporting 87 .Recruitment has completed however the employment specialists were required to complete training prior to taking on a full caseload from February 2026 and the service has a period of maternity leave.



Trend, Reason and Action

OP80 / T909 The metric measuring the number of services achieving 4 week waits reports that 83.13% of services are achieving the four week wait standard, with 69 of 83 services compliant. While the majority of services are compliant, a small number of breaches persist, largely due to workforce capacity pressures, particularly within Children’s services where sickness absence has impacted delivery and within Physical Health Services, podiatry continues to experience extended waits due to increased demand. Additional resources have been approved and recruitment is underway to improve capacity.

3.0 Quality & Safety In Focus

Indicators for April 2026/2027 Trust				Quality and Safety				
Indicator	Metric	Target		Value	QTD Target	QTD Actual	YTD Target	YTD Actual
QS05	Number of MRSA Infections (Monthly)	0		0	0	0	0	0
QS06	Number of Clostridium difficile infections (Monthly)	0		0	0	0	0	2
QS07	Number of gram-negative bloodstream infections (Monthly)	0		0	0	0	0	0
QS08	Bi patients >= 16 admitted with completed VTE	>= 95%	130/140	92.86%	>= 95%	93%	>= 95%	93%
QS15	No of wards reporting registered staff on nights/days >90%	>=90%	0	88.23%	>= 90%	88.23%	>= 90%	88.23%
QS19	Number of AWOL's from low secure (Amber Lodge)			0		0	0	0
QS20	No of detained patients absconded acute adult / OP inpatient MH			2		2	2	2
QS21a	Physical aggression incidents mod or above to staff (%)		0	0.00%		0%		0%
QS21b	Physical aggression incidents mod or above to staff/pats (%)		0	0.00%		0.00%		0%
QS23	Number of Suspected Suicides (inpatient settings)	0		0	0	0	0	0
QS27	Ligature incidents mod or above all inpatient areas		1/9	11.11%		11%	>=10%	11%
QS29	Number of racist incidents against staff members			4		4	0	4
QS31	Episodes of seclusion - Internal MDT within 5 hours		15/16	93.75%		93.75%	100%	93.75%
QS36	Inpatients that have a completed MUST assessment		110/143	78.06%		78.06%	100%	78.06%
QS37c	Inpatients commenced falls assessment in 12 hrs		62/65	95.38%		95.38%	100%	95.38%

Narrative

QS08- The percentage of VTE assessments completed within 14 hours is below the 95% target at 92.86% (130/140).

QS15- The number of wards reporting registered staff below 90% for the month of April is below target at 88.23% (15/17 wards).

QS20 - Two patients absconded in April from acute adult and OP inpatient mental health units.

QS27 - The number of ligature incidents moderate or above in all inpatient areas is above the target of 10% at 11.11% (1/9).

QS29 –Reporting a decrease in April to 4 racist incidents reported.

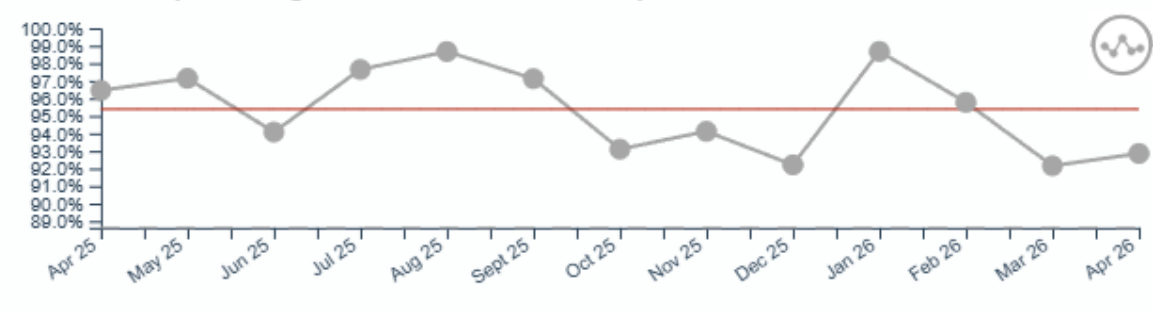
QS31- The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting an increase 93.75% (15/16).

QS36 - Reporting a decrease in April to 78.06% (110/143) from the 85.62% (131/153) in March of the % of Inpatients that have a completed MUST assessment.

QS37C –This metric is showing an increase to 95.38% (62/65) from the 92.95% (66/71) in March of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission.

3.1 Quality and Safety In Focus - Exceptions

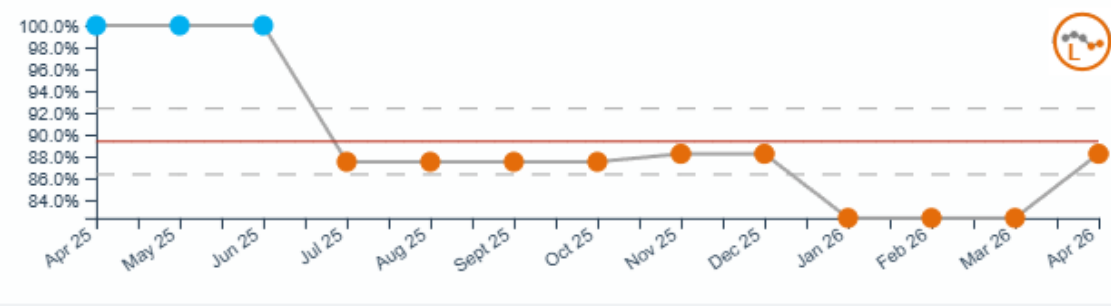
QS08 (N) - No patients aged >=16 admitted with completed VTE



Trend, Reason and Action

QS08- The percentage of VTE assessments completed within 24 hours is reporting an increase to 92.86% (130/140) from the 91.50% (140/154) reported in March. The timeframe was reduced in March to 14 hours in line with NICE guidance and Trust policy for completion of assessments. There continues to be ongoing monitoring in all Care Groups including missed VTE assessments being added to the Radar system during May to ensure there is an improvement, and any learning can be addressed more promptly with feedback to individual clinicians and any actions to learn from each delay is implemented.

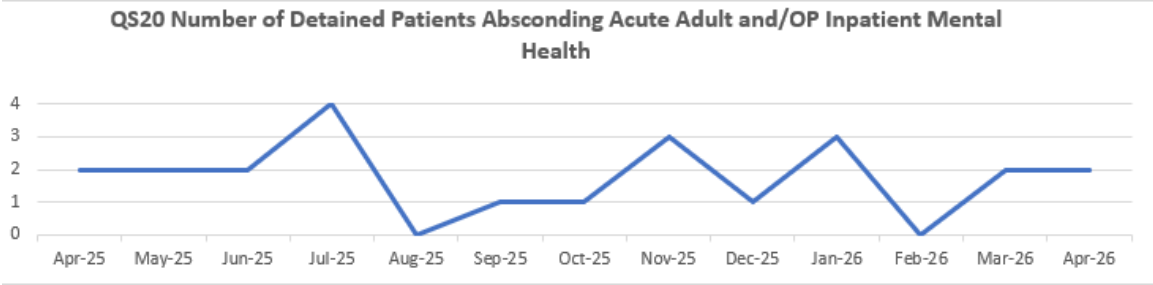
QS15 (L) - No of wards reporting registered staff on nights/days >90%



Trend, Reason and Action

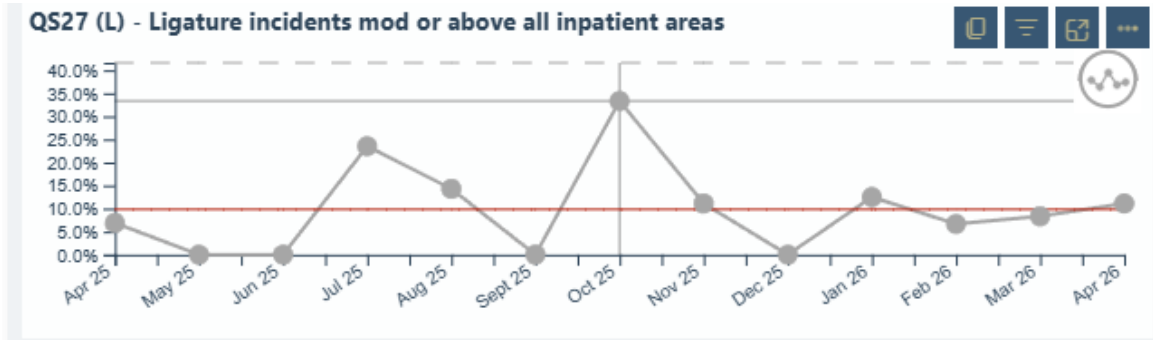
QS15 - The number of wards reporting registered staff below 90% for the month of April is below target at 88.23% (15/17 wards). During April, two wards reported registered nurse fill rates below 90%: Kingfisher and Mulberry. Where reduced registered nurse staffing was identified on shifts, this was mitigated through increased healthcare assistant provision and clinical support from Deputy Ward Managers to maintain safe care delivery. Kingfisher Ward experienced consistently high levels of patient acuity throughout the month, and increased staffing levels as required to ensure patients requiring enhanced observations received appropriate care and supervision. Laurel and Mulberry wards remained co-located during the ongoing building works at Great Oaks and were able to provide cross-cover support where required to maintain operational resilience. In April, four safer staffing incidents were reported via Radar: two relating to Kingfisher Ward, one relating to Laurel Ward, and one relating to Mulberry Ward.

3.1 Quality and Safety In Focus - Exceptions



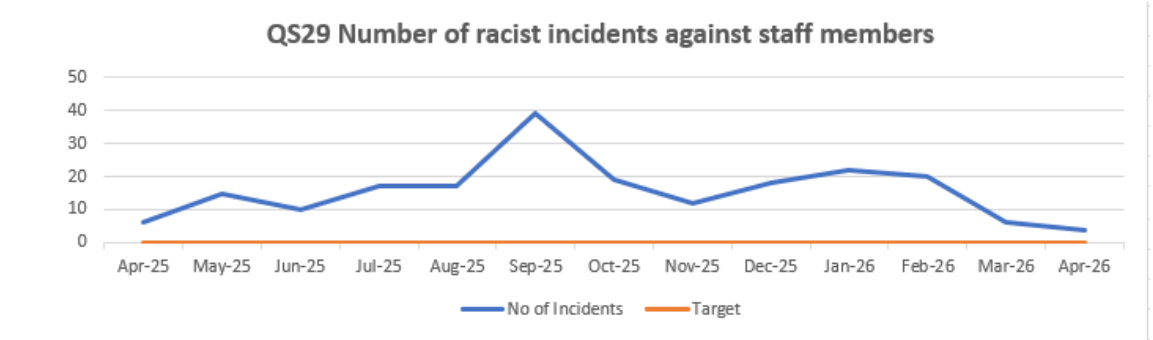
Trend, Reason and Action

QS20 – Two patients absconded in April from acute adult and OP inpatient mental health units. One patient absconded while detained on the acute ward via the Garden and safely returned by Police the same day to the PICU ward for his own safety. The second patient pushed past a staff member and exited the building but returned with prompting All incidents are reviewed in Swarm huddles for learning.



Trend, Reason and Action

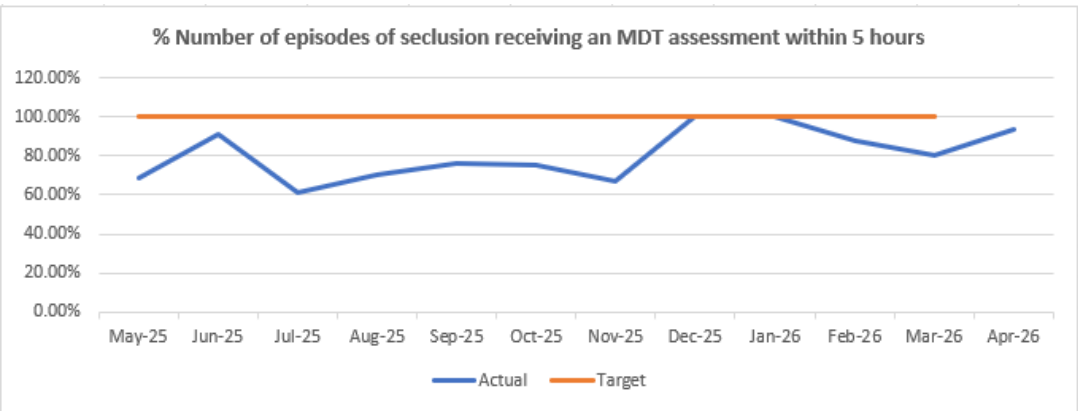
QS27 – The number of ligature incidents moderate or above in all inpatient areas is above the target of 10% at 11.11% (1/9). The number of ligature attempts on Mulberry House increased due to two patients who experienced distress and used self-ligature as a way of managing this distress. PBS plans and keeping safe plans were completed with both patients.



Trend, Reason and Action

QS29 –Reporting a decrease to 4 from the 6 reported in March. All Care Groups are continuing to follow the acceptable behaviour policy where appropriate and supporting colleagues who experience any form of abuse. The Anti Racism pilot on Mulberry House has encouraged staff to challenge abusive racist language proactively rather than reactively. SAFE project commenced on Kingfisher to support staff following any discrimination. For 26/27 anti-racism is a focus and reflects staff feedback and Radar learning.

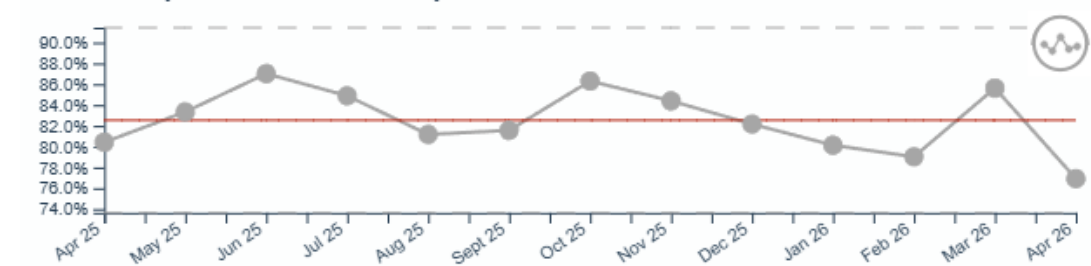
3.1 Quality and Safety In Focus - Exceptions



Trend, Reason and Action

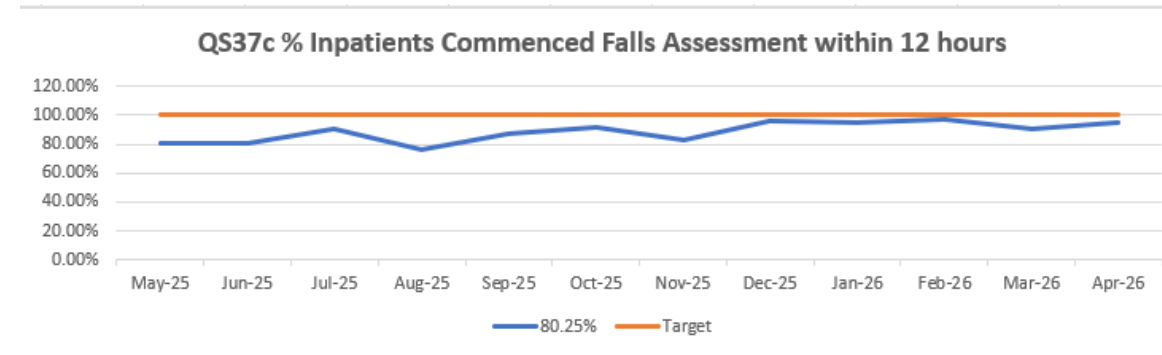
QS31- The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting an increase to 93.75% (15/16) from the 80% (20/25) in March. The changes have been implemented to the seclusion visualisation on System 1 to allow a pop-up message to appear giving instructions to the Doctors in what circumstances the particular review should be completed that has been selected. The risk continues to be highlighted on the risk register for each Care Group and the Mental Health Act Manager has instructed the Matrons that all audits of episodes of seclusion must be taken through the Mental Health Legislation Monitoring

QS36 (N) - Inpatients that have a completed MUST assessment



Trend, Reason and Action

QS36-Reporting a decrease in April to 78.06% (110/143) from the 85.62% (131/153) in March of the % of Inpatients that have a completed MUST assessment. Following a deep dive of all patients a Performance Clinic took place with ward managers in Doncaster Mental Health Care As a result compliance has increased and this will be rolled out across N Lincs and Rotherham.



Trend, Reason and Action

QS37C –This metric is showing an increase to 95.38% (62/65) from the 92.95% (66/71) in March of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission. The three MFRA’s which were not completed to timescale were on Hawthorne Ward, two were completed late and one was a re-admission and wasn’t completed as a review.

4.0 People and Organisational Development – In Focus

Indicators for April 2026/2027 TRUST

Human Resources

Indicator	Metric	Target	Value	QTD Target	QTD	YTD Target	YTD
POD09 (L)	Trust Retention Rate (Rolling 12 months)	<= 10%	11.08%		11.08%		11.08%
POD10 (L)	Working days lost to staff sickness absence	< 5.1%	5.40%				
POD12 (L)	Number staff who have had an annual flu vaccination		2466		2466	= 0.7	2466
POD14 (L)	Staff agree Trust acts fairly career prog/protected chrchs*		60.20%		60.20%	> 66.4%	60.20%
POD15 (L)	Number of Consultant Vacancies	<= 10	8		8		8
POD16 (L)	Qualified nursing vacancies	<= 2.5%	8.19%		8.19%		8.19%
POD17 (L)	Support worker vacancies	<= 2.5%	9.19%		9.19%		9.19%
POD18 (L)	Individuals Performance Development Review in 12 mnth	> 90%	93.19%		93.19%		93.19%
POD19a (L)	Individuals completed mandatory/statutory training	> 90%	95.50%		95.50%		95.50%
POD23 (L)	Number of individuals currently suspended from employment		0				
POD24 (L)	Average suspension length in calendar days	<= 150	0		0		0
POD25b (L)	Recruitment average working days - Advert to checks complete		39		39		39
POD26 (L)	Compliance for safeguarding children's training		88.24%		88.24%		88.24%
POD27 (L)	Compliance for safeguarding Adult's Level 3 training		95.94%		95.94%		95.94%
POD28 (L)	Total Vacancies		283		283		283
POD29 (L)	Total Vacancy Rate %		7.48%		7.48%	<= 2.5%	7.48%

Narrative

POD09 – The trust retention rate on a rolling 12 month remains above the 10% target. Turnover for March was 11.08%. As predicted, the turnover for March was high with 53 staff leaving the Trust compared to last March (43). We expect the turnover to remain high for Q1 as we complete the change management programme.

POD10 – The rolling 12 month sickness Absence % is above target (5.40% vs 5.10%), which has decreased from 6.69% in March. Monthly sickness absence appears to have peaked in January 2026 at 7.60% rising steadily from 6% in April 2025.

POD16-17 – Reporting as 8.19% and 9.19% against the revised target of 2.5% for both qualified and support worker vacancies

POD18 – PDR's reporting 93.19%.

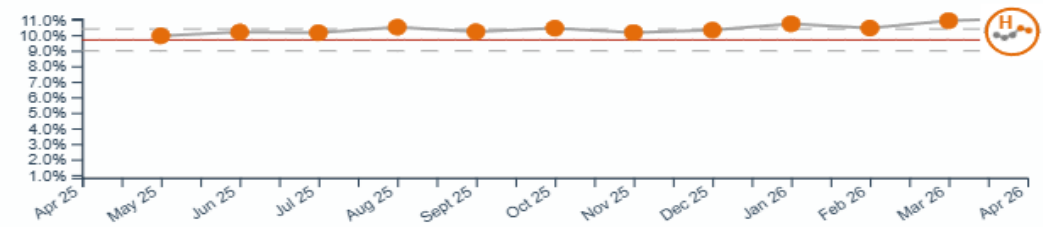
POD2ba – During January to March 2026 the Trust has filled 122 vacancies. The average time to hire from vacancy approval to final offer letter across the 122 vacancies was 39 working days compared to the NHS England target of 40 working days.

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

POD28/29 – Reporting as 7.48% against the target total vacancy rate percentage of less than or equal to 2.5% with 238 vacancies currently across the trust.

4.1 People and Organisational Development - Exceptions

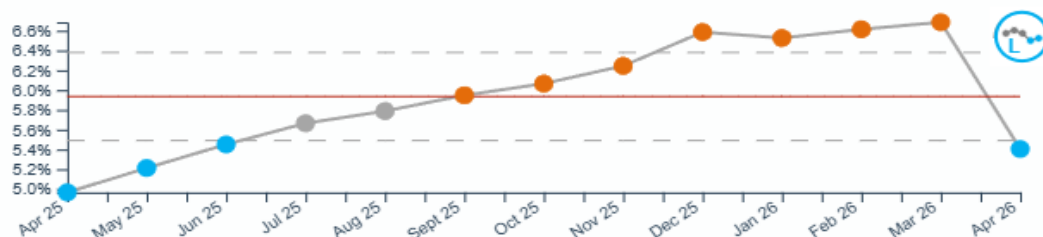
POD09 (L) - Trust Retention Rate (Rolling 12 months)



Trend, Reason and Action

POD09 – The trust retention rate on a rolling 12 month remains above the 10% target at 11.08%. As predicted, the turnover for April remained high with 40 staff leaving the Trust compared to 35 last April. It is anticipated that the turnover will remain high for H1 as the change management programme completes.

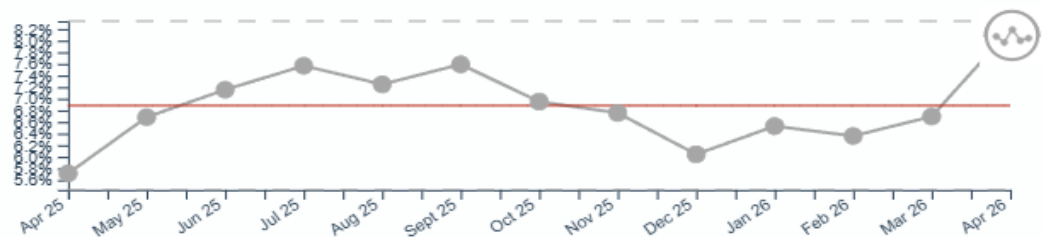
POD10 (L) - Working days lost to staff sickness absence



Trend, Reason and Action

POD10 –The sickness absence % is above target (5.40% vs 5.1%), which has decreased from 6.69%. Monthly sickness absence appears to have peaked in January 2026 at 7.60. March and April 2026 sickness rates have continued to trend downwards. Quarterly LT sickness review clinics have been scheduled for all areas and these will be chaired by the Director of People and OD. In the intervening months, the HR team will also facilitate local review meetings

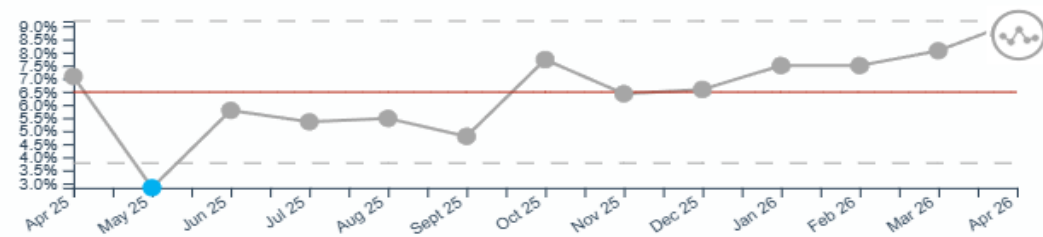
POD16 (L) - Qualified nursing vacancies



Trend, Reason and Action

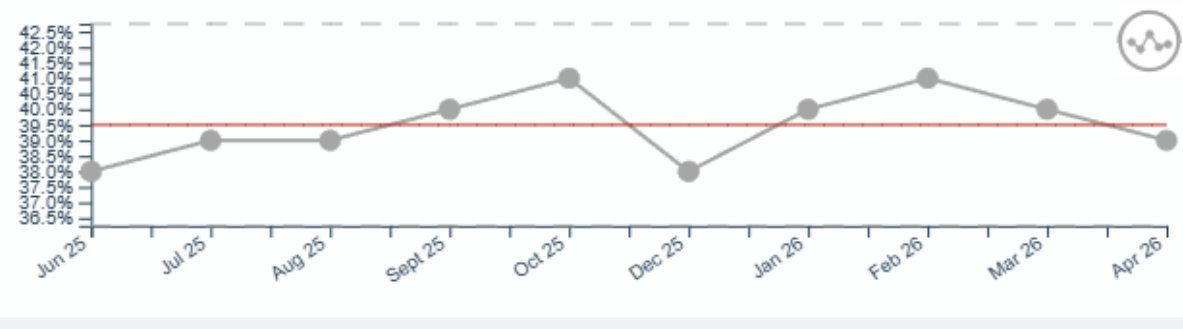
POD16/17 - Vacancies for these cohort remained above the 2.5% target reporting 8.19% and 9.19%. Vacancies are being reviewed on a weekly basis to ensure appropriate posts are held or released in line with the change management process. We expect vacancies to remain high for the early part of Q1, as we have held a number of posts to support colleagues who are displaced. Once we have concluded the change management programme we will advertise any remaining vacancies with the intention to achieve the 2.5% vacancy factor during Q2 as this is dependent upon applicants notice periods.

POD17 (L) - Support worker vacancies



4.1 People and Organisational Development - Exceptions

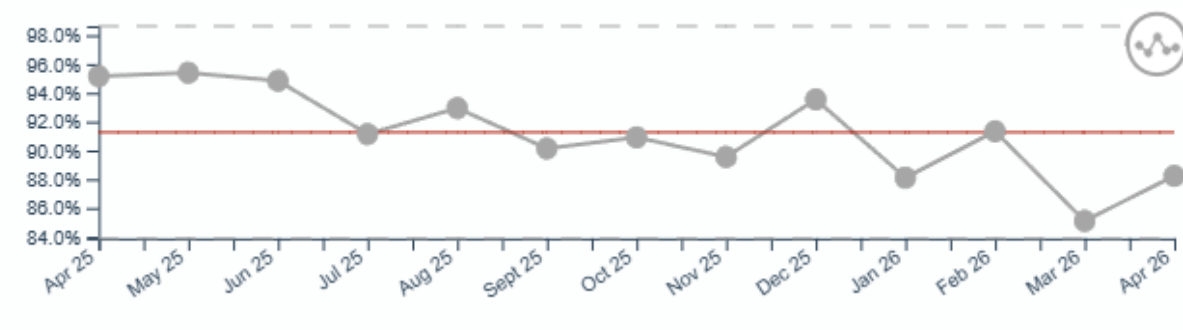
POD25b (L) - Recruitment average working days - Advert to checks complete



Trend, Reason and Action

POD25b - During February to April 2026 the Trust has filled 107 vacancies. The average time to hire from vacancy approval to final offer letter across the 107 vacancies was 39 working days compared to the NHS England target of 40 working days.

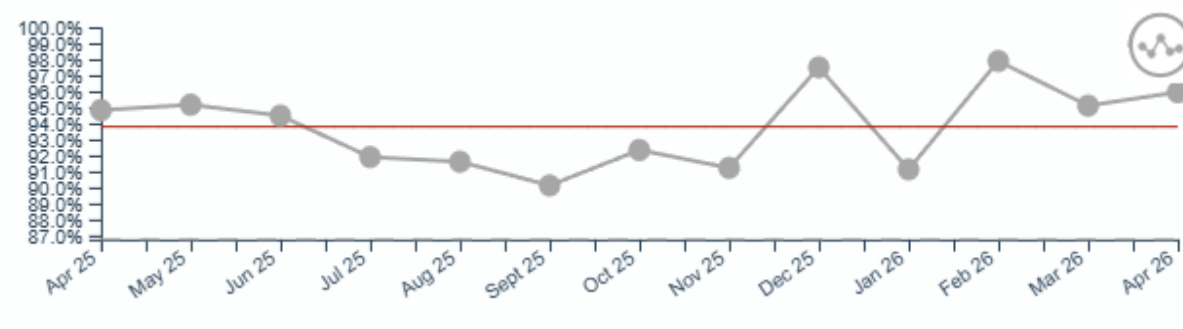
POD26 (L) - Compliance for safeguarding children's training



Trend, Reason and Action

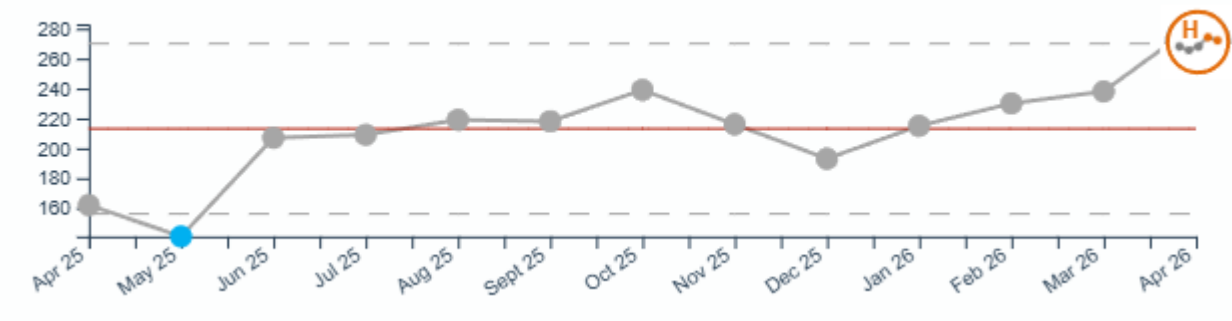
POD26/27 - Trust Level 1 and 2 (both adult and child) are compliant but level 3 for adult and child are amber. The compliance matrices have been reviewed, bespoke sessions have been scheduled on the half day LEARN event calendar and any non-compliance will be shared with Directors of Nursing with a view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

POD27 (L) - Compliance for safeguarding Adult's Level 3 training

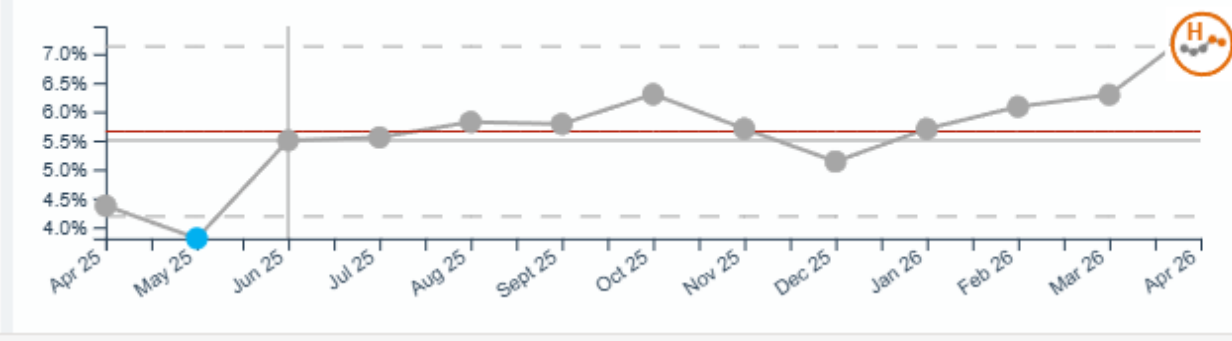


4.1 People and Organisational Development - Exceptions

POD28 (L) - Total Vacancies



POD29 (L) - Total Vacancy Rate %



Trend, Reason and Action

POD28/29 - The vacancy rate increased from 238 to 283 vacancies, currently standing at 7.48%. against a target of 2.5% however the budgeted establishments in ESR have not been changed and will be updated in May 2026. Vacancies are being reviewed on a weekly basis to ensure appropriate posts are held or released in line with the change management process. We expect vacancies to remain high for the early part of Q1, as we have held a number of posts to support colleagues who are displaced. Once we have concluded the change management programme we will advertise any remaining vacancies with the intention to achieve the 2.5% vacancy factor during Q2 as this is dependent upon applicants notice periods. There are 53 vacancies which are currently being advertised a further 115 in the recruitment process and 82 vacancies in authorisation

4.0 Finance – In Focus

Finance				
Indicator	Metric	Target	Actual	Variance
FIN01	Year to date actuals vs budget	(62)	(41)	21
FIN02	Forecast outturn vs budget	0	0	-
FIN03	Year to date savings target vs schemes identified	1,146	1,146	0
FIN04	Annual savings target vs schemes identified	13,750	13,750	0
FIN05i	Agency spend as % of total pay bill - year to date	0.41%	0.48%	0.1%
FIN05ii	Agency spend - year to date	70	82	12
FIN06	Year to date capital plan vs spend	722	24	(698)
FIN07	Annual capital plan vs forecast spend	6,708	6,708	-
FIN08	No of directorates compliant with budget - year to date	23	23	100.0%
FIN09	No of directorates compliant with budget - forecast	23	23	100.0%
FIN10	Directorates not compliant with budget - YTD:			
				0
FIN11	Directorates not compliant with budget - Forecast:			
	None			

Narrative

- FIN01 - At M1 the year to date (YTD) position is £21k better than planned, this is driven by vacancies being higher than planned.
- FIN03 - At M1, the YTD for forecast expected savings are on plan.
- FIN05 - FIN05 - YTD agency costs are overplan at M1, this is due to the additional agency medic in the Children's care Group, which is due to end in M2.
- FIN06 & FIN07 - Capital spend is behind plan year to date by £0.7m, this is because detailed budgets are set to be set for capital and therefore no real spend has happened to date. Forecast spend is expected to be on plan.
- FIN08 & FIN10 - 26/27 budgets were agreed and signed off on the basis that all directorates would manage their budgets and not overspend. At M1, all of the 23 directorates has an underspend.
- FIN09 & FIN11 - The Trust is currently forecasting breakeven for year end. All 23 directorates are forecasting their year end positions to be on plan.

Appendix 1`

SPC Icon Description



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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises and Priorities Scorecard	Agenda Item	Paper N
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points			
As indicated last month, we spent time within CLE in April hearing from care group SLTs how they planned to integrate promises delivery into their workplans for the year: Promise 26, 1, 2, 7 and 8 featured strongly: we acknowledged, as this paper discusses, some promises which will not progress much further during 2026. At the Board in March, I agreed that as EG (executive group), we would focus on acceleration of the mid-table success measures. <i>That process is reported within this submission and may be usefully our focus as a Board this time.</i> Objectives among the executive group do have a focus in some key promise areas: 16, 23, 24, 28. The acknowledged weakness remains some, but not all of our inequalities promises and PHPIP has escalated that matter given the limited impact on promise 8, and sizeable work yet to do on parts of 9, 10 and 12.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
N/A			
Recommendation (delete options as appropriate and elaborate as required)			
The Board of Directors is asked to:			
NOTE work done to ensure rhythm and focus on the mid-table success measures			
RECOGNISE Board time has been scheduled twice in 2026 to ensure collective effort on Promise 26			
RECOGNISE the need for Board committees to focus on 16 (QC), 24 (E&L) and 28 (PHPIP)			
Alignment to strategic objectives (indicate those that the paper supports)			
SO1: Nurture partnerships with patients and citizens to support good health			X
SO2: Create equity of access, employment, and experience to address differences in outcome			X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services			X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings			X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			X
Alignment to the plans: (indicate those that this paper supports)			
People and teams plan			X
Quality and safety plan			X
Equity and inclusion plan			X
Education and learning plan			X
Research and innovation plan			X
Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X

Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
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)			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services			X

If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.							X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.							X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees							X
System / Place impact (advise which ICB or place that this matter relates to)							
Work to improve wait times and tackle inequalities and popn. health issues							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Annex A – May 2026 promises scorecard or league table							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Latest Promises Update

Purpose and introduction

- 1.1 The published and co-produced annual report will rely on partner views and assessment as at March, which the Board reviewed last time it met. This report aims to provide, in several key respects, a forward look. It also highlights some focused work done by colleagues to move forward delivery.
- 1.2 When we last met, fourteen of our 28 promises were showing an overall compliant position, and we highlighted the particular challenges posed by Promises 26 and 27: related to gas migration and to anti-racism. Over this, and the coming Board meeting both are materially addressed and considered.

Moving the middle

- 2.1 38 success measures in March (reported erroneously as 37) sat in the middle. The position has slightly moved in a positive direction since. But having reviewed the position across the executive group, we see that:
 - **9 will credibly move on or before the mid-point of this year:** notably in relation to evidence around promises 5, 6, 13 and 28. The opening up of cross Trust clozapine clinics and the opportunity to move forward promise 5 success measures with CoLE in place are notable, and the availability of EMRI resources alongside Grounded Research is also impactful.
 - Almost all of the other success measures (19) should be moving towards delivery by the end of 2026 (calendar year): this relies on execution of the scrutinised Promise 2 plan, as well as extant programmes on urgent care waits, inclusion health access assessment, and paired outcomes, as well as the expansion of the Burns Court development in another geography.
 - Whilst last time I expressed some confidence we could move forward promise 21 success measures such as proactive care, Thrive and South Scunthorpe, work within the CAKE meetings suggest, in practical reality, these are further away from service improvements than had been understood. These form the bulk of the 8 measures where it now seems unlikely we can deliver in year: with one measure in relation to promise 22 moved now towards a lower rating in our league table as we have no funded weekend change plans for 26/27 but will need some for 27/28.
- 2.2 The Board recognised last time a patterning where central oversight and drive was often needed to move forward results. The above recognises and, in effect, assumes that. It also **assumes that more Executive Group time is focused on promise delivery than hitherto**. Meeting Room 3 now has visual displays set up that very much focus as a 'nerve centre' on that task: reminding us what the Board has agreed. Of those in the sticky middle, Promise 8 measures remain the most sticky: we know that the neurodiversity measure can be met, as it is largely in input measure and an important one within culture

of care – but materially shifting older adult talking therapies volumes or dementia diagnosis among black and minority ethnic citizens is proving more difficult to achieve.

- 2.3 As a first step in the path outlined, in July we will confirm whether all 12 measures cited remain on track to move ‘up’. In September we will consider the 19. In the attached league table the former group have a small a) next to them, the latter group b). **Clearly shifting 27 or so of our success measures would see us enter 2027 with the majority (52+) of the overall strategy on track for delivery.** In addition, we have a clear way forward on a number of the Promise 9 specialist employment workstreams which were highlighted last time. In particular the POD senior team are focused on employment among people with Learning Disabilities locally which is one of our four pillars.

Less discussed promises?

- 3.1 In the nature perhaps of the role research and education plays in the Trust’s life, we rarely tend to view either through the lens of their respective promises (24/28). When the Board holds its annual education and learning focused meeting in July, there is an opportunity to reflect on whether we are meeting Promise 24. Health Education England will, by then, have provided us with their review material from examining some, though not all, of our key professional disciplines. There is certainly not a lack of resource being devoted to educational supervision nor to training: and final approved job plans will likely underscore that. Contrastingly, we see modest alignment among clinicians in research, though growing interest, with all of our care groups now boasting communities of research practice, which were seen as an antecedent of success in Children’s, and increasingly in Physical Health.
- 3.2 Promise 16 is the fulcrum of the quality element of our agreed quality and safety plan. The Board will recognise that, in 2026, we are committed to our safety always measures, and to full and universal use of standard care plans, including DIALOG+. That is then, of course, the basis for rating scale and paired outcome analysis, with the latter featuring now in the National Oversight Framework for Trusts. Certainly, from mid-year, it would be helpful for the quality committee to give the outcome measurement real focus, recognising it will take time moving into 2027 to develop outcome measures across all services and directorates.

Moving forward at pace?

- 4.1 Promise 9 and 10 were identified in my last report as needing further work and clarity. I remain the executive responsible for the latter, with Carlene Holden leading on the latter.
- A comprehensive assessment of our NICE guidance compliance for homelessness and inclusion health will be completed for July to progress through our usual compliance process for clinical quality.
 - The E&I sponsored ‘secret shopper’ exercise, led by service users, will take place over this summer.

- In addition to the learning disabilities employment proposition cited above, colleagues within HR have clear plans for refugee, carer and veteran employment work.
- We have an upcoming session with relevant contacts to explore the homelessness-into-employment pathway, mindful that estate options may be relevant to live-work option.

4.2 We do not have a settled way forward on Promise 20 and virtual ward. Board members will recognise that:

- We have a well regarded 'physical health' virtual ward. The Akeso report into the Doncaster system/interfaces identifies scope for that to grow further and we are working through what it will take to enact that and how we achieve relevant buy-in across the acute pathway.
- We have begun, but only just begun, to explore with children's services future year possibilities to support their work, and we need this summer to determine more certainly our forward plan in relation to older adults. Our initial pilot in North Lincolnshire remains relevant, and our upcoming discussions over dementia may be too.

Responsibility for virtual ward remains diffuse at the executive level and we will finalise that once we are clearer on the work programme for the coming 18 months.

Recommendations

As suggested within the cover sheet, we have two promises receiving overt Board attention, and three where the work of our committees in coming months can add real value:

- RECOGNISE Board time has been scheduled twice in 2026 to ensure collective effort on Promise 26
- RECOGNISE the need for Board committees to focus on 16 (QC), 24 (E&L) and 28 (PHPIP)

Toby Lewis, Chief Executive
21st May 2026

Promises and priorities
Annex A, Board May 2026

Top third

Promises and priorities – delivery plan and delivery self-assessment

Promises & Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known or fully elaborated	Comments on likelihood of delivery
Promise 2 Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Green	The opening hours and patient/carers 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.	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 throughout Q4.	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.
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 – there is real appetite to join this up with our care group SLTs.	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 have significant work to do to make sure everyone’s contribution is supported and valued.

Promises & Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known or fully elaborated	Comments on likelihood of delivery
Promise 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: successful investment bids have proceeded in 2026 to extend this further	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. There is express confidence that this can be sustained in 26/27 but a new plan will be needed as the levy changes from April 2027.	Green	We did it! 830k of levy spend being identified with shift from high banded roles. We need to continue to grip delivery through the coming year.
Promise 13 Sustain and expand our IV provision in out-of-hospital settings.	Amber green	We agreed a plan with the care group but it remains amber green pending some further conversations over DRI buy in.	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.	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 Q2
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.

Promises & Measures of success	Delivery plan	Comments on delivery plan	Likelihood of delivery	Comments on likelihood of delivery
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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 red	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 a review of inpatient feedback from peers is being completed for mid year.
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 understand a revised national workforce plan is in the works with DHSC and HMT. In the meantime, we are fully delivering our workforce plan, assuming we reach 2.5% in December 2026.		
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	Green	No identified reason why assessment outcomes would change over coming period, and med ed concerns previously debated have been allayed.

Promises & Measures of success	Delivery plan	Comments on delivery plan	Likelihood of delivery	Comments on likelihood of delivery
	Green (G) – Finalised and agreed 		Green (G) – On track to succeed 	
	Amber/Green (AG) – Developed and being refined 		Amber/Green (AG) – Largely on track, and properly understood 	
	Amber/Red (AR) – Understood but Not well documented 		Amber/Red (AR) – Solutions known but implementation requires support 	
	Red (R) – Not constructed yet 		Red (R) – Actions to succeed not yet known or fully elaborated 	
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 time for the annual report.
Promise 26 Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.	Green	Submissions for NW accreditation at Bronze Level have been successful.	Green	These frameworks tend to be input based, not outcome derived. Organisational commitment to compliance is not in question.
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	Green	This is very much a well led measure and we would expect to succeed again in 2026/27.

Middle third

Promises and priorities – delivery plan and delivery self-assessment

Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known or fully elaborated	Comments on likelihood of delivery
Promise 1 Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care. B	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. B	Amber green	Self-assessment baseline overdue being finalised by July.	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. B	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 2 Identify all-age carers that use our services and ensure their rights under the carers act are recognised. B	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 4. Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026. A	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 did evidence to evidence a small number of meaningful impactful changes in our 26/27 Quality Account. This needs to become routine in year collated information.

Measures of success	Delivery plan Green (G) – Finalised and agreed  Amber/Green (AG) – Developed and being refined  Amber/Red (AR) – Understood but Not well documented  Red (R) – Not constructed yet 	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed  Amber/Green (AG) – Largely on track, and properly understood  Amber/Red (AR) – Solutions known but implementation requires support  Red (R) – Actions to succeed not yet known or fully elaborated 	Comments on likelihood of delivery
Promise 5 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	We will work with CoLE in July to think through what full deployment could look like with a meaningful trajectory.
Promise 5 Apply patient participation tests to new policies and plans developed within the Trust . A	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 April.
Promise 5 Deliver the annual priorities set by our council of governors B.	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). B	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. The texting/travel passes are the key step.
Promise 8 Increase diagnostic rates for dementia among minority ethnic citizens. B	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. B	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, and was again missed. 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 B	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 B	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 10 Specific service offers in place for all or most inclusion health groups by 2027. B?	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.
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. B	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 H1 2026.	Amber green	As part of Promise 1 work, need to confirm that arrangements are in place for the Trust to support relevant peer led groups and to connect that work to service evaluations. We expect this work to include an externally hosted peer worker, which we understand is imminent.

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Promise 12 Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access. B	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.
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. A	Green	Both Doncaster and Rotherham AMH have service plans internally: with a successful Invest Fund bid agreed for North Lincs.	Amber green	CLE has agreed that this will be in place in all 3 areas by June 2026
Promise 13 Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme. A	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 – bandwidth alone is holding this back.
Promise 14 Meet 48 hour wait standard in 2025/26 for all urgent referrals. B	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 green	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 16 Report and improve patient recorded outcome measures (PROMS) supported nationally. B	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.

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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. Our culture of care assessment is complete and has been considered within CLE.
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. A	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. 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. A	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. <u><i>Moving to zero may not be achievable.</i></u>
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 (sometimes) the focus of neighbourhood proposition in North Lincolnshire: work to be done to ensure that all partners are focused on the same success measures and changes in ways of working.	Amber red 	We need to ensure that focus has not been lost on this geography as the work to join up ways of working is ongoing.
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 – request of CCG to finalise the metrics we might use.

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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 green	Work still to be done to model care home option as part of neighbourhood planning. Good engagement with Rotherham colleagues on how to have RDaSH play a larger part.
Promise 21 Consistently integrate our community mental health offer with that provided by voluntary sector organisations, sharing training, data and expertise to improve outcomes. B	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 green	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 22 Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services. A	Amber green	N&F have submitted drafts of this work to CLE. It needs further refinement into a final document, which we will a) have available in April 2026 and b) precis within our 25/26 quality account.	Amber green	This input measure can be met: mindful of SDR 4 the more challenging question will be what we plan to do as a result. That has two parts to it: our own crisis teams, and work across MHLDA on system wide mutual aid/change.
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. B	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	The sole barrier presently is identifying a housing partners for Doncaster. May move to market offer during Q1 if we are to deliver during 2026 – a key objective for strategic development team.

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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 brought all partners together at Tickhill Road under the auspices of the HWBB. Very encouraging support from other agencies including LA, PCD and DRI	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). A	Amber green	Implementation deadlines are clear and being met but some supply chain issues to resolve: next data review with finance team at April delivery review.	Green	Measure defined, suppliers aware. Food and travel most challenging areas to execute, albeit both consistent with P27 agenda.
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. 2025 data being analysed. However, there are some adverse indications in our recent quarterly HR data.	Amber green	A complex and longstanding issue, which, is subject to events beyond the Trust. We have work to do to build trust and confidence among BME colleagues. The move to being anti-racist has to be manifest in how our 555 line managers operate. We need evidence in fairly short order if this is not to move to amber red.
Promise 27 Agree and deliver specific contribution to local authority climate change plans. B	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. B	Amber red	Significant work is now needed to convert the research priorities we have agreed into a delivery plan owned across Care Groups: communities of practice are all now launched which will help to move this measure rapidly to amber green in time for June 2026.	Amber red	The 2028 ambitions are deliverable, but a cultural shift is probably needed in how GR/CGs operate together

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Promise 28 Work to further increase the reach of research into excluded communities locally. A	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 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 further at the June 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 – all appt texting starts from May 2026.
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 is now clear we will not meet this measure in LD in 25/6. But we do not have a delivery plan for 26/27 either – with no reconciled registers in place. 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 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

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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	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 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	The ratings here have not changed since March but as set out in the report there is much work being done to improve this position.
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. May E&I group will have sight of intended plan, across all inclusion health groups.	Amber red	This will require concerted work to make ‘mainstream’ services available, as well as to develop specialised services. Baseline mapping will take place in June and July 2026.
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 12 Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.	Amber red	Not yet meaningfully planned but will be accelerated as we try to ensure our estate plan does not consume all available resource.	Amber red	Rating reflects planning comments made: we need to describe a standard village offer before the end of Q1.

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Promise 15 Support development of integrated neighbourhood teams (INTs) in 2024/5 in all three places.	Amber red	It is broadly positive that the ten-year plan places such emphasis on this space. The emerging challenge is to ensure that we work as neighbourhoods not place. During Q1, realistically, it should be possible to review the scale of changes needed in our teams to move from current to future state. This will be important to wider work to reform how community teams work and the balance of generalism and specialism.	Amber red	Time passes and 26/27 is the earliest feasible delivery date now for restructure. There remains some enthusiasm to shift services onto neighbourhood settings on a pilot or targeted basis.
Promise 15 Restructure Trust services into those INTs during 2025/26.	Red	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 red	
Promise 15 Evaluate and incrementally improve joint working achieved through these teams.	Amber red	This forms part of our Q&S plan but may take us half way into 2026/27.	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	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	The illustrative example of DIALOG+ and paired outcomes needs to be studied as we develop an approach to other directorates and services: we will be asking the CMO team to lead on this work during Q2.
Promise 17 Narrow the school readiness gap between our most deprived communities and average in each place in which we work.	Amber green	Establishing this data feed is taking time and requires collaboration across a number of teams inside and outside the Trust. Annual data is feasible as we look to stem a deteriorating position.	Amber red	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		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.

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Promise 20 Introduce and evaluate virtual ward pilot into our mental health services 2024/25.	Amber red	We implemented a pilot proposition in North Lincolnshire older adult care, as part of implementing the Phase ¾ changes. <u>This has shown promise but also highlighted the nature of the difference required.</u>	Amber green	Clearly the timescale has passed, but it remains possible to deliver this measure – we are exploring how best to do that across mental health services moving into 2027.
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 <u>did not come forward within planning for 25/26.</u> Discussions will continue with the CCG as we look to manage longer term support to complex young people.	Red	See lack of plan – left side
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.
Promise 22 Support substantially increased discharge and admission capacity over weekends.	Red	This will be an important part of our work on promise 19, and efforts to reduce LOS. To have a coherent plan we are going to need to develop criteria led discharge and to make decision shift to expecting weekend teams to offer support to early stage discharges.	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 in July to connect up services and build confidence to succeed
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 – with real hotspots emerging.	Amber red	The Board will again discuss racism when we meet in July to understand what has happened since November: and to ensure that our work on culture addresses head on the lived experience of staff inside the Trust.

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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 – among those dependencies is patient travel, which counts towards our net zero target. If we proceed with Ambient Loop the ratings for this will change.
Promise 27 Change service models for patients and staff to reduce travel required by 2027.	Red	A lot of good work has been done to move this forward. The remote working template is nearing completion. But the red rating reflects the need to pull this work together into a plan of actual action that makes a scaled difference. During Q1 this has to happen.	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. As we begin redesign work in community services we will work through our changes from this ‘angle’ as part of our community development event on June 30th.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Organisational Change Key Performance Indicators	Agenda Item	Paper O
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Dr Judith Graham, Director of Psychological Professionals and Therapies, Dr Sinclair, Chief Medical Officer & Steve Forsyth, Chief Nursing Officer		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
The Board is asked to discuss two points within this paper: 1. Whether the early QSIA KPI findings for April and May 2026 provide sufficient guarantee that the change management and vacancy removal programme is not currently creating significant adverse effects on quality, safety, access, workforce support, or experience. 2. Whether the Board is satisfied that the monitoring, governance, validation, and escalation arrangements described in the paper are robust enough to identify and respond promptly to any sustained adverse trend as data maturity improves.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
N/A			
Recommendation (delete options as appropriate and elaborate as required)			
The Board is asked to:			
NOTE that no significant adverse trends have been observed in the initial two months of QSIA monitoring (April–May 2026), indicating no immediate intervention is required before the end of Q1.			
RECOGNISE that robust monitoring mechanisms are in place, with clear governance and escalation processes, and that any future sustained adverse trend (“signal”) will trigger prompt action. Early data should be interpreted with caution, as several new indicators lack historical baselines and some fields are still undergoing validation.			
Alignment to strategic objectives (indicate those that the paper supports)			
SO2: Create equity of access, employment, and experience to address differences in outcome			X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services			X
Alignment to the plans: (indicate those that this paper supports)			
People and teams plan			X
Finance plan			X
Quality and safety plan			X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	
Financial risks			

Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X		
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.			
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.			
Patient care risks					
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X		
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X		
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that support care quality.			
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.			
Performance risks					
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.			
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.			
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.			
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.			
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.			
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.			
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.			
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.			
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.			
Strategic Delivery Risks (indicate those that this paper supports)					
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees			X		
System / Place relevance (advise whether it is national, regional or local)					
Equality Impact Assessment	Is this required?	Y	N	If 'Y' date completed	Completed – Board approval
Quality Impact Assessment	Is this required?	Y	N	If 'Y' date completed	

Appendix (please list)
Early KPI Data Snapshot (April–May 2026)

1. Purpose & Context

A Quality & Safety Impact Assessment (QSIA) framework was established to monitor the early impact of a suite of change management and vacancy removal schemes launched in April 2026. These changes span five Care Groups and corporate functions, affecting approximately 70–95 whole-time equivalent roles, ranging from team restructures to pathway, role, and clinic-hour adjustments. The purpose was to determine whether these changes would compromise patient safety, access, or staff support. Each scheme has specific KPIs aligned to its risks (e.g. access, response times, safety incidents, workforce support). This paper provides early findings on monitoring, highlighting any emerging trends and advising whether any action is required before the end of Q1.

2. Monitoring Approach & Data Maturity

Monitoring draws on established Trust systems (patient records, incident reporting, workforce data, and feedback sources) and is collated into a central QSIA dashboard showing monthly values and month-on-month trends. Early data are partially immature: several indicators are new and lack historical baselines, and some April–May fields have only recently completed validation. Interpretation therefore follows SPC-style principles: one-off monthly movements are treated as normal variation; only sustained trend changes constitute a signal requiring escalation.

3. Key Early Findings (Emerging Trends)

Overall, the first two months' data show no sustained adverse trends across access, safety, workforce, or experience. Most KPIs are flat or show minor month-on-month variation consistent with normal fluctuation.

Peaks: None identified at this stage. Incident and unmet-need counts remain low, although early data should be interpreted cautiously.

- Troughs: None identified that meet escalation thresholds. Small movements in activity, waits, DNAs or cancellations remain within expected ranges.
- Workforce & Experience: No early indication of reduced supervision, training support, or deterioration in patient or staff feedback.

4. Implications & Need for Action

No immediate action is required before the end of Q1, subject to continued monitoring and final validation of May data. All observed movements are within expected limits and assessed as common-cause variation rather than a sustained adverse trend. Clear escalation routes are in place should sustained deterioration emerge.

5. Governance, Oversight & Transparency

The Board can be confident that robust, proportionate monitoring is in place and that no early KPI trends indicate a need for intervention at this stage. Vigilance will continue as data maturity improves.

Monitoring is embedded within established governance, with regular review through quality forums and escalation by exception. The approach is transparent and publicly reported, reinforcing confidence that unintended harm would be identified and addressed promptly.

6. Conclusion

The Board can be confident that robust, proportionate monitoring is in place and that no early KPI trends indicate a need for intervention at this stage. Vigilance will continue as data maturity improves.

Appendix 1 – Early KPI Data Snapshot (April–May 2026)

Alignment of QSIA Schemes and Early KPI Data (April–May 2026).

The table below cross-maps each Quality & Safety Impact Assessment (QSIA) scheme to its care group and corresponding Key Performance Indicators (KPIs) from the April–May 2026 data snapshot (Word doc Appendix 1). It highlights where KPIs align clearly with the scheme's intended success measures, where alignment exists but is implicit, and where a scheme is missing or only partially represented in the early data. "N/A" and 0%/0 values indicate that a metric is not yet recorded (a data gap / immature indicator, as noted in the Excel file) and should be labeled as such for consistency.

The referencing in the tables below is simply to a numeric per Care group. Future reports to Board will incorporate a unique scheme reference number to ensure consistent points in future discussions and analysis.

Children & Young People (CYP) Care Group

This care group implemented multiple schemes (CYP1–CYP13) in April 2026. Most are monitored by specific KPIs in the early data snapshot, showing no significant changes in April–May. One scheme (CYP3, Practice Educators) has no data yet (not in Appendix 1 due to unavailable metrics). Below is a mapping of each scheme to its metrics:

Scheme (#)	Scheme Descriptor (CYP CG)	KPI (April–May 2026)	Apr '26	May '26
1	Call Handlers	Number of abandoned calls	185	146
		Average call answer time (111) (data not yet available)	0	0
2	Child Sexual Exploitation	(No specific KPI – safeguarding duties monitored via incident reports; no incidents reported)	N/A	N/A
3	Practice Educators	(No KPI – data not currently held)	N/A	N/A
4	With Me in Mind	% staff receiving required supervision	0.0%	0.0%
		(Supervision data relies on new report; not yet populated in April–May)		
7	Sexual Health drop-in sessions	# Attended clinically relevant contacts	38	40
		# Did Not Attend (DNAs)	4	2
		# Cancelled contacts	2	2

8	Nurse Consultant	# Attended clinically relevant contacts	15	6
		# DNAs	0	0
		# Cancelled contacts	1	0
9	North Lincs School Nursing	% NCMP completed – Reception year	0.0%	0.0%
		% NCMP completed – Year 6	0.0%	0.0%
10	Doncaster School Nursing	# Attended clinically relevant contacts	2,122	3,220
		# DNAs	5	4
		# Cancelled contacts	7	3
11	Health Visiting	Numbers on caseload (Health Visiting)	1,743	1,813
		%(positive/negative) feedback from service users	0 / 0	0 / 0
13	Health Bus Driver	No direct KPI (minimal measurable impact) (No “unmet needs” recorded)	N/A	N/A

Key: NCMP = National Child Measurement Programme; “N/A” or 0 indicates data not yet collected or not applicable.

Doncaster Adult Mental Health & Learning Disabilities (DMH & LD) Care Group

This care group implemented five schemes in April 2026. Three of the five (DMH&LD1, 3, 4) have corresponding KPIs captured in Apr–May. Two schemes (DMH&LD2 and DMH&LD5) have incomplete or undeveloped measures and are not clearly reflected in early data. The table below aligns each scheme with its KPIs:

Scheme (#)	Scheme Descriptor (DMH & LD CG)	KPI / Measure	Apr '26	May '26
1	LD Band 7 Role review	% staff receiving required supervision (LD teams)	0.0%	0.0%
		# Urgent dysphagia referrals >14 days wait	75	87
		# Patients on Rotherham LD – Art Therapy caseload	41	41

2	LD Care Home Liaison	<i>(No specific KPI – “Always measure 5” currently undefined; no direct early data)</i>	N/A	N/A
3	Early Intervention in Psychosis service changes	# Attended clinically relevant contacts	0	0
		# DNAs	0	0
		# Cancelled contacts	2	2
4	Primary Care Mental Health	# Attended clinically relevant contacts	999	979
		# DNAs	72	68
		# Cancelled contacts	229	200
		# Patients waiting for assessment <4 weeks	19	16
		# Patients waiting for assessment >4 weeks	54	81
		# Patient complaints (GP referrals)	0	0
5	Assertive Outreach & Rehab	# DNAs	8	8
		# Patients on Rotherham Assertive Outreach Team caseload	119	119
		<i>(Other KPI measures TBD – “not sure what is required”, per plan)</i>		

Key: “LD” = Learning Disabilities; EIP = Early Intervention in Psychosis

North Lincs Adult Mental Health & Talking Therapies (NLMH & TT) Care Group

This care group implemented multiple schemes. Several scheme KPIs are reflected in the early data (showing stable performance or slight improvements), while a few measures (those marked “not sure” in Excel) did not yet produce separate KPIs. Mapping:

Scheme (#)	Scheme Descriptor (NL MH & TT CG)	KPI / Measure	Apr '26	May '26
1	ARMS Pathway review	# Patients waiting for assessment <4 weeks	9	16
		# Patients waiting for assessment >4 weeks	3	6
2	ARMS Psychotherapy	# Attended clinically relevant contacts	508	557
		# DNAs	72	61
		# Cancelled contacts	47	45
		# Patients waiting for assessment <4 weeks	9	16
		# Patients waiting for assessment >4 weeks	3	6
3	EIP Support Worker	# Attended clinically relevant contacts	15	6
		# DNAs	0	0
		# Cancelled contacts	1	0
6	Community SMI (health checks)	% patients with all 8 SMI health checks completed	0.0%	1.0%
		# Unmet needs identified	0	0
7	Medication Mgmt Clinic	% annual medication reviews done (within 12m)	N/A	N/A
		<i>(Measure in development; not in early KPI snapshot)</i>		
8	Primary Care Hub (routine) changes	# Patients waiting for assessment <4 weeks	19	16
		# Patients waiting for assessment >4 weeks	54	81
9	Memory Service Nursing	# Patients waiting for assessment <4 weeks	9	16

		# Patients waiting for assessment >4 weeks	3	6
		# Patients on Memory Team caseload (Rotherham)	671	630
10	Memory Service OT	# Patients waiting for assessment <4 weeks	16	16
		# Patients waiting for assessment >4 weeks	54	81
		<i>(No adverse impact on waitlist or capacity observed in early data)</i>		

Rotherham Adult Mental Health Care Group (RCG)

Two schemes in the Rotherham Care Group involve service integration and re-structuring. Both have relevant KPIs tracked, but scheme RCG2's supervision metric is not yet available early on:

Scheme (#)	Scheme Descriptor (Rotherham CG)	KPI / Measure	Apr '26	May '26
1	Health & Wellbeing service integration	# Patients waiting for assessment <4 weeks	N/A	N/A
		% patients on caseload with Dialog recorded (12m)	5.0%	6.0%
2	Primary & CMHT OT hub merger	% staff receiving required supervision (OT)	0.0%	0.0%
		<i>(Supervision report data not yet captured for new OT structure)</i>		

Key: CMHT = Community Mental Health Team; "Dialog" refers to patient-rated outcome measure.

Physical Health & Neurodiversity (PH&N) Care Group

This care group implemented numerous schemes affecting community physical health services. Most schemes are monitored via service volumes (caseload, contact counts) and waiting times. Early data show minor fluctuations but no alarming trends. Some metrics (like *Central Access Point* changes) are pending development (“Always measure 5” – not in snapshot). The table below details each scheme and its KPIs:

Scheme (#)	Scheme Descriptor (PH & N CG)	KPI / Measure	Apr '26	May '26
1	Palliative Care service model change	# Incidents reported via RADAR	0	0
		<i>(No increase in clinical incidents or harm – target met so far)</i>		
3	Integrated Discharge (	# Delays in discharge	211	194
6	Centralised Access (CAP) introduction	<i>(No specific KPI – “Always measure 5” not yet defined; no early KPI data)</i>	N/A	N/A
7	Night HCSW role change (unplanned care)	# Incidents reported via RADAR	0	0
		# “No access” home visits (unattended)	3	7
8	Neighbourhood teams merger	Caseload at month-end – Planned care	276	157
		Caseload at month-end – “TVAL” service	2,000	2,012
		Caseload at month-end – Diabetes service	1,739	1,763
		# Cancelled contacts – Diabetes service	1	0
		Caseload at month-end – Specialist Palliative care	76	81
		Caseload at month-end – End-of-Life care	612	529
		Caseload at month-end – Continence service	4,285	4,309
		Caseload at month-end – Phlebotomy service	326	324

9	Urgent Care Team leadership	<i>(No specific KPI set; measure under development)</i>	N/A	N/A
10	Macmillan Info Centre role expansion	# Patients waiting for assessment <4 weeks	N/A	N/A
		<i>(No waits currently for service; consistent with expectation)</i>		

Corporate (Backbone) Functions

The Finance & Procurement scheme (invoice scanning solution) has a clear KPI tracked – the percentage of invoices paid within 30 days, which remains on target (≥95%) in Apr–May:

Scheme	Corporate Initiative	KPI / Measure	Apr '26	May '26
Finance & Procurement	Invoice scanning solution	% invoices paid within 30 days	96%	95%

Observations & Consistency Notes: The early KPI data suggests that no scheme is causing adverse effects in these first two months; most KPIs are flat or fluctuating only within expected common cause variation. Where data fields are immature or unavailable (marked as *N/A* or 0%), the Board paper should explicitly note these as “*data not currently available*”.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	Agenda Item	Paper P
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
It is positive that the overwhelming majority of employees impacted by organisational change have been placed into revised roles and our pay-bill position is within the post-CIP parameters we agreed and submitted externally. Despite national deadlines, neither local ICB has complied meaningfully with the need to share, or agree, a contract for 2026/27 and an oral update will be offered on whether our many, many actions to escalate and resolve this have succeeded in time. We recognise both ICBs are amid their own personnel changes.			
The Board's agenda continues our sustained interest in improving our culture, and includes The Value Circle Well-Led report: in common with the [draft] highest possible assurance rating from our internal auditors, our work in partnership with others, and their feedback on the distinctive nature and success of that, is important - perhaps especially as we begin our Communities' Leadership Executive experiment. As we move into a two year journey to nurture the culture our staff, students, volunteers and patients deserve (high care, high challenge), we need to be measured and intentional in what we do, recognising that the journey will not carry everyone with us, but that the feedback of staff, who have joined us since 2023, offers encouragement: even as we face honestly up to the not unanticipated pain and criticism of many within our staff survey and elsewhere.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
n/a except CLE annex			
Recommendation (delete options as appropriate and elaborate as required)			
The Board of Directors is asked to:			
EXPLORE the patient, people and population issues described			
CONSIDER any matters of concern not covered within the report			
NOTE the uncertainty over our Q1 'segmentation' outcome with NHS NEY			
Alignment to strategic objectives (indicate those that the paper supports)			
SO1: Nurture partnerships with patients and citizens to support good health			X
SO2: Create equity of access, employment, and experience to address differences in outcome			X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services			X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings			X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			X
Alignment to the plans: (indicate those that this paper supports)			
Estates plan			X
Digital plan			X
People and teams plan			X
Finance plan			X
Quality and safety plan			X
Equity and inclusion plan			X
Education and learning plan			X
Research and innovation plan			X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
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.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
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.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
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)							
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1							X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services							X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.							X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees							X
System / Place impact (advise which ICB or place that this matter relates to)							
Contract gaps should be of real concern as they vitiate the intention of national returns.							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Annex 1: CLE summary April and May 2026							
Annex 2: Communities' Leadership Executive (CoLE) notes May 2026							
Annex 3: Current register of Trust vacancies – as at time of issue							
Annex 4: National publications – April/May 2026							
Annex 5: Neurodiversity activity and wait scorecard							
Annex 6: South Yorkshire Eating Disorders Joint Committee Meeting Note – 11 th May 2026							
Annex 7: South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note – 13 March 2026							

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report - May 2026

- 1.1 The intentional development of **our organisational culture** is very much the focus for a number of Board papers being discussed this month. Over coming weeks, we want to be clearer about our flexible and remote working plans to 2030, more specific about the work to become an anti-racist organisation, and more focused on what it will take to become a high care/high accountability Trust, with both elements of that ambition needing sustained work. Whilst the poor 2025 staff survey comes as no surprise, the work to turn around a trend line over some years is needed if we are to sustain lowered vacancy rates and improve retention further, and address our outlier sickness position.
- 1.2 We should be concerned by progress implementing **a consistent DIALOG+ care plan**. There is some encouragement from the near 100% position across our wards, but it remains surprisingly contested in community settings that we need a single plan document instead of other localised forms. RDaSH has long struggled with this topic (see 2019 CQC reports, Board debates in 2023 etc) and a relentless quantified programme to see this resolved is a feature of the first half of this new year. Paired outcome measurement, central to our Quality and Safety Plan, follows from this enabler.
- 1.3 The organisational changes, which form almost half of our financial plan for the current year, are now being implemented, further, to go-live Board approval in March. The majority of at-risk staff have been placed into suitable alternative employment trials, which continue. KPI tracking of safety impacts is separately reported to the Board this month and **productivity measurement** is also ongoing: July's Board meeting will have chance to review Q1 data, recognising that, across the Trust as a whole, we are looking for not less than a 2% activity gain, including through reducing missed appointments. Text reminders across all ambulatory services begin this month, including notification of our travel subsidy scheme arising from the Poverty Proofing work we have done since 2024.
- 1.4 I reported last time that we were entering the year without sight of the proposed NOF (**National Oversight Framework**) **measures for 2026-27**. The Trust had spent 2025-26 at segment 3 (of four), owing to the finance override applied because we received deficit support funding. With the same metrics on April 1 we would, therefore, be rated at 2. However, a raft of novel measures have been published, but as yet without data definitions and, moreover, without sight of peer group comparison. Initial publication in July will, therefore, be something of a lottery, which we can explore further at the next Board meeting. We have raised concerns that the format ostensibly proposed for restrictive intervention and incident reporting measurement raises perverse incentives that we will wish to resist.

Our patients

- 2.1 We have received **a Prevention of Future Deaths** (PFD, Reg 28) notice in respect of the death of our patient, Delwyn. The Board is familiar with unrelated 2023 and

2024 notices issued by the coronial office. The key actions in response to this notice are in hand, and were undertaken prior to receipt: an auditable focus on timeliness of record keeping and an end to long-day, end of shift recording, together with the alignment of our Section 17 leave policies with actual practice. Both changes have been widely, formally and informally, communicated, and initial audit work will come to the Board in September. In July, we need to review the first phase engagement/disengagement data from our revised 2025 policy – a set of changes which pre-figure what we expect may emerge from the Nottingham Inquiry.

- 2.2 We discussed disparate community practices in mental health in March, and before that in September 2025. We only avowed amber level confidence in our assertive outreach practice. In October 2026, our physical health teams will move to a new neighbourhood configuration and general/speciality split in Doncaster. The **Community Powered Healthcare Taskforce**, modelled on our HQTc, will start work in July, after a launch event in Hexthorpe on June 30th. The taskforce will need to juggle the contra-distinction between much greater consistency of approach across teams and places, with shaping work to fit neighbourhoods and people. The benefit for our patients needs to be clearer expectations of us and perhaps, thereby, an improvement in complaints about communication, highlighted in the learning review, which came to the Board last time.
- 2.3 **PCREF** remains a useful comparative tool through which to consider our widespread work on equity, specifically in relation to discrimination. Our annual review (self-assessment) shows strong progress, and a real prospect during 2026 of the overwhelming majority of measures reaching a good rating. Ultimately, it must be right for patient groups to judge our evidence, as we do with, for example, PLACE ratings, and we will be working with our Communities' Leadership Executive and Council of Governors to undertake that later this summer. Prior to that, the work we commissioned through Diarmid Sinclair to look at presenting population data vs detained population data through the lens of ethnic origin must be completed: Board members are reminded that we continue to detain disproportionate to the underlying census population data.
- 2.4 **Families First** is one of several local government led 'left shift' programmes to which we need to pay attention (alongside Pride in Place). Christina Harrison is leading our work to support directors of children's services as we look to 'fuzzy' boundaries between agencies and better wrap MDTs around the needs of a household. Working jointly with North Lincolnshire and Doncaster, we want to ensure that our health visiting and school nursing services, in particular, make their contribution, recognising that a generalist service expectation remains the contracted position.
- 2.5 **Out of area placements** continue to be kept at the lowest levels in our records (<7). Since we took on the budget/risk in South Yorkshire, we have been able to reduce use of such placements to zero levels (since January 2026), and discussions continue over the best approach in North Lincolnshire. Simultaneously, we are working to help tackle complex care placements for the wider ICB. Phoenix now has ten patients, and we are cautiously optimistic of fully occupying the ward by the end

of June – which is a major financial risk reduction in our plans, but more importantly, a key benefit to patients.

- 2.6 On May 31st *work completes on the Great Oaks ward refurbishment in Scunthorpe*. This is the final mental health ward transformation, following investments in Swallownest Court, and in our acute ward triptych at Tickhill. But we now begin **the cross-site gardens project**. The decision to place outdoor green space at the heart of our therapeutic activities work is important, merits future research enquiry, and is a refocusing on our grounds and gardens team away from the wider ‘park’, which we are largely rewilding, pending some disposal decisions this summer.

Our people

- 3.1 Sustaining promise 3, having got above 350 volunteers, is an important step for the Trust. **The evaluation work on volunteering** will feature in future Board discussions, alongside a clear infographic of which teams do, and which teams currently do not, benefit from volunteers. In the autumn, we will return to the subject of creating volunteering time in our communities for our staff. Volunteers will be celebrated at our annual fun day on July 18th, and it is increasingly clear that this route into employment is becoming significant for us, perhaps especially in reaching some communities, which we had previously struggled to do. Work experience access featured strongly in our last council of governors meeting, and we need to be confident that, for the next school year, that work will be offered at scale and equitably to local young people.
- 3.2 In executing our redeployment process, as part of organisational change, we have made use of ‘centralised’ **recruitment panels**, removing local line managers from hiring decisions. The intention is to retain some of those changes for the great majority of vacancies to which we hire during 2026. We have hard work ahead to move from over 250 vacancies down to our target level of 100, at a time when exit rates have risen (as we expected them to do). It is important that this summer sees significant recruitment, and then induction of new starters within our organisation, as we aim to reach 2.5% before the end of the calendar year.
- 3.3 Multi-faceted efforts to address sickness absence, and indeed **to reduce sickness**, are discussed within a distinct paper before the Board. At any given time, almost 200 colleagues are away from work, some backfilled by bank, but many not. The strain this pattern places on teams, alongside parental leave absence, is something we need to place at the heart of our considerations of workload and productivity – and we need to work to consider a better visual of that cumulative impact across our directorates and their teams. It also explains why job planning all senior clinicians properly is so important as a boundary setting and protective measures in strained and stretched teams.
- 3.4 There is real encouragement to be taken from **the latest annual NETs survey** of trainee experiences. RDaSH again performs comparatively very strongly, building on a tradition of medical education in the Trust. From August 2026, we will rebalance some roles between our sites, putting more roles into Doncaster and North Lincolnshire, responding to trainee feedback about ‘crowding’ in Rotherham. Joe

Brougham has been appointed to the Resident Doctor Lead role for the Trust, and Kath Lavery will be the Board's non-executive champion for resident doctors, both facets of the national ten-point plan.

- 3.5 At a joint conference with colleagues at SHPU, we have launched our **social work vision** document. This sets out how we will support the discipline within the Trust, and how we can sustain identity in the context of multi professional teams. With over eight social workers within the Trust, we are one of the largest local employers and will look to play our part in educational programme commissioning locally, even as some universities step back from provision.
- 3.6 The full suite of our work on anti-racism is being socialised and finalised. In the meantime, from July, **all interview panels at band 7 or above at the Trust will be mandatorily required to be ethnically diverse – or they will not proceed**. One in seven RDaSHians are drawn from GM/BME backgrounds, a major change from earlier this decade. The interview panel change is intended to support promotional equity, as distribution at more senior levels of the Trust (especially if we exclude medical posts) is not keeping pace with our wider work on inclusion. Training to prepare for this change, and to make it real, not tokenistic, has been taking place for some time and the project featured prominently in our latest monthly online staff team brief.

Our population and partners

- 4.1 We are all mindful that both Rotherham and Doncaster are part of the national **neighbourhood health pilot process** and, of course, latterly we have the framework for neighbourhood health published. No neighbourhood contracting model is yet visible and we are advised that may not come until next year. Iona Johnson's work is helping us to accelerate our own thinking, and this summer we will begin work to move to the adult physical health neighbourhood model in Doncaster that was an accompaniment to other changes of almost £1m within our change programme in April.
- 4.2 Statutory partners across Doncaster commissioned Akeso in late 2025 **to help us to size the opportunity of collaboration with a dual focus on outpatient transformation within the DRI and the potentiality of the RDaSH-located frailty, or pond, project**. This work, allied to the clinical leadership being offered by Ben Allen and Cora Turner, is showing real promise to help re-size the acute hospital and develop a more coordinated offer for older adults under the auspices of the city's Health and Wellbeing Board.
- 4.3 Further to discussions in the prior Board in private, owing to commercial confidentiality, it is now widely known that **we signed the Waterdale contract**. We hope acute partners will join in with the development, but the first phase is having patients from our CAMHS pathway sited on the first floor by March 2027. The wider regeneration of the city centre, of which this project is a key part, is moving forward at pace and, on a future occasion, we will ask the local authority's development partner to share their plans with the board as an accompaniment to our own estate master-planning work, which returns to our meeting in late July. Following the OBC

support given in March, frontline employee engagement work for this project is moving ahead – focusing on what is valued about our existing estate and what are the gains sought by our teams from some fairly-radical changes before 2030.

- 4.4 The largest risk to the delivery of our promises remains the mixed progress being made with **our inequalities related objectives**. A renewed drive to return to our prior success, in respect of annual health checks, sits alongside the completion of all our poverty proofing work in September. Positively, our homeless health team has now started work, and reviews of our Promise 10 NICE compliance, and some ‘mystery shopper’ exclusion audits are ongoing. Moving faster with promises 8 and 9 is crucial if strategic objective 2 is not to become unachievable as we move next year into the final two years of the strategy. Jo McDonough and Carlene Holden are focusing resources around these two promises, *which both rely on our ability to work differently with different communities*.
- 4.5 The Board should be aware **our three-year plan submission** (2026-2029) received a compliant rating from NHS North-East and Yorkshire. Somewhat perplexingly four conditions were appended to this approval, and when we meet with the regional team on June 1st we will seek further clarity on these conditions before a chair-to-chair reply will be issued.
- Provision in Q1 26/27 of a workforce reduction plan: given that the submission itself contains this, and the changes are already concluded we are seeking clarity on the value and form of this.
 - Details of any unidentified CIP plans: given that the submission makes explicit that there are no unidentified plans, we suspect this is a standard clause sent to us in error.
 - Further work on out of area placements: we have already made clear we will not be further amending the plan, which we are already exceeding, with fewer OOAP than feared.
 - A Board approved sickness implementation plan: this has merit and its before the Board on this occasion. Clarity on the format of submission has been sought.
- 4.6 I am conscious that the governance of Your Hearts and Minds runs via our trustee, not our Trust, Board. Notwithstanding that, it is worth highlighting here that we ended 2025/26 with our highest ever income total, and one that, if the improvement trajectory was maintained, **would see us reach our aim of a £1m per year charity in 2027**. Given the big ambitions of our five missions, this is timely as we consider not only how we deliver on the Hydrotherapy Pool appeal as soon as we can, but then move onto our strategic aims, including in both research and education, committing some if not much of longstanding assets of the charity in that regard.

Toby Lewis, Chief Executive
21 May 2026

Annex 1

Clinical leadership executive summary April and May 2026

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

April	May
Social work vision/delivery plan 26-29	Cultural commitments work
Successor arrangement for cowheels	Flexible/agile/remote working arrangements
Estate plan deployment/roadshows	Community Clozapine position in all 3 places
Community services directory	Reducing Restrictive Interventions advocates
Care Group SLT priorities 26-27	Community powered healthcare taskforce
	Culture of care second phase report

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

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

Over the next two meetings (June/July) we will consider in particular:

- Execution of transitional care plan for young adults across services
- Being ready for Always measure implementation during Q1
- Sickness absence approaches/deployment
- Our appraisal model for 2027/8
- Promise 2 work to improve our engagement/activity in relation to carers

Toby Lewis, Chief Executive
22 May 2026

Annex 2

Communities' leadership executive summary May 2026

Board members will recognise this body arising from Promise 5. After recruitment and selection in March, and development work in April, it met for the first time in May and started its work of prioritisation, which we expect will conclude in June.

Sixteen organisations form the executive, with five drawn from each of our three places and the People Focus Group, our longstanding LERO partner since 2022, operating across sites, and linking CoLE with CLE. A profile of all sixteen will appear in Trust Matters in June. One of our governors, Chris Pope, from the North Lincolnshire parent carer forum is a member of CoLE.

For this month, the visual minutes are shared. Typically, a briefer report, akin to the Clinical Leadership Executive note will be used.



RDASH Communities' Leadership Executive

Visual Minutes



Meeting Summary | Date: 7th May 2026



Rotherham Doncaster
and South Humber
NHS Foundation Trust

1 MEETING INTRODUCTION & PARTICIPANT SELF-INTRODUCTIONS



15 of the 16 member organisations were represented with apologies noted from Changing Lives Through Changing Minds.



They were joined by:

- Dr Jude Graham, Director of Psychological Professionals and Therapies
- Nomalanga Makhanda, Deputy Chief Allied Health Professional
- Paula Rylatt, Head of Quality and Promises
- Iona Johnson, Community Development Director

3 CLINICAL SERVICES

RDASH provides a wide range of mental health and physical health clinical services.

SERVICE CATEGORY	KEY OFFERINGS
Mental Health (Children & Adults)	Children's services, CAMHS, e-psychology assessments, therapy, Improving Access to Psychological Therapies (IAPT), inpatient care, crisis services
Learning Disabilities & Forensics	Secondary care community services, day habs and specialist services for adults with learning disabilities and / or forensic, Conductive Education Service.
Physical Health (Adults)	Community services including district nursing, diabetes and cardiac clinics, and community hospital wards integrated with mental health teams.
Neurodiversity & Specialty Care	Neuro-diversity offer (ADHD, AS assessments), parental ADHD and ASD services, perinatal mental health and recovery services.
Other Services	Wholebody service (eating, continence services), and community IV infusions.

2 ORGANISATIONAL OVERVIEW: RDASH NHS FT

RDASH provide a diverse range of services proudly delivered with pride in serving the community that she also lives in.

KEY ORGANISATIONAL FACTS



Established: RDASH was formed in 1999 and became a Foundation Trust in 2010.



Service Areas: Provides clinical services across the entire geographic areas of Doncaster, Rotherham and North Lincolnshire.



Population Served: Approximately 790,000 people.



Workforce: Around 3,600 full-time equivalent staff, with a total head count of over 4,000.



Service Locations: Operates from approximately 100 locations, including large sites like Tickhill Road in Doncaster and Swallownest Court in Rotherham, as well as health centres, GP surgeries, and community premises.



Financial: Current annual income is £271 million, primarily spent on staff and service investments.

6 LEADERSHIP & GOVERNANCE STRUCTURE



2 Rotational Co-Chairs – Based on meeting locations: Rotherham, North Lincolnshire, Doncaster.



Chair facilitates meetings and keeps to time – no voting, no taking minutes.



Glyn is the conduit for feedback to the Clinical Leadership Executive (CLE).



Chair & Co-Chair model adopted to share workload and offer diverse gender diversity.

4 ORGANISATIONAL STRENGTHS & CHALLENGES



SUCCESSES & NOTABLE FEATURES

- Most services (excluding neurodevelopmental assessments) have a four-week wait time.
- "Phoenix" clinic in Doncaster focuses on bringing patients back to their local area for mental health rehabilitation.
- Pays the "Real Living Wage".
- Strong recruitment in staff training: vacancy rate under 10%.
- "Grounded Research" hub in Doncaster focusing on under-served communities and patient-led research.
- Active community partnerships, e.g. supporting relocated refugees.
- Uses "Can-Do guides" for open, transparent patient feedback.



AREAS FOR IMPROVEMENT

- Achieve 100% completion of care plans with patients.
- Improve timeliness and accessibility of patient documentation.
- Actively address racism within the Trust.
- Enhance digital accessibility and literacy.
- Reduce significant wait times for neurodevelopmental (ADHD/ASD) assessments.
- Improve how we work with Primary Care.

5 KEY DISCUSSION THEMES



Feedback on Transparency: Appreciation for openness about areas to improve and for clarifying that physical health accounts for nearly 50% of care.



Service Integration & Partnerships: Need to strengthen links with GPs, education, SEND services and the voluntary sector through neighbourhood working ("Promises") and multi-agency collaboration.



Cultural Competence & Diversity: Addressing faith and belief needs, language and interpretation challenges, harmful terminology (e.g. FGM), and tackling unconscious bias such as ageism.



Strategic Priorities & Next Steps: Moving from conversation to action, establishing accountability and agreeing governance and leadership arrangements.



Future Meetings: Interest in site visits, workshops on specific topics and facilitated focus groups.

7 WHAT CoLE WANTS TO ACHIEVE



A strong, united community voice.



Bring lived experience to shape services.



Strategic bridge between RDASH and VCFS.



Accountability & transparency in decision-making.



Tangible improvements in access, experience and outcomes.

SUCCESS LOOKS LIKE:

- ✓ Residents feel heard, respected and able to shape care.
- ✓ Positive shifts in care environments and experience.
- ✓ Patients able to lead and Co-create with influence.
- ✓ Measurable changes from our work.

MEMBER NEEDS:

- ✓ Clear purpose & Terms of Reference
- ✓ Access to raw data & performance info
- ✓ Better understanding of trust governance
- ✓ Leadership commitment to partnership skill

THEMATIC STRATEGY:

- ✓ The executive selects a theme (e.g. Access, Inclusivity or Equity).
- ✓ Trust aligns KPIs and work leaders, hosts 3 site visits each.
- ✓ All agree with RDASH strategic objectives and the 28 Promises.



ACCOUNTABILITY & COMMUNITY CONNECTION:

Challenge leaders, ask bold questions, avoid "mystery shopping" and capture the truth of community experiences.



WORKING TOGETHER FOR HEALTHIER COMMUNITIES

Thank you to everyone for your valuable contributions.



Annex 3: Current register of Trust vacancies – as at time of issue

We are aiming to return to 100 vacancies or fewer by December 2026, with the intent to be consistently below 200 from Q2 onwards, recognising our exit rate has risen as expected since March and we would anticipate that will continue to June.

Org L4	FTE Budget	FTE Actual	FTE Variance		Awaiting Authorisation	Out to Advert	Shortlisting	Interview	Offered	Start Date Given	Total	Vacancy Rate
Trust Total	3711.50	3495.20	-216.30		73.69	45.89	20.53	49.65	32.91	14.33	237.00	5.83%

Org L4	FTE Budget	FTE Actual	FTE Variance		Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total	Vacancy Rate
376 Corporate Assurance	27.99	28.82	0.83	Recruitment	1.00	0.00	0.00	0.55	0.00	0.00	1.55	
376 Estates	46.18	43.43	-2.75		0.00	0.00	0.00	0.00	1.35	1.00	2.35	
376 Finance & Procurement	40.19	40.17	-0.02		0.00	0.00	0.00	4.00	0.00	0.00	4.00	
376 Health Informatics	75.19	68.17	-7.02		1.00	0.00	0.00	0.00	0.00	0.00	1.00	
376 Medical, Pharmacy & Research	51.03	54.11	3.08		0.00	0.05	1.05	0.05	0.00	1.00	2.15	
376 Nursing & Facilities	170.40	151.40	-19.00		3.14	4.56	0.00	2.53	3.12	0.53	13.88	
376 Operations	49.39	49.20	-0.19		1.00	0.00	0.00	0.00	0.00	0.00	1.00	
376 People & Organisational Development	84.97	78.11	-6.86		5.00	0.00	0.00	0.00	0.40	0.00	5.40	
376 Psychological Professionals and Therapies	20.09	17.20	-2.89		1.80	0.00	0.00	1.00	0.00	0.00	2.80	
376 Strategic Development	18.04	18.56	0.52		1.00	0.00	0.00	0.00	0.00	0.00	1.00	
Total	583.47	549.18	-34.29		13.94	4.61	1.05	8.13	4.87	2.53	35.13	5.87%

Org L4	FTE Budget	FTE Actual	FTE Variance	Recruitment	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total	Vacancy Rate
376 CCG Mental Health	297.81	293.91	-33.90		9.20	9.80	3.00	4.60	2.60	1.00	30.20	
376 CCG Physical Health	358.49	335.66	-22.83		5.08	6.56	1.00	6.80	8.24	0.00	27.68	
376 DMHLD Acute Services	224.72	204.68	-20.04		5.00	0.00	0.00	2.70	3.00	2.00	12.70	
376 DMHLD Community Services	328.58	321.11	-7.47		6.93	5.44	1.60	3.15	1.00	0.00	18.12	
376 DMHLD Learning Disabilities & Forensics	187.00	177.47	-9.53		2.30	3.50	1.00	3.80	0.00	0.00	10.60	
376 NLCG Acute Care Services	137.26	120.72	-16.54		3.80	0.54	8.50	3.66	1.00	2.00	19.50	
376 NLCG Community Care Services	148.18	145.33	-2.85		1.70	4.04	0.50	0.00	1.00	0.00	7.24	
376 NLCG NHS Talking Therapies	185.07	179.56	-5.51		2.60	0.60	0.00	0.00	0.00	0.00	3.20	
376 PHND Community & Long Term Conditions	409.90	393.56	-16.34		8.73	5.00	2.40	1.80	1.60	1.80	21.33	
376 PHND Neurodiversity	43.70	38.18	-5.52		2.00	1.00	0.00	2.00	0.00	0.00	5.00	
376 PHND Rehabilitation	316.96	299.68	-17.28		3.30	0.50	0.00	2.21	3.00	3.00	12.01	
376 RCG Acute Services	220.69	204.26	-16.43		4.60	1.50	0.98	7.00	3.00	0.00	17.08	
376 RCG Community Services	232.14	225.75	-6.39		3.11	2.80	0.50	3.00	3.60	1.00	14.01	
376 High Dependency Rehabilitation Unit	37.53	36.15	-1.38		1.40	0.00	0.00	0.80	0.00	1.00	3.20	
Total	3,128.03	2,976.02	-182.01		59.75	41.28	19.48	41.52	28.04	11.80	201.87	5.81%

Annex 4: National publications – April/May 2026

1 April 2026 next steps on planning and priorities for 2026/27

(NHS England, published 01/04/2026)

Letter from Sir James Mackey, Chief Executive, NHS England covering the collective priorities and a look ahead for the new financial year.

<https://www.england.nhs.uk/long-read/1-april-2026-next-steps-on-planning-and-priorities-for-2026-27/>

Supporting young people to transition into adolescent and adult services

(NHS England, published 08/04/2026)

This guidance supports services to provide developmentally appropriate care for 0 to 25-year-olds.

<https://www.england.nhs.uk/long-read/supporting-young-people-to-transition-into-adolescent-and-adult-services/>

Neighbourhood health centres

(NHS England, published 15/04/2026)

The Neighbourhood health centre guidance for regions and integrated care boards sets out the practical planning instructions for developing NHCs in the current planning period.

<https://www.england.nhs.uk/long-read/neighbourhood-health-centre-guidance-for-regions-and-integrated-care-boards/>

The future of Freedom to Speak Up

(NHS England, published 16/04/2026)

Following the [Dash review](#) of patient safety across the health and care landscape, the government has agreed that the National Guardian's Office will close at the end of June 2026.

<https://www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up/>

Best practice guide for NHS frailty pathways

(NHS England, published 14/05/2026)

This best practice guide sets out the priorities and related key actions to help ensure people living with frailty and those who support them experience high-quality care and support: co-ordinated, compassionate care that is personalised, consistent, and easy to navigate.

<https://www.england.nhs.uk/long-read/best-practice-guide-for-nhs-frailty-pathways/>

Better patient care as NHS set to introduce single patient record

(Department of Health and Social Care, published 15/05/2026)

Safer and faster care for patients as NHS set to introduce single patient record and cut bureaucracy.

<https://www.gov.uk/government/news/better-patient-care-as-nhs-set-to-introduce-single-patient-record>

Government to transform mental health care with new strategy

(Department of Health and Social Care, published 15/05/2026)

New mental health strategy will transform care in England and drive shift from crisis intervention to preventative care. Frontline workers, clinicians and mental health experts are being invited to share their views on how to transform mental health care for children and adults in England, as the government launches a [call for evidence to shape its once-in-a-generation cross-government mental health strategy](#).

<https://www.gov.uk/government/news/government-to-transform-mental-health-care-with-new-strategy>

Health Bill: oversight of the health system - fact sheet

(Department of Health and Social Care, published 19/05/2026)

Outlines how the Department of Health and Social Care will set direction and maintain oversight of the health system, once NHS England has been abolished.

<https://www.gov.uk/government/publications/health-bill-oversight-of-the-health-system-fact-sheet/health-bill-oversight-of-the-health-system-fact-sheet>

Workforce Race Equality Standard: 2025 data analysis report for NHS Trusts

(NHS England, published 07/04/2026)

Previous reports are available on the [WRES webpage](#).

<https://www.england.nhs.uk/publication/workforce-race-equality-standard-2025-data-analysis-report-for-nhs-trusts/>

Workforce Disability Equality Standard: 2025 data analysis report for NHS Trusts

(NHS England, published 07/04/2026)

Previous reports are available on the [WDES webpage](#).

<https://www.england.nhs.uk/publication/workforce-disability-equality-standard-2025-data-analysis-report-for-nhs-trusts/>

Annex 5: Neurodiversity waiting time scorecard

CYP Neurodevelopment Scorecard (April–May Position)

1. Trajectory & Key Milestones

Metric	Position	Commentary / assurance	RAG
104-week cohort cleared by 30 Sept 2026	On track (planned)	All 202 patients offered and booked prior to deadline; delivery subject to WNB/cancellations	●
104+ weeks – offer by April 2026	Achieved	All 202 CYP offered appointments	●
6-month standard trajectory	Unclear	Planned: Doncaster & North Lincs by Dec 2026, Rotherham by Apr 2027. Awaiting updated trajectory confirmation	●

2. Waiting Lists & Demand (by Place)

Metric	Rotherham	Doncaster	North Lincs	Commentary	RAG
Total waiting (assessment)	1,425	787	728	Significant backlog across all places	●
Medication waits	207	211	N/A*	Ongoing pressure.	●
Initial screening waits (medication)	288	139	N/A*	*North Lincs contextual backlog: ADHD (306), NLaG (280), RDaSH circa 600 (TBC)	●

3. Activity & Throughput (April)

Metric	Rotherham	Doncaster	North Lincs	Commentary	RAG
CYP receiving full assessment (April)	772	450	243	In line with trajectory for Rotherham and North Lincolnshire	●
Discharges (April)	173	123	143	Flow through system in place	●

4. Trajectory Assurance by Place

Place	On Trajectory?	Position Summary	RAG
Rotherham	Yes	Delivering against current trajectory but demand and post diagnostic waits remain high	●
Doncaster	No	Off trajectory – requires recovery plan	●
North Lincs	Yes	Trajectory on track; data gaps remain, particularly for post diagnostics	●

Adult ADHD Scorecard (April–May)

1. Assessments (Diagnostics)

April (actual)

Metric	Position	Commentary / drivers	RAG
Expected capacity (full)	173 / month	Baseline expectation at full capacity	—
Completed assessments	123	71% of expected (50 below capacity)	●
DNA appointments	20	DNAs reduce productivity and increase rebooking pressure	●
Missed/cancelled due to staff sickness	44	Sickness: 3 WTE staff members	●

April utilisation (vs expected):

- 123 / 173 = 71.1% delivered.

May (planned / booked)

Metric	Position	Commentary / drivers	RAG
Expected capacity (full)	173 / month	Baseline expectation at full capacity	—
Booked assessments	121	70% of expected booked (52 below capacity)	●
Workforce impact	Ongoing	Same sickness as April + maternity leave + short-term sickness x2	●

May booked utilisation (vs expected):

- 121 / 173 = 69.9% booked (before any DNAs/cancellations).

2. Treatments (ADHD)

Activity vs expected capacity

Period	Expected capacity	Delivered	Delivery vs expected	RAG
April (full month)	199 / week	942	~110%	●
May (first 2 weeks)	199 / week	342	~86%	●

3. Waiting List Position

Adult ADHD Waiting List

Month	Longest wait (weeks)	Total waiting	Change vs prior
April	196	6,273	—
May	194	6,232	-2 weeks, -41 patients

Adult Autism Waiting List

Month	Longest wait (weeks)	Total waiting	Change vs prior
April	327	2,215	—
May	325	2,209	-2 weeks, -6 patients

Annex 6:

South Yorkshire Eating Disorders Joint Committee Meeting Note – 11th May 2026

The South Yorkshire Eating Disorders Joint Committee (SYEDJC) met on 11th May 2026. The main areas of discussion and subsequent actions are outlined below.

Medical emergencies in eating disorders (MEED)

The EDJC reviewed an implementation plan to commence an improved MEED service offer by November 2026. This includes additional services for both adults, and children and young people (CYP). A meeting has been organised with the acute and MHLDA providers to progress phases one and two together, now that MEED funding has been finalised. Further consideration is being given to the final model and impact on psychiatric liaison services. Key performance indicators have been developed in draft for further discussion with clinical teams and commissioners to ensure this development creates improved care and value for money.

Particular focus will be on the provision of service to young people between the ages of 16-18 to ensure that there are no service gaps between the CYP and adult models.

Adult community development

Establishment of the expanded community service continues in line with the plan. The service is seeing increases in demand, not just in the Rotherham, Doncaster and Barnsley population but also in Sheffield. The EDJC received a plan to address the subsequent trend in increasing waits given the agreed target of a 4 week wait for this service. Immediate actions are being taken to mitigate risk and prioritise based on clinical need and this issue has been added to the risk register and will continue to be assessed and actioned through the ED Operational group and the EDJC.

Inpatient care development

The adult inpatient feasibility business case for an integrated community and inpatient service has been agreed, subject to a number of actions including the need to mitigate risks around capital investment. This issue will be taken forward through the MHLDA Chief Executives and ICB Chief Executive to agree a way to ensure capital prioritisation. Lived experience input will be actively sought on the design phase and support from external clinical specialists will also feed into this process.

Feasibility work around provision of integrated Children and Young People (CYP) services is ongoing, however, there is now an appraisal of options being undertaken by Sheffield Children's NHS Foundation Trust that should be concluded by end July 2026.

Therefore, adult and CYP teams will work together once the options for the CYP service have concluded, to align plans and ensure the collective model provides for developmentally appropriate care.

The previous EDJC meeting, members agreed to separate the timelines for implementation and procurement of the adult and CYP model and discussed any potential risks and how they might be mitigated. The separation of timescales continues to be a risk and work to commission the adult integrated service continues with shared legal advice being sought for the ICB and lead provider on next steps.

Physical Health Monitoring (PHM)

A PHM workshop with primary and secondary care colleagues and commissioners took place on 18th March. Existing processes and best practice were reviewed in context of feedback from clinicians and people with lived experience. The was well attended and the outputs were reported to the May EDJC. Work has already commenced to streamline the referral process, and to improve requesting and management of tests. A Local Enhanced Service agreement, to formalise and provide consistent primary care monitoring, is in draft form for review by commissioning and primary care colleagues. Performance indicators will be agreed as part of this process and progress will continue to be reported through the EDJC route.

ARFID

Building on work that has already undertaken with MHLDA stakeholders, it is apparent that a system wide and multi-agency approach to ARFID is required to provide prevention and early intervention, alongside ensuring that there is sufficient specialist input to meet the needs of people with more complex ARFID-like presentations. The extent to which this can be achieved within existing services is being reviewed and an action plan will be developed for presentation to the EDJC in September 2026, to align with planning for 2026/27 investment decisions.

Annex 7:

South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative Board Meeting Note – 13 May 2026

The South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative Board (the Board) met on 13 May 2026. The main areas of discussion and subsequent action are outlined below.

Planning for 2026-29

- National Oversight Framework (NOF) and Metrics Alignment

Members of the Board discussed the NOF metrics and noted that they do not directly align to the planning guidance, so feedback has been provided to the NHSE team with a request for a unified set of metrics. The ICB and Collaborative team are mapping NOF measures against ICB requirements and will report back through the Chief Executives Group, once finalised.

In particular, concerns were noted about a lack of peer group visibility to understand relative performance for the new mental health indicators, recognising the importance of this for collective oversight and clear communication to boards and the public.

Progress on this area will be overseen through Chief Executives Group to maintain advocacy for sector-specific responses to the evolving development of the metrics.

- Mental Health Investment Standard (MHIS)

The collective proposal from the MHLDA trusts for MHIS funding in 2026-27 are being favourably considered, with expectation of additional resources into Trust alongside a commitment to work collectively on MHLDA indicators where the ICB is not compliant. There has also been agreement to work with the ICB on MHLDA planning for 2027-29 over summer, ahead of the next planning round.

- Specialist Commissioning

Discussions are ongoing with NHS England regarding lead provider arrangements. Providers expressed a local preference for a shift towards more collaborative models for adult secure services, but have highlighted the need to maintain current arrangements for eating disorders and Children and Adolescent Mental Health inpatient services, to enable development of intensive community provision in line with good practice guidance.

Out of Area Placements (OAP)

A paper was presented to the Board to update on the out of area placements programme. Review of existing placements continues and repatriation of people in complex out of area placements continues as planned. Several people have moved to the new rehabilitation unit at RDASH, with good progress towards community discharge.

Members of the Board noted the good progress made to date but also the associated risks around securing appropriate accommodation and care packages and navigating local authority involvement.

Members of the Board highlighted the success of the recent women's mental health event, with positive clinical and lived experience engagement. Next steps include the OAP Steering Group agreeing which of the proposed system wide actions will be prioritised, communicating back to participants in June and work to integrate learning into the ICB women's health strategy.

Eating Disorders

A paper was presented on the eating disorder programme, along with verbal feedback from the Eating Disorders Joint Committee (held on 11th May 2026).

The Board noted that the EDJC reviewed an implementation plan for improved Medical Emergencies in Eating Disorders (MEED) provision and this work was progressing as expected.

Plans for developing an integrated community, intensive community and inpatient offer are proceeding to plan however, capital funding to enable the development are highlighted as a key risk, with ongoing work to ensure viability and affordability, and contingency planning if capital is not secured. The associated challenge of recruiting and retaining clinicians for the eating disorders service without this investment was noted, with a suggestion that the EDJC also addresses workforce as a priority area.

Forensics Programme

The Board received a paper outlining plans for an equitable community forensic service offer across South Yorkshire, including operational updates and contracting considerations. A workshop is scheduled for 10th June to refresh the community forensic service specification, involving all local MHLDA forensic services providers, incorporating national guidance and lived experience input.

The aim is to have a robust plan by July 2026 with implementation before the end of the year.

Health Inequalities

Application of the Board's recently agreed approach to health inequalities was raised and confirmation was provided that a formal assessment is underway, with data collection and action planning in progress. The process is being used initially in the Out of Area Placements Programme with learning then being applied to the other programmes.

Development Session

The Board will meet with ICB colleagues on 4th August by which time the ICB MHLDA Executive Lead should have been identified. The focus of the day will be to agree new ways of working in line with the new ICB operating model, MHLDA planning for 2027-2029, and the changing remit of the Collaborative.

**Marie Purdue, Managing Director,
South Yorkshire MHLDA Provider Collaborative**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Energy Feasibility Study – route to Full Business Case (FBC)	Agenda Item	Paper Q
Sponsoring Executive	Jo McDonough, Director of Strategic Development		
Report Author	Jo McDonough, Director of Strategic Development Simon Sheppard, Director of Finance and Estates		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
This report provides a summary of the energy feasibility study that has been undertaken, walking the Board through: - Why we need to change energy provision; - Why we are initially focusing on Tickhill Road; - What the different options are for alternative green energy supply; - Why Ambient Loop is the preferred option; - What the indicative costs and benefits are of ambient loop; and - What the high level timeline is for installation. The Board should consider whether ambient loop is the right choice for us at TRH, as against other technologies and mindful of VFM.			
Previous consideration			
Board timeout February 26			
Recommendation (delete options as appropriate and elaborate as required)			
The Board is asked to:			
NOTE the option appraisal undertaken to identify a preferred approach to reducing carbon emission from gas			
CONSIDER the options appraisal outcome alongside costs and benefits			
RECOGNISE the focus on Tickhill Road site initially			
NOTE work commenced to attract external investment in the capital required			
DECIDE if Ambient Loop is the preferred approach on Tickhill Road site.			
Alignment to strategic objectives (indicate those that the paper supports)			
SO2: Create equity of access, employment, and experience to address differences in outcome			X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			X
Alignment to the plans: (indicate those that this paper supports)			
Estate plan			X
Digital plan			X
People and teams plan			X
Finance plan			X
Quality and safety plan			X
Equity and inclusion plan			X
Education and learning plan			X
Research and innovation plan			X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	

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.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	X
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	X
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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)			
Not applicable			
System / Place impact (advise which ICB or place that this matter relates to)			
Neighbourhood working			
Equality Impact Assessment	Is this required?	Y	N X
Quality Impact Assessment	Is this required?	Y	N X

Appendix (please list)
Annex A – Energy Feasibility Study

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Energy Feasibility Study - route to FBC

1. Introduction

1.1. The Trust renewed its Green Plan in 2025 in support of promise 27:

“Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change”.

1.2 The Trust’s Green Plan sets the following objective:

“Reduce annual gas emissions by 500 carbon tonnes via estates decarbonisation”

Our current annual emissions are 3,562 carbon tonnes. By the end of 2028, we aim to reduce this by 2,000 carbon tonnes per year in line with Promise 27 in the RDaSH Clinical and Organisation Strategy.

1.3 Reliance on gas to power our buildings uses 1,896 carbon tonnes per year, which is approximately 53% of our total tonnage. Reducing our need for fossil fuels like gas provides an opportunity to make a significant reduction on our emissions. Achieving such a sizeable reduction will require~:

- Exiting some of our energy inefficient building in line with our Estate Plan;
- Improving the energy efficiency of remaining buildings for example, with improved insulation;
- Moving to an alternative energy source i.e. stopping the use of gas to heat our buildings.

2.0 Where to start?

2.1 The largest use of gas is the Tickhill Road site in Doncaster due to its size and in part, age of buildings. To have the biggest impact on our carbon emissions, it would make sense to focus our initial plans on this site. It would also align with the estate plan work providing opportunities to reduce carbon emissions and align timelines and dependencies.

2.2 To move from using gas to heat and/or cool our buildings we need to identify an alternative, more carbon neutral, energy source. There are a number of alternatives available, all of which have differing benefits and challenges. To understand the different technologies an options appraisal was undertaken to provide the Trust with an overview of the potential pathways for decarbonising heat supply at the Tickhill Road Hospital (TRH) site and to identify the most technically feasible and cost-effective solutions to progress to the next phase of development. The intention of this work was not only to identify a preferred

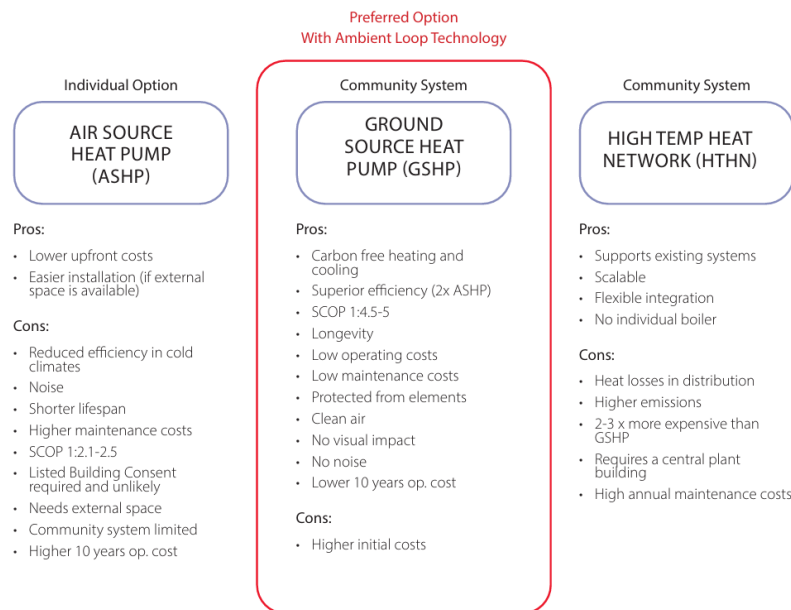
pathway for TRH, but also to draw lessons that may be applied across the wider Trust estate.

- 2.3 The appraisal considered a range of technologies and delivery approaches, including individual building heat pumps, ambient loop and several forms of heat network infrastructure. Each option was assessed against consistent criteria including carbon reduction potential, technical maturity, impact on the existing estate, alignment with the Trust's strategic objectives, and investment requirements. A "do nothing" option, representing continuation of the existing gas-based system, was included as a baseline comparator. While useful for benchmarking costs and performance, this option does not align with the Trust's long-term decarbonisation commitments.
- 2.4 The appraisal considered a range of technologies including – do nothing, ground source heat pumps (including ambient loop), air source heat pumps, electric boiler heat pumps and individual heat pumps on each building. Technologies were assessed against the following criteria:
- Capital cost
 - Revenue cost
 - Maintenance requirements
 - Efficiency
 - Ease of installation
 - Speed of installation
 - Impact on environment
 - Scalability.

3.0 Potential Options

- 3.1 The option appraisal led us to identify three potential options of individual air source heat pumps (per building), ground source heat pump (using ambient loop technology) and a high temperature heat network. The option of 'Do-Nothing' - was discounted because it does not align with our strategic ambition set out in our Clinical and Organisational Strategy nor our Green Plan. The pros and cons of each of the three options identified are shown in figure 1 below:

Figure 1 – Pros and Cons of each option



3.2 A range of low carbon heating strategies were considered, including air source heat pumps (ASHP), ground source heat pumps (GSHP), and a high temperature heat network (HTHN). A 'Do Nothing' option was also considered.

3.3 Option 1 – Do Nothing

3.31 This option is not recommended because the Trust has made a commitment in its strategy to reduce our carbon footprint and the number one contributor to our footprint is the use of gas. Therefore, if we didn't change from gas to a cleaner energy source, especially on the Tickhill Road site, we would not make any progress towards our promise.

3.3.2 In addition, the cost of gas is rising and the risk of supply increasingly unstable due to world events. Current annual utility costs are £891k.

3.3.3 The land that we intend to divest of as part of the new estate plan includes our current energy centre. Therefore, in order to move forward with the estate plan we need to identify a new energy source for the site. We also need to install the new energy source before we divest ourselves of the land, so speed and ease of installation is important.

3.4 Option 2 – Air Source Heat Pump (AHSP)

3.4.1 While ASHP systems offer lower upfront costs and are relatively straightforward to install, they are less efficient in colder conditions, blow hot air into the environment, and typically have higher operational and maintenance costs. They also introduce challenges in this context, including noise, visual impact, the requirement for external space, and when applicable the need for Listed Building Consent, which is considered unlikely to be granted. In addition,

ASHP systems have a lower seasonal efficiency), resulting in higher long term energy costs. This option is not recommended.

3.4.2 Upfront capital costs for Air Source Heat Pumps are lower, primarily because ASHP avoids the borehole array. On an indicative basis, capital for the retained estate would be in the order of £5–6m, compared to £8.7m for the Ground Source Heat Pump Ambient Loop option.

3.4.3 However, the apparent capital saving is offset by materially higher annual operating costs. ASHP operates at a seasonal efficiency of SCOP 2.5–3.5, compared to 4.8–5.8 for GSHP. Based on the site's modelled heating loads, this difference in efficiency translates to an estimated additional electricity cost of approximately £80–130k per year relative to GSHP. Over a ten-year horizon, this premium is sufficient to erode and potentially eliminate the initial capital advantage.

3.4.4 Additional constraints at Tickhill Road include noise and visual impact, external plant space requirements, and the need for Listed Building Consent for a number of the retained buildings — consent which is considered unlikely to be granted.

3.4.5 Annual utility costs with Air Source Heat Pumps are estimated to be c£500k for electricity.

3.4.6 Air Source Heat Pumps require space next to each individual building to be available and prepared and planning permission is likely to take longer. Whilst disruption is limited to each building as it is installed, the time to install across the whole of the Tickhill Road site is likely to take longer than ground source heat pump. It is not scalable other than adding more individual heat source pumps to each building.

3.5 Option 3 – High Temperature Heat Network (HTHN)

3.5.1 HTHN was also reviewed as a potential solution. Although these systems can integrate with existing infrastructure and offer scalability, they are associated with higher capital and operational costs, including significant heat losses through distribution, particularly due to long runs of insulated pipework required to circulate high-temperature water. They also require a central plant building and typically result in higher emissions compared to low temperature systems. Overall, they are estimated to be significantly more expensive than GSHP over the project lifecycle. This option is not recommended.

3.5.2 High Temperature Heat Network can integrate with existing infrastructure and offers scalability, it is not recommended for this site. Capital cost is estimated at 2–3 times the equivalent GSHP/ambient loop system, placing indicative infrastructure cost for the retained estate in the region of £17m–£26m, before building-level works and the requirement for a dedicated central plant building.

3.5.3 Annual maintenance costs are significantly higher than GSHP due to the complexity of the distribution network and central plant. The system also carries higher operational emissions than a low-temperature approach, primarily as a result of heat losses across the insulated pipework distribution runs. It should be noted that it does not offer cooling.

3.5.4 Annual utility costs with High Temperature Heat Network are estimated to be c£600k for electricity.

3.5.5 High Temperature Heat Networks require the building of one large energy centre on the site. This is likely to require a more detailed and longer planning permission process and will require significant space on the new, retained site. Each building then needs to be connected to the energy centre which would take time to install and the whole system is likely to take longer than ground source heat pump. It is scaleable should we wish to add other buildings to the network later.

3.6 Option 4 – Ground Source Heat Pumps (GSHP)

3.6.1 GHSP systems provide a highly efficient and low carbon solution, with a typical seasonal efficiency, approximately twice that of ASHP. They offer both heating and cooling capability, low operating and maintenance costs, and long system lifespan. As the system is located below ground, it avoids issues related to noise, visual impact, and exposure to weather, making it particularly suitable for sensitive or constrained sites. Based on this assessment, GSHP was selected as the preferred strategy as it provides the most balanced solution in terms of performance, carbon reduction, operational cost, and long term reliability, despite the higher initial capital cost.

3.6.2 Annual utility costs with Ground Source Heat Pump High (Ambient Loop) are estimated to be c£250k electricity.

3.6.3 Ground Source Heat Pumps require the installation of c230 bore holes across the site and then connections to each building with the installation of an internal heat pump. Planning permission is likely to take less time as very little is changed above ground – approximately 6-10 months. Installation is likely to take approximately 6-8 months. It is scaleable should we wish to add other buildings to the network later.

3.6.4 All options apart from Option 1 of Do Nothing will require capital funding/investment which depending on the funding model will also incur a cost for repayment over an extended period of time. This will be calculated as part of the next stage of the work.

3.6.5 In summary a comparison of capital and revenue costs of each option are:

Cost	Air source £	High Temp Network ££	Ground Source – Ambient Loop £
Capital	5-6m	17-26m	8.7m
Revenue	500k	600k	250k

Appendix 1 sets out all the key criteria considered for the option appraisal using a scoring system

Recommendation - The feasibility study has identified that ground source heat pump is the preferred option for Tickhill Road site. The ground source heat pump system recommended is Ambient Loop.

4.0 What is Ambient Loop?

- 4.1 Ambient Loops deliver low-carbon heating and cooling from a central renewable source to multiple buildings through uninsulated underground boreholes. This shared approach used in developments from housing estates to hospital campuses is more efficient and sustainable than individual heating systems, cutting both carbon emissions and energy costs across entire communities.
- 4.2 Also known as “5th generation district heating”, the system circulates water at near-ground temperature through a network connecting multiple buildings. Each building has its own heat pump to extract heating or provide cooling, while the loop acts as a shared thermal battery, buildings that need cooling reject heat into the loop, which is then used by buildings requiring heating.
- 4.3 The ambient loop is proposed as a site-wide energy distribution network, following the primary circulation routes across the campus. It is typically routed below ground along the main perimeter road and key internal spines, allowing it to connect efficiently to both existing and proposed buildings. Positioning the loop within these corridors provides ease of access for installation and maintenance, while minimising disruption to buildings and sensitive areas. From the main loop, branch connections extend to individual buildings, linking into local plant rooms where heat pumps and associated systems are located. The routing strategy is designed to ensure the loop is flexible and scalable, allowing for phased implementation and future expansion as additional buildings are connected or upgraded over time.
- 4.4 Ground source heat pumps are not novel and have been used effectively for many years. Ambient loop is a newer concept but not so new that it isn't tried and tested. A number of sites across the UK have Ambient Loop in place and have had for over 10 years with success for example, One New Change commercial building opposite St Pauls' Cathedral, London, The Crystal Building, Siemens, London Docks. A couple of case studies are provided at appendix 2.

- 4.5 The lifespan of the ambient loop infrastructure is 100 years. The loop connects into an electrical heat pump in each building that it provides energy to and the lifespan of these heat pumps are the same as any other heat pump currently in use across the Trust.
- 4.6 Ambient loop is low maintenance as there is very little in the loop system to go wrong. If the loop is disconnected for example by being dug up it can be easily repaired. Maintenance of the electrical heat pumps in each building would be as normal.
- 4.7 Ambient loop is also able to provide cooling to buildings during hot weather. We are more likely to experience extended periods of extreme heat in the UK and we will need to cool our buildings for our patients and staff without using air conditioning which is harmful to the environment. Ambient Loop can do this by using cool temperature from the ground and drawing out heat from buildings. The heat from the buildings is put back into the ground rather than into the atmosphere.

5.0 Disadvantages of Ambient Loop

- 5.1 No solution has no drawbacks so it is important to recognise what those are for ambient loop as part of the decision making process. The three main disadvantages are:
- higher capital costs. To install ambient loop will result in a higher initial capital cost when compared to other technologies. However, the costs of maintenance are much lower than other when installed;
 - if we required hotter water than ambient loop produces, which some hospitals require, we may still need to heat the water a little more in some buildings using electricity. However, this will not be required in all buildings and is do-able. The water for flushing for legionella can be heated to 65 degrees when required.
 - disruption – the installation of the boreholes across the site for ambient loop is likely to cause more disruption across the site when compared to the building of one large energy centre. However, connections would still need to be installed from an energy centre to each building which would cause some disruption.

6.0 Delivery net zero and reduced energy usage and costs

- 6.1 To maximise the benefits of this work, we must consider all potential approaches to reduce energy usage and costs as well as carbon emissions associated with gas. In addition to the installation of ambient loop proposal include improving the energy efficiency of remaining buildings on the proposed estate plan and in any new building erected e.g. improved windows and insulation plus instalment of solar panels on roofs.
- 6.2 With the impact of climate change already leading to longer spells of extreme heat each year, it is important to also consider how to cool our buildings to provide comfortable environments for our patients and colleagues. This needs

to be done in the most cost effective and energy efficient way, so the proposal for ambient loop also includes a cooling option from the system. This will be more cost effective and efficient moving forward from having separate air conditioning units installed in individual clinical areas and offices.

7.0 Costs and benefits

7.1 Initial estimates of costs and benefits for the proposal of installing Ambient Loop on the Tickhill Road site are:

Capital

Required	Existing buildings (new estate plan) - £000	New Buildings - £
Boreholes	2,573	606
Ground Source Heat Pumps	1,072	252
Ancillaries	643	151
Windows upgrade	1,071	
Roof insulation	214	
Cooling infrastructure	1,454	865
Active Cooling	363	216
Solar PVs	800	350
Battery Storage	520	180
TOTAL	8,714,023	2,621,616

7.2 External Funding - The analysis indicates that there is potential for part of the energy infrastructure to be funded through external capital, subject to detailed agreement. Such an approach could reduce the Trust's upfront capital requirement, but would typically involve a long-term indexed payment structure and should therefore be assessed against the benefits of direct Trust investment and ownership.

Revenue – annual – note these are the costs of heating and cooling – not for lighting.

Required	Existing buildings (new estate plan) £000	New Buildings £000
Electricity	117	57
Gas	0	0
Ground source heat pump – electrical consumption	49	17
Cooling infrastructure – electrical consumption	5	-
TOTAL	172	74

7.3 Benefits

- Carbon free heating and cooling
- Superior efficiency
- Longevity
- Low operating costs
- Low maintenance costs
- Clean air
- No noise

- Protected from elements
 - No visual impact.
- 7.4 The plans proposed and the estimated costs above will result in a reduction of carbon emissions from gas on the Tickhill Road site from **1,237 carbon tonnes per annum to zero.**
- 7.5 The analysis in this report has not sought to place a specific financial value on the wider resilience benefits of reduced dependence on imported gas and electricity. Those benefits may nevertheless be material, particularly given the continuing exposure of energy markets to geopolitical instability and resulting price volatility. In practice, a strategy that reduces reliance on externally supplied fossil fuels and lowers imported electricity demand may provide the Trust with greater long-term resilience, improved energy security and reduced exposure to future utility-cost shocks, even where those benefits are not fully reflected in the cost comparisons presented here.

8.0 Timescales

- 8.1 Timescales are dependent upon the development of a full business case and programme plan, consultation and permissions such as planning which is anticipated could take 6-12 months. Installation of the bore holes on the Tickhill Road site is likely to take 6-8 months. Additional upgrades to individual buildings such as improved windows and insulation would need to be scheduled throughout that period.

9.0 Summary

- 9.1 This report concludes that the Tickhill Road site is well suited to a site-wide ambient loop energy strategy based on a closed-loop borehole field and building level ground source heat pumps replacing conventional gas boiler plant. This approach provides a practical route to decarbonising both retained and new buildings of the estate while establishing an energy infrastructure capable of supporting long-term estate renewal and potential future extension beyond the immediate Trust site.
- 9.2 The proposed direction of travel is not limited to plant replacement alone. The strongest overall outcome is achieved where the ambient loop and heat pump strategy is combined with a progressive package of fabric improvement, mechanical ventilation with heat recovery, cooling where operationally required, and solar PV with battery storage. Together, these measures reduce heating demand, lower reliance on imported electricity, improve environmental performance, and strengthen the long-term resilience of the estate. In broad terms, the higher the building performance and on-site generation, the lower the ongoing dependence on grid-supplied energy and the smaller the energy infrastructure required to serve the site.
- 9.3 This should therefore be understood as more than an energy project. It is a delivery framework for estate transformation: enabling replacement and refurbishment of outdated buildings, supporting NHS Net Zero objectives, improving long-term operational performance, and creating the basis for a coherent and future-adaptable site-wide energy system. It also presents a potential precedent for wider connection to adjacent residential development over time, should this be desirable.

10.0 Recommendations and Next Steps

- 10.1 The feasibility study has identified that ambient loop is the preferred option for Tickhill Road site due to the benefits identified in figure 1.
- 10.2 If approved, the next steps would be to proceed to detailed design, business-case development and commercial testing. This should include refinement of the borehole field and ambient loop design, confirmation of building level heat pump strategy, further development of fabric and ventilation measures, testing of renewable generation and storage potential, and evaluation of delivery and funding structures, including the possible role of third-party infrastructure finance
- 10.3 The Trust Board is asked to:
- **NOTE** the option appraisal undertaken to identify a preferred approach to reducing carbon emission from gas
 - **CONSIDER** the options appraisal outcome alongside costs and benefits
 - **RECOGNISE** the focus on Tickhill Road site initially
 - **NOTE** work commenced to attract external investment in the capital required
 - **DECIDE** if Ambient Loop is the preferred approach to implement on Tickhill Road site.

Appendix 1 – Option Appraisal scoring

Scoring:

3 – most advantageous

2 - moderately advantageous

1 – least advantageous

Criteria	Ground Source Heat Pump – Ambient Loop	Air Source Heat Pump	High Temperature Network
Capital Cost	2	1	3
Revenue Cost	3	2	2
Maintenance	3	2	2
Efficiency	3	2	1
Ease of installation	2	1	1
Speed of installation	3	2	1
Impact on environment	3	2	2
Scaleable	3	1	2
TOTAL	22	13	14

Appendix 2 – Case Studies of use of Ambient Loop

The Crystal, Siemens UK HQ

Docklands, London, UK



Key Facts

- Vertical Closed Loop
- Energy Piles™
- 614 kW Cooling
- 614 kW Heating
- Completed 2012



GI Energy

- Specialists in planning, consulting, feasibility studies & design
- Planned maintenance, controls & pro-active performance optimisation to suit any system
- Experts in providing renewable energy systems for prestigious developments

Why Did They Do It?

The Crystal is a sustainable cities initiative by Siemens exploring the future of cities. Home to the world's largest exhibition focused on urban sustainability and a world-class center for dialogue, discovery and learning.

The Crystal is one of the world's greenest buildings, achieving Outstanding BREEAM accreditation and Platinum LEED accreditation - the most stringent standards for sustainable design and construction. It demonstrates firsthand the remarkable systems and technologies that are employed to reduce its carbon footprint and ensure its environmental credentials over the long term.

What We Did?

The Crystal is an all-electric building that

uses solar power and ground source heat pumps to generate its own energy. That means no fossil fuels are burnt within the building. The Crystal showcases state-of-the-art technologies to make buildings more efficient and also profiles Siemens' Environmental Portfolio.

How We Did...

"For the past 18 months I have felt fully reassured of the mechanical output of the GI installed system and I have been impressed with its reliability. During walk around visits with clients I have championed the technology and the resilience of the installation. I would be surprised if you did not generate some sales leads from this."

Andy Chandler
Building Manager
Siemens Crystal

City of London Visitor Centre

St Paul's, London, UK



Key Facts

- Vertical Closed loop
- 6 Bores to 60m
- 20% Improvement Over Part L



The new city of London Information Centre introduces a dynamic contemporary structure to an area of exceptional architectural and urban heritage. Destined to become a local landmark in its own right, this exciting new building provides all the facilities required to offer a state-of-the-art information service to the millions of people who pass through the area each year.

The building meets exacting environmental standards and has been engineered to exceed current Part L targets for CO₂ emissions by 20%. The computer and audio-visual equipment housed within the building generates a significant heating load which is handled by a vertical bore hole system to 60m. In addition to being highly effective, the unobtrusiveness of the ground source system is particularly advantageous for such a highly sensitive site.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Sickness Absence	Agenda Item	Paper R
Sponsoring Executive	Carlene Holden, Director of People and Organisational Development		
Report Author	Carlene Holden, Director of People and Organisational Development		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points			
Sickness absence remains challenging with the organisation with a number of colleagues experiencing both short term (less than 28 days) and long term sickness absence, to achieve the target of 4.1% this equates to each colleagues having the equivalent of 2 weeks sickness per annum, which is contrasted by 890 colleagues who have been employed for the full financial year having no periods of absence and 2920 colleagues having 4.1% or less sickness absence. The initial focus is on our high level of long-term sickness to enable colleagues to return to work timely either in their substantive role or an alternative role and the suggested 1.5% improvement this will deliver. Given the difference of approach and the additional external support, we have previously focussed on our 555 line managers within their Trust, their ability to lead discussions in a timely and compassionate way is key to our success. In addition to the wide ranging support which we are implementing, does this represent a step change in the approach to deliver the stretching targets.			
Previous consideration			
Not Applicable			
Recommendation			
The Board is asked to:			
NOTE – the focus on long term sickness for the first twelve months and the suggested 1.5% reduction			
CONSIDER – whether any wider support can be offered			
RECOGNISE – the focussed work in this area and the wider workstreams which are being considered and implemented			
DELEGATE – the review and scrutiny of the approach and delivery to the People and Organisational Development Committee			
Alignment to strategic objectives (indicate those that the paper supports)			
SO1: Nurture partnerships with patients and citizens to support good health			x
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			x
Alignment to the plans: (indicate those that this paper supports)			
People and teams plan			x
Finance plan			x
Quality and safety plan			x
Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	x

Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	x
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	x
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	x
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	x
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	
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.	
Strategic Delivery Risks			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are			X

distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services							
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.							X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.							X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees							X
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Appendix (please list)							
Annex 1 : Table One – 12 month rolling sickness for South Yorkshire NHS organisations taken from Model Hospital.							

Sickness Absence

1.0 Introduction

- 1.1 The oversight of sickness absence management, both long term and short term has been an area of focus in H2 of 2025/26 and is a key area of focus in 2026/27.
- 1.2 We strive to have a consistent workforce to deliver patient care to our patients/families and to build effective working relationships in teams, which requires in the main sustained attendance during the course of the year. Sickness absence also directly influences our bank/overtime expenditure within the Trust.
- 1.3 The purpose of this paper is to update on the work to date and also the focus within 2026/27 to further improve our sickness absence position. As colleagues are aware this is a key area of focus from the National Oversight Framework (NoF) and it is recognised that to achieve a 4.1% sickness absence rate by March 2029 requires oversight and a laser focus.

2.0 Current Trust position

- 2.1 The Trust's current sickness absence rate for April 2026 is 7.25%, as a comparator the position for April 2025 was 5.95%.
- 2.2 The table below summarises the quarterly position

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Sickness %	5.8%	6.7%	7.3%	7.2%
Of which LTS	4.3%	4.9%	5.2%	5.1%
Of which STS	1.5%	1.8%	2.1%	2.1%

- 2.3 Throughout 2025/26 the top three reasons for absence, as recorded on the Electronic Staff Record system were
- Anxiety/Stress/Depression
 - Gastrointestinal problems
 - Musculoskeletal (MSK) problems
- 2.4 At points in our careers most, if not all colleagues, will experience a period of sickness absence and the intention is to support colleagues, but to facilitate a return to work, earlier than previous, wherever possible, whether this be in their current role, a temporary role or a VCSE placement. The CIPD research is clear, the longer a colleague remains absent from work then it becomes more difficult to facilitate and sustain a return to work.
- 2.5 Whilst nationally we report and are also measured against an overall sickness %, we are keen to personalise the position for colleagues regarding the ask and the expectation. For the organisation to achieve an absence rate of 4.1%, the reality is this equates to each full-time equivalent colleague (pro rata for part time colleagues) averaging two weeks sickness absence each financial year.

- 2.6 During 2025/26, 890 colleagues who were employed for the full financial year had no periods of sickness absence, which represents a significant proportion of our workforce. Effective sickness management in the NHS combines a clear policy, early support, good data and a culture which balances colleague wellbeing with service delivery, therefore alongside the supportive absence management culture we also need to recognise and reward colleagues who have no or very low periods of absence.
- 2.7 Given our focus on achieving 4.1% sickness absence overall, it is helpful to understand the number of our colleagues who currently achieve this, based on the previous financial years data. Including the colleagues who had no sickness absence last financial year, we have 2920 colleagues within the organisation who last year achieved a 4.1% or lower sickness absence rate, which represents the majority of our workforce. Again, alongside our colleagues having no absence this needs to be celebrated and recognised.
- 2.7 Sickness absence management should not be perceived as a punitive approach, we are keen to avoid an increase in presenteeism (56.9% of colleagues responding to the 2025 staff survey responded that they had attended work in the previous three month despite not feeling well enough to perform their duties - the average result for our comparator is 54.3%). When colleagues experience a period of sickness absence managers must contact colleagues early, explore the barriers to work, agree adjustments quickly and document support plans consistently. Despite the sickness absence policy recently being revised to move the focus and emphasis onto wellbeing, having an enhanced bereavement support programme and the Trust having one of the few dedicated reasonable adjustment budgets in the NHS, our sickness absence levels remain an outlier (Annex One). One of the policy changes was to move away from a return-to-work interview to a welcome back to work discussion to focus on prevention and support.

3.0 Our 2026/27 approach

- 3.1 We are asking of our line managers to support colleagues in line with the approved policy framework and best practice, the key difference being colleagues experiencing sickness are our focus and priority.
- 3.2 When a colleague contacts their manager to notify their absence, it may be the case that they feel 'left' and not a priority and they should feel cared for, not as in a parent/child relationship but one as a valued colleague who we are keen to support but also facilitate a return to work. Rather than an assessment whether the colleague is fully fit for their role and if not they remain absent, the focus will be on what the colleague can do rather than what they cannot do to facilitate a return to a meaningful role from long term sickness.
- 3.3 4.9% of sickness absence in the previous financial year was long term sickness and our target at the end of the 3-year planning cycle for all sickness absence is 4.1%. In November 2025 the Director of People and Organisational Development facilitated the first long term sickness clinics across the Trust. In January 2026 we experienced a 1% reduction in our sickness absence, which may or may not be as a direct result or in part as a result of the clinic approach. It was identified that managers were not consistently meeting with colleagues in a timely way and supporting them with exploring options regarding a return to work, often silo focussed on their current role and very rarely considering wider roles in the Directorate or Trust. Given long term sickness is our largest proportion of absence, the clinics have been scheduled quarterly for 2026/27 with the first clinics held in April 2026. These will continue on a quarterly basis with the quarter 2 clinics resulting in a long-term sickness rating for

the Care Groups/Backbone and in time Care Group Directorates. Given the relentless focus to support our colleagues, the Human Resources team will facilitate similar clinics in the intervening months.

- 3.4 Long term sickness absence accounts for the majority of total sickness absence in many NHS organisations, but our starting point remains high therefore we anticipate that we can reduce our long-term sickness absence rate by 1.5% in the first instance to support the overall delivery of a 4.1% sickness absence rate.
- 3.5 To support short term sickness absence we are exploring wider support for colleagues, focussing on team wellbeing metrics and how we can support colleagues, recognising the difference in teams, a one size fits all approach will not work. It is also acknowledged that rostering provides shift working colleagues with some control over their working pattern, whilst colleagues have 4 requests per four-week period, we are exploring shift changes (same grade/team) not requiring managerial approval prior to considering a wider roll out of self-rostering later this financial year. We have a wealth of support which is available to colleagues, but the consistency of application and managerial approach is varied, we have
- structured post-incident decompression,
 - psychological “hot debriefs,”
 - peer reflective spaces,
 - Schwartz rounds,
 - proactive counselling after traumatic events,
 - psychological screening after repeated exposure
- 3.6 In addition to the long-term sickness absence clinics, we will launch additional interventions to support colleagues and this is a key difference in our approach for this financial year and future years, to seek innovative approaches to support colleagues and sustain a reduction in our sickness absence.
- 3.7 It is often beneficial to have a different manager support someone during long-term sickness, but it does depend on the circumstances. A different manager may help when:
- The colleague’s illness is connected to stress, conflict, workload, or anxiety involving their direct manager or team.
 - The relationship has become strained, overly emotional, or awkward.
 - The employee would feel safer discussing health, phased returns, or reasonable adjustments with someone more neutral.

There are times when keeping the same manager may work better when:

- There is already strong trust and psychological safety.
- The manager knows the colleague’s role, triggers, and support needs well.
- Continuity and familiarity reduce anxiety for the colleague.

Therefore, when we use an alternative manager to support the long-term sickness, the

- direct manager keeps responsibility for work planning and return-to-work arrangements;
- another manager provides welfare check-ins and pastoral support such as Cavell Wellbeing conversations which offers both independent and practical support to the colleague

That can reduce pressure on colleagues whilst maintaining continuity. In addition to this support recognising at times colleagues may not feel able to be open and transparent with managers within the Trust, we are exploring the support of external agencies to facilitate the discussions and explore alternatives to work. This is a model which is being supported within the general communities to reduce the number of long term unemployed colleagues in our communities, so we are taking the best practice and testing this out from an RDaSH perspective.

- 3.8 We are also looking to partner with 'Thank You Healthcare Staff' whose mission is to improve the health and wellbeing of NHS workers, support them in maintaining good health and living healthier, more sustainable working lives while helping patients across the NHS, which includes but not limited to, by:
1. Providing financial assistance and grants for treatment, therapy, and wellbeing support.
 2. Providing information and funding initiatives that promote mental health resilience and measures to prevent workplace stress and burnout; and
 3. Providing grants for those who are experiencing or at risk of ill health, disability, stress, or burnout to prevent or alleviate such conditions.
- 3.9 This offers a self referral route for our colleagues, which isn't currently an option of our Occupational Health contract which is further enhanced by an offer by Wellmind Health which provides timely clinical grade therapeutics for mental health and MSK, which are our top two reasons for sickness absence.
- 3.10 We expect through a tailored approach for each colleague we can offer early support which in turn reduces our overall sickness absence rate. We will have an enhanced 'toolkit' of options available to support colleagues which in turn meets their individual needs. We should not underestimate the change in approach for our managers, colleagues and the HR team as this becomes a very tailored and personalised approach rather than the standard policy application.
- 3.11 Our occupational health model is key in supporting colleagues, alongside our health and wellbeing offer. We have external occupational health provision which is delivered by People Asset Management (PAM), as has been the case since 2014. In 2023 the contract was tendered and was awarded again to PAM, this was on a three plus one plus one model. As such we are exploring the longer-term provision and the retendering of this service, to ensure it meets our needs and covers our geographical area. At the present time the contract offer is the core occupational health offer plus pay as you go options, for counselling, physiotherapy etc. The occupational health provision needs to be timely and also tailored to meet individual needs.
- 3.12 Whilst not as a direct result, we recognise the need for colleagues to take regular breaks from work and within the NHS we have a generous annual leave entitlement, this year we will be working with our line managers to ensure colleagues have regular periods of leave as part of our minimum leave utilisation monitoring. Whilst this has been in our policy framework for several years this hasn't been actively monitored to facilitate an equal distribution of the leave.
- 3.13 The challenges some of our teams face are significant, as you will recall from the Workplace Violence and Aggression: Staff Safety and Incident Trends (April 2025 – March 2026) paper at the March Board meeting, this is not about asking colleagues to become more resilient per se but to move to a recovery culture, which is touched upon in the culture paper also at today's Board. The focus being on workload recovery, psychological recovery, staffing levels (our drive to become fully staffed

supports this) rostering scheduling and fairness, protected breaks and restorative leadership.

3.14 Whilst long term sickness is the initial focus of our interventions, we will also ensure colleagues have timely welcome back to work meetings to provide timely support to colleagues and to explore wider health and wellbeing support which is available to colleagues. The welcome back to work meetings are usually most impactful when they happen:

- Promptly after the employee returns
- After meaningful absences — not just long ones
- Before problems reappear
- When the manager creates psychological safety
- When there is flexibility to act

Whilst our managers have received training in this area, a welcome back to work meeting is often delayed due to competing priorities, which then reduces the impact. Given this the welcome back to work meeting dates will be recorded on the ESR system to facilitate performance reporting and to offer further support to our line managers where meetings are not happening timely.

4.0 Recommendations

The Board of Directors is asked to:

NOTE the focus on long term sickness for the first twelve months and the suggested 1.5% reduction

CONSIDER whether any wider support can be offered

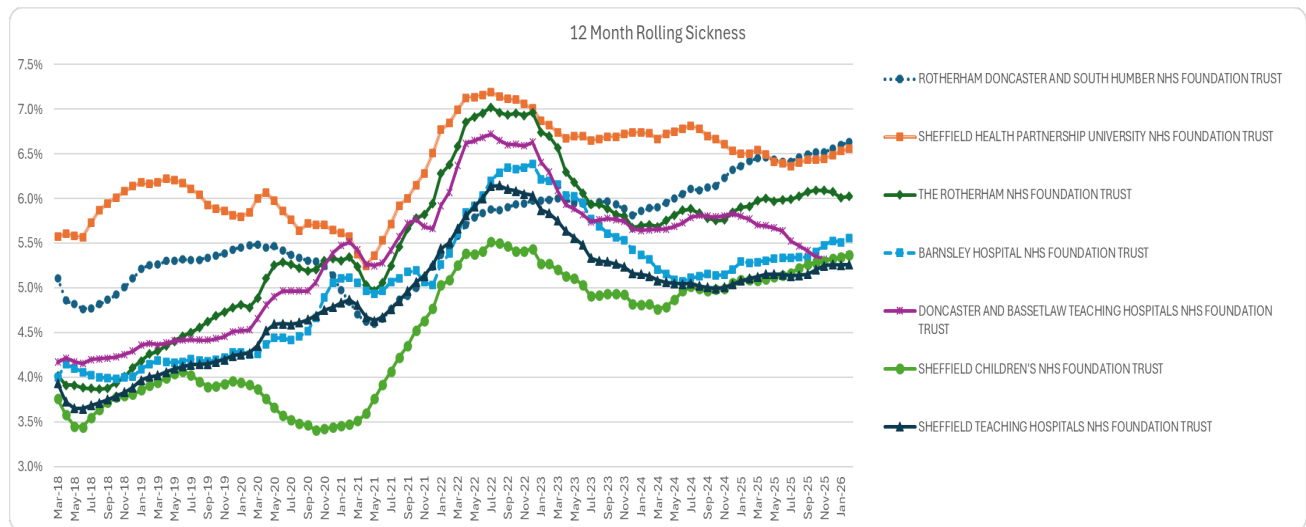
RECOGNISE the focussed work in this area and the wider workstreams which are being considered and implemented

DELEGATE the review and scrutiny of the approach and delivery to the People and Organisational Development Committee

Carlene Holden
Director of People and Organisational Development
May 2026

Annex 1

Table One – 12 month rolling sickness for South Yorkshire NHS organisations taken from Model Hospital



Organisation	Data Source	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	ESR Sickness	5.1%	5.1%	5.1%	5.1%	5.2%	5.2%	5.3%	5.3%	5.3%	5.3%	5.3%	5.4%	
	OpsPlan Sickness	5.0%	4.1%	4.0%	4.1%	4.4%	4.1%	4.2%	4.7%	4.9%	5.1%	5.2%	4.7%	4.5%
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	ESR Sickness	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.4%	5.5%	5.5%	5.5%	5.6%	
	OpsPlan Sickness	5.5%	5.6%	5.4%	5.5%	5.2%	5.1%	5.2%	4.9%	5.0%	4.7%	4.8%	4.5%	4.5%
THE ROTHERHAM NHS FOUNDATION TRUST	ESR Sickness	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.1%	6.1%	6.1%	6.1%	6.0%	6.0%	
	OpsPlan Sickness	6.4%	6.2%	6.1%	6.0%	5.8%	5.7%	5.6%	5.5%	5.3%	5.2%	5.1%	4.9%	4.8%
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	ESR Sickness	5.1%	5.2%	5.2%	5.2%	5.1%	5.1%	5.2%	5.2%	5.3%	5.3%	5.3%	5.3%	
	OpsPlan Sickness	4.7%	4.6%	4.6%	4.7%	4.9%	4.8%	5.0%	5.5%	5.3%	5.8%	5.7%	5.2%	4.7%
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	ESR Sickness	5.7%	5.7%	5.7%	5.6%	5.5%	5.5%	5.4%	5.4%	5.3%	5.3%	5.3%	5.4%	
	OpsPlan Sickness	5.7%	5.7%	5.6%	5.5%	5.3%	5.1%	5.0%	5.0%	5.0%	5.5%	5.5%	5.5%	5.0%
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	ESR Sickness	6.5%	6.5%	6.4%	6.4%	6.4%	6.5%	6.5%	6.5%	6.5%	6.6%	6.6%	6.6%	
	OpsPlan Sickness	6.4%	6.2%	6.1%	6.0%	6.0%	5.8%	5.7%	5.5%	5.4%	5.3%	5.3%	5.2%	5.1%
SHEFFIELD HEALTH PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	ESR Sickness	6.5%	6.5%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.5%	6.5%	6.6%	
	OpsPlan Sickness	6.7%	6.6%	6.3%	6.2%	6.1%	6.0%	5.8%	5.7%	5.6%	5.5%	5.4%	5.4%	5.1%

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	2025-26 serious patient safety incidents – learning update	Agenda Item	Paper S
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	James Cooper, Deputy Chief Nursing Officer Steve Forsyth Chief Nursing Officer		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points			
This paper provides a summary of learning from the 2025/26 Patient Safety Incident Investigations (PSIIs), outlining the key safety actions identified, common themes, measures of success and current delivery status, and also updates the Board on follow-up actions against the “so-what” learning themes from 2024/25. It demonstrates strong progress, with evidence that the majority of PSII safety actions have been delivered or are on track (each with clear measures of success defined and robust governance oversight in place), aligning the Trust’s patient safety approach with national expectations under PSIRF. The update also highlights the remaining areas requiring continued focus – notably improving clinical documentation standards and ensuring consistent family/carers involvement – which are being actively addressed and monitored to ensure these improvements fully embed. Given similarities between 24/5 PSIIs and 25/6 PSIIs the Board should consider whether we have sight of, and there exist, suitable data measures to match the assurances of change being offered by clinical executive Board members.			
Previous consideration			
Patient Safety Operational Group, Quality and Safety Group, Quality Committee			
Recommendation			
The Board is asked to:			
NOTE the significant progress and assurance outlined in the PSII Learning and Assurance Report (2025/26), including evidence that the majority of safety actions from 2024/25 and 2025/26 PSIIs have been delivered or are on track, and that RDaSH’s patient safety learning approach is aligned with national expectations.			
RECOGNISE the ongoing areas of risk highlighted – notably the need for further improvement in clinical documentation standards and consistent family/carers involvement – and the importance of sustained focus to ensure these improvements are fully embedded and residual safety risks are mitigated.			
Alignment to strategic objectives			
SO1: Nurture partnerships with patients and citizens to support good health			X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services			X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings			X
Alignment to the plans:			
People and teams plan			X
Quality and safety plan			X
Education and learning plan			X
Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	

Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	
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.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	
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.	
Strategic Delivery Risks			
Not applicable			
System / Place impact			
Trust-wide (RDaSH services across Rotherham, Doncaster, and North Lincolnshire – ensuring consistent patient safety improvements in all localities).			

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							
Appendix One - 2024/25 PSII Themes, evidence of delivery and status							

Patient Safety Incident Investigations (PSII) – Learning Report

1. Context and Purpose

Purpose: To provide Board confidence in the learning from Patient Safety Incident Investigations (PSIIs), progress against agreed actions, alignment with national learning, and remaining areas of risk requiring continued focus.

Executive Summary

This paper presents a clear, factual and evidence-based update on Patient Safety Incident Investigations (PSIIs) for 2025/26, together with a clear account of delivery of actions arising from 2024/25. It reflects a full cross-check against the RDaSH Safety Action Reviews and supporting system protocols.

RDaSH has acted decisively on PSII learning, with the majority of actions either delivered and embedded, or on a clear trajectory to completion. The paper is deliberately balanced: it highlights where we are progressing well, where improvement is demonstrable, and where risks remain live and require sustained oversight.

Under the Patient Safety Incident Response Framework (PSIRF), RDaSH undertakes PSIIs when a system-level investigation is most likely to add value. The Trust applies a proportionate approach to incident review, rather than investigating all serious incidents; this was agreed by the Board in May 2025. This paper supports the Board in:

- Understanding the most serious patient harms investigated in 2025/26.
- Gaining confidence that learning has translated into action.
- Testing whether actions are realistic, achievable and sustainable.
- Identifying residual risk requiring continued executive focus.

By focusing on the most significant incidents and their learning potential, the Trust aligns its resources with national patient safety guidance and ensures deep systemic investigations where needed. The ultimate aim is to translate lessons from PSIIs into tangible improvements in safety and care, and to evaluate the effectiveness of actions taken.

2. Overview of PSIIs in 2025/26

Between 1 April 2025 and 31 March 2026:

- 8 incidents were considered for PSII.
- 6 incidents were investigated via PSII (2 were managed through alternative PSIRF learning responses).
- Distribution of PSIIs in 2025/26 across the Care Groups:
 - Rotherham Mental Health: 3

- Doncaster Mental Health: 2
- North Lincolnshire: 1

The dominant category remained suspected suicide, consistent with 2024/25 and reflecting a national risk profile.

This shows that while the number of PSII's has reduced compared to prior years (as intended under PSIRF), the Trust has continued to focus on incidents of high severity or complexity where system-level learning is maximised. The predominance of suspected suicides aligns with known mental health safety priorities nationally, reaffirming our focus on strengthening suicide prevention measures.

3. Summary of Key Learning from 2025/26 PSII's

Each PSII yields specific action plans, tracked via our Master Safety Action Plan. The table below summarises each 2025/26 PSII, key safety actions identified, and current status:

PSII (Ref & Brief)	Key Safety Actions	Measures of Success	Status
884 (Male, 53, serious fracture)	<i>Action plan not yet finalised – in Quality Assurance (QA) stage before sign-off.</i>		
1224 (Female, 35, suspected suicide)	Ensure accurate and updated Next of Kin details upon admission; strengthen community–inpatient collaboration for discharge; complete & document MDT actions; Update risk assessment methods: replace RAG-rated risk with formulation-based approach aligned to	• Evidence that risks were identified early, mitigated effectively, and managed through robust multidisciplinary and community-based working. • Timely action on early relapse indicators, • Full compliance with MDT documentation standards, including accurate Next of Kin details • coordinated discharge planning with community teams, confirmed follow-up arrangements, and no immediate escalation of risk or avoidable readmission.	Most actions implemented by Q2 2025/26, with ongoing documentation audits for compliance. Risk tools being refreshed Trust-wide; new risk assessment training delivered via national programme by mid-year (embedding in progress).

	national guidance;	• Embed new risk assessment approach aligned with national guidance	
2719 (Male, 35, suspected suicide)	Update risk assessment methods: replace RAG-rated risk with formulation-based approach aligned to national guidance; provide national training on new risk assessment techniques.	• Embed new risk assessment approach aligned with national guidance	Risk tools being refreshed Trust-wide; new risk assessment training delivered via national programme by mid-year (embedding in progress).
2893 (Female, 41, suspected suicide)	Ensure pre- and post-leave risk assessments are always completed and documented; record all attempts to involve family (especially in discharge planning); implement NHS England "Staying Safe from Suicide" holistic safety planning guidance by Jan 2026.	• Demonstrable early discharge planning with community and inpatient clinical leads, • clear recording of all attempts to involve families in discharge planning, reliable • Embed new risk assessment approach aligned with national guidance • completion of pre- and post-leave risk assessments.	In progress. Local practice changes underway (improving compliance with leave risk checklists and family involvement); national guidance remains on track for Trust-wide implementation.

5129 (Female, 72, physical health deterioration)	Improve physical health management in mental health settings: require documentation of rationale for any omitted medications or tasks; update care plans promptly for changes in physical health needs; deliver regular physical health training to ward staff; strengthen inpatient–community joint working for discharge planning.	• Clear and accurate clinical records, documented clinical rationale for omissions or incomplete tasks, and care plans that are promptly updated following changes in physical health treatment. • Staff capability will be strengthened through targeted training, with a reduction in repeat learning themes linked to physical health management. • Effective joint working between inpatient teams and OPCMHT will be demonstrated through robust discharge planning that supports continuity of physical health care	Delivered. Multiple actions completed by Q3 2025/26 (e.g. new competency frameworks and training sessions delivered by Jan 2026) with continuous audits ongoing.
6808 (Male, 34, unresponsive on ward)	Enhance Duty of Candour: provide timely written feedback to families raising concerns; ensure robust documentation of PICU referral decisions; record supportive care interventions during prolonged patient	• Robust recording of the rationale and outcomes of PICU referral decisions, • clear documentation of supportive care provided during extended periods of sleep, • Timely, written responses to family concerns in line with Duty of Candour. • Greater sensitivity is applied to operational decisions, with explicit consideration of the	Delivered. All actions implemented by Q4 2025/26 (completed by Mar–Apr 2026), now embedded via updated SOPs (standard operating procedures) and daily patient flow reviews.

	inactivity; consider families' emotional needs in bed management decisions.	emotional impact on patients and families, supported by improved communication and involvement when such decisions are required.	

Table: Summary of 2025/26 PSII investigations, key actions, and status. All data are verified against the Master Safety Action Matrix (updated May 2026).

All six PSII investigations during the year returned common learning themes, some of which mirror those from 2024/25. The recurring nature of these issues underlines the need for continued improvement and vigilance to ensure changes are fully embedded into practice

3.1 Documentation and Recording Quality

What we found: Documentation remains the most consistent learning theme across PSIIIs. Issues relate not to an absence of care provided, but to insufficient recording of critical details, including:

- Clinical reasoning and rationale for decisions.
- Risk assessments and escalation decisions.
- Family involvement and clear documentation of multidisciplinary decision-making (MDT) trails.

Action taken: The Trust has introduced measures (such as enhanced record-keeping training, peer record audits, competency frameworks for staff) to improve documentation standards.

Current position: These actions are being implemented, but evidence of sustained improvement is not yet consistent. The 2025/26 PSIIIs continued to find some records with missing entries (for example, unrecorded risk summaries or leave assessments) or unclear rationale when tasks were left incomplete. This persists as a live risk, because poor documentation limits real-time clinical oversight and retrospective learning.

Status: Not yet fully delivered. Documentation training and audits have been enacted. However, consistent high-quality record-keeping is not yet fully embedded and remains a focus for continued monitoring via our Quality & Safety governance processes.

3.2 Risk Recognition, Escalation and Monitoring

What we found: In most cases, clinical teams recognised patients' risks in isolation, but did not always synthesise these into a coherent, escalating response. Monitoring was often compliant with required observation protocols, but the qualitative understanding of risk indicators and triggers for escalation varied.

Action taken: RDaSH has updated its risk assessment processes – moving away from simplistic, RAG-rated risk scoring towards a person-centred, formulation-based approach in line with national suicide prevention guidance. Nationally developed risk management training has been rolled out, and the Trust has committed to implementing NHS England’s “Staying Safe from Suicide” safety planning guidance.

Current position: Continued reinforcement and auditing are needed to ensure that all teams consistently apply the new risk formulation methods and escalate concerns sooner. The Trust’s trajectory is aligned with national best practice in risk assessment. No further PFDs or PSII findings have identified risk tool failures in the period, indicating early positive impact.

Status: Significant progress, ongoing reinforcement. The new risk assessment framework and training are progressing, but consistent use and confidence require sustained support to become fully embedded.

3.3 Family and Carer Involvement

What we found: Family and carer involvement in care was variable. Some PSIIIs highlighted limited or delayed engagement with families at critical points (for example, during discharge planning or when concerns were raised), or incomplete documentation of those contacts.

Action taken: The Trust has strengthened its approach to carer involvement. Families are invited to care planning and discharge discussions (with patient consent). Staff are expected to document all attempts to involve families in care decisions, and these are checked through record audits. This has been prioritised as a quality “always event” in our Quality & Safety plan. A Carers’ Network has been established to support ongoing improvements, in collaboration with partner organisations. The introduction of the Dialog+ person-centred care planning tool has replaced the need for a separate carer-involvement procedure, by systematically incorporating family input (again, with patient consent).

Current position: Partially delivered. Structural improvements (policies, training, support networks) are in place, but consistent practice is still in progress. Some 2025/26 incidents continued to find gaps in recording or engaging families, indicating further work is needed to translate these changes into reliable day-to-day practice across all teams.

Status: In progress. Focus on carer involvement is yielding some improvement (for example, better carer consultation was noted in a North Lincolnshire inpatient case), but full consistency is not yet achieved. The Trust will maintain this as a priority area for continued improvement and oversight.

3.4 Transitions of Care and Discharge Planning

What we found: Transitions of care (for example, moving between inpatient and community settings, or during ward leave and discharge) remain points of vulnerability. Several investigations revealed inadequate coordination, such as

incomplete handover information or insufficiently robust discharge planning, potentially contributing to relapse or missed follow-up.

Action taken: The Trust is strengthening transitional safeguards. We have emphasised earlier joint discharge planning – for example, crisis team can and will join inpatient early-discharge planning meetings to ensure continuity of care. Staff are mandated to use pre- and post-leave risk checklists, and to clearly evidence family inclusion in discharge planning discussions. This year's reviews noted some instances of improvement; for example, one PSII highlighted effective collaboration between inpatient and community teams around a patient's discharge, leading to a smoother transition.

Current position: The recurrence of transition-related issues in incident analyses indicates that improvements are not yet fully reliable. However, measures are being reinforced through policy updates and audits.

Status: In progress, with improvements underway. These include earlier and multi-agency discharge planning and formalised risk checks at key transition points. These measures are being hardwired through policy and audited for compliance, but continued focus is required until transitions are consistently safe and well-coordinated.

3.5 Workforce, Systems and Environment

What we found: Many PSIs underscored how system-level pressures and resources can impact care. Notable themes included:

- Staffing pressures: Instances where staffing shortages were not escalated robustly or mitigated effectively, potentially affecting patient oversight.
- Staff wellbeing: Staff distress and fatigue were at times factors in clinical decision-making and vigilance.
- Operational constraints: Challenges such as high bed occupancy and bed pressures impacted patient experience and sometimes influenced care decisions (for example, discharges or transfers under pressure).

Action taken: Senior leadership has reinforced safe staffing escalation procedures to ensure any staffing concerns are promptly raised and addressed. The Trust recognises staff welfare as a patient safety issue; it provides psychological support and reflects on staff wellbeing in safety reviews. The High-Quality Therapeutic Care (HQTC) programme addressed both crisis and patient flow practices – for instance, aiming to minimise the disruption caused by transfers and to ensure that bed management decisions consider patients' and families' emotional needs.

Current position: Policies, staff support initiatives, and taskforces are in place to mitigate systemic risks. The Trust collaborates with external partners to manage pressures (for example, via joint protocols with acute hospitals for mental health patients in A&E).

Status: In progress, under ongoing oversight. The Trust remains vigilant. Regular patient flow reviews, seclusion and debrief audits, and workforce metrics are monitored through governance frameworks to confirm these improvements lead to consistent front-line safety outcomes.

4. Update on 2024/25 “So-What” Themes

The Board’s May 2025 PSII report identified nine overarching “so-what” themes from the 2024/25 PSIIIs. RDaSH has acted on all nine through policies, training, audits and service changes. Many planned improvements have been delivered, but some themes remain active because they recurred as issues in 2025/26 or lack firm outcome evidence yet. The Board should note progress *and* where further work is needed. Appendix One summarises the nine themes, and the markers of delivery.

Areas of Strong Progress

- **Access and referral:** The Trust has removed *paper triage* and reinforced “no wrong door” principles. All community mental health referrals now receive direct, timely follow-up (no “letters only” responses). A joint protocol with acute hospital partners ensures rapid mental health assessment and proactive safety planning in A&E if a patient leaves before being seen. These changes are in place and expected to reduce the risk of patients “falling through the gaps” due to access delays or self-discharge.
- **Risk assessment:** The Trust’s approach is shifting to formulation-based risk assessment, in line with national suicide prevention guidance and Staying Safe from Suicide (NHS England’s 2025 framework). By early 2026, all inpatient areas have access to the new training and tools.
- **Physical healthcare in mental health settings:** There has been a concerted effort to ensure physical health is a priority on mental health wards. Cross-agency protocols with acute hospitals are in place for timely medical care. Physical health deterioration training was launched in 2025, with Rotherham wards piloting improved emergency response tools. Pharmacy audits show a reduction in the use of certain high-risk medications as a result of PSII learning. A PSII in 2025/26 confirmed largely good physical healthcare delivery for a complex patient, indicating this focus is yielding results.
- **Crisis response:** Governance around crisis escalation and seclusion management has been strengthened. The HQTC improvement group is concentrating on better crisis care pathways and reducing disruptive transfers, ensuring more timely and compassionate responses. Revised training on restraint and seclusion now emphasises clear roles and communication to keep patient dignity at the forefront even in challenging situations.

Areas Requiring Continued Improvement:

- **Documentation quality:** Despite new training and audits, records are still not consistently meeting required standards. Evidence of sustained Trust-wide improvement in record-keeping is not yet clear. 2025/26 PSIIIs echoed prior

concerns – for example, incomplete risk documentation and insufficient detail in care records – indicating that documentation quality remains not fully delivered and must remain under active monitoring.

- **Family and carer involvement:** The Trust's structures for carer involvement are in place, but full consistency is not yet achieved. Family engagement still appears as a theme in new incidents. Continued coaching, feedback from carers, and audit are necessary to ensure that every service reliably involves and supports families as partners in care, where appropriate.
- **Transitions and discharge planning:** Many safety initiatives have been introduced (for example, early discharge planning, mandated risk checklists, cross-team meetings), but transitions remain a vulnerability until these measures are universally adopted and proven effective. The Trust will continue to audit and monitor transitional care, aiming for evidence that these new processes reliably prevent relapse or lost follow-up in the future.

These themes mirror national findings – for example, external investigations (including HSSIB mental health reports and multiple coroners' PFDs) repeatedly cite documentation, discharge planning, communication, and family involvement as ongoing system challenges. This reinforces that our local issues are part of wider national patient safety concerns and that our targeted actions are in line with addressing known problem areas in mental health care.

5. Benchmarking Against Other NHS Organisations

Compared with peer mental health providers:

- RDaSH's Board-level PSII reporting is aligned with – and in some areas more developed than – current national practice. The Trust's focus on system learning, sustainability and oversight (rather than just task completion) reflects a high maturity level under PSIRF and is consistent with best practice.
- Transparency: We are open about what we have not yet fully embedded, which aligns with recommended best practice and national expectations for candour and continuous improvement.
- Our learning themes and actions correspond to those identified by national bodies. This suggests that we are focusing on the right areas, and that our improvement efforts address issues common across the NHS, adding confidence that we are benchmarking correctly.

6. Conclusion and Board Position

In summary, RDaSH has responded appropriately and proportionately to PSII learning and the organisation demonstrates a credible learning culture with strong executive oversight and willingness to address shortcomings. The majority of actions from PSII are delivered or clearly progressing as planned and residual risks are explicitly recognised, monitored and escalated through our governance processes.

However, we must remain vigilant and continue to focus on areas where improvements are still embedding – particularly the consistency of documentation standards and family engagement. Sustained oversight and further evidence are required here.

Recommendations: The Board is invited to:

- **NOTE** the significant progress and assurance outlined in the PSII Learning and Assurance Report (2025/26), including evidence that the majority of safety actions from 2024/25 and 2025/26 PSII's have been delivered or are on track, and that RDaSH's patient safety learning approach is aligned with national expectations.
- **RECOGNISE** the ongoing areas of risk highlighted – notably the need for further improvement in clinical documentation standards and consistent family/carer involvement – and the importance of sustained focus to ensure these improvements are fully embedded and residual safety risks are mitigated.

By acknowledging both our successes and remaining risks, the Board can take confidence that RDaSH's approach to PSII learning is robust and aligned with national safety priorities. This will ensure sustained improvement in patient safety and better outcomes for those we serve.

Appendix One – 2024/25 PSII Themes, evidence of delivery and status

2024/25 “So-What” Theme (Implication)	Source (May 2025 paper and PSII actions)	Evidence of Delivery (2025/26) – <i>How We Know</i>	Monitoring Route (Monitoring and Measures)	Current Status (Documented)
1. Communication (Internal & External)	<i>2024/25 paper:</i> Multi-organisation changes needed. For example, PSII 4279 identified cross-provider gaps.	Joint working initiated: RDaSH convened a cross-organisation meeting with acute trusts (Q1 2025/26) to agree shared protocols. External partners (e.g. TRFT) also launched their own investigations in response.	Integrated governance: Learning shared via ICS partner meetings and the Quality & Safety plan. Ongoing tracking through the Delivery Review cycle (Board oversight from May 2025).	In progress: Documented evidence of joint actions with external providers indicates some delivery. Continued multi-agency monitoring is needed; there is no evidence of full resolution yet, and the theme still arises in 2025/26 PSIIIs. DBTH, RDaSH and CDC, have created a SOP to ensure consistency around the assessment pathway for patients in acute crisis in the emergency department. Similarly, RMBC, RBaSH have created a clear process for sharing AMHP reports following MHA assessments
2. Record Keeping Below Standard	<i>2024/25 paper:</i> Widespread documentation gaps. PSII actions target record improvements,	Still a key theme: 2025/26 PSII reviews confirm that documentation quality remains the most consistent issue , with risk	Audit and training: Multiple actions have been implemented, including new documentation training and matron-led record audits to	Not fully delivered: Ongoing issue. Efforts have been launched through training and audits, but there is no documented improvement . 2025/26 incidents

	such as audits of family interactions and training on record standards.	notes and rationales for decisions often incomplete. <i>No evidence yet</i> shows sustained improvement; it remains one of the strongest learning themes.	ensure, for example, that all family interactions are logged. The Board expects evidence through audit reports in 2025/26, but this has not yet been seen.	still show documentation lapses. The issue remains under active monitoring.
3. Personalised Care Planning	<i>2024/25 paper:</i> Care plans were not always person-centred. For example, PSII 4279 and 9559 highlighted the need for personalised care plans and Positive Behaviour Support for challenging behaviours.	Partial progress: Some improvements have been noted. <i>One 2025/26 PSII</i> shows holistic care in place for a complex patient, demonstrating good practice. However, inconsistency persists in care plan quality, including continued issues with routine risk and leave plan completion.	Policy and audit: Care plan quality is now emphasised in routine ward MDT reviews and audits , including weekly audits of physical health care plans. Positive Behaviour Support training has also been introduced for staff and is monitored through the RRI team.	In progress: Some evidence of improvement exists, including instances of good personalised care in 2025/26, but this is not yet uniform . The issue is being addressed through training and audits, and further evidence is needed that all care plans are consistently person-centred.
4. Family/Carer Involvement Deficits	<i>2024/25 paper:</i> The Trust did not consistently hear carers well. PSII's flagged limited carer involvement. Actions included always involving families in discharge and leave planning and making	Remains a theme: 2025/26 reviews show that family involvement remains uneven , with multiple incidents showing limited or undocumented carer involvement. However, the Trust has made structural changes, including launching a	"Always" measures: Carer engagement is now an expected element in planning, monitored through Quality & Safety plan KPIs and "always events". Audits , such as matron audits, also check that family involvement is documented in clinical records.	Partial delivery: Structures are in place , including the carer network and policy expectations, but there is no clear evidence of full embedding yet. Family involvement continues to appear as a gap in incidents, indicating that work is ongoing.

	carer support a standard “always event” in the Quality & Safety plan.	Carers’ Network and strengthening partnerships with carer organisations to improve engagement.	Carer feedback is tracked as an outcome measure.	
5. Access/Waiting Issues (Referrals)	<i>2024/25 paper:</i> One theme was delayed or impersonal access , for example where “paper triage” in CMHT hindered timely help.	Direct action taken: Paper triage was abolished after the incident. All community referrals now receive direct contact or face-to-face assessment, with no more letter-only responses. The service is also undergoing capacity-and-demand improvement work to manage referrals better.	Operational change: The new referral process is in place. Evidence comes through patient feedback and monitoring : patients should always speak to CMHT on referral, within hours, and have crisis access out of hours. Policy updates , including the disengagement policy under review by the CMO, also align processes across the Trust.	Delivered and monitoring: Key process change delivered. The end of paper triage directly addresses the “so-what” for access. <i>Impact needs ongoing evaluation</i> , but the change itself is complete and is expected to reduce future delays.
6. Disengagement Approach	<i>2024/25 paper:</i> A cultural shift was needed to better support those disengaging. A new disengagement policy and referral triage pathways were initiated, including an extraordinary meeting in January 2025 to	Policy underway: The Trust’s disengagement policy was formally reviewed as a result, led by the CMO. As above, referral processes have been tightened to ensure patients are not dropped without contact. There is no specific outcomes data on disengagement yet, but	Governance oversight: The revised policy and triage approach are monitored through the Quality Committee and executive oversight. Future audits and incident reviews will test whether patients are lost to follow-up and whether the policy is adhered to, including verification of consistent	In progress: Structural changes , including policy updates, have been made, but there is no documented outcome evidence yet on reduced disengagement-related incidents. Monitoring continues, and success will be measured by fewer cases of patients “falling through gaps”; no such incidents appear in the 2025/26 data so far.

	align referral decisions.	structural fixes are in place, including policy changes and a cultural emphasis on persistence with follow-up.	contact attempts and safer discharge practices.	
7. Risk Assessment (Holistic/Contextual)	<i>2024/25 paper:</i> The paper emphasised moving from tick-box risk assessment to a formulation-based approach. Actions included aligning Trust risk tools with national guidance , such as updating the RAG-rating approach, and implementing NHSE's "Staying Safe from Suicide" guidance by January 2026.	Alignment achieved: The Trust updated its risk assessment approach . By 2025/26, RAG-rated risk tools had been refreshed to match national best practice, and new training was in place across inpatient services. The Staying Safe from Suicide framework was on track for January 2026 implementation, with no contrary evidence identified.	Audit and outcomes: Success is measured by consistent use of updated risk tools and templates , such as pre- and post-leave risk forms, and by improved early risk mitigation, for example where no incidents occur during leave or admission if risks are managed. These are being monitored through internal audits and outcome tracking , including rates of repeat serious incidents, which remain low.	Substantially delivered: Policy and training changes have been delivered through nationally aligned risk processes. <i>Evidence of impact</i> includes the absence of new PSII findings highlighting risk tool failures; some 2025/26 PSIIs instead noted that risk was documented and explored in line with guidance . Continued audit will confirm full embedding.
8. Physical Health in MH Care	<i>2024/25 paper:</i> Address diagnostic overshadowing by ensuring equal focus on physical health for mental health patients. Cross-	Improvement actions: Joint protocols are being developed with acute hospitals to improve medical care for mental health inpatients. Training: RDaSH rolled out physical	Evidence: Audit of physical health care plans on mental health wards includes weekly review of individualised plans. Pharmacy measures show that Clonazepam prescribing was significantly reduced	In progress: Positive steps have been taken , including cross-agency collaboration, staff training, and a clear reduction in some risk factors such as sedative use. However, physical health management still featured in at

	agency partnerships were needed for complex comorbid cases.	deterioration recognition training on mental health wards, with the pilot starting in Rotherham in 2025. One 2025/26 PSII confirmed that physical health care was largely appropriate and holistic.	after the 2024 case, tracked through prescribing audit. Full roll-out of NHSE suicide prevention guidance by January 2026 will further embed holistic risk formulation.	least one 2025/26 PSII, indicating that further improvement is needed. Continued focus on audits and training is being maintained.
9. Crisis & Seclusion Practice	<i>2024/25 paper:</i> Improve timeliness and consistency in crisis responses across community and ward settings, including safer seclusion management . PSII 8656 identified multiple transfers and communication failures in a seclusion case.	Process reforms: The High-Quality Therapeutic Care (HQTC) taskforce is addressing crisis care pathways, for example by focusing on reducing patient transfers during PICU and seclusion episodes. Restraint training has been updated, with the RRI team now emphasising assignment of a lead for transfers. Improved seclusion review processes are being embedded to centre the patient , including communication with the	Monitoring: Patient flow data track seclusion-related transfers, with the aim of reduction. Patient feedback and debriefs are used to assess communication and care quality during seclusion. The new 50-day PSII turnaround standard also helps ensure timely learning and action after serious incidents.	In progress: Policy and practice changes have been initiated , including updated training and HQTC focus, but there are no explicit 2025/26 outcome data yet. One late-2025 PSII suggests that some missteps remained in a crisis scenario, so this area is still being addressed. The Trust is actively monitoring it for improvement.

		patient, role clarity, and physical health checks.		

Reference List

Regulation 28 – Prevention of Future Death (PFD) Reports:

- *Delwyn Preece – Regulation 28 Report to Prevent Future Deaths (17 March 2026, South Yorkshire East District, Ref: 2026-0165).*
- *Ethel Robertson – Regulation 28 Report to Prevent Future Deaths (17 November 2025, Hampshire (Portsmouth & Southampton), Ref: 2025-0584).*
- *Darren Neil Turner – Regulation 28 Report to Prevent Future Deaths (17 March 2025, Essex, Ref: 2025-0144).*

HSSIB Reports (Mental Health Inpatient Settings Investigations):

- *Mental Health Inpatient Settings – Overarching Investigations Report (HSSIB, May 2025).*
- *Themed Investigation: Assessment of Suicide Risk and Safety Planning (HSSIB, 2024).*
- *Themed Investigation: Learning from Deaths in Mental Health Inpatient Settings (HSSIB, 2025).*

NCISH Reports:

- *The assessment of clinical risk in mental health services – National Confidential Inquiry into Suicide and Safety in Mental Health (University of Manchester, 2018).*

Internal Learning Sources (RDash):

- *RDash PSII Reports (2024/25 and 2025/26) and associated investigation findings.*
- *RDash Master Safety Action Plan for 2024/25 PSII Learning (Updated May 2026).*
- *PSIRF Implementation Plan and related RDash Patient Safety Incident Review documentation (2023/24).*
- *RDash “High-Quality Therapeutic Care” (HQTC) improvement programme and internal action plans (2025/26).*
- *Joint RDash & Acute Trust A&E Mental Health Management Protocol (2025).*

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Well led – externally commissioned developmental review	Agenda Item	Paper T
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
Since November 2024, the Board has received, as part of the CQC Readiness work, four papers specifically in relation Well Led, and colleagues will recall that in November 2025, the paper included the most recent self-assessment ratings and the introduction of the directorate level maturity matrix. The Board, in September 2025, also received the related Provider Capability Assessment Framework submission – the position of which was confirmed (supported) by NHS England. These together, provide a sound basis against which the Board can understand its current position in respect of the CQC Well Led criteria and any scope for improvement. Further, in January 2026, The Value Circle (TVC) were appointed, following an open procurement process, to provide the Trust with an independent Well Led Developmental Review. Throughout Q4 2025/26 TVC undertook a programme of interviews, desk top reviews and observations and have now issued their final report to the Trust, attached to this paper at Appendix 1. The Board of Directors will take the opportunity in its private session today to reflect with TVC on the report, its findings and recommendations and will receive in June 2026, a management response to the recommendations made in the report – that will also inform the Board paper in July 2026 on Culture. The management response will outline the work considered necessary to advance the Trust to a ‘Good’ rating for Well-led and a ‘Green’ rating for the PCA framework.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
Board of Directors (May and Nov 24 / May and Nov 25) The initial paper set a baseline; the subsequent updates noted marginal gain and further evidence that would be sort to support the assessment. The TVC report has not been discussed elsewhere prior to todays Board of Directors meeting.			
Recommendation (delete options as appropriate and elaborate as required)			
The Board of Directors is asked to:			
RECEIVE and NOTE the Well Led Development Review Report from The Value Circle (TVC) acknowledging the conclusions and recommendations it contains.			
CONSIDER any informal feedback on our preparedness and readiness for a well led assessment from TVC in the private session of the Board			
NOTE the intention for a management response report to be presented to the Board of Directors in July 2026, that will respond to the TVC report recommendations and that will describe the actions to be taken in respect of the related Provider Capability Assessment Framework			
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)			
All Plans			x
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	x
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	x
Financial risks			
Financial Planning, CIP and Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	x
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	x
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	x
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	x
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	x
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	x
Capacity and Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	x
Estates, Equipment and Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	x
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	x
Digital Infrastructure and Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	x
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	

Legal and Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	x
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	x
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	x
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	x
Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services			X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.			X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.			X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees			X
System / Place impact (advise which ICB or place that this matter relates to)			
Reputation, Partnership, Workforce			
Equality Impact Assessment	Is this required?	Y	N x If 'Y' date completed
Quality Impact Assessment	Is this required?	Y	N x If 'Y' date completed
Appendix (please list)			
Appendix 1. The Value Circle (TVC) Well Led Developmental Review Report – May 2026			

Rotherham Doncaster and South Humber NHS Foundation Trust
Well led – externally commissioned developmental review

1. Introduction

- 1.1** The Board of Directors recognises the importance of compliance with the CQC's Well-Led key question as a key part of the foundations of the business in which it operates. Over the last two years, it has received a series of papers that have focused on this topic and in September 2025, a separate but very related paper in respect of the Trust's compliance with the Provider Capability Assessment Framework. Strong compliance with these two frameworks is a desire of the Board of Directors.
- 1.2** To this end, to supplement and indeed verify, the work that has been underway internally, the Board of Directors agreed in November 2025, to commission an external, independent Well-led Developmental Review. Following an open, competitive procurement process, The Value Circle (TVC) were appointed to undertake that review and commenced with the Trust in January 2026.
- 1.3** The TVC report is the key focus of this paper to the Board of Directors today but it should be clear to colleagues that other papers on the agenda – most notably the papers on Culture, Staff Survey and Freedom to Speak Up as well as the Board and Committee workplans all are very pertinent to the Well led work too.

2. Well Led Self-Assessment

- 2.1** By way of recap, the Board of Directors should recall that its self-assessment work to date, reported on a six monthly basis since May 2024, is based across the following eight criteria
- Shared Direction and Culture
 - Capable, compassionate and inclusive leaders
 - Freedom to Speak Up
 - Workforce Equality, Diversity and Inclusion
 - Governance, Management and Sustainability
 - Partnerships and Communities
 - Learning, Improvement and Innovation
 - Environmental Sustainability – Sustainable Development

The position, reported to the Board in November 2025, resulted in five areas being assessed as 'green' (evidence shows a good standard) with the following three areas being 'amber' (evidence shows some shortfalls)

- Freedom to Speak Up
- Workforce Equality, Diversity and Inclusion
- Learning, Improvement and Innovation

Maintaining the 'green' areas and improving on the three 'amber' areas will be the forward plan.

3. Provider Capability Assessment Framework

3.1 By way of recap, the Board of Directors should recall that the PCA Framework assessment focuses sixteen criteria across the following six areas:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

3.2 The Board of Directors supported a self assessment of 'green' (high confidence) across fourteen of the sixteen criteria with two assessed as 'amber' (Some concerns or areas that need addressing), being:

- 5: Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients; and
- 9. Staff can express concerns in an open and constructive environment.

4. Externally Commissioned Well Led Development Review

4.1 The Trust commissioned the review from The Value Circle and it commenced in January 2026 and during the following four months TVC colleagues undertook a range of interviews, observations and desktop paper reviews. Their work is set out in their report, attached at Appendix 1.

4.2 The report sets out a range of conclusions that provide positive and supporting commentary across many aspects of the Well led key question. As expected, given the developmental approach, the report identifies a range of areas where, in the view of TVC, the Trust could extend, improve or develop in order to be 'better still'.

4.3 Of note within the positive and supporting commentary are the following:

- *RDaSH has set out a clear strategic direction and framework that places people, communities, lived experience and participation at the centre of its approach.*
- *....strength and maturity in its system approach.*
- *At Board level, leadership behaviours were observed to be professional, respectful and values-driven, with challenge actively encouraged.*
- *Overall, RDaSH is an organisation with strong foundations, clear intent and demonstrable momentum during a period of change.*

4.4 With respect to the areas of 'better still', the following are highlighted – and the recommendations associated are presented in pages 33 to 36:

- *As RDaSH is delivering significant transformation to the way it operates, senior leaders recognise that the pace of change is an ongoing area for attention, particularly in balancing organisational capacity with the scale and complexity of change.*

- *There is opportunity to strengthen how insight is routinely gathered, triangulated and used to inform organisational understanding of staff experience*
- *It is important to recognise that several development areas relating to culture, staff experience and leadership visibility are legacy issues. These areas reflect challenges that RDaSH's leadership recognise as requiring sustained effort and consistent leadership attention to address.*

4.5 The Board will also recall that it commissioned work during 2023/24 from Good Governance Improvement (GGI). Whilst largely superseded by the more recent work and by progress made since that point, there will as below, be a check back to ensure that nothing remains outstanding. Whilst not a specific Well Led based review, the content and conclusions were very much aligned to the other works referred to in this paper.

5. Next Steps

- 5.1** The Board of Directors should take time to reflect on the report from TVC and will do so in the private session of the Board meeting today, with TVC colleagues.
- 5.2** At the Board of Directors timeout meeting in June 2026, a management response paper will be presented and outline how the Trust will respond to the report and its recommendations. This response will also reflect on the related Provider Capability Assessment Framework and the areas agreed by the Board and subsequently supported by NHS England, where further progress was required in respect of compliance with this framework, and any legacy actions from the GGI work.
- 5.3** The separate, but very much aligned initiatives, provide the Board of Directors with sound assessment and opportunities for improvement in its governance and capability foundations. The proposed responses will be reflected in an updated Well-led self-assessment and Culture paper, also being presented in July 2026. The aim will be to set out the path and timescales for the Well led assessment to be improved to 'green' overall and for the PCA framework to also move to 'green' overall.

6. Recommendations to the Board

The Board of Directors is asked to:

RECEIVE and NOTE the Well Led Development Review Report from The Value Circle (TVC) acknowledging the conclusions and recommendations it contains.

CONSIDER any informal feedback on our preparedness and readiness for a well led assessment from TVC in the private session of the Board

NOTE the intention for a management response report to be presented to the Board of Directors in July 2026, that will respond to the TVC report recommendations and that will describe the actions to be taken in respect of the related Provider Capability Assessment Framework

Philip Gowland
Director of Corporate Assurance
15 May 2026



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Rotherham Doncaster and South Humber NHS Foundation Trust

Developmental Well Led Review

8th May 2026

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Executive summary

Executive summary

Context

This report sets out the findings from a Developmental Well-Led review undertaken between February and May 2026. The review was commissioned by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) to provide an independent assessment of the Trust's leadership, governance and organisational effectiveness.

The review has considered the Trust's position against the Care Quality Commission's Single Assessment Framework, with a specific focus on the Well-Led domain. The process was developmental, and designed to support reflection, learning and continuous improvement.

This executive summary highlights the key themes from the review, with detailed evidence and analysis set out in the main body of the report. We would like to thank all those who contributed to the review for their openness, engagement, and willingness to share their time and insights in support of the Trust.

Executive Summary

The RDaSH leadership team describe significant organisational ambition and change. The Trust is intentionally moving towards a stronger delivery culture, with increased emphasis on accountability and clarity of expectations. The Board have acknowledged this as a shift in ways of working for staff and recognise that, while progress is being made, further development is required to embed this consistently across the organisation.

RDaSH has set out a clear strategic direction and framework that places people, communities, lived experience and participation at the centre of its approach. This intent is articulated through the Trust's Clinical and Organisational Strategy, which sets out 28 Promises, and reflects a deliberate move towards more participative and community-focused models of leadership and delivery.

As RDaSH is delivering significant transformation to the way it operates, senior leaders recognise that the pace of change is an ongoing area for attention, particularly in balancing organisational capacity with the scale and complexity of change.

The review highlights the Trust's strength and maturity in its system approach. The Trust is externally recognised for its role in system leadership. Partners described RDaSH as a credible and active contributor within collaborative and place-based arrangements, supported by visible and consistent engagement from the Chair and Chief Executive.

Executive summary

Community participation and the use of lived experience is also integral in shaping strategic priorities, informing decision-making and influencing service design and delivery. This creates a clear and sustained 'golden thread' across the organisation.

At Board level, leadership behaviours were observed to be professional, respectful and values-driven, with challenge actively encouraged. The Board also operates within an intentionally cultivated high support, high challenge environment, which was described as widely valued by Non-Executive and Executive Directors. Challenge across Board and sub-committee forums are viewed as a key strength.

The governance arrangements that support this leadership are well established and provide a strong foundation. Committee structures are clear, assurance routes are in place, and reporting mechanisms give the Board regular insight into performance, quality, risk and delivery. The review identified opportunities to further strengthen assurance through developing triangulation across quality, workforce and finance.

Staff voice is present and engagement mechanisms are established, providing routes for staff to contribute views, raise issues and influence discussion. A range of mechanisms are in place to support openness, including informal briefings with trade union colleagues, open staff meetings and dedicated communication channels. There is opportunity to strengthen how insight is routinely gathered, triangulated and used to inform organisational understanding of staff experience.

It is important to recognise that several development areas relating to culture, staff experience and leadership visibility are legacy issues. These areas reflect challenges that RDaSH's leadership recognise as requiring sustained effort and consistent leadership attention to address.

Overall, RDaSH is an organisation with strong foundations, clear intent and demonstrable momentum during a period of change. The findings identify opportunities to build on this progress, supporting sustained delivery over time. The review is intended to support the Trust in consolidating its approach, strengthening alignment, and progressing its ambitions for staff, services users, communities, and the wider system.



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Background, scope, and approach

Background and scope

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) provides mental health and learning disability services across Rotherham, Doncaster and North Lincolnshire, alongside substance misuse services in Doncaster. The Trust also delivers community health services and adult social care across Doncaster, school nursing services in Scunthorpe, and a hospice in Doncaster. RDaSH provides services from over 100 locations and serves a population of approximately 735,000 people.

The Trust's most recent CQC inspection took place in November 2019, with the report published in February 2020. RDaSH is currently delivering its 2023–2028 strategy, focused on partnership working, equity of access and experience, strengthening community provision, high-quality inpatient care, and delivering social value through local partnerships.

The Trust is operating within a complex and evolving context, including system-wide financial pressures, workforce challenges and service demand. There has also been recent organisational change and a refreshed Executive team.

This report presents the findings from a developmental Well-Led review, using the CQC's updated Single Assessment Framework, with a specific focus on the Well-Led domain. The review considered both the mechanics of governance (structures, processes, and systems) and the dynamics of leadership (behaviours, values, and ways of working).

The Developmental Well-Led review aims to highlight areas of strength and identify opportunities for further development.

We would like to thank all those who contributed to the review for their openness, engagement, and willingness to share their time and insights in support of the Trust.

Approach

This review was undertaken between February and May 2026. The review applied a multi-method approach aligned to the CQC Well-Led domains. Evidence was drawn from document review, observation of key governance and leadership forums, interviews with senior leaders and external partners, and a staff focus group.

Documentation Review

We conducted a detailed review of relevant and identified documentation submitted by the Trust. We evaluated key documents relating to organisational and clinical governance. This included a review of the documentation set out in the appendix A.

Observations

We observed the following 12 key forums:

- Board of Directors (Public and Private)
- Quality Committee
- Finance, Digital and Estates Committee
- People and Organisational Development Committee
- Audit Committee
- Mental Health Act Committee
- Public Health, Patient Involvement and Partnership Committee
- Charitable Funds Committee
- Council of Governors
- Clinical Leadership Executive
- Delivery Reviews

We assessed the dynamics and effectiveness of the leadership teams within these meetings, how decisions are made, the level of accountability, and the quality of information presented.

Interviews

We worked with the Trust to identify and interview 28 individuals, including senior leadership and external partners. The themes from these interviews were then triangulated with documentary evidence throughout the review.

Focus Group

We undertook a single focus group with staff. The design of the focus group was modelled around the key lines of enquiry of the CQC single assessment framework.

It should be noted while this provided valuable qualitative insight, the limited number of focus groups constrained the extent to which broader staff perspectives could be triangulated across our findings.



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Findings

Shared direction and culture

Shared direction

The Trust has a clear and well-articulated strategic direction, set out in the Clinical and Organisational Strategy 2023–2028. This strategy is widely understood by Board members, senior leaders, system partners and wider stakeholders interviewed as part of the review. Strategy is consistently referenced across governance forums and operational discussions, creating a strong and visible ‘golden thread’ linking strategic intent to delivery structures, decision-making processes and performance oversight.

The 28 Promises operate as an effective delivery framework for the strategy. They provide clarity on organisational priorities, are aligned to established governance arrangements and support the tracking of progress. The promises were routinely referenced in meetings and interviews, indicating that they are well understood by leaders and used to guide delivery.

The strategy is viewed as a practical tool that leads day-to-day activity in the Trust. Committee observations evidenced clear articulation by leaders of how strategic priorities translate into operational activity, demonstrating a strong connection between strategic intent and delivery on the ground. We were unable to test the embeddedness of the strategy further across the organisation.

There is strong alignment between the Trust’s strategic direction and system priorities. System partners described the strategy as well aligned to neighbourhood health, community-based care and prevention, reflecting effective collaborative working. The Chief Executive and Chair play an active and visible role in external system relationships, and their leadership is recognised by partners as supporting alignment between organisational ambition and system direction.

There is clear evidence of co-creation with communities and people with lived experience in the development of the strategy, consistent with the Trust’s participative approach. Evidence provided by the Trust indicates that the strategy was also informed through workforce involvement, including large-scale workshops and multiple opportunities for Clinical Leadership Executive (CLE) members to co-design and shape its development.

Feedback from staff and leaders suggests that challenges with engagement in the strategy are not due to a lack of opportunity to contribute to its development. Triangulated evidence did indicate a potential variation in how staff experience ownership of, and connection to, the strategy in practice, affecting how consistently the strategy is locally owned across services.

Shared direction and culture

As part of the strategic approach to nurturing community power and strengthening participation, the Trust has expanded its use of volunteers under Promise 3. The strategy positions volunteering as a means of deepening community connection, extending lived experience and peer contribution, and supporting quality of care beyond traditional service models. This approach reflects the Trust's broader ambition to work alongside communities, patients and carers as active partners in delivery. During implementation, we were told that some staff experienced uncertainty about the purpose, expectations and scale of volunteering, particularly within the context of wider organisational change. Greater clarity and consistency in communicating the role and intended contribution of volunteers would support shared understanding and successful embedding of this strategic intent.

When the strategy is refreshed in 2028/29, there is an opportunity to build on the engagement already undertaken by strengthening how strategic intent and rationale is communicated and reinforced through delivery. Clear, consistent communication and continued workforce engagement will support ownership across staff and services.

Culture

Values and behaviours

The Trust has clearly articulated values, including strong commitments to anti-racism and equality. Board-level papers reviewed, including a November 2025 paper (Anti Racism Stocktake) gave a number of key highlights on the progress towards becoming an anti-racist organisation. The paper positions racial inequality and discrimination as behavioural issues requiring clear leadership accountability. This demonstrates that the Trust's anti-racism work is formally considered and monitored within established governance arrangements, and explicit recognition of the role of leadership behaviours in shaping organisational culture.

Our engagement with senior leaders and review of governance arrangements demonstrate a clear intent to understand staff experience, supported by a range of listening and engagement mechanisms. However, the material reviewed also suggested there is an opportunity to strengthen how insight is routinely gathered, triangulated and used to inform organisational understanding of staff experience. This would strengthen the systematic and consistent exploration of the factors shaping staff experience, including where staff feel disengaged or under-valued.

Shared direction and culture

Community engagement

The Trust's approach to community engagement and the use of lived experience is well developed and consistently evidenced in practice. Community participation is embedded within strategic development, decision-making and service delivery, and operates as a clear and sustained 'golden thread' across the organisation. Evidence reviewed demonstrates that lived experience actively informs strategic priorities, tests decisions and influences service design, indicating a mature and purposeful participative approach.

Staff engagement, voice and experience

There is a clear intent and desire by senior leaders to understand staff experience, which is supported by a range of listening and engagement mechanisms, including Trust People Council (TPC) and staff networks. Staff engagement is widely recognised as central to shaping organisational culture, and engagement activity does take place across the Trust. However, engagement with some professional groups, including medical staff, was described as an area that remains a challenge.

Recent Board papers evidence sustained discussion of the complexity of the Trust's change programme and explicit recognition that meaningful consultation with staff is critical. They also show that the Executive team and CLE have acknowledged the need to strengthen engagement and communication, including pausing or re-sequencing schemes where proposals were not supported.

The TPC operates as a formal sub-committee of the Board, with terms of reference that position it as a structured forum to support the Board in developing organisational culture. Our understanding of the TPC is based on review of meeting minutes and feedback. The minutes reviewed reflect a meeting that is largely aligned to the Trust's agenda, which is consistent with its formal governance role. There is evidence within the minutes of constructive discussion and challenge, including consideration of staff concerns and emerging issues. For example, discussion relating to staff confidence in reporting and fear of detriment appears to have contributed to subsequent consideration of anonymous reporting through RADAR, triangulating with themes raised through Freedom to Speak Up.

The presentation of the voice scorecard reinforces the role of the TPC as a forum to test and triangulate quantitative measures with qualitative staff insight. However, while questions were posed within the papers about how the Trust might further strengthen staff experience, the extent of discussion and resulting actions is not always clearly reflected in the minutes reviewed.

Shared direction and culture

Evidence indicates that staff voice is present and that engagement mechanisms are established. However, the consistency with which staff experience their voice translating into influence on decisions and visible follow-through is not yet fully embedded. Further work is required to build confidence that staff voice leads to change, and the Trust Board should consider how it evidences follow-through and closes the loop from engagement.

Freedom to speak up

RDaSH has multiple routes and options available for staff to raise concerns. The Trust has established Freedom to Speak Up (FTSU) systems and processes and has invested in strengthening the service. Resources aligned to FTSU have increased, with the Guardian now supported by approximately 75 champions who reflect the diversity of the organisation. This provides multiple routes for staff to access support.

The FTSU Guardian has developed the service offer and strengthened the visibility and communication of the FTSU process through champions, training, induction, and engagement with managers. However, feedback from staff and a review of the Staff Pulse Survey indicates variable confidence in the FTSU processes.

Feedback regarding the effectiveness of the FTSU process was mixed. We heard there was, for some staff, a perception that their voices would not be listened to, and at times, this had a limiting effect on the raising of concerns or the sharing of improvement ideas.

Additionally, triangulation across interviews, staff feedback, and Trust papers indicate that confidence to raise concerns may have decreased in some areas of the organisation with some staff perceiving that raising concerns may lead to negative consequences.

To address this, the Board has acknowledged that staff may not be confident to raise concerns in respect of detriment and the Trust is developing a standard operating procedure (SOP). The SOP should be completed as a priority, with staff actively consulted and involved in its development. The SOPs effectiveness and impact should then be regularly reviewed and audited to ensure it is achieving the intended outcome.

The Trust has also recognised only a small proportion of staff had raised concerns through the FTSU route and have sought to enable staff to feel more comfortable with reporting. We heard that the recent introduction of an anonymous reporting route via RADAR in December 2025 offers staff an additional route to raise concerns. We heard that there are indications that this appears to be associated with increased speaking up. The Trust may wish to reflect on whether increased use of anonymous reporting suggests there are opportunities to strengthen confidence in existing processes.

The FTSU service reports bi-annually to the People and Organisational Development Committee and the public Trust Board. The FTSU report includes national level information, trends, and themes. In addition, there is oversight through the voice scorecard which is reported and discussed at the Trust People Council.

Freedom to speak up

The Trust has implemented mechanisms for staff to freely speak and reflect on their experiences. These include, Cultivating Compassion Circles together with numerous staff networks. Whilst recognising the Trust has been proactive and has multiple routes in which staff can raise concerns, leaders highlighted that reporting could benefit from greater triangulation and transparency, alongside clearer evidence of improvement and actions taken in response to staff raising concerns.

The FTSU function is well established, and the Trust has acknowledged that the function does not yet have the confidence of all employees. We understand that the Board has asked the CEO and his team to review how this concern can be addressed with action to be completed by end July 2026.

Capable, compassionate and inclusive leaders

Board

Board behaviours are consistently described by Board members and partners as professional and values-driven. We observed these behaviours during Board and committee meetings among both Executive and Non-Executive Directors. Leaders described these behaviours as extending beyond formal governance settings, reflecting the way senior leaders work together more broadly and contributing to a constructive leadership environment characterised by mutual respect and a shared commitment to effective decision-making.

The Trust operates Board timeout sessions on a bi-monthly basis. These sessions were consistently described as impactful and valued, providing dedicated space for relationship building, reflection and discussion outside the formal Board meeting environment.

Leaders described an open, honest and transparent Board dynamic, where curiosity is encouraged and appropriate challenge is welcomed. Observation and feedback emphasised that Non-Executive Directors routinely offer curious and probing questions, supporting constructive challenge and effective Executive accountability.

Most leaders reported that challenge at Board level is effective and operates within a psychologically safe environment, supporting rigorous discussion while maintaining respectful and inclusive behaviours. This approach aligns with the Board's intentional emphasis on maintaining a high support, high challenge culture as a core feature of effective governance.

Community values and engagement

We observed and heard a strong values-driven leadership approach exhibited by RDaSH's senior leaders. This is particularly evident in the leadership approach to community engagement, addressing inequalities and their role within the wider system. Leaders were consistently described as values-led in how they engage with service users, communities and partners, with a clear focus on improving outcomes.

The Trust has well-established values and practices regarding community participation and the use of lived experience, which were described as meaningful and substantive rather than tokenistic. Communities and people with lived experience are actively involved in shaping priorities, informing decisions and contributing to service improvement. This aligns with the Trust's broader strategic intent to work alongside communities as partners in delivery.

Capable, compassionate and inclusive leaders

Leadership intent in this area is further reflected in the ambition of the 28 organisational promises, commissioning decisions and the introduction of new access standards. Senior leaders were described as willing to take considered risks in service design where this supports strategic objectives and improved outcomes. Examples include investment in new models of care, changes to service configuration, and the development of Phoenix Ward as part of wider efforts to reduce out-of-area placements.

Leadership development

Leadership at Board and executive level provides a clear values-driven foundation and is widely described as committed and ambitious. Senior leaders explicitly recognised the tension between moving at pace and bringing the organisation with them and described active efforts to hold this balance through the current period of change. While this balance is not yet fully resolved in all areas, leaders demonstrate strong intent and judgement, with a clear focus on sustaining progress and a recognition that further development is required to embed this consistently across the organisation.

We were informed that the Trust has invested over £1m in leadership development with established partners from both the public and private sector, with involvement and engagement from Trust employees and community partners. Capability is acknowledged as variable, and there remains work to do to ensure that all leaders meet a core standard and that leadership is aligned to the organisation's mission. Looking ahead to 2026/27, leaders described constructive choices about how colleagues are supported to develop, and where necessary to seek other opportunities.

An intentional organisational shift to strengthening a delivery culture with clearer expectations around accountability was described. This change in the way of working was acknowledged by leaders as an area of development and not yet consistently embedded across all parts of the organisation. There are clear examples of how this shift towards a more accountable delivery culture is being supported in practice, including the strengthening of the Clinical Leadership Executive leadership and delivery forum.

The introduction of regular delivery reviews on an eight-weekly cycle was described as providing a more forward-focused mechanism to track progress, test delivery and build accountability. These reviews use enquiry-based questions to support constructive challenge and to explore organisational development issues within directorates, helping to embed clearer expectations around delivery and follow-through.

Capable, compassionate and inclusive leaders

Leadership Visibility

Senior leadership engagement and visibility across the organisation is supported by a range of established mechanisms. Examples provided to the review include a weekly CEO vlog, quarterly frontline face-to-face executive meetings, and executive directors undertaking part of their working week across different sites. Together, these approaches provide a visible foundation for leadership presence and engagement with services.

Formalised peer review visits were also identified as a well-established mechanism for Executive and Non-Executive visibility. These visits provide a structured route for Board-level engagement with frontline teams, with clear purpose and focus, and were described by Board members as a valuable opportunity to see services first-hand and engage directly with staff.

While leaders are physically present, there is less consistent clarity on how learning and intelligence gathered through leadership visits, including peer reviews, is systematically captured, fed back or translated into action through Board or committee assurance routes. As a result, it is not always evident how insight from leadership engagement informs strategic discussion, improvement priorities or governance oversight.

Beyond peer review activity, leadership visibility was described by the Board as less structured, with potential for uneven coverage across services. Feedback primarily referenced visits to inpatient settings, which may limit visibility across the Trust's geographically dispersed and predominantly community-based services. The scale and complexity of RDaSH's service footprint is recognised as a genuine challenge, particularly where teams are not based in fixed locations. Leaders acknowledge that that community-based visibility remains an area for further strengthening.

Some staff described inconsistency in visible follow-through when issues were escalated. Where feedback was not clearly seen to result in action or response, this was reported as affecting confidence that concerns and improvement ideas lead to change. Strengthening clear and consistent approaches to tracking, responding to and communicating outcomes from issues raised by staff would help reduce variation in experience and support a more consistent staff experience, particularly during periods of organisational change.

As the Trust continues to strengthen and develop its culture, with an increasing focus on delivery and accountability, there is an opportunity to consider how insights from leadership engagement are further triangulated with other staff feedback mechanisms, tracked and reported.

Capable, compassionate and inclusive leaders

The Chair's leadership approach was consistently described as supportive, inclusive and engaging, particularly in creating an environment where non-executive directors are encouraged to contribute effectively, feel confident to engage, and where constructive challenge is welcomed.

The Chair's leadership profile was also described as visible beyond the Board itself, with positive recognition from external system partners. The working relationship between the Chair and the Chief Executive was viewed as effective and complementary, with both roles operating cohesively as a leadership partnership. This visible alignment was seen to contribute positively to a constructive culture.

We observed that the Chief Executive's leadership style is visible, knowledgeable and candid, with a strong emphasis on accountability and results for patients. We heard from leaders that this approach has been a significant driver of improvement during the recent period. Plans to broaden the skills and capabilities of others are in place, together with succession plans, and both the Chair and Chief Executive are sensitive to an overreliance on key individuals. We were informed of steps being taken to distribute responsibility, including work on relationship managers for key partnerships.

Workforce equality, diversity and inclusion

RDaSH has a strong and well-developed approach to equity, inclusion, and reducing inequalities for the communities it serves. The 28 promises play a central role in articulating this commitment, providing a clear and visible framework for improving access and outcomes for underserved populations. This is a notable strength and is embedded across strategy and service delivery.

The People and Organisational Development Committee discussions reflected a high level of insight, openness, and willingness to engage with complex and sensitive issues, including racism, cultural barriers, and health inequalities. Governance oversight of workforce equality is provided through the Committee, which reviews the top ten people measures on a rotational basis. Measure four relates to anti-racism and discrimination, and measure eight relates to workforce diversity. The Committee minutes (December 2025) acknowledge that further work is required in these areas, particularly to improve the availability and effective use of meaningful workforce data.

Some notable actions taken by the Trust include the transition to the real living wage, which has had a positive impact on the gender pay gap. In addition, The Trust is intensifying its efforts to tackle and eliminate the Workforce Race Equality Standard (WRES) gap by 2026 in line with Promise 26. Progress against this commitment is monitored through the Promises and Priorities scorecard which is received and reviewed by Board. The Trust is also committed to, and actively working towards, accreditation for inclusion frameworks for all excluded protected characteristics, beginning with the global majority. Alongside this, the Trust has increased its reasonable adjustment budget to better support staff with disabilities.

However, there are further opportunities to strengthen how equality and inclusion translates into consistent, measurable improvements in workforce experience.

Workforce equality data continues to show disparities in staff experience. These include differences in recruitment outcomes, career progression, and experiences of bullying or harassment for some staff groups. Several indicators relating to staff experience and engagement have shown limited improvement over time.

Clearer visibility at Board of workforce-focused equality commitments, supported by enhanced evidence of impact and sustained change, would further strengthen assurance. It would also increase confidence that equality, diversity and inclusion ambitions are being realised for staff as well as the communities the Trust serves.

Workforce equality, diversity and inclusion

The Trust has made a commitment to become anti-racist organisation as part of a wider commitment discrimination and positively promoting inclusion. Further work is needed to ensure that the positive actions and learning from the anti racist work is built into and supports the boarder workforce equality, diversity, and inclusion programme.

Governance, management and sustainability

Organisational Governance

Governance structures across the organisation were observed as generally strong and well embedded. The Trust actively reviews the effectiveness of its governance arrangements and has further strengthened them in response to internal and external reviews.

Reporting lines are clear and consistently understood, and committee structures operate effectively to support scrutiny and discussion.

Committees observed, including Quality, Finance, Digital and Estates, People and Organisational Development, and Audit, were well run, with effective chairing, constructive challenge, and good levels of engagement from members.

Established assurance routes provide a coherent flow of information from service to Board, enabling oversight of performance and potential risks. This supports a structured and organised approach to governance across the organisation.

Review of the Integrated Quality and Performance Report (IQPR) demonstrates a structured and mature approach to performance governance. Clear prioritisation through a defined set of core metrics, alongside distinction between areas 'In Focus' and those reported by exception, supports focused oversight and Board-level scrutiny. Regular Performance Clinics and waiting list meetings provide evidence of active performance management, and reporting is transparent where performance is off track.

Overall, the IQPR provides a solid foundation for governance and assurance. Further strengthening the articulation of how the workforce, quality and financial analysis are triangulated, alongside clearer communication of sustainability and delivery grip, would enhance its value for Board oversight and decision-making.

Board

The Board meeting observed was well structured, with a clear agenda and well-organised board papers. The Board was chaired effectively, with an inclusive approach that encouraged constructive contribution and challenge. Observations and wider feedback indicated a good balance of contributions between Executive and Non-Executive Directors.

Governance, management and sustainability

In circumstances where further discussion or understanding was required, the Chair and CEO agreed the topic would be taken to the Board 'timeout' sessions. These sessions were consistently described as valuable and beneficial, providing additional space for reflection and deeper consideration outside the formal Board setting.

Board packs are well organised, however, feedback highlighted extensive papers, often contain large volumes of information. This led to some papers being discussed at pace, minimising the opportunity for full discussion.

We heard feedback from some board members that Board-level oversight and depth of discussion in relation to financial aspects of the Trusts business could be further strengthened to support shared understanding. Some feedback suggested a degree of confidence from some board members that financial challenges will be resolved, and that this could lead to more re-assurance being taken by some individuals. This may reduce the opportunity for deeper exploration at Board level for assurance (see [The insightful provider board](#), *Figure 1: lines of enquiry board members should be pursuing*). The recent appointment of a new Chief Finance Officer presents an opportunity to further strengthen Board-level conversation, understanding, and assurance around the Trust's financial position.

We noted the Board agenda did not consistently include the full name and professional title of paper leads. To tighten clarity and records, the Trust should ensure that professional titles are included for agenda leads at public Board. This will also ensure accessibility for members of the public.

Committees

Across the committees observed, meetings were generally well chaired, with constructive and productive discussion. Chairs managed agendas effectively and created an environment where members felt able to contribute, with appropriate challenge and open discussion encouraged. Committee discussions were focused on understanding key issues, particularly in relation to quality, safety, and performance.

Committee papers were often lengthy and agendas were full. This resulted in some items being taken at pace or deferred, limiting the opportunity for deeper scrutiny and exploration. While discussion remained focused, the volume and breadth of information presented reduced the space available for more detailed consideration in certain areas.

The Trust should consider a targeted approach to committee agenda setting, aligning agendas around priorities and utilising shorter, more focused papers, to improve function and clarity.

Governance, management and sustainability

Risk Management

Risk management processes are generally well defined, with clear escalation routes. The arrangements support the identification, review, and escalation of risks through existing governance frameworks. There is evidence that risk is considered through formal processes and that key issues are actively managed across different levels of the organisation.

Key risks are clearly identified, including patient safety, inequalities, and workforce pressures. Strategic risks align well with the organisation's objectives and are assigned to Executive leads. Structured mitigation plans are in place, and risks are reported regularly through Board and committee structures. The Strategic Delivery Risks document (SDR) operates as the Board Assurance Framework. Review of the SDR demonstrates a clear and structured approach to capturing and monitoring key risks and supports the Board in maintaining oversight of strategic priorities and organisational performance. This enables alignment between risks, assurance, and delivery.

Leaders demonstrate a clear understanding of their accountabilities and maintain a focus on delivery against measurable outcomes. This supports a culture of ownership at senior levels and reinforces effective governance and performance management across the organisation.

The Radar system is in place and used across the organisation to support the recording and management of risks, incidents, and actions. There is evidence of engagement with the system, supported by training and increasing staff confidence, and it provides a structured framework for risk management. This aligns with the organisation's current position within the risk maturity matrix, where core processes and governance arrangements are established and functioning.

However, application of the system is not yet fully consistent or embedded in practice. Challenges were identified in relation to usability, workflow, and the timely progression of actions. We observed in the Risk Management Committee a number of risks and approvals remain overdue, indicating that while the framework is established, further work is required to ensure Radar supports timely action and effective risk reduction in practice.

The Trust should continue to develop approaches that ensure the RADAR system is fully embedded in the governance framework and risk and assurance processes.

Governance, management and sustainability

Financial Governance

Financial sustainability has improved over recent years, supported by strengthened financial control and mature strategic planning. The Trust has a clear medium-term financial strategy and has made progress in reducing its underlying deficit. Financial risks are openly discussed, with clear oversight of savings delivery, capital investment and estate planning through the Finance, Digital and Estates Committee. Reporting is structured and supports informed, data-led decision-making.

Looking ahead, the longer-term financial position will be shaped by the assumptions underlying the financial plan and the ongoing delivery of cost improvement programmes. While these assumptions are recognised, assurance would be strengthened by clearer, more consistent articulation of contingency arrangements should assumptions not be realised, and by greater visibility of upside and downside scenarios.

Financial sustainability is addressed through a range of governance and reporting mechanisms rather than being presented as a standalone strategic risk. However, it was not always clear during the review how financial assumptions, workforce implications, quality impact, and related risks were brought together into a single, consistent assurance narrative.

Quality Safety Impact Assessments (QSIA) are referenced within papers are part of the Trust's approach to considering quality and safety implications. There is further opportunity to ensure their outputs and influence are more visible within wider assurance and risk reporting.

Overall, financial governance and executive grip appear strong. To further strengthen Board assurance on longer-term sustainability, there is an opportunity to make the articulation of financial risk, including upside and downside scenarios. This would support a clearer line of sight for assurance without changing the existing governance or risk architecture.

Governance, management and sustainability

Patient Safety, Experience and Quality Governance

Patient safety and patient experience was observed as prominent within governance and risk discussions. These areas are prioritised consistently across committees, with regular focus on incident trends, safety themes, and patient feedback. There is a clear commitment within Care Groups to understanding what is happening and learning from it, reflecting a governance culture in which the quality of care remains central to decision-making.

A recent internal audit of PSIRF (November 2025) identified several actions, with implementation overseen through the Quality Committee. The policy places strong emphasis on a restorative and just learning culture, reinforcing the expectation that staff should feel able to report incidents openly and without fear of blame. The Quality Committee routinely receives a Patient Safety Escalation Report, which provides visibility of learning identified and actions taken following patient safety incidents.

The Trust's Patient Safety Incident Response Policy and Incident Response Approach are due for refresh. This refresh provides an opportunity to re-engage staff and stakeholders and to further strengthen how learning from patient safety incidents is translated into improvement across the organisation.

Patient voice was also identified as visible and valued. Feedback from complaints, Care Opinion, and lived experience are used to inform discussion and identify areas for improvement. This provides a strong foundation for effective risk management and quality enhancement.

Assurance and Impact

In several committees we observed, reporting places greater emphasis on activity and narrative, with less consistent evidence of measurable impact or sustained improvement. While issues are well understood and discussed in depth, it is not always clear how this translates into risk reduction or improved outcomes over time. This creates a potential gap between insight and delivery to support assurance.

The risk framework and risk appetite matrix are well developed, with clear scoring, defined ownership, and alignment to strategic objectives, providing a strong foundation for oversight. However, it is not always evident how effectively risks are being reduced over time or how progress against mitigation plans links to demonstrable impact.

The Trust should further strengthen assurance by improving how risk reduction and improvement is sustained.

Governance, management and sustainability

Environmental sustainability

The Trust has a Green Plan in place, setting out the key drivers for organisational sustainability and identifying priority areas for action between 2025 and 2028. The plan focuses on five key priorities aimed at addressing areas of greatest impact on carbon emissions and is aligned to the Trust's clinical and organisational strategy for 2023–2028. Progress against this work is supported through the strategic promise that local communities and environments will benefit from reductions in carbon dioxide (CO₂) emissions, alongside adaptation to the challenges of climate change.

Senior leaders have recognised that further work is required to ensure progress is applied consistently and sustained over time. Strengthening delivery and maintaining momentum will be important to embedding environmental sustainability as a core and enduring component of organisational practice.

Partnerships and communities

System partners consistently described RDaSH as a credible, influential, and an increasingly proactive system leader. Particular emphasis was placed on the leadership provided by the Chief Executive and Chair. The organisation is recognised for investing leadership time in complex, shared challenges and working collaboratively to deliver change. External partners reported a clear shift from RDaSH being perceived primarily as a traditional mental health provider to an organisation that actively shapes system dialogue and direction, particularly within collaborative and place-based arrangements. Sustaining this position will depend on maintaining delivery grip and ensuring system ambition remains aligned to operational capacity.

Senior system leaders highlighted the energy, confidence, and constructive challenge brought by the Chief Executive into system forums. The Chief Executive's leadership approach was described as willing to test established thinking, hold difficult conversations, and maintain focus on long-term strategic priorities. Stakeholders cited advocacy for prevention, early intervention, and reduced reliance on inpatient care, noting that RDaSH leaders were prepared to challenge system partners where operational or financial pressures risked diverting the system from these objectives.

The Chair was similarly recognised as an active and visible system leader, providing constructive challenge and balance within partnerships. Stakeholders described open, honest, and respectful working relationships with the Chair, enabling candid dialogue. The partnership between the Chair and Chief Executive was viewed as a key enabler of RDaSH's system influence, with both roles reinforcing consistent messages and behaviours across system leadership forums.

Stakeholders also described RDaSH as demonstrating system-aware decision-making, particularly through its willingness to engage with complex, high-risk challenges that span organisational and commissioning boundaries. This was evidenced through collaborative work to reduce out-of-area placements and strengthen local system capacity. System leaders highlighted RDaSH's active role within collaborative arrangements across South Yorkshire, noting that this work has progressed beyond discussion to tangible outcomes, including joint approaches to eating disorder services, forensic pathways, and additional places of safety.

While stakeholders valued RDaSH's willingness to take on system leadership roles, including where this involved additional complexity and exposure, they also highlighted that this level of ambition brings delivery risk. This was particularly noted in the context of workforce constraints, financial pressures, and competing system priorities. Sustaining system leadership credibility was therefore seen as dependent on maintaining delivery grip and ensuring ambition remains aligned to operational capacity.

Partnerships and communities

Stakeholders also noted that the pace and ambition of system leadership set by the Chief Executive and Chair may not yet be consistently mirrored across all levels of the organisation. There was recognition that sustaining this system-leading role will require continued focus on embedding system thinking beyond the most senior leaders, particularly within operational and middle-management layers.

Community engagement and involving people with lived experience emerged as one of the strongest and most distinctive features of RDaSH's leadership approach. Stakeholders described this as a 'golden thread' running through strategy, decision-making, and delivery. Community partners consistently reported high levels of involvement, influence, and ownership, with engagement taking place at early stages of strategy development and service design.

Community reported feeling listened to and supported, including where feedback required the organisation to rethink or adjust plans. Examples included changes to ward environments, crisis service opening hours, and the development of accessible strategy materials in response to community feedback.

The 28 Promises were referenced by stakeholders as a shared and well-understood framework, with a strong sense of ownership rather than simple contribution. Stakeholders were able to articulate the promises and identify evidence of how they are being delivered in practice, which was described as building confidence in RDaSH's intent and follow-through.

Community engagement was also described as extending into community capacity building, partnership with the voluntary sector, and practical support initiatives. Examples included joint work on poverty-proofing wards, use of Trust facilities to support community events, and investment in peer roles and development pathways.

Learning, improvement, and innovation

Learning and development

RDaSH demonstrates a strong commitment to learning and development, particularly through established approaches to staff training and professional development. Learning and development is supported by a protected budget, providing a solid foundation for building capability across the organisation and supporting ongoing professional growth.

Leaders place clear value on inclusion and accessibility within learning. There is an intentional focus on ensuring development opportunities are available to a wide range of staff, supporting equitable and inclusive approach to capability building.

The Trust has integrated community partners into its leadership and development offer. This was seen as an example of positive partnership working, enabling shared learning beyond organisational boundaries and strengthening both leadership practice and system collaboration.

Examples of innovative clinical practice were observed that support organisational learning, including the use of patient stories to inform care delivery. These approaches help to anchor learning and improvement in lived experience and support reflective practice. This was particularly evident in community-based models of care, demonstrating a commitment to innovation that is grounded in patient experience and outcomes.

The Trust utilises the Patient Safety Operational Group to share key learning and information. The implementation of key learning briefs to disseminate information regarding patient safety incidents, learning outcomes, and areas for improvement was described as a developing area. The review team observed a clear emphasis on patient safety and organisational learning within governance discussions.

Positive examples were observed of improvement and learning in Board level discussions. This included the use of patient stories, prevention of future deaths report and the Trust work aligned to CQC readiness. In addition, the Trust proactively undertakes quality and peer reviews, led by an Executive, providing staff with opportunities to share good practice and areas of concern. However, there was less evidence of how triangulation of learning from these reviews was consistently translated into strategic organisational learning, improvement, or innovation workstreams.

Learning, improvement, and innovation

The involvement of people with lived experience and members of the Council of Governors in the Clinical Leadership Executive and Board Sub-Committee discussions brings an additional lens to both the information presented and the resulting discussion, strengthening challenge and accountability.

While there is a high level of learning activity and open discussion, it was observed that the same themes continue to recur across committees over time. This indicates that learning is not always fully embedded or consistently translated into sustained change. The Trust should consider strengthening the connection between learning, action, and impact which would provide clearer assurance that learning is resulting in measurable improvement.

Quality Improvement

Staff empowerment to drive change and improvement at a local level was described as often reliant on individual capability and the support of line managers. While a number of staff have previously completed Quality Service Improvement and Redesign (QSIR) training, the absence of a standardised and consistent quality improvement methodology and processes has resulted in improvement activity being largely dependent on individual staff confidence rather than a systematic organisational approach and methodology.

Interviewees described that a balance is required between having a consistent improvement methodology and enabling staff to feel empowered and flexible to make local improvements. There is a recognition that a clearly defined framework and consistent quality improvement approach could further support staff capability to deliver improvement and better support the Trust's improvement ambitions.

We understand that the Trust Board has considered the adoption of a single quality improvement methodology and has decided not to progress this at this time.

The Trust should consider keeping under review the potential future development of an organisation-wide quality improvement methodology, while retaining flexibility to support locally led improvement activity.

Learning and improvement remains an ongoing organisational focus. While the Trust supports shared learning across the system, particularly through patient safety leadership networks, there were mixed views on the value and use of wider benchmarking to inform improvement.

Learning, improvement, and innovation

The Trust should consider how wider benchmarking and external learning is used more consistently to inform quality improvement priorities and support assurance on improvement progress.

The Trust's Quality, Service and Impact Assessment (QSIA) process was described as continuing to develop and has strengthened over the last six months, with improvements to its application and use. There is recognition that further work is required to ensure there is routine and review of the impact of QSIAs. The outputs of QSIAs were reported to Board bi-annually, however, limited visibility of how learning from QSIAs is used to inform broader improvement and innovation activity was identified.

The QSIA process is in place and referenced in discussions. A clear example of this was seen at the People and Organisational Development Committee, which cross referenced the QSIA process to examine how people related factors were affecting patient care. The committee also sought assurance that the management of change process was not having a direct negative impact on patients or on the delivery of services, demonstrating effective use of the QSIA to inform oversight and decision-making.

However, the level of detail and assurance in some areas was identified as limited, and it was not always clear how robustly the process is applied in practice. It was difficult to understand how QSIA outputs are triangulated with other sources of information, including patient safety data, workforce impacts, and performance metrics.

There was limited clarity around how quality risks identified through QSIAs are reflected within the wider risk management framework. Where risks to quality are identified, it was not consistently evident how these are escalated, recorded in risk registers, or monitored through governance processes. This reduces assurance that risks associated with cost improvement or transformation programmes are being effectively tracked and mitigated over time.

Overall, while the QSIA process is established, the review team concluded that strengthening its visibility, consistency, and integration would enhance assurance. In particular, clearer links between financial decisions, quality impact, workforce considerations, and risk management would support a more robust and systematic approach to quality improvement and innovation.

To support further strengthening the QSIA process the Trust should improve the visibility of quality, workforce, and risk management frameworks, to provide clearer assurance on the impact of financial and transformation decisions.



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Recommendations

Recommendations

Theme	No.	Recommendation
Shared direction and culture	1	When the strategy is refreshed in 2028/29, there is an opportunity to build on the engagement already undertaken by strengthening how strategic intent and rationale is communicated and reinforced through delivery. Clear, consistent communication and continued workforce engagement will support ownership across staff and services.
	2	The Trust should consider the opportunity to strengthen how insight is routinely gathered, triangulated and used to inform organisational understanding of staff experience. This would strengthen the systematic and consistent exploration of the factors shaping staff experience, including where staff feel disengaged or under-valued.
	3	Trust Board should consider how it evidences follow-through and closes the loop from engagement.
Capable, compassionate and inclusive leaders	4	The Trust should consider how insights from leadership engagement are further triangulated with other staff feedback mechanisms, tracked and reported.
Workforce equality, diversity and inclusion	5	The Trust should consider further work to ensure that the positive actions and learning from the anti racist work is built into and supports the boarder workforce equality, diversity, and inclusion programme.

Recommendations

Theme	No.	Recommendation
Governance, management and sustainability	6	To tighten clarity and records, the Trust should ensure that professional titles are included for agenda leads at public Board. This will also ensure accessibility for members of the public.
	7	The Trust should consider a targeted approach to committee agenda setting, aligning agendas around priorities and utilising shorter, more focused papers, to improve function and clarity.
	8	The Trust should continue to develop approaches that ensure the RADAR system is fully embedded in the governance framework and risk and assurance processes.
	9	To further strengthen Board assurance on longer-term sustainability, the Trust should consider opportunity to make the articulation of financial risk, including upside and downside scenarios. This would support a clearer line of sight for assurance without changing the existing governance or risk architecture.
	10	The Trust should further strengthen assurance by improving how risk reduction and improvement is sustained.

Recommendations

Theme	No.	Recommendation
Learning, improvement, and innovation	11	The Trust should consider strengthening the connection between learning, action, and impact which would provide clearer assurance that learning is resulting in measurable improvement.
	12	The Trust should consider keeping under review the potential future development of an organisation-wide quality improvement methodology, while retaining flexibility to support locally led improvement activity.
	13	The Trust should consider how wider benchmarking and external learning is used more consistently to inform quality improvement priorities and support assurance on improvement progress.
	14	To support further strengthening the QSIA process the Trust should improve the visibility of quality, workforce, and risk management frameworks, to provide clearer assurance on the impact of financial and transformation decisions.



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Appendix

Appendix A – Documentation Reviewed

- RDaSH-clinical-and-organisational-strategy-2023-to-2028.pdf
- Quality and Safety Plan.docx
- Digital Enabling Plan 2023-2028.pdf
- Equity and Inclusion Plan.docx
- Learning & education Plan- July 2024.pdf
- People and Teams Plan.pdf
- RDaSH Finance Enabling Plan 2025-2028.pptx
- Research & Innovation Plan.pptx
- Strategic Delivery Risks as at 23.01.2026.docx
- All Risks as at 19.01.2025.xlsx
- CQC Readiness Jan 2025 BOD.docx
- MHA Action Statement - Windermere - 30.09.2025 FINAL.doc
- MHA Action Statement FINAL - Amber 17.06.25.doc
- MHA Action Statement FINAL - Skelbrooke - 17.06.25.doc
- MHA Provider Action Statement - The Willows - FINAL to CQC v2.doc
- MHA Provider Action Statement Osprey_Kingfisher FINAL.doc
- Summary of CQC MHA Visits 2025-2026 091225.docx
- Summary of CQC MHA Visits 2025-2026.docx
- 20250616 Amber Lodge MHV-by CQC.pdf
- 20250617 Skelbrooke MHV by CQC.pdf
- 20251006 The Willows MHV by CQC.pdf
- 20250930 Windermere Lodge MHV by CQC.pdf
- 20250908 Osprey MHV by CQC.pdf
- Amber OOH Quality Review report 110525 v3.docx
- Brodsworth OOH Quality Review report 250225.docx
- Brodsworth Ward - Quality Review - Inpatient wards v2 23-10-25.pdf
- Cusworth OOH Quality Review report 090225 v2.docx
- Cusworth OOH REVISIT Quality review report 11 and 260625 v3.docx
- Cusworth Quality Review report 240925 v3.docx

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- Hawthorne OOH Quality Review report 170525 v2.docx
- Hazel OOH Quality Review Report 231125 v3.docx
- Hazel Quality peer review report 120325 v2.docx
- Kingfisher Ward - Quality Review - Inpatient wards 11-12-25.pdf
- Laurel brief review report v1 01-12-2025.docx
- Mulberry brief review report v3 01-12-2025.docx
- Mulberry Quality Review report 240625 v3.docx
- North Lincs CRHT Quality Review report 250225 v1.docx
- Osprey OOH Quality Review report 151025 v2.docx
- Osprey Quality Review report 180825 v3.docx
- Sandpiper Ward - Quality Review - Inpatient wards v2 15.01.2026.pdf
- St Johns IPU OOH Quality Review report 140925 v2.docx
- St Johns IPU Quality peer review report 200225 v3.docx
- The Glade OOH Quality Review report v2.docx
- CQC Report - RDASH Acute AMH and PICU RI 310725 - UPDATED PUBLISHED Dec 2025.docx
- RXE Annual Governance Statement 2024-25.pdf
- Appendix-A-The-QSIA-checklist.docx
- Appendix-B-The-QSIA-full-assessment.docx
- Quality and Safety Impact Assessment (QSIA) Policy v2.doc
- Patient Safety Incident Response Policy and Plan v1.1.doc
- PSIRA v1.1 Sept 25.docx
- PSIRF IA Review - Final Report.pdf
- Claims handling policy v7.docx
- Board and Committee chairs and attendees.docx
- Trust Governance Structure January 2026.pdf
- Board Comm AC ToR v1.1.docx
- Board Comm CFC ToR v1.1.docx
- Board Comm FDE ToR v1.1.docx
- Board Comm MHAC ToR v1.1.docx
- Board Comm PHPIP ToR v1.1.docx

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- Board Comm PODC ToR v1.1.docx
- Board Comm QC ToR v1.1.docx
- BoD ToR.docx
- CLE ToR v1.1.docx
- CLE Group Digital ToR v1.1.docx
- CLE Group Education and Learning both ToR v1.1.docx
- CLE Group Equity and Inclusion ToR v1.1.docx
- CLE Group Estate Sustainability ToR v1.1.docx
- CLE Group Finance ToR v1.1.docx
- CLE Group OMG ToR v1.1.docx
- CLE Group People and Teams ToR v1.1.docx
- CLE Group Quality and Safety ToR v1.1.docx
- CLE Group Research and Innovation ToR v1.1.docx
- CLE Group RMG ToR v1.1.docx
- TPC ToR v1.docx
- RDASH-Constitution-2024.pdf
- Audit Committee Agenda Pack 6.08.2025 V2.pdf
- Audit Committee - Agenda Pack - 8 October 2025.pdf
- Audit Committee 3 December 2025 - Agenda Pack v2.pdf
- AC 3 December 2025 - Agenda Pack B - Apps for Paper G.pdf
- AC Minutes 03.12.2025 Draft.docx
- CF Committee - Agenda Pack - 4 June 2025 v2.pdf
- CF Committee Agenda Pack 03.09.2025.pdf
- CF Committee Agenda Pack 3 December 2025.pdf
- CFC Minutes 03.12.2025 Draft.docx
- CoG - Agenda Pack A - 11 June 2025.pdf
- CoG - Agenda Pack B - 11 June 2025.pdf
- CoG Combined Papers 10.09.2025 Pack A.pdf
- CoG Combined Papers 10.09.2025 Pack B.pdf
- CoG Agenda Pack extra ord 27 October 2025.pdf
- CoG Combined Papers Pack A v2 - Dec.pdf
- CoG Combined Papers Pack B - Dec.pdf
- FDE Agenda Pack 20 August 2025 v2.pdf

Appendix A – Documentation Reviewed

- FDE Agenda Pack 22.10.2025 v2.pdf
- FDE Agenda Pack - 17 December 2025 v2.pdf
- FDE Minutes 17 December 2025 Draft.docx
- MHA Committee agenda pack 20 August 2025.pdf
- MHA Committee 22 October 2025.pdf
- MHA Committee - Agenda Pack - 17 December 2025.pdf
- MHAC Draft Minutes 17.12.2025 Draft.docx
- PHPIPC Agenda Pack 17.09.2025 v2.pdf
- PHPIP Committee 19.11.2025 - Agenda Pack.pdf
- PHPIP Committee - Agenda Pack - 21 January 2026 v2.pdf
- PODC 20.08.2025 Agenda Pack A.pdf
- PODC 20.08.2025 Agenda Pack B - For information.pdf
- PODC 22.10.2025 Agenda Pack v3.pdf
- PODC Agenda Pack 09.12.2025 v2.pdf
- POD Minutes 17 December 2025 Draft.docx
- Quality Committee 17 September 2025.pdf
- Quality Committee Agenda Pack 19 November 2025 v3.pdf
- Quality Committee V2 Agenda Pack - 21 January 2026.pdf
- TPC Agenda pack 30-04-2025.pdf
- TPC Agenda Pack 20250723.pdf
- TPC Agenda Pack 20251029.pdf
- TPC Minutes 20251029 Draft.docx
- Board of Directors 24 July 2025 - Agenda Pack A v3.pdf
- Board of Directors 24 July 2025 - Agenda Pack B.pdf
- Board of Directors 24 July 2025 - Private Agenda Pack.pdf
- Board of Directors 25.09.2025 - Agenda Pack A v2.pdf
- Board of Directors 25.09.2025 - Agenda Pack B.pdf
- Board of Directors 25.09.2025 - Private Agenda Pack.pdf
- Board of Directors 27.11.2025 - Agenda Pack A v2.pdf

Appendix A – Documentation Reviewed

- Board of Directors 27.11.2025 - Agenda Pack B.pdf
- Board of Directors 27.11.2025 - Private agenda pack.pdf
- Public Board of Directors Agenda Pack - 16 December 2025.pdf
- Board of Directors - Agenda Pack - 8 January 2026.pdf
- Freedom to Speak Up Policy Raising Concerns (Whistleblowing) Policy v8.doc
- Safeguarding adults policy v2.3 web.docx
- Safeguarding children policy v3 web copy.docx
- List of policies as at 2 February 2026.docx
- Paper M - Public BOD - Operating model - Nov 2023.docx
- Paper N - Operating Model - public board SeptemberSK.docx
- Paper M - Appendix Reservations and Scheme of Delegation November 2023.xlsx
- IQPR Dashboard December V6.pptx
- 20251027_Estates, finance and procurement DR outcome letter October 2025.pdf
- 20251027_Health informatics DR outcome let Oct 2025.pdf
- 20251029_Med, Phar, Res DR outcome letter October 2025.pdf
- 20251029_PPT DR outcome letter October 2025.pdf
- 20251106_Operations DR outcome letter Oct2025.pdf
- 20251106_Corporate assurance DR outcome letter October 2025.pdf
- 20251208_Doncaster AMH&LD delivery review outcome letter from TL Nov 2025.pdf
- 20251106_People and OD DR outcome letter October 2025.pdf
- 20251029_N&F DR outcome letter October 2025.pdf
- 20251208_Childrens DR outcome letter from TL Nov 2025.pdf
- 20251208_North Lincs AMH&TT DR outcome letter from TL Nov 2025.pdf
- 20251208_Rotherham AMH DR outcome letter from TL Nov 2025.pdf

Appendix A – Documentation Reviewed

- 20251208_Physical health and Neurodiversity DR outcome letter from TL Nov 2025.pdf
- 20251027_Strategic development DR outcome let Oct 2025.pdf
- Planning Submission 26-28 presented to the BoD.docx
- RXE-benchmark-2022.pdf
- RXE-breakdown-2024.pdf
- NHS People Pulse Report - ROTHERHAM DONCASTER AND SOUTH HUM Jan 25.pptx
- NHS People Pulse Report - ROTHERHAM DONCASTER AND SOUTH HUM April 25.pptx
- NHS People Pulse Report - ROTHERHAM DONCASTER AND SOUTH HUMB July 25.pdf
- NSS23 Breakdown Reports_RXE.pptx
- WRES-WDES-2024 - Easy Read Report.docx
- WDES Data 2024 - 2025 v.1.docx
- Workforce Disability Equality Standard - Annual Report 2023.docx
- Workforce Disability Equality Standard - Annual Report 2024 v.1.docx
- Workforce Race Equality Standard - Annual Report 2024 v.3.docx
- North East Yorkshire - RXE - Rotherham Doncaster and South Humber NHS Foundation Trust.pdf
- Workforce Race Equality Standard - Annual Report 2023.pdf
- RDaSH summary PCA October 2025.docx
- RXE RDASH PCA Declaration October 2025.xlsx
- Leadership Paper.pdf
- CLE papers 17-02-2026.pdf
- CLE investment fund proposal 202627.docx
- Children QSIA Checklist.pdf
- Medium Term Financial Plan Sept Board meeting.pdf
- Nursing & Facilities QSIA Checklist.pdf
- RDaSH 2526 06 SDR final report - Feb 2026.pdf
- Savings Programme Dashboard - M9.pdf
- 2.0 Paper A RATIFIED Minutes 20250723 TPC
- 2.0 Paper A DRAFT Minutes 20251029 TPC



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Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 28 May 2026

Item 24 – Patient Story

Our patient story this time: Promise 11 - Deliver in full the NHS commitment to veterans and those within our service communities, recognising the specific needs many have, especially for access to suitable mental health and trauma response services.

Success Measures

1. Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees).

2. Introduce peer-led service support offer for local residents.

2025/26 saw the profile of this Promise expand to include more organisations, more colleagues and more representatives from the VCSE.

First and foremost, it is imperative to highlight that this year observed a sustained increase in the number of patients being recognised as members of the Armed Forces Community (veterans, reservists and dependants). In 2025/26, there were 14,951 referrals from known members of the Armed Forces Community across our patient cohort, which is an increase of 380 since 2024/25 and an increase of 2,632 since 2023/24. This is testament to multiple initiatives and training which has been promoted widely across the Trust:

- 'Ask the Question' campaign
- 150+ colleagues attending training via Veterans Covenant Healthcare Alliance (VCHA) for Learning Half Days
- Exec Team attending training via VCHA
- Strategic Development team visiting services to deliver workshops on Promise 11 (more to come in 2026/27).

More veterans are receiving faster access to our services due to our 4 week wait, and more services know that if necessary they can expedite the wait for a veteran.

The first RDaSH Armed Forces Day in November 2025 was attended by 48 RDaSH colleagues, 6 NHS providers, 2 local authorities, 8 charities and more. Attendees heard about lived experience, saw presentations and had the opportunity to engage in specific workshops. This has helped to raised awareness across the area, strengthen local commitment and identify joint working opportunities. During the course of this day, RDaSH committed to achieving 8 actions to ensure that the entirety of the Armed Forces Community receive trauma-informed, expedited care while in our services. Work is ongoing to complete these actions.

Colleagues in RDaSH also worked collaboratively to amend clinical policies to better reflect our commitments to the Covenant and in Promise 11. These policies now provide more clarity for services to implement procedures such as the expedited waiting times and transition from/into waiting lists nationally.

Achieving 'Gold' in the Defence Employer Recognition Scheme was another milestone after having held 'Silver' for 5 years. This means that RDaSH is outstanding within its sector, advocating for the Armed Forces Community to partners, patients and suppliers with promising results. It also means RDaSH actively encourages an inclusive workplace environment for Reservists and Cadets.

Unfortunately, the implementation of our Peer Support offer faced some setbacks due to changes taking place across our proposed partner organisations. RDaSH remain committed to delivering this element of the Promise and has identified a new route to implement this much-needed provision for our Armed Forces Community.

Plans for 26/27

It is anticipated that 2026/27 will see continued progress with Promise 11 as momentum grows across the Trust.

The key priority for the upcoming year is to recruit Peer Support into RDaSH to support veterans, dependents and reservists in our services. This resource will provide a bridge between RDaSH and the Armed Forces Community specifically offering; a shared understanding of military life, practical support in transitioning to civilian life and improved treatment engagement.

There are still changes which need to be made to our clinical systems to ensure the Armed Forces Community are appropriately identified and our colleagues are able to easily access this information. This piece of work began in November 2025 following the RDaSH Armed Forces Workshop and it is expected to be completed by August 2026.

Practical engagement with our services remains at the forefront of this Promise. It is pivotal that all patient-facing colleagues continue to receive appropriate training and support so that they understand why it is important to 'ask the question' and what is expected of them when somebody does declare their Armed Forces status. This engagement takes multiple forms:

- Training via VCHA on Learning Half Days.
- A guide of what external support is available and how to refer (OpCourage, OpRestore, Combat Stress etc).
- Support from Strategic Development Team and Armed Forces Clinical Lead at team meetings.
- Hearing Lived Experience about how the Armed Forces Community have benefitted from NHS colleagues being aware of their status, and the impact this has had on their care.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Culture Work	Agenda Item	Paper U
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Carlene Holden, Director of People & Organisational Development Toby Lewis, Chief Executive		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points			
We agreed, as a board in 2025, the culture we wished to develop. This is shown at annex A, taken from our People and Teams Plan. This paper explores how we embed this, through a combination of two types of intervention: behavioural norms supporting our established values and changes to how we work that reinforce this intent. The underlying premise is that the status quo is not sustainable, for a variety of reasons outlined, and that a high care/support, high challenge/accountability model is needed. This will take time to inculcate, and the paper needs further co-developed refinement. The Board is asked to comment on the need for further diagnosis, and to offer views on the current draft intent outlined.			
Previous consideration			
Clinical Leadership Executive, May 2026; Trust People Council, January & April 2026			
Recommendation (delete options as appropriate and elaborate as required)			
The Board is asked to:			
NOTE - the planned actions and the associated timescales which provide co-production opportunities across the organisation			
COMMENT - on the planned actions and refine the planned work/terms of reference prior to the co-production			
AGREE - a further paper will be presented in July 2026 to enhance the proposals and the associated delivery plan			
Alignment to strategic objectives			
SO1: Nurture partnerships with patients and citizens to support good health			X
SO2: Create equity of access, employment, and experience to address differences in outcome			X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services			X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings			X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			X
Alignment to the plans: (indicate those that this paper supports)			
Digital plan			X
People and teams plan			X
Quality and safety plan			X
Equity and inclusion plan			X
Education and learning plan			X
Research and innovation plan			X
Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X

Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
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			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are			X

Rotherham Doncaster and South Humber NHS Foundation Trust

Culture work

1. Context and framing

- 1.1 This paper invites the Board to re-discuss the culture we wish to nurture. This is not our first such discussion in the last fifteen months, but it takes place against an important, arguably time sensitive, backdrop. That includes:
- a) Considerable progress in **opening-up our organisation**, through the use of peer support and presence of volunteers – with the voices of patients being heard at scale within Care Opinion and in spaces where they were not previously invited or accepted: though this remains contested.
 - b) Significant **concern over racism** and discrimination faced by one in seven RDaSHians: a concern that translates into a quality and safety priority for the Trust, as well as being Promise 26.
 - c) **Tangible improvements on key safety and quality measures** including out of area placements, knowing-valuing-cutting wait times, as well as examples of home first transformations associated with ward closures and HTT expansion, with expanding virtual wards, with community-based clozapine prescribing and IV provision, and with all-age crisis services.
 - d) Stubbornly **high rates of sickness absence**, notably in some teams and among senior medical staff. Long term sickness forms the majority of that and, of course, increases workload for other team members.
 - e) **Better recruitment and retention** that before 2023, and some evidence that new joiners align more favourably to the mission, values and promises of the Trust: but with risks ahead arising from the ‘fracture’ of change management and redundancy.
 - f) At aggregate level, **a poor staff survey position** over some years; with evidence some do not feel valued, fear the pace of change, or see a discrepancy between intent and real lived experience in the workplace. Four staff survey indicators now feature in the NOF, and we know that getting to good with the CQC will be disproportionately influenced by feedback and mood.
 - g) The need for **more change ahead**, either through our own work to embed productivity measures, or through neighbourhood redesign work, which should alter what we do, and doubtless will involve reorganising it; despite the weariness we see among us.
- 1.2 We acknowledge that there is not one culture within the organisation, with teams and groups having sub-cultures, which have developed over time within areas. We also recognise that some colleagues do not recognise they work for RDaSH, they understand their employer to be the local team, such as

Community Nursing or Laurel ward for example. This is a key focus when reviewing the culture within the Trust as colleagues need an affinity with the team and the wider organisation.

- 1.3 This paper sets out the steps, which we are taking over the next few months, with a period of engagement for a Cultural Commitments Programme (not a defined title, at this stage) designed to strengthen psychological safety, improve behavioural accountability, support patient safety, and create a more consistent leadership culture across the organisation, one which offers high support and high challenge. This links to the staff survey improvement work programme which we have acknowledged will be a two-year journey of renewal. 2.3 This proposed programme establishes culture as a core operational and safety priority, supported through formal governance, measurable indicators, and tiered accountability.
- 1.4 When we agreed the People and Teams Plan, we did define the culture we sought. Annex A reshapes that shared view. In practice, since that agreement in July 2025, the only, albeit it is significant, intervention made to develop this has been the leadership development offer to our most senior 150 people, including fifteen community partners. That work ends in September, and we are actively considering what next, for whom, and how. The Board is familiar with the '555' line managers we have at grades ranging from band 3 - VSM – and the implicit desire to work through these colleagues to improve delivery and the lived experience of working here.
- 1.5 The intention is that, not later than the Leaders' Conference in September, and via the Board's meeting in July, we define the path of action on our cultural improvement: we do that having co-produced plans with the Trust People Council, with both CoLE and CLE, and working with TLC via the ATI and other forums, as well as engaging directly with professional stakeholders.
- 1.6 We anticipate that our cultural improvement work should be rooted in the six values we re-committed to in 2023. The launch of those values earlier in the decade did come with quite detailed behavioural descriptors, but there is little evidence those have embedded – and this paper considers how that might begin to change.
- 1.7 Going back to the future is often helpful in an organisation with a memory. We can see, within the staff survey paper, a stark divide between more longstanding employees and those who have joined us in recent years. We simply must understand and connect better with longstanding and experienced colleagues. We know that the NHS has broadly similar levels of employee engagement to healthcare systems internationally. What we also know is that NHS carries/tolerates levels of active disengagement (as distinct from neutrality/equanimity) which are comparatively unusual. The impact of that active dissatisfaction (as distinct from constructive disagreement and dissent) is borne by other colleagues. One potential route to be explored is to restore Listening Into Action style working practices into some of our change approaches: we sense that was valued by many and has a more bottom-up

character than some of the other ways we have needed to 'drive' change.

1.8 The framing explored in this paper, and it needs far more development, is 'top 8%' based: high performing organisations aim to have both:

- High care and support, **and**
- High challenge and accountability

1.9 It may feel more 'board-like' to discuss the latter element. Whilst we can likely see some of the behaviours around us that resist the introduction of accountability since 2023, **it may be most useful to explore rather more fully what the care and support proposition needs to be.** One clear consistent staff voice in this area seeks that we 'get the basics right'. Just as we are looking to implement always measures for certain pathways of care, what are the equivalent rights and entitlements that we need to not just promise but consistently deliver for our people, be they be students, volunteers, peers or staff?

The Approach to Date

2.1 The approach on developing the culture within the Trust has been varied over the previous ten years, with different initiatives and strategies, which have been aligned to national priorities but not necessarily aligned to the Trust strategy and our 28 promises. When the Board committed to the new strategy in 2023, we made a positive decision to retain the six values of the organisation. What has not, however, happened is work to practically embed that within our ways of working.

2.2 Prior to the launch of the 10-year health plan - Fit for the Future, in the mid 2010's, we had a development programme titled 'Fit for the Future' which aimed at changing the culture and the leadership approach within the Trust, but this was not sustained. Followed by Listening into Action and a cultural charter.

2.3 We then moved to a 'no blame' cultural approach with mixed success, which then, in turn, developed to a fair blame approach to promote individual accountability and responsibility and then, in the covid era, the development of the just and restorative culture work, which was led by Mersey Care NHS Foundation Trust and Professor Sidney Dekker, with the aim to create a culture/environment where colleagues feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. This approach applies to Human Resources, Patient Safety and Safeguarding to name a few, and still resonates with our approach to the promises work; the promises are difficult and challenging and at times we do fail, we need to regroup and try again. This remains a core part of the cultural approach, but colleagues need to feel able to try and fail without fear of retribution, in a high support but high challenge environment.

2.4 We continue, like other NHS Trusts, to operate in a highly pressured environment characterised by operational demand, workforce pressures,

service transformation, and increasing expectations regarding patient safety, staff experience, and organisational transparency.

2.5 Whilst existing improvement initiatives have delivered some localised progress, there remains variation in staff experience, leadership behaviours, psychological safety, and confidence in reporting concerns.

2.6 Evidence from NHS improvement programmes, staff survey findings, patient safety reviews, and organisational learning indicates that sustained cultural improvement is associated with:

- Improved patient safety outcomes
- Higher staff engagement and retention
- Increased incident reporting and organisational learning
- Reduced bullying and harassment behaviours
- Stronger operational performance sustainability.

This paper proposes a structured Board-sponsored culture reset programme designed to:

- Define and reinforce expected leadership and behavioural standards
- Improve speaking up and feedback mechanisms
- Strengthen group/directorate accountability
- Establish measurable cultural indicators
- Align operational performance with behavioural expectations
- Reduce variation in culture across services and groups/directorates.

2.7 The programme is intended to support delivery of the Trust's strategic priorities by improving organisational conditions that underpin safe, effective, compassionate care.

3. Case for Change

3.1 The Trust has established a range of existing workforce and organisational development initiatives, including:

- Leadership development programmes – significant investment in our LDO, First Line Managers and commencing this year our Multi Professional Leadership Team programme
- Freedom to Speak Up arrangements - 1 full time dedicated guardian and 82 champions, which is due to increase to 93 champions
- Staff engagement activity
- Staff wellbeing support, which is enhanced by our networks
- Patient safety improvement programmes
- Equality and inclusion initiatives – our commitment to Promise 26.

However, review of organisational indicators demonstrates continued variability in:

- Staff confidence to raise concerns (as detailed in the staff survey paper)
- Experience of bullying and harassment – including racial discrimination
- Leadership consistency
- Feedback and closure following incident reporting
- Workforce retention and sickness patterns
- Localised patient experience themes.

3.2 In addition, triangulation of workforce, governance, and operational information demonstrates that cultural experience differs significantly between divisions and teams. Therefore, we recognise culture as a strategic organisational risk requiring formal oversight and structured intervention as reflected in the SDR.

3.3 Through our Trust People Council (TPC), we have been engaging with colleagues on the culture of the Trust, how it feels to work here, areas of success and areas for improvement. Representatives of TPC have been candid with their feedback and are supportive of the suggested approach to redefine our approach but are also realistic the time this will take to adjust the culture and the sub-cultures which we have.

4. What Do We Aim to Do

4.1 To establish a consistently safe, respectful, accountable, and improvement-focused organisational culture across all our six Groups to:

- Strengthen psychological safety and speaking up culture.
- Establish consistent behavioural expectations.
- Improve visibility and consistency of leadership behaviours.
- Strengthen Group/Directorate accountability for culture.
- Improve learning and feedback following concerns or incidents.
- Reduce variation in staff experience across Groups/directorates.
- Embed culture indicators into core organisational performance oversight.

4.2 Whilst we have the Trust values, which colleagues in the main do recognise, we do not have a set of behavioural standards which support our values. Therefore, it is proposed that we develop six cultural commitments/ behavioural standards, which are aligned to each of our values. These behaviour standards will be coproduced with the support of TPC and other groups. As a reminder, our agreed values are:



4.3 Possible cultural commitments/behaviours standards could include:

- Speaking up is expected and always responded to within X days
- Disrespectful behaviour is always addressed (no “informal exceptions” for high performing colleagues)
- Patient safety concerns override operational targets in defined scenarios (this is already the case, but not always the practice)
- Leaders are required to close the loop on feedback.

4.4 Accountability will be aligned to the cultural commitments, so colleagues are unable to opt of the approach. Given most NHS cultural problems persist because accountability is fragmented, this will be linked to the new appraisal framework (due to launch before April 2027), to Delivery Reviews and HR/OD processes. It is understood that those processes themselves need to be refreshed in light of this cultural work, because the management of people is a managerial matter rather than something refereed through a corporate function. That change is a big one.

4.5 But accountability without care and support will not be successful. Rather than assuming that care simply comes from intent, we need to be insistent on putting care, for one another and our patients, into the way in which we work, in a manner that is known and recognised – but also in way that is competent for the various cultures we have within our organisation – different professional cultures and a diversity of heritage.

5. Some parts of the mix

High care / support

5.1 We are committed to our Learning Half Day construct. Recognising the need to offer equivalence for shift-based workers, we want to build on this time to learn, time to improve, time to talk space. Within this time, we need to ensure that there is sufficient and visible access, in all three localities, to reflective learning and restorative interventions. This will need to be coupled with developing the

facilitation skills of local team leaders to better equip them to curate conversations and discussions within their teams.

- 5.2 Whilst widely lauded we know that our wellbeing support could be larger in scale, broader in scope, and better aligned to reach far more of our workforce. Since October 2025, work has been ongoing to reset fundamentally that offer and during the summer we need to bring that thinking work to a conclusion, and set an ambitious target in relation to reach (i.e. how many RDaSHians are accessing some part of that offer). We know that not everyone will wish to get this support from their employer, and so, probably through the third sector, we need to ensure there are a broader menu of options available to staff.
- 5.3 Supervision has to be a part of the support offer. As we progress with difference approaches to accountability and expectations of delivery, we have to retain the kindness and listening aspects of supervision, recognising the additional benefits that Professional Advocates and Legacy Mentors can bring to this space. PAs are a strong resource, which we could draw on further and expand as part of this cultural work. There is real appetite for this in many disciplines and this summer that could again be a practical, tangible step for us to take.
- 5.4 In the Board's discussion about tackling violence and aggression we have made a number of commitments, of which RRI advocates is one part, and high-quality therapeutic activities another. But the Chief Nurse's analysis demonstrates the mixed picture in terms of accessing actual practical support after being attacked. Whether it is through line managers, legacy mentors or TRS, we need to make this restorative support an assumed and always accessed part of recovery – both inside 72 hours and some weeks thereafter, as the cycle of harm is not always immediate or mitigated.
- 5.5 Flexible working, and the scope to work remotely and operate on an agile basis, has been extensively explored over recent months. It was notably well received when presented to the TPC in recent days, and likewise within CLE. There is no question that operating 'with line manager's discretion' will be a change for us, but it is the underpinning of creating an expectation that all of our employees have access to flexibility in the workplace, operating as part of a team. The new policy, toolkit, and six-month transition period are a major undertaking for us in the balance of 2026: and one that will, for some staff, seem less than supportive as legacy arrangements may need to be reset to the revised fair-for-all approach. In changing notions of 'base points', logging in and rotas issued to you, without your input, these are major cultural adjustments – ones that speak to autonomy and professionalism.
- 5.6 If we want to value experience, and we surely do, then we need to consider how we use existing contractual flexibilities better. We have discussed before blurring the rigidity of bands 2-3 and bands 5-6, in an effort to allow colleagues to progress in their career without changing role. This thought process may need to be accelerated somewhat, without complicating the current national band 4-9 work. At the same time, for all professions, but perhaps notably medical and psychological roles, we might explore a more formal 'earnt'

sabbatical or career break option within employment at the Trust. We, anyway, need to reset retention premia. Both these ideas aim to think about retention, and what it means to commit to the Trust over more than a decade.

High challenge / accountability

- 5.7 The Board committed in late 2024 to implementing job plans across all of our professions as a senior level. That has proved a very challenging transition and one that is not yet in place. Completing that prior to the launch of this wider work is fundamental. That planning cycle seeks to 'hard-code' SPA/non patient facing activities within people's working time. Of course, it also sets boundaries of availability, complexity and throughput. We know from the work to implement community-based changes, and from the continued challenge in a minority of wards to implement standard work weeks, that this is far from easy to do. Line managers need both training and backing to see through difficulty conversations. The legacy position in which 'to grievance' became a weaponised verb (akin to datixing in some cultures) will take time to abate.
- 5.8 Likewise, almost eighteen months ago, we undertook to develop a wholly different appraisal model. Drawing on feedback about the value of appraisals within the staff survey, but also the fuzziness of our existing frameworks, we want to reset for both delivery and method (not just what, but how). A part of that is a four-part scoring model, which will be centrally collated and evaluated: another part is the move to mandatory 360-degree approaches for all line managers (which is, anyway, about to become national policy). A finalised timeline to get this right is being developed by the authors, recognising our December 2025 CLE decision to delay.
- 5.9 The mechanics of an acceptance of challenge is perhaps simpler to document than the dynamics of the same. And challenge in this framing is upward, downward and sideways. Further thought, consultation and socialisation are needed to understand what barriers of skill, permission and anxiety impede difficult conversations in our Trust, and how we move past avoidant behaviours. Psychological safety is a necessary part of that discussion but is not sufficient condition.
- 5.10 Work to hold ourselves individually accountable, notably in respect of anti-racism, cannot be a separate initiative. Instead, it is core to this reset. The executive is developing a first proposal on the practical steps needed to support every single RDaSHian to demonstrate positive anti-racism. This will be central to the appraisal process and part of institutional accountability, in spaces like ward scorecards, directorate delivery reviews, and peer visits. We know from the initial work done in Mulberry that the shift from 'not being racist' to being actively 'anti-racist' is a misunderstood step in many cases and the time and care needed to have impact will be a tangible test of a cultural reset.
- 5.11 In developing the leadership structure since 2023, and in agreeing a series of decision-making spaces, we have tried to introduce accountability more clearly. More refinement of this is needed yet. We know that directorates have not developed in all cases to the timeline hoped, and 'think directorate' will take

more work in the year ahead. It is, perhaps, helpful to reiterate that, in 2028, whilst there may be structural 'tweaks' there is no intention to move away from Care Groups nor directorates: as such time invested in the development and growth of teams and individuals is time to a purpose and not time limited. In that context, we will need to consider carefully our talent pools with the aim of fully populating our management structure by autumn 2027. That includes the current process of exploring why, and where, there are gaps, but also evaluating role performance and ceilings of improvement. Leadership is not for everyone, and it is important that those operating within CLE, and indeed TLC, can operate to a coherent set of values and accept collective responsibility, even where decisions are not agreed by all.

6. Likely delivery approach

- 6.1 As Board are aware, we have recently identified our line managers within the organisation, previously 555 in number, all of whom have a significant influence on the day to day working practices of our colleagues, all of whom will be key as part of our cultural reset work.
- 6.2 In practice, culture is shaped (or broken) by our line managers, Care Group/Corporate SLTs, matrons / service managers, clinical leads, very senior managers and, as such, we need to provide training and simulation exercises in holding adult (sometimes referred to as difficult) conversations, giving them permission and confidence to act and removing any perceived or "informal immunity" for high performers.
- 6.3 Furthermore, most culture change fails because middle leaders are not consistently backed when they challenge behaviour and, as such, this must be an area of focus, to build confidence, consistency and accountability.
- 6.4 Some of the actions proposed may appear basic, but this supports a common understanding across the Trust, irrespective of a colleague's length of service (given the numerous different approaches over the years), clarity on the response and then ultimately the consequence, as colleagues need to believe that their voice will be heard and the appropriate action taken, (our staff survey results demonstrate that the colleagues who responded to the survey do not have this level of confidence, hence the reset work required). If we focus on the Maslow's hierarchy of needs in an employment setting, we need to ensure a solid foundation before we progress further.
- 6.5 It is envisaged that, following the development of the cultural commitments, we will have a small set of cultural indicators. which will have the same standing as our operational KPIs, such as out of area placements, 4 week waits, expected date of discharge, these may include:
 - Staff survey engagement + psychological safety items
 - Freedom to Speak Up reports and closure rates
 - Sickness/turnover in hotspots
 - Patient complaint's themes by group/directorate/team
 - Repeat incident patterns.

- 6.6 Colleagues will be critical of our focus on the cultural commitments when a team, Directorate or the Trust enters a different period; this is the real measure, when its difficult colleagues will be watching/observing to note whether we stand behind the cultural commitments and adhere to them at difficult times.
- 6.7 Most colleagues in the NHS do not come to work to cause harm and this is our starting point, but given our experiences of racism within the Trust (which we have acknowledged publicly in previous Board papers and discussions), we need clear thresholds for intervention with consistent consequences (not case by case drift but acknowledging colleagues mitigation will be different) which will be driven by clear thresholds for intervention.
- 6.8 Whilst we promote FTSU and continue to do so, colleagues are reporting via the staff survey diminishing levels of confidence. Based on this one area, we may choose to consider embracing a closure culture, rather than a reporting culture, as speaking up is the initial aspect, but just as important to build credibility is clear decision ownership, documented outcomes, feedback loops, evidence that action has happened and then wider organisational learning to prevent similar issues arising again, wherever possible.
- 6.9 We need both longevity and consistency in the approach and, as such, this should not be seen as another initiative, which may come and go (as other cultural initiatives have), but about providing clarity to colleagues at all levels, in all teams, in all of our geographies, which removes tolerated poor behaviour, contradictory indicators, leadership inconsistency and ambiguity in consequences and our focus for until possibly 2030, which spans the current organisational strategy and the next.

7. Conclusion

- 7.1 Over coming weeks, we will continue to iterate with directorates and care groups, as well as networks and other spaces, not the idea of the programme, which is probably uncontentious but instead:
- What issues this work must help solve and what it should not harm
 - Practical steps that are needed within it to make it real
 - How we deploy something rooted in the middle of our organisation first, supported from the top and hearing from everyone.
- 7.2 Interested Board colleagues will be invited to a think-tank session with other senior leaders in early July, as we build towards an approvable proposition in July.
- 7.3 There is then considerable work to do to launch the work in and via the leader's conference in late September.

Toby Lewis, Chief Executive
Carlene Holden, Director of People and Organisational Development
20th May 2026

Annex 1

The culture we wish to be part of

Culture cannot be prescribed. It brings together the learnings and beliefs, symbols and behaviours of the Trust as it is today, experiences from the past, and hopes for the future. But a culture can be enhanced by intention, altering what is working less well, adjusting to bring greater consistency framed around best practice. It is this cultural adaptation that this Plan can contribute to, that leaders can enhance, and that we can measure through feedback and another means – testing our success against that intention, recognising that cultures change slowly.

Colleagues have developed ideas about the culture that they wish to be part of:

- Caring, Supporting, Fair and Equitable culture for all: we want staff to treat patients with respect, care and compassion, so all leaders and staff must treat their colleagues with respect, care and compassion
- Climate that supports equality, diversity and inclusion: celebrate the diversity and different thoughts, perspectives and views
- Climate that supports 'nurturing the power of our communities': encouraging learning and innovation, working alongside those within services and in neighbourhoods
- Collective leadership: where staff at all levels are empowered as individuals, within and between teams to act to improve care within and across health and care organisations and systems – 'leadership of all, by all and for all'

In an organisation the size of RDaSH it is unlikely we will have one culture. Indeed, the climate of diversity and innovation described will come best from the fusing of different cultures; by place, profession, tradition, and team. But some common threads are needed if we are to support the care we provide to be outstanding in its caring nature, and the development of individuals and teams to be respectful and compassionate. Those common threads will come with behavioural expectations that reflect the pace and ambition set by the Board's strategy, as well as the expectations for reform anticipated in the NHS Ten Year plan.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Staff Survey – Areas of Focus	Agenda Item	Paper V
Sponsoring Executive	Carlene Holden, Director of People and Organisational Development		
Report Author	Carlene Holden, Director of People and Organisational Development		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points			
In March 2026 the Board received the staff survey results, this paper suggests our areas of focus for the next two years, recognising the work required to improve our results, our working environments for colleagues and ultimately the care which we deliver to our patients. The two-year timescale is reflective of the work which is required to further improve the results whilst also balancing the 2026 staff survey will commence within the next sixth months. As a minimum (our floor) we expect our staff survey results to be rated as average or above average against our comparator group, with two specific area of focus for this financial year – care of patients/service users is our top priority and the raising concerns sub section score. The Board are also asked to consider the disconnect between our performance with the four week wait for example and how colleagues do not recognise this as improving patient care, which is reflected in the free text comments, which may be indicative of the view at the time of the survey rather than the current view.			
Previous consideration			
People and Organisational Development Committee in April 2026 – overview of the results			
Recommendation			
The Board is asked to:			
NOTE the staff survey results and the suggested areas of focus			
CONSIDER the nine staff survey areas and whether we should focus our attention on other areas to those suggested, the two-year suggested improvement journey and the two areas of focus for this year			
RECOGNISE the work and commitment required to facilitate the suggested improvements			
DELEGATE the development and subsequent monitoring of the work to the People and Organisational Development Committee and Trust People Council. In addition, delegate to the People and Organisational Development Committee the review and submission of the 2024 WRES and WDES data.			
Alignment to strategic objectives (indicate those that the paper supports)			
SO2: Create equity of access, employment, and experience to address differences in outcome			x
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings			x
Business as usual			x
Alignment to the plans:			
Estates plan			x
Digital plan			x
People and teams plan			x
Finance plan			x
Quality and safety plan			x
Equity and inclusion plan			x

Education and learning plan			X
Trust Risk Register			
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Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
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Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	

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.					
Strategic Delivery Risks							
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees							X
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Appendix							
Annex 1 – Directorate results							
Annex 2 – Length of Service comparison							
Annex 3 – Heat Map from free text comments and free text comments							
Annex 4 – Raising concerns analysis							

1.0 Staff Survey – Areas of Focus

- 1.1 The purpose of this paper is to provide a summary of our results, and to outline our proposed areas of focus, which will form a two-year improvement trajectory.
- 1.2 We are committed to creating a culture where colleagues can thrive and feel motivated to work at RDaSH, further detail is available in the Culture paper, also on today's agenda. While rolling turnover has remained stable and broadly aligned to our target of 10.5%, the Trust has experienced a period of organisational change during H2 of 2025/26 and Q1 of 2026/27. The staff survey launched during H2, at the outset of the change programmes, and this is reflected, in part, in the survey results.
- 1.3 The annual staff survey provides a comprehensive dataset at both Trust and Directorate level, enabling identification of areas of strength and informing our medium-term priorities for improvement.
- 1.3 As a reminder, the staff survey comprises the 7 People Promise elements plus two themes: staff engagement and morale – providing nine areas in total. The following infographic summaries our results for the 2025 survey across all 9 areas.

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.

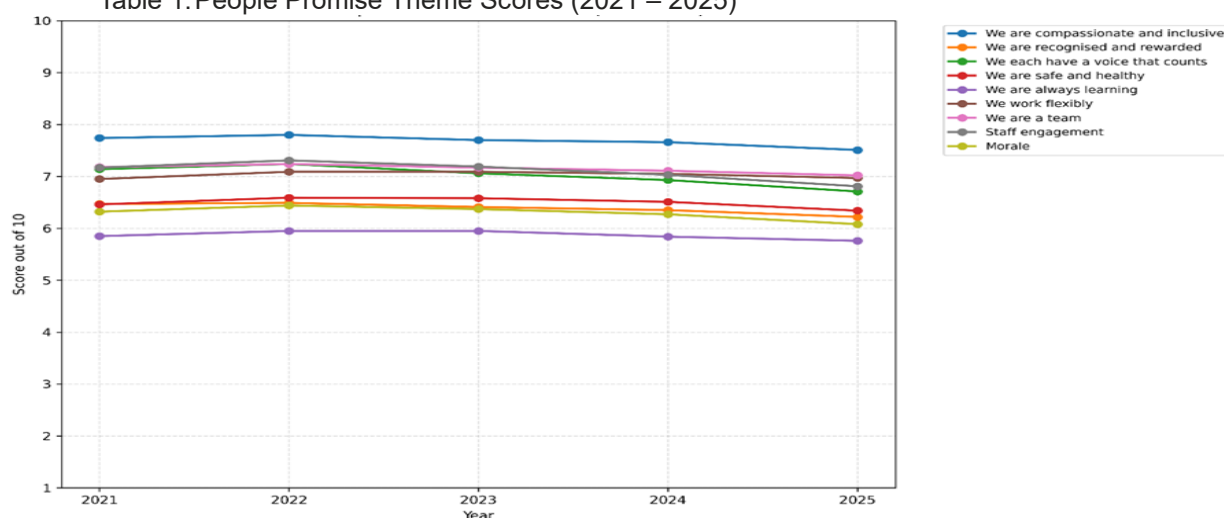


Key: Our results - Navy blue bar, Best result – Green line, Average result – Light blue bar, Worst result – orange line

- 1.4 Overall, the Trust has seen a decrease in results against each of the people promise themes when compared against our 2024 scores. Whilst our peer group (Mental Health & Learning Disability and Mental Health Learning Disability & Community Trusts) results remain typically better than the overall NHS results, our medium-term reduction gradient continues and we are now below our peer group average scores for all bar 2 promises; one of which remains above (We work flexibly) and the other equal to (We are safe and healthy) our peer average score. To provide context, nationally within our peer group the average score has reduced for 8 of the areas [between 0.01 and 0.08] and has slightly improved for one.

- 1.5 As part of the results, six areas of change were statistically significant when compared to our 2024 scores, specifically; we are compassionate and inclusive, we are recognised and rewarded, we each have a voice that counts, we are healthy and safe, staff engagement and morale. Of which 5 areas were considered significantly worse than our benchmarking group average which are; we are compassionate and inclusive, we are recognised and rewarded, we each have a voice that counts, we are a team and staff engagement.
- 1.6 While none of the Trust's results fall within the lowest-performing category nationally, benchmarking against all providers (207 in total) shows our lowest-ranked area is People Promise Theme: Staff Engagement (111th out of 207), followed by We Each Have a Voice That Counts (95th out of 207). When compared with our benchmarking group, our lowest-ranked areas are: We Are Recognised and Rewarded (39th out of 48), We Each Have a Voice That Counts, and: We Are a Team (both ranked 36th out of 48). Our strongest-performing area, both nationally and within our benchmarking group, is We Work Flexibly, where we rank 19th out of all trusts and 14th within our peer group, which has been a strong performing area for several years.
- 1.7 A review of our five-year trends across all People Promise themes indicates a gradual decline in scores against each of the people promises and themes, particularly over the past three years. We are committed to understanding the factors contributing to this trend and implementing targeted actions to drive improvement.

Table 1: People Promise Theme Scores (2021 – 2025)



2.0 What should we and more importantly our colleagues expect?

- 2.1 This year, our analysis has focused on directorate-level results across our 23 directorates, with a summary provided in Annex 1. To ensure we meet the needs of colleagues/teams and Directorates, results at these levels have been shared with relevant leads, to facilitate directorate level engagement.
- 2.2 As a minimum expectation, staff survey scores across all 23 Directorates should, over time (two-year improvement trajectory), perform at the average or above average across all nine themes. Analysis set out in Annex One shows that **6 Directorates currently score below the Trust average across all nine measures, and in total 16 Directorates require targeted improvement to achieve Trust average benchmarks**. Positively, six Directorates performed at or above the Trust average across all nine measures; of these, all are also aligned

with peer group averages, with four Directorates exceeding peer group averages across all People Promise measures.

- 2.3 Given the overall decline in results, the scale of improvement required should not be underestimated, hence the two-year trajectory. Annex One highlights Directorate and Group-level performance against Trust averages and underscores the need for focused action across all 23 Directorates. While it is positive that six Directorates are performing at or above the Trust average, the overall position relative to peer group benchmarks indicates that improvement is required across all Directorates, albeit to varying degrees
- 2.4 For the first time, results have been analysed at trust level by length of service to assess the impact of work undertaken over the past few years with the new induction programme and the work to reduce leaver rates within the first year of employment. As set out in Annex 2, there is a positive correlation in results among colleagues with less than five years' service, suggesting these interventions are having a positive impact. The analysis has also highlighted the need for further work to better understand the experiences of long-serving colleagues, whose results fall below the Trust average across all areas as you would also expect for the results to be higher for longer standing employees, with a dip in satisfaction in the middle years.
- 2.5 Each year the Trust receives anonymised free-text comments (342) from staff surveys, which provide valuable qualitative insight. These have been analysed to identify key themes and areas of risk and have been shared with the Board in full as part of the private Board papers. Annex 3 presents a risk heat map of emerging themes by Care Group/Backbone, with the Children's Care Group rated "very high" and the Rotherham Care Group "significant," indicating the need for further analysis. The heat map reflects the frequency of reported themes based on the free text comments rather than confirmed incident prevalence. Due to low response volumes, analysis at directorate level was not possible and not all Directorates received free text comments at the required level to facilitate the sharing.
- 2.6 Although our approach this year is to focus our efforts at directorate level on a two-year improvement trajectory across all staff survey measures, there are two main areas suggested where particular focus should be given across all Directorates, given they are core to our ways of working.
- People Promise 1 – We are compassionate and inclusive
 - People Promise 3 – We each have a voice that counts

A neighbouring Trust, NAVIGO Health and Social care CIC are the most improved organisation within our peer group sector and as we already have close working relationships with them, we are further exploring the work which they have undertaken which had resulted in an improvement in their staff survey results.

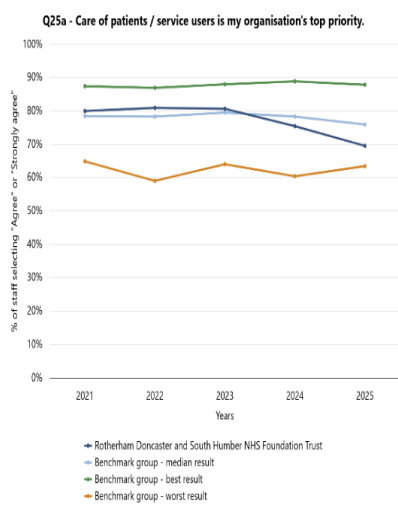
3.0 People Promise 1 – We are compassionate and inclusive

- 3.1 Our scores in we are compassionate and inclusive have now fallen for 3 consecutive years and are now below our benchmarking group average [7.61]. Our score is currently 7.51 with the best being 7.94



This People Promise contains 4 areas of focus – compassionate culture, compassionate leadership, diversity and equality and Inclusion

- 3.2 A detailed review of the four areas highlights Compassionate Culture as a particular area of concern. Our scores have fallen in this area for the third consecutive year with scores declining from 7.19 to 6.96 and, whilst the peer average also reduced this year, this places the Trust significantly below the peer group average. This section contains the staff family and friends questions, which tend to influence a number of the staff survey outcomes. Given our focus on improving patient care across the services, this is concerning.



Of particular concern is the reduction in the proportion of staff who feel that the care of patients and service users is the organisation's top priority. As a Trust committed to patient safety and compassionate care, it is essential that we understand the factors driving these results and take appropriate action to understand why our colleagues carry this belief, and take steps to address them. When reviewing the free text comments a number relate to the four week wait and our focus in this area, which is most definitely about improving the care our patients receive, but colleagues haven't connected the two as improving patient care and instead focus on the delivery of a key performance indicator, which at times is reported negatively.

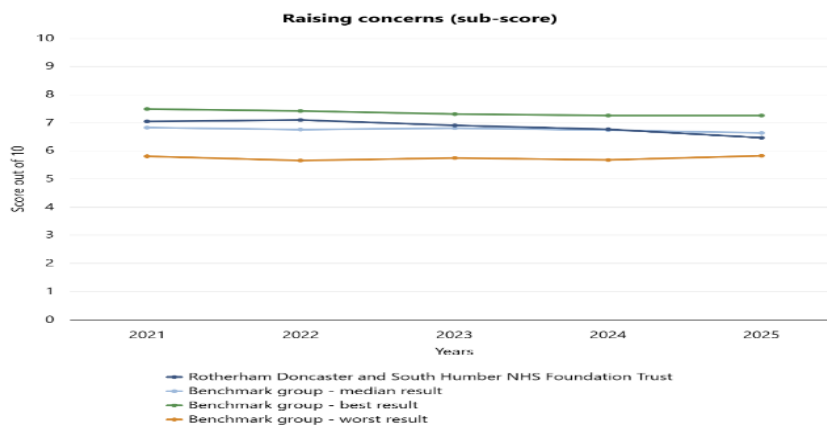
4.0 People Promise 3 - We each have a voice that counts

- 4.1 Our score in we each have a voice that counts is currently 6.71, a reduction from our 2024 score of 6.93 and below our peer average. Nationally the raising concerns sub-score is at a five year low.

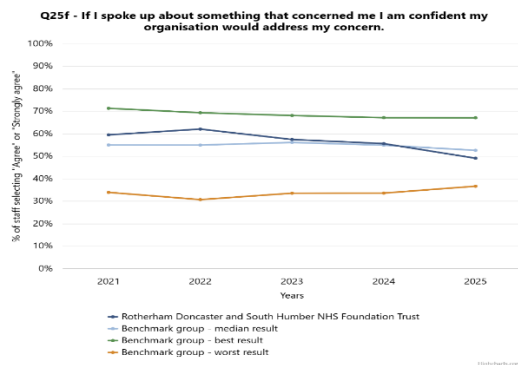


This people promise is made of 2 elements; autonomy and control and raising concerns.

- 4.2 Of particular note are our scores for the element of raising concerns. Results have seen a decline for 3 consecutive years, with the 2025 results seeing a sizeable drop from 6.77 to 6.47, with the average result being 6.64.



- 4.3 It is of concern that colleagues do not feel confident that the organisation will address concerns when raised, with our results only now being slightly above the average result (59.51 versus 59.29%) and some significant distance from the best results at 73.72%, when historically this was a strong reporting area.



While prioritising strategic actions to improve safety across Directorates, it is equally important to ensure that core safety fundamentals are consistently in place. This requires strong leadership at all levels, with line managers and Directorate and Care Group leaders taking responsibility for ensuring that essential safety standards are understood and maintained.

- 4.4 This is a key area for all Directorates to ensure timely action is taken and feedback provided to colleagues to close the loop as otherwise when colleagues do not report concerns, or feel unable to speak up the risks become serious for patients, colleagues and the wider organisation. All of which can lead to a closed culture as colleagues feel unable or unsafe to speak openly about concerns, mistakes, risks or poor behaviour. This also links to the Culture paper on today's agenda as we must facilitate a culture in which we foster a safety first ethos and speaking up makes a difference.

5.0 Next Steps

- 5.1 The staff survey results have been shared with all directorate leads and the engagement commenced with colleagues. Each Directorate has been asked to identify a small number (two or three) actions which they wish to focus on.
- 5.2 Each directorate has been offered the opportunity to receive support in analysing their staff survey results by a member of the POD Directorate
- 5.2 If the areas of focus are supported from a Board perspective, then the refinement of these areas, the scrutiny of the questions and the agreed plans will be developed and monitored via People and Organisational Committee and the Trust People Council, as again engagement is key to ensuring success.
- 5.3 The WRES and WDES data and the associated national submissions will be reviewed by the People and Organisational Development Committee in August, in advance of the national reporting deadline in October 2026.

6.0 Recommendations

- 6.1 The Board of Directors are asked to:
1. Consider the suggested areas of focus (safety first and speaking up) which will be complemented by the Directorate and Trust wide action areas which are agreed each year.
 2. Recognise the need for the Directorates to undertake the engagement and associated work.

3. As in 2024 to delegate the review and submission of the 2025 WRES and WDES data to the People and Organisational Development Committee.
4. Agree the development and subsequent monitoring of the work to the People and Organisational Development Committee and Trust People Council.

Carlene Holden
Director of People and Organisational Development
May 2026

Annex 1

Staff Survey – All Areas – Comparison of results against trust average scores

[illegible]

People and Organisational Development	X	X	X	✓	X	✓	✓	X	X
Psychological Therapies	-	-	-	-	-	-	-	-	-
Strategic Development	X	X	X	X	X	✓	✓	X	X
Children's	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mental Health	X	X	X	X	X	X	X	X	X
Physical Health	✓	✓	✓	✓	✓	✓	✓	✓	✓
Doncaster Mental Health and Learning Disabilities	X	✓	X	X	✓	X	✓	X	X
Acute Services	X	X	X	X	X	X	✓	X	X
Community Services	X	X	X	X	✓	X	X	X	X
Learning Disabilities and Forensics	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Lincs Adult Mental Health & Talking Therapies	✓	✓	X	X	X	✓	X	X	✓

Acute Services	X	X	X	X	X	X	X	X	X
Community Services	✓	✓	✓	X	✓	✓	X	✓	✓
Talking Therapies	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical Health and Neurodiversity	✓	✓	X	✓	↔	X	X	✓	X
Community & Long Term Conditions	✓	X	✓	X	✓	X	✓	✓	✓
Neurodiversity	X	X	X	X	X	X	X	X	X
Rehabilitation	X	X	✓	✓	✓	✓	X	✓	✓
Rotherham Adult Mental Health	X	X	X	X	X	X	X	X	X
Acute Services	X	X	X	X	X	X	X	X	X
Community Services	X	X	X	X	X	X	X	X	X

Key X - below Trust average, ✓ - above Trust average, ↔ same as Trust average

Annex 2

Staff survey result analysis - Length of Service comparison

Question	Organisation	< 1 Year	1 - 2 Years	3 - 5 Years	6 - 10 Years	11 - 15 Years	> 15 years
PP1 We are compassionate and inclusive	7.52	7.87	7.52	7.61	7.45	7.47	7.31
PP2 We are recognised and rewarded	6.21	6.66	6.35	6.14	6.04	6.22	6.04
PP3 We each have a voice that counts	6.73	7.03	6.76	6.82	6.63	6.74	6.49
PP4 We are safe and healthy	6.37	6.90	6.44	6.41	6.22	6.28	6.19
PP5 We are always learning	5.74	6.08	6.10	5.85	5.52	5.54	5.41
PP6 We work flexibly	6.98	7.25	7.02	7.01	7.04	6.94	6.69
PP7 We are a team	7.04	7.31	7.02	7.08	6.92	7.09	6.94
E Staff engagement	6.82	7.29	6.86	6.92	6.67	6.81	6.51
M Morale	6.10	6.67	6.17	6.19	5.88	6.04	5.87

Annex 3

Staff survey free text questions - Risk Heat Map (Care Group / Backbone)

Legend: ■ Low | ■ Moderate | ■ High | ■ Very high | ■ ■ Significant

Care Group	Leadership & culture	Communication & engagement	Workforce capacity & workload	Targets / promises pressure	Equity / recognition / progression	Safety & clinical risk	Overall
Backbone Directorates							
Children’s Care Group							
Doncaster MH & LD Group							
North Lincs MH & Talking Therapies							
Physical Health & Neurodiversity							
Rotherham Care Group							

Annex 4

People Promise 3 – We each have a voice that counts, sub score 2 – Raising concerns

Group / Directorate	We each have a voice that counts, Sub score – Raising Concerns 	We each have a voice that counts, Sub score – Raising Concerns 
	Above Trust Average (6.50)	Above Peer Group Average (6.64)
Backbone	X	X
Corporate Assurance	✓	✓
Estates	X 4.53	X
Finance and Procurement	✓	X
Health Informatics	✓	X
Medical, Pharmacy & research	✓	X
Nursing & Facilities	X	X
Operations	X	X
People and Organisational Development	X	X
Strategic Development	X 5.63	X
Children's	✓	✓
Mental Health	X	X
Physical Health	✓	✓
Doncaster Mental Health and Learning Disabilities	X	X
Acute Services	X 5.99	X
Community Services	X	X
Learning Disabilities and Forensics	✓	✓
North Lincs Adult Mental Health & Talking Therapies	✓	X

Acute Services	X5.45	X
Community Services	✓	✓
Talking Therapies	✓	✓
Physical Health and Neurodiversity	✓	✓
Community & Long Term Conditions	✓	✓
Neurodiversity	X5.51	X
Rehabilitation	✓	✓
Rotherham Adult Mental Health	X	X
Acute Services	X	X
Community Services	X5.83	X

Key X - below Trust average, ✓ - above Trust/Peer Group average, ↔ same as Trust/Peer Group average

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Freedom To Speak Up bi annual update	Agenda Item	Paper W
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	James Hatfield, Freedom to speak up guardian		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points			
This paper provides an update on Freedom to Speak Up (FTSU) at RDaSH, presenting the key themes in recent concerns raised, comparative benchmarking against peers, and the forward plan for 2026/27. Analysis of concerns raised during 2025/26 shows patient safety, workforce experience and leadership behaviours remain the dominant themes (with fewer bullying/harassment cases and an increase in anonymous reporting), and staff survey results indicate a decline in confidence to speak up (Raising Concerns score down from 6.77 to 6.47 in 2025). A mid-year FTSU review benchmarks RDaSH broadly in line with neighbouring trusts – volumes and concern types sit within expected ranges, focused on staff well-being issues with minimal detriment cases. The paper also outlines the forward plan for 2026/27, which includes targeted actions for directorates with low reporting or confidence and a range of initiatives (such as expanding the FTSU Champions programme, enhanced leadership engagement, and improved communications) to further strengthen a safe, responsive speak-up culture. It is understood that the wider review of speak up culture, under the auspices of the Chief Executive and wider leadership, will be visible at the July Board - in line with the action log. This will assimilate actions outlined here and confirm which will be sustained and augmented.			
Previous consideration			
This paper (and the FTSU data/learning it contains) has been reviewed by the Patient Safety Operational Group, Quality and Safety Group, and the People & OD Committee.			
Recommendation			
The Board of Directors is asked to:			
NOTE the content of this report as a confidence on the Trust's Freedom to Speak Up arrangements and oversight, including the <i>trends, themes and comparisons</i> presented.			
CONSIDER the key findings and data – notably the trends in concerns raised and the benchmarking against peers – and discuss any implications for sustaining and strengthening the Trust's speak-up culture.			
RECOGNISE the key findings and data – notably the trends in concerns raised and the benchmarking against peers – and discuss any implications for sustaining and strengthening the Trust's speak-up culture.			
AGREE to continue supporting and championing the FTSU forward plan and associated improvement actions (as outlined in the paper's appendices) – including visible leadership support for FTSU, reinforcing that no detriment will be tolerated for speaking up, and promoting the new initiatives to further embed a safe, responsive speak-up culture.			
Alignment to strategic objectives			
SO1: Nurture partnerships with patients and citizens to support good health			X
SO2: Create equity of access, employment, and experience to address differences in outcome			X
Alignment to the plans:			
People and teams plan			X
Quality and safety plan			X
Equity and inclusion plan			X

Education and learning plan			X
Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
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.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
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.	
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Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	

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.						
Strategic Delivery Risks								
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1								X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services								X
System / Place impact								
None identified – this paper is focused on internal Trust culture and processes (with learning shared regionally via the National Guardian Office benchmarking data)								
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								
Appendix One – Total concerns received since 2016, per financial quarter (FTSU concerns trend data).								
Appendix Two – 2025/2026 FTSU concerns by Directorate (breakdown of concerns raised per directorate in H2 2025/26).								
Appendix Three – Staff Survey Results - People Promise 3 – We each have a voice that counts, sub score 2 – Raising concerns								
Appendix Four - Freedom to Speak Up (FTSU) Forward Plan 2026/2027 (planned initiatives to further strengthen the speak-up culture in the next year).								
Appendix Five - Freedom to Speak Up (Closed) – Feedback Questionnaire								

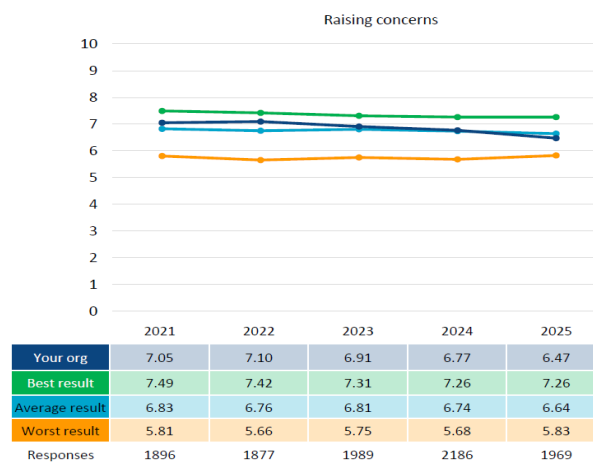
Freedom To Speak Up bi annual update

1. Introduction

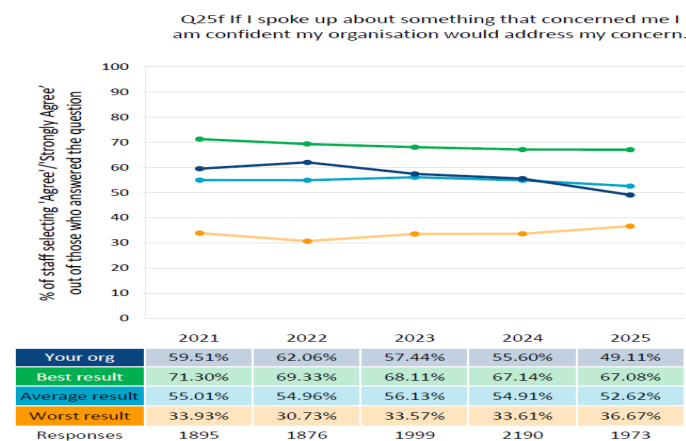
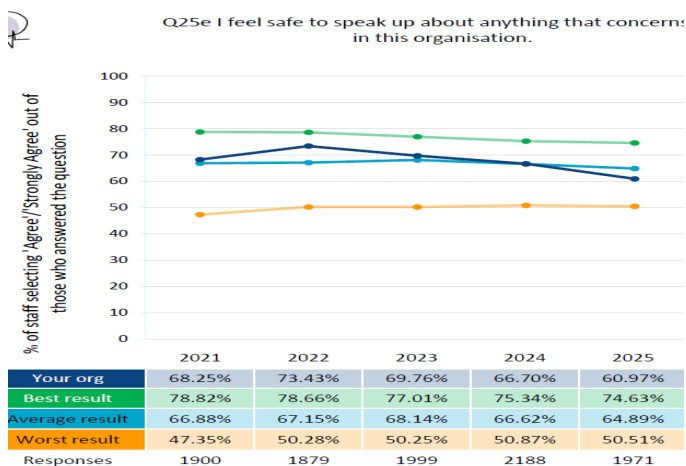
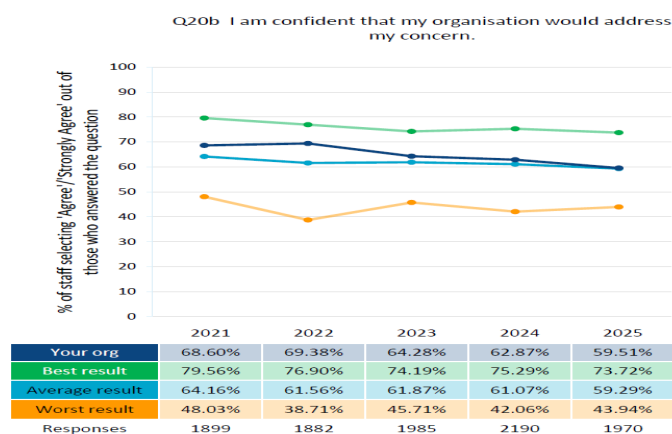
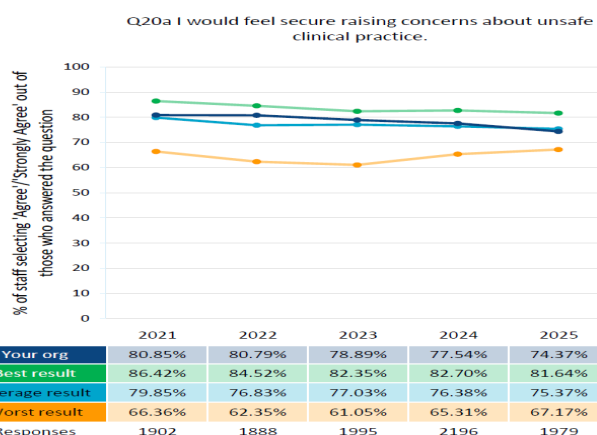
This report provides a dedicated update on our Freedom to Speak Up (FTSU) activities and their impact on fostering a safe, transparent, and learning culture within our NHS Trust. We will review key data from the last two quarters, focusing on the nature of concerns raised, the significant themes emerging, and crucially, the learning and improvements that have been implemented as a direct result.

2. Number of concerns raised

In 2025/26, we saw **101** concerns raised, against **96** in 2024/25, half 2 of 25/26 saw an increase against half 1, which was a similar pattern to the year prior. Appendix 1 shows the number of FTSU concerns raised from April 2016 to April 2026. Overall, the long-term trend shows the FTSU route is embedded within the organisation, however the staff survey indicates that colleagues do not feel confident to raise concerns. Staff survey results for raising concerns have seen a decline for 3 consecutive years, with the 2025 results seeing a sizeable drop from 6.77 to 6.47. Appendix 2 presents the Freedom to Speak Up (FTSU) concerns raised by directorate between October 2025 and April 2026, with appendix 3 showing the staff survey results by directorate for People Promise 3 – we each have a voice that counts, sub score 2 – Raising concerns.



The subsections of raising concerns are shown on the following graphs, at Trust level compared to previous years and national average.



Whilst the following data is people promise 2 combined (autonomy and control, and raising concerns) it does offer a lens on where there might need to be focus within 2026/27, notwithstanding directorate level split.

Question	Organisation	< 1 Year	1 - 2 Years	3 - 5 Years	6 - 10 Years	11 - 15 Years	> 15 years
PP3 We each have a voice that counts	6.73	7.03	6.76	6.82	6.63	6.74	6.49

Strong leadership at team and directorate level will be pivotal in 2026/27 to ensure that colleagues feel safe and confident to speak up, in an organisation that will address concerns. Action plans are being developed by directorate leads based upon their localised results. Triangulation of FTSU concerns and the staff survey identifies several directorates with comparatively low levels of FTSU reporting, with staff indicating they do not feel confident in speaking up. This reinforced the need for targeted intervention in 26/27. The directorates of focus are:

- North Lincolnshire Acute
- Children's Mental Health
- PHND Neurodiversity
- Operations
- Strategic Development
- People and OD
- Estates
- Nursing and Facilities

2.2 Why these directorates are a focus in 2026/27

These directorates have been selected through triangulation of two data sources in this report: (1) very low FTSU reporting volumes by directorate (Appendix 2) and (2) below-average staff survey scores for raising concerns (Appendix 3). For example, Estates recorded a Raising Concerns score of 4.53 against a Trust average of 6.50, and reported no FTSU concerns in the period shown in Appendix 2. This combination of low reporting and low confidence indicates a risk that concerns are not being raised early; it is therefore the basis for targeted engagement and leadership action.

Appendix 4 also details the forward plan for FTSU, current and future actions that have been taken to increase knowledge around FTSU principles and improve the culture of the organisation so that all staff feel safe and secure raising concerns.

3. Patient and Worker Safety/ Experience

Table 1 – Comparisons concerning “speak up” theme and experience (Q3/Q4)

Theme or experience	RDaSH 2024-2025 Q3/4 65 concerns (as at 01/04/2025)	RDaSH 2025-2026 Q3/4 71 concerns (as at 26/03/2026)
Patient Safety Concerns	36	32
Bullying / Harassment Concerns	11	4
Reported anonymously	9	14
Reported perceived disadvantageous and/or demeaning treatment (detriment)	2	2

3.1 Themes and trends

Analysis of FTSU concerns continues to show patient safety, workforce experience and leadership behaviours as dominant themes. Whilst patient safety concerns remain the largest single category, there has been a reduction in bullying and harassment-related concerns in the most recent comparison, alongside an increase in anonymous reporting. While there is evidence of greater confidence to raise issues, anonymity may also reflect areas where staff continue to test psychological safety and perceive risk in being identifiable.

The introduction of enhanced FTSU functionality within Radar has strengthened the Trust's ability to capture protected characteristics associated with concerns, enabling identification of whether staff groups may experience barriers or differential outcomes when raising issues. Initial use of this functionality from **February** 2026 has identified **2** concerns raised by colleagues relating to disability.

3.2 Protected characteristics (gender and ethnicity)

Protected characteristics were not consistently captured in FTSU case records during 2025/26, so we cannot yet report a complete gender or ethnicity profile for colleagues who raised concerns. Appendix 5 provides protected characteristics from the FTSU feedback questionnaire (n=5) and should be interpreted cautiously due to the small sample size. From April 2026, Radar has been updated to capture protected characteristics for each concern. Future Board reports will include the gender and ethnicity breakdown for colleagues who speak up, enabling us to identify any differential access or barriers and target action.

FTSU feedback questionnaire (Protected Characteristics January 2026-May 2026) see appendix 5:

Results are presented as counts and percentages of the total respondents and should be interpreted cautiously due to the small sample size (percentages change in 20% increments). Where provided, date of birth has been converted to age bands (as at 19 May 2026) and missing information is reported explicitly. Respondents were predominantly female (80%), most reported no religion (80%) and no disability (100%), and all reported English as their main language and speaking English very well (100%). In relation to ethnic group, all respondents recorded themselves within the White ethnic group field (English/Welsh/Scottish/Northern Irish/British); however, as ethnic group is captured across multiple fields on the questionnaire, this finding should be interpreted as what was recorded in the White field rather than a fully derived single-category ethnic group distribution.

The Guardian wants to create awareness of, confidence in, and access to FTSU routes among colleagues from ethnic minority backgrounds by improving visibility of relatable contacts and simplifying access routes.

A targeted communications campaign using **posters featuring FTSU Champions from ethnic minority backgrounds**, with clear "how to access" information (e.g., direct contact options, email/phone, drop-in details where applicable). This is designed to reduce barriers linked to trust, confidence, and knowing "who to speak to".

Not all concerns are straightforward to resolve. Some anonymous concerns, by their nature, lack sufficient specificity to clearly identify services or individuals, while others involve complex interpersonal dynamics, protracted investigations or ongoing employment processes. In such cases, concerns are deliberately held in view through senior multidisciplinary discussion, to ensure that issues are neither prematurely closed nor pursued in a way that creates unintended consequences. This reflects a mature and proportionate approach to managing complexity, risk and fairness.

Overall, the pattern of concerns and the way in which they are managed provides confidence that staff can raise issues, that these are taken seriously at senior levels, and that the Trust remains focused on leadership behaviour, civility, inclusion and psychological safety as core drivers of culture and quality.

3.3 Q1-Q2 Comparison with neighbouring Trusts.

Table 2 compares RDaSH to neighbouring Trusts, based upon 2025/26 H1 data, this provides confidence that the FTSU profile is broadly consistent with neighbouring Trusts, both in scale and in concerns raised. The predominant themes relate to workforce wellbeing, behaviours and culture rather than disproportionate patient safety risk. Volumes sit within expected system variation, detriment cases remain low but visible, and anonymous reporting is limited, suggesting a degree of confidence in raising concerns openly. Overall, the data supports the conclusion that RDaSH's FTSU arrangements are functioning as intended and that current improvement activity is appropriately focused on leadership behaviour, civility and psychological safety

Table 2: FTSU Guardian Report Q1-Q2 2025/26 – comparison with neighbouring Trusts

Trusts	Number of concerns brought to FTSUGs	anon	patient safety/ quality	worker safety or wellbeing	bullying or harassment	inappropriate attitudes or behaviours	disadvantageous and/or demeaning treatment (detriment) because of speaking up
RDaSH	30	3	6	13	9	20	2
DBHT	47	3	8	28	9	15	1
Humber	21	0	20	20	0	0	0
LPT	66	2	8	38	11	9	0
NLAG	216	3	20	106	14	32	1
SCH	63	1	12	14	11	40	3
SH PU	66	0	23	28	1	9	0
STH	41	7	18	10	8	10	3
TRFT	35	5	6	27	1	25	0

3.4 What this means at RDaSH –

Concerns raised through the Freedom to Speak Up route are escalated promptly, proportionately and transparently. Where issues relate to patient safety, safeguarding, professional practice or potential workforce detriment, a “no surprises” approach is consistently applied, with same-day escalation to relevant leaders.

This provides confidence that staff can raise concerns, that issues are being surfaced at an early stage, and that the Trust is appropriately focused on leadership behaviour, civility and psychological safety.

The Trust uses this data to triangulate learning through established governance forums and to target improvement activity, demonstrating an open culture, effective oversight and a commitment to learning and continuous improvement in line with Well-led expectations.

4. Learning and Improvement

During 2025/26, high-level learning themes have included civility and respect, leadership visibility, communication and feedback, team dynamics, workforce fatigue and staffing pressures, patient safety experience, and issues related to equality and inclusion, including racism. These themes are consistent with the Trust's wider intelligence from staff surveys

and Well-Led assessments, reinforcing the value of Freedom to Speak Up as a complementary insight rather than an isolated signal.

Importantly, learning from individual concerns is not confined to isolated resolution. In a number of cases, Freedom to Speak Up intelligence has directly prompted wider system interventions, including targeted work on digital inclusion and access to mandatory training for estates and facilities colleagues. This demonstrates how individual voices are translated into organisational learning and improvement.

Concerns relating to detriment are managed proactively and treated as ongoing risks rather than retrospective checks. Where staff continue to report anxiety, strained working relationships or perceived disadvantage following speaking up, additional escalation and leadership review have taken place to ensure that appropriate protections remain in place. This approach reinforces the Trust's commitment to safeguarding those who speak up and sends a clear signal that retaliation or disadvantage is not tolerated. In June 2026, it is anticipated that the adverse effects of speaking up (detriment) SOP will be approved, and this will formalise the support offered to colleagues at risk of or experiencing the adverse effects of speaking up.

5. Summary

Within this paper details have been provided in terms of FTSU approaches, developments and concerns raised within RDaSH since the previous report in April 2025. Internal and external data is summarised and presented to the Board of Directors to help review Freedom to Speak Up arrangements. It also highlights actions taken regarding concern management monitoring arrangements, as well as activities to promote leadership visibility and encourage a systemic approach to raising concerns.

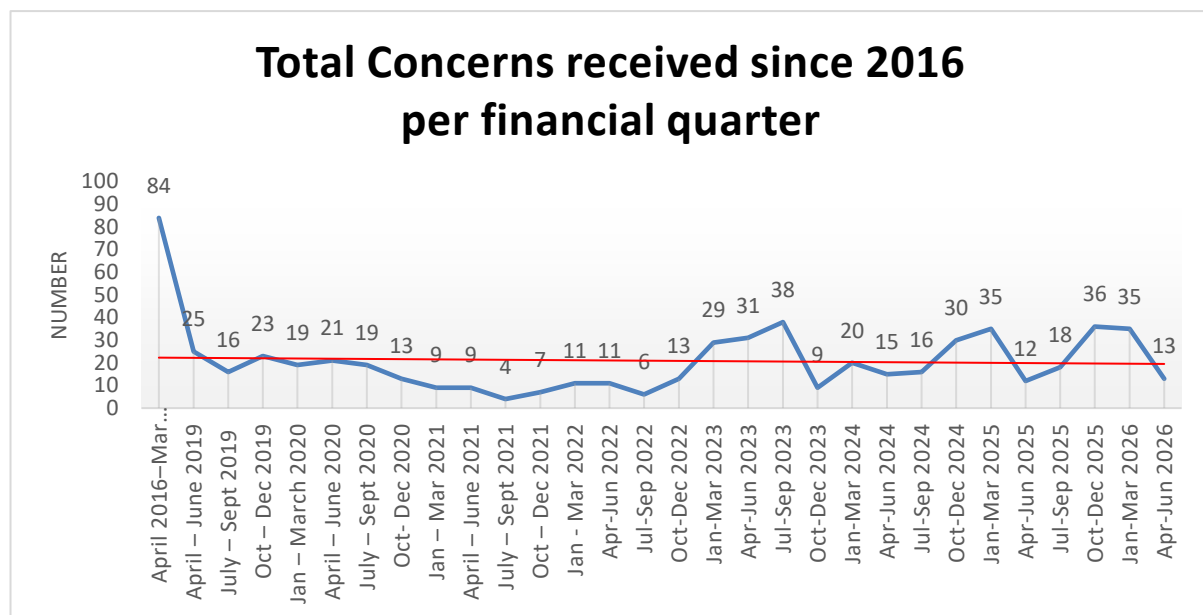
6. Next steps: improving confidence to speak up

Staff survey results show that confidence in raising concerns has declined for three consecutive years, with the 2025 Raising Concerns score falling from 6.77 to 6.47. The next steps below are therefore focused on practical actions that will improve confidence to speak up, particularly in directorates where staff survey scores are lowest. Progress will be tracked through staff survey results and FTSU reporting trends, including reporting volumes, levels of anonymous reporting and timely resolution.

Within the next 6-12 months, the following work is recommended to enhance FTSU approaches at RDaSH:

- For leaders and board members to articulate the importance of workers feeling able to speak up whilst also communicating the organisation's vision for achieving this.
- Speak up, listen, and constructively challenge each other during meetings to model open communication.
- Be visible and approachable to all workers and welcome their input.
- Reflect on and develop insight into how your position or power could intentionally silence truth and take steps to mitigate this.
- Use your position to articulate that detriment will not be accepted in the organisation.
- Thank workers who speak up to acknowledge their courage and contribution.
- Ensure instances where individuals may have suffered detriment for speaking up are promptly and fairly investigated and acted on.

Appendix One



Appendix Two – 2025/2026 FTSU concerns by Directorate

- CCG Management = 0
- CCG MH = 0
- CCG PH = 0
- DMH Management = 0
- DMH Acute = 1
- DMH LD & Forensics = 2
- DMH Community = 1
- PH&NG Management = 0
- PH&NG Community & LTC = 0
- PH&NG Rehabilitation = 0
- PH&NG Neurodiversity = 0
- NLCG Management = 0
- NLCG Talking Therapies = 0
- NLCG Acute = 0
- NLCG Community = 0
- RCG Management = 0
- RCG Acute = 8*
- RCG Community = 1
- Corporate Assurance = 0
- Estates = 0
- Finance & Procurement = 0
- Informatic Services = 0
- Medical, Pharmacy & Research = 0
- Nursing & Facilities = 0
- Operations = 0
- People & OD = 0
- Strategic Development = 0
- Therapies & Psychological Therapies = 0
- Not provided = 0

Appendix Three – Staff Survey Results - People Promise 3 – We each have a voice that counts, sub score 2 – Raising concerns

Group / Directorate	We each have a voice that counts, Sub score – Raising Concerns	
	Is the directorate above Trust Average? (6.50)	Is the directorate above Peer Group Average (6.64)
Backbone	X	X
Corporate Assurance	✓	✓
Estates	X 4.53	X
Finance and Procurement	✓	X
Health Informatics	✓	X
Medical, Pharmacy & research	✓	X
Nursing & Facilities	X	X
Operations	X	X
People and Organisational Development	X	X
Strategic Development	X 5.63	X
Children's	✓	✓
Mental Health	X	X
Physical Health	✓	✓
Doncaster Mental Health and Learning Disabilities	X	X
Acute Services	X 5.99	X
Community Services	X	X
Learning Disabilities and Forensics	✓	✓
North Lincs Adult Mental Health & Talking Therapies	✓	X
Acute Services	X 5.45	X
Community Services	✓	✓
Talking Therapies	✓	✓
Physical Health and Neurodiversity	✓	✓
Community & Long-Term Conditions	✓	✓
Neurodiversity	X 5.51	X
Rehabilitation	✓	✓
Rotherham Adult Mental Health	X	X
Acute Services	X	X
Community Services	X 5.83	X

Key X - below Trust average, ✓ - above Trust/Peer Group average, ↔ same as Trust/Peer Group average

Appendix Four - Freedom to Speak Up (FTSU): Forward plan

- The Trust currently has **82 trained FTSU champions, with an additional 10 colleagues** expressing interest in joining the programme.
- **Targeted Engagement and Induction:** Efforts continue to enhance FTSU visibility through improved communication and induction processes.
- **Schwartz Rounds and Team Time:** Schwartz Rounds have been facilitated to encourage storytelling and promote open dialogue about healthcare experiences. The Guardian, co-delivers these sessions alongside Organisational Development (OD) colleagues, responding to high demand for bespoke rounds in clinical areas.
- **Cultivating Compassion Circles (3Cs):** Monthly interactive sessions via Teams, based on 10 themes, provide safe spaces for staff at all levels to share experiences. The Guardian collaborates with OD colleagues to deliver these sessions, fostering a culture of empathy and support.
- **Half-Day Learning Events** Half-day sessions have been conducted to educate managers on effective responses to FTSU concerns, offering practical strategies to support staff and promote a culture of openness.
- **FTSU Promotional Volunteer** - A FTSU promotional volunteer has been appointed to assist in raising awareness across the Trust.
- **Guardian Visibility** the Guardian visits each Care Group every 4–6 weeks, attending staff diversity networks, peer reviews, and expanding the champions' network.
- **Additional initiatives** include shadowing opportunities, maintaining confidentiality, and engaging in regional peer networks.
- **Adverse Effects SOP:** A new Standard Operating Procedure and accompanying communications will reassure staff affected by speaking up, including those impacted historically.
- **Positive Learning Sharing:** "Learning Matters" will highlight positive outcomes from FTSU concerns.
- **Resolution Timescale:** A new **4-week resolution target** has been implemented via Radar FTSU functionality, ensuring timely responses to concerns.
- **Long-Term Communication Strategy:** Ongoing discussions are underway to establish a comprehensive FTSU communication plan. (now in situ)
- **Executive Engagement:** Senior executives will attend FTSU Champion meetings, with two already committed.
- **Future Plan for Enhanced Reporting-** From April 2026, the Freedom to Speak Up (FTSU) reporting process now includes data on protected characteristics. This enhancement aims to provide deeper insights into whether certain groups experience barriers or differing outcomes when raising concerns.

Appendix Five - Freedom to Speak Up (Closed) – Feedback Questionnaire

Responses included: n=5. Placeholders removed for reporting. Age band derived from date of birth where provided (reference date: 19 May 2026). Summary percentages use total respondents (n=5).

Table 1. Core demographics

Respondent	Age band (as at 19 May 2026)	Main language	English spoken	Religion/belief	Disability?	Sexual orientation	Sex/gender	Carer?	Pregnant?	Baby <12 months?	Partnership status
1	35–44	English	Very well	No religion	No (no long-term physical or mental health conditions, or have a condition/s that did not limit day-to-day activities);	Gay or lesbian	Female	No	No	No	Never married and never registered a civil partnership
2		English	Very well	No religion	No (no long-term physical or mental health conditions, or have a condition/s that did not limit day-to-day activities);	Straight or Heterosexual	Female	No	No	No	Divorced or formerly in a civil partnership

3	45–54	English	Very well	No religion	No (no long-term physical or mental health conditions, or have a condition/s that did not limit day-to-day activities);	Straight or Heterosexual	Female	No	No	No	Married
4		English	Very well	No religion	No (no long-term physical or mental health conditions, or have a condition/s that did not limit day-to-day activities)	Straight or Heterosexual	Male	No	No	No	Never married and never registered a civil partnership
5	45–54	English	Very well	Christian (incl Church of England; Catholic; Protestant and all other Christian denominations)	No (no long-term physical or mental health conditions, or have a condition/s that did not limit day-to-day activities)	Straight or Heterosexual	Female	No	No	No	Married

Table 2. Ethnicity fields

Respondent	White	Mixed	Asian	Black	Other	Other detail
1	English/Welsh/Scottish / Northern Irish/British					
2	English/Welsh/Scottish / Northern Irish/British	British	British	British	British	British
3	English/Welsh/Scottish / Northern Irish/British					
4	English/Welsh/Scottish / Northern Irish/British					Each group of ethnicities is a required question to submit the form
5	English/Welsh/Scottish / Northern Irish/British	British	British	British	British	British

Table 3. Counts and percentages summary by characteristic

Characteristic	Category/Response	n	%
Age band	35–44	1	20.0
Age band	45–54	2	40.0
Age band	Missing/Not provided	2	40.0
Main language	English	5	100.0
English spoken	Very well	5	100.0
Religion/belief	Christian (incl Church of England; Catholic; Protestant and all other Christian denominations)	1	20.0
Religion/belief	No religion	4	80.0
Disability?	No	5	100.0
Sexual orientation	Gay or lesbian	1	20.0
Sexual orientation	Straight or Heterosexual	4	80.0
Sex/gender	Female	4	80.0
Sex/gender	Male	1	20.0
Carer?	No	5	100.0
Pregnant?	No	5	100.0
Baby <12 months?	No	5	100.0
Partnership status	Divorced or formerly in a civil partnership	1	20.0
Partnership status	Married	2	40.0
Partnership status	Never married and never registered a civil partnership	2	40.0
Ethnicity: White	English/Welsh/Scottish / Northern Irish/British	5	100.0
Ethnicity: Mixed	British	2	40.0
Ethnicity: Mixed	Missing/Not provided	3	60.0
Ethnicity: Asian	British	2	40.0
Ethnicity: Asian	Missing/Not provided	3	60.0
Ethnicity: Black	British	2	40.0
Ethnicity: Black	Missing/Not provided	3	60.0
Ethnicity: Other	British	2	40.0
Ethnicity: Other	Missing/Not provided	3	60.0
Ethnicity: Other detail	British	2	40.0
Ethnicity: Other detail	Each group of ethnicities is a required question to submit the form	1	20.0
Ethnicity: Other detail	Missing/Not provided	2	40.0

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	OPMH Quality Indicators		Agenda Item	Paper X	
Sponsoring Executive	Dr Diarmid Sinclair, Chief Medical Officer				
Report Author	Dr Diarmid Sinclair, Chief Medical Officer				
Meeting	Board of Directors		Date	28 May 2026	
Suggested discussion points (two or three issues for the meeting to focus on)					
In April 2025 the Trust Board took the decision to close an older adult ward and to repurpose another existing ward from a purely organic older adult ward to a mixed functional/organic older adult ward. At that time, it was agreed that, in addition to operational indicators related to the Rotherham ward merger, we would agree and track a series of older adult QIs – revisiting in 2026 whether a blended model was delivered good-enough care. It is intended to return to the overall quality of care provided to dementia patients across the Trust in a separate paper this summer.					
Suggested discussion points:					
- Does the data presented reassure the board that the mixed model adopted provides good enough care or should there be alternative models explored such as dementia hub in one locality and functional spokes in other localities - Racist behaviour from colleagues towards other colleagues and the sense of safety of being able to do this - The adequacy of physical health management on our mental health wards					
Previous consideration (where has this paper previously been discussed – and what was the outcome?)					
Q1, Q2 and Q3 data have previously been presented to the Trust board					
Recommendation (delete options as appropriate and elaborate as required)					
The Trust Board is asked to:					
NOTE the data around the performance of our inpatient and community teams					
AGREE the mixed model of functional and organic older adults wards					
SUPPORT the exploration of further work to develop our management of physical health deterioration and also consider ward colocation issues					
Alignment to strategic objectives (indicate those that the paper supports)					
SO2: Create equity of access, employment, and experience to address differences in outcome				X	
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services				X	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings				X	
Alignment to the plans: (indicate those that this paper supports)					
Finance plan				X	
Quality and safety plan				X	
Equity and inclusion plan				X	
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)					
People risks					
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.			X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.			X

Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
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 (indicate those that this paper supports)			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.			X
System / Place relevance (advise whether it is national, regional or local)			

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

Rotherham Doncaster and South Humber NHS Foundation trust

Board of Directors

Quality Indicators in Older Adults Q1-Q4 data

1. Background

- 1.1. The Trust Board approved a major service change in April 2025, closing one of the dedicated older people's wards and moving all older adult mental health inpatient services to a mixed-diagnosis model. This shift replaces the traditional functional–organic split still used by most Trusts, though RDaSH has implemented the combined model successfully elsewhere. Because inpatient environments and staffing vary across sites, the Trust anticipates both localised and cross-cutting implementation challenges.
- 1.2. The Trust has also been responding to regulatory and operational pressures. Following a Regulation 28 notice in September 2024 concerning crisis access for over-65s, equitable crisis pathways were introduced Trust-wide in December 2024. In North Lincolnshire, building works beginning in September 2025 temporarily reduced bed capacity, with some older adult beds converted to virtual ward beds under enhanced clinical oversight. Additionally, the Board agreed a set of quality indicators for Older Adults in September 2025 with the first presentation occurring in November 2025.

2. Progress in presenting the data

- 2.1. Data is now available from Q1 to Q4 for the year 2025-2026 comparing our adult and older services both to each other and also over time. Although the comparison between wards are important it is also worth noting that we now have no dedicated dementia wards in the Trust and so as well as comparing our wards it is necessary to also compare the experience and outcomes of our patients with functional mental health conditions like psychosis and depression to those that have organic conditions like dementia.
- 2.2. The data to make the comparison between functional and organic patients is not currently available but work is ongoing to make this comparison available.

3. Summary of findings in inpatient areas

- 3.1. Across the year, inpatient services show increasing operational pressure, particularly within safe staffing, older people length of stay, and bed occupancy, alongside some clear areas of improvement. The most consistent positive change is reduction in inappropriate out of area placements for Adults, which fell across all three localities by Q4, while Older People out of area placements remained at zero throughout. This shows significant progress with Promise 19. Discharge to usual place of residence has largely remained the same across both age groups across all localities with the exception of North Lincolnshire. This reflects a reduction in beds due to the building work. This would suggest that patients are not being discharged with significantly higher care needs compared to their status on admission.

- 3.2. Safer staffing gaps have widened, particularly for Adult wards in Doncaster and Rotherham and for Older People wards in Doncaster and North Lincolnshire. Rotherham is a notable exception, where Older People safe staffing gaps reduced over the period, diverging from the wider Trust pattern but it is worth noting that Rotherham started from a high baseline in part due to the service change and consultation.
- 3.3. The Doncaster Older People's ward has largely maintained a low length of stay but it has remained persistently longer in Rotherham and has increased in North Lincolnshire. Of note in North Lincolnshire some patients that would have previously been admitted to a physical bed have been admitted to the virtual ward and so it would potentially be expected that the remaining patients admitted to a physical bed base would be more complex.
- 3.4. From a quality and safety perspective, MUST compliance has varied across both older and adult services. VTE completion rates have decreased in older adult services.

4. Summary of findings in community areas

- 4.1. The strongest and most consistent improvement is seen in SMI annual health checks, which increased substantially for both Adult and Older People cohorts across all three localities and continued to rise into Q4. DNA rates remain low overall, with no material deterioration over the period.
- 4.2. Over the full year, there were large reductions in the number of patients breaching the four week routine referral standard, particularly for Older People in Rotherham and North Lincolnshire. However, the most recent data indicate renewed access pressure in Q4, most notably for Adult routine waits in Rotherham and Older People routine waits in Doncaster, both of which rose sharply compared with Q3.
- 4.3. Talking therapies access increased from Q3 to Q4 across all localities and age groups, reversing earlier declines, with particularly strong recovery in Doncaster. Crisis team activity remains relatively stable for Adults, while Older People crisis caseloads have increased in Rotherham and North Lincolnshire. Workforce indicators show modest improvement or stability overall, although staff sickness among Older People teams has trended upward into Q4 in some areas.

5. Functional vs Organic patient comparisons

- 5.1. We routinely code our inpatient admissions and this is done by the clinical coding team. This is in addition to any diagnostic codes that may be entered into the record whilst someone is an inpatient by a clinician. Whilst there is a degree of diagnostic instability with psychiatric diagnoses there is high assurance that our inpatients will have diagnostic coding to allow comparisons to be made between organic and functional patients.
- 5.2. For community patients the records are not routinely reviewed by a clinical coding team and clinicians are encouraged to code patients with diagnostic codes but the up take of this has been variable across teams and localities.

- 5.3. By July we intend to provide a comparison of the outcome of both inpatient and community patients with functional and organic diagnoses but it is important to stress that the data between community settings and inpatient is not directly comparable due to the difference in data completeness.

6. The Willows Care Opinion feedback

- 6.1. Four stories have been written on Care Opinion and the feedback has been very positive with people praising both the dementia care and also treatment for anxiety conditions. Some of the stories referenced negative things such as the onsite canteen closing.
- 6.2. There is fluctuation in how often Care Opinion is completed in our inpatient areas. Comparing Willows to its peer older adult wards Laurel has the most completed with 20 but Windermere has the fewest with 2.

7. The Willows complaints and PALS feedback

- 7.1. There were two complaints over the period for Willows. This compares to 3 complaints for Windermere and 4 for Laurel.
- 7.2. One of the complaints related to how a visitor was treated by staff when they visited their relative on the ward.
- 7.3. The second complaint related to concerns from a family member about how their relative with bipolar disorder was managed. The complaint references concerns that their relative was placed on a “dementia ward”. The other concerns in the complaint are that the relative did not have intensive treatment and physical health concerns such as fractures were missed. There were also other allegations including allegations of assault, neglect and a breakdown in trust. This complaint is still being investigated and an outcome is awaited.

8. The Willows incidents vs other wards

- 8.1. The following information is based on comparing incidents recorded on the RADAR system from 1st April 2025 until 31st March 2026.
- 8.2. Table 3 shows a comparison between the three Older Adult wards in the Trust. The 3 top incident categories are very similar to each other with these being falls, violence/aggression and medication incidents. There is variation across the wards in relation to physical health with the Willows having physical health recorded as a factor in 6.1% of incidents and the next highest being Windermere with 3.7%. Both Windermere and the Willows are isolated units. The comparative rate for Laurel which is colocated with Mulberry is 2.3%
- 8.3. Table 4 shows a comparison between our mental health older adult wards and our intermediate care wards. Falls and medication are frequent incident categories across both wards but on the mental health wards there are far more incidents of restrictive practice and violence and aggression. Physical health deterioration is far less common on our mental health wards compared to the intermediate care wards. This data suggests that the high number of falls on our

older adult wards compared to our general adult wards is partly explained by older age and frailty

- 8.4. Table 5 compares our older adult wards to the general adult wards. There are comparatively fewer uses of restrictive interventions on the older adult wards and much fewer incidents of self-harm. There is a higher rate of physical deterioration on our older adult wards and a much higher rate of falls and medication incidents. Some of the difference in the falls data can be explained by the different patient cohorts as evidenced when comparing the older adult wards to the intermediate care wards

9. The Willows and racism

- 9.1. There have been a number of racist incidents that have occurred on the Willows. This led to 4 needing to be redeployed due to being accused of racist incidents. Civility and respect training has been provided to all staff on the ward and active bystander training is planned across all the Rotherham wards. An independent report was commissioned and its findings are expected shortly.
- 9.2. Of note 6 RADAR reports mentioned racist incidents but more reports were obtained during supervision and the consultation. Additionally some concerns were raised via the FTSU process. When asked why RADAR reports were not completed staff mentioned fearing that there would be potential retribution were they to do so.

10. The Willows serious incidents

- 10.1. There have been two PSIs since the Willows opened:
- 10.2. The first PSI relates to the unexpected death of an 85-year-old following sudden physical deterioration. The investigation identified that while a venous thromboembolism (VTE) risk assessment was completed on admission, appropriate thromboprophylaxis was not initiated, and there were delays and process failures relating to blood tests, ECG access, and medical oversight when a non-medical Approved Clinician was acting as Responsible Clinician. The learning arising from this was on strengthening assurance around VTE prophylaxis compliance, clarifying medical oversight arrangements, improving out-of-hours pathology processes and ensuring staff familiarity with physical health equipment such as ECG machines.
- 10.3. The second PSI concerns the death of a 72-year-old woman with psychosis and insulin-dependent diabetes who deteriorated physically and died in an acute hospital following diabetic ketoacidosis and stroke. The investigation found that care was largely compassionate and appropriately escalated, with good liaison with acute services; however, learning identified omissions of long-acting insulin over several days, reflecting gaps in staff knowledge, documentation, handover, and confidence in managing complex physical health conditions on a mental health ward. Safety actions have already been implemented, including enhanced training in physical health management, strengthened record-keeping and handover processes, and improved collaborative working between inpatient teams, community services, and acute providers.

- 10.4. Neither of these PSIs appear to indicate that the mixed model of functional and organic patients were contributory factors to the PSIs. Both of these incidents do highlight incidents relating to physical health deterioration which triangulates with the incident data which also shows a higher number of patients having physical health deteriorations on the Willows ward.
- 10.5. It is worth noting that the wards that have had higher physical health deteriorations are Windermere and the Willows which essentially act as standalone units. The other wards in the Trust operate in units where there are multiple wards collocated and this leads to greater availability of medical staff
- 10.6. For comparison no PSIs have been completed on Windermere or Laurel wards over the same period. Not to diminish the severity of the incidents that have occurred on the Willows the comparative data does not suggest that the incidents are inherent to the model chosen.

11. Community reinvestment

- 11.1. Following the closure of Brambles ward £250k was made available to reinvest into older people's services across the Trust.
- 11.2. In Doncaster, funding has been allocated for a Band 6 Nurse (0.8 WTE) and a Band 3 support worker (0.55 WTE). Both roles will sit with the Crisis and Home Treatment Teams.
- 11.3. In Rotherham, funding has been allocated for a Band 6 nurse (0.8 WTE) and a Band 6 Occupational Therapist (0.8 WTE). These posts will support the development of Rotherham's Older Adult Home Treatment Pathway. Weekly working group meetings are in place to progress pathway development. In parallel, a training schedule for existing staff is being developed, and a change management proposal is being prepared to enable the redeployment of some staff to further support delivery of the pathway.
- 11.4. In North Lincolnshire funding was allocated for a full time Band 7 Clinical Nurse Specialist.

12. Conclusions

- 12.1. Following the closure of Brambles ward and the merger with Glade to create the Willows there have been a number of serious incidents. These serious incidents seem to indicate problems with managing physical health deteriorations. There have been problems with racism on the combined ward. The nexus of these issues does not appear related to the mixed older adult inpatient model with the available data. There are signals to suggest that isolated units are more vulnerable to managing physical health deteriorations less effectively compared to units with greater collocation. Reviewing complaint and feedback information there is only one incident of relatives complaining about their relative who had a functional mental illness being placed with patients that had dementia.

12.2. The overall data suggests that a mixed model is able to operate to deliver timely and effective care but there are lessons to learn and share given that the Doncaster older adult ward has persistently demonstrated a much shorter length of stay compared to its peer wards in other localities.

13. Recommendations

- 13.1. Agree the mixed older adult inpatient model should continue to be the Trust model accepting that this is a minority approach nationally
- 13.2. Support the new physical health training initiative in order to minimise the risk of missing opportunities to prevent or minimise physical health deteriorations
- 13.3. Explore whether there are further staffing models or training that would further improve the management of physical health deteriorations on mental health wards
- 13.4. Explore whether further colocation of inpatient units would lead to improved outcomes such as consolidating Rotherham acute inpatient services onto the Swallownest site.
- 13.5. A further analysis is provided in July 2026 to look at any difference in outcomes for functional and organic patients across the inpatient and community services
- 13.6. Support the continued anti-racism work in line with Promise 26

Table 1 – Inpatient Indicators

[illegible]

Safe Staffing Levels: Number of shifts without safe staffing levels.	AD	117	110	123	158	35	156	137	160	257	97	46	33	59	66	7
Safe Staffing Levels: Number of shifts without safe staffing levels.	OP	34	28	97	106	9	123	11	75	51	-24	30	44	88	111	23
Complaints: Number of complaints (Inpatient data.)	AD	0	0	3	3	0	0	2	4	2	-2	1	0	0	1	1
Complaints: Number of complaints (Inpatient data.)	OP	1	2	0	0	0	0	0	1	1	0	0	1	2	1	-1
MAST Compliance: Number of staff who are not fully compliant with MAST training.	AD	72	81	73	70	-3	64	57	67	72	5	15	26	28	24	-4
MAST Compliance: Number of staff who are not fully compliant with MAST training.	OP	30	26	29	32	3	15	23	26	26	0	10	20	16	11	-5

Inpatient Metrics with Percentages

Metric	Category	Doncaster					Rotherham					North Lincolnshire				
		Q1	Q2	Q3	Q4	Change	Q1	Q2	Q3	Q4	Change	Q1	Q2	Q3	Q4	Change
72 hour follow-up: Percentage of patients having follow up within 72 hours of discharge.	AD	90.63%	85.00 %	94.53%	95.92 %	1.39%	81.82%	81.25 %	94.74%	96.10%	1.36%	81.82%	81.25%	94.74%	87.50%	- 7.24%
72 hour follow-up: Percentage of patients having follow up within 72 hours of discharge.	OP	78.57%	95.45 %	95.83%	96.55 %	0.72%	100.00 %	85.00 %	72.73%	94.74%	22.01 %	100.00 %	83.33%	72.73%	40.00%	- 32.73 %
Bed Occupancy: Adult bed base occupancy percentage.	AD	98.83%	98.75 %	97.59%	99.90 %	2.31%	96.45%	96.77 %	101.70 %	99.49%	- 2.21%	108.46 %	100.15 %	104.88 %	105.34 %	0.46%

Bed Occupancy: Older Adult bed base occupancy percentage.	OP	76.07%	83.23 %	77.30%	89.89 %	12.59 %	93.41%	96.53 %	90.43%	100.74 %	10.31 %	90.02%	91.78%	103.67 %	95.92%	- 7.75%
Malnutrition Universal Screening Tool (MUST): Percentage of patients with a completed MUST assessment within 24 hours of admission.	AD	85.00%	61.00 %	82.60%	75.00 %	- 7.60%	75.00%	76.00 %	69.20%	58.00%	- 11.20 %	46.00%	29.00%	62.50%	82.00%	19.50 %
Malnutrition Universal Screening Tool (MUST): Percentage of patients with a completed MUST assessment within 24 hours of admission.	OP	38.00%	38.00 %	61.50%	70.50 %	9.00%	64.00%	62.00 %	86.60%	65.00%	- 21.60 %	96.00%	100.00 %	100.00 %	75.00%	- 25.00 %
Venous Thromboembolism (VTE) assessment: Percentage of patients with a completed VTE assessment within 16 hours of admission.	AD	93.00%	98.00 %	97.70%	92.00 %	- 5.70%	64.00%	62.00 %	100.00 %	87.00%	- 13.00 %	96.00%	100.00 %	90.90%	84.00%	- 6.90%
Venous Thromboembolism (VTE) assessment: Percentage of patients with a completed VTE assessment within 16 hours of admission.	OP	100.00 %	98.00 %	100.00 %	76.00 %	- 24.00 %	91.00%	75.00 %	100.00 %	82.00%	- 18.00 %	100.00 %	100.00 %	100.00 %	75.00%	- 25.00 %
Staff Sickness: Rolling average of staff sickness.	AD	9.42%	6.75%	6.67%	7.54%	0.87%	6.22%	6.27%	7.48%	9.35%	1.87%	7.27%	7.20%	8.94%	8.39%	- 0.55%
Staff Sickness: Rolling average of staff sickness.	OP	13.74%	14.31 %	15.87%	15.35 %	- 0.52%	6.74%	8.13%	10.46%	12.19%	1.73%	9.56%	10.87%	12.28%	12.14%	- 0.14%
Staff Turnover: Rolling average of 12 months.	AD	5.20%	7.54%	10.44%	12.68 %	2.24%	9.03%	11.01 %	11.76%	7.12%	- 4.64%	7.56%	12.80%	10.28%	7.63%	- 2.65%
Staff Turnover: Rolling average of 12 months.	OP	8.72%	10.48 %	8.48%	17.15 %	8.67%	10.78%	13.39 %	20.66%	28.99%	8.33%	11.82%	11.53%	21.25%	22.00%	0.75%

Table 2 – Community Indicators

Community Metrics with Absolute Numbers																
Metric	Category	Doncaster					Rotherham					North Lincolnshire				
		Q1	Q2	Q3	Q4	Change	Q1	Q2	Q3	Q4	Change	Q1	Q2	Q3	Q4	Change
4 week wait for routine referrals: Number of Adult patients not seen within 4 weeks of a routine referral	AD	46	39	42	19	-23	288	259	36	124	88	2	1	0	9	9
4 week wait for routine referrals: Number of Older Adult patients not seen within 4 weeks of a routine referral	OP	105	85	84	104	20	225	193	120	35	-85	185	176	68	0	-68
<4 hours wait for emergency referrals: Number of Adult patients not seen within 4 hours of an emergency referral.	AD	0	0	0	0	0	0	0	1	0	-1	0	0	0	0	0
<4 hours wait for emergency referrals: Number of Older Adult patients not seen within 4 hours of an emergency referral.	OP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<48 hours wait for urgent referrals: Number of Adult patients not seen within 48 hours of an urgent referral.	AD	3	2	3	1	-2	7	6	12	1	-11	0	0	0	2	2
<48 hours wait for urgent referrals: Number of Older Adult patients not	OP	1	0	0	5	5	6	6	5	4	-1	0	0	1	0	-1

seen within 48 hours of an urgent referral.																
Crisis Referrals - Number of Adult patients taken onto Crisis Team caseload	AD	247	267	214	211	-3	376	429	416	414	-2	44	38	56	59	3
Crisis Referrals - Number of Older Adult patients taken onto Crisis Team caseload	OP	16	18	22	12	-10	31	32	43	45	2	4	9	11	14	3
Talking therapies: Number of Adults accessing NHS talking therapies.	AD	2593	2930	2414	2938	524	1925	1978	1992	2110	118	1432	1447	995	1126	131
Talking therapies: Number of Older Adults accessing NHS talking therapies.	OP	213	268	193	280	87	143	134	144	151	7	107	90	112	77	-35
MAST Compliance: Number of staff who are not fully compliant with MAST training.	AD	103	112	102	69	-33	77	68	74	79	5	38	32	30	34	4
MAST Compliance: Number of staff who are not fully compliant with MAST training.	OP	40	32	31	27	-4	25	26	26	34	8	15	23	21	20	-1
Community Metrics with Percentages																
Metric	Category	Doncaster					Rotherham					North Lincolnshire				
		Q1	Q2	Q3	Q4	Change	Q1	Q2	Q3	Q4	Change	Q1	Q2	Q3	Q4	Change
DNA rate: Percentage of appointments where the patient did not attend.	AD	0.88%	0.94%	0.01%	0.28%	0.27%	1.32%	1.38%	0.01%	0.46%	0.45%	3.24%	7.27%	0.01%	0.12%	0.11%
DNA rate: Percentage of appointments where the patient did not attend.	OP	0.13%	0.12%	0.00%	0.63%	0.63%	0.36%	0.16%	0.00%	2.12%	2.12%	0.13%	0.11%	0.00%	1.05%	1.05%

SMI Checks - Percentage of patients with SMI that have had an annual health check completed.	AD	19.46 %	35.51 %	50.25 %	70.70 %	20.45 %	9.60%	22.48 %	46.44 %	67.88 %	21.44 %	10.57 %	22.27 %	47.43 %	84.62 %	37.19 %
SMI Checks - Percentage of patients with SMI that have had an annual health check completed.	OP	15.63 %	38.74 %	60.71 %	64.13 %	3.42%	3.67%	22.59 %	47.77 %	76.47 %	28.70 %	13.64 %	22.52 %	56.60 %	78.26 %	21.66 %
Dementia diagnosis rate: Percentage of patients in a locality with a recorded diagnosis of dementia compared to expected prevalence.	OP	69.40 %	70.00 %	70.06 %	68.55 %	-1.51%	88.00 %	89.00 %	89.70 %	88.70 %	-1.00%	65.00 %	66.00 %	68.03 %	66.70 %	-1.33%
Staff Sickness: Rolling average of staff sickness.	AD	8.17%	8.64%	8.75%	8.47%	-0.28%	13.16 %	11.91 %	10.44 %	10.07 %	-0.37%	9.98%	9.86%	8.52%	8.40%	-0.12%
Staff Sickness: Rolling average of staff sickness.	OP	1.22%	1.85%	3.54%	4.17%	0.63%	5.43%	6.13%	7.04%	7.78%	0.74%	8.46%	6.82%	8.19%	7.52%	-0.67%
Staff Turnover: Rolling average of 12 months.	AD	4.66%	4.87%	2.74%	3.32%	0.58%	3.57%	4.44%	7.03%	8.58%	1.55%	9.33%	11.32 %	10.60 %	8.69%	-1.91%
Staff Turnover: Rolling average of 12 months.	OP	11.18 %	10.59 %	8.50%	10.17 %	1.67%	5.26%	8.12%	8.67%	9.79%	1.12%	11.78 %	9.53%	12.04 %	12.63 %	0.59%

Table 3 – Older Adult ward comparison

	Laurel Ward	The Willows	Windermere Lodge
Total incidents	133	180	215
Falls / collapse	24	34	46
Medication (error/omission/storage/prescribing)	18	15	42
Violence / aggression / abuse	19	32	41
Restrictive intervention (restraint/seclusion/rapid tranq/holds)	13	7	2
Self-harm / ligature / overdose	0	1	3
Safeguarding	4	2	0
Staffing / skill mix / cover	12	5	6
Documentation / legal / governance / IG	1	15	10
Environmental / facilities	1	3	1
Physical health / deterioration / injury / pressure ulcer	3	11	8
Other / unspecified	38	55	56

Table 4 – MH Older Adult ward comparison vs Intermediate care wards

Category	OA Mental Health wards	Intermediate Care Wards	Difference
Falls / collapse	104 (19.7%)	63 (15.5%)	4.2
Pressure damage / skin integrity	6 (1.1%)	61 (15.0%)	-13.9
Physical deterioration / acute illness	18 (3.9%)	93 (22.9%)	-21.7
Medication (error/omission/storage/prescribing)	69 (13.1%)	77 (18.9%)	-5.9
Violence / aggression / abuse	91 (17.2%)	3 (0.7%)	16
Restrictive intervention (restraint/seclusion/rapid tranq/holds)	22 (4.2%)	0 (0.0%)	4.2
Self-harm / ligature / overdose	3 (0.6%)	0 (0.0%)	0.6
Absence/leave/absconding (AWOL/MISPER)	2 (0.4%)	0 (0.0%)	0.4
Documentation / discharge / transfer / information governance	9 (1.7%)	16 (3.9%)	-2.2
Staffing / training / capacity	36 (6.8%)	19 (4.7%)	2.1
Equipment / environment / security	2 (0.4%)	11 (2.7%)	-2.3
Other / unspecified	178 (33.7%)	64 (15.7%)	18

Table 5 – MH Older Adult ward vs MH General Adult

Category	Older Adult wards	General Adult ward	Difference
Falls / collapse	104 (19.7%)	38 (3.0%)	16.7
Medication (error/omission/storage/prescribing)	73 (13.8%)	77 (6.1%)	7.7
Violence / aggression / abuse	92 (17.4%)	225 (17.9%)	-0.4
Restrictive intervention (restraint/seclusion/rapid tranq/holds)	23 (4.4%)	82 (6.5%)	-2.2
Self-harm / ligature / overdose	4 (0.8%)	201 (16.0%)	-15.2
Safeguarding	6 (1.1%)	16 (1.3%)	-0.1
Absence/leave/absconding (AWOL/MISPER)	2 (0.4%)	109 (8.7%)	-8.3
Staffing / skill mix / cover	23 (4.4%)	15 (1.2%)	3.2
Documentation / legal / governance / IG	20 (3.8%)	23 (1.8%)	2
Environmental / facilities	5 (0.9%)	26 (2.1%)	-1.1
Physical health / deterioration / injury / pressure ulcer	22 (4.4%)	28 (2.2%)	2.1
Other / unspecified	153 (29.0%)	419 (33.3%)	-4.3

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Board and Committee Workplans	Agenda Item	Paper Y
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
The Trust's Operating Framework provides structure and clarity of role for the Board and its Committees – agreed terms of reference set out that clarity. This paper presents the proposed work plan for the Board and its Committees in 2026/27 - giving all members maximum notice of agenda items. The schedules attached outlines the planned agenda items (excluding the standing items) for the meetings of the Board and Committees through to the end of the financial year, ensuring the key components within the terms of reference are covered. Of course, additional items may be suggested and considered, albeit there will be a corporate check of whether such items are covered by the terms of reference. Any variation (addition or deletion) to these schedules should be minimal during the year. What this helps all Board members to collaborate to do is to look across forward agendas and explore what might be being missed or overlooked – or indeed duplicated.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
None.			
Recommendation (delete options as appropriate and elaborate as required)			
The Board of Directors is asked to:			
RECEIVE and APPROVE the work schedules for the Board of Directors and Committees for the remainder of the financial year.			
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 addition services.			X
SO4. Deliver high quality and therapeutic bed-based care on our own sites and in other settings.			X
SO5. Help deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			X
Alignment to the plans: (indicate those that this paper supports)			
Estates plan			X
Digital plan			X
People and teams plan			X
Finance plan			X
Quality and safety plan			X
Equity and inclusion plan			X
Education and learning plan			X
Research and innovation plan			X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	

Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	
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.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
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.	
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.	
Strategic Delivery Risks (indicate those that this paper supports)			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are			X

distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services							
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.							X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.							X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees							X
System / Place relevance (advise whether it is national, regional or local)							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Appendix 1 - Planned agendas for Board and Committees through to the end of the financial year 2026 – 2027							

Board and Committee reporting – June 2026 to March 2027

1. Background

- 1.1 The Trust's Operating Framework provides structure and clarity of role for the Board and its committees, as set out in each respective terms of reference. Key focus for the committees would be on four roles:
1. statutory compliance,
 2. plan delivery,
 3. partnership duties and
 4. matters delegated by the Board
- 1.2 It is imperative that there is clear structure to the work of the Board and its Committees to ensure they fulfil their roles and hence having a forward plan is especially important.
- 1.3 The importance of strong governance arrangements is highlighted with the Well Led Developmental Review Report (The Value Circle) provided to the Board of Directors at today's meeting – the report noting the arrangements are well established and that Committee structures are clear, assurance routes are in place and reporting mechanisms give the Board regular insight.

2. 2025/26

- 2.1 In July 2025, the Board approved forward workplans for its own meetings and for its Committees, through to March 2026 – this proactively provided early clarity on expectations and aimed to ensure that the agendas of the respective meetings ensured that requirements of terms of reference were achieved. It also meant that we reduced the time during the year spent formulating agendas; hence contributors had significant forewarning of what was required of them, and by when.
- 2.2 Ultimately, the process allowed us collectively to ensure that the time available in Board and Committees – circa 125 hours per year – was spent effectively. The Committees, by their nature, focus largely on a topic or component parts to a single topic – with perhaps Finance, Digital and Estates Committee being a slight exception. The Board of Directors however brings together multiple topics and indicatively in 2025/26 spent its time as below:

Topic	% of time
Quality	33
Governance (risk, strategy, assurance, minutes, actions,	31
Finance	16
People / HR	15
Estates	5

3. 2026/27

- 3.1 The process is repeated here for the remaining meetings of the 2026/27 financial year for the Board of Directors and its Committees. The forward plans and agendas are included at Appendix 1.

- 3.2 Any variation to these schedules should be minimal during the year, although it is acknowledged these workplans may, when and where necessary, be added to as matters emerge or escalate during the year that require the Board's attention or decision. These may be unplanned matters, but they may also be current matters that need to continue based on current work.
- 3.3 Appendix 1 includes the proposed agendas for the Board and Committee meetings for the remainder of the financial year. As referred to in 1.1 above, these plans ensure that the four roles of Committees are addressed
- 3.4 The workplan for POD Committee no longer includes the TPC report nor the FTSU reports given both come direct to the Board of Directors.
- 3.5 The workplan for Quality Committee introduces a new Chief Nurse Triangulation Report to cover patient safety escalations and patient feedback; and the introduction of a Care group Representation at each meeting of QC – care groups attending QC in rotation throughout the year to provide an opportunity of focus on their related work including CQC readiness.
- 3.6 Workplans continue to provide opportunity throughout the year within PHPIP, POD, FDE and Quality Committee for the receipt and discussion of the related Strategic Delivery Risks and the receipt of, and follow up to internal audit recommendations.
- 3.7 Each Committee will continue to report to the Board of Directors after each of its meetings, any matters of concern or escalation.

4. Recommendations

The Board of Directors is asked to:

RECEIVE and APPROVE the work schedules for the Board of Directors and its Committees for the remainder of the financial year.

Philip Gowland, Director of Corporate Assurance
15 May 2026

Board of Directors				
Jul 26	Sept 26	Nov 26	Jan 27	Mar 27
Water's Edge, Barton Upon Humber	Rossington Miner's Welfare Doncaster	Brinsworth Centre, Rotherham	Visual Arts Centre, Scunthorpe	Doncaster
Promise 1: Peer Support: progress and actions	Promise 16 – Outcomes of service delivery	Promise 6: Poverty Proofing	Promise 2: Carers Plan, forward look to 27/28	
Promise 2: Carers: delivery plan	14 weeks	Promise 12: Rurality	Promise 28: super6 and research	Promise 15: Integrated neighbourhood teams
Promise 3: Volunteers	P26: Anti racism	Promise 20: Virtual care model		Promise 21: Local PCNs and Voluntary sector
Promise 9: (not apprentice levy)				P26: Anti racism
Promise 24: Education				
Promise 10: inclusion healthcare	Community powered healthcare taskforce.			
NICE compliance	Prevention of Future Deaths (PFD) audit outcomes	Inpatient High Quality Therapeutic Care (HQTC) Stocktake	CMHT Update	Preventing Future Deaths (R28) Lookback
engagement/disengagement data	Safe Staffing Bi Annual Report	25-26 PSII What has been learnt		Safe Staffing Annual Declaration
Dialog+	CQC readiness	Older Adults		Transitional care
Estates Full Business Case		2027/28 Financial Plan	Financial Plan 2027/28 to 2029/30	Finance Year End
National Oversight Framework (NOF) initial publication		National Planning Guidance	National Planning Submission	
		Contracting 27-28		
Culture @ RDaSH (Trust People Council)	Freedom To Speak Up Bi-annual Update		Culture @ RDaSH (Trust People Council)	Freedom To Speak Up Bi-annual Update
Change management: Concluding Report inc protected characteristics analysis and Q1 productivity and activity data	Medical Job Planning		Training Needs Analysis (TNA) 2027/28	
Well Led: Response to TVC / PCA		Well-Led		
EPRR Annual Report	EPRR Core Standards submission			
		Provider Capability Assessment		
Risks - High impact and low likelihood				
	Cyber Security (private)			Cyber Security (private)

Board of Directors Timeout				
Jun 26	Aug 26	Oct 26	Dec 26	Feb 27
Brinsworth Centre, Rotherham	The Arc, Scunthorpe	The Point, Doncaster	Trust Wide	The Arc, Scunthorpe
Annual Accounts and Annual Report Sign off	POND Project		Christmas appreciation and decoration judging	
DSPT submission	CMHT Update			
'Power in our communities'				
P5: Making it real				

Audit Committee				
Jun-26	Aug-26	Oct-26	Dec-26	Feb-27
Counter Fraud, Bribery & Corruption Annual Report inc Counter Fraud Functional Standard Return (CFFSR)	Counter Fraud, Bribery and Corruption Report			
360 Assurance (Internal Audit) Progress report				
RDaSH Internal Audit Progress Report				
External Audit Progress Update	Trust Response to ISA260 Report	Annual Audit Letter	External Audit Plan	External Audit Progress Report
Draft Annual Report and Accounts 2025/26				Final Accounts Timetable and Plans
Progress on audit of Charitable Funds and Flourish				Statement of Changes to Accounting Policies
		Annual Governance Statement Update		Annual Governance Statement Update
Education Governance Report	Research Governance Report		Education Governance Report	Research Governance Report
Risk Management Framework Update	Risk Management Framework Update	Risk Management Framework Update	Risk Management Framework Update	Risk management framework update
	Clinical Audit Report			Clinical Audit Report
				Clinical Coding Audit Review
Standing Financial Instructions Q4	Standing Financial Instructions Q1		Standing Financial Instructions Q2	Standing Financial Instructions Q3
	Trust wide Arrangements for Raising Concerns	Declarations of Interest Report		

Finance, Digital and Estate Committee				
Jun-26	Aug-26	Oct-26	Dec-26	Feb-27
Finance performance (inc capital and savings)				
Estates Enabling Plan: Full Business Case	Estates Enabling Plan: Waterdale and Riverside	Estates Enabling Plan :Full Business Case	Estates Enabling Plan: Land Sale	Estates Enabling Plan: ??
Medium Term Finance Plan – 2025-26 to 2029-30	Medium Term Finance Plan – 2025-26 to 2029-30	Trust Procurement Function Development	Medium Term Finance Plan – 2025-26 to 2029-31	Trust's Standing Financial Instructions / Schemes of Delegation Annual Review
Information Quality Work Programme 2026/27	National Costing Collection			Information Quality Work Programme 2026/27
Strategic Delivery Risks	Internal Audit Recommendations	Strategic Delivery Risks	Internal Audit Recommendations	Strategic Delivery Risks
Information Governance	Digital Enabling Plan 2023 – 2028		Information Governance	
		Information Quality Work Programme 2026/27		Clinical Coding Audit Report
	Cyber Security			Cyber Security
Estate Compliance - Health and Safety at Work Act 1974		Estate Compliance - Health and Safety at Work Act 1974		
Estates Maintenance Function – Sustainability & Future Options				

People and Organisational Development Committee				
Jun-26	Aug-26	Oct-26	Dec-26	Feb-27
Workforce Dashboard/ IQPR Top Ten measures - themes				
Staff Incidents, Violence and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Report (RIDDOR) Quarterly		Staff Incidents, Violence and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Report (RIDDOR) Quarterly		Staff Incidents, Violence and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Report (RIDDOR) Quarterly
Guardian of Safe Working Hours	Guardian of Safe Working Hours	Guardian of Safe Working Hours	Guardian of Safe Working Hours	Guardian of Safe Working Hours
Work Experience Engagement and Update		Staff Survey Results		
Biannual report on CPD Spend overview TNA			Biannual report on CPD Spend overview TNA	
Strategic Delivery Risks SDR5	Internal Audit Recommendations	Strategic Delivery Risks SDR5	Internal Audit Recommendations	Strategic Delivery Risks SDR5
Learning & Education Plan: Learning Focus	Learning & Education Plan: Education Focus	Learning & Education Plan: Learning Focus	Learning & Education Plan: Education Focus	Learning & Education Plan: Learning Focus
		Annual Medical Revalidation		
	Gender Pay Gap (Equality Act 2010) annual report - Analysis			
		Partnerships		Partnerships
	Promise 26 - EDI Review against delivery plan			Promise 26 - EDI Review against delivery plan
	WDES Action Plans & Annual submission			
	WRES Action Plans & Annual submission			

Public Health, Patient Involvement and Partnerships Committee					
May-26	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27
Promise 2 – Unpaid Carers	Promise 3: Volunteers	Promise 17 – School Readiness	Promise 6 – Poverty Proofing	Promise 10 – Inclusion Health	Promise 2 – Unpaid Carers
Promise 5 – Community Involvement	Promise 10: Inclusion Health	Promise 28 – Research and Innovation	Promise 5 – RDaSH 5	Promise 12 – Rurality	Promise 5 – Community Involvement
Promise 8: Patient, Carers, Race Equality Framework - PCREF	Promises 15 and 21 – Integrated Neighbourhood Health and Primary Care and Hyperlocal			Promises 15 and 21 – Integrated Neighbourhood Health and Primary care and hyperlocal	Promise 7 – Core2-plus5
	Promise 28 – Research and Innovation		Promise 28 – Research and Innovation		Promise 28 – Research and Innovation
Health Inequalities Data Report					
Risk Register – related 'high' risks (scoring 12 and above)					
Partnership Scorecard					
Aspire Partnership update	Flourish Enterprise update	Eating Disorders Collaborative	Aspire Partnership	Flourish Enterprise	Eating Disorders Collab
Internal Audit Recommendations	Strategic Delivery Risks 1 and 3	Internal Audit Recommendations	Strategic Delivery Risks 1 and 3	Internal Audit Recommendations	Strategic Delivery Risks 1 and 3
	Internal Audit Report – Health Inequalities				

Mental Health Act Committee				
Jun-26	Aug-26	Oct-26	Dec-26	Feb-27
MHA Performance Report				
MHA Compliance Report				
CQC MHA Inspections Report incl findings from the Monitoring the Mental Health Act Reports				
Mental Health External Reports				
MHA training and RRI training compliance data analysis				
Blanket Restrictions Report			Blanket Restrictions Report	
Patient Experience		Patient Experience		Patient Experience
		Section 17 leave report		
Annual MHA Equalities Report	Thematic Analysis for Improvements Identified by the CQC			Thematic Analysis for Improvements Identified by the CQC
	Rotherham Care Group (Deep Dive)			
Hospital Managers Report		Hospital Managers Report		Hospital Managers Report

Quality Committee					
May-26	Jul-26	Sep-26	Nov-26	January 207	Mar-27
Chief Nurse Triangulation Report: (Patient Safety Escalations - Incidents / PSII / PFD and Patient Feedback: Complaints / Care opinion)					
Integrated Quality Performance Report					
	Care Group Representation	Care Group Representation	Care Group Representation	Care Group Representation	Care Group Representation
		PSIRF Mortality Report			PSIRF Mortality Report
		Learning and Improvement Mid-year review of the PSIRF approach		Learning and Improvement PSII presentation	PSIRF The Learning Captured Report
		Safety Ligature Report: what has changed	Safety Peer reviews mid-way review		
		Quality Promise 16	Quality Promise 4 update	Quality Promise 22 7/365 working	Quality Summary of promises impact on Q&S only)
	Quality Always Measures: Implementation and Impact Update			Quality Always Measures: Implementation and Impact Update	
			Quality CQC Readiness and Self- Assessment Update		Quality Quality Account Priorities 2026/27: Sign-Off
Internal Audit Recommendations	Strategic Delivery Risks	Internal Audit Recommendations	Strategic Delivery Risks	Internal Audit Recommendations	Strategic Delivery Risks
Learning and Improvement Family engagement compliance (inc Duty of Candour)			Learning and Improvement Family engagement compliance (inc Duty of Candour)	Learning and Improvement Learning from Repeated Harms and Feedback	
Learning and Improvement Thematic Learning Review (Quarterly)		Learning and Improvement Thematic Learning Review (Quarterly)		Learning and Improvement Thematic Learning Review (Quarterly)	

Charitable Funds Committee			
Jun-26	Sep-26	Dec-26	Mar-27
Charitable Funds: Performance		Charitable Funds Performance	
Charitable Funds: Risk Register	Charitable Funds Risk Register	Charitable Funds Risk Register	Charitable Funds Risk Register
Charitable Funds: Fundraising Plan	£1m Plan	Expenditure Plan 2027 - 2030	£1m Plan
	Mission – A Good Death	Mission – A Good Start	Mission – Our Best Self
	Review of Investment Policy (Annual)		
	Review of Reserves and Liquidity Policy (Annual)		
	Fundraising & Lotteries, Raffles and other forms of gaming Policy and Procedure		
Annual Report 25/26 inc Annual Accounts and Independent Examination			

Remuneration Committee		
June 2026	November 2026	March 2027
Outcome from the 25/26 Executive Group PDRs	Chief Operating Officer (COO) Recruitment process	Succession Planning
Very Senior Managers (VSM) Framework Update (if available)	VSM 2026/27 Remuneration Review	VSM Framework Annual Compliance Statement 26/27

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Fit and Proper Person Test (FPPT)	Agenda Item	Paper Z
Sponsoring Executive	Kath Lavery, Chair		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	Date	28 May 2026
Suggested discussion points (two or three issues for the meeting to focus on)			
Fit and Proper Person Test (FPPT) guidance issued in April 2024 remains relevant and the Board received confirmation in May 2025 that all members, in place at that time, were deemed to achieve the Fit and Proper Person test. For those appointed in the year their respective recruitment process has confirmed FPPT requirements have been met and all members, in place at the year end, have again confirmed their respective positions of compliance with the FPPT requirements. These have been reviewed by the Chair who has concluded that all members of the Board of Directors are 'Fit and Proper' with no exceptions.			
Previous consideration (where has this paper previously been discussed – and what was the outcome?)			
The Board of Directors last received a report on this topic in May 2025 when all the then members of the Board were deemed to meet the FPPT requirements.			
Recommendation (indicate with an 'x' all that apply and where shown elaborate)			
The Board of Directors is asked to:			
x	RECEIVE and NOTE the concluding statement from the Chair that, following the receipt and review of self-attestation statements and where applicable, the checks undertaken during recent appointments, she has deemed all members of the Board to meet the requirements of the fit and proper person test.		
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
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			x
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	
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.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	

Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
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.	
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.	
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.	
Strategic Delivery Risks (indicate those that this paper supports)			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services			X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.			X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees			X
System / Place relevance (advise whether it is national, regional or local)			

Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
None							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Fit and proper person test framework for board members

1 Background

- 1.1 NHS England published updated guidance, effective from 1 April 2024, [NHS England Fit and Proper Person Test Framework for board members](#). The revised framework introduced new and more comprehensive requirements around board appointments, annual reviews, and provision of references, which had widespread implications from a HR, legal and governance perspective. It is considered to be a key element of patient safety and good leadership in organisations – recognised by all board members, and with an intent that poorly performing managers and directors are prevented from moving between health organisations.

2. Fit and Proper Person Test (FPPT) in 2025/26

- 2.1 A previous assessment undertaken, and reported to the Board in May 2025, concluded for those individuals who were on the Board of Directors at that time, that all met the requirements of the fit and proper person test. Since then there have been a number of new appointments to the Board of Directors - during each appointment process the requirements were achieved and relevant records maintained.
- 2.2 In May 2026, every member of the Board of Directors was asked to confirm their continued compliance with the FPPT requirements – this was those in place at the start of the year and those that had joined part way through the year.
- 2.4 The Chair has considered all responses and any supporting documentary evidence for the individuals listed below and has concluded that there were no matters of concern and that all current members of the Board of Directors meet the requirements of the FPPT.

Kathryn Lavery
Sarah Fulton Tindall
Richard Falk
Toby Lewis
Carlene Holden
Judith Graham
Shabir Pandor

Dave Vallance
Kathy Gillatt
Maria Clark
Richard Chillery
Simon Sheppard
Jo McDonough

Pauline Vickers
Rachael Blake
Rumit Shah
Steve Forsyth
Diarmid Sinclair
Philip Gowland

- 2.5 The conclusion will be included within a declaration to the NHS England Regional team (due 30 June 2025) by the Chair.

The Board of Directors is asked to:

RECEIVE and NOTE the concluding statement from the Chair that, following the receipt and review of self-attestation statements and where applicable, the checks undertaken during recent appointments, she has deemed all members of the Board to meet the requirements of the fit and proper person test.

Philip Gowland, Director of Corporate Assurance
15 May 2026