NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 30 July 2026 at 9.30am
Waters Edge, Barton upon Humber

No	Time	Item	Request to	Lead	Enc.
1	09.30	Welcome	Note Information	Kath Lavery, Chair	
2		Apologies for Absence:			
3		Quoracy (One third of the Board; inc. one NED and one ED)			
4		Declarations of Interest			A
		Standing items			
5	09.32	Minutes of the meeting held in public on the 28 May 2026	Decision	Kath Lavery, Chair	B
6		Matters Arising and Follow up Actions	Decision		C
		Board 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	Integrated Quality Performance Report (IQPR)	Information	Toby Lewis, Chief Executive	K
15	10.15	Operational Risk Report	Information	Philip Gowland, Director of Corporate Assurance	L
16	10.25	Strategy Delivery Risks	Information	Philip Gowland, Director of Corporate Assurance	M
17	10.40	Promises and Priorities Scorecard**	Information	Toby Lewis, Chief Executive	N
18	10.55	Organisational Change Key Performance Indicators **	Information	Steve Forsyth, Chief Nurse	O
19	11.05	Chief Executive's Report	Information	Toby Lewis, Chief Executive	P
20	11.20	Promise 24: Education		Dr Judith Graham, Director of Psychological Professionals / Carlene Holden, Director of People and OD	Q
BREAK 11.40 (15 mins)					

RDaSH nurturing the power in our communities

No	Time	Item	Request to	Lead	Enc.
21	11.55	Promise 3: Volunteers	Information	Steve Forsyth, Chief Nurse	R
22	12.10	NICE Guidance 2025/26 Position	Information	Dr Diarmid Sinclair, Chief Medical Officer	S
23	12.30	Estates Full Business Case	Decision	Simon Sheppard, Director of Finance and Estate	T
Staff Story					
24	13.00	Staff Story	Information	Carlene Holden, Director of People and OD	Verbal
LUNCH 13.20 (30 mins)					
25	13.50	Older Adults Mental Health Services	Information	Dr Diarmid Sinclair, Chief Medical Officer	U
26	14.05	Culture @ RDaSH	Information	Toby Lewis, Chief Executive / Carlene Holden, Director of People and OD	V
27	14.25	Promise 9: employment opportunities**	Information	Carlene Holden, Director of People and OD	W
28	14.40	Engagement/Disengagement data	Information	Dr Diarmid Sinclair, Chief Medical Officer	X
29	14.55	Promise 10: inclusion healthcare**	Information	Toby Lewis, Chief Executive	Y
30	15.10	Dialog+	Information	Dr Judith Graham, Director of Psychological Professionals	Z
Supporting Papers (previously presented at Committee)					
31	15:30	Guardian of Safe Working Hours Mortality Report: March and April 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 *			
Chair to resolve '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press are excluded from the remainder of the meeting, which will conclude in private.'*				Kath Lavery, Chair	
35	*15:40*	*Minutes of the private meetings held on the 28 May and 25 June 2026*	*Decision*	Kath Lavery, Chair	AA
36		*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
37		*Reflections on the staff story*	*Discussion*		Verbal
38		*Chief Executive Private Update to the Board of Directors*	*Information*	Toby Lewis, Chief Executive	CC
39	*16:00*	*Close*			

*** 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 24 September 2026 at The Rossington Miners Welfare, Doncaster

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Phil Gowland, Director of Corporate Assurance Diane Jeavons, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	30 July 2026

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

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

There are no amendments to report this month.

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.

There are no amendments this month.

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 Guiness Trust • Solicitor, Taylor Emmet Solicitors • Lay member National Institute of Clinical Excellence (NICE) • Associate Hospital Manager at Leeds and York Partnerships NHS FT and Derbyshire Healthcare NHS FT • Volunteer - Stroke Rehab Services Review, Joined Up Care Derbyshire • Research Ethics Committee Member, Ministry of Defence • 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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING
ON THURSDAY 28 MAY 2026 AT 9.30 AM
RIVERSIDE HOUSE, MAIN STREET, ROTHERHAM, S60 1AE

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
Dr Andrew Heighton	Deputy Chief Medical Officer
Carlene Holden	Director of People and Organisational Development
Toby Lewis	Chief Executive
Simon Sheppard	Director of Finance and Estates
Dave Vallance	Non Executive Director
Pauline Vickers	Non Executive Director

IN ATTENDANCE

Dr Jude Graham	Director for Psychological Professions and Therapies
Jo McDonough	Director of Strategic Development
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)
Gary Cox	Veteran – for the Patient Story
James Hatfield	Freedom to Speak Up Guardian

3 members of staff, 1 governor and 1 member of public

Ref		Action
Bpu 26/05/01	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. Apologies were noted from Dr Diarmid Sinclair, Chief Medical Officer. Mrs Lavery noted that there were items on the agenda to be managed through a question led format to support focused discussion and efficient use of time. Feedback on the meeting and any subsequent questions were welcomed, with any public questions to be addressed at the conclusion of the public meeting. Mrs Lavery emphasised the strong and explicit focus on organisational culture, reflecting its importance across multiple agenda items.	
Bpu 26/05/02	**Quoracy** Mrs Lavery noted the meeting was quorate.	
Bpu 26/05/03	**Declarations of Interest** Mrs Lavery presented the declarations of interest report and confirmed there had been amendments to the register since the last meeting in	

	respect of Kath Lavery, Rachael Blake, Maria Clark, Kathy Gillatt and Pauline Vickers. **The Board received and noted the changes to the Declarations of Interest Report.**	
	STANDING ITEMS	
Bpu 26/05/04	**Minutes of the previous Board of Directors meeting held on the 26 March 2026** The Board approved the minutes of the meeting held on the 26 March 2026 as an accurate record.	
Bpu 26/05/05	**Matters Arising and Follow up Action Log** The Board received the action log and noted the progress updates. All seven actions noted as 'propose to close' were agreed, and noted that six remaining actions would be addressed at the July meeting. <u>Future Adult ADHD and Adult Autism Services</u> With reference to closed action Bpu 26/03/13, Mr Lewis advised a further discussion would take place at the next Board of Directors in July 2026 which may include proposals regarding how the adult autism service goes forward. Members of the Board were encouraged to discuss concerns in this regard with either himself, Dr Graham or Mr Chillery prior to the next meeting. <u>Estate Enabling Plan</u> In response to a query from Mr Lewis regarding capacity and capability to deliver the Estate Enabling Plan, Mr Sheppard advised that additional resource had been secured to support development of the business case. Project management support from an external organisation was expected to be confirmed by the end of the following week, ensuring sufficient capacity and capability ahead of the July Board meeting. Internal teams, including Strategy, Estates and Finance, were also contributing to the work. <u>Workplace Violence and Aggression</u> With reference to closed actions BPU 26/03/17 and BPU 26/03/28, Mr Forsyth noted that Board feedback had been welcomed, particularly the request to strengthen and expand the recommendations, and confirmed further progress had since been made. Firstly the recommendations were discussed at the Risk Management Group (RMG) in early May, where it was agreed that psychological professional leads would work to ensure (1) a consistent response to incidents across all care groups, including strengthened immediate and follow up debrief arrangements, with progress to be reported back. (2) Oversight of incident reporting through the Radar system was enhanced to improve executive visibility of violence and aggression incidents and ensure timely and visible action, addressing staff survey feedback. Work, led through HQTC, focused on developing more (3) neuro specific and trauma informed environments, including physical and sensory improvements to support calmer therapeutic settings. There was also (4) an increased focus on therapeutic activity within inpatient wards with a broader and more patient led programme to support	

	violence reduction. Mr Lewis referred to meaningful debriefs for colleagues, and Dr Graham added that debrief processes had reflected both immediate and more reflective approaches, supported by the Trauma and Resilience Team, with specific attention given to incidents involving racism through dedicated oversight arrangements. **The Board received and noted the update related to Workplace Violence and Aggression and four actions Mr Forsyth had oversight of**.	
BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS		
	Mrs Lavery introduced a revised approach to this non-executive led section of the meeting and asked for the discussion to initially focus on the four escalated matters from within the committee reports to Board. .	
Bpu 26/05/06	**Quality Committee (QC)** <u>Lithium Prescribing And Monitoring</u> Dr Heighton advised that the main issue had been a lack of clarity around shared care arrangements. A recent internal review found good compliance, with no patients identified as unmonitored. The remaining gap was the development of a comprehensive register shared with primary care. Most patients, including those under shared care, continued to receive monitoring through secondary care. Dr Falk noted that the risk had been escalated through the QC due to limited progress, but further discussion had confirmed this reflected system complexity rather than a failure in monitoring. The risk on the register had remained escalated longer than necessary. Challenges were identified with primary care blood monitoring, where GPs retain responsibility for results, and clearer arrangements were considered to enable testing in primary care with results actioned by secondary care. Dr Heighton noted that patients on lithium should have appropriate records and many were included on the SMI register, and this would provide additional safeguards. The issue was recognised as wider than lithium prescribing and relevant to broader system improvements in result sharing and clinical responsibility. Mr Lewis advised that related shared care discussions were ongoing and would inform this work. Dr Shah highlighted the need to consider the issue within South Yorkshire medicines optimisation forums to ensure system oversight, which Mr Lewis agreed would be picked up with Dr Crichton. <u>Safe Staffing Annual Report and Establishment Review</u> The Board had received the 2025/6 Safe Staffing Annual Report and Establishment Review following detailed scrutiny by the Committee that included the triangulation of workforce, quality, and safety data. This included acuity-based staffing information, roster and fill rate metrics, incident reporting, workforce indicators, and quality outcomes, as detailed in Agenda Pack B. Mr Forsyth advised the QC confirmed that there were **<u>no</u>** escalated concerns arising from the review, the Trust had met National Quality Board (NQB) standards for safe staffing, and safe staffing governance arrangements were robust and effective, with appropriate oversight and mitigation of risks. The QC therefore recommended that the Board note the strong position in relation to safer	**TL**

	staffing across the Trust, and approve the Annual Safe Staffing Declaration, based on the comprehensive data set presented. **The Board agreed the positive assurance provided by the Quality Committee.**	
Bpu 26/05/07	**Mental Health Act Committee (MHAC)** Ms Holden provided an update on MHA and RRI training compliance, noting that 421 colleagues (across the Trust and all competencies) had outstanding elements as at year end. Individuals had been written to with a deadline of 1 June to achieve compliance, with further follow up planned where this had not been met. It was confirmed that sufficient training capacity was in place, with the main challenge being releasing colleagues and attendance. It was acknowledged that further work was required to validate the accuracy of mandatory and statutory training requirements (MAST), particularly for RRI training, to ensure they were proportionate and role appropriate. A review was underway, led through the Education and Learning governance structure, with a report to be presented to its next meeting. Ms Holden confirmed that progress was being made, with improvements already evident following recent validation work. The focus remained on core mandatory training, ensuring requirements were proportionate, relevant and aligned to roles. Mr Sheppard added that this exercise had been undertaken with the estate team and had proved efficient, effective and valuable. Mr Lewis emphasised the importance of enabling colleagues to challenge training requirements where these seem inappropriate and of maintaining a proportionate and manageable programme. Dr Graham added that although training requirements continued to be reviewed against national guidance, MAST needed to remain sensible and appropriate to role. Mrs Lavery advised this would also apply for non-executive director training requirements. **The Board received and noted the report from the Mental Health Act Committee.**	
Bpu 26/05/08	**Public Health Patient Involvement & Partnerships Committee (PHPIP)** Ms Blake reported that progress against inequalities related to Promises 8, 9 and 10 remained slow and would be addressed through risk registers and delivery reviews. There was emphasis on the need for sustained focus, noting that gaps were not closing and required new approaches to access services, including stronger system working, community engagement and collaboration with the voluntary sector to improve access for underrepresented groups. Ms Blake understood this would be discussed further later in the agenda. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	
Bpu 26/05/09	**Trust People Council (TPC)**	

	Mrs Lavery noted that the Trust People Council had identified a key risk in relation to organisational culture, which would be considered later on the agenda. **The Board received and noted the report from the Trust People Council.** Mrs Lavery then invited Board members to raise any questions on other issues within the reports. Dr Falk commended the revised process of reporting escalated matters from committees to the Board, noting it worked well to have a question led format with executive responses. It was also recognised that this approach allowed for more detailed narrative within reports (more than one page), which was helpful and effective in sharing connection between committees.	
Bpu 26/05/10	**People & Organisational Development Committee (PODC)** Ms Clark noted reference made of the impact to nationally determined Clinical Excellence Awards and potential reputational risk. Concern was raised that the term "trust control" could imply a lack of influence when the Trust can influence this and support female colleagues to apply. Mrs Lavery declared her interest as Chair of the ACCIA Yorkshire and Humber Panel. Ms Holden clarified the wording was not intended in that way, while recognising the concern as valid. The findings, including awards outcomes, would inform supportive employment actions, with further analysis by directorate planned to identify patterns, set targets, and drive improvement. Mrs Lavery added that national work in this area would also be shared as information arose. Ms Clark raised concern about a spike in reported racial incidents in Rotherham, questioning whether this reflected increased racism or improved reporting and support. Mr Lewis advised the spike in data was largely attributed to two patients involved in multiple incidents. Mr Lewis drew attention to the antiracism work on Mulberry ward, with plans to extend this to Rotherham wards over the next four to five months. Whilst the data reflected specific cases, there was concern about possible underreporting in Rotherham, alongside a welcomed recognition that awareness and reporting may be improving. Mr Lewis referred to the work to address gender pay gap, noting significant progress in reducing it to around 1%, while recognising it had not been fully closed and what the next steps would entail. Ms Fulton Tindall advised further analysis was planned before agreeing next steps, and Ms Holden explained this would include reviewing the impact of the real living wage and Agenda for Change pay awards, post change management workforce and remaining pay protection cases, noting for the first time analysis would be undertaken at directorate level to identify any hotspots and address the 1% gender pay gap. This would inform more targeted actions and future Board discussions. Dr Graham highlighted the importance of addressing occupational segregation, particularly increasing opportunities for women in underrepresented workforce areas through targeted recruitment and apprenticeships.	

	The Board received and noted the report from the People & Organisational Development Committee.	
Bpu 26/05/11	**Audit Committee (AC)** **The Board received and noted the report from the Audit Committee.**	
Bpu 26/05/12	**Finance, Digital & Estates Committee (FDE)** **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
OPERATING PERFORMANCE / GOVERNANCE / RISK MANAGEMENT		
	Mrs Lavery advised the meeting moved to a section of the agenda that had traditionally been taken at the end, but was now brought forward in recognition of its importance as core Board business.	
Bpu 26/05/13	**Strategy Delivery Risks (SDRs)** Mr Gowland presented the paper. Strategic delivery risks remained central to the Trust's work of risk mitigation, noting the recent triannual meetings with executive leads and Mr Gowland outlined changes in lead responsibilities following the retirement of Mr Banks. Timescales for risk mitigation had been revised, recognising that while significant progress had been made, further work was still required and the end point had not yet been reached. Ongoing internal development work with leaders and colleagues was highlighted, alongside external dependencies, particularly with system partners and primary care colleagues, which were critical to progress, especially regarding seven day working. A comprehensive update on each risk was included in the paper. Mr Gowland addressed whether additional strategic risks should be included, particularly finance, and advised against this given the Trust's going concern position and robust finance plans being in place, confirming that focus should remain on the existing five SDRs. The Board was asked to confirm that these SDRs remained relevant for 2026/27 unless material changes arose. Mr Vallance queried whether the capability of the middle management group (known as the 555) represented a more significant organisational risk, given their role in leading teams and embedding change. It was suggested this could be greater in magnitude than existing risks and may warrant increased Board focus. Mr Lewis responded that this should sit within SDR5 (leadership capability), with further strengthening of content rather than adding a new risk. It was agreed SDR5 may require refinement. Mr Sheppard supported not adding a standalone finance strategic risk but questioned whether a "top 10 risks" tier was missing between strategic and operational levels, noting potential inconsistency in identifying risks to delivering the 2026 to 2027 financial plan. Mr Gowland did not support creating an additional tier, stating risks should already be clearly articulated within the existing register. He emphasised better presentation of risks within and outside tolerance, and that "top risks" should be reflected through existing operational risk reporting. Mr Lewis noted a potential behavioural gap in ownership of corporate risks, and on behalf of the Executive Group agreed to review the risk register to ensure it captured key risks and was easy to interpret.	**PG**

	Mrs McDonough supported retaining the five SDRs, noting concerns about progress against SDR1 and that the December 2026 target appeared ambitious and may require review. Mr Forsyth sought assurance that mitigations for SDR2 and SDR3 were progressing at pace and that plans were resilient to external factors. Ms Fulton Tindall noted that, while not requiring a new strategic risk, leadership development alongside the change programme presented challenges around capacity, engagement, and consistency, and required continued Board focus. Ms Gillatt highlighted that while some risks were progressing well, others were constrained by complexity and external factors. She encouraged a more focused approach, including decluttering, prioritisation, and root cause analysis. Ms Blake added that health inequalities should be more explicitly reflected within risk descriptions. Mr Chillery supported further focus on SDR5 and questioned whether identical scoring across all SDRs limited effective differentiation. Mr Gowland thanked members and acknowledged the need to ensure all relevant elements were captured within SDR5, to involve a broader range of contributors, and to strengthen delivery plan resilience. He also noted the need to review risk scoring and refresh actions to support progress. **The Board received and noted the Strategic Delivery Risk report, and confirmed the strategic delivery risks were relevant for the remainder of the 2026/27 year.**	
Bpu 26/05/14	**Operational Risk Report** Mrs Lavery invited questions for Mr Gowland. Mr Lewis welcomed the report but raised two concerns firstly the specific estates issue of a door not closing correctly on Sandpiper Ward (RSK 547), and secondly the confusion regarding lack of a reliable method for monitoring disengagement (RSK 044), given the amount of work contributed to implement an existing policy and data driven reporting being built linked to disengagement. Dr Falk noted the report was helpful but questioned whether the organisation was focusing on the most important risks. He suggested that once risks were identified as out of tolerance, the red/amber colour distinction may be unnecessary and potentially misleading, and proposed this be reviewed. Ms Gillatt encouraged that future reports more clearly draw out the key themes and “so what” implications, providing greater clarity on the impact of the work described. Responding to Mr Lewis, Mr Forsyth advised that the estates risk regarding the door had not been clearly articulated until review at the Risk Management Group, after which it was promptly resolved within two weeks. Mr Forsyth clarified that the disengagement risk reflected previously unidentified gaps, including patients being discharged from crisis without being seen, and noted that while a policy had been approved, implementation remained variable and required further assurance. Mr Lewis stated although the clarification was helpful he	

	recommended that a position statement be brought to the next Board to clarify progress in operationalising the policy and identifying where key risks sat. **The Board received and noted the Operational Risk Report.**	**DS**
Bpu 26/05/15	**Integrated Quality Performance Report** Mr Chillery introduced the Integrated Quality Performance Report (IQPR) for May 2026 review (data as at 30 April 2026). The IQPR would undergo change in light of national guidance and metrics still evolving. Mr Chillery provided context on the challenges of reducing length of stay, emphasising this was a complex issue without quick solutions. This was discussed by Board members. Progress was highlighted in significantly reducing the number of out of area placements, improving ward flow and partnership working, but acknowledged further work was required across the pathway, particularly at the point of admission and discharge. He noted that improvements in out of area placements may have increased the complexity of remaining patients, impacting on length of stay. Actions underway included reviews of patients with stays over 32 days, recognising the complexity of multi-agency discharge arrangements, and earlier engagement with housing and social care partners. Some progress was noted in embedding MDT and HQTC improvement work across wards, but still needed further embedding with imminent work in community services which may lead to support admission avoidance. Social housing remained a key constraint. Mr Chillery cautioned that improvements would take time and may have unintended impacts, and emphasised a balanced and realistic approach, while recognising the efforts of colleagues working in challenging environments. Mr Lewis noted that the introduction of increased personal accountability for length of stay had strengthened oversight, led by responsible clinicians. However, this had generated discomfort among some clinical colleagues, who could feel scrutinised, despite the approach being implemented supportively and developmentally. The intention was to intervene earlier in admissions to prevent delays. It was recognised that length of stay reduction was critical to maintaining low out of area placements, though this required sustained effort and systemwide flow improvements. Variations across services were acknowledged, alongside the importance of analysing data more meaningfully, including use of data by diagnosis to better understand performance. Dr Graham outlined key factors influencing length of stay, including strengthened clinical oversight through weekly executive review and escalation processes for complex cases. Analysing length of stay by diagnostic group provided more meaningful insights, despite added complexity from multiple diagnoses and local factors. She highlighted the impact of workforce and service factors, including seven day working and weekend delays, and emphasised the need for joint working between inpatient and community services. Dr Graham also noted wider system and cultural challenges, including shifting models of care, patient expectations, and potential workforce impacts, with increased accountability possibly leading to some staff turnover.	

	Dr Heighton emphasised the importance of the full patient pathway, noting that continuity between inpatient and community interventions could affect length of stay. He highlighted the impact of complex long stay patients on flow, staff wellbeing, and incident pressures, and impact on crisis team's capacity to support admission avoidance and timely discharge. Mr Forsyth noted that length of stay was influenced by multiple factors, including clinical decisions such as one to one observations and Section 17 leave outcomes, highlighted that legal frameworks under the Mental Health Act, including Section 3 and other longer sections, could inherently extend length of stay. Ms Blake highlighted the importance of social housing and its impact on mental health, and queried current work in this area. Mr Chillery advised that work was ongoing on a case by case basis with local partners, though strategic work remained limited due to housing challenges in the wider system. Mr Pandor highlighted the tension between reducing length of stay and ensuring safe community support, and queried variation between localities, including a three week difference between Doncaster and Rotherham. Mr Lewis clarified that the focus was on reducing restrictive care rather than cost, with no change to the bed base. He noted that variation was a systemic issue and outlined plans for targeted improvement, acknowledging that meaningful change would take time. **The Board received and noted the Integrated Quality Performance Report, the continued delivery of promise 14 in respect of planned care and further improvements in out of area placements. The Board recognised that without length of stay reductions, notably in Rotherham, we cannot meet our agreed aims for inpatient care quality improvement.**	
Bpu 26/05/16	**Promises and Priorities Scorecard** Mrs Lavery invited questions for Mr Lewis. Dr Falk queried whether limited improvement in access to talking therapies for older adults, recorded as unknown, may be linked to GP awareness of available capacity. Mr Forsyth highlighted trade-offs between priorities and sought assurance that overall strategic objectives would still be achieved. Mr Lewis responded that low referral rates, rather than capacity, were limiting access to talking therapies for older adults. He highlighted ongoing work to increase awareness, noting this reflected a wider national issue despite strong outcomes for those who access the service. In response to Mr Forsyth, it was acknowledged that assurance could not be fully given, noting the need to prioritise and accept trade offs between delivery areas. Mr Lewis highlighted work to better distinguish between what was effective, ineffective, or uncertain, particularly in relation to health inequalities. It was recognised some areas, including Promise 12, required further focus and resourcing, and that progress may be slower than expected. However, there remained ongoing work to map activity, improve visibility, and drive progress through focused oversight, with continued emphasis on Board committee scrutiny and prioritisation.	

	The Board received and noted the Promises and Priorities Scorecard, and the work done to ensure rhythm and focus on the mid table success measures. The Board recognised it had time scheduled twice in 2026 to ensure collective effort on Promise 26, and the need for Board committees to focus on promises 16 (QC), 24 (E&L) and 28 (PHPIP).	
Bpu 26/05/17	**Organisational Change Quality & Safety Indicators** Mr Forsyth presented the paper and gave key highlights. The report was the first presentation following the change management process, with further reporting expected in July including full quarter 1 (Q1) data. It was highlighted that some data gaps reflected a lack of historical baseline rather than absence of activity, and that indicators to date appeared stable with minimal variation. It was emphasised that early variation should prompt inquiry rather than concern. No patient harm had been identified at this stage, though some workforce challenges were noted within one scheme relating to unplanned nursing care. Mr Forsyth invited any questions. Mrs Vickers queried whether unplanned nursing care, including weekend staffing gaps, represented an emerging risk requiring further monitoring. Ms Blake welcomed the early report, noted improving data maturity, and queried whether high 'did not attend' (DNA) rates in North Lincolnshire talking therapies were typical or linked to recent changes. Mr Forsyth reported that mitigations were in place to maintain safe staffing during unplanned absence, including flexible team responses and prioritisation of urgent patient needs such as pain relief and end of life care, which has resulted in some delays to planned care. No patient harm had been identified. Mr Chillery added that whilst risks were being managed, further time was required to embed the model, understand underlying causes, and gather staff feedback. Ms Holden advised early feedback indicated some staff concerns and a small number of short term absences, mainly among Band 5 colleagues. Proactive support and return to work processes were in place, with close monitoring to prevent escalation. A short term increase in absence was anticipated as the model embedded, with ongoing management oversight and engagement to address emerging issues. Regarding DNA rates in North Lincolnshire, Mr Forsyth advised that System Connect and patient led bookings had increased DNAs, as patients may not be able attend within four weeks, creating a misleading performance signal. Mr Chillery noted current patterns reflected system embedding, and Dr Graham confirmed digital access was supporting, not worsening, attendance, in line with national trends. A further update would be presented to the Board in July. **The Board received and noted the Organisational Change Key Performance Indicators report, and that no significant adverse trends had been observed in the initial two months of QSIA monitoring (April–May 2026), indicating no immediate intervention was required before the end of Q1.**	

	The Board recognised that robust monitoring mechanisms were in place, with clear governance and escalation processes, and that any future sustained adverse trend ("signal") would trigger prompt action. Early data should be interpreted with caution, as several new indicators lack historical baselines and some fields are still undergoing validation.	
Bpu 26/05/18	**Chief Executive's Report** Mr Lewis drew attention to the five key items within his report. The establishment of the Community Leadership Executive (CoLE) was celebrated which brought together sixteen voluntary sector organisations to work alongside the trust's management. Mr Lewis noted this was a significant development and acknowledged that realising its full potential would require a shift in approach, including sharing influence and embracing alternative perspectives. Overall, this was seen as a positive opportunity in the medium term. Attention was drawn to recruitment and learning from the recent change management process indicated that devolved recruitment arrangements had created inconsistencies and inefficiencies. A move towards more centralised recruitment for certain roles would therefore continue, despite some managerial resistance, to improve equity and reduce vacancies. It was noted that achieving full establishment (ie. < 100 vacancies) was unlikely before late November or early December. The Akeso report referred to in his paper, focused on aligning partners such as the ICB and Doncaster and Bassetlaw Hospitals, providing a quantified assessment of opportunity and included consideration of different patient flows and experiences across the system. It was emphasised that the work of this third party would be important in informing the forthcoming estate full business case, with investment expected to focus on patient benefit. An initial neurodiversity waiting time scorecard was presented within the annex. Whilst still work in progress, concerns were raised regarding the coherence of current management arrangements. As advised earlier, a more detailed discussion would take place at the next meeting in July. Some positive progress was noted, particularly increased uptake of digital offers among children waiting over two years, given our commitment to a CYP maximum wait of 104 weeks by October 2026. They're remained ongoing uncertainty regarding national operating measure indicators, with data definition for the current year still outstanding. It was anticipated these would be published shortly, although Q1 performance may be reported before full clarity was available. Mr Lewis also informed of delays in contract finalisation with the ICBs, despite repeated efforts. A further deadline had been set. Concerns were raised regarding proposals for providers to assume demand risk in certain areas, which would not be supported in relation to neurodiversity given legacy under-commissioning which the national prevalence study may contribute to tackling.	

	Finally, issues relating to Talking Therapies access data were discussed. Mr Lewis noted that the reported increase in waits may reflect either previous data inaccuracies or a loss of process control. Remedial actions would include restating the access policy and reinforcing disengagement processes to ensure waiting times were reported appropriately and capacity was managed effectively. Mr Chillery noted that, in relation to Talking Therapies, the figure of 200 was under review as it may not reflect accurate data. An update would be provided, with a fuller discussion to return to the Board in July as previously outlined. In response to Dr Falk's query, Mr Lewis clarified that perceived resistance to Dialog+ reflected maintenance of existing care planning approaches rather than opposition to the new. Transitioning to a single, standardised model remained a practical challenge, particularly where patient contact was infrequent. He acknowledged that consistent care planning had not yet been fully embedded across the Trust. Mr Vallance noted this reflected longstanding issues seen in areas such as risk assessment, transitions, and documentation. Mr Lewis advised that, while some progress had been made, consistency remained difficult to achieve. "Always measures" and increased oversight were identified as key improvement mechanisms, alongside a shift towards real time action to address noncompliance. It was emphasised that consistent care planning was a fundamental requirement requiring clear and sustained organisational focus across 2026. Ms Clark raised concerns regarding recruitment panels and sickness. The reference to parental leave alongside sickness absence in particular noted the potential perception and impact on colleagues. Mr Lewis clarified that the intention was to reflect the overall strain on services from staff absence, where both factors pertained. In relation to mandatory ethnically diverse interview panels, it was noted that initial feedback had been more positive than anticipated, although some challenges were expected as implementation progressed. Mr Lewis acknowledged that perceptions of tokenism may arise, particularly among global majority colleagues, while some resistance was anticipated more broadly. The importance of maintaining focus on improving equity and progression at senior levels was emphasised. Positive feedback was given on the CoLE visual materials, and it was requested that progress against its ambitions be reported regularly (quarterly), supported by clear metrics. **The Board received and noted the Chief Executive's report and the forward actions it contained, and noted the uncertainty over our Q1 'segmentation' outcome with NHS NEY.**	
Bpu 26/05/19	**Energy Feasibility Study – route to Full Business Case** Mrs McDonough presented the paper and reminded of the ambient loop presentation at a previous Board time out session. The Trust was committed to reducing its carbon footprint, with current emissions of approximately 2,500 tonnes, of which around 1,200 tonnes related to gas usage at the Tickhill Road site in Doncaster. A range of	

green energy options had been appraised, with no single solution being without drawbacks. Ground source heat pumps using an ambient loop had been identified as the preferred option, offering the greatest reduction in carbon emissions (removing gas related emissions at the site) alongside lower ongoing energy and maintenance costs, despite requiring significant upfront capital investment.

The approach would need to be considered alongside wider estate improvements, including upgrades to insulation and glazing, and the inclusion of solar energy where appropriate, to maximise energy efficiency. The proposal was noted to be interdependent with the wider estate enabling plan, particularly given the potential future control of energy source via energy centre on the Tickhill Road site. While installation would involve some disruption, it was considered the most effective option in balancing sustainability outcomes and deliverability. Mrs McDonough invited members of the Board to consider the proposal and raise any questions.

Members of the Board expressed strong support for the proposed solution and the outcome of the options appraisal. Ms Gillatt queried the anticipated payback period, noting the importance of understanding the scale and timeframe of return on investment. Mr Pandor sought clarification on the relationship between the proposed works and the wider estate development, including whether implementation would be phased to minimise disruption. Mrs Vickers questioned the scheme's interdependencies with the estate enabling plan, including the assumptions required to progress and the potential availability of national funding to support delivery.

Mrs McDonough advised that payback details were not yet available and would be confirmed in the full business case, including both financial and carbon benefits. However, she did note that there would not be a full financial pay back, the pay back for this will be measured in carbon emissions saved. She confirmed the programme could progress alongside the estate plan, subject to clarity on the retained estate, and noted the solution was scalable. Previous bids for national funding had been unsuccessful due to oversubscription but further opportunities and funding options, including external investment, would continue to be explored.

Mr Lewis raised a query regarding current energy expenditure and the anticipated revenue savings, alongside clarification of the cost differential between the preferred option and the air source heat pump alternative. Mr Sheppard advised that annual gas expenditure was approximately £700k and electricity approximately £1.3m, with the proposed solution expected to significantly reduce this, alongside further savings from improved electricity efficiency. Mrs McDonough highlighted that, while the air source option (not preferred) presented a lower upfront cost, it would require more frequent replacement and maintenance, whereas the preferred ambient loop solution offered greater longevity and higher long term savings. It was noted detailed financial analysis, including payback and revenue comparisons, would be provided in the full business case.

	Ms Holden queried the impact of installation disruption on patient flow and activity. Mrs McDonough advised that, while works would be significant, disruption would be minimised, with limited impact on ward occupancy. Some decanting may be required for window upgrades, and works would be delivered in phases to maintain service continuity. Mr Forsyth noted that the full business case would set out return on investment assumptions, including energy price variability and capital costs. He highlighted additional benefits, including potential income from energy generation and increased land resale value. Mr Forsyth drew attention to risk 468, noting it currently reflected uncertainty regarding funding availability and access, and that this would need to be addressed. Dr Heighton queried the patient safety implications, particularly in relation to water heating requirements. Mrs McDonough advised that additional heating via electrical heat pumps would be required to achieve necessary temperatures (for hot water and Legionella control), with systems operating per building. It was noted that the solution would also provide a cooling function, supporting colleagues and patient comfort during periods of high temperatures. **The Board received and noted the Energy Feasibility Study – route to Full Business Case paper, and noted the option appraisal undertaken to identify a preferred approach to reducing carbon emission from gas.** **The Board had considered the options appraisal outcome alongside costs and benefits, recognised the focus on Tickhill Road site initially, and noted work commenced to attract external investment in the capital required.** **The Board decided that Ambient Loop was the preferred approach on Tickhill Road site.**	
	Mr Gary Cox joined the meeting at 12.40pm	
Bpu 26/05/20	**Sickness Absence** Ms Holden presented the paper and highlighted some key ideas. Sickness absence remained higher than comparator organisations, despite similar levels of deprivation, indicating further improvement was required. Sickness absence clinics had been reintroduced and would continue, with a focus on reducing long term absence, which had increased. Data showed a significant proportion of the workforce had little or no absence, with around a quarter of employees accounting for higher levels. The importance of manager capability, timely interventions, and effective return to work discussions was emphasised. Additional support measures, including improved engagement with colleagues during absence and partnership working with external organisations, were outlined to support earlier returns. Ms Holden advised reducing sickness absence would require sustained focus and would support	

	improvements in patient care, workforce stability, and reduced reliance on bank staffing. Mr Lewis welcomed the paper, highlighting key improvement measures including sickness absence clinics, internal redeployment to enable faster return, and occupational health pathways. He emphasised a more proactive approach to managing cases unlikely to resolve and the need for timely HR processes where these overlapped with long term absence. Mr Sheppard noted the scale of absence, equating to over 200 colleagues off daily, and highlighted that reducing long term absence would return significant capacity, with benefits comparable to a 1% CIP and improvements to patient care and team resilience. Ms Clark queried differentiation between work and non work related causes of anxiety, stress and depression, and the impact of external waiting times, particularly for MSK services. She also raised concerns around presenteeism, including infection control risks and alignment with flexible working. Dr Falk emphasised preventative action and engagement with GPs on fit notes, noting forthcoming national changes and capacity concerns. Mr Forsyth queried links between long term sickness and increased turnover, and whether further action was required. Ms Fulton Tindall highlighted the importance of wellbeing and personal responsibility, querying whether expectations on sickness and attendance could be strengthened through recruitment and organisational culture. Mr Chillery queried whether stress levels reflected contextual factors specific to mental health and community services, given that peer Trusts were typically higher than acute sites, and whether additional targeted support was required. Ms Holden responded and acknowledged inconsistent practice remained in managing long term sickness, with some managers delaying action despite clear occupational health advice. Work was underway to address this and promote more timely, appropriate decision making. Links between long term sickness and HR processes were recognised, with actions in place to improve the timeliness of investigations, including exploring centralised and outsourced approaches. Data on sickness absence causes was available but limited by inconsistent coding of secondary reasons which makes it difficult to separate stress, anxiety and depression into work, personal related. Or both. Support for MSK conditions was available via occupational health, although access to surgical interventions remained dependent on external and acute services. Presenteeism was acknowledged as a concern, with measures in place to support flexible working and protect vulnerable colleagues and patients. Greater use of occupational health advice and engagement with GPs was identified as an area for improvement. A small link between long term sickness and turnover was noted. The importance of staff wellbeing, personal responsibility, and strengthening organisational expectations was emphasised, alongside addressing cultural factors within mental health services. Mr Lewis summarised that the paper constituted the Board's agreed sickness absence plan and formed the Trust's response to the relevant regional compliance requirement.	

	The Board received and noted the Sickness Absence paper, and noted the focus on long term sickness for the first twelve months and the suggested 1.5% reduction. The Board had considered whether any wider support could be offered, and recognised the focussed work in this area and the wider workstreams which were being considered and implemented. **The Board delegated the review and scrutiny of the approach and delivery to the People and Organisational Development Committee.**	
Bpu 26/05/21	**2025-26 serious patient safety incidents – learning update** Mr Forsyth presented the paper and gave key highlights. The patient safety incident learning update was part of an ongoing series rather than a one off review, supporting sustained focus on learning and improvement. It was reported that progress had been made in areas including referral and access, with no further incidents relating to missed referrals, and improvements in risk assessment practices, with no new incidents citing risk failures. Early improvements were noted in physical health management, prescribing practices, and crisis response, although these were not yet consistently embedded. Further improvement was required in documentation, particularly timely and contemporaneous record keeping, as well as family involvement in care planning and transitions and discharge processes. It was noted that the implementation of Always Measures would support sustained improvement. Mr Lewis welcomed the report but noted limited assurance on transitions of care and discharge planning safeguards and documentation, and sought clarity on safer staffing huddle decision making and when robust data would be available. It was advised that further work was required to define and measure transition safeguards. Documentation monitoring would begin in quarter 1, while assurance on medical documentation remained limited. Implementation of ambient voice technology was expected to improve timeliness and data availability. Ms Blake acknowledged the importance of staff engagement with carers and families, noting that while improvements had been made, consistency remained an issue and further work was required in line with promise 2 and Always Measures. Ms Holden queried the status of action plan 884 (male with serious fracture) and the challenges in finalising it. The summary of key learnings highlighted the reliance on training, emphasising that training alone would not deliver sustained improvement. Ms Holden asked what additional measures were in place alongside training. Mr Vallance questioned whether sufficient time and resources were in place for frontline teams to deliver the required improvements, highlighting the risk of continued underperformance if underlying conditions were not addressed. Regarding the challenges in finalising the action plan 884, Mr Forsyth explained that while the investigation had concluded, finalisation of the action plan had been delayed due to an ongoing police investigation and the need to confirm whether the injury was directly related to the incident. In relation to training, it was acknowledged that improvement	

	required a broader approach, including system and IT developments, improved access to equipment, and protected learning time. These measures aimed to support consistent practice and embed learning alongside training, including learning half days, with a continued focus on key themes to strengthen organisational consistency. Mr Lewis drew the chair's attention to the report recommendations. The Board accepted the second recommendation but considered the first overly reassuring. It was agreed to amend the recommendation to reflect clearer timelines and measurable progress, particularly for documentation and transition safeguards, and the recommendations were approved as amended. **The Board received and noted the 2025-26 serious patient safety incidents learning update report, the progress outlined and the areas of ongoing risk or challenge where work remained outstanding which, when complete, would provide stronger evidence that the identified safety actions from 2024/25 and 2025/26 PSIIs had been delivered or were on track, and that RDaSH's patient safety learning approach was aligned with national expectations.** **The Board recognised the ongoing areas of risk highlighted, notably the need for further improvement in clinical documentation standards and consistent family and carer involvement, and the importance of sustained focus to ensure these improvements are fully embedded and residual safety risks are mitigated**.	
STORY TO BOARD		
Bpu 26/05/22	**Patient story** Mrs Lavery welcomed Mr Gary Cox, a veteran, who was in attendance to share his experiences of accessing services. Mr Cox shared his lived experience of accessing services following a significant post traumatic stress disorder (PTSD) episode triggered by traumatic events in his community. He described initial difficulties accessing support, particularly with remote and telephone based services, and highlighted gaps in provision for complex veteran needs. Mr Cox spoke positively about the response from the Crisis Team and Tickhill Road Hospital, emphasising the timely, compassionate and family-centred approach, which he described as lifesaving. He highlighted the importance of face to face support and coordinated care, including the effective transition to OP Courage, where ongoing treatment had supported his recovery. Members of the Board reflected on Mr Cox's experiences and noted both the areas for improvement, particularly awareness of services and accessibility, and examples of excellent practice, including partnership working and continuity of care, and thanked Mr Cox for sharing his experience. Mrs Lavery noted the intended reflection time later on the agenda in the private Board.	
Mr Gary Cox left the meeting at 1.20pm		

Bpu 26/05/23	**Well led – externally commissioned developmental review** Mrs Lavery invited feedback and questions for Mr Gowland, noting this built on reports previously presented to the Board, and a further discussion would take place in the private session. Mr Lewis, Mrs Vickers and Mr Pandor reflected that overall the review felt balanced, appropriately highlighting both strengths and areas for improvement, although some recommendations were considered low level. It was noted that similar challenges were evident across the wider public sector, reflecting broader system complexity. Mr Forsyth referred to the importance of ensuring recommendations were followed through effectively, with clear arrangements to demonstrate impact and learning over time. Mr Lewis noted that, ahead of the next report, clarity would be required on which actions would be progressed and which would not. It was further suggested that consideration be given to how decisions not to proceed would be reviewed over time to ensure continued assurance and learning. Mr Gowland agreed this should be treated as a continuous improvement process and Mrs Lavery acknowledged the significant contribution of colleagues in delivering the report. Mr Sheppard noted the report provided some strong assurance ahead of CQC inspection and should be used as a tool to support ongoing improvement. Mr Chillery cautioned against any perceived complacency, emphasising the need to remain alert to further improvement opportunities. Mr Gowland highlighted the importance of ongoing cultural development and stressed that implementation of recommendations should be seen as part of continuous improvement rather than a definitive end point. **The Board received and noted the Well led externally commissioned developmental review report from The Value Circle (TVC) acknowledging the conclusions and recommendations it contains. The Board had considered any informal feedback on our preparedness and readiness for a well led assessment from TVC in the private session of the Board.** **The Board noted 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.**	
Bpu 26/05/24	**Culture Work** Mr Lewis introduced the report, noting that it linked to previous agenda items discussed earlier in the meeting. While progress had been made, the Trust had not yet achieved anyone's desired culture, with differing views across the organisation on whether we needed to go forward, or indeed back to the future. Mr Lewis emphasised the importance of recognising both achievements and areas for development, and outlined initial proposals for a wider cultural development or reset programme to commence in early autumn. This would focus on strengthening both accountability and care across the organisation.	

	Particular focus was given to the concepts of high support and high challenge, noting that while expectations around accountability were clearer, further work was required to define and embed "high care" in practice. Engagement with staff and leaders would be critical in shaping this work. It was noted that the pace of development would be deliberate to ensure meaningful and sustainable change, with leadership capability and capacity identified as key enablers of cultural improvement. Dr Graham welcomed the paper, emphasising the need to maintain context by balancing incident learning with recognition of positive patient experience and organisational strengths. She noted the importance of avoiding overly negative narratives, acknowledged the value of past achievements, and highlighted the need for this work to be clearly distinct from previous cultural initiatives before the lifetime of this Board team. Mr Vallance highlighted the need to balance high support and high challenge, emphasising that sustainable improvement requires setting clear expectations alongside ensuring the right conditions and support are in place for staff to deliver. Mrs McDonough noted real comparative strengths in the current culture but recognised concerns that staff perceived reduced compassion. She also emphasised the need to balance high support and high challenge, addressing reluctance to challenge and ensuring staff felt valued through consistent people management practices with effective PDRs and clear objectives. Ms Fulton Tindall reflected on the need to clearly define and embed the language of high support and high challenge. Mr Chillery noted a perceived shift away from a staff centric culture and highlighted a potential disconnect between strategic intent and staff experience, with a risk that delivery could be seen as metric driven. The importance of continued listening to address this gap was emphasised. Mr Forsyth recognised the cultural development work as a continuous journey rather than a time limited initiative, with consideration given to how progress would be sustained alongside ongoing operational and financial pressures. Mrs Lavery acknowledged the wider national NHS context, with the need for the organisation to adapt its culture to current system demands, while recognising that this may not always be visible or understood by staff. Mr Lewis highlighted the importance of strengthening basic employment conditions, demonstrating consistent listening behaviours, and identifying internal advocates to support change was highlighted. Mrs Lavery recognised this as a key priority area for the Board and agreed that further detailed work, including clarity on risks, mitigations, and measures of success, would be brought back over the summer. **The Board received and noted the culture work report, the planned actions and the associated timescales which provide co-production opportunities across the organisation. The Board had opportunity to comment on the planned actions and refine the planned work/terms of reference prior to the co-production.** **The Board agreed a further paper would be presented in July 2026 to enhance the proposals, leading then to a delivery plan before September launch.**	**TL**

Bpu 26/05/25	**Staff Survey** Mrs Lavery invited feedback and questions for Ms Holden. Mr Lewis sought clarification on the potential scope of collaboration with Navigo, noting its relevance to forthcoming discussions with NEY and requesting an overview of the intended direction. Dr Graham reflected that this represented only one aspect of how the organisation listens to staff, noting the importance of recognising that different channels, including anonymous feedback, encourage different types of engagement and insight. Mrs Vickers queried whether any key themes or unexpected findings had emerged from the staff survey results. Ms Holden advised, in response to Mr Lewis, that initial engagement with Navigo would focus on understanding their approach and learning from their experience, rather than adopting a predetermined model. Regarding Dr Graham's comment, Ms Holden acknowledged that staff survey feedback represented only one element of listening but remained important as it covers all colleagues and due to benchmarking, noting low response rates in other engagement routes. It was emphasised that, despite this, feedback highlighted perceptions that patient care was not always seen as the top priority, which required further exploration. In response to Mrs Vickers question, Ms Holden noted some unexpected findings, including more positive feedback from corporate services than anticipated and continued positive responses regarding flexible working, despite variation across service areas and in particular inpatient areas. Mr Vallance emphasised that the identified priorities required visible leadership, with the Board and Executive modelling expected behaviours. Ms Holden confirmed this would be reflected across related work, highlighting the need to strengthen feedback loops and ensure staff concerns were addressed. Mr Lewis confirmed that a separate staff survey action plan would not be developed, with findings instead informing a broader cultural development programme focused on underlying issues. Ms Blake queried whether engagement reached all colleagues and highlighted a disconnect between organisational messaging, staff experience, and patient feedback. Ms Holden acknowledged that staff survey engagement did not yet reach all colleagues as demonstrated via our response rate. Mr Lewis noted the number of recommendations and sought clarity on decision making. It was agreed that the People and OD Committee would have a role in monitoring progress, but it was emphasised that overall accountability should remain with the Board and that the wording of the recommendation should be adjusted accordingly. **The Board received and noted the staff survey results and the suggested areas of focus.**	

	The Board had considered 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. **The Board recognised the work and commitment required to facilitate the suggested improvements.** **The Board confirmed its overall accountability for responding to the outcomes of the Staff Survey, but delegated the subsequent monitoring of the work to the People and Organisational Development Committee and Trust People Council.** **In addition, the Board of Directors delegated to the People and Organisational Development Committee the review and submission of the WRES and WDES data.**	
Bpu 26/05/26	**Freedom To Speak Up bi annual update** Mrs Lavery invited questions for Mr Hatfield and Mr Forsyth. Mr Lewis asked what further actions could be taken to improve staff confidence in Freedom to Speak Up arrangements and encourage greater willingness to raise concerns. Ms Blake reinforced this, querying how feedback loops could be strengthened to ensure staff felt concerns were taken seriously and acted upon. Ms Holden queried what could be learned from comparator organisations and how best practice could inform improvement. Dr Graham asked whether reduced confidence reflected a shift in how staff were raising concerns and how different feedback channels could be better understood and aligned. Mr Lewis also queried how data could be further disaggregated, including to provide insight into neurodiverse staff. Mr Pandor asked how outcomes of concerns were communicated back to individuals and how assurance could be provided that feedback was meaningfully closed. In response, Mr Hatfield advised that further work was required to understand areas of low reporting and confidence, with targeted engagement planned, including use of Freedom to Speak Up champions. It was noted that feedback mechanisms were in place, with around 82% of respondents indicating they would raise concerns again, although this did not capture all staff. The importance of strengthening visibility of outcomes and closing the feedback loop was emphasised. Mr Forsyth acknowledged that triangulation with wider workforce and patient data would be strengthened, and further work would be undertaken to improve understanding of specific groups, including neurodiverse staff. **The Board received and noted the Freedom To Speak Up bi annual update, including the content of this report as a confidence on the Trust's Freedom to Speak Up arrangements and oversight, including the trends, themes and comparisons presented.**	**SF**

	The Board considered the key findings and data, notably the trends in concerns raised and the benchmarking against peers, and discussed any implications for sustaining and strengthening the Trust's speak up culture. The Board recognised the key findings and data, notably the trends in concerns raised and the benchmarking against peers, and discussed any implications for sustaining and strengthening the Trust's speak-up culture. **The Board agreed 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 would be tolerated for speaking up, and promoting the new initiatives to further embed a safe, responsive speak-up culture.**	
Bpu 26/05/27	**Older Adults Indicators** Dr Heighton, on behalf of Dr Sinclair, presented the report. An update on the review of the move to a mixed older adults ward model in Rotherham reported that no evidence had been identified to suggest the change had resulted in patient harm. Whilst some incidents had been examined, including those relating to physical health deterioration and other concerns, these had not been attributed to the model itself. Instead, issues were noted regarding medical input and ward support, potentially linked to broader service factors rather than the ward configuration. Further analysis, including comparative outcomes for patients with dementia and non organic conditions, would be brought back to the Board in July. Dr Falk welcomed the report, noting it provided assurance that no patient harm had been identified. A query was raised regarding the use of the term "good enough care" in the introduction, which was acknowledged as historic wording and potentially misleading. Ms Blake suggested that future reports could include more qualitative feedback from staff to complement patient and carer information. Clarification was sought on follow up actions relating to specific incidents, with Mr Lewis responding that findings from the independent review would inform appropriate action. Dr Graham welcomed the report, noting it was based on patient experience and supported a consistent, inclusive care model. She highlighted the challenges in distinguishing between organic and functional conditions and noted that staff perspectives may have evolved following implementation. Dr Heighton noted increasing dual training across specialties and highlighted improvements in staff training, including enhanced ILS training and planned bite sized physical health sessions for resident doctors from August. Mr Forsyth highlighted challenges in benchmarking older adult wards, stressing the need for better comparators and further learning. Concerns were raised about attributing serious incidents to physical health decline within an "isolated" model, given wider system factors and prevalence across services. Staffing and medical cover were seen as more likely contributors than ward design. Mr Lewis noted the report provided assurance on the current model, with no evidence for change, and	**DS**

	emphasised that any further idea of relocation would need overwhelmingly strong evidence which he felt was not currently present: as such the proposed third recommendation in the paper was not supported by the Board. **The Board received and noted the Older Adults Indicators report, and noted the data around the performance of our inpatient and community teams.** **The Board agreed the mixed model of functional and organic older adult wards was safe to be retained, and asked for a further paper on dementia to be considered over the summer.**	
Bpu 26/05/28	**Board and Committee workplans** Mr Gowland presented the paper. The proposed workplan for the Board and its Committees for 2026–2027 was presented for approval. It set out focused, prioritised agendas aligned to committee terms of reference, reflecting key components within the terms of reference. The approach strengthened tracking of rescheduled and delegated actions, improved clarity on forward agendas, and maintained a clear focus on partnerships and delivery oversight. Workplans were intended to demonstrate tangible progress rather than fragmented activity, providing transparency on priorities and timelines while retaining flexibility for emerging issues. In response to Mr Vallance's observation, Mr Lewis and Mr Gowland would review the workplans to ensure they fully reflected the intended scope of Committees and in particular the delivery of the relevant Plans. Any further commentary from Mr Vallance would be welcomed after the meeting. Mr Vallance noted that broader strategic themes, particularly prevention between hospital and community, and digital transformation, were not clearly reflected in the workplans and suggested these be considered at Board level, potentially through an autumn development session. Mr Chillery queried why Promise 22 was referenced within the quality committee workplan. It was explained other promises sat outside committee workplans and reported to the Board, with Promise 22 specifically highlighted as it was not sufficiently covered within the Quality and Safety Plan and it required a clear forum for discussion. **The Board received, noted and approved the work schedules for the Board of Directors and Committees for the remainder of the financial year**.	**PG**
Bpu 26/05/29	**Fit and Proper Person Test** Mrs Lavery presented the paper as read and confirmed that, following the receipt and review of self attestation statements and where applicable, the checks undertaken during recent appointments, she had deemed all members of the Board met the requirements of the fit and proper person test.	

	The Board received and noted 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.	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEE)		
Bpu 26/05/30	**Establishment Review Paper for Safer Staffing and Annual Declaration Report and Mortality Report (January and February 2026)** Mrs Lavery informed the Board of the mortality report and the establishment review paper for safer staffing and annual declaration 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 Establishment Review Paper for Safer Staffing and Annual Declaration report for information**.	
CLOSING ITEMS		
Bpu 26/05/31	**Any Other Urgent Business** There was no further business raised.	
Bpu 26/05/32	**Any risks that the Board wishes the Risk Management Group to consider** In relation to the staff survey results, Mr Lewis advised that a review would be undertaken to identify any emerging risks that were not currently captured on the risk register, and to ensure these were considered by the Risk Management Group as appropriate.	**PG**
Bpu 26/05/33	**Public Questions** There were no public questions.	
Bpu 26/05/34	**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 30 July 2026 at 9.30am, Barton upon Humber		

BOARD OF DIRECTORS : JULY 2026 **PAPER C – ACTION LOG**

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 25/11/22b	**Health Inequalities: Review of IQPR** A review of the format and focus of future reports would be undertaken, with a new reporting format to be confirmed in April.	JMcD	**July 2026:** Developments in respect of the IQPR are made in the version included in today's meeting papers.	Propose to Close
Bpu 26/05/14	**Operational Risk Report** Regarding RSK 044 (disengagement), a position statement be brought to the next Board to clarify progress in operationalising the policy and identifying where key risks sat.	DS	**July 2026:** The response is covered within the paper on today's agenda.	Propose to Close
Bpu 26/05/24	**Culture Work** The Board agreed a further paper would be presented in July 2026 to enhance the proposals, leading then to a delivery plan before September launch.	TL	**July 2026:** The Board spent time in its timeout session in June and today receives a further paper on this topic.	Propose to Close
Bpu 26/05/27	**Older Adults Indicators** Further analysis, including comparative outcomes for patients with dementia and non organic conditions, would be brought back to the Board in July.	DS	**July 2026:** Paper U on today's agenda responds to this action.	Propose to Close
Bpu 26/05/06	**Quality Committee (QC)** Regarding Lithium Prescribing and Monitoring, Dr Shah highlighted the need to consider the issue within South Yorkshire medicines optimisation forums to ensure system oversight, which Mr Lewis agreed would be picked up with Dr Crichton.	TL	**July 2026:** A note on this point has been shared with the Board.	Propose to Close
Bpu 26/05/13	**Strategy Delivery Risks (SDRs)** Mr Lewis noted a potential behavioural gap in ownership of corporate risks, and on behalf of the Executive Group agreed to review the risk register to ensure it captured key risks and was easy to interpret.	PG	**July 2026:** The Board's approach to set appetite levels for themes and the risk management process via the registers and the escalation reports to RMG and the Board (see Paper L on today's agenda) ensure that those risks furthest from tolerance are reported. The Operational Risk report today includes additional analysis by theme, appetite level and includes trajectory to bring back into tolerance. This report ensures that	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
			the Board are sighted on the most significant operational risks.	
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	**July 2026**: Recruitment progress remains positive, with 2.6 WTE Band 5 posts filled. A revised trajectory is currently being agreed, with a planned route to achieving a 4 week position. Further progress, including the updated trajectory and impact of recruitment activity, will be included in the next scheduled report to the Board in **September**, in line with the agreed workplan.	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	**July 2026:** This topic, 'power in our communities', was included in the Board's timeout session in June 2026. The Board will return to the topic again in **February 2027** alongside CoLE members.	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	**July 2026:** The workplan paper included in May's papers confirmed that a final plan on 14 week waits would be included in **September**'s Board meeting.	Open
Bpu 25/11/15	**Freedom to Speak Up (FTSU) Guardian six month update** Mr Lewis agreed to consider with executive colleagues outside this meeting of a broader culture of speaking up beyond formal FTSU processes.	TL	**July 2026:** This is reflected upon in the private Chief Executive's report and will be merged within the cultural reset in the **September** paper to the Board. Note, FTSU annexes within the public CEO report today	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.	SF	**July 2026:** An update on H1 Radar closures will be shared with the Board in **September 2026**.	Open
Bpu 26/05/26	**Freedom To Speak Up bi annual update** Triangulation with wider workforce and patient data would be strengthened, and further work would be undertaken to improve understanding of specific groups, including neurodiverse staff.	SF	**July 2026:** Inclusion of neurodiversity alongside protected characteristics is being developed for future reporting.	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 26/05/28	**Board and Committee Workplans** Workplans would be reviewed to ensure they fully reflected the intended scope of Committees and in particular the delivery of the relevant Plans.	PG	**July 2026:** As Committees meet, their respective workplan is being presented to confirm this review. QC and PHPIP Committee meetings in July identified a number of adjustments needed to ensure the workplans fully reflected terms of reference and that there was an appropriate inclusion of items that would demonstrate the progress with the delivery of the Plans. This will be repeated in August's meetings of the FDE and POD Committees.	Open
Bpu 26/05/32	**Any risks that the Board wishes the Risk Management Group to consider** In relation to the staff survey results, Mr Lewis advised that a review would be undertaken to identify any emerging risks that were not currently captured on the risk register, and to ensure these were considered by the Risk Management Group as appropriate.	PG	**July 2026:** Four areas (Speaking Up, discrimination, learning from incidents and retention) were identified and their respective inclusion in the risk register is being reviewed (discrimination and learning from incidents) or will be considered for inclusion and reflect (mitigation) work already underway.	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:	22 July 2026		
Attendees:	Dr Richard Falk, Richard Chillery, Maria Clark, Dr Judith Graham, Hannah Hall, Dr Rumit Shah, Steve Forsyth, Dr Diarmid Sinclair, Dave Vallance; with Philip Gowland		
Matters of concern or key risks to escalate to the Board:	Continued recognition of service pressure in Rotherham, which are being managed, but it is worth the Board being sighted on.		
Key points of discussion relevant to the Board:	**Chief Nurse Triangulation: Experience, Safety and Effectiveness** April and May 2026 data indicate a stable patient safety position. Most reported incidents resulted in no harm or minor harm. Patient feedback remains mainly positive, with recurring themes relating to communication, access to services and waiting times. The Committee noted continued focus is required on workforce resilience, violence and aggression, racism related incidents, pressure ulcer prevention, and timely completion of governance actions. **Mortality Report: March and April 2026** There were 74 deaths reported across the Trust in March and April 2026. No significant mortality trends or concerns were identified. Most reviewed cases identified no problems in care with a small number required further investigation, structured judgement review or learning discussion. The Committee noted learning from coronial activity, Prevention of Future Deaths notices and suicide prevention work. Mortality surveillance provides assurance that no emerging Trust-wide concerns have been identified. **Committee Workplan** The Committee reviewed the workplan approved by the Board of Directors in May 2026. The workplan aligns with the Committee terms of reference and provides appropriate coverage of its responsibilities for 2026/27. The Committee confirmed the workplan has sufficient clarity, sequencing and forward planning to support delivery including execution of the Quality and Safety Plan (Not discussed in the meeting, but this will be explored during Q2 in light of the new National Quality Strategy issued by NHSE).		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Committee Chair	Kathy Gillatt, Non Executive Director		
Lead Executive	Philip Gowland, Director of Corporate Assurance		
Date of meeting:	3 June 2026		
Attendees:	Kathy Gillatt, Dr Richard Falk, Pauline Vickers; with Laura Brookshaw, Steve Forsyth, Philip Gowland, Simon Sheppard, Matt Trehearne-Clarke, Phil Mason, Cheryl Rollinson.		
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** The Committee reviewed a positive report, noting strong assurance ratings and increased counter fraud activity. It was highlighted that an increase in referrals reflected improved awareness and reporting culture rather than deterioration in controls. Discussion focused on the robustness of self assessment and the need for continued objectivity and external challenge. Benchmarking was also considered, with recognition that comparisons should account for organisational size to improve interpretation. . **Internal Audit Progress Report** The report indicated steady progress against the internal audit plan and confirmed that work was aligned to strategic risks. Two audits completed since the previous report had provided significant assurance, while safer staffing had received moderate assurance. Some audit work remained outstanding close to year end, with reliance on timely engagement from management to complete this work – none of this was expected to materially affect the final Head of Internal Audit opinion. Progress against audit recommendations was reviewed, with most actions progressing as expected. It was noted that some actions were substantively complete but remained open due to dependencies on system developments. The Committee emphasised the need for accurate tracking and clear timelines, while supporting a pragmatic approach to closure where underlying work had been completed. **External Audit Progress Update and Annual Accounts** The Committee noted that external audit activity was progressing well and remained on track for completion. Minor delays were identified in relation to external inputs and data quality, though these were not expected to impact delivery. A significant change in asset valuation was discussed, with assurance provided that this had been subject to specialist review and did not present a material risk. Overall, the Committee received assurance that audit progress remained positive with no significant concerns. The Committee noted that key financial reports had been completed, independently reviewed, and expected to receive a clean opinion, with timelines significantly improved compared to previous years. The Committee acknowledged strong progress and emphasised the importance of maintaining quality through finalisation and public reporting.		

	Risk Management Framework Update The Committee noted improvements in risk management processes, including enhanced analysis and greater focus on priority areas. Discussion highlighted the need for clearer reporting on the expected trajectory and timescales for reducing risks outside tolerance. It was also identified that current reporting could obscure individual high risks and would benefit from stronger thematic analysis to support preventative action. Further development was required to strengthen reporting, improve visibility, and support more proactive risk management. **Standing Financial Instructions Quarter 4 Report Summary** The Committee reviewed financial controls and noted low levels of losses and appropriate use of corporate processes. Discussion focused on the use of procurement waivers, with recognition that while often justified by operational factors, reliance on waivers could limit value for money. Bad debt write offs were also considered, with assurance required that these remained controlled.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Mental Health Act Committee	**Agenda Item**	Paper F
Committee Chair	Maria Clark, Non Executive Director		
Lead Executive	Dr Andy Heighton, Chief Medical Officer (deputising for Dr Diarmid Sinclair)		
Date of meeting:	17 June 2026		
Attendees:	Maria Clark, Dr Richard Falk, Dr Jude Graham, Dr Andy Heighton; with Carlene Holden and Tim Shaw		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**Trust Hospital Managers Report** Trust Associate Hospital Managers remained compliant with training requirements and delivered 22 hearings during quarter 4. Two recommendations were made in North Lincolnshire regarding medication side effects, nearest relative arrangements and future placement planning. Delays to annual and 3 yearly reviews had occurred because of a vacancy in the Mental Health Act Manager role, however, this work was being prioritised. Training requirements had been reviewed and support was being provided to ensure compliance. **MHA Training and RRI Training Compliance Data Analysis** Mental Health Act Level 1 compliance was 99.29% and Level 2 compliance improved to 96.15%. Mental Health Act in Practice Level 3 reached 86.40% and Reducing Restrictive Interventions reached 79.91%, both remaining below target despite additional training and monitoring measures **MHA Compliance Report March and April 2026** There were 304 detentions processed during March and April 2026. Three detentions were found to be unlawful following documentation errors and failures in scrutiny processes. Twenty detention records required amendments, mainly due to minor administrative issues. Medical and matron scrutiny compliance was 100%. Consent to treatment on admission remained strongest in Doncaster at 93%, while Rotherham achieved 76%. Section 132 rights compliance was 80% in Rotherham, 90% in Doncaster and 91% in North Lincolnshire. Work continued to improve recording, data quality and staff understanding. **MHA Performance Report March and April 2026** There were 304 detention episodes involving 275 people, with Doncaster recording the highest. Eighty two Section 136 assessments were completed within timescales. No under 18 admissions occurred within the trust adult inpatient services, although 1 admission to an acute general hospital bed was recorded. Six Mental Health Act incidents were reported, including 2 unlawful detentions. No medication incidents occurred. Seclusion review compliance improved to 94% and Community Treatment Order requirements were fully met. They were 2 absent without leave incidents in March and April 2026. Work continues on policy reviews, length of stay analysis and appeals monitoring.		

	CQC MHA Inspections Highlight Report No Care Quality Commission Mental Health Act inspections took place during March and April 2026. Outstanding actions remained from earlier inspections, with recurring themes relating to the environment, risk assessments, care planning, advocacy, activities and communication with families

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, Executive Director of People and Organisational Development		
Date of meeting:	17 June 2026		
Attendees:	Sarah Fulton Tindall, Steve Forsyth, Dr Jude Graham, Carlene Holden, Ian Spowart, Dave Vallance, Pauline Vickers; with Dr Babur Yusufi and Lisa Earnshaw.		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	Workforce capacity, staff wellbeing, learning culture and resident doctor workload pressures remain areas of ongoing focus and oversight for the Committee; other key points of relevance are: . **Integrated Performance and Quality Report and top ten measures** The Committee reviewed ongoing workforce pressures, including vacancies remaining around 6%, alongside turnover and sickness absence challenges. Short-term sickness absence continues to show an upward trend, with stress and anxiety identified as a key contributing factor. Members noted the time required to realise improvements, given recruitment lead times, notice periods and organisational change activity. Turnover benchmarking indicates the Trust has moved from the lowest to the second quartile regionally, reflecting wider increases in staff movement across NHS organisations and the impact of the change management, where higher turnover was anticipated. The reduction in the Trust's gender pay gap from 11% to 2% was welcomed. Members discussed the need to better understand the factors influencing the remaining gap, including workforce demographics and working patterns, to support further improvement. The Committee also challenged whether current reporting sufficiently demonstrates the impact of People and Teams Plan priorities and requested greater emphasis on outcomes and organisational benefit. **Education and Learning plan** Progress continues against the Learning and Education Plan, including strong apprenticeship performance, with 209 apprentices currently in post and a further 41 awaiting commencement. Apprenticeship levy utilisation continues to exceed expectations and supports workforce sustainability and future skills development. Members highlighted the ongoing challenge of maintaining access to learning during periods of operational pressure, particularly within inpatient and 24-hour services. Discussion focused on learning as a patient safety and quality improvement issue, with recognition that training and development activity can be deprioritised when workforce pressures increase, potentially limiting opportunities for staff development, service improvement and organisational learning. The Committee supported further work to strengthen protected learning time, improve training attendance and increase accountability for learning across services.		

	Work Experience Engagement Update The Committee supported the introduction of a cohort-based work experience model designed to improve equitable access to NHS careers and strengthen future workforce pipelines. Members particularly welcomed the focus on widening participation through engagement with young carers, care leavers and individuals without existing links to healthcare professions, recognising the contribution this could make to future recruitment and social mobility. **Guardian of Safe Working Hours Report** The Committee noted continued resident doctor workload pressures, with 114 exception reports submitted during the reporting period, more than double the previous reporting cycle. Members noted workforce gaps, cross-cover arrangements and work extending beyond scheduled shifts as factors contributing to workload pressures. There are currently 56 doctors in training, with 7 vacant training posts. Whilst no significant patient safety concerns were identified, the Committee discussed the sustainability of current arrangements and opportunities to reduce avoidable workload pressures through workforce redesign, multidisciplinary approaches and service improvement initiatives. Four contractual breaches resulting in fines were reported during the period. Workforce gaps and workload pressures continued to be discussed as contributory factors to resident doctor exception reporting.

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:	22 July 2026		
Attendees:	Jo Cox, Dr Richard Falk, Carlene Holden, Toby Lewis, Jo McDonough, Dr Rumit Shah, Dr Diarmid Sinclair, Dave Vallance; with Phil Gowland (Flourish and SDR) and Steve Forsyth (Volunteers)		
Matters of concern or key risks to escalate to the Board:	None		
Key points of discussion relevant to the Board:	**Promises 15 and 21 Integrated Neighbourhood Teams, Primary Care and Hyperlocal** Neighbourhood working continued to develop across all 3 places but progress is lumpy and contested. A 6 and an 18-month Trust programme of work was established. Defining neighbourhood working and what it means for us is challenging and we are committed to reflecting the needs of our communities, not simply followed the NNHIP programme. **Promise 28 Research and Innovation Plan Progress Report** Research activity exceeded target, with 927 participants recruited into studies already. Progress was being made in dementia research, workforce development and research partnerships. The committee asked, for a second time, to have the reporting format clarified to distinguish: research volumes, the research Super Six and innovation. A timescale for this was confirmed. **Promise 3 Volunteers** Volunteer numbers increased to 357 active volunteers. Good progress was made, but volunteer support remained uneven across services. Work continued to strengthen recruitment, training and retention, with an ambition to maintain more than 400 active volunteers. **Promise 10 Inclusion Health** The paper proposed a 'top left' rating on the new Board 'assurance' model. Progress was made in supporting inclusion health groups through targeted services for people experiencing homelessness, prison populations, sex workers and Gypsy Roma Traveller communities. Further work was needed to improve access to mainstream services and strengthen delivery arrangements. **Health Inequalities Data Report** Limited improvement was seen in health inequalities measures. Differences in access and outcomes by ethnicity and gender remained, and further work was planned to improve data quality and reduce inequalities. **Flourish Enterprise Report from Shareholder Representative** Flourish reported positive service developments and regulatory outcomes, although financial pressures remained. Actions were underway to improve performance and support future growth. **Partnerships Scorecard**		

	A new partnership scorecard framework was introduced to assess partnership effectiveness, strategic alignment, engagement, innovation and outcomes. The framework was intended to strengthen oversight and identify areas for improvement. The matter will be discussed further at the Board timeout in August. **Strategic Delivery Risks Update** Key risks remained linked to partnership working, health inequalities, neighbourhood development and organisational change. Reporting arrangements were strengthened to improve oversight and assurance. **Risk Register Related High Risks Scoring 12 and Above** One high risk remained relating to local eating disorder bed provision. Mitigating actions were in place to maintain service capacity and reduce the risk. A new risk has been added relating to not meeting the success measures under Strategic Objective 2 and reducing health inequalities.

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:	17 June 2026		
Attendees:	Pauline Vickers, Rachael Blake, Carlene Holden, Simon Sheppard, Sarah Fulton Tindall, David Smith, Ian Spowart; with Philip Gowland and Shabir Pandor		
Matters of concern or key risks to escalate to the Board:	None at the meeting. (At the time, discussions with commissioners regarding contract agreement / signature were ongoing; subsequently they have not progressed to agreement and hence this matter is raised to Board.)		
Key points of discussion relevant to the Board:	**Estate Enabling Plan** Progress on the estate plan focused on governance, engagement and preparation for Board approval in July 2026. An energy study identified ground source heat pumps using ambient loop as the preferred solution for Tickhill Road, reducing emissions by 1,237 tonnes each year and supporting long term efficiency despite higher capital cost. **Health and Safety Act Compliance Air Quality Legionella Fire Safety** An improving position in estates compliance was reported, with continued progress in fire safety and further work planned for quarter 2 of 2026. A new authorising engineer had been appointed for low voltage safety, additional authorised persons were being put in place, and a 2 day compliance review had been completed. Fire damper surveys had been completed and asset data had been uploaded to the helpdesk system to support ongoing compliance. **Information Governance** Compliance remained strong with data security toolkit submission due by 30 June 2026 following a positive audit. Between January and March 2026, 148 incidents were reported with no cases escalated externally, indicating effective management. **Information Quality Work Programme** Overall assurance was high, with most indicators achieving strong data quality results. One indicator showed moderate assurance and improvement actions were agreed for completion by July 2026. **Performance against the finance domain of the integrated quality and performance report** Month 1 of 2026 to 2027 reported a deficit of £41k which was £21k better than plan, with all directorates on plan. Pay underspend and reduced workforce costs were noted, with financial risks including staffing, energy and HDRU activity. **Medium Term Financial Plan including underlying position** The Trust exited 2025/26 with an underlying deficit of £6.3m. This has been reduced to £3.8m in Q1 and forecast to be at breakeven by the end of the financial year.		

	Trust Procurement Development The proposed procurement collaboration aimed to improve resilience and efficiency. Progress had been delayed, with consultation expected to begin from August 2026 with revised timelines in place.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Trust People Council	**Agenda Item**	Paper J
Committee Chair	Dave Vallance, Non Executive Director		
Lead Executive	Carlene Holden Director of People and Organisational Development		
Date of meeting:	15 July 2026		
Attendees:	Dave Vallance, Dr Navjot Ahluwalia, Amanda Ambler, Atique Arif, Glyn Butcher, Prachi Goulding, Cheryl Gowland, Carlene Holden, Iona Johnson, James Hatfield, Kath Lavery, Toby Lewis, Tinashe Mahaso, Vikki Mitchell, Dr Simon Mullins, Susan Statter and Dr Babur Yusufi.		
Matters of concern or key risks to escalate to the Board:	No notified safety concerns (see first segment) have been shared since the meeting but dialogue with the BMA continues: members will be briefed through the chief executive should any concerns come forward in advance of October's meeting.		
Key points of discussion relevant to the Board:	**Medical staff perspectives** Under matters arising there was a discussion about feelings among some medical colleagues. This largely reflected Board conversations from spring 2025: and was framed in the context of the staff survey (which TPC had discussed in detail in April). The LNC cochair raised patient safety concerns and was provided with immediate and post meeting advice about how those could be scrutinised and addressed. The GSWH noted that resident doctor reporting had not identified immediate safety concerns but was consistent with pressure and strain. Reflecting on the medical dominance of the item, some members voiced the need to find a balance between professional identity and an overall culture in a multiprofessional organisation. **Estate plan** A well received presentation briefed attendees on the estate plan and especially on the at scale engagement from employees in the work, both through roadshows and the survey work. Key themes have focused on team identity, agile spaces, amenities including parking, and dissatisfaction with the current buildings in many cases. **Cultural reset** The meeting explored emerging themes in the cultural reset work, with a stress on coproduction during August and September. The conversation highlighted work on getting the basics right, distributed leadership, high care/high accountability. The importance of staff engagement, tackling antiracism, effective line management, health and wellbeing and flexible working was recognised alongside the need to better understand, and address staff experience to support the development of the Trust's future culture. Colleagues reflected on the language used and how this may include or exclude others – some members noted the seriousness with which the issues faced were being addressed 'by the board'. **Newly launched NHS staff standards** These minimum standards were considered in the context of the wider cultural work. The standards covered six areas which were line management, health and wellbeing, violence prevention and reduction, sexual safety, tackling racism and flexible working. The importance of visible leadership, staff engagement and consistent implementation was recognised to support implementation. Some members noted that if		

	these standards were already embedded then given morale and wellbeing issues they do not go far enough.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated Quality and Performance Report (IQPR)	**Agenda Item**	Paper K
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	30 July 2026

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

June performance remains broadly stable. The Trust is on plan financially, with a year-to-date surplus and forecast breakeven. Recruitment is improving and vacancies are beginning to reduce, although exit numbers have increased compared to 2025.

The main pressures are access, waiting times and inpatient flow. Most services are meeting the internal 4-week access standard, but there is unacceptable variation in Talking Therapies with a deterioration from 25/26 reported positions. Long waits still exist in the 3 neurodiversity waiting lists. Length of stay and S136 breaches remain key areas of concern, particularly in Rotherham.

Patient safety indicators do not show areas of elevated concern, with no reported MRSA infections, gram-negative bloodstream infections or suspected inpatient suicides. Significant improvement is still needed in Learning Disability physical health checks, dementia diagnosis rates for minority ethnic communities, and Perinatal access for people identifying as Black or Black British.

Workforce performance is mixed. Mandatory training and appraisal compliance remain strong, and vacancies are reducing, but sickness absence remains high. The Trust is to be part of a national improvement programme building on the paper presented in May to the Board.

The Trust has a year-to-date surplus of £52k and maintains a breakeven forecast, but there are pressures from temporary staffing, agency and bank costs, agency medical extensions, HDRU income below plan, and overspends in several directorates: delivery reviews will be used to explore these overspends in detail.

Performance against the Promise standards remains mixed, with the most significant concern being urgent 48-hour access, which is only achieving 60.6% against an October compliance aspiration. Health inequalities measures remain below target, and a few Promise metrics are still under development.

We have altered and are altering what we report. New Oversight Framework and Promises measures are improving visibility of quality, outcomes and inequalities. Some measures go live from 1 August 2026, while others internal quality metrices require technical definition before inclusion.

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

Clinical Leadership Executive

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the ongoing length of stay and S136 breach pressures.

CONSIDER the workforce risks to 4-week waits, safer staffing and clinical delivery.

DISCUSS the financial position and the underlying vacancy-related overspends.

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
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 (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
Strategic Delivery Risks (indicate those that this paper supports)			
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 A - NOF Metrics

Board Briefing Paper

Transition from IQPR 2025/26 Methodology (Top 9 Metrics) to 26/27 methodology and alignment with National Oversight Framework (NOF)

Purpose

This paper is an addendum to the July 2026/27 IQPR. It sets out the planned move away from the previous “Top 9” metrics towards a broader set of measures aligned with the NHS Oversight Framework (NOF) for 2026/27. This change has been signalled previously to the Board. The Trust has only recently received the technical guidance from NHS England for the revised 2026/27 NOF.

The revised IQPR will also include a wider set of measures linked to the delivery of some of the 28 RDaSH Promises, the Trust’s three-year planning metrics and strengthened people indicators. There will be a greater focus on quality. For example, the four-week wait will be presented as a quality indicator because it is about improving patient care, rather than simply meeting a performance target.

This change is intended to strengthen Board oversight and support a clearer “golden thread” between national expectations, Trust priorities and the way performance is reviewed through the IQPR.

Background

The Trust’s Top 9 metrics have provided focused oversight of operational performance during 2025/26. They have helped maintain focus on several key priorities, including Children and Young People’s access, Talking Therapies outcomes, Out of Area Placements, Dementia Diagnosis and Perinatal Services. Monthly Performance Clinics have provided additional scrutiny and accountability for delivery.

The Top 9 model has been helpful, but it was developed before the refreshed NHS Oversight Framework for 2026/27 was published. The NOF now sets out the measures that will be used nationally to assess provider performance, compare organisations with similar providers and determine the level of regional oversight required. It brings together measures covering access, quality, patient experience, effectiveness, patient safety, productivity, finance and workforce.

The Trust has reviewed its IQPR measures over recent months and developed a revised framework. This brings together NOF metrics, national planning requirements, refreshed quality measures, existing local measures and a section to provide assurance on delivery of several Promise measures. Some indicators previously shown in the Operational Performance section of the IQPR have now been moved into the Quality domain. This is deliberate. It helps reinforce that priorities such as reducing out of area placements are about improving the quality and continuity of care for patients, rather than simply reporting against a performance KPI.

The table below shows the number of metrics in each section of the revised framework.

Segment	Total Number of Metrics
National Oversight Framework	39
Quality	52

People and Organisational Development	6
Finance	4
Promises	31
Total Metrics	132

The NOF includes several mental health and community indicators that better reflect current NHS priorities. These include:

- Children and Young People's mental health waits over 104 weeks.
- Community mental health outcome measures.
- Mental health crisis response within 24 hours.
- Adult mental health inpatient follow up within 72 hours.
- Mental health 14-day readmission rates.
- Length of stay in adult and older adult mental health services.
- Community waiting time standards.
- Service user experience measures.
- Workforce, productivity and data quality indicators.
- Financial delivery.

A full breakdown of the NOF metrics is included in Appendix A. Some metrics are being considered nationally for oversight but do not contribute to the overall organisational score. These are clearly marked and will still be included in the new IQPR so that they remain visible and receive appropriate focus.

The metrics are also linked to the national ambition to deliver the three shifts set out in the NHS 10-Year Health Plan: hospital to community, analogue to digital and sickness to prevention. The revised framework will help the Board oversee the measures by which RDaSH is increasingly likely to be judged externally, while also strengthening the link between local governance and national assurance.

The NOF metrics provide assurance against national priorities and oversight arrangements. However, they do not fully capture the commitments the Trust has made directly to patients, carers and local communities.

The Promise and revised Quality metrics have therefore been included so that the Board continues to see where the Trust has made specific commitments to improve care and experience. They add a patient-centred view alongside the national measures and support the Trust's ambition to improve access, responsiveness and outcomes.

Some of these measures are not contained within the NOF however, remain important indicators of whether patients are receiving support in a timely way. They also provide a direct measure of progress against the Trust's strategic commitments, including reducing waiting times and improving access across services.

Keeping the Promise and Quality metrics alongside the NOF measures creates a more balanced framework. It enables the Board to monitor both nationally mandated priorities and locally agreed commitments, so that oversight remains focused on what matters to regulators, commissioners, patients and communities. We will not be moving away from the Board's pecking order, so NOF measures remain a 3, with promises at 2 and immediate safety at 1.

A review of all measures has been undertaken to minimise duplication across the framework. Where metrics contribute to more than one domain, they will be reported once. This will ensure Board reporting remains focused and proportionate.

The revised framework will be implemented from Quarter 2 2026/27. A number of metrics are already in place, having transferred from the 2025/26 framework or been developed during Quarter 1 where national definitions were available. Where metrics remain under development or require further definition, placeholders have been included to provide visibility of forthcoming requirements. All remaining measures are expected to be finalised by the end of July 2026, at which point the full framework will be operational.

Services will be supported through guidance, metric definitions and ongoing engagement via existing management processes to promote consistent interpretation and understanding of the framework. The narrative for the changes will be key, particularly the shift from performance to a deeper focus on quality & safety. In effect the construct of performance is being retired and the word targets deprecated: we have a series of quality gains we are working to achieve including those within our Promises.

The framework has been designed to be adaptable although the technical changes can be complex and take time. Should the NHS Oversight Framework change in 2027/28, the Trust will undertake a structured review to maintain alignment with national requirements while retaining visibility of locally important priorities, including Quality and Promise measures. However, constantly changing metrices can impede analysis within services and organisations.

Conclusion

The move from the Top 9 metrics to a NOF-aligned framework will ensure Board reporting reflects the measures used nationally to assess mental health and community providers. It will provide stronger oversight of access, quality, outcomes, patient safety, workforce and productivity, while improving alignment with NHS planning and regulatory requirements. The inclusion of the Promise measures and revised Quality metrics ensures the Board continues to monitor the Trust's commitments to patients, including timely access to care and a stronger focus on quality and safety. Taken together, the full set of metrics provides a balanced framework that supports both national accountability and local priorities. The framework will need to be kept under review, particularly as the NOF may change again for 2027/28.

Appendix A

NOF Metrics

National /Local	NOF segment	NOF Metric	NOF Metric	Metric
NOF Metric for Trusts with inhouse tobacco treatment service	Domain 1 Preventing ill health	✓	✓	Percentage of inpatients referred to and seen by an in-house tobacco treatment services who make a supported attempt to stop smoking (Rolling 12 month)
NOF Metric Commnity National Planning Metric	Domain 2B - Access to Services	✓	✓	The % Number of Commnunity CYP waiting 18 weeks or less
NOF Metric Commnity National Planning Metric	Domain 2B - Access to Services	✓		The % Number of Ccommunity Adults waiting 18 weeks or less
NOF Metric Commnity National Planning Metric	Domain 2B - Access to Services	✓	✓	Percentage of cases where a CYP is waiting more than 52 weeks for community treatment
NOF Metric Commnity National Planning Metric	Domain 2B - Access to Services	✓		The Number of Ccommunity Adults waiting over 52 weeks (excluding ADHD and Autism Services)
NOF Metric MH Providers & National Planning Metric	Domain 2B - Access to Services	✓	✓	Percentage of open CYP mental health waiting time periods for patients that had waited over 104 weeks from waiting period start date. (Excluding waiting times only for neurodevelopmental conditions, autism, or gender discomfort issues.)
NOF Metric MH Providers	Domain 2B - Access to Services	✓	✓	Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)
NOF Metric MH Providers	Domain 3 Experience of Care	✓	✓	CQC community mental health suvey satisfaction rate
NOF Metric all Providers	Domain 3 Experience of Care	✓	✓	NHS staff survey advocacy rate
NOF Metric MH Providers	Domain 3 Experience of Care	✓	✓	Mean length of stay for adult acute and PICU patients
NOF Metric MH Providers	Domain 3 Experience of Care	✓	✓	Mean length of stay for older adult acute discharges
NOF Metric MH Providers	Domain 3 Experience of Care	✓	✓	Percentage of patients readmitted within 30 days of discharge – comparative band
NOF Metric MH Providers	Domain 3 Experience of Care	✓	✓	The percentage of discharges from adult acute mental health beds which were readmitted within 14 days of discharge.
NOF Metric CH Providers	Domain 3 Experience of Care	✓	✓	Percentage of intermediate care beds occupied by patients without criteria to reside
NOF Metric MH Providers National Planning Metric 5 A 4 a	Domain 4 Effectiveness of Care	✓	✓	NHS Talking Therapies for anxiety and depression - Reliable Recovery rate for those completing a course of treatment %
NOF Metric MH Providers NHS Standard Contract - SC National Quality Requirement	Domain 4 Effectiveness of Care	✓	✓	The percentage of discharges from adult mental health, learning disability and autism settings which receive a follow-up within 72 hours after discharge.
NOF Metric MH Providers	Domain 4 Effectiveness of Care	✓	✓	% of acute mental health admissions with no contact with community mental health services in the previous year
NOF Metric All Trusts	Domain 5 Patient Safety	✓	✓	The percentage of urgent/serious referrals to mental health crisis teams receiving their first face-to-face contact within 24 hours.
NOF Metric All Trusts	Domain 5 Patient Safety	✓	✓	NHS staff survey raising concerns sub-score
NOF Metric All Trusts	Domain 6 Finance, productivity and innovation	✓	✓	Planned surplus or deficit
NOF Metric All Trusts	Domain 6 Finance, productivity and innovation	✓	✓	Variance to plan year-to-date
NOF Metric All Trusts	Domain 6 Finance, productivity and innovation	✓	✓	Relative cost difference (National Cost Collection Index)
NOF Metric All Trusts	Domain 6 Finance, productivity and innovation	✓	✓	Percentage of clinical trials set up within 90 days
NOF Metric All Trusts	Domain 6 Finance, productivity and innovation	✓	✓	Data Quality Maturity Index
NOF Metric All Trusts	Domain 7 People	✓	✓	The percentage of working days in the previous quarter where staff are sick and unable to work
NOF Metric All Trusts	Domain 7 People	✓	✓	NHS Staff Survey engagement theme score
NOF Metric All Trusts	Domain 7 People	✓	✓	National education and training survey satisfaction rates
NOF Metric All Trusts	Domain 7 People	✓	✓	NHS staff standards score
NOF Metric All Trusts	Domain 7 People	✓	✓	Healthcare worker flu vaccination rate
NOF Metric All Trusts	Domain 7 People	✓	✓	Temporary staffing cost as a % of total pay bill
NOF Metric Providers with inpatient services	Domain 3 Experience of Care	✓		CQC inpatient survey satisfaction rate
NOF Metric All Trusts	Domain 5 Patient Safety	✓		The number of restrictive intervention (by individual type) 1,000 occupied bed days in the period.
NOF Metric All Trusts	Domain 5 Patient Safety	✓		Number of cases of MRSA in the last 12 months
NOF Metric All Trusts	Domain 5 Patient Safety	✓		Rate of e-coli
NOF Metric All Trusts	Domain 5 Patient Safety	✓		Rate of c-difficile
NOF Metric All Trusts with inpatient services	Domain 5 Patient Safety	✓		Percentage of inpatients who suffer a new hip fracture while an inpatient
NOF Metric All Trusts with inpatient services	Domain 5 Patient Safety	✓		Percentage of hospital spells (acute) or community caseload (community) with a new grade 3 or 4 pressure ulcer
NOF Metric All Trusts	Domain 5 Patient Safety	✓		Percentage of all patient safety incidents defined as resulting in low, moderate, severe or fatal harm
NOF Metric All Trusts	and innovation	✓		Rate of Implied productivity growth
NOF Metric ICB	Domain 4 Effectiveness of Care			% of patients on GP learning disability registers to receive a full physical health check in the last 12 months
NOF Metric ICB	Domain 4 Effectiveness of Care			% of patients on GP severe mental illness registers to receive a full physical health check in the last 12 months

Integrated Quality Performance Report

June 2026 Review

Data as at the 30th June 2026

Contents

Executive Report

Introduction: Transition to the New Integrated Quality Performance Framework
Please refer to the two-page briefing paper provided for an overview of the changes made to the IQPR. Performance across the four quadrants remains broadly positive, with noted delivery in workforce, safety and financial performance, offset by ongoing challenges in access, waiting times and workforce capacity.

Quality
The Quality quadrant remains mixed. Talking Therapies access (OP03a) is below trajectory, with 4,189 year-to-date accesses against a target of 5,414, although service outcomes remain positive and improvements are underway through expanded long-term condition pathways, support for older adults and physical activity programmes. Learning Disability annual physical health checks remain below target at 81.74% against a 95% standard and continue to be monitored through the monthly Performance Clinic. IPS employment support is also below plan, with 95 people accessing support against a target of 120, although additional Employment Specialists and commissioner investment are expected to improve delivery.

Children and Young People's services continue to perform strongly, with CAMHS access remaining significantly above target. The new 104-week wait measure (OP86) continues to be influenced negatively by NHS England methodology, which records referral spells rather than actual patient waits and can therefore overstate waiting times where patients transfer between services. Internally we are likely to be sub 104 weeks in the next week or so. Several new Oversight Framework measures, including OP100/101, OP19, OP89, OP93 and OP96-99, remain under development and are due to commence reporting from August 2026. Patient safety indicators remain positive. There were no MRSA infections, gram-negative bloodstream infections or suspected inpatient suicides during the period. Compliance with seclusion MDT reviews remains at 100%, MUST assessment completion has improved and racist incidents reduced from 37 to 21 in June. Areas requiring improvement include VTE compliance, physical health checks and some inpatient assessment measures.

People
Performance across the People quadrant remains strong, with PDR completion at 94.27% and mandatory and statutory training compliance maintained at approximately 96%.
The principal workforce challenge remains sickness absence, which has increased to 7.04% against a target of 5.1%. In response, quarterly long-term sickness review clinics, enhanced management oversight and targeted HR support have been implemented. Recruitment performance remains positive, with 103 vacancies filled between March and May and an average time to hire of 39 working days, outperforming the NHS England target. Vacancy levels have reduced from 283 to 221 posts, although at 5.96% they remain above the Trust target. Retention remains slightly above target at 11.13%, with registered nurses and healthcare support workers continuing to present the most significant recruitment and retention challenges.

Finance
The Trust continues to deliver its financial plan, reporting a £52k year-to-date surplus at Month 3 and maintaining a forecast breakeven position for 2026/27.
Overall financial performance remains stable, supported by strong financial controls and delivery of planned savings. Key variances include a £2.7m substantive pay underspend, offset in part by agency and bank overspends, lower-than-planned HDRU income and temporary staffing pressures within some services. Capital expenditure is currently £2.4m behind plan but remains consistent with expected expenditure phasing and does not present a significant risk to delivery of the annual programme. Most directorates continue to forecast favourable positions despite a small number of localised pressures.

Promises
The Promises quadrant continues to mature, providing greater focus on delivery of the commitments made to patients, carers and communities. Promise 14 remains the most established area of reporting, with four-week access compliance at 77.11% and 64 of 83 services achieving the standard. Whilst encouraging overall, workforce pressures continue to affect a small number of services, including Children's Services, Podiatry and Community Mental Health pathways. Performance against the urgent 48-hour access standard remains below target at 60.60%, although strengthened oversight through the Waiting List Group and targeted recovery actions are in place. Health inequalities measures continue to highlight areas requiring improvement, including Learning Disability physical health checks, dementia diagnosis rates for minority ethnic communities and access to Perinatal Services by people identifying as Black or Black British. These measures will become increasingly important as the framework develops and reporting matures.

1.0 – Quality - In Focus

Indicators for June 2026/2027 TRUST — Quality

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP03a (L)		People accessing Talking Therapies - Cumulative Annual			1521		4189	>= 5414	4189
OP03c (N)	NOF04a	Reliable recovery rate within Talking Therapies	>= 49%	336/717	46.86%		48.86%		48.86%
OP03d (N)		Reliable Improvement rate within Talking Therapies	>= 68%	516/757	68.16%		69.37%		69.37%
OP07b (L)		Women supported by perinatal MH service (Rolling 12M)	>= 587		677		677		677
OP100 (L)	NOF02c	% CYP waiting more than 52 weeks for community treatment			in development				
OP101 (L)	NOF02d	% cases over 52 weeks (excluding ADHD and Autism Services)			in development				
OP12 (N)	NOF04b	People discharged from MH inpatients followed up in 72 hrs	>= 80%	78/92	84.78%		87.84%		87.84%
OP13a (N)		People accessing CYP services with >= 1 contact (13mth roll)	>= 9424		11949		11949		11949
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		1/1	100.00%		100.00%	>= 95%	100.00%
OP17c (N)		The number of active inappropriate adult acute OAPs	<= 15		0		0		0
OP19 (N)	NOF06e	MHSDS score for data quality maturity index (DQMI)			in development				
OP54c (L)		Virtual ward occupancy - on day 30	>= 80%	58/60	96.67%		96.67%		96.67%
OP61c (N)		Patients with SMI having full annual physical health check		2651/3981	66.59%		66.59%	>= 95%	66.59%
OP78 (L)		Number of people accessing Individual Placement Support	>= 120		95		95		95
OP85 (N)		Attended Community Care Contacts	>= 57610		90924		268216		268216
OP86 (N)	NOF02e	CYP community mental health related waits > 104 weeks	<= 262		2324		2324		2324

Narrative

OP03a – Reporting 4,189 year to date against a target of 5,414. When compared with activity in the same period last year (4,358) we are reporting 169 below last year's actual.

OP100/101 – New metrics remain in development and will be reported from the 1st August 2026

OP19 - New metric remains in development and will be reported from the 1st August 2026

OP61c - Reporting as 66.59% (down from 74.43%) against the 95% target.

OP78 - The metric measuring the number of people accessing individual placement support has remains below the target of 120 individuals reporting 95

OP85 – reporting 268,216 for the YTD

OP86 – The reported position of 2,324 waits over 104 weeks reflects the NHS England measurement methodology rather than the length of time patients are waiting for care.

1.0 – Quality In Focus

Indicators for June 2026/2027 TRUST — Quality

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP87a (N)	NOF03c	Mean length of stay for adult acute and PICU patients	<= 47	8460/214	39.53		43		43
OP87b (N)	NOF03d	Mean length of stay for older adult acute discharges	<= 67	3489/62	56.27		56		56
OP88 (N)	NOF05a	Percent Urgent Referrals seen within 24 Hours	<= 79%	2/8	25.00%		60.00%		60.00%
OP89 (N)		The no of referrals for urgent community response			in development				
OP90 (N)	NOF08i	% LD patients on GP registers receiving PH check last 12m	>= 95%	1070/1309	81.74%		81.46%		81.46%
OP91 (N)	NOF04c	% Acute admissions without community contact previous year	<= 10%	9/218	4.13%		5.08%		5.08%
OP92 (L)		Access to MHST Support in schools and colleges	>= 3214		4588		13635		13635
OP93 (L)	NOF03e	% readmitted within 30 days of discharge – comparative band			in development				
OP94 (L)	NOF03f	% Readmissions within 14 days after adult acute discharge	<= 10%	2/35	5.71%		5.71%		5.71%
OP95 (L)	NOF03g	% intermediate-care beds patients without right to reside	<= 8%	0/100	0.00%				
OP96 (L)	NOF02f	Access MH services with >= 2 contacts & paired outcome score			in development				
OP98 (L)	NOF02a	The % Number of Commnunity CYP waiting 18 weeks or less			in development				
OP99 (L)	NOF02b	The % Number of Community Adults waiting 18 weeks or less			in development				

Narrative

OP89 - New metric remains in development and will be reported from the 1st August 2026

OP90 - % LD patients receiving PH check is reported as 81.74% below the 95% target.

OP93 - New metric remains in development and will be reported from the 1st August 2026

OP96-OP99 - New metric remains in development and will be reported from the 1st August 2026

1.0 – Quality In Focus

Indicators for June 2026/2027 TRUST — Quality

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS05 (N)	NOF08b	Number of MRSA infections (Monthly)	= 0		0		0		0
QS06 (N)	NOF08d	Number of Clostridum difficile infections (Monthly)	= 0		0		0		0
QS07 (N)		Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q1 = 0	0	= 0	0
QS08 (N)		No patients aged >=16 admitted with completed VTE	>= 95%	125/156	80.13%	Q1 >= 95%	82.27%	>= 95%	82.27%
QS09 (N)	NOF7e	Healthcare worker flu vaccination rate							
QS27 (L)		Ligature incidents mod or above all inpatient areas		1/6	16.67%		16.67%	<= 10%	16.67%
QS29 (L)		Number of racist incidents against staff members			21		81	= 0	81
QS31 (L)		Episodes of Seclusion - Internal MDT within 5 hours		6/6	100%		67.74%	= 100%	67.74%
QS36 (N)		Inpatients that have a completed MUST assessment		137/156	87.82%		81.49%	= 100%	81.49%
QS37c (L)		Inpatients commenced falls assessment in 12 hrs		61/65	93.85%		91.63%	= 100%	91.63%
QS56 (L)	NOF03a	CQC community mental health suvey satisfaction rate			1	Q1 <= 2	1		1
QS57 (L)	NOF08c	Rate of e-coli	= 0		0		0		0
QS59 (L)	NOF08e	% Acute-Spells/Community with new grade 3/4 pressure ulcer			6		6		6
QS60 (L)	NOF08f	% Safety incidents low/moderate/severe/fatal harm		5713/10000	57.13%		57.13%		57.13%
QS61 (L)	NOF05b	NHS staff survey raising concerns sub-score			7		7		7
QS62 (L)	NOF06d	Percentage of clinical trials set up within 90 days		4/4	100.00%		100.00%		100.00%
QS63 (L)	NOF08a	Restrictive interventions (by type) per 1K occupied bed days	in development						
QS64 (L)	NOF01a	% inpatients supported attempt to stop smoking (12M rolling)		16/291	5.50%		5.50%		5.50%

Narrative

QS08 – The percentage of VTE assessments completed within 24 hours is reporting below the 95% target at 80.13% (125/156).

QS09 – New metric under development

QS27 – The number of ligature incidents moderate or above in all inpatient areas is above the target of 10% at 16.67% (1/6).

QS29 – Reporting a decline to 21 incidents reported in June from the 37 reported in May.

QS31 – The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting a sustained position of 100% (6/6).

QS36 – Reporting an increase to 87.82% (137/156) from the 80.42% (115/143) reported in May of the % of Inpatients that have a completed MUST assessment.

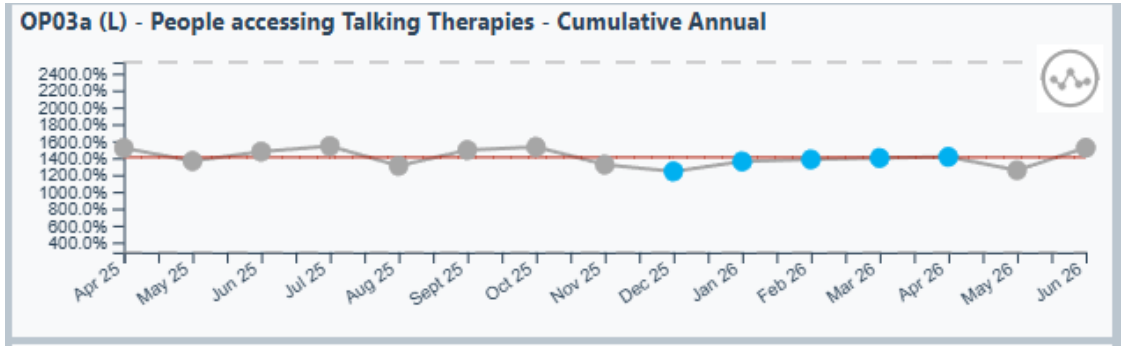
QS37c – This metric is showing a slight decrease to 93.85% (61/65) from the 96.49% (55/57) reported in May of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission.

QS59 - Reporting 6 community new grade 3 or 4 pressure ulcers for the month of June.

QS60 – Reporting 57.13% for the month of June.

QS63 - New metric under development

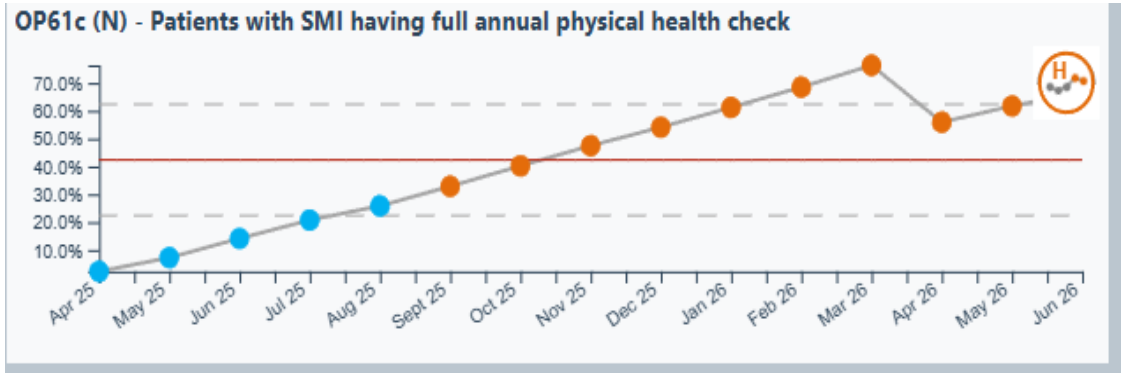
1.1 Quality In Focus - Exceptions



Trend, Reason and Action

OP03a Reporting 4,189 year to date against a target of 5,414. When compared with activity in the same period last year (4,358) we are reporting 169 below last year's actual.

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.

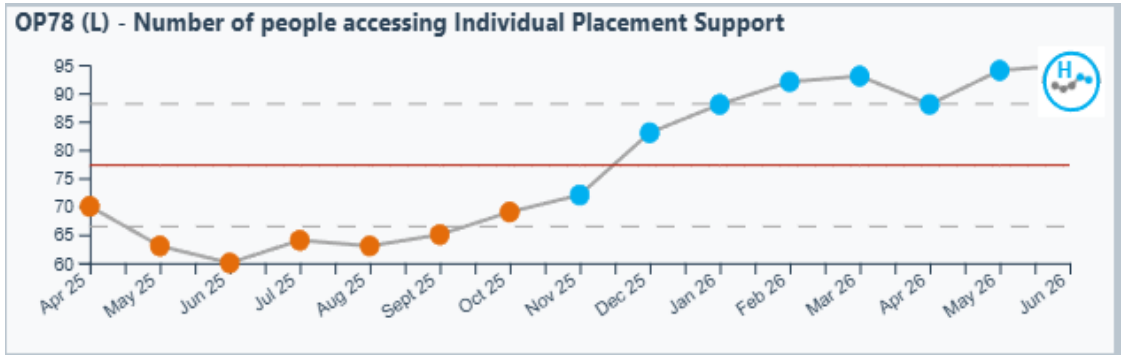


Trend, Reason and Action

OP61C–Reporting as 66.59% (down from 73.36%) 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.

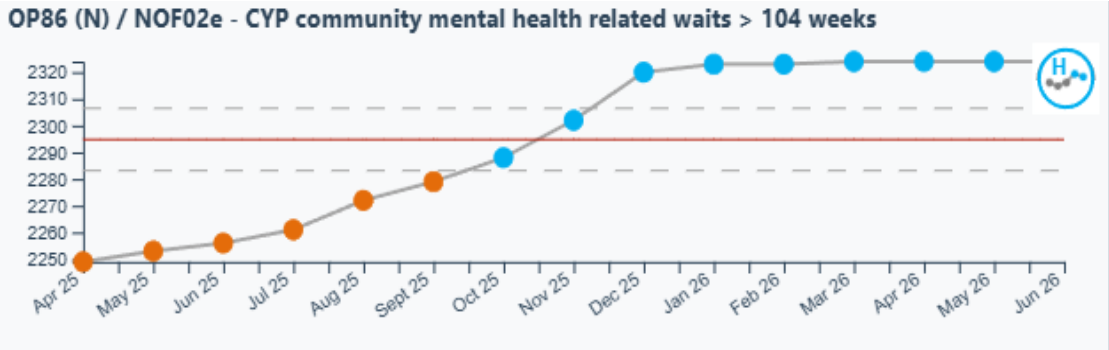
Metric performance to be escalated through the monthly performance clinic to drive improvement and to provide additional oversight.



Trend, Reason and Action

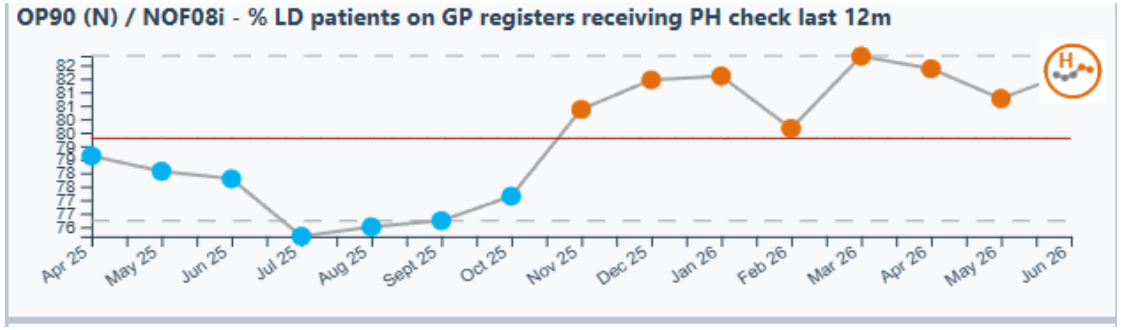
OP78 The metric measuring the number of people accessing individual placement support has remains below the target of 120 individuals reporting 95 .Recruitment has completed with job starts now improving with new Employment Specialists (ES) trained and taking on full caseloads. A new ES has been in post for 2 weeks and a further 0.6 WTE ES will join the team shortly. Team Lead will be full time position shortly. Additional funding has been released by the Commissioner to support expansion.

1.1 Quality In Focus - Exceptions



Trend, Reason and Action

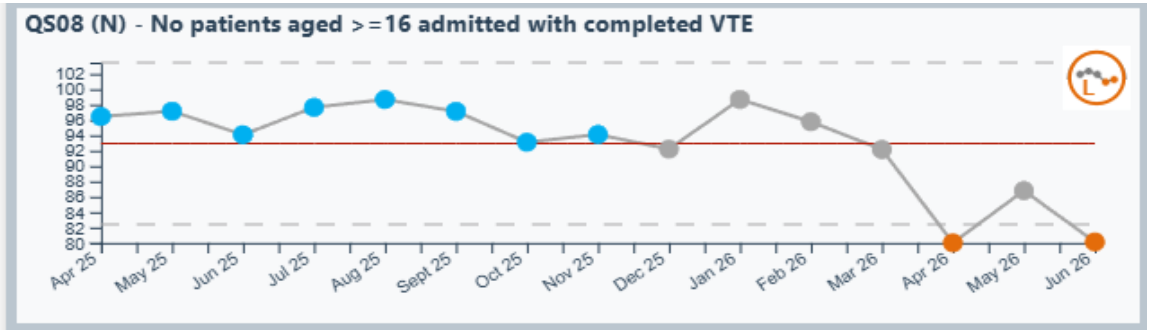
OP86 - The reported position of 2,324 waits over 104 weeks reflects the NHS England measurement methodology rather than solely the length of time patients are waiting for care. The metric is based on referral spells, and the way patient pathways are recorded when individuals transfer between RDaSH services can lead to extended referral durations being reported against this measure, adversely affecting performance.



Trend, Reason and Action

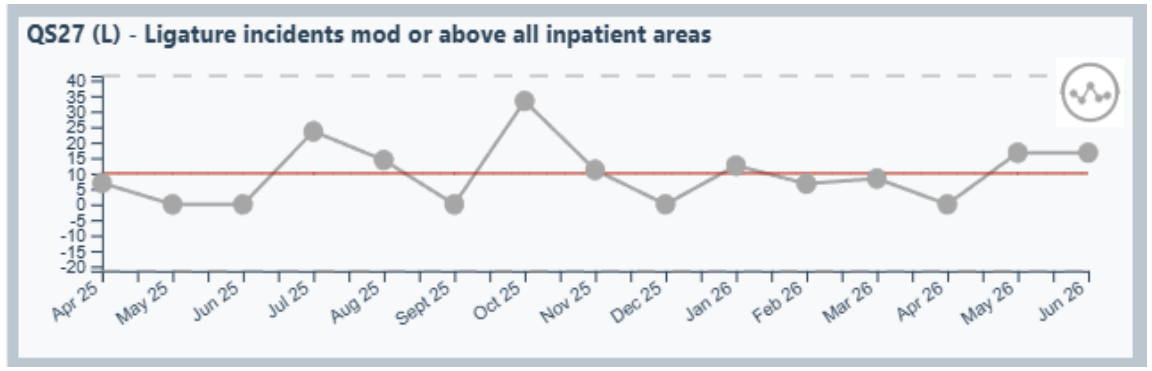
OP90 - Improvement initiatives are in place which include a continuing focus on declines across all 3 Care groups, embedding POC machine blood testing, and support from peer support workers to support access. Metric performance to be escalated through the monthly performance clinic to drive improvement and to provide additional oversight.

1.1 Quality In Focus - Exceptions



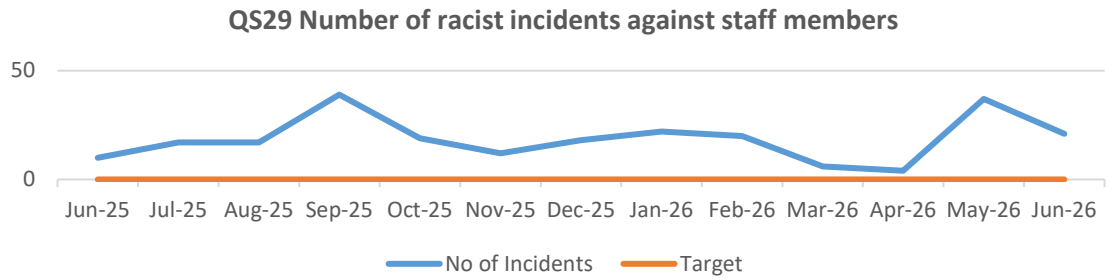
Trend, Reason and Action

QS08- The percentage of VTE assessments completed within 24 hours is reporting below the 95% target at 80.13% (125/156). There continues to be ongoing monitoring in all Care Groups including missed VTE assessments being added to the Radar system during June 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.



Trend, Reason and Action

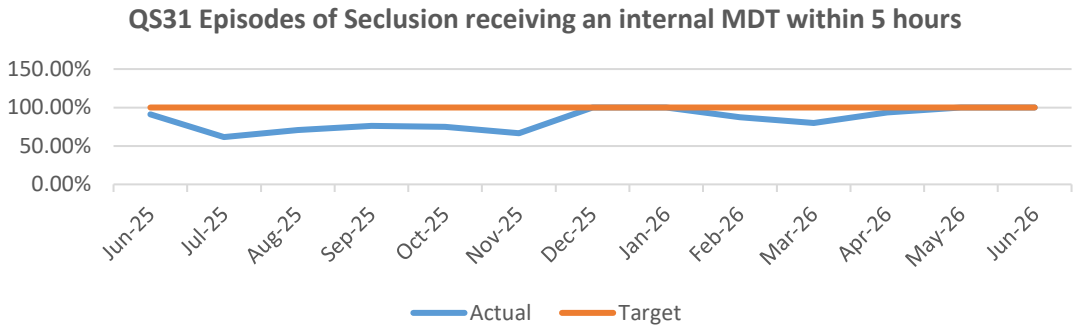
QS27 – The number of ligature incidents moderate or above in all inpatient areas is above the target of 10% at 16.67% (1/6). This is linked to 1 patient in North Lincolnshire where ligatures are a way to manage distress, the incidents have reduced recently and awaiting funding for discharge. Staff support the patient and use a Positive Behaviour Support to manage distress.



Trend, Reason and Action

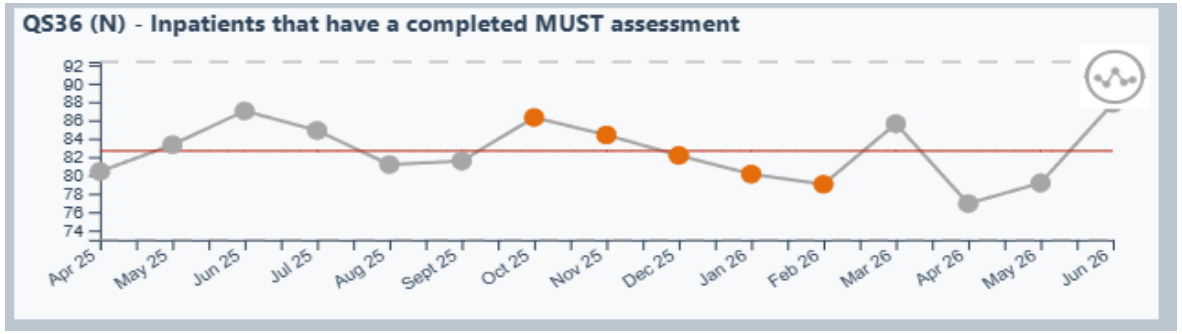
QS29 –Reporting a decline to 21 incidents reported in June from the 37 reported in May. All Care Groups are continuing to follow the acceptable behaviour policy where appropriate and supporting colleagues who experience any form of abuse. Rotherham is implementing the SAFE project to support staff following any discrimination. For 26/27 anti-racism is a focus and reflects staff feedback and Radar learning.

1.1 Quality In Focus - Exceptions



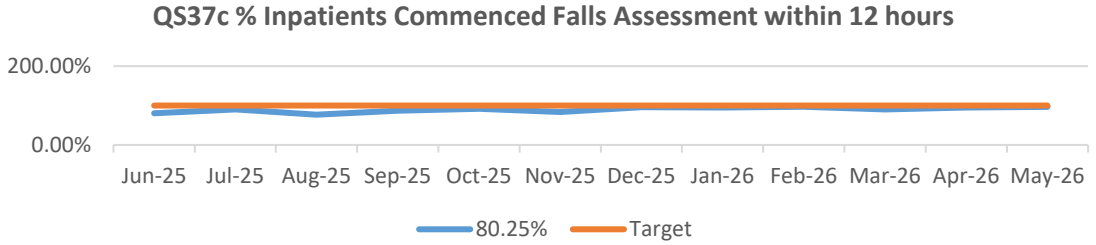
Trend, Reason and Action

QS31 - The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting a sustained position of 100% (6/6). 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.



Trend, Reason and Action

QS36- - Reporting an increase to 87.82% (137/156) from the 80.42% (115/143) reported in May of the % of Inpatients that have a completed MUST assessment. MUST has been included in the admission checklist and is being led with daily oversight by the inpatient ward managers and is discussed in PIPA. There continues to be ongoing monitoring in all Care Groups during July 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



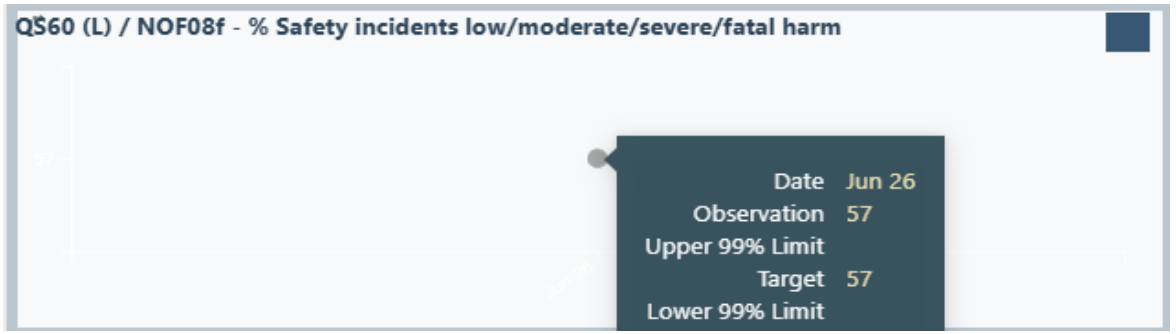
Trend, Reason and Action

QS37C –This metric is showing a slight decrease to 93.85% (61/65) from the 96.49% (55/57) reported in May 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 Hazel, Hawthorn and Laurel wards and all were missed on admission.

1.1 Quality In Focus - Exceptions

Trend, Reason and Action

QS59 – New metric from June 2026 - Reporting 6 community new grade 3 or 4 pressure ulcers for the month of June. The denominator is still in development. **The SPC chart will appear from August when we have two months data for this metric.**



Trend, Reason and Action

QS60- New Metric from June 2026 Reporting 57.13% safety incidents low/moderate severe or fatal harm for the month of June. 52% of incidents were reported as no harm and all incidents moderate or above continue to be investigated under Duty of Candour. **The SPC chart will appear from August when we have two months data for this metric.**

Trend, Reason and Action

QS64- Reporting 5.50% (16/291) for the month of June for the % of inpatients supported to stop smoking. A newly introduced metric with the QUIT team remains active across inpatient services, supporting service users to engage with smoking cessation interventions and increasing the number of supported quit attempts

2.0 People and Organisational Development – In Focus

Indicators for June 2026/2027 TRUST — People

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
POD10 (L)		Working days lost to staff sickness absence	< 5.1%	22390/318075	7.04%				
POD18 (L)		Individuals Performance Development Review in 12 mnth	> 90%	3145/3336	94.27%		94.27%		94.27%
POD30 (L)	NOF07a	% days previous quarter where staff sick, unable to work		23899/318069	7.51%		7.51%		7.51%
POD31 (L)	NOF07b	NHS Staff Survey engagement theme score			7		7		7
POD32 (L)	NOF07c	National education and training survey satisfaction rates			in development				
POD33 (L)	NOF07d	NHS staff standards score			in development				
POD34 (L)	NOF07f	Temporary staffing cost as a % of total pay bill		2061/50848	4.05%		4.05%		4.05%
POD36 (L)		Apprenticeship levy			in development				
POD37 (L)		Turnover <24 months			in development				
POD38 (L)		Turnover 24 months +			in development				
POD39 (L)		Recruitment from local communities			in development				

Narrative

POD10 – The rolling 12 month sickness Absence % is above target (7.04% vs 5.10%).

POD12 – Flu vaccination programme commences from October 2026 and will be included from that point.

POD18 – PDR's reporting 94.27% above the 90% target.

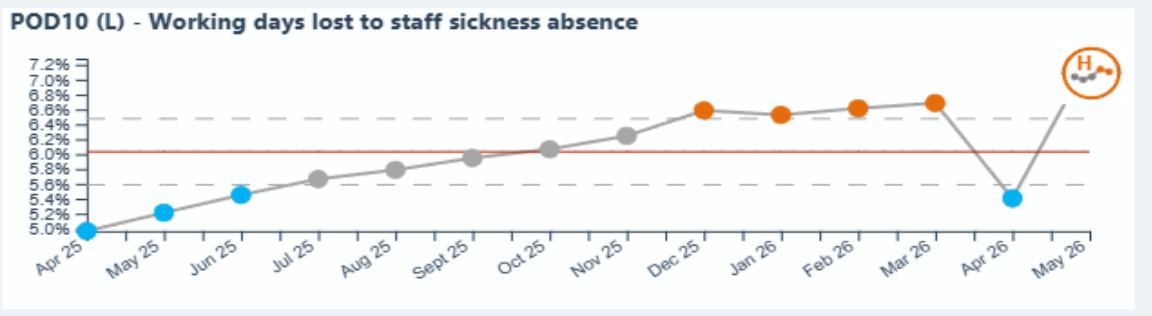
POD30 – % days for the previous quarter where staff were sick and unable to work is reported as 7.04%

POD32/33 - New metrics are implemented from this month and data will be provided from the 1st August onwards

POD34 – Temporary staffing cost as a ^ of total pay bill is reported as 4.05%

POD36/39 - New metrics are implemented from this month and data will be provided from the 1st August onwards

2.1 People and Organisational Development - Exceptions



Trend, Reason and Action

POD10 –The sickness absence % is above target (7.04% vs 5.1%), which has reduced from the previous months of 7.28%. Quarterly LT sickness review clinics have been held for all areas chaired by the Director of People and OD, with attendance from the Care Group SLT, Service Managers and HR. These clinics will be held on a quarterly basis, with the first RAG rating score applied this quarter. In the intervening months, the HR team will also facilitate local review meetings

3.0 Finance – In Focus

Finance				
Indicator	**Metric**	**Target**	**Actual**	**Variance**
NOF6a	Forecast outturn vs budget - planned breakeven	0	0	-
NOF6b	Year to date actuals vs budget	(143)	(91)	52
NOF6c	Relative cost difference (National Cost Collection Index) 24/25	1	0.88	(0.12)
NOF8g	Rate of implied productivity growth	Not yet able to report		
FIN01	Year to date savings target vs schemes identified	3,438	3,468	30
FIN02	Annual savings target vs forecast savings (non-recurrent & recurren	13,750	13,750	-
FIN03	Annual savings target vs forecast savings (recurrent only)	9,930	7,018	(2,912)
FIN04	Year to date capital plan vs spend	1,832	(551)	(2,383)
FIN05	Annual capital plan vs forecast spend	7,475	7,257	(218)
FIN06	Agency spend - year to date	210	329	119
FIN07	No of directorates compliant with budget - year to date	24	21	87.5%
FIN08	No of directorates compliant with budget - forecast	24	18	75.0%
FIN09	***Directorates not compliant with budget - YTD:***			
	Doncaster Acute	3,065	3,078	13
	Backbone - Operations	747	752	5
	North Lincs - Acute	2,279	2,280	1
FIN10	***Directorates not compliant with budget - Forecast:***			
	Doncaster Acute	12,338	12,435	97
	Childrens Physical Health	19,779	20,164	385
	PH - Rehabilitation	14,822	14,843	21
	PH - Community &LTC	27,620	27,742	122
	Finance & Procurement	2,992	3,029	37
	Medical, Pharmacy & Research	3,074	3,344	270

Narrative

NOF6a - The 2026/27 forecast as at M3 is to achieve a breakeven plan.
NOF6b - At M3 the year to date (YTD) position is £52k better than planned. This masks some significant differences compared to plan, however: substantive pay underspent by £2.7m, bank & agency overspent by £0.5m, out of area placements underspent by £0.7m and HDRU income is less than plan by £0.5m. Main contract income has been deferred to align with costs that will be incurred later in the year resulting in a financial position that remains close to plan.
NOF6c - the latest published data is for 2024/25. The 2025/26 National Cost Collection for RDaSH was submitted to NHSE in June and the results compared to other trusts will be published later in the year.
FIN01, FIN02 & FIN03 - At M3, the YTD and forecast expected savings are on plan. Some recurrent schemes are not yet delivering but this is a timing issue, and the gap has been offset by non-recurrent savings from vacancies being higher than planned.
FIN05 - YTD agency costs are over plan at M3, this is due to an additional agency medic in the Children's care Group, which is now due to end in July, extensions in the Doncaster Care Group until October and an additional agency medic in Rotherham Care Group..
FIN06 & FIN07 - Capital spend is behind plan year to date by £2.4m. This is expected for this stage of the year and includes a £1m grant that was received in M2; spend will ramp up over the next few months. The Trust's capital plan included an additional £218k of expected funding, as permitted under the planning rules. However, NHSE has since confirmed that this funding cannot be spent. As a result, the Trust is forecasting capital expenditure in line with its original capital allocation of £7.257m.
FIN08 & FIN10 - The 2026/27 budgets were approved on the basis that all directorates would operate within their allocated budgets. At M3, 21 of the 24 directorates are forecasting an underspend. Doncaster Acute is overspent by£ 13k and this is mainly attributed to the current level of bank spend. Whilst the Operations directorate and North Lincs Acute are overspending as at M3, these have both been reviewed in month and are forecast to be in a surplus position by the end of the year.
FIN09 & FIN11 - The 2026/27 budgets were approved on the basis that all directorates would operate within their allocated budgets. At Month 3, 18 of the 24 directorates are forecasting an underspend. The forecast overspend in Doncaster Acute is mainly due to the continued use of agency and bank staffing. Children's Physical Health is forecasting an overspend because the planned vacancy factor has not been achieved. The two Physical Health services are also forecasting overspends due to lower-than-planned income from the TVAL Hub and wheelchair repairs. The Finance & Procurement overspend is due to a change in VAT rules that has increased the amount payable to HMRC and is outside the directorate's control. The MPR overspend reflects research and other income generated during the year not being sufficient to cover costs.

4.0 Promises – In Focus

Indicators for June 2026/2027 TRUST — **Promises**

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
P01a (L)		% of Peer Support Workers embedded in Clinical Services			in development				
P02a (L)		Number of unpaid carers in our workforce							
P02b (L)		The number of all-age carers that use our services			1605		4610		4610
P03a (L)		50 volunteers registered to work with us or VIA another body			in development				
P03b (L)		Of the 350 volunteers, do they reflect population diversity			in development				
P06a (L)		Steady drop in service-attendance gap in lower decile areas		3178/80749	3.94%		3.94%		3.94%
P07a (L)		CYP with LD/autism seen by specialist epilepsy nurse in 4wks		1/1	100.00%		100.00%		100.00%
P07b (L)		Increase referrals from children of a black background 10%	>= 309		1344		4107		4107
P07c (L)		% Was Not Brought (DNA) from deprived areas	<= 7%	163/3149	5.18%		5.18%		5.18%
P08b (L)		TT access - Increasing access rates for older adults		41/420	9.76%		9.76%		9.76%
P08c (L)		% Minority adults with LD active month end with health check	>= 95%	84/100	84.00%		84.00%		84.00%
P08d (L)		Dementia Diagnosis rate		7403/9909	74.71%		74.71%	>= 67%	74.71%
P08e (L)		Dementia diagnostic rates for people from a minority	>= 4.2%	14/391	3.58%		3.58%		3.58%
P08f (L)		% Perinatal referrals from people of a black background	>= 5%	0/61	0.00%				
P09a (L)		Achievement of Levy Spend			in development				
P10a (L)		Meet standards set out in NICE/NHS England (2022) guidance			in development				

Narrative

P01a-P02a – New metrics under development

P03a-P03b – New metrics under development

P08c - % LD patients receiving PH check is reported as 84% below the 95% target.

P08e – Dementia diagnosis rates for people from minority backgrounds is reported at 3.58% and remains below the 4.2% target.

P08f – no referrals were received into Perinatal Services from people identifying as Black or Black British.

P09a/P10a – new metrics under development

4.0 Promises – In Focus

Indicators for June 2026/2027 TRUST — Promises

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
P11a (L)		Achieve priority access to services for veterans	>= 3.89%	1042/39350	2.65%		2.65%		2.65%
P12a (L)		% Referrals from rural areas compared to rural population		5416/38251	14.16%		14.16%		14.16%
P13a (L)		Sustain/expand our IV provision in out-of-hospital settings			in development				
P13c (L)		Sustain and expand clozapine service in off ward settings			in development				
P13d (L)		Meet 5 community mental health transformation measures(2024)	= 100%	4/5	80.00%		80.00%		80.00%
P14a (L)		The number of referrals seen within 4 weeks		64/83	77.11%	Q1 >= 94%	77.11%		77.11%
P14b (L)		% Urgent referrals seen within 48 hours		1486/2452	60.60%		60.60%	= 100%	60.60%
P18a (L)		Meet patient-care obligations for Safer-Staffing & MHA			in development				
P22a (L)		% Individuals admitted over the weekend		6/65	9.23%		9.23%		9.23%
P22b (L)		% Individuals discharged over the weekend		2/152	1.32%		1.32%		1.32%
P25a (L)		Transfer spend to local suppliers (25%+ compared to 2023/24)							
P25b (L)		Reduce our carbon tonnage by 2000 (and offset balance).			in development				
P28a (L)		Portfolio recruitment targets, deliver metrics in R&I plan			in development				
P28b (L)		Increase the reach of research into excluded communities			in development				

Narrative

P11a – 2.65 % of veterans received priority access below the target of 3.89%.

P13a, P13c – metrics remain under development

P13d – of the 5 measures the number of individuals receiving an annual physical health check is below target as identified in Quality quadrant OP61c

P14a - The metric monitoring four-week compliance to Promise 14 with 77.11% of services achieving the 4 week wait standard, this equates to 66 of 83 services.

P14b - The metric monitoring compliance to 48 hr response to referrals classified as urgent for Promise 14. Reported 60.60% of referrals seen within the 48 hr target.

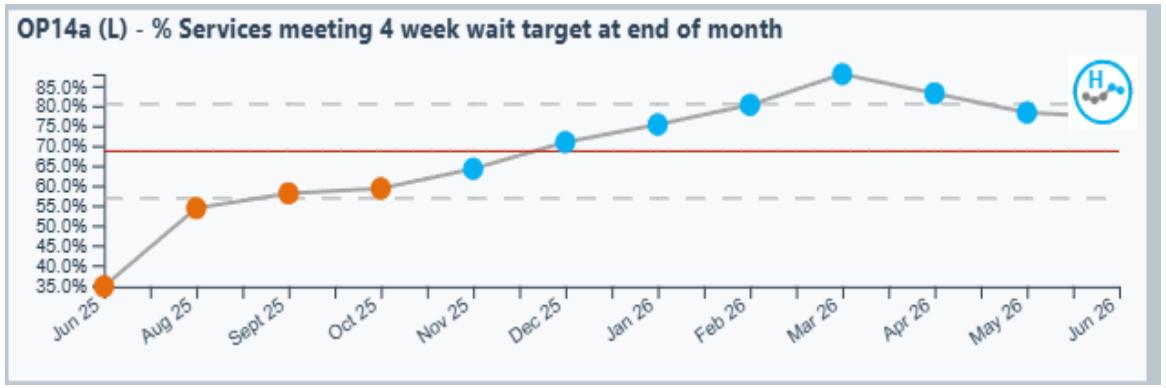
P18a – metric remains in development

P25a-P28b – metrics remain under development

4.1 Promises In Focus- Exceptions

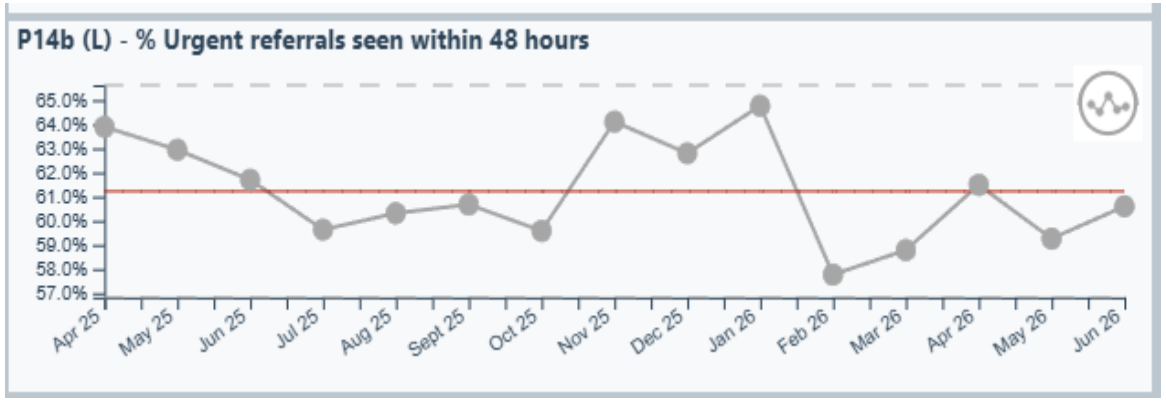
Trend, Reason and Action

P08C – 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. Metric performance to be escalated through the monthly performance clinic to drive improvement and to provide additional oversight.



Trend, Reason and Action

P14a - The metric monitoring four-week compliance to Promise 14. 77.11% of services are currently achieving the standard, with 64 of 83 services compliant. While overall performance remains strong, a small number of services continue to report breaches. These are primarily driven by workforce capacity pressures. Within Children's Services, four services exceed the four-week standard, largely due to the impact of sickness absence on delivery. In Physical Health Services, three services remain above four weeks, with podiatry continuing to experience extended waits as a result of increased demand. Community Mental Health Services in Doncaster have recently breached the four-week standard. Focus within the Care Groups will be continued to recover performance against the standard with oversight at the fortnightly waiting list group.



Trend, Reason and Action

P14b - The metric monitoring compliance to 48 hr urgent response for Promise 14 reported 60.60% of referrals seen within the 48 hr target. This equates to 1486/2452 referrals seen within the timescale. Delivery of the standard remains a key focus for Care Groups, supported by targeted improvement actions. Oversight has been strengthened through the fortnightly Waiting List Group, which now includes routine monitoring of urgent response performance, corrective actions and escalation where required.

Appendix 1`

SPC Icon Description

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	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**	30 July 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 a step back from the improving position reported to the last Board, with the total number of risks on the register and the number sitting outside tolerance both having increased.

The more material observation, and the one drawn to the Board's specific attention, is the concentration of out-of-tolerance exposure in themes for which the Board has set a Low tolerance position, and particularly within Patient Care. This concentration is the position most requiring focused oversight in the current period.

The report also introduces a summary of the Trust's High Impact, Low Likelihood risks, presenting a separate cohort of exposures whose consequences would warrant sustained Board sight should they materialise. These are reported alongside the routine tolerance-based position rather than in place of it.

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?)

The Board receives, at each of its meetings, details of the operational risks.

Recommendation (delete options as appropriate and elaborate as required)

RECEIVE and NOTE the operational risk report with attention drawn to those risks that are out of tolerance and further, those with low risk appetite.

RECEIVE and NOTE the focus on those risks described as High Impact / Low Likelihood.

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.	

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

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 Risks presented in this report have been moderated through the Risk Management Group, with pre-moderation review of scores and appetite alignment ahead of each meeting. This ensures the position reported to the Board reflects considered judgement on control effectiveness and residual exposure, rather than a raw register position

1.3 This period's report introduces those risks that we consider to be High Impact and Low Likelihood (HH/LL) risks that may sit within tolerance by score, but whose potential consequences are significant enough that the Board should retain sight of them regardless.

1.4 The Board's role in respect of operational risk is to seek assurance that risks material to the Trust's operations are being identified, moderated and managed within the appetite the Board has set, and to challenge where exposure, direction of travel or control effectiveness gives cause for concern. This report is structured to support that role.

2. Current Operational Overview

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 The position this period reflects a step back from the improving trajectory reported to the last Board. The register has grown by 20 risks, and the number of risks sitting outside tolerance has risen from 27 to 38. Beneath that headline, the register has continued to turn over actively approximately 70 risks have been opened and 50 closed over the quarter, with 18 risks newly moved into the out-of-tolerance position and 7 moved back within tolerance. The current out-of-tolerance risks are listed at **Appendix 2**.

2.4 The Board's attention is drawn to where these risks sit against the Trust's appetite themes. Of the 38 risks outside tolerance, 27 (71%) sit in themes for which the Board has set a Low tolerance position — Patient Care (19), External and Partnership (5)

and Financial (3). Patient Care alone accounts for half of all risks currently outside tolerance. The concentration of exposure in areas where the Board has expressly signalled low appetite is the position most requiring focused oversight this period.

2.5 Seven risks recorded as out of tolerance in the previous Board report have moved back within tolerance in this reporting period, reflecting the effectiveness of controls and actions progressed since the last report. Two examples are highlighted below.

2.6. The seven 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.**

3. Significant Risks

3.1 All out-of-tolerance risks are significant. Each represents an exposure operating outside the threshold the Board has set, and each remains on the register for active oversight through the Risk Management Group and the responsible care group governance arrangements. The full list of risks currently outside tolerance is presented at **Appendix 2**, and no risk should be read as less material because it is not featured in this section.

3.2 The following two risks are drawn to the Board's specific attention because they have newly moved into the out-of-tolerance position in this reporting period and reflect material exposures that have emerged since the last Board report. Both relate to medical workforce capacity in mental health services, and both carry consequences for statutory duty and patient safety.

3.3 RSK-679 — Insufficient medical cover in Rotherham Older People's Community Mental Health Team South. The team's substantive medic gave notice in April and left the service in early June, and while partial cover arrangements had been in place across the intervening period, these have since fallen away without a locum or alternative backfill in place. The team is now operating with substantially reduced medical presence across the working week, and the risk has been re-scored to 25 to reflect the position.

3.4 The team carries Responsible Clinician duties, Mental Health Act assessments and consultant-dependent clinical decisions for older people and cannot discharge these obligations reliably without adequate medical cover. The risk has been raised with the Medical Director and taken through Senior Leadership Team routes, with further escalation to the directorate. Recruitment to a substantive replacement is progressing, though the immediate concern is whether interim cover can be secured to bridge the gap until a permanent appointment is in place. The Board is asked to note the position and the escalation route being pursued.

3.5 RSK-695 — Consultant vacancies across Rotherham Acute Mental Health Directorate. 4.4 WTE consultant posts are vacant or due to become vacant across locality teams, the Older Adult CMHT, hospital liaison and Sandpiper Ward, with one further consultant on long-term sickness absence. As with RSK-679, the exposure sits primarily in the Trust's ability to fulfil Responsible Clinician duties, Mental Health Act assessments and consultant-dependent clinical decisions across affected services. The implications extend to statutory compliance, treatment timeliness and patient safety.

3.6 Consultant gaps have been escalated across the Trust to identify internal cover options, and staffing levels and service impact are being monitored through operational oversight. Recruitment to fill the vacant posts is underway. The risk currently scores 12, having reduced from 16 following initial mitigations, but the underlying workforce exposure remains material until substantive appointments are made. The Board is asked to note the position and the ongoing recruitment activity.

4. High Impact, Low Likelihood Risks

4.1 In addition to the risks reported against appetite and tolerance, the Board is asked to note a separate cohort of risks classified as High Impact, Low Likelihood (HH/LL). These are risks whose current scores do not place them at the top of the register, but whose potential consequences would be severe enough to warrant sustained Board sight if they were to materialise. Reporting them separately ensures that low-probability but high-consequence exposures are not lost within routine tolerance-based reporting, and that the Board retains a clear line of sight on risks that matter by nature of their impact rather than by score alone. The full list of HH/LL risks is presented at **Appendix 3**

4.2 The controls appropriate to this cohort differ from those relied on elsewhere on the register. Where routine risks are managed through operational mitigations that reduce the likelihood of occurrence, HH/LL risks depend more heavily on preparedness, response capability and recovery arrangements. The question the Board is asked to hold in mind is not only "how likely is this to happen?" but "if it did happen, would the Trust be able to respond effectively?" This shifts the assurance question from prevention to resilience and requires a different form of oversight.

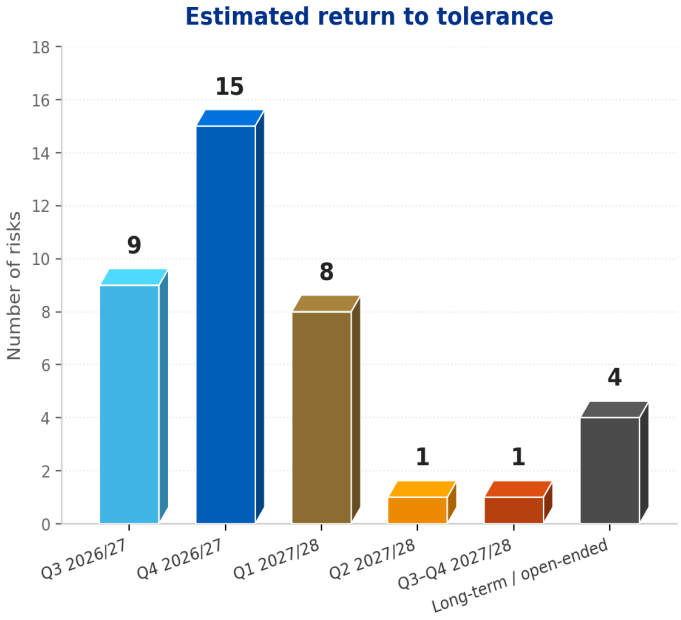
4.3 The cohort currently comprises 32 risks. The largest single grouping relates to estates and infrastructure resilience, accounting for roughly a third of the cohort, and covers the potential consequences of extended utility failures, structural deterioration, and contamination of essential services on inpatient care. Digital and cyber exposure forms the second grouping, spanning cyber-attack, network and telephony failure, data centre loss, disaster recovery arrangements and clinical data integrity. Emergency preparedness risks, including chemical, biological or radiological events and other deliberate acts targeting the Trust, form a smaller but distinct grouping. The remainder reflect a mix of patient safety, workforce continuity and regulatory exposures whose day-to-day probability is low, but whose realisation would carry significant consequence.

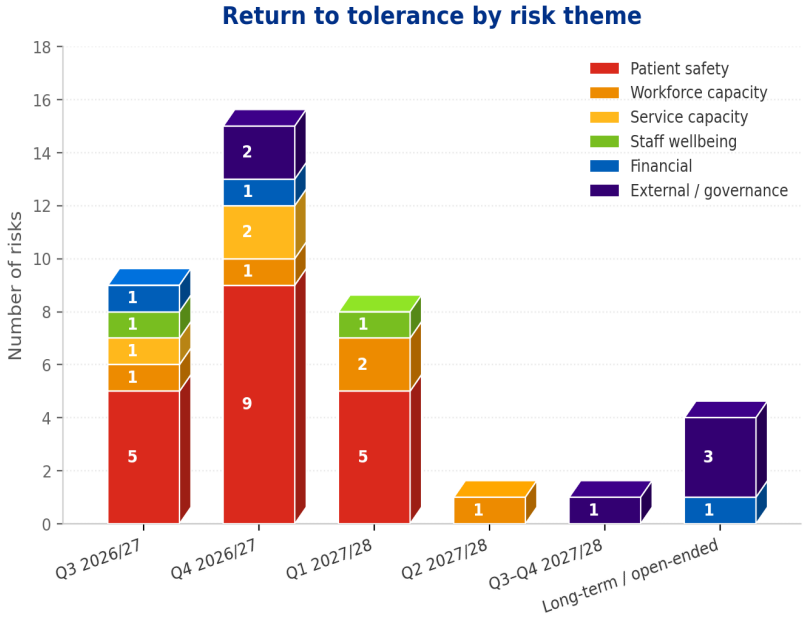
4.4 The Board is asked to note that three risks within the HH/LL cohort are also reported as outside tolerance in the main risk position — RSK-476 (installation of anti-ligature doors on Windermere), RSK-671 (delays in admission to mental health services) and RSK-676 (discontinuation of Levemir). Their appearance in both positions reflects an active operational exposure combined with a potential consequence of a scale that warrants Board sight regardless of the movement in likelihood. These risks are being managed through the routine tolerance process, and their HH/LL classification is a signal of the potential severity of consequence rather than a separate assurance route.

4.5 For most HH/LL risks, the response strategy is one of tolerate. This reflects the position that certain low-probability events cannot be prevented at a cost proportionate to their likelihood, and that the appropriate assurance focus is therefore on the adequacy of preparedness, response and recovery arrangements

rather than on further reduction of probability. A smaller number are being actively treated where mitigation is judged both feasible and material to reducing the residual exposure. The Board is asked to note that this pattern is consistent with the nature of the cohort and does not itself indicate weakness in the control environment.

5. Risk return-to-tolerance assessment





5.1 Of the 38 Red risks currently on the register, our best-judgement view is that 24 will return within tolerance during 2026/27, with the majority landing in Q4 as workforce, capital and delivery actions mature. A further ten are expected to move within tolerance across 2027/28, largely reflecting the time needed to embed recruitment, cultural change and system-partner arrangements.

5.2 Four risks are held as long-term positions and it is important that Board sees this as a considered assurance judgement rather than a delivery gap. The two neurodevelopmental waiting-time risks (RSK-220, RSK-152), the Aspire estate exposure (RSK-463) and decarbonisation funding (RSK-468) share a common feature: the levers to move them sit outside the Trust's direct control, whether that is national demand, capital investment or grant timelines.

6. Conclusion

6.1 This report reflects a step back from the improving position reported to the Board in May. The direction of travel has reversed, and the Board is asked to note the change openly rather than to read it as a temporary movement.

6.2 The more material observation sits in the appetite alignment position. The concentration of out-of-tolerance exposure in themes for which the Board has set a Low tolerance position, and particularly within Patient Care, is the position most requiring focused oversight this period.

6.3 Two risks are drawn to the Board's specific attention in Section 3, both relating to

medical workforce capacity in mental health services and both carrying implications for statutory duty and patient safety. The High Impact, Low Likelihood cohort presented in Section 4 sets out a separate category of exposure whose consequences would warrant sustained Board sight should they materialise.

6.4 Beneath the reported movement, the register has continued to turn over actively. This reflects a live and responsive risk identification process across care groups and directorates, and the Board is asked to take assurance that the underlying governance arrangements are operating as intended, notwithstanding the reversal in headline position this period.

7. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the operational risk report with attention drawn to those risks that are out of tolerance and further, those with low risk appetite.

RECEIVE and NOTE the focus on those risks described as High Impact / Low Likelihood.

Philip Gowland
Director of Corporate Assurance
30 July 2026

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

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
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	Rotherham Community Mental Health	Q3 2026/2027	6	Amber
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	Doncaster Learning Disabilities and Forensics	Q2 2026/2027	6	Amber
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	Health Informatics	Q2 2026/2027	6	Amber
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	Finance & Procurement	Q2 2026/2027	6	Amber
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	Corporate Assurance	Q4 2026/2027	8	Amber
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	Community & Long Term Conditions	Q2 2026/2027	9	Amber
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	Community & Long Term Conditions	Q3 2026/2027	9	Amber

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

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-676	Due to the discontinuation of Levemir, there is a risk that patients currently prescribed this medication are not transitioned to an appropriate alternative insulin in a timely manner, which may result in poor glycaemic control, hyperglycaemia or hypoglycaemia, and avoidable hospital admission.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions Directorate	Q3 2026/27	10	Red
RSK-672	If the EPMA system becomes unavailable on Willows Ward and no contingency plan is in place, there is a risk that medication administration cannot be safely managed during system downtime, which may result in medication errors and direct harm to patients.	Patient Care Risk - Clinical Safety	Rotherham Acute Mental Health Directorate	Q3 2026/27	12	Red
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	North Lincolnshire Acute Mental Health Directorate	Q3 2026/27	12	Red
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 week wait standard, and deterioration in patient experience and outcomes.	Performance Risk - Capacity & Demand Management	North Lincolnshire Acute Mental Health Directorate	Q3 2026/27	15	Red
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 absconsion (AWOL), and impact patient safety.	Patient Care Risk - Clinical Safety	Rotherham Acute Mental Health Directorate	Q3 2026/27	9	Red
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	Children's Mental Health (CAMHS) Directorate	Q3 2026/27	12	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-491	Due to limited medical cover within the PCIMHH service, including only six hours of clinical time to support patient reviews and the GP advice and guidance pathway, there is a risk that patients experience prolonged waits for medical input, which may result in clinical deterioration requiring crisis intervention, inappropriate treatment decisions due to lack of timely review, and reduced confidence from PCN partners in the advice and guidance service.	Patient Care Risk - Clinical Safety	Rotherham Community Mental Health Directorate	Q3 2026/27	9	Red
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	Children's Mental Health (CAMHS)	Q3 2026/27	12	Red
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	Community & Long Term Conditions	Q3 2026/27	12	Red
RSK-083	If the Trust lacks a single, authoritative and accessible source of information on medicines use, including prescribing and dispensing data, there is a risk that prescribers, teams and care groups will be unable to effectively interrogate activity and cost information. This may impair oversight of prescribing practice and financial management, potentially resulting in suboptimal clinical decision-making, reduced professional oversight, and increased or uncontrolled expenditure.	Performance Risk - Information Governance	Medical, Pharmacy & Research Directorate	Q4 2026/27	9	Red
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	Community & Long Term Conditions Directorate	Q4 2026/27	15	Red
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	Community & Long Term Conditions Directorate	Q4 2026/27	9	Red
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	Doncaster Acute Mental Health Directorate	Q4 2026/27	10	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-509	Due to the long term absence of a Rotherham CAMHS Consultant and the role not being backfilled, there is a risk that the service does not have sufficient senior clinical oversight and capacity for timely decision making, which may result in delays to complex clinical reviews, increased pressure on remaining clinicians, and a heightened risk to patient safety and quality of care.	Patient Care Risk - Clinical Safety	Children's Mental Health (CAMHS) Directorate	Q4 2026/27	9	Red
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	Rotherham Community Mental Health Directorate	Q4 2026/27	9	Red
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 26/27.	Financial Risk - Financial Planning, CIP & Sustainability	Talking Therapies Directorate	Q4 2026/27	12	Red
RSK-561	Due to patients with highly complex needs being held on community caseloads without comprehensive care plans and clear escalation pathways recorded on SystmOne, there is a risk that changes in condition, equipment issues or urgent needs will not be managed appropriately, which may result in delayed or inappropriate responses and increased risk of harm.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions Directorate	Q4 2026/27	9	Red
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	Children's Physical Health (CYP) Directorate	Q4 2026/27	12	Red
RSK-627	Due to differences between contract management processes for healthcare and non-healthcare services following the transfer of the contracts function to the Finance and Procurement Directorate, there is a risk that income and expenditure healthcare contracts are awarded, extended, or managed without full alignment to Procurement Act 2023 requirements and other relevant legislation, which could result in legislative non-compliance, legal challenge to contract awards, delays to service delivery, financial and reputational damage, and increased regulatory and audit scrutiny for the Trust.	External and Partnership Risk - Legal & Governance	Finance & Procurement Directorate	Q4 2026/27	9	Red
RSK-640	Due to significant damage to the aluminium doors of the S136 suite caused by patient attacks, leaving them able to be forced open, there is a risk that patients abscond from the suite, which may result in serious harm to the patient, risk to public safety, breach of detention under the Mental Health Act, and significant reputational and regulatory consequences for the Trust.	Patient Care Risk - Clinical Safety	North Lincolnshire Acute Mental	Q4 2026/27	12	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
			Health Directorate			
RSK-664	Due to significant reductions in psychology staffing capacity, including an unfilled maternity leave vacancy, an imminent permanent departure, and the potential loss of the remaining psychologist covering four localities, there is a risk that psychology services cannot meet caseload demand within safe waiting times, which may result in reduced access to timely psychological interventions, increased pressure on the wider MDT, and deterioration in patient outcomes.	Performance Risk - Capacity & Demand Management	Doncaster Community Mental Health Directorate	Q4 2026/27	12	Red
RSK-673	Due to ongoing IT system failures on Sandpiper Ward (including prolonged laptop login times, system errors, and ECG application malfunction) and limited availability of alternative ECG machines, there is a risk that ECGs cannot be performed in a timely manner or at all, which could result in delayed or missed identification of cardiac abnormalities (such as QTc prolongation or acute cardiac events), potentially leading to serious patient harm and compromised patient safety.	Patient Care Risk - Clinical Safety	Rotherham Acute Mental Health Directorate	Q4 2026/27	9	Red
RSK-679	Due to a medic leaving in June with no replacement expected until September or October, there is a risk that the Older People's Community Mental Health Team South cannot fulfil Responsible Clinician duties, Mental Health Act assessments, medication prescribing, and patient reviews, which may result in patients being unable to access timely medical input, statutory breaches under the Mental Health Act, and serious deterioration in patient outcomes.	Patient Care Risk - Clinical Safety	Rotherham Community Mental Health Directorate	Q4 2026/27	20	Red
RSK-687	Due to an increase in prescribing errors within the Doncaster Community Learning Disability Team and multiple recent incident reports highlighting medication and prescribing issues, there is a risk that patients may receive incorrect prescriptions or not receive medication at the right time. This may cause delays in treatment or incorrect medication being administered, which may impact patient safety and potentially lead to harm.	Patient Care Risk - Clinical Safety	Doncaster Learning Disabilities and Forensics Directorate	Q4 2026/27	16	Red
RSK-671	If capacity constraints, staffing shortages, or bed unavailability cause delays to urgent or planned admission to mental health services, there is a risk that individuals do not receive timely inpatient care, which may result in further deterioration of mental health and increased risk of serious harm.	Patient Care Risk - Clinical Safety	Operations Directorate	Q1 2027/28	8	Red
RSK-656	Due to a current Band 5 absence rate of 33.3%, which exceeds available budget headroom of 28%, there is a risk that staffing capacity cannot be sustained within funded levels. This may result in increased reliance on temporary staffing, reduced continuity of care, increased pressure on substantive staff, and a potential impact on the quality and safety of patient care	People Risk - Capacity	Community & Long Term Conditions Directorate	Q1 2027/28	12	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-652	Due to unplanned nursing staff now operating alone in services where patients require two clinicians for joint visits, there is a risk that joint visits cannot be coordinated or delivered in a timely manner, which may result in delays to patient assessment and treatment, missed opportunities for early intervention, and deterioration in patient condition.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions Directorate	Q1 2027/28	12	Red
RSK-631	Due to continued incorrect documentation of patient allergy status by staff within the electronic clinical system and system limitations that prevent timely amendment of records by clinicians outside their own clinical area, there is a risk that inaccurate allergy information overrides inpatient drug charts, leading to inappropriate prescribing or medication administration errors, delayed correction of records, increased risk of patient harm, and adverse quality, safety, and regulatory impacts across care groups.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions Directorate	Q1 2027/28	9	Red
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	Children's Physical Health (CYP) Directorate	Q1 2027/28	12	Red
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	Doncaster Learning Disabilities and Forensics Directorate	Q1 2027/28	12	Red
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	Medical, Pharmacy & Research Directorate	Q1 2027/28	9	Red
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	Medical, Pharmacy & Research Directorate	Q1 2027/28	9	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-695	Due to 4.4 WTE consultant posts being vacant or due to become vacant across locality teams, Older Adult CMHT, hospital liaison, and Sandpiper Ward, compounded by the peripatetic consultant being on long term sick leave, there is a risk that Responsible Clinician duties, MHA assessments, and consultant-dependent clinical decisions cannot be fulfilled across affected services, which may result in statutory breaches under the Mental Health Act, delays to treatment, and serious harm to patients.	People Risk - Capacity	Rotherham Acute Mental Health Directorate	Q2 2027/28	12	Red
RSK-574	Due to inconsistent overnight refreshing and updating of the Reportal system, caused by daily delays in data processing and downloads pushed through Informatics systems, there is a risk that Personalised Care Plans, SMI Registers, Learning Disability Registers and associated compliance reports will display out-of-date or incorrect patient data, impacting the reliability, accuracy and timeliness of reporting required for operational performance, assurance, and regulatory compliance.	External and Partnership Risk - Change and Improvement Delivery	Operations Directorate	Q3–Q4 2027/28	20	Red
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	Strategic Development Directorate	Long-Term	9	Red
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	Doncaster Community Mental Health Directorate	Long-Term	12	Red
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	Children's Physical Health (CYP) Directorate	Long-Term	15	Red
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	Neurodiversity Directorate	Long-Term	15	Red

Appendix 3 - High Impact, Low Likelihood Risks

Ref	Description	Category	Scope name	Consequence score	Likelihood score	Current score	Risk response	Appetite Status
RSK-042	If the roof of the St Cath's stable block substation fails, there is a risk of structural collapse, which may compromise the electrical supply to part of the site and result in service disruption because the generator is also located in the stable block and feeds Skelbrooke	Performance Risk - Estates, Equipment & Supply Chain	Estates Directorate	4	2	8	Tolerate	Green - Within Appetite
RSK-676	Due to the discontinuation of Levemir, there is a risk that patients currently prescribed this medication are not transitioned to an appropriate alternative insulin in a timely manner, which may result in poor glycaemic control, hyperglycaemia or hypoglycaemia, and avoidable hospital admission.	Patient Care Risk - Clinical Safety	Community & Long-Term Conditions Directorate	5	2	10	Treat	Red - Escalate
RSK-008	If an extended electricity outage occurs on the estate, there is a risk that patient care will be disrupted, which may result in severe impacts on inpatient buildings, including compromised safety, and operational challenges.	Performance Risk - Estates, Equipment & Supply Chain	Estates Directorate	5	1	5	Tolerate	Green - Within Appetite
RSK-029	If an extended water outage occurred on the estate, there is a risk that patient care would be disrupted, which may result in significant impacts on service delivery, particularly in inpatient buildings, potentially compromising patient safety and hygiene standards.	Performance Risk - Emergency Preparedness	Estates Directorate	5	2	10	Tolerate	Amber - Within Tolerance
RSK-068	If insufficient training is available or the Trust cannot report on compliance, there is a risk that the workforce will be inadequately trained, which may result in reduced service quality, increased clinical and operational errors, and potential regulatory non-compliance.	People Risk - Capability and Performance	People & Organisational Development Directorate	4	2	8	Tolerate	Amber - Within Tolerance

Ref	Description	Category	Scope name	Consequence score	Likelihood score	Current score	Risk response	Appetite Status
RSK-087	If there is insufficient assurance regarding medicines management through a written strategic framework then this may lead to inconsistent practice	Patient Care Risk - Quality Improvement	Medical, Pharmacy & Research Directorate	4	2	8	Treat	Green - Within Appetite
RSK-130	If the Transformation team does not work in collaboration with the Clinical Systems team, there is a risk that data capture and reporting requirements will not be met, which may result in incomplete or inaccurate information for internal and external reporting, affecting decision-making and compliance.	Performance Risk - Information Governance	Health Informatics Directorate	4	1	4	Tolerate	Amber - Within Tolerance
RSK-137	If the Trust's data centers are lost simultaneously, there is a risk that critical Trust services will fail, which may result in significant disruptions to patient care, compromised data access, and potential harm to the Trust's operations and reputation.	Performance Risk - Emergency Preparedness	Health Informatics Directorate	4	2	8	Tolerate	Green - Within Appetite
RSK-146	If a robust process is not in place to ensure continued compliance with CQC registration requirements, there is a risk that conditions may be imposed on the Trust or services may be suspended, which may result in regulatory sanction and reputational harm.	External and Partnership Risk - Regulatory	Corporate Assurance Directorate	4	1	4	Tolerate	Amber - Within Tolerance
RSK-191	If Disaster Recovery plans are not in place and kept up to date, there is a risk that the Trust will be unable to recover effectively from an incident, which may result in prolonged service disruption, data loss, and harm to patient care and organisational reputation.	Performance Risk - Emergency Preparedness	Health Informatics Directorate	5	1	5	Tolerate	Green - Within Appetite
RSK-193	If a user or system error occurs on a Trust health IT system, there is a risk of service delivery disruption, which may negatively impact patient care and operational efficiency.	Performance Risk - Digital Infrastructure & Cyber Security	Health Informatics Directorate	5	1	5	Tolerate	Green - Within Appetite

Ref	Description	Category	Scope name	Consequence score	Likelihood score	Current score	Risk response	Appetite Status
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	Corporate Assurance Directorate	4	2	8	Treat	Amber - Within Tolerance
RSK-245	Non Conventional Terrorist Attack - or other malicious or deliberate attack directly targeting the Trust, using chemical, biological or radiological substances. Causing fatalities, casualties, environmental damage or social/economic disruption.	Risk Log- EPRR	Organisation	5	2	10	Tolerate	Amber - Within Tolerance
RSK-252	Accidental release of biological pathogen/substance, Large toxic chemical release, Civil nuclear accident directly effecting one of the Trust's sites or buildings. Potential for loss of life and long term health consequences. Increased demand on all health services. Long term contamination of affected area	Risk Log- EPRR	Emergency Planning Team	5	1	5	Tolerate	Green - Within Appetite
RSK-296	If on-call managers (non-medical) are not appropriately trained in EPRR procedures, there is a risk that the Trust's ability to manage emergency situations out of hours will be compromised, which may result in failure to meet statutory obligations related to core standards and potential risks to patient and staff safety.	Performance Risk - Emergency Preparedness	Operations Directorate	4	1	4	Treat	Green - Within Appetite
RSK-326	A malicious or deliberate attack directly targeting the Trust. Causing fatalities, casualties, environmental damage or social/economic disruption.	Risk Log- EPRR	Emergency Planning Team	4	2	8	Treat	Green - Within Appetite

Ref	Description	Category	Scope name	Consequence score	Likelihood score	Current score	Risk response	Appetite Status
RSK-394	If the current Senior Leadership Team capacity within Corporate Assurance is not maintained, there is a risk that the directorate will lose critical leadership continuity, strategic oversight, and the ability to effectively deliver its objectives, which may result in weaker trust governance, slower risk escalation, and reduced compliance with statutory and regulatory requirements.	People Risk - Capacity	Corporate Assurance Directorate	4	2	8	Treat	Amber - Within Tolerance
RSK-453	Due to limited administrative resources and reliance on a small team to provide director support, there is a risk that prolonged staff absence cannot be adequately covered and service levels will drop below acceptable tolerences.	People Risk - Capacity	Corporate Assurance Directorate	4	2	8	Not applicable	Amber - Within Tolerance
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	Doncaster Acute Mental Health Directorate	5	2	10	Treat	Red - Escalate
RSK-616	Due to racial discrimination within the organisation not being sufficiently addressed and discriminatory behaviours continue, this could lead to psychological harm to colleagues, and reduced morale and wellbeing. This could impact on the ability to attract and retain colleagues, increase litigation risk, and result in reputational damage.	People Risk - Well-being & Retention	People & Organisational Development Directorate	4	2	8	Treat	Amber - Within Tolerance
RSK-635	Due to door widths in four patient bedrooms on Mulberry Ward being narrower than the width required for medical beds used by older adult patients, there is a risk that patients with limited mobility cannot be safely evacuated from their bedrooms in an emergency, which may result in	Performance Risk - Emergency Preparedness	North Lincolnshire Acute Mental Health Directorate	4	1	4	Tolerate	Green - Within Appetite

Ref	Description	Category	Scope name	Consequence score	Likelihood score	Current score	Risk response	Appetite Status
	delays to evacuation and serious harm to or loss of life of affected patients.							
RSK-685	Due to 2.0 WTE non-medical prescriber/ADHD nurses leaving the service, there is a risk that capacity to deliver timely assessment, prescribing, and medication reviews will be significantly reduced, which may result in delays to patient care, increased waiting times, potential deterioration in patient outcomes, and increased pressure on remaining staff and wider services.	People Risk - Capacity	Children's Physical Health (CYP) Directorate	4	2	8	Treat	Amber - Within Tolerance
RSK-001	Due to inadequate control of ignition sources, there is a risk that serious fire-related incidents could occur, particularly on acute adult mental health inpatient wards. This may result in patient and staff harm, compromised safety, significant property damage, regulatory non-compliance, and reputational harm to the Trust.	Patient Care Risk - Patient Experience	Estates Directorate	4	1	4	Tolerate	Green - Within Appetite
RSK-009	If an extended gas outage occurred on the inpatient estate, there is a risk that patient care would be disrupted, which may result in significant impacts on service delivery, particularly in inpatient buildings, potentially compromising patient safety.	Performance Risk - Emergency Preparedness	Estates Directorate	5	2	10	Tolerate	Amber - Within Tolerance
RSK-159	If processes to secure and manage the Trust's social-media accounts are insufficient, there is a risk that accounts could be compromised or misused, which may result in adverse reputational damage to the Trust	Performance Risk - Digital Infrastructure & Cyber Security	Strategic Development Directorate	4	2	8	Tolerate	Amber - Within Tolerance

Ref	Description	Category	Scope name	Consequence score	Likelihood score	Current score	Risk response	Appetite Status
RSK-671	If capacity constraints, staffing shortages, or bed unavailability cause delays to urgent or planned admission to mental health services, there is a risk that individuals do not receive timely inpatient care, which may result in further deterioration of mental health and increased risk of serious harm.	Patient Care Risk - Clinical Safety	Operations Directorate	4	2	8	Treat	Red - Escalate
RSK-713	If Trust water systems become contaminated because water safety controls, monitoring or remedial arrangements are ineffective, there is a risk that patients, staff or visitors are exposed to Legionella, Pseudomonas or other harmful organisms, which may result in serious infection or death, an outbreak, closure of inpatient or clinical areas and regulatory action.	Performance Risk - Estates, Equipment & Supply Chain	Estates Directorate	4	1	4	Tolerate	Green - Within Appetite
RSK-714	If medical gas infrastructure or supply arrangements fail, become contaminated, are incorrectly connected or supplies are depleted, there is a risk that patients cannot receive oxygen or other medical gases when clinically required, which may result in deterioration in a patient's physical condition, serious harm or death and disruption to inpatient and physical health services.	Performance Risk - Estates, Equipment & Supply Chain	Estates Directorate	4	1	4	Tolerate	Green - Within Appetite
RSK-715	If deterioration, hidden defects or insufficient investment in the Trust estate are not identified and addressed, there is a risk that roofs, ceilings, walls, floors or other structural elements fail while buildings are occupied, which may result in serious injury or death, evacuation of services, prolonged closure of clinical areas and significant financial or regulatory consequences.	Performance Risk - Estates, Equipment & Supply Chain	Estates Directorate	5	1	5	Tolerate	Green - Within Appetite

Ref	Description	Category	Scope name	Consequence score	Likelihood score	Current score	Risk response	Appetite Status
RSK-716	If the mains electricity supply is lost and backup power arrangements fail or are exhausted, there is a risk that critical clinical and life safety systems, including fire detection, access controls, nurse call systems, alarms, medication refrigeration, telephony and IT, become unavailable, which may result in serious patient harm or death, increased risk of unauthorised access or absconding, evacuation and prolonged disruption to services.	Performance Risk - Estates, Equipment & Supply Chain	Estates Directorate	5	1	5	Tolerate	Green - Within Appetite
RSK-717	If the Trust's network, internet, Wi-Fi or telephony services fail across one or more locations, there is a risk that inpatient and community staff are unable to access clinical systems or communicate with colleagues, patients and emergency services, which may result in delayed emergency responses, reduced oversight of patient risk, increased risks to lone workers and significant disruption to clinical services.	Performance Risk - Digital Infrastructure & Cyber Security	Health Informatics Directorate	4	1	4	Tolerate	Green - Within Appetite
RSK-718	If clinical information is corrupted, incorrectly migrated, inaccurately transferred between systems or displayed incorrectly because of a system, interface or configuration error, there is a risk that staff make clinical decisions using inaccurate or incomplete information, which may result in incorrect treatment or medication, missed allergies or risk alerts, inappropriate application of Mental Health Act requirements, serious patient harm or death.	Performance Risk - Information Governance	Health Informatics Directorate	4	1	4	Tolerate	Amber - Within Tolerance

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks	**Agenda Item**	Paper M
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	30 July 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 of progress on mitigating the five risks that it felt had the biggest opportunity to disrupt the delivery of the Strategy. Consideration has previously been given to whether any other risk should replace or be added to the current five, and the The Value Circle (TVC) Well-Led Developmental Review report on today's agenda suggests for a finance related risk to be considered. The Board is today asked to confirm the SDRs to be its focus throughout 2026/27.

The presentation of the SDRs has been reworked since the last cycle to strengthen the structure, the treatment of controls and assurances, and the visibility of movement and action over time. The detail of these changes, and one area of development still to conclude on assurance ratings, is set out at Section 2.

Progress on the SDRs will continue to be monitored routinely through the respective Committees and to the Board during the year, at the frequencies set out in the Board and Committee Workplan paper on today's agenda. It remains the case that there is a contrast across the SDRs, with large aspects within our gift to develop our staff, alongside reliance on the ability of external partners and stakeholders to help and support the way forward — an aspect that carries its own challenges as reported.

In considering the paper, Directors should cross refer this update with the Promise 9 and Promise 10 reports, the Promises and Priorities Scorecard and the paper on the Culture work also on today's agenda.

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:

NOTE and **FEEDBACK** on the revised format and content in this update report; and

RECEIVE and **NOTE t**he update position for each SDR;

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

SDR DASHBOARD BOARD ASSURANCE FRAMEWORK

Strategic Delivery Risk and Assurance Profile July 2026

Strategic Delivery Risk	Current Assurance Rating	Current Risk Score	Direction of Travel	Oversight Committee
SDR1: Partnerships Because the leadership is unable to identify, communicate and engage, there is a risk that the Trust's changed ways of working with the diverse population, including excluded communities, are not delivered by 2027.	ADEQUATE *(inferred)*	12	◄►	PHPIP
Owner's view: Position materially stronger than the previous baseline, but assurance is not yet outcome based. Score retained until effectiveness is evidenced rather than activity. **Latest:** Place Partnership Reviews have run monthly since January 2026, most recently on Rotherham, following North Lincolnshire and Doncaster. **Next:** **Develop a process to embed values alignment in recruitment and appraisal — SF - due July 2026.**				
SDR2: Equity and data Because leaders lack the time, skills or diligence to see through specific changes, or are distracted by wider system priorities, there is a risk that the Trust does not execute plans to consistently create, use and respond to data inside its services and with others.	ADEQUATE *(inferred)*	9	▼	FDE
Owner's view: Recently took ownership and refreshed the risk, adding a third cause. Controls cover two of the three strands; the gap is leadership time and focus, where control design is underway. **Latest:** The Internal Audit of the IQPR returned significant assurance, and the Clinical Coding Audit assured FDE that robust processes are in place. **Next:** **Complete the health inequalities analysis and reformatted IQPR, due July 2026.**				
SDR3: Community offer Because there is not the skill to change or the confidence to experiment in both parties, or funding models are restrictive, there is a risk that the Trust cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT, PCN and neighbourhood level.	ADEQUATE *(inferred)*	12	◄►	PHPIP
Owner's view: This risk is about the Trust's behaviours as much as those of primary care. ICB change and the national neighbourhood contract consultation leave the future architecture unclear. **Latest:** The survey of GP practices closed on 30 April 2026; analysis is underway and will drive next steps in 26/27. Waiting times are now routinely published on the Trust website. **Next:** **LDO research and evaluation planned outputs — K Williamson, first output due April 2026, second September 2026.**				
SDR4: Bed based care Because of resistance, inflexibility or affordability, with colleagues able to move elsewhere, there is a risk that seven day working and other bed-based service alterations are not implemented fully.	ADEQUATE *(inferred)*	12	◄►	QC
Owner's view: Ownership recently transferred. A stock take of all services against Promise 22 and hyperlocal neighbourhood working, with a measurable forward plan, completes September 2026. **Latest:** As this SDR has recently transferred in terms of director ownership a stock take is currently being undertaken in terms of all services reviewing aligned with promise 22 **Next:** **Make 24/7 therapeutic discharges part of the inpatient improvement programme — from Q3. This is the only dated action on this risk; all others remain undated.**				
SDR5: Social value Because the Trust does not develop and practice the skillsets required to make change occur, there is a risk that it does not achieve the step up in institutional and system capability to deliver multiple time bound simultaneous changes with impact by 2027.	ADEQUATE *(inferred)*	12	◄►	POD
Owner's view: Sustained investment in development, with early LDO evaluation showing improvement. This must now become business as usual, and the cultural reset address the divide between newer and longer serving colleagues. **Latest:** MAST and PDR compliance letters issued to 421 and 157 colleagues in May, with follow up due early June 2026. Internal audits on induction and MAST both returned significant assurance. **Next:** **Undertake the planned Promise 26 Anti Racism audit — due 26/27.**				

KEY | SUBSTANTIAL | ADEQUATE | LIMITED | NONE | ▲ increased ◄► unchanged ▼ decreased (vs prior month)

Strategic Delivery Risks

1. Background

1.1 The Strategic Delivery Risks are those risks that the Board has determined as having most potential to disrupt the delivery of the strategic objectives. These are different from the risks manged via the range of risk registers (operational risks). The latter reflects the challenges to the organisation's functioning on a year by year, week by week basis. It is a live document that will show identification, mitigation and escalation of key risks faced by teams across the organisation. In contrast, the SDRs focus on factors which could interrupt delivery of the organisation's objectives over the medium term. These are also risks that the Board has a unique ability to solve.

1.2 The Board is focused on mitigating the likelihood, or more typically the impact, of these factors. Individual executive directors have been tasked with progressing actions to this effect.

The five risks, each aligned to a strategic objective, were agreed in 2024 and have been periodically reviewed since to ensure they continue to reflect the organisation's strategic risk position. The Board is asked in this meeting to reconsider the risks and confirm the SDRs for 2026/27. The current five SDRs are set out 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 — What happened Since the Last Report

2.1 Following the Board meeting in May and further reflective input on the SDR process, the planned presentation of the Strategic Delivery Risks to the committees was deferred, to allow all five SDR risks to be consistently updated in line with the feedback and development opportunities identified since the last cycle. The full revised set is brought to the Board today.

2.2 The structure of each SDR entry has been reworked to make the risk easier to read and to draw out the owner's own assessment of the current position and the way forward. Controls and associated assurances have been refined to make the links between them clearer and mapped across the three lines of defence model with the sufficiency of each source made explicit. This makes visible where assurance is robust, where it is self-reported, and where it is absent — a distinction that was not previously drawn out in the presentation.

2.3 Each SDR now carries a direction of travel and a movement log showing how the position has shifted period on period, rather than being presented as a single fixed picture. An action tracker sits alongside, tying every identified gap to a named action, owner and due date, so that the route back to target is visible and can be held to account across reporting cycles.

2.4 A single-page dashboard has also been developed to provide an at-a-glance view of all five Strategic Delivery Risks, showing current assurance rating, score, direction of travel and latest position. The intention is to give the Board a consolidated picture of the strategic risk position before engaging with the detail of any individual risk, in the same way the operational dashboard supports the current report.

2.5 Feedback on the changes is welcomed and there is one area of development remains outstanding. The Trust does not currently apply assurance ratings to its Strategic Delivery Risks, and while the risk management framework references assurance levels, it does not set out the criteria against which those ratings would be assigned. This will likely mirror the new four-box grid assessment process. Once the framework is in place, the assurance rating work on the SDRs can be progressed and reported alongside the wider revisions set out above.

2.6 The Board is asked to note the revised presentation of the Strategic Delivery Risks, the development work still to conclude on assurance ratings, and to confirm the five SDRs as set out at Section 1.3 as the strategic risk position.

3. Strategic Delivery Risks

3.1 With respect to the SDRs, review and monitoring work continues through

- 3.2.1 Individual executive leads – as a result of the changes in the Executive Group from 1 April, SDR2 is now led by Richard Chillery, COO and SDR4, by Dr Jude Graham, Director of Psychological Professionals.
- 3.2.2 The tri-annual review meetings with executive leads, the audit committee chair and the Director of Corporate Assurance (most recently in May 2026)
- 3.2.2 Board Committees
- 3.2.3 Board of Directors; most recently in March 2026

3.3 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 are both held at a score of 12 (impact 4, likelihood 3). The two SDRs continue to share substantial synergy. Work to build inclusive leadership, power sharing and a partnership ethos strengthens the Trust's engagement with communities and its wider leadership and governance in parallel, and the recent focus on the LDO and induction as the primary points of change with colleagues has been reinforced by broader activity through Learning Half Days, active bystander training and community immersion. The forthcoming 555 Line Managers work provides a further opportunity to embed community engagement. The Community Leadership Executive, established in May 2026, along with the continuing involvement of volunteers and carers, will support the mitigation of both risks as it embeds. The scoring is held at this position because the recent controls are still in their early stages. The LDO impact evaluation is planned but yet to complete, the CoLE is newly established, and the wider practice of the leadership skillset that SDR5 is designed to develop is still to be evidenced through the planned assurance cycle. The

impact remains at 4 on the basis that loss of local confidence combined with non-delivery of a Strategic Objective is major, but not catastrophic.

SDR2: This risk has reduced from a score of 12 to 9 (impact 3, likelihood 3). The reduction reflects a reassessment of the risk's impact rather than a change in likelihood. The risk describes a lack of precision in how the Trust reshapes services, which is a genuine effect on the quality of decision making but one that is recoverable rather than of a scale associated with lasting service disruption, serious harm to patients or significant regulatory consequence. On that basis a score of 3, moderate, sits more rightly than 4. The likelihood remains at 3. Progress since March supports the reassessment. The health inequalities data suite continues to develop, a recent internal audit acknowledged the progress being made, and System Connect is being expanded as the next major control. Efforts to maintain data quality standards continue in parallel.

SDR3: The draft Partnership Scorecard is now at an advanced stage and was presented to PHPIP in July 2026. It is intended to give us a much clearer picture of the value our partnerships are adding, the outcomes they are helping to deliver and where there may be opportunities to strengthen how we work together. Importantly, the scorecard will not only support the Trust to assess the contribution of its partners; partners will also be able to score and provide feedback on the Trust's contribution to the partnership. This should help create a more balanced and honest view of how well the arrangements are working from both sides. The scorecard has not yet been shared with partners, and the next step will be to engage with them to test and refine the proposed measures before it is finalised and introduced.

SDR4: This is held at a score of 12 (impact 4, likelihood 3). Full seven day working, particularly weekend discharges, remains limited by workforce, system and cultural constraints, and matters such as job planning and the ways of working of system partners will continue to challenge the pace of progress. Notwithstanding this, the likelihood of non-delivery is assessed as possible rather than likely, because the Trust's delivery strategy is not contingent on the national position shifting. The High-Quality Therapeutic Taskforce has already delivered consistent seven-day provision across activities, visiting times, MDT working, care planning and ward handover. New services are being designed as seven-day services from the outset, and external provision is being commissioned on a seven-day basis. Tangible progress on weekend access, out of area placements and length of stay has been evidenced through Promise 22 reporting, and the 24/7 mental health centre in North Lincolnshire, due to open from noon on 30 September, will provide a further step forward.

As this SDR has recently transferred in terms of director ownership a stock take is currently being undertaken in terms of all services reviewing aligned with promise 22 and also considering the shift to hyperlocal neighbourhood working. This stocktake and an associated forward plan based on measurable actions will be complete by Sept 2026.

4. Recommendations

The Board of Directors is asked to:

NOTE and FEEDBACK on the revised format and content in this update report; and RECEIVE and NOTE the update position for each SDR;
Philip Gowland, Director of Corporate Assurance
30 July 2026

SDR1 STRATEGIC DELIVERY RISK

Strategic Objective 1: nurture partnerships with patients and citizens to support good health

AGGREGATED ASSURANCE RATING	**ADEQUATE**

THE RISK As a Strategic Delivery Risk

There is a risk that (Risk)	the Trust's 'changed ways of working' with the diverse population, including excluded communities, are not delivered by 2027
Because (Cause)	of the leadership's inability to consistently identify, communicate, engage, co-produce and act on feedback.
Then (Impacts)	it will lead to a loss of confidence locally and the likely non-delivery of SO1

Live issue feeding this risk: *N/A*

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.

KEY EFFECTS AND CONSEQUENCES

- Loss of confidence locally and the likely non-delivery of SO1

Accountabilities and review history	
Strategic risk owner	Chief Nursing Officer-Steve Forsyth
Board oversight forum	PHPIP

Risk analysis	**Current — July 2026**	**Previous-March 26**
Risk score (Impact x Likelihood)	4 x 3 = **12**	4 x 3 = **12**
Target score by Dec 2026	4 x 2 = **8**	

Risk category	External and Partnerships Risks - Change and Improvement Delivery Risk	**Risk appetite**	Moderate
Last deep dive review		**Appetite Status**	Within Tolerance
Date of last update			
Next review			

Commentary

Strategic Risk Owner Commentary

SDR1 remains live, but the position is materially stronger than the previous baseline. The infrastructure for power sharing has matured: CoLE is now operating with agreed terms of reference and a Promise focused workplan, Promise 2 has moved into practical implementation, volunteering has reached 357 active volunteers with a cohort more diverse than the workforce, and Care Opinion is running at scale with 82 to 90 percent positive stories, while still surfacing recurring themes on access, waiting and communication. The score should nonetheless be retained. The independent Well Led Review confirmed strong direction and meaningful community participation but found the assurance not yet outcome based, recommending clearer evidence of follow through, impact and sustained risk reduction. Until effectiveness is evidenced rather than activity, a reduction cannot be supported

Director of Corporate Assurance — second line

Progressive movement on this SDR; anticipated movement in score within six months. Clear link and synergy to SDR5 and the ongoing work developing our leaders.

Tables of Controls and Assurances

Key Controls / Mitigations	**Assurance / Evidence**		
For Cause: the leadership is unable to identify, communicate and engage with a diverse population *[system in place to help manage the cause / effect]*	*[where can we gain evidence that the controls we are placing reliance on are working]*		
	First Level	**Second Level**	**Third Level**

	[Service delivery and day to day management - how do we know day to day that controls are working?]	*[Oversight - who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]*	*[Independent challenge - has anyone external come in to check that the controls are working]*
Stakeholder Management Matrix and place-based partnership meetings	• Place based partnership meetings now monthly; March meeting focused on Rotherham, previous meetings on North Lincolnshire and Doncaster; attended by two EG colleagues and relevant care group representatives.	• PHPIP Strategic Delivery Risk Report to the PHPIP Committee each meeting (most recent July 2025). • Management reporting to Board and CLE against related Promises via the Promises and Priorities Scorecard.	• Internal Audit on Partnership Governance and Risk Management, significant assurance, all actions complete.
Community Leadership Executive (CoLE)	• Terms of reference and initial workplan agreed 9 July 2026; positioned as a sister executive to the Clinical Leadership Executive, designed to challenge, advise, support co production and strengthen VCFS and community influence over Trust decisions. • Membership of 15 community representatives selected from more than 35 applications, including voluntary and faith sector leaders. • Initial focus on Promise 5 and Promise 12, with Promise 6 and Promise 21 to follow; scrutiny of seldom heard voices and review of induction material for cultural competence.	-	-
Coproduction as the standard for service and policy change (Promise 5)	• Major policy and service changes involve patient and carer input through co design sessions, steering groups and public workshops, with community representatives shaping	-	-

	solutions rather than being consulted Kafter the fact.		
Delivering services in community and faith settings	• Services taken into non-traditional settings to improve access for excluded groups, including memory assessment delivered in a mosque and health checks offered in community hubs.	• Example of dementia assessment in a community faith setting reported to the Rotherham Quality and Safety meeting.	-
Engaging our communities, seeking feedback (Care Opinion)	• Care Opinion launched for patients and carers; featured in Care Group Delivery meetings in 2024 and May 2025. • Volume of Care Opinion stories tracked as an indicator of patient voice; feedback loop closed through you said, we did communications.	• Care Opinion featured in the February 2025 Board Timeout led by the CEO of Care Opinion, and at Council of Governors June 2025; overarching analysis of responses, including those leading to action, reported to Board in September 2025 within the Chief Executive's Report.	• Internal Audit on Patient Experience, Engagement and Inclusion, significant assurance.
Carers, volunteers and peer support roles as partners (Promise 2)	• Expansion of peer roles, volunteer and carer involvement across care and governance; over 350 volunteers contributing regularly, with a volunteer cohort more diverse than the paid workforce; carers engaged in care planning and Trust improvement work. • Standardised Think Carer, always ask always support model in place, with a SystmOne carer identification and referral template and Carer Peer Support Worker roles; joint local authority reporting from Q2 2026/27 and Carers Federation Accreditation trajectory to December 2026.	• Promise 2 carries measurable milestones reported through the Promises and Priorities Scorecard.	• Internal audit of the Carers Plan and internal audit on the Promises cited as sources of independent assurance.

Representative workforce, patient safety partners and members	• Collation and presentation of numbers, action plans for increased numbers, and analysis against the communities served, used within recruitment and decision making.	• WRES report reviewed and approved by POD Committee (August); some areas improved, others declined. WDES not improving as fast as WRES, discussed at POD and to be taken to the DAWN network and Combined Staff Network to identify actions.	-
Leadership Development Offer (LDO), compassionate and inclusive leadership to unlock community power	• Baseline data established at commencement of the programme; further cohort feedback and analysis as cohorts complete. • Programme covers approximately 150 leaders in cohorts across 2024 to 2026, explicitly aligned to SO1, with modules including Unlocking Community Power and Active Bystander. • Community immersion experiences and reflective modules on equitable leadership; leadership forums, action learning sets and supervision incorporate power, privilege and voice.	• LDO feedback and further detailed analysis planned, including whether the Trust has developed compassionate leadership and whether the LDO improved leaders' engagement; review of impact on cohorts planned by March 2026. • Featured as LDO learning outcome 2, enhancing the ability to lead change and deliver improvements; LDO providers have added a line manager evaluation question.	-
Active Bystander training	• Training deployed to move staff from passive observation to active intervention where discrimination, bullying, micro aggressions or unsafe practice are witnessed, framing intervention as a professional duty. • Over 300 staff trained by late 2024; extension underway to further teams and to managers in higher risk areas.	-	-

Anti Racist Behavioural Framework and taught learning culture	• Anti Racist Behavioural Framework in place setting explicit behavioural expectations; racism, discrimination and exclusion treated as organisational risks within risk management and improvement work rather than as individual matters. • Culture change delivered through formal training, continuous reinforcement in meetings and modelling of expected norms rather than reliance on good intentions.	• Learning Half Days discussed at the Education and Learning meeting June 2025; paper to CLE June 2025; paper to Board March 2025. • Equity and inequality data, including patient feedback trends by demographic and volunteer diversity, routinely discussed at Board and committee.	-
Induction for all new starters, RDaSH and our communities	• Thirteen inductions since launch in October 2024, circa 650 staff progressed; evaluation asks whether participants understand how their role supports the Strategic Objectives and Promises. • Induction sets cultural expectations from day one, stating the Trust's position on racism and exclusion and that speaking up and challenge are expected behaviours.	• Evaluation of induction presented in the Autumn to the People and Teams CLE Group.	• Internal Audit on Induction, significant assurance (25/26 audit plan).
Freedom to Speak Up, staff networks and staff voice	• Freedom to Speak Up route available to all staff, supported by staff networks and leadership open forums as additional routes to raise concern. • Staff Survey Voice Scorecard and the Trust People Council used to test whether staff experience aligns to stated expectations.	• Freedom to Speak Up data and internal pulse surveys in late 2025 indicate a higher proportion of staff confident to speak up than at baseline.	-

Monitoring of leadership behaviour through appraisal and feedback	• Appraisal and 360 feedback used to observe whether leaders make space for challenge and demonstrate inclusive behaviour; leadership cohorts provide structured peer reflection on shifts in practice.	-	-
Control Lead: SF			**Assurance Level: ADEQUATE**

Gaps in control	**Gaps in assurance**
• Anti Racist Behavioural Framework is in place but there is no process to test whether the behavioural expectations it sets are applied in practice. (No action currently in the plan) • Induction process refinements identified from feedback not yet deployed. (Action 3) • No embedded process yet to ensure recruitment and appraisal test alignment to the Trust's values. (Action 4) • Learning Half Days control not yet fully developed; forward plan and learning library outstanding. (Action 5) • Volunteer coverage patchy, with several services having none, roles not consistently backfilled, and over 100 active volunteers not registered as Trust members owing to data issues. (Action 8) • Community Physical Health Team not yet launched; it becomes a control only from the August 2026 launch. (Action 9) • Carer involvement inconsistent at ward level, with PSII and governance evidence still identifying documentation and embedding issues. (Action 11) • Ethnicity and protected characteristic data gaps, with interpreter service uptake low and variable. (Action 12)	• CoLE began meeting in May 2026 with no second- or third-line assurance and no defined reporting route into Board or committee. (Action 7) • Active Bystander training evidenced by delivery volume only; no oversight reporting of coverage by team or service, no measurement of behavioural impact, and no independent review. (No action currently in the plan) • Flow of partnership review outcomes within the Trust not yet confirmed; reporting route to CLE to be clarified. (Actions 1 and 6) • LDO impact on leaders' capability and engagement not yet evaluated; outcome thresholds and quantitative measures still to be determined. (Action 2) • WDES not improving at the rate of WRES; actions still being identified. • No closed loop evidence yet showing how CoLE, Care Opinion, carer, volunteer or community feedback has changed decisions, practice or outcomes. (Action 13) • Outcome metrics inconsistent across Promise 2, Promise 3, Always Measures and equity and inclusion work, with no common measures or thresholds. (Actions 10 to 13) • Staff Survey raising concerns score has declined for three consecutive years, with some directorates combining low reporting and low confidence. (Action 14)

Action plan to close the gaps

Action	Gap addressed	Owner	Due	Progress	Status
Place Partnership Reviews (cake meets) scheduled monthly	**Assurance gap**	-	Commenced Jan 2026	Meetings commenced January 2026; March 2026 meeting focused on Rotherham, previous meetings on North Lincolnshire and Doncaster. Reporting process to CLE still to be clarified.	**In progress**
LDO research and evaluation, including assessment against expected levels of achievement	**Assurance gap**	K Williamson	May 2026	-	**Planned**
Consider changes to the induction process to reflect feedback	**Control gap**	Induction and Widening Participation Manager	July 2026 onwards	Changes to be deployed over the summer of 2026.	**Planned**
Develop a process to embed values alignment in recruitment and appraisal	**Control gap**	-	From July 2026	Explored via the Trust People Council and the annual Staff Survey Voice Scorecard; from July 2026 all interview panels for roles B7 and above constructed to ensure panel diversity.	**In progress**
Develop a robust forward plan for Learning Half Days, including a learning library	**Control gap**	-	-	-	**Planned**
Confirm the flow of partnership outcomes and reporting to CLE	**Assurance gap**	-	-	-	**-**
Embed CoLE evidence and outputs into the Board and committee reporting cycle	**Assurance gap**	SF	From Sept 2026	-	**Planned**
Establish the volunteer dashboard and backfill process, including	**Control gap**	SF	Q3 to Q4 2026/27	-	**Planned**

registration of active volunteers as Trust members					
Launch the Community Physical Health Team and produce the first outbrief, validated workplan and coverage dashboard	**Control gap**	SF	Aug to Sept 2026	Launch event held 30 June 2026 with 81 participants; 118 service validated Community Services Directory in place.	**In progress**
Deliver Promise 2 Q2 reporting, including SystmOne carer data, local authority outcomes, Carer Peer Support Worker activity and accreditation gap analysis	**Assurance gap**	SF	By Sept 2026	-	**Planned**
Close equity and inclusion gaps on ethnicity coding, interpreter service oversight and Promise 8 measures	**Control gap**	SF	Sept 2026 and Q3	-	**Planned**
Strengthen patient experience triangulation across Care Opinion, PALS, complaints, patient safety and FTSU	**Assurance gap**	SF	Sept to Nov 2026	-	**Planned**
Deliver FTSU targeted directorate engagement and the adverse effects SOP	**Control gap**	SF	Next cycle 2026/27	-	**Planned**

SDR2 STRATEGIC DELIVERY RISK

Strategic Objective 2: create equity of access, employment and experience to address differences in outcome

AGGREGATED ASSURANCE RATING	ADEQUATE

THE RISK As a Strategic Delivery Risk

There is a risk that (Risk)	that the Trust does not consistently create, use and respond to data to inform service change
Because (Cause)	Leaders and staff lack the data literacy and confidence to interrogate and act on data; because operational and system pressure removes the time, focus and follow through needed to sustain data driven change; and because the data itself is not consistently complete, timely, reliable or usable enough to support targeted action.
Then (Impacts)	it will lead to a lack of precision in how the Trust reshapes services

Live issue feeding this risk: *N/A*

What could get in the way?

Challenges generating data and / or evidence to support interventions to address health inequalities

KEY EFFECTS AND CONSEQUENCES

- A lack of precision in how the Trust reshapes services-

Accountabilities and review history	
Strategic risk owner	RB (RC from 1 June 2026)
Board oversight forum	FDE
Risk category	External and Partnerships - Change and Improvement Delivery Risk.
Last deep dive review	
Date of last update	

Risk analysis	Current — July 2026	Previous – Maar 2026
Risk score (Impact x Likelihood)	3 x 3 = **9**	4 x 3 = **12**
Target score by Mar 2027	4 x 2 = **8**	
Risk appetite	Moderate	
Appetite Status	Within Tolerance	

Next review			

Commentary

Strategic Risk Owner Commentary

I have recently taken ownership of this risk and used the transition as an opportunity to review and refresh it. The risk statement has been strengthened by adding a third cause, so it now reflects three distinct strands: data literacy and confidence, the time and focus lost to operational and system pressures, and the completeness and reliability of the data itself.

Controls are in place against two of these three areas, with the strongest assurance currently sitting around data quality. The main gap is in relation to leadership time and focus, where work is now underway to identify and develop appropriate controls.
I am also linking this risk more clearly to related work across the Trust, particularly the health inequalities programme and neighbourhood development. This will help ensure that our approach to data-driven change is tested through practical delivery and improvement work, rather than being considered in isolation.

Director of Corporate Assurance — second line

-Positive movement in score with the opportunity within the financial year to progress; System connects and broader data quality initiatives will be pivotal to the progress.

Tables of Controls and Assurances

Key Controls / Mitigations For Cause: leaders lack the time, skills or diligence to see through changes, or are distracted by wider system priorities *[system in place to help manage the cause / effect]*	**Assurance / Evidence** *[where can we gain evidence that the controls we are placing reliance on are working]*		
	First Level *[Service delivery and day to day management - how do we know day to day that controls are working?]*	**Second Level** *[Oversight - who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]*	**Third Level** *[Independent challenge - has anyone external come in to check that the controls are working]*
Educating our leaders (Data Saves Lives campaign, Digital Needs Survey, Learning Half Days)	• Data Saves Lives campaign launched November 2024; posters distributed and three vlogs launched December 2024; December key messages on trust and transparency, accurate	• Summary outcome reports provided to the Digital Transformation Group, informing the Data Saves Lives programme and training, including the SystmOne interface.	-

	recording, the Yorkshire and Humber Care Record and data flows; Ask Me Anything session January 2025. • Learning Half Days ongoing from September 2024, featuring the importance of data and health inequalities. • Use case and visualisation sessions run through 2024 and 2025 (shared record use cases, personalised care visualisation for PROMs, digital patient communication, SMI physical health check visualisation, shared care records).	• Post campaign business as usual plan agreed, incorporating Q3 and Q4 evaluation and changes to the systems training offer. • Board Timeout June 2025, an NHS Digital session facilitated by NHS Providers.	
Health inequalities data and reporting (IQPR with a health inequalities lens; PHPIP Promises data set)	• IQPR carries supplementary health inequalities information from July 2025. • Improved operational data developed to drive change: Promise 14 delivery (48-hour assessment and 4 week wait) reported to Board November; 4 week wait position and waiting times published on the Trust website July 2025; neighbourhood data at March CLE; sickness absence and Staff Survey cuts March 2026.	• Board received an analysis of the IQPR through a health inequalities lens (July 2025) and agreed the CLE Equity and Inclusion Group would review the data to understand local needs of patients with protected characteristics. • PHPIP Committee receives and discusses the Health Inequalities Promises Data Set Report at each meeting, for example DNA rates for deprived areas and referrals for veterans. • Management reporting to Committee, Board and CLE on related Promises (Promise 6 Poverty Proofing, promise 8 Inequalities) via the Promises and Priorities Scorecard; FDE Strategic Delivery Risk Report overseeing SDR2.	• Internal Audit of the IQPR - Significant Assurance.

Information Quality Programme (data quality workplan, kitemarking, data quality indicators)	• Information Quality Programme in place with a structured and demonstrable process; kitemarking used within the IQPR against individual indicators.	• Reports to FDE. FDE February 2026 reviewed the latest three indicators in the 26/27 workplan: High Assurance for SMI annual physical health checks (OP61c); High Assurance for seclusion MDT within 5 hours (QS31); Moderate Assurance for Section 136 breaches (OP73a). • Completeness of ethnicity data reported to September Board.	• Internal Audit on Waiting Lists - Significant Assurance for waiting list management, Limited Assurance for waiting list validation. • Clinical Coding Audit (February 2026) - FDE assured that robust processes are in place for accurate clinical coding.
Control Lead: RB (RC from 1 June 2026)			**Assurance Level: ADEQUATE**

Gaps in control	Gaps in assurance
• No control addresses the leadership time and prioritisation part of the cause. The controls cover data and skills, not leaders being distracted by wider system priorities. (No action currently identified) • System Connect not yet fully implemented; enhanced two-way patient communication and self-referral still being rolled out. (Action 4) • Suite of health inequalities data not yet fully developed. (Action 5)	• Ethnicity data incomplete where a person's ethnicity is not known or not stated. (Action 5) • Impact of the leadership education effort not yet evidenced; colleague responses demonstrating learning not yet identified. (Action 6) • Final two data quality indicators still to complete and report. (Action 1) • No independent, third line assurance on the leadership education control. (No action currently identified)

Action plan to close the gaps

Action	Gap addressed	Owner	Due	Progress	Status
Complete the final two data quality indicators in the 25/26 workplan (adult ADHD waiting list OP59a; CYP neurodevelopment OP59b)	Assurance gap	-	June 2026	-	In progress
Complete the health inequalities analysis and reformatted IQPR	Assurance gap	-	July 2026	-	Planned
Internal Audit on ESR and Finance Ledger reconciliation, to give a single source of truth for staff data	Assurance gap	-	May 2026	Completed and report received	Completed

Conclude the System Connect work (two-way patient communication and self-referral)	**Control gap**	-	May 2026	Enhanced functionality moving from basics to greater use across teams from June 2026 onwards	**In progress**
Develop the health inequalities data suite and Equity and Inclusion Group action plan (ethnicity data gaps, SO2 metrics, RDaSH 5 and Poverty Proofing, IQPR analysis follow up)	**Assurance gap**	Equity and Inclusion Group	From April 2026	-	**In progress**
Embed data and digital in the TNA 2026/27 and evidence colleague learning from Data Saves Lives. Also offered digital apprenticeships. Enhanced AI and copilot usage	**Assurance gap**	-	2026/27	-	**Planned**

SDR3 STRATEGIC DELIVERY RISK

Strategic Objective 3: expand our community offer, in each of - and between - physical, mental health, learning disability, autism and addiction services

AGGREGATED ASSURANCE RATING	ADEQUATE

THE RISK As a Strategic Delivery Risk

There is a risk that (Risk)	the Trust cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT, PCN and neighbourhood level
Because (Cause)	there is not the skill to change or the confidence to experiment in both parties, and funding models are restrictive
Then (Impacts)	the Trust cannot deliver its new community offer with the effectiveness the strategy requires, shared care will not be achieved, and patients will suffer harm

Live issue feeding this risk: *N/A*

What could get in the way?

Capacity, capability and willingness of local primary care leadership cannot match the reform intended, or at least implied, by others' strategies

KEY EFFECTS AND CONSEQUENCES

- The new community offer is not delivered with the effectiveness the strategy requires.
- Shared care is not achieved.
- Patients suffer harm.

Accountabilities and review history	
Strategic risk owner	TL
Board oversight forum	PHPIP
Risk category	External and Partnerships - Partnership Working Risk.
Last deep dive review	

Risk analysis	Current — July 2026	Previous
Risk score (Impact x Likelihood)	3 x 4 = **12**	4 x 3 = **12**
Target score by Mar 2027	3 x 3 = 9	
Risk appetite	High Tolerance	
Appetite Status	Within Tolerance	

Date of last update	14/07/2026
Next review	

Commentary

Strategic Risk Owner Commentary

It is important this risk is not read as being about primary care, but rather about the Trust's behaviours and those of primary care. With ICB changes their role in primary care is changing, and the new architecture is very unclear. The consultation on neighbourhood contracts has started nationally. This may see PCNs demise. At the same time policy is pushing for at-scale federated general practice. The Trust is working closely with primary care partners, recognising there may be strategic tensions over future role in places: and immediate operational issues which drive GP perceptions and reactions.

Director of Corporate Assurance — second line

-Significant external influence on this SDR which will impact on progress. Internal work is progressive and provides some opportunity before the end of the financial year for progress.

Tables of Controls and Assurances

Key Controls / Mitigations For Cause: there is not the skill to change or the confidence to experiment in both parties, and funding models are restrictive *[system in place to help manage the cause / effect]*	**Assurance / Evidence** *[where can we gain evidence that the controls we are placing reliance on are working]*		
	First Level *[Service delivery and day to day management - how do we know day to day that controls are working?]*	**Second Level** *[Oversight - who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]*	**Third Level** *[Independent challenge - has anyone external come in to check that the controls are working]*
Stakeholder Management Matrix and place-based partnership meetings	• Stakeholder Management Matrix covering a range of stakeholders, with clarity for each relationship over roles, responsibilities, authority and capacity of identified leaders; important to understand the dynamic at place and directly with local authorities.	• The regular place partnership reviews afford the opportunity to assure on their effectiveness; CLE need to become more aware of their progress and impact. •The new draft partnership scorecard will provide a basis for evaluating primary care relationships by place. It	• Internal Audit on Partnership Governance and Risk Management - significant assurance, all actions complete.

	• Place based meetings monthly; March focused on Rotherham, previous meetings on North Lincolnshire and Doncaster; attended by two EG colleagues and relevant care group reps to discuss progress with building relationships and create synthesis with other sources.	is recognised that care group teams need help with the skills to drive these relationships locally and gaps in medical director roles in those groups is an impediment.	
Practical programme of change with primary care (five CLE priorities: removing cross referral barriers, simple electronic referral forms, coherent communication and senior escalation routes, auditing work passed to GPs, published waiting time information)	• Waiting times now routinely published on the Trust website (Priority 5). • Priorities 1 to 4 identifying and progressing pilot sites with primary care partners, test and learn agreed.	• Latest assessment with CEO, DoSD, DCOO, Contracting and GP Liaison clarified progress; delivery plan agreed, seeking substantial progress on the four priorities by 31 July 2026 with stakeholder satisfaction and feedback work planned during Q3 2025/26.	-
Deep involvement in neighbourhood health decision making (place bodies; Safe care GP Federation in North Lincolnshire; Rotherham Federation including Doncaster East PCN; Doncaster leadership groups)	• Direct work with the Safe care GP Federation in North Lincolnshire, the Rotherham Federation including Doncaster East PCN, and the various Doncaster leadership groups. • Working with one PCN (Doncaster East) to develop an integrated physical and mental health approach as a prototype for the Trust.	• PHPIP and Board have received recent papers on Promises 15 and 21; in Doncaster there is a clear neighbourhood response within Physical Health Services. • Community Powered Healthcare Taskforce holds a responsibility to do the thinking on a common mental health team response to these challenges learning from prior Transformation work (20-22)	-
Community Development Director role (new Director role within Operations, managing GP Liaison; four priority areas: primary and secondary care interface, neighbourhood health delivery, community services transformation, Family First national programme)	- Role proving effective in galvanising work related to neighbourhoods and better connecting the Trust into pilots and initiatives externally. - Important that Families First role allows children's services to form part of neighbourhood conversations	-	-

GP Liaison role (regular touchpoints in each of the three places; programme of visits to every practice, PCNs and local Federations)	• Feedback mechanisms with GPs established and embedded. • Engagement, at differing levels, with circa 90 percent of practices. • Initial survey (May 2025) of how practices rate integration, collaboration and partnership with RDaSH scored 2.52 out of 5.	-	-
Facilitating insight into general practice (NED and Associate NED GPs, GP Partner Governor, Place CEX route to CLE, GP appointments into care groups, LDO and LHD awareness aligned to GP training schedules, monthly Lunch Collab)	• Lunch Collab monthly, an RDaSH team meeting primary care colleagues on roles, waits, referrals and support; five sessions to date with over 100 primary care colleagues attending. • Individual meeting evaluation undertaken.	• PHPIP Committee March 2025, presentation of the GP Liaison role and work to date. • Board Timeout April 2025 on GP Liaison; Board Timeout April 2026, update on GP liaison within a broader understanding primary care session.	-
Control Lead: TL			**Assurance Level: ADEQUATE**

Gaps in control	Gaps in assurance
• Community Development Director is a new role still establishing clearer controls across much of this work, no evidence yet of it operating. (No action currently identified) • Neighbourhood definition unresolved; while the neighbourhood guidance (17 March 2026) is understood and the GP neighbourhood contract dispute continues, defining a neighbourhood team is unlikely to be possible during 2026. (No action currently identified because it is not in Trust control) • Internal relationships with Trust clinicians face a range of challenges that need resolving for key GP relationships to be built. ((No firm action but ongoing work in respect of clinician/primary care familiarity.))	• Flow of place partnership review outcomes within the organisation not yet confirmed; reporting to CLE to be clarified. (Action 1- From October) • Working group reporting mechanism for the programme of change not yet clarified, to ensure agreed timescales are achieved with the intended benefits. (Likely to report into OMG or CHPT) • LDO impact on leaders' engagement with primary care and partners not yet confirmed through feedback and evaluation. (Action 2) • 2026 GP survey outcomes still under review; headline may be uneven progress with some original concerns remaining. (Action 3 to which pace on 4 key changes is needed). • No independent, third line assurance beyond the partnership governance audit; nothing independent on the programme of change, neighbourhood work or GP liaison. (No action currently identified)

Action plan to close the gaps					
Action	**Gap addressed**	**Owner**	**Due**	**Progress**	**Status**
Place Partnership Reviews (cake meets) scheduled monthly	**Assurance gap**	-	Commenced Jan 2026	Meetings commenced January 2026; March 2026 meeting focused on Rotherham, previous ones likewise on North Lincolnshire and Doncaster. Reporting process to CLE needs clarifying.	**In progress**
LDO research and evaluation planned outputs	**Assurance gap**	K Williamson	Apr and Sept 2026	Will be shared in September	**Planned**
Repeat the survey of GP practices to establish the increase or improvement in reputation, engagement and responsiveness	**Assurance gap**	-	Survey closed 30 Apr 2026	Analysis will drive next steps in 26/27.	**Overdue**

SDR4 STRATEGIC DELIVERY RISK

Strategic Objective 4: deliver high quality and therapeutic bed based care on our own sites and in other settings

AGGREGATED ASSURANCE RATING	ADEQUATE

THE RISK As a Strategic Delivery Risk

There is a risk that (Risk)	seven days working and other bed-based service alterations are not implemented fully
Because (Cause)	of resistance, inflexibility or affordability, with colleagues able to move elsewhere, where such difficulties are not occurring
Then (Impacts)	the Trust will continue to place patients out of area and see severe stress, burnout and increased turnover among its own employees

Live issue feeding this risk: *N/A*

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

KEY EFFECTS AND CONSEQUENCES

- Patients continue to be placed out of area.
- Severe stress and burnout among the Trust's own employees.
- Increased turnover.

Accountabilities and review history	
Strategic risk owner	RC (JG from 1 June 2026)
Board oversight forum	QC
Risk category	External and Partnerships - Change and Improvement Delivery Risk
Last deep dive review	

Risk analysis	Current — Mar 2026	Previous
Risk score (Impact x Likelihood)	4 x 3 = **12**	4 x 3 = **12**
Target score by Mar 2027	4 x 2 = **8**	
Risk appetite	Moderate	
Appetite Status	Within Tolerance	

Date of last update	
Next review	

Commentary

Strategic Risk Owner Commentary

As this SDR has recently transferred in terms of director ownership a stock take is currently being undertaken in terms of all services reviewing aligned with promise 22 and considering the shift to hyperlocal neighbourhood working. This stocktake and an associated forward plan based on measurable actions will be complete by Sept 2026

Director of Corporate Assurance — second line

Awaiting stock take output; progression as previously reported on service extensions and expansions and new services is positive; changes in existing large scale services may require additional effort to be successful and will be impact upon by system partners.

Tables of Controls and Assurances

Key Controls / Mitigations For Cause: resistance, inflexibility or affordability, with colleagues able to move elsewhere *[system in place to help manage the cause / effect]*	**Assurance / Evidence** *[where can we gain evidence that the controls we are placing reliance on are working]*		
	First Level *[Service delivery and day to day management - how do we know day to day that controls are working?]*	**Second Level** *[Oversight - who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]*	**Third Level** *[Independent challenge - has anyone external come in to check that the controls are working]*
High Quality Therapeutic Taskforce (established January 2025)	• HQTC has progressed meaningful measures creating consistency across all wards: activities available seven days per week, visiting times consistent across the week, MDT meetings, care planning and ward handover consistent across seven days. • Progress towards seven day admissions and discharges,	• P22 Seven Day Services reported to PHPIP Committee January 2026, presenting 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. • Promises and Priorities Scorecard to Board of Directors each meeting;	-

	including with local partner organisations.	P19 Out of Area Placements to Board May 2025. • QC Strategic Delivery Risk Report on this risk at each meeting in 2025/26.	
Discharge baseline data and live Flow Dashboard	• Baseline developed of the number of discharges by day of the week and the timing of discharges by ward. • Live Flow Dashboard distributed daily to senior staff across the Trust.	• IQPR reporting improvements: waiting times under regular oversight and now published on the website; out of area placements; delays in discharge; length of stay metric introduced; utilisation of talking therapies; patients remaining on the ward over 32 days.	-
Enhanced weekday discharges using EDDs, with weekly senior nurse EDD reviews and a complex CRFD forum with the three Local Authority partners and two ICBs	• Enhanced discharges during weekdays using current infrastructure, with EDDs used more consistently and appropriately. • Weekly meetings with senior nurses to review EDDs (from Q2). • Complex CRFD forum operating with the three Local Authority partners and two ICBs.	-	-
Seven days by design for new services	• New services developed with the seven-day process in mind, for example the new HDU and Community Rehab Unit; recent Physical Health Care Group developments such as IV and Phlebotomy launched as seven day services in the last twelve months. • Further opportunities being considered to extend the approach: extension of medical on call to support weekend discharge; extending CAMHS psychiatry to	-	-

	crisis assessment for young people; Promise 14 access commitments (anytime appointment management, 48 hour urgent response due Q1 26/27, Q2 for Physical Health). • Work on Promise 1 (peer support workers), Promise 3 (volunteers) and Promise 21 (neighbourhood working, aided by the recently appointed Community Development Director) contributing to seven-day consistency.		
Commissioning VCSE partners on a seven-day basis	• Commissioning of support via VCSE partners, such as PFG, being completed on the basis of them being seven-day services.	-	-
Staff side and union engagement on the changes	• Consultation and engagement processes with union and staff side reps to discuss and agree changes. • Implementation of the consistent handover process included a consultation involving 170 staff and staff side; broad engagement with staff during the implementation of seven day per week activities.	• Ongoing work through TPC and OMG on developing and implementing greater flexibility within staff shifts.	-
Control Lead: RC (JG from 1 June 2026)			**Assurance Level: ADEQUATE**

Gaps in control	Gaps in assurance
• Full seven day working, particularly weekend discharges, remains limited due to workforce, system and cultural constraints, the 24/7 therapeutic discharge model is not yet in place. (Actions 1, 2 and 3) • No alternative or step-down provision is commissioned and operational; all options remain under consideration. (Action 4) • Workforce models of support (training, flexibility, supervision, safety) not yet in place. (Action 5)	• Formal quality and safety risk analysis not yet completed, so the full benefits of Promise 22 are unevidenced. (Action 1) • No comprehensive mechanism to collate and report staff feedback (Staff Survey, Pulse Check, peer reviews, consultation responses, union responses, Employee Relations indicators) to understand the impact of the changes. (Action 6)

• Nothing addresses the affordability element of the cause, or the national terms and conditions context that sits above the Trust. (No action currently identified)	• No independent, third line assurance; the Inpatient HQTC Stocktake Report to the Board of Directors is not due until November 2026. (No action currently identified)

Action plan to close the gaps					
Action	**Gap addressed**	**Owner**	**Due**	**Progress**	**Status**
Complete the further phased development, system alignment and formal quality and safety risk analysis required to deliver the full benefits of Promise 22	**Assurance gap**	-	-	-	**Planned**
Make 24/7 therapeutic discharges part of the inpatient improvement programme (the middle bit)	**Control gap**	-	Q3 onwards	-	**Planned**
Pilot programme on one ward to test the ability, capacity and affordability of the proposed changes	**Control gap**	-	-	-	**Under consideration**
Explore alternative and step down provision: two additional Rotherham crisis beds as a step-down test; co location with 24/7 partners (LA, acute, police) or extended GP hours; expansion of the virtual offer, AOT and remote working; outsourcing to community partners; future investment in step down provision; a 24/7 assistant offer	**Control gap**	-	-	-	**Under consideration**
Develop workforce models of support: training, enhanced work flexibility, clarity on support and supervision models, safety	**Control gap**	-	-	-	**Planned**
Establish a comprehensive mechanism for collating and reporting colleague feedback (Staff Survey, Pulse Check, peer reviews, consultation responses,	**Assurance gap**	-	-	-	**Planned**

union and staff side responses, Employee Relations indicators)					
Increase self-help services with swift access to advice and support, including enhanced community support for those discharged in the first 72 hours	**Control gap**	-	-	-	**Planned**

SDR5 STRATEGIC DELIVERY RISK

Strategic Objective 5: help deliver social value with local communities through outstanding partnerships with neighbouring local organisations

AGGREGATED ASSURANCE RATING	ADEQUATE

THE RISK As a Strategic Delivery Risk

There is a risk that (Risk)	the Trust does not achieve the step up in institutional and system capability to deliver multiple time bound simultaneous changes with impact by 2027
Because (Cause)	the Trust does not develop and practice the skillsets required to make change occur
Then (Impacts)	the Trust's strategy will not achieve what it has promised, and the Trust will face reorganisation, frustration and turnover among employees

Live issue feeding this risk: *N/A*

What could get in the way?

The Trust lacks the cultural capability and competence on wider issues

KEY EFFECTS AND CONSEQUENCES

- The Trust's strategy does not achieve what it has promised.
- Reorganisation.
- Frustration and turnover among employees.

Accountabilities and review history	
Strategic risk owner	CH
Board oversight forum	POD

Risk analysis	Current — July 2026	Previous – March 2026
Risk score (Impact x Likelihood)	4 x 3 = **12**	4 x 3 = **12**
Target score by Dec 2026	4 x 2 = **8**	

Risk category	External and Partnerships - Change and Improvement Delivery Risk.	**Risk appetite**	Moderate
Last deep dive review		**In / out of appetite**	Within Tolerance
Date of last update			
Next review			

Commentary

Strategic Risk Owner Commentary

Over the previous two – three years we have invested in colleagues' development, with the LDO, First Line Managers Training, Multi Professional Leadership Team and various other courses coupled with our investment in the apprenticeship levy, a new induction programme and the development of CoLE. The early evaluation results from the LDO support an improvement in this area, but we need to replicate this and expand the approach across all areas and teams of the Trust – to become business as usual. We also recognise the disconnect with those colleagues which have joined the Trust in the previous five years and those longer serving colleagues – the cultural rest programme will be key to addressing this difference – RDaSH needs to evolve.

Director of Corporate Assurance — second line

Synergy with SDR1; impact of development work with our leaders

Tables of Controls and Assurances

Key Controls / Mitigations For Cause: the Trust does not develop and practice the skillsets required to make change occur *[system in place to help manage the cause / effect]*	**Assurance / Evidence** *[where can we gain evidence that the controls we are placing reliance on are working]*		
	First Level *[Service delivery and day to day management - how do we know day to day that controls are working?]*	**Second Level** *[Oversight - who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]*	**Third Level** *[Independent challenge - has anyone external come in to check that the controls are working]*

Induction (launched 28 October 2024)	Evaluative feedback from participants after each induction	• Periodic induction feedback to the People and Teams CLE Group; next due in the Autumn.	• Internal audit - significant assurance, received September 2025.
Feedback from our colleagues (Staff Survey, Open Staff meetings, Pulse Check, Care Opinion staff view, Ask Talk Influence)	• Staff Survey as the primary source of feedback from colleagues internal to the Trust. • Open Staff meetings in the Autumn with over 200 attending; new dates have been scheduled for 2026. • Pulse Check underway quarterly; Care Opinion capturing the staff point of view within teams. • Ask, Talk, Influence meetings started April 2026, undertaken monthly as a team brief to all RDaSHians.	• Headlines and recurring themes from Open Staff meetings shared within EG. • Voice Scorecard Report to the Trust People Council. • Staff Survey results show useful differences by length of service, with those at the Trust under five years being more positive.	-
Monthly Learning Half Days (commenced September 2024)	Scheduled, pilot in Children's, pilot for inpatients - launch of the learning hub	-	-
Leadership Development Offer - compassionate leadership to unlock community power	• Baseline data established at commencement of the programme; additional feedback and analysis as cohorts complete.	• POD Strategic Delivery Risk Report relating to the oversight and management of SDR5, to the POD Committee at each meeting throughout 25/26.	-

Wider learning opportunities (Leaders Annual Conference, First Line Managers Training Scheme, 555 Line Managers)	• Leaders Annual Conference reaching circa 130 staff as the top leaders' cadre. • First Line Managers Training Scheme launched April 2025. • 555 Line Managers focused on development and communication channels.	• People and Teams CLE Group and Education and Learning CLE Group established and meeting regularly.	-
Community Leadership Executive (CoLE)	• New body of 15 community representatives established to provide community-based feedback, be involved in decision making and holding to account, provide strategic input, facilitate communication, develop partnerships, build capacity and help co production; first meeting May 2026. Community partners feedback to be extracted from LDO feedback as a distinct category.	-	-
Increased capacity (apprenticeship levy under Promise 9, full recruitment to 97.5 percent, ringfenced training budget)	• Apprenticeship levy overused in 25/26, with levy transfers including to community colleagues. Planned over spend in 2026/27 as demonstrated by the Q1 data • Current vacancies tracked in the CEX Report Annex and within the change management process, aiming to keep the total below 100 at any one time. • 2026/27 ringfenced training budget in place again, with utilisation of 100 percent or more anticipated. Additional investment in the	Promises and Priorities Scorecard: P9 Apprenticeships reported March 2025; P26 Anti Racism reported to the Board of Directors March and May 2025.	• Internal audit on MAST - significant assurance, received April 2025.

	training budget from our own investment fund _ £75k • MAST and PDR compliance letters to 421 and 157 colleagues respectively in May; follow up due early June 2026.		

Control Lead: CH **Assurance Level: ADEQUATE**

Gaps in control	Gaps in assurance
• Planned learning programmes not yet delivered: Clinical Leaders Training Programme and the Multi Professional Leadership Team development programme, both 2026. (Action 3) • Revised appraisal process not yet in place; it will identify and respond to the need to create learning opportunities for each colleague. (Action 4) • 2026/27 Training Needs Analysis approved but not yet implemented. (Action 5) • CoLE newly established, first meeting May 2026; not yet evidencing effect. (No action currently identified)	• No assurance yet on Learning Half Days; mechanisms for feedback from leaders demonstrating increased competence and confidence in making change and adding social value are not in place. (Action 1) • LDO impact analysis outstanding, including whether the Trust has developed compassionate leadership to unlock community power and whether the LDO improved leaders' engagement; the level at which the outcome is deemed positive, for example 85 percent, still to be defined. (Action 2) • Pulse Check needs more work in generating responses. (No action currently identified) • Further internal assurance on induction anticipated via an independent colleague and the newly appointed Induction and Widening Participation Manager. (Action 7) • Promise 26 Anti Racism audit not yet undertaken. (Action 6)

Action plan to close the gaps

Action	Gap addressed	Owner	Due	Progress	Status
Develop mechanisms of feedback from leaders to demonstrate their increased competence and confidence in making change occur and adding social value, with colleagues on the stated programmes as the audience	Assurance gap	-	-	-	Planned
Complete the further LDO analysis, review the capability and capacity of leaders post LDO, and establish in advance the level at which the	Assurance gap	-	Review by Mar 2026	Evaluative feedback from participants after each induction	In Progress

outcome is deemed positive (for example 85 percent)					
Deliver the planned learning programmes: Clinical Leaders Training Programme and the MPLT development programme	**Control gap**	-	2026	Commenced in July	**In Progress**
Implement the revised appraisal process, identifying and responding to the need to create learning opportunities for each colleague	**Control gap**	-	During 26/27	-	**Planned**
Implement the approved 2026/27 Training Needs Analysis	**Control gap**	-	-	Approved	**In progress**
Undertake the planned Promise 26 Anti Racism audit	**Assurance gap**	-	Q4 25/26	-	**Planned**
Secure further internal assurance on induction via an independent colleague and the Induction and Widening Participation Manager	**Assurance gap**	-	-	Delivered. But the review and development will be ongoing	**Completed**

**Paper to be managed via questions only

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**	30 July 2026

Suggested discussion points

In May we considered especially ways to move the middle table forward. The Promises scorecard shows some progress in that regard, which we need to sustain over the next two reports: executive focus is very much on progress, perhaps especially on health inequalities and neighbourhood health. Board committees have considered carefully promises 6, 8, 15 and 21 – each of which have proved sticky to shift over the prior three years.

This report suggests a route to 20 in 20 – in other words less than a quarter of our success unmet as we move into 2027/28 with 20 months left to deliver by December 2028. That requires a palpable move in delivery in remaining 2026/27 months and it will be important that all of us retain the integrity of not lowering the bar in our assessment. The 2025/6 Promises Report is attached with the league table – and it is worth remembering that it will be the Communities' Leadership Executive writing and judging us in 2026. From my meeting with members as they have begun to storm not form, it is clear how seriously they take that responsibility of holding us to account.

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 continuing to be done to ensure rhythm and focus on the mid-table success measures

RECOGNISE a positive focus on the nine measure we are trying to move by October

ACKNOWLEDGE the displacement risk highlighted as we look to work on culture as well as strategy

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.	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.	
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	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 (advise which ICB or place that this matter relates to)

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

Appendix (please list)

Annex A – July 2026 promises scorecard or league table
Annex B – Promises Report, as published 2025/26 (please refer to Agenda Pack B)

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Latest Promises Update

Purpose and introduction

1.1 Seeing a shift in our overall Promises delivery during this year is crucial to the momentum of our strategy. Peer support growth and delivery of Promise 2 are perhaps the key steps for coming months. It is understood, I trust, that we have a handful of promises (12, 17, 20, 22, 26) which will take the time we have through 2028.

1.2 Promises 9, 16, 24, 26 and 27 are considered elsewhere on the Board agenda; with DIALOG+ an antecedent to the Paired Outcomes work which underpins Promise 16. Having agreed the switch to Ambient Loop, if we can agree the wider estate FBC, we have a clear trajectory for Promise 27. A similar clarity is now needed for our anti-racism work, recognising how long it may take.

Focus on the middle, still

2.1 We discussed last time work to shift the middle league table, with a view to cleared space to focus on the 'lower third; moving into 2027. The presence of the pillar plans on the Board agenda confirms that that is not a narrative of leaving those areas until then.

2.2 **Using an 'a' on the league table we highlighted last time and again today nine measures we felt would coherently move to AG and indeed some G by October**. Review in July suggests that that can indeed be achieved. A review, for example of the community transformation metrics from 2023 suggests good progress and whilst better measures will emerge through CHPT we can evidence reducing crisis calls and improved volumes of care within CMHTs over time. The clinical leadership executive has confirmed that all three places community clozapine pathways are now operational and have been used, and attention will continue to focus on the safety and efficacy of that revised offer. Likewise in August we will revisit our March 2026 initial assessment of seven-day provision (promise 22), as we focus too on urgent referrals under Promise 14 noted within the IQPR cover sheet. Sustaining our Promise 19 delivery is under increased pressure with a sizeable leap in admitted numbers since June but is currently being achieved.

2.3 As we reported eight weeks ago, "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". None of these measures are easy ones, and the expansion of Burns Court into Doncaster is proving difficult: but all options are being pursued.

2.4 With the eight measures highlighted last time as most at risk, among the middle third, we therefore have 31 success measures which are proving especially

sticky. Five of these are covered by promises 9 and 10 under consideration today, another is via promise 16 likewise, and the promise 5 membership measure is frankly a matter of focus and capacity/capability. With the actions plans on promise 15 presented to the relevant committee this month, we can see a route to reducing below twenty the promise non-delivery risks entering 2027/28. I would suggest that in January's Board and in February's timeout we work backwards from December 2028 and consider what it the twenty-month countdown we need to apply, and how, as a Board we tweak our governance with that in mind. Even as we work to create in 2028 our 2035 strategy, it will be important we do not feel or appear to have 'moved on'.

2.5 The next Executive Group mid table 'huddle' takes place on August 12th. This will directly inform the mid table assessment to the Board for Seprember.

Shifting health inequality measures

3.1 We have spent time re-reviewing the elements of Promise 8. It is clear from that review that colleagues are very focused on the work to be done, but it is difficult work. For example, initially very promising engagement within mosques and other community settings has not translated into increased dementia referrals, similarly work to review older adults across the Trust's caseloads has not seen us approach the 1000 additional referrals for Talking Therapies. What has become clear is that we need to better join up and support colleagues undertaking 'community engagement' and 'communication/outreach' roles: as such a community of practice will seek to create better alignment and insight from work on different pathways in different communities.

3.2 We have work to continue to deliver on both our annual health check aims (promise 7). In 2024/5 we largely delivered this for serious mental illness – sustaining that success has been difficult, and whilst learning disability health checks among our caseload has improved, we have not seen success in the larger full GP caseload.

3.3 We will complete our poverty proofing work in September, and as outlined in my chief executive's report have begun to deploy transport assistance to our patients. The Board is sighted on the work to support benefit claims and debt assistance. We are sustaining our own support to employees. That written we need to better support our employees working in the field in their efforts to tackle poverty (as mentioned at the AMM) – avoiding a sense that they are not empowered to act. The relational intention of neighbourhood health is to support frontline clinicians to take risks in wrapping support around those in need.

Not being distracted

4.1 The risk of our wider cultural work is that it shifts the focus from the delivery of our strategy. Of course we need to be able to do both. We cannot give succour to the false narrative that there is antithesis between getting things and supporting our staff. Our challenge is to better support our staff to get things done.

4.2 Part of the LDO next steps we need to adopt with managers is to instil slightly better skills in structuring problem solving in delivery. Whether it is in addressing neurodiversity waits, or considering perinatal mental health changes, it is clear that we have not relying yet on some basic skills of issue trees or other structured approaches (despite them being modules in the programme). We need to consider with managers what the barriers to applying that consistency is, as we think about a more standard improvement methodology for 2027.

Toby Lewis, Chief Executive
23rd July 2026

Promises and priorities

Annex A, Board July 2026

Top third

(two added)

Promises and priorities – delivery plan and delivery self-assessment

Promises & Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known or fully elaborated	Comments on likelihood of delivery
Promise 2 Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Green	The opening hours and patient/carer handbook launched. We now need to structure an evaluation of access needs with carers and begin to test whether those changes are more effective for advocates and carers' access to improve.	Amber green	Carer feedback will be critical, as we implement the new approach – and gather insight into what works (critical too with changes to MHA). **We have not delivered until that feedback is available: we have had informal feedback via PFG and will use the new peer support feedback portal to evaluate this.**
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. We have sustained over time but are not yet at 400. The Board's focus on volunteering remains as we look towards a 2027 evaluation.
Promise 3 For that body of volunteers to reflect the diversity of our populations.	Green	The data validation outlined as necessary in prior reports is now completed and reflected in the Board's papers in July 2026.	Green	Data shows more global majority and more male volunteers than our wider staff base, and likewise many 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. We are starting now to write the 2026/27 Quality Account as a route to ensuring real qualitative feedback on these changes among our teams.**
Promise 4 Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	Amber Green ↓	The pilot for this work has proved successful and has been assessed by the Board's MHAC: **with other pressures we need to regroup and ensure we have a focus on this measure alongside Care Opinion – and that the work does not rely on one person.**	Green	We will track this work more closely in Q2 and Q3 in the Q&S sub-committee of CLE – and expect to see changes as a result of the feedback received.
Promise 5	Green	This work continues and has been evaluated for further improvement. **The remaining step planned is to create communities of**	Green	As the work continues, the need to ensure accountability from representatives back to the local

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Involve patient and community representatives fully in our board, executive and care group governance .		**practice among those involved, for example through our CoLE** – there is real appetite to join this up with our care group SLTs.		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, *including our governors within Board committees.***
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 and those funds have now been committed in practice.**	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 and it that which is holding this assessment at AG.**
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.	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 26/27 and papers before the Board speak to that.
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.	Green ↑	As part of Promise 1 work, needed to confirm that arrangements are in place for the Trust to support relevant peer led groups and to connect that work to service evaluations. This is moving forward at pace and will be included within the September due paper on peer support.
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	We know from delivery reviews that the service is expanding. What we need to consider, and may engage outside help to do building on the Akeso work, is what is the upper ceiling of possibility.

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Promise 13 Take annual opportunities to transfer services to homecare where safe to do so.	Red	Moving through 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. We will seek to position this within upcoming national work on unpicking the block contract.	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 13 Sustain and expand our Clozapine service in off ward settings.	Green	Both Doncaster and Rotherham AMH have service plans internally: with a successful Invest Fund bid agreed for North Lincs.	Green ↑	CLE agreed that this will be in place in all 3 areas by June 2026: this was achieved. Monitoring continues.
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: there is some slippage back, which is being considered in delivery reviews.
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. An annex before the Board shows the performance YTD.
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. Pending success in September the LOD will improve to Amber Green.
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.**

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Promise 23 Expand the scale of our residential forensic rehabilitation service.	Green	Additional capacity is now open.	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. However, **we need to acknowledge that the unit concerned has now been rated as Requires Improvement.**
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 still performing strongly when compared to other organisations.
Promise 24 Trust workforce plan for 2028 on track to be delivered.	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. To this is now added a post change flight pattern, which we need to see dissipate.
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 before move to Green!	Green	No identified reason why assessment outcomes would change over coming period, and med ed concerns previously debated have been allayed.
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 have paid 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.

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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 was not complete in time for the annual report and is pending.**
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: YTD we have met the annual target inside four months!!

Middle third

(two exited)

Promises and priorities – delivery plan and delivery self-assessment

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Promise 1 Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care. 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/RAW starting in coming weeks.**	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 being finalised and considered at the N&F delivery review in August.**	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 a small number of meaningful impactful changes in our 26/27 Quality Account. This needs to become routine in year collated information – hence starting now on next year's.

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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 had a good discussion with CoLE about the outreach part of the CIF, which we considered too at the recent Board timeout. We will be agreeing some practical steps to draw leaders out into community settings over coming weeks.**
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 now full in place (and this measure will shortly move to the top third list!)**
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 late 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 2025 as a stimulus to change – confidence and energy to change needs more work. **The texting/travel passes are the key step and early signs are encouraging from their June 2026 deployment.**
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). There is some evidence that our outreach work does not translate into actual service referrals via primary care.
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 through 26/27 our second try will work better.**	Amber red	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, including ensuring obstetrician support in local DGHs.
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 and the Board paper outlines the steps to that end.
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 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.

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Promise 13/20 Deliver over 130 care packages through our physical health virtual ward service.	Amber green	A strong plan exists, has been peer reviewed, and is being delivered. We are exploring further winter expansion plans which would assist with this model.	Amber red	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes. Unfortunately currently that is not job planned or in place and work by the CGMD is seeking to change that. The recent Akeso work does suggest that there is material scope for growth, and that is now the basis of planning concluding within the neighbourhood redesign work for physical health.
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	An initial review is encouraging. Further discussions are taking place in August about how best to reflect that in this assessment.
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 and is a focus at July’s delivery reviews.
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.
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.**

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Promise 18 Implement programme of multi-professional quality improvement across all inpatient services by April 2026 and routinely publish data on the care provided in each environment. 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. *Moving to zero may not be achievable.*
Promise 21 Fulfil our commitment to support a community-first model working alongside partners in South Scunthorpe: focusing first on those with serious mental illness.	Amber green	This remains (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.
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.

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Promise 21 Consistently integrate our community mental health offer with that provided by voluntary sector organisations, sharing training, data and expertise to improve outcomes. 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 Q3 if we are to deliver during 2026 – a key objective for strategic development team.
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.

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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 chair issues to resolve: **the delivery plan is due from finance colleagues at their August 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 green ↑	The 2028 ambitions are deliverable, but a cultural shift is probably needed in how GR/CGs operate together
Promise 28 Work to further increase the reach of research into excluded communities locally. 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 August 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 started from June 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	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 the plan for RDaSH for 26/27: this may rapidly shift to AG once that is validated.	Amber red	These ratings may improve starkly in September, when we have had chance to reflect on the resourcing behind the Board paper on pillars.

Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
Promise 9 In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Amber green ↑	The work plan for refugees is contained within the Board's paper and relies on others outside the Trust who are in place, hence the AG confidence.	Amber red	
Promise 9 In 2026/27 introduce tailored access scheme for people with learning disabilities.	Amber red ↑	We have a very clear plan, albeit its key element may not start in practice until August 2027, hence the rating.	Amber red	
Promise 10 Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber green	Plan of action presented to Public Health, Patient Involvement and Partnerships Committee of BOD – work to do to embed that across teams so too early to confirm shift to greener rating for the plan. 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.
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. The workplan outlined by Iona Johnson to the public health committee does envisage some team creation moving into 2027/28, hence the slight rating tweak here.	Amber red	Time passes and 27/28 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. The failure to commission a neighbourhood offer locally in 26/27 is disappointing and partners are working to address that in good time for 27/28.
Promise 15 Restructure Trust services into those INTs during 2025/26.	Amber red ↑		Amber red	
Promise 15 Evaluate and incrementally improve joint working achieved through these teams.	Amber red	Planning this work can follow from further definition of the INT plans we have. This work was considered with the PHPIP committee on that basis.	Amber green	Once the above measures are met, this item is feasible!
Promise 16 Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Amber red	This forms part of our Q&S plan but may take us past half way in 2026/27.	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 Q3 and Q4.
Promise 17 Narrow the school readiness gap between our most deprived communities and average in each place in which we work.	Amber green	A challenging plan exists, which has strong support from across corporate functions and is led through the Children's Care Group. Implementation to date is strong – the challenge is huge!	Amber red	Gap narrowing on school readiness has proved elusive: joint working with school is going to be needed to deliver any plan. This feels feasible, if difficult, in Doncaster and North Lincs.
Promise 17 Seek to see 80% of children meet their own potential for school readiness by 2028.	Amber red	Establishing this data feed is taking time and requires collaboration across a number of teams inside and outside the Trust. Annual data is feasible as we look to stem a deteriorating position.	Amber red	It is much easier to be confident of the inputs than the results in this field: the Trust has developed and is implementing a clinically led hypothesis which may transpire to make a difference.

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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.	Amber red ↑	The intent and commitment to do this is clear from the leadership team – but a tangible plan to trial this is not yet visible and <u>did not come forward within planning for 26/27.</u> Discussions have now taken place with the CCG as we look to manage longer term support to complex young people and a 27/28 IF bid is due in December.	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 green ↑	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. Cheryl Gowland has taken this work forward with PCN partners and this will inform the CPHT.	Amber red	Work needed to scale and shape the project….
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 CHPT in August 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 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.	Amber 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. **With ambient loop agreed the rating has changed slightly!**
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.

**Paper to be managed via questions only

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Organisational Change Key Performance Indicators - Quality, Safety and Impact Assessment (QSIA) – July CIP Monitoring Report	**Agenda Item**	Paper O
Sponsoring Executive	Steve Forsyth, Chief Nurse		
Report Author	Steve Forsyth, Chief Nurse Dr Judith Graham, Director of Psychological Professionals and Therapies Dr Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	30 July 2026

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

- that current July QSIA evidence does not show a sustained adverse CIP-related impact on quality, safety, access, patient experience or workforce support.
- that the identified exceptions and data gaps have sufficient ownership, monitoring and escalation: NHS 111 calling time, Assertive Outreach DNAs, Memory Service waits, Integrated Discharge delays, Phlebotomy movement, With Me in Mind supervision definition, NCMP reconciliation and Corporate BPPC.
- Whether the Board supports continued routine monitoring with escalation if any exception becomes sustained, clinically material or operationally material.

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

The Board received an earlier version of this paper in May 2026.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE: the July QSIA monitoring position and the conclusion that the available evidence does not demonstrate sustained CIP-related harm.

CONSIDER: the exceptions and data-quality points requiring continued oversight, particularly access, waits, supervision definition and call-handling

RECOGNISE: that several indicators remain stable or improving, including zero GP complaints in Primary Care Mental Health, zero LD unmet needs, zero negative Health Visiting feedback and improving waits in some pathways.

DELEGATE: continued monitoring of identified exceptions to the relevant care group, corporate and executive governance routes, with escalation if sustained or material deterioration emerges.

AGREE: that the report provides reasonable confidence at this point, subject to continued monitoring, reconciliation of highlighted data gaps and clear ownership of exception actions.

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

System / Place impact (advise which ICB or place that this matter relates to)
Trust-wide impact across RDaSH services, including Rotherham, Doncaster and North Lincolnshire places. Relevant system interfaces include South Yorkshire and Humber and North Yorkshire arrangements, with specific reference to DBTH interface discussions for Integrated Discharge.

Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	N/A - monitoring report; scheme-level EIAs as required
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	July 2026 - QSIA review/monitoring completed for this report

Appendix (please list)
Appendix 1: Supporting graphical evidence.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
BOARD OF Directors – July 2026

1. Executive Summary — Confidence Statement

The July monitoring position provides a reasonable organisational basis for concluding that the CIP programme and associated vacancy-removal and change-management schemes are not currently demonstrating a sustained adverse pattern across quality, safety, access, workforce support or patient experience.

The supporting graphs in Appendix 1 broadly strengthen that position, but they also add important nuance. Several graphical indicators show stable or improving positions, such as reductions in abandoned calls, reduced DNAs in some pathways, zero GP complaints in Primary Care Mental Health[1], zero unmet needs in LD Care Home Liaison, and no negative feedback in North Lincs Health Visiting. However, some indicators require clearer explanatory narrative: average calling time for NHS 111 is shown as 40 with +90.5% MoM; Doncaster School Nursing attended contacts are 1,296 with -27.8% MoM; Assertive Outreach DNAs are 50 with +66.7% MoM; Integrated Discharge delays are 383 with +32.1% MoM; and some waiting-time graphics show over-four-week activity that needs to be reconciled with narrative wording.

Overall, the available material does not evidence sustained CIP-related harm, but it identifies a small number of indicators requiring clarification, continued oversight or focused review.

2. Integrated alignment of care groups, narrative and graph evidence

Care Group	Narrative Position	Graphical Evidence	Integrated Interpretation
Children and Young People	Broadly stable; response times consistent; safeguarding escalations not increased; supervision compliance not declined; school nursing and health visiting continue to meet relevant standards.	Graphs include abandoned calls 51 / -51.9% MoM, NHS 111 average calling time 40 / +90.5% MoM, Doncaster School Nursing contacts 1,296 / -27.8% MoM, DNAs 4 / 0.0% MoM, cancellations 5 / 0.0% MoM, NCMP Reception 90.0%, NCMP Year 6 86.0%, positive feedback 18 / +80.0% MoM, negative feedback 0 / -100.0% MoM, attended contacts 303 / -12.2%	The graphs mostly support the absence of obvious harm but add nuance: abandoned calls improve, feedback is positive, DNAs reduce in one pathway, but call duration/calling time, contacts, cancellations, NCMP percentages and supervision values need

[1] This KPI relates only to Primary Care Hub Teams.

		MoM, DNAs 12 / -45.5% MoM, cancellations 6 / +50.0% MoM, supervision 1.0% / +1.0% MoM, and caseload 1,210 / +8.3% MoM.	clearer explanation before the narrative can be read as wholly stable.
Doncaster Mental Health & LD	No adverse position identified; supervision is available; no Section 117 issues are reported; Early Intervention remains within national standards and four-week waits; Primary Care Mental Health access is broadly unchanged; Assertive Outreach/Rehabilitation shows no reported change in engagement, incidents or out-of-area placements.	Graphs include Assertive Outreach DNAs 50 / +66.7% MoM; CMHT caseloads Central 318 / -3.6%, East 214 / +16.9%, North 178 / +19.5%, South 245 / +2.5%; Early Intervention contacts 810 / -4.5%, DNAs 48 / -11.1%, cancelled contacts 46 / +24.3%, waits under four weeks 14 / -12.5%, waits over four weeks 2 / -50.0%, caseload 188 / +1.1%; LD unmet needs 0; Primary Care Mental Health contacts 1,465 / +6.2%, DNAs 134 / +18.6%, cancellations 201 / -11.1%, waits over four weeks 12 / -29.4%, GP complaints 0.	The graphs strengthen the access narrative where waits over four weeks reduce and complaints remain zero, but they nuance the “no change” wording because DNAs and cancellations move in different directions and some caseload shifts are material. These do not evidence CIP-related harm in isolation but should be interpreted as monitored variation.
North Lincolnshire & Talking Therapies	Mostly stable; several pathways maintain four-week waits; SMI checks show slight deterioration attributed to patient adherence; Medication Management has moved from four to five weeks due to sickness; Memory Clinic breach is linked to sickness; Step 3 treatment is subject to focused review and is not solely related to CIP.	Graphs include ARMS caseload 12 / -7.7%, ARMS Psychotherapy contacts 49 / +53.1%, DNAs 4 / -20.0%, cancelled contacts 1 / -60.0%, Intervention NCAP 106 / +21.8%, Community SMI checks 49.0% / +8.0%, SMI caseload 1,063 / 0.0%, Early Intervention Support Worker contacts 76 / +6.7%, DNAs 4 / +300.0%, cancellations 5 / +150.0%, Memory Service nursing waits completed over four weeks 6 / +20.0%, Memory Service caseload 664 / +0.2%, and Memory Service	This is the most nuanced care group. The supporting graphical evidence does not fully show Medication Management or Talking Therapies Step 3, so those statements remain narrative-only. The Community SMI graph shows a month-on-month improvement to 49.0%, which requires reconciliation with the written statement of slight

		OT waits completed over four weeks 19 / -5.9%.	deterioration. Memory Service graphs show more than a simple single-breach position; nursing and occupational therapy waits are therefore best described separately, with sickness attribution included only where evidenced.
Rotherham	No adverse position identified; Health and Wellbeing four-week waits are maintained; Dialog+ is improving; OT Hub remains within the expected 14-week pathway; PDR and supervision are improving and monitored through delivery reviews and POD.	Rotherham section headings — Adult CMHT, Assertive Outreach, Numbers on Caseload, Care Home Liaison Caseload, Early Interventions in Psychosis Caseload, Health and Wellbeing Service Review, and Memory — but no visible KPI values or graph data in the retrieved content.	The Rotherham narrative is supported by written commentary rather than by visible graph data in the retrieved QSIA document. This is a presentation and data-completeness limitation rather than an adverse finding.
Physical Health & Neurodiversity	Broadly stable but mixed; activity is stable in several services; complaints have not increased; some areas require continued monitoring due to newer data, sickness or annual leave effects, or implementation still progressing; Unplanned Care staff reaction to change is monitored through incidents, experience feedback, meetings and shadowing.	Graphs include Enhanced Care Home caseload 2,236 / +2.6%, Integrated Discharge delays 383 / +32.1%, Neighbourhood Teams Planned 311 / -6.9%, TVAL 2,234 / +1.1%, Diabetes 1,619 / -1.0%, Specialist Palliative 70 / +2.9%, Continence 4,310 / +1.6%, Phlebotomy 728 / -29.1%, Respiratory 362 / +6.8%.	The graphical evidence supports the mixed interpretation. Most caseload movements are modest, while Integrated Discharge and Phlebotomy require clearer explanation and continued oversight. The evidence indicates that PH&N remains an area requiring continued oversight without implying CIP causation.

Corporate / Backbone	Payroll self-service has no reported errors; Finance and Procurement BPPC has four elements, with two NHS targets achieved for April and May but not non-NHS; partial achievement is attributed to year-end, vacancies and timing misalignment before the new scanning solution is implemented in August/September.	No Corporate/Backbone graph is visible.	Corporate findings are narrative-only in the absence of a visible BPPC/payroll graph. The Finance and Procurement issue is the clearest CIP timing impact described and remains a specific monitored exception.

3. Domain-based analytical report

3.1 Safety and Potential Harm

There is no identified sustained adverse safety pattern directly attributed to the CIP programme.

The strongest graphical safety indicators are low or zero-event measures: LD Care Home Liaison shows unmet needs at 0, Primary Care Mental Health shows GP complaints at 0, and North Lincs Health Visiting shows negative feedback at 0. These indicators support the view that, within the limits of the available data, there is no obvious escalation signal in those specific areas. Interpretation remains limited because several indicators are low-volume, newly monitored, or not direct harm measures.

For Physical Health & Neurodiversity, the available narrative identifies issues relating to staff reaction to change in Unplanned Care, with incident rates and experience monitored through data, meetings and shadowing. Appendix 1 does not provide a direct incident trend for Unplanned Care, so the appropriate conclusion is that the current evidence supports continued targeted monitoring rather than a definitive judgement of impact.

3.2 Access and Waiting times

Access and waiting-time indicators broadly support the conclusion that there is no system-wide access deterioration linked to CIP. Doncaster Mental Health & LD shows Primary Care Mental Health contacts at 1,465 / +6.2% MoM, waits over four weeks at 12 / -29.4% MoM, and GP complaints at 0, which supports the view that access and availability remain broadly unchanged. Early Intervention in Psychosis also shows waits over four weeks at 2 / -50.0% MoM, which suggests improvement in that specific graphical measure, although the existence of any over-four-week waits should be described clearly rather than simplified as entirely within four weeks.

In North Lincolnshire and Talking Therapies, several areas require continued visibility. Medication Management has moved from a four-week to a five-week wait due to sickness, Memory Clinic breaches are linked to sickness, and Step 3 treatment is subject to a focused review and is not solely related to CIP. The supporting graphical evidence reinforces the need for nuance because Memory Service nursing waits completed over four weeks are 6 / +20.0% MoM, while Memory Service OT waits completed over four weeks are 19 / -5.9% MoM. The Memory Service nursing and OT positions are therefore separated in the interpretation, avoiding a single undifferentiated breach narrative unless the underlying source is clarified.

Physical Health and Neurodiversity requires the clearest access narrative. Integrated Discharge delays are shown at 383 / +32.1% MoM, while no concerns from DBTH were reported through interface meetings. These statements can coexist: the absence of interface concerns does not remove the need to monitor the delay trajectory. This is not evidence of CIP causation, but it is a clear graphical movement that warrants visibility.

3.3 Clinical Effectiveness and Service Delivery

The clinical effectiveness position is generally stable, but several indicators are proxy measures rather than direct outcome measures. For Children and Young People, the written narrative states that school nursing continues to meet national standards and health visiting continues to achieve mandated Healthy Child Programme levels. The supporting graphical evidence shows NCMP Reception at 90.0% and Year 6 at 86.0%, while the wider narrative references a 97% achievement rate for the National Childhood Measurement Programme. Clarification is required on whether 97% is the stated KPI or target and whether 90.0% and 86.0% are the current graphical monthly positions, because the graphical values do not in themselves display 97%.

Community SMI is another area where the written narrative and graphical data need careful alignment. The narrative states that SMI checks show a slight deterioration, attributed more to patient adherence than organisational change. The graph shows Community SMI checks at 49.0% / +8.0% MoM, which suggests month-on-month improvement in the displayed period rather than deterioration. The current graph does not visibly demonstrate the described deterioration, and the statement may relate to a wider time horizon, target position or context not shown in Appendix 1.

In Physical Health and Neurodiversity, Enhanced Care Home caseload is 2,236 / +2.6% MoM, Neighbourhood Team caseload indicators are mostly within small single-digit movements, and Continence is 4,310 / +1.6% MoM. These support a broadly stable delivery picture, while Phlebotomy at 728 / -29.1% MoM is a notable movement requiring explanation as expected variation, seasonal fluctuation or operational change if that evidence is available. If not, it remains appropriate for monitoring rather than interpretation as a CIP effect.

3.4 Patient and Carer Experience

The experience evidence is mainly positive or neutral where graphical data is available. North Lincs Health Visiting shows positive feedback at 18 / +80.0% MoM and negative feedback at 0 / -100.0% MoM, which supports the view that no adverse

feedback signal is evident in that area. In Primary Care Mental Health, GP complaints are shown as 0, supporting the written position that access and availability have not generated a visible complaints signal in Appendix 1.

In Children and Young People, Appendix 1 shows Doncaster School Nursing contacts at 1,296 / -27.8% MoM, with DNAs 4 / 0.0% MoM and cancellations 5 / 0.0% MoM. The narrative says no adverse school feedback was reported, which is not contradicted by the graphs. The reduction in contacts is a service-activity movement and is separate from the experience evidence.

For Physical Health and Neurodiversity, the narrative reports no increase in care home complaints and no complaints for the Macmillan Information Centre, while Appendix 1 provides caseload rather than complaint graphs for the relevant service areas. The analysis therefore distinguishes between direct complaint evidence and activity or caseload proxy indicators.

3.5 Workforce, Culture and Support

The workforce narrative focuses on supervision, PDR, role changes and staff reaction to change. It states that CYP supervision compliance has not declined, Rotherham PDR and supervision compliance is improving, and PH&N management-structure changes are being monitored through PDR and supervision metrics. Appendix 1 provides a With Me in Mind clinical supervision value of 1.0% / +1.0% MoM and a caseload of 1,210 / +8.3% MoM.

The With Me in Mind supervision value of 1.0% / +1.0% MoM requires validation before it can be used as evidence of sufficient supervision compliance. The current position is therefore treated as monitored, with clarification needed on data definition, denominator and compliance threshold.

In PH&N, the narrative explicitly identifies staff reaction to change in Unplanned Care, with monitoring through data, meetings and shadowing. This is a balanced finding: it recognises workforce sensitivity without attributing harm or concluding service failure. It remains an area for continued oversight because it is a qualitative workforce signal rather than a purely numerical KPI movement.

3.6 Corporate / Backbone Impact

The Corporate/Backbone section contains the clearest explicitly described timing impact from the CIP programme. Payroll self-service has generated no reported payroll errors, while Finance and Procurement is achieving the two NHS BPPC targets for April and May but not non-NHS, with partial achievement attributed to year-end, team vacancies and a timing gap before the electronic scanning system is implemented in August/September.

No Corporate/Backbone graph is visible in the available material. The Finance and Procurement position therefore remains a narrative-only monitored exception, with the available narrative identifying a timing impact from CIP and a planned mitigation through the scanning solution.

4. Areas requiring continued oversight or focused review

Area	Why it remains visible	Evidence-led interpretation
Talking Therapies Step 3	A focused review is under way and the issue is not solely related to CIP.	This remains a named focused review and is not attributed to CIP unless further evidence supports that conclusion.
Medication Management	Waits moved from four to five weeks due to staff sickness, not CIP.	This remains in monitoring as an access issue, with current attribution described as sickness-related.
Memory Service waits	A four-week breach is linked to sickness; graphs show nursing waits over four weeks 6 / +20.0% and OT waits over four weeks 19 / -5.9%.	The interpretation separates nursing and OT waits and avoids reducing the position to a single breach unless source data confirms that framing.
Integrated Discharge delays	Graph shows 383 / +32.1% MoM; no DBTH interface concerns are reported.	There is insufficient evidence to attribute this issue to CIP, but the movement is material enough for continued monitoring.
With Me in Mind supervision	No decline is reported; graph shows 1.0% / +1.0% MoM.	Definition and denominator require validation before the figure is used as evidence of compliance.
NCMP Reception / Year 6	The narrative references a 97% achievement rate and no change in national standard; graph shows 90.0% and 86.0%.	Target, national standard and current monthly graph values require reconciliation.
Finance and Procurement BPPC	NHS targets are achieved but non-NHS targets are not achieved; timing issue linked to redeployment/scanning system.	This remains a Corporate exception with mitigation and timeline.
Rotherham and Corporate graph completeness	Rotherham headings appear without visible graph values; Corporate graphs are not visible in the available QSIA content.	These sections remain narrative-only unless the missing graphs are added.

5. Conclusion

The combined narrative and graphical evidence supports a balanced conclusion: the CIP programme is not currently showing a sustained adverse impact on quality, safety, access, patient experience or workforce support in the evidence provided.

The areas requiring continued oversight are set out in section 4 and include call handling, NCMP values, With Me in Mind supervision, Assertive Outreach DNAs, Memory Service waits, Integrated Discharge delays, Phlebotomy caseload movement and the Corporate BPPC timing issue.

6. Overall Position

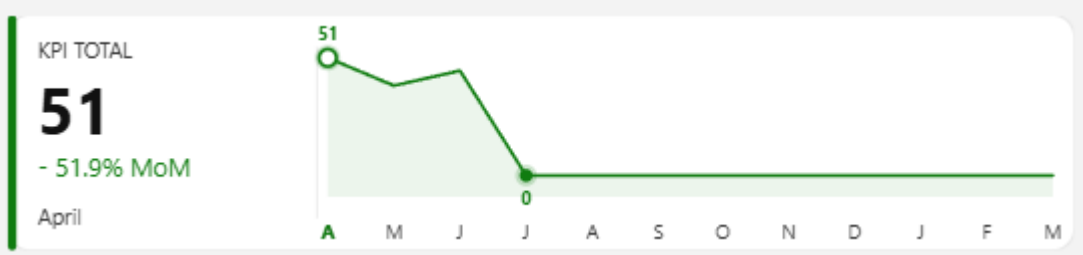
The monitoring framework appears proportionate, embedded and capable of identifying emerging concerns. The identified exceptions should remain within routine directorate and corporate monitoring, with escalation if patterns become sustained or clinically or operationally material.

Appendix 1: Supporting Graphical Evidence

Children's Care Group

Call Handlers

Number of Abandoned Calls

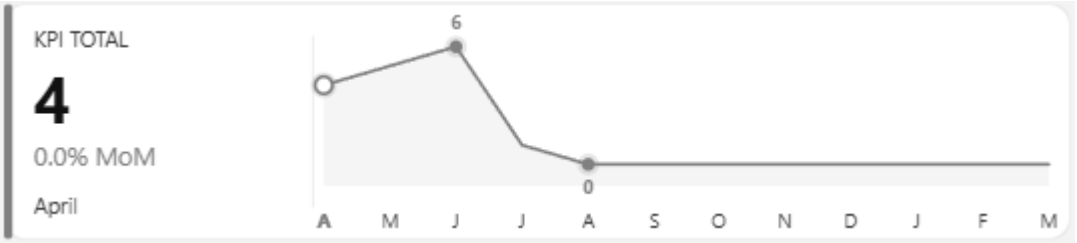


Average Calling time for NHS 111

Doncaster School Nurses

Number of Attended, Clinically Relevant Contacts

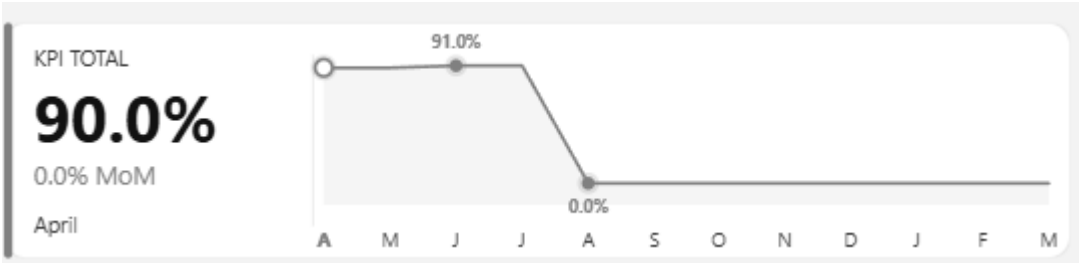
Number of DNA's



Number of Cancelled Contacts

North Lincs School Nurses

National Child Measurement Programme (Reception)



National Child Measurement Programme (Year 6)

North Lincs Health Visiting

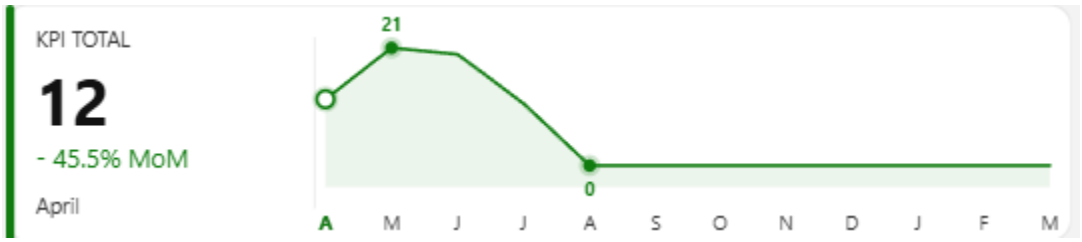
Number of Positive Feedback Received

Number of Negative Feedback Received

Sexual Health

Number of Attended, Clinically Relevant Contacts

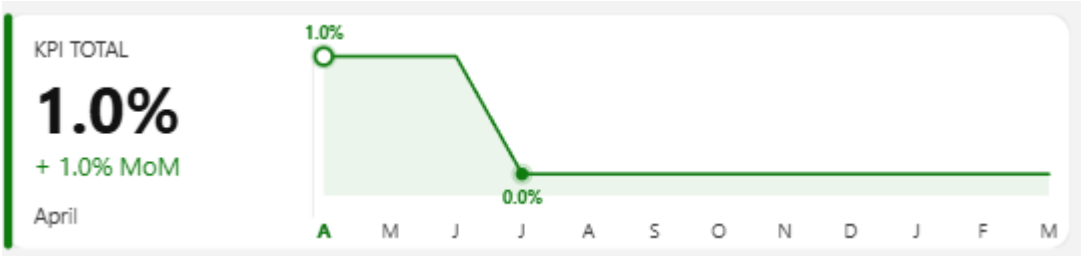
Number of DNA's



Number of Cancelled Contacts

With Me in Mind

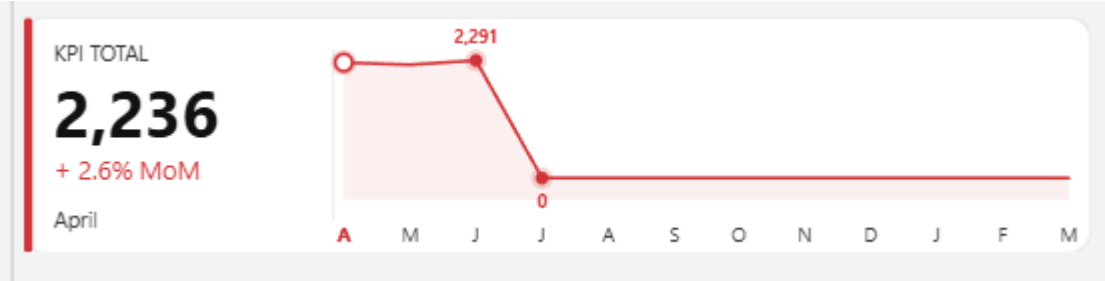
% of Clinical Supervision for Staff



Numbers on Caseload

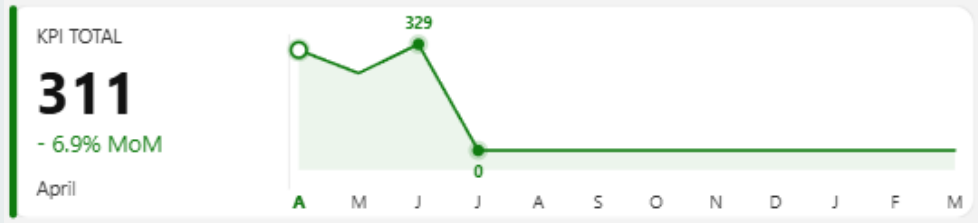
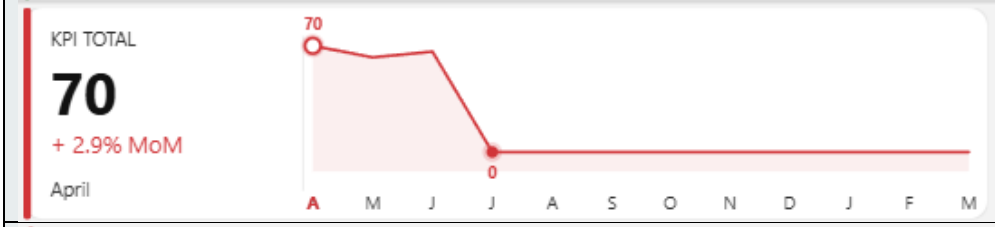
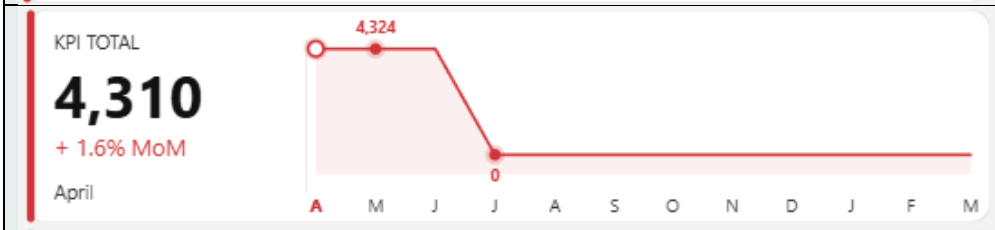
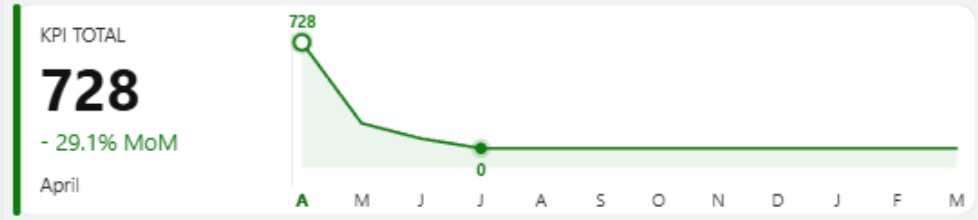
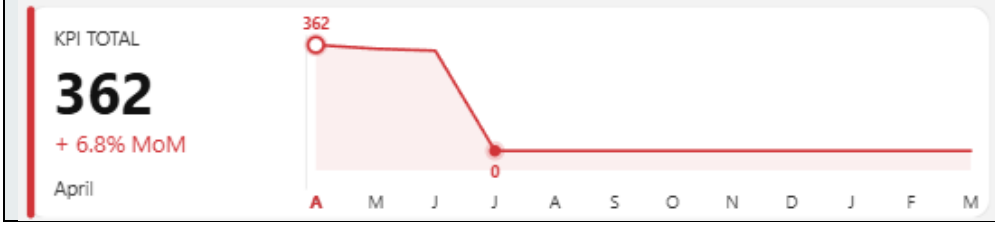
Physical Health and Neurodiversity

Enhanced Care Home: Numbers on Caseload



Integrated Discharge: Number of Delays

Neighbourhood Teams – Caseload at Month End	

	**Planned**
	**TVAL**
	**Diabetes**
	**Specialist Palliative**
	**Continence**
	**Phlebotomy**
	**Respiratory**

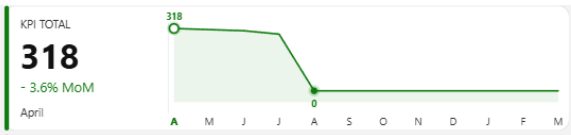
Doncaster Mental Health & LD

Assertive Outreach

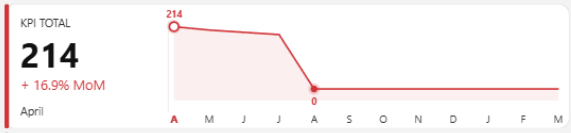
Number of DNA

CMHT Caseload

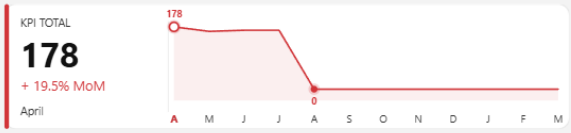
6.1 Numbers on caseload - DONCASTER CENTRAL ADULT CMHT



6.2 Numbers on caseload - DONCASTER EAST ADULT CMHT



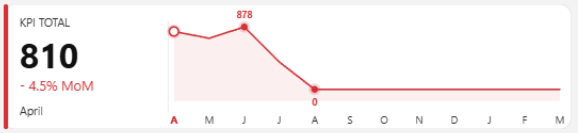
6.3 Numbers on caseload - DONCASTER NORTH ADULT CMHT



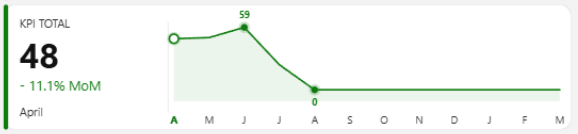
6.4 Numbers on caseload - DONCASTER SOUTH ADULT CMHT

Early Intervention in Psychosis

3.1 Number of attended, clinically relevant contacts

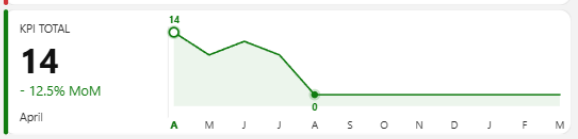


3.2 Number of DNA's



3.3 Number of Cancelled contacts

3.4 Number of patients waiting for assessment under 4 weeks



3.5 Number of patients waiting for assessment over 4 weeks

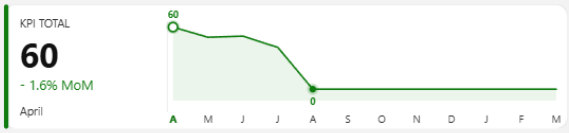
3.6 Numbers on caseload

LD Care Home Liaison

2.1 Number of unmet needs

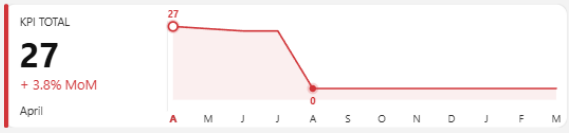
LD Physiotherapy

7.1 Numbers on caseload - NORTH LINCS LD - PHYSIOTHERAPY



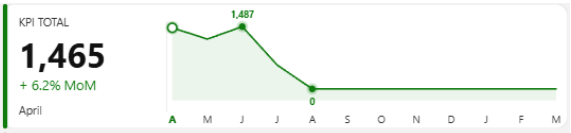
LD Psychologist

8.1 Numbers on caseload - ROTHERHAM LD - CLINICAL PSYCHOLOGIST

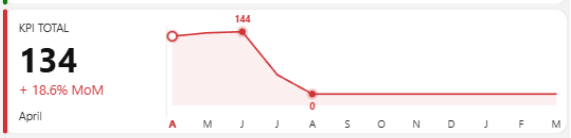


Primary Care Mental Health

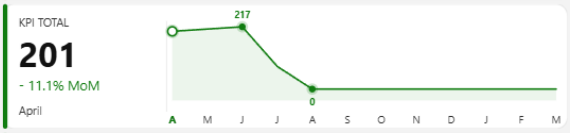
4.1 Number of attended, clinically relevant contacts



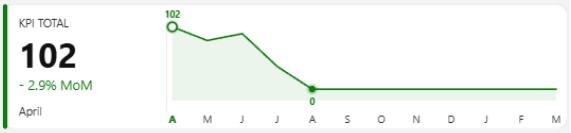
4.2 Number of DNA's



4.3 Number of Cancelled contacts



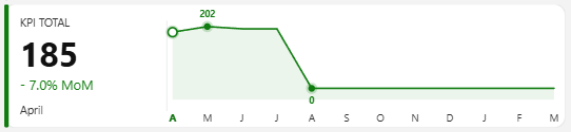
4.4 Number of patients waiting for assessment under 4 weeks



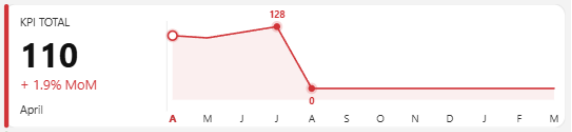
4.5 Number of patients waiting for assessment over 4 weeks

4.6 Number of GP Complaints

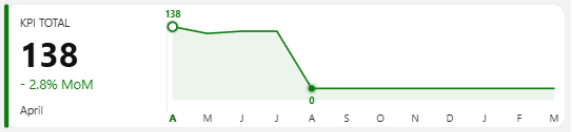
4.7 Numbers on caseload - DONCASTER CENTRAL PRIMARY CARE MENTAL HEALTH HUB



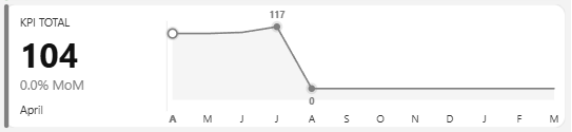
4.8 Numbers on caseload - DONCASTER EAST PRIMARY CARE MENTAL HEALTH HUB



4.9 Numbers on caseload - DONCASTER NORTH PRIMARY CARE MENTAL HEALTH HUB



5.0 Numbers on caseload - DONCASTER SOUTH PRIMARY CARE MENTAL HEALTH HUB

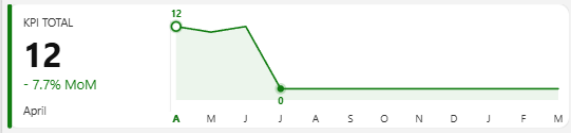


North Lincolnshire Mental Health

ARMS Pathway

ARMS Pathway

1.1 Numbers on caseload

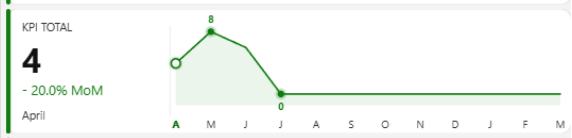


ARMS Psychotherapy

ARMS Psychotherapy

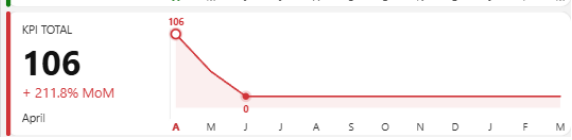
2.1 Number of attended, clinically relevent contacts

2.2 Number of DNAs



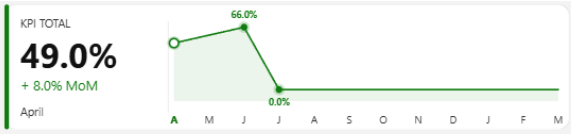
2.3 Number of Cancelled contact

2.5 Intervention NCAP



Community SMI

6.1 % patients who have completed all 8 health checks

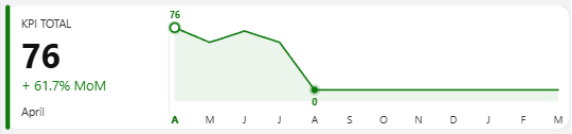


6.2 Numbers on caseload

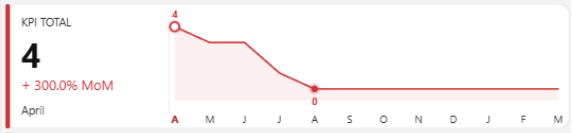
Early Interventions Support Worker Review

Early Interventions support worker review

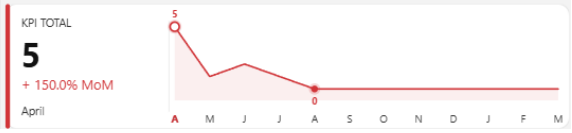
3.1 Number of attended, clinically relevant contacts



3.2 Number of DNA's



3.3 Number of Cancelled contacts

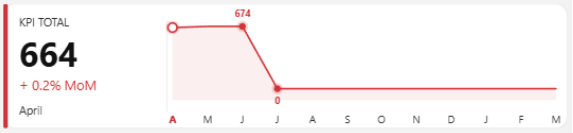


Memory Service

Memory Service Changes – Nursing

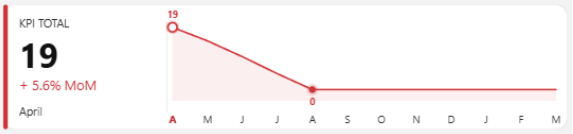
9.1 Number of waits completed over 4 weeks

9.2 Numbers on caseload



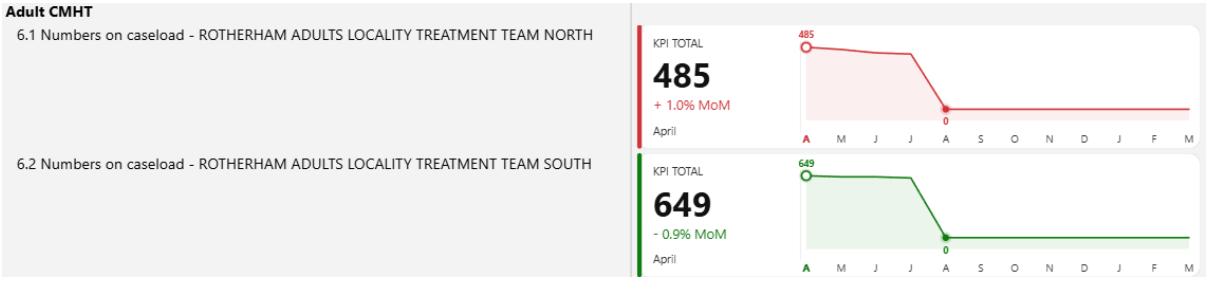
Memory Service Changes – OTs

10.1 Number of waits completed over 4 weeks



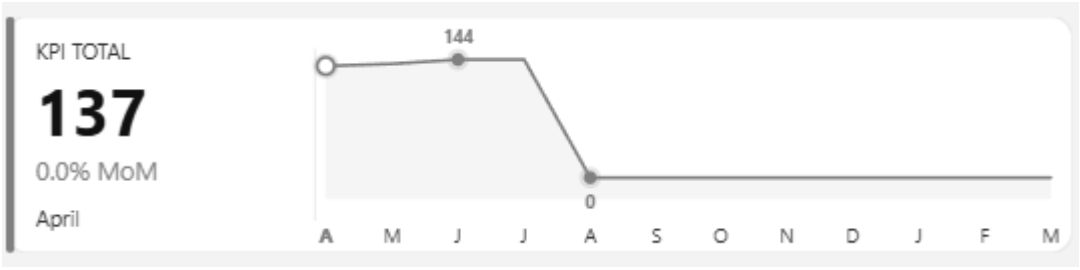
Rotherham Care Group

Adult CMHT



Assertive Outreach

Numbers on Caseload



Care Home Liaison Caseload

Early Interventions in Psychosis Caseload

Health and Wellbeing Service Review

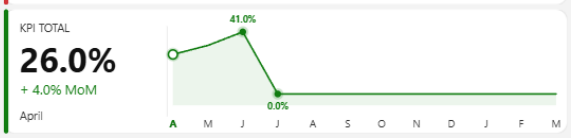
Health and Wellbeing Service review

1.1 Numbers on caseload

1.2 Number of waits under 4 weeks

1.3 Number of waits over 4 weeks

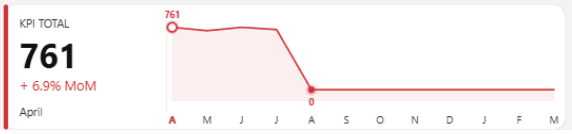
1.4 % with a Dialog Scale completed



Memory

Memory

3.1 Numbers on caseload - ROTHERHAM MEMORY TEAM



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**	30 July 2026

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

It is important to remember this Board meeting is our annual focus on learning and education. Despite other pressures, much of our agenda, and tone of our conversation, needs to build on that intent, because curiosity about ourselves and enquiry about what works is inherently the work of the Board and the task of leadership. We meet in the afterglow of a successful annual member's meeting, CYP-AGM, and community fun day, which reinforced again the support we have from local people to both tackle the real issues and be honest about the journey.

The report includes annexes addressed in the recommendations. It is not yet possible to advise on the Q1 segmentation position taken by NHSE because promised data-drafts have not been delivered. We would expect on the new additional financial governance evaluation we would achieve the highest rating: despite the need to spend far more than planned on agency doctors. We remain on track to remove our underlying deficit by April 2027 if we can recruit to those roles: if not, further service changes may be needed. An oral update will be offered on unsigned ICB contracts, albeit for the second time we appear to have agreement, but it is not yet in written/signed form.

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

N/A except CLE/CoLE annexes and TVC action plan (considered in private June 2026)

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

EXPLORE the patient, people and population issues described (including stability in RCG)

CONSIDER any matters of concern not covered within the report

NOTE the annex reporting the organisational change process, to be considered alongside the second QSIA report elsewhere within the papers

ACCEPT the action plan in response to the TVC well led report and agree to monitor progress through the Board, supported by the NED meeting held monthly

NOTE the EPRR submission of 100% compliance, up from 91% in 2025

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.	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.	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.	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 (including 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 June and July 2026
Annex 2: Communities' Leadership Executive (CoLE) notes June and July 2026
Annex 3: Current register of Trust vacancies – as at time of issue
Annex 4: National publications – June/July 2026
Annex 5: Neurodiversity activity and wait scorecard: Q1
Annex 6: South Yorkshire Eating Disorders Joint Committee Meeting Note – June 2026
Annex 7: 2025/26 Change management: latest report on Q1 outcomes
Annex 8: EPRR submission 2026 – report on Trust readiness to evacuate and respond
Annex 9: Trust response to the recommendations from TVC on the well-led report
Annex 10: FTSU detriment protocol – final consulted upon

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report - July 2026

1.1 Our weakest parts of the National Oversight Framework - and have of the Provider Capability Assessment - will relate to **our culture**: or rather our self-assessment of it, informed by views from our staff. The intention remains to make commitments to a 2 – 4-year change process by the time of our leaders' conference in September, which falls just after the Board's next meeting. We have begun to engage outside advisors to support us with this work, which will be subject to considerable co-production over coming weeks, grounded in conversations with the Trust People Council, which began in January. The radical change in the relationship, and the power dynamic, achieved with our communities since 2023, is one we now need to achieve with our people.

1.2 As last time, I wish **to emphasis the drive to having in place a consistent DIALOG+ care plan** for or with our patients. This is our long-term weakness in repeated CQC evaluations of services. Whilst patients have documentation, it is not consistent, nor does it span settings. We are just short of 70% coverage on the present dashboard and are aiming to achieve 100% coverage by/in September. Previously labelled as 'this year's four weeks' to indicate its significance, all Board members will appreciate, from our review of care quality compliance in August, the work being done across community directorates to transition to this position.

1.3 In January, and again in March Boards, we were asked to provide assurance over **contract documentation with commissioners.** Notwithstanding that apparent profile, progress to create contracts has been glacial, and yet has consumed a significant amount of senior management time. HNY-ICB have sought to add significant revenues to the Trust as part of moving forward neurodiversity (for young people) and also moving out of area placement spend to providers: within a 3+2 contract. This out of area transfer is along the lines the Board accepted from South Yorkshire in 2025/26 and removes the equity gap that the Board was then and since been deeply concerned about: making it easier for us to manage our bed base fairly across our sites. SY-ICB have had multiple personnel changes, but escalated discussions this week, have taken place. The difficulty the ICB is having implementing their CIP programme seems to have bled into their contract offer to us which is slightly lower than that guaranteed in mid-March 2026.

1.4 There continues to be a considerable volume of national guidance and instruction issued, outside the framework of the three-year planning guidance. Reconciling these instructions, and considering the cost of their implementation, is a balancing act. Fortunately, in many cases - such as the Personalised Care Framework - the intention of national policy reflects our direction of travel with DIALOG+. Curiously, our plans for **Talking Therapies** were signed off in planning, but those of our commissioners were not. We are in discussion with ICBs over their growth plans for 2027-2029 as instructions come to grow WTE, as well as to improve access volumes: our focus is on high intensity therapy, where we have longer waits, as well as on innovative adoption of technology delivered treatment and research into that modality. We anticipate a revised approach with ICBs from September, which should

provide certainty for the remaining planning period. No such prioritisation is apparent yet for neurodiversity waits, despite their clear educational and employment sequalae.

Our patients

2.1 Considerable time was spent in 2025 creating support for more **therapeutic activities** across our mental health wards, on a seven-day per week basis. This remains a focus of work because we know that it brings value to patients and improved safety management for staff. Data from Safecare suggests that daily access is being maintained, but the hours of availability need to expand further: clinical executives have met with all three acute directorate leadership teams to explore the barriers that they are facing.

2.2 We remain committed to **a short wait culture for care**, symbolised by the four-week promise, largely achieved by April 2026 and sustained since. In September, we are due to consider the route to 14 weeks for secondary waits, as we look to match the NHS' 18-week pledge (even though that does not apply – in policy - to services not led/delivered by medics). Focusing on the quality benefit of short waits remains central to the work we do, and the clear feedback from patients is that it should remain our focus. Our website continues to offer up to date information on service waits, and we are rolling out use of System Connect as a booking route to provide patients with some measure of choice about their appointment time within that booking window.

2.3 Over the coming eight months, we are rolling out use of **Ambient Voice (AVT) technologies into all our clinical areas, including physical health.** The intention is to reduce clinicians' time on administration, and to streamline processes for collecting information within consultations and MDTs. Led by Mike Seneviratne, our associate medical director, success for this work will be in adoption and use, not deployment: and in ensuring that the tool allows us to validate that data has been shared with our patients and with primary care partners as it should be.

2.4 Having signed the contract for **Waterdale** in March 2026, we are progressing well to a finalised RIBA Stage 4, informed by feedback from children and young people. Discussions continue with other potential tenants, and we aim to have that finalised not later than August 6th. Occupation of the upper floor by patients is on track to take place by March 2027 providing city-centre access for young people, including sexual health services and mental health provision. We understand that the wider area re-development, though Capital and Centric, is also running to time, and creation of a clearer walking-based accessible city centre from the CAST Theatre to the railway station is taking shape. As the estate FBC cover paper outlines, our bigger, or certainly sooner, priority remains Riverside in Rotherham, with a shared ambition to conclude commercial agreement by the end of August (two months late), such that officer and political consideration can be given: that timetable is still consistent with occupation in summer 2027.

2.5 With one final recruitment push on July 28th, **the Acorn Centre** is due to open on September 30th. The centre is the chosen name for our Great Oaks based urgent

mental health 24/7 facility, created as part of the refurbishment and modelled on Harrison House in Grimsby. It explicitly seeks to draw mental health presentation away from Scunthorpe General and to take direct ambulance arrivals through EMAS. Peer support workers will form a key staffing resource, and the MIND safe space will also be co-habiting with the Centre in the early evening: Assistant psychology led services will, for the first time at the Trust, run groups over weekends.

2.6 The **wider Estate FBC** is within the Board's papers. This sets out the big steps we need to make to complete the re-design of our estate not later than 2030. It is clear from the deepening staff engagement done this spring that the buildings we have do not meet people's needs, and that there is appetite to see change, providing that change maintains identity for teams, and offers benefit in terms of meeting spaces and educational facilities. Patient feedback focuses on the accessibility of buildings, navigability of sites, suitability for those with dementia, sensory needs, and disabilities, and space to sit and wait should that be needed. As we have begun to open up our estate for us by others, including through our dignity rooms, there is enthusiasm for that to continue.

Our people

3.1 We have circulated, with the Board's papers, the NHS England report into our educational calibre, which is a bi-annual process covering all of our professions, except social work. The report **positively reflects on the experiences of those being educated, and of those engaged in education**. It will be important we set clear time aside for those providing education to support their trainees and students, and that this is given equivalent value alongside service and research.

3.2 Contained within the Board's papers is the first attempt at a **volunteering evaluation** from the work done to date on Promise 3. We are not yet above 400 volunteers, which is our stabilising figure intended to manage turnover, and we know from the evaluation that we have work to do to ensure that all areas of the Trust see the value brought by volunteers and feel supported to introduce new roles into their teams. We have sustained promise delivery since October 2025 but want to ensure that in all five care groups it is a consistent priority.

3.3 As we support more peer support worker roles, and mindful of the prior paragraphs about students and volunteers, there is a gentle redefinition going about who staff are, *who we are*. This theme is picked up in the culture paper, as we look to ensure that multiple identities can be retained: for example, peers are not employees and, whilst they should have access to skills/assets from the Trust, it is important that, as with volunteers, we do not lose the unique elements they bring to our mission. Similarly, it may be timely to consider **whether the architecture of support to each of our professions is well constructed**, and that those who may consider themselves less involved, including pharmacists, some medical staff and, of course, social workers, can see their reflection in our collective work.

3.4 We discussed, in some detail last time the Board met, the **Rotherham staffing issue**s that the Trust is facing, with concurrent medical staff departures, and a surge in mid-term sickness too. We have agreed to a series of agency locums outside our

plan and made clinical/educational supervision cover arrangements for incoming trainees who start on August 5th. Within our delivery review structure, time is being spent on how the next three-month period is co-managed to support staff who remain with us – with movement of some posts to ensure that, in the short term, service configurations are sustained.

3.5 **Sickness absence review clinics**, led by Carlene Holden, continue with all clinical directorates and nursing/facilities. The intention, based on the Board's plan agreed in May, is for the policy intervention to help us to reduce absence by around 1%. At the same time, we are moving to put in place a radically revised and more pacey approach to grievance and disciplinary processes, to reduce the burden of these processes on all involved, including frontline managers' time. We expect that revised approach to be live by the time the Board next meets in September.

3.6 I have now agreed the internal audit scope for **our review of job planning** in all clinical disciplines. At the time of writing, we are working to have 50 of 76 medical consultant plans signed off by the end of July, and I understand that AHP, psychological professionals and nurse consultant plans are largely all completed. In the medium term the clarity and accountability, that comes from these mutual documents, will be important, but we need to reflect, before the 2027/28 cycle, on how we can improve the process and shorten it considerably.

Our population and partners

4.1 On June 30th, our Communities' Leadership Executive led a successful **community development event across the RDaSH footprint in Hexthorpe**. This helped us to consider, with third sector and primary care partners, a more relational view of neighbourhood health focused on multiple disadvantage. It also provided a backdrop to the Community Powered Healthcare Taskforce that the Board discussed in March, and which meets for the first time in August. This will be the space in which to broker conversations about generalism/specialism in mental health, in particular.

4.2 Our **neighbourhood model in physical health** was refined during the engagement work done for organisational change in late 2025 and, as outlined in the February 2026 consultation document, we plan to engage and consult on these changes in Q3 2026/27. There is not necessarily an expectation of further posts being removed, but consultation will see changes to basepoints, and a significant shift from specialist teams into locally focused teams.

4.3 Discussions about the translation of shared frailty work into a facility on the Tickhill Road site are progressing, with the likely creation of a sub-group of the Doncaster UEC Alliance to ensure that the work is jointly governed. More work is needed to shape this summer and early autumn, **the step-up capability,** which is a key part of the model, intended to displace patients from ED attendance, and sit alongside virtual ward pathways. As the place system looks to re-commission a variety of services in 2027, it is important that this foundational piece is well established.

4.4 In June, we initiated our text-based reminder system for clinical appointments, at scale, and combined this with access to subsidized bus passes for patients from neighbourhoods with low socio-economic indicators. Take up, which had previously

been slow, has increased markedly, which is welcome. This is one of five steps in ensuring **our Poverty Proofing agenda** (promise 6) remains active and action orientated, as we move towards a full set of reports covering all Trust services by the end of September 2026.

4.5 I reported in May our then-upcoming June 1 meeting with NHS-NEY ('region'), which proceeded. One element of that meeting was the four '**plan conditions'** issued to us in April when our three-year plan was approved. We have now had written confirmation that the cost improvement measure has been discharged, as have the workforce planning and sickness planning conditions. We have not sought to meet the Out of Area placement condition, albeit we are achieving well above our planned trajectory, but are mindful of some confusion externally between inappropriate, appropriate, and complex placements, and a discrepancy between the approach to their funding and reporting.

4.6 Our **antisemitism training work** starts in earnest from the Learning Half Day in July. The Board has recognised that this will take some effort to create the confidence among staff to speak to this subject, to lived experiences, and to consider how we weave this work into our efforts. As agreed, from our private timeout session, this is specifically discussed within the anti-racism paper before the Board.

Toby Lewis, Chief Executive
24 July 2026

Annex 1

Clinical leadership executive summary
June and July 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.

June	July
S17 leave and LIO VBMS policies	Community Powered Healthcare Taskforce
DIALOG+	Appraisal update
Decision tree around MCA	Diagnostic led LOS
Mobile first working	Always measure launch plans
Frailty centre in Doncaster	Management development post LDO

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 (August/September), we will consider in particular:

- Execution of transitional care plan for young adults across services
- Sickness absence approaches/deployment
- Estate plan governance
- Anti-racism work in North Lincs and Rotherham wards
- Cultural commitments

Toby Lewis, Chief Executive
21 July 2026

Annex 2

Communities' leadership executive summary
June and July 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. In June priorities and terms of reference were reagreed and then approved at the CLE in July.

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 (CoLE)
VISUAL MINUTES

MEETING DATE:
4 JUNE 2026
10:00AM – 12:00PM
AT NEW YORK STADIUM

Passionate · Reliable · Caring and safe · Supportive · Open · Progressive

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

1 HOUSEKEEPING & ACCESSIBILITY

- Visual minutes approved
- Add Jargon Buster to information packs
- Add recurring Actions / Matters Arising section
- Use red, amber and green ratings where possible

2 TERMS OF REFERENCE & WAYS OF WORKING

- Power sharing – not top-down
- Stronger relationship with CLE
- Learning and development role
- Challenge and accountability
- Better understanding of the 28 Promises

3 KEY DECISIONS

- [x] Update Terms of Reference
- [x] Reflect power sharing principles
- [x] Clarify relationship with CLE
- [x] Standing agenda items can evolve
- [x] Learning is part of CoLE's role

4 INITIAL CoLE PRIORITIES AGREED

Promise 5 – Community Power
Communities involved in decision-making throughout the year

Promise 6 – Poverty Proofing
Reduce discrimination and digital exclusion

Promise 12 – Rural Communities
Better support for villages and rural communities

Promise 21 – Hyper Local Care
Stronger links between primary care, VCSE and local communities

These priorities were selected by combining survey feedback with lower-scoring areas of the Promises Scorecard.

5 DECISION MAKING

- Majority voting if consensus not reached
- Record disagreement openly
- Fair geographical representation
- At least one RDaSH representative present

6 LANGUAGE MATTERS

- Use person-centred language
- Avoid labels such as "hard to reach"
- Respect community preferences
- Different terminology may be appropriate for different communities

ACTIONS

- [x] Create an Easy Read version of the Terms of Reference
- [x] Include a clearer statement about CoLE's relationship with CLE
- [x] Build in a regular route for CLE feedback to be presented to CoLE
- [x] Add the 28 Promises One Page Summary to the pack
- [x] Share the current Promises scorecard with the group
- [x] Consider a practical session or workshop on the 28 Promises
- [x] Add a Jargon Buster / acronym list to the information pack

OTHER KEY POINTS DISCUSSED

Education & Learning
Education and shared learning are part of CoLE's role.

Meeting Frequency
Monthly meetings are a commitment but help maintain momentum.

Standing Agenda Items
The group can identify agenda items over time.

Accessible Information
Documents and information should be accessible to all.

Policy Consultation
CoLE will be consulted on policies relevant to its role, but policy review is not a core responsibility of members. Relevant policies will be shared selectively for feedback.

NEXT MEETING

Thursday 9 July 2026
10:00am – 12:00pm
New York Stadium, Rotherham

CoLE is about shared power, community challenge and turning priorities into action.

COMMUNITIES' LEADERSHIP EXECUTIVE (CoLE)

Shared Power • Shared Voice • Shared Action

VISUAL MINUTES

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

MEETING SNAPSHOT

- Forum: Communities' Leadership Executive (CoLE)
- Date: 6 July 2026
  Time: 10:00 AM – 12:00 PM
- Location: New York Stadium
- Leadership: Co-chaired by Mukhmar Jamil and Dan Wilson

CoLE is about shared power, community challenge and turning priorities into action.

KEY GOVERNANCE & DECISIONS

TERMS OF REFERENCE
Unanimously approved by the Executive and advancing to the Clinical Leadership Executive (CLE) for final ratification in July.

STRATEGIC PRIORITIES
CoLE officially selected Promises 5, 6, 12, and 21 as its initial priorities.

COMMUNICATION BRIDGE
A formal two-way "outbrief" channel will be established between CoLE and the CLE to keep both executives aligned.

TEAM BUILDING
Agreed: there will be separate, optional meeting with a 10-minute informal "getting to know you" presentations by members, starting with Graham Keeton.

HOW WE WORK

HOUSEKEEPING AND ACCESSIBILITY

- Visual minutes approved
- Jargon Buster
- Actions / Matters Arising
- RAG ratings

TERMS OF REFERENCE AND WAYS OF WORKING

- Power sharing
- Stronger CLE relationship
- Learning & development
- Challenge & accountability
- Understanding the 29 Promises

THE "PROMISES" ACTION PLAN

PROMISE 5 COMMUNITY INVOLVEMENT

- Community integration remains inconsistent across 14 clinical directorates. CoLE will scrutinise progress, challenge self-assessments and prioritise seldom-heard voices when reviewing Trust-wide Promise 5 delivery outcomes.
- RDaSH's five-day community induction could include CoLE orientations, helping new colleagues meet voluntary organisations, understand local needs and value community involvement from their first day.
- CoLE will review Promise 5 induction materials, recommending stronger cultural competence content so colleagues understand diverse communities, recognise barriers and work respectfully with local people.
- As paid volunteering develops, CoLE will help create placements in member organisations, giving staff direct community experience, stronger partnerships and better understanding of local challenges.

PROMISE 12 RURAL NEEDS

- Members identified transport as the main barrier preventing rural communities from accessing health services. Although mobile clinics and local hubs provide some support, villages including Beltoft, West Butterwick and Fishlake remain isolated. CoLE agreed that improving transport access should become the central focus of work on this promise going forward.
- CoLE will use its community networks to gather direct evidence from people living in hyper-local rural areas. A targeted questionnaire will ask what support communities need from the Trust. Members will also examine innovative transport and healthcare approaches used elsewhere in rural Britain, identifying ideas that could be adopted locally.

ESSENTIAL TRUST OPERATIONS & UPDATES

SERVICE PRESSURES
Short-term operational pressures are currently impacting Rotherham adult inpatient services and community mental health teams due to concurrent senior staff departures. Highlighting this reality will be crucial for broader awareness across the trust.

NEW INFRASTRUCTURE
RDaSH is on track to launch its first open-access urgent mental health facility in North Lincolnshire by late September.

TRUST MATTERS
Published containing a large feature on CoLE with a biography of all CoLE members

THE FORWARD PLAN TIMELINE

18 JULY 2026
RDaSH Fun Day and Annual General Meeting (AGM) taking place.

6 AUGUST 2026
Promise 6 and Promise 21 focus

SEPTEMBER 2026
Scheduled briefing on the new Open Access Mental Health Services.

DECEMBER 2026
Deep dive transparency discussion regarding funding disparities and financial pressures between NHS and VCSE sector

Building stronger partnerships between communities and RDaSH.

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	3711.22	3476.53	-234.69		34.78	40.08	12.50	47.73	69.80	36.58	241.47	**6.32%**

Org L4	FTE Budget	FTE Actual	FTE Variance	Recruitment	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total	Vacancy Rate
376 Corporate Assurance	27.99	27.02	-0.97		0.00	0.00	0.00	0.00	0.55	0.00	0.55	
376 Estates	47.18	42.43	-4.75		1.00	0.00	0.00	0.00	1.35	1.00	3.35	
376 Finance & Procurement	40.19	39.21	-0.98		0.00	0.00	0.00	1.00	1.00	1.00	3.00	
376 Medical, Pharmacy & Research	54.67	53.71	-0.96		0.00	0.50	0.00	1.00	0.60	1.00	3.10	
376 Nursing & Facilities	170.40	153.48	-16.92		1.65	0.00	0.00	2.53	8.30	1.00	13.48	
376 Operations	124.58	116.01	-8.57		0.00	1.00	0.00	0.00	0.00	0.00	1.00	
376 People & Organisational Development	84.97	78.31	-6.66		3.00	1.50	1.00	0.00	1.00	0.00	6.50	
376 Psychological Professionals and Therapies	20.09	15.20	-4.89		0.20	0.00	0.00	0.00	1.00	0.00	1.20	
376 Strategic Development	18.04	18.83	0.79		0.00	0.00	0.00	0.00	0.00	1.00	1.00	
Total	**588.11**	**544.21**	**-43.90**		**5.85**	**3.00**	**1.00**	**4.53**	**13.80**	**5.00**	**33.18**	**7.46%**

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	266.00	-31.81		3.50	3.40	1.00	8.20	12.80	1.60	30.50	
376 CCG Physical Health	356.28	332.94	-23.34		2.20	2.00	1.00	5.40	10.08	8.44	29.12	
376 DMHLD Acute Services	222.72	201.36	-21.36		2.80	1.00	3.00	2.00	2.72	2.00	13.52	
376 DMHLD Community Services	331.10	317.87	-13.23		2.93	4.00	1.00	3.60	2.40	2.00	15.93	
376 DMHLD Learning Disabilities & Forensics	187.60	176.97	-10.63		2.60	2.00	0.50	0.00	2.00	1.00	8.10	
376 NLCG Acute Care Services	138.54	119.52	-19.02		2.00	5.56	2.00	4.50	2.90	5.54	22.50	
376 NLCG Community Care Services	148.16	143.52	-4.64		0.00	1.80	0.00	2.65	0.40	2.40	7.25	
376 NLCG NHS Talking Therapies	185.07	178.20	-6.87		0.00	0.00	1.00	1.60	0.72	0.00	3.32	
376 PHND Community & Long Term Conditions	407.64	390.62	-17.02		3.50	3.20	1.00	4.60	10.00	3.00	25.30	
376 PHND Neurodiversity	43.30	37.65	-5.65		1.00	0.00	0.00	0.80	2.00	0.00	3.80	
376 PHND Rehabilitation	313.64	300.93	-12.71		3.60	3.00	0.00	5.25	1.00	0.00	12.85	
376 RCG Acute Services	221.15	203.60	-17.55		2.80	5.32	0.00	3.00	6.28	2.00	19.40	
376 RCG Community Services	231.72	224.99	-6.73		1.00	5.20	0.00	1.60	1.30	3.60	12.70	
376 High Dependency Rehabilitation Unit	38.38	38.15	-0.23		1.00	0.60	1.00	0.00	1.40	0.00	4.00	
Total	**3,123.11**	**2,932.32**	**-190.79**		**28.93**	**37.08**	**11.50**	**43.20**	**56.00**	**31.58**	**208.29**	**6.10%**

Annex 4: National publications – June/July 2026

A consultation on proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models to support neighbourhood health services

(NHS England, published 16/07/2026)

To support neighbourhood delivery models, the 10 Year Health Plan committed to developing new contracts based on population size. This consultation seeks views on two proposed contracting models: a Multi-Neighbourhood Provider (MNP) Contract and a Single Neighbourhood Provider (SNP) Contract. It explains the proposals and asks questions to help us understand the likely benefits, risks and practical implications, including how the contracts would interact with existing arrangements. The consultation is aimed at integrated care boards (ICBs), general practice, Primary Care Networks (PCNs), community and other providers, local authorities, patient representatives and other stakeholders. Patients and members of the public may also wish to contribute to the consultation.
https://www.engage.england.nhs.uk/consultation/mnp-snp-neighbourhood-provider-models/
https://www.england.nhs.uk/long-read/a-consultation-on-proposed-mnp-and-snp-contracting-models-high-level-summary/

Quality strategy for NHS-funded care in England

(NHS England, published 14/07/2026)

Published on behalf of the National Quality Board, this strategy provides a structured approach to making quality the organising principle of NHS-funded care in England over the next decade. In doing so, it sets out a shared approach to quality across 3 interdependent domains: safety, effectiveness and experience.
https://www.england.nhs.uk/publication/quality-strategy-for-nhs-funded-care-in-england/

Letter to NHS leaders following publication of the Lord Mann Review

(NHS England, published 04/06/2026)

Letter from Sir Jim Mackey, Chief Executive, NHS England and Danny Mortimer, Director General for People, NHS England regarding Lord Mann's review into tackling racism and antisemitism.
https://www.england.nhs.uk/long-read/lord-mann-review/

NHS Oversight Framework 2026/27

(NHS England, published 11/06/2026)

This framework describes NHS England's approach to oversight of integrated care boards, NHS trusts and foundation trusts.
https://www.england.nhs.uk/long-read/nhs-oversight-framework-2026-27/

Board and executive assurance: cyber security risk
(NHS England, published 10/06/2026)

Letter from Tom Wechsler, Group Director for Cyber Security, NHS England and the Department for Health and Social Care, asking boards and executives to assure themselves that cyber security risks are being managed effectively, with clear, sustained programmes for improvement.
https://www.england.nhs.uk/publication/board-and-executive-assurance-cyber-security-risk/

NHS staff standards
(NHS England, published 06/07/2026)

The 10 Year Health Plan committed to developing a new set of staff standards to outline minimum standards for employment across a range of areas, aimed at improving staff experience. To address this, the Department of Health and Social Care has worked with NHS England and the Social Partnership Forum (SPF) to develop the new NHS staff standards. These standards set clear minimum expectations for employers, focusing on:

- line management
- health and wellbeing
- violence prevention and reduction
- tackling racism
- championing sexual safety
- promoting flexible working

https://www.gov.uk/government/publications/nhs-staff-standards

Mental health personalised care framework: the modern care programme approach
(NHS England, published 17/07/2026)

This framework sets out the approach and related principles and actions for delivering personalised care for adults and older people with severe mental health problems. Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs.
https://www.england.nhs.uk/publication/mental-health-personalised-care-framework-the-modern-care-programme-approach/

NHS England Net Zero Supplier Roadmap – April 2027 milestone requirements
(NHS England, published 09/06/2026)

Guidance to ensure suppliers and buyers have clarity on what is required to prepare for compliance with and support for delivery of the NHS England Net Zero April 2027 milestone requirements.
https://www.england.nhs.uk/publication/net-zero-supplier-roadmap-april-2027-milestone-requirements/

Supporting autistic people and people with a learning disability to live well in their communities
(NHS England, published 14/07/2026)

This publication sets out the essential components that help autistic people and people with a learning disability to live good, meaningful lives in their communities. It is designed to support local systems plan and deliver this support across all ages.
https://www.england.nhs.uk/publication/supporting-autistic-people-and-people-with-a-learning-disability-to-live-well-in-their-communities/

Advanced Foundation Trust Programme policies and guides
(NHS England, published 10/06/2026)

As set out in our 10 Year Health Plan, the Advanced Foundation Trust Programme rewards and incentivises good performance. Advanced foundation trust status is the new marker of excellence for providers that drive the delivery of the three shifts, and work with partners to improve population health. This link contains the policy framework underpinning the Advanced Foundation Trust Programme, alongside a guide for applicants that offers practical information for trusts seeking to apply.
https://www.england.nhs.uk/publication/advanced-foundation-trust-programme-policies-and-guides/

Strategic commissioning of hospice services and update on the Modern Service Framework for Palliative Care and End-of-Life Care
(NHS England, published 15/06/2026)

Letter from Dr Amanda Doyle, NHS England National Director for Primary Care and Community Services, regarding strategic commissioning of hospice services, and an update on the Modern Service Framework for Palliative Care and End-of-Life Care.
https://www.england.nhs.uk/long-read/strategic-commissioning-hospice-services-update-modern-service-framework-palliative-care-end-of-life-care/

Flu Vaccination Programme 2026/27
(NHS England, published 02/07/2026)

Letter from Sir James Mackey, Chief Executive Officer, NHS England.
https://www.england.nhs.uk/long-read/flu-vaccination-programme-2026-27/

Model discharge pathway
(NHS England, published 07/07/2026)
This publication sets out the model needed to make timely, clinically-led discharge routine – so all patients receive the right care, at the right time, no matter when or where they are treated. The model applies to hospital and community bedded care and addresses:

- in-hospital discharge planning and delivery
- daily ward-based practices within the control of hospital teams
- standardising basic processes to reduce variation

https://www.england.nhs.uk/long-read/model-discharge-pathway/

Preventing unlawful access to patient records
(NHS England, published 08/07/2026)

A letter and supporting information from Sir James Mackey about preventing unlawful access to patient records.
https://www.england.nhs.uk/long-read/preventing-unlawful-access-to-patient-records/

Screening and vaccinations trust framework for NHS employees
(NHS England, published 13/07/2026)

All NHS trusts are required to carry out health assessment screening on their staff to determine suitability and fitness to undertake their roles. Similarly, healthcare workers have a duty to protect patients from communicable diseases, including taking reasonable precautions to protect them. This framework has been developed to standardise and streamline occupational health screening requirements of NHS employees by establishing a baseline standard for all NHS trusts.
https://www.england.nhs.uk/publication/screening-and-vaccinations-trust-framework-for-nhs-employees/

Nursing Band 5 job evaluation
(NHS England, published 02/06/2026)

This letter sets out how the employer-led review of all Band 5 nursing roles should proceed, and how organisations will be expected to report and evidence progress.
https://www.england.nhs.uk/long-read/nursing-band-5-job-evaluation/

Winter planning 2026/27 – expectations and assurance
(NHS England, published 17/07/2026)

Winter planning 2026/27 – expectations and assurance letter, from Sarah-Jane Marsh CBE, NHS England Chief Operating Officer.
https://www.england.nhs.uk/long-read/winter-planning-2026-27-expectations-and-assurance/

Annex 5:

Neurodiversity waiting time scorecard – June/July

CYP Neurodevelopment Scorecard

1. Trajectory & Key Milestones

Metric	Position	Commentary	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	**On track**	Planned: All three places by December 2027	🟠

2. Waiting Lists & Demand (by Place)

Metric	Rotherham	Doncaster	North Lincs	Commentary	RAG
Total waiting (assessment)	1,306	787	746	Reduction of 179 since May data	🟠
Medication waits	234	258	N/A* *North Lincs contextual backlog: ADHD 360 (72), NLaG (502), RDaSH circa 583	Ongoing pressure.	🔴

3. Activity and throughput (June)

Metric	Rotherham	Doncaster	North Lincs	Commentary	RAG
CYP receiving full assessment (June)	92 + 32 Digital	45 + 54 Digital	49 + 10 Digital		🟠

4. Trajectory assurance by place

Place	On Trajectory?	Position Summary in month	RAG
Rotherham	No	**-40**	🟠
Doncaster	No	**-19**	🟠
North Lincs	No	**-15**	🟠

Adult ADHD Scorecard

1. Assessments (Diagnostics)

June (actual)

Metric	Position	Commentary / drivers	RAG
Expected capacity (full)	**173 / month**	**Baseline expectation at full capacity**	—
Completed assessments	**121**	**69% of expected (52 below capacity)**	🔴
DNA appointments	**15**	**25 missed appts due to admin error**	🟠
Missed/cancelled due to staff sickness	**56**	**Sickness: 3 WTE staff members** **1 mat leave/ 1 short term**	🔴

July (planned / booked)

Metric	Position	Commentary / drivers	RAG
Expected capacity (full)	**94/ 173 completed**	**Provided so far in July**	—
Booked assessments	**16 further booked before end July= 110**	**63% of expected booked (63 below capacity)**	🔴
Workforce impact	**Ongoing**	**Same sickness as June + 1 maternity leave + short-term sickness x 6** **Vacancy 3.2 recruited 0.8**	🔴

2. Treatments (ADHD)

Activity vs expected capacity

Period	Expected capacity	Delivered	Delivery vs expected	RAG
June (full month)	**199 / week**	**942**	**796/942 69%**	🟠
July (first 2 weeks)	**199 / week**	**278**	**278/398 69%**	🟠

3. Waiting list period

Adult ADHD waiting list

Month	Longest wait (weeks)	Total waiting
April	**196**	**6,273**
May	**194**	**6,232**
June	**231**	**6,373**

Adult autism waiting list

Month	Longest wait (weeks)	Total waiting
April	**327**	**2,215**
May	**325**	**2,209**
June	**Doncaster 3 years 28 weeks (average 2 years 9 weeks)** **Roth 4 years 24 weeks – 1 patient (next waiting 3 years 43 weeks Average -2 years 30 weeks)**	**877** **1354** **Total – 2,231**

Annex 6:

South Yorkshire Eating Disorders Joint Committee Meeting Note – 13th July 2026

The South Yorkshire Eating Disorders Joint Committee (SYEDJC) met on 13th July 2026. The main areas of discussion and subsequent actions are outlined below.

Children and Young People's (CYP) Eating Disorder Services Update

Members of the EDJC had a comprehensive discussion on the development of the CYP eating disorder model, including Medical Emergencies in Eating Disorders (MEED), strategic options for integrated service delivery, and the need for clear age parameters and transition planning.

- **CYP MEED (Medical Emergencies in Eating Disorders) Model:** Work is progressing on the children's model, including expert training, virtual MDT access, and MEED liaison practitioner support. Next steps include finalising the proposed delivery model and costs within Sheffield Children's and wider stakeholders. EDJC requested specific consideration of age appropriate services, especially around the 16–18 age group.
- **CYP Strategic Options Appraisal: S**trategic options appraisal continues for delivery of integrated CYP eating disorder services configuration, assessed against criteria such as quality, affordability, sustainability, integration, and equity, with ongoing clinical discussions. This will also need to incorporate views from other CYP eating disorder service providers. A further update on the conclusion will be provided at the August EDJC.

Development of ARFID Service Model (all age)

The EDJC reviewed an update on a recent workshop to progress on designing a South Yorkshire ARFID approach. This followed a learning session with colleagues in Manchester who shared their experience and how they have developed and adapted their initial approach.

There was a spectrum of views on the extent to which ARFID care should be provided as a standalone service or integrated within existing eating disorder pathways, with consensus leaning toward a middle-ground consultation model. A clear focus needed to also be on a universal offer for early intervention and support.

The committee agreed next steps including development of a task and finish group with cross-organisation and lived experience input, which will report back to EDJC in September.

MEED (Medical Emergencies in Eating Disorders) Services

The EDJC reviewed an update on the plan presented in May.

Acute providers have contributed to the MEED Liaison Practitioner roles job description and hosting arrangement and will the roles will be advertised now in late July.

Work continues to develop a more robust data set to help finalise discussions around the potential double hub model, and this is expected to be concluded by the next EDJC. Development of supporting operational processes with lived experience engagement will follow in line with the proposed plan.

Physical Health Monitoring

Member of the EDJC reviewed a paper on discussed challenges and options for delivering physical health monitoring (PHM) for people with an eating disorder.

Engagement with primary care colleagues has commenced and this has highlighted potential limitations with the initial proposed Local Enhanced Service model. Therefore, there has also been consideration of alternative delivery models, including delivering PHM through eating disorder services or at scale via GP federations, noting the need to ensure equity and timely access.

Members of the EDJC highlighted the importance of system interoperability for result sharing and associated accountability for actions. They noted the need to design a model that supports near real-time data access for MDTs, balancing centralisation with local accessibility. Plans to appraise all feasible models were supported, with costing for blood tests, ECGs, training, and admin support. This will also include input from providers and learning from services elsewhere for example Navigo and Nottinghamshire.

Adult Integrated Service Procurement Process

This item was discussed in a confidential session with limited membership to address potential conflicts of interest. The EDJC agreed the procurement route and endorsed a proposal for implementation of a procurement-specific conflict protocol, requiring declarations of interest, a register of actions, and exclusion of conflicted individuals from evaluation and award decisions. The EDJC will help define the ‘what’ of the procurement. Executing that procurement will be led by RDaSH and SY ICB, with a separate evaluation panel distinct from the provider contributors to the EDJC.

Annex 7:

Update at end of Q1 on organisational change (25/26) – to be read alongside QSIA report

Purpose

There continues to be work to implement the changes to community services consulted upon in February. This annex focuses solely on caseload and volume impacts: there is considerably wider enabling work which is running to plan and purpose.

Clinical Activity Delivery

Table 1 below details the volume of clinical activity delivered in each service affected by the Community Change Implementation Programme as a percentage variance from the activity plan (which has been set based on the volume of clinical activity delivered by each team in 2025/26 +2% in line with national productivity expectations):

Table 1: Clinical Activity Delivery

Care Group	Team	Implementation Point	April (% variance from plan)	May (% variance from plan)	June (% variance from plan)	Headline	Narrative
Children's Care Group	Child Exploitation	5 May 2026	-91.8	-91.3	-88.9	➲	Activity now in CAMHS Getting Help which is stable YTD
	Single Point of Access	Not implemented	N/A	N/A	N/A	N/A	Change not yet implemented
	Doncaster 5- 19 Children in Care	1 May 2026	3.7	-12.3	25.6	✓	Activity above plan post change
	Doncaster 5- 19 School Nursing/Community Nursing	1 May 2026	-16.1	-29.7	-5.5	☒	Flagged for monitoring – some unrelated sickness absence and universal offer can result in fluctuation of demand, possible recovery in June 2026 but more monthly data points required to identify trend.
	Doncaster East 0-5	1 April 2026	2.7	-2.8	15.5	➲	No trend – monitoring (possibly caused by birth rate fluctuation)
	Healthbus	12 May 2026	N/A	N/A	N/A	N/A	Service does not deliver direct clinical activity
	North Lincolnshire 0-19 North	29 May 2026	11.7	-4.7	31.2	✓	Activity above plan post change
	North Lincolnshire 0-19 South	29 May 2026	9.6	8.1	31.2	✓	Activity above plan post change
	North Lincolnshire 0-19 Brigg and Barton	29 May 2026	24.1	18.1	41.6	✓	Activity above plan post change
	Mental Health Support Teams (WMiM)	1 April 2026	30.8	14.3	12.0	✓	Activity above plan post change
	Intellectual Disability	1 April 2026	-6.09	-29.0	-8.2	➲	Monitoring – change doesn't affect direct clinical and was in effect before consultation in practice. Possible impact of Barnsley changes could reduce total contacts
	Sexual Health	1 April 2026	Not a separate data line - requested	N/A	N/A	N/A	Activity data included in broader service line – overall position stable but separation requested for future reporting
Physical Health and Neurodiversity Care Group	Rehabilitation	1 April 2026	-22.9	-29.2	-12.4	☒	Flagged for monitoring – pathway redesign has removed duplication. Need to agree approach to impact that this has on activity plan.
	Palliative Care	1 April 2026	-17.5	-20.4	-29.5	☒	Flagged for monitoring – activity transferred to Woodfield 24 which is better placed. Need to agree approach to impact that this has on activity plan.
	Central Community Nursing	Not implemented	N/A	N/A	N/A	N/A	Change not yet implemented
	South Community Nursing	Not implemented	N/A	N/A	N/A	N/A	Change not yet implemented
	North Community Nursing	Not implemented	N/A	N/A	N/A	N/A	Change not yet implemented
	East Community Nursing	Not implemented	N/A	N/A	N/A	N/A	Change not yet implemented
	Unplanned Community Nursing	1 May 2026	-15.6	-28.4	-16.8	☒	Flagged for monitoring – significant sickness absence since implementation of change
	Urgent Community Response and VW	Not implemented	N/A	N/A	N/A	N/A	Change not yet implemented
	Enhanced Care Home	Not implemented	N/A	N/A	N/A	N/A	Change not yet implemented
	Dietetics	1 April 2026	27.6	2.3	7.4	✓	Activity above plan post change
	SaLT	1 April 2026	68.8	34.6	60.5	✓	Activity above plan post change
	Therapy Hub	20 April 2026	-8.9	-28.5	-19.5	☒	Flagged for monitoring - no trend and change did not reduce DCC hours so to be monitored
	Information Service	Not implemented	N/A	N/A	N/A	N/A	Change not yet implemented
Rotherham Care Group	Memory Service	1 April 2026	6.6	12.9	60.4	✓	Activity above plan post change
	Young Onset Dementia Service	1 April 2026	-22.9	-45.4	-13.3	☒	Flagged for monitoring – implementation of change has been rocky due to delayed recruitment to new role combined with retirement and sickness, forecast to stabilise with signs of possible recovery in June
	Perinatal	1 April 2026	45.4	-5.0	23.7	✓	Activity above plan post change

Care Group	Team	Implementation Point	April (% variance from plan)	May (% variance from plan)	June (% variance from plan)	Headline	Narrative
	Early Intervention Team	1 April 2026	34.0	60.4	39.8	✓	Activity above plan post change
	Assertive Outreach Team	1 April 2026	57.9	73.2	57.8	✓	Activity above plan post change
	Health and Wellbeing Service	6 May 2026	8.2	-3.3	3.3	✓	Activity above plan post change
	North CMHT	1 April 2026	-11.1	-19.7	25.3	➲	No trend – monitoring
	South CMHT	1 April 2026	10.2	16.0	20.2	✓	Activity above plan post change
	Care Home Liaison	20 April 2026	58.9	8.3	22.0	✓	Activity above plan post change
	OT Hub Formation	1 April 2026	No baseline	No baseline	No baseline	N/A	N/A
North Lincolnshire and Talking Therapies Care Group	Talking Therapies	1 April 2026	10.2	-0.1	14.6	✓	Activity above plan post change
	EIT / Psychosis pathway	7 April 2026	-2.2	3.9	-5.6	➲	Reduction unrelated to change – bereavement
	Older People	1 April 2026	30.0	35.9	34.3	✓	Activity above plan post change
	Primary Care (PCN H&W)	14 April 2026	15.1	27.1	50.2	✓	Activity above plan post change
	Memory Service	1 May 2026	17.5	-17.0	-24.3	☒	Flagged for monitoring –capacity impacted by Nurse Consultant sickness absence in May 2026 but to be monitored due to sustained reduction in June 2026
Doncaster Mental Health and Learning Disabilities Care Group	Doncaster Community LD	20 April 2026	5.4	-12.4	16.0	➲	No trend – monitoring
	Rotherham Community LD	13 April 2026	12.2	21.2	48.4	✓	Activity above plan post change
	N. Lincs Community LD	12 May 2026	-4.9	1.3	-5.6	✓	Activity above plan post change
	Forensic Outreach & Liaison	20 April 2026	2.1	-64.0	-10	☒	Flagged for monitoring – no trend and change did not reduce DCC hours but to be monitored
	Doncaster Assertive Outreach	Not implemented	N/A	N/A	N/A	N/A	Change not implemented
	Early Intervention	Not implemented	N/A	N/A	41.2%	N/A	Change took effect within June 2026
	Primary Care MH	24 April 2026	42.7	19.6	35.2	✓	Activity above plan post change
	North	20 May 2026	-9.1	-9.2	-1.39	☒	Flagged for monitoring – when aggregating across both CMHTs activity is stable but North to be monitored, signs of possible recovery in June 2026
	South	20 May 2026	35.8	25.8	42.8	✓	Activity above plan post change
	East	20 May 2026	-9.6	-22.8	-16.7	➲	Reduction unrelated to change – high sickness absence
	Central	20 May 2026	29.2	55.4	26.4	✓	Activity above plan post change

The table above identifies that, of the 51 services affected by the Community Change Implementation Programme

- 22 have delivered more activity than required based on the 2026/27 activity plan. In some services, delivery is significantly above plan which could be explained by an increased focus on activity and therefore increased data capture/quality.
- 13 have not been analysed:
    - 9 have not yet implemented a change that would affect delivery of clinical activity
    - 1 has implemented change too recently for meaningful analysis (Doncaster Early Intervention)
    - 1 does not deliver clinical activity (Healthbus)
    - 1 does not currently have data on a separate service line which is being resolved for the next report (Sexual Health)
    - 1 does not have baseline data due to the formation of a new hub (Rotherham OT Hub Formation)

- 7 have variable performance that is being monitored, with no trend or with causes known to be outside of the Community Change Implementation Programme

- 9 have consistently delivered less activity than required based on the 2026/27 activity plan. Of these:
    - 2 in Physical Health and Neurodiversity schemes were intended to reduce duplication (Rehabilitation) or transfer activity into Woodfield24 (Palliative Care) and therefore the reduced activity is in line with the expectations of the scheme.

- 5 have shown signs of recovery in June 2026 and therefore need to be monitored to confirm if this improvement is sustained.
- **Overall, 2 services are of concern:**
  - Unplanned Community Nursing – this scheme has escalated for several reasons including high levels of sickness absence. Mitigations are in place with effective senior involvement of the Care Group SLT.
  - North Lincolnshire Memory Team – activity has markedly reduced since the implementation of the scheme, to be monitored as more monthly data points are available to identify whether this is a downward trend or common cause variation.

The Community Change Programme Implementation Team has also reviewed whole team caseload for each of the affected teams in the adult mental health services which showed no statistically significant change when compared to the baseline position in all teams except North Lincolnshire Early Intervention. However, to make this metric more meaningful, it needs to be calculated based on caseload per whole time equivalent (WTE) which is not available currently due to WTE data including non-caseload holding team members e.g. administrators, support workers etc. This analysis will therefore be completed during quarter 2, 2026/27. As a mechanism for seeking confirmation that caseloads remain in safe thresholds whilst this analysis is produced, all service managers of affected teams have been asked to confirm that the caseloads in their services remain within safe tolerance limits which they have confirmed that they do.

Overall, early post-implementation data does not indicate a sustained Trust-wide deterioration in clinical activity, with most teams where change has been implemented delivering more activity than required in the plan; however, a small number of services require continued monitoring and targeted support during Quarter 2. We must also bear in mind service issues, such as staff sickness which is unrelated to the change programme.

The Board is asked to note the progress made in implementing the Community Change Implementation Programme, the early assurance provided by clinical activity and caseload monitoring, and the continued focus on those services where activity is below plan or where data remains immature. The oversight group will remain in place until September 2026, particularly to support resolution of final schemes; the changes in physical health and monitor and embed scheme changes. The delivery reviews for the corporate operations function will be used to provide Chief Executive oversight of this work on behalf of the Board. A further annex will come in September's CEO report.

Emma Sly, Senior Transformation and System Lead
Iona Johnson, Community Development Director
Richard Chillery, Chief Operating Officer
July 2026

Annex 8

EPRR submission 2026 – report on Trust readiness to evacuate and respond July 2026

1. Introduction

1.1 The Trust is in a stronger and more mature position than the previously reported 2025 position. The Board can take reasonable assurance that evacuation and business continuity arrangements are in place, tested and improving. Continued focus is required during 2026 to sustain this position, complete CBRN/HAZMAT work and evidence and further strengthen operational resilience against disruptive incidents. This work should be completed in time for the Core Standards submission in October 2026.

1.2 This is strengthened by the fact that the Trust now has a defined business continuity planning baseline of 147 plans, an established monthly review cycle averaging 14 formal BIA/BCP reviews, more than 70 completed digital exercises, and a growing evidence base from audits, incident debriefs and targeted training. These arrangements demonstrate that plans are being reviewed, exercised and tested with services rather than held as static compliance documents.

1.3 The key question for the Board is: can the Trust safely evacuate relevant services if required, and can it maintain or recover critical services during disruptive incidents?

1.4 The Board is asked to note the reasonable assurance provided within this paper, recognise the progress made since the 2025 position, and support the continued 2026/27 programme of testing, audit, training and improvement, particularly for evacuation, business continuity and CBRN/HAZMAT Initial Operational Response.

2. Reporting position compared with 2025

2.1 The Trust's 2025 reported position showed improvement from 67% to 91%, achieving a Substantially Compliant rating for the first time and placing RDaSH in a strong local position. This reflected a significant improvement in governance, planning, training, exercising and business continuity arrangements.

2.2 The predicted 2026/27 Core Standards position is Fully Compliant, with 58 of 58 applicable standards assessed as fully compliant and 9 standards not applicable to mental health trusts. This position remains subject to completion of the CBRN/HAZMAT improvement programme and external validation. The next steps are to complete that work, continue the 2026/27 evacuation and business continuity testing programme, and report progress through EPRR governance and scheduled Board reporting.

Compliance Level	Evaluation and Testing Conclusion
Fully Compliant	The organisation will be 100**%** compliant with the core standards in 2026.

Predicted Core Standard Position After 2026 Check and Challenge				
Number of Standards Applicable	Fully Compliant	Partially Compliant	Non-Compliant	Do Not Apply to MH Trusts
67	58	0	0	9

2.3 Reasonable assurance can be provided that the Trust has safe and usable arrangements for evacuation and business continuity. This is based on documented plans, local exercising, business continuity reviews, audits, digital exercises, incident debriefs and evidence that learning is being captured and acted on. This is not presented as absolute assurance; residual risks and planned improvements are set out below.

3. Evacuation plans

3.1 Evacuation plans are in place for all inpatient areas. These have been developed with clinical and operational leads so that they reflect local environments, patient acuity, staffing arrangements, site constraints and statutory responsibilities. Plans are available through the Trust intranet and form part of the wider site and service preparedness arrangements.

3.2 Plans have been exercised at site level to test practicality and usability. An out-of-hours exercise was also undertaken in late 2025 to test command, communication and escalation under reduced staffing conditions. During 2026/27, the EPRR Team will continue themed audits, scheduled exercising and review of plans for any new or reconfigured inpatient environments.

3.3 The focus for evacuation is not limited to the existence of a document. Testing and review activity considers whether staff know where the plan is, whether the plan reflects the service environment, whether local escalation routes are understood, whether temporary shelter or receiving areas are clear, and whether learning from exercises or incidents is recorded and acted upon.

4. Business continuity management

4.1 The Trust Business Continuity Management System is now embedded and continues to mature. Following review and rationalisation of the Trust register, the current number of departments or services requiring Business Impact Analyses and Business Continuity Plans is 147. This provides a defined planning baseline against which review, exercise and audit activity can be measured.

4.2 The EPRR Team undertakes an average of 14 formal BIA/BCP reviews per month. These reviews validate critical activities, dependencies, recovery time objectives, maximum tolerable periods of disruption, escalation arrangements and local response and recovery actions. The programme has moved business continuity from a periodic document refresh into a routine monthly learning cycle.

4.3 The review process has also improved consistency across the Trust. Services are being asked to ensure that plans are practical and usable, that action cards describe what should happen during an incident, and that appendices contain the supporting detail needed in a disruption, including contact routes, fallback processes, job role information, local arrangements and key dependencies.

4.4 Business continuity remains a key area of continued focus because recent incidents have shown that services are highly dependent on estates, digital systems, telephony, workforce availability, clinical records, medicines, suppliers and effective local decision-making. The 2026/27 programme therefore prioritises review of existing plans, testing through Exercise-in-a-Box, targeted audits and learning from real incidents.

5. Exercising and audit

5.1 More than 70 digital Exercise-in-a-Box exercises have been completed across Care Groups and Corporate Services. The model captures attendance, narrative answers and confidence scores, enabling the EPRR Team to identify common themes, target support and provide auditable evidence that teams are testing plans rather than simply holding them.

5.2 Exercise-in-a-Box scenarios have been used to test loss of SystmOne, business continuity response, service fallback arrangements and the ability of teams to describe how they would maintain or recover critical activities. The outputs provide evidence for EPRR monitoring and allow themes to be escalated through governance routes where repeated issues are identified. The table below summarises exercise completion rates to date.

Exercise scenario	Completed returns	Date range captured	Recorded participants
Loss of IT	18	30 Sep 2025 to 27 Apr 2026	129
Loss of Premises	14	23 Jul 2025 to 27 Apr 2026	83
Loss of Staff	23	09 Oct 2025 to 05 May 2026	114
Loss of Suppliers	9	10 Nov 2025 to 11 May 2026	75
Loss of Utilities	10	03 Sep 2025 to 13 Apr 2026	76
CLINICAL: Loss of SystmOne	10	01 Apr 2026 to 18 May 2026	Not reliably recorded

5.3 Site-based audits and direct service reviews provide an additional layer of credibility to the programme. These test whether staff can locate relevant plans, understand local arrangements, identify dependencies and explain practical fallback actions. Audit and review findings are used to update plans, inform service-level actions and shape the wider EPRR work programme.

6. Learning from real incidents

6.1 The 2026 incident programme has provided additional real-world tests of business continuity arrangements, including loss of LAN access affecting SystmOne, loss of telephony, kitchen freezer failure, power outage at Tickhill Road, loss of internet service and heat-related operational pressures. Hot and cold debriefs are used to identify good practice, learning and improvement actions.

6.2 Common themes include fallback awareness, equipment readiness, backup communication routes, telephony dependency, reliance on key digital systems, access to paper or offline arrangements, local decision-making **and the need for services to understand what continuing "on paper" actually means in practice.**

6.3 The value of these real incidents is that they test the Trust's resilience outside an exercise environment. Learning is being used to strengthen the BIA/BCP review process, refine Exercise-in-a-Box scenarios, inform command and loggist training, and improve the practical quality of local plans and action cards.

6.4 Recent experience during high temperatures and Heat-Health Alert period, suggests a maturing resilience as disruption was found to be relatively minimal, with issues identified early, escalated appropriately and managed through existing operational, Estates, Pharmacy, Care Group and EPRR support arrangements.

7. 2026/27 test and assurance process

7.1 The 2026/27 approach is summarised below. This is the Trust test process for demonstrating that arrangements are safe, understood and usable.

Area	2026 test process	Evidence generated	Purpose
Evacuation	Site exercises, out-of-hours learning, themed audits and plan review	Exercise records, audit findings, updated plans and action logs	Confirms plans can be used safely in realistic conditions
Business Continuity	BIA/BCP reviews, Exercise-in-a-Box, site audit and incident debriefs	Reviewed plans, confidence scores, narrative learning and debrief actions	Confirms critical services can continue or recover during disruption

Area	2026 test process	Evidence generated	Purpose
Command and control	Commander training, Learning Half Days, on-call induction and peer support	Attendance records, feedback, CPD and exercise learning	Confirms leaders understand escalation, decision-making and response arrangements
IOR / CBRN HAZMAT	Risk-based site assessment, face-to-face training, e-learning and remote exercises	Training records, competency evidence and YAS engagement / assessment feedback	Confirms proportionate response capability for contaminated self-presenters
Incident learning	Hot debriefs, cold debriefs and action tracking following disruptive incidents	Debrief reports, themes, action logs and governance updates	Confirms the Trust learns from actual disruptions and improves resilience

8. Cyber and digital disruption

8.1 Cyber-related disruption is acknowledged as a significant cause of business continuity risk, particularly where it affects access to clinical systems, telephony, networks or digital records. This paper considers cyber only as a disruptive scenario within business continuity planning. Detailed cyber security governance and Board assurance are managed through separate digital, information governance and cyber risk routes.

8.2 The business continuity programme has nevertheless identified digital dependency as a repeated operational theme. Reviews and exercises therefore have been adapted to ensure continued ask of services how they would access critical information, contact staff and patients, maintain records, use paper or offline processes, and recover data once systems are restored. Future exercises throughout 26/27 will continue this deepened focus.

9. Residual risks and forward plan

9.1 The main residual risks are completion and external assessment of CBRN/HAZMAT arrangements; ensuring all relevant staff maintain competence for evacuation, business continuity and IOR; strengthening backup communication arrangements; and ensuring learning from digital and telephony disruption is embedded across services. The main risk will be the volume of reception staff across the Trust requiring training. If these are not all achieved, further improvement from the 2025 Core Standards compliance of 91% may not be possible.

9.2 The 2026/27 programme will continue evacuation review and audit, BIA/BCP reviews, Exercise-in-a-Box expansion, Loggist and Commander training, IOR training

through Learning Half Days, incident debriefing and improvement tracking through governance routes including RADAR where appropriate.

9.3 Progress will continue to be monitored through the EPRR Group, operational governance routes, regular delivery reviews and scheduled Board reporting. The programme will also maintain a focus on practical matters: plans being understood, tested and improved, rather than simply recorded as present.

Richard Chillery, Chief Operating Officer
21st July 2026

Annex 9

Trust response to the recommendations from The Value Circle (TVC) on the well-led report

No	Well Led Key Question	Recommendation	Trust Response	Intended action
1	Shared direction and culture	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.	There was considerable staff engagement in the 2023/2028 strategy, including with the clinical leadership executive, senior doctors' committee and JLNC – as well as through bespoke events. That narrative has been consistently repeated since, but we know that even among senior leaders it can struggle: including with resistance to the idea of a defined obligations, measurement and work to achieve change.	We will continue to ensure our current and new colleagues are familiar with the Strategy (focus at induction for example) and when we come to refresh the strategy in 2028, we will consider how best to engage colleagues across the organisation, in two parts: - what issues should the strategy address - how best should we address those issues
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.	The voice scorecard, used within the Trust People Council, needs to become the template for this work. But this needs to be enhanced to gather much more regular staff feedback on priorities and actions. The initial effort to do this will use the re-formatted app, but we may need further interventions later in 2026 if this is not working. Softer intelligence needs to come via the Trust People Council, and we may need to create a clearer expectation among members of their contribution to that.	Revamp the voice scorecard by the end of July 2026 and expand its use beyond the TPC. Include staff feedback more clearly in expectations covered within delivery reviews for both corporate and care group teams Start measuring the two priorities for staff engagement agreed with the Board much more regularly through Pulse surveys and other models
3		Trust Board should consider how it evidences follow-through and closes the loop from engagement	The Board is strengthening how it demonstrates follow-through on staff engagement. For example, our Quality Account 2025/26 has adopted a "You Said – We Did" format to openly show staff and stakeholders	A formal review of our staff networks and closing the loop in those networks will take place during Q2 to agree clear priorities and mechanisms for feedback within those networks on this.

No	Well Led Key Question	Recommendation	Trust Response	Intended action
			what changes resulted from their feedback. Trust Matters has focused time on FTSU successes and the positive feedback from those involved in the process.	The commitments given to Trade Unions over 4-week delivery of key processes needs to be tracked at Board level from July. Major initiatives, like the estate plan, are underpinned by the roadshows. Using that as an example, we will demonstrate you said/we did steps associated with the final agreed plan.
4	Capable, compassionate and inclusive leaders	The Trust should consider how insights from leadership engagement are further triangulated with other staff feedback mechanisms, tracked and reported.	This appears to repeat ideas considered in prior recommendations. We will consider how 'listening' moments notably Board walkabouts and peer reviews are best reflected in Board discussions.	Summary of all 25/26 peer reviews to be shared with Board in August timeout with an opportunity to consider how insights collated in these peer reviews are more widely considered.
5	Workforce equality, diversity and inclusion	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.	The report fails to consider the positive steps taken over recent years, and did not spend time exploring that. We need to accept that we have a) an anti-racism programme with 7 specific actions in it b) a broader set of promise 26 initiatives which are not especially advanced c) an intent to become anti-racist which needs greater definition. At the same time our OD/EDI functions are being restructured to achieve better impact and follow through.	The July Board meeting receives a paper on anti-racism, alongside an update on the wider EDI work. That paper explains how we will track impact through the balance of 26/27 – and what work the small central EDI team will actually do.
6	Governance, management and sustainability	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	A broader set of exclusions merit noting. We have not consistently uploaded our Board papers on Friday before issue. We have more work to do to have easy read/AI assisted summaries available.	Agenda for the Board from May has included titles. We will monitor the availability of on time paperwork including to the public (and its accessibility). In Match 2027 we will report

No	Well Led Key Question	Recommendation	Trust Response	Intended action
				delivery to the Board, tracking it through the DOCA delivery review.
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	It remains the case that external expectations of what the Board 'sees' is in direct conflict with work to streamline agendas and focus more time on fewer things. Committee agendas have been reconsidered, and we will review in April 2027 how effectively committees have worked with revised expectations.	Board has agreed workplans for itself and its Committees (May 26); a new commissioning of Board papers process commenced in April 26 to better articulate the 'ask' or the focus of the papers being presented; The Board has for at least the last three meetings taken a small number of items as 'questions only'; the coversheet for Board and Committees and the Outbrief to Board from Committees have been revised; A new approach to assurance will be implemented from July – with specific papers assessed; also from July Committees will commence a new process that seeks them to set out planned achievement of their four key roles and to take stock at each meeting of progress.
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.	The Trust's RADAR system (for risk, assurance and quality monitoring) is now integral to our governance framework. RADAR is used routinely in reporting to committees – for instance, new fields in RADAR allow detailed categorisation of incidents (e.g. flagging any discriminatory element) and are improving Board oversight of key issues. A dedicated RADAR Implementation Group meets monthly to oversee continued module roll-out. Over the past year, RADAR has demonstrably strengthened our capture and	A presentation of May 2025 to May 2026 RADAR analytics will take place for the Board as a whole in August 2026. We can then consider how data and insight from RADAR is more clearly built into our management systems, alongside the IQPR.

No	Well Led Key Question	Recommendation	Trust Response	Intended action
			follow-up of learning (over 8,400 incidents and 1,700 resulting action plans logged). Work continues to ensure that RADAR metrics and alerts are fully embedded in all risk and assurance processes – each care group and corporate directorate is now using RADAR data in their risk reviews, so that nothing is "off-system". *However, review with groups suggests that RADAR familiarity and use of analytics tool remains limited. That use case needs to change*.	
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	As TVC were repeatedly advised, the Board has kept this matter under review – and again did so in May 2026. We agreed to retain the existing five SDRs but the strengthen the employee engagement work within SDR 5. Financial key risks were clearly set out to the Board for 26/27 in March Board papers. FDE continues to focus on those risks. At September's Board we will consider the route to underlying breakeven in March 2027.	In receiving the latest position in respect of the five SDR risks in May, the Board also considered whether there were other risks that may warrant SDR status including the financial risk. The Board concluded there were no others and reaffirmed its commitment to the five current SDRs.
10		The Trust should further strengthen assurance by improving how risk reduction and improvement is sustained.	Trust has strengthened how it sustains risk mitigation and improvement over time, to provide robust assurance that risk reduction is not temporary. However, Board members have suggested that a) the operational risks outside tolerance need a much more defined timelined plan via RMG and CLE for resolution.	Each Strategic Delivery Risk has a defined target risk score and timeframe for reduction, agreed by the Board (e.g. aiming to reduce all SDR scores from 12 to 8 by specific dates in 2026). Progress against these targets is tracked through routine Board and sub-committee reports. Additionally, our Quality & Safety Plan requires that improvement actions (resulting from

No	Well Led Key Question	Recommendation	Trust Response	Intended action
			b) committees in addition to the Board may need to consider whether they are identifying risks and are satisfied that these are captured on the risk register. We have discussed but rejected the idea of creating a 'third' register (in addition to the SDRs/RR) for 'corporate risks'.	incidents, audits or inspections) include *sustainability measures* – for example, assigning an owner to monitor the area for a period after initial improvement. This way, the Board can see evidence that risk controls and service improvements remain effective in the long run, not just at the point of delivery.
11	Learning, improvement, and innovation	The Trust should consider strengthening the connection between learning, action, and impact which would provide clearer assurance that learning is resulting in measurable improvement.	This is a work in progress. The struggle to produce a quality account with clear learning illustrates the journey we still have to go. Learning Matters can help to communicate learning, but we have more work to do in 2026 to identify learning. There are greenshoots. For example, a recent annual Patient Safety & Experience report showed tangible outcomes from learning: we tightened Section 17 leave processes and achieved 100% compliance with timely falls risk assessments after identifying gaps. We also introduced a "So What" log at Quality Committee that maps past lessons learned to evidence of change.	We need to tighten our grip and steps arising from the PSII report 2025/26. We cannot wait until May 2027 to consider another report. In November 2026 we need to devote time, possibly enabled via the timeout in October, to considering whether we have got evidence of having moved sufficiently far forward in the themes identified. The Board in July will consider a first review of the engagement /disengagement data – and this too will need to become a high profile measure of our ability to learn from harms.
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	This remains part of a forward look, alongside other development and skills needs among our managers. Presently it is not the top priority in that work, being behind work to enhance line management skills, and to introduce core delivery skills.	When we consider leadership development next steps in November's Board, we will revisit the timing and form of a 27/28 QI methods intervention, building on existing QSIR skills.

No	Well Led Key Question	Recommendation	Trust Response	Intended action
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.	It is a little unclear what this recommendation directly responds to. We are benchmarking ourselves through the National Oversight Framework in 2026/27. We can demonstrate an outward look in how we approach QI priorities. For instance, after reviewing our latest staff survey results, we initiated a collaboration with Navigo (a high-performing peer trust) to learn from their best practice where their staff experience outperforms ours. We also routinely share and discuss external reports – e.g. each month the governance team circulates summaries of other trusts' CQC reports and national insights. We made a deliberate decision to withdraw from the costly/time consuming NHS Benchmarking club in 2025.	Continue the focus on NOF comparison, with revised IQPR assisting in this process and reference to the national league tables and the 63 other Trusts that are deemed equivalent / in our sector. The Trust will work to identify by September 2026, a subset of five or six organisations to purposefully engage with and with whom we will routinely compare ourselves for key workforce and quality measures. Discuss how these comparisons can be better articulated within Board material.
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	The Quality, Workforce, and Risk impact of major financial or transformation decisions is made highly visible through our governance processes. Specifically, the Quality & Safety Impact Assessment (QSIA) process has been embedded for all significant change programmes and will continue to be so in the future. An example of its use is further to the most recent change management process, the	Sustain the QSIA scrutiny developed for the change process, and as we mobilize other changes during 26/27 consider the applicability of this type of approach.

No	Well Led Key Question	Recommendation	Trust Response	Intended action
			Board now receives a regular QSIA KPI report tracking any early effects on quality, safety, access, workforce, and staff experience from cost improvement or transformation schemes. Early data (Apr–May 2026) show no sustained adverse trends in these domains, which provides reassurance that cost/transformation initiatives are not compromising core quality or workforce standards.	Revamp our EIA process to make it a more meaningful part of our work, with a presumption to EIA analysis for all decision papers considered by the Board.

Annex 10

Rotherham Doncaster and South Humber NHS Foundation Trust

Adverse effects or negative impact from speaking up SOP

DOCUMENT CONTROL:	
Version:	1
Ratified by:	Clinical policy review and approval group.
Date ratified:	
Name of originator/ Author:	James Hatfield
Name of responsible individual:	Steve Forsyth
Unique Reference Number:	
Date issued:	
Review date:	
Target Audience	All RDaSH employees/students/volunteers/ Contractors/ Bank and agency/ Peer workers/Fixed term contract employees.
Description of change	

1. Aim

The aim of this standard operating procedure (SOP) is to provide a clear, supportive, and consistent process for any colleague who believes they are experiencing detriment as a result of speaking up or raising a concern. This procedure ensures that such matters are handled swiftly, confidentially, and effectively. Its primary goals are to:

- Ensure that any perceived adverse effect is addressed through a fair, impartial, and timely investigation to determine the facts.
- Ensure that the organisation learns from these instances to strengthen its culture, making it safer for others to speak up in the future.
- Reinforcing the organisations commitment to our no blame and restorative just and learning culture where colleagues are thanked and supported for raising concerns.
- Confidentiality: Where requested by a worker, confidentiality is protected wherever possible, and information will be kept strictly confidential, only shared on a need-to-know basis. If it is not possible to investigate without the person's identity being known, this should be clearly communicated with the person speaking up.
- The colleague may produce a written statement to expand upon their reasons for believing they have suffered as a result of raising a concern or may choose to present their concerns verbally/ sign language/ through an approved and verified interpreter.

Define detriment as per the national definition

Discrimination at work Under the Public Interest Disclosure Act 1998 (PIDA) it is unlawful to treat a worker who has spoken up detrimentally or dismiss them. Additionally, vicarious liability means an employer can be liable for the actions of their workers if they fail to act on reports of detrimental treatment of those that have spoken up. If a worker faces detrimental treatment from colleagues after making a protected disclosure and the employer fails to address or prevent this behaviour, the employer could be vicariously liable for the harm caused to the worker who has spoken up.

Defining adverse effects from speaking (detriment), disadvantageous or demeaning treatment

This guidance refers to detriment, disadvantageous or demeaning treatment by colleagues, line managers or leaders towards a worker as a result of the act of speaking up, rather than the specifics of the matter raised by speaking up. This can be a deliberate act or a failure to act or omission. Sometimes detriment can be subtle and not always easy to recognise. While these behaviours might not be intentional, the impact can still be significant if a person believes they are being treated poorly or differently.

Such treatment may include (these are examples and not limited to):

- experiencing poor behaviours not in line with the organisational values such as being ostracised, gaslighting, gossiping, incivility (please see appendix 2)
- demonstrable bias in relation to being given unfavourable shifts; repeated denial of overtime/bank shifts; being denied shifts in a certain area/department without good reason; changes to shifts at short notice with no apparent reason
- being repeatedly denied annual leave; failure on a regular basis to approve leave in reasonable time; or leave cancelled without good reason
- micro-managing; excessive unwarranted scrutiny
- sudden and unexplained changes to work responsibilities, or not being given adequate support
- being moved from a team or inexplicable management of change without clear rationale
- being denied access to development opportunities, training or study leave without good reason
- being disadvantaged in the recruitment process whether that be in the application, shortlisting and interview stage of recruitment. Can this be defined more clearly in our NHS context, open recruitment requires application, short listing and interviews. Detriment can occur at any stage, colleagues should be advised as such. I would hope it is not possible to be simply 'overlooked'
- receiving a negative performance appraisal or disciplinary
- being moved to less desirable duties or locations, or being demoted or suspended
- being denied the information or resources to do the job properly
- being criticised for speaking up
- being refused support to manage the stress associated with speaking up
- being bullied, excluded or treated negatively
- being dismissed, a contract not being renewed or being made redundant
- being treated as a troublemaker

NGO guidance on detriment (https://nationalguardian.org.uk/wp-content/uploads/2025/03/Detriment-guidance.pdf)

2. Scope

This SOP applies to all individuals working for the Trust, regardless of the role contract type. This includes but is not limited to:

- Permanent employees
- Fixed term contract employees
- Colleagues on secondment
- NHSP/Bank and agency colleagues
- Volunteers
- Students
- Contractors
- Peer workers

This procedure is initiated when a colleague perceives that they are facing detriment or adverse effects directly linked to having raised a concern. Detriment can take many forms including but not limited to:

- bullying or harassment
- being and ignored, isolated, or excluded by colleagues or managers
- unwarranted disciplinary action
- blocks on promotion or training/ development opportunities
- unfair changes to duties or shifts
- negative impacts on professional/work relationships

This SOP is not a substitute for the formal grievance process, Civility and respect policy or freedom to speak up procedures. Instead, it runs alongside them providing an additional layer of support focused specifically on the link between concern raised and any subsequent negative treatment. The Freedom To Speak Up (FTSU) Guardian will work with the colleague member to determine the most appropriate pathway to follow regarding their concern/issue.

3. Link To Overarching Policy

Freedom to speak up Policy

3.1 Link to other policies

- Civility, respect and resolution policy
- Grievance and dispute policy

4. Procedure

Distinction between detriment and reported negative impact
Detriment is treatment by an employer that is demeaning or detrimental. It can include:

- denying training or development opportunities
- giving someone harder or more mundane work
- making demeaning or humiliating comments
- micro-managing/excessive scrutiny
- highlighting insignificant issues about conduct
- not taking grievances and disciplinary issues seriously or not dealing with them properly
- withholding a reference

To avoid confusion, the Trust will use the term negative impact as it would be within the power of an employment tribunal to determine detriment

Legally, the burden will be on the employer to prove that the reason for any potentially detrimental treatment was not because of the disclosure but due to another acceptable reason. If the employer is unable to provide a suitable

reason for the treatment, an employment tribunal is entitled to infer that the detriment was on the grounds that the worker made a protected disclosure.

This legal position shall be the basis for dealing with reported negative impact from the perspective of this SOP.

Who can claim Reported Negative Impact

Anyone who has spoken up, raised an issue and reports a negative impact as a result can raise this. It does not have to be through the Freedom To Speak Up (FTSU) Guardian route. Colleagues speak up in many ways and may suffer detriment. It's important that the Trust investigates these claims robustly.

There are clear processes and roles involved in working in this area.

The FTSU Guardian, must report any negative impact to the Board and the National Guardian's Office. However, the FTSU Guardian cannot lead or be involved in what follows in terms of process. The FTSU Guardian can and must ensure the colleague is supported to raise the impact issue.

For the colleague who raises a concern about negative impact, the Trust should ensure that they are heard, and pastoral support is offered to the colleague as this process could increase stress and anxiety. The **Healthy workplaces staff support and stress at work policy contents** can be referred to**.** This can be helped by the allocated 'keeping in touch' person or by the FTSU Guardian however this is led by how the individual feels and is most comfortable with.

The ambition is to have initial feedback within 20 working days and a plan of timescales to be shared with the individual around what action will be taking place.

For the organisation, there is a need to ensure an independent (from the service) investigation takes place. This where relevant should involve Human Resources and relevant bodies (e.g. staff networks around race, women's network, disability, gender, unions etc) and an independent case manager assigned to manage the independent investigation.

The Non-Executive Director (NED) for FTSU should be informed of the reported negative impact and be kept updated by the independent case manager for oversight of this work. The NED should seek assurance on the findings and report to the Board.

It is important to note that the individual who has raised concerns and claims to have suffered negative impact will not be actively involved in the investigation process but will be met with as part of the investigation. The assigned independent case manager needs to have the skills and level of experience to manage this sensitively and ensure that the investigation remains robust.

Protect Risk assessment

When a colleague raises a concern and indicates they may have experienced a negative impact as a result of speaking up, the Freedom to Speak Up (FTSU) Guardian must take proactive steps to assess and mitigate this risk. This includes completing the **PROTECT Detriment Risk Assessment**, (see appendix 3 which is designed to identify potential harm and ensure appropriate safeguards are in place.

Role of the Freedom to Speak Up (FTSU) Guardian in Detriment Concerns

1. **Escalation Responsibility**
   The FTSU Guardian is **not responsible for implementing changes** following a detriment concern. Their role is to **escalate the concern** to an appropriate senior leader representative for further **investigation and exploration**.
2. **Ownership of Actions**
   Any actions, adjustments, or protective measures required to safeguard the individual who raised the concern must be implemented by the **relevant service or department**.
3. **Impartiality and Support**
   To maintain impartiality, the FTSU Guardian must **not participate in the investigation or decision-making process**. Their role is limited to **providing support and guidance to the individual raising the concern** throughout the process.
4. **Escalate to the FTSU NED.**

Actions

The report authored by the assigned independent case manager will determine the likelihood that negative impact has taken place. The outcomes will be reported to Board separately by the NED.

In addition, there should be:

- **Acknowledgment** - there needs to a clear acknowledgment of what has happened and this must be formally communicated in the colleague preferred and identified form of communication both verbal and written. Taking into consideration https://www.rdash.nhs.uk/policies/healthy-workplaces-staff-support-and-stress-at-work-policy/
- **Apology** - there needs to be a formal apology to the colleague if negative impact is determined and upheld
- **Repairment** – to help ensure that the future of the colleague is a more positive experience than what they have experienced. A programme of development, support and mentoring etc may be relevant. Where this process has been supported through the FTSU Guardian they will follow up with the colleague affected through a feedback questionnaire at 3,6 and 12, month post reported adverse effect from speaking up. The format of this questionnaire is in anonymous email format requiring the colleague to pass on their contact details for support from the FTSU Guardian.

Appeal

If the employee remains dissatisfied following receipt of the letter confirming the outcome of the investigation, they have the right to appeal to the assigned independent case manager. However, no new matters will be raised at the Appeal Stage.

Appeals must be received by the assigned independent case manager within 10 working days of date on the letter confirming the written outcome of the investigation by the colleague.

The appeal must be heard by another manager who has not previously been involved in the appeal.

An appeal will normally be convened within 30 working days of receipt of the intention to appeal.

The independent case manager hearing the appeal will be supported by two advisers, one of whom will be from Human Resources,(HR person supporting the hearing manager would need to be a different person to the one that supported the initial investigation) and the other will be an accredited trade union representative nominated by Staff Side Council. In addition, the manager hearing the appeal may invite a relevant specialist/professional manager to attend in an advisory role. Whilst advice may be taken, the final decision rests solely with the manager hearing the appeal.

Also present at the appeal will be the employee, the employee's representative (as appropriate) and the independent case manager who had carried out the initial investigation.

The employee may produce a written statement to expand upon their reasons for appeal or may choose to present their concerns verbally/ sign language/ through an approved and verified interpreter/communication support (lip speaker, speech-to-text) written information advanced/advocate support person/flexible scheduling/additional breaks/remote or hybrid attendance/adjusted questioning style/private or quiet environment/trauma informed approach/notetaking support/recording the hearing/extended time to respond/adjustment for neuro diversity/adjustment for mental health/physical accessibility/cultural or religious considerations/alternative formats for evidence/prehearing briefing/named point of contact/stage to attendance/post hearing support.

Any documents to be presented at the appeal should be submitted 10 working days prior to the appeal.

Following completion of the appeal, the manager hearing the appeal may either: verbally communicate the decision on the day or communicate the decision in writing later. In either case, the manager hearing the appeal will formally write to both parties within 10 working days to confirm the following:

- any findings of fact
- their decision
- the rationale for the decision

There is no further right of appeal beyond this stage within the Trust.

In line with National Guardian's Office guidance, the independent case manager will report the outcome of the appeal to Board, and or through the non-Executive Director lead for Speaking Up.

Anonymous follow-up process by FTSU Guardian

Overview

This is to ensure that individuals who have spoken up feel safe, supported, and protected from Adverse effects, the FTSU Guardian will conduct anonymous follow-ups via email at 3, 6, and 12 months after the concern is raised. These emails will provide the opportunity for colleague to report any adverse effects they may have experienced without the pressure of a face-to-face meeting. If colleagues wish to discuss concerns further, they will be given the option to share their contact details so the FTSU Guardian can provide direct support and escalate the issue to senior leadership. This process is also followed when FTSU concerns are closed down in order to offer further support to colleagues who have gone through raising a FTSU concern.

Purpose

- Create a safe way for colleagues to report adverse effects without fear
- Monitor for long-term impacts of speaking up, including subtle career or workplace disadvantages
- Ensure senior leadership remain accountable for protecting colleagues on their treatment
- Provide an opportunity for those initially reluctant to report adverse effects to come forward at a later stage

5. Appendices

Appendix 1

What to do flow chart

Developed from; A Best Practice Guide developed by representatives in the Freedom to Speak Up Midlands Regional Network. Recording Cases and Reporting Data National Guardians Office) (2024), NHSE guidance (2022)

Route 1 .
I /my colleague spoke up and now I believe *I am/my colleague is* experiencing disadvantageous or demeaning treatment as a result.

Speak to a manager or the Freedom to Speak Up Guardian as soon as possible

(or see FTSU policy for other options of who to speak to)

- Your concern will be taken seriously
- You will be supported whilst your concern is reviewed
- You will be kept informed and provided with feedback
- You will be signposted to wellbeing support if needed
- The matter will be looked into by their manager or someone more independent, or through your formal grievance procedure

Route 2

A colleague reports (or thinks they are seeing) disadvantageous or demeaning treatment after speaking up to a manager or the Freedom to Speak Up (FTSU) Guardian

Manager to inform FTSU Guardian

Issue reported to FTSU Guardian

- Clarify matters of confidentiality, what information will be shared and with whom
- FTSU Guardian will undertake a (Protect) risk assessment
- FTSU Guardian will record on the central FTSU database

Within 72 hours
or immediately if significant risks identified

FTSUG to inform

Non-executive lead
Chief executive officer Executive lead for speaking up

- Consider if any immediate action is required to protect the worker from disadvantageous or demeaning treatment. *(particularly important in the case of perceived bullying and/or harassment)*
- Consider any potential patient safety issues and immediate action required
- Receive assurance line management arrangements are in place to support anyone who might be affected
- Responsible executive to co-ordinate discussion involving FTSU Guardian and appropriate colleagues, for example. Operational colleagues, HR, Patient Safety, Safeguarding, Staff Side

Follow your organisations speak up process

In line with Speak Up Process:

- Clarify matters of confidentiality
- Agree how and what to be explored (terms of reference), and timescales for completion
- Identify independent lead for any review/investigation
- Agree arrangements for monitoring and feedback
- Share and record key actions, outcomes, learning and recommendations.
- Share wider learning across the organisation
- consider signposting the worker to NHS England's Speaking Up Support Scheme

Developed from; A Best Practice Guide developed by representatives in the Freedom to Speak Up Midlands

If the investigation reveals any unresolved issues relating to individual performance or conduct, consult with Human Resources colleagues according to local policies/process.

Regional Network
(May 2022), Recording Cases and Reporting Data (nationalguardian.org.uk)
(2022), NHSE guidance (2022
Include the Speaking up Support scheme which can be accessed once the internal processes are completed.

Appendix 2

Glossary of Poor Behaviours

Poor Behaviour	Plain-Language Meaning	What it Might Look Like
Ostracising	Deliberately leaving someone out or making them feel unwelcome	Not inviting someone to meetings, conversations or team interactions that affect their work
Gaslighting	Making someone doubt their own experience or understanding	Denying things were said, twisting events, or suggesting someone is overreacting when they raise concerns
Gossiping	Talking about someone in a harmful or inappropriate way behind their back	Spreading rumours, sharing private information, encouraging others to take sides
Incivility	Low-level rude or disrespectful behaviour	Eye-rolling, dismissive tone, interrupting, ignoring colleagues, abrupt communication
Bullying	Repeated behaviour intended to intimidate, control or undermine	Shouting, belittling, setting unrealistic expectations, public criticism
Exclusion	Unfairly leaving someone out of information or decisions	Not sharing key updates, excluding from meetings, withholding information needed to do the role
Micromanaging	Excessively controlling how someone completes their work	Constant checking, limiting autonomy, not allowing professional judgement
Excessive Scrutiny	Singling someone out for disproportionate monitoring or criticism	Over-checking work, focusing on minor issues, treating one person differently to others
Retaliation	Treating someone unfairly because they have spoken up	Changing shifts unfairly, blocking leave, negative appraisals after raising concerns
Undermining	Weakening someone's confidence, authority or credibility	Dismissing ideas, contradicting unnecessarily, criticising in front of others
Blocking Development	Preventing fair access to opportunities for growth	Refusing training, study leave or progression opportunities without clear reason
Unreasonable Work Allocation	Assigning work in an unfair or punitive way	Allocating undesirable tasks, sudden role changes, unrealistic workloads
Isolation	Leaving someone unsupported or disconnected from the team	Lack of communication, not offering help, excluding from informal support networks

Victimisation	Treating someone badly because they raised or supported a concern	Labelling as a troublemaker, excluding from opportunities, targeting after speaking up

Appendix 3

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

Adverse effects or negative impact from speaking up risk assessment

Partnering with the National Guardian's Office

Protect is a leading expert in fostering ethical workplaces and protecting whistleblowers. We've partnered with the National Guardian's Office to provide our whistleblower risk assessment tool to you.

This collaboration strengthens the ability of healthcare professionals to speak up about concerns, ultimately benefiting patient safety and the entire healthcare system.

<u>This Whistleblowing Risk Assessment</u>

This risk assessment is designed to help your organisation identify and mitigate potential areas of vulnerability regarding whistleblower disclosures. By completing this assessment, you will gain valuable insights into the effectiveness of your current whistleblowing processes and identify areas for improvement.

Website:
www.protect-advice.org.uk
Email:
info@protect-advice.org.uk
LinkedIn: Protect-Advice
X:
@WhistleUK
Person completing assignment: Date:
Person completing risk assessment:

Past history of whistleblower:

E.g. previous issues the whistleblower has had in their department or with the subject of the report, previous history of whistleblowing, experiences of previous whistleblowers in the department.

Nature of wrongdoing:

E.g. seriousness of concerns, nature of any allegations against individuals, seniority of alleged wrongdoers, who will be impacted by investigations into concerns, reports to external bodies, difficulty of verifying concerns (e.g. due to lack of evidence).

Vulnerability of whistleblower:
E.g. worker status & length of contract, seniority of whistleblower, relationships with colleagues, support systems in and outside work.

Reporter anonymous at time of assessment ○ Yes ○ No

Risks relating to origin of whistleblower's concerns:

E.g. proximity to alleged wrongdoing (e.g. participant, victim), relationship with the subject of the report, number of people aware of alleged wrongdoing, professional obligations to report

Previous raising of issue:

E.g. who has the whistleblower spoken to about the issue, either formally or informally.

Is the whistleblower anxious about the detriment?: ○ Yes ○ No

Issues identified by the whistleblower:

E.g. particular kinds of victimisation they are concerned about, threats made against the whistleblower, other repercussions whistleblowing might have for them.

Proposal from whistleblower:

E.g. any suggestions or requests from the whistleblower around protecting them from victimization.

Early warning indicators:

Likelihood of reporter's identity being compromised:

Action taken to mitigate detriment:

Detriment status at point of reporting:

Current detriment status:

Person completing reassessment:
Date:

Reassessment trigger and changes made:

Current detriment status:

Updated action taken to mitigate detriment:

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 24: Education	**Agenda Item**	Paper Q
Sponsoring Executive	Dr Judith Graham, Director for Psychological Professionals & Therapies		
Report Author	Dr Judith Graham, Director for Psychological Professionals & Therapies		
Meeting	Board of Directors	**Date**	30 July 2026

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

The purpose of this paper is to share the results from our recent external review and also for consideration and discussion, concerning our work on Promise 24 (which is to expand and improve undergraduate/postgraduate education, supporting existing and new roles and delivery of the NHS Long Term Workforce Plan).

Key issues for consideration:-

- What is the Boards reflections concerning the external review, and internal work pertaining to the education training plan. Focussing on whether it will deliver Promise 24 equitably across the whole workforce, rather than reinforcing existing professional funding patterns?

- Education equity means parity of visibility and access, not identical provision. How would the Board wish to be sighted on which staff groups are benefiting from spend, which are not, and how the gap will be closed during 2026/27.

- Given the RDaSH performance assessment framework, does the Board agree that Promise 24 is appropriately placed in the “Ready to Deliver” quadrant, with residual Amber-Green actions focused on spend transparency, equity of access and benefits realisation?

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

Education and Learning Meeting and Executive Group have had draft report

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

CONSIDER the key recommendations and request a 2026/27 training spend dashboard linked to Promise 24 success measures.

NOTE the outcomes of the external review and NETs

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	X
Finance plan	X
Quality and safety plan	X
Equity and inclusion plan	X
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: NHS England WT&E Senior Leader Engagement review (DRAFT Version) Annex 2 - National Education Training Survey (NETS) Data

Promise 24 – Education Quality and Multi-professional Learning

1. Introduction

The NHS England WT&E Senior Leader Engagement review (Draft Report included at Annex 1; final report awaited) was completed in March 2026, taking evidence from a range of different sources, professionals and disciplines. The review recognises RDaSH as performing strongly as a learning organisation, with learner data used to inform improvement, education embedded into quality processes and educator/ supervision requirements more visible in job planning. This report has relevance to both our ratings in the CQC well-led domain, as well as contributing to our strategic promises.

2. Analysis

Within the Education and Learning Group Promise 24 is treated as a strategic workforce and quality programme rather than as a training compliance objective. By this we mean that structures and processes have now been built by the group which enable a forward planning education and learning cycle, that focusses upon parity of investment for staff, explores and combines education spend, focusses upon placements, CPD, apprenticeships, research and protected learning time support recruitment, retention, safety, inclusion and new roles.

It is hoped that the Board take positive assurance from both the work of the E&L Group and also the external assessment but strengthen grip on professions and staff groups at risk of being less visible: AHPs, nurses, psychological professionals, peer support workers, pharmacists, social workers, healthcare support workers and other non-professionally registered staff.

The training spend implication for 2026/27 is that the Trust should move from activity-based spend to strategic investment: a single view of funds, sources, actual use, under/overspend, staff group distribution, protected learning/SPA investment and impact. This is needed because the SLE Review notes greater transparency around education funding would be beneficial, and the Education & Learning Plan states success includes spending the education budget in a way that supports multi-professional learning and under-represented colleagues.

A last consideration under this section concerns how we gain feedback in terms of the quality of the educators providing the training. The current position is:-

- Internally RDaSH delivered MAST training – anecdotal feedback and for some courses, questionnaire feedback is gained for face-to-face delivery. The intention is that we will review this approach and make sure it is consistent and robust, but we can only do this when the NHSE MAST provision that has been announced has been finalised in terms of dates as this is likely to adjust our internal training delivery.
- RDaSH commissioned delivery – we tend to ask for feedback from attendees or write it into the commissioning specifications from trainers. This feedback explores learner experience and training quality.
- NHSE commissioned training – In terms of the NHSE commissioning through higher education institution, each course has learner feedback embedded.
- Where educators are mentors/ supervisors for placement - we gain feedback through our placement learning team and from universities and through the NHSE SLE Engagement review.

3. Key recommendations

No.	Recommendation	Timescale
1	Agree a Promise 24 education and training spend dashboard showing planned and actual spend by source, professional group, staff group, protected characteristic where available, learner experience and workforce outcome.	Q3 2026/27
2	Progress a part of the bimonthly Education meeting into a multi-professional education investment panel to review high-value training requests, tariff use, CPD, apprenticeship priorities and return on investment.	Q3 2026/27
3	Adopt a principle of proportionate universalism spend for staff groups traditionally less visible in professional funding models, including peer support, HCSWs and non-registered staff. (Proportionate universalism means the resourcing and delivering of training at a scale and intensity proportionate to the degree of need).	Q3 2026/27
4	Set a Trust principle that registered staff need job-planned SPA where appropriate, and non-registered staff need equivalent protected learning/development time.	Q3 2026/27
5	Bring an annexed NETS/PARE/placement quality report to Board showing RDaSH results by profession, placement area and geography against national NETS themes.	Q3 2026/27
6	Collate the feedback in terms of the quality of education and educator across all of the different training provided and ensure consistency in learning and feedback.	Q4 2026/27

4. Our Promises

An update on each of our promises is provided every 2 months in the CEO paper to Board. There are two promises that are associated specifically for education Promise 24 regarding all education and Promise 9 about our apprenticeship offer – the apprenticeship information is detailed in a separate paper.

Regarding Promise 24 there are 4 measures of success, and we are progressing well with each one. This is a summary of the measures and progress –

- Student feedback to reach upper quintile when compared to peers – we have a strong baseline position and have maintained this through the work to date. This is not only assessed internally but also through feedback such as the NHSE SLE assessment attached. This helps us show a good position, but we are always looking for ways to improve, hence as identified in the table on page 5 an action to improve the triangulation of feedback in the coming year.

- Trust workforce plan for 2028 on track to be delivered – The workforce plan covers a number of areas not just training, however the training part is being delivered well, we have maximised our Apprenticeship spend, we have progressed a successful LDO for internal staff and place partners, our progress with a forward planning training cycle is in place, and our LHD are utilised by the majority of staff in the trust. Our outstanding area for focus is to improve engagement in LHD in our inpatient and 24-hour services. We are also expanding our approach to learning in terms of triangulation and across different domains.

- Trust meets expectations applied through national Long Term Workforce Plan roll out – we have a good understanding of the workforce plan and the training elements in relation to this. We have positive relationships with educational partners and education and training is in focus in our PDR and job planning processes. We take up training places offered in terms of regional and national allocation, where sustainable funding is supplied which adheres to our Trust values and have declined some positions where training is offered that does not support our work on equity, inclusion or training delivery. Examples can be provided if required.

- NHS England assessment outcomes remain outstanding in all disciplines – We have received consistent feedback in terms of all disciplines, and this is demonstrated in the information contained in the report. In addition, we look beyond the traditionally recognised disciplines and are investing in training opportunities that benefit people working in administrative roles, peer support roles, back bone services, who all contribute to our clinical care delivery.

The resource being devoted to educational support, commissioning and training has been maintained despite of the cost pressures and cost improvement programmes, this has been extremely important for our staff, our services, and to enable achievement of both our people plan and education and learning plan.

5. RDaSH performance assessment position

Applying the RDaSH Deliverology-style performance assessment, Promise 24 is currently assessed as being in the upper-right “Ready to Deliver” quadrant. This reflects strong evidence of delivery planning and a high likelihood of delivery, supported by external assurance, established governance and executive leadership. The programme should remain Amber-Green moving towards Green until the Board has routine evidence of equitable training spend, benefits realisation and workforce impact across professional and staff groups.

6. What the SLE assessment says and why it matters

The SLE assessment records a successful bid for increased education investment, additional leadership roles and Promise 24 as the vehicle for expanding undergraduate and postgraduate education across all disciplines, apprenticeships, research, CPD and post-professional learning.

The review identifies good progress in educator job planning, review of partner placement expectations, regional place-based learning, a research hub, expanded peer support, and a broad multi-professional workforce that includes nursing, AHPs, psychological professionals, pharmacists, social workers, peer support and healthcare support workers.

The key improvement themes are also clear: learner concerns may be under-reported; the flow of education feedback to Board can be perceived by some as a lengthy; and transparency around education funding requires some improvement, specifically requested by medical colleagues. These are precisely the areas the Learning and Education Group will convert into measurable Promise 24 controls for 2026/27.

7. National NETS comparison and RDaSH interpretation

Theme	National 2024	National 2025	RDaSH implication
Overall experience	87% positive; induction 86%; supervision 89%.	88% positive; induction 87%; supervision 90%.	RDaSH has positive SLE feedback, but Board should see full local NETS benchmark data.
Learning opportunities	86% sufficient learning opportunities; 88% access to multi-disciplinary learning.	88% sufficient opportunities; learner forums 79%; education valued by 89%.	Multi-professional learning should be reported by profession, staff group & place.
Workload/ retention	59% reported workload negatively affected learning; 30% considered leaving.	58% workload impact; 26% considered leaving.	Protected learning/SPA time is a retention and safety control, not a discretionary benefit.
Raising concerns	95% knew how to raise concerns; 81% comfortable; 76% knew FTSU support.	95% knew how to raise concerns; 84% comfortable; 78% knew FTSU support.	Under-reporting risk should be triangulated through NETS, PARE, FTSU, GOSWH and local listening.

* The National Education Training Survey (NETS) is the only national survey open to all undergraduate and postgraduate students and trainees undertaking a practice placement, training post or work-based learning in healthcare as part of their education and training programme.

** The attached SLE report references 2024 and 2025 NETS and describes RDaSH feedback as overall positive but does not include a full RDaSH NETS numerical comparison table. A quantitative annex (2) is therefore provided to support evidence for Board.

8. Training spend implications for 2026/27

Spend implication	Board interpretation	Required control
RDaSH Education investment increased by 12% in the current year	The Board can take positive assurance that education has been prioritised despite system savings pressure.	Show whether additional investment reaches all professions/staff groups and supports Promise 24 outcomes. This is overseen by the Education and Learning Group – feeding into CLE and then the annual Education focussed BoD.
Some funding remains professionally ringfenced	Ringfencing protects regulatory requirements but can reinforce inequity if not balanced by fair access routes.	Report spend by source and profession; create a multi-professional route for non-ringfenced investment decisions.
Placement funding, CPD and other education components are broader funding streams	A single finance view is needed; separate budget lines can obscure the full cost and benefit of education.	Produce monthly dashboard: planned/actual spend, forecast utilisation, under/overspend and workforce impact.
2026/27 TNA includes AI, data interrogation and using data for decisions	The coming year needs digital/data capability as a cross-cutting workforce priority, not only a specialist offer.	Septembers Education and Learning Group is ringfenced to focus upon - Agreeing priority cohorts and ensure access for clinical, operational and backbone services.
Education Plan success includes spending all budget and privileging under-represented colleagues	Full utilisation alone is insufficient; the Board needs assurance on equity and return on investment.	Link spend to learner experience, retention, recruitment, placement growth and staff survey learning opportunity metrics.

9. Professions and groups at risk of being undervalued

The SLE is multi-professional, but national education assurance remains strongest where formal tariffs, regulatory requirements and national survey infrastructures are most mature. It is therefore suggested that the Board should therefore not use medical education strength as a proxy for whole-workforce education assurance.

AHPs are central to recovery, independence, communication, swallowing, physical health, sensory integration and creative therapies. The SLE notes limited local provision for some specialist training, meaning some development is accessed through providers outside the local system. This should be treated as a pipeline and equity risk.

Nurses and healthcare support workers are the largest workforce group. The SLE recognises better support for student nurses, professional nurse advocates and nurse consultant job planning. Promise 24 should show progression, apprenticeship routes and protected development for both registered nurses and HCSWs.

Psychological professionals contribute formulation, supervision, personalised care, outcomes and research across approximately 20 professional groups. Their pipelines, post-qualification development and supervision contribution should be visible alongside medical and nursing arrangements.

The number of peer support workers have expanded substantially in RDaSH, with the SLE noting that the peer support workforce has quadrupled and moved into physical health settings. Promise 24 will now expand to include induction, reflective supervision, CPD and career routes for peer support roles, not assuming that professional registration is the only route to education priority.

This inclusive priority is something that we will locally drive as there is no educational workstream that focusses in this area in the way national workstreams focus upon medical or nurse education. And it joins the work from Promise 24 to Promise 1.

Pharmacists and social workers contribute medicines safety, rights-based care, safeguarding, legal literacy, Mental Health Act training, discharge planning and community integration. Their education needs should be reported in the same Promise 24 dashboard as other groups.

10. SPAs and protected learning time

One of the largest pieces of work the Education and Learn Group has completed is the introduction of Learning Half Day (LHD) sessions in the Trust. This is protected learning time for all in clinical and backbone services and is not just ringfenced around professional groups, which SPA guidance and training monies are often focussed. The LHD has progressed well for the majority of staff, the only staff group there is problems in terms of full mobilisation for is our ward staff, which is the focus also for the coming year in the Education and Learn Group.

For registered staff, LHD sessions provide some of the SPA time which is job-planned. Due to professional requirements this time can be used for supervision, CPD, revalidation, educator/mentor updates, research, governance, QI and professional

standards. The SLE recognises progress in trainer job planning and work on tariffs for supervision across medical and non-medical professions.

For non-professionally registered staff, the LHD is also protected development time in which they can access supervision, a range of different learning opportunities and also networking through activities such as the staff diversity networks. The parity we have created at RDaSH for protected learning time for professionally registered and non-registered (i.e. domestic staff, IT staff, HR colleagues, HCA) staff means that Promise 24 activity opposes the exclusion that is reinforced by national training hierarchies. The ration for this is both linked with our progressive approach to inclusion and the fact we feel if we do not do this we will undermine retention in roles that are essential to patient experience and operational flow.

11. Success measures for Promise 24

Domain	2026/27 success measure	Board evidence
Spend transparency	All education and training spend visible in a single dashboard, including source, planned/actual use and forecast utilisation.	Finance and education dashboard reviewed through People/OD governance & Board.
Equity of access	Evidence that under-represented and non-registered groups access development opportunities, apprenticeships and protected learning time.	Spend and uptake analysed by profession/staff group and equality lens where available.
Quality of education	NETS/PARE/local feedback demonstrates safe supervision, learning opportunities and action plans for outliers.	Quarterly learner experience report and exception escalation.
Workforce impact	Education investment linked to recruitment, retention, internal progression, placement growth and service transformation.	Promise 24 dashboard linked to workforce plan and strategic risks.
SPA/protected time	Registered staff have SPA/job-planned education time where appropriate; non-registered groups have protected development time.	Annual job-plan/protected learning audit and service recovery plan for gaps.

12. Key risks and mitigations

Risk	Impact	Mitigation
Spend is fully utilised but not strategically deployed	Board cannot evidence return on investment or equity of access.	Prioritise funding decisions through a multi-professional panel and dashboard.
Ringfenced funding reinforces visibility gaps	Smaller/unregistered groups remain underdeveloped despite Promise 24 intent.	Create fair access reserve and monitor spend distribution.
Learning time is not protected in inpatient services	Training is cancelled by operational pressure and learner support weakens.	SPA/protected development time principle approved and audited.
RDaSH NETS benchmark not visible	Positive assurance cannot be quantified against national data.	Add NETS/PARE quantitative annex with action plan for variance.
Digital/data skills underdeveloped	TNA priorities for AI and data do not translate into practice.	Define priority cohorts and learning outcomes for 2026/27.

13. RDaSH performance assessment – Deliverology position

Overall position: Ready to Deliver (Amber-Green moving towards Green).

The evidence within this paper indicates that Promise 24 has a clear strategic purpose, established governance, visible leadership and positive external validation. The work should therefore be considered in the upper-right quadrant of the RDaSH four-box performance grid (presented on the next page). The rating is not yet fully Green because the Board requires routine, quantified assurance on the distribution of training spend, educational equity, protected learning time and benefits realisation for under-represented professional and staff groups.

Figure 1: RDaSH four-box performance assessment grid – Promise 24 is assessed as "Ready to Deliver".

Assessment component	Current rating	Interpretation
Quality of delivery planning	Amber-Green	The problem, proposed solution and 2026/27 recommendations are clear; further detail is needed on milestones, dependencies and quantified impact.
Likelihood of delivery	Green	Leadership, governance, stakeholder engagement and implementation capability are sufficiently established to support delivery.
Four-box grid position	Ready to Deliver	The work has moved beyond early planning and should now be managed through delivery grip, routine data and benefits realisation.

14. Quality of delivery planning assessment

Delivery criterion	Rating	Rationale	Next steps for sustained change
Understanding of the problem	Green	The paper clearly describes the need to move from training compliance to strategic, equitable education investment aligned to Promise 24.	Maintain Board focus on profession, staff group and place-level variation rather than relying on aggregate assurance.
Understanding of the proposed solution and impact	Amber-Green	The dashboard, investment panel, fair access principles and protected learning time proposals are well described, but outputs, outcomes and impact measures require further definition.	Define a benefits realisation framework linking education investment to recruitment, retention, learner experience, placement growth, safety and service transformation.
Understanding of how and when delivery will occur	Amber-Green	The recommendations include clear quarter-based timescales for 2026/27; however, detailed milestones, dependencies and implementation risks should be strengthened.	Develop a milestone plan for Q2–Q4 2026/27, including dependencies with finance, workforce planning, OD, digital, professions and operational services.
Understanding of sustainability requirements	Amber-Green	Sustainability is recognised through SPA/protected time, dashboard reporting and governance, but the recurrent resource requirements and assurance cycle need to be made explicit.	Agree recurrent ownership, reporting frequency, data definitions and escalation routes for gaps in protected learning time or equity of access.

15. Likelihood of delivery assessment

Delivery criterion	Rating	Rationale	Next steps for sustained change
Skills for implementation	Green	The Education and Learning Group has established the work as a strategic workforce and quality programme, supported by positive external SLE assurance.	Ensure dedicated analytical and finance support for the dashboard and benefits realisation work.
Accountability through effective governance	Green	Governance routes through the Education and Learning Group, Clinical Leadership Executive and Board are identified in the paper.	Use a standard dashboard report and exception escalation route so governance provides delivery grip, not only oversight.
Leadership	Green	Executive sponsorship and senior professional leadership are visible, with Promise 24 positioned as a Trust-wide strategic commitment.	Maintain senior leadership visibility and require profession-specific ownership of improvement actions.

Stakeholder engagement and buy-in	Amber-Green	The SLE review and paper evidence multi-professional engagement, but the paper recognises that some groups may remain less visible in conventional funding models.	Co-produce the dashboard and fair access approach with AHPs, nurses, psychological professionals, peer support workers, pharmacists, social workers, HCSWs and non-registered staff.

16. Conclusion

The SLE assessment gives strong positive feedback, but the coming year should shift the Education and Learning Group focus from whether education activity is happening to whether education investment is equitable, transparent and demonstrably improving workforce supply, retention, learner experience, patient safety and service transformation.

The Board is asked to agree the five key recommendations, require the 2026/27 training spend dashboard, and endorse SPA/protected learning time as a core enabler of Promise 24 for both registered professionals and non-professionally registered staff. In addition, the Board is asked to note that the programme is assessed as “Ready to Deliver” within the RDaSH performance assessment framework and to use the recommended dashboard and benefits realisation measures to move the programme from Amber-Green to a sustained Green position during 2026/27.

ANNEX 1

Classification: Official

Education quality review

Senior Leader Engagement Meeting: Rotherham Doncaster and South Humber NHS Foundation Trust

Yorkshire and the Humber
Date of Review/Intervention: 24 March 2026
Date of Final Report: XXXX

Executive Summary

NHS England Workforce Training and Education, Yorkshire and the Humber (NHS England WT&E YH) would like to thank the education and senior leadership representatives from the Rotherham Doncaster & South Humber NHS Foundation Trust for attending this Senior Leader Engagement (SLE) meeting.

The trust was recognised as performing strongly as a learning organisation, with learner data actively used to inform improvement. Progress has been made since the last review, particularly in embedding education into quality processes and more effectively reflected in job planning. There is a clear ambition to become an anti-racist organisation, although racism remains a recognised challenge. Substantial work is ongoing to support all learners and to encourage speaking up. Trainee data indicates significant reporting levels but also potential underreporting. While the trust has a strong focus on empowering staff, learner representation and reporting mechanisms require ongoing scrutiny to ensure concerns are fully captured and addressed.

Professional leadership arrangements were discussed, noting clear structures across medical and non-medical groups. Some differing perspectives between professions were identified, and further work is planned to strengthen cohesion. Progress has been made in improving multiprofessional integration, oversight, and alignment of education and training within trust strategies, though variation across areas remains.

Mechanisms exist to escalate education related feedback to the People and Teams Clinical Leadership Executive, the People and Organisational Development Committee (sub board level) and Trust Board. However, the flow of information was noted to be lengthy in some instances. It was emphasised that positive feedback should be shared with the Boards, as well as maintaining focus on what genuinely improves quality.

There was recognition that greater transparency around the use of education funding would be beneficial, though this reflects a wider national challenge. The trust noted that investment in education and learning exceeds hypothesised income and plans to articulate this more clearly.

Significant progress has been made in job planning for trainers, with clearer identification of supervision requirements, and increased focus on educator development. Audits show improving recognition of educator experience, including lived experience, and work continues on tariffs for supervision time across medical and non-medical professions. An annual education-focused board meeting is held each July.

Support for learners continues to expand across professions with strengthened support for student nurses and professional nurse advocates, increased job planning for nurse consultants, and expansion of social work education. The shift from hospital to community settings was noted as aligning well with current strategic direction.

Feedback was overall positive, with recognition of increasing cohesion linking education across all professions including medicine, and the trust's position as a national leader in this area. A planned follow-up session will take place in the future to reflect on progress.

Review Overview

Background to the review

Senior Leader Engagement (SLE) meetings aim to strengthen working relationships with senior leaders, and to develop an understanding around the commitment to the education and training quality agenda.

Evidence

- 2026 SLE Quality Intelligence Summary
- 2026 Practice Assessment Record & Evaluation (PARE) reports and comments
- 2026 Guardian of Safe Working Hours report (Oct 2025-Jan 2026)
- 2024 and 2025 National Education & Training Survey (NETS) Results
- 2024-25 Trust Tariff Summary
- 2025 Trust Self-Assessment (SA)
- 2025 General Medical Council (GMC) National Training Survey (NTS) Scores and Ranks
- 2024 NHS England Deans' Equality, Diversity and Inclusion (EDI) Committee Summary
- 2024 SLE Quality Interventions Review Report

Who we met with

Trust Attendees

- Executive Director for Psychological Professionals & Therapies and Trust Chair for Education and Learning
- Director of Medical Education
- Director of Undergraduate Education
- Equality, Diversity and Inclusion Lead
- Head of HR and Medical Staffing
- Deputy Chief Nurse
- Medical Staffing Manager
- Guardian of Safe Working Hours
- Freedom to Speak up Guardian

Senior Team Attendees

- Chief Executive Officer
- Director of People & Organisational Development
- Chief Medical Officer
- Director of Finance & Estates
- Chief Nursing Officer

Review Panel

- Education Quality Review Lead: Adam Burns, Quality Associate Dean (Chair)
- Specialty Expert: Michelle Bamforth, Regional Head of Nursing and Midwifery
- Speciality Expert: Anthony Hann, Education, Investment and Commissioning Lead
- Speciality Expert: Cheryl Guest, Regional Workforce Transformation Lead
- Lay/Patient Voice Representative: Paul Richardson
- Education Quality Manager: Sandra Furniss, Quality Coordinator

Review findings

Rotherham Doncaster & South Humber NHS Foundation Trust colleagues began their update by highlighting that since the last SLE on 8 February 2024, a bid for increased investment in education was successful, with the trust committing to additional leadership roles in this area.

The trust strategy is framed around five core objectives and 28 promises, with a strong focus on partnerships, equity of access, organisational culture, safety and a high-quality learning environment. It is underpinned by values of social justice and cooperation with communities.

A key strategic priority (Promise 24) is the expansion and enhancement of undergraduate and postgraduate education across all disciplines. This includes more strategic use of apprenticeships to develop targeted workforce groups, alongside a strong emphasis on research, continuing professional development (CPD) and post-professional learning. Progress is monitored through a monthly dashboard, tracking investment, learner experience and outcomes, and the characteristics of those accessing development opportunities.

The trust continues to support undergraduate medical student placements from both Sheffield Medical School and Hull York Medical School (HYMS), operating across three geographical locations. This multi-site model presents some logistical challenges, particularly as Sheffield students are placed across Rotherham and Doncaster, while HYMS students attend placements in Scunthorpe. Overall responsibility for medical student education across the three sites sits with a single director, supported by deputy leads in each locality. This leadership group meets regularly, including quarterly medical undergraduate governance group (MUGG) meetings, to address local issues and share good practice. While the curricula differ slightly between the two medical schools, efforts are made to adopt effective approaches consistently across sites.

Placements are structured to provide varied clinical exposure, including time in inpatient services, older adult services, and consultant-led experiences. Individual student interests, such as CAMHS (Children and Adolescent Mental Health Service) or perinatal services, are explored during introductory meetings where possible. Mandatory integrated learning activities are supported, alongside additional enrichment opportunities, including Balint groups for medical students, which are considered a unique offer, and wider experiential learning sessions. The trust additionally offers an Extended Clinical Placement (ECP) for students with a specific interest in psychiatry which last approximately eight weeks and differs from standard Phase 3a placements.

Educational scholarship and research activity were highlighted, with several posters accepted at national conferences, including one award-winning project. A formal research project is also due to commence, focusing on how learning and good practice are shared across trusts and educational institutions.

Equality, Diversity and Inclusion (EDI) is embedded as a core “golden thread” across the trust, applying to students, learners and patients alike. The trust has established five Inclusion Networks—Race Equality, Carers, Disability and Wellbeing, Rainbow, and Women’s Network—

to support this agenda. As part of Promise 26, the trust has made a formal commitment to becoming an anti-racist organisation and to embedding inclusive practice for all colleagues.

EDI allies play a central role in promoting inclusive culture. Allies are encouraged to act as active bystanders by appropriately challenging discriminatory or inappropriate behaviour and supporting colleagues who experience discrimination. Allies are also encouraged to attend Care Group meetings along with colleagues from the EDI team, to provide advice and support. A Safe Protocol is in place to ensure a consistent and sustainable approach to managing discrimination, incidents and concerns.

Embedding EDI within education and training is a key focus. It was noted that EDI runs through all aspects of trust activity, and that education policies are developed and reviewed through a clear EDI lens. Monthly induction sessions include presentations on diversity and racism, and EDI allies engage regularly with resident doctor rotations to promote allyship, workforce awareness, race equality standards and identified areas of concern. Education and training were highlighted as pivotal to sustaining cultural change.

Targeted training initiatives continue to expand. A recent Rainbow training session had strong engagement, and participants are supported to act as visible allies for LGBTQ+ (Lesbian, Gay, Bisexual, Trans, Queer+) issues. Cultural humility training is provided across care groups, including sessions with resident doctors, exploring concepts such as culture, power, racism, prejudice and the role of active bystanders.

Reasonable adjustments are routinely made for colleagues with long-term conditions or disabilities, with clear points of contact identified to ensure appropriate support. The trust has achieved Bronze Accreditation with the North West BAME (Black Asian and Minority Ethnic) Assembly, the second trust in South Yorkshire to achieve this accreditation, recognising the trust as an active anti-racist organisation with mitigation strategies in place. Progression towards Silver Accreditation is underway, with the race and equality network and the EDI team leading.

The Guardian of Safe Working Hours (GOSWH) operates as an independent role within the trust, providing assurance that resident doctors are working safely and are not overworked. Exception reports are submitted when there is a deviation from agreed work schedules or where concerns arise relating to workload or training. Between February 2025 and January 2026, exception reports which predominantly reflected increased workload pressures, were particularly within Rotherham inpatient services and Doncaster adult services. Common themes included resident doctors remaining on duty beyond 5pm due to unplanned work undertaken late in the day, covering additional wards due to gaps in resident doctor cover, and challenges relating to supervision and support.

Between January 2025 and January 2026, there were no Freedom to Speak Up (FTSU) concerns raised directly by learners. Concerns are escalated to appropriate senior leaders and investigated and managed within Care Group Senior Leadership Teams. The online reporting mechanism allows concerns to be raised confidentially with management and oversight of

submissions maintained by the FTSU Guardian, who is the only individual with visibility of all reports.

The trust hosts FTSU leadership workshops aimed at colleagues in senior or leadership roles and the Guardian also attends induction sessions to promote awareness of speaking-up routes. Quarterly supervision sessions are held for FTSU Champions. Updated terms of reference and a new application process have been introduced to strengthen governance and role clarity. A comprehensive policy review has been completed to ensure alignment with National Guardian's Office requirements, and the revised FTSU Policy has now been implemented across the trust.

The trust supports a highly diverse multiprofessional workforce operating across physical health, mental health (MH), and learning disabilities (LD), delivering care in both inpatient and community settings. A wide range of professional groups contribute to service delivery, education, and system leadership.

Nursing and Healthcare Support Workers represent the largest workforce group. The psychological workforce includes around 20 distinct professional groups, and Allied Health Professionals (AHPs) include occupational therapists, physiotherapists, speech and language therapists (SaLT), dietitians, podiatrists, and art and creative therapists. Due to limited local education provision, some specialist training is accessed through providers in London. Pharmacists form part of the multiprofessional workforce, alongside a growing and structured development offer for healthcare support workers, including apprenticeship pathways. A strong emphasis has been placed on the peer support workforce, which has quadrupled in size, primarily within MH and LD services and more recently expanded into physical health settings. Social workers deliver health based interventions and provide placements and education, including Mental Health Act training, with clear crossover working alongside medical and nursing colleagues. Over the past 2–3 years, partner placement expectations have been reviewed and aligned to a fair share model, resulting in expanded collaboration with universities nationally. This has enabled continuity of training provision where local university programmes have changed or ceased.

The organisation provides a comprehensive internal learning offer, underpinned by clear education governance from board to ward level. All staff groups are supported to access half a day of learning per month, with a strong emphasis on multiprofessional learning. While this may result in short-term reductions in some non-clinical services, it supports integrated learning events, including multidisciplinary sessions involving general practitioners (e.g. diabetes education).

There is a clear and well-defined education governance structure, ensuring oversight and accountability for education investment. Despite broader system pressures and the requirement to implement savings and investment plans, education investment has increased by 12% in the current year. While some funding remains professionally ring-fenced, development opportunities are also extended across professional boundaries, including areas such as serious incident management and palliative care.

The trust hosts and supports conference-based learning for staff and academic partners, including psychology, AHP, and healthcare support worker conferences. In addition, regional place-based learning is delivered in specialist areas such as hospice and end-of-life care, in partnership with local providers.

In response to national and regional issues relating to racism and aggression, enhanced learner support has been implemented, particularly for those travelling through affected areas. Engagement has focused on safety, inclusion, and reinforcing learners' sense of belonging within the trust.

Undergraduate and access placements have been expanded, with targeted support for individuals experiencing barriers, including those with protected characteristics. This work is supported through reverse mentoring and inclusive engagement approaches.

Significant progress has been made in international recruitment, particularly within medical, nursing and AHP roles. Structured induction, transitional support, and mentorship have been established, including support for staff moving between inpatient and community roles.

The trust demonstrated sustained development of advanced practice roles, particularly within MH through the MPAC (Multi Professional Approved Clinician) programme. To date, two advanced practitioner nurses are working across community services, alongside the qualification of a psychological consultant and continued progression of additional candidates.

A dedicated research hub is established on site, supported by a commercial partner. The organisation has produced over 30 research publications and actively encourages staff and learners to engage with research activity as part of professional development and service improvement.

International Medical Graduates (IMG) are provided with enhanced support and induction arrangements to facilitate safe integration into clinical practice. IMGs are exempt from on-call duties for a minimum of two weeks, with this period typically extending to four weeks, depending on individual needs and service context. Where mentoring needs are identified, additional support is provided, including guidance on mentoring arrangements, social prescribing, and orientation to local primary care services. An IMG-produced video outlining lived experiences and support pathways was presented at the Untying the Knot IMG Conference, supporting shared learning and national dissemination of good practice. To enable effective supervision and induction, up to ten days of backfill is offered where operationally feasible. Buddying arrangements are consistently implemented, alongside promotion of the REACH network, which is introduced during induction. An IMG Handbook has also been developed to provide clear and accessible information for incoming doctors.

All resident doctors are actively encouraged to engage in CPD activity and to attend Resident Doctor Forum (RDF) meetings to support professional development and governance requirements.

The trust acknowledged there are challenges to address in a few areas, including the need for fiscal responsibility whilst balancing savings and investment, and an increased requirement for trainer wellbeing and needs to be considered, around health, personal, financial and neurodiversity. Industrial action has also been ongoing but managed both supportively and tightly within the trust.

Work is underway to develop a clearer understanding of the funding process. As part of this, discussions have taken place with lead employers to improve transparency and shared understanding of funding arrangements. Funding generated from unfilled posts is being used in a creative and flexible manner. For example, resources have been deployed to support the on-call rota, ensuring that service delivery pressures do not negatively impact the quality of residents' education and training. There are broader funding streams, including placement funding, CPD, and other educational components. Investment is made across these areas to support development opportunities for staff.

The increasing transparency around medical funding was welcomed and recognised as aligning more closely with established multiprofessional approaches.

In terms of the challenges around facilities and technology provision, a resident lead has been appointed to strengthen advocacy and representation at all levels, including board level. Investment is being made to enhance the learning environment with consideration being given to the use of GOSWH fines to deliver further improvements. Liaison with local trusts is taking place to enable the sharing of good practice such as the provision of 24-hour access to hot food, which has been highlighted as an example of effective wellbeing support. Reasonable adjustments are well established, with tools such as dictation having long been available, and there is a renewed focus on expanding access to specialised software. A recent training needs analysis identified a requirement across all professional groups for skills development in areas such as artificial intelligence, data interrogation, and the use of data to inform decision-making. Addressing these needs will form a key part of the work programme for 2026/27.

Previous feedback identified the need to further embed education and training considerations when clinical service reconfigurations are planned. In response, the trust reviewed its Quality and Safety Impact Assessment (QSIA) process and introduced additional sub-domains to assess the impact of clinical changes on education. This includes prompts on the effect on placements, learners, supervisory requirements, and equipment (e.g. laptops). A standard proforma is now used, providing an auditable record. The trust confirmed that its service reconfigurations do not impact trainees or learning in the coming twelve months, and no inpatient changes will take place before March 2028. The QSIA alterations were intended to introduce a robust mechanism for reviewing the impact of service configurations on training and education. The review panel felt that this was an appropriate response to the previously raised concerns.

With regards to governance and oversight and the statutory responsibility of the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC), the trust advised that the care group quadrum has been replicated at board level, providing executive oversight for each professional group in relation to national priorities and regulatory

requirements. This includes oversight of investment decisions and the tracking of learning from incidents and regulatory changes. Enhanced professional leadership roles are in place across nursing, AHPs, psychological professions and other regulated groups, with regular engagement at national and regional level. Any concerns are escalated appropriately, including through relevant regulators where required.

Areas that are working well

Description	Domain(s) and Standard(s)
Significant progress has been made in job planning for trainers, with clearer identification of supervision requirements, and increased focus on educator development.	4.2, 4.7
Partner placement expectations have been reviewed and aligned to a fair share model, resulting in expanded collaboration with universities nationally. This has enabled continuity of training provision where local university programmes have changed or ceased.	5.1, 5.2, 5.3, 5.4
Regional place-based learning is delivered in specialist areas such as hospice and end-of-life care, in partnership with local providers.	5.3, 5.4, 5.5

Good Practice

Description	Domain(s) and Standard(s)
The trust has achieved its Bronze Accreditation with the North West BAME Assembly, recognising the trust as an active anti-racist organisation with mitigation strategies in place.	1.2, 1.3, 1.8, 2.2, 2.3
International Medical Graduates (IMG) are provided with enhanced support and induction arrangements to facilitate safe integration into clinical practice.	1.2, 1.3
A dedicated research hub is established on site, supported by a commercial partner. The organisation has produced over 30 research publications and actively encourages staff and learners to engage with research activity as part of professional development and service improvement.	1.9
Facilities: Liaison with local trusts to share good practice such as the provision of 24-hour access to hot food, which has been highlighted as an example of effective wellbeing support. And there is a renewed focus on expanding access to specialised software.	1.11, 3.1, 3.2, 3.3
Individual student interests are explored during introductory meetings where possible. Mandatory integrated learning activities are supported, alongside additional enrichment opportunities, including Balint groups for medical students, which are considered a unique offer. The trust additionally offers an Extended Clinical Placement (ECP) for students with a specific interest in psychiatry.	6.2, 6.3, 6.4

Areas for improvement

Recommendations

Recommendation	Domain(s) and Standard(s)
Trainee data indicates significant reporting levels but also potential underreporting. While the trust has a strong focus on empowering staff, learner representation and reporting mechanisms require ongoing scrutiny to ensure concerns are fully captured and addressed.	1.7
Mechanisms exist to escalate education related feedback to the People and Teams Clinical Leadership Executive, the People and Organisational Development Committee (sub board level) and Trust Board. However, the flow of information was noted to be lengthy in some instances. It was emphasised that positive feedback should be shared with the Boards, as well as maintaining focus on what genuinely improves quality.	2.4
There was recognition that greater transparency around the use of education funding would be beneficial, though this reflects a wider national challenge. The trust noted that investment in education and learning exceeds hypothesised income and plans to articulate this more clearly.	2.5

Report approval

Report completed by: Sandra Furniss, Quality Coordinator

Review lead: Adam Burns, Associate Dean for Quality

Date approved by review lead: 12 May 2026

NHS England authorised signature: Jon Hossain, Deputy Postgraduate Dean

Date authorised: 12 May 2026

Final report submitted to organisation: [Date]

Glossary

AHP	Allied Health Professionals
BAME	Black Asian and Minority Ethnic
CAMHS	Children and Adolescent Mental Health Service
CPD	Continuing Professional Development
ECP	Extended Clinical Placement
EDI	Equality, Diversity and Inclusion
ER	Exception Reporting
FTSU	Freedom to Speak Up
GMC	General Medical Council
GOSWH	Guardian of Safe Working Hours
HCPC	Health and Care Professions Council
HEI	Higher Education Institute
HYMS	Hull York Medical School
IMG	International Medical Graduate
LD	Learning Disabilities
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer+
MH	Mental Health
MPAC	Multi Professional Approved Clinician
MUGG	Medical Undergraduate Governance Group
NETS	National Education & Training Survey
NHSE	National Health Service England
NMC	Nursing and Midwifery Council
NTS	National Training Survey
OD	Organisational Development
PARE	Practice, Assessment, Record and Evaluation
QSIA	Quality and Safety Impact Assessment
REACH	Race, Ethnicity and Cultural Heritage
RDF	Resident Doctors Forum
SA	Self Assessment
SaLT	Speech and Language Therapists
SLE	Senior Leader Engagement
WT&E	Workforce, Training and Education
YH	Yorkshire and the Humber

Annex 2 –NETs data comparison including SY and HY ICB data

Organisation	Bullying & Undermining	Discrimination	Facilities	Induction	Overall Experience	Quality of Care	Raising Concerns	Sexual Safety	Supervision	Teaching & Learning	Teamwork	Wellbeing	Workload
Yorkshire Coast & Wolds PCN	100.00	100.00	75.00	95.83	81.67	85.00	88.89	94.44	87.50	80.56	79.17	66.67	83.33
Yorkshire and Humberside (24 months) Scheme	70.37	75.93	75.00	76.39	73.89	81.67	88.89	94.44	68.75	72.69	72.22	81.25	66.67
York East PCN	100.00	85.00	81.25	87.50	87.00	78.00	100.00	100.00	86.25	69.58	72.50	100.00	60.00
York And Scarborough Teaching Hospitals NHS Foundation Trust	89.12	86.95	66.24	82.53	75.25	71.89	85.91	90.28	71.13	66.09	75.78	83.04	66.32

Organisation	Bullying & Undermining	Discrimination	Facilities	Induction	Overall Experience	Quality of Care	Raising Concerns	Sexual Safety	Supervision	Teaching & Learning	Teamwork	Wellbeing	Workload
Scheme													
West Outer And North East York PCN	83.33	91.67	62.50	77.08	72.71	72.29	94.44	94.44	77.08	57.64	62.50	66.67	75.00
Townships 2 PCN	100.00	100.00	75.00	100.00	95.00	80.00	83.33	100.00	88.02	72.40	81.25	87.50	75.00
Townships 1 PCN	100.00	100.00	83.33	91.67	83.33	75.83	100.00	100.00	89.58	80.56	83.33	100.00	66.67
The Rotherham NHS Foundation Trust	85.43	92.59	68.85	84.42	76.78	74.08	89.76	91.00	72.88	68.83	76.70	85.08	66.93
Tapton Care Ltd	77.78	100.00	83.33	87.50	85.00	66.67	77.78	100.00	89.58	81.25	75.00	66.67	100.00
South Yorkshire Scheme	95.56	93.33	73.33	86.67	86.67	81.42	77.78	98.33	85.00	78.61	77.50	86.67	80.00
Sheffield Teaching Hospitals NHS Foundation Trust	88.19	87.53	60.32	83.48	76.92	72.49	84.27	94.85	72.44	68.83	76.75	81.46	62.94
Sheffield Health & Social Care NHS Foundation Trust	89.81	86.11	72.22	85.65	79.44	78.43	92.59	90.74	78.40	72.15	84.72	92.59	72.22
Sheffield Diagnostic Genetics Service	89.29	100.00	67.86	73.21	69.46	76.00	90.48	91.43	56.25	76.49	83.93	100.00	64.29
Sheffield Children's NHS Foundation Trust	84.12	91.40	69.84	83.68	78.07	75.23	90.53	96.82	74.53	71.39	81.12	84.27	68.95
Selby War Memorial Hospital	100.00	100.00	62.50	91.67	88.33	80.00	77.78	83.33	77.08	75.00	83.33	66.67	66.67
Safecare Network	100.00	91.67	68.75	81.25	78.75	78.75	91.67	100.00	65.63	62.50	81.25	100.00	100.00

Organisation	Bullying & Undermining	Discrimination	Facilities	Induction	Overall Experience	Quality of Care	Raising Concerns	Sexual Safety	Supervision	Teaching & Learning	Teamwork	Wellbeing	Workload
Rotherham Doncaster And South Humber NHS Foundation Trust	100.00	100.00	70.59	87.87	80.44	78.09	90.20	96.37	79.41	69.79	84.19	90.91	72.06
Rother Valley South PCN	100.00	100.00	66.67	91.67	88.33	78.75	100.00	100.00	77.08	64.58	75.00	66.67	66.67
Primary Care Sheffield Ltd	83.33	83.33	91.67	91.67	86.67	85.00	66.67	100.00	89.58	85.42	95.83	33.33	66.67
Porter Valley PCN	93.33	80.00	75.00	80.00	71.00	78.00	73.33	100.00	73.75	70.42	67.50	80.00	80.00
Northern Lincolnshire And Goole NHS Foundation Trust	74.01	83.41	58.80	78.21	64.44	67.56	85.63	90.34	61.97	56.73	69.72	66.67	61.93
Nimbuscare Limited	58.33	56.25	58.33	59.38	64.06	71.88	41.67	100.00	50.00	61.46	62.50	50.00	75.00
Navigo Health And Social Care Cic	90.48	89.29	79.17	98.21	92.86	82.86	100.00	92.86	89.29	88.39	89.29	100.00	85.71
Leeds Teaching Hospitals NHS Trust	58.33	77.78	68.75	84.38	77.50	73.75	100.00	100.00	73.44	70.31	75.00	66.67	50.00
Humber Teaching NHS Foundation Trust	92.47	77.55	72.95	85.89	79.90	80.06	86.56	90.51	78.73	74.93	81.85	89.83	79.84
Hull University Teaching Hospitals NHS	80.18	84.12	61.43	79.82	71.47	69.26	82.82	92.62	68.49	64.28	73.81	78.05	58.02

Organisation	Bullying & Undermining	Discrimination	Facilities	Induction	Overall Experience	Quality of Care	Raising Concerns	Sexual Safety	Supervision	Teaching & Learning	Teamwork	Wellbeing	Workload
Hull Symphonie PCN	100.00	100.00	75.00	87.50	86.67	86.67	100.00	83.33	83.33	79.86	91.67	100.00	66.67
Hull Medicas PCN	100.00	100.00	75.00	87.50	79.17	76.67	77.78	100.00	75.00	68.75	66.67	33.33	83.33
Holderness PCN	77.78	75.00	75.00	83.33	73.33	74.44	55.56	100.00	66.67	68.75	79.17	100.00	83.33
Harrogate And District NHS Foundation Trust	86.43	91.15	64.84	85.31	81.26	75.40	87.97	90.55	73.50	69.95	77.58	85.33	65.98
Hambleton North PCN	88.89	70.83	75.00	81.25	79.17	70.00	83.33	100.00	80.21	72.57	75.00	100.00	66.67
Gpa1 PCN	100.00	100.00	83.33	91.67	85.00	85.00	100.00	100.00	81.25	75.00	87.50	100.00	50.00
Foundry PCN	80.00	75.00	65.00	87.50	73.00	57.00	80.00	100.00	68.75	60.42	75.00	90.00	40.00
Doncaster South PCN	100.00	100.00	81.25	87.50	75.00	71.25	66.67	100.00	71.88	75.00	81.25	100.00	37.50
Doncaster North PCN	100.00	100.00	87.50	93.75	91.25	86.25	83.33	100.00	90.63	87.50	96.88	75.00	87.50
Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	83.72	87.80	61.90	81.15	71.60	69.86	80.99	92.14	67.08	64.76	73.92	70.76	60.16
City Health Care Partnership Cic	100.00	97.73	62.50	86.46	85.63	81.98	94.44	83.33	81.25	73.44	70.83	100.00	75.00
Barnsley Hospital NHS Foundation Trust	88.12	91.33	68.90	84.25	79.50	76.08	91.86	94.41	75.81	73.29	81.59	84.55	68.50
4 Doncaster PCN	100.00	100.00	75.00	84.38	78.75	76.25	100.00	100.00	75.00	60.94	71.88	100.00	62.50

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 3 Volunteering Programme: 2026 Baseline Evaluation and Implementation Analysis	**Agenda Item**	Paper R
Sponsoring Executive	Steve Forsyth, Chief Nurse		
Report Author	Steve Forsyth, Chief Nurse		
Meeting	Board of Directors	**Date**	30 July 2026

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

1. **How the trust moves from strategic support to consistent operational ownership of volunteering.** The report concludes that the main issue is not a need for further Board support, but inconsistent operational ownership, requiring stronger directorate and Care Group grip over role design and supervisor allocation.
2. **How to address patchy coverage and sustainability of volunteer roles across services.** The evaluation identifies established volunteer involvement in some areas, but no or limited involvement in others and notes that some roles are not being backfilled when volunteers leave, creating a risk that coverage reduces over time.
3. **How to strengthen safe, meaningful implementation through recruitment, onboarding, supervision, role boundaries and training.** The report identifies inconsistent recruitment and onboarding, training compliance, role suitability, and the need for clear local management ownership.

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

PHPIC a first iteration July 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE: Volunteers and staff report positive experiences, with volunteers improving patient experience and day-to-day support where roles are well designed, supervised and integrated. P3 also widens participation: 30% of volunteers are under 30 compared with 17% of staff, and 32% are from Black, Asian and minority ethnic/global majority backgrounds compared with 8% of staff.

RECOGNISE: That the report frames the main implementation issue as an operational ownership and middle-management implementation problem, for which a different response from the central corporate function is needed

AGREE: That the next phase of the Promise 3 volunteering programme should move from expansion to consistent, safe and well-governed implementation and that the requested survey method that was not used in 2026 is used in 2027

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.	
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.	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.	
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.	
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	x

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

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

Evaluation Report:
RDaSH Promise 3 Volunteering Programme

2026 Baseline Evaluation and Implementation Analysis

Executive Analytical Conclusions

The 2026 baseline evaluation of the RDaSH Promise 3 volunteering programme indicates that the programme has achieved scale and is experienced positively by many volunteers and staff, but it is not yet consistently embedded across services. The Trust reported 357 active volunteers as of June 2026, 462 volunteers recruited in total, 105 leavers, and a turnover figure of 22.7%, with around 2% of leavers transferring into paid NHS roles. The programme also contributes to widening participation, with 30% of volunteers aged under 30 compared with 17% of staff, and 32% of volunteers from Black, Asian and minority ethnic backgrounds compared with 8% of staff.

The principal evaluation finding is patchy coverage. Volunteering is well established in some areas, including Doncaster Physical Health services, St John's Hospice and Palliative Care, Doncaster 0–5 health visiting, CAMHS "Getting Advice", Rotherham and North Lincolnshire acute mental health wards, and some corporate functions. However, the same mapping identifies services with no or limited volunteer involvement, including Getting Help CAMHS, North Lincolnshire Adult Mental Health community services, Community Nursing unplanned services, Doncaster perinatal services, Young Onset Dementia services, parts of Older People's Mental Health, and sections of Doncaster homeless and substance misuse services. In this rewritten report, "Operations Directorate" has been removed from the list of omitted areas, as requested.

The evaluation only partially distinguishes between the views of volunteers, line managers or supervisors, and other staff. The survey was distributed to volunteers and staff, including volunteer supervisors, and received 50 responses. Some results are separated by respondent type, particularly volunteer-reported experience and staff-reported perceptions of volunteer contribution. However, the available analysis does not provide sufficiently segmented findings for line managers or supervisors as a distinct group. This limits the validity of conclusions about whether concerns are held by supervisors responsible for recruitment, induction and oversight, or by wider staff who work alongside volunteers.

The primary implementation issue should therefore be framed as an operational ownership and middle-management implementation problem, not as a requirement for further Board support. The evaluation identifies barriers related to local role ownership, inconsistent recruitment processes, variable supervision capacity, cultural resistance, and roles not being backfilled when volunteers leave. These are issues requiring stronger directorate and care group management grip: role design, supervisor allocation, local induction, service-level uptake plans, barrier resolution, and routine monitoring. The wider context should also be acknowledged. The increased focus on volunteering took place alongside a wider change management process during 2025/26, and it is understandable that, in a period of organisational uncertainty, some staff may have suspected that volunteer roles were being used to

remove or replace paid roles. That was not the case. However, the perception itself is important, because it may have contributed to anxiety, confusion and resistance in some services, and therefore needs to be addressed explicitly through clear communication, role boundaries and local management ownership.

1. Introduction

The Promise 3 volunteering programme forms part of RDaSH's wider ambition to increase volunteer involvement across services and strengthen community participation in the Trust's work. The 2026 baseline evaluation was commissioned in December 2025 as a descriptive, longitudinal service evaluation of the implementation of 350 volunteers, with repeat data collection planned for January 2027 to enable comparison over time.

This report presents a rewritten evaluation analysis of the 2026 baseline findings. It focuses on what the data can validly support, where interpretation must be bounded, and what operational implications follow for the next phase of implementation. The report draws on three evidence sources: the baseline evaluation content, volunteer and staff survey data within that document, and the additional embedded staff concern statements supplied for this review as qualitative evidence of barriers and perceptions.

The purpose of this report is not to restate the programme narrative, but to assess implementation. It asks: what does the baseline evaluation show, what does it not yet show, why is coverage uneven, and what does directorate and care group middle management need to do differently to ensure volunteering is safe, meaningful and consistently implemented where appropriate?

2. Evaluation Methodology

2.1 Evaluation Design

The evaluation is described as a descriptive, longitudinal service evaluation designed to examine participants' views and experiences over time, with the 2026 findings acting as baseline data and a repeat evaluation planned for January 2027. This is an appropriate design for assessing early implementation, because it allows the Trust to establish an initial position and then test whether perceptions, experience and coverage change over time.

The baseline incorporated survey responses from volunteers and staff, including volunteer supervisors, and received 50 responses. The evaluation also used programme monitoring data, including volunteer numbers, leavers, turnover and distribution across services.

2.2 Qualitative Data

The embedded staff concern statements supplied for this review have been treated as qualitative implementation data. They are not presented as a statistically

representative sample. Instead, they provide insight into the perceived barriers and risks that may explain why some teams have not adopted volunteering or have adopted it cautiously. These comments are particularly valuable because they represent concerns that may be under-represented in survey responses from areas already engaged with the volunteering programme.

2.3 Scope

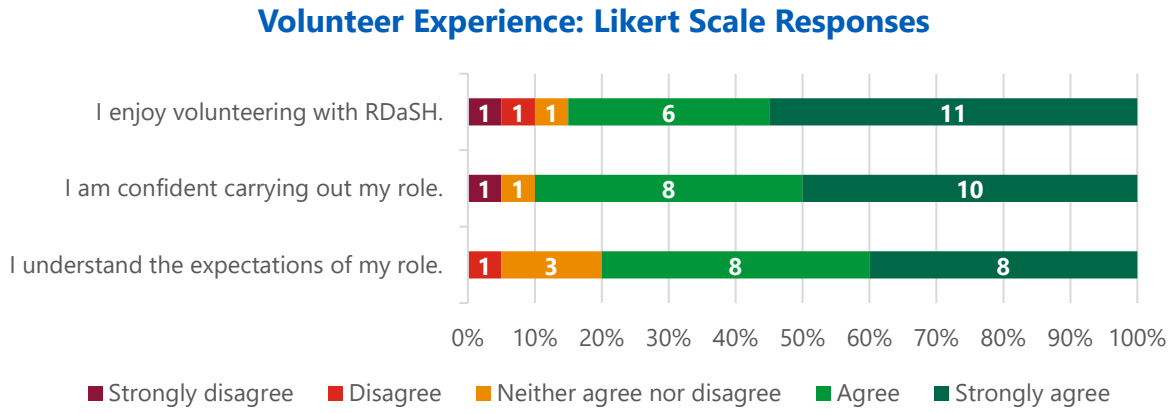
This report evaluates implementation, coverage, experience, barriers, and the adequacy of the 2026 baseline evaluation design. It does not evaluate the Trust membership issue. Membership access may affect wider volunteer recognition and inclusion, but it is outside the evaluation question and should be handled through separate corporate governance rather than as an evaluation conclusion.

3. Key Findings

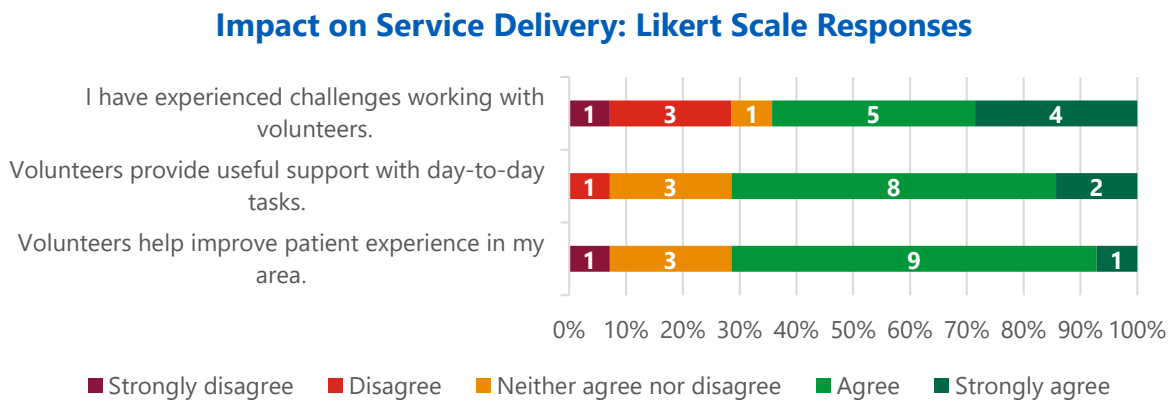
3.1 Programme Scale and Contribution

The programme has reached a significant level of activity. The baseline reports 357 active volunteers, 462 volunteers recruited, 105 leavers, and turnover of 22.7%. It also reports widening participation indicators, with a younger and more ethnically diverse volunteer cohort than the staff profile in the comparison provided.

Volunteer experience is generally positive. Volunteers reported high levels of role clarity, confidence and enjoyment: 8 agreed and 8 strongly agreed that they understood the expectations of their role; 8 agreed and 10 strongly agreed that they were confident carrying out their role; and 6 agreed and 11 strongly agreed that they enjoyed volunteering with RDaSH. Volunteers also reported that they were able to make a meaningful contribution, with 6 agreeing and 8 strongly agreeing that their volunteering makes a positive difference, and 7 agreeing and 10 strongly agreeing that they can make a meaningful contribution in their role.



Staff responses also suggest perceived value. Staff generally agreed that volunteers improve patient experience and provide useful day-to-day support, although some staff also reported challenges working with volunteers. This supports the conclusion that volunteering can add value where roles are appropriately designed, supervised and integrated into local workflows.



3.2 Patchy coverage is the central implementation finding

The core finding is that volunteer involvement is uneven - some services have established volunteer roles and appear to have integrated volunteers into service activity. Examples include Doncaster Physical Health services, St John's Hospice and Palliative Care, Doncaster 0–5 health visiting, CAMHS "Getting Advice" roles, acute mental health wards, and corporate functions.

However, the same mapping identifies services with no or very limited volunteer involvement, including Getting Help CAMHS, North Lincolnshire Adult Mental Health community services, Community Nursing unplanned services, Doncaster perinatal services, Young Onset Dementia services, parts of Older People's Mental Health, and sections of Doncaster homeless and substance misuse services. This means the programme is not yet operating as a consistent Trust-wide model. The evaluation characterises the programme as a "patchwork model" and indicates that it is not yet a reliable Trust-wide offer.

A further coverage risk is sustainability. Some roles are not being backfilled when volunteers leave, including examples in Assertive Outreach, Perinatal Mental Health and CMHT services. If volunteer leavers are not treated as vacancies for review and, where appropriate, re-advertisement, then coverage will reduce over time even where initial recruitment has succeeded.

3.3 Recruitment and onboarding remain inconsistent

Recruitment and onboarding have improved but remain insufficiently systematic. The process continues to depend on local knowledge, individual support and workarounds. Respondents reported mixed experiences: some described recruitment as lengthy and difficult to access, while others reported more positive experiences, particularly where face-to-face support was available.

It is necessary to note, however, that a number of improvements have been made to the recruitment process in the previous year, including a simplified application form. Moreover, the Volunteer and Involvement Co-ordinators also provide *ad hoc* face-to-face sessions to prospective volunteers who may require additional support filling out their application. As the time period in which volunteers who responded to the form completed the recruitment process is not known, it is unclear whether responses

reflect these changes. In fact, some volunteers pointed out that they had applied to be a volunteer a long time ago.

Continued efforts should be made to ensure that this process is as accessible as possible, but this must also be balanced against the Trust's duty of care to patients and wider legal obligations. As such, this feedback is to be expected, as the process for NHS volunteer recruitment will always be lengthier than that of other organisations.

Identified process barriers include inconsistent advertising of volunteer roles, use of TRAC, and difficulties onboarding volunteers into workforce systems for training and data. While guidance has been developed, including recruitment flowcharts and application processes, implementation remains inconsistent at service level.

3.4 Training and safety findings are positive but incomplete

Volunteer safety findings are generally positive, with respondents either agreeing or remaining neutral that they felt safe in their roles. However, mandatory training completion presents an implementation issue. Some respondents reported completing all required training, while others reported completing none or only some. The main barriers identified were lack of clarity about required training and inability to access systems.

Actions taken include simplification of training modules, integration into workforce systems for tracking, and provision of supported training sessions. Despite these improvements, training compliance remains variable and requires continued focus.

4. Does the evaluation distinguish volunteers, supervisors and other staff?

The evaluation only partially distinguishes between the views of volunteers, line managers or supervisors, and other staff. It does distinguish between volunteer-reported experience and general staff-reported perceptions. However, it does not provide a distinct analysis of line managers or supervisors as a separate group. This is a significant limitation. Supervisors are responsible for recruitment, induction, training compliance, role boundaries and day-to-day oversight, and are therefore likely to experience different pressures from other staff. Without separating these perspectives, the evaluation cannot determine whether concerns are primarily supervisory, operational, or general workforce perceptions.

5. Barriers to adoption in teams with limited or no volunteer involvement

The qualitative staff feedback indicates seven main barrier categories:

Barrier category	What staff concerns indicate	Likely implementation cause
Role suitability	Volunteers not appropriate in some environments	Insufficient role design
Supervision burden	Volunteers increase workload	Lack of protected supervision capacity
Confidentiality	Concerns about patient and volunteer confidentiality	Unclear governance and boundaries
Training	Volunteers near patients without adequate training	Inconsistent training compliance
Process burden	Recruitment and onboarding seen as complex	Fragmented processes
Logistics	Travel challenges in community services	Poorly adapted role design
Substitution	Concern volunteers replace paid roles	Lack of clear role boundaries

These barriers arise from operational, structural and cultural causes rather than simple resistance.

6. Interpretation: from Board support to operational ownership

The evidence indicates that the key issue is inconsistent operational ownership rather than lack of Board support. Directorate middle management and Care Group Leads need to:

- Confirm service-level suitability of volunteering
- Own role design and ensure roles are safe and meaningful
- Identify named supervisors for every role
- Resolve local implementation barriers
- Monitor uptake and ensure backfill where appropriate
- Prevent substitution for paid roles
- Use staff concerns as structured feedback for improvement

7. Limitations

The evaluation has several limitations:

- Limited sample size and representativeness
- The survey sampling frame was currently active volunteers, but it is unclear when these volunteers were recruited and so their experiences may not be contemporaneous.
- Lack of role-based segmentation
- Likely selection bias toward participating services and staff

8. Evaluation improvement plan for 2027

The 2027 evaluation should:

- Segment responses by volunteers, supervisors and other staff
- Include non-adopting services explicitly
- Use mixed methods including qualitative interviews
- Maintain longitudinal comparability

9. Implications for practice

The programme should move from expansion to consistent implementation. Volunteering should be treated as a standard operational responsibility, requiring clear role design, supervision, training and governance.

10. Conclusion

The programme is high-impact but inconsistently delivered.
The key issue is patchy coverage driven in part by variable middle-management ownership but also by some limitations in the structure and coherence, though not the intent of central and support. The next phase must therefore focus on consistent, safe and well-governed implementation across services, which includes a better understanding of what those who are hesitating need from the nursing and facilities team. The volunteering team within that directorate are consistently praised for going above and beyond.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	NICE Guidance 2025/26 Position	**Agenda Item**	Paper S
Sponsoring Executive	Dr Diarmid Sinclair, Chief Medical Officer		
Report Author	Dr Diarmid Sinclair , Chief Medical Officer		
Meeting	Board of Directors	**Date**	30 July 2026

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

The Trust is good at tracking whether guidance has been reviewed but how good is the evidence that we are actual tracking implementation?

The current system relies heavily on self-rating. How much assurance does this provide and should there be greater triangulation with outcomes?

How confident are we that we have robust systems for highlighting high priority guidance and tracking its implementation?

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 Trust Board is asked to:

NOTE the Trust's current position regarding NICE guidance implementation and compliance.

SUPPORT that the policy be amended to allow changes in systems but also improving assurance

RECEIVE in July 2027 an enhanced annual assurance report

SUPPORT that updates for NICE go through the QSSG and Quality Committee

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

Annex 1 NICE compliance highlighting relevance of Core, For information and N/A per care group

Rotherham Doncaster and South Humber NHS Foundation trust
Board of Directors

NICE Guidance 2025/26 Position

1. Introduction

1.1 NICE guidelines are evidence-based recommendations issued by the National Institute for Health and Care Excellence (NICE). They direct health, public health, and social care practitioners on the most effective ways to diagnose, treat, and manage specific conditions and diseases, while ensuring efficient use of resources.

1.2 The nice-guidance-dissemination-implementation-and-monitoring-policy sets out the trust wide process for review, dissemination, implementation, and monitoring of National Institute for Health and Care Excellence (NICE) guidance across the organisation.

1.3 All NHS organisations must have an approved documented process for taking into account agreed best practice as defined in NICE clinical guidelines. The NHS Constitution states that patients have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if the doctor or treating responsible persons for the patients care says they are clinically appropriate. The Health and Social care Act 2012 also state that the Secretary of State and the NHS commissioning board (NHS England) should have with regards to the quality standards prepared by NICE as part of their duty to secure continuous improvement in the quality of services the commission. NHS constitution for England.

2. What do NICE guidelines cover?

2.1 NICE produces multiple types of guidance spanning a broad range of physical and mental health conditions:

- Clinical guidelines: Recommendations for the treatment and care of patients by healthcare professionals.
- Technology appraisals: Assessments on the clinical and cost-effectiveness of new medicines, devices, and treatments.
- Diagnostics & HealthTech: Guidance on utilising medical devices, digital technologies (including AI), and diagnostic agents.

3. How are they created?

3.1 The guidance is developed by independent committees comprised of health and social care experts, academics, and lay members (including patients and caregivers). Committees review the best available evidence and apply health economics principles to ensure that recommendations are both clinically effective and value for money.

4. How are they used?

4.1 While NICE is a non-departmental public body in the UK, the guidelines are highly influential:

- They are heavily utilised by the NHS in England and Wales to standardise and improve the quality of care.
- They help shape local formularies and define quality standards across healthcare trusts.
- Healthcare professionals rely on them to inform patients and make optimal, evidence-informed decisions.

NICE Process

5. Review of recently published National Institute for Health and Care Excellence (NICE) guidance:

5.1 Each piece of NICE guidance should be reviewed and have responses recorded on the portal within 1 month of the summary report being disseminated.

6. Lead identification

Each care group has a designated NICE lead:

Doncaster Mental Health & Learning Disabilities Care Group	**Naomi Cheshire**
Children's Care Group	**Kate Jones**
North Lincolnshire Adult Mental Health and Talking Therapies Care Group	**Claire Coppens**
Rotherham Adult Mental Health Care Group	**Helen Wordsworth**
Physical Health and Neurodiversity Care Group	**Sam Butcher**
Medical, Pharmacy & Research Directorate	**Andrew Houston**

7. Dissemination of National Institute for Health and Care Excellence (NICE) guidance

7.1 The clinical effectiveness support officer disseminates the issued guidance via a report from NHS South Yorkshire Integrated Care Board (SY ICB) NICE guidance summary to the identified NICE leads and other identified colleagues in the trust, for the localities of Rotherham, North Lincolnshire and Doncaster which includes physical health and neurodiversity, mental health, learning disabilities and children's services. The guidance is uploaded to RADAR that is sent as an action for the leads.

8. Responding to NICE guidance

8.1 The NICE leads will review the guidance with services within their care group and assess which of the following responses is to be applied to each piece of guidance:

- not applicable
- for information
- relevant
- core

9. Baseline assessments

9.1 Baseline assessments are prioritised into high, medium and low and this determines the timeframe for completing the assessment.

10. Summary reports and governance

10.1 Leads should develop and present summary reports to the quality and safety sub-clinical leadership executive group within the timescales set out in section of the policy.

11. Completed baseline assessment and actions plans

11.1 Completed baseline assessments and any subsequent action plans will be presented in a summary report to quality and safety sub-clinical leadership executive group to approve the level of implementation (fully or partially or not implemented) and the NICE portal will be updated with the new level of implementation.

12. Process for documenting any decision not to implement National Institute for Health and Care Excellence (NICE) recommendations or guidance

12.1 If a decision has been made not to implement NICE guidance a summary report with a full assessment of risk is to be completed by the identified lead and this will be reported into the quality and safety sub-clinical leadership executive group, so the risk register can be reviewed and updated accordingly aligned to the care groups. This will be recorded on the NICE portal.

12.2 Currently only such piece of NICE guidance shows as not being implemented. This was in relation to the pharmacy position on venous thrombus embolism quality standards in order to allow the VTE policy to be updated. Of note the main relevant quality standard from this is that patients admitted should be assessed for risk venous thromboembolism within 14 hours of admission which is part our policy.

13. Deviation from timelines and standard process

13.1 Where the standard process and timelines are deviated from an exception report is to be presented to the quality and safety sub-clinical leadership executive group outlining the rationale behind the deviation and any associate risks.

14. Timelines for implementation

14.1 The NICE policy states that implementation should generally not take longer than 18 months although it should be noted that for NICE technology appraisals where they authorise the use of medicines or interventions that these should be made available within 90 days or 30 days for medicines under the early access to medicines scheme for conditions such as cancer.

15. NICE Compliance 2025/26

15.1 Annex 1 outlines compliance highlighting relevance of Core, For information and N/A per care group.

16. Baseline assessments

16.1 Baseline assessments are prioritised into high, medium and low and this determines the timeframe for completing the assessment.

17. Areas of potential improvement

17.1 The current NICE process is very strong at tracking whether care groups have considered if NICE guidance is applicable and then recorded whether or not they have implemented the guidance. There is current system provides less assurance that these changes have resulted in embedded changes in clinical practice.

17.2 The current system relies mainly on self-assessment by services. In certain circumstances some changes may lead to periodic clinical audit processes but this is relatively rare and so there is less assurance of ongoing compliance to standards.

17.3 There is also limited sense checking with the current system having different care groups arrive at different conclusions on the applicability of NICE guidance leading for the potential for some services to consider advice core and others may consider it not relevant. It should be noted that service composition can vary between care groups. For example it would be expected that the physical health services had different ratings of applicability for guidance compared to talking therapies services.

17.4 Related to this the scope of services offered by RDaSH can change such that previously not applicable guidance may become applicable within new services. At present there is not a robust system to look back to review these decisions.

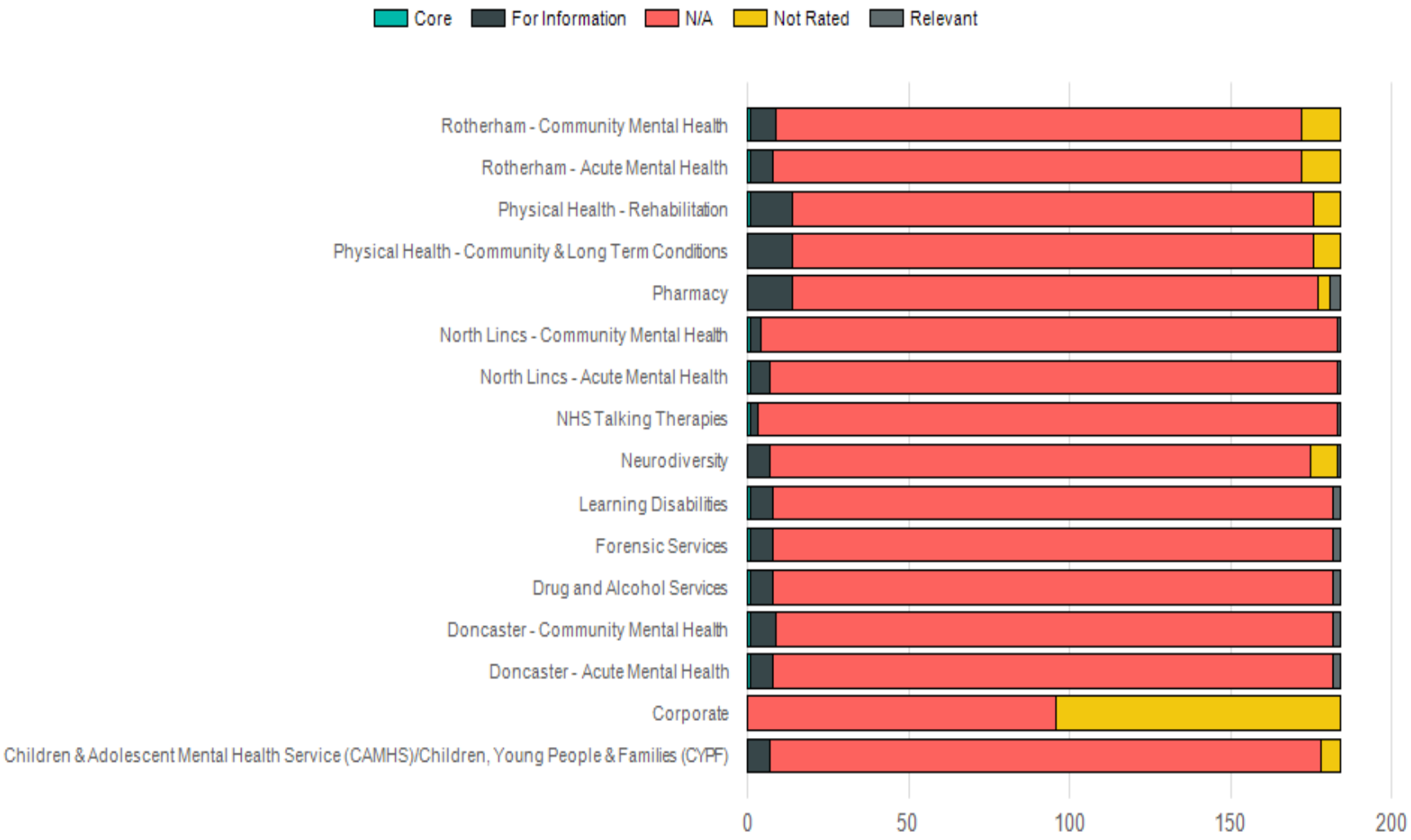
17.5 The current report does not record planned implementation dates and so would not provide automatic reporting of guidance where actions are overdue. Setting milestones would allow this to be tracked more effectively and ensuring that this is information is available on reports would improve accountability and assurance.

17.6 Linking implementation to measurable clinical outcomes and patient experience, where appropriate, would provide stronger assurance that the policy is achieving its intended purpose of improving the quality and safety of care, rather than simply evidencing completion of the implementation process.

18. Recommendations

- **NOTE** the Trust's current position regarding NICE guidance implementation and compliance.
- **SUPPORT** that the policy be amended to take into account the use of RADAR for dissemination of guidance and actions carried out by the leads for review. This update should also allow for reviews when providing new services to consider old guidance that has been deemed not applicable as a base line may become relevant. This will work on a new policy and process will be progressed by the MPR directorate and will present a new policy to CLE in November 2026. This policy will be updated taking into account feedback from care groups and corporate directorates.
- **SUPPORT** the proposed enhancements to strengthen assurance, including implementation milestones, exception reporting, consistency of applicability assessments, and greater use of outcome measures.
- **RECEIVE** in January 2027 an enhanced annual assurance report incorporating overdue actions, implementation risks, and evidence of impact on patient care.
- **SUPPORT** that updates for NICE go through the QSSG and Quality Committee. Consideration needs to be made in relation in these committees work plans

Annex 1 NICE compliance highlighting relevance of Core, For information and N/A per care group



ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Estate Plan – Full Business Case (FBC)	**Agenda Item**	Paper T
Sponsoring Executive	Simon Sheppard, Director of Finance and Estates		
Report Author	Toby Lewis, Chief Executive & Simon Sheppard, Director of Finance and Estates		
Meeting	Board of Directors	**Date**	30 July 2026

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

Awareness of our strategic intent to alter our estate between 2026 and 2029 is widely known among partners, staff colleagues and across the Board: it is also included in our approved cash and capital 3-year plan lodged with NHS England. **The key purpose of this paper is to provide the Board with an executive summary of the detailed full business case and to seek approvals as noted in the recommendations.**

The focus of the paper is the Tickhill Road site in terms of land disposal and building of the new facilities, these being a frailty centre and education centre. The paper considers in further detail the options available on the Tickhill Road site and identifies a preferred way forward based on a rigorous option appraisal, including the shape and nature of the disposal of surplus land. The FBC also recommends a procurement route for the decant and new-build works at Tickhill Road.

None of that will proceed until we have a settled state for our Rotherham plans. The Board is also asked to note the importance of Rotherham as a place and the priority in securing access to the ground and first floors of the Riverside building in order to unlock the ability to exit buildings that are not fit for the future.

The Board discussed and agreed the proposals relating to the ambient loop network as an energy source and decarbonisation of the Tickhill Road site in March. The FBC examines the procurement routes and funding mechanisms available. The paper concludes that the ambient loop should be procured with a view to securing external finance and the new build works at Tickhill Road are funded by a combination of Public Dividend Capital (PDC) and land sales. This is consistent with the previous papers considered by the Board.

Finally the paper describes the formal governance structure to drive the key elements of the Estate paper forward over the next 6 -12 months and clarifies the specific actions.

Previous consideration

Board March 26/Board timeout / Feb 26, Public Board (financials) / Dec 25, Private Board / Aug 25,
Public Board / July 25 Board timeout / June 24 [and CLE 3 times in twelve months]

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

CONSIDER the Full Business Case supported by the Executive Summary

RECOGNISE the progress made since the March 2026 Board meeting

SUPPORT the recommended option regarding the Tickhill Road site development

SUPPORT The recommended option for procurement of the Tickhill Road redevelopment is early contractor involvement through an approved procurement framework. The final recommendation on a procurement framework will be proposed to the Board via the Director

of Finance & Estates over the coming ten weeks. The Board's decision will then be transacted within the oversight of the Finance, Digital and Estates Committee.			
SUPPORT, for Ambient Loop the procurement route is via a competitive flexible procedure. The Board delegate the relevant authority to the Chief Executive and Director of Finance & Estates working with the chair of Finance, Digital and Estate committee to finalise the procurement route following further discussions with our legal advisors.			
SUPPORT Option B of the funding options, Public Funding for the Tickhill Road Redevelopment and Ambient Loop via a revenue model			
SUPPORT to delegate the relevant authority as regarding the land sale to the Chief Executive and Director of Finance and Estates to pursue this further and make a final recommendation through the Finance, Digital and Estates Committee			
Alignment to strategic objectives (indicate those that the paper supports)			
SO1: Nurture partnerships with patients and citizens to support good health			X
SO2: Create equity of access, employment, and experience to address differences in outcome			X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services			X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings			X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			X
Alignment to the plans: (indicate those that this paper supports)			
Estate plan			X
Digital plan			X
People and teams plan			X
Finance plan			X
Quality and safety plan			X
Equity and inclusion plan			X
Education and learning plan			X
Research and innovation plan			X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
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.	X

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

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)
Na
System / Place impact (advise which ICB or place that this matter relates to)
Neighbourhood working in Rotherham and Doncaster

Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	At final FBC stage
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	At final FBC stage

Appendix (please list)
Annex A – Full Business Case (Please also refer to Agenda Pack B)

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Executive Summary: Estate Plan – Full Business Case

1. Introduction

1.1. Awareness of our strategic intent to alter our estate between 2026 and 2029 is widely known among partners, staff colleagues and across the Board: it is also included in our approved cash and capital 3-year plan lodged with NHS England. This paper aims to bring together the work that has taken place in developing the Estate Plan over the last year, including the impact of the digital plan priorities.

1.2. The Full Business Case (FBC) provided separately has been prepared in accordance with HM Treasury's Green Book and the Five Case Model. The cases being strategic, economic, commercial, financial and project management. The management case also includes the proposed external governance route and the key next steps over the next 6-12 months.

1.3. The FBC identifies six principal Investment Objectives. Each objective has been developed from the strategic context and case for change:

- IO1 – Improve the quality, efficiency and long-term sustainability of the Tickhill Road estate, reducing backlog maintenance to an agreed target level.
- IO2 – Reduce operational carbon emissions arising from the Tickhill Road estate, in line with NHS Net Zero commitments.
- IO3 – Develop an integrated model of frailty care supporting the shift from acute to community-based care.
- IO4 – Ensure the estate footprint reflects clinical need, releasing any land or buildings no longer required for service delivery to support wider public value, including local housing need where appropriate.
- IO5 – Improve the Trust's long-term financial sustainability by reducing the cost of operating and maintaining the estate.
- IO6 – Ensure the estate is capable of adapting to future changes in models of care and service configuration.

1.4. Specifically, the FBC has been prepared to identify and confirm

- the preferred option for the redevelopment of the Tickhill Road Hospital estate and the recommended procurement route
- the preferred option for the implementation of the ambient loop energy solution in terms of procurement route.
- The preferred funding options for the Tickhill Road Hospital development and ambient loop solution
- The preferred configuration of the Tickhill Road site identifying areas for retention and disposal, with an overview of the options available for disposal
- and also to identify ways forward for the Rotherham development

1.5. This Executive summary provides colleagues with the key points from the 100+ page Full Business Case. *The wording of the case itself will continue to iterate during August.*

2. Preferred option for the redevelopment of the Tickhill Road Hospital estate and the recommended procurement route (Chapters 3 and 4 of the FBC)

2.1. HM Treasury's Green Book requires that a proportionate long list of credible options is considered before a shortlist is developed. The purpose of the long-list appraisal is to demonstrate that a reasonable range of strategic responses has been identified and that the shortlisted options are derived objectively rather than being predetermined.

2.2. An initial option generation exercise was undertaken to identify the broad range of strategic responses capable of addressing the investment objectives described in section 1.3. These options include maintaining the existing estate, incremental investment, phased redevelopment and more comprehensive redevelopment approaches.

2.3. Six strategic options were identified for detailed assessment. The options represent a continuum of intervention ranging from Business as Usual through to comprehensive redevelopment and were themselves assessed against a common set of criteria to ensure a transparent and evidence-based comparison.

2.4. The criteria included factors such as strategic fit, clinical benefits, estate performance, financial impact, and economic value.

2.5. **The recommended option is a phased redevelopment of the Tickhill Road site, with the draft position shown below.**

2.6. Chapter 4 of the FBC, the commercial case, includes the evaluation of the procurement options for the redevelopment of Tickhill Road. The 3 options are summarized below:

Options	Attributes
Traditional Procurement	The contractor would be appointed after substantial design development had already been completed.
Early Contractor Involvement	The Trust appoints a contractor at an earlier stage of programme development through an approved framework arrangement. The contractor works collaboratively with the Trust, advisers and stakeholders throughout programme development.
Strategic Delivery Partner	The Trust appoints a partner who works across a number of domains - design, planning, strategy and programme development.

2.7. **The recommended option for procurement of the Tickhill Road redevelopment is early contractor involvement through an approved procurement framework.**

2.8. **The final recommendation on a procurement framework will be proposed to the Board via the Director of Finance & Estates over the coming ten weeks. The Board's decision will then be transacted within the oversight of the Finance, Digital and Estates Committee.**

3. Preferred option for the implementation of the ambient loop energy solution in terms of procurement route (Chapter 4)

3.1. The Trust Board agreed to the further development of the "Energy Feasibility Study – route to Full Business Case" on 28 May 2026. The ambient loop solution was agreed as the preferred way forward.

3.2. The FBC describes a number of procurement routes for the ambient loop energy solution including Carbon Energy Fund (direct award or mini competition), Government Energy Framework, Framework Direct Award, and Competitive Flexible Procedure.

3.3. Framework-based routes (particularly a CEF mini-competition if suitable) are likely to reduce procurement duration materially while retaining competition. A Competitive Flexible Procedure is the longest route but offers the greatest flexibility where the Trust seeks a bespoke Strategic Energy Partner or long-term concession. The choice should therefore reflect the commercial model rather than procurement speed alone.

3.4. **It is recommended that:**

3.4.1. **The procurement route is via a competitive flexible procedure.**

3.4.2. **The Board delegate the relevant authority to the Chief Executive and Director of Finance & Estates working with the chair of Finance, Digital and Estate committee to finalise the procurement route following further discussions with our legal advisors.**

4. Preferred funding options for the Tickhill Road Hospital development and ambient loop solution (Chapter 5 – Financial Case)

4.1. The financial case sets out the financial implications for the Trust of the options which are available. The purpose of this is to demonstrate that the Trust is able to meet its financial obligations under a variety of scenarios.

4.2. The financial case is set in the context of the Trust having a relatively healthy financial position, with a breakeven plan for 2026/27 and an expectation the underlying deficit is eliminated by 2027/28. It is also expected to be in Tier 2 of NHS Oversight Framework (Tier 1 being the most favourable).

4.3. The financial case assesses a number of funding options ranging from public funding to private finance. A multi-step qualitative and quantitative appraisal was undertaken to assess the different financing requirements and implications of each programme component. PricewaterhouseCoopers LLP (PwC) supported the Trust in structuring and completing the appraisal, applying established public sector investment appraisal best practice.

4.4. The potential funding options are shown in the following table;

Option	Land	Ambient Loop	Refurbishment	Frailty Unit
A. Traditional Public	Sale	PDC	PDC	PDC
B. Public and Ambient Loop revenue model	Sale	Revenue model	PDC	PDC
C. Private & Ambient Loop revenue model	Sale	Revenue model	Income strip	Income strip
D. Hybrid income strip / PDC	Sale	Revenue model	PDC	Income strip
E. Hybrid income strip with prepayment / PDC	Sale & prepayment	PDC	PDC	Income strip
F. Hybrid income strip with prepayment / Developer	Sale & prepayment	Developer funded	PDC	Income strip
G. PF2 development	Sale & prepayment	PF2	PF2	PF2
H. Joint Venture	Land into JV	JV	Trust/PDC	JV governance

4.5. The 3 highest ranked options were:

- **Option B** – combines the land sale with an Ambient Loop revenue model, such as energy-as-a-service, alongside the Public Dividend Capital (PDC) requirement to fund the retained estate refurbishment and new-build frailty unit through a blend of ICB strategic capital, Trust cash capital budgetary CDEL cover and PDC funding.

- **Option A** - relies on land receipts and PDC funding to deliver the Tickhill site redevelopment, with the PDC requirement expected to be met through a blend of ICB strategic capital, Trust cash capital budgetary CDEL cover and PDC funding.

- **Option F** - combines several funding routes: a land sale and prepayment to reduce the funding required for the income strip of the new build frailty unit. A developer who will also be responsible for delivering and maintaining the Ambient Loop infrastructure, PDC funding for the retained estate refurbishment.

4.6. Based on the options appraisal, **the Board is asked to support Option B, Public Funding for the Tickhill Road Redevelopment and Ambient Loop via a revenue model**, as the preferred funding mix for the Tickhill site redevelopment, subject to further financial, commercial analysis, and assumption refinement as we progress through the procurement process.

4.7. The financial details of Option B are shown in Appendix 1 of this paper but for clarity:

- Ambient Loop development will be funded via a revenue model
- The new build at Tickhill Road will be funded by the contribution from the land sale plus PDC. PDC being a mixture of Trust, System and Region. This PDC requirement could be reduced if approval is achieved for the Trust to use it's cash balance.

5. Preferred option for the land sale

5.1. The preferred option for the Tickhill Road site identifies the potential for the disposal of circa 21.1 hectares of the total site area of 37.9 hectares.

5.2. This a complex area to ensure that there is the right balance of costs, risks and benefits is achieved in the context of the requirement in Doncaster for additional homes which achieve the optimum social benefit (especially in the Balby Bridge area of Doncaster).

5.3. Positive initial discussions have been held with Homes England about the potential for transfer of land to them (via an appropriate sale payment). There are several other options available to the Trust for managing the disposal.

5.4. The Trust will therefore ensure that we have engaged fully with Doncaster City Council to explore the most appropriate number and configuration of housing as part of seeking a planning consent for the surplus land (as this will generate

a more optimised land sale value for the Trust). This might involve a deeper engagement with Homes England as the government's housing and regeneration agency.

5.5. This approach, may or may not, involve forward sale of land (with an appropriate lease back period) to assist in capital cash flows. This will be developed further over the coming months.

5.6. **The Board is asked to delegate the relevant authority for this matter to the Chief Executive and Director of Finance and Estates to pursue this further and make a final recommendation through the Finance, Digital and Estates Committee**

6. Rotherham development

6.1. The borough remains key to our plans although the Rotherham chapter of our Estate Plan is the one that contains arguably the most challenges. Leased properties such as Kimberworth Place, Badsley Moor Lane and Centenary Clinic offer poor quality spaces for our colleagues and patients, with Trust owned Ferham Clinic requiring some minor works investment to improve the useability of some clinic spaces.

- Kimberworth is shared and well located, but lacks consultation space
- Centenary is 'maxed out' and does not offer accommodation at the standard of the organisation, as per this paper
- Badsley Moor Lane is shared space, well used by partners. Our space there is poor quality and the ideal solution will be vacation to allow others to develop the space
- Ferham, which we own, and which is well located – but which lacks parking and access

6.2. The above were common comments and feedback received during the estate roadshow and subsequent survey. We will continue to deepen our engagement with service users, carers and staff in line with our overall Trust strategy and through the governance structure set out in the management case of the FBC.

6.3. The approach is to negotiate town centre space. In late 2024 we hoped this could come from the Riverside Library redevelopment, but for varying reasons progress stalled. This option is now back on the table; it has now been confirmed the space RDaSH had been considering becomes vacant in autumn 2026. This is 'plan A' and discussions with the local authority continue, and we would hope to reach a conclusion before the end of August 2026 in principle.

7. Governance Approval Route and Next Steps

7.1. The NHS 10 Year Health Plan for England commits to reforming how capital funding is managed and streamlining the approvals process so capital schemes can be delivered faster. As part of this drive for more flexibility and freedom, NHS England and Department of Health and Social Care (DHSC) have agreed a number of increases to capital delegated limits with HM Treasury (HMT).

This includes a willingness to allow Trusts to retain 100% of proceeds for land sale and can spread this over a number of years with agreement from NHS England.

7.2. The updated delegated limits set out in the following table will apply to all NHS trusts and foundation trusts. Delegated limits apply to all capital investment and property transactions business cases, including those for property, plant or equipment, disposals, IT or digital investment, leased property, managed equipment, managed services and energy service performance contract schemes.

7.3. High performing trusts will have greater delegated authority, which on an interim basis will be based on the NHS Oversight Framework (NOF). This will be revisited as we develop the new foundation trust regime. This addendum does not cover transactions covered by the NHS England subsidiaries guidance, mergers and acquisitions or equity transactions which are covered in the NHS England.

Trusts	Delegated limit for trusts and foundation trusts	Delegated limit measure
Self-financed capital investment – non-digital		
NOF Segment 1–2	£100m CDEL	CDEL
NOF Segment 3–5	£50m CDEL	CDEL
Centrally funded capital investment – non-digital (see note 1 below)		
NOF Segment 1–2	All schemes that are centrally funded require approval.	CDEL
NOF Segment 3–5	All schemes that are centrally funded require approval.	CDEL
Self-financed digital and technology investment		
NOF Segment 1–2	£100m CDEL and / or £150m RDEL	CDEL and RDEL
NOF Segment 3–5	£50m CDEL and / or £50m RDEL	CDEL and RDEL
Centrally funded – digital and technology investment (see note 1 below)		
NOF Segment 1–2	All schemes that are centrally funded require approval.	CDEL and RDEL
NOF Segment 3–5	All schemes that are centrally funded require approval.	CDEL and RDEL

Note 1: Centrally funded means funded from NHS England or DHSC national capital programmes. For example, Diagnostics or Right to Constitutional Standards.

7.4. The key point for the Board to note is irrespective of which NOF segment we are in, the Board would have delegated approval up to £50m if the investment was self-funding, £100m if we were in segments 1-2. Conversely, all centrally funded schemes require NHS England approval.

7.5. Based on the proposed funding sources recommended and the requirement for PDC following clarification of the costs the Trust would need NHSE approval via the submission of a short form business case.

8. Next Steps

8.1. A summary of the next steps for the upcoming 12 months (and beyond) is set out in the table below:

Activity	Target Date (Range)
Ambient Loop	
• Select final procurement route	Q2 2026/7
• Commence procurement	Q2 2026/7
• Select Preferred Bidder	Q2 2027/8
• Financial close	Q3 2027/8
• Implementation	Q3 2027/8 – Q4 2028/9
Tickhill Road	
• Select Construction Partner	Q3 2026/7
• Conclude Design	September 2027 (earliest)
• Construction Completion	March 2029 (likeliest)
Land Sale	
• Confirm April land sale method and commercials	Q3 2026/7
Riverside	
• Achieve conclusion of discussions	End August 2026
• Sign the lease	December 2026
• Renovation / Refurbishment	January 2027 – June 2027
• Earliest occupation	July 2027

Notes: *Timings beyond Q2 2027/28 are estimates which are considered realistic but challenging*.

9. Recommendations

9.1. The Board of Directors is asked to:

9.1.1. **CONSIDER** the Full Business Case supported by the Executive Summary

9.1.2. **RECOGNISE** the progress made since the March 2026 Board meeting

9.1.3. **SUPPORT** the recommended option regarding the Tickhill Road site development

9.1.4. **SUPPORT** The recommended option for procurement of the Tickhill Road redevelopment is early contractor involvement through an approved procurement framework.

The final recommendation on a procurement framework will be proposed to the Board via the Director of Finance & Estates over the coming ten weeks. The Board's decision will then be transacted within the oversight of the Finance, Digital and Estates Committee.

9.1.5. **SUPPORT**, for Ambient Loop the procurement route is via a competitive flexible procedure.

The Board delegate the relevant authority to the Chief Executive and Director of Finance & Estates working with the chair of Finance, Digital and Estate committee to finalise the procurement route following further discussions with our legal advisors.

9.1.6. **SUPPORT** Option B of the funding options, Public Funding for the Tickhill Road Redevelopment and Ambient Loop via a revenue model

9.1.7. **SUPPORT** to delegate the relevant authority as regarding the land sale to the Chief Executive and Director of Finance and Estates to pursue this further and make a final recommendation through the Finance, Digital and Estates Committee

Appendix 1 - Sources and application of capital funding of Option B

Financial Year (£'m)	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	Total
Sources						
Land receipts	-	-	-	18.0	-	18.0
PDC allocation*	-	8.1	10.1	0.9	-	19.1
ICB Strategic Capital	-	3.0	3.0	3.0	-	9.0
Internal Trust Funding (CDEL)	-	1.3	1.3	1.3	-	4.0
Revenue Model	-	7.9	3.4	-	-	11.3
Total Sources	**-**	**19.3**	**16.8**	**6.2**	**-**	**61.4**
Uses						
New build (Frailty Unit/Admin/Education)	-	20.0	20.0	5.1	-	45.1
Refurbishment	-	2.5	2.5	-	-	5.0
Ambient Loop infrastructure	-	7.9	3.4	-	-	11.3
Total Uses	**-**	**30.4**	**25.9**	**5.1**	**-**	**61.4**

***** There will be further discussions regarding the Trusts use of some of its cash balances to replace any PDC ask

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 30 July 2026

Item 24 – Staff Story

Ms Louisa Redhead, Continuous Service Improvement Manager in our North Lincolnshire and Talking Therapies Care Group will join us to share her experience of development opportunities at RDaSH and how they have supported her career progression in the Trust.

Louisa will share her experiences of joining as a Band 2 colleague and progressing to her current Band 8a role, her completion of two apprenticeship programmes and how she has taken these skills and applied them to her role, to improve patient and colleague experiences.

Louisa was recently named Health and Public Service Apprentice of the Year at the East Yorkshire Apprenticeship Awards 2026. This award recognises the commitment, impact and achievement Louisa has demonstrated throughout her apprenticeship journey.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Avoiding Unnecessary Hospital Admission for People Living with Dementia	**Agenda Item**	Paper U
Sponsoring Executive	Dr Diarmid Sinclair, Chief Medical Officer		
Report Author	Dr Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	30 July 2026

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

How would suggested changes in this paper align with the Trust's wider ambitions around neighbourhood care and the "home first" model and what would “good” look like in 5 years time?

Admissions are often the consequence of failures across the whole health and care system rather than within one organisation. It would be useful to discuss what partners need to work on this alongside RDaSH

Given the potential scope of this work there would likely be a gradual phased implementation. Consideration would need to be given on how to prioritise this work

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

This is a new paper but the topic has previously been considered at the clinical leadership executive

Recommendation (delete options as appropriate and elaborate as required)

The Trust board is asked to:

RECOGNISE avoidable hospital admission for people living with dementia as a clinical priority

SUPPORT the development of a system-wide "Right Care, Right Place, Right Time" model with partners

REQUEST a detailed proposal including workforce, partnership, digital, and financial implications

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

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.	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.	
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.	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
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 (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 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

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

Avoiding Unnecessary Hospital Admission for People Living with Dementia

1 Background

1.1 This paper looks at the case for making avoidable hospital admission for people living with dementia a priority for RDaSH and its partners. It argues that hospital admission should never be the default response to deterioration, distress, behavioural change, carer stress or care home uncertainty. Admission must remain available when a person has an acute medical, surgical or mental health need that cannot safely be met elsewhere. However, for many people living with dementia, the better clinical response is often rapid personalised care in their usual place of residence.

1.2 This paper not only considers hospital admission to mental health wards but also considers admissions to acute hospitals as well. The reason for this is that tackling this problem requires coordination across the system. Admitting somebody to an acute hospital may lead to increased disorientation and confusion leading to increased distress and consequently requests for admission to mental health wards. In this example potentially intervening earlier could have prevented this chain of events such that it is important to consider the system as whole and not a narrow mental health and physical divide which is often illusory.

1.3 The national direction of travel is clear. The NHS 10 Year Health Plan sets out three major shifts: from hospital to community, from analogue to digital, and from sickness to prevention. Dementia is directly relevant to all three.

1.4 The demographic challenge makes this urgent. Around one million people are currently living with dementia in the UK, and this is projected to rise to around 1.4 million by 2040. The annual cost of dementia is forecast to rise from £42 billion in 2024 to £90 billion by 2040, with the greatest pressures falling on families, unpaid carers, social care and the NHS.

1.5 For RDaSH this means that a model of care that relies on crisis response, conveyance and hospital admission will lead to potential clinical harms and be operationally unsustainable.

1.6 This paper also needs to be seen in the context of work that was previously done with the closure of Brambles and the creation of a mixed inpatient model in older adults comprising of organic and functional patients. The paper presented to the May board identified that this mixed model was fundamentally safe albeit being a minority model nationally. Closure of the split cohort model in Rotherham has reduced the size of the older adult bed base. Currently the bed base is large enough to manage the demand but this demand will increase over the coming decade such that without proactive action the existing bed base will no longer be sufficient.

2. What is dementia

2.1 Dementia is a group of conditions that affect the brain, causing problems with memory, thinking, communication and everyday activities. Alzheimer's disease is the most common cause, but there are several different types of dementia. Symptoms usually develop gradually and become more severe over time, eventually affecting a person's independence and ability to carry out daily tasks.

2.2 Because dementia is caused by a range of conditions there isn't a singular cause for it nor is there a singular treatment as this needs to be bespoke to the actual cause of someone's dementia

2.3 Mild cognitive impairment means a person has noticeable problems with memory or thinking that are greater than expected for their age, but not severe enough to stop them managing everyday life independently. It can sometimes progress on to dementia but for many it will remain stable and not progress to this.

3. Why admission can be harmful

3.1 Firstly, it should be recognised that as for other patients hospital admission can be lifesaving and necessary. As a result people living with dementia should not be denied access to hospital when they require investigation or treatment for acute illness that can only be provided in hospital.

3.2 The argument is not that people with dementia should be excluded from hospital. The argument is that avoidable admission should be treated as a failure of system design, because hospital is often the least therapeutic environment for a person whose cognition, orientation, communication and sense of safety depend heavily on familiar people, routines and surroundings.

3.3 People living with dementia they are at an increased risk of delirium, falls, functional decline, distress, restrictive practice, medication-related harm, hospital-acquired infection and delayed discharge for multiple complex reasons.

3.4 NHS England's virtual ward framework specifically recognises that frailty virtual wards can reduce the risk of deconditioning and loss of independence associated with emergency conveyance and admission to hospital. The NHS RightCare scenario points out that 10 days of hospital admission can lead to the equivalent of 10 years of muscle ageing due to deconditioning.

3.5 NICE guidance on dementia emphasises assessment, individualised care, staff training, carer involvement and support for people living with dementia and their carers. These principles are often harder to deliver in a busy hospital environments.

4. The opportunities for RDaSH

4.1 Dementia admission avoidance speaks directly to our clinical strategy and the promises contained within it because it requires partnership with families, carers, care homes, primary care, local authorities, ambulance services, acute trusts, voluntary sector partners and neighbourhood teams in order to be successful.

4.2 The practical aim should be that people living with dementia are supported earlier, closer to home and in a way that reflects their wishes.

4.3 This would mean moving from a reactive model to a proactive one. In a reactive model, the system waits until risk escalates, carers are exhausted, a care home feels unable to cope, or ambulance conveyance appears to be the only option. In a proactive model, the person has an anticipatory care plan, their carers know who to call, care homes can access specialist advice, physical health deterioration is identified early, crisis teams can respond rapidly, and hospital alternatives are available seven days a week.

4.4 Accepting that our services differ depending on geography RDaSH is uniquely placed in order to develop this. In Doncaster we provide virtual wards as well as other community physical health services alongside mental health services leading to opportunities for further collaboration between physical and mental health services.

4.5 Success with this would support Promise 13 and increasing our home first ethos. More importantly it will lead to better patient outcomes and care. Failure to implement such a model would likely mean that the current bed base would be insufficient.

4.6 In April 2025 the Trust board agreed to close one of the older adult inpatient wards in Rotherham. This led to the Trust having a mixed inpatient model throughout the Trust rather than a specialist organic inpatient ward. £250k of money from this closure was recycled into community posts across the 3 localities to lead on admission avoidance. Since closing the ward we have not had to place any older adult patients out of area showing that the Trust has a proven track record of being able to successfully reinvest into the community.

5. What our own data tells us

5.1 The average length of admission for an organic patient in RDaSH is between 43-55 days depending on which ward somebody is placed on. This doesn’t show a significant difference compared to our functional patients but they are more likely to be clinically ready for discharge compared to our functional patients. This data has only considered admissions to our mental health wards rather than including our physical health wards.

6. How avoidable admission can be reduced

6.1 The first enabler is earlier identification of people at risk of crisis. RDaSH and partners should use metrics such as frailty scores, previous ED attendance, falls data, carer stress etc to identify people most likely to deteriorate. This would allow services to intervene before someone potentially hits a point of deterioration where hospitalisation may become necessary. Kent NHS Foundation Trust introduced a service that proactively identified people at risk of deterioration and this led to a 25% reduction in medical attendances for people aged over 75. This was primarily focused on preventing physical health admissions but Sussex Partnership NHS Trust has launched a pilot scheme which has shown evidence of effectiveness at preventing mental health admissions.

6.2 The second enabler is a community based service that can rapidly respond with sufficient intensity and skill mix in the person's usual place of residence. There are multiple models that have been trialled nationally ranging from virtual ward models to dementia crisis teams. The evidence base is variable for dementia crisis teams in an uncontrolled trial showing that the service had helped avoid hospital admission in 70% of cases but another study looking at 23 teams following best practice showed no statistically significant effect on hospital admissions compared to teams that weren't using the best practice tool kit. It is worth noting that this study had limitations given the large variation between teams involved in the trial.

6.3 The third enabler is a stronger interface with urgent and emergency care. Greater interface with services such as NHS 111 would allow more acute hospital admissions to be avoided and potentially more appropriately placed on a virtual ward. NHS England evaluations of virtual ward models nationally show that for every 2.5 virtual ward admissions one non-elective acute hospital admission can be avoided.

6.4 The next enabler is left shift on digital. Digital tools should not replace human care, but they can support earlier recognition of deterioration and better shared decision-making. The HealthCall Digital Care Homes app, for example, allows care home staff to record observations and share them with clinicians; NIHR Evidence reported that this model reduced hospital admissions by 25% and length of stay by 11%. Promise 14 encourages us to embrace innovation and the potential for more novel remote monitoring cannot be discounted nor can the potential place of AI powered algorithms but these are emergent and do not carry an evidence base.

6.5 The last enabler is supporting carers. Promise 2 commits us to supporting carers and carer burnout is a common driver of admission. A systematic review found that carer interventions can delay institutionalisation but this effect is modest but given the cost of placements even a small delay could potentially be cost effective. The evidence for carer interventions in reducing hospitalisation appears to be limited although carer burnout is a frequent reason for admission. Although providing carer interventions do not have robust evidence that they would reduce admissions it is worth noting that carers are estimated to save approximately £11 billion in care costs and there are the negative consequences to their own mental health which needs to be considered.

7. Future treatment considerations

7.1 For many years the drugs to treat dementia have been symptomatic such as helping to improve memory or behavioural symptoms. They did not prevent further gradual deterioration but did help improve symptoms.

7.2 There are now newer mono-clonal antibody treatments that can slow the progression of Alzheimer's type of dementia which is the most common type of dementia. These drugs are most effective when given early with them showing the most benefit when given to somebody who has not yet developed dementia but has mild cognitive impairment which can sometimes be a precursor to someone going on to develop dementia.

7.3 This means that early diagnosis and reaching hard to reach groups will be even more essential as there is evidence that these drugs can slow cognitive decline by up to 35% over 18 months but it is worth noting that the effectiveness of these drugs are contested.

7.4 The relevance to RDaSH is that it is foreseeable that other future treatments will possibly have the most efficacy in the early stages of the disease as well.

8. Conclusions

8.1 Admission to an RDaSH mental bed for dementia is most commonly for periods of 43-55 days and this timeframe in hospital can lead to deconditioning and other potential iatrogenic harms.

8.2 Future treatments will likely rely on early identification and diagnosis of dementia possibly in mild cognitive impairment but may have effects on modifying the trajectory of the disease.

8.3 To minimise admissions it is best to consider a system wide approach given that many patients with dementia will be admitted to acute hospitals as well as mental health units.

8.4 No singular intervention will likely minimise hospital admissions on its own and a multi-faceted approach of recognising those at risk of deterioration, having the ability to divert away from hospital early and having the intensive community support available will likely yield the highest reductions in hospitalisations.

Recommendations

1. **Recognise** avoidable hospital admission for people living with dementia as a clinical priority aligned to the Trust Clinical Strategy
2. **Support** the development of a system-wide "Right Care, Right Place, Right Time" model with partners, promoting care at home wherever safe and appropriate.
3. **Request** a detailed proposal including workforce, partnership, digital, and financial implications

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Culture Work – moving forward	**Agenda Item**	Paper V
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Carlene Holden, Director of People & Organisational Development Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	30 July 2026

Suggested discussion points

This paper may frustrate in that it is not as conclusive nor as defined as we might have hoped when we met in May. It does however set out a route to that specificity for September: it also reflects many, many conversations since May in a variety of places, whilst acknowledging that depth now needs to be added to breadth. The paper confirms we are still working towards the high care/high accountability ideas we explored first at the leaders' conference in 2025, and which in many ways reinforce themes that have then run through our LDO.

Because we wanted anti-racism to form a core part of the cultural reset, this is discussed within the paper. A more specific set of actions, many already in hand are laid out. There are some forward actions to be taken which will then complete a picture of what we will be doing in 2026, in 2027 and in 2028 to try to meaningfully deliver Promise 26. The paper includes comments on antisemitism, on language and asks the Board to agree a definition to anti-muslim hate. We envisage that our anti-racism work will both have its clear exposition for staff and managers, and be explicitly woven into the equivalent cultural reset material.

Previous consideration

Clinical Leadership Executive, May 2026; Trust People Council, January & April 2026. BOD May 2026, Board timeout June 2026, Trust People Council July 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE - the report's description of ongoing work since the Board last met

DISCUSS – the anti-racism theme within the paper to a conclusion (noting three pieces of work to return)

ACCEPT and AGREE – the definition of anti-muslim hatred contained within the paper

COMMENT – on the intended co-production work in advance of the leaders' conference in September

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 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							
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	At final version in September 2026
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Appendix (please list)

Annex 1: Our agreed 2025 culture aims (people and teams plan)
Annex 2: NHS Staff Standards documentation
Annex 3: Wheel of inclusion (LDO product, credit VMI)
Annex 4: Anti-Muslim hatred definition for adoption

Rotherham Doncaster and South Humber NHS Foundation Trust

Culture work – latest update

1. Introduction

1.1 This paper assumes that the why behind our cultural reset is now well understood within the Board, and likewise the continued drive towards becoming an anti-racist organisation. The focus of conversation needs to sharpen on what and how, whilst acknowledging that this is a not a programme we can simply do, instead it needs to impact how we work in teams and wards, as well as within the Board.

1.2 Despite the listed dialogue on the front-sheet, conversations deeper within the organisation have been modest to date, and that needs to change during August and September. The clinical leadership executive expressed enthusiasm for the behavioural commitments to re-energise our values, and there is a recognition that the re-launch of appraisal offers one mechanism to enact that. The leaders' conference on September 29th represents an opportunity (as we did with the strategy in 2023) to shape a final proposition, but by that point we need both the what and the how to be clear – to react to (remembering that we need to circle back around the why with each new engagement).

1.3 NHS England have published, since we last met and they are annexed, a mandated set of staff standards, in six domains, together with their proposed leadership framework. There is nothing colleagues are likely to dissent from within this work, but, in our conversations in the Trust People Council, for example, these would appear to be the minimum that should be expected from this work, and focus mostly on individual conduct, whilst cultural change comes too from how teams behave and interact.

1.4 There is a strong preference from some stakeholders, including some trade union voices, for a clear theoretical underpinning to this work: in effect a model from research applied to the Trust. As we move forward the co-production of this work, we need to consider that carefully and Board direction in this space would be welcome. In leaning towards high support/high challenge we are, of course, already drawing on the literature about high performing organisations.

1.5 This paper updates Board colleagues on both thinking and proposed actions. In the latter regard the actions are incomplete as presented and there is space for others to be added. The output from the timeout has been considered in preparing this paper. It is worth recalling that in the timeout the framing was about how our work to share power with, and recognise power in, our communities, might best translate to a similar compact with our people, staff, students and volunteers. That remains an intended storyline.

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2. Anti-racism including antisemitism

2.1 Part of the reset work is proposed to be our renewed effort to meet our promise 26. We have also explored, and I would suggest need to continue to explore, how we manifest a commitment to tackling antisemitism within that work. July 29th saw our first learning half day session focused on that topic, which is repeated in September: the national e-learning announced by DHSC in response to the Mann Review has not yet been issued and may not now be available until April 2027.

2.2 The commitment from our review of our anti-racism work in November 2025 was to seek to shift the obligation from colleagues who identify as being from a global majority or black and minority ethnic heritage, to make all employees positively demonstrate their anti-racism. The implication being that in team meeting and development activities, in applying techniques like the wheel used in our LDO (annex B), and then within appraisal, we would each be needing to evidence our awareness or and enactment of anti-racist behaviours. In taking forward work on Mulberry, which shortly to transition to The Willows, some such behaviours have been developed.

2.3 We should not neglect the seven-point plan which we enacted in 2024 to begin our work on this promise. That included work to change recruitment panel composition, which went live this July, as well as important changes to who investigated concerns, disciplinary investigations and grievances that could involve racism allegations. This work has been routinely scrutinised within the People and OD bi-monthly delivery review and explored to in the people and teams' sub-group. It may be helpful for the Board's People and OD committee to form a single view of how much of this plan remains to deploy, and assuming that, what measures or metrics of success we should use in H2 to test its effectiveness and impact. Alongside this we will review the NHS Race and Health Observatory Seven Anti-Racism Principles, and explore incorporating their framing into our plan and signing up to their principles.

2.4 Notwithstanding that review, in 2023 we made a commitment that the senior leadership of the Trust (band 8+) would change to better reflect the communities we serve and the staff we lead. This goes beyond, but does include, the make-up the Board. A numeric analysis of the current state will come to the Board in September to allow us to consider what further steps are needed to deliver that commitment. I would anticipate that this will require specific trajectory plans associated with foreseeably vacant roles in corporate functions as well as a move in some domains to 'affirmative action' hiring practices in early 2027. Work has already commenced in the P&OD Directorate to consider our approach and will be explored in their upcoming delivery review. In essence we cannot leave to organic change the change in who we are, even though the transition to one in seven RDaSHians being from a black and minority ethnic background is a stark change in our employee base since 2023 – it makes all the more urgent the change needed in who leads these colleagues.

2.5 The REACH network have made some specific proposals about what they feel has to form part of the anti-racism work, in addition to lending their support towards the change in our recruitment panels for band 7+ roles. They wish us to introduce (arguably reintroduce) a Reverse Mentoring programme into the Trust from October 2026 – with a first phase lasting to December 2027. In addition the prominent See Me First campaign, which seeks to promote psychological safety in the workplace associated with diversity, is one they urge us to adopt. It seems astute to accept this advice, not least as ultimately it is the judgement of our staff on Promise 26 which surely is the test of our success, and the benefit of trust earnt, and patience offered is not to be overlooked.

2.6 Part of our discussion on antisemitism has been a re-exploration of terminology. Our networks have been reflecting on these issues and trying to consider what terminology may best be applied, recognising that language that minoritises can offend, but as we have discussed so can labels like Global Majority. The current thinking is that we will not succeed in finding a single template of terms, without affront to anyone. As such we need to use a variety of terms where required and specificity when we can, and as they are used seek to check-in on their suitability with those around us. It would be helpful for the Board to consider whether this approach can work for us.

2.7 The Trust Board has previously accepted a definition of antisemitism that was government endorsed and derived from academic work in the field. At that time, we noted no such definition was agreed nationally in respect of Islamophobia, or put slightly differently, anti-muslim hatred. Annexed to this paper is a government endorsed definition which I would propose we now adopt. In November, we will conclude work to explore the practical implications for our work of both definitions, as well as how we take forward the terminology conclusions outlined above.

2.8 Taking the above considerations in the round, that would suggest that we have a sizeable series of actions to take in furtherance of the Promise:

a) Sustain and see the benefit for our existing seven-point plan
b) Implement to be agreed actions consistent with moving to a more representative leadership
c) Adopt the proposals from our REACH network in addition to the above
d) Include within our new appraisal framework a behavioural demonstration expectation consistent with the work developed for some of our wards
e) Review the second year of the Acceptable Behaviour policy, now aligned to the anti-racism pathway within RADAR, to consider whether adoption has grown and take action in places where it has not
f) During 2027 specifically review service pathways through the lens of ethnic origin and religious tradition, as we have done in terms of poverty and are doing in terms of inclusion health
g) Ensure that our successor plans beyond the LDO, as well as other management training programmes we have, contain allyship and other relevant modules to support this agenda – whilst continuing to deliver

the Active Bystander training to wider colleagues to increase the spread across the organisation

2.9 Internal audit criticised our implementation arrangements associated with Promise 26, in their review in 2024/25. Key to that legitimate critique was that the various plans and initiatives were understood differently by different layers of the leadership. With the Trust's EDI function changing presently, and a small restructure of the POD team having taken place, I am suggesting that, led by Carlene Holden we develop a simple visual that seeks to capture (and put into plainer language) the 13-15 actions outlined. We would use targeted and specific events in late October to make sure that those who need act to deliver this 'plan' understand not only the actions but who is doing what. This does not preclude very clearly including elements of this anti-racism work within our wider reset discussions at the leader's conference in September – anti-racism having featured strongly in last year's event.

3. The now four themes within the wider reset

3.1 We agreed in May that settlement on language needed co-production. That remains a work in progress. Care seems to divert the discussions into a focus on patient experiences not staff experiences, and, for some, accountability is an affronting term. It remains to be considered whether that 'jar' is helpful or a hindrance. Bearing this in mind, I use the terms support and challenge below.

3.2 In discussion within the Trust People Council, we explored the merits of:

- Getting the basics right: a series of guarantees all our people should expect of their employment experience
- A high support culture: what we want everyone to do behaviourally to care/support (?respect) for one another and operate compassionately at work
- A high challenge culture: how we ensure bi-directional accountability and make sure that respectful challenge and difficult conversations are positively promoted in the Trust
- Distributed leadership: how we build this into how we work, recognising that structurally we have this already, but we need to hear that that is now how it can feel – and acknowledging significant asymmetry of capability

These themes are explored in a short pack circulated with the private Board papers because the material is frank and should not understood as a likely final draft of our reset work. It may be that we will end up collapsing four themes back into two, but the basic right/distributed leadership in different ways seem important call outs to acknowledge – the former for our 'frontline' teams who may be in survival mode, the latter for our middle and clinical leaders who are often focused on their service or team and not always on the 'corporate' view.

3.3 It seems possible now to try and commit to a list of experiences that everyone should have in the workplace, as of right. This will be a more practical list than the national standards, but those standards would deployed as a second layer.

The third layer would then be the behaviours behind our values that were explored in the Board paper in May. Putting that differently:

- Layer one are things we promise to you
- Layer two are things the NHS is saying must happen
- Layer three are those things we would expect of you and ourselves
- Layers one and three are what it means to be RDaSH not just the NHS

We would launch these expectations as part of the support/care part of the cultural commitments work. Launch would mean that during October, November and December we undertook deep engagement across the Trust. This is conversational and has to happen where people work. Senior leaders including Board members would be spending time in those workplaces (in and out of hours) to introduce the support, and to hear what it means to people within their work. Our efforts have to help people solve their problems, even as we introduce beliefs about what will solve those we see Trust-wide. This will likely be happening alongside deployment of the always measures for safety.

3.4 High challenge (accountability) needs to be introduced concurrently. However, there is considerable nuance to how it is narrated with different parts of the Trust. We want our healthcare support workers, peer colleagues, cleaning teams, and others to feel that they can 'stop the line' and hold others to account. At the same time, for senior managers and responsible clinicians the accountability framework will have a different hue. Whilst for some Board members this framework may seem like evident-clarity, our advice is that even at a very senior level it is relatively novel. Our positivity about a delivery mindset, delivery reviews, data led enquiry, and objective setting, is not necessarily shared even within the top leaders' cadre. We need to make the case, to explain the practicalities, and to provide skills training and simulative experiences if we are going to have the impact we know is needed. Building on the LDO, we are working with outside partners to think about a one-year programme of work, which includes but is not limited to skills training, that seeks to support the introduction of this more defined RDaSH Way. This may include the beginnings of a single methodology to improvement, not least because if we introduce more "deliverology" without talking to improvement approaches we will likely end up with the two ideas bifurcated as nasty/nice by 2028.

3.5 It is sometimes helpful to define what we need to avoid, alongside what we need to do. As was acknowledged in the paper in May, this cultural reset requires change among us all, including the people and OD directorate. We need to guard against HR professionals becoming seen as the care/support arm, whilst management is viewed as the challenge/accountability space. As this perhaps implies we need during August, even as we are working through the what more fully, to begin to create space in the work-schedules of both managers and HR colleagues for H2 ready for the how. Both business partners and the revamped OD team, as well as L&D, and professional educational roles, will be needed to play a part in deployment.

3.6 Cultural work, especially overtly led work, often fails because it defaults (or appears to) to a branding exercise. Symbolism is important, and we will need to use such approaches as reinforcement and as 'moments'. But our aim here is to **change daily habits**. Perhaps the most critical of such is to allow real conversations between professions and between layers of hierarchy that do not rely on formal processes, third party interposition, or structured conflict. Better to call in something in real time, better to stop the line than to report elsewhere. That has to come from a place of safety and a belief that we all matter – that RDaSH is all of us.

3.7 Whilst the proposals on anti-racism have a specificity, this wider cultural work remains emergent. The intention now is to use August to sharpen that what-gap, and to focus in September on visualising the how of H2 and 27/28 – noting that this is a four-year hike to 2030, with results expected over the first eighteen months to two years. Q3 26/27 will be us asking our organisation if they agree to this work, and what it means to them: not us telling the Trust's staff that this is it. That will mean learning about the organisation almost anew.

3.8 Board members will recognise longstanding discussions about medical engagement, and indeed behaviours, inside the Trust. We explored in May some facets of that both in public and private session. Andrew Heighton is undertaking some exploratory work to put some 'flesh on the bones' of both what is troubling some colleagues, and how we might respond to that. Notwithstanding that that is ongoing, it is already clear that there are some practical frustrations we want to address, as well as a need to try and reset *mutual* expectations: and talk honestly to bi-directional perceptions. Medical colleagues are an essential part of the care we provide, and at a service level often undertake that work on a very intra-disciplinary basis. However, professional identity matters – as we explored in social work earlier in 2026. We need to, within the cultural reset, provide an insistently multi-professional culture, without allowing that to be portrayed as diminution of status or standing.

4. Co production of the prototype

4.1 Acknowledging the argument above that we will continue to shape and change ideas as we deploy, we nonetheless need a final draft or indeed a prototype to create a conversation. With this in mind, we will be working as follows:

- From mid-August (wb 10/8) a weekly steering group will be meeting to chew over ideas and options: in addition to executive group will use some of our routine time to consider how we foresee this work succeeding and what it will take to arrive at that success.
- We will work with both the CoLE and PFG as our LERO (lived experience recovery organisation) partner, alongside volunteer and peer representatives, to think about how patients, carers and communities can narrate their experiences of change and improvement relevant to this different journey.
- Discussion within ATI in June, July and again in August, with September having a full focus in this space.

- We have open staff meetings starting on August 3rd, and whilst as always we will use those to listen, we will begin to seed these ideas, alongside relevant parallel projects like 'agile' and the estate work, into conversation.
- Each staff network will have an opportunity during August and early September to be introduced to this work and how it might develop.
- As indicated above a specific change for POD colleagues will be established to think through time-release and practice change, and we will use the leaders' conference to do that work with a more cross-sectional cohort of managers.
- Trade union engagement has been taking place via the TPC, but we will introduce this work into other forums of discussion in the hope that this work is seen as a shared endeavour to improve the workplace experience.
- The experience of employee engagement used with the estate plan (roadshows followed by survey) has generally been well received in the organisation – we are working through how to mimic that in September for this slightly more abstract topic. Doing that alongside the launch of the national staff survey is probably a beneficial concurrence: we will be paying to add questions to this year's survey and also pushing hard in Q3 and Q4 on the Pulse survey.

4.2 The output from this work will be reviewed next at the Board's August timeout, in the expectation that what will be explored at the leaders' conference will come to the Board in September. Without losing the nuance we need a simple what / how / why – and that may need to be framed differently for different traditions within our organisation. Part of the success of the Promises has been that most people can see themselves in some of them, and in most cases, they are clear and practical enough. This contrasts with a more 'high level' set of aspirations that are inoffensive but meaningless. That 'promises' test is what the Board needs to apply in the next two conversations, especially in September. If we cannot meet that test we will need to take further time until we do.

Toby Lewis, Chief Executive
Carlene Holden, Director of People and Organisational Development
23rd July 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.

Annex 2

NHS Staff Standards documentation

Staff standards

Line management

Standard

Staff can expect supportive, fair, developmental and compassionate line management, enabled by employer support for line managers, to help staff to perform well, feel valued and fulfil their potential.

Employer actions

To support line managers, employers must:

- embed the NHS Management and Leadership Framework by aligning local communications, strategies, policies, processes, training, appraisal and recruitment to it to ensure line managers have the skills they need
- ensure all managers complete the NHS Management and Leadership Framework self assessment tool and undertake development to progress towards achieving the standards within it
- ensure comprehensive line management training is offered to all line managers, with a particular focus on first-time managers, through the NHS Management and Leadership Framework, so that they are aware of their responsibilities under the expectations of line management guidance, and monitor line manager performance, taking action to improve quality as necessary
- ensure that job plans accurately incorporate and allocate sufficient time for line management responsibilities so that managers have the capacity to meaningfully discharge their role
- ensure all roles have clear, accurate and up to date job descriptions and review role changes promptly through agreed processes when requested, in accordance with the NHS Job Evaluation Scheme
- ensure that all line managers have appropriate supervision, mentorship and support from their immediate managers and that line management policies are easily accessible and actively enable line managers to provide timely support and responses to their line reports
- ensure board level oversight of how line managers are being enabled, by routinely gathering and acting on feedback from line managers about the

systemic enablers they need and the barriers that prevent them supporting staff effectively

- work in partnership with trade unions through local arrangements to build a more illustrative picture of line management on the ground by reviewing data, health and safety risk assessments and culture trends, and assessing compliance with legal duties in line with the Public Sector Equality Duty to proactively assess fairness and monitor impact, for example through equality impact assessments

Line managers must be enabled by their employers to ensurethat:

- all employees receive high-quality appraisals, in line with contractual requirements, that set clear, achievable objectives
- staff development and career progression is actively supported through regular and meaningful feedback and access to appropriate learning and development and support to apply learning in practice
- a culture is created where line managers model behaviours such as openness, respect and inclusivity, and challenge behaviours that undermine this. To enable that culture change, they must:
  - provide compassionate, constructive support to staff, working with staff representatives and trade unions where needed
  - enable a psychologically safe environment where staff feel comfortable to raise issues, knowing they will be escalated where necessary
- teams are led effectively by setting shared objectives, enabling appropriate autonomy, addressing differences constructively and fostering respectful team environments where staff feel connected to their team and able to make a full contribution

Standard

Staff can expect their organisation to protect their health, safety and wellbeing at work. Employers are responsible for supporting staff wellbeing, preventing ill-health associated with work and helping staff to feel safe, cared for and able to perform well.

Employer actions

- appoint a health and wellbeing guardian at board level, who will ensure the organisation is compliant with the standard by ensuring collection of workforce data pertaining to health and wellbeing

- use the NHS Health and Wellbeing Framework to produce a localised health and wellbeing strategy that is built on workforce data and provides needs-driven health and wellbeing support. This will be co-produced through staff engagement and partnership working with unions. It will incorporate the 7 core elements of creating health and wellbeing culture. The strategy will have board-level oversight

- employers must take steps to ensure that, where practicable, staff have access to safe, non-clinical environments to take their rest periods. Where call demand or operational pressures may disrupt break opportunities, employers must ensure policies and rostering practices support staff to take restorative rest as soon as practicable

- employers must ensure that all staff, regardless of work location or shift pattern, have reliable access to nutritious food and drink. For settings where catering or rest space facilities are limited or unavailable, or where the site is too small to sustain such provision (including ambulance stations, community sites and mobile staff), employers should consider implementing practical alternatives. These solutions should prioritise healthier options aligned with NHS food and drink standards and be accessible 24/7 to support staff working irregular hours, including night shifts. Alternatively, employers should ensure that there are safe options

available for staff to store and prepare their own food

- ensure all managers are supported to complete mandated competencies on safety, and health and wellbeing in line with statutory and mandatory training so that all staff can expect health and wellbeing conversations to be embedded into one-to-ones and appraisals, with dedicated health and wellbeing conversations that are supportive and additional to formal HR processes
- ensure managers are trained on how to discuss reasonable adjustments with disabled staff and staff with alternative needs as part of these health and wellbeing discussions, as well as trained on how to sensitively support and encourage staff disclosures about being disabled
- ensure protection and provision for pregnant and breastfeeding staff and for those experiencing perimenopause and menopause
- ensure all staff have access to occupational health and wellbeing support and local services that are needs-driven and in line with the latest specification and ensure that occupational health recommendations are acted upon
- work in partnership with trade unions through local arrangements to review data and monitor progress to deliver improvements that meet local need

Standard

Staff have a right to feel safe and supported at work, in an environment that is free from sexual harassment, abuse and unwanted or inappropriate sexual behaviours. Staff can expect: their organisation to take clear, consistent action to prevent sexual misconduct and harassment; promote a culture of transparency and openness that ensures incidents are reported and acted upon promptly and appropriately; training to be provided on how to recognize and report inappropriate behaviours; and a victim centred approach, with support provided to those affected and lessons learned to reduce the risk of future incidents.

Employers must:

- fully implement the actions set out in the Sexual Safety in Healthcare- Organisational Charter, assessing progress using the sexual safety charter assurance framework, ensuring board level ownership and accountability
- ensure all staff complete Understanding sexual misconduct in the workplace e-learning
- ensure that investigators of sexual misconduct allegations receive specialist training
- ensure they have robust staff policies and processes for dealing with sexual misconduct and that staff do not suffer detriment as a consequence of reporting, in line with victimisation legislation
- share concerns about employees with future employers and host organisations
- ensure all staff are familiar with the sexual misconduct people policy framework so that they understand how to recognise and report sexual misconduct, and what actions should be taken when sexual misconduct is reported and where staff are the perpetrators, including the other policies that might be used
- work in partnership with trade unions and staff networks through local arrangements to provide assurance on support for staff, to shape local plans and to encourage staff to call out where organisations are failing

Standard

NHS staff can expect flexible working (flexibility in how, where and when they work) to be openly encouraged and supported, fairly and equitably considered, and embedded into everyday practice, creating a 'flexible first' culture, rather than treated as an exception.
Requests must be considered objectively and not unreasonably refused, and where they cannot be agreed, alternatives will be explored.

Employer actions

Employers must:

- appoint a board level flexible working champion who is responsible for:
  - promoting and leading improvements in flexible working across the organisation
  - recognising and challenging the barriers to accessing flexible working
  - ensuring implementation of a flexible working action plan
  - promoting a positive organisational culture towards ensuring fair and equitable access to flexible working for all staff

- implement a flexible working action plan using organisational workforce data to ensure a consistent approach across the organisation and individual teams which is owned by the board

- following an equality impact assessment, implement preference-based team e-rostering for all frontline workers (where operationally appropriate) within the organisation to bring flexibility and choice of shift patterns to staff who need to maintain safe services

- collect data on the number of flexible working requests (formal through contractual changes and informal through manager one-to-one discussions) which are approved or rejected, the types of flexible working requests, and broken down by protected characteristic as per the Equality

Act 2010, staff groups and/or professions, bands and at department level

- publish this data for staff and linked to the flexible working action plan set out what actions will be taken to improve areas where there are concerns. This data should also be available to the CQC as requested

- work in partnership with trade unions through local partnership arrangements to assess progress, including by sharing data with unions to enable transparent dialogue in a timely fashion

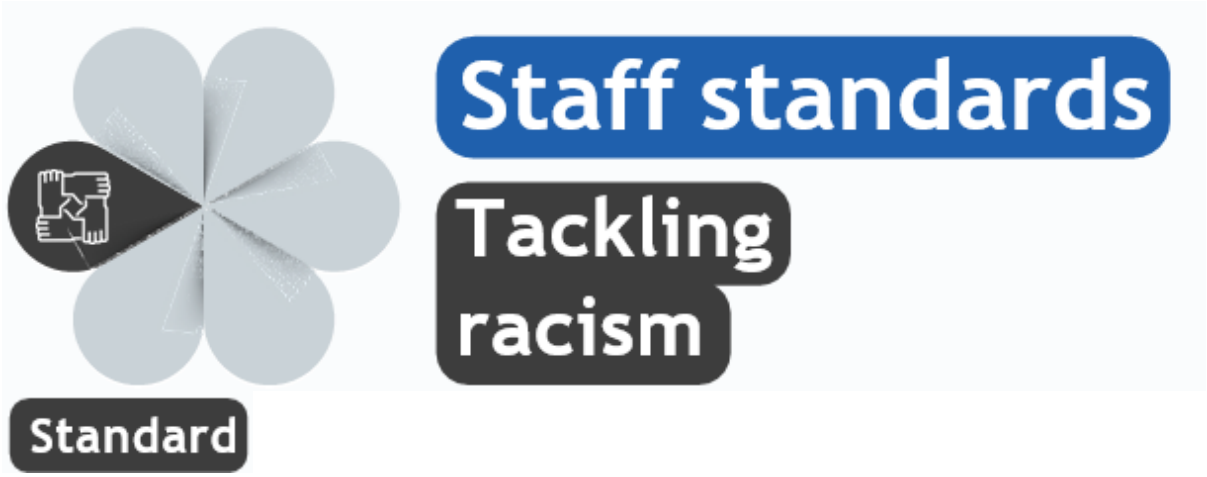
- ensure and evidence that managers, leaders and staff members have training in line with their roles to ensure they are confident to lead flexible teams

- include flexible working as an option in all job adverts, job interviews, pre-retirement conversations, and line manager conversations such as appraisals or regular one to one discussion

- regularly review (at least every 12 months) flexible working (informal arrangements) with staff to ensure they still meet the staff member, team and service needs. Review discussions should be recorded

- ensure your organisation is following the guidance set out in The National Flexible Working People Policy Framework and reference this within the local flexible working policy

- ensure staff within the organisation have been trained and supported with digital skills, infrastructure and resources to effectively use systems that change howthey do their work, in a more flexible way



Staff can expect their organisation to take sustained and meaningful action to prevent and root out racism and discrimination in the workplace (encompassing all forms of violence, abuse and/or harassment from patients and/or service users, their relatives, members of the public and staff), ensuring staff experience safe working environments and a supportive culture where they can expect restorative support, clear accountability and defined consequences in the organisation.

Employer actions

Employers must:

- set clear consequential outcomes for misconduct at the individual level, (including bullying, harassment and discrimination both verbal and physical) including from members of the public, patients, and/or service users and their relatives, and at organisational level. This should include a review of policies related to staff misconduct, and where appropriate, explicitly state the standard of behaviour expected from staff and the penalties including up to dismissal for certain behaviours and/or repeated incidents. It should also include the potential for refusal of care for patients in non-emergency situations, as well as consequences for organisational performance and professional non-compliance (Care Quality Commission (CQC) and/or professional regulators)

- work in partnership with trade unions to ensure representation of the staff voice, reviewing policies to ensure they are fair/proportionate, supporting staff to speak up safely and support during formal procedures to ensure racism is taken seriously in delivering this standard

- ensure implementation and monitoring of the 6 high level impact actions as part of the NHS Equality, Diversity and Inclusion Improvement Plan, and as set out in the NHS Standard Contract

- ensure every board member (including Non-Executive Directors) has a published Specific Measurable Achievable Relevant Time-bound objective on tackling racism. Either the chief executive officer or chief operating officer must be appointed as the senior responsible officer for tackling racism and must be guided by the Race and Health Observatory

leadership toolkit and anti-racism principles. They will be held to account against relevant workforce data and there must be clear incentives in place for strong and clear consequences for poor performance

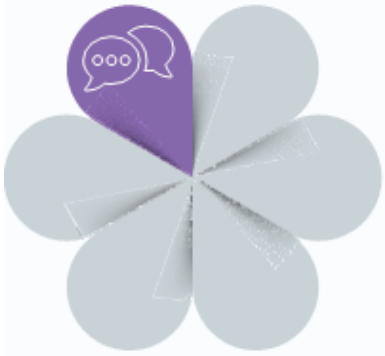
- implement inclusive recruitment and talent management practices by developing a recruitment and career progression plan that ensures equity of opportunity (expanding on the high impact actions and the specific measurable targets as part of the current EDI plan and the workforce race equality standard (WRES))

- work to create inclusive cultures (embedding basic values of culture and respect) that encourage staff at all levels to report and for employers to consistently work to root out racist behaviour. Employers must ensure that their internal reporting mechanisms and systems capture the experience of racism on an individual basis to enable wider analysis and trend monitoring that contributes to local improvement plans in tackling racism

- update emergency protocols and responses to include adequate and appropriate responses that help to maintain safe working environments

- update grievance, disciplinary and investigative processes so they are responsive to the experiences of racism and discrimination and are void of biased applications in their process. Ensure they encourage thorough and unbiased investigation, with careful examination of evidence to clarify when and why racism has not been proven

- where appropriate, evaluate and implement the recommendations of key leading bodies on good practice, to ensure work is reflective of the evolution and growing body of work to tackle racism at every level



Staff standards

Violence prevention and reduction

Standard

Staff have a right to feel safe and supported at work, in an environment that takes meaningful action to prevent violence, aggression, intimidation or abuse in any form. Staff should have access to simple, safe and supportive channels for reporting violence in the workplace; timely, compassionate support after any violent or harmful incident; and the right training to equip them with the confidence and knowledge to keep themselves and others safe.

Employer actions

Employers must:

- implement and embed the violence prevention and reduction (VPR) standard. They should have a named senior responsible officer for VPR with an annual VPR improvement plan, using VPR risk assessment tools and evidence-based interventions in relevant settings
- ensure that reporting systems are in place and actively promoted, so that all staff feel supported to report any incident of violence or abuse, irrespective of a patient's circumstances or condition
- accurate and timely data should be recorded to inform strategies on tackling and preventing violence and feed into national VPR data collections
- ensure staff who are subject to violence or abuse have access to high-quality post-incident psychological and welfare support. Managers should understand how to ensure staff receive post incident support and where to signpost staff to
- develop and implement HR policies and procedures that provide staff with the right support following incidents and during investigations
- ensure that all staff receive training appropriate to their role
- ensure the appropriate health and safety committee and/or forum is engaged in VPR planning and monitoring
- work in partnership with trade unions through local arrangements, staff networks and local VPR groups to provide assurance on support for staff and to encourage staff to call out where organisations are failing. This should ensure that staff voice shapes local improvements with feedback and lived experience underpinning policies and interventions

Annex 3

Wheel of inclusion
(LDO product, credit VMI)

Inequity areas is VMI's newest waste wheel

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

- Use this tool to study a process, programme, or policy to identify inequities
- **Violet** inequities may be experienced by people without power and privilege
- **Blue** inequities may be displayed by people with power and privilege, often unintentionally

Annex 4

Definition of anti-Muslim hostility

Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.

Gov.uk, published 09/03/2026

**Paper to be managed via questions only

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 9 Employment Opportunities	**Agenda Item**	Paper W
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**	30 July 2026

Suggested discussion points

To focus on the second part of promise nine and the plans to develop dedicated recruitment pillars across four different pathways, the associated timescales and the work involved to support this and whether this will deliver the Promise within the associated timescales.

To reflect on the changed approaches required within the People and Organisational Development Directorate and also the wider organisation to support the delivery of the promises and the ongoing requirement to support colleagues. Given our previous experience with volunteers whether sufficient steps have been planned and the organisation is 'ready' to adequately support colleagues joining via these dedicated pathways.

To reflect on the linkages with other work programmes such as the cultural reset and how we drive forward implementation in this area without it feeling tokenistic and causing harm.

Previous consideration

Not applicable.

Recommendation

The Board of Directors is asked:

NOTE the change in practice to support the delivery of the four associated pillars.

NOTE the delay in the delivery of the homelessness pillar, pending external support.

RECOGNISE the change in both managerial and HR practices to support the delivery and the longevity of the promise.

RECOGNISE the impact on both POD and organisational wide areas to support the delivery of this promise.

Alignment to strategic objectives	
SO2: Create equity of access, employment, and experience to address differences in outcome	x
Alignment to the plans:	
People and teams 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.	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.	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.	
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 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 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							
Not applicable.							
Equality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	TBC

Quality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	TBC
Appendix (please list)							
Annex One – Employment Pathways							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
BOARD OF DIRECTORS

Promise 9 – Tailored Programmes of Employment Access

1.0 Summary

1.1 Promise nine is in two parts, the apprenticeship levy, and the tailored programmes of employment. As Board are aware we exceeded (for the first time) in 2025/26 our apprenticeship levy spend and we expect to do the same again in 2026/27. The purpose of this paper is not to cover the success of the apprenticeship levy, but the second part of promise nine and the tailored programmes of employment, where delivery has been limited to date.

1.2 The second aspect of Promise 9 commits to widening access to employment by removing barriers and creating meaningful employment opportunities for people from underrepresented communities. Whilst this should also have a positive impact on the Workforce Disability Equality Standard (WDES) which is legally mandated in the NHS Standard Contract. This not the reason for undertaking the work. The work is also closely linked to the culture rest work which was discussed at Board in May 2026 and again in July 2026 as we need a culture which helps staff to feel supported, engaged and listened to.

1.3 As part of this work there is an opportunity to develop a more coordinated, structured, and sustainable approach that creates clear pathways into NHS employment for individuals who traditionally experience inequalities in accessing employment.

1.4 Recruiting and retaining a skilled talent pipeline, which comprises staff with the right skills to deliver high-quality patient care is a key focus for the NHS. For some roles applicants are limited in number, it is important that the workforce is supported to thrive and disadvantaged applicants are encouraged to apply for roles in RDaSH and also across the country.

1.5 Attracting and retaining disadvantaged, disabled people and those with learning disabilities and difficulties (LDD) requires an organisation-wide approach, underpinned by shifts in culture, and authentic and open leadership. Therefore we have been measured with our delivery of this aspect of Promise 9 to ensure we have a solid foundation to build upon and strong partnerships developed (which facilitate candidate reach) and to learn from the experience of achieving Promise 3 (Volunteers) and the wider pastoral support which is required, similar to what will be required for this promise and the learnings associated with the delivery.

This paper proposes the development of a Trust-wide Widening Access to Employment Programme bringing together a number of targeted employment pathways under one strategic framework.

The programme would initially focus on four priority groups:

- People with Learning Disabilities and/or Autism
- Refugees
- Care Leavers and Young people/ Not in Education Employment or Training (NEETs)
- Members of the Armed Forces Community

With a fifth area to following utilising external expertise, homelessness.

2.0 Background

2.1 Many individuals within our local communities continue to experience barriers to accessing meaningful employment despite possessing valuable skills, experience, and potential. One of the most effective approaches is to move beyond simply being "open to applications" and actively design the campaign around accessibility, supported employment and inclusion.

2.2 These barriers include:

- Lack of work experience
- Unfamiliarity with NHS recruitment
- Reduced confidence
- Language barriers
- Limited understanding of NHS careers
- Additional support needs
- Challenges transitioning from education or military service

2.3 Developing structured employment pathways supports the Trust to become a more inclusive employer, improve workforce diversity representing the communities we serve.

3.0 Proposed Widening Access Framework

3.1 Each pathway would follow the same five stages. The specific details for each of the pillars are contained in Annex One.

3.2 **Stage 1 – Engagement and Early Connection**

The aim is to build confidence and awareness of RDaSH and career opportunities before recruitment begins.

Activities include:

Engaging with the local community	Co-production	Introduction to RDaSH and NHS careers
Values and behaviours workshops	Career awareness sessions	Workplace/Venue/Site visits
Staff ambassadors	Lived experience speakers	Confidence building
Identification of barriers	Signposting to external support services	

3.3 Stage 2 – Pre-employment Support

Participants receive tailored employability support including:

Assessing skills and identifying solutions to barriers	Completing NHS applications/ CV writing	Interview preparation
Mock interviews	Understanding NHS recruitment	Digital skills where required
Advice regarding right to work documentation	Support identifying suitable vacancies	

3.4 Stage 3 – Placement or Work Experience

Participants undertake structured placements appropriate to their pathway.

Placements may include:

Supported internships	Work experience	Work trials
Departmental rotations	Volunteering opportunities	Apprenticeship tasters

Each placement would include:

3.5 **Stage 4 – Recruitment and Onboarding**

Support continues throughout recruitment as this can be the most challenging stage, transitioning from unpaid to paid employment.

This includes:

Assistance completing applications	Access to technology for job searching and completing applications	Access to technology for job searching and completing applications
Interview support	Guidance with pre-employment checks	Implementation of reasonable adjustments
Health Passports where appropriate	Tailored induction	Workplace buddy
Underpinned by the following		
Easy Read versions of adverts, job descriptions, and recruitment information	Plain English with minimal jargon and acronyms.	Short videos explaining the role and what to expect.
Clear contact details for applicants who need support completing applications.		

3.6 **Stage 5 – Retention and Career Development**

Support continues following appointment as colleagues require ongoing support and coaching.

This includes:

Regular wellbeing check-ins	Mentoring	Career conversations
Development opportunities	Progression into apprenticeships	Access to Trust network

4.0 Principles

The following principles would underpin every pathway.

4.1 **Co-production**

Services have been designed alongside people with lived experience, community partners, and staff networks and will be reviewed by the same cohort.

4.2 **Partnership Working**

Strong relationships are developed with:

- Community Partners
- Local Authorities
- Colleges
- VCSE organisations
- Department for Work and Pensions
- South Yorkshire Mayoral Combined Authority
- NHS partners
- Local CICs

4.3 **Inclusive Recruitment**

Recruitment processes will be reviewed to minimise barriers whilst maintaining fair and transparent selection.

4.4 **Evaluation**

Measures of success will include:

- Referrals received
- Placements completed
- Appointments made
- Retention rates
- Participant feedback
- Manager feedback
- Diversity measures
- Social value outcomes

5.0 What needs to change?

5.1 **People and Organisational Development (POD) Directorate**

5.1.1 Within the POD Directorate we need to ensure that our recruitment team have the time to support colleagues who are interested in applying for opportunities associated with the pillars, to increase the number of applicants and then support those applicants through the recruitment process and the onboarding, which for all colleagues, can be difficult at times to navigate.

5.1.2 At the present time, the recruitment activity is high, given the drive to fill our vacancies, the vacancy position has increased in late 2025/26 and early 2026/27 which was further compounded by an increase in turnover in late 2025/26. However, we expect the recruitment activity to stabilise in H2 which will provide time for the recruitment team to focus on this workstream. This will be further supported by the move to organisation wide recruitment panels in September 2026 for a number of vacancies which will reduce the number of individual advertisements and then the associated administration with the management of separate advertisements. As we move to this new way of working, we will undertake a review of our working practices to further

streamline, where possible, the recruitment and associated administration to hopefully release time and improve the applicant experience.

5.1.3 The Recruitment team will review our advertisements, applicants, interview processes, and the associated onboarding to identify revised approaches to support the recruitment across the pillars and design dedicated recruitment campaigns across the pillars.. This is likely to be an iterative process in which we will apply a PDSA approach seeking feedback and engagement from the recruitment team, recruiting managers and the applicants.

5.1.4 In addition to the recruitment team, the Employee Relations Team will need to support managers with a compassionate approach linked to the policy framework which is tailored to individual needs. Whilst we have a number of training programmes further development opportunities will be offered to managers as part of the Learn Half Days in 2026/27.

5.1.5 Alongside the above, we will undertake a review of the Trust Induction programme to ensure this continues to meet the diverse range of needs and provides a solid foundation to all colleagues joining the Trust.

5.1.6 In summary, the POD team approach will need to be more forward facing across the organisation and our communities to respond timely to emerging and changing needs.

5.2 **Managers**

5.2.1 Reflecting on our experience of volunteer recruitment, we should not underestimate the amount of pastoral support, which is required for colleagues, which some managers found difficult to embrace and stated a constraint being the lack of time.

5.2.3 Our limited success to date in the delivery of Promise nine has been heavily reliant on pastoral support which has remained following the recruitment/placement which has built a level of trust and wider development opportunities, but this has focussed on a small number of committed managers rather than the wider management cohort, which needs to be addressed as part of the wider roll out.

5.2.4 With one of the pillars (Learning Disabilities and Neurodiversity pathway) we have identified a number of posts which we will actively market and encourage applications from applicants from within this cohort. This allows additional bespoke support to the applicants and the management team, to apply a proof-of-concept model, prior to a more extensive roll out. We will also promote our success with colleagues who have progressed via this pillar, whilst limited in number, the personal impact is significant.

5.2.5 Key managers will be assigned actions to support the recruitment across the pillars, and they will then act as change agents within their Teams.

5.2.6 Managers will also need to tailor their approaches to meet individual needs, whilst this is an expectation for all colleagues, the requirement is heightened, especially in the first few months of a placement/employment to ensure success. At times, this is challenging for some of our managers as they apply the policy framework rigidly and struggle with the application of management discretion.

6.0 Professional Lead support

6.1 To support a refugee healthcare professional to *revalidate* or *re-enter practice* in the UK, we will need to support colleagues to help them navigate registration**,** English-language exams**,** clinical adaptation, and NHS workplace integration**.** There is a network of support channels available which we will access primarily via Building Bridges and ReSTORE. These programmes provide exam preparation, pastoral support, work placements, and guidance through GMC/NMC/HCPC processes. We will utilise Building Bridges for Medics and ReSTORE for Nurses and AHPs, this will be in conjunction with the professional leads and the wider pastoral support.

6.2 However there is a key step prior to supporting refugee colleagues with their revalidation or to re-enter practice, we need to ensure we have a prominent place and advertise our vacancies on the Refugee Employment Support App, which NHS Employers have launched in partnership with Ryalto. The digital app is designed to help refuges explore and access employment opportunities, providing clear information on NHS job opportunities across three key pathways – entry level roles, nursing and AHP roles and doctor roles. This will then increase our reach within the refugee community.

6.3 It is recognised that some refugees require limited support with revalidation or to re-enter clinical practice as they are seeking employment in an administration, managerial or support service role and we need to ensure these colleagues are equally supported to access our vacancies and opportunities, rather than a sole focus on the clinical role.

6.4 In September 2026 we will advertise our first ring fenced roles within the Learning Disabilities pillar for Domestics to join the organisation. This will involve a bespoke recruitment campaign and extensive support to applicants to facilitate their successful appointment and then wider pastoral support. We will review or success, or not in late Q3/Q4 prior to a more extensive roll out.

7.0 Delivery Plan

7.1 The intention is to progress delivery across all the four pillars in 2026/27, but some will have more success than others this financial year due to some national workstreams and associated advertisements dates.

The delivery plan is detailed below

Pillar	Delivery Plan
Learning Disabilities and Neurodiversity	Continue with the current approach in 2026/27 which has proved successful for a small number of applicants and then commence Project Seach in February 2027. Should there be any applicants which Project Search are unable to place in 2026 we have advised that we would be delighted to support the colleagues in advance of the 2027 recruitment
Refugee Employment	Delivery in 2026/27 with targeted recruitment, improving the employer brand and the visibility of our support in this area. Commitment to the digital app, Refugee Employment Support App in Q2/Q3.
Armed Forces Community Employment Pathway	Delivery in 2026/27 with targeted recruitment, improving the employer brand and the visibility of our support in this area.
Care Leavers and NEETs	Delivery in 2026/27 with targeted recruitment, improving the employer brand and the visibility of our support in this area.

8.0 What does success look like?

8.1 It would be easy to define a set number of colleagues to be recruited through each of the pathways, but this is likely to become a target which appointing officers feel they are being performance managed against, as was the case with the volunteer recruitment. When what we need is the opposite, a cultural shift to embrace and support colleagues from these pillars.

8.2 It also isn't about recruiting a set number for each of these pillars, but colleagues' development, experience, promotion and retention across the pillars. The recruitment opens the door but does not ensure the colleagues thrive, proposer and remain in our employment.

8.3 We need to demonstrate though both quantitative and qualitative data (workforce data and lived experience) that every candidate has a fair chance to enter, progress and thieve which leads to a more representative, stable and high-performance workforce, which is also reflected via our WDES and WRES data. Therefore, a positive aspect should be the improvement of these nationally benchmarked data points. A suggested framework, may be along the following lines

Area	What You Measure	What Success Looks Like
Representation	Workforce vs. community demographics	Reflects local population
Equity	Pass-through rates	No structural bias
Experience	Candidate feedback, adjustments	Fair, respectful, transparent
Outcomes	Retention, progression, belonging	Diverse hires thrive

8.4 Given the focus though in this area, we should expect a number of colleagues to access employment via the pillars prior to the end of the current strategy in 2028 and then to further access development opportunities. In Q2 a detailed deliver plan will be finalised which will include aspirational numbers and the delivery period.

9.0 Recommendations

91 To note the change in practice to support the delivery of the four associated pillars.

9.2 To note the delay in the delivery of the homelessness pillar, pending external support.

9.3 To recognise the change in both managerial and HR practices to support the delivery and the longevity of the promise.

94 To recognise the impact on both POD and organisational wide areas to support the delivery of this promise.

Carlene Holden
Director of People and Organisational Development
July 2026

Annex One

Employment Pathways

1. Learning Disabilities and Neurodiversity Pathway

Aim

To increase sustainable employment opportunities for people with learning disabilities and autistic people through supported work experience and employment opportunities.

Proposed Offer

- Supported internships (3–6 months)
- Flexible placements based upon individual need
- Two or three departmental rotations person centred
- Named workplace mentor
- Weekly pastoral support
- Employability workshops
- Confidence building
- Interview preparation
- Entry-level NHS roles
- Individual transition into employment

Placement areas currently identified include:

- Administration
- Domestic Services
- Catering
- Facilities
- Support Services

Delivery Method

As part of this workstream we will operate two models in the first twelve months and then evaluate the success, or not, of both models. This includes an internal model with vacancies being advertised in the above service areas and then also an external model, Project SEARCH Partnership, which will provide structured supported internships delivered alongside education partners to commence engagement February 2027 for a Cohort starting in September 2027. It is hoped that we may be able to test a proof-of-concept model in 2026, but this is yet to be confirmed. In addition to the above options, not all applicants will ‘fit’ into either model and where this is the case, we will offer ‘job carving’ (designing a role around tasks that match an applicant’s strengths which we have already undertaken informally on a few occasions.

2. Refugee Employment Pathway

Aim
To support refugees with the right to work into NHS employment by recognising existing skills whilst addressing barriers to employment.

Proposed Offer

- Career conversations
- Skills and qualification mapping
- English language support where appropriate
- NHS recruitment workshops
- Application support
- Departmental work placements
- Interview coaching
- Pastoral support
- Career development planning

A common barrier is that experienced professionals are under-employed because their qualifications are unfamiliar to UK recruiters. Recruiting managers will be encouraged to:

- Consider transferable skills
- Value overseas leadership and clinical experience
- Avoid unnecessary UK-experience requirements
- Support professional registration pathways where appropriate

Referral Sources
- Thrive Capital CIC
- Local Authority Refugee Teams
- Refugee Integration Service
- Doncaster Conversation Club
- ReSTORE **(Refugee Support, Training, Orientation, Recruitment and Education)** programme, which combines recruitment support with strong pastoral support and system partnerships to help refugee nurses return to practice
- Community partners

3.0 Armed Forces Community Employment Pathway

Aim

The Armed Forces community includes veterans, reservists, service leavers, cadet force adult volunteers, wounded, injured or sick personnel, and military families. It is recognised that their values often align strongly with NHS values, including service, commitment, teamwork, and respect.

Proposed Offer
- Career mapping
- Skills translation
- Work trials

- Application support
- Interview coaching
- Retraining opportunities
- Pastoral support
- Mentoring, which includes an offer of mentoring by veteran colleagues
- Signposting to specialist wellbeing support

Referral Sources
- Community Partners
- Career Transition Partnership
- Step into Health
- Armed Forces Covenant
- Local Authority Armed Forces Leads

4.0 Care Leavers and NEETs

To support care leavers and young people not in education, employment, or training (NEET)
Recent NHS guidance explicitly identifies care leavers and disadvantaged young people as priority groups for widening participation and social mobility. The Fit for the future 10-year health plan also states that the NHS will actively support care leavers and continue its commitment as a signatory to the Care Leaver Covenant. Whilst this may increase the provision across the NHS, we identified this as an area of focus in 2023.

Proposed Offer
- Application support
- Interview coaching
- Pastoral support
- Mentoring

Referral Sources
- Community Partners
- Local Authorities
- Affinity (CIC) Rotherham
- Leaving Care teams
- Virtual schools
- Job Centre plus
- Youth Hubs
- The Kings Trust

This aligns to our ambition to use employment as a vehicle for social mobility while recruiting more people directly from our local communities.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Engagement and Disengagement data	**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**	30 July 2026

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

DNA numbers have increased while disengagement discharges have remained relatively stable. Are increasing numbers of DNAs are sign of more proactive engagement or are there other interpretations to consider?

Previously disengagement has been viewed as a patient problem but we have progressed work to increase understanding that services themselves may contribute to disengagement. How much evidence do we have that this has made it to frontline services?

Work around disengagement is receiving national attention given the Nottingham (Calocane) case. Do we have assurance that we have learned from the work that has come out of this?

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:

NOTE the national and local learning relating to disengagement from mental health services, including learning arising from the Nottingham (Calocane) case and the Trust's October 2023 Prevention of Future Deaths Report.

NOTE the implementation of the revised Engagement and Disengagement Policy in September 2025

RECEIVE the findings of the first Trust-wide audit examining DNA activity and discharges due to disengagement.

REQUEST a further assurance report following completion of the next audit cycle (Q2) to demonstrate progress and identify any additional improvement actions required. This next cycle should include data from local dip samples. To improve governance around these local audits these should be added onto the Quality and Safety Group workplan to enable bimonthly review but then also analysis of any cross cutting issues that emerge.

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

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.	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 (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 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)

Table 1 – DNA numbers
Table 2 – Discharges due to disengagement

Rotherham Doncaster and South Humber NHS Foundation trust

Board of Directors

Engagement and Disengagement data

1. Background

1.1 Engagement with mental health services is fundamental to the safe delivery of care. Whilst many patients actively seek treatment and remain engaged throughout their care, others disengage either temporarily or permanently. Disengagement may occur for many reasons including deterioration in mental illness, lack of insight, medication side effects and patient choice. It can be appropriate for patients to utilise their autonomy and choose to disengage from services but sometimes this can have devastating results.

1.2 The fatal attacks in Nottingham in June 2023, perpetrated by Valdo Calocane, highlighted the risks associated with disengagement from mental health services. The subsequent independent review identified repeated episodes of missed appointments, disengagement from follow-up and discontinuation of antipsychotic medication. This alongside missed opportunities to reassess risk, consider more assertive engagement and other interventions.

1.3 This national learning mirrors concerns identified locally. In October 2023 the Trust received a Prevention of Future Deaths Report following the death of a patient where concerns were identified regarding follow-up after antipsychotic medication had been discontinued. The Coroner highlighted shortcomings in maintaining engagement and ensuring adequate follow-up after treatment had ceased.

1.4 Following this Prevention of Future Deaths Report we committed to the Coroner of rewriting our Disengagement Policy to focus on Engagement such that it is the Engagement and Disengagement Policy.

1.5 The revised Trust policy recognises that disengagement is often multifactorial and that services themselves can unintentionally contribute through barriers to access, communication or inflexible models of care. Rather than concentrating solely on managing disengagement once it occurs, the policy places equal emphasis on proactively promoting engagement throughout a patient's care journey.

1.6 The National Confidential Inquiry into Suicide and Safety in Mental Health has consistently identified non-attendance and loss of contact with services as recurring features in both suicide and homicide investigations, further emphasising that disengagement should prompt active review rather than passive discharge. This evidence is reflected within the revised Trust policy.

1.7 Whilst recognising these risks, the Trust must also respect the rights of adults who have mental capacity to refuse treatment or decline ongoing involvement with services. One of the key changes to the new policy was that any decision to discharge a patient open to secondary mental health services is supported by a robust multidisciplinary discussion.

1.8 Recognising that policy implementation alone is insufficient, the revised policy also introduced new assurance processes requiring routine audit of Did Not Attend rates and discharges resulting from disengagement across mental health services. These audits provide the Board with ongoing oversight of engagement patterns and enable services to identify unwarranted variation and opportunities for quality improvement.

1.9 This was in addition to existing audits completed at team level where dip samples would be completed and compliance against the policy for DNAs and Disengagement discharges would be completed and discussed in local quality meetings.

Audit Findings

2. DNA rates

2.1 The audit demonstrates in Table 1 shows that non-attendance remains common across mental health services, although the frequency varies considerably between specialties. Community Mental Health Teams account for the largest volume of missed appointments but these teams also have higher numbers of patients on caseload compared to specialised teams such as Assertive Outreach.

2.2 There are different team configurations and pathways throughout the localities and so making direct comparisons between localities is difficult. There are higher numbers of DNA'd appointments in Rotherham Older Adult teams compared to comparators. The number of DNA'd appointments has increased in both Doncaster and Rotherham but remained largely similar in North Lincolnshire. Doncaster Home Treatment has seen an increasing number of DNAs whereas Rotherham has seen a decrease in number.

2.3 The adult CMHTs have the highest number of DNAs but there is variation amongst these. Even taking into account the larger population size Doncaster appears to have disproportionately more DNA'd appointments compared to other localities.

2.4 In terms of trends over time the main trend of note is that DNAs have broadly been increasing across most Rotherham services. This is not consistently replicated in the other localities.

3. Discharge due to disengagement

3.1 The data in Table 2 shows that the number of patients discharged from Assertive Outreach services is very low with only 3 patients being discharged due to disengagement across the entire time period. This is despite the number of DNA appointments increasing for these patients. This potentially suggests that despite repeated DNAs patients are remaining within the service and not being discharged which is encouraging. Other specialised psychosis services also have relatively low rates of discharge.

3.2 The PCNs have the highest rates of discharge for disengagement and this triangulates with their high DNA rates. This patient group would be less likely to have significant risks given that this is a lower intensity service and so does not necessarily indicate a high level of risk.

4. Limitations of the audits

4.1 This data helps to quantify the rates of DNA and discharge from disengagement. Whilst this quantitive data can provide some reassurance of the scale of these issues it can not provide detail about where discharge occurred was the new policy followed.

4.2 These rates of DNA and Discharge have also not been normalised to caseload size or team contact numbers and so larger localities such as Doncaster would be expected to have higher numbers of these events.

4.3 This central quantitive audit could be more richly analysed with having local care group data alongside as this would potentially allow for refuting or confirming hypotheses whereas the current data given its high level mainly allows for hypothesis generation.

4.4 The urgent Q2 audit work needs to focus on the various actionable steps contained within the policy and ensuring that all teams are now applying those. The three clinical executives will work jointly to ensure that this analysis is prioritised.

5. Conclusions

5.1 The revised Engagement and Disengagement Policy represents a significant strengthening of the Trust's approach by placing greater emphasis on promoting engagement and understanding the reasons for disengagement. At the core of this is improving multidisciplinary decision-making and ensuring that discharge decisions fully consider foreseeable future risks.

5.2 Recently the rate of DNAs has increased but the rate of discharge for disengagement has remained broadly similar when looking across the Trust as a whole. This may indicate that teams are trying to more assertively manage cases and not necessarily looking to discharge when a DNA occurs which is positive.

5.3 Explaining some of the differences with solely quantitative data is not possible and local dip sample data where fidelity with the Engagement and Disengagement policy is assessed would allow for a more comprehensive assessment of compliance with the new policy.

6. Recommendations

The Board is asked to:

1. **Note** the national and local learning relating to disengagement from mental health services, including learning arising from the Nottingham (Calocane) case and the Trust's October 2023 Prevention of Future Deaths Report.
2. **Note** the implementation of the revised Engagement and Disengagement Policy in September 2025
3. **Receive** the findings of the first Trust-wide audit examining DNA activity and discharges due to disengagement.
4. **Request** a further assurance report following completion of the next audit cycle (Q2) to demonstrate progress and identify any additional improvement actions required. This next cycle should include data from local dip samples. To improve governance around these local audits these should be added onto the Quality and Safety Group workplan to enable bimonthly review but then also analysis of any cross cutting issues that emerge.

Dr Diarmid Sinclair

Chief Medical Officer

Table 1 – DNA numbers

Locality	Type of Service	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Doncaster	Assertive outreach	68	291	373	240
North Lincs	Assertive outreach	180	98	90	115
Rotherham	Assertive outreach	117	138	191	329
Doncaster	CMHT General Adult	1,295	1,361	1,586	1,699
North Lincs	CMHT General Adult	225	264	210	210
Rotherham	CMHT General Adult	695	641	772	759
Doncaster	CMHT Older Adult	50	46	68	97
North Lincs	CMHT Older Adult	66	76	66	66
Rotherham	CMHT Older Adult	397	356	408	623
Doncaster	Crisis	16	22	10	10
North Lincs	Crisis	0	0	0	0
Rotherham	Crisis	8	2	18	10
Doncaster	Early Intervention	383	372	294	267
North Lincs	Early Intervention	132	184	165	190
Rotherham	Early Intervention	142	111	188	292
Rotherham	Hospital Liaison	20	8	10	20
Doncaster	Hospital Liaison	2	4	2	0
North Lincs	Hospital Liaison	0	4	0	0
Doncaster	Home Treatmen Team	190	205	204	198
North Lincs	Home Treatmen Team	70	34	28	51
Rotherham	Home Treatmen Team	132	66	77	88
Doncaster	PCN	474	686	645	766
North Lincs	PCN	542	536	536	665
Rotherham	PCN	948	1,276	1,227	1,136

Table 2 – Discharges due to disengagement

Locality	Type of Service	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Doncaster	Assertive outreach	0	0	1	0
North Lincs	Assertive outreach	0	0	1	0
Rotherham	Assertive outreach	1	0	0	0
Doncaster	CMHT General Adult	18	12	23	20
North Lincs	CMHT General Adult	5	6	7	3
Rotherham	CMHT General Adult	31	22	33	35
Doncaster	CMHT Older Adult	11	8	13	6
North Lincs	CMHT Older Adult	11	10	14	10
Rotherham	CMHT Older Adult	95	67	54	65
Doncaster	Crisis	21	12	6	16
North Lincs	Crisis	0	0	0	0
Rotherham	Crisis	45	32	38	49
Doncaster	Early Intervention	10	7	5	4
North Lincs	Early Intervention	0	3	0	1
Rotherham	Early Intervention	3	3	5	4
Doncaster	Hospital Liaison	43	31	20	19
North Lincs	Hospital Liaison	18	20	8	8
Rotherham	Hospital Liaison	50	49	40	36
Doncaster	Home Treatment Team	11	22	6	9
North Lincs	Home Treatment Team	13	14	8	4
Rotherham	Home Treatment Team	2	2	0	2
Doncaster	PCN	136	164	193	199
North Lincs	PCN	95	180	181	146
Rotherham	PCN	116	160	182	163

**Paper to be managed via questions only

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 10 Inclusion Healthcare – where are we up to?	**Agenda Item**	Paper Y
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Nicola Abdy, Strategic Development Lead and Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	30 July 2026

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

The paper is an updated version of one reviewed within the public health, partnerships and patient involvement committee: itself a build on consideration within the Equity and Inclusion Group. It is possible both to be pleased with scale of work being done, and struck by the gaps to be filled.

The Board's attention is drawn to the expected 'pinch point'. As we gather the NICE assessment outcome (homelessness) and finish the 'mystery shopper' work (all domains), we suspect that access and stigma issues with 'general' services (as distinct from bespoke ones) will need a concerted response. The 2027/28 investment fund will likely need to help to further expand bespoke provision, even as we lean into grant applications to provide 2 year funding for important pilot projects.

Previous consideration

Public Health, Patient Involvement and Partnerships Committee held 22 July 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

REAFFIRM our individual commitment as Board members to explore seldom heard voices which we discussed when we held our timeout in April

NOTE the quadrant judgement explored with the committee

RECOGNISE the work to do during H2 to cover all IH groups and all places

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

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

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.	
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)							
Inequalities remain a place priority: inclusion health is however not 'just' an inequality							
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 Summary view of bespoke service coverage Annex B Visual effort to show analysis outlined in later paragraphs of the paper

ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Promise 10 – working forward

Introduction and purpose

1.1 The focus of the Council of Governors on this promise has been helpfully insistent over some time. It may be that, as we have done with transitional care, it is useful to take each domain of inclusion health into those meetings. The Board too has been concerned about the pace of progress, notwithstanding the intent we all share. This paper provides:

- a current stocktake of what we are doing
- confirms the next steps we have planned, which have action owners
- considers that against our 'assurance' model
- highlights a key future pinch point

1.2 Board members within our timeout in April began to explore the depth of our understanding and experience with Inclusion Health. This cohort of citizens spans five areas of life-experience[1] that people typically 'wish to move away from' – together with Gypsy-Roma Traveller communities on which the committee has had prior expert briefing. This paper does not outline how we will all as individuals take that effort to better understand forward, but we will return to that agenda in the August timeout with a few to facilitating time and places of understanding.

1.3 We outline here work being done and try and set out how that is governed for a measure of success, recognising that the success measures we have for this promise combine our own self-assessment (NICE), with the view of others. As a reminder the three success measures for Promise 10 are:

a. Specific service offers in place for all or most inclusion health groups by 2027
b. Meet standards set out in published guidance issued by NICE/NHS England (2022)
c. Internal audit confirms access rates being met and feedback from specific communities corroborates that insight

Do we understand the issues and what work is taking place to address them?

2.1 Contrary perhaps to the lay impression, the literature from research on these topics is fairly comprehensive and well developed. Multiple disadvantages (another frame for inclusion health) lead to systematic exclusion from statutory services. This happens because of stigma, shame, and because

[1] Homelessness, sustained addiction, forced migration and refugees, sex workers, prisoners and ex prisoners

survival does not leave scope sometimes for health to be prioritised. A compelling response to that requires deep end engagement with those with very complex lives, but it also needs statutory providers to both offer bespoke services and to make routine service stigma-free/trauma informed.

2.2 In terms of deep engagement, we have made a strong start in the following ways:

- We have worked closely with the amber project, which is a sex worker focused initiative based on Doncaster – as well as with the third sector in Scunthorpe.
- We have built relatively strong relationships with those with lived experience of homelessness in Doncaster – and that work is deepening currently in North Lincs both as part of the grant bid and in readiness for the opening of the Acorn Centre[2].
- The Trust has various points of current connection into local prisons, both through governor contact and in work with NHS England associated with health access for prisoners.
- Over two years, since briefings to our public health committee, we have been working with the local GRT community, creating dedicated roles for this purpose in adult and children's services
- We remain for Doncaster the drug and alcohol specialist service provider and that service has an established pattern of user engagement and involvement and significant lived experience recovery work within its remit
- Through our collaboration with Rush House, Changing Lives, and Apna Haq in the CoLE we have the opportunity to build a better understanding of refugee and migrant health experiences locally

We recognise that there are gaps within the list above, both in terms of coverage and in terms of geography. *Broadly our network of involvement is stronger in Doncaster, and weakest in Rotherham*. The intention is to formalise a stakeholder and partner mapping exercise over the coming three months in order to allow us to make targeted approaches to grow those involved with this work. **A simple ticks and crosses diagram an annex A visualises a self-assessment of where we are now. This tilted towards RDaSH involved offers, not population offers from other agencies.**

2.3 For the last six months, the focus has been on seeking to develop bespoke service models where that would be appropriate, or to lean into the work of others where a different provider (VCSF typically) may have better reach to do the work.

a) In Doncaster, funded by the so-called 'public health monies', we now have - live and with caseload - **homeless health team**. This is an eighteen-month experiment in offering mental health support directly to those experiencing

[2] The Acorn Centre is the new name for our 24/7 urgent care mental health service which launches on 30/09/26

street homelessness and itinerant housing. The MDT is connected to sessions purchased in primary care and will have psychiatry input that reaches into our wards. Though based with Aspire, the service is not wholly focused on those addiction backgrounds. Likewise the service has been built alongside colleagues in physical health and has established pathways for joint assessment where that is needed.

b) We continue to work closely with LA funded **GRT case workers**. In practice this means we are offering clinical service input by invitation into local traveller sites, for adults, and gently for children and young people. We have not widely publicised this work as that has the potential to impede its effectiveness and trust among the GRT community.

c) A **sex worker focused mental health practitioner** is now based within our Doncaster CMHTs, working alongside the Amber Project. This post is both providing clinical input and working to self-assess services for their suitability for clients to use our services.

d) The expansion of our TRS service into North Lincolnshire has focused on **partnership with DV and refugee related voluntary sector group**s: there is more to do to have the service established by Jude Graham offers assurance and confidence within delivery reviews that the service will be fully in place before the end of 2026.

e) We are working with **prison services**, specifically in Doncaster, to do two things – to improve the pathway of access to our services, for example memory assessments – and to establish how we can better connect with those exiting prisons, who we know routinely fall through 'the net' and whose health needs move from a private prison health model into NHS service.

As with the engagement there is not an even spread to these efforts, albeit in some way that reflects not organisations but populations. Doncaster has the largest GRT, rough-sleeping, refugee and prison cohorts within the RDaSH footprint.

2.4 But the other aspect of our response has to be to improve understanding of Inclusion Health among our teams, and **access to so-called mainstream services.**

We have worked with the Pathway organisation to deliver specific inclusion health training to those stepping into the roles cites above. In addition, by November, we will have in place a training package of material which can be used across Learning Half Days in Q4 2026/27. We know that that training will work best if it reflective and discursive not simply knowledge sharing, as we need to create spaces for professionals to consider their fears and experiences of working in this field.

But in order to understand better the use of our services (bear in mind there is no 'data flag' for inclusion health, nor arguably should there be) we have been

working with those with lived experience to ‘mystery shop’ our services. An assessment tool for this purpose has been co-designed and co-produced (it is arguably astonishing that no such tool existed in the literature). It has been applied in some services as an initial test, and we anticipate by the middle of October that we will have assessed urgent and community health service access in all three places. The mooted pinch point is that if the pilot work is validated by the wider work, it is apparent that services represent a significant barrier for some elements of Inclusion Health in terms of:

- Criteria for exclusion
- Location and wider cultural accessibility
- Contact structure

Changing these apparent patterns will not be as simple as altering local working instructions, although that will need to happen. As considered in the training comments in this paper, we know that these systems of exclusion arise for a reason or from experiences that professionals cite, and we have real work to do to help colleagues to work with different arrangements.

What does the evidence tell us we need?

3.1 For some inclusion health groups, there is not a documented or validated model of what *service arrangements* might be most effective. The exception to that is homelessness, where there is NICE approved guidance for system’s service structures. Though aimed at ‘commissioners’, it can be readily applied to our view of the services in place. A draft self-assessment against those NICE criteria has been developed as part of the work done to create the Doncaster Homeless Health Team and submitted to the NICE assessment process – the wider self-assessment is due by September across the full geography of RDaSH.

3.2 Inevitably the assessment will describe gaps in service and reflect some of the barriers outlined earlier in this paper. However, it should provide a very clear basis for investment decisions moving into 2027/28 – by November, we will have in effect the data from our own self-assessment about bespoke services and the data from the lived experience analysis about mainstream services.

3.3 The challenge we need to meet is to use the development of bespoke service expertise to raise expectations of those mainstream services. The more typical pattern is that specific bespoke services allow the wider service community to ‘outsource’ responsibility. Part of that pattern is the preferences of patients, who may also seek the reassurance of dedicated services – beyond an acute phase where that may be truly necessary.

What ‘assurance’ / delivery view might the committee take?

4.1 We have the capacity and capability, tools and resources, to undertake the assessments cited in our success measures, so the focus needs to be on

service creation and service change – leading to patient experiences that build the esteem that is the spirit of the promise.

4.2 We do have real clarity over what we are trying to do. Albeit the 'we' is a coalition that this paper has recognised could be broader. **We appear to be on the boundary between 'top right' and 'top left'.** Top right would suggest we know what to do and have the implementation architecture to do it. Top left would suggest our intent is more developed than our delivery plan.

4.3 The Board has been tracking the success measures. Our May ratings were: a) amber green/amber red, b) amber red/amber green c) red/red (bullets refer back to para 1.4 above). This acknowledges that this promise is proving one of more difficult to mobilise.

4.4 However, using the revised Board framework our delivery plan position would be consistently amber-green against the questions we have, that cover understanding the problem, the solution, and how to do this. Arguably this is a judgement over influenced by the homelessness, GRT and sex worker position. But we are potentially more amber-red when we consider likelihood of delivery, with the exception of stakeholder engagement: our leadership, governance, and the distribution of our implementation skills needs work.

4.5 Annex B seeks to visually represent this analysis for ease. The committee raised issues over data analysis and 'proofs'. It is possible to undertake some analysis, but we know that standard recording systems do not capture 'activity'. That is why we are going to rightly rely on patient voice through the shopper work and on standards assessment. The Board will recall we wish to use CoLE to evaluate much of our promise delivery and whilst Promise 10 is not one of their four top priorities for their first six months (P5, 6, 12, 21), I have little doubt that they will want to lean into this work in early 2027.

4.6 **To improve our overall position we need to:**

- Complete the mapping and assessment work outlined
- Recognise a likely need to invest in 2027/28 through the Investment Fund, with a focus on permanent funding to encourage risk taking (as we have done on Promise 17)
- Create a promise specific governance model that allows us to work with all five care groups moving into 2027 (this would be situated underneath the CLE E&I group)

Toby Lewis, Chief Executive
24th July 2026

Annex A – diagrammatic representation of current service view

Inclusion health cohort	North Lincolnshire	Rotherham	Doncaster
Homelessness	**Grant application at final stage to expand homeless team from early 2027**	Strong local VCSF offer – exploring potential for RDaSH outreach, including with dedicated deep-end practices	**Homeless health team since May 2026**
Forced migrants and refugees	Work as we expand Trauma Resilience service (MOJ grant) in next six months	Work through TRS but not bespoke wider provision. Once RCG more stable this is a priority.	Work within hotels (TB) but strong partnership opportunity with Changing Lives to go further
Sex workers	Some cross-over with refugee offer outlined above, but more to do to see opportunities especially among temporary labour		Embedded new post alongside Amber project
Addiction/dependency	Some joint work, so need to review where the gaps and opportunities may lie	Public health team continue to highlight issues of joint work gaps – in community redesign (CHPT) must be addressed	Provide Aspire service: acknowledged work to do to better integrate with dual diagnosis offer
Prisoners	As highlighted to the public health committee this is our next focus, with some links made both via NHSE commissioning and direct with prisons. Need to both work on in-prison and post-prison pathways.		
Gypsy roma travellers	Some local people drawn from this heritage, alongside immigrant communities sometimes hostile to roma. Work to be done to consider how best to proceed.	Significant population albeit often housed. Discussions with third sector partners to explore opportunities.	Good links made with sites and communities through lived experience workers within the city – into CHS and childrens services

Annex B


NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust
Quality of Delivery Plan - Demonstrating an understanding of:
the problem
proposed solution and its impact
how and when the project will be delivered
requirements to ensure sustainability
High
Low momentum / High clarity
Clear plan but weak delivery conditions.
Risk: overconfidence, 'paper exercise'
Focus: What is preventing delivery?
High momentum / High clarity
Clear plan and strong delivery conditions
Risks
Focus: how do we sustain pace and track impact?
Low
Low momentum / Low clarity
Unclear plan and low likelihood of progress.
Risk: wasted effort or drift
Focus: Should this proceed or be reset?
High momentum / Low clarity:
Energy and activity but weak direction
Risk: misdirected effort; unintended consequences
Focus: Are we doing the right things, or just doing things well?
Low
High
Skills for implementation
Accountability through effective governance
Leadership
Stakeholder engagement and buy-in
Likelihood of Delivery - Demonstrating clarity of
RDaSH
nurturing the power in our communities

DELIVEROLOGY-STYLE ASSESSMENT TEMPLATE – (1) QUALITY OF DELIVERY PLANNING – RAG-RATING CRITERIA

Delivery criterion	Red RAG-rating definition	Amber-Red RAG-rating definition	Amber-Green RAG-rating definition	Green RAG-rating definition
Understanding of the problem	The problem being addressed by the project is not yet clearly understood	There is a high-level understanding of the problem being addressed	There is a clear articulation of the problem being addressed, together with some understanding of the causes	There is a clear articulation of the problem being addressed, together with a detailed root cause analysis
Understanding of the proposed solution and its impact	There is not yet a clear understanding of what the solution being proposed will entail	There is a clear understanding of what the solution will entail, but no clear articulation of its expected impact	There is a clear understanding of what the solution will entail, together with some level articulation of expected impact	There is a clear understanding of what the solution will entail, together with a detailed articulation of outputs, outcomes & impact
Understanding of how and when the project will be delivered	Phases of work and milestones are not yet understood	There is some understanding of the phases of work and milestones required, but a lack of clarity on project interdependencies	The phasing of work and milestones required are fully understood, with some clarity on project interdependencies	Phases of work and milestones are fully set out, together with a clear and comprehensive view of project interdependencies
Understanding of requirements to ensure sustainability	Requirements to ensure sustainability are not yet understood	There is only a high-level understanding of what is required to ensure sustainability	Requirements to ensure sustainability are understood, but it is unclear whether resourcing and enablers are put in place to support	Requirements to ensure sustainability are fully understood, with assurance that resources and enablers can be put in place to support

 Source: this tool is based on Michael Barber's approach to "Deliverology", developed as Head of the Prime Minister's Delivery Unit under Tony Blair

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

DELIVEROLOGY-STYLE ASSESSMENT TEMPLATE – (2) LIKELIHOOD OF DELIVERY – RAG-RATING CRITERIA

Delivery criterion	Red RAG-rating definition	Amber-Red RAG-rating definition	Amber-Green RAG-rating definition	Green RAG-rating definition
Skills for implementation	It is not clear what the required skills and capabilities for implementation are	It is clear what the required skills and capabilities for implementation are, but these are not easily available in the organisation	It is likely that required skills and capabilities can be made available for implementation, but not necessarily in the shape of dedicated resource	Dedicated skills and capabilities can be allocated to ensure implementation
Accountability through effective governance	It is not clear what the governance and reporting routes will be	There are plausible governance and reporting routes, but it isn't clear that these will ensure robust accountability	Governance and reporting routes are agreed, with some work to do on ensuring robust accountability	Tried and tested governance and reporting routes can be put in place to ensure fully robust accountability
Leadership	There is no established leadership at either day-to-day or senior level	There is some leadership in place – more likely at day-to-day than senior level	There is clearly identified leadership in place at both day-to-day and senior level, but there are question marks about capacity to take on full responsibility	There is visible leadership at all levels, with a high degree of commitment to role-modelling any behaviour changes required
Stakeholder engagement and buy-in	There is, or is likely to be, active opposition to the project	There is no obvious opposition to the project, but positive engagement of stakeholders has been limited	There are clear signs of engagement with and buy-in to the project, but this is not widespread across all stakeholders	There is widespread engagement with and buy-in to this project across all stakeholders

 Source: this tool is based on Michael Barber's approach to "Deliverology", developed as Head of the Prime Minister's Delivery Unit under Tony Blair

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	DIALOG+ Report	**Agenda Item**	Paper Z
Sponsoring Executive	Dr Judith Graham, Director for Psychological Professionals and Therapies		
Report Author	Dr Judith Graham, Director for Psychological Professionals and Therapies		
Meeting	Board of Directors	**Date**	30 July 2026

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

The paper provides positive evidence that RDaSH has made significant progress in moving meaningful care planning from a long-standing faultline (See CQC inspection 2018 and 2020) into an active improvement programme, using DIALOG and DIALOG+ to link patient voice, outcome measurement and co-produced care planning.

Trustwide DIALOG scale completion has improved from 33.8% in January 2026 to 73.3% in July 2026, and DIALOG+ care plan completion has improved from 26.0% to 68.4% over the same period, supporting a 'Ready to deliver' position in the Trust's assurance grid. The key judgement is that the programme now has a clear plan, visible delivery, locality-level data and credible implementation conditions; however, full assurance is not yet appropriate because completion is not universal, locality variation remains, and the next phase must evidence the quality, co-production and routine clinical use of care plans, not simply the volume completed.

For completion – on the 17th July 2026 NHSE published the Mental Health Personalised Framework (MHPCF) – A summary is provided as an Annex to this paper mapping which components of the MHPCF are met by the DIALOG+ model and which other parts of the Trust's operating model.

Points to consider:

- **Sustaining delivery to the September 2026 ambition** - Does the current locality and Trustwide trajectory provide sufficient assurance that the 100% ambition can be achieved by September 2026?
- **Quality, not just completion, of care plans** – Although compliance rates are important, its not just about the numbers. The DIALOG+ model emphasizes meaningful, co-produced, accessible, plans, used within MDT review, risk planning & discharge planning. What would the Board want to see in terms of quality rather than just quantity?
- **Locality variation and targeted support** What support is required for localities or teams with lower completion or weaker improvement?

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

Education and Learning Meeting

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

CONSIDER the points raised in the discussion box above

NOTE the progress made, and plans for the future.

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:	
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.	X
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.	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.	
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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 & 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			X

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.	
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)

The information reported in this paper relates to the new NHSE paper regarding the Mental Health Framework, although reporting arrangements are not yest detailed for this framework the paper is presented to enable reporting if and when it is introduced.

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: Aggregated data pertaining to DIALOG implementation
Annex 2: NHSE Mental Health Personalised Framework

Meaningful Care Planning and DIALOG+

1. Introduction

Meaningful care planning is a core component of safe, therapeutic and recovery-orientated care. Annex 1 data shows that RDaSH has made substantial trustwide progress in embedding use of the DIALOG scale and the DIALOG+ care plan during 2026. Trustwide DIALOG scale completion increased from 33.8% in January 2026 to 73.3% on 10 July 2026, and DIALOG+ care plan completion increased from 26.0% to 68.4% over the same period. This is a material shift from implementation intent to demonstrable delivery.

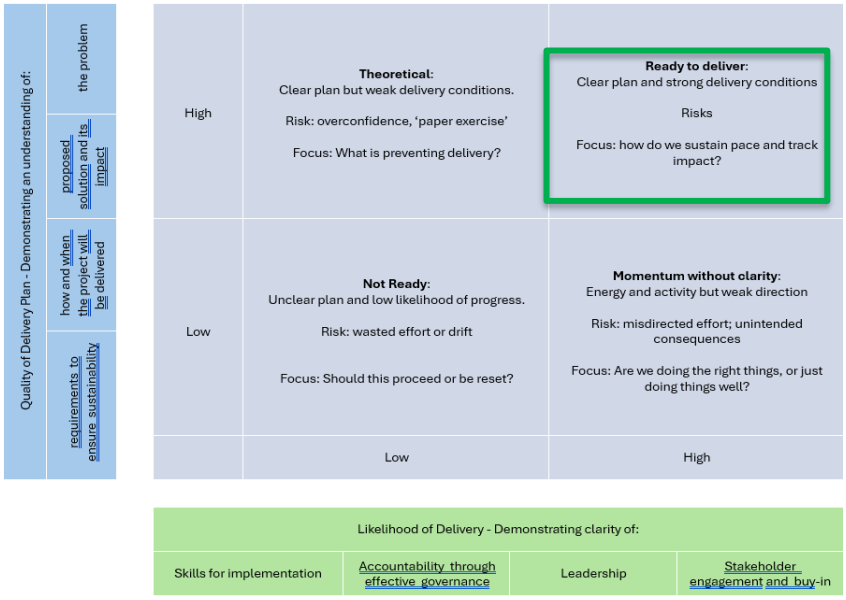
2. Analysis

The latest trustwide position shows 4,495 completed DIALOG scales and 4,194 completed DIALOG+ care plans out of 6,134 patients who had started treatment, with 795 patients not yet started treatment. Local delivery remains variable: Doncaster is at 76.9% for DIALOG scale and 71.4% for care plan completion; North Lincolnshire is at 73.2% and 69.3%; and Rotherham is at 70.7% and 66.0%. The data therefore supports a positive but not yet fully mature position.

Using the Trust's new evaluation system (summarised in the box grid at the bottom of this page), the work is best described as sitting in the top-right quadrant: Ready to deliver. This means that the quality of delivery planning is high and the likelihood of delivery is high. The rationale is that the problem is clearly understood, the proposed solution is defined, the measurement system is active, governance oversight is evident through repeated reporting points, and delivery is now visible across all three localities. However, if RAG rated in this grid the position should be framed as Amber-Green rather than Green because the work is not yet consistently sustained at the level expected across all localities, there is month-on-month variation, and care plan completion remains below the standard that would normally support full assurance.

The principal risk is now one of sustainability and standardisation rather than concept or adoption. The Board should seek assurance that the remaining gap is being managed through clear trajectory, named operational ownership, routine quality audit, patient voice testing, and service-level improvement support where completion rates are below trajectory. The next phase should therefore move from reporting completion to evidencing quality, co-production, impact on patient experience, and routine use of DIALOG+ outputs within care planning, review and MDT decision-making.

RDaSH Evaluation System / Grid



3. Indicative position: Ready to deliver

The work has moved beyond a theoretical model because there is a clear data set, a defined intervention, evidence of improvement at trustwide level, and visible locality-specific delivery. It is not yet a fully assured Green position because completion is not yet consistently high across all localities and the next phase must evidence the quality and impact of care planning, not only completion. The most proportionate assurance wording is therefore: ready to deliver, with continued executive oversight required to convert Amber-Green delivery into sustained Green assurance.

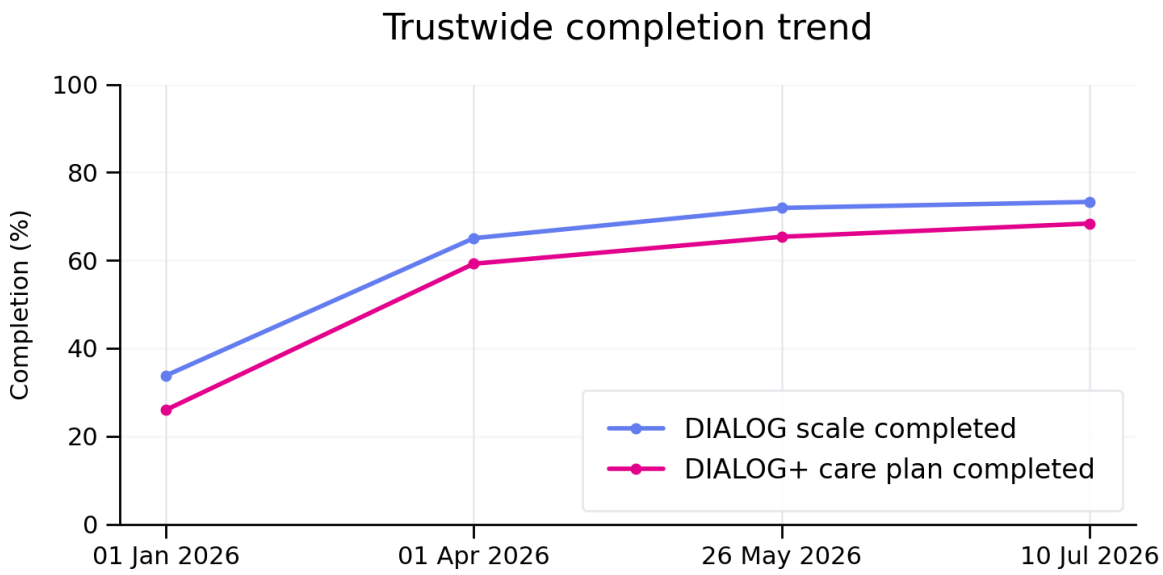
4. Summary data position

The data attached covers completed DIALOG scale and DIALOG+ care plan use across Doncaster, North Lincolnshire and Rotherham mental health services. The denominator used in the completion metrics is patients who had started treatment. The data also distinguishes patients who had not yet started treatment, which is important when interpreting the size of the whole cohort and the remaining operational opportunity.

Trustwide, patients started treatment reduced from 9,500 in January 2026 to 6,134 on 10 July 2026, while completion improved. This indicates that the improvement is not simply a denominator effect; the number of completed DIALOG scales increased from 3,210 to 4,495, and the number of completed DIALOG+ care plans increased from 2,468 to 4,194.

The point-in-time movement between May 2026 and July 2026 needs to be read with care. Trustwide DIALOG scale completion increased from 71.9% to 73.3%, while care plan completion increased from 65.4% to 68.4%. This indicates continued improvement, but the locality data shows variation that should be managed through targeted support rather than generic messaging.

5. Trustwide DIALOG and DIALOG+ care plan completion trend



6. Latest locality position at 10 July 2026

Area	Patients started treatment	Patients not yet started	DIALOG scale completed	DIALOG+ care plan completed	Comment
Doncaster	2,270	265	1,745 (76.9%)	1,620 (71.4%)	Strongest care plan completion; slight reduction from May should be monitored.
North Lincolnshire	713	223	522 (73.2%)	494 (69.3%)	Good DIALOG scale trajectory; care plan position close to 70%, with further consolidation needed.
Rotherham	3,151	307	2,228 (70.7%)	2,080 (66.0%)	Material improvement from January and April; continued support needed to close the gap with Doncaster.
Trustwide	6,134	795	4,495 (73.3%)	4,194 (68.4%)	Credible delivery with clear remaining standardisation challenge.

*Please note that there is a team in the PHNCG who provide care requiring use of DIALOG+, their position is incorporated into the Doncaster locality as this is where the patients are positioned geographically.

**Please note that the CYP data is manually counted but not included here due to the fact that they are using different measures that are personalised to age group.

7. Delivery assessment

Quality of delivery planning is assessed as high. The improvement work has a clear problem statement: care planning must be meaningful, person-centred, outcome-informed and consistently embedded. The proposed solution is clear: use DIALOG scale and DIALOG+ care planning to support structured conversations, co-produced goals and more systematic review. The data provides repeated points of measurement and can be used to inform both executive oversight and local service improvement.

Likelihood of delivery is also assessed as high. The work is already visible across localities and the trend is moving in the right direction. The key conditions for delivery are present: leadership interest, a shared metric, repeat reporting, locality comparison and a clear operational focus. There is enough progress to indicate that delivery is manageable if governance continues to focus on closing the gap between reported completion and quality of use.

The assurance position should not be described as complete or fully sustained. A Green assurance position would require consistently high completion rates across all localities, evidence from care record audit that plans are co-produced and clinically meaningful, and evidence that DIALOG+ outputs are used in MDT reviews, risk planning, discharge planning and outcome evaluation. On the current evidence, Amber-Green is the most balanced judgement.

The presence and use of the DIALOG tools is becoming increasingly evident in patient notes, MDT notes and discussions and also in patient feedback. This evidence demonstrates the value that patients see from the change in model and also the evidence of coproduction. However, it should be noted that at this stage the focus has been more towards 100% compliance than quality of care plan monitoring, which is within the next phase. We have however gathered case studies of use from championing clinicians and patients.

8. Key risks and actions

Risk / issue	Current assurance	SMART priority action	Current Issues
Variation by locality	Locality completion differs materially, particularly in care plan completion.	Through the Education and Learning meeting and delivery reviews, each locality has described a plan with a trajectory to reach at 100% DIALOG+ care plan completion and to evidence weekly review of variance, by a member of the Care Group Directorate team.	Across all care groups – older peoples services are outliers in terms of % In children's services there are still data reporting issues linked with personalised outcomes for different ages Sickness reported in certain teams is affecting achievement of compliance
Completion versus quality	Data demonstrates completion, but not the quality or impact of the care plan conversation.	In October 2026, implement a monthly quality audit sample in each locality, including peer support workers in terms of patient voice, focussed on goal quality, review date and evidence of MDT use.	We are gathering qualitative information as we progress to 100% compliance, but it is in the form of feedback (from staff, patients and carers) this is being used in training and HDL sessions. After reaching 100% we will then progress the quality dip sample.
Patients not yet started treatment	There are 795 trustwide patients not yet started treatment at the latest point.	By 30 September 2026, define the monitoring and assessment approach for patients awaiting treatment, including communications, safety planning and when DIALOG should commence.	Initial work has commenced in terms of triage and assessment DIALOG use however the position in terms of when to use a DIALOG with a small cohort remains under discussion. This issue pertains to a backlog clearance discussion, rather than a 'new patient' discussion
Sustainability	Progress is visible, but there is evidence of month-on-month variation.	By 31 December 2026, report sustained three-month performance and quality-audit findings through the agreed governance route.	A performance management approach led at a senior level is being used at the current time, once 100% has been achieved care groups intend to work with line managers, and focus upon the Always Measures in terms of embedding this as business as usual

9. Conclusion

The paper provides good evidence and DIALOG+ care planning work has moved from mobilisation into active delivery and is now generating measurable improvement at trustwide level. The recommended evaluation grid judgement is Amber-Green: Ready to deliver. The judgement recognises significant progress and a credible delivery framework, while avoiding over-assurance until locality variation is reduced and quality-of-use evidence confirms that care plans are consistently meaningful, co-produced and used to shape care decisions.

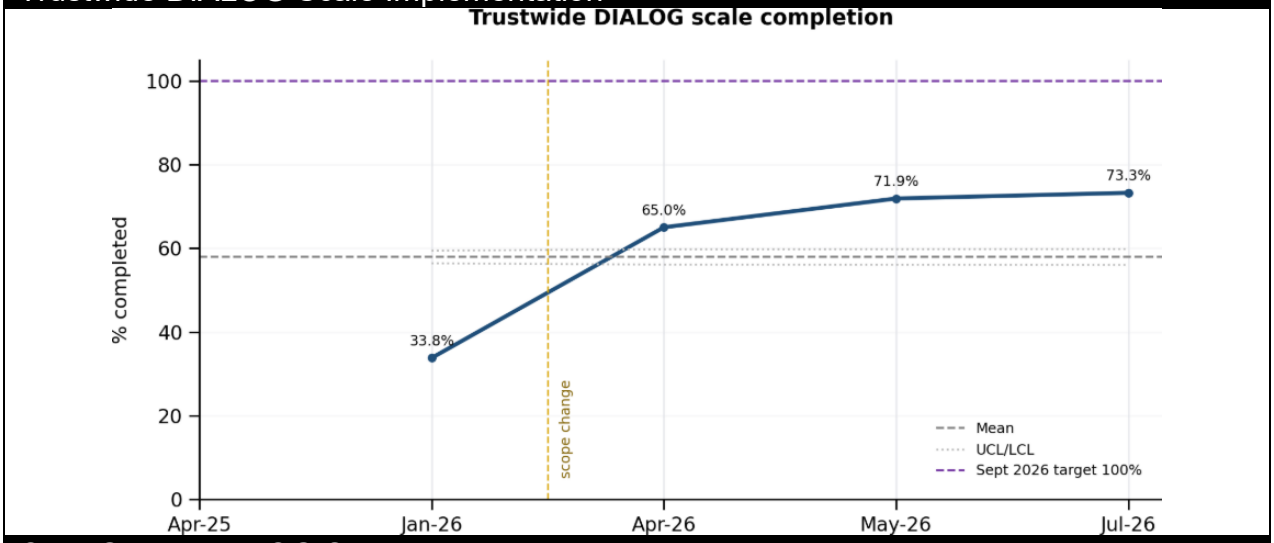
10. Sources and assumptions

This paper is based on the care group and Trustwide data (Annex) and user. Percentages have been calculated using the source spreadsheet values. The assurance judgement applies the slide pack's distinction between quality of delivery planning and likelihood of delivery.

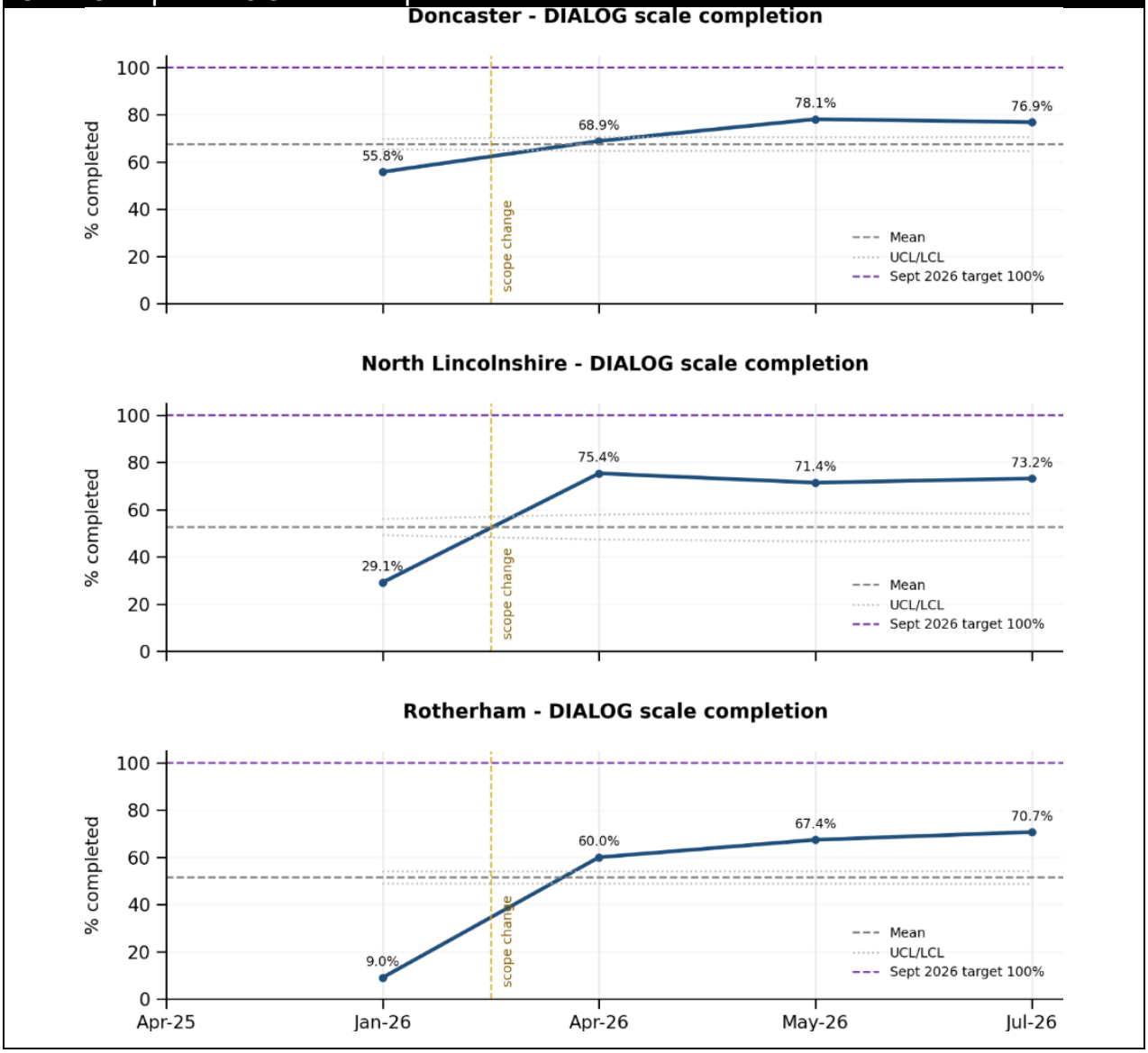
This version does not include a full patient experience audit, care record audit, or qualitative sample of DIALOG+ plans. Those elements are therefore presented as recommended next-phase work requirements.

Annex 1 – Aggregated data pertaining to DIALOG+ Implementation

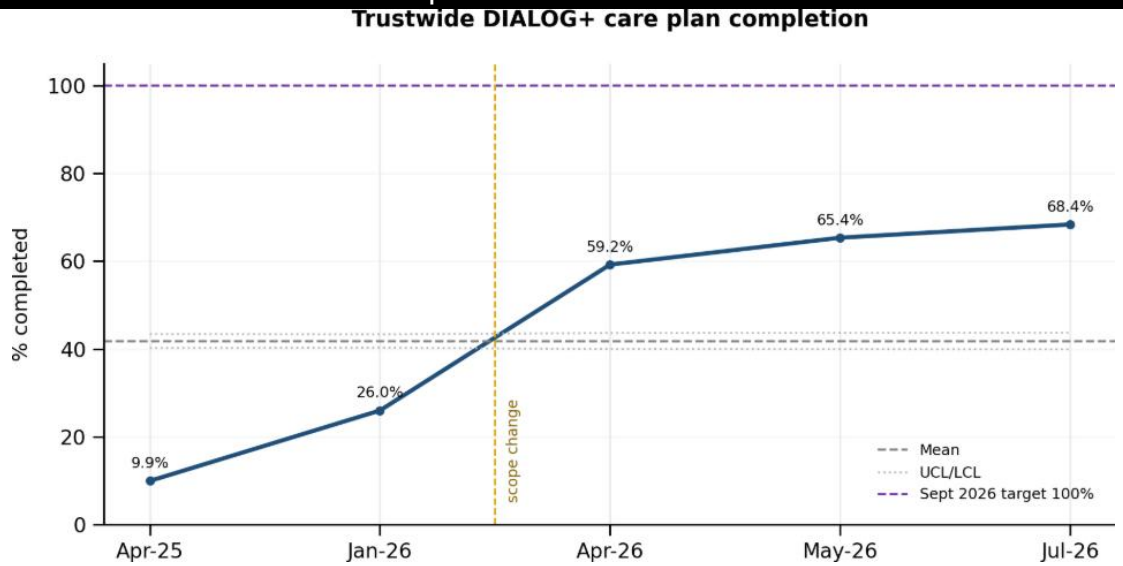
Trustwide DIALOG Scale Implementation



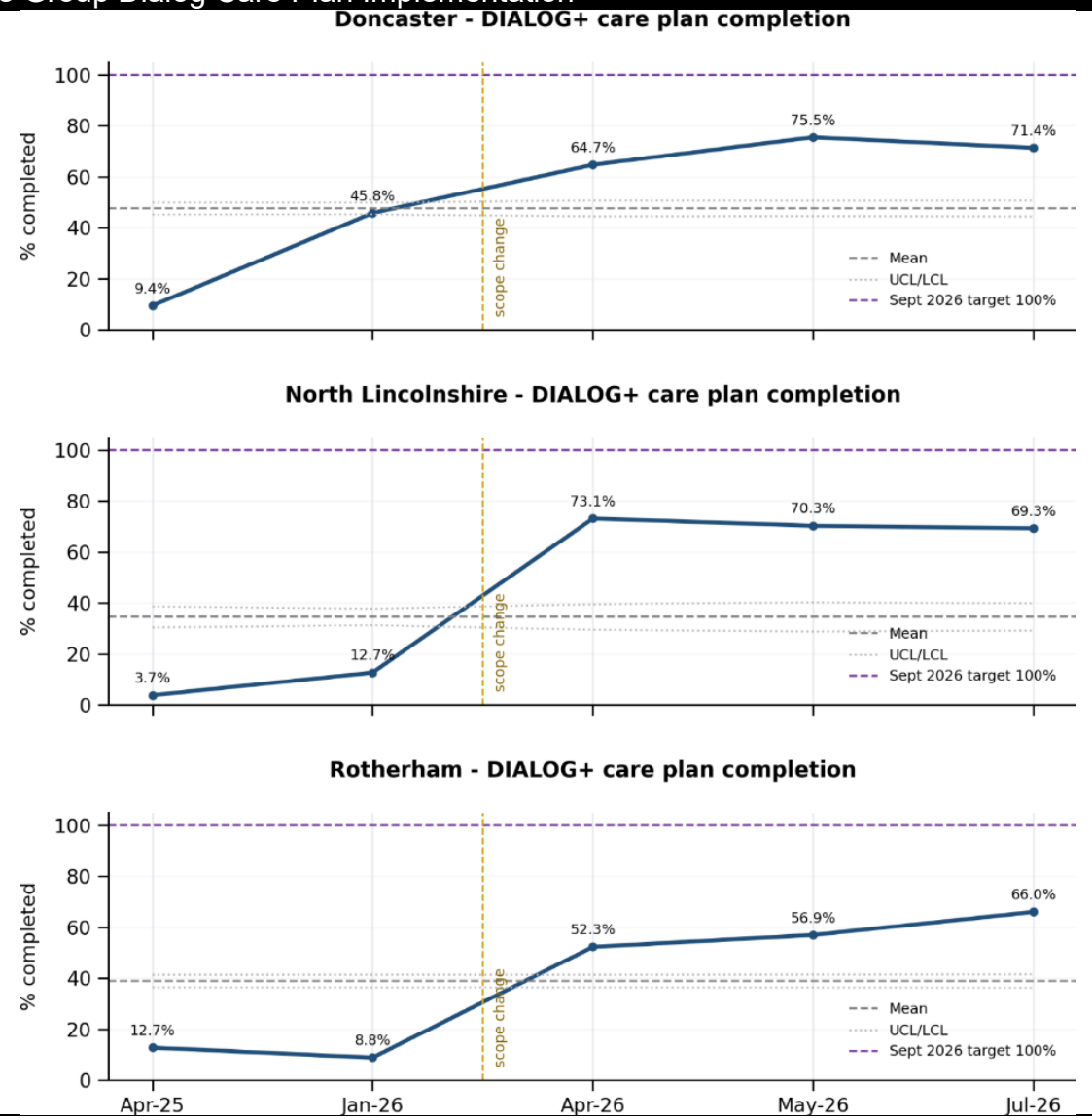
Care Group DIALOG Scale Implementation



Trustwide DIALOG+ Care Plan Implementation



Care Group Dialog Care Plan Implementation



Annex 2 – Adherence with NHS England's Mental Health Personalised Care Framework

1.Introduction

This briefing considers whether implementation of DIALOG+ is sufficient to evidence compliance with NHS England's Mental Health Personalised Care Framework: the modern Care Programme Approach and identifies additional components that RDaSH should assure itself are reliably in place.

The report is framed for Board, Committee and Clinical Leadership Executive use. It draws on the NHS England framework published on 17 July 2026, publicly available DIALOG/DIALOG+ descriptions, RDaSH policy material, and internal RDaSH papers referencing DIALOG+ implementation and care plan coverage.

2. Context

DIALOG+ substantially supports the framework because it provides a structured, person-centred conversation, uses patient-reported outcome information, focuses on areas of life and treatment that matter to the person, and can support co-produced care planning and review. It is therefore a strong foundation for the framework.

However, DIALOG+ is not, by itself, a complete compliance mechanism. The framework is broader than the completion of an outcome tool or care plan. It requires a whole pathway and governance model: clear communication and access, no wrong door arrangements, comprehensive assessment and formulation, safety and risk management, named responsibility for the care and support plan, timely review, rapid re-access, support network involvement, reasonable adjustments, equality monitoring, trauma-informed practice, information sharing, legal literacy and audit of both quality and coverage.

Within this document therefore wider processes in the Trust that contribute in an evidence based in terms of adherence to the Framework. The Board should therefore understand that as we continue to implement DIALOG+ as the core personalised care planning and outcome conversation model, we should treat DIALOG+ as one key component within a broader Mental Health Personalised Care Framework assurance programme.

3. What the NHSE Framework requires

NHS England describes personalised care as care in which people have choice and control over how care is planned and delivered, based on what matters to them and their strengths and needs. The framework applies to adults and older adults with severe mental health problems in NHS commissioned secondary mental health services or integrated primary, community and VCSE mental health services.

The framework reiterates four core expectations: everyone has a current personalised care and support plan; a person within the service is responsible for that plan and for developing a trusted therapeutic relationship; the plan can be reviewed when things change and people can quickly re-access help; and the person's experience of and response to care and treatment is measured and acted on.

The framework also describes enabling expectations, including population health approaches, reducing disparities through PCREF and Advancing Mental Health Equality, lived experience, carers and support networks, digital technologies, effective governance and information sharing, staff competence and legal duties, trauma-informed practice, PRSB personalised care and support plan standards, co-occurring conditions guidance and reasonable adjustments.

4. Framework to DIALOG+ mapping chart

The chart below maps the constituent parts of the NHS England framework to the DIALOG+ model and identifies areas where further Trust assurance is required.

Framework constituent part	How DIALOG+ contributes	Coverage assessment	Additional RDaSH auditable processes in place to address the constituent part of the framework
1. Clear and welcoming communication at referral / acceptance / decline	DIALOG+ can support the first meaningful conversation once a person is engaged, but it does not itself specify referral communication, appeal routes, advocacy, waiting support, service contact details or information about the local offer.	In place and developing	Policies and guidance in place regarding acceptance/ decline communication, accessible information, advocacy, waiting support, and guidance to alternatives where the service is not right. What we are aware of is that there are better areas than others in terms of supporting those who are waiting than others, and so there are some developmental areas (i.e. neurodiversity & TT)
2. Current assessment based on presenting mental health need	DIALOG prompts discussion of life domains, treatment satisfaction and needs for care. It can help identify what matters to the person and support formulation when used well.	Strong	In addition, where relevant to the treatment biopsychosocial assessment, formulation, collateral information, physical health, co-occurring conditions, substance use, social care, safeguarding, and risk/safety assessment are completed and integrated. (An example of this is the Physical Health checks in medication management and SMI clinics)
3. Personalised care and support plan	DIALOG+ is strongly aligned because it facilitates a structured, co-produced conversation and can generate a personalised care plan focused on priorities, goals and agreed actions.	In place and developing	Our current priority is ensuring that DIALOG (care plan and paired outcomes are in place for 100% of people) then we have a quality checking proposal – described within the July 2026 DIALOG+ paper) which utilises peers support worker & other clinical staff to look at the quality of work including areas of:- ownership by the person, accessibility, Care Act / s117 integration, agreed actions for person, carers & services
4. Named person responsible for the care and support plan and trusted relationship	DIALOG+ creates a framework for meaningful dialogue but does not allocate the responsible person or define key worker responsibilities.	Strong	Within both our inpatient and community mental health services we have clear keyworker / named nurse / responsible clinician named roles in place. Our policies and processes also ensure cover arrangements during absence, MDT accountability, and clarity when external partners hold coordination roles.
5. Review when things change and rapid re-access	Repeated DIALOG+ reviews can track changes in quality of life, treatment satisfaction and care priorities over time.	Strong	Evidence review triggers, review frequency by need, response to deterioration, discharge / step-down plans, relapse/crisis plans, & rapid re-access routes.
6. Patient voice: experience of and response to care measured and acted on	DIALOG/DIALOG+ is a patient-reported outcome and structured conversation; it directly supports measurement of the person's view of life and treatment domains.	Strong	In addition to the DIALOG engagement model, we have several different ways in which we gain patient experience feedback. This includes care opinion, complaints/themes, carer feedback, qualitative audit and demonstrable action from feedback at team and Trust level.
7. Safety, risk and crisis planning	DIALOG includes personal safety as a domain, and the DIALOG+ conversation may surface concerns; it is not a comprehensive risk assessment or safety planning framework.	Strong	Within the Trust we additionally use the FACE/risk assessment, bespoke safety plans (i.e. PBS), and in these we focus on harm to self/others/from others, history of violence, safeguarding, leave/discharge risk, frailty risk, crisis contacts and multi-agency risk working/sharing.
8. Carers, family and chosen support network	DIALOG+ can include what matters in relationships and can support shared planning where consent is given.	Partial	Evidence in Promise 2 and Always Measure 3 & 4 - routine identification and involvement of carers/support network, consent/capacity decisions, Triangle of Care principles, carer assessment/signposting, and documentation of involvement or rationale when not involved.
9. Reasonable adjustments and accessible information	DIALOG+ may help identify accessibility needs if staff ask and record them, but it is not a reasonable adjustments system.	Strong	We use Accessible Information Standard, reasonable adjustments digital flag where consented, interpreter/ sensory/physical access needs, easy-read plans, BSL, different formats (visual, audible, different languages) and adaptation for neurodiversity, learning disability and dementia.

Framework constituent part	How DIALOG+ contributes	Coverage assessment	Additional RDaSH auditable processes in place to address the constituent part of the framework
10. Equality, inclusion and population health	DIALOG+ provides person-level information but does not by itself deliver population health management or equality improvement.	Partial but developing see the work of E&I group	This is a developing area, we look at some population comparators (i.e. MHA), care quality, access and outcomes by protected characteristics, locality and diagnosis; link to PCREF, AMHE, inclusion health and underserved-group recovery plans. (including in Promise 6,7,8 and SDR 2)
11. Governance, information sharing and standards	DIALOG+ supports a standardised clinical conversation, but assurance depends on governance, records, data quality and system interoperability.	Partial but developing see the work of Q&S group	Enact personalised care and support plan standard alignment, information governance, MDT information sharing, audit dashboards, policy alignment, and quality governance reporting. There is currently a development of an inpatient and community dashboard, expected end of Q2 (under CNO portfolio). Always measure 1 & IQPR. There is also monitoring through CQC readiness meeting.
12. Workforce competence, supervision and culture	DIALOG+ requires staff confidence in person-centred communication and solution-focused conversations.	Good processes but rated as partial due to record issues	Training has been provided and is ongoing re DIALOG. We have supervision in place for staff (managerial and clinical see policy). 360 audit feedback, legal literacy, trauma-informed practice, MCA/MHA/Equality Act competence, and support for cultural change, and PSIRF training supports the learning. Work is being completed on defensive documentation.

*RAG – Green = process in place and used, Amber = processes in place but not fully adhered to/or problems with, Red = no process)

5. Interpretation

Current RDaSH material shows that the Trust has moved significantly toward DIALOG+ as a structured communication, shared decision-making and care planning tool. Internal Board material refers to DIALOG+ rollout and an expectation of full care plan compliance in specific areas. A July 2026 RDaSH Board paper records Trustwide DIALOG scale completion of 73.3% and DIALOG+ care plan completion of 68.4% on 10 July 2026 for people within the agreed treatment-team scope, with a stated ambition to move to 100% completion by September 2026.

The same RDaSH material correctly recognises that meaningful care planning is not simply a documentation task. The assurance question should therefore move beyond whether a DIALOG+ form exists to whether the conversation, plan, safety planning, support network involvement, review and outcome measurement are meaningful, current and used in clinical decision-making.

RDaSH policy material already contains many components required by the framework: flexible and responsive assessment; personalised care planning; key worker arrangements; family/carer involvement; safety planning; review; and a no wrong door approach. This policy foundation means the Trust is not starting from a blank page, but the framework strengthens the need to evidence reliability and quality.

6. Compliance assessment: does DIALOG+ make the Trust compliant?

Assessment area	Position	Judgement
DIALOG+ as a model	Strongly aligned with “what matters”, outcome measurement, shared conversation and care planning.	The model is necessary but not sufficient on its own, however with other Trust evidenced above compliance is achieved. In terms of the 3 amber areas, there are processes in place for achievement, however we have evidence that they are either not consistently utilised or concerns have been raised in terms of quality.
Care plan completion	RDaSH has made progress but internal evidence shows	Good process and model in place which is consistent with the NHSE Framework, however this area requires continued performance grip and exception management until 100% compliance is completed.

Assessment area	Position	Judgement
	completion was not yet at 100% in July 2026 for the agreed scope.	
Care plan quality	Framework requires meaningful, current, co-produced plans that influence care, safety and outcomes.	Work currently is to achieve 100% compliance. There is also a plan in place in terms of quality assessment/ assurance involving peer support staff (please see associated paper in Board of Directors July 2026). Requires ongoing audit of quality, not only completion.
Whole pathway compliance	Framework extends to access, assessment, review, re-access, carers, reasonable adjustments, equality and governance.	The broader policies procedures and actions and aligned with framework requirements. However, due to carers assessment compliance and also record keeping issues raised within learning from incidents this area cannot be rated as complete and there is planned work being progressed which the Board are cited on and are reported on through the work on the Trust Promises and also through the Quality and Safety plan.

7. Recommendations

Dashboard development/ or integration: review current dashboards / reportal reports to consider whether a separate dashboard is required or whether tweaks can be made to ensure compliance reporting can be provided if required.

Quality audit: this concerns sample audit of DIALOG+ care plans against co-production, strengths, goals, safety, support network, reasonable adjustments, review date, actions and outcome use – detailed in the DIALOG paper to Board in July 2026.

Safety integration: ensure DIALOG+ does not sit separately from risk assessment, safety management, crisis planning, safeguarding and discharge/leave planning. This will be reported through Q&S Group, chaired by the Trust Chief Nursing Officer.

Equality and population health: monitor DIALOG+ completion, quality and outcomes by locality, age, ethnicity, disability, gender, diagnosis, service line and legal status, aligned to PCREF and Advancing Mental Health Equality. The PCREF work is currently managed and reported through the E&I group which is chaired by the Director for Strategy, and therefore this is where this action will be taken.

Workforce and culture: maintain training, reflective supervision and clinical leadership support so DIALOG+ is used as a therapeutic conversation rather than a compliance form. This is reported through the Education and Learning Group – chaired by Director for Psychological Professionals and Therapies.

8. Proposed dashboard contents (either integrated into current report or stand alone)

Metric / evidence area	Standard	Frequency	Owner	Board / governance question
DIALOG scale completion	100% in agreed scope, with justified exclusions	Weekly (whilst moving to 100%) then monthly	Care group (with nominated lead from the care group directorate team) with central oversight via E&L meeting	Are all eligible people supported to complete DIALOG at the right point in care?

Metric / evidence area	Standard	Frequency	Owner	Board / governance question
DIALOG+ care plan completion	100% in agreed scope, with justified exclusions	Weekly (whilst moving to 100%) then monthly	Care group (with nominated lead from the care group directorate team) with central oversight via E&L meeting	Does everyone have a current plan?
Care plan quality audit	Agreed quality threshold	Monthly	Local combination of clinical and managerial leads working with peer support workers in the area worked	Are plans meaningful, co-produced and used?
Safety plan and risk integration	Clear link between care plan, risk assessment and crisis plan	Bi-Monthly	Clinical teams / Nursing and Facilities (safety leads) and reported through the Quality and Safety sub-subgroups	Is safety personalised and dynamic?
Named worker / MDT accountability	Named responsible person recorded	Ongoing	Team manager	Is responsibility clear during usual care and absence?
Review and re-access	Review dates, review triggers and re-access routes recorded	Ongoing	Operational leads	Can people quickly get help when needs change?
Carer/support network involvement	Evidence of consent, involvement or rationale	Quarterly	Promise 2 reporting	Are carers and chosen supporters meaningfully included?
Reasonable adjustments	Accessible information and adjustment needs recorded	Ongoing	Equality, Diversity and Inclusion (under the people and OD team) and the clinical teams	Are care plans accessible and equitable?

9. Board considerations

The Board is asked to note that DIALOG+ is a strong and appropriate core model for implementing personalised care planning, shared decision-making and outcome-focused conversations.

The Board is asked to agree that full processes are in place to ensure compliance with the newly published Mental Health Personalised Care Framework, notwithstanding that there are three key areas which are currently in focus in terms of care plan % compliance, record keeping and carers assessment, inclusion and support.