Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 30 July 2026

Agenda Pack B Index

1. **Paper N** **Annex B: Promises Report as published 2025/26**

2. **Paper T** **Annex A: Estates Full Business Case**

3. **Supporting papers**
    a. **Guardian of safe working Hours**
    b. **Mortality Report: March and April 2026**

NHS

Rotherham Doncaster and South Humber

NHS Foundation Trust

Are we delivering our promises?

This is our third annual report on the trust's work, with partners, to deliver the promises which form our clinical and organisational strategy 2023 to 2028 to nurture the power in our communities.

This report is trust produced but it contains peer-led feedback on our work over the past 12 months, including from those members of our local communities who have been contributing within our decision-making leadership groups: part of Promise 5.

The report outlines the success measures for all of our promises, provides an Easy Read summary of the strategy, and offers an honest assessment of work carried out to improve care.

RDaSH

nurturing the power in our communities

Contents

Front cover photographs left to right: Your Hearts and Minds charity abseil, Pride, health on the high street, Phoenix ward opening, Elizabeth Quarter's opening and social work event.

What we think we know: an introduction

This is our story so far. For the third time we are reporting back openly on the work to deliver the promises that we made to local communities, to patients and to carers in our strategy.

Once again, our peer-led partner, the People Focused Group has provided feedback on some of this work, using the voices of those who work with us. As we launch work to deliver Promise 2, our focus on carers, the feedback is clear that we have much more to do to succeed. Unpaid carers are by far the biggest health service everywhere we live and work. Among our own staff and in working with our patients, we know we could be much more successful in identifying and supporting them.

Other parts of the trust's annual reporting cycle draw attention to delivery in 2025 of some of our promises. With now just over 2 years left in our 5-year time period, we are starting to see a conclusion of hard work by very many people. There are few if any promises which have not found expression within our services. There are plenty not yet finished. However, some now are, and we have begun the hard work of sustaining that success. In particular, 4 promises have made great progress since we last reported:

- We are an accredited Living Wage employer, and for the last 2 years have paid the NHS' lowest paid staff that higher, living, wage. This, together with a continued transfer of expenditure to local businesses, are the basis for Promise 25.

- Since October 2025 we have had over 350 volunteers, drawn from a diverse range of backgrounds. This is what we committed to in Promise 3. It is clear that we now have volunteering in parts of our care and spaces in our communities that we never had before. It is clear too that this is proving a gateway into employment and a really important insight into some communities.

- At the time of writing, we have no, in NHS jargon, inappropriate out of area placements, and very few people whose lives are dislocated by care miles from home. This is the spirit of Promise 19, and because Scunthorpe is a long way from Rotherham, our approach goes beyond the 'definitions' used by other NHS organisations, focusing on, out of someone's own area, not out of NHS organisations.

- The trust's staff can now proudly say we have the shortest wait times in the NHS, with a 4-week wait being our maximum for many, but not yet all services We are investing to shorten waits in podiatry and to tackle the very long waits in neurodiversity assessment and care. These are the important exceptions to our delivery of Promise 14. But the success of moving other services to a consistent trusted position of less than 4 weeks is an extraordinary achievement.

In the next few months, we will succeed in becoming the first NHS organisation to poverty proof

Brighter Futures Event 2025

all our services in line with Promise 6. We have rolled out changes to the support we offer patients with travel and with food, expanded interpreting support, and begun to make appointments for care available outside 'core' working hours. These are the things communities asked us to do. Just as importantly among our staff, insight into poverty and exclusion has been heightened and sensitised by undertaking the work to deliver this promise.

Similarly, our considerable efforts to deliver Promise 9 around employment and apprenticeships, has led to a much greater awareness of the impact we make as an employer. In 2025 and 2026, for the first time, we committed to the full Apprenticeship Levy and did so in part sharing our wealth with local peer and community organisations. We are working to meet our commitments to be an accessible employer for a variety of traditionally excluded communities, including veterans and care leavers.

Our traditional strength as a trust in education and research, Promises 24 and 28, are well reflected in this report. We are proud to have become the host for the region's Ethnic Minorities Research Inclusion network (EMRI), and proud too for the second time in 3 years the work of our educators, in a range of clinical professions, has been recognised by NHS England as outstanding; and perhaps more importantly feedback from learners on placement is better than almost anywhere else in the NHS.

We must not overlook where we have not yet succeeded. In addition to Promise 2, we have been open that our anti-racism Promise 26 is not achieved in the lives of the many RDaSHians who face racism not only from patients and carers, but from others they work with. We have not yet reshaped services to fully meet the needs of those living in rural communities who we serve, as we want to at Promise 12. And we have much more to do to deliver our promise to the planet, as Promise 27, with the Board now agreeing a huge investment to end our dependence on gas as a heating source. Work to expand virtual wards has taken place (Promise 20) but is not yet embedded.

We feel that Promise 4 is increasingly a mainstream part of how we work. Aided especially by Care Opinion, the voices and feedback of patients and carers is at the heart of our care and how we manage the services. This year our published Quality Account reflects that reality. We are humbled and grateful to the well over 3,000 people who have shared their care stories with us, and with their local communities too.

In 2027 when this report is published, it will be our Communities' Leadership Executive (CoLE) that shape it. That executive gathers together 16 voluntary sector enterprises, drawn from many who applied, to take part in a shadow executive for the trust, with equal standing to those paid to lead the organisation. Their honesty about our weaknesses and their reflection on our strengths will be formative in the development of our care and the delivery of our mission to nurture the power in our communities. Promise 5 opens the trust up to those voices, not just in that forum but in many other ways, our learning and education spaces, how we recruit, when we meet with regulators and others, and everywhere where we make long-term decisions. Over time this body will shape and set our agenda, not simply add value to the agenda we have decided on. The Council of Governors provides that honesty mirror for the Board. CoLE will do the same for the executive and operational leadership of an organisation which wants to belong to, and be embedded in, our communities.

Thank you for taking time to read this report. Please let us know your thoughts and experiences. You may feel your voice, views and values are seldom heard. We want to continue to be curious to understand how we can work with, and learn from, you.

Kath Lavery
Chair

Toby Lewis
Chief Executive

Promise 1 is Promise 1 for a reason

All 28 Promises are important to the mission the trust has. But very deliberately peer support is the first promise we made.

2026 marks our year of peer support, as we look to hugely extend the scale and reach of peers across the trust. We must have peer support in place across our ward-based teams in every part of RDaSH. We want to have peer support in 'physical health' services as well as within the more traditional mental health spaces. And we want to make sure that peer support is embedded and valued, not simply present, within our multi-disciplinary team meetings.

We do employ our own peer support workers, especially in children's services. In the main however, we are investing in local third sector experts to provide peers into our clinical teams. The People Focused Group (PFG) has successfully bid for those contracts and is working to develop other organisations to host peers too.

The Board agreed in November 2025 an Outcomes Framework through which to evaluate peer support, and to optimise and deepen it. To be clear, peers at RDaSH are a fixed point, not a passing enthusiasm. We do not think we can develop neighbourhood health, without peers as lived experience experts who are part of those neighbourhoods.

Opening our services up to peer support workers (PSWs) is not simple or without nuance. It is not 'adding another person' but changing the ethos of how teams work. We have examples, perhaps especially our community wellbeing services that leads on annual health checks for patients with a serious mental illness, where that transformation has fundamentally altered the quality of care we provide. We have other services where that journey is beginning but not yet done.

The diversity of our peers matters if we are to truly see our communities in ourselves. We know too that we have had to work hard to ensure peer support is accessible and relevant in some of our older adult services. These development needs must be acknowledged, even as we celebrate the growth of PSWs since 2023. A growth in which we have now invested over £1m recurrently.

Working with peers, gives us insight into the quality of our services. But PSWs offer our patients much more than that. As experts with experience, they can offer hope, empathy, and connection that complements the clinical expertise of the trust's clinicians. If you are reading this and work as PSW thank you. If you have an interest in peer roles, please contact us, or the People Focused Group direct.

RDaSH and PFG Peer support event 2026

Nathan Lindley

Peer Support Worker

Being a peer support worker means choosing every single day to turn pain into purpose. It means standing in front of people who feel forgotten by the world and saying, without judgement or conditions, "I understand." Not from a textbook. Not from a distance. But from lived experience, from surviving storms that once felt impossible to escape.
A peer support worker carries something rare into the lives of others, real empathy, earned through struggle, heartbreak, healing, and hope. And because of that, their words reach places that clinical language never can.

For me, being a peer means becoming proof that people can rebuild themselves after life has tried to break them. It means sitting with someone in their darkest hour and helping them believe that tomorrow still belongs to them. It means listening when someone feels invisible, staying when others walk away, and reminding people that their story still has chapters left to write. There is no applause for most of these moments. No spotlight.

Just quiet acts of compassion that save lives in ways the world may never fully see. A peer support worker is not someone who has all the answers. They are someone brave enough to walk beside another human being through fear, trauma, addiction, grief, or despair and whisper, "You do not have to carry this alone anymore."

That kind of work changes people forever. Because sometimes healing does not begin with treatment or advice, sometimes it begins the moment somebody finally feels understood. And that is what truly means to be a peer. To become a light for people who cannot yet see their own. The beautiful truth is that every one of us holds the ability to be a peer in some way. We do not need titles, certificates, or perfect lives to offer kindness, understanding, and presence to another person. Sometimes being a peer simply means listening without judgement, checking in on someone who is struggling, or reminding a hurting soul that they matter. In a world where so many people feel alone, even the smallest act of compassion can become a lifeline. We all carry the power to help another human being feel seen, heard, and hopeful again, and that power can change lives. Make someone realise their lowest point is actually their foundation!

Joanne O'Marr
Macmillan Cancer Information and Support Service Lead

Peer Support and Physical Health Services Peer support is a very recent addition to the service, helping to support people affected by cancer and promoting cancer awareness and health education within the community, with a more meaningful and targeted approach as we increase our capacity.

As a team we have already identified areas where the peer support role adds significant value and enables us to deliver more responsive, personalised care and support. We are excited about the future potential of this role, as we continue to recruit peer volunteers and integrate and develop the model, guided by the experiences and feedback of our service users.

RDaSH and PFG Peer support event 2026

Meet Jeanette

Peer Support Worker, Community Wellbeing team (RDaSH)

My name is Jeanette, and I work for People Focused Group as part of RDaSH's Community Wellbeing Team. I have been with People Focused Group for the past 18 months, and I thoroughly enjoy the diversity that my role brings.

No 2 days are ever the same. One day we might be swimming or supporting someone to access the gym, and the next we could be accompanying someone to a GP appointment or helping them overcome the everyday challenges that can often feel overwhelming.

From the very beginning, the team at RDaSH has fully embraced peer support and has made me feel valued as part of the wider team. It is a fantastic example of what can be achieved when lived experience is recognised as an essential part of someone's recovery journey.

I genuinely love what I do. Watching someone overcome obstacles, grow in confidence and begin to believe in themselves again is incredibly rewarding. Seeing people blossom and achieve things they once thought impossible is the greatest reward I could ever ask for.

Meet Siân

Peer Support Worker, Community Wellbeing team (RDaSH)

Hi, my name is Siân, and I am a Peer Support Worker at People Focused Group, embedded within RDaSH's Community Wellbeing team, formerly known as the severe mental illness team.
I have worked at People Focused Group for 2 years, and I am incredibly grateful to have found a place where people are encouraged to be open, honest and completely themselves.
Working here has given me the opportunity to use both my own lived experience and my professional skills to support others on their recovery journeys.

What I value most is that we always see the person before the problem. We focus on people's strengths, hopes and aspirations rather than simply the challenges they face. Every individual has something unique to offer, and it is a privilege to support people as they rebuild confidence, reconnect with their communities and move towards the life they want.

Being part of People Focused Group means being part of a team that truly believes in the power of connection, compassion and peer support. I have seen first-hand the difference that having someone who genuinely understands, listens without judgement and believes in you, can make. I feel incredibly fortunate to be able to offer that support to others every single day.

Are we delivering our 28 promises?

Promise 1. Employ peer support workers at the heart of every service that we offer by 2027.

Success Measures

1. Each clinical service in the trust will have a peer support worker aligned to it and working with patients in their care.

Progress made in 2025 and 2026

The trust built strong foundations for expanding peer support. A baseline review identified 37 active peer support workers (PSWs), mostly through the PFG. Targeted recruitment and new support structures enabled rapid growth, leading to full PSW coverage across all mental health inpatient wards by March 2026.

Community gaps began to be addressed through shared-resource models. Peer workers contributed to improved outcomes, for example in Rotherham's primary care mental health hub, their involvement reduced overdue severe mental illness (SMI) health checks from 129 to 40. PSWs also became more involved in governance, joining interview panels and ward quality reviews. As we look to open a 24-hour 7 day a week mental health open access service in Scunthorpe, peer support workers will be the principal, and first, responders in that unit.

A Doncaster peer support hub with 5 full-time staff launched, signalling a scalable model for wider rollout across the trust.

Plans for 2026 and 2027

The focus shifts to scaling and sustaining peer support across all services. Recruitment will expand into community and outpatient areas, supported by new locality-based peer support hubs in North Lincolnshire and Rotherham. A co-produced Community Peer Support Charter will set consistent standards across the trust. The PSW workforce is expected to grow by at least 50% (around 20 new roles). A centralised PSW register and monthly monitoring will improve oversight. An outcomes framework has been developed to measure PSW impact, with quarterly reporting to the Board and Clinical Leadership Executive. The year will focus on completing recruitment, strengthening training and supervision, and embedding sustainable governance for peer support.

Promise 1 easy read:

Employ peer support workers at the heart of every service by 2027

What we achieved:

We have more peer support. There is better support for people using services. Peer support workers playing a bigger role in improving care.

What's next?

Recruiting new peer support workers. Providing good training and support. Making sure peer support is well organised and can continue in the future.

Promise 1

Employ Peer Support workers at the heart of every service by 2027

1. Rotherham, Doncaster, and North Lincolnshire have all employed Peer Support Workers.

2. Equity is increasing across Rotherham, Doncaster, and North Lincolnshire.

3. Rotherham now has a Peer Support Hub Model in adult Mental Health services.

4. North Lincolnshire now has a Peer Support Hub Model in adult mental health services.

5. Doncaster now has a Peer Support Hub Model in adult Mental Health Services.

6. Doncaster has Peer Support in Cancer and Cardiac Rehabilitation Services.

7. Peer Supporters are visiting every adult mental ward in Rotherham, Doncaster, and North Lincolnshire.

8. Children's Services all have Peer Supporters in Rotherham, Doncaster, and North Lincolnshire.

9. Where do we need to see more Peer Support?

Physical Health Rehabilitation
Neurodiversity All ages Long Term Conditions.

NEARLY THERE

Promise 2. Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy

Success Measures

1. Achieve Carers Federation accreditation for the work that we do across the trust.

2. Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.

3. Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.

4. Identify all-age carers who use our services and ensure their rights under the Carers Act are recognised.

Progress made in 2025 and 2026

The trust made substantial progress in getting ready to better identify and support unpaid carers. A Carers Support Action Plan was launched, and all inpatient wards adopted extended visiting hours and consistent carer-friendly practices from September 2025. Carer involvement was built into clinical processes through new electronic record prompts and formal assessments. Internally, the unpaid Staff Carers Network more than doubled in size, and more employees identified themselves as carers on Electronic Staff Record. The trust prepared for the Carers Leave Act 2023 by reviewing Human Resources (HR) policies. Externally, partnerships strengthened through participation in Doncaster Council's Carers Strategic Oversight Board and joint events such as Carers Rights Day. Carer referrals for formal support increased significantly, but from a very low base.

Plans for 2026 and 2027

We will work to achieve Carers Federation Accreditation by December 2026. All services will adopt a standardised carer identification question and referral pathway by mid-2026, aiming for every patient to have any informal carer recorded. Accreditation evidence, training records, feedback, and compliance data, will be compiled throughout the year. Further initiatives will strengthen support for staff carers, expand partnership working, and ensure carers' rights under the Carers Act are consistently upheld.

The big priority is to increase by at least 5 times the number of people referred for carer assessments. In practice this means identifying carers much earlier in the care of our patients. We have spent 2025 building processes to do this. We now need to go big.

Promise 2 easy read:

Support unpaid carers in our communities and among our staff

What we achieved:

Better support for unpaid carers. Carers are more involved in care and treatment. Stronger partnerships with local organisations. More carers getting the help they need but even more carers need help.

What's next?

More carers identified early. More carers getting support. Better support for staff who are carers. Carers getting their rights.

The views of others about Promise 2 kindly gathered by People Focused Group:

PROMISE 2

Getting it right for communities

Check understanding

"I was given information about carers but I couldn't read it and didn't really understand that I could get help."

Follow up

"I was asked if I was a carer then that was it nothing else happened."

Clear across all services

"Carers information is too fragmented - it needs to be consistent and not depend on getting a good worker."

Easier access

"It was hard to get any help but when we got the right support it worked really well."

BIG theme

"Tell people carer support exists."

Front door for carers

"Where would I go for support? There should be a place where carers can just drop in and get the help they need - I just don't know where to start looking."

Carers describe a messy system that needs to be clearer and more consistent. Make sure people know what is available.

The carers that have had support describe that this has helped.

PROMISE 2

Getting it right for staff

Flexible Working

'Some weeks I have a lot of appointments with the person I care for and instead of taking leave being able to condense my hours at these times."

Rapid Response

"more understanding when sudden issues arise."

Carer Network

"I feel supported by The Carer Network and my Manager"
"More involvement from senior leaders in the carers network."

Full Team Understanding

"I think understanding is better from managers but feel isolated from my team when I need time off for caring."

Multiple Caring Roles

"I have to build time owed for caring appointments its hard when you care for more than one person."

Information

"More awareness of carers rights and what support there is."

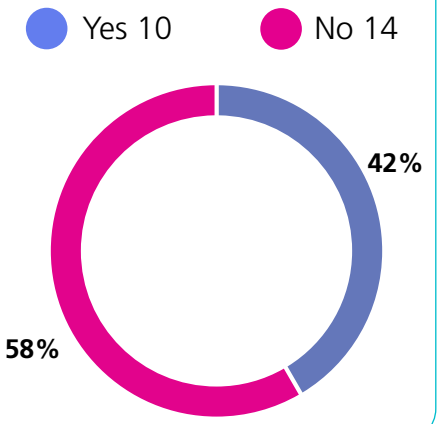
Staff need more clarity about what is available and greater flexibility, especially with multiple caring roles.

Staff describe improved management support and Carers' Network as positive.

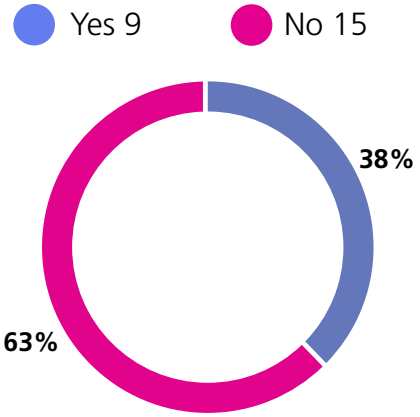
Support unpaid carers in our communities and among our staff.

24 people completed a short survey, and we spoke with 12 people to get a better understanding.

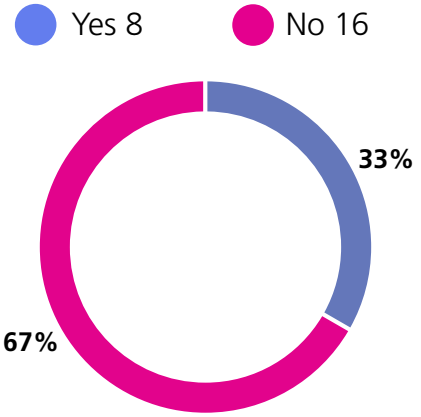
Were you asked about identifying as a carer as part of the assessment or discussion?



Were you provided with details about any carer support available within your own community?

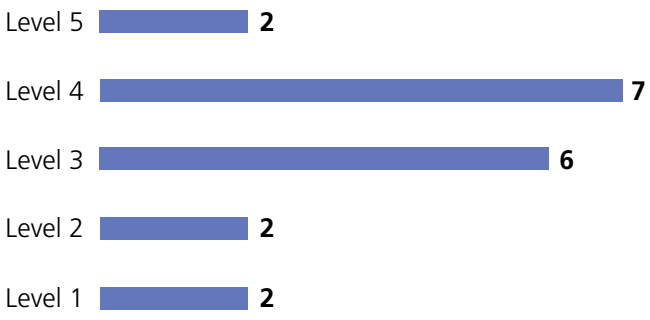


Were you provided with information about any support available for carers?



On a scale of 1 to 5, how would you rate the support provided by RDaSH to assist you in your role as a carer?

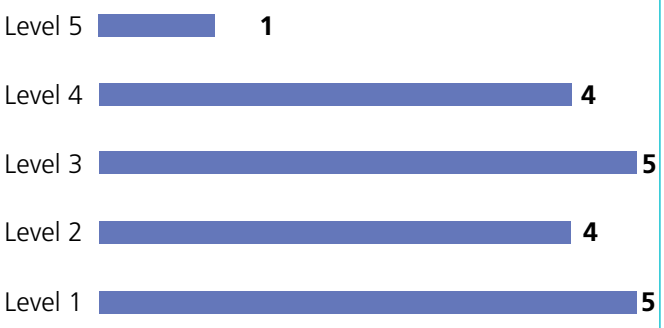
(1 = Not supportive at all, 5 = Extremely supportive)



Average rating 3.26

On a scale of 1 to 5, how well do you think RDaSH understands the challenges faced by staff members who are also carers?

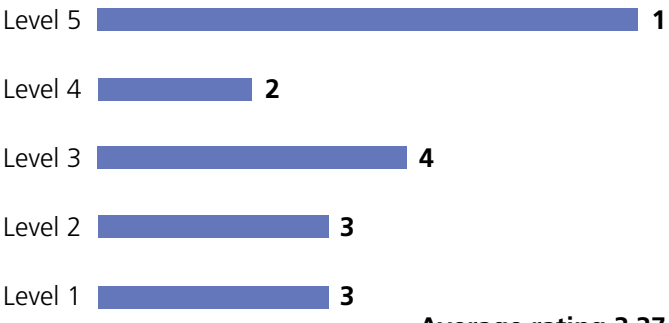
(1 = Not well at all, 5 = Extremely well)



Average rating 2.58

How often do you feel comfortable discussing your caring responsibilities with your line manager or HR?

(1 = Never, 5 = Always)



Average rating 3.37

Meet Heather

Young Carer.

Karen and Heather

My name is Heather, and I am a carer for my mum, Karen, who has been accessing RDaSH community and inpatient mental health services for over 30 years.

Growing up as a young carer, it was important for me to understand the support that was available for carers and how I could access it. I first found out about RDaSH's carer services through attending Better You Young People's Service, as well as through my mum's involvement with The Wellness Centre.

Being a carer can sometimes feel overwhelming, and I know how important it is to have the right support. I would like more help from RDaSH carer services to better understand my mum's mental health, access the support available to carers, receive an up-to-date carer's assessment, and have support that recognises my own wellbeing alongside my caring responsibilities.

Caring for someone you love can be challenging, but having the right information, understanding and support can make a real difference, not only for the person receiving care, but for carers too. Every carer deserves to feel listened to, valued and supported throughout their own journey.

Promise 3. Work with over 350 volunteers by 2025 to go the extra mile in the quality of care that we offer.

Success Measures

1. Have 350 volunteers registered to work with us or have equivalent to that figure volunteering time with us through another body.

2. For that body of volunteers to reflect the diversity of our populations.

Progress made in 2025 and 2026

RDaSH delivered an exceptional year for volunteering, meeting, and surpassing the target of 350 active volunteers by October 2025. This represents a major rise from around 100 volunteers in 2023. By March 2026, the trust had over 360 active volunteers across all 6 service groups, with 5 groups hosting at least 50 volunteers each. The opening of the Elizabeth Quarter building in Scunthorpe will see further expansion in North Lincolnshire.

Diversity improved significantly. Targeted outreach brought in younger volunteers and more people from minority ethnic backgrounds. An internal report confirmed the volunteer cohort is now more diverse than the paid workforce. Volunteers contributed substantial time and impact, some logging over 360 hours in a year, and their presence was repeatedly praised by patients and staff. Our evaluation work found volunteering boosted both volunteer wellbeing and staff morale.

Overall, RDaSH met every success measure for Promise 3. Hitting the numeric target, improving diversity, and embedding volunteers into governance and service delivery.

Plans for 2026 and 2027

The trust aims to maintain momentum by keeping volunteer numbers above 400 throughout the year, recruiting at least 50 new volunteers to offset natural turnover. Diversity efforts will continue, with a focus on young people and underrepresented communities. A new "volunteer ambassador" scheme will support targeted recruitment.

Training and support will be strengthened through a new Volunteer Learner Zone offering eLearning and workshops. Each service directorate will create at least one new volunteer role or project that directly contributes to service quality, ensuring volunteering remains meaningful and impactful.

Promise 3 easy read:

Work with over 350 volunteers by 2025

What we achieved:

More volunteers are helping us. A wide range of people are becoming volunteers. Better support for patients and staff. Volunteers play an important role in our services and decision-making.

What's next?

More volunteers helping us. Better training and support for volunteers. More opportunities for volunteers to get involved. Volunteers making a positive difference to services and patients.

The views and experience of Promise 3 kindly gathered by People Focused Group:

PROMISE 3 VOLUNTEERING

- **Volunteer numbers have continued to grow**
- **The range of opportunities has increased**
- **Young people are supported well**
- **Working across all 3 areas**
- **Regular training opportunities**
- **Volunteers feel valued**

COUNT ME IN! RDaSH Volunteers

Meet Nancy

Volunteer.

Volunteering with RDaSH has been one of the most fulfilling, rewarding and eye-opening experiences of my life. It brings me great joy to give something back to RDaSH and to the people who use its services because I have ridden the stormy waves of mental health myself, and, like many people, I continue to navigate that journey.

Volunteering has given me a real sense of purpose. It has shown me that I am wanted, valued and needed. There is a place for me where I can not only help others but also continue to grow in my own recovery.

Using my lived experience, I am able to offer genuine support and insight in many different ways. Whether I'm volunteering as a peer on the ward, sitting on interview panels, or attending RDaSH staff inductions to talk about what I do and why peer support matters. I know that my experiences can make a real difference.

Every opportunity gives me an incredible sense of achievement. I feel respected because lived experience is something that cannot be taught in a classroom. There are no degrees or university courses that can replace what comes from walking the journey yourself. Those of us with lived experience hold a unique set of skills, and I am proud to see RDaSH recognising, valuing and nurturing those skills every single day.

I truly believe exciting things lie ahead as peer support continues to grow and become an even more important part of mental health services.

In short, I care about caring, and I couldn't imagine doing anything more meaningful.

Promise 4. Put patient feedback at the heart of how care is delivered in the trust, encouraging all staff to shape services around individuals' diverse needs

Success Measures

1. Increase by 15% the scale of feedback received in the trust versus 2024 and 2025 baselines.
2. Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.
3. Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.

Progress made in 2025 and 2026

The rollout of Care Opinion in late 2024 led to a surge in feedback. By summer 2025 the trust had received over 1,000 stories, rising to more than 1,800 by March 2026, with an 82% response rate. This comfortably exceeded the aim of increasing feedback by 15%.

The trust acted visibly on what people said. Feedback led to extended weekend therapeutic activities, clearer ward welcome packs, and improved communication with families.

Feedback is now a standing item at Board and Clinical Leadership Executive meetings, and directorates routinely review stories to inform improvements. To reach underrepresented groups, the trust co-designed a paper-based tool for patients detained under the Mental Health Act, piloted in early 2026.

The impact is encouraging. The 2025 Community Mental Health Survey showed RDaSH's best-ever results, complaints about not being listened to fell, and no new Care Quality Commission warning notices were issued in 2025 related to communication. An internal audit in March 2025 gave "Significant Assurance" that the trust is embedding a strong culture of patient involvement.

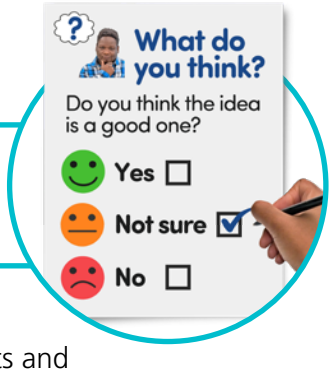
Plans for 2026 and 2027

We aim to increase feedback volume by another 15% and broaden the range of voices heard. This includes expanding Care Opinion promotion (for example QR codes in clinical areas), strengthening feedback routes for detained patients and people with communication needs, and ensuring every directorate can demonstrate how feedback has shaped service changes.

But this promise is not about quantity it is about meaning and impact. Both the positive and less positive feedback we hear has to affect what we do, what we keep, and what we value. Making that ambition true more widely in the trust is our ambition.

Promise 4 easy read:

Put patient feedback at the heart of how care is delivered



What we achieved:

More people are sharing their views. We are listening and making changes. Patients and families are having a stronger voice. Services are improving because of feedback.

What's next?

More people sharing their views. Feedback leading to real change. Patients and families being listened to. Better services for everyone.

Meet Kathleen
(kindly provided by People Focused Group)

Kathleen, from North Lincolnshire, shared her experience through Care Opinion after feeling deeply disappointed by the decision to end her weekly support group. She spoke openly about how let down she felt and the impact that losing the group would have on her wellbeing.

Her feedback was made publicly through Care Opinion and received a prompt response. Most importantly, her concerns were listened to and acted upon. Working alongside Kathleen and other members of the group, a new solution was found.

Rather than the group coming to an end, it is now facilitated by peer supporters, ensuring there was no break in support for those who rely on it.

Kathleen describes the experience as one where her voice genuinely mattered. She felt listened to, involved in the decision-making process and reassured that her views had influenced a positive outcome.

The experience has inspired Kathleen to give back to others. She is now progressing to become an RDaSH volunteer, supporting other people to share their experiences, have their voices heard and help shape services for the future.

Kathleen's story demonstrates the power of listening, co-production and acting on feedback. When people are heard and involved, services can evolve in ways that make a real difference, not only for one individual, but for entire communities.

Pictured top, Paula Rylatt, Deputy Patient Experience and Involvement Director RDaSH, Kathleen Green, Feedback/Care Opinion Volunteer and Samantha McBride Peer Support Worker PFG.

Promise 5. From 2024 systematically, involve our communities at every level of decision making in our trust throughout the year, extending our membership offer and delivering the annual priorities set by our staff and public governors

Success Measures

1. Involve patient and community representatives fully in our board, executive and care group governance.
2. Deliver the Board's community involvement framework in full.
3. Apply patient participation tests to new policies and plans developed within the trust.
4. Support active membership participation in the work of the trust, implementing a new membership offer in 2024 and 2025 and evaluating it in 2026 and 2027.
5. Deliver the annual priorities set by our Council of Governors.

Progress made in 2025 and 2026

All of our committees that make decisions include community members, and our elected governors join appointed members of the Board in our committees. These voices have begun to change what we talk about and how we talk about it, impacting the choices we make as a trust. That is increasingly too inside our care groups and directorates, aided by the presence in our leadership development education of 10% of places reserved for community leaders. This has built awareness, knowledge and relationships.

The launch of our Communities' Leadership Executive in May 2026 will bring a closer and more impactful relationship between voluntary sector leaders and our organisation. As advocates, providers, and partners these groups will speak truth to power, and we aim to change how we work because of their contribution. Our policies are now filtered through a patient-led process. With all those policies being re-formatted by October 2026, we believe that that process will grow in influence.

The trust also strengthened our membership. Targeted outreach increased public membership from around 400 to 600 by October 2025, with improved demographic completeness (unknown ethnicity reduced from 57% to 41%). Members played an active role in decision-making, including voting on annual quality priorities, nearly 1,000 votes were cast in 2025.

Plans for 2026 and 2027

Our community involvement framework is not just about bringing community voices into RDaSH, but about RDaSH being present in spaces and places in our community. That is mixed at present. Working place by place, with our care groups working together as one RDaSH, we will see that change in the year ahead.

The Board has begun to consider its own privilege and explore how we can hear better Seldom Heard voices within our communities, including all of the Inclusion Health groups covered by Promise 10.

Promise 5 easy read:

Involve our communities in decision making

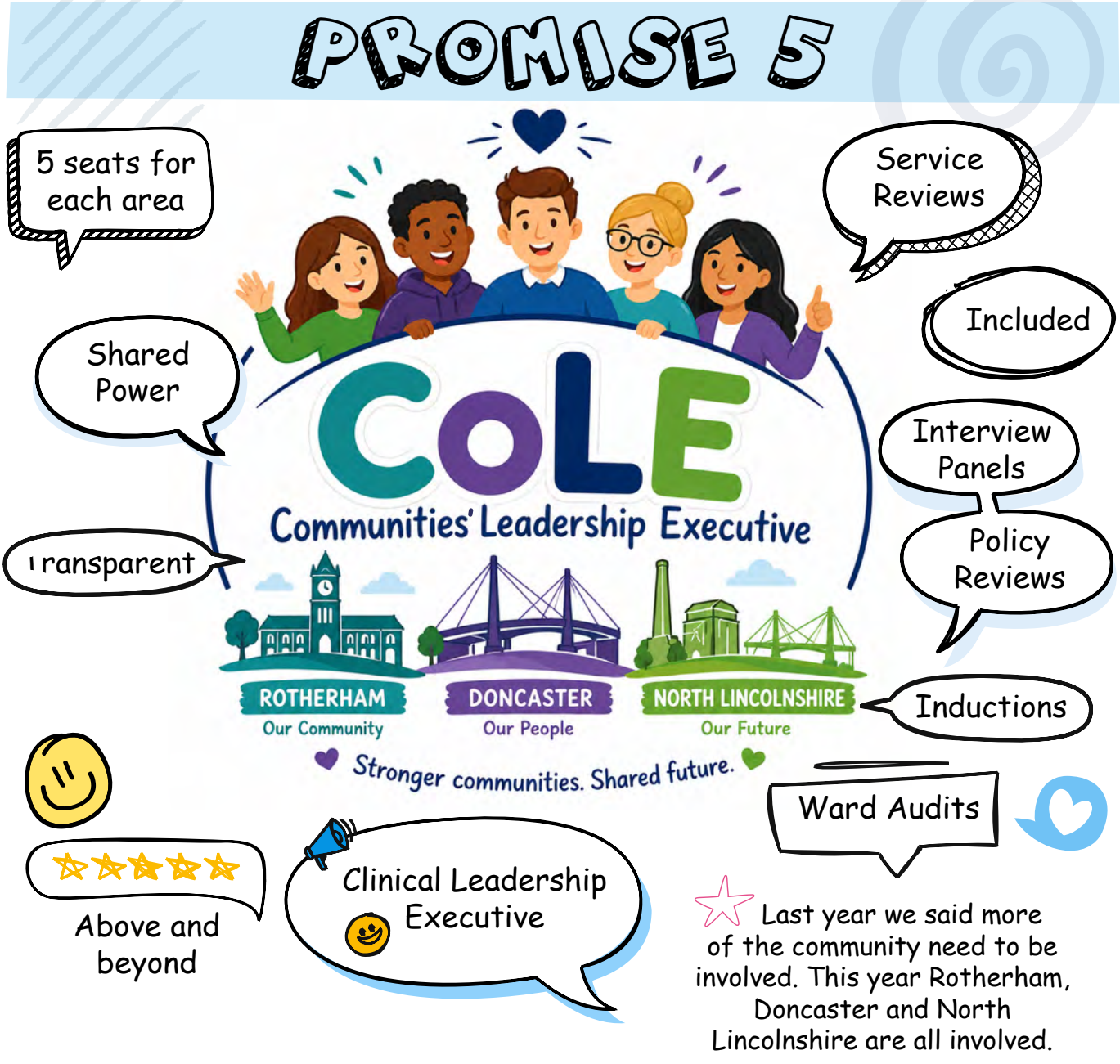
What we achieved:

More local people helping to shape services. Stronger relationships with community groups. Patients having a bigger voice. More people involved in decisions we make. Policies that are easier to understand and use.

What's next?

Stronger links between communities and us. More opportunities for people to have their say. Better understanding of different community needs. Services shaped by a wider range of voices.

What our communities told us about how we did (kindly provided by People Focused Group)



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

Success Measures

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

Progress made in 2025 and 2026

We made substantial progress in poverty proofing our services. Working with a national expert organisation, 110 services completed a poverty proofing review, with all others scheduled to be completed by September 2026.

A baseline target was set to reduce "did not attend or was not brought" rates by 7% in the most deprived areas. This has not been achieved at all, but we are hopeful that the use of text reminders and free travel access from June 2026 may begin to change that.

The trust also strengthened its partnership with Citizens Advice across Rotherham, Doncaster, and North Lincolnshire, enabling over £1 million in income gains or debt relief for patients during 2025 and 2026. We are investing to expand this further, as we know that there is much overlooked and unclaimed entitlement. Disability is closely associated with poverty, and we can do much more to help local people to tackle that.

Plans for 2026 and 2027

Next year's focus is on removing practical and financial barriers to care. RDaSH will offer travel support, including home or community appointments, volunteer-driver transport, and free bus passes. More flexible appointment options (home visits, video, telephone) will be expanded, supported by the rollout of SystmConnect so patients can request suitable times. We will also provide digital equipment to those who need it.

Financial wellbeing will become a routine part of appointments, recorded on SystmOne and embedded via Dialog+ in mental health services. The trust will also improve access to food support, including easier

Promise 6 easy read:

Money shouldn't be a barrier to use services

What we achieved:

We are helping more people's financial challenges. More people are getting help with money or debt problems. We are making it easier for people to get appointments. More support is available for those who need it most.

What's next?

More support for travel costs. Easier access to appointments. Help with money worries and debt. More choices about how and where people receive care. Better access to food support and computers.

What people told us about how we did on Promise 6 (kindly provided by People Focused Group)

PROMISE 6

Money shouldn't be a barrier to use services.

RDasH now has a system in place to help people to get to their appointments. This means people can access a daily bus pass before their appointment, previous systems of claiming bus fares back did not work for people that needed help the most.

We asked what difference this has made....

'I live in Askern and had to give up work because of my health, money is really tight. Being able to have a bus pass for appointments is literally the difference between me being able to get the help I need or not'

Such a small act of support removes such a big barrier.

Making a big impact.

Dr Jude Graham, Director of Psychological Professionals and Therapies RDaSH pictured with Kelly Hicks, Managing Director PFG.

A Dignity Room for Doncaster

RDaSH has supported the creation of a Dignity Room in Doncaster.

The Dignity Room gives people in hospital free access to everyday essentials if they need them.

Items include:

- Clothes
- Underwear
- Nightwear and pyjamas
- Socks
- Slippers
- Toiletries

No one should have to worry about not having the basic things they need while they are in hospital.

The Dignity Room helps people feel comfortable, respected and cared for.

If the Doncaster Dignity Room is successful, the plan is to open Dignity Rooms in Rotherham and North Lincolnshire, so even more people can benefit.

Promise 7. Deliver all 10 health improvements made in the Core20PLUS5 programme to address healthcare inequalities among children and adults: achieving 95% coverage of health checks for citizens with serious mental illness and those with learning disabilities from 2024

Success Measures

1. Achieve measured goals for chronic obstructive pulmonary disease (COPD), hypertension, asthma, diabetes, epilepsy, oral health, and children and young people mental health by 2026 and 2027

2. Achieve learning disability and serious mental illness health check measure in 2024 and 2025 and recurrently.

Progress made in 2025 and 2026

Performance remained strong across key areas of the Core20PLUS5 programme. All children and young people with an intellectual disability or autism referred to the specialist epilepsy nurse were seen within the 4-week standard, improving on already high performance. "Was not brought" rates for children from deprived areas fell further, narrowing the inequality gap.

Although referrals for children from black backgrounds increased in number, their overall proportion remained at around 2%. A major focus was sustaining the significant rise in annual health checks for people with severe mental illness (SMI) or learning disabilities. By March 2026, over 80% of people supported by RDaSH had received their annual health check, exceeding national expectations but well short of our 95% aim.

Plans for 2026 and 2027

The trust will strengthen culturally responsive approaches to improve early access and experience for black children and young people in mental health services. It will maintain the 4-week standard for epilepsy nurse referrals and continue reducing "was not brought" rates.

RDaSH will begin monitoring cancer awareness events and follow-up referrals from blood pressure checks. Services will continue ensuring high coverage of annual health checks for people with SMI or learning disabilities, building on the peer support already in place.

Promise 7 easy read:

Make healthcare fair for everybody, including children and adults

What we achieved:

Faster access to specialist support for children with epilepsy. Fewer children and young people missed appointments. More people receiving important health checks. Progress in reducing health inequalities

What's next?

More mental health support for black children and young people. More people receiving important health checks. Continue faster access to specialist support for children with epilepsy.

Promise 8. Research, create and deliver five impactful changes to inequalities faced by our population in accessing and benefitting from our autism, learning disability and mental health services as part of our wider drive to tackle inequality ("the RDASH 5")

Success Measures

1. Increase access to health checks for minority ethnic citizens with learning disabilities.
2. Increase diagnostic rates for dementia among minority ethnic citizens.
3. Improve access rates to talking therapies among older adults.

Progress made in 2025 and 2026

Talking Therapies:

Access for older adults increased, supported by the rollout of the long-term conditions service across all 3 places, outreach to older adult groups and care homes, and awareness work on our intermediate care wards, Hazel and Hawthorne. Text messaging to people using physical health services and closer work with GPs also helped boost referrals.

Perinatal mental health:

Perinatal care was added to Promise 8 in 2025 and 2026. 21 people from black backgrounds were referred, more than the whole of 2024 and 2025, helped by investment in peer support. However, the trust recognises this is early progress and that wider system changes are needed.

Dementia:

Referrals from global majority communities did not increase. To address this, RDaSH invested in partnerships with voluntary and community organisations already working with these communities and developed place-based plans across Rotherham, Doncaster, and North Lincolnshire.

Learning disability:

Initial research suggests some global majority groups may be under-represented on learning disability registers. Health check uptake for people with a learning disability from global majority backgrounds remains lower than expected. Closing this gap is a priority for 2026 and 2027.

Autism friendly:

We have made our environments more autism and neurodivergent friendly, with a focus upon our workforce. Healthcare support workers on our wards had training on knowledge and awareness of neurodiversity. We have rolled out Oliver McGowan training across the trust as well. We have worked with people with lived experience and our psychological professionals to adapt psychological intervention. As well as this, we have invested in bringing our waiting lists down for both adults, children and young people, who have been waiting a diagnosis of autism or ADHD.

Promise 8 easy read:

Agreeing 5 changes to make services better for people with a learning disability, autism or a mental illness

What we achieved:

A lot of groundwork took place in 2025. With the exception of our commitment to autism suitable ward environments, we remain a long way from delivering the RDaSH 5.

For older adults in talking therapies, changing who accesses perinatal mental health, and addressing gaps in dementia diagnosis, we will push harder to succeed with our existing projects. For our work on annual health checks for global majority citizens with learning disabilities, we will use research and feedback to launch a new approach by November 2026.

What's next?

Better access to services for different communities. More people receiving important health checks. Continued improvement for neurodiverse people.

Promise 9. Consistently exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities

Success Measures

1. Achieve the levy requirements in 2024 and 2025 and thereafter.

2. In 2024 and 2025 introduce tailored access scheme for veterans and for care leavers.

3. In 2025 and 2026 introduce tailored access scheme for refugees and homeless citizens.

4. In 2026 and 2027 introduce tailored access scheme for people with learning disabilities.

Progress made in 2025 and 2026

We exceeded our apprenticeship levy allocation for the first time, achieving 102% spend in 2025 and 2026. With courses already committed, the trust is confident it will meet the requirement again in 2026 and 2027.

Foundations and networks for all tailored access schemes, veterans, care leavers, refugees, homeless citizens, and people with learning disabilities, were established. However, the schemes themselves have not yet launched, which the trust acknowledges as a disappointment.

Plans for 2026 and 2027

National changes to apprenticeship levy rules mean some courses are no longer eligible, so RDaSH will review its approach and increase use of short courses to maintain levy spend from 2027 and 2028 onwards.

With the groundwork now in place, 2026 and 2027 will focus on launching all tailored access schemes, ensuring meaningful employment pathways for refugees, homeless citizens, care leavers, veterans, and people with learning disabilities.

Promise 9 easy read:

Offer apprentice and learning opportunities for all our communities

What we achieved:

More investment in apprenticeship and training. Better plans to support people into work. More work needed for new schemes and make them available for different people.

What's next?

New employment programmes starting. More support for people facing barriers to work. Better opportunities for local people to learn, work, succeed.

Promise 10. Be recognised by 2027 as an outstanding provider of inclusion health care, implementing National Institute for Health and Care Excellence (NICE) and NHS England (NHSE) guidance in full, in support of local Gypsy, Roma and Travellers (GRT), sex workers, prisoners, people experiencing homelessness and misusing substances, and forced migrants.

Success Measures

1. Meet standards set out in published guidance issued by NICE and NHS England (2023)
2. Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.
3. Specific service offers in place for all or most inclusion health groups by 2027.

Progress made in 2025 and 2026

During 2025 and 2026, work on homelessness and inclusion health focused primarily on Doncaster as the pilot site. The team completed the NICE NG214 baseline assessment for integrated health and social care for people experiencing homelessness, identified gaps and produced an action plan aligned with the national NHS Inclusion Health framework. Pathways also completed a Homeless Health Needs Assessment for Doncaster. Partnerships began to strengthen with local community organisations supporting people experiencing homelessness and those involved in sex work, helping to identify barriers, develop a self-assessment audit and review service accessibility.

A new Mental Health Homeless team was established in Doncaster, including a specialist practitioner role for people involved in sex work, and RDaSH and Pathways jointly submitted a bid to the Throne Trust to develop a similar team in North Lincolnshire.

Progress made in 2025 and 2026

Looking ahead to 2026 and 2027, Rotherham and North Lincolnshire will complete their NG214 baseline assessments, identify gaps and develop aligned action plans. The partnership model piloted in Doncaster may be expanded across both places, with engagement beginning with community organisations supporting inclusion health groups. Work will continue to assess services through self-audit, and data collection will begin to support the evaluation of the Doncaster Mental Health Homeless team.

People from inclusion health groups with lived experience will help us to audit access to our services trust wide in 2026. This real time feedback must lead to change in how our policies and practices can prevent service access.

Promise 10 easy read:

Deliver outstanding health care to all parts of our community

What we achieved

More support starting for homeless people. More understanding of challenges people face. Plans to expand support to other areas.

What's next?

Better understanding of what different communities need. People with lived experience helping to improve services. More support for people facing challenges.

The views of Alex and others about how we have done on Promise 10 (kindly provided by People Focused Group)

PROMISE 10

Meet Alex

Alex is someone who sleeps rough. He gave his support to test out Promise 10 and check how services responded to people experiencing homelessness. He mystery shopped, he completed questionnaires with other people who sleep rough and we held a quiz session.

Mental health services have much more to do.

Drug and alcohol services were spot on. Reception staff and call handlers need more training.

Alex has pledged to support RDaSH to make sure services improve for people who sleep rough.

Alex is pictured with Sheryl Scott Peer Support Worker PFG and Nicola Abdy, Strategic Development Lead RDaSH.

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

Success Measures

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

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

Progress made in 2025 and 2026

Awareness and engagement increased across the trust, supported by the Ask the Question campaign, extensive Veterans Covenant Healthcare Alliance training and workshops delivered by the Strategic Development team. Identification of Armed Forces Community members continued to rise, with 14,951 referrals recorded in 2025 and 2026.

The first RDaSH Armed Forces Day brought together colleagues, NHS providers, local authorities and charities, strengthening local commitment and generating 8 organisational actions to improve trauma-informed, expedited care. Clinical policies were updated to reflect Covenant commitments, and RDaSH achieved Gold status in the Defence Employer Recognition Scheme after holding Silver for 5 years.

Plans for 2026 and 2027

In 2026 and 2027, the priority is to recruit peer support roles to provide lived-experience support for veterans, reservists and dependants, helping to improve engagement and support transitions into civilian life. Work to update clinical systems to ensure Armed Forces status is clearly recorded will continue, with completion expected by August 2026. Training, guidance and lived-experience engagement will remain central to ensuring colleagues understand the importance of identifying Armed Forces status and responding appropriately. The voices of veterans and their families will continue to shape all activity under Promise 11 as momentum builds across the trust.

Promise 11 easy read:

Provide support for veterans and their families

What we achieved

Better support for the Armed Forces Community members. More staff understanding veterans' needs. National recognition for the work we do for Armed Forces Community members.

What's next?

More support from people with Armed Forces lived experience for Armed Forces Community members. Improved recording of Armed Forces status. Better response by us to support Armed Forces Community members.

Promise 12. Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve

Success Measures

1. Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access.

2. Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.

Progress made in 2025 and 2026

We have made minimal progress on this promise this year. We undertook 3 pilot rural proofing audits using the National Centre for Rural Health and Care's Rural Proofing for Health Toolkit. In particular in Winterton in North Lincolnshire, Dinnington in Rotherham, and Moss and Fenwick in Doncaster. This involved primary care, councils, voluntary sector and Healthwatch. On completion, follow-up meetings were held with participants with actions agreed to more effectively support rural communities such as identifying what community facilities are available in Winterton that mental health services could be provided from. We are yet to start more digital and outreach work in rural areas.

Plans for 2026 and 2027

There will be an initial focus upon Winterton, based upon the rural toolkit. The actions agreed to take forward are, to identify community facilities available in Winterton that mental health services could be provided from, establish how people in Winterton get information about mental health services from, recruit more additional volunteer drivers, work with GP practices to increase attendance and reduce stigma for attending, link with Lincolnshire Rural Services Network, and work with GP Practice to see non-practice Talking Therapy clients (to make a local offer more visible and viable).

Promise 12 easy read:

Help people who don't live in towns or cities get healthcare

What we achieved

We have started to understand better the needs of rural communities. More work is needed to bring services closer to people who live in rural communities. Local organisations are starting to work together.

What's next?

We will do more work in Winterton. There will be better information about mental health support available. There will be help with travelling to appointments. More services will be available closer to where people live.

Promise 13. Substantially increase our Home First ethos, which seeks to integrate physical and mental health provision to support residents to live well in their household, children's home, or care home, including older adults.

Success Measures

1. Deliver over 130 care packages through our physical health virtual ward service.
2. Sustain and expand our intravenous (IV) provision in out-of-hospital settings.
3. Sustain and expand our Clozapine service in off ward settings.
4. Take annual opportunities to transfer services to homecare where safe to do so.

Progress made in 2025 and 2026

We have seen a decisive shift during 2025.

The IV service in Doncaster's adult physical health team has expanded significantly, and community Clozapine projects are in place now in all 3 places. The work to do this has been extensive and complex, and rich in learning.

Our virtual ward service continues to expand, and to see more complex and acutely unwell patients. Work to analyse how that can scale up further has taken place.

We have invested over £250,000 in older adult community services intended to tackle avoidable admissions.

Plans for 2026 and 2027

All the work done in 2025 has to be sustained and nurtured. We will get into a rhythm of proactively identifying service opportunities for transfer.

This will be enabled by our work to make sure that agile and remote working among our staff is well supported, with our mobile first approach extended and expanded. If home based care is much or most of what we do, we need to change how we support RDaSHians to deliver care in that way.

Promise 13 easy read:

Where we can care for people in their own home

What we achieved

There was a big change in 2025. More care in the community. Better support for people taking Clozapine. Extra support for older adults. More people receiving care at home through virtual wards.

What's next?

Build on progress in 2025. More care will be provided closer to home. Improve how we support staff working in the community. Improved technology and mobile working. Helping more people receive care where it suits them best.

Promise 14. Assess people referred urgently inside 48 hours from 2025 (or under four where required) and deliver a 4-week maximum wait for all referrals from April 2026 maximising the use of technology and digital innovation to support our transformation

Success Measures

1. Meet 4-hour wait standard in 2025 and 2026, where it applies.
2. Meet 48-hour wait standard in 2025 and 2026 for all urgent referrals.
3. Make progress to reduce waiting lists and times and close supply gap in 2024 and 2026.
4. Meet 4-week standard from April 2026 across all services. Progress made in 2025 and 2026.

Progress made in 2025 and 2026

In 2025 and 2026, significant progress was made against Promise 14. Performance against the 4-week standard continued to improve, reaching 88% by year-end. Remaining shortfalls were largely due to isolated, low-volume breaches linked to cancellations or the timing of bookings. Oversight has been strengthened through weekly reviews at both care group and trust level. A new 1-week standard for issuing appointments has also been introduced, with almost all services now compliant.

92% of services now have effective processes in place to respond to urgent referrals within 48 hours. A recent secret-shopper exercise provided additional assurance and highlighted only minor improvements required. The remaining 8% relates to children's services, where a telephony change has affected responsiveness; this is currently under review.

Plans for 2026 and 2027

Looking ahead to 2026 and 2027, the focus will be on sustaining performance against both the 4-week and 1 week standards through continued governance and oversight. Podiatry will recruit to approved posts to increase capacity, while adult ADHD and children's neurodevelopment services will continue to deliver against agreed trajectories, including meeting the national requirement that no child waits over 104 weeks for a neurodiversity assessment by Q2.

Governance arrangements will remain in place to monitor compliance and support improvement across all care groups, with the ambition of achieving full compliance by October 2026. Work will continue to embed a culture that recognises the urgency of responding to referrals 7 days a week, supported by wider clinical engagement. Engagement with referrers will also continue to strengthen the identification and escalation of urgent referrals at the point of triage.

Promise 14 easy read:

Reduce the time that people have to wait to be seen by any service

What we achieved

More people are being seen within 4 weeks. Better responses to urgent referrals. Faster appointment information. Regular checks to improve performance. Continued work to improve children's service response time.

What's next?

Keep waiting times short. More investment in services where waits are still too long. Make sure all people have short waits.

Promise 15. Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs

Success Measures

1. Support development of integrated neighbourhood teams (INTs) in 2024 and 2025 in all 3 places.
2. Restructure trust services into those INTs during 2025 and 2026.
3. Evaluate and incrementally improve joint working achieved through these teams.
4. Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme

Progress made in 2025 and 2026

As last year, these plans have been shaped and paused by national policy in relation to neighbourhoods. As such we know that we are some way behind the success measures we set.

However, for adult physical health in Doncaster we have an agreed plan that reshapes all our services into 4 neighbourhood teams. This moves us decisively to a more 'generalist' model. Implementation begins in autumn 2026.

We have worked with other partners to try to agree the framework for neighbourhood health in a way that is shaped by circumstance. Alongside the Pride in Place programme that shaping is almost concluded. The time taken to do this will hopefully ensure that this is a multi-agency piece of work, rather than the trust acting alone.

We have undertaken work to better understand declined mental health referrals in Doncaster South Primary Care Network and the learning from that work will be used to help alter how we practice trust wide. In Doncaster East we are working with GP leaders to consider what a more rurally suitable service model looks like.

Plans for 2026 and 2027

In June 2026, we brought patients, community leaders, and others together to start to build our community development work. Reimagining how the trust's teams and resources might work better embedded into communities and real neighbourhoods.

From this point we expect to spend a year adapting and developing our service models to become more bespoke and shaped to the needs of our communities. Neighbourhood teams are anticipatory in their nature and rely on continuity of care. Both are changes to how we sometimes work, and we know that they will take development, training and the alteration of our practices to be successful.

Promise 15 easy read:

Make sure care workers and the voluntary and community sector work together

What we achieved

We didn't achieve as much as we wanted to. We have been working with others so that services are closer to where people live. We have worked with local doctors to make sure people get mental health support quicker.

What's next?

We will work with others to make sure services meet the needs of local people. This also means helping people to avoid them becoming unwell or getting worse. There will be changes to the way we work and other services work.

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

Success Measures

1. Implement Dialog+ by 2026, collating individual outcomes from that work.
2. Report and improve patient recorded outcome measures (PROMS) supported nationally.
3. Ensure each trust service is reporting one local or national outcome measure by 2025 and 2026 as part of our quality plan.

Progress made in 2025 and 2026

During 2025 and 2026, the trust introduced a new approach for understanding patient experience through patient recorded outcome measures. These tools help us understand how people feel about their care and how their wellbeing changes over time. At the same time, we moved away from fixed care-plan templates and adopted Dialog+, a more personalised and collaborative way for staff and patients to plan care together.

The trust agreed to use 3 core patient recorded outcome measures (PROMs), Dialog, ReQoL-10 and Goal Based Outcomes, alongside the Dialog+ care plan, all of which are used nationally. Training was delivered across all clinical services, and by April 2026, 90% of clinical staff, totalling 1,768 people, had completed the programme. All services are expected to use at least one PROM, and most are now moving towards using Dialog+ for care planning. A small number of services have agreed exemptions from PROMs, but they still ensure personalised care through the use of Dialog+.

We continue to collect information on how well PROMs and Dialog+ are being used across teams. Uptake is steadily increasing, and services regularly review their own data, which is also shared with senior leaders to provide oversight and assurance.

Plans for 2026 and 2027

Looking ahead, PROMs training will continue, now supported by the Learning and Development team so that all new staff receive training and remaining staff can complete it. The training offer will be updated whenever new national guidance is released. Regular audits will begin to assess how effectively PROMs and Dialog+ are being used, helping teams understand what is working well and where further support is needed. We will also continue to strengthen how we use outcome data, including tracking changes in individual scores over time. These "paired measures" will help us understand whether treatments are effective and provide valuable insights into the needs of different groups and communities.

Promise 16 easy read:

Concentrate on what works for people and local communities so we can get better together

What we achieved

Care plans are more focused on what matters to people. Patients have a bigger say in care. Patients and staff work together to make decisions. We can better understand if care is helping people.

What's next?

More staff trained to support personalised care. Better understanding of what works for patients. Better support for different communities and people. Services that are learning and keep improving.

Promise 17. Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities

Success Measures

1. Narrow the school readiness gap between our most deprived communities and average in each place in which we work.
2. Seek to see 80% of children meet their own potential for school readiness by 2028.

Progress made in 2025 and 2026

In 2025 and 2026, delivery became fully established in both Doncaster and North Lincolnshire. Building on last year's parent feedback, Ready for Reception events were delivered across both places, alongside Healthy Child Programme work focused on toileting, oral health, emotional regulation and communication. Engagement has been targeted towards communities experiencing the highest levels of deprivation, with particular attention to Roma and Gypsy Traveller families. In response to what these communities told us, the approach has shifted towards relationship-led, psychologically informed engagement, working closely with trusted community contacts and outreach teams.

Place-based work has centred on neighbourhoods with the greatest inequalities and lowest school-readiness outcomes. Strong partnerships have developed across early years, family hubs and local authorities, supported by psychological professionals embedded within the system. The most recent available data, which runs only to 2024, shows a decline in school-readiness outcomes, meaning it is too early to see the impact of the new model.

Plans for 2026 and 2027

The next phase will prioritise consolidating delivery, securing sustainable capacity, and deepening system learning to ensure that early identification consistently translates into improved outcomes for children and families.

Promise 17 easy read:

Make sure pre school and school workers are working together

What we achieved

More support for children before they start school. Stronger relationships with families and communities. Extra help in areas facing the biggest challenges. Better partnership working. More time needed to see the full results of the work.

What's next?

More support for children before they start school. See if it is making a difference.

Promise 18. From 2023, invest, support, and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery

Success Measures

1. 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.
2. 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.
3. Work with patients and peers to assess the quality of services, including through peer reviews, and ensure that teams can act on that feedback and those evaluations.

Progress made in 2026 and 2027

Over the past year, the trust has made clear progress in strengthening how patient and peer feedback shapes the quality of inpatient care. A stronger emphasis has been placed on listening to what matters most to patients and carers, supported by the culture of care programme and the internal high-quality therapeutic care taskforce. This reflects a deliberate shift towards co-production, transparency and responsiveness in everyday practice.

Standardised visiting hours have been introduced across all inpatient wards, providing greater clarity and fairness while still allowing personalised arrangements where needed. Peer involvement has also grown significantly, with peer support workers now present on every mental health ward. These roles, developed with local peer support organisations, have expanded opportunities for patients to share feedback, engage in therapeutic activity and benefit from lived-experience support.

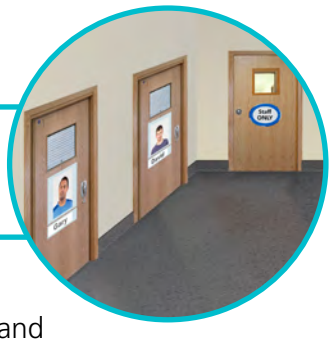
Therapeutic activity has been strengthened through an expanded 7-day timetable delivered by ward teams and wider trust colleagues, including healthy hospital teams. Workforce capability has also improved, with increased therapeutic staffing levels and targeted training for healthcare assistants on neurodevelopmental conditions, ensuring better support for neurodiverse patients. The introduction of DIALOG+ has further embedded personalised, co-produced care planning and structured outcome measures, ensuring patient feedback directly informs ongoing service improvement.

Progress made in 2026 and 2027

During the next year we will focus on diagnostic led length of stay to support patients, carers and staff to better navigate inpatient stays, strengthen the ability to use paired outcomes in treatment decisions and personalised care planning and work on the improving picture in terms of mental health act reviews and training.

Promise 18 easy read:

Work with people and carers to see how we can make time on hospital wards more useful



What we achieved

We now have standard hours for people to visit patients. There are more activities and support every day. More peer support is available on all our wards. Care plans focus on what matters to people. Better support for neurodiverse people. Services are listening to patient feedback.

What's next?

Patients and carers will know what to expect during hospital stays. Care plans are more personal and focused on a person's needs. Improved Mental Health Act training and support. Better understanding if treatment is helping. Patients and staff making decisions together. Better care and experiences for patients and families.

Promise 19. End out-of-area placements in 2024, as part of supporting people to be cared for as close to home as is safely possible

Success Measures

1. Cease to place patients out of their home district except where that is their choice or in their best interests.

Progress made in 2025 and 2026

We have made significant progress with this promise. With the introduction of a range of clinical and improved management processes to appropriately manage the flow of patients in and out of inpatient wards we have reduced the number of patients who are inappropriately placed out of area from 25 in April 2024 to 0 in May 2026. This means that patients are being cared for closer to home so their families and loved ones can visit them during their stay on our wards, and they continue to be connected to local services and communities on discharge.

Plans for 2026 and 2027

We aim to sustain having no patients inappropriately placed out of area in 2026 and 2027. To do this we will introduce further work on managing the flow of our patients through our wards including reducing length of stay, providing more therapeutic care and work with patients earlier in their stay with our partners on their planned discharge.

Promise 19 easy read:

By 2024 stop sending people to different areas for hospital care

What we achieved

Nobody being placed unnecessarily in a hospital in another area. More people are receiving care closer to home. Easier visits for family and friends. Smoother support for people when they leave hospital..

What's next?

Fewer unnecessary stays in hospital. Nobody being placed unnecessarily in a hospital in another area. Earlier planning for going home. More support and activities on wards.

Promise 20. Deliver virtual care models in our mental and physical health services by 2025, providing a high-quality alternative to prolonged admission

Success Measures

1. Deliver over 130 care packages through our physical health virtual ward service working with partners.
2. Introduce and evaluate virtual ward pilot into our mental health services 2024 and 2025.
3. Introduce and evaluate virtual ward pilot within our children's services 2025 and 2026.

Progress made in 2025 and 2026

Throughout 2025 and 2026 the virtual ward service for our physical health patients has consistently delivered between 60 and 70 virtual ward beds. This did increase during winter months to between 80 and 90 beds when we flexed our capacity in other services to respond to winter pressures within the acute hospital.

During 2025 and 2026 physical health services have continued to trial remote monitoring technology and this requires further embedding and development. We also further developed virtual ward pathways and are now able to offer first dose IV antibiotics and IV Frusemide. This has enabled our virtual ward pathway for heart failure to be used by a wider cohort of people.

Our mental health services trialled a 7 bedded virtual ward from September 2025 and is expected to conclude in May 2026. This was in response to a reduced bed base at Great Oaks hospital as part of the building improvement works but gave us the opportunity to experiment.

By the end of March 2025, a total of 13 people had received care from the virtual ward with an average length of stay of 36 days. Qualitative feedback from patients, carers and other services was extremely positive.

Plans for 2026 and 2027

The virtual ward service will move into urgent care as part of community transformation, enabling more overnight activity and more comprehensive care packages. Step-up pathways from the Emergency Department continue to support frailty and acute medicine, with further work underway to create a more proactive step-up approach for people with heart failure to avoid unnecessary admissions. A second community geriatrician post, planned for Autumn 2026, will strengthen this capability and align with the emerging Frailty Centre being developed with system partners. Doncaster's urgent and emergency care pathways are also under review, with the virtual ward remaining central to future plans, though additional investment will be required to expand capacity to 130 beds.

In mental health, a review of the virtual ward pilot began in April, examining activity data, costs, rurality challenges and case studies demonstrating benefits for patients and families. An options appraisal will provide recommendations to Clinical Leadership Executive on whether a sustainable virtual ward model could be maintained in North Lincolnshire, subject to funding. The trust is also contributing to the wider South Yorkshire review of children's virtual ward pilots, with further analysis needed to determine whether a virtual ward approach would be beneficial for RDaSH children's services.

Promise 20 easy read:

Support more people to stay at home instead of having to go to hospital

What we achieved

More people receiving care at home. Extra support during busy winter months. New treatments available through the virtual ward. More choice for people where they receive care. Positive feedback from patients.

What's next?

More care provided at home. Fewer unnecessary hospital admissions. Better support for older adults and people with frailty. Continued development of virtual ward services. Decisions based on feedback and evidence. More choice for people where they receive care.

Promise 21. Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents, developing services on a hyper-local base

Success measures

1. Fulfil our commitment to support a community-first model working alongside partners in South Scunthorpe, focusing first on those with severe mental illness.
2. Contribute actively to the city-wide Thrive programme in Doncaster, using a liberated method to ensure that duplication and handoffs of care are reduced.
3. Promise 21, implement anticipatory preventive care models supported in the Rotherham Place programme, where possible using such approaches to reduce demand for secondary care.
4. Consistently integrate our community mental health offer with that provided by voluntary sector organisations, sharing training, data and expertise to improve outcomes.
5. 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.

Progress made in 2025 and 2026

There are some encouraging signs in our work to support the Doncaster City Council Thrive model, in our contribution to neighbourhood working in Rotherham, and in our continued engagement with partners in Scunthorpe. Our care groups and selected executives now meet monthly to review progress.

But we need to acknowledge that our hyper local work is often person dependent and short term. With the appointment from April 2026 of a dedicated director level role in community development, we have reset those efforts. We would expect to be reporting a different position in 2027.

There are great examples, in dementia care in Rotherham, community mental health in North Lincolnshire and perinatal and community nursing in Doncaster of individual clinicians and leaders developing adaptive local service models. Our success will depend on liberating that capability further.

Plans for 2026 and 2027

Put simply, we will deliver the success measures we set in 2024. And we will learn from those successes to help to build more hyper local working. We will resist the traditional public service lift and scale approach and support our teams to keep creating bespoke responses.

Promise 21 easy read:

Give money, time and love to local areas to support local residents

What we achieved

Stronger links with local communities. Examples of local services designed around community needs. More support for staff to develop new ideas. A stronger focus on community development in the future.

What's next?

Achieve goals we set. Learn from success. More local services designed around community needs. Support staff to develop new ideas. Care that works for local people and communities.

Promise 22. Develop consistent 7-day-a-week service models across our intermediate care, mental health wards, and hospice models from 2025 in order to improve the quality of care

Success Measures

1. Ensure that access to urgent and emergency services is equitably available through Saturday and Sunday (this must include crisis and safe space availability).
2. Support substantially increased discharge and admission capacity over weekends.
3. Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services.

June 2025 Update

The High-Quality Therapeutic Inpatient Care (HQTC) programme was launched during the year, strengthening the delivery of 7-day therapeutic activity and establishing a consistent, multidisciplinary rhythm across wards. Work also continued to improve the use of the 3 Section 136 suites, ensuring timely responses, maintaining functionality, and sustaining compliance with the 24-hour breach metric. Joint workshops with the South Yorkshire Integrated Care Board helped reduce the number of mental health patients waiting over 24 hours in emergency departments to fewer than one per month. But everyone would accept that this should not occur at all.

While weekend discharges have not increased at the same pace as weekday activity, weekend admissions have improved, supported by the introduction of the Leave Bed Standard Operating Procedure. During 2025 and 2026, the trust undertook a structured analysis of quality and safety risks associated with weekend working, reported to the Clinical Leadership Executive in March 2026 through the Promise 22 paper.

The review confirmed that urgent care continues to be delivered safely through established 24 hour, 7-day arrangements. Highlighting that reduced routine and specialist provision at weekends shifts risk onto a smaller number of crisis and emergency services. These risks were actively mitigated through strengthened handovers, clear escalation routes and Board-level oversight, providing assurance for the year and establishing a baseline for future 7-day service planning.

Plans 2026 and 2027

Work is underway with the 3 local authorities to see if we can review the social work offer on the inpatient wards and begin preparing for discharges in a timelier way, particularly complex discharges. This will start with Doncaster City Council, first to test model.

During this year we will introduce diagnostically led admissions, which will support the right therapeutic offer for patients and support a more meaningful use of expected day of discharge (EDD).

As we seek to expand our consultant cover in physical health services by recruiting to a second full-time older person consultant in October 2026, we look to then able better "step up" arrangements for our virtual ward preventing acute admissions.

Promise 22 easy read:

Have services that are open 7 days

What we achieved

More therapeutic activity for patients. Timely support for people in mental health crisis. Better planning for a future 7-day service

What's next?

Earlier planning for patients to go home. Earlier support for people with complex needs going home. Better teamwork between hospitals and councils. Smoother and safer discharges from hospital.

Promise 23. Invest in residential care projects and programmes that support long-term care outside our wards, specifically supporting the expansion of community forensic, step-down and step-up services

Success Measures

1. 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.
2. Expand the scale of our residential forensic rehabilitation service.
3. Establish and support a step-up service for older peoples' care in Doncaster by 2027.

Progress made in 2025 and 2026

During 2025 and 2026 we developed a partnership with South Yorkshire Housing Association (SYHA) to deliver specialist mental health and housing support. In April 2025, we opened accommodation in Burns Court, Rotherham which consists of 10 self-contained flats, a communal lounge and a garden. SYHA provide housing and housing support. We support mental health needs from our Assertive Outreach team. We successfully repatriated 10 people from out of area long stay specialist mental health care into Burns Court throughout the year.

The service provides safe and stable housing to adults with complex mental health issues while working towards building their independence. This aligns with the community rehabilitation vision of working with adults in a holistic manner to enable people to manage their mental health needs and work towards managing their own tenancy.

Plans for 2026 and 2027

We plan to extend this service into Doncaster and North Lincolnshire places and are in discussion with potential partners to do this.

Promise 23 easy read:

Develop safe long term care in communities

What we achieved

Safe and secure housing provided for people. More independence for people. Help people build skills for everyday life.

What's next?

More safe and secure housing provided for people.

Promise 24. Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan and step-up services

Success Measures

1. Student feedback to reach upper quintile when compared to peers.
2. Trust workforce plan for 2028 on track to be delivered.
3. Trust meets expectations applied through national Long Term Workforce Plan roll out.

Progress made in 2025 and 2026

Student placement numbers have expanded. Our student feedback remains positive when compared to our peers, but we also recognise this does not cover all our students because our apprentices are also students and their feedback is not captured.

We have begun meaningful job plan clinical roles to ensure that they have the time to undertake educational roles. This enables us, with those postholders, to consider how we support them as educators.

The training budget for the trust has continued to expand, through savings made elsewhere, as we look to ensure all of our people have access to the developmental training they aspire to have.

Progress made in 2025 and 2026

Our focus ii on being fully staffed. This will help to liberate more time for educational supervision, and time for learning.

In developing educational supervisors, we want to support a move from ‘good to great’ and our Learning and Education Plan explains how we might do this.

Promise 24 easy read:

Make sure we train people to work for us well

What we achieved

More opportunities for students. Positive learning experiences. Better support for staff who teach others. More training and development opportunities.

What’s next?

Enough staff to support learning. More time for training and development.

Promise 25. Achieve Real Living Wage accreditation by 2025, whilst transitioning significantly more of our spend to local suppliers in our communities

Success Measures

1. Obtain Real Living Wage Foundation accreditation in first half of 2025.
2. Pay the Real Living Wage to our own employees from April 2025, or sooner.
3. Transfer more of our spend to local suppliers (shift of 25%+ compared to 2023 and 2024).

Progress made in 2025 and 2026

Real Living Wage accreditation was achieved in June 2025. This has been maintained with the payment of the uplift to colleagues in April 2026. The Trust Board is clear that we will meet this annual commitment. All our contractors have been contacted about their pay models, with a clear indication that we will begin to cease contracts with those who do not meet these standards.

Plans for 2026 and 2027

Our focus is on the transfer of more spend to local employers, and local employers who meet the Real Living Wage. A structured plan to do this will be in place by September 2026.

Promise 25 easy read:

Pay our staff the real living wage so they can afford to live

What we achieved

Staff are paid a fair wage. People who work on our contracts should pay fairly.

What's next?

Spend money locally with people who pay fairly.

Promise 26. Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion

Success Measures

1. Implement suite of policies and practice to kick racism out of our trust.
2. Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.
3. Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.
4. Tackle our gender pay gap.

Progress made in 2025 and 2026

In October 2025 we heard clearly from staff in our trust that our efforts to tackle discrimination had not yet succeeded. In November, the Board took a decision that to deliver before 2028 we needed to move to a position where all employees could demonstrate that we are actively anti-racist. We have not met this promise yet.

We have successfully achieved the NHS North-West Framework accreditation this year. This reflects our strategic work but that does not minimise the acknowledgement that we need to do more in real life. From July 2026, all promotion panels at the trust, and appointment panels above band 7, will only proceed if the appointing panel has visible diversity.

Our gender pay gap has further reduced to a very low level, and we are hopeful that during 2026 it can be eliminated entirely.

Plans for 2026 and 2027

We will launch our antisemitism training in July 2026. As we change our appraisal model the commitment to individual work in anti-racism will find a clear place at scale.

We remain focused on ensuring that the leadership of the trust is diverse, and that those in leadership roles develop and deliver objectives related to cultural competence and diversity.

Promise 26 easy read:

Remove racism through education

What we achieved

More needed to tackle discrimination. More diverse decision-making panels. Fairer recruitment processes. Progress towards equal pay for everyone.

What's next?

More training about equality and respect. Diverse leadership teams. Everyone playing their part to tackle discrimination.

Promise 27. Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change

Success Measures

1. Reduce our carbon tonnage by 2000 (and offset balance).
2. Agree and deliver specific contribution to local authority climate change plans.
3. Change service models for patients and staff to reduce travel required by 2027.

Progress made in 2025 and 2026

We have refreshed and relaunched our Green Plan which focuses on 5 key priorities aimed to deliver our promise. We have undertaken an energy feasibility study to identify how we can reduce carbon emission from gas across our sites. The Board of Directors agreed in May 2026 to move Tickhill Road site away from gas by installing ground source heat pumps which should reduce carbon emissions from gas from 1200 tonnes per annum to 0 by December 2028.

We held a Climate Adaptation workshop with partners and undertaken a self-assessment against a national framework to identify areas where our service delivery would be at risk due to climate change across our 3 places.

We have started weighing our food waste across the trust to identify ways to reduce unnecessary waste.

Plans for 2026 and 2027

Finalise plans for installation of ground source heat pumps on the Tickhill Road site and secure planning permission. We will then need to go out to procure a partner to work with us to deliver and install the pumps. We will also work to reduce our food waste and identify where we need to align our work on climate adaptation with our local authority partners.

Promise 27 easy read:

Make choices to protect our planet

What we achieved

Plans for less pollution from our buildings. Plans for more environmentally friendly heating. Less food waste.

What's next?

Get permission for more environmentally friendly heating. Work with others to reduce food waste. Work together to protect the future environment.

Promise 28. Extend the scale and reach of our research work every year, creating partnerships with industry and universities that bring investment and employment to our local community

Success Measures

1. Meet portfolio study recruitment targets each year.
2. Deliver metrics contained in the trust's research and innovation plan.
3. Work to further increase the reach of research into excluded communities locally.

Progress made in 2025 and 2026

Over the past year, a lot of patients and members of the public have been able to take part in research, thanks to the hard work of our staff and research team. We have opened more research studies than ever before. We have also offered a wider range of research opportunities across our services. This includes both mental health and physical health care, and we are pleased to see more research happening in physical health services.

We have made good progress with the research element of our Research and Innovation Plan, especially with our "super 6" priorities and our work with universities and industry partners. In September 2025, we started a partnership with Clerkenwell Health. This gives patients and the public the chance to take part in new and advanced clinical trials close to where they live.

We have also worked to make sure more people from our local communities can take part in research. We continue to involve patients and the public in planning and running all our research and innovation work. This year, we were chosen to host the Ethnic Minority Research Inclusion (EMRI) network. This is a regional project that helps more people from different backgrounds take part in research across Yorkshire and the Humber. EMRI includes many public contributors who help with research studies and help design and lead the work.

Plans for 2026 and 2027

Our plans include growing the number of clinical trials we run with companies. We will do this by building strong partnerships, such as the one we have with Clerkenwell Health.

We are also continuing to develop our work in our "super 6" priority areas, with an early focus on dementia research.

Our research staff have been recognised for their hard work by winning fellowships and awards from the National Institute for Health and Care Research (NIHR). We have also helped more staff apply for these opportunities, so we can grow our research skills and increase the amount of research we can do in the future.

Promise 28 easy read:

Do research together with communities

What we achieved

More people took part in research. More opportunities to take part in research. More mental and physical health research. More people from different communities getting involved. Patients helping to shape research. New ideas to improve health and care in the future.

What's next?

More opportunities to take part in research. More research taking place closer to home. A stronger focus upon dementia research.

Our 28 Promises set out our commitment to improving the lives of the people and communities we serve through nurturing the power that we know already exists in our communities.

This report has been produced by people in our communities to give an independent update on the progress we're making. In 2027 and 2028, our reports will be produced by our Communities' Leadership Executive. This is a unique 'shadow' body which tracks and supports, and challenges, and stretches, the senior leadership of the Trust. Launched in April 2026, this body includes 16 local representatives from: the Parent and Carer Forum – North Lincs, Citizen Advice – Doncaster, Rush House – Rotherham, the People Focused Group, Changing Lives in Doncaster, APNA Haq in Rotherham, MIND in North Lincs and in Doncaster, Choice for all Doncaster (CHAD), Voluntary Action Doncaster, You Asked We Responded Services (YAWR), RAW people (S62), Rotherham United Community Trust, Rubiks Inclusive Counselling Interventions (North Lincs), Carers' Support Service – North Lincolnshire, and Changing Lives Through Changing Minds (CLCM).

We want to hear what you think about the progress we are making.

- Does it feel like we're delivering the changes we promised to?
- Where are we making a difference?
- Where do we need to do better?
- Are we missing anything?

Whether your feedback is positive, challenging or somewhere in between, we want to hear from you. *So please do get in touch*. The more views we have the better! You can provide feedback. You can contact us in any of the 5 ways outlined below, whichever makes sense to you:

- Through Care Opinion, visit www.careopinion.org.uk/services/rxe
- via our partner (People Focused Group, email hello@peoplefocusedgroup.org.uk
- using our Corporate Communications team, email: rdash.rdashcommunications@nhs.net
- or direct to the trust's Chief Executive on behalf of the Board, email: tobylewis@nhs.net

A big thank you to the People Focused Group (PFG) who have given their input on our Promises 1 to 5 which sit under objective 1 which covers nurturing partnerships with patients and citizens to support good health and promise 6 and 10.

Trust Headquarters

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DRAFT FULL BUSINESS CASE

TRUST ESTATE PLAN

24 JULY 2026

TRUST ESTATE PLAN

DRAFT FULL BUSINESS CASE

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Draft Full Business Case – Trust Estate Plan

Chapter 1 - Executive Summary

1. Purpose

1.1 This draft Full Business Case has been prepared in accordance with HM Treasury Green Book and the Five Case Model and follows a proportionate option appraisal process appropriate to the current scope and stage of programme development.

1.2 This Full Business Case has been prepared to identify and confirm

- the preferred option for the redevelopment of the Tickhill Road Hospital estate in terms of 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 option for the land sale
- and also to identify ways forward for the Rotherham development

1.3 This Full Business Case explores the five cases which underpin Government investments.

1.4 This is set out in the table below:

Table 1. Structure of the Full Business Case

Business Case Section	Narrative and Role of this Paper
Strategic Case	This paper and previous presentations to the Board have set out the key policy drivers and the case for change. This will only be examined for changes to policy drivers which could have an impact on how the Trust will proceed.
Economic Case	This looks at the wider balance between costs, benefits and risks in selecting the option which provides optimal value for money. Benefits include those that can be quantified, those which cannot and also include the wider opportunities for social benefits.
Commercial Case	The commercial case (s) will be made for (a) the decarbonisation solution, (b) how to implement the preferred way forward and (c) the land sale as well as proposed procurement routes for Riverside and Waterdale.

Business Case Section	Narrative and Role of this Paper
Financial Case	This looks at the direct financial impacts and affordability, both in capital and revenue terms of the proposed estate plan. It is implied by the financial inputs into the economic case.
Project Management Case	This will set out how the plan will be managed through implementation, how we will involve our patients, carers and staff in the development and make sure that our neighbors and partners are aware of our plans. The chapter also includes outline plans for the management of risks and benefits

1.5 The Case supports the Trust's ambition to implement an Estate Plan which delivers the overall policy objectives of moving care into the community, working with local partners across the Trust's catchment, decarbonising the estate and wider based regeneration in local places through release of land for housing.

1.6 Confirmation of the outstanding items will inform finalisation of this Business Case.

1.7 This paper is presented as the Full Business Case for the Trust's Estate Plan as a whole. Within this, the financial and procurement decisions sought from the Board relate specifically to three Tickhill Road workstreams:

1.7.1 decarbonisation of the site through the implementation of an ambient loop energy solution;

1.7.2 construction of a new Frailty Unit and associated accommodation, including catering facilities for patients, carers and staff, a new entrance pavilion and an Education and Learning Centre; and

1.7.3 disposal of surplus land for housing, thereby contributing to local regeneration and contributing to wider social value.

1.8 Riverside and Waterdale are also described in this paper, as the other two strategic enablers within the Trust's Estate Plan, with Waterdale being already in delivery under prior approvals; the Board is separately asked to delegate authority for their procurement and contract award given their smaller scale as regards Riverside.

Strategic Context

1.9 National policy places increasing emphasis on moving care closer to home, decarbonising the public estate, improving productivity and releasing public land to support housing delivery. These objectives are reinforced by the NHS 10-Year Health Plan, the Government's 10-Year Infrastructure Strategy, the 10-Year Capital Plan, local planning policy and the RDaSH strategic direction which has anticipated, and reacted to, those policies.

1.10 Collectively these drivers establish a compelling strategic case for intervention to deliver the proposed investment in Rotherham (Riverside) and in Doncaster at Waterdale and Tickhill Road, whilst continuing our community estate focus.

Strategic Need

1.11 The Estate plan sets out the overall areas which require investment to meet overall the overall strategic need.

1.12 The Trust has already delivered several significant investments across the three places it serves; North Lincolnshire, Rotherham and Doncaster.

1.13 The main final deliverables within the Estate Plan are:

- Delivery of the Riverside Centre in Rotherham. Planning is at an advanced stage with regards to the content and delivery of the scheme;
- Delivery of the Waterdale development in Doncaster. A lease has been signed for the building. It is intended that one floor of the building will be occupied by the CAMHS services currently located at Tickhill Road (which will remove a dependency on any proposed development of Tickhill Road). The development will be completed by Q1 2027/28. It is also proposed that other areas of the building could be used for other healthcare uses by other providers in Doncaster;
- The redevelopment of the Tickhill Road site. The existing estate at Tickhill Road is characterized by fragmented services in dispersed buildings, backlog maintenance liabilities, relatively high operational carbon emissions and opportunities for estate rationalisation. At the same time there is an opportunity to develop an integrated Frailty Centre and other facilities for patients, carers and staff, improve patient pathways, reduce pressure on acute services and release surplus land for housing and wider regeneration. This development of Frailty services is important to the overall emerging service and financial strategy across Doncaster.

Investment Objectives

- IO1 Improve the quality, efficiency and long-term sustainability of the estate, reducing backlog maintenance to an agreed target level and in particular the Tickhill Road site which makes up 70% of the Trust's backlog maintenance liability.
- IO2 Reduce operational carbon emissions arising from the Tickhill Road estate, in line with NHS Net Zero commitments, as that will remove circa [60%] of the Trust's carbon emissions
- IO3 Develop an integrated model of frailty care supporting the shift from hospital 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.

Option Appraisal

1.14 Six options for the development of the Tickhill Road site have been shortlisted for comparative assessment. Each shortlisted option has been assessed consistently against strategic fit, economic performance, affordability, deliverability, risk, carbon reduction, housing benefits and social value.

1.15 The outcome of the appraisal is for a preferred way forward to be identified from the six shortlisted options described in Chapter 3, ranging from Business as Usual through to comprehensive new-build. On the basis of the current, indicative appraisal, Option 4 (Balanced Development) is the emerging preferred option, subject to completion of the switching value and sensitivity analysis referenced in Section 8.

Recommendation

1.16 The Board of Directors is asked to:

1.16.1 **CONSIDER** the Full Business Case supported by the Executive Summary

1.16.2 **RECOGNISE** the progress made since the March 2026 Board meeting

1.16.3 **SUPPORT** the recommended option regarding the Tickhill Road site development

1.16.4 **SUPPORT** The recommended option for procurement of the Tickhill Road redevelopment is early contractor involvement through an approved procurement framework.

1.16.5 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.

1.16.6 **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.

1.16.7 **SUPPORT** Option B of the funding options, Public Funding for the Tickhill Road Redevelopment and Ambient Loop via a revenue model

1.16.8 **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

Basis of Approval

1.17 This document is presented to the Board as the Full Business Case for the Trust's Estate Plan.

1.18 **The Board is asked to approve Option 4 as the preferred option for Tickhill Road**, together with the procurement strategy set out in the Commercial Case and the funding strategy set out in the Financial Case, so that the three Tickhill Road workstreams – decarbonisation, the new Frailty Unit and associated accommodation, and land disposal – can proceed without delay.

1.19 **The Board is also asked to delegate authority** for procurement and contract award for the **Riverside and Waterdale schemes**, which are of materially smaller scale, to the Chief Executive and Director of Finance & Estates, reporting to the Finance, Digital and Estates Committee.

1.20 This approval confirms the preferred option, procurement route and funding strategy for Tickhill Road. It does not yet confirm final affordability, as the

underlying economic appraisal, sensitivity analysis, distributional impacts and land receipt assumptions remain to be finalised.

1.21 Financial close and contract award for Tickhill Road to satisfactory discharge of the areas noted above, which is delegated to the Finance, Digital and Estates Committee, which will report progress to the Board.

Chapter 2 – The Strategic Case

2. Introduction

2.1 The purpose of this chapter is to establish the strategic context within which the Trust's Estate Plan is being considered.

2.2 HM Treasury's Better Business Case guidance structures the Strategic Case around four elements:

2.2.1 Strategic Context,
2.2.2 Business Needs (the case for change),
2.2.3 Existing Arrangements, and
2.2.4 Business Scope (what the programme does and does not cover).

2.3 This paper addresses all four, though not as separately labelled sections throughout, reflecting the fact that earlier Board papers have already covered much of the strategic context.

2.4 HM Treasury's Green Book requires that investment proposals demonstrate a clear alignment with national, regional and local policy before alternative options are appraised.

2.5 This chapter therefore provides the 'golden thread' linking Government policy, local healthcare priorities and the Trust's strategic ambitions to the redevelopment options considered later in this appraisal.

National Policy Context

2.6 Recent Government policy has fundamentally changed expectations of public investment. Capital programmes are now expected to deliver multiple public benefits rather than simply replace ageing infrastructure. Investment should simultaneously support healthcare transformation, environmental sustainability, productivity, housing delivery and place-based regeneration.

2.7 The redevelopment programme should therefore be assessed not solely as an estate project but as a strategic investment capable of delivering multiple public policy objectives.

Fit for the Future, the NHS 10 Year Health Plan for England

2.8 The NHS 10 Year Health Plan establishes three strategic shifts:

- moving care from hospitals into community settings;
- moving from analogue to digital models of care;
- and moving from treatment towards prevention.

2.9 These shifts require healthcare estates that are flexible, integrated and capable of supporting new models of care.

2.10 For the Trust's Estate Plan, these policy objectives reinforce the opportunity to strengthen community-based frailty services, improve patient pathways and reduce pressure on acute services through an integrated model of care.

Government Infrastructure Strategy and 10 Year Capital Plan

2.11 The Government's Infrastructure Strategy and 10 Year Capital Plan promote long-term investment in productive public infrastructure. Within healthcare this includes estate modernisation, decarbonisation, improved utilisation of public assets, backlog maintenance reduction and better whole-life value for money. The plans also encourage the release of surplus public land where this contributes towards wider housing objectives.

Regional and Local Context

2.12 The Trust works across two Integrated Care Boards and Systems (Humber and North Yorkshire and South Yorkshire).

2.13 Within the system there are three Places which bring together local partners to work together to achieve better health outcomes in each Place. These typically include local authorities, NHS providers, other private or this sector providers and voluntary groups.

2.14 Typically, the objectives across the ICSs are broadly similar in looking to tackle areas of deprivation where health is relatively poor, to support people in living well for longer, to provide better facilities for child and adult mental health and for an increasingly ageing population.

<u>The NHS in Humber and North Yorkshire</u>

2.15 Humber and North Yorkshire ICB cover a population of circa 1.7m and covers 6 places:

- East Riding of Yorkshire
- North Yorkshire
- North Lincolnshire
- North East Lincolnshire
- Hull
- York

2.16 Of these places, the RDaSH catchment covers North Lincolnshire, with the other Places served by other providers of community and mental health services.

2.17 The main population centre in North Lincolnshire is Scunthorpe and surrounding towns and villages with a combined population of 170,000

The NHS in South Yorkshire

2.18 South Yorkshire Integrated Care Board (ICB) has the overview of NHS services across South Yorkshire and works as a key partner within the South Yorkshire Integrated Care System.

2.19 The ICS has a population of over 1.4 million and health provision is made up of:

- 170 GP practices
- 5 acute trusts
- 9 NHS trusts
- 4 local authorities
- 3 community/mental health trusts (one of which is RDaSH)
- 1 ambulance trust
- Over 6000 VCSE organisations

2.20 It covers the main population centres of:

- Barnsley borough, which has a population of circa 245,000 and mainly rural with a large number of towns, wards and villages. Barnsley is served by South West Yorkshire Partnership NHS Foundation Trust for mental health, leaning disability and community healthcare services.
- Sheffield city and metropolitan brough which has a population of circa 585,000. Sheffield is served by Sheffield Partnerships University NHS Foundation Trust for mental health, leaning disability and community healthcare services.
- Rotherham Metropolitan Borough which has a population of circa 265,000. The Health & Wellbeing Strategy for Rotherham is currently being refreshed, and;
- Doncaster Metropolitan Borough has a population of circa 310,000 and is also refreshing its overall strategy.

2.21 Each of the main population centres has a Place Board which brings today the key partners for health and social care (Councils, NHS providers and other providers) to develop and oversee population need-specific plans for each Place.

The NHS in North Lincolnshire

2.22 RDaSH provides all age mental health services children's physical services and learning disability services across North Lincolnshire

The NHS in Rotherham

2.23 As noted above, the Health & Wellbeing Strategy for Rotherham is being refreshed. Rotherham ranks as the 35th most deprived upper tier local authority in England out of a total of 151 local authorities. Rotherham residents have higher than usual long-term mental health problems than the England average (12.9% versus 9.9%).

2.24 RDaSH provides all age mental health and learning disability services for Rotherham.

Rotherham

2.25 The borough remains key to our plans although the Rotherham chapter of our Estate Plan is the one that contains arguably the most challenges. We know that capacity to see more patients in our non-inpatient services across Rotherham has been one of the reasons for slower progress on productivity and waiting list reduction work.

2.26 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

The above were common comments and feedback received during the estate roadshow and subsequent survey.

2.27 A key part of the Rotherham phase of the Estate plan is to exit, where appropriate, the buildings highlighted above, including a potential land sale of Ferham. The potential pace of that will be determined by the alternative

accommodation available, with some options being potentially realisable from late 2026 / early 2027.

2.28 We have invested heavily in Swallownest Court however it remains a problematic site because:

- It lacks onsite amenities, including food, albeit is has ample parking
- We have one unused ward – earmarked for a female HDRU/PICU should Phoenix rise and commissioners support us further
- The wards lack sensory space in deviation to Promise 8
- It is not truly in the town centre/orbit
- It has continued drainage and flooding issues which we have struggled to stem

2.29 The Woodlands is a purpose-built older adult in patient unit which is situated at the back of The Rotherham Foundation Trust Hospital (TFRT) site on Moorgate Road. The unit is approximately 15 years old and is sited on land which is owned by TRFT and leased to RDaSH on a 99-year lease. With the decision to close Brambles ward in March 2025, the building now houses The Willows ward which provides both functional and organic older adult mental health care. There is lots of potential to utilise the space at Woodlands in a more efficient way. In early 2025 our focus was on relocating services from our hospital partners into the space. That having stalled, Clinical Leadership Executive (CLE) is expecting a cogent plan to move Trust services into this clinical space. This includes the potential move of Magnolia Ward into Woodlands over time, recognising that this will require consultation with staff, and potentially through OSCs.

2.30 Our CIP plans will see the café close from April after many years of subsidy. In addition to the proposed Magnolia move we are exploring a variety of options for 2026/27:

- Use of space within the site for neurorehabilitation
- Conversion of one wing into consulting space for adult and children's services
- Move of some services from Centenary
- Availability of space to VCSE and primary care partners

2.31 As well as the Woodlands changes, an 'Elizabeth Quarter' type solution for Rotherham to address the current issues would be ideal and is the preferred solution for Rotherham.

2.32 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 remains an option, and 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. For the Board's clarity, we are seeking to acquire:

- Significant consulting space which can be used across a range of clinical services, but which is defined 'mental health' space, because we have found that use of more medical space is not conducive to our practice
- Distinct space for clinicians' administrative time and needs
- Ideally wider amenity, such as a café, which helps us and VCSE partners to create an ongoing asset for patients as a community after their care pathway concludes
- Accessible car parking, free to trust staff, negotiated with Rotherham Football Club.

2.33 At the time of writing the commercial discussions are ongoing with the local authority in terms of the costs of both the ground and 1st floor. As regards the 1st floor (office and meeting space) the current proposal is based on local authority partners paying a proportionate amount based on floor area occupied for rent / rates and utilities based actual costs of running the building. To give the trust board an indicative idea of the potential costs the initial offer is circa £350k per annum based on 144 workstations.

2.34 As well as the annual rental of the two floors we will also need to factor in the costs of refurbishing the ground floor for clinical and consulting space. A prudent estimate of £3m-4m has been factored into the case.

2.35 As with North Lincs the final Estate Plan will also maximise the use of neighbourhood facilities, most likely, through rented/leased solutions. This is an important discussion as Rotherham MBC considers how best to progress its Pride in Place funding: a significant proportion of local residents live in village, including places like Maltby and Wath, which we need to ensure we reach, even if a main town centre facility is more accessible than our current estate.

<u>The NHS in Doncaster</u>

2.36 For the Doncaster place, RDaSH provides all age mental health, children's physical services, community integrated services, learning disabilities, forensic services and drug and alcohol services.

2.37 There is an opportunity to redesign frailty services across Doncaster. The Trust already operates a frailty service and a virtual ward system which is working well. This is an exciting opportunity for the city of Doncaster, though this business case focuses on the requirements of RDaSH and not that of the wider Place. Any subsequent city-wide changes to frailty services will be considered as Phase 2 and a separate business case.

Trust Strategic Context

2.38 The Estate Plan directly supports the Trust's strategic ambitions by creating a more sustainable, efficient and flexible estate capable of supporting future service transformation. The plan as a whole integrates estate rationalisation, decarbonisation, clinical transformation and land optimisation across the Trust's catchment.

RDaSH Clinical & Organisational Strategy 2023–2028
Strategic Objectives and 28 Promises

Strategic Objective	Promise
1. Nurture partnerships with patients and citizens to support good health	1. Employ peer support workers at the heart of every service by 2027.
	2. Support unpaid carers in our communities and among our staff.
	3. Work with over 350 volunteers by 2025.
	4. Put patient feedback at the heart of service delivery.
	5. Systematically involve communities at every level of decision making from 2024.
2. Create equity of access, employment and experience to address differences in outcome	6. Deliver a poverty-proof approach across services by 2025.
	7. Deliver the Core20PLUS5 health improvement commitments.
	8. Deliver five impactful changes to reduce health inequalities.
	9. Improve employment opportunities for under-represented groups.
	10. Be recognised as an outstanding provider of inclusive healthcare by 2027.
	11. Deliver NHS commitments to veterans.
	12. Improve recognition and response to the needs of rural communities.
3. Extend our community offer	13. Integrate physical and mental health support within communities.
	14. Assess urgent referrals within 48 hours and achieve four-week waits.
	15. Support integrated neighbourhood teams in every Place.

Strategic Objective	Promise
	16. Measure and improve outcomes year on year.
	17. Embed psychological health teams across schools and early years.
4. Deliver high quality and therapeutic bed-based care	18. Invest in and research therapeutic multidisciplinary inpatient care.
	19. End out-of-area placements wherever possible.
	20. Deliver virtual care models.
	21. Support primary care networks and the voluntary sector.
	22. Develop consistent seven-day services.
	23. Invest in residential care and step-up/step-down services.
5. Help deliver social value through partnerships	24. Expand education and workforce opportunities.
	25. Achieve Real Living Wage accreditation and increase local spend.
	26. Become an anti-racist organisation.
	27. Deliver the NHS Green Plan.
	28. Expand research through university partnerships.

Trust Existing Estate

2.39 The Trust operates from around 149 buildings across the three key areas within its operating catchment. Of those, the Trust owns 116 and the rest are leased from other organisations.

2.40 The majority of sites that the Trust operates from are in the Doncaster area, with the Tickhill Road site at 37.9 hectares being the most substantial. It also accounts for £20m of the Trust's backlog maintenance total of £27m.

2.41 The Trust operates from 4 main sites for the provision of inpatient beds as shown below:

Figure 1. RDaSH Inpatient Ward Locations and Bed Capacity

Doncaster Adult Mental Health and Learning Disabilities		
Ward name	**No. beds**	**Patient group**
Amber Lodge	13	Low secure inpatient unit for adult males with learning disabilities
Brodsworth	20	Mixed gender inpatient adult mental health (ages 16 – 65) unit.
Coniston	20	Closed
Cusworth	20	Mixed gender inpatient adult mental health (ages 16 – 65) unit.
New Beginnings	13	Specialist detoxification service from drugs and alcohol.
Skelbrooke + s.136	5	Adult inpatient psychiatric (ages 16 – 65) intensive care unit for the most unwell patients.
Windermere Lodge	20	Older persons inpatient mental health unit specialising in assessment and treatment for memory difficulties and dementia.
Physical Health and Neurodiversity Care Group – Doncaster		
Hawthorn	19	Rehabilitation services for patients who have experienced illness or a fall to enable them to regain their independence at home.
Hazel	19	
Magnolia Lodge	8	Neuro-rehabilitation unit: 8 inpatinbet beds and 6 bed virtual ward/early discharge
St John's Hospice	10	Specialist palliative and end of life care for adult patients in Doncaster.

Rotherham Adult Mental Health Care Group		
Rotherham - Swallownest Court		
Kingfisher + s.136	5	Adult inpatient psychiatric (ages 16 – 65) intensive care unit for the most unwell patients.
Sandpiper	18	Mixed gender inpatient adult mental health (ages 16 – 65) unit.
Osprey	18	Mixed gender inpatient adult mental health (ages 16 – 65) unit.
Goldcrest	18	Closed
Rotherham – The Willows		
The former Glade and Brambles wards merged in January 2025 and were renamed the Willows in September 2025.		
	15	Older persons inpatient mental health unit focused on assessment and treatment for patients experiencing memory issues or dementia.
Rotherham - Phoenix		
Phoenix High Dependency Rehabilitation Unit	16	Specialised mental health service focused on intensive support for people (male) with more complex mental health needs.
North Lincolnshire - Great Oaks		
Mulberry + s.136	17	Mixed gender inpatient adult mental health (ages 16 – 65) unit.
Laurel	13	Older persons inpatient mental health unit.

Trust Estate Plan

2.42 The Trust developed a high-level estate plan in 2024 and good progress has been made to date in delivering the required outputs of that plan.

2.43 Progress to date is summarised in the table below:

Place	Element	Progress
North Lincolnshire	Elizabeth Quarter	Complete
	Vacate Monarch House	Complete
	Vacate The Ironstones Centre	Complete
	Vacate 19 Market Hill	Complete
	Vacate Health Place Brigg	Complete
	Sale of Stockshill Road	Complete
	St Nicholas House Works	Complete
	Great Oaks Capital Programme	Complete

Place	Element	Progress
	Mapping and Use of Community Assets for future opportunities	Ongoing
Rotherham	Ferham Clinic Minor Works	Complete
	Riverside building	Covered within this Business Case
	Phoenix Ward	Complete
	Swallownest Court catering and entrance	Ongoing
	Woodlands inpatient unit on Rotherham FT Hospital site- use of space	Ongoing
Doncaster	Decisions required for future of non-Tickhill Road properties	Ongoing
	Review of use of space in CHP (LIFT) buildings	In train
	Waterdale	Covered within this Business Case
	Tickhill Road	Covered within this Business Case as the main focus

2.44 The approach has been to deliver these as individual projects under the aegis of the overall estate plan.

2.45 This will remain the primary route of delivery, but there are interdependencies between Riverside, Waterdale and Tickhill Road which requires a more co-ordinated approach to be taken between those three. This is covered further in the management case.

2.46 Given the nature of the Tickhill Road site, it is pertinent to add the need for housing across Doncaster as set out below:

Doncaster City Council

2.47 The Government's 10-year Infrastructure Plan is clear in the objective of building 1.5m new homes over that period through the Affordable Housing Programme with investment from the National Housing Bank., the impact of which is that many local authorities have had their targets for new housing provision increased.

2.48 Doncaster City Council is currently revising its Local Plan (to 2040) to take account of the increase in housing targets which have been identified as a result of the 10 Year Infrastructure Plan.

2.49 Doncaster had a target of delivering 920 new dwellings per annum and this has been increased to 1235 dwellings/annum.

2.50 The general policy in Doncaster is that of the 1235 new homes, circa 25% should be affordable which is applicable to developments of 15 housing units or more.

2.51 Doncaster City Council has identified that within the target for affordable new homes, there is a shortage of affordable family-sized rentals (3+ bedrooms) for social housing and there is also a shortage of energy-efficient housing stock.

2.52 The key areas for development are in the areas of the City which demonstrate a number of key indicators of deprivation. These are:

- Hexthorpe
- Mexborough
- New Edlington and
- Balby Bridge

2.53 Housing shortages in the Balby Bridge area (which is close to the Tickhill Hospital site) are heavily driven by a lack of quality social housing, lingering anti-social behaviour (ASB) in high-density flat blocks, and a broader shortage of suitable, affordable family and elderly-care homes.

2.54 The key constraints in the area include:

- **Shortage of Quality Social Housing**: Although it contains a significant number of social/council properties managed by St.Leger Homes, there is a severe deficit of modern, energy-efficient, and appropriately sized homes.
- **High-Density Flat Issues**: The area features a high concentration of aging apartments. Persistent ASB and drug-related crime in communal areas have rendered certain blocks unattractive and difficult to let, shrinking the pool of functional, desirable housing
- **Deprivation and Viability**: Identified as one of the most deprived areas in England, the local market suffers from poor investment viability. This deters private developers from building without council intervention and Section 106 agreements.

- **Lack of Older Persons' Accommodation**: There is a documented shortfall in specialist and supported housing for older and vulnerable residents in the wider Balby area, forcing many into unsuitable or difficult-to-maintain properties.

2.55 These will be key areas to consider in the potential development of Tickhill Road.

Strategic Summary

2.56 The strategic context demonstrates a strong alignment between Government policy, local priorities and the Trust's strategic ambitions.

2.57 This is summarised in the table below:

Policy Objective	**Delivered by**
Fit for the Future – shift to community care	
	Riverside
	Waterdale
	Tickhill Road
Government Infrastructure Plan	
• Decarbonisation	Tickhill Road
• 1.5m new homes	Tickhill Road
Doncaster Council	
• Increase in housing target	Tickhill Road
NHS in North Lincs	
• Elizabeth Quarter development	Complete
• Great Oaks refurbishment	Complete
NHS in Rotherham	
• Shift to locally based services	Riverside
NHS in Doncaster	
• Potential Shift of Outpatients	Waterdale
• Potential Reconfiguration of Frailty services	Tickhill Road
The Trust	
Trust Promises (including the Trust's Green Plan)	Riverside
	Waterdale
	Tickhill Road

2.58 The three key strategic enablers of the of these policy and strategy drivers are:

- The Riverside development in Rotherham
- The Waterdale development in Doncaster and
- The redevelopment of the Tickhill Road site in Doncaster partly enabled by the land sale

Each of these key elements are at different stages of development and this will be set out clearly in the rest of the Business Case. Given the overall scope and scale of the Tickhill Road programme, this Business Case is

therefore more focussed with the various elements of that in delivering the strategic and policy objectives set out.

2.59 The Business Case will therefore focus on the economic, commercial and financial imperatives of Tickhill Road

Business Scope

2.60 This paper is presented as the Full Business Case for the Trust's Estate Plan as a whole, comprising three strategic enablers: Riverside (Rotherham), Waterdale (Doncaster) and Tickhill Road (Doncaster).

2.61 Waterdale is already in delivery under prior approvals and is described in this paper to give a complete picture of the Estate Plan; they are not re-appraised here, and the financial implications are already embedded within the Trust's business-as-usual baseline.

2.62 The financial and procurement decisions sought from the Board in this paper relate specifically to the three Tickhill Road workstreams:

- decarbonisation of the site through the ambient loop and associated energy infrastructure;
- construction of the new Frailty Unit and associated accommodation, including catering, a new entrance pavilion and the Education and Learning Centre; and
- disposal of surplus land for housing.

2.63 Each of these three workstreams has a distinct delivery profile and risk interface, which is why the Commercial Case sets out a separate procurement route for each, and why the Financial Case appraises separate funding routes for each.

2.64 For Riverside and Waterdale, given their smaller scale relative to Tickhill Road, the Board is separately asked to delegate authority for their procurement and contract award to the Chief Executive and Director of Finance, reporting to the Finance, Digital and Estates Committee, rather than bringing each back to full Board.

The Case for Change

Introduction

2.65 The purpose of this section is to demonstrate why and how the Trust's Estate Plan is required and why maintaining the status quo would fail to meet emerging national, regional and local policy objectives. In accordance with HM Treasury Green Book guidance, the case for change establishes the strategic need for investment before alternative options are appraised.

Strategic Need

2.66 The estate – in its widest sense - remains an important component of the Trust's service delivery model. The Trust owns its own estate and has leases with commercial and other public sector landlords.

2.67 However, the estate has developed incrementally over many decades and no longer reflects contemporary models of healthcare delivery. The interaction between estate condition, changing models of care, financial pressures, decarbonisation requirements and local regeneration opportunities creates a compelling strategic case for intervention.

2.68 The objective is not simply to improve buildings, but to create an estate capable of supporting future service development while delivering improved public value.

The Trust's Current Estate

2.69 The Trust's Estate Plan set out the projects needed to improve the Trust's estate to meet policy and local strategic needs.

2.70 The most substantial part of the estates of located in Tickhill Riad in Doncaster.

2.71 The site extends to approximately 37.9 hectares and comprises buildings of varying age, condition and utilisation. Historic investment has been uneven, resulting in a dispersed estate with increasing maintenance liabilities, inconsistent environmental performance and operational inefficiencies. Backlog maintenance is currently estimated at approximately £20 million, with lifecycle replacement costs significantly higher once professional fees, VAT, inflation and optimism bias are considered.

2.72 The estate is also patient and carer unfriendly. The Trust has heard that the dispersed nature of the facilities make it difficult for patients – many of whom have long-term needs – and their carers to access the site and find the departments, service to essential items that they might need during a stay or as carers in supporting them.

2.73 The estate plan is driven as much by the opportunity to improve and expand services as it is by estate condition. Analysis undertaken by the Trust indicates opportunities to improve frailty pathways, reduce unnecessary admissions, improve patient flow and strengthen community-based models of care. Development of a modern frailty facility would support closer integration between inpatient, community and virtual models of care and contribute to reducing pressure on acute services.

2.74 The Trust must balance continued investment in ageing infrastructure against investment that delivers long-term strategic benefit. Maintaining the existing estate configuration would require continuing expenditure on backlog maintenance and operational costs without fundamentally addressing estate inefficiency or supporting service transformation. Consequently, the appraisal must consider both the costs of intervention and the costs of inaction.

Decarbonisation

2.75 National policy requires NHS organisations to reduce operational carbon emissions and improve energy efficiency. In particular, Tickhill Road represents a significant opportunity to achieve meaningful carbon reduction through estate rationalisation and the introduction of an ambient heat network. These measures have the potential to reduce operating costs while contributing to wider Net Zero objectives.

2.76 The Trust has undertaken a detailed appraisal and analysis of the options available to decarbonise the site.

Housing and Place

2.77 The programme also presents an opportunity to release surplus land for residential development, contributing towards local housing requirements and wider regeneration objectives. Subject to planning policy, land disposal could support delivery of affordable housing, specialist accommodation and key worker housing while generating capital receipts to support the wider redevelopment programme.

2.78 As noted above, the adjacent area of Balby Bridge has some significant housing needs and the release of surplus land through the plan for Tickhill Road will contribute to that. The economic appraisal makes some assumptions about the mix of housing to be provided based on Doncaster City Council Planning Policies, but these will need to be explored further.

Strategic Rationale

2.79 Taken together, the evidence demonstrates that intervention is required for reasons extending beyond estate condition alone.

2.80 The redevelopment programme has the potential to deliver multiple strategic outcomes through a coordinated investment, including improved clinical services, reduced carbon emissions, greater estate efficiency, enhanced financial sustainability and wider social value. The following chapter establishes the investment objectives and critical success factors against which all shortlisted options will be assessed.

Investment Objectives, Critical Success Factors and Theory of Change

Introduction

2.81 The Green Book requires investment options to be assessed against clearly defined objectives before they are compared. This chapter establishes the Investment Objectives, Critical Success Factors and Theory of Change that form the basis of the subsequent option appraisal.

Investment Objectives

2.82 The estate plan has six principal Investment Objectives. Each objective has been developed from the strategic context and case for change and provides a measurable basis for comparing the shortlisted options.

- 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.

SMART Objectives

2.83 The table below sets out the measurable outputs for each Investment Objective. These will be finalised as the Conditions Precedent at Section 9.8 are resolved.

Objective	**Measure**	**Target**	**Status**
Carbon reduction	tCO_2e reduction. Current Trust levels are 3,562 tCO2	Reduce by 2,000 tCO2 by 2028/29 (Promise 27 of Trust Strategy)	To be delivered through the ambient loop proposal.
Frailty service	Beds/services operational	Complete development by 2030.	As part of the development

Objective	Measure	Target	Status
Land release	Hectares released	At least 20% of the current estate (circa 8 hectares) by 2030 or earlier	To be confirmed
Estate efficiency	Backlog/occupancy/ running costs	Reduce backlog maintenance by 50% by 2030	To be confirmed
Financial sustainability	Revenue savings	Maintain financial balance throughout	In hand.

Critical Success Factors

2.84 Critical Success Factors represent the minimum conditions that any preferred option must satisfy and are linked to the SMART Objectives above.

- **Achievability** – deliverable within an acceptable programme timeframe (all elements by 2030), allowing for planning, procurement and delivery risk, while maintaining continuity of clinical services
- **Affordability** – deliverable within the Trust's and system's capital and revenue constraints, including CDEL and PDC availability.
- **Strategic Fit** – addresses the identified business need and aligns with national, regional and Trust strategic objectives, without presupposing a particular solution.
- **Manageable Risk** – risk can be identified, allocated to the party best placed to manage it, and mitigated to an acceptable residual level.
- **Value for Money** – represents demonstrable value for money, based on a robust and consistent economic appraisal against the do-minimum option.
- Achievable within planning, statutory and market constraints.
- **Supplier Capacity and Capability** – confidence that the construction, energy and development markets can deliver the option to the required quality, cost and timescale.

Theory of Change

2.85 The programme is founded on the principle that targeted investment in the Tickhill Road estate will enable transformation of services, improved estate performance and wider public value. Investment in modern infrastructure, estate rationalisation and clinical reconfiguration is expected to generate improved patient pathways, reduced carbon emissions, lower operating costs and opportunities for land release. These outputs are expected to contribute to improved health outcomes, greater organisational sustainability and wider economic and social benefits for Doncaster.

Section Summary

2.86 The Investment Objectives and Critical Success Factors defined within this chapter provide the assessment framework for the remainder of the appraisal. Each shortlisted option will be assessed consistently against these objectives to identify the option that delivers the greatest overall public value.

Chapter 3 – The Economic Case

Purpose

3.1 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.

Proportionality

3.2 Given the nature of the overall estate plan and the potential to develop Tickhill Road in particular, the Trust has adopted a proportionate approach to option generation. The plan is constrained by the existing operational estate, clinical service configuration, planning considerations and the requirement to maintain continuity of services. Consequently, the number of realistic strategic alternatives is limited compared with a greenfield development – for any of the elements of the estate plan - which is not plausible or achievable.

Long-List Development

3.3 An initial option generation exercise has been undertaken to identify the broad range of strategic responses capable of addressing the investment objectives established in Chapter 2. These options include maintaining the existing estate, incremental investment, phased redevelopment and more comprehensive redevelopment approaches.

3.4 However, it became clear that delivering the policy imperatives, identified objectives and critical success factor meant that any long-list of options were only marginally different to each other as there are only limited areas of the site suitable for development, allowing the wider rationalisation and service development to take place.

3.5 It was therefore concluded as part of the site masterplanning exercise for Tickhill Riad in particular, that there a continuum of 6 options shortlisted represented an appropriate and proportionate spread for analysis.

3.6 For the avoidance of doubt, given the timescales set out by the SMART objectives in Chapter 2, this long-list appraisal has been conducted at a level of detail proportionate to the physical constraints of a single, substantially built-up 37.9-hectare site with continuing operational services, rather than

through exhaustive appraisal of a wide range of non-site-based or service-only alternatives.

3.7 The Investment Objectives at Section 1.13 have been drafted to describe the underlying need (e.g. reducing carbon emissions, ensuring the estate footprint matches clinical need) rather than a specific solution, so that the options below are genuinely tested against those needs; readers should note, however, that the physical masterplanning constraints referred to above necessarily limit how wide a range of alternative delivery models could realistically be considered within this appraisal.

Transition to the Shortlist

3.8 Following completion of the long-list appraisal, six strategic options were identified for detailed comparative assessment. These options represent an increasing continuum of intervention ranging from continuation of the current estate through to comprehensive redevelopment. Each option is assessed consistently against the Investment Objectives and Critical Success Factors established in Chapter 4. For the avoidance of doubt, this appraisal looks solely at the Tickhill Road site as this the remaining significant element of the estate plan.

3.9 The following section describes each shortlisted option in detail before undertaking the comparative appraisal.

Shortlisted Options

Introduction

3.10 Following the proportionate long-list analysis, six strategic options have been identified for detailed assessment. The options represent a continuum of intervention ranging from Business as Usual through to comprehensive redevelopment.

3.11 Each option is described using a common structure to facilitate objective comparison in accordance with HM Treasury Green Book guidance.

An appendix to this paper sets out the shortlisted options in more detail. The table below summarises the key aspects of each option.

Option	Description	Benefits/Disbenefits	Capital Cost (£'m)	Revenue Impact (£'m) pa	Outline Programme
1 Business as Usual	The Trust would continue to operate the Tickhill Road estate in its current configuration, undertaking only essential maintenance necessary to maintain statutory compliance and operational continuity. In order to progress along the continuum of development, the Trust would terminate some third party leases and release two parcels of land.	• No major capital investment. • Increasing backlog maintenance. • Limited contribution to decarbonisation. • No significant clinical transformation. • Minimal land release. • Lowest short-term capital cost but highest long-term strategic risk	[8.668]	[+0.75]	Complete by 28/29
2 Do Minimum	The Trust would undertake targeted essential investment to maintain safe operation while implementing only limited service and estate improvements. The Trust would also release two parcels of land as per Business as Usual.	• Addresses highest priority maintenance. • Limited estate rationalisation. • Minimal carbon reduction. • Limited improvement to clinical pathways. • Minimal land release. • Does not fully address investment objectives.	[15.096]	[+0.75]	Complete by 28/29

Option	Description	Benefits/Disbenefits	Capital Cost (£'m)	Revenue Impact (£'m) pa	Outline Programme
3 Further rationalisation	The Trust would implement a coordinated programme including an ambient heat network, phased estate rationalisation, development of a new frailty facility and planned release of surplus land. Delivery would be phased to maintain operational continuity and maximise affordability.	• Supports all Investment Objectives. • Improves clinical pathways. • Reduces operational carbon emissions. • Facilitates further land release. • Balances affordability and deliverability. • Provides flexibility for future phases.	[49.1]	[+0.72]	Complete 2029/30
4 Balanced Development	The Trust would implement a coordinated programme including an ambient heat network, phased estate rationalisation, development of a new frailty facility and planned release of surplus land. Delivery would be phased to maintain operational continuity and maximise affordability.	• Supports all Investment Objectives. • Improves clinical pathways. • Reduces operational carbon emissions. • Facilitates further land release. • Balances affordability and deliverability. • Provides flexibility for future phases.	[50.1]	[+0.72]	Complete 2029/30
5 More ambitious option	Further rationalization which allows release of some further surplus land.	• Supports all Investment Objectives. • Improves clinical pathways.	[87.9]	[+0.712]	Complete 2030/31

Option	Description	Benefits/Disbenefits	Capital Cost (£'m)	Revenue Impact (£'m) pa	Outline Programme
		• Reduces operational carbon emissions. • Facilitates land release. • Balances affordability and deliverability. • Provides flexibility for future phases.			
6 Complete New-Build	This option completely rebuilds the site	• Eliminates backlog maintenance. • Highest capital cost • Reduces future site flexibility. • Largest area of land disposal.	[170]	[+0.708]	Complete 2030/31

Notes: at the moment all capital costs and revenue costs/savings are shown in [ ] as they are still to be firmed up to the appropriate level of detail. This can be completed fully once the costs/benefits of the various elements are tested during procurement. All capital costs exclude the cost of the ambient loop system as it assumed that this will be a managed system expensed through revenue. Revenue costs do not include the costs of capital at the moment.

All programme timescales shown will also need to be tested further

Shortlist Appraisal Methodology

Introduction

3.12 This section sets out the methodology used to compare the six shortlisted options. The appraisal has been prepared in accordance with HM Treasury's Green Book and follows the principles of the Five Case Model. Each option is assessed against a common set of criteria to ensure a transparent, proportionate and evidence-based comparison.

Assessment Framework

3.13 The assessment framework has been developed directly from the Investment Objectives and Critical Success Factors established in Chapter 4. This ensures that the preferred option is identified through objective comparison rather than predetermined preference.

Criterion	Purpose	Evidence Source
Strategic Fit	Alignment with national, local and Trust priorities	Policy review
Clinical Benefits	Improved patient pathways and service transformation	Clinical analysis
Estate Performance	Estate efficiency and utilisation	Estate data
Financial Impact	Capital, revenue and affordability	Financial model
Economic Value	Public value, NPV and BCR	Economic appraisal
Carbon & Sustainability	Contribution to Net Zero	Carbon model
Housing & Place	Contribution to housing and regeneration	Planning evidence. Homes England Research
Deliverability & Risk	Programme, planning and commercial risks	Risk register

Appraisal Process

3.14 Each shortlisted option will be assessed using both qualitative and quantitative evidence. Qualitative assessment will consider strategic alignment, deliverability and risk, while quantitative assessment will consider capital costs, operating costs, carbon impacts, social value and wider economic benefits where these can be robustly quantified.

Green Book Assessment

3.15 The appraisal will consider:

- Strategic Case
- Economic impacts
- Commercial considerations
- Financial implications
- Management and deliverability
- Distributional impacts
- Equalities and statutory duties
- Risks and uncertainties

3.16 The level of analysis will remain proportionate to the scope and scale of the programme.

Economic Appraisal

3.17 Economic appraisal has been completed using Green Book methodology. Quantified benefits are discounted to present values and compared against whole-life costs to calculate Net Present Social Value (NPSV) and Benefit Cost Ratio (BCR).

3.18 Once more robust costs are evident through the procurement process and further option testing and definition, a full sensitivity analysis and identification of switching values would need to be undertaken.

3.19 The sensitivity analysis and switching values identifies the key drivers within each option – and particularly the preferred way forward – and identifies how much any of the costs, (capital and revenue), benefits and risks would need to increase/decrease so that a different option could be the preferred way forward.

3.20 This analysis would also identify the likelihood of those values being true or plausible, thereby identifying the robustness of the preferred way forward to those factors.

Preferred Option

3.21 The preferred option will be the one that delivers the optimum balance between strategic fit, public value, affordability, deliverability and risk. Selection will be based on the cumulative evidence presented within the appraisal rather than any single assessment criterion.

Chapter Summary

3.22 The methodology provides a consistent framework for comparing the shortlisted options.

Economic Appraisal and Comparative Assessment

Introduction

3.23 An economic appraisal has been undertaken to compare the relative costs and benefits of each shortlisted option using a proportionate methodology consistent with HM Treasury's Green Book and NHS England business case guidance. The appraisal draws together indicative capital investment requirements, estimated marginal revenue implications, monetised housing-related social value, discounted cash flows over the expected asset life and calculation of Net Present Social Value (NPSV) and Benefit Cost Ratios (BCR).

3.24 The Net Present Social Value (NPSV) is the overall value a project creates for society after all costs and benefits have been converted into today's money. It combines financial savings with wider economic, social and environmental benefits, allowing decision-makers to compare investment options on a consistent basis. A higher NPSV indicates that a project delivers greater overall value for society.

3.25 The Benefit: Cost Ratio as it relates to a simple benefit: cost ratio – essentially how efficient the option is at creating benefits.

3.26 However, a limitation of the exercise to date is that clinical benefits (and other benefits which may accrue from the Trust investment) have yet to be defined and assigned to each option. Also, some of the options with higher BCRs may not deliver the Investment Objectives of the Trust and are therefore are appraised as they provide a benchmark.

3.27 At this stage the appraisal is indicative and will be refined and confirmed s the procurement process for each of the elements of the esate plan are progressed.

Appraisal Assumptions

Assumption	Basis
Discount rate	HM Treasury Green Book (3.5%, reducing after Year 30)
New build appraisal period	60 years
Refurbishment appraisal period	30 years
Capital costs	Indicative strategic estimates
Revenue impacts	Marginal changes from current position
Housing social value	Homes England Social Value approach
Construction / CIAM benefits	To be refined in the next 2-3 months.

Indicative Economic Appraisal Results

3.28 The current Mini CIAM model provides an indicative comparison of the shortlisted options. The CIAM is the Comprehensive Investment Appraisal Model which is supports the analysis to be undertaken as part of the requirements of the Green Book. For the purposes of this draft Full Business Case, a truncated version has been used to generate the NPSVs and BCRs for guidance.

3.29 Results should be interpreted as supporting the selection of a preferred way forward rather than representing the final economic appraisal as these can only be presented when final costs and benefits are known following the ambient loop procurement, a separate procurement to appoint a constructor to refurbish existing properties and build new and also a commercial deal with a developer for the land sale.

Option	PV Total Costs (£'m)	PV Social Benefits (£'m)	NPSV (£)	BCR	Comment
A Business as Usual	(-3.9)	17.01	14.8	-4.34	Indicative only
B Do Minimum	(0.91)	17.01	13.66	-18.73	Indicative
C Preferred (-)	25.29	49.56	11.11	1.96	Indicative
D Preferred	30.6	60.11	31.18	1.96	Indicative

Option	PV Total Costs (£'m)	PV Social Benefits (£'m)	NPSV (£)	BCR	Comment
E Preferred (+)	70.13	67.01	26.2	0.96	Indicative
F Total Rebuild	144.16	83.12	-34.96	0.57	Indicative

Interpretation of Results

3.30 The **indicative** economic appraisal demonstrates material differences between the shortlisted options.

3.31 Options releasing greater areas of surplus land generate significantly higher monetised housing social value and therefore higher indicative NPSV. The appraisal also demonstrates the importance of considering whole-life costs rather than capital expenditure alone. Whilst annual revenue savings are modest relative to total capital investment, their discounted value contributes positively to the economic case over the appraisal period.

Limitations

3.32 The current model is intentionally proportionate and several benefit streams remain to be incorporated, including detailed CIAM operational benefits, carbon valuation, construction employment, Gross Value Added (GVA), wider regeneration effects, distributional impacts and environmental externalities. Consequently, the results should be regarded as indicative until costs and benefits can be finalized following the various procurements.

Emerging Preferred Option

3.33 The economic appraisal provides one important component of the overall decision-making framework. The preferred option will be selected through a balanced assessment of strategic fit, economic performance, affordability, deliverability, commercial considerations and programme risk, consistent with the Five Case Model. The current appraisal nevertheless indicates that the phased redevelopment options provide the strongest balance of public value and deliverability and **Option 4 is the preferred way forward, as it provides the highest NPSV**

Distributional Impacts

3.34 The Government's Green Book assessment provides a requirement to undertake a distributional analysis of how the benefits which are prposed to be divided are expereinecd in different locations and in defferent socio-

economic classes to ensure a greater fairness in the deployment of investment to create social value. A full quantitative distributional analysis is not considered proportionate or robust at the current stage of this programme for three reasons:

- First, Green Book distributional analysis is principally designed for national policy interventions where the beneficiary population is reasonably identifiable; for a single-site estate scheme, HM Treasury guidance itself expects a proportionate response, and a city-wide or ward-level breakdown risks spurious precision.
- Second, the final tenure and unit mix of any housing released at Tickhill Road has not yet been agreed with Doncaster City Council, so it is not possible to say what proportion (if any) would be allocated to existing Balby Bridge residents as opposed to the wider Doncaster housing register — assuming otherwise would misrepresent the current state of the scheme.
- Third, occupancy of new housing is a matter for the Council's allocations policy, not the Trust, so the Trust cannot itself determine who benefits.

3.35 Given this, the proportionate approach at this stage is to retain the Balby Bridge deprivation evidence (Section 3.6) as strategic context for why land release in this location is likely to support wider social value — without presenting it as a quantified distributional benefit in the economic appraisal. Once Doncaster City Council's affordable housing mix and allocations approach for the site are confirmed (expected alongside planning consent), the Trust should revisit this section to provide a qualitative distributional statement, and should also confirm whether distributional weights have or have not been applied to the housing social value already monetised in Table 8.3, and why.

Preferred Option

Purpose

3.36 The purpose of this chapter is to identify the preferred option based on the comparative assessment undertaken in the preceding chapters. Consistent with HM Treasury Green Book guidance, the preferred option is identified through objective appraisal against the Investment Objectives and Critical Success Factors rather than through predetermined preference.

Basis of Selection

3.37 The preferred option has been identified by considering the cumulative evidence relating to:

- Strategic alignment.
- Clinical transformation.
- Estate rationalisation.
- Decarbonisation.
- Financial sustainability.
- Deliverability.
- Risk.
- Wider public value.

The preferred option should represent the optimum balance between benefits, affordability and risk rather than maximising performance against any single criterion.

Emerging Preferred Option

3.38 The qualitative assessment indicates that a phased redevelopment approach provides the strongest overall balance between strategic ambition, affordability and deliverability. Such an approach supports delivery of the Investment Objectives while maintaining operational continuity and allowing investment to be phased in line with organisational capacity and funding availability.

This option also provides the flexibility to respond to future changes in healthcare delivery, technological development and estate requirements while minimising programme risk.

Benefits of the Preferred Option

- Supports national, regional and Trust strategic priorities.
- Facilitates transformation of frailty services.
- Reduces operational carbon emissions.
- Improves estate efficiency and long-term sustainability.
- Creates opportunities for release of surplus land.
- Improves long-term financial resilience.
- Provides flexibility for future phases of development.

Key Risks and Mitigation

Risk	Potential Impact	Mitigation
Funding	Delay to programme	Phased delivery and funding strategy
Planning	Programme delay	Early engagement with planning authority
Operational continuity	Service disruption	Detailed decant and phasing plans
Construction inflation	Cost escalation	Robust cost planning and contingency
Approvals	Delay to implementation	Progressive business case development

Further Work

3.39 The finalization of all values – costs, risks and benefits – will need to be undertaken when final costs are known and agreed, and these will form the analysis supporting confirmation of the Conditions Precedent at Section 9.8.

Recommendation

3.40 It is recommended that option 4 for the Tickhill Road site should be taken forward as the preferred way forward to inform the positioning of the redline for development, which in turn facilitates the procurement of the ambient loop, a contractor for the decant and new-build phases and a development partner to realize the value of the surplus land.

3.41 This recommendation reflects the current balance of strategic fit, public value, affordability, deliverability and programme risk. The Board's approval of Option 4, and of the associated procurement and funding strategies, is given on the basis set out below: it authorises the procurements described above to proceed, but does not itself confirm final affordability. Financial close and contract award remain subject to satisfactory resolution of the various procurements proposed, confirmation of which is delegated to the Finance, Digital and Estates Committee.

Chapter 4 – The Commercial Case

Introduction

4.1 The purpose of the commercial case of the FBC is to set out the proposed way forward for the Trust to deliver the preferred option.

4.2 The key areas to be covered within this section are:

- To determine procurement strategies for each of the key elements within the overall estate programme
- To identify required inputs and outputs
- Provide an indicative risk allocation
- Identify proposed payment mechanisms and
- Outline any contractual agreements

Procurement Strategies

4.3 The Case will now set out the key elements of the overall plan which require a procurement solution:

- The Riverside development in Rotherham – refurbishment of the areas for occupation by the Trust
- The Waterdale development in Doncaster – refurbishment of the areas for occupation by the Trust
- The Tickhill Road site on Doncaster comprising
    - Site wide energy solution
    - Construction of new-build frailty wards and associated accommodation
    - Proposed approach to land disposals

Procurement Strategy for the Riverside Facility in Rotherham

4.4 The Trust intends to sign a lease, subject to finalizing commercial discussions, with Rotherham Metropolitan Borough Council for the Riverside building. This has previously been used as a library and neighborhood hub and will continue to retain some local authority functions. An opportunity arose to lease the ground and first floor as the Council intends to relocate the library elsewhere.

4.5 As noted earlier, Riverside House is centrally located on the high street in Rotherham.

4.6 It is expected that the capital cost of any refurbishment works will be circa £3m-£4m and will be funded through the Trust's capital programme, potentially with CDEL cover for the cost and the costs of the lease.

4.7 Given the size of the investment, a proportionate procurement strategy and contractual approach is proposed.

Procurement Strategy for the Waterdale Facility in Doncaster

4.8 The Trust signed a long-term lease for the Waterdale building close to Doncaster town centre in March 2026. The Trust is planning a refurbishment for the Child and Adolescent Mental Health Service which is currently located on the Tickhill Road site.

4.9 It is planned that works will commence in late 2026 with transfer of service in 2027.

4.10 The investment is planned to be circa in the order of £3-4m.

4.11 Once again, a proportionate procurement strategy and contractual approach is proposed.

4.12 For NHS investments of this size and complexity, the table below sets out the most widely used procurement and contractual routes

Procurement Strategy Comparison – £4 Million NHS Refurbishment Project

Procurement Route	Typical Contract	Cost Certainty	Programme Certainty	Risk Allocation	Overall Recommendation
Traditional (Design–Bid–Build)	JCT Standard Building Contract (SBC/Q)	🟢 **High**	🟡 **Medium**	Design risk retained by the Trust; construction risk transferred to the Contractor	🟢 **Recommended**
Single-Stage Design & Build	JCT Design & Build (DB 2024)	🟢 **High**	🟢 **High**	Majority of design and construction risk transferred to the Contractor	🟢 **Recommended**
Two-Stage Design & Build	Pre-Construction Services Agreement (PCSA) followed by JCT Design & Build (DB 2024)	🟡 **Medium***(becomes High once Stage 2 Contract Sum is agreed)*	🟢 **High**	Risks identified and managed collaboratively during Stage 1 before transfer to the Contractor	🟡 **Recommended only where refurbishment risk or operational complexity is high**

Key

- 🟢 **Green** – Preferred procurement route for a typical £4 million NHS refurbishment.
- 🟡 **Amber** – Appropriate where specific project risks justify a more collaborative procurement approach

Overall Conclusion – Riverside and Waterdale

4.13 For a typical one-off project of circa £4 million refurbishment, Traditional Procurement and Single-Stage Design & Build represent the most proportionate and commonly adopted procurement strategies within the NHS.

4.14 Two-Stage Design & Build is generally reserved for projects involving significant uncertainty within the existing building, complex phasing, or operational constraints that justify early contractor involvement.

4.15 It is proposed that the final decision on procurement route, based on the above, is taken by the CEO and Director of Finance & Estates (taking advice from the Head of Estates and the Design Team).

4.16 **A final choice will be made and updates reported to the Finance Digital and Estates Committee.**

Procurement Strategy for the Ambient Loop/Energy Solution at Tickhill Road Doncaster

4.17 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.

4.18 The Programme Team has since been considering the potential ways in which the energy solution (ambient loop) can be procured and implemented and these are identified in the table below:

Identification and Nature of the Options

Option	A – Ambient Loop	B – Strategic Energy Partner	C – Strategic Energy Partner with well-defined Phase 1 (THR site)
Objective	Deliver an affordable, reliable and low-carbon energy system supporting the current redevelopment.	Create a long-term infrastructure partnership supporting future healthcare, housing, education and research developments.	As B, but with more focus on the initial THR ambient loop
Nature of Procurement	Procure a partner to design, build, finance, operate and maintain the ambient loop and associated energy infrastructure. The relationship is centred on delivery of a defined engineering project.	Appoint a long-term partner responsible for planning, financing, delivering and operating the campus energy infrastructure as the site evolves with the potential to extend to neighboring areas.	Appoint a Strategic Energy Partner with a committed first phase (ambient loop, boreholes, energy centre and initial connections), while future phases remain optional and subject to future business cases and Board approval.
Scope	Boreholes, ambient loop, energy centre, primary distribution network, operation, maintenance and lifecycle replacement.	This still provides for the same scope as A but provides potentially greater overall flexibility for the partner to design and deliver solutions to a potentially wider area.	This option is somewhere between A and B in providing greater specificity around the Tickhill Road site with a looser definition of what might happened in the future.
Level of Definition Required	High level of certainty before procurement, with most engineering and commercial matters defined.	Confidence in the long-term site vision but allows the partner to shape many technical and	Requires certainty around the committed first phase together with a defined site masterplan, while

Option	A – Ambient Loop	B – Strategic Energy Partner	C – Strategic Energy Partner with well-defined Phase 1 (THR site)
		commercial solutions.	allowing future phases to remain indicative and subject to governance.
Potential Benefits	Lower procurement complexity, clearly defined scope, lower transaction costs and simpler governance.	Strategic optimisation, innovation, integrated investment planning and strong investor appeal.	Balances certainty with flexibility, provides confidence to investors, supports phased site development and retains Board control over future investment.
Potential Risks	Future expansion may require separate procurements, reduced strategic continuity and fewer opportunities for long-term optimisation.	Greater procurement complexity, more demanding governance, longer procurement and the need to define future scope carefully.	Requires careful contract drafting, robust governance and clear definition of future scope.
Relative Procurement Complexity	Low	High	Medium/High
Future Flexibility	Low	Very High	High
Investor Attractiveness	Medium	Very High	Very High
Board Control	High	Moderate	High

Overall Assessment

4.19 Option A delivers an effective engineering solution but may lead to a series of disconnected future procurements.

Option B offers the greatest strategic ambition but also the highest procurement and governance complexity.

Option C provides the strongest balance. It secures immediate delivery of the ambient loop while creating a strategic framework for future campus development. Future phases remain subject to affordability, governance and separate business cases, while the contractual framework is already in place.

4.20 A discussion about which option to take is recommended so that we are clear on the what before deciding upon the how and this will require furtjer discussion with subject matter experts and the Trust's legal advisers.

Indicative Procurement Routes and Timescales for Site Energy Solution

4.21 These indicative timescales are planning assumptions for a complex NHS site energy infrastructure project such as the Tickhill Road programme. Actual durations will depend on project readiness, governance, market engagement and legal complexity. It is assumed that externally financed solutions are available for all options.

Procurement Route	Typical Procurement Duration	Contract Award to Financial Close	Overall Programme	Comments
Carbon and Energy Fund Direct Award (where permitted)	2–4 months	1–2 months	3–6 months	Fastest route but only where framework rules and value-for-money requirements permit.
CEF Mini-Competition	4–7 months	1–3 months	5–10 months	Good balance of competition and speed.
Government Energy Framework Mini-Competition	5–8 months	1–3 months	6–11 months	Depends on framework scope and bidder engagement.
Other Framework	5–9 months	1–3 months	6–12 months	Varies by framework.

Procurement Route	Typical Procurement Duration	Contract Award to Financial Close	Overall Programme	Comments
Mini-Competition				
Competitive Flexible Procedure	12–18 months	2–4 months	14–22 months	Allows dialogue, negotiation and bespoke commercial structures.
Open Procedure	5–8 months	1–2 months	6–10 months	Suitable only where requirements are well defined.
Framework Direct Award	2–4 months	1–2 months	3–6 months	Limited flexibility.
Dynamic Market	4–7 months	1–2 months	5–9 months	Generally better for repeat purchases than major infrastructure.
Innovation Partnership	15–24 months	2–4 months	17–28 months	Appropriate only where technology requires development.

Notes

CEF is the Carbon and Energy Fund, a membership organization founded in 2011 procured by the Countess of Chester Hospital as a legal entity to deliver a Framework for energy upgrades etc. They offer the opportunity to manage the whole design, procurement, installation and monitoring process. The fee for this is paid at financial close from the provider (and therefore added to the Trust's annual payment).

The Competitive Flexible Procedure seemed to be the route favoured by the Trust's legal advisers and the legal advisers to Ambient Energy Holdings Ltd, although the assessment of the procurement period identified above and by AEH is somewhat at variance (14-22 months versus 6 months). This suggests that we may need further discussion in this regard.

Comparative Assessment

4.22 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.

Recommendation

4.23 SUPPORT, for Ambient Loop the procurement route is via a competitive flexible procedure.

4.24 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.

Tickhill Road- Enabling and New-Build

4.25 The purpose of this section is to evaluate the procurement options available to the Trust and identify the approach most likely to support successful development and delivery of the estate plan.

4.26 The assessment has been undertaken against the procurement requirements identified in Section 2 above and reflects the current maturity of the of this element of the plan.

4.27 It should be noted that the procurement decision is not simply a question of how best to construct a future development; rather, the decision concerns how best to support the objectives.

4.28 Three main procurement approaches have been considered:

- Option A – Traditional Procurement
- Option B – Early Contractor Involvement (ECI)
- Option C – Strategic Delivery Partner

4.29 The paper then goes on to identify the potential ways in which the preferred procurement approach can then be executed.

Option A – Traditional Procurement

4.30 The contractor would therefore be appointed after substantial design development had already been completed.

4.31 This approach remains one of the more widely used procurement routes within the NHS and is familiar to Boards, auditors and procurement teams.

Option B - Early Contractor Involvement (ECI)

4.32 Under an Early Contractor Involvement model, the Trust appoints a contractor at an earlier stage of programme development through an approved framework arrangement.

4.33 The contractor works collaboratively with the Trust, advisers and stakeholders throughout programme development.

4.34 This approach enables construction expertise to inform key decisions before solutions become fixed.

4.35 The ECI model demonstrates strong alignment with programme requirements and provides significant advantages in relation to affordability, flexibility and programme development.

Option C – Strategic Delivery Partner

4.36 A Strategic Delivery Partner model extends beyond conventional procurement arrangements.

4.37 The appointed organisation could support:

- Programme Development
- Commercial Strategy
- Financing Strategy
- Design coordination
- Delivery Planning

4.38 This sort of structure is more typically used for much larger scale and more complex programmes with high degrees of uncertainty across all the domains noted in the procurement objectives.

4.39 The table below provides a subjective narrative of the strengths and weaknesses of each option against the procurement criteria identified.

Assessment of Procurement Strategies against Procurement Objectives

Procurement Objective	Traditional Procurement	Early Contractor Involvement (ECI)	Strategic Delivery Partner
Affordability	Affordability can be assessed through conventional cost planning, but challenges often emerge later, increasing redesign risk. Competitive tension is maintained through the tender process.	Continuous affordability testing through contractor expertise, live pricing and supply chain intelligence. Less likely to have competitive tension.	Strong programme-level affordability support but less direct construction market intelligence.
Cost Intelligence	Early estimates developed without direct contractor input may be less reflective of market conditions.	Direct access to market pricing, inflation monitoring and benchmarking throughout programme development.	Provides commercial insight but less direct contractor pricing intelligence.
Buildability	Construction expertise introduced later in development.	Buildability informs programme development from an early stage.	Provides strategic delivery advice but less contractor-led buildability expertise.
Programme Flexibility	Best suited to stable scope; significant changes may result in redesign and delay.	Supports evolving requirements without significant disruption.	Provides flexibility but may introduce governance complexity.
Market Engagement	Limited engagement until later procurement stages.	Direct engagement with contractors and supply chains throughout development and therefore access to real-time market intelligence.	Supports engagement through advisory functions.
Business Case Development	Supports business cases through traditional design and cost planning.	Strong support to OBC/FBC through affordability testing, risk review and validation.	Provides strategic support but less delivery-focused evidence.

Procurement Objective	Traditional Procurement	Early Contractor Involvement (ECI)	Strategic Delivery Partner
Risk Management	Established processes but delivery risks may emerge later.	Enables earlier identification and mitigation of risks.	Strong programme-level risk management capability.
Commercial Opportunity	Limited support for wider commercial opportunities. More usual to have all funding streams clearly agreed.	Supports integrated consideration of commercial opportunities.	Particularly effective for partnerships and financing opportunities.
Governance & Assurance	Strong governance, auditability and compliance. Provides a higher and more direct control over design development.	Requires benchmarking, independent assurance and gateway reviews.	Requires additional governance and oversight structures.

Conclusion - Subjective

4.40 The assessment demonstrates that Early Contractor Involvement provides the strongest overall alignment with the Trust's requirements. Whilst Traditional Procurement offers advantages in governance and procurement compliance, it performs less strongly in supporting programme development, affordability management and market engagement.

4.41 The Strategic Delivery Partner model performs well in relation to commercial opportunity and strategic programme support but introduces additional complexity and cost that are not currently justified by programme maturity.

4.42 Accordingly, on this subjective analysis, Early Contractor Involvement is considered the procurement approach most likely to support successful progression of the Tickhill Road Redevelopment Programme through to implementation.

4.43 However, to reduce the level of subjectivity the analysis below undertakes a weighted scoring exercise, with sensitivities to provide a more robust analysis and outcome.

Weighted/Scoring Evaluation

Evaluation Principles

4.44 The scoring methodology has been developed to reflect the requirements identified within Section 2.

4.45 The intention is not to identify a theoretical best procurement route. The intention is to identify the procurement route most likely to support successful development of the Programme.

4.46 Each procurement option has therefore been assessed against nine criteria and scored against a five-point scale.

Scores to be applied

Score	Description
1	Poor Alignment
2	Limited Alignment
3	Moderate Alignment
4	Strong Alignment
5	Excellent Alignment

4.47 Each of the procurement objectives has been assigned a relative weight as per the table below:

Weights to be Applied

Criterion	Weight
Affordability	20%
Cost Certainty	15%
Programme Flexibility	15%
Buildability	10%
Market Engagement	10%
Risk Management	10%
Deliverability	10%
Governance & Assurance	5%
Commercial Opportunity	5%
Total	100%

4.48 The weighting structure intentionally places greatest emphasis upon affordability and programme development because these are considered the most significant challenges currently facing the Trust.

4.49 The table below indicates that the preferred way forward would be to take the route of Early Contractor Involvement (ECI).

Procurement Criteria Weighted Scoring Exercise

		Traditional Procurement		Early Contractor Involvement		Strategic Delivery Partner	
Evaluation Criterion	**Weight**	**Score**	**Weighted**	**Score**	**Weighted**	**Score**	**Weighted**
Affordability	20%	3	60	5	100	4	80
Cost Intelligence	15%	3	45	4	60	3	45
Programme Flexibility	15%	2	30	5	75	4	60
Buildability	10%	2	20	5	50	3	30
Market Engagement	10%	2	20	5	50	4	40
Business Case Development	10%	3	30	5	50	4	40
Risk Management	10%	3	30	4	40	4	40
Governance & Assurance	5%	5	25	3	15	3	15
Commercial Opportunity	5%	2	10	5	25	5	25
TOTAL	**100%**		**270**		**465**		**375**
Rank			***3***		***1***		***2***

Sensitivity Analysis

4.50 In line with good practice, a sensitivity analysis has been applied to the weighted scoring exercise. This exercise varies the relative weights between the procurement criteria to see if a change in the relative importance of a particular criterion changes the outcome of the exercise.

4.51 The outcome of the sensitivity analysis is summarised below:

Summary Outcome of Sensitivity Analysis

Scenario	Preferred Option
Baseline	ECI
Affordability Focus	ECI
Governance Focus	ECI
Deliverability Focus	ECI
Commercial Focus	ECI

Conclusion – Procurement Strategy

4.52 The weighted evaluation demonstrates that Early Contractor Involvement provides the strongest overall alignment with the Trust's requirements, achieving a weighted score of 465 compared with 375 for the Strategic Delivery Partner model and 270 for Traditional Procurement. The result reflects ECI's superior performance in affordability management, programme flexibility, market engagement, buildability and business case development.

4.53 The recommendation remains unchanged under all sensitivity testing scenarios **and is therefore considered robust, evidence-based and resilient to alternative Board priorities.**

Frameworks Assessment

4.54 The section above has concluded that Early Contractor Involvement appears to a robust approach to take to the Tickhill Road Redevelopment Programme when considering the shape and nature of the procurement.

4.55 The next step to take is to identify a preferred way of procuring Early Contractor Involvement. The usual way to do this is to use one of the many Framework which are in place across the public sector.

4.56 The analysis below considers four of the most commonly used frameworks that are available:

- **ProCure23 / NHS ProCure** — NHS England's preferred route to market for health construction works, designed around health requirements and collaborative delivery.
- **NHS SBS** — provides healthcare planning, construction consultancy and ancillary services, including core consultancy disciplines, healthcare planning and net zero/environmental consultancy.
- **CCS** (Crown Commercial Services) — broad public sector construction works framework route, available to NHS and wider public sector bodies.
- **Pagabo** — considered as a credible public sector framework alternative, but less healthcare-specific for this programme.

4.57 As per the earlier analysis to select a procurement approach, the table below is a subjective assessment of each of the four frameworks when compared to the procurement objectives.

Table 7: Framework Assessment Against Procurement Objectives

Procurement Objective	ProCure23 / NHS ProCure	NHS SBS	CCS	Pagabo
Affordability	Strong. Supports early cost engagement and NHS-specific delivery assurance. Particularly helpful where affordability must be tested during programme development.	Strong. Provides access to consultancy and cost planning support, with capped rates and pricing options that can support early affordability testing.	Moderate/Strong. Broad public sector market access may support value testing, but healthcare-specific affordability support is less direct.	Moderate. Can support procurement efficiency but less directly aligned to NHS affordability and business case development.
Cost Intelligence	Strong. Early contractor and supply chain engagement provides useful market pricing intelligence.	Strong. Strong consultancy route for QS, project management, multidisciplinary and healthcare planning support.	Moderate. Broad construction market intelligence available, but less tailored to NHS estate transformation.	Moderate. Useful market input, but weaker NHS-specific cost intelligence.
Buildability	Excellent. Strongest framework for contractor-led input and ECI-style buildability testing.	Moderate. Strong design and consultancy input, but less direct contractor-led buildability support.	Moderate/Strong. Can access construction expertise, but less specifically structured around NHS ECI requirements.	Moderate. Can provide construction market access but less compelling for complex NHS healthcare redevelopment.
Programme Flexibility	Strong. Designed for collaborative NHS construction delivery and can support programme development.	Strong. Flexible consultancy lots and procurement support can help shape options before contractor appointment.	Moderate/Strong. Broad framework scope, but may require more client-side integration.	Moderate/Strong. Flexible framework route, but less NHS-specific assurance.
Market Engagement	Strong. Provides direct access to NHS-experienced	Strong. Useful for benchmarking,	Strong. Broad public sector market reach.	Moderate/Strong. Market access

Procurement Objective	ProCure23 / NHS ProCure	NHS SBS	CCS	Pagabo
	supply chains and contractor market input.	consultancy and market-testing activity.		available but less targeted to NHS healthcare transformation.
Business Case Development	Strong. Well aligned to NHS capital works and ECI development through OBC/FBC.	Strong. Particularly strong for consultancy support, healthcare planning, net zero and multidisciplinary inputs to business case development.	Moderate. Can support procurement route but less tailored to NHS business case development.	Moderate. Can support procurement but less strong as an NHS business case route.
Risk Management	Strong. NHS-specific governance, collaborative model and ECI capability help surface risk early.	Strong. Consultancy and advisory support can help identify risks early, though contractor risk input may be less direct.	Moderate/Strong. Strong public sector compliance, but more reliant on Trust-side management to integrate risks.	Moderate. Risk controls available but less healthcare-specific.
Commercial Opportunity	Moderate/Strong. Strong for construction delivery; less directly focused on wider commercial/development partnerships.	Strong. Useful where commercial, planning, net zero and consultancy advice is needed before a final delivery route.	Moderate. Broad public sector capability but less tailored to NHS commercial estate opportunity.	Moderate/Strong. Flexible, but evidence base for NHS commercial estate transformation is less compelling.
Governance & Assurance	Excellent. NHS-specific, designed by/for NHS health construction and described by NHS England as a trusted compliant route to market.	Strong. NHS public sector route with structured lots, customer support and Constructing the Gold Standard verification.	Excellent. Very strong public sector governance and compliance, but less health-specific.	Strong. Credible framework governance, but less aligned to NHS-specific assurance needs.

Weighted Scoring Evaluation

4.58 In the same way as was set out in section 3 above, the way to provide a more objective analysis of the preferred route to market is to undertake a weighted scoring exercise.

4.59 This is set out in the table below.

Weighted Scoring Framework Evaluation

		ProCure 23		NHS SBS		CCS		Pagabo	
Objective	**Weight**	**Score**	**Weighted Score**	**Score**	**Weighted Score**	**Score**	**Weighted Score**	**Score**	**Weighted Score**
Affordability	20	5	100	4	80	3	60	3	60
Cost Intelligence	15	5	75	4	60	3	45	3	45
Buildability	10	5	50	3	30	3	30	3	30
Programme Flexibility	15	4	60	4	60	3	45	3	45
Market Engagement	10	5	50	4	40	4	40	3	30
Business Case Development	10	5	50	5	50	3	30	3	30
Risk Management	10	5	50	4	40	4	40	3	30
Commercial Opportunity	5	4	20	5	25	3	15	4	20
Governance & Assurance	5	5	25	4	20	5	25	4	20
TOTAL	**100**		**480**		**405**		**330**		**310**
Rank			***1***		***2***		***3***		***4***

4.60 The table above indicates that Procure 23 may be the most advantageous framework route to take.

Sensitivity Analysis

4.61 Once again to reduce the level of subjectivity, a sensitivity analysis has been undertaken.

Sensitivity Analysis of Framework Weighted Scoring Exercise

Scenario	Preferred Framework
Baseline	ProCure23
Affordability Focus	ProCure23
Governance Focus	ProCure23
Deliverability Focus	ProCure23
Commercial Focus	ProCure23
Consultancy Focus	ProCure23

Conclusion – Framework Selection

4.62 The framework analysis supports **ProCure23 / NHS ProCure as the preferred framework route** because it is the strongest match against the Trust's core procurement requirement: securing NHS-experienced contractor input to support affordability testing, buildability, market engagement and business case development.

4.63 **NHS SBS should be retained as a secondary route** for consultancy support, benchmarking and market validation. CCS and Pagabo remain credible fallback options but are less closely aligned to the specific requirements of a complex NHS estate transformation programme.

Conclusion

4.64 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

Strategic Land Value Realisation Strategy

Executive Summary

4.65 This paper separates the strategic question of when land value should be realised from the commercial question of how that strategy should be delivered. It provides a structured framework for comparing disposal mechanisms and identifying those most likely to maximise value in line with the Trust's objectives.

Commercial Disposal Mechanisms

Mechanism	Description	Advantages	Disadvantages
Open Market Sale	Immediate freehold sale.	Simple; quick receipt.	Lowest uplift retained.
Homes England Disposal	Sale to Homes England.	Affordable housing alignment.	Receipt may not be maximised.
Forward Sale	Staged payments agreed early.	Improves cashflow.	Reduced flexibility.
Conditional Contract	Completion after conditions.	Higher value.	Longer programme.
Option Agreement	Right to purchase later.	Transfers planning risk.	No guaranteed sale.
Promotion Agreement	Promoter secures planning.	Maximises planning uplift.	Promoter shares proceeds.
Sale with Overage	Future uplift shared.	Protects value.	Monitoring complexity.
Phased Disposal	Land released progressively.	Higher aggregate receipts.	Longer programme.
Development Agreement	Partner delivers planning/infrastructure.	High value and control.	Commercial complexity.
Long Lease	Retain freehold.	Ownership retained.	Lower upfront receipt.
Building Leases	Leasehold development.	Estate control.	Management responsibility.
Joint Venture / Strategic Partnership	Shared development.	Highest long-term value.	Most complex.

Indicative Value Realisation by Commercial Mechanism and Development Stage

Mechanism	Raw Land	Outline Planning	Full Planning	Serviced Parcels	Strategic Partnership
Open Market Sale	Low	Medium	High	High	Medium
Homes England Disposal	Low	Medium	High	High	Medium
Forward Sale	Medium	Medium	High	High	Medium
Conditional Contract	Low	Medium	High	High	Medium
Option Agreement	Low	Medium	High	High	Medium
Promotion Agreement	Low	High	Highest	Highest	High
Sale with Overage	Medium	High	Highest	Highest	Highest
Phased Disposal	Medium	High	Highest	Highest	Highest
Development Agreement	Medium	High	Highest	Highest	Highest
Long Lease	Low	Medium	High	Highest	Highest
Building Leases	Low	Medium	High	Highest	Highest
Joint Venture / Strategic Partnership	Medium	High	Highest	Highest	Highest

Heat Map Legend

Low	Limited value creation.
Medium	Some value enhancement.
High	Significant value enhancement.
Highest	Maximum value creation.

Development Lifecycle

4.66 The development lifecycle is defined at the point at which and organisation which has surplus land to put on the market decides to do that depending upon the level of certainty it has achieved in the outcomes.

Stage	Meaning	Typical Value
Raw Land	No planning/enabling works.	Low
Outline Planning	Principle established.	Medium
Full Planning	Detailed consent.	High
Serviced Parcels	Infrastructure installed.	Very High
Strategic Partnership	Trust shares long-term profit.	Highest

Definition of Strategic Tiers

4.67 The strategic tiers have been defined to act as a guide in managing risk and/or balancing that with cashflow and affordability.

Tier	**Definition**	**Typical Circumstances**
Tier 1 – Maximum Value Creation	Capture greatest share of value uplift.	Maximise long-term value.
Tier 2 – High Value Enhancement	Enhance value without full participation.	Balanced value/risk.
Tier 3 – Early Capital Realisation	Prioritise early receipt.	Cashflow and affordability.

Methodology for Tiering the Commercial Mechanisms

4.68 The Indicative Value Realisation Index is derived for the table above. Scores are assigned as Low=1, Medium=2, High=3 and Highest=4. The total across the five development stages produces an index out of 20. This is a comparative strategic tool rather than a formal valuation.

Assessment	**Score**	**Meaning**
Low	1	Limited value retained.
Medium	2	Some uplift retained.
High	3	Significant uplift retained.
Highest	4	Maximum value participation.

Tiering of Commercial Mechanisms Based on Indicative Value Realisation

Tier	Mechanism	Low	Medium	High	Highest	Index (/20)	Commentary
Tier 1	Development Agreement	0	1	1	3	18/20	Maximises value.
	Joint Venture / Strategic Partnership	0	1	1	3	18/20	Long-term profit share.
	Phased Disposal	0	1	1	3	18/20	Captures value over time.
	Sale with Overage	0	1	1	3	18/20	Protects future uplift.
Tier 2	Promotion Agreement	1	0	2	2	17/20	Planning-led uplift.
	Long Lease	1	1	1	2	17/20	Retains ownership.
	Building Leases	1	1	1	2	17/20	Estate control.
Tier 3	Forward Sale	0	3	2	0	12/20	Early cashflow.
	Conditional Contract	1	2	2	0	12/20	Balanced approach.
	Open Market Sale	1	2	2	0	12/20	Simple disposal.
	Homes England Disposal	1	2	2	0	12/20	Policy alignment.
	Option Agreement	1	2	2	0	12/20	Deferred commitment.

Conclusion

4.69 The Trust should first determine the preferred point in the development lifecycle at which it wishes to realise land value. It should then select the commercial mechanism that best delivers that strategy, taking account of the estate plan objectives, affordability, risk and the opportunity to capture value created through the wider estate plan. This section has been included as a guide for further decision making and may not be the final position achieved.

4.70 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

Chapter 5 - Financial Case

5 Introduction

5.1 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.

Financial Position of the Trust

5.2 The Trust has a relatively healthy financial position, with a breakeven plan for 2026/27 and an expectation the underlying deficit is eliminated for 2027/28. It is also expected to be in Tier 2 of NHS Oversight Framework (Tier 1 being the most favourable). This indicates that the governance, service performance and financial position are amongst the highest in England.

5.3

This section sets out the options appraisal process undertaken for financing the redevelopment of the Tickhill site. The appraisal followed a structured and objective process comprising qualitative and quantitative assessments. The qualitative assessment was structured on a three-step process to identifying and combining discrete funding routes into programme-level options, applying a high-level RAG rating of each option to determine their viability, and conducting a structured and fully auditable options assessment against weighted critical success factors.

5.4 The quantitative assessment comprised a high-level cost optioneering of short-listed option based on high-level input assumptions.

5.5 The qualitative assessment identified a top 3 ranking of

- Option B - Public and Ambient Loop revenue model (weighted score of 79%),
- Option A - Traditional Public (land receipt + PDC) (76.5% weighted score)
- Option F - Hybrid income strip with prepayment / Developer (weighted score 71.0%) as the preferred financing options.

5.6 Option B combines a land sale with a revenue model for the Ambient Loop infrastructure (e.g. energy-as-a-service) and Public Dividend Capital (PDC) for the refurbishment of retained estate and the construction of the new-build frailty unit.

5.7 Based on the options appraisal, the Board is asked to endorse Option B, Public and Ambient Loop revenue model, as the preferred funding mix for the Tickhill site redevelopment, subject to further financial and commercial analysis.

5.8 Option B achieved the highest overall critical success factor score at 79.0%, reflecting the strongest balance of strategic alignment, affordability, stakeholder support and deliverability. It also reduces reliance on PDC by using a revenue model for the specialist Ambient Loop infrastructure, while retaining public funding for the retained estate refurbishment and new-build frailty unit.

Summary of funding options assessed

5.9 The table below summarises the funding mix options assessed, ranked by qualitative score. The top three options were then taken forward for financial comparison.

5.10 **For clarity, the funding options assessed below refer to the Preferred Option identified in Chapter 3 (Economic Case).**

Summary of funding options assessed

Rank	Option	Description	Score
1	**B. Public and Ambient Loop revenue model**	The Trust sells surplus land. A third-party energy provider funds and operates the Ambient Loop, with the Trust paying an annual service charge. Public capital funds the refurbishment works and new-build Frailty Unit.	**79.0%**
2	**A. Traditional Public (land receipt + PDC)**	The Trust sells surplus land and uses public capital to fund the Ambient Loop, refurbishment works and new-build Frailty Unit.	**76.5%**

Rank	Option	Description	Score
3	**F. Hybrid income strip with prepayment / Developer**	The Trust sells surplus land and uses the receipt to reduce the private lease funding needed for the Frailty Unit. The Ambient Loop is developer funded, and refurbishment is publicly funded.	**71.0%**
4	E. Hybrid income strip with prepayment / PDC	The Trust sells surplus land and uses the receipt to reduce the private lease funding needed for the Frailty Unit. The Ambient Loop and refurbishment works are publicly funded.	69.0%
5	D. Hybrid income strip / PDC	The Trust sells surplus land. The Ambient Loop is funded through a third-party revenue model, refurbishment is publicly funded, and the Frailty Unit is privately funded through long-term lease payments.	67.5%
6	H. Joint Venture (shared development)	The Trust contributes land into a joint venture with a development partner, with delivery and funding shared through the JV structure.	57.0%
7	C. Private and Ambient Loop revenue model	The Trust sells surplus land. The Ambient Loop is funded through a third-party revenue model, while the refurbishment works and Frailty Unit are privately funded through long-term lease payments.	48.5%
8	G. PF2 development	The whole scheme is delivered through a PF2-style private finance model, with the Trust making long-term payments rather than funding the assets upfront.	32.5%

Note 1: *Private lease funding refers to an income strip-style arrangement where a third party funds the asset upfront and the Trust repays through long-term annual lease payments.*

Note 2: *Public capital refers to NHS capital funding available to the Trust, including PDC, ICB Strategic Capital and/or internal Trust capital funding, subject to CDEL approval.*

Background and approach

5.11 The major element of the estate plan is intended to transform the Tickhill Road Hospital site into a more efficient, sustainable and accessible healthcare campus. It will consolidate operational functions, improve estate efficiency, enhance the campus environment, release surplus land for redevelopment and generate funding for future investment, supporting the Trust's long-term financial viability.

5.12 The redevelopment programme includes a land sale, Ambient Loop infrastructure, refurbishment of the retained estate and construction of a new frailty unit / education centre. Each component has distinct characteristics from a funding perspective and therefore may suit different financing mechanisms respectively. As a result, the programme may be funded through a blended approach, with each route creating a materially different financial impact for the Trust.

5.13 A multi-step qualitative 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.

Qualitative assessment

Methodology

5.14 Step 1: Discrete funding route assessment

Step 1 assessed each discrete funding route individually to identify all theoretically available mechanisms before excluding combinations that were not commercially or strategically credible. The assessment considered:

- which individual components each funding route could support (i.e. Ambient Loop infrastructure, new build, and refurbishment elements); and
- The key advantages and constraints of each route.

The following discrete funding routes were assessed:

5.14.1 **Public Dividend Capital (PDC) allocation.** This financing route represents the lowest-cost source of funding, with the Trust retaining ownership of the asset. It is potentially suitable for the Ambient Loop infrastructure, refurbishment of the retained estate and construction of the new Frailty Unit. However, the availability of PDC is limited, highly competitive and requires approval from NHS England and Department of Health and Social Care (DHSC) with no guarantee that funding will be available when needed. While securing PDC at the scale required to fund the full programme is considered unlikely given NHS England's constrained and oversubscribed capital funding position, a blended funding solution that combines PDC with alternative financing mechanisms could significantly reduce the overall PDC requirement, making this route more achievable.

5.14.2 **Grant funding for Ambient Loop infrastructure.** This route would involve seeking grant funding to pay for some or all of the upfront cost of the Ambient Loop. This could reduce the amount of PDC, Trust capital or private finance needed. However, the availability, timing and conditions of any grant funding are uncertain and would need to be tested. Grant funding would also not remove the need to agree who delivers, owns, operates and maintains the Ambient Loop, particularly given the interface with the wider residential development. Grant funding has not been treated as a separate option in the appraisal at this stage but should be considered in the next phase as a possible way to reduce the upfront funding requirement for the Ambient Loop.

5.14.3 **Land Receipts from selling surplus land.** The sale receipt provides an internal source of capital, reducing the amount of external public funding required and could be suitable for enabling infrastructure, refurbishment, and capital contribution. The key constraint is reliance on surplus land value and market conditions at the point of sale, which makes the timing and value of receipts uncertain. This funding route was carried forward as core element of financing with surplus land identified at the Tickhill site.

5.14.4 **Developer financing through a lease structure such as an "Income Strip",** which would see a private developer funding and building the Tickhill development and the Trust paying an agreed annual lease over a long term instead of paying the construction costs upfront. This funding route transfers construction risk and reduces or eliminates the need for upfront capital or public funding. It is mostly suitable for the construction of new assets (the new Frailty Centre in this case) as opposed to refurbishment of existing assets as a result of the risk interface. The main constraint is that long-term

lease payments carry IFRS 16 lease liability (CDEL implications) and may prove unaffordable in a budgetary context depending on their scale and engagement with NHSE.

5.14.5 **Joint Venture partnership** between the Trust and a private developer to deliver the redevelopment. The upside of this option is the shared development costs and risks, and access to private-sector expertise which can potentially accelerate delivery. It is likely suitable for surplus land development but could also cover the delivery of new clinical buildings. The main downside is that this route is more complex to establish and manage, requiring shared decision-making and careful alignment between NHS and commercial objectives. It is also uncommon as a commercial delivery model in an NHS context meaning stakeholder engagement may be complex in order to gain necessary support / approvals.

5.14.6 **Energy as a Service / Concession / Offtake Agreement.** Under this financing route a private provider funds and operates an asset with the Trust paying for the service it uses rather than buying the asset itself. For the Tickhill development this funding route is considered potentially suitable for the Ambient Loop infrastructure. This approach reduces the need for upfront capital investment and transfers the construction, operational and performance risks associated with specialist infrastructure to an experienced private sector provider. It also has the potential to achieve off-balance sheet accounting treatment, however, this is subject to the detailed contractual structure and the application of IFRS 16. For the purposes of this appraisal, it has been assumed that the arrangement can be structured to achieve the intended accounting treatment, although this will need to be confirmed through the detailed commercial and legal development of the procurement. The principal constraint is that the model requires an investable and market-tested revenue mechanism, supported by long-term contractual service payments.

5.14.7 **Trust Cash.** This funding route uses the Trust's available cash reserves to fund part of the redevelopment, reducing the need for external public or private financing. It is considered most suitable for smaller-scale investments, including elements of the refurbishment of the retained estate. This approach provides the Trust with greater control over investment decisions and avoids external financing costs. However, its use is constrained by a Trust's liquidity position, as deploying significant cash reserves for capital investment could reduce financial resilience and limit flexibility to respond to future operational pressures or strategic priorities.

5.14.8 **Operational Capital (CDEL).** This funding route utilises the Trust's annual operational capital allocation (CDEL) to fund capital investment. It is potentially suitable for discrete elements of the redevelopment programme, particularly refurbishment works and smaller capital schemes that can be delivered within annual capital allocations. The principal advantage is that it provides a source of public capital without requiring additional borrowing. However, the availability of operational capital is constrained by the Trust's annual CDEL allocation, which must also support competing capital priorities across the organisation.

5.15 **Step 2: Establishing programme funding structures**

The funding mechanisms identified in step 1 were combined into a long list of programme-level funding mix options as shown in the table below. Each option reflects a different funding configuration across the four development components: land, Ambient Loop, refurbishment and the frailty unit.

Programme level funding mix options

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

Notes:

- *Sale = with or without deferred land payments to support cashflow considerations.*
- *References to PDC mean a blend of PDC and Trust Capital Departmental Expenditure Limit (CDEL).*
- *Revenue model examples: offtake agreement and energy-as-a-service.*

5.16 Step 3: Assessment of funding mix options against critical success factors

The qualitative financing options appraisal followed a structured and objective process. Critical Success Factors (CSFs) were agreed as shown in Table 3.2 below, to provide the criteria for scoring, ranking and comparing the shortlisted options. During a workshop, each funding mix option was assessed against the weighted CSFs using the six-point scale set out below, from Unacceptable to Excellent. The option with the highest overall score was identified as the preferred financing option.

Weighted Critical Success Factors

Evaluation criteria	Weighting	Description
Strategic Alignment	**20.0%**	The extent to which the funding route supports RDaSH's strategic objectives for the Tickhill site redevelopment including: • Service deliverability and flexibility • Partnering with patients • Ensuring equitable access and experience • Integrated care services • Providing quality bed-based care • Delivering social value through community collaboration and is consistent with wider NHS and ICS capital priorities.
Whole Life affordability	**12.5%**	The overall cost-effectiveness of the funding route over the life of the Tickhill assets, taking account of the estimated capital requirement financing charges, lifecycle and maintenance obligations, and any residual value or land receipt implications.
Revenue and capital affordability	**12.5%**	The capacity of RDaSH to meet the ongoing revenue commitments arising from the funding route and any residual CDEL or Trust capital requirements. - IFRS

Evaluation criteria	Weighting	Description
Risk allocation and transfer	**15.0%**	The extent to which the funding route enables appropriate risk allocation between the Trust, lenders, developers, and / or supply chain partners, with manageable residual risk in relation to the assets.
Programme deliverability and flexibility	**10.0%**	The extent to which the funding route and timeline can deliver the Tickhill outline programme, minimises delays from financing approvals, legal negotiations, or funding conditions, and retains flexibility to accommodate emerging strategic decisions.
Stakeholder support	**10.0%**	The extent to which the funding route is likely to receive support from NHS England, Trust Board, ICS partners, local authorities, and any other local or key stakeholders.
Governance and assurance	**10.0%**	The ability of the funding route to operate effectively within RDaSH's governance and assurance framework, including compliance with NHSE capital regime requirements and any necessary regulatory approvals for the Tickhill site redevelopment.
Market attractiveness	**10.0%**	The extent of how attractive the funding route is likely to be to lenders, investors, or development partners, ensuring competitive financing terms.
Total weighting	**100%**	

Structured scoring mechanism

Rating	Score
Unacceptable	0
Very poor	2
Poor	4
Fair	6
Good	8

Rating	Score
Excellent	10

Qualitative assessment outcome

5.17 The qualitative assessment of funding mix options produced the outcome as shown below:

Table 3.4: Outcome of qualitative assessment

Rank	Option	Score
1	**B. Public and Ambient Loop revenue model**	**79.0%**
2	**A. Traditional Public (land receipt + PDC)**	**76.5%**
3	**F. Hybrid income strip with prepayment / Developer**	**71.0%**
4	E. Hybrid income strip with prepayment / PDC	69.0%
5	D. Hybrid income strip / PDC	67.5%
6	H. Joint Venture (shared development)	57.0%
7	C. Private and Ambient Loop revenue model	48.5%
8	G. PF2 development	32.5%

5.18 **As shown above the three options with the highest weighted CSF score are:**

- **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.

Preferred financing solution - score rationale

5.19 **Option B** achieved the highest weighted CSF score because it provides:

- Clear alignment with the Trust's strategic objectives, supporting service deliverability through an Ambient Loop revenue model that reflects established market practice.
- A manageable affordability profile, combining comparatively low-cost PDC for the refurbishment and frailty unit with an outsourced revenue model for the Ambient Loop infrastructure.
- Strong whole-life affordability, as the Ambient Loop revenue model incorporates maintenance costs within the service charge and improves cost certainty.
- An appropriate balance of risk transfer for the specialist Ambient Loop infrastructure, with PDC-funded elements retaining a conventional public sector risk profile.
- Good programme deliverability, supported by a lower PDC requirement and a proven Ambient Loop revenue model, reducing the risk of funding delays or delivery constraints.
- Likely strong stakeholder support, reflecting the continued use of public funding, a relatively limited PDC requirement and the transfer of Ambient Loop delivery risk.
- Manageable governance requirements.
- Positive market attractiveness, supported by an emerging market of specialist energy providers able to deliver Ambient Loop concession models in a cost effective manner.

5.20 The overall weighted CSF score for Option B can be broken down as follows against each Critical Success Factor:

Option B weighted CSF score breakdown

Critical Success Factor	Score	Weighted
Strategic Alignment	Good (8/10)	16/20
Whole Life Affordability	Good (8/10)	10/12.5
Revenue and Capital Affordability	Good (8/10)	10/12.5
Risk Allocation and Transfer	Fair (6/10)	9/15
Programme Deliverability and Flexibility	Good (8/10)	8/10
Stakeholder Support	Excellent (10/10)	10/10
Governance and Assurance	Good (8/10)	8/10
Market Attractiveness	Good (8/10)	8/10
TOTAL	**79/100**	**79.0%**

Key considerations for quantitative cost analysis

5.21 A quantitative analysis is being prepared which identifies several issues for the Trust to consider when assessing the options. In particular, options that reduce the upfront public capital requirement may still create material long-term revenue commitments, accounting liabilities, CDEL implications or deliverability risk.

CDEL and capital funding availability

5.22 For NHS bodies, capital expenditure is constrained not only by whether cash is available, but also by whether the organisation has capital spending approval within its CDEL envelope. In simple terms, the Trust may have cash on its balance sheet, but this does not automatically mean it can spend that cash on capital works.

5.23 The analysis therefore distinguishes between:

- **Cash availability**, being the Trust's ability to fund payments as they fall due; and
- **CDEL capacity**, being the approval / headroom to incur capital expenditure from a budgetary perspective.

5.24 The Trust holds material cash balances of c. £35m, which provide flexibility to support the programme. Further work should assess whether the full level of cash currently held is required for operational resilience, working capital and other commitments and therefore how much could prudently be available for the scheme. Using cash for a material capital scheme would need to be tested against the Trust's liquidity requirements, minimum cash levels and CDEL cover. Cash availability should therefore not be read as evidence that the scheme can proceed without external approval or capital allocation.

5.25 This is particularly relevant to the three highest-ranked options from the qualitative assessment. If the Trust is able to use a proportion of it's cash reserves, reliance on PDC approval could be reduced, particularly under options A and B. Option A has the greatest reliance on PDC and public capital, while Option B still requires PDC for the refurbishment and new-build elements. Option F lowers the immediate PDC requirement by using private finance for the Frailty Unit but introduces a long-term lease commitment with potential IFRS 16 and CDEL implications.

Use of Trust cash

5.26 The financial appraisal does not treat the Trust's cash balance as freely available for the scheme. Although the Trust may hold cash reserves, this does not equate to unrestricted capital funding. Cash must support day-to-day operations and financial resilience, while capital expenditure remains subject to CDEL constraints.

5.27 The Trust may still decide to use some cash to support the programme where this is financially appropriate. This could apply where:

- land receipts are delayed;
- the Trust wants to reduce reliance on external financing;
- PDC is unavailable or insufficient in a particular year; or
- using some cash improves overall affordability without undermining liquidity.

5.28 Any use of cash would need to be assessed against the Trust's overall financial position, liquidity requirements and capital approvals. However, as it currently stands, the use of Trust cash remains subject to the Trust securing the necessary CDEL. Without this, the Trust would not be able to use the cash to fund capital expenditure, even where cash is available.

Timing of land receipts and capital spend

5.29 The timing of cashflows is a key consideration across all options. The working assumption at this point in time is that the land receipt is received in FY29/30, while material capital spend is incurred in earlier years. As a result, even if the land receipt reduces the overall net funding requirement, the Trust may still need to finance construction costs before those proceeds are received.

5.30 For example, if capital spend is required in FY27/28 and FY28/29 but the land receipt is not received until FY29/30, the Trust will need a bridging finance solution. This could be provided through PDC, existing CDEL funding capacity, Trust capital resources, deferred land payment arrangements, or another form of interim funding support.

5.31 This timing issue is a key practical difference between the options. Options that depend on land sale proceeds to reduce the upfront funding remain exposed to uncertainty over the timing, value and deliverability of the land transaction. While this is the case, the use of Trust cash could help mitigate this timing risk by bridging the spend incurred before land receipts are received, subject to liquidity requirements, minimum cash levels and CDEL cover.

Sensitivities

5.32 The cost analysis should be reviewed in the context of key sensitivities. These have not been assessed quantitatively at this stage, but should be considered as the next phase of financial analysis is developed.

Land receipt without planning

5.33 The base case assumes a land receipt secured with planning consent. A downside sensitivity should test the impact of receiving a lower land value without planning, as both the value and timing of proceeds are key drivers of the net funding requirement.

5.34 If the land receipt is below the base case, the resulting shortfall would need to be met through one or more of:

- additional PDC / CDEL allocation;

- additional Trust capital funding;
- higher private finance / lease exposure; or
- a reduced scope or revised delivery timetable.

5.35 This sensitivity is most relevant to options where land receipts are used to reduce either the PDC requirement or the balance funded through the income strip.

CDEL limit / public capital availability

5.36 A CDEL sensitivity should test the impact of reduced public capital availability, recognising that PDC and CDEL are not guaranteed and depend on wider NHS capital prioritisation.

5.37 Under this sensitivity, the analysis should assess whether each option remains deliverable if the Trust cannot secure the full PDC / CDEL allocation assumed in the base case.

5.38 This is relevant to the three highest-ranked options from the qualitative assessment:

- **Option A** has the greatest reliance on PDC and public capital;
- **Option B** still requires PDC for the new-build Frailty Unit and refurbishment; and
- **Option F** reduces the PDC requirement but creates long-term lease commitments for the Trust.

5.39 This sensitivity is not intended to set the final funding envelope. It's purpose is to show how exposed each option is to constraints on public capital.

Qualitative sensitivity: use of Trust cash rather than full land receipt

5.40 A further qualitative sensitivity is whether the Trust uses part of it's existing cash balances rather than applying the full land receipt to the scheme. This tests whether the Trust retains some land sale proceeds for other priorities and uses balance sheet cash to support the redevelopment.

5.41 This might happen if:

- the Trust wants to retain some land receipt proceeds for other strategic priorities;
- land sale proceeds are delayed and cash is needed as short-term bridging;
- using cash reduces the need for more expensive private finance;
- PDC is constrained in a particular year; or

- the final land transaction structure means proceeds are phased or deferred.

5.42 This however, would require careful assessment. Trust cash supports liquidity, operational resilience and other commitments, and capital expenditure would still require CDEL cover. Any use of cash should therefore be tested against the Trust's overall financial position and capital approval route.

5.43 At this stage, this sensitivity should be assessed qualitatively. Detailed modelling should follow once the Trust confirms how much cash could realistically be made available without weakening financial resilience.

Recommendation

5.44 Based on the qualitative options appraisal, **the Board is asked to endorse Option B,** Public and Ambient Loop revenue model, as the preferred funding mix for the Tickhill site redevelopment, subject to further financial, commercial analysis, and assumption refinement. Option B achieved the highest overall critical success factor score at 79.0%, reflecting the strongest balance of strategic alignment, affordability, stakeholder support and deliverability. It also reduces reliance on PDC by using a revenue model for the specialist Ambient Loop infrastructure, while retaining public funding for the retained estate refurbishment and new-build frailty unit.

5.45 The endorsement should be conditional on the next phase confirming that Option B is financially affordable, commercially deliverable, capable of securing appropriate market interest and acceptable within the Trust's governance and approval framework. This further work should include detailed financial modelling, accounting and CDEL assessment, confirmation of PDC / public capital availability from the ICB, NHS England and/or other relevant approvers as appropriate, commercial structuring of the Ambient Loop revenue model, market engagement, risk allocation, procurement route assessment and confirmation of the land receipt assumptions.

5.46 The Board is also asked to retain Option A, Traditional Public: land receipt plus PDC, as the second-ranked sequential alternative, and Option F, Hybrid income strip with prepayment / Developer, as the third-ranked sequential alternative. These options should not be progressed in parallel as preferred solutions but should remain available as options if the preceding option is shown not to be viable following the next stage of analysis and approvals discussions.

5.47 This approach preserves a clear decision pathway for the programme. It allows the Trust to focus resources on testing and developing the highest-ranked option first, while maintaining momentum and optionality if affordability, commercial deliverability, market appetite, governance approvals or funding availability prevent Option B from being taken forward.

Chapter 6 – The Management Case

Introduction - Purpose of the Management Case

6.1 This Management Case has been prepared in accordance with HM Treasury's Green Book and the Five Case Model and demonstrates that the Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) has established appropriate governance, programme management, assurance and benefits management arrangements to deliver the Estate Plan Programme successfully.

6.2 The preceding Strategic, Economic, Commercial and Financial Cases establish the overall estate plan investement (and the Tickhill Road development particularly) is strategically justified, represents the preferred option, is commercially deliverable and is financially affordable.

6.3 The purpose of the Management Case is to demonstrate that the Trust possesses the organisational capability, governance arrangements and programme controls necessary to translate that preferred option into successful delivery and sustainable operational benefits.

6.4 The Management Case therefore focuses on how the programme will be governed, managed, monitored and assured throughout its lifecycle, from approval of the Outline Business Case through procurement, design, construction, commissioning and ultimately into post-occupancy evaluation and benefits realisation.

The Tickhill Road Development

6.5 The Tickhill Road Development represents a major transformation of the Trust's principal Doncaster campus: rather than a conventional capital project, it comprises a coordinated programme of interdependent workstreams designed to modernise clinical services, improve estate utilisation, support decarbonisation and release wider public value.

6.6 The programme comprises five integrated components:

- development of an ambient loop energy network (which needs to be established before the completion of any new build and vacation of buildings on surplus land;

- delivery of a new Frailty Centre to reflect modern models of care such as re-enablement and securing safety of patient before they return home;
- establishment of a facility for meeting, teaching, research, education and learning, including facilities for staff who will need to work on site through a hybrid, flexible model and
- disposal of surplus land to facilitate housing delivery, generate capital receipts and support wider place-based regeneration.

6.7 Each component is dependent upon the successful delivery of others. For example:

- the ambient loop needs to be completed prior to the vacation of buildings on the areas of the estate which are vacant;
- The Waterdale project needs to be complete before the vacation of surplus estate to ensure the continuation of the CAMHS service without disruption;
- The new-build can be completed just before or after the ambient loop;
- Land disposals can be undertaken during implementation (as forward sale of land with lease-back) to assist with cashflow if required. The vacation of the surplus land will need ot be within defined timescales in that case.

Management Principles

6.8 The Trust will adopt recognised programme management principles consistent with HM Treasury guidance, the Infrastructure and Projects Authority's Project Routemap and Managing Successful Programmes (MSP). Governance arrangements are intended to be proportionate to the scale and complexity of the programme whilst remaining sufficiently flexible to respond to changes in policy, funding, service configuration and market conditions.

6.9 The programme which is made up of the Estates Plan will be governed through clear accountability, transparent decision-making and robust assurance processes. Delivery will be supported by integrated programme planning, disciplined change control, active risk management and structured benefits management, ensuring that strategic objectives remain aligned with operational delivery throughout the programme lifecycle.

6.10 Success will be measured not only by completion of capital works within approved cost and programme parameters, but by demonstrable improvements in patient care, clinical outcomes, estate performance, financial sustainability, environmental performance and wider social and economic value.

Scope of this Section

6.11 This section describes the governance arrangements, organisational structure and programme management framework that will be employed to deliver the Estate Plan. It explains the responsibilities of the Trust Board, Executive Team, Programme Board and individual workstreams, together with the programme controls, assurance arrangements and reporting mechanisms that will provide confidence that the programme remains aligned with its strategic objectives and delivers the outcomes described elsewhere within this Business Case.

Programme Governance

6.12 The governance arrangements for the Estate Plan have been designed to provide clear accountability, effective decision-making and proportionate assurance throughout the programme lifecycle. Recognising that the programme comprises a series of interdependent clinical, estate, commercial and enabling projects, the Trust will manage delivery as a single transformation programme rather than a collection of individual schemes.

6.13 Overall accountability rests with the Trust Board, which retains responsibility for approving the Business Case, monitoring delivery against the approved investment objectives and ensuring that the programme continues to support the Trust's strategic objectives. Formal oversight will be provided through the Finance, Digital and Estates Committee, which will receive regular reports on programme performance, strategic risks, affordability, benefits realisation and key decisions requiring Board approval.

6.14 The overall flow of governance and assurance is identified in the figure below:

Governance Structure

6.15 Executive leadership will be provided through the Executive Group, supported by a Programme Board chaired by the Senior Responsible Owner. The Programme Board will coordinate delivery across the programme workstreams, approve key programme decisions within delegated authority and ensure that interdependencies are effectively managed.

6.16 Day-to-day programme leadership will be provided by the Programme Director, supported by a Programme Management Office. Weekly Programme Principals meetings will maintain momentum, review emerging risks and issues and coordinate activity across all workstreams before formal reporting to the Programme Board.

Programme Workstreams

6.17 Delivery will be organised through eight integrated workstreams covering the Frailty Model, Business Case, Workforce, Digital, Ambient Loop, Land Disposal, Communications and Engagement, and Estates. The Estates workstream will provide the overview of the delivery of the Riverside and Waterdale projects.

6.18 Each workstream will be led by a nominated senior lead and supported by an Executive Sponsor who will be accountable for delivery of agreed outputs.

6.19 Although each workstream has distinct responsibilities, they are expected to operate collaboratively and this will be assured by the Programme Director and the Programme Manageement Office. Major decisions affecting programme scope, affordability, sequencing or benefits realisation will be considered at Programme Board level to ensure that decisions optimise the programme as a whole rather than individual projects.

Governance Principles

6.20 The governance model is founded on five principles:

- Clear accountability through defined executive ownership
- Transparent decision-making supported by timely programme reporting
- Integrated management of scope, programme, cost, risk and benefits.
- Proportionate assurance through regular review and escalation
- Continuous focus on delivery of strategic outcomes and benefits rather than completion of individual projects.

6.21 These arrangements provide an appropriate balance between strategic oversight and operational flexibility and are considered proportionate to the scale, complexity and duration of the overall implementation of the overall estate plan and the Tickhill Road development in particular.

6.22 The individual roles and responsibilities are set out below:

Accountable Officer

6.23 The Accountable Officer (AO) is the CEO of the Trust and will hold the project organization (including individiuals) to account for delivery. The AO will also a key strategic bridge to partner organisations and manage those relationships at the highest level.

Senior Responsible Owner

6.24 The Senior Responsible Owner (SRO) is accountable to the Trust Board for successful delivery of the programme. The SRO will ensure that the programme remains aligned with the Trust's strategic objectives, approve key decisions within delegated authority, oversee affordability and benefits realisation, and provide executive leadership throughout the programme lifecycle. The SRO will be the Director of Finance and Estates.

Programme Director

6.25 The Programme Director will lead the day-to-day management of the programme on behalf of the SRO. Responsibilities include programme planning, coordination of workstreams, reporting, risk and issue management, stakeholder engagement, assurance, and delivery of the approved Business Case. The Programme Director will ensure that interdependencies between workstreams are actively managed and that emerging issues are escalated promptly.

Programme Management Office

6.26 A dedicated Programme Management Office (PMO) will provide programme support, maintain programme documentation, coordinate governance meetings, manage reporting cycles, administer change control and maintain the programme risk, issue, action and decision logs. The PMO will provide a single source of programme information to support informed decision-making.

Programme Workstreams

6.27 Eight workstreams will deliver the programme: Frailty Model; Business Case; Workforce; Digital; Ambient Loop; Land Disposal; Communications and Engagement; and Estates. Each workstream will be led by a nominated senior manager supported by an Executive Sponsor. Workstream Leads will prepare detailed delivery plans, monitor progress against milestones, manage risks within their area of responsibility and report regularly to the Programme Board.

Decision Making and Accountability

6.28 Operational decisions will be taken at the lowest appropriate level, with matters affecting programme scope, affordability, timetable, strategic risk or benefits escalated to the Programme Board or Trust Board (or Board Sub-Committee) in accordance with the agreed Scheme of Delegation. This approach promotes timely decision-making whilst ensuring that strategic control remains with the Trust.

Integrated Working

6.29 The success of the programme depends upon effective collaboration across all workstreams. Regular Programme Board meetings, weekly Programme Principals meetings and integrated reporting arrangements will ensure that decisions consider the wider programme implications rather than individual projects. This integrated approach will support efficient delivery whilst maintaining focus on the programme's strategic objectives and intended benefits.

Programme Delivery and Controls

Programme Delivery Strategy

6.30 The Tickhill Road element of the estate plan will be delivered using an integrated programme management approach recognising the interdependency between the ambient loop energy infrastructure, estate rationalisation, refurbishment, the Frailty Centre, Education and Education Centre and the phased disposal of surplus land. Delivery sequencing will be actively managed to minimise disruption to clinical services while maintaining affordability and maximising programme benefits.

Integrated Programme Planning

6.31 A single integrated master programme will be developed and maintained by the Programme Management Office and approved by the Programme Board. The master programme will identify critical path activities, key dependencies, statutory approvals, procurement milestones, enabling works, decant activities and commissioning milestones. Individual workstream programmes will be aligned to the master programme and reviewed monthly.

Programme Controls

6.32 Robust programme controls will be implemented to provide early warning of emerging issues and to support informed decision-making. Reporting will include progress against programme, cost, risk, scope, quality, benefits and key milestones. Performance information will be presented through a standardised dashboard to enable trends and exceptions to be identified quickly.

Risk, Issue and Change Control

6.33 Programme risks, issues, assumptions and dependencies will be maintained within controlled registers and reviewed routinely by the Programme Board. Formal change control procedures will apply to any proposed changes affecting scope, cost, programme, quality or expected benefits. Significant changes will require approval through the agreed governance structure before implementation.

Financial and Commercial Monitoring

6.34 The Financial Case establishes the approved funding strategy for the programme and affordability parameters overall. Delivery performance will therefore be monitored against approved budgets, forecast expenditure, cash flow and anticipated capital receipts. Commercial performance will also be monitored throughout procurement and contract delivery to ensure continued value for money and alignment with the objectives established within the Commercial Case.

Reporting and Performance Management

6.35 Monthly highlight reports will be prepared for the Programme Board summarising delivery progress, key achievements, risks, issues, financial performance, benefits, stakeholder matters and decisions required. Exception reporting will be used where agreed tolerances for cost,

programme or scope are forecast to be exceeded, enabling timely intervention by the appropriate governance body.

Quality Management

6.36 Quality will be managed throughout the programme lifecycle through structured design reviews, technical assurance, clinical engagement, gateway reviews and post-completion evaluation. Success will be measured not only by delivery of physical assets but by the extent to which the completed programme achieves its intended clinical, operational, financial and strategic outcomes.

Programme Assurance

Purpose of Assurance

6.37 Programme assurance provides confidence to the Trust Board that the Tickhill Road Strategic Estate Programme remains deliverable, affordable and aligned with its strategic objectives. Assurance activities will operate throughout the programme lifecycle, providing independent challenge, confirming compliance with approved governance arrangements and identifying opportunities for continuous improvement.

Three Lines of Assurance

6.38 The programme will adopt a proportionate three-line assurance model. Firstly, management assurance will be provided by the Programme Director, Programme Management Office and Workstream Leads through routine monitoring, reporting and performance management. Secondly, executive assurance will be provided through the Programme Board, Executive Group and Finance, Digital and Estates Committee. Thirdly, independent assurance will be obtained through Internal Audit, external specialist advisers, the Independent Cost Adviser, Gateway Reviews and any assurance processes required by NHS England or other funding bodies (as required and agreed).

Gateway Reviews

6.39 Formal gateway reviews will be undertaken at key decision points including completion of the Business Case, prior to procurement, prior to contract award, commencement of construction, commissioning and programme completion. Gateway reviews will assess programme readiness, governance, affordability, commercial arrangements, risk management and benefits realisation, ensuring that the programme remains capable of achieving its approved objectives. This approach will need to be agreed.

Performance Assurance

6.40 Programme performance will be reviewed routinely against agreed cost, programme, quality, scope and benefits baselines. Exception reporting will be used where agreed tolerances are forecast to be exceeded. Corrective actions will be monitored by the Programme Board until satisfactory resolution has been achieved.

Benefits and Post-Project Evaluation

6.41 Assurance will extend beyond completion of the capital works. Benefits realisation will continue to be monitored following occupation of the completed facilities to confirm that anticipated clinical, operational, financial, environmental and wider public value benefits are being achieved. Post-project evaluation will capture lessons learned to inform future investment decisions and continuous improvement across the Trust's wider estate portfolio.

Summary

6.42 The proposed assurance arrangements are proportionate to the scale and complexity of the Tickhill Road Strategic Estate Programme and provide the Trust Board with confidence that delivery will be subject to robust governance, transparent reporting and independent scrutiny throughout the programme lifecycle.

6.43 The next sections deal in further detail with the arrangements for monitoring and assuring the management of benefits and risks.

Introduction - Benefits Management Plan

6.44 The purpose of the Benefits Management Plan is to ensure that the investment in the delivery of the estates plan provides the required measurable improvements in patient outcomes, service performance, estate utilisation, environmental sustainability and wider public value. The strategy establishes the framework through which benefits will be identified, owned, monitored and realised throughout the plan’s lifecycle.

Benefits Management Principles

6.45 The Trust will manage benefits as a continuous process extending from business case approval through to post-occupancy evaluation. Benefits management will be integrated with programme governance and will inform decision-making throughout delivery. Each significant benefit will have a named owner, a defined baseline, agreed performance measures and a planned date for realisation.

Benefits Framework

6.46 Benefits will be grouped into six principal categories: clinical and patient benefits; operational and productivity benefits; financial benefits; estate and environmental benefits; workforce, education and research benefits; and wider economic and social value benefits. This framework reflects the programme's strategic objectives and aligns with the CIAM approach adopted elsewhere within the Business Case.

Benefits Ownership and Governance

6.47 Responsibility for delivery of individual benefits will rest with Executive Sponsors and Workstream Leads, whilst overall accountability for benefits realisation will remain with the Programme Board. Progress will be reviewed routinely through programme reporting and will form part of regular assurance to the Finance, Digital and Estates Committee and Trust Board.

Measurement and Reporting

6.48 Benefit performance will be monitored against agreed key performance indicators using information drawn from clinical systems, estate performance data, financial records and operational reporting. Benefits

reporting will distinguish between forecast and realised benefits, enabling timely intervention where delivery is at risk. Both cash-releasing and non-cash-releasing benefits will be monitored together with strategic and qualitative outcomes.

Continuous Benefits Realisation

6.49 Benefits management will continue beyond completion of construction activities. Formal post-occupancy reviews will confirm whether anticipated benefits have been achieved and identify any additional actions required to optimise operational performance. Lessons learned will be captured to support future investment decisions and continuous improvement across the Trust's estate portfolio.

Benefits Realisation Plan

Purpose

6.50 The Benefits Realisation Plan describes how the anticipated benefits of the Trust’s estate plan will be delivered, monitored and sustained throughout its lifecycle. It provides a structured approach to ensuring that the investment delivers measurable improvements rather than simply the completion of capital projects.

Phased Benefits Realisation

6.51 The plan has been designed so that benefits are realised progressively as individual components are delivered. Early benefits will arise from strengthened governance, improved coordination and completion of enabling activities. Medium-term benefits will emerge through estate rationalisation, refurbishment and implementation of the ambient loop energy network. Longer-term benefits will be realised following completion and occupation of the Frailty Centre, Education and Learning Centre and the disposal of surplus land.

Benefit Categories

6.52 The principal benefit categories comprise improved patient outcomes and experience; enhanced operational efficiency; reduced backlog maintenance and estate costs; lower energy consumption and carbon emissions; improved workforce development and education; increased research capability; capital receipts from land disposal; delivery of new housing; and wider social, economic and environmental value for the local community.

Monitoring and Ownership

6.53 Each benefit will be allocated to a named Executive Sponsor and operational benefit owner. Baseline performance measures will be established prior to implementation and monitored through agreed key performance indicators. Progress will be reported routinely through the Programme Board and included within regular reports to the Finance, Digital and Estates Committee and Trust Board.

Review and Optimisation

6.54 Benefits realisation will continue beyond the completion of individual projects or elements of the plan. Formal post-occupancy evaluations will assess whether anticipated outcomes have been achieved and identify opportunities to optimise operational performance. Where expected benefits are not realised, corrective actions will be agreed by the Programme Board and monitored until satisfactory performance has been achieved.

Benefits Realisation Summary

6.55 By adopting a structured benefits management approach, the Trust will ensure that investment decisions remain focused on strategic outcomes rather than asset delivery alone. This approach supports the principles of HM Treasury's Green Book and provides confidence that the programme will deliver enduring value for patients, staff, the Trust and the wider health and care system.

Programme Phase	**Key Activities**	**Principal Benefits**	**Lead**
Mobilisation	Governance, approvals, procurement	Programme readiness, assurance	Programme Director
Enabling Works	Decant, refurbishment, ambient loop	Operational resilience, estate efficiency	Estates Lead
Main Delivery	Frailty Centre, Education Centre	Clinical and workforce benefits	COO / Strategy

Programme Phase	**Key Activities**	**Principal Benefits**	**Lead**
Completion	Land disposal, optimisation	Financial, social value, carbon reduction	Director of Finance & Estates

Risk Management Plan

Purpose

6.56 The Trust will adopt a proactive approach to risk management throughout the lifecycle of the estate paln. Risk management will support informed decision-making, protect delivery of programme objectives and maximise the opportunity to realise anticipated benefits.

Risk Management Framework

6.57 Risks will be identified, assessed, owned, monitored and reviewed using the Trust's corporate risk management framework. Programme risks will be considered alongside strategic, operational, financial and clinical risks to ensure that decisions reflect the wider organisational context.

Risk Governance

6.58 The Programme Board will maintain overall oversight of programme risks, supported by Workstream Leads and the Programme Management Office. Significant risks will be escalated through the Executive Group and Finance, Digital and Estates Committee to the Trust Board where required.

Risk Appetite

6.59 The Trust recognises that delivery of a complex estate transformation programme requires informed risk-taking. Decisions will therefore balance opportunity, affordability and operational resilience while maintaining patient safety, statutory compliance and financial sustainability. This will be undertaken consistently with the Trust’s

Monitoring and Reporting

6.60 Strategic risks will be reviewed monthly by the Programme Board and reported through routine programme dashboards. Risk trends, mitigation actions and residual exposure will be monitored to ensure timely intervention where delivery objectives are threatened.

Continuous Review

6.61 The programme risk register will remain a live management tool throughout planning, procurement, construction, commissioning and post-project evaluation. Emerging risks and lessons learned will be incorporated into future programme decisions.

Strategic Risk Register

6.62 The Table below summarises the principal strategic risks identified at this stage of programme development. The register will be maintained by the Programme Management Office and reviewed routinely by the Programme Board.

Risk	Impact	Mitigation	Owner	Status
Business Case approvals delayed	Programme	Early engagement with regulators and robust assurance	Programme Director	Open
Capital affordability	Financial	Phased delivery and funding strategy	SRO	Open
Ambient loop procurement	Programme	Early market engagement and specialist advisers	Director of Strategy	Open
Planning or statutory approvals	Programme	Early liaison with authorities	Programme Director	Open
Clinical service disruption	Clinical	Detailed decant planning	COO	Open
Construction inflation	Financial	Cost management and contingencies	Director of Finance and Estates	Open
Land disposal underperforms	Financial	Market testing and phased disposal	Director of Finance & Estates	Open
Benefits not realised	Strategic	Benefits owners and post-	Programme Board	Open

Risk	Impact	Mitigation	Owner	Status
		occupancy review		
Stakeholder resistance	Strategic	Communications and engagement	Comms Lead	Open
Programme resource capacity	Operational	Dedicated PMO and specialist support	Programme Director	Open

6.63 The strategic risk register will be reviewed monthly and updated to reflect changing programme circumstances. Risks will be closed only where mitigation has been successfully implemented or the underlying exposure has been eliminated.

6.64 As the various procurement routes are pursued to enable the appointment of preferred partners for each element of the plan, detailed risk registers will be developed to ensure that risks are managed in the most appropriate way by each of the workstreams set out above.

Conclusion

6.65 The Trust's strategy to 2028 sets out a number of key objectives and promises which are at the heart of everything the Trust does. The estate plan is an important enabler for many of these promises and these are set out below:

Strategic Objective	Promise	Commentary / Programme Response
1. Nurture partnerships with patients and citizens to support good health	1. Employ peer support workers at the heart of every service by 2027.	
	2. Support unpaid carers in our communities and among our staff.	
	3. Work with over 350 volunteers by 2025.	

Strategic Objective	Promise	Commentary / Programme Response
	4. Put patient feedback at the heart of service delivery.	The Programme Team is currently developing an engagement strategy as one of its key programme workstreams. Feedback on the estate has been sought through te Estates Roadshows held in June 2026.
	5. Systematically involve communities at every level of decision making from 2024.	The Programme Team is currently developing an engagement strategy as one of its key programme workstreams
2. Create equity of access, employment and experience to address differences in outcome	6. Deliver a poverty-proof approach across services by 2025.	
	7. Deliver the Core20PLUS5 health improvement commitments.	
	8. Deliver five impactful changes to reduce health inequalities.	This could be achieved through the release of land through housing and the development of the frailty service
	9. Improve employment opportunities for under-represented groups.	This can be linked to the release of land for housing and therefore providing stable housing for underrepresented groups to be able to secure employment
	10. Be recognised as an outstanding provider of inclusive healthcare by 2027.	
	11. Deliver NHS commitments to veterans.	

Strategic Objective	Promise	Commentary / Programme Response
	12. Improve recognition and response to the needs of rural communities.	Further work required here through the analysis proposed to be done in North Lincolnshire in particular.
3. Extend our community offer	13. Integrate physical and mental health support within communities.	The development of more “health in the high street” opportunities and a more user friendly campus at Tickhill Road will support this.
	14. Assess urgent referrals within 48 hours and achieve four-week waits.	
	15. Support integrated neighbourhood teams in every Place.	
	16. Measure and improve outcomes year on year.	The benefits identification for the business case will support and provide better visibility of this.
	17. Embed psychological health teams across schools and early years.	
4. Deliver high quality and therapeutic bed-based care	18. Invest in and research therapeutic multidisciplinary inpatient care.	The development of an integrated frailty service
	19. End out-of-area placements wherever possible.	
	20. Deliver virtual care models.	The development of an integrated frailty service which includes enhancement of the existing successful virtual ward service.
	21. Support primary care networks and the voluntary sector.	

Strategic Objective	Promise	Commentary / Programme Response
	22. Develop consistent seven-day services.	
	23. Invest in residential care and step-up/step-down services.	The development of an integrated frailty servce
5. Help deliver social value through partnerships	24. Expand education and workforce opportunities.	Learning & Education Centre
	25. Achieve Real Living Wage accreditation and increase local spend.	
	26. Become an anti-racist organisation.	
	27. Deliver the NHS Green Plan.	Through the ambient loop at Tickhill Road
	28. Expand research through university partnerships.	Supported by the Education and Learning Centre.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Supporting Paper	**Agenda Item**	Agenda Pack B
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Various		
Meeting	Board of Directors	**Date**	30 July 2026

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

The following reports, received and discussed by the People and Organisational Development Committee and Quality Committee, are presented today to be noted by the Board of Directors:

Guardian of Safe Working Hours – The People and Organisational Development Committee were assured on the work of the Guardian of Safe Working Hours and the adherence to national requirements.

Mortality report – The Quality Committee were assured that the organisation is fully sighted on Learning from Deaths.

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

People and Organisational Development Committee held 17 June 2026
Quality Committee held 22 July 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE and CONSIDER the appended reports for information

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

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

Strategic Delivery Risks (indicate those that this paper supports)	
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.	X

System / Place 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)
Refer to Agenda Pack B

Rotherham Doncaster and South Humber NHS Foundation Trust

Guardian of Safe Working Hours (GoSWH)'s Report on Resident Doctors

01 February 2026 to 31 May 2026

Dr Babur Yusufi
Guardian of Safe Working Hours

June 2026

RDaSH nurturing the power in our communities

EXECUTIVE SUMMARY

This report covers a period of four months; from 1 February 2026 to 31 May 2026.

In keeping with the implementation of Exception Reporting Reforms on 4 February 2026 and introduction of Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Version 14 on 1 June 2026, this report contains details of trainees currently subject to TCS, information on Exception Reporting and GoSWH's Fines and a summary of Issues highlighted at the Resident Doctors' Forum (RDF). A short summary of important themes and issues is provided in the end. As per the new process, educational exception reports are managed by the Director of Medical Education (DME), while the rest by Medical HR. GoSWH retains oversight of all exception reports, to identify exception reporting patterns to ensure reports are accurate, valid and adhere to the purpose of exception reporting.

Since the start of new rotation in April 2026, there are 56 Resident Doctors in the Trust, with 7 vacant posts. A total of 114 exceptions reports were filed: 71 from Rotherham, 25 from Doncaster and 18 from North Lincs, more than double from preceding four months (n= 114 vs n= 52). Most were about hours working beyond the day shift, i.e. from 09:00hrs to 17:00hrs (n = 58 vs n= 35 from preceding four months). There were 12 for Missed Educational Opportunities, 6 each for Working Beyond On-Call Shift and not being able to take Contractual Breaks and 5 for Inadequacy of Clinical Support. There was no report of Immediate Safety Concern. Payment/ Toil have been agreed on all, barring those where the reporting doctors have not responded and failed to provide relevant information. GoSWH's fines have been applied on 4 occasions of Breach of Contractual Limits.

There were no major gaps in the Rota.

Current balance in GoSWH's Fines' Account is Nil as all monies have been spent on Blackwell Book Vouchers, for all Resident Doctors working in Trust from 1 January to 31 December 2026, to have a £100 voucher, each.

Main points discussed at RDF (Resident Doctors' Forum) were, inclusion of LE and SAS Doctors on First On-Call Rota on Allocate Exception Reporting Software, Cross-cover for GoSWH during their absence, Minimum Resident Doctor Cover in Services, Concerns about Workload (due to activities not related to Training and Core Competencies and lack of appropriate Cross-Cover) and managing issues with Allocate.

Key considerations coming out of this report are; (1) Embedding new ER Process and managing issues to do with Allocate (2) Ensuring Minimum Resident Doctors Cover/ appropriate Cross-Cover and Workload Management (3) Mitigating Impact of Service Changes on Resident Doctors.

INTRODUCTION

A revised version of Terms and Conditions of Service for NHS Doctors and Dentists in Training England (TCS 2016) was introduced on 1 June 2026, which is applicable to all higher, core, foundation and GPVT residents within the Trust.

This report covers a period of four months; from 1 February 2026 to 31 May 2026.
The report provides details of trainees currently subject to TCS, information on Exception Reporting and GoSWH's Fines and a summary of Issues highlighted at the Resident Doctors' Forum (RDF). A short summary of important themes and issues is provided in the end. As per the new process, educational exception reports are managed by the

Director of Medical Education (DME), while the rest by Medical HR. GoSWH retains oversight of all exception reports, to identify exception reporting patterns to ensure

CURRENT RDASH DOCTORS IN TRAINING

There are 56 trainees working in the trust with 7 vacant posts, starting from the start of the new rotation in April 2026. A breakdown of their grades is as follows:

	GP	CT	F2	F1	HT ST	**Total**	Vacant
Doncaster	4	1	3	3	4	**15**	2
Rotherham	5	9	2	4	8	**28**	1
North Lincolnshire	2	3	1	4	3	**13**	4
TOTAL	**11**	**13**	**6**	**11**	**15**	**56**	**7**

The above figures do not include the Hospice Doctors: x1 GP and x1 HT ST

EXCEPTION REPORTS (ERs) MANAGED BY MEDICAL HR

This feedback only covers ERs submitted for Extra Hours Worked (Beyond Day and Night On-Call Shifts), more hours Worked than Paid For during First On-Call and Mandatory Rest Conditions for Second On-Call.

Since the implementation of the Exception Reporting reforms in February 2026, there has been a modest increase in the number of exception reports submitted.

Between February 2026 and 31 May 2026, the Medical Staffing team received processed 90 Exception Reports, compared with 65 reports raised between 1 October 2025 and 31 January 2026.

The 84 exception reports received between February and May 2026 were distributed as follows:

Rotherham: 57
Day Time - Inpatient: 48
Day Time - Community: 0
First On-Call Shifts: 4
Second Non-Resident On-Call: 0
More Hours Worked During First On-Call then Paid For: 5

Doncaster: 16
Day Time - Inpatient: 6
Day Time - Community: 4
First On-Call Shifts: 2
Second Non-Resident On-Call: 0
More Hours Worked During First On-Call then Paid For: 4

North Lincolnshire: 18
Day Time - Inpatient: 15
Day Time - Community: 0
First On-Call Shifts: 0
Second Non-Resident On-Call: 1
More Hours Worked During First On-Call then Paid For: 2

Categories of Exception Reports
Exception reports are categorised as follows:

- Unscheduled late finish
- Unscheduled early start
- Breach of on-call working pattern

Out of 90 ERs, During the reporting period, 84 exception reports were submitted. Of these, 71% related to unscheduled early start/ late finishes.

The distribution of unscheduled late finish reports was as follows:

Service Area	Number of Reports	Average additional Time Worked
Rotherham	48	1 hour 10 minutes
Doncaster Mental Health	6	1 hour 4 minutes
Doncaster Physical Health (Hospice)	4	1 hour 47 minutes
North Lincolnshire	15	54 minutes

For Unresolved/ Outstanding ERs, as the residents have yet to provide the required evidence for working above the hours. Follow-up requests have been made on multiple occasions; however, no response has been received to date.

Please refer to the following tables for more details.

Key to the tables is as follows.

KEY:

1. n = Total Number
2. IP = Inpatient
3. CM = Community
4. UR = Unresolved
5. PAY = Payment
6. TOIL = Time-off in Lieu
7. WSR = Work Schedule Review
8. Comments Options:
    a. Escalated to GoSWH for Work Schedule Review for a pattern observed; two or more in two ERs in Two Consecutive Weeks.
    b. In case of UR:
        - Clarification from Doctor/ GoSWH Sought
        - Extra-contractual Report not actioned
        - Extra-contractual Report actioned

Table 1: WORKING BEFORE 0900hrs – DAY SHIFT (n= 1)

ROTHERHAM (n = 1)									
Grade	**Loc.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
FY1	IP	1	X	X	1	X	X	X	X
	CM	X	X	X	X	X	X	X	X

DONCASTER (n = 0)
NORTH LINCS (n = 0)

Table 2: WORKING AFTER 1700hrs – DAY SHIFT (n= 57)

ROHERHAM (n= 47)									
DOCTOR'S DEPARTMENT: GENERAL ADULT (n = 43)									
Grade	**Loc.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
FY1	IP	17	3	X	20	X	X	X	X
	CM	X	X	X	X	X	X	X	X
CT2	IP	5	1	X	X	6	X	X	X
	CM	X	X	X	X	X	X	X	X
CT3	IP	5	9	2	7	9	X	1	WSR
	CM	X	X	X	X	X	X	X	X
ST4-6	IP	X	1	X	1	X	X	X	X
	CM	X	X	X	X	X	X	X	X
DOCTOR'S DEPARTMENT: OLDER PEOPLE (n = 4)									
Grade	**No.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
FY1	IP =	4	X	X	4	X	X	X	X
	CM =	X	X	X	X	X	X	X	X

DONCASTER (n= 10)									
DOCTOR'S DEPARTMENT: GENERAL ADULT (n = 10)									
Grade	**Loc.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
FY1	IP	X	X	X	X	X	X	X	X
	CM	2	1	X	3	X	X	X	X
FY2	IP	X	X	X	X	X	X	X	X
	CM	X	X	1	1	X	X	X	X
GPST	IP	2	X	X	2	X	X	X	X
	CM	X	X	X	X	X	X	X	X
ST4-6	IP	X	3	1	4	X	X	X	X
	CM	X	X	X	X	X	X	X	X

NORTH LINCS. (n= 15)									
DOCTOR'S DEPARTMENT: General Adult (n =)									
Grade	**No.**	**≤60 Mins**	**≤120 Mins**	**>120 Mins**	**Outcome Payment**	**Outcome Toil**	**Unresolved**	**Escalated to GoSWH**	**Comments**
FY1	IP =	9	4	X	X	5	8	X	Clarification from Doctor Sought
	CM =	X	X	X	X	X	X	X	X
GPST	IP =	1	X	X	1	X	X	X	X
	CM =	X	X	X	X	X	X	X	X
CT1	IP =	X	X	1	1	X	X	X	X
	CM =	X	X	X	X	X	X	X	X

Table 3: WORKING BEYOND ON-CALL SHIFT (>12.30hrs) (n= 6)

ROTHERHAM (n = 4)								
DOCTOR'S DEPARTMENT: General Adult (n = 2)								
Grade	**No of ERs**	**Regular Hrs**	**Premium Hrs**	**Total Hrs**	**Outcome (UR/ PAY/TOIL)**	**Escalated to GoSWH (No.)**	**GoSWH's Fine**	
							Breaching Shift Time	**Breaching Rest Time**
CT1	1	X	6hrs 30 mins	6hrs 30 mins	Payment	Yes	Yes	X
CT3	1	X	2hrs 3mins	2hrs 3mins	Payment	Yes	Yes	X
DOCTOR'S DEPARTMENT: Older People (n = 2)								
Grade	**No of ERs**	**Regular Hrs**	**Premium Hrs**	**Total Hrs**	**Outcome (UR/ PAY/TOIL)**	**Escalated to GoSWH (No.)**	**GoSWH's Fine**	
							Breaching Shift Time (Hrs)	**Breaching Rest Time (Hrs)**
CT3	2	X	7hrs 45 mins	7hrs 45 mins	Payment	Yes	Yes	X

DONCATER (n = 2)								
DOCTOR'S DEPARTMENT: General Adult (n = 2)								
Grade	**No of ERs**	**Regular Hrs**	**Premium Hrs**	**Total Hrs**	**Outcome (UR/ PAY/TOIL)**	**Escalated to GoSWH (No.)**	**GoSWH's Fine**	
							Breaching Shift Time	**Breaching Rest Time**
FY2	2	2hrs 30 mins	X	2hrs 30mins	Unresolved	Yes	X	X

NORTH LINCS (n = 0)

TABLE 4: MORE HOURS WORKED DURING ON-CALL THAN PAID FOR (n = 11)

GRADE	NUMBER	COMMENTS
ROTHERHAM (n = 5)		1. These figures do not include reports withdrawn by the Resident. 2. Hours Worked during On-Call are calculated through a six-monthly On-Call Monitoring Audits and Payments determined based on that. Therefore, these reports are for Information Only.
CT 1	3	
CT 3	2	
DONCASTER (n = 4)		
FY2	4	
NORTH LINCS. (n = 2)		
CT1	2	

TABLE 5: BREACH OF MANDATORY REST FOR SECOND ON-CALL (n = 1)

GRADE	BREACH	PAYMENT/ TOIL	GoSWH's FINE
ROTHERHAM (n = 0)			
DONCASTER (n = 0)			
NORTH LINCS. (n= 1)			
ST6	5-Hr Rest (Between 2200 & 0700hrs) not achieved	TOIL	YES

EXCEPTION REPORTS (ERs) MANAGED BY DIRECTOR MEDICAL EDUCATION (DME)

While these ERs are primarily managed by the DME, GoSWH's feedback is based on the information available on Allocate.

TABLE 6: MISSED EDUCATIONAL OPPORTUNITIES (n= 12)

GRADE	NO.	REASONS
ROTHERHAM (n= 9)		1. Absence of Colleague and Resident having to Cross-Cover. 2. Adequate Medical Cover not being available. 3. Completion of Urgent Documentation carried over from last day. 4. Excessive Clinical Workload
FY1	4	
CT1	1	
CT3	4	
DONCASTER (n= 3)		
ST2	3	
NORTH LINCS. (n= 0)		

EXCEPTION REPORTS (ERs) MANAGED BY GoSWH

TABLE 6: THE INADEQUECY OF CLINICAL SUPPORT (n= 5)

GRADE	NO.	REASONS	OUTCOME
ROTHERHAM (n= 2)		1. Asked to cover another Ward with no Doctor. 2. Cross-covering Colleague's Emergency Leave 3. Cross-covering Colleague's Routine Leave when no Locum Cover arranged	Work Schedule Review and discussion with DME
FY1	2		
DONCASTER (n= 3)			
ST2	3		

NORTH LINCS. (n= 0)	4. Lack of Clinical Resources like dedicated Phlebotomy arrangement	

TABLE 7: THE INABILITY TO TAKE CONTRACTUAL BREAKS (n= 6)

GRADE	NO.	REASONS	OUTCOME
ROTHERHAM (n= 3)		Excessive Workload	Did not reach the Threshold i.e. unable to take scheduled breaks on at least 25 per cent of occasions across a four-week reference period. Recommended raising this in Clinical Supervision and considering Work Schedule Review
CT 1	1		
CT 3	2		
DONCASTER (n= 3)			
ST2	2		
ST4	1		
NORTH LINCS. (n= 0)	0		

IMMEDIATE SAFETY CONCERN (ISC) (N = 0)

There was no Immediate Safety Concern report.

GOSWH's FINES UPDATE

The final decision to spend the remaining amount of £15600 on Blackwell Book Vouchers, to provide £100 voucher each to all Resident Doctors working in the Trust from 1 January 2026 to 31 December 2026, has been implemented.

Vouchers have been purchased and there is no current balance in the account.

FEEDBACK FROM RESIDENT DOCTORS' FORUM DATED 21 MAY 26

1. **Disbursement of GoSWH's Fines' Money**
   Completed as given above,

2. **Local Agreement for Hybrid First On-Call**
   This has now been concluded

3. **Inclusion of LED/ SAS Doctors on First On-Call Rota on Allocate for Exception Reporting**
   Members of RDF agree all those the Frist On-Call Rota should have access to Allocation Exception Reporting System, as it helps to generate data on Rota compliance and provides evidence to doctors, to be compensated for extra hours worked. Moreover, it also allows GoSWH to apply fines in case of Contractual Breaches occur. This will be finalised after meeting between the LNC Chair, Medical HR and SAS Rep.

4. **Cross-Cover for GoSWH during absence**
   To action Exception Reports during GoSWH's Absence/ Annual leave, cross-cover arrangements are required. GoSWH will approach Senior Medical Management Team about it.

5. **Resident Doctors' Workload in North Lincs**
   Concerns were raised about the smaller First On-Call Rota in North Lincs as compared to Rotherham and Doncaster, due to less doctors available. This leads to doctors doing On-Call Shifts more frequently. Moreover, a significant time during the day is spent taking bloods, doing ECG's and sorting physical health issues. These not only increase workload and interfere with the training but also result in more fatigue. It has also been noticed that on calls seem to be busier than the anticipated call out times. Resident Doctors want On-Cal monitoring to conducted. Moreover, a word will be put to the Care Group Director, through DME, to organise Physical investigations through other members of the team. First On-Call monitoring will be commencing in the next few weeks.

6. **Doncaster Care Group Feedback**
   Impact of Non-medical staff changes on Resident Doctors' Work Schedules was discussed. While no impact is anticipated, the situation will be closely monitored. Need for inclusion of DME/ Resident Doctors' Reps in Service Change was highlighted.

   Concerns were raised about the Resident Doctors being asked to obtain blood samples, which take a chunk of their time away from their real Clinical Work and Training. It was suggested for a phlebotomist, to be employed, as the was in Rotherham, until recently.

   RDF were informed while High Dependency Unit (HDU) is Doncaster, is under Rotherham Care Group operational and financial control.

7. **Rotherham Care Group Feedback Locality Feedback**
   Concerns were raised about the staffing and cover issues in the HDU, as while being financially and operationally managed by the Rotherham Care Group, there is a local agreement for on-call cover in Doncaster. There is only a part-time SAS doctor employed to work in the HDU and there are times Resident Doctors are asked to do some work, in their absence. On occasions this work may spill over to the First On-Call.

   Loss of Phlebotomist has resulted in increased Workload for the Doctors. Resident doctors spend a lot of their 'training time' sorting a lot of non-psychiatry related issues, for example, taking Bloods and Care of Physical Health Needs, which can be demanding at times. It was agreed for this be raised with the Care Group Medical Director.

8. **Exception Reporting and Allocate Feedback**
   GoSWH highlighted times when doctors submitting ERs do not respond to their comments or requests for escalation to the DME. The Resident Doctors maintained they did not receive any intimation from Allocate for them to act. It was agreed for this to be escalated to Allocate Support and for the doctors submitting the reporting, checking their messages on their report, on a daily.

It was further added if any Resident Doctor in unable access Allocate, then can send the report directly to those managing them (i.e. Medical HR, DME and GoSWH0 by email.

9. **JLNC/ BMA Feedback**
   Minimum Resident Doctor cover within the services was discussed. It was highlighted that the Trust should consider hiring locum doctors to cover Resident/ Middle Grade Doctors' absences, instead of asking Residents to provide Cross-cover. This increases their workload, often having them to stay longer at work, than Work Scheduled. extending their time at work.

KEY THEMES:

1. **New Exception Reporting Process and Allocate**
   This has been implemented in February and given some major changes, it is gradually taking roots. The new Allocate Exception Reporting Software has thrown some unexpected challenges and difficulties. Some have been raised with their Support Team while others are in process of escalation.

   Accumulating data for reports like this, has been a huge challenge.

2. **Minimum Resident Doctor Cover, Cross-cover and Workloads**
   ERs and feedback at the RDF point towards excessive workloads in some areas, due to lack of appropriate Cover, Cross-cover and Residents having to undertake procedures like Phlebotomy, conducting ECGs and carrying out other Physical Interventions, which fall within the remits of other Professionals. Lot more work is required to mitigate these issues; to improve focus on training and for Residents to develop skills in areas related to the Core Competencies.

3. **Impact of Service changes on Resident Doctors**
   The Trust is in middle financial cuts and service changes, impact of which on Resident Doctors' Work Schedules and Training must be ascertained at the planning stage. Recommendation is for the DME to be involved in Impact Assessment on Training Posts, considering any such changes.

Dr Babur Yusufi
Guardian of Safe Working Hours (GoSWH) for RDaSH

15 June 2026

Rotherham Doncaster and South Humber NHS Foundation Trust

Mortality Report

March and April 2026

Mortality Report – PLFD

(Data focus March – April 2026)

1. Situation

The Chief Medical Officer for the Trust chairs the bimonthly Prevention of & Learning from Deaths Group, (PLFDG), previously the Mortality Surveillance Group (MSG)

A report is then provided to the Quality Committee (QC) and forms part of the Chief Medical Officers Quarterly report to the Board of Directors (Public)

2. Background

This report provides the Quality Committee with salient features and issues in relation to mortality surveillance management with a focus of data for March and April 2026.

The figures can increase due to late reporting on RADAR by services and the timescales of when the deaths occurred and subsequently reported. (Figures accurate at the time of the report). Any late reporting identified will be added to the next report.

3 Assessment

3.1 Mortality Reporting and Management

During the months of March and April 2026 there were 74 deaths reported in the Trust.

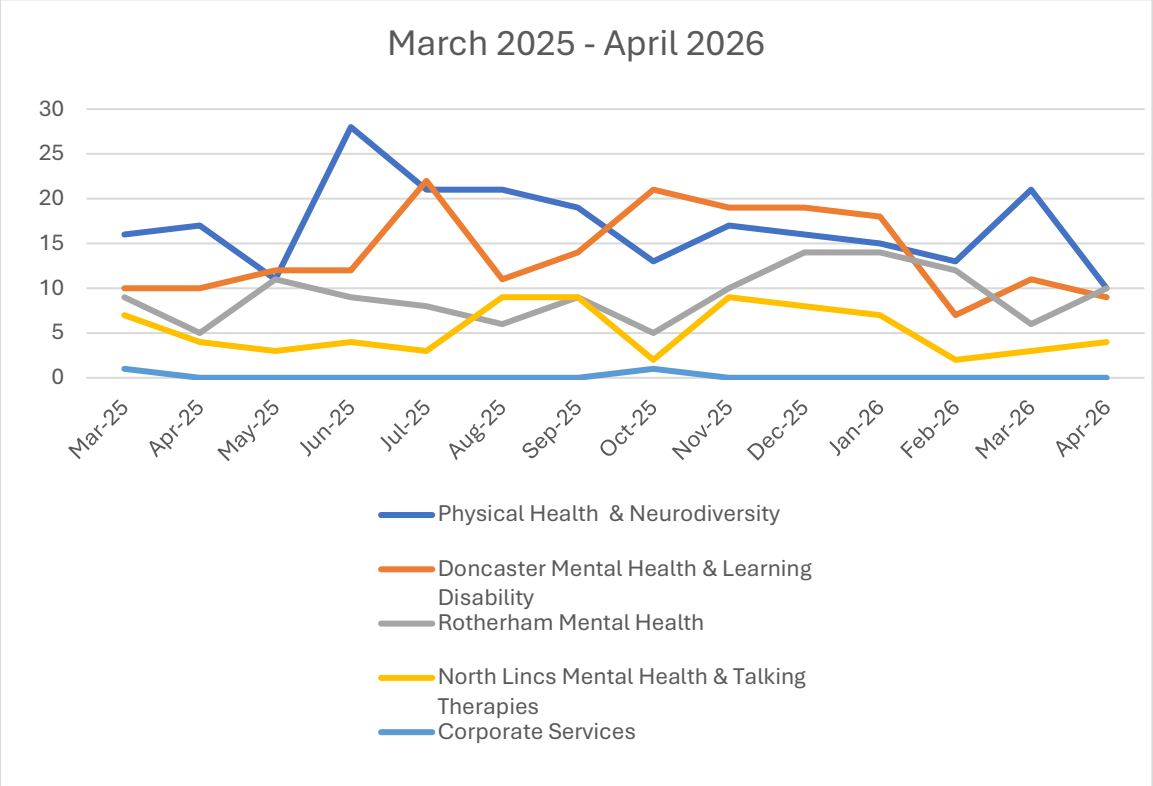
Table 1. – Status of deaths reported during March and April 2026.

Outcome of review	March	April
Reviewed by MOG and closed as no problem in care being identified	36	25
Reviewed by MOG, however , require further information and have been returned to the author	0	2

Reviewed and requires a Structured Judgement Review (SJR)	4	3
Reviewed and required further discussion in a Learning from Patient Safety Event meeting.	1	3
Awaiting further information from the coroner on cause of death	0	0
Awaiting review by MOG	0	0
Total	**41**	**33**

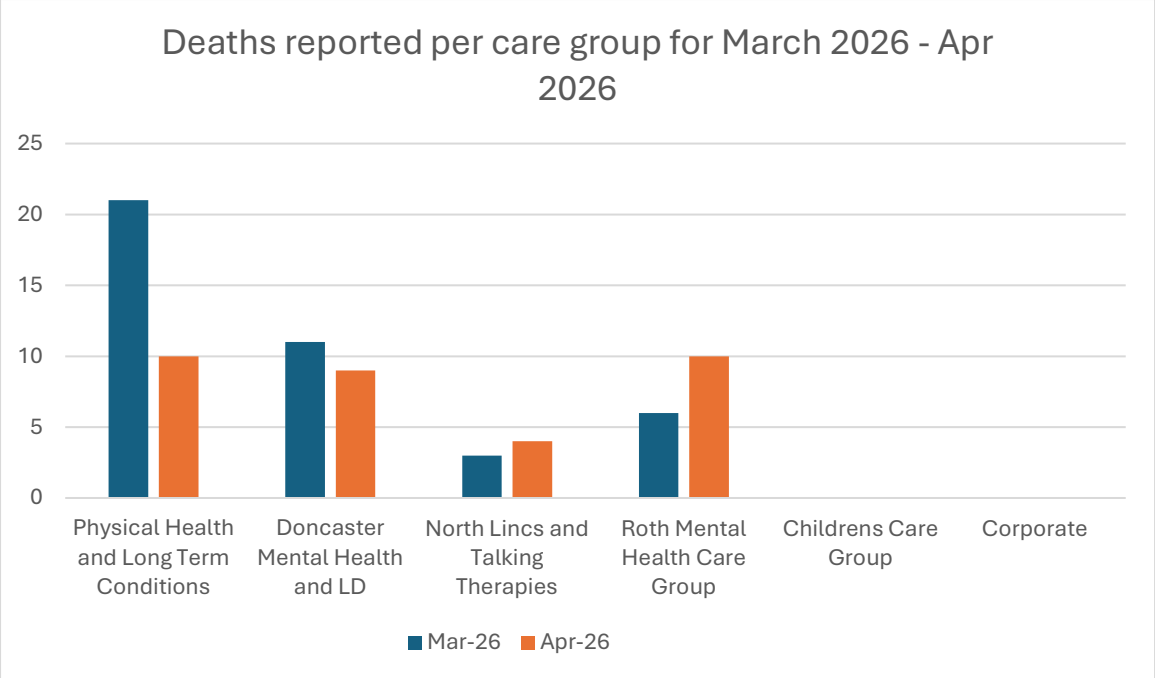
Deaths by Care Group from March 2025 - April 2026. Figures are offered in the longitudinal data as detailed below in graph 1.

Graph 1.



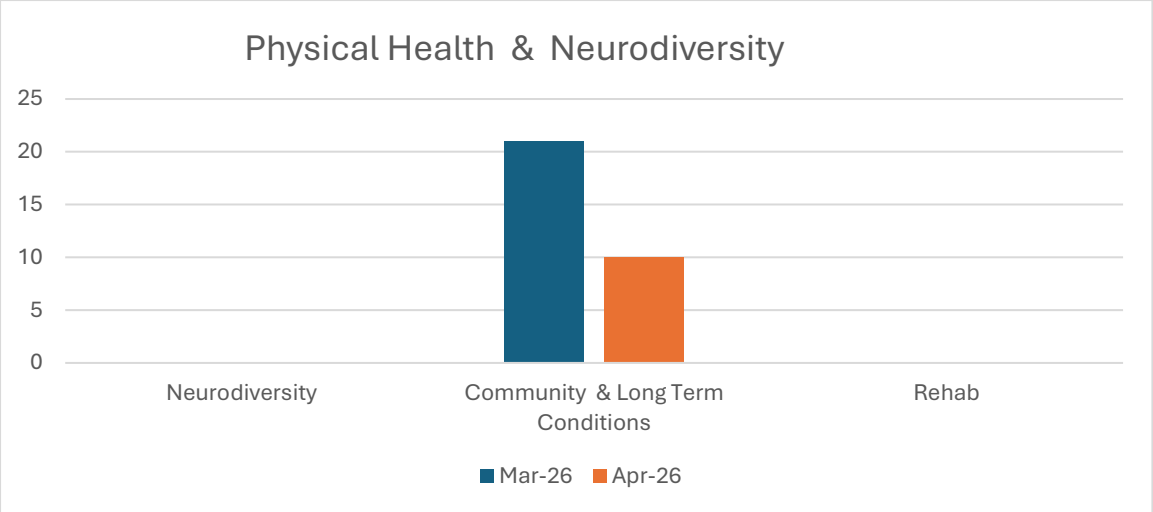
Graph 2 gives detail of the number of deaths as reported via the RADAR mortality forms from the care groups within the Trust during March and April 2026.

Graph 2



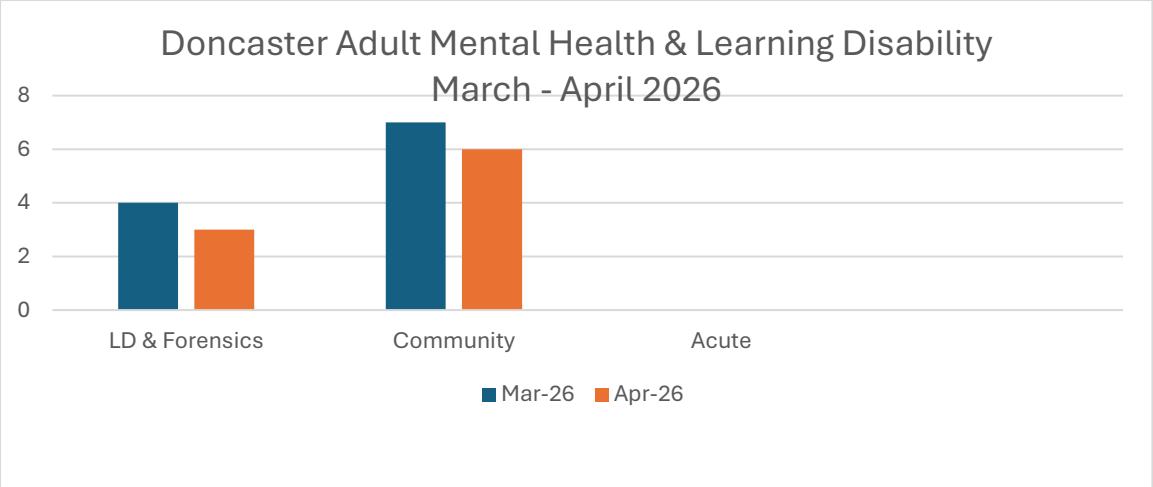
Graphs 2a – 2d offer a further breakdown of the data reported by individual care groups across the localities of the Trust.

2a Physical Health and Neurodiversity.



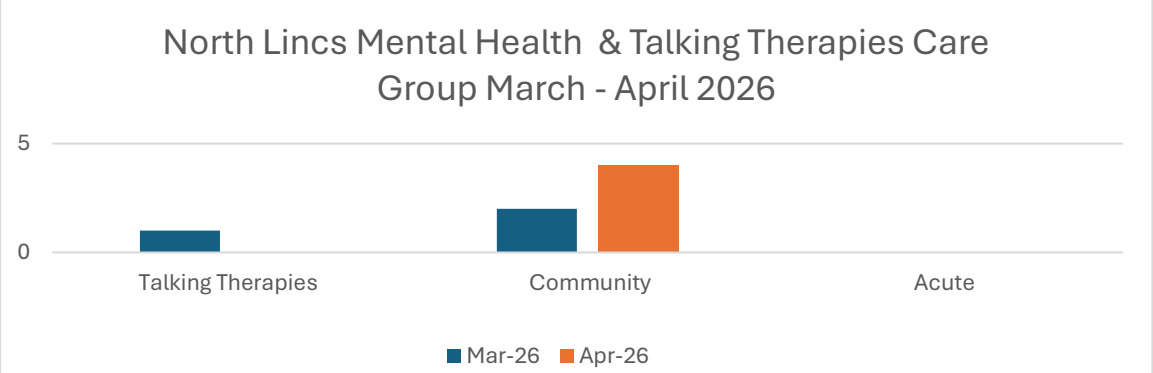
Highest figure of reported deaths from the Physicasl Health and Neurodiversity care group were as expected from the community and long term conditions services.

2b Doncaster Adult Mental Health & Learning Disability



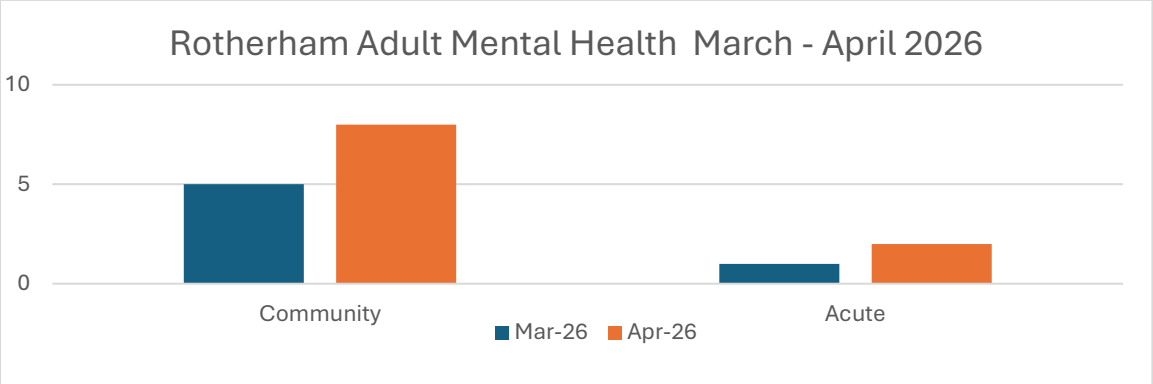
Highest numbers reported were from the community mental health teams. Learning Disability services reported 7 deaths during these two months.

2c **North Lincolnshire Mental Health & Talking Therapies.**



During March and April , 7 deaths reported by North Lincolnshire care group with 84% being from the Memory and Diagnostic community team.

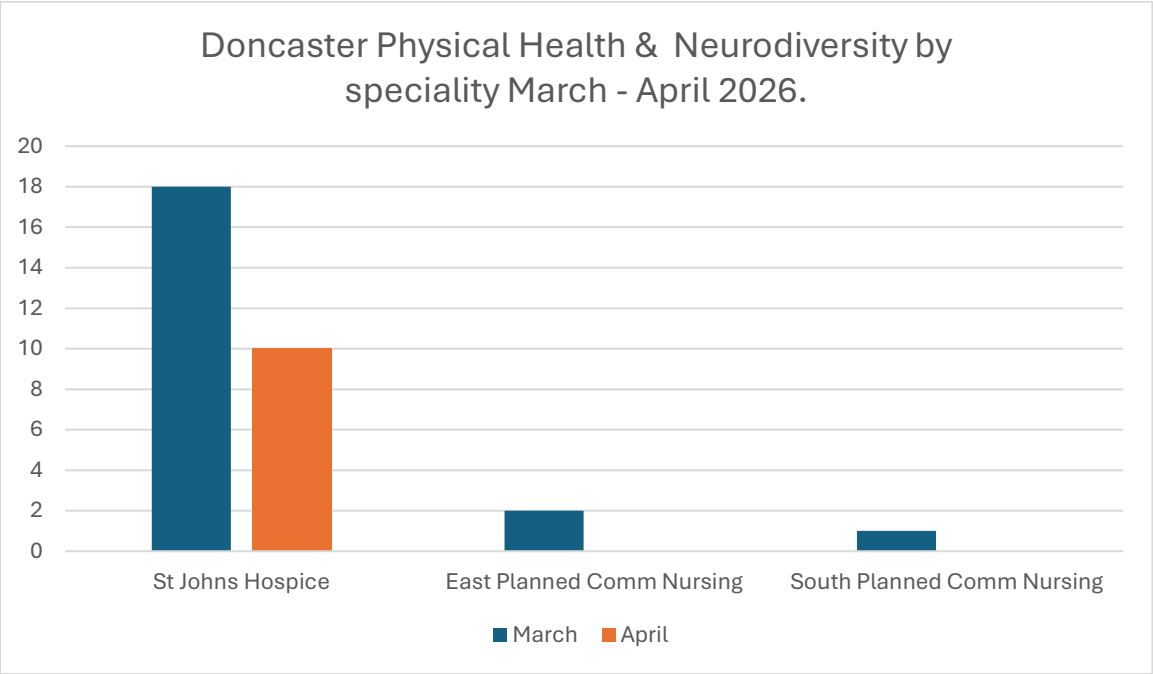
2d **Rotherham Adult Mental Health**



During the two months , 16 deaths reported by Rotherham, with 81% being from the community services.

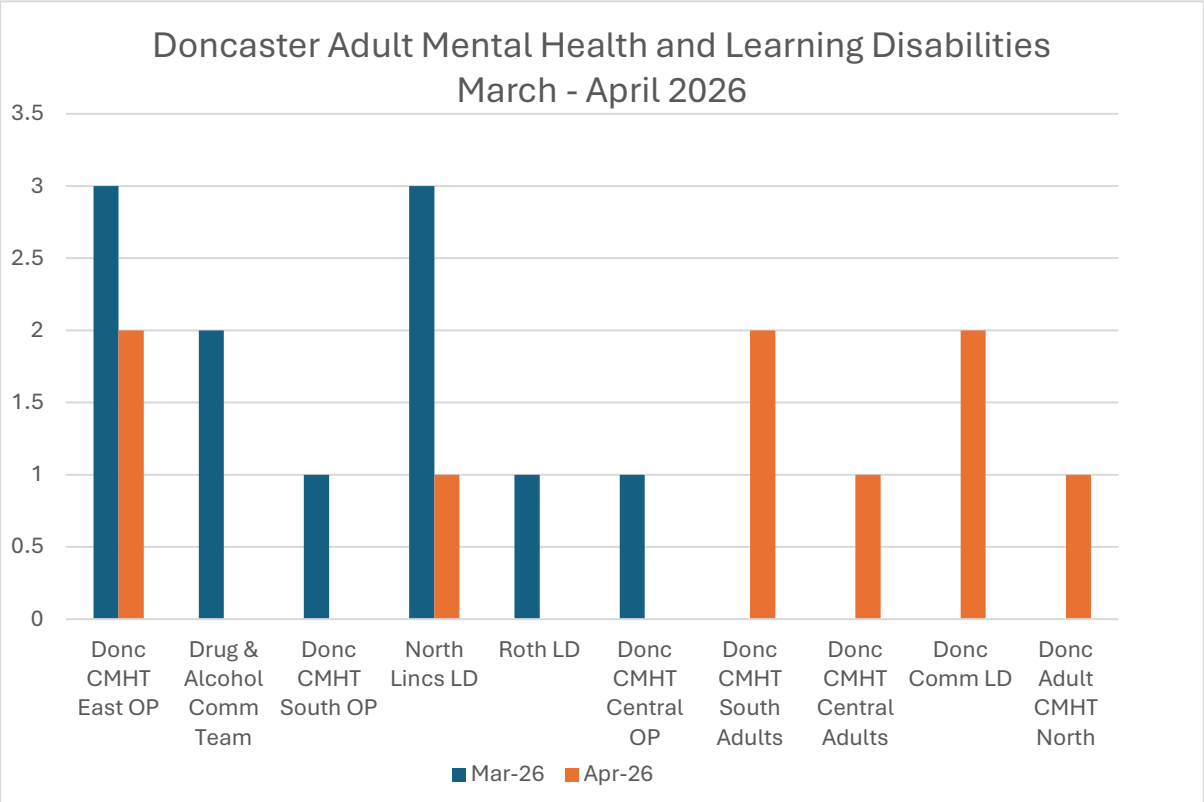
A further breakdown is offered in the following graphs 3a -3d, providing detail by speciality as reported from the RADAR system.

3a



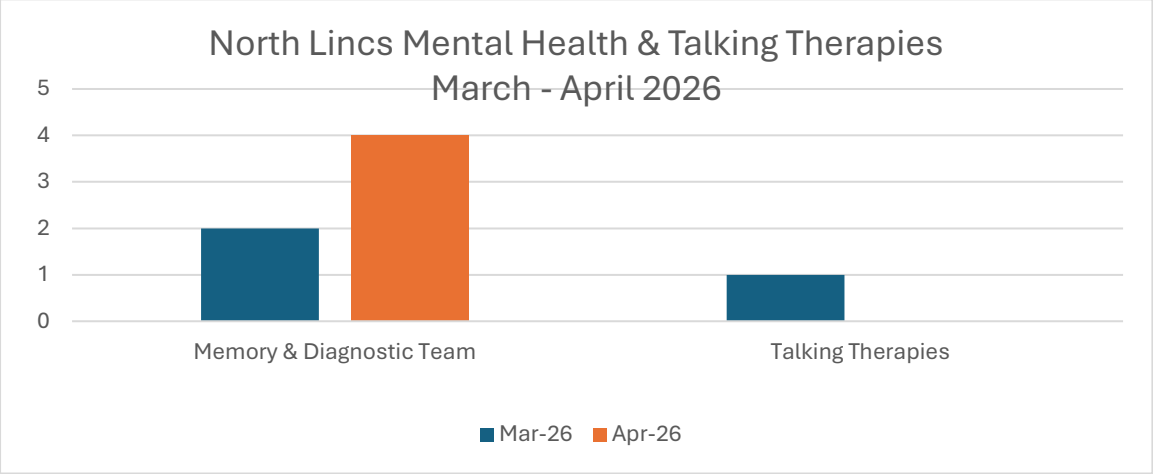
The highest percentage reported were from the hospice with 90% of overall figures. 31 deaths in total from the care group.

3b



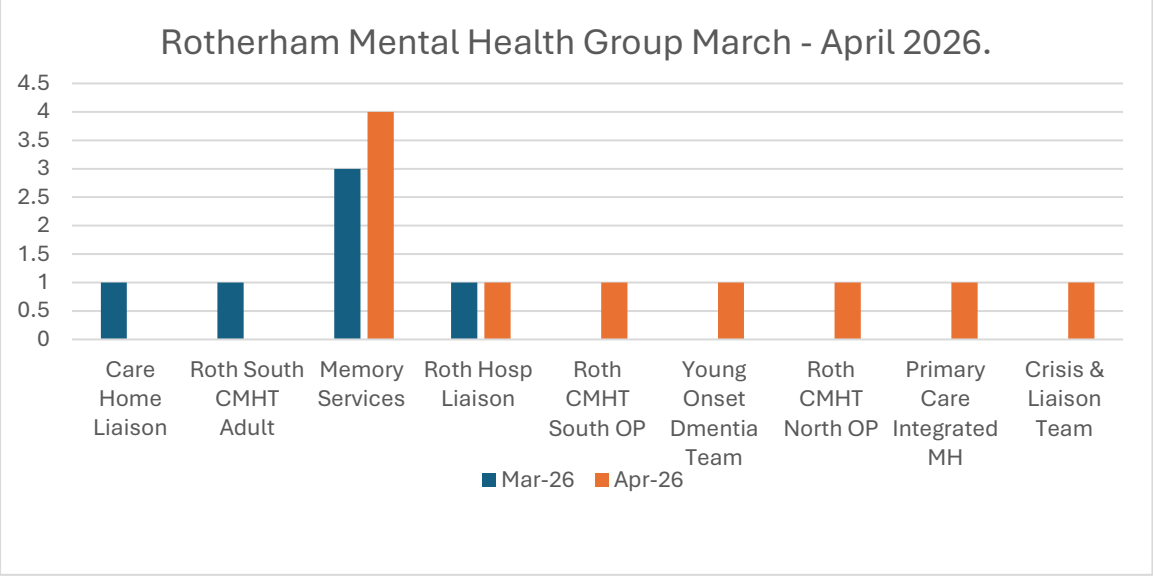
During March and April 20 deaths were reported from the Doncaster Adult mental health and LD services. 20% reported from the Adult CMHT services and 35% reported from the Learning Disability community teams across the organisation.

3c



Services from the Memory and Diagnostic teams reported the highest numbers.

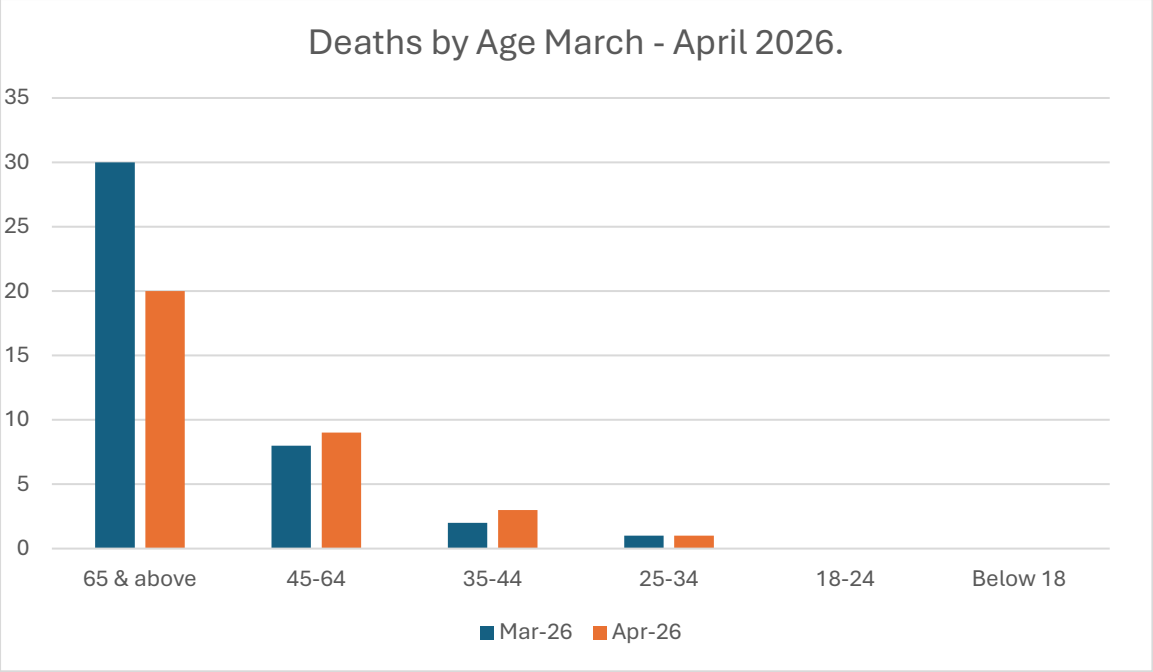
3d



Highest numbers of deaths remain to be reported from the older adult services for Rotherham, primarily for people who have been known to the Memory services.

Deaths reported by age – March – April 2026

Graph 4

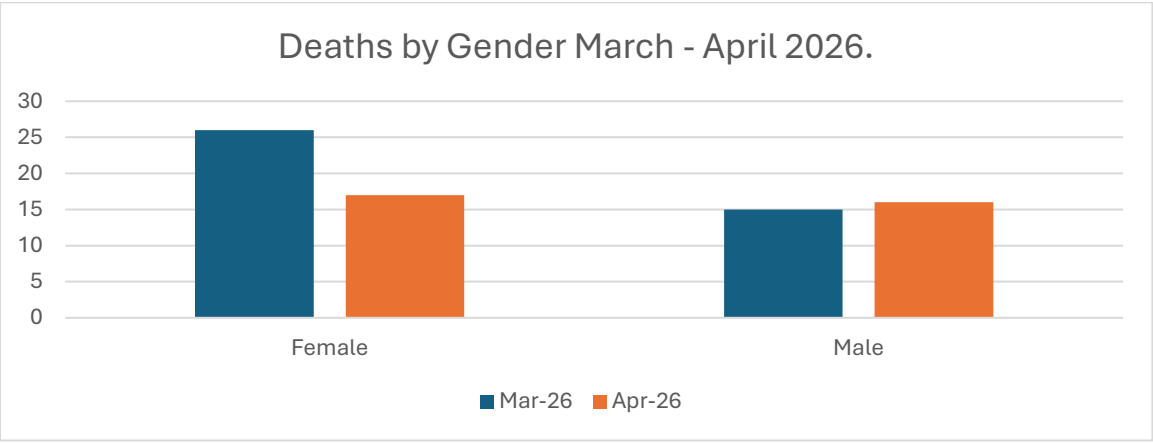


During the months of March and April the data showed that 33% of deaths reported in the 65+ group were for people above the age of 80 years, and with 34% between the age of 65 – 80.

Data identified that 33% of deaths reported were under the age of 65 years.

These figures were inclusive of the LD deaths with further detail identified in later graphs.

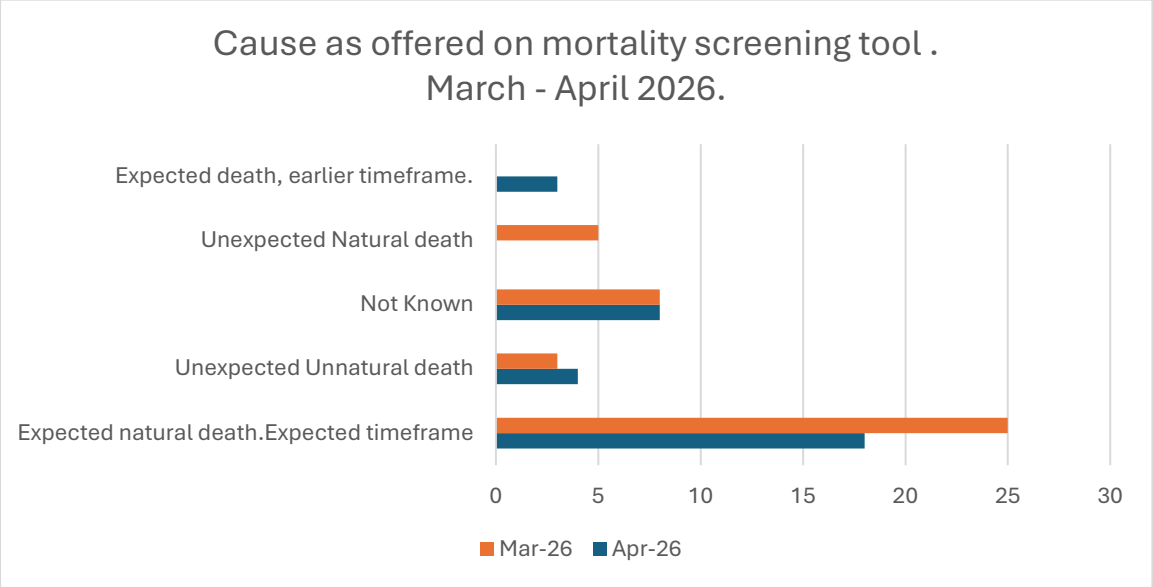
Graph 5



Females continue to be the highest gender of reported deaths. Of the 74 deaths recorded 43 were female compared to 31 male. Of the 43 female deaths 18 were recorded from the hospice.

Graph 6 shows detail relating to timeframes in respect to the deaths. 58% being expected death in the expected timeframe.

Graph 6



3.2 Structured Judgement Review process

The Mortality Operational Group (MOG) reviews all deaths recorded via the RADAR reporting system. During which, any that have identified as a “Red Flag” the incident is escalated to either a Structured Judgement Review if the person is known to have a Learning Disability or is tasked back via RADAR to the author, care group, or service for a further review under the PSIRF approach options.

Should MOG request further detail to be added to the form, this is also tasked back to the author and once completed a further review takes place.

Once MOG are satisfied and with no further concerns are noted, the form will then be closed.

A member of the Patient Safety Team attends the weekly MOG and together discuss and decide if further escalation is required at the LFPSE meeting. If so, a decision will then be made at the LFPSE and the appropriate action proposed. This process allows for the opportunity for further learning and shared outcome responses.

Up to the end of April 2026 , 19 SJR’s are to be completed on RADAR.

Table 2 The table below indicates the detail of the monthly reviews of each death which was reported during March and April 2026 on the RADAR system.

Month	March	April
Total number of deaths reported	41	33
Total No of deaths reported by Care Group		
Donc AMH & LD	11	9
Physical Health and Neurodiversity	21	10
Rotherham AMH	6	10
North Lincs & Talking Therapies	3	4
Children's services	0	0
Corporate Services	0	0
Cause group		
Expected natural death, expected timeframe	25	18
Expected natural death, earlier than expected timeframe	0	3
Expected unnatural death	0	0
Not known	8	8
Unexpected natural death	5	0
Unexpected Unnatural death	3	4
Gender		
Male	15	16
Female	26	17
Age Group		
<18	0	0
18- 24	0	0
25-34	1	1
35-44	2	3
45-64	8	9
>65	30	20
MOG data		
Incident appraisal screening tool only	36	25
Await further information and returned by MOG to the author	0	2
SJR Inc for LeDer report	4	3
Escalated to Patient Safety Team	1	3
Await info from coroner re Cause of Death	0	0

Await review by MOG	**0**	**0**
Learning response to be done	**0**	**0**

3.3 LeDeR reports & Structured Judgement Reviews.

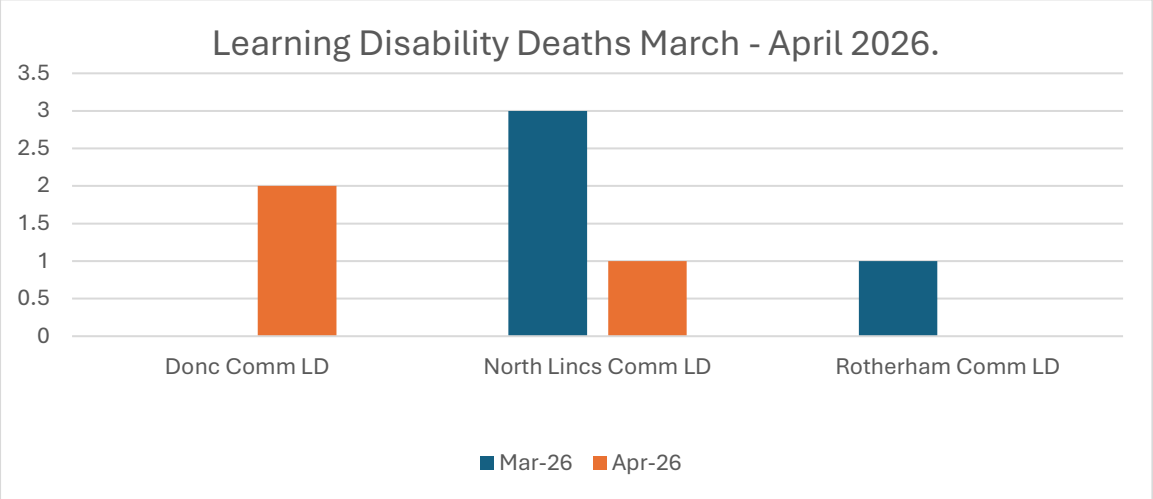
The LeDeR report published in 2025 which provided data taken from 2023 was withdrawn after being informed by NHS England of a technical issue within the cause of death data . This was due to a technical error being identified on a platform used to collate data installed in 2023. The report was republished in January 2026 with amended detail along with an explanation of the issues . A link to the updated republished report can be found in the appendices of this report. (Appendix 1).

During March and April 2026, 7 deaths were recorded from the Learning Disability services from across the Trust.

All of which are subject to a LeDeR review being completed as well as an SJR.
The " Learning from Lives and Deaths, LeDeR process reviews the health and social care records of individuals who have died and are known to have a learning disability or autism.
The graph below offers detail of the teams which have reported the death of someone known to their service during this data collection period.

Learning Disability Deaths

Graph 7



Detail offered in graphs 8 and 9 provides information in respect to the age and gender of people with a known learning disability and or autism who died during March or April 2026.

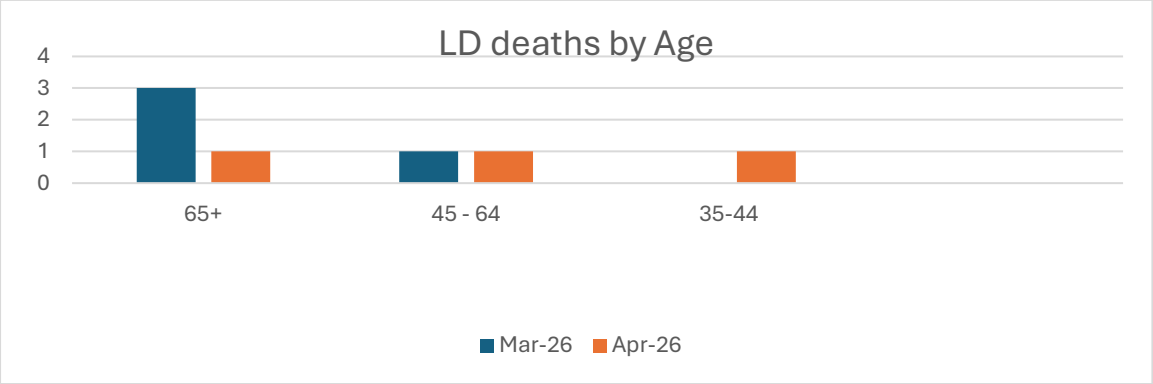
Two of the deaths were expected deaths and with in the expected timeframes . Male 82 and female 74, respectively.

Two reported as expected natural deaths , earlier than expected timeframe , female 72 and male 35 .

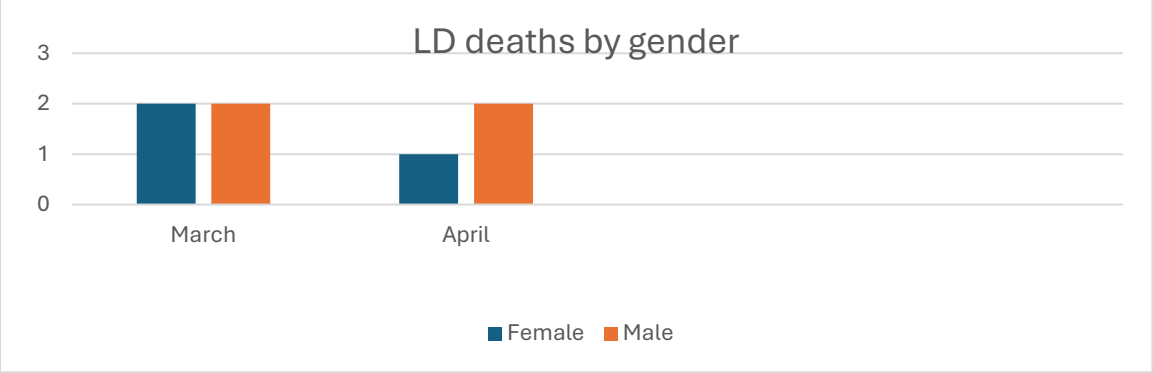
Two were detailed as unknown in respect of the cause and timeframe , female 72, and male 58.

One male aged 61 whose deaths was reported as expected unnatural death.

Graph 8



Graph 9



During a recent meeting with the Matron from the Learning Disability and Forensic Services for the Trust, areas of clarification were identified in respect of the documentation and detail in care records when Structured Judgement Reviews have taken place.

Areas for consideration included risk assessment , hospital passports, and care planning for specific known physical health concerns . Whilst there have been noted areas of good practice and following expected standards of documentation, it was highlighted the inconsistencies in how detail is recorded.

Following this initial discussion with the Matron a further meeting is planned with the proposal of SJR's being discussed with nominated key senior members of staff and

in order to identify and proactively address areas which raise a concern and allows for immediate learning.

The week commencing the 15th June 2026 is “Learning Disability Awareness” week and it is planned for focussed themes as identified from the LeDeR report and findings from SJR’s to be promoted throughout the services across the Trust.

These key themes include.

- Diabetes
- Constipation
- Physical health checks
- Improving access to screening programmes and uptake of available vaccines
- Documentation and record keeping.

4. Learning from Deaths

The Chief Coroner for England and Wales is the most senior coroner, and they are appointed by the Lord Chief Justice of England and Wales in consultation with the Lord Chancellor. The past four Chief Coroners were all Crown Court judges at the time of their appointment to the role.

At an inquest, a coroner may issue a Regulation 28 Prevention of Future Deaths ,(PFD). report where it is believed that action should be taken to prevent future deaths. These can be issued during the inquest proceedings or at the conclusion of the inquest. The recipient of the report has a statutory duty to respond within 56 days.

Whilst PFDs are rarely issued, they can offer a valuable insight and opportunity for learning for the NHS and other authorities and these, along with other information received by NHS England, help to improve services .

The Trust received a PFD in March 2026 following the conclusion of an inquest heard by the Area coroner for South Yorkshire East. A response was provided by the Chief Executive for the Trust offering detail of changes made during the time of the scheduled inquest and since the conclusion. Detail was offered in respect of the changes and how improvements have been implemented along with assurance of effective and continued oversight across the Trust.

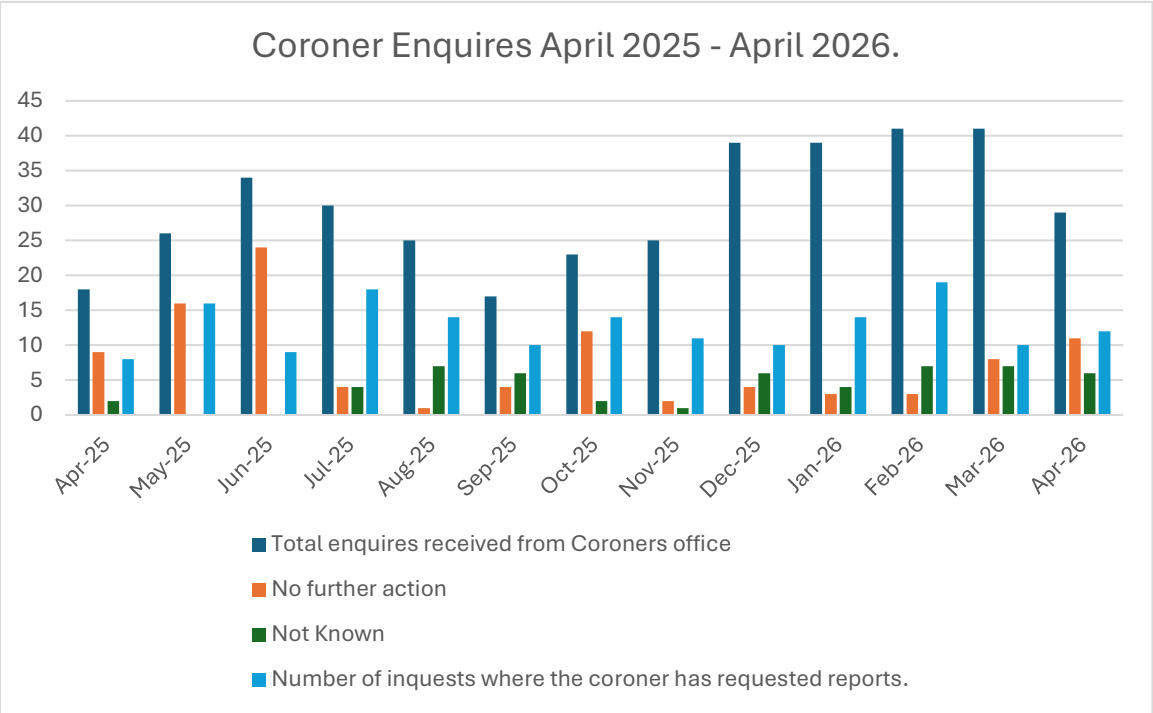
Detailed in Appendix 2 of this report are a selection of PFD’s along with the concerns raised from each inquest which have been issued to other authorities and organisations and where it was felt that future attention was required in the prevention of future deaths. The selection is from a number of jurisdictions and offers opportunities for our Trust to be proactive in recognising areas for improvement in respect of continued learning and development from deaths. Information has also

been added where similar inquests have been heard locally or pending where it is felt areas for improvement and learning could be debated.

4.1 Coronial inquests

Information below in graph 10, offers the detail of enquires and inquests from a number of jurisdictions involving the Trust dating from April 2025 – April 2026.

Graph 10



During March and April 2026 , the Trust received 70 enquires from the coroner's office and local jurisdictions. Following further detail provided to the coroner , requests were formally made by the coroner on 22 occasions for statement or reports to be submitted.

In March and April, the Coroner and Mortality team attended 4 inquests. All of which were heard in Doncaster.

During these months, the Trust was stood down for 30 inquests as the evidenced provided to the coroner was sufficient and deemed acceptable to be read in court under Rule 23.

This in turn offers clinicians and colleagues the opportunity to provide increased direct patient care by not being required to attend court.

Information offered in graph 11 shows over the time period of April 2025 – April 2026 the number of inquests where the Trust has had legal representation at inquest as well as the amount of occasions as to where the Trust has been stood down to provide live evidence.

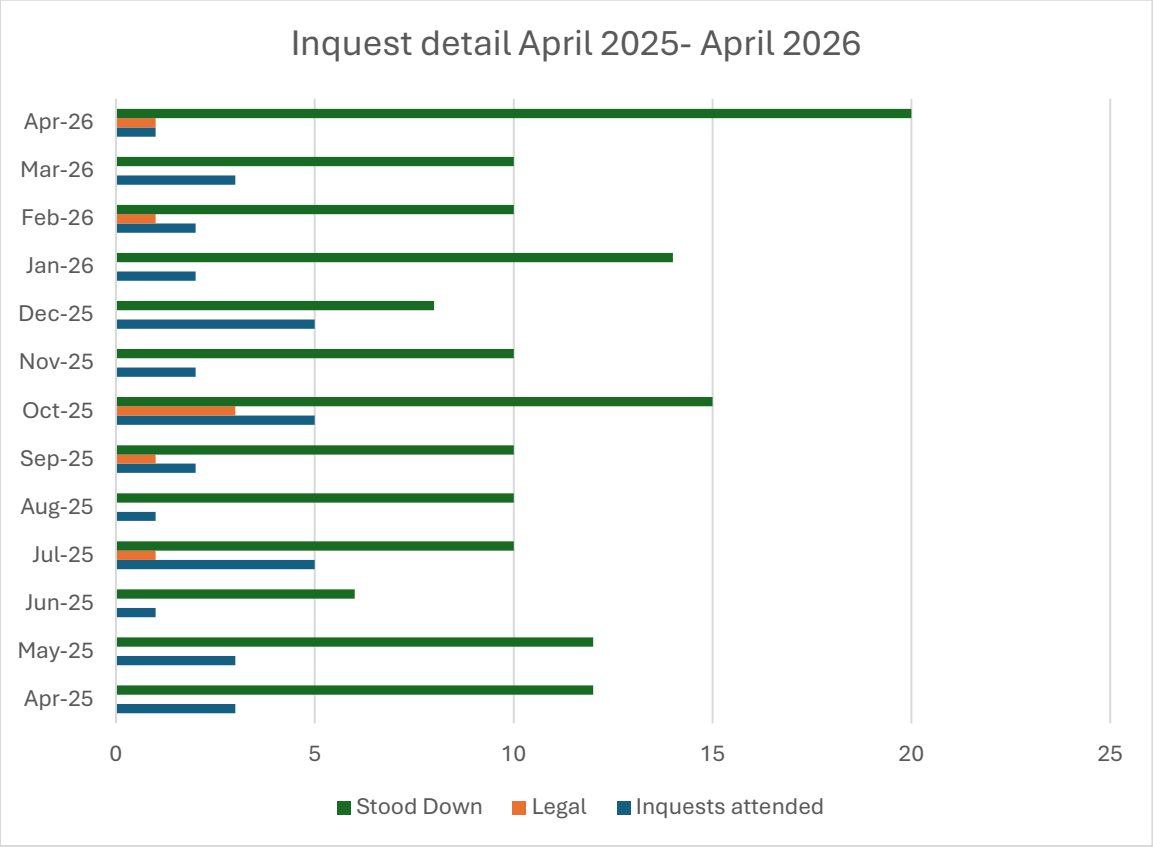
This is testament to the time, support and information offered by the coroner and mortality team to colleagues who have been requested to complete reports for His Majesty's Coroner and submission to the court.

Over the past twelve months the team have offered face to face and Teams sessions to colleagues throughout the organisation to provide awareness training and an insight into the process of an inquest and what is expected in regard to information detailed with reports / statements.

It has been recognised that the standard of reports have improved and this is supported with the team having a final review of each report prior to submission to court. This in itself offers the opportunity to be proactive in respect of learning and possible actions required prior to inquest.

The sessions have been welcomed with others planned throughout 2026 in all three localities of the Trust.

Graph 11



4.2 Suicide prevention

Doncaster's updated suicide prevention plan is scheduled to be launched in September 2026 along with a new suicide awareness campaign. With this comes an explicit focus on safety planning and what this means in practice.

Recent guidance published by the Royal College of General Practitioners offers information based on principles of ‘Staying Safe from Suicide’ guidance for Mental Health practitioners in England and associated NICE guidance.(Appendix 3).

There are approximately over 6.5 thousand people who die by suicide in the UK each year with many attending primary care or NHS services for unrelated complaints in the preceding months.

On average that is 17 people each day who die by suicide in the UK. Of which five are in contact with mental health services, with four of those five assessed as ‘low’ or ‘no’ risk at their last contact.

The British Psychology Society have also issued a guide ‘Helping Older People Stay Safe from Suicide’ with tips to help mental health practitioners when working with older adults. (Appendix 3).

The presentation, Staying Safe from Suicide : Safety Assessment , Formulation and Management on NHS futures (Appendix 4) offers information of why new guidance is needed in respect of the focus around suicide prevention work.

Within the presentation detail is offered around the 10 non-negotiable principles re best practice and suicide prevention work.

- Relational Safety
- Biopsychosocial approach
- Safety assessment and formulation
- Safety management and planning
- Dynamic understanding
- Evidence based practice.
- Involving others Inclusivity
- Clear communication
- Continuous improvement

There is an expectation at both local and national level that concerns are actioned as detailed in the points below-

<u>Local level</u>

- Secure senior , Executive leadership support, and commitment
- Develop local implementation strategy.
- Mandatory training
- Collaboration across disciplines and teams
- Review and update record systems.
- Engage with local coroner’s office.
- Monitor progress including patient experience and evaluate outcomes.

National level

- Integrate this guidance into NHS Policy, NHS commissioned services , inspections, professional standards, and training.
- Share evidence and examples of implementation through resource hubs.
- Oversight by key agencies and professional bodies.