

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

**ANNUAL REPORT AND ACCOUNTS
APRIL 2025 TO MARCH 2026**

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**PRESENTED TO PARLIAMENT PURSUANT TO SCHEDULE 7, PARAGRAPH 25(4)(a)
OF THE NATIONAL HEALTH SERVICE ACT 2006**

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PERFORMANCE REPORT

Overview of Performance

This section provides an introduction to the annual report from the chief executive and chair. It describes the trust and highlights some of the major achievements in the year, the risks we have faced and provides some facts and figures about the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).

Chair Introduction

That most of our services have ended the year with the shortest waiting times in the NHS should be a source of pride to the colleagues who have worked so hard and to local people who have supported our journey since 2023. I, likewise, take pride in the over 2,000 stories local people have told us about our care, the changes made as a result, and the positive impact of this feedback on clinical teams that I meet.

The Board relies deeply on the work of our governors, as frank voices of reality, as well as on our wider leadership of over one hundred and fifty clinicians and professional managers who help to drive forward our strategy. Thank you to everyone who has tried to innovate, to take risks, and to make change happen since April 2025. Annual reports often attest only to successes, and there are many in this report. But we should take confidence and learn from our failures too: racism remains a feature of some people's experiences in the trust, sixteen patient safety incidents led to harm in our care, and our staff survey testifies to some teams where engagement and involvement is not what we would want.

Opening up the trust to feedback is a key marker of safety. Our now over 350 volunteers, alongside peer support workers in increasing numbers of services, will help us hear different perspectives on what we do at our best and how we can improve. The overwhelming focus on therapeutic activities for those in inpatient care continues, as it has over the year, and is now a core part of our safer staffing model at the trust. Tackling violence and aggression experienced by staff is linked directly to the work we do to support patients during their time in our care. My Board continues to focus on reducing restrictive interventions but also on addressing injuries at work and rejecting normalisation of violence.

We delivered our financial plan in March 2026. We also submitted a balanced financial plan for the year ahead. If delivered that plan will remove all subsidy and give us greater freedom of action to prioritise what matters to staff and patients. The determination and precision required to deliver the plan are skills that readily transfer to other areas of our work including quality and safety, as well as workforce development.

Implementing significant organisational change in community based services, whilst guaranteeing no further changes to our wards until 2028, has come with many difficult conversations. We will continue to listen, as we did in changing much of what was proposed during consultation, and to work towards an organisation that is known both for delivery and compassion in all that we do.



Kathryn Lavery, Chair

25 June 2026

Chief Executive Introduction

Annual reports follow a nationally mandated format. They do not therefore tell the story of our organisation in the most accessible or direct of formats. That is why we publish additional local material and why we launch our reports at large-scale events with many voices present, publishing in a range of local languages.

Being open to listen is crucial to our mission of nurturing the power in our communities. What matters in Maltby, or Armthorpe, to rural residents on the Isle; to young people using child and adolescent mental health service (CAMHS), or older adults accessing physio support, or those detained under the Mental Health Act, all need personalisation and adaptation. The trust will succeed only if we can best balance core common standards, with that person-shaped approach to someone who needs our help, or who reaches out to us and through us accesses the help of others.

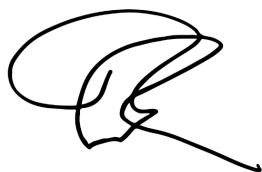
This report suggests some major progress has been made by colleagues across the trust. Waiting times for memory assessments is in line with our country-leading wait time promise. But we have also taken action to make sure those waiting are supported with their DVLA assessment, so they do not lose unnecessarily the connection of travel. We continue to expand mental health support in schools, even as we cannot yet promise shorter waits for neurodiversity assessments than the two-year standard that we will meet in October 2026. Our financial stability has allowed us to invest to reduce waits in podiatry, the only part of 'community health services' with a wait beyond our Promise 14. All of these stories rely on innovation, on learning across our organisation and on financial stability and discipline.

There is honesty in the report too. We have been open that we have not yet authentically met our commitment to be an anti-racist organisation. There is work to do to build confidence in our extensive freedom to speak up offer, even as we have invested in trade unions and staff networks as important support to RDaSHians. And not everyone who works for the trust feels fully part of our work and mission, our engagement efforts will intensify over the next two years building on the success of work to tackle a lack of trust among local residents when we launched the strategy in 2023.

With three years to go to meet that strategy, we are intensifying efforts to change our estate and in so doing to reduce our reliance on gas for heating. We have invested heavily on further roles to meet Promise 1, our commitment to have peer support across our organisation, which sees new posts starting in cancer and cardiac care, as well as focused on carers and veterans. It is great news that we spent the apprenticeship levy in full for the first time: my congratulations to everyone who studied alongside and through their work. We continue to expand our training spend, and educational offer, and to amplify our learning half days, which offer everyone across the trust time and space to develop, to contribute and to shape care quality.

Wherever we can we are making more and more use of technology to save clinical time, reduce patient travel, and apply best clinical practice to both assessment and treatment. In all trust services now, the website tells everyone how long you will wait; in most trust services you can direct message us with questions or queries; and increasingly you will be able to pick appointment times and dates to suit your wider needs. RDaSH is changing,

and this report highlights some of those improvements, as we try to play our part in the health of our communities, with a focus ever more clearly on justice and tackling inequality.



Toby Lewis, Chief Executive

25 June 2026

The history of Rotherham Doncaster and South Humber NHS Foundation Trust

The trust operates a wholly owned community interest company (CIC) called Flourish, which in addition to its community activities, provides social care services. A separate annual report for Flourish is issued, reflecting its distinct governance and separate regulatory license. The trust's board members are charitable trustees for the organisation's charity, Your Hearts and Minds. This holds assets of £1.5 million and, again reflecting separate governance arrangements, produces a distinct annual report and audited accounts.

The trust provides a range of health and care services across three localities, Rotherham, Doncaster, North Lincolnshire serving a population of approximately 797,696. The trust operates from over 60 community and inpatient sites, employs 3,633 (average whole time equivalent) staff and has an annual income of approximately £267 million. The accounts set out its held assets. The trust has an extensive research and educational portfolio, and both facets of our work are highly regarded by regulators and investors.

The trust was originally formed in October 1999, and in 2002, took on responsibility for the delivery of mental health services in Rotherham. On 1 August 2007, the trust was authorised to operate as an NHS foundation trust under the NHS Act 2006. In 2010, the trust integrated with Doncaster Community Healthcare and Rotherham Community Health Services under the Transforming Community Services programme. The trust was renamed Rotherham Doncaster and South Humber NHS Foundation Trust (formerly known as Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust) to reflect the range of services provided.

In 2021 the trust was appointed lead provider for the Adult Eating Disorder Provider Collaborative within the South Yorkshire integrated care system (ICS) and as such has commissioning responsibilities in respect of the adult eating disorder service across the whole of South Yorkshire. In the year April 2025 to March 2026 a new joint committee for all-age eating disorder services was created, bringing together the local provider trusts with the ICB in South Yorkshire to try to improve service delivery and plan workforce skills for the medium term. New commissioning arrangements are expected to be required by NHS England from April 2027.

In summer 2023, the trust's board published an ambitious five-year strategy to 2028, which confirmed a mission to nurture the power in our communities. Whilst retaining longstanding values as a behavioural guide, the organisation set out to deliver 28 promises to tackle exclusion, improve outcomes and play a key role in the social fabric of local communities.

During the year April 2025 to March 2026 the board agreed a series of supporting and enabling plans, governed through its committees, which reinforce those ambitions, notably in the areas of quality and safety, learning and education, equity and inclusion, and research and innovation. The finance, people, estate and digital plans are those which underpin three- year planning submissions to NHS England in February 2026.

Our services

The trust is registered with the Care Quality Commission (CQC) to provide safe care that is responsive and effective and as such provides a range of health and social care services across three localities through a care group (and directorate) model in Rotherham, Doncaster and North Lincolnshire.

We structure the management of our services into groups, with five of our six being clinical. Within those clinical care groups, we have managed services in aggregate through 14 directorates. The details of these arrangements are listed below:

- Children's care group:
 - children's mental health directorate, providing services across Doncaster, North Lincolnshire and Rotherham
 - children's physical health directorate, providing services across Doncaster, North Lincolnshire and Rotherham
- Physical health and neurodiversity care group:
 - neurodiversity directorate, providing services across Doncaster, North Lincolnshire and Rotherham
 - community and long-term conditions directorate, providing physical health services across Doncaster
 - rehabilitation directorate, providing physical health services across Doncaster
- Doncaster adult mental health and learning disabilities care group:
 - learning disabilities and forensic directorate, providing forensic services to the communities of Doncaster and learning disabilities services across Doncaster, North Lincolnshire and Rotherham.
 - community directorate, providing adult and older peoples mental health services within Doncaster
 - acute directorate, providing adult and older peoples mental health inpatient and crisis services within Doncaster
- North Lincolnshire adult mental health and talking therapies care group:
 - talking therapies directorate, providing services across Doncaster, North Lincolnshire and Rotherham
 - community directorate, providing adult and older peoples mental health services within North Lincolnshire
 - acute directorate, providing adult and older peoples mental health inpatient and crisis services within North Lincolnshire
- Rotherham adult mental health care group:
 - community directorate, providing adult and older peoples mental health services within Rotherham

- acute directorate, providing adult and older peoples mental health inpatient and crisis services within Rotherham
- our rehabilitation service offering adult mental health inpatient care for patients across the trust

Trust Strategy

The trust's strategy (2023 to 2028) was developed after eighteen months of staff and community engagement and co-production. It is very much at the heart of how the trust is managed and which priorities we set. It is a strategy to deliver five objectives, which are to:

1. nurture partnerships with patients and citizens to support good health
2. create equity of access, employment, and experience to address differences in outcome
3. extend our community offer, in each of, and between, physical, mental health, learning disability, autism and addiction services
4. deliver high quality and therapeutic bed-based care on our own sites and in other settings
5. help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations

The five objectives are underpinned by 28 promises made to our community, due to be achieved during the lifetime of the strategy (further detail is available within the Clinical and Organisational Strategy 2023 to 2028 on the [trust's website](#)). For each promise, the trust board has received a rating to outline if there a specific delivery plan has been developed and the likelihood of delivery. The rating is dynamic and is considered every eight weeks: **a separate report to the local community is published annually for our annual members' meeting and includes feedback from community leaders on our work.** With the launch in April 2026 of the new Communities' Leadership Executive, we would expect the report in summer 2027 to be primarily driven by these partners and stakeholders.

The trust has delivered some significant achievements against these promises during the year April 2025 to March 2026. Firstly, in relation to Promise 25 and the real living wage. From April 2025, all relevant staff are paid the real living wage: the rate rose by 6.7% in April 2026 further narrowing pay gaps within the trust as the agenda for change increment was around half that figure. The trust also met Promise 3, reaching over 350 volunteers engaged in the organisation by October 2025. Significantly for patient care, we are on course to meet our commitment to a maximum 4 week wait (Promise 14) for care initiation from April 2026, neurodiversity services and podiatry are currently managed outside this measure, and this will continue through the year April 2026 to 2027. We are the only trust in England to deliver this level of performance which will significantly improve the quality of care experienced by our patients and families.

In relation to Promise 4 and putting patient feedback at the heart of how care is delivered, following the launch of care opinion in 2024, during the year April 2025 to March 2026 we had received feedback from 1918 patients and carers.

In line with our commitment to 'poverty' proof all of our services as part of Promise 6, the trust has continued to roll out its programme of poverty proofing audits and by the end of March 2026, 110 services out of 132 had been reviewed. In response to the findings of the poverty proofing audits, we have introduced money and debt advice for our patients.

During the year April 2025 to March 2026, 601 patients were supported with advice resulting in just over £1m of potential income gained and debts managed or written off.

For the first time we have met the commitment made at Promise 9 to fully commit our apprenticeship levy funding: and have done with the involvement of local community partners to whom we have gifted, or shared, some of our levy allowance. The use of levy has brought more staff into apprenticeships, notably among band 2 and 3 staff, and helped us to introduce new courses and programmes during the year.

During the year we have run a High-Quality Therapeutic Care programme in line with Promise 18's commitment to implement best practice in the delivery of therapeutic, multi-disciplinary in-patient care on our mental health wards. This has resulted in an expansion of the range and frequency of therapeutic activities provided on our wards 7 days a week with the support of an increased number of peer support workers.

Health Inequalities

The vast majority of the trust's promises are focused on aspects of inequality. A separate committee of the Board meets bi-monthly to consider patient involvement, partnerships and public health.

In the year April 2025 to March 2026, we moved to report our routine data according to recommended characteristics suggested by NHS England. In July 2025, the Board of Directors received an analysis of the integrated quality performance report (IQPR) for the year April 2024 to March 2025 through the lens of four protected characteristics: namely ethnicity, deprivation, age and gender. The analysis was then repeated for the year April 2025 to March 2026 IQPR data and presented to the Board of Directors in September and November 2025, which drew similar conclusions. The November 2025 Board of Directors additionally were provided with research that compared our data to understand how the trust position compares nationally, which was very similar.

The analysis undertaken led us to draw the following conclusions:

- a significant number of our services do not fully reflect the communities that they serve in relation to at least one protected characteristic
- for a number of services, we cannot draw a robust conclusion in relation to ethnicity because the data about patients' ethnicity is not as complete in our patient records.
- patients from our most deprived communities access our services more than the wider population

Whilst the Board of Directors recognise that it has been useful to understand the trust's performance when compared to population and nationally, it does not mean that our performance for some of our patients is good enough.

We are undertaking work to improve the number of people in deprived areas accessing our services e.g. poverty proofing work and travel fund. There are other areas that will form a deeper analysis and actions taken to address inequalities. This includes to:

- address the data gaps where a person's ethnicity is not known or not stated
- provide targeted, culturally appropriate services
- review further the research findings and determine areas of focus and or action that will be taken in 2026

We are already taking steps to improve in some of these areas for example via Promise 8 and the RDaSH 5:

- increase the number of people from a global majority background accessing dementia services
- increase the number of people from a global majority background accessing perinatal services
- increase the number of people with learning disability from a global majority background accessing their annual health checks services
- ensure that our services, starting with our inpatient services, are accessible to patients with neurodiverse and other sensory relevant conditions
- increase the number of older adults accessing talking therapies dementia services

Working with our integrated care boards

Over the year in question the government indicated an intent to change the role and shape of Integrated Care Boards. It also published a Ten-Year Plan for Health, and important guidance on neighbourhood working. A quality strategy and modern service frameworks are due for publication in the year ahead.

The trust has actively engaged with its commissioners throughout the year. Internal audit's review of the trust's partnering arrangements offered significant assurance of the governance of these and other relationships. The Board was also very actively involved in assessing risks and opportunities arising from a three-year planning cycle and considering its assurance in doing so. This gave rise to concerns over the commissioning process, notably in relation to 2027 to 2029.

Arrangements for contracting and commissioning remain in flux. The trust is active in seeking to ensure the best balance of hyper local neighbourhood working, place-based leadership with local authority and primary care colleagues, and system wide opportunities. The trust contributes to two mental health learning disability and autism collaboratives, which have helped to reduce acute care waits and to improve eating disorder care. Their forward focus now is framed to tackle complex care placements often out of area that have previously been managed by commissioners without provider involvement.

Summary of principal risks

The trust's risk profile reflects not only local pressures, but also challenges that are being felt widely across the NHS and public sector. In particular, workforce availability, service capacity, and the delivery of large-scale change have continued to shape the risks facing the organisation. These are managed through an increasingly mature and transparent risk management model, which is overseen monthly through the Risk Management Group on behalf of the Clinical Leadership Executive. Over the year, risk discussions have focused more strongly on how different pressures interact, rather than viewing issues in isolation. This has supported a more realistic understanding of where services are under pressure and where the organisation needs to focus its efforts.

Whilst the risks in this register reflect operational delivery, the trust's strategic delivery risks continue to be structured for the effective and focused management of the principal risks in meeting the trust's strategic objectives. All strategic delivery risks have an executive director lead who has reviewed these risks and the associated actions in place on a

regular basis to progress mitigation. The strategic risks in place during April 2025 to March 2026 remain unchanged from the prior year, having been actively reviewed. They are:

1. If our 'changed ways of working' with the diverse population (including excluded communities) are not delivered by 2027 because of the leadership's ability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of strategic objective 1 (Nurture partnership with patients and citizens to support good health)
2. 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
3. If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT, PCN, neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm
4. 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
5. If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees

Overall performance of the trust in the year April 2025 to March 2026

Category	Indicator	Performance	
		April 2024 to March 2025	April 2025 to March 2026
NHS England	NHS Oversight Framework segmentation (1 to 4 with 1 = maximum autonomy)	3	3
		The April 2025 to March 2026 scoring related to the trust receiving deficit support funding. Without this the segment would have been rated as 2.	
CQC	Overall rating (either 'inadequate', 'requires improvement', 'good' or 'outstanding')	Requires Improvement	Requires Improvement
		Only our acute mental health wards and intensive care units were assessed during the year reported. Although there was a change in scoring the domains for these services the overall scoring for the trust remains as 'Requires Improvement'.	
Finance	The Group accounting deficit was £3,739k for the financial year April 2025 to March 2026. The position against which operational performance is measured by NHS England (NHSE) was a surplus of £646k compared to a planned breakeven position. Further detail is provided at pages 18 to 21.		
National Targets	National target relevant to mental health and community services: see pages 13 and 14	(5 out of 9)	(4 out of 9)

Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury financial reporting manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Significant events since year end and overseas operations

There have been no important events since the end of the financial year affecting the trust nor is there any overseas operations to report against.

Performance Analysis

How the trust measures performance

The Board of Directors are responsible for setting the strategic direction of the trust and for ensuring that its objectives and priorities are clearly communicated. The Quality Committee provides oversight of national, local and access standards, monitoring delivery and assurance against key performance measures. However, quality and performance are a shared responsibility across the organisation, with ultimate accountability resting with the chief executive and the executive group.

A core principle of the trust's operating model is that quality, safety and performance are the responsibility of every member of staff. This is reinforced through the appraisal process, which supports colleagues to perform at their best and ensures that quality and performance expectations are clearly understood within every role. Performance is measured through a range of objectives, including nationally mandated standards, locally agreed measures and individual contributions to team, ward or service goals. The Board has a published pecking order to how competing demands and expectations are to be prioritised and this is actively used in formulating plans.

Measuring Performance

Performance is monitored through a comprehensive and integrated framework, including the trust's top nine metrics for the year April 2025 to March 2026. These are aligned to the April 2024 to March 2025 Long Term Plan priorities, the NHS Oversight Framework, the trust promises and other essential quality and access measures. The top nine provides a purposeful and accessible subset of performance metrics, enabling all staff to focus on what matters most for improving quality and patient care. This includes, for example, improving timely access to talking therapies and increasing uptake of annual physical health checks for people with severe mental illness (SMI).

Performance information is brought together through a range of reporting mechanisms, culminating in the integrated quality and performance report (IQPR). The IQPR brings together quality, workforce and financial information to provide a clear and consistent "golden thread" across the organisation. It is reviewed by the Clinical Leadership Executive (CLE), relevant board sub-committees and their supporting sub-groups, enabling a shared understanding of performance trends, emerging risks and areas of successful delivery. This intelligence is triangulated with trust delivery reviews before formal presentation to the Board of Directors.

Oversight and Review

The trust maintains a robust cycle of bi-monthly delivery reviews for all directorates, chaired by the chief executive. These reviews provide focused oversight of performance, quality and safety, workforce and financial management, and are structured around agreed data sets and key lines of enquiry relevant to each directorate. They support timely identification of risks and enable corrective action to be taken where required.

This approach is mirrored within care groups, where similar review processes operate across the 13 clinical directorates, ensuring consistent performance management and accountability throughout the organisation. In addition, the trust monitors a comprehensive set of service-specific key performance indicators (KPIs) aligned to contractual and commissioning requirements. These are reviewed at care group, directorate or individual service level, ensuring that local performance is effectively managed alongside trust-wide priorities.

Operational Performance

In the year April 2025 to March 2026, the trust focused on delivering against nine key performance priorities, with regular oversight in place to monitor progress and support improvement. By the end of the year, the trust had met several important standards, including children and young people's access, talking therapies outcomes, reduced out of area placements, dementia diagnosis rates, and access to perinatal mental health services.

Top Nine Ref	Metric	Target	April 2025 to March 2026 Outturn	Position
T901	CYP access (12 months)	≥9,437	11,318	Achieved
T902a	inpatient spell is less than 32 days	32 days	57 days	Not achieved
T903a	Talking Therapies – Access	22,860	16,919	Improved, not achieved
T903b	Talking Therapies – Reliable Recovery	≥48%	48.70%	Achieved
T903c	Talking Therapies – Reliable Improvement	≥68%	68.55%	Achieved
T904	Out of Area Placements	9	7	Achieved
T905	Section 136 suite breaches	0	1,267 hours	Not achieved
T906	Dementia Diagnosis Rate	≥66.7%	79.09%	Achieved
T907b	Perinatal access	≥574	632	Achieved
T908	Individual Placement Support	≥120	93	Not achieved
T909	% Services meeting 4 Week wait	94%	85.54%	Significant improvement, not achieved

Good progress was also made against the four-week wait promise, with a significant increase in the number of services meeting the standard over the course of the year. While the milestone was not fully achieved, most services are compliant from April 2026.

More people were able to access talking therapies compared with the previous year, and clinical outcomes remained strong, with the majority of people completing treatment reporting meaningful improvements in their mental health.

There were some areas where performance remained challenging. Access to employment support was affected by temporary staffing pressures within North Lincolnshire, and average length of stay remains above our intentions. Whilst the approach to performance

measurement from April 2026 will align to the promises and the National Oversight Framework and move away from the approach taken 2023 to 2025, all of the measures cited will continue to be a focus for the trust's improvement work.

Quality Improvement Priorities

The safety and quality priorities for the year April 2025 to March 2026 are outlined below.

1. Achieving a Good rating under the Care Quality Commission (CQC) framework

We said: we will implement improvements to achieve a 'Good' rating under the CQC framework.

We did: during April 2025 to March 2026, RDaSH implemented a trust-wide programme of work to improve performance against the CQC framework. This included completing a full internal self-assessment against all CQC domains, identifying gaps, and implementing targeted improvement actions. Evidence libraries were established across all directorates to demonstrate compliance with CQC quality statements. These were supported by structured peer reviews and mock inspections, enabling the trust to identify and address issues proactively.

Evidence:

- Completion of trust-wide self-assessment against the CQC assessment framework during 2025.
- Establishment of team and directorate-level CQC evidence libraries, reviewed through delivery reviews and escalated to Board time out oversight.
- Implementation of peer review activity across inpatient wards, with findings and action plans reviewed through quality governance structures.
- CQC readiness activity, including internal review sessions and inspection preparation exercises during late 2025 and early 2026.

2. Implementation of the first phase of the Quality and Safety Plan

We said: we will implement the first phase of our agreed Quality and Safety Plan.

We did: the trust launched its Quality and Safety Plan in spring 2025. The first phase focused on patient safety, clinical effectiveness, experience of care and equitable access. Key actions included embedding new patient safety systems, strengthening clinical assurance, improving access standards, and increasing responsiveness to patient feedback.

Evidence:

- Formal approval and launch of the Quality and Safety Plan in 2025.
- Implementation of new patient safety and incident management arrangements during April 2025 to March 2026.
- Delivery of access improvements, including achievement of the trust-wide four-week standard for core mental health services by October 2025.
- Elimination of out-of-area acute mental health placements (out of hours).

3. Improving consistency of inpatient care (Strategic Objective 4)

We said: we will improve the consistency of our inpatient care and deliver against the promises within strategic objective 4.

We did: RDaSH delivered a significant programme of work to improve the quality and consistency of inpatient mental health care during April 2025 to March 2026. The High-Quality Therapeutic Care (HQTC) Taskforce was used as the primary delivery vehicle to define and implement consistent ward practices. Standardised ward routines, multidisciplinary working arrangements and therapeutic timetables were developed and rolled out. Five trust wide “always measures” were agreed to ensure that core elements of care occurred reliably for every inpatient. These changes were developed across all adult mental health wards, reducing unwarranted variation and improving patient experience.

Evidence:

- Establishment and operation of the HQTC Taskforce throughout the year April 2025 to March 2026.
- Introduction of trust-wide standard ward timetables and consistent multidisciplinary processes.
- Secured five “always measures”, including timely personalised care planning, consent, and carer involvement.
- Achievement of seven-day therapeutic activity provision on all adult mental health wards.
- Audit and performance data demonstrating improved compliance with care planning and ward-level standards by late 2025 and early 2026.

4. Flu vaccination focus (April 2025 to March 2026)

We said: we will continue to focus overwhelmingly on flu vaccination for students, volunteers and staff, as well as selected patients.

We did: the trust delivered an intensive flu vaccination campaign throughout the year April 2025 to March 2026 season, prioritising staff, students, volunteers and bank workers. Multiple delivery methods were used, including roving vaccinators with every level of nurse vaccinating including the Chief Nurse, workplace clinics and targeted communications. Senior leaders monitored uptake closely and introduced additional incentives and outreach where needed. The programme also included vaccination of selected patient groups, particularly inpatients and those being discharged to high-risk settings.

Evidence:

- Delivery of a trust-wide flu vaccination campaign during autumn and winter of the year April 2025 to March 2026
- Vaccination of large numbers of staff, volunteers, students and bank workers within the first weeks of the campaign.
- Extension of flu vaccination to eligible inpatient groups as part of discharge and infection prevention planning.
- Ongoing monitoring of uptake data through workforce and infection prevention governance arrangements.

Patient Feedback

Patient feedback is received in a variety of ways, primarily care opinion, patient advice and liaison service (PALS) contacts, compliments and complaints. The table below shows the feedback received from 1 April 2025 to 31 March 2026, along with the figures for the previous year.

	April 2024 to March 2025	April 2025 to March 2026
Patient Advice and Liaison (number of contacts)	417	364
Your Opinion Counts (number of returned forms)	667	NA
Care Opinion stories	666	1918
Complaints	80	188

Your opinion counts ceased to be used in May 2024 and was replaced by care opinion from June 2024.

Care Opinion

The trust implemented care opinion in June 2024, and since then have continued to ensure it is embedded in everyday practice. There are over 170 different services listed on care opinion each with a unique QR code. Patients, families and carers can share their story via the QR code, direct on the website, by telephone, paper form, or the story can be added by a staff member or volunteer on their behalf. This ensures that no-one is digitally excluded.

At the time of this report, the trust has received 2,716 stories on care opinion with 1,918 reported during April 2025 to March 2026. The trust stories have had over 230,000 views.

86% of the stories received are positive, highlighting many examples of good practice. Common praises include staff warmth and professionalism, helpful and compassionate care, and effective support that made patients “feel listened to and valued”. This positive feedback provides a morale boost to staff and is celebrated in communications.

However, care opinion also serves as an insightful source of constructive criticism. A small proportion of stories are mixed or critical in tone. These often revolve around the same issues as formal complaints and examples of these are:

- communication gaps: Patients reporting that they did not understand who to contact, or felt their concerns were dismissed. One recurrent question in negative posts was “Did anyone really listen to me?”
- delays and access issues: Stories about long waits for therapy appointments, assessments (especially in Neurodiversity and ADHD services and CAMHS), or difficulty reaching services out of hours.
- coordination of care: Instances of feeling lost during care transitions. For example, not knowing what the aftercare plan was post-discharge, or lack of follow-up calls when promised.
- staff interactions: While most comments about staff were positive, the few negative ones typically involved poor attitude or perceived lack of empathy, which can deeply affect patients in distress.

Staff from the relevant service respond to stories, offering further support and assistance

where needed and when comments have been critical.

Mental Health Community Survey

The mental health community survey is an independently administered national survey of patients receiving mental health care in community settings. The survey is comprehensive and provides valuable quantitative data to facilitate comparison with other trusts and benchmark our services numerically against a range of indicators. The survey for RDaSH in 2025 contacted 1,205 service users, of which 201 completed the survey.

The results for specific questions are categorised depending on whether they are 'better', 'worse' or 'about the same' compared with other trusts. For RDaSH the breakdown was as follows:

- in 15 questions, RDaSH was 'About the Same'
- in 5 questions, RDaSH was 'Somewhat Better'
- in 12 questions, RDaSH was 'Better'
- in 1 question, RDaSH was 'Much Better'

RDaSH remains comparable with most trusts and in some cases performed better or much better than other trusts. The one 'Much Better' question was related to the amount of time given to discuss needs and treatment. For the 'Better' questions, these related to several aspects of support and communication from mental health teams, as well as the overall experience of using NHS mental health services.

Complaint handling

Complaints are managed by the patient safety, carer and community team. The team support patients, their families and their carers through the complaints process. The team work with the care groups to investigate the complaint, identify key areas of learning and provide a compassionate response. All complaint response letters are approved and signed by the chief executive.

Indicator	April 2024 to March 2025	April 2025 to March 2026
Number of complaints received	80	188
Number acknowledged within 3 working days	70	165
Number ongoing (still open)	0	38
Number upheld	7	25
Number partially upheld	11	45
Number not upheld	7	53
Number withdrawn	14	27
Number investigated to the Ombudsman	0	0
Number of clinical negligence claims raised which had previously been a complaint	2	0

The main three categories for complaints in were:

April 2024 to March 2025		April 2025 to March 2026	
Category	Number	Category	Number
Patient Care	25	Communication	49
Communication	11	Patient Care	38
Values and behaviours of staff	12	Access to Treatment or Drugs	37

The number of complaints received between April 2025 and March 2026 has increased significantly when compared to previous years. It is believed that the trust's complaint figures are now more in line with similar organisations, having previously been lower. Information from a national complaints network suggests that complaints have increased across the whole of the NHS. The trust has seen an increase in the use of artificial intelligence (AI) being used to write complaints letters. This may suggest that people who may not have felt able to complain previously are now more confident with the use of AI.

The trust welcomes this increase in complaints as an important and constructive source of patient and carer feedback, providing a stronger evidential basis to drive service improvement. This reflects a deliberate and transparent shift in approach from late 2024, where the organisation actively sought to encourage and enable feedback, recognising that historically low complaint levels may not have fully reflected the experiences of our patient population.

Alongside increasing accessibility and openness to raising concerns, the trust has focused on improving the timeliness and quality of responses, as well as reducing the number of complaints that are reopened.

Complaints are monitored closely as they are received to identify any concerns and hot spots. The top themes in complaints were communication problems (patients feeling uninformed or poorly listened to), access to services (long waiting times or difficulty accessing specific treatments) almost entirely focused now on neurodiversity diagnosis and treatment, and staff attitude or manner in a minority of cases. For example, patients and families frequently complained about not being kept up to date on care plans or discharge arrangements, confusion around who to contact for information, and delays in getting appointments or diagnoses. In response, we took steps to improve communication and manage expectations. Clinical teams implemented new standards for keeping patients and carers informed. For instance, setting expectations at admission about how and when updates are given, and ensuring discharge communications (like summaries and follow-up instructions) are clear.

Financial Performance

The accounts have been prepared in compliance with the accounting requirements of the DHSC Group Accounting Manual (GAM) 2025 to 2026. The accounting policies contained in the manual follow the International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation trusts.

This section provides the financial performance summary for the year ended 31 March 2026.

Revenue

Total operating revenue in year April 2025 to March 2026 amounted to £267m (£249m in the year April 2024 to March 2025), an increase, on the prior year total, of £18m.

Around £228m (85%) of our income is received from NHS bodies for the purchase of healthcare activity. A further £25m (9%) is received from local authorities for public health activity. Overall revenue also included £12.2m (4.6%) of notional income recorded in the

accounts for additional pension contributions which have been paid directly to NHS pensions in year (compared to £11.6m in the year April 2024 to March 2025).

Expenditure

Our operating expenditure excluding financing costs was £268m and the largest element of this was the pay bill for our staff costs of £213m (80%). Other significant components of the trust's expenditure baseline are the purchase of healthcare services from other providers of £13m (5%), establishment and premise costs of £11m (4%) and supplies, service, and drugs costs of £12m (5%).

Capital and Cash

The group had a cash balance of £30.6m (£32.2m in April 2024 to March 2025) at the close of the financial year. Capital expenditure excluding lease additions in April 2025 to March 2026 totalled £8.1m (£8m in the year April 2024 to March 2025), of which £6.4m (79%) was spent on clinical refurbishment and reconfiguration, £1.3m (16%) on IT, £0.3m (4%) on estate maintenance and £0.1m (1%) on medical equipment.

Capital expenditure was also incurred on leases in year. £0.7m was spent on the revaluation of existing building and vehicles leases plus new vehicles leases. A further £5.2m was spent on the lease for the Waterdale building in Doncaster, which will be refurbished during the year April 2026 to March 2027 in partnership with the City of Doncaster Council. Services will be moved into the site on completion of the works and will include child and adolescent psychiatry for the city.

Group Position and Underlying Position for NHSE monitoring purposes

The accounts included in the annual report reflect a group position which consolidates the foundation trust, charitable funds accounts and Flourish CIC. The charitable funds accounts had a net adverse movement in funds of £0.4m in the year April 2025 to March 2026, with Flourish CIC finishing the year with a £5,092 surplus.

A reconciliation from the overall group position as reported in the Statement of Comprehensive Income (page 95) to the underlying surplus for NHSE operational performance purposes is shown overleaf:

Group Position April 2025 to March 2026 Underlying Surplus for NHSE Operational Performance	Surplus (deficit) £'000
RDaSH FT	(3,366)
Flourish CIC	5
Charitable Fund	(378)
Group Position	(3,739)
Remove impairment charged to operating expenses	3,184
Remove capital donation and peppercorn lease impact	14
Remove PFI revenue costs on an IFRS 16 basis	2,707
Add back PFI revenue costs on a UK GAAP basis	(1,916)
Remove non-cash pension movement	18
Remove Charitable Fund Deficit	378
Underlying surplus or NHSE Operational Performance	646

Group Position April 2024 to March 2025 Underlying Surplus for NHSE Operational Performance	Surplus (deficit) £'000
RDaSH FT	(527)
Flourish CIC	2
Charitable Fund	(484)
Group Position	(1,009)
Remove impairment charged to operating expenses	(41)
Remove capital donation and peppercorn lease impact	3
Remove PFI revenue costs on an IFRS 16 basis	2,730
Add back PFI revenue costs on a UK GAAP basis	(1,835)
Remove non-cash pension movement	198
Remove Charitable Fund Deficit	484
Underlying surplus or NHSE Operational Performance	512

Cost Allocation and Charging

The trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political Donations

No political donations were made in the year April 2025 to March 2026 (none in the year April 2024 to March 2025).

Better Payment Practice Code

The trust adopts the Better Payment Practice Code in respect of invoices received from suppliers. The code requires the trust to aim to pay all undisputed invoices within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

The table below shows the performance against this metric by NHS and Non-NHS supplier and shows the volume and value of invoices paid. The target of paying 95% of valid invoices within 30 days has been achieved across all the domains. **This is a significant improvement as the target was not met in any domain in the two previous financial years.**

Process enhancements implemented in the last quarter of the financial 2025 to 2026, including the introduction of an extra payment run every week, have made the positive difference, which benefits the cashflow of our supplier, an increasing number of whom are local businesses.

April 2025 to March 2026	By Number				By Value £'000			
	Total	Paid in 30 days	Not paid in 30 days	% paid in 30 days	Total	Paid in 30 days	Not paid in 30 days	% paid in 30 days
NHS	1,409	1,392	17	98.8%	21,123	20,498	625	97.0%
Non NHS	15,268	14,598	670	95.6%	41,080	40,325	755	98.2%
Total	16,677	15,990	687	95.9%	62,203	60,823	1,380	97.8%

April 2024 to March 2025	By Number				By Value £'000			
	Total	Paid in 30 days	Not paid in 30 days	% paid in 30 days	Total	Paid in 30 days	Not paid in 30 days	% paid in 30 days
NHS	1,524	1,424	100	93.4%	16,163	15,002	1,161	92.8%
Non NHS	18,473	16,879	1,594	91.4%	43,969	40,196	3,773	91.4%
Total	19,997	18,303	1,694	91.5%	60,132	55,198	4,934	91.8%

Interest Liability

The trust paid an interest liability of £1,596 in the year April 2025 to March 2026. This was payable under The Late Payment of Commercial Debts (Interest) Act 1998 following 3 claims where the trust failed to pay invoices within 30 days. Two of the claims totalling £1,501 were raised by a company specialising in identifying and recovering interest under the Act and the late payments occurred in the financial years 2019 to 2020 and 2020 to 2021.

No interest was accrued or paid by the trust for the year April 2024 to March 2025.

Income generation

The trust has not levied any fees and charges where the full cost exceeds £1 million or the service is otherwise material to the accounts. In accordance with Section 43(2A) of the NHS Act 2006, the trust can confirm that income from the provision of goods and services for the purposes of the health service in England is greater than our income from the provision of goods and services for any other purposes. The trust has, therefore, met this requirement. Also, in accordance with section 43(3A) of the NHS Act 2006, the trust can confirm that the other income received has had no impact on the provision of goods and services for the purposes of the health service in England.

Forward look to the year April 2026 to March 2027

Delivery of our promises remains our key priority in the year ahead: promise 1 in relation to peer support, promise 2 in relation to carers, work to ensure access for all inclusion health groups (promise 10), and sustaining gains in wait times are areas of notable focus.

With the publication in April 2026 of the oversight framework for the year April 2026 to March 2027 the Board is reviewing the credible route to segment 2. Our national plan submission has been agreed as compliant with conditions including the submission of more detailed plans in relation to sickness rates where the trust remains a sectoral outlier, despite many directorates seeing a reduction year on year.

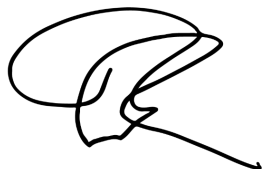
The trust has submitted a breakeven plan for April 2026 to March 2027 (breakeven in the year April 2025 to March 2026), which includes £13.75m of planned efficiency savings. The plan, when delivered, will restore the trust to recurrent financial balance, without subsidy, for the first time since the Covid-19 pandemic.

Recognising that in 2025 we published a multi-year Quality and Safety Plan we will focus time on the following quality priorities for the year April 2026 to March 2027:

1. sustain focus on using patient's feedback at service and directorate level to adapt and improve services
2. improve the rigour of the use of our patient safety incident response framework approach, ensuring that we can evidence genuine change resulting from PSIs

3. tackle racism within our services as part of work to address inequalities and exclusion
4. implement our quality and safety plan, applying always measures to services during the year April 2026 to March 2027
5. increase the uptake of, and learning from, paired outcome measures across all-age services

Performance Report signed on behalf of the Board of Directors

A handwritten signature in black ink, appearing to be 'Toby Lewis', with a large loop at the start and a long, sweeping tail.

Toby Lewis, Chief Executive

25 June 2026

ACCOUNTABILITY REPORT

Staff Report (subject to audit)

The trust values its employees and has 3,633 (average whole time equivalent) staff working across our geographical footprint.

Staff Costs	Permanent £'000	Other £'000	April 2025 to March 2026 Total £'000	April 2024 to March 2025 Total £'000
Staff and Executive Directors*	150,981	4,369	155,350	149,480
Social security costs	18,978	0	18,978	14,238
Apprenticeship levy	716	0	716	697
Employer's contributions to NHS pensions	18,686	0	18,686	17,814
Pension cost: employer contributions paid by NHSE on provider's behalf	12,189	0	12,189	11,569
Pension cost: other	81	0	81	90
Other post-employment benefits	0	0	0	0
Agency	0	813	813	2,956
External bank **	0	6,342	6,342	2,719
Total staff costs	201,631	11,524	213,156	199,563
Of which				
Costs capitalised as part of assets	198	0	198	199
Total staff costs excluding capitalised costs	201,433	11,524	212,958	199,364
Termination benefits	306	0	306	206

* RDaSH operated an internal staff bank up to 20 October 2024; these costs are included within 'Other'.

** Internal bank staff transferred to NHS Professionals from 21 October 2024.

Average number of employees (WTE basis)	Permanent WTE	Other WTE	April 2025 to March 2026 Total WTE	April 2024 to March 2025 Total WTE
Medical and dental	73	50	123	109
Administration and estates	1,050	23	1,073	1,082
Healthcare assistants and support staff	604	61	665	692
Nursing	1,165	28	1,193	1,180
Scientific and technical staff	577	2	579	543
Total Average numbers	3,469	164	3,633	3,606
Of which				
Average engaged on capital projects	3	0	3	4

Year-end analysis

The profile of staff in post (by headcount) was:

April 2025 to March 2026	Male	Female
Directors	10	9
Senior Managers (Band 8a and above)	32	100
Others	614	3,307
Total	656	3,415

April 2024 to March 2025	Male	Female
Directors	10	8
Senior Managers (Band 8a and above)	38	130
Others	624	3,294
Total	672	3,432

April 2025 to March 2026	White	BME	Not stated
Directors	16	3	0
Senior Managers (Band 8a and above)	125	6	1
Others	3,487	411	23
Total	3,628	420	24

April 2024 to March 2025	White	BME	Not stated
Directors	15	3	0
Senior Managers (Band 8a and above)	159	8	1
Others	3,510	378	30
Total	3,684	389	31

Sickness absence data

April 2025 to March 2026	
Sickness Figure	6.6%
WTE days lost	59,123
Average WTE	3,559
Days per employee (WTE)	16.61

April 2024 to March 2025	
Sickness Figure	6.4%
WTE days lost	58,489
Average WTE	3,489
Days per employee (WTE)	16.71

Staff Turnover

Turnover data is published by NHS Digital: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>.

Rolling 12 month turnover continuous to remain around 10% and the trust is in the lowest quartile for turnover compared to our NEY peer providers.

Work has been undertaken to improve the turnover rate for staff leaving within the first two years of employment with RDaSH including changes to onboarding and induction. This has resulted in a significant reduction in voluntary resignation turnover, 23% in the year April 2024 to March 2025 to 16% in the year April 2025 to 2026.

Staff policies and actions applied during April 2025 to March 2026

We have a full suite of people policies which are developed and reviewed in partnership with staff side representatives. These include recruitment and selection (including how applications for employment by those with disabilities will be given full and fair consideration), learning and development, attendance management, flexible working, conduct and standards and performance management. These policies are underpinned by processes that provide opportunity for employees with a disability and their managers to agree and put in place reasonable adjustments to support them within the workplace throughout their career, which are captured within their personal Health Passport. We are committed to employ, retain and develop our disabled staff. We undertake an equality impact assessment on all of our people policies to ensure that our employment practices do not discriminate against colleagues.

Our people policies are also used in the event that a member of staff develops a disability or long-term condition during their employment with us.

The trust appointment of staff policy provides detailed information to recruiting managers on how to ensure fair and consistent recruitment practices. In order to provide additional support, the trust also provides specific training through our first line manager portal and training programme to ensure recruiting managers are able to learn through practice knowledge and experience.

We have a range of policies and procedures to support colleagues in relation to their protected characteristics, and this has been further supported by bespoke career development workshops.

We have a range of mechanisms to consult with colleagues and their accredited staff side representatives via our Joint Consultative Committee and our Joint Local Negotiating Committee. This is further expanded by our trust People Council, a committee of the Board, which is focused primarily on improving the culture of the trust in line with our People and Teams plan.

The supporting health wellbeing and attendance management policy allows for increased levels of absence where it is recognised that a declared disability may impact upon levels of absence. Time off for treatment or rehabilitation, which may be categorised as disability leave may be given as a reasonable adjustment. In addition, where an employee's disability will increase the levels of disability related sickness the trust may, as a

reasonable adjustment, allow a greater level of absence before progressing through the stages of the policy.

Access to education, training and development is as open and inclusive as possible, with no discrimination in terms of the protected characteristics and is readily available to part-time and full-time staff irrespective of working pattern and geographical location. Courses are advertised via the staff portal and electronic staff record (ESR) for self-booking and are available to all.

An analysis on protected characteristics is undertaken in relation to how our training budgets are spent, this report is presented to our educational and learning group meeting. This helps us to monitor and ensure that their underrepresented groups are not disadvantaged.

The trust acknowledges that “no one size fits all” with regards to training and supports access to a range of learning and development opportunities that meet individuals’ learning styles and circumstances.

We endeavour to ensure that all our training is accessible for every colleague, our main training facility at Tickhill Road has disabled access. We ensure that all learning styles are accommodated throughout the training delivery. Colleagues can and do actively request reasonable adjustments prior to training commencing such as handouts in advance, larger font, hearing loop. We have accommodated training for a colleague who required an assistant dog, and we adapt lessons according to need. Where training requires an assessment, colleagues are supported throughout the process, given continual feedback and additional time and support is offered. We work with colleagues across the wider organisation to ensure that the training is trauma informed.

Staff engagement

The trust has an extensive model in place for engaging individuals, teams and leaders. However, our 2025 staff survey shows a continued pattern dating back almost five years, which suggests this work is not optimised. During 2026, the Board has set out to refresh the effectiveness of its arrangements, as indicated by its self-assessment of ‘amber-green’ within the provider capability assessment report issued by NHS England in autumn 2025.

We engage with our staff in line with our value of openness and transparency. In particular this is evidenced by:

- board meetings are advertised regularly and are open for all colleagues to attend in person if they wish or to dial in remotely. Alongside this all meetings are recorded and available to watch at a later time
- chair’s video post board meeting, staff are always welcome to feedback comments to the chair or chief executive directly
- the chief executive weekly vlog updates colleagues on current issues whilst also welcoming direct feedback: additional leaders’ voices drawn from our staff base and partners also contribute content each month
- our bi-monthly staff newsletter, Trust Matters, alongside our well register staff app (over 3000 sign-ups), providing information from across the organisation
- monthly briefing materials issued directly to all backbone staff
- directorate level newsletters issued in all our clinical directorates

- discipline specific conferences, including during 2025, our second healthcare support workers' event, one for psychological professionals, another for allied health professionals, and our third annual leaders' conference.

Listening to people across RDaSH really matters. We are expanding from April 2026 how we do this with the launch of the Team Brief (Ask, Talk, Influence) model: an online regular briefing across key topics, open to all staff but mandatory for line managers. Between April 2025 and March 2026, we relied on the following tools, all of which we retain:

- the quarterly people pulse survey is an email survey about individual experiences of working within the organisation: use of this tool has grown over the last year
- the annual staff survey goes to all colleagues and gathers their views and experiences (see pages 31 to 32 for the results of the last survey)
- the executive group offers a regular series of drop-in meetings across the geographical footprint to gather first hand feedback and views from the workforce
- extensive use of advice gathered from within our five employee networks, whose meetings now often fall on learning half days (DAWN, REACH, Rainbow, Women's, and Carers')
- ad-hoc open meetings with staff, including the extremely well attended Racism meeting in October 2025, which directly informed revisions to the trust's approach discussed with the Board in November

Engaging with staff, students and volunteers, is embedded into our governance.

Examples of this 'wiring' include:

- our Trust People Council meeting quarterly with voices drawn from staff networks, professions, trade unions, and other groupings, and attended by two non-executive directors, together with the director of people and OD, and the Chief Executive
- joint trade union negotiating groupings, attended by executive directors
- the launch of the new leadership development offer for the top 150 leaders within the organisation

Freedom to Speak Up

The table below shows the Total Freedom to Speak Up concerns raised by year.

Year	Number of FTSU concerns
April 2016 to March 2017	20
April 2017 to March 2018	25
April 2018 to March 2019	39
April 2019 to March 2020	82
April 2020 to March 2021	64
April 2021 to March 2022	38
April 2022 to March 2023	59
April 2023 to March 2024	98
April 2024 to March 2025	96
April 2025 to March 2026	101

The freedom to speak up (FTSU) service continues to be fully embedded and operating effectively across the trust, with clear evidence of sustained improvement in accessibility, capability, and organisational engagement. We know however that many staff continue to report that they do not see the value in speaking up or believe that nothing will change as

a result. Tackling this is a priority for the Trust People Council and for the Board as a whole.

All staff now have access to the national Freedom to Speak Up e-learning programme via the Electronic Staff Record (ESR). The programme comprises three modules which are aligned to staff roles and responsibilities:

- speak up: available to all workers, supporting awareness, confidence, and understanding of how to raise concerns.
- listen up: targeted at managers and those with supervisory responsibility, focusing on listening skills and addressing barriers to speaking up.
- follow up: available to senior leaders, supporting the strategic oversight and leadership of freedom to speak up within organisational and system-wide contexts.

The FTSU Guardian continues to engage proactively with the organisation and is undertaking workplace visits to champions within their local environments. This approach supports visibility, relationship building, and consistency of practice across the champion network. The trust currently has 72 trained freedom to speak up champions, with a further 18 colleagues expressing interest in becoming champions, providing assurance of ongoing sustainability and capacity within the service. Monthly face-to-face freedom to speak up drop-in sessions for corporate staff are now embedded alongside established care group-based drop-ins, strengthening accessibility and awareness across all staff groups. In addition, quarterly structured supervision sessions for champions, delivered by the guardian, are now fully embedded. These sessions provide a forum for champions to discuss concerns, receive support to escalate issues where appropriate, obtain signposting, and share learning. The sessions also include updates from the National Guardian's Office (NGO) and reinforce best practice, providing assurance of consistency and compliance with national expectations.

The service provides assurance that the trust is delivering in line with the freedom to speak up principles:

- accessibility: multiple routes to speak up are available, including champions, guardian engagement, drop-in sessions, and universal access to e-learning.
- support and protection: champions are supported through structured supervision, and managers are trained to listen and respond appropriately.
- independence: the guardian maintains independent oversight, supported by direct engagement with champions and staff.
- responsiveness: the revised engagement and supervision model ensures concerns are addressed promptly, with appropriate support or signposting.
- learning and improvement: Ongoing training, NGO updates, and shared learning through supervision sessions contribute to continuous improvement and best practice.

Whilst the inputs outlined offer considerable assurance, the reflections from some staff challenge a view that everything works as well as we would wish. There is a commitment to continuous improvement in 2026, reflecting renewed efforts to address considerations of detriment or prior exclusion.

Staff support

The trust is committed to supporting the health and wellbeing of our colleagues and recognises that maintaining both the physical, mental, emotional and spiritual needs of its workforce impacts upon the quality of patient care we provide and also impacts positively upon employee experience. The trust has a commitment to work in a trauma informed way.

The trust's healthy workplaces staff support and stress at work policy outlines a wide range of interventions that can be accessed by colleagues.

The support offered for staff continues to be well accessed and includes staff support services, face to face counselling, financial advice, access to online training and development sessions, coaching, distance supervision, personal resilience, team effectiveness and team reflective practice.

Health and Wellbeing

The health and wellbeing offer is a broad offer which covers all the primary elements of wellbeing including physical, emotional, mental, financial and spiritual wellbeing. The health and wellbeing interventions on offer include financial wellbeing advice and support, weight management classes, fitness classes, wellbeing campaigns.

It also includes a robust occupational health service, access to in the moment telephone support anytime day or night, face to face counselling and wellbeing awareness sessions and development workshops. Access to workplace wellbeing and workstation assessments, access to reasonable adjustments, moving and handling and musculoskeletal support.

During the year April 2025 to March 2026, 1,839 employees attended appointments with the occupational health service with a total of 6,633 referrals broken down as follows:

- | | |
|---------------------------------|-------|
| • wellbeing | 1,130 |
| • case management | 2,774 |
| • vaccinations and Bloods | 982 |
| • musculo-skeletal issues (MSK) | 849 |
| • health surveillance | 755 |
| • neurodiversity | 143 |

The highest reason for case management referral was mental health at 42% with the main reason being stress, followed by anxiety with 60% of staff being in work at the time of referral. There were 9 employees who were referred for needlestick injuries.

In 2026 the wellbeing offer will change at the trust, with a move to ensure greater access to core basics being consistently in place. We are also reviewing the health support provided to employees who are absent from work, in line with our drive to tackle high rates of sickness absence.

Policies in relation to countering fraud and corruption

The trust has a fraud, corruption and bribery policy in place and has an identified executive director who is the trust's fraud champion. The role of a fraud champion is to support and challenge the organisation in relation to its commitment to fraud work. The champion will

help promote a zero-tolerance approach to fraud within our organisation. The role and duties of the fraud champion includes:

- promoting awareness of fraud, bribery and corruption within your organisation
- understanding the threat posed by fraud, bribery and corruption
- understanding best practice on counter fraud

The trust also has an accredited person, nominated to the NHS Counter Fraud Authority, to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption, and reactive work to hold those who commit fraud, bribery or corruption to account.

Our policies, procedures and staff training reflect our commitment to acting ethically in all our business relationships, and to implementing effective systems and controls to protect public funds and mitigate the risk of fraud.

Equality Diversity and Inclusion

One in ten trust employees is drawn from a black or minority ethnic background. We know that the experiences of these colleagues can sometimes reflect overt discrimination and micro aggressions. In November 2025 the Board shifted its strategy to focus on ensuring all employees can demonstrate an anti-racist stance in their behaviour at work.

Male staff are 16% of the workforce (lower than national norms, 24%). There is a focus on eliminating the trust's gender pay gap, as part of our commitment to equity.

In relation to disability, we have a higher proportion of colleagues declaring they have a disability than the NHS average, this has been an area of focus for our carers' network and we expect this to further increase. We want to be an organisation that is positive about disability and indeed workplace flexibility.

Within the organisational strategy promise 26 states the ambition is to 'become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion'. This promise has not been met, despite extensive work since 2024. We have commenced a pilot programme in our inpatient setting in North Lincolnshire as a bespoke programme to support the organisation in becoming an anti-racist organisation and improving the working conditions for our colleagues and the care for our patients.

The trust has successfully achieved Bronze Accreditation of the Northwest Anti-racism framework. This achievement has acknowledged the work happening in the equality, diversity and inclusion (EDI) space and collated robust and detailed evidence of all the work happening across the organisation to tackle racism and effect positive culture change.

Across the organisation there continues to be training and development of the workforce focussed upon:

- active bystander
- rainbow badge training
- cultural humility level 1 and Level 2
- talent development
- diverse recruitment panel training

As an organisation the completion of the equality impact assessment (EIA) before implementing any change at care group and directorate level and assurance that the Public Sector Equality Duty (PSED) detailed in the Equality Act 2010 has been upheld. As part of the RDaSH approach to inclusive recruitment diverse recruitment panels are in place and monitored to ensure fair, open and transparent recruitment. From July 2026 these will become mandated for all band 7 and above appointments.

The following staff networks are active within the trust:

- ReaCH, Racial Equality and Cultural Heritage Network
- DAWN, Disability and Wellbeing Network
- Rainbow Network
- Women's Network
- Carer's Network.

Their role is to drive action in line with all the promises but especially Promise 26 and strengthen employee voice, improve diverse representation and employee experience.

Staff Survey

The trust has a variety of ways of getting feedback from people who work in the organisation. The national staff survey is one such approach and over 1,997 colleagues completed this for 2025, which is an 8% reduction on last year's survey.

The NHS staff survey is conducted annually, and we use a mixed model approach (paper and digital surveys) to ensure that we are not digitally excluding colleagues from completing the survey due to a lack of access to IT or IT skills.

From the year April 2021 to March 2022 the survey questions align to the seven elements of the NHS 'People Promise', retaining two previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the survey in the year April 2025 to March 2026 among trust staff was 49% (in the year April 2024 to March 2025, 57%).

Scores for each indicator together with that of the survey benchmarking group (48 organisations across mental health and learning disability and community trusts) are presented overleaf.

Indicators People Promise elements and themes	April 2025 to March 2026		April 2024 to March 2025		April 2023 to March 2024	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.51	7.61	7.58	7.55	7.63	7.58
We are recognised and rewarded	6.22	6.37	6.34	6.35	6.41	6.41
We each have a voice that counts	6.71	6.89	6.93	6.94	7.06	7.01
We are safe and healthy	6.34	6.34	6.50	6.40	6.57	6.38
We are always learning	5.76	5.83	5.83	5.93	5.95	5.93
We work flexibly	6.97	6.84	7.05	6.83	7.09	6.84
We are a team	7.02	7.17	7.11	7.15	7.17	7.18
Staff engagement	6.81	7.02	7.02	7.07	7.19	7.11
Morale	6.08	6.12	6.27	6.20	6.38	6.17

A breakdown of the trust's performance against the benchmarking group for the 9 key themes and areas in the year April 2025 to March 2026 is detailed below:

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.94	6.72	7.31	6.72	6.38	7.20	7.43	7.48	6.57
RDaSH	7.51	6.22	6.71	6.34	5.76	6.97	7.02	6.81	6.08
Average	7.61	6.37	6.89	6.34	5.83	6.84	7.17	7.02	6.12
Worst	7.15	5.92	6.23	5.89	5.14	6.18	6.79	6.37	5.48

Areas of focus for the year April 2026 to March 2027

Our results are also very different for colleagues who have recently joined the trust and therefore an area of focus will be on our longer serving colleagues and how we improve their responses across the People Promises. Overall whilst the latest survey shows a continued fall in most measures, in reality this maintains a trend over some time at the trust. In 2026, 2027 and 2028 we will look to address that, learning from directorates that have shown improvement over the recent past. With the launch of ask, talk, influence (ATI) in April 2026, we expect this to increase communication and staff engagement across the organisation.

Modern Slavery

Although the trust is not classed as a “commercial organisation” for the purpose of the Modern Slavery Act 2015, a number of steps have been taken to ensure that slavery and human trafficking is not taking place in any of our supply chains or in any part of our business to the best of our knowledge, through recruitment and payroll processes. The inclusion of statements in contracts that the trust enters into with providers that states that the supplier agrees that it is responsible for controlling its own supply chain and that it shall encourage compliance with ethical standards, human rights, health and safety and environmental standards by any subsequent supplier of goods and services that are used by the supplier when performing its obligations under this agreement.

Expenditure on consultancy

As per note 6 to the accounts, the trust spent a total of £0 on consultancy in the financial year (During April 2024 to March 2025 - £0).

Off-payroll arrangements

The trust adheres to the HM Treasury recommendations that for central government departments and their arm’s length bodies, all new engagements and contract renewals for board members and senior officials with significant financial responsibility should be on the organisation’s payroll, unless there are exceptional circumstances, in which case the Accounting Officer should approve the arrangements, and such exceptions should exist for no longer than six months.

The trust is required to disclose certain information in connection with such arrangements as set out in the three tables overleaf.

Table 1: Highly paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater

Number of existing engagements as of 31 March 2026	
Of which:	
Number that have existed for less than one year at time of reporting.	2
Number that have existed for between one and two years at time of reporting.	1
Number that have existed for between two and three years at time of reporting.	0
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater.

Number of off-payroll workers engaged during the year ended 31 March 2026	
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in scope of IR35 *	9
Subject to off-payroll legislation and determined as out of scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

*A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out of scope for tax purposes

Table 3: For any off-payroll engagements of board members, and or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026

Number of off-payroll engagements of board members, and or senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	20

Staff exit packages (subject to audit)

There were 5 exit packages agreed in the year April 2025 to March 2026 totalling £0.288 (4 in in the year April 2024 to March 2025 totalling £0.206m). The amounts disclosed for the exit packages are inclusive of employer's national insurance contributions where relevant.

For the year April 2025 to March 2026:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	0	1
£10,000 – £25,000	0	0	0
£25,001 – £50,000	1	0	1
£50,001 – £100,000	3	0	3
£100,000 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	5	0	5
Total cost (£'000s)	288	0	288

For the year April 2024 to March 2025:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	2	0	2
£10,000 – £25,000	0	0	0
£25,001 – £50,000	1	0	1
£50,001 – £100,000	0	0	0
£100,000 – £150,000	0	0	0
£150,001 – £200,000	1	0	1
Total number of exit packages by type	4	0	4
Total cost (£'000s)	206	0	206

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally agreed arrangements or local arrangements for which DHSC or HM Treasury approval was required.

Exit packages: Non-compulsory departure payments

In the year April 2025 to March 2026, there were no non-compulsory departure payments. This is the same as for the year April 2024 to March 2025.

Gender pay gap

In accordance with the Equality Act 2010 (gender pay gap information) Regulations 2017, employers with 250 or more employees are required to publish information on the pay gap between male and female employees as of 31 March each year. This information must be published on the employer's website. The Gender Pay Gap Report is based on a snapshot date of pay of 31 March 2025. <https://www.rdash.nhs.uk/about-gender-pay-gap>

RDaSH data can be compared to other organisations by using the government Gender Pay Gap reporting portal. <https://gender-pay-gap.service.gov.uk/>

Whilst the 2026 data has not yet been published, our work on reducing the gender pay gap is having a positive impact, whilst recognising we still have further work to do. The March 2025 gender pay gap (based on median hourly rate of pay) was 5.09 and in March 2026 it was 1.93.

Gender	March 2026	March 2025	March 2024	March 2023
Male	19.58	18.87	17.82	16.84
Female	19.20	17.91	16.52	15.21
Difference	0.37	0.96	1.29	1.62
Pay gap percentage	1.93	5.09	7.27	9.64

The trust pay gap report also includes data and analysis on medical gender pay gap, ethnicity and disability pay gap which is in line with the NHS Equality, Diversity and Inclusion Improvement Plan which is to develop and implement an improvement plan to eliminate all pay gaps.

Environmental Matters

In the year April 2025 to March 2026, RDaSH revised its Green Plan in line with national NHS requirements. The new Green Plan for 2025 to 2028 identifies the key areas of focus over the next 3 years, with a view to reaching the wider NHS ambitions of achieving net zero for all scope 1 emissions by 2040. In this plan, RDaSH set out:

- what the priorities will be
- how RDaSH will monitor progress
- the current status of each priority area
- where RDaSH would be like to be by 2028

The Green Plan also supports with delivering on promise 27 of the RDaSH clinical and organisational strategy:

“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”

The 5 key priority areas in the Green Plan have been defined are:

1. estates decarbonisation: target a 500-tonne annual reduction in gas emissions through building rationalisation and capital projects.
2. business mileage: aim to cut emissions by 200-tonnes annually by optimising route planning, increasing electric vehicle use, expanding charging infrastructure, and promoting sustainable travel schemes.
3. digital transformation: leverage digital tools to reduce paper use by 20%, expand virtual care pathways and procure low-carbon IT hardware with net zero supplier requirements.
4. food waste: reduce waste from 137 to 30 tonnes annual via smarter inventory management, portion control, sustainable menus and food redistribution partnerships.
5. climate adaptation: prepare all services for climate impacts through benchmarking, adaptation planning, staff education, and supplier engagement.

The RDaSH Green Plan 2025 to 2028 represents a clear and committed pathway toward reducing our environmental impact and preparing our services for the challenges of a changing climate. These are also examples of risks or opportunities that our outlined in Tables A.1.1 and A1.2 HM Treasury's Task Force Climate Disclosures.

While we acknowledge the setbacks experienced since our last plan, this renewed focus on five key priorities demonstrates our determination to make measurable progress over the next three years. By decarbonising our estates, reducing business mileage, embracing digital innovation, minimising food waste, and strengthening climate adaptation, we will contribute meaningfully to the NHS's Net Zero ambitions and support healthier, more sustainable communities. Success will depend on strong accountability, collaborative effort, and continuous engagement across all levels of the organisation.

Additionally in the year April 2025 to March 2026, RDaSH made significant progress in understanding how Priority 1 in the Green Plan could be achieved. RDaSH formed partnerships with external sustainable building experts to determine the best way forward. As it stands, RDaSH will be investing further efforts into the potential implementation of an Ambient Heat Loop solution.

Prior to the tentative decision to invest in an Ambient Heat Loop, RDaSH submitted a bid to the Heat Network Decarbonisation Fund (in partnership with Heat Networks Delivery Unit) to fund an Air Source Heat Pump solution at Tickhill Road Hospital. This was, unfortunately, unsuccessful due to significant demand on the available funding pot.

During the year April 2025 to March 2026, we introduced food waste bins across trust sites including on our wards. This will help us to understand better where there are higher levels of food waste, so that appropriate action can then be taken.

Finally, RDaSH has also placed focus on Priority 5 in the Green Plan, which is Climate Adaptation. In 2026, RDaSH completed the NHS Climate Adaptation Maturity Framework with each 'place' (Doncaster, Rotherham and North Lincolnshire). Places were assessed on their own readiness for climate change against given criteria to reduce vulnerability to the impacts of changing weather patterns. This includes the Global Warming pathway of 2 degrees Celsius or lower.

It is evident that we are still at the “starting” point in most areas of the Climate Adaptation Framework. This was something which could have been predicted; however, the framework has given us solid evidence of this. Out of the 4 capabilities, “Understanding the Challenge” and “Working Together” feel the most urgent at RDaSH. They are also areas where it is possible to make significant progress in our Adaptation journey.

Waste management

A proactive approach is taken to waste management, last year we reported that approximately 59.8% of waste, including food waste, produced by the trust is reused or recycled: this year this has increased to 62%, this is largely due to improved recycling of clinical waste. Waste overall decreased by approximately 4% from 533 to 512 tonnes.

Food waste decreased in the year April 2025 to March 2026 from 99 in the year April 2024 to March 2025 to 98 tonnes, this is a decrease since implementing additional collections from all trust kitchens due to the introduction of the Simpler Recycling regulations in April 2025, making it a legal requirement to segregate all food waste from the general waste, where previously it was recorded only from the main kitchen and inpatient wards across the trust.

We reported last year that during the year April 2024 to March 2025 the trust achieved its zero to land fill promise, and in the year April 2025 to March 2026 we continued to do so.

The NHS clinical waste strategy requires trusts to meet or better a 60:20:20 target. That is 60% offensive waste (OW), 20% alternative treatment (AT) and 20% high temperature incineration (HTI). The trust percentage is 81.6% OW:14.8% AT: 3.6%HTI: Which keeps us performing significantly better than the NHS target.

Task force on climate-related financial disclosures (TCFD)

Introduction

NHS England’s NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury’s TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to April 2025 to March 2026 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for April 2025 to March 2026. These disclosures are provided below.

Governance

Climate related issues form part of the trust’s Clinical and Operational Strategy. The Equity and Inclusion Plan, which is a delivery plan of the Clinical and Operational Strategy, includes promise 27 “Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service modes to climate change”. Progress on overall Equity and Inclusion Plan is formally reported into the Public Health, Patient Involvement and Partnerships Committee (PHPIP), which then reports progress into the Board. Out-briefs are presented to the Board by the Committee Chair.

The Board have received reports on progress against promise 27. Every eight weeks, the Board considers the metrics for all the Promises and the overall focus of how they will be delivered (in this case, corporately). This is done through an outline Promises 'scorecard' report which was an assessment of the delivery plan and the likelihood of delivery which was carried out for all 28 promises.

The delivery of promise 27 is undertaken by the Sustainability Group and progress is overseen by the Estates and Sustainability Group which reports to Clinical Leadership Executive (CLE). Progress and escalation are taken to CLE on matters in relation to Promise 27. The Director of Strategic Development is overall responsible for the management of the trust's work on promise 27, bringing options and proposals through the respective governance structure.

Identifying and assessing climate-related risks

We identify climate-related risks as part of our overall risk management framework, considering both the immediate and longer-term implications of climate change. Our assessment process is embedded in existing risk reviews at service and corporate levels. Climate-related risks are identified through a mix of strategic planning and input from operational teams. They are then assessed using our standard scoring model based on likelihood and impact. The framework allows us to judge how material a risk is and how it compares to other threats we face across the organisation.

At this stage, climate-related risks are not among our highest rated or principal risks, but we recognise their increasing relevance. Given their potential to grow in significance over time, especially in relation to estate management, service continuity and community wellbeing, they are being monitored more closely. We do have a risk on our risk register in relation to securing additional investment that would be needed to meet our estates decarbonisation commitment Priority 1 in our Green Plan.

Managing climate-related risks

Once we've identified climate-related risks, we decide how best to respond. We use the same core principles we apply to all risk types, deciding whether to mitigate the risk, transfer it, accept it, or put controls in place. These decisions are made in the context of how the risk aligns with our objectives and what options are realistically available to us.

In assessing and prioritising these risks, we make assumptions about the likely direction of climate policy, expected changes to the environment, and developments in national or local regulations. We use materiality as a guide, looking at how climate-related impacts could affect our services, reputation, and the people we support. We also refer to external frameworks and government guidance to help shape our approach and keep our understanding current.

For example, as referenced earlier, Priority 5 of our Green Plan relates to Climate Adaptation and to help inform our work we have adopted use of the NHS Maturity Framework for Climate Adaptation. This references four capabilities that determine how prepared the trust is prepared for climate change. These are:

- understanding the challenge.
- organisational culture and resources.
- planning and implementation.
- working together.

The NHS Maturity Framework outlines four levels of maturity: we have self-assessed as 'starting'.

Integration into overall risk management

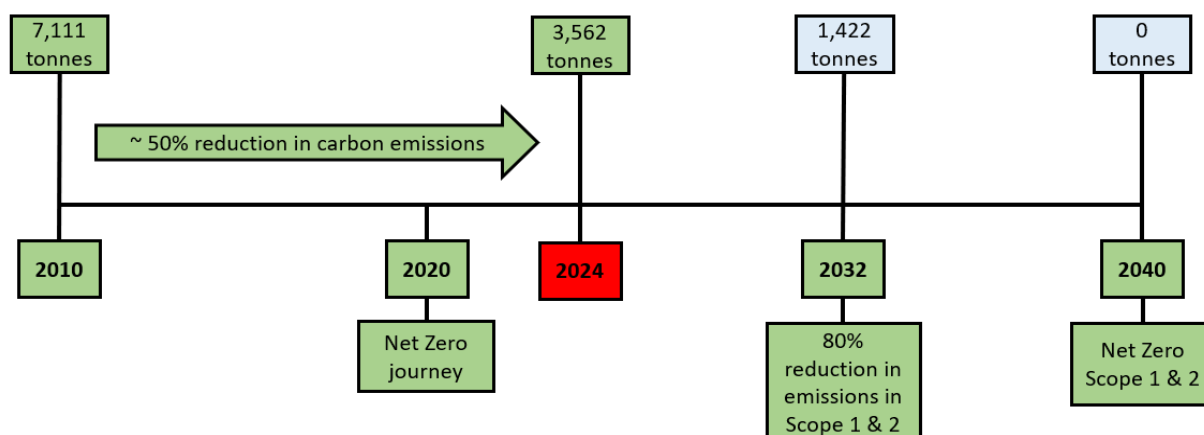
Climate risks are not managed in isolation. They are considered as part of our overall risk management process, sitting alongside operational, clinical, financial, and strategic risks. These risks are reviewed through existing governance channels and included in directorate-level risk registers and corporate oversight discussions.

Although climate-related risks are not currently identified as one of our principal risks, we are continuing to strengthen how they are considered and integrated.

Metrics and Targets

RDaSH has already made some progress towards reducing its carbon emissions from Scope 1 and 2 since 2010 (see Figure 3). In 2010, RDaSH produced 7,111 tonnes of carbon emissions and this has been successfully reduced by approximately 50% over the last 14 years. The carbon emissions now stand at 3,508 tonnes. In order to achieve NHS targets, we must cut our emissions further to reach an 80% reduction target by 2032. This means our emissions need to reach 1,422 carbon emissions by 2032, prior to reaching Net Zero in 2040.

Internally at RDaSH, it is felt that many of the "easy wins" have already been utilised in order to reach our current success with halving emissions. This implies that the journey to Net Zero will be much trickier, and potentially more costly, from now on.



With regards to the quantitative progress data of the carbon footprint, as an NHS foundation trust we are not required to disclose or develop processes to disclose scope 1, scope 2 and scope 3 emissions under the 'metrics and targets pillar' in the HM Treasury guidance as emissions estimates for the NHS in England are derived centrally by NHS England.

Our CO2 emission for business travel decreased in the year April 2025 to March 2026 from 893 to 862 tonnes, a decrease of 4%. In the year April 2026 to March 2027, we will be looking at business miles as part of the review of our remote working arrangements. The carbon intensity of our fleet decreased from 127 tonnes in the year April 2024 to March 2025 to 101 tonnes in the year April 2025 to March 2026.

Our use of gas decreased and mean our emissions went from 1,915 tonnes in the year April 2024 to March 2025 to 1,775 tonnes in the year April 2025 to March 2026. As referenced earlier, in the year April 2026 to March 2027 we will be looking to pursue opportunities to reduce our reliance use of gas, through innovations such as ambient heat loops.

Directors Report

The board of directors has a wide range of skills and experience and considers it is balanced and complete in its composition, and appropriate to the requirements of the trust, and is in line with the NHS England's Code of Governance for NHS FTs and with our standing orders.

All directors are required to comply with the fit and proper persons test requirements (FFPR) to meet the requirements of the general conditions of the provider licence and are required to make an annual declaration of compliance in this regard. All directors were considered to meet the requirements in year.

Board of Director Profiles

There were a number of changes to board membership through the year, the details of which can be found in the remuneration report. The descriptions below of each director's expertise and experience demonstrates the relevance of the skills, knowledge and expertise that each director brings to the trust. Where terms of office expire in the coming year necessary processes of extension or succession are in hand.



Kathryn Lavery, Non-Executive Chair
(term of office expires 30 November 2030)

Kath joined the trust as chair in December 2022 and was re-appointed in October 2025. She was first appointed to an NHS board in 1998 and since then served as the chair of West Hull Primary Care Trust and NHS Hull, as a non-executive director of NAViGO (a community interest company which runs NHS mental health services in Northeast Lincolnshire) and as a Hull City Councillor.

Kath is currently also chair ACCIA Yorkshire and Humber Panel, chair of the Advisory Board Space2BHeard CIC HULL and non-executive director at Locala Community Interest Company.



Dave Vallance, Non-Executive Director
(term of office expires 31 December 2027)

Dave joined the trust as non-executive director in December 2019 and was re-appointed in December 2022 and again in October 2025. Dave was the Vice Chair and Senior Independent Director for trust until 31 December 2025 after which Pauline took on the role. Dave built up a vast range of HR experience through working for over 20 years with Walgreen Boots Alliance, and was latterly HR director, Global Brands.

He previously worked in the NHS for the Audit Commission for 5 years, evaluating the value for money of a range of health and local government organisations.

He has been a trustee of one of the largest UK Pension schemes, a school governor and holds a Master of Business Administration (MBA) and a BA in Organisation Studies.



Pauline Vickers, Non-Executive Director Vice Chair and Senior Independent Director

(term of office expires 31 March 2029)

Pauline joined the board of directors in April 2021 and was re-appointed by the council of governors in April 2023 and again in October 2025. Pauline took over the role of Vice Chair and Senior Independent Director from Dave on 31 January 2026

Prior to joining the trust, she was a non-executive director and senior independent director with Bradford Teaching Hospitals NHS Foundation Trust. She worked for Royal Mail since graduating in 1985 across a range of leadership and commercial executive roles, most recently as export director for Royal Mail's International business. Pauline now enjoys a portfolio career as an accredited executive coach and is an end point assessor for the business sales degree apprenticeship courses at Leeds Trinity and Middlesex Universities.

She holds a degree in management science from the University of Manchester Institute of Science and Technology, a post graduate diploma in personnel training and development from Leeds Metropolitan University and is a Chartered Member of the Institute of Personnel and Development.



Sarah Fulton Tindall, Non-Executive Director

(term of office expires 31 December 2027)

Sarah joined the trust as a non-executive director in January 2022 and was reappointed in November 2024.

She has a strong executive level professional services delivery background in the Higher Education sector. Sarah spent over 20 years in a wide range of leadership roles at the University of Sheffield, and more latterly advising universities both in the UK and

overseas.

Sarah has extensive experience in leading successful organisation-wide strategy, business transformation and people talent growth.

In addition to her current role, Sarah is also a member of the Patient Participation Group at a local GP practice and an Age UK Readers' Panel member.

Sarah holds a BA (Hons) in politics and social policy from the University of Sheffield.



Kathryn Gillatt, Non-Executive Director

(term of office expires 31 March 2029)

Kathryn joined the trust in April 2023 and became chair of Audit Committee 1 January 2024. Kathryn was reappointed in March 2026.

Kathryn is a graduate of Nottingham University and is a Chartered Accountant by profession. Her career to date includes roles as a finance and corporate services director in a number of sectors including frontline NHS and children's services, the department for transport, community pharmacy services, the leisure industry, chemical manufacturing, audit and tax services. She is also a non-executive director at NHS Business Services Authority and chairs their audit and risk committee.



Rachael Blake, Non-Executive Director

(term expires 30 April 2027)

Rachael lives in Doncaster and joined the trust in May 2024.

She started her career by qualifying as a Registered General Nurse and has now amassed 40 years' experience in the NHS, Local Government, voluntary and community sector and in the private sector in a range of roles from front line delivery to chief officer and board level positions.

She currently works in the rail industry as a people and transformation lead and is a local councillor with City of Doncaster Council. She was previously a non-executive director at North Lincolnshire and Goole NHS Foundation Trust.



Dr Richard Falk, Non-Executive Director

(term expires 30 April 2027)

Richard joined the board of directors in May 2024 as an associate non-executive director and was appointed by the council of governors in November 2024 as a full non-executive director.

He is a retired local GP and clinical leader with extensive experience working at PCT and CCG board level within the NHS and therefore has skills as both a commissioner and provider. After retirement from his NHS role Richard worked for nearly 3 years in Western Australia as a Medicare GP before returning to the UK in 2019.

Prior to joining RDASH he worked in an advisory capacity with Weldricks Pharmacy a local pharmaceutical services provider.



Maria Clarke, Non-Executive Director
(term expires 30 April 2028)

Maria joined the board of director on 1 May 2025.

She is a practising solicitor working in private practice. She has also worked with various third sector organisations throughout Yorkshire. She also works with 2 neighbouring Mental Health Trusts as an Associate Hospital Manager and works with the National Institute for Health and Care Excellence and the Royal College of Obstetricians and Gynaecologists. She is also on the Board of the College of General Dentistry and was awarded an honorary fellowship by the Royal College of Surgeons in 2020 for her work with vulnerable communities during the height of the covid 19 pandemic.

She carries out various roles within research and in particular health research, sitting on steering groups for national research projects, the Research Ethics Committee at the University of Sheffield and more recently took up a public appointment with the Ministry of Defence when she joined their own Research Ethics Committee in 2024. She has also worked previously with NHS Digital sitting on an advisory group advising its board on the release of patient data, often for health research purposes.



Dr Rumit Shah, Associate Non-Executive Director
(term expires 31 December 2027)

Rumit was appointed as associate non-executive director at the beginning of January 2026 after having just completed a 6-year term as a Non-executive director at The Rotherham Foundation Trust where he chaired the Quality Committee and the People Committee as well as being a member of their Audit Committee.

Rumit started his medical education in the university of Sheffield medical school back in 1979-1984. Having graduated his initial career was in trauma and orthopaedics, and after several posts in Acute hospital made the change to General practice. Rumit joined the Hatfield health centre as a principal partner in 1994 and has been there 32 years and now working part time in clinical practice.

Other leadership roles have involved appraising GPs, was a member of the PCG and PCT's and a clinical director for East PCN at its inception.



Toby Lewis, Chief Executive

Toby joined the trust in March 2023 from The King's Fund where he was a senior visiting fellow in health inequalities, with a focus on poverty and inclusion health. He joined the NHS in 1994 and began his career in Worksop. He has worked in primary care, mental and community health, and hospitals in London, West Yorkshire and the West Midlands.

After working in Downing Street, he joined his first NHS board in 2005 and has served in executive roles since that time, including eight years as chief executive of an integrated care organisation in the Black Country. He helped establish a new medical school at Aston University and led work to use the apprenticeship levy to the benefit for

often excluded populations, such as care leavers and those at risk of experiencing homelessness, creating jobs as a route to better health. He holds a Masters degree in Public Health from Edinburgh University and degrees in occupational psychology and history from Oxford and London.



Dr Diarmid Sinclair, Chief Medical Officer

Diarmid was formerly the deputy medical director (since March 2023) prior to becoming the chief medical officer in September 2024.

Diarmid joined the trust in 2015 as a Consultant Psychiatrist, although he spent time in the trust as a resident doctor before this. Prior to joining RDaSH he worked over South Yorkshire and the East Midlands as a psychiatrist having first completed his medical degree in London. He has led on the recruitment of international educated medical staff. Diarmid continues to work clinically part time as a Consultant Psychiatrist in the Crisis Resolution and Home Treatment Team.



Steve Forsyth, Chief Nursing Officer

Steve joined the trust in April 2024 from Birmingham and Solihull Mental Health NHS Foundation Trust where he was the chief nurse since October 2022. Prior to this Steve was the director of nursing at Betsi Cadwaladr University Health Board in North Wales.

Over the last two decades, Steve has worked in criminal justice, physical health, commissioning, and mental health services. He is a registered nurse in both adult nursing and mental health.

Steve is a member of the National Global Majority Chief Nurse Officer Group, an active and proud member of the Jabali network, the Nola Ishmael Executive Nurses' Group, Asian professionals National Alliance (APNA) and British Indian Nurses Association (BINA), the Gambian Police Force and a director, trustee for the African Caribbean Community Initiative.



Simon Sheppard, Executive Director of Finance and Estates

Simon joined the trust in December 2025 as Director of Finance and Estates. He previously worked at Sandwell and West Birmingham NHS Trust as the Chief Finance Officer. Before that, he was the Director of Finance at The Rotherham NHS Foundation Trust.

He has also held senior finance roles at Nottingham University Hospitals NHS Trust and University Hospitals of Leicester NHS Trust. Simon is a qualified accountant (CPFA) with the Institute of Chartered Public Finance and Accountancy.



Carlene Holden, Executive Director of People and Organisational Development

Carlene was formally the deputy director of HR and learning at our trust and prior to up the role of director of people and organisational development in May 2024. Carlene held several senior roles in human resources and organisational development in local commissioner and provider trusts. Prior to joining the NHS in 2003 Carlene worked in a range of HR roles in the private sector.

Carlene is an experienced HR practitioner who has undertaken further academic studies in both employment law and management and leadership. Carlene is also a qualified coach and mediator.



Richard Chillery, Executive Chief Operating Officer

Richard took up the post of Chief Operating Officer in October 2023, from his previous role where he was Deputy Chief Operating Officer for Lancashire and South Cumbria NHS Foundation Trust. For part of his time with Lancashire he was a Poverty Truth Civic Commissioner with the Morecombe Bay Poverty Truth Commission. He was also a non-executive director with Sheffield Childrens NHS Foundation Trust, from June 2019 to December 2023.

Prior to these roles Richard has had a range of senior NHS management roles within acute, community and mental health services and has been a Technical Advisor with Public Health England. He has worked in Public Services both in the UK and New Zealand, since 1989.

Richard remains a registered social worker and has a range of different psychosocial training for working with children, young people and their families and spent much of his clinical career working in Child and Adolescent Mental Health Services.



Dr Judith Graham BEM QN, Director of Psychological Professionals and Therapies

After working as a clinical Consultant in the trust for a number of years Judith joined the board of directors in 2016. Judith was appointed as interim director of people and organisational development in 2019 and progressed to the substantive director for psychological professionals later that year. Since 2022 Judith has had expanded portfolio with inclusion of wider therapeutic professionals including allied health professionals and social work.

As well as her trust role, Judith has also held a number of national positions related to the work of health and social care. These have included board member on the NHS Confederations Mental Health Network Board, Clinical Fellow at NICE, Member of the FTSU National Advisory Panel and currently a trustee at the Queens Nursing Institute.

Judith is a registered mental health nurse, holds a Post Graduate Bachelor's Degree in Forensic and Intensive Mental Health Care, a Post Graduate Master's Degree in Cognitive

Behavioural Psychotherapy, a second Master's Degree in Advanced Clinical Practice, and a Professional Doctorate in Psychotherapy. Judith has chartered MCIPD status with the Chartered Institute of Personnel and Development, she has Accreditation as Master Practitioner and Executive Coach via the European Mentoring Coaching Council and has also completed the Kings Fund Top Managers programme.



Richard Banks, Director of Health Informatics

Richard was appointed to his current role in 2016. Before this he was the director of business assurance from 2009. He has had a number of senior roles since joining the trust in 2000, including as the director of performance, planning and service improvement, at the time the trust achieved Foundation status in 2007.

Prior to joining RDaSH he worked in local government, the Sheffield FHSA, Health Authority and Community Health Sheffield, before joining RDaSH in 2000 as Head of Planning.

Richard has a degree in economic and social history, a post graduate certificate in managing health and social care and has completed the Kings Fund top manager programme. In 2016 he gained an MSc in Health and Social Care leadership.

Richard retired from NHS service on April 6th 2026. His responsibilities in the main have transferred into the Chief Operating Officer's portfolio.



Philip Gowland, Director of Corporate Assurance and Board Secretary

Philip was appointed as director of corporate assurance in February 2016 having joined the trust as Head of Corporate Affairs in 2007. He has been the board secretary since 2009.

Prior to joining the trust Philip was internal audit manager for a number of NHS organisations having worked for Internal Audit Consortia across both South and West Yorkshire.

Philip is a member of the Institute of Chartered Secretaries and Administrators (ICSA); a qualified accountant (Chartered Institute of Public Finance and Accountancy CIPFA) and holds a degree in Accounting and Management Control from Sheffield Hallam University.



Joanne McDonough, Director of Strategic Development

Joanne joined the trust in April 2011 when the Community Services transferred into the trust from the Primary Care Trust in Doncaster.

Prior to that she worked with a range of public sector organisations on service improvement with the Audit Commission for 11 years including working with NHS Providers on improving mental health and physical health services.

Since joining the trust, Joanne has held a number of roles including deputy director for business assurance, head of business services unit and care group director for Doncaster.

She moved into the director of strategic development role in 2020 which includes responsibility for communications. Joanne holds a Master of Business Administration (MBA).

During the year there were one change to the board of directors as follows:

- Izaaz Mohammed left the trust on 2 November 2025 after which Jill Savoury acted as Interim executive director of finance until Simon Sheppard joined the trust on 8 December 2025 as executive director of finance and estates

In the year April 2023 to March 2024 the NExT director scheme was introduced into the trust and 2 successful candidates each commenced a 24-month placement. This scheme is a development programme created and designed to help find and support the next generation of talented people who are currently under-represented on our NHS boards into the non-executive roles.

The NExT directors in post during the year April 2025 to March 2026 are detailed below.



Lea Fountain, NExT Director

Lea joined the trust as a NExT director in October 2023. She brings 25 years' experience in engaging communities, influencing change and building reputation, through roles in the media, the NHS and local government.

She is a Chartered Institute of Public Relations (CIPR) chartered practitioner, committed to ethical working to bring meaningful changes to improve the experiences of service users and NHS staff.

Lea completed her NExT Director programme with the trust on 31 August 2025.



Shabir Pandour, NExT Director

Shabir joined the trust as a NExT director on 1 December 2025 and brings over 25 years' experience in Local Government and the NHS. He is a public sector leader, entrepreneur, housing and NHS specialist and was Director of his own company delivering large capital projects within the NHS.

Shabir has high-level academic credentials, including Postgraduate qualifications in Management, Public Sector Modernisation, and Housing and he is a Corporate Member of the Chartered Institute of Housing (MCIH).

Director Independence and Register of Interests

The trust is committed to ensuring that the board of directors is comprised of a majority of independent non-executive directors who objectively challenge management. Our non-executive directors provide a wide range of skills and experience. They bring strong, independent oversight and judgement on issues of strategy, performance and risk through their contribution at board and committee meetings. The board of directors considers that

throughout the year each non-executive director was independent in character and judgement.

The council of governors is responsible for all decisions to reappoint non-executive directors and is supported in its consideration by the recommendations it receives from the chair and the Nominations Committee. Non-executive directors declare their interests and in the unlikely event that such interests conflict with those of the trust, then the individual would be excluded from any discussion and decision relating to that specific matter.

All board directors are required to disclose their relevant interests as defined in our constitution. These are recorded in a publicly available register that is formally reported to the board of directors at the beginning of each meeting. A copy of the full register of declarations is available on the website <https://www.rdash.nhs.uk/about-us/declaration-and-conformance/> or on request from the director of corporate assurance, board secretary at Woodfield House, Tickhill Road Hospital Site, Balby, Doncaster DN4 8QN or email rdash.doi@nhs.net

Furthermore, all members of the Board of Directors are subject to the requirements of the fit and proper persons test which is considered on appointment and on an annual basis. All Directors were deemed to meet these requirements.

Role of the Board of Directors

The board of directors acts as a unitary board and has corporate responsibility for the decisions it makes. It is the legally responsible body for the delivery of high quality, effective services, and for making decisions relating to the strategic direction, financial control and performance of the trust. It comprises both executive directors and non-executive directors:

- eight non-executive directors (including the chair), bring independent judgement and scrutiny to the board of directors to make sure that sound and well-informed decisions are made
- six executive directors (including the chief executive), responsible for implementing trust policy and for the effective day-to-day running of the organisation

In addition, the director of health informatics, director of psychological professions and therapies, director of strategic development and director of corporate assurance attend each board of directors meeting. From July 2026, the trust's remuneration committee has agreed that the director of psychological professions and therapies will become a seventh executive director.

The composition of the board of directors is in accordance with our constitution and it is appropriately composed to fulfil its statutory and constitutional function and to meet the terms of the licence issued by NHS England.

There is a clear division of responsibilities between the chair and chief executive. The chair has throughout the year been responsible for the effective working of the board of directors, and for ensuring the board of directors has a strategy that delivers a service that meets the expectations and requirements of the communities we serve, ensuring all directors are able to play their full part in the strategic direction of the trust and its performance. The chair facilitates the contribution of non-executive directors and their constructive relationships with the executives. The non-executive directors share the corporate responsibility for ensuring that the organisation is run efficiently, economically

and effectively. Non-executive directors use their expertise, interest and experience, and attend the meetings of the board and its committees to achieve this. Regular involvement in the peer review process and service and site visits are undertaken by all directors in order to gain a more rounded understanding of the services being delivered and the issues faced by our colleagues in those services.

The chair also chairs the council of governors meetings and ensures that there is effective communication between the board of directors and the council of governors and that, where necessary, the views of the governors are obtained and considered by the board of directors. Non-executive directors attend the council of governors meetings along with the chief executive and director of corporate assurance. The chair supported by the senior independent director, also seeks to foster a strong, engaging relationship between the board of directors and the council of governors. There is frequent attendance at the board of directors by governors and during 2024 governors were identified as members of the Board's committees in line with promise 5 to involve our communities at every level of decision making in our trust, this has continued to be the case. Further details of Governors' involvement at the trust are provided at pages 63 to 65.

This engagement helps ensure that all parties maintain an understanding of the views and aspirations of the trust and our members and contribute to the future development of the organisation. Furthermore, the Board of Directors meetings always include a patient or staff member story, allowing the Board members the opportunity to hear first-hand, the experiences of others. During the year the stories have focused on:

- modern slavery
- experience of a staff member being a carer whilst working within the trust
- patient experience of partnership work between with housing association and the early intervention team in Rotherham
- recruitment of volunteers, experience they have had and contributions made to the trust
- patient experience of partnership work between the People Focused Group and Doncaster physical health unplanned community and long-term conditions services
- staff career journey as a social worker

The chief executive is responsible for all aspects of the management of the trust. This includes the leadership of the executive team and for implementing our clinical and organisational strategy and delivering our overall objectives, and for ensuring that we have an appropriate risk management system in place. The executive directors are responsible for the day-to-day operational management of the trust.

The chair and chief executive continue to review the board of directors balance, completeness and appropriateness, and ensure that this is maintained when new appointments are made. During the year, our performance, clinically and financially was closely monitored by the board of directors through the presentation and discussion of key performance information at every one of its meetings, in the integrated quality and performance report (IQPR).

The board of directors acknowledges its responsibility for preparing the annual report and accounts and considers that, taken as a whole, they are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the trust's performance, business model and strategy. As far as the board of directors are aware, there is no relevant audit information of which the external auditors

are unaware. Each of the directors has taken all the steps they ought to have taken as directors, in order to make themselves aware of any relevant audit information and to establish that the trust's auditor is aware of that information. Attendance by directors at the board's meetings in the year is presented in the board of directors' attendance table at the end of this section.

The terms of reference of the board and its committees are focused in line with Clinical and Organisational Strategy and the forward trajectory of the trust. Each committee provides a report to the board of directors after every meeting outlining key areas of discussion.

Audit Committee

The Audit Committee provides the board of directors with a means of independent and objective review of financial, clinical, corporate, education and research governance and risk management across the whole of the trust's activities. The committee has delegated responsibility from the board of directors for specific areas of concern and to work alongside other committees to assess control strengths, weaknesses and themes.

The committee is a non-executive body of three members, one with recent and relevant financial experience. Also in regular attendance at meetings are the director of finance and estates, chief nursing officer, director of corporate assurance, representatives from internal and external audit and the trust's anti-crime specialist.

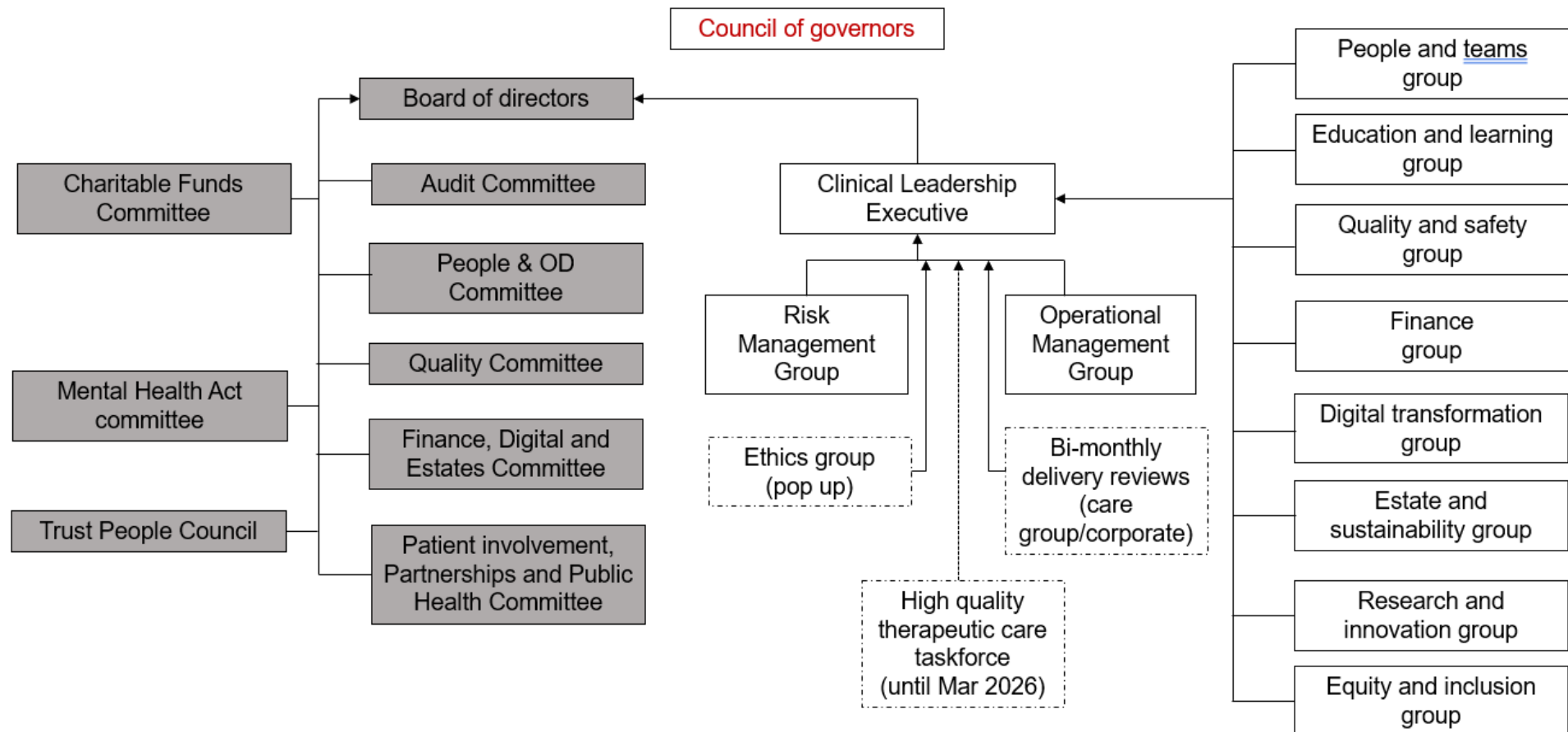
Internal audit and anti-crime services are provided by 360 Assurance who predominantly focus on delivery of services to the NHS and associated partners, 360 Assurance has a strong reputation of providing quality services.

External audit is provided by Deloitte and the year of April 2025 to March 2026 was their ninth year since their appointment. A protocol is in place following agreement with the Council of Governors for the engagement of the external auditors to undertake work outside of the Audit Code. The agreement includes provisions to ensure continued external auditor independence.

The significant risks identified by Deloitte for their audit are validity of accruals and management override of controls.

In addition to the board and its committee, as part of the operating model, there is a clinical leadership executive with a range of supporting groups in place. The meeting structure is depicted in the diagram below.

Trust decision making and Board assurance committee



The table below shows the attendance of the board of directors at the board, its committees during the financial year 1 April 2025 to 31 March 2026. Details on the council of governors is available on pages 63 to 65.

Director	Title	Board of directors	Audit	Remuneration	Mental Health Act	Charitable Funds	Public Health, Patient Involvement and Partnerships	Quality	People and Organisational Development	Finance, Digital and Estates
Kathryn Lavery	Chair	6 of 7		3 of 3		2 of 4				
Dave Vallance	Non-executive director and vice chair	6 of 7		3 of 3			6 of 6	6 of 6	5 of 6	
Pauline Vickers	Non-executive director	7 of 7	5 of 6	3 of 3		3 of 3			6 of 6	6 of 6
Sarah Fulton Tindall	Non-executive director	5 of 7		1 of 3	6 of 6	4 of 4				5 of 6
Kathy Gillatt	Non-executive director	7 of 7	6 of 6	2 of 3		4 of 4				
Rachael Blake	Non-executive director	6 of 7		3 of 3					5 of 6	4 of 6
Dr Richard Falk	Non-executive director	6 of 7	5 of 6	3 of 3	2 of 2		5 of 6	5 of 6		
Maria Clarke	Non-executive director	7 of 7		3 of 3	4 of 4	1 of 1	5 of 6	5 of 6		
Toby Lewis	Chief executive	7 of 7			6 of 6	3 of 4	5 of 6			
Steve Forsyth	Chief nursing officer	7 of 7	3 of 6			3 of 4		6 of 6	4 of 6	
Dr Diarmid Sinclair	Chief medical officer	7 of 7			6 of 6		6 of 6	6 of 6		
Izaaz Mohammed	Director of finance and estates	3 of 3	2 of 2			2 of 2				3 of 3
Jill Savoury	Interim Director of Finance	2 of 2	3 of 3			2 of 2				2 of 2
Simon Sheppard	Director of finance and estates	2 of 2	1 of 1							1 of 1
Carlene Holden	Director of people and OD	7 of 7					6 of 6		6 of 6	5 of 6
Richard Chillery	Chief operating officer	7 of 7						6 of 6	4 of 6	4 of 6
Richard Banks	Director of health informatics	7 of 7						6 of 6		5 of 6
Philip Gowland	Director of corporate assurance and board secretary	7 of 7	4 of 6							
Joanne McDonough	Director of strategic development	5 of 7				4 of 4	5 of 6			
Dr Judith Graham	Director of psychological professionals and therapies	5 of 7			4 of 6			6 of 6	4 of 6	

Remuneration Report

In accordance with the requirements of the HM Treasury Financial Reporting Manual and reporting requirements issued by NHS England, this report is in three parts:

- **Annual statement on remuneration** describes the major decisions on senior managers' remuneration as well as any substantial changes to senior managers' remuneration which were made during the year and the context in which those changes occurred and decisions taken
- **Senior managers' remuneration policy** sets out information about the trusts policy
- **Annual report on remuneration** includes details about senior managers' service contracts and sets out other matters such as committee membership, attendance and the business transacted

A 'senior manager' is defined as 'Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the foundation trust.' For the trust, the report covers eight non-executive directors (including the chair), six executive directors (including the chief executive), the director of health informatics, director of corporate assurance, director of psychological professions and therapies and the director of strategic development these are the 'senior managers'. The associate director and similarly, given their informal role with the trust, the named NExT directors are also not considered to be within the definition of 'senior manager' for the purposes of this Remuneration Report.

Whilst the annual report is prepared on a group basis, Flourish CIC and the Charity are not considered to be material and as such none of the senior managers of Flourish CIC meet the definition of senior manager above and are not therefore included in this Remuneration Report.

Details of the directors including their start date in their role and their relative experience and expertise are on pages 40 to 47. For detail on the number of meetings attended please refer to page 52.

Annual statement on remuneration

The trust has two committees responsible for reviewing the remuneration of the senior managers:

- Nominations Committee of the council of governors: chair and non-executive directors (as detailed in the directors report on pages 40 to 47)
- Remuneration Committee: executive directors and other directors (as detailed in the directors report on pages 40 to 47)

The two committees aim to ensure that senior managers' remuneration is set appropriately taking into account relevant market conditions and to ensure that the senior managers are fairly rewarded for their individual contribution to the trust, having proper regard for affordability based on the corporate performance of the trust.

In setting the remuneration, the committees take due account of any guidance issued for NHS staff regarding the level of pay inflation which may be awarded, for example the annual agenda for change and very senior manager (VSM) guidance but does not consult with those employees. The committee also takes due account of national benchmarking

data collated particularly that distributed annually by NHS Providers. This allows for sector and geographical comparisons to be made.

The Remuneration Committee can confirm that the trust adopted the new VSM framework from 1 April 2025 and in doing so ensured that all relevant Directors receive remuneration in line with the thresholds set out in the Framework (for a trust of our size).

Whilst new appointments have been made during the year there has been no requirement to obtain national approval for the pay case associated with these appointments, and all appointments have been made conscious of and in line with the requirements of the Framework. There are no performance related pay conditions within any contract at the present time.

The minutes of the Remuneration Committee meetings have recorded all pay decisions and copies have been supplied to external audit in support of this statement and their respective audit work.

During the year April 2025 to March 2026 the members of the Nominations Committee were involved in the appointment of Maria Clark and the reappointment in the year of Kath Lavery, Dave Vallance, Paulin Vickers and Kathy Gillatt.

The Chair of the Remuneration Committee summarised the work of the committee as follows. The Committee met on three occasions during the year April 2025 to March 2026. The key matters discussed at the meetings included:

- revised national arrangements for VSM terms and conditions framework and the adoption and implementation impact for Executive Group pay
- chief executive's appraisal for the financial years 2024 to 2025 and 2025 to 2026 and Executive Group performance for financial year 2024 to 2025
- arrangements for the appointments of directors of finance and estates and people and organisational development and the retirement and subsequent impact on the Executive Group, of director of health informatics

In the year April 2025 to March 2026, 11 board members received expenses and the total amount reimbursed was approximately £8,050 (£13,025 in the year April 2024 to March 2025).

Senior managers' remuneration policy

In any recruitment process undertaken, the trust utilises open, widely advertised recruitment processes, with on occasion external professional support, to ensure the best candidates are identified and appointed.

For information on the policy for equality diversity and inclusion please refer to pages 30 and 31 within the staff report.

Non-Executive Directors

The remuneration of the chair and non-executive directors has, since 2019, been in line with the guidance document entitled "Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts Implementation document: November 2019". No review of the chair and non-executive director remuneration has since taken place. The trust, and specifically the Nominations Committee of the council of

governors, awaits a further update to that guidance, although at the present time no agreed date for such has been published.

The component of the remuneration packages for the non-executive directors is shown below:

Element	Policy
Fee payable	a 'spot fee' which is in line with the guidance document referred to above
Additional fee	the senior independent director receives an additional £1,000; the vice chair receives an additional £1,000; and the chair of the Audit Committee an additional £2,000
Percentage uplifts (cost of living increase)	the current remuneration is line with the guidance document entitled Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts November 2019, no uplift has been considered or actioned since 2020
Travel	travel and subsistence expenses are reimbursed and paid with remuneration via payroll
Pension contributions	non-executive directors do not have access to the NHS pension scheme
Other remuneration	none

The chair and non-executive directors do not have a notice period.

The letters of appointment include no provisions or obligations which could give rise to, or impact on, remuneration payments or payments for loss of office.

Executive Directors

The component of the remuneration packages for these senior managers is shown below:

Element	Policy
Salary	a 'spot' salary which is reviewed annually; the setting of that salary and the subsequent review are undertaken with reference to relevant guidance and other related information as described above, this is the maximum amount that will be paid; there are no provisions for the recovery of sums paid or for the withholding of the payments
Percentage uplifts (cost of living increase)	reviewed annually by the Remuneration Committee taking into consideration national pay awards, benchmarking data and the related financial implications
Travel benefits	travel and subsistence expenses are reimbursed and paid with salary via payroll
Annual performance related bonuses	there are no annual performance related matters within any Board members' contract of employment
Long-term performance related bonuses	no long-term performance related bonuses are paid
Pension related benefits	executive directors and directors can access the NHS pension scheme

The current senior managers are on substantive contracts that incorporate a six-month notice period, except for the director of health informatics, director of strategic development, director of psychological professions and therapies and the director of corporate assurance and board secretary who have a three-month notice period.

The contracts include no provisions or obligations which could give rise to, or impact on, remuneration payments or payments for loss of office.

Annual Report on Remuneration

The council of governors has responsibility for the appointment, re-appointment, remuneration and appraisal of the chair and non-executive directors. The work to discharge that responsibility is undertaken by the Nominations Committee which comprises seven governors (four service user and or carer or public governors and three appointed or staff governors).

The Nominations Committee is chaired by the lead governor, Joan Cox, community services, carer and is supported administratively by the director of corporate assurance and board secretary.

Non-executive directors are appointed for a fixed term of office, following an open, advertised recruitment campaign in which representatives of the Nominations Committee join the chair and an external assessor to form an interview panel that recommends an appointment to the full council of governors.

The Remuneration Committee is chaired by Kath Lavery, chair. The remaining members of the committee are the other non- executive directors. By invitation from the chair of the committee, the chief executive attends meetings as does the director of corporate assurance and board secretary and the executive director for people and organisational development.

The Remuneration Committee has delegated responsibility for all aspects of remuneration and terms of service for the executive directors and directors. Its responsibility includes all aspects of salary, provision for other benefits including pensions, arrangements for termination of employment, and other contractual terms.

The chief executive is remunerated at a level greater than £150,000 (this equates to the Prime Minister's ministerial and parliamentary salary). The remuneration paid to this director is considered to be reasonable for the post given the relative position in terms of benchmarking with similar foundation trusts.

During the year, neither the Remuneration Committee nor the Nominations Committee sought nor received advice or services from any person that materially assisted their consideration of these matters.

Remuneration for each senior manager (subject to audit)

	April 2025 to March 2026					
	(a) Salary (bands of £5,000)	(b) Taxable benefits total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Kathryn Lavery, Chair	40 to 45	0	0	0	0	40 to 45
Toby Lewis, Chief executive	200 to 205	0	0	0	75 to 77.5	275 to 280
Diarmid Sinclair, Chief medical officer	180 to 185	0	0	0	0	180 to 185
Steve Forsyth, Chief nursing officer	135 to 140	3,500	0	0	0	140 to 145
Izaaz Mohammed, Director of finance and estates: 1 April to 2 November 2025	80 to 85	2,600	0	0	22.5 to 25	105 to 110
Jill Savoury, Acting Director of finance: 10 October to 31 December 2025	25 to 30	0	0	0	5 to 7.5	30 to 35
Simon Sheppard, Director of finance and estates: from 8 December 2025	45 to 50	700	0	0	32.5 to 35	80 to 85
Richard Chillery, Chief operating officer	145 to 150	0	0	0	15 to 17.5	160 to 165
Judith Graham, Director of psychological professionals and therapies	115 to 120	1,800	0	0	50 to 52.5	165 to 170
Carlene Holden, Director of people and organisational development	125 to 130	0	0	0	137.5 to 140	265 to 270
Joanne McDonough, Director of strategic development	110 to 115	0	0	0	37.5 to 40	150 to 155
Richard Banks, Director of health informatics	110 to 115	0	0	0	32.5 to 35	145 to 150
Philip Gowland, Director of corporate assurance and board secretary	110 to 115	0	0	0	45 to 47.5	155 to 160
Dave Vallance, Non-executive director	10 to 15	0	0	0	0	10 to 15
Pauline Vickers, Non-executive director	10 to 15	0	0	0	0	10 to 15
Sarah Fulton Tindall, Non-executive director	10 to 15	0	0	0	0	10 to 15
Kathryn Gillatt, Non-executive director	15 to 20	0	0	0	0	15 to 20
Rachael Blake, Non-executive director	10 to 15	0	0	0	0	10 to 15
Richard Falk, Non-executive director	10 to 15	0	0	0	0	10 to 15
Maria Clark, Non-executive director	10 to 15	0	0	0	0	10 to 15

Four executive directors leased a vehicle through the trust's salary sacrifice lease car scheme in the year April 2025 to March 2026. The taxable benefit disclosed in the remuneration table represents the HMRC cash equivalent value of the leased car.

Executive directors are members of the NHS defined benefit pension scheme managed by NHS Pension Authority. All pension related benefits' disclosed above show the increase in 'lifetime' pension which has arisen in the year April 2025 to March 2026; it is not the amount paid into the pension during the year. The sum reported reflects the amount by which the annual pension received on retirement age has increased in April 2025 to March 2026, multiplied by 20 (the average number of years a pension is paid to members of the NHS scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004. The figures tend to be highest when an individual is promoted to an executive director role within the current or previous financial year.

Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000, they would be shown in the salary band (£'000) 45 to 50.

Where an employee has been in post for part of the year, their pay and pension amount are time apportioned to reflect time in post. Any start and end dates are shown in the table April 2025 to March 2026.

Dr Sinclair undertakes, on average, two days per week working clinically and three days per week as the chief medical officer. This equates to salary bands of 75 to 80 and 105 to 110 respectively.

April 2024 to March 2025						
Name and Title	(a) Salary (bands of £5,000)	(b) Taxable benefits total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Kathryn Lavery, Chair	40 to 45	0	0	0	0	40 to 45
Toby Lewis, Chief executive	175 to 180	0	15 to 20	0	25 to 27.5	220 to 225
Graeme Tosh, Medical director	70 to 75	0	0	0	0	70 to 75
Diarmid Sinclair, Medical director	115 to 120	0	0	0	120 to 122.5	235 to 240
Steve Forsyth, Chief nursing officer	125 to 130	9,000	0	0	122.5 to 125	255 to 260
Ian Currell, Director of finance and estates	45 to 50	0	0	0	0	45 to 50
Izaaz Mohammed, Director of finance and estates	100 to 105	13,500	0	0	22.5 to 25	135 to 140
Richard Chillery, Chief operating officer	140 to 145	0	0	0	132.5 to 135	275 to 280
Judith Graham, Director of psychological professionals and therapies	100 to 105	9,400	0	0	55 to 57.5	165 to 170
Nicola McIntosh, Director of people and organisational development	10 to 15	0	0	0	7.5 to 10	15 to 20
Carlene Holden, Director of people and organisational development	95 to 100	0	0	0	167.5 to 170	265 to 270
Joanne McDonough, Director of strategic development	110 to 115	0	0	0	20 to 22.5	130 to 135
Richard Banks, Director of health informatics	105 to 110	0	0	0	10 to 12.5	120 to 125
Philip Gowland, Director of corporate assurance and board secretary	105 to 110	0	0	0	12.5 to 15	120 to 125
Dave Vallance, Non-executive director	10 to 15	0	0	0	0	10 to 15
Dawn Leese, Non-executive senior independent director	5 to 10	0	0	0	0	5-10
Pauline Vickers, Non-executive director	10 to 15	0	0	0	0	10 to 15
Sarah Fulton Tindall, Non-executive director	10 to 15	0	0	0	0	10 to 15
Janusz Jankowski, Non-executive director	10 to 15	0	0	0	0	10 to 15
Kathryn Gillatt, Non-executive director	15 to 20	0	0	0	0	15 to 20
Rachel Blake, Non-executive director	10 to 15	0	0	0	0	10 to 15
Richard Falk, Non-executive director	10 to 15	0	0	0	0	10 to 15

Pension entitlement (subject to audit)

The pension benefit table provides further information on the pension benefits accruing to the individual. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

Name and Title	Real Increase in Pension at pension age (bands of £2,500)	Real Increase in Pension Lump Sum at pension age (bands of £2,500)	Total Accrued Pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employers Contribution to Stakeholder Pension
	£000	£000	£000	£000	£000	£000	£000	£000
Toby Lewis, Chief executive	2.5 to 5	2.5 to 5	85 to 90	205 to 210	1,737	87	1,878	-
Diarmid Sinclair, Chief medical officer	0	0	35 to 40	85 to 90	737	-	716	-
Steve Forsyth, Chief nursing officer	0	0	40 to 45	100 to 105	891	-	842	-
Izaaz Mohammed, Director of finance and estates: 1 April to 2 November 2025	0 to 2.5	0	10 to 15	-	89	10	122	-
Jill Savoury, Acting Director of finance: 10 October to 31 December 2025	2.5 to 5	0	20 to 25	-	253	6	297	-
Simon Sheppard, Director of finance and estates: from 8 December 2025	0 to 2.5	2.5 to 5	65 to 70	160 to 165	1,271	37	1,462	-
Richard Chillery, Chief operating officer	0 to 2.5	0	60 to 65	155 to 160	1,474	-	172	-
Judith Graham, Director of psychological professionals and therapies	2.5 to 5	2.5 to 5	30 to 35	70 to 75	534	43	600	-
Carlene Holden, Director of people and organisational development	5 to 7.5	12.5 to 15	35 to 40	85 to 90	580	128	734	-
Joanne McDonough, Director of strategic development	2.5 to 5	0	30 to 35	-	493	33	550	-
Richard Banks, Director of health informatics	0 to 2.5	5 to 7.5	50 to 55	140 to 145	1,207	59	1,301	-
Philip Gowland, Director of corporate assurance and board secretary	2.5 to 5	0 to 2.5	45 to 50	110 to 115	934	51	1,016	-

Pensions figures included in the above table are for senior managers that have pensions paid directly by RDaSH and include all of their NHS Service not just pension payments that relate to April 2025 to March 2026.

The cash equivalent transfer value (CETV) is the estimated amount that would transfer if the pension benefits were moved from one scheme to another.

The pension calculation uses an inflation value of 1.7% on previous year values which can make previous pension, lump sum and CETV values appear to have decreased in the year April 2025 to March 2026. Where these values are negative, they are shown as zero.

This information has been audited.

Payments for loss of office

In the year to 31 March 2026, no payments were made by the trust to senior managers for loss of office. This is the same as for the year April 2024 to March 2025.

Payments to past senior managers

In the year to 31 March 2026, no payments were made by the trust to past senior managers. This is the same as for the year April 2024 to March 2025.

Fair pay disclosures (subject to audit)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration for the highest-paid director in the organisation in the financial year April 2025 to March 2026 was £200k to £205k (for April 2024 to March 2025 was £195k to £200k). This is a change between years of 3%.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the trust as a whole, the range of remuneration in the year April 2025 to March 2026 was from £23,832 to £282,000 (in the year April 2024 to March 2025 it was £22,817 to £258,500). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 7.8%. Five employees received remuneration in excess of the highest-paid director by annualised remuneration in the year April 2025 to March 2026 (4 in the year April 2024 to March 2025).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

April 2025 to March 2026 (highest paid director ratio)	25 th percentile	Median	75 th percentile
Salary component of pay	26,598	36,136	46,580
Total pay and benefits excluding pension benefits	29,286	38,682	47,841
Pay and benefits excluding pension: pay ratio for highest paid director	6.91:1	5.23: 1	4.23:1

April 2024 to March 2025 highest paid director ratio	25 th percentile	Median	75 th percentile
Salary component of pay	25,674	36,483	44,962
Total pay and benefits excluding pension benefits	26,877	36,351	45,304
Pay and benefits excluding pension: pay ratio for highest paid director	7.53:1	5.56:1	4.46:1

Remuneration report signed on behalf of the board of directors



Toby Lewis, Chief Executive

25 June 2026

The Council of Governors

The council of governors comprises 36 seats for members of the public, service users and carers, colleagues and representatives from partner organisations. Governors have responsibility for:

- advising the trust on its strategic direction
- representing the interests of members and partner organisations and regularly feeding back to their constituency
- appointing (and removing) of the chair and non-executive directors
- approving the appointment of the chief executive
- appointing the trust's auditor and receiving the annual accounts, auditor's report and annual report
- informing NHS England of any unresolved issues

The council of governors provides an important link between the trust, the local community and key organisations, sharing information and views that can be used to develop and improve services. The council of governors is chaired by Kathryn Lavery, who ensures that there are strong links between the council of governors and the board of directors. The lead governor Joan Cox, community services, carer, took up the lead governor position in June 2021 having been in the governor role since August 2017.

The board of directors is responsible for the operational management of the trust, the delivery of high quality, effective services, and for making decisions relating to the strategic direction, financial control and performance of the trust. The board of directors takes account of the views of the governors, and members of the board of directors have attended council of governors meetings in the last year. The table below sets out the composition of the council of governors:

Public 11	Patient and Carer 9	Staff 6	Partner 10
4 in Doncaster	9 Governors	Rotherham Adult Mental Health Care Group	1 City of Doncaster Council
4 in Rotherham		Doncaster MH and Learning Disabilities Care Group	1 Rotherham MBC
2 in North Lincolnshire		Physical Health and Neurodiversity Care Group	1 North Lincolnshire Council
1 in Rest of England		North Lincolnshire Adult MH and Talking Therapies Care Group	1 University
		Children's Care Group	1 GP
		Corporate Backbone	1 ICB
			2 Youth forum
			1 Health-watch
			1 Community Voluntary Sector

At the start of the year, 30 governors were in post. Over the year there have been a number of changes to those holding positions on the council of governors, through resignations and elections (see below), resulting in 29 seats being filled at the year end.

Four meetings were chaired by the chair of the trust. Meetings were attended by members of the board of directors. The governors and their attendance at the meetings are shown in the table below:

Council of Governors	Meetings in public				Total no. of meetings	% Attendance	Term expiry	Appointed or Elected
	June 2025	September 2025	December 2025	March 2026				
Mabrookah Agbabiaka			✓		1	50%	Nov 28	A
Allen Bell			✓		1	50%	Nov 28	E
Joy Bullivant	✓	✓	✓	✓	4	100%	Nov 26	E
Arun Chaudhary		✓		✓	2	50%	Nov 27	U
Baz Cooper					0	0%	May 28	U
Joan Cox	✓	✓		✓	3	75%	Nov 26	U
Dean Eggitt					0	0%	Feb 26	A
Andrew Flynn			✓	✓	2	100%	Nov 28	E
Robert Foster			✓		1	50%	Nov 28	E
Jennie Gaul	✓		✓		2	50%	Nov 27	E
Kym Gleeson	✓	✓		✓	3	75%	Mar 28	A
Lee Golze					0	0%	Nov 26	A
Prachi Goulding	✓	✓		✓	3	75%	Nov 27	E
Hannah Hall	✓	✓	✓	✓	4	100%	Nov 27	E
Pippa Harder	✓	✓		✓	3	75%	May 28	U
Kevin Hodgkiss	✓			✓	2	50%	Nov 27	U
Mark Johnson					0	0%	Nov 28	U
Ann Llewellyn	✓	✓	✓		3	100%	Stood Down	U
Sam O'Brien	✓		✓	✓	3	75%	May 28	U
Chris Pope	✓	✓	✓	✓	4	100%	Nov 27	E
Emma Price	✓	✓	✓	✓	4	100%	Nov 27	A
Richard Rimmington		✓	✓		2	50%	Nov 26	U
Ruth Sanderson					0	0%	Nov 25	E
Mike Seneviratne					0	0%	Nov 28	E
Champion Solesi		✓	✓	✓	3	75%	Nov 27	A

Council of Governors	Meetings in public				Total no. of meetings	% Attendance	Term expiry	Appointed or Elected
	June 2025	September 2025	December 2025	March 2026				
Ian Spowart		✓	✓	✓	3	75%	Nov 26	U
Vicky Stocks		✓	✓		2	66%	Stood Down	E
Debra Taylor	✓				1	25%	Mar 28	A
Kamlesh Vatish	✓		✓	✓	3	75%	Nov 27	U
David Vickers	✓	✓	✓	✓	4	100%	Nov 28	U
Jessica Williams		✓	✓	✓	3	75%	Nov 27	E
Emma Wilsher				✓	1	25%	Nov 27	E
Maureen Young	✓	✓		✓	3	75%	Nov 27	E

Register of interests

The interests for the council of governors are presented to the council of governors at each meeting and are part of the register of interests. The register of interests is a public document and is available via the trust's website.

<https://www.rdash.nhs.uk/about-us/declaration-and-conformance/>

Expenses

Governors receive no remuneration for their role. However, the trust provides appropriate reimbursement, for example to cover travel expenses for governors who participate in events or activities arranged by the trust. In the year April 2025 to March 2026, one governor received expenses and the total amount paid and or reimbursed to support their attendance was approximately £20. In the year April 2025 to March 2026 the total amount paid and or reimbursed to support their attendance was approximately £49.

How to contact your Governor

Governors represent the members of their respective constituencies. If you have any comments, concerns or questions, or if you have any other need to speak to the governor who represents you, contact can be through the corporate assurance team:

Telephone: 07929656113

Post: Corporate Assurance Team,
Woodfield House, Tickhill Road, Balby, Doncaster, DN4 8QN.

Email: rdash.corporate-assurance@nhs.net

Foundation trust membership

Becoming a member of the trust offers local people a unique opportunity to have their say and to be involved in how the trust and its services are developed. The trust wants to build a meaningful and representative membership.

New employees automatically become members of the trust. As with all members, they can influence plans for the trust and its services for the benefit of service users and carers. They can elect to the council of governors and stand for election themselves. All our colleagues are encouraged to be actively involved as members and to spread the word, highlighting the benefits of membership.

The trust continued its engagement with members in the wider community (patients, service users, carers and public) through the launch of the house of membership in Summer 2025. The new membership recognises people as bronze, silver or gold members depending on the level of activity with the organisation and offers benefits and rewards. In addition, engagement has been made through attendance at a range of community events such as The Rotherham Show and PRIDE, events in both Doncaster and North Lincolnshire. Members are also invited to the Annual Members Meeting held by the trust. These are great opportunities to speak to the members and hear from them about their experiences with the trust and its services. They also allow for suggestions and information sharing. The trust has also engaged members during the governor election process and on a more regular basis through its website, social media such as X, Facebook and Instagram and via the trust app.

Membership constituencies

Anyone aged 12 or over is eligible to become a member. The trust has three membership constituencies:

Public

To be eligible for membership to one of our public constituencies, people should live in the four electoral areas of either:

- Rotherham Metropolitan Borough Council
- City of Doncaster Council
- North Lincolnshire Council
- Rest of England (rather than defining a further boundary for those living in close proximity to our localities, the trust chooses to add a 'Rest of England' to include those people in neighbouring boroughs who may be interested).

Service users and carers

To be eligible for membership of the service user and carers constituency, a person should have accessed within the last five years any of our services as a service user or as the carer of a service user in any of our services.

Staff

A fixed term of at least 12 months, or who has been continuously employed by the trust for at least 12 months. New members of staff automatically become members of the foundation trust, although they are given the opportunity to opt out if they wish. Members of the staff constituency are allocated to the following areas:

- Doncaster adult mental health and learning disabilities care group

- Rotherham adult mental health care group
- North Lincolnshire adult mental health and Talking Therapies care group
- Physical health and neurodiversity care group
- Children's care group
- Corporate and other services

As at 31 March 2026, the trust had a total membership of 649 (excluding staff). For April 2024 to March 2025 this was 461.

Membership size and movement

As part of the House of Membership launch, the membership size was reviewed. The chief executive wrote to all members and invited them to remain as active members within the new offer. Membership engagement continues with a smaller cohort of people who opted to remain.

	1 April 2025	New Members	Leavers	31 March 2026
Public constituency	410	164	9	565
Service User and Carer constituency	51	37	4	84
Staff constituency	4,104	437	481	4,074

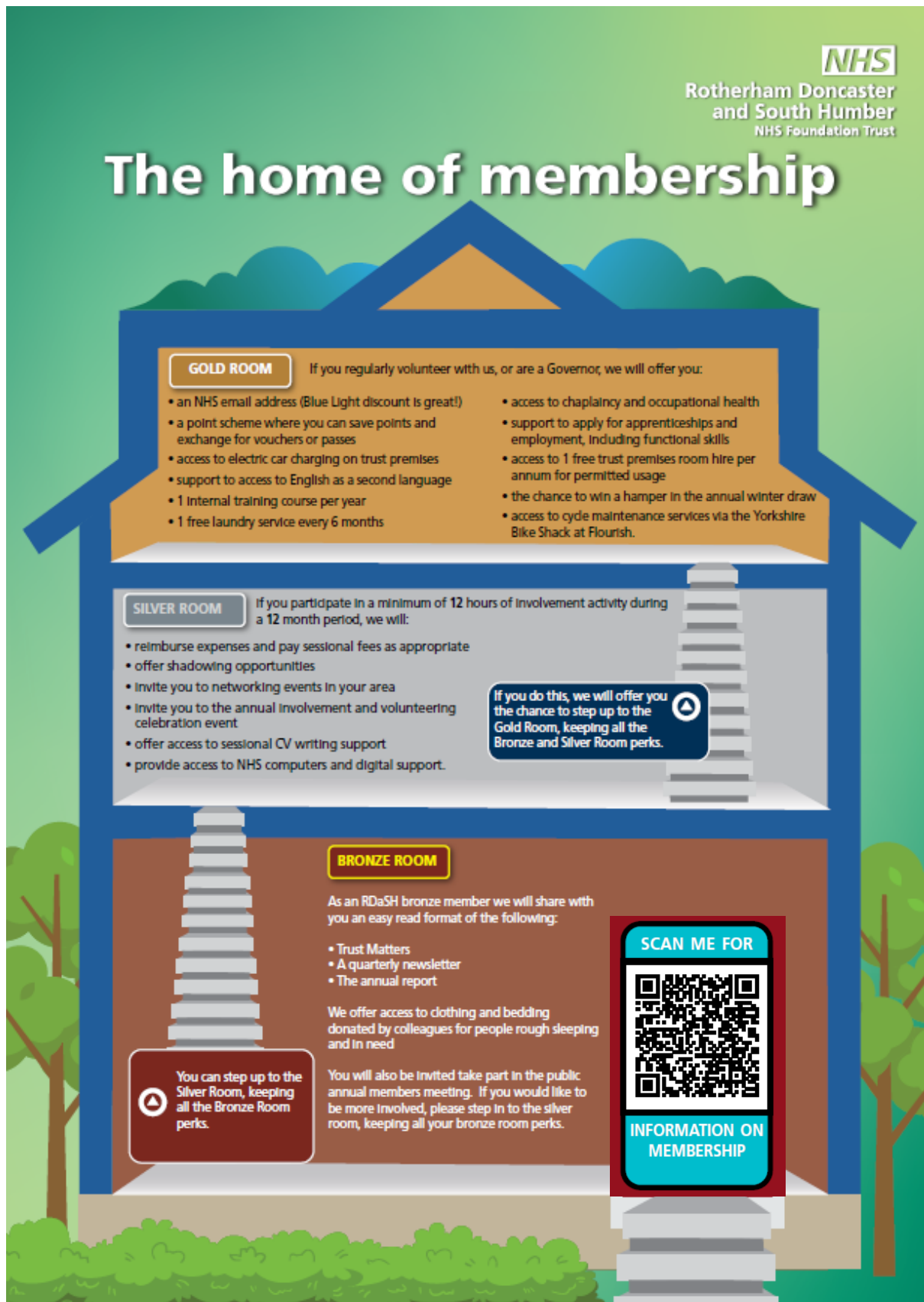
During the period from April 2026 there will be focused work undertaken to grow the membership numbers, ensuring that it is representative of the communities served. We will ensure membership is purposeful and rewarding for those that engage with us on an increasing scale, with more benefits and opportunities provided to those that engage and are involvement the most. This work forms part of Promise 5 of the trust's strategy.

Analysis of current public, service user ad carer membership:

	Number of members	Eligible membership*
Age (years):		
0 to 16	6	176,724
17 to 21	25	47,912
22+	559	696,740
Not stated	76	0
Ethnicity:		
White	300	839,964
Mixed	5	11,887
Asian or Asian British	38	31,325
Black or Black British	54	8,437
Other	3	8,929
Not stated	249	0
AB	126	51,265
C1	166	100,711
C2	138	100,101
DE	157	139,112
Gender:		
Male	156	454,688
Female	255	466,687
Transgender	1	0
Unspecified	1	0

* For the purpose of the table, the eligible membership is taken as those members of the public that live in the trust's principle geographical locations, Doncaster, Rotherham and North Lincolnshire. There is, however, Rest of England membership constituency which effectively means that any member of the public in England can be a member.

Membership offer



NHS FT Code of Governance Disclosures

The purpose of the code of governance is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice but imposes a number of disclosure requirements.

Rotherham Doncaster and South Humber NHS Foundation Trust has applied the principles of the code on a comply or explain basis. The board of directors and council of governors are committed to continuing to operate according to the highest standards of corporate governance, and support and agree with the principles set out in the Code.

Provision	Requirement
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.
Comply: We are involved in several provider collaboratives. As well as being the lead provider for South Yorkshire Adult Eating Disorder Provider Collaborative. We actively seek opportunities to collaborate with other providers, and we do this through the MHLDA Alliance, networking, and fostering relationships with other mental health and community providers. The strategic development team reviews opportunities that align with our objectives as outlined in the trust's 2023 to 2028 Clinical and Organisational Strategy. See also 'Role of the Board' on pages 48 to 49.	
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.
Comply: Health and Wellbeing on page 29	
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.
Comply: Stakeholder relationships on pages 80 to 81	
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school.

Provision	Requirement
	Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.
Comply: Board of Director Profiles on pages 40 to 47, Director Independence and Register of Interests on pages 47 to 48, Remuneration Report on pages 53 to 62.	
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.
Comply: Attendance table on page 52	
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.
Comply: Council of Governors on pages 63 to 65.	
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.
Comply: Consultancy expenditure on page 33.	
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.
Comply: Council of Governors on pages 63 to 65.	
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.
Comply: Board of Director Profiles on pages 40 to 47.	
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.
Comply: During the year April 2025 to March 2026, the trust commissioned The Value Circle (TVC) to undertake a development Well-led review. TVC and its representatives are independent of the trust and were appointed through an open, competitive tender process.	
C 4.13	The annual report should describe the work of the Nominations Committee(s), including: - the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline - how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition - the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives - the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served - the gender balance of senior management and their direct reports.
Comply: Council of governors on pages 63 to 65.	
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
Comply: Council of governors on pages 63 to 65.	

Provision	Requirement
D 2.4	The annual report should include: - the significant issues relating to the financial statements that the Audit Committee considered, and how these issues were addressed - an explanation of how the Audit Committee (and or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans - where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit - an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non audit services.
Comply: Role of the Board of Directors on pages 48 to 49.	
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
Comply: Role of the Board of Directors on pages 48 to 49.	
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.
Comply: Annual Governance Statement (pages 77 to 79) and Summary of principal risks (pages 10 to 11) confirm the use of the Risk Management Framework to establish and manage the principal risks to the organisation.	
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.
Comply: Annual Governance Statement on pages 77 to 79.	
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going-concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over 'going concern' are expected to be rare.
Comply: Going-concern statement on page 12.	
E 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.
Not applicable	
Appendix B, para 2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.
Comply: Council of Governors on pages 63 to 65.	
Appendix B, para 2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.
Comply: Council of Governors on pages 63 to 65.	
Appendix B, para 2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.
Comply: Role of the Board of Directors on pages 48 to 49.	

Provision	Requirement
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trusts or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)
Not applicable	

There are no provisions within the NHS Code of Governance that we did not comply with for the period 1 April 2025 to 31 March 2026.

NHS England Well-led Framework

NHS England's well-led framework identifies the characteristics required of good provider organisations that ensure quality services are provided:

- leadership capacity and capability
- clear vision and credible strategy
- culture of high-quality care
- clear responsibilities, roles and systems of accountability
- clear and effective processes for managing risks
- robust and appropriate information effectively processed and challenged
- people using services, the public, staff and partners engaged and involved
- robust systems and processes for learning, continuous improvement and innovation

The trust has robust quality and corporate governance arrangements in place to ensure the quality of services it provides, and reviews these on an annual basis to consider further improvements. Quality governance and quality performance are covered in detail in the Annual Governance Statement as well as in the performance section of the annual report.

The board undertakes regular reviews of its performance and effectiveness as this provides a useful opportunity to step back and reflect. This includes:

- the chair conducts individual performance evaluations of the non-executive directors and the chief executive, as well as executive directors in relation to their duties as board members
- the senior independent director conducts a performance evaluation of the chair having collectively met with all other non-executive directors and received feedback from governors and executive directors
- the chief executive conducts performance evaluations of the executive directors, which are then discussed with the remuneration committee

Foundation trusts are strongly encouraged (in the Code of Governance) to "Carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years".

The trust previously commissioned a review by the Office of Modern Governance in 2022 and whilst not a formal Well-led review, also engaged Good Governance Improvement in 2024 and 2025 on related matters. To ensure that the trust continues to respond to the

Code of Governance expectations and to provide the Board with an independent view on our more recent work, the trust appointed The Value Circle to deliver an independent review of Well-led at the trust, which will be considered by the Board in May 2026.

Care Quality Commission (CQC)

The trust is required to register with the CQC and its current registration status is 'Registered with no conditions applied'. The CQC has not taken enforcement action against the trust during the year April 2025 to March 2026.

The latest full inspection by the CQC was in 2020 and therefore the current rating of Requires Improvement still stands. However, in May 2025, the CQC undertook an unannounced assessment of the acute wards for adults of working age and psychiatric intensive care units.

A final report was published on the CQC website in December 2025 (report dated 30 July 2025). The themes identified within this report were cleanliness in our therapy kitchen at Swallownest Court, unfounded concerns regarding medicines management arrangements at the Tickhill Road site and the lack of activities available to patients, and delays in respect of occupational therapy assessments. The ratings for these services are shown below under the category Acute Wards for adults of working age and psychiatric intensive care units (**July 2025**):

- Safe: Requires improvement
- Effective: Requires improvement (declined vs prior assessment)
- Caring: Good
- Responsive: Good
- Well-led: Good (improved vs prior assessment)
- Overall: Requires improvement

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

NHS system oversight framework

NHS England's NHS Oversight Framework April 2025 to March 2026 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

- a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
- b) considering financial override which may limit a segment to be no better than 3

- c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and
- d) capability assessments which consider the organisation's leadership and governance.

Segmentation

Rotherham Doncaster and South Humber NHS Foundation Trust received the segmentation rating of 3 (most recently published rating). This decision related to the trust receiving deficit support funding which override performance in the other domains regardless of how good performance is. Absent this override the trust would be rated in segment 2.

This segmentation information is the trust's position as at 2 April 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: <https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/>. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: <https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/> The trust is included on the non-acute trust dashboard.

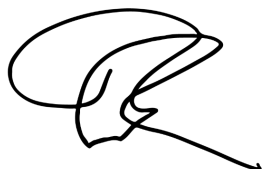
Counter Fraud, Bribery and Corruption

The NHS counter fraud authority provide the framework through which trust's sought to minimise losses through fraud. The chief executive and director of finance and estates are jointly responsible for ensuring the trust meets its obligation and are supported by the local counter fraud specialist (LCFS). In addition, the Director of corporate assurance is the trust's fraud champion. A work plan has been completed in the year by the LCFS. The work plan addresses the requirements of the trust's counter fraud, bribery and corruption policy. The key aims are to seek to proactively create an anti-fraud culture, implement appropriate deterrents and preventative controls and to ensure that allegations of fraud are appropriately investigated.

Regular reports are received throughout the year by the Audit Committee as well as an annual report. Reported concerns have been investigated by our LCFS specialists in liaison with the NHS counter fraud authority (CFA) and the police as necessary. The Audit Committee reviewed the levels of fraud reported and detected, and the arrangements in place to prevent, minimise and detect fraud and bribery.

Further information on policy is provided with the staff report (see page 23).

Accountability report signed on behalf of the board of directors



Toby Lewis, Chief Executive

25 June 2026

Statement of the chief executive's responsibilities as the accounting officer of Rotherham Doncaster and South Humber NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Rotherham Doncaster and South Humber NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Rotherham Doncaster and South Humber NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. To the best of my knowledge and belief, I have properly

discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

A handwritten signature in black ink, consisting of a large, stylized 'T' followed by a series of loops and a long, sweeping underline.

Toby Lewis, Chief Executive

25 June 2026

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS foundation trust accounting officer memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Rotherham Doncaster and South Humber NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Rotherham Doncaster and South Humber NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The trust's capacity to manage risk is supported by clear leadership, established governance arrangements, and a shared understanding of risk appetite. Risk management is embedded in how the organisation plans and delivers services, supporting informed decision making and a consistent focus on patient safety, staff wellbeing, and service sustainability.

Leadership of the risk management process is provided at both executive and operational level. The Risk Management Group (RMG), chaired by the chief nursing officer, plays a central role in overseeing how risks are identified, assessed, and managed across the organisation. The RMG provides focused review and challenge of all risks assessed as outside the trust's agreed risk tolerance, ensuring that they are clearly described, appropriately owned, and supported by proportionate mitigating actions. The group also considers alignment with the trust's risk appetite, helping to ensure consistency in how risk is understood and managed across services.

The RMG sits within the wider governance structure and reports into the Clinical Leadership Executive, ensuring that significant risks and emerging themes inform senior clinical and organisational decision making. Executive Directors lead on key areas of risk within their portfolios and are actively involved in reviewing risk position, progress with actions, and any changes in risk exposure. The Audit Committee receives regular updates on the effectiveness and development of the trust's risk management framework. The Board itself considers a risk register report at each meeting, with a focus on risks outside risk tolerance, it also assesses low likelihood, high impact risks. Separately cyber related risks are considered with two formal reports to the Board each year, as a minimum.

Staff across the trust are supported to manage risk in a way that reflects their roles and responsibilities. This includes access to proportionate training, targeted workshops for senior managers and risk owners, and ongoing support from risk and governance leads working closely with directorates. Clear guidance, templates, and tools are available to support consistent risk assessment and escalation, risk management features on the first day of the trust's induction and take up the RADAR tool introduced by the trust in May 2025 is monitored and addressed in supervision.

The trust places emphasis on learning and continuous improvement. Good practice and shared learning are identified through review of risk information, governance discussions, and thematic analysis. Together, these arrangements support an open and reflective approach to risk, where concerns are identified early, discussed openly, and managed in line with the trust's values and agreed risk appetite.

The risk and control framework

Both the trust's risk management framework and the risk appetite framework set out how risks are identified, assessed, managed, and monitored, and how assurance is obtained that key controls are operating effectively. The frameworks support safe, high-quality care and compliance with statutory and regulatory requirements and is embedded within the trust's governance arrangements.

Risks are identified through routine operational activity, incident reporting, quality and performance monitoring, service change, and internal and external review. Risks are assessed using a consistent scoring methodology and reviewed regularly to reflect changes in likelihood or impact. The Board of Directors agreed a risk appetite statement for each category (and subcategory) of risk. Purposefully, this approach recognises that not all risks can or should be avoided and that informed risk taking is sometimes necessary to deliver better outcomes. The appetite framework reflects both our internal priorities and the external environment we operate in and has been shaped through engagement with leaders across clinical, corporate roles. This guides decision making and supports consistency in how risks are escalated and managed across the organisation.

Oversight of risk is provided through established governance routes. The Risk Management Group reviews risks across the organisation, including all risks assessed as outside the trust's agreed tolerance, and ensures that appropriate mitigating actions are in place. All 23, now 24, directorates have recorded risks, with the greatest proportions categorised as 'People', 'Performance' and Patient Care' accounting over three-quarters of all recorded risks. Strategic and significant risks are subject to executive ownership and Board and committee oversight, providing assurance that they are being actively managed.

Risk management is a feature of the trust's delivery review process. A root and branch review of clinical directorates risks took place in September 2025, following on from a similar exercise with backbone directorates in August. This sequence will be repeated in 2026, against a backdrop of actions taken since to address teams who are low or non reporters of risk.

Quality governance is integral to the risk and control framework. Quality and performance information is reviewed routinely at operational, executive, and Board level, with triangulation of data used to support effective oversight. Assurance on compliance with

CQC registration requirements is obtained through ongoing self-assessment, audit, performance reporting, and learning from inspections and well-led reviews.

During April 2025 to March 2026, the Board has very actively sought assurance by reference to the CQC framework. In May and July 2025, it considered detailed reports and set an ambition to achieve self-assessed good ratings before the close of the period. This was reported, discussed and agreed in the public meeting in January 2026. An in-depth evidence vault investigation by executive and non-executive Board members took place, alongside clinical staff, in April 2026.

The trust is committed to supporting patient safety by ensuring information is accessible, its integrity is protected against loss or damage, and confidentiality is maintained. The trust recognises that information handling represents a corporate risk in that, failures to protect information properly, or to use it appropriately, can have a damaging impact on the safety of our patients and the reputation of the organisational.

Information risk management is monitored via our information risk management framework. As part of this, information risks are clearly recognised, and the appropriate controls implemented through the risk management framework. The senior information risk owner (SIRO) is responsible for overseeing the development and implementation of the information risk management framework. The SIRO is supported in this by the information governance (IG) team and by the information asset owners (IAO) within each business area. IAO's are responsible for managing information risks to the assets within their control. Until March 2026 the SIRO was Richard Banks, and with his departure this role is now independent of the wider informatics governance, undertaken by Phillip Gowland.

Quality of data is overseen by the information quality work programme, which audits and kitemarks key performance metrics set by the trust as part of its floor to board assurance and reported to the Finance Digital and Estates Committee. More broadly the performance team who are embedded in operational services undertake regular data quality samples of the performance data reported both internally and externally. Audit work suggests that there is a strong basis for overall data quality governance but improvements needed in local operational guidance.

The trust recognises that effective governance is central to compliance with the NHS provider licence, particularly in relation to licence condition 4. Risks to compliance are managed through clear governance structures, defined responsibilities for directors and committees, and well-established reporting lines between the Board, its subcommittees, and the executive team.

Timely and accurate information is provided to support assessment of performance and risk, enabling the Board to maintain effective oversight of the trust's activities. The degree and rigour of Board oversight are supported through regular reporting, challenge, and assurance processes, ensuring that governance arrangements remain effective and proportionate.

NHS Foundation Trust License Conditions Compliance

As an NHS foundation trust, the trust is required by its license to apply relevant principles, systems and standards of good corporate governance (FT4). To discharge this requirement the trust has a board of directors and committee structure with responsibilities

set out in formal terms of reference. The board and its committees have associated reporting lines, performance and risk management systems. Each committee is chaired by a non-executive director and has an associated executive team member as its executive lead. The work plans of the committees are reviewed regularly, and the board considers any proposed amendments to their terms of reference.

A self-assessment of compliance against the trust's licence is undertaken by the director of corporate assurance. The board of directors has not identified any principal risks to compliance with provider licence condition FT4 and is satisfied with the timeliness and accuracy of information to assess risks to compliance with the provider licence and degree of rigour of oversight it has over performance.

The trust also has a comprehensive programme of internal audit in place aligned to key areas of potential financial and operational risk. This will increasingly be examined, set, and managed alongside our clinical audit programme, as we look to work on an integrated basis.

Stakeholder relations

The trust recognises the importance of working in partnership with others including statutory organisations, voluntary sector and communities. During the year April 2025 to March 2026, we have continued to review our key partnerships with stakeholders in Rotherham, Doncaster and North Lincolnshire and across the two integrated care systems that we work in. We have also created a partnership scorecard to help guide and develop our partnership work. Our approach to managing stakeholder relations and partnerships was rolled out in the year April 2025 to March 2026, which involved executive directors taking a relationship manager role with each key partner. The Public Health, Patient Involvement and Partnerships Committee (PHPIP) has a remit to focus on our partnership working.

The trust has a social enterprise called "Flourish". Flourish was formed in 2014 and is a wholly owned subsidiary of the trust. It is incorporated as a community interest company and is registered with Companies House. It was established with the following objectives that improve people's health and wellbeing:

- to provide work, vocational training and therapeutic opportunities to the people who need our support
- to work with partners and stakeholders to provide a valuable contribution to the local economy
- to provide opportunities for community involvement.

The trust is also the lead provider for the South Yorkshire Adult Eating Disorder Provider Collaborative. This includes commissioning beds from independent sector providers that is supported by financial and quality oversight: this is delivered through a joint agreement with other providers in South Yorkshire. Funding is provided via NHS England's specialist commissioning team. The purpose is to provide the highest quality eating disorder care that is person centred, supports recovery, is responsive and is delivered as close to home as possible. By doing this we are reducing the need of people to need care in hospital and support people to lead successful lives supported in their local community.

The trust has a range of patient and public involvement activities and consultation with its communities and empowering them. There are many examples of this. We work with our

voluntary and charity sectors to deliver our Aspire drug and alcohol services. This includes a strong peer support model. In Rotherham we have invested fully in community resources to support individuals beyond traditional service boundaries. Local community groups were micro-commissioned and funded according to the needs of our service users and were provided in communities across Rotherham. This included peer support, befriending, activity and exercise. We have also supported community groups through our charitable funds, where organisations are working in partnership with services in the trust.

The People Focused Group (PFG) working in the voluntary sector are our patient participation partner and together we engage with many parts of our communities to work with them on designing and delivering services. PFG deliver part of our services for people experiencing a mental health crisis by providing the safe space service in Doncaster. The service is delivered by a large network of peer support workers and provides much needed care to our communities. We also commission PFG to provide a range of other community-based services in Doncaster.

As part of our strategic plan promise 5, we have actively sought to make our work on involvement go further. We have systematically started to 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. This includes:

- annual priorities set by our Council of Governors, who hold the Board of Directors to account for delivery
- apply patient participation tests to new policies and plans developed within the trust
- support active membership participation in the work of the trust, implementing the membership offer that was agreed in the year April 2024 to March 2025
- peers form part of senior level interview panels consistently, albeit this needs to be expanded to senior clinical hires over the coming year
- patients sit within our Clinical Leadership Executive (CLE) and its subgroups, and governors sit within our Board committees, the largely now populated and active governing body is a further step change
- a shadow CLE, known as the Communities Leadership Executive, made up of community representatives, has recently come into being as a key, and growing, part of our decision-making structure

Safe staffing and workforce development

The trust continues to have regard for the national quality board (NQB) requirements, endorsed by the Care Quality Commission. The guidance articulates for all NHS providers the accountabilities in respect of safe sustainable and productive staffing and recommends that the board of directors should have processes in place to provide assurance that the right staff with the right skills are in the right place at the right time. It acknowledges that validated tools are not common in all settings or professions, and the focus of much data analysis therefore remains on nursing roles in inpatient settings.

We contribute to the national reporting system by submitting our data and providing insights into our staffing levels and practices. This shared information contributes to a broader understanding of healthcare staffing across the country.

Internally, we maintain our own safe staffing data. This data helps us to ensure safe and effective management on our wards. By closely monitoring our staffing levels, we ensure a secure and supporting environment for both our staff and the individuals under our care.

The trust's safe staffing policy describes the process that should be followed to anticipate, plan and manage optimal staffing requirements. The policy provides guidance to ensure that rosters are safe, balanced and efficient. It also outlines the required actions and governance arrangements required to support the management of rosters and escalation mechanisms where there are shortfalls in staffing number. Internal audit review of this system, formalised in February 2026, has suggested some adaptations of this governance which are being implemented.

Safe staffing is monitored continuously at operational level, formally declared through the Quality & Safety Group, scrutinised and endorsed by the Quality Committee, and ultimately acknowledged and overseen by the Board of Directors in line with National Quality Board requirements. The appropriateness of current levels was confirmed to the Board in November 2025 by the Chief Nurse, following the receipt of the bi-annual report on safe staffing at the Quality Committee in November 2025.

In line with national guidance the trust also reports via UNIFY (a reporting system to NHS England) each month the care hours per patient day (CHPPD) data. In April 2026 the trust has additionally implemented the SafeCare tool, which will support us to use care hours more routinely on our operational management of staffing.

All service changes have a quality and safety impact assessment (QSIA) and are reviewed by the QSIA panel. This provides scrutiny and advice on monitoring arrangements. In October 2025 the trust's Board agreed engagement work with staff on significant service changes. A detailed and public process moved to statutory change consultation from 2 February 2026 which concluded on 6 March 2026. Prior to the consultation detailed QSIA material was developed, with patient involvement, and shared with the Board to inform its decision making. That material was then included with consultation materials to be further informed by staff feedback. At the conclusion of consultation, when decisions over change were made the QSIA material was revisited, a set of KPIs are now in place to track 'red flags' for key data items at a team specific level as the trust begins to implement the consulted upon changes. Redeployment of staff associated with the changes is continuing, and a separate wellbeing framework is in place for impacts on those affected and those with whom they work. Both will have Board visibility through the year ahead.

Compliance Statements

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the managing conflicts of interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a green plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Finance, Digital and Estates Committee (FDEC) and ultimately the board of directors ensure through a series of robust review mechanisms, that the use of resources is planned in an efficient and effective manner, and that our financial position is monitored and scrutinised. They oversee the monthly position against the approved financial plan for the year though their primary focus is underlying financial viability on a multi-year basis.

I have responsibility for ensuring that the resources used in the day-to-day operational activities of the trust are done so in an economic, efficient and effective manner. This is discharged through two formal systems. A subgroup of the clinical leadership executive oversees financial performance. Every month by rotation our care groups and each corporate directorate undertake a delivery review, where alongside safety, workforce and wider delivery matters, financial control is discussed, and relevant actions taken.

In addition to the monthly budgetary control system, the trust ensures economy, efficiency and effectiveness as well as value for money through the implementation of a suite of effective and consistently applied financial controls, effective tendering procedures and procurement practices, robust establishment controls and continuous service improvement and modernisation programmes. Our standing financial instructions have been reviewed and revisited in-year.

We have a bi-monthly Audit Committee that includes reports from internal and external audit. The auditors provide their respective views to the committee on our overall governance and control processes. The Audit Committee also receives a quarterly update of losses, special payments and single quote and tender and waivers. The Finance, Digital and Estates Committee and the Audit Committee are two of the eight committees put in place by the board of directors as part of its governance structure. For further details on the structure and the attendance of directors at meetings of the board (see page 52). In addition, please also refer to the annual statement on remuneration regarding the senior managers' remuneration (see pages 53 to 54). The annual assessment of compliance statement with the Corporate Governance Code is provided in the Annual Report, see pages 69 to 72.

Information governance

The trust has a nominated senior information risk officer (SIRO) at executive level who has nominated responsibility for information risk. The data protection officer (DPO) oversees data protection compliance throughout the trust and provides independent advice.

Information Governance, IT and Cyber incidents are monitored through the Information Governance and Cyber Group (chaired by the SIRO) on a monthly basis. During the year April 2025 to March 2026 there were 478 incidents reported (572 incidents were reported

in the year April 2024 to March 2025). Five of which required notification to the Information Commissioner via the Data Security and Protection Toolkit.

No action was taken by the ICO for any of the reported incidents.

Data quality and governance

Throughout the year April 2025 to March 2026, the trust maintained a comprehensive framework for assuring the quality of performance and operational data used for internal management, board assurance and statutory reporting.

Strategic oversight of data quality was provided through the information quality work programme, which undertook structured audit and kitemarking of a defined set of critical performance metrics, including waiting time data. These metrics were aligned to the trust's floor to board assurance model and routinely reported through the integrated quality and performance report (IQPR). Formal assurance on metrics that had achieved kitemark status was reported to the Finance, Digital and Estates Committee, providing senior level oversight of data integrity.

In parallel with this programme, the performance team, working closely with operational colleagues carry out regular data quality sampling of both internally used and externally submitted performance data. This activity provided ongoing operational assurance and supported early identification and resolution of data quality issues.

The trust's data quality arrangements during the year April 2025 to March 2026 were underpinned by a suite of corporate documents, including the Data Quality Policy, Management Information Guide, and Quality Assurance and Performance Framework Flowchart. These documents set out clear standards for report development, validation and sign off, with data quality testing embedded at each stage of the reporting process. The Management Information Guide also clarifies roles and responsibilities for data ownership, ongoing monitoring and escalation.

Operational oversight of data quality issues is coordinated through the Data Quality Group. The group reviewed audit findings, considered emerging data quality risks and tracked the delivery of corrective actions. The group reports into the Digital Transformation Group, with onward escalation and assurance provided to the Clinical Leadership Executive (CLE) as part of the trust's wider governance arrangements.

Management of waiting times during the year April 2025 to March 2026 was governed by the trust's access and waiting times policy, which defined the services to which referral to treatment (RTT) principles apply.

The performance team monitor waiting times on a monthly basis, providing routine reporting to responsible care groups and escalating risks where performance or data quality concerns were identified. Investigation of potential data quality issues formed an integral part of this monitoring and escalation process.

Review of effectiveness

Based on the work undertaken during the year April 2025 to March 2026 the Head of Internal Audit has stated that their Head of Internal Audit Opinion as significant assurance as detailed below:

I am providing an opinion of **significant assurance** that there is a generally sound framework of governance, risk management, and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

The output of individual audit assignments has been largely positive, with six significant and three moderate assurance opinions provided. We note that the moderate opinions have all arisen in the quality domain, although the Trust demonstrates a commitment to improvement and culture of learning in these areas, our audits assessed that control frameworks need to become better embedded and more consistently applied. The action implementation rate has been high throughout the year, concluding at 90% of high and medium risk actions implemented on time.

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee, the Quality Committee, the People and Organisational Development Committee, the Finance, Digital and Estate Committee, Public Health, Patient Involvement and Partnerships Committee and the Mental Health Act Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

During the period from April 2025 to March 2026, we have more fully embedded an operating model that we adopted through our board of directors in late 2023. Two reviews of that model in practice, commissioned through Good Governance Institute (GGI), suggest good adherence to the intent of those changes, and particularly positive changes in the involvement of patients' voices within our processes. We await formal receipt of a report from The Values Circle against the Well-Led Framework. Importantly, during the year, the Board has reviewed practice against the Board Capability Assessment standards issued by NHS England. Our self-assessment was validated in full by NHS England: with the highest assessment in most areas, but room for improvement in our culture and in our use of data in assessing patient safety and quality.

In considering our controls in practice, I do not have material concerns to highlight. I actively considered whether our arrangements to tackle racism experienced by some colleagues required consideration here. Having reliance on our acceptable behaviour policy, improved implementation of disciplinary codes, and an openness now across the trust to these risks, I consider that we do not have material weaknesses but do need to give the subject continued and focused attention.

More widely, we have work to do to improve further, consistent with annual governance statements issued since 2023. The adoption of the RADAR system from 1 May 2025 has been important in providing senior leaders, but also staff across the organisation, with ready access to information on harms, incidents and risks. It will be used in future years to track policy compliance as well. Deployment of DIALOG+ provides a basis for all-age mental health services for standardising our care planning documentation and reducing a proliferation of approaches which pre-date this. Full implementation of both changes will be important in the coming six to twelve months, as we also reflect on a Prevention of Future Deaths notice which called into question the timeliness of some clinical documentation.

The considerable organisational change process on which we embarked from mid-year tested, and in places found wanting, the alignment of our finance and workforce data. This was at a local level in two care groups. In aggregate I remain satisfied by the alignment we achieved in 2024 and since, as evidenced by our delivery of the submitted workforce plan for the year, and by our congruence in annual plan submissions in February 2026. Our internal audit review of the revised arrangements for congruence in the coming year is shortly due to report, illustrating again an openness to adapt and learn. Similarly, we will receive a report on the governance of out of area placement finances in light of our success during 2025, reducing our margin or headroom for error in the future.

The substantial reduction in waiting times that we have achieved has, as expected, relied on good data quality, governance of that data quality, and feedback from staff and patients. The additional move to issue appointments inside one week is intended to provide choice and reflection time for patients and carers. Widely advertising the achievement of our wait time measures offers a further layer of assurance, as partners, practitioners and patients can challenge omissions and decisions made. It will be important to sustain our work to track and explain rates of declining referrals within pathways, as we seek a best fit service for patients in partnership with general practice.

We have continued to seek to embed the voices of patients and our staff in our management processes. The Quality Account for the period under review attests to real changes made as a result of patient feedback: and this work has been tested routinely in in year delivery reviews. I am personally aware of significant numbers of practice changes and policies arising from employee feedback, but it needs to be acknowledged that that awareness is not widely shared among our people and the latest staff survey, like several before it, requires of us all, me included, renewed efforts to tackle those perceptions and experiences. Our success in delivering promises 3, 4 and 5, and the work done with care opinion attest to a willingness to hear and to act as we seek to break down closed cultures inside our organisation.

In the year ahead we will 'up our game' in terms of business intelligence. This means both that we will become more rigorous in our use of scorecards at levels beyond our directorate tier, and that we will begin to share pushed data on performance and practice with individual senior clinicians. Both will in themselves help our data quality, not least as it is frontline staff who generate data, for example on ethnicity of patients attending, or the coding of diagnosis.

The Board should reflect positively on a number of internal audit review of topics that are perhaps not 'traditional' assurance areas. Reviews of partnering, of health inequalities, and of patient inclusion have all suggested a depth and subtlety to our work which is a

credit to those involved. None can be taken for granted looking forward and we know that to be effective in supporting true neighbourhood health all need to be nurtured further.

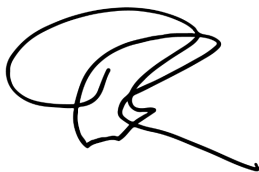
Conclusion

The progression of the trust from limited assurance in 2024 to significant assurance in 2026 is a welcome indication of progress and attention. The trust's control regime is strong, but our ability to improve care rests on depth and breadth of leadership.

Importantly over the year under review, we have been active in implementing a range of management and leadership development programmes to develop better consistency of how we are led. Among first time managers, clinicians in management, and those working corporately including among the executive group. These interventions attest to a determination to ensure that good quality leadership practice is distributed, as we begin to work towards a high care and high challenge model of leadership for coming years.

Directorate led working will allow frontline managers to make decisions and manage risk, whilst more senior leaders focus on the challenges presented by the future landscape of population need, workforce supply, and financial constraint. We are not yet as advanced in that directorate tier as we would wish to be, but it is this tier and those within our frontline team leadership roles whose efforts and successes will define the period to 2028. Sustaining our promises and leading with care is something that relies on many voices and talents and we will continue to invest time and attention in supporting that for the long term.

With the continued, and further improved use, of outcome data to manage quality and safety, the controls we have position the trust well to meet the future challenges of the NHS locally. Consistent application of our best practice needs to be the focus of our drive to further improve the effectiveness of our approach, which we had committed will be community powered, clinically led, and system enabled. No significant internal control issues have been identified, but it can continue to be improved in the specific respects outlined by my review and that of our auditors and advisors. This view has been discussed with our audit committee and board of directors prior to being issued here.



Toby Lewis, Chief Executive

25 June 2026

AUDITORS REPORT

Independent auditor's report to the Council of Governors and Board of Directors of Rotherham Doncaster and South Humber NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Rotherham Doncaster and South Humber NHS Foundation Trust (the 'Foundation Trust') and its subsidiaries (the 'Group'):

- give a true and fair view of the state of the Group's and the Foundation Trust's affairs as at 31 March 2026 and of the Group's and Foundation Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the Consolidated Statement of Comprehensive Income;
- the Group and Foundation Trust Statements of Financial Position;
- the Group and Foundation Trust Statements of Changes in Taxpayers' Equity;
- the Group and Foundation Trust Statements of Cash Flows; and
- the related notes 1 to 38.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the Group and the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material

uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Foundation Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the Group and the Foundation Trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of the chief executive's responsibilities as the accounting officer, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the Group's and the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Foundation Trust without the transfer of the Foundation Trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from

fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

We considered the nature of the Group and its control environment, and reviewed the Group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and local counter fraud, about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the Group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the Group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address it are described below:

- Validity of accrued expenditure. This is the area that we believe is most susceptible to manipulation by management given the level of judgement involved. We have tested a sample of accruals to supporting documentation to assess whether the liability had been incurred as at 31 March 2026.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management and internal audit concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, reviewing internal audit reports, and reviewing correspondence with NHS England and the Care Quality Commission.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of these matters.

Respective responsibilities of the accounting officer and auditor relating to the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether

the Foundation Trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the Foundation Trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026 by the time of the issue of our audit report. Other findings from our work, including our commentary on the Foundation Trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

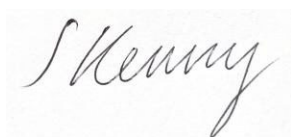
As at the date of this audit report, we have not yet completed our work in respect of the Trust's consolidation returns for the year ended 31 March 2026 and have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Rotherham Doncaster and South Humber NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of the

National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

This report is made solely to the Council of Governors and Board of Directors (“the Boards”) of Rotherham Doncaster and South Humber NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

A handwritten signature in black ink, reading "Stuart Kenny", is displayed on a light grey background.

Stuart Kenny (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Newcastle upon Tyne, United Kingdom
26 June 2026

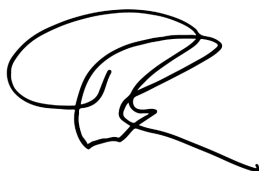
ACCOUNTS

Foreword to the accounts

Rotherham Doncaster and South Humber NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Rotherham Doncaster and South Humber NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed



Name	Toby Lewis
Job Title	Chief Executive
Date	25 June 2026

Consolidated Statement of Comprehensive Income for the year ended 31 March 2026

Group

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	252,969	235,706
Other operating income	4	14,153	13,372
Operating expenses	6	(267,914)	(247,878)
Operating (deficit)/surplus		(792)	1,200
Finance income	11	1,457	1,873
Finance expenses	12	(2,024)	(1,898)
PDC dividends payable		(2,369)	(2,257)
Net finance costs		(2,936)	(2,282)
Other (losses)/gains	13	(11)	54
Deficit for the year		(3,739)	(1,028)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,929)	(1,640)
Revaluations	16 and 17	9,065	1,334
Remeasurements of the net defined benefit pension scheme liability / asset	33	18	(162)
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains on financial assets mandated at fair value through OCI	20	96	28
Other comprehensive income/(expense) for the year, net of tax		7,250	(440)
Total comprehensive income/(expense) for the period		3,511	(1,468)

Consolidated and Trust Statement of Financial Position as at 31 March 2026

		Group		Trust	
		31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Non-current assets	Note				
Intangible assets	15	1,849	2,372	1,849	2,372
Property, plant and equipment	16	101,375	94,045	101,375	94,045
Right of Use Assets	19	16,548	12,492	16,548	12,492
Investment property	18	3,721	3,670	3,721	3,670
Other investments / financial assets	20	1,275	1,447	22	22
Receivables	24	135	145	135	145
Total non-current assets		124,903	114,171	123,650	112,746
Current assets					
Inventories	23	297	315	281	299
Receivables	24	10,008	7,297	10,090	7,340
Non-current assets held for sale	25	-	86	-	86
Cash and cash equivalents	26	30,568	32,208	29,870	31,421
Total current assets		40,873	39,906	40,241	39,146
Current liabilities					
Trade and other payables	27	(16,907)	(16,395)	(16,795)	(16,200)
Borrowings	29	(3,456)	(3,181)	(3,456)	(3,181)
Provisions	30	(1,620)	(653)	(1,614)	(653)
Other liabilities	28	(555)	(294)	(374)	(167)
Total current liabilities		(22,538)	(20,523)	(22,239)	(20,201)
Total assets less current liabilities		143,238	133,554	141,652	131,691
Non-current liabilities					
Borrowings	29	(31,552)	(28,841)	(31,552)	(28,841)
Provisions	30	(692)	(734)	(692)	(734)
Total non-current liabilities		(32,244)	(29,575)	(32,244)	(29,575)
Total assets employed		110,994	103,979	109,408	102,116
Financed by					
Public dividend capital		48,374	44,870	48,374	44,870
Revaluation reserve		44,311	37,307	44,311	37,307
Income and expenditure reserve		16,774	19,985	16,723	19,939
Charitable fund reserves	22	1,535	1,817	-	-
Total taxpayers' equity		110,994	103,979	109,408	102,116

The notes on pages 101 to 142 form part of these accounts.



Name: Toby Lewis
Position: Chief Executive
Date: 25 June 2026

Statement of Changes in Equity for the year ended 31 March 2026 - (Group)

Group	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2025		44,870	37,307	19,985	1,817	103,979
Surplus/(deficit) for the year		-	-	(3,361)	(378)	(3,739)
Transfer to retained earnings on disposal of assets		-	(132)	132	-	-
Net Impairments	7 and 16	-	(1,929)	-	-	(1,929)
Revaluations	16 and 17	-	9,065	-	-	9,065
Fair value gains on financial assets mandated at fair value through OCI		-	-	-	96	96
Remeasurements of the defined net benefit pension scheme liability/asset	33	-	-	18	-	18
Total comprehensive income/(expense) for the period		-	7,004	(3,211)	(282)	3,511
Public dividend capital received		3,504	-	-	-	3,504
Taxpayers' and others' equity at 31 March 2026		48,374	44,311	16,774	1,535	110,994

Statement of Changes in Equity for the year ended 31 March 2025 - (Group)

Group	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2024		42,530	37,613	20,672	2,292	103,107
Surplus/(deficit) for the year		-	-	(525)	(503)	(1,028)
Net Impairments	7 and 16	-	(1,640)	-	-	(1,640)
Revaluations	16 and 17	-	1,334	-	-	1,334
Fair value gains on financial assets mandated at fair value through OCI		-	-	-	28	28
Remeasurements of the defined net benefit pension scheme liability/asset	33	-	-	(162)	-	(162)
Total comprehensive expense for the period		-	(306)	(687)	(475)	(1,468)
Public dividend capital received		2,340	-	-	-	2,340
Taxpayers' and others' equity at 31 March 2025		44,870	37,307	19,985	1,817	103,979

Statement of Changes in Equity for the year ended 31 March 2026 (Trust)

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025		44,870	37,307	19,939	102,116
Surplus/(deficit) for the year		-	-	(3,366)	(3,366)
Transfer to retained earnings on disposal of assets		-	(132)	132	-
Impairments	7 and 16	-	(1,929)	-	(1,929)
Revaluations	16 and 17	-	9,065	-	9,065
Remeasurements of the defined net benefit pension scheme liability/asset	33	-	-	18	18
Total comprehensive income for the period		-	7,004	(3,216)	3,788
Public dividend capital received		3,504	-	-	3,504
Taxpayers' and others' equity at 31 March 2026		48,374	44,311	16,723	109,408

Statement of Changes in Equity for the year ended 31 March 2025 (Trust)

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024		42,530	38,383	20,628	101,541
Surplus/(deficit) for the year		-	-	(527)	(527)
Impairments	7 and 16	-	(1,640)	-	(1,640)
Revaluations	16 and 17	-	1,334	-	1,334
Other - Trust only Investment Property classification		-	(770)	-	(770)
Remeasurements of the defined net benefit pension scheme liability/asset	33	-	-	(162)	(162)
Total comprehensive expense for the period		-	(1,076)	(689)	(1,765)
Public dividend capital received		2,340	-	-	2,340
Taxpayers' and others' equity at 31 March 2025		44,870	37,307	19,939	102,116

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 22.

Statements of Cash Flows

	Note	Group		Trust	
		2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Cash flows from operating activities					
Operating (deficit)/ surplus		(792)	1,200	(379)	1,774
Non-cash income and expense:					
Depreciation and amortisation	6	6,708	6,553	6,708	6,553
Net impairments	7	3,184	(41)	3,184	(41)
Income recognised in respect of capital donations		(36)	(44)	(36)	(44)
Non-cash movements in on-SoFP pension liability		18	(19)	18	(19)
Decrease/ (increase) in receivables and other assets		(2,702)	(981)	(2,729)	(695)
Decrease/ (increase) in inventories		18	305	18	303
Increase/ (decrease) in payables		50	(235)	138	(164)
Increase/ (decrease) in other liabilities		261	(109)	207	(124)
Increase/ (decrease) in provisions		919	430	913	430
Movements in charitable fund working capital		17	2	-	-
Other movements in operating cash flows		-	(42)	(1)	(40)
Net cash flows from operating activities		7,645	7,019	8,041	7,933
Cash flows from investing activities					
Interest received		1,403	1,805	1,400	1,800
Purchase of intangible assets		(152)	(833)	(152)	(833)
Purchase of PPE and investment property		(7,523)	(6,274)	(7,523)	(6,274)
Sales of PPE and investment property		106	9	106	9
Cash flows from charitable fund investing activities		36	87	-	-
Net cash flows used in investing activities		(6,130)	(5,206)	(6,169)	(5,298)
Cash flows from financing activities					
Public dividend capital received		3,504	2,340	3,504	2,340
Movement on loans from DHSC		(363)	(363)	(363)	(363)
Capital element of lease liability repayments		(1,398)	(1,337)	(1,398)	(1,337)
Capital element of PFI, LIFT and other service concession payments		(1,395)	(1,224)	(1,395)	(1,224)
Interest on loans		(129)	(144)	(129)	(144)
Other interest		(2)	-	(2)	-
Interest element of lease liability repayments		(168)	(147)	(168)	(147)
Interest paid on PFI, LIFT and other service concession obligations		(1,092)	(1,157)	(1,092)	(1,157)
Net cash flows from charitable fund financing activities		268	645	-	-
PDC dividend paid		(2,380)	(2,629)	(2,380)	(2,629)
Net cash flows used in financing activities		(3,155)	(4,016)	(3,423)	(4,661)
Increase/ (decrease) in cash and cash equivalents		(1,640)	(2,203)	(1,551)	(2,026)
Cash and cash equivalents at 1 April		32,208	34,411	31,421	33,447
Cash and cash equivalents at 31 March	26	30,568	32,208	29,870	31,421

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, investment properties and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Fund

The Trust is the corporate trustee to the Rotherham Doncaster and South Humber NHS charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients, and staff from its involvement with the charitable fund and could affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March each year in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities, and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

Flourish Enterprises Community Interest Company (Flourish) is a wholly owned subsidiary of the Trust.

Subsidiary entities are those over which a Trust is exposed to, or has rights to, variable returns from its involvement with the entity and can affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The amounts consolidated are drawn from the financial statements of the subsidiary for the year ended 31 March 2026.

Flourish prepares its financial statements in accordance with Financial Reporting Standard 102.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102), then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office for National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Payment is typically received within thirty days of the satisfaction of the performance obligations and as such has no impact on contract balances.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Mental health provider collaboratives

NHS led provider collaboratives for specialised mental health, learning disability and autism services involve a lead NHS provider taking responsibility for managing services, care pathways and specialised commissioning budgets for a population. As lead provider for the South Yorkshire Adult Eating Disorder Provider Collaborative, the Trust is accountable to NHS England and as such recognises the income and expenditure associated with the commissioning of services from other providers in these accounts. Where the trust is the provider of commissioned services, this element of income is recognised in respect of the provision of services, after eliminating internal transactions.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income (SOCi) to match that expenditure. Where the grants are used to fund capital expenditure, they are credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

There are Trust employees that are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

The Trust's involvement with the Local Government Pension Scheme is subject to an asset ceiling or cap which limits the asset value recorded within these accounts.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis. A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss (if any). Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Assets which are not sufficiently low value and/or do not have sufficiently short lives are valued at depreciated historic cost as a proxy for current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated, on a straight line basis, over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses (impairments) are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI)

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy 1.14).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is set out in note 16.4 of the accounts.

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust . They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it can operate in the manner intended by management.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives, on a straight line basis, in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is set out in note 15.1 of the accounts.

Note 1.10 Inventories

All of the Trust's inventories are in respect of consumables. Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.11 Investment Properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether they pay rent at market rates, are not classified as investment properties.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits held with established financial institutions claimable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of establishment and that are readily convertible to cash with insignificant risk of change in face value.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or present other financial instruments in settlement. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that, in all other respects, would be a financial instrument and do not give rise to transactions classified as a tax by the Office for National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost or fair value through other comprehensive income.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Impairment of financial assets

The Trust's financial assets which are measured at amortised cost, are in respect of contract and other receivables. At the Statement of Financial Position date, the Trust assesses whether any receivables are impaired. Financial receivables are impaired and credit losses recognised if, and only if, there is objective evidence of impairment because of one or more events which occurred after the initial recognition of the asset and which has an impact on future cash flows of the asset.

For financial assets measured at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying value and the expected future cash flow from the asset.

The Trust assess potential credit loss on an ongoing basis and makes provision based on actual credit loss. A review of historic credit loss provides evidence that such losses are not material and therefore the Trust does not make provision for expected general credit loss.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The trust as a lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior Year Rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	Exceeding 10 years	5.32%	4.81%
Very long-term	Exceeding 40 Years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior Year Rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme for which the Trust pays an annual contribution. NHS Resolution in turn settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed on note 30.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of these claims, are charged to operating expenditure when liability arises.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed on note 31 where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in note 31.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.18 Public dividend capital

Public dividend capital (PDC) is public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Value added tax

Most of the activities of the Trust are outside the scope of VAT. In general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax

All activities of the Trust are exempt from corporation tax. Flourish, the subsidiary of the Trust, is subject to corporation tax at the rate of 19% (2024/25:19%). The Corporate tax rates changes with government budgets.

Note 1.21 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. The Trust has very few foreign currency transactions.

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed on a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that arise outside the expected norms of operating services. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accrual basis.

Losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis except where they are provisions for future known losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated without preconditions and expectations of any returns. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

The Trust received no gifts in this or the previous reporting period.

Note 1.25 Early adoption of standards, amendments, and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IAS 16 The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in property plant and equipment valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. Property plant and equipment and right of use assets currently subject to revaluation are disclosed in note 16.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis are disclosed in note 16 to the accounts.

The expected impact of the above has not yet been assessed.

Note 1.27 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant impact on the amounts recognised in the financial statements:

Valuation of Buildings

The Department of Health and Social Care (DHSC) guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as 'the cost of a modern replacement asset that has the same productive capacity as the property being valued'. Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds but a theoretical calculation for accounting purposes of what the Trust could need to spend in order to replace the current assets. The Trust does this on an alternative site basis.

In determining the MEA the Trust developed Modern Equivalent Asset Value (MEAV) designs of an alternative site, and these have been reviewed and approved by its appointed Valuer (the Valuation Office Agency). The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, and would meet the service levels currently offered with no impact on service delivery or the level and volume of service provided. The Trust has no plans to implement any of the theoretical assumptions that underpin the MEA valuation.

The valuation of the Trust's land and buildings is done on a quinquennial (5-year) cycle, as per the Government Financial Reporting Manual (the FReM) adaptation of IAS 16 Property Plant and Equipment. This is supplemented by indexation and / or desktop revaluations in intervening years.

The last full revaluation of the Trust's land and buildings was done in 2023/24, with a desktop valuation having been carried out in 2024/25. The next full revaluation is due to be completed in 2028/29, per the FReM requirements.

In applying critical judgements, the Trust has satisfied itself that there is no material difference caused by performing a desktop revaluation in 2025/26 as compared with a full revaluation by confirming that there are no material changes to service delivery so the alternative site is still fit for purpose; and by disclosure of all capital expenditure on Trust buildings to the Trust's valuer for including in the desktop calculation and by disclosure of any significant dilapidations of buildings to the Trust's valuer for including in the desktop calculation. There were no significant dilapidations of buildings during 2025/26.

Note 1.28 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property valuation and asset lives:

Property valuations are undertaken by an independent external valuer. These values are subject to market conditions and market values. Asset lives are also estimated by the external valuer and are subject to their professional judgement. A 1% variation in value would result in a £0.95 m increase or decrease in the value of land and buildings and a 5% variation would result in an £4.75 m increase or decrease in the value of land and buildings. Valuation information is set out in note 16.

Accruals:

Estimates of accruals are based on the best available information. This is applied in conjunction with historic experience and individual circumstance.

Provisions

Provisions have been calculated after recognising obligating events during the year and include estimates and assumptions relating to the carrying amounts and timing of anticipated payments. Litigation provisions are based on estimates provided through NHS Resolution and injury benefit provisions calculated on figures from NHS Business Services Authority. Refer to Paragraph 1.16 and note 30 for further details.

A provision has been recognised for probable redundancy costs as a result of 55 staff members being placed at risk of redundancy in March 2026. The provision is the median of the average likely cost. The range of average possible cost is from £35k for one redundancy to £1.9m if all 55 staff were made redundant. Every effort is being made to redeploy these staff members and there are vacancies in the Trust so the worst case scenario is not realistic.

Local government pension scheme:

Estimation of the net liability of the local government pension fund depends on several complex judgements relating to the discount rate used, the rate at which salaries are projected to increase, changes in retirement ages, mortality rates and the expected return on pension fund assets. Sensitivity analysis is provided in Note 33.2. Hymans Robertson LLP is engaged through South Yorkshire Pension Fund to provide the Trust with expert advice on the assumptions used.

Note 2 Operating Segments

The activity of the Rotherham Doncaster and South Humber NHS Foundation Trust is healthcare. The Board of Directors is considered to be the chief operating decision maker (CODM); management information provided to the CODM reports activities as a whole and not segmentally.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)

	2025/26 £000	2024/25 £000
Mental health services		
Income from commissioners under API contracts*	144,003	143,359
Income for commissioning services in a mental health collaborative	3,386	4,168
Services delivered under a mental health collaborative	2,831	2,416
Clinical income for the secondary commissioning of mandatory services	1,274	-
Other clinical income from mandatory services	1,441	1,806
Community services		
Income from commissioners under API contracts*	62,162	50,531
Income from other sources (e.g. local authorities)	25,682	21,837
All services		
National pay award central funding**	-	20
Additional pension contribution central funding***	12,189	11,569
Private patient income	1	-
Total income from activities	252,969	235,706

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2025/26 £000	2024/25 £000
Income from patient care activities received from:		
NHS England	16,677	18,128
Department of Health and Social Care	-	257
Integrated care boards	207,039	191,116
Other NHS providers	4,272	4,222
Local authorities	24,778	21,837
Non NHS Private patients	1	-
Non NHS: other	202	146
Total income from activities	252,969	235,706

Note 4 Other operating income (Group)

	2025/26	2024/25
	£000	£000
Research and development	1,315	1,413
Education and training (excluding notional apprenticeship levy income)	6,596	6,674
Non-patient care services to other bodies	1,068	1,709
Income in respect of employee benefits accounted on a gross basis	1,102	1,220
Education and training - notional income from the apprenticeship fund	859	550
Receipt of capital grants and donations and peppercorn leases	36	44
Rental revenue from operating leases	905	593
Charitable fund incoming resources	661	317
Other contract income	1,611	852
Total other operating income	14,153	13,372

Note 5.1 Transaction price allocated to remaining performance obligations

	2025/26 £000	2024/25 £000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	34	187

Note 5.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26 £000	2024/25 £000
Income from services designated as commissioner requested services	228,191	214,809
Income from services not designated as commissioner requested services	38,931	34,269
Total	267,122	249,078

The income from activities arising from commissioner requested services is in respect of the consolidated income of the Trust and Flourish and excludes charitable fund income of £661,000 (2024/25 £317,000).

Note 5.3 Profits and losses on disposal of property, plant and equipment

There were sales of 3 owned assets and disposals of 4 leased assets in 2025/26 which resulted in a gain or loss on disposal (2024/25 – 1 owned asset).

The overall net loss on disposal of assets was £2k, comprised of gains on disposals of owned assets, £20k, and losses on disposal of Right of Use (RoU) assets, £22k.

The owned assets sold were one building, which had been classed as an Asset Held For Sale within the 2024/25 accounts, which was sold for a gain on disposal of £19k, and two estates vehicles (mower and utility vehicle), sold for scrap, at a gain on disposal of £1k.

The leased assets disposed were 4 RoU Leased buildings, all subject to early termination of the lease. At the point of disposal, all of these had a net book value within the Fixed Asset Register and a liability value within the Trust's borrowings. The net loss on disposal from these 4 assets was £22k.

The 3 owned assets were not used in the provision of commissioner requested services, but all of the 4 RoU assets were being used in the provision of commissioner requested services. Those services were transferred to a new RoU asset which had been acquired in 2024/25 and was used for service provision from October 2025.

Note 6 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC group bodies	16	20
Purchase of healthcare from non-NHS and non-DHSC bodies	10,595	5,136
Mental health collaboratives (lead provider) purchase of healthcare - from NHS bodies	72	64
Mental health collaboratives (lead provider) purchase of healthcare - from non-NHS bodies	2,645	4,330
Staff and executive directors costs	209,960	195,906
Remuneration of non-executive directors	162	173
Supplies and services - clinical (excluding drugs costs)	5,744	6,378
Supplies and services - general	2,865	2,349
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,598	3,610
Establishment	1,899	2,390
Premises - business rates paid to local authorities	749	820
Premises - other	7,863	7,696
Transport (including patient travel)	2,295	2,920
Depreciation on property, plant and equipment and right of use assets	6,033	6,024
Amortisation on intangible assets	675	529
Net impairments	3,184	(41)
Movement in credit loss allowance: contract receivables / contract assets	20	33
Change in provisions discount rate(s)	(11)	1
Audit fees payable to the external auditor *	240	277
Internal audit costs	112	125
Clinical negligence	645	754
Legal fees	578	627
Insurance (as a policy holder)	175	215
Research and development staff costs	1,297	1,466
Research and development non staff	28	14
Education and training staff costs	1,394	1,786
Education and training non staff	1,326	1,525
Expenditure on short term leases	466	493
Education and training - notional expenditure funded from the apprenticeship fund	859	550
Redundancy	306	206
Car parking & security	141	128
Losses, ex gratia & special payments	13	6
Other NHS charitable fund resources expended	1,075	888
Other	895	480
Total	267,914	247,878

Audit fees payable to the external auditor *

All below fees are inclusive of non recoverable VAT

Contracted fee	231	221
Additional fees in relation to 23/24 paid in 24/25	-	47
Flourish statutory audit undertaken by GBAC	9	9
Total	240	277

Additional fees of £47k for work on the 2024/25 accounts were accrued within the 2024/25 'Other' line of note 6 as an estimate before the year-end audit. The final fee charged was £35k.

Note 6.1 Limitation on auditor's liability (Group)

The limitation on the auditor's liability for external audit work is £1m (2024/25: £1m).

Note 7 Impairment of assets (Group)

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus resulting from:		
Changes in market price	3,184	(41)
Total net impairments charged to operating surplus	3,184	(41)
Impairments charged to the revaluation reserve	1,929	1,640
Total net impairments	5,113	1,599

As at 31 March 2026 land and buildings were valued using an alternative site methodology. This resulted in a net reversal of impairment to operating expenses of a debit for £3,184k (2024/25 -£41k credit) and a net impairment to the revaluation reserve of a debit of £1,929k (2024/25 £1,640k debit).

Note 8 Employee benefits (Group)

	2025/26 Total £000	2024/25 Total £000
Staff and executive directors costs *	155,350	149,480
Non - executive directors	162	173
Social security costs	18,978	14,238
Apprenticeship levy	716	697
Employer's contributions to NHS pensions	18,686	17,814
Pension cost - employer contributions paid by NHSE on provider's behalf	12,189	11,569
Pension cost - other	81	90
Temporary staff - external bank **	6,342	2,719
Temporary staff (agency)	813	2,956
Total gross staff costs	213,317	199,736
Included within		
Costs capitalised as part of assets	198	199
Total employee benefits excluding capitalised costs	213,119	199,537
Operating expenditure analysed as:		
Employee expenses - staff and executive directors	210,122	196,079
Research and development	1,297	1,466
Education and training	1,394	1,786
Termination benefits - redundancy	306	206
Total	213,119	199,537

* The Trust operated an internal staff bank up to 20th October 2024.

** Internal bank staff transferred to NHS Professionals from 21 October 2024.

Note 8.1 Retirements due to ill-health (Group)

During 2025/26 there were 4 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £119k (£427k in 2024/25).

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Local government pension scheme

Some employees are members of the Local Government scheme, which is a defined benefit scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's financial statements. The assets are measured at fair value and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan is recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

NEST pension scheme

Some employees are members of the NEST pension scheme, a scheme set up by Government to enable employers to meet their pension duties and is free for employers to use. Employee and employer contribution rates were a combined minimum of 5% (with a minimum of 2.1% contributed by the Trust) up to October 2018; from 2018 the combined contribution is 8% (with a minimum of 3% contributed by the Trust).

Employer contributions in 2025/26 were £81k (24/25: £90k).

Note 10 Operating leases (Group)

This note discloses income generated in operating lease agreements where Rotherham Doncaster and South Humber NHS Foundation Trust is the lessor.

The receipts in the main are for building rental income.

Note 10. 1 Operating leases income (Group)

	2025/26	2024/25
	£000	£000
Operating lease revenue		
Minimum lease receipts	905	593
Total	905	593

	31 March 2026	31 March 2025
	£000	£000
Note 10.2 Future lease receipts (Group)		

Future minimum lease receipts due in:

- not later than one year	932	615
Total	932	615

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,421	1,786
NHS charitable fund investment income	36	68
Other finance income	-	19
Total finance income	1,457	1,873

Note 12 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2025/26	2024/25
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	129	143
Interest on lease obligations	217	148
Main finance costs on PFI and LIFT schemes obligations	1,092	1,157
Interest on late payment of commercial debt	2	-
 Remeasurement of the liability resulting from change in index or rate	 560	 437
Total interest expense	2,000	1,885
 Unwinding of discount on provisions	 6	 13
Other finance costs	18	-
Total finance costs	2,024	1,898

Note 12.1 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	2	-
 Compensation paid to cover debt recovery costs under this legislation	 -	 -

Note 13 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	23	9
Loss on disposal of assets	(25)	-
Total (losses)/gains on disposal of assets	(2)	9
Fair value (losses)/gains on investment properties	(9)	45
Total other (losses)/gains	(11)	54

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's deficit for the period was £3.366m (2024/25: £0.527m deficit). The Trust's total comprehensive expense for the period was £3.788m surplus (2024/25: £1.765m deficit).

Note 15 Intangible assets - 2025/26

Group and Trust	Software licences £000	Total £000
Cost at 1 April 2025 *	4,924	4,924
Additions	152	152
Disposals / derecognition	(207)	(207)
Cost at 31 March 2026	4,869	4,869
Amortisation at 1 April 2025	2,552	2,552
Provided during the year	675	675
Disposals / derecognition	(207)	(207)
Amortisation at 31 March 2026	3,020	3,020
Net book value at 31 March 2026	1,849	1,849
Net book value at 1 April 2025	2,372	2,372

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 15.1 Intangible assets - 2024/25

Group and Trust	Software licences £000	Total £000
Valuation / gross cost at 1 April 2024	5,887	5,887
Additions	833	833
Reclassifications	10	10
Disposals / derecognition	(1,806)	(1,806)
Valuation / gross cost at 31 March 2025	4,924	4,924
Amortisation at 1 April 2024	3,829	3,829
Provided during the year	529	529
Disposals / derecognition	(1,806)	(1,806)
Amortisation at 31 March 2025	2,552	2,552
Net book value at 31 March 2025	2,372	2,372
Net book value at 1 April 2024	2,058	2,058

Note 15.1 Useful economic life of intangible assets

Group and Trust	Min life Years	Max life Years
Software licenses	1	10

Note 16 Property, plant and equipment - 2025/26

Group and Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025	5,222	81,598	190	555	2,674	186	8,341	671	99,437
Additions	-	6,603	-	-	131	-	1,112	73	7,919
Additions - assets purchased from cash donations/grants	-	-	-	-	-	-	-	-	-
Impairments	-	(4,785)	-	-	-	-	-	-	(4,785)
Impairments charged to the revaluation reserve	-	(1,929)	-	-	-	-	-	-	(1,929)
Reversals of impairments	-	1,601	-	-	-	-	-	-	1,601
Revaluations	671	5,664	-	-	-	-	-	-	6,335
Reclassifications	-	555	-	(555)	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(50)	-	(736)	(385)	(1,171)
Valuation/gross cost at 31 March 2026	5,893	89,307	190	-	2,755	186	8,717	359	107,407
Accumulated depreciation at 1 April 2025	-	-	-	-	1,346	103	3,463	480	5,392
Provided during the year	-	2,777	11	-	182	9	1,530	32	4,541
Revaluations	-	(2,719)	(11)	-	-	-	-	-	(2,730)
Disposals / derecognition	-	-	-	-	(50)	0	(736)	(385)	(1,171)
Accumulated depreciation at 31 March 2026	-	58	-	-	1,478	112	4,257	127	6,032
Net book value at 31 March 2026	5,893	89,249	190	-	1,277	74	4,460	232	101,375
Net book value at 1 April 2025	5,222	81,598	190	555	1,328	83	4,878	191	94,045

Note 16.1 Property, plant and equipment - 2024/25

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024	5,107	81,209	160	10	2,344	103	11,909	702	101,544
Additions	-	4,124	-	555	327	83	2,106	-	7,195
Impairments	-	(364)	-	-	-	-	-	-	(364)
Impairments charged to the revaluation reserve	-	(1,640)	-	-	-	-	-	-	(1,640)
Reversals of impairments	-	405	-	-	-	-	-	-	405
Revaluations	150	(2,081)	30	-	-	-	-	-	(1,901)
Reclassifications	-	-	-	(10)	31	-	-	(31)	(10)
Transfers to/from assets held for sale and assets in disposal groups	(35)	(55)	-	-	-	-	-	-	(90)
Disposals / derecognition	-	-	-	-	(28)	-	(5,674)	-	(5,702)
Valuation/gross cost at 31 March 2025	5,222	81,598	190	555	2,674	186	8,341	671	99,437

Accumulated depreciation at 1 April 2024	-	-	-	-	1,217	103	7,873	441	9,634
Provided during the year	-	3,230	9	-	157	(0)	1,264	39	4,699
Revaluations	-	(3,226)	(9)	-	-	-	-	-	(3,235)
Transfers to/from assets held for sale and assets in disposal groups	-	(4)	-	-	-	-	-	-	(4)
Disposals / derecognition	-	-	-	-	(28)	-	(5,674)	-	(5,702)
Accumulated depreciation at 31 March 2025	-	-	-	-	1,346	103	3,463	480	5,392
Net book value at 31 March 2025	5,222	81,598	190	555	1,328	83	4,878	191	94,045
Net book value at 1 April 2024	5,107	81,209	160	10	1,127	-	4,036	261	91,910

Note 16.1 (continued) Property, plant and equipment - 2024/25

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	5,107	82,429	160	10	2,344	103	11,909	702	102,764
Additions	-	4,124	-	555	327	83	2,106	-	7,195
Impairments	-	(364)	-	-	-	-	-	-	(364)
Impairments charged to the revaluation reserve	-	(1,640)	-	-	-	-	-	-	(1,640)
Reversals of impairments	-	405	-	-	-	-	-	-	405
Revaluations	150	(2,081)	30	-	-	-	-	-	(1,901)
Reclassifications	-	(1,220)	-	(10)	31	-	-	(31)	(1,230)
Transfers to/from assets held for sale and assets in disposal groups	(35)	(55)	-	-	-	-	-	-	(90)
Disposals / derecognition	-	-	-	-	(28)	-	(5,674)	-	(5,702)
Valuation/gross cost at 31 March 2025	5,222	81,598	190	555	2,674	186	8,341	671	99,437
Accumulated depreciation at 1 April 2024	-	-	-	-	1,217	103	7,873	441	9,634
Provided during the year	-	3,230	9	-	157	(0)	1,264	39	4,699
Revaluations	-	(3,226)	(9)	-	-	-	-	-	(3,235)
Transfers to/from assets held for sale and assets in disposal groups	-	(4)	-	-	-	-	-	-	(4)
Disposals / derecognition	-	-	-	-	(28)	-	(5,674)	-	(5,702)
Accumulated depreciation at 31 March 2025	-	-	-	-	1,346	103	3,463	480	5,392
Net book value at 31 March 2025	5,222	81,598	190	555	1,328	83	4,878	191	94,045
Net book value at 1 April 2024	5,107	82,429	160	10	1,127	-	4,036	261	93,130

Note 16.2 Property, plant and equipment financing - 2025/26

Group and Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2026									
Owned - purchased	5,893	59,543	190	-	1,259	74	4,460	232	71,651
On-SoFP PFI contracts and other service concession arrangements	-	26,470	-	-	-	-	-	-	26,470
Owned - donated/granted	-	3,236	-	-	18	-	-	-	3,254
NBV total at 31 March 2026	5,893	89,249	190	-	1,277	74	4,460	232	101,375

Note 16.3 Property, plant and equipment financing - 2024/25

Group and Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2025									
Owned - purchased	5,222	55,992	190	555	1,307	83	4,878	191	68,418
On-SoFP PFI contracts and other service concession arrangements	-	25,606	-	-	-	-	-	-	25,606
Owned - donated/granted	-	-	-	-	21	-	-	-	21
NBV total at 31 March 2025	5,222	81,598	190	555	1,328	83	4,878	191	94,045

Note 16.4 Useful economic life of property, plant and equipment

Group and Trust	Min life Years	Max life Years
Land	Infinite	Infinite
Buildings, excluding dwellings	5	44
Dwellings	16	16
Plant & machinery	3	10
Transport equipment	7	10
Information technology	2	10
Furniture & fittings	5	10

Note 17 Revaluations of property, plant and equipment

The Trust carried out a desktop revaluation of land and buildings as at 31 March 2026. The valuation was performed by an independent RICS registered valuer from the District Valuer Service. The valuation was that of an alternative site basis.

The revaluation is on hypothetical basis from an alternative site and assumes that clinical and support services will be delivered from three sites, Swallownest in Rotherham; Great Oaks in North Lincolnshire and Tickhill Road in Doncaster.

The Doncaster PFI is valued exclusive of VAT (as opposed to the Trust owned land and buildings which are valued gross of VAT) and is therefore valued as a separate asset.

The valuation of the Trust owned land and building (including dwelling) resulted in a decrease in value of £1,449k (2024/25: increase £26k). This reflects the difference between the net book value before revaluation and the valuer's updated assessment.

The decrease mainly relates to significant capital spending of £6.6m on Trust-owned buildings. While this investment did increase values, alongside increases in BCIS indices and location factors, the uplift was lower than the amount spent.

The valuation of the PFI resulted in an increase in value of £1,494k (2024/25: decrease of £291k). This increase was driven by higher BCIS indices and location factors, alongside relatively low capital expenditure on the Trust's PFI buildings during the year.

The Trust previously valued St John's Hospice as a £0k donated asset due to leasing arrangements with Doncaster Cancer Detection Trust (DCDT). DCDT formally closed as a charity in 2025/26. As such, the Trust's valuer revalued St John's Hospice during 2025/26. The valuation gain was £3,907k. This is the St John's Hospice land (owned, £671k) and building (owned, donated, £3,236k).

Note 18 Investment Property Group and Trust

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	3,670	3,579	3,670	3,129
Fair value gains taken to SoCI	(9)	45	(9)	45
Acquisitions in year	60	46	60	-
Reclassifications to/from PPE	-	-	-	496
Carrying value at 31 March	3,721	3,670	3,721	3,670

Note 18.1 Investment property income and expenses (Group)

	2025/26	2024/25
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	-	-
Total investment property expenses	-	-
Investment property income	102	90

IAS 40 defines investment property as property that is held by the owner to earn rentals or for capital appreciation or both. Investment properties are measured at fair value and are categorised at level 3 of the fair value hierarchy. The fair value is measured using the price per square metre for a building from observable market data (for example, prices derived from observed transactions involving comparable buildings in similar locations), adjusted to reflect differences in physical characteristics such as the quality of interior finishes, size and parking.

The Trust carried out a revaluation of investment property as at 31 March 2026. The valuation was performed by an independent RICS registered valuer from District Valuer Service.

Note 19 Leases Rotherham Doncaster and South Humber NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust has a lease for land with The Rotherham NHS FT for the provision of an older people's unit. It commenced in October 2009 and is for 99 years with a minimum lease term of 60 years. All other leases are short and medium term and are reviewed in accordance with service provision. These are building leases and leases for RDaSH vehicles. During 2025/26, the Trust entered into a new 25-year lease for a service-provision building in Doncaster at a value of £5,176k.

Note 19.1 Right of use assets - 2025/26

Group and Trust	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2025	15,824	428	16,252	12,893
Additions	5,212	264	5,476	-
Remeasurements of the lease liability	346	-	346	346
Reclassifications	(157)	-	(157)	-
Disposals / derecognition	(687)	(47)	(734)	(271)
Valuation/gross cost at 31 March 2026	20,538	645	21,183	12,968
Accumulated depreciation at 1 April 2025	3,555	205	3,760	3,238
Provided during the year	1,350	142	1,492	1,096
Reclassifications	(157)	-	(157)	(95)
Disposals / derecognition	(413)	(47)	(460)	(219)
Accumulated depreciation at 31 March 2026	4,335	300	4,635	4,020
Net book value at 31 March 2026	16,203	345	16,548	8,948
Net book value at 31 March 2025	12,269	223	12,492	9,655

Net book value of right of use assets leased from other NHS providers

-

Net book value of right of use assets leased from other DHSC group bodies

8,948

Note 19.2 Right of use assets - 2024/25

Group and Trust	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024	13,867	222	14,089	12,514
Additions	1,484	280	1,764	-
Remeasurements of the lease liability	473	-	473	473
Reclassifications	-	-	-	(94)
Disposals / derecognition	-	(74)	(74)	-
Valuation/gross cost at 31 March 2025	15,824	428	16,252	12,893
Accumulated depreciation at 1 April 2024	2,298	211	2,509	2,147
Provided during the year	1,257	68	1,325	1,091
Disposals / derecognition	-	(74)	(74)	-
Accumulated depreciation at 31 March 2025	3,555	205	3,760	3,238
Net book value at 31 March 2025	12,269	223	12,492	9,655
Net book value at 31 March 2024	11,569	11	11,580	10,367

Net book value of right of use assets leased from other NHS providers

-

Net book value of right of use assets leased from other DHSC group bodies

9,655

Note 19.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 29 .

Group and Trust	2025/26	2024/25
	£000	£000
Carrying value at 1 April	16,004	15,186
Lease additions	5,440	1,720
Lease liability remeasurements	346	473
Interest charge arising in year	217	148
Early terminations	(252)	(39)
Lease payments (cash outflows)	(1,566)	(1,484)
Carrying value at 31 March	20,189	16,004

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 19.4 Maturity analysis of future lease payments at 31 March 2026

Group and Trust	Total	Of which leased from DHSC group bodies:
	31 March	31 March
	2026	2026
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	2,009	1,243
- later than one year and not later than five years;	7,173	4,934
- later than five years.	16,606	8,290
Total gross future lease payments	25,788	14,467
Finance charges allocated to future periods	(5,599)	(1,293)
Net finance lease liabilities at 31 March 2026	20,189	13,174
Of which:		
Leased from other NHS providers		4,099
Leased from other DHSC group bodies		9,075

Note 19.5 Maturity analysis of future lease payments at 31 March 2025

Group and Trust	Total	Of which leased from DHSC group bodies:
	31 March	31 March
	2025	2025
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	1,680	1,251
- later than one year and not later than five years;	5,692	4,837
- later than five years.	10,607	9,354
Total gross future lease payments	17,979	15,442
Finance charges allocated to future periods	(1,975)	(1,417)
Net finance lease liabilities at 31 March 2025	16,004	14,025
Of which:		
Leased from other NHS providers		4,172
Leased from other DHSC group bodies		9,853

Note 20 Other investments / financial assets (non-current)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	1,447	2,082	22	22
Acquisitions in year	-	610	-	-
Movement in fair value through OCI	96	28	-	-
Disposals	(268)	(1,273)	-	-
Carrying value at 31 March	1,275	1,447	22	22

The balances for Group is the consolidated Investment Portfolio of the subsidiary charity, for Trust this is the investment share capital of the subsidiary Flourish Enterprises CIC.

Note 21 Disclosure of interests in other entities

Flourish is a wholly owned subsidiary of the Trust. The accounting date of Flourish is 31 March 2026. In 2025/26 Flourish's income was £2,531k (2024/25: £2,592k), the expenditure was £2,529k (2024/25: £2,595k), interest receivable was £3k (2024/25: £5k). At 31 March 2026 the net assets are £76k (At 31 March 25: £71k) . Flourish trading results are consolidated in the Trust's financial statements.

Note 22 Analysis of charitable fund reserves

The Rotherham Doncaster and South Humber NHS Charitable Fund is a subsidiary of the Trust and the Fund's trading results are consolidated in the Trust's financial statements. The accounting date of the Fund is 31 March 2026.

	31 March	31 March
	2026	2025
	£000	£000
Unrestricted funds:		
Unrestricted income funds	358	607
Restricted funds:		
Other restricted income funds	1,177	1,210
	1,535	1,817

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the corporate trustee in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the discretion of the corporate trustee only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 23 Inventories

Consumables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Balance 1 April	315	620	299	602
Additions	2,386	1,803	2,386	1,803
Consumed and recognised in expenditure	(2,404)	(2,108)	(2,404)	(2,106)
Balance 31 March	297	315	281	299

Note 24 Receivables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Contract receivables	3,554	2,041	3,544	2,027
Contract receivables not yet invoiced	4,090	3,668	4,168	3,739
Allowance for impaired contract receivables	(37)	(153)	(37)	(153)
Prepayments (non-PFI)	1,689	1,698	1,689	1,698
VAT receivable	672	-	687	-
PDC dividend receivable	37	25	37	25
Clinician pension tax provision reimbursement funding from NHSE	2	4	2	4
NHS charitable funds receivables	1	14	-	-
Total current receivables	10,008	7,297	10,090	7,340
Non-current				
Clinician pension tax provision reimbursement funding from NHSE	135	145	135	145
Total non-current receivables	135	145	135	145
Total receivables	10,143	7,442	10,225	7,485
Of which receivable from NHS and DHSC group bodies:				
Current	1,360	1,056	1,360	1,056
Non-current	135	145	135	145

Note 25 Non current assets held for sale

The Trust had no assets held for sale in 2025/26.

The Trust had one asset held for sale (AHfS) as at 31 March 2025. The building had a carrying value of £86k prior to being held for sale. AHfS should be measured at the lower of the carrying amount or fair value less costs to sell. The lower of these two values was the carrying amount, therefore the AHfS was held at the carrying amount of £86k. As at 31 March 2025, the Trust had put the property on the market, received offers, and accepted one of these offers. The sale completed in 25/26 at a value of £105k and a gain on disposal recognised (see note 13). There was no impairment to the asset in 24/25 since its last valuation on 31 March 2024. The buyer was not a related party.

Note 26 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	32,208	34,411	31,421	33,447
Net change in year	(1,640)	(2,203)	(1,551)	(2,026)
At 31 March	30,568	32,208	29,870	31,421
Broken down into:				
Cash at commercial banks and in hand	755	895	57	109
Cash with the Government Banking Service	29,813	31,313	29,813	31,312
Total cash and cash equivalents as in SoFP	30,568	32,208	29,870	31,421
Total cash and cash equivalents as in SoCF	30,568	32,208	29,870	31,421

Note 26.1 Third party assets held by the trust

Rotherham Doncaster and South Humber NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March	31 March
	2026	2025
	£000	£000
Bank balances	114	130
Monies on deposit	218	239
Total third party assets	332	369

Note 27 Trade and other payables

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Trade payables	3,428	3,116	3,431	3,128
Capital payables	2,259	1,803	2,259	1,803
Accruals	4,815	5,046	4,718	4,851
Social security costs	2,050	1,806	2,050	1,806
VAT payable	-	107	-	107
Other taxes payable	1,733	1,759	1,733	1,759
Pension contributions payable	2,537	2,545	2,537	2,545
Other payables	78	210	67	201
NHS charitable funds: trade and other payables	7	3	-	-
Total current trade and other payables	16,907	16,395	16,795	16,200
Non-current				
Other payables	-	-	-	-
Total non-current trade and other payables	-	-	-	-
Total trade and other payables	16,907	16,395	16,795	16,200
Of which payables from NHS and DHSC group bodies:				
Current	1,106	1,220	1,106	1,220

Note 28 Other liabilities

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	555	294	374	167
Total other current liabilities	555	294	374	167

Note 29 Borrowings

Group and Trust	31 March	31 March
	2026	2025
	£000	£000
Current		
Loans from DHSC	368	369
Lease liabilities	1,565	1,476
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,523	1,336
Total current borrowings	3,456	3,181
Non-current		
Loans from DHSC	2,752	3,115
Lease liabilities	18,624	14,528
Obligations under PFI, LIFT or other service concession contracts	10,176	11,198
Total non-current borrowings	31,552	28,841

Note 29.1 Reconciliation of liabilities arising from financing activities

Group and Trust - 2025/26	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2025	3,484	16,004	12,534	32,022
Cash movements:				
Financing cash flows - payments and receipts of principal	(363)	(1,398)	(1,395)	(3,156)
Financing cash flows - payments of interest	(129)	(168)	(1,092)	(1,389)
Non-cash movements:				
Additions	-	5,440	-	5,440
Lease liability remeasurements	-	346	-	346
Application of effective interest rate	128	217	1,092	1,437
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	560	560
Early terminations	-	(252)	-	(252)
Carrying value at 31 March 2026	3,120	20,189	11,699	35,008

Group and Trust - 2024/25	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2024	3,848	15,186	13,322	32,356
Cash movements:				
Financing cash flows - payments and receipts of principal	(363)	(1,337)	(1,224)	(2,924)
Financing cash flows - payments of interest	(144)	(147)	(1,157)	(1,448)
Non-cash movements:				
Additions	-	1,720	-	1,720
Lease liability remeasurements	-	473	-	473
Application of effective interest rate	143	148	1,157	1,448
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	436	436
Early terminations	-	(39)	-	(39)
Carrying value at 31 March 2025	3,484	16,004	12,534	32,022

Note 30 Provisions for liabilities and charges analysis

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Clinicians' pension reimbursement	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2025	126	139	103	103	767	149	1,387
Change in the discount rate	(2)	(9)	-	-	-	(11)	(22)
Arising during the year	10	2	39	963	474	-	1,488
Utilised during the year	(15)	(6)	(13)	-	(344)	(2)	(380)
Reversed unused	(29)	-	(28)	(103)	(8)	(8)	(176)
Unwinding of discount	3	3	-	-	-	9	15
At 31 March 2026	93	129	101	963	889	137	2,312
Expected timing of cash flows:							
- not later than one year;	15	6	91	963	543	2	1,620
- later than one year and not later than five years;	56	24	10	-	200	17	307
- later than five years.	22	99	-	-	146	118	385
Total	93	129	101	963	889	137	2,312

Pension provisions are calculated using the criteria provided by the Government Actuary department. Payments are made over the lifetime of the member and on his/her death a reduced sum is paid to the survivor.

The personal injury allowance is in respect of one ex employee. The provision is calculated using information as to gender, life expectancy and amount of allowance payable.

The legal claim provision is in respect of personal injury claims and is calculated using information provided by NHS Resolution as to probability of outcome and cost.

The redundancy provision has been recognised for potential liabilities arising from the Trust wide staff consultation process that placed 55 staff at risk of redundancy in March 2026. Every effort is being made to redeploy staff into other roles but it is probable that some redundancies will happen in 2026/27.

Other includes a dilapidation provision relating to the 'dilapidation' costs for expired building leases and a VAT provision following a HMRC tribunal ruling against NHS Midlands Partnership University NHS Foundation Trust that is likely to change the VAT treatment of some or all local authority income from 'non-business' to 'exempt' resulting in increased partial exemption VAT charges.

The clinicians' pension provision is in respect of liabilities arising from the 2019/20 clinicians' pension compensation scheme.

The exact timing of cash-flows is uncertain; the expected timing is shown above.

Note 30.1 Clinical negligence liabilities

At 31 March 2026, £2.686m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2025: £4.479m).

Note 31 Contingent assets and liabilities

Group and Trust	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	37	12
Gross value of contingent liabilities	37	12
Amounts recoverable against liabilities		
Net value of contingent liabilities	37	12

Contingent liabilities relate to employer and public personal injury claims.

Note 32 Contractual capital commitments

Group and Trust	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	72	4,164
Total	72	4,164

For 25/26 the Trust has a capital commitment for the completion of the Great Oaks project.

As at 31 March 25, capital commitments were £4,164k. The majority of this value (£3,994k) was a refurbishment of the Scunthorpe Mental Health unit, Great Oaks. This refurbishment commenced in March 2025 and was due to be completed in the year 2025/26. The remainder was items not completed from the 2024/25 capital programme.

Note 33 Defined benefit pension schemes

The following information relates to the South Yorkshire Local Government Pension Scheme:

Note 33.1 Actuarial assumptions

The main actuarial assumptions used at the date of the Statement of Financial Position in measuring the present value of the defined benefit scheme liabilities are:

	31 March 2026	31 March 2025
Rate of increase in pensions (CPI)	3.00%	2.80%
Rate of increase in salaries	3.60%	3.40%
Discount rate	6.20%	5.80%

Duration information at the end of the accounting year

As at the date of the most recent valuation, the duration of the Employer's funded obligations is 15 years.

The financial actuarial assumptions used for IAS19 calculations at the 31 March year ends depends on the market yields at that date. These yields vary from employer to employer depending on the duration of their pension liabilities. For accounting purposes, the duration is assessed as at the date of the latest formal actuarial valuation of the Fund (or the date of admission to the fund if later).

In June 2023, the UK High Court issued a ruling in the case of Virgin Media Limited v NTL Pension Trustees II Limited and other relating to the validity of certain historical pension changes. This judgement was appealed in 2024 and on 24 July 2024, it was confirmed that the earlier ruling by the Court was still applicable. On 5 June 2025, the UK Government announced it will introduce legislation relating to issues arising from this case and, as a result, no impact has been included in the liability of the Local Government Pension Scheme.

Note 33.2 Sensitivity analysis

The sensitivities regarding the principal assumptions used to measure the scheme obligations are set out below: This methodology in regards to the sensitivity disclosures in respect of pensions, details the effect on the obligations of changes to the key assumptions in the sensitivity analysis below:

	Approximate % increase in Defined Benefit Obligation	Approximate monetary amount (£000)
Change in assumptions at 31 March 2026		
0.1% decrease in Real Discount Rate	1%	54
1 year increase in member life expectancy	4%	174
0.1% increase in Salary Increase Rate	0%	1
0.1% increase in the Pension Increase Rate (CPI)	1%	53

Note 33.3 Detailed asset breakdown as at 31 March 2026

	31 March 2026 £000's	31 March 2025 £000's
Equities	4,810	4,371
Government bonds	1,435	1,238
Property	559	504
Cash/liquidity	86	94
Total	6,890	6,207

The plan assets are invested in a wide range of categories of investments and therefore the Trust is not exposed to any plan specific risks.

Note 33.4 Changes in the defined benefit obligation and fair value of plan assets during the year

Group and Trust	2025/26 £000	2024/25 £000
Present value of the defined benefit obligation at 1 April	(4,231)	(4,892)
Current service cost	(18)	(28)
Interest cost	(239)	(231)
Contribution by plan participants	(6)	(7)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial gains/(losses)	(108)	724
Benefits paid	244	203
Present value of the defined benefit obligation at 31 March	(4,358)	(4,231)
Plan assets at fair value at 1 April	4,231	5,035
Interest income	239	278
Remeasurement of the net defined benefit (liability) / asset:		
- Return on plan assets	309	(306)
- Actuarial gain	258	-
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	(441)	(580)
Contributions by the plan participants	6	7
Benefits paid	(244)	(203)
Plan assets at fair value at 31 March	4,358	4,231
Plan surplus/(deficit) at 31 March *	-	-

* The pension asset is stated net of a £2,533k asset ceiling restriction (31 March 25: £1,977k), the movement is reconciled as follows:

Effect of asset ceiling as at 31 March 2025	1,977
Effect of asset ceiling as at 31 March 2026	2,533
Overall movement	(556)
Changes in the effect of limiting a net defined benefit asset to the asset ceiling	(441)
Interest on the effect of the asset ceiling within 'interest income'.	(115)
Overall movement	(556)

Employer contributions in 2026/27 are projected to be £21k.

Note 33.5 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

Group and Trust

	31 March 2026	31 March 2025
	£000	£000
Present value of the defined benefit obligation	(4,358)	(4,231)
Plan assets at fair value	4,358	4,231
Net defined benefit (obligation) / asset recognised in the SoFP	-	-
Fair value of any reimbursement right		
Net asset/(liability) after the impact of reimbursement rights	-	-

Note 33.6 Amounts recognised in the SoCI
Group and Trust

	2025/26	2024/25
	£000	£000
Current service cost	(18)	(28)
Interest income/(expense)	-	47
Total net (charge)/gain recognised in SoCI	(18)	19

Note 34 On-SoFP PFI

The PFI provides services accommodation for Mental Health services for Older People and for Mental Health Rehabilitation services. The PFI buildings are on the St Catherine's site and Bentley in Doncaster.

The PFI agreement is with Albion Healthcare Ltd who have a contract with HBG (Facilities Management) Ltd to provide the hard facilities management services to the buildings. The PFI arrangement is for 27 years commencing in 2005 and ending in 2032. There are no renewal or termination options in the agreement.

The service element of the lease was bought out in 2017/18 and payments now relate solely to the lease of the property. The annual payment in 2025/26 was £2.487m. The re-pricing of the annual charge is yearly on 1 April in line with the movement in the Retail Price Index.

The scheme has not resulted in any guarantees, commitments or other rights or obligations.

Note 34.1 On-SoFP PFI obligations

The following obligations in respect of the PFI are recognised in the statement of financial position:

Group and Trust	31 March 2026	31 March 2025
	£000	£000
Gross PFI liabilities	15,135	16,869
Of which liabilities are due		
- not later than one year;	2,488	2,381
- later than one year and not later than five years;	9,952	9,526
- later than five years.	2,695	4,962
Finance charges allocated to future periods	(3,436)	(4,335)
Net PFI obligation	11,699	12,534
- not later than one year;	1,523	1,336
- later than one year and not later than five years;	7,614	6,678
- later than five years.	2,562	4,520

Note 34.2 Total on-SoFP PFI commitments

Total future commitments under these on-SoFP schemes are as follows:

Group and Trust	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	15,135	16,869
Of which payments are due:		
- not later than one year;	2,488	2,381
- later than one year and not later than five years;	9,952	9,526
- later than five years.	2,695	4,962

Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust	
	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	2,487	2,381
Consisting of:		
- Interest charge	1,092	1,157
- Repayment of balance sheet obligation	1,395	1,224
Total amount paid to service concession operator	2,487	2,381

Note 35 Financial instruments**Note 35.1 Financial risk management**

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with the ICBs and local authorities and the way in which these bodies are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk that would be typical of listed companies, to which the financial reporting standard mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by internal audit.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations; the Trust therefore has low exposure to currency rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has little exposure to credit risk. The maximum exposures at 31 March 2026 are in receivables from other customers, as disclosed in Trade and other receivables, note 24.

Liquidity risk

The Trust's operating costs are incurred under annual service agreements with ICBs and local authorities, which are financed from resources voted annually by Parliament. The Trust is not, therefore exposed to significant liquidity risk.

Interest rate risk

The Trust is not exposed to any interest rate risk. The only loan that the Trust has is with the Department of Health and Social Care and this is at a fixed interest rate.

Note 35.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026

Trade and other receivables excluding non financial assets	7,606
Cash and cash equivalents	30,224
Consolidated NHS Charitable fund financial assets	345
Total at 31 March 2026	38,175

	Held at amortised cost £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	7,606	-	7,606
Cash and cash equivalents	30,224	-	30,224
Consolidated NHS Charitable fund financial assets	345	1,275	1,620
Total at 31 March 2026	38,175	1,275	39,450

Carrying values of financial assets as at 31 March 2025

Trade and other receivables excluding non financial assets	5,484
Cash and cash equivalents	31,777
Consolidated NHS Charitable fund financial assets	445
Total at 31 March 2025	37,706

	Held at amortised cost £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	5,484	-	5,484
Cash and cash equivalents	31,777	-	31,777
Consolidated NHS Charitable fund financial assets	445	1,447	1,892
Total at 31 March 2025	37,706	1,447	39,153

Note 35.2 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026

Trade and other receivables excluding non financial assets	7,676
Other investments / financial assets	22
Cash and cash equivalents	29,870
Total at 31 March 2026	37,568

	Held at amortised cost £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	7,676	-	7,676
Other investments / financial assets	22	-	22
Cash and cash equivalents	29,870	-	29,870
Total at 31 March 2026	37,568	-	37,568

Carrying values of financial assets as at 31 March 2025

Trade and other receivables excluding non financial assets	5,613
Other investments / financial assets	22
Cash and cash equivalents	31,421
Total at 31 March 2025	37,056

	Held at amortised cost £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	5,613	-	5,613
Other investments / financial assets	22	-	22
Cash and cash equivalents	31,421	-	31,421
Total at 31 March 2025	37,056	-	37,056

Note 35.3 Carrying values of financial liabilities (Group)**Carrying values of financial liabilities as at 31 March 2026**

	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	3,120	3,120
Obligations under leases	20,189	20,189
Obligations under PFI, LIFT and other service concessions	11,699	11,699
Trade and other payables excluding non financial liabilities	10,256	10,256
Total at 31 March 2026	45,264	45,264

Carrying values of financial liabilities as at 31 March 2025

	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	3,484	3,484
Obligations under leases	16,004	16,004
Obligations under PFI, LIFT and other service concessions	12,534	12,534
Trade and other payables excluding non financial liabilities	8,049	8,049
Consolidated NHS charitable fund financial liabilities	3	3
Total at 31 March 2025	40,074	40,074

Note 35.3 Carrying values of financial liabilities (Trust)**Carrying values of financial liabilities as at 31 March 2026**

	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	3,120	3,120
Obligations under leases	20,189	20,189
Obligations under PFI, LIFT and other service concessions	11,699	11,699
Trade and other payables excluding non financial liabilities	10,152	10,152
Total at 31 March 2026	45,160	45,160

Carrying values of financial liabilities as at 31 March 2025

	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	3,484	3,484
Obligations under leases	16,004	16,004
Obligations under PFI, LIFT and other service concessions	12,534	12,534
Trade and other payables excluding non financial liabilities	7,857	7,857
Total at 31 March 2025	39,879	39,879

Note 35.4 Fair values of financial assets and liabilities

The book value of the Trust's assets and liabilities at 31 March 2026 is a reasonable approximation of fair value.

Note 35.5 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual, undiscounted cash flows. This differs to the amounts recognised in the statement of financial position, which are discounted to present value.

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
In one year or less	15,122	12,482	15,018	12,287
In more than one year but not more than five years	18,940	17,033	18,940	17,033
In more than five years	20,238	16,869	20,238	16,869
Total	54,300	46,384	54,196	46,189

Note 36 Losses and special payments

Group and trust	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses *	1	-	2	-
Bad debts and claims abandoned	2	3	1	12
Stores losses and damage to property *	-	-	2	-
Total losses	3	3	5	12
Special payments				
Compensation under court order or legally binding arbitration award	2	8	1	1
Ex-gratia payments	8	5	10	5
Total special payments	10	13	11	6
Total losses and special payments	13	16	16	18

* The cumulative costs are small and round down to £0k so displayed as a value of £Nil k.

Note 37 Related Parties

The Trust is a body corporate established by order of the Secretary of State.

The Department of Health and Social Care is regarded as the ultimate controlling party. During the year the Trust had a number of material transactions with the Department and with other entities for which the Department is regarded as the parent. The Trust also had a number of material transactions with other Government departments and other central and local government bodies. These entities are listed below.

- The Department of Health and Social Care
- Other NHS providers
- ICBs and NHS England
- Other health bodies
- Other Government departments
- Local authorities

The Board does not have any related party transactions to disclose.

Note 38 Events after the reporting date

There are no events after the reporting date.

