NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 24 September 2026 at 9.30am
Rossington Miner's Welfare, West End Lane, Rossington, Doncaster, DN11 0DU

No	Time	Item	Request to	Lead	Enc.
1	09.30	Welcome	Note Information	Kath Lavery, Chair	
2		Apologies for Absence:			
3		Quoracy (One third of the Board; inc. one NED and one ED)			
4		Declarations of Interest			A
		Standing items			
5	09.32	Minutes of the meeting held in public on the 30 July 2026	Decision	Kath Lavery, Chair	B
6		Matters Arising and Follow up Actions	Decision		C
		Board Committee Reports to the Board of Directors			
7	09.35	Quality Committee	Assurance	Dr Richard Falk, NED	D
8		Audit Committee	Assurance	Kathy Gillatt, NED	E
9		Mental Health Act Committee	Assurance	Maria Clark, NED	F
10		People & Organisational Development Committee	Assurance	Sarah Fulton Tindall, NED	G
11		Public Health Patient Involvement & Partnerships Committee	Assurance	Rachael Blake, NED	H
12		Finance, Digital & Estates Committee	Assurance	Pauline Vickers, NED	I
		Operating Performance / Governance / Risk Management			
13	10.10	Strategy Delivery Risks	Information	Philip Gowland, Director of Corporate Assurance	J
14	10.25	Operational Risk Report	Information	Philip Gowland, Director of Corporate Assurance	K
15	10.40	Promises and Priorities Scorecard	Information	Toby Lewis, Chief Executive	L
16	10.50	Integrated Quality Performance Report (IQPR)	Information	Toby Lewis, Chief Executive	M
17	11.00	Organisational Change Key Performance Indicators	Information	Steve Forsyth, Chief Nurse	N
		BREAK 11.10 (10 mins)			
18	11.20	Chief Executive's Report	Information	Toby Lewis, Chief Executive	O
19	11.40	Peer support framework: first report		Toby Lewis, Chief Executive, Dr Judith Graham, Director of Psychological Professions Steve Forsyth, Chief Nurse Officer	P
20	12.00	CQC readiness		Steve Forsyth, Chief Nurse Officer	Q

RDaSH nurturing the power in our communities

Patient Story					
21	12.20	Patient Story	Information	Steve Forsyth, Chief Nurse Officer	Verbal
LUNCH 12.35 (30 mins)					
No	**Time**	**Item**	**Request to**	**Lead**	**Enc.**
22	13.05	Response to the items highlighted within the Young Advisors work in the AMM		Philip Gowland, Director of Corporate Assurance	R
23	13.25	Promise 16 – Outcomes of service delivery 14 weeks		Richard Chillery, Chief Operating Officer	S
24	13.45	Provider Capability Assessment Framework		Philip Gowland, Director of Corporate Assurance	T
25	14.00	Culture @ RDaSH		Toby Lewis, Chief Executive	U
26	14.25	Autism Assessment Services		Toby Lewis, Chief Executive, Dr Judith Graham, Director of Psychological Professions	V
27	14.40	Deliverology Implementation	Assurance	Philip Gowland, Director of Corporate Assurance	W
Supporting Papers (previously presented at Committee)					
28	14:50	Medical Revalidation Mortality Report: May and June 2026 Guardian of Safe Working Hours	Information	Kath Lavery, Chair	Agenda Pack B
Closing Items					
29		Any Other Urgent Business (to be notified in advance)		Kath Lavery, Chair	Verbal
30		Any risks that the Board wishes the Risk Management Group to consider			
31		Public Questions *			
Chair to resolve '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press are excluded from the remainder of the meeting, which will conclude in private.*'				Kath Lavery, Chair	
32	*14:50*	*Minutes of the private meeting held on the 30 July 2026*	*Decision*	Kath Lavery, Chair	AA
33		*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
34		*Reflections on the patient story*	*Discussion*		Verbal
35	*14.50*	*Chief Executive Private Update to the Board of Directors*	*Information*	Toby Lewis, Chief Executive	CC
36	*15.10*	*Cyber Security*	*Assurance*	Richard Chillery, Chief Operating Officer	DD
37	*15:20*	*Close*			

*** Public Questions:**
Questions from the public may be raised at the meeting where they relate to the papers being presented that day. Alternatively, questions on any subject may sent in advance and they will be presented to the Board of Directors via the Director of Corporate Assurance. Responses will be provided after the meeting to the originator and included within the formal record of the meeting.
****Paper to be managed via questions only**
The next meeting of the Board of Directors will take place on Thursday 26 November 2026 at The Centre, Brinsworth Lane, Brinsworth, Rotherham, S60 5BU

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Declarations of Interest	**Agenda Item**	Paper A
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Phil Gowland, Director of Corporate Assurance Diane Jeavons, Corporate Assurance Officer		
Meeting	Board of Directors	**Date**	24 September 2026

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

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

Amendments this month have been received from Rachel Blake and Kathy Gillatt and are highlighted in the report.

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

Paper presented to each public Board meeting

Recommendation
(indicate with an 'x' all that apply and where shown elaborate)

The Board of Directors is asked to:

x	**RECEIVE** and note the Register of Interests.

Alignment to strategic objectives (indicate those that the paper supports)

Not applicable

Alignment to the plans: (indicate those that this paper supports)

People and teams plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	

Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	

Strategic Delivery Risks (indicate those that this paper supports)							
Not applicable							
System / Place relevance (advise whether it is national, regional or local)							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Appendix (please list)							
None							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

BOARD OF DIRECTORS – REGISTER OF INTERESTS

Executive Summary

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

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

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

Name / Position	Interests Declared
Maria Clark Non-Executive Director	• Lay Examiner for the Royal College of Obstetrics and Gynaecology • School appeals and Chair of the Independent Review Panel, Barnsley MBC • Grant making panel member for the Three Guiness Trust • Solicitor, Taylor Emmet Solicitors • Lay member National Institute of Clinical Excellence (NICE) • Associate Hospital Manager at Leeds and York Partnerships NHS FT and Derbyshire Healthcare NHS FT • Volunteer - Stroke Rehab Services Review, Joined Up Care Derbyshire • Research Ethics Committee Member, Ministry of Defence • Voluntary member of the Research Ethics Committee, University of Sheffield • Voluntary Board member (non-voting) College of general Dentistry • Honorary fellow of the Royal College of Surgeons of England • Rental property, Sheffield
Dr Richard Falk, Non-Executive Director	• Nil
Steve Forsyth, Chief Nursing Officer	• Coach at the Gambian National Police Force • Ambassador and Affiliation for WhizzKidz • Non-Executive Director for the African Caribbean Community Initiative • Fellow of The Queens Institute of Community Nursing • Member of Asian Professionals National Alliance • Member of British Indian Nurses Association • Member of Jabali Men's Network • Member of Nola Ishmael Executive Nurses
Kathryn Gillatt, Non-Executive Director	• Non-Executive Director at the NHS Business Services Authority and Chair of the Audit and Risk Committee • Independent Member of the Audit, Risk and Assurance Committee of Child and Family Court Advisory and Support Service (Cafcass) • **From 11 August 2026, for a period of 4 months, undertaking a part-time, fixed term contract providing senior strategic and operational financial leadership at Royal Berkshire NHS Foundation Trust.**
Philip Gowland, Board Secretary and Director of Corporate Assurance	• Wife is Primary Care Strategic Lead employed by RDaSH

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING
ON THURSDAY 30 JULY 2026 AT 9.30 AM
WATERS EDGE, BARTON UPON HUMBER, NORTH LINCOLNSHIRE, DN18 5JP

PRESENT

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

IN ATTENDANCE

Jo McDonough	Director of Strategic Development
Philip Gowland	Director of Corporate Assurance / Board Secretary
Shabir Pandor	NExT Director
Dr Rumit Shah	Associate Non Executive Director
Sarah Dean	Corporate Assurance Officer (Minutes)
Louisa Redhead	Continuous Service Improvement Manager, North Lincolnshire Adult Mental Health and Talking Therapies Care Group

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

Ref		Action
Bpu 26/07/01	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. There were no apologies. Mrs Lavery noted that the meeting included the annual focus on learning and education and asked Board members to keep this in mind when considering the papers and welcomed Dr Jude Graham to her first Board meeting as an Executive Director.	
Bpu 26/07/02	**Quoracy** Mrs Lavery declared that the meeting was quorate.	
Bpu 26/07/03	**Declarations of Interest** Mrs Lavery presented the declarations of interest report and confirmed there had been no amendments to the register since the last meeting. Ms Blake noted that she had additional declarations, which would be reflected at the next meeting.	

	The Board received and noted the changes to the Declarations of Interest Report.	
	STANDING ITEMS	
Bpu 26/07/04	**Minutes of the previous Board of Directors meeting held on the 28 May 2026** The Board approved the minutes of the meeting held on the 28 May 2026 as an accurate record.	
Bpu 26/07/05	**Matters Arising and Follow up Action Log** The Board received the action log and noted the progress updates. All six actions noted as 'propose to close' were agreed, and noted that eight remaining actions remained open, with several matters returning to the Board in September's meeting. **Bpu 26/05/18 Chief Executive Report.** Mr Lewis referred to page 12 of the minutes regarding talking therapies, and explained that issues relating to four week delivery had been reviewed and were expected to be resolved during quarter 2. Core practice issues in the administration of waits had been identified, particularly in Doncaster, which had been exacerbated by booking authorisation issues since April. These issues had been resolved, with no patient risk identified, but highlighted the importance of the Trust's control environment. There were no other matters arising.	
	BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS	
	Mrs Lavery confirmed the revised approach to the section of the meeting and asked for the discussion to initially focus on the three escalated matters from within the committee reports to Board.	
Bpu 26/07/06	**Finance, Digital & Estates Committee (FDE)** Mrs Vickers introduced the report and noted that the contract position had been further escalated since the June Committee meeting. Mr Sheppard reminded the Board that the final financial plan submitted on 13 March 2026 included assumptions relating to contract positions with both South Yorkshire (SY) and Humber and North Yorkshire (HNY) Integrated Care Boards (ICB). For HNY ICB, Mr Sheppard reported that an agreed baseline had been reached and that secure transport would be managed on a cost per case basis. Discussions continued regarding the transfer of budgets and the final model for neurodiversity services, although good progress had been made and the agreement was expected to be finalised on 3 August. For SY ICB, Mr Sheppard reported that a baseline of £177.6m had been agreed with a number of contract variations requiring completion. The variations had been prepared since April, but agreement had been delayed by the mental health investment standard contract variation. Mr Sheppard advised that SY ICB had revised its position from the original £2.9m investment across all providers to an offer of £1.2m, which created a potential Trust pressure of approximately £600k to £700k if distributed on a fair share basis. Mr Sheppard confirmed that the Trust had responded through the Chief Executive to advise that it could not agree the offer and required a further proposal, ideally at £2.9m and no	

	lower than £2m, noting the issue was financially significant and highlighted the need for stronger formal records and correspondence in future contract negotiations. Mrs Lavery asked about next steps. Mr Lewis advised that the HNY ICB meeting was scheduled for 3 August 2026 and that, if agreement could not be reached, the Trust would need to consider restricting services from 1 September 2026. Mr Lewis confirmed that the SY ICB position may take longer to resolve, but that the financial risk was manageable, while the HNY ICB position required resolution due to uncertainty regarding future configuration. In response to questions raised by Ms Gillatt and Ms Fulton Tindall, Mr Lewis confirmed that HNY ICB payments to date were consistent with the Trust's financial plan, while Mr Sheppard confirmed that SY ICB cash continued to be received up to the agreed baseline. Mr Lewis advised that the absence of a signed contract did not create wider legal risks, as standard contractual arrangements remained unchanged, but did create risks relating to documentation, leverage and timely resolution. Dr Shah asked about financial three year planning cycles. Mr Lewis advised that commissioners had mainly engaged in a one year process to date, but that South Yorkshire mental health trusts intended to provide a forward financial plan aligned to the ICB's three year investment plan for mental health. Mrs Lavery acknowledged the update and reaffirmed the Board's support for the forthcoming HNY ICB meeting. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
Bpu 26/07/07	**Quality Committee (QC)** Mr Lewis advised that the escalation from the QC related to long standing concerns regarding adult services in Rotherham. Whilst there were no immediate safety indicators of concern, Mr Lewis recognised that the position required continued oversight. Mr Lewis advised that improvements had been made on Willows Ward following previous collective concern, which provided assurance that local leaders had made progress when given the capacity to address issues. The main remaining concern related to medical cover. Mr Lewis reported that three colleagues were on medium term sickness absence, one further colleague was leaving, and other resignations were due to take effect over the coming weeks. Three medium term locums had been secured to provide stability through to Christmas, and proposals were being developed for staff grade and specialty doctors from early 2027. Mr Lewis welcomed the QC's escalation and confirmed that a specific annex on Rotherham would be added to the Chief Nurse triangulated report for the next Quality Committee to provide clearer oversight of the position. **The Board received and noted the report from the Quality Committee.**	

	Mrs Lavery invited Board members to raise any questions on other issues within the reports.	
Bpu 26/07/08	**Trust People Council (TPC)** Mr Vallance drew attention to safety concerns referenced in the TPC report and advised that he and Mr Lewis had met with Dr Mullins immediately following the meeting to understand the matters raised. It was confirmed that there were no notified immediate safety concerns, although Dr Mullins would test this directly with clinical colleagues and the leadership team would continue to ensure any concerns were followed up appropriately. Mr Lewis advised that the matters raised were being progressed as six areas of enquiry, five of which were areas where the Trust was already sighted, with the remaining area relating to learning disability services. Mr Lewis noted the importance of enabling staff to raise concerns openly and ensuring these were heard and addressed, and noted the positive response from the British Medical Association to the Trust's handling of the matter. **The Board received and noted the report from the Trust People Council.**	
Bpu 26/07/09	**Audit Committee (AC)** **The Board received and noted the report from the Audit Committee.**	
Bpu 26/07/10	**Mental Health Act Committee (MHAC)** **The Board received and noted the report from the Mental Health Act Committee.**	
Bpu 26/07/11	**People & Organisational Development Committee (PODC)** **The Board received and noted the report from the People & Organisational Development Committee.**	
Bpu 26/07/12	**Public Health Patient Involvement & Partnerships Committee (PHPIP)** **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	
OPERATING PERFORMANCE / GOVERNANCE / RISK MANAGEMENT		
Bpu 26/07/13	**Integrated Quality Performance Report** Mr Chillery introduced the Integrated Quality Performance Report (IQPR) for June 2026 review (data as at 30 June 2026). The revised IQPR provided a broader view to strengthen the measure set, with more quality and safety measures, enhanced workforce measures, additional finance measures and a new section on promises and planning. Further measures were in development while technical definitions were finalised.	

	Mr Chillery reported that access times were being maintained overall, although there were areas of concern. Podiatry waiting times were improving following recruitment to two posts, although demand had increased significantly. Talking therapies had already been discussed. Inappropriate out of area placements remained at one, although Mr Chillery cautioned that demand was relentless and had spiked in June, consistent with pressures reported by neighbouring mental health trusts. Discharge requirements were being met but noted that future zero out of area placement performance could not be guaranteed. Dr Falk welcomed the proposed additional IQPR measures and noted Quality Committee oversight. Regarding Section 136 pressures, Dr Sinclair explained in certain circumstances, the legal timeframe could be extended and that the issue related to a local operating standard rather than unlawful practice. Referring to estate pressures, inpatient bed availability and Section 140 arrangements, Mr Chillery advised they were linked to avoiding out of area placements, reducing demand and length of stay. Dr Falk discussed serious mental illness and learning disability registers. It was noted that work was under way to align primary care and Trust records and improve visibility of people requiring health checks, and that the most practical approach was to maintain one visible register and work with partners to improve accuracy. Mrs McDonough referred to meaningful data, and highlighted future reporting of the IQPR continued to develop through a health inequalities lens. This included work to identify disparities in access, experience and outcomes. Dr Graham noted that the developing triangulated learning report would strengthen Board oversight of learning, good practice, incidents and improvement work. Ms Blake welcomed progress in podiatry and requested continued reporting. Ms Blake also noted how services engaged people with learning disabilities who may only have contact with voluntary and community sector organisations, and how perinatal services were promoted to women who may benefit. Reflecting on the recommendations contained within the report, Mr Lewis suggested the Board focused only on the first recommendation and asked that future reporting continued to develop through a health inequalities lens. **The Board received and noted the Integrated Quality Performance Report, including the ongoing length of stay and S136 breach pressures.**	
Bpu 26/07/14	**Operational Risk Report** Mr Gowland presented the report and gave key highlights. The operational risk report continued to develop including improved analysis and commentary, with a clearer focus on risks outside tolerance. The report highlighted themes relating to patient safety, medical staffing, estates, infrastructure and high impact low likelihood risks. Mr Gowland drew attention to those risks sat outside of tolerance, including those linked to the earlier discussion on Rotherham medical	

staffing, noting the report reflected the position at a point in time and that work was continuing to mitigate and respond to the identified risks.

The annual review of high impact, low likelihood risks was reflected in the report and included a cohort of risks across estates and infrastructure, digital, cyber and other themes. Several risks were being tolerated because mitigation was in place, including emergency preparedness, resilience and response testing. Mr Gowland advised that these risks were generally tolerated because of their likelihood, but required preparedness and testing through business continuity and emergency preparedness (EPRR) arrangements. The recent learning half day exercise, which tested the response to a limited power outage scenario, was cited as an example of how the Trust tested preparedness and identified learning. Mr Gowland noted that the exercise supported assurance that, while some risks were tolerated, arrangements were in place to test readiness and strengthen future response.

Mrs Lavery and Ms Fulton Tindall welcomed the improved commentary and format, noting that it provided clearer assurance and supported Board engagement with key risks. Ms Fulton Tindall sought assurance on RSK 574 and whether delays in overnight data refresh affected frontline clinical information. Dr Sinclair confirmed the issue related to the reporting system only, not the live clinical record used by staff, and that live clinical information remained available to staff at the point of care on SystmOne.

Ms Fulton Tindall sought assurance on RSK 687, including the Quarter 4 resolution date. Mr Lewis advised that risks would be reviewed in August and September, which may reduce the current score, and Dr Sinclair confirmed that the medication management action plan would need to evidence sustained improvement before closure.

Mr Vallance sought assurance on the timescales for RSK 515 and RSK 476, including door and infrastructure risks. Mr Lewis advised that risk trajectories would be reviewed to ensure they remained realistic, noting market constraints in relation to door replacements. Mr Chillery confirmed the door replacement programme was separate from Section 136 pressures and was being managed through a planned approach. Mr Lewis reminded that Board members could and indeed should access Radar to improve visibility of current risks.

Dr Shah sought assurance on fire risk assessments (RSK 001) and medical staffing vacancies. Mr Gowland confirmed the annual fire risk assessment had been completed in March and reported to FDE, with no significant issues identified. Mr Lewis and Dr Sinclair advised that medical recruitment interest remained limited, with some vacancies expected to continue, and that work was under way to review inpatient medical roles and potential service configuration.

In response to Ms Blake query on RSK 570, Mr Gowland confirmed that antisocial behaviour incidents continued to be reported periodically and remained an active risk. Ms Holden noted that mitigations were in place for affected colleagues, including risk assessments and use of personal safety devices, and that the Trust continued to work with North

	Lincolnshire Council and other partners to address the wider environmental issues. **The Board received and noted the Operational Risk Report with attention drawn to those risks that were out of tolerance and further, those with low risk appetite, and the focus on those risks described as High Impact / Low Likelihood.**	
Bpu 26/07/15	**Strategy Delivery Risks (SDRs)** Mrs Lavery invited questions for Mr Gowland. Dr Falk and Mr Vallance welcomed the revised reporting format and direction of travel. Mr Vallance sought assurance that actions relating to SDR2, including data availability, capability and the translation of insight into action across the organisation. Mr Chillery explained that data capability was being addressed through several routes, including training linked to the community change project, learning from local delivery organisations and work to improve the capacity of leaders and teams to interpret data. It was noted that work was being brought together to assess leadership skills and will, including whether recruitment criteria were sufficiently aligned to the future leadership profile required by the Trust. **The Board received and noted the Strategic Delivery Risk report, had given opportunity to feedback on the revised format and content in this update report, and noted the position for each SDR.**	
Bpu 26/07/16	**Promises and Priorities Scorecard** Mrs Lavery invited questions for Mr Lewis. Dr Falk noted that a typographical correction was required on the cover sheet to clarify, " …..retain the integrity of **not** lowering the bar…" but to retain the integrity of the Trust's current expectations. Mrs Lavery advised that the report should be received as insight, recognising that individual policy matters would be considered through separate agenda items. Mr Lewis advised that paragraph 4.2 addressed leadership capability, including skills, will and alignment with future recruitment requirements. A broader assessment would be developed, with a definitive position expected before Christmas. **The Board received and noted the Promises and Priorities Scorecard, and the work continuing to be done to ensure rhythm and focus on the mid-table success measures. The Board recognised a positive focus on the nine measure we are trying to move by October, and acknowledged the displacement risk highlighted as we look to work on culture as well as strategy.**	
Bpu 26/07/17	**Organisational Change Key Performance Indicators** Mrs Lavery invited questions for Mr Forsyth. Mr Lewis asked whether the areas highlighted in the cover sheet, including primary care, mental health and health visiting, were those requiring continued focus or whether there were other areas of greater	

	concern. Dr Falk noted that it was too early to delegate some elements, given the low prevalence of several indicators, and suggested that these should continue to be monitored over the coming months, with the early intervention in psychosis service as an area requiring continued oversight. Mr Forsyth advised that the report should be simplified to focus on noting and agreeing the key recommendations, and cautioned against taking false assurance at this early stage. Mr Forsyth confirmed that there was no evidence of direct patient harm arising from the change management programme. The DNA rate within the assertive outreach team would continue to be monitored and that further information would be brought back in future reports. Mr Vallance welcomed the attempt to explain complex data clearly, and Mrs Lavery summarised that the Board would continue to receive further updates as the position developed. **The Board received and noted the Organisational Change Key Performance Indicators reporting, the July QSIA monitoring position and the conclusion that the available evidence does not demonstrate sustained CIP-related harm.** **The Board considered the exceptions and data quality points requiring continued oversight, particularly access, waits, supervision definition and call handling, and recognised that several indicators remain stable or improving, including zero GP complaints in Primary Care Mental Health, zero LD unmet needs, zero negative Health Visiting feedback and improving waits in some pathways.** **The Board delegated continued monitoring of identified exceptions to the relevant care group, corporate and executive governance routes, with escalation if sustained or material deterioration emerges.**	
Bpu 26/07/18	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report, including the Trust's emergency, preparedness, resilience and response (EPRR) position, The Value Circle (TVC) action plan, neurodiversity waiting times, the opening of the Acorn Centre, sickness and grievance processes, organisational change impacts, recruitment, ambient voice technology, coproduction, homelessness, the Communities Leadership Executive, medical job planning and planning conditions. The improved EPRR position was noted and need to ensure the final submission and associated actions were completed. Mr Lewis advised that the Trust was expected to submit full compliance in September, subject to the remaining HAZMAT element. The TVC action plan sought to respond to the matters previously discussed in private Board, and would continue to be reported routinely through Mr Gowland and informal Board spaces, with Board members invited to raise any further matters as required.	

Regarding neurodiversity waiting times, Mr Lewis advised that, while progress had been made in children's services, there remained no commissioned solution for adult neurodiversity waits and the position would continue to require national and system attention.

The Acorn Centre would open as an urgent mental health access facility, supported by local partners and linked to the North Lincolnshire crisis offer. Mr Lewis noted the importance of maintaining the intended open access philosophy and culture of the service.

In relation to sickness and organisational change, Mr Lewis advised that work continued to improve the grievance process, with the intention to move towards a four week process from October. Mr Lewis noted the overlap between sickness absence and staff affected by formal processes, and that further engagement and consultation would take place in September and October, including in relation to adult physical health, Doncaster neighbourhood working, end of life care, specialist palliative care and the movement of some specialist teams towards a more generalist model.

Mr Vallance discussed organisational change, including community caseload analysis, sickness, turnover, culture and vacancy levels. Mr Lewis advised that actions were in place for the issues anticipated through the change process and that a more centralised recruitment approach would be introduced from September to reduce reliance on local managers and improve consistency.

Responding to Ms Clark, Mr Lewis confirmed that ambient voice technology (AVT) was used for transcription purposes rather than decision making and stated that early assessment of national guidance indicated broad compliance, but that privacy notices would be reviewed. Ms Clark noted the language within the report and the need to ensure that collaboration and coproduction were accurately reflected, particularly in work with young people and communities.

Dr Graham highlighted homelessness work in North Lincolnshire, including engagement with North Lincolnshire Council and a national charitable bid to expand a homeless health model in a rural and semi rural context. Mr Lewis noted the importance of lived experience feedback in shaping this work.

Following a question from Mr Pandor, Mr Lewis updated the Board on the Communities Leadership Executive (CoLE), noting that the agreed terms of reference provided autonomy to hold the Executive and care groups to account and that the group would have a key role in shaping future strategy beyond 2028.

Dr Shah discussed medical job planning and productivity. Mr Lewis advised that progress had been made and that the Trust intended to complete the current cycle with a focus on quality, before moving to wider productivity discussions in 2027 and 2028. Dr Sinclair noted that medical job planning completion rates had improved significantly compared with previous years.

	The Board received and noted the Chief Executive's report and the forward actions it contained, had explored the patient, people and population issues described (including stability in RCG), and considered any matters of concern not covered within the report. **The Board noted the annex reporting the organisational change process, to be considered alongside the second QSIA report elsewhere within the papers.** **The Board accepted the action plan in response to the TVC well led report and agree to monitor progress through the Board, supported by the NED meeting held monthly.** **The Board noted the EPRR submission of 100% compliance, up from 91% in 2025.**	
Bpu 26/07/19	**Promise 24: Education** Dr Graham presented the paper. The Trust's education journey was highlighted, noting the progress made since the introduction of the current structure and the wider cultural shift towards recognising education as a key strand of learning. Focus was particularly on Promise 24 and drew on internal reflection, feedback from the Education and Learning Group, external scrutiny and assessment, and consideration of equity in access to education and development opportunities across the workforce. Dr Shah reflected on protected learning and asked about the impact of education within learning half days, including how success was assessed beyond attendance. Dr Graham advised that the learning half days had been piloted in Quarter 1 of the previous year and had since been implemented more widely. Although the approach had been successful in many services, there remained challenges in 24 hour services where release time was more difficult to protect. Dr Graham explained that impact was being assessed through a combination of mandatory training compliance, uptake and activity data, and qualitative feedback from staff and applicants. Work was also under way, with external support, to strengthen reporting through ESR. Dr Falk welcomed the clarity of the report and commented that the format made the education position easier to understand. He also referred to the use of terminology such as 'deliverology' and noted feedback from Quality Committee that this should be considered carefully to ensure language remained accessible. Mr Lewis referred to the NHS England biannual assessment process and noted that this was the second time the Trust had received such an assessment, and overall had been broadly positive. Dr Graham advised that feedback from trainees was received through a range of sources, including the National Education Training Survey (NETS) and universities. Mr Lewis and Ms Holden noted that whilst some survey response rates were low, the overall position appeared broadly stable over a five year period and no significant concerns had been raised through alternative routes.	

Mr Chillery welcomed the breadth of education activity and asked about placement development. Dr Graham advised that placements were managed on a multi professional basis, with nursing requirements met and increased opportunities across allied health professional, psychological professions and work experience routes. Mr Sheppard noted the need to better communicate the value of the Trust's significant investment in education and training as part of its employment offer and commitment to staff development.

Ms Blake asked how ward based staff opportunities were being addressed. Dr Graham advised that different approaches had been tested and that the Trust would continue to build on what had worked with leaders. Ms Clark raised apprenticeships, which would be covered later on the agenda, and Dr Sinclair noted the importance of recognising the Trust's positive work for learners.

Dr Graham summarised that learning events were increasingly being opened to wider partners, including GPs, community partners and people with lived experience. The developing online learning hub would support wider access to learning opportunities and strengthen the visibility of the Trust's commitment to education. Mr Lewis requested that the six key recommendations from the paper be reflected in the minutes.

The Board received and noted the Promise 24: Education report, considered the key recommendations and request a 2026/27 training spend dashboard linked to Promise 24 success measures.

The Board noted the outcomes of the external review and NETs.

The Board supported the six key recommendations stated in the paper:

Agree a Promise 24 education and training spend dashboard showing planned and actual spend by source, professional group, staff group, protected characteristic where available, learner experience and workforce outcome.

Progress a part of the bimonthly Education meeting into a multi-professional education investment panel to review high-value training requests, tariff use, CPD, apprenticeship priorities and return on investment.

Adopt a principle of proportionate universalism spend for staff groups traditionally less visible in professional funding models, including peer support, HCSWs and non-registered staff. (Proportionate universalism means the resourcing and delivering of training at a scale and intensity proportionate to the degree of need).

Set a Trust principle that registered staff need job-planned SPA where appropriate, and non-registered staff need equivalent protected learning/development time.

	Bring an annexed NETS/PARE/placement quality report to Board showing RDaSH results by profession, placement area and geography against national NETS themes. **Collate the feedback in terms of the quality of education and educator across all of the different training provided and ensure consistency in learning and feedback.**	
Bpu 26/07/20	**Promise 3: Volunteers** Mr Forsyth presented the paper and highlighted the baseline evaluation and implementation analysis for Promise 3. There were just under 360 active volunteers and more than 450 had been recruited overall. Turnover was around 22%, with some volunteers moving into paid employment and showed 10 volunteers recorded through ESR as moving into employment, although local records indicated the total was likely to be over 20 volunteers. Mrs Lavery welcomed the progress made and recognised volunteering as an important route into employment, as well as a positive contribution to patient experience, therapeutic activity, peer support, dialogue and care planning. Ms Fulton Tindall, Dr Falk and Mrs Vickers discussed the variation in adoption across services, and queried sustainability where local volunteer leads changed, reasons for volunteer turnover, and the need to strengthen qualitative feedback and evaluation. Mr Forsyth advised that volunteers were offered exit interviews and that no significant concerns about volunteer experience had been identified. Ms Blake and Mr Pandor also discussed diversity, inclusion and access to volunteering opportunities, including younger people, people from deprived communities and underrepresented groups. Ms Holden advised that learning from the volunteering programme should inform work experience and wider employment pathways, and that this would be picked up through the relevant People and Organisational Development route. Mr Lewis noted that the next phase should deepen understanding before the 2027 evaluation and consider how management focus and operational ownership could be strengthened. Mr Lewis suggested that Promise 3 should move from expansion to consistent, safe and well governed implementation, and that the requested survey method should be used in 2027. **The Board received and noted the Promise 3: Volunteers paper, and noted the volunteers and staff report positive experiences, with volunteers improving patient experience and day-to-day support where roles are well designed, supervised and integrated.** **The Board recognised that the report framed the main implementation issue as an operational ownership and middle management implementation problem, for which a different response from the central corporate function is needed.**	

	The Board agreed the next phase of the Promise 3 volunteering programme should move from expansion to consistent, safe and well-governed implementation and that the requested survey method that was not used in 2026 is used in 2027.	
	Ms Louisa Redhead joined the meeting at 12.30pm	
Bpu 26/07/21	**NICE Guidance 2025/26 Position** Dr Sinclair presented the paper and advised that the cover sheet should refer to January 2027, rather than July 2027. The current approach to assessing NICE guidance was outlined, undertaking baseline audit where guidance was relevant, and confirming whether guidance had been partially or fully implemented. Areas of potential improvement were noted to support NICE processes. Mr Lewis discussed weaknesses in the existing process, including limited assurance on the quality and ongoing compliance of implementation, variation between care groups, and the need to better identify when service changes brought guidance into scope. It was noted that, while relevant NICE guidance had generally been implemented, the process required strengthening to provide clearer ongoing assurance. Dr Falk welcomed the honesty of the paper and supported taking time to develop a revised process by January 2027. Dr Shah discussed the role of ICB optimisation, whilst Ms Clark referred to the use of NICE quality standards, participation in consultation processes, how guidance was reflected in Trust policy and clinical practice, and how any variation from NICE or Royal College guidance should be managed. Dr Sinclair responded that the Trust generally followed NICE guidance, particularly in relation to medicines, but acknowledged the need to improve how clinicians and staff were kept up to date. Dr Sinclair advised the Board's first focus would be on confirming NICE implementation. In response to questions from Mr Vallance and Dr Falk on outcomes and metrics, Dr Sinclair advised that the next step would be to take a selective approach to identifying the outcome measures and quality standards requiring ongoing monitoring, to avoid overloading existing reporting mechanisms. Dr Sinclair advised that NICE guidance would remain the primary reference point, with more specialist guidance considered where appropriate. **The Board received and noted the Trust's current position regarding NICE guidance implementation and compliance, and supported the policy be amended to allow changes in systems but also improving assurance. The Board agreed to receive in January 2027 an enhanced annual assurance report, and support that updates for NICE go through the QSSG and Quality Committee.**	
	STORY TO BOARD	
Bpu 26/07/22	**Staff story** Mrs Lavery welcomed Louisa Redhead, who was in attendance to share her experiences of development opportunities at RDaSH and how they had supported her career progression in the Trust. Louisa had recently been named Health and Public Service Apprentice of the Year at the	

	East Yorkshire Apprenticeship Awards 2026. This award recognised the commitment, impact and achievement Louisa had demonstrated throughout her apprenticeship journey. Louisa shared her progression from joining the Trust at age 18 in a Band 2 role to her current Band 8a Continuous Service Improvement Manager post. Louisa reflected on the development opportunities she had taken across administration, leadership, project support, programme management and service improvement, including completion of a Master's in Business Administration, a Level 7 Senior Leader apprenticeship and a Level 5 Coaching Professional apprenticeship, all with distinction. Louisa explained that this learning had strengthened her approach to strategy, leadership, change management and service improvement, including work on the depression support pilot, the Elizabeth Quarter, capital schemes and the Acorn Centre. Louisa advised that coaching had influenced her leadership style by encouraging her to listen, ask curious questions and support others to find their own solutions. In response to a question from Ms Gillatt, Louisa advised that she had recently discussed opportunities with the apprenticeship team to share her experiences more widely. Mrs McDonough reflected on Louisa's curiosity throughout her career and asked how others could be supported to take a similar approach where opportunities were not always visible. Louisa advised that leading by example, encouraging curiosity and sharing positive experiences through administration services could help colleagues to explore development opportunities. Mr Chillery noted that some colleagues may not feel confident or included enough to access opportunities and asked how this could be improved. Louisa highlighted the value of protected learning time, coaching and mentoring, and noted that these opportunities could be promoted more widely across the organisation. Mrs Lavery thanked Louisa for her attendance and work at the Trust and noted the intended reflection time later on the agenda in the private Board.	
	Ms Louisa Redhead left the meeting at 1pm	
Bpu 26/07/23	**Estates Full Business Case** Mr Sheppard presented the paper, together with the full business case (FBC). The estates roadshow had engaged with more than 600 colleagues and since then further feedback had been reflected in the wider document. The recommendations had been informed by that engagement, and Mr Sheppard recognised that the Board was required to make the final decision. Rotherham remained the immediate priority and that no wider estate proposals would proceed until a settled plan was agreed. Mr Sheppard advised that discussions continued regarding the Riverside proposal, with an aim to agree the position by the end of August and to support occupation by summer 2027, enabling the Trust to exit buildings that were no longer fit for purpose.	

	Mr Sheppard outlined the five key areas for Board consideration, which were the preferred option for Tickhill Road, the procurement route for the redevelopment, the procurement route for Ambient Loop, the funding proposals, and the proposed land disposal. The preferred option was a phased redevelopment of the retained Tickhill Road site, with land disposal supporting the overall scheme and further design refinement expected. Members supported the direction of travel and discussed funding options, associated risks, cash management, procurement routes, land valuation, overage arrangements, staff involvement, benefits to local communities, and the need to maintain staff identity and team design within future estate planning. Mr Sheppard advised that early contractor involvement through an approved framework was recommended for Tickhill Road, subject to further work, and that a competitive flexible procedure was recommended for Ambient Loop, supported by external procurement expertise. Funding would be through a combination of land sale, public dividend capital and Trust cash, with Ambient Loop funded through a revenue model. Mr Lewis clarified that the revenue model constituted private finance and should be clearly understood. Mr Lewis advised that corporate service location and any Rotherham disposals remained future decisions. Clinical teams would be closely involved in design, supported by experienced architects. **The Board received, noted and considered the Full Business Case supported by the Executive Summary, and recognised the progress made since the March 2026 Board meeting.** **The Board supported the recommended option regarding the Tickhill Road site development.** **The Board supported the recommended option for procurement of the Tickhill Road redevelopment is early contractor involvement through an approved procurement framework. The final recommendation on a procurement framework will be proposed to the Board via the Director of Finance & Estates over the coming ten weeks. The Board's decision will then be transacted within the oversight of the Finance, Digital and Estates Committee.** **The Board supported for Ambient Loop the procurement route is via a competitive flexible procedure.** **The Board delegated the relevant authority to the Chief Executive and Director of Finance & Estates working with the chair of Finance, Digital and Estate committee to finalise the procurement route following further discussions with our legal advisors.** **The Board supported Option B of the funding options, Public Funding for the Tickhill Road Redevelopment and Ambient Loop via a revenue model.**	

	The Board supported to delegate the relevant authority as regarding the land sale to the Chief Executive and Director of Finance and Estates to pursue this further and make a final recommendation through the Finance, Digital and Estates Committee.	
Bpu 26/07/24	**Avoiding Unnecessary Hospital Admission for People Living with Dementia** Dr Sinclair presented the paper and outlined the need to reduce avoidable hospital admissions for people living with dementia. Following recent changes to older people's inpatient service in Rotherham, the Trust was currently able to manage demand. However, demographic growth and increasing dementia prevalence meant that the current model would not be sustainable in the longer term. Dr Sinclair noted that admission to hospital could cause harm for people living with dementia, including deconditioning, delirium and falls, and that future models should focus on prevention, early planning and alternatives to admission where safe and appropriate. There were opportunities to strengthen integrated pathways, particularly in Doncaster where the Trust provided both physical and mental health services. Dr Sinclair noted that a single intervention was unlikely to remove the need for admission, but that a combination of preventative approaches, crisis planning, carer support, partnership working and improved community response could reduce avoidable admissions over time. Dr Falk welcomed the paper and highlighted the importance of advance planning, including supporting carers and families to understand lasting power of attorney arrangements and crisis plans. Dr Falk noted that preventative work with care homes and neighbourhood partners could help reduce unnecessary emergency responses and avoid escalation where alternative support was available. Ms Fulton Tindall welcomed the direction of travel and noted the need to consider the wider social care context, including the practical and financial implications of supporting people safely at home. Ms Blake supported the proposal and emphasised the importance of involving partners, carers, care homes and local groups in developing any future model, recognising that families may see hospital as the safest option unless alternatives are clearly understood and trusted. Mr Lewis supported the paper and noted that setting an ambitious goal to reduce avoidable admissions could help galvanise partners and provide a clear measure of collective effort. Mr Lewis recognised that admissions would not be eliminated entirely, but that a stronger shared focus could significantly reduce the use of hospital settings where community based alternatives were more appropriate. Dr Graham referred to under represented dementia groups, including people with learning disabilities and neurodiversity, and noted the importance of considering comorbidity, exclusion and diagnostic complexity. There would also be opportunity to strengthen research in	

	underdeveloped areas and to link this work with the Trust's wider research priorities. Mr Vallance emphasised the importance of codesign with carers and care homes, drawing on the experience of families who had supported people living with dementia through repeated admissions. Ms Holden noted the potential for digital and technology enabled support to help people remain safely at home, while recognising the need to consider access, affordability and support for carers. Dr Sinclair confirmed that dementia was one of the Trust's key research focus areas and that future work would consider research, under representation, regional collaboration and digital support. **The Board received and noted the Avoiding Unnecessary Hospital Admission for People Living with Dementia paper, and recognised avoidable hospital admission for people living with dementia as a clinical priority.** **The Board supported the development of a system-wide "Right Care, Right Place, Right Time" model with partners, and requested a detailed proposal including workforce, partnership, digital, and financial implications.**	
Bpu 26/07/25	**Culture at RDaSH** Mr Lewis presented the paper, noting the significant programme of work underway in relation to antiracism, antisemitism, antimuslim hatred and wider culture development. Mr Lewis advised that the paper asked members of the Board to form a definitive view on whether the seven actions within the antiracism action plan had been fully addressed, and set out the Trust's movement towards a more proactive and targeted approach to inclusive senior recruitment. Mr Lewis also noted that further analysis of leadership across the organisation would be undertaken and that the REACH Network had requested specific points be included in the proposals. Mr Lewis advised that work on the practical implications of the antisemitism definition and the Government's definition of antimuslim hatred would return in November. Mr Lewis advised that the wider culture work would be developed through coproduction over the following weeks, supported by a steering group and external partner expertise. This work would inform the forthcoming Board time out, September Board discussion and leaders' conference, before a wider programme of engagement with the organisation took place between October and December. Mr Lewis emphasised that this was intended to be a substantive programme of work to help the Board and Executive understand and reconnect with the organisation. Mr Vallance supported the direction of travel and highlighted the importance of ensuring that concepts such as high care, high challenge and accountability were clearly understood and experienced positively by staff. Mr Vallance also noted that the Executive team should reflect on what it meant to lead in that environment, both individually and collectively, and that Non Executive Directors should be included in that dialogue. Mr Lewis agreed that accountability remained important	**TL / CH**

	alongside care and that the Trust should not defer accountability until all aspects of care had been resolved. Ms Blake sought assurance on involvement of people with lived experience in the definition of antimuslim hatred. Mr Lewis advised that the definition used in the paper was the Government definition and had been developed nationally, and that the Trust's next step would be to involve people in understanding the practical implications rather than developing a separate local definition. Mr Forsyth asked whether the antiracism work would apply to all staff. Mr Lewis confirmed that it would apply to everyone, recognising intersectionality and that racism could be experienced across and between different groups. Mr Chillery noted the importance of moving power to staff as well as to communities, and ensuring that coproduction did not become a process led only by the Board. Mr Lewis agreed and noted that the work would need to be reshaped with partners and staff as it developed. Mr Pandor supported the use of the national definition and emphasised the importance of considering how the work was taken forward tactically with the workforce. Mr Lewis noted that staff engagement and coalition building may vary across different aspects of the equality, diversity and inclusion agenda, and that the Trust may need both to work with staff and, where necessary, provide leadership ahead of wider staff consensus. **The Board received and noted the Culture report, and the report's description of ongoing work since the Board last met. The Board had opportunity to discuss the antiracism theme within the paper to a conclusion (noting three pieces of work to return).** **The Board accepted and agreed the definition of antimuslim hatred contained within the paper, and had opportunity to comment on the intended coproduction work in advance of the leaders' conference in September.**	
Bpu 26/07/26	**Promise 9: employment opportunities** Mrs Lavery invited questions for Ms Holden. Mr Lewis noted that the paper described a move towards more targeted and inclusive employment support, including improving existing recruitment processes and investing in approaches aimed at groups who may experience barriers to employment. Mr Lewis asked that the distinction between targeted support and fairness within the recruitment process was made clear. Ms Blake asked whether any policy changes would be required. Mr Vallance sought clarification that the approach was intended to prioritise support and assistance to help level the playing field, rather than favour applicants within the recruitment process. Mr Lewis confirmed that some roles would be ring-fenced for certain applicants, citing the example of citizens with learning disabilities. Ms Holden noted that the work was focused on tailoring recruitment practice to make it more inclusive and accessible to local communities. Standard NHS application processes could be difficult to navigate and were digitally enabled, which did not meet the needs of all applicants.	

	The Trust was therefore considering approaches such as community based recruitment activity, one stop shop support, and practical assistance with applications, interviews and pre employment checks. Ms Clark asked whether a more specific approach or strategy was needed to support people with learning disabilities and autistic people into the organisation at all levels, including through volunteering routes. Ms Holden advised that the paper described a range of entry routes, including volunteering, apprenticeships and paid employment, and noted that the Trust had colleagues with autism who were open about their diagnosis and felt supported within the organisation. The use of reasonable adjustments was highlighted, as well as individual support and the need to open the front door to employment before supporting people to progress within the organisation. Ms Holden also noted the importance of recognising the needs of carers and young people, and shared a recent example from the IT department where T Level placements had generated significant interest in apprenticeship opportunities. **The Board received and noted the Promise 9: employment opportunities update, including the change in practice to support the delivery of the four associated pillars, and the delay in the delivery of the homelessness pillar, pending external support.** **The Board recognised the change in both managerial and HR practices to support the delivery and the longevity of the promise, and the impact on both POD and organisational wide areas to support the delivery of this promise.**	
Bpu 26/07/27	**Engagement/Disengagement data** Dr Sinclair presented the report and reminded the Board of the national and local context for the work on engagement and disengagement, including learning from the Nottingham case and the Trust's own Prevention of Future Deaths learning from 2023. The Trust had revised its previous disengagement policy to strengthen proactive engagement with patients, and that the revised engagement and disengagement policy had been ratified in 2025. As part of this, the audit arrangements had changed from local care group dip samples to a more centralised Trust wide audit intended to provide quantitative data, with further patient record review to follow. Mrs Lavery noted the level of Board interest in the subject and proposed that the audit scope and terms of reference should be reviewed before the next stage of work commenced, to ensure the audit provided the assurance required by the Board. Mr Lewis supported this approach and advised that the work should be framed primarily around learning from the loss of life in Doncaster in 2023, while recognising the wider national context, and emphasised the importance of keeping the local learning and national conversation sufficiently distinct. Mr Vallance noted that the work should consider two important lenses, the management of high risk in community settings, and the health inequalities factors associated with people disengaging from services.	

	Mr Lewis agreed and noted that the Trust should be able to contribute to wider public debate with clear information, including evidence on the relationship between mental illness and serious harm to others, while recognising that national debate could sometimes conflate separate issues. Mrs Lavery noted that the Board needed to understand the reality of how clinical colleagues managed engagement, disengagement and associated risk, so that Board members could describe the Trust's approach accurately. Ms Clark asked that the work also consider self harm and suicide, recognising that the greatest risk associated with disengagement may be to the individual patient rather than to the public. Dr Graham emphasised the need for balance and noted that most patients had capacity and the right to disengage from services, even where clinicians may consider that decision unwise. Dr Graham advised that the Board should be supported to understand the legal, capacity and human rights considerations that informed clinical decision making in this area. It was agreed that the audit scope should be recast and brought back for review, with patient representative input considered as part of the next stage. **The Board received and noted the national and local learning relating to disengagement from mental health services, including learning arising from the Nottingham (Calocane) case and the Trust's October 2023 Prevention of Future Deaths Report.** **The Board noted that the revised Engagement and Disengagement Policy had been implemented in September 2025 and agreed to receive the findings from the first Trust-wide audit of DNA activity and discharges related to disengagement.** **The Board requested a further assurance report following completion of the next audit cycle (Q2) to demonstrate progress and identify any additional improvement actions required. This next cycle should include data from local dip samples. To improve governance around these local audits these should be added onto the Quality and Safety Group workplan to enable bimonthly review but then also analysis of any cross cutting issues that emerge.**	**DS**
Bpu 26/07/28	**Promise 10: inclusion healthcare** Mrs Lavery invited questions for Mr Lewis. Ms Blake asked that Non Executive Directors have further discussion about how individual Board members could reaffirm their commitment to seldom heard voices, following the Board time out in April. Mr Lewis supported this and agreed that the matter should be revisited collectively by the Board, recognising both individual responsibilities and the role of the Board as a unitary body. Dr Falk noted the revised presentation of the quadrant judgement and the additional detail provided in response to previous committee discussion. Mr Lewis commented that the different ways of viewing the data created different perspectives, with some overall judgements appearing more positive than the line by line analysis by geography and	**TL**

	inclusion health group. Mr Lewis advised that, while progress had been made, the paper illustrated significant challenges for the second half of the year. Mrs McDonough highlighted the changing needs of people in prison, including an ageing prison population and increasing dementia related needs, and noted the contractual and partnership complexities involved in providing appropriate support. Mr Lewis advised that the Trust would need to work with local prisons, governors and prison health providers to better understand the current position and how pathways could be strengthened. Mr Lewis also noted that staff may need support to recognise people leaving or accessing care from prison as part of the Trust's patient population. Mr Forsyth highlighted the importance of language when describing people in prison and noted previous work which had supported the use of person centred terminology, such as men or women in prison. Mr Forsyth also noted the need to consider continuity of secondary mental health pathways on release from prison. Mr Lewis agreed that there was a gap between the expected pathway and current practice, and that the Trust should start by understanding current practice before determining what improvements were possible. **The Board received and noted the Promise 10: inclusion healthcare report, and reaffirmed individual commitment as Board members to explore seldom heard voices which we discussed when we held our timeout in April.** **The Board noted the quadrant judgement explored with the committee and recognised the work to do during H2 to cover all IH groups and all places. The Board had opportunity to consider the points raised, noted the progress made, and plans for the future.**	
Bpu 26/07/29	**Dialog+** Dr Graham presented the paper. Dialog+ formed part of a wider personalised care planning approach, noting that the Trust had been seeking to improve consistency in care planning for a number of years. A recent publication of national personalised care guidance was highlighted, which provided helpful context for the Trust's current approach and had been reflected in the annex to the paper. Dr Graham advised that progress had been made in increasing the number of people receiving care through personalised care planning and outcome measures, but that the Trust had not yet achieved the required level of consistency across all services. The Trust had set a target to reach the required position by the end of September and that delivery reviews were focused on areas of variation. Particular attention was being given to substance misuse services, older people's services and some children's services, including the children's eating disorder service. Dr Graham noted that the majority of the issues related to capacity, demand, data quality and the cultural change required to move consistently to a personalised care planning model.	

	Mr Lewis welcomed the clarity of the paper and asked whether the Trust was confident that the September target would be achieved, particularly given the delivery conditions and data flow issues. Dr Graham advised that work was progressing at pace, supported by health informatics, and that some apparent performance issues related to how patients were recorded across multiple services and whether a Dialog+ care plan was clinically required. Work was being undertaken nationally and locally to ensure the data reflected the right cohort of patients. Dr Graham advised that children's services continued to work to the end of September target, with some additional complexity relating to age appropriate outcome measures and existing personalised ways of working. Some legacy system functions were being withdrawn to support migration to the new approach, while colleagues who were anxious about the change would be supported through training, individual discussion and clear expectations about the required model. Dr Falk emphasised the importance of quality as well as quantity in care planning. Dr Graham agreed and advised that the next stage would include qualitative review and audit, including the involvement of people with lived experience and peer support workers in considering whether care plans were meaningful to patients. Dr Graham highlighted the importance of combining numerical assurance with patient and staff experience to understand the quality and impact of Dialog+ in practice. Mr Lewis noted that the national personalised care framework should support the Trust in describing and evidencing its approach to regulators, including the Care Quality Commission. Dr Graham advised that the framework aligned with the Trust's model and that work would continue to ensure staff were able to evidence why particular approaches had been used for individual patients, within the relevant legal and regulatory parameters. There was recognised need to socialise this approach with regulators and to ensure staff were supported to understand what may be expected during inspection. **The Board received and noted the Dialog+ report and noted the progress made and plans for the future**.	
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEE)		
Bpu 26/07/30	**Guardian of Safe Working Hours and Mortality Report (March and April 2026)** Mrs Lavery informed the Board of the Guardian of Safe Working Hours and Mortality Report for information which was presented as a supporting paper that had both previously been presented at committee level for scrutiny and challenge. Mr Lewis noted that the Guardian of Safe Working Hours report identified no immediate safety concerns. It was advised that the report on medical job planning and associated actions would be brought back to the next Board meeting, recognising that a number of actions were already progressing. **The Board received and noted the Guardian of Safe Working Hours and Mortality Report for information**.	**DS**

CLOSING ITEMS		
Bpu 26/07/31	**Any Other Urgent Business** There was no further business raised.	
Bpu 26/07/32	**Any risks that the Board wishes the Risk Management Group to consider** In relation to engagement and disengagement, Mr Lewis recommended a review to be undertaken to identify any emerging risks not currently captured on the risk register, and to ensure these were considered by the Risk Management Group as appropriate. Mr Forsyth added that RSK 044 was monitored through the Risk Management Group.	**PG**
Bpu 26/07/33	**Public Questions** There were no public questions.	
	Close The Chair resolved 'that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press would be excluded from the remainder of the meeting, which would conclude in private.'	
Next Meeting - Thursday 24 September 2026 at 9.30am, Rossington Miners Welfare, Doncaster		

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

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 26/03/14a **Bpu 26/03/14b**	**Promise 14 – Delivering a 4 week wait for all referrals** Regarding the podiatry service, a detailed trajectory would be provided once the additional staff were in place.	RC	**September 2026**: As agreed previously, Paper S provides the latest position within the broader paper on service waits. A separate (service specific) trajectory will be circulated to Board members in September	Propose to Close
Bpu 25/11/15	**Freedom to Speak Up (FTSU) Guardian six month update** Mr Lewis agreed to consider with executive colleagues outside this meeting of a broader culture of speaking up beyond formal FTSU processes.	TL	**September 2026**: July's Culture paper identified changes to the FTSU arrangements which are being operationalised from October. The wider cultural senior management 'look-listen-do' work will provide a further opportunity to understand the concerns of employees.	Propose to Close
Bpu 26/03/06	**Quality Committee (QC)** Regarding Radar task burden, Mr Lewis expressed concern that constant reminders risked desensitising staff, and he asked that the issue be taken through the action log for further refinement.	SF	**September 2026**:The update will be covered as an oral item under the CEO Report today.	Propose to Close
Bpu 26/05/28	**Board and Committee Workplans** Workplans would be reviewed to ensure they fully reflected the intended scope of Committees and in particular the delivery of the relevant Plans.	PG	**September 2026**: The remaining Committees met in August and considered their workplans. Paper X on today's agenda confirms the position and the progress with the receipt of papers written in the new format and the assessment of the workplans.	Propose to Close
Bpu 26/07/24	**Avoiding Unnecessary Hospital Admission for People Living with Dementia** Dr Sinclair to lead the development of a system-wide "Right Care, Right Place, Right Time" model with partners, and provide a detailed proposal including workforce, partnership, digital, and financial implications.	DS	**September 2026:** This has been discussed with the CLE and a work programme is emerging for the coming six months. The Board will be updated on progress in **May 2027**.	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 26/07/25	**Culture at RDaSH** Mr Lewis advised that work on the practical implications of the antisemitism definition and the Government's definition of antimuslim hatred would return in November.	TL / CH	**September 2026**: As reported at the last meeting, the action will be completed through presentation in **November 2026**.	Propose to Close
Bpu 26/07/28	**Promise 10: inclusion healthcare** Regarding how individual Board members could reaffirm their commitment to seldom heard voices, the matter would be revisited collectively by the Board at a future time out, recognising both individual responsibilities and the role of the Board as a unitary body.	TL	**September 2026**: The Board will discuss this matter further within its **October 2026** timeout session.	Propose to Close
Bpu 26/07/32	**Any risks that the Board wishes the Risk Management Group to consider** In relation to engagement and disengagement, Mr Lewis recommended a review to be undertaken to identify any emerging risks not currently captured on the risk register, and to ensure these were considered by the Risk Management Group as appropriate.	PG	**September 2026**: There is a single risk on the register related to disengagement, owned by Dr Sinclair with a key control being the Disengagement / Engagement policy – as above, an audit of its use and effectiveness is underway and will be reported to a future meeting. Within the RMG meetings, the topic has been raised with the five Care Groups and at present no further, service specific risks have been added to the risk register.	Propose to Close
Bpu 26/07/21	**NICE Guidance 2025/26 Position** The Board agreed to receive in January 2027 an enhanced annual assurance report.	DS	**September 2026**: As agreed, the Board will next receive a paper on this topic in its **Janaury 2027** meeting.	Propose to Close
Bpu 26/01/23	**Promise 5 – Making it Real** A dedicated time out session in June for the Board to revisit and align on its understanding of power sharing, and to explore how we would know if our Community Involvement Framework was being delivered.	TL	**September 2026:** This topic, 'power in our communities', was included in the Board's timeout session in June 2026. The Board will return to the topic again in **February 2027** alongside CoLE members. :	Propose to Close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 26/07/27	**Engagement/Disengagement data** It was agreed that the audit scope should be recast and brought back for review, with patient representative input considered as part of the next stage.	DS	**September 2026**: The recast audit scope was shared with all Board members and feedback sought; with support confirmed during the Board timeout session in August. The output of the audit would be presented to the Board of Directors on completion at the **November 2026** Board meeting.	Propose to Close
Bpu 26/05/26	**Freedom To Speak Up bi annual update** Triangulation with wider workforce and patient data would be strengthened, and further work would be undertaken to improve understanding of specific groups, including neurodiverse staff.	SF	**September 2026**: Inclusion of neurodiversity alongside protected characteristics is being developed for future reporting. The next report to Board will be in **November 2026**.	Propose to Close
Bpu 26/07/30	**Supporting paper previously presented at committee: Guardian of Safe Working Hours** The report on medical job planning and associated actions would be brought back to the next Board meeting, recognising that a number of actions were already progressing.	DS	**September 2026**: The current state is being reported to the Board on a weekly basis by CEO and CMO and will be covered orally under the CEO Report item. This item remains open until it is concluded.	Open

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Quality Committee	**Agenda Item**	Paper D
Committee Chair	Dr Richard Falk, Non-Executive Director		
Lead Executive	Steve Forsyth, Chief Nursing Officer		
Date of meeting:	16 September 2026		
Attendees:	Dr Richard Falk, Steve Forsyth, Dr Jude Graham, Dave Vallance, David Vickers. In attendance: Sam Butcher. Phil Gowland, Dr Andrew Heighton Victoria Takel, Cora Turner		
Matters of concern or key risks to escalate to the Board:	None to escalate		
Key points of discussion relevant to the Board:	**Chief Nurse's Triangulation Experience Safety and Effectiveness** Patient feedback was positive, most incidents resulted in low harm and governance performance improved. Areas requiring ongoing oversight included staffing pressures – unexpected sickness and roster discipline (post approval changes), pressure ulcers and waiting times. **Integrated Quality Performance Report** Performance challenges remained in several quality indicators, physical health checks and waiting times, while out of area placements and serious harm incidents remained low. **Ligature Report: What Has Changed** The ligature reduction programme continued to progress through environmental improvements, risk assessments and safety measures. Remaining risks related to some external areas and outstanding estates actions. The anti ligature door investment was noted as a significant quality and safety improvement that has seen Windermere benefit from huge upgrades to patient privacy and dignity that had been replicated across all our wards. **Care Group Representation: Physical Health and Neurodiversity** The Care Group presented an excellent deep-dive session focusing on three principal concerns: transfers of care, community nursing capacity and the ADHD pathway. **Safety and Quality Concerns – Committee View** The Committee undertook exercise to identify the Trust's principal quality and safety concerns. From 11 categories, the theme voted as being the most significant risks included; violence and aggression to staff and operational pressures (short and long term sickness) affecting safe staffing. **Promise 16** Dialog and Dialog Plus were increasingly embedded within routine care, with high completion rates for care plans. Further work was required to strengthen data quality and demonstrate patient outcomes. **VBMS Report** The Vision Based Monitoring System (VBMS) remained well utilised and supported patient safety through improved monitoring, earlier intervention and incident review. Future work would focus on demonstrating measurable impact and progress to achieving 100%		

	training compliance to relevant staff. **Mortality Report May and June 2026** A total of 102 deaths were reported. No significant mortality trends or concerns were identified. Learning themes included mental capacity, communication, self neglect and discharge processes. **Patient Safety Incident Response Framework Approach - Mid Year Review** Implementation of the framework continued to develop through strengthened governance, training and learning processes. Greater use of proportionate learning responses was reported. Open and overdue tasks and workflows are a priority to ensure learning is captured as close to the event/incident as is possible and shared across RDaSH. **Quarterly Thematic Learning Review** Recurring learning themes that have been shared across RDaSH included patient safety incidents, communication, personalised care, speaking up, workforce development and information governance. The review highlighted continued progress in sharing organisational learning and promoting improvement, with work to do.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Committee Chair	Dr Richard Falk, Non-Executive Director		
Lead Executive	Phil Gowland, Director of Corporate Assurance and Board Secretary		
Date of meeting:	4 August 2026		
Attendees:	Dr Richard Falk (Chair), Pauline Vickers. In attendance: Phil Gowland, Laura Brookshaw (360 Assurance), Matt Treharne-Clarke (360 Assurance), Stuart Kenny (Deloitte), Steve Forsyth, Oluwasegun Odumoye, Jill Savoury.		
Matters of concern or key risks to escalate to the Board:	None identified.		
Key points of discussion relevant to the Board:	**Counter Fraud, Bribery and Corruption Progress Report** Counter fraud activity continued to progress, with no active investigations at the time of reporting. Our Counter Fraud work identified an NHS-wide system weakness that has now been addressed nationally. **Internal Audit Progress Report** Significant assurance for Out of Area Placements Financial Governance and a 'low risk high confidence' outcome for the Data Security and Protection Toolkit. Moderate assurance was received for CQC readiness, with some improvement actions identified. **Standing Financial Instructions Quarter 1 Report** Losses and compensation payments totalled £254. An increase in single quote waivers was reported and a review of financial instructions was planned to improve compliance. **Risk Management Framework Update** Risk management arrangements continued to strengthen, with improved oversight and reporting. There were 37 risks outside of tolerance. **RDaSH Internal Audit Progress Report** Overall performance remained positive and the Trust compared favourably with benchmark organisations. **Research Governance Report** Research recruitment exceeded the annual target and the Trust achieved Gold Standard accreditation from the International Accrediting Organisation for Clinical Research. Work also progressed to prepare for future regulatory inspections. **Trust Wide Arrangements for Raising Concerns** Existing arrangements for raising concerns remained in place and use of the process had increased. A more detailed review of staff feedback was planned. Committee noted anticipated changes to FTSU.		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Mental Health Act Committee	**Agenda Item**	Paper F
Committee Chair	Maria Clark, Non-Executive Director		
Lead Executive	Dr Diarmid Sincliar, Chief Medical Officer		
Date of meeting:	19 August 2026		
Attendees:	Rachel Blake, Maria Clark, Dr Jude Graham, Toby Lewis, Shabir Pandor, Dr Rumit Shah, Dr Diarmid Sinclair, David Vickers. In attendance – Philip Gowland, Carlene Holden.		
Matters of concern or key risks to escalate to the Board:	There are ongoing MHA performance concerns within Rotherham Care Group. This was explored with a deep dive that identified that the performance concerns are multifactorial. There were concerns about the completeness of recording ethnicity and work was underway through the Equity and Inclusion Group to understand this better.		
Key points of discussion relevant to the Board:	**MHA Training and RRI Training Compliance Data Analysis** Training compliance improved across all Mental Health Act and Reducing Restrictive Interventions programmes by 30 June 2026. Mental Health Act level 1 compliance remained above 98%, level 2 increased to 96% and level 3 improved to 88% percent. Reducing Restrictive Interventions compliance increased to 86%. Additional training, monitoring and attendance management were implemented to support further progress. **MHA Compliance Report May and June 2026** There were 295 detentions had been processed, with 3 unlawful detentions identified, all within Rotherham. Most issues related to Section 5(2) processes, delayed scrutiny and documentation errors. Performance for capacity assessments on admission remained below expected levels, although improvements were reported and a new expectation of completion within 72 hours of admission was being introduced. Compliance with treatment certification at 3 months remained fully compliant. Section 132 rights performance remained below the internal target, particularly in Rotherham, and further work was underway to validate data and improve recording. Compliance with treatment requirements at 3 months remained fully compliant. **MHA Performance Report May and June 2026** There were 295 detention events involving 245 people, with the highest activity in Doncaster. There were 91 Section 136 assessments all completed within the legal timescales. Section 136 suites experienced several temporary closures due to repurposing, lack of bed availability and cleaning requirements. There were no admissions of people under 18 years into Trust adult inpatient beds. Ten Mental Health Act incidents were reported, no medication incidents occurred, and seclusion review compliance achieved 100% in both months. **Annual MHA Equalities report** The annual MHA equalities report showed that ethnic inequalities in detention continued during 2025 to 2026. Black and mixed ethnicity groups remained disproportionately represented in Mental Health Act detentions, particularly in Rotherham and North Lincolnshire. Although there was improvement compared with the previous year, inequalities		

	remained evident both within the local population and among people already accessing trust services. **Rotherham Care Group– deep dive** The review examined why Rotherham had consistently appeared as an outlier in Mental Health Act reporting. Key concerns related to consent to treatment on admission, Section 132 rights performance, Mental Health Act training compliance and Reducing Restrictive Interventions training compliance. The review found that some reported differences were influenced by variations in reporting methods, data quality concerns and inconsistencies in how capacity assessments had been measured across localities. Operational pressures also contributed, including medical staffing challenges, out of hours admissions, Section 136 demand and communication gaps between ward teams and the Mental Health Act team. Improvement actions included workshops, enhanced monitoring, ward level performance information and exploration of system controls to improve compliance. **CQC MHA Inspections Highlight Report** No Care Quality Commission inspections took place during May and June 2026. Outstanding actions from previous inspections remained, mainly relating to the environment, risk assessments, care planning, advocacy, activities and communication with carers. Several estates related actions were still awaiting completion. **Committee workplan** The committee reviewed its approved workplan. Amendments to the terms of reference were proposed to remove items not directly relevant to the committee role, while maintaining oversight of performance, compliance, inspections, equalities and patient experience

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	People and Organisational Development Committee	**Agenda Item**	Paper G
Committee Chair	Sarah Fulton Tindall, Non-Executive Director		
Lead Executive	Carlene Holden, Executive Director of People and Organisational Development		
Date of meeting:	19 August 2026		
Attendees:	Richard Chillery, Steve Forsyth, Dr Jude Graham, Carlene Holden, Ian Spowart, Sarah Fulton Tindall, Pauline Vickers. In attendance: Jayne Booth, Phil Gowland, Shirley Kirkland, Dr Diarmid Sinclair, Dr Babur Yusufi.		
Matters of concern or key risks to escalate to the Board:	No matters were identified for formal escalation		
Key points of discussion relevant to the Board:	**People and Teams Plan Top Ten Measures** Vacancy levels were 6.32%, turnover at 11%, and PDR compliance exceeded target at 94.27%. Sickness absence improved but remained above target at 7.04%. Agency spend increased due to service pressures associated with medical vacancies. **Medical Staffing Revalidation Annual Compliance** The Trust remained fully compliant with medical revalidation requirements, with appraisal and governance arrangements operating effectively. Of 79 doctors, 72 completed appraisals, all seven revalidation recommendations were positive, and no regulatory concerns were identified. **Education and Learning Plan** Good progress continued, supported by positive external review findings. Investment in education increased, with ongoing focus on equitable access to learning, apprenticeships including the continued success of the levy spend and its link to improved organisational capacity as well as individual career development and professional development. Further work will strengthen reporting on outcomes and spending. **Workforce Race Equality Standard (WRES)** Board representation from minority ethnic staff increased to 25%. While development opportunities remained equitable, disparities persisted in recruitment, disciplinary outcomes and staff experience and this requires further scrutiny alongside the shared lived experiences from our global majority/ethnic minority colleagues. Improvement work continues with a further paper at the October meeting to assess progress. **Workforce Disability Equality Standard (WDES)** Representation of disabled staff improved and recruitment outcomes remained positive. However, challenges remained around engagement, inclusion, bullying and presenteeism. Targeted support programmes continue. **Gender Pay Gap Report** The gender pay gap has reduced significantly over time to 2.22%. A gap remained within senior medical roles, and further work is planned to understand and address underlying causes.		

	Internal Audit Recommendations There is one open audit recommendations under the remit of the People and OD Committee. Work continued on induction improvements and preparations for forthcoming workforce audits. **Staff Safety Incident Report** Violence and aggression incidents reduced to 151, although most occurred in inpatient mental health services. Four reportable staff injury incidents occurred, with corrective actions implemented. **Guardian of Safe Working Hours Report** Exception reports highlighted pressures relating to workload, staffing and training opportunities. Three immediate safety concerns were addressed, with no significant patient safety issues identified but an increase in reporting was acknowledged. It was agreed that future reports will also include an annex from the CMO to summarise the action taken as a result of the exceptions reporting and feedback which will assist in the identification of ongoing areas of risk.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Public Health Patient Involvement Partnerships Committee	**Agenda Item**	Paper H
Committee Chair	Rachael Blake, Non-Executive Director		
Lead Executive	Toby Lewis, Chief Executive (covering Jo McDonough)		
Date of meeting:	16 September 2026		
Attendees:	Rachael Blake, Dr Richard Falk, Carlene Holden, Toby Lewis, Dr Rumit Shah, Dave Vallance In attendance: Dr Andrew Heighton, Ray Hennessey, Dr Roberta Radclifffe-Burns		
Matters of concern or key risks to escalate to the Board:	**Poverty proofing:** The trust has completed the huge task of poverty proofing the entire Trust's clinical services, an unprecedented step within the NHS. The concern now is to ensure that the Board remains preoccupied with implementing real change as a result of this work, and supporting staff to experiment, innovate and act on this promise.		
Key points of discussion relevant to the Board:	**Promise 17 School Readiness** Progress continued across Doncaster and North Lincolnshire, with 3,499 questionnaires issued and 1,625 returned with the additional 2-3 year 'check'. The committee's discussion focused on the welcome depth of engagement and delivery of what we had promised: initial data in November will be too early to know whether we have succeeded but late 2027 will be more indicative. Kindred (a national thought leader) has recognised the innovation in this service. The committee noted no spike as yet in safeguarding concerns – and asked for further consideration of home-schooled young people. **Promise 11 Veterans** Positively, the peer led support work will take place from later in Q3. Colleagues discussed the visibility of Op Courage etc and LHD information was outlined which starts from September 30th. It was agreed to consider consultation records might be mined for veteran status, and whether the information ask can easily be added to pre-consultation PROMs questionnaires. **Health Inequalities Promises (data) Report** With the exception of perinatal mental health, and young people with epilepsy, data indicators do not show the progress needed to deliver. We agreed to revisit in January whether for each area of work we have the right team and ideas to foreseeably succeed during 2027. The revised assurance model will be employed. **Eating Disorders Collaborative** Progress continued in expanding community services and developing a new care model across South Yorkshire was outlined, including new endeavours in relation to physical health monitoring and ARFID. **Risk Register (out of tolerance)** The paper was misframed around >12 risks, but that notwithstanding there are not out tolerance risks, but the viability/sustainability of the current contract and supplier was explored. **Workplan** Amendments were agreed to what was presented separate research, promise 28 and innovation: and to ensure JSNAs are shared before the close of 26/27		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Finance Digital and Estates Committee	**Agenda Item**	Paper I
Committee Chair	Pauline Vickers, Non-Executive Director		
Lead Executive	Simon Sheppard, Director of Finance and Estates		
Date of meeting:	19 August 2026		
Attendees:	Rachael Blake, Richard Chillery, Sarah Fulton Tindall, Carlene Holden, Shabir Pandour, Simon Sheppard, Ian Spowart. Pauline Vickers. In attendance: Philip Gowland.		
Matters of concern or key risks to escalate to the Board:	The contracts with South Yorkshire Integrated Care Board and Humber and North Yorkshire Integrated Care Board had still not been signed.		
Key points of discussion relevant to the Board:	**Strategic Delivery Risk:** The Committee reviewed the strategic risk relating to the use of data to support service change. The risk score reduced from 12 to 9 and further work was planned to strengthen data driven decision making across the organisation. **Cyber Security Update:** The Trust maintained strong compliance with national cyber requirements, achieved Standards Met for the Data Security and Protection Toolkit and continued to strengthen cyber security controls. Future priorities included cloud infrastructure, enhanced monitoring and management of artificial intelligence related risks. **National Health Service Finance Provider Assurance Model:** A new regional financial oversight model was introduced. The Trust was assessed as green retained autonomy, reflecting confidence in financial delivery and reducing external scrutiny. **Integrated Quality Performance Report (Finance):** At the end of June 2026 (month 3), the Trust reported a deficit of £0.09 million, which was better than plan by £0.05m. Cost improvement delivery remained on target, although workforce vacancies, temporary staffing costs and lower than planned rehabilitation unit occupancy continued to present risks. **Trust Procurement Development:** The proposed procurement merger with Sheffield Health Partnership University National Health Service Foundation Trust was discontinued following continued delays. The Trust would now undertake a review of its own procurement arrangements. **National Cost Collection:** The Trust completed the mandatory national submission and continued to demonstrate a low-cost index compared with regional providers. Costing information was being used to support financial planning and future funding discussions, namely the national deconstructing the block exercise. **Estate Plan Full Business Case Progress:** The Committee received an update on the redevelopment of Tickhill Road, future energy infrastructure, land disposal and accommodation plans in Rotherham following the Board approval of the full business case in July 2026.		

**Paper to be managed via questions only

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks	**Agenda Item**	Paper J
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	24 September 2026

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

The Board continues to receive update reports on the Strategic Delivery Risks. At its meeting on 30 July 2026 the Board reaffirmed the five SDRs as its focus for 2026/27.

Each SDR is reported to its allocated Committee before coming to the Board. This report covers the two SDRs considered by their committees since the last Board: SDR2 at the Finance, Digital and Estates Committee on 19 August 2026, and SDR4 at the Quality Committee on 14 September 2026. The approach is set out at Section 2, and the dashboard and Annex continue to show all five SDRs.

SDR2 is held at 9 following the reduction reported in July, and its risk statement has been strengthened with a third cause. SDR4 is held at 12, with a stock take of all services due to complete in September 2026. Both remain within tolerance.

360 Assurance will undertake an audit of the Strategic Delivery Risks in late Q3 or Q4 2026/27, as set out at paragraph 2.6.

In considering the paper, Directors should cross refer this update with the Committee reports to the Board.

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

Each Board of Directors meeting includes this agenda item. SDR2 was considered by the Finance, Digital and Estates Committee on 19 August 2026, and SDR4 by the Quality Committee on 14 September 2026.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and NOTE the update position for SDR2 and SDR4;

NOTE the approach to reporting the SDRs through their allocated Committees, set out at Section 2; and

NOTE the planned 360 Assurance audit of the Strategic Delivery Risks in late Q3 or Q4 2026/27.

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

Equity and inclusion plan			X
Education and learning plan			X
Research and innovation plan			X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X

Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (indicate those that this paper supports)	
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1	X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.	X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.	X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	X

System / Place relevance (advise whether it is national, regional or local)

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

Appendix (please list)
Individual Strategic Delivery Risk forms are in the Annex to the Report.

SDR DASHBOARD BOARD ASSURANCE FRAMEWORK

Strategic Delivery Risk and Assurance Profile September 2026. SDR1, SDR3 and SDR5 reflect the position reported in July 2026.

Strategic Delivery Risk	Current Assurance Rating	Current Risk Score	Direction of Travel	Oversight Committee
SDR1: Partnerships Because the leadership is unable to identify, communicate and engage, there is a risk that the Trust's changed ways of working with the diverse population, including excluded communities, are not delivered by 2027.	ADEQUATE *(inferred)*	12	◀ ▶	PHPIP
Owner's view: Position materially stronger than the previous baseline, but assurance is not yet outcome based. Score retained until effectiveness is evidenced rather than activity. **Latest:** CoLE terms of reference and initial workplan agreed on 9 July 2026, with an initial focus on Promises 5 and 12. **Next:** **Embed CoLE evidence and outputs into the Board and committee reporting cycle, SF, from September 2026.**				
SDR2: Equity and data Because leaders and staff lack the data literacy and confidence to act on data, operational and system pressure removes time and focus, and the data is not consistently complete, timely, reliable or usable, there is a risk that the Trust does not consistently create, use and respond to data to inform service change.	ADEQUATE *(inferred)*	9	◀ ▶	FDE
Owner's view: Controls cover two of the three causes; the gap is leadership time and focus. Score held at 9 following the reduction reported in July. **Latest:** FDE, 19 August 2026: high assurance on two Information Quality Programme indicators. System Connect two way communication and self referral due in place by end October 2026. **Next:** **Proposal to embed the IQPR and core metrics to Executive Group or September CLE; refreshed IQPR due October 2026.**				
SDR3: Community offer Because there is not the skill to change or the confidence to experiment in both parties, or funding models are restrictive, there is a risk that the Trust cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT, PCN and neighbourhood level.	ADEQUATE *(inferred)*	12	◀ ▶	PHPIP
Owner's view: This risk is about the Trust's behaviours as much as those of primary care. ICB change and the national neighbourhood contract consultation leave the future architecture unclear. **Latest:** The survey of GP practices closed on 30 April 2026; analysis is underway and will drive next steps in 26/27. Waiting times are now routinely published on the Trust website. **Next:** **LDO research and evaluation outputs, K Williamson, to be shared in September 2026.**				
SDR4: Bed based care Because of resistance, inflexibility or affordability, with colleagues able to move elsewhere, there is a risk that seven day working and other bed-based service alterations are not implemented fully.	ADEQUATE *(inferred)*	12	◀ ▶	QC
Owner's view: Stock take of all services against Promise 22 and hyperlocal neighbourhood working is on track to complete in September 2026, and will give the actions owners and dates. **Latest:** QC, 14 September 2026: stock take scope and approach defined and on track for September; four gaps in control and three in assurance now identified. **Next:** **24/7 mental health centre in North Lincolnshire opens 30 September 2026; HQTC Stocktake Report to Board November 2026.**				
SDR5: Social value Because the Trust does not develop and practice the skillsets required to make change occur, there is a risk that it does not achieve the step up in institutional and system capability to deliver multiple time bound simultaneous changes with impact by 2027.	ADEQUATE *(inferred)*	12	◀ ▶	POD
Owner's view: Sustained investment in development, with early LDO evaluation showing improvement. This must now become business as usual, and the cultural reset address the divide between newer and longer serving colleagues. **Latest:** Clinical Leaders Training Programme and MPLT development programme commenced in July 2026. Internal audits on induction and MAST both returned significant assurance. **Next:** **Undertake the planned Promise 26 Anti Racism audit, due 2026/27.**				

KEY	SUBSTANTIAL	ADEQUATE	LIMITED	NONE	▲ increased ◀ ▶ unchanged ▼ decreased (vs previous report)

Strategic Delivery Risks

1. Background

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

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

The five risks, each aligned to a strategic objective, were agreed in 2024 and have been periodically reviewed since. At its meeting on 30 July 2026 the Board reaffirmed the five SDRs as its focus for 2026/27. They are set out below:

- The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities (links to SO1)
- Challenges generating data and / or evidence to support interventions to address Health Inequalities (links to SO2)
- Capacity / Capability / Willingness of local primary care leadership cannot match the reform intended or at least implied by others' strategies (links to SO3)
- Movement to seven-day working is poorly reflected in national terms and conditions and the Trust is therefore unable to shift to new models of care without major retention risk (links to SO4)
- The Trust lacks the cultural capability and competence on wider issues (links to SO5)

2. Reporting Approach

2.1 Each SDR is allocated to a Board Committee. The Committee receives a detailed update on its allocated risk, scrutinises the controls, assurances, gaps and actions, and reports to the Board through the Committee reports. The SDR update to the Board then brings forward the position as considered by the Committee.

2.2 From this meeting, the body of this report covers the SDRs that have been considered by their Committee since the Board last met. The Board therefore receives positions that have already been tested at Committee, and its attention is drawn to where the position has moved or new information has emerged.

2.3 Since the Board met on 30 July 2026, SDR2 has been considered by the Finance, Digital and Estates Committee on 19 August 2026, and SDR4 by the Quality Committee on 14 September 2026. These are set out at Section 3.

2.4 SDR1, SDR3 and SDR5 have not been to Committee in the period, and their positions are unchanged from July. Where action dates in their forms have passed, these will be

updated with the Executive leads when each SDR is next considered by its Committee. The dashboard continues to show all five SDRs, and the full forms for all five remain in the Annex, so the Board keeps sight of the complete strategic risk position at each meeting. The remaining SDRs will come into the body of this report as they are considered by their Committees, in line with the Board and Committee Workplan.

2.5 The development work on assurance ratings reported in July remains in progress. The updated Risk Management Framework, presented for approval at this meeting, sets out four assurance levels for operational and strategic risk. Subject to its approval, these will be applied to the SDRs, and until then the ratings shown in the dashboard remain inferred.

2.6 360 Assurance will undertake an audit of the Strategic Delivery Risks in late Q3 or Q4 2026/27, and its findings will be reported to the Board.

3. SDR2 and SDR4 Update Position

3.1 Review and monitoring of the SDRs continues through the executive leads, the tri annual review meetings with executive leads, the Audit Committee Chair and the Director of Corporate Assurance, the Board Committees and the Board of Directors.

3.2 The current position for each SDR is presented in the Annex. Of note for the two SDRs considered by their Committees in the period:

SDR2: Considered by the Finance, Digital and Estates Committee on 19 August 2026. The score is held at 9 (impact 3, likelihood 3), following the reduction from 12 reported to the Board in July, and the risk remains within tolerance. The Chief Operating Officer, who took ownership on 1 June 2026, has strengthened the risk statement with a third cause, so that it now covers the data literacy and confidence of leaders and staff, the time and focus lost to operational and system pressure, and the completeness and reliability of the data itself.

Assurance reported to the Committee included high assurance on two Information Quality Programme indicators, annual physical health checks for people with a serious mental illness and seclusion multidisciplinary review within five hours, and moderate assurance on Section 136 breaches. The Clinical Coding Audit confirmed that robust processes are in place, and the Internal Audit of the reconciliation between ESR and the finance ledger provides a single source of truth for staff data. System Connect has moved from basic functionality to wider use across teams since June 2026.

Controls cover two of the three causes, and the open gap is leadership time and focus. The Operations and Health Informatics Directorate is developing a plan to embed the IQPR and a small core set of metrics through the Senior Leadership Team, Directorate Management Teams and team leaders, supported by training and a three month buddy from the performance function. A proposal is going to Executive Group or the September meeting of CLE and, once approved, will be built into the risk as a planned control.

SDR4: Considered by the Quality Committee on 14 September 2026. The score is held at 12 (impact 4, likelihood 3), unchanged from July, and the risk remains within tolerance. The date for reaching the target score of 8 has been revised from September 2026 to March 2027. Ownership transferred to the Director of Psychological Professions and Therapies on 1 June 2026.

The stock take of all services, aligned to Promise 22 and hyperlocal neighbourhood working, has defined its scope and approach and remains on track to complete in September 2026. Its findings will give the actions in the plan owners, dates and a sequence. There has been no material change to the risk position in the period.

The revised format identifies four gaps in control and three gaps in assurance. The most significant are that no control currently addresses the affordability element of the cause or the national terms and conditions that sit above the Trust, and that there is no independent third line assurance on the risk. The Inpatient High Quality Therapeutic Taskforce Stocktake Report to the Board in November 2026 is the first route to third line assurance.

The 24/7 mental health centre in North Lincolnshire opens from noon on 30 September 2026, and its effect on weekend access and out of area placements will be reflected in the next update.

4. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the update position for SDR2 and SDR4;
NOTE the approach to reporting the SDRs through their allocated Committees, set out at Section 2; and
NOTE the planned 360 Assurance audit of the Strategic Delivery Risks in late Q3 or Q4 2026/27.

Philip Gowland, Director of Corporate Assurance
September 2026

SDR1 STRATEGIC DELIVERY RISK

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

AGGREGATED ASSURANCE RATING	**ADEQUATE**

THE RISK As a Strategic Delivery Risk

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

Live issue feeding this risk: *N/A*

What could get in the way?

The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities.

KEY EFFECTS AND CONSEQUENCES

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

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

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

Risk category	External and Partnerships Risks - Change and Improvement Delivery Risk	**Risk appetite**	Moderate
Last deep dive review	July 2026	**Appetite Status**	Within Tolerance
Date of last update	July 2026		
Next review	October 2026		

Commentary

Strategic Risk Owner Commentary

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

Director of Corporate Assurance — second line

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

Tables of Controls and Assurances			
Key Controls / Mitigations For Cause: the leadership is unable to identify, communicate and engage with a diverse population *[system in place to help manage the cause / effect]*	**Assurance / Evidence** *[where can we gain evidence that the controls we are placing reliance on are working]*		
	First Level *[Service delivery and day to day management - how do we know day to day that controls are working?]*	**Second Level** *[Oversight - who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]*	**Third Level** *[Independent challenge - has anyone external come in to check that the controls are working]*
Stakeholder Management Matrix and place-based partnership meetings	• Place based partnership meetings now monthly; March meeting focused on Rotherham, previous meetings on North Lincolnshire and Doncaster; attended by two EG colleagues and relevant care group representatives.	• PHPIP Strategic Delivery Risk Report to the PHPIP Committee each meeting (most recent July 2025). • Management reporting to Board and CLE against related Promises via the Promises and Priorities Scorecard.	• Internal Audit on Partnership Governance and Risk Management, significant assurance, all actions complete.
Community Leadership Executive (CoLE)	• Terms of reference and initial workplan agreed 9 July 2026; positioned as a sister executive to the Clinical Leadership Executive, designed to challenge, advise, support co production and strengthen VCFS and community influence over Trust decisions. • Membership of 15 community representatives selected from more	-	-

	than 35 applications, including voluntary and faith sector leaders. • Initial focus on Promise 5 and Promise 12, with Promise 6 and Promise 21 to follow; scrutiny of seldom heard voices and review of induction material for cultural competence.		
Coproduction as the standard for service and policy change (Promise 5)	• Major policy and service changes involve patient and carer input through co design sessions, steering groups and public workshops, with community representatives shaping solutions rather than being consulted after the fact.	-	-
Delivering services in community and faith settings	• Services taken into non-traditional settings to improve access for excluded groups, including memory assessment delivered in a mosque and health checks offered in community hubs.	• Example of dementia assessment in a community faith setting reported to the Rotherham Quality and Safety meeting.	-
Engaging our communities, seeking feedback (Care Opinion)	• Care Opinion launched for patients and carers; featured in Care Group Delivery meetings in 2024 and May 2025. • Volume of Care Opinion stories tracked as an indicator of patient voice; feedback loop closed through you said, we did communications.	• Care Opinion featured in the February 2025 Board Timeout led by the CEO of Care Opinion, and at Council of Governors June 2025; overarching analysis of responses, including those leading to action, reported to Board in September 2025 within the Chief Executive's Report.	• Internal Audit on Patient Experience, Engagement and Inclusion, significant assurance.

Carers, volunteers and peer support roles as partners (Promise 2)	• Expansion of peer roles, volunteer and carer involvement across care and governance; over 350 volunteers contributing regularly, with a volunteer cohort more diverse than the paid workforce; carers engaged in care planning and Trust improvement work. • Standardised Think Carer, always ask always support model in place, with a SystmOne carer identification and referral template and Carer Peer Support Worker roles; joint local authority reporting from Q2 2026/27 and Carers Federation Accreditation trajectory to December 2026.	• Promise 2 carries measurable milestones reported through the Promises and Priorities Scorecard.	• Internal audit of the Carers Plan and internal audit on the Promises cited as sources of independent assurance.
Representative workforce, patient safety partners and members	• Collation and presentation of numbers, action plans for increased numbers, and analysis against the communities served, used within recruitment and decision making.	• WRES report reviewed and approved by POD Committee (August); some areas improved, others declined. WDES not improving as fast as WRES, discussed at POD and to be taken to the DAWN network and Combined Staff Network to identify actions.	-
Leadership Development Offer (LDO), compassionate and inclusive leadership to unlock community power	• Baseline data established at commencement of the programme; further cohort feedback and analysis as cohorts complete. • Programme covers approximately 150 leaders in cohorts across 2024 to 2026, explicitly aligned to SO1, with modules including Unlocking Community Power and Active Bystander.	• LDO feedback and further detailed analysis planned, including whether the Trust has developed compassionate leadership and whether the LDO improved leaders' engagement; review of impact on cohorts planned by March 2026. • Featured as LDO learning outcome 2, enhancing the ability to lead change and deliver improvements;	-

	• Community immersion experiences and reflective modules on equitable leadership; leadership forums, action learning sets and supervision incorporate power, privilege and voice.	LDO providers have added a line manager evaluation question.	
Active Bystander training	• Training deployed to move staff from passive observation to active intervention where discrimination, bullying, micro aggressions or unsafe practice are witnessed, framing intervention as a professional duty. • Over 300 staff trained by late 2024; extension underway to further teams and to managers in higher risk areas.	-	-
Anti Racist Behavioural Framework and taught learning culture	• Anti Racist Behavioural Framework in place setting explicit behavioural expectations; racism, discrimination and exclusion treated as organisational risks within risk management and improvement work rather than as individual matters. • Culture change delivered through formal training, continuous reinforcement in meetings and modelling of expected norms rather than reliance on good intentions.	• Learning Half Days discussed at the Education and Learning meeting June 2025; paper to CLE June 2025; paper to Board March 2025. • Equity and inequality data, including patient feedback trends by demographic and volunteer diversity, routinely discussed at Board and committee.	-
Induction for all new starters, RDaSH and our communities	• Thirteen inductions since launch in October 2024, circa 650 staff progressed; evaluation asks whether participants understand how their role supports the Strategic Objectives and Promises.	• Evaluation of induction presented in the Autumn to the People and Teams CLE Group.	• Internal Audit on Induction, significant assurance (25/26 audit plan).

	• Induction sets cultural expectations from day one, stating the Trust's position on racism and exclusion and that speaking up and challenge are expected behaviours.		
Freedom to Speak Up, staff networks and staff voice	• Freedom to Speak Up route available to all staff, supported by staff networks and leadership open forums as additional routes to raise concern. • Staff Survey Voice Scorecard and the Trust People Council used to test whether staff experience aligns to stated expectations.	• Freedom to Speak Up data and internal pulse surveys in late 2025 indicate a higher proportion of staff confident to speak up than at baseline.	-
Monitoring of leadership behaviour through appraisal and feedback	• Appraisal and 360 feedback used to observe whether leaders make space for challenge and demonstrate inclusive behaviour; leadership cohorts provide structured peer reflection on shifts in practice.	-	-
Control Lead: SF			**Assurance Level: ADEQUATE**

Gaps in control	Gaps in assurance
• Anti Racist Behavioural Framework is in place but there is no process to test whether the behavioural expectations it sets are applied in practice. (No action currently in the plan) • Induction process refinements identified from feedback not yet deployed. (Action 3) • No embedded process yet to ensure recruitment and appraisal test alignment to the Trust's values. (Action 4)	• CoLE began meeting in May 2026 with no second- or third-line assurance and no defined reporting route into Board or committee. (Action 7) • Active Bystander training evidenced by delivery volume only; no oversight reporting of coverage by team or service, no measurement of behavioural impact, and no independent review. (No action currently in the plan) • Flow of partnership review outcomes within the Trust not yet confirmed; reporting route to CLE to be clarified. (Actions 1 and 6)

• Learning Half Days control not yet fully developed; forward plan and learning library outstanding. (Action 5) • Volunteer coverage patchy, with several services having none, roles not consistently backfilled, and over 100 active volunteers not registered as Trust members owing to data issues. (Action 8) • Community Physical Health Team not yet launched; it becomes a control only from the August 2026 launch. (Action 9) • Carer involvement inconsistent at ward level, with PSII and governance evidence still identifying documentation and embedding issues. (Action 11) • Ethnicity and protected characteristic data gaps, with interpreter service uptake low and variable. (Action 12)	• LDO impact on leaders' capability and engagement not yet evaluated; outcome thresholds and quantitative measures still to be determined. (Action 2) • WDES not improving at the rate of WRES; actions still being identified. • No closed loop evidence yet showing how CoLE, Care Opinion, carer, volunteer or community feedback has changed decisions, practice or outcomes. (Action 13) • Outcome metrics inconsistent across Promise 2, Promise 3, Always Measures and equity and inclusion work, with no common measures or thresholds. (Actions 10 to 13) • Staff Survey raising concerns score has declined for three consecutive years, with some directorates combining low reporting and low confidence. (Action 14)

Action plan to close the gaps

Action	Gap addressed	Owner	Due	Progress	Status
Place Partnership Reviews (cake meets) scheduled monthly	**Assurance gap**	-	Commenced Jan 2026	Meetings commenced January 2026; March 2026 meeting focused on Rotherham, previous meetings on North Lincolnshire and Doncaster. Reporting process to CLE still to be clarified.	**In progress**
LDO research and evaluation, including assessment against expected levels of achievement	**Assurance gap**	K Williamson	May 2026	-	**Planned**
Consider changes to the induction process to reflect feedback	**Control gap**	Induction and Widening Participation Manager	July 2026 onwards	Changes to be deployed over the summer of 2026.	**Planned**

Develop a process to embed values alignment in recruitment and appraisal	**Control gap**	-	From July 2026	Explored via the Trust People Council and the annual Staff Survey Voice Scorecard; from July 2026 all interview panels for roles B7 and above constructed to ensure panel diversity.	**In progress**
Develop a robust forward plan for Learning Half Days, including a learning library	**Control gap**	-	-	-	**Planned**
Confirm the flow of partnership outcomes and reporting to CLE	**Assurance gap**	-	-	-	**-**
Embed CoLE evidence and outputs into the Board and committee reporting cycle	**Assurance gap**	SF	From Sept 2026	-	**Planned**
Establish the volunteer dashboard and backfill process, including registration of active volunteers as Trust members	**Control gap**	SF	Q3 to Q4 2026/27	-	**Planned**
Launch the Community Physical Health Team and produce the first outbrief, validated workplan and coverage dashboard	**Control gap**	SF	Aug to Sept 2026	Launch event held 30 June 2026 with 81 participants; 118 service validated Community Services Directory in place.	**In progress**
Deliver Promise 2 Q2 reporting, including SystmOne carer data, local authority outcomes, Carer Peer Support Worker activity and accreditation gap analysis	**Assurance gap**	SF	By Sept 2026	-	**Planned**
Close equity and inclusion gaps on ethnicity coding, interpreter service oversight and Promise 8 measures	**Control gap**	SF	Sept 2026 and Q3	-	**Planned**

Strengthen patient experience triangulation across Care Opinion, PALS, complaints, patient safety and FTSU	**Assurance gap**	SF	Sept to Nov 2026	-	**Planned**
Deliver FTSU targeted directorate engagement and the adverse effects SOP	**Control gap**	SF	Next cycle 2026/27	-	**Planned**

SDR2 STRATEGIC DELIVERY RISK

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

AGGREGATED ASSURANCE RATING	ADEQUATE

THE RISK As a Strategic Delivery Risk

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

Live issue feeding this risk: *N/A*

What could get in the way?

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

KEY EFFECTS AND CONSEQUENCES

- A lack of precision in how the Trust reshapes services

Accountabilities and review history	
Strategic risk owner	Chief Operating Officer- Richard Chillery
Board oversight forum	FDE
Risk category	External and Partnerships - Change and Improvement Delivery Risk.
Last deep dive review	July 2026
Date of last update	**September 2026**

Risk analysis	Current — September 2026	Previous – July 2026
Risk score (Impact x Likelihood)	3 x 3 = **9**	3 x 3 = 9
Target score by Mar 2027	3 x 2 = 6	
Risk appetite	Moderate	
Appetite Status	Within Tolerance	

Next review	October 2026		

Commentary

Strategic Risk Owner Commentary

Since taking ownership of this risk in June, I have strengthened the risk statement with a third cause, so it now reflects three distinct strands: data literacy and confidence, the time and focus lost to operational and system pressures, and the completeness and reliability of the data itself.

Controls are in place against two of these three areas, with the strongest assurance currently sitting around data quality. The main gap is leadership time and focus. A plan to embed the IQPR and a small core set of metrics through our leadership and team structures is going to Executive Group or CLE in September and will become the control for this gap.
Two assurance actions, the final data quality indicators and the health inequalities analysis, depend on the refreshed IQPR due in October 2026 and will be completed by the end of the year. System Connect will be fully in place by the end of October. I am also linking this risk more clearly to the health inequalities programme and neighbourhood development, so that our approach to data driven change is tested through practical delivery.

Director of Corporate Assurance — second line

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

Tables of Controls and Assurances

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

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

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

Gaps in control	Gaps in assurance
• No control addresses the leadership time and prioritisation part of the cause. The controls cover data and skills, not leaders being distracted by wider system priorities. (Action 7) • System Connect not yet fully implemented; enhanced two-way patient communication and self-referral still being rolled out. (Action 4) • Suite of health inequalities data not yet fully developed. (Action 5)	• Ethnicity data incomplete where a person's ethnicity is not known or not stated. (Action 5) • Impact of the leadership education effort not yet evidenced; colleague responses demonstrating learning not yet identified. (Action 6) • Final two data quality indicators still to complete and report. (Action 1) • No independent, third line assurance on the leadership education control. (No action currently identified)

Action plan to close the gaps

Action	Gap addressed	Owner	Due	Progress	Status
Complete the final two data quality indicators in the 25/26 workplan (adult ADHD waiting list OP59a; CYP neurodevelopment OP59b)	Assurance gap	Jo MacDonough	December 2026	Dependent on the refreshed IQPR, due October 2026. The two indicators will be completed once it is in place.	In progress
Complete the health inequalities analysis and reformatted IQPR	Assurance gap	Jo MacDonough	November 2026	Dependent on the refreshed IQPR, due October 2026. The analysis will follow once it is in place.	Planned
Internal Audit on ESR and Finance Ledger reconciliation, to give a single source of truth for staff data	Assurance gap	-	May 2026	Completed and report received	Completed

Conclude the System Connect work (two-way patient communication and self-referral)	**Control gap**	-	October 2026	In wider use across teams since June 2026. Two way patient communication and self referral are on track to be in place by the end of October 2026.	**In progress**
Develop the health inequalities data suite and Equity and Inclusion Group action plan (ethnicity data gaps, SO2 metrics, RDaSH 5 and Poverty Proofing, IQPR analysis follow up)	**Assurance gap**	Equity and Inclusion Group	From April 2026	-	**In progress**
Embed data and digital in the TNA 2026/27, evidence colleague learning from Data Saves Lives, and extend digital apprenticeships and the use of AI tools, including Copilot	**Assurance gap**	-	2026/27	Two digital apprenticeship posts recruited. All staff have access to Copilot, and around 450 have access to the premium version until the end of March 2027. Its use is being evaluated.	**In progress**
Develop and agree the plan to embed the IQPR and a small core set of metrics through SLT, DMTs and team leaders, with training and a three month buddy from the performance function	**Control gap**	Operations and Health Informatics	September 2026	Proposal to Executive Group or September CLE	**In progress**

SDR3 STRATEGIC DELIVERY RISK

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

AGGREGATED ASSURANCE RATING	ADEQUATE

THE RISK As a Strategic Delivery Risk

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

Live issue feeding this risk: *N/A*

What could get in the way?

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

KEY EFFECTS AND CONSEQUENCES

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

Accountabilities and review history	
Strategic risk owner	CEO-Toby Lewis
Board oversight forum	PHPIP
Risk category	External and Partnerships - Partnership Working Risk.
Last deep dive review	July 2026

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

Date of last update	July 2026
Next review	October 2026

Commentary

Strategic Risk Owner Commentary

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

Director of Corporate Assurance — second line

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

Tables of Controls and Assurances

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

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

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

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

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

SDR4 STRATEGIC DELIVERY RISK

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

AGGREGATED ASSURANCE RATING	ADEQUATE

THE RISK As a Strategic Delivery Risk

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

Live issue feeding this risk: *N/A*

What could get in the way?

Movement to seven-day working is poorly reflected in national terms and conditions, and the Trust is therefore unable to shift to new models of care without major retention risk

KEY EFFECTS AND CONSEQUENCES

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

Accountabilities and review history	
Strategic risk owner	Director of Psychological Professions and Therapies – Judith Graham
Board oversight forum	Quality Committee
Risk category	External and Partnerships - Change and Improvement Delivery Risk
Last deep dive review	July 2026

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

Date of last update	**September 2026**
Next review	October 2026

Commentary

Strategic Risk Owner Commentary

Initial work has defined the scope and approach for the stock take of all services, aligned to Promise 22 and hyperlocal neighbourhood working. It remains on track to complete in September 2026, and its findings will inform the forward plan of measurable actions. There has been no material change to the risk position in the period.

Director of Corporate Assurance — second line

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

Tables of Controls and Assurances

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

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

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

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

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

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

union and staff side responses, Employee Relations indicators)					
Increase self-help services with swift access to advice and support, including enhanced community support for those discharged in the first 72 hours	**Control gap**	-	-	-	**Planned**
Complete the stock take of all services aligned to Promise 22 and hyperlocal neighbourhood working, and develop the forward plan of measurable actions	**Control gap**	JG	September 2026	Scope and approach defined; on track	**In progress**

SDR5 STRATEGIC DELIVERY RISK

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

AGGREGATED ASSURANCE RATING	ADEQUATE

THE RISK As a Strategic Delivery Risk

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

Live issue feeding this risk: *N/A*

What could get in the way?

The Trust lacks the cultural capability and competence on wider issues

KEY EFFECTS AND CONSEQUENCES

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

Accountabilities and review history	
Strategic risk owner	Director of People & OD- Carlene Holden
Board oversight forum	POD

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

Risk category	External and Partnerships - Change and Improvement Delivery Risk.
Last deep dive review	July 2026
Date of last update	July 2026
Next review	October 2026

Risk appetite	Moderate
Appetite Status	Within Tolerance

Commentary

Strategic Risk Owner Commentary

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

Director of Corporate Assurance — second line

Synergy with SDR1; impact of development work with our leaders

Tables of Controls and Assurances			
Key Controls / Mitigations For Cause: the Trust does not develop and practice the skillsets required to make change occur *[system in place to help manage the cause / effect]*	**Assurance / Evidence** *[where can we gain evidence that the controls we are placing reliance on are working]*		
	First Level *[Service delivery and day to day management - how do we know day to day that controls are working?]*	**Second Level** *[Oversight - who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]*	**Third Level** *[Independent challenge - has anyone external come in to check that the controls are working]*
Induction (launched 28 October 2024)	Evaluative feedback from participants after each induction	• Periodic induction feedback to the People and Teams CLE Group; next due in the Autumn.	• Internal audit - significant assurance, received September 2025.
Feedback from our colleagues (Staff Survey, Open Staff meetings, Pulse Check, Care Opinion staff view, Ask Talk Influence)	• Staff Survey as the primary source of feedback from colleagues internal to the Trust. • Open Staff meetings in the Autumn with over 200 attending; new dates have been scheduled for 2026. • Pulse Check underway quarterly; Care Opinion capturing the staff point of view within teams. • Ask, Talk, Influence meetings started April 2026, undertaken monthly as a team brief to all RDaSHians.	• Headlines and recurring themes from Open Staff meetings shared within EG. • Voice Scorecard Report to the Trust People Council. • Staff Survey results show useful differences by length of service, with those at the Trust under five years being more positive.	-
Monthly Learning Half Days (commenced September 2024)	Scheduled, pilot in Children's, pilot for inpatients - launch of the learning hub	-	-

Leadership Development Offer - compassionate leadership to unlock community power	• Baseline data established at commencement of the programme; additional feedback and analysis as cohorts complete.	• POD Strategic Delivery Risk Report relating to the oversight and management of SDR5, to the POD Committee at each meeting throughout 25/26.	-
Wider learning opportunities (Leaders Annual Conference, First Line Managers Training Scheme, 555 Line Managers)	• Leaders Annual Conference reaching circa 130 staff as the top leaders' cadre. • First Line Managers Training Scheme launched April 2025. • 555 Line Managers focused on development and communication channels.	• People and Teams CLE Group and Education and Learning CLE Group established and meeting regularly.	-
Community Leadership Executive (CoLE)	• New body of 15 community representatives established to provide community-based feedback, be involved in decision making and holding to account, provide strategic input, facilitate communication, develop partnerships, build capacity and help co production; first meeting May 2026. Community partners feedback to be extracted from LDO feedback as a distinct category.	-	-
Increased capacity (apprenticeship levy under Promise 9, full recruitment to 97.5 percent, ringfenced training budget)	• Apprenticeship levy overused in 25/26, with levy transfers including to community colleagues. Planned over spend in 2026/27 as demonstrated by the Q1 data	Promises and Priorities Scorecard: P9 Apprenticeships reported March 2025; P26 Anti Racism reported to the Board of Directors March and May 2025.	• Internal audit on MAST - significant assurance, received April 2025.

	• Current vacancies tracked in the CEX Report Annex and within the change management process, aiming to keep the total below 100 at any one time. • 2026/27 ringfenced training budget in place again, with utilisation of 100 percent or more anticipated. Additional investment in the training budget from our own investment fund _ £75k • MAST and PDR compliance letters to 421 and 157 colleagues respectively in May; follow up due early June 2026.		

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

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

Action plan to close the gaps

Action	Gap addressed	Owner	Due	Progress	Status
Develop mechanisms of feedback from leaders to demonstrate their	**Assurance gap**	-	-	-	**Planned**

increased competence and confidence in making change occur and adding social value, with colleagues on the stated programmes as the audience					
Complete the further LDO analysis, review the capability and capacity of leaders post LDO, and establish in advance the level at which the outcome is deemed positive (for example 85 percent)	**Assurance gap**	-	Review by Mar 2026	Evaluative feedback from participants after each induction	**In Progress**
Deliver the planned learning programmes: Clinical Leaders Training Programme and the MPLT development programme	**Control gap**	-	2026	Commenced in July	**In Progress**
Implement the revised appraisal process, identifying and responding to the need to create learning opportunities for each colleague	**Control gap**	-	During 26/27	-	**Planned**
Implement the approved 2026/27 Training Needs Analysis	**Control gap**	-	-	Approved	**In progress**
Undertake the planned Promise 26 Anti Racism audit	**Assurance gap**	-	Q4 25/26	-	**Planned**
Secure further internal assurance on induction via an independent colleague and the Induction and Widening Participation Manager	**Assurance gap**	-	-	Delivered. But the review and development will be ongoing	**Completed**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Operational Risk Report	**Agenda Item**	Paper K
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	24 September 2026

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

This report provides the Board with an update on the Trust's operational risk position, drawing on the Risk Management Group meetings held on 4 August and 1 September 2026. Reporting continues to be aligned to the agreed risk appetite and tolerance levels. The number of risks outside tolerance has reduced from 38 to 35 since the last Board, while the register has grown from 386 to 431 risks – from 1 October all risks will be visible via Radar to all colleagues in the Trust.

Thirteen risks have moved into the out of tolerance position since the last report and sixteen have left it. Two of the newly out of tolerance risks, relating to care records at Danescourt and paper-based medication recording at Diamond Lodge, are drawn to the Board's attention in Section 3. Patient Care continues to hold the largest share of out of tolerance risks, all within Clinical Safety.

The report also presents version 13 of the Risk Management Framework, included in Pack B of the Board papers. The framework has been restructured into a clearer format and refined, rather than rewritten, with three key changes: a Risk Escalation Schedule, delegated risk closure, and clear authority for accepting risk. The Risk Management Group has reviewed and supported the proposals, and the framework is presented for the Board's approval

A reminder that expected resolution timeframes are not fixed. They are based on the current assessment of control effectiveness and planned mitigation, and will be refined as actions progress, controls embed, and further assurance is obtained.

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

The paper has not been considered elsewhere although the content and stated position has been subject to review via Risk Management Group

Recommendation (delete options as appropriate and elaborate as required)

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

APPROVE the Risk Management Framework, version 13, which is included in Pack B of the Board papers.

Alignment to strategic objectives (indicate those that the paper supports)

Not applicable

Alignment to the plans: (indicate those that this paper supports)

Estate plan	X
Digital plan	X
People and teams plan	X
Finance plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X
Research and innovation plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	

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

Strategic Delivery Risks (indicate those that this paper supports)							
Not applicable							
System / Place relevance (advise whether it is national, regional or local)							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Appendix (please list)							
Appendix 1- Downgraded Out of Tolerance Risks (No longer Out of Tolerance) Appendix 2 - Out of Tolerance Risks (Currently Out of Tolerance)							

1. Overview

1.1 Operational risk reporting continues to focus on alignment to the Trust's defined appetite and tolerance levels, providing a clearer and more meaningful view of risk exposure across all directorates.

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

1.3 This report also presents the updated Risk Management Framework for the Board's approval. The framework has not been rewritten. It has been restructured into a clearer format and updated, with three key changes, set out in Section 5. The Risk Management Group has reviewed and supported the proposals, and the framework is presented for the Board's approval.

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

2. Current Operational Overview

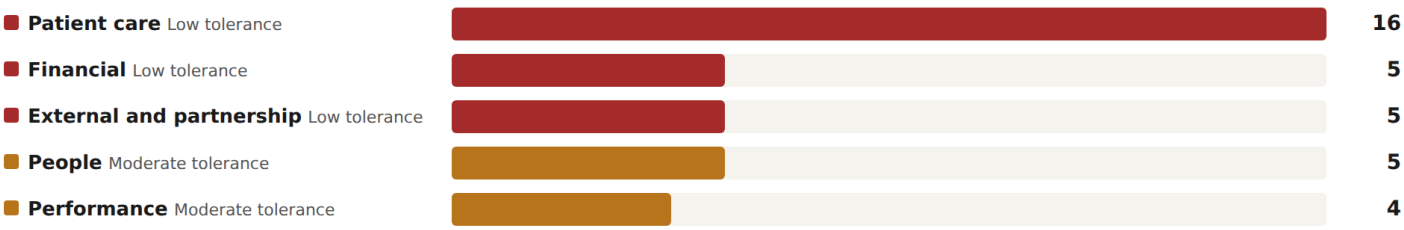
Operational risk position

Total risks	Within appetite	Within tolerance	Out of tolerance
431	**137**	**259**	**35**
from 386 · **+45**	from 127 · **+10**	from 221 · +38	from 38 · **−3**

Position vs last Board (July)

Out of tolerance by theme

74% sits in Low tolerance themes: Patient Care, Financial, External and Partnership



Movement since the last Board

Opened	Closed	Newly out of tolerance	Moved back within
100	**55**	**13**	**9**

2.1 The rolling approach to reviewing out of tolerance risks continues to operate as intended. The focus remains on those areas where assurance is most needed, allowing sufficient time for actions to take effect and for progress to be meaningfully assessed.

2.2 A moderation session continues to be held ahead of each Risk Management Group meeting to review risk scores and appetite alignment. This allows the group to direct its attention to the adequacy and effectiveness of controls and mitigations, rather than recalibrating scores during the meeting itself.

2.3 The register has grown from 386 to 431 risks since the last Board. Across the two reporting cycles, 100 risks were opened and 55 closed. Ten of the new risks sit with High Dependency Rehabilitation, a new directorate whose register was built through a risk identification session with the team. The number of risks outside tolerance has reduced from 38 to 35. Thirteen risks have moved into the out of tolerance position and sixteen have left it, nine by moving back within tolerance or appetite and seven through closure. The current out of tolerance risks are listed at Appendix 2.

2.4 Of the 35 risks outside tolerance, 26 (74%) sit in themes for which the Board has set a Low tolerance position: Patient Care (16), Financial (5) and External and Partnership (5). This compares with 71% at the last report. All 16 Patient Care risks sit within Clinical Safety. People Risk is now the largest theme on the register with 118 risks, having overtaken Patient Care. In September the Risk Management Group escalated to CLE the staffing pressures in North Lincolnshire, including the effect of sickness in Rotherham on cover for North Lincolnshire.

2.5 Nine risks recorded as out of tolerance in the previous Board report have moved back within tolerance or appetite. They include RSK 679, insufficient medical cover in Rotherham Older People's Community Mental Health Team South, which was drawn to the Board's attention in July and now scores 8. These risks remain on the register and continue to be monitored through the relevant care group governance arrangements. They are presented in Appendix 1.

2.6 At its last meeting the Board sought assurance on RSK 687, prescribing errors in the Doncaster Community Learning Disability Team. The risk has reduced from 16 to 12. An audit of incident forms from June to September found no related incidents, and the likelihood score has reduced to 3 while the impact remains at 4. A repeat audit will be undertaken in October. At 12 the risk remains outside tolerance for Clinical Safety, and its expected resolution remains Q4 2026/27.

2.7 The Board also sought assurance on the timescales for door replacement. Installation of anti-ligature doors on Windermere (RSK 476) has now been completed through the capital programme. The risk scored 10 at the last review and will be reassessed through the Risk Management Group. The damaged Section 136 suite doors in North Lincolnshire (RSK 640) have been strengthened in the interim, the risk has reduced from 12 to 9, and the replacement door is expected by October.

3. Significant Risks

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

3.2 The following two risks are drawn to the Board's specific attention because they have newly moved into the out of tolerance position in this reporting period and reflect material exposures that have emerged since the last Board report. Both sit within Doncaster Learning Disabilities and Forensics and relate to the reliability of clinical records, one for care plans and risk assessments and the other for medication administration.

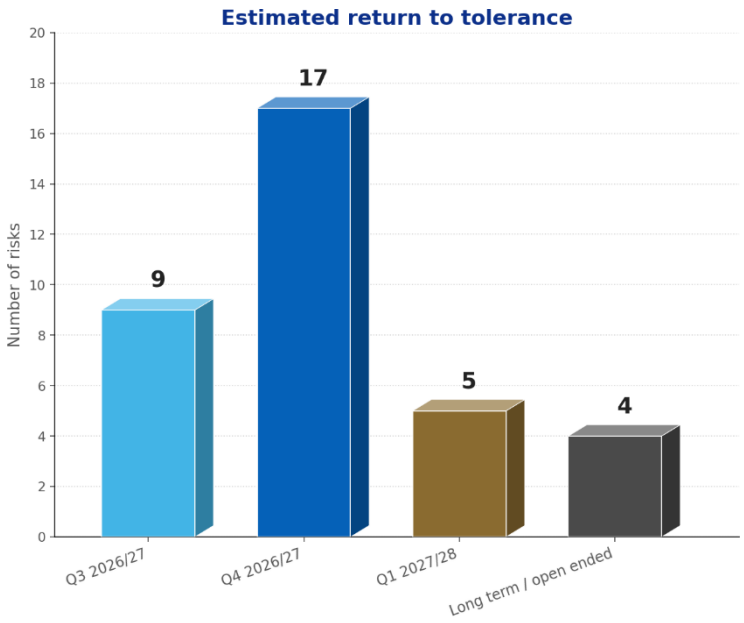
3.3 RSK 798, inadequate care records at Danescourt. Care plans and risk assessments at Danescourt have not been kept up to date or reviewed in line with best practice and NICE guidance, so records may not clearly identify patient needs. The risk was added to the register in August following the CQC's Requires Improvement rating for the service. It sits within Clinical Safety, where the Board's appetite is averse, and carries both patient safety and regulatory exposure.

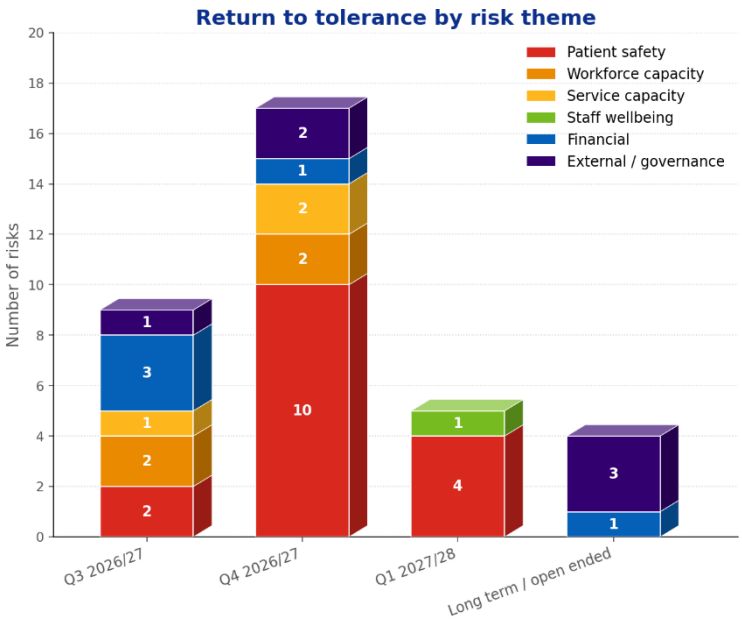
3.4 An immediate action plan is in place for named nurses to update care plans and risk assessments, supported by an overarching improvement plan held by the care group and by the Director of Nursing's team. Refresher SystmOne training for all staff and a care records audit by the registered manager remain outstanding. The score will be reviewed once the update on the quality and completion of care plans has been received.

3.5 RSK 590, paper-based medication recording at Diamond Lodge. Diamond Lodge records medication administration on paper, and the system has been assessed as inadequate and unsafe. There is a risk of further medication and transcribing errors, which could lead to people receiving the wrong medication. The risk sits within Clinical Safety. It was listed in July among the risks no longer out of tolerance, and it currently scores 9 and is outside tolerance.

3.6 The current system and administration process have been reviewed, and the paper medication sheet has been simplified with pharmacy to reduce the risk of errors. An electronic recording system has been raised with the Head of Informatics, and options are to be explored with the Chief Pharmacist. The expected resolution is now Q4 2026/27.

4. Risk return-to-tolerance assessment





4.1 Of the 35 risks currently outside tolerance, our best judgement view is that 26 will return within tolerance during 2026/27, nine in Q3 and seventeen in Q4, as workforce, capital and delivery actions take effect. A further five are expected to move within tolerance in Q1 2027/28. Expected timeframes for the thirteen newly out of tolerance risks are based on the actions recorded against each risk and the Risk Management Group's discussion of them.

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

5. Risk Management Framework

5.1 Version 13 of the Risk Management Framework is included in Pack B of the Board papers. It retains the substance of version 12.1, restructured into a clearer format and updated where needed. The three key changes are set out in paragraphs 5.3 to 5.5. The Risk Management Group reviewed and supported the proposals on 4 August 2026 and considered the implementation plan on 1 September 2026. The framework is now presented for the Board's approval.

5.2 The framework is now one document in three parts, so that staff can find the parts relevant to their role. Part 1 sets out how risk is governed and is the part the Board approves. Part 2 is the working guide for risk owners and directorate risk leads. Part 3 is a short guide for all staff.

5.3 A new Risk Escalation Schedule has been introduced to further aid the movement of risks from ward to Board. It sets out what each level of the Trust does with a risk, where the risk goes next and how quickly. The Risk Management Group continues to provide the Trust wide view of operational risk, but it is no longer the only place risks are considered.

5.4 Authority to close risks will be delegated to directorate risk leads once they have completed training on risk closure. The grounds for closure have also been tightened. A risk is closed only when it has stopped being a risk, and a reduced score or the completion of all actions is no longer a reason to close it.

5.5 The framework sets out who can accept a risk and for how long. A risk outside tolerance cannot be tolerated. Where it cannot be reduced after six consecutive monthly reviews, CLE may approve temporary acceptance for up to six months, with the rationale, conditions and review date recorded.

5.6 Subject to approval, implementation will begin in October 2026 and will focus on training and support. This includes briefing sessions for directorate risk leads, risk appetite and scoring training, drop-in sessions and directorate support, and communication of the framework across the Trust. Delegated closure authority will be introduced once directorate risk leads have completed closure training, and the Risk Management Group will monitor closures quarterly.

6. Risk Management System

6.1 All risks and their movement between levels are recorded on Radar, which went live during 2026.

6.2 From 1 October 2026, access to view the risk register will be extended to all colleagues. Anyone will be able to see the risks recorded in their own directorate and across the Trust, without needing to request a report. Permission to add or amend risks remains with risk owners and directorate risk leads.

7. Conclusion

7.1 The out of tolerance position has improved slightly since the last Board. Beneath the headline the list has turned over substantially, and more than a third of the risks now outside tolerance have moved into that position since July.

7.2 The concentration of out of tolerance exposure in themes for which the Board has set a Low tolerance position remains the position requiring most focused oversight, with Patient Care, and Clinical Safety in particular, carrying the largest share.

7.3 The two risks drawn to the Board's attention in Section 3 both concern the reliability of clinical records within Doncaster Learning Disabilities and Forensics, which also holds RSK 687. Improvement actions are in place for each, and progress will be reported through the Risk Management Group.

7.4 The Risk Management Framework has been restructured and updated, with three key changes, and has been reviewed and supported by the Risk Management Group. It is presented for the Board's approval, with implementation from October 2026.

8. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the operational risk report with attention drawn to those risks

that are out of tolerance and further, those with low-risk appetite.

APPROVE the Risk Management Framework, version 13, which is included in Pack B of the Board papers, as reviewed and supported by the Risk Management Group.

Philip Gowland
Director of Corporate Assurance
September 2026

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

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-508	Due to staff turnover and maternity leave, staffing within Rotherham Getting Advice will reduce from January 2026 to one point zero WTE Band four and two point zero WTE Band six, there is a risk that this reduction in capacity will lead to not being able to maintain promise 14 (4 week wait) and also the increased pressure will have further impact on staff wellbeing in the team, which may result in increased pressure on remaining staff, further sickness or turnover, and young people not accessing the service in a timely way.	People Risk - Capacity	Children's Mental Health (CAMHS)	Q3 2026/2027	6	Amber
RSK-509	Due to the long term absence of a Rotherham CAMHS Consultant and the role not being backfilled, there is a risk that the service does not have sufficient senior clinical oversight and capacity for timely decision making, which may result in delays to complex clinical reviews, increased pressure on remaining clinicians, and a heightened risk to patient safety and quality of care.	Patient Care Risk - Clinical Safety	Children's Mental Health (CAMHS)	Q4 2026/2027	6	Amber
RSK-576	Due to a lack of available clinical rooms within the North Lincolnshire locality at St Nicholas House, there is a risk that the service will be unable to deliver the neurodevelopmental pathway as planned, which may result in delays to appointments, inability to meet the 4 week waiting time trajectory, and reduced access to timely care for children and young people.	Performance Risk - Capacity & Demand Management	Children's Physical Health (CYP)	Q4 2026/2027	6	Amber
RSK-652	Due to unplanned nursing staff now operating alone in services where patients require two clinicians for joint visits, there is a risk that joint visits cannot be coordinated or delivered in a timely manner, which may result in delays to patient assessment and treatment, missed opportunities for early intervention, and deterioration in patient condition.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions	Q1 2027/2028	6	Amber
RSK-656	Due to a current Band 5 absence rate of 33.3%, which exceeds available budget headroom of 28%, there is a risk that staffing capacity cannot be sustained within funded levels. This may result in increased reliance on temporary staffing, reduced continuity of care, increased pressure on substantive staff, and a potential impact on the quality and safety of patient care	People Risk - Capacity	Community & Long Term Conditions	Q1 2027/2028	6	Amber
RSK-086	If the Care Group does not review the continence-products contract with Procurement support, there is a risk that current cost pressures and future financial risks will remain unknown and unmanaged, which may result in significant financial impact on the Care Group.	Financial Risk - Financial Planning, CIP & Sustainability	Community & Long Term Conditions	Q3 2026/2027	8	Amber
RSK-559	Due to staffing shortages within the Routine Assessment Pathway PCN, there is a risk that clinical capacity will be insufficient to meet demand, which may result in delays to assessments, increased waiting times from referral to first appointment, failure to meet the 4 week wait standard, and deterioration in patient experience and outcomes.	Performance Risk - Capacity & Demand Management	North Lincolnshire	Q3 2026/2027	8	Amber

			Community Mental Health			
RSK-574	Due to inconsistent overnight refreshing and updating of the Reportal system, caused by daily delays in data processing and downloads pushed through Informatics systems, there is a risk that Personalised Care Plans, SMI Registers, Learning Disability Registers and associated compliance reports will display out-of-date or incorrect patient data, impacting the reliability, accuracy and timeliness of reporting required for operational performance, assurance, and regulatory compliance.	External and Partnership Risk - Change and Improvement Delivery	Operations	Q3 to Q4 2027/2028	8	Green
RSK-679	Due to a medic leaving in June 2026 with no replacement expected until September or October, there is a risk that the Older People's Community Mental Health Team South cannot fulfil Responsible Clinician duties, Mental Health Act assessments, medication prescribing, and patient reviews, which may result in patients being unable to access timely medical input, statutory breaches under the Mental Health Act, and serious deterioration in patient outcomes.	People Risk - Capacity	Rotherham Community Mental Health	Q4 2026/2027	8	Amber

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

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-599	Due to significantly reduced workforce capacity within the Mental Health Act team from sickness absence and essential leave, alongside manual and interruption prone processes, there is a risk that statutory MHA functions will not be delivered within required timescales, which may result in delayed scrutiny of detention papers, missed tribunal and hearing deadlines, potential unlawful detention, and increased pressure on remaining staff leading to burnout.	People Risk - Capacity	Medical, Pharmacy & Research Directorate	Q3 2026/27	12	Red
RSK-701	Due to staffing absences within the Community Phlebotomy Team, there is a risk that the service will be unable to meet patient demand, which may result in delays to blood sample collection, potential delays to diagnosis and treatment, increased patient dissatisfaction, and ongoing pressure on administrative and clinical staff to continually manage competing priorities.	Performance Risk - Capacity & Demand Management	Community & Long Term Conditions Directorate	Q3 2026/27	12	Red
RSK-754	Due to a 0.6 WTE Consultant Psychiatrist vacancy within Older People CMHT North and the long term absence of the 1.0 WTE Nurse Consultant, there is a risk that the service will be unable to meet demand for medical and advanced clinical input, with remaining consultants required to provide additional cover, which may result in delays to clinical reviews, psychiatric assessments and treatment decisions, reduced service resilience, and impacts on the timely delivery of care across the Older People's Service	People Risk - Capacity	Rotherham Community Mental Health Directorate	Q3 2026/27	12	Red
RSK-757	Due to the commissioning and pricing model not guaranteeing a referral volume sufficient to keep all sixteen beds funded and filled, there is a risk that the unit does not achieve and sustain full occupancy, which may result in an income shortfall against the level assumed in the Trust's financial plan	Financial Risk - Financial Planning, CIP & Sustainability	High Dependency Rehabilitation Directorate	Q3 2026/27	12	Red
RSK-794	Due to the Homelessness Team being reliant on time-limited funding for 18 months, there is a risk that the service will be unable to continue if further funding is not secured, which may result in people experiencing homelessness and mental health difficulties losing access to dedicated support and gaps in the existing care pathway.	Financial Risk - Financial Planning, CIP & Sustainability	Doncaster Community Mental Health Directorate	Q3 2026/27	12	Red
RSK-640	Due to significant damage to the aluminium doors of the S136 suite caused by patient attacks, leaving them able to be forced open, there is a risk that patients abscond from the suite, which may result in serious harm to the patient, risk to public safety, breach of detention under the Mental Health Act, and significant reputational and regulatory consequences for the Trust.	Patient Care Risk - Clinical Safety	North Lincolnshire Acute Mental Health Directorate	Q3 2026/27	9	Red
RSK-681	If the medication backup computer is not maintained and the primary system or internet connection fails, there is a risk that staff have no access to patient medication records during	Patient Care Risk - Clinical Safety	North Lincolnshire Acute Mental	Q3 2026/27	9	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
	system downtime, which may result in medication errors, delays to prescribing and administration, and serious harm to patients.		Health Directorate			
RSK-746	Due to the failure to formally confirm a funding source for Ambient Voice Technology despite approval in principle, there is a risk that funding may not be secured or may be delayed. This could result in delays to implementation, reduced programme delivery, or an inability to sustain the programme beyond the initial phase, leading to financial uncertainty, resource constraints, impacts on staffing, and failure to realise the anticipated benefits.	Financial Risk - Financial Control and Oversight	Operations Directorate	Q3 2026/27	9	Red
RSK-764	Due to the substantive psychiatrist not holding Approved Clinician status and the unit relying on an external approved clinician, there is a risk that Responsible Clinician duties under the Mental Health Act are not reliably discharged, which may result in delay or unlawful action in detention renewals, leave authorisation and tribunals, and gaps in medical leadership.	External and Partnership Risk - Legal & Governance	High Dependency Rehabilitation Directorate	Q3 2026/27	9	Red
RSK-676	Due to the discontinuation of Levemir, there is a risk that patients currently prescribed this medication are not transitioned to an appropriate alternative insulin in a timely manner, which may result in poor glycaemic control, hyperglycaemia or hypoglycaemia, and avoidable hospital admission.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions Directorate	Q4 2026/27	20	Red
RSK-798	Due to inadequate processes for maintaining, reviewing and updating care records, there is a risk that patient care records do not clearly identify patient needs, are not kept up to date, and contain care plans that have not been regularly reviewed in line with best practice and NICE guidance. This could result in unsafe or inconsistent patient care, poor clinical decision-making, reduced patient outcomes, and regulatory non-compliance.	Patient Care Risk - Clinical Safety	Doncaster Learning Disabilities and Forensics Directorate	Q4 2026/27	16	Red
RSK-108	Due to existing qualified podiatry vacancies and impending maternity leave within the Podiatry team, there is a risk that the service will be unable to offer some patients an appointment within a 4-week timescale. This may result in patients experiencing deteriorating foot conditions that could lead to infection, sepsis, loss of limb and potential death.	People Risk - Capacity	Community & Long Term Conditions Directorate	Q4 2026/27	15	Red
RSK-457	If demand continues to outstrip capacity in the planned Community Nursing service, patient visits or elements of care may be deferred resulting in delays in care delivery, compromised patient safety, and poor patient experience. Staff may also suffer with increased fatigue, poor job satisfaction and presenteeism or absenteeism.	Performance Risk - Capacity & Demand Management	Community & Long Term Conditions Directorate	Q4 2026/27	15	Red
RSK-555	Due to a reduction in training related income, there is a risk the established £320k CIP target will not be achieved, which may result in the directorate not being able to deliver a positive year end budget position 26/27.	Financial Risk - Financial Planning, CIP & Sustainability	Talking Therapies Directorate	Q4 2026/27	12	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-664	Due to significant reductions in psychology staffing capacity, including an unfilled maternity leave vacancy, an imminent permanent departure, and the potential loss of the remaining psychologist covering four localities, there is a risk that psychology services cannot meet caseload demand within safe waiting times, which may result in reduced access to timely psychological interventions, increased pressure on the wider MDT, and deterioration in patient outcomes.	Performance Risk - Capacity & Demand Management	Doncaster Community Mental Health Directorate	Q4 2026/27	12	Red
RSK-687	Due to an increase in prescribing errors within the Doncaster Community Learning Disability Team and multiple recent incident reports highlighting medication and prescribing issues, there is a risk that patients may receive incorrect prescriptions or not receive medication at the right time. This may cause delays in treatment or incorrect medication being administered, which may impact patient safety and potentially lead to harm.	Patient Care Risk - Clinical Safety	Doncaster Learning Disabilities and Forensics Directorate	Q4 2026/27	12	Red
RSK-750	Due to a substantive 1.0 WTE Consultant Psychiatrist vacancy within the Health and Wellbeing Clinic resulting from staff turnover, there is a risk that medical workload cannot be adequately covered and Consultant Psychiatrist provision for ZTAS patients cannot be maintained, which may result in increased pressure on medical staff across the Care Group, delays in clinical oversight and decision making, and an inability to fulfil statutory responsibilities	People Risk - Capacity	Rotherham Community Mental Health Directorate	Q4 2026/27	12	Red
RSK-476	If anti ligature doors are not installed on Windermere, there is a risk that staff will be unaware of a patient attempting self-harm, which may result in serious or catastrophic injury, including suicide, before help can arrive.	Patient Care Risk - Clinical Safety	Doncaster Acute Mental Health Directorate	Q4 2026/27	10	Red
RSK-083	If the Trust lacks a single, authoritative and accessible source of information on medicines use, including prescribing and dispensing data, there is a risk that prescribers, teams and care groups will be unable to effectively interrogate activity and cost information. This may impair oversight of prescribing practice and financial management, potentially resulting in suboptimal clinical decision-making, reduced professional oversight, and increased or uncontrolled expenditure.	Performance Risk - Information Governance	Medical, Pharmacy & Research Directorate	Q4 2026/27	9	Red
RSK-459	Due to the potential unavailability of complex equipment, lack of staff knowledge on its use, absence of a confirmed process for responsibility, and no financial agreements in place, there is a risk that specialist equipment provided by the community nursing service (e.g., ventilators, cough assists, suction machines) may not be maintained, serviced, repaired, or replaced in a timely manner, which could lead to delays and significant implications for patient safety.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions Directorate	Q4 2026/27	9	Red
RSK-540	Due to a number of patients across community teams not having an up to date care plan in place, there is a risk that the Trust is unable to provide assurance that care is being delivered safely and effectively, which may result in gaps in coordination, unclear responsibilities, and increased risk to patient safety.	Patient Care Risk - Clinical Safety	Rotherham Community Mental Health Directorate	Q4 2026/27	9	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-561	Due to patients with highly complex needs being held on community caseloads without comprehensive care plans and clear escalation pathways recorded on SystmOne, there is a risk that changes in condition, equipment issues or urgent needs will not be managed appropriately, which may result in delayed or inappropriate responses and increased risk of harm.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions Directorate	Q4 2026/27	9	Red
RSK-590	Due to the inadequate and unsafe paper-based system for recording medication on Diamond Lodge, there is a risk that further medication errors and transcribing errors will occur. This may result in people being administered the wrong medication, leading to significant clinical safety concerns and potential harm.	Patient Care Risk - Clinical Safety	Doncaster Learning Disabilities and Forensics Directorate	Q4 2026/27	9	Red
RSK-627	Due to differences between contract management processes for healthcare and non-healthcare services following the transfer of the contracts function to the Finance and Procurement Directorate, there is a risk that income and expenditure healthcare contracts are awarded, extended, or managed without full alignment to Procurement Act 2023 requirements and other relevant legislation, which could result in legislative non-compliance, legal challenge to contract awards, delays to service delivery, financial and reputational damage, and increased regulatory and audit scrutiny for the Trust.	External and Partnership Risk - Legal & Governance	Finance & Procurement Directorate	Q4 2026/27	9	Red
RSK-673	Due to ongoing IT system failures on Sandpiper Ward (including prolonged laptop login times, system errors, and ECG application malfunction) and limited availability of alternative ECG machines, there is a risk that ECGs cannot be performed in a timely manner or at all, which could result in delayed or missed identification of cardiac abnormalities (such as QTc prolongation or acute cardiac events), potentially leading to serious patient harm and compromised patient safety.	Patient Care Risk - Clinical Safety	Doncaster Acute Mental Health Directorate	Q4 2026/27	9	Red
RSK-782	Due to learning disability consultants working across separate localities and limited capacity to provide cover during periods of absence, there is a risk that adequate consultant cross-cover arrangements are not in place, resulting in delays to clinical decision-making and patient care, which may negatively impact patient safety and service delivery.	Patient Care Risk - Clinical Safety	Doncaster Learning Disabilities and Forensics Directorate	Q4 2026/27	9	Red
RSK-570	Due to ongoing antisocial behaviour, the presence of rough sleepers, and environmental hazards such as urine, human faeces, cannabis odour and drug paraphernalia (including used needles) within the Parishes Multistorey Car Park in Scunthorpe - used by staff based at Elizabeth Quarter; there is a risk that staff may feel unsafe when travelling between the car park and the office. This may lead to increased anxiety, reduced wellbeing, negative impacts on staff health, potential needlestick injury, reluctance to attend the workplace and possible effects on staff attendance and overall service delivery.	People Risk - Well-being & Retention	Children's Physical Health (CYP) Directorate	Q1 2027/28	12	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-038	Due to the absence of a robust process to assure the Trust that lithium prescribing and drug-monitoring responsibilities are being met with partner organisations, there is a risk that patient safety will be compromised, which may result in clinical harm, reputational damage, and failure of the Trust to meet its accountability obligations.	Patient Care Risk - Clinical Safety	Medical, Pharmacy & Research Directorate	Q1 2027/28	9	Red
RSK-044	Due to the absence of a reliable method for identifying and monitoring patient discharges resulting from disengagement, there is a risk that patients may be discharged inappropriately without adequate support, which may result in harm to themselves or others.	Patient Care Risk - Clinical Safety	Medical, Pharmacy & Research Directorate	Q1 2027/28	9	Red
RSK-631	Due to continued incorrect documentation of patient allergy status by staff within the electronic clinical system and system limitations that prevent timely amendment of records by clinicians outside their own clinical area, there is a risk that inaccurate allergy information overrides inpatient drug charts, leading to inappropriate prescribing or medication administration errors, delayed correction of records, increased risk of patient harm, and adverse quality, safety, and regulatory impacts across care groups.	Patient Care Risk - Clinical Safety	Community & Long Term Conditions Directorate	Q1 2027/28	9	Red
RSK-671	If capacity constraints, staffing shortages, or bed unavailability cause delays to urgent or planned admission to mental health services, there is a risk that individuals do not receive timely inpatient care, which may result in further deterioration of mental health and increased risk of serious harm.	Patient Care Risk - Clinical Safety	Operations Directorate	Q1 2027/28	8	Red
RSK-152	Due to insufficient capacity to meet the demand for ADHD assessments, there is a risk that patients will remain unassessed, which may result in compromised wellbeing and health outcomes for patients and their families, adversely affect service delivery and staff wellbeing, jeopardize the Trust's ability to meet Strategic Objective Promises 8 and 14, and damage the Trust's reputation.	External and Partnership Risk - Delivering Our Promises	Neurodiversity Directorate	Long-Term	15	Red
RSK-220	If waiting times for ASD and ADHD assessments remain above target, there is a risk that children and young people will receive delayed diagnoses, which may result in poorer educational and health outcomes, increased strain on the service and staff, failure to meet Strategic Objective Promises 8 and 14, reputational damage, and additional unfunded financial pressure on the Care Group.	External and Partnership Risk - Delivering Our Promises	Children's Physical Health (CYP) Directorate	Long-Term	15	Red
RSK-463	Due to the age and size of the two Aspire buildings and the potential for further deterioration requiring compliance with safety standards, there is a risk that repair or replacement costs will be very high, leading to significant financial pressure on the Doncaster Community Mental Health Directorate.	Financial Risk - Financial Planning, CIP & Sustainability	Doncaster Community Mental Health Directorate	Long-Term	12	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-468	If the Trust does not secure funding for decarbonisation initiatives, there is a risk that the Trust will not meet its Green Plan targets, impacting sustainability commitments and regulatory expectations.	External and Partnership Risk - Regulatory	Strategic Development Directorate	Long-Term	9	Red

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises and Priorities Scorecard	**Agenda Item**	Paper L
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	24 September 2026

Suggested discussion points

Last time we met we considered promises 3, 9, 10 and 24 in some detail. In a separate paper Philip Gowland updates the Board on the adoption of the new review mechanism, which is similar if distinct in some ways from the delivery assessment presented here. The Board is fully sighted, I would suggest, on the health inequalities promise position, and we agreed at the Public Health, Patient Involvement and Partnerships committee that we would bring a more detailed delivery plan to the mid-January meeting of that body.

For the last two reports we have focused on trying to move nine measures by October, as part of a 26/27 effort to shift the middle table rated items. The outcome of that work will be visible in the November scorecard. This time we only report the lower table, and the improvement work to secure these promises and measures by the end of 2028. This recognises that there is a final two-year push to do this and we some confidence by late January that we have the bandwidth and resources to succeed.

Previous consideration

N/A

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the themes and challenges that lie behind our reddest success measures

ACKNOWLEDGE progress described in terms of membership, carbon and targeted recruitment

CONSIDER the described timetable to bring a 'lower third' action plan to the Board in Q4

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

Trust Risk Register

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X

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

If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.	X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.	X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	X

System / Place impact (advise which ICB or place that this matter relates to)							
Some promises form part of our underlying contract with South Yorkshire ICB							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
Annex A – Sept 2026 promises scorecard (part of)							

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Latest Promises Update

Purpose and introduction

1.1 In May and July's reports we have focused attention primarily on shifting the middle third. There is some progress, as outlined eight weeks ago. The focus of November's report will be on the nine measures we tried to shift by October, and the balance by the end of 2026/7.

1.2 This report includes a 'lower third' only league table. It is intended to focus attention just on the most stuck of our measures and to enable discussion on the work needed to be ready to move these twenty-three measures forward in 2027 and 2028.

There is some progress for some measures

2.1 Promise 9 was presented to the prior board meeting. For most employment cohorts we have a clear plan, which combines some work to improve our processes with ringfenced projects to reach into excluded communities. There is a high measure of confidence that with a new deputy director of people and OD, liberating some time for Carlene Holden, and Julia Shaw very focused on this agenda, we can see real progress over coming months; very much in the manner that it took until our second push to execute apprenticeship changes.

2.2 Promise 27 features twice in the lower league. The first success measure, on carbon, arguably is rated too harshly given the approval for ambient loop last time. If executed this helps us to meet this measure, unless we see other drivers of carbon move in another direction. Shifting our delivery model to reduce patient and staff travel is less progressed, albeit the September 10th mobile first workshop commences a conversation about how we begin to structure some travel out of our services, with more local hubs, bases used only for what they are truly needed for, and some increase in digital delivery.

2.3 The only part of promise 5 in considerable delay has been the membership measure. As we move away from the external database and building on work done over the past three months, we are beginning to evidence the sort of gains we hoped for when we changed how membership worked in early 2025. Arguably with the removal of elections for governors it will be even more important to connect the members to the governors, and that is a focus of effort before the end of the year.

2.4 Promise 16 could be presented through two entirely different lens. The growth in DIALOG+ coverage means that we have a route to be reported paired outcome data at scale for the first time. However, the success measures is about each service, or even before that each directorate having outcome measures. We had agreed in early 25/26 that this would follow from our always measures, which themselves are in delay (nine months). As we bring further leaders into our directorates, including we hope medics into our DMTs, we will

be asking them to offer some thought leadership in finalising outcome measures for each clinical directorate that we lead.

2.5 We have had direct engagement with Promise 17 as a Board over some time. The impressive work in Doncaster and North Lincolnshire, but not yet in Rotherham, shows promise, recognising that it will be late 2027 before we have some confidence about impact. The clarity of intervention, the addition of some resource (self-generated in the care group), and capable leadership of the issue, points the way to how we need our other exclusion/equity promises to be moving forward. That said, those other areas have put in the work, but the results are not there as yet (with the exception of perinatal mental health); whereas for school readiness we were not yet expecting results.

<u>There are some themes to our difficulties</u>

3.1 With the exception perhaps of promise 5, which is now moving, the work on rurality which has slowed, and our virtual ward prospects, it is not in fact a lack of effort going in which explains the position of these promises in our league table. These are some of the most challenging parts of our work on the strategy, and things that knew would take the most time to fully understand and improve. They necessarily will demand executive level leadership to move forward, because **they require us to reach beyond a better version of what we presently do.**

3.2 The tangible success measure for Promise 22 goes right to the heart of operational function in running our bed base. Our aim had been to improve processes and decision making to reduce occupancy closer to 92%. We have seen that happen and continue to work with one in/one out bed models, certainly for acute and PICU beds. Discharge is clustered within weekdays, and our weekend bed capacity is generated by leave beds (which we have improved the management of). The focus on expected dates of discharge is the Q3 priority and this can improve our bed flow. But the follow on from that has to begin to see MDT decisions to discharge made a few days earlier in the stay, allowing exit once support is confirmed as in place. The anxiety about weekend discharge remains support at hand, and we will want to work with crisis and Home Treatment Teams to help to consider, alongside peer support workers, how we best support people in the first 48 hours of their discharge, recognising that a 72-hour appointment fits well with weekend discharge patterns.

3.2 Health inequalities pervade our lower third list. But within that there are distinctions. We know for SMI AHCs what we need to do, and we largely know for inclusion health too. For learning disabilities and for rurality, our thinking is much less developed, including because we are more imprecise about the problem we are trying to solve. In December we will need to set aside structured time, across the E&I group, to better shape what we intend to do from April: if we are to meet our commitment to have a plan in place for January's PHPIP committee.

3.3 With the evolution of our neighbourhood working leadership arrangements, the Trust is well connected now to thinking in each of our places. That underscores the need to take a lead, as we are doing in Doncaster physical health services. As we finalise our estate plan for community bases, and move forward the 'mobile first' (auto-glass) considerations, it feels as we are nudging nearer to having a plan in place. It cannot, in year, be accelerated because it relies on coaching frontline colleagues into considering a different model of care.

3.4 Anti-racism is one of the most debated and focused upon topics for the Board since 2024. We now have a second very clear plan. But we know that our first plan did not deliver the gains we sought. We have some concerns over our delivery architecture, and changes of personnel within that space are taking place. We need the now very all encompassing plan for changes in how our People and OD function runs processes, and how line managers act on and curiously seek out, concerns to matched by clarity among those staff on what needs to change.

<u>Getting into shape for 2027/28</u>

4.1 Given that we are now entering the final lap of delivery, we need to translate each of these measures into a fairly clear programme plan that spans 27/28 and the first half of 28/29. That has to come with definition of leadership arrangements, milestones and the unblocking structures to adapt at pace if preferred ideas are not delivering. What is fortunate is that, in the main the measures span a small number of priorities:

- Service redesign for localism, rurality and neighbourhood working
- Virtual ward technologies
- Outcome measurement, whether in schools or across services
- Inequalities including promises 7, 8, 10
- Our anti-racism work

As such they lend themselves to a PMO model pointed into the executive group. During Q4 we will re-aligning some of the strategic development resource we have to support the chief executive and wider leadership to build these plans during January and February. This will come to the Board with our de-factor annual plan for 27/28 in March.

4.2 For promises 9 and 27 we already have in place strong nascent plans, with clear leadership from Carlene Holden and now from Simon Sheppard. As was outlined last time the Board met, we are expecting some virtual ward proposals to come forward as part of investment bids for 27/28. Neighbourhood working has started to get clearer shape both in the initial phases of the community powered healthcare taskforce, and in the promise 15 action plan. And the Board is explicit in its intention around anti-racism, including making it core to the work of the 555 and our new appraisal model. Promises 10 (TL), 12 (TBC) and 16 (JG/DS) do need a more structured approach in coming weeks to test whether our thinking is sufficiently well formed, as none of these three measures can be taken forward without care group delivery from Q1/2: as such we need well-articulated shape to our work during Q4.

Lower third only

(upper tables will be presented in November as usual)

Promises and priorities – delivery plan and delivery self-assessment

Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
Promise 5 Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.	Amber green ↑	With changes to our database it is clearer what are doing and the improvements that we are beginning to see. The team involved have begun to take ownership of this, with expectations of changes in early 2027.	Amber red	We now have to expand active membership, recruiting in tandem with our volunteering and VCSE partnering work. This work was in major delay, but has now found its place and is building some momentum towards our 1000 target.
Promise 6 Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods.	Amber red	The data is not shifting, albeit it is now readily available. Part of Strategic Objective 2 tracker: implementation of AI tool may assist us to make progress but this remains to be determined.	Amber red	It is evident how challenging this is proving to be. But there remains basic work to do on reminders/timing adjustment – all appt texting started from June 2026.
Promise 7 Achieve learning disability and serious mental illness health check measure in 2024/25 and recurrently.	Amber red	This rating reflects the position in terms of Learning Disabilities. As the IQPR illustrates for Serious Mental Illness, we have and continue to make progress against our joined-up QOF measure. Focus of work with the LD&F management team, with new DMT in place.	Amber red	For SMI, there is confidence we can go beyond what is currently being achieved, and materially intervene to improve physical health status among the SMI population.
Promise 8 Increase access to health checks for minority ethnic citizens with Learning Disabilities.	Red	There is not yet a cogent plan to address this (and the investment fund bid proved unaffordable). A reset of approach needs to be undertaken considering what can be achieved (and what problem we are trying to solve)	Red	The LOD has deteriorated in view of the plan being unaffordable, and the wider challenges for this AHC approach outlined under promise 7 reporting.
Promise 9 In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Amber red ↑	The leadership team are exploring models elsewhere to finalise the plan for RDaSH for 26/27: this may rapidly shift to AG once that is validated.	Amber green ↑	These success measures were considered by the Board in July. For

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Promise 9 In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Amber green	The work plan for refugees is contained within the Board's paper and relies on others outside the Trust who are in place, hence the AG confidence.	Red ↓	some cohorts there is confidence of change moving through 2027. We are reliant on external collaboration in respect of refugees and migrants. **The bigger known unknown is the changed mindset needed among line managers and teams. The cohorts cited need in role support and we have work to do, learning from the volunteering and peer support experience, to structure this, if we are not to depend on too narrow a base.**
Promise 9 In 2026/27 introduce tailored access scheme for people with learning disabilities.	Amber red	We have a very clear plan, albeit its key element may not start in practice until August 2027, hence the rating.	Amber red	
Promise 10 Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber green	Plan of action presented to Public Health, Patient Involvement and Partnerships Committee of BOD – work to do to embed that across teams so too early to confirm shift to greener rating for the plan. The finalised view of NICE compliance is anticipated from November..	Amber red	This will require concerted work to make 'mainstream' services available, as well as to develop specialised services. This will need capability building among local leaders and a determined driven push moving into 2027.
Promise 10 Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.	Amber red ↑	Our expectation is that the mystery shopper exercise does not suggest good patterns of access. For the client groups concerned we know that more formal data sets are unlikely to be available. The Board is sighted on work on homelessness in particular, with work on prisons being built presently.	Red	Until a baseline plan is in place it is not possible to offer a more optimistic view of changes needed – nor how much resistance in practice could be experienced in developing TIC models in this field.

Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
Promise 12 Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.	Amber red	Not yet meaningfully planned but will be accelerated as we try to ensure our estate plan does not consume all available resource.	Amber red	Rating reflects planning comments made: we need to describe a standard village offer before the end of Q4
Promise 15 Support development of integrated neighbourhood teams (INTs) in 2024/5 in all three places.	Amber red	It is broadly positive that the ten-year plan places such emphasis on this space. The emerging challenge is to ensure that we work as neighbourhoods not place. The workplan outlined by Iona Johnson to the public health committee does envisage some team creation moving into 2027/28, hence the slight rating tweak here.	Amber red	Time passes and 27/28 is the earliest feasible delivery date now for restructure. There remains some enthusiasm to shift services onto neighbourhood settings on a pilot or targeted basis. The failure to commission a neighbourhood offer locally in 26/27 is disappointing and partners are working to address that in good time for 27/28.
Promise 15 Restructure Trust services into those INTs during 2025/26.	Amber red ↑		Amber red	
Promise 15 Evaluate and incrementally improve joint working achieved through these teams.	Amber red	Planning this work can follow from further definition of the INT plans we have. This work was considered with the PHPIP committee on that basis.	Amber red ↓	As we look to co-locate more teams with primary care and local authorities inside the lifetime of the strategy we might reasonably expect some improvement in this rating
Promise 16 Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Red ↓	Our plan currently is focused on DIALOG+ and paired outcomes, alongside talking therapies measures and PROMs. A consistent by directorate approach remains to be built. More positively, our wider safety reporting does reflect our directorate structure more closely.	Amber red	It remains possible moving into 2027/28 to meet this success measure but it will require concerted corporate thought leadership, as we know from prior bottom up efforts that imagining the measures is not within the skill set of a distributed leadership group.
Promise 17 Narrow the school readiness gap between our most deprived communities and average in each place in which we work.	Amber green	We have a compelling hypothesis, and have demonstrated in 2026 the ability to mobilise our resources and that of partners to deliver it. Data in 2027 will be needed to demonstrate results and impact, but input data does suggest strong take up.	Amber red	Delivery remains very challenging of what is a long-term national trend. Our challenge is not year one results, but sustaining success over time. It may also rely on our ability to connect with households not using traditional schooling, and those moving between birth and starting school.

Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
Promise 17 Seek to see 80% of children meet their own potential for school readiness by 2028.	Red ↓	We need to do more work on the data flow for this item. We should be able to conclude this work in time for the next report, building on the analysis presented to the PHPIP committee in September.	Amber red	The current view is similar to the prior success measure.
Promise 20 Introduce and evaluate virtual ward pilot into our mental health services 2024/25.	Amber red	We implemented a pilot proposition in North Lincolnshire older adult care, as part of implementing the Phase ¾ changes. This has shown promise but also highlighted the nature of the difference required: a QI poster entry for 2026 contest illustrates some of those dilemmas.	Amber green	Clearly the timescale has passed, but it remains possible to deliver this measure – we are exploring how best to do that across mental health services moving into 2027.
Promise 20 Introduce and evaluate virtual ward pilot within our children's services 2025/26.	Amber red	The intent and commitment to do this is clear from the leadership team – but a tangible plan to trial this is not yet visible and <u>did not come forward within planning for 26/27.</u> Discussions have now taken place with the CCG as we look to manage longer term support to complex young people and a 27/28 IF bid is due in December.	Red	This rating can change, albeit the date has passed, if we move ahead with the 2027/28 pilot proposition.
Promise 21 Understand and act on local research into patterns of referral, cross referral and best fit services for mental health in adults and older adults linked to general practice.	Amber green ↑	Commissioned work from PCD, has now been received (3/1/26): important to understand the patterning before we begin to make changes to service flows. Cheryl Gowland has taken this work forward with PCN partners and this will inform the CPHT.	Amber red	Work needed to scale and shape the project….
Promise 22 Support substantially increased discharge and admission capacity over weekends.	Red	As admitting volumes rise, and we seek to sustain promise 19, our management of safe discharge becomes ever more important. Our main focus remains on diagnosis-based coding of admissions inside five days (led by JG/DS) and movement to meaningful EDDs led by	Amber red	This measure can be met in the lifetime of the strategy. And if we look at the demand spike that comes with late in the week and the weekend, it is critically necessary that more of weekend admissions use emptied

Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
		care groups and especially the acute directorates. We are working to see during Q3 a much more consistent delivery of EDDs, alongside better delivery of leave rights and purposeful use of leave (as outlined in the CE action plan).		beds, where presently we rely heavily on leave beds. There is some encouragement and medical engagement with this agenda, but it remains the case that our primary clinical model is weekday based.
Promise 26 Implement suite of policies and practice to Kick Racism Out of our Trust.	Amber green	We had a plan from 2024, and revised that approach in late 2025 and agreed a revised plan in July 2026. We have sought to simplify our governance and oversight, mindful of the early 25/26 audit review. It remains the case that our management capability and HR support in this area needs considerable support.	Amber red	If the ultimate test of success in doing this lies in the feedback of people of colour among our colleagues, the rating will contain an element of caution as the influences on that judgement will reflect internal and external pressures between now and 2028.
Promise 27 Reduce our carbon tonnage by 2000 (and offset balance).	Amber green ↑	The ambient loop agreed plan provides a clear basis now for meeting this aim. We have not yet worked through the cost of offset overall. The challenge now is to keep to the timeline agreed with the Board in July and move to implementation in late 2027 and early 2028. Planning conditionalities have been taken forward and appear promising,	Amber red	We continue to have a narrow path to success, in which we cannot see other elements of carbon increase within our footprint. Once a tender is let, and risk transferred we would expect this assessment to improve to amber green.
Promise 27 Change service models for patients and staff to reduce travel required by 2027.	Red	A lot of good work has been done to move this forward. The remote working template is nearing completion. But the red rating reflects the need to pull this work together into a plan of actual action that makes a scaled difference. This will not be ready until the end of 2026/27.	Amber red	The implementation of digital care alternatives is a national priority, and we would expect our own and others efforts to intensify in 2027. Both our CPHT work, and the ‘mobile first’ conversations about how technology might better support community based teams have started to address the options in this area.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated quality performance report months 1-5	**Agenda Item**	Paper M
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	24 September 2026

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

Different measures and a different format are shown, with a handful yet to be added. The aim is to help committees to have an overview of a range of metrics rather than being over-focused on a handful of perspectives. We continue to need to address vacancy and sickness issues, acknowledging that our financial position remains strong.

Operational focus remains on addressing neurodiversity waiting times and ensuring our bed base is run through expected dates of discharge. Underneath those two headlines, the deterioration in four week waits illustrates the grip still required, and work to reset talking therapies job plans to a measure commensurate with both four and fourteen week waits continues, as it now has for almost six months.

The NOF position is noted elsewhere for Q1 as 2.06, with a need to work on data gaps between our view and that pulled nationally in respect of crisis services and 104 week waits for Children and Young People.

Previous consideration

CLE September 2026, quality committee September

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE the deterioration in four week delivery within the report

CONSIDER the new format of measures and offer relevant feedback

RECOGNISE work to improve operational practices in Talking Therapies

ASK the quality committee to consider how far this provides a basis for reviewing all fourteen directorates' quality and safety performance

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

Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	X
Finance plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Research and innovation plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	**X**

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

If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.	
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.	
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	X

System / Place relevance (advise whether it is national, regional or local)							
various							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)
Appendix 1 – SPC Icon description

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated quality performance report months 1-5	**Agenda Item**	Paper M
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	24 September 2026

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Previous consideration

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

Alignment to the plans: (indicate those that this paper supports)	
Estate plan	
Digital plan	
People and teams plan	X
Finance plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	
Research and innovation plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	**X**
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (indicate those that this paper supports)	
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1	X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.	
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.	
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	X

System / Place relevance (advise whether it is national, regional or local)							
various							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)
Appendix 1 – SPC Icon description

Integrated Quality Performance Report

September 2026 Review

Data as at the 31st August 2026

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Executive Report

Introduction

This is the first full version of the IQPR in its new format, with quality measures now given greater prominence and the inclusion of several measurables demonstrating progress against the Trust Promises. Delivery across the Trust remains mixed. Strong outcomes continue across workforce, financial and several quality measures; however, challenges remain in access to Talking Therapies, physical health standards, long waits, workforce sickness absence and selected patient safety indicators. Recovery actions are in place through Performance Clinics, the Waiting List Group and Care Group improvement plans.

Quality

Quality outcomes remain strong overall; however, there are ongoing challenges with Talking Therapies access, physical health standards and selected patient safety metrics. Talking Therapies access has seen significant improvement during the month but remains below trajectory (7,222 YTD vs 9,374 target), with recovery actions focused on expanding long-term condition pathways and targeted support for priority cohorts. Physical health checks remain below target for both people with Severe Mental Illness (64.55%) and people with a Learning Disability (83.41%), with additional oversight through the monthly Performance Clinic, expanded Point of Care testing and targeted work to reduce declines across Care Groups. The reported 2,324 waits over 104 weeks continue to be significantly influenced by NHS England referral-spell methodology; however, a deep dive of the data has identified a high number of data quality issues relating to the application of outcome measures. These are not true waits. Informatics colleagues are continuing to understand how a bulk fix can be applied to the cohort of patients. Several inpatient quality measures deteriorated during August, including VTE assessments, MUST assessments and falls assessments, with strengthened ward-level monitoring, audit and clinical oversight implemented. Further areas of focus include FACE risk assessment compliance (22.95% out of date), which is subject to a targeted recovery plan and enhanced Care Group focus.

People

Workforce indicators remain positive overall, with PDR compliance at 93.56%, exceeding the Trust target. The principal workforce challenge remains sickness absence at 7.56% against a target of 5.10%, although this has improved from the previous month. Quarterly long-term sickness review clinics, strengthened HR support and enhanced operational oversight are now embedded to support further reduction in sickness levels. Temporary staffing expenditure remains controlled at 4.05% of pay spend.

Finance

At Month 5, the Trust is reporting a year-to-date favourable variance to plan of £89k and continues to forecast delivery of its breakeven financial plan for 2026/27. While the overall position is on track, this includes a number of significant variances, notably a £3.2m underspend in substantive pay, a £1.1m overspend on bank and agency staffing, a £1.2m underspend on out-of-area placements, and HDRU income £0.8m below plan. Savings delivery remains on track, with delays in some recurrent schemes being offset by higher-than-planned vacancy-related savings. Agency expenditure is significantly above plan due to temporary staffing pressures within Rotherham, Children's, Doncaster and North Lincolnshire Care Groups. Capital expenditure is £3.9m behind plan year to date, reflecting the changed phasing of scheme spend; the Trust continues to forecast spending within its approved capital allocation. Financial delivery across directorates remains positive overall, with the majority (21 of 24) forecasting underspends; however, three directorates are reporting overspends, primarily driven by staffing pressures from bank and agency costs.

Promises

Delivery against Promise 14 remains mixed. Four-week waiting times compliance is 74.7%, with 62 of 83 services achieving the standard. Workforce and capacity pressures continue to impact a small number of Children's, Community Mental Health and Physical Health services. Delivery against the urgent 48-hour response standard remains below target, with improvement actions focused on the recording and categorisation of urgent referrals.

Several health inequalities measures also remain below target, including Learning Disability physical health checks, dementia diagnosis rates for minority ethnic communities, veterans' priority access and access to Perinatal Services. Recovery actions are focused on understanding barriers to access, improving identification and recording, strengthening referral pathways and increasing uptake amongst underserved groups, supported through Performance Clinics and health inequalities governance arrangements.

1.0 – Quality - In Focus

Indicators for August 2026/2027 TRUST — Quality

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP03a (L)		People accessing Talking Therapies - Cumulative Annual			1420		3024	>= 9374	7222
OP03c (N)	NOF04a	Reliable recovery rate within Talking Therapies	>= 48%	268/556	48.20%		48.20%		48.66%
OP03d (N)		Reliable Improvement rate within Talking Therapies	>= 68%	402/577	69.67%		68.78%		69.32%
OP07b (L)		Women supported by perinatal MH service (Rolling 12M)	>= 587		671		671		671
OP100 (L)	NOF02c	% CYP waiting more than 52 weeks for community treatment	= 0%	0/74	0.00%				
OP101 (L)	NOF02d	% cases over 52 weeks (excluding ADHD and Autism Services)	= 0%	0/2525	0.00%				
OP12 (N)	NOF04b	People discharged from MH inpatients followed up in 72 hrs	>= 80%	74/83	89.16%		90.27%		89.47%
OP13a (N)		People accessing CYP services with >= 1 contact (13mth roll)	>= 9424		11720		11720		11720
OP15 (N)		People (CYP) with urgent eating disorders seen within 1 wk		1/1	100.00%		100.00%	>= 95%	100.00%
OP17c (N)		The number of active inappropriate adult acute OAPs	<= 15		5		5		5
OP19 (N)	NOF06e	MHSDS score for data quality maturity index (DQMI)		958/1000	95.80%		93.50%		94.72%
OP54c (L)		Virtual ward occupancy - on day 30	>= 80%	49/60	81.67%		81.67%		81.67%
OP61c (N)		Patients with SMI having full annual physical health check		2558/3963	64.55%		64.55%	>= 95%	64.55%
OP78 (L)		Number of people accessing Individual Placement Support	>= 120		108		108		108
OP85 (N)		Attended Community Care Contacts	>= 57610		75829		162622		399857
OP86 (N)	NOF02e	CYP community mental health related waits > 104 weeks	<= 122		2324		2324		2324

Narrative

OP03a – Reporting 7,222 year to date against a target of 9,374. When compared with activity in the same period last year (7,206) we are reporting 16 above last year's actual.

OP61c - Reporting as 64.55% (down from 74.43%) against the 95% target.

OP78 - The metric measuring the number of people accessing individual placement support has remains below the target of 120 individuals reporting 108 (up from 95 last month)

OP86 – The reported position of 2,324 waits over 104 weeks reflects the NHS England measurement methodology rather than the length of time patients are waiting for care. These are not true waits.

1.0 – Quality In Focus

Indicators for August 2026/2027 TRUST — Quality

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP87a (N)	NOF03c	Mean length of stay for adult acute and PICU patients	<= 47	10257/235	43.65		44		43
OP87b (N)	NOF03d	Mean length of stay for older adult acute discharges	<= 67	3446/64	53.84		56		56
OP88 (N)	NOF05a	Percent Urgent Referrals seen within 24 Hours	<= 79%	7/9	77.78%		85.71%		80.49%
OP90 (N)	NOF08i	% LD patients on GP registers receiving PH check last 12m	>= 95%	1111/1332	83.41%		83.28%		82.22%
OP91 (N)	NOF04c	% Acute admissions without community contact previous year	<= 10%	11/219	5.02%		4.24%		4.73%
OP92 (L)		Access to MHST Support in schools and colleges	>= 3214		4260		8587		22434
OP93 (L)	NOF03e	% readmitted within 30 days of discharge – comparative band		0/35	0.00%				
OP94 (L)	NOF03f	% Readmissions within 14 days after adult acute discharge	<= 10%	2/21	9.52%		9.52%		9.52%
OP95 (L)	NOF03g	% intermediate-care beds patients without right to reside	<= 8%	0/100	0.00%				
OP96 (L)	NOF02f	Access MH services with >= 2 contacts & paired outcome score		607/6029	10.07%		10.07%		10.07%
OP98 (L)	NOF02a	The % Number of Commnunity CYP waiting 18 weeks or less	= 100%	74/74	100.00%		100.00%		100.00%
OP99 (L)	NOF02b	The % Number of Community Adults waiting 18 weeks or less	= 100%	2451/2451	100.00%		100.00%		100.00%

Narrative

OP90 - % LD patients receiving PH check is reported as 83.41% up from 81.74% in the previous month however remains below the 95% target.

1.0 – Quality In Focus

Indicators for August 2026/2027 TRUST — Quality

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS05 (N)	NOF08b	Number of MRSA infections (Monthly)	= 0		0	0	0	0	0
QS06 (N)	NOF08d	Number of Clostridium difficile infections (Monthly)	= 0		0	0	0	0	0
QS07 (N)		Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q2 = 0	0	= 0	0
QS08 (N)		No patients aged >=16 admitted with completed VTE	>= 95%	117/145	80.69%	Q2 >= 95%	81.64%	>= 95%	82.01%
QS09 (N)	NOF7e	Healthcare worker flu vaccination rate		Flu campaign commences from October					
QS27 (L)		Ligature incidents mod or above all inpatient areas	2/7	28.57%		28.57%		<= 10%	21.05%
QS29 (L)		Number of racist incidents against staff members		34		60		= 0	141
QS31 (L)		Episodes of Seclusion - Internal MDT within 5 hours	= 100%	93.75%	15/16				95.47%
QS36 (N)		Inpatients that have a completed MUST assessment	112/147	76.19%	78.18%	= 100%			80.13%
QS37c (L)		Inpatients commenced falls assessment in 12 hrs	65/73	89.04%	91.84%	= 100%			91.71%
QS56 (L)	NOF03a	CQC community mental health survey satisfaction rate		1		Q2 <= 2	2		3
QS57 (L)	NOF08c	Rate of e-coli	= 0	0		0			0
QS59 (L)	NOF08e	% Acute-Spells/Community with new grade 3/4 pressure ulcer	= 0	8		13			19
QS60 (L)	NOF08f	% Safety incidents low/moderate/severe/fatal harm	235/418	56.22%		56.22%			56.22%
QS61 (L)	NOF05b	NHS staff survey raising concerns sub-score		7		7			7
QS62 (L)	NOF06d	Percentage of clinical trials set up within 90 days	= 100%	100.00%		100.00%			100.00%
QS63 (L)	NOF08a	Restrictive interventions (by type) per 1K occupied bed days	17000/17761	0.96		1			1

Narrative

QS08- The percentage of VTE assessments completed within 24 hours has decreased to 80.69% (117/145) from the 82.50% (132/160) in July.

QS09 – Reported from October 2026 once the flu vaccination campaign begins.

QS27 – The percentage of ligature incidents reported as moderate or above in inpatient settings is reporting above target at 28.57% (2/7).

QS29 – Reporting an increase to 34 incidents in August from the 26 incidents in July.

QS31- The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting a slight decline to 93.75% (15/16) from the 100% reported in July.

QS36 - Reporting a decrease to 76.19% (112/147) from the 80% (128/160) reported in July of the % of Inpatients that have a completed MUST assessment.

QS37c – This metric is showing a decrease to 89.04% (65/73) from the 96.34% (79/82) reported in July of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission.

QS59 - Reporting 8 community new grade 3 or 4 pressure ulcers for the month of August.

QS60 – Reporting 56.22% for the month of August % of safety incidents low/ moderate/severe/fatal harm.

1.0 – Quality In Focus

Indicators for August 2026/2027 TRUST — Quality

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS63 (L)	NOF08a	Restrictive interventions (by type) per 1K occupied bed days		17000/17761	0.96	1	1	1	1
QS64 (L)	NOF01a	% inpatients supported attempt to stop smoking (12M rolling)		18/322	5.59%	5.59%	5.59%	5.59%	5.59%
QS65 (L)		Complaints received in month	<= 168	23	23	23	23	23	23
QS66 (L)		Phoenix ward Patients over one year Length of Stay	= 0	0	0	0	0	0	0
QS67 (L)		CMHT Staff with caseload over 20		*In development*					
QS68 (L)		Out of date face risk assessments	<= 5%	1893/8248	22.95%	22.95%	22.95%	22.95%	22.95%
QS69 (L)		DNA rate lower decile attendees		*Awaiting definition*					
QS70 (L)		Number of patients discharged due to disengagement		763		763	763	763	763
QS71 (L)		Depot/clozapine measure		*Awaiting definition*					
QS72 (L)		Child deaths escalated to Safeguarding review		*Awaiting definition*					
QS73 (L)		New birth visits within 14 days	>= 85%	277/390	71.03%	71.03%	71.03%	71.03%	71.03%
QS74 (L)		CEDs – one week wait		78		78	78	78	78
QS75 (L)		Childhood Vaccinations/Immunisations by age and eligibility		*Awaiting definition*					
QS76 (L)		Unplanned transfers to acute care (Rehab wards)		*Awaiting definition*					
QS77 (L)		District Nurses average visits per day		*Awaiting definition*					
QS78 (L)		Advocacy coverage in LD settings – Already added		*Awaiting definition*					
QS80 (L)		Formal vs informal admissions ratio		*Awaiting definition*					

Narrative

QS67 - Awaiting definition prior to development

QS68 – Reporting 22.95% (1893/8249) above the target of <5% for the number of out-of-date face risk assessments for the month of August.

QS69, QS71 - Awaiting definition prior to development

QS72 – Awaiting development

QS73 – Reporting 71.03% (277/390) against a target of > 85% of new birth visits completed within 14 days.

QS76-80 - **-** Awaiting definition prior to development

1.0 – Quality In Focus

Indicators for August 2026/2027 TRUST — **Quality**

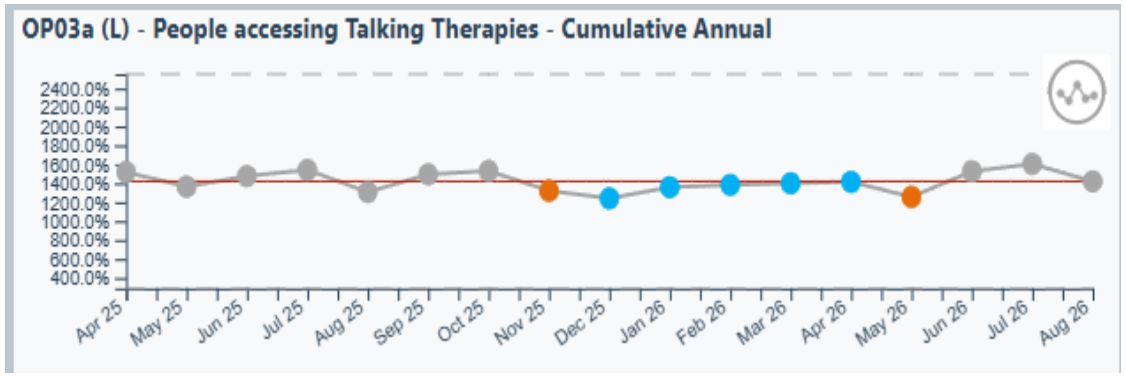
Indicator ▲	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS80 (L)		Formal vs informal admissions ratio		*Awaiting definition*					
QS81 (L)		Number of fully compliant audited Mental Health Act records		*Awaiting definition*					
QS83 (L)		Number of LD patients with Stomp recorded		*Awaiting definition*					
QS84 (L)		7-day therapeutic day misses in reporting period		*Awaiting definition*					
QS85 (L)		% Seclusion Days vs OBD	16/2002	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%

Narrative

QS80-QS82 Awaiting definition prior to development

QS84 Awaiting definition prior to development

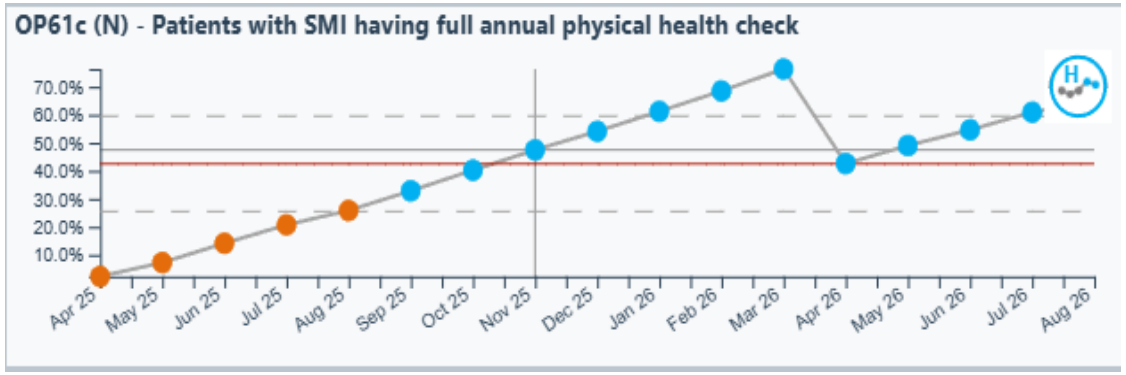
1.1 Quality In Focus - Exceptions



Trend, Reason and Action

OP03a Reporting 7,222 year to date against a target of 9,374. When compared with activity in the same period last year (7,206) we are reporting 16 above last year's actual.

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

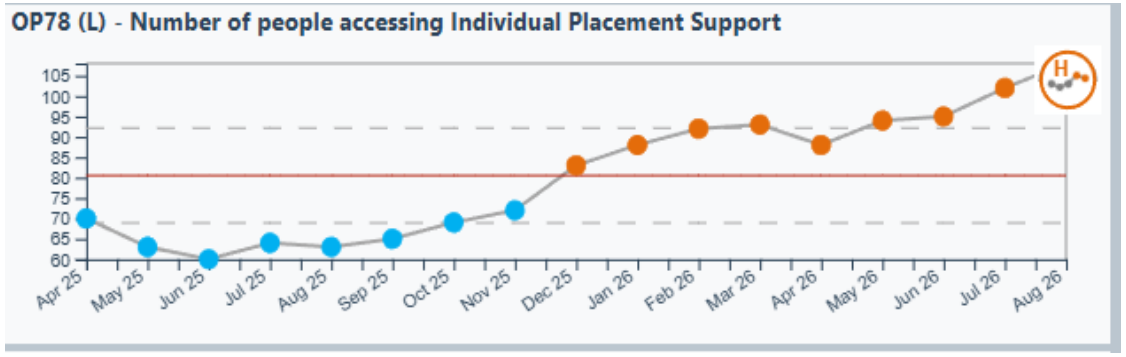


Trend, Reason and Action

OP61C Reporting as 64.55% (down from 74.43%) against the 95% target.

Improvement initiatives are in place which include a continuing focus on declines across all 3 Care groups, embedding POC machine blood testing, and support from peer support workers to support access.

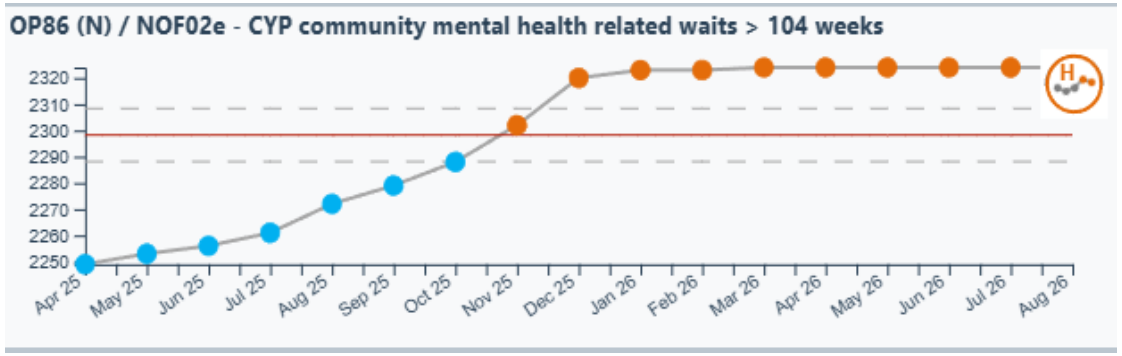
Metric performance to be escalated through the monthly performance clinic to drive improvement and to provide additional oversight.



Trend, Reason and Action

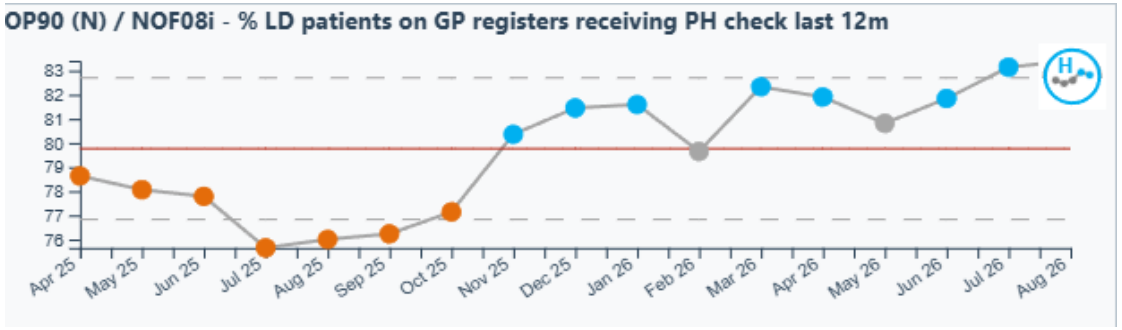
OP78 The metric measuring the number of people accessing individual placement support has remains below the target of 120 individuals reporting 108. Recruitment has completed with job starts now improving with new Employment Specialists (ES) trained and taking on full caseloads. A new ES has been in post for 2 weeks and a further 0.6 WTE ES will join the team shortly. Team Lead will be full-time position shortly. Additional funding has been released by the Commissioner to support expansion.

1.1 Quality In Focus - Exceptions



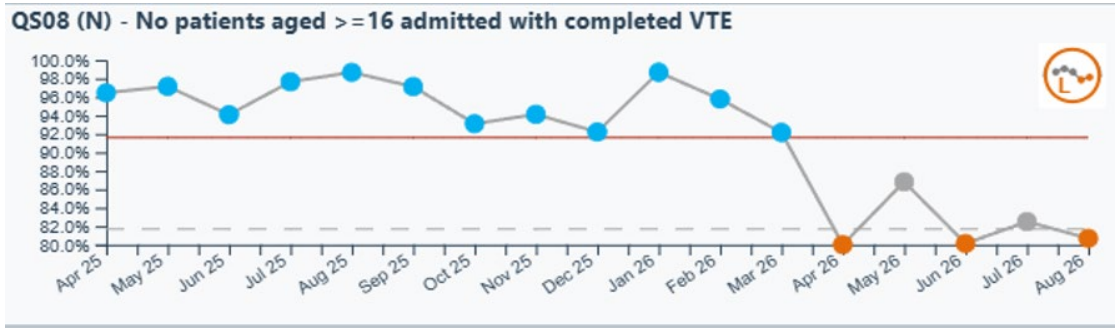
Trend, Reason and Action

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



Trend, Reason and Action

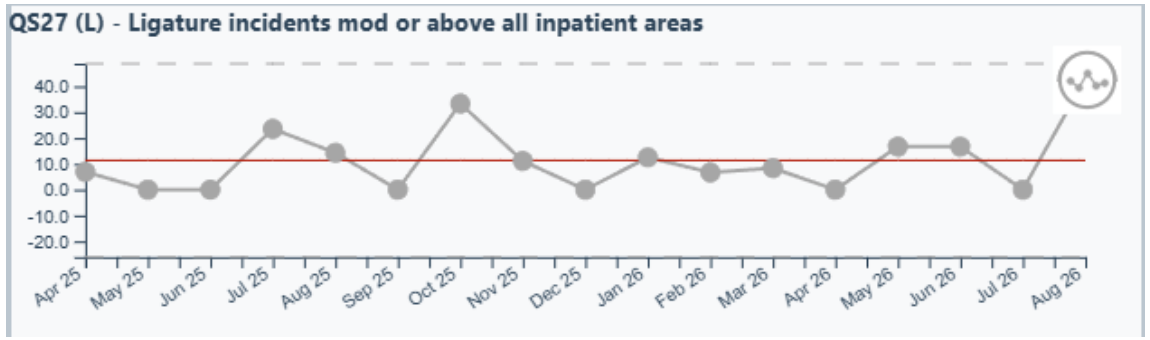
OP90 Improvement initiatives are in place which include a continuing focus on declines across all 3 Care groups, embedding POC machine blood testing, and support from peer support workers to support access. Metric performance to be escalated through the monthly performance clinic to drive improvement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



Trend, Reason and Action

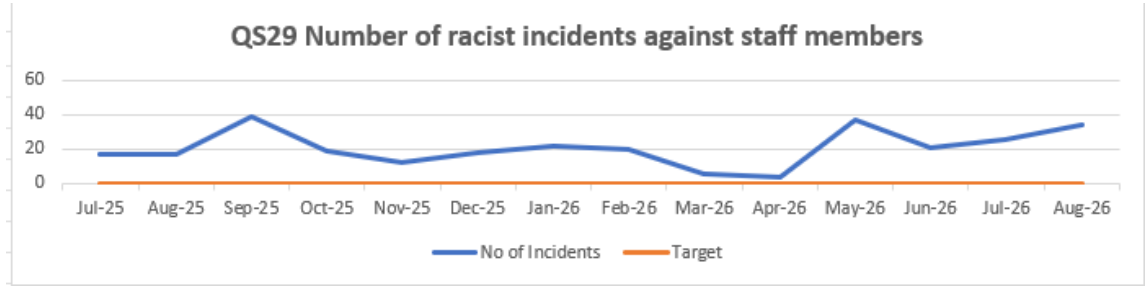
QS08 The percentage of VTE assessments completed within 24 hours has decreased to 80.69% (117/145) from the 82.50% (132/160) in July. There continues to be ongoing monitoring in all Care Groups including missed VTE assessments which has been escalated to the Trust Medical Director and any learning can be addressed more promptly with feedback to individual clinicians and any actions to learn from each delay is implemented.

1.1 Quality In Focus - Exceptions



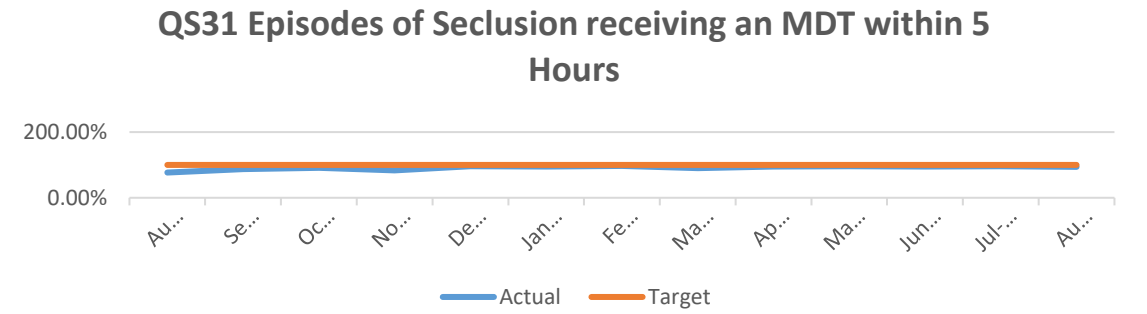
Trend, Reason and Action

QS27-The percentage of ligature incidents reported as moderate or above in inpatient settings is reporting above target at 28.57% (2/7). One patient on Kingfisher is using his catheter to ligature this is the same patient with multiple episodes.



Trend, Reason and Action

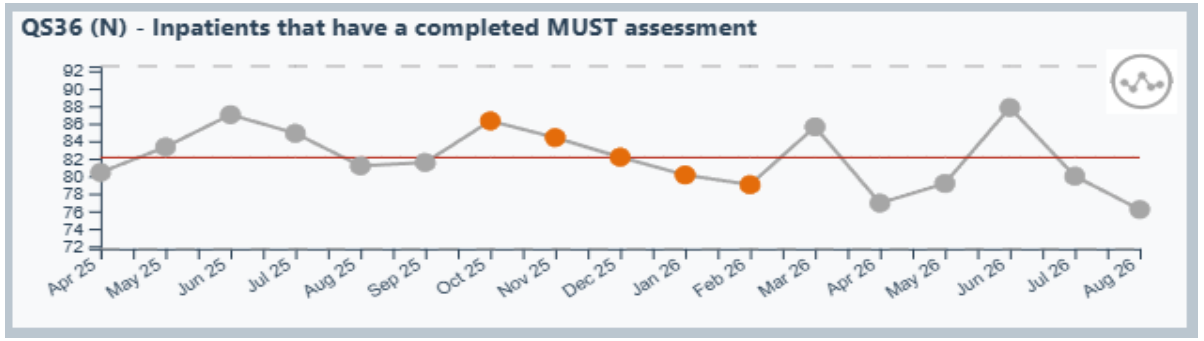
QS29 –Reporting an increase to 34 incidents in August from the 26 incidents in July. All Care Groups are continuing to follow the acceptable behaviour policy where appropriate and supporting colleagues who experience any form of abuse which has led to staff being more proactive in reporting incidents with an increase in active by stander reports. Rotherham continues to implement the SAFE project to support staff following any discrimination and the North Lincs Anti racism programme is continuing. For 26/27 anti-racism is a focus and reflects staff feedback and Radar learning.



Trend, Reason and Action

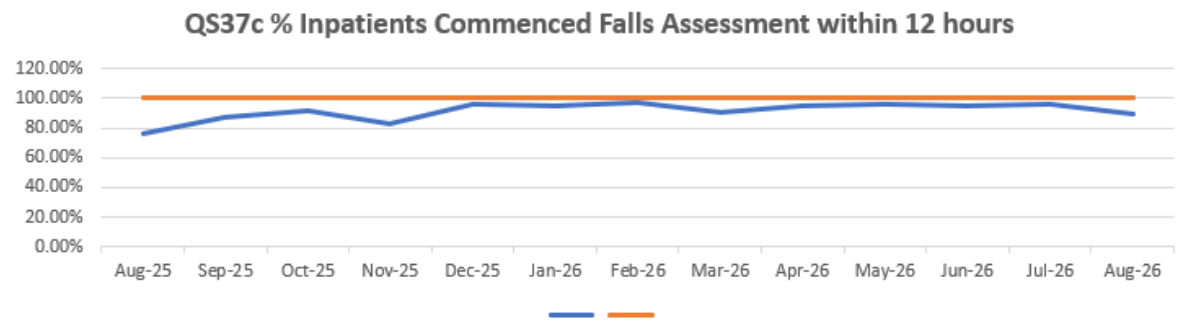
QS31- The number of episodes of seclusion receiving an internal MDT assessment within 5 hours is reporting a slight decline to 93.75% (15/16) from the 100% reported in July. The changes have been implemented to the seclusion visualisation on System 1 to allow a pop-up message to appear giving instructions to the Doctors in what circumstances the particular review should be completed that has been selected. The risk continues to be highlighted on the risk register for each Care Group and the Mental Health Act Manager has instructed the Matrons that all audits of episodes of seclusion must be taken through the Mental Health Legislation Monitoring.

1.1 Quality In Focus - Exceptions



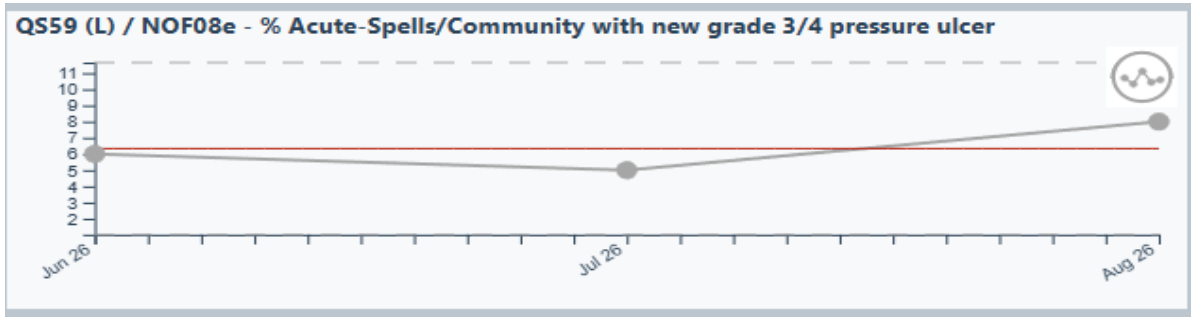
Trend, Reason and Action

QS36 Reporting a decrease to 76.19% (112/147) from the 80% (128/160) reported in July of the % of Inpatients that have a completed MUST assessment. Following a deep dive MUST has been completed late on most patients which could be linked to an increase in admission and acuity in the month of August. There continues to be ongoing monitoring in all Care Groups during September to ensure there is an improvement



Trend, Reason and Action

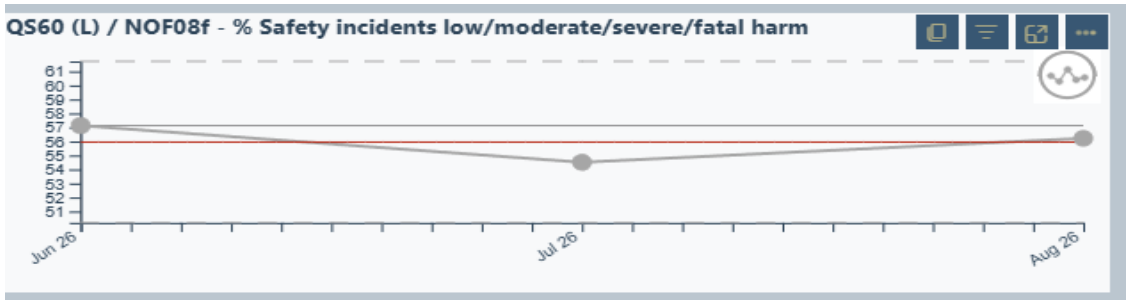
QS37C This metric is showing a decrease to 89.04% (65/73) from the 96.34% (79/82) reported in July of the % of patients who are admitted to inpatient wards that received a falls assessment within 12 hours as part of their admission.



Trend, Reason and Action

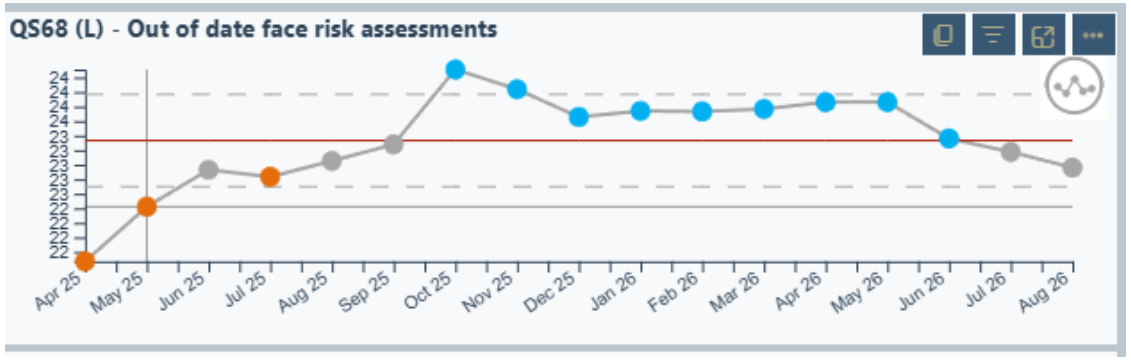
QS59 Reporting an increase to 8 from the new grade community 3 or 4 pressure ulcers reported for the month of August. Across all teams and inpatient areas, there was an overall reduction in incidents resulting in higher levels of harm between July and August. In July, 12 incidents were reported as moderate or major harm (10 moderate and 2 major), compared with 8 moderate-harm incidents and no major-harm incidents in August. This represents a 33% reduction in incidents resulting in moderate or major harm. Of particular note, no major-harm incidents were reported across the Directorate during August, compared with two in July.

1.1 Quality In Focus - Exceptions



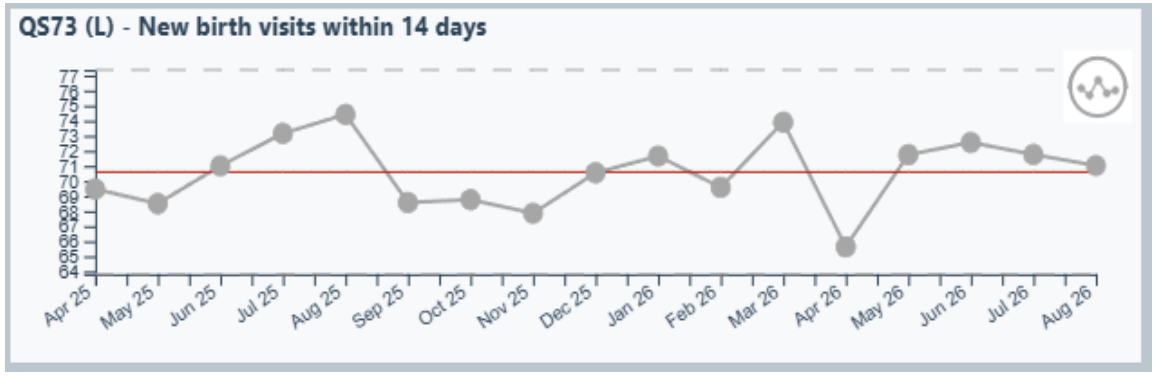
Trend, Reason and Action

QS60-Reporting a decline to 56.22% (235/418) from the 57.13% safety incidents low/moderate severe or fatal harm in the previous reporting period. All incidents moderate or above continue to be investigated under Duty of Candour.



Trend, Reason and Action

QS68 – Reporting 22.95% (1,893/8,249) against a target of <5% in August. Director's of Nursing are working with Care Groups to review the causes of underperformance, strengthen oversight of reporting processes, and improve compliance through targeted actions which includes weekly monitoring for in particular Learning Disability Services, this also includes data quality reviews and enhanced governance monitoring.



Trend, Reason and Action

QS73 –-New birth visit performance remains below target at 71.03%. The reported position includes a cohort of authorised exceptions where a visit could not be completed within the required timeframe for reasons outside the service's control, for example where the child is an inpatient in hospital, resident outside the service area, or where other valid clinical or operational circumstances apply. A detailed review of the current breaches is underway to identify and validate these exceptions manually, alongside targeted actions to improve timeliness of completed visits. This work will provide greater assurance regarding the true level of performance and help focus recovery actions on avoidable delays.

2.0 People and Organisational Development – In Focus

Indicators for August 2026/2027 TRUST — People

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
POD18 (L)	-	Individuals Performance Development Review in 12 month	> 90%	3081/3293	93.56%	93.56%	93.56%	93.56%	93.56%
POD30 (L)	NOF07a	% days previous quarter where staff sick, unable to work		24044/318 091	7.56%	7.56%	7.56%	7.56%	7.56%
POD31 (L)	NOF07b	NHS Staff Survey engagement theme score	7	6.81	6.81	14	21	7	6.81
POD32 (L)	NOF07c	National education and training survey satisfaction rates		*Awaiting performance baseline from NHSE NOF publication*					
POD33 (L)	NOF07d	NHS staff standards score		*Awaiting performance baseline from NHSE NOF publication*					
POD34 (L)	NOF07f	Temporary staffing cost as a % of total pay bill		4.05%	4.05%				4.05%
POD36 (L)	-	% spend of Apprenticeship Levy				185348		308913	460292
POD37 (L)	-	Turnover <24 months		21/46	45.65%				
POD38 (L)	-	Turnover 24 months +		25/46	54.34%				
POD39 (L)	-	Recruitment from local communities		29/57	50.88%				

Narrative

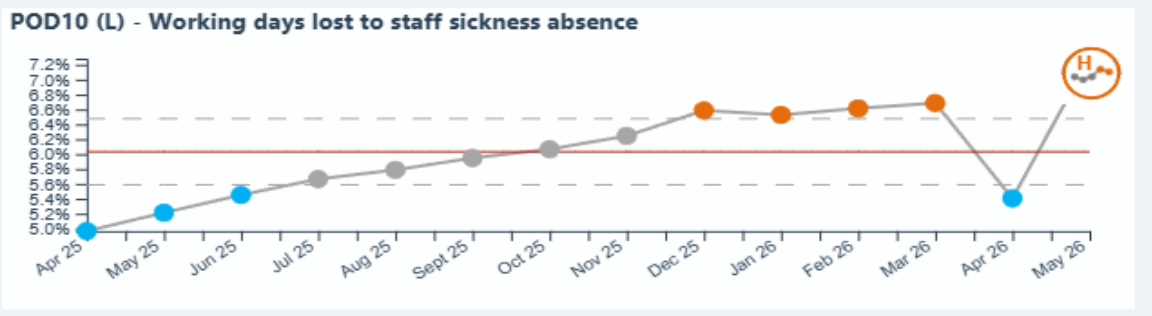
POD18 – PDR's reporting 93.56% above the 90% target.

POD30 – % days for the previous quarter where staff were sick and unable to work is reported as 7.56%

POD33 - New metric are implemented by national team awaiting release of NOF scores to determine current performance

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

2.1 People and Organisational Development - Exceptions



Trend, Reason and Action

POD10 –The sickness absence % is above target (7.56% vs 5.1%), which has increased from the previous months of 7.28%. Quarterly LT sickness review clinics have been held for all areas chaired by the Director of People and OD, with attendance from the Care Group SLT, Service Managers and HR. These clinics will be held on a quarterly basis, with the first RAG rating score applied this quarter. In the intervening months, the HR team will also facilitate local review meetings

3.0 Finance – In Focus

Finance				
Indicator	Metric	Target	Actual	Variance
NOF6a	Forecast outturn vs budget - planned breakeven	0	0	-
NOF6b	Year to date actuals vs budget	(157)	(68)	89
NOF6c	Relative cost difference (National Cost Collection Index) 24/25	1	0.88	(0.12)
NOF8g	Rate of implied productivity growth	Not yet able to report		
FIN01	Year to date savings target vs schemes identified	5,730	5,730	0
FIN02	Annual savings target vs forecast savings (non-recurrent & recurren	13,750	13,750	0
FIN03	Annual savings target vs forecast savings (recurrent only)	9,930	10,124	194
FIN04	Year to date capital plan vs spend	3,540	(381)	(3,921)
FIN05	Annual capital plan vs forecast spend	7,475	7,257	(218)
FIN06	Agency spend - year to date	350	734	384
FIN07	No of directorates compliant with budget - year to date	24	24	100.0%
FIN08	No of directorates compliant with budget - forecast	24	21	87.5%
FIN09	***Directorates not compliant with budget - YTD:***			
FIN10	***Directorates not compliant with budget - Forecast:***			
	Doncaster Acute	12,445	12,518	74
	Rehabilitation	14,822	14,871	49
	Community & LTC	27,668	27,707	39

Narrative

NOF6a - The 2026/27 forecast as at M5 is to achieve a breakeven plan.

NOF6b - At M5 the year to date (YTD) position is £89k better than planned. This masks some significant differences compared to plan, however: substantive pay underspent by £3.2m, temporary staffing overspent by £1.1m, out of area placements underspent by £1.2m and HDRU income is less than plan by £0.8m. Main contract income has been deferred to align with costs that will be incurred later in the year resulting in a financial position that remains close to plan.

NOF6c - The latest published data is for 2024/25. The 2025/26 National Cost Collection for RDaSH was submitted to NHSE in June and the results compared to other trusts will be published later in the year.

FIN01, FIN02 & FIN03 - At M5, the YTD and forecast expected savings are on plan. Some recurrent schemes are not yet delivering but this is a timing issue and the directorate level gap has been offset by non-recurrent savings from vacancies being higher than planned.

FIN04/05 - Capital spend is behind plan year to date by £3.9m. This is expected for this stage of the year and includes a £1m grant that was received in M2; spend will ramp up over the next few months. The Trust's capital plan included an additional £218k of expected funding, as permitted under the planning rules. However, NHSE has since confirmed that this funding cannot be spent. As a result, the Trust is forecasting capital expenditure in line with its original capital allocation of £7.257m

FIN06 - YTD agency costs are over plan at M5, the driver of this is related to agency medics, there have been further extensions of agency medics in month in the Doncaster and Rotherham Care Groups.

FIN08 & FIN10 - At M5, 21 of the 24 directorates are forecasting an underspend. Doncaster Acute is overspent by £74k and this is mainly attributed to the current level of bank spend. Two directorates within the Physical Care group are forecasting to overspend, however the care group overall will break-even by year end.

FIN09 & FIN11 - The 2026/27 budgets were approved on the basis that all directorates would operate within their allocated budgets. At Month 5, 24 of the 24 directorates are underspending year to date.

4.0 Promises – In Focus

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

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
P02b (L)		The number of all-age carers that use our services		1552		3203			7837
P06a (L)		Steady drop in service-attendance gap in lower decile areas		2654/94045	2.82%	2.82%			2.82%
P07a (L)		CYP with LD/autism seen by specialist epilepsy nurse in 4wks		0/100	0.00%				
P07b (L)		Increase referrals from children of a black background 10%	>= 309		1133	2487			6695
P07c (L)		% Was Not Brought (DNA) from deprived areas	<= 7%	128/2026	6.32%	6.32%			6.32%
P08b (L)		TT access - Increasing access rates for older adults		29/398	7.29%	7.29%			7.29%
P08c (L)		% Minority adults with LD active month end with health check	>= 95%	82/94	87.23%	87.23%			87.23%
P08d (L)		Dementia Diagnosis rate		7458/10032	74.34%	74.34%		>= 67%	74.34%
P08e (L)		Dementia diagnostic rates for people from a minority	>= 4.2%	11/326	3.37%	3.37%			3.37%
P08f (L)		% Perinatal referrals from people of a black background	>= 5%	4/63	6.35%	6.35%			6.35%
P11a (L)		Achieve priority access to services for veterans	>= 3.89%	1004/36877	2.72%	2.72%			2.72%
P12a (L)		% Referrals from rural areas compared to rural population		5219/36278	14.39%	14.39%			14.39%
P13d (L)		Meet 5 community mental health transformation measures(2024)	100%	4/5	80%				
P14a (L)		The number of referrals seen within 4 weeks		62/83	74.70%	Q2 >= 94%	74.70%		74.70%
P14b (L)		% Urgent referrals seen within 48 hours		1422/2163	65.74%		65.74%	= 100%	65.74%
P22a (L)		% Individuals admitted over the weekend		13/52	25.00%		25.00%		25.00%

Please select a measure to see the Comment and monthly comparison value vs target

Narrative

P08c – Annual health checks for individuals from a minority background is reported slightly below the 95% target at 87.23%.

PO8e – Dementia diagnosis for minority adults us reported at 3.37% below the 4.2% target.

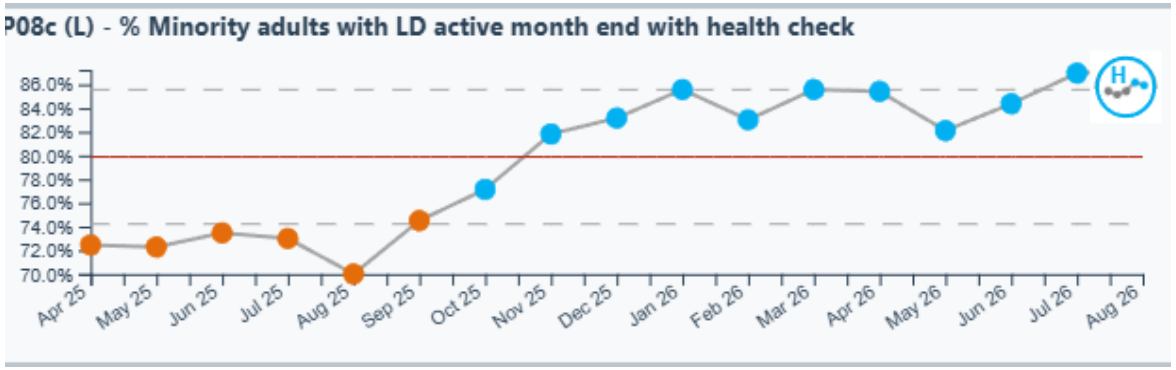
P11a – 2.72 % of veterans received priority access below the target of 3.89%.

P13d – of the 5 measures only 4 are meeting target as the one measure relating to the number of individuals receiving an annual physical health check is below target as identified in Quality quadrant OP61c

P14a - The metric monitoring four-week compliance to Promise 14 with 74.7% of services achieving the 4 week wait standard, this equates to 62 of 83 services.

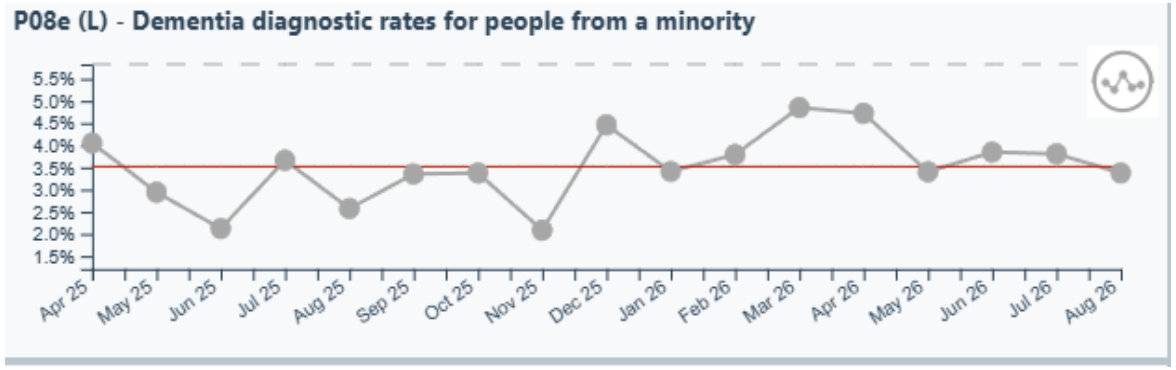
P14b - The metric monitoring compliance to 48 hr response to referrals classified as urgent for Promise 14. Reported 65.74% of referrals seen within the 48 hr target.

4.1 Promises In Focus- Exceptions



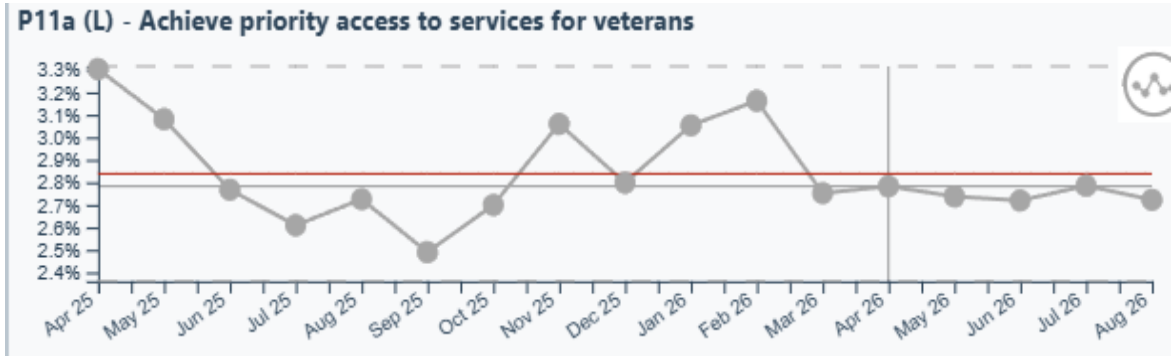
Trend, Reason and Action

P08C– Improvement initiatives are in place which include a continuing focus on declines across all 3 Care groups, embedding POC machine blood testing, and support from peer support workers to support access. Metric performance to be escalated through the monthly performance clinic to drive improvement and to provide additional oversight.



Trend, Reason and Action

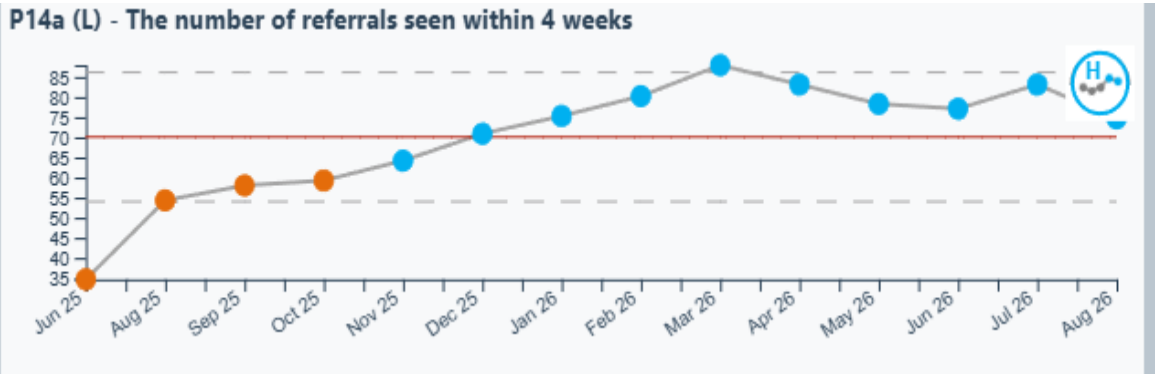
P08e - Performance is below the target of 4.2%, achieving **3.37% (11/326)**. A review is being undertaken to better understand referral patterns, identify potential barriers to access and determine whether there are any issues relating to awareness, engagement, recording or pathway utilisation within minority ethnic communities. Recovery actions include targeted outreach, strengthening links with community organisations and referrers, and improved monitoring of referral trends to ensure equitable access. Progress will be reviewed through existing health inequalities and performance governance arrangements



Trend, Reason and Action

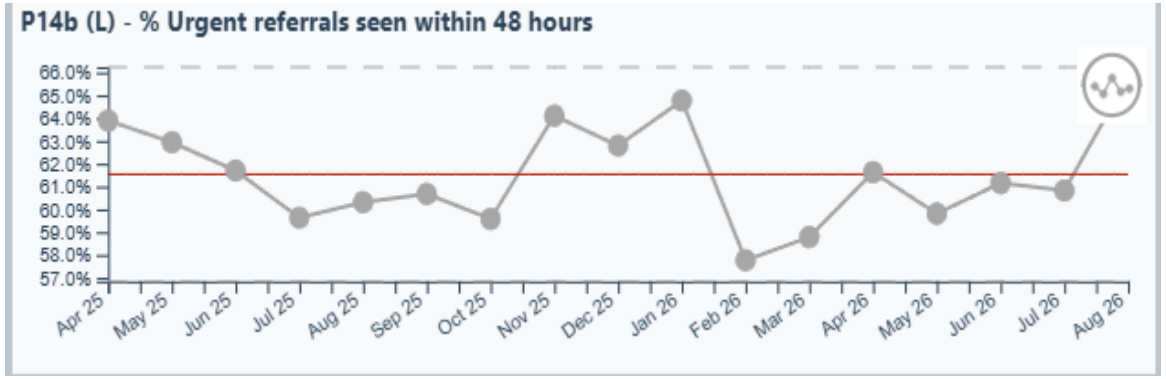
P11a - Performance remains below target at **2.72%**. Analysis is underway to understand whether underperformance is driven by identification, recording or access issues. Actions are focused on improving veteran identification processes, strengthening referral pathways and increasing awareness of support available to veterans.

4.1 Promises In Focus- Exceptions



Trend, Reason and Action

OP14a - The metric monitoring four-week compliance to Promise 14. 74.7% of services are currently achieving the standard, with 62 of 83 services compliant. While overall performance remains strong, a small number of services continue to report breaches. Within Children's Services, four services exceed the four-week standard, largely due to the impact of sickness absence on delivery. In Physical Health Services, three services remain above four weeks, with podiatry continuing to experience extended waits as a result of increased demand. Community Mental Health Services in Doncaster have recently breached the four-week standard. Focus within the Care Groups will be continued to recover performance against the standard with oversight at the fortnightly waiting list group.



Trend, Reason and Action

P14b - The metric monitoring compliance to 48 hr urgent response for Promise 14 reported 65.74% of referrals seen within the 48 hr target. This equates to 1422/2163 referrals seen within the timescale. Delivery of the standard remains a key focus for Care Groups, supported by targeted improvement actions. Oversight has been strengthened through the fortnightly Waiting List Group, which now includes routine monitoring of urgent response performance, corrective actions and escalation where required.

Appendix 1`

SPC Icon Description

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Organisational Change Key Performance Indicators	**Agenda Item**	Paper N
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	Steve Forsyth, Chief Nursing Officer		
Meeting	Board of Directors	**Date**	24 September 2026

Suggested discussion points

Access and waiting-time deterioration: Primary Care Mental Health waits over four weeks rose from 4 to 13, while Memory Service waits completed over four weeks doubled from 13 to 26. The Board should seek assurance on causes, recovery actions, ownership and timescales.

Service capacity and responsiveness: NHS111 average call duration increased from 46 to 73 minutes, and Phlebotomy continues to show workforce and capacity pressure. The Board should test whether these are isolated variations or early indicators of reduced resilience following organisational change.

Reliability of Board assurance data: The Rotherham EIP caseload-per-WTE KPI cannot yet be validated because the monthly WTE denominator, staff inclusion rules and some pathway/documentation data are incomplete.

Previous consideration

N/A

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE the August 2026 QSIA monitoring position, approximately four months following implementation of the organisational changes associated with the CIP programme.

CONSIDER the specific areas of variation identified within the report, noting that none currently meets the agreed parameters for escalation as evidence of adverse impact arising from the CIP programme.

NOTE the more detailed review of the Early Intervention Team undertaken in response to the identified concern and the conclusion that, when considered against the wider EIT dataset, the reduction in the individual contact indicator does not currently demonstrate service deterioration associated with organisational change.

Alignment to strategic objectives	
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
Alignment to the plans:	
People and teams plan	X
Finance plan	X
Quality and safety plan	X

Trust Risk Register

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	

Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that support care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	

Strategic Delivery Risks	
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	X

System / Place relevance							
N/A							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Quality and Safety Impact Assessment (QSIA) Monitoring Report - September 2026

RDaSH | Organisational change KPIs | Public Board | August 2026 data

1. Purpose, confidence statement and Board decisions

1.1 This report presents the August 2026 Quality and Safety Impact Assessment monitoring position for organisational change and vacancy-removal schemes implemented from April 2026. It builds on the monitoring reports received in May and July 2026.

1.2 The August position is broadly stable. Specific access, capacity, documentation and data-quality exceptions require focused action; the available evidence does not establish that organisational change caused or materially worsened them.

2. Scope, method and interpretation

2.1 The QSIA framework covers Children and Young People, mental health, learning disabilities, physical health and neurodiversity, community services and corporate functions.

Data caveat: All figures and findings are correct as shown in the source material available at the time of review. Dashboard data may subsequently change following refreshes, validation, correction or retrospective recording. The Rotherham EIP caseload-per-WTE KPI is specifically qualified pending operational validation of its data pull, workforce denominator and reporting definition.

2.2 Interpretation follows four disciplines:

- A single monthly movement is treated as variation, not automatically as deterioration.
- Movement sustained across several periods is treated as a potential signal.
- Quality, safety, workforce, access and experience information is read together before reaching a judgement.
- Correlation with organisational change is not treated as causation without supporting evidence.

3. Board-level position

3.1 The August dataset does not show a Trust-wide increase in incidents, complaints, unmet need or safeguarding concerns associated with the change programme. The principal exceptions requiring scrutiny are set out below.

Area requiring scrutiny	August evidence / reason
Primary Care Mental Health	Patients waiting over four weeks increased from 4 to 13.
Memory Service	Waits completed over four weeks increased from 13 to 26.
NHS111	Average call duration increased from 46 to 73 minutes.
Rotherham EIP caseload KPI	Band 6 caseload totals were refined to 267 in June, 268 in July and 269 in August. This partly resolves the original concern, but no validated monthly WTE denominator is available; compliance with a cases-per-WTE threshold cannot yet be confirmed.
Phlebotomy	Capacity and workforce pressure remain visible through continued variation.
KPI assurance	Some supervision measures, legacy definitions and the Rotherham EIP caseload-per-WTE methodology require validation.

4. Integrated Care Group analysis

4.1 Children and Young People

Indicator	July	August
NHS111 abandoned calls	51	39
School Nursing DNAs	22	12
NCMP Reception	91%	91%
Sexual Health DNAs	12	5
Sexual Health cancellations	2	0

4.1.1 NHS111 average call duration increased from 46 to 73 minutes and remains the principal exception. The simultaneous reduction in abandoned calls indicates that callers continued to reach the service, but does not remove the need to understand the longer duration.

4.1.2 Sexual Health attended contacts reduced from 48 to 29. Doncaster School Nursing contacts reduced from 1,451 to 990, while DNAs reduced from 9 to 8 and cancellations from 7 to 6. Both activity reductions coincided with the school summer holiday period and were not accompanied by an increase in incidents, complaints, negative feedback, safeguarding concerns or unmet need. The current interpretation is seasonal variation rather than evidence of harm from organisational change; this should be tested against September data.

4.2 Doncaster Mental Health and Learning Disabilities

Community Mental Health	July	August
Contacts	923	965
DNAs	66	49
Cancellations	71	28
Waits under four weeks	13	12
Waits over four weeks	5	4

4.2.1 Primary Care Mental Health is the clearest Doncaster access exception. Contacts reduced, DNAs and cancellations increased, and the number waiting over four weeks increased from 4 to 13. GP complaints remained at zero and no associated incident or adverse feedback signal was identified. This should be treated as a focused access concern, not as evidence of wider quality deterioration.

Primary Care Mental Health	July	August
Contacts	1,482	1,310
DNAs	122	135
Cancellations	198	227
Waits under four weeks	85	76
Waits over four weeks	4	13
GP complaints	0	0

4.3 North Lincolnshire Mental Health and Talking Therapies

4.3.1 The Early Intervention contact indicator reduced from 106 to 56. In isolation this is concerning; however, the wider EIT information shows referral growth, sustained activity and stable engagement. The contact measure should be treated as a subset of service activity pending further validation.

4.3.2 Community SMI completion of all eight physical health checks improved from 60% to 67%. Memory Service waits completed over four weeks doubled from 13 to 26 while caseload increased from 696 to 703. The evidence is insufficient to attribute this directly to organisational change, but the position requires focused review.

Memory Service	July	August
Waits completed over four weeks	13	26
Caseload	696	703

4.4 Rotherham Care Group

Service	July	August
EIP	717	715
Assertive Outreach	146	142
Locality Treatment North	462	456
Locality Treatment South	683	681
Care Home Liaison	299	310
Memory Team	788	774

4.4.1 The overall Rotherham position is stable. The separate EIP practitioner-level validation described below has narrowed the specific caseload concern but also identified that the current KPI data pull and denominator require operational correction before the metric can provide reliable assurance.

4.5 Physical Health and Neurodiversity

4.5.1 The August position is more reassuring than July. Core safety indicators remained stable: incidents, negative feedback, lone-worker incidents and unmet need were all reported as zero; positive feedback was stable. Integrated Discharge delays reduced from 59 to zero, resolving the specific concern highlighted in July. Most caseloads were stable, including TVAL (2,294 to 2,292), Diabetes (1,574 to 1,607), Continence (4,306 to 4,357) and Respiratory (332 to 351).

4.5.2 Phlebotomy caseload reduced from 82 to 71. Given previously identified workforce and capacity pressure, Phlebotomy remains the principal area requiring visibility; the movement does not on its own establish either harm or improvement.

5. Early Intervention in Psychosis caseload review

5.1 The question examined was whether Rotherham EIP practitioner caseloads were within the expected threshold of 20 cases per full-time equivalent (WTE/FTE). The validation journey demonstrated that the original dashboard view could not answer that question: it displayed caseloads against staff records but did not provide contracted WTE, included records for colleagues who had left, and contained an “UNKNOWN” record.

5.2 What the review established

Measure	June	July	August
Band 6 caseload total identified by filtering the supplied practitioner list	267	268	269

5.2.1 The monthly caseload totals above were produced by filtering the QSIA practitioner data to the Band 6 staff identified by the Care Group. A staff member was identified by the Care Group as a 0.8 WTE Band 6 care lead, but no named caseload record for the staff member was present in the QSIA report. This may be represented within the "UNKNOWN" data point, but this has not been confirmed and requires further validation.

5.2.2 The Care Group also advised that current caseloads are held by Band 6 staff and provided a current operational snapshot of 179 people on caseload across 12 Band 6 staff, producing 14.9167 cases per Band 6 staff member (179 ÷ 12). This is a headcount calculation, not a WTE calculation, because not all 12 staff are full time. It therefore provides useful operational context but does not establish performance against a per-WTE threshold.

Calculated estimates: The values of 17.8, 17.9 and 17.9 were calculated by dividing the monthly caseload totals of 267, 268 and 269 by an assumed 15 WTE following direct operational review by the Service Manager and Deputy Care Group Director. The WTE denominator was not verified for each month, so these values are estimates and are not presented as validated KPI performance.

5.3 Validation journey and current assurance

5.3.1 On 14 September, the initial dashboard review generated displayed-staff averages of 17.2, 17.1 and 17.1 for June to August, but the dashboard did not identify staff WTE and required "UNKNOWN" to be treated as one staff record. On 15 September, intervention by the Chief Nurse and the Executive Director for People and Organisational Development brought together workforce information and Care Group operational knowledge. The ESR list included people who had left, while some current records lacked WTE; the Care Group then supplied a current team list and clarified which roles held caseloads. Further filtering on 16 September narrowed the numerator to Band 6 caseload totals of 267, 268 and 269.

5.3.2 This work has somewhat resolved the immediate concern by replacing the original all-staff average with a more relevant Band 6 numerator and identifying the source of key discrepancies. It has not validated the KPI. A verified Band 6 WTE denominator for each month is still unavailable on the same inclusion basis as the caseload numerator. Other EIP indicators continue to show service activity rather than clear service-wide deterioration. Approximately 48,000 contacts were recorded and the DNA rate was 3.06%. However, 41.74% of the pathway was recorded as No Allocation Category; its definition and use should be validated because it limits confidence in pathway analysis.

Documentation measure	Performance
Assessment and Review	74.2%
FACE Risk compliance	78.9%
Care Plan compliance	75.5%

6. Monitoring, limits and next steps

6.1 The Board-level exceptions and service-specific actions are set out in sections 3 to 5. Continued confidence depends on maintaining focused review of Primary Care Mental Health and Memory Service waits; understanding and monitoring the increase in NHS111 average call duration; completing operational validation and remediation of the Rotherham EIP caseload-per-WTE KPI and re-running June to August using the approved definition and exact monthly WTE; maintaining visibility of Phlebotomy capacity and workforce pressure; completing validation of supervision measures and legacy KPI definitions; and reviewing September data to test whether the August school-holiday activity reductions reverse as expected.

6.2 The main limitation remains attribution. The report can identify timing and association, but it cannot conclude that organisational change caused a movement unless supporting operational, workforce, safety and experience evidence points in the same direction.

7. Conclusion

7.1 The August QSIA position is broadly stable but contains specific access, capacity, documentation and data-quality exceptions that require investigation and remedial action.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper O
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	24 September 2026

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

The report confirms that in April-June 2026 the Trust's segmentation position **improved from 3 to 2**, largely because of the removal of the deficit support override: analysis of published data suggests that our position is unlikely to decline in year and may yet improve. Board members are sighted on continued contractual disputes with ICB commissioners, and the cash under-accrual associated YTD, which is of concern given our Estate Plan. Nonetheless we have a green finance rating from NHS NEY and our 'mid-year review' is desktop/low risk.

Next week the leaders' conference will see an important moment in respect of Our RDaSH Way, and our associated cultural commitments; and the Board is reminded that both PSC and TVC are working with us as independent advisors in that work. Preparations for a Well Led Review during 2026/27 by the Care Quality Commission continue.

The patient facing section to this report juxtaposes the possibilities of the Acorn Centre, with the learnings we urgently need to adopt arising from the death of a patient (CE) who we cared for. Likewise, the adoption of a 'never event stance' related to street discharge is highlighted.

Previous consideration

N/A except CLE/CoLE annexes – and EPRR discussion at July's Board

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

EXPLORE the patient, people and population issues described

CONSIDER any matters of concern not covered within the report

RECONFIRM support of the definition of anti-semitism provided

ACCEPT the EPRR submission agreed in our July meeting [100%!]

NOTE assurances related to the Winter Plan 2026 and outlined in the relevant annex

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

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks

Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	X
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X
Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)			

If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1	X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.	X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	X

System / Place impact (advise which ICB or place that this matter relates to)

The implications of arbitration for future year planning submissions are outlined

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

Appendix (please list)

Annex 1: CLE summary August and September 2026
Annex 2: Communities' Leadership Executive (CoLE) notes August and September 2026
Annex 3: Current register of Trust vacancies – as at time of issue
Annex 4: National publications – August/September 2026
Annex 5: Neurodiversity activity and wait scorecard: YTD August 2026
Annex 6: South Yorkshire Mental Health, Learning Disabilities & Autism (MHLDA). Provider Collaborative Board Development Session 4th September 2026 - Report and Action
Annex 7: South Yorkshire Eating Disorders Joint Committee Meeting Note – Sept 2026
Annex 8: Winter planning submission: detailed response for approval
Annex 9: EPRR submission 2026 – further detail post July consideration
Annex 10: Danescourt Requires Improvement outcome – CQC submitted action plan
Annex 11: Coroner's submitted action plan (due for delivery 31-10-26)
Annex 12: Trust's published National Oversight Framework position April - June 2026

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report - September 2026

1.1 Always measure one relates to **care planning**. Our analysis of ten years of RDaSH wide CQC reports points to the same necessary focus. Mindful of this we have spoken to DIALOG+ care planning being 'this year's four weeks': in other words, *an overwhelming emphasis*. We discussed in July 2026's Board, delivering consistent coverage by the end of September – we will miss that deadline but palpably have got closer than ever before. Week by week October remedial plans are being discussed in the two care groups where we have likely fallen short – adult mental health in Rotherham and Doncaster.

1.2 Board members will be aware of the national publication of the **NOF framework** data for Q1 (April-June 2026). We had expected improvement with the work to remove deficit support funding and our final move towards exiting 2026/27 without an underlying deficit (£16m in 22/3). On the other hand, the radical reshaping of the indicators for our 'sector' created known-unknowns. Annex 11 outlines our now published position, and we have work to do to address data on smoking and on crisis access, *with a strong likelihood of improvement on both measures during 2026/27*. I should emphasis that the length of stay measure chosen quirkily advantages us, and that work to address outlier stays in our wards must continue – as it is; with green shoots in Rotherham since July.

1.3 We will be using the forthcoming leaders' conference to introduce **our cultural commitments for the future**. The intention is that our move towards a high support / high accountability approach begins work to address views expressed in a variety of settings that the organisation is not consistently putting safety at the forefront, creating psychological safety in speaking up for change, and is not always managing individuals or teams with the right balance of rigour and kindness. None of these are areas where nothing has been done in prior months and years, but we have agreed to judge ourselves by results – and feedback from our colleagues is part of that assessment. We do need however to recognise that for some in the organisation, the future strategy and culture may not be to their taste or preference, and we have to avoid ongoing dissatisfaction where there is no fit or alignment.

1.4 We have submitted **the nationally requested 'unbundled'** information for the April 2027 changes to mental health and community health contracting currencies. This appears to suggest a legacy under-funding of services in both ICBs, but especially for North Lincolnshire residents. It remains unclear how the transition path will be undertaken locally, notwithstanding national direction, and which currencies will be in use in the coming financial year. It is to be hoped that this is clarified materially before the start of national annual planning which launches in November 2026.

Our patients

2.1 We have had positive engagement in recent weeks with **the local coronial service**, building on work associated with recent inquests. We have been working to provide not only appropriate and timely statements, to reduce the use of avoidable legal

positioning, but also to ensure action plans on Trustwide improvements are in place. Sadly, all of these considerations formed part of a recent inquest where a local resident completing suicide in the days following discharge. We have agreed a deadline of the end of October to have fully deployed the learning from this case (annexed the action plan), while we reopen a PSIRF process. Senior leaders are meeting to enquire how, five months on from passing, we had not completed this work in time for the inquest. The Board may juxtapose this, alongside the engagement audit paper eight weeks ago, and slow progress on contemporaneous record keeping, and question the follow through and delivery capability associated with our learning (notwithstanding examples like all-age crisis, where we appear to have got this right).

2.2 Broadly we are sustaining our short wait (4 week) model for initial care and assessment. But to excel we know that we **to cut 'secondary' waits**, often for psychological and subspecialist care, where waits remain measures in multiples of weeks. The specific Board paper suggests we are behind where we wanted to be at this point in remedying this, but that it remains possible to hit our aim of having rectified these waits by June 2027. In the main analysis would suggest that it will improved productivity, and liberating clinicians to focus on patient-facing time, that will be key to this transition, and the upcoming job planning audit may provide some salutary considerations in that move.

2.3 For Doncaster and Rotherham patients we are continuing to deliver a no or low **out of area placement position**. Discussions continue over the delegation of a budget in North Lincolnshire that we first sought in 2024 to support improvement there (where five patients are OOA at the time of writing). Regional ambition to remove any planning trajectories other than zero for this measure remain, but at the time of writing we will continue sadly to see some out placement (albeit one of the lowest levels regionally). Length of stay changes in North Lincolnshire, alongside a more stable staffing model on the acute ward, are both essential steps to improvement before the end of the year, with a new care group medical director starting this month.

2.4 The annex on **neurodiversity waits** continues to show red indicators, and we consider a paper elsewhere in the Board's agenda over autism assessment. It would be misleading to suggest that there is, or is any imminent prospect of, a plan for funding adult waits which extend over four years and are intentionally omitted from national reporting models, despite many representations for this to be changed. We have received some investment from Humber and North Yorkshire ICB to establish the post-diagnostic Children and Young People's services; and further investment from April 2027, which in aggregate exceeds £2m. Work continues to shape our trajectory of improvement – including to confirm when young people's assessment waits will be below one year and then six months. Our data (but not yet the national data) shows us meeting the 104-week maximum wait from October 1 2026, as we promised we would. We also promised that we would not accept medication secondary waits (other than North Lincs): that is proving increasingly difficult to deliver and a more insistent approach to discharge to shared care is a necessary if perhaps not fully sufficient condition for change.

2.5 I trust that it has been impossible to miss advertisements for **the opening of the Acorn Centre** at midday on Wednesday September 30th. Based in Great Oaks, this approach fundamentally alters our Crisis service and brings both new clinical roles and extensive peer support into the unit 24/7. Humber and North Yorkshire ICB provided some capital for this, and revenue funding has come from our investment fund. We very much hope, learning from Harrison House in Grimsby, that this offers a calm and welcoming space for care, far removed from the difficulties of presenting in a busy Emergency Department. The centre will accept walk-in, police delivered, and ambulance delivered, patients – and there is a strong measure of uncertainty about volumes overall and the pattern of arrival. Steve Forsyth, our Chief Nurse, has led this work and will continue to sit alongside the opened service for some weeks, as we experiment to solve issues unforeseen and embed practices we have agreed on the use of. In time, we expect that working in this service may be more rewarding for professionals and peers than legacy models of care, and we are delighted that MIND have relocated their Safe Space service into Acorn of an evening.

2.6 **Our extension of the use of Systm Connect**, and our transition as an early adopter with further features within the NHS App in early 2027, offer real benefits to patient experience. Reminder texting at scale began in June 2026, and since the start of August patients have been able to cancel appointments by text. From the end of October in most scheduled or planned services, patients will have the ability to select appointments inside a four-week window themselves using technology. We do not expect take up to be a huge in the first instance, but the sharing of power and control is an important one. In March's Board we will consider lessons from this work throughout the year, alongside analysis of our work on digital exclusion, which now includes our project to upcycle IT equipment and reinvest those funds into free available technology for those without money in our community and Voluntary Sector partners, including those within the Communities Leadership Executive. Martin Wilson deserves significant credit for driving this project with his colleagues over the last eighteen months.

2.7 The CQC, under its social care parameters, inspected our **Danescourt** facility in Q1. Annexed to this report is the resultant action plan we have developed and issued to address the concerns raised by inspectors. These speak to recognised weaknesses in processes like care planning but also indicate a need for greater grip in our learning disabilities and forensics directorate. The CQC self-assessment work before the Board this month reflects on the difference between April's team-led assessment and the CQC's subsequent external view.

2.8 The Board discussed inclusion health when we met in July. Within that we have invested to try and address exclusion for patients who are or have experienced homelessness. In that context, and also discussions in 2025 within the High-Quality Therapeutic Care taskforce, it is disappointed to have had a '**street discharge' from one of our wards, and a near-miss on another**. The former is being considered through our PSIRF process, and unambigious guidance both to avoid this, and to report it should it occur, has been shared across both the clinical leadership executive, and acute directorate management teams. Our homeless health team in

Doncaster is launched, and we hope to find out if our Grant Bid for rural homelessness funding has succeeded before the next meeting of the board.

Our people

3.1 The launch of **RDaSH Connect** on September 21st is an important moment. It will be helpful if all Board members with NHS Mail accounts adopt it, as we have collectively with Care Opinion. Connect can be used on phones and tablets or indeed set onto your computer. The intention is very much that aim to use this tool to interact much more in near real time with staff and staff groups. Equally we want to encourage managers at local level to do the same, and to view communication as part of their role. We know, for example, from the engagement work at the end of 2025 that some leaders are more comfortable than others in this space.

3.2 Third time (f)lucky is the strapline for **our 2026 Flu Vaccination** campaign. This recognises that we have come a long way since 2022 on vaccination but not yet hit the 3000 coverage we sought. Doing so this year will be really difficult, as in 2025 we saw a rise in refusals, and notwithstanding leavers/joiners, having perhaps 400 colleagues who may opt in this time. The start of the campaign is to get to 2000 vaccinations as fast as possible and certainly no later than late October.

3.3 In 2025 half of staff undertook the anonymised national staff survey. Our efforts to improve on that in 2026 start very shortly, and the invite letter has this year been signed by Drs Sinclair and Graham, together with Steve Forsyth. We want to stress **the power of making suggestions**, and emphasis the role the voices of employees make in putting forward ideas that are adopted: blood breaks being the latest example.

3.4 Our second **QI Poster contest** has attracted over seventy entries, which is tremendous and builds on last year. This is the most visible demonstration of our work on innovation, which remains a key part of what we are trying to better inculcate and spread. Everyone has had chance to vote for one of the winners, and a judging panel is making the balance of decisions. We are hoping that the contest symbolises the merit of evaluating and making local improvements, and we will discuss with the Public Health, Patient Involvement and Partnerships Committee how we might build on that spirit in 2027.

3.5 Regrettably, as with North Lincolnshire over a decade ago, and Rotherham in 2023, City of Doncaster Council have confirmed that they can no longer support partnering arrangement for **Section 76 obligations**. As such some staff in the Doncaster mental health service will, before April, we subject to a TUPE process, as the council looks to move the service in house. We are working alongside colleagues in the council to reflect on this change and to think through how we avoid financial pressures inside institutions driving separation rather than integration.

3.6 The Board's support for our Estate Plan (26-30) has led to extensive publicity and dialogue within the organisation since late July. In my private report I explore further the commercial choices delegated from our prior meeting: but at pace we are moving to ready land for disposal, to work with planning officers on consent processes, and to **think through with staff some of the remaining known-**

unknowns, as well as to explore the benefits of the Education and Learning space and the frailty developments. With more roadshows planned for January we have clearly committed to tackling the major questions during 2026, with a final meeting regarding whether Riverside represents an option for us in Rotherham at the start of November.

3.7 It is very positive that **trade union colleagues**, within JCC, have leant into the changes to our grievance processes which kick in from October. These grievance changes are intended to secure a maximum four week wait for end-to-end processes, as well as to introduce traditional NHS arrangements whereby grievances are heard with both parties present. This work will be built on with changes in our disciplinary investigation processes, largely removing line managers from this investigative space, and leaving them solely in the adjudicatory role, with a rota to ensure we are always able to hear matters in a timely fashion. Having jointly led projects of this type with trade union partners seems new for the Trust, and a welcome step.

Our population and partners

4.1 During October we undertake employee consultation on changes in **our physical health and neurodiversity care group** in Doncaster. These changes would take effect in early March 2027 and form part of altering how community and specialist services work together: broadly an 8-8 seven-day service in each of four larger geographies will break down some boundaries and barriers between community teams. This is a fascinating change process and one where we need to remain ambitious about 2028 success, whilst acknowledging the work needed to move to this. We have agreed to undertake some important comparative work comparing this future to community changes being made in Rotherham, and potentially Barnsley.

4.2 **Place structures** continue to take some shape, as ICBs change, and there is work to better define neighbourhood working. Whether it is through IHO contracting, or by buying from 'systems' ICB colleagues continue to speak to an appetite to commission differently, over the medium term, and from collaborations. It is difficult to advise how ready place partnerships locally are for this type of work, or whether in truth we will be into 2028 or 2029 before this form of approach is feasible. It may be that 'total place budgeting' may root down a devolved line with MCAs, or from wider local government changes in time.

4.3 As the Board agreed in June, we look likely to sign up to continue to be the Specialised Services adult eating disorder collaborative commissioner. Plans to disband these arrangements regionally have back off, and peers for CAMHS and Forensics may likewise continue from South Yorkshire. Investing upstream is probably key to changing **the forensics overspend** that is putting pressure on budgets Yorkshire wide: with that in mind we expect to vary our amber contract to establish community forensics teams in Rotherham and in Doncaster working alongside our CMHTs and AOT services, we already hold a FOLs sub-contract in North Lincolnshire.

4.4 In July the Board agreed to adopt a definition of anti-muslim hatred, and to receive a paper on implications from that at our November meeting. Some time ago we adopted **a definition of antisemitism**, and in light of wider debate within the NHS over this, including a BMA resolution in opposition, it is repeated here, such that the Board can re-support, or otherwise what is outlined: “Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.” The controversy includes the contention that this definition impedes criticism of the state of Israel or its government’s action. The International Holocaust Remembrance Alliance (IHRA) has specifically confirmed that it does hold not that interpretation, albeit clearly case law may take a different view in time.

4.5 September marks the end of our **Poverty Proofing audit programme**, which began in 2024. We have undertaken these audits at a scale no one else in the public sector has ever done. We are the first NHS Trust to complete this work, but the task now to see through the changes that those audits commend. In particular, it is apparent we have work to do to put food and money into the hands of practicing clinicians working with excluded patients. We are working alongside COLE partners to consider how best to do this without stigma and at scale – for 2027 this has to be a key element of our investment work if we are to equip staff with the material to avoid moral injury and to do what we have said we will do.

4.6 Before our November meeting, we will hear whether we have succeeded in being named **Trust of the Year**, in the HSJ awards. In early October we meet the judging panel – and the Board is reminded of the three facets of our bid: work to address poverty, short waits for patients to build trust, and the inclusion of communities in our decision-making processes as part of the underlying mission to nurture the power in our communities. Making these three things irrevocable at the Trust is far more important than any award or recognition.

Toby Lewis, Chief Executive
18 September 2026

Annex 1

Clinical leadership executive summary
August and September 2026

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

August	September
Governance of the estate plan	Martha's Rule
Royal College accreditation	Leaders' conference and culture
Cultural reset	Flexible working
Dementia commitments	14 week waits
Promise 22 stocktake	FTSU/patient safety curiosity (Board July)

In terms of decisions made, we have continued to focus on how we migrate our culture, without it becoming another new initiative.

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

Over the next two meetings (October/November), we will consider in particular:

- Sickness absence approaches/deployment
- Cultural commitments
- Out of area placements and length of stay
- Investment fund
- Governance of voluntary sector contracts
- Always measure go live

Toby Lewis, Chief Executive
16 September 2026

Annex 2

Communities' leadership executive summary (CoLE)
August and September 2026

Communities' Leadership Executive (CoLE) meetings routinely consider a Clinical Leadership Executive summary which was an early request of CoLE and the remainder of the agenda is set based on what has been requested by members in previous meetings, supported by a Forward Plan. As with its sister Executive of CLE, any member can list an item on the agenda, which is finalised with the Co-Chairs of the meeting, a rotational role that is aligned to the programme of 4 meetings being held in each place before moving to the next. The key items explored are listed below. Minutes and the action log are available to any Board member on request through Sarah Dean.

August	September
Appraisal Model • During the item giving feedback from the Clinical Leadership Executive, the Communities' Leadership Executive were interested in the developments relating to the Trust's Appraisal Model, from the following two aspects: o How community involvement/immersion could feature o The role appraisal has in accountability and assessing how colleagues interact with patients	Estate Plan • Presentation from Simon Sheppard, Director of Finance and Estate on the Trust Estate Plan. Focus on CoLE's role with two strands; influencing the plan as it develops and driving how the Trust can make its estate a genuine community facility that can be used by communities.
Promise 6 – Poverty Proofing • CoLE received a presentation from Jo McDonough, Director of Stategic Devleopment on Promise 6 to inform development of its workplan for this promise.	Community Digital Poverty • Presentation from Martin Wilson, Senior Digital Programme Manager on the Community Digital Poverty Project that sees the credit that the Trust receives for end of life devices being used to purchase refurbished devices for citizens and community organisations.
	CoLE Workplan • CoLE noted the development of its workplan so far spanning Promises 5, 6 and 12 which now totals 12 actions.

In terms of <u>decisions made</u>, CoLE's focus has been on agreeing items for inclusion in its Workplan. There are no specific matters to <u>escalate</u> to the Board from CoLE

Over the next two meetings (October/November), CoLE will consider in particular:

- Finalising its workplan with a focus on identifying actions for Promise 21 and identifying CoLE Member Leads and RDaSH Buddies for each action
- Promise 12 – Rurality
- What happens after the LDO (with a community involvement lens)
- Always Measures

Annex 3

Current register of Trust vacancies – as at time of issue

Org L4	FTE Budget	FTE Actual	FTE Variance		Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total	Vacancy Rate
Trust Total	**3,743.88**	**3,472.41**	**-271.46**		**25.09**	**32.89**	**28.01**	**36.42**	**69.15**	**51.22**	**242.78**	**7.24%**
Org L4	FTE Budget	FTE Actual	FTE Variance	Recruitment	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total	Vacancy Rate
376 Corporate Assurance	28.59	26.09	-2.49		0.00	0.00	0.00	1.00	2.20	0.00	3.20	
376 Estates	47.18	43.77	-3.40		0.35	1.20	1.20	1.00	1.00	0.00	3.55	
376 Finance & Procurement	40.19	40.21	0.02		0.00	1.00	1.00	0.00	0.00	0.00	1.00	
376 Medical, Pharmacy & Research	54.67	52.34	-2.33		0.00	0.00	0.00	1.00	0.50	1.00	4.50	
376 Nursing & Facilities	170.40	161.09	-9.30		1.40	1.30	1.30	1.12	3.97	0.00	8.19	
376 Operations	49.39	48.59	-0.79		0.00	0.00	0.00	0.00	0.00	0.00	0.00	
376 People & Organisational Developn	84.97	77.40	-7.56		1.00	1.00	1.00	2.00	1.00	3.00	10.00	
376 Psychological Professionals and T	20.49	17.20	-3.29		0.20	1.60	1.60	0.00	0.00	0.00	1.80	
376 Health Informatics	75.19	67.41	-7.77		0.00	2.00	2.00	0.00	2.00	1.00	5.00	
376 Strategic Development	18.04	18.26	0.22		0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Total	**589.11**	**552.36**	**-36.69**		**2.95**	**8.10**	**4.40**	**6.12**	**10.67**	**5.00**	**37.24**	**6.22%**

Org L4	FTE Budget	FTE Actual	FTE Variance	Recruitment	Awaiting Authorisation	Out to Advert	Shortlisting	Interview	offered	Start Date Given	Total	Vacancy Rate
376 CCG Mental Health	299.81	268.30	-31.50		0.00	2.00	1.00	6.00	5.80	4.60	19.40	
376 CCG Physical Health	362.65	343.00	-19.65		2.60	0.00	1.00	2.00	7.20	9.40	22.20	
376 DMHLD Acute Services	227.94	195.37	-32.56		3.35	5.50	1.00	5.00	7.68	2.72	25.25	
376 DMHLD Community Services	333.16	317.51	-15.64		2.40	2.57	2.53	2.80	3.80	3.50	17.60	
376 DMHLD Learning Disabilities & For	187.53	171.11	-16.41		0.00	3.00	1.00	0.70	1.80	2.50	9.00	
376 NLCG Acute Care Services	143.95	126.75	-17.19		1.00	2.00	3.88	1.00	9.70	2.00	19.58	
376 NLCG Community Care Services	149.06	140.03	-9.03		2.00	1.52	0.00	2.80	1.00	2.00	9.32	
376 NLCG NHS Talking Therapies	185.07	174.10	-10.96		0.00	0.00	0.00	0.00	1.00	0.00	1.00	
376 PHND Community & Long Term C	411.64	391.13	-20.50		4.44	0.80	1.40	1.00	4.90	6.40	18.94	
376 PHND Neurodiversity	44.30	37.95	-6.34		0.00	0.00	0.80	1.00	3.80	0.00	5.60	
376 PHND Rehabilitation	314.64	298.51	-16.12		2.80	2.60	4.00	4.00	1.40	3.80	18.60	
376 RCG Acute Services	225.65	196.90	-28.74		2.15	1.80	6.00	1.60	4.80	5.00	21.35	
376 RCG Community Services	230.41	223.29	-7.12		0.80	2.00	1.00	2.40	3.00	3.30	12.50	
376 High Dependancy Rehabilitation U	38.96	35.98	-2.97		0.80	1.00	0.00	0.00	2.60	1.00	5.20	
Total	**3,154.77**	**2,919.93**	**-234.73**		**22.14**	**24.79**	**23.61**	**30.30**	**58.48**	**46.22**	**205.54**	**7.44%**

Annex 4

National publications – August/September 2026

Better Care Fund: 2026-27 planning data
(NHS England, published 11/08/2026)

This publication provides the aggregated planning data submitted nationally through the Better Care Fund (BCF) 2026–27 plans. The data includes BCF funding sources, planned income, planned expenditure and the three core BCF metrics covering:

1. Non-elective admissions to hospital for people aged 65 and over per 100,000 population.
2. Average length of discharge delay for all acute adult patients.
3. Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population.

The publication also includes a tab containing historical planned expenditure data from previous BCF planning cycles.

https://www.england.nhs.uk/publication/better-care-fund-2026-27-planning-data/

2026/27 NHS pay awards: revenue finance and contracting guidance
(NHS England, published 20/08/2026)

This guidance sets out how commissioner allocations have been updated for the impact of the NHS pay awards and resident doctors (RDs) deal in 2026/27, as well as the impact on other areas of income and expenditure. It also advises how commissioners and providers should update contract values for relevant services and how integrated care boards (ICBs) and NHS trusts should reflect the impact of the pay awards and RDs deal on income and expenditure as part of in-year financial reporting.
https://www.england.nhs.uk/long-read/2026-27-nhs-pay-awards-revenue-finance-and-contracting-guidance/

Framework for NHS boards: monitoring research activity
(NHS England, published 26/08/2026)

This framework defines what NHS boards need to do to monitor research and describes what a high-performing, research-active organisation looks like.
https://www.england.nhs.uk/long-read/framework-for-nhs-boards-monitoring-research-activity/

Enhanced therapeutic observations and care (ETOC): workforce deployment models
(NHS England, published 26/08/2026)

This guidance supports organisations to undertake ETOC workforce planning within the existing National Quality Board's guidance on safe staffing and Developing workforce safeguards guidance.

https://www.england.nhs.uk/long-read/enhanced-therapeutic-observations-and-care-etoc-workforce-deployment-models/

Guidance on NHS registration requirements for use of psychological professions titles
(NHS England, published 27/08/2026)

The public need to know whether psychological professionals are appropriately qualified and competent to do their job. This guidance helps by defining clear registration requirements for the use of each of the psychological professions titles within the NHS in England. The guidance has been developed in consultation with psychological professions registering and professional bodies, the Health and Care Professions Council (HCPC), the Professional Standards Authority (PSA) and the Department of Health and Social Care (DHSC).
https://www.england.nhs.uk/long-read/guidance-on-nhs-registration-requirements-for-use-of-psychological-professions-titles/

The Thirlwall Inquiry
(Latest update from the Thirlwall Inquiry, published 15 September 2026)

The Thirlwall Inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital.

On the 15th of September 2026, Lady Justice Thirlwall, published her report into the failings by all those responsible for the safety of babies at the Countess of Chester hospital.
https://thirlwall.public-inquiry.uk/

Government to act on Thirlwall patient safety recommendation
(Department of Health and Social Care and The Rt Hon Yvette Cooper MP, published 15 September 2026)

The Health and Social Care Secretary has set out immediate actions to strengthen patient safety, safeguarding and accountability across the NHS, following the publication of Lady Justice Thirlwall's final report into the Countess of Chester Hospital
https://www.gov.uk/government/news/government-to-act-on-thirlwall-patient-safety-recommendations

RCPsych: responds to planned expansion of community mental health services in England
(Royal College of Psychiatrist's, published 6 August 2026)

Professor Subodh Dave, President of the Royal College of Psychiatrists responding on the UK Government's announcement that there is a plan to expand community mental health services in England.
https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2026/08/06/rcpsych-responds-to-planned-expansion-of-community-mental-health-services-in-england

Friends and Family Test data – July 2026
(NHS England, published 10 September 2026)

Data on all these services is published on a monthly basis.
https://www.england.nhs.uk/publication/friends-and-family-test-data-july-2026/

Annex 5

Neurodiversity waiting time scorecard – August

CYP Neurodevelopment Scorecard

1. Trajectory & Key Milestones

Metric	Position	Commentary	RAG
104-week cohort cleared by 30 Sept 2026	**On track (planned)**	1 patient at 111 weeks – transfer in at over 104 weeks from another provider. All other patients have received an assessment.	🟢
104+ weeks – offer by April 2026	**Achieved**	All 202 CYP offered by deadline and received assessment.	🟢
6-month standard trajectory	**On track**	Planned: All three places by December 2027	🟠

2. Waiting Lists & Demand (by Place)

Metric	Rotherham	Doncaster	North Lincs	Commentary	RAG
Total waiting (assessment)	1364	820	801	Increase of 146 since July data	🟠
Medication waits	252	312	NLaG now migrated across 517, RDaSH original waiters 522, ADHD 360 71 Total: 1,110	Ongoing pressure.	🔴

3. Activity and throughput (August)

Metric	Rotherham	Doncaster	North Lincs	Commentary	RAG
CYP receiving full assessment (August)	91 + 116 Digital	26 + 93 Digital	27 + 14 Digital	Dip in service assessments through August due to A/L and sickness.	🟠

4. Trajectory assurance by place

Place	On Trajectory?	Position Summary in month	RAG
Rotherham	No	**-145**	🟠
Doncaster	No	**-157**	🟠
North Lincs	No	**-140**	🟠

Adult ADHD Scorecard

1. Assessments (Diagnostics)

August (actual)

Metric	Position	Commentary / drivers	RAG
Expected capacity (full)	**173 / month**	**Baseline expectation at full capacity**	—
Completed assessments	**74**	**46% of expected (52 below capacity)**	🔴
DNA appointments	**4**	**4 missed appts due to admin error**	🟠
Missed/cancelled due to staff sickness	**76**	**Sickness: 3 WTE staff members** **1 mat leave/ 1 short term**	🔴

September (planned / booked)

Metric	Position	Commentary / drivers	RAG
Expected capacity (full)	**36/ 173 completed**	**Significant sickness within the admin team necessitating business continuity measures that require more time from clinicians to do their own admin**	—
Booked assessments	**60 further booked before end July= 96**	**55% of expected booked (77 below capacity)**	🔴

Workforce impact	**Ongoing**	**Same sickness as June + 1 maternity leave + short-term sickness x 6**	🔴

2. Treatments (ADHD)

Activity vs expected capacity

Period	Expected capacity	Delivered	Delivery vs expected	RAG
June (full month)	**199 / week**	**942**	**942/796 118%**	🟠
July (full month)	**199 / week**	**645**	**645/796 81%**	🟠
August (full month)	**199/ week**	**629**	**645/796 79%**	🟠

3. Waiting list period

Adult ADHD waiting list

Month	Longest wait (weeks)	Total waiting
April	**196**	**6,273**
May	**194**	**6,232**
June	**231**	**6,373**
August	**171**	**6,248**

Adult autism waiting list

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

July	**339**	**2,322**
August	**343**	**2,310**

Annex 6

South Yorkshire Mental Health, Learning Disabilities & Autism (MHLDA)
Provider Collaborative Board Development Session 4th September 2026
Report and Actions

South Yorkshire Mental Health, Learning Disabilities & Autism (MHLDA)

Provider Collaborative Board Development Session 4th September 2026

Report and Actions (Drafted on: 8.9.26 – revised on 9.9.26)

1. Purpose

The purpose of this report is to provide a note of the key points from the South Yorkshire MHLDA Provider Collaborative Board Development Session 4th September 2026 and to highlight the agreed actions.

As this was a Board development session there were no formal minutes.

2. Programme Updates

Prior to the meeting, papers were circulated that outlined progress to date with:

- Reducing complex out of area mental health placements
- Report on the work of the South Yorkshire Eating Disorders Joint Committee (EDJC)
- Achieving equity in community forensic services across South Yorkshire

MP presented an update on the programmes, highlighting the main areas of progress, challenges and escalations. Workplans are underway on each of the programmes.

After discussion, the Board agreed to the following additional actions:

- **Complex OAP** - Request to ICB colleagues (CS and SB) to work with ICB colleagues in other teams to respond to concerns about the pace of the work, and in particular, the adherence to the agreed processes and timelines. A response was promised in a week. CS will feedback to MP, and a note will be circulated round to Board for information and assurance, with a formal update from the ICB at the next meeting in December 2026.
- **Community Forensics** SWYPFT raised a considerable deficit on the commissioning side of specialist commissioning and their concern that the deficit risk sits with one provider. Discussions will be advanced through the Chief Executives group, recognising commissioning budgets are between the lead providers and NHSE.
- **Specialised commissioning** updates will be circulated to Collaborative board members, as the future structure emerges – MB/TL/BJ

3. Talking about Money and Priorities

Full note circulated by Toby Lewis on 6/9/26 – the following is a summary and actions.

TL presented slides on money and priorities and invited discussion with the group.

Colleagues supported the four steps set out in the slide deck. There was a desire to strengthen the place positions. CE colleagues to send TL key additions to the place ideas

expressed in Annex A, which Sarah Boul kindly drafted.

Discussions covered the 3 year planning process, impact of unbundling blocks (community and MHLDA), potential impact on neighbourhood and left shift and clarity around commissioning intentions. ICB colleagues expressed a view that this year commissioning intentions would be more connected about where they wished to decommission/invest.

8 national must dos were discussed, in particular support for MHST and concerns about TT trajectories and investment. Commitment to continued investment in eating disorders was noted, whilst being clear that rebasing the inpatient and community sector needs to be inside commissioning budgets (which is local and spec comm budgets are being considered together).

The need to strengthen the LD element within the plan was also agreed.

The ICB and the MHLDA CEs will seek over coming weeks to understand whether any structured approach to neurodiversity is planned by the ICB, given the growing RTC spend.

4. The choices we must make together for mental health, learning disabilities and autism in South Yorkshire

SY presented slides on the choices we must make together for mental health, learning disabilities and autism in South Yorkshire.

Discussion was around collective choices, the voice of the sector in South Yorkshire and how we apply a test for collective collaboration. Deepening what works, extending where the test is met and keeping local where it isn't. This is collaboration across MHLDA organisations in its widest sense not just within the MHLDA Collab programmes. The group discussed opportunities and suggestions included:

- Shared learning as MSF (SMI and CYP) is released
- Implementation of MHA changes – what this means for the system
- Digitization opportunities and efficiencies e.g. MHA and S12 doctor finder software
- U&E care pathways – especially how we learn from the MH ED models
- Shared strategy on TT
- Learning from MH and CYP neighbourhood work – and how this might influence roll out

There was also a discussion around challenge on working differently and what this might need to be and how the new health commissioner and the two new MSFs might influence local and national priorities.

5. Future Meetings

As previously discussed by members of the Collaborative Board, meetings will be less frequent and will also be reduced to 1.5 hours.

The next Collaborative Board meeting is planned for **Wednesday 9th December 11-12.30 on MS Teams**

Annex 7

South Yorkshire Eating Disorders Joint Committee Meeting Note – Sept 2026

The South Yorkshire Eating Disorders Joint Committee (SYEDJC) met on 14 September 2026, and the main areas of discussion and subsequent actions are outlined below.

Avoidant Restrictive Food Intake Disorder (ARFID) Support Model

The Committee considered a proposal developed with clinical colleagues to enhance support for individuals presenting with ARFID-type eating difficulties. Recognising the limited evidence base for ARFID interventions but the increasing demand, members endorsed a pilot and evaluation approach to test effectiveness before committing to longer-term investment. The proposed model for people with ARFID-type symptoms includes workforce training, support groups for younger children, specialist support for teams working with young people, and a risk-based approach for adults aligned to the emerging Medical Emergencies in Eating Disorders (MEED) model. The Committee requested a range of costed implementation options for consideration in November 2026 to inform discussions relating to the 2027/28 Mental Health Investment Standard.

Children and Young People Community Eating Disorders Programme

The Committee approved the scope of a programme of work to benchmark and share learning across community-based Children and Young People (CYP) eating disorder services across South Yorkshire. The review will identify opportunities and support the development of an enhanced community offer, including clearer interfaces with inpatient provision and emerging MEED services. Further clarification was requested on provider engagement, age-range coverage and lived-experience involvement, with an update at the next meeting and recommendations expected by December 2026.

Lived Experience Involvement Strategy

The Committee approved the South Yorkshire Eating Disorders Lived Experience Involvement Strategy, reaffirming its commitment to ensuring that people with lived experience, alongside carers, families and loved ones, are meaningfully involved in the design, delivery and governance of eating disorder services.
The strategy establishes a framework for embedding lived experience across service development and decision-making, building on engagement activity already undertaken. It adopts an inclusive, trauma-informed and co-production approach, ensuring participation is proportionate to individual workstreams and reflects the diversity of local communities, including groups currently underrepresented in service development.

A progress update on implementation of the strategy will be presented to the Committee in February 2027.

Annex 8

Winter planning submission: detailed response for approval

1. Executive Summary

The Trust has developed its Winter Plan 2026/27 covering prevention, capacity, flow and discharge, workforce, infection prevention and control (IPC), operational leadership and mental health resilience.

This report supports Board completion and sign-off of the Winter Planning Board Assurance Framework. The Trust has completed 29 of 32 domains and will test its arrangements through the regional winter exercise on 17 September 2026. It also identifies residual system risks that may affect flow and patient outcomes.

Learning from Winter 2025/26 has informed the plan. Early preparation, visible senior leadership, daily flow processes and robust on-call communication will continue, with stronger cross-cover, rota governance, corporate support and festive-period discharge oversight.

No additional national winter funding for mental health services is anticipated. Existing successful measures have therefore been refined and retained. The plan provides a strong basis for managing winter pressures, although demand, workforce resilience and estate constraints remain.

2. Assurance Position by Domain

- **Prevention:** accessible flu vaccination from 1 October 2026 to 31 March 2027, with targeted outreach, reliable recording and weekly Executive monitoring.
- **Flow and discharge:** 24/7 Patient Flow oversight, daily admission reviews, regular length-of-stay and discharge reviews, discharge coordination and Home Treatment pathways.
- **Capacity and workforce:** advance rostering, safe staffing review, flexible cross-cover and redeployment, bank support, daily leadership review and seven-day Ward Manager cover.
- **Admission avoidance and crisis care:** 24/7 SPA, Urgent Community Response and crisis services, Virtual Wards, liaison psychiatry, Safe Spaces and the Acorn Centre.
- **IPC, resilience and leadership:** established outbreak, PPE, on-call, OPEL, mutual-aid, business-continuity, severe-weather and staff-welfare arrangements.
- **Mental health resilience:** all-age 24/7 crisis access, flexible Crisis Resolution/Home Treatment and liaison cover, tailored crisis plans and oversight of Section 136 demand.

3. Key Risks and Mitigations

The principal risks and mitigations are:

- **Crisis demand:** sustained demand may exceed capacity. The Trust will maintain 24/7 crisis pathways, maximise alternatives to admission and escalate delayed transfers.
- **Discharge capacity:** limited local authority and community capacity may delay discharge. The Trust will work with partners to resolve barriers and implement consistent Care Transfer Hub standards.
- **Emergency department waits:** delayed visibility of people approaching 12 hours may restrict early action. Access to live acute trust dashboards has been requested through the ICB.
- **Children and young people:** specialist bed shortages may lead to prolonged waits in unsuitable settings. Delays will be escalated through CAMHS Crisis and the Provider Collaborative, with continuing assessment and risk management.
- **Mental Health Act assessments:** limited Section 12 doctor availability may cause delay. Early escalation and 24/7 Patient Flow coordination will be used.
- **Workforce:** seasonal sickness may affect continuity. Vaccination, wellbeing support, PPE, redeployment and surge arrangements will mitigate this.
- **Severe weather:** travel disruption may affect services. Agile working, virtual appointments, 4x4 support and coordinated adverse-weather plans will be used.

- **Risk**: Limited local authority, community provider or wider system capacity may delay discharge, reduce inpatient bed availability and create pressure across urgent and emergency pathways.

  Mitigation: Continue joint working with system partners to resolve barriers, reduce delays and implement consistent Care Transfer Hub operating standards.

- **Risk**: If the 12-hour ED measure is calculated from arrival rather than the decision to admit, the Trust may not identify people approaching the threshold early enough to intervene and prevent breaches.

  Mitigation: Secure access to acute trust live emergency department dashboards to support earlier identification, escalation and intervention. This requirement has been raised with the ICBs through the winter planning process.

- **Risk**: Children and young people: Delays in securing an appropriate inpatient bed may result in children and young people waiting for prolonged periods in environments that are not designed to meet their needs, potentially increasing clinical, safeguarding and operational risks.

Mitigation: Escalate delays through CAMHS Crisis and the relevant Provider Collaborative, with ongoing assessment, risk management and transfer planning undertaken in the most appropriate available environment.

- **Risk**: Limited availability of Section 12-approved doctors may delay Mental Health Act assessments, prolong waiting times and delay access to appropriate care.

  Mitigation: Use early communication and escalation to identify potential delays, supported by 24/7 Patient Flow oversight to coordinate the assessment process and address barriers promptly.

- **Risk**: Increased seasonal sickness may reduce staffing capacity, affect service continuity and place additional pressure on the available workforce.

  Mitigation: Deliver the seasonal vaccination campaign; provide staff wellbeing support and PPE; use flexible redeployment where safe and appropriate; and activate agreed surge and escalation arrangements when staffing levels are under pressure.

- **Risk:** Severe weather may prevent staff and patients from travelling safely, disrupt face-to-face appointments and affect the continuity of essential services.

  Mitigation: Use agile-working arrangements, virtual appointments and 4x4 volunteer support; maintain updated adverse-weather plans; and coordinate the response with Local Resilience Forums and ICB partners.

4. Systemwide Considerations: ICB Winter Plan

The South Yorkshire ICB plan provides a coordinated response, but three material risks remain outside the Trust's direct control:

- **Care home capacity:** limited nursing-home availability remains the largest cause of clinically ready for discharge delays and may particularly affect people with complex dementia needs.
- **Urgent care waits:** prolonged waits for mental health patients remain a safety and experience risk; RDaSH records approximately one patient each month waiting more than 24 hours across DRI and TRFT emergency departments.
- **Specialist placements:** constrained Tier 4 CAMHS and eating-disorder capacity can extend stays in acute settings and increase reliance on intensive home treatment.

These issues will continue to be escalated through SCC and ICB forums for system-level mitigation.

5. Learning from Winter 2025/26

Winter 2025/26 showed the value of early planning, visible senior leadership, daily on-call and flow meetings, and clear Trust-wide escalation.

For 2026/27, the Trust will:

- Begin formal preparation in September and include winter readiness in Weekend Planning meetings.
- Maintain the 09:00 on-call handover and 10:00 and 15:00 flow meetings.
- Ensure visible senior leadership across the festive period and published professional cross-cover rotas.
- Include Estates, IT and domestic-service cover in daily operational information.
- Review expected discharges and escalation needs throughout the festive period and January.
- Use SafeCare to strengthen consistency in daily staffing information.

6. Conclusion and Board consideration

RDaSH has strong arrangements across prevention, workforce, flow, community and crisis care, IPC and operational leadership. The plan incorporates learning from 2025/26 and strengthens senior presence, cross-cover, rota control, corporate support and festive-period discharge oversight.

Residual risks are understood and will be monitored, but several depend on acute, local authority, ambulance, Provider Collaborative and Mental Health Act partners.

The Board of Directors is asked to:

1. Note the Trust's readiness for winter pressures and the residual risks requiring monitoring.
2. Note the need for system-level action on discharge capacity, urgent care waits and specialist placements.
3. Approve completion and sign-off of the Winter Planning Board Assurance Framework, subject to learning from the regional exercise being managed through established governance.

Appendix 1 - Winter Plan Assurance Map

Assurance domain	RDaSH actions and evidence	Residual risks / qualifications
1. Prevention	Accessible flu offer from 1 October to 31 March; majority planned by 30 November; 24/7, mobile, walk-in and bookable vaccination; 3,000 vaccines available; RAVS/clinical-record reporting; outreach to staff, eligible inpatients and vulnerable groups; weekly Executive monitoring.	COVID-19 vaccination capability for long-stay inpatients and people discharged to care homes is being explored.
2. Occupancy and discharge	24/7 Patient Flow; daily admission reviews; weekly CRFD and 15-day reviews; monthly complex-delay escalation; physical health discharge hub and integrated team; mental health discharge coordinators; early discharge via Home Treatment; pre-holiday reviews and MADE when required.	Ongoing dependence on local authority, community and system capacity; care transfer hub standards remain under development. SDEC/ambulatory emergency care is outside direct Trust scope.
3. Capacity	Safe staffing and skill-mix review; rosters at least six weeks ahead; standard ward shifts; redeployment, cross-cover and bank use; seven-day Ward Manager cover; daily leadership review; SPA/UCR and Virtual Ward capacity; Core 24 liaison and within-12-hour admission focus.	Access to acute trust live ED dashboards would support earlier intervention. Elective and cancer delivery is outside direct Trust scope.
4. Flow	24/7 crisis lines, Safe Spaces and Acorn; liaison and crisis alternatives;	Delivery depends on partner capacity and timely escalation.

Assurance domain	RDaSH actions and evidence	Residual risks / qualifications
	direct intermediate-care and Virtual Ward pathways; Section 136 ambulance handover target within one hour; Trust and system escalation arrangements.	
5. Infection prevention and control	National manual and local patient-placement/outbreak guidance; cohorting support; PPE and emergency stock; DIPC/IPC engagement and QSSG oversight; 28 fit testers with eight further volunteers planned.	Operational readiness must be maintained through stock management, fit-testing coverage, IPC engagement and exercise review.
6. Leadership and operational grip	24/7 operational and clinical on-call chain; twice-daily flow meetings; daily OPEL reporting; mutual aid; business continuity testing; severe weather and infrastructure plans; industrial action contingencies; comprehensive staff welfare support.	External mutual aid is availability-dependent. Final assurance remains subject to regional exercise testing and closure or management of actions arising.
7. Mental health-specific actions	All-age 24/7 crisis access; flexible Crisis Resolution/Home Treatment and liaison cover; high-intensity-user reviews planned for September 2026; tailored crisis plans; 24/7 Section 136 and admission oversight; regional Section 136 mutual aid in South Yorkshire.	No RDaSH CYP inpatient beds or CYP access to Trust Section 136 suites; admission depends on Provider Collaborative capacity. Section 12 doctor availability may delay Mental Health Act assessments.

Annex 9

EPRR submission 2026 – further detail post July consideration

1. EPRR Core Standards – Current Position

1.1 As discussed in the Board's meeting of July 2026, RDaSH is preparing for the October 2026 EPRR Core Standards assessment, with the aim of achieving 100% compliance, subject to achieving full compliance across Domain 10 CBRN/IOR. This domain holds our only non-compliant standards.

1.2 The format is similar to previous years with the Trust completing a self-assessment, followed by an ICB level 'check and challenge' prior to formal submission. The ICB Core Standard 'check and challenge' is booked for 12 October. Evidence has been and will continue to be uploaded into the ICB repository as soon as it is considered inspection-ready, allowing review to take place in advance.

1.3 Alongside the remaining Domain 10 work, we are auditing standards currently rated compliant to ensure there are no gaps or "banana skins". It was noted by the South Yorkshire ICB EPRR team that declaring a 100% would be likely to attract further regional scrutiny of the Trust's self/peer assessment by NHSE EPRR.

1.4 Current position / key points

- **1.4.1** The main risk remains Domain 10 (IOR). We are confident of making significant gains in compliance; the key question is whether we can evidence compliance against every individual standard within the remaining timescale.
- **1.4.2** The principal constraint is time rather than capability. To ensure our evidence meets the required standard, we need periodic review with YAS to identify any gaps or shortfalls before final submission.
- **1.4.3** YAS assurance activity has experienced repeated delays due to postponed meetings. Three assurance meetings have now taken place, with the latest on 7 September. YAS confirmed that the evidence submitted meets the required criteria and is expected to be accepted, subject to final assurance that the face-to-face training scheduled for 30 September meets the required standards.
- A further dependency is completion of a sufficient number of FFP3 face-fit tests to provide a robust evidence base demonstrating a reliable and sustainable process, alongside sufficient workforce capacity to ensure appropriate PPE can be worn as part of the reception capability. A programme of face-fit testing is already in place and is being delivered by IPC. Additional capacity is also being developed through the EPRR Team undertaking Face Fit Tester training. Completion of testing and training is recorded on ESR, providing an auditable record of compliance and workforce readiness.
- **1.4.4** Training is progressing: the first IOR training session has been completed successfully in North Lincs, e-learning is live on ESR ready for maintenance of competence and awareness training, and training/compliance/competence/assurance is being tracked through

Monday.com. YAS will attend the September training session in Rotherham to assess delivery against requirements.

- **1.4.5** IOR equipment procurement is largely on track, with most box contents now procured and a small number of outstanding items awaited and being tracked.
- **1.4.6** FFP3 provision is the main emerging delivery risk. We need to evidence that the correct PPE is available and that implementation is underway across identified sites. IPC are focusing on Doncaster CG, so a data set for that area of the Trust will be available as evidence, in addition to a plan for the rest of the organisation. We expect this to be sufficient evidence to 'claim' that element.
- **1.4.7** The repository approach originated from RDaSH's suggestion last year and was adopted by the ICB as the formal approach for all organisations this year; Humber has also adopted the same model.
- **1.4.8** In parallel, we are re-auditing current green/compliant standards to ensure existing compliance remains robust and can withstand further NHSE regional scrutiny should we achieve 100%.
- **1.5** Our internal target for most of the evidence submission is 25th September with the next key date being 12th October for the ICB Check and Challenge. Informal feedback on the day of the check and challenge assessment will be given by the ICB, with written formal feedback by the end of October 2026. The COO will present the outcome verbally to the Board.

2. Exercise Dark Hours – Overview and Key Learning

2.1 Exercise Dark Hours was a live business continuity exercise held at Tickhill Road Hospital to test the Trust's response to a significant loss of mains power. The exercise involved isolation of the mains supply, operation on generator power, loss of generator power to clinical and none-clinical areas, and a series of injects designed to test operational response, command and control, communications and service continuity. Operational, Tactical and Strategic command arrangements were exercised.

2.2 Although a wealth of learning was identified as part of this exercise, alongside some good practice, the key learning has been abbreviated below for the awareness of the Board of Directors.

- **2.3.1** Command and decision logging – the exercise reinforced the importance of effective decision logging and sufficient loggist capacity, particularly out of hours and during prolonged incidents.
- **2.3.2** Generator demand management – clearer arrangements are required to identify essential and non-essential electrical demand and reduce load where necessary to protect generator resilience.
- **2.3.3** UPS and critical equipment resilience – further assurance is required around UPS provision, what equipment is supported, expected duration and contingency where UPS protection is limited.

- **2.3.4** Clinical and service representation – minimum attendance/representation for Tactical and Strategic command should be clearer, including appropriate clinical, nursing and operational input.
- **2.3.5** Communications during infrastructure failure – the exercise highlighted the need for resilient methods of communicating with staff and services where normal IT, telephony or network-based systems may be disrupted.
- **2.3.6** Wider service dependencies – learning extended beyond power itself, including cold-chain management, catering/food safety, equipment recovery and ensuring critical support services are included in incident planning.
- **2.3.7** Out-of-hours arrangements – contact routes, escalation arrangements and access to key Facilities, Catering and other specialist support require continued testing and assurance.
- **2.3.8** Effective multi-disciplinary working – the exercise demonstrated good engagement and collaborative working across clinical, operational and support teams, enabling issues to be identified and addressed collectively during the scenario.
- **2.3.9** Staff awareness and response – staff demonstrated a good level of engagement with the exercise and an understanding of the need to adapt operational arrangements during an infrastructure failure, providing a strong foundation for further resilience work.

2.4 Next steps

2.4.1 Actions from the exercise are being incorporated into business continuity plans, infrastructure resilience work and future exercising, with learning being shared across relevant services. All actions have owners and associated timescales for completion. The actions will be tracked through the monthly EPRR Group, with escalations to OMG, and through to CLE. The learning will also be tested through a further planned Trust-wide exercise, providing an additional opportunity to assess the effectiveness of actions and identify any further learning.

Annex 10

Danescourt Requires Improvement outcome – CQC submitted action plan

Danescourt CQC Action Plan

Field	Detail
Service	Danescourt
Basis	Action Plan v2 and three supporting review or factual accuracy documents provided Steve Forsyth – Chief Nurse
Regulatory focus	Regulation 11 Need for Consent, Regulation 12 Safe Care and Treatment, Regulation 17 Good Governance
Document status	Enhanced assurance version for review
Generated	5 August 2026

RAG definitions used in this review

RAG	Definition
Green	Action directly addresses the issue, has a named accountable owner, clear completion evidence, audit or re-audit, escalation route and closure criteria.
Amber/Green	Action is substantially developed and appears capable of achieving compliance, but requires final evidence, sign-off, audit confirmation or a short period of sustained implementation before it can be rated Green.
Amber	Action addresses the issue but needs stronger evidence, clearer detail, explicit mapping, sustainability testing or governance escalation.
Amber/Red	Action partially addresses the issue but there are material gaps in evidence, ownership, timescale, assurance or governance escalation, creating a significant residual risk until strengthened and tested.
Red	Issue is missing, action is too broad to assure CQC, evidence is absent, or no mechanism exists to prove sustained improvement.

Ref	Priority	Action	Owner	Timescale	Success measure	Evidence required	Assurance and re-audit	Escalation and closure	RAG
1.1	Consent/MCA	Create live MCA, consent, best-interest and DoLS tracker for every person, including decision, status, expiry/review date, record location and staff guidance.	Registered Manager with Named Nurses	12 August 2026	100 percent of people have completed tracker entries and record location identified.	Tracker, case note links, legal status summary sheets.	Monthly manager audit for three months then quarterly MCA audit.	Escalate overdue or missing entries to Matron within 48 hours. Close after two consecutive compliant audits.	Amber
1.2	Consent/MCA	Complete decision-specific capacity assessments for care, treatment, medication, restrictions and community access where indicated.	Registered Manager Named Nurses	2 September 2026 or earlier	All relevant decisions have dated assessment and review date.	Completed MCA assessments and review schedule.	Matron sample audit of all records then monthly 20 percent sample.	Escalate any missing assessment to service governance. Close when 100 percent complete and sampled.	Amber
1.3	Consent/MCA	Complete best-interest decisions and consent records where capacity is absent or fluctuating.	Registered Manager Named Nurses	9 September 2026	Best-interest records present and linked to care plan guidance.	Best-interest forms, MDT/family involvement where applicable.	Monthly MCA review and supervision knowledge check.	Escalate any decision without evidence to Matron and MCA Lead.	Amber

1.4	Consent/MCA	Introduce monthly staff retrieval drill for MCA/DoLS records and current restrictions.	Registered Manager	Start immediately, monthly	Staff can locate records within five minutes and explain current legal status.	Retrieval drill log and staff questions.	Monthly for three months, then quarterly.	If less than 90 percent pass, repeat briefing within seven days. Close after three Green results.	Amber
1.5	Consent/MCA	Deliver MCA, consent and DoLS refresher training with scenario competence check.	Yvonne Taylor and Registered Manager	7 October 2026	95 percent attendance and 90 percent competence pass.	Attendance, competence test, non-attendance escalation.	Training matrix reviewed monthly.	Escalate non-compliance to Matron. Close after all permanent staff completed.	Amber
2.1	Medicines	Complete pharmacy-led medicines management review covering PRN, MAR, variable dose, time-sensitive medicines, self-administration, topical medicines and community medicines.	Pharmacy and Registered Manager	26 August 2026	All medicine risks have action owner and completion date.	Pharmacy report and medicines action log.	Re-audit four weeks after completion and monthly until Green.	Escalate high-risk gaps immediately to Matron and Pharmacy Lead.	Amber
2.2	Medicines	Update all PRN protocols with indication, dose, interval, maximum dose, monitoring, escalation and community access arrangements.	Registered Manager Named Nurses with Pharmacy	2 September 2026	100 percent PRN medicines have complete protocols.	PRN protocol pack and pharmacy sign-off.	Monthly PRN sample audit.	No missing PRN protocol tolerated. Close after three months sustained 100 percent.	Amber/Green
2.3	Medicines	Reconcile MAR charts, prescriptions and care plans for time-sensitive and variable dose medicines.	Registered Manager Named Nurses and Pharmacy	2 September 2026	No discrepancy between MAR, prescription and care guidance.	MAR reconciliation log and corrective action record.	Weekly manager check for four weeks then monthly pharmacy audit.	Escalate unresolved discrepancies same day.	Amber
2.4	Medicines	Complete self-administration risk assessments and create register stating person, medicine, responsibility and review date.	Registered Manager Named Nurses	19 August 2026	All current or potential self-administration covered.	Risk assessments, register and MAR role clarity.	Monthly register review.	Escalate missing assessment to Registered Manager immediately.	Amber/Green
2.5	Medicines	Update topical cream and emollient records, body maps, flammability advice and storage guidance.	Registered Manager Named Nurses with Pharmacy	19 August 2026	Care plan, MAR and topical record are consistent.	Topical MAR, body maps, risk guidance.	Monthly topical medicine audit.	Escalate inconsistency to pharmacy action log.	Amber/Green
2.6	Medicines	Train and competency-assess support staff for approved community medicines administration.	Registered Manager, Anil Ranil, Pharmacy	30 August 2026	Sufficient competent staff for planned community activities.	Competency records, supervised practice sign-off.	Roster and outing audit monthly.	Community activity with medicines need not proceed without competent cover or safe alternative.	Amber
2.7	Medicines	Issue interim community medicines guidance pending full SOP update.	Registered Manager, Matron, Pharmacy	Before 20/08/2026 and SOP by 28 October 2026	No missed dose, unmet PRN need or curtailed outing due to medicines arrangements.	Interim guidance, SOP, activity audit.	Monthly audit of outings against medicine requirements.	Escalate any missed/delayed medicine or curtailed activity as incident and governance exception.	Amber
3.1	Care planning	Use CQC finding checklist for all care plans: skin integrity, dementia/cognition, behaviour support, high-risk medicines, community access, self-administration, topical medicines, incidents and consent.	Registered Manager Named Nurses	11 September 2026	100 percent care plans reviewed against checklist.	Completed checklist and updated plans.	Matron validation of all records then monthly sample.	Close only after all CQC themes evidenced in records.	Amber

3.2	Care planning	Update skin integrity plans to include specialist advice, monitoring, escalation and staff guidance.	Registered Manager Named Nurses	11 September 2026	All identified skin risks have clear plan and review.	Care plan extracts and specialist advice links.	Monthly care record audit.	Escalate missing guidance to Matron.	Amber
3.4	Care planning	Update behaviour support plans with communication strategies, early warning signs, de-escalation, PRN indication and review arrangements.	Registered Manager Named Nurses with MDT input	11 September 2026	Behaviour plans provide clear guidance and align with medicines protocols.	Updated behaviour support plans and MDT record.	Manager and Matron sample audit.	Escalate incomplete plans to MDT review.	Amber
3.5	Care planning	Add high-risk medicine section to care plans, GP arrangements where applicable.	Registered Manager Named Nurses	11 September 2026	All high-risk medicines reflected in each care plan.	High-risk medicines checklist and GP monitoring evidence.	Pharmacy and care plan cross-audit.	Escalate missing high-risk guidance same day.	Amber
3.6	Care planning	Implement post-incident SWARM huddle, care plan and risk assessment update check within 72 hours of relevant incident.	Registered Manager	Immediate	All relevant incidents generate review record and, where needed, plan update.	Incident review forms, care plan update log.	Monthly incident-to-record reconciliation.	Escalate omissions to patient safety meeting.	Amber
3.7	Care planning	Complete Dialog and GBO records and link to person-centred goals and outcome monitoring.	Registered Manager Named Nurses	11 September 2026	All people have current person-centred outcomes **and review date.**	Dialog report and GBO records.	Monthly outcome review.	Escalate missing records through supervision.	Amber
4.1	Environment	Complete COSHH review and introduce daily locked-storage confirmation.	Registered Manager	7 August 2026	No unsecured hazardous substances identified.	COSHH audit, daily checklist.	Weekly manager spot-check for six weeks then monthly.	Immediate correction and incident/RADAR if recurrence.	Green/Amber
4.2	Environment	Review fire and evacuation routes, clarify designated exits and record daily route checks.	Registered Manager and EPRR Manager	12 August 2026	All designated routes unobstructed and understood.	Fire route checklist, EPRR review.	Weekly route audit for six weeks then monthly.	Escalate obstruction immediately and record action.	Green/Amber
4.3	Environment	Introduce CPAP and medical equipment cleaning, maintenance and safety log.	Registered Manager	Immediate	All equipment checks recorded and missed checks escalated.	CPAP log, equipment register, maintenance labels.	Monthly equipment audit.	Escalate missing checks to Matron if not corrected within 24 hours.	Amber
4.4	Environment	Develop environmental safety checklist covering COSHH, routes, equipment, water, trip hazards, infection prevention and estate defects.	Registered Manager	12 August 2026	Checklist completed daily and reviewed weekly.	Completed checklists and actions.	Monthly H&S validation.	Recurring omissions to risk register and DMT.	Amber
5.1	Incident/safeguarding	Review previous 12 months incidents and safeguarding records for themes, reporting timeliness, care plan updates and learning.	Matron	2 September 2026	Thematic report with actions and risk controls.	Analysis report and learning action plan.	Re-audit three months after implementation.	Significant themes to DMT and risk register.	Amber
5.2	Incident/safeguarding	Implement debrief/swarm huddle template for relevant incidents, including learning, immediate actions and record updates.	Registered Manager	Immediate	100 percent eligible incidents have completed debrief record.	Debrief forms, RADAR links and learning log.	Monthly patient safety audit.	Escalate missing debrief to service governance.	Amber
5.3	Incident/safeguarding	Ensure all staff have RADAR access and know reporting route for incidents and safeguarding.	Registered Manager	19 August 2026	100 percent staff have access or approved route and pass knowledge check.	Access report and staff knowledge check.	Monthly until complete then new starter audit.	Escalate access barriers to systems admin.	Green/Amber

5.4	Incident/safeguarding	Audit safeguarding referrals against RADAR entries and local authority notifications.	Registered Manager and Safeguarding Lead	Monthly	No safeguarding concern without correct external and internal reporting.	Safeguarding log reconciliation.	Monthly governance review.	Immediate escalation of missed referral.	Amber
5.5	Incident/safeguarding	Share learning from incidents through team meeting, supervision and learning bulletin.	Registered Manager	Ongoing	Staff can describe recent learning and practice change.	Minutes, supervision records, bulletin and staff sign-off.	Quarterly staff knowledge sample.	Escalate if staff cannot describe learning.	Amber
6.1	Governance	Create Danescourt improvement dashboard aligned to CQC themes, actions, audit results, incidents, safeguarding, medicines, MCA, training and environment.	Matron and Registered Manager	30 September 2026	Dashboard reviewed monthly and informs decisions.	Dashboard and meeting minutes.	Monthly DMT review until Green.	Any Red action escalated to DMT within one month, urgent risks immediately.	Amber/Red
6.2	Governance	Embed within CQC evidence library with index, owner, date, source location and inspection retrieval standard.	Registered Manager and Business Support	30 September 2026	Core evidence can be produced within five minutes.	Evidence index and retrieval test results.	Monthly retrieval drill.	Escalate missing evidence to Matron. Close after three Green drills.	Red
6.3	Governance	Strengthen RADAR audit schedule with action owner, due date, closure evidence, re-audit date and escalation trigger.	Registered Manager, Matron, Jane Hillier	30 September 2026	All audits lead to tracked actions and closure evidence.	RADAR schedule, action log and re-audit records.	Monthly governance review.	Overdue high-risk actions to DMT.	Amber/Red
6.4	Governance	Introduce weekly recovery huddle and monthly service governance meeting with standing Danescourt CQC agenda.	Registered Manager and Matron	Immediate	Actions reviewed, slippage escalated and decisions recorded.	Huddle notes, governance minutes and action log.	Monthly DMT scrutiny.	Any missed meeting reported to directorate governance.	Amber
6.5	Governance	Complete targeted peer review and follow-up review focused on CQC breach themes.	Matron and independent peer reviewer	Initial within 8 weeks, follow-up 3 months later	Independent validation confirms improvement embedded.	Peer review report and follow-up report.	Report to directorate governance.	Any Red finding added to risk register and action tracker.	Amber
6.6	Governance	Protect Registered Manager management time and monitor delivery through roster review.	Matron and Service Manager	30 September 2026	Protected time delivered and exceptions recorded.	Job plan, rota evidence and exception log.	Monthly matron sign-off.	Escalate repeated loss of protected time to DMT.	Amber
6.7	Governance	Maintain live risk register entries for CQC-related residual risks, with controls, review dates and owner.	Registered Manager and Matron	Ongoing	All residual Amber/Red risks are reflected and reviewed.	Risk register report.	Monthly DMT review.	Escalate score increases immediately.	Amber
7.1	Staff development	Create integrated training and competence matrix for MCA, medicines, safeguarding, PSIRF, Dialog and risk assessment.	Registered Manager	30 September 2026	Training compliance at or above 95 percent, with competence evidence for high-risk topics.	Training matrix and competence records.	Monthly workforce governance review.	Non-compliance escalated through supervision and line management.	Amber
7.2	Staff development	Embed supervision prompts for MCA/DoLS, medicines, incidents, safeguarding, care records and environmental safety.	Registered Manager	Immediate	Supervision evidence shows discussion and actions.	Supervision template and audit.	Monthly supervision audit.	Escalate missed supervision or repeated knowledge gaps.	Amber

7. Governance and assurance framework

Frequency	Lead forum/person	Purpose	Evidence	Escalation
Daily	Qualified on shift	Environmental walk-round, CPAP/equipment log, medicines exceptions, immediate safeguarding and incident reporting.	Daily checklist, RADAR entries, equipment logs.	Immediate escalation to Registered Manager for missed checks, unsafe medicines or safeguarding concerns.
Weekly	Registered Manager	Recovery huddle, action tracker review, evidence library update, outstanding actions and immediate risks.	Weekly huddle record and action log.	Escalate Red actions or overdue high-risk actions to Matron within 48 hours.
Monthly	Service governance meeting	Dashboard review across MCA, medicines, care records, incidents, safeguarding, environment, staffing and training.	Dashboard, minutes, action closure evidence.	Escalate exceptions through LD directorate governance to Q&S subgroup to CLE and risk register.
Monthly	Matron/DMT	Independent scrutiny of dashboard, risks, overdue actions and assurance evidence, with escalation through LD directorate governance to Q&S subgroup to CLE.	DMT minutes, LD directorate governance report, risk register, exception report.	Escalate unresolved risk or repeated slippage through LD directorate governance to Q&S subgroup to CLE.
Quarterly	LD directorate governance	Sustained compliance review and themes across audits, incidents, complaints, feedback and outcomes.	Quarterly assurance report.	Escalate significant residual risk to Q&S subgroup to CLE.
Six-monthly	Peer review or matron validation	Independent validation of care records, medicines, MCA/DoLS, environment and governance evidence.	Peer review report and improvement actions.	Any Red finding restarts recovery cycle and remains open until re-audited.

8. Enhanced live RAG-rated action tracker template

ID	Action cluster	Owner	Current RAG	Target RAG	Dependencies	Risks to delivery	Assurance indicators	Escalation	Closure position
CQC-001	MCA/DoLS tracker and retrieval	Registered Manager	Amber	Green	Service user list, MCA forms, DoLS records	Missing electronic links or staff unfamiliarity	Tracker complete, retrieval under five minutes, three Green checks	Matron	Open until 3 Green monthly checks
CQC-002	PRN and medicines protocol remediation	Pharmacy and Named Nurses	Amber	Green	Prescription data, MAR, pharmacy capacity	Pharmacy availability, protocol variation	100 percent PRN complete and pharmacy signed off	Pharmacy Lead	Open until 3 months 100 percent compliance
CQC-003	Care plan review against CQC checklist	Named Nurses	Amber	Green	Electronic care records, staff time	Documentation volume, system save issues	All records include CQC example themes and matron validation	Matron	Open until validation complete
CQC-004	CPAP/equipment log	Registered Manager	Amber	Green	Equipment register	Missed daily checks	All checks recorded and audited monthly	Matron	Open until two clean audits
CQC-005	Incident learning loop	Registered Manager	Amber	Green	RADAR data, debrief template	Incomplete debriefs or weak learning evidence	100 percent eligible incidents reviewed and learning shared	Patient Safety Meeting	Open until 3 monthly reconciliations complete
CQC-006	Governance dashboard and evidence library	Matron and Registered Manager	Red	Green	Administrative support and RADAR data	Evidence fragmentation, overdue actions	Dashboard in use and evidence retrieved within five minutes	DMT	Open until 3 monthly dashboard reviews and retrieval tests

9. Regulation compliance assessment

Regulation	Residual RAG	Assessment	Controls in revised plan	Closure test
Regulation 11 Need for Consent	Amber	The revised plan addresses consent, capacity, best-interest and DoLS documentation. Residual risk remains until staff can consistently locate records and explain restrictions in real time.	MCA/DoLS tracker, retrieval drill, scenario competence, monthly audit and supervision checks.	Green when 100 percent records are complete and three retrieval drills achieve compliance.
Regulation 12 Safe Care and Treatment	Amber	The revised plan addresses medicines, risk assessments, care planning, environmental safety, equipment checks, incident learning and safeguarding. Residual risk remains until re-audits demonstrate sustained compliance.	Medicines re-audit, care plan checklist, CPAP log, environmental checklist, incident reconciliation and safeguarding audit.	Green when named CQC issues are closed and three months of compliant audits are available.
Regulation 17 Good Governance	Amber/Red	This is the main residual regulatory risk. The revised plan strengthens local and provider-level evidence that risks are identified, acted on, closed and tested.	Dashboard, action tracker, evidence library, risk register, DMT escalation, peer review and closure criteria.	Green when dashboard evidence shows sustained controls, closed actions have re-audit evidence and retrieval tests are passed.

10. Prioritised CQC inspection-readiness recommendations

1. Treat Regulation 17 as the central recovery risk. CQC will expect a live evidence trail, not just completed actions.

2. Create a one-page Danescourt CQC assurance dashboard and review it weekly during recovery, then monthly once stable.

3. Maintain an electronic evidence library with the key proof needed for inspection: MCA/DoLS tracker, PRN protocols, pharmacy audits, care plan checklist, incident learning log, safeguarding log, environmental checklists, CPAP logs, training matrix and governance minutes.

4. Use a CQC finding checklist during every care record audit so that specific examples are not lost inside broad reviews.

5. Move from attendance-based training assurance to competence-based assurance for MCA, safeguarding, medicines and risk assessment.

6. Ensure every action has a documented closure standard. Completion should require evidence, owner sign-off, audit confirmation and, where relevant, re-audit showing sustained improvement.

7. Prepare staff for inspection questions using short scenario-based checks: how to find a DoLS record, how to report safeguarding, how to escalate a medicine concern, and how a post-incident care plan review is completed.

8. Report progress through service governance, DMT and relevant Trust assurance routes until the residual dashboard position is Green.

11. Executive sign-off checklist

Sign-off requirement	Complete	Accountable confirmer
All CQC findings mapped to an action	☑	Chief Nurse
Named lead and due date present for every action	☑	Matron
Evidence source defined for every action	☐	Registered Manager
Audit and re-audit schedule agreed	☐	Matron
Escalation route agreed for overdue or Red actions	☐	DMT
Evidence library established and retrieval tested	☐	Registered Manager
Dashboard reporting route agreed	☐	LD directorate governance to Q&S subgroup to CLE
Closure criteria accepted by executive lead	☐	Chief Nurse

Annex 11

Coroner's submitted action plan (due for delivery 31 – 10- 2026)

No.	Required change	Owner and deadline	Measures and confidence
1	**Embed patient voice, autonomy and lawful carer involvement.** At admission, formal discharge reviews and discharge, record the patient's wishes, priorities, preferences for family or carer involvement and information sharing, relevant decision-specific capacity considerations, and need for advocacy or trusted support. Respect a refusal of family involvement unless another lawful basis applies. Staff may receive and consider information from relatives or carers without disclosing confidential information. Do not rely on informal support until the person's willingness, ability and role are confirmed.	**Owner:** Chief Nurse, with Caldicott Guardian oversight. **Deadline:** 31 October 2026.	**Measures:** 100% record involvement and information-sharing preferences; 100% confirm any informal support relied upon. Audit 10 consecutive adult inpatient discharges per locality each month. **Confidence:** at least 95% overall compliance across two consecutive months and 100% confirmation of relied-upon support. Escalate any gap within two working days; re-audit at six months.
2	**Set a reliable discharge MDT and professional-challenge standard.** Give at least three working days' notice of planned discharge MDTs unless clinically urgent. The chair must secure the care coordinator or community clinician and relevant inpatient medical and nursing input, plus other material contributions. Input may be verbal, written or virtual. Record missing information, non-attendance, differing views and challenge. Where material information is absent, document whether discharge is deferred or proceeds, with rationale, mitigation, owner and deadline.	**Owner:** Chief Medical Officer. **Deadline:** 31 October 2026.	**Measures:** at least 95% timely notice; 100% required input or documented exception; 100% defer-or-proceed decisions where material information is missing. **Confidence:** challenge is visible and resolved, with no unmitigated missing input in sampled cases. Escalate unresolved dependencies before discharge; re-audit at six months.

No.	Required change	Owner and deadline	Measures and confidence
3	**Use one whole-person discharge-readiness and purposeful-leave record.** Before discharge, record the formulation, patient's account, clinical readiness, medication, home and housing issues, financial pressures, social-care and substance-misuse support, available support, outstanding actions, learning from leave, follow-up arrangements, named responsibilities and contingencies. For unresolved issues, record defer or proceed, rationale and mitigation. Where leave informs discharge, record its purpose, outcome and impact on the decision. Extended or overnight leave is optional and must be clinically justified.	**Owner:** Chief Operating Officer. **Deadline:** 31 October 2026.	**Measures:** 100% use the record; 100% of assessment or transition leave records purpose and evaluation; at least 95% link readiness, circumstances, patient wishes, leave evidence and contingency. **Confidence:** one compliant monthly sample, followed by a three-month re-audit and thematic review of any early readmission or serious incident.
4	**Strengthen 72-hour follow-up and escalation.** Compare the patient's presentation with their discharge baseline and record their account, self-care, medication, social stressors, suicidal or self-harm concerns, relevant risk and protective factors, support, safety formulation, actions, owner, timescale and out-of-hours contingency. Deterioration, suicidal thinking, reduced self-care, difficulty coping or failure of the discharge plan requires same-day senior clinical review and a documented response. Consider options proportionate to need, including increased contact, review, practical support, crisis input, urgent assessment or readmission.	**Owner:** Chief Medical Officer. **Deadline:** 31 October 2026.	**Measures:** at least 95% follow-up within 72 hours, with all exceptions managed; 100% of deterioration cases record formulation, options, rationale, owner, timescale and contingency. **Confidence:** at least 95% meet the full quality standard and 100% of triggered cases are escalated. Missing same-day plans are escalated within one working day; immediate concerns follow the urgent or emergency pathway.
5	**Make information visibility a clinical safety control.** Relevant inpatient, community, OT, social-care, housing and pharmacy information must be available to the decision-maker, or conveyed	**Owner:** Director of Psychological Professionals.	**Measures:** at least 95% of sampled discharges share the latest care plan within 24 hours; 100% of unavailable external

No.	Required change	Owner and deadline	Measures and confidence
	through a verified summary or direct discussion. Records must show the information and views considered, formulation, challenge, decision, rationale, actions, ownership and contingencies. Send the latest care plan to identified onward professionals within 24 hours, subject to lawful information sharing.	**Deadlines:** interim **process by 31 October**; **system resolution plan by 30 November 2026.**	assessments have a verified summary, direct discussion or defer-or-proceed decision. **Confidence:** review confirms the thresholds are met.
6	**Deliver Trust-wide learning and test application.** Share learning through the **CEO Vlog on 23 October 2026**, Learning Matters and mandated learning half-days. Target staff and leaders involved in assessment, leave, discharge and early follow-up. Use anonymised scenarios covering family involvement, missing MDT input, unresolved housing issues, purposeful leave, bank-holiday discharge and refusal of crisis support. Participants must apply the standard and record their decision, rationale and contingency.	**Owner:** CEO. **Deadlines: Vlog 23 October; Learning Matters 31 October; first** learning **cycle 30 November 2026.**	**Measures:** publication, delivery and scenario-testing results. **Confidence:** staff apply the standards consistently and case review shows sustained improvement.

Annex 12

Trust's published National Oversight Framework position April – June 2026

The NHS Oversight Framework (NOF) is the structured approach NHS England uses to assess the performance of NHS providers. Its purpose is to ensure public accountability for performance and provide a foundation for how NHS England works with systems and providers to support improvement.

The framework measures organisational delivery across five scored domains - access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity - and places providers into segments (1–4) indicating their level of performance and the degree of support they receive from NHS England.

This interactive dashboard allows you to see how NHS England has assessed each provider under the NOF. It provides a view of how providers are performing compared to one another, including the overall segment of each provider, which indicates the breadth of challenges it faces

https://data.england.nhs.uk/nhs-oversight-framework/providers/rotherham-doncaster-and-south-humber-nhs-foundation-trust

The Trust scores are shown overleaf.

Access to services

Measures how effectively patients can access NHS services, covering elective care waiting times, cancer treatment pathways, mental health access, and urgent and emergency care responsiveness. Timely access is fundamental to early diagnosis, effective treatment, and patient confidence in the health system.

Domain summary

Average score

2.25

Performance declined
1.22 in previous quarter

Quartile

2 Second-highest-scoring 25%

Performance declined
Quartile 1 in previous quarter

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Percentage of patients waiting less than 18 weeks for community care	Elective care	**100%**	78%	1	1
Percentage of patients waiting over 52 weeks for community services	Elective care	**0%**	0%	1	1
Percentage of people discharged from community mental health services with a paired outcome score recorded (adult and older adult)	Mental health care	**8.20%**			
Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages)	Mental health care			3	
Percentage of people discharged from community mental health services with a paired outcome score recorded (children and young people)	Mental health care	**13.59%**			
Percentage of total open children's and young persons mental health related waits that are over 104 weeks	Mental health care	**32.04%**		4	34

Patient safety

Tracks indicators that reflect the safety of care provided to patients, including incident rates, infection control, and harm prevention. Patient safety is the foundation of high-quality healthcare - these metrics help identify risks and drive improvements that protect patients from avoidable harm.

Domain summary

Average score

3.21

Performance declined
2.93 in previous quarter

Quartile

4 Lowest-scoring 25%

Performance declined
Quartile 3 in previous quarter

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
NHS Staff survey – raising concerns sub-score	Safe culture	**6.47 out of 10**		3.42	47
Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours	High quality care	**67.44%**		3	36

Finance, productivity and innovation

Evaluates the financial sustainability and operational efficiency of the provider, including revenue and expenditure balance, use of resources, and productivity measures. Strong financial performance ensures the provider can maintain services, invest in improvements, and deliver value for public funding.

Domain summary

Average score

1.09

Performance improved
1.65 in previous quarter

Quartile

1 Highest-scoring 25%

Performance improved
Quartile 2 in previous quarter

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Combined finance score	Finance			1	
Data Quality Maturity Index score	Innovation	**96.40**		1.36	13
Percentage of clinical trials set up within 90 days	Innovation	**100%**		1	1
Planned surplus/deficit	Finance	**0%**		1	9
Relative difference in costs	Productivity	**87.91%**	100%	1	6
Variance year-to-date to financial plan	Finance	**0.09%**		1	9

People

Monitors workforce stability, staff retention, and organisational culture, including vacancy rates, staff turnover, and employee survey results. A well-supported, stable workforce is essential to delivering safe, effective care and sustaining long-term service improvement.

Domain summary

Average score

2.67

Performance improved
3.47 in previous quarter

Quartile

3 Third-highest-scoring 25%

Performance improved
Quartile 4 in previous quarter

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Healthcare Worker Flu Vaccination Rate	People and culture	**62.80%**		1.10	2
NHS staff standards score	People and culture	**7.75 out of 10**		2.84	36
NHS staff survey engagement theme sub-score	People and culture	**6.81 out of 10**		3.37	46
National Education and Training Survey satisfaction rate	People and culture	**80.44%**		1.90	36
Sickness absence rate	People and culture	**7.16%**		3.79	53
Temporary staffing agency	Workforce			3	
Temporary staffing bank	Workforce			3	
Temporary staffing cost relative band score	Workforce			3	

Experience of care

Monitors how patients, service users, and staff experience NHS services, including patient satisfaction, access to primary care, staff advocacy, complaints handling, and the flow of patients through services. These metrics help assess whether care is responsive, person-centred, and delivered in a way that supports positive experiences and timely transitions through the healthcare system.'

Domain summary

Average score

1.54

Quartile

1 Highest-scoring 25%

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
CQC community mental health survey satisfaction rate	Experience			1	
Mean length of stay for adult acute and psychiatric intensive care unit patients (Days)	Patient flow	**39 days**		1	9
Mean length of stay for older adult acute discharges (Days)	Patient flow	**57 days**		1	2
NHS staff survey advocacy rate Score	Experience	**6.59 out of 10**		3.47	48
Percentage of intermediate care beds occupied by patients without criteria to reside	Patient flow	**2.89%**		1.25	6

Effectiveness of care and population health

Measures how successfully healthcare services improve health outcomes and deliver evidence-based care, including mortality, recovery, long-term condition management, discharge outcomes, and prevention-focused interventions. These metrics highlight whether services are achieving meaningful improvements in population health, reducing avoidable harm, and providing care that leads to better outcomes for patients and communities.

Domain summary

Average score

2.00

Quartile

2 Second-highest-scoring 25%

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Mental health 14-day readmission rate	Effective discharge	**5.76%**		2	23
Percentage of acute and rehabilitation adult discharges followed up within 72 hours	Outcomes	**90.70%**		1	8
Percentage of acute inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Preventing ill health	**0.94%**	0%	3	25
Percentage of patients readmitted within 30 days of discharge – comparative band	Effective discharge			2	

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Peer support framework: first report	**Agenda Item**	Paper P
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Dr Judith Graham, Director of Psychological Professions and Therapies and Steve Forsyth, Chief Nurse and Glyn Butcher, PFG Service Director		
Meeting	Board of Directors	**Date**	24 September 2026

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

In November 2025 the Board considered progress with Promise 1. Since that time we have seen three big shifts: much greater adoption of peer support in our ward environments; funding of peer support at scale in the Rotherham Care Group; introduction of roles into areas such as neurodiversity, carer support, and more physical health teams.

The paper recognises the risk of quantity without the impact peers deserve and can make qualitatively. It highlights practical steps of voice, support, identity and recognition – in each area seeing space for further gains. Eleven recommendations are outlined which it will be for the executive to take forward, recognising that promise 1 necessarily sits between two director roles. The Board should consider the lessons from this first outcome framework evaluation – and comment too on the approach to that evaluation being taken, mindful that this is one of four areas of meaningful health services research we plan to deploy from 2027.

Previous consideration

n/a

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE the considerable progress of work on peer support since our review in November 2025

CONSIDER whether the executive is sufficiently clear on how to take forward the eleven recommendations within this paper

RECOGNISE that 2027/28 represents a final 'round' of peer support growth in executing Promise 1

AGREE to assess the degree of MDT integration of PSWs at the timeout in April 2027 (hearing there from the diverse voices this paper relies upon)

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

Alignment to the plans: (indicate those that this paper supports)	
People and teams plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X
Research and innovation plan	X

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	**X**

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

If we 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	
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.	
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.	
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	

System / Place relevance (advise whether it is national, regional or local)

n/a

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

Appendix (please list)

Annex A: Peer support framework logic model
Annex B: Draft outcomes dashboard
Annex C: Easy-read dashboard
Annex D: Cultural aspects of peer support
Annex E: Governance meeting attendance
Annex F: Methodology and contributors
Annex G: Abbreviations and references
Annex H: Peers on the Wards data

1. Introduction

1.1. Peer support, delivered by colleagues who draw on their own lived experience of mental health difficulties, learning disability or service use, is a recognised part of NHS mental health provision (NHS England, 2023) and is central to RDaSH Strategic Promise 1: to employ peer support workers at the heart of every service that we offer by 2027. This paper sets out our progress to date, brings together the evidence we hold, and proposes a Peer Support and Lived Experience Framework to embed the role consistently and to measure its impact.

1.2. **Where we are.** The Trust has grown from 3 paid peer support workers in 2023 (all in the Children and Young People care group) to 17 employed peer support workers across four directorates in 2026, alongside an expanding network of volunteer and partner-provided lived experience roles and strong lived experience and governor representation across our board committees and Clinical Leadership Executive (CLE) groups. Roles are increasing and the experience of the workforce is maturing.

1.3. **What the evidence tells us.** The Trust set out to view peer support from three perspectives: the experience of peers themselves, the perspective of staff, and the quantitative picture of activity and feedback. This integrated paper now includes the peer and lived experience evidence and the available Peers on the Wards activity and feedback data. Between October 2025 and August 2026, 539 hours of peer support were recorded across 267 sessions. The staff perspective is being gathered through a questionnaire and remains the principal open evidence gap. Broader activity and outcome reporting beyond the ward programme also requires further development.

1.4. **What peers told us.** Peer support workers have been interviewed and contributed to reflective groups as part of this evaluation process. The peer support workers have been from across mental health and LD inpatient and community services.

1.5. The peer support workers described the heart of their role as building meaningful, unhurried relationships, sharing their own recovery journey to instil hope, and modelling that recovery is possible. They are motivated by a desire to give back. Their experience of working within clinical teams is mixed and depends on the clinical area: some teams welcome and integrate them fully, while in others the role is poorly understood, seen as ambiguous, or treated as an add-on.

1.6. Consistent, practical barriers were identified: no access to the electronic patient record (SystmOne), inconsistent supervision, variable personal safety equipment, referral pathways that do not allow a peer worker to refer back into community teams, and gaps in access to training and learning available to other staff.

1.7. **What we are proposing.** A three-part Peer Support and Lived Experience Framework: (a) domains of good practice generated from our learning, (b) an outcomes and performance dashboard (with an easy-read version), and (c) a clear

set of actions to embed peer support consistently across services, required to deliver Promise 1 credibly by 2027.

2. Purpose and recommendation

2.1 This paper is presented to CLE / the Board of Directors regarding progress against Strategic Promise 1 (with linked assurance on Promises 3 and 5), and to seek a discussion of the direction of the proposed Peer Support and Lived Experience Framework and its associated next steps.

3. Strategic and policy context

3.1 The Trust's Clinical and Organisational Strategy 2023 to 2028 is built around five objectives carried by 28 numbered public promises. This paper connects directly to three of them, which together form an overall lived experience approach:

Promise	Commitment	Relevance to this paper
Promise 1	Employ peer support workers at the heart of every service that we offer by 2027	The primary focus: paid and partnership peer support roles in services.
Promise 3	Work with over 350 volunteers to go the extra mile in the quality of care	Many volunteers bring lived experience; recommend capturing lived experience data on recruitment.
Promise 5	Systematically involve our communities at every level of decision-making	Lived experience, peer and governor representation in board committees and CLE groups.
Promise 16	Personalised care and paired outcomes (DIALOG+)	The outcome measurement vehicle for peer support; led by the sponsoring Director.

3.2 **National policy.** Peer support delivered by trained workers with lived experience is a recognised part of NHS mental health provision (NHS England, 2023, Supported self-management: peer support guide). In 2021 the World Health Organization published guidance encouraging person-centred and rights-based approaches, in part through the implementation of peer support. At its core, peer support aims to help people with the issues they consider important to their own lives and recovery, free from judgement and assumptions.

3.3 **CQC domains.** The content of this paper relates principally to the **Caring** and **Responsive** domains (the experience of people using services and of peers themselves), the **Effective** domain (outcomes and DIALOG+), and the **Well-led** domain (governance, workforce parity, culture and co-production). With the Trust's overall CQC position at Requires Improvement, embedding peer support with clear

assurance, ownership and measurement supports improvement across these domains.

4 Background

4.1 In RDaSH we have historically had a small number of peer support workers, primarily in children's mental health and adult learning disability services. Since the launch of the strategy we have expanded peer support in two ways: through directly employed roles, and through partnerships with place-based community organisations (for example S62, 'Better You', Family Lives and the People Focused Group). We have worked through the High Quality Therapeutic Care (HQTC) taskforce towards peer support workers on all 11 of our inpatient mental health and learning disability wards, and expanded roles in Early Intervention in Psychosis, perinatal services, and the mental health rehabilitation pathways through the 2024/25 investment bids.

4.2 This paper is presented now because the roles have reached a scale where consistent practice, integration into the multi-disciplinary team (MDT) and credible measurement matter, both to deliver Promise 1 by 2027 and to protect the distinctiveness and wellbeing of the peer workforce. It draws together, for the first time, the direct evidence from peers, the emerging outcomes picture, and a proposed framework.

5. Current position: the three perspectives

The Trust committed to understanding peer support from three perspectives. This section reports each in turn and is explicit about what is evidenced and what remains a gap.

5.1 Perspective 1: Peer and lived experience

5.1.1 **The workforce position.** In 2023 we had 3 employed paid peer support workers, all in the Children and Young People care group. Our current directly-employed position is 17 peer support workers across four directorates:

Directorate (and locality where applicable)	Peer support workers
Children's Mental Health Directorate	4
Children's Physical Health Directorate	1
Rotherham Mental Health Community Directorate	7
North Lincolnshire Community Directorate	5
Total	**17**

5.1.2 This is in addition to peer and lived experience roles delivered in partnership with community organisations, and volunteer lived experience roles. Roles are

increasing and experience is improving. The central challenge is how peer support roles are included in the MDT alongside more established staff groups (nursing, AHP, medical, pharmacy and psychological professionals).

5.1.3 Our main peer support partner is PFG in Doncaster, they are a mature peer support organisation who are not only providing peer support in many RDaSH services, but also supporting less mature peer organisations such as RAW (formerly S62 in Rotherham) and MIND in NL to develop place based lived experience representation and service provision.

5.1.4 Through work with PFG we now have peer support sessions (these are additional to the paid peer support roles employed by the Trust and detailed in page 4) on each of our mental health inpatient service areas which is very well thought of by staff, patients, families and peers. As a part of this review we have conducted focus groups with lived experience experts and peer support workers who are both in paid roles in RDaSH and also in peer roles with PFG, RAW and MIND. We also interviewed peer support workers who have started to support our physical health services, who have previously not had colleagues with this specialty before.

5.1.5 **What peer support workers told us.** We interviewed peer support workers directly, using an appreciative inquiry approach, across two sites and several groups (see Annex F). The findings below integrate that evidence. They are the voice of the peer workforce and form the core of the lived experience perspective.

5.1.6 **The heart of the role: relationships, hope and giving back.** Peer workers described the role as building meaningful and thoughtful relationships with patients and staff, slowly and consistently, and being led by empathy, compassion and curiosity. Sharing their own journey helps to instil hope at times of hopelessness. They are a visible, living example that recovery is possible. Goal-setting, ideally led by the patient, was valued as a tangible way of building the relationship and measuring progress. The dominant motivation was a desire to give back and to offer an alternative and additional route to recovery alongside the traditional offer of medication and talking therapies.

5.1.7 **Impact that outlasts the contact.** Feedback from patients described positive outcomes that outlast the time spent together, including people going on to further and higher education (some in the health sciences) and some wanting to become peer support workers themselves, pointing to a legacy effect of the role.

5.1.8 **A mixed experience within teams.** The experience of working within clinical teams is mixed and depends on the clinical area. On some wards peers feel genuinely welcomed and are invited to team business meetings and MDTs. On others, the role is not well understood or clearly defined, is seen as ambiguous, and can be treated as an add-on. Some peers reported hearing concerns from staff that their own role (for example support worker) might be replaced by peer support workers. Some peers also noted that their presence influenced how staff behaved (the language used, where information was discussed) and that they were sometimes still viewed through a clinical lens, as patients rather than colleagues.

5.1.9 **Information, safety and pathways -** Peers do not consistently have access to SystmOne (the patient record), so important information, including on clinical risk, is not consistently passed on, which affects their ability to work safely and effectively.

5.1.10 Personal safety equipment (alarms) availability is inconsistent and some devices are harder to use than others.

5.1.11 In community teams, once a patient is discharged the peer worker cannot refer back into the Community Mental Health Team (a GP referral is required), which feels inequitable and frustrating.

5.1.12 Peer support is frequently referred for through the MDT rather than being a core part of the team, and some community peers attend every new assessment as a second person and find themselves underused, and peer support can feel like an add-on at the end of an assessment rather than integrated into it.

5.1.13 **Support and supervision.** Overwhelmingly, peers said their main source of support and supervision is each other. They text, call and meet to talk through what is and is not working. This shows the strength of peer networks, but formal individual or group supervision is not consistently offered, and some peers were unaware of, or not invited into, organisational wellbeing and post-incident support forums.

5.1.14 **Practical improvements identified.** Peers identified a set of practical needs, several of which already have owners and actions:

Need identified by peers	Agreed action / owner
Training to help patients complete Personal Independence Payment (PIP) forms	Facilitator to be identified
Training on sexual safety	To be facilitated (Dr Jude Graham)
Medicines management awareness (what medicines do, side effects)	Session designed and facilitated in August 2026 (Rob Edwards)
Travel cards for patients to attend appointments	10 cards provided per team (50 total); PFG to request more when below 50% (Ray Hennessey)
Consistent, easier-to-use personal alarms (card-style)	To be raised with the Chief Nursing Officer (Steve Forsyth)
Access to Learn Half-Day material and portal	Access route being progressed (Rachel Warren)
Consistent supervision and wellbeing offer	Develop a consistent individual/group supervision and reflective practice offer (TBC)

Need identified by peers	Agreed action / owner
Referral back into CMHT after peer support ends	Solution to be explored (action open)

5.1.15 **A language change.** Peer support workers have agreed a change of language when a person finishes their work with peer support, moving from “discharge” to “ending their journey with peer support”, reflecting a less medical, more humanistic approach. This is a small but meaningful example of co-production in action.

5.1.16 **Career Progression**. Within the paid peer support worker discussions, they raised that there is a single banding used for peer support and therefore no structure available to them or means to progress. Other Trusts (i.e. TEWV) offer career pathways with different levels and pay for different peers, this may be something in the future we need to explore at RDaSH.

5.2 Perspective 2: Staff perspective (gap)

5.2.1 **This perspective is an identified gap.** A questionnaire is currently in the field with staff to capture their perspective on working alongside peer support workers, their understanding of the role, and the impact on team culture and integration. The offer was to feedback either by name or anonymised. The questionnaire was highly publicised through matrons and team leads, however despite being out and promoted for over 6 weeks, only one response was gained. Therefore findings are not able to be generalised.

5.2.2 **Why it matters:** the peer evidence shows that the staff relationship is the single biggest determinant of whether peer support works well in a given team. The staff perspective will allow us to triangulate the peer experience, target support where role understanding is weakest, and measure culture change over time (see Annex D on cultural aspects).

5.3 Perspective 3: Quantitative activity and feedback

5.3.1 This perspective is now evidenced for the Peers on the Wards programme. Broader Trust-wide activity and outcome coverage remains under development.

5.3.2 The available ‘Peers on the Wards’ activity and feedback data have been integrated into this paper and are set out in Annex H. From October 2025 to August 2026, 539 hours were recorded across 267 sessions. Peer support workers registered 86 compliments and 58 concerns. Ten scheduled sessions could not be attended because clinical staff judged ward conditions to present too much risk. The average monthly form completion proportion for October 2025 to June 2026 was 68.9%. Section 8 and Annex B retain the wider reporting structure needed for Trust-wide activity, experience and outcome measures.

5.3.3 **What we can and cannot currently explore.** For directly-employed peer support workers we can gather activity data with relative ease, because they have electronic patient records, job descriptions, job plans and PDRs. Two issues limit the quantitative picture:

- **Job-title inconsistency:** not all lived experience and peer support workers carry the same job title, which makes activity difficult to identify and aggregate.

- **Partnership data:** where peer support is delivered by partner agencies, workers often do not have Trust email, SystmOne access or a defined caseload, so their activity, outcomes and feedback are harder to capture. Feedback is currently gathered mainly through Care Opinion and the Friends and Family Test, where peer-specific contributions are hard to separate from the wider team.

5.4 Governance and meeting representation (Promise 5)

5.4.1 People with lived experience, peer support workers and governors do not only directly work with patients and carers accessing our services, but they are represented across our board committees, the Clinical Leadership Executive (CLE) and sub-CLE meetings.

5.4.2 Working jointly with a Director of the People Focused Group (our largest peer support partner) on an A3 change project, we interviewed representatives using appreciative inquiry, focused on three questions: what is working well, what is not working well, and what we could do better. Attendance data and the full findings are at Annex E. The headline learning was consistent with the barriers peers raised elsewhere:

- **Working well:** feeling welcomed by chairs, being able to attend in person or remotely, clear introductions, and being invited to contribute on specific matters.

- **Not working well:** papers that are too long with no easy-read or quick-read version, too much scheduled into meetings, over-use of abbreviations, papers presented verbally at length (leaving little time for discussion), and some people not feeling confident to speak.

- **What we could do better:** consistent pre-briefs and debriefs, the ability to pre-submit questions, printed minutes and devices for those who need them, an abbreviations list with every paper, easy-read/quick-read versions issued alongside full papers, a better matching process so people are assigned to meetings within their area of experience, and ensure feedback if a lived experience worker / peer worker has made a suggestion, feedback on whether or not it has been taken forward with a rationale.

5.4.3 This learning directly informs the accessibility principles built into the framework and the easy-read dashboard (Annex C), and is the reason an easy-read version of this very paper has been produced for the peers who contributed.

6. Learning, actions and measures

6.1 Consistent with the expectations for RDaSH quality papers, the table below summarises the narrative spine: what we have learned, what we are doing or propose, and how we will know it has worked.

Learning	Action	Measure of success
Peer support works best when it is understood, valued and embedded, not treated as an add-on.	Framework domains, MDT integration guidance, and staff learning sessions (LHD).	Proportion of teams with embedded, understood peer roles; staff survey/questionnaire results.
Peers do not always have access to information (SystmOne) needed to work safely.	Agree a proportionate information-access and information-sharing solution.	Peers report having the information they need; reduction in risk-information gaps.
Supervision relies on peer networks; formal supervision is inconsistent.	A consistent individual/group supervision, reflective practice and wellbeing offer.	% of peers receiving regular supervision; wellbeing and retention indicators.
Activity and outcomes are hard to aggregate due to job-title variation and partnership data gaps.	Consistent job titles; contractual data requirements for partners; EPR upload of peer-collected measures.	Complete activity and outcomes dashboard (Annex B) populated across employed and partner roles.
Referral pathways do not let peers refer back into CMHTs.	Design an equitable re-referral route.	A working re-referral pathway; peer-reported reduction in pathway friction.
Meeting papers are inaccessible to lived experience contributors.	Easy-read/quick-read versions, abbreviation lists, pre-briefs.	Easy-read versions issued alongside papers; contributor feedback.

7. A Peer Support and Lived Experience Framework

7.1 Our learning supports the co-production of a Peer Support and Lived Experience Framework in three parts:

1. **Domains generated from learning** (Annex A), a logic model of inputs, activities, outputs, outcomes and assumptions, drawing on our lived experience partners and the NHS England (2023) peer support guide.

2. **An outcomes and performance dashboard** (Annex B), with an easy-read/quick-read version (Annex C).

3. **A set of enabling actions** to embed peer support consistently, addressing the 14 practice points below.

7.2 Feedback from peer support workers points to fourteen practice points that, applied consistently, would embed the role. Some are already in place in some teams; the aim of the framework is consistent application:

1. Leadership development so leaders can articulate the benefit and contribution of lived experience and peer support.
2. Co-produced education and learning sessions for Learning Half Days (MDT case studies, boundaries, confidentiality, outcomes).
3. Named worker involvement.
4. Named activities with patients and carers.
5. Access to a Trust email address (and therefore weekly and monthly briefings) and the Electronic Patient Record.
6. Relevant supervision that is focused on lived experience, not general.
7. Clearer escalation processes (safeguarding, risk escalation, managing distress).
8. Involvement of peer support workers in team meetings.
9. Involvement of peer support workers in transformation, redesign and improvement programmes.
10. Recording peer support worker activity and viewing it alongside non-peer colleague data to demonstrate impact.
11. Inclusion of peer support workers in directorate and care group recognition activity (for example awards).
12. Organisational policy inclusion of peer support alongside other MDT roles.
13. Equality and Quality Impact Assessments supported by peer support and experts by experience.
14. Better career progression for people with lived experience.

8. Outcomes and performance indicators

8.1 With the peers on the ward work, we have been able to explore the things that matter for patients and peers and also think about outcomes and performance indicators in a more informed way. There are six key areas we would suggest to measure, regardless of whether activity is delivered via a peer support role, a volunteer lived experience role or a meeting role. A seventh area, cost and efficiency, is noted for longer-term monitoring once peers are in every area. Progress and issues are summarised below; the full dashboard is at Annex B.

***Key area 1*: Activity and access**

Indicators: Number of people supported, contacts per service user, referral-to-first-contact time, and equality of access.

Progress and issues: Readily mined for employed peers via EPR/PDRs. Limited for partner-delivered peers without Trust email, EPR access or defined caseload. Recommend consistent job titles and a partnership data route.

Key area 2: **Experience and satisfaction**

Indicators: Patient and carer satisfaction (FFT, bespoke surveys), qualitative themes (trust, hope, empathy), and staff/team feedback.

Progress and issues: Feedback runs mainly through Care Opinion and FFT, where peer contributions are hard to isolate within a team or pathway. Cultural integration is complex (Annex D). The staff perspective (5.2) will strengthen this.

Key area 3: **Patient outcomes**

Indicators: Recovery and wellbeing (hope, empowerment, goal attainment via DIALOG), and service use (crisis contacts, admissions, DNAs, discharge outcomes).

Progress and issues: Positive progress: employed peers and partner agencies are trained in DIALOG. Open issue: paired outcomes collected by non-RDaSH partners cannot yet be uploaded to the EPR, a task on the DIALOG implementation group's list, with a risk of duplicate measures and disengagement.

Key area 4: **Workforce**

Indicators: Recruitment and retention, training and competency completion, supervision frequency, wellbeing and burnout.

Progress and issues: Reportable via ESR for employed peers. Partner data should be built into contracts. Supervision is currently inconsistent (see 5.1).

Key area 5: **Service quality and implementation**

Indicators: Fidelity to peer principles, MDT integration, proportion of teams with embedded peers, and complaints/incidents/safeguarding learning.

Progress and issues: MDT integration is the current focus (Sections 2 and 5). Proportion of teams with embedded peers is a headline framework measure.

Key area 6: **Equality, diversity and inclusion**

Indicators: Representation of peers from diverse backgrounds, equity of experience among service users, and reasonable adjustments delivered.

Progress and issues: Numbers are still low, so demographic comparison to local populations is not yet possible. As we expand we will prioritise inclusive, diverse recruitment.

Additional area (longer-term): **Cost and efficiency**
Cost per service user supported, cost savings from reduced admissions or crisis contacts, and return on investment for business cases. Not yet in focus, as peers are not yet in every area.

9. Risks

Risk	Mitigation
"Every service by 2027" is undefined, so progress against Promise 1 cannot be measured precisely.	Agree a clear definition of "every service" and the mix of paid and unpaid roles that counts (Recommendation R1).
Peer-collected outcome measures cannot be uploaded to the EPR, risking under-reporting and patient disengagement through repeated measures.	In most mental health and LD services the completion of the DIALOG care plan and scales would be preferable data. Where dialog is not used (ie. Physical health, many childrens services, neurodiversity services, single diagnostic services) other outcome measures will need to be considered. (R5, R6).
Peer support is reported less rigorously than other staff groups, creating a parity and assurance gap.	Expand People and OD dashboards and outcome reporting to include peers (R7, R8).
Inconsistent supervision and safety equipment risk peer wellbeing, turnover and safe practice.	Consistent supervision/wellbeing offer; standard card-style alarms; information access (5.1 actions).
Cultural resistance and role ambiguity dilute the peer model or lead to tokenism.	Framework domains, staff learning, 'grandparenting' support for new roles, MDT audit (Annex D).
Partnership-delivered activity, outcomes and staff-experience data cannot be captured.	Build reporting requirements into current and future partner contracts.

These connect to the Board-declared strategic risk that the Trust may not consistently create, use and respond to data inside its services.

10. Loop closure

10.1 This is the first integrated paper bringing the three perspectives together, so it establishes the baseline against which future loop closure will be reported. The commitments made in this paper include the framework direction, the dashboard,

the closure of the staff and quantitative gaps, and the named actions arising from the peer interviews (PIP training, sexual safety training, medicines awareness, travel cards, alarms, Learn Half-Day access and the supervision offer). These will be tracked and their status reported when peer support next returns to the Board or its committees. Progress will be auditable against the agreed actions, consistent with the Trust's expectations for loop closure.

11. Recommendations

R1. **Define "every service".** Agree a clear definition of what Promise 1's "every service by 2027" means, including the treatment of paid versus unpaid roles, so progress can be measured.
R2. **Embed peer support in the MDT.** Consider the 14 practice points (Section 7) and secure CLE commitment to an approach, including an across-site session, to establish, embed and audit them, connected to the Promises Team in Nursing and Facilities.
R3. **Capture lived experience in volunteering.** Collect lived experience data when recruiting volunteers (Promise 3).
R4. **Consistent titles and partnership data.** Use consistent job titles for peer support workers across all services, and agree how partnership data (activity, outcomes, staff experience) is obtained; gather demographics of both workers and people who access them.
R5. **Shared DIALOG training.** Offer partner peer support agencies places on future DIALOG training for RDaSH new starters, to maintain consistent outcome measurement.
R6. **Enable EPR upload of peer-collected measures.** Complete the DIALOG implementation group task so outcome measures collected by non-RDaSH peers can be uploaded to the EPR.
R7. **Parity of workforce reporting.** Expand People and OD dashboards so peer support workers, as a professional group, are reported at the same level as nurses, medical staff and others.
R8. **Contractual reporting.** Ensure current and future peer support contracts include reporting on staff experience and turnover.
R9. **Approve the framework and dashboard.** Approve the direction of the three-part framework (Annex A), the outcomes dashboard (Annex B) and its easy-read version (Annex C).
R10. **Close the remaining gaps.** Integrate the staff questionnaire findings into the next version of this paper, extend quantitative reporting beyond the Peers on the Wards programme, and agree the reporting forum(s) for peer support workforce, activity, experience and clinical outcomes.

Annex A: Peer support framework logic model

Drawn from our learning with lived experience partners and local peers and from the NHS England (2023) peer support guide.

Inputs: what we invest

- Lived experience workforce (peer support workers, lived experience leads)
- Peer-specific training, induction, safeguarding and trauma-informed training
- Lived experience supervision and line management structure
- Funding and staffing establishment
- Clinical team support and MDT integration
- Policies: peer support framework, EDI, safeguarding
- Digital tools and workspace for peers
- Co-production capacity and time
- Partnerships with VCSE and community organisations

Activities: what the service does

- 1:1 peer support intervention
- Co-facilitating recovery and wellbeing groups
- Supporting goal setting and recovery planning
- Hope-based, strengths-based conversations
- Role-modelling recovery and self-management
- Support in community and inpatient settings
- Signposting to community resources and social inclusion
- Co-production of service improvements
- Engagement with families and carers where appropriate
- Training staff teams in lived experience approaches
- Collecting outcome measures and feedback

Outputs: measurable activity

- Number of individuals receiving peer support
- Number of peer support sessions delivered
- Number of groups co-facilitated
- Recovery stories / co-produced resources
- MDT meetings attended
- Care plans co-developed
- Co-production events/projects
- Staff teams trained in peer principles
- Recorded wellbeing/recovery measures completed

Short/medium-term changes: service users

- Increased hope, control and sense of recovery
- Improved confidence, self-efficacy and self-management
- Reduced loneliness and social isolation
- Increased engagement with care
- Faster transitions and reduced DNAs

Short/medium-term changes: staff and teams

- Improved team culture and recovery orientation
- Reduced stigma towards lived experience
- Improved communication between services
- Better relationships between service users and clinicians

Short/medium-term changes: peer workforce

- Increased job satisfaction
- Clearer role identity and development
- Reduced burnout through supportive supervision

Long-term impact

- Improved recovery outcomes
- Reduced use of crisis and urgent care pathways
- Better transitions from inpatient to community care
- Enhanced patient experience across services
- Increased community connection and independence
- Strengthened co-production culture
- Sustained lived experience leadership
- Contribution to NHS commitments for personalised care and workforce diversification

Assumptions: what must be true

- Peers receive high-quality training and supervision
- MDTs value and integrate peer roles
- Clear boundaries and safeguarding expectations
- Trust culture supports lived experience leadership
- Services commit to co-production and continuous improvement

External factors

- Workforce shortages and funding constraints
- Community (VCSE) resource availability
- National NHS policy (personalised care, trauma-informed approaches)
- Social determinants of health
- Digital access

*please note that many of the above outcomes are captured, but this is currently on a Microsoft BI format with manual data added. This has been designed by our business analyst in the Nursing and Facilities directorate. The analyst has advices it could be added to the clinical system, but as yet due to work load and priority lists, this cannot be done, which poses a challenge.

One solution put forward by the buidness analyst is for him to build this into the system. He has the skills of this, and it would be less burdensome and subject to error than the current manual system. It would however require a Trusted system access approach, in order for the BI analyst to complete this. This poses a challenge in terms of across directorate working and also Trusted jobcards.

Annex B: Draft outcomes dashboard

A structured dashboard for Trust-wide peer support activity, experience and DIALOG+ outcomes. The available Peers on the Wards data are presented in Annex H. The dashboard should be populated across all delivery models as consistent data become available; RAG ratings and trends (↑ / → / ↓) should then be completed.

Overview

Indicator	Target	Current	RAG	Trend
Number of patients supported this month				↑ / → / ↓
Total peer support contacts				↑ / → / ↓
Average contacts per service user				↑ / → / ↓
% of contacts completed face-to-face				↑ / → / ↓

Access and activity

Indicator	Target	Current	RAG	Trend
New referrals received				↑ / → / ↓
Referral-to-first-contact time (days)				↑ / → / ↓
Number on waiting list				↑ / → / ↓
DNA rate				↑ / → / ↓

Outcomes: recovery and wellbeing

Indicator	Target	Current	RAG	Trend
Average score change (DIALOG or ReQoL)				↑ / → / ↓
% reporting increased hope/confidence				↑ / → / ↓
Goal attainment (DIALOG suite)				↑ / → / ↓

Outcomes: use of services

Indicator	Target	Current	RAG	Trend
Crisis contacts for supported cohort				↑ / → / ↓
A&E attendances				↑ / → / ↓
Inpatient admissions				↑ / → / ↓
Average length of stay (if admitted)				↑ / → / ↓

Experience: patient and carer

Indicator	Target	Current	RAG	Trend
Friends & Family Test: % positive				↑ / → / ↓
Qualitative themes (summary)				↑ / → / ↓
Carer feedback				↑ / → / ↓

Experience: staff

Indicator	Target	Current	RAG	Trend
Staff feedback on peer integration				↑ / → / ↓
MDT satisfaction rating				↑ / → / ↓

Workforce

Indicator	Target	Current	RAG	Trend
Peer support workers in post				↑ / → / ↓
Vacancy rate				↑ / → / ↓
Retention rate				↑ / → / ↓
Mandatory training compliance				↑ / → / ↓

Quality and safety

Indicator	Target	Current	RAG	Trend
Incidents involving peer support				↑ / → / ↓
Complaints received				↑ / → / ↓
Safeguarding concerns raised				↑ / → / ↓
Fidelity to peer support model				↑ / → / ↓

Equality, diversity and inclusion

Indicator	Target	Current	RAG	Trend
Demographic representation of service users				↑ / → / ↓
Diversity of peer workforce				↑ / → / ↓
Equity of experience outcomes				↑ / → / ↓

Annex C: Easy-read dashboard

A quick-read version of the dashboard, designed with the accessibility learning from Annex E. Blank lines are for entering figures.

1. How many people we supported
People supported this month: _____
Total meetings or contacts: _____
Average contacts per person: _____
How many contacts were face-to-face: _____

2. Access to peer support
New people referred: _____
Waiting time for first contact (days): _____
People waiting: _____
Did Not Attend (DNA) rate: _____

3. Outcomes: how people feel
People feel better / more hopeful: _____
Wellbeing improved: _____
People reached their goals: _____
Crisis contacts reduced: _____
A&E visits reduced: _____
Hospital admissions reduced: _____
Average time in hospital (days): _____

4. Experience of the service
Friends and Family Test rating: _____
Care Opinion feedback (positive/negative): _____
Good feedback themes: _____
Team (MDT) satisfaction: _____

5. Peer support workforce
Number of peer support workers: _____
Vacancies: _____
Retention rate: _____
Training completed: _____
Supervision received: _____

6. Quality and safety
Incidents: _____
Complaints: _____
Safeguarding concerns: _____
Peer support model fidelity rating: _____

7. Equality and inclusion
Are different groups using the service?: _____
Is the workforce diverse?: _____
Good experiences for all groups?: _____

8. Actions
Main issue: _____
Action needed: _____
Owner: _____
Deadline: _____

Annex D: Cultural aspects of peer support

Cultural integration of lived experience and peer support is complex and takes time. These themes were raised by peer support workers, people with lived experience, and managers and staff consulted during the coproduction of this paper. They centre on power, identity, stigma, understanding, risk culture and readiness for change.

1. Power dynamics and professional identity
Services are traditionally hierarchical. Peer support challenges norms by treating lived experience as expertise. Some clinicians may feel peer roles undermine professional authority, or see 'experts by experience' as less valid than 'experts by education', with uncertainty about where peers fit.

Impact: role tension, resistance or exclusion from decision-making. Solutions: training about peer support; personal reflections/vlogs from those who trained traditionally; advising services on cultural change before introducing new roles.

2. Stigma and attitudes toward lived experience
Stigma around mental health, learning disability, substance misuse or past service use persists in parts of the workforce. Peers can face assumptions about reliability, concerns about risk, micro-aggressions or 'othering'.

Impact: peers feeling undervalued, unsafe or pressured to hide their lived experience. Solutions: learn from the journey so far; oversight and a 'grandparenting' model when new roles are introduced.

3. Role clarity and role confusion
Peer support is a distinct discipline, not a junior support role nor a therapy role. Without shared understanding, staff may expect peers to act like HCAs or clinicians, or misuse them for tasks outside their role.

Impact: dilution of the peer model and burnout. Solutions: monitoring of roles and outcomes; a senior peer support worker role; inclusion of peers in organisational workforce categories.

4. True co-production, not tokenism
Some teams risk introducing a peer worker to 'tick a box'. A sign is when team members do not know who the peer worker is or what they do.

Impact: peer support loses credibility and impact. Solutions: integration into induction for all staff; audit of MDT input.

5. Cultures focused on risk and control
Peer support emphasises mutuality, empowerment, choice, recovery and hope; NHS cultures often emphasise risk aversion, observation, compliance and crisis management.

Impact: peers may feel their values are incompatible with the dominant culture.

6. Workplace inclusion and psychological safety
Peers may need wellbeing adjustments, trauma-informed team cultures and flexible working patterns, which teams do not always provide consistently.
Impact: higher turnover and loss of experienced peers.

7. Professionalisation and identity tension
NVQs, competency frameworks, job descriptions and banding can pressure peers to conform to clinical norms and make peer work 'just another NHS role'. Impact: reduced distinctiveness of the peer support model.

Annex E: Meeting attendance and input

Attendance by lived experience, peer and governor representatives at board committees and CLE groups (source data as gathered for this paper).

Committees (governor attendance)

Committee	Total meetings	Number attended
Finance, Digital and Estates Committee (2 governors)	12	9
Mental Health Act Committee (1 governor)	6	6
People and OD Committee (2 governors)	12	10
Public Health, Patient Involvement and Partnerships Committee (2 governors)	12	5
Quality Committee (2 governors)	11	10

CLE groups (patient representative attendance)

Group	Total meetings	Number attended
Digital Transformation Group	6	4
Education and Learning Group	11	7
Equity and Inclusion Group	6	6
Estates and Sustainability Group	6	1
Finance Group	6	3
People and Teams Group	6*	1
Quality and Safety Group	6	5
Research and Innovation Group	6	5
Risk Management Group	12	5
Operational Management Group	10	7

**Deputy attended 4.*

Annex F: Methodology and contributors

Peer experience interviews

Interviews with peer support workers were conducted over two days at two sites, both pre-arranged. In Doncaster we met peer support workers at the People Focused Group for approximately 90 minutes as a group of 8 (one male, seven female). In Scunthorpe (Elizabeth Quarter) we met several smaller groups providing peer support across all RDaSH sites, spanning inpatient and community mental health and learning disability services.

Questions were asked by facilitators (Dr Jude Graham); and Rob Edwards (Nurse Consultant) rather than completed on paper, to generate discussion. A literature review was completed using CINAHL and EBSCOhost. Biographical factors (age, gender, diagnosis, inpatient experience, level of recovery) were discussed during the interviews. To maintain confidentiality, findings are presented collectively.

Governance representation interviews

Conducted through Q3 2025/26, face to face and via MS Teams, using an appreciative inquiry approach with peer support, lived experience and governor representatives, focused on three questions (working well / not working well / could do better). Results are presented collectively and not attributed to named individuals except where agreed.

Contributors and thanks

Specific thanks to those interviewed to contribute to the governance learning:

- Ian Spowart (lived experience of RDaSH services)
- Glyn Butcher (PFG Director)
- Kate Ryalls (Better You, Young People's VCSE Partner)
- Kelly Hicks (PFG, North Lincolnshire inpatient services)
- Sharon Pederson (PFG, North Lincolnshire inpatient services)
- Samantha Smith (S62, Rotherham inpatient services)
- Helen Ward (lived experience of RDaSH services and Grounded Research)
- Joy Bullivant (Staff Governor)
- Veterans who contributed over two engagement events

Annex G: Abbreviations and references

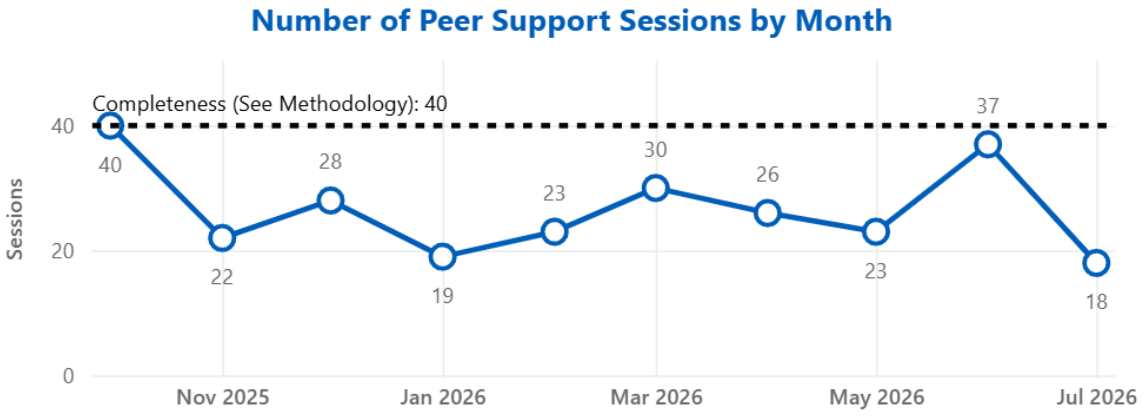
Abbreviations

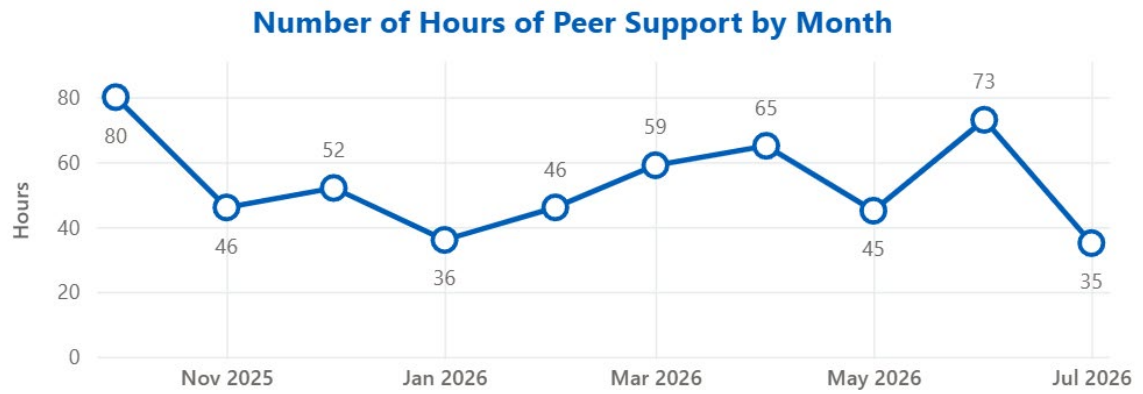
Abbreviation	Meaning
AHP	Allied Health Professional
CLE	Clinical Leadership Executive
CMHT	Community Mental Health Team
DNA	Did Not Attend
EDI	Equality, Diversity and Inclusion
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FFT	Friends and Family Test
HCA	Health Care Assistant
HQTC	High Quality Therapeutic Care (taskforce)
LHD	Learning Half Days
MDT	Multi-Disciplinary Team
OD	Organisational Development
PFG	People Focused Group
PIP	Personal Independence Payment
VCSE	Voluntary, Community and Social Enterprise
WHO	World Health Organization

Annex H: Peers on the Wards Data

Over the period of October 2025 to August 2026[1], 539 total hours of peer support have been recorded across 267 sessions. For the purposes of accurate session counts, a session is defined as *a continuous period of peer support provided by two or more peer support workers over a single day on the same ward*. Peer ward activity is displayed in the charts below.

On ten occasions, peers reported that they were unable to attend their scheduled sessions – for all these occasions, the reason related to conditions on the ward which clinical staff judged to involve too much risk for patients and peer support workers. For instance, a patient with suspected COVID-19 and a patient experiencing severe distress.





The dashed line in the first chart indicates the cumulative expected hours, as set out in the service specification visit schedule for the peers on the wards program. The completeness of this data can be estimated from this expectation, but it should be noted that this is **not** a direct measure of engagement, as this would require perfect engagement with the ward survey instrument which is unlikely for any survey instrument.

Dividing the actual number of sessions by the number of expected sessions indicates that for the period October 2025 to June 2026, the average monthly form completion

[1] Data extracted on 04/08/26

proportion was 68.9%[2]. Considering the length of the data collection tool and the detail required, this is an exceptionally high level of engagement which has been consistently maintained, demonstrating the dedication and tenacity of peer support workers.

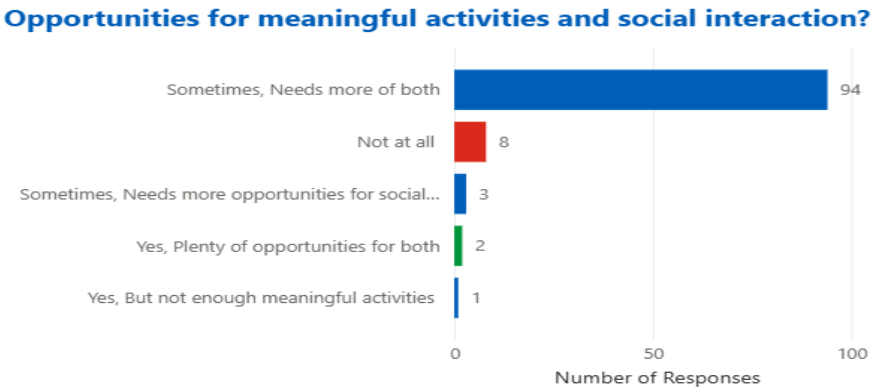
Total sessions and hours are stratified by care group in the following table:

Care Group	Recorded Hours	Recorded Sessions
Doncaster	295	150
Rotherham	179	91
North Lincolnshire	65	26

Compliments and Concerns
Across the period, a total of 86 compliments and 58 concerns were registered by peer support workers. From analysis of the qualitative data, peer feedback was highly sensitive to the conditions of the ward on the day of the visit. Most concerns relate to lack of activity and patient interaction with staff.

It is generally agreed that opportunities for meaningful activity and social interaction do exist, but these should be more frequent[3]. In a minority of cases (7.4%), peer support workers reported 'Not at all' to the question 'Are there opportunities for meaningful activities and social interaction?'.

Paradoxically, the most common compliment was that staff members were engaging with patients and activities were available. These likely relate to staffing considerations and patient acuity on the day of the visit, but this would require further analysis and triangulation with other data sources.



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ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	CQC Readiness, Safe Caring Effective and Responsive	**Agenda Item**	Paper Q
Sponsoring Executive	Steve Forsyth, Chief Nurse		
Report Author	Steve Forsyth, Chief Nurse Roshanne Bottomley, Backbone Nurse Director		
Meeting	Board of Directors	**Date**	24 September 2026

Suggested discussion points
The Board should discuss whether the Chief Nurse's proposed evidence-position judgement of **reasonable, but not comprehensive** is supported by the September 2026 refresh, recognising that the internal position is predominantly Good but includes material deterioration, persistent gaps and uneven evidence strength. Discussion should test the validity of reported improvement and stability, particularly whether judgements are supported by current, retrievable and triangulated evidence rather than self-assessment alone. The Board should consider the Danescourt discrepancy between the internally Good position presented at the 30 April evidence-review timeout and the subsequent CQC Requires Improvement judgement, including the implications for medicines, consent/MCA, safe care and treatment, governance, evidence reliability and action closure.
Previous consideration
CQC Readiness Group; Public Board in May 2025, July 2025 and Jan 2026; the dedicated Board development session on 30 April 2026
Recommendation
The Board is asked to:
NOTE the longitudinal development of the CQC readiness programme and the September 2026 internal position.
RECOGNISE the improvement and sustained performance demonstrated across a number of services alongside the deterioration and persistent gaps identified through the September reassessment.
REQUIRE areas remaining below the expected threshold, together with evidence of the impact of recovery actions, to be reported through Quality Committee and returned to the Board during Q4 2026/27.

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

Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	

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

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	
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.	
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.	X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	

System / Place relevance							
N/A							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix
Appendix 1 – Longitudinal Board confidence journey **Appendix 2 – Material deterioration, mitigation and residual evidence** **Appendix 3 – Programme controls for Q3–Q4 2026/27** **Appendix 4 – Evidence base used for this revised paper**

1. Purpose, proposed evidence-position judgement and Board decisions

1.1 This paper provides the Board with the Chief Nurse's updated assessment of RDaSH readiness against the CQC Safe, Effective, Caring and Responsive domains, identifies material movement and exceptions, and seeks agreement to the strengthened evidence and challenge standard.

1.2 The formal internal baseline is May 2025; January 2026 was a targeted reassessment; the 30 April 2026 Board timeout reviewed evidence libraries; and September 2026 is the current full refresh across 14 clinical directorates. Published CQC ratings remain the external comparator and are not replaced by this internal assessment.

Proposed Chief Nurse evidence-position judgement
Reasonable, but not comprehensive. The programme is established and records improvement and deterioration, but material exceptions and validation gaps remain. The comprehensive threshold is not met because independent testing, community peer review, improvement-plan controls and evidence reliability are not yet consistently embedded.

1.3 A reasonable evidence position supports the broad direction of the assessment while recognising material exceptions. A comprehensive position would require consistent triangulation, reliable retrieval, peer or independent testing and sustained evidence of closure.

1.4 Since the May 2025 baseline, RDaSH has moved from establishing a common method to a more repeatable and increasingly candid readiness programme. The September 2026 internal return is predominantly Good, with Caring the strongest domain. The trajectory is not uniform: some services have improved, some remain stable and others have reduced assessments as evidence or operating conditions have changed.

2. Baseline, comparators and longitudinal assessment

2.1 The May 2025 standardised self-assessment is the formal internal baseline. Earlier activity in 2024 and early 2025 established the programme context but should not be represented as a comparable four-domain baseline.

2.2 The January 2026 reassessment was targeted at statements previously assessed internally as Requires Improvement or Inadequate. It reported a consolidated Good internal position across all four domains, while residual Requires Improvement assessments remained within individual directorates and quality statements.

2.3 The September 2026 refresh is the current assessment point. It is broader than January, covers 14 directorates, and records movement in both directions. Comparison should therefore consider scope as well as rating movement; High Dependency Rehabilitation has no previous internal comparator.

Assessment point	Purpose and scope	How it informs the Chief Nurse judgement
May 2025	First standardised four-domain directorate self-assessment.	Formal internal baseline for direction of travel.
January 2026	Targeted reassessment of previous RI/Inadequate statements.	Tests reported improvement, but is narrower than the September refresh.
30 April 2026	Board scrutiny of evidence libraries; not a new rating exercise.	Tests articulation and evidence presence; Danescourt shows the need for deeper reliability and retrievability testing.

Assessment point	Purpose and scope	How it informs the Chief Nurse judgement
September 2026	Full refresh across 14 directorates, including first HDR assessment.	Current internal readiness position and movement against prior assessments.
Published CQC position	External regulatory ratings and service-specific assessments.	External comparator; does not automatically validate or invalidate internal judgements.

3. Current position: improvement, deterioration and stability

3.1 The internal position remains predominantly Good, but the strength of evidence is uneven. Improvement and stability coexist with material deterioration, and an unchanged assessment does not raise the evidence threshold where a known gap persists.

Position	Evidence in September 2026	Threshold interpretation
Improved	Rotherham reports ten improved quality statements; North Lincolnshire reports 12 improved statements; Doncaster reports nine improvements; Neurodiversity is internally Good across all areas; Children's Physical Health reports improvement.	Positive movement requires evidence sampling and sustainability testing; counts describe direction, not validation.
Deteriorated	Doncaster reports 12 declining statements and North Lincolnshire ten. Reductions also concern consent in Rotherham community and medicines/consent in North Lincolnshire community.	Each reduction remains below threshold until mitigation produces measurable and sustained recovery.
Stable	Physical Health remains internally Good across all areas; both Children's directorates remain Good overall; CAMHS reports no movement; Caring remains strongest.	Stability meets the threshold only where persistent documentation, outcomes, MCA/consent, PSIRF and validation gaps are also controlled.
First assessment	High Dependency Rehabilitation reports Good across all four domains, with Caring strengths.	This is a baseline, not longitudinal improvement, and remains subject to validation.

4 Danescourt: evidence gap, learning and current position

4.1 The April-to-May discrepancy

4.1.1 Danescourt sits within the Learning Disability and Forensic directorate. The directorate position presented around the 30 April 2026 Board evidence-review timeout was internally assessed as Good. The available evidence at that point included the directorate self-assessment, evidence-library material, governance and audit evidence, and the ability of colleagues sampled by internal audit to describe their position and supporting evidence. The source material reviewed does not provide a separate Danescourt-only score awarded by the Board; the relevant comparison is therefore the internally Good directorate/service position presented at the timeout against the subsequent service-specific CQC judgement.

4.1.2 CQC visited Danescourt on 5 and 13 May 2026 as part of a comprehensive assessment conducted from 5 to 21 May. The final outcome was Requires Improvement overall: Safe and

Well-led were Requires Improvement; Effective, Caring and Responsive were Good. CQC identified three breaches relating to consent, safe care and treatment and good governance.

4.2 What the April process did not test sufficiently

4.2.1 The central learning is that positive lived experience and the presence of evidence do not alone demonstrate reliable systems. CQC identified inconsistent care and risk records; gaps in MCA, best-interest, consent and DoLS information; incomplete medicines controls; environmental and equipment-check weaknesses; and governance that had not consistently identified and closed corrective action.

4.2.2 Later evidence or remedial action did not alter whether systems were effective at the point of assessment. The revised standard therefore tests current records, lawful decisions, staff understanding, delivery in practice, exceptions, corrective action, re-audit and governance closure in real time.

Evidence question	April/previous emphasis	Revised evidence standard
Does evidence exist?	Evidence library and reported governance material.	Evidence must be current, indexed, attributable and retrievable promptly at the point of care.
Is care experienced positively?	Patient experience and staff knowledge supported a Good narrative.	Retain lived-experience evidence, but test it alongside records, legal compliance, outcomes and safety controls.
Are systems embedded?	Policies, audits and action descriptions could be accepted as evidence of process.	Sample actual practice, test staff retrieval and understanding, identify exceptions and require re-audit.
Can a Good judgement be challenged?	Board and management challenge, but limited service-level disconfirmation.	Actively seek contradictory evidence through record tracing, direct observation, incidents, medicines, MCA/DoLS, complaints, staffing and external findings.
Can actions close?	Activity completion could dominate.	Closure requires defined evidence, owner sign-off, audit/re-audit, sustained compliance and governance approval.

4.3 Changes already made or formally incorporated into the Danescourt plan

4.3.1 Position at 11 September 2026

Progress is material but incomplete. Medicines review and reconciliation, consent/MCA and best-interest evidence, care-record validation, dashboard and risk controls, evidence retrieval and sustained peer review remain open or require validation. The regulatory position is summarised below.

Regulatory area	11 September position	Chief Nurse threshold view
Regulation 11 - Consent	Amber. Tracker/visibility improved; decision-specific MCA, best-interest, retrieval and competence evidence incomplete.	Threshold partly met; complete records, staff retrieval/understanding and sustained audit are still required.

Regulatory area	11 September position	Chief Nurse threshold view
Regulation 12 - Safe care and treatment	Amber. Environmental, incident and some care controls improved; medicines and care-record validation remain incomplete.	Threshold partly met; pharmacy work, cross-audit and re-audit are required.
Regulation 17 - Good governance	Amber/Red. Dashboard, indexed evidence library, risk controls and sustained closure evidence are not yet complete.	Main residual concern. The comprehensive threshold is not met until actions can be retrieved, tested, re-audited and governed to closure.

4.4 Counter-factual challenge: how it works now and what must strengthen

Counter-factual challenge means testing the proposition “this service is Good” by deliberately seeking evidence that could disprove, qualify or date-limit that judgement. It is stronger than asking whether supporting evidence exists; it asks what contrary evidence is available, what has not been sampled and whether the conclusion survives that test.

4.5 Current challenge mechanisms

Mechanism	How it tests the judgement	Current maturity
Directorate reassessment	Directorates reassess quality statements and may reduce prior judgements. September records movement in both directions.	Operating, but remains self-assessment.
Board evidence-review timeout	On 30 April 2026 the Board scrutinised evidence libraries and questioned the basis for judgements.	Operating; Danescourt shows that evidence presence and articulation need deeper practice testing.
Care-group delivery reviews	Chief Executive questions ask what persuades a service that previous RI areas are now Good and what state the evidence library is in. Outcome letters document challenge.	Operating, but improvement plans were not consistently presented for detailed oversight.
CQC readiness meeting/check and challenge	Cross-directorate discussion considers consistency and other data, including RADAR incidents/risks, Care Opinion and performance.	Operating; internal audit found no specific centrally coordinated validation.
Peer review	Inpatient peer reviews and developing community reviews use multidisciplinary challenge and action follow-up.	Inpatient process established; community rollout incomplete against earlier timetable.
Audit and operational triangulation	Audit, incidents, risks, complaints, patient voice, staffing, sickness, waits, outcomes and direct observation can qualify the self-assessment.	Available but not yet applied with a consistent minimum evidence standard to every Good judgement.

Mechanism	How it tests the judgement	Current maturity
External findings	CQC assessments, factual-accuracy outcomes and other external reviews provide disconfirming evidence.	Operating; Danescourt must be treated as programme learning, not a service-specific exception.
Recovery plans and governance	Deteriorated areas should have measurable plans, owners, evidence, escalation and reassessment.	Not consistently embedded; identified by internal audit as a control gap.

5 Chief Nurse judgement on sufficiency

The minimum challenge standard is to define the judgement and threshold; identify contradictory evidence; use reviewer-selected records and observations; triangulate with relevant patient, workforce, safety, outcome and legal evidence; test staff knowledge and retrieval; record exceptions and residual risk; and require re-audit or peer/independent validation before material risks are closed.

Counter-factual question to accompany every Good judgement
What evidence would show that this judgement is wrong, incomplete or no longer current - and have we actively looked for it?

5.1 Domain-level Chief Nurse proposed evidence position

Domain	Longitudinal and external position	Current strengths	Threshold gaps	Proposed evidence position
Safe	Published Trust-wide rating remains RI. Internal improvement since baseline is offset by September service-level volatility.	Environmental and risk-management improvements in selected services; improved Neurodiversity escalation; Rotherham pathway technology.	Staffing/sickness, safeguarding, acute pathways, medicines, falls/records, ligature and training.	PARTIAL. Strong local improvement exists, but Safe is least consistent and targeted areas remain below the validation threshold.
Effective	Published Trust-wide rating remains RI. Internal position is predominantly Good, with mixed movement in outcomes and consent.	Partnership/virtual-ward working; LD/Forensic transformation; Children's multidisciplinary working; SMI physical health.	DIALOG+/paired outcomes, consent/MCA, inter-team working, supervision and demonstrated outcomes.	MODERATE BUT VARIABLE. Majority internal position meets threshold; material exceptions remain.
Caring	Published Trust-wide rating is Good. Internal	Patient involvement, Doncaster community	Workforce wellbeing and inconsistent feedback	STRONGER

Domain	Longitudinal and external position	Current strengths	Threshold gaps	Proposed evidence position
	position is strongest and most stable.	Caring strengths, HDR independence/choice and positive feedback.	evidence in some areas.	RELATIVE EVIDENCE POSITION, subject to triangulation and sustainability under pressure.
Responsive	Published Trust-wide rating is Good. Internal movement is mixed.	Rotherham integration/information; Children's response/access; selected person-centred improvements.	Waiting times, ward-crisis-discharge interfaces, continuity, older-adult access and equity.	MODERATE. Gaps in access, equity and continuity require recovery evidence.

5.2 Care-group position and required focus

Care group	Improved	Deteriorated / pressure	Unchanged / evidence position	Priority next step
Rotherham AMH	Ten statements improved: acute pathways, records, consent and Responsive; stronger community staffing oversight.	Community consent reduced; ligature, restrictive practice, safeguarding, MCA and PSIRF remain.	HDR first assessment Good with Caring strengths.	Validate through evidence/peer review; re-audit consent/MCA; track ligature actions.
Doncaster MH, LD & Forensic	Nine improved: estates safety, person-centred care, community outcomes, Caring strengths, transitions and evidence-based care.	Twelve declined: vacancies/sickness, ward-crisis links, discharge, DIALOG+, safeguarding, waits and equity. Danescourt adds service-specific regulatory learning.	Mixed rather than uniformly deteriorating.	One measurable recovery approach; apply Danescourt evidence standard across the care group.
North Lincolnshire AMH & TT	Twelve improved: acute Effective/Caring/Responsive, community risk/environment/access, TT risk/environment.	Ten declined: acute Safe, community medicines/consent, TT staffing, safeguarding, waits and older-adult access.	Greatest movement in both directions.	Stabilise workforce and safeguarding; medicines/MCA re-audit; targeted access/continuity review.
Children's	Physical Health improved	Post-diagnostic caseloads, risk/safety	Both directorates Good overall;	Test caseload, risk and outcome

Care group	Improved	Deteriorated / pressure	Unchanged / evidence position	Priority next step
	collaboration, immediate response and access.	plans, outcomes, inequalities and PSIRF require work.	CAMHS unchanged.	evidence through peer review and triangulation.
Physical Health & Neurodiversity	Neurodiversity improved to Good with stronger risk escalation, waiting-list communication and learning.	MCA, PSIRF, pathways, system interfaces and Always Measures remain development areas.	Physical Health Good across all areas with maturing evidence libraries.	Community peer review; strengthen outcome, equity and lived-experience evidence.

6 Interpreting fluctuation, recovery and next steps

6.1 During Q3 2026/27 the programme will reconcile the September matrix, narrative, evidence libraries and recovery plans into one source of truth; apply the revised counter-factual standard; prioritise workforce-sensitive acute services, Talking Therapies, medicines, consent/MCA, safeguarding, pathways and Danescourt; and complete targeted peer review and validation. The sequenced controls are set out in Appendix 3, Table A3.1.

6.2 Every deteriorated or internally Requires Improvement statement will require a measure, baseline, milestone, accountable owner, due date, evidence source, residual risk and reassessment date. Closure will require evidence of implementation and impact, not activity completion alone.

6.3 Unresolved exceptions and evidence of impact will be reported during Q4 2026/27. Royal College accreditation will proceed through a readiness gateway; subject to evidence readiness and College availability, RDaSH intends to seek peer-review dates in early 2027. The longitudinal chronology, material deterioration and source evidence are set out in Appendix 1, Table A1.1; Appendix 2, Table A2.1; and Appendix 4, Table A4.1.

7 Conclusion

The Board is invited to note the reasonable, but not comprehensive, evidence position; recognise the material exceptions and Danescourt programme learning described in this paper; and endorse the strengthened evidence, recovery and counter-factual challenge standards for Q3-Q4 2026/27.

Appendix 1: Longitudinal evidence journey

Table A1.1: Longitudinal evidence journey
Supports the "Baseline, comparators and longitudinal assessment" section.

Date / period	Assessment stage	What changed	Evidence significance
2024	Regulatory transition	Transition to quality statements; no separate comparable four-domain public Board baseline identified.	Preparatory context; do not overstate as formal baseline.
January 2025	Programme re-established	Readiness forum re-established amid variable evidence strength and evidence-library maturity.	Need for common method, evidence development and community peer review.
May 2025	Initial four-domain self-assessment	All directorates completed standardised assessment; Board reviewed consolidated position.	Formal internal comparison baseline.
July 2025	Programme update	Evidence libraries, community peer review and standard delivery plans described.	Commitments later tested by internal audit; slippage/inconsistency identified.
6-7 May 2025; report dated 30 July and published December 2025	External focused assessment	Acute wards for working-age adults and PICU.	External findings remain distinct; no new Trust-wide rating.
November 2025	Separate Well-led update	Programme paper outside four-domain audit scope.	Extends Board oversight but is not a four-domain self-assessment point.
January 2026	Targeted reassessment	Previous RI/Inadequate statements revisited; consolidated internal Good with residual exceptions.	Tests reported improvement and sustainability.
30 April 2026	Board timeout	Evidence libraries scrutinised; internal audit observed.	Direct challenge, but Danescourt shows need for deeper reliability testing.
5-21 May 2026	Danescourt CQC assessment	Danescourt moved from Good to RI overall; Safe/Well-led RI; three breaches.	Material disconfirming evidence and programme learning.
August-September 2026	Full refresh	All 14 clinical directorates refreshed; HDR first assessment; movement both directions.	Current position; broader and more candid but still requires validation.

Appendix 2: Material deterioration, mitigation and residual evidence

Table A2.1: Material deterioration, mitigation and residual evidence
Supports the "Current position" and "Care-group position and required focus" sections.

What deteriorated	Reported reason	Mitigation underway	Evidence required before the threshold changes
Safe/effective staffing - Doncaster and North Lincolnshire/Talking Therapies	Vacancies, recruitment and short-/long-term sickness affecting deployable capacity and continuity.	Recruitment, induction review, staffing protocol, daily management and escalation.	Sustained fill, reduced sickness impact, safe skill mix, supervision, activity and outcomes.
Acute pathways, transitions and discharge	Weak ward-crisis-community interfaces and clinically ready for discharge processes.	Clinical leads, discharge review, virtual-ward and partnership working.	Delayed discharge, readmission, continuity, patient/carer experience and cross-service action closure.
Safeguarding and supervision	Compliance, learning needs and workforce pressure.	Targeted compliance, supervision focus, safeguarding capacity and learning.	Quality/application evidence, case triangulation and service-level re-audit.
Outcomes and DIALOG+	Inconsistent embedding and paired outcomes.	Training, local implementation and monitoring.	Eligible cohort completion, paired outcomes, quality audit and patient voice.
Medicines optimisation	Errors/process variation in North Lincolnshire community; Danescourt medicines actions incomplete.	Refresher work and pharmacy support; Danescourt review scheduled.	Competency, incident trend, audit/re-audit and sustained improvement.
Consent and MCA	Reduced assessments and continuing variation; Danescourt retrieval/best-interest gaps.	Always Measures, audit, champions, training and Danescourt tracker/retrieval controls.	Recording quality, decision-specific assessment, best-interest records, staff understanding and re-audit.
Access, waits and equity	Community waits, older-adult access and affected communities.	Capacity/demand review, engagement, pathway work and mutual aid.	Longest-waiter/harm review, outcomes/equality analysis, affected-community evidence and sustained trajectory.
Evidence and improvement-plan controls	Community peer reviews incomplete; standard plans inconsistent; Danescourt evidence reliability gap.	Revised reviews, RADAR, evidence-library strengthening and new closure standard.	Completed reviews, measurable plans, retrieval tests, action closure and independent sample validation.

Appendix 3: Programme controls for Q3–Q4 2026/27

Table A3.1: Programme controls for Q3–Q4 2026/27
Supports the "Interpreting fluctuation, recovery and next steps" section.

Step	Control	Expected evidence
A3.1.1	Confirm one source of truth	Reconciled September matrix, narrative, evidence library and recovery plans; no blank or inconsistent rating cells.
A3.1.2	Apply evidence-status label	Each judgement states whether it is self-assessed, triangulated, peer-reviewed or independently validated.
A3.1.3	Standardise recovery plans	Measure, baseline, owner, milestone, due date, evidence, residual risk and reassessment date.
A3.1.4	Apply counter-factual challenge	Reviewer-selected samples, contrary data, staff questions, direct observation and documented exceptions.
A3.1.5	Prioritise validation	Workforce-sensitive acute services, Talking Therapies, medicines, MCA/consent, safeguarding, pathways and Danescourt.
A3.1.6	Strengthen closure	Implementation evidence, audit, exception management, remedial action, re-audit and governance sign-off.
A3.1.7	Report exceptions	Quality Committee receives exceptions; Board receives Q4 longitudinal update and validation results.
A3.1.8	Embed routine readiness	CQC readiness remains within Quality and Safety Plan and is improvement-led, not inspection-led.

Appendix 4: Evidence base used for this revised paper

Table A4.1: Evidence base used for this revised paper

Lists the evidence sources used across the report and Appendices 1–3.

Evidence category	Source	Use in this paper
Master paper	board sept 26 CQC Ax sf version.docx	Preserved longitudinal, domain, care-group, deterioration and programme-control content.
Current self-assessment	CQC Readiness Paper.docx and September 2026 readiness drafts	Current movement across 14 directorates and external/internal distinction.
Internal audit	RDaSH CQC readiness draft report v1.0 - 360 Assurance	Board scrutiny, delivery-review challenge, lack of centrally coordinated validation, incomplete community peer review and inconsistent improvement plans.
January comparison	CQC Readiness January 2026 Board paper	Targeted reassessment and residual RI position.
Danescourt external findings	Danescourt CQC assessment, assessment summary and factual-accuracy material	Rating, domain outcomes, breaches, strengths, evidence-access and governance findings.
Danescourt recovery	Danescourt CQC Action Plan 25.08.26 and assurance review	Actions, RAG logic, evidence, audit/re-audit, escalation, closure and 11 September status.
Current Danescourt	Rachael Deakin update of 11	Current progress, outstanding

Evidence category	Source	Use in this paper
update	September; Chief Nurse updates to Philip Gowland and Toby Lewis	medicines/MCA/care/governance work and pharmacy meeting scheduled for 15 September.
Board/management challenge	Board timeout, care-group delivery-review and CQC readiness material	Current counter-factual mechanisms and their limitations.

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 24 September 2026

Item 21 – Patient Story

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Secondary Waits: Progress Update and Improvement Programme	**Agenda Item**	Paper R
Sponsoring Executive	Richard Chillery, Chief Operating Officer		
Report Author	Victoria Takel, Deputy Chief Operating Officer		
Meeting	Board of Directors	**Date**	24 September 2026

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

The Board should the focus on the current secondary waits position, including that 40% of identified pathways are currently reported as achieving a maximum wait of 14 weeks, the limitations in pathway-level reporting in several services, and whether the revised reporting and improvement programme provides sufficient assurance that the Trust can achieve a maximum secondary wait of 14 weeks by June 2027.

There is a need for focus over coming weeks to achieve. This includes work across Care Groups, the Performance Team and Health Informatics, including completion of the remaining demand and supply reviews by 16 October 2026, the early November productivity workshop, and completion of the Informatics development, QSIA and EIA work by 30 November 2026. To consider whether there is sufficient organisational focus, capacity and engagement to deliver these milestones within the associated timescales.

Previous consideration

Board March 2026.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECOGNISE the potential to deliver real change in 2027 on secondary waits

ACKNOWLEDGE we are running a little behind programme with data flows and reporting

NOTE the intention to focus over the coming 8-10 weeks on finalising information and alignment

NOTE that the majority of shortened waits will come from revised job plans and throughput

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

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	

Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
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Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X
Strategic Delivery Risks (indicate those that this paper supports)			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X

If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	**X**
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.	
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.	
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	**X**

System / Place relevance (advise whether it is national, regional or local)							
National, regional and local relevance. The programme responds to national waiting-time requirements and supports Trust-wide pathway improvement across local Care Groups and services.							
Equality Impact Assessment	Is this required?	Y	**X**	N		If 'Y' date completed	Due 30 November 2026
Quality Impact Assessment	Is this required?	Y	**X**	N		If 'Y' date completed	Due 30 November 2026

Appendix (please list)
Appendix 1: Breakdown of secondary waiting lists and longest waits (current visibility).

RDaSH Board of Directors – Secondary Waits: Progress Update and Improvement Programme, September 2026

1. Introduction

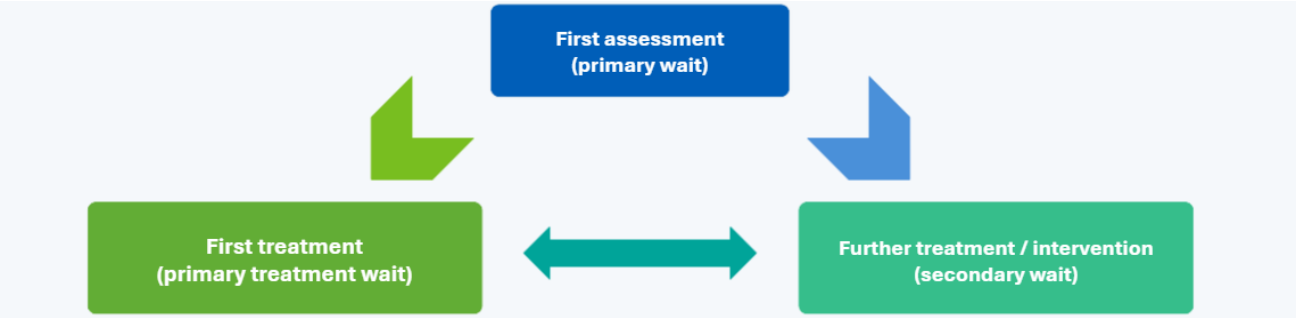
1.1 The Board has previously received updates on the Trust's waiting list improvement programme and the delivery of Promise 14, with the most recent paper being delivered in March 2026. Whilst significant organisational effort throughout 2025/26 was appropriately focused on eliminating extended referral-to-meaningful assessment, and primary intervention waits, thus achieving compliance with the four-week standard, it has always been recognised that a broader and more comprehensive understanding of patient waiting times requires visibility of delays throughout the entire patient pathway, including those pathways previously identified in the March 2026 paper as 'secondary waits'.

1.2 Secondary waits have rightly remained an important area of focus for the Trust. These waits occur after a patient has entered a service and are often associated with progression through assessment, diagnosis, treatment, intervention or review pathways. Whilst some secondary waits reflect clinically appropriate periods of observation or treatment planning, others may indicate capacity constraints, pathway inefficiencies or variation in service delivery.

1.3 This paper provides an update on progress towards establishing a robust framework for the identification, monitoring, management, and active improvement of secondary waits across the Trust. It outlines the current position – visible in Appendix 1 -, the challenges encountered in developing the required reporting infrastructure, and the planned programme of work to enable pathway-level analysis and improvement during the remainder of 2026/27.

2 Current Position

2.1 Pathway mapping work across all Care Groups has been completed, and the definitive list of secondary waits across the Trust has been agreed. This definitive list has previously been presented to the Board of Directors in March 2026. No changes have been made to this list post presentation. This work has provided clarity regarding the key stages within patient pathways where waiting times may occur and has established the foundation for a systematic approach to monitoring and in some areas, the significant improvement that is required. This is in line with the definition and the below diagram approved at CLE in August 2025, with only specific treatments pathways falling into the secondary wait cohort.



2.2 Appendix 1 contains a breakdown of current performance on secondary wait pathways in all areas, with 40% currently achieving a maximum wait of 14 weeks. The secondary wait pathways are unable to be broken down fully in Rotherham Mental Health and North Lincolnshire and Talking Therapies Care Groups due to reports not being fully developed. These pathways are currently present in the table but demonstrated underneath the overarching team name.

2.3 Since this work was presented to the Board in March 2026, progress in developing secondary wait reporting has been slower than originally anticipated. This has primarily been due to competing organisational priorities within the Health Informatics and Performance Teams. During the first half of 2026/27, significant analytical and reporting resource was necessarily redirected to support implementation of the national 104-week waiting time metric and development of the Integrated Quality and Performance Report (IQPR). Both programmes represented mandatory organisational priorities and required substantial informatics capacity.

2.4 These priorities have settled but are ongoing, alongside implementation of the Trustwide introduction of AVT and associated reports, which continue to impact the amount of resource available within Informatics to deliver the move to referral allocation and the development of the secondary wait reporting infrastructure.

2.5 A revised delivery plan is now in place, with the required informatics developments expected to be completed by the end of November 2026.

3 Reporting and Data Maturity

3.1 Current reporting provides a Trust-wide overview of secondary waits, although pathway-stage visibility remains under development in several services.

3.2 At present, Trust-wide waiting list data can identify overall secondary waits within services; and local visibility can be achieved, however, in most areas it cannot yet be consistently segmented into individual pathway stages at a central level. This limits the ability to fully understand where delays occur and whether those delays relate to assessment, intervention, treatment, review or transfer between different elements of a pathway. The exceptions to this are Talking Therapies and Doncaster Mental Health and Learning Disability services, where pathway-level reporting capability is more advanced and currently provides greater visibility of secondary waits. This, however, does require a substantial amount of manual oversight.

3.3 The revised informatics development plan, to ensure all services are moved to referral allocation, and reports are built at pathway level, is now scheduled for completion by 30th November 2026. This will enable improved recording and extraction of pathway-stage data from SystmOne and provide a more accurate and consistent view of patient journeys. Following completion, a six-week validation and bedding-in period will take place during December 2026 and January 2027 to test data completeness, consistency and usability before pathway baselines are

confirmed. Until then, Appendix 1 should be treated as the best available overview rather than a definitive pathway-stage analysis.

4 Demand and Supply Review

4.1 In tandem with the informatics development programme, the Performance Team, alongside colleagues in Care Groups, have commenced a detailed review of demand and capacity across all services with identified secondary waits. This work examines:

- Current demand levels and referral patterns.
- Available clinical and non-clinical capacity.
- Activity and productivity levels.
- Variations between localities and teams.
- Pathway bottlenecks contributing to delays.
- Opportunities for pathway redesign and service optimisation.

4.2 Demand and supply reviews have now been completed for Doncaster Mental Health and Learning Disabilities Care Group and Talking Therapies step 3 treatments. These reviews did not identify a requirement for additional investment, indicating that improvement can be achieved within existing resources through productivity improvement, pathway optimisation and more consistent use of available clinical capacity. This conclusion will continue to be monitored as actions are implemented and waiting-time performance changes. The North Lincolnshire and Talking Therapies Care Group Director of Psychological Professionals is also confident that the remaining Care Group pathways can achieve the required improvement through productivity. In addition, the secondary wait pathway within Wheelchair Services and two Older Adult pathways within Rotherham Adult Mental Health Care Group have already evidenced their ability to achieve a maximum wait of 14 weeks without further investment.

4.3 A workshop is being scheduled for early November with the Care Group Senior Leadership Teams, the Chief Executive, the Chief Operating Officer and the Deputy Chief Operating Officer. The workshop will develop a plan to supportively enhance productivity within teams, including consideration of activity or work that can be ceased or reallocated. A Quality and Safety Impact Assessment (QSIA) and Equality Impact Assessment (EIA) will be completed for all pathways by the end of November 2026.

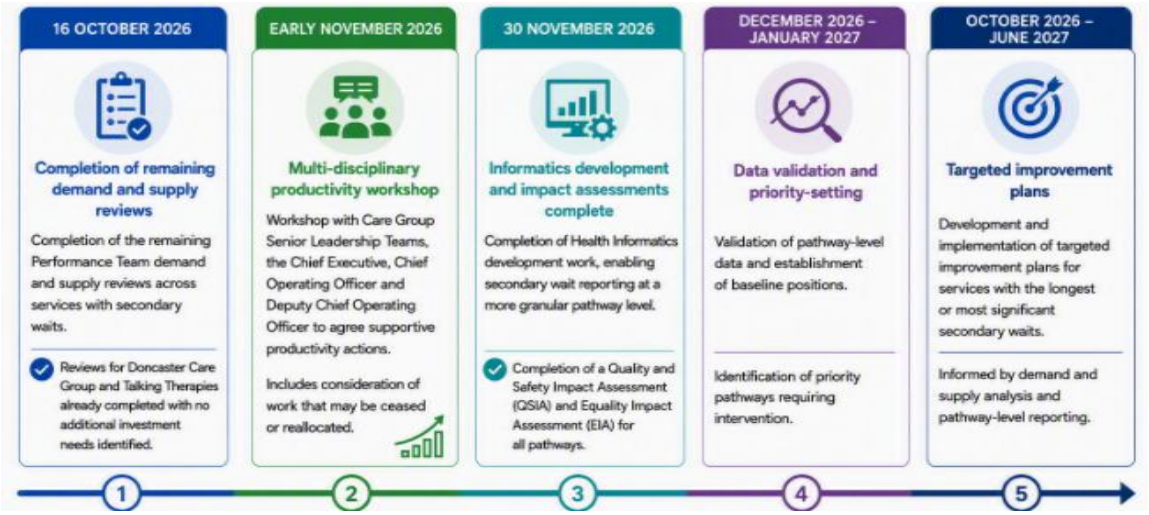
4.4 The remaining deep-dive demand and supply reviews across services are scheduled for completion by 16th October 2026, after which a prioritised improvement plan will be developed. The plan will build on the completed reviews for Doncaster Mental Health and Learning Disabilities Care Group and Talking Therapies and will rely heavily on improved productivity within services, including revisiting established pathways and job plans where required. Services that are evidenced as unable to

achieve the necessary improvements through productivity measures alone will retain the opportunity to submit a bid to the Trust Investment Fund.

5 Next Steps

5.1 The next phase of the programme will focus on moving from identification to improvement. In areas where the demand and supply analysis are already completed, this work has commenced but requires further refinement and consistency of application across all Trust pathways to ensure achievement of a maximum wait of 14 weeks across the Trust.

5.2 The key milestones are:



- 16th October 2026 - Completion of the remaining demand and supply reviews across services with secondary waits, with reviews for Doncaster Mental Health and Learning Disabilities Care Group and Talking Therapies already completed and no additional investment needs identified to date.
- Early November 2026 – A multi-disciplinary productivity workshop is being scheduled with Care Group Senior Leadership Teams, the Chief Executive, Chief Operating Officer and Deputy Chief Operating Officer to agree supportive productivity actions, including work that may be ceased or reallocated to allow for clinicians to dedicate more time to patient facing activities.
- 30th November 2026 - Completion of Health Informatics development work, enabling secondary wait reporting at a more granular pathway level, and completion of a QSIA and EIA for all pathways.
- December 2026 to January 2027 - Validation of pathway-level data, establishment of baseline positions and identification of priority pathways requiring intervention.
- October 2026 to June 2027 - Development and implementation of targeted improvement plans for services with the longest or most significant secondary waits, informed by demand and supply analysis and pathway-level reporting.
- Governance arrangements will continue through existing Care Group and Trust-wide performance structures, with regular reporting to Clinical Leadership Executive and Board committees as appropriate.

6 Patient, Quality and Equality Impact

6.1 The purpose of the programme is not solely to improve reported waiting times. Reducing avoidable secondary waits will support more timely progression through treatment, reduce uncertainty for patients and families, and improve continuity of care. Proposed productivity and pathway changes will be assessed to ensure that improvements in access do not adversely affect clinical quality, patient experience or equality. A QSIA and EIA will be completed for every pathway by 30th November 2026.

7 Risks

7.1 There are several key risks associated with the secondary wait programme:

- Current reporting limitations mean that some pathway delays cannot yet be accurately quantified. A full breakdown of secondary waits is visible in Appendix 1 of this report, but only Doncaster Mental Health and Learning Disabilities Care Group and Talking Therapies currently have the granular level of detail required by pathway. This will be mitigated by the report development and completion of the outstanding demand and supply analysis.
- Variation in data recording practices across services may affect the consistency of reporting until the new reporting infrastructure is embedded and the reports are fully validated (6 weeks post report development).
- Early demand and supply findings provide assurance that improvement can be achieved through productivity and pathway optimisation in several areas. However, this position cannot yet be assumed across every pathway, and the remaining reviews will determine whether any services require more substantive pathway redesign, transformation or evidence-based investment. The early November workshop will agree how productivity changes are taken forward supportively, including consideration of work that could be ceased, simplified or reallocated. A QSIA and EIA will be completed for every pathway by 30th November 2026 to provide assurance that proposed changes are safe, equitable and do not create unintended consequences.
- National reporting requirements and competing analytical priorities may continue to place pressure on available informatics resources.

8 Governance, Accountability and Measures of Success

8.1 Programme assurance will distinguish between completion of enabling activities and evidence of improved outcomes. Measures will include the proportion of identified pathways achieving a maximum wait of 14 weeks; the number of people waiting beyond 14 weeks; longest wait by pathway; variation between teams and localities; delivery of agreed activity and productivity trajectories; implementation of pathway improvement plans; sustainability of improvement; and patient experience and equality impacts. Demand and supply reviews are jointly owned by Care Groups and the Performance Team; reporting development by Health Informatics; and productivity and pathway plans by Care Group clinical and operational leadership. Assurance will continue through existing Care Group and Trust-wide performance

structures, with regular reporting to Clinical Leadership Executive and Board committees as appropriate.

9 Conclusion

9.1 The Trust has established the core foundations required to manage secondary waits in a systematic and sustainable way. Pathway mapping is complete, the cohort of secondary waits has been agreed, and 40% of identified pathways are currently reported as achieving a maximum wait of 14 weeks. Reporting maturity is not yet consistent across all services, and further development is required before the Trust has a fully validated pathway-stage position.

9.2 Early operational findings are encouraging. Demand and supply reviews for Doncaster Mental Health and Learning Disabilities Care Group and Talking Therapies have not identified additional investment requirements, while Wheelchair Services and two Rotherham Older Adult pathways have evidenced the ability to achieve a maximum wait of 14 weeks without further investment. North Lincolnshire leadership is also confident that improvement in it's remaining pathways can be delivered through productivity.

9.3 The remaining demand and supply reviews are scheduled for completion by 16th October 2026. The early November workshop will agree a supportive approach to productivity and pathway optimisation, including consideration of work that could be ceased, simplified or reallocated. Informatics development and pathway-level QSIA and EIA work are scheduled for completion by 30th November 2026, followed by data validation and baseline confirmation during December 2026 and January 2027. The position is therefore positive but requires continued organisational focus. Delivery will depend on timely Care Group engagement, effective implementation of productivity actions, completion and validation of the reporting infrastructure, and early escalation where barriers cannot be resolved within existing resources. This provides a credible route towards the Trust's ambition of achieving a maximum secondary wait of 14 weeks by June 2027.

9.4 Whilst current reporting does not yet provide comprehensive pathway-level visibility in all services, the combination of improved data infrastructure and detailed operational analysis will provide the basis for targeted improvement activity throughout the second half of 2026/27, and in Q1 of 27/28 with ambition to achieve a maximum wait of 14 weeks by June 2027. This will enable the Trust to move beyond referral-to-meaningful assessment waits and develop a more comprehensive understanding of delays across the entire patient journey, supporting sustainable continued improvement in access, experience and outcomes.

10 Conclusion

The Board should note that

1. Note the progress made in establishing the Trust's framework for identifying and monitoring secondary waits.

2. Note the delays experienced in developing reporting infrastructure as a consequence of competing organisational priorities associated with the national 104-week metric and IQPR programme, and the ongoing resource pressures experienced by Health Informatics.

3. Note that Health Informatics development work is scheduled for completion by the end of November 2026.

4. Note that demand and supply reviews have been completed for Doncaster Care Group and Talking Therapies, with no additional investment needs identified, and that the remaining service reviews will be completed by 16 October 2026. This will require timely Care Group engagement and close management of the Performance Team workplan.

5. Support the early November productivity workshop and the completion of a QSIA and EIA for all pathways by the end of November 2026.

6. Support the continued programme of work to establish pathway-level reporting and implement targeted improvement plans to address identified secondary waits by June 2027.

Appendix 1 – breakdown of secondary waiting lists and longest waits (current visibility)

Secondary Wait Service Name	Report built y/n	Number on WL	Longest wait (WEEKS)	Validated Y/N	Date for validation	Demand and supply completed Y/N	Date for Demand and supply to be completed
ROTHERHAM COMMUNITY MENTAL HEALTH TEAMS	N	140	32	N	6 weeks post report completion	N	16/10/2026
ROTHERHAM EARLY INTERVENTION IN PSYCHOSIS	N	5	17	N	6 weeks post report completion	N	16/10/2026
ROTHERHAM OLDER PEOPLE'S PHYSIOTHERAPY	Y	33	7	Y	N/A	N	16/10/2026
ROTHERHAM OLDER PEOPLE'S PSYCHOLOGY	Y	19	26	Y	N/A	N	16/10/2026
ROTHERHAM PERINATAL TEAM	N	22	11	N	6 weeks post report completion	Y	16/10/2026
DONCASTER COMMUNITY MENTAL HEALTH CBT	N	15	22	N	6 weeks post report completion	Y	16/10/2026 - to be refreshed
DONCASTER COMMUNITY MENTAL HEALTH FAMILY THERAPY	N	6	15	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER COMMUNITY MENTAL HEALTH OCCUPATIONAL THERAPY	N	29	14	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER COMMUNITY MENTAL HEALTH PSYCHOLOGICAL THERAPIES	N	24	52	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER COMMUNITY MENTAL HEALTH DBT	N	15	14	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER COMMUNITY MENTAL HEALTH ARMS PSYCHOLOGY	N	4	22	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER COMMUNITY MENTAL HEALTH EIP CBT	N	4	11	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER OLDER PEOPLE PSYCHOLOGY	N	4	2	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER PERINATAL TEAM - COSP	N	1	14	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER PERINATAL TEAM - OT	N	3	2	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER PERINATAL TEAM - PSYCHOLOGY	N	2	1	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER PERINATAL TEAM - VIG	N	3	15	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER COMMUNITY MENTAL HEALTH PHYSIOTHERAPY	N	20	15	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER PRIMARY CARE PSYCHOTHERAPY (LOW INTENSITY)	N	9	12	Y	N/A	Y	16/10/2026 - to be refreshed
DONCASTER PRIMARY CARE PSYCHOTHERAPY (HIGH INTENSITY)	N	26	23	Y	N/A	Y	16/10/2026 - to be refreshed
NORTH LINCS EARLY INTERVENTION IN PSYCHOSIS TEAM	N	4	9	N	6 weeks post report completion	N	16/10/2026
NORTH LINCS PCN HEALTH AND WELLBEING PRACTITIONERS	N	89	32	N	6 weeks post report completion	N	16/10/2026
NORTH LINCS RECOVERY INTEGRATED	N	41	60	N	6 weeks post report completion	Y	16/10/2026 - to be refreshed
TALKING THERAPIES ROTHERHAM CBT	N	508	26	Y	N/A	Y	N/A
TALKING THERAPIES ROTHERHAM COUNSELLING	N	460	34	Y	N/A	Y	N/A
TALKING THERAPIES ROTHERHAM COUPLES THERAPY	N	8	26	Y	N/A	Y	N/A
TALKING THERAPIES ROTHERHAM DIT	N	5	6	Y	N/A	Y	N/A
TALKING THERAPIES ROTHERHAM IPT	N	12	39	Y	N/A	Y	N/A
TALKING THERAPIES ROTHERHAM LTC CBT	N	9	28	Y	N/A	Y	N/A
TALKING THERAPIES ROTHERHAM LTC COUNSELLING	N	8	18	Y	N/A	Y	N/A
TALKING THERAPIES NORTH LINCS CBT	N	213	34	Y	N/A	Y	N/A
TALKING THERAPIES NORTH LINCS COUNSELLING	N	83	22	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER CBT	N	309	18	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER EMDR	N	23	16	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER DIT	N	19	14	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER COUNSELLING	N	185	26	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER COUPLES COUNSELLING	N	4	10	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER IPT	N	8	20	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER LTC CBT	N	50	17	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER LTC COUNSELLING	N	36	15	Y	N/A	Y	N/A
TALKING THERAPIES DONCASTER LTC IPT	N	1	3	Y	N/A	Y	N/A
DONCASTER WHEELCHAIR AND SPECIALIST SERVICES	N	54	14	N	6 weeks post report completion	Y	16/10/2026 - to be refreshed
CYP ROTHERHAM EATING DISORDERS	N	5	5	N	6 weeks post report completion	N	16/10/2026
CYP DONCASTER EATING DISORDERS	N	5	5	N	6 weeks post report completion	N	16/10/2026
CYP NORTH LINCS EATING DISORDERS	N	6	31	N	6 weeks post report completion	N	16/10/2026

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Responding to feedback from our Young Advisors	**Agenda Item**	Paper S
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	24 September 2026

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

In July 2026, and for the second year as part of the Annual Fun Day and AMM, the Board welcomed representatives from our Young Advisors to meet and discuss their feedback and suggestion on the things that matter most to them. There was much to consider following the interactive session and this paper presents the proposed response to the ideas put forward. Some, notably on bullying will require external support and help.

Many members, but not all, were party to the discussion, but as a Board we should consider the proposed response and explore how we collectively demonstrate the progress of this work well before the AMM 2027 (and other points prior). Toby Lewis is meeting our Young Advisors on October 1st to discuss the Board's response and our meeting will be attended by Sylvia Akoma.

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

Explored by the full executive group who strongly support what is outlined

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and **NOTE** the feedback and topics provided by the Young Advisors.

ENDORSE the proposed actions in response and note the future reporting and feedback to the Young Advisors.

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	x
SO2: Create equity of access, employment, and experience to address differences in outcome	x
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	x

Alignment to the plans: (indicate those that this paper supports)	
Digital plan	x
People and teams plan	x
Quality and safety plan	x
Equity and inclusion plan	x
Education and learning plan	x
Research and innovation plan	x

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	x
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	

Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

SDR1: If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1

System / Place Relevance

N/A

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
BOARD OF DIRECTORS: 24 SEPTEMBER 2026
RESPONDING TO FEEDBACK FROM OUR YOUNG ADVISORS

1. Background

1.1 The Trust has, within the Children's Care Group, established some time ago a forum to provide a voice for young people – for them to act as role models, support others to get involved and to provide an active voice and engagement mechanism from an ever-growing cohort of young people that use our services. The forum is well established across Doncaster and continuing to grow in Rotherham and North Lincolnshire.

1.2 Over the last two years, in addition to the Care Group continuing and extending support to the forum, the Trust extended its Council of Governors in order to provide a second avenue by which their voice and contribution could be channelled and two young people have since joined the Council of Governors.

1.3 In creating the Communities' Leadership Executive it was recognised that we did not want to duplicate the work of the Youth Advisors, and so COLE continues to follow closely the workplan now being finalised in this paper: the intention thereby is that the Youth Advisors reach extends Trustwide, while still being hosted inside the Children's Care Group.

1.4 At the 2025 Annual Members Meeting / Fun Day, the Board of Directors held a session with the young people to hear about their work, to engage and create relations and to think about how future work together could tackle issues faced and raised. This process was repeated at the 2026 event with a more focused approach to hearing about issues with a commitment that the Board would receive and respond to these issues.

1.5 The paper provides details of the feedback and sets out how the Board proposes to respond and to monitor progress prior to but also at the next annual event in 2027.

2 The Feedback

2.1 Via an interactive session members of the Board discussed in small groups with the young people the following topics:

- What can the Trust do to include youth volunteers and increase employment opportunities for young people?
- How can children and young people be involved in Research at the Trust?
- How can the Trust work with education to reduce bullying in schools and work with partners to ensure we are safe travelling to and from school?
- What are the key patient safety concerns for children and young people and what is being done to improve them?

2.2 The key points arising from each were captured and are presented within the Annex to his paper. Each discussion created a range of points and provided the Board with a rich insight into the things that matter for the young people.

2.3 The summary and suggested focus, specifically of what the Board was asked to consider is presented overleaf, with the table below providing the responses that consider how achievable they are and whether they are reliant upon support of partners and other colleagues.

BOARD IDEAS FOR YAG

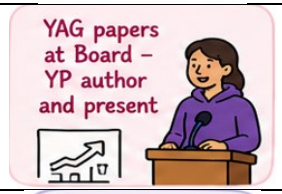
FOR THE NEXT 12 MONTHS...

NHS RDaSH Young Advisors Group

- Nurse Cadet places for brown and black boys
- Have reverse mentoring between a young person and a member of the board
- Introduce a deputy sexual safety guardian who is a young person
- Trust leaders in schools
- Trust leaders as school governors
- Trust sponsor young people to University
- Interview Panel and/or specific Stakeholder Panel
- Set up a bike amnesty and upcycle in the Trust – this will help transport safety and can be researched
- Have a young person ON the board
- Have the young advisors group as a formal "sub" group to CLE/CoLE
- Young Advisors Group to Board Time Out
- Support Young People in Tier 4 – help parents/ carers/families to visit (travel fund)
- Sort ethics out so children CAN do research
- Provide opportunities to co-research and shadow
- YAG take control of RDaSH App
- Bully mentor
- YAG papers at Board – YP author and present
- YP Gillick
- YP Change channel – for feedback

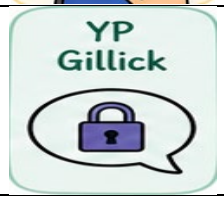
LISTEN | RESPECT | INCLUDE | EMPOWER | CREATE CHANGE

3. The Response

Topic / Issue / Suggestion	Response – What will the Trust do?	Timeline / Deliverable
	YES: we intend to start from January 2027 a formal reverse mentoring programme with interested Young People at Board level. We recognise the mutual time commitment, especially alongside the REACH reverse mentoring programme agreed in July. *We will explore the mechanics of taking this on within our October informal Board timeout.*	Carlene Holden January 2027 to July 2028
	NO: this is not going to progress per se, instead we want to work with our Youth Governors through COG to influence the work of the Board. But **we can take two practical steps**: firstly, to explore the Board's work programme with the YAG (when we meet on 1/10/26) and adopt suggestions for under-considered items; and secondly to ensure that at least one of 3 'patient' stories annually comes from a young person.	Philip Gowland Review in March 2027 to confirm both have happened
	YES: This is covered above. We will also start to share the outbriefs from the YAG meetings into COLE and thereby summarise them in the Chief Exec's Report to the Board.	n/a
	YES: Making the YAG a sub-group of the Communities' Leadership Executive feels like the right step. Enacting that needs some developmental work with both parties, but it can be accomplished before the end of 2026. The aim here is to ensure that community voices and views, clearly include views and ideas from young people.	Toby Lewis December 2026
	YES: This is very feasible notwithstanding the school day. We need to explore with YAG what they want to gain from that interaction, so it is well structured and a good use of people's time. That is why the February timeout (with April as a fall back) is suggested. We will consider whether a timeout venue near or in a relevant school may assist with logistics.	Philip Gowland March 2027

	YES: We need to explore what precisely is sought here. But on the face of it, we would be creating spaces to mentor young people on Trust time using Trust staff who volunteer to do so. Practically such mentoring is likely to be remote in many cases, and would need the support of school leadership. Organising that, as well as recruiting volunteers inside the Trust, is why it may take six months to come to fruition.	Jude Graham April 2027
	YES: this idea is strongly supported by the current executive sexual safety guardian, who is exploring how we may this happen during 2026.	Jude Graham January 2027
	PROBABLY: we need to explore what appetite exists in local schools for a visiting process where we consider what the collaboration may be. It may be most efficient to address this with a number of foundations, once we are clearer on aims and objectives from spending time. This work links to our wider health ambassadors programme https://www.hee.nhs.uk/our-work/health-ambassadors	Carlene Holden
	YES: this again represents something we can offer to our staff, recognising that some already do. Our offer would be based on advertising vacancies and ensuring that we work flexibly to allow staff to attend as governors (as some events/meetings) are day based; it will also be build into our talent management process.	Carlene Holden April 2027
	YES: Our current response is to create a targeted promotion and recruitment campaign rather than to ringfence places. The diversity of nurse entrants matters very much and the Trust, with a male south Asian heritage chief nurse is in a strong place to campaign on this locally.	Steve Forsyth June 2027
	YES: what is being proposed here is to create a scholarship funding model to meet the fee cost of 3 young people going to University from 2027/28. Recognising this would aggregate to nine people over three years, the maximum exposure would be c£95,000. It is proposed to fund this from the Investment Fund, if the Board supports the principle: of course, fairness, selection, publicity etc is to be developed, with an expectation that applicants would be undertaking health relevant qualifications.	Toby Lewis August 2027

	YES: we have spent time reviewing our Work Experience policy. This is now complete. This is part of a wider effort to being more open to YP finding out about what happens in a Trust ('beyond nurses and doctors'); we need to structure an annual offer to local schools (we work with very many). We need to discuss how that is best coordinated and organised, now that the policy barriers have lessened.	Carlene Holden April 2027
	YES: we have struggled to engage many young people with care opinion. As such we need help from the Young Advisors Group to think through what format this channel needs to take, for it to be used and effective at scale.	Steve Forsyth January 2027
	YES: we have already extended our scheme, which was set up to support our placements in other settings, to try to support those using complex placements elsewhere. The best focus for administration will be within the CCG, as they are most likely to know of the local Tier 4 utilisation.	Richard Chillery December 2026
	PROBABLY: we already have arrangements to seek to have patients involved in recruitment for some roles. For CYP facing roles it makes sense for that seat to be typically taken by a young person, recognising that interviews take place during the working/school day.	Carlene Holden March 2027
	DEFINITELY: this is the key issue raised over twelve months. We will work to bring partners together in an event focused on this, recognising that another party may emerge as best placed to take the visible lead. We wish to work with 2-3 schools who share a commitment to genuine change and to finding a reflective practice route to making bullying something spoken about and acted upon dynamically within the school week. Other ideas in this list (mentors and transport) relate.	Toby Lewis and Kath Lavery May 2027
	PROBABLY: we will work with our partners at Flourish to see how best to create this, which may also be part of our bullying response, as bus travel is persistently raised (including by Victor) as a key issue. The Trust will reach out to the local authority and SYMCA to explore this wider narrative.	Toby Lewis March 2027

	YES: it is possible to create research shadow opportunities, but not to promise to expand research on children for ethical reasons relating to consent. We will seek to develop young person's research champions linked to Grounded Research.	Jude Graham March 2027
	KIND OF: this has a practical issue in that the app is available only to people with an nhs mail account. We are working to create a Youth Advisors group email account, and if that is surmounted, then the YAG can contribute to the app, and we can have a dedicated week when we prioritise this content corporately.	Jo McDonough December 2026
	This needs to be explored further to see how our Gillick competency work and training can be supported through our YAG.	

4. Recommendations

The Board of Directors is asked to RECEIVE and NOTE the feedback and topics provided by the Young Advisors.

The Board of Directors is asked to SUPPORT the proposed actions in response and note the future reporting and feedback to the Young Advisors.

What can the Trust do to include youth volunteers and increase employment opportunities for young people?

NHS RDaSH Young Advisors Group

Promise 9 Pillars

PLACEMENTS → After the placements, get linked to an employer

How can we make this happen?

MAKE THE APPLICATION PROCESS SIMPLER

SHORTER (APP FORM)

TikTok opt in model

100s of careers

OPPORTUNITIES

- VIA SOCIAL MEDIA – TIKTOK, SNAPCHAT

- ANIMATION & MEMES

- MAKE THE NHS 'SEXY' 'ATTRACTIVE' TO YOUNG PEOPLE

- SHOWCASE CAREERS IN SCHOOLS

WORK IN THE BIG SMOKE VS STRAIGHT OUTTA DONNY

MAKING ACCESSING PLACEMENTS EASIER

INCREASE PLACEMENTS

INCREASE ACCESS TO EMPLOYER

OUTREACH TO AREAS WE CANNOT GET TO →  BREAK STEREOTYPES →  FEMALE CEO

How can Children and Young People be involved in Research in the Trust?

NHS RDaSH Young Advisors Group

Young People follow a research study end-to-end

to see how it works

Shadowing and co-researching

Placement with Grounded Research

- ✓ All stages – involvement prior to "research"
- ✓ Formal clinical trials – clarity on age restrictions

Research and link with Safety

- Including Bikes NOT Buses
- Specific studies on bullying interventions

Link Grounded Research with a school and agree a piece of research

Start research with CAMHS in Schools

Anti-Bullying

✓ Staff in schools working with our RDaSH Young People

RESPECT
SUPPORT
KINDNESS

Key Principles

- Meaningful involvement
- Work with schools & services
- Keep it safe
- Give young people real opportunities

How can the Trust work with education to reduce bullying in schools and work with partners to ensure we are safe travelling to and from school?

Think about what the bullying is about and support targeted work on themes

NHS RDaSH Young Advisors Group

HOW TO PREVENT IT?

KEY

Listening

- ✓ on buses
- ✓ in school
- ✓ Texts to alert "safe" words?
- ✓ Training for drivers/teaching staff?
- ✓ Providing safe places and support
- ✓ Having "mood cards" to gather feedback at the end of the day/week – How is it feeling?

PRACTICAL SAFE OR ALTERNATIVE TRAVELLING

- ✓ Cycle
- ✓ Volunteer drivers

MAKE BULLYING A NEVER EVENT

- SEE IT
- REPORT IT
- TEXT IT (HELP!)

BULLY MENTORS

TRUSTED PERSON

Listen to trust, test safety ideas and support people to report and access what they need.

TOOLS WE CAN USE

- Phones
- ChatGPT (AI) Algorithms
- Alerting App
- Safe Word
- Safe Signal
- Trusted Person

PARTNERS ENSURING WE ARE SAFE TRAVELLING TO AND FROM SCHOOL

SCHOOLS | POLICE | TRANSPORT PROVIDERS | COMMUNITY GROUPS | PARENTS & CARERS | SAFETY TEAMS

Within the Trust we have safety roles who train and support and hold people to account for change.

Would young people want to join this work? Work as deputy guardians?

ALERTING APP

Quick alerts for help when needed.

SAFE WORD

A safe word you can use to get help.

SAFE SIGNAL

A signal to let someone know you need help.

What are the key patient safety concerns for children and young people and what is being done to improve them?

NHS RDaSH Young Advisors Group

- Society
- Self Harm
- Substances
- Assault – Physical/Sexual
- Escooters

More Bus –
Anxiety, Bullying

More Cycling –
Safer Routes,
Bike Donation and Upcyle –
CYP can access

In hospital young people might not feel confident to speak up – training with Youth Support to help give confidence would be useful!

In hospital CYP are away from their families!


Mentors


Active Listening


Social Media


Oral Hygiene


Physical Health


Eyes


Sexual Health

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Provider Capability Framework Assessment 2026	**Agenda Item**	Paper T
Sponsoring Executive	Kath Lavery, Chair and Toby Lewis, Chief executive		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	24 September 2026

Suggested discussion points

The Trust submitted its first Provider Capability self-assessment in October 2025. It rated itself green against all criteria except two, quality of care and staff ability to express concerns, both of which were rated amber-green. NHS England agreed the Trust's assessment.

NHS England updated the guidance in July 2026. The self-assessment must now be refreshed and resubmitted by 4 October 2026. Three changes matter to the Board.

- The rating is now given at domain level against the six domains of the insightful provider board, taking account of eighteen supporting capability statements, rather than criterion by criterion as in 2025.
- There is a new capability statement on cyber security and the use of digital technology, statement 5, against which the Trust has no previous assessment.
- The guidance now states expressly that having processes in place is not sufficient if the Trust cannot demonstrate the effectiveness of those processes in delivering improvement. That is a higher bar than in 2025 and it falls most heavily on the two areas previously rated amber-green.

The central question for the Board is whether the two amber-green positions have moved, on what evidence, and where they have not, what is committed over the next six to nine months to move them on. Section 5 sets this out. The paper invites consideration of whether the quality of care measure should move to green but argues strongly that the people and culture remains amber-green, with a multi-year change programme in place. The Board's judgement is sought on whether green is the right rating to submit.

The Board should also note that capability ratings are now published by provider by NHS England, and that a national moderation panel and ratification by the NHS England executive board now sit between the Trust's submission and the final rating. The timing of this, and publication, is unconfirmed.

Previous consideration

Board of Directors, 25 September 2025, initial self-assessment received and reviewed, with approval of the final submission delegated to the Chair, Vice Chair, Chief Executive and Director of Corporate Assurance. An update on the submission and the feedback received was provided in November 2025.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and **NOTE** the changes to the Provider Capability guidance published in July 2026, in particular the move to domain level rating, the new capability statement on cyber security and digital, and the requirement to demonstrate the effectiveness of processes rather than their existence.

REVIEW the position on the two areas rated amber-green in 2025 and the plans set out for the next six to nine months, and **DETERMINE** whether quality of care is confirmed as green or moderated to amber-green.

DELEGATE approval of the final self-assessment to the Chair, Vice Chair, Chief Executive, and Director of Corporate Assurance in order that the Trust achieves the submission

requirement deadline of 4 October 2026 and to **RECEIVE** an update in November 2026 of this process and any feedback received, including the outcome of national moderation.			
Alignment to strategic objectives (indicate those that the paper supports)			
SO1: Nurture partnerships with patients and citizens to support good health			X
SO2: Create equity of access, employment, and experience to address differences in outcome			X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services			X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings			X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.			X
Alignment to the plans: (indicate those that this paper supports)			
People and teams plan			X
Digital plan			X
Quality and safety plan			X
Equity and inclusion plan			X
Education and learning plan			X
Research and innovation plan			X
Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	X
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	X
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	X
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X

Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	X
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	X
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	X
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)	
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1	X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.	X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.	X
If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees	X

System / Place impact (advise which ICB or place that this matter relates to)							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)
Appendix 1: Supporting information relating to the Provider Capability Assessment Framework, including the revised capability ratings and the material in year changes that require notification to NHS England.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Provider capability assessment: 2026 refresh

1. Introduction and background

1.1 As part of the NHS Oversight Framework, NHS England assesses the capability of NHS trusts and uses that assessment alongside the Trust's oversight segment to judge what action or support is appropriate. Boards assess their own organisation against expectations drawn from the insightful provider board across six domains: strategy, leadership and planning; quality of care; people and culture; access and delivery of services; productivity and value for money; and financial performance and oversight.

1.2 The self-assessment is an input to the rating, not the rating itself. Regional oversight teams review it alongside their own view of management, the Trust's track record and third-party information, and form a judgement on grip, meaning the Board's ability to understand problems, retain control and deliver effective action.

1.3 The Board received the first self-assessment in September 2025 and delegated approval of the final submission. The Trust submitted in October 2025 rating itself green against all criteria other than two, which were rated amber green. NHS England agreed the Trust's assessment, but no domain or criterion feedback was provided despite request.

2. What has changed in the guidance

2.1 NHS England updated the guidance on 28 July 2026. The framework is recognisably the same but four changes affect how the Trust must respond.

- The rating is now given at domain level. Boards RAG rate against each of the six domains, taking account of eighteen supporting capability statements. In 2025 the Trust rated itself criterion by criterion and reported green against all but one of sixteen. That formulation is no longer available. The Board is now asked to consider six ratings.
- There are eighteen capability statements rather than sixteen criteria, and the numbering has changed throughout. One statement is genuinely new, statement 5 on cyber security and the use of digital technology, and the Trust holds no previous assessment against it. The criterion rated amber-green in 2025 has been divided into two statements, 6 and 7, which requires the Board to decide where that rating now properly attaches.
- The guidance now states expressly that having specific processes in place is not sufficient if the Trust cannot demonstrate the effectiveness of those processes in delivering improvement. The test is of outcome rather than of arrangements, and it bears most heavily on the two areas previously rated amber-green
- Proposed ratings now pass through a national moderation panel of regional and national directors and are ratified by the NHS England executive board before being confirmed. Ratings are published by provider by NHS England. Supporting evidence is no longer routinely submitted with the return unless the region requests it.

2.2 Because the numbering has changed, the table below maps the 2025 criteria onto the 2026 statements. The areas under scrutiny are the same ones, differently arranged. Each statement block in the self-assessment carries the same reference.

Domain	2025 numbering	2026 numbering	Note
I. Strategy, leadership and planning	1 to 4	1 to 4	Unchanged in substance. New lines of enquiry on adapting arrangements and on Board understanding of strategic risk.
	none	5	New. Cyber security and the use of digital technology. No previous assessment.
II. Quality of care	5	6 and 7	Divided into two. The 2025 amber-green attaches to statement 6, the internal procedures test, not to statement 7, which tests Board arrangements.
	6	8	Unchanged in substance. New lines of enquiry on complaints escalation and on CQC follow up actions.
III. People and culture	7	9	Scope widened to include monitoring and improving staff experience, and to name the NHS Staff Standards, which the Board saw in July.
	8	10	Unchanged in substance. New line of enquiry on a log of avoidable staff-initiated events.
	9	11	Statement unchanged. This carries the second 2025 amber-green, agreed at the September 2025 Board.
IV. Access and delivery of services	10 to 12	12 to 14	Unchanged in substance.
V. Productivity and value for money	13	15	Unchanged in substance. New line of enquiry on track record of delivery rather than plans.
VI. Financial performance and oversight	14 to 16	16 to 18	Unchanged in substance.

2.3 Several individual statements have also acquired new lines of enquiry. Those with a direct bearing on the Trust's assurance arrangements are: whether the Board understands the key risks to delivering the strategy and ensures these are assessed and mitigated, statement 1; whether cyber risk is held on the Board Assurance Framework or corporate risk registers, statement 5; whether staff training and appraisal on patient safety and quality foster a culture of continuous improvement, statement 7; whether serious or recurring complaints are escalated to executive decision makers, statement 8; whether the NHS Staff Standards score is routinely reported to the Board with issues discussed and actions followed up, statement 9; and whether there is a track record of delivering planned productivity improvement rather than simply a plan, statement 15.

3. Relationship to the Developmental Well Led Review

3.1 The Trust's Developmental Well Led Review, facilitated externally by Value Circle, reported to the Board in May 2026. The two exercises overlap substantially and the guidance encourages boards to use existing governance work rather than duplicate it. The indicative evidence for this assessment names board effectiveness reviews, well led reviews, the Board Assurance Framework and risk registers directly.

3.2 The evidence assembled for the well led review therefore serves as the evidence spine for this return, coded to the well led statements and traceable to source. This avoids a parallel evidence gathering exercise and gives the return a consistent and auditable basis.

3.3 The guidance instructs oversight teams to discount CQC well led ratings and information more than twelve months old and to engage local CQC teams for a current view instead. The Trust's Developmental Well Led Review does not stand in place of a current CQC position and is not offered as though it does. It gives the Trust recent, structured, externally facilitated evidence about its own governance.

4. The 2026 self-assessment

4.1 The Trust's proposed position is set out below and the supporting detail follows in the self-assessment tables. One of the six domains remains rated amber-green.

	Domain	Proposed rating	Basis
I	Strategy, leadership and planning	**Green**	Five statements, all green. Includes the new statement 5 on cyber security and digital, assessed for the first time and supported by external assurance.
II	Quality of care	**Green**	Three statements, all green. Statement 6 is proposed to move from the 2025 amber-green position, on the strength of two delivered improvement goals and external corroboration of the risk system.
III	People and culture	**Amber-Green**	Three statements. Statement 11 remains amber-green, carrying the 2025 position. Statements 9 and 10 green.
IV	Access and delivery of services	**Green**	Three statements, all green. Standards met consistently since 2023, with the four week wait promise and the elimination of inappropriate out of area placements both delivered.
V	Productivity and value for money	**Green**	One statement, green. Best National Cost Collection index score in the mental health and community sector, with a track record of delivery.
VI	Financial performance and oversight	**Green**	Three statements, all green. Nine of eleven control areas assessed as enhanced or strong by external review.

4.2 Quality of care is vert tentatively proposed to move to green. The Trust set itself two improvement goals for 2025/26 and delivered both, and four separate reviewers have commented on the improvement in its risk management arrangements since 2024. However, the test is our wider approach to quality and safety.

4.3 People and culture remain amber-green. The Chief Executive reported to the Board in July that culture, and the Trust's self-assessment of it informed by the views of colleagues, is the weakest part of the Trust's position under both the Oversight Framework and this assessment.

5. Movement on the two areas rated amber-green

5.1 Where an area has not moved to green, the guidance requires the Trust to state the reason, how long it has persisted, the mitigating action taken and the plan to address it with the measures that will show progress. The table overleaf sets that out for both areas.

5.2 On quality of care, both areas identified in 2025 have moved. The Trust set itself two improvement goals for the year and delivered both: inappropriate out of area placements have been eliminated in Doncaster and Rotherham, and the four week wait promise was largely achieved by April 2026 and has been sustained since. Neither now appears on the Trust's safety risk profile, where both would have featured in 2023 and 2024. On the shift from assurance narrative to data, we need to discuss as a Board whether this has come far enough. The changed approach is validated for risk management, and is becoming more routine in the wider realm of quality metrics with changes from this month to the IQPR. Conversely our two most recent CQC inspections have been Requires Improvement, and internal audit reviews in 25/26 were more moderate for relevant audits. But, at base, data is now our model for Q&S – is this sufficient to shift from amber green to green? The assessment is offered as green on the evidence. The Board's judgement is sought on whether that is the right rating to submit.

5.3 Consistency of care planning has been a long-standing theme in CQC evaluation of the Trust's services, and while patients have documentation it is not consistently structured and does not span settings. A Trust wide programme is replacing legacy care planning arrangements across children's and adult mental health services with completion targeted for the autumn. The Board has given it the same internal priority as the four weeks wait, and we care quality compliance in August 2026. It is carried as a residual rather than in the rating because the programme has a completion point inside the current year.

5.4 On people and culture, the guidance asks directly whether the Trust is an outlier on staff surveys across peers. It is not, in aggregate. The Trust sits close to the average of its benchmarking group of mental health, learning disability and community trusts on the raising concerns measure, and its concern volumes and themes sit within the range of neighbouring trusts. The rating rests on direction rather than position: the measure has moved in the wrong direction over five successive years, and the Trust has moved from above its peer group average to below it.

5.5 The Board has acted on that. Colleagues are close to the peer average on feeling able to raise a concern and further below it on confidence that a concern will be acted upon, and most of those who do raise a concern report positively on the experience at a rate above the national position. The gap is therefore in visible organisational response rather than in access. Changes to the configuration of the Freedom To Speak Up function were agreed in July 2026 on that basis, moving to a more anticipatory model that reaches into services rather than waiting to receive

concerns, and a multi-year culture change programme with external advisory support is being co-produced with colleagues, with commitments to be set out at the leaders' conference in September 2026. Learning from concerns has already produced Board level action, including the commitment to retain the current ward base until at least March 2028 and the move to a positively anti-racist position under Promise 26.

5.6 The delegation sought in the recommendations allows for drafting changes, notably in relation to our cultural actions, before submission.

6. Recommendations

6.1 **RECEIVE** and **NOTE** the changes to the Provider Capability guidance published in July 2026, in particular the move to domain level rating, the new capability statement on cyber security and digital, and the requirement to demonstrate the effectiveness of processes rather than their existence.

6.2 **REVIEW** the position on the two areas rated amber-green in 2025 and the plans set out for the next six to nine months, and DETERMINE whether quality of care is confirmed as green or moderated to amber-green.

6.3 **DELEGATE** approval of the final self-assessment to the Chair, Vice Chair, Chief Executive, and Director of Corporate Assurance in order that the Trust achieves the submission requirement deadline of 4 October 2026 and to RECEIVE an update in November 2026 of this process and any feedback received, including the outcome of national moderation.

Philip Gowland
Director of Corporate Assurance
18 September 20265

The self-assessment

Ratings are shown by the shading of each capability statement. Each block records where the statement sat in the 2025 return. The key to ratings appears at the end of this section.

Movement on the areas rated amber-green in 2025

Statement 6, Quality of care. Proposed to move from amber-green to green				
Gaps Identified in 2025	**What has changed since September 2025**	**Residual position**	**Committed action, next six to nine months**	**Governance route**
Clinical performance improvement	The Trust set two improvement goals for 2025/26 and delivered both. Inappropriate out of area placements have been eliminated in Doncaster and Rotherham. The four week wait promise was largely achieved by April 2026 and sustained since. Neither now appears on the Trust's safety risk profile, where both would have featured in 2023 and 2024.	Occupancy across wards remains above the level the Trust is aiming for because length of stay has not yet materially reduced. Neurodiversity waits remain worse than the Trust would wish, with no national prioritisation apparent.	Work on standard ward practice, seven day admission and discharge and effective use of step down provision, directed at length of stay. A neurodiversity waits and volumes scorecard is now a standing feature of Board reporting.	Integrated Quality Performance Report to the Board, with delivery reviews on a bi-monthly cycle and oversight through the Quality Committee.
Shift from assurance narrative to data	RADAR is now the Trust's integrated system, carrying incidents, risks, mortality reviews, learning responses and Freedom To Speak Up on a single platform, so quality intelligence sits together rather than in separate systems. From 1 October 2026 all colleagues will be able to view risks on RADAR. Changes now embedded in the IQPR provide three times as much data on the clinical quality of services than before, and span all 14 clinical directorates. Always measures set a defined standard expected for every relevant patient within a set timeframe, with omissions caught close to real time and accountability	Consistency of what services record, and when, is the remaining work. The Trust's own information quality work identifies data entry as the continuing challenge rather than the reporting systems themselves. Always measures are in place on wards and not yet at every point of care. Action closure discipline is not yet consistent across all services, most notably in acute inpatient settings. Outcome information generated with the patient and any nominated carer is not yet available across all services, so quality is better measured than it was but not yet routinely	Completion of the care planning programme, which brings outcome information into the record at the point of care with the patient and any nominated carer. Continued rollout of always measures beyond wards to other points of care. Completion of the recovery plan agreed by the Quality Committee, with monthly executive oversight. All colleagues able to view risks on RADAR from 1 October 2026.	Quality Committee, through the IQPR, the triangulation report and the care quality compliance review. Risk Management Group to the Audit Committee and the Board for incident and action closure.

	held between peers rather than through managerial escalation. Reported quality and performance indicators are independently tested against national technical definitions in two stages and kitemarked before use, with reporting error found and corrected rather than reported on. Data quality is reviewed alongside operational performance and clinical practice at the Operational Management Group, and the triangulation report brings the separate quality sources together for the Quality Committee. The improvement in the underlying system since 2024 has been commented upon by internal audit, external audit, the Good Governance Institute and the Developmental Well Led Review.	understood through what patients themselves report.		

Statement 11, People and culture. Remains amber-green				
Gaps Identified in 2025	**What has changed since September 2025**	**Residual position**	**Committed action, next six to nine months**	**Governance route**
Weighting of Freedom to Speak Up feedback against staff survey data	The question the Trust put to itself in 2025, how to weight Freedom to Speak Up feedback against comparative staff survey data, has been answered. Concerns are now triangulated with survey results at directorate level, identifying those directorates that combine low	The Trust is not an outlier against its peer group, but the measure has declined over successive years, and the Trust has moved from above the group average to below it. The gap is in confidence that a concern will be addressed rather than in the ability to raise one.	Implementation of the reconfigured function agreed in July 2026, moving to a more anticipatory model that reaches into services, owned by the Chief Nursing Officer with the Guardian. A multi-year culture change programme with external advisory support, co-produced with	Freedom To Speak Up bi-annual report to the Board of Directors and quarterly review with the Chief Executive, with the People and Organisational Development Committee receiving the underlying data. Culture programme reporting

	reporting with below average confidence. The volume of concerns raised is the highest since the function began, and most colleagues who raise a concern report positively on the experience, above the national position. Learning has produced Board level action, including the commitment to retain the current ward base until at least March 2028 and the move to a positively anti-racist position under Promise 26. In July 2026 the Board agreed changes to the configuration of the function in direct response to the confidence gap.	The arrangements in place have not yet delivered improvement in the measured outcome. A high proportion of concerns relate to relationships between colleagues rather than to patient safety.	colleagues, with commitments to be set out at the leaders' conference in September 2026. Targeted engagement and leadership action in the directorates identified through triangulation. Introduction of an interactive staff engagement platform allowing colleagues to give and receive feedback directly.	through the Trust People Council to the Board.

Current Assessment

I. Strategy, leadership and planning | Proposed domain rating: Green

1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners. *This statement was criterion 1 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**

• Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? • Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level? • Can the board recognise when change is required and adapt arrangements as the organisation evolves? • Does the board understand the key risks to delivering the strategy and ensure these are appropriately assessed and mitigated?	Our strategy and plans, financial, clinical and public health, do reflect those of aligned partners. The Trust has a very widely understood and specific Clinical and Operational Strategy 2023 to 2028, whose five objectives reflect the priorities of our communities. The 28 Promises are widely understood by both patients and our staff and are increasingly used by commissioners themselves in contracting with us. The Board understands the risks to delivering the strategy and holds them formally through the Board Assurance Framework, with each Strategic Delivery Risk owned by a named executive. The Trust's governance structure was redesigned and approved alongside the strategy in September 2023, and time limited structures are created with retirement dates rather than as permanent committees.	• Development began in 2022 with large scale events involving colleagues and partners, followed in 2023 by consultation with the Joint Consultative Committee, the senior doctors' group and the staff networks to finalise the promises, which were approved by both the Clinical Leadership Executive and the Board before launch in September 2023 • Delivery is overseen by cross cutting groups with all professions represented and executed in the main through care groups and directorates. Each of the Trust's plans has an owning group beneath the Clinical Leadership Executive, covering people and teams, education and learning, quality and safety, finance, digital transformation, estate and sustainability, research and innovation, and equity and inclusion. • Progress on promise delivery is reported at every Board meeting. Annual progress is additionally subject to verification by patient, carer and peer representatives, whose commentary is published alongside the Trust's own account of what it has achieved. • The Board Assurance Framework sets out the Strategic Delivery Risks, the controls in place, the assurances received and the gaps being addressed, reviewed by the Board and in year by the Risk Management Group and the assurance committees. The Board	• The relationship between the Trust's strategy and the Humber and North Yorkshire blueprint strategy continues to require attention.	• Clinical and Operational Strategy 2023 to 2028 • Delivering our Promises, including the patient led version • Promise verification commentary from patient, carer and peer representatives • Board Assurance Framework, Strategic Delivery Risks • Risk Management Framework and Risk Appetite Statement, Board approved • Trust decision making and Board assurance structure, Board approved September 2023 • Annual Report and Annual Governance Statement 2025/26 • Developmental Well Led Review, May 2026 • Details of promises incorporated into contracts • CQC well led review – acute services (good rating) • Capital plan reconciliation

		approved Risk Management Framework and Risk Appetite Statement give a defined appetite and tolerance position against which strategic and operational risks are scored and escalated. ● The Trust's plans align to the objectives of system partners and to related local and national plans, with the 10-Year Health Plan reaffirming a number of intentions already in place within our strategy. ● Following concerns raised by colleagues about a pattern of ward closures, the Board committed to retain the current ward base until at least March 2028 and to focus instead on improving care and performance within those wards. ● The Community Powered Healthcare taskforce carries a defined end date and the ethics group is convened as required rather than standing.		

2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England. *This statement was criterion 2 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
• Is the trust currently complying with the conditions of its licence? • Is the trust complying with regulatory instruments, for example discretionary requirements and statutory undertakings, and is there a board level plan to return to compliance? • Is it co-operating with the requirements of any national performance improvement or recovery programmes?	The Trust is compliant with all licence and regulatory requirements and is not subject to any enforcement action from NHS England.	• Compliance with the provider licence is confirmed annually through the Annual Governance Statement, signed by the Chief Executive and supported by the Head of Internal Audit Opinion. • Regulatory compliance is held within the Trust's risk management arrangements against an averse appetite for non-compliance with regulatory standards and reporting obligations. • The Trust maintains a consistent view of its compliance with CQC core standards, with annual consideration before the Annual Members' Meeting so that the Board can describe its current state candidly to governors, members and the public.	No gap identified.	• Annual Governance Statement 2025/26 • Head of Internal Audit Opinion 2025/26 • Provider licence compliance self certification • Risk Appetite Statement, regulatory subcategory

3. The board has the skills, capacity and experience to lead the organisation. *This statement was criterion 3 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
• Are all board positions filled and, if not, are there plans in place to address any vacancies? What proportion of board members are in interim or acting roles? • Is an appropriate board succession plan in place? • Are there clear objectives, accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?	Succession planning is in place. Changes made over the past year were pre-planned rather than reactive. Objectives are set annually for every Board member through the appraisal process, cascaded from the objectives of the Chair and Chief Executive, with accountabilities and responsibilities redefined in 2023/24. The Trust is committed to diversity in its leadership and can evidence positive results in that direction over the past five years.	• Non-executive chairmanship of committees changed in the latter part of 2025/26 with roles and responsibilities realigned, grounded in annual appraisal practice. The retirement of the health informatics director was managed through planned changes to executive portfolios and substructures rather than a like for like replacement. • The Trust invests deliberately in leadership capability. The Leadership Development Offer launched in early 2025 and concluded in September 2026. A senior leadership and directorate management team approach operates across care groups and clinical directorates. • Appointments are made with targeted impact where appropriate, including the deliberate appointment of individuals with primary care experience, at Board level as well as below it. • The Deputy Executive Group brings together the specific deputies to executive roles to take on responsibilities and projects as preparation for future career development,	• Board level digital literacy has been developed deliberately but has not been assessed as a distinct competence within the Board skills audit.	• Board of Directors page on the public website https://www.rdash.nhs.uk/about-us/governance/board-of-directors/ • Fit and Proper Person Test framework and audit • Board development specification and programme • Leadership Development Offer curriculum and completion • Deputy Executive Group terms of reference • Remuneration Committee minutes • Board skills audit • Developmental Well Led Review, May 2026

		providing a visible succession pipeline. ● A robust Fit and Proper Person Test process is in place, audited with significant assurance, and an annual appraisal process for all Board members is evidenced in Remuneration Committee minutes. ● Board development sessions are held bi-monthly, including with the ICB chair and chief executive, and a Board skills audit and self assessment has been undertaken, discussed and translated into practical actions. ● The Developmental Well Led Review completed in May 2026, facilitated externally by Value Circle, provided a structured external view of Board capability and governance, with recommendations converted into owned and measurable actions.		

4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served. *This statement was criterion 4 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
• Is the trust contributing to and benefiting from its provider collaborative? • Can the board evidence that it is working effectively with the wider system, not just focused on the organisation itself, for example in terms of sharing resources and supporting wider service reconfiguration and left shifts to community care where appropriate and agreed? • Do the trust's operating and financial plans align with those of its commissioning ICB or ICBs, in particular regarding activity and capital expenditure?	The Trust Chief Executive is the convening chief executive for the South Yorkshire Mental Health, Learning Disability and Autism collaborative, and most collaborative senior responsible officers are drawn from RDaSH. Members' and partners' assessment of contribution show results in respect of eating disorders and urgent mental health need. The Trust's Communities' Leadership Executive, created under Promise 5, brings sixteen organisations together with five drawn from each place, and has agreed its own priorities and terms of reference. The Trust has returned monies to system partners to support collective balance and has taken on demand side risk to better balance the ICB and Trust position.	• The Trust has a clear partnering model which forms part of Board and committee terms of reference, and internal audit review shows strong assurance on the meaningfulness of that approach. • Consistently positive feedback is received from voluntary, community and social enterprise partners and from local authority partners for the Trust's presence, impact and commitment to working together with a purpose. • The Trust works closely with south Humber NHS partners on international recruitment and on peer aid for shared issues, and the Chief Executive is the system lead on the reduction of out of area placements. • The Trust has accepted the transfer of out of area placement spend from commissioners, removing an equity gap the Board had been concerned about and making it easier to manage the bed base fairly across sites. • Neighbourhood working is being developed with third sector and primary care partners through the Communities' Leadership Executive and the Community Powered Healthcare taskforce, alongside shared frailty work with acute partners.	• Contracting with both commissioning ICBs has been slower than the Trust would wish and has absorbed significant senior management time. The Trust's own plans have been submitted and its operating assumptions set in conjunction with partners throughout. • The relationship with Humber and North Yorkshire ICB remains more challenging than that with South Yorkshire. The Trust contributes to the HNY Mental Health Collaborative, recognising that that vehicle has its own challenges.	• Collaborative papers and senior responsible officer arrangements • Communities' Leadership Executive terms of reference and out-briefs • Internal audit report on partnering • System Leadership Executive and System Executive Board minutes and attendance • Chief Executive's reports to the Board of Directors • Operational and financial plan submissions

5. The trust has an effective cyber security strategy and uses digital technology to support improvement. *This statement is new in 2026. The Trust holds no previous assessment against it.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
• Is there sufficient digital literacy at board level and is digital a core element of discussions regarding planning, delivery, assurance and risk? • Is cyber risk included on Board Assurance Frameworks and/or corporate risk registers? • Can the board articulate how digital is an enabler across the organisation's operations, quality, productivity, access and safety, and supports the governance and culture of the organisation? • Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?	The Trust holds no 2025 baseline against this statement. The position below rests on external assurance. The Trust achieved Standards Met in its Cyber Assessment Framework aligned Data Security and Protection Toolkit submission, with all recommendations from the independent audit of that submission discharged. Independent penetration testing assessed the overall security risk of the Trust's external infrastructure and wireless services as low, with assessors unable to reach internal systems until given network access, and the high risk actions arising have been completed. NHS England has selected the Trust as a first adopter of its new national cloud firewall service, and the Trust's devices report compliance and risk information directly to NHS England's Cyber Security Operations Centre. Cyber and digital are held as Board business rather than delegated as a technical matter. The Chief Operating Officer is the executive lead, supported by a Chief Digital Information Officer,	• Cyber security is a core element of the Digital Enabling Plan 2023 to 2028, which is subject to annual update to the Board, rather than a separate technical concern. • Cyber and information risk is captured within the Trust's risk management arrangements and scored against Board approved appetite and tolerance limits, with escalation through the Risk Management Group. Supply chain cyber and data protection risk is a named risk under active management, with the national Digital Technology Assessment Criteria embedded into procurement. • Digital is demonstrably an enabler across the Trust's work. Patients have a single digital route to services for self referral, appointment management, questionnaires and medication requests. Migration to the Yorkshire and Humber Care Record has strengthened interoperability with partners. A mobile clinical application puts records at the point of care across inpatient and community services. Waiting times for all services are published on the Trust website. Costing and productivity dashboards underpin the Trust's National Cost Collection position. RADAR provides a single system for	• Board level digital literacy has been developed but has not been separately assessed as a distinct competence within the Board skills audit. • Costing and productivity dashboards are not yet used consistently across all directorates, which limits the improvement the Trust's digital investment is capable of delivering.	• Data Security and Protection Toolkit submission, Cyber Assessment Framework aligned, Standards Met • Independent penetration testing report and remediation record • Cyber security updates to the Board of Directors and the Finance, Digital and Estates Committee • Digital Enabling Plan 2023 to 2028 and annual update • Board Assurance Framework and risk register extracts covering cyber and digital • NHS England Cyber Security Operations Centre reporting • Independent security benchmarking reporting • South Yorkshire Cyber Strategy • Published waiting times, rdash.nhs.uk

	with assurance through the Finance, Digital and Estates Committee and reporting to the Board.	risk, incident, mortality and Freedom To Speak Up reporting. ● The Trust is an active partner in the South Yorkshire Cyber Forum and contributes to the regional cyber strategy on a defend as one basis. It provides IT services to all Doncaster general practices, and the ICB has aligned its general practice estate to the Trust's antivirus arrangements. The Data Protection Officer leads data security awareness communications across the wider ICB footprint on the Trust's behalf. ● National funding was secured to support deployment of high specification laptops and additional smart lockers, supporting the Trust's mobile first approach. ● Board digital literacy has been developed deliberately, including Board development work undertaken with NHS Providers on the digital role of the board. ● The Trust has registered the emerging risk of unauthorised or unsupported artificial intelligence tools being used without oversight and is developing the processes and tooling to manage it, while simultaneously deploying artificial intelligence in clinical documentation at scale.		

II. Quality of care | Proposed domain rating: Green

6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).

This statement, with statement 7, replaces criterion 5, which was rated amber-green in 2025. The rating is proposed to move to green.

Indicative evidence or lines of enquiry	Headline Statement	Contributing Statement	Contra / Gap / Area for Improvement	Evidence
• The trust can demonstrate and assure itself that internal procedures: ensure required standards are achieved, internal and external; investigate and develop strategies to address substandard performance; plan and manage continuous improvement; identify, share and ensure delivery of best practice; identify and manage risks to quality of care.	The rating is proposed to move from amber-green to green. The two areas the Trust identified in 2025 have both moved. On clinical performance, the Trust set itself two improvement goals for 2025/26 and delivered both. Inappropriate out of area placements have been eliminated in Doncaster and Rotherham, and the four weeks wait promise was largely achieved by April 2026 and has been sustained since. Neither now appears on the Trust's safety risk profile, where both would have featured in 2023 and 2024. On the shift from assurance narrative to data, the improvement in the Trust's risk management system since 2024 has been commented on by internal audit, external audit, Good Governance Institute and the Developmental Well Led Review. RADAR is the Trust's single system for risk, incident and mortality reporting, and reported performance indicators are independently tested and kitemarked before use.	• The Quality and Safety Plan 2025 to 2028 sets the framework for standards, improvement and the management of quality risk, with delivery reported through the Quality Committee to the Board. It defines what safety means for the Trust and selects the measures the Trust will hold itself to. • The Trust operates always measures, a defined set of standards expected for every relevant patient within a set timeframe, with omissions caught close to real time. This introduces peer accountability rather than managerial escalation and is a deliberate change from legacy arrangements. • The Patient Safety Incident Response Framework is applied proportionately, matching the review method to the learning value of the event, with all decisions and outcomes recorded in RADAR. Learning themes are analysed thematically at team, directorate, care group and Trust level. • The Quality and Safety Impact Assessment panel reviews assessments arising from the savings programme and other organisational change, with cumulative impact	• Consistency of care planning is the Trust's principal quality priority and has been a long standing theme in CQC evaluation of its services. Patients have documentation, but it is not consistently structured and does not span settings. A Trust wide programme is replacing legacy care planning arrangements across children's and adult mental health services, with completion targeted for the autumn, and the Board reviewed care quality compliance in August 2026. • Consistency of what services record, and when, is the linked residual. Action closure discipline is not yet consistent across all services, most notably in acute inpatient settings, with a recovery plan agreed by the Quality Committee and monthly executive oversight in place.	• Quality and Safety Plan 2025 to 2028 • Quality Account 2025/26 • CQC provider and inspection reports • Integrated Quality and Performance Report • Information Quality Work Programme reports and kitemarks • Quality and Safety Impact Assessment panel activity reports • Patient Safety Incident Response Framework reporting to the Quality Committee • Risk Management Framework and Risk Appetite Statement, Board approved • RADAR risk, incident and mortality reporting • Risk Management Group papers and Trust risk profile reporting • Annual Governance Statement 2025/26 • Developmental Well Led Review, May 2026

	The Trust's remaining quality priority is the consistency of care planning. It is carried as a residual rather than in the rating because a Trust wide programme is running against it with a completion point this autumn.	grouped, themed and monitored, and reported to the Quality Committee. ● Reported quality and performance indicators are independently tested through the Information Quality Work Programme against national technical definitions, producing an assurance opinion and kitemark on a methodology approved by the Data Quality Group. Where testing has identified reporting error, the error has been corrected and the assessment repeated. ● Data quality is reviewed alongside operational performance and clinical practice at the Operational Management Group, rather than in a separate report, with variation across care groups considered together. ● Risks to quality of care are held on directorate risk registers, moderated against Board approved appetite, and escalated through the Risk Management Group to the Quality Committee and the Board. Out of tolerance risks are considered at every public Board meeting and risk turnover is evidenced. ● The Trust commits to fund safety and to use its risk registers and analysis of patient safety events to determine priorities. ● The Developmental Well Led Review reported in May 2026 and provided an external view of the Trust's quality governance arrangements, with recommendations converted into owned and measurable actions.	● Rollout of always measures is complete on wards and continues across other points of care.	

7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. *This statement, with statement 6, replaces criterion 5. Nothing in the 2025 amber-green rating attached to the arrangements this statement tests.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
• There is board level engagement on improving quality of care across the organisation. • Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients. • Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community. • Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust. • Board is satisfied that current staff	There are cogent answers to each of these lines of enquiry and considerable evidence of Board consideration and action. Since 2023, 23 per cent of inpatient wards have closed with reinvestment into community-based services, and the virtual ward now provides an alternative to admission. The Board's consideration of compliance with core standards includes reflecting on whether data exists that would contradict the assessment reached, drawing on incident learning, complaints, Freedom To Speak Up material, coroners' reports and the views of Healthwatch and commissioners.	• Board engagement with quality, safety and the reality of care is demonstrated through delivery reviews on a bi-monthly cycle, peer reviews, frontline visits, patient stories and open meetings, supported by informal timeout sessions used to collate Board insight. • The move to fourteen clinical directorates has rebalanced that focus across all facets of clinical service, physical and mental health, adults and children and young people. • The Board considers quantitative and qualitative information together, through the Integrated Quality and Performance Report alongside patient stories, patient feedback and complaints learning. • Services have transferred onto a community footing through the virtual ward and, at Board level, through the closure of inpatient wards since 2023 with reinvestment into community-based services. From 2025 the Board committed to a mental health bed base offering local services in each place while working together as one hospital. • Learning from quality issues elsewhere in the NHS reaches the Board through a defined route. The Trust reviews Prevention of Future Deaths reports issued to other	• Learning Half Days are more difficult to deliver consistently in some ward-based areas than elsewhere, and work continues to make the model workable across all settings. • Organisational learning is drawn from several separate sources, and work is in hand to connect them so the Board can point to a single mechanism.	• Quality Committee papers and minutes • Board of Directors papers and minutes, including delivery review and peer review reporting • Prevention of and Learning from Deaths Group reporting and Chief Medical Officer quarterly report • Prevention of Future Deaths correspondence and Chief Executive response • Integrated Quality and Performance Report • Quality Account 2025/26 • CQC provider and inspection reports • Annual Governance Statement 2025/26 and Head of Internal Audit Opinion • Developmental Well Led Review, May 2026, and action plan • Well led evidence vault

training and appraisals regarding patient safety and quality foster a culture of continuous improvement.		organisations across a range of jurisdictions specifically to identify where it should act, and cross references these against inquests heard or pending locally. National Patient Safety Alert compliance is reported alongside. ● The Trust's own learning from deaths runs from individual death to Board. The Chief Medical Officer chairs the Prevention of and Learning from Deaths Group, reporting to the Quality Committee and forming part of the Chief Medical Officer's quarterly public report to the Board, with an operational group reviewing every death recorded and escalating to structured judgement review or to the incident response framework as appropriate. ● Where the Trust received a Prevention of Future Deaths report, the Chief Executive responded personally, setting out changes made during the inquest and since its conclusion together with assurance of continued oversight. ● The standard of the Trust's inquest reporting has improved, with each report reviewed before submission, which surfaces required action before inquest rather than after it and returns clinical time to patient care where the Trust is stood down from giving live evidence. ● Training and appraisal in patient safety and quality reaches the Board through mandatory training reporting in the Integrated Quality and Performance Report and		

		through the People and Organisational Development Committee, supported by monthly Learning Half Days that give every colleague protected time to learn. ● The Annual Governance Statement provides the Board's own assurance on the robustness of internal governance, supported by the Head of Internal Audit Opinion and, for 2025/26, by an externally facilitated Developmental Well Led Review.		

8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board. *This statement was criterion 6 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
● Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience? ● Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities? ● Is the board satisfied that it receives timely information on quality	There is strong evidence against each of these lines of enquiry, including comparative data use, protected characteristics analysis, timely datasets, patient involvement in service evaluation and the use of complaints as learning tools. The Trust's patient feedback platform is open to all colleagues to read and respond to, with several hundred colleagues able to respond to stories, and almost every service participating. It is the heart of the Promise 4 delivery plan. Patient representatives form part of all Board and executive committee spaces and are increasingly visible at directorate	● Story volumes continue to grow and the Trust records those stories that have led to change in services, alongside those that reinforce what works well. ● Reading and learning from feedback is encouraged across colleagues and within directorates, with directorates challenged through the delivery review process on volumes, responses, learning and the celebration of good practice. ● The shadow Clinical Leadership Executive, launched in 2025, provides a locus for the perspectives of carers, volunteers and peer support workers to influence the Trust's	● The Trust records the volume of warnings and exclusions issued under its acceptable behaviour arrangements but does not routinely analyse them by protected characteristic. Work is in hand to add that analysis, given the significance of any decision to withdraw services.	● Patient feedback platform reporting ● Complaints reports to the Quality Committee and the Board ● Integrated Quality and Performance Report, health inequalities analysis ● Council of Governors papers ● Shadow Clinical Leadership Executive terms of reference ● Acceptable Behaviour Policy and audit measures

that is focused on the right matters? ● Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real time measures, and explore whether staff effectively respond to this? ● How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance? ● Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? ● Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious or re-occurring complaints to the relevant executive decision makers? ● Where there are follow up actions resulting from CQC inspections, is the trust addressing these and can the board articulate how care will improve as a result?	and care group level, influencing priorities, practice and policies.	most senior decision making forums. ● Board agreed Quality Indicators have been introduced into the older people's mental health inpatient model, accompanied by consistent consideration of patient and carer feedback. ● The Council of Governors, including patient and carer representation, provides a further avenue for feedback and challenge on service delivery. ● Complaints are received through a defined process that involves the highest level of the Trust in response, with serious and recurring complaints escalated to executive decision makers and executive intervention where required. ● Where colleagues face abuse or discrimination from patients, carers or visitors, the Trust operates a graduated response up to withdrawal of services, with contested decisions determined by the Chief Executive and referral to the police where a criminal offence may have occurred. ● The Board receives analysis of the Integrated Quality and Performance Report through a health inequalities lens at each meeting, and follow up actions from CQC inspection are tracked to completion through the Quality Committee.		● CQC action plan and tracking ● Patient partner and promise verification reporting

III. People and culture | Proposed domain rating: Amber-green

9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience.

This statement was criterion 7 in 2025 and was rated green. Its scope has widened to include the monitoring and improvement of staff experience in its own right.

Indicative evidence or lines of enquiry	Headline Statement	Contributing Statement	Contra / Gap / Area for Improvement	Evidence
• Does the board look at all relevant staff, including trainee, information to monitor the experience of working at the trust and identify areas for improvement? • Does the board engage in staff forums to consider how quality of care can be improved and any cultural or staff experience issues addressed? • Are staff surveys and other information, such as the NHS Staff Standards, routinely reported to the board and issues discussed? Are agreed actions followed up? • Does the board monitor the diversity of staff across the organisation to ensure it is representative of its local population?	The Board has a dedicated staff sub committee, the Trust People Council, focusing on the culture of the Trust, where the overwhelming majority of members are from bands 8 and below and where protected characteristic diversity is well reflected. Staff Survey results are reported to the Board with issues discussed and agreed actions followed up. Results are analysed to directorate level and shared with directorate leads, who develop their own actions, with a Trust wide view maintained alongside. Diversity analysis is a core feature of the Board's work and of its committees, and the Trust scores above its peer group average on diversity and equality. The Board's assessment of its own culture position, and the change programme responding to it, are set out at statement 11.	• There is a clear audit trail of engagement and action, including investment in reasonable adjustments, protected time to learn through Learning Half Days, the development of non patient facing time for senior clinicians, and ringfenced training with advanced training plans. • The Trust analyses its survey results in ways it had not previously, including by length of service, which has surfaced a pattern the Board is now acting on. • Workforce Race Equality Standard and Workforce Disability Equality Standard analysis is reported and shows improvement, with further work evidently needed. Training spends and the Apprenticeship Levy are analysed by protected characteristics. • The Trust People Council and staff networks are well established and routinely provide engagement opportunities with staff, union representatives and staff governors. Peer reviews undertaken by Board representatives provide a further	• The NHS Staff Standards score is a new named requirement in the guidance. The Trust is confirming its route for reporting that score to the Board. • Board monitoring of staff diversity is currently against the workforce rather than systematically against the local population, and this is being developed.	• Staff Survey report and benchmark report • Trust People Council minutes • Workforce Race Equality Standard and Workforce Disability Equality Standard reports • People and Organisational Development Committee papers • NHS England report on educational calibre • Samples of communication to staff and links to communication via the RDaSH YouTube channel

		interface for staff feedback and voice. ● Monthly Backbone emails from the Chief Executive, Trust wide drop in sessions and a weekly video log from the Chief Executive all provide for two way communication and discussion. ● The Trust received a positive NHS England report on its educational calibre, covering the experiences of those being educated and those engaged in education across all professions. ● An interactive staff engagement platform is being introduced, designed on the model of the Trust's patient feedback platform, to allow colleagues to give and receive feedback directly. It responds to the finding that most colleagues do not use email and that some do not know who to ask.		

10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels. *This statement was criterion 8 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
● Does the trust regularly review skills at all levels across the organisation? ● Does the board see and, if necessary, act on levels of	The Board is very focused on mandatory training. In the past two years it has completed a full review of inclusions, made changes, and altered how mandatory and statutory training is reported so that colleagues	● From a comprehensive five day induction, including immersion in our communities and time to fulfil mandatory training requirements, the Trust supports colleagues through multiple development schemes including the Leadership	● Sickness absence remains higher than at peer organisations and is the Trust's key improvement area under the Oversight Framework. Absence	● Integrated Quality and Performance Report, including mandatory and statutory training ● Learning and education plan, agreed July 2025

compliance with mandatory training? ● Have all staff completed relevant training, for example safety, clinical, cyber security and information governance, counter fraud and safeguarding, and does the board see a log of avoidable staff initiated events?	who miss part of their training are not counted as compliant. The Board holds a dedicated education and learning meeting and can evidence a consistent focus on skills and learning, with an education and learning plan agreed in July 2025, investment in additional education roles and a single annually growing training budget. Job planning is being put on a systematic footing across all clinical disciplines, under an internal audit scope agreed by the Chief Executive, with the majority of medical consultant plans signed off and allied health, psychological professions and nurse consultant plans largely complete.	Development Offer and the First Line Managers scheme. ● A Trust wide Training Needs Analysis identifies the needs of the Trust so that resources are appropriately and routinely used to develop colleagues, covering all directorates and staff groups. ● Mandatory and statutory training compliance, covering safety, clinical, information governance and cyber, counter fraud and safeguarding, is reported to the Board through the Integrated Quality and Performance Report and reviewed at the People and Organisational Development Committee. ● Every care group has a research community of practice, and dedicated time for research has been formally introduced into job plans for doctors, nurses, psychologists, allied health professionals and social workers. ● Recruitment has been given priority to close the gap between establishment and staffing, with all vacancies placed on advert without exception and centralised hiring introduced. ● The estate plan includes the intention to invest in an education and learning centre.	review clinics led by the Director of People and Organisational Development are running with all clinical directorates and with nursing and facilities, against a Board agreed plan, and a faster approach to grievance and disciplinary processes is being introduced to reduce the burden on frontline managers. ● Concurrent medical staff departures and a rise in medium term sickness in one care group required locum cover outside plan, with supervision arrangements made for incoming trainees and a co-managed approach through the delivery review structure. ● The line of enquiry on a log of avoidable staff-initiated events is new. The Trust reports the constituent workforce information to the Board and is confirming whether a consolidated log is required.	● Induction, Leadership Development Offer and First Line Managers programmes ● Training Needs Analysis ● Job planning internal audit scope and completion reporting ● People and Organisational Development Committee papers ● Chief Executive's reports to the Board of Directors

11. Staff can express concerns in an open and constructive environment. *This statement was criterion 9 in 2025. It was rated amber-green at the Board's September 2025 meeting and NHS England agreed that assessment. It remains amber-green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
• Does the board engage effectively with information received via Freedom To Speak Up channels, using it to improve quality of care and staff experience? • Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required? • Is there a clear and streamlined Freedom To Speak Up process for staff and are concerns visibly addressed, providing assurance to any others with similar concerns? • Is there a safe reporting culture throughout the organisation? How does the board know?	Robust arrangements are in place, are used with increasing frequency, and produce action in response. On the question the guidance asks directly, the Trust is not an outlier on staff surveys across peers. It sits close to the average of its benchmarking group of mental health, learning disability and community trusts on the raising concerns measure, and its concern volumes and themes sit within the range of neighbouring trusts. The rating remains amber-green because the measure has moved in the wrong direction over successive years and the Trust has moved from above its peer group average to below it. The Chief Executive has been explicit with the Board that culture, and the Trust's self assessment of it informed by the views of colleagues, is the weakest part of the Trust's position under both the Oversight Framework and this assessment.	• The Guardian reports bi-annually to the Board of Directors and holds quarterly reviews with the Chief Executive, with the People and Organisational Development Committee and the quality and safety route receiving the underlying data and learning. • Speaking up is treated as a matter of wider culture rather than the responsibility of one function. Over seventy trained champions operate across services, with national speak up, listen up and follow up e-learning available to all colleagues, managers and senior leaders respectively, and with Freedom To Speak Up included in Trust induction. • The volume of concerns raised is the highest since the function began, and most colleagues who raise a concern and give feedback report positively on the experience, at a rate above the national position. • Learning from concerns has produced action at Board level, not only local resolution. Concerns following a ward closure led the Board to commit	• The gap is in confidence that a concern will be acted upon rather than in the ability to raise one. Colleagues are close to the peer group average on feeling able to raise a concern and further below it on confidence that it will be addressed. The Board's judgement is that the arrangements in place have not yet delivered improvement in the measured outcome, which is the test the revised guidance applies. • As is common across the NHS, a high proportion of concerns relate to relationships between colleagues rather than being directly focused on patient safety. The reconfiguration agreed in July 2026	• Freedom To Speak Up bi-annual reports to the Board of Directors • Board of Directors, July 2026, agreed changes to the configuration of the function • Chief Executive's report to the Board of Directors, July 2026 • People and Organisational Development Committee minutes • Staff Survey report and benchmark report • Freedom To Speak Up Policy and Detriment Standard Operating Procedure • Trust People Council minutes • National Guardian's Office data submission summary • Corporate and local induction checklist

• Is the trust an outlier on staff surveys across peers?	Changes to the configuration of the Freedom To Speak Up function were agreed in July 2026, and a multi-year culture change programme with external advisory support is being co-produced with colleagues, with commitments to be set out at the leaders' conference in September 2026.	to retain the current ward base until at least March 2028 and to focus on improving care within those wards. An open staff meeting on racism hosted by the Chief Executive and the Director of People and Organisational Development led the Board to move from tackling racism within the Trust to a positively anti-racist position under Promise 26, now among the Trust's quality priorities, with feedback from the REACH network on the visibility and authenticity of that work strikingly positive. Concerns about a change to crisis service access criteria were worked through with staff and escalated to the Chief Executive, with colleagues reporting that they were listened to and with resulting investment in the service. • Concerns are triangulated with staff survey results at directorate level, which has identified those directorates combining low reporting volumes with below average confidence, and these are the focus of targeted engagement and leadership action. • Detriment is managed proactively rather than checked retrospectively, with a standard operating procedure formalising the support offered to colleagues at risk of adverse effects from speaking up, and an online reporting route in	is intended to close that gap through a more anticipatory function that reaches into services rather than waiting to receive concerns. • Survey participation fell below the peer group median, which the Board treats as material context for the results rather than as a separate issue. • The national Freedom To Speak Up Guardian's Office closes during 2026, with functions transferring to NHS England, the Department and the Care Quality Commission. The Trust will lose an external comparator at the point at which regulatory scrutiny of speaking up culture strengthens.	• Trust intranet, raising concerns page

		place for sexual safety concerns. ● A resolution target is monitored through RADAR, which also captures protected characteristics against each concern, enabling the Trust to identify whether any staff group experiences differential access or outcomes. ● The Trust People Council, chaired by a non executive director and attended by the Chair and Chief Executive, provides a standing forum with union representatives, staff governors and the Freedom To Speak Up Champion among its members.		

IV. Access and delivery of services | Proposed domain rating: Green

12. Plans are in place to improve performance against the relevant access and waiting times standards. *This statement was criterion 10 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
● Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving	The Trust has met operating guidance standards consistently since 2023 and meets referral to treatment standards routinely. The Trust set itself two improvement goals for 2025/26 and delivered both. The four week wait promise, which goes considerably beyond national standards, was largely achieved by April 2026 and has been sustained since. Inappropriate out	● Standards are examined on the basis of local services rather than aggregated to Trust level, which is important to how the Board understands and acts on the position. ● Sustainability is being tracked deliberately, including through a measure of appointments offered within a week, so that appointments can be forward	● Occupancy across wards remains above the level the Trust is aiming for, because length of stay has not yet materially reduced. Work on standard ward practice, seven day admission and discharge, and effective use of step	● Published waiting times, rdash.nhs.uk ● Integrated Quality and Performance Report ● Board papers on promise delivery and on the four week wait

system partners as necessary? • Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? • Is there a plan to deliver improvement?	of area placements have been eliminated in Doncaster and Rotherham. The Board treats these as quality gains rather than targets, and the sustaining of them as the current challenge. Waiting times across all services are measured, scrutinised and published on the Trust's website.	planned and patients given due notice. • The Board is considering the route to shorter secondary waits, against the wider NHS pledge, as the next step beyond the four week promise. • Productivity measures support access directly, including text based appointment reminders introduced to reduce non attendance, and a patient booking route giving patients some choice of appointment time. • The Chief Executive is the system lead on the reduction of out of area placements, and the Trust has accepted transfer of out of area placement spend from commissioners.	down provision is directed at this. • Neurodiversity waits remain worse than the Trust would wish, notwithstanding sustained investment in assessment and treatment capacity and a position better than many other places. Adults waiting for neurodiversity assessment are omitted from national waiting list reporting, and no national prioritisation is yet apparent despite the educational and employment consequences. A neurodiversity waits and volumes scorecard is now a standing feature of Board reporting.	• Neurodiversity waits and volumes scorecard • Operational plan 2026/27 • Chief Executive's reports to the Board of Directors

13. The trust can identify and address inequalities in access and waiting times to NHS services across its patients.

This statement was criterion 11 in 2025 and was rated green.

Indicative evidence or lines of enquiry	Headline Statement	Contributing Statement	Contra / Gap / Area for Improvement	Evidence
• The board can track and minimise any unwarranted variations in access to and delivery of	Information is available to identify variation, and the Board receives at each meeting an analysis of its Integrated Quality and	• Service data presented by protected characteristic and deprived area is broken down to clinical directorate level, and is reported by protected	• Further work is required to establish whether the actions taken are making a difference to the	• Equity and Inclusion Plan • Promises data reports

services across the trust's patients and population, and plans to address variation are in place.	Performance Report through a health inequalities lens. The Board has a dedicated committee for patient involvement, partnerships and public health, and the focus on inequalities is evidenced through the content of papers and through the strategy itself.	characteristic and deprivation for the promises that sit under the Equity and Inclusion Plan. ● The Equity and Inclusion Group oversees action related to delivering those promises and monitors performance data and progress against actions, reported onward to the Patient Involvement, Partnerships and Public Health Committee. ● Health inequalities reporting aligned to national Core20PLUS5 priorities has continued to mature, improving visibility of service utilisation, access and outcomes across patient populations. ● Concrete action is in place to narrow gaps, including Citizens Advice support, the Travel Fund, poverty proofing work now undertaken by well over a hundred services, additional school readiness work, rurality assessments and plans, and homeless health. ● Subsidised travel for some patients has been introduced up front, arising directly from the poverty proofing work, alongside text based appointment reminders.	communities affected, as shown through the data. The key measures are improved representation of communities in patient referrals, improved appointment attendance for patients from deprived areas and some ethnic communities, improved outcomes for patients from deprived areas and those with protected characteristics, and equitable waiting times across all patient groups.	● Integrated Quality and Performance Report health inequalities data ● Core20PLUS5 aligned reporting ● Poverty proofing programme, findings and actions ● Rurality assessments ● Patient Involvement, Partnerships and Public Health Committee papers

14. Appropriate population health targets have been agreed with the integrated care board. *This statement was criterion 12 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**

• Is there a clear link between specific population health measures and the internal operations of the trust? • Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?	The Trust developed its data suite and baselines working closely with local authority public health teams, using national public health datasets alongside data from ICBs, and used this to develop the Strategic Plan, the 28 Promises and the supporting Equity and Inclusion Plan. The Trust's strategic plan is in line with the strategies of both ICBs, which focus on improving the health of their populations.	• The strategy and promises strongly address population health and aim to reduce health inequalities, with the Equity and Inclusion Plan setting out delivery and success measures informed by population health information from the Trust's three places. • Trust data has contributed to the self assessment against the Patient and Carer Racial Equality Framework, driven forward with a supporting action plan. • The Communities' Leadership Executive, formed under Promise 5 from sixteen partner organisations, is the Trust's principal vehicle for working with communities on population health, and has considered neighbourhood delivery with third sector and primary care partners. • Neighbourhood working in physical health has been refined during the year, alongside shared frailty work with acute and primary care colleagues, and investment in older adult care has been proportionately higher than across the wider Trust. • Teams across the Trust have been involved in developments to address and improve population health, and for some teams, such as Health Visiting, this is their primary focus.	• There is more to do to embed the use of population health data to drive action in every team across the Trust. • More needs to be evidenced that the actions being taken are improving the health of our population. On life expectancy and healthy life years this will take a long time, potentially a decade or a generation, and success and proxy measures have been developed to monitor progress in the meantime.	• Neighbourhood health profiles • Joint Strategic Needs Assessments • Equity and Inclusion Plan • Communities' Leadership Executive terms of reference and out-briefs • Promises data reports • Integrated Quality and Performance Report health inequalities data • Poverty proofing programme, findings and actions

V. Productivity and value for money | Proposed domain rating: Green

15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.

This statement was criterion 13 in 2025 and was rated green.

Indicative evidence or lines of enquiry	Headline Statement	Contributing Statement	Contra / Gap / Area for Improvement	Evidence
• Does the board use all available and relevant benchmarking data, as updated from time to time by NHS England, to review its performance against peers, identify and understand any unwarranted variations, and put programmes in place to reduce unwarranted negative variation? • Is there a track record of delivery of planned productivity improvements?	The Trust leads on productivity and value for money in the mental health and community provider sector, holding the best National Cost Collection index score in the sector, demonstrating the efficient use of resources to deliver high quality care. There is a track record of delivery, not simply of planning. The Trust has met the required level of cost improvement and control totals over several years, delivered a break even outturn, and delivered the two improvement goals it set for 2025/26. The Trust has embraced digital solutions in progressing productivity work and works with NHS England to develop mental health specific solutions in this space.	• The Trust has led the sector in developing Power BI dashboards for costing data used in productivity work across directorates. • Delivered productivity change in the year includes text based appointment reminders to reduce non attendance, and bringing medication supply for wards in house on the ending of a private contract, which shortens the time patients wait for their medication. • The cost improvement programme includes a substantial productivity scheme focused on the Trust's promise to reduce waits, with performance monitored through the Finance, Digital and Estates Committee. • Quality improvement is incentivised across the organisation, including through an annual Trust wide improvement contest which explicitly invites failures to learn from as well as successes. • The Trust received a clean value for money conclusion from its external auditors, and its financial governance and controls were assessed	• Although productivity work has progressed in a number of directorates, there is more to do to ensure all directorates use the available dashboards and implement the learning from that information and from changes made by peers.	• National Cost Collection report • Value for money conclusion • Deloitte Improvement and Innovation controls assessment • Finance, Digital and Estates Committee papers • Cost improvement programme reporting • Power BI costing dashboards

		externally as enhanced or strong in nine of eleven areas of spend.		

VI. Financial performance and oversight | Proposed domain rating: Green

16. The trust has a robust financial governance framework and appropriate contract management arrangements. *This statement was criterion 14 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
• Does the trust have a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data? • Have there been any contract disputes over the past 12 months and, if so, have these been addressed? • Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency or bank staff than planned?	A robust framework is in place, with the Board discharging its financial governance role through the Finance, Digital and Estates Committee. Budget delegation through an annual sign off process with the Chief Executive and Director of Finance ensures all directorates are clear on their responsibility. The reliability of performance data is assured through a dedicated programme, separate from the financial audit programme. Reported indicators are independently tested against national technical definitions in two stages, covering whether report logic is correct and whether source data flows accurately, producing an assurance opinion and kitemark reported to the Finance, Digital and Estates Committee.	• The Trust has undergone external assessment by Deloitte on behalf of South Yorkshire ICB and NHS England of its financial governance and controls across key areas of spend, with controls assessed as either enhanced or strong in nine of eleven areas. • Internal Audit undertakes financially related audits on a rolling programme, with the External Auditors annually providing additional assurance on the system of control, the management of key risks, the delivery of value for money and the production of the annual report and accounts. • Where the information quality programme has identified reporting error, it has been corrected and the assessment repeated, with improvement plans owned and monitored through the Data Quality Group. • Staffing and financial systems are aligned to ensure consistency of reporting on	• The two areas assessed as having standard levels of control in the external assessment were the provision of a programme management office function and absence monitoring. Absence monitoring is now subject to a Board agreed improvement plan. • Assurance on the reliability of quality and safety indicators currently reports through the Finance, Digital and Estates Committee. The Trust is considering whether the Quality Committee should also see the reliability of the indicators it scrutinises,	• Annual financial plan • Internal audit plan and reports • Information Quality Work Programme reports and kitemarks • Deloitte Improvement and Innovation controls assessment • Finance, Digital and Estates Committee papers • External audit report and value for money conclusion

		operational costs. Bank support continues to be used, while agency use has reduced significantly to minimal levels, with limited exceptions agreed by the Board where clinical cover required it.	alongside their values.	

17. Financial risk is managed effectively, and financial considerations, for example efficiency programmes, do not adversely affect patient care and outcomes. *This statement was criterion 15 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
• Does the board stress test the impact of financial efficiency plans on resources available to underpin quality of care? • Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? • Does the board track performance against planned surplus or deficit and, where performance is lagging, does it understand the underlying drivers?	The Board balances finance and patient safety through dedicated governance committees, active risk management and strategic planning. Patient safety and quality are core Board priorities, while financial sustainability is treated as an essential enabler of safe and effective care. Decisions are considered through both a quality and a financial lens, and the Quality and Safety Impact Assessment process is pivotal to this. Assessments are completed before changes are agreed and again afterwards to monitor impact, with reporting to the Board continuing. Through a year that included a substantial change programme, patient safety metrics remained within tolerance alongside delivery of the financial plans.	• The Trust operates an explicit order of precedence in which patient safety sits at the top, supported by an averse risk appetite in respect of clinical safety, demonstrating a clear intent not to compromise patient safety when balancing competing requirements. • Quality and Safety Impact Assessments are reviewed by a panel with core membership, which tests the robustness of mitigating actions and the metrics proposed, and requires a tolerance threshold defining normal or safe variation. Assessments are grouped and themed so that cumulative impact is monitored rather than only individual schemes. • Financial performance is monitored by budget holders, directorate senior leadership teams, through delivery reviews, by the Finance, Digital and Estates Committee and by the	• The impact of organisational change on staff wellbeing requires continued attention. This is monitored through change management processes and staff experience reporting, and is addressed through the culture programme described at statement 11.	• Quality and Safety Impact Assessment policy, panel activity reports and completed assessments • Finance, Digital and Estates Committee papers • Risk Appetite Statement, clinical safety subcategory • Board finance reporting • Delivery review documentation

		Board, with supporting narrative articulating the rationale for any performance not in line with plan. ● A rigorous budget setting process is supported by regular budget management, with scrutiny through delivery reviews. Where necessary, budget delegation has been temporarily removed where additional management control was judged necessary to ensure corrective action. ● The impact of change on staff wellbeing is considered through the impact assessment process and through change management arrangements, with staff experience reported to the People and Organisational Development Committee.		

18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn. *This statement was criterion 16 in 2025 and was rated green.*				
Indicative evidence or lines of enquiry	**Headline Statement**	**Contributing Statement**	**Contra / Gap / Area for Improvement**	**Evidence**
● Is the board contributing to system wide discussions on allocation of resources? ● Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? ● Would system partners agree the trust is doing all it can to balance its local and organisational	The Trust engages fully with system partners across ICB and Place to support the optimal use of resources and to contribute to the delivery of the relevant financial outturn plans. The Trust has returned monies to system partners to support collective balance, has taken on demand side risk to better balance the ICB and Trust	● The Trust sets its plan in conjunction with system partners, with Chief Executive and Director of Finance involvement in system planning and resource allocation discussions throughout the year. ● The Chief Executive is the system lead on the reduction of out of area placements, and the Trust has absorbed change that	● Contract documentation with both commissioning ICBs has taken considerably longer to conclude than the Trust would wish, and one ICB's offer has moved from the position previously indicated. The Trust has kept the Board	● System Leadership Executive and System Executive Board minutes and attendance ● Finance and Contracting Executive Delivery Group minutes

priorities with system priorities for the overall benefit of the wider population and the local NHS?	position, and has accepted the transfer of out of area placement spend. The Trust has met all its financial obligations over several years, achieving the required level of cost improvement and control totals, and delivered a break-even outturn.	removes an equity gap in placement funding across its sites. ● The Trust is working with both ICBs on growth plans for the remainder of the planning period, including on access and workforce expectations arising from national instruction.	sighted throughout and has continued to plan on the basis agreed with partners.	● Annual financial plan and system plan alignment ● Chief Executive's reports to the Board of Directors

Key to ratings applied

Green	High confidence in management. Strong track record across the management team, no concerns with the board's grip, no reputational, system partner or other third party concerns.
Amber green	Some minor issues that should be addressed. No material concerns, but some areas may require a watching brief and as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS. Or, trust in probation, no concerns but capability recovering from previous concerns before final assurance.
Amber red	Material issue needs addressing or failure to address major issues over time. Serious governance or capability issues in at least one domain or capability statement. Or, trust recovering from a red rating with serious issues still present but evidence of improvement and grip.
Red	Significant and persistent concerns. Serious issues in multiple domains, or serious ongoing issues in a single domain that management has been unable to address sufficiently over time, or trust in breach of its governance licence condition or likely to be.

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 24 September 2026

Item 25, Paper U Culture @ RDaSH

To Follow

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Autism Assessment Services	**Agenda Item**	Paper V
Sponsoring Executive	Toby Lewis – Chief Executive		
Report Author	Dr Judith Graham – Executive Director for Psychological Professionals and Therapies and Toby Lewis – Chief Executive		
Meeting	Board of Directors	**Date**	24 September 2026

Suggested discussion points

This paper sets out a proposed future model for **adult autism diagnostic services** in response to sustained growth in demand, long waiting times and insufficient capacity within the current pathway. The proposal is **not to cease autism services for children and young people**, which would continue unchanged, but instead to redesign the adult pathway so that, from April 2027, new adult referrals are triaged through a locally developed, peer-led voluntary, community and social enterprise (VCSE) service, with RDaSH retaining responsibility only for adults with diagnosed mental health conditions requiring integrated specialist support.

The paper argues that there is currently no credible prospect of reducing adult waiting times below two years under the existing model and proposes a shift towards earlier needs-led support while people pursue assessment through alternative routes. The proposal remains subject to engagement, equality and quality impact assessment, commissioner agreement, clinical review and formal governance, with a final decision proposed for November 2026. The paper explicitly highlights significant clinical, ethical and equity considerations, including the risks of delayed diagnosis, potential exclusion, fragmentation of care and the need to ensure that any transition is safe, transparent and co-produced with autistic people and their families.

Potential Board Discussion Points

1. **Strategic Balance Between Diagnostic Access and Earlier Support -** Does the proposed model strike an appropriate balance between providing earlier practical support for autistic adults and reducing reliance on an increasingly unsustainable diagnostic waiting list, whilst maintaining equitable access to formal diagnosis where this may materially affect outcomes?
2. **Clinical Risk, Equity and Reputation -** Are the proposed safeguards, governance arrangements and mitigation plans sufficient to manage the identified risks of delayed diagnosis, unmet need, diagnostic overshadowing and unequal access, particularly for vulnerable groups and those with communication, learning disability or mental health needs?
3. **Readiness for System-Wide Implementation -** What will the Board require before November 2026 to be satisfied that the VCSE-led model has sufficient capacity, sustainability, safeguarding arrangements and commissioner support to safely become the primary entry point for adult autism referrals?

Previous consideration	
None	
Recommendation	
The Board is asked to:	
NOTE the national context and the local recommendations	
CONSIDER the suggestions, bearing in mind patient and staff feedback	
RECOGNISE the risk in either continuing our current approach or making the suggested change	
Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	x

SO3: extend our community offer, in each of and between physical, mental health, learning disability, autism and addictions services.			x
Business as usual			x
Alignment to the plans:			
People and teams plan			x
Finance plan			x
Quality and safety plan			x
Equity and inclusion plan			x
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	**X**
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	x
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	x
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	x
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	x
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	

Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	

Strategic Delivery Risks	
The Trust's inability to work effectively with a diverse population using diverse methods and create alignment between the Trust's agenda and that of the patients and communities (links to SO1). Challenges generating data and / or evidence to support interventions to address Health Inequalities (links to SO2)	X

System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	Required as part of process
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	Required as part of process

Appendix

ADULT AUTISM DIAGNOSTIC PATHWAY

Proposed future model and transition approach

1. Introduction

Autism services in South Yorkshire and Humber are insufficiently funded specifically in adult services, like other places throughout the country (as recognised in National taskforce reports). Despite this demand for autism assessment has risen both in children's and adult pathways. The consequence is frustration from our patients and their families, our staff providing what they can, a backlog that is difficult to address and growing specifically in adult services where the resource investment is the scarcest. On current assumptions, in adult services there is no credible prospect of reducing waits below two years or more while continuing the same model.

The proposed direction is therefore to retain the children's autism diagnostic services, but move from a predominantly Trust-held adult diagnostic waiting-list model to a locally developed, peer-led voluntary, community and social enterprise sector service, only retaining assessment for those people who have comorbid mental health problems.

Therefore, the proposal is that from 1 April 2027, all new adult referrals for autism assessment would be triaged through that service and would not be added to an RDaSH adult autism diagnostic waiting list. This would mean that people can access support from the peer and voluntary led services in terms of the needs that the patient feel are restricting them, whilst they wait for an assessment which may be through a 'right to chose pathway' rather than just waiting on a waiting list.

Before Christmas 2026, the Trust would approach every adult currently waiting, explain the proposed transition, offer engagement with the emerging community model and clarify the route available to them. RDaSH would retain and accept only those adults who have a diagnosed mental health condition and whose needs require an integrated mental health and autism-informed response.

This is not a final decision, but a proposal for discussion. It will also be subject to engagement, equality and quality impact assessment, commissioner agreement, clinical review and governance, a final decision would be made in November 2026.

2. Purpose, scope and strategic context

2.1 Purpose

This paper sets out a proposed change in the adult autism pathway, the reasons for change, the intended transition arrangements and the principal clinical, quality, equality and delivery risks. It is designed to support a decision in principle, followed by formal consideration in November 2026.

2.2 Clear separation of children's and adult services

CHILDREN AND YOUNG PEOPLE'S SERVICES WILL CONTINUE

There is no proposal to cease autism assessment or support within children and young people's services. Any redesign described in this paper applies to adults only.

The distinction is important for staff, families, commissioners and partners. The children and young people's pathway should not be described as closing, withdrawing or transferring as a consequence of this paper. It remains a continuing service, while its capacity and waiting-time pressures continue to require active management.

2.3 Why the adult model requires change

The adult pathway is operating in a context of sustained referral growth, increasing recognition of autism and a widening range of people seeking assessment. Demand is materially greater than the pathway can accommodate. A waiting list that continues to grow faster than assessments can be completed cannot be resolved by process improvement alone.

The central planning assumption for this paper is therefore explicit: there is no prospect, under the current adult delivery model, of waits becoming shorter than two years or more. Continuing unchanged would mean continuing to add people to a queue without a credible route to timely assessment.

2.4 Principles for redesign

- Be honest with people about likely waiting times and avoid creating false expectations.
- Provide practical, needs-led and peer-led support without making all help dependent on a formal diagnosis.
- Protect access to integrated specialist input where a person has a diagnosed mental health condition.
- Co-produce the model with autistic adults, families, the voluntary sector and clinicians.
- Maintain clear clinical governance, safeguarding, escalation and reasonable-adjustment arrangements.
- Minimise inequity during transition and monitor differential impact across protected and underserved groups.

2.5 What this paper does not rely upon

This paper does not rehearse historical adult funding arrangements. The case for change is based on current and foreseeable demand, the duration of waits, clinical sustainability and the opportunity to establish a different model with Humber and North Yorkshire partners and local voluntary, community and social enterprise organisations.

3. Proposed future model for adults

The proposed model changes both the front door and the purpose of the pathway. It places early navigation, peer support and needs-led help in a locally developed voluntary, community and social enterprise setting, while retaining a defined RDaSH role for adults whose diagnosed mental health condition requires an integrated specialist response.

3.1 Model components

Component	Proposed arrangement	Intended effect
Local capacity	Build a peer-led VCSF service locally, co-produced with autistic adults and connected to wider community support.	Earlier contact, navigation and practical support that does not depend on joining a diagnostic queue.
Single adult front door	From 1 April 2027, triage all new adult referrals through the VCSE service.	Consistent triage, clearer information and support matched to presenting need.
No new Trust waiting-list additions	After the change date, new adult referrals would not be added to an RDaSH diagnostic waiting list.	Stops further growth of an open-ended queue and avoids implying a timely assessment can be offered.
Transition of existing waiters	Approach all adults currently waiting before Christmas 2026 to explain and engage them in the transition.	Provides early, direct communication and an opportunity to shape individual next steps.
Defined RDaSH cohort	Retain and accept only adults with a diagnosed mental health condition where integrated mental health and autism-informed input is required.	Focuses Trust specialist capacity on clinical complexity and mental health need.

3.2 What triage should achieve

- Clarify the person's goals, current needs, risks, strengths and reasonable adjustment requirements.
- Identify support that can be offered without a diagnosis, including peer support, information, self-advocacy and connection to local services.
- Identify safeguarding, crisis or mental health concerns requiring prompt referral or escalation.
- Explain clearly that triage is not a diagnostic assessment and does not itself confer or exclude a diagnosis.
- Provide a transparent outcome and route for review where needs change or information was incomplete.

3.3 Boundary of the retained Trust offer

The retained RDaSH pathway would not be a general adult autism diagnostic service. Eligibility would be linked to an existing diagnosed mental health condition and a need for integrated clinical input. Detailed criteria, interfaces and exceptions would require clinical agreement before implementation so that people are not excluded solely because services disagree about ownership.

4. Transition and implementation

4.1 Transition of people already waiting

The transition must be active, personal and transparent. Before Christmas 2026, every adult on the current waiting list should be contacted. Communication should explain the proposed model, the reality of waits of three years or more, the status of the November decision and the support available during transition.

Contact should not be framed as a simple removal from a list. It should invite the person to engage with the developing VCSF offer, check communication and reasonable adjustment needs, identify immediate risk or deterioration, and explain how concerns or new clinical information can be reviewed.

4.2 Proposed milestones

Timing	Milestone	Minimum evidence required	Status
September–October 2026	Co-design and due diligence	Service specification; clinical model; equality and quality impact assessments; information governance; safeguarding and escalation routes.	Develop
Before November 2026 decision	Engagement and assurance	Views of autistic adults, people waiting, carers, staff, commissioners, primary care and VCSE partners; documented response to issues raised.	Required
November 2026	Final decision	Clear recommendation, risk appetite, mitigations, commissioning agreement and governance approval.	Decision
Before Christmas 2026	Contact all adults waiting	Accessible communication; individual contact record; risk screen; transition preference; review and complaints route.	Plan now
January–March 2027	Mobilise and test	Workforce, training, referral protocol, digital and telephone access, data flow, demand modelling, clinical escalation and go-live readiness.	Mobilise
1 April 2027	New adult front door begins	All new adult referrals triaged through VCSE service; no additions to the RDaSH adult autism waiting list except within agreed retained criteria.	Proposed

4.3 Conditions before go-live

- A safe and accessible triage specification, with clinical oversight and escalation thresholds.

- A staffed and sustainable peer-led VCSE offer with supervision, training and safeguarding support.
- Agreed referral, information-sharing, consent, complaints and re-entry arrangements.
- Clear criteria for adults with a diagnosed mental health condition who remain within RDaSH.
- Arrangements for people with communication barriers, learning disability, sensory needs, digital exclusion or no access to family advocacy.
- Benefits, outcomes and safety dashboard, including experience, equity, incidents, escalation and unmet need.

IMPLEMENTATION PRINCIPLE - The 1 April 2027 date should be treated as a controlled change, not an automatic deadline. Go-live depends on completion of agreed safety and readiness conditions.

5. Clinical and quality downsides

The proposed model may offer earlier support and a more honest alternative to an unmanageable waiting list, but it also creates significant clinical risks. These should be recognised explicitly rather than presented as administrative consequences of redesign.

Potential downside	Clinical consequence	Required mitigation
Missed or delayed diagnosis	Some adults may benefit from diagnostic clarification, formulation or reasonable adjustments that are more difficult to secure without a formal diagnosis.	Define routes for clinical review, second opinion and escalation where diagnosis may materially change care or risk management.
Triage becoming a barrier	A new front door could function as gatekeeping if thresholds, capacity or communication are poor.	Publish criteria; provide accessible routes; audit outcomes and rejected or redirected referrals; establish an independent review process.
Fragmentation of care	Separating community support from NHS assessment may weaken continuity, information-sharing and accountability.	Named interfaces, shared protocols, consent-based information exchange, multidisciplinary consultation and clear ownership.
Risk hidden within long waits	People may deteriorate, experience crisis or develop mental health needs while waiting or transitioning.	Risk screening at contact and triage; rapid escalation routes; repeat review where circumstances change.
Diagnostic overshadowing or exclusion	Requiring a diagnosed mental health condition for RDaSH access may disadvantage people whose distress	Clinically nuanced criteria; staff training; access to mental health assessment where symptoms

Potential downside	Clinical consequence	Required mitigation
	is unrecognised, masked or attributed solely to autism.	are suspected but not yet diagnosed.
Unequal access	Peer-led or digital routes may be less accessible to some people, including those with learning disability, sensory or communication differences, language barriers or digital exclusion.	Multiple access routes, proactive reasonable adjustments, advocacy and monitoring by protected characteristic and geography.
VCSE capacity and sustainability	Community service may be overwhelmed or may lack the infrastructure required for complex risk and safeguarding.	Commissioned capacity, safe caseloads, supervision, training, safeguarding links, escalation and business-continuity arrangements.
Loss of specialist workforce	Reduced diagnostic activity could lead to loss of expertise that is also valuable to mental health and learning disability care.	The workforce plan would include retaining all the current pathway staff but ensuring that the focus of their work is within teams supporting people who have co-morbidity and require assessment, consultation, formulation, (i.e. inpatient, CMHT) and also providing training and appropriate specialist assessment capability.

5.1 Ethical tension

The ethical choice is not between a perfect diagnostic pathway and a community model. It is between continuing to place adults on a waiting list of two years or more, with limited benefit while they wait, and introducing a different route that may provide earlier support but less routine access to specialist diagnosis. The decision must therefore weigh honesty, benefit, harm, equity, autonomy and stewardship together.

6. Decision and recommendations

6.1 Matters to resolve before November 2026

- The final clinical model, including the roles of the current RDaSH pathway staff, the purpose and limits of VCSE triage and the retained RDaSH pathway.
- Commissioner support, contracting route and confirmation that the VCSE service can be safely mobilised.
- The treatment of people already waiting, including choice, review, risk escalation and any exceptional routes.

- Quality, equality, legal, safeguarding, information-governance and workforce implications.
- How outcomes and unintended consequences will be monitored and reported after implementation.
- Contingency arrangements if the VCSE model is not ready or demand is materially different from assumptions.

6.2 Recommended decision in principle

The Trust is asked to support further development of the proposed adult model, without committing to implementation until the required engagement and assurances are complete. The model to be developed is:

- Continue autism services for children and young people. No cessation is proposed.
- Build a locally based, peer-led VCSF adult support and triage service.
- From 1 April 2027, triage all new adult referrals through that service and do not add them to an RDaSH adult autism diagnostic waiting list.
- Before Christmas 2026, all adults currently on the waiting list approach and engage them in the proposed transition.
- Retain and accept within RDaSH only adults with a diagnosed mental health condition who meet the agreed criteria for integrated mental health and autism-informed care.
- Require a final decision in November 2026, informed by engagement, clinical advice and completed quality and equality assurance.

6.3 Proposed decision

DECISION - To endorse continued development and formal engagement on the proposed adult autism pathway model, while confirming that children and young people's autism services will continue; and to receive a final, fully assured recommendation for decision in November 2026.

6.4 Suggested assurance measures

Domain	Measure	Oversight focus
Safety	Safeguarding escalations, crises, deterioration and serious incidents during transition.	Early warning and rapid response
Access and equity	Triage outcomes and access by locality, protected characteristic and adjustment need.	Identify unequal impact
Experience	Understanding of the offer, confidence in next steps, complaints and themes from feedback.	Respect and transparency
Clinical effectiveness	Appropriateness of triage decisions, review outcomes and access to mental health assessment.	Avoid missed need
Delivery	People contacted, VCSF capacity, timeliness of triage and unresolved hand-offs.	Readiness and flow

Workforce	Training, supervision, retention of specialist expertise and staff wellbeing.	Safe capability

Conclusion and next steps:

This paper is to support the strategic discussion about the future direction. The final decision is proposed for November 2026 and remains subject to formal governance.

**Paper to be managed via questions only

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Deliverology Implementation – current summary	**Agenda Item**	Paper W
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	24 September 2026

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

Collective endeavours earlier in the year resulted in the adoption from July of a new approach and this paper provides an early update on its implementation through papers to Committees in the meetings held since. It shows that the Committees have embraced this through assessment of their respective workplans and that there has been limited use with specific reference to the individual papers presented. The Board of Directors should consider these first examples and discuss how effective those papers and related discussions have been and how, over the remainder of the financial year, the use of this new approach is increased with more regular use of it.

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

Board Timeout sessions in early 2026 and specifically June 2026; with resultant work through Committee and Board in subsequent meetings including July, August and September 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

The Board of Directors to **RECEIVE** the paper and **NOTE** the progress made since implementation commenced on 1 July 2026.

The Board of Directors to **NOTE** the planned work via the Director of Corporate Assurance with Committee Chairs and Executive leads to identify more opportunities for the use of the new approach in forthcoming meetings; and to achieve consistency in presentation.

The Board of Directors to **AGREE** to receive a further update in March 2027 on this matter.

Alignment to strategic objectives (indicate those that the paper supports)

The new approach does not specifically link to any of the strategic objectives	

Alignment to the plans: (indicate those that this paper supports)

The new approach does not specifically link to any of the Plans	

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)

People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	

Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

Not directly linked to any of the SDR

System / Place Relevance

A key element of the work of the Committees is that linked to Partnerships and therefore there is a link then to the work undertaken within local systems and in place.

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
BOARD OF DIRECTORS: 24 SEPTEMBER 2026
DELIVEROLOGY

1. Background

1.1 The Board of Directors undertook to review and reframe within its governance / operating model the use of the term 'assurance' such that it was clear in expectation and deliver of the roles of the Committees and the way in which those Committees considered information and papers presented to it – ultimately how and in what format it concluded on matters.

1.2 First discussions in Q1 2026/27 were developed through a small subgroup before the Board took time in its June timeout to agree a way forward and to implement it from 1 July 2026.

1.3 This paper presents the first review of progress since to identify any early learning opportunities or where there maybe further refinement to ensure the model as described and agreed has been implemented.

2 The Revised Approach

2.1 The revised approach was two fold – one part linked to the overall workplans of the Committees of the Board (and in this respect the work was focused in four Committees: FDE, POD, PHPIP and Quality); secondly linked to the conclusions formed in respect of some, but not all, papers presented to those Committees.

2.2 The respective format or methodology for each of those two parts was broadly similar, nuanced for the topic of 'workplan (for the Committee) and 'paper' (for the specific papers received but essentially the common ground was in respect of :

- The completeness and robustness of the plan; and
- The likelihood of that plan being delivered.

The conclusion being represented within one box of the 'four-box-grid' as below:

		High Momentum (likelihood of delivery)	
High Clarity (complete and robust)		Low	High
	High		
	Low		

3. Progress within Committees

3.1 The implementation of the new approach commenced on 1 July and has seen each Committee, in its first meeting from that point, revisit its workplan (previously agreed by the Board of Directors in May 2026) to ensure that it fully reflected the terms of reference.

3.2 This first ‘check’ identified a small number of adjustments that were needed to the workplans, as summarised in the table below:

Committee	Identified changes
FDE	• Specific paper to describe the partnerships work relevant to the remit of the Committee; • Specific paper to ensure the Committee is sighted on the work undertaken in respect of achieving Value for Money
Quality	• Specific paper to describe the partnerships work relevant to the remit of the Committee; • Specific papers to consider the related annual declarations for Eliminating Mixed Sex Accommodation (EMSA); and for Safe Staffing – bi annual and annual declaration. • Specific consideration of the progress with the Quality and Safety Plan.
POD	• Specific consideration of the progress with the People and Teams Plan.
PHPIP	• Specific consideration of the relationship with the Trust’s participation partner, PFG; • Specific consideration of the work of local Directors of Public Health and of the local Joint Strategic Needs Assessments and Annual Reports of the DPHs (including inviting them to attend the Committee meeting).

3.3 Considering the updated workplans, each Committee then utilised the four-box-grid approach . The work to ensure workplans met ToR was essentially the first part and therefore in each case that with the changes noted, the Committee concluded that it had a complete and robust plan of work – with all aspects of the terms of reference included such that by the end of the financial year, it (each Committee) would have discharged its role as per the TOR.

3.4 The second part required the Committee to then assess the likelihood of achieving that workplan. This would consider the number of items per meeting and the confidence with which each scheduled item would be delivered/presented on time. In essence, can it be delivered and can the Committee and its members and contributors achieve the pace and requirements of the plan and is there sufficient time in each meeting to ensure discussion and debate can occur.

Committee	Conclusion relating to the Workplan
FDE	High Clarity / High Momentum
Quality	High Clarity / High Momentum
POD	High Clarity / High Momentum
PHPIP	High Clarity / High Momentum

3.6 From 1 July 2026 a number of papers presented to respective Committees have been done so in line with this new approach – and so on an individual paper basis they have been subject to the four-box-grid approach; and specifically the authors have made consideration for the completeness and robustness of the plan of action and the likelihood of deliver of those plans

3.7 These papers are summarised in the table below:

ommittee	Paper	Conclusion
FDE	August: Performance Against the Finance Domain on the IQPR	High Clarity / High Likelihood
POD	August: Promise 24 Education Quality and Multi-professional learning	High Clarity / High Likelihood
PHPIP	July: Promise 10 – Forward look	High Clarity / Low Likelihood *

* the paper proposed the likelihood quadrant was very close to the 'border' between Low likelihood and high likelihood

4. Conclusions

4.1 Since agreeing the new approach the Committees' have embraced its adoption, specifically in respect of the respective workplans to good effect resulting in all four indicating high confidence that their workplans are complete and robust and with high confidence of delivery. Workplans will be presented at each Committee meeting with a purposeful review at the end of Q3 to confirm delivery is occurring – this will also annotate the individual conclusions per paper, where the new methodology is used..

4.2 Whilst there are limited examples of the use then of the new methodology within Committee reports and papers and whilst acknowledging that it was, from the outset agreed, that not all papers would be subject to review in this way, there are more opportunities for its adoption going forward.

4.3 Whilst the methodology is agreed and not to be varied, the way in which the papers have considered it and presented the conclusion has varied between authors. Some have been more detailed and analytical in their assessment and presented essentially 'the workings', others have not. The Director of Corporate Assurance will work with paper authors to consider the differing approaches, to identify a more consistent approach.

5. Recommendations

5.1 The Board of Directors to **RECEIVE** the paper and **NOTE** the progress made since implementation commenced on 1 July 2026.

5.2 The Board of Directors to **NOTE** the planned work via the Director of Corporate Assurance with Committee Chairs and Executive leads to identify more opportunities for the use of the new approach in forthcoming meetings; and to achieve consistency in presentation.

5.3 The Board of Directors to **AGREE** to receive a further update in March 2027 on this matter.

Philip Gowland
Director of Corporate Assurance
18 September 2026