NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS

Thursday 26 November 2026 at 9.30am
The Centre, Brinsworth Lane, Brinsworth, Rotherham, S60 5BU

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 24 September 2026	Decision	Kath Lavery, Chair	B
6		Matters Arising and Follow up Actions	Decision		C
		Board Committee Reports to the Board of Directors			
7	09.35	Quality Committee	Assurance	Richard Falk, NED	D
8		Audit Committee	Assurance	Kathy Gillatt, NED	E
9		Mental Health Act Committee	Assurance	Maria Clark, NED	F
10		People & Organisational Development Committee	Assurance	Sarah Fulton Tindall, NED	G
11		Public Health Patient Involvement & Partnerships Committee	Assurance	Rachael Blake, NED	H
12		Finance, Digital & Estates Committee	Assurance	Pauline Vickers, NED	I
13		Trust People Council	Assurance	Dave Vallance, NED	J
		Operating Performance / Governance / Risk Management			
14	10.05	Strategy Delivery Risks **	Information	Philip Gowland, Director of Corporate Assurance	K
15	10.15	Operational Risk Report	Information	Philip Gowland, Director of Corporate Assurance	L
16	10.30	Promises and Priorities Scorecard	Information	Toby Lewis, Chief Executive	M
17	10.40	Integrated Quality Performance Report (IQPR) **	Information	Toby Lewis, Chief Executive	N
18	10.50	Organisational Change Key Performance Indicators	Information	Steve Forsyth, Chief Nurse	O
		BREAK 11.00 (10 mins)			
19	11.10	Chief Executive's Report	Information	Toby Lewis, Chief Executive	P
20	11.35	Engagement/Disengagement Audit	Information	Dr Diarmid Sinclair, Chief Medical Officer	Q
21	11.55	Freedom to Speak Up	Information	Steve Forsyth, Chief Nurse Officer	R

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Staff Story					
22	12.10	Story to Board: Learning Disability Advocates	Information		Verbal
LUNCH 12.30 (30 mins)					
No	**Time**	**Item**	**Request to**	**Lead**	**Enc.**
23	1.00	Autism Assessment Services (adult only)	Decision	Dr Judith Graham, Director of Psychological Professions	S
24	1.20	CQC well led **	Information	Philip Gowland, Director of Corporate Assurance	T
25	1.30	2027/28 Financial Plan	Decision	Simon Sheppard, Director of Finance and Estate	U
26	1.45	Promise 6: Poverty Proofing	Information	Jo McDonough, Director of Strategic Development	V
27	2.05	Inpatient High Quality Therapeutic Care (HQTC) Stocktake: follow up work **	Information	Toby Lewis, Chief Executive	W
28	2.20	Serious Patient Safety incidents - Learning	Information	Steve Forsyth, Chief Nurse Officer	X
29	2.40	Cultural reset (including antiracism)	Information	Toby Lewis, Chief Executive and Carlene Holden, Director of People and Organisational Development	Y
30	3.00	Estate Plan **	Information	Simon Sheppard, Director of Finance and Estate	Z
Supporting Papers (previously presented at Committee)					
31		No applicable papers this month			
Closing Items					
32		Any Other Urgent Business (to be notified in advance)		Kath Lavery, Chair	Verbal
33		Any risks that the Board wishes the Risk Management Group to consider			
34		Public Questions *			
Chair to resolve '*that because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, the public and press are excluded from the remainder of the meeting, which will conclude in private.'*				Kath Lavery, Chair	
35	*3.20*	*Minutes of the private meeting held on the 24 September 2026*	*Decision*	Kath Lavery, Chair	AA
36		*Matters Arising and Follow up Action List (private session)*	*Decision*		BB
37		*Reflections on the story to Board*	*Discussion*		Verbal
38		*Chief Executive Private Update to the Board of Directors*	*Information*	Toby Lewis, Chief Executive	CC
39	*3.50*	*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 28 January 2027 at 20-21 Visual Arts Centre Scunthorpe (Church Square, Scunthorpe, DN15 6TA)

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**	26 November 2026

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

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

There has been one new declaration since the previous meeting held on 24 September 2026 in respect of Philip Gowland

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 • Member of the Labour Party • Chair Rossington Pride in Place
Richard Chillery, Chief Operating Officer	• Nil
Maria Clark Non-Executive Director	• Lay Examiner for the Royal College of Obstetrics and Gynaecology

Name / Position	Interests Declared
	• 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 • **Wife is a Trustee of Doncaster MIND**
Dr Jude Graham, Director of Psychological Professionals and Therapies	• Trustee for The Queens Institute of Community Nursing • Executive Coach – registered and accredited with the European Mentoring and Coaching Council • ImpACT International Fellow for the University of East Anglia

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING
ON THURSDAY 24 SEPTEMBER 2026 AT 9.30 AM
ROSSINGTON MINER'S WELFARE, WEST END LANE, ROSSINGTON, DONCASTER, DN11 0DU

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

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)

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

Ref		Action
Bpu 26/09/01	**Welcome and Apologies** Mrs Lavery welcomed all attendees to the meeting. Attendees were advised that questions relating to the agenda could be submitted to the Director of Corporate Assurance before midday. The Board noted that the quality improvement poster competition would take place later that afternoon and that a patient story would be presented by video. Mrs Lavery noted Sylvia Akoma, Young Advisor, was welcomed later in the meeting for the relevant agenda item on behalf of YAG. Apologies for absence were noted from Mrs McDonough, Director of Strategic Development. Ms Fulton Tindall would be joining the Board meeting after lunch.	
Bpu 26/09/02	**Quoracy** Mrs Lavery declared that the meeting was quorate.	
Bpu 26/09/03	**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. **The Board received and noted the changes to the Declarations of Interest Report.**	

STANDING ITEMS		
Bpu 26/09/04	**Minutes of the previous Board of Directors meeting held on the 30 July 2026** The Board approved the minutes of the meeting held on the 30 July 2026 as an accurate record, subject to minor amendments within Bpu 26/07/06 Finance, Digital & Estates Committee (FDE). Mr Lewis asked Mr Sheppard to clarify the position regarding South Yorkshire Integrated Care Board cash receipts and provide suitable wording for inclusion. POST MEETING NOTE: Mr Sheppard amended the minutes.	
Bpu 26/09/05	**Matters Arising and Follow up Action Log** The Board received the action log and noted the progress updates. All twelve actions noted as 'propose to close' were agreed, including the Freedom to Speak Up action, noting that several matters were scheduled to return to a future meeting, and one action remained open. **Bpu 26/07/30 Supporting paper previously presented at committee: Guardian of Safe Working Hours**. The action relating to medical job planning remained open until the work had concluded. Dr Sinclair reported that 55 medical job plans had been signed off, with a further 3 expected imminently and the total anticipated to reach 60 early the following week. **Matters Arising Bpu 26/07/08 Trust People Council (TPC)** Mr Vallance sought an update on concerns previously raised at the TPC. Mr Lewis advised that 6 areas of enquiry had been identified, with 4 concluded, and had primarily reflected disagreements between colleagues rather than immediate safety concerns. Further work would consider why some clinicians did not use established incident and risk reporting processes through Radar. Mr Lewis agreed to provide a further update at the next Board meeting. There were no other matters arising.	**TL**
BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS		
	Mrs Lavery reaffirmed 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 26/09/06	**Finance, Digital & Estates Committee (FDE)** Mrs Vickers introduced the report and the continuing absence of signed contracts with South Yorkshire Integrated Care Board (SY ICB) and Humber and North Yorkshire Integrated Care Board (HNY ICB). Mr Sheppard reported that the Trust had accepted an offer from SY ICB of £600k recurrently in relation to the Mental Health Investment Standard. Although this was 600k below the previously agreed the in-year financial impact was manageable and the agreement enabled attention to move to the recurrent position and the national work to deconstruct block contracts. For HNY ICB, Mr Sheppard advised that the core contract, ADHD medication service and out of area placement arrangements had now largely been agreed. Queries remained on the recurrent right to choose variation of approximately £1.2m. Mr Lewis explained that the contractual elements were interdependent and that separating them	

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	would render parts of the service financially unviable. If agreement could not be reached, the Trust would need to consider restricting activity. The deconstruction work indicated that services for North Lincolnshire residents were underfunded by approximately 30%, which represented a material strategic issue. Dr Shah asked whether anticipated commissioner reorganisation could delay the unbundling work. Mr Lewis agreed that this was a risk, although unbundling remained national policy. Greater clarity was expected by the November Board meeting. Mrs Vickers confirmed that the matter would remain on the FDE Committee agenda. Ms Fulton Tindall asked whether the SY ICB agreement supported High Dependency Rehabilitation Unit capacity. Mr Sheppard advised that a trajectory was in place to achieve 16 occupied beds by November, although risks remained. Mr Lewis highlighted the positive expectation that 8 patients might be discharged from the unit before Christmas and advised that any proposal for further capacity, including provision for women, would require caution and clear evidence of affordability. **The Board received and noted the report from the Finance, Digital and Estates Committee.**	
Bpu 26/09/07	**Public Health Patient Involvement & Partnerships Committee (PHPIP)** Ms Blake presented the paper and recognised the significant achievement of poverty proofing all clinical services and positive impact already made for patients and carers. The value of the training was highlighted, alongside the need to embed the learning through sustained changes to clinical practice and service delivery. Mr Lewis advised that the programme's full impact was still emerging but its scale was unprecedented and suggested poverty proofing should remain a Board level matter. Work was progressing on a Poverty Truth Commission to involve people with lived experience and, by March 2027, arrangements to enable clinicians to provide immediate, non-stigmatising financial and food support to patients. It was acknowledged that staff should not use their own money to support patients and that appropriate assistance mechanisms were required. Mr Lewis would report in Q4 on poverty proofing implementation to clinical practice, including non-stigmatising financial and food support. **The Board received and noted the report from the Public Health, Patient Involvement & Partnerships Committee.**	**TL**
Bpu 26/09/08	**Mental Health Act Committee (MHAC)** Ms Clark presented the report and advised that the deep dive into Mental Health Act compliance within the Rotherham adult mental health Care Group had been helpful and identified several areas for further exploration. Dr Sinclair confirmed there was no single cause for the variation in compliance, which reflected differences in assessment and reporting methods across services. Work was underway with the Mental Health Act Manager, matrons, service managers and multiprofessional leadership teams to standardise	

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	processes. The data did not support concerns that the use of locum medical staff had contributed to poorer compliance. Dr Falk challenged the absence of a clear timescale for improvement. Mr Lewis advised that the most material intervention would be to provide ward leaders with timely performance information. The lead time for developing that reporting would be confirmed outside the meeting and an update would return to the next Board meeting. **The Board received and noted the report from the Mental Health Act Committee.** Mrs Lavery invited Board members to raise any questions on other issues within the reports.	**DS**
Bpu 26/09/09	**Audit Committee (AC)** Mr Lewis noted that the Audit Committee had identified no matters for formal escalation, and requested a discussion outside the meeting with the Committee Chair and Director of Finance and Estates to understand the concern regarding the increase in single quote waivers, which he did not currently regard as a material control concern. **The Board received and noted the report from the Audit Committee.**	
Bpu 26/09/10	**Quality Committee (QC)** **The Board received and noted the report from the Quality Committee.**	
Bpu 26/09/11	**People & Organisational Development Committee (PODC)** **The Board received and noted the report from the People & Organisational Development Committee.**	
OPERATING PERFORMANCE / GOVERNANCE / RISK MANAGEMENT		
Bpu 26/09/12	**Strategy Delivery Risks (SDRs)** Mrs Lavery invited questions for Mr Gowland. Mr Vallance asked whether the proposed intervention for SDR2 sufficiently addressed leadership capability as well as time and focus. Mr Chillery advised that leadership and data training had begun, including work with approximately 100 managers, but accepted that current controls did not fully capture the wider programme which was in its early stages. Mr Chillery emphasised that leaders required both the capability and protected time to use data effectively. Ms Blake challenged gaps in control and assurance for which no action was recorded for SDR1. Mr Gowland confirmed that each identified gap should have an action and that these would be addressed with executive leads in the next iteration. Mrs Vickers and Mr Lewis questioned whether the score and treatment for SDR5 adequately reflected the significant culture challenges described elsewhere in the Board papers. Ms Holden agreed that the longer term culture programme and immediate listening work were not	

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	sufficiently reflected. Mr Lewis outlined plans for the executive group to review all five SDRs collectively before the November Board meeting, including overdue actions, addressing control gaps, and realistic delivery dates. Regarding SDR1, Ms Blake asked how the impact of the CoLE would be assessed without overburdening a developing group. Mr Lewis advised that its members would be involved in assessing impact and that this would form part of the Promise 5 audit during quarter 4. Mr Chillery felt that governance should support rather than constrain the group's development. **The Board received and noted the Strategic Delivery Risk report, including the update position for SDR2 and SDR4, and noted the approach to reporting the SDRs through their allocated Committees, set out at Section 2. The Board noted the planned 360 Assurance audit of the Strategic Delivery Risks in late Q3 or Q4 2026/27.**	**PG**
Bpu 26/09/13	**Operational Risk Report** Mr Gowland presented the report and gave key highlights. The number of risks outside tolerance had reduced from 38 to 35, while the total register had increased from 386 to 431 risks. Mr Gowland highlighted the 2 newly significant risks concerning care records at Danescourt and paper based medication recording at Diamond Lodge. Mr Gowland also presented version 13 of the Risk Management Framework, which had been restructured to clarify escalation, delegated closure and authority to accept risk. From 1 October 2026, all colleagues would be able to view Trust risks on Radar. Dr Falk commented that the Risk Management Framework was logical, clearly structured and easy to read. Mr Vallance asked whether the Trust had become riskier or whether the increased register reflected better identification. Mr Lewis advised that both could be true and that a single Trust wide conclusion would obscure material differences between services. Mr Lewis advised that the principal concern remained risks that had not yet been recorded. Mr Chillery added that, although clinical risks could be controlled, higher sickness and vacancies increased the resources and effort required to sustain mitigation. Mr Lewis noted that the duration of a risk was also significant and expressed his reduced confidence in achieving the 5.5% sickness target by March 2027. Continued focus was required on filling vacancies at pace during Q4. Dr Graham referred to risk RSK 570 concerning staff safety at the public multistorey car park in Scunthorpe, used by staff based at Elizabeth Quarter, and noted the need to distinguish actual, perceived and potential risks, while taking staff concerns seriously. Ms Blake noted risk RSK 676 had a score of 20 for the discontinuation of Levemir (insulin medication). Dr Falk and Dr Shah considered that the risk should be reviewed because transition arrangements were already known across the region. The Board asked the Risk Management Group	**PG**

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	to reassess the score without discouraging appropriate high scoring where warranted. With reference to RSK 108, Ms Blake also sought assurance on podiatry waiting times. Mr Chillery advised that the longest wait was approximately 18 weeks and was expected to reduce to 4 weeks by February 2027. Clinical prioritisation and open access arrangements reduced the risk of deterioration while recruitment and newly qualified staff supported recovery. It was noted that referrals had increased substantially with alternative routes and lower-level interventions continued to be considered. Ms Holden referred to RSK 701 and highlighted continuing workforce and capacity pressures in phlebotomy. Similar concerns had been raised at the People and Organisational Development Committee, and wider access to the risk register would support triangulation and assessment of the cumulative organisational impact. Mr Lewis sought assurance that Quality Development Leads would address access to phlebotomy on wards. Dr Sinclair advised that each care group had developed action plans reflecting different starting positions, including arrangements for electrocardiograms, staff training and ongoing monitoring. [POST MEETING NOTE: concerns over the pace of change on this matter in Rotherham wards have been escalated by the Lead Resident] Mrs Vickers welcomed the report and referred to RSK 746 concerning funding for Ambient Voice Technology, a matter which the Finance, Digital and Estate Committee had previously received. Mr Sheppard confirmed that funding had been secured through a three year plan. Mr Lewis noted that wider visibility of the risk register would help identify and correct outdated entries. It was agreed that Mr Gowland would remove RSK 736 from the risk register. **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 with low risk appetite.** **The Board approved the Risk Management Framework, version 13, included in Pack B of the Board papers, as reviewed and supported by the Risk Management Group.**	**RC** **PG**
Bpu 26/09/14	**Promises and Priorities Scorecard** Mr Lewis presented the paper. The lower third measures were highlighted and Mr Lewis advised that the immediate priority remained the progression of the middle group of measures by the end of 2026. The lower third would then form the principal focus for 2027 and 2028. Mr Lewis suggested that clearer routes were emerging for neighbourhood health, carbon reduction and membership, but the health inequalities measures remained the greatest concern because significant effort had not yet produced sufficient results, as noted within	

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	the PHPIP report. Mr Vallance noted that, 3 years into delivery, the Trust remained committed to its Promises and continued to pursue them. Dr Graham asked how the Trust would secure greater progress on antiracism. Mr Lewis advised that the revised plan agreed in July would require alignment of People and Organisational Development processes, consistent line management practice and accountability through appraisal. Mr Lewis acknowledged the need to address resistance and concerns about fairness while maintaining a clear commitment to antiracism. Mr Forsyth asked how the Trust could ensure that predominantly white line managers held the antiracism element of appraisal to account. Mr Lewis advised that the revised appraisal model would include wider oversight and that diverse input would be built into the process. Mr Lewis also confirmed that more targeted and affirmative recruitment action would be required because change would not occur organically. Dr Falk highlighted rurality as an area at risk of losing focus. Mr Lewis accepted the challenge and agreed that clearer leadership and ownership were required. Ms Holden emphasised that improvements in several Workforce Race Equality Standard (WRES) measures did not yet match the lived experience of global majority and minority ethnic colleagues. Mr Sheppard welcomed the openness of the discussion but asked for clearer practical expectations for leaders. Mr Lewis agreed that leaders needed both guidance and responsibility to remain curious and learn from staff networks and existing resources. Mr Pandor asked about the relationship between antiracism, faith, antisemitism and antimuslim hatred. Mr Lewis advised that faith had been intentionally incorporated into the antiracism work to support a more nuanced organisational dialogue and strengthen awareness of misogyny and other forms of discrimination. Clinical services would be considered through ethnicity and faith perspectives during 2027. Completion of ethnicity data coding was the focus of discussion within the E&I group on 10 November 2026, with a view to overcoming our missing data in Q4. **The Board received and noted the Promises and Priorities Scorecard, including the themes and challenges that lie behind our reddest success measures. The Board acknowledged progress described in terms of membership, carbon and targeted recruitment, and had opportunity to consider the described timetable to bring a 'lower third' action plan to the Board in Q4.**	
Bpu 26/09/15	**Integrated Quality Performance Report** Mr Chillery introduced the first full version of Integrated Quality Performance Report (IQPR) in its new format. Further internal measures and definitions remained in development, but the report placed greater emphasis on quality, safety, integrated workforce and finance measurables demonstrating progress against the Trust Promises. The 4 week wait performance had reduced to 74.7%, although in many services the breach involved only a small number of people. Sickness and vacancies made delivery fragile and required close oversight.	

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	Mr Chillery also highlighted work to reconcile the Trust's position with national reporting on crisis response and waits exceeding 104 weeks. These figures reflected NHS England's measurement methodology rather than the actual length of time patients had waited for care and therefore did not represent genuine waits of over 104 weeks. Dr Falk welcomed the new format and confirmed that the Quality Committee would consider whether it provided an appropriate basis for reviewing all 14 clinical directorates, while avoiding over interpretation of small numbers. Mr Vallance welcomed the report but challenged whether the narrative sufficiently explained the causes of variation, particularly in Talking Therapies. Mr Lewis agreed that deeper analysis was required and that some explanations, including sickness, needed to be tested against the underlying activity and capacity data rather than accepted automatically. Mr Lewis stated the Board needed to retain a clear focus on four-week delivery, and that the Trust's promise was about maintaining trust with patients and that December pressures should be planned more effectively than August pressures. **The Board received and noted the Integrated Quality Performance Report, including the deterioration in four week delivery within the report.** **The Board considered the new format of measures and offer relevant feedback, and recognised work to improve operational practices in Talking Therapies. The Board asked the Quality Committee to consider how far this provides a basis for reviewing all fourteen directorates' quality and safety performance.**	
Bpu 26/09/16	**Organisational Change Key Performance Indicators** Mrs Lavery invited questions for Mr Forsyth and asked the Board to consider the August Quality and Safety Impact Assessment monitoring position, noting that November would mark six months since implementation. Responding to Dr Falk, Mr Forsyth advised that there was no evidence of direct patient harm attributable to the organisational change programme, although access, capacity, documentation and data quality exceptions required continued scrutiny. Dr Falk asked when the Board could move from a conclusion that no harm had been demonstrated to positive assurance that services remained safe. Mr Forsyth advised that complaints, incidents, safeguarding and unmet need had not increased, but accepted that more data over time were required to identify sustained trends. Mr Lewis advised that the 6 month point in November should begin to provide a stronger basis for positive assurance. Mr Lewis asked about the reliability of Early Intervention in Psychosis caseload data. Mr Forsyth explained that detailed work in Rotherham had clarified the numerator but that the monthly whole time equivalent denominator and inclusion rules still required validation. Mr Forsyth confirmed that comparable work was needed in North Lincolnshire. Mr Lewis advised that the next report should provide assurance that caseloads across all three Early Intervention teams were known and	

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	within expected thresholds. Responding to Ms Blake, Mr Forsyth clarified that the NHS 111 measure related to calls routed through option 2 to the Trust's crisis services. **The Board received and noted the Organisational Change Key Performance Indicators August 2026 QSIA monitoring position, approximately four months following implementation of the organisational changes associated with the CIP programme. The Board had opportunity to 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.** **The Board noted 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.**	
Bpu 26/09/17	**Chief Executive's Report** Mr Lewis drew attention to the key items within his report, including the Trust's improved National Oversight Framework position, the EPRR submission (100%), winter readiness, patient safety learning, organisational change, care planning, cultural commitments and to reconfirm support of the definition of antisemitism provided. Regarding the National Oversight Framework position, the Trust had moved from segment 3 to segment 2 and was unlikely to deteriorate during the year, although data relating to crisis access and children's waits required correction. The patient safety annexes included the Danescourt action plan and learning from the death by suicide of a patient following discharge from Trust care. Mr Lewis stressed that the organisation must fully implement and sustain both action plans. One was specific to a service, while the other applied across community and inpatient services, with five directors involved in delivery. Mr Lewis reported that the organisational change process had largely concluded, apart from a small number of cases affected by absence or outstanding implementation. Mr Lewis stressed that the remaining work was not primarily financial but concerned delivery of the operational changes promised to staff. Consultation would begin in October on significant changes to physical health services from March 2027, including a neighbourhood model balancing specialist and generalist care, with proposed success measures returning to the Board in March 2027 after the consultation had concluded. In relation to care planning, Mr Lewis advised that the Trust would miss the end of September target for full DIALOG+ coverage but expected most outstanding work to conclude during October. The remaining gaps were concentrated in adult mental health services in Doncaster and Rotherham, with further work required to define the appropriate cohort in drug and alcohol services.	**TL**

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	Dr Shah discussed the learning and action plans arising from the CQC Danescourt inspection and the death of a patient following discharge. Mr Forsyth emphasised that the action plans had to be delivered and sustained. Ms Clark welcomed the expansion of System Connect but cautioned that digital routes could overwhelm or exclude some people and should not become the only means of access. Ms Clark also asked that opportunities to connect eating disorder work with research and evidence development were explored. Mr Lewis agreed the South Yorkshire Eating Disorders Joint Committee would be considering those opportunities when it meets in November. Mr Sheppard asked about the proposed reaffirmation of the definition of antisemitism. Mr Lewis explained the debate nationally, with advocacy groups reaching out on either 'side' to chairs and CEOs, but he advised that the definition did not per se preclude criticism of the actions of the Israeli Government, although he recognised the case law was to be established in practice and practical application required care. Dr Falk described the importance of understanding Zionism and the effect of language on Jewish colleagues. Board members acknowledged the need for further education. Ms Holden confirmed that further training sessions were planned and that a paper on the practical application of the antisemitism and antimuslim hatred definitions would return in November. Ms Blake asked about increased refusal of flu vaccination. Mr Lewis explained that a higher proportion of unvaccinated colleagues had made an explicit choice, which might reflect improved engagement rather than a decline in uptake. Mr Forsyth reported that more than 300 colleagues had been vaccinated during the first three days. Mr Forsyth asked how the Trust would respond to the findings of the Thirlwall Inquiry. Mr Lewis advised that the detailed implications would be considered at the Board time out session in October, with no immediate additional actions identified for the Trust before that discussion. **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, and considered any matters of concern not covered within the report.** **The Board reconfirmed support of the definition of antisemitism provided.** **The Board accepted the EPRR submission (100%) agreed at its July meeting.** **The Board noted assurances related to the Winter Plan 2026 and outlined in the relevant annex.**	
Bpu 26/09/18	**Peer Support framework: first report**	

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	Dr Graham presented the first report on the Peer Support and Lived Experience Framework. It was emphasised that progress should not be judged only by the number of peer support workers. The framework sought to understand impact through the experience of peers, the views of staff and quantitative activity and outcomes. Peer workers had described meaningful relationships, hope and recovery as central to their role, but had also identified inconsistent integration into multidisciplinary teams, access to information, supervision, safety equipment, training and career progression. Ms Clark reflected that her view of peer support had changed positively as evidence of its impact had grown. Mr Lewis noted that the original strategic emphasis on peer support had been supported by senior medical colleagues and asked whether the Executive was clear about what good multidisciplinary integration would look like. Dr Graham advised that good practice would include clear role identity, equal access to information and training, involvement in risk and care planning, effective supervision and participation in team decision making. Mr Vallance welcomed the framework but challenged whether the 11 recommendations were sufficiently prioritised and resourced. Dr Graham acknowledged the competing demands and advised that the Executive would need to agree sequencing and ownership. Mrs Vickers highlighted lower attendance by lived experience representatives at some governance meetings and accepted that Committee Chairs had a role in ensuring contributions were valued and supported. Ms Blake asked how relationships and staff perspectives would be tested. Dr Graham advised that the staff questionnaire had received only one response and could not be generalised. Further work would therefore be required through staff engagement and partnership contracts. Ms Holden emphasised the importance of ensuring that partner employed peer workers received comparable support and were not treated as a second class workforce. Dr Shah queried the requirement for a general practitioner referral after a patient had ended their work with a peer support worker. Dr Graham confirmed that this reflected an existing pathway barrier rather than a clinical requirement and that work would be undertaken to establish a more equitable route back into community mental health services. **The Board received and noted the Peer Support framework: first report, and the considerable progress of work on peer support since our review in November 2025.** **The Board had considered whether the executive is sufficiently clear on how to take forward the eleven recommendations within this paper, and recognised that 2027/28 represents a final 'round' of peer support growth in executing Promise 1.** **The Board agreed 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).**	**JG**
Bpu 26/09/19	**CQC Readiness**	

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	Mr Forsyth presented the paper and highlighted the refreshed position across all 14 clinical directorates. The internal position remained predominantly “Good” but included material improvements, deterioration and uneven evidence strength. The proposed judgement was reasonable but not comprehensive. Mr Forsyth stressed that Danescourt had demonstrated the difference between positive experience and the existence of evidence, and reliable systems that could be retrieved and tested at the point of inspection. Dr Falk welcomed the focus on contradictory evidence and emphasised Mental Capacity Act compliance, medicines and care records. Mr Vallance asked how independent challenge could be strengthened. Mr Forsyth agreed to consider more detailed service-level testing of care plans, medicines and risk management, Ms Gillatt called for clearer second line assurance through independent oversight and contrary indicators. Mr Vallance supported focused, risk based sampling to avoid excessive assurance activity. Mr Vallance asked how the Board could enable independent minded colleagues to provide constructive challenge. Mr Forsyth advised that future CQC readiness reviews should move beyond aggregated directorate level assurance to include more service level testing of care plans, medicines and risk management. Mr Lewis emphasised that external findings should be considered objectively and that the inability to retrieve care plans and medicines information represented a substantive concern. Mr Forsyth agreed to consider how future CQC readiness reviews could incorporate service level scrutiny and independent constructive challenge. Ms Gillatt referred to the three lines governance model and advised that the Trust needed clearer second line assurance between service level controls and external regulatory review. Ms Gillatt supported routine controls, independent oversight and active use of contrary indicators. Mr Vallance also cautioned against creating excessive assurance activity that diverted staff from improvement and care delivery. The balance should be achieved through focused, risk based sampling rather than universal checking. **The Board received and noted the CQC Readiness paper, and noted the longitudinal development of the CQC readiness programme and the September 2026 internal position.** **The Board recognised the improvement and sustained performance demonstrated across a number of services alongside the deterioration and persistent gaps identified through the September reassessment.** **The Board required 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.**	
STORY TO BOARD		

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Bpu 26/09/20	**Patient story** The Board received a patient story by video. The Journey Home by Jenette Depledge, Autism Diagnostic Practitioner, about balancing her NHS role with caring for her grandfather, Ged, during the final stage of his life. Jenette's request for leave to accompany Ged home from hospital had been declined, meaning she missed that final journey with him. The story was shared to encourage reflection on how RDaSH's Promise 2 and Always Measures 3 and 4 could support staff when caring circumstances suddenly became exceptional. It proposed consideration of a compassionate review or escalation route to provide consistent advice and support to both staff and managers before decisions were made. The Board agreed that reflections on the story would be considered during the private session.	
	Kate Jones, Chloe Jones and Sylvia Akoma joined the meeting at 1.10pm	
Bpu 26/09/21	**Response to the items highlighted within the Young Advisors work in the AMM** Mrs Lavery welcomed Sylvia Akoma to the meeting. Mr Gowland outlined the feedback from the Young Advisors at the Annual Members' Meeting and the proposed response to approximately 20 ideas covering volunteering, employment, research, bullying, safety, mentoring and involvement in Trust governance. Ms Akoma welcomed the overall response and asked how demand would be managed for university support and work experience opportunities. Mr Lewis advised that the proposed university scheme would need clear and fair criteria, likely linked to health and care related study and communities experiencing barriers, while avoiding an onerous application process. Mr Lewis confirmed that the proposal was for three awards each year, funded from the investment fund, and that Young Advisors would be involved in developing the criteria. Ms Blake emphasised that recipients should retain reasonable choice over how the award supported their study, within an agreed financial limit. Responding to Ms Akoma, Ms Holden described the proposed reverse mentoring model, which would match Young Advisors with Board members over an extended period and allow both parties to test whether the relationship was suitable. Ms Holden also described work to support staff to become school governors and health ambassadors, recognising the practical challenges of school day meetings. Ms Clark offered to connect the Young Advisors with research ethics and university contacts to support meaningful participation in research. Dr Graham confirmed that young person research champion opportunities would be developed with Grounded Research. Mr Forsyth highlighted the RCN cadet programme and suggested exploring a similar Trust nursing cadet route. Mr Lewis emphasised the importance of promoting opportunities through trusted voices. Mr Chillery suggested using the Children's Care Group's local intelligence and established school networks to improve engagement.	

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	Mr Lewis emphasised that bullying had been the strongest and most consistent concern raised by Young Advisors, and advised that successful delivery could not be claimed unless the Trust and its partners made tangible progress on bullying in schools and during travel. Ms Blake suggested building on schools already engaged in the Choose Kindness work while also reaching schools where engagement was more difficult. Mr Lewis stated that personal relationships with schools, local authorities and transport partners should be used to advance this work and supported using the Children's Care Group's knowledge and community relationships to reach less engaged schools. Board members were explicitly asked to, and did indicate their support for the plans outlined, including for the introduction of a university bursary scheme from August 2027. **The Board received and noted the report, including the feedback and topics provided by the Young Advisors. The Board endorsed the proposed actions in response and note the future reporting and feedback to the Young Advisors.**	
	Sylvia and Chloe left the meeting at 1.35 pm *Ms Fulton Tindall joined the meeting at 1.35pm*	
Bpu 26/09/22	**Outcomes of service delivery 14 weeks** Mr Chillery presented the programme to achieve a maximum secondary wait of 14 weeks by June 2027. The secondary waits position at the time of reporting stood at 40% of identified pathways as meeting the standard. Reporting development had progressed more slowly than planned because Health Informatics capacity had been redirected to national waiting time requirements and the revised Integrated Quality Performance Report. Remaining demand and capacity reviews were due by 16 October, the productivity workshop would take place in early November, and informatics development, quality impact assessments and equality impact assessments were due by 30 November. Mr Lewis welcomed the fixed list of secondary pathways and the separation between primary assessment waits and secondary treatment waits. Mr Lewis asked how the Trust would conduct supportive but honest conversations with clinical teams where improvement depended on productivity, job planning and stopping or reallocating lower value work. Mr Chillery advised that job plans should protect both patient facing activity and professional development, supported by effective supervision and reliable team level data. Mr Chillery acknowledged that some teams were working beyond expected levels while others required clearer accountability. Mr Vallance questioned whether 14 weeks was appropriate for every service, particularly where people experienced severe anxiety. Dr Graham and Dr Sinclair advised that urgency and clinical risk would continue to be assessed and that some interventions should occur sooner. The 14 week standard represented a maximum, not a uniform expected wait. They also emphasised that patients should receive meaningful assessment, planning and support during the period rather than being left without contact.	

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	Dr Shah highlighted the wider cost of delay through crisis services, primary care and emergency departments and asked how variation between localities would be addressed. Mr Chillery advised that consistent expectations, better demand and capacity information and clinical leadership would be required, while recognising legitimate differences between pathways. **The Board received and noted the outcomes of service delivery 14 weeks report, and recognised the potential to deliver real change in 2027 on secondary waits.** **The Board acknowledged the programme was running little behind with data flows and reporting. The Board noted the intention to focus over the coming 8-10 weeks on finalising information and alignment. The Board noted that the majority of shortened waits will come from revised job plans and throughput.**	
Bpu 26/09/23	**Provider Capability Assessment Framework** Mr Gowland presented the Provider Capability Assessment Framework. The refreshed assessment reflected the 2026 guidance, which required ratings at domain level, introduced a new cyber security and digital statement, and placed greater emphasis on evidence of effectiveness rather than the existence of processes. The proposed ratings were Green for five domains and Amber Green for People and Culture. The paper recommended that the Trust move to green for Quality of Care but invited challenge of that position. Dr Falk, Mr Forsyth, Mrs Gillatt and Mrs Vickers highlighted fragility in performance, continuing care planning gaps, the Danescourt learning, uneven evidence of sustained improvement and the distinction between committed action and demonstrated impact, all of which did not support the proposed Green rating for Quality of Care. Mr Lewis suggested that the Quality of Care rating should remain Amber Green and advised that the reasons and required evidence for future movement needed to be stated precisely. It was also agreed that People and Culture should remain Amber Green. It was considered that an Amber Red rating would not accurately reflect the Trust's position relative to peers, but that the length and scale of the culture improvement programme did not support a Green assessment. **The Board received and noted the Provider Capability Assessment Framework, including 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.** **The Board reviewed the updated position, specifically on the two areas previously rated amber-green in 2025. It acknowledged the reports contents and the progress made but confirmed that the Trust's position in respect of both should remain Amber-Green.**	

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	The Board delegated 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.	**PG**
Bpu 26/09/24	**Culture @ RDaSH** Mr Lewis presented the developing culture programme, centred on high support and high accountability. The paper set out 12 emerging commitments but did not present a final model because the organisation needed to understand staff experience more deeply before completing the programme. The proposed approach included time spent where people worked, structured engagement with staff representatives and professional leaders, and use of RDaSH Connect to test ideas and priorities. Mrs Vickers asked whether the listening programme would include all shifts, professions and Board members. Mr Lewis advised that the programme would include clinical and corporate teams, different working patterns, group sessions and informal time in services. Mr Lewis emphasised that visible presence and follow through would be essential because staff might reasonably question the authenticity of the programme. Mr Sheppard highlighted the importance of helping all staff understand that patient safety was the organisation's first priority, including colleagues in corporate services who might not readily see their contribution. Mr Sheppard also asked whether staff would be given permission to stop lower priority work. Mr Lewis advised that leaders needed to coach teams to make good choices and remove unnecessary friction, rather than issue a central list of work to stop. Mr Vallance supported the model but stressed that engagement depended on emotional, intellectual and physical energy, and that line managers needed to hold regular two way conversations about expectations, support and barriers. Mr Lewis agreed and advised that the revised appraisal model, honest conversations and 360 degree feedback would strengthen mutual accountability. Mr Lewis stressed that line managers would need both support and clearer responsibility, and that the Trust would need to respond where role fit or capability remained insufficient. Ms Gillatt emphasised that high performance depended on trust, empowerment and shared responsibility rather than a hierarchy in which accountability sat only at the top. Dr Falk cautioned that staff scepticism was likely to be considerable and should be openly acknowledged. Dr Graham highlighted the need for consistent application, appropriate resources, attention to bias and recognition that organisational systems could inhibit good leadership. Mr Lewis drew attention to the paper's commitment to High Support and High Accountability. He noted that in effect this item was the final moment to pull back from that route. Board members may have	

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	privately divergent perspectives including over language but this paper marked a final approval of that framing. Mrs Lavery sought and received colleagues' support for the approach proposed. **The Board received and noted the Culture @ RDaSH update, and recognised the work being undertaken and the discursive nature of this paper's development. The Board had opportunity to comment on the commitments given within it and examined whether the intention outlined goes far enough in adapting the culture we have and wish to see.**	
Bpu 26/09/25	**Autism Assessment Services** Dr Graham presented the proposed future model for adult autism assessment services. Dr Graham stressed that children and young people's autism services would continue unchanged. The proposal responded to sustained demand, waits of several years and insufficient commissioned capacity. It would develop a locally based peer led voluntary, community and social enterprise support and triage service for adults, while retaining specialist RDaSH assessment and consultation for people with diagnosed mental health conditions requiring integrated support. Dr Sinclair supported exploration of a different model but asked what proportion of people would remain eligible for the retained Trust pathway, given the high level of mental health comorbidity. Ms Blake welcomed the emphasis on needs led support and asked that training for community partners and evidence about what people seeking assessment actually wanted were central to the next stage. Mrs Lavery welcomed the paper but also challenged whether the voluntary sector had sufficient capacity, governance and sustainability. Dr Graham advised that the market and local partnerships would need to be tested and that implementation could not proceed unless safeguarding, supervision, information sharing, workforce and business continuity arrangements were robust. Ms Clark expressed concern about the timing and potential for the proposal to be perceived as withdrawal of care. Ms Clark asked how the model would address people whose mental health needs were unrecognised, young people transitioning into adult services, the risk that right to choose routes might reduce, and the need to communicate openly with current waiters. Mr Lewis advised that the key question for commissioners was whether they could offer any credible route to reduce a four year wait. Mr Lewis emphasised that the proposal sought to provide support rather than leave people waiting without benefit, as presently, but accepted that the safeguards and transition arrangements required substantial further work. Mr Vallance asked that people with emerging rather than established mental health needs were not excluded by the retained pathway criteria. Dr Falk also raised the distinction between chronological age and transitions for young people in further education. Dr Graham agreed that criteria would need to be clinically nuanced, with clear routes for review, escalation and reasonable adjustments but was explicit that only a	

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	secondary care formal diagnosis would remain in purview for the autism pathway for adults. **The Board received and noted the Autism Assessment Services report, including the national context and the local recommendations. The Board had considered the suggestions, bearing in mind patient and staff feedback, and recognised the risk in either continuing our current approach or making the suggested change**. **The Board endorsed 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**.	**JG**
Bpu 26/09/26	**Deliverology Implementation – current summary** Mrs Lavery invited questions for Mr Gowland. Dr Falk supported the underlying method but questioned whether the term deliverology was helpful or accessible. Mr Gowland agreed that alternative terminology should be tested without changing the agreed method. **The Board received and noted the Deliverology Implementation – current summary, and noted the progress made since implementation commenced on 1 July 2026.** **The Board noted 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 agreed to receive a further update in March 2027 on this matter.**	**PG**
SUPPORTING PAPERS (PREVIOUSLY PRESENTED AT COMMITTEE)		
Bpu 26/09/27	**Medical Revalidation, Guardian of Safe Working Hours and Mortality Report (May and June 2026)** Mrs Lavery informed the Board of the Medical Revalidation, 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 confirmed that the action relating to medical job planning would remain open for some time further (Bpu 26/07/30). **The Board received and noted the Medical Revalidation, Guardian of Safe Working Hours and Mortality Report for information**.	
CLOSING ITEMS		
Bpu 26/09/28	**Any Other Urgent Business** There was no further business raised.	

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Bpu 26/09/29	**Any risks that the Board wishes the Risk Management Group to consider** Mr Lewis suggested that the developing culture programme and the adult autism pathway should be considered for future reflection within the Trust's risk registers as the proposals matured. The Board agreed that the relevant executive leads and the Director of Corporate Assurance would consider this, without creating a premature risk entry before the work had been sufficiently developed.	**PG**
Bpu 26/09/30	**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 26 November 2026 at 9.30am, The Centre, Brinsworth Lane, Brinsworth, Rotherham, S60 5BU		

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

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 26/09/12	**Strategy Delivery Risks (SDRs)** The Executive team would review all five SDRs collectively before the November Board meeting, including overdue actions, addressing control gaps, and realistic delivery dates.	PG	The paper on today's agenda includes the latest position regarding the five SDRs having, in the last two months, been the subject to discussion with individual Executive leads, a collective EG review, discussion at Committee and discussion with the Audit Committee Chair.	Propose to Close
Bpu 26/09/25	**Autism Assessment Services** The Board to receive a final, fully assured recommendation for decision **in November 2026**.	JG	Paper S on today's agenda responds to this previously agreed action.	Propose to Close
Bpu 26/09/13c	**Operational Risk Report** With reference to RSK 736 concerning funding for Ambient Voice Technology and confirmation that funding had been secured through a three-year plan. It was agreed that Mr Gowland would remove RSK 736 from the risk register.	PG	RSK736 has been closed because the source of funding is confirmed.	Propose to Close
Bpu 26/09/13a	**Operational Risk Report** Regarding risk RSK 676 (score of 20 for the discontinuation of Levemir), noting the transition arrangements were already known across the region. The Board asked the Risk Management Group to reassess the score without discouraging appropriate high scoring where warranted.	PG	The score for RSK 676 was reassessed through the Risk Management Group and has reduced from 20 to 9. Clinics are now in place to switch patients from Levemir to an alternative medication, and a number of patients have already been switched. At 9 the risk remains outside tolerance for clinical safety and continues to be reviewed monthly	Propose To Close
Bpu 26/09/23	**Provider Capability Assessment Framework** An update would be provided **in November 2026** of this process and any feedback received, including the outcome of national moderation.	PG	The paper on today's agenda regarding Well-Led makes reference to the PCA submission. To date, there has been no feedback from the regional team nor a request for the implied action planning.	Propose to close

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 26/09/05	**Matters Arising Bpu 26/07/08 Trust People Council (TPC)** Mr Lewis to provide a further update at the next Board meeting on the remaining areas of enquiry following concerns raised at TPC in July 2026.	TL	Colleagues may recall a safety comment pitched to the July TPC. Subsequent discussion with the BMA confirmed no immediate safety issues but underlying concern in six areas, each of which has now progressed either to a conclusion or to defined actions.	Propose to close
Bpu 26/09/29	**Any risks that the Board wishes the Risk Management Group to consider** The developing culture programme and the adult autism pathway should be considered for future reflection within the Trust's risk registers as the proposals matured.	PG	These will be considered at December's RMG.	Open
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	The current position is being reported to the Board regularly by CEO and CMO and will be covered orally under the CEO Report item. This item remains open until it is concluded with a paper planned to be presented to the Board in **January 2027** which will also reference an ongoing piece of internal audit work on job planning generally.	Open
Bpu 26/09/08	**Mental Health Act Committee (MHAC)** Dr Sinclair to confirm the timescale for providing Mental Health Act performance information to ward managers and report back to the next Board meeting.	DS	This is expected to be provided **during Q4** and is now being linked to the ward scorecards discussed in the private action log and referenced in the HQTC Board paper.	Open
Bpu 26/09/12	**Public Health Patient Involvement & Partnerships Committee (PHPIP)** Mr Lewis would report **in January 2027** on poverty proofing implementation to clinical practice, including non-stigmatising financial and food support and future Board or Audit Committee oversight.	TL	As per the agreed action, this matter will return to the Board in **January 2027**.	Open
Bpu 26/09/17	**Chief Executive's Report** Following the October consultation on physical health service changes, including a neighbourhood model, success measures would return to the Board **in March 2027.**	TL	As per the agreed action, this matter will return to the Board in **March 2027.**	Open

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
Bpu 26/09/26	**Deliverology Implementation – current summary** The Board agreed to receive a further update **in March 2027** on this matter.	PG	As per the agreed action, this matter will return to the Board in **March 2027**.	Open
Bpu 26/09/13b	**Operational Risk Report** With reference to RSK 108, a further update would be presented to the Board in **March 2027** regarding podiatry wait times.	RC	We remain on track for podiatry to 'catch up' the four-week standard from **March 2027**, and this will be incorporated within the IQPR report to the Board at that time.	Open
Bpu 26/09/18	**Peer Support framework: first report** The Board agreed 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).	JG	As per the agreed action, this matter will return to the Board via our timeout work in **April 2027**.	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:	18 November 2026		
Attendees:	Dr Richard Falk, Steve Forsyth, Hannah Hall, David Vickers, Dave Vallance, Maria Clark, Dr Rumit Shah, Dr Jude Graham, Richard Chillery, Dr Diarmid Sinclair. In addition: Phil Gowland, Julie Thornton, Natasha Littlewood, Claire Klein, Dr Barathy Kandhasamy.		
Matters of concern or key risks to escalate to the Board:	**Safer Staffing Report, Establishment Review and workforce resilience.** The Committee supported the nursing establishment review as an evidence-informed baseline, including use of recognised staffing tools, acuity and dependency information, peer validation and professional judgement. This sign-off confirms the methodology and minimum establishment position. However, sickness, vacancies, acuity, skill mix, geography, redeployment and missed breaks continue to create ward-level fragility. The Committee noted the investment identified through the review, including the Mulberry healthcare support worker uplift and resilience for isolated or single-unit registered-nurse cover, and supported its funding through 2027/28. Board action requested: Receive the full safer-staffing establishment review, appendices and required nursing/executive assurance statement; endorse the review methodology and establishment-planning assumptions; require the identified investment to be explicitly considered through 2027/28 planning; and maintain oversight of ward-level staffing variance.		
Key points of discussion relevant to the Board:	**Strategic Delivery Risk.** Strategic Delivery Risk 4 remained scored at 12. Following risk-benefit assessment and benchmarking with 10 comparable trusts, the Committee accepted the recommendation not to proceed with the proposed evening and weekend extension for medical, psychological and allied health professional groups because an isolated model could adversely affect recruitment and retention. Patient benefits are to be retained through seven-day therapeutic activity, protected clinical time and community-linked support. Weekend discharge remains possible when clinically planned and when medical, managerial, pharmacy/medicines and social-care arrangements are available. **Chief Nurse Triangulation Report.** Radar reporting had increased and the overdue incident position had deteriorated. More than 95% of incidents in the highest 13-month period were described as near miss, no harm or minor harm; moderate-and-above incidents continued to receive investigation and Duty of Candour contact. The Committee did not take full assurance from the backlog. The quarter-four recovery plan requires approximately 60-70 closures each week, but timeliness must not displace investigation quality, learning or evidence that actions prevent recurrence. The triangulation report is a “work in progress” and will be refined to provide validated data, clearer ownership, a stronger multidisciplinary executive view and explicit “so what” actions. **Pressure damage.** Pressure damage remained the most prominent recurring harm signal.		

The Committee recognised that a proportion may be present before entry to Trust services, but source attribution does not remove the requirement to assess, prevent deterioration and learn. The October review is to be circulated, and the next triangulation report will show the acquired/present-on-entry split, grade, service and recurrence patterns, together with evidence of prevention and healing outcomes.

Integrated Quality and Performance Report.

Talking Therapies access remained below trajectory and required data reconciliation. SMI physical-health performance had improved and exceeded the stated national benchmark but remained below the Trust's 95% ambition; completion requires all eight domains. It was restated that good Care planning is central to everything that we do and is identified as an organisational risk.

North Lincolnshire Care Group Presentation.

The Acorn Centre had received 359 referrals by 10 November. Repeat attendance was reported at approximately 23% in October and 42.5% in November and requires analysis to distinguish appropriate accessibility from unmet need or pathway gaps. Twelve safety incidents led to temporary security provision, while interim management arrangements and liaison-team sickness reduced resilience. Mulberry continued to experience vacancies, redeployment and sickness with reliance on NHS Professionals, although a permanent ward manager had commenced and the multidisciplinary team was maintaining a seven-day therapeutic timetable where staffing allowed. Talking Therapies sickness was reported at 13.65% following job-plan changes; activity had increased and waiting times were maintained, but outcomes were adversely affected where people declined transfer to a different clinician and left the service before completing treatment. North Lincolnshire acute demand was reported as 10% higher over four months and around 70% of the acute caseload had recently been in hospital for more than 100 days. These data support a resilience and flow concern but do not establish a single causal mechanism.

Patient Experience, Duty of Candour and CQC readiness.

Care Opinion feedback remained predominantly positive, although response growth had slowed and complaints had increased. Seventy-one Duty of Candour incidents generated nine recurring themes; evidence did not consistently demonstrate that families' questions had always been answered, findings shared and improvement implemented. Detailed oversight will proceed through the Quality and Safety subgroup and return to the Committee. Evidence libraries had improved, but inspection outcomes cannot be inferred from preparedness alone; flow, ward configuration/gendering and temporary placement of adults on older-adult wards remain inspection and patient-experience concerns.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Audit Committee	**Agenda Item**	Paper E
Committee Chair	Kathryn Gillatt, Non-Executive Director		
Lead Executive	Phil Gowland, Director of Corporate Assurance and Board Secretary		
Date of meeting:	7 October 2026		
Attendees:	Kathryn Gillatt (Chair), Dr Richard Falk In attendance: Jane Charlesworth, James Cooper, Simon Sheppard, Phil Gowland, Stuart Kenny (Deloitte), Kay Meats (360 Assurance), Cheryl Rollinson (360 Assurance), Matt Treharne-Clarke (360 Assurance).		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Internal Audit Progress Report** Internal audit work remained on track. The Access Policy Compliance audit received moderate assurance and several reviews were underway. The Committee approved the proposed approach for the external quality assessment of the internal audit service. **Annual Audit Report and Trust Response** External Audit issued unqualified opinions on the financial statements and value for money arrangements. No significant weaknesses were identified, although a recommendation was made to strengthen oversight of vesting certificates. **External Audit Tender Process** The Committee noted progress with the external audit procurement process and that a recommendation on the preferred bidder would be made to the Council of Governors following completion of the tender exercise. **Counter Fraud, Bribery and Corruption Progress Report** The Committee received an update on delivery of the counter fraud work programme. New fraud risks had been identified, fraud awareness activity had increased, and two investigations remained ongoing. Additional counter fraud support days were approved and further work was planned to address concerns relating to employees working whilst on sick leave. **Risk Management Framework Update** The revised Risk Management Framework had been approved and improvements had been made to risk visibility across the Trust. Forty one operational risks remained outside tolerance and members requested clearer reporting on actions and timescales to reduce these risks. **Declarations of Interest Report** High levels of compliance were reported across all staff groups required to complete declarations of interest. Twenty-five outstanding declarations remained under review and members were assured that robust monitoring arrangements were in place.		

	Review of the Standing Financial Instructions and Scheme of Delegation An initial review identified the need to update the documents to reflect legislative changes and clarify financial delegations. A revised version would be brought back to a future meeting. **Patient Monies** The Committee received an update on patient monies held by the Trust and noted that further options for future arrangements would be developed for consideration. **Disposal of Zero Net Book Value Assets** Approval was granted for the disposal of fully depreciated assets that no longer held a net book value. **Assurance Map** Members reviewed the updated Assurance Map and welcomed its use in strengthening assurance and governance arrangements. Further feedback would be incorporated as the approach continued to be developed and refined.

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 Sinclair, Chief Medical Officer		
Date of meeting:	21 October 2026		
Attendees:	Rachel Blake, Maria Clark, Dr Jude Graham, Toby Lewis, Dr Rumit Shah, Dr Diarmid Sinclair. In attendance – Carlene Holden, Diane Jeavons, Shabir Pandor Apologies – David Vickers		
Matters of concern or key risks to escalate to the Board:	Consent to treatment on admission has shown a deteriorating position as noted below: the expectation is that always measures work will see that change during 2027.		
Key points of discussion relevant to the Board:	**MHA Training and RRI Training Compliance Data Analysis** The Committee noted the significant improvement seen in MHA level 3 and RRI training. Mental Health Act level 3 compliance has shown an improvement to 91.32%, with the number of non-compliant colleagues reducing from 71 to 64. The did not attend rate during September 2026 was 18.9%. RRI stood at 88.12%, the did not attend rate was 28%. **MHA Compliance Report July and August 2026** During July and August 2026, 219 detentions were processed across the trust. Of these, 218 were lawful and 1 was unlawful. Consent to treatment on admission was reported as Rotherham, 77% Doncaster 76% and North Lincolnshire 61%. Consent to treatment requirements at 3 months were in place for all patients. Section 132 rights compliance was reported as Rotherham 85%, Doncaster 94% and North Lincolnshire 100%. Section 17 leave audits were delayed because of staffing and capacity pressures within the Mental Health Act team. There was 1 discharge where Section 23 paperwork had not been completed before discharge. **MHA Performance Report July and August 2026** There were 219 detentions during July and August 2026, with the highest number recorded in Doncaster. There were 84 Section 136 assessments during the reporting period. Section 136 suites experienced a number of temporary closures across all localities because of repurposing to prevent someone being moved off site.. Seclusion review compliance achieved 100% during July 2026 and 94% during August 2026. There were 2 patients absent without leave. Community Treatment Order consent requirements at 3 months achieved 100% compliance across all localities. Tribunal and Hospital Manager hearing timescales were largely achieved, although a small number of delays occurred because of tribunal requests and other factors. **Patient Experience Peer Support Framework First Report** Peer support provision expanded from 3 paid peer support workers in 2023 to 17 workers across 4 directorates in 2026. Additional peer support was provided through partner organisations and volunteer		

	roles. Between October 2025 and August 2026, 539 hours of peer support were delivered through 267 sessions. There were 86 compliments and 58 concerns and they described their role as building meaningful relationships, sharing lived experience and providing hope for recovery. The report proposed a Peer Support and Lived Experience Framework to support consistent practice, improve measurement of outcomes and embed peer support across services before 2027. Key priorities included improving integration within multidisciplinary teams, strengthening supervision, improving data collection, enhancing accessibility of committee papers and establishing clearer career progression opportunities. **CQC MHA Inspections Highlight Report** There were 2 Care Quality Commission Mental Health Act inspections during July 2026 on Mulberry and Laurel Ward. Mulberry identified 8 main findings and 4 patient specific issues. Laurel identified 6 main findings and 1 patient specific issue. Analysis of inspection findings identified 7 established themes across services. These included environment and facilities, Mental Health Act rights and legal compliance, staffing and therapeutic engagement, care planning and documentation, advocacy, physical healthcare and medication, and communication with carers and families. Outstanding actions from previous inspections remained open at Amber, Osprey and Kingfisher wards, with some delays linked to estates work and refurbishment programmes. *The Chief Executive committed to briefing members before the Board meeting on this topic.*

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:	21 October 2026		
Attendees:	Richard Chillery, Steve Forsyth, Dr Jude Graham, Carlene Holden, Ian Spowart, Sarah Fulton Tindall, Pauline Vickers, Dave Vallance. In attendance: Phil Gowland, James Hatfield, Jane Charlesworth, Rachel Shiels.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**People and Teams Plan Top Ten Measures and Integrated Quality Performance Report** Vacancy, agency expenditure and sickness absence remained above target, although recruitment activity and long-term sickness interventions continued. Turnover remained comparatively favourable, Performance and Development Review compliance exceeded the current target but were not at 100%. Our gender pay gap reduced further and the flu vaccination programme commenced. **Learning and Education Plan** Work continued to align education investment with organisational priorities and improve organisational learning through enhanced sharing of learning, insight and good practice. **Anti Racism Next Steps** A single anti racism framework for 2026 and 2027 was proposed to strengthen accountability, allyship, inclusion and the use of data to address inequalities. Members emphasised the importance of demonstrating meaningful impact and embedding anti racist practice across the organisation. **Real Living Wage Annual Update and Next Steps** The Real Living Wage increased to £14.10 per hour and would be implemented from 01/04/2027. Members noted the financial impact and the Trust's continued commitment to being a Real Living Wage employer. **Staff Survey Update** The staff survey response rate at the time of the meeting exceeded the sector average and work continued to maximise participation ahead of publication of the results. **Strategic Delivery Risk 5** Leadership and workforce development activity continued to support organisational change. Members highlighted the importance of evidencing the impact of development programmes and using forthcoming staff feedback to identify barriers to improvement. **Staff Incidents Violence and Reporting of Injuries Diseases and Dangerous Occurrences Regulations Report Quarter 2**		

	Violence and aggression incidents increased during the quarter, with inpatient services reporting the greatest number of incidents. Members expressed concern regarding the impact on staff, discussed support arrangements and noted that some incidents were associated with individuals experiencing acute mental health crises. **Freedom to Speak Up** Concerns continued to relate mainly to patient safety, workplace behaviours and staff experience. Work progressed to strengthen reporting arrangements, organisational learning and protection from detriment.

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	Jo McDonough, Director of Strategic Development		
Date of meeting:	18 November 2026		
Attendees:	Rachael Blake, Dr Richard Falk, Carlene Holden, Toby Lewis, Dr Rumit Shah, Dave Vallance, Jo McDonough, Jo Cox, Rumit Shah, Shabir Pandor.		
Matters of concern or key risks to escalate to the Board:	The committee noted some evidence of ostensibly high rates of declined referrals, including within CAMHS. Recognising that this was an incidental discussion, and acknowledging positive feedback on GP referral understanding work in Doncaster, it is nonetheless helpful to highlight to the Board a need for some transparency in this space.		
Key points of discussion relevant to the Board:	**Promise 28 – Research Super Six** Noting that the Trust continues to meet the headline national research measures many months early, the committee remained frustrated with the clarity over the R&I super six. Dr Sinclair confirmed that draft KPIs are now in place which will be circulated and emphasised the success of work on dementia. Exciting steps in respect of health services research were highlighted. The KPIs will become the business of the CLE R&I group, which aims to ensure all our groups, including all five care groups contribute to research. **Innovation Plan Update** The committee noted the paradox of many examples of innovation and improvement yet a report highlighting slippage in infrastructure adoption. For example, more than 130 quality improvement posters had been shared over 2 years, and radical service models like the Acorn Centre had opened. There was a commitment to a more structured QI methodology in which relevant staff would be trained from 2028/29. Proposed priorities for 2027 had included action learning sets, a Dragon's Den (staff pitching) competition, more work on protected professional time, as well as a focus virtual wards and paired outcomes. A structured action plan across the two years will be received in March 2027. **People Focused Group** The committee undertook a partnership review of work with the People Focused Group. Peer support had extended geographically into Rotherham and North Lincolnshire, while physical health provision in Doncaster had expanded from an initial project 4 additional services. The Acorn Centre had opened at the end of September 2026, combining nurse practitioner and lived experience peer support roles. Work had also progressed to strengthen community connections and identify venues in North Lincolnshire. A revised memorandum of understanding and bi-annual review is going to be developed for 2027 onwards, which sets out how the Trust will provide support to PFG in its role as the organisation's LERO partner.		

	Patient, Carers, Race Equality Framework The 3rd assessment had demonstrated improvement, with 3 of the 4 main areas rated good overall and no scores now in the red zone. By September 2026, all 3 leadership and governance recommendations and both legislative and statutory compliance recommendations had been rated good. Policy and practice had retained 3 good and 3 developing ratings, while data and information had achieved 5 good and 2 developing ratings. The review cycle had remained every 6 months. More work is planned to check and challenge the robustness of the evidence, seek a peer review similar the CQC readiness process, and work with CoLE on checking the experience of global majority and minority ethnic communities. **Strategic Delivery Risk 1** A reduction in the risk score from 12 to 8 had been proposed, with likelihood reducing from 3 to 2 and impact remaining at 4. This would have brought the risk to its target score and within appetite but this was not supported by the Committee at this time. Supporting evidence had included strengthened induction, community participation, carers accreditation and developing neighbourhood arrangements. However, the Committee felt that more evidence of improvement and impact with diverse communities was needed before the score was reduced. **Strategic Delivery Risk 3** The risk score had remained at 12 and within tolerance, with a target of 9 by March 2027. The target date had been under review because key dependencies extended beyond that date. The 2026 general practice survey had received responses from 19 of 83 practices, representing 23% compared with 60% in 2025. A programme addressing 5 primary care priorities had been established. Phase 2 had commenced on 11 November 2026, and a direct route for general practitioners to contact a psychiatrist had been expected by February 2027. Neighbourhood programmes had progressed across all 3 localities. Assurance had remained adequate.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Finance, Digital and Estate Committee	**Agenda Item**	Paper I
Committee Chair	Pauline Vickers, Non Executive Director		
Lead Executive	Simon Sheppard, Executive Director of Finance and Estates		
Date of meeting:	21 October 2026		
Attendees:	Richard Chillery, Andy Flynn, Carlene Holden, Simon Sheppard, Sarah Fulton Tindall, Ian Spowart, Pauline Vickers. In attendance – Sarah Dean, Phil Gowland, Shabir Pandour		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Strategic Delivery Risk 2** The risk remained unchanged at 9, with a target of 6 by March 2027. Data quality assurance was mixed, with improvement plans due by December 2026. System Connect was in use across all services for appointments and 2-way communication, while self-referral in all services had been delayed to March 2027 but will not be delayed further. **Estate Plan Update** Progress continued across the Estate Plan. The procurement approach for Tickhill Road had been approved on 24 September 2026. Work continued on the ambient loop, land sale and Riverside proposals, with planning for the land sale expected by March 2027. Waterdale had received unconditional planning permission and remained on track for completion in March 2027. **Estate Compliance Health and Safety at Work Act 1974** Compliance continued to be monitored across key estate requirements. South Yorkshire Fire and Rescue had identified some concerns with fire alarm testing, fault management and emergency lighting at Tickhill Road. An improvement plan is in place which will ensure compliance and will be monitored through FDE. **Information Quality Work Programme 2026 to 2027** Overall moderate assurance had been provided. High assurance had been achieved for access to Children and Young People services, while moderate assurance had been provided for first episode psychosis treatment and Individual Placement Support. Improvement plans were due for completion by December 2026, with future work focusing on the Mental Health Services Dataset. **Performance Against the Finance Domain of the Integrated Quality and Performance Report** At the end of August 2026, the Trust had reported a £0.07 million deficit, which was £0.09 million favourable to plan. Efficiency savings of £5.7 million were on plan, cash stood at £36.5 million but the workforce was below establishment. The Trust continued to forecast a breakeven position. It was noted the contracts with the South Yorkshire Integrated Care Board and Humber and North Yorkshire Integrated Care Board have now been signed.		

	Medium Term Financial Plan Including Underlying Position The underlying deficit had reduced from more than £16 million in 2022 to 2023 to £6.3 million at the end of 2025 to 2026. The pledge to remove the underlying deficit recurrently will be met with further opportunities (post meeting note -which have now crystalised) were being developed to support an underlying breakeven position as we enter 2027/28. **Deconstructing the Block Contract** The exercise indicated that the Trust was underfunded by £12.3 million across South Yorkshire and Humber and North Yorkshire based on the methodology used. This comprised £3.5 million for South Yorkshire and £8.8 million for Humber and North Yorkshire. Block contracts were expected to begin being deconstructed during 2027 to 2028. **National Health Service Oversight Framework Value for Money** The Trust had achieved an overall score of 2.06, placing it in segment 2 and 18 out of 58 trusts. This represented an improvement from segment 3 in 2025 to 2026, including the removal of DSF, although performance varied across individual domains and measures. **Pharmacy Subsidiary** Phase 1 had been completed, with pharmacy dispensing transferred to the internal service at 1 Jubilee Close. The next phase focused on establishing a wholly owned subsidiary by 1 April 2027.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Trust People Council	**Agenda Item**	Paper J
Committee Chair	Dave Vallance, Non Executive Director		
Lead Executive	Carlene Holden, Director of People and Organisational Development		
Date of meeting:	14 October 2026		
Attendees:	Dave Vallance, Rosie Elliott, Glyn Butcher, Prachi Goulding, Cheryl Gowland, James Hatfield, Carlene Holden, Iona Johnson, Kath Lavery, Tinashe Mahaso, Dr Simon Mullins, Dr Mike Seneviratne, Susan Statter.		
Matters of concern or key risks to escalate to the Board:	None.		
Key points of discussion relevant to the Board:	**Staff Network Priorities 2027/28** The Council considered the priorities of the staff networks for 2027 and 2028, which focused on improving colleague support, strengthening inclusion, promoting wellbeing, increasing engagement and ensuring staff voices informed organisational development. Common themes included organisational support, funding, managerial engagement, policy development, working environments and peer support, with members supporting continued collaboration and the sharing of good practice across networks.		

**Paper to be managed via questions only

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Strategic Delivery Risks	**Agenda Item**	Paper K
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	26 November 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. Each SDR is reported to its allocated Committee before coming to the Board, and all five have now been considered by their committees in the revised format: SDR2 and SDR5 on 21 October 2026, and SDR1, SDR3 and SDR4 on 18 November 2026. All five are therefore set out at Section 3.

SDR1 is held at 12; SDR2 is held at 9. SDR3, SDR4 and SDR5 are held at 12. All five remain within tolerance.

The SDR4 stocktake asks the Board to note the intent not to pursue the proposed pilot extending routine evening and weekend working to medical, psychological and allied health professionals.

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 and SDR5 by the People and OD Committee on 21 October 2026. SDR1 and SDR3 were considered by the Public Health, Patient Involvement and Partnerships Committee, and SDR4 by the Quality Committee, on 18 November 2026.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

RECEIVE and NOTE the update position for all five SDRs;
and
NOTE the intent, in the SDR4 stocktake, not to pursue the pilot extending routine evening and weekend working to medical, psychological and allied health professionals.

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 November 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: Reduction from 12 to 8 proposed to PHPIP Committee, but Committee wished to see evidence of sustained effect (of the planned actions) before supporting this reduction in risk score. **Latest:** PHPIP, 18 November 2026: the reduction proposed based on Carers Federation Quality Standard achieved; revised Day 2 induction live from September 2026. **Next:** Longer term LDO evaluation and Promise 2 outcome measures, Steve Forsyth, February 2027.				
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: Position unchanged since August and the score of 9 remains right. Target 6 by March 2027. **Latest:** FDE, 21 October 2026: refreshed IQPR to Board September 2026; moderate assurance on the Access Policy audit and the services data audit. **Next:** Secondary care waiting times leadership programme launching November 2026; System Connect self referral, March 2027.				
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 as much about the Trust's behaviours as those of primary care. Held at 12; the main drivers sit with the ICB and partners beyond March 2027. **Latest:** PHPIP, 18 November 2026: GP survey rated partnership at 2.32 against 2.52 in 2025, on a 23% response rate; Phase 2 of the primary care priorities began 11 November 2026. **Next:** Direct route for GPs to speak with a psychiatrist, February 2027; ICB clarity on the neighbourhood funding model sought by April 2027.				
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: Stocktake shows high momentum and improving clarity; recommends not pursuing extended professional hours and redirecting effort to neighbourhood, discharge and first 72 hours actions. **Latest:** QC, 18 November 2026: stocktake presented and action plan aligned to it; most delivery elements rated amber red or red. **Next:** Board decision on the professional hours pilot; ward test of therapeutic discharge, January to February 2027.				
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: LDO evaluation positive in all but one area; investment in development must become business as usual across the Trust. **Latest:** POD, 21 October 2026: MPLT programme under way since July 2026; third LDO cohort commissioned; Promise 26 Anti Racism audit delayed to later in 2026. **Next:** Target date reviewed with the Director of Corporate Assurance; 2026 NHS Staff Survey results in Q4.				

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 The body of this report covers the SDRs considered by their Committee since the Board last met, the approach noted by the Board in September 2026. The Board therefore receives positions that have already been tested at Committee.

2.3 Since the Board met on 24 September 2026, all five SDRs have been considered by their committees: SDR2 by the Finance, Digital and Estates Committee and SDR5 by the People and OD Committee on 21 October 2026, and SDR1 and SDR3 by the Public Health, Patient Involvement and Partnerships Committee and SDR4 by the Quality Committee on 18 November 2026. For SDR1, SDR3 and SDR5 this was the first Committee consideration in the revised format. All five are set out at Section 3.

2.4 The action dates that had passed in the SDR1, SDR3 and SDR5 forms, noted to the Board in September, have been updated with the executive leads, and each action now carries an owner and a due date. In the SDR4 form the leads are the proposed role based leads from the stocktake and are still to be confirmed.

2.5 The Risk Management Framework approved by the Board in September 2026 sets out four assurance levels for operational and strategic risk. These are still to be applied to the SDRs, and 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. SDR1 to SDR5 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 each SDR, as considered by its Committee:

SDR1: Considered by the Public Health, Patient Involvement and Partnerships Committee on 18 November 2026, the first update there since March 2026. The executive lead proposed reducing the score from 12 to 8, with the impact held at 4 and the likelihood reduced from 3 to 2. At 8 the risk would reach its target score and move from within tolerance to within appetite.

The proposal rested on controls that are now established and operating: the Leadership Development Offer, whose evaluation found participants' self rated engagement with community partners rose from 5.14 to 6.06; the revised Day 2 induction from September 2026; the Carers Federation Quality Standard in Carer Support for Hospital Trusts, which provides independent assurance; the Community Leadership Executive's move into its workplan; and strengthened Freedom to Speak Up arrangements.

The second line view is that the controls have strengthened, but the proposal rested largely on controls being in place rather than on evidence of their effect. The LDO evaluation is self reported, the Developmental Well Led Review found assurance not yet outcome based, and the Freedom to Speak Up outcome measures have not yet moved. The same LDO evidence held SDR5 at a likelihood of 3. Given this second point – controls in place, but no evidence of their effect, and the self reporting at present, the Committee did not support the reduction in risk score, which therefore remains at 12.

SDR2: Considered by the Finance, Digital and Estates Committee on 21 October 2026. The score is held at 9 (impact 3, likelihood 3) and the risk remains within tolerance, with a target of 6 by March 2027.

The refreshed IQPR was presented to the Board in September 2026, which allows the two assurance actions that depended on it to complete. The Information Quality Work Programme reported high assurance on one of the three indicators tested in the first half of 2026/27 and moderate assurance on two, with improvement plans due by December

2026. The Internal Audit of the Access Policy and an audit of data across services reported to the Operational Management Group both returned moderate assurance.

System Connect is in use across all services for appointments and two way communication; self referral requires work with each care group and has a revised date of March 2027. The leadership time and focus gap is being addressed through a secondary care waiting times programme, launching with a workshop in November 2026 and designed as a short leadership development programme on the use of data.

SDR3: Considered by the Public Health, Patient Involvement and Partnerships Committee on 18 November 2026, the first update there since March 2026. The score is held at 12 (impact 3, likelihood 4) and the risk remains within tolerance. The target is 9 by March 2027; the main factors that will move the risk sit with the ICB and partners and run beyond that date, and the target date is being reviewed with the executive lead.

The 2026 GP survey rated integration, collaboration and partnership with the Trust at 2.32 out of 5, against 2.52 in 2025, on a response rate of 23% against 60%. Ratings were higher where practices had engaged with the GP Liaison role, and pressure points remain in referral processes and thresholds and the timeliness of advice and guidance.

A structured programme to deliver the five primary care priorities is in place, with Phase 2 in the Community Mental Health Teams from 11 November 2026, and a direct route for GPs to speak with a psychiatrist is expected by February 2027. The Trust is involved in the neighbourhood programmes in all three places. The executive lead has identified three matters that will move the risk: a neighbourhood funding and commissioning model, which depends on the ICB; a practical approach to transitioning primary care facing mental health services through the Community Powered Healthcare Taskforce; and shared agreement between partners on the scale of neighbourhood action.

SDR4: Considered by the Quality Committee on 18 November 2026, alongside the SDR4 stocktake. The score is held at 12 (impact 4, likelihood 3) and the risk remains within tolerance, with a target of 8 by March 2027.

The stocktake reports that the core controls for seven-day therapeutic care and flow are in place, but that a defined, costed and sustainable model for weekend discharge, first 72 hours support and measurable benefits is not yet evidenced. Most delivery elements are rated amber red or red, and the action plan in the form has been aligned to the stocktake tracker.

The stocktake recommends that the Board does not pursue the proposed pilot extending routine evening and weekend working to medical, psychological and allied health professionals. Colleagues in those groups did not support it and some indicated it could lead them to move elsewhere, none of ten neighbouring or comparable providers has made this extension, and local workforce fragility is material. Effort would be redirected to a neighbourhood partner model in inpatient services, safer discharge pathways and first 72 hours support. The Board is asked to approve the recommendation.

The colleague feedback behind the recommendation shows that the workforce elements of the cause remain live, and the score is held while the redirected actions move into delivery. The risk statement is not changed in year; it will be considered at the March 2027 review of benefits and residual risk, in light of the Board’s decision.

SDR5: Considered by the People and OD Committee on 21 October 2026, the first update there in the revised format. The score is held at 12 (impact 4, likelihood 3) and the risk remains within tolerance. The target is 8 by December 2026, and the executive lead is reviewing the target date with the Director of Corporate Assurance given the timing of the leadership programmes.

The Leadership Development Offer evaluation found participants' combined self ratings across twelve leadership behaviours rose from 6.47 to 7.04, with the strongest gains in networking, engagement and relationships, but no measurable change in ownership of the 28 Promises. The Multi Professional Leadership Team development programme began in July 2026, the Clinical Leaders Training Programme has not yet started, and a third LDO cohort has been commissioned. The Promise 26 Anti Racism audit has been delayed to later in 2026.

4. Recommendations

The Board of Directors is asked to:

RECEIVE and NOTE the update position for all five SDRs;
and
NOTE the intent, in the SDR4 stocktake, not to pursue the pilot extending routine evening and weekend working to medical, psychological and allied health professionals.

Philip Gowland, Director of Corporate Assurance
November 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, coproduce 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	**Proposed, November 2026**	**Previous, July 2026**
Risk score (Impact x Likelihood)	4 x 3 = 12	4 x 3 = 12

Risk category	External and Partnerships Risks, Change and Improvement Delivery Risk		**Target score by Mar 2027**	4 x 2 = **8**
Last deep dive review	July 2026		**Risk appetite**	Moderate
Date of last update	November 2026		**Appetite Status**	Within Appetite
Next review	February 2027			

Commentary

Strategic Risk Owner Commentary

The picture has moved on since July. The potential impact of failing to change how we work with diverse communities remains significant, so the impact stays at 4.. In July much of the evidence showed that programmes and controls existed. By the end of October there is a broader mix of delivery, evaluation, independent assurance and external corroboration showing that those controls are beginning to make a difference.

The case does not rest on one initiative. It is the combined effect of stronger leadership capability shown in the LDO evaluation, the refreshed induction, more mature community participation and coproduction through CoLE and the Community Powered Healthcare Taskforce, the neighbourhood physical health redesign now in formal consultation, independent accreditation of our carers arrangements, strengthened Freedom to Speak Up arrangements, established equality governance, and the Well Led findings on community influence.

The evidence is not yet complete. We still need longer term evaluation of behaviour change and a clearer connection to service and patient outcomes, and Promise 2 outcome reporting is still developing. These are now questions of sustained effectiveness rather than whether the controls exist. Over the next three months the focus moves from showing that controls are established to showing outcomes and sustained effect.

Director of Corporate Assurance — second line

The controls have strengthened since July, and the carers accreditation adds independent assurance not available then. The executive lead's proposal to reduce the score rested largely on controls being in place rather than on evidence of their effect. The LDO evaluation is self-reported, the Developmental Well Led Review found assurance not yet outcome based, and the FTSU outcome measures have not yet moved. The same LDO evidence held SDR5 at a likelihood of 3 at POD in October. The proposal was presented for the Committee's view but not supported at this moment in time. The stated position will be tested through the 360 Assurance audit of the SDRs.

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; last received March 2026, presented in the revised format November 2026. • 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	-	• Developmental Well Led Review (TVC), reported to the Board July 2026: community participation and lived experience influencing strategic priorities, governance, decision making and service design; assurance not yet outcome based.

	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. • Community Powered Healthcare Taskforce, August to October 2026 meetings: locality variation, community worker and mobile first approaches, continuity between community and inpatient services, DIALOG+, primary care mental health models, the Talking Therapies interface and outcomes that matter to patients.	-	-
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. • Physical Health and Neurodiversity neighbourhood model in formal consultation: four neighbourhood	• Example of dementia assessment in a community faith setting reported to the Rotherham Quality and Safety meeting. • Clinical and Quality Committee material on the emerging neighbourhood models shows operational pressures visible and	-

	teams, urgent care and neighbourhood interventions; implementation planned March 2027.	actively managed, with the models challenged and refined.	
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.	• Promise 2 carries measurable milestones reported through the Promises and Priorities Scorecard.	• Carers Federation Quality Standard in Carer Support for Hospital Trusts achieved: independent assurance across governance, carer identification, information, involvement, partnership working and staff support. • 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.	-

		• WRES, WDES and EDI performance remains mixed; measured and governed, with committee scrutiny focused on impact.	
Leadership Development Offer (LDO), compassionate and inclusive leadership to unlock community power	• Baseline data established at commencement of the programme; further cohort feedback and analysis as cohorts complete. • Programme covers approximately 150 leaders in cohorts across 2024 to 2026, explicitly aligned to SO1, with modules including Unlocking Community Power and Active Bystander. • Community immersion experiences and reflective modules on equitable leadership; leadership forums, action learning sets and supervision incorporate power, privilege and voice. • LDO evaluation report received October 2026 (LDO Task and Finish Group), 144 participants across seven programme stages: combined leadership self ratings up from 6.47 to 7.04; engagement with community partners up from 5.14 to 6.06; no measurable change in ownership of the 28 Promises.	• LDO evaluation reported to the POD Committee October 2026; the level at which the outcome is deemed positive to be set against the results. • Featured as LDO learning outcome 2, enhancing the ability to lead change and deliver improvements; LDO providers have added a line manager evaluation question.	-
Active Bystander training	• Training deployed to move staff from passive observation to active intervention where discrimination, bullying, micro aggressions or unsafe	-	-

	practice are witnessed, framing intervention as a professional duty. • Over 300 staff trained by late 2024; extension underway to further teams and to managers in higher risk areas.		
Anti Racist Behavioural Framework and taught learning culture	• Anti Racist Behavioural Framework in place setting explicit behavioural expectations; racism, discrimination and exclusion treated as organisational risks within risk management and improvement work rather than as individual matters. • Culture change delivered through formal training, continuous reinforcement in meetings and modelling of expected norms rather than reliance on good intentions.	• Learning Half Days discussed at the Education and Learning meeting June 2025; paper to CLE June 2025; paper to Board March 2025. • Equity and inequality data, including patient feedback trends by demographic and volunteer diversity, routinely discussed at Board and committee.	-
Induction for all new starters, RDaSH and our communities	• Thirteen inductions since launch in October 2024, circa 650 staff progressed; evaluation asks whether participants understand how their role supports the Strategic Objectives and Promises. • Induction sets cultural expectations from day one, stating the Trust's position on racism and exclusion and that speaking up and challenge are expected behaviours. • Revised Day 2 programme commenced September 2026, covering the Trust strategy and Promises, community power, anti	• Evaluation of induction presented in the Autumn to the People and Teams CLE Group.	• Internal Audit on Induction, significant assurance (25/26 audit plan).

	racism, carers, Freedom to Speak Up and behavioural expectations.		
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. • Champion refresher training delivered June 2026; Champion role description and terms of reference refreshed; online concern form and recording through RADAR; follow up at 3, 6 and 12 months after closure. • Adverse Effects or Negative Impact from Speaking Up SOP signed off.	• 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. • FTSU Bi Annual Report to the POD Committee October 2026: 55 concerns logged to the end of September 2026; 3 included perceived detriment (1 at the same point in 2025/26); of 9 colleagues giving feedback, 5 would speak up again, 2 would not and 2 were unsure.	-
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 identified) • No embedded process yet to ensure recruitment and appraisal test alignment to the Trust's values. (Action 4) • Learning Half Days control not yet fully developed; forward plan and learning library outstanding. (Action 5) • Volunteer coverage patchy, with several services having none, roles not consistently backfilled, and over 100 active volunteers not registered as Trust members owing to data issues. (Action 8) • Physical Health and Neurodiversity neighbourhood model in formal consultation; it becomes a control from implementation, planned for March 2027. (Action 9) • Carer involvement inconsistent at ward level, with PSII and governance evidence still identifying documentation and embedding issues. (Action 10) • Ethnicity and protected characteristic data gaps, with interpreter service uptake low and variable. (Action 11)	• CoLE has no defined reporting route into Board or committee and no second line assurance. (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 identified) • Flow of partnership review outcomes within the Trust not yet confirmed; reporting route to CLE to be clarified. (Actions 1 and 6) • LDO evaluation is self reported; longer term evidence of behaviour change, further 360 and LEIPA evidence, and links to service and workforce outcomes not yet available; no measurable change in ownership of the 28 Promises. (Action 2) • Revised induction not yet evaluated for colleagues' understanding and application. (Action 3) • WDES not improving at the rate of WRES; actions still being identified. (No action currently identified) • Evidence that variation identified by the Community Powered Healthcare Taskforce is driving action not yet available. (Action 14) • No closed loop evidence yet showing how CoLE, Care Opinion, carer, volunteer or community feedback has changed decisions, practice or outcomes. (Action 12) • Outcome metrics inconsistent across Promise 2, Promise 3, Always Measures and equity and inclusion work, with no common measures or thresholds; Promise 2 local authority outcome and carer experience measures still developing. (Actions 10 to 12) • Staff Survey raising concerns score has declined for three consecutive years; detriment reports and the proportion of colleagues who would speak up again show no improvement yet. (Action 13)

Action plan to close the gaps					
Action	**Gap addressed**	**Owner**	**Due**	**Progress**	**Status**
Place Partnership Reviews (cake meets) scheduled monthly	**Assurance gap**	Steve Forsyth	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	December 2026	Evaluation report received October 2026 and reported to POD: combined leadership self ratings up from 6.47 to 7.04; engagement with community partners up from 5.14 to 6.06; no measurable change in ownership of the 28 Promises. Longer term follow up, further 360 and LEIPA evidence and links to outcomes to follow.	**In progress**
Deploy the revised induction and evaluate colleagues' understanding and application	**Assurance gap**	Induction and Widening Participation Manager	By February 2027	Revised Day 2 programme commenced September 2026. Outstanding local actions to complete, followed by post change evaluation.	**In progress**
Develop a process to embed values alignment in recruitment and appraisal	**Control gap**	Carlene Holden	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**	Carlene Holden	-	-	**Planned**
Confirm the flow of partnership outcomes and reporting to CLE	**Assurance gap**	Steve Forsyth	-	-	**-**

Embed CoLE evidence and outputs into the Board and committee reporting cycle	**Assurance gap**	Steve Forsyth	From Sept 2026	-	**Planned**
Establish the volunteer dashboard and backfill process, including registration of active volunteers as Trust members	**Control gap**	Steve Forsyth	Q3 to Q4 2026/27	-	**Planned**
Complete consultation on the Physical Health and Neurodiversity neighbourhood model, finalise the model and confirm workforce and capacity readiness for implementation	**Control gap**	Steve Forsyth	March 2027	Launch event held 30 June 2026 with 81 participants; 118 service validated Community Services Directory in place. Model now in formal consultation: four neighbourhood teams, urgent care and neighbourhood interventions.	**In progress**
Deliver Promise 2 Q2 reporting, including SystmOne carer data, local authority outcomes, carer experience measures, Carer Peer Support Worker activity and accreditation gap analysis	**Assurance gap**	Steve Forsyth	By February 2027	Carers Federation Quality Standard in Carer Support for Hospital Trusts achieved. Integrated outcome reporting and data quality still developing.	**In progress**
Close equity and inclusion gaps on ethnicity coding, interpreter service oversight and Promise 8 measures	**Control gap**	Steve Forsyth	Sept 2026 and Q3	-	**Planned**
Strengthen patient experience triangulation across Care Opinion, PALS, complaints, patient safety and FTSU	**Assurance gap**	Steve Forsyth	By February 2027	Combined FTSU and patient safety report in development, to be reported monthly to PSOG once agreed (FTSU report to POD, October 2026).	**In progress**
Deliver FTSU targeted directorate engagement and the adverse effects SOP	**Control gap**	Steve Forsyth	Next cycle 2026/27	Adverse effects SOP signed off. Champion refresher training delivered June 2026. Champion coverage review and targeted	**In progress**

				engagement with lower reporting groups under way.	
Evidence that variation identified by the Community Powered Healthcare Taskforce is driving action, including comparative outcomes, DIALOG+ continuity and changes to patient journeys	**Assurance gap**	Steve Forsyth	By February 2027	August, September and October 2026 meetings examined locality variation, service models and the outcomes that matter to patients.	**In progress**

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	**October 2026**
Next review	February 2027

Risk analysis	Current — October 2026	Previous – September 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	

Commentary

Strategic Risk Owner Commentary

The position is unchanged since August and I am content that the score of 9 remains right. The refreshed IQPR went to the Board in September, with further quality metrics to follow in November, so the two assurance actions that depended on it can now be completed. The Information Quality Work Programme has reported moderate assurance overall on the three indicators tested this year, and the internal audit of the Access Policy and the audit of services data reported to OMG in October both returned moderate assurance. These confirm that reporting processes are in place and that accurate record keeping and the consistent interpretation of activity remain our main data quality challenges.

System Connect is now used by all services for appointments and two way communication. Self referral is more complex, because the way referrals are managed differs across the care groups, and it will take longer than the end of October. I have set a revised date of March 2027.

The main development over the next three months is the work on secondary care waiting times, launching with a workshop in November. I am reframing this from a one off productivity workshop into a short leadership development programme that builds leaders' capability to understand and use waiting list, demand and capacity data, cascading from SLT and executives through DMTs to team and service leads. This is the practical response to the leadership time and focus gap.

Director of Corporate Assurance — second line

Holding the score at 9 is supported. The refreshed IQPR went to the Board in September, and the Information Quality Work Programme, the Access Policy audit and the services data audit show that reporting processes are in place, with moderate assurance on most of the indicators tested. The target of 6 by March 2027 is consistent with the current impact assessment. The open gap remains leadership time and focus; the secondary care waiting times programme is the planned response and should be built into the risk as a control once it launches. System Connect self referral has moved to March 2027, so reaching the target depends on both. There is no independent assurance on the leadership education control.

Tables of Controls and Assurances			
Key Controls / Mitigations For Cause: leaders lack the time, skills or diligence to see through changes, or are distracted by wider system priorities *[system in place to help manage the cause / effect]*	**Assurance / Evidence** *[where can we gain evidence that the controls we are placing reliance on are working]*		
	First Level *[Service delivery and day to day management - how do we know day to day that controls are working?]*	**Second Level** *[Oversight - who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]*	**Third Level** *[Independent challenge - has anyone external come in to check that the controls are working]*
Educating our leaders (Data Saves Lives campaign, Digital Needs Survey, Learning Half Days)	• Data Saves Lives campaign launched November 2024; posters distributed and three vlogs launched December 2024; December key messages on trust and transparency, accurate 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).	• Summary outcome reports provided to the Digital Transformation Group, informing the Data Saves Lives programme 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.	• Board received an analysis of the IQPR through a health inequalities lens (July 2025) and agreed the CLE	• Internal Audit of the IQPR - Significant Assurance.

	• 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.	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. • Refreshed IQPR presented to the Board of Directors September 2026; further quality metrics to be added for November 2026.	
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. • FDE October 2026 reviewed the three indicators tested in the first half of 2026/27: High Assurance for CYP services with at least one contact (OP13a); Moderate	• 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. • Internal Audit of the Access Policy (2026) - Moderate Assurance.

		Assurance for first episode psychosis treatment within two weeks (OP01); Moderate Assurance for access to Individual Placement Support (OP78). Improvement plans in place for all three, due December 2026. • Audit of data across a number of services reported to the Operational Management Group October 2026 - Moderate Assurance.	
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 self referral not yet implemented; the technical build can be delivered but the management of self referrals differs across the care groups. (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	The refreshed IQPR was presented to the Board in September 2026. The two indicators will now be completed against it.	In progress
Complete the health inequalities analysis and reformatted IQPR	Assurance gap	Jo MacDonough	November 2026	The refreshed IQPR was presented to the Board in September 2026, with further quality metrics to be added for November. The analysis will follow.	In progress

Internal Audit on ESR and Finance Ledger reconciliation, to give a single source of truth for staff data	**Assurance gap**	Richard Chillery	May 2026	Completed and report received	**Completed**
Conclude the System Connect work (two-way patient communication and self-referral)	**Control gap**	Richard Chillery	March 2027	In use across all services for appointments and two way patient communication. Self referral: the technical build can be delivered, but work is required with each care group on how self referrals are managed. Will not complete by 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**	Richard Chillery	March 2027	-	**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**	Richard Chillery	March 2027	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**	Richard Chillery	November 2026	Being taken forward through the secondary care waiting times leadership development programme, launching with a workshop in November 2026, which cascades from SLT and executives through DMTs to team and service leads with a focus on the use of data.	**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	Chief Executive, Toby Lewis
Board oversight forum	PHPIP
Risk category	External and Partnerships, Partnership Working Risk
Last deep dive review	July 2026

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

Date of last update	November 2026
Next review	February 2027

Commentary

Strategic Risk Owner Commentary

The position is unchanged and the score remains at 12. This risk is as much about the Trust's behaviours as about those of primary care. We now have a structured programme to deliver the five primary care priorities this year, with the second phase under way in our Community Mental Health Teams, and a direct route for GPs to speak with a psychiatrist will be in place by February. The GP survey shows that relationships are better where practices use the GP Liaison role, but the overall rating and the response rate are both lower than last year, and the pressure points on referrals and advice and guidance remain. We are part of the neighbourhood programmes in all three places. Integrating children and young people's services into neighbourhood working, and setting our approach to Families First, remain challenging.

Three things will move this risk. The neighbourhood funding and commissioning model needs to be established; this depends on the ICB and we are pressing for clarity by April. The Community Powered Healthcare Taskforce needs to set out a practical approach to transitioning our primary care facing mental health services, by June. And partners need a shared view on the scale of neighbourhood action, which the system has yet to resolve. The next steps and timescales on the GP neighbourhood contract also remain unclear.

Director of Corporate Assurance — second line

Holding the score at 12 is supported. The controls within the Trust's reach have strengthened, with a structured programme now delivering the five primary care priorities and the GP Liaison role effective where practices use it. The 2026 GP survey shows a lower rating of 2.32 against 2.52, on a much lower response rate, and the pressure points on referrals and advice and guidance remain. The main factors that will move the risk sit with the ICB and partners, and all fall beyond March 2027, so the target date is under review. There is no independent assurance yet on the programme of change, neighbourhood work or GP liaison.

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. • 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.	• The regular place partnership reviews afford the opportunity to assure on their effectiveness; CLE need to become more aware of their progress and impact. • Partnership scorecard implementation moved from Q3 to Q4 2026/27; it will provide a basis for evaluating primary care relationships by place. Vacant care group medical director roles expected to be filled by Q4. • PHPIP Strategic Delivery Risk Report to the PHPIP Committee; last received March 2026, presented in the revised format November 2026.	• Internal Audit on Partnership Governance and Risk Management, significant assurance, all actions complete.

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 published on the Trust website (Priority 5); as of June 2026 all services other than adult and children's neurodiversity working to a four week wait. • Structured work programme for 2026/27 delivered through the Primary Care Priorities Delivery Group: Phase 1 complete, with teams invited to complete Primary Care Friendly Accreditation; Phase 2 (Community Mental Health Teams) commenced 11 November 2026. • Direct route for GPs to speak with a psychiatrist being put in place, expected February 2027. • Advice and guidance: 87% of 46 requests answered within five working days, 27 April to 30 June 2026.	• Primary Care Priorities Delivery Group oversees delivery of the five priorities; progress reported to CLE through the Community Development outbrief (October and November 2026).	-

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. • Doncaster: relational casework prototype (NNHIP) launched in Conisbrough 3 November 2026 with an initial cohort of 13 patients; Kingthorne at co design stage and Flying Scotsman planning co design. • Rotherham: first Frailty Integrated Neighbourhood Team in Rotherham North due December 2026, further rollout from April 2027. • North Lincolnshire: work to develop five neighbourhoods progressing; frailty and children and young people agreed as first priority cohorts; update to the Health and Wellbeing Board January 2027. • Physical health neighbourhood community change schemes in formal consultation; implementation planned March 2027.	• 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	• Role galvanising work related to neighbourhoods and better connecting the Trust into pilots and initiatives externally.	• Community Development update outbrief to CLE, October and November 2026.	-

health delivery, community services transformation, Family First national programme)	• Work started in Rotherham to complement the Families First and neighbourhood work in North Lincolnshire and Doncaster.		
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. • Over 130 interface issues raised through the role since February 2025. • Conversations started with the first of 16 PCNs; Primary Care Information Hub launched; GP WhatsApp group approved for a soft launch with LMC leads and senior medics. • Q4 focus on problem solving with GPs, including shared care arrangements for children's and adult neurodiversity.	• GP survey: 2.52 out of 5 in 2025; 2.32 in 2026 (April 2026, 19 of 83 practices, 23% response against 60% in 2025). • GP Liaison and Collaboration 12 Month Evaluation: over half of respondents valued the role; ratings higher where practices engaged with it; pressure points remain on referral processes and thresholds, advice and guidance, and awareness of the role.	-
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. • Trust contributed to the discussion on the GP neighbourhood contract; next steps and timescales remain unclear. • North Lincolnshire primary and secondary care interface group relaunched; inaugural meeting held with positive initial feedback.	• 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
• Integration of children and young people's services into neighbourhood working, and the Trust's approach to Families First, not yet established. (No action currently identified) • Neighbourhood funding and commissioning model not yet established and dependent on the ICB; next steps on the GP neighbourhood contract unclear; no shared agreement between partners on the scale of neighbourhood action. (Action 8) • Internal relationships with Trust clinicians face a range of challenges that need resolving for key GP relationships to be built. (No firm action; ongoing work on clinician and primary care familiarity) • Referral thresholds and advice and guidance responsiveness vary by team; a dip test found one team declined 312 of 483 referrals. (Action 4) • Direct route for GPs to speak with a psychiatrist not yet in place. (Action 5) • Approach to transitioning the Trust's primary care facing mental health services not yet set. (Action 6) • Vacant care group medical director roles limit the capacity of care group teams to drive primary care relationships locally. (Action 9)	• Flow of place partnership review outcomes within the Trust not yet confirmed; reporting to CLE to be clarified. (Action 1) • Partnership scorecard not yet implemented; moved from Q3 to Q4. (Action 7) • LDO evaluation shows self rated engagement with community partners up from 5.14 to 6.06; impact on leaders' engagement with primary care not yet confirmed. (Action 2) • 2026 GP survey rated integration, collaboration and partnership at 2.32 against 2.52 in 2025, on a 23% response rate against 60%; improvement not yet evidenced and findings not yet fed back to practices. (Action 3) • 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**	Toby Lewis	March 2027	Meetings commenced January 2026, rotating across North Lincolnshire, Doncaster and Rotherham. Reporting process to CLE to be clarified.	**In progress**
LDO research and evaluation planned outputs	**Assurance gap**	Iona Johnson	December 2026	Evaluation report received October 2026 and reported to POD: self rated engagement with community partners up from 5.14 to 6.06. Links to engagement with primary care to be drawn out.	**In progress**
Act on the 2026 GP survey findings: close the feedback loop with	**Assurance gap**	Toby Lewis	April 2027	Survey completed April 2026 and evaluation report produced: 19 of 83	**In progress**

practices, raise the visibility of the GP Liaison role, and repeat the survey annually with face to face as well as online responses				practices responded (23%); rating 2.32 against 2.52 in 2025.	
Deliver Phase 2 of the primary care priorities programme with the Community Mental Health Teams, with targeted improvement of referral pathways, thresholds and advice and guidance	**Control gap**	Toby Lewis	March 2027	Phase 1 complete, with teams invited to complete Primary Care Friendly Accreditation. Phase 2 commenced 11 November 2026.	**In progress**
Put in place a direct route for GPs to speak with a psychiatrist	**Control gap**	Toby Lewis	February 2027	-	**In progress**
Set out, through the Community Powered Healthcare Taskforce, a practical approach to transitioning the Trust's primary care facing mental health services	**Control gap**	Toby Lewis	June 2027	Third Taskforce meeting (22 October 2026) reviewed primary care mental health and Talking Therapies models across the three places.	**In progress**
Implement the partnership scorecard to evaluate primary care relationships by place	**Assurance gap**	Toby Lewis	March 2027	Implementation moved from Q3 to Q4 2026/27.	**Planned**
Secure clarity from the ICB on the neighbourhood funding and commissioning model	**Control gap**	Toby Lewis	April 2027	Trust pressing for clarity by April 2027.	**In progress**
Fill the vacant care group medical director roles	**Control gap**	Toby Lewis	March 2027	Expected to be filled by Q4 2026/27.	**In progress**

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, Dr Jude Graham
Board oversight forum	QC
Risk category	External and Partnerships, Change and Improvement Delivery Risk
Last deep dive review	November 2026

Risk analysis	Current, November 2026	Previous, September 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	November 2026
Next review	March 2027

Commentary

Strategic Risk Owner Commentary

The stocktake is complete and comes to the Committee this month. It shows high momentum with improving clarity. The foundations for Promise 22 are in place, particularly inpatient standardisation, governance and flow infrastructure, but we have not yet evidenced a fully defined, costed and sustainable model for weekend discharge, first 72 hours support after discharge, or the benefits.

The most significant finding concerns our workforce. Medical, psychological and allied health professional colleagues did not support extending routine evening and weekend working, some said it could lead them to move elsewhere, and none of the ten providers we spoke to has done so. I am therefore recommending that we do not pursue that pilot, and that we redirect the effort into a measurable neighbourhood partner model, safer and more reliable discharge pathways, and first 72 hours support. The score stays at 12 while these actions move into delivery, with a benefits and residual risk review in March 2027.

Director of Corporate Assurance — second line

The stocktake is a management assessment. Most of the delivery plan is rated amber red or red, and the evidence of improvement remains largely process based. The colleague feedback behind the stop recommendation shows that the workforce elements of the cause remain live, so holding the score at 12 is supported. Stopping the pilot is a reasonable response to workforce fragility, but it closes one route to delivery rather than reducing the risk. The risk statement should not change in year and should be considered at the March 2027 review in light of the Board's decision. The leads in the action plan are proposed and need confirming, and there is no independent assurance on this risk.

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, including with local partner organisations. • Inpatient standardisation mostly enacted and monitored through care group governance and bimonthly acute delivery reviews; full recording of therapeutic activities on SafeCare due end of November 2026. • Weekly length of stay meeting led by the COO and the Director of Psychological Professions and Therapies, in place for over nine months: diagnostic led length of stay, therapeutic culture, complex case review and barriers to discharge.	• 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; P19 Out of Area Placements to Board May 2025. • QC Strategic Delivery Risk Report on this risk at each meeting in 2025/26. • SDR4 Stocktake (November 2026) to the Quality Committee: overall assessment high momentum, improving clarity; evidence strength rated for each control.	-
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. • Board material reports improvement in discharge numbers,	-

		length of stay and inappropriate out of area placements, while describing overall progress as limited.	
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. • Internal sense checking with medical, psychological and AHP colleagues on extending routine evening and weekend working: not well received, with some indicating it could lead them to move to another Trust.	• Ongoing work through TPC and OMG on developing and implementing greater flexibility within staff shifts. • Engagement with ten neighbouring or comparable providers: none has extended these professional groups into routine evening or weekend working, or intends to.	-
Control Lead: JG			**Assurance Level: ADEQUATE**

Gaps in control	Gaps in assurance
• Full seven day working, particularly weekend discharge, remains limited; the 24/7 therapeutic discharge model is not yet defined or tested. (Actions 1 and 2) • No alternative or step down provision is commissioned and operational; options are identified but not yet prioritised, costed or tested. (Action 4) • Workforce models of support, and profession and locality specific thresholds for stopping or modifying workforce changes, not yet in place. (Action 5) • First 72 hours post discharge self help, advice and community support offer not yet defined or implemented. (Action 7) • Neighbourhood partner activity standard agreed but not yet implemented; baselines, partner maps and named owners to be confirmed. (Action 8)	• 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 colleague feedback (Staff Survey, Pulse Check, peer reviews, consultation responses, union responses, Employee Relations indicators). (Action 6) • Assurance on seven day ward activity rests on timetables and process measures; delivery and quality not yet tested by audit or peer review, patient feedback variable, and no benefits dashboard yet separating process from outcomes. (No action currently identified)

• Nothing addresses the affordability element of the cause, or the national terms and conditions context that sits above the Trust; the stocktake proposes an explicit affordability statement and recurrent funding decision before any Trust wide workforce change. (No action currently identified)	• No independent, third line assurance on this risk; the stocktake is a management review. (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	Chief Nurse	March 2027	Rated amber red in the stocktake. System workshop and consolidated quality, safety and equality assessment by December 2026; controls approved January 2027; benefits and residual risk review March 2027.	In progress
Make 24/7 therapeutic discharges part of the inpatient improvement programme	Control gap	Chief Operating Officer	March 2027	Rated amber red in the stocktake. Standard to be defined by November 2026 and dependencies agreed by December; ward test January to February 2027; scale or modify decision March 2027.	In progress
Pilot extending routine evening and weekend working to medical, psychological and allied health professionals on one ward	Control gap	Chief Operating Officer	Next Board	Stocktake recommends the Board does not proceed, on the basis of internal colleague feedback, practice at ten neighbouring or comparable providers and local workforce fragility. Effort to be redirected to Actions 2, 7 and 8.	Stop proposed
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	To be confirmed	March 2027	Rated red in the stocktake. Options mapped and prioritised by November 2026; costed appraisal and partner commitments December; feasible tests from January 2027; investment and scale decisions March 2027.	In progress
Develop workforce models of support, and profession and locality specific	Control gap	Director of People and OD	March 2027	Rated amber red in the stocktake. Baselines validated by November 2026; thresholds and	In progress

thresholds for stopping or modifying workforce changes				mitigations agreed January 2027; monthly exception reporting February to March 2027.	
Establish a comprehensive mechanism for collating and reporting colleague feedback (Staff Survey, Pulse Check, peer reviews, consultation responses, union and staff side responses, Employee Relations indicators)	**Assurance gap**	Director of People and OD	March 2027	Rated amber red in the stocktake. Single dataset agreed by November 2026; dashboard prototype December; first triangulated report January 2027.	**In progress**
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**	Director of Psychological Professions and Therapies	March 2027	Rated red in the stocktake. Minimum offer co produced by November 2026; tested with the therapeutic discharge pilot January 2027; commissioning decision March 2027.	**In progress**
Implement a measurable neighbourhood partner model in inpatient services: at least one partner led activity each weekend day and three partner sessions on separate weekdays in each inpatient service	**Control gap**	Community Development Director	March 2027	Rated amber in the stocktake. Baseline and partner map by November 2026; local plans and named owners December; delivery January to March 2027 with monthly exception reporting.	**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 category	External and Partnerships - Change and Improvement Delivery Risk.
Last deep dive review	July 2026
Date of last update	October 2026
Next review	February 2027

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

Commentary

Strategic Risk Owner Commentary

Since the last update the Multi Professional Leadership Team development programme has started and is progressing well, although the September session had to be postponed because of diary pressures on delegates. The Clinical Leaders Training Programme has not yet started because the focus has been on MPLT, and we have commissioned a third cohort of the LDO. The LDO evaluation report is now available and shows positive progress in all but one area: leaders' confidence, relationships and networks have improved, and sustainability leadership has moved into the 'Good' band, but there was no measurable change in ownership of the 28 Promises. The report's eight priorities will shape the third cohort.

The Promise 26 Anti Racism audit has been delayed until later this year, and a detailed paper on Promise 26 comes to the Committee this month. The Leaders Conference has taken place, this year's Staff Survey has launched, RDaSH Connect has launched, we will exceed the apprenticeship levy spend this year, and the 2027/28 Training Needs Analysis is in draft.

We continue to invest in colleagues' development so that it becomes business as usual across all areas and teams of the Trust. The cultural reset programme remains key to addressing the difference between colleagues who have joined in the last five years and longer serving colleagues.

Director of Corporate Assurance — second line

Holding the score at 12 is supported. The LDO evaluation is positive across most leadership behaviours, but it is self reported and found no measurable change in ownership of the 28 Promises. The Clinical Leaders Training Programme has not started and the Promise 26 Anti Racism audit has been delayed, so the December 2026 target date is unlikely to hold and is rightly under review. The same LDO evaluation is cited in support of the proposed reduction in SDR1, and the two positions should be read together: this risk concerns the Trust's capability to deliver change, which the evaluation does not yet evidence. Third line assurance is limited to the induction and MAST internal audits.

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. • 2026 NHS Staff Survey launched October 2026. RDaSH Connect launched.	• 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. • LDO evaluation report received October 2026 (LDO Task and Finish Group): leadership self ratings up from 6.47 to 7.04; engagement with community partners up from 5.14 to 6.06; sustainability leadership moved from Requires Improvement to Good. Third LDO cohort commissioned.	• 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. • Leaders Annual Conference 2026 held. MPLT development programme commenced July 2026; September session postponed.	• People and Teams CLE Group and Education and Learning CLE Group established and meeting regularly.	-
Community Leadership Executive (CoLE)	• New body of 15 community representatives established to provide community-based feedback, be involved in decision making and holding to account, provide strategic input, facilitate communication, develop partnerships, build capacity and	-	-

	help co production; first meeting May 2026. Community partners feedback to be extracted from LDO feedback as a distinct category.		
Increased capacity (apprenticeship levy under Promise 9, full recruitment to 97.5 percent, ringfenced training budget)	• Apprenticeship levy overused in 25/26, with levy transfers including to community colleagues. Planned over spend in 2026/27 as demonstrated by the Q1 data • Current vacancies tracked in the CEX Report Annex and within the change management process, aiming to keep the total below 100 at any one time. • 2026/27 ringfenced training budget in place again, with utilisation of 100 percent or more anticipated. Additional investment in the 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. • Apprenticeship levy spend in 2026/27 will exceed the levy, in line with the planned position. 2027/28 Training Needs Analysis in draft.	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.
Control Lead: CH			**Assurance Level: ADEQUATE**

Gaps in control	Gaps in assurance
• Clinical Leaders Training Programme not yet commenced; MPLT development programme commenced July 2026 with the September session postponed. (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 evaluation report received October 2026; the level at which the outcome is deemed positive still to be defined and the findings to be built into assurance; no measurable change yet evidenced in ownership of the 28 Promises. (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 delayed to later in 2026. (Action 6)

Action plan to close the gaps

Action	Gap addressed	Owner	Due	Progress	Status
Develop mechanisms of feedback from leaders to demonstrate their increased competence and confidence in making change occur and adding social value, with colleagues on the stated programmes as the audience	Assurance gap	Carlene Holden	March 2027	-	Planned
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	Carlene Holden	December 2026	Evaluation report received October 2026: leadership self ratings up from 6.47 to 7.04; strongest gains in networking and relationships; sustainability leadership moved from Requires Improvement to Good; no measurable change in ownership of the 28 Promises. Level at which the outcome is deemed positive to be set against these results.	In Progress
Deliver the planned learning programmes: Clinical Leaders Training Programme and the MPLT development programme	Control gap	Carlene Holden	March 2027	MPLT development programme commenced July 2026 and progressing well; September session postponed. Clinical Leaders Training Programme	In Progress

				not yet commenced. Third LDO cohort commissioned.	
Implement the revised appraisal process, identifying and responding to the need to create learning opportunities for each colleague	**Control gap**	Carlene Holden	March 2027	-	**Planned**
Implement the approved 2026/27 Training Needs Analysis	**Control gap**	Carlene Holden	March 2027	2026/27 TNA approved. 2027/28 TNA in draft.	**In progress**
Undertake the planned Promise 26 Anti Racism audit	**Assurance gap**	Carlene Holden	December 2026	Delayed from Q4 2025/26, as reported to the Board in July 2026. Detailed Promise 26 paper to POD Committee October 2026.	**Planned**
Secure further internal assurance on induction via an independent colleague and the Induction and Widening Participation Manager	**Assurance gap**	Carlene Holden	October 2026	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 L
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	26 November 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 in October and November 2026. Reporting continues to be aligned to the agreed risk appetite and tolerance levels. The number of risks outside tolerance has reduced from 35 to 34 since the last Board, while the register has grown from 431 to 434 risks.

Sixteen risks have moved into the out of tolerance position since the last report and seventeen have left it. The expiry of the contract for the Trust's costing system, and two linked risks on sickness absence across the Trust, are drawn to the Board's attention in Section 3. Patient Care continues to hold the largest share of out of tolerance risks, and People Risk now holds eight against five at the last report.

The Risk Management Framework approved by the Board in September is being implemented, with delegated risk closure going live on 16 November 2026.

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.

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 The Board approved version 13 of the Risk Management Framework at its meeting in September 2026. An update on implementation is set out in Section 5.

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

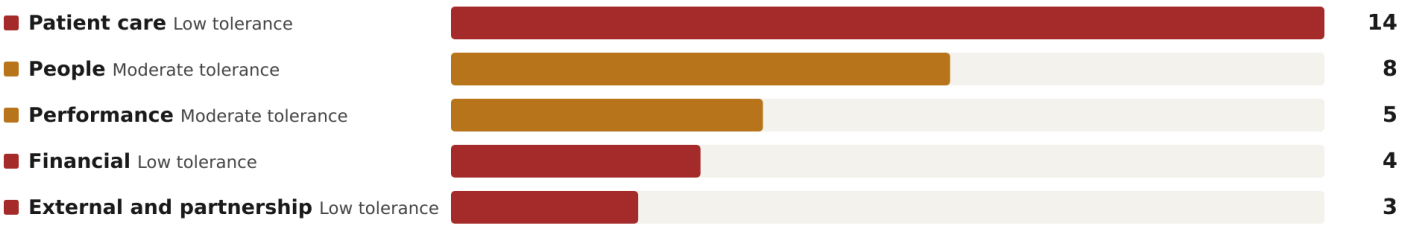
Total risks	Within appetite	Within tolerance	Out of tolerance
434	**143**	**257**	**34**
from 431 · **+3**	from 137 · **+6**	from 259 · −2	from 35 · **−1**

Position vs last Board (September)



Out of tolerance by theme

62% 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
86	**83**	**16**	**11**

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 431 to 434 risks since the last Board. The number of risks outside tolerance has reduced from 35 to 34. Sixteen risks have moved into the out of tolerance position and seventeen have left it, eleven by moving back within tolerance and six through closure. The current out of tolerance risks are listed at Appendix 2.

2.4 Of the 34 risks outside tolerance, 21 (62%) sit in themes for which the Board has set a Low tolerance position: Patient Care (14), Financial (4) and External and Partnership (3). This compares with 74% at the last report. Twelve of the 14 Patient Care risks sit within Clinical Safety. People Risk remains the largest theme on the register with 126 risks, and now holds eight of the out of tolerance risks against five at the last report.

2.5 Eleven risks recorded as out of tolerance in the previous Board report have moved back within tolerance. They include RSK 599, workforce capacity in the Mental Health Act Office, which now scores 9, and the two consultant vacancy risks in Rotherham Community Mental Health, RSK 750 and RSK 754. 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 The Board has previously sought assurance on RSK 687, prescribing errors in the Doncaster Community Learning Disability Team. The risk remains at 12 and outside tolerance for Clinical Safety. The repeat audit of incident forms planned for October is still outstanding, and the score will be reviewed once it has been completed. The expected resolution remains Q4 2026/27.

2.7 The Board also sought assurance on the timescales for door replacement. Both risks have now been closed: RSK 476, anti ligature doors on Windermere, where installation was completed through the capital programme, and RSK 640, the Section 136 suite doors in North Lincolnshire.

2.8 The two risks drawn to the Board's attention in September remain outside tolerance. RSK 798, care records at Danescourt, remains at 16, and RSK 590, paper based medication recording at Diamond Lodge, remains at 9. Both have an expected resolution of Q4 2026/27.

2.9 In this period the Risk Management Group set the incidents recorded on Radar over the last twelve months alongside the risk register. Incidents are not risks, and most are managed through care planning and the PSIRF learning process. The aim is to consider whether repeated incidents point to underlying factors that should be managed as risks, or could themselves give rise to new risks. This is being taken forward with the directorate risk leads.

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 risks are drawn to the Board's specific attention because they have newly moved into the out of tolerance position in this reporting period. The first concerns the contract for the Trust's costing system. The other two are linked and concern sickness absence across the Trust.

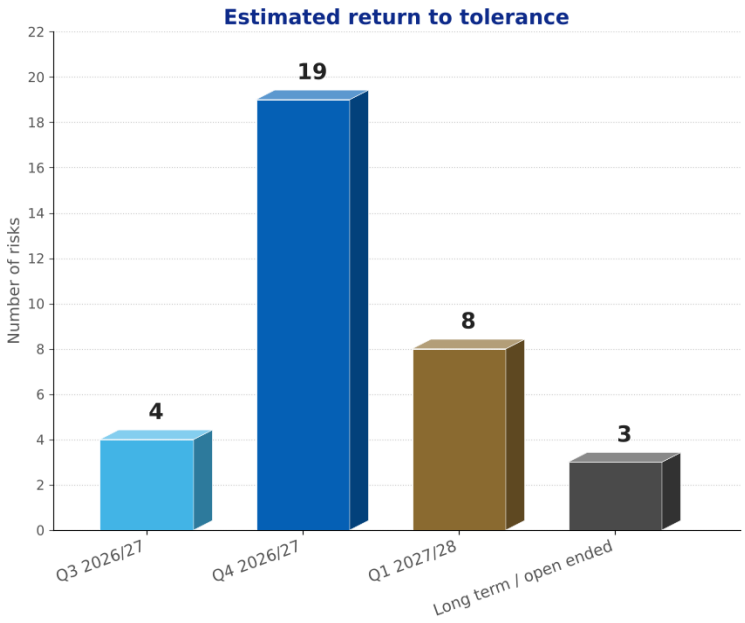
3.3 RSK 813, expiry of the Civica Costmaster contract. The contract for the Trust's costing system expires on 31 March 2027, support for the current on premises version is being withdrawn, and the cloud hosted replacement carries an additional cost. There is currently no contract in place from 1 April 2027. The risk is that a suitable costing solution is not procured and implemented in time, which would disrupt the National Cost Collection submission and reduce the costing information available for financial reporting, benchmarking and contract monitoring. The score has risen from 12 to 16, the joint highest score on the register, and the risk sits within Digital Infrastructure and Cyber Security, where the Board has set a low tolerance.

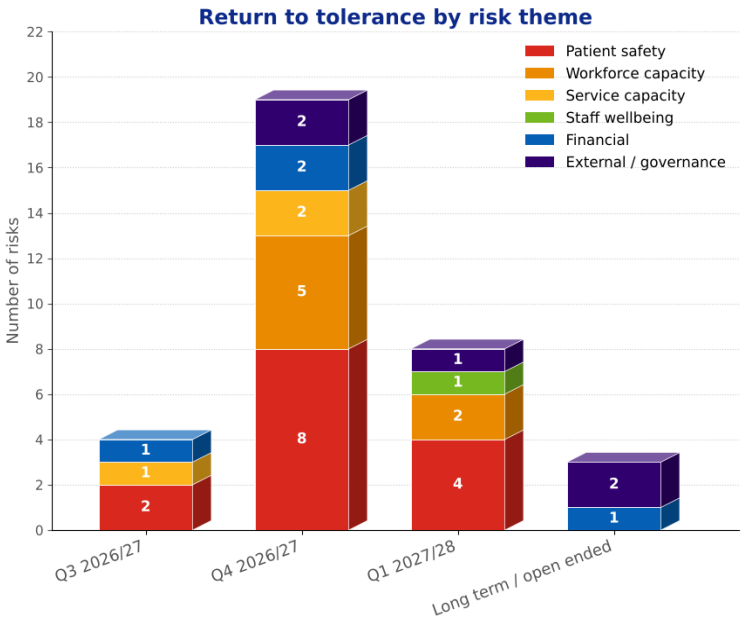
3.4 A solution needs to be in place by the end of January 2027 to allow enough time to plan the change with Health Informatics, and the score was increased because of the limited time remaining. The procurement and costing teams are exploring contract renewal options and alternative solutions to maintain continuity of service and compliance with NHS England requirements. The expected resolution is Q4 2026/27.

3.5 RSK 057 and RSK 802, sickness absence across the Trust. These two risks are linked. RSK 057, held by People and Organisational Development, is that high sickness levels compromise workforce consistency, and its score rose from 6 to 12 in October. RSK 802, held by Finance and Procurement, is that sickness increases reliance on agency and bank staff, taking staffing spend above budget and the national agency cap and affecting the planned year end breakeven position. It scores 12. Both sit in subcategories where the Board has set a low tolerance.

3.6 Sickness absence is reported monthly, with escalation if the rate reaches 6.5%, and is overseen through the People and Teams CLE Group and the People and OD Committee. Quarterly reviews are held with each directorate and care group, and monthly sickness clinics bring HR and service managers together on individual cases. The financial effect is overseen through Delivery Reviews, the Finance Group, CLE and the FDE Committee. The process for stress risk assessment is being reviewed so that it is more proactive. The expected resolution is Q4 2026/27 for RSK 802 and Q1 2027/28 for RSK 057.

4. Risk return-to-tolerance assessment





4.1 Of the 34 risks currently outside tolerance, our best judgement view is that 23 will return within tolerance during 2026/27, four in Q3 and nineteen in Q4, as workforce, capital and delivery actions take effect. A further eight are expected to move within tolerance in Q1 2027/28. Expected timeframes for the sixteen newly out of tolerance risks are based on the actions recorded against each risk.

4.2 Three risks continue to be held as long term positions: the two neurodevelopmental waiting time risks (RSK 220 and RSK 152) and the Aspire estate exposure (RSK 463). The levers to move them sit outside the Trust's direct control, whether that is national demand or capital investment. The Board is asked to see this as a considered assurance judgement rather than a delivery gap. RSK 468, decarbonisation funding, was held as a long term position at the last report and has since reduced to 6, which is within tolerance.

5. Risk Management Framework

5.1 The Board approved version 13 of the Risk Management Framework at its meeting on 24 September 2026. Implementation is under way and is focused on training and support for directorates.

5.2 Authority to close risks is being delegated to directorate risk leads, for risks on their own directorate's register. Closure guidance and a short training video have been produced, and each lead confirms they have completed both before access is given. Delegated closure goes live on 16 November 2026. Out of tolerance risks are referred to the Head of Risk Management before they are closed, 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 Since 1 October 2026 all colleagues have been able to view the risk register on

Radar, for 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 is broadly unchanged since the last Board, at 34 risks against 35. Beneath the headline the list has again turned over substantially, and sixteen of the 34 risks now outside tolerance have moved into that position since September.

7.2 Patient Care, and Clinical Safety in particular, continues to carry the largest share of out of tolerance exposure. People Risk has grown, with eight risks now outside tolerance against five at the last report.

7.3 The risks drawn to the Board's attention in Section 3 concern the contract for the Trust's costing system and sickness absence across the Trust. Actions are in place for each, and progress will be reported through the Risk Management Group.

7.4 The Risk Management Group has begun to set incidents alongside the risk register, to consider whether repeated incidents point to underlying factors that should be managed as risks.

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.

Philip Gowland
Director of Corporate Assurance
November 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-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	9	Amber
RSK-754	Due to a 0.6 WTE Consultant Psychiatrist vacancy within Older People CMHT North 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	9	Amber
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	8	Amber
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	6	Amber
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	9	Amber
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	9	Amber

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.	Performance Risk - Estates, Equipment & Supply Chain	Community & Long Term Conditions Directorate	Q4 2026/27	9	Amber
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.	People Risk - Capacity	Learning Disabilities and Forensics Directorate	Q4 2026/27	6	Amber
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	6	Amber
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.	Performance Risk - Capacity & Demand Management	Operations Directorate	Q1 2027/28	8	Amber
RSK-468	If the Trust does not secure funding for decarbonisation initiatives for sites other than Tickhill Road Hospital Site that has already been agreed by the Board, 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	6	Amber

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

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
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-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-872	Due to the loft hatch being unsecured and the hook design not preventing access, there is a risk that patients could access the loft space, leading to absconding, exposure to ligature hazards and potential patient harm.	Patient Care Risk - Clinical Safety	North Lincolnshire Acute Mental Health Directorate	Q3 2026/27	12	Red
RSK-829	Due to incomplete clinical information and medication handover during transfers from acute hospital services, there is a risk that patients are admitted without the information required to support safe and effective care, which may result in medication errors, delays in treatment, patient deterioration, patient harm, longer lengths of stay and readmission to acute services.	Patient Care Risk - Clinical Safety	Rehabilitation Directorate	Q3 2026/27	9	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	Learning Disabilities and Forensics Directorate	Q4 2026/27	16	Red
RSK-813	Due to the Civica Cost Master contract expiring on 31 March 2027, withdrawal of support for the existing on-premises solution and the additional cost of a cloud-hosted replacement, there is a risk that a suitable costing solution will not be procured and implemented before the current contract expires, which may result in disruption to National Cost Collection submissions and reduced availability of costing information required for financial reporting, benchmarking and contract monitoring.	Performance Risk - Digital Infrastructure & Cyber Security	Finance & Procurement Directorate	Q4 2026/27	16	Red
RSK-876	Due to reduced workforce capacity and unfilled clinical shifts form November 2026 to January 2027 , there is a risk that the Crisis Service cannot maintain safe and responsive staffing, which	People Risk - Capacity	Children's Mental Health	Q4 2026/27	16	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
	may result in delays to assessment and intervention, reduced clinical oversight and compromised patient safety.		(CAMHS) Directorate			
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-804	Due to lower than planned occupancy and placement activity within the HDRU, there is a risk that income targets will not be achieved, resulting in a financial deficit against plan and impacting the Trust's ability to deliver its financial sustainability objectives and planned year-end breakeven position.	Financial Risk - Financial Planning, CIP & Sustainability	Finance & Procurement Directorate	Q4 2026/27	15	Red
RSK-002	Due to inconsistent arrangements for implementing and monitoring actions arising from medicines audits, incidents and safety reviews, there is a risk that identified medicines safety improvements may not be consistently implemented or sustained across services, which may result in recurring medicines safety incidents, variation in practice and continued exposure to previously identified risks.	Patient Care Risk - Learning and Oversight	Medical, Pharmacy & Research Directorate	Q4 2026/27	12	Red
RSK-596	Due to the absence of a designated Lead Medic within the Community Directorate Management Team, there is a risk that clinical concerns, patient safety issues and medical governance matters will not be identified, escalated or managed in a timely manner, which may result in delayed decision making, inadequate clinical oversight, and insufficient medical input into operational and strategic discussions.	Patient Care Risk - Learning and Oversight	Doncaster Community Mental Health Directorate	Q4 2026/27	12	Red
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	Patient Care Risk - Clinical Safety	Learning Disabilities	Q4 2026/27	12	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
	may cause delays in treatment or incorrect medication being administered, which may impact patient safety and potentially lead to harm.		and Forensics Directorate			
RSK-802	Due to increased staff sickness absence levels across the Trust, there is a risk that services will be required to increase reliance on agency and bank staff to maintain safe staffing levels, resulting in staffing expenditure exceeding planned budgets and national agency spend caps, which may impact the Trust's ability to achieve its planned year-end breakeven position.	Financial Risk - Financial Planning, CIP & Sustainability	Finance & Procurement Directorate	Q4 2026/27	12	Red
RSK-819	Due to insufficient funding and the absence of commissioned resources to deliver Severe Mental Illness (SMI) physical health checks within existing staffing capacity, there is a risk that Rotherham Care Group will be unable to achieve the required SMI physical health check target, resulting in patients not receiving essential physical health assessments, missed opportunities to identify and treat physical health conditions, poorer health outcomes, and an increased risk of premature mortality.	People Risk - Capability and Performance	Rotherham Community Mental Health Directorate	Q4 2026/27	12	Red
RSK-830	Due to low compliance with management supervision requirements, there is a risk that staff wellbeing, performance and development needs are not identified and addressed in a timely manner, which may result in reduced staff engagement, unaddressed performance concerns, poor oversight of practice, and potential impacts on the quality and safety of patient care.	People Risk - Capability and Performance	Community & Long Term Conditions Directorate	Q4 2026/27	12	Red
RSK-870	Due to Occupational Therapist vacancies and long term sickness within the registered workforce, there is a risk that the Community Rehabilitation Team will have insufficient registered staffing to safely maintain the 7 day service, resulting in reduced service capacity, disruption to patient care and increased pressure on remaining staff.	People Risk - Capacity	North Lincolnshire Community Mental Health Directorate	Q4 2026/27	12	Red
RSK-540	Due to a number of patients across community teams not having an up to date care plan in place, there is a risk that the Trust is unable to provide assurance that care is being delivered safely and effectively, which may result in gaps in coordination, unclear responsibilities, and increased risk to patient safety.	Patient Care Risk - Clinical Safety	Rotherham Community Mental Health Directorate	Q4 2026/27	9	Red
RSK-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	Patient Care Risk - Clinical Safety	Learning Disabilities	Q4 2026/27	9	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
	result in people being administered the wrong medication, leading to significant clinical safety concerns and potential harm.		and Forensics Directorate			
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-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	9	Red
RSK-015	Due to the absence of a comprehensive Trust-wide framework for valproate oversight, monitoring, audit and shared-care governance, there is a risk that national MHRA safety requirements, reproductive risk management measures and monitoring arrangements are not consistently implemented, documented or reviewed across services. This may result in preventable patient harm, failure to identify reproductive risks, inappropriate continuation of treatment, missed opportunities for medicines optimisation, reduced compliance with national safety requirements, and inadequate organisational assurance regarding the safe use of valproate.	Patient Care Risk - Clinical Safety	Medical, Pharmacy & Research Directorate	Q1 2027/28	12	Red
RSK-038	Due to the absence of a robust Trust-wide system to identify, monitor and provide assurance for all patients prescribed lithium across shared care arrangements, and the lack of a standardised lithium transfer of care and discharge pathway, there is a risk that monitoring responsibilities are not clearly communicated between inpatient, community, primary care and other provider organisations. This may result in required biochemical monitoring, clinical review, side-effect assessment and follow-up actions not being completed or acted upon within recommended timescales. Consequently, patients may experience preventable harm including lithium toxicity, deterioration in renal or thyroid function, sub-optimal therapeutic outcomes, missed opportunities for medicines optimisation, and reduced organisational assurance regarding the safe use of lithium.	Patient Care Risk - Clinical Safety	Medical, Pharmacy & Research Directorate	Q1 2027/28	12	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
RSK-057	If sickness levels remain high or increase, there is a risk that workforce consistency will be compromised, which may result in greater reliance on agency and bank staff, overspend, and potential litigation if sickness is managed inconsistently across the organisation.	People Risk - Well-being & Retention	People & Organisational Development Directorate	Q1 2027/28	12	Red
RSK-447	Due to volume of referrals and prioritisation of first contact appointments there is a risk that following initial assessment there is a delay in being able to allocate a lead professional to new patients in locality teams. This could result in delays in patient care and impact on patient safety.	People Risk - Capacity	Rotherham Community Mental Health Directorate	Q1 2027/28	12	Red
RSK-770	Due to increased demand and complexity associated with ADHD and mental health comorbidities, there is a risk that prescribing capacity is insufficient to meet service demand, resulting in treatment delays and poorer patient outcomes.	People Risk - Capacity	Children's Physical Health (CYP) Directorate	Q1 2027/28	12	Red
RSK-828	Due to insufficient governance, oversight and control of artificial intelligence technologies, there is a risk that AI is used inappropriately or beyond its approved purpose, which may result in data breaches, patient safety risks, regulatory non-compliance, poor decision-making and reputational damage to the Trust.	Performance Risk - Digital Infrastructure & Cyber Security	Health Informatics Directorate	Q1 2027/28	12	Red
RSK-044	Due to the absence of a reliable method for identifying and monitoring patient discharges resulting from disengagement, there is a risk that patients may be discharged inappropriately without adequate support, which may result in harm to themselves or others.	Patient Care Risk - Clinical Safety	Medical, Pharmacy & Research Directorate	Q1 2027/28	9	Red
RSK-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-152	Due to insufficient capacity to meet the demand for ADHD assessments, there is a risk that patients will remain unassessed.	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	External and Partnership Risk -	Children's Physical	Long-Term	15	Red

Ref	Description	Category	Region	Expected Resolution Time	Current score	Tolerance status
	Promises 8 and 14, reputational damage, and additional unfunded financial pressure on the Care Group.	Delivering Our Promises	Health (CYP) Directorate			
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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promises and Priorities Scorecard	**Agenda Item**	Paper M
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	26 November 2026

Suggested discussion points

Every success measure has been reevaluated in the league table, and there is some movement reported here. Emboldened text changes draw Board members attention to key advice or next steps. The overall message remains of delivery possibility by the end of 2028, the more so after the executive group review of the bottom tier measures during November.

Bandwidth is an issue in three dimensions: the time to conclude some analytical and 'tidying up' work on some measures; the time to provide thought leadership on one handful of red/red measures during Q4, and the routine operational pressure of sustaining promises 14 and 19 whilst implementing our always measures which are key to promises 2 and 18.

It is important to recognise since the last report, carer accreditation, really positive progress on promise 23, and some increasing clarity on how we are structuring both work and a clinical conversation in relation to promise 16. Perhaps the single most positive step however is the widely reported gains in relation to Promise 17 which have featured both in my vlog and in our November Ask-Talk-Influence session: with both our active geographies defying national data trends on school readiness for the most excluded cohort of children.

Previous consideration

N/A

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the updated entries for most success measures in the league table

RECOGNISE the focus on promises 2 and 18 implied in this and other Board papers

RECEIVE and ACCEPT confirmation of the intended EG approach to the lower third league table

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

Trust Risk Register

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

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

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)	
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1	X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are	X

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

System / Place impact (advise which ICB or place that this matter relates to)							
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 – November 2026 promises scorecard

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Latest Promises Update

Purpose and introduction

1.1 The scorecard is completely reframed and refreshed with some more promises moving into the top part of our assessment. Of course, with two years to go, we should be **rigorous and curious** about what might be achieved, what might be overlooked – and how use the delivery of our promises to move us closer to our mission to nurture the power in our communities. At a time when neighbourhood health is being refocused nationally, and arguably narrowed, and at a time when commissioning budget cuts may see the VCSF again unwittingly targeted, that wider mission has real importance and needs our allyship.

1.2 **Two promises** stand out moving into the next period. Both are within our grasp as we look to add to a list of delivered commitments: our work on inpatient care has renewed attention with the launch of our Always Measures in earnest from December 7th 2026 (promise 18), and those same always measures are central to work to deliver in full Promise 2 during 2027. Given what we consider strong progresses with promises 1, 3, 4 and 5 – that would see us achieve the first of our strategic objectives.

1.3 There are a number of **emboldened comments** in the table text, which are worth Board colleagues noting, either because they are important updates or because they are forward considerations for us to return to in discussion.

Clinical leadership will be key

2.1 The two promises noted will test the bandwidth and impact of our clinical leaders at executive, care group, and directorate level. The practicalities of many, many more carer assessments are in place and have been since spring 2026. But the involvement of carers in conversations, MDTs, care plans, and in being assessed is as fundamental a shift in practice as the work we have done to bring volunteers into RDaSH and the work we are still doing to embed peer support workers. We will need in Q4, as we really work through our always measures, and move that implementation into community settings, to truly understand what the barriers are. It is unlikely to be simply ignoring carers, or the organisational drive of the promise. The Board, and our quality committee, needs to be curious about finding out.

2.2 We know that our always measures – care planning, consent, carer identification, carers assessment, and unmet need – will take considerable effort and subtly to implement. This is discussed within the HQTC paper elsewhere on the agenda and was likewise the focus of a workshop across the clinical leadership executive this month. Steve Forsyth will be devoted a substantial proportion of his time to delivery over coming weeks and through Q4. Our emphasis is on conversational delivery, working alongside teams through our nurses in charge. This, as distinct from a resort to email, is a change of style and one that has wider implications for how leaders operate.

Shifting the middle during 2026/27

3.1 There remain 33 success measures in the middle tier of our ratings. We had indicated that for the balance of 2026/27 the effort would be to shift many but not all of these into a more consistently green position. The promise 8, 12, 21 and 22 elements of these measures are unlikely to move in that timeframe, but the balance of what is shown can.

3.2 Promises 14 and 19 remain fragile in key aspects as is apparent from the wider papers. To move them into the top tier requires a period of consistent delivery, including the conclusion of the 48-hour secret shopper work that the COO is overseeing. Similarly, one would expect promises 4, 5, 23, 27 and 28 to see a substantial ratings gain before March, especially if we conclude work on the bungalows deal within Q3 as Jo McDonough is seeking to do: this, with the Danescourt bed expansion last year, would see this promise added to our list of those delivered in full.

Getting into shape for 2027/28

4.1 In September we discussed as a Board the 'lower third' of our promises, recognising the intractability of some and the scale of others. Changes to our leadership arrangements on promise 12, commercial decisions made in respect of promise 27, and structuring resource to support the success measures within promise 9 are important steps that have been taken since summer. In our executive group away day we began to structure the redder promises for 2027/28 and will bring the output of that work to the Board in March 2027. They will be a feature of executive objective setting thereafter.

4.2 Encouragingly most of the more challenging objectives have clear plans for execution, together with engaged executive and sub-executive leadership. Through January we will complete work to assess that work using the board's assurance/deliverology methodology. However, there are a number of areas where workshop work, likely across CLE, are planned for Q4 to ensure we have collective clarity over what is needed: virtual wards, outcome measurement, rurality, neighbourhood teams (via CPHT), and, on a more project basis our work on learning disabilities annual health checks once alignment to GP registers have been completed as we did for SMI.

4.3 I recognise that these are process steps, or governance ones. However, we do need to be mindful that in most cases where we have organised ourselves and placed some top-level leadership emphasis behind objectives we have seen gains, with inequalities being the exception that we will discuss in committee in January. As a senior team we were encouraged by the relatively small and discreet nature of the areas where greater clarity is judged necessary.

Toby Lewis, Chief Executive – 20th November 2026

Promises and priorities

Annex A, Board November 2026

Top third

Promises and priorities – delivery plan and delivery self-assessment

Promises & Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known or fully elaborated	Comments on likelihood of delivery
Promise 2 Achieve Carers Federation accreditation for the work that we do across the Trust.	Green	**This has been achieved with accreditation successfully obtained. Of course that is based on work intended and there remains much to do to improve carer experience at work.**	Green	The Trust is in a better place viz a vis carers work, and the implementation of a consistent agile, remote and flexible working policy during 2027 is the route to further gains. **Ged's story at the last Board is something to reflect upon.**
Promise 2 Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Green	The opening hours and patient/carer handbook launched. We now need to structure an evaluation of access needs with carers in Q4 and begin to test whether those changes are more effective for advocates and carers' access to improve.	Amber green	Carer feedback will be critical, as we implement the new approach – and gather insight into what works (critical too with changes to MHA). **We have not delivered until that feedback is available.**
Promise 3 Have 350 volunteers registered to work with us or have equivalent to that figure volunteering time with us through another body.	Green	The process for recruiting and onboarding volunteers is now mostly optimised, and appears replicable at pace. We need to sustain this and move beyond 400 postholders to account for attrition. **Presently we are not at 400.**	Green	We need not only to achieve but to sustain, and we are, and we know that volunteers leave as well as join.
Promise 3 For that body of volunteers to reflect the diversity of our populations.	Green	Some validation of data this increased diversity is still needed as we now have over 350 postholders on ESR – and have sustained that throughout H1.	Green	Data shows more global majority and more male volunteers than our wider staff base, and likewise more younger and older (65+) volunteers. This is hugely encouraging. We are exploring how this can be expanded working with local prisons too.
Promise 4 Increase by 15% the scale of feedback received in the Trust versus 2024/25 baselines.	Green	Both via Care Opinion, and bearing in mind other routes, we can see that the scale of feedback we have in place will continue to expand. We did not set a 2026/27 volume but must certainly sustain 25/26 figures including among older adults.	Green	**There is more work to be done in a handful of directorates.** The big focus, perhaps allied to Waterdale, is to improve CYP mental health feedback loops. And to consider how we use CO as part of waiting well in neurodiversity.
Promise 4 Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	Amber green	The pilot for this work has proved successful and has been assessed by the Board's MHAC: **we now need to sustain the work over time.**	Green	We will track this work in the Q&S sub-committee of CLE – and expect to see changes as a result of the feedback received.

Promises & Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
Promise 5 Involve patient and community representatives fully in our board, executive and care group governance .	Green	This work continues and has been evaluated for further improvement. The remaining step planned is to create communities of practice among those involved, for example through our CoLE – there is real appetite to join this up with our care group SLTs.	Green	As the work continues, the need to ensure accountability from representatives back to the local community will grow. **This includes work to connect our governors and members.**
Promise 5 Apply patient participation tests to new policies and plans developed within the Trust . A	Green	This is now in place – building on pilot work with PFG. Corporate assurance need to make sure, as we move faster on policies, that this engagement is maintained.	Green	As left.
Promise 6 All our services to have completed poverty proofing and be able to evidence resultant change (including digital). B	Green	We have delivered as the first Trust ever to poverty proof every single service we offer: and have the reports as receipts to prove it.	Green	**As the Board discussed in September we need to demonstrably stick with this in 2027 – with the move to put money in the pockets of clinicians being the headline step for the year ahead**
Promise 6 Benefits and debt advice access to be routine within Trust services to tackle ‘claims gap’.	Green		Amber green	Increasing uptake welcome, and visible, with continued concerns over Doncaster service access emerging. Consistent focus needed to deliver and **reach into older adults to be determined: this will needs work.**
Promise 7 Achieve measured goals for chronic obstructive pulmonary disease (COPD), hypertension, asthma, diabetes, epilepsy, oral health, and children and young people mental health by 2026/27.	Green	This now moves to green with the consistent data flow and ability for the E&I group to track progress, with strong evidence we are succeeding.	Green	Teams involve convey confidence within delivery reviews that they can meet these measures over the time period.
Promise 9 Achieve the levy requirements in 2024/25 and thereafter.	Green	The Board has received the plan of action for this measure: It is now being enacted. There is express confidence that this can be sustained in 26/27 but a new plan will be needed as the levy changes from April 2027.	Green	Success in 2025-6 is being matched by success in 2026-7. **Being ready for the changes HMG have introduced is important,** with apprentice first a growing obligation for us to deliver as more ‘senior’ supplements are withdrawn.

Promises & Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
Promise 11 Introduce peer-led service support offer for local residents.	Green ↑	The new peer support home for veterans launched this last month. It will be important that that is accessible across all three places, and works with veterans from all military backgrounds.	Green	**It is, clearly, far too early to begin to assess impact.** During 2027 it will be important to work with the project, which PFG are leading.
Promise 13 Sustain and expand our IV provision in out-of-hospital settings.	Amber green	The enlarged service continues to succeed. **As part of our winter planning work we continue to monitor how effective this work is,** including in diverting patients from hospital admission.	Green	Strong clinical leadership is key to supporting the service and developing it. It is an important part of work that can go unseen within the Trust, and something we can act to give profile to.
Promise 13 Take annual opportunities to transfer services to homecare where safe to do so.	Amber red	Moving into 2027-28 we need to be perhaps more intentional about our plans and shift, in line with national guidance to do so: the national focus is very much on frailty, which ostensibly is our priority too.	Amber green	This measure is ours, and others, and will see substantial emphasis in coming years – with DHSC focus on frail elderly patients and M-LTCs.
Promise 13 Sustain and expand our Clozapine service in off ward settings.	Green	CLE reviewed in June 2026 the services we will run and all have provided assurance that they are operational.	Green	It will important to review the scale of provision being offered and evaluate why any inpatient offer is still being used when a community alternative is available.
Promise 14 Meet four hour wait standard in 2025/26, where it applies.	Green ↑	The mystery shopper process is being used to test what appears, on core data, to be good progress to meeting this standard during 2026. Teams and leaders have focused on it since February 2026.	Amber green	We need to sustain delivery, recognising other wait time measures and the potential of distraction, before confirming that this is a delivered part of our portfolio.
Promise 14 Make progress to reduce waiting lists and times and close supply gap in 2024/26.	Green	Work continues to deliver our wait time goals, and the Board has reviewed the preparatory work to meet a 14-week standard for secondary waits. Further work is taking place on individual pathways, with strong executive support needed to mobilise the transition to this standard	Amber green	This is a challenging change, and will rely on exit rates for psychology pathways creating capacity to see new patients more quickly. The enablers are in place to make the changes but the work to do this across a diverse range of service is significant.
Promise 14 Meet 4 week standard from April 2026 across all services.	Green	We have now largely sustained this measure through three quarters. The Board is aware of some fragility and deterioration which needs attention and that needs to match the focus on 14 weeks we will bring in 2027.	Green ↑	. It feels as if this measure is part of the 'DNA', and that offers motivation to sustain, at the same time as wait time targets for mental health services are promised by Govt.

Promises & Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
Promise 16 Implement Dialog+ by 2026, collating individual outcomes from that work.	Amber green	We need to recognise the immense achievement of getting to consistent care planning. We are almost there, being above 95% in mental health services. During Q4 there is a clear plan to begin to collate the outcome data that needs a plan as a baseline.	Amber green ↑	There is some momentum now behind the use of this outcome data, with both CPHT and the Learning and Education sub taking a lead. This key quality plan ambition needs delicate profile, as this is data about individual's practice: ethical clinical leadership will be critical.
Promise 18 Work with patients and peers to assess the quality of services, including through peer reviews, and ensure that teams are able to act on that feedback and those evaluations.	Amber green ↓	Peer view work continues, and our HQTC work is reported into the Board. There is encouraging progress on ward care within our peer support dashboard. Our acute directorate quarterly reviews and the development of our MPLTs will help to embed a culture of quality improvement at a local level.	Amber green	We can deliver this measure. But we need to ensure that among all the voices raised about ward care – our own views, regulators, staff, students and so – **our patients' voices are heard loudly and clearly**. That balance is something we need to actively make sure occurs.
Promise 23 Expand the scale of our residential forensic rehabilitation service.	Green	Additional forensic capacity is now open and a patient moved into that capacity during February 2026. Of course the overall quality of Danescourt has been a concern – and we need to ensure that the action plan is delivered.	Green	A 20% forensic expansion has already taken place.- and we now need to consider what more is needed to match need as part of a wider review of LD&F
Promise 24 Student feedback to reach upper quintile when compared to peers.	Amber green	Strong baseline position, albeit varies annually. The current risk is low reporting within NETs, and the Board is aware of some feedback issues within our acute Rotherham service.	Green	Last year's data shows Trust among top ten nationally. Whilst comparative data is clearer or more visible for doctors, we have strong feedback from students across a range of disciplines.
Promise 24 Trust workforce plan for 2028 on track to be delivered.	Amber green ↓	We should be concerned that we will miss our 100 vacancies target for 2026/7 and miss it by a considerable margin. However, the measure remains very achievable and can be delivered and sustained by 2028.	Amber green	The current trajectory is to reach 100 vacancies during Q1 in 2027/28: the Board will wish to take a more active oversight of sustaining that once it is achieved, given past experience.
Promise 24 Trust meets expectations applied through national Long Term Workforce Plan roll out.		The national workforce plan to replace the national workforce plan is delayed. The prior plan is not longer extant in the meantime.		

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Promise 24 NHS England assessment outcomes remain outstanding in all disciplines.	Amber green	Currently strong in all assessed disciplines (latest report just received). Social work assessment still due. **Our current regulatory issues with trainee doctors are a context to this rating; as we look to ensure we can offer educational excellence with a predominantly part time workforce.**	Green	No identified reason why assessment outcomes would change over coming period, and med ed concerns previously debated have been allayed.
Promise 25 Obtain Real Living Wage Foundation accreditation in first half of 2025.	Green	Engagement started some time ago. Components required all being taken forward and visible within corporate delivery reviews.	Green	We achieved accreditation in July 2025: and the plaque has now arrived. It is a key manifestation of our values to pay the RLW. **We will pay the growth in 2027/28!**
Promise 25 Pay the Real Living Wage to our own employees from April 2025, or sooner.	Green	We have completed the work on both back pay and RLW for implementation to the timetable agreed with the Board. **Reaccreditation work is acknowledged for late 2027.**	Green	As above.
Promise 26 Tackle our gender pay gap.	Green	Notwithstanding the need for localised plans, the shift to the RLW will move the position on this measure to compliance.	Green	As left
Promise 26 Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.	Green	Submissions for NW accreditation at Bronze Level have been successful.	Green	These frameworks tend to be input based, not outcome derived. Organisational commitment to compliance is not in question.
Promise 28 Meet portfolio study recruitment targets each year.	Green	The Trust is consistently meeting the measures and has a process in place to support engagement where there are shortfalls	Green	We met the full year measure in four months. **This is a tribute to focus and determination among our researchers and ground research team.**

Middle third

Promises and priorities – delivery plan and delivery self-assessment

Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
Promise 1 Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care. B	Amber green	With the opening of the Rotherham hub at the end of November 2026, we now have a stable basis for PSW delivery across all three geographies. The considerable number of roles funded in our investment fund for 2026/27 have all been recruited into.	Amber green	One final push to deliver PSW expansion is envisaged for 2027/28, with the focus, as the Board is aware shifting to the quality of engagement and inclusion using our outcomes framework.
Promise 2 Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded. B	Amber green	The plan presented to the Board, which was previously considered through CLE, sets out some of the actions needed to move forward with this – it is work which has a broad and enthusiastic support among local leaders.	Green ↑	We are not yet seeing a big rise in self identification of carers among our workforce and this data point is going to be one of two critical ones as we look to move Promise 2 to full delivery in 27/28.
Promise 2 Identify all-age carers that use our services and ensure their rights under the carers act are recognised. B	Amber green ↓	The always measures (3-4) are now key. Having built the loop for carers' assessment we need to use it and use it at scale. Only in doing that will we understand the gap we need to then fix.	Green ↑	Teams commitment to this measure is growing, and the visibility of performance may help to harness more challenge of practice, as we must during 2027.
Promise 4. Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026. A	Green	Directorates have provided good evidence of use of feedback and of Care Opinion: in the three acute adult MH, rehab and children's mental health directorates we have more work to do to expand use and make documented use of alternatives.	Amber green	Recognising that feedback is not all about 'change' – we did evidence a small number of meaningful impactful changes in our 26/27 Quality Account. This needs to become routine in year collated information. **This is being taken forward through the comprehensive audit of complaint actions.**
Promise 5 Deliver the Board's community involvement framework in full.	Green	This CIF has broad support (and is now approved) but needs operationalisation plans to deepen with Care Groups, supported by a revised VCSE register.	Amber green ↑	**CoLE has the potential to be impactful in moving forward as does the place (cake) work. A deeper look before 2027/28 is needed at board level.**

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Promise 5 Deliver the annual priorities set by our council of governors B	Amber green	Most priorities set with COG are in hand: there is work to do on the digital aid/MH work which needs resourcing.	Amber green	We need to resource the remaining missed priorities, and this is routinely delayed but can still be achieved in the timetable of the strategy.
Promise 8 Increase diagnostic rates for dementia among minority ethnic citizens. B	Amber green	All three services are now in place, and engagement with communities is building. We need to understand better the barriers to converting those connections into referrals.	Amber red	The difficulty converting to referrals is the reason this remains amber red: until we move from good discussions with communities to rising inflow we cannot be confident of a green result.
Promise 8 Improve access rates to talking therapies among older adults. B	Amber red	We have reviewed plans to act (and increase by over 1000 the number of older adults using the service annually) within the latest delivery review (the service is managed cross Trust). **But two waves of action (25-6 and 26-7) have not yet delivered to scale hence the falling rating.**	Red ↓	There is sufficient capacity exists to shift the dial towards 12% coverage. Right now our miss of this measure is cause-unknown.
Promise 8 Neurodiversity – ensure ward teams and environments are truly suitable for the patients that we serve B	Amber green	Cogent training plans have been built and will be further embedded in the TNA for 26/7. The estate change needed need reconsideration and confirmation before end of January.	Amber green	This measure can be delivered in 2026/7, and we then need to work to sustain it, and test its ‘meaningfulness.
Promise 8 Tackle exclusion of BME and other GM groups from peri-natal mental health services B	Amber green	Teams are still working hard to understand the problem and build a response to it. It may lie in midwifery referral, but our performance will also improve with better coding.	Amber green ↑	Purely on the data, recognising small numbers, this is the inequality measure where we can evidence impact and real change. That needs now to be sustained.

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Promise 10 Specific service offers in place for all or most inclusion health groups by 2027. B?	Amber red	The launch of the homeless team is a step forward and the possible expansion in North Lincolnshire is welcome, as is our changed profile there on domestic violence. An emerging programme of work with prisons and probation is also being finalised after productive governor level engagement in November 2026.	Amber green	Most inclusion health groups can benefit from revised access arrangements, and some element of specialised support, over the next two years. But only if organisation and emphasis is stepped up in 2027.
Promise 11 Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees).	Amber green	Strong planning work has taken place and whilst the reasons for gaps are speculated, the right actions are in place. **The intention now is to refocus on the Op Courage referral rate as a better measure of the work being done.**	Amber green	Over time, with trial and error, we are expecting to close the gap we presently see through a combination of data improvement and better performance.
Promise 12 Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access. B	Amber green ↓	Good connections have been built to help us to think through what the issues and potential solutions may be. Care Group led work at this stage with buy in from other teams. Iona Johnson will take on the leadership role in this space to provide a focus for driving this measure forward.	Amber red ↓	A clear set of intended steps have been defined and agreed in principle through E&I. Further testing needed going into 2027, building on the two pilot sites.
Promise 13/20 Deliver over 130 care packages through our physical health virtual ward service.	Amber green	A strong plan exists, has been peer reviewed, and is being delivered. We are exploring further winter expansion plans which would assist with this model.	Amber red	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes. Unfortunately currently that is not job planned or in place and work by the CGMD is seeking to change that.
Promise 13 Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme.	Amber green	This work was defined in late 23/24 and a monitoring structure established. Indications remains positive that we are on track.	Amber green	Needs a clear frame of analysis. This will be documented over coming weeks – bandwidth alone is holding this back.

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Promise 14 Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Green ↑	We cannot meet this in 25/26 but can meet it in late 26/27, and appears to be doing so on the latest data.	Amber green	**It will be important that this work is tracked in 2027, alongside work on referral diversion and decline.**
Promise 16 Report and improve patient recorded outcome measures (PROMS) supported nationally. B	Amber green	We report as we need to. Further clarity is needed about our completeness and whether we are maximising opportunities to go beyond minimum response.	Amber green	An improvement trajectory remains to be understood and defined, but data is beginning to be shared to build it.
Promise 18 Meet guidance obligations from NHS England relevant to the quality of inpatient care, including safer staffing measures where they exist, and fully comply with the Mental Health Act.	Amber red ↓	The Board may wish to take a view on this measure. Both indicated items, safter staffing and MHA compliance, might best be labelled as “mostly”. The always measure programme is intended to tackle the latter, work on sickness the former.	Amber green	The intent and structures to deliver remain strong. But we should be concerned over local capacity, and **in that context the MPLT development work being led by the CNO and director of people and OD will be critical to watch and consider in Q4.**
Promise 18 Implement programme of multi-professional quality improvement across all inpatient services by April 2026 and routinely publish data on the care provided in each environment.	Amber green ↓	A programme has run and transitioned to a second phase. The upcoming conference in Q4 will be a moment to explore what more is needed to deliver; at the same time as the learning from the always measures go live.	Amber green	**The publication of data has been delayed, owing to bandwidth but is now scoped and in development.**
Promise 19 Cease to place patients out of their home district except where that is their choice or in their best interests. A	Amber green	The plan of action is widely understood. Success is coming from enormous sustained effort. Considerable strain remains with rising demand and some growth in LOS. This measure has been hit but sustaining it is by no means assured.	Amber green	We continue to deliver but also are experiencing ‘winter’ pressures – in 2026/7 concerted work in North Lincolnshire will be needed. *Moving to zero may not be achievable.*

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Promise 21 Fulfil our commitment to support a community-first model working alongside partners in South Scunthorpe: focusing first on those with serious mental illness.		This project is now in abeyance with other parts having moved on. A redefined NL neighbourhood project will replace it in 2027.		As left
Promise 21 Contribute actively to the city-wide Thrive programme within Doncaster, using a liberated method to ensure that duplication and handoffs of care are reduced.	Amber green	Engagement from the Trust remains strong but project still largely LA led/held. Intention to blend this work with Neighbourhood work may offer a route to different impact in coming months.	Amber green	Need to find an agreed success measure as the 'method' denies benefits of KPIs. Work with Families First shows promise in that regard – and measures are emerging for us in 27/28..
Promise 21 Implement anticipatory preventive care models supported within the Rotherham Place programme, where possible using such approaches to reduce demand for secondary care.	Amber green	A positively viewed programme which is at the heart of the neighbourhood planning in borough. Need to extend this work into Care Homes if it is to impact patterns of use/need in our services.	Amber green	Work still to be done to model care home option as part of neighbourhood planning. Good engagement with Rotherham colleagues on how to have RDaSH play a larger part.
Promise 21 Consistently integrate our community mental health offer with that provided by voluntary sector organisations, sharing training, data and expertise to improve outcomes. B	Amber red	This work links to the item above: we do plenty of signposting but need to make that a more systematic offer tied to our investments in peer support workers. CPHT recently reviewed this diversion in one service (TT) and is moving into examination of how we demonstrate success or face weaknesses in others.	Amber green	In one place deep work on this has taken place, and received positive feedback. This forms part of neighbourhood work to be led by Iona Johnson. We are looking to take the lessons from that work into a wider landscape.
Promise 22 Ensure that access to urgent and emergency services is equitably available through Saturday and Sunday (this must include crisis and safe space availability).	Amber green	This is not P14! This measure is mostly met in Trust delivered/commissioned services. The intention is to use the MHLDA programme for 25/26 to influence configuration.	Red	This is rated red to reflect the reality our patients face – where there is substantial variety in non-Trust services which we need to now influence. **There is also a fragility to crisis services which needs continued attention.**

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Promise 22 Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services. A	Amber green	N&F have submitted drafts of this work to CLE twice. We are still working through what pilots, if any, we wish to consider to begin to alter weekend staffing and service.	Amber green	This input measure can be met: mindful of SDR 4 the more challenging question will be what we plan to do as a result. That has two parts to it: our own crisis teams, and work across MHLDA on system wide mutual aid/change.
Promise 23 Develop bed-based mental health services within each of our communities by 2028, as additions or alternatives to ward based practice: ideally delivering these services through partner organisations. B	Amber green	**Excitingly a second residential facility, as step down, for SMI patients is also taking shape pending commercial completion this side of Christmas.**	Green ↑	As left
Promise 23 Establish and support a step-up service for older peoples' care in Doncaster by 2027.	Amber green	Work advancing alongside partners: project resource defined and starts work shortly. Significant place support. We brought all partners together at Tickhill Road under the auspices of the HWBB. Very encouraging support from other agencies including LA, PCD and DRI	Amber green	This may be an optimistic rating given scale of change: but the pressing need to change gives this natural priority and we have 2 years to deliver.
Promise 25 Transfer more of our spend to local suppliers (shift of 25%+ compared to 2023/24). A	Amber green	Implementation deadlines are clear and being met but some supply chair issues to resolve: next data review with finance team at Feb delivery review.	Amber green ↓	Measure defined, suppliers aware. Food and travel most challenging areas to execute, albeit both consistent with P27 agenda.
Promise 26 Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.	Amber red ↓	**This specific measure would merit attention as we have finalised our anti racism plan and need to be clear which indicators are relevant to this success measure.**	Amber green	A complex and longstanding issue, which, is subject to events beyond the Trust. We have work to do to build trust and confidence among BME colleagues. The move to being anti-racist has to be manifest in how our 555 line managers operate. We need evidence in fairly short order if this is not to move to amber red.

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Promise 27 Agree and deliver specific contribution to local authority climate change plans. B	Amber red	Advancing this measure is a matter of time/priorities. Good engagement exists with each LA, and in due course this work will need to be documented and reviewed.	Amber green	LA feedback on Trust engagement remains positive, and we are doing what is asked. The plan may give rise to a larger ask in time.
Promise 28 Deliver metrics contained in the Trust's Research and Innovation plan. B	Amber red	Significant work is now needed to convert the research priorities we have agreed into a delivery plan owned across Care Groups: communities of practice are all now launched which will help to move this measure rapidly to amber green in time for April 2027.	Amber green	The 2028 ambitions are deliverable, but a cultural shift is probably needed in how GR/CGs operate together. **The PHPIP committee are very focused now on the big six and the KPIs behind them.**
Promise 28 Work to further increase the reach of research into excluded communities locally. A	Amber green	This is a longstanding programme of work for grounded research. A more detailed delivery plan may be needed going into 26/7. This may include developing a community researchers' programme. The Trust is now hosting EMRI, which further contributes to our aspirations.	Amber green	This is an input measure which we are confident of sustaining focus on, without too much corporate input

Lower third

Promises and priorities – delivery plan and delivery self-assessment

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Promise 5 Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.	Amber green	With changes to our database in November away from Civica 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 green	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.	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. In March 2027 we will determine what else we may need to do to address DNAs generally and this measure in particular.
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. The executive will take ownership of the LD measure, firstly to align the LD dataset and then to consider how it can be embedded into the seven pathways work.
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.

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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 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 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Amber green	The work plan for refugees is contained relies on others outside the Trust who are in place, hence the AG confidence. Initiating the homeless project will be incorporated into our estate planning work during the first half of H1 with external expertise applied to move this on.	Amber Red ↑	
Promise 9 In 2026/27 introduce tailored access scheme for people with learning disabilities.	Amber green ↑	We have a very clear plan, albeit its key element may not start in practice until August 2027. Julia Shaw has worked with Lisa Grandcourt to identify roles and an early 2027 pilot of moving people into roles is expected.	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 in December (delays within the wider NICE work).	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. The E&I group is thinking through how this work, as we look to encourage colleagues to adjust their practice on the back of the mystery shopper results.

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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.
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

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Promise 16 Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Amber red	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. **The E&L group, led by Dr Graham, have agreed to begin to marshall this work and a CLE workshop will take place with this in mind.**
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. The initial data is in and it is extremely encouraging for both Doncaster and North Lincs with free school meal rates outperforming national numbers.	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.
Promise 17 Seek to see 80% of children meet their own potential for school readiness by 2028.	Red	The own potential measure is yet more complex. We may need to move to a long term tracked cohort in the model of a millennium study to move this on. Work with our new HSR unit will consider this in the first half of 2027.	Amber red	
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. We will be making this an Investment Fund priority for 2027/28 which we hope will kick start activity in the two areas cited.	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.

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 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 did not come forward within planning for 26/27. 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 January	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 in January 2027.	Amber red	Work needed to scale and shape the project and this is referred to within the covering paper.
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 care groups and especially the acute directorates. We are working to see during Q4 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).	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 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.

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 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. **As this report was written HMG published new guidance on funding flows, which may necessitate a change of approach.**
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.

****Paper to be managed via questions only**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Integrated quality performance report (IQPR)	**Agenda Item**	Paper N
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Richard Chillery, Chief Operating Officer		
Meeting	Board of Directors	**Date**	26th November 2026

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

Other papers before the Board attest to the mixed picture on performance, highlighting ward acuity/volume and sickness as two priority areas. They will be considered in the Chief Executive's report item rather than the IQPR.

There are a number of areas of clinical focus where we are not yet seeing the **pace of improvement we had sought**. Timely FACE risk assessments remain at 21.63% against an aim that is certainly below 5%. Seclusion MDT compliance declined to 80%, albeit on small numbers, and falls assessment compliance fell to 93%. As we move towards five defined Always Measures will perhaps see a halo effect in some areas, but also need to guard against local managers or leaders adding de facto other always measures which detract from delivery and priority.

The Board discussed **four week compliance** in September, and it again features in many delivery reviews, our latest Q3 position is 69 of 83 services meeting the standard. The Board discussed Talking Therapies last time, and there is some encouraging progress towards improvement, but with large spikes in staff absence. The transfer of 300 longer waiting patients to Mindler will help the longest waits, and discussions over 400 more continue.

Delayed discharges have improved to 10.5%, but remain above the 8% target, with five patients experiencing delays of 17–29 days because of care-package and partner-capacity constraints. Alongside any work to alter our supply, we need to sustain reductions in CRFD patients.

Medical vacancies continue to drive agency reliance, with Rotherham locum arrangements extending to March 2027, and reluctance to extend them further, albeit agency use in Children's and North Lincolnshire has ended. Notwithstanding this the Trust's financial position will deliver to plan and work to ensure all directorates live within their budgets and do so recurrently is important as we move to budget sign off for 27/28 in February.

Previous consideration

CLE November 2026, quality committee November 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE the continued fragility of a number of areas of performance principally associated with staff sickness and data quality.

NOTE the consideration of revised approaches to staff sickness and managing sustained demand increases contained in the separate Chief Executive's Report.

ACKNOWLEDGE and **DISCUSS** some of the clinical quality issues highlighted in the report, recognising the imminent commencement of always measures in the inpatient setting.

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

Integrated Quality Performance Report

November 2026 Review

Data as at the 31st October 2026

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Executive Report

Introduction

Delivery remains mixed across the Trust, with positive progress across several quality, workforce, access and financial measures. Key areas requiring continued focus are Talking Therapies, annual physical health checks, PDR compliance and selected patient safety indicators. Recovery actions continue through established governance arrangements.

Quality

Talking Therapies access remains below trajectory at 10,163 against 11,160 YTD. Reliable Recovery is 48.28%, below the 50% target, while Reliable Improvement is 68.96% YTD, above the 68% standard, although there was a considerable decline in October, particularly in Rotherham. Increased sickness, patient reallocation and early treatment drop-out have contributed to the position. A deep dive and specific work is being completed in terms of job planning and productivity. Revised Step 3 job plans are increasing clinical capacity, targeted follow-up is being introduced to reduce early drop-out, and approximately 300 patients are planned to transfer to Mindler by the end of December to support reduced treatment waits and improved outcomes. SMI annual physical health checks have improved to 70.45%, but remain below the 95% standard, with targeted actions and weekly monitoring in place. Learning disability annual health checks are 80.91%, with pathway-specific actions also in place. Reported 104-week referral spells have reduced significantly from 2,210 to 305, with further work underway to improve pathway recording and alignment with national reporting. Seclusion MDT compliance is 80%, MUST assessment compliance is 83.01% and falls assessment compliance is 92.68%. Out-of-date FACE risk assessments remain high at 21.63%. Overall, improvement activity remains focused on measures below standard, with additional scrutiny through Care Group governance arrangements and targeted recovery actions where required.

People

The People position remains mixed. PDR compliance reported at 91.41% and remains below the 100% target. Continued focus is required through Care Group oversight to improve completion and ensure outstanding PDRs are addressed. The NHS Staff Survey engagement theme score is 6.81, while the NHS Staff Standards score is 7.75. These measures will continue to be considered alongside the wider staff experience programme and associated improvement activity. The National Education and Training Survey satisfaction rate is 80.44%, above the 80% target. Use of the Apprenticeship Levy is 86.01%. Bank use continues to be reviewed alongside vacancies, sickness absence and Care Group bank reduction plans.

Finance

The 2026/27 forecast as at M7 is a £1m surplus position. This has improved from breakeven at M6 reflecting reduced expectations on the amount of recruitment possible in the remainder of the year and better than budgeted delivery of the out of area position. At Month 7, the year-to-date position is £768k better than plan, with a £613k surplus. That position includes a £3m substantive pay underspend, a £1.4m temporary staffing overspend, and HDRU income approximately £1.0m below plan. Agency expenditure continues to be above plan, reflecting medical staffing pressures. Savings delivery is slightly better than plan overall, although a handful of minor delays in recurrent schemes are currently being offset by higher non-recurrent vacancy savings.
Capital expenditure remains £5.2m behind plan year to date, largely reflecting the phasing of schemes, with expenditure forecast to remain within the revised capital allocation.

Promises

Delivery against the Trust Promises remains mixed, with improvement evident in key access measures. Compliance with the four-week waiting-time standard has increased to 83.13%, with 69 of 83 services achieving the standard. Compliance with the 48-hour urgent response standard has decreased to 91.16%. Oversight continues through the fortnightly Waiting List Group, with targeted recovery activity focused on services remaining outside the required standards and on reducing the longest waits. Health inequalities measures remain an area requiring focus. Completed annual health checks for people from a minority background are 81.44%, below the 95% target. Referrals to Perinatal Services for people from a Black background are 6.90%, above the 6% target fluctuating significantly month on month due to the smaller referral numbers, while referrals from our veterans are reported at 2.64%, below the 3.89% target. Improvement activity continues to focus on identification and recording, reducing barriers to access, strengthening referral pathways and increasing uptake amongst underserved groups.

1.0 Quality - In Focus

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

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP003a (L)		People accessing Talking Therapies - Cumulative Annual			1483		1483	>= 12933	10163
OP003c (N)	NOF04a	Reliable recovery rate within Talking Therapies	>= 51%	299/674	44.36%		44.36%		48.28%
OP003d (N)		Reliable Improvement rate within Talking Therapies	>= 68%	462/700	66.00%		66.00%		68.96%
OP007b (L)		Women supported by perinatal MH service (Rolling 12M)	>= 587		636		636		636
OP012 (N)	NOF04b	People discharged from MH inpatients followed up in 72 hrs	>= 80%	65/73	89.04%		89.04%		89.65%
OP013a (N)		People accessing CYP services with >= 1 contact (13mth roll)	>= 9424		12382		12382		12382
OP015 (N)		People (CYP) with urgent eating disorders seen within 1 wk		1/1	100.00%		100.00%	>= 95%	100.00%
OP017c (N)		The number of active inappropriate adult acute OAPs	<= 14		5		5		5
OP019 (N)	NOF06e	MHSDS score for data quality maturity index (DQMI)		958/1000	95.80%		95.80%	>= 90%	95.03%
OP054c (L)		Virtual ward occupancy - on day 30	>= 80%	54/60	90.00%		90.00%		90.00%
OP061c (N)		Patients with SMI having full annual physical health check		2765/3925	70.45%		70.45%	>= 95%	70.45%
OP078 (L)		Number of people accessing Individual Placement Support	>= 120		113		113		113
OP085 (N)		Attended Community Care Contacts			60919		60919	>= 57610	409817
OP086 (N)	NOF02e	CYP community mental health related waits > 104 weeks	= 0		305		305		305
OP087a (N)	NOF03c	Mean length of stay for adult acute and PICU patients	<= 47	8649/212	40.80		41		43
OP087b (N)	NOF03d	Mean length of stay for older adult acute discharges	<= 67	3228/58	55.66		56		57

Narrative

OP003a – Reporting 10,163 year to date against a target of 12,933. When compared with activity in the same period last year (10,231) we are 68 contacts below.

OP003c – Reporting 44.36% in month below the 50% target. The year-to-date position is 48.28% slightly decreasing from 48.85% from the previous period.

OP003d – Reporting 66% in month, below the 68% target. The year-to-date position is 68.96% decreasing from 69.26% from the previous period.

OP061c – Reporting 70.45%, an increase from 63.47% in the previous month, but remaining below the 95% target.

OP78 – Reporting 113 increasing from 111 in the previous month, remains on target to achieve the 120 people accessing by the end of March 2027.

OP86 – Reporting 305 waits over 104 weeks, has seen a significant reduction locally from 2,210 and is higher than forecasted position. However, it is still worth noting that this measure reflects the NHS England measurement methodology rather than the length of time patients are waiting for care. These are not true waits over 104 weeks.

1.0 Quality - In Focus

Indicators for October 2026/2027 TRUST — Quality

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
OP089 (N)		The no of referrals for urgent community response	>= 64		12		12		155
OP090 (N)	NOF08i	% LD patients on GP registers receiving PH check last 12m	>= 95%	1051/1299	80.91%		80.91%		81.80%
OP091 (N)	NOF04c	% of acute MH admissions with no contact with CMH services in the previous year	<= 10%	12/192	6.25%		6.25%		5.30%
OP092 (L)		Access to MHST Support in schools and colleges	>= 3214		4269		4269		31023
OP093 (L)	NOF03e	% readmitted within 30 days of discharge – comparative band		0/21	0.00%				
OP094 (L)	NOF03f	% Readmissions within 14 days after adult acute discharge	<= 10%	0/21	0.00%				
OP095 (L)	NOF03g	% intermediate-care beds patients without right to reside	<= 8%	4/38	10.53%		10.53%		10.53%
OP096 (L)	NOF02f	Access MH services with >= 2 contacts & paired outcome score		5946/25577	23.25%		23.25%		23.25%
OP096a (L)	NOF02f	Access MH services with >= 2 contacts & paired outcome score (Children)	>= 27%	796/5924	13.44%		13.44%		13.44%
OP096b (L)	NOF02f	Access MH services with >= 2 contacts & paired outcome score (Adults)	>= 11%	5150/19653	26.20%		26.20%		26.20%
OP098 (L)	NOF02a	% Number of Commnunity CYP waiting 18 weeks or less	= 100%	76/76	100.00%		100.00%		100.00%
OP099 (L)	NOF02b	% Number of Community Adults waiting 18 weeks or less	= 100%	2574/2574	100.00%		100.00%		100.00%
OP100 (L)	NOF02c	% of cases where a CYP is 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%	0/2574	0.00%				
QS005 (N)	NOF08b	Number of MRSA infections (Monthly)	= 0		0		0		0
QS006 (N)	NOF08d	Number of Clostridum difficile infections (Monthly)	= 0		0		0		0
QS007 (N)		Number of gram-negative bloodstream infections (Monthly)	= 0		0	Q3 = 0	0	= 0	0
QS008 (N)		% of patients aged > = 16 admitted with completed VTE within 14 hours	>= 95%	129/153	84.31%	Q3 >= 95%	84.31%	>= 95%	82.15%
QS009 (N)	NOF7e	% frontline healthcare workers receiving there annual flu vaccination		1915/3335	57.42%		57.42%		33.15%

Narrative

OP089 – Reporting 12 referrals in month reduced from 22 the previous month and remains below the monthly target of 64.

OP090 – Reporting 80.91% in month reduced from the 82.40% in the previous month and remains below the 95% target.

OP095 – Reporting 10.53% in month reducing from 13.59% the previous month (reduced by 2 patients) however remains above the 8% target.

OP096a – Reporting 13.44% in month reduced from 13.59% the previous month against the target of 27%.

QS008- Reporting 84.31% in month increasing from 81.38% in the previous month but remains below the 95% target.

1.0 Quality - In Focus

Indicators for October 2026/2027 TRUST — Quality

NHS Rotherham Doncaster and South Humber NHS Foundation Trust

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS027 (L)		% ligature incidents reported as moderate or above in inpatient areas		0/36	0.00%	8.33%	0.00%	8.33%	0.00%
QS029 (L)		Number of racist incidents against staff members		23		23	= 0		184
QS031 (L)		% episodes of seclusion receiving an MDT assessment within 5 hours	12/15	12/15	80.00%	80.00%	80.00%	100%	80.00%
QS036 (N)		% Inpatient that have completed a MUST assessment within 36 hours	127/153	83.01%	83.01%	83.01%	= 100%		79.89%
QS037c (L)		Inpatients commenced falls assessment in 12 hrs	76/82	92.68%	92.68%	92.68%	= 100%		92.29%
QS056 (L)	NOF08a	CQC community mental health survey satisfaction rate		1	Q3 <= 2		1		1
QS057 (L)	NOF08c	Rate of e-coli	= 0	0			0		0
QS059 (L)	NOF08e	% Acute-Spells/Community with new grade 3/4 pressure ulcer	= 0%	0.00%					
QS060 (L)	NOF08f	% Safety incidents low/moderate/severe/fatal harm		283/568			49.82%		49.82%
QS061 (L)	NOF05b	NHS staff survey raising concrens sub-score		7			7		7
QS062 (L)	NOF06d	% of Clinical trials set up with 90 days	= 100%	100/100	100.00%		100.00%		100.00%
QS063 (L)	NOF08a	Restrictive interventions (by type) per 1K occupied bed days		16000/19052	0.84		1		1
QS064 (L)	NOF01a	% inpatients supported attempt to stop smoking (12M rolling)		203/346	58.67%		58.67%		58.67%
QS065 (L)		Number of complaints received in month	<= 168	29	29		29		29
QS066 (L)		Number of patients on Phoenix ward with a length of stay > 1 year	= 0	0	0		0		0
QS068 (L)		% Number of patient with an out of date face risk assessment	<= 5%	1784/8246	21.63%		21.63%		21.63%
QS070 (L)		Number of patients discharged due to disengagement		1102			1102		1102
QS072 (L)		Number of child deaths escalated to safeguarding review		0			0		0
QS073 (L)		% of New births visits within 14 days	>= 85%	411/423	97.20%		95.00%		95.00%

Narrative

QS029 – Reporting at 23 in month increasing from 19 in the previous month.

QS031 – Reporting 80% in month reducing from 87.50% the previous month, below the 100% target.

QS036 - Reporting an increase to 83.01% in month from the 74.83% from the previous month, below the 100% target.

QS037c – Reporting 92.68% in month from the 94.9% reported in the previous month breached the 100% target.

QS068 – Reporting 21.63% in month from 21.77% in the previous month, remains above the target of <5%.

1.0 Quality - In Focus

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

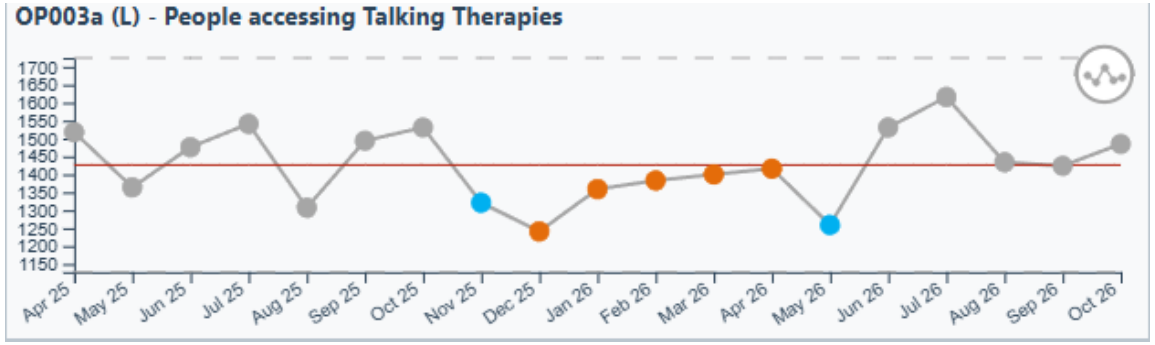
Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
QS075 (L)		Number of childhood vaccinations and immunisations			19		19		19
QS081a (L)		MHA - Documentation Compliance							
QS081b (L)		MHA - Matron and Medical Scrutiny Compliance							
QS081c (L)		MHA - Consent to treatment (on Admission)		25/38	65.79%		65.79%		65.79%
QS081d (L)		MHA - Consent to treatment (3 months)							
QS081e (L)		MHA - Section 132 Rights		68/76	89.47%		89.47%		89.47%
QS081f (L)		MHA - Section 17 leave							
QS081g (L)		MHA - Section23 Compliance							
QS082 (L)		Deprivation Of Liberty							
QS083 (L)		Number of LD patients with Stomp recorded			0		0		0
QS084 (L)		Number of 7 day theraputic days missed			0		0		0
QS085 (L)		% Seclusion Utilisation rate		32/1886	1.70%		1.70%		1.70%
QS086 (L)		Number of CMHT staff with a caseload > 20 patients	<= 20		87		87		87
QS087 (L)		Number of formal admission against number of information admissions for Adult Acute MH Wards		20/24	0.83		1		1
QS088 (L)		Average number of contacts per day for district nursing service			698		698		698

Narrative

QS81a, 81b, 81d, 81f and 81g. – the Mental Health Act metrics are being introduced to the report in a phased programme. Some of the new measures are included in this report and the remaining ones will following in the November 2026 report (published in December 2026).

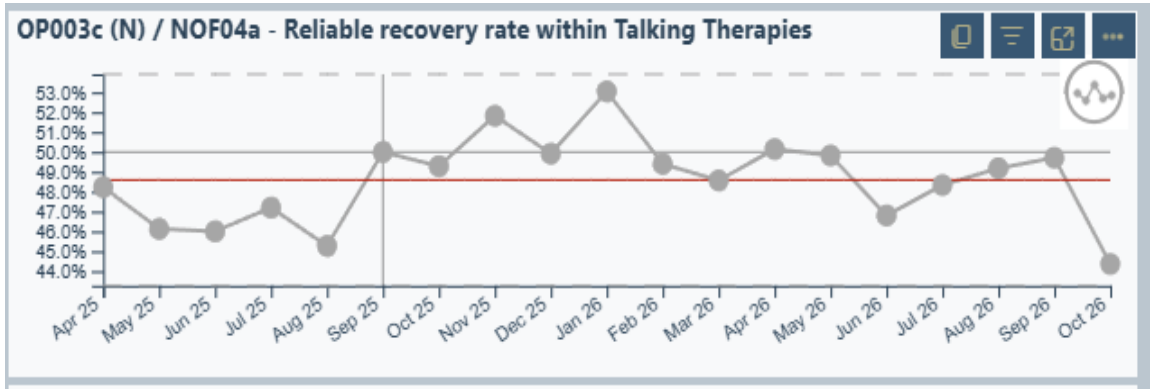
QS086 – CMHT caseloads are reported at 87 against a target of 20. The position remains materially above target, although recognised limitations in the reporting methodology mean the result requires validation before it can be interpreted as caseload position. **Discussion within CPHT confirmed no caseloads at that scale, and an interim escalation model will be implemented over the next 8 weeks.**

1.1 Quality - In Focus Exceptions



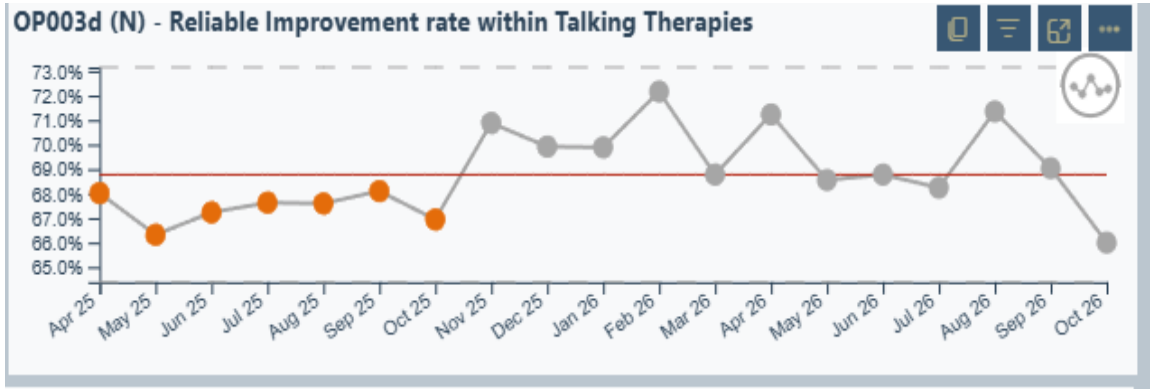
Trend, Reason and Action

OP003a - The long-term conditions pathway is now formally established in Rotherham, aligning with the existing Doncaster offer. October referrals increased among people aged 65 and over and those under 18, with a corresponding increase in access anticipated in November. The Lifting Your Mood group is established in Doncaster, and work continues to embed physical activity conversations across the service. Volunteer-led pre-appointment calls continue to support attendance, with plans to prioritise patients and pathways with higher non-attendance rates



Trend, Reason and Action

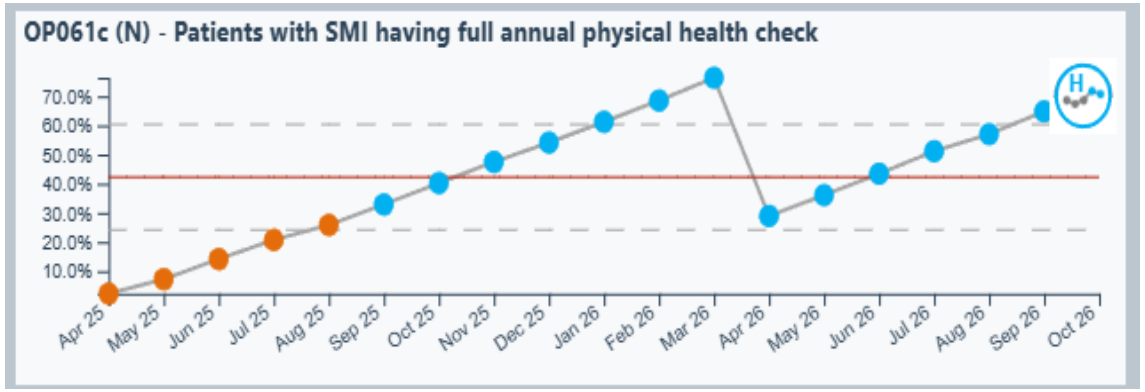
OP003C – Reliable Recovery declined considerably in October across all sites, most notably in Rotherham and North Lincolnshire. Data analysts have been tasked with reviewing data quality to determine whether it is contributing to the reported decline. Increased short and long term sickness has required patients to be reallocated to alternative clinicians, with some patients choosing not to resume treatment. Early treatment drop-out is associated with poorer outcomes. Planned mitigation includes targeted volunteer-led follow-up calls after non-attendance to support re-engagement and reduce early drop-out. Revised Step 3 job plans are now in place across the service, increasing clinical capacity to reduce treatment waits and support improved Reliable Recovery. Step 3 outsourcing to Mindler has commenced for the SYB teams, with approximately 300 patients due to transfer by the end of December.



Trend, Reason and Action

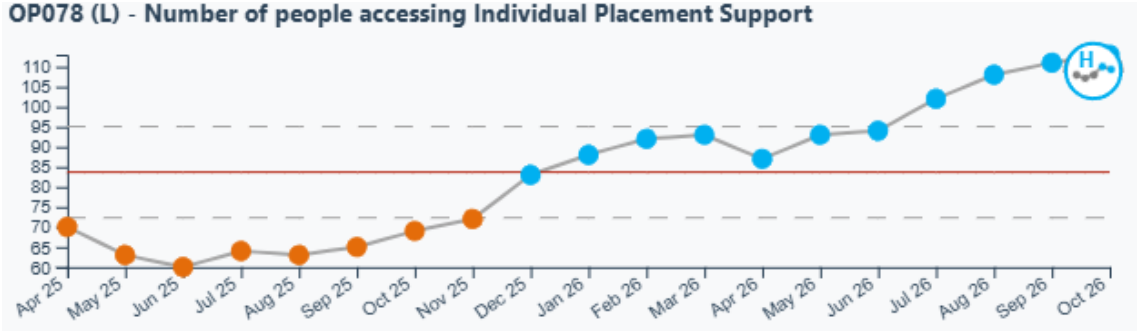
OP003d - Reliable Improvement declined considerably in October across the service, most notably in Rotherham. The cause and actions are the same as OP003C above Reliable Recovery.

1.1 Quality - In Focus Exceptions



Trend, Reason and Action

OP061C - All three places are below target, with Doncaster reporting 70.95%, Rotherham 68.55%, and North Lincolnshire 71.81%. A small variance has also been identified between the IQPR reporting position and the figure reported by the Change and Improvement Team, and validation work is underway to reconcile this. An action plan is in place ratified at Operational Management Group on the 6th November. Actions include record validation and correction, recruitment of a dedicated SMI Register data analyst, additional SMI clinics, improved recording of care plan activity, and weekly performance monitoring and a request to set a clear date by when the target will be reached. The importance of completing these checks for our patients was stressed during the November 2026 OMG and agreed that it will be subject to close monitoring and scrutiny in Care Groups and OMG until delivered.



Trend, Reason and Action

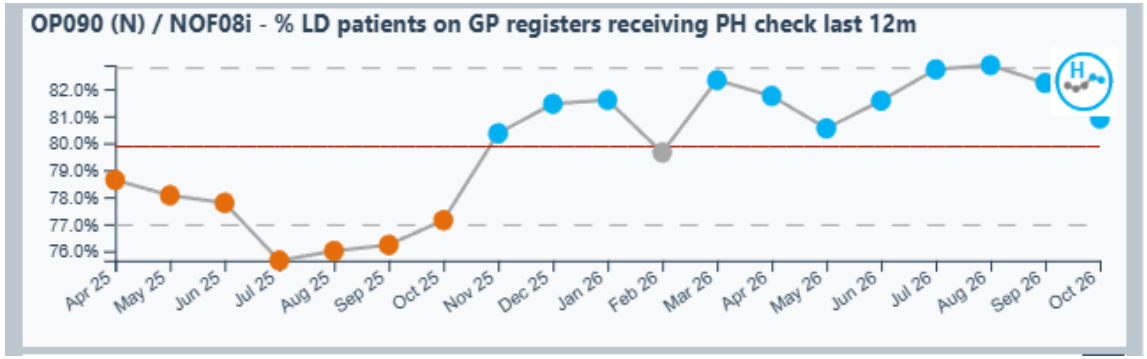
OP078 - The Individual Placement Support service is fully recruited, with a 1.0 WTE staff member now returned from maternity leave, increasing capacity. The current caseload is 66 and access has increased steadily from 87 in April to 113 in October, against a rolling 12-month target of 120, leaving a gap of 7. Actions to close the gap include increased promotion across Community services, supporting CMHT staff to discuss employment with patients, strengthening links with DWP and larger employers, embedding IPS within MDTs, and reviewing CMHT caseloads to identify suitable referrals, particularly within the SMI pathway. Monthly updates and patient stories will continue to support awareness and referrals.



Trend, Reason and Action

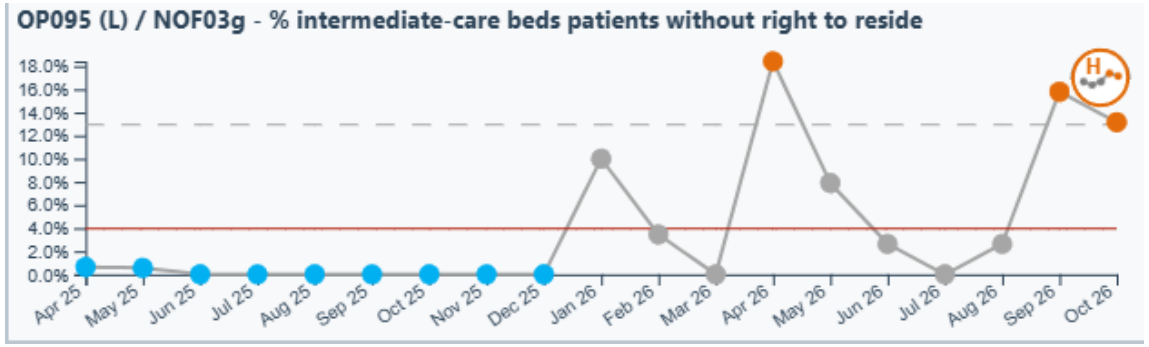
OP86 - The metric is based on referral spells, and the way patient pathways are recorded when individuals transfer between RDaSH services can lead to extended referral durations being reported against this measure, adversely affecting the reported position. As a result, the reported figure should not be interpreted as representing 305 patients experiencing a true waiting time of more than 104 weeks. Significant work is ongoing to align recording practices with the NHS England methodology and improve pathway recording, ensuring the reported position more accurately reflects patient journeys whilst remaining compliant with national reporting requirements. An extract has been requested from NHS England to enable this but they have advised this will be delayed due to their capacity constraints.

1.1 Quality - In Focus Exceptions



Trend, Reason and Action

OP090 - Improvement initiatives remain in place to increase uptake of annual physical health checks for people with a learning disability. An action plan is in place ratified at Operational Management Group on the 6th November. Actions include record validation and correction, recruitment of a dedicated SMI Register data analyst, additional SMI clinics, improved recording of care plan activity, and weekly performance monitoring. The measure requires continued Care Group and OMG oversight.



Trend, Reason and Action

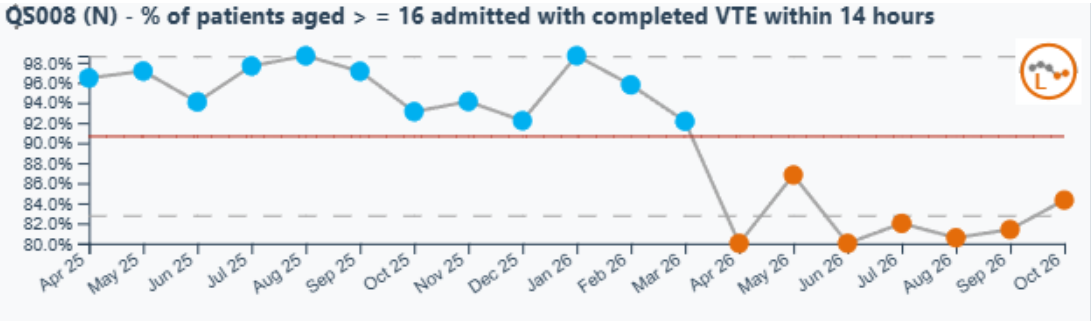
OP095 - Five delayed discharge cases remained at month end, with delays ranging from 17 to 29 days. The main causes were delays in securing appropriate packages of care and limited community support capacity. Three patients were awaiting home care packages, including delays linked to social services and out-of-area arrangements. A further patient was delayed due to joint organisational arrangements, with another patient awaiting reablement capacity from an external provider. These cases reflect wider system pressures across social care, care package availability and partner capacity. Close working with external agencies continues to support timely discharge and reduce unnecessary inpatient length of stay.



Trend, Reason and Action

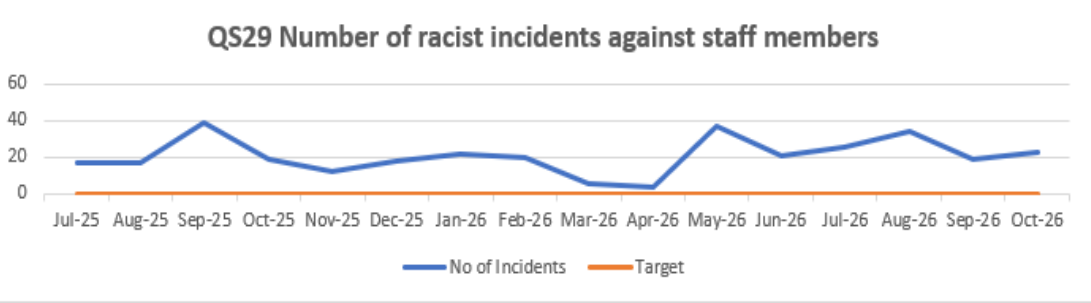
OP096a - This measure remains below the expected level, reflecting inconsistent completion and recording of outcome measures at both the start and end of intervention pathways. Children's Care group to undertake targeted review of services with the lowest completion rates, with named service leads responsible for addressing gaps in recording and embedding outcome measures within routine clinical practice. A refreshed action plan is in place monitored monthly through the Performance Clinic, with services required to demonstrate improvement against their baseline position and provide specific recovery actions where compliance does not improve. Data quality checks will also be undertaken to identify incomplete or incorrectly recorded outcomes and ensure that we are reporting accurately and that delivery reflects the impact of care provided.

1.1 Quality - In Focus Exceptions



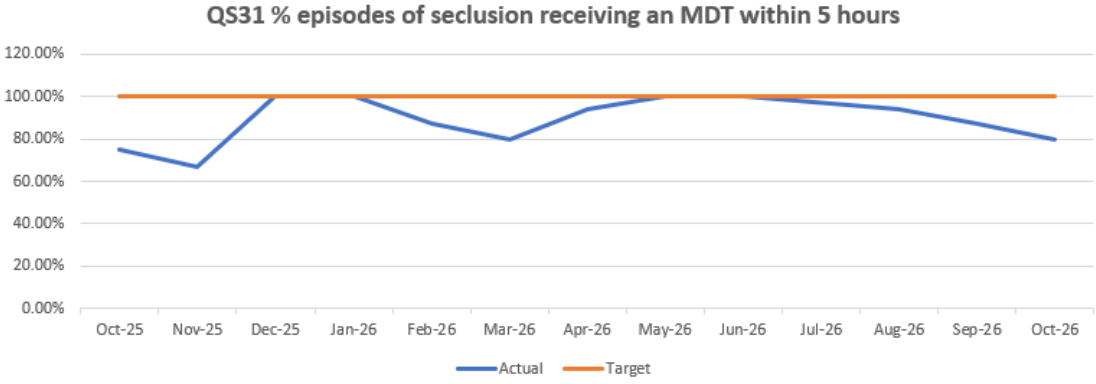
Trend, Reason and Action

QS08- Ongoing monitoring of VTE assessments continues across all care groups and has been escalated to the Trust medical director. This enhanced oversight supports the timely review of non-compliance ensuring learning from delays is identified and acted upon promptly. Care groups will continue to monitor closely and implement improvement actions to increase compliance with the required standard.



Trend, Reason and Action

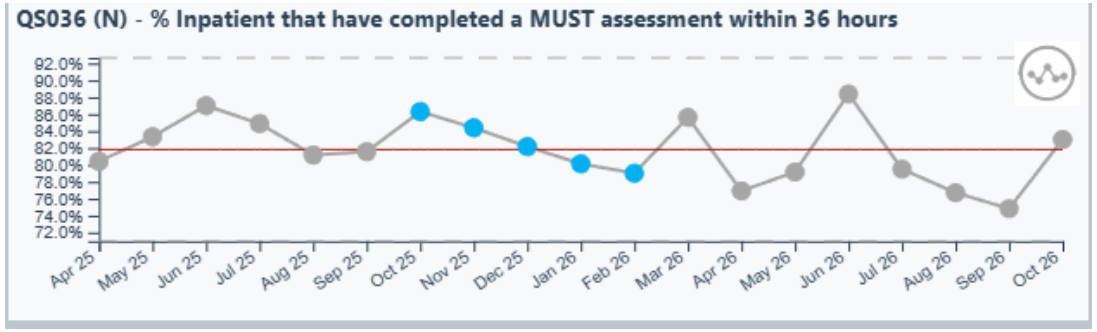
QS29 - Care Groups continue to implement the Acceptable Behaviour Policy and provide appropriate support to colleagues affected by unacceptable behaviour. The SAFE project remains ongoing in Rotherham, while the Children's Care Group continues to progress its targeted programme of work. Although the North Lincolnshire culture programme has concluded, the Care Group remains committed to embedding and advancing its anti-racism work. A Trust-wide review of the Acceptable Behaviour Policy is also underway to ensure the policy remains current, effective and aligned with organisational priorities.



Trend, Reason and Action

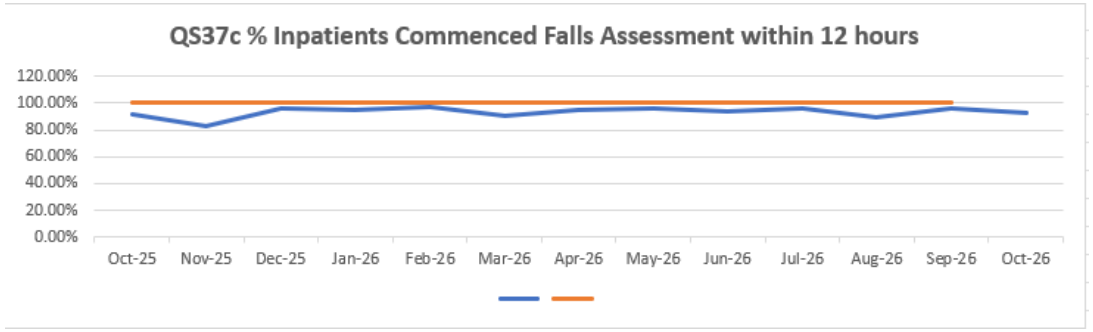
QS031 – The changes have been implemented to the seclusion visualisation on SystmOne to allow a pop-up message to appear giving instructions to the Doctors in what circumstances the particular review should be completed that has been selected. The risk continues to be highlighted on the risk register 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



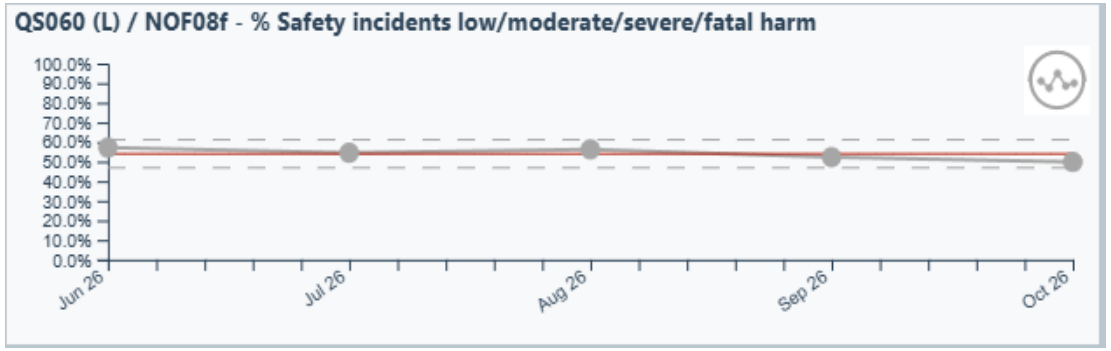
Trend, Reason and Action

QS036- A focused deep dive identified a small number of recording and documentation issues. These have been addressed through targeted staff support and feedback. Key learning will be shared across all Care Groups through the monthly Matrons' meeting. Enhanced monitoring will continue throughout November to improve compliance, strengthen recording practices and provide assurance that patients receive timely nutritional risk assessments.



Trend, Reason and Action

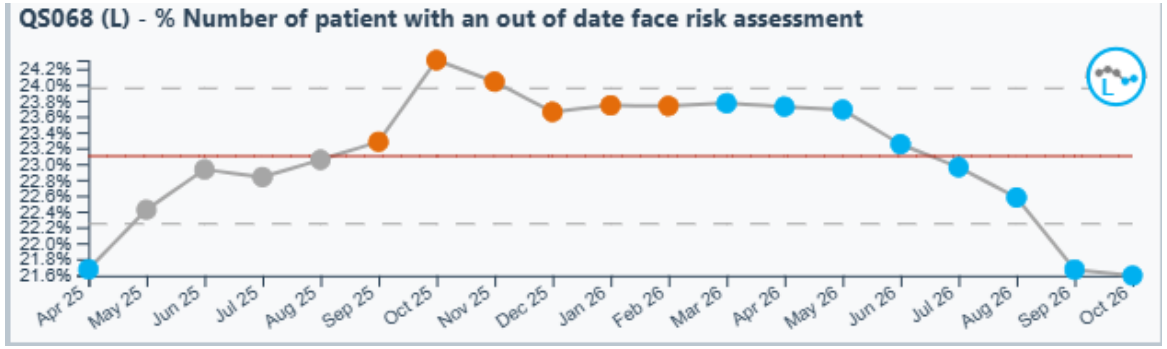
QS037C - Four Falls assessments were not completed within the required timescale, on Laurel, The Willows, Hazel and Hawthorne wards. A review of these cases identified that the assessments were missed on admission and subsequently completed on the next working day outside of the 12 hour timescale.



Trend, Reason and Action

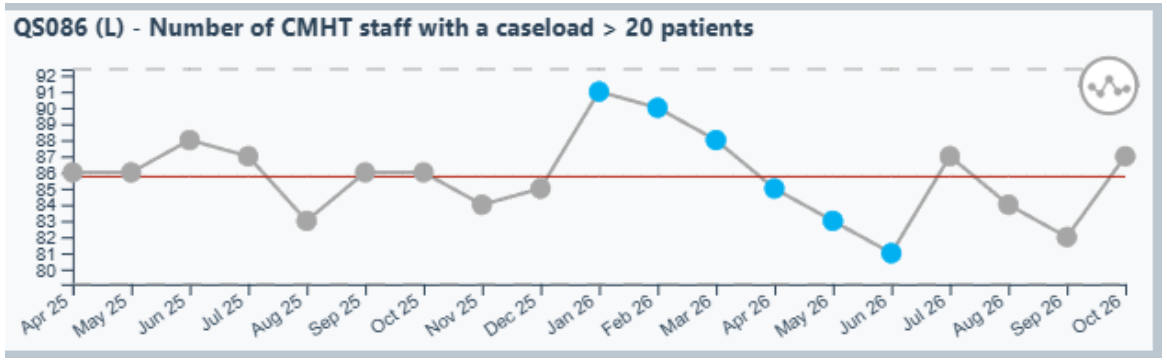
QS060 -The proportion of safety incidents resulting in harm has reduced and all incidents graded moderate harm or above continue to be reviewed and investigated in accordance with Trust policy and Duty of Candour requirements. Learning identified through investigations is shared through local governance arrangements to support improvements in patient safety and reduce the likelihood of recurrence.

1.1 Quality - In Focus Exceptions



Trend, Reason and Action

QS068 – The Nurse Director for Backbone Services will complete a deep dive in November to ensure areas of greatest non-compliance are identified to ensure all outstanding assessments are completed and accurately recorded. Targeted monitoring will continue, with Care Groups reporting the highest levels of non-compliance required to implement specific recovery actions. Progress will be monitored through established Care Group governance arrangements, with continued non-compliance escalated where sufficient improvement is not demonstrated.



Trend, Reason and Action

QS086 – This metric is being refined to align the teams in scope and maturing the reporting to align to best practice guidance alongside a deep dive to determine how enhanced risk can be reported alongside caseload volumes. The current position may be influenced by activity from staff groups included within the dataset who do not hold traditional community caseloads, including clinic-based and medical staff.

2.0 People and Organisational Development – In Focus

Indicators for October 2026/2027 TRUST — People and Organisational Development

NHS Rotherham Doncaster and South Humber NHS Foundation Trust

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
POD18 (L)		% performance development review compliance	= 100%	3159/3456	91.41%	91.41%	91.41%	91.41%	91.41%
POD30 (L)		% of day in the previous quarter where staff are sick and unable to work		24369/320652	7.59%		7.59%		7.59%
POD31 (L)	NOF07d	NHS Staff Survey engagement theme score			6.81		6.81		6.81
POD32 (L)	NOF07c	National education and training survey satisfaction rates	80%	80.44%	80.44%	80.44%	80.44%	80.44%	80.44%
POD33 (L)	NOF07d	NHS staff standards score			7.75		7.75		7.75
POD34 (L)	NOF07f	Temporary staffing cost as a % of total pay bill	0.40%		0.40%		0.99%		0.59%
POD36 (L)		% spend of Apprenticeship Levy		637636/741392	86.01%		86.01%		86.01%
POD37 (L)		Number of staff turnover < 24 months					20		283
POD38 (L)		Number of Staff turnover > 24 months					19		330
POD39 (L)		Number of recruitment from local communities		20/51	39.21%		84		84

Narrative

POD18 – Reporting 91.41% in month a reduction from 92.48% last month

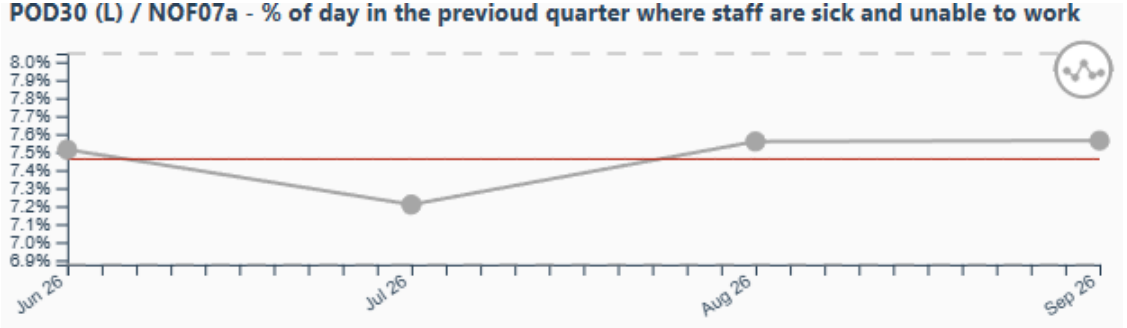
POD30 – Reporting 7.59% in month an increase from 7.56% last month.

2.1 People and Organisational Development - Exceptions



Trend, Reason and Action

POD18 – PDR compliance reduced to 91.41% (3159/3456) in October and remains below the 100% target. Care Groups are reviewing outstanding PDRs with managers, with completion monitored through established workforce governance arrangements. Areas showing limited improvement will be required to provide targeted recovery actions.



Trend, Reason and Action

POD30 – Executive oversight of long-term sickness continues, with clinics scheduled for Q4 in January and March 2027. The HR team continues to support local clinics monthly, with hotspot areas identified through Operational Management Group. To support prevention and help colleagues remain well at work, plans are underway to develop a Health and Wellbeing Guide, bringing together our core offer into a single, supportive resource.

3.0 Finance – In Focus

Finance				
Indicator	Metric	Target	Actual	Variance
NOF6a	Forecast outturn vs budget - planned breakeven	0	1000	1,000
NOF6b	Year to date actuals vs budget	(155)	613	768
NOF6c	Relative cost difference (National Cost Collection Index) 25/26	100	83	(17)
NOF8g	Rate of implied productivity growth	2%	15%	13%
FIN01	Year to date savings target vs schemes identified	8,022	8,188	166
FIN02	Annual savings target vs forecast savings (non-recurrent & recurrent)	13,750	14,750	1,000
FIN03	Annual savings target vs forecast savings (recurrent only)	9,930	10,475	545
FIN04	Year to date capital plan vs spend	5,412	192	(5,220)
FIN05	Annual capital plan vs forecast spend	7,475	7,257	(218)
FIN06	Agency spend - year to date	490	1,181	691
FIN07	No of directorates compliant with budget - year to date	24	23	95.8%
FIN08	No of directorates compliant with budget - forecast	24	21	87.5%
FIN09	*Directorates not compliant with budget - YTD:*			
	Estates	4,517	4,691	174
FIN10	*Directorates not compliant with budget - Forecast:*			
	Rehabilitation	14,843	14,959	116
	Estates	8,055	8,395	340
	Childrens Physical Health	20,229	20,289	60

Narrative

NOF6a - The 2026/27 forecast as at M7 is a £1m surplus position. This has improved from breakeven at M6 reflecting reduced expectations on the amount of recruitment possible in the remainder of the year and higher savings from the out of area position.

NOF6b -At M7 the year to date (YTD) position is £768k better than planned, reporting a £613k surplus. This masks some significant differences compared to plan, however: substantive pay underspent by £3m, including temporary staffing overspent by £1.4m, out of area placements underspent by £3.5m (now including HNY) and HDRU income is less than plan by £0.9m. Main contract income has been deferred to align with costs that will be incurred later in the year.

NOF6c -The 2025/26 National Cost Collection for RDaSH was submitted to NHSE in June and the results compared to other trusts has just been published. RDaSH has seen it's score reduce from 88 to 83 meaning it has become more efficient. For context the SY provider patch averages 94

FIN01, FIN02 & FIN03 -At M7, the YTD and forecast expected savings are both now achieving over plan, this reflects the current similar to the forecast the current OOA and vacancy position of the Trust..

FIN04/05 -Capital spend is behind plan year to date by £5.2m. This isn't unusual 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 still continue to be overplan at M7, the driver of this is agency medics within Doncaster and Rotherham Care Groups. Rotherham locums have been extended to March 2027.

FIN07 & FIN09 - The 2026/27 budgets were approved on the basis that all directorates would operate within their allocated budgets. At Month 7, 23 of the 24 directorates are underspending year to date.

FIN08 & FIN10 –These items reflect local forecasts, which in two cases show movements in H2. Budget autonomy will be removed in M09 unless these forecasts are mitigated with the CFO and CEO, and this will be picked up in the delivery review cycle.

4.0 Promises – In Focus

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

NHS Rotherham Doncaster and South Humber NHS Foundation Trust

Indicator	Alt Ref	Metric	Target	Actual	Value	QTD Target	QTD	YTD Target	YTD
P02b (L)		Number of all-age carers that use our services			1630		1630		11350
P03a (L)		Number of volunteers registered to work with us or with us through another body	>= 350		363		363		1449
P06a (L)		% of sustained reduction in service attendance gap in lower decile neighbourhoods		2922/121924	2.40%		2.40%		2.40%
P07b (L)		Number of referrals from children with a black background	>= 390		1340		1340		9354
P07c (L)		% of CYP that was not brought from deprived areas	<= 7%	141/2788	5.06%		5.06%		5.06%
P08b (L)		Number of patients aged > 65 accessing Talking Therapies			49		49		49
P08c (L)		% of adults from minority communities with LD active at month end receiving a health check	>= 95%	79/97	81.44%		81.44%		81.44%
P08d (L)		% Diagnosis rate for dementia patients aged > 65		7564/9858	76.73%		76.73%	>= 67%	75.02%
P08e (L)		% Diagnosis rate for dementia patients from a minority ethnic community	>= 4.6%	6/355	1.69%		1.69%		1.69%
P08f (L)		% of referrals to perinatal from people of a black background	>= 6%	4/58	6.90%		6.90%		6.90%
P11a (L)		% of referrals received identifying as veterans	>= 3.89%	1071/40599	2.64%		2.64%		2.64%
P12a (L)		% of referrals from rural areas compared to rural population		5445/39479	13.79%		13.79%		13.79%
P13d (L)		% of the 5 measures of community mental health transformation agreed in 2024 met		4/5	80%		80%	= 100%	80%
P14a (L)		% of services meeting the 4 week wait target		69/83	83.13%	Q3 >= 94%	83.13%		83.13%
P14b (L)		% of urgent referrals seen within 48 hours		1794/1968	91.16%		91.16%	= 100%	89.91%
P22a (L)		% Individuals admitted over the weekend		8/44	18.18%		18.18%		18.18%
P22b (L)		% Individuals discharged over the weekend		10/138	7.25%		7.25%		7.25%

Narrative

P08c – Reporting 81.44% down from 84.21% last month and below the 95% target.

P11a – Referrals from veterans reported as 2.64% increasing from 2.60% last month and remaining below 3.89% target.

P13d – Four of the five measures are meeting target. The exception relates to annual physical health checks, as identified under OP061c in the Quality quadrant.

P14a - The proportion of services achieving the Promise 14 four-week standard increased to 83.13% with 69 of the 83 services achieving the standard, compared with 81.93% last month.

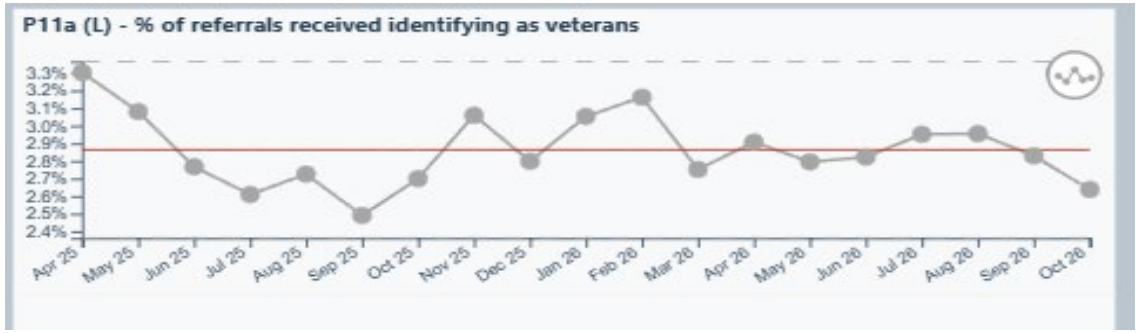
P14b - Reporting 91.16% reduced from 92.1% last month below the 100% target.

4.1 Promises - Focus Exceptions



Trend, Reason and Action

PO8C - Doncaster has experienced a decline in learning disability health-check performance due to staffing pressures. Recovery actions are in place, with targeted activity planned over the next month for the 19 people from Global Majority communities whose health checks are currently out of date. Performance remains stronger than six months ago, while Rotherham and North Lincolnshire continue to achieve above 82%.



Trend, Reason and Action

P11a - Using distinct patients, we still have a long way to go to ensure that veterans in services are more reflective of our population and the year to date is a lower % than last year. However, looking at the number of people identified as veterans in services, this increased in 2025/26. There have been discussions with services on identifying and recording veteran status on patient records, so that we meet our commitments more fully under Promise 11. However, we cannot assume that every veteran requires one of our services at all times. We have recently invested in veteran led peer support with our community partner (PFG), to encourage veterans to access our services and get support when they have done so.



Trend, Reason and Action

P14a – Delivery remains below the target standard, with several services continuing to report breaches. 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 delivery against the standard with oversight at the fortnightly waiting list group.

4.1 Promises - In Focus Exceptions



Trend, Reason and Action

P14b - 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 delivery against the urgent response standard, 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	Quality and Safety Impact Assessment: Organisational Change KPI Monitoring Report	**Agenda Item**	Paper O
Sponsoring Executive	Steve Forsyth, Chief Nurse		
Report Author	Steve Forsyth, Chief Nurse		
Meeting	Board of Directors - Public	**Date**	26 November 2026

Suggested discussion points

Access and recovery: Memory Service waits completed over four weeks reduced from 58 in September to 37 in October but remain above July (13) and August (26). Primary Care Mental Health waits over four weeks reduced from 15 to 12 but remain above July (4). The Board should scrutinise recovery trajectories, accountable ownership and evidence of sustained improvement.

Capacity and comparability: NHS111 average call duration reduced from 73 minutes in August to 41 in September; October is not stated. Phlebotomy caseloads of 19 and 16 are not readily comparable with August (71). Integrated Discharge movement of +44.7% (272) lacks a clear measure and comparable series. Confirm definitions and operational context, with continued oversight of capacity and deferred or missed care.

Reliability and limits of assurance: Rotherham EIP caseload per WTE remains not validated pending confirmation of the denominator, inclusion rules and source reconciliation. October NCMP Reception (118%) and inconsistent School Nursing contact figures require validation. The longitudinal position is broadly stable and supports reasonable, not comprehensive, assurance; attribution to organisational change remains unproven.

Previous consideration

Public Board reports in May, July and September 2026: establishing the scheme-specific monitoring framework, developing longitudinal assurance and identifying focused service and data-quality exceptions. This report adds September-October 2026 data to that sequence.

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE the September-October 2026 QSIA monitoring position for organisational changes implemented from April 2026 and the longitudinal assessment from the May, July and September Public Board reports. The position remains broadly stable, supporting reasonable, not comprehensive, assurance; attribution to organisational change remains unproven.

CONSIDER the focused exceptions: Memory Service and Primary Care Mental Health waits; the unvalidated Rotherham EIP caseload-per-WTE KPI; Phlebotomy comparability and capacity; Integrated Discharge movement; and identified data-quality anomalies.

SUPPORT focused corrective action and validation through the accountable Care Groups and Performance, including recovery trajectories for access concerns, resolution of the NCMP value above 100%, reconciliation of inconsistent figures and confirmation of KPI definitions and comparable time series.

AGREE continued business-as-usual QSIA surveillance alongside the Integrated Quality and Performance Report (IQPR), with escalation where adverse movement is sustained, clinically or operationally material and supported by triangulated evidence.

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
Trust-wide monitoring across Care Groups and corporate functions, supplementing the IQPR and Care Group governance. North Lincolnshire and corporate functions lack sufficiently detailed September-October tables to support a new service-level conclusion; absence of a reported exception is not positive assurance.

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

Organisational Change KPI Monitoring Report

November 2026 Public Board

September-October 2026 data | Organisational changes implemented from April 2026

1. Purpose and central judgement

1.1 This report presents the September and October 2026 Quality and Safety Impact Assessment (QSIA) monitoring position for organisational change and vacancy-removal schemes implemented from April 2026. It adds the current factual position to the sequence of reports received by the Public Board in May, July and September 2026.

1.2 The central judgement remains broadly stable, with focused exceptions requiring action. The available evidence does not establish that organisational change caused or materially worsened the identified concerns.

1.3 This is a longitudinal surveillance judgement rather than a statement that every indicator is stable. Individual movements are visible in access, capacity and activity measures. They require proportionate investigation, but they do not currently align with a Trust-wide deterioration in incidents, complaints, safeguarding, unmet need or patient experience.

2. Longitudinal Public Board narrative

2.1 The assurance position has developed from establishing the monitoring architecture to testing whether emerging movements are sustained and triangulated. The progression is summarised below.

Board point	What the Board was told	Assurance development
May 2026	Scheme-specific KPIs, data sources and governance routes were established. Early indications showed no red flags, while the dashboard and some measures remained in validation.	Initial assurance was principally about the completeness and operation of the surveillance framework, not mature outcome trends.
July 2026	The available evidence did not demonstrate sustained CIP-related harm. Specific exceptions and data gaps required oversight, including call handling, Assertive Outreach DNAs, Memory Service waits, Integrated Discharge delays, Phlebotomy, supervision definitions, NCMP reconciliation and Corporate BPPC.	The Board moved from framework assurance to early longitudinal interpretation, with routine monitoring and escalation if a movement became sustained or material.
September 2026 (August data)	The wider dataset remained broadly stable, but access, capacity, documentation and data-quality exceptions required focused action. Primary Care Mental Health and Memory Service waits, NHS111 call duration, Phlebotomy and KPI validation were highlighted. The Rotherham EIP numerator was clarified, but the WTE denominator and KPI rules were not validated.	Assurance became more cautious and explicit: isolated deterioration required action, but attribution to organisational change remained unproven.
November 2026 (September-October data)	Several August concerns have improved or reduced, but some remain unresolved or require validation. No new triangulated Trust-wide adverse pattern is demonstrated.	The appropriate position is continued business-as-usual surveillance by exception, with clear ownership of the residual data and service issues.

2.2 Across the sequence, the escalation threshold has remained consistent: an individual monthly movement is not treated automatically as deterioration; a potential signal requires persistence across reporting periods or deterioration across more than one domain; and attribution to organisational change requires supporting operational, workforce, safety and experience evidence.

3. Scope, method and limitations

3.1 The framework covers Children and Young People, mental health, learning disabilities, physical health and neurodiversity, community services and corporate functions. It supplements, rather than replaces, the Integrated Quality and Performance Report and Care Group governance.

- 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.

4. Board-level position and focused exceptions

4.1 The September-October dataset does not show a Trust-wide increase in incidents, complaints, unmet need or safeguarding concerns associated with the change programme. The current position is therefore not one of general deterioration. It is a mixed position in which several prior exceptions have improved, while a smaller group requires continued action or validation.

Area	Longitudinal evidence	Current interpretation / required response
NHS111 call duration	46 minutes in July; 73 minutes in August; 41 minutes in September. October duration is not stated in the current draft.	The August spike has not persisted in the available September data. Continue routine monitoring and confirm the October value before describing full resolution.
Primary Care Mental Health waits over four weeks	4 in July; 13 in August; 15 in September; 12 in October. Contacts rose from 1,590 to 1,671 between September and October; DNAs fell from 164 to 149; GP complaints remained zero.	October is improved on September, but the wait count remains above the July position. Retain as a focused access exception; no evidence in this dataset attributes it to organisational change.
Memory Service waits completed over four weeks	13 in July; 26 in August; 58 in September; 37 in October. Physical-health-check completion improved from 66% to 69%; caseload reduced from 611 to 592.	October improved, but the level remains above July and August. This is the clearest sustained access exception and requires an operational trajectory and continued scrutiny.
Rotherham EIP caseload per WTE	Band 6 caseload totals were established as 267, 268 and 269 for June-August, but the monthly WTE denominator and inclusion rules were not validated. Current EIP caseload is 183 in September and 186 in October, on a different reported basis.	Do not combine or compare the figures as though they are the same KPI.
Phlebotomy	Previous reports described capacity and workforce pressure and an August caseload of 71. The current paper shows 19 in September and 16 in October.	The scale discontinuity indicates that definition, reporting basis or data extraction may have changed. Validate comparability before interpreting the reduction as improvement. Maintain operational visibility of capacity and deferred/missed care.
Integrated Discharge	A July delay exception improved to zero in August. The current overview reports +44.7% (272), without a sufficiently clear measure name or September-October series.	Re-open as a focused data/operational exception pending confirmation of the measure, denominator and service context. Do not infer recurrence or harm solely from the percentage movement.
NCMP Reception	89% in September and 118% in October.	A percentage above 100% is internally implausible for a conventional completion rate unless the denominator or measure is defined differently. Validate before publication; do not normalise or explain without evidence.

4.2 Low-volume changes should be interpreted using absolute values. Sexual Health cancellations increased from 2 to 5 (+150%), while attended contacts increased from 295 to 320 and DNAs reduced from 19 to 12. This requires visibility but does not, on its own, demonstrate reduced access or harm.

5. Integrated Care Group analysis

5.1 Children and Young People

Indicator	September	October	Interpretation
NHS111 abandoned calls	52	43	Improved month on month.
NHS111 average call duration	41 minutes	Not stated	Return from the August spike; October value should be confirmed.
Doncaster School Nursing contacts	1,220	1,103	Reduced activity; should be considered with DNAs, cancellations and seasonal/service context.
School Nursing DNAs	19	12	Improved.
NCMP Reception	89%	118%	October value requires validation before interpretation.
Sexual Health attended contacts	295	320	Increased.
Sexual Health DNAs	19	12	Improved.
Sexual Health cancellations	2	5	Increase of three events; low-volume variation requiring monitoring.

5.1.1 Taken together, the service-level indicators do not demonstrate a coherent adverse access pattern: abandoned calls and DNAs reduced, and Sexual Health contacts increased. The reduction in School Nursing contacts and the increase in Sexual Health cancellations require local context.

5.2 Doncaster Mental Health and Learning Disabilities

Indicator	September	October
Community Mental Health contacts	909	929
DNAs	50	58
Cancellations	36	53
Waits under four weeks	12	12
Waits over four weeks	6	4
Primary Care Mental Health contacts	1,590	1,671
Primary Care Mental Health DNAs	164	149
Primary Care Mental Health cancellations	205	205
Primary Care Mental Health waits under four weeks	105	87
Primary Care Mental Health waits over four weeks	15	12
GP complaints	0	0

5.2.1 Community Mental Health contacts increased and waits over four weeks reduced, although DNAs and cancellations increased. Primary Care Mental Health improved between September and October across contacts, DNAs and waits over four weeks, with GP complaints remaining at zero. These movements are reassuring but do not yet establish sustained recovery from the August exception.

5.3 Memory Services

Indicator	September	October
Waits completed over four weeks	58	37
Caseload	611	592
Completion of all eight physical health checks	66%	69%

5.3.1 The October position improved across the three reported measures. However, the over-four-week wait count remains above the July and August levels reported previously. Memory Services should therefore remain a focused exception until a sustained downward trajectory is demonstrated and the operational causes and actions are clear.

5.4 Rotherham Care Group

Service / caseload	September	October	Movement
EIP	183	186	+3
Assertive Outreach	133	129	-4
Locality Treatment North	462	462	0

Service / caseload	September	October	Movement
Locality Treatment South	670	640	-30
Care Home Liaison	490	476	-14
Memory Team	813	792	-21

5.4.1 Most movements are modest in absolute or proportional terms, with no aligned adverse safety or experience signal presented.

5.5 Physical Health and Neurodiversity

Measure	September	October	Movement
TVAL caseload	2,300	2,310	+0.4%
Respiratory caseload	350	358	+2.3%
Continence caseload	4,852	5,165	+6.5%
Specialist Palliative caseload	66	87	+31.8%
End of Life caseload	2	3	+50.0%
Diabetes caseload	1,635	1,466	-10.3%
Planned caseload	323	241	-25.4%
Phlebotomy month-end caseload	19	16	-15.8%

5.5.1 Incidents, negative feedback and lone-worker incidents remained low in the source material, with one reported unmet need in October. Percentage movements in very small denominators, such as End of Life, should be read with the absolute values. Larger caseload movements require service context but are not, in isolation, evidence of harm or causation.

5.5.2 Phlebotomy remains a focused assurance issue because the current 19-to-16 series is not readily comparable with the August value of 71 reported previously. The data definition and extraction should be reconciled before a trend judgement is made, alongside continued operational oversight of capacity, deferred care and any evidence of harm.

5.6 North Lincolnshire and corporate functions

5.6.1 The current source paper does not provide sufficiently detailed September-October indicator tables for these areas to support a new service-level conclusion. The absence of a reported material exception should not be interpreted as positive assurance without data. Existing business-as-usual governance should continue, with any sustained or material exception escalated through the established route.

6. Dashboard movements requiring contextual interpretation

6.1 The source paper includes a set of month-on-month percentage movements. These are preserved below as reported, but the measure represented by each value, its denominator and its materiality are not consistently stated. They should therefore be used as screening prompts rather than standalone evidence of deterioration.

Reported as warranting attention	Reported movement / value	Interpretive note
Sexual Health	+150.0% (5)	Low absolute volume; current detailed table identifies cancellations increasing from 2 to 5.
LD B7 Role Review	+81.0% (76)	Measure and baseline require explicit definition.
Integrated Discharge	+44.7% (272)	Measure and September-October series require confirmation.

Reported as warranting attention	Reported movement / value	Interpretive note
Memory	+13.8% (792)	Likely caseload movement; distinguish from waiting-time exception.
Early Interventions support worker review	-13.8% (75)	Direction is not inherently adverse without defining the measure.
Memory Service Changes - Nursing	+11.1% (592)	Current detailed table reports October caseload 592; do not conflate caseload growth/change with wait deterioration.
ARMS Pathway	+11.1% (10)	Small denominator; define measure.
Doncaster School Nurses	-9.4% (1,108)	Consistent with reduced contacts, subject to final data reconciliation (detailed text reports 1,103).
Nurse Consultant Changes	0 to 1	Single event; review nature and severity, not percentage.
North Lincs Health Visiting	0 to 1	Single event; review nature and severity, not percentage.
Macmillan Information Centre	0 to 1	Single event; review nature and severity, not percentage.

6.2 The Doncaster School Nursing value is internally inconsistent within the draft: the overview gives 1,108 while the detailed narrative gives 1,103 for October. The final published paper should use one validated figure and record the correction through the normal data-quality process.

7. Required actions and governance

Action	Owner / route	Evidence required for closure
Validate the October NCMP Reception value and confirm numerator, denominator and reporting definition.	Children and Young People / Performance	Reconciled value and signed-off definition before publication or clearly marked “not validated”.
Provide a Memory Service recovery trajectory for waits completed over four weeks.	Relevant Care Group operational governance	Cause, action, accountable owner, milestones and evidence of sustained reduction.
Continue focused review of Primary Care Mental Health waits.	Doncaster Mental Health and LD	Monthly wait trajectory triangulated with activity, workforce, complaints, incidents and patient experience.
Reconcile Phlebotomy and Integrated Discharge measures with earlier reports.	Physical Health and Neurodiversity / Performance	Stable KPI definition, comparable time series and operational interpretation, including deferred/missed care where relevant.
Resolve internal data inconsistencies and define percentage movements.	Report owner / Performance	Validated final values, explicit measure names and clear low-volume interpretation.
Continue QSIA surveillance as business as usual alongside the IQPR.	Care Groups and organisational governance	Escalation of sustained, clinically material or operationally material adverse variation supported by triangulated evidence.

8. Conclusion and Board position

8.1 The longitudinal position from May to November 2026 is broadly stable. The monitoring system has progressed from establishing scheme-specific surveillance to identifying and testing exceptions over time. The evidence does not show a sustained Trust-wide adverse pattern across quality, safety, access, workforce support or patient experience attributable to organisational change.

8.2 This conclusion is not an absence-of-risk statement. Memory Service waits remain a sustained access exception; Primary Care Mental Health waits remain above the earlier July position despite October improvement; and the Phlebotomy, Integrated Discharge and NCMP data require reconciliation or validation. These issues require focused action and governance oversight.

8.3 The current evidence supports continued business-as-usual surveillance by exception. Any future attribution to organisational change should be based on a sustained and material pattern supported by aligned operational, workforce, safety, access and experience evidence, rather than timing or a single monthly movement alone.

Appendix 1. Evidence basis for the longitudinal review

Source	Use in this report
May 2026 QSIA Board material	Initial monitoring framework, KPI architecture, governance and early data limitations.
July 2026 QSIA Public Board paper and coversheet	Early longitudinal assurance, named exceptions, data-quality issues and escalation threshold.
September 2026 updated Public Board QSIA report (August data)	Broadly stable judgement; focused access, capacity, documentation and data-quality exceptions; detailed Rotherham EIP validation position.
QSIA Report - November 2026 draft	September-October factual values and current care-group narrative.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Chief Executive's Report	**Agenda Item**	Paper P
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	26 November 2026

Suggested discussion points (two or three issues for the meeting to focus on)	
Since the last report the Trust has seen the first data reported on school readiness and has achieved carers' federation accreditation: and we have *nearly* made the first step on DIALOG+ care plan that we said we would deliver in September. All are important leaps forward. We have also been part of a tragic local major incident with William's death, seen the start of a likely programme of CQC service inspections across the Trust, and seen the sectoral financial model for 2027/28 (unbundling) summarily upended, or maybe just deferred. That busyness is reflected in real strain among individuals and across a wider landscape. The report nonetheless primarily seeks to animate a discussion on twin pressures that we face: an almost 8% staff sickness rate with no lowering of long-term sickness and a spike in short term, together with a 10% rise in acute demand over a sustained period of some months. Both are driving a diversion of management effort into managing day to day choices, contributing to an increasing fragility in progressing short to medium term wider goals.	
Previous consideration	
N/A except CLE/CoLE annexes – and EPRR discussion at July/Sept 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	
NOTE further detail on matters related to the widely discussed EPRR position	
REFLECT on the emerging 'national' planning process and deadlines	
DISCUSS the key issues highlighted in the opening two paragraphs of the report	
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 October and November 2026
Annex 2: Communities' Leadership Executive (CoLE) - October and November 2026
Annex 3: Current register of Trust vacancies – as at time of issue
Annex 4: National publications – October and November 2026
Annex 5: Neurodiversity activity and wait scorecard: to September 2026
Annex 6: South Yorkshire Eating Disorders Joint Committee Meeting Note – 09/11/2026

Rotherham, Doncaster and South Humber NHS Foundation Trust

Chief Executive's Report – November 2026

1.1 Two reports have been released since the Board last met that I wished to draw attention to here. The Milburn Review into young people not able to access education, training, or employment has been a very high-profile generational reconsideration of the role of the (welfare) state. It does provide a context of what we know clinically, which is that diagnosed but unsupported, and not-yet diagnosed, mental health conditions, and especially neurodiversity, are a feature of our local communities. It is difficult to see how, absent substantial investment and energy in better supporting older teenagers with ADHD and autism, we will materially shift the exclusion the review highlights. In October, **Peter Fonargy's long awaited report on prevalence and incidence of neurodiversity** was published (see annex 4). This myth-busts the narrative of overdiagnosis or soft-touch benefits and asks us to consider how we reshape services around people, both as adults and children. It is to be hoped that with the Health Commissioner pilot now live in South Yorkshire creates a unique opportunity to bend effort to tackle this public health issue. As I outline below, in October we signed a contract in Humber and North Yorkshire which will see £1.2m of new funds invested in neurodiversity services from April 2027, as well as putting our post-diagnostic service for young people onto a commissioned and funded footing.

1.2 Notwithstanding these medium-term considerations, **two realities** are day-to-day dominating the working life of the organisation.

- Accommodating a sustained rise in acute/PICU bed pressure since May 2026 is consuming time and careful attention, not just in the flow team or care groups, but among responsible clinicians and executive colleagues. The repurposing of S136 suites, use of older adult beds for younger people, and invocation at scale of our agreed leave policy for bed management is significant. We are seeking this side of Christmas to make choices about how we mitigate the position on a more sustainable footing in H1 2027. It must be said that we have not reduced length of stay as we had hoped, and indeed in North Lincolnshire LOS has substantially increased, with CRFD numbers rising, but the inflow rise is the new variable for 2026/27 which we need to address.

- As the Board explored in May, sickness absence is the confounding factor in our staffing arrangements in many teams, including our ward teams. We have implemented our plans to better grip the policy we agreed in 2025, but the results have not produced the net drop in absence that we sought, as we look to reduce sickness to 4% by 2028/9 in line with the (very ambitious) goal set in 26-29 planning guidance nationally. I discuss below the likely shape of a renewed package of steps which a) seek to balance support and accountability and b) lean into short term sickness too, where our focus hitherto has been LTS orientated.

1.3 On October 2nd **we signed contract** variations with South Yorkshire ICB for 2026/27, and just before this signed a 3+2 contract with Humber and North Yorkshire ICB, backdated to April 2026. The Board will likely share my frustration that agreements reached in March had to be varied, and that the process of signature took six months, with many agreements lapsed over that time. In both ICBs singular commissioning meetings are now in place monthly, which we trust will reduce the considerable hours otherwise taken up for operational managers and others in commissioning meetings: likewise, we will hold tightly to the notion of one integrated quality and safety, operational and financial conversation in those processes, and expect our ICBs to do the same. The management time-load is considerable and has to reduce even in an era of renewed 'strategic commissioning'.

1.4 **A planning process to update** 2026-2029 plans for 2027-2029 is being narrated. The timing of the actual planning guidance remains unclear. A November submission date has latterly moved to mid-December, and in practice we might expect final submissions to take until March 2027. Positively the key indicators being reported seem similar in tone to the work done last winter, so we are working to make the process more proportionate. Across our host commissioner landscape (SYICB) we are working with other mental health providers to have one joined up conversation in respect of MHIS obligations and agree a shared approach to national must dos. That process has also fore-fronted the continued pay award allocation discrepancy faced by community and mental health providers[1] with a commitment by the ICB to better use local flexibilities to address future year costs. Sadly, what is now clear is that the unbundling of mental health contracts has been deferred until, at least, April 2028. Unbundling community contracts is proceeding for acute providers, and we are working to understand the intended approach to block community contracts with providers like ourselves. The vast majority of our contracts contain no quantified volume information or expectations, but are dominated instead by service descriptions: whilst managing to those contracts may seem appealing, its service effect would be incredibly disruptive and likely harmful for our patients so will not be the spirit of our approach.

1.5 September's public health, partnerships and patient involvement committee considered the work done since 2024/5 on promise 17, which relates to **school readiness**. In late November, the first national data was published on the position in each local authority. Nationally there have been improvements reported in school readiness, which maintain a long-term trend cited by Marmot (2020), but continued fall-back on readiness among children in receipt of school meals (often the most societally disadvantaged). In contrast in Doncaster and North Lincolnshire, those cohorts have also improved, and significantly. This is a tremendous first step, and one to build on over coming years.

[1] The Board has long been briefed, and the Trust has campaigned about, the allocation formula which in effect shares national pay award funding on an assumed pay-bill proportion of turnover. However, because that single proportion is calculated using an all-sectors average, non-acute Trusts of all types are disadvantaged, having typically if not universally higher proportionate pay costs; a disadvantage which is redoubled because we have block fixed income models and no ability to 'trade' our way out of expenditure gaps with income.

Our patients

2.1 Other Board papers and committee reports today touch on the safety of our wards, and of course the CQC undertook an unannounced inspection of our acute/PICU wards (Nov 17-19). Assurance is offered to the Board by our CNO through **our safer staffing** tool and reports, and more detailed exposition of that material has been separately circulated to members of the Board. The bi-annual MHOST review has been completed, which gives rise to an agreed change to acuity staffing in one ward, which has been expedited. Staffing levels, and skill-mix, are principally challenged by sickness absence, albeit some poor rostering practice continues. With relatively small shifts teams (often 4-6 people), skill-mix and employee flexibility does make a difference, certainly to quality, and we are exploring how we might bolster our resilience, including ensuring that all roles other than our ward managers, that are clinically based, are seeing patients, as well as supporting staff skill development. Ideally, and certainly typically, ward manager roles (not deputies) are supernumerary to our staffing numbers. Of course, the key acknowledged resilience we have, and indeed the challenge to staffing tools, lies in a multi-professional approach, which is why we should be principally and initially always concerned about weekend and out of hours staffing where such mitigations are far less prevalent. In 2024 we made explicit that senior nursing staff rostering could and should take place over seven days; in light of a some 'push back' in formalising that a brief consultation in Doncaster will conclude in December, and more formal monitoring in H1 of weekend seniority under promise 22 will begin.

2.2 Huge publicity followed the sad death in October of William Chapman in the Yorkshire Wildlife Park. Some of that publicity related to NHS failures in relation to data protection of his care record. William was open that we provided care to him over the last year, and no inappropriate access to his records took place among our staff. **Coronial proceedings** continue in this case, and our externally delivered investigation into his care will take we anticipate until February 2027. Support for staff involved in his care, and clinical input to support those at the YWP, has been well organised and continues as appropriate.

2.3 Our Board timeout saw us renew our commitment to work in 2027 on **seldom heard voices** within our communities, with a focus on the inclusion health (IH) cohort covered by our Promise 10. During November we have had purposive discussions with local prisons, the probation service and NHS England, as we look to build both better clinical pathways for service (in prison health is offered by a commissioned private provider) and employment paths too. Our 'mystery shopper' work is running to a January conclusion, and is likely to paint a discomforting picture of service exclusion for many of the inclusion cohort, notwithstanding increasingly encouraging work on trust and care within the local gypsy-Roma & traveller community. Working with our Communities' Leadership Executive we will begin to mobilise the work for board members in sitting within VCSF projects associated with the IH cohorts.

2.4 Our Community Powered Healthcare Taskforce has begun a workstream focused on better tracking of, and understand of, **declined and signposted referrals**. This builds on the well-regarded work with some practices in Doncaster on mental health

referrals for adults and can also pick up CAMHS concerns voiced in board committees. The initial data review looked at Talking Therapies, which is a self-referral service, with 37% of those presenting not proceeding to treatment, the majority through direction elsewhere – we are now looking to much greater clarity on those diverted locations, when within the Trust, and the patient/referrer experience of being moved.

2.5 Our success with both 48 hour waits, and four weeks for first treatment, will be augmented in 2027 with our work on maximum secondary waits of no more than **14 weeks**, which the Board explored last time we met. Final preparatory workshops with teams to mobilise the re-design effort to achieve this are taking place, with the principal focus on psychology pathways. This work will be grounded in job planning, with 75% of time spent in patient facing care; and a focus on fidelity to need and guidance in discharging people from pathways. The wait-time work we have done and are doing should be mutually reinforcing in that once this measure is in place, we will have visibility of all our key pathway waits alongside one another which removes the risk or perception of any gaming within our system. It should be acknowledged that the Prime Minister has publicly committed to a wait-time measurement regime for mental health services from 2028.

<u>Our people</u>

3.1 Recognition is a major complaint of colleagues across the NHS. In that context November's **awards ceremony** is the apex of our efforts since 2024 to change the dynamic. Those efforts briefly also include our Distinguished Service awards (Feb 2027), the chair's thrice yearly Shining Star awards, and local group awards and ceremonies, which are very intended to have local leaders share their gratitude and pride. Allied to the open-source visibility of Care Opinion as a route for staff to see their patient's feedback, this package is a structured one. We will be taking further steps in 2027 to improve it further, and to listen to what would 'cut through' with colleagues, students and our volunteers.

It was pleasing to see real reach in our silver and gold award winners across all parts of RDaSH's services and geographies: from clinician of the year, Dr Anne Wisdom in North Lincolnshire, through many winners from Rotherham including for peer support with Kamal Lawrence, to the Doncaster based Speech and Language therapy team who were clinical team of the year for 2026. Young volunteers won, and our team who work with young people in the care system too.

3.2 As described at the outset of this paper, **sickness absence** remains the most consistent feature of delivery review discussions. Separate 'clinics' with directorates have been taking place since Q1 to improve the adherence to, and imagination within, application of our policy. An emerging five-point plan is taking shape (but is not yet agreed and may change wholly or in part) to build on that work, which has not this year delivered the gains we sought:

- Move to short term sickness reporting through a clinically 'manned' central reporting line during Q4 26/7

- Likely introduce a financial acknowledgement in 27/8 for staff who have 100% attendance
- Assertively approach CCE procedures where there is no defined pathway of workplace return, specifically in cases of undiagnosed stress or anxiety
- Introduce a job role test into absence authorisation (including OH consideration) which supports staff to return into the workplace in different roles or on a part-time basis
- Complete the introduction of our remote/flexible working changes into service by the end of Q4, whilst supporting more staff to work compressed hours across four days

3.3 There is, as ever, a separate paper on our culture work, which is taking shape since the agreement of our approach at September's Board. I recognise that the pace may be slower than some would wish, but we need to operate with trust and co-production. That **co-production** includes work with our managers and leaders as the key aim to remains to enquire, understand and adapt how they work to make change happen locally and with alacrity when good ideas come from their teams. This distributed leadership has certainly been an aim within the LDO work, but we know that most of our line managers sit outside the top leaders' cadre group. The offer or narrative to that '555' has been slow to develop and will return as a separate "thought piece" in January in advance of a final paper in March 2027.

3.4 In 2025 considerable time was spent as a board reflecting on the challenges ourselves and **trade union** colleagues found in working together. Of course, the major collective consultation in February 2026 for community service change could have crystallised that didactism, however, support by unions to their members was strong and helpful to the outcome of that progress. This was also true of the launch at the start of October of the *4-week maximum end to end wait for grievances*. As we progress the cultural reset, we are doing so with both negotiating committee leads round the table, and reflecting on TPC too, there are soft signs of real change and of an emerging partnership. I would hope as we move towards changes in flexible working, in appraisal, in 360-degree feedback for managers and leaders, and of course our anti-racism work that that partnership can not only deepen but become overt and public. It would be to the benefit of staff to see that trust, fragile as it can be, spoken to in 2027.

3.5 The bi-annual **speaking up report** is with the Board papers, and colleagues are aware from our choices in July of an effort to move the FTSU function to a more reach-out curious space within services. Under that guise it would not simply wait for voices to come to the guardian but go searching for hidden risk/concern. It is worth testing pace and progress on that as we look to find harms. It remains the case that on most indicators with peers we are at or above average, that feedback on the FTSU experience is overwhelmingly positive, but that our 2025 staff survey confirms a long-term scepticism that the organisation will act on concerns. The 2026 survey is likely too early to see change in this objective which we prioritised as a board and is the core of our Provider Capability Assessment amber-green culture submission. We will try and use findings from our Learning into Action work to understand both what

sits behind those doubts and what would persuade people that the reality is one of absolute commitment to make safety changes when they are highlighted.

3.6 The Trust now has completed its 2026 NHS EPRR Core Standards self-assessment and formerly declared 100% compliance, improving from 21% (2023), 67% (2024) and 92% (2025). South Yorkshire ICB's Check and Challenge process confirmed that the evidence supported this position. Minor amendments were completed before the final compliance statement was submitted through the national reporting process. The ICB identified a small number of areas for further improvement over the next 12 months, but none affected the Trust's compliance. NHS England may undertake further sampling of Core Standards across the region, which may affect scoring. It is not yet known whether RDaSH will be included.

We continue to make the connection between this work and **cyber security** and further to our board discussion in September the latest Pen Testing position is as follows: our work is done through third-party CREST- and NCSC CHECK-accredited suppliers to support cyber security assurance and our Data Security and Protection Toolkit (DSP Toolkit) compliance. Testing covers internet-facing web servers and systems, alongside key internal systems. NHS England guidance states that testing should take place at least annually and must include all web servers, vulnerability scans and checks that default network passwords have been changed, with an expectation that critical network infrastructure is covered. Findings are graded by severity; results in recent years have been positive, with testing teams identifying no weaknesses of concern due to secure perimeter controls. The next penetration tests are planned for February 2027. I have asked that the governance of that reaches into our CLE sub-groups and is shared too with FDE on behalf of the Board.

<u>Our population and partners</u>

4.1 The Board's timeout brought together two years of work on **all-age eating disorders, recognising the likelihood of us continuing as a commissioner from April 2027**. Likewise, I briefed the Health Leaders Forum in November on this work, which is driven the EDJC, aligned to our MHLDA Collaborative. Settling the MEED investment implementation, moving forward to the re-procurement of integrated adult services, and aiming to put in place investments in relation to ARFID and physical health monitoring, are the three priorities for the coming few months.

4.2 Secretary of State has announced a focusing for **NHSE work on neighbourhood health**, which initially tries to create a frailty team organised around INTs. This is very consistent with the work Dr Ben Allen had been leading for us, which put the frailty centre at Tickhill Road at the heart of just such a distributed model, whilst introducing a 'step up' capability into the city. It is also already the priority cohort for the Rotherham INT work. The neighbourhood refresh does, however, challenge the deeper community immersion narrative for the most excluded people, which is central to the relational practice pilots we continue to support in Doncaster. Presently our ICBs funding narratives for these projects remain opaque, and we will be looking to see both funders make much more defined their approach to 2027-29 funding during the planning round. Yvette Cooper's announcement also introduced Young People's Mental Health as a new neighbourhood priority, which given our Waterdale

building, is timely – and we will look to see how the planning guidance picks up this thread. It may be through the school-based MHSTs, and as we have discussed with the Young Advisors Group we need to begin to shift our view of these teams to focus on outcomes and reach for those teams, including potentially their place in neurodiversity 'screening' work.

4.3 The Estate Plan update is elsewhere within the papers. Since written we have made strong progress with RMBC in moving forward **the Rotherham Riverside proposal**, with agreement in principle that the Trust is a preferred occupant for the space, with a real prospect of the move happening during 2027. As this was the Board's precursor to moving forward with the Tickhill Road re-development when we agreed the business case in July, this is a hugely significant moment and one we expect to contract by the end of January 2027, with Simon Sheppard leading both that dialogue and finalising the design plan before the end of 2026/27.

4.4 It is worth reflecting on the journey that led us to be shortlisted for **trust of the year** 2026 by the HSJ. The focus of our joint bid was work on poverty, the delivery of the shortest wait times in the NHS at four weeks, and our deep community engagement. Each of these pieces of work individually represent a sizeable project, but clearly taken together with our broader promises work, together they represent a shift in mindset and an orientation to face the reality of our patient's experiences and try to help.

4.5 Within the Clinical Leadership Executive we have begun to consider how we can **respond to feedback from the wider VCSF sector,** and specifically from CoLE, about how we work together. One part of that is to reduce procurement and contracting friction. We will move to establish a simple framework which pre-qualifies partners for investment opportunities, and more widely reduces the contracting mentality that we impose on small organisations to no great benefit. We expect to have this in place for May 2027.

Toby Lewis, Chief Executive
21st November 2026

Annex 1

Clinical leadership executive summary
October and November 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.

October	November
Trust-wide pharmacy and medicines stocktake and improvement programme	Intended investment fund approach for 2027/28
Agile Working and Hyper-Mobile Estates - Follow-up to the Mobile First Approach	Changes to management of voluntary sector 'contracts'
Anti-racism	Workshop on always measures
DIALOG+	Workshop discuss of learning into action

In terms of decisions made, a revised antiracism paper, following comments made, would be taken to the Board in November.

Over the next two meetings (December/January), we will consider in particular:

- DIALOG+ and Paired outcome measures
- NHSP and overtime
- Co-wheels
- Acorn centre – progress
- Length of Stay/Out of area placement
- Deep clean of SystmOne
- Value circle work on medical and clinical engagement

Toby Lewis, Chief Executive
19th November 2026

Annex 2

Communities' leadership executive summary
October and November 2026

Communities' Leadership Executive (CoLE) meetings routinely consider a Clinical Leadership Executive (CLE) 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.

October	November
Always Measures Presentation from Roshanne Bottomley, Nurse Director on Always Measures, what these were and what this meant in practice across the Trust's portfolio of services. • This sparked significant interest from CoLE members regarding consideration of social determinants of health, follow up to carer's referrals, accessibility of information and the approach to quality monitoring.	Promise 21 Cheryl Gowland, GP Liaison presented on Promise 21, giving an overview of the promise, its success measures and what had already been delivered for this promise. • Following this, the group agreed the four headline actions for its workplan on Promise 21.
Promise 12 Rural Health Presentation • Presentation from Ray Hennessy, Deputy Director of Strategic Development on the Trust's progress to date on delivery of *Promise 12 - Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve.* • CoLE has selected this as one of its priority areas and this presentation enabled strengthening of the actions for this element of the CoLE workplan.	What comes after Leadership Development Offer? • Carlene Holden, Director of People and Organisational Development attended to discuss the plans for what comes after the LDO and their role in next steps. • It was agreed that there was a wealth of training available to the Trust and that this could be extended to CoLE colleagues. • There are 6 places for members who have not already participated in LDO to complete it. • It was agreed that Carlene will attend again in the future to discuss community immersion and how this can be explicitly included in the Appraisal Framework.

In terms of decisions made, CoLE's focus has been on finalising its workplan, which is now complete with CoLE Member Leads identified for all 16 of the actions which make up the workplan spanning Promises 5, 6, 12 and 21.

There are no specific matters to escalate to the CLE from CoLE

Over the next two meetings (December/January), CoLE will consider in particular: Resourcing the voluntary, community, faith and social enterprise sector

- Islamophobia Awareness Month
- Estate Plan Follow Up Discussion
- Workplan Delivery

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

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

Org L4	FTE Budget	FTE Actual	FTE Variance		Awaiting Authorisation	Out to Advert	Shortlisting	Interview	Offered	Start Date Given	Total	Vacancy Rate
Trust Total	3745.87	3483.77	-262.1		**21.23**	**66.21**	**20.08**	**31.38**	**107.79**	**36.17**	**282.86**	7.00%
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	25.60	23.11	-2.49		0.00	0.00	0.00	0.00	1.00	1.20	2.20	
376 Estates	47.18	42.38	-4.80		0.53	0.40	1.00	0.00	2.75	0.00	4.68	
376 Finance & Procurement	40.90	40.21	-0.69		0.00	0.00	0.00	0.00	1.00	0.00	1.00	
376 Medical, Pharmacy & Research	54.84	53.50	-1.34		0.00	0.64	0.00	0.00	2.50	0.00	3.14	
376 Nursing & Facilities	172.04	162.23	-9.81		1.00	0.00	0.00	0.00	4.46	0.67	6.13	
376 Operations	47.67	48.60	0.93		0.00	1.00	0.00	1.00	0.00	0.00	2.00	
376 Health Informatics	72.50	69.71	-2.79		0.00	0.00	0.00	0.00	3.00	1.00	4.00	
376 People & Organisational Development	84.02	81.24	-2.78		1.00	3.51	0.00	1.00	2.00	2.00	9.51	
376 Psychological Professionals and Therapies	19.89	17.20	-2.69		0.00	0.00	0.00	0.40	1.60	0.20	2.20	
376 Strategic Development	22.39	21.55	-0.84		0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Total	**587.03**	**559.73**	**-27.30**		**2.53**	**5.55**	**1.00**	**2.40**	**18.31**	**5.07**	**34.86**	**4.65%**

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	300.63	271.65	-28.98		2.75	6.80	4.00	4.80	9.20	7.60	35.15	
376 CCG Physical Health	367.25	346.92	-20.33		1.00	4.77	2.00	3.00	8.00	3.20	21.97	
376 DMHLD Acute Services	227.99	194.30	-33.69		4.15	6.00	0.00	3.80	8.28	2.00	24.23	
376 DMHLD Community Services	333.30	317.93	-15.37		1.00	4.25	0.00	3.70	7.64	1.60	18.19	
376 DMHLD Learning Disabilities & Forensics	184.64	163.81	-20.83		0.00	6.96	1.00	2.00	7.00	3.80	20.76	
376 NLCG Acute Care Services	142.03	129.19	-12.84		3.00	6.70	3.88	0.00	7.00	1.00	21.58	
376 NLCG Community Care Services	150.56	139.85	-10.71		0.00	3.58	2.00	1.00	2.46	2.00	11.04	
376 NLCG NHS Talking Therapies	186.27	171.33	-14.94		1.00	5.00	0.00	0.00	1.00	0.00	7.00	
376 PHND Community & Long Term Conditions	431.16	409.30	-21.86		1.00	5.10	0.00	2.60	7.70	4.40	20.80	
376 PHND Neurodiversity	43.30	39.15	-4.15		1.00	0.50	0.00	0.80	5.00	0.00	7.30	
376 PHND Rehabilitation	294.31	282.16	-12.15		0.00	5.00	1.20	2.80	10.00	2.40	21.40	
376 RCG Acute Services	225.63	200.52	-25.11		1.60	5.40	4.00	2.80	8.00	0.60	22.40	
376 RCG Community Services	232.54	220.33	-12.21		2.20	0.60	1.00	0.80	5.20	2.00	11.80	
376 High Dependency Rehabilitation Unit	39.23	37.59	-1.64		0.00	0.00	0.00	0.88	3.00	0.50	4.38	
Total	**3,158.84**	**2,924.04**	**-234.80**		**18.70**	**60.66**	**19.08**	**28.98**	**89.48**	**31.10**	**248.00**	**7.43%**

Annex 4: National publications – October/November 2026

Independent review into prevalence and support for mental health conditions, ADHD and autism – Professor Peter Fonagy
(Published October 2026)
The Fonagy review examines rising prevalence and diagnoses of mental health conditions, ADHD and autism, and how support should be organised. It has potentially significant implications for demand, assessment, thresholds and service models.
https://assets.publishing.service.gov.uk/media/6ad730112b09b7fc6b7cd7c2/independent-review-into-prevalence-and-support-for-mental-health-conditions-ADHD-and-autism.pdf

Prevent: Guidance for NHS mental health services
(Department of health and social care, published 19/10/2026)
Guidance to help reduce the risk of radicalisation in children, young people and adults.
https://www.gov.uk/government/publications/prevent-guidance-for-nhs-mental-health-services

Elective Single Point of Access: technical guidance and implementation considerations
(NHS England, published 12/10/2026)
These documents provide an overview of elective Single Point of Access and set out actions for integrated care systems and their partners to expand Advice and Guidance, improve digital assessment through the e-Referral Service and implement elective Single Point of Access locally.
https://www.england.nhs.uk/long-read/elective-single-point-of-access-technical-guidance/

Guidance on NHS staff facilities
(NHS England, published 15/10/2026)
This guidance advises NHS trusts, NHS foundation trusts and integrated care boards (ICBs) on the approach they must take in the provision and use of physical staff facilities – including changing, washing and showering areas, toilets and staff accommodation.

People with severe mental illness four times more likely to die early from cardiovascular disease, report warns
(Royal College of Psychiatrists, published 09/11/2026)
People living with severe mental illness are around four times more likely to die early from cardiovascular disease than the general population in England, according to a new report published by the British Heart Foundation (BHF) with Center for Mental Health, Equally Well UK, and the Royal College of Psychiatrists.
https://medicalxpress.com/news/2026-11-people-severe-mental-illness-die.html#google_vignette

We must build infrastructure for a needs-based system of mental healthcare
(BMJ, published 10/11/2026)
Builds on the national review and argues that need rather than diagnosis alone should unlock support. It also highlights problems with diagnostic reliability, workforce training, NHS waiting lists and gaps in national prevalence data.
https://www.bmj.com/content/395/bmj-2026-101382

Government urged to introduce maximum waiting times for CAMHS by 2028

(Centre for Mental health, published 17/11/2026)
Calls for greater investment in mental health support in schools, colleges and communities, acceleration of early support hubs, CAMHS waiting-time standards and expansion of Individual Placement and Support.
https://www.centreformentalhealth.org.uk/news/item/young-people-need-the-right-support-not-punitive-measures/

Future mental health and a changing workforce
(Nature Mental Health, published October 2026)
Looks internationally at how mental health systems can respond to growing demand and shortages of psychiatrists. It highlights telehealth, psychiatric pharmacists, interventional psychiatry and community-based interventions as possible parts of future workforce models.
https://www.nature.com/natmentalhealth/volumes/4/issues/10

We are imminently expecting national NHS England planning guidance for the 2027-2029 period. This will be shared with Board members on receipt.

Annex 5:

Neurodiversity waiting time scorecard – November 2026

CYP Neurodevelopment Scorecard

1. **Trajectory & Key Milestones**

Metric	Position	Commentary	RAG
104-week cohort cleared by 30 Sept 2026	Achieved	0 CYP waiting > 104 weeks	🟢
104+ weeks – offer by April 2026	Achieved	0 CYP waiting > 104 weeks.	🟢
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)	1373	764	700	decrease of 89 since August data	🟠
Medication waits	1063	600	NLaG now migrated across 517, RDaSH original waiters 584, Total: 1,101	Ongoing pressure.	🔴

3. **Activity and throughput (October)**

Metric	Rotherham	Doncaster	North Lincs	Commentary	RAG
CYP receiving full assessment (August)	84 + 84 Digital	34 + 68 Digital	27 + 14 Digital	Increase in assessments through October from the August position +167.	●

Trajectory assurance by place

Place	On Trajectory?	Position Summary in month	RAG
Rotherham	No	-401 There are specific pressures within Rotherham which are expected to continue to impact delivery in the short term. Digital developments should provide mitigation with some of this pressure and support the overall position.	●
Doncaster	No	-218	●
North Lincs	No	-177	●

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	🔴

October

Metric	Position	Commentary / drivers	RAG
Expected capacity (full)	66/ 173 completed	Compared to full capacity	—
Booked assessments	63/161	39% of expected booked capacity - Low booked assessment figure is reflective of significantly reduced assessment capacity. Of 12 assessors in the service, 4 are currently on sick leave, 4 vacancies are either unfilled or have replacements still in induction	●
Workforce impact	98 assessment slots lost	October potential losses: sickness (7 assessors) 44; vacancies (2 assessors) 24; Staff undergoing NMP training (1 assessor) 13; capacity lost to annual leave 17. Combined 98	●

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	629/796 79%	●
September (full month)	199 / week	828	828/796 104%	●
October (full month)	199 / week	807	807/796 101%	●

2. **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
September	168	5,437
October	109	5,563

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
September	347	2,388
October	109 weeks (based on date referral registered, not referral date) Significant number of patients have previously shown far higher waiting times due to being based on date referred to original services prior to referral to RDaSH Autism assessment service	2,421

Annex 6:

South Yorkshire Eating Disorders Joint Committee Meeting Note – 9th November 2026

The South Yorkshire Eating Disorders Joint Committee (SYEDJC) met on 9 November 2026, and the main areas of discussion and subsequent actions are outlined below.

Avoidant Restrictive Food Intake Disorder (ARFID) Proposals

The Committee supported progression of a business case to enhance support for children with ARFID-type eating difficulties, and their parents/carers. Consideration of a fully costed adult model required further development.

These updates follow previous papers to the Committee outlining the lack of national strategy for ARFID and includes clinical engagement with partners in South Yorkshire as well as nationally. The business case will include lived experience voices and be part of 2027/28 Mental Health Investment Standard (MHIS) discussions.

Children and Young People Community Eating Disorders Programme

An update was provided on the children and young people's service development programme. Invitations to four workshops had been issued to stakeholders. The programme aims to establish the current baseline, co-design an enhanced community offer and explore a model which provides care closer to home and is financially sustainable. Proposals will return to the EDJC and are expected in March 2027.

Risk register

Members reviewed risks detailed on the register and noted opportunities to reduce scores following progress and developments made across the system and overseen by the Committee. A further review of several risks was requested ahead of the December meeting.

Forward planning

Updates on the following were agreed to be tabled at the next meeting:

- Proposals for improvements to physical health monitoring for adults with eating disorders including detailed options;
- Progression with the Medical Emergencies in Eating Disorders (MEED) model, including successful recruitment to the Liaison Practitioner Roles.

Marie Purdue
Managing Director, South Yorkshire MHLDA Provider Collaborative
November 2026

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Engagement and Disengagement audit	**Agenda Item**	Paper Q
Sponsoring Executive	Dr Diarmid Sinclair, Chief Medical Officer		
Report Author	Dr Diarmid Sinclair, Chief Medical Officer		
Meeting	Board of Directors	**Date**	26 November 2026

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

This paper comes on the back of a disappointed position discussed in July 2026. The audit reports accelerated intervention mobilising the clinical effectiveness resource of the Trust. The Board may wish to explore therefore:

- To what extent have the lessons from the Coroner's 2023 findings been embedded in clinical practice, and are further actions required to address the risks associated with disengagement, particularly for patients with serious mental illness?
- Are the proposed actions sufficiently robust and timely, and what evidence should the Board expect to see to demonstrate sustained improvements in practice and patient safety?

Previous consideration

None but topic discussed in July and in August timeout

Recommendation (delete options as appropriate and elaborate as required)

The Trust board is asked to:

RECEIVE the DNA and Disengagement audits.

SUPPORT the proposed recommendations to improve practice and performance

REQUIRE a further audit be completed in Q4 and brought to the Board in May 2027

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

Alignment to the plans: (indicate those that this paper supports)	
Quality and safety plan	X
Equity and inclusion plan	X
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.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	X
Partnership Working	**High Tolerance**	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X
Strategic Delivery Risks (indicate those that this paper supports)			
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are 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			X

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)

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

Appendix (please list)

Table 1 – Did not attend
Table 2 – Discharges due to disengagement

Rotherham Doncaster and South Humber NHS Foundation trust

Board of Directors

Engagement and Disengagement Audit

1. Background

1.1 In October 2023 the Trust received a Prevention of Future Deaths Report following the death of a patient where concerns were identified regarding follow-up after antipsychotic medication had been discontinued. The Coroner highlighted shortcomings in maintaining engagement and ensuring adequate follow-up after treatment had ceased.

1.2 Following this Prevention of Future Deaths Report we committed to the Coroner of rewriting our Disengagement Policy to focus on Engagement such that it is the Engagement and Disengagement Policy (Mental Health). There is also a similar policy that covers our physical health services. This policy was ratified in November 2025 via the Clinical Leadership Executive, after extensive discussions. Over the intervening period the Board was repeatedly kept appraised of the delay in progression.

1.3 At the July 2026 Board meeting data was presented to the Board regarding the number of discharges due to disengagement and appointments that were not attended that occurred across our mental health services. The limitations of this data is that it did not show how closely the Engagement and Disengagement Policy was being followed but did provide some assurance that the number of patients being discharged from our services that manage patients with psychosis was low, with extremely low numbers being discharged from our assertive outreach teams.

1.4 The Board requested more data that would allow an analysis of whether the current policy is being followed and the scope of this was co-produced in August 2026.

2. Scope and Method

2.1 For each of the two audits, 30 records were selected at random from records that were flagged as having the outcome of interest i.e. an appointment that had not been attended or a patient that had been discharged due to disengagement.

2.2 For both audits the sample included all community teams across the entire age range from children to older adults.

Audit Findings

3. Did not attend (DNA) Audit

3.1 The data in Table 1 show that teams recorded DNA contacts in the electronic record reliably, there was good evidence of further contact being attempted in 22 of 26 cases and these contact attempts were documented.

Areas for improvement are around there being evidence that risk was reviewed following a DNA as well as involving other agencies and professionals as well as families and carers. A review by a senior clinician or an MDT was only occurring in 6 of 11 cases which is arguably not policy compliant.

3.2 In terms of outcomes 20 of 30 the cases that did not attend appointments subsequently did have meaningful contact re-established. For the 10 cases where this was not re-established all 10 were discharged from the service.

3.3 In total 22 of the 30 records audited were fully compliant with the policy.

4. Discharge due to disengagement

4.1 The data in Table 2 shows that in all cases meaningful contact was attempted before discharge where this was applicable. These contact attempts were documented in the record in almost all cases. Furthermore, there was good communication with GPs and other agencies with these being informed again in almost all cases, with this only not occurring on one occasion.

Slightly lower was communication with the patient but this was done in 20 out of 28 applicable cases. In some cases did these letters to patients or other agencies highlight that the patient need not be re-referred back by a GP but could directly access the services within 2 years. But this should be universal as this step is judged likely to potentially complicate and lessen the chances of successful re-engagement in time.

4.2 The audit highlighted a number of areas for improvement.

- There was little evidence of alternatives for discharge being considered nor was the fact that the patient was disengaging being a risk indicator well evidenced.
- Evidence of there being MDT decision was also not reliable only occurring on 10 out 28 occasions. In a number of cases there was little evidence that risk was being dynamically reviewed and considered when making discharge decisions but this did happen in 17 out of 25 cases.
- Another area of weakness was that only in approximately half of cases was there evidence that contact had been considered with families or carers.
- Likewise the audit showed that in only a third of cases was information being sought from partner agencies.

4.3 In total 7 of the 30 records audited were <u>fully</u> compliant with the policy.

5. Serious Mental Illness (SMI)

5.1 The discharge due to disengagement only contained 2 patients that had a diagnosis of SMI. This correlates with the previous audit which showed relatively low numbers of patients being discharged from our services that manage patients with psychosis. In the two patients that were discharged the policy was not followed with the main weakness identified being the lack of MDT involvement in the decision.

5.2 In the DNA audit the patients who had a diagnosis of SMI there was only 1 case where the policy was not followed out of 18 records.

5.3 Through CPHT we are beginning to explore shared standards for case management, and this may introduce slightly higher velocity of step down from active care in the SMI group. It will be important for the weaknesses highlighted in this audit for the whole cohort to be resolved before such a step takes place.

6. Neurodiversity

6.1 Overall compliance was very similar between the recorded neurodivergent and non-neurodivergent groups for both audits. For this cohort similar to the neurotypical audits there was not consistent evidence of alternative provision being considered but this does suggest that teams are not considering reasonable adjustments when talking to patients and planning care.

6.2 The inclusion of this criteria has been suggested for the audit as a key consideration, given overshadowing concerns, and issues of our ability, as perhaps a neuro-typical organisation in corporate form to engage this cohort of patients.

7. Ethnicity

7.1 Only a small number of patients in both audits were non-white. These patients had a rate of full compliance in the DNA audit but only about half records were fully compliant in the discharge audit. Given the small sample size, it is not possible to draw definitive conclusions.

7.2 In the successor audit we may seek to draw deliberately on a sample which is disproportionate in order to enquire better into any disparities.

8. Deprivation

8.1 There was no evidence that compliance changed consistently as deprivation decreased or increased. It was observed that most patients fell into the lower deprivation deciles but given the audit methodology it wasn't possible to determine whether the lower deprivation rates represented the presenting population or whether they were overrepresented.

9. Conclusions

9.1 The audit data supports the previous analysis of discharges due to disengagement within the Trust that showed that patients with SMI were less likely to be discharged due to disengagement compared to non-SMI patients given that the discharge sample contained few SMI patients. The methodology of the audit was designed to determine the prevalence of SMI rates however and so this finding should be interpreted with caution.

9.2 Compliance with Engagement and Disengagement policy was better for patients with SMI compared to non-SMI patients across the 2 audits in general but where patients with SMI were discharged the process was not followed correctly in both cases. This finding in the discharge audit is based on small numbers of patients that limit the reliability of this finding.

9.3 The audit does not allow us to draw conclusions by team or by geography. As we look to ensure that all teams by the end of January positively provide evidence to the CMO of policy awareness, we will consider how the successor audit can explore this feature.

9.4 Across both audits a common finding was the lack of MDTs occurring either when a patient did not attend or when a decision was being made to discharge. Another finding was that disengagement was not being considered as a risk factor and was not leading to dynamic re-assessment of risk.

9.5 Nationally Coroners have issued prevention of future death reports due to services not adequately sharing information and not involving families and carers. These audits show that this is not reliably happening across our teams and of note discharge decisions were being made without this contact more than when managing patients who did not attend appointments.

10. Recommendations

The Board is asked to:

1. Receive the findings of the first Trust-wide audit examining DNA activity and discharges due to disengagement that analyses the quality of implementation

2. Support the amending of standard patient discharge letters and GP/referrer communication letter. This would allow for greater consistency of ensuring key points are communicated such as the expectation that patients need not be re-referred by GP to access services. Expected timeline February 2027

3. Support amending the discharge checklist so that there are prompts to ensure greater compliance with the policy. Expected timeline February 2027

4. Support exploration of amending SystmOne to allow for prompting for staff when entering DNA information. Expected timeline April 2027

5. Support that these audit findings are discussed in all community team meetings and that are a required topic of discussion in clinical supervision for all community staff. Expected timeline February 2027

6. Request a further assurance report following completion of the next audit cycle (Q4) to demonstrate progress and identify any additional improvement actions required.

Dr Diarmid Sinclair

Chief Medical Officer

Table 1 – Did not attend

DNA measure	Compliant / applicable	Rate
DNA documented in EPR	30/30	100.0%
Contact attempted	27/30	90.0%
Contact attempts documented	29/30	96.7%
Further appointment offered/discussed	22/26	84.6%
Alternative method/venue/time considered	15/24	62.5%
Risk reviewed following DNA	17/28	60.7%
Family/carers contacted or considered	15/22	68.2%
Relevant professionals/agencies contacted	13/22	59.1%
Senior clinician/MDT review	6/11	54.5%
MDT for ongoing non-engagement	1/9	11.1%
Meaningful contact re-established	20/30	66.7%

Table 2 – Discharges due to disengagement

Disengagement measure	Compliant / applicable	Rate
Meaningful contact attempted	27/27	100.0%
Contact attempts fully documented	25/27	92.6%
Broader engagement options considered	7/24	29.2%
Risk reviewed before discharge	17/25	68.0%
Disengagement considered as a risk signal	1/22	4.5%
Family/carer information sought	10/22	45.5%
Other professionals/agencies consulted	6/17	35.3%
MDT held	10/28	35.7%
Manager agreement documented	8/21	38.1%
Alternatives to discharge considered	3/22	13.6%
GP/referrer/relevant agencies informed	28/29	96.6%
Two-year direct re-engagement explained	7/24	29.2%

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Freedom To Speak Up bi annual update	**Agenda Item**	Paper R
Sponsoring Executive	Steve Forsyth, Chief Nursing Officer		
Report Author	James Hatfield, Freedom to speak up guardian		
Meeting	Board of Directors	**Date**	26 November 2026

Suggested discussion points

Speaking-up confidence: consider what reporting trends, staff feedback and service-level patterns indicate about confidence in speaking up, recognising that reporting volumes alone do not provide assurance of a healthy culture: and mindful of the Board's focus on this question within the staff survey.

Patient safety: seek assurance that FTSU concerns are considered alongside incidents, complaints and risks to identify recurring themes and inform learning.

Protection from detriment: seek assurance that the approved standard operating procedure is embedded and that protective actions and follow-up are effective.

Future priorities: consider Board views for integrated reporting, targeted engagement and Champion coverage, while safeguarding Guardian independence and confidentiality.

Previous consideration

This paper (and the FTSU data/learning it contains) has been reviewed by the Patient Safety Operational Group, Quality and Safety Group, and the People & OD Committee.

Recommendation

The Board of Directors is asked to:

NOTE the content of this report as a confidence on the Trust's Freedom to Speak Up arrangements and oversight, including the *trends, themes and comparisons* presented.

CONSIDER the key findings and data – notably the trends in concerns raised and the benchmarking against peers – and discuss any implications for sustaining and strengthening the Trust's speak-up culture.

RECOGNISE the key findings and data – notably the trends in concerns raised and the benchmarking against peers – and discuss any implications for sustaining and strengthening the Trust's speak-up culture.

AGREE to continue supporting and championing the FTSU forward plan and associated improvement actions (as outlined in the paper's appendices) – including visible leadership support for FTSU, reinforcing that no detriment will be tolerated for speaking up, and promoting the new initiatives to further embed a safe, responsive speak-up culture.

Alignment to strategic objectives	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X

Alignment to the plans:	
People and teams plan	X
Quality and safety plan	X
Equity and inclusion plan	X
Education and learning plan	X

Trust Risk Register

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

Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
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.	
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External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	
Strategic Delivery Risks			
If our ‘changed ways of working’ with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership’s inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1			X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are			X

distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	

System / Place impact

None identified – this paper is focused on internal Trust culture and processes (with learning shared regionally via the National Guardian Office benchmarking data)

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

Appendix

Appendix 1: FTSU concerns per quarter (trust wide)

Appendix 2: FTSU concerns by Directorate, April–September 2026.

Appendix 3: Actions taken to improve FTSU culture and delivery plan for the next 6–12 months.

Appendix 4: Demographics of staff raising concerns.

Appendix 5: Review of Patient Safety–Related Freedom to Speak Up Concerns.

1. Introduction

1.1 This report provides a dedicated update on our Freedom to Speak Up (FTSU) activities and their impact on fostering a safe, transparent, and learning culture within our NHS Trust. We review key data from the last two quarters, focusing on the nature of concerns raised, the significant themes emerging, and crucially, the learning and improvements that have been implemented as a direct result.

2. Number of concerns raised.

2.1 FTSU concerns increased from 20 in 2016/17 to a record 103 in 2025/26, although annual totals fluctuated: 84 in 2019/20, 39 in 2021/22, 60 in 2022/23, 98 in 2023/24 and 96 in 2024/25. The latest full-year increase was seven concerns (approximately 7.3%). By September 2026, 55 concerns were logged in 2026/27: 35 in Q1 and 20 in Q2. These six-month figures are not directly comparable with full-year totals. The quarterly decline warrants monitoring alongside themes, service-level patterns, anonymous reporting, detriment and staff feedback. Sustained higher volumes since 2022/23 indicate an established, used route, but do not alone demonstrate a strong speaking-up culture or effective organisational responses.

2.2 Appendix 2 presents the Freedom to Speak Up (FTSU) concerns raised by directorate between April 2026 and September 2026.

2.3 The Board agreed in July that from October 1 the FTSU service should be undertaking a program of work within identified directorates to create safe, structured opportunities for staff to share concerns and experiences. These engagements will be both unstructured and semi-structured with relevant staff survey themes and questions to ensure a coherent and meaningful approach.

2.4 Appendix 3 also details the forward plan for FTSU, current and future actions that have been taken to increase knowledge around FTSU principles and improve the culture of the organisation so that all staff feel safe and secure raising concerns.

2.5 Appendix 4 summarises available protected characteristic data for **45 individual staff members** who raised concerns in April 2026 and September 2026. This is fewer than the **55 concerns reported** because staff raising multiple concerns are counted once, and data was unavailable for some who had left the organisation.

2.6 Appendix 5 reviews **20 patient safety-related FTSU concerns**, summarising the themes identified, completed and ongoing actions, and assurance provided to the Board. These are staff reports, not necessarily 20 separate incidents, as several staff may raise the same issue. Some matters remain under investigation, and not every concern was substantiated.

3. Patient and Worker Safety/ Experience

Table 1: RDaSH speaking-up themes and experience—year-on-year comparison

Theme or experience	2026/27 Number	2026/27 %	2025/26 Number	2025/26 %
Patient safety concerns	24	43.6%	4	16.7%

Bullying or harassment concerns	8	14.5%	8	33.3%
Reported anonymously	8	14.5%	4	16.7%
Perceived disadvantageous and/or demeaning treatment (detriment)	3	5.5%	1	4.2%

3.1 Themes & trends

3.1.1 Tables 1 and 2 highlight patient safety, worker experience and workplace behaviour. Table 1 compares 55 concerns by 23 September 2026 with 24 by 12 September 2025. Differing dates and overlapping categories mean these figures indicate themes, not additive totals or direct measures of culture.

- 3.1.2 **Patient safety:** 24 concerns (43.6%) in 2026/27 to date, compared with 4 (16.7%) at the 2025/26 comparison point. The increase requires thematic review and triangulation with patient-safety intelligence to identify recurring services, risks and learning.
- 3.1.3 **Bullying or harassment:** unchanged at 8 concerns; the share fell from 33.3% to 14.5% as total concerns increased. Continued focus on civility, respect and timely management responses remains necessary.
- 3.1.4 **Anonymous reporting:** 8 concerns (14.5%), compared with 4 (16.7%). The lower share may suggest greater willingness to be identified, but cases still require review for speaking-up barriers.
- 3.1.5 **Detriment:** 3 concerns (table 6) involved perceived disadvantageous or demeaning treatment after speaking up, compared with 1 previously (5.5% versus 4.2%).

3.2 Comparison with neighbouring Trust's.

- 3.2.1 Table 2 places RDaSH's 103 concerns mid-range among the eight Trusts shown: above Humber, STH and TRFT, but below DBHT, SCH, SH&SC, LPT and NLAG. Differences in workforce size, services, Guardian access and recording practices limit direct comparison.
- 3.2.2 In 2025/26, RDaSH recorded 42 patient safety or quality concerns and 45 worker safety or wellbeing concerns. Inappropriate attitudes or behaviours formed the largest category (48), highlighting culture, relationships and behavioural standards as continuing priorities.
- 3.2.3 RDaSH recorded 19 anonymous concerns and 4 detriment reports. Anonymous reporting was proportionately among the highest shown; detriment was broadly within neighbours' range. Neither should be normalised: both require review of worker experience, responses and further action needed.

Table 2: FTSU Guardian Report Q1-Q4 2025/26 – comparison with neighbouring Trusts

Trusts	Number of concerns	anon	patient safety/ quality	worker safety or wellbeing	bullying or harassment	inappropriate attitudes or behaviours	disadvantageous and/or demeaning treatment as a result of speaking up
RDaSH	103	19	42	45	3	48	4
DBHT	118	19	25	88	21	26	3
Humber	51	0	43	48	8	8	1
LPT	180	10	22	142	6	12	10
NLAG	388	10	38	181	30	65	2
SCH	114	3	25	26	22	65	4
SH&SC	141	0	37	47	4	20	0
STH	95	17	24	28	19	21	4
TRFT	67	6	14	51	9	51	0

What this means at RDaSH –

3.2.4 Concerns raised through the Freedom to Speak Up route are escalated promptly, proportionately and transparently. Where issues relate to patient safety, safeguarding, professional practice or potential workforce detriment, a “no surprises” approach is consistently applied, with same-day escalation to relevant leaders.

3.2.5 This provides confidence that staff can raise concerns, that issues are being surfaced at an early stage, and that the Trust is appropriately focused on leadership behaviour, civility and psychological safety.

3.2.6 The Trust uses this data to triangulate learning through established governance forums and to target improvement activity, demonstrating an open culture, effective oversight and a commitment to learning and continuous improvement in line with Well-led expectations.

4. Learning and Improvement

4.1 Learning informing the Q1–Q2 2026/27 report includes civility and respect, leadership visibility, communication and feedback, team dynamics, workforce fatigue, staffing pressures, patient safety, and equality and inclusion, including racism. These themes align with staff survey and Well-Led intelligence, providing complementary insight into improvement priorities.

4.2 Individual concerns have prompted wider improvement work, including digital inclusion and access to mandatory training for estates and facilities colleagues, translating staff voice into organisational learning.

4.3 Detriment is managed as an ongoing risk, with further escalation and leadership review where anxiety, strained relationships or perceived disadvantage persist. The Adverse Effects or Negative Impact from Speaking Up SOP has been signed off, formalising risk assessment, support, senior escalation, monitoring and learning to protect colleagues who speak up.

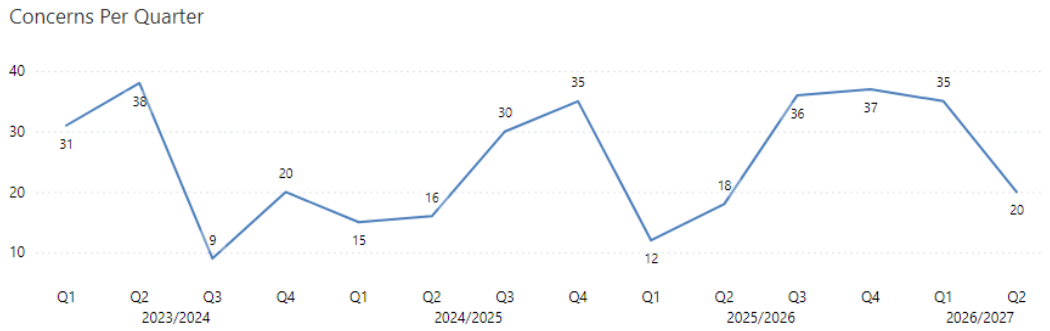
5. Summary

5.1 This report summarises FTSU activity and learning for Q1–Q2 2026/27: 55 concerns were recorded, comprising 35 in Q1 and 20 in Q2. These included 24 patient safety concerns, 8 bullying or harassment concerns, 8 anonymous reports and 3 reports of perceived detriment; categories overlap. Reporting volumes alone do not demonstrate a strong speaking-up culture. Appendix 5 reviews 20 patient safety-related staff reports, which may relate to shared issues rather than separate incidents. Completed actions and ongoing investigations are distinguished, and not all concerns were substantiated. The detriment SOP has been signed off, strengthening risk assessment, support, escalation and follow-up.

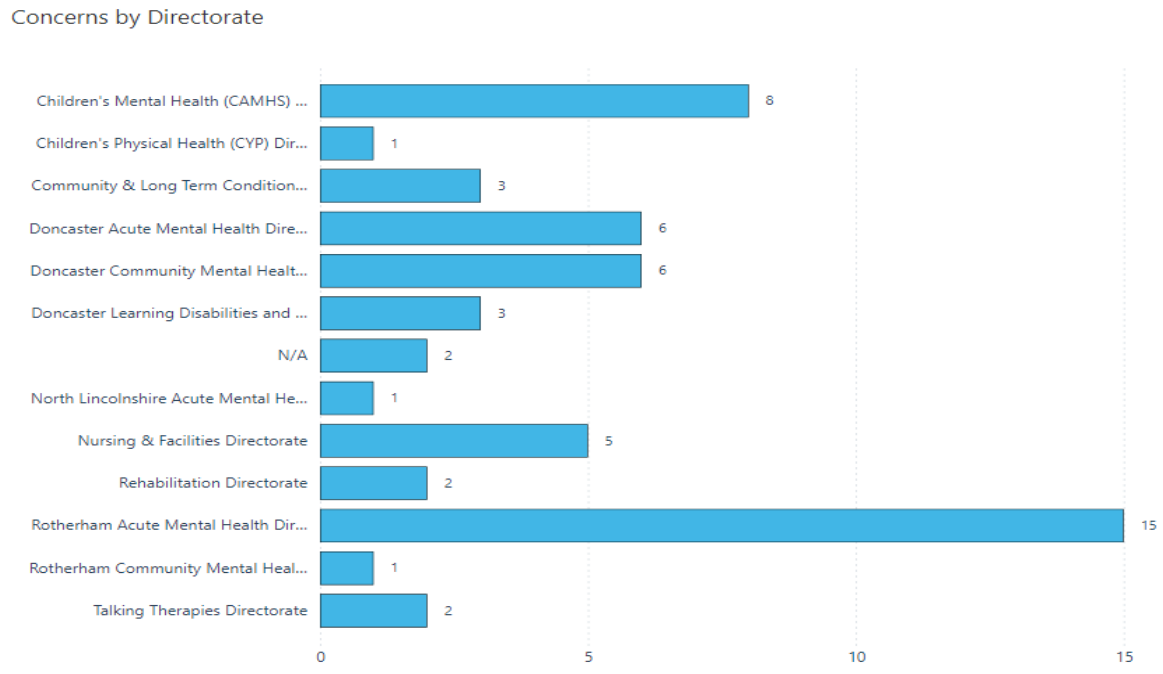
5.2 Over the next 6–12 months, priorities are to deliver the plan in Appendix Three and reinforce visible, responsive leadership through the following actions:

- Develop combined FTSU and patient-safety reporting, linking themes, responses and learning through PSOG and wider governance.
- Embed the detriment SOP, with protective actions, senior oversight and follow-up at 3, 6 and 12 months.
- Review Champion coverage and target engagement where access or confidence to speak up may be limited.
- Strengthen RADAR action tracking, timely feedback and confidential communications demonstrating learning and outcomes.
- Ensure leaders remain visible and approachable, model listening and constructive challenge, and address power-related barriers to speaking up.
- Thank staff for speaking up, communicate that detriment is unacceptable, and ensure reported detriment is promptly and fairly reviewed and acted on.

Appendix One



Appendix Two – 2026 FTSU concerns by Directorate



Appendix Three

Actions taken to improve FTSU culture

- A3.1 **Improved access and visibility:** the substantive Guardian has maintained regular workplace engagement, Care Group visits, staff-network attendance, peer-review involvement, induction activity and face-to-face, telephone, email, Champion and anonymous routes. An online concern form and FTSU reporting through RADAR have further strengthened access, recording and oversight.
- A3.2 **Strengthened the Champion network:** updated full and refresher training was developed and delivered in June 2026, with a psychologically safe and practical focus on listening, confidentiality, boundaries, signposting, inclusion and follow-up. Quarterly supervision and network meetings provide continuing support, reflection and escalation routes.
- A3.3 **Clarified Champion recruitment and expectations:** the expression-of-interest process, role description and Terms of Reference have been refreshed. These set expectations for line-manager support, initial and refresher training, participation in supervision and network meetings, visible local engagement and appropriate escalation to the Guardian.
- A3.4 **Strengthened protection from detriment:** the Adverse Effects or Negative Impact from Speaking Up SOP has been signed off, providing a consistent, confidential route for risk assessment, support, senior escalation, monitoring and organisational learning where a colleague believes they have been treated adversely after speaking up.
- A3.5 **Improved concern management and governance:** concerns, outcomes and learning actions are tracked through RADAR, supported by monthly SBAR reporting, Board and committee updates, manager-response templates and clearer closing correspondence. FTSU themes are increasingly considered alongside patient safety, workforce, culture and equality intelligence.
- A3.6 **Improved feedback and follow-through:** staff are thanked for speaking up, offered feedback discussions and provided with clearer explanations of actions, outcomes and any information that cannot be shared. Follow-up at 3, 6 and 12 months supports identification of detriment or unresolved impact after closure.
- A3.7 **Developed leadership capability:** half-day learning sessions and Champion training reinforce the responsibilities of leaders and managers to listen without judgement, respond compassionately, act promptly, explain decisions and close the feedback loop.
- A3.8 **Targeted inclusion and psychological safety:** engagement has continued with new starters, internationally educated workers, staff diversity networks and groups who may experience greater barriers to speaking up. Schwartz Rounds, Team Time and Cultivating Compassion Circles provide additional safe spaces for reflection and staff voice.
- A3.9 **Maintained regional learning and support:** participation in regional Guardian networks and peer support has enabled shared learning, challenge and resilience during the transition of national FTSU responsibilities to NHS England.

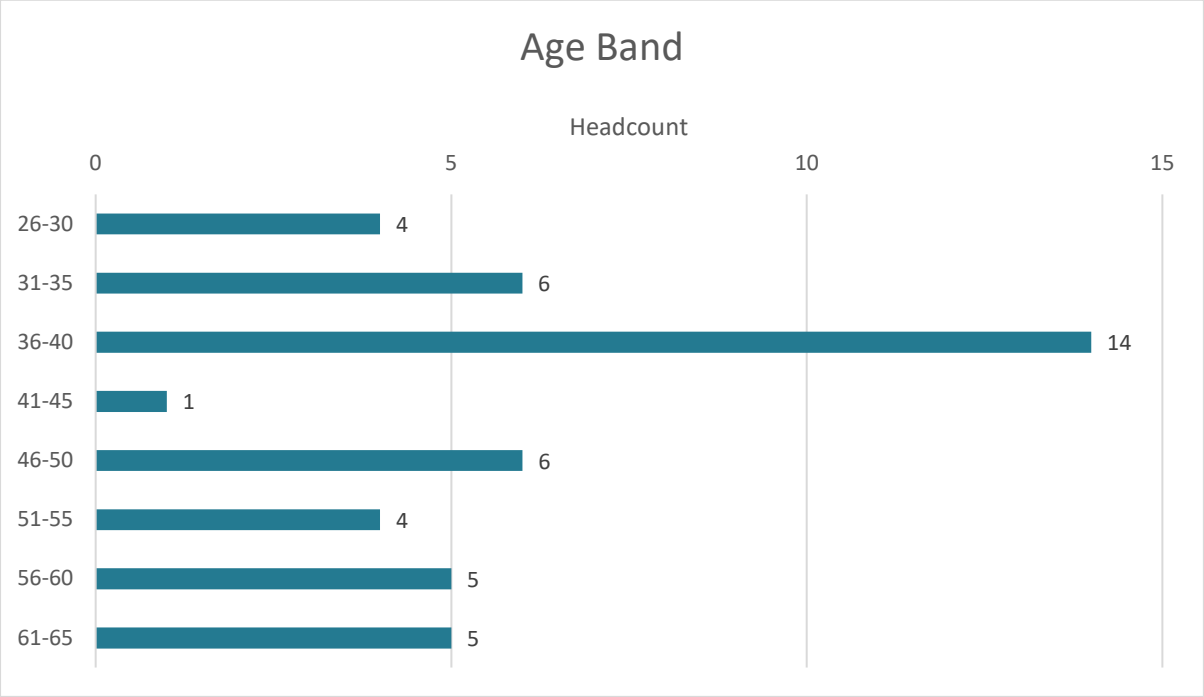
Continued and planned work

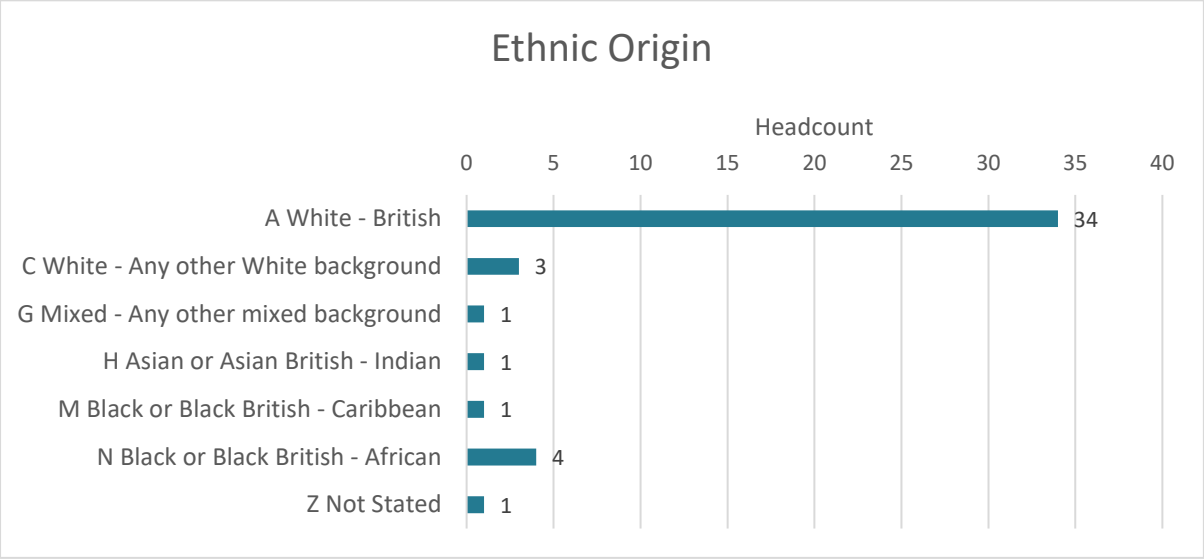
Delivery plan for the next 6–12 months

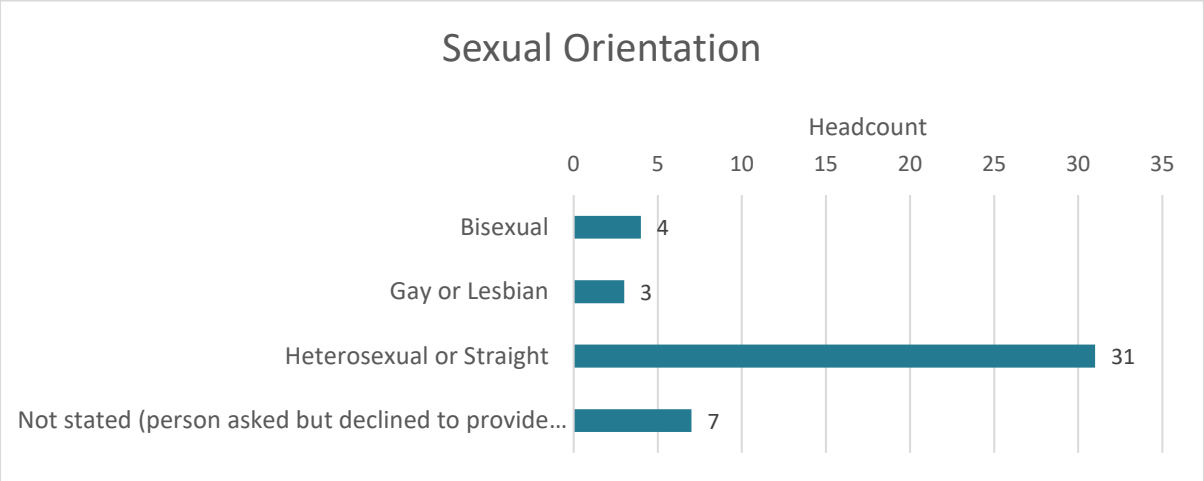
Workstream	Planned activity and deliverables	Timing and assurance
Combined FTSU and patient-safety report	Develop a monthly report linking FTSU themes with patient-safety incidents, PSIRF learning, complaints, risks and service intelligence. For relevant concerns, record the RADAR or governance response, learning action, owner, completion evidence and worker feedback.	Agree the format, inputs, ownership and linkage criteria in months 1–3; pilot, then submit monthly to PSOG for review and escalation. Monitor timeliness, completeness, action closure and documented responses and feedback.
Detriment and psychological safety	Embed the adverse-effects SOP, apply a consistent risk assessment, identify protective actions and named senior oversight, and complete scheduled follow-up at 3, 6 and 12 months.	Immediate and ongoing; exception reporting on delays, unresolved risk and follow-up completion.
Champion coverage and targeted engagement	Map Champion coverage by care group, profession, site, shift and working pattern; recruit to identified gaps; maintain refresher learning and supervision; focus engagement on medical colleagues, ethnic minority and internationally educated staff, temporary workers, lower-band colleagues and lower-reporting services.	Coverage review in months 1–3; recruitment and engagement in months 3–9; monitor reach, local intelligence and confidence to speak up.
Feedback, action tracking and visible learning	Use RADAR alerts and standard outcome fields to monitor acknowledgement, updates, overdue actions, closure and evidence of learning. Introduce “You said, we did, we are considering, or we cannot yet do—and why” communications while protecting confidentiality.	Standard approach introduced by month 3; quarterly assurance on timeliness, completed actions, feedback rates and whether workers would speak up again.
Evaluation and governance	Evaluate whether the integrated approach improves early risk detection, avoids duplicate or missed escalation, increases documented learning, strengthens feedback and preserves Guardian independence. Report emerging risks and unintended consequences.	Quarterly progress to People and OD and Quality governance; formal 12-month evaluation and recommendations to Board.

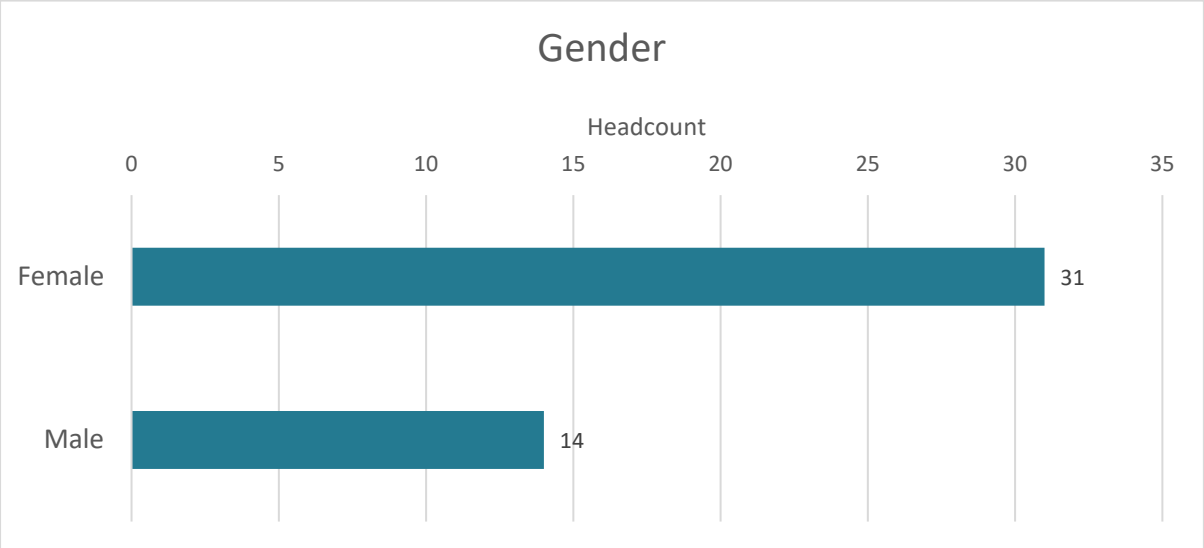
Appendix 4

Concern raised demographics






Sexual Orientation
Headcount
0
5
10
15
20
25
30
35
Bisexual
4
Gay or Lesbian
3
Heterosexual or Straight
31
Not stated (person asked but declined to provide...
7


Gender
Headcount
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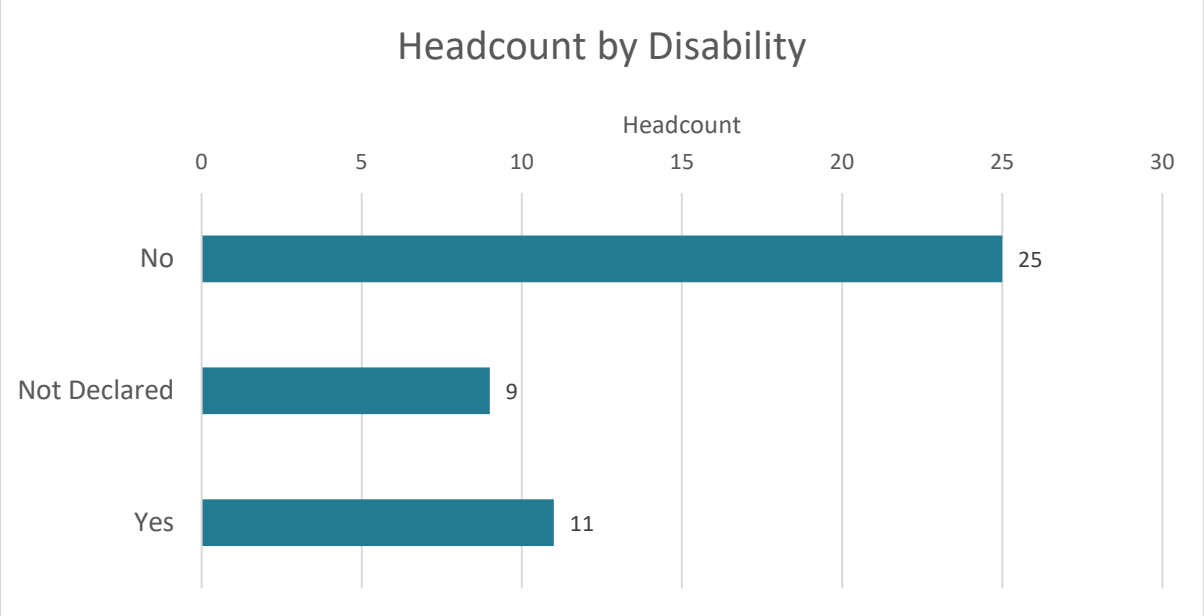
5
10
15
20
25
30
35
Female
31
Male
14


Headcount by Disability
Headcount
0
5
10
15
20
25
30
No
25
Not Declared
9
Yes
11

Appendix 5

Review of Patient Safety–Related Freedom to Speak Up Concerns

Reporting context

A5.1 The 20 patient safety–related concerns represent individual staff reports to the Freedom to Speak Up Guardian. Each concern is logged separately against the staff member raising it, even where several staff members raise the same issue. For example, five staff members raising the same patient safety issue would be recorded as five individual concerns for reporting purposes. The concerns included in this review may therefore relate to shared underlying issues; the total should not be interpreted as 20 distinct patient safety issues or incidents.

Key themes identified

A5.2 The review identified the following overlapping themes. These reflect issues raised by staff, not necessarily substantiated findings or separate incidents.

Theme	Scope
Staffing and capacity	Safe staffing, workload, clinical and leadership capacity, and supervision.
Clinical risk and decisions	Risk assessment, care planning, clinical decision-making and escalation.
Treatment and care transitions	Medication, treatment, discharge and continuity of care.
Consent and autonomy	Mental Capacity Act, consent and best-interest decision-making.
Communication and accountability	Documentation, handovers, multidisciplinary working and professional accountability.
Safeguarding and dignity	Observation arrangements and management of escalating risk.
Competence and oversight	Staff competence, role clarity, training and access to clinical oversight.
Speaking-up culture	Psychological safety, leadership communication and confidence to raise concerns.

Review and actions taken

A5.3 **Completed actions:** Concerns were triaged and escalated proportionately to relevant senior clinical, operational and executive leaders. Reviews included fact-finding, senior leadership consideration and, where required, formal review. Staffing, rosters, vacancies, cross-cover, supervision and operational pressures were examined; clinical expectations, decision-making responsibilities and escalation routes were clarified; and risk controls included changes to local arrangements, strengthened observation and therapeutic engagement, recruitment activity and enhanced management oversight. Feedback and assurance were provided where reviews had concluded. Some reviews identified no direct patient-safety concern or evidence that a service was an outlier, while still highlighting opportunities to improve communication, leadership visibility and staff confidence.

A5.4 **Ongoing actions:** A number of matters remain subject to further fact-finding, formal investigation or final senior feedback. Associated actions and assurances continue to be monitored through the appropriate operational and governance routes, with feedback to be provided to those who spoke up where appropriate.

Rotherham Doncaster and South Humber NHS Foundation Trust

Board of Directors – 26 November 2026

Item 22 – Story to Board: Learning Disability Advocates

Background

Speakup is a long-established independent advocacy organisation that works collaboratively with RDaSH Learning Disability Services to promote the voices, rights and inclusion of people with learning disabilities across Rotherham and the wider South Yorkshire area. Through the provision of independent advocacy, self-advocacy groups, peer support and community engagement activities, Speakup supports individuals to express their views, exercise choice and control, and access services that meet their needs. Their work aligns closely with the principles of the Mental Capacity Act (2005), the NHS Long Term Plan and national learning disability policy, ensuring that people with learning disabilities are supported to be active participants in decisions affecting their lives and care.

Speakup currently employs two peer support workers with lived experience who work for RDaSH services. One individual works within the CAMHS service and the other in Rotherham Learning Disability Service. The partnership between RDaSH Learning Disability Services and Speakup provides an important mechanism for co-production and service improvement. Speak Up advocates routinely support individuals to engage with care planning, health appointments, safeguarding processes, and service reviews, while also providing valuable feedback to services on the lived experiences of people with learning disabilities and their families. This collaborative approach helps ensure that services remain person-centred, responsive and aligned with the priorities of local communities. Through joint consultation and engagement activities, Speakup helps reduce health inequalities, improve access to healthcare, and strengthen the Trust's commitment to involving people with lived experience in the development and evaluation of services.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Autism Assessment Services (adult only)	**Agenda Item**	Paper S
Sponsoring Executive	Dr Judith Graham – Director of Psychological Professionals and Therapies		
Report Author	Dr Judith Graham – Director of Psychological Professionals and Therapies and Dr Vicky Hughes, Consultant Psychologist		
Meeting	Board of Directors	**Date**	26 November 2026

Suggested discussion points

The paper seeks approval for the detailed, cost-neutral operating model and controlled transition arrangements for the adult autism pathway, following the strategic approval of the Autism Paper presented at the Board of Directors in September 2026. The current waiting list is 2,283 people. While the longest recorded wait exceeds five years because of historic children's and ADHD exception waits, the current longest adult autism wait is 2 years and 41 weeks. Under the proposed model, 212 people would transfer to the retained RDaSH specialist pathway, while 2,071 people would be supported by the end of Q4 to access Right to Choose, alongside complexity screening and VCSE diagnostic support. Children and young people's services would remain unchanged, with clear transition arrangements for those waiting beyond the age of 18.

Modelling indicates that the retained RDaSH specialist pathway could reduce waiting time to approximately 14.1 weeks, bringing it within the RDaSH target and creating a potentially sustainable model, subject to the identified readiness conditions. The proposal is intended to operate within the existing recurrent financial envelope, although implementation remains dependent on workforce consultation, procurement, appropriate due diligence and confirmation of the financial baseline. Approval is therefore sought for the overall operating model, transition arrangements, VCSE tender, complexity screening process, deterioration/escalation route and associated assurance arrangements.

Board Discussion Points

1. Safety and equity of transition: Does the proposed combination of complexity screening, VCSE diagnostic support and deterioration/escalation arrangements provide sufficient assurance that the 2,071 people moving towards Right to Choose are supported safely and equitably, particularly those whose needs change or who may experience barriers to exercising choice?

2. Deliverability and sustainability: Is the Board/Committee sufficiently assured that the projected reduction to a 14.1-week specialist RDaSH wait is deliverable and sustainable within the existing financial envelope, and are the proposed readiness conditions around workforce, procurement, due diligence and financial baseline confirmation strong enough to govern the move from approval into implementation?

Previous consideration

Within the Board of Directors meeting in Sept 2026 the initial proposals described were approved. This paper builds on the agreed proposal providing full data, descriptions and plans to transact the change.

Recommendation

The Board is asked to:

NOTE the national context and the local recommendations.

CONSIDER the suggestions, bearing in mind patient and staff feedback & the Fonagy Report

DECIDE if the paper is supported

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

This will require commissioner and 'place' discussion, the Trust CEO has agreed to take forward these discussions and has already set the conversation concerning capacity and demand in all areas.

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

Annex

Annex 1 – Readiness Checklist
Annex 2 – Key assumptions requiring validation
Annex 3 – Recommendations from National Review published 21.10.2026

Adult Autism Pathway - Follow-up paper: approved direction, revised operating model and implementation assurance

Authors and People consulted – (Authors) Dr Judith Graham, Dr Vicky Hughes. Consulted:- Dr Rachel Walton (Consultant Psychologist), Kathy Horne (Occupational Therapist & Advanced Sensory Integration Practitioner), Dr Michael Seneviratne (Associate Medical Director), Jola Obisesan (Service Manager), Shelley Maddison (Matron) Cora Turner (Care Group Director), Steph Blyth (Assistant Director for Allied Health Professionals), Rebecca Pease (Deputy Care Group Director), Sam Bucther (Nurse Director) as well as discussions with people who have lived experience of autism services who work as peer support workers in RDaSH.

1. **Introduction**

In September 2026 Public Board of Directors approval was given for the strategic direction for adult autism services. This is the agreed follow-up paper, translating that direction into a deliverable operating model and incorporates the completed waiting-list analysis, revised referral routes, a proposed VCSE diagnostic support pathway, and additional safeguards for people using *"Right to Choose"*.

There are 2,283 people on the current waiting list. The reported longest wait is over 5 years and 41 weeks from referral because the current measure incorporates historic ADHD and children's waits. When those exception waits are removed, the current adult autism wait is 2 years and 41 weeks. This remains unacceptable and cannot be resolved through continuation of the existing model.

Application of the proposed model indicates that 212 people, who are currently receiving secondary or primary care mental health services (other than NHS Talking Therapies), would transfer to the retained RDaSH specialist assessment pathway. This would reduce the modelled wait for the retained pathway to 14.1 weeks, and the position is expected to be sustainable if workforce capacity, referral criteria and demand controls are maintained.

The remaining 2,071 people would require a sensitive, supported transition to *"Right to Choose"*. Experience indicates that many *"Right to Choose"* providers only accept referrals for patients with non-complex needs. The preparatory questionnaire used at entry to the RDaSH assessment sessions includes a complexity screening tool; local experience suggests approximately 70% of patients on the waiting list may be suitable for a non-complex *"Right to Choose"* assessment pathway, while approximately 30% may require a *"Right to Choose"* provider able to accommodate additional complexity related to individual characteristics. Complexity in this context does not automatically mean that the person requires mental health services.

The proposed model therefore does not rely on bulk transfer or simple signposting. Every person would be screened, supported to make an informed choice, matched to a provider whose scope can meet their needs, and actively connected to the selected pathway. A commissioned VCSE diagnostic support offer would provide preparation, navigation, practical help and continuity before, during and after assessment. RDaSH specialist assessors would provide training, consultation and supervision to the VCSE team.

The model also creates a formal escalation route for anyone whose mental health deteriorates while waiting with a *"Right to Choose"* provider. Where the person is subsequently taken on by a Primary Care Network or secondary mental health service, there will be a clinically governed route

to review and, where appropriate, transfer the person from *"Right to Choose"* into the RDaSH specialist assessment pathway without restarting the process unnecessarily.

2. Decisions requested

- Approve the revised adult autism operating model and the two referral routes described in this paper.
- Note the waiting-list baseline of 2,283 people, including the distinction between the reported longest wait and the underlying adult autism wait after exception waits are removed.
- Approve the transfer of the modelled cohort of 212 people to the retained RDaSH specialist pathway, subject to individual clinical review.
- Approve a sensitive, screened and supported transition process for the modelled cohort of 2,071 people to Right to Choose.
- Approve procurement of a VCSE-led diagnostic support service across Doncaster, Rotherham and North Lincolnshire, rather than a narrowly defined post-diagnostic service.
- Require the VCSE specification to draw on the strengths of Rotherham and District Autism Spectrum (RANDS) service, address the current absence of an equivalent North Lincolnshire offer, and incorporate learning from the differing experience of Doncaster Autism Service.
- Approve RDaSH training, supervision and "expert at hand" support for the VCSE partner.
- Approve a formal escalation and transfer route where a person's mental health deteriorates while waiting in *"Right to Choose"* and they are accepted by PCN or secondary mental health services.
- Require a formal readiness decision before implementation, based on safety, procurement, workforce, information governance, equality, capacity and financial criteria.

3. Background and published guidance since Sept 2026

Since the September 2026 paper was considered there has been a National publication - Independent review into mental health conditions, ADHD and autism: final report (21st Oct 2026) – Recommendations summarised in Annex. This paper takes into account both the newly publicised report and builds on the earlier paper's description that demand is materially above available capacity and concluded that continuing the existing model would perpetuate waits of two years or more.

The approved direction was to retain specialist RDaSH assessment for people who need integrated mental health and autism-informed care, create a VCSE-led support pathway, and enable informed use of *"Right to Choose"*.

Measure	Current / modelled position	Interpretation
Total current waiting list	2,283 people	The transition requires a population-level plan as well as individual review.
Reported longest wait	Over 5 years and 41 weeks since referral	Includes historic ADHD and children's waits and should be described transparently.
Adult autism wait excluding exception waits	2 years and 41 weeks	Still substantially outside the required position.

Measure	Current / modelled position	Interpretation
Modelled retained RDaSH cohort	212 people	People in secondary or primary care mental health services, excluding Talking Therapies, subject to individual review.
Modelled RDaSH wait after transfer	14.1 weeks	Within the RDaSH target and expected to be sustainable if assumptions hold.
Modelled Right to Choose transition cohort	2,071 people	Requires screening, informed choice, provider matching, warm handover and tracking.
Indicative lower-complexity proportion	Approximately 70%	Potentially suitable for providers accepting non-complex cases.
Indicative added-complexity proportion	Approximately 30%	Likely to need a Right to Choose provider able to support additional complexity or review for the specialist pathway.

These figures are modelling assumptions for implementation planning, not automatic allocation decisions. Final routing must follow an individual review, consideration of current mental health involvement, informed preference, provider scope, risk, reasonable adjustments and any new information.

4. Design principles

- Needs first: practical help is not conditional on diagnosis.
- No bulk discharge or transfer: each person receives an individual review and recorded plan.
- Complexity is matched, not excluded: additional individual characteristics should inform provider choice and support, rather than being treated automatically as mental illness.
- Active connection, not signposting: consented transfer, confirmation of receipt and tracking of acceptance.
- Choice with continuity: *"Right to Choose"* does not sever access to local needs-led support or clinical escalation.
- No wrong front door: responsibility follows need, supported by warm handovers and rapid escalation.
- Equity by design: advocacy, interpretation, reasonable adjustments, non-digital access and monitoring by locality and protected characteristic.
- One financial envelope: implementation remains subject to the confirmed recurrent control total and safe procurement.
- Learning system: lived experience, safety information, outcomes and provider performance refine the pathway.

5. Proposed operating model

5.1 Two referral routes

The revised model has two main referral routes. Both routes use shared criteria, clear feedback, active handovers and a route for clinical discussion.

Referral source	Initial destination	Possible outcomes
Existing RDaSH mental health services	RDaSH specialist autism assessment pathway	Specialist assessment where criteria are met; consultation/formulation to the treating team; or agreed alternative support with a recorded plan.

Referral source	Initial destination	Possible outcomes
GP referral or potential self-referral	Commissioned VCSE diagnostic support partner	No further service required after discussion and information; needs-led VCSE support; supported referral to an appropriate Right to Choose provider; or discussion with RDaSH specialist assessors regarding entry to the specialist pathway and mental health service involvement.

NHS Talking Therapies is not included in the automatic 212-person retained cohort. Where a person using Talking Therapies has needs that may meet the specialist criteria, the case should be discussed through the same clinical consultation route rather than allocated solely on service label. The reason for excluding Talking Therapies is that they support people with primary care level non-complex mental health problems, however Primary Care Mental Health Services support people with SMI who have less complex risk and needs.

5.2 VCSE-led diagnostic support and coordinated access

The commissioned offer should be described as diagnostic support rather than post-diagnostic support. This reflects that people may benefit from navigation, preparation, reasonable-adjustment planning, peer support and practical assistance while waiting, during assessment and after an assessment outcome, including where no diagnosis is made.

- Meet with the person, understand their goals, strengths, difficulties, functional impact, communication needs and reasonable adjustments.
- Use the agreed preparatory questionnaire and complexity screening tool, with consent and appropriate clinical governance.
- Provide accessible information about local support, RDaSH specialist criteria and *"Right to Choose"* options.
- Support completion of referral information and transfer of relevant records.
- Match people to a *"Right to Choose"* provider whose acceptance criteria and capability are appropriate, rather than defaulting everyone to the same provider type.
- Seek consultation from RDaSH specialist assessors where complexity, mental health need, risk or diagnostic uncertainty may indicate the specialist pathway.
- Provide support while waiting and after assessment, including peer navigation, self-advocacy, sensory and communication support, family/carer information and community participation.
- Maintain safeguarding, incident, complaints, data-sharing and escalation arrangements.

5.3 Right to Choose segmentation and provider matching

The proposed transfer of 2,071 people should be phased and clinically supported. Before transfer, each person should complete or update the preparatory questionnaire containing the agreed complexity tool. The output should guide a conversation, not operate as an automated exclusion or diagnostic decision.

Indicative segment	Planning assumption	Required approach
Potentially suitable for a non-complex Right to Choose pathway	Approximately 70% of the transfer cohort	Offer balanced provider information; confirm eligibility and provider acceptance criteria; transfer records with consent; confirm receipt and provide VCSE support while waiting.

Indicative segment	Planning assumption	Required approach
Likely to require a provider supporting added complexity	Approximately 30% of the transfer cohort	Identify providers whose specification accommodates additional individual characteristics; seek RDaSH consultation where needed; avoid repeated rejection and referral cycling; retain a review route if no suitable provider is available.
Possible need for RDaSH specialist pathway	Identified through screening, clinical discussion or deterioration	RDaSH specialist review against agreed criteria, including current mental health involvement, risk, diagnostic uncertainty and impact on treatment planning.

Staff communication should avoid describing people as “too complex”. The relevant question is whether the proposed provider can safely and appropriately meet the person’s assessment and adjustment needs. Provider acceptance criteria, exclusions, waiting times and report standards should be maintained in a current directory for use by the VCSE and RDaSH teams.

5.4 Retained RDaSH specialist pathway

The retained specialist pathway is for adults whose presentation requires integrated autism-informed input because of current mental health service involvement, learning disability, inpatient admission, high risk, diagnostic complexity, substantial reasonable-adjustment need, or where diagnosis will materially alter treatment or care planning. The modelled initial cohort is 212 people, subject to individual review.

- Comprehensive autism assessment, formulation and reasonable-adjustment planning.
- Consultation to primary care mental health, secondary care, crisis, home treatment and inpatient teams.
- Joint discussion with the VCSE diagnostic support team where routing is uncertain.
- Training, supervision and specialist consultation for the VCSE workforce.
- Quality oversight of pathway decisions and review of *“Right to Choose”* reports where they affect local care.
- A route back for review when mental health status, risk or circumstances materially change.

5.5 Deterioration and transfer from Right to Choose

A person may enter a *“Right to Choose”* pathway and subsequently become mentally unwell while waiting. The pathway must not leave the person between services or require them to restart the entire process. Where new mental health needs result in the person being accepted by a Primary Care Network or secondary mental health service, the treating service may request a review by the RDaSH specialist autism team.

Step	Required action
1. Identify	Right to Choose provider, VCSE partner, GP, PCN, mental health service, person or carer identifies deterioration, new risk or a material change in need.
2. Respond to immediate need	Urgent mental health or safeguarding needs are managed through the appropriate local clinical or emergency route; autism pathway transfer is not a substitute for urgent care.
3. Clinical discussion	With consent, the VCSE/Right to Choose information and current mental health assessment are shared with the RDaSH specialist team.

Step	Required action
4. Review criteria	RDaSH decides whether the person now requires the specialist pathway, whether consultation alone is sufficient, or whether Right to Choose remains appropriate with added support.
5. Warm transfer	If accepted, relevant information and waiting time history transfer with the person; duplicated assessment is minimised and the person receives a named contact and updated plan.
6. Track and learn	Transfers, rejected escalations, incidents and unresolved handovers are reviewed through the pathway dashboard and clinical governance.

6. VCSE commissioning approach

A partnership tender should establish an equitable diagnostic support service across the three RDaSH localities. Funding for this aspect of the service has been identified by the Trust CEO. The procurement is proposed to support the RDaSH aim of 'hyperlocal' service provision whilst not presuming that a single existing model can be copied without adaptation, but it should use available local learning.

Locality / service position	Learning for the tender
Rotherham - Rotherham and District Autism Spectrum (RANDS)	Rated locally as providing excellent support and should be considered as a potential blueprint for peer-led, practical and trusted community support within a partnership specification.
North Lincolnshire	There is currently no equivalent service. The tender must require a credible mobilisation plan, local presence, community links and equitable access from go-live rather than treating North Lincolnshire as a later extension.
Doncaster - Doncaster Autism Service	Experience has been different and should be reviewed explicitly, including strengths, patient feedback, access, interfaces, capacity, governance and lessons for contract design and mobilisation.

6.1 Minimum tender requirements

- Either 'place based' partnership services or a service that can delivery local coverage across Doncaster, Rotherham and North Lincolnshire with locality-sensitive delivery and consistent minimum standards.
- Co-production and meaningful leadership by autistic adults and people awaiting assessment.
- Diagnostic support before, during and after assessment, not diagnosis-dependent post-diagnostic provision only.
- Capacity to deliver screening, navigation, provider matching, warm handovers and waiting-period support.
- Named safeguarding, clinical escalation, incident, complaints and business-continuity arrangements.
- RDaSH-provided training, supervision and expert consultation, with clear boundaries of accountability.
- Competence in reasonable adjustments, communication, trauma-informed practice, equality and digital exclusion.
- Data-sharing, consent, information governance and minimum dataset requirements.
- Outcome measures covering access, experience, participation, safety, equity, provider acceptance and continuity.

- Mobilisation and contingency arrangements if a provider fails, withdraws or cannot meet contracted activity.

7. Workforce and financial framework

The model remains based on the existing recurrent financial envelope. Before mobilisation, finance, commissioning, procurement and the service must confirm a single baseline covering RDaSH staffing, the VCSE contract, infrastructure, transition costs and any commissioner implications arising from *"Right to Choose"* activity.

Resource / control	Requirement
RDaSH specialist workforce	Capacity sufficient to assess the retained cohort, maintain a 14.1-week trajectory, provide VCSE supervision and manage escalation.
VCSE contract	Affordably funds triage conversations, diagnostic support, screening, navigation, safeguarding, data and locality coverage.
Right to Choose interface	Commissioner assurance regarding provider availability, eligibility, cost exposure, report quality and management of rejection.
No double running	Any overlap between old and new arrangements is time-limited, costed and explicitly approved.
Sustainability test	Monthly demand, activity, waiting-time and workforce review confirms that 14.1 weeks remains achievable without unsafe workload or unplanned exclusion.

8. Transition plan for the current waiting list

The transition will be conducted as a managed clinical and communication programme. Nobody will be removed from the waiting list solely through an administrative exercise.

1. Validate the list of 2,283 people, remove duplicates only through auditable checks, and separate historic ADHD/children's exception waits for transparent reporting.
2. Write to every person in accessible language to explain the approved change, current wait, available support, *"Right to Choose"* and the review process.
3. Complete or update the preparatory questionnaire and complexity screening, offering supported, telephone, paper and reasonable-adjustment routes.
4. Identify people currently in secondary or primary care mental health services, excluding Talking Therapies from automatic allocation, and complete clinical review for the RDaSH specialist cohort.
5. Segment the remaining cohort for *"Right to Choose"* provider matching, distinguishing likely non-complex pathways from providers able to support added complexity.
6. Ensure commissioner has these recommendations in terms of arranging/ agreeing the *"Right to Choose"* for each individual.
7. Make a warm referral, confirm provider receipt and acceptance, and avoid closing the local record until the handover is complete.
8. Offer VCSE diagnostic support while waiting and retain a named route for questions, deterioration and review.
9. Track rejection, non-response, failed contact, deterioration, re-entry, complaints and equality impact, with rapid remedial action where patterns emerge.

9. Risks and mitigations

Risk	Initial rating	Key controls	Target
People experience transfer as loss of access	High	Individual review, accessible communication, informed choice, warm handover, review route and VCSE support.	Moderate
Right to Choose provider rejects added-complexity cases	High	Up-front screening, current provider directory, matched choice, pre-referral discussion and commissioner escalation.	Moderate
Complexity tool becomes an exclusion mechanism	High	Use as decision support only; clinician oversight; audit by protected characteristic and outcome; review/appeal route.	Moderate
Mental health deteriorates during Right to Choose wait	High	Named monitoring route, urgent-care signposting, PCN/secondary-care involvement and formal transfer process to RDaSH specialist pathway.	Moderate
VCSE capacity or governance is insufficient	High	Competitive tender, due diligence, safe caseloads, supervision, safeguarding, data requirements and break clauses.	Moderate
North Lincolnshire remains underserved	High	Tendered locality coverage, mobilisation milestones, minimum local access standard and performance monitoring.	Low/Moderate
Fragmentation across services	High	Shared protocols, named interfaces, consented information transfer, confirmation of receipt and unresolved-handover dashboard.	Moderate
14.1-week trajectory is not sustained	High	Capacity-and-demand model, referral criteria, monthly trajectory, workforce safeguards and stop/go thresholds.	Moderate
Cost exceeds the recurrent envelope	High	Signed baseline, costed procurement, transition profile, monthly finance review and governance escalation.	Low/Moderate

10. Implementation plan

Should this decision be approved, it would require change management support, and this is the proposed phased implementation plan.

Phase	Timing	Core deliverable
1. Validate and design	0-6 weeks	Validate the 2,283-person list and waiting-time definitions; confirm 212/2,071 modelling; finalise criteria, screening governance, workforce and finance baseline; complete QSIA/EIA.
2. Commission and build	6-16 weeks	Tender VCSE diagnostic support; undertake learning review of RANDS and Doncaster Autism Service; specify North Lincolnshire mobilisation; create provider directory, protocols, DPIA, training and dashboard.

Phase	Timing	Core deliverable
3. Prepare transition	During mobilisation	Accessible communications; staff scripts; questionnaire and screening routes; provider-matching process; consent and handover standards; escalation SOP.
4. Pilot	Minimum 6-8 weeks	Test both referral routes and a representative waiting-list cohort across all three localities; include people with added complexity and deterioration scenarios.
5. Readiness decision	Before scale-up	Executive sign-off against safety, workforce, procurement, information governance, equality, finance, provider capacity and 14.1-week sustainability evidence.
6. Phased transition	After readiness	Cohort-by-cohort transfer with clinical oversight; weekly early-warning review for 12 weeks; no bulk closure.
7. Evaluate and refine	3, 6 and 12 months	Lived-experience-led evaluation of experience, equity, safety, acceptance, waits, outcomes, cost and sustainability.

11. Action plan

Action	Lead	Timing	Measure / evidence
Validate waiting-list baseline, exception waits and cohort modelling	Service Manager with Change Team support	Within 4 weeks	Signed dataset: 2,283 total; longest waits reconciled; 212 and 2,071 cohorts reproducible.
Finalise specialist eligibility and deterioration-transfer criteria	Clinical lead	Within 6 weeks	Approved SOP, including PCN/secondary-care escalation and decision times.
Complete capacity-and-demand model for the retained pathway	Service manager & Finance Partner	Within 6 weeks	Evidence that 14.1 weeks is achievable and sustainable, with sensitivity analysis.
Develop and govern the complexity screening process	Clinical lead / Psychology / Lived experience	Within 8 weeks	Approved tool/process; staff training; audit plan; no automated exclusion.
Map *"Right to Choose"* providers by complexity capability	Clinical Lead communicating with commissioner	Within 8 weeks, then monthly	Current directory of acceptance criteria, exclusions, waits, adjustments and escalation contacts.
Tender the VCSE diagnostic support pathway	Service Manager, Clinical Lead and Finance Team	Specification by week 8; award subject to timetable	Specification covers all localities, pre/during/post assessment support, screening, navigation, supervision, safeguarding and outcomes.
Undertake locality learning and due diligence	Finance Team	Before tender award	Documented learning from RANDS, Doncaster Autism Service and North Lincolnshire gap; implications reflected in scoring and mobilisation.
Agree RDaSH training and supervision offer to VCSE	RDaSH specialists & clinical lead	Before mobilisation	Training curriculum, supervision frequency, competence framework and escalation access.

Action	Lead	Timing	Measure / evidence
Design the waiting-list communication and transfer process	Service Manager Communications Team & VCSE	Before pilot	Accessible materials, consent process, named contact, confirmation of acceptance and audit trail.
Test deterioration and warm-transfer scenarios	Operational and Clinical Leads in all MH services	During pilot	Simulation completed; issues resolved; transfer times and outcomes reported.
Establish dashboard related to clinical outcomes and QSIA & EIA	Informatics & Change Management	Before pilot	Monthly reporting on waits, acceptance/rejection, complexity segment, handovers, deterioration, equity, incidents, experience and finance.
Complete readiness review and take stop/go decision	Care Group Director	Before full implementation	Formal decision record with evidence against every gate.

12. Data / Dashboard

Domain	Core indicators
Access and flow	Total waiting list; RDaSH and Right to Choose cohorts; time to VCSE contact; time to provider acceptance; RDaSH wait against 14.1 weeks and Trust target.
Provider matching	Proportion screened; indicative 70/30 segmentation; acceptance and rejection by provider/reason; repeated referrals; time to confirmed handover.
Safety	Deterioration, urgent escalation, safeguarding, incidents, transfer into RDaSH specialist pathway and unresolved clinical handovers.
Quality	Appropriateness of route; report quality; clarification requests; duplicated assessment; adherence to reasonable adjustments.
Experience	Understanding, choice, respect, continuity, complaints, compliments and themes by pathway/locality.
Equity	Access, rejection, waits, outcomes and attrition by locality and protected or underserved group, including digital exclusion.
VCSE contract	Contacts, caseload, locality coverage, supervision, safeguarding, outcomes, workforce and service continuity.
Finance and sustainability	Spend against envelope; Right to Choose implications; transition costs; specialist demand/capacity; sustained waiting-time trajectory.

13. Recommendations

The RDaSH Board is asked to approve the recommended operating model as the detailed implementation of the previously approved adult autism pathway direction. Approval should be conditional on individual review of everyone waiting; validation of the cohort and waiting-time data; sustainable delivery of the retained RDaSH pathway; procurement of an equitable VCSE diagnostic support service; robust matching to Right to Choose providers; and a tested escalation route for people whose mental health deteriorates while waiting.

Implementation should proceed only through the stated readiness deliverables/gates and as a phased, monitored transition. The Trust should receive early assurance on provider acceptance, the experience of people transferred, the safety of the deterioration pathway, locality equity, and whether the 14.1-week RDaSH position is being sustained.

Annex 1. Readiness checklist

Requirement	Owner	Evidence	Status
Validated waiting-list and cohort model	Operational lead / BI	Signed data-quality report	Required
Confirmed recurrent baseline and costed model	Finance / service lead	Signed schedule	To confirm
Final specialist, complexity and escalation criteria	Clinical lead	Approved SOP	To develop
Right to Choose provider capability directory	Commissioning	Current assured directory	To develop
VCSE tender, due diligence and mobilisation	Commissioning / Procurement	Contract and mobilisation plan	To develop
RDaSH training and supervision model	Clinical lead	Curriculum and supervision agreement	Required
Waiting-list transition and accessible communication	Operational / Communications	SOP, materials and audit trail	Required
Equality and Quality Impact Assessments	Quality / EDI	Approved assessments	Required
Safeguarding, incident and complaints routes	Clinical governance	Tested protocols	Required
Information governance and data sharing	IG lead	DPIA and agreements	Required
Deterioration and transfer pathway	Clinical governance / PCN / secondary care	Tested escalation protocol	Required
Dashboard and early-warning thresholds	BI / Quality	Tested report	Required
Go-live and contingency decision	Executive SRO	Formal readiness record	Not yet due

Annex 2. Key assumptions requiring validation

- The 2,283-person total is the current validated waiting-list position at the agreed reporting date.
- The longest wait of over 5 years and 41 weeks is driven by included ADHD and children's exception waits; the adult autism wait after removing those exceptions is 2 years and 41 weeks.
- The 212-person retained cohort and 2,071-person Right to Choose cohort are modelling outputs and remain subject to individual review.
- The 14.1-week RDaSH wait assumes the retained workforce, activity and referral controls are delivered as modelled.
- The approximately 70% / 30% complexity split is based on experience and should be tested prospectively during transition.
- Suitable Right to Choose provider capacity exists for both non-complex and added-complexity presentations.
- The VCSE tender can be funded safely within the confirmed envelope and mobilised equitably across all three localities.

Annex 3. Recommendations from National Review

Department of Health and Social Care. Independent review into mental health conditions, ADHD and autism: final report. Published October 2026. – Key Recommendations for National and Local services are:-

Recommendation 1 - Tackle the drivers of mental distress and ill health through an ambitious approach to prevention, early intervention and improving public mental health and wellbeing.

Recommendation 2 - Move from a 'diagnosis-dependent' to a 'needs-led plus diagnosis' system by developing a digitally and AI-enabled shared needs assessment and prioritisation framework for people with mental health and neurodevelopmental needs.

This framework should be based on the 'no wrong front door' principle, with prioritisation according to each person's needs, level of functional impairment and risk. There should also be a clinically led review of current ADHD and autism assessment waiting lists to:

- identify the primary presenting concern
- prioritise the most relevant existing pathway
- organise assessments for other potential co-existing conditions around this core assessment to determine the best course of action for each individual
- offer evidence-based support while waiting
- The purpose is not to remove people from waiting lists, but to make sure each person is offered the right response to their needs. Crucially, no one should be taken off a waiting list without being connected to appropriate help, and alternative support should be actively arranged with the person, not simply signposted.

Recommendation 3 - Commission and deliver integrated, digitally-enabled mental health and neurodevelopmental assessment and support that is age-appropriate and responds to the needs of local communities. Support should be:

- easy to access
- as close to home as possible
- organised around people through multidisciplinary teams, following the 'expert at hand' principle
- joined up from childhood through to adulthood
- There should be a focus on parity of access and supporting participation.

Integrated assessment of the possible reasons for mental health and neurodevelopmental problems should minimise misdiagnosis and ensure appropriate treatment.

Recommendation 4 Close treatment gaps while protecting, strengthening and investing in specialist services to improve access and outcomes for those with the most severe, complex and enduring needs, including specialist support delivered in the community, and crisis and inpatient services. Actions include that:

- access to NICE-recommended and evidence-based interventions and therapies should be expanded
- specialist capacity should be focused where it adds greatest value
- timely medication reviews and safe deprescribing practices should be strengthened and standardised
- there should be a focus on improving social inclusion and quality of life for people with the highest support needs

Recommendation 5 - Overhaul the commissioning, funding, oversight and regulation of mental health and neurodevelopmental services, including making all diagnostic assessments for ADHD and autism Care Quality Commission (CQC) regulated activity and banning direct-to-public advertising of NHS-funded ADHD and autism assessments. Actions include to:

- move away from separately commissioned ADHD, autism and mental health assessment and support services towards outcome-based commissioning of integrated neurodevelopmental and mental health assessment and support
- ensure consistent quality standards and reporting
- shift from episodic specialist care for ADHD to long-term management in primary care where required

Recommendation 6 - Build capacity and capability across the multidisciplinary workforce to deliver more integrated mental health and neurodevelopmental support, backed by investment in training, supervision and career development. Actions include that:

- multidisciplinary workforce strategies should be co-produced with relevant professional bodies, practitioners and people with lived experience
- neighbourhood multidisciplinary teams (MDTs) should be built with representation across the health sector and beyond, including education, social care and the voluntary sector
- all staff should have a core competence in mental health and neurodevelopmental needs, supported by training and a nationally agreed competency framework

Recommendation 7 - Take an ambitious approach to scaling up safe digital and AI-enabled tools within a digitally enabled and integrated care pathway, while sharing and using data to improve quality of care, efficiency and productivity. Actions include to:

- build an integrated digital infrastructure platform for the organisation of care pathways, using AI to support delivery of the needs assessment and prioritisation framework
- extend regulated digital therapies safely and securely
- improve information and support available on the NHS app
- build interoperable data infrastructure
- preserve in-person care rather than replacing it

Recommendation 8 - Improve data collection and evaluation for mental disorders, ADHD and autism, including through regular population prevalence studies, and update NICE guidelines to strengthen the evidence-base for policy development and implementation.

Invest in more regular national population prevalence surveys and improve the national data infrastructure with disaggregated data to better understand inequalities. Disaggregated data is data that has been broken down according to factors such as age, sex, ethnicity or region.

Recommendation 9 - Commission a national public information and education campaign to help people better understand, support and accommodate neurodevelopmental conditions and manage their mental health, supported by a trusted digital platform providing evidence-based information, tools and support without requiring a diagnosis.

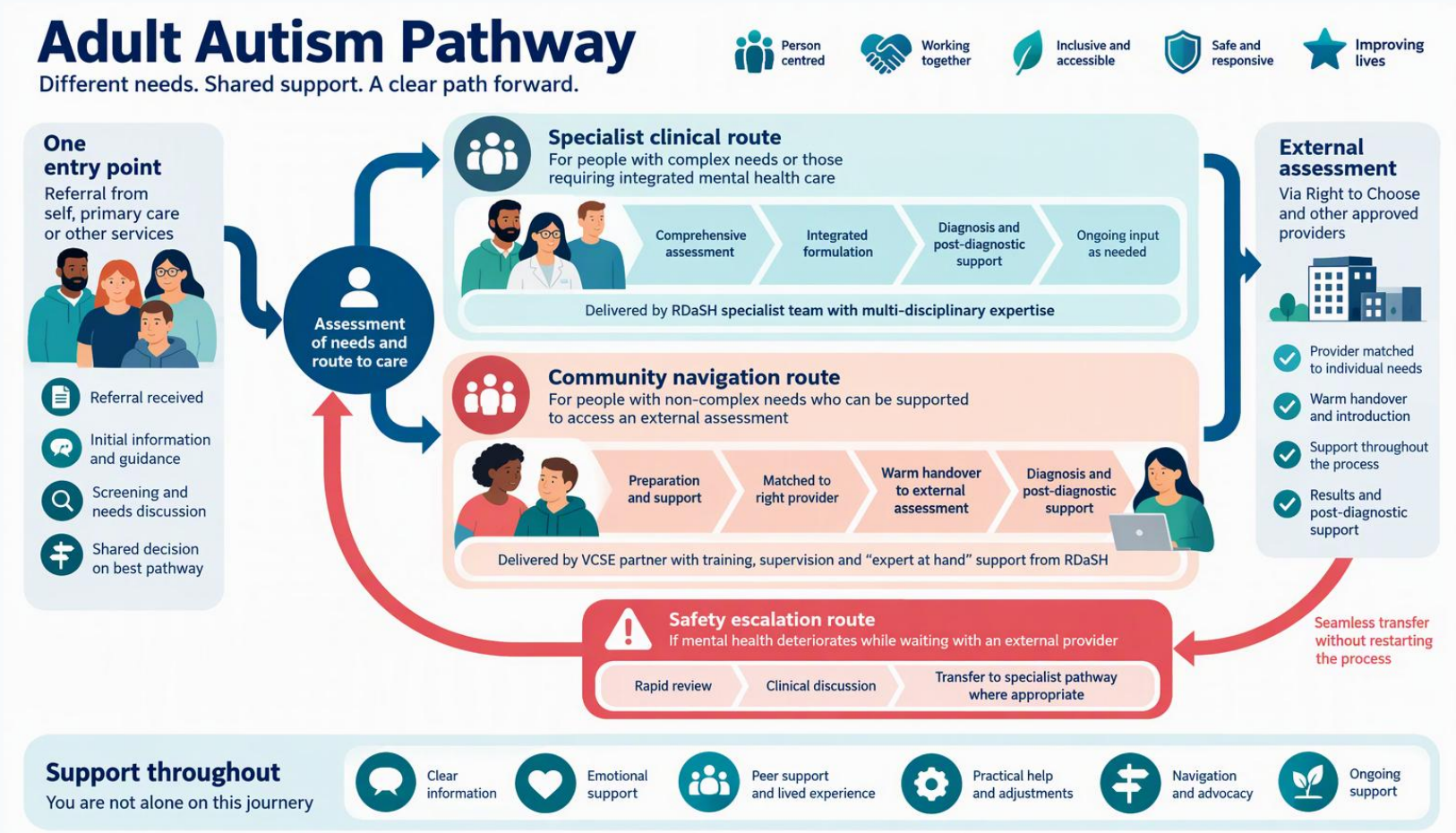
This campaign should be co-produced with people with lived experience and evaluated against mental health and wellbeing outcomes as well as awareness and knowledge.

Recommendation 10 - Publish a cross-government mental health strategy this year setting out how this report's recommendations will be implemented through immediate actions in the next 12 to 24 months and a 10-year reform plan.

This strategy should put improving mental health and wellbeing and improving participation at the centre of government decision-making, underpinned by transparent departmental accountability, investment and workforce requirements.

A simpler, safer adult autism pathway

Two coordinated routes, with support before, during and after assessment



What is changing?

1 RDaSH specialist pathway

For people whose autism assessment must be integrated with mental health, learning disability, inpatient, risk or diagnostic-complexity needs.

2 VCSE diagnostic support

A community partner helps people prepare, navigate options, obtain reasonable adjustments and stay supported throughout.

3 Matched Right to Choose

Provider choice is based on capability and individual need, with consented records transfer and confirmed acceptance.

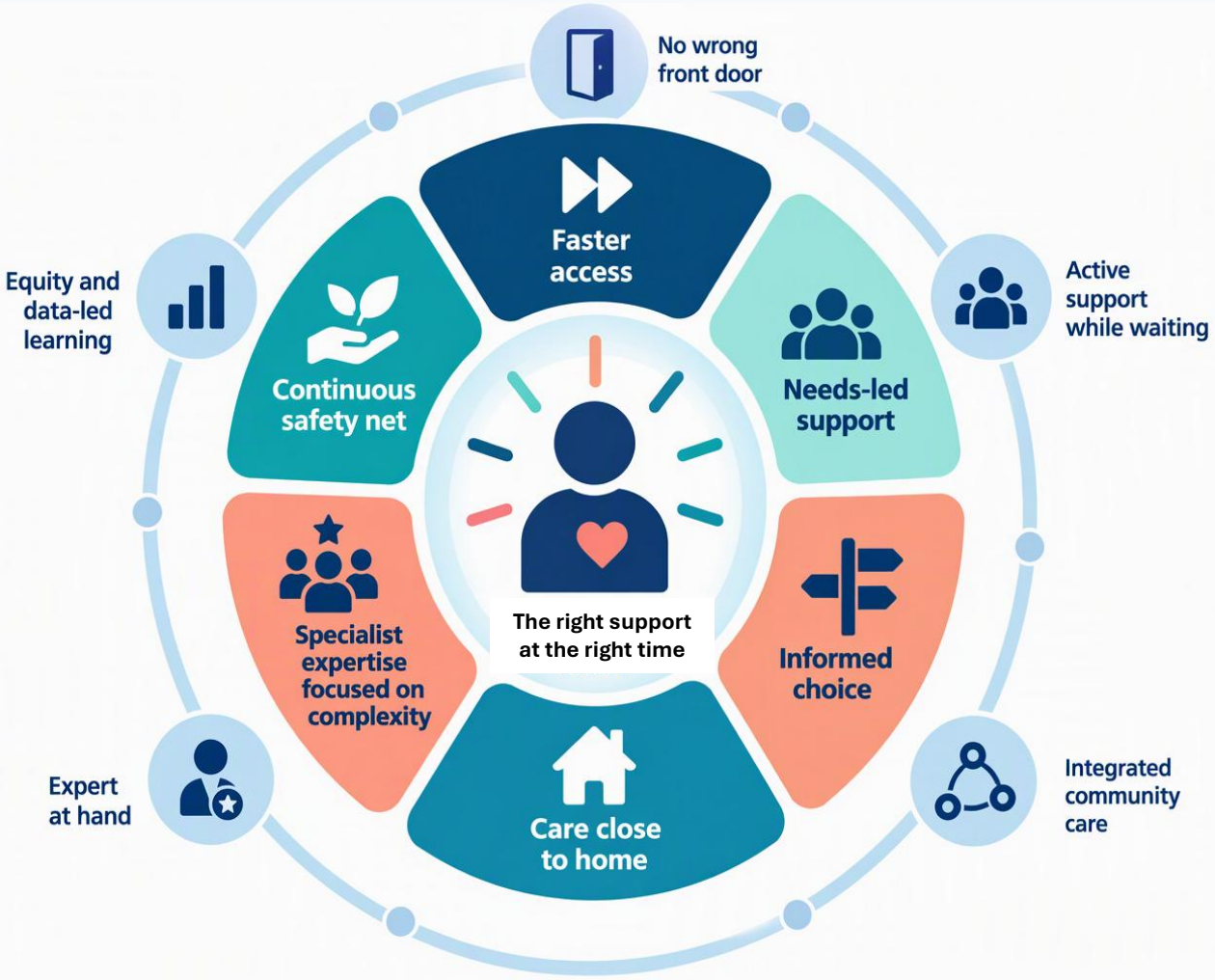
4 Safety net

A formal review and warm-transfer route back to RDaSH if mental health or risk changes.

No bulk transfer **Warm handovers**

Why the change benefits patients

Faster access without sacrificing choice, continuity, equity or specialist care



Patient benefit

- Needs-led help is available while people wait, not only after a diagnosis.
- Individual screening and provider matching reduce rejection, referral cycling and repeated assessments.
- The retained specialist cohort is modelled to reduce the RDaSH wait from 2 years 41 weeks to 14.1 weeks, subject to validation and sustained capacity.
- Accessible communication, advocacy, non-digital routes and locality monitoring build equity into the model.

Aligned with the 2026 national review

Needs-led plus diagnosis:	Practical support is not conditional on a diagnostic outcome.
No wrong front door:	People are actively connected to help rather than simply signposted.
Integrated, local support:	VCSE navigation, RDaSH expertise and external assessment work as one pathway.
Protect specialist capacity:	Specialist input is focused where complexity, risk and treatment planning require it.
Expert at hand and learning:	RDaSH training, supervision, data and lived-experience feedback strengthen quality.

****Paper to be managed via questions only**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	CQC Readiness: Well-Led	**Agenda Item**	Paper T
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Board of Directors	**Date**	26 November 2026

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

This paper updates the position of its self assessment, last presented in November 2025, albeit the Board has engaged both in the receipt of related papers – in May 2026; and in discussions in other forums in the period since. This paper continues the series of six monthly updates to the Board on this topic that commenced in November 2024.

Key to this update are three strands of work: the paper in May 2026, which was the output of an externally commissioned developmental review, undertaken by The Value Circle, and from which the Trust received 14 recommendations; an updated Provider Capability Framework assessment was presented and approved by the Board in September 2026; and further work specifically in support of the self-assessment process.

The Board will recall the contribution to all three strands and seek to ensure that the self-assessment has been appropriately updated such that it reflects the very latest position and is representative of the Trust at this time. The Board should acknowledge the areas where there remains work to undertake and discuss the extent to which the stated actions will close gaps and move the Trust towards a more complete and robust self-assessment – which ultimately supports an anticipated position of being 'good'.

Taken all together, the sources do not fundamentally alter the overall previous self-assessment, rather they provide additional validation of the original conclusions whilst providing some other evidence to demonstrate maturity and strengthening of the previously supported position.

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

Board of Directors (six monthly since Nov 24) The initial paper set a baseline; the subsequent updates noted marginal gain and further evidence that would be sort to support the assessment.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE:

- the update and status report in respect of the Well-Led key question.
- the next steps and planned reporting schedule

COMMENT on the status currently assigned of each of the eight quality statements and with specific reference to the examples of key sources of evidence.

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)			
Business as usual			x
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	x
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	x
Financial risks			
Financial Planning, CIP and Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	x
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			
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	x
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	x
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	x
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	x
Capacity and Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	x
Estates, Equipment and Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	x
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	x
Digital Infrastructure and Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	x
External and partnership risks			
Legal and Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	x
Partnership Working	High Tolerance	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	x
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	x
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	x

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)

System / Place impact (advise which ICB or place that this matter relates to)							
Reputation, Partnership, Workforce							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)
Appendix 1. CQC assessment framework key questions and quality statements – examples of the key evidence and potential gaps.

Rotherham Doncaster and South Humber NHS Foundation Trust
CQC Readiness - Well Led

1. Introduction

1.1 This paper is the fifth in a series of papers that focuses on the Well-Led key question, a part of the overall CQC's single assessment framework. Previous papers have been presented in six monthly intervals since May 2024. It is also supported by several of the other papers on todays' agenda that focus on or are linked to Well-Led key questions - specifically the Freedom to Speak Up presentation and Culture paper but also to those papers regarding Poverty Proofing, Learning from Serious Incidents and the Estate Workplan.

2. Well Led Framework Assessment

2.1 The Trust developed an assessment framework using CQC guidance and scoring methodology and gathered information from diverse sources to provide a basis for the initial self-assessment in November 2024.

2.2 Supporting the assessment is a detailed 'vault' of evidence that demonstrates compliance with regulatory standards and allows for the triangulation of information from all relevant sources and purposefully to include a range of types of evidence. The design of the vault aligns to the requirements set out by the CQC itself, within such as "*CQC Guidance for NHS Trusts and Foundation Trust: Assessing the well-led key Question*" – and to the eight key statements and their respective 42 supporting statements.

2.3 The table below summarises and presents the outcome of the initial assessment (Nov 24), through updates and to the current position (Nov 26). For each question there are four levels of assessment indicated in the key below the table. November 2026 position reaffirms that in the previous self-assessment.

Quality Statement		Assessment		
	Nov 26	Nov 25	May 25	Nov 24
Shared Direction and Culture				
Capable, compassionate and inclusive leaders			↑	
Freedom to Speak Up				
Workforce Equality, Diversity and Inclusion				
Governance, Management and Sustainability				
Partnerships and Communities				
Learning, Improvement and Innovation				
Environmental Sustainability – Sustainable Development		↑		

Evidence shows significant shortfalls
Evidence shows some shortfalls
Evidence shows a good standard
Evidence shows an exceptional standard

2.4 There remains three areas rated as Amber, with planned actions outstanding that, when complete, will position the Trust much closer or at 'Green'. Their continued assessment at Amber remains consistent with other related assessments such as the Provider Capability Assessment and the Annual Governance Statement (2025/26) albeit there has been progress and work undertaken in each.

2.5 Appendix 1 provides additional information in support of the latest assessment including the additional 42 supporting statements (and their individual respective assessment 'rating') and the planned next steps.

2.6 Since the last self assessment, presented to the Board in November 2025, there have been multiple areas of progress, pertinent to the Well-led Framework and in particular the following are highlighted given their individual and collective impact:

- **Plans** – the implementation of all eight supporting plans (to the Strategy) continues.
- **Colleague Development:** Leadership Development Offer (LDO) (150 people including community partners) – two phases complete; phase three commissioned; Staff Induction (circa 600 colleagues over the last 12 months); along with monthly Learning Half Days; First Line Managers (FLM) and Multi Professional Leaders Training (MPLT) development programmes as other examples of developmental and supportive schemes for colleagues all enabling greater understanding of the strategy, promises and communities and provide opportunities to meet colleagues including the Board and senior leaders.
- **Internal Audit** Reviews – 25/26 Internal Audit Plan resulted in an overall 'significant assurance' Head of Internal Audit opinion; 26/27 Plan has already included a positive opinion in respect of Data Security and Protection Toolkit (high confidence / low risk) and a 'moderate assurance' for Access Policy compliance; with a consistently positive response rate to implementing audit recommendations.
- **Care Opinion** – continues to be the focal point of feedback; increasing number of feedback provided (Nov 26 circa 3,800 stories – Nov 25 circa 2,000 stories); and maintaining prompt responses including almost fifty that have led to change.
- **Staff Survey** – the response rate is above 40% (as at 12 November) with continued effort to increase this prior to the close of the survey on 27 November. Results in Q4 will afford the opportunity to identify and respond to any continuing or newly emerging matters raised.

2.7 In the previous report to the Board in November 2025, reference was made to a recent CQC inspection of the Acute wards for adults of working age and psychiatric intensive care units. The resultant report concluded with an overall 'requires improvement' rating – sustaining the previous assessment rating; but with a 'good' for Well-Led – which was an improvement on this key question since the last inspection in this area. In November 2026, and as this report was being drafted, the CQC was at the midpoint of undertaking an inspection of that same cohort of services. The outcome and recommendations will be reported to the Board in due course and will be reflected in the next version of this self-assessment.

2.8 The CQC and the Trust have continued to hold regular engagement meetings throughout the year and there was one further formal review undertaken in July 2026 at Danescourt – a learning disability service. The overall rating was 'requires improvement' which was also the rating assigned to the Well Led component.

3.7 A further contributory and relevant piece of work is the recently submitted self-assessment against the **Provider Capability Assessment (PCA).** This is another example of related guidance that affords the Trust the opportunity for

self-reflection and assessment and that is scrutinized and reviewed externally. The Trust made an original submission in October 2025 (and the position outlined was supported / agreed by the Regional Team. In September 2026, an updated assessment was submitted. No response has yet been received from the Regional Team. The assessment presented the same overall position against the criteria with the Trust continuing to assess two areas as 'partially confirmed' – those being

- quality of care (where the 'partial confirmation' relates to our concern to ensure that a handful of areas of service that "require improvement" have a credible path to continued improvement to good; and that the wider quality and safety infrastructure of the Trust becomes increasingly and sufficiently data-driven) and
- people and culture (where 'partial confirmation' relates to our continuing concern that an insufficient proportion of our staff are persuaded of the safety of speaking up and the likelihood of change).

3.8 In addition, during the last twelve months the Trust commissioned an external Well Led Development Review. This was undertaken by The Value Circle and the resultant report was presented to the Board of Directors in May 2026.

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

3.9 Of note within the positive and supporting commentary were the following:

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

3.10 With respect to the areas of 'better still', the following are highlighted

- *As RDaSH is delivering significant transformation to the way it operates, senior leaders recognise that the pace of change is an ongoing area for attention, particularly in balancing organisational capacity with the scale and complexity of change.*
- *There is opportunity to strengthen how insight is routinely gathered, triangulated and used to inform organisational understanding of staff experience*
- *It is important to recognise that several development areas relating to culture, staff experience and leadership visibility are legacy issues. These areas reflect challenges that RDaSH's leadership recognise as requiring sustained effort and consistent leadership attention to address.*

3.11 The report included 14 recommendations. Two were declared complete in the June timeout session; one is predominantly focused on the future Strategy

refresh approach; work is progressing in respect of all the remaining eleven recommendations and will be concluded before the end of February.

3.12 The work undertaken over the last twelve months strengthens the stated position, with notably the external (independent) work of TVC reinforcing the Green ratings for areas such as Shared Direction and Culture, Governance, Management and Sustainability and Partnerships and Communities. Equally their conclusions about Learning, Improvement and Innovation, Workforce Equality, Diversity and Inclusion concur with the Amber position stated. The FTSU conclusions remains supportive too and the Board will hear today via the specific paper on the agenda the latest position on this topic.

4. Continuing our own self-assessment

4.1 Any well-led organisation will need to demonstrate leadership across and throughout the whole organisation - this principle must be prevalent through all trust services**.** This continues to represent a positive assessment which will be further added to in the coming months as the assessment receives further input and as planned work progresses. We continue to identify further evidence sources and will log and update the vault accordingly.

3.3 Within the Appendix and for each quality statement there are examples of the key pieces of evidence that support the assessment. It also identifies examples of the potential gaps and therefore areas of focus in the coming period that will need to be addressed. These are not the entirety of the evidence available, but included to provide supporting information to the assessments.

4.2 In making the assessment we need to consider not just the quantity of evidence but the type – we should include evidence to support processes, feedback, confirmation of sustainability / consistent application, links to strategy, culture and values. This ensures a rounded set of evidence is in place. Embedding a mechanism of sharing information: This will be done to ensure that all evidence, learning, best practices and legislation are being acted upon and recorded across all five key questions with precision to enable the vault and the resultant assessment to be maintained.

4.3 We will continue to engage with partners on related work that will contribute and be reflected within the next iteration of the assessment. These partners will include; 360 Assurance reporting on their 2026/27 internal Audit plan and their Head of Internal Audit Opinion at the year-end; Deloitte, our external auditors as they too report on their respective audit and value for money work in the coming months and at the year-end.

4.4 Other related work such as our assessment of compliance with the Code of Governance, our reflections on CQC inspections at peer organisations, feedback from our stakeholders, and our work in respect of CQC readiness focusing on the other four key statements – will all play an important role in the strength of the assessment in respect of the Well-led key question.

4.5 Further reflections by the Board: It is important that the Board continues to remain sighted on the position and on the further work necessary. A further paper will be scheduled to come to the Board in May 2027.

5. Recommendations to the Board

RECEIVE and NOTE the update and status report in respect of the Well-Led key question.

COMMENT on the status currently assigned of each of the eight quality statements and with specific reference to the stated sources of evidence.

NOTE the next steps and planned reporting schedule.

Philip Gowland
Director of Corporate Assurance
20 November 2026

Quality Statement : Shared direction and culture: We have a shared vision, strategy and culture that is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding and meeting the needs of people and our communities.						
Quality statement criteria	**Nov 26**	Nov 25	May 25	Nov 24	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Leaders ensure there is a shared vision and strategy and that staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.					Inclusion of Governors within Committees and patient representatives in CLE Groups – Feedback via GGI Revisit Report Staff Networks inc new Carers network Fit and proper person's test (Internal Audit review – revised opinion significant assurance) Strategic Delivery Risk management (internal audit review – significant assurance) Leadership Development Offer (LDO) – Includes Community immersion. Cohorts include partner representatives. First Line Managers training launched Clinical and Organisational Strategy 23-28 – Development process and engagement / distribution. Partnerships with 3rd sector organisations. Development of roles with Strategic Development Directorate	Risk management framework (Maturity) Peer review – Outcomes / Actions / Impact Stakeholder feedback - demographic information being collected / analysed. Measurement of social impact. PSIRF (Embed) – Internal Audit to review in H1 25/26 First line manager training and other development schemes – (Maturity)
Staff and leaders ensure that the vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.						
Staff and leaders demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service and is focused on learning and improvement.						
Staff at all levels have a well-developed understanding of equality, diversity and human rights, and they prioritise safe, high-quality, compassionate care.						

Equality and diversity are actively promoted, and the causes of any workforce inequality are identified, and action is taken to address these.					Governance framework – reporting Board to Ward. - PHPIP Committee - Promises aligned to CLE groups. QSIR Programme	
Staff and leaders ensure any risks to delivering the strategy, including relevant local factors, are understood and have an action plan to address them. They monitor and review progress against delivery of the strategy and relevant local plan					IQPR QS29 – Racist incidents reported against staff. Robust training / OD offer in relation to Culture and Equality and Diversity Revised 5-day Induction	

Capable, compassionate and inclusive leaders:
We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively and do so with integrity, openness and honesty.

Quality statement criteria	**Nov 26**	Nov 25	May 25	Nov 24	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Leaders have the experience, capacity, capability and integrity to ensure that the organisational vision can be delivered, and risks are well managed.					Leadership Development Offer (LDO) Revised Induction and sessions pointed towards our communities. Dedicated Half day learning (Embed, Maturity) – to be mandated Shadow CLE (Q3 25/26) and Dep EG (Q3 25/26) Trust People Council Training needs assessments. FTSU , 3 C's, OD offer. Introduction of Matron roles. Peer review timetable. Board visits programme. Sexual safety charter. Safe recruitment – values based, fit and proper persons test.	PSIRF (Embed) – Internal Audit to review in H1 25/26 Succession planning / talent management (Maturity) Delivery Review 'League tables' (Implementation / Maturity) Pulse survey Job Planning
Leaders are alert to any examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff. They address this quickly.						
High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning.						
Leaders are knowledgeable about issues and priorities for the quality of services and can access appropriate support and development in their role.						
Leaders at every level are visible and lead by example, modelling inclusive behaviours.						

Quality Statement Freedom to speak up: We foster a positive culture where people feel that they can speak up and that their voice will be heard.						
Quality statement criteria	**Nov 26**	Nov 25	May 25	Nov 24	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Staff and leaders act with openness, honesty and transparency.					Care Opinion implemented across the Trust Quality Account 2024/25 Staff Survey (57% response) +7 in engagement score; Decrease in scores across each people promise theme Training and Awareness offer – Induction programme (Inc. Medics) Open staff meetings with Chief Executive and Executive colleagues – Autumn 25 and forward schedule FTSU Guardian (Peer reviews, listening circles, Oversight / support of FTSU Guardian at Exec level. FTSU Reporting to QC and Board Complaints / Duty of Candour	Embedding / Maturity of 'detriment' procedures. Staff survey – action re discrimination and appraisals; plus identified 'true aims' to achieve to 2028 Promotion / Awareness records (Comms) Triangulation - Peer review process and other areas of 'speaking up'.
Staff and leaders actively promote staff empowerment to drive improvement.						
They encourage staff to raise concerns and promote the value of doing so. All staff are confident that their voices will be heard.						
There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.						
When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again						

Quality Statement: Workforce equality, diversity and inclusions: We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.						
Quality statement criteria	**Nov 26**	Nov 25	May 25	Nov 24	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Leaders take action to continually review and improve the culture of the organisation in the context of equality, diversity and inclusion.					Staff networks inc new Carers Network and the Trust People Council Chair and Chief Executive Vlogs and communications to all staff and related Trust matters articles Equity and Inclusion plan – presented for approval at the Board of Directors (May 2025) Reasonable adjustments – dedicated budgets available with intentional overspend Acceptable Behaviour Policy launched and implementation review undertaken Leadership Development Offer (LDO) Includes Active Bystander. Gender and Ethnicity Pay Gap (December 2024) 2024 Staff Survey (57% response) +7 in engagement score; Decrease in scores across each people promise theme (areas of positivity diversity, discrimination but work needed in compassionate culture / leadership and inclusion. Promise 26 – Board of Directors reports and internal audit work Governance framework - reporting Board to Ward - E& I CLE group - WRES WDES reporting	Equity and Inclusion plan (progress with implementation / Maturity) Acceptable behaviour policy – relaunch following audit of use 2024 Staff survey – action re discrimination and appraisals; plus identified ‘true aims’ to achieve to 2028 2025 Staff Survey: underway Representation: continued review of staff, patients, volunteers - Pulse survey relaunch. Leadership development offer (continue to deliver the programme through 2025/26) Social Impact Code of Governance compliance
Leaders take action to improve where there are any disparities in the experience of staff with protected equality characteristics, or those from excluded and marginalised groups. Any interventions are monitored to evaluate their impact.						
Leaders take steps to remove bias from practices to ensure equality of opportunity and experience for the workforce within their place of work, and throughout their employment. Checking accountability includes ongoing review of policies and procedures to tackle structural and institutional discrimination and bias to achieve a fair culture for all.						
Leaders take action to prevent and address bullying and harassment at all levels and for all staff, with a clear focus on those with protected characteristics under the Equality Act and those from excluded and marginalised groups.						
Leaders make reasonable adjustments to support disabled staff to carry out their roles well.						
Leaders take active steps to ensure staff and leaders are representative						

of the population of people using the service.					Including identified areas for action (via DAWN network)	
Leaders ensure there are effective and proactive ways to engage with and involve staff, with a focus on hearing the voices of staff with protected equality characteristics and those who are excluded or marginalised, or who may be least heard within their service. Staff feel empowered and are confident that their concerns and ideas result in positive change to shape services and create a more equitable and inclusive organisation.					Robust training /development offer Global majority program. Delivered Talent Management workshops for GM colleagues Submitted North West Anti racism accreditation Health and Wellbeing offer Accreditations: Veterans, PICU standards, baby friendly	

Quality Statement: Governance management and sustainability: We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.						
Quality statement criteria	**Nov 26**	Nov 25	May 25	Nov 24	**Examples of the Key Evidence to support score**	**Examples of the Expected Evidence: Areas of Improvement / Future Planned actions**
There are clear and effective governance, management and accountability arrangements. Staff understand their role and responsibilities. Managers can account for the actions, behaviours and performance of staff.					GGI Revisit report – operating framework and community voices Data security reporting (DSPT review underway Q1 25/26) Code of Governance Compliance (in Annual Report 24/25) EPPR Compliance Safe recruitment - Fit and proper person's test (Internal Audit review – revised opinion significant assurance) PSIRF – progress on implementation Strategic Delivery Risk management (internal audit review – significant assurance) Operational Risk Management improvements – risk identification, risk velocity, risk profile; training, RMG Risk Appetite	Policy on Policies (Implementation / Maturity) Risk management framework (Maturity) Delivery review 'league table' implementation PSIRF (Embed) – Internal Audit to review in H1 25/26 Information Quality Work Programme (Implementation / Maturity) Think Directorate – completion of work to enable all data and reporting by directorate; and hold to account mechanisms for directorates
The systems to manage current and future performance and risks to the quality of the service takes a proportionate approach to managing risk that allows new and innovative ideas to be tested within the service.			⇧			
Data or notifications are consistently submitted to external organisations as required.						
There are robust arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information is used effectively to monitor and improve the quality of care.						

Leaders implement relevant or mandatory quality frameworks, recognised standards, best practices or equivalents to improve equity in experience and outcomes for people using services and tackle known inequalities.					Robust budget sign off process Revised Induction and sessions pointed towards our communities. MAST – Internal Audit (significant assurance) 'Think Directorate' more devolved, delegated and distributed leadership approach Governance (Operating) Framework Feedback from stakeholders including at Annual Members Meeting – July 2025 IQPR Annual Report Research and Innovation CLE Accreditations - Veterans, PICU standards, Baby friendly,	

Quality Statement : Partnerships and community: We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.						
Quality statement criteria	**Nov 26**	Nov 25	May 25	Nov 24	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Staff and leaders are open and transparent, and they collaborate with all relevant external stakeholders and agencies.					Care Opinion launched and implemented. Community reps within governance structure – CLE and its Groups GGI Revisit report – operating framework and community voices PSIRF – progress on implementation Leadership Development Offer (LDO) – both cohorts now launched. Includes Community immersion. Cohorts include partner representatives. Revised Induction and sessions pointed towards our communities. Primary Care Liaison role (since Nov 24) within Strategic Development Team P3, 4 and 5 – Internal Audit (significant assurance) and Partnership Governance and Risk Management – Internal Audit (significant assurance) Staff Networks Provider collaboratives Virtual wards Peer support workers	Care Opinion (continue to embed, mature our use and extract and act on learning) PSIRF (Embed) – Internal Audit to review in H1 25/26 Relationship Managers (Embed / Maturity) - Feedback from stakeholders including at Annual Members Meeting – July 2025 Social Impact data
Staff and leaders work in partnership with key organisations to support care provision, service development and joined-up care.						
Staff and leaders engage with people, communities and partners to share learning with each other that results in continuous improvements to the service. They use these networks to identify new or innovative ideas that can lead to better outcomes for people.						

					Partnerships with 3rd sector organisations. Governance framework – reporting Board to Ward. - PHPIP Committee - Promises aligned to CLE groups. RNC Cadets Hospice Step Down Accreditations: Veterans, PICU standards, Baby friendly	

Quality Statement Learning, improvement and innovation: We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.						
Quality statement criteria	**Nov 26**	Nov 25	May 25	Nov 24	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Staff and leaders have a good understanding of how to make improvement happen. The approach is consistent and includes measuring outcomes and impact.					Strategic Delivery Risks pertinent to this element. Leadership Development Offer (LDO) and other development programmes including First Line Managers Shadow CLE and Dep EG meetings recently established PSIRF – progress on implementation Approved Quality and Safety Plan Approved Learning and Education plan Approved Research and Innovation plan Implementation of RADAR system to better facilitate reporting and learning Dedicated Half day learning (Embed, Maturity) – to be mandated Responses to R28 letters Diverse OD offer Research collaboration with service users. Grounded research initiatives	PSIRF (Embed) – Internal Audit to review in H1 25/26 RADAR implementation and embeddedness – benefits realization. Move towards implementation for the Quality and Safety / Learning and Education / research and Innovation plans Change team (Embed / Maturity) QSIR programme (Embed / Impact) Pulse survey – embed Listening events - Restart 2025
Staff and leaders ensure that people using the service, their families and carers are involved in developing and evaluating improvement and innovation initiatives.						
There are processes to ensure that learning happens when things go wrong, and from examples of good practice. Leaders encourage reflection and collective problem-solving.						
Staff are supported to prioritise time to develop their skills around improvement and innovation. There is a clear strategy for how to develop these capabilities and staff are consistently encouraged to contribute to improvement initiatives.						
Leaders encourage staff to speak up with ideas for improvement and innovation and actively invest time to listen and engage. There is a strong sense of trust between leadership and staff.						

The service has strong external relationships that support improvement and innovation. Staff and leaders engage with external work, including research, and embed evidence-based practice in the organisation.					Governance framework - E & L CLE group Guardian of safe working Safe staffing NICE compliance Peer reviews	

Quality Statement - Environmental sustainability - sustainable development:
We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

Quality statement criteria	**Nov 26**	Nov 25	May 25	Nov 24	Examples of the Key Evidence to support score	Examples of the Expected Evidence: Areas of Improvement / Future Planned actions
Staff and leaders understand that climate change is a significant threat to the health of people who use services, their staff, and the wider population.					Equity and Inclusion plan – presented for approval at the Board of Directors (May 2025) Climate Adaptation Day Promises and Priorities Report to Board – Promise 27 Annual Report – inc enhanced task force on climate-related financial disclosures Refreshed Green Plan approved by Board in July 2025 Expression of Interest submitted to Heat Network Development Unit for funding to develop a business case to install a heat network on Tickhill Road Site. Virtual Ward Carpool offer Cycle to work scheme. Executive leadership and governance framework - Estate and sustainability group Change in working practices.	Project Development / Future bids – e.g. Gas heating replacement Climate Adaptation Framework Self Assessment to complete Equity and Inclusion plan (progress with implementation / Maturity) Trajectory / Targets Place and system work. Health promotion i.e. Quit team.
Staff and leaders empower their staff to understand sustainable healthcare and how to reduce the environmental impact of healthcare activity.						
Staff and leaders encourage a shared goal of preventative, high quality, low carbon care which has health benefits for staff and the population the providers serve, for example, how a reduction in air pollution will lead to significant reductions in coronary heart disease, stroke, and lung cancer, among others.						
Staff and leaders have Green Plans and take action to ensure the settings in which they provide care are as low carbon as possible, ensure energy efficiency, and use renewable energy sources where possible.						

Staff and leaders take active steps towards ensuring the principles of net zero care are embedded in planning and delivery of care. Low carbon care is resource efficient and supports care to be delivered in the right place at the right time.						

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	2027/28 Financial Plan	**Agenda Item**	Paper U
Sponsoring Executive	Simon Sheppard, Director of Finance & Estates		
Report Author	Simon Sheppard, Director of Finance & Estates		
Meeting	Board of Directors	**Date**	26 November 2026

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

The Board of Directors is aware that we will shortly be submitting our draft financial plan for 2027/28. This paper updates the Board on the key assumptions, provides a high-level bridge from the 2026/27 plan to the exit underlying position.

The paper provides further details regarding the **key aspects of the financial plan** for 2026/27 which are worthy of a brief discussion.

- National and regional planning principles
- Cost Pressures
- Cost Improvement Programme
- Budget principles and sign off process
- Capital
- Workforce

The recommendation is to submit a breakeven plan for 2027/28 and to delegate the draft submission (expected in December 2026) to the Chief Executive and Chair of the Finance, Digital and Estate Committee

The specific details regarding the cost pressures, capital plan schemes and final cost improvement schemes will follow in January 2027 alongside the planning guidance once received.

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

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the cost improvement target of £7.8m in 2027/28

RECOGNISE the 2026/27 exit underlying position

AGREE the submission of a break-even Income and Expenditure plan for 2027/28,

DELEGATE authority for the first plan submission to the Chief Executive and Chair of the Finance, Digital and Estate Committee

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Business as usual	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
Business as usual			X
Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
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
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
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			
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	
Performance risks			
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
External and partnership risks			
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 (list which strategic delivery risks reference this matter relates to)
N/A
System / Place impact (advise which ICB or place that this matter relates to)
The financial plan is particularly relevant to the South Yorkshire ICB and to a lesser extent Humber and North 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 Appendix 1 – NEY Region Planning Principles

2027/28 Financial Plan

1. Introduction

1.1. The Board of Directors and its committees have consistently considered the **underlying deficit of the Trust**, notwithstanding better-than-plan delivery of the in-year Income & Expenditure plan in 2023/24, 2024/25 and 2025/26. Also, there is likely to be a favourable position against the breakeven plan in 2026/27.

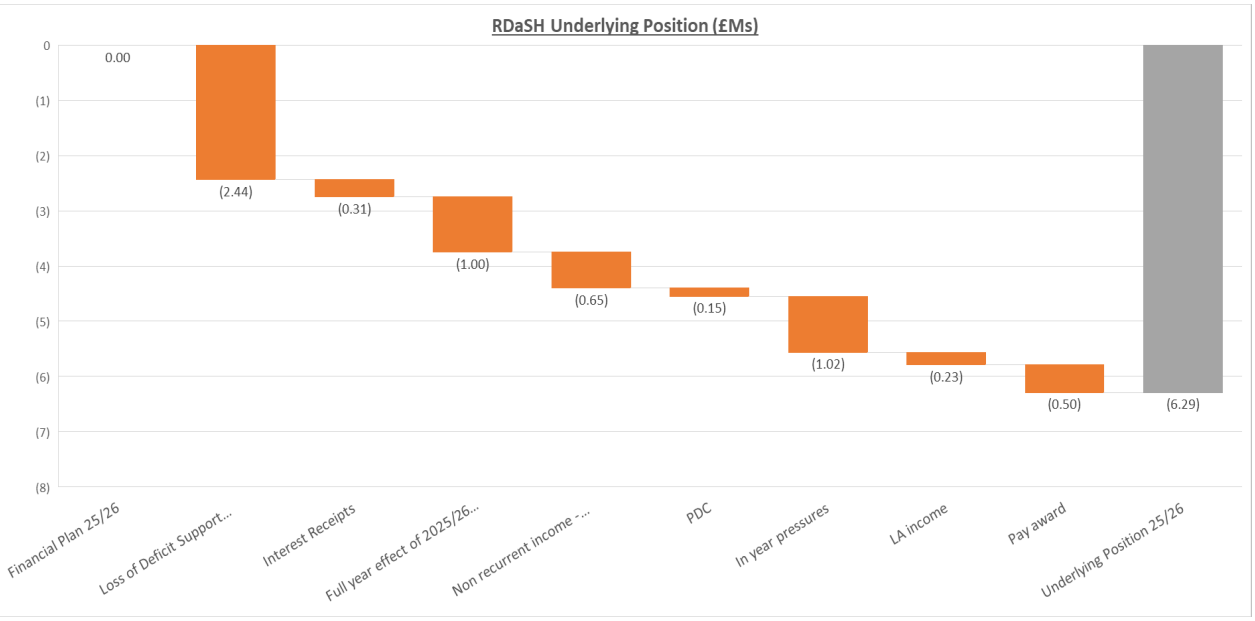
1.2. This paper provides the Board of Directors with an update on the underlying deficit as we exit 2026/27 alongside further details regarding the **key aspects of the financial plan** for 2027/2:

- National and regional planning principles
- Cost Pressures
- Cost Improvement Programme
- Budget principles and sign off process
- Capital
- Workforce

2. Underlying Deficit

2.1 The Board of Directors will be aware that in 2022/23 the underlying deficit of the Trust was in excess of £16m. This reduced to £12m in 2023/24 and the closing position at the end of 2024/25 was a deficit of £8.4m. It was pleasing to note that the exit underlying deficit position for 2025/26 into 2026/27 also showed a reduction; to £6.3m. (shown in Chart 1 – bridges from the 2025/6 breakeven financial plan)

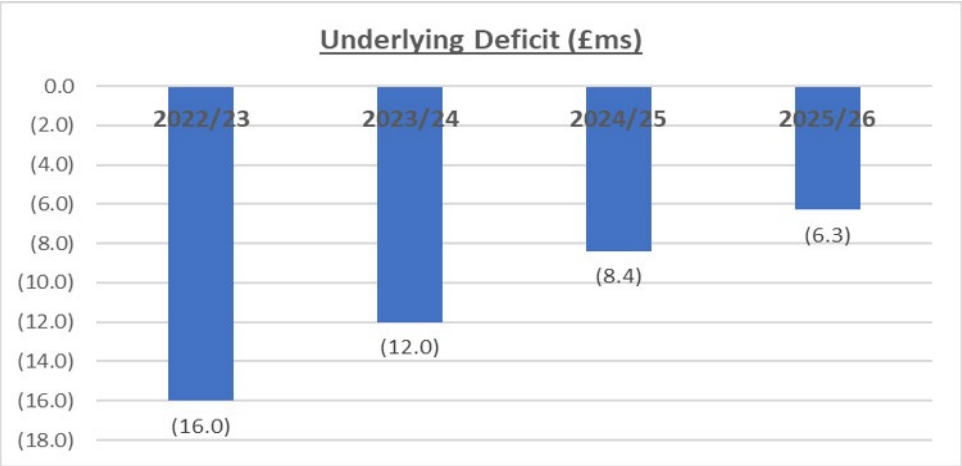
Chart 1 – Bridge from the 2025/6 Plan to the Underlying Deficit



2.2 The key drivers of the bridge from the 2025/26 financial plan shown above include:

- Loss of national deficit support funding, £2.44m
- Full year effect of the cost pressures from 2025/26, £1.02m
- Non recurrent income in 2025/26, £0.65m
- Recurrent cost pressures in 2025/26, £1.02m

2.3 The underlying deficit movement from 2022/23 to the exit of 2025/26 is shown below. This clearly shows the year on year improvement.



3. 2026/ 27 Income & Expenditure Changes

3.1 It is important to remind the Board of the key assumptions regarding the 2026/27 financial plan and the inherent link to the underlying deficit.

3.2 Table 1 sets out the impact of changes to the Trust's income allocations as well as planned changes to expenditure from national planning metrics. Tariff uplifts of 2.03% have been passed to providers to fund inflation, with a reduction in income of 2% for efficiency.

3.3 Key expenditure increases based on the planning guidance included a total pay cost increase of 2.10%. Please note that this reflected a nominal 2% for pay included in 2026/27 allocations, and then a 0.1% for pay drift. The pay cost estimate has now been updated to include the announced pay settlement for Agenda for Change staff (a pay uplift of 3.3%)

Table 1 - NHS Cost Uplift for Planning – 2026/27

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.10%	71.31%	1.49%
Drugs	0.58%	2.37%	0.01%
Capital	1.66%	4.44%	0.07%
Other	2.20%	19.66%	0.43%
Unallocated CNST	0.52%	2.22%	0.01%
Total			**2.03%**

3.4 The financial implications at a Trust level of the national assumptions were:

Table 2 – National Planning assumption impact

	£m
2026/27 tariff increase @ 2.03%	4.5
2026/27 tariff reduction – efficiency @ 2%	(4.2)
Pay inflation	(4.3)
Non-Pay inflation	(1.1)
Net change	**(5.1)**

3.5 With a net £5.1m pressure, before any cost pressures, the Trust required a CIP of £5.1m in 2026/27 just to stand still. With an underlying deficit as described in section 2 this level of CIP was not realistic. The Board is aware, as previously reported, the CIP target for the Care Groups and Corporate Directorates for 2026/27 is £10m (4% of turnover), noting a further stretch to £13.75m (5.1%) inclusive of central schemes. The difference of £3.75m was made up of non-recurrent solutions including a central vacancy factor, slippage on investment funds and balance sheet flexibility.

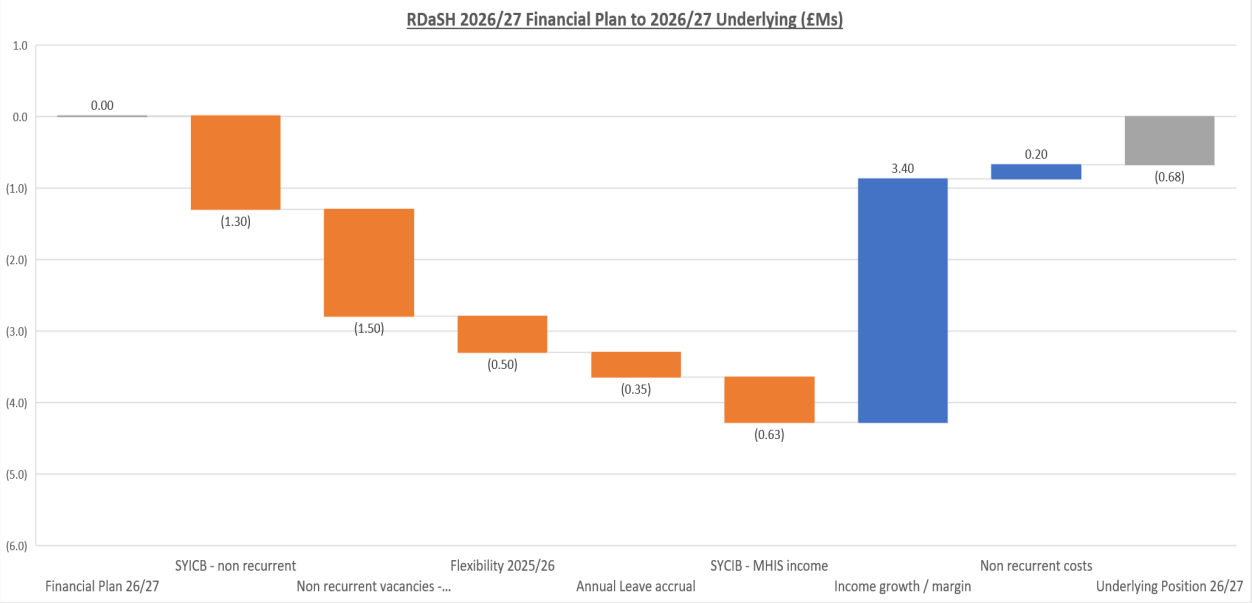
3.6 At the time of writing, the CIP report shows the recurrent value is over £10m.

4. 2026/27 Underlying Deficit to 2026/27 Financial Plan

4.1. Building on the 2026/27 financial plan the Board is asked to receive an update to the underlying position as we exit 2026/27 and the key actions required to ensure this position is a breakeven underlying deficit, if not a surplus.

4.2. Chart 2 shows the underlying position prior to any further actions. The movements from the breakeven 2026/27 financial plan are:

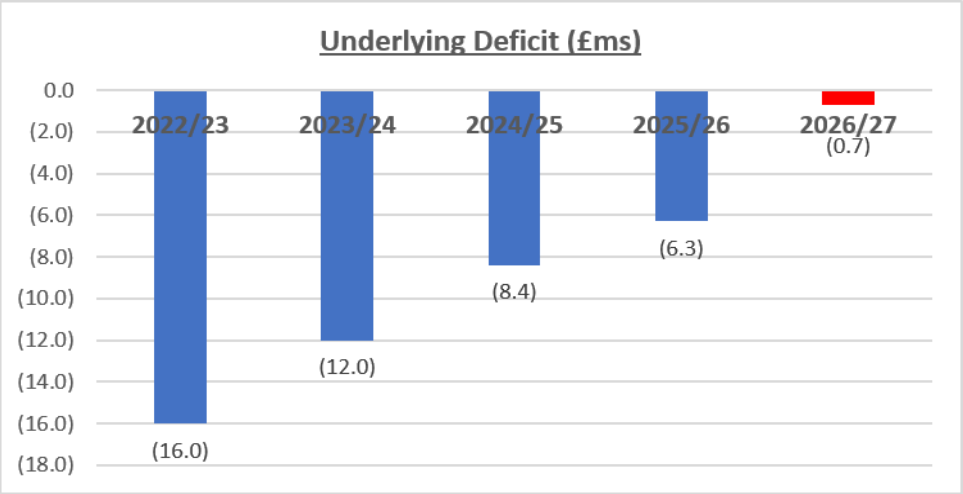
- £1.30m non recurrent income from SY ICB
- £0.63m non recurrent MHIS income from SYICB
- £1.50m of additional costs assumed regarding to filling of vacancies in 2026/27
- £0.85m of costs linked to the flexibility in 2026/27
- £3.40m of additional income growth / margin



4.3. Based on the assumptions in section 4.2 the underlying deficit would fall from the £6.3m in 2025/26 to £0.68m at the end of 2026/27. To remind the Board, we had planned on a £0.70m deficit at the end of 2026/27.

4.4. As we progress through Q3 of the financial year, we will assess the recurrent full year effect of 2026/27 CIPs with the aim to move this position to breakeven.

4.5. The revised underlying position continues the year on year improvement towards financial sustainability.



5. National & Regional Planning Principles

5.1. At the time of writing there is no national planning guidance or formal timescales. That said, CEOs and executive leads are sighted on regional planning principles and financial next steps.

5.2. North East & Yorkshire region has developed the following planning principles:

- Share information openly throughout the planning cycle in the spirit of 'No surprises'
- Engage clinical, operational, finance, workforce and quality leaders throughout plan development. Adopting an MDT approach to support the development and testing of planning assumptions
- Set clear expectations early that translate national requirements and regional priorities into clear tests for an acceptable plan.
- Escalate risks and issues early.
- Demonstrate that plans are realistic, deliverable and affordable, transparently sharing underpinning assumptions and ensuring triangulation.
- Ensure planning decisions are supported by evidence and data.
- Support system-wide optimisation – Providers and ICBs own plans but need to work collaboratively

5.3. The intention is to promote consistency, transparency and constructive challenge, while recognising that organisations operate in different contexts and may face specific local circumstances. The opportunity to "explain" any area of non-compliance

should not be interpreted as an automatic exemption from a delivery requirement or a means of avoiding appropriate challenge and scrutiny.

5.4. In practice, the expectation is the following principles apply:

5.4.1. **Compliance as the default**: Plans should demonstrate how they meet national/local requirements, statutory duties, agreed financial and operational parameters and regional planning principles.

5.4.2. **Clear and evidence-based explanations**: Where an expectation can't be met, organisations should explain why, supported by relevant evidence. All areas of non-compliance and underpinning assumptions will be tested through MDT meetings.

5.4.3. **Assessment of deliverability**: Explanations should consider delivery implications and demonstrate that plans are credible, affordable and fully triangulated across finance, activity, performance, workforce and quality.

5.4.4. **Executive and Board ownership**: Any areas of non-compliance should be subject to appropriate executive scrutiny and explicit Board oversight, ensuring that the rationale, implications and proposed recovery actions are understood.

5.4.5. **Credible mitigation and recovery**: For any delivery challenges, organisations should set out the mitigating/recovery actions required, with clear milestones, timescales and measurable outcomes.

5.5. Appendix 1 provides further details from a regional perspective on the planning principles. In essence NHS providers will remain accountable for developing robust organisational operational plans that contribute to both system and regional objectives.

5.6. Providers will be expected to develop plans to deliver:

Theme	Delivery Expectation
National Priorities	Providers should set out credible trajectories and delivery plans for all nationally mandated priorities
Safe and High-Quality Care	Plans should demonstrate how quality and patient safety remain central to operational delivery. Ensure plans maintain compliance with statutory and regulatory requirements. Clearly identified actions to improve patient outcomes and reduce unwarranted variation. How quality impact assessments have informed planning decisions.
Financial Sustainability	Deliver agreed financial control totals. Demonstrate delivery of efficiency programmes supported by realistic implementation plans. Clearly identify financial risks and mitigating actions. Maximise productivity opportunities and minimise reliance on non-recurrent solutions. Identify recurrent savings wherever possible.
Operational Performance	Demonstrate credible activity and demand assumptions.

	Clearly set out delivery trajectories and milestones with detailed underpinning assumptions. Maximise productivity opportunities. Identify operational risks. Describe operational improvement programmes.
Workforce requirements	Affordable workforce establishments. Recruitment and retention strategies while reducing agency reliance. Workforce transformation initiatives. Contingency arrangements.
Capital and Digital	Align capital investment with strategic priorities. Demonstrate deliverability within capital allocations. Include digital transformation programmes. Show how estates and digital investment supports improved productivity.

5.7. From a purely financial planning perspective there has been a little more guidance on the expectations and timescales building on section 5.6.

5.8. For 2027/28, all providers will be required to complete a planning **Provider Assurance Model**, providing a common and transparent view of the underlying financial and workforce position exiting 2026/27 and a clear bridge into the 2027/28 plan. This is not intended to add a further layer of assurance, but to ensure plans are demonstrably built from the position organisations are exiting 2026/27.

5.9. The model will:

- Establish a **normalised underlying exit run-rate**, removing only genuine non recurrent, technical, seasonal or other distorting items, with **items otherwise assumed recurrent** unless there is clear evidence to the contrary.
- Ensure the impact and full-year effect of management actions and CIP already delivered in 2026/27 are reflected in the exit position of organisations.
- Provide an evidence-based and reconcilable bridge from the underlying position, through existing and new actions, to the 2027/28 financial and workforce plan.

5.10. A particular priority will be ensuring that 2027/28 CIP represents genuine new financial improvement requirements for boards to understand and sign off. New CIP should reduce the underlying cost base and workforce or demonstrably improve the financial run-rate from the position entering the year. It should not include income growth, cost avoidance, technical or balance-sheet adjustments, or savings already delivered and reflected in the opening position.

5.11. Plans should therefore distinguish between:

- The full-year effect of actions already delivered.
- Genuine new 2027/28 CIP.
- Income movements, cost avoidance and technical or non-recurrent measures.
- Any residual unidentified CIP requirement.

5.12. Identified CIP should be supported by appropriate costing, whole time equivalent (WTE) impact where relevant, operational or clinical engagement and a credible implementation date. From November 2026, high risk trusts on weekly reporting

(which we are not) will be asked to include the development status of 2027/28 CIP, providing early visibility of scheme maturity, risk and delivery.

5.13. Each Chief Executive will be required to write to the Regional Director confirming Board assurance on their plan and summarising:

1. The underlying financial position exiting 2026/27, including any material adjustments to the forecast March 2027 exit spend position
2. The genuine new 2027/28 CIP requirement, including progress on delivering these schemes and any remaining unidentified requirements.
3. The Board's assessment of material risks, dependencies and overall plan credibility and deliverability, including triangulation across finance, workforce, activity, performance and quality.

5.14. To support a consistent regional approach in implementation the following timetable will apply for the initial financial modelling:

Date	Requirement
4 November 2026	Training for finance teams on the planning Provider Assurance Model and methodology. This will be recorded and shared across organisations in recognition of the notice given.
From November 2026	For organisations currently required to complete weekly reporting the reporting requirements will be updated to include 2027/28 CIP development status.
12 November 2026	Month 7 Provider Assurance Model with underlying exit financial position assessment for 2026/27 additional section to be included and completed. *(only applies to organisations already completing these monthly).*
30 November 2026	Initial submission from all providers of planning PAM – minimum return exit run rate and underlying position.
7 December 2026	Opportunity to resubmit following review and further development between trust and regional colleagues.
Mid-December 2026	Initial Full Planning Provider Assurance Model submission aligned with the anticipated first draft 2027/28 planning return.
February 2027	Final Full Provider Assurance Model aligned with the final 2027/28 planning return.

6. Budget Setting Principles and Budget Sign Off

6.1. There are very clear, and consistently applied budget principles, to support the sign off of the budgets during February 2027. These include:

- Directorate budgets in recurrent balance in 2026/27 with no centrally held CIP, and all schemes delivered recurrently.
- 2026/27 directorate recurrent budgets are the baseline for 2027/28
- Out of Area Placement deal agreed with SY ICB in October 2024 (inappropriate placements) and August 2025 (appropriate placements) and HNY ICB in October 2026 remain in place.
- Cost Pressure Reserve is the **only** route to additional funds for directorate budgets, “additional” in year income received will be held centrally / offset against any central risk reserve.
- Vacancy factor remains at 2.5% for all directorates.
- Directorate CIPs will be allocated from 1 April 2027.
- Pay budgets will all be uplifted for the national pay award ideally from the 1st of April 2027; however, this is dependent upon the national announcement.
- The Real Living Wage has been re-calculated for 2027/28 based on the newly announced figure on the 15th of October 26. This will be the first port of call

upon the investment bid pot and will be reflected in budgets from the 1st of April 2027.

- Sign off of the budgets will be by the Care Group or Executive director.

6.2. Board members are aware that annually a process of local budget sign off takes places. This culminates in 24 reviews with the CEO and Director of Finance & Estates. Last year that process concluded in April 2026, albeit was largely completed in March. For 2027/28, it will be completed in February 2027 – this allows the finance function to focus hard in March on making sure every line of local budgets reflects accurately these decisions including the monthly profile. This is intended to reduce to almost none in year budget movements between teams. It then allows the audit process to consume April and early May.

6.3. The 2027/28 process includes improvements from the generally positive 2026/27 cycle including enhanced levels of engagement and revised documentation.

6.4. Sign off is by the care group or executive director, but in the case of our five care groups and 13 directorates, Directorate Management Team (DMT) service managers will attend for a third-year to ensure that they understand and can contribute to discussions of risk and an understanding of local flexibility.

6.5. In the main, at directorate level, there is virement flexibility between teams, and it is important not to under-estimate how novel that was in 2024/25 and remained this year for this Trust, where prior to 2023, budget ownership was highly centralised, and managers regarded budgets as fixed at a literal lateral entry level.

7. Cost Improvement Programme 2027/28

7.1. The level of cost improvement required is driven by two main factors, the underlying position and the national inflation and efficiency assumptions. There is arguably a third, this being any cost pressures / developments not externally funded.

7.2. The following table highlights the key drivers of the financial plan with the first section showing the £4.8m pressure from the tariff and inflation changes – this is in effect the minimum level of CIP required to stand still. The underlying deficit and the cost pressures then increase this to £7.8m.

7.3. The first column is the plan and assumptions we modelled in 2025 with the second column the revised position. This should give the Board confidence we have done what we said we would do.

	2027/28 £m	**2027/28 £m**
Tariff increase @ 2%	4.9	4.9
Tariff reduction – efficiency @ 2%	(4.3)	(4.3)
Pay inflation	(4.3)	(4.3)
Non-Pay inflation	(1.1)	(1.1)
Net change	**(4.8)**	**(4.8)**
Underlying	(0.7)	(0.7)
Cost Reserve	(2.1)	(2.3)
Financial Gap	**(7.6)**	**(7.8)**
Cost Improvement	5.3	7.8
Income Growth Margin	2.3	0.0
Financial Plan	**0.0**	**0.0**

7.4. We have commenced planning for the **2027/28 Cost Improvement Programme** and this includes areas such as:

- Care Group Directorate – specific target
- Backbone Directorates – specific target
- Bank staffing focus – both price and volume
- Procurement workstream
- Medicines management / drugs workstream
- Maximising commercial opportunities
- Contract management
- Central schemes

Table 3 – 2027/28 cost improvement programme

Area	£000s
Care Group Directorates	1,922
Backbone Directorates	629
Bank spend	1,000
Procurement	250
Contract Management	150
Medicines Management	100
Logistics	300
Non Pay Inflation	1,100
Incremental Drift	225
Vacancy Management	1,000
Central	1,500
Total	8,176

5.1 At this stage the themes and targets are in excess of the £7.8m to give us some flexibility for slippage and / or unexpected costs.

5.2 As we go through the 2027/28 it will be important we monitor both the in-year performance but also the recurrent full year effect value. The latter will help support the medium-term financial position.

5.3 All budget reductions will be actioned from the 1 April 2027 and phased appropriately (most will be from 1 April 2027). This will help to support not only the submission of a balanced plan but also a realistic monthly profile.

8. Cost Pressures

8.1. Consistent with our prior and annual practice, the Medium-Term Financial Model (MTFM) has included a planned full year effect (FYE) and part year effect (PYE) investment for 2027/28. This is now widely acknowledged inside the Trust as the sole pathway to covering new or unavoidable costs. It should be considered alongside the previously reported “business rules” agreed annually with the Clinical Leadership Executive: these are clear about corporately managed risks, and about the local management of non-pay inflation and incremental drift.

8.2. As in prior years, the clinical leadership executive (CLE) is forming a view on priorities, and the Board will be asked to sign off on that, probably in January 2027.

8.3. Prior to decision, our usual cross reference to the risk register will be completed, both to establish that no mitigation plans presume funding that is unacknowledged in this round.

9. Workforce

9.1. Workforce is a critical part of any annual plan in terms of the numbers (headcount and whole time equivalent), the mix of staff (bands), the cost of staff, and more importantly the role they play in delivering safe care.

9.2. As described in section 5.6 the key workforce deliverables are expected to be:

- Affordable workforce establishments.
- Recruitment and retention strategies while reducing agency reliance (for RDaSH we can add bank reliance)
- Workforce transformation initiatives.
- Contingency arrangements.

9.3. In addition to the above it is expected that the Trust focus on these 6 areas:



9.4. The table that follows details the key lines of enquiry that will be undertaken as part of the plan reviews.

KLOE	Key questions
1. Deliverability of workforce reductions	Are Workforce deep dive V4.pptx planned WTE reductions fully identified, phased monthly and supported by named owners, milestones and Board-approved?
2. Alignment of workforce and finance plans	Do WTE movements reconcile with pay-CIP values, investment plans and the financial forecast? What explains any divergence between workforce and pay performance?
3. Investment control	Are new or replacement posts limited to safety-critical? Have non-critical investments been paused where delivery confidence is low?
4. Vacancy and recruitment controls	What vacancy and recruitment control measures are in place?
5. Temporary and premium staffing	Are agency, bank, overtime, insourcing and outsourcing reducing in both WTE and cost? Are substantive recruitment and service redesign replacing premium-cost capacity? Do you have a temporary staffing reduction plan? Are bank and agency rates reviewed across place? Is there oversight and action taken to align and review peer temp staffing costs via the temporary staffing dashboard? Is oversight data available including overtime, discretionary pay, fixed term contracts etc.
6. Safety and quality assurance	Are all workforce changes supported by skill-mix reviews, quality impact assessments and EQIAs? How are risks to patient safety, access and performance monitored?
7. Workforce productivity and service redesign	Do plans go beyond transactional reductions and include pathway redesign, job planning, rostering, digital automation and changes to models of care? Are benefits quantified? Are workforce productivity metrics monitored routinely at service level?
8. Workforce planning	Are workforce plans developed and triangulated at service level and include skill mix reviews, skill requirements, regular demand reviews, supply pipeline information, productivity and transformation opportunities. Where fragile services and professions exist are plans developed on a system/place level including commissioners? Are workforce plans around resident Drs and LEDS in place which could offset temporary staffing. Does the board consider its anchor role in workforce plans
9. Sickness absence	Is there a Board-approved absence reduction plan with trajectories by staff group and service? Are targeted actions delivering measurable reductions, particularly in high-absence areas?
10. Establishment and workforce growth	Has the organisation reconciled its funded establishment, actual workforce and vacancies? Has post-Covid growth been reviewed against activity, outcomes and funding?
11. Governance and accountability	Is there clear Board and executive ownership, regular scheme-level scrutiny and consistent reporting across workforce, finance and operations? Are corrective actions triggered promptly?
12. Redundancy and voluntary exit schemes	Are VR/MARS/VSS assumptions realistic regarding take-up, cost, timing and recurrent benefit? Are consultation, implementation and cost-of-change risks reflected in forecasts?
13. Sustainability and benefits realisation	Will reductions persist beyond 2026/27 without increased temporary staffing or poorer performance? Are benefits from EPR, automation and transformation tracked after implementation?

10. Capital

10.1. As well as the financial plan we will be submitting a capital plan. The indicative allocation for 2027/28, excluding any funding linked to the estate plan development, is £5.1m – this is inclusive of £0.6m related to the Estate Safety fund.

10.2. There is a session planned in early December with the CEO, Chief Operating Officer and Director of Finance & Estates to work through the priorities. The draft plan will be submitted to Finance, Digital and Estates Committee in December 2026.

11. Recommendations

11.1. The Board is asked to:

NOTE the cost improvement target of £7.8m in 2027/28.

RECOGNISE the 2026/27 exit underlying position

AGREE the submission of a break-even Income and Expenditure plan for 2027/28,

DELEGATE authority for the first plan submission to the Chief Executive and Chair of the Finance, Digital and Estate Committee

Simon Sheppard, Director of Finance & Estates
13 November 2026

North East & Yorkshire

2027/28 Regional Planning Principles

Overarching Planning Principles

Purpose - A shared set of principles for developing, assuring and accepting plans across North East and Yorkshire.

Our collective overarching principles for the planning round are:-

- Share information openly throughout the planning cycle in the spirit of ‘No surprises’
- Engage clinical, operational, finance, workforce and quality leaders throughout plan development. Adopting an MDT approach to support the development and testing of planning assumptions
- Set clear expectations early that translate national requirements and regional priorities into clear tests for an acceptable plans.
- Escalate risks and issues early.
- Demonstrate that plans are realistic, deliverable and affordable, transparently sharing underpinning assumptions and ensuring triangulation.
- Ensure planning decisions are supported by evidence and data.
- Support system-wide optimisation – Providers and ICBs own plans but need to work collaboratively.

Comply or Explain

The key Regional operational planning principle for 27/28 is that providers and ICBs should develop plans that comply with national planning requirements. Plans should clearly demonstrate how expectations will be met.

Non-compliance against any plan requirement should be considered an absolute last resort, only in exceptional circumstances where all reasonable delivery options and mitigations have been thoroughly explored. Where an organisation is unable to meet a particular requirement, this should be explicitly identified and supported by a clear, evidence-based explanation which is supported and agreed by the ICB.

The intention is to promote consistency, transparency and constructive challenge, while recognising that organisations operate in different contexts and may face specific local circumstances. The opportunity to, “explain” any area of non-compliance should not be interpreted as an automatic exemption from a delivery requirement or a means of avoiding appropriate challenge and scrutiny.

In practice, we expect the following principles to apply:

- **Compliance as the default**: Plans should demonstrate how they meet national/local requirements, statutory duties, agreed financial and operational parameters and regional planning principles.
- **Clear and evidence-based explanations**: Where an expectation can’t be met, organisations should explain why, supported by relevant evidence. All areas of non-compliance and underpinning assumptions will be tested through MDT meetings.
- **Assessment of deliverability**: Explanations should consider delivery implications and demonstrate that plans are credible, affordable and fully triangulated across finance, activity, performance, workforce and quality.
- **Executive and Board ownership**: Any areas of non-compliance should be subject to appropriate executive scrutiny and explicit Board oversight, ensuring that the rationale, implications and proposed recovery actions are understood.
- **Credible mitigation and recovery**: For any delivery challenges, organisations should set out the mitigating/recovery actions required, with clear milestones, timescales and measurable outcomes.

Comply or Explain

Any explanation of non-compliance should demonstrate that the organisation understands the issue and has a realistic plan to manage or resolve it.

Any area of Provider non-compliance must be discussed with and supported by the relevant ICB, with clear evidence of system-level consideration, an agreed understanding of the risks and joint commitment to the proposed mitigations and recovery route towards compliance.

Explanations will be reviewed through the MDT arrangements in the first instance and escalated to the Regional Executive Team. The level of challenge will be proportionate to the materiality of the non-compliance and the associated delivery risk.

Where an explanation is insufficient, unsupported by evidence or does not provide credible mitigation, further information, plan revision or further escalation may be required.

In-year delivery risks will continue to be managed through the appropriate oversight and intervention arrangements.

The purpose of this approach is to provide a clear distinction between compliance and non-compliance, while ensuring that any departure from planning expectations is transparent, evidence-based and subject to appropriate accountability.

Ultimately, the objective is to ensure that plans are credible, deliverable and aligned with national and regional expectations.

Planning Principles | Activity & Performance

Expected performance improvement achieved	Organisations should meet mandated performance improvement requirements (e.g. UEC, RTT, cancer standards, diagnostics improvement)
Individual provider performance delivery	Each provider is expected to meet performance standards individually rather than offsetting weaker performance elsewhere.
Trajectories realistic and deliverable	Performance improvement trajectories should be realistic and deliverable and reflect historic performance trends. They should not assume sudden step changes or back-loaded recovery without supporting evidence.
Seasonality	Seasonality should be reflected in performance and activity plans. Straight-line activity and performance plans are not acceptable.
Demand and capacity alignment	Plans should demonstrate robust capacity and demand modelling. Activity assumptions must support performance trajectories.
ICB and provider plan alignment	Plans should align where dependency of activity is required
Left shift expectations evidenced	Plans should demonstrate increased out-of-hospital activity and reduced reliance on acute services over time.
Credible recovery	Plans must show a clear recovery trajectories towards meeting constitutional performance standards.

Planning Principles | Finance

Control total must be met	Plans must deliver within the agreed financial plan limit as a minimum requirement for acceptance.
Contracts signed	Contracts to be agreed and signed by XX. Material issues to be escalated to region early. Plans will not be accepted where contracts have not been agreed/signed.
Exit run rate	Where planned exit run rate is not delivered, 2027/28 plans will not be accepted unless there is evidence of appropriate scrutiny by the Board of the underlying position, and the 2027/28 plan demonstrates recovery of the underlying position to align with the trajectory set out in 2026/27 plans no later than 31 March 2028.
Triangulation	Plans will only be accepted if Finance, activity, quality and workforce trajectories align.
Revenue affordability	Plans must show funding is in place to support additional capacity, workforce and service expansion.
CIP	Plans will not be accepted unless CIP schemes are fully developed.
Left shift	Growth in community spend should be evidenced in plans where applicable.
Revenue affordability	Plans must show revenue funding is in place to support additional capacity, workforce and service expansion.

Planning Principles | Workforce

Optimisation of workforce	Workforce plans should deliver sustainable productivity and efficiency improvement, through improved deployment, team design and digital adoption.
Temporary Staffing	Plans should demonstrate sustained reductions in temporary staffing dependency through substantive and alternative ways of working and workforce transformation solutions.
Triangulation	Plans must be triangulated. Activity, workforce and financial assumptions must not create unacceptable quality or safety risks to the workforce or our patients. Plans should be underpinned by credible baselines and assumptions.
Workforce Supply, Education, Training & Skills Development	Workforce plans should demonstrate the recruitment and staffing capacity required to deliver activity, and performance targets. Workforce capability should support future service models, changes in skill mix. Plans should address recruitment, supply and demand for newly qualified staff, while protecting education quality, placement capacity and supervision.
Talent Management	Plans in place to develop leaders at all levels to support workforce transformation, productivity, staff wellbeing and delivery of future models of care.
Culture & Behaviours, Workforce Wellbeing, Inclusion and Safety	Plans in place to actively improve staff wellbeing, inclusion, safety and organisational culture, retention of the current workforce, including continual improvement in sickness absence rates.

Planning Principles | Quality

Safe, Effective Care	Plans must demonstrate safe, effective and person-centred delivery, with quality at the forefront.
Risk	Plans with unresolved quality concerns, safety risks or deterioration in outcomes must include credible mitigations, clear milestones and escalation routes.
Triangulation	Workforce plans must be fully aligned and triangulated with finance, activity and performance assumptions.
Health Inequalities	Plans should identify unwarranted variation and set out targeted actions to reduce Health inequalities.
Board ownership	Plans must evidence Board ownership and active oversight of material quality risks.

Plan Acceptance Principles

CONDITIONS FOR PLAN ACCEPTANCE

Compliance - Plans should be compliant with national expectations. Any areas of non-compliance should be by exception only and will require a clear, credible and time-bound route to recovery, which is agreed by the ICB and Region.

Credible, deliverable and triangulated - Plans must be realistic, deliverable and evidence-based. Plans should be fully triangulated across activity, workforce, quality and finance using consistent, aligned assumptions.

Financial & workforce sustainability - Plans must demonstrate financial balance and a credible route to workforce sustainability.

Quality at the forefront - Plans must demonstrate how quality is embedded across strategic objectives, delivery assumptions and assurance arrangements, with evidence across safety, outcomes and effectiveness, patient experience, inequalities and long-term value. Quality risks must be actively managed through robust governance.

Delivering the three shifts - Plans must clearly demonstrate how they will deliver the three fundamental shifts in the model of care – from hospital to community, analogue to digital, and sickness to prevention.

Strategic alignment – Plans should be aligned to national priorities, MTP Framework and system strategy, with clear delivery of the three shifts (prevention, community, digital).

Governance – Plans should demonstrate that robust governance arrangements are in place with formal Board ownership.

Plan Acceptance Outcomes

Plans will be assessed and categorised as ‘Accepted’, ‘Accepted with Conditions’, or ‘Not Accepted’, with enhanced oversight applied where delivery risk remains high.

Accepted

Plan meets all core requirements:

- Conditions for plan acceptance
- Planning principles

No material conditions required for approval

OUTCOME

Plan accepted and closed down – moves to routine in-year delivery oversight.

Accepted with conditions

Plan broadly meets requirements, but specific areas need strengthening. Typical indicators:

- Limited triangulation or data consistency
- Weak delivery assumptions or unresolved risks
- Gaps in workforce, productivity, transformation or quality impact

OUTCOME

Organisation must meet agreed conditions and provide evidence of improvement.

Formal plan acceptance is dependent on conditions being met, with potential enhanced oversight and escalation if delivery risks persist.

Not accepted

Plan does not meet minimum acceptance standards. Typical indicators:

- A Plan is non-compliant and/or there is no clear route to recovery.
- The plan is not deemed credible or deliverable
- Material sustainability, governance or quality risk

OUTCOME

Significant revision and resubmission required; an executive leadership meeting may be scheduled, with enhanced regional oversight and potential national escalation if issues remain unresolved.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Promise 6 – Poverty Proofing	**Agenda Item**	Paper V
Sponsoring Executive	Jo McDonough, Director of Strategic Development		
Report Author	Jo McDonough, Director of Strategic Development Ray Hennessy, Deputy Director of Strategic Development		
Meeting	Board of Directors	**Date**	26 November 2026

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

Promise 6 set out to poverty proof all of our services, including addressing digital exclusion. Whilst the completion of the programme took a year longer than planned due to the scale of the work, we have now completed the programme. Good progress has been made against two of the three success measures with some positive impact. More time is needed to see if the actions taken begin to have an impact on our Did Not Attend/Was Not Brought rates, which we assumed in the strategy that they would over time.

However, whilst the work has been significant there is still more to do in making sure all services incorporate discussions about the impact of poverty and cost of living on patients' care and ability to access our services. We also need to be innovative in finding solutions to challenges which our patients and colleagues tell us about. Finally, we must not forget that our own employees face challenges with cost of living and we must continue to find ways to support them.

The Board is asked to consider:

- The impact to date of the poverty proofing work and remaining challenges;
- The areas planned to undertake further work and identify any other areas to consider;
- Support the ongoing strategic intention to address poverty as part of our delivery of care, as an employer and as a community partner.

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

Regular updates to PHPIP and Equity and Inclusion Group.

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors are asked to:

NOTE progress to date;

NOTE further areas of work to deliver in relation to poverty;

AGREE any other areas to focus on.

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

If we 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)							
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)							
See attached report.							

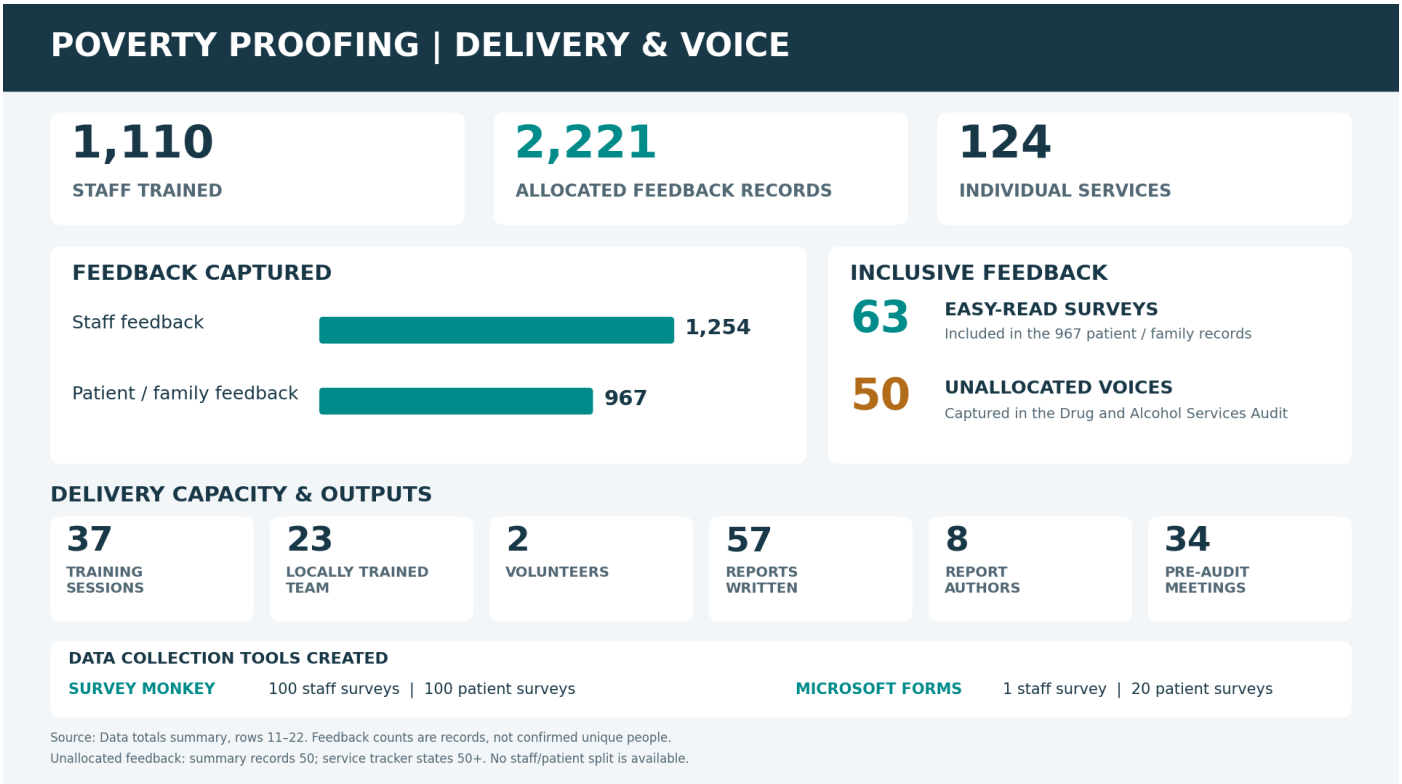
Promise 6 - "Poverty Proof" all our services by 2025 to tackle discrimination, including through digital exclusion.

1.0 Introduction

1.1 Promise 6 set out to poverty proof all of our services by 2025. The Board has previously received reports on progress and the need to extend the programme to September 2026, in order to cover all services. This paper provides an update on progress, achievements and next steps.

2.0 Success Measure One - All our services to have completed poverty proofing and be able to evidence resultant change

2.1 We have now completed poverty proofing audits with all of our operational services (124) and the respective reports are available on our website. We are the first Trust in the Country to have achieved this at such a scale. The infographic below gives an outline of the process, and deliverables. As a reminder, 'poverty proofing' a service entailed training staff on the impact of poverty and how to engage patients in conversations to support them, undertaking surveys with staff about the impact of poverty on them and their patients and surveys of patients and carers. Whilst we have reached a large number of staff and patients this hasn't been consistent across all services, with a small number of service not engaging well in the process.



2.2 Key themes from patient surveys were:



3.0 Resultant changes - patients

3.1 There have been a range of recommendations arising from these audits, including some that have required a cross-organisation response. More details are given below on the actions we have taken to address the concerns raised by patients and carers.

Self-booking of appointments

3.2 Self-booking of appointments through SystmConnect is linked with the Trust's work to reduce inequalities and poverty-proof services. SystmConnect gives patients another, more flexible way of contacting services and managing aspects of their care digitally, while helping services manage and triage demand more efficiently.

Travel Fund

3.3 Alongside the changes to the (self) booking system, in June we introduced appointment text reminders to patients. We also now send a text to offer patients support with their travel costs if they are struggling to attend their appointment. Patients are offered either a free one-day bus pass in Rotherham or Doncaster or free community transport via a provider in North Lincolnshire (as no such bus pass is available). Through this process, we have issued 260 bus passes for Doncaster, 60 in Rotherham and supported 5 community transport requests in North Lincolnshire. Clearly the take up of this offer is low in North Lincolnshire. More analysis and work will be undertaken to understand this variance, including with the VCS in North Lincolnshire.

3.4 This is not the only route where people are offered travel passes. Here are other examples:

- People Focused Group (PFG) have a supply to assist with people getting to appointments with their peers;
- Doncaster North Mental Health Team and Doncaster Primary Care Hub to support people to get to their appointment;
- In physical health TVALS, Continence Service, Community Nursing;
- Aspire to support people with their substance misuse appointments;

- Trialling through Conisbrough GP Practice to support people who are being referred to us by primary care.

There are some case studies emerging of the impact this offer has had (see Appendix 1 for an example), and in 2027 we will undertake further evaluation to assess impact.

Interpreter Service

3.5 An area of improvement that was identified, particularly through the earlier poverty proofing audits, was the poor reliability and quality of interpreter services. The Trust has a new provider for interpreter services since September 2025. The Equity & Inclusion Sub-CLE Group has overseen the move to this new service and has been monitoring coverage of all languages and requests by the new provided. It has also been monitoring the use interpreters across all trust services to understand where there hasn't been a booking and why. It has been made clear that cost of interpreters must not be a barrier to services booking if a person needs one.

3.6 Between April and October 2026, over 5,000 booking requests have been made which are face to face or online. Over 71 languages were requested with the 'top 6' by demand being Polish, Slovak, Arabic, Romanian, Farsi, and Urdu. Since the beginning of 2026, five incidents have been recorded on Radar regarding interpreters (example being the interpreter did not attend). The majority of our services have accessed interpreter services and all know how to access.

4.0 Digital

4.1 For the ***'…including digital…'*** part of Promise 6, we can now safely turn retired trust devices into digital devices which can be provided to those people in our community who may not have been able to afford them. How this works is shown in the image below.



4.2 By piloting and working with the local citizens advice organisations and others, 19 Laptops, 6 tablets, 5 phones have been either requested or supplied since July. This comes to a value of £21k. By partnering with citizens advice, it also means people can access low cost data.

5.0 Community of Practice

5.1 We have established a Poverty Proofing Community of Practice within the trust, and we are starting to hear of some changes being made by services as a result of the process. The table below shows some examples.

Hasan Qasim (Rotherham Inpatients) told us:
• There has been a big focus on improving access and awareness around translation services – 24/7, emergencies etc. • They continue to develop strong links with community teams. • Supporting incontinence remains a priority within the service. • There is work to be done on making the wards more contactable to families/carers.
Selina Khunkhuna (Talking Therapies) told us:
• They are actively referring into the in-house Citizen's Advice offering, with strong uptake. • High utilisation rate of translation services. • Highest uptake at RDaSH of Poverty Proofing training. • Flexibility of appointments is always improving. • There is more work to be done on offering out-of-hours appointments, and this is recognised.
Theo Browne (Children's Neurodiversity) told us:
• They are trialling system connect to enable parents to book their own appointments subject to availability. • Clinical reports are now more neuro affirming and streamlined for parents. • Citizen's Advice have attended the NL meeting to advertise their services. • Currently trialling a one-day clinic model to reduce travel for the patients. • Post diagnosis teams are utilising the community hubs.

6.0 Resultant changes - staff

6.1 Key themes from staff surveys were:



6.2 A number of actions have been taken in the trust to support colleagues with cost of living challenges and poverty:

- In April 2025, the trust delivered on Promise 25 to achieve Real Living Wage Accreditation with approximately 20% of our colleagues moving onto the Real Living Wage;
- Food cupboards were funded and stocked across trust sites to provide support to colleagues;
- Free period products were made available for colleagues;
- The trust Hardship Fund was established and promoted to support colleagues access funds when needed;
- Mileage rates for community workers were increased to support those struggling with the cost of fuel. The trust had already provided an uplift over and above agenda for change rates and this was increased further in the Summer of 2026 and has been again in November 2026;
- Offered 'Transave' service to colleagues- providing the opportunity to save funds and access discounted loan rates.

7.0 Success Measure Two - Benefits and debt advice access to be routine within Trust services to tackle 'claims gap'

7.1 We partnered with our three local Citizens Advice organisations to provide money and debt advice for patients and staff. This is based upon a simple referral process, with the respective Citizens Advice organisation proactively following up with the individual (in person or via the 'phone). This overcomes the traditional 'signposting' approach that is often in place, that can mean a delay in a person getting to see someone for support.

7.2 The table below outlines the overall impact since this started in 2025/26: over 1,100 people have been supported with potential income gains or debt managed / written off exceeding £2 million. With continued awareness raising of this offer, the number of people seen in the first six months of 2026/27 exceeds the number seen for the whole of 2025/26. A case study of the impact on an individual is shown at Appendix 2.

Place	People Supported	Potential Income Gains	Debt write-offs and other
Rotherham	501	£553k	£211k
Doncaster	432	£552k	
North Lincs	231	£881k	£127k
Total	1,164	£1,986k	£238k

7.3 Whilst the progress so far has been positive (importantly, especially for those individual households that have been supported), we continue to use progress to refine and learn. For example:

- In North Lincolnshire, an advisor has been linking in with staff and peers working through the Acorn Centre. This includes having a drop-in as well as time for scheduled appointments;

- In Doncaster, based upon low service take up there will be a presence at the Jade Centre. This is to raise awareness with staff, and be a prompt for those who may not know the offer exists;
- Rotherham Citizens Advice are providing Fuel Poverty Awareness on our Learning Half Days;
- Sharing the offer with and to our peers, so they can make people aware this is available (e.g. patients on wards).

8.0 Success Measure Three - Sustained reduction in service attendance gap in lower decile

8.1 The third success measure related to this promise assumes that by supporting people with cost of living challenges and other challenges, they are more likely to attend their appointments and therefore, reduce the overall Did Not Attend / Was Not Brought (DNA / WNB). This is especially so for those living in our more deprived areas where the DNA/WNB rates are higher than other areas. The data is shown below.

	Target	2024/2025	2025/2026	Apr	May	Jun	Jul	Aug	Sep	Oct	Current Year Total
Promise 6 - Poverty proof all our services by 2025 to tackle discrimination, including through digital exclusion.											
⊟Sustained reduction in service attendance gap in lower decile neighbourhoods		3.85%	3.86%	3.96%	3.55%	4.04%	3.98%	2.91%	2.55%	2.43%	3.28%
Total DNA contacts	---	32201	34162	3082	2708	3200	3190	2696	3100	1892	19868
Total contacts	---	836747	884933	77749	76273	79224	80068	92755	121349	77827	605245
⊟Reference figures for the remaining decile neighbourhoods		2.27%	2.31%	2.47%	2.28%	2.49%	2.46%	1.84%	1.63%	1.52%	2.07%
Total DNA contacts	---	23658	25634	2302	2084	2462	2552	2045	2279	1423	15147
Total contacts	---	1040917	1110353	93135	91471	98929	103807	111214	140165	93424	732145

8.2 Progress on this measure is likely to take time to improve. As of October 2026, people living in the most deprived neighbourhoods continue to have higher non-attendance rates than those in less deprived areas; however, the gap is slightly narrower than in 2025/26. The year to date also shows a modest decrease in DNAs/WNBs as well, suggesting that poverty-proofing and access improvement measures may be helping to sustain progress. This will be monitored closely over the coming months.

9.0 What are we doing next?

9.1 As well as sustaining the actions described above, it is vital that we continue with our work to support patients and colleagues with the impact of poverty and the cost of living. We are in the process of plans to implement the proposals below.

Food and money – putting funds in 'clinicians hands' to support patients.

9.2 Our poverty proofing audits highlighted that staff often find patients living in their own homes with no food at all. Through their own goodwill, staff have been buying patients food but struggling to claim back these costs from the Trust.

9.3 In order to prevent this, we plan to:

- Introduce local (petty) cash funds so that clinicians can support patients with things like food, clothing, bedding, carpets and other one-offs such as train fares to go to embassies;
- Make sure there are food cupboards including toiletries available in the trust for staff to access food for patients from;
- Provide supermarket food vouchers, to help for example someone is discharged from a ward and the local foodbanks are closed;
- Ensure we help people to access money and debt advice;
- Systemise the use of local grants and other things available in communities, with the help of our Communities of Leadership Executive (CoLE).

Money and Debt Advice

9.4 Use referral data from Citizens Advice to understand better which services are referring or not and work with those services to support improvement. For example, we know that across the Trust our mental health inpatient services and services under Doncaster Care Group are not referring as many people for advice as we would expect. We know that some services use other means for people to get support (examples being Children's Services have advice available in Family Hubs, Rotherham Wards have support through P3), the analysis can then be used to target individual services to encourage uptake. We will also work closely with Peer Support Workers to promote and understand any barriers.

Routine Financial Conversations

9.5 Our work will have raised awareness of the impact of poverty on patients and colleagues, but there is still more to do to build confidence in having those conversations and being aware of what we can do to support. We will establish a programme of one hour training for staff on how to have constructive conversations about finance with patients that will be available on Learning Half Days.

Help with Prescription Costs

9.6 CoLE have identified this as a priority for its poverty proofing work. The Chief Executive of Citizens Advice Doncaster is the CoLE lead on this,and will be working with the Deputy Director of Strategic Development on proposals.

Using AI to predict people at risk of DNA / WNB

9.7 Sheffield Children's FT have a process in place which uses artificial intelligence to predict the level of risk whether a child or young person will not be brought to their appointment (based upon socio-economic data of all their caseload). Working with our own system provider, we will explore how we can build the same capability with our Informatics Team.

Travel Fund

9.8 As well as a general evaluation, there will be more understanding sought about the low take-up of the travel fund offer in North Lincolnshire working with VCSE.

Evaluation

9.9 We will be working with Children's North East on an evaluation of the proverty proofing programme to look at impact and identify any further areas to take action on.

10. Next Steps

10.1 The Board is asked to note the position in respect of the progress made to achieve Promise 6, and actions to be taken forward.

Appendix 1 Travel Fund Case studies

Doncaster CMHT

Patient had engaged with the assessment stage of the Complex Emotional Needs pathway and was identified for treatment with the secondary mental health service.
Within this the expectation for this pathway is for the patient to attend 1x group session f2f and 1x individual session f2f or via teams per week for a total of 6-12 months.
This is a huge commitment that the patient was able to show they were in the preparation stage of the cycle of change and wanting to address their presenting issues. Their treatment was well under way but suddenly it was noted by the practitioner a pattern of DNA's and cancellations recently had occurred.
The patient appeared to be disengaging and there was a query in-line with the treatment pathway guidelines to discharge the patient due to non-attendance. On discussing this further there had been additional social presenting issues that had arose that the patient had discussed minimally in their sessions.
It was queried on further discussion whether a financial impact was causing the patient to be unable to engage in the identified treatment pathway. This was addressed with the patient who agreed this was the case of which they felt ashamed of and felt discharge was the only way forward. The patient was provided with a total of 3 daily bus passes.
The result of this was the patient was able to engage in his treatment pathway whilst await a change in his finances, prevent an early discharge and complete his treatment.
The discharge from CMHT was successful and the patient had received the appropriate treatment pathway.

Community Wellbeing Team

The Peers are supporting a gentleman who would normally pay £88 a month for bus travel to attend appointments and groups that are vital for his mental health. An unexpected bill meant he could not afford this cost for the last three months.
Living in Adwick, he has often resorted to walking three hours round-trip to the city centre just to attend essential appointments. Despite our efforts, he does not meet the mobility PIP criteria required to access a long-term bus pass. I therefore gave a one-day pass as he had appointment at DRASACS (Doncaster Rape & Sexual Abuse Counselling service).

Appendix 2 – Money and Debt Advice

Case Study 1

'Bob', a 25-year-old White British male, was referred to Citizens Advice North Lincolnshire (CANL) by the RDaSH Talking Therapies service. Bob was living with complex and ongoing mental health challenges, which had significantly affected his ability to maintain employment and led to unstable income and growing debts.
Over several appointments with CANL, Bob received comprehensive support, starting with a full benefits check. This identified potential entitlement to:

- Universal Credit (UC)
- Personal Independence Payment (PIP)
- Council Tax Support (CTS)
- Discretionary Housing Payment (DHP)
- Limited Capability for Work and Work-Related Activity (LCWRA)

With guidance from the adviser, Bob successfully submitted claims for all of the above. His projected annual income, based on successful claims, is approximately £19,082.20. While decisions on PIP and LCWRA are still pending (with an expected processing time of 4–6 months due to DWP backlogs), securing UC and other support has already begun to stabilise his financial situation.
Bob also received energy advice and was issued fuel vouchers worth £30 per meter, helping him stay on top of essential utility costs during a difficult period. In parallel, Bob is now being supported by the CANL Debt Advice team to begin addressing and resolving his outstanding debts.
Bob said that he has felt supported and listened to throughout the process. While his mental health continues to fluctuate, Bob shared that he feels there has been real progress, and he is thankful for the service and the support provided.

Case Study 2

The care coordinator for 'Simon' referred them to Citizens Advice Rotherham & District (CARD) immediately after his discharge from the ward. Simon had lost his accommodation in the months after he was detained under section. Simon faces criminal charges for behaviour that happened because he was so very unwell at the time. Simon hallucinates when he is having a spike in their underlying psychotic symptoms.
Simon needed CARD help to make sense of the benefit applications he made when first arrested and lost his job. The applications were made a very short time before he was detained. This meant that benefits agencies rang Simon while on the ward and spoke to them about his claims, undertaking telephone assessments. This was done without acknowledgement by DWP that they were speaking to a person who was so unwell at the time that they thought that they had scanned and emailed documents using a folded towel.

CARD supported Simon to secure their right to resubmit for a higher rate of benefit and support from DWP. CARD referred them to a specialist service who can help Simon appeal the entirely inappropriate zero award decision for Personal Independence Payment (PIP). Simon shared with CARD that they are now getting support category Employment Support Allowance and fully engaged with the PIP appeal. Simon shared that the help received means they feel much more positive about his future prospects and capacity to cope.

Case Study 3
A nursing assistant referred ‘Carol’ to CARD for help with his managed migration from a legacy benefit to Universal Credit (UC). Carol had at that point been under section for approximately five months.

In that time, Carol was selected by DWP to go through the mover to UC. The deadline for this was approximately a week and a half after the referral. Carol was seen on the ward with the support of staff who know her well and have earned Carol’s trust. Carol remains very unwell and it was clear she would not be able to speak to DWP or be directly involved in any way.

The workers on Carol’s ward worked with CARD to support her in this matter. CARD were able to secure an indefinite delay to Carol’s managed benefit migration and allocation to a complex case manager within DWP.

This means that Carol will have a higher level of support and the professionals supporting Carol will be able to further support her when she is well enough to leave the ward. The allocation to a complex case manager means that DWP will see her in a holistic way as a person

****Paper to be managed via questions only**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	High-quality therapeutic care taskforce: follow up work	**Agenda Item**	Paper W
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	26 November 2026

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

This is in places a sobering read. Two cycles of reviews at executive level with our acute DMTs suggest both continued commitment to, and limited capability to, implement the changes with purpose that were co-constructed with clinicians during 2025/26. The implementation of Always Measures from next month will further test that capacity.

However, that same introduction will help to bridge the data-gap set out in this paper, where we have not put into place some of our promised enablers. Doing so, allied to a continued focus on MPLT and ward manager development does suggest that there is a vitamin effect possible in H1 of 2027, as these threads come together.

As with other papers before the board, the twin pressures of ward sickness, and acute demand, overshadow the work. Until we see these pressures abate this work will remain the 'nice to have' steps that follow when headspace allows.

Previous consideration

March 2026 HQTC Taskforce closure report

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE the identified strengths and weaknesses identified through directorate reviews

CONSIDER the depth of change required by staff and patients within our wards

RECOGNISE the need to continue to develop ward managers and the wider MPLTs we have begun to create if we are to see sustained quality improvement at ward level

AGREE to receive a further update in May 2027 drawing on patient and carer feedback

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
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

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

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

Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	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.	
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Partnership Working	**High Tolerance**	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	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 we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If seven-day working and other bed-based service alterations are not implemented fully because of resistance, inflexibility or affordability - with colleagues able to move elsewhere (where such difficulties are not occurring) then we will continue to place patients out of area and see severe stress and burnout; and increased turnover, among our own employees.	X

If we do not achieve the step-up in institutional and system capability to deliver multiple time-bound simultaneous changes with impact by 2027 because we do not develop and practice the skillsets required to make change occur then the Trust's strategy will not achieve what it has promised and we will face reorganisation, frustration and turnover among employees							X
System / Place relevance (advise whether it is national, regional or local)							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Appendix (please list)							
n/a							

ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

High-quality therapeutic care taskforce – further stocktake of work across our wards

Context and purpose

1.1 Through 2025, ending in March 2026, the clinical leadership executive brought together leaders from our inpatient mental health wards to seek to drive greater consistency of approach and to see improvements in the quality of care we were able to offer. **That taskforce closed in March**, with a report to the Board, and a commitment to continue the work in a variety of ways, discussed below. Then we committed to sustain some Board oversight and discussion, with a stocktake in November 2026. Part of that commitment was to not "move on" from the work nor to believe it was concluded, even as we look to bring similar developmental focus to our community teams through the extant community powered healthcare taskforce, co-chaired by the author and Glyn Butcher.

1.2 Within the wider papers before the Board at this time, are considerations of staffing safety, which paint a picture of 'just about' acceptable levels of staff on shift: with acuity matched (MHOST) but rostering and sickness pressures creating real fragility. At the same time, rising demand and a desire rarely to use out of area placements is leading to common invocation of leave bed policies, S136 repurposing, and use of some older adult beds for working age adult care. We have not reduced length of stay materially through 2026 as we had hoped we could, though there are some green shoots within Rotherham, and some good practice in our Doncaster wards.

1.3 Some of the key enablers for change and oversight are now in place, others are not. *Ward scorecards*, providing an overall evaluative view of ward performance, are delayed with the chief nurse and chief executive and should be in place in Q4 rather than Q2 as we had hoped. *Reviews of our acute directorates* have happened quarterly and take place again in January: they provide much of the window to inform this stocktake. And our multi-professional leadership teams, or *MPLTs*, are taking shape within the wards to varying degrees of cohesion: albeit the construct, which took time to create, has got some traction on the back of the development programme being co-led by Carlene Holden and Steve Forsyth.

What's the state of our wards' processes presently?

2.1 The taskforce endeavoured to introduce some core processes consistently across our mental health wards. That scope was broad across considerations of safety, leadership, and process. For example, we introduced standard **ward visiting hours for carers** across the Trust seven days each week. By opening up our wards to carers we hoped to support recovery but also to see better engagement with loved ones in our ward teams. Those visiting hours remain extant, and informal feedback remains positive. We have had a handful of instances that have needed intervention to ensure that carers are welcomed within our wards, and indeed within MDTs, as the standards we set expected. Our last culture of care assessment saw some gains in this area,

and we continue to work with patients who have been detained to share their experiences of care, bringing that work into our mental health act committee.

2.2 Weekly monitoring of our **care planning approach**, DIALOG+, continues and ward delivery at, or close to, 100% remains. The exceptions typically sit around organic diagnoses (dementia etc), and the clinical leadership executive will review in December our agreed use of alternative rating scores and care planning approaches for these older adults. As with DIALOG+ more widely, attention is shifting to quality alongside quantity, and there are reasons to be concerned about teams understanding of, and functional ability to deliver, what DIALOG+ expects: some report struggles with updating the tool, using it in live form within MDTs, and certainly with transitioning the report between inpatient and community settings – CPHT will examine solutions for this significant weakness when we meet in December.

2.3 Review with our ward leaders suggests that there is now consistent application of **the PIPA and MDT standards** on a five day a week basis. In the main the distinction between the two 'meetings' is being better understood in practice, and teams are following through actions arising from PIPA meetings, with most having some structure to that loop closing. MDT functioning is more mixed, albeit there are positive reports of community team engagement, and use of the better IT introduced in early spring 2026. Long stay patients, poor use of a discharge planning checklist in some cases (CE for example), and rapidly rising length of stay in North Lincolnshire, should make us cautious in feeling that these meetings are as purposive as they need go be, rather than sharing information more descriptively.

2.4 The key outbrief from the closure report sought to next introduce **diagnosis-based length of stay into every ward**, inside five days of admission. This is now consistently in place in our Doncaster and North Lincolnshire wards, with Rotherham catching up to put this in place. Most RCs (responsible clinicians) can see the connection between this work and Expected Dates of Discharge (EDDs), but EDD delivery remains weak (at just over 30%) – and we can only now start to compare EDDs set to the length of stay we would expect by diagnosis. A Q4 analysis of that alignment will be key to supporting the directorate reviews taking place in April 2027.

2.5 We agreed within HQTC, and then formalised through CLE, processes both to manage **the use of leave beds**, and expectations of discharge before 11.00 am (a sitting out process). Positively we have seen the policy for leave beds being used, with recognised limitations identified elsewhere regarding S17 documentation. But of course, that places pressure on staff, and creates some anxiety among patients too. A review of how the policy is working, and how that experience can be improved, will take place in January 2027 drawing on feedback from ward leaders.

2.6 A key focus of the past work was the introduction of **seven-day therapeutic activities into our wards**. This reflected our own peer review visits, as well as the outcome from the prior CQC inspection process (2025) which criticised a lack of stimulation and diversion, especially over weekends. Significant delays in creating the dataflow through safe care have led to a lack of visibility until very recently over real take-up and an inability to use safer staffing meetings to balance this focus on activities as core work, key to reducing

restrictions and potentially violence against staff. In April 2027 internal audit will undertake an audit of our H2 safer staffing processes specifically focused on how they approach therapeutic activities. Meanwhile, and more positively, the commitment to activities among directorate leaders and ward teams remains strong, with requests for still better community connection, and more reliance on peer support. Of the cited items in this section of the update, it is the prevalence of therapeutic activities that gives greatest cause for concern, albeit conversely this is the area where, when undertaken, we have the greatest confidence in the calibre and effectiveness of action.

What happens next?

3.1 We were due to undertake a Trust-wide **Royal College of Psychiatrists' Accreditation programme for all of our wards** in October 2026. Weak preparatory oversight has led to this being delayed to April 2027, but evidence gathering should be complete in November 2026. This evidence file should additionally inform our insight and response to the recent Care Quality Commission review of our wards, which we anticipate will offer significant criticism of some processes related to medication, sexual safety, flow, care planning, and staffing sufficiency. Engagement with the accreditation process among ward managers and matrons will be important, not least as the process of RCPsych evaluation includes on site time in April, spending time with teams to explore their perspective on compliance: we will work to ensure that patient and carer voice is also central to this assessment.

3.2 We have decided to go-live with **our Always Measures across our wards**, including mental health wards, from December 7th 2026. This will test in live time the ability of our nurses-in-charge to support teams to deliver four routine standards and the fifth expectation of identifying unmet needs. The hope is that this work both closes a gap in consent and carer assessment processes, as well as reducing gaps of understanding between our shift, ward, directorate and more senior leadership. When we undertake acute directorate reviews in January we will have initial data in place through which to explore this shift-by-shift management, which we will place alongside e-roster and safe-care information. It seems reasonable to expect our supernumerary band 7 ward managers to be able to triangulate this data, using it within supervision, as well as in making operational decisions about how best to run their wards.

3.3 We need to recognise that during Q4 we will need to respond to **the recent CQC inspection**, from which a report is anticipated in early January 2027. Whatever the frustrations felt by staff and leaders over the style and conduct of the inspection, it will offer a valuable insight into some standards, and certainly into how some staff feel. In respect of the gender separation of our bed base, we had agreed earlier in November to undertake an analysis of the last two years, and how well we are managed to meet our day-to-day corridor separation expectations: this can inform our mixed sex compliance declaration. The cost and disruption of moving to gender separated wards would need to be weighed carefully, and with unbundling deferred it seems unlikely that this will be a commissioning priority in the near-term.

3.4 We know that **staffing consistency** and stability sits at the root of many of the challenges our people face. Recruitment and sickness continue to be issues for our ward staffing, the former in roles beyond nursing, the latter

focused on registered and unregistered staff. Changes in approach to short term sickness are set out elsewhere in the Board's papers. Two important steps in coming weeks and months are: the introduction of defined seven day working expectations among ward managers across all of our sites, as we look to ensure weekend seniority is more robust; and the implementation of *team rostering* in all our wards before April. Given lead times this means changes from January 2027. We will specifically update the Board on this work and the rollout plan when we next meet. Team rostering, sometimes known as self-rostering, will, we believe help with staff autonomy and work-life balance as we look to bring better flexibility into our shift work.

<u>Getting some basics into place with more rigour in Q4</u>

4.1 The delays in creating data-flows impede the prevision of analysis we are able currently to offer. Each are on the edge of solution:

- Most positively, the better take up of diagnosis-based LOS does mean that we will be able to compare what is being planned and what is being achieved against the EDDs set. However, there is limited evidence that EDDs are being used in the manner they should, rather they are a descriptive label. Managing to an EDD is simply central to having a system of flow that can safely balance the next patient with the current one. That understanding is too narrowly held in our system at present.

- We should from January be able to use Safecare to have insight into hours of therapeutic activity, spread across the week, and the balance of group and individual work. Our Doncaster acute directorate are the only one of three, currently analysing data and seeking to drive this work on an aggregated basis. A much clearer personal accountability through our matrons for this item will be key, recognising we have one of three roles vacant, and a second who started in post in late October.

- Whilst we have much data about our wards, the care we provide, and how they are staffed, we do not pull that information together. As we discussed in March that can lead to whack-a-mole approach to intervention and support. Significant weaknesses in the North Lincolnshire care group have diverted the majority of executive attention in H1, while the Board would recognise that performance concerns in our Swallownest Court wards persist, including in feedback from the deanery and some of our trainees. A prototype for the scorecard will be visible in the second week of January.

4.2 We will, as we planned to do, seek to join up the dots between inpatient and community settings by hosting both HQTC and CPHT teams in a single conference event. This will help to look more at the boundary-edge of work, both in admitting and discharging patients. Moving into 2027/28 we would expect that to focus on:

- Reducing friction and improving practical alignment for EDDs of admitted patients, whether they were previously in services before admission or not

- Improved and enhanced structure to risk taking associated with avoiding admission, including but not limited to work on crisis-bed alternatives, and the wider role of our Home Treatment Teams, a resource which remains relatively under-considered by our improvement work to date

4.3 None of this will deliver in a sustainable way unless our ward managers and MPLTs are both in place and highly functional. We do have a ward managers group who meet regularly with the chief nurse, and as described above we have a development programme for our MPLTs. Further consideration is needed now to how that architecture, and the role of our acute directorate DMTs, can be more clearly documented and expectations and responsibilities set. With operational pressures, and staffing gaps, it is too easy to overlook the support needs within this immature system, but also to miss the accountability that should be expected in adhering to core processes, be they care planning or roster discipline.

<u>Concluding comments</u>

5.1 There remains genuine and real commitment to the various ideas and outcomes from the HQTC work. Management capability, and capacity, remain a barrier to better implementation.

5.2 The data limitations cited in this paper then make it difficult for us to have genuine oversight of the quantitative impact of changes made, and there is too much reliance on impression and narration.

5.3 The four major changes described for Q4 in this paper are significant. Positively they can be mutually reinforcing, but of course the risk of overwhelm is evident. Discussions with care group SLTs about how they are supporting their acute directorate DMTs will be a feature of delivery reviews through this period.

Toby Lewis, Chief Executive (taskforce chair)
November 23rd 2026

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Serious Patient Safety Incidents: Learning (Update — April 2024 to 8 November 2026)	**Agenda Item**	Paper X
Sponsoring Executive	Steve Forsyth, Chief Nurse		
Report Author	Steve Forsyth, Chief Nurse		
Meeting	Board of Directors	**Date**	26 November 2026

Suggested discussion points

May 2025 Board paper — 2024/25 learning: Revisit the learning from 18 completed PSIIs and the nine recurring themes: communication, record keeping, personalised care planning, family and carer involvement, access to mental health and A&E services, engagement with people who disengage, contextual risk assessment, physical healthcare and timely crisis support. The focus is what changed in clinical practice and service delivery, and whether the actions agreed were realistic, achievable and sustainable.

May 2026 Board paper — 2025/26 learning: Consider the subsequent year's learning alongside progress on the 2024/25 actions. Eight incidents were considered for PSII, with six proceeding to investigation and two managed through alternative learning responses. The Board noted progress in referral and access pathways, risk assessment, physical healthcare and crisis response, while recognising that improvements were not consistently embedded. Documentation, family and carer involvement, and transitions and discharge planning remained priorities.

Board focus — evidence of sustained improvement: Test whether the response to the May 2025 learning has addressed the themes recurring in the 2025/26 paper. At the May 2026 meeting, the Board required clearer timelines and measurable progress, particularly for documentation and transition safeguards, rather than an overly reassuring account of action completion. Seek evidence that changes work reliably in day-to-day care, supported by audit, family and carer feedback, and the systems, equipment and protected learning time needed alongside training.

Previous consideration

Public Board incident-learning reporting during 2024; March 2025 PSII discussion and revised learning update on 29 May 2025; March 2026 Trust-wide learning reporting and PSII learning report on 28 May 2026. Related Quality Committee, mortality, Regulation 28, delivery-review and 360 Assurance material informs the longitudinal review.

Recommendation

The Board is asked to:

NOTE revised governance approach to now be taken from 1/12/26 through Q4 to tracking of agreed actions, conscious of report due in May 2026

RECOGNISE that the pace of change and adoption of revised approaches is too slow

DISCUSS how our learning infrastructure can be better used to support narrative and take up of change from these key harms

ACKNOWLEDGE work to be led by the Chief Executive within CLE in January and February 2027 which will look at the care group level infrastructure for quality and safety alongside the support model provided and funded within clinical corporate directorates

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

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

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

Strategic Delivery Risks	
If 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
Trust-wide learning with investigations in Rotherham, Doncaster and North Lincolnshire; none in the current cohort related to Children's services. Relevant interfaces include inpatient, community, crisis, liaison, local-authority and acute-provider pathways, including AMHP information transfer. Improvement must be tested across intended services and partners.

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

Serious Patient Safety Incidents

Learning and confidence update

Longitudinal review: April 2024 to 8 November 2026

Reader note

This report discusses suicide, unexpected deaths and serious harm. It uses anonymised information and avoids unnecessary detail. Support should be made available to anyone who finds the content distressing.

Board summary — 2024/25 learning update (May 2025)

This summary covers the 2024/25 Serious Patient Safety Incidents – Learning update reported in May 2025. It focuses on the learning, proposed actions and evidence available in that paper, excluding subsequent developments.

May 2025 position	The May 2025 report presented 18 of 19 PSIIs for 2024/25. It identified weaknesses in communication, records, personalised care, family/carer involvement, access and waiting, disengagement, risk assessment, physical healthcare and crisis/seclusion practice. Some learning remained imprecise, and delays had limited timely sharing and embedding.
May 2025 commitments	Key PSII learning was to enter the delivery-review cycle from May 2025, with a sample of specific 2024/25 actions to be audited in July and August.
Board discussion focus	Test whether the actions are realistic, achievable and sustainable; note the proposed success measures; and establish how, where and when changes will be evidenced. The May 2025 report identified learning and actions, but did not establish comprehensive confidence that improvements were embedded.

1. Purpose and evidence standard

This report brings together the Trust's Public Board reporting on serious patient safety incidents and organisational learning from 2024 to November 2026. It draws on the 2024 incident-learning material, the March and May 2025 PSII papers, the March and May 2026 learning papers, mortality and Prevention of Future Deaths reporting, the PSII action tracker, delivery-review records, internal audit material, Quality Committee papers and relevant correspondence.

The evidence standard used is deliberately practical. "Action completed" means there is a record that the stated task was done. "Changed practice evidenced" means there is objective evidence that staff are using the new process. "Outcome demonstrated" means the intended benefit or reduction in risk has been measured. "Sustained" means the change continues over time and across the intended services. These are different tests and should not be treated as interchangeable.

2. The longitudinal position: 2024 to November 2026

2.1 2024: moving from investigation counts to meaningful learning

The Trust's 2024 reporting took place as PSIRF was being embedded. The core challenge was already clear: the organisation needed to move beyond describing incidents and completing investigations, towards identifying system learning, assigning practical actions and testing whether those actions changed care. Earlier Board discussion, including the Chief Medical Officer's March 2024 analysis, identified a similar demographic pattern in suspected suicides to that subsequently seen in 2024/25. The later May 2025 paper reported that the number had reduced, but the demographic remained dominated by middle-aged men.

During this period the Trust was developing a broader organisational-learning model. Work led by Dr Judith Graham described learning as a connected system drawing on incidents, complaints, safeguarding, Freedom to Speak Up, infection prevention, health and safety, patient and staff feedback, national inquiries and external scrutiny. Proposed routes included team reflection, after-action review, learning half-days, professional meetings, Learning Matters, delivery reviews and Board committees. The strength of this approach is breadth; its risk is that dissemination can be mistaken for implementation.

2.2 March and May 2025: the first full PSII learning account

The March 2025 Board discussion concluded that too many investigations were not yet reported and that learning and success measures were insufficiently clear. The revised May 2025 paper therefore presented 18 of 19 PSIIs from 2024/25. It reported 23 proposed PSIIs: four were addressed through other proportionate learning responses, one was subject to an independent investigation connected with criminal proceedings, and 18 were reported as completed PSIIs.

The May paper was notably candid. It apologised for the harm experienced, acknowledged that some learning was imprecise, and asked the Board to test whether actions were realistic, achievable, measurable and sustainable. It identified nine recurring themes: communication; record keeping; personalised care planning; family and carer involvement; access and waiting; disengagement; risk assessment; physical healthcare in mental health services; and crisis/seclusion practice.

It also made two specific commitments: key PSII learning would be escalated through delivery review from May 2025, and a sample of 2024/25 actions would be audited during July and August 2025. Those commitments were sensible because they attempted to move from report production to operational confidence. The evidence position against them is considered in section 7.

2.3 2025/26: a more proportionate PSIRF approach, with variable evidence

The May 2026 Public Board paper reported eight incidents considered for PSII during 2025/26. Two were managed through alternative learning responses and six proceeded as PSIIs. This reduction in full investigations is consistent with PSIRF's proportionate approach: a full PSII is not required for every serious incident if another learning response is more likely to add value.

2.4 Position at 8 November 2026

The current draft records 15 investigations commissioned since May 2025, of which 11 were recorded as completed and four remained ongoing. Nine related to Rotherham mental health services, four to Doncaster mental health and learning disability services, and two to North Lincolnshire mental health services. Acute mental health accounted for the largest share. None related to Children's services. Suspected suicide remained the most common incident type, with other investigations concerning physical-health deterioration and assault.

3. What the investigations repeatedly tell us

Clear, timely and reliable records

Important assessments, decisions, care delivered and outstanding actions were not always recorded clearly or promptly. Poor recording does not prove that care was absent, but it weakens continuity, accountability and the Trust's ability to demonstrate safe decision-making. The same issue appears in PSII, mortality, CQC-readiness and Regulation 28 learning.

Communication with patients, families and carers

Correspondence was sometimes generic; next-of-kin information was not always accurate; and families were not consistently involved in leave, discharge or safety planning when appropriate. Structural improvements are visible, including carer networks, written-response processes and audit expectations, but case reviews still show uneven practice.

Handover, transitions and follow-through

Risk increased when care moved between inpatient, community, crisis, liaison, local-authority and acute-provider pathways. Information and responsibility did not always follow the person. Earlier discharge planning, direct contact after referral, safety huddles and clearer MDT ownership are sensible controls, but their reliability across services is not yet fully demonstrated.

Physical healthcare and medicines

Investigations identified diagnostic overshadowing, delayed escalation, omitted medicines, unclear prescribing instructions, depot continuity and the need for specialist advice. RDaSH has introduced competency work, training,

care-plan audit, safety huddles and medicines controls. However, later lithium and shared-care reporting shows that reliable identification and monitoring of all patients remained an active risk.

Person-centred formulation, safety planning and leave

The repeated lesson is that safety cannot be reduced to a score. Care needs to consider the person's changing circumstances, distress, behaviour, physical health, relationships, recent losses, family knowledge, strengths and protective factors. Leave decisions require a current, proportionate assessment and clear pre- and post-leave recording.

Responsibility, escalation and operational grip

Several investigations showed that allocating a task is not enough. A named person must remain accountable for completing it, identifying barriers and escalating delay. This applies to clinical observations, medicines, physical-health concerns, safeguarding, MDT tasks and follow-up when a person leaves before assessment.

Timeliness and quality of learning responses

Some investigations took too long or needed substantial revision. Delay can prolong distress for patients, families and staff and slows the transfer of learning into practice. The newer 50-working-day planning, weekly supervision and RADAR controls are practical improvements, but performance and quality need continued testing.

Learning versus impact

RDaSH has multiple ways to share learning. The remaining organisational challenge is to show that learning has changed everyday practice and reduced recurrence. A newsletter, policy, training session or completed action is an input; it is not, on its own, evidence of safer outcomes.

4. Where care was good

The investigations do not describe uniformly poor care. They include examples of compassionate and patient-focused practice, appropriate clinical assessment and treatment, strong multidisciplinary working, effective communication with families, good partnership working and rapid emergency response. One investigation found no avoidable harm or clinical error following a cardiac arrest and described an effective emergency response; another described largely patient-focused physical healthcare and good specialist diabetes liaison, notwithstanding a serious medicines omission. The task is to understand why good care occurred and make it the reliable standard, rather than treating positive practice as incidental.

5. What has changed and how strong is the evidence?

Area	Change reported	Practice / outcome evidence	Board interpretation
Referral and triage	Paper-only triage stopped in the service reviewed; direct contact is expected for each referral.	A service update confirms the process change. The risk policy/formulation work remained incomplete.	Changed practice evidenced; outcome and coverage not fully demonstrated.
Depot medicines	Weekly depot recall report; morning meeting allocation; SystmOne recall responsibility reinforced.	Process completion reported. Further depot training and clinical-lead arrangements were not fully complete.	Partially evidenced.
Inpatient clinical tasks	Three daily safety huddles; monthly record/care-plan review; handover updates when physical-health treatment changes.	Implementation dates recorded and ongoing audits described.	Strong evidence of process change; patient outcome evidence limited.

Area	Change reported	Practice / outcome evidence	Board interpretation
Leave	SystmOne pre/post-leave forms and four-weekly audits.	One sample reported 7 of 8 records compliant (87.5%); other checks found forms were not completed every time.	Improvement signal, not full embedding.
Family and carers	Carer network, complaint-response process, family involvement expectations, discharge/leave planning actions.	Later PSIIs and audits still show inconsistent involvement and recording.	Structures in place; practice remains variable.
AMHP information	Assessment-report transfer and checking arrangements clarified, including date checks and supervision/induction reinforcement.	Tracker records completion through an alternative mechanism to the original action.	Completed mechanism; effectiveness not independently tested.
Physical health and diabetes	Competency framework, physical-health/diabetes training, care-plan audit and specialist liaison.	Implementation recorded; one PSII still identified insulin omission contributing to deterioration.	Necessary controls introduced; sustainability requires audit.
Observations and staffing	SafeCare, refreshed safeguarding training, recruitment and real-time observation recording.	One service reported fill rates from 80% to 95% and contemporaneous observation recording from about 60% to over 90%.	Promising service-level measures; verify source data and sustainment.
Crisis / A&E follow-up	Leaving-before-assessment process reinforced and joint protocol work reported.	Immediate reinforcement reported; supporting evidence was not consistently available in the tracker.	Partially evidenced.
Oxevision / LIO	Training, SOP and usage/supervision arrangements introduced; later governance emphasised technology must support, not replace, clinical judgement.	Training and governance activity evidenced; Trust-wide outcome evidence limited.	Partially evidenced; retain clinical-judgement safeguard.

6. Coronial, mortality, organisational and regulatory learning

6.1 Regulation 28 and mortality learning

Mortality reporting led by Dr Diarmid Sinclair provides an important second line of sight. The May 2026 Quality Committee papers reported an expected Regulation 28 notice following the death of an informal inpatient during leave. The concerns related to documentation of pre-leave risk assessment and clarity of review processes. A revised Section 17 and informal-patient leave policy had already been introduced, including a proportionate approach for frequently repeated short leave. Later Quality Committee reporting confirmed that the Regulation 28 concerns also included retrospective record entries and the need to strengthen governance for leave and timely clinical documentation.

This coronial learning reinforces, rather than creates, the themes already visible in PSII: current risk formulation, safe leave, contemporaneous records, clear clinical accountability and reliable oversight. The response included revised leave arrangements and enhanced monitoring for retrospective entries. The remaining confidence question is whether these controls are used consistently and improve practice across all inpatient settings.

The mortality reports did not identify a concerning overall mortality trend in the periods reviewed. They did identify continuing themes requiring attention, including diabetes and constipation in learning-disability mortality, physical-health deterioration, lithium/shared-care monitoring, and the need for stronger documentation following Structured Judgement Reviews. Absence of an adverse mortality trend does not remove the need to act on repeated process weaknesses.

6.2 Organisational learning architecture

Dr Judith Graham's work sets out a sensible organisational-learning architecture: learning should be drawn from incidents, complaints, safeguarding, staff and patient feedback, Freedom to Speak Up, infection prevention, health and safety, external reports and national inquiries; it should then be discussed through teams, professional leadership, care groups, delivery reviews and Board committees. Learning half-days, Learning Matters, a learning hub and feedback loops are intended to spread learning beyond the service where the event occurred.

The March 2026 Quality Committee recognised progress but also variability, especially in 24-hour and inpatient services. The September 2026 thematic paper asked the right question: not simply whether learning had been disseminated, but whether it had been implemented consistently and made a measurable difference. That distinction should remain central to this Board paper.

6.3 Wider patient-safety and experience data

The March 2026 Trust-wide learning report described nearly 8,500 incidents, more than 2,000 learning responses and more than 150 Good Care events, alongside more than 300 open tasks and delays of approximately 8 to 25 days in uploading some learning responses. The scale of reporting is evidence of intelligence and activity; it is not, by itself, evidence of closure. Communication and expectation management recurred across incidents, complaints, PALS and Care Opinion. The practical priority is therefore to convert high reporting and multiple learning routes into timely, visible and verified action.

The 360 Assurance audit gave moderate confidence. It recognised the governance structure while finding inconsistent recording of learning responses, data-quality weaknesses and insufficient tracking of actions through to closure. Those findings are consistent with this review and support a partial, not comprehensive, confidence judgement.

7. Delivery against the May 2025 commitments

7.1 Delivery review

The intention is evidenced. An April 2025 delivery-review outcome stated that PSIIs from 1 April would be considered through delivery review after reporting, and contemporaneous correspondence described delivery review as the end point of the PSII journey. The June 2026 delivery-review material introduced a clearer operating model: learning recorded on RADAR, a signed learning summary, named ownership, monthly or quarterly governance review, directorate feedback and examples of practice change.

7.2 July-August 2025 action audit

No contemporaneous sample list, sampling method or specific audit report was located showing that selected 2024/25 PSII actions were tested during July and August 2025. The 360 Assurance work started in the relevant broad period and tested 30 incidents raised between May and July 2025, weighted towards moderate harm and above. It considered whether appropriate learning responses occurred, whether evidence was held in RADAR and whether actions were entered and tracked.

That work is relevant to the wider confidence objective, but it did not sample the specific actions arising from the 2024/25 PSIIs. It should therefore not be described as having discharged the precise Board commitment. A later or broader audit can strengthen the control environment, but it cannot retrospectively demonstrate that the promised audit occurred.

8. National context

The local findings are consistent with national patient-safety learning, but national alignment should not be confused with local compliance.

- NCISH has repeatedly highlighted suicide risk in working-age and middle-aged men and the importance of safer care around transitions, follow-up and changing clinical circumstances. RDaSH's 2024/25 cohort, in which 72% were male and the principal age band was 46-55, is consistent with that broad pattern.
- NHS England's PSIRF expects proportionate learning responses focused on system improvement rather than automatic full investigation of every serious event. RDaSH's use of alternative learning responses is therefore appropriate where the decision and rationale are recorded.
- NHS England's 2025 Staying safe from suicide direction supports collaborative, person-centred formulation and safety planning rather than reliance on low/medium/high prediction categories. RDaSH's move away from RAG-based prediction is appropriate, but training, policy, records and practice need to align.
- CQC's current approach expects providers to demonstrate a learning culture, safe systems, effective medicines and physical-health care, person-centred involvement and governance that closes the loop. Policy, training and self-assessment are useful but need reliable operational evidence.
- National coronial and safety-investigation learning commonly identifies documentation, care interfaces, family involvement, physical-health recognition, leave, escalation and action follow-through. These are also the repeated local themes.

Conclusion

There are genuine changes in process and some measurable service-level improvements. There is also a more mature and candid learning architecture, moderate internal-audit confidence, clearer RADAR workflows and stronger expectations for named ownership and evidence.

Full or comprehensive confidence is not justified because:

- not every action in the earlier Board papers is present in one reconciled register;
- case-specific learning is not consistently visible in delivery-review records;
- outcome and sustainability measures are weaker than records of policy, training and process change;
- some issues recur in later PSIIs, mortality, Regulation 28 and CQC-readiness evidence;
- independent or peer testing is not yet routine enough to rule out the risk of the Trust "marking its own homework".

10. Practical next steps

One register: Create one reconciled register covering every PSII action from 2024/25 onwards. It should distinguish investigation status, action status, evidence status and effectiveness status.

Named accountability: Record one accountable executive or care-group owner, one operational owner, a realistic target date and a clear escalation date for every action.

Evidence before closure: Do not close an action solely because a policy was issued, training was delivered or an owner reported completion. Require the stated evidence and retain it in an accessible evidence pack.

Measures that matter: For each action, define a process measure, an outcome measure and a sustainability/coverage test. Use patient and carer evidence where the action concerns communication, involvement or experience.

Targeted independent testing: Commission a risk-based sample of completed actions, including 2024/25 legacy actions, Regulation 28 themes and recurring 2025/26 issues. Report the sample, method, findings and follow-up transparently.

Delivery-review standard: Use a standard delivery-review question set: what was learned; what changed; what evidence shows use in practice; what has improved; where has the change not held; and what needs escalation?

Overdue-action control: Use RADAR to show overdue actions by age, risk, owner and revised completion date. Escalate repeated non-response and actions without evidence.

Board reporting: Report fewer activity counts and more evidence of impact: recurrence, audit compliance, service coverage, patient outcomes, family/carer experience and whether changes remain in place.

Learn from good care: Use PSII and Good Care events to identify the conditions that support compassionate, coordinated and clinically effective care, and deliberately spread those conditions.

Appendix 1 - PSII action confidence summary

This appendix summarises the material actions and confidence position. It is intentionally concise.

PSII	Main actions / learning	Evidence position	Status
2024/4279	Oxevision training/usage; clonazepam training and reduction; cross-provider work; physical-health care plans; deterioration training; discharge planning.	Training and some controls evidenced; cross-system work and physical-health embedding remained ongoing.	**Partially evidenced / in progress**
2024/4896	Personalised care plan at first contact with direct contacts and signposting.	Wider personalised-care work found;	**Evidence located**
2024/5228	Equal focus on physical and mental health; better provider communication.	Thematic physical-health work and training evidenced, but not a PSII-specific outcome test.	**Superseded / alternative mechanism**
2024/5229	No care/service-delivery problem and no action recorded.	No action requiring closure.	**No action recorded**
2024/7457	Care planning/MDT/risk improvement; family involvement in leave; repairs.	DIALOG+ superseded proposed SOP; monitoring and repairs process reported. Outcome evidence limited.	**Superseded / alternative mechanism**
2024/8656	HQTC learning; transfer lead; seclusion review; physical-health checks.	Programme, training and monitoring activity evidenced; no clear outcome data.	**Partially evidenced / in progress**
2024/8654	Family-engagement peer review; learning half-day; record training; audit.	Tracker recorded implementation in May 2025; sustained audit results limited.	**Completed / evidenced**
2024/9559	RIDDOR review; coordinated PSII/HR/safeguarding; PBS; OT review.	Report revision and missing issues were still being addressed in June 2025.	**Partially evidenced / in progress**
2024/9561	Peer review; learning half-day; recording; carer assessment.	Wider structures exist; specific update remained unavailable and family involvement continued to recur.	**Partially evidenced / in progress**
2024/9565	Medical cover for MDTs; action documentation/audit; referral-triage alignment.		**TBC**
2024/9566	Spread positive ambulance/crisis handover learning.	Correspondence identified unresolved questions about handover and partner actions.	**TBC**
2025/473	End paper triage; trauma-informed communication; capacity/demand; risk and disengagement policy.	Paper triage removal evidenced; risk/formulation and disengagement work incomplete.	**Partially evidenced / in progress**

PSII	Main actions / learning	Evidence position	Status
2025/474	Accurate AMHP assessment transfer and removal of draft-document risk.	Revised report-sharing and date-check arrangements recorded as completed.	**Completed / evidenced**
2025/1065	Weekly depot recall; visit allocation; electronic recalls; training; leadership.	Recall and meeting controls reported complete; training/clinical leadership remained incomplete.	**Partially evidenced / in progress**
2025/1066	VTE/physical-health and medical oversight action in May paper; later records also describe communication/medicines concerns.	Policy/design work and some tracker activity found; source/action definition requires reconciliation.	**TBC**
2025/1496	Crisis records; face-to-face assessment for high risk; Staying Safe from Suicide implementation.	Paper triage stopped; wider formulation programme delayed/ongoing.	**Partially evidenced / in progress**
2025/1494	Out-of-area/CTO repatriation; complex discharge; safety guidance; CTO training.	Operational exception and local-team involvement documented; broader action set not fully evidenced.	**Partially evidenced / in progress**
2025/1500	Protocol and follow-up when a person leaves ED before assessment.	Immediate reinforcement/implementation date reported; supporting evidence not consistently available.	**Partially evidenced / in progress**
2025/884	Physical complaint and safeguarding escalation; observations; family involvement; workforce/speaking up.	SafeCare, training, recruitment and service-level staffing/observation measures reported; detailed action dates incomplete.	**Partially evidenced / in progress**
2025/1224	NOK accuracy; discharge planning; MDT completion; pre/post-leave checks; formulation.	Local actions and audit route implemented; forms not completed every time.	**Partially evidenced / in progress**
2025/2719	Move from RAG prediction to formulation-based assessment.	No new case action; relies on Trust-wide work not yet fully embedded.	**Partially evidenced / in progress**
2025/2893	Leave checks; family involvement; bereavement; Staying Safe from Suicide.	Sample showed 87.5% leave-record compliance; inconsistent completion remains.	**Partially evidenced / in progress**
2025/5129	Physical-health/diabetes competency; records; care plans; huddles; joint discharge work.	Implementation dates, training and ongoing monitoring recorded.	**Completed / evidenced**
2026/6808	Family feedback; PICU referral rationale; supportive interventions; emotional impact of bed decisions.	SOP, RADAR patient-flow reporting and monthly review recorded.	**Completed / evidenced**

Appendix 2 - Principal evidence reviewed

- RDaSH Public Board and Quality Committee learning-from-incidents and PSII papers during 2024.
- Patient Safety Incident Investigation YTD report and thematic analysis presented in March 2025.
- 2024/25 Serious Patient Safety Incidents - Learning update, Public Board, 29 May 2025.
- PSII and delivery-review correspondence and outcome material, April 2025 to November 2026.
- 360 Assurance PSIRF audit and related governance reporting, 2025-26.
- Trust-Wide Learning from Patient Safety and Experience reporting, April 2025 to March 2026, including March 2026 Board discussion.
- Patient Safety Incident Investigations - Learning Report, Public Board, 28 May 2026.
- Master safety action plan / PSII action-tracking material updated in 2026.
- Mortality and Prevention of and Learning from Deaths reports led by Dr Diarmid Sinclair, including Regulation 28 and leave-documentation learning.
- Dr Judith Graham's organisational-learning, escalation and thematic-learning papers and related Quality Committee reporting.
- RDaSH CQC readiness papers and the published 2025 CQC assessment findings referenced in Board reporting.
- NHS England Patient Safety Incident Response Framework and April 2025 Staying safe from suicide guidance.
- National Confidential Inquiry into Suicide and Safety in Mental Health: clinical-risk and suicide-safety learning referenced in the RDaSH papers.
- CQC national assessment expectations for safe, effective, caring, responsive and well-led services.
- Relevant HSSIB mental-health inpatient safety investigations and coronial Prevention of Future Deaths learning referenced in the May 2026 Board paper.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Cultural reset (including anti-racism)	**Agenda Item**	Paper Y
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive and Carlene Holden, Director of People and OD		
Meeting	Board of directors	**Date**	26 November 2026

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

The paper is in effect in three parts: an update on continued work, some specific matters the Board needs to discuss relating to racism and our approved stance on discrimination, and a material update on the work we are structuring to build better local listening, which, as explained is framed as learning into action (LeIA).

The Board may wish to explore how we are ensuring co-production with networks, trade unions and others. And to note the need to do better in developing a programme of clear work focused on the 555, as we had begun to explore in March and May. With some greater bandwidth this may come, but the higher priority is to execute in Q4 within POD on the policy transitions we have promised the Trust People Council.

Board members attention is drawn to further antisemitism training in Q4, together with new Islamic faith awareness sessions being procured for later in that quarter. The expectation is to include within our annual report confirmation of all Board members having attended. This recognises that national work in this 'lane' has slowed and so local action is imperative.

Previous consideration

Board papers Jan, March, May, July, Sept 2026, and CLE papers in Q1, Q2 and Q3

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the work programme needed in Q4 to deliver key amendments to policy and approach which Carlene Holden is largely leading

CONSIDER the work reported on anti-racism further to our agreements in July 2026 and November 2025

NOTE the initial actions associated with definitions of anti-muslim hate and antisemitism confirmed when we met in November

RECOGNISE the preparatory work for organisational listening outlined

AGREE to consider a further paper in March 2027

Alignment to strategic objectives (indicate those that the paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO3: Extend our community offer, in each of – and between – physical, mental health, learning disability, autism and addiction services	X
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X
Alignment to the plans: (indicate those that this paper supports)	
Estate plan	X
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.	X
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	X
Financial risks			
Financial Planning, CIP & Sustainability	Low Tolerance	We accept minimal risk in financial planning and cost improvement initiatives; budgets must remain balanced, and sustainability protected.	X
Counter Fraud	Averse	We have no tolerance for fraud, bribery, or corruption; all suspicions must be reported and addressed.	
Financial Control and Oversight	Averse	We do not tolerate breaches of financial control or non-compliance with reporting and oversight requirements.	
Patient care risks			
Clinical Safety	Averse	We do not tolerate risks that could result in avoidable harm or serious compromise to patient safety.	X
Quality Improvement	High Tolerance	We support innovation and experimentation in quality improvement, accepting some controlled risk in pursuit of better outcomes.	X
Learning and Oversight	Low Tolerance	We accept minimal risk in the operation of governance, audit, and learning systems that assure care quality.	X
Patient Experience	Moderate Tolerance	We are willing to take limited risk to improve experience where dignity, communication, and outcomes are protected.	X
Performance risks			
Emergency Preparedness	Moderate Tolerance	We tolerate limited, well-managed risk to improve resilience and emergency response capability through ongoing learning and stress-testing.	
Capacity & Demand	Low Tolerance	We accept minimal risk of demand exceeding capacity; service delays or access issues must be actively managed.	X
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	**High Tolerance**	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X

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

Strategic Delivery Risks (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.	
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)
NA

ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Cultural reset including anti-racism work

Introduction

1.1 Plausibly this matter has been so routinely discussed as a Board that it needs no reintroduction. But it is perhaps timely to recall that this is not a paper wholly rooted in staff survey results, either those between 2020 and 2025, or the survey for 2026 which closes tomorrow. Instead, **the work reflects a wide range of indicators and concerns, where our culture is not consistently as we would want it**. The Board's agreed position (May 2026) is that the first focus is on employee beliefs about speaking up leading to change (reflected upon by another board paper) and the view about whether safety is the Trust's top priority. Both, though we did not know that in May, are among indicators used now within the National Oversight Framework.

1.2 In September 2026 we agreed the **framing of high support and high accountability** as an underpinning for how we wished to see the leadership approach within the Trust develop by 2030, with clear measures of success by the end of 2028. In July 2026 we had also agreed a revised approach to anti-racism, which is considered further in this paper.

1.3 We are working to take this all forward with co-production. That necessarily means it operates at **a pace of trust among others**. Extensive and repeated conversations have taken place across the board, sessions with the governors, several discussions with the Trust People Council, as well as time spent in the leaders' conference and many conversations as the clinical leadership executive. Among a strata of the organisation there is strong appreciation for not just what we are trying to do but how, but that knowledge is not widespread. That communication piece is explored in this paper. The small time-limited steering group brings together a range of voices to offer advice from beyond the typical structure, recognising that leaders need to be carried with us on this journey, and their comfort with ambiguity will vary.

The work as a whole

2.1 Whilst there is not a fixed and final list of what we will do, the prior Board paper set out a number of actions (12) which can contribute to the support and accountability emphasis. These included:

- The relaunch of our approach to health and wellbeing. This has been delayed inside the directorate, and remains not yet finished and issuable, but it is very close. We advertised in Team Brief the intention from January that local health and wellbeing champions will have some budgetary freedom to take local actions they judge can make a difference within their teams.

- The rollout of agreed and significant change to our remote, agile and flexible working approach. The expectation is that this is largely deployed by April, with clear agreements documented about work patterns with line managers, against the policy which expect to finish

approval of in 2026. This has been fairly widely socialised, with strong support from TPC and elsewhere. The focus online managers needing to be on sites a minimum of 60% of time (more in many cases) has created the right amount of discourse, while we need to ensure our informatics and estate functions are ready for the changes in home support we will be promising, and the changes in our spaces we will bring to facilities like Riverside.

- Changes to our PDR and appraisal model, from April, for all disciplines which will include a focus on objectives, and a quantified and centrally recorded assessment of delivery. The PDR will also be a space in which individuals can evidence, and will be expected to, their anti-racist steps and actions at work.

- Introducing 360-degree feedback for line managers from April, which inherently provides those who are managed with a chance to offer feedback on behaviours they experience.

- A variety of steps to reduce violence and fear of violence in the workplace, which the Board supported when we discussed this in some depth in March 2026. Initially we saw some positive data points as we introduced RRI advocates and other changes including personal attack alarms. It may be useful to return to a more reflective evaluation of what the data is now telling us in January 2027.

2.2 None of these actions are without impact, difficulty, dissent, or coaching to make sure they are deployed as intended. There is a balance to be struck between them being seen as joined up dots, or standing as individual initiatives. The same connection dilemma applies to our work to ensure equitable access to training funds and training, and to grow participation in Learning Half Days.

2.3 Five of our twelve elements are as yet less developed or defined and it may be useful here to just remind the Board of that work:

- As part of a supportive and inclusive culture we committed that people should be best able to bring their whole selves into the workplace. Our carers commitment is part of that story, as is the flexible working changes we are making, and our anti-racism work explored below. The staff networks had chance in October's TPC to set out their priorities and ambitions, and within that we have more work to do to ensure an environment that feels supportive for colleagues with disabilities perhaps especially those who are neurodivergent. Against the backdrop of our work on sickness, and the five additional actions outlined for 2027 in the Chief Executive's report, this work has renewed salience and urgency.

- We also discussed a recognition and reward gap that staff still report. Again, within the Chief Executive's report there is a discussion of our

existing systems, which we overhauled in 2024. It may be that the listening work described below gives us new and better cues for what is not cutting through: and we should not overlook that awareness of and knowledge about the various recognition schemes and systems may be poorer than we think.

- Within the accountability framing, we indicated we would reach conclusions about our management system, think again about the benefits/consequences regime, and develop better support for honest conversations. The last of these is being taken forward aligned to the Action Learning Sets but that alone may be an insufficient intervention even when teamed with specific programme support such as that for 14-week waits and always measures. Consideration has been given to our management structure, and I would prefer to return to that topic having discussed more fully with CLE the likely intention to tweak but not fundamentally change the structure (before 2030) and instead to focus on how clinical/thought leaders can be more visibly brought into the work we do during 2027. The unbarking dog is the tricky topic of consequences/benefits. Specific time for that across EG will be found before a proposal can be considered with trade union partners and within the wider Board: the rewards and benefits side of this equation is typically more difficult to define, ramping up a capability process at greater pace is fairly well trodden territory.

2.4 Within the steering group, there is some encouragement for us to give greater profile in the very early new year to some of this work. The idea is that that gives validation to those who want to feel that there is an acknowledgment of necessary cultural change. That timing may work well given the timeline for listening work outlined below, albeit is carries the risk that that listening is seen as simply confirmatory in its timing. If there is good alignment with trade unions on the work on flexible working, appraisal, and health and wellbeing in particular then the balance of risk is probably in favour of positive promotion.

Anti-racism work

3.1 We agreed a series of further steps as a Board in July. Since that time a number of discussion papers have circulated reflecting on WRES action plans, national staff standards material, and other influences, and the Board's POD committee was also asked to formally consider the extant (2024) seven point anti-racism plan, where the executive self-assessment would consider that six of seven commitments are in place.

3.2 In trying to pull the work into a format that might be accessible to a wider group of staff and partners, it was suggested we could frame the work around the following broad parameters (and this was considered by CLE):

- Name racism and set clear standards.
- Demonstrate accountable and representative leadership.

- Use data and evidence to identify and reform inequality.
- Value lived experience and co-design action.
- Apply fair, culturally capable and evidence-based interventions.
- Build anti-racist capability and active allyship.
- Ensure transparency, accountability, wellbeing and cultural safety

However, these are not 'ronseal' enough for the work we want to do, needing themselves explanation of what will happen and what it is intended to achieve. We are therefore working through a simpler way to express the agreed actions we have, which are listed again below.

- Sustain and see the benefits of our existing seven-point plan.
- Implement actions to be agreed consistent with moving to a more representative leadership.
- Adopt the proposals from our REaCH network in addition to the above.
- Include, within our new appraisal framework, a behavioural demonstration expectation consistent with the work developed for some of our wards.
- Review the second year of the Acceptable Behaviour Policy, now aligned to the anti-racism pathway within RADAR, to consider whether adoption has grown and take action in places where it has not.
- During 2027, specifically review service pathways through the lens of ethnic origin and religious tradition, as we have done in terms of poverty and are doing in terms of inclusion health.
- Ensure that our successor plans beyond the LDO, as well as other management training programmes we have, contain allyship and other relevant modules to support this agenda – whilst continuing to deliver the Active Bystander training to colleagues across the wider workforce to increase the spread across the organisation.

A working version might be developed from the following simplification:

- Recruit, develop and promote people fairly but with a specific intention to change by 2028/9 the diversity of leaders at all levels and in all professions at the Trust
- Require of all RDaSHians demonstrable anti-racist behaviours, embedding that expectation into supervision and appraisal processes
- Ensure that minority ethnic and global majority staff involved in HR processes have access to appropriate protections to address unconscious bias among those applying such processes
- Support and celebrate inclusion and diversity in our work, applying See Me First principles across all our roles
- Embed cultural competency at the heart of our training and learning work, using reverse mentoring to begin to improve the confidence of all involved
- Address exclusion within service pathways, building on our promises and on PCREF, reviewing accessibility, suitability and equity from 2027 to 2029

3.3 The difficulty framing this, and the proliferation of approaches, even after the Board has agreed some speaks to the challenge of capacity and capability,

but also to the inherent difficulty of describing both specific actions and wider behaviours. We will have a further effort to do this ready for January's Board.

3.4 These delays are not holding back the actual actions that we agreed – and a summary follows below:

- Reverse mentoring is moving towards recruitment among staff in December and starting workshops with mentees/mentors in Q4 (CH)

- See Me First is aimed to launch in February using a roadshow format to build engagement and understanding (TL)

- Specific anti-racism behavioural work has taken place in Mulberry ward, and is now taking place across wards in Rotherham, whilst within delivery reviews (Nov) we have discussed with other care groups their intelligence and aspirations (JG)

- The second review of the Acceptable Behaviour Policy is due to come to the Board, through corporate assurance, during Q4 (PG)

- PCREF is moving forward and the next steps are summarised within the committee papers the Board is considering today (JM/TL)

- Data analysis of our senior leadership has been completed as outlined, and whilst in aggregate there is some proportionality, it is clear that in given role cohorts there is none: work to in effect 'corporately take over' leadership of some vacancies, and to apply affirmative action principles to those roles is in hand from Q4 (CH/TL/RC/PG)

3.5 Fairly consistently, in leadership forums, and indeed each month within our induction, the question of success is raised. It remains the case that the views of those who work in the organisation from a global majority or minority ethnic heritage need to drive that judgment. Discussions are taking place with the REACH network about how we might structure more regular quantified and qualitative assessment of their views of how this feels, and whether progress is truly being made. Those close to the network leadership are of course often involved in initiatives and can see the intent: it is existing and new joiners into the Trust whose experiences and assessment we need to consistently tap into.

<u>Anti-semitism and anti-muslim hatred: practical applications</u>

4.1 The Board when we met in September agreed to adopt definitions of both of these constructs, acknowledging the views of those nationally and locally who resist that approach. We now need to be practical in embedding those definitions into our work and how we will do that is summarised below.

4.2 During Q4 we will complete *a rapid policy review of all of our people-related policies*. We do not expect that any will themselves breach these definitions, but we do consider that they may be unhelpfully silent where relevant examples or instances could be drawn out. We would wish to include these definitions where suitable within existing policies, consistent with our wider policy approach of not adding to the overall volume of documents we have.

4.3 Ensure that *our training plans*, and indeed LHD plans, clearly provide space for knowledge building and awareness raising in both fields during 2027. A successful pilot of antisemitism training attending by all executive directors will run again in January, March and likely April, with an expectation of full board compliance prior to the completion of our annual report. Alongside this knowledge training relating to Islam, and to anti-muslim hate, is being commissioned.

4.4 Discussion on these definitions since the adoption of this approach has suggested that there is a need to be more clearcut with managers, and perhaps with staff, about *the place of faith within the workplace*. We will look to develop more explicit positive guidance about what is considered very suitable for people to display and promote at work, and how we can support that: and conversely offer examples of what might breach definitions and our wider values. By implication the general tone of this work will recognise all traditions, accept that being one's whole self includes faith, but highlight how that could be considered oppressive by others including our patients. The Mann Review offers some guidance in this field.

4.5 Much of the discourse over the definitions nationally has focused on implications for free speech among NHS staff. We will during Q4 *revisit our social media and communications guidance*, again to explicitly both reference and exemplify what might be accepted and what clearly will not be. Some of the harder issues within this work are likely to relate to criticism of religious practices that others may extol as cultural difference: in reaching judgements on these examples, we may bring our ethics committee into operation, as well as involved faith leaders and those explicitly of no-faith. What is certainly important is that we do not arrive at an implied position whereby discussion of two faiths, or indeed our celebration of Diwali, is seen to exclude other faiths, nor require equivalence in all displays or discussion.

4.6 Some of *the most practical steps* we can take to support staff and patients with these issues is to take advantage of changes we have already made in the Trust. Our food offer is more diverse than before, albeit we may consider it has further to improve. By offering patients, not later than March 2027, appointment choice we avoid providing appointments which clash with observance. And our own work on employee flexibility, including team rostering, can help to support staff, students and volunteers.

Learning into action (LeIA)

5.1 Since September's board we have been working to define how this will operate. This is not a one-off listening exercise, but **the creation of norms and expectations about hearing from, and acting on, staff ideas and considerations throughout 2027 and thereafter**. But the work is also a curious, and appreciative, enquiry into the barriers managers and leaders face in adopting good ideas, doing so at pace, and persuading their teams that they have been heard. This should not be read as implying we have no knowledge of the barriers, nor any hypotheses of what impedes this – and discussions across the steering group, and now within CLE are deepening some of those ideas. The gap between the Top Leaders' Cadre and team leaders/band 7s is very much reinforced, as are concerns over divisive behaviours by and against 'managers'.

5.2 **A training, or learning package, during December** will be applied for those due to be involved in this work during Q4. The curriculum or format for this continues to be co-produced and a number of senior leaders outside the executive group will play a prominent role in delivering this work. Whilst the board's commitment to this, and the drive of very senior leaders around it, is helpful on the one hand, we need to counter the idea that this is 'another thing to do' designed at some distance.

5.3 **Time is being defined** for us to be "out and about" during late January and through February, and again before Q3 starts. The working expectation is that this work will extend through 2028 too but then be formally stepped back to be replaced by something more organic. That decision can of course be revisited at the time in light of experience. In the first phase typically, we will be working in teams of three drawn from our DMTs, corporate deputies, CLE and the wider Board. The local relevant leader will be part of the listening where they work. We have resisted the idea that this will suppress views heard, though clearly it may, against the bigger picture that this is not an exercise in collating ideas, but a conversation locally about change. That has to include sitting with the discomfort of hearing ideas one disagrees with, has heard before, or feels criticised by. Crucially ideas are not being taken away to be decided on somewhere else: we want this material to be held and visible locally. That does not prevent some thematic analysis group and Trust-wide, especially as the communication mobilisation from April will very much focus every week on changes made from people's ideas.

5.4 As explored earlier in this paper there is a balance between viewing this work as something to be announced, or to see it grow socially and more organically. It may be better for the brand of **learning into action to appreciate through people experiencing good conversations**, reflective practice and real change. Whilst among some staff there is a sense of nothing changes, we know that for others too much or constant change is their voiced concern. Moreover, there is some strong feedback, perhaps especially among senior medical colleagues, of over-promotion of corporate ideas and programmes. The clinical leadership executive workshop pack will be circulated to Board members with the background reading material for our meeting.

5.5 A critical consideration here, and part of the learning process, will be **managers' capability**, at every level including board level, to engage well in this type of work. Some of this listening and talking can happen in mildly set piece moments, but the vast majority of it should be garnered by walking about and by being in workplace. Steve Forsyth role-modelled some of this with his approach in the last few weeks before Acorn opened up, while Cora Turner is doing much that is similar and some different things around the engagement and consultation exercise associated with neighbourhood models in adult physical health and staff changes.

5.6 Like much we have done since 2023 there is **a step of faith here**. We know that simply hearing and then acting on some issues voiced by teams will not change the Trust's culture, nor necessarily impact staff survey scores. Likewise, we may worry about our ability to make changes at pace based on staff feedback (inside 50 days is the working metric we are toying with). However, the intent is to see being visible in our workplaces becoming an

expected standard among our leaders. That is perhaps already mostly true of team leaders (though some feedback on the flexible working policy may challenge that), but it is variable as we move into more 'senior' tiers. In a locationally diffuse organisation this is not easy. How often does someone need to be present before they are viewed as 'often around'? That again explains why the working emphasis here is on backing up, developing, and coaching local leaders rather than bringing saviourism into teams from 'the board'.

5.7 Before we start in earnest and co-developed during the training, we will do **some boundary definitional work**. This includes being clear how we might approach with some consistency common questions and issues that may arise. It includes being clear anything that is open-for-explanation but off-the-table in terms of change. We need to be honest with people that this work does not mean that no changes will ever happen without their agreement, but that we are sure that <u>their voice in defining problems and proposing solutions should be far louder</u> than in some places it has been for a long while.

Toby Lewis, Chief Executive
November 22nd 2026

****Paper to be managed via questions only**

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Estate Plan Workplan	**Agenda Item**	Paper Z
Sponsoring Executive	Simon Sheppard, Director of Finance and Estates		
Report Author	Simon Sheppard, Director of Finance and Estates		
Meeting	Board of Directors	**Date**	26 November 2026

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

The Board of Directors is asked to focus the discussion points on progress against the recommendations agreed at the Trust Board in July 2026. These being:

1. The preferred configuration of the Tickhill Road site identifying areas for retention and disposal
2. The preferred option for the redevelopment of the Tickhill Road Hospital estate and the recommended procurement route
3. The preferred option for the implementation of the ambient loop energy solution in terms of procurement route.
4. The preferred funding options for the Tickhill Road Hospital development and ambient loop solution
5. To identify ways forward for the Rotherham development

In addition, the Board of Directors will be updated on progress regarding the Waterdale development

Previous consideration

Board March 26, July 26/Board timeout / Feb 26, Public Board (financials) / Dec 25, Private Board / Aug 25,
Estate & Sustainability Group – April, June 2026
FDE Committee – April, June, August, October 2026
Public Board / July 25 Board timeout / June 24 [and CLE 3 times in twelve months]

Recommendation (delete options as appropriate and elaborate as required)

The Board of Directors is asked to:

NOTE the progress against the key aspects of the estate plan and the key next steps

NOTE progress and the next steps regarding the Riverside proposal.

NOTE progress regarding the Waterdale development and the project timetable.

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

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

Strategic Delivery Risks (list which strategic delivery risks reference this matter relates to)							
Na							
System / Place impact (advise which ICB or place that this matter relates to)							
Neighbourhood working in Rotherham and Doncaster							
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	At final FBC stage
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	At final FBC stage
Appendix (please list)							

Rotherham, Doncaster & South Humber NHS Foundation Trust

Estate Plan Workplan

1. Introduction

1.1. The Board of Directors is aware of our strategic intent to alter our estate between 2026 and 2029: it is also included in our approved cash and capital 3-year plan lodged with NHS England. This paper updates the Board on progress since the Trust Board on 30 July 2026, and the workplan moving forwards to March 2029.

1.2. To remind the Board the Full Business Case (FBC) identified six principal investment objectives. Each objective has been developed from the strategic context and case for change:

- IO1 – Improve the quality, efficiency and long-term sustainability of the Tickhill Road estate, reducing backlog maintenance to an agreed target level.
- IO2 – Reduce operational carbon emissions arising from the Tickhill Road estate, in line with NHS Net Zero commitments.
- IO3 – Develop an integrated model of frailty care supporting the shift from acute to community-based care.
- IO4 – Ensure the estate footprint reflects clinical need, releasing any land or buildings no longer required for service delivery to support wider public value, including local housing need where appropriate.
- IO5 – Improve the Trust's long-term financial sustainability by reducing the cost of operating and maintaining the estate.
- IO6 – Ensure the estate is capable of adapting to future changes in models of care and service configuration.

1.3. Specifically, the FBC was prepared to identify and confirm

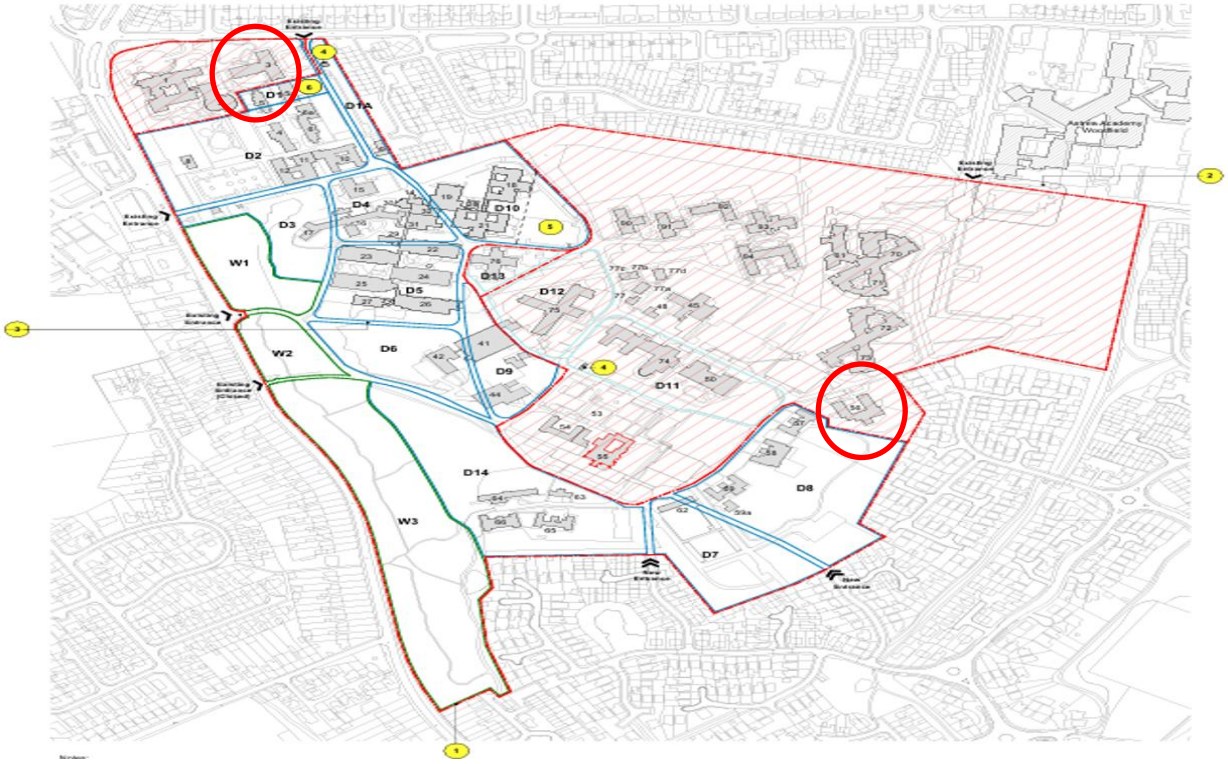
- the preferred option for the redevelopment of the Tickhill Road Hospital estate and the recommended procurement route
- the preferred option for the implementation of the ambient loop energy solution in terms of procurement route.
- The preferred funding options for the Tickhill Road Hospital development and ambient loop solution
- The preferred configuration of the Tickhill Road site identifying areas for retention and disposal, with an overview of the options available for disposal
- and also to identify ways forward for the Rotherham development.

1.4. This paper will provide an update against these key themes and also progress with the Waterdale development.

2. Preferred option for the redevelopment of the Tickhill Road Hospital estate and the recommended procurement route (Chapters 3 and 4 of the FBC)

2.1. The Board approved the redevelopment of Tickhill Road Hospital site with the final recommendation on a procurement framework to be proposed to the Board via the Director of Finance & Estates by the end of September 2026. The Board's decision will then be transacted within the oversight of the Finance, Digital and Estates Committee.

2.2. In terms of the Tickhill Road Hospital site, the latest position, which is expected to be the final layout is shown below:



2.3. The key changes to the previous version are highlighted in red:

- Forest Gate to remain alongside the Hospice
- Cherry Tree Court to be retained

2.4. Chapter 4 of the FBC, the commercial case, includes the evaluation of the procurement options for the redevelopment of Tickhill Road. The 3 options are summarized below:

Options	Attributes
Traditional Procurement	The contractor would be appointed after substantial design development had already been completed.
Early Contractor Involvement	The Trust appoints a contractor at an earlier stage of programme development through an approved framework arrangement. The contractor works collaboratively with the Trust, advisers and stakeholders throughout programme development.
Strategic Delivery Partner	The Trust appoints a partner who works across a number of domains - design, planning, strategy and programme development.

2.5. In summary, and consistent with the Trust Board in July 2026, the Board on 24 September 2026 approved the following:

- Proceed with the ProCure23 (P23) framework and Early Contractor Involvement (ECI), as already established through the Full Business Case (FBC) Commercial Case evaluation.

- Adopt NEC4 Option C (target cost) as the contract mechanism for the new build, with a Guaranteed Maximum Price (GMP) overlay to be agreed once Modern Methods of Construction (MMC) decisions are settled.
- Commission an independent cost adviser, engaged on behalf of the Trust and independent of the contractor, to scrutinise contractor costs and administer the contract throughout delivery — a requirement regardless of procurement route.
- Note the programme risks and required mitigations including the requirement for early Trust input on building envelope, scale and siting ahead of RIBA Stage 2 sign-off.
- Note the requirement to establish delegated levels of authority for change decisions ahead of the ECI period, to be settled separately and in due course.

2.6. The table sets out each milestone for the new build and what needs to be true for the milestone to be met. The dates are indicative. A firm completion date will be set at the end of Stage 2, in spring 2027, when the P23 partner has reviewed the programme.

2.7. Progress against each milestone will be reported to the Finance, Digital and Estates Committee.

Milestone	Date	What needs to happen
RIBA Stage 2 starts	30 November 2026	The design team is appointed on a basis that meets the Procurement Act. (or a 6 week delay if done when the P23 partner is appointed)
P23 partner and cost adviser appointed	Mid-January 2027	Tender documents are issued by the end of November. Tenders are returned before Christmas. Evaluation is completed in the first week of January.
Brief frozen (end of Stage 2)	Mid-March 2027	Operational policies and the Schedule of Accommodation are signed off by named leads. Measured survey and ground investigation results are in hand. The sale boundary is fixed. Pre-application meetings have been held.
Design frozen and planning application submitted (end of Stage 3)	Mid-August 2027	No change to the brief after the freeze. Room layouts and data sheets are signed off. The Environmental Statement is complete, with surveys done in season. The council has confirmed what the application needs.
Planning consent, and judicial review period passed	February 2028	The council decides within the agreed period. There is no call-in or challenge. A planning performance agreement is in place.

2.8. The key immediate decision is whether the design team is appointed

- by the end of November 2026 or
- after the P23 partner is appointed.

2.9. In the first option the current design team carries out Stage 2 and the partner takes design responsibility from Stage 3. This needs a compliant basis for appointing the design team.

2.10. In the second option all of the new-build design sits within the ProCure23 framework and the partner holds design responsibility from the start. Completion is about 4 -6

weeks later. The appointment of the partner in January sets the start of design, so that date has to be held.

2.11. The Trust, through the CEO and Director of Finance & Estates, will confirm the approach in November. On either basis:

- Engagement with the P23 contractors starts in November 2026. Tenders are returned in December and evaluated in early January 2027.
- The independent cost adviser appointment is in preparation and will be aligned with the appointment of the P23 partner.
- The Town Planning Adviser is expected to be appointed in early December 2026. Pre-application meetings with the council follow from January 2027. A planning performance agreement will be sought.
- The design is signed off and frozen at the end of each stage. Later changes go through change control.
- The construction contract is awarded once planning consent is in place and the judicial review period has passed.

2.12. The key next steps following those described in section 2.7 include stage 4 (technical design being frozen and price agreed), construction (estimated at 15 months) and the vacating of the buildings on the disposed estate.

2.13. As shown in the sections above there are a number of actions to be undertaken which all have a direct impact on the timeline. At this stage it is too early to confirm the overall timeline though there are a number of areas, that when consolidated, suggest a 3-month slippage from the March 2029 date. The revised governance described in section 9 will support the detailed review of the overall plan timeline and interdependencies, and any actions required to meet the March 2029 deadline.

3. Preferred option for the implementation of the ambient loop energy solution in terms of procurement route (Chapter 4)

3.1. The Board of Directors agreed to the further development of the “Energy Feasibility Study – route to Full Business Case” on 28 May 2026. The ambient loop solution was agreed as the preferred way forward.

3.2. The FBC describes a number of procurement routes for the ambient loop energy solution including Carbon Energy Fund (direct award or mini competition), Government Energy Framework, Framework Direct Award, and Competitive Flexible Procedure.

3.3. To remind Board colleagues in July we agreed to delegate the relevant authority to the Chief Executive and Director of Finance & Estates working with the chair of Finance, Digital and Estate committee to finalise the procurement route following further discussions with our legal advisors. The next sections update on this.

3.4. Framework-based routes (particularly a CEF mini-competition if suitable) are likely to reduce procurement duration materially while retaining competition. A Competitive Flexible Procedure is the longest route but offers the greatest flexibility where the Trust seeks a bespoke Strategic Energy Partner or long-term concession. The choice should therefore reflect the commercial model rather than procurement speed alone.

3.5. The appointment of a Strategic Energy Partner (“SEP”) to deliver the Phase 1 ambient loop scheme at Tickhill Road has been further considered.

3.6. The long-term SEP relationship, with an anticipated contract term of up to 30 years, includes the design, finance, deliver and operate Phase 1 (ambient loop network, boreholes, air source heat pumps, solar panels, storage batteries and initial building connections), while preserving the ability to add future phases. It includes possible connection of additional Trust buildings and, subject to separate approval, third-party developments such as housing on surplus land.

3.7. The delivery and operating model is not yet settled: a design-build-finance model with the Trust retaining operation, and a hybrid model are all still live options and each affects the procurement comparison. This will be concluded over the coming weeks as material changes during competition will generate delay and risk value for money.

3.8. Two routes are currently being compared: a mini-competition under the Carbon Energy Fund (CEF) Framework, and a standalone Competitive Flexible Procedure ("CFP") under the Procurement Act 2023.

3.9. The comparison will include factors such as the following,

- Timetable to contract / financial close
- Operational date
- Cost
- Competitive field
- Programme risk
- Internal resource requirement
- Contract flexibility
- Whole life cost

3.10. Legal advice has been sought to support this analysis prior to a recommendation being provided to the CEO and Director of Finance & Estates in December 2026 through the Finance, Digital & Estate Committee. The Board of Directors is reminded in July 2026 it supported the competitive flexible procedure subject to this further due diligence.

3.11. The ambient loop is a separate procurement from the new build and will run to its own timetable:

- December 2026 to February 2027: design phase for the loop, using the measured survey of the existing buildings and the ground investigation. A quote for the measured survey has been received. The same is true of the Design Team appointments,
- December 2026: recommendation on the procurement route, following legal advice formally approved.
- End of March 2027: out to tender.
- The Trust applies for planning consent once it has the preferred bidder's design. Consent is in place before the contract is signed. The tender will ask bidders for the planning information with their final tenders.

4. Preferred funding options for the Tickhill Road Hospital development and ambient loop solution (Chapter 5 – Financial Case)

4.1. The financial case set out the financial implications for the Trust of the options which are available. The purpose of this is to demonstrate that the Trust is able to meet its financial obligations under a variety of scenarios.

4.2. The financial case is set in the context of the Trust having a relatively healthy financial position, with a breakeven plan for 2026/27 and an expectation the

underlying deficit is eliminated by 2027/28. It is also in Segment 2 of NHS Oversight Framework (Tier 1 being the most favourable).

4.3. The financial case assessed a number of funding options ranging from public funding to private finance. A multi-step qualitative and quantitative appraisal was undertaken to assess the different financing requirements and implications of each programme component. PricewaterhouseCoopers LLP (PwC) supported the Trust in structuring and completing the appraisal, applying established public sector investment appraisal best practice.

4.4. Based on the options appraisal, **the Board supported Option B, Public Funding for the Tickhill Road Redevelopment and Ambient Loop via a revenue model**, as the preferred funding mix for the Tickhill site redevelopment, subject to further financial, commercial analysis, and assumption refinement as we progress through the procurement process.

4.5. Putting this simply the following remains the funding route being progressed:

- Ambient Loop development will be funded via a revenue model
- The new build at Tickhill Road will be funded by the contribution from the land sale plus PDC. PDC being a mixture of Trust, System and Region. This PDC requirement could be reduced if approval is achieved for the Trust to use its cash balance.

4.6. In terms of progress the Trust continues to engage with NHS England to gain clarity on the approval process for both aspects of the plan. This is a key focus for our provider oversight meeting with them on 23 November 2026. The Board will be updated orally on any feedback.

4.7. As well as engagement we are updating the cashflow for the overall estate plan to support commitments required in 2027/28 and 2028/29. The early year costs will predominately be fees.

5. Preferred option for the land sale

5.1. The Board of Directors approved the delegation of this matter to the Chief Executive and Director of Finance and Estates to pursue this further and make a final recommendation through the Finance, Digital and Estates Committee.

5.2. The preferred option for the Tickhill Road site identifies the potential for the disposal of circa 21.1 hectares of the total site area of 37.9 hectares. (see section 2.2)

5.3. This a complex area to ensure that there is the right balance of costs, risks and benefits is achieved in the context of the requirement in Doncaster for additional homes which achieve the optimum social benefit (especially in the Balby Bridge area of Doncaster).

5.4. Positive initial discussions have been held with Homes England about the potential for transfer of land to them (via an appropriate sale payment).

5.5. The Trust will therefore ensure that we have engaged fully with Doncaster City Council to explore the most appropriate number and configuration of housing as part of seeking planning consent for the surplus land (as this will generate a more optimised land sale value for the Trust). This might involve a deeper engagement with Homes England as the government's housing and regeneration agency.

5.6. In terms of the key actions completed and next steps:

- Town Planning procurement underway.
- Initial discussions with Planning Authority regarding potential use of land and housing density completed
- Relevant information sent to Homes England regarding title. Further information release is complete.
- Discussions with Homes England regarding use of land and value continue (following the above)
- Continue discussions with Planning Authority
- Written planning advice received from the council (September 2026) and an initial meeting held on housing density and mix.
- Representation submitted to the Doncaster Local Plan Call for Sites 2026.
- District Valuer briefed and site information provided.
- Land Registry pack received.

Next steps and timescales

- November 2026: start the call-off for the Development / Property Adviser.
- Early December 2026: appoint the Town Planning Adviser.
- December 2026: District Valuer to value the land on a range of housing density and mix assumptions. Decide how the land is sold: on its Local Plan allocation, or with outline consent secured first.
- December 2026 to February 2027: plan the move out of the existing buildings outside the new site boundary, so that the land is released as soon as the new building is in use.
- December to mid-February 2027: further meetings with the council on density and mix.
- Mid-January 2027: fix the sale boundary, reserving the land and rights needed for the ambient loop and for services to the retained buildings.
- By early February 2027: list the land on the public sector register (40 working days).
- Complete the sale and leaseback by 31 March 2027.

6. Rotherham development

6.1. The borough remains key to our plans although the Rotherham chapter of our Estate Plan is the one that contains arguably the most challenges. Leased properties such as Kimberworth Place, Badsley Moor Lane and Centenary Clinic offer poor quality spaces for our colleagues and patients, with Trust owned Ferham Clinic requiring some minor works investment to improve the useability of some clinic spaces.

- Kimberworth is shared and well located, but lacks consultation space
- Centenary is ‘maxed out’ and does not offer accommodation at the standard of the organisation, as per this paper
- Badsley Moor Lane is shared space, well used by partners. Our space there is poor quality and the ideal solution will be vacation to allow others to develop the space
- Ferham, which we own, and which is well located – but which lacks parking and access

6.2. The above were common comments and feedback received during the estate roadshow and subsequent survey. We will continue to deepen our engagement with

service users, carers and staff in line with our overall Trust strategy and through the governance structure set out in the management case of the FBC.

6.3. The approach is to negotiate town centre space. In late 2024 we hoped this could come from the Riverside Library redevelopment, but for varying reasons progress stalled. This option is now back on the table; it has now been confirmed the space RDaSH had been considering becomes vacant in autumn 2026. This is 'plan A' and discussions with the local authority continue.

6.4. The CEO and Director of Finance & Estates met with their counterparts at the end of August 2026 with a follow up, and final meeting, scheduled for 20 November. Prior to the meeting RDaSH has provided the local authority with a proposal inclusive of commercial terms and conditions. This will include scenarios of vacating the 4 buildings listed in section 6.1.

6.5. The Board of Directors will be updated orally at the meeting on 26 November on the feedback from the meeting scheduled on 20 November.

7. Next Steps

7.1. A summary of the next steps for the upcoming 12 months (and beyond) is set out in the table below:

Activity	Target Date (Range)	Update
Ambient Loop		
• Select final procurement route	December 2026	On track
• Design Phase	Dec 2026 to Feb 2027	On track
• Tender	End of March 2027	On track
• Preferred Bidder	Q4 2027/28	On track
Tickhill Road		
• Select Procure 23 partner and cost advisor	January 2027	On track
• RIBA Stage 2 complete	March / April 2027	On track
• RIBA Stage 3 complete	August / Sept 2027	On track
• Planning decision	February 2028	On track
• Construction Completion	March - June 2029	To be confirmed
Land Sale		
• Appoint Town Planning Advisor	December 2026	On track
• Confirm sale route	December 2026	On track
• Fix sale boundary	January 2027	On track
• List of budget sector register	February 2027	On track
• Financial close on sale and leaseback	31 March 2027	On track
Riverside		
• Achieve conclusion of discussions	End August 2026	Scheduled for 20 November 2026
• Sign the lease	December 2026	Subject to the 20 November agreement and NHSE capital approval
• Tender	Q4 2026/27	
• Renovation / Refurbishment	March 2027 – July 2027	
• Earliest occupation	August 2027	

Notes: *Timings beyond Q2 2027/28 are estimates which are considered realistic but challenging*.

8. Waterdale development

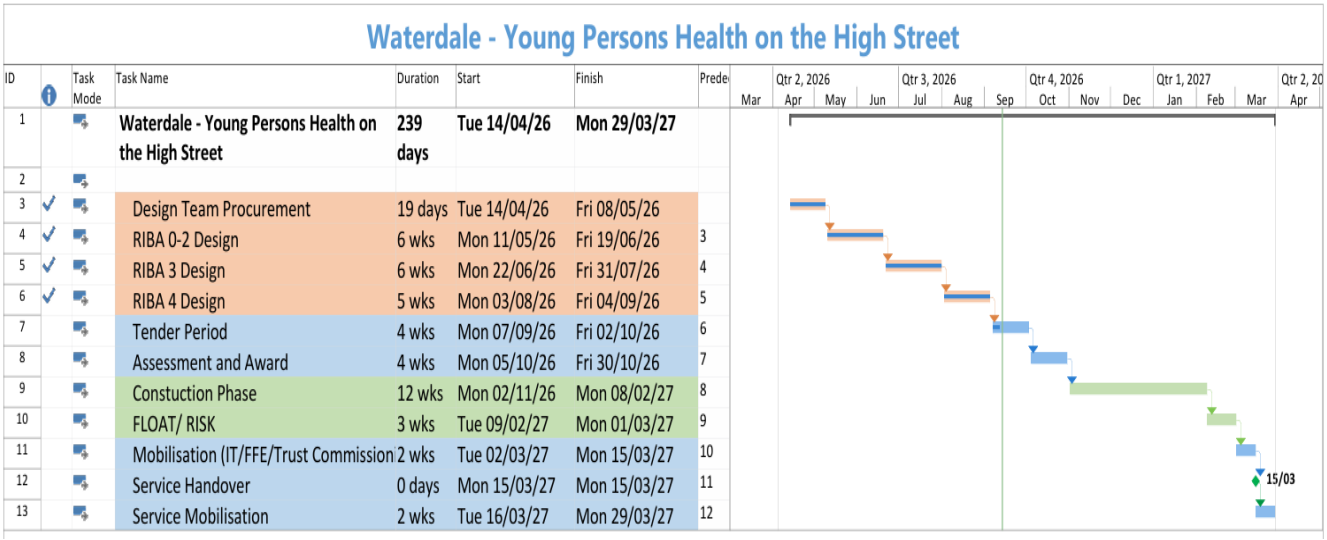
8.1. The Waterdale Development project continues to make positive progress, with ongoing stakeholder engagement ensuring that key partners remain involved and informed as the scheme advances. A significant milestone has been achieved with the granting of unconditional planning permission, providing certainty for the next phase of delivery and reinforcing confidence in the programme's continued progression.

8.2. The procurement process has also moved forward as planned, with tenders closing on 2 October 2026 and evaluations completed on 6 October 2026. The principal contractor commenced works on site on 9 November. The Estates team is working closely with the contractor to support programme delivery and maximise the opportunity to achieve the planned completion timetable by the end of March.

8.3. Whilst a number of project challenges remain, these are being actively managed and progressed through established governance arrangements. In addition, discussions are continuing with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) regarding the potential occupation of ground floor accommodation, with options currently being explored to inform future space utilisation requirements.

8.4. Overall, progress remains encouraging, with development activities continuing in line with the approved timetable and key project objectives. Following these activities, the project remains on programme and is still on track for completion by March 2027.

8.5. The timetable is shown as follows:



ID	Task Mode	Task Name	Duration	Start	Finish	Predec
1		**Waterdale - Young Persons Health on the High Street**	**239 days**	**Tue 14/04/26**	**Mon 29/03/27**	
2						
3		Design Team Procurement	19 days	Tue 14/04/26	Fri 08/05/26	
4		RIBA 0-2 Design	6 wks	Mon 11/05/26	Fri 19/06/26	3
5		RIBA 3 Design	6 wks	Mon 22/06/26	Fri 31/07/26	4
6		RIBA 4 Design	5 wks	Mon 03/08/26	Fri 04/09/26	5
7		Tender Period	4 wks	Mon 07/09/26	Fri 02/10/26	6
8		Assessment and Award	4 wks	Mon 05/10/26	Fri 30/10/26	7
9		Constuction Phase	12 wks	Mon 02/11/26	Mon 08/02/27	8
10		FLOAT/ RISK	3 wks	Tue 09/02/27	Mon 01/03/27	9
11		Mobilisation (IT/FFE/Trust Commission	2 wks	Tue 02/03/27	Mon 15/03/27	10
12		Service Handover	0 days	Mon 15/03/27	Mon 15/03/27	11
13		Service Mobilisation	2 wks	Tue 16/03/27	Mon 29/03/27	12

9. Governance

9.1. To support the delivery of the Estate plan to time and to budget we have implemented a formal governance structure across all aspects of the plan. Amongst other things this is to ensure we maintain the momentum, identify key actions, timescales and risks.

9.2. The governance structure is centred on two key aspects, splitting the plan into 4 distinct workstreams and then having the drumbeat of regular meetings / touch points.

9.3. The workstreams and leads are shown in the following chart:



9.4. To support the workstreams there are the following key touchpoints / meetings:

- Weekly meetings of the core team – (Director of Finance & Estates; Head of Estates; Plan Director)
- Fortnightly meetings with the CEO
- Task and finance sessions of the workstreams
- Monthly Steering Group – multi-disciplinary members covering the 4 workstreams, the core team, plus representatives from communications, digital and people and organisational development
- Bi-monthly Estates & Sustainability Group
- Bi-monthly Finance, Digital & Estate Committee
- Bi-monthly Board of Directors

9.5. All the above focus of the detailed project plan, using consistent documentation including plan updates, key actions, risks and mitigations, and timelines.

10. Recommendations

10.1. The Board of Directors is asked to:

- **NOTE** the progress against the key aspects of the estate plan and the key next steps
- **NOTE** progress and the next steps regarding the Riverside proposal.
- **NOTE** progress regarding the Waterdale development and the project timetable.