AGENDA

COUNCIL OF GOVERNORS – IN PUBLIC

Wednesday 09 September 2026 at 5pm – 7pm
Unity Centre, Rotherham, S65 1PD
(Hybrid Meeting)

No	Item	Lead	Enc
1	Chairman's welcome		
2	Quorum / Apologies for absence		
3	Declarations of Interest		A
4	Minutes and actions from the previous meeting held on 10 June 2026		B
5	Estate Update		C
6	Cultural Reset		D
7	CQC: Well-Led.		E
8	**RDASH Performance – Committee Reports** (from Committee Chairs and Governor members) • Finance, Digital and Estates Committee (FDE) • People and Organisational Development Committee (POD) • Public Health, Patient Involvement and Partnerships Committee (PHPIP) • Quality Committee (QC) • Mental Health Act Committee (MHA) • Audit Committee (AC) • Trust People Council (TPC)		F

RDaSH nurturing the power in our communities

TRUST UPDATE			
9	**Trust Update: Regular reports** • Chair's Report • Chief Executive's Report • Other Committee Reports (Audit, Mental Health Act and Remuneration)	 	G
10	**Governor Activities**		H
11	Any Other Business (to be notified in advance to the Chair)		
12	Public questions *		
	Meeting close.		

	Kathryn Lavery Chair		Toby Lewis Chief Executive		Simon Sheppard Director of Finance and Estates
	Philip Gowland Director of Corporate Assurance				

* Public Questions:
Questions from members of the public are welcomed at the appointed time during the agenda. The following guidance is offered in respect of this item on the agenda: • Questions at the meeting should ideally relate to papers being presented on the day • Members of the public are very much welcome to raise questions at any other time, on any other matter, through the office of the Chair and Chief Executive or via rdash.corporate-assurance@nhs.net • There is no need for questions to be submitted in advance, although this may mean that it is not always possible to provide an answer at the meeting. In that case, the questioner's contact details will be requested for response. Questions will be taken in rotation, to ensure those wishing to raise questions have equal opportunity, within the limited time available. **PLEASE NOTIFY THE CORPORATE ASSURANCE TEAM OF ANY SPECIAL REQUIREMENTS AT LEAST 48 HOURS IN ADVANCE OF THE MEETING** rdash.corporate-assurance@nhs.net

The next meeting of the Council of Governors will take place on Wednesday 9 December 2026 at 5pm ** ONLINE MEETING**

Agenda items – Secondary Waits; Improving Transitional Care – Rotherham Care Group; and Disengagement, psychosis, serious violence - learning related to people with mental illness

ROTHERHAM DONCASTER AND SOUTH HUMBER
NHS FOUNDATION TRUST

REGISTER OF INTERESTS OF THE GOVERNORS

ELECTED GOVERNORS…

Name	Constituency	Interests Declared
Richard Rimmington	Public - Doncaster	Member of the Labour Party
Maureen Young	Public – Doncaster	Nil declaration – **Now stepped down**
Andrew Flynn	Public – Doncaster	Public Governor Doncaster & Bassetlaw NHS Foundation Trust – from October 2024
Joy Bullivant	Public Doncaster	Retired employee of RDaSH updated September 2025
Hannah Hall	Public - Rotherham	Employee at The Rotherham NHS Foundation Trust – Non Financial Dialled In Agency Ltd. – Financial Interests Nova Blade Ltd. Financial Interests Multiverse – apprenticeship student -Academic Member - Society of Radiographers Academic
Mabrookah Agbabiaka	Public - Rotherham	Nil declaration
Kamlesh Vatish	Public – Rotherham	Nil declaration
David Vickers	Public - Rotherham	Good News for Everyone (formerly Gideons) Rotherham Branch – Chair Yorkshire and Humber Regional Pensioners' Convention member Care Quality Commission Public Engagement Group – member South Yorkshire Transport Users' Group – member Rotherham NHS Foundation Hospital Trust – Readers' Panel, PLACE team and Public Panel – member South Yorkshire ICB Readers' Panel – Member AgeUK Policy Sounding Board – Policy Reviewer Age Uk Strategy Group – Member The Richmond Group of Charities – Lived Experience Network Member The Rivers Team Church Council – Member/Trustee Rotherham Deanery Synod (Church of England – Member Patients' Association – member Your Party – Member Rotherham and Barnsley MIND – member Blue Mission Organisation, Sido n, Lebanon – International advisor National Development Team for Inclusion – Advisor/ Blogger
Arun Chaudhary	Public - North Lincolnshire	Nil declaration

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REGISTER OF INTERESTS OF THE GOVERNORS

Chris Pope	Public - North Lincolnshire	Foster Carer Local authority foster carer for North East Lincolnshire Council Receives fostering allowances and payments. Foster Panel Member North Lincolnshire Council Foster Panel Member Receives payment/expenses as a panel member Trustee, :The Fostering Network, 87 Blackfriars Road, London SE1 8HA The Fostering Network is a charity (280852 and SCO39338) and is registered in England and Wales as a limited company no. 1507277 Receives expenses for travel and meetings Delta Academy Trust Vale Academy, Brigg Academy Advisory Board Member Enquire Learning Trust, Broughton Primary Academy Academy Improvement Committee Member Communities' leadership executive (CoLE) member - representing North Lincs Parent Forum
Sam O'Brien	Public – Rest of England	Navigo – Occasional work – from June 2024 University of Hull – Occasional work – from September 2017 Rethink Occasional work – from January 2023
Joan Cox	Patient & Carer	Employee of His Majesty's Prison and Probation – Probation Service Manager – The Service uses RDaSH ASPIRE Services
Ian Spowart	Patient & Carer	Daughter works for RDASH as a social work nurse
Mark Johnson	Patient & Carer	Labour Party, Hatfield Parish Councillor. Member of CHAD Choice for all Doncaster.
Kevin Hodgkiss	Patient & Carer	Nil Declaration
Allan Bell	Patient & Carer	Nil Declaration
Baz Cooper	Patient & Carer	Nil Declaration
Robert Foster	Patient & Carer	Nil Declaration
Pippa Harder	Patient & Carer	Voluntary Action Rotherham - 1) Recovery Volunteer 2) Community Volunteer Ambassador 3) health & Wellbeing Volunteer St James's Church Clifton PCC & Volunteer RMBC - Volunteer with: RASCALS Board Member, Rotherham Borough that Cares (Carers), Rotherham Adult Safe Guarding Committee, Rotherham Health & Wellbeing, Rotherham Autism Strategy Board, Public Health - Mental Health Voluntary Community Connecter. Rotherfed Digital Inclusion Champion Rotherham Day - Committee Member & Ambassador. Rotherham United Community Trust - Committee Member - Premier League Fans Fund & Volunteer Rotherham Hospice - Volunteer Rotherham Dementia Network - member & volunteer

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

REGISTER OF INTERESTS OF THE GOVERNORS

		Safehaven Homeless Project - Volunteer Lost Chord UK - Volunteer RDasSH - Council of Governors & Volunteer Rotherham Hospital Foundation Trust - Volunteer Stag Medical Patient Participation Group - Volunteer Stag Medical Centre - Volunteer Rotherham Interfaith Group Member
Jennie Gaul	Staff - Physical Health and Neurodiversity Care Group	Nil Declaration
Prachi Goulding	Staff North Lincolnshire Adult Mental Health and Talking Therapies Care Group	Nil Declaration
Jessica Williams	Staff Children's Care Group	Nil Declaration
Emma Wilsher	Staff Rotherham Adult Mental Health Care Group	Nil Declaration
Mike Seneviratne	Staff – Corporate	Trustee of SAGE Greenfingers charity in Sheffield Employee of RDaSH

NOMINATED / APPOINTED GOVERNORS

Lee Golze	City of Doncaster Council	Employee DMBC - Assistant Director: Partnerships, Early Intervention & Localities: Children, Young People & Families MGMT Digital Marketing – shareholder	
Kym Gleeson	Healthwatch Rotherham	Non-financial professional interests - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career – 1/4/2025 to present	

ROTHERHAM DONCASTER AND SOUTH HUMBER
NHS FOUNDATION TRUST

REGISTER OF INTERESTS OF THE GOVERNORS

Emma Price	South Yorkshire ICB	Employed by partner organisation – Non-financial Professional Interest	
Champion Solesi	Young Advisory Group	Nil Declaration	
Alexia Dibdin	Young Advisory Group	Newly appointed	
Debra Taylor	Partner – Citizens Advice North Lincolnshire	Nil Declaration	
Ruksana Ismail	Rotherham Metropolitan Borough Council	Nil Declaration	

This Register is maintained by the designated Board Secretary and is available as a Public document in line with Paragraph 34.1.3 of the Constitution.

Rotherham Doncaster and South Humber NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS MEETING – PUBLIC SESSION

WEDNESDAY 10 JUNE 2026 AT 5:00 – 7:00PM

CAST THEATRE, DONCASTER & VIA MICROSOFT TEAMS

PRESENT

Kath Lavery	Chair
Jo Cox	Lead Governor
Mabrookah Agbabiaka	Public: Rotherham
Allan Bell	Patient and Carer
Joy Bullivant	Public: Doncaster
Jennie Gaul	Staff: Physical Health and Neurodiversity Care Group
Kym Gleeson	Partner: Healthwatch Rotherham
Prachi Goulding	Staff: NL Adult Mental Health and Talking Therapies Care Group
Pippa Harder	Patient and Carer
Hannah Hall	Public: Rotherham
Mark Johnson	Patient and Carer
Sam O'Brian	Public: Rest of England
Chris Pope	Public: North Lincolnshire
Emma Price	Partner: South Yorkshire Integrated Care Board (SYICB)
Richard Rimmington	Public Governor: Doncaster
Ian Spowart	Patient and Carer
Dr Michael Seneviratne	Staff: Backbone
Jess Williams	Staff: Children's Care Group
David Vickers	Public: Rotherham

IN ATTENDANCE

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
Kathy Gillatt	Non Executive Director
Philip Gowland	Director of Corporate Assurance and Board Secretary
Dr Judith Graham	Director of Psychological Therapies
Carlene Holden	Director of People and Organisational Development
Jo McDonough	Director of Strategic Development
Simon Sheppard	Director of Finance and Estates
Dr Rumit Shah	NeXT Director
Pauline Vickers	Non Executive Director

PUBLIC/STAFF

Sarah Dean	Corporate Assurance Officer (Minutes)
Selina Khunkhuna	Clinical Lead for Talking Therapies
Dr Susannah Parker	Director of Psychological Therapies, Doncaster Mental Health and Learning Disabilities Care Group
Glyn Butcher	People Focused Group
Laura Cox	People Focused Group
Leana Gater	Staff - Senior Project Manager, Children's Care Group

Minute Ref		ACTION
COG 01/06/26	**Welcome** Kath Lavery, Chair, opened the meeting and welcomed all attendees.	
COG 02/06/26	**Quoracy and Apologies for Absence** Kath declared that the meeting was quorate. Apologies were received from Governors, Andrew Flynn, Emma Wilsher, and Kevin Hodgkiss, and from members of the Board Rachael Blake, Dr Diarmid Sinclair and Toby Lewis. Dr Mike Seneviratne was attending both as a Governor and as Dr Sinclair's deputy.	
COG 03/06/26	**Declarations of Interest** No further declarations were made in respect of the agenda items for this meeting. Thanks were given to Paul Kinnell, volunteer, who had helped to keep the declaration of interest register updated and was regularly engaging Governors. **The Council of Governor's received the Declarations of Interest.**	
COG 04/06/26	**Minutes and Actions of the Previous Meeting Held on 11 March 2026** The Council of Governors approved the minutes of the previous meeting as an accurate record with the following amendment. COG 05/03/26 third paragraph to read, *"In respect of policies, Carlene mentioned that she had been working with Dr Alex Tansell, Widening Participation and Apprenticeship Manager, on the work experience policy."* The Council of Governors received the action log and noted the progress updates. One action noted as 'propose to close' was agreed, and it was noted that four actions would remain open including COG 04/09/2024 and the introduction of Martha's Rule. Steve updated on Martha's Rule, confirming a phased rollout in Rotherham and Doncaster using a PDSA approach (plan do study act). Daily physical health checks would be recorded via updated patient record systems, with delays due to IT changes. Radar was also being updated to track any incidents and outcomes. The action remained open for ongoing updates and learning from pilots.	
COG 05/06/26	**Transitional Care Update – Children's Services** Richard Chillery introduced the item and noted the Council of Governors' interest in transitions between children's and adult services, highlighting concerns about the historically binary approach at age 18. Richard advised Kate Jones, Children's Care Group Director, was	

	overseeing the area following earlier input from a children's perspective. Richard outlined that Selina, Clinical Lead for Talking Therapies, and Susannah, who worked in the Doncaster adults mental health and learning disabilities leadership team, would present on their work in supporting care leavers. The Council of Governors were invited to listen to both presentations with opportunity to ask questions afterwards. Susannah then presented on transitions for care leavers, explaining the focus in adult services due to their high prevalence of mental health need. It was highlighted that between around 46% and up to 80% of care leavers experience mental health difficulties, with many not accessing services and therefore falling through gaps in provision. Care leavers were noted to have significantly higher unmet need compared to their peers, alongside increased risks of self harm and suicide, including a much higher likelihood of suicidal ideation and behaviours. The transition from CAMHS to adult services was emphasised as a particularly high risk period, as individuals moved into early adulthood and faced increase independence alongside challenges such as housing, relationships, and navigating services. The importance of effective, supportive transitions during this time was highlighted to reduce risk and improve outcomes. Selina outlined the role of Talking Therapies within transition pathways, supporting young people with mild to moderate anxiety and depression through cognitive behaviour therapy (CBT) and counselling. Access had been extended from age 17½ to 16 to provide earlier support, complementing rather than replacing children's services. Implementation included additional training, supervision, and close working with children's services to ensure appropriate referrals and clear pathways. While referral numbers remained low due to limited promotion, they had more than doubled over the past year, indicating increasing uptake. Richard advised the proposed pathway involved starting transitions earlier (up to a year before the typical age), making the process more person centred and needs led, and extending support beyond the age of 18, recognising that legal frameworks allow support up to age 25. David Vickers referred to broader transition challenges for young people, including the impact of early adolescence and wider social factors such as family background. Richard Chillery suggested that earlier preventative support could improve later transitions. It was acknowledged that some young people experience complex or unsupported systems and that, while earlier intervention may reduce risk, not all issues can be fully resolved, with some continuing into adult services. Chris shared his lived experience as a foster carer and supported the overall direction of travel, highlighting the differing needs of those in residential, foster, and kinship care, alongside potential impacts from forthcoming national changes. The "cliff edge" at age 18 was described as abrupt and often traumatic, particularly when combined with	

	education pressures and financial responsibilities, with limited guidance available. These challenges were noted as contributing to low progression into higher education. Local variation in service access was also highlighted, alongside positive examples of effective transition support and the valuable role of external partners. Jo Cox raised concerns about the high levels of self harm and how maturity and individual needs were being appropriately considered, including neurodivergence. It was acknowledged that this was a national, complex and growing challenge, requiring greater awareness and training. Susannah advised that staff working with care leavers were receiving additional training, with further support in place to improve understanding of neurodivergence. Selina confirmed there was a high prevalence of people with neurodiverse needs who were accessing Talking Therapies and noted plans to further upskill clinicians through dedicated training. Sam raised concerns about self harm and suicide, highlighting LGBTQ+ young people as a high risk group and asking what support was in place. Susannah acknowledged a potential gap in LGBTQ+ awareness and support. Richard Chillery noted the high prevalence within this group and emphasised the importance of addressing this within Talking Therapies, where young people were more likely to present. Richard also highlighted the role of community organisations, recognising that some young people preferred peer support than accessing NHS services, and noted that stigma and wider societal factors, including poverty, remained barriers. Selina welcomed the point and confirmed this was an area of focus, with ongoing work alongside the children's care group, as well as national initiatives and training. Kath concluded that this would remain a focus for future discussions and thanked Selina and Susannah for their contributions. **The Council of Governors received and noted the paper for information.**	
COG 06/06/26	**Who we think we are** Jude presented an overview of the Trust, noting it had previously been shared at the Communities' Leadership Executive (CoLE). The presentation provided a refresher on the organisation as a community provider of physical health, mental health and learning disability services across multiple localities. Services were delivered across more than 100 sites to meet the needs of urban and rural populations, supported by approximately 3,600 staff across a wide range of professional groups. Provision included children's services, Talking Therapies, inpatient and community mental health services, learning disability services and specialist physical health and neurodiversity services. The Trust's development and scale were outlined, including its transition to Foundation Trust status, financial position and links with partner	

	organisations and community services. Emphasis was placed on partnership working, co design with service users and reducing barriers and improving transitions across services. Strengths included timely access to services, a skilled and diverse workforce, strong community engagement and investment in local facilities. Areas for improvement included care planning, digital development, documentation, consistency of service delivery and partnership working with primary care. Jude invited questions from the Council of Governors. In response to a query from David Vickers regarding culture, Kath Lavery advised that culture underpinned all organisational activity and reflected a challenging year involving change and difficult decisions. Kath acknowledged that communication with communities had not been sufficiently clear and confirmed that improving culture would inform future engagement with patients, communities and the workforce. Governors commended the presentation for its clarity and value. Rumit noted progress in relation to four week waits and assessment times and highlighted the importance of sustaining improvements. Jude reported that assessments were often completed within four hours, while treatment times varied according to clinical urgency. Improving the timeliness of treatment remained a priority, with engagement required to agree appropriate expectations across services. Richard Rimmington suggested that the information be used in communications to support governor engagement and recruitment. In response to the earlier question, Steve Forsyth confirmed that culture would be reviewed following staff survey results, with discussion planned for September. Richard Chillery highlighted targets to achieve an eighteen week pathway by April 2027 and to ensure no child waited more than two years in neurodevelopmental services by October 2026. Work to address longer secondary care waits across identified services was underway. It was clarified that the four week standard constituted a substantive intervention. **The Council of Governors received and noted the paper for information.**	
COG 07/06/26	**Ambient Loop** Jo McDonough gave a presentation which summarised plans to decarbonise the Trust's estate heating, focusing initially on the Tickhill Road site due to its high gas usage and alignment with estate plans. It had identified reliance on gas as a major contributor to emissions and set out the need to move to a low carbon energy source to meet net zero targets.	

	An options appraisal had compared air source heat pumps, a high temperature heat network and ground source heat pumps with an ambient loop system, assessing cost, efficiency and deliverability. Ground source heat pumps using an ambient loop had been identified as the preferred option, offering the best balance of carbon reduction, efficiency and long term cost, despite higher upfront investment. The proposal had been expected to eliminate gas use at Tickhill Road, reduce carbon emissions to zero on the site, lower running costs and provide both heating and cooling. Overall, Jo concluded that the ambient loop approach provided a practical route to achieving net zero while supporting wider estate transformation, with the Board approval in May, to progress to an estate full business case. David Vickers and Ian Spowart asked whether the Trust would be the first to implement the approach. Jo confirmed that, whilst examples and case studies existed elsewhere and interest had been shown by organisations such as the Royal Marsden, the Trust would be at the forefront. The system was described as scalable and could potentially support energy provision to future housing developments, although it would not generate additional energy. Hannah sought clarification on alignment with the NHS ten year plan. Jo advised that the estate plan included reducing the site footprint and relocating services closer to town centres while retaining key services at Tickhill Road. Steve highlighted the potential to increase land value, support affordable housing and significantly reduce carbon emissions. It was noted that the NHS was a major contributor to national carbon output. Richard Chillery outlined ongoing consideration of agile and hybrid workforce models, supported by Health Informatics and HR. Simon reported positive feedback from the estates roadshow. Kath concluded that estates, green energy and workforce developments were aligned and represented a significant opportunity. **The Council of Governors received the presentation for information.**	
COG 08/06/26	**RDASH Performance, Committee Reports (from Committee Chairs and Governor members)** Phil presented the report which reflected a revised reporting approach focusing on key areas of escalation, and highlighted an additional page from the Quality Committee had been circulated in advance, These matters for escalation included prescribing concerns from the Quality Committee, matters relating to the Mental Health Act and reducing restrictive interventions training from the Mental Health Act Committee, and slow progress against inequality related promises from the Public Health Patient Involvement Partnership Committee. It was also noted that trust culture had been discussed at the recent Trust People Council meeting.	

	Attendance by governors at committee meetings was acknowledged and welcomed as an important mechanism for engagement and assurance. Governors were invited to highlight any matters arising from committees. It was confirmed that arrangements would be maintained to ensure continued governor attendance at committees despite forthcoming changes in membership. Dr Richard Falk referred to the escalation on lithium prescribing, advising that concerns identified through the risk register had been addressed promptly with appropriate senior clinical input and reported back to the Board, demonstrating effective governance. The statutory safer staffing declaration had been noted by both the Quality Committee and the Board. It was reported that there had been a shift towards evidencing the impact of learning, including in relation to mortality reviews and Regulation 28 reports, with an emphasis on demonstrating measurable improvement. Regarding inpatient settings, improvements had been made and progress had been noted in enhancing patient information and access to support for those awaiting services. The Council of Governors noted the updates and was reminded that further queries could be submitted following the meeting. **The Council of Governors accepted and noted the Committee papers.**	
COG 09/06/26	**Trust Update Regular Reports** Kath presented her report and advised that Non Executive Directors' performance development reviews (PDRs) had been completed, with her own in progress and Toby's nearly complete. Thanks were given for the coffee and cake sessions, with further sessions to be planned from September and invitations to be extended to Non Executive Directors. No questions were raised on Kath's report. **The Council of Governors received and noted the Chairs report**. **Chief Executive's Report** Steve, on behalf of Toby, presented the report and governors were invited to raise any questions they had. Steve presented the key highlights. Recognition was given to the work undertaken at Great Oaks to ensure it reopened on 1 June, including the achievement of zero out of area placements and successful repatriation of patients. Work undertaken in workforce and culture since the previous meeting was highlighted, including the launch of Ask Talk Influence staff sessions, open to all staff and supporting improved communication and engagement with senior leaders.	

	Positive progress was reported on Waterdale with a 25 year lease secured and funding confirmed. Partnerships across the system were noted as important, including the introduction of the Communities' Leadership Executive (CoLE) with voluntary sector representation. The regulatory landscape and the trust's position was described as amber green pending system changes, with a revised National Oversight Framework rating due to be issued. Dr Richard Falk noted that the trust would take on responsibility for prescribing for neurodiversity in children in North Lincolnshire. Kath reminded governors of previous commissioning arrangements which ceased in February 2025 and paid tribute to Toby and colleagues for enabling the new service to commence on 1 July. Hannah referred to the CoLE and partnership working and it was agreed that contact details would be shared with her regarding engagement opportunities in Rotherham. David Vickers queried whether the achievement of zero out of area placements reflected increased provision or confidence in services. Steve confirmed that this reflected a collective effort, including reviewing admissions, length of stay, repatriation work and the opening of the Phoenix ward. It was noted that a ward closure in Rotherham had not resulted in negative impact. Richard Chillery advised that the position was sustainable but required continued focused effort, particularly in relation to length of stay, discharge processes and social housing, and that embedding this work would take time. Kath noted that maintaining zero out of area placements required ongoing effort. Chris requested detail on the children's neurodevelopmental prescribing service in North Lincolnshire. Richard Chillery advised that the service would mobilise from 1 July, predominantly nurse led, with most staff in post by the end of July. Existing complex cases, including those from the private sector, would be worked through over a period of at least three months. It was acknowledged that progress had been made to reinstate the service and the impact on families was recognised. It was further noted that an integrated treatment and pathway model would be in place within a year. Jo Cox highlighted the requirement for ethnically diverse interview panels at band 7 and above and queried wider application. Steve advised that this was an important starting point given workforce demographics at senior levels. Carlene referenced previous work demonstrating improvement at band 6 and below and noted that further work would extend to wider banding and centralised recruitment approaches to reduce bias.	

	Pippa requested clarification on criteria for hospital admission and was advised this would be provided offline. It was agreed that all questions would be circulated to the Council of Governors. **The Council of Governors received and noted the report.**	
COG 10/06/26	**Governor Activities** Phil presented the report and highlighted the activities undertaken by the governors, including spiritual and religious care event, and encouraged Governor participation in scheduled peer reviews, and invited people to come forward for opportunities. The quality statement was highlighted, and Phil acknowledged positive feedback from some contributors, noting it would be published in June after stakeholder approval and input of governors statement for the year April 2025 to March 2026. Regarding upcoming events, the Annual Members Meeting (AMM) and a fun day would take place on 18 July. Upcoming publications would include the trust's annual reports and accounts, Flourish annual impact report, charitable funds 'Your hearts and minds' annual report and accounts, and the Quality Account. **The Council of Governors received and noted the report. The Council of Governors approved the statement, for inclusion in the Quality Account 2025/26**	
COG 11/06/26	**Any Other Business** None	
COG 12/06/26	**Public Questions** No public questions had been received. Glyn Butcher provided a reflection on the earlier item and emphasised the importance of supporting people to live with some of their thoughts and behaviours rather than expecting them to get better. He explained that he would always for example hear voices, and that part of his recovery involved understanding and making sense of them.	
COG 13/06/26	**Date, Time, and Venue of Next Meeting** Wednesday 9 September 2026 at 5pm, the Unity Centre, Rotherham	

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING – ACTION LOG

REF	AGREED ACTION	OWNER	PROGRESS	OPEN / CLOSED
COG 04/09/2024	**RDASH Performance – Committee Reports - Quality Committee** An update in June noted the commencement of the roll-out in Rotherham and Doncaster with an ongoing review process in place. The action would remain open for further updates to be provided on the introduction of Martha's Rule	SF	**September 2026**: Further to the update provided at the last CoG meeting, the Chief Nurse will outline the very latest position to Governors at the meeting.	Open
COG 05/03/25b	**RDASH Performance – Committee Reports - Public Health, Patient Involvement and Partnerships (PHPIP) Committee** Information on the Community Involvement Framework was circulated in June 2026 and it was agreed that the CoG would return to the topic at a future meeting.	TL	**September 2026**: This is to be scheduled.	Open
COG 09/12/25	**Trust Update Regular Reports** More information on the community rehabilitation initiative would be provided at a future Governor meeting.	RC	**September 2026**: This is to be scheduled.	Open
COG 05/03/26	**Young Advisors Group– What do we do and Why do we do it?** Young advisors had provided initial thoughts and comments on bulling in schools and it was to be determined how the NHS – but more specifically the Trust - could support this.	PG	**September 2026**: The Young Advisors met the Board of Directors on the Annual Fun Day in a session aimed specifically at this topic. A range of topics were highlighted and the Board of Directors agreed to, and will, make a response to them within the September Board of Directors meeting.	Open

Estate Plan 2026 -2030

Council of Governors
9 September 2026

Estate plan 2026 - 2030

- **We want to be able to offer environments that match the skills and needs of those who care for our patients, and backbone colleagues who support their work**. The Elizabeth Quarter building we opened in 2025 sets a standard for what we want to achieved.

- There is no discernible legacy plan for that estate, and investments have made piecemeal: the exception to that is a programme of investing over five years in our mental health wards, which has seen refurbishment work completed in Doncaster (2022), Rotherham (2024) and North Lincs (2026). **This year we are finishing that with our work to create therapeutic garden space.**

- We have a commitment to the Waterdale, Health on the High Street, development, which opens spring 2027. This will house much of our children and young people's mental health service for the city.

- *Broadly our estate changes in North Lincolnshire are complete* – we open the open - access mental health facility in October 2026 and take full occupancy of St Nicholas House later this year.

- Trust Board approved the Estate Plan 2026 -2030 full business case at the meeting in July 2026 .

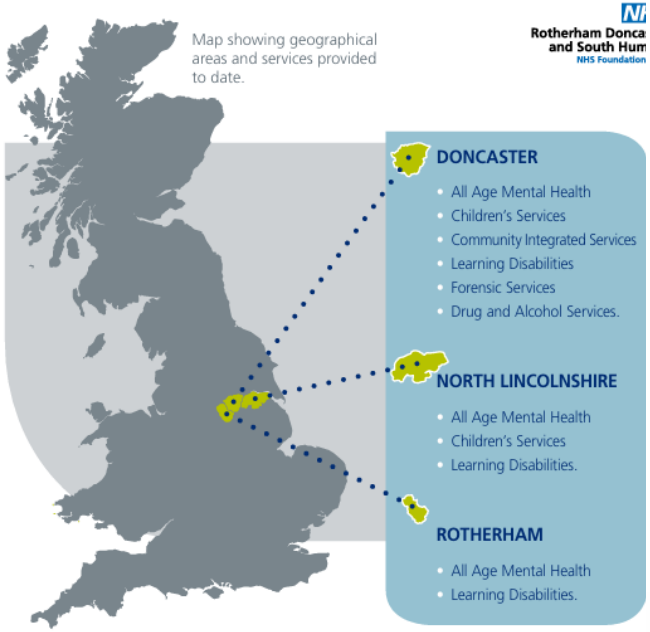
A couple of considerations

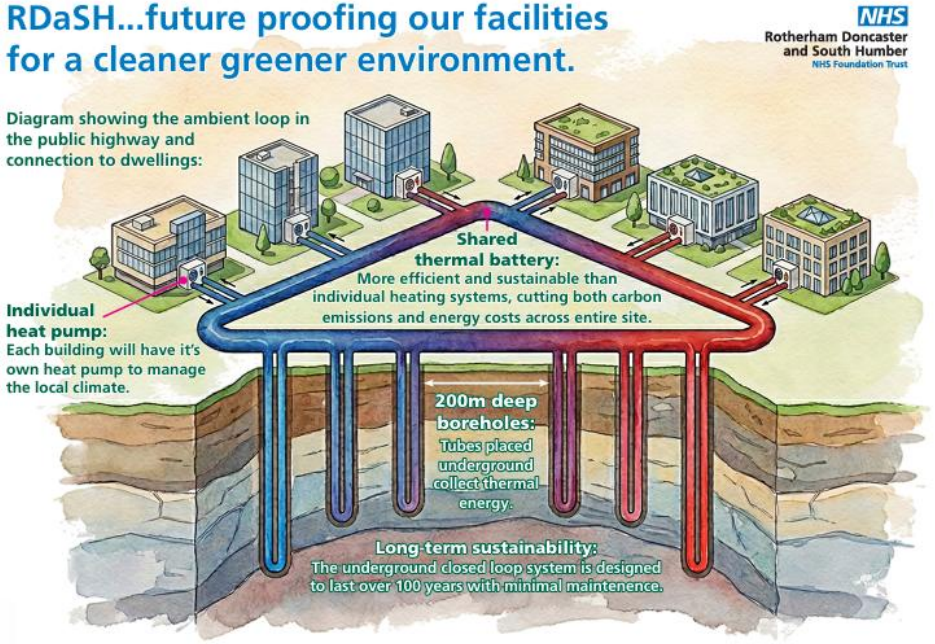
- The cost of doing nothing is significant, and that repairs buildings not fit for purpose
- We do bring in some income from leasing properties and also expend a significant sum on NHS Prop Co buildings
- The Board agreed in May to support an ambient loop heat pump solution to tackle use of gas in Doncaster
- This is a cooling, as well as a heating, solution and work will start during 2027

149 Buildings
116 RDaSH owned
£19,771,786.00 cost to repair

£591,088.76 Income received from rental properties

£1,871,863.51 expenses for leasing properties





Estate Roadshow

Estate Roadshow

- Over 600 people contributed to our estate roadshow and estate survey….
- We were able to explore immediate issues and long-term plans and nothing raised will be lost.
- We continue to work hard with impacted staff to give them a voice in new designs and clarity over timescales

Estate Roadshow – Key Themes from the week

1. **Car Parking**
   - Staff, service users and visitors
   - Safe
   - Accessible e.g. disabled / parent parking
   - Appropriate lighting

2. **Consultation Rooms**
   - Not enough for increased face to face appointments
   - Often blocked booked
   - Need better lighting

3. **Therapy Rooms**
   - Not enough
   - “Sheds / Chalets” outside
   - Improved lighting and soundproofing needed

4. **Booking System**
   - Need an electronic booking system for consultation rooms

5. **Current Buildings**
   - Need repairs / improvements
   - Signage and wayfinding not great
   - Not “fit for purpose” without significant work:
     - BML
     - Kimberworth
     - Ferham
     - Centenary Clinic

6. **Communication**
   - Needs to continue
   - #Askmeanything
   - Send survey
   - Patient Feedback should be sought

7. **Amenities**
   - Canteen/Servery ++
   - Showers
   - Bike racks
   - Lockers
   - Pop up Fruit n Veg stall
   - Vending machines (contactless)

8. **Co-location of services**
   - Services who work close together to be co-located
   - Supports teamwork, well being and improved patient care

9. **Meeting Rooms / Office**
   - Varied sizes to support team meeting – 10/25/50/100
   - PODs for 1:1s and confidential discussions
   - Hot Desks in zones
   - Supports training on differing sites rather than excess travel

10. **General**
    - Mobile clinics
    - Central store – “hub and spoke
    - IT connectivity

Estate Survey

10. **Open Feedback.** Biggest issue:

More details

288
Responses

Latest Responses

"Workspaces being limited yet expectations are we are present in bases. Limit..."

"."

"Limitations within current basepoints: Lack of space Lack of facilities Lack of ... "

...

36 respondents (12%) answered building for this question.

Update

Estate Survey

1. **What do you value about your workplace now?**

More details

290
Responses

Latest Responses

"We have a good team working together and offering support to one another."

"I enjoy having somewhere my team can work together as we are very suppo... "

"The opportunity to liaise with other colleagues within the team"

...

71 respondents (24%) answered team for this question.

Estate Survey

5. **What is wrong with where you work right now?**

More details

290
Responses

Latest Responses

"Work stations becoming limited resulting in staff having to complete record... "

"The area I work in right now all be it a little outdated is absolutely fit for pur... "

"The lack of adequate spacing within the current two rooms at the Hollybush ..."

...

87 respondents (30%) answered building for this question.

Estate Survey

7. **Thinking about working flexibly and in an agile way:** What features of our estate will help you best balance work a nd home? More details

287
Responses

Latest Responses

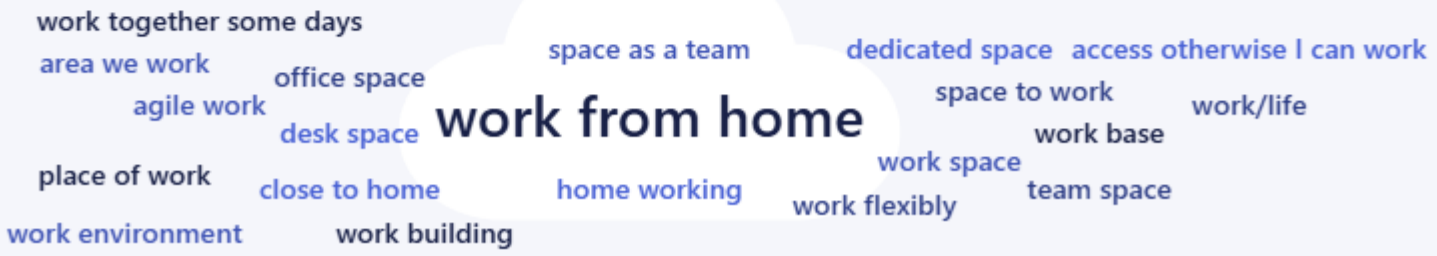
"enough work space and equipment such as printers and scanners."

"I work from an RDaSH building general, I don't work from home very often."

"Working within a basepoint is more appropriate for myself. This allows me t... "

...

50 respondents (17%) answered work from home for this question. Update



What happens next?

1. The priority is to try and settle the Rotherham estate with a 2027 move into the Riverside building. This is pending between ourselves and the Local Authority – and could unlock the future of Ferham, Centenary etc.

2. Following Trust Board approval we are finalising plans to release over half of the 38 hectares at Tickhill Road and to focus services in existing and new buildings adjacent to the Loversall entrance by 2029/30.

3. New buildings will be:
   - A “frailty centre” to include the current Hawthorne and Hazel wards
   - An education / learning centre

4. Where specific issues were raised in the survey/roadshows (for example therapy space at Swallownest) we are working to find solutions for those issues and to communicate with those involved not later than September.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Cultural reset	**Agenda Item**	Paper D
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Carlene Holden, Director of People and OD and Toby Lewis, Chief Executive		
Meeting	Council of governors	**Date**	9 September 2026

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

There are two annexes to this paper which are prior papers. They are shared with the council of governors to give just a flavour of the work to get to a final position: that work continues. To a degree, the process of developing the work matters as much as a final position.

RDaSH consists of many cultural and identities. What is common is the need to become better at balancing both support and accountability. Sometimes called care and challenge. Defining support and ensuring the skills exists to ensure accountability effectively yet kindly is the essence of the work we aim to do. The extensive leadership development offer is a basis for the next phase of work.

Within this a theme is getting the basics consistently right. This may be something the council wishes to discuss. The key idea in this paper is the final paragraph.

Previous consideration

TPC January, April and July, CLE June and July, Board May, July and timeouts: June/Aug

Recommendation (delete options as appropriate and elaborate as required)

The Council of Governors is asked to:

NOTE the work the Board is leading to address over two and four years our culture

CONSIDER any areas of emphasis it wishes to suggest

RECOGNISE the limitations of action/outcome when undertaking cultural change

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

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

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

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

If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	X
If we cannot agree with local GPs and the wider primary care leadership how to coordinate care at HCT/PCN/neighbourhood level because there is not the skill to change, or confidence to experiment in both parties; or funding models are restrictive then we cannot deliver our new community offer with the effectiveness that our strategy requires and shared care will not be achieved and patients will suffer harm.	
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	X	N		If 'Y' date completed	Sept 23rd
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)

Annex A: Board culture paper July 2026
Annex B: CLE culture paper August 2026
Annex C: TPC briefing pack July 2026

ROTHERHAM, DONCASTER, AND SOUTH HUMBER NHS FOUNDATION TRUST

'Cultural reset'

Introduction to governors' discussion

1.1 Since 2023, the Board has sought to change and adapt the culture of the Trust. Two elements of that broader change effort are worth emphasis. We have actively tried to inculcate a delivery mindset, in which we aim to manage the future not commentate on the present. This contrasts with an assurance approach, where reassurance is offered up a system, often without supporting quantified evidence. Secondly, and consistent with the first strategic objective in our strategy, we have sought to open up RDaSH to outside voice and perspectives including peers, carers, volunteers, patients and public representatives including governors.

1.2 We know that these changes are not always understood or contextualised as they happen. We know too that both generate some resistance, or disquiet. Much of that resistance is constructive and helpful, some less so. There is a view from some that we have "gone too far" and that patient voices overwhelm staff opinion or advice. But also, that delivery creates expectations that folk find hard to meet. This especially is because delivery relies on candid, sometimes difficult conversations, and active line management. In all sorts of ways, the prior culture militated against that; for example, it had a high veto, high grievance, vibe, with some individuals and professions tacitly exempted or protected. It is important that this paper is not read as a defence of the present nor an attack on the past. RDaSH has real long-term cultural strengths, and the present has genuine and evident weaknesses that we need to tackle.

1.3 The discussion with Council of Governors is really one of many taking place to collect perspectives, ideas, and reflections. These could be about:

- What is most important to you
- What worries you about what is outlined
- How you might want success to be thought about in 2028 and 2030

How does this work fit with other work?

2.1 The development of our senior and middle managers has been a priority since 2024. In addition to the leadership development offer for our top 150 leaders (TLC: top leaders' cadre), introduced a first line manager development offer in early 2025, and training for those co-leading our wards in 2026 (MPLT: multi professional leadership teams). We also set out to be sure we knew who line manages someone. This ongoing analysis suggested 555 people among over 4000 had some form of line management role. To date our only additional intervention to support that group is the introduction since April 2026 of a monthly online team brief (ATI: ask talk influence), which is well attended by over 200 people each month.

2.2 Our cultural work does not de-prioritise our promises. Quite the opposite it should be seen as reinforcing them in two specific ways:

- Our promises can only be delivered by fully staffed teams who are well led and motivated. We know that some of the highest profile promise delivery (3, 14, 19)

has required initial and sustained top-down support, often drawn from less than a dozen people. Absent motivated, engaged distributed leadership we will struggle to execute all 28 promises, and certainly struggle to sustain it.

- Our promises are a means to an end. That end is the mission to nurture the power in our communities. That transfer of power, that acknowledgement of what is most important absolutely intends to change how we work in our 'day job'. Again, that necessitates a balance of culture and strategy.

2.3 The current anticipation is that we aim to embody our reset work in a series of **Cultural Commitments 2030**. The timeframe matters. It acknowledges that this work takes time. Time to fully embed. But it also deliberates bridges two strategies, our promises work to 2028, and what comes next which we think will timeline to 2035 with a redoubled focus on equity and addressing health inequalities. Commitments, like promises, are relational in their framing: these are commitments to ourselves, and to one another, across the organisation. They will include a restatement of the behaviours that sit within our six constant values, and likely a relaunch of those values to make sure that colleagues understand 'how we work around here'.

<u>What it is?</u>

3.1 Annex B sets out the clearest exposition we yet have of what is planned. This recognises that high support/high accountability needs practical examples of how we both do some new things, but especially how we do what we currently try to do: but do it *more consistently and more effectively*. Allied to that we wish to make good on our long-standing hope of distributed leadership, the frustration of which lies in part in capability issues and in part in experiences that disempower. By and large the Board reserves very little to itself, and I define I believe clearly what stays with me – creating significant space for local adaptation and adoption. But as is explored in Annex C that is not the feedback, so we need to do better.

3.2 Getting the basics consistently right is the strongest feedback we receive of what staff leaders wish to see change. Consistently is not uniformly, and that transition from managers working to a defined list, as against operating guidance, is another shift, and one that our work on flexible working (explored in this COG CEO report) will test. Annex B contains the current draft list of basics and hints at an MOT process of adoption. That approach may change as we move through coming weeks.

3.3 Annex A is explicit that our work on discrimination and anti-racism is a central feature of the cultural work. The Board approved the approach for this outlined in the paper and it will feature visibly and explicitly in what we move to launch.

<u>How is this being governed and what's next?</u>

4.1 Multiple leadership spaces have had time since May to debate the ideas within these papers. Whilst there is not a cut off for this, there is a need to narrow and define what we expect. In September's Board that moment will arrive, linked then to the annual leaders' conference of the Trust the following week.

4.2 A staff involved steering group, that includes staff networks, trade unions, line managers and senior leaders is trying to oversee a September-January process of adaptive implementation. That meets first next week. The Trust has engaged the PSC, who worked with us the leadership development offer, to partner with us into

2027. They are provided outside-in expertise to the programme and seeking to help us to remain structured.

4.3 But importantly we need to close the gap we have between senior leaders and those working on key work day-to-day (sometimes mislabelled as a frontline). In late October and through November we plan to devote significant amounts of management time to that 'reintroduction' work – stepping into spaces within the organisation, listening to what matters to others, and beginning to 'join the dots': this has to reinforce not bypass local leaders but it has a critical purpose:

RDaSH, under the guise of the strategy, has done a phenomenal amount of work on development. Yet for many staff, including some senior leaders, they remain in 'survival' mode. We need to better understand the support and fixes for that survival state if we are going to truly benefit from the development ambitions we are delivered and aspire to sustain and extend.

Toby Lewis, Chief Executive
1st September 2026

COG 09/09/2026 Paper D, Annex A

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Culture Work – moving forward	**Agenda Item**	Paper V
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Carlene Holden, Director of People & Organisational Development Toby Lewis, Chief Executive		
Meeting	Board of Directors	**Date**	30 July 2026

Suggested discussion points

This paper may frustrate in that it is not as conclusive nor as defined as we might have hoped when we met in May. It does however set out a route to that specificity for September: it also reflects many, many conversations since May in a variety of places, whilst acknowledging that depth now needs to be added to breadth. The paper confirms we are still working towards the high care/high accountability ideas we explored first at the leaders' conference in 2025, and which in many ways reinforce themes that have then run through our LDO.

Because we wanted anti-racism to form a core part of the cultural reset, this is discussed within the paper. A more specific set of actions, many already in hand are laid out. There are some forward actions to be taken which will then complete a picture of what we will be doing in 2026, in 2027 and in 2028 to try to meaningfully deliver Promise 26. The paper includes comments on antisemitism, on language and asks the Board to agree a definition to anti-muslim hate. We envisage that our anti-racism work will both have its clear exposition for staff and managers, and be explicitly woven into the equivalent cultural reset material.

Previous consideration

Clinical Leadership Executive, May 2026; Trust People Council, January & April 2026. BOD May 2026, Board timeout June 2026, Trust People Council July 2026

Recommendation (delete options as appropriate and elaborate as required)

The Board is asked to:

NOTE - the report's description of ongoing work since the Board last met

DISCUSS – the anti-racism theme within the paper to a conclusion (noting three pieces of work to return)

ACCEPT and AGREE – the definition of anti-muslim hatred contained within the paper

COMMENT – on the intended co-production work in advance of the leaders' conference in September

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

Trust Risk Register			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	X
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Financial risks			
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Patient care risks			
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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.	X
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Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	X
Delivering our promises	Low Tolerance	We accept minimal risk in failing to meet agreed commitments to our partners and communities; delivery must be reliable and transparent.	X

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

System / Place impact							
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	At final version in September 2026
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Appendix (please list)

Annex 1: Our agreed 2025 culture aims (people and teams plan)
Annex 2: NHS Staff Standards documentation
Annex 3: Wheel of inclusion (LDO product, credit VMI)
Annex 4: Anti-Muslim hatred definition for adoption

Rotherham Doncaster and South Humber NHS Foundation Trust

Culture work – latest update

1. Introduction

1.1 This paper assumes that the why behind our cultural reset is now well understood within the Board, and likewise the continued drive towards becoming an anti-racist organisation. The focus of conversation needs to sharpen on what and how, whilst acknowledging that this is a not a programme we can simply do, instead it needs to impact how we work in teams and wards, as well as within the Board.

1.2 Despite the listed dialogue on the front-sheet, conversations deeper within the organisation have been modest to date, and that needs to change during August and September. The clinical leadership executive expressed enthusiasm for the behavioural commitments to re-energise our values, and there is a recognition that the re-launch of appraisal offers one mechanism to enact that. The leaders' conference on September 29th represents an opportunity (as we did with the strategy in 2023) to shape a final proposition, but by that point we need both the what and the how to be clear – to react to (remembering that we need to circle back around the why with each new engagement).

1.3 NHS England have published, since we last met and they are annexed, a mandated set of staff standards, in six domains, together with their proposed leadership framework. There is nothing colleagues are likely to dissent from within this work, but, in our conversations in the Trust People Council, for example, these would appear to be the minimum that should be expected from this work, and focus mostly on individual conduct, whilst cultural change comes too from how teams behave and interact.

1.4 There is a strong preference from some stakeholders, including some trade union voices, for a clear theoretical underpinning to this work: in effect a model from research applied to the Trust. As we move forward the co-production of this work, we need to consider that carefully and Board direction in this space would be welcome. In leaning towards high support/high challenge we are, of course, already drawing on the literature about high performing organisations.

1.5 This paper updates Board colleagues on both thinking and proposed actions. In the latter regard the actions are incomplete as presented and there is space for others to be added. The output from the timeout has been considered in preparing this paper. It is worth recalling that in the timeout the framing was about how our work to share power with, and recognise power in, our communities, might best translate to a similar compact with our people, staff, students and volunteers. That remains an intended storyline.

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2. Anti-racism including antisemitism

2.1 Part of the reset work is proposed to be our renewed effort to meet our promise 26. We have also explored, and I would suggest need to continue to explore, how we manifest a commitment to tackling antisemitism within that work. July 29th saw our first learning half day session focused on that topic, which is repeated in September: the national e-learning announced by DHSC in response to the Mann Review has not yet been issued and may not now be available until April 2027.

2.2 The commitment from our review of our anti-racism work in November 2025 was to seek to shift the obligation from colleagues who identify as being from a global majority or black and minority ethnic heritage, to make all employees positively demonstrate their anti-racism. The implication being that in team meeting and development activities, in applying techniques like the wheel used in our LDO (annex B), and then within appraisal, we would each be needing to evidence our awareness or and enactment of anti-racist behaviours. In taking forward work on Mulberry, which shortly to transition to The Willows, some such behaviours have been developed.

2.3 We should not neglect the seven-point plan which we enacted in 2024 to begin our work on this promise. That included work to change recruitment panel composition, which went live this July, as well as important changes to who investigated concerns, disciplinary investigations and grievances that could involve racism allegations. This work has been routinely scrutinised within the People and OD bi-monthly delivery review and explored to in the people and teams' sub-group. It may be helpful for the Board's People and OD committee to form a single view of how much of this plan remains to deploy, and assuming that, what measures or metrics of success we should use in H2 to test its effectiveness and impact. Alongside this we will review the NHS Race and Health Observatory Seven Anti-Racism Principles, and explore incorporating their framing into our plan and signing up to their principles.

2.4 Notwithstanding that review, in 2023 we made a commitment that the senior leadership of the Trust (band 8+) would change to better reflect the communities we serve and the staff we lead. This goes beyond, but does include, the make-up the Board. A numeric analysis of the current state will come to the Board in September to allow us to consider what further steps are needed to deliver that commitment. I would anticipate that this will require specific trajectory plans associated with foreseeably vacant roles in corporate functions as well as a move in some domains to 'affirmative action' hiring practices in early 2027. Work has already commenced in the P&OD Directorate to consider our approach and will be explored in their upcoming delivery review. In essence we cannot leave to organic change the change in who we are, even though the transition to one in seven RDaSHians being from a black and minority ethnic background is a stark change in our employee base since 2023 – it makes all the more urgent the change needed in who leads these colleagues.

2.5 The REACH network have made some specific proposals about what they feel has to form part of the anti-racism work, in addition to lending their support towards the change in our recruitment panels for band 7+ roles. They wish us to introduce (arguably reintroduce) a Reverse Mentoring programme into the Trust from October 2026 – with a first phase lasting to December 2027. In addition the prominent See Me First campaign, which seeks to promote psychological safety in the workplace associated with diversity, is one they urge us to adopt. It seems astute to accept this advice, not least as ultimately it is the judgement of our staff on Promise 26 which surely is the test of our success, and the benefit of trust earnt, and patience offered is not to be overlooked.

2.6 Part of our discussion on antisemitism has been a re-exploration of terminology. Our networks have been reflecting on these issues and trying to consider what terminology may best be applied, recognising that language that minoritises can offend, but as we have discussed so can labels like Global Majority. The current thinking is that we will not succeed in finding a single template of terms, without affront to anyone. As such we need to use a variety of terms where required and specificity when we can, and as they are used seek to check-in on their suitability with those around us. It would be helpful for the Board to consider whether this approach can work for us.

2.7 The Trust Board has previously accepted a definition of antisemitism that was government endorsed and derived from academic work in the field. At that time, we noted no such definition was agreed nationally in respect of Islamophobia, or put slightly differently, anti-muslim hatred. Annexed to this paper is a government endorsed definition which I would propose we now adopt. In November, we will conclude work to explore the practical implications for our work of both definitions, as well as how we take forward the terminology conclusions outlined above.

2.8 Taking the above considerations in the round, that would suggest that we have a sizeable series of actions to take in furtherance of the Promise:

a) Sustain and see the benefit for our existing seven-point plan
b) Implement to be agreed actions consistent with moving to a more representative leadership
c) Adopt the proposals from our REACH network in addition to the above
d) Include within our new appraisal framework a behavioural demonstration expectation consistent with the work developed for some of our wards
e) Review the second year of the Acceptable Behaviour policy, now aligned to the anti-racism pathway within RADAR, to consider whether adoption has grown and take action in places where it has not
f) During 2027 specifically review service pathways through the lens of ethnic origin and religious tradition, as we have done in terms of poverty and are doing in terms of inclusion health
g) Ensure that our successor plans beyond the LDO, as well as other management training programmes we have, contain allyship and other relevant modules to support this agenda – whilst continuing to deliver

the Active Bystander training to wider colleagues to increase the spread across the organisation

2.9 Internal audit criticised our implementation arrangements associated with Promise 26, in their review in 2024/25. Key to that legitimate critique was that the various plans and initiatives were understood differently by different layers of the leadership. With the Trust's EDI function changing presently, and a small restructure of the POD team having taken place, I am suggesting that, led by Carlene Holden we develop a simple visual that seeks to capture (and put into plainer language) the 13-15 actions outlined. We would use targeted and specific events in late October to make sure that those who need act to deliver this 'plan' understand not only the actions but who is doing what. This does not preclude very clearly including elements of this anti-racism work within our wider reset discussions at the leader's conference in September – anti-racism having featured strongly in last year's event.

3. The now four themes within the wider reset

3.1 We agreed in May that settlement on language needed co-production. That remains a work in progress. Care seems to divert the discussions into a focus on patient experiences not staff experiences, and, for some, accountability is an affronting term. It remains to be considered whether that 'jar' is helpful or a hindrance. Bearing this in mind, I use the terms support and challenge below.

3.2 In discussion within the Trust People Council, we explored the merits of:

- Getting the basics right: a series of guarantees all our people should expect of their employment experience
- A high support culture: what we want everyone to do behaviourally to care/support (?respect) for one another and operate compassionately at work
- A high challenge culture: how we ensure bi-directional accountability and make sure that respectful challenge and difficult conversations are positively promoted in the Trust
- Distributed leadership: how we build this into how we work, recognising that structurally we have this already, but we need to hear that that is now how it can feel – and acknowledging significant asymmetry of capability

These themes are explored in a short pack circulated with the private Board papers because the material is frank and should not understood as a likely final draft of our reset work. It may be that we will end up collapsing four themes back into two, but the basic right/distributed leadership in different ways seem important call outs to acknowledge – the former for our 'frontline' teams who may be in survival mode, the latter for our middle and clinical leaders who are often focused on their service or team and not always on the 'corporate' view.

3.3 It seems possible now to try and commit to a list of experiences that everyone should have in the workplace, as of right. This will be a more practical list than the national standards, but those standards would deployed as a second layer.

The third layer would then be the behaviours behind our values that were explored in the Board paper in May. Putting that differently:

- Layer one are things we promise to you
- Layer two are things the NHS is saying must happen
- Layer three are those things we would expect of you and ourselves
- Layers one and three are what it means to be RDaSH not just the NHS

We would launch these expectations as part of the support/care part of the cultural commitments work. Launch would mean that during October, November and December we undertook deep engagement across the Trust. This is conversational and has to happen where people work. Senior leaders including Board members would be spending time in those workplaces (in and out of hours) to introduce the support, and to hear what it means to people within their work. Our efforts have to help people solve their problems, even as we introduce beliefs about what will solve those we see Trust-wide. This will likely be happening alongside deployment of the always measures for safety.

3.4 High challenge (accountability) needs to be introduced concurrently. However, there is considerable nuance to how it is narrated with different parts of the Trust. We want our healthcare support workers, peer colleagues, cleaning teams, and others to feel that they can 'stop the line' and hold others to account. At the same time, for senior managers and responsible clinicians the accountability framework will have a different hue. Whilst for some Board members this framework may seem like evident-clarity, our advice is that even at a very senior level it is relatively novel. Our positivity about a delivery mindset, delivery reviews, data led enquiry, and objective setting, is not necessarily shared even within the top leaders' cadre. We need to make the case, to explain the practicalities, and to provide skills training and simulative experiences if we are going to have the impact we know is needed. Building on the LDO, we are working with outside partners to think about a one-year programme of work, which includes but is not limited to skills training, that seeks to support the introduction of this more defined RDaSH Way. This may include the beginnings of a single methodology to improvement, not least because if we introduce more "deliverology" without talking to improvement approaches we will likely end up with the two ideas bifurcated as nasty/nice by 2028.

3.5 It is sometimes helpful to define what we need to avoid, alongside what we need to do. As was acknowledged in the paper in May, this cultural reset requires change among us all, including the people and OD directorate. We need to guard against HR professionals becoming seen as the care/support arm, whilst management is viewed as the challenge/accountability space. As this perhaps implies we need during August, even as we are working through the what more fully, to begin to create space in the work-schedules of both managers and HR colleagues for H2 ready for the how. Both business partners and the revamped OD team, as well as L&D, and professional educational roles, will be needed to play a part in deployment.

3.6 Cultural work, especially overtly led work, often fails because it defaults (or appears to) to a branding exercise. Symbolism is important, and we will need to use such approaches as reinforcement and as 'moments'. But our aim here is to **change daily habits**. Perhaps the most critical of such is to allow real conversations between professions and between layers of hierarchy that do not rely on formal processes, third party interposition, or structured conflict. Better to call in something in real time, better to stop the line than to report elsewhere. That has to come from a place of safety and a belief that we all matter – that RDaSH is all of us.

3.7 Whilst the proposals on anti-racism have a specificity, this wider cultural work remains emergent. The intention now is to use August to sharpen that what-gap, and to focus in September on visualising the how of H2 and 27/28 – noting that this is a four-year hike to 2030, with results expected over the first eighteen months to two years. Q3 26/27 will be us asking our organisation if they agree to this work, and what it means to them: not us telling the Trust's staff that this is it. That will mean learning about the organisation almost anew.

3.8 Board members will recognise longstanding discussions about medical engagement, and indeed behaviours, inside the Trust. We explored in May some facets of that both in public and private session. Andrew Heighton is undertaking some exploratory work to put some 'flesh on the bones' of both what is troubling some colleagues, and how we might respond to that. Notwithstanding that that is ongoing, it is already clear that there are some practical frustrations we want to address, as well as a need to try and reset *mutual* expectations: and talk honestly to bi-directional perceptions. Medical colleagues are an essential part of the care we provide, and at a service level often undertake that work on a very intra-disciplinary basis. However, professional identity matters – as we explored in social work earlier in 2026. We need to, within the cultural reset, provide an insistently multi-professional culture, without allowing that to be portrayed as diminution of status or standing.

4. Co production of the prototype

4.1 Acknowledging the argument above that we will continue to shape and change ideas as we deploy, we nonetheless need a final draft or indeed a prototype to create a conversation. With this in mind, we will be working as follows:

- From mid-August (wb 10/8) a weekly steering group will be meeting to chew over ideas and options: in addition to executive group will use some of our routine time to consider how we foresee this work succeeding and what it will take to arrive at that success.
- We will work with both the CoLE and PFG as our LERO (lived experience recovery organisation) partner, alongside volunteer and peer representatives, to think about how patients, carers and communities can narrate their experiences of change and improvement relevant to this different journey.
- Discussion within ATI in June, July and again in August, with September having a full focus in this space.

- We have open staff meetings starting on August 3rd, and whilst as always we will use those to listen, we will begin to seed these ideas, alongside relevant parallel projects like 'agile' and the estate work, into conversation.
- Each staff network will have an opportunity during August and early September to be introduced to this work and how it might develop.
- As indicated above a specific change for POD colleagues will be established to think through time-release and practice change, and we will use the leaders' conference to do that work with a more cross-sectional cohort of managers.
- Trade union engagement has been taking place via the TPC, but we will introduce this work into other forums of discussion in the hope that this work is seen as a shared endeavour to improve the workplace experience.
- The experience of employee engagement used with the estate plan (roadshows followed by survey) has generally been well received in the organisation – we are working through how to mimic that in September for this slightly more abstract topic. Doing that alongside the launch of the national staff survey is probably a beneficial concurrence: we will be paying to add questions to this year's survey and also pushing hard in Q3 and Q4 on the Pulse survey.

4.2 The output from this work will be reviewed next at the Board's August timeout, in the expectation that what will be explored at the leaders' conference will come to the Board in September. Without losing the nuance we need a simple what / how / why – and that may need to be framed differently for different traditions within our organisation. Part of the success of the Promises has been that most people can see themselves in some of them, and in most cases, they are clear and practical enough. This contrasts with a more 'high level' set of aspirations that are inoffensive but meaningless. That 'promises' test is what the Board needs to apply in the next two conversations, especially in September. If we cannot meet that test we will need to take further time until we do.

Toby Lewis, Chief Executive
Carlene Holden, Director of People and Organisational Development
23rd July 2026

Annex 1

The culture we wish to be part of

Culture cannot be prescribed. It brings together the learnings and beliefs, symbols and behaviours of the Trust as it is today, experiences from the past, and hopes for the future. But a culture can be enhanced by intention, altering what is working less well, adjusting to bring greater consistency framed around best practice. It is this cultural adaptation that this Plan can contribute to, that leaders can enhance, and that we can measure through feedback and another means – testing our success against that intention, recognising that cultures change slowly.

Colleagues have developed ideas about the culture that they wish to be part of:

- Caring, Supporting, Fair and Equitable culture for all: we want staff to treat patients with respect, care and compassion, so all leaders and staff must treat their colleagues with respect, care and compassion
- Climate that supports equality, diversity and inclusion: celebrate the diversity and different thoughts, perspectives and views
- Climate that supports 'nurturing the power of our communities': encouraging learning and innovation, working alongside those within services and in neighbourhoods
- Collective leadership: where staff at all levels are empowered as individuals, within and between teams to act to improve care within and across health and care organisations and systems – 'leadership of all, by all and for all'

In an organisation the size of RDaSH it is unlikely we will have one culture. Indeed, the climate of diversity and innovation described will come best from the fusing of different cultures; by place, profession, tradition, and team. But some common threads are needed if we are to support the care we provide to be outstanding in its caring nature, and the development of individuals and teams to be respectful and compassionate. Those common threads will come with behavioural expectations that reflect the pace and ambition set by the Board's strategy, as well as the expectations for reform anticipated in the NHS Ten Year plan.

Annex 2

NHS Staff Standards documentation

NHS Staff Standards

NHS Staff Standards aim to reduce variability and improve consistency of staff experience across the NHS and will work alongside other initiatives like the NHS People Promise.

They will set a national required standard, providing a clear framework of accountability for improving staff experience. Setting out the areas employers should prioritise and focus on, this will make improving staff experience a priority for boards, alongside areas like finance and operational performance.

The standards will cover:

Staff standards

Line management

Standard

Staff can expect supportive, fair, developmental and compassionate line management, enabled by employer support for line managers, to help staff to perform well, feel valued and fulfil their potential.

Employer actions

To support line managers, employers must:

- embed the NHS Management and Leadership Framework by aligning local communications, strategies, policies, processes, training, appraisal and recruitment to it to ensure line managers have the skills they need
- ensure all managers complete the NHS Management and Leadership Framework self assessment tool and undertake development to progress towards achieving the standards within it
- ensure comprehensive line management training is offered to all line managers, with a particular focus on first-time managers, through the NHS Management and Leadership Framework, so that they are aware of their responsibilities under the expectations of line management guidance, and monitor line manager performance, taking action to improve quality as necessary
- ensure that job plans accurately incorporate and allocate sufficient time for line management responsibilities so that managers have the capacity to meaningfully discharge their role
- ensure all roles have clear, accurate and up to date job descriptions and review role changes promptly through agreed processes when requested, in accordance with the NHS Job Evaluation Scheme
- ensure that all line managers have appropriate supervision, mentorship and support from their immediate managers and that line management policies are easily accessible and actively enable line managers to provide timely support and responses to their line reports
- ensure board level oversight of how line managers are being enabled, by routinely gathering and acting on feedback from line managers about the

systemic enablers they need and the barriers that prevent them supporting staff effectively

- work in partnership with trade unions through local arrangements to build a more illustrative picture of line management on the ground by reviewing data, health and safety risk assessments and culture trends, and assessing compliance with legal duties in line with the Public Sector Equality Duty to proactively assess fairness and monitor impact, for example through equality impact assessments

Line managers must be enabled by their employers to ensurethat:

- all employees receive high-quality appraisals, in line with contractual requirements, that set clear, achievable objectives
- staff development and career progression is actively supported through regular and meaningful feedback and access to appropriate learning and development and support to apply learning in practice
- a culture is created where line managers model behaviours such as openness, respect and inclusivity, and challenge behaviours that undermine this. To enable that culture change, they must:
  - provide compassionate, constructive support to staff, working with staff representatives and trade unions where needed
  - enable a psychologically safe environment where staff feel comfortable to raise issues, knowing they will be escalated where necessary
- teams are led effectively by setting shared objectives, enabling appropriate autonomy, addressing differences constructively and fostering respectful team environments where staff feel connected to their team and able to make a full contribution

Standard

Staff can expect their organisation to protect their health, safety and wellbeing at work. Employers are responsible for supporting staff wellbeing, preventing ill-health associated with work and helping staff to feel safe, cared for and able to perform well.

Employer actions

- appoint a health and wellbeing guardian at board level, who will ensure the organisation is compliant with the standard by ensuring collection of workforce data pertaining to health and wellbeing

- use the NHS Health and Wellbeing Framework to produce a localised health and wellbeing strategy that is built on workforce data and provides needs-driven health and wellbeing support. This will be co-produced through staff engagement and partnership working with unions. It will incorporate the 7 core elements of creating health and wellbeing culture. The strategy will have board-level oversight

- employers must take steps to ensure that, where practicable, staff have access to safe, non-clinical environments to take their rest periods. Where call demand or operational pressures may disrupt break opportunities, employers must ensure policies and rostering practices support staff to take restorative rest as soon as practicable

- employers must ensure that all staff, regardless of work location or shift pattern, have reliable access to nutritious food and drink. For settings where catering or rest space facilities are limited or unavailable, or where the site is too small to sustain such provision (including ambulance stations, community sites and mobile staff), employers should consider implementing practical alternatives. These solutions should prioritise healthier options aligned with NHS food and drink standards and be accessible 24/7 to support staff working irregular hours, including night shifts. Alternatively, employers should ensure that there are safe options

available for staff to store and prepare their own food

- ensure all managers are supported to complete mandated competencies on safety, and health and wellbeing in line with statutory and mandatory training so that all staff can expect health and wellbeing conversations to be embedded into one-to-ones and appraisals, with dedicated health and wellbeing conversations that are supportive and additional to formal HR processes
- ensure managers are trained on how to discuss reasonable adjustments with disabled staff and staff with alternative needs as part of these health and wellbeing discussions, as well as trained on how to sensitively support and encourage staff disclosures about being disabled
- ensure protection and provision for pregnant and breastfeeding staff and for those experiencing perimenopause and menopause
- ensure all staff have access to occupational health and wellbeing support and local services that are needs-driven and in line with the latest specification and ensure that occupational health recommendations are acted upon
- work in partnership with trade unions through local arrangements to review data and monitor progress to deliver improvements that meet local need

Standard

Staff have a right to feel safe and supported at work, in an environment that is free from sexual harassment, abuse and unwanted or inappropriate sexual behaviours. Staff can expect: their organisation to take clear, consistent action to prevent sexual misconduct and harassment; promote a culture of transparency and openness that ensures incidents are reported and acted upon promptly and appropriately; training to be provided on how to recognize and report inappropriate behaviours; and a victim centred approach, with support provided to those affected and lessons learned to reduce the risk of future incidents.

Employers must:

- fully implement the actions set out in the Sexual Safety in Healthcare- Organisational Charter, assessing progress using the sexual safety charter assurance framework, ensuring board level ownership and accountability
- ensure all staff complete Understanding sexual misconduct in the workplace e-learning
- ensure that investigators of sexual misconduct allegations receive specialist training
- ensure they have robust staff policies and processes for dealing with sexual misconduct and that staff do not suffer detriment as a consequence of reporting, in line with victimisation legislation
- share concerns about employees with future employers and host organisations
- ensure all staff are familiar with the sexual misconduct people policy framework so that they understand how to recognise and report sexual misconduct, and what actions should be taken when sexual misconduct is reported and where staff are the perpetrators, including the other policies that might be used
- work in partnership with trade unions and staff networks through local arrangements to provide assurance on support for staff, to shape local plans and to encourage staff to call out where organisations are failing

Standard

NHS staff can expect flexible working (flexibility in how, where and when they work) to be openly encouraged and supported, fairly and equitably considered, and embedded into everyday practice, creating a 'flexible first' culture, rather than treated as an exception.
Requests must be considered objectively and not unreasonably refused, and where they cannot be agreed, alternatives will be explored.

Employer actions

Employers must:

- appoint a board level flexible working champion who is responsible for:
  - promoting and leading improvements in flexible working across the organisation
  - recognising and challenging the barriers to accessing flexible working
  - ensuring implementation of a flexible working action plan
  - promoting a positive organisational culture towards ensuring fair and equitable access to flexible working for all staff

- implement a flexible working action plan using organisational workforce data to ensure a consistent approach across the organisation and individual teams which is owned by the board

- following an equality impact assessment, implement preference-based team e-rostering for all frontline workers (where operationally appropriate) within the organisation to bring flexibility and choice of shift patterns to staff who need to maintain safe services

- collect data on the number of flexible working requests (formal through contractual changes and informal through manager one-to-one discussions) which are approved or rejected, the types of flexible working requests, and broken down by protected characteristic as per the Equality

Act 2010, staff groups and/or professions, bands and at department level

- publish this data for staff and linked to the flexible working action plan set out what actions will be taken to improve areas where there are concerns. This data should also be available to the CQC as requested

- work in partnership with trade unions through local partnership arrangements to assess progress, including by sharing data with unions to enable transparent dialogue in a timely fashion

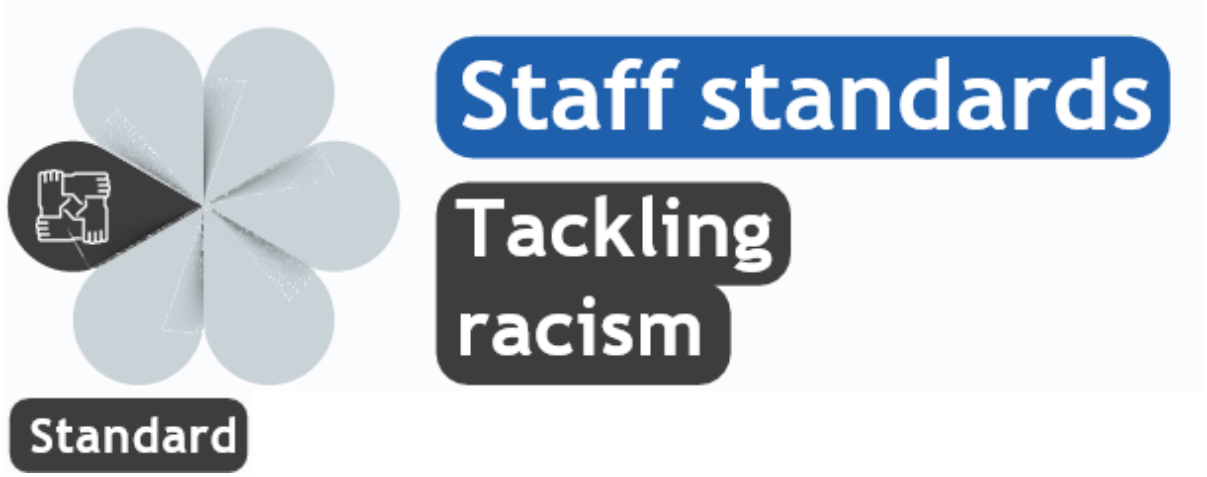
- ensure and evidence that managers, leaders and staff members have training in line with their roles to ensure they are confident to lead flexible teams

- include flexible working as an option in all job adverts, job interviews, pre-retirement conversations, and line manager conversations such as appraisals or regular one to one discussion

- regularly review (at least every 12 months) flexible working (informal arrangements) with staff to ensure they still meet the staff member, team and service needs. Review discussions should be recorded

- ensure your organisation is following the guidance set out in The National Flexible Working People Policy Framework and reference this within the local flexible working policy

- ensure staff within the organisation have been trained and supported with digital skills, infrastructure and resources to effectively use systems that change howthey do their work, in a more flexible way



Staff can expect their organisation to take sustained and meaningful action to prevent and root out racism and discrimination in the workplace (encompassing all forms of violence, abuse and/or harassment from patients and/or service users, their relatives, members of the public and staff), ensuring staff experience safe working environments and a supportive culture where they can expect restorative support, clear accountability and defined consequences in the organisation.

Employer actions

Employers must:

- set clear consequential outcomes for misconduct at the individual level, (including bullying, harassment and discrimination both verbal and physical) including from members of the public, patients, and/or service users and their relatives, and at organisational level. This should include a review of policies related to staff misconduct, and where appropriate, explicitly state the standard of behaviour expected from staff and the penalties including up to dismissal for certain behaviours and/or repeated incidents. It should also include the potential for refusal of care for patients in non-emergency situations, as well as consequences for organisational performance and professional non-compliance (Care Quality Commission (CQC) and/or professional regulators)

- work in partnership with trade unions to ensure representation of the staff voice, reviewing policies to ensure they are fair/proportionate, supporting staff to speak up safely and support during formal procedures to ensure racism is taken seriously in delivering this standard

- ensure implementation and monitoring of the 6 high level impact actions as part of the NHS Equality, Diversity and Inclusion Improvement Plan, and as set out in the NHS Standard Contract

- ensure every board member (including Non-Executive Directors) has a published Specific Measurable Achievable Relevant Time-bound objective on tackling racism. Either the chief executive officer or chief operating officer must be appointed as the senior responsible officer for tackling racism and must be guided by the Race and Health Observatory

leadership toolkit and anti-racism principles. They will be held to account against relevant workforce data and there must be clear incentives in place for strong and clear consequences for poor performance

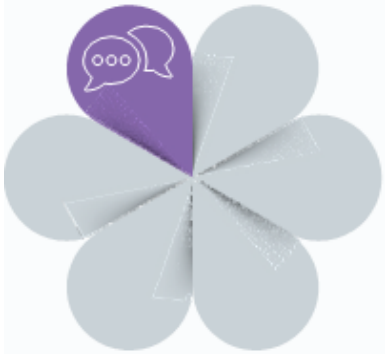
- implement inclusive recruitment and talent management practices by developing a recruitment and career progression plan that ensures equity of opportunity (expanding on the high impact actions and the specific measurable targets as part of the current EDI plan and the workforce race equality standard (WRES))

- work to create inclusive cultures (embedding basic values of culture and respect) that encourage staff at all levels to report and for employers to consistently work to root out racist behaviour. Employers must ensure that their internal reporting mechanisms and systems capture the experience of racism on an individual basis to enable wider analysis and trend monitoring that contributes to local improvement plans in tackling racism

- update emergency protocols and responses to include adequate and appropriate responses that help to maintain safe working environments

- update grievance, disciplinary and investigative processes so they are responsive to the experiences of racism and discrimination and are void of biased applications in their process. Ensure they encourage thorough and unbiased investigation, with careful examination of evidence to clarify when and why racism has not been proven

- where appropriate, evaluate and implement the recommendations of key leading bodies on good practice, to ensure work is reflective of the evolution and growing body of work to tackle racism at every level



Staff standards

Violence prevention and reduction

Standard

Staff have a right to feel safe and supported at work, in an environment that takes meaningful action to prevent violence, aggression, intimidation or abuse in any form. Staff should have access to simple, safe and supportive channels for reporting violence in the workplace; timely, compassionate support after any violent or harmful incident; and the right training to equip them with the confidence and knowledge to keep themselves and others safe.

Employer actions

Employers must:

- implement and embed the violence prevention and reduction (VPR) standard. They should have a named senior responsible officer for VPR with an annual VPR improvement plan, using VPR risk assessment tools and evidence-based interventions in relevant settings
- ensure that reporting systems are in place and actively promoted, so that all staff feel supported to report any incident of violence or abuse, irrespective of a patient's circumstances or condition
- accurate and timely data should be recorded to inform strategies on tackling and preventing violence and feed into national VPR data collections
- ensure staff who are subject to violence or abuse have access to high-quality post-incident psychological and welfare support. Managers should understand how to ensure staff receive post incident support and where to signpost staff to
- develop and implement HR policies and procedures that provide staff with the right support following incidents and during investigations
- ensure that all staff receive training appropriate to their role
- ensure the appropriate health and safety committee and/or forum is engaged in VPR planning and monitoring
- work in partnership with trade unions through local arrangements, staff networks and local VPR groups to provide assurance on support for staff and to encourage staff to call out where organisations are failing. This should ensure that staff voice shapes local improvements with feedback and lived experience underpinning policies and interventions

Annex 3

Wheel of inclusion
(LDO product, credit VMI)

Inequity areas is VMI's newest waste wheel

NHS
Rotherham Doncaster and South Humber
NHS Foundation Trust

- Use this tool to study a process, programme, or policy to identify inequities
- **Violet** inequities may be experienced by people without power and privilege
- **Blue** inequities may be displayed by people with power and privilege, often unintentionally

Annex 4

Definition of anti-Muslim hostility

Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.

Gov.uk, published 09/03/2026

COG 09/09/2026 Paper D, Annex B

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Framing the cultural reset	**Agenda Item**	Paper G
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Clinical Leadership Executive	**Date**	18th August 2026

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

We are trying to remake the way we work inside the Trust in order to improve how we partner with our people, improve alignment to our values and promises, and support patient safety. The aim is to do that without losing the manifest improvements made to quality of care, community collaboration, and results since 2023. Doing both-and can feel daunting.

The paper moves forward work on High Support / High Challenge, outlining some specific elements which will happen and work to engage a wider coalition of staff over coming weeks. It recognises that we plan to use our Leaders' Conference to anchor this work. The clinical leadership executive has a vital role to play as we need to more consistent behaviours, language and approaches between us, if we are to help the wider 555 leadership to adapt.

'Launch' from October means a different set of conversations across the Trust, requiring leaders to free considerable time to be 'out and about', both understanding and listening but also reframing perspectives that you hear. The people and OD team's work changes starkly too, as we look to re-pace some of our processes, but liberate senior HR time to join a more purposive OD effort alongside our 24 directorates.

Previous consideration

(all 2026) Board March, Board May, Board July, CLE May, TPC January, TPC April, TPC July

Recommendation (delete options as appropriate and elaborate as required)

The Clinical Leadership Executive is asked to:

EXPLORE further the issues within the paper, noting the timetable agreed with the Board

CONSIDER what changes in behaviour we need to make from October to deliver this

ENSURE each senior team within CLE spends time discussing these topics before the leaders' conference

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	
SO4: Deliver high quality and therapeutic bed-based care on our own sites and in other settings	
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	

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

Trust Risk Register (indicate the risk references this matter relates to against the appropriate risk appetite)			
People risks			
Planning and Supply	Moderate Tolerance	We will take calculated risks in developing new workforce pipelines and sourcing models, provided staffing remains safe and sustainable.	
Capacity	Low Tolerance	We accept only minimal risk in having the right number and mix of staff; unsafe or inadequate coverage must be escalated immediately.	
Well-being and Retention	Low Tolerance	We have low tolerance for working conditions or practices that may compromise staff wellbeing, morale, or retention.	X
Capability and Performance	Low Tolerance	We accept only minimal risk that staff lack the skills, training, or supervision required to meet clinical or operational standards.	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.	
Estates, Equipment & Supply Chain	Moderate Tolerance	We accept limited risk while modernising our estate or reconfiguring supply chains, provided patient safety is not compromised.	
Information Governance	Averse	We do not tolerate breaches of information confidentiality, integrity, or availability.	
Digital Infrastructure & Cyber Security	Low Tolerance	We accept minimal risk to core digital infrastructure and cyber defences; outages or vulnerabilities must be minimised and quickly addressed.	
External and partnership risks			
Change and Improvement Delivery	Moderate Tolerance	We are prepared to accept limited risk in delivering improvement programmes or transformation, provided governance remains effective.	X
Legal & Governance	Averse	We do not tolerate breaches of legal duties, regulatory obligations, or governance standards.	
Partnership Working	**High Tolerance**	We are open to new partnerships and collaborations, accepting uncertainty where aligned to strategic goals and public benefit.	X
Regulatory	Averse	We do not tolerate non-compliance with regulatory standards and reporting obligations.	

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

Strategic Delivery Risks (indicate those that this paper supports)	
If our 'changed ways of working' with the diverse population (inc excluded communities) are not delivered by 2027 because of the leadership's inability to identify, communicate and engage then it will lead to a loss of confidence locally and likely non-delivery of SO1	X
If we do not execute plans to consistently create, use and respond to data inside our services and with others because our leaders lack the time, skills or diligence to see through specific changes or are distracted by 'wider system' priorities then this will lead to a lack of precision in how the Trust reshapes services	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	X	N		If 'Y' date completed	Before September Board meeting
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Appendix (please list)
Annex 1 - national 'staff standards' Annex 2 – work programme emerging with PSC Annex 3 - 'Culture' Board paper – July 2026 (excluding annexes)

ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Framing the cultural reset

Purpose and introduction

1.1 This paper is pared back. There have been a sizeable series of other papers to reach this point, and CLE colleagues are advised to read those anew. Together they describe a journey which dates back into 2025, but which has deepened through reflection on data points around our staff survey (especially the <3 yr/>3 yr divide) in 2026. This paper then tries to describe more specifically what we are going to do.

1.2 The July Board paper on this topic included a major focus on **anti-racism**, including anti-semitism. That work returns to CLE next time when the various cited additional actions will have been completed. We absolutely intend that anti-racism is an integral part of the cultural work we are doing. There are some encouraging signs of progress in feedback from employees, but a stark and real challenge ensuring our band 8a+ leadership reflects our organisation and wider population.

1.3 We will also be folding into this cultural reset work being done with medical staff in the Trust. Colleagues playing a key and unique part of our care pathways, albeit proportionately small in number. This 'cultural' work is presently being undertaken internally but we will be bringing The Value Circle, who worked with us on our external well led assessment, from September in to try and support a two-way dialogue over future behaviours and expectations: we know already that an important part of that work will be improving actual/perceived responsiveness to individual clinicians.

Getting the basics right

2.1 As new colleagues start; we complete pre-employment checks, give them a contract and pay them for their work. In our mind, they attend a five-day induction. That should be completed inside three months of joining. The expectation is that their access to places of work and to computerised information will be facilitated from day one. We have a little work to do to be confident these processes happen on time, every time.

2.2 For some time we have spoken of 'our people' being the combined efforts of staff, students and volunteers. We also tend to fuse peer supporters in, many of whom are volunteers but not with us. As we consider what is 'routine' or basic we need to make sure that there is a defined path for each part.

2.3 After joining, in reality, our consistency dissipates. As CLE we would expect a PDR, MAST training, attendance at LHDs, and, in due course, the reading of

identified policies. Supervision should be consistently taking place and being recorded. We need again to be much more confident that this list is being done by person in each team consistently.

2.4 But is that the right - or the whole - list? These, at paragraph 2.3, are things the institution expects, wants and needs. But what does the employee need? Feedback suggests that the list is incomplete. Ideas floated to add to the 'basics' list include:

- A place from which to work which is functional and suitable
- Clarity of role, and role within a team
- Access to wellbeing support and wellbeing resources
- Regular feedback on how work is going, and chance to offer their own feedback
- The right equipment including where relevant a uniform
- Knowledge of how to get support outside the line mgmt./team space
- A rapid training needs assessment and knowledge of how to get that training

2.5 The suggestion is not that we 'expand induction'. The logic here is that all 4000 RDaSHians need confidence that over a dozen or so basics are true for them too. We might argue that that is good line management. We need to confront the reality that data points suggest many of these basics are not consistently in place. Some happen, some are signposted, some necessarily draw on skills we know not everyone yet has (e.g. feedback).

2.6 Of course it is possible for us to tickbox our way through this. That is not the intention. And it should also be acknowledged that plenty of work has gone on, and is going on, in these areas already. However, we simply cannot be confident, as the most senior leaders in the Trust that for all RDaSHians these things are true. An MOT is needed, not just a driving test.

High support

3.1 We tried to call this high care. This led to confusion over patient-facing needs as distinct from staff-facing ones. There was also feedback that some people did not foresee work caring for them, which is a more nuanced idea. The language challenge is real, because support is something done with (or sometimes to) someone. But the environment at work we want to create includes strong self-care, and the ability to meet and source help with one's own needs. As distinct from something solely the Trust does.

3.2 There has been work done to begin to change our '**health and wellbeing'** offer. This work is due for review at the POD delivery review in August. Broadly the aim is to make Peek Box a one stop shop for many standard needs that staff may have. The question then is between centrally provided options (yoga, mindfulness etc) and offering teams locally determinable finances to let them shape their own wellbeing efforts. Presently thinking is leaning towards that latter approach where sums of up to £150 could be

claimed locally to fund efforts, probably using a deployment model used around our Diwali and Christmas contests.

3.3 We have come some distance in improving access to **training**. Directorate level training needs analysis should now be a routine part of our calendar (it is due for 2027/8 in October 2026). There have been improvements in how we purchase what is then needed. But we know from the review paper presented to the Board in July, that the equity of access and take up of training remains an issue. We know too that staff sickness, poor rostering, and to a degree vacancies, combine to make time-release sometimes difficult. Nonetheless it is difficult to pitch a high support motif if we cannot find solutions to our training dilemmas, backed by a guarantee regarding the budget.

3.4 Similarly, all of us have sought to develop a learning model, and to ringfence time for learning. The currently being piloted hub may make more transparent how that is progressing. The expectation is that everyone in work attends **LHD** activities, either formal learning, reflective practice or QI time in their team, unless they are part of so-called Christmas Day cover. Aligned to this is our distinctive commitment to SPA time for clinical professionals. This is a national contractual expectation, but we are working to make it real, not only for psychiatrists but among all our clinical disciplines.

3.5 We know from the staff survey that **violence**, fear of violence, and the restorative work done in light of harm, are important factors in how our colleagues feel in the workplace. Violence, like racism, is not evenly distributed among our teams, but it is a significant feature of working life for many RDaSHians. In March 2026 Steve Forsyth outlined the actions we planned to take to make violence less likely, and restorative work both certain and immediate. It is important that this work is core within our efforts to care and support, not least because this is the no1 issue faced by many we work with.

3.6 The ability to **work more flexibly**, remotely, to balance caring and work, and to take time off is fundamental. To this we plan to add ‘volunteering days’ in 2027 (launch in 2026). All of these programmes place a pressure on stretched teams, but we know that they can lead us to be more productive and effective in work. We have a latent ambition to maximise the 4-day week too (acknowledging not all jobs allow for this and we need 7-day coverage). The work on flexible/agile/remote working is due to be rolled out before the end of 2026. For rostered staff we are committed to self-rostering. Key executives are working on a rollout programme to have this in place Trust-wide (certainly for all wards) before March 2027.

3.7 **Recognition** matters. Both for individuals and teams. The most important recognition is local and can be very simple. As we rollout RDaSH Connect we will have the ability to ‘high five’ colleagues, as we already do within RADAR by reporting good practice (this could be much better known). We reworked our awards systems, and we now have local schemes across all six groups,

as well as the Shining Star scheme three times a year, and our annual award gala (with over 450 entries again this year). However, does the combined effect of this make people feel seen? Can we do more to publicise gratitude for work? Should we ask all our line managers to make it their business every month to share some thank yous?

3.8 Part of **seeing the whole person** is our work under Promise 26. The wider work on this now agreed with the Board will come to CLE next time. But this work does include the See Me First campaign work, which aims to empower identity and identities in our workforce and the ability to bring one's whole self to work. Feedback suggests that we are not yet an organisation that is truly embracing of neurodiversity and we have work to do to think through with the DAWN network and others what else we can do, and how we become much more organically able to adjust workplaces and practices to meet someone's declared needs.

3.9 Compassionate models of **just leadership** have form part of both halves of the work we are trying to do. We'd want expectations of one another to be predictable, justified, and supportive. We know that as we have become more delivery orientated, more inclined to rely on data and evidence not assurance, and pacier, some feel that we have become less compassionate as leaders; and with some redundancies latterly and service changes being more regular the organisational 'contract' feels different. We want to define the behaviours which sit under our six values and ensure we hold ourselves accountable for those behaviours – permitting and encouraging challenge, especially in a timely way that can be addressed in near-time.

3.10 It may not have escaped CLE's notice, that, with the additional of a getting the basics right approach, this could easily become **an RDaSH 10 commitments**, which together lay out the rights we would want our people to have in the workplace. If that sort of approach has merit (there is a counter case that it is too planned), it would need to be paired with what follows on challenge and accountability. *The temptation to do one first is very much to be resisted.*

High challenge

4.1 We have very intentionally set out to create **a management system**. It expects a lot of our directorates and our groups. It then brings people to together in subs and holds people to account in delivery reviews. The unitary boards hold this effort to account, and the council of governors holds the non-executive element of the Board and the Chief Executive to account. The developmental subs and the more action orientated delivery review processes are meant to be complimentary not duplicative: we have heard feedback that some subs stray into accountability, recognising that RMG/OMG were always intended to work distinctly from the other eight. There is every likelihood that, even after two+ years, this feels different from before, albeit it is fairly 'mainstream' in NHS management; with the larger clinical and patient presence being the unusual feature vs peers. We have invested heavily to

skill up parts of this system and need to consider how that skill gain is taken further – and how core skill issues (chairing a meeting, for instance) – are addressed. It is important that the system is ambitious for what can be achieved but is never ever punitive or disrespectful.

4.2 **PDRs** could reasonably have been framed under the prior section. Any good appraisal or development review will only succeed if it supportive, not just in the moment, but as part of a wider pattern of line management support. However, we do intend that the PDR process, specifically a) the objective element and b) the behavioural element are, where necessary, challenging. The real challenge in a PDR ideally comes from the appraisee themselves and a desire to improve incrementally. The scoring aspect creates an outcome language for that work, as well as allowing the organisation to own the development of colleagues.

4.3 Through training, safe space practice, simulation, and other tools, we want to develop a more habitual muscle in the **techniques to have difficult conversations**. A difficult conversation may be about behavioural or performance concerns, contractual or work/life balance issues, or quality of care. The suggestion is that such discussions are often avoided or become ritualistically formalised. Long delays commencing performance management processes appear a normed feature of RDaSH. This avoidant dynamic is one we want to constructively change: supporting candour and compassionate challenge.

4.4 An important step in these directions will be the introduction, for all line managers, potentially starting with band 7/above first, is **360 – degree feedback as routine**. This is already, to a degree, part of revalidation for doctors, and a standard part of the chair's appraisal by governors. Many of us have undertaken a form of 360 within the LDO. This new step, which is also nationally mandated, sees us move to having feedback from line reports, line manager, and peers, as part of our own PDR cycle. This makes explicit that we are each accountable in a range of dimensions, not simply 'upward'. It must be introduced intended to support a compassionate model, but not one that avoids the difficult. A positive 360 is not one that simply affirms, but one that offers insights to consider.

4.5 The high challenge work continues but quickens **an evolution of what we expect from ourselves as leaders**. Roles have changed from before 2023, and we may need to codify that more explicitly, both for line managers, and for 'thought leaders'. Expectations of corporate functions have changed, as we have tried to introduce more peer accountability to clinical services, and a shift to a focus on results (e.g. an IT project is complete when well used, not when put in place: likewise, estates). We need to think about how we are both supporting this sharpening of role, and offering reflective spaces for colleagues to make sense of it. An off-ramp for those who do not wish to work in that model is needed, as we cannot prosper in 2027 and 2028 if we have leaders in post where there is a 'will gap'. Without prejudging this, this

could be combined with a structured relook in mid-2027 at senior clinical roles, and clinical lead roles, at band 7 – ensuring these are patient facing and job planned to spend time undertaking clinical care. This is work to make sure AfC is not nudging people into management whose better work lies in patient facing practice.

Distributed leadership

5.1 When we explored this topic with TPC, as when we explored it with TVC and the Board, we faced something of a paradox: we have all the ingredients for a distributed model, yet it does not feel distributed 'on the plate'.

To explain this, a little further:

- The review of the Board's role in 2023 reserved a handful of matters to the Board and delegated the balance to the accountable officer, in line with routine NHS formal practice
- Executives have defined portfolios with clear and sizeable levels of expected discretion (CLE subs exist within that discretion)
- CLE has a clear and likewise documented role in supporting those matters that are at the discretion of the CEO
- Care Groups have properly agreed budgets and freedom to recruit within them
- Trust-wide approaches mandate *some issues but not remotely all* (broadly either via policy, or via a consistency approach – the latter is growing)
- We have spent 18 months developing directorates, which vary in their maturity, and in some groups the delegation model to directorates is documented
- and - yet - we will have/hear a view that decisions are made in a few places or singularly

Of course, some of this is excuse making and deflection (or a genuine lack of curiosity or willingness to explain difficult things). But we may need a concerted effort to **own** decisions differently, not just inside CLE but in the wider TLC. Some of this work may be in explicitly considering the facets of followership which are intrinsic to all leadership roles.

5.2 It may be that that concerted effort needs to build from the scale and breadth of the clinical leadership executive, which is NHS-atypical (as is having 5 clinicians on the Board of 15 people). There is not an 'executive' per se. That may surprise or confuse some.

Our Investment Fund 'opens up' funding decisions, but we can go further with that process including providing for some staff voting: *the suggestion is that a staff vote may form part of one tranche of the IF for 2027/28.*

More philosophically, we sought a leadership model that tends to say yes, may sometimes say no, but rarely defers or delays. That is not how many

experience it. We have tried to be clear how people can progress their concerns into that process, but as per the comment in paragraph 1.3, we may need to renew that effort. Experimentation and innovation need more permission than perhaps we thought!

What happens next

6.1 A steering group to guide the reset work has started to meet. This will help us move the work into an operational phase in the run up to the Leaders' Conference. Within that conference we will have **chance in workshop sessions to mould further the things we plan to do**. Some of those things are new, most are not. Most are about moving from sometimes to greater consistency: and a mentality that catches and adjusts when that consistency is missed.

6.2 Interests represented within TPC are being actively engaged to help shape this work. The aspiration is to seek to do this **alongside trade union bodies**, as well as networks. The Board understands that the trust and allyship of patient representatives has been key in moving promise 5 forward: we need to find a similar coalition in this case. Because in this case too we are sharing power.

6.3 What is envisaged is that during October and November, and likely December, we begin to reintroduce ourselves to the organisation. Taking overt yet genuine steps to see the Trust through others' eyes, including the eyes of those working inside parts of the organisation. This leadership visibility 'drive' is intended to further shape not just the things/what within this paper but the how of managing and leading that we need to continue to shape – **staff do not believe that we say yes, and that has to change**: without creating the misstep of reintroducing vetoes, siloes or pace of the slowest.

Everything in this paper remains a work in progress – and to be explicit – will be best shaped by your additionality, suggestion and nuance. Please come to CLE's conversation with that in mind.

Toby Lewis
Chief Executive
August 2026

Trust People Council – ongoing discussions over cultural reset

We began these discussions at TPC in January 2026: and Carlene sought feedback on those summaries when we met in April.

In May the Board had in-depth discussion of the intentions, followed up by a dedicated timeout session in June: a further discussion takes place in July.

There remains time/space and necessity to **co-production through August and September** prior to a soft launch at the leaders' conference in late September

- All of us are part of building the culture or cultures that we want to see in our organisation – both the board and group/directorate leadership have to play particular roles in this two-year transition
- The intended framing focuses on **high care/support and high accountability/challenge** – both of which need real definition and work to help everyone to see the necessity of them and sensemake their meaning
- Identity matters to culture, whether that is professional autonomy, team belonging, heritage and lived experience, or site/place specific relevance, and *many people will have many identities*. RDaSH is one wrapper among several. Anti-racism will be part of this reset work.
- Improving the quality, inclusivity, and effectiveness of line management is a fixed point in any cultural reset, and the day to day experience of being supported and coached by a manager is fundamental to the workplace experience.

The basic proposal being considered by the Board includes (but is not limited to..)

Getting the basics right: 1

- This is something strongly advocated for by several trade union voices
- It recognises that safety in the workplace is foundational for any developmental work we might wish to do
- A series of every-time (or always) measures are being explored to support not just the on-boarding but the annual, weekly experience of work – a local guarantee that is corporately supported
- One part of this work is how we make our Health and Wellbeing offer more meaningful to employees – with local funding available for local initiatives that are staff led…
- By always growing the training budget we ought to be expanding access to education – but experiences vary

2 High care / support:

- Care is not only being kind to one another, but being kind to one another matters
- We are looking to what is in place locally: access to food and drink, warm/cool spaces, safe places including sensory space
- We want to be known for being the most flexible employer, both for those with a disabilities/LTC/carer responsibilities and for others
- We want to build on protected learning time (LHDs) and think about mid career sabbaticals and other initiatives which give people 'space'. We will continue to invest in TRS.
- Current exposure to violence is not compatible with a narrative of compassion – nor is the staff/staff racism. Tackling both meaningfully matters at work
- Experience of line managers as a support varies. We need to build on the positive experiences some report…

The basic proposal being considered by the Board includes (but is not limited to..)

High accountability / challenge

3

- Resetting the PDR/appraisal model is foundational. This will be based around *objective setting* and a scored review of results and behaviours.
- Clinicians at band 7 and above will have annual agreed job plans which make choices about precious time: and our investment/reform work needs to optimise clinical time
- Corporate functions need to deliver to a high standard, both in terms of outcome (estates/IT) and pace (HR)
- Accountability is bi-directional (two way) – and 360- degree leadership appraisal is our routine model from 2027
- As we move the Trust towards a new funding model (which includes volume related income) it will be easier to hold local 'trading accounts' giving teams clarity and a measure of future foresight of balance.

4

Distributed leadership

- We have 24 directorates who have a significant degree of autonomy of action: we have removed vacancy control, delegated budgets etc. But that is not 'felt' out there.
- Our clinical leadership executive is far larger and broader than most Trust executives. We are supporting members to step into their power….
- Our Investment Fund 'opens up' funding decisions, but we can go further with that process including providing for some staff voting…
- The leadership model we want tends to say yes, not usually no. And needs to enable. A handful of decisions are held in one place but everything else is open to local determination

Since 2023 we have worked hard to 'share power' with our communities: we now need to do that more successfully and overtly internally with students, volunteers and staff ('we')

What has been important in the communities' journey?

trust:

- we made bold and clear promises and tried to stick to them
- we showed up in places and spaces, even when we did not need to
- we were intensely candid about how hard this was but how much it mattered to us. Partners believed in leaders' sincerity.
- we did not care who got the credit. Other peoples' pride and voices have mattered

allyship:

- we have invested money, time and love into making this truly work
- the Board itself spent time on power-sharing
- allies have been welcomed into spaces and places that are surprising to them and to others
- who comes to speak for us impacts who else listens. And those relationships cannot be transactional

As a Board, and we can begin to do this through TPC too, we have begun to think through the characteristics of a coalition for cultural change.

The commitment to shared power is not just a question for the Board but for other groups: just as 'we' has changed to include peers…

We have invested in trade unions and in networks, we have work to do to remake our professional advisory groups as effective inclusive spaces

Trust has been lost over time, just as it was with patients, carers and communities. Remaking trust will come from consistent small changes not grand intent: but the clarity of purpose and promises will matter – in a 2026 – 2030 cultural commitment.

Maybe the exam question at this stage is two-fold…

1. When we think about getting the basics right, distributed leadership, high accountability and high care what are your reflections on those ideas?

2. What role might the tradition you represent (unison, Rainbow, senior docs etc) play in both trust building and allyship?

RDASH Council of Governors

Well-Led (CQC)
Preparation for anticipated inspection

Who we are

CQC is the independent regulator of health and adult social care in England.

Our purpose

We regulate health and adult social care, we work together with the public, systems and providers of care to protect people, and to promote and improve the quality of care.

Our vision

Everyone receives safe, effective and compassionate care.

RDASH

Overview

Report published: 21 February 2020

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Anticipation of a Well-led Review……What We Know

No recent (full or WL) CQC inspection since 2019 (last report published 21.02.2020 following a visit in late 2019)

CQC increasing inspection activity particularly in respect of Well-Led

Possible Well-Led inspection during the remainder of this financial year

Our anticipation is not new …..
We have had four papers to Board re: self-assessment over the last 2 years
We have sought external views on Well Led (GGI/TVC)
We have completed related work on Provider Capability Assessment Framework

We have a strong baseline from which to start these preparations.

We have stood up a small working 'Cell' that is meeting weekly to coordinate and oversee preparations

We would expect to receive notification of the visit.

Well-Led is based on 8 quality statements each with arrange of supporting statements

Shared direction and culture	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.
	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.
Capable, compassionate and inclusive leaders:	Leaders have the experience, capacity, capability and integrity to ensure that the organisational vision can be delivered, and risks are well managed.
	High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning.
	Leaders at every level are visible and lead by example, modelling inclusive behaviours.
	Leaders are knowledgeable about issues and priorities for the quality of services and can access appropriate support and development in their role.
	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.
Freedom to speak up:	Staff and leaders act with openness, honesty and transparency.
	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

Workforce equality, diversity and inclusion	Leaders take action to continually review and improve the culture of the organisation in the context of equality, diversity and inclusion.
	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.
	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.
Governance management and sustainability	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.
	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.

Partnerships and community	Staff and leaders are open and transparent, and they collaborate with all relevant external stakeholders and agencies.
	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.
Learning, improvement and innovation	Staff and leaders have a good understanding of how to make improvement happen. The approach is consistent and includes measuring outcomes and impact.
	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.
Environmental sustainability	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.
	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.

Our strong foundations…….

Eight Well-Led quality statements and internal readiness

Green/Amber below is the November 2025 RDaSH self-assessment, not a formal CQC rating.

1 Shared direction & culture — Green	2 Freedom to speak up — Amber
3 Capable, compassionate & inclusive leade — Green	4 Workforce equality, diversity & inclusion — Amber
5 Governance, management & sustainability — Green	6 Partnerships & communities — Green
7 Learning, improvement & innovation — Amber	8 Environmental sustainability — Green

What is the Well-Led Inspection?

What Inspectors Will Do

🔍 **Review Documentation** such as Board papers and committee papers, Board Assurance Framework, Corporate and operational risk registers, Performance, quality and workforce information, Policies, strategies and improvement plans

🗣️ **Speak to People:** Board members, Executive and senior leaders, Clinical and operational teams, Staff networks and Freedom to Speak Up representatives, Partners, governors, patients and carers

📊 **Test Assurance:** Follow themes and evidence from Board to frontline services; Examine how risks are identified, escalated and managed; Explore examples of improvement and organisational learning; Assess whether leaders understand challenges and take action

How CQC will look at Well-Led

More than documents: evidence must be consistent across experience, observation, process and outcomes.

The strongest answer links a real story, a reliable process, a measurable outcome and a known risk or assurance route.

Our Preparation: Getting colleagues prepared

The CQC will want to meet with a range of colleagues and this may include a number of representatives from the Council of Governors (This will likely be as one of the stakeholder groups)

We have commenced our preparations and are developing a range of guidance and briefing for all colleagues on the process and expectations about the review process.

During any interaction with Governors the CQC may be interested to hear and discuss a range of topics, that might include the following:

Understand their role.
Provide constructive challenge.
Receive meaningful assurance.
Represent members and the public effectively.
Have a good relationship with, but are not captured by, the Board.
Understand the Trust's key quality, workforce and financial risks.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Reports	**Agenda Item**	Paper F
Sponsoring Executive	Philip Gowland Director of Corporate Assurance		
Report Author	Philip Gowland Director of Corporate Assurance		
Meeting	Council of Governors	**Date**	9 September 2026

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

The report is presented as a standing agenda item at each meeting to ensure the Council of Governors awareness to any escalation from the committee to board.

Escalations were raised by 3 committees:

- Quality Committee raised Continued recognition of service pressure in Rotherham, which are being managed, but it is worth the Board being sighted on.
- Finance Digital and Estates Committee raised that discussions with commissioners regarding contract agreement and signature were ongoing; as, following the FDE meeting, the contracts were not progressed to agreement, it was escalated to Board.
- Trust People Council raised that dialogue with the BMA continued and informed that they would be briefed through the chief executive should any concerns come forward in advance of October's meeting.

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

Committee papers were presented to each public Board meeting

Recommendation (delete options as appropriate and elaborate as required)

The Council of Governors are asked to:

NOTE the committee papers

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

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

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

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

Appendix (please list)

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

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

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

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

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

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

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Committee	Quality Committee	**Agenda Item**	Paper D
Committee Chair	Dr Richard Falk, Non-Executive Director		
Lead Executive	Steve Forsyth, Chief Nursing Officer		
Date of meeting:	22 July 2026		
Attendees:	Dr Richard Falk, Richard Chillery, Maria Clark, Dr Judith Graham, Hannah Hall, Dr Rumit Shah, Steve Forsyth, Dr Diarmid Sinclair, Dave Vallance; with Philip Gowland		
Matters of concern or key risks to escalate to the Board:	Continued recognition of service pressure in Rotherham, which are being managed, but it is worth the Board being sighted on.		
Key points of discussion relevant to the Board:	**Chief Nurse Triangulation: Experience, Safety and Effectiveness** April and May 2026 data indicate a stable patient safety position. Most reported incidents resulted in no harm or minor harm. Patient feedback remains mainly positive, with recurring themes relating to communication, access to services and waiting times. The Committee noted continued focus is required on workforce resilience, violence and aggression, racism related incidents, pressure ulcer prevention, and timely completion of governance actions. **Mortality Report: March and April 2026** There were 74 deaths reported across the Trust in March and April 2026. No significant mortality trends or concerns were identified. Most reviewed cases identified no problems in care with a small number required further investigation, structured judgement review or learning discussion. The Committee noted learning from coronial activity, Prevention of Future Deaths notices and suicide prevention work. Mortality surveillance provides assurance that no emerging Trust-wide concerns have been identified. **Committee Workplan** The Committee reviewed the workplan approved by the Board of Directors in May 2026. The workplan aligns with the Committee terms of reference and provides appropriate coverage of its responsibilities for 2026/27. The Committee confirmed the workplan has sufficient clarity, sequencing and forward planning to support delivery including execution of the Quality and Safety Plan (Not discussed in the meeting, but this will be explored during Q2 in light of the new National Quality Strategy issued by NHSE).		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

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

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

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

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

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

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

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Trust Update	**Agenda Item**	Paper G
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Kath Lavery, Chair, Philip Gowland, Director of Corporate Assurance		
Meeting	Council of Governors	**Date**	9 September 2026

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

The Chair's Report summarises the key events, meetings and work undertaken in the last quarter.

The Chief Executive's Reports to the Board in May and July are appended to this report in paper pack B, as is the latest Promises and Priorities scorecard.

The remaining Committee Reports – not referred to in the earlier agenda item - are included in this paper.

Alignment to strategic objectives (indicate with an 'x' which ambitions this 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

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

Some related Committee to Board Reports have been received at recent Board meetings

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

The Council of Governors is asked to:

X	**RECEIVE** the paper for information

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register							
Strategic Delivery Risks							
System / Place impact	x						
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)

Both these appendices are provided to Governors in Paper Pack B:
1 Chief Executive's Reports to the Board of Directors from May and July 2026.
2 Promises and Priorities Scorecard from the Board of Directors in July 2026.

Chair's Report to the Council of Governors: September 2026

The report to the Council of Governors this month captures the meetings and events that I have attended during the period from June 2026.

I start with a thank you to you our Governors for the continued dedication to the role and making yourselves available to contribute and engage across so many different activities. There is a separate paper on those activities but I highlight the continued dedication to the role with really positive attendance and engagement in multiple ways – I particularly enjoyed the Coffee and Cake session with some Governors where we were joined by the Vice Chair and Senior independent Director Pauline Vickers – another session will follow later this month.

Other key aspects of my work in the last quarter are listed below:

My schedule continues to afford and require regular meetings with Toby Lewis, Chief Executive to understand the current issues, successes, and challenges at the Trust and how the Trust is participating in the system-based environment.

I have continued to foster many important relationships through multiple 1-2-1 meetings with individual members of the Board of Directors, senior staff and with our partners in particular, through the Yorkshire and Humber and National Chairs Networks and the South Yorkshire Mental Health, Learning Disability and Autism Collaborative - all continue to be interesting and extremely valuable in terms of understanding the role of the Trust within this wider system-based environment.

My regular 1-2-1 meetings include those with Jo Cox, Lead Governor

Within the Trust I meet regularly with my Non-Executive colleagues, attend the Charitable Funds Committee and the Trust People Council (alongside the Staff Governors).

I have also attended / participated in the following:

- Annual Fun Day including the Annual Members Meeting (AMM) and the Young Advisors showcase (including our young Governors). A fantastic, community facing day and a pleasure to see so many colleagues and members of the public who joined in the fun!
- Dr Joe Brougham, Resident Doctors Lead (I fulfil a role of being the Board NED lead for Resident Doctors)
- Service visit to Cantley Health Centre with Selina Khunkhuna regarding Talking Therapies and Physical Health Community Nursing with Sam Butcher
- Introductory meetings with Simone Scott, Interim Head of Communications and David Sturrock, Head of Estates
- Consultant interviews
- Board Development Session and Board Meeting – for the SY Mental Health, Learning Disabilities and Autism Provider Collaborative

And finally, I will be making a number of presentations in the next week of the Chair's Shining Star Awards….an absolute joy for me to meet and give recognition to some colleagues across the Trust.

Kath Lavery, Chair
2 September 2026

Chief Executive's Report to Council of Governors: September 2026

1.1 In introducing this report in June, I drew attention to our work on cultural change, the importance of delivering a consistent DIALOG+ care plan, and the implementation work on changes arising from staff consultation. All remain very much central to work since: our aim remains to have all adult and older adult mental health patients using this care plan format from October. In thinking about the regulatory reports received about RDaSH over more than a decade from the Care Quality Commission, it is this foundational change which we need to consistently have in place. Before March 2027 we launch the 'always measures' which are the basis for our quality and safety plan – with a focus on carers assessments and a consistent care plan being the essence of that daily check and challenge.

1.2 The Council of Governors was deeply involved in the changes we needed to make to staffing models in order to return the Trust to underlying financial balance in 2026/27. I am expecting to confirm that the upcoming Board meeting that we have closed the transitional arrangements for staff with eight or fewer redundancies, which is slightly better than the 'most likely' position forecast to the Board before we commenced consultation. This would mean, allowing for a handful of retirements and sickness terminations, that around forty colleagues had been compulsorily redeployed into new roles: we will continue to work with those colleagues to track and support them. The QSIA harm review seen each month by the Board suggests that we have not seen adverse impacts in services where we have made changes, although it is clear that a small minority of change schemes have not yet fully implemented the working practices changes, we consulted upon. We owe the staff involved an absolute unremitting insistence that these changes will be made, and this will be addressed in the September delivery review cycle.

Our patients

2.1 At the end of September (30th) we open **the new Acorn Centre in Scunthorpe**. In late May we finished the ward redevelopments on the site, and this week the final planting takes place on the ward gardens. The latter is part of a Trustwide programme to ensure that garden spaces are part of our wards, and support seven-day-a-week therapeutic activities. The Acorn Centre is however something quite new for the Trust. If it is successful we would likely consider opening a second such facility, probably within the Woodlands building in Rotherham in 2028: Acorn will offer 24/7 adult mental health support on a walk-in basis and be staff by our expert clinicians including our crisis services, alongside peer support workers employed by the People Focused Group, and the MIND safe space facility in the early evening. The development is similar to national initiatives intended to address emergency waits for mental health; albeit in this case it is internally funded from our Investment Fund.

2.2 We continue to see a rise in demand for admission to our mental health beds, and despite a slight reduction in length of stay, this means occupancy remains very high, and regrettably a small number of **out of area placements** have occurred in August. COG will recall that in 2022 this figure was thirty, and we had sustained a zero figure since January. The most impactful action we can take to sustain our recent success remains better Expected Date of Discharge planning (EDDs). This allows us to manage risk with some insight in and out of hours – alongside this we continue to focus on meaningful diagnosis within five days of admission. We have begun as an

executive team to review implementation of key change initiatives ward by ward, through our acute directorate delivery reviews – the next round of which takes place at the end of October. EDD is a high priority within those conversations, albeit the highest priority remains safer staffing of which therapeutic activities are a key part.

2.3 Since July we have begun to **provide post-diagnostic care** to young people diagnosed with ADHD, and autism, in North Lincolnshire. This is a situation we have discussed many times in the Board and COG, arising from the ceasing a service at NLAG in 2025, and subsequent commissioning hiatus by the relevant ICB. Our service is created at risk, financially, and we are looking to conclude discussions on the contract shortly. It will take some months to stabilise the position and gear up to meet need, and the pace of that will be materially affected by shared care willingness among local GPs. We should remain very concerned over the prevalence and need as against commissioned resources, not simply in North Lincolnshire, but across the footprint. The gap is especially sizeable for adult services, and the Board will discuss in September an aim to change the autism diagnosis offer for adults from RDaSH from either April 2027 or from January 2027.

2.4 As a Trust Board we continue, we believe to be prepared to make not only difficult decisions but to set ambitious goals. In March 2025 the Board decided that we would close a ward for older adults in Rotherham and make the care model across our sites consistent. The subsequent few months were difficult ones, but in May 2026 the Board accepted clinical advice that the service model was now stable. In addition, in March 2026, the clinical leadership executive invested further funds on admission avoidance for older adults. In July's Board meeting, we reviewed and approved an important medium-term paper from Diarmid Sinclair which seeks to **develop proposals to wholly prevent or largely avoid admissions (into multi-person spaces) for patients with dementia** as a primary diagnosis. This is conceptualised as a two-to-three-year journey, but it is important step in recognising the particular challenges often associated with ageing and being clear yet again that older adult services are not to be the 'poor relation' of local care.

2.5 August saw the formal launch of **our new homeless health team**. The Board in July considered our wider efforts to support patients within the 'inclusion health' group (Promise 10). Recognising work yet to do with people who have been in prison, and the need for consistently better service awareness of refugee and sex worker cohorts locally, it is encouraging nonetheless that we are trying to find the right balance between 'specialist' services or bespoke teams, and improved general access. There is no reason for example that a memory assessment for someone in prison cannot be safely conducted on our sites. Lived experience reviews of our services' accessibility are taking place presently, and the board was advised that likely early 2027 we will need to face into some genuine if inadvertent barriers to service that we have to address, as we have other realms of exclusion or discrimination such as ending age-cut offs in crisis services in late 2024.

Our people

3.1 Later in September we again undertake our largest single health and wellbeing endeavour of the year, as we look to vaccinate staff, students and volunteers, against the flu virus. Last year we aimed to reach 3000 staff and fell short, but as in 2024 delivered a huge campaign with increased update. The **3rd time flucky** campaign drives again to get the largest number of colleagues vaccinated as rapidly as possible. Our success with this work has been based more than anything on overwhelming emphasis and focus, as well as real enthusiasm from key clinicians.

Any Governor wishing to be vaccinated should contact our Chief Nurse, albeit your GP should be able to provide you with a vaccine.

3.2 Since 2023, the voices of patients, carers and communities, inside the Trust are increasingly high profile and certainly influential. Governors, including staff governors, have played a key role in that. But we know from the staff survey that many employees feel they have less say, in changes or choices being made. Part of our cultural 'reset' aims to address that where we can, as part of a broader suite of changes intended to create more consistency in how people are managed, supported, and developed. One part of **staff voice** is to create better spaces for two-way communication and feedback. Monthly well over 200 staff join us for the Ask Talk Influence sessions we run – which combine a patient voice, with leadership messages and discussion of an upcoming project. In a fortnight's time we launch our new App, which crucially like Care Opinion will allow staff to post comments and get responses in near real time. This could offer, among many benefits, real insight for staff governors into what is being said among our teams.

3.3 Dating back to autumn 2025, we have re-visiting our approach to both **remote and flexible working**. In many cases existing arrangements date from the pandemic, whereas working life has now made routine some new expectations among staff and potential employees. As a Trust that hopes to privilege the 'four day week', and one where we are actively promoting work life balance, carer responsibilities and personal flexibility, we have chosen to create a new framework to address when someone can work from off-site, and how we ensure workplace flexibility is fair to all, including other team members. These changes will roll-out over the rest of 2026-2027, because we need to transition employees from current practice. It may be helpful at one of the next council meetings to explore this, alongside our planned changes to appraisal.

3.4 We want to create an environment in which anyone feels safe to speak (up) and feels that is worthwhile. 82% of people who contact our FTSU service are satisfied with the experience, yet we know from our staff survey that only just over half of staff feel that speaking up changes things. The Board some time ago asked for proposals to tackle this, and our interim actions agreed were confirmed in July. For other reasons we are altering our approach to staff grievances to speed up such procedures; this itself creates an opportunity to **shift the time of our FTSU function**. Triaging 'HR' related issues overtly across into that process and liberating time to focus on direct patient safety. Instead of waiting for reports to come in, the guardian and champions will now be out looking for safety issues and concerns, going into services actively curiously seeking out issues. This is a new approach for us, but much closer to the original post Frances intent of the model. We are doing this very publicly, because we want anyone to know that reporting issues does make a difference and is what the Trust needs to keep us all safe.

3.5 **Promise 9** is one that we have been proud to have made real progress with, in that we have an unprecedented number of colleagues enrolled as apprentices, and the latest financial projections for this across Yorkshire's NHS, shows RDaSH has the highest spender against the national levy. Conversely our commitment to create roles filled by people from specific backgrounds and communities, including those who have come from overseas as forced migrants, those with a learning disability, or people have experienced homelessness, have taken a backseat: the Board's review suggests that we now have a relatively cogent forward plan to see that change over the coming two years. In the specific instance of learning disabilities roles will be

held on a part-time basis for people looking to move into work, and that programme commences in earnest in August 2027.

3.6 In January 2026 the Trust employed both the largest number of doctors and the greats number of consultant medical staff in its history, having filled many vacancies since 2023. A number of departures, specifically from our Rotherham services this spring and summer, have altered that picture, and at the time of writing we are working with **seven locum consultant staff, not the two we had planned**. Three of these end in short order with new arrivals. Medical staff engagement and some professional relationships have had a degree of strain dating back at least eighteen months, and we are working through adjustments and changes to try and address this with a determined effort to bring some new consultant staff into the deputy leadership roles within medical education and into directorate leadership roles. The Value Circle, who worked to review our well-led position (published with our May Board papers), will return to provide third party input into a brief review of relationships intended to create a clear path forward in 2027 and 2028.

Our population and partners

4.1 We have a more detailed presentation on estate plans elsewhere on the agenda of this council meeting. But it is important to recognise that these are developments designed to improve health. That is the case with moves to place young people's mental health in a city centre, likewise with the Acorn Centre outlined above, and with changes to how we support older adults, frailty and other care pathways in Doncaster. It is also significant to recognise that most care we provide is in people's homes, and as such the flexible/remote working **'mobile first' model** is a significant step to better aligning our infrastructure to the care we offer. For staff the new estate frame gives spaces that colleagues deserve, and the intended focus on shared spaces and on an education centre is critical to developing better multi-disciplinary care and places to learn and simulate how we work in that way.

4.2 Partner feedback generally about the Trust continues to be strong. There is a sense that we are active, visible, and prepared to work practically to find solutions. The Board has agreed a **new partnership 'scorecard' model** to introduce a degree more rigour into how we work with key partners: this is based on our and their assessment of shared endeavours on five key indicators which are both results and approach based. It will take time for this approach to mature, and a second cycle of assessment will occur for May 2027 – as such inclusion of this item in the June 2027 council may be relevant.

4.3 Colleagues will be aware that whilst the Trust is a provider of young people's eating disorder services, we do not offer an adult service. We are instead the **commissioners of adult services (for South Yorkshire)**, and in that guise have been investing in expanding the service offer from colleagues whose Trust is based Sheffield. Through the commissioning body we are working to make sure face to face ambulatory care is available throughout our patch, whilst welcoming the extension of day hospital services to residents in Rotherham and Doncaster who before this year had no such service.

4.4 In this report in June, I advised council of the 'conditions' imposed by **NHS England** on our approved plan. I also indicated that some were somewhat surprising to us, indeed may have been 'boilerplate'. I am pleased to confirm that conditions related to our workforce, sickness reduction and cost improvement plans have all now been satisfied and removed. We continue to discuss out of area placements with the

regional team, recognising that our delivery is among best in the region. Later in October we will submit this year's Provider Capability Assessment. In 2025 we submitted as amber-green, highlighting weaknesses in culture and elements of patient safety: we will not likely have seen that assessment deteriorate; not least bearing in mind our external well led review. We already know that in a separate rating for financial management we obtained the highest possible rating. If there is a focus to regulatory concern about the Trust it remains our unsigned contracts with both main commissioners almost at the halfway point of the year. I would hope by the time the council meets to have made headway in this respect.

Toby Lewis, Chief Executive
2 September 2026

Other Board of Director Committee Reports.

Further to the four reports in Paper F, the reports from the other Board Committees are listed below.

The **Mental Health Act Committee (MHA)** – whose membership comprises of three Non-Executive Directors and is chaired by Maria Clark. The Committee focuses on ensuring that the Trust adheres to the Mental Health Act. This will include the work undertaken on a daily basis across a range of services in each geographical area and the work of the Trust Associate Managers – the lay (independent) people who sit on panels to review the cases of patients detained under the Mental Health Act. Governor David Vickers is a member of the Committee.

Since the last Council of Governors meeting, the Committee met on 17 June 2026 and on 19 August 2026. The report based on June's meeting was presented to the Board of Directors in July 2026 (August's meeting will be reported to the Board in September).The key focus is the compliance with the MH Act.

The **Audit Committee** – whose membership comprises of three Non-Executive Directors and is chaired by Kathy Gillatt – primarily focuses on the oversight and delivery of the work of the external auditors, Deloitte (who are appointed by the Council of Governors), and of the internal audit team and counter fraud teams – both services are provided to the Trust by *360 Assurance*, an NHS internal audit consortium. The remit of the Committee also includes clinical audit as well as research and educational governance.

The Audit Committee met on the 5 August 2026 (chaired on this occasion by Dr Richard Falk) and the output report from the meeting will go to the Board in September 2026.

The work of the **Charitable Funds Committee** focuses on the oversight and management of the Charitable Funds, of which the Trust is the Corporate Trustee. Key to the work is the ability to raise funds, but to also have clear plans for expenditure. Maria Clark chairs the Committee, which met most recently on 5 August 2026.

The work of the **Remuneration Committee** – which comprises of all the Non-Executive Directors and is chaired by Kath Lavery, Chair – focuses on the remuneration and related issues of the Executive Directors and Senior Managers. The Committee meets on an 'as and when' basis but must meet at least once annually. The Committee met on 29 June 2026 to receive the outcomes of the annual appraisals of the Executive Group members and to note the inclusion as a voting member of the Board of Dr Graham, Director of Psychological Professions and Therapies.

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Governor Activities	**Agenda Item**	Paper H
Sponsoring Executive	Philip Gowland, Director of Corporate Assurance		
Report Author	Philip Gowland, Director of Corporate Assurance		
Meeting	Council of Governors	**Date**	9 September 2026

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

This report to the Council of Governors comprises three parts:

- An update on a number of Governor changes
- A summary of the work and activities undertaken both individually and collectively by Governors between July 2026 and August 2026.

Alignment to strategic objectives (indicate with an 'x' which ambitions this paper supports)	
SO1: Nurture partnerships with patients and citizens to support good health	X
SO2: Create equity of access, employment, and experience to address differences in outcome	X
SO5: Help to deliver social value with local communities through outstanding partnerships with neighbouring local organisations.	X

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

This report has not been previously presented, although a similar paper is presented to each CoG meeting.

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

The Council of Governors is asked to **RECEIVE AND NOTE**:

	the update regarding current Governors
	the planned work to approve appointments to Board Committees
	the summary of Governor Activities

Impact (indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate)

Trust Risk Register							
Strategic Delivery Risks							
System / Place impact							
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: Current Governor terms of election / appointment
Appendix 2: Easy Read Board Papers July 2026

1 Governor Changes

I am sure you will join me in welcoming 2 new partner governors who have been appointed to the Council of Governors. Rukhsana Ismail from Rotherham Metropolitan Borough Council and Alexia Dibdin a Young Advisor from North Lincolnshire, Alexia previously met some Governors when she attended the March Council of Governors meeting

Sadly, in July Maureen Young stepped down for the governor role, Maureen has many other commitments which were requiring a lot of her attention. We are sad to see Maureen go as she has contributed so much to the trust over the last few years but also wish her well with all her other interests.

There remain 3 vacancies of the 10 partner governor positions and work is ongoing to fill these places:

- North Lincolnshire Council
- University representative
- GP Community

Appended to this paper is a full list of all current Governors and their respective terms of election / appointment.

Prachi is pausing the role during her maternity leave and we wish her all the best for this exciting news.

2 Governor Activities

2a Attendance of Governors as members of Committees to the Board of Directors

(Aligns with Governor Responsibilities 1-Holding non-executive directors to account for the performance of the Board; and 2-Representing the interests of members and the public)

For Governors to be in a better position to hold the Non-Executive Directors to account and to know more about the workings of the Trust and its performance, Governors were appointed as members for the Committee meetings.

Committee	Governor One	Governor Two
Finance, Digital and Estates	Andy Flynn	Ian Spowart
People and Organisational Development	Vacancy	Ian Spowart
Quality	David Vickers	Hannah Hall
Public Health, Patient Involvement and Partnerships	Jo Cox	Joy Bullivant
Mental Health	David Vickers	

See Paper F (Item 8) for more details about the Committees.

2b Attendance of Governors at meetings of the Board of Directors (Public Session)

(Aligns with Governor Responsibilities 1-Holding non-executive directors to account for the performance of the Board; and 2-Representing the interests of members and the public)

The Board of Directors holds a meeting in public every other month. The July meeting was attended by Champion. As part of the papers prepared for that meeting was an Easy Read document that summarises each paper succinctly and clearly, this is included for you today (see pack B). Governors are invited to attend the next meeting on 24 September 2026.

Please contact Phil for the link and to receive the papers in advance of future meetings.

2c Trust People Council July
(Aligns with Governor Responsibilities 2-Representing the interests of members and the public)

The Trust People Council aims to help our employee staff networks, staff governors and other specified leaders (including a patient representative) to directly influence the cultural programme of the organisation. TPC operates as a peer to our non-executive led Board committees: and supports the ambition of the Council to see the staff governor role given substantially greater prominence inside RDaSH.

One of the staff Governors attended the most recent meeting in July 2026 (Prachi).

2d Peer Reviews scheduled to September 2026
(Aligns with Governor Responsibilities 2 - Representing the interests of members and the public)

Governors have participated in recent Peer Reviews focusing on the patient experience aspect of the review – where a number of staff from different parts of the Trust attend a specific location.

Governors attending these visits include: Jo, Kym, Joy, Emma, Mike, David, Kamlesh, Jennie and Richard.

2e Annual members Meeting and Family Fun Day July
(Aligns with Governor Responsibilities 1-Holding non-executive directors to account for the performance of the Board 2 - Representing the interests of members and the public)

This years event was held at St Cathrines House Doncaster, and it was another successful community event incorporating the Annual members meeting. Other events taking place included the gladiator challenge, netball, bright futures (attended by our young advisor governors) and the feel good singers.

Governors attending the event and the annual members meeting included Jo, Richard, Ian, Pippa, Champion and Mabrookah who also spent time engaging with the public and 8 new members were signed up for the trust.

2f Armed Forces Day Doncaster August
(Aligns with Governor Responsibilities 2 - Representing the interests of members and the public)

This year's Armed forces day was held at Elmfield park, Doncaster and was attended by Jo and Joy who had a lovely day talking to different members of the public about the trusts work and successfully signed up 25 new members for the trust. This takes the trust's current public membership to above 700.

2g Pre-Cog Meeting August
(Aligns with Governor Responsibilities 2 - Representing the interests of members and the public)

A Governor only meeting to review and discuss the forthcoming Council of Governors' meeting. The meeting was chaired by Lead Governor Jo and attended by Hannah, Pippa, Mark, Sam, Chris, Ian, Joy, Andy, Richard, Kamlesh and Mike.

The group discussed the reoccurring themes raised by the governors which were:

1 Waiting times / Waiting Well / Access to treatment
2 ADHD, Autism & Neurodiversity services
3 Patient care quality and experience

4 Information, communication and accessibility
5 Finance and value for money
6 Consistency of services across localities
7 Community partnerships and integrated care
8 Estates, storage and waste reduction
9 Veterans and Armed Forces support

2h Committee members meeting August
(Aligns with Governor Responsibilities 1-Holding non-executive directors to account for the performance of the Board 2 - Representing the interests of members and the public)

Phil hosted the meeting for governor committee members and covered a number of topics including .
1 to hold the Non-Executive Directors to account for the actions of the board, and:
2 to participate at the meeting as a committee member with input

Governors attending were: Jo, Andy, Richard, Joy, Hannah, Chris and Ian.

2i Coffee and Cakes with Kath and the Non Executive Directors
(Aligns with Governor Responsibilities 2 - Representing the interests of members and the public)

This informal meeting was greatly appreciated by those who attended Jo Joy Kamlesh Ian Chris and Phil. Hosting the meeting was Kath our Chair and Pauline Vickers our Non-Executive director who also chairs committees for Charitable funds and Finance, digital and estates . Pauline is also the vice chair and senior independent director.

Kamlesh commented that This kind of environment was essential , to allow individuals to express their views , their feelings , their concerns as they feel are important to them . In equal dose highly appreciative of Kath and Pauline and Jo to spare time from their busy schedules .

Joy said that she really felt that these sessions helped us get to know one another much better and strengthened the relationships we were already building. Spending time together outside of formal meetings makes such a positive difference, and I'm sure it will contribute to us working together even more effectively as a team.

Jo found these sessions enlightening and so important and I'd would like us to think of ways in which we can help to promote them so that other governors have the opportunity to engage in these valuable sessions.

Other governors are encouraged to attend these events, more of which will be planned in the next quarter.

2j Doncaster Pride August
(Aligns with Governor Responsibilities 2-Representing the interests of members and the public)

This year's pride was held at Town fields Doncaster. Jo was successful in engaging with the public and signing up 21 new members for the trust a number of whom were interested in becoming volunteers.

2k Lead Governor Activities
(Aligns with Governor Responsibilities 2 - Representing the interests of members and the public, 8 -Preparing the forward plan)

Jo has again had a busy period as the Lead Governor and has been involved in a range of activities at the Trust, as listed below:

June:
11th June – Kath's appraisal pre meeting with Pauline Vickers
13th June – collating governor feedback for Kath's appraisal
16th June – Kath's PDR meeting with Kath and Pauline
17th June – Catch-up meeting with Kath
22nd June – catch up meeting – Sue B
26th June – meeting with Louise Wood to organise coffee and cake with Kath meetings
27th June – Armed Forces Day

July:
2nd July – Governor/volunteer film with Tim Buckle
15th July – peer review pre-meeting
18th July – AMM and RDaSH fun day
21st July – Jo and Kath catch up
22nd July – PHPIP meeting
23rd July – Peer review – Amber
23rd July – Leading with Cultural Intelligence meeting
31st July – catch up with Dr Jude Graham

August:
3rd August – coffee and cake with Kath
4th August – catch up Sue B
8th August – Doncaster Pride
17th August – initial meeting with HMPPS (Probation) Health and Justice lead to discuss health inequalities re prisoners/those on probation and RDaSH responsibilities
19th August – Kath and Jo catch up
24th August – Initial Meeting with Nicola Abdy, RDaSH – focused on building relationships and addressing health inequalities of prisoners and those released from prison subject to probation supervision
27th August – peer review pre-meet

September:
3rd Sept – Peer review

3. External Audit Appointment

One of the key roles of the Council of Governors is the appointment of the External Auditors, their main focus and task is to audit our Annual Report and Accounts.

We currently have Deloitte appointed but are about to test the market and establish if there are other firms that may wish to tender to provide the service. This process will take place over the next two months.

As we confirm the arrangements for the process, we will seek to engage Governors to ensure they are aware the of the progress and to better prepare them to make the decision, which will be following a receipt of a recommendation from the Trust (a panel including the Director of Finance and Audit Committee representatives)

4. Forthcoming Events

The next public Board of Directors meeting being held on the 24 September 2026 which governors are invited to attend.

Young governors meeting with Kath and Non Executive Director Maria 27 October 2026 at Woodfield House 11:30 to 13:30.

Philip Gowland, Director of Corporate Assurance
3 September 2026

Appendix 1 : Current Governors and their terms of election / appointment

Governor	Term End Date	Type	Where	Term
Joy Bullivant	30-Nov-26	Public	Doncaster	1st
Richard Rimmington	30-Nov-26	Public	Doncaster	3rd
Ian Spowart	30-Nov-26	Patient /Carer	Mental Health	1st
Joan Cox	30-Nov-26	Patient /Carer	Community Services	3rd
Lee Golze	30-Nov-26	Partner	City of Doncaster Council Appointed	2nd
Emma Wilsher	30-Nov-27	Staff	Rotherham Care Group	1st
Jennie Gauld	30-Nov-27	Staff	Physical Health Care Group	1st
Jessica Williams	30-Nov-27	Staff	Children's Care Group	1st
Prachi Goulding	30-Nov-27	Staff	NL Care Group	1st
Arun Chaudhary	30-Nov-27	Public	North Lincolnshire	1st
Chris Pope	30-Nov-27	Public	North Lincolnshire	1st
Hannah Hall	30-Nov-27	Public	Rotherham	1st
Kamlesh Vatish	30-Nov-27	Public	Rotherham	2nd
Kevin Hodgkiss	30-Nov-27	Patient /Carer	Patient	1st
Champion Solesi	30-Nov-27	Partner	Young Advisory Group	1st
Emma Price	30-Nov-27	Partner	SY ICB	1st
Debra Taylor	31-Mar-28	Partner	Citizens Advice N Lincs	1st
Kym Gleeson	31-Mar-28	Partner	Health Watch Rotherham	1st
Sam O'Brien	31-May-28	Public	Rest of England	1st
Baz Cooper	31-May-28	Patient /Carer	Patient /Carer	1st
Pippa Harder	31-May-28	Patient /Carer	Patient /Carer	1st
Mike Seneviratne	30-Nov-28	Staff	Corporate / Backbone	3rd
David Vickers	30-Nov-28	Public	Rotherham	2nd
Mabrook Agbabiaka	30-Nov-28	Public	Rotherham	1st
Andrew Flynn	30-Nov-28	Public	Doncaster	1st
Allen Bell	30-Nov-28	Patient /Carer	Patient /Carer	1st
Robert Foster	30-Nov-28	Patient /Carer	Patient /Carer	1st
Mark Johnson	30-Nov-28	Patient /Carer	Patient /Carer	2nd
Alexia Dibdin	30-Jun-29	Partner	Young Advisory Group - NL	1st
Rukhsana Ismail	31-Aug-29	Partner	Rotherham Metropolitan Borough Council	1st