

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

MINUTES OF THE BOARD OF DIRECTORS MEETING ON THURSDAY 30 JULY 2026 AT 9.30 AM

WATERS EDGE, BARTON UPON HUMBER, NORTH LINCOLNSHIRE, DN18 5JP

PRESENT

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

IN ATTENDANCE

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

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

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

	The Board received and noted the changes to the Declarations of Interest Report.	
STANDING ITEMS		
Bpu 26/07/04	Minutes of the previous Board of Directors meeting held on the 28 May 2026 The Board approved the minutes of the meeting held on the 28 May 2026 as an accurate record.	
Bpu 26/07/05	Matters Arising and Follow up Action Log The Board received the action log and noted the progress updates. All six actions noted as 'propose to close' were agreed, and noted that eight remaining actions remained open, with several matters returning to the Board in September's meeting. Bpu 26/05/18 Chief Executive Report. Mr Lewis referred to page 12 of the minutes regarding talking therapies, and explained that issues relating to four week delivery had been reviewed and were expected to be resolved during quarter 2. Core practice issues in the administration of waits had been identified, particularly in Doncaster, which had been exacerbated by booking authorisation issues since April. These issues had been resolved, with no patient risk identified, but highlighted the importance of the Trust's control environment. There were no other matters arising.	
BOARD ASSURANCE COMMITTEE REPORTS TO THE BOARD OF DIRECTORS		
	Mrs Lavery confirmed the revised approach to the section of the meeting and asked for the discussion to initially focus on the three escalated matters from within the committee reports to Board.	
Bpu 26/07/06	Finance, Digital & Estates Committee (FDE) Mrs Vickers introduced the report and noted that the contract position had been further escalated since the June Committee meeting. Mr Sheppard reminded the Board that the final financial plan submitted on 13 March 2026 included assumptions relating to contract positions with both South Yorkshire (SY) and Humber and North Yorkshire (HNY) Integrated Care Boards (ICB). For HNY ICB, Mr Sheppard reported that an agreed baseline had been reached and that secure transport would be managed on a cost per case basis. Discussions continued regarding the transfer of budgets and the final model for neurodiversity services, although good progress had been made and the agreement was expected to be finalised on 3 August. For SY ICB, Mr Sheppard reported that a baseline of £177.6m had been agreed and included in the March planning submission. At the time of the Board meeting there were a number of contract variations requiring completion. The variations had been prepared since April, but agreement had been delayed by the mental health investment standard contract variation. Mr Sheppard advised that SY ICB had revised its position from the original £2.9m investment across all providers to an offer of £1.2m, which created a potential Trust pressure of approximately £600k to £700k if distributed on a fair share basis. Mr Sheppard confirmed that the Trust had responded through the Chief Executive to	

	advise that it could not agree the offer and required a further proposal, ideally at £2.9m and no lower than £2m, noting the issue was financially significant and highlighted the need for stronger formal records and correspondence in future contract negotiations. Mrs Lavery asked about next steps. Mr Lewis advised that the HNY ICB meeting was scheduled for 3 August 2026 and that, if agreement could not be reached, the Trust would need to consider restricting services from 1 September 2026. Mr Lewis confirmed that the SY ICB position may take longer to resolve, but that the financial risk was manageable, while the HNY ICB position required resolution due to uncertainty regarding future configuration. In response to questions raised by Ms Gillatt and Ms Fulton Tindall, Mr Lewis confirmed that HNY ICB payments to date were consistent with the Trust's financial plan, while Mr Sheppard confirmed that SY ICB cash continued to be received with the exception of the outstanding contract variations (circa £1m year to date). Mr Lewis advised that the absence of a signed contract did not create wider legal risks, as standard contractual arrangements remained unchanged, but did create risks relating to documentation, leverage and timely resolution. Dr Shah asked about financial three year planning cycles. Mr Lewis advised that commissioners had mainly engaged in a one year process to date, but that South Yorkshire mental health trusts intended to provide a forward financial plan aligned to the ICB's three year investment plan for mental health. Mrs Lavery acknowledged the update and reaffirmed the Board's support for the forthcoming HNY ICB meeting. The Board received and noted the report from the Finance, Digital and Estates Committee.	
Bpu 26/07/07	Quality Committee (QC) Mr Lewis advised that the escalation from the QC related to long standing concerns regarding adult services in Rotherham. Whilst there were no immediate safety indicators of concern, Mr Lewis recognised that the position required continued oversight. Mr Lewis advised that improvements had been made on Willows Ward following previous collective concern, which provided assurance that local leaders had made progress when given the capacity to address issues. The main remaining concern related to medical cover. Mr Lewis reported that three colleagues were on medium term sickness absence, one further colleague was leaving, and other resignations were due to take effect over the coming weeks. Three medium term locums had been secured to provide stability through to Christmas, and proposals were being developed for staff grade and specialty doctors from early 2027. Mr Lewis welcomed the QC's escalation and confirmed that a specific annex on Rotherham would be added to the Chief Nurse triangulated report for the next Quality Committee to provide clearer oversight of the position.	

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

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

	including those linked to the earlier discussion on Rotherham medical staffing, noting the report reflected the position at a point in time and that work was continuing to mitigate and respond to the identified risks. The annual review of high impact, low likelihood risks was reflected in the report and included a cohort of risks across estates and infrastructure, digital, cyber and other themes. Several risks were being tolerated because mitigation was in place, including emergency preparedness, resilience and response testing. Mr Gowland advised that these risks were generally tolerated because of their likelihood, but required preparedness and testing through business continuity and emergency preparedness (EPRR) arrangements. The recent learning half day exercise, which tested the response to a limited power outage scenario, was cited as an example of how the Trust tested preparedness and identified learning. Mr Gowland noted that the exercise supported assurance that, while some risks were tolerated, arrangements were in place to test readiness and strengthen future response. Mrs Lavery and Ms Fulton Tindall welcomed the improved commentary and format, noting that it provided clearer assurance and supported Board engagement with key risks. Ms Fulton Tindall sought assurance on RSK 574 and whether delays in overnight data refresh affected frontline clinical information. Dr Sinclair confirmed the issue related to the reporting system only, not the live clinical record used by staff, and that live clinical information remained available to staff at the point of care on SystemOne. Ms Fulton Tindall sought assurance on RSK 687, including the Quarter 4 resolution date. Mr Lewis advised that risks would be reviewed in August and September, which may reduce the current score, and Dr Sinclair confirmed that the medication management action plan would need to evidence sustained improvement before closure. Mr Vallance sought assurance on the timescales for RSK 515 and RSK 476, including door and infrastructure risks. Mr Lewis advised that risk trajectories would be reviewed to ensure they remained realistic, noting market constraints in relation to door replacements. Mr Chillery confirmed the door replacement programme was separate from Section 136 pressures and was being managed through a planned approach. Mr Lewis reminded that Board members could and indeed should access Radar to improve visibility of current risks. Dr Shah sought assurance on fire risk assessments (RSK 001) and medical staffing vacancies. Mr Gowland confirmed the annual fire risk assessment had been completed in March and reported to FDE, with no significant issues identified. Mr Lewis and Dr Sinclair advised that medical recruitment interest remained limited, with some vacancies expected to continue, and that work was under way to review inpatient medical roles and potential service configuration. In response to Ms Blake query on RSK 570, Mr Gowland confirmed that antisocial behaviour incidents continued to be reported periodically and remained an active risk. Ms Holden noted that mitigations were in place for affected colleagues, including risk assessments and use of personal safety devices, and that the Trust continued to work with North	
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	Lincolnshire Council and other partners to address the wider environmental issues. The Board received and noted the Operational Risk Report with attention drawn to those risks that were out of tolerance and further, those with low risk appetite, and the focus on those risks described as High Impact / Low Likelihood.	
Bpu 26/07/15	Strategy Delivery Risks (SDRs) Mrs Lavery invited questions for Mr Gowland. Dr Falk and Mr Vallance welcomed the revised reporting format and direction of travel. Mr Vallance sought assurance that actions relating to SDR2, including data availability, capability and the translation of insight into action across the organisation. Mr Chillery explained that data capability was being addressed through several routes, including training linked to the community change project, learning from local delivery organisations and work to improve the capacity of leaders and teams to interpret data. It was noted that work was being brought together to assess leadership skills and will, including whether recruitment criteria were sufficiently aligned to the future leadership profile required by the Trust. The Board received and noted the Strategic Delivery Risk report, had given opportunity to feedback on the revised format and content in this update report, and noted the position for each SDR.	
Bpu 26/07/16	Promises and Priorities Scorecard Mrs Lavery invited questions for Mr Lewis. Dr Falk noted that a typographical correction was required on the cover sheet to clarify, “retain the integrity of not lowering the bar...” but to retain the integrity of the Trust’s current expectations. Mrs Lavery advised that the report should be received as insight, recognising that individual policy matters would be considered through separate agenda items. Mr Lewis advised that paragraph 4.2 addressed leadership capability, including skills, will and alignment with future recruitment requirements. A broader assessment would be developed, with a definitive position expected before Christmas. The Board received and noted the Promises and Priorities Scorecard, and the work continuing to be done to ensure rhythm and focus on the mid-table success measures. The Board recognised a positive focus on the nine measure we are trying to move by October, and acknowledged the displacement risk highlighted as we look to work on culture as well as strategy.	
Bpu 26/07/17	Organisational Change Key Performance Indicators Mrs Lavery invited questions for Mr Forsyth. Mr Lewis asked whether the areas highlighted in the cover sheet, including primary care, mental health and health visiting, were those requiring continued focus or whether there were other areas of greater	

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

	Regarding neurodiversity waiting times, Mr Lewis advised that, while progress had been made in children's services, there remained no commissioned solution for adult neurodiversity waits and the position would continue to require national and system attention. The Acorn Centre would open as an urgent mental health access facility, supported by local partners and linked to the North Lincolnshire crisis offer. Mr Lewis noted the importance of maintaining the intended open access philosophy and culture of the service. In relation to sickness and organisational change, Mr Lewis advised that work continued to improve the grievance process, with the intention to move towards a four week process from October. Mr Lewis noted the overlap between sickness absence and staff affected by formal processes, and that further engagement and consultation would take place in September and October, including in relation to adult physical health, Doncaster neighbourhood working, end of life care, specialist palliative care and the movement of some specialist teams towards a more generalist model. Mr Vallance discussed organisational change, including community caseload analysis, sickness, turnover, culture and vacancy levels. Mr Lewis advised that actions were in place for the issues anticipated through the change process and that a more centralised recruitment approach would be introduced from September to reduce reliance on local managers and improve consistency. Responding to Ms Clark, Mr Lewis confirmed that ambient voice technology (AVT) was used for transcription purposes rather than decision making and stated that early assessment of national guidance indicated broad compliance, but that privacy notices would be reviewed. Ms Clark noted the language within the report and the need to ensure that collaboration and coproduction were accurately reflected, particularly in work with young people and communities. Dr Graham highlighted homelessness work in North Lincolnshire, including engagement with North Lincolnshire Council and a national charitable bid to expand a homeless health model in a rural and semi rural context. Mr Lewis noted the importance of lived experience feedback in shaping this work. Following a question from Mr Pandor, Mr Lewis updated the Board on the Communities Leadership Executive (CoLE), noting that the agreed terms of reference provided autonomy to hold the Executive and care groups to account and that the group would have a key role in shaping future strategy beyond 2028. Dr Shah discussed medical job planning and productivity. Mr Lewis advised that progress had been made and that the Trust intended to complete the current cycle with a focus on quality, before moving to wider productivity discussions in 2027 and 2028. Dr Sinclair noted that medical job planning completion rates had improved significantly compared with previous years.	
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	The Board received and noted the Chief Executive's report and the forward actions it contained, had explored the patient, people and population issues described (including stability in RCG), and considered any matters of concern not covered within the report. The Board noted the annex reporting the organisational change process, to be considered alongside the second QSIA report elsewhere within the papers. The Board accepted the action plan in response to the TVC well led report and agree to monitor progress through the Board, supported by the NED meeting held monthly. The Board noted the EPRR submission of 100% compliance, up from 91% in 2025.	
Bpu 26/07/19	Promise 24: Education Dr Graham presented the paper. The Trust's education journey was highlighted, noting the progress made since the introduction of the current structure and the wider cultural shift towards recognising education as a key strand of learning. Focus was particularly on Promise 24 and drew on internal reflection, feedback from the Education and Learning Group, external scrutiny and assessment, and consideration of equity in access to education and development opportunities across the workforce. Dr Shah reflected on protected learning and asked about the impact of education within learning half days, including how success was assessed beyond attendance. Dr Graham advised that the learning half days had been piloted in Quarter 1 of the previous year and had since been implemented more widely. Although the approach had been successful in many services, there remained challenges in 24 hour services where release time was more difficult to protect. Dr Graham explained that impact was being assessed through a combination of mandatory training compliance, uptake and activity data, and qualitative feedback from staff and applicants. Work was also under way, with external support, to strengthen reporting through ESR. Dr Falk welcomed the clarity of the report and commented that the format made the education position easier to understand. He also referred to the use of terminology such as 'deliverology' and noted feedback from Quality Committee that this should be considered carefully to ensure language remained accessible. Mr Lewis referred to the NHS England biannual assessment process and noted that this was the second time the Trust had received such an assessment, and overall had been broadly positive. Dr Graham advised that feedback from trainees was received through a range of sources, including the National Education Training Survey (NETS) and universities. Mr Lewis and Ms Holden noted that whilst some survey response rates were low, the overall position appeared broadly stable over a five year period and no significant concerns had been raised through alternative routes.	

	Mr Chillery welcomed the breadth of education activity and asked about placement development. Dr Graham advised that placements were managed on a multi professional basis, with nursing requirements met and increased opportunities across allied health professional, psychological professions and work experience routes. Mr Sheppard noted the need to better communicate the value of the Trust's significant investment in education and training as part of its employment offer and commitment to staff development. Ms Blake asked how ward based staff opportunities were being addressed. Dr Graham advised that different approaches had been tested and that the Trust would continue to build on what had worked with leaders. Ms Clark raised apprenticeships, which would be covered later on the agenda, and Dr Sinclair noted the importance of recognising the Trust's positive work for learners. Dr Graham summarised that learning events were increasingly being opened to wider partners, including GPs, community partners and people with lived experience. The developing online learning hub would support wider access to learning opportunities and strengthen the visibility of the Trust's commitment to education. Mr Lewis requested that the six key recommendations from the paper be reflected in the minutes. The Board received and noted the Promise 24: Education report, considered the key recommendations and request a 2026/27 training spend dashboard linked to Promise 24 success measures. The Board noted the outcomes of the external review and NETs. The Board supported the six key recommendations stated in the paper: Agree a Promise 24 education and training spend dashboard showing planned and actual spend by source, professional group, staff group, protected characteristic where available, learner experience and workforce outcome. Progress a part of the bimonthly Education meeting into a multi-professional education investment panel to review high-value training requests, tariff use, CPD, apprenticeship priorities and return on investment. Adopt a principle of proportionate universalism spend for staff groups traditionally less visible in professional funding models, including peer support, HCSWs and non-registered staff. (Proportionate universalism means the resourcing and delivering of training at a scale and intensity proportionate to the degree of need). Set a Trust principle that registered staff need job-planned SPA where appropriate, and non-registered staff need equivalent protected learning/development time.	
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	Bring an annexed NETS/PARE/placement quality report to Board showing RDaSH results by profession, placement area and geography against national NETS themes. Collate the feedback in terms of the quality of education and educator across all of the different training provided and ensure consistency in learning and feedback.	
Bpu 26/07/20	Promise 3: Volunteers Mr Forsyth presented the paper and highlighted the baseline evaluation and implementation analysis for Promise 3. There were just under 360 active volunteers and more than 450 had been recruited overall. Turnover was around 22%, with some volunteers moving into paid employment and showed 10 volunteers recorded through ESR as moving into employment, although local records indicated the total was likely to be over 20 volunteers. Mrs Lavery welcomed the progress made and recognised volunteering as an important route into employment, as well as a positive contribution to patient experience, therapeutic activity, peer support, dialogue and care planning. Ms Fulton Tindall, Dr Falk and Mrs Vickers discussed the variation in adoption across services, and queried sustainability where local volunteer leads changed, reasons for volunteer turnover, and the need to strengthen qualitative feedback and evaluation. Mr Forsyth advised that volunteers were offered exit interviews and that no significant concerns about volunteer experience had been identified. Ms Blake and Mr Pandor also discussed diversity, inclusion and access to volunteering opportunities, including younger people, people from deprived communities and underrepresented groups. Ms Holden advised that learning from the volunteering programme should inform work experience and wider employment pathways, and that this would be picked up through the relevant People and Organisational Development route. Mr Lewis noted that the next phase should deepen understanding before the 2027 evaluation and consider how management focus and operational ownership could be strengthened. Mr Lewis suggested that Promise 3 should move from expansion to consistent, safe and well governed implementation, and that the requested survey method should be used in 2027. The Board received and noted the Promise 3: Volunteers paper, and noted the volunteers and staff report positive experiences, with volunteers improving patient experience and day-to-day support where roles are well designed, supervised and integrated. The Board recognised that the report framed the main implementation issue as an operational ownership and middle management implementation problem, for which a different response from the central corporate function is needed.	

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

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

	Mr Sheppard outlined the five key areas for Board consideration, which were the preferred option for Tickhill Road, the procurement route for the redevelopment, the procurement route for Ambient Loop, the funding proposals, and the proposed land disposal. The preferred option was a phased redevelopment of the retained Tickhill Road site, with land disposal supporting the overall scheme and further design refinement expected. Members supported the direction of travel and discussed funding options, associated risks, cash management, procurement routes, land valuation, overage arrangements, staff involvement, benefits to local communities, and the need to maintain staff identity and team design within future estate planning. Mr Sheppard advised that early contractor involvement through an approved framework was recommended for Tickhill Road, subject to further work, and that a competitive flexible procedure was recommended for Ambient Loop, supported by external procurement expertise. Funding would be through a combination of land sale, public dividend capital and Trust cash, with Ambient Loop funded through a revenue model. Mr Lewis clarified that the revenue model constituted private finance and should be clearly understood. Mr Lewis advised that corporate service location and any Rotherham disposals remained future decisions. Clinical teams would be closely involved in design, supported by experienced architects. The Board received, noted and considered the Full Business Case supported by the Executive Summary, and recognised the progress made since the March 2026 Board meeting. The Board supported the recommended option regarding the Tickhill Road site development. The Board supported the recommended option for procurement of the Tickhill Road redevelopment is early contractor involvement through an approved procurement framework. The final recommendation on a procurement framework will be proposed to the Board via the Director of Finance & Estates over the coming ten weeks. The Board's decision will then be transacted within the oversight of the Finance, Digital and Estates Committee. The Board supported for Ambient Loop the procurement route is via a competitive flexible procedure. The Board delegated the relevant authority to the Chief Executive and Director of Finance & Estates working with the chair of Finance, Digital and Estate committee to finalise the procurement route following further discussions with our legal advisors. The Board supported Option B of the funding options, Public Funding for the Tickhill Road Redevelopment and Ambient Loop via a revenue model.	
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	The Board supported to delegate the relevant authority as regarding the land sale to the Chief Executive and Director of Finance and Estates to pursue this further and make a final recommendation through the Finance, Digital and Estates Committee.	
Bpu 26/07/24	Avoiding Unnecessary Hospital Admission for People Living with Dementia Dr Sinclair presented the paper and outlined the need to reduce avoidable hospital admissions for people living with dementia. Following recent changes to older people's inpatient service in Rotherham, the Trust was currently able to manage demand. However, demographic growth and increasing dementia prevalence meant that the current model would not be sustainable in the longer term. Dr Sinclair noted that admission to hospital could cause harm for people living with dementia, including deconditioning, delirium and falls, and that future models should focus on prevention, early planning and alternatives to admission where safe and appropriate. There were opportunities to strengthen integrated pathways, particularly in Doncaster where the Trust provided both physical and mental health services. Dr Sinclair noted that a single intervention was unlikely to remove the need for admission, but that a combination of preventative approaches, crisis planning, carer support, partnership working and improved community response could reduce avoidable admissions over time. Dr Falk welcomed the paper and highlighted the importance of advance planning, including supporting carers and families to understand lasting power of attorney arrangements and crisis plans. Dr Falk noted that preventative work with care homes and neighbourhood partners could help reduce unnecessary emergency responses and avoid escalation where alternative support was available. Ms Fulton Tindall welcomed the direction of travel and noted the need to consider the wider social care context, including the practical and financial implications of supporting people safely at home. Ms Blake supported the proposal and emphasised the importance of involving partners, carers, care homes and local groups in developing any future model, recognising that families may see hospital as the safest option unless alternatives are clearly understood and trusted. Mr Lewis supported the paper and noted that setting an ambitious goal to reduce avoidable admissions could help galvanise partners and provide a clear measure of collective effort. Mr Lewis recognised that admissions would not be eliminated entirely, but that a stronger shared focus could significantly reduce the use of hospital settings where community based alternatives were more appropriate. Dr Graham referred to under represented dementia groups, including people with learning disabilities and neurodiversity, and noted the importance of considering comorbidity, exclusion and diagnostic complexity. There would also be opportunity to strengthen research in	

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

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

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

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

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

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

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