Public Board of Directors

UNCONFIRMED Minutes of the Public Board of Directors meeting held on Wednesday 30 July 2025

Present: (voting)	Sharon Mays, Chair (SM) Salma Yasmeen, Chief Executive (SY) Heather Smith, non-executive director (HS) (online) Olayinka Monisola Fadahunsi-Oluwole, Non-executive director, (OFO) Owen McLellan, non-executive director (OMcL) Anne Dray, non-executive director (AD) Caroline Johnson, executive director of nursing, quality, and professions (CJ) Phillip Easthope, executive director of finance, digital and performance (PE) Caroline Parry, executive director of people (CP) Prof. Helen Crimlisk, executive medical director (interim) (HC)
In Attendance: (non-voting)	Prof. Brendan Stone, associate non-executive director (BS) Gulnaz Akhtar, director of performance and delivery (GA) Dawn Pearson, associate director of communications and corporate governance (Board Secretary) (DP) Jason Rowlands, deputy director of stagey and planning for item 23 (JR) Liam Casey, associate director of estates and facilities for item 21 (LC) Helen Smart, chief operating officer (HSm) Zoe Dodd, Peer Support Lead/RMN for item 00 (ZD)
Other attendees:	Holly Cubitt, Communications lead (HC) Bethan Devonald, senior corporate assurance officer (minutes) (BD)
Apologies:	James Drury, director of strategy (JD)

Min Ref:	Board strategy planning and development session
30/07/2025 Item 0	**Experience story** Caroline Johnson (CJ) executive director of nursing, quality, and professions introduced CC who is a volunteer and expert by experience and Zoe Dodd (ZD), peer support lead. ZD introduced the story which was about career pathways for people with lived experience, and supporting peer support workers to be an embedded role in the workforce. CC told the Board about their journey from a service user to a volunteer, working as an expert by experience and now as a peer support worker for the Trust. CC outlined their early journey including diagnosis and referral to the short-term educational programme (STEP) team, a service providing free educational courses designed to help with a range of mental health conditions, and which supported diagnosis and past behaviours. CC explained how the course had helped improve confidence and led to participation in other support groups such as Andy's Man Club, and further courses with STEP. Adding that he moved on to volunteer at STEP and has now progressed to become an employee. CC noted the difficulty in doing this at that time and how far the volunteer process has come since then. CC noted the exploration of diagnosis and identity, and how the Trust helped him be more than his diagnosis.

	CC described the benefits of having people with lived experience work in services. Adding his positive experience with STEP made him realise how much people could benefit from the service, excellent staff who work to continually improve the courses they deliver. Caroline Johnson (CJ) thanked CC for sharing his inspirational story, which highlighted the opportunities and pathways to work following referral to the STEP service. Adding that sharing this shows what is possible for peer support workers and how vital they are to having person-centred services. The Chair thanked CC for sharing their story. The Chair invited CC to participate in the learning and reflections from the Board discussion in the following item.
30/07/2025 Item 1	**Experience story learning and reflection** The Chair invited Board members to reflect on what they had heard. • Olayinka Monisola Fadahunsi-Oluwole (OFO) noted the positive work from the STEP team, which reflected her own Board visit experience. • Phillip Easthope (PE) reflected that there was a consistent message to Board of the need to embed work and experience in a service model, suggesting the Board reflect on its commitment and actions to address this issue. • Caroline Parry (CP) noted that there is a peer support worker plan in place, and the ambition is to increase the amount of peer support workers in the Trust. Adding that pathways into work will be reflected in the refreshed people strategy. • Salma Yasmeen (SY) thanked CC for his powerful story and leadership, in particular support to developing volunteers, noting that the increasing numbers of volunteers in the Trust over the previous two years with the support of the peer support lead's leadership was now having a positive impact. • Helen Smart (HSm) highlighted the importance of lived experience in senior team and divisional team meetings to ensure quality and noting that lived experience is an agenda item on the senior leadership teams meetings. • CJ discussed the need to move away from traditional models to consider how service models for peer support workers can be integrated into service configurations to ensure success. • The Chair noted and highlighted the importance of peer support workers being integrated into teams, ensuring that peer support workers are supported to succeed. • Anne Dray (AD) reflected on the importance of peer support workers being able to relate to service users and the importance of having person centred care and using feedback to capture and improve services continuously. • Helen Crimlisk (HC) commended the group work of STEP which had created a community for service users, and group empowerment. Reiterating the importance of adjusting the care model to reflect the increasing number of peer support workers at the Trust. • Gulnaz Akthar (GA) suggested that a sustainable model for peer support workers should link to the Trust strategy and asked whether the diversity of service users using STEP was understood. CC confirmed that there is a diverse group of people using the service, which is inclusive and open. The Chair noted that the Board will continue to reflect on the experience story throughout the meeting, ensuring agenda items draw through the learning. Noting that the experience story provides a strong narrative that already links to several items on the Board agenda such as the patient safety and learning report, the lived experience report and the improvement and change report. It was agreed the impact of Board stories would be documented to highlight changes resulting from these stories, and to demonstrate their value and effectiveness. It was recommended that the role of the support worker be showcased at the annual members meeting in September 2025. **note and take forward CJ.** SY suggested that the next iteration of the performance framework and dashboard should set an ambition for an increase in peer support workers. **Action: GA, CP and CJ to pick up the action.** **Approvals, recommendations, and actions:**

	The Chair noted the following: • The impact of Board stories would be documented to highlight the changes resulting from these stories, and to demonstrate the value and effectiveness of the Board stories. **DP and CJ to note and take forward.** • The role of the support worker in Trust could be showcased at the annual members **CJ to note and take forward.** • The next iteration of the performance improvement dashboard should consider an ambition for increase in peer support workers over the following year **to note and take forward GA, CP and CJ**
30/07/2025 Item 2	**Welcome and apologies** The Chair welcomed the Board, the Governors and public who were observing the meeting. Apologies were noted from James Drury, director of strategy.
30/07/2025 Item 3	**Declarations of interest** None specifically noted over and above the regular formal declarations of interests made by the Board members.
30/07/2025 Item 4	**Minutes of the public Board of directors meeting held in May and June** The Board approved the minutes of the public Board of directors meeting held on 28 May 2025 as a true and accurate record. The Board approved the minutes of the public Board of directors meeting held on 25 June 2025 as a true and accurate record.
30/07/2025 Item 5	**Matters arising and action log** The Board approved closure of actions as indicated on the actions log and the following updates were provided in the meeting: • Action 47- it was noted that this action is monitored through the mental health legislation committee (MHLC) and an update will be provided to the Board in September 2025. **Matters arising** Caroline Parry (CP), executive director of people, presented the conversion therapy statement prior to publication and following the British association of counselling and psychotherapy memorandum of understanding on conversation therapy. Explaining that the Rainbow Staff Network Group (RSNG) have worked with the communications team and the RSNG membership to develop a clear statement clarifying the Trust's position. The Board **approved** the statement for publishing on the Trust website and intranet. SY thanked the RSNG for their work on the statement, which shows solidarity with LGBTQ+ colleagues and service users and asked for further clarification on any next steps. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **approved** the conversion therapy statement for publication on the Trust's website and intranet pages. • Work will take place with the communications team to ensure the statement is promoted **DP to note and take forward.**
30/07/2025 Item 6	**Questions from the public and governors** There were no questions received.
30/07/2025 Item 7	**Chair's report** The Chair started by acknowledging the significant contribution of Brendan Stone (BS) associate non-executive director, noting the positive impact of his lived experience at the Board in the previous six and a half years. BS will be ending his term of office on 6 September 2025. BS thanked the Chair and the Board noting that his journey with the Trust began as a service user governor adding that service users and carers remain the focus of Board which was a sign of the positive culture. BS noted particular thanks to Phillip Easthope (PE), executive director of finance and digital for his compassionate leadership. BS added that he will remain a critical friend of the Trust. The Chair provided an update noting the following key areas:

	• The NHS landscape continues to evolve significantly, with key announcements including the Fit for the Future: 10-Year Health Plan including increased focus on neighbourhood mental health care, digital transformation and quality governance. • A strengthened approach to the regulation and professional standards for NHS managers with legislation expected in 2026. • The Mental Health Bill progressing through parliament, with anticipated changes to legislation during the following year. • Governor elections opened for nominations on 28 March 2025 with 20 vacant seats. Fourteen seats have been filled bringing the total number of governors on the council to 34, subject to due diligence checks. • The Chair thanked Terry Proudfoot, Billie Critchlow, Jonathan Hall and Alistair Brash for their contribution as Governors, noting their terms of office ended in June 2025. • The specialist psychotherapy service has been shortlisted for the mental health safety improvement award. • The Trust has been shortlisted for three categories in the health service journal (HSJ) patient safety awards, recognising innovation and partnership and congratulations to Decisions Unit team, working in close partnership with Yorkshire Ambulance Service (YAS) shortlisted for Mental Health Innovation of the Year at the HSJ Awards, one of the most prestigious honours in UK healthcare. • A star of the month award has been introduced rewarding and recognising a staff member for improving lives and living the Trust values. • The annual members meeting will be held on 25 September from 4.30pm-7.30pm. This is a public meeting held each year to receive the final annual report and accounts 2024-2025. **Approvals, recommendations, and actions:** The Chair noted the following: • There were no agreed next steps or actions on this item.
30/07/2025 Item 8	**Chief Executive Officer Briefing** Salma Yasmeen (SY), Chief Executive drew attention to the national, regional, and local matters which are now setting the operating context for the Trust: • Developments in the NHS landscape and key publications will have significant implications for the Trust's strategic and operational direction, including increased focus on neighbourhood mental health care, digital transformation and quality governance. The content of which has been incorporated into our own strategy refresh process and shared as part of recent Trust Strategy Board discussions. • Dr Penny Dash's review commissioned by the Secretary of State to look at 6 organisations that were established to assure or improve the safety of care across the health and care landscape has been published. SY noted the need for greater focus on building skills and capabilities, effective governance structures, clearer accountability for quality and safety. • The revision of the Mental Health Act intended to protect the rights of people subject to restrictions and to support steps to maintain public safety. The legislation is currently in the report stage in the House of Commons and is expected to be passed this year. • The NHS oversight framework (NOF) 2025/2026 launched, noting the Board have been briefed. • Positive progress made on the expansion of community eating disorders services with the South Yorkshire Eating Disorders Joint Committee; implementation is expected to be later in the year. • Finances remain a challenge nationally and regionally and further details will be provided in the finance update on the system and Trust financial position • Despite the large amount of change taking place throughout the system, the Trust has continued to deliver safe care. In addition, plans developed with partners to meet the expectations of the Urgent and Emergency Care Plan 2025/26 and to significantly increase urgent care services provided outside hospital compared to last winter. • NHS England is proposing legislation to be introduced next year to establish

	professional standards and a regulatory framework for NHS managers. BS noted that the Trust has continued to focus on driving the improvement and change agenda, making progress across most key transformation programmes. BS said that programmes such as home first, therapeutic environments and new models of community care will lead the way for sustainable progress, meeting peoples needs closer to home, serving communities and creating resilience year-round. OFO commended the teams nominated for the HSJ awards, noting that one of the teams up for this award is the decisions unit. SY added that by improving referral pathways and streamlining how people are assessed and supported, the team has ensured individuals are seen more quickly and receive the right care, first time. Adding, that as a part of the Gleadless and Heeley pilot, having responsive care closer to home should detract from people needing emergency departments. In addition to this, the decisions unit has the potential to influence the conversation locally, to shape any additional funding that may arise and build on what is already in place. **Approvals, recommendations, and actions:** The Chair noted the following: • There were no agreed next steps or actions on this item.
30/07/2025 Item 9	**Board committee activity reports** The Board received and noted updates provided through the Alert, Advise and Assure (AAA) reports. The reports were from the Board assurance committee meetings held in June and July 2025. <u>Quality Assurance Committee (QAC)</u> Heather Smith (HS) chair of the committee provided an update on the July meeting, noting for the attention of The Board: • There has been a deteriorating position in the recording of protected characteristic and targeted improvement work remains underway, but committee are concerned about the pace of improvement. • Progress against the Out of Area (OOA) trajectory is being made, the last few weeks have not seen the same level of progress. Assurance was provided that work is underway to address this. • The committee continue to monitor issues such as referrals to community mental health teams (CMHT) and the waiting times for eating disorders, Sheffield autism and neurodevelopmental service (SAANS) and gender identity service, along with the 111-response rate. There are signs of improvement but not enough to provide full assurance at this stage. • The committee noted no quality and equality impact assessments (QEIA) panel meetings since June 2025, but assurance was given that this would be reviewed by the chief operating officer given the number of value improvement programmes (VIP) waiting for review. HC clarified that QEIAs panels have been set up for August 2025 and requested that the wording in the report relating to Home First targets remaining off trajectory is reviewed as this does not align to other reports. **To note and take forward HC** CJ highlighted the quality improvement (QI) work taking place regarding the recording of protected characteristics advising that although this work is showing significant progress; further work is required, including links to supervision. Further updates will be provided to QAC. HSm added that further work to cleanse the data is required to ensure it gives an accurate representation. In relation to waiting lists HSm noted that monthly recovery plan meetings have been set up with the director of operations, the deputy director of operations and service managers to support improvement. Owen McLellan (OMcL) noted the plan for improving the recording of protected characteristics and asked whether regular progress will continue to be received. HS noted that the recovery plans will be presented at QAC to monitor. It was confirmed that recording of protected

characteristics would be a standing agenda item at the senior leadership team (SLT) and progress is reported in the Integrated Performance and Quality Report (IPQR). It was agreed that executive colleagues would continue to highlight this in discussions and to include demographic data in Board reports which supports population health insight and addressing health inequalities in Board discussions. – **all to note and take forward.**

People Committee (PC) Heather Smith (HS) interim chair of the committee provided an update for the attention of the Board:

- Sickness data has seen an improvement to 5.9% during May 2025. The committee had challenged the Trust target of 5.1% which is not being met and does not match the local integrated care board (ICB) target of 4.8% or the national target of 4%.
- Moving and handling level 2 sessions have not been held since December 2024 as the previous lead retired, and the compliance rate is now low which presents a risk. Assurance was given that an interim trainer has been identified, with training planned to restart in July 2025. A recovery plan will be presented to the September meeting.
- Twelve out of 20 required actions plans have been received since the staff survey 2024 and this has been escalated to operational colleagues.
- The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports and Action Plans were received and are for discussion in item 22 of the Board agenda.

Positive alerts highlighted include:

- The national time to hire parameters have changed and a review of data has taken place, which has reduced the Trust's calculation of time to hire from 97 days to 48.61. The new national target is 60 days.
- There has been a positive reduction in employee relation cases moving to formal processes between April and May 2025.
- There has been a significant improvement in supervision and performance development review (PDR) compliance with supervision at 72.67% and PDR at 74.23% against the target of 80%. HSm was commended for her leadership in driving these improvements and it was noted that the Trust is now above 80% and it is expected that this trajectory will continue.

The Chair highlighted the need to improve sickness absence figures, noting the Trust has been an outlier for some time. CP noted engagement is taking place with managers to ensure people are supported and the right processes are followed in relation to supporting sickness absence and this will be a standing item on people committee agenda.

HSm provided further assurance on the improvement work relating to the staff survey, noting that a programme of visits has been scheduled to listen to staff on their views and share outcomes of learning from the staff survey.

SY added that a refreshed communications plan is being launched in preparation for the survey in September 2025, noting that NED colleagues had offered to support promotion the staff survey.

Finance and Performance Committee (FPC) Owen McLellan (OMcL) chair of the committee provided an update for the attention of the Board:

- At the end of month two, committee were advised of £400k overspend, primarily due to the value improvement programme (VIP) which was noted to have an adverse variance of £450k. £1.4m was added to VIP in June and weekly monitoring is taking place with executive colleagues. Month 3 is expected to be a continued challenge, and plans will continue to be monitored at the committee.
- Out of area (OOA) was broadly in line with the plan despite continued pressures and the committee will sustain focus in this area.
- Capital expenditure is currently well controlled
- A longstanding aged debt has been resolved, and further reflection and learning will take place to support improved process moving forward.
- The sustainability group assurance report was received and the committee requested to

see the action plan and milestones around achieving carbon net zero in the next report.

The Chair confirmed that OMcL has agreed to become the NED champion for sustainability, addressing an action recommended from the Good Governance Institute (GGI) review received in April 2025.

Audit and Risk Committee (ARC) Anne Dray (AD) chair of the committee provided an update, noting for the attention of the Board:

- The head of internal audit opinion 2024-25 was received with signification assurance
- External auditors provided an unqualified opinion on the financial statements and identified no significant weaknesses regarding the Trust's value for money arrangements for 2024/25.
- Internal audit action implementation remains on a positive trajectory with 100% closure on follow up actions.PE noted that strong controls have been embedded for internal audit to continually drive improvement reflecting the large improvement in recent years.
- Counter fraud confirmed that the Trust had a return on investment of £1.91 for every pound spent, compared to the NHS average of £1.06 and noted there is low participation of counter fraud training.
- Learning and reflections from the annual report and accounts process will be incorporated into the process for next year. PE noted that strong governance process for the annual report and accounts is in place.

It was noted that an internal audit of the fit and proper person process is underway, and it was agreed that the outcome of this will be shared with the Chair, who has overall responsibility for the Board process **– to note and take forward DP**.

Mental Health Legislation Committee (MHLC) Olayinka Fadahunsi (OF) chair of the committee provided an update on the meeting, noting for the attention of the Board:

- The committee noted the improvements in the percentage of consent and treatment forms being completed and that the number of incidents related to section 17 leave has fallen.
- Quarter 4 in 2024/25 had the lowest use of seclusion since recording began with 68 days without seclusion in the psychiatric intensive care unit (PICU).
- Two associate mental health act managers (AMHAMs) have recently completed their training and have started to shadow hearings.
- There has been non-compliance with tribunal reports in respect of legal directions being issued by HM court and tribunal service. A focussed update on this area will be presented in the September committee.
- Compliance with mental health act (MHA) mandatory training is being clarified as commissioners have recently indicated that compliance must be 90% which is at variance to the compliance target of 80% understood by the Trust. It was requested that future reports include the training trajectory and recovery action plan.
- The committee were given assurance that the third regional suite is often kept available for its intended purpose, and there is an escalation process in place to executive level where a service user's admission exceeds the timeframe. A report will be presented to the September committee.
- Funding issues for peer support workers on inpatient wards was highlighted to the committee, and it was noted that metrics and evaluation of parameters will be put in place to evaluate the effectiveness of various components in the new female ward.
- Compliance for RESPECT training remains below the 80% target despite improvements and due to staff non-attendance and limited training capacity.

HC clarified that the Trust had been unaware of the training compliance rate moving from 80% to 90% for MHA mandatory training and the people directorate have since confirmed the compliance rate of 90%, which is a system target. The Chair asked for a further review to identify how the error had occurred. **Action: CP**

The Chair asked for assurance on the non-compliance with tribunal reports. HC clarified that

	the non-compliance related to the disaggregation of social work, following which there is reduced clarity of responsibility. In addition, there has been uncertainty relating to tribunal requests not being received and a new escalation process is being drafted so senior service managers have improved oversight and involvement in resolutions. The Chair noted the importance of compliance with this legal requirement, and it was agreed that the committee will continue to focus on improvements in this area. The Chair requested further assurance on the delayed restrictive practice work stream actions. CJ confirmed that six actions are currently delayed within community areas, including improvements to digital infrastructure, environmental reviews, and embedding peer support roles and these delays are primarily due to staffing constraints and funding limitations. It was confirmed that this should be noted as an alert rather than an 'advise' to the Board– **CJ to note and take forward.** **Approvals, recommendations, and actions:** The Chair noted the following: • A review to investigate the error in target level for mental health act mandatory training **action CP.** • Restrictive practice workstream actions to be noted as an alert to the Board in the AAA report – **to note and take forward CJ**.
30/07/2025 Item 10	**Quality Assurance Report** Dr Caroline Johnson (CJ), executive director of nursing, professions and quality provided an update on clinical quality assurance activity across the Trust during Q4 2024/25 and Q1 2025/26. CJ noted key highlights: • A system refresh of both fundamental standards of care (FSoC) and culture of care visits is planned to align with the care quality commission (CQC) and with further focus on engagement. • There is progress in embedding the quality management system (QMS) and transitioning to the Ulysses audit platform which will go live in August 2025. Allowing for better audits in clinical areas, providing sound governance and oversight. • Improving care planning and risk assessment documentation requires ongoing focus with planned staff engagement in this process. • Enhancing mandatory training compliance targets is starting to improve and will have continued focus. • Addressing environmental improvements in specific services are being managed through improvement plans and continue to be a vital aspect of improving quality. • CQC enquires relating to care at Woodland View Nursing Home and Birch Avenue have been fully investigated by the Trust, with findings shared with the CQC. Most of the concerns were found to have limited or no substantiating evidence, and the CQC has since closed it enquiries, having received assurance from the organisation. • The Trust received positive verbal feedback regarding the overall quality of care following a CQC visit to Burbage ward this ward has been a focus of supportive improvements and the CQC. • The good governance institute (GGI) have been commissioned to undertake a comprehensive, independent review of quality governance arrangements across all levels of the organisation and is scheduled to conclude in August 2025. HS noted that the narrative in the report does not reflect the current position as indicated by CJ, and it would be helpful to have this in future iterations. Anne Dray (AD) agreed adding the need for evidence of impact and third-party assurance (such as GGI and CQC feedback) be included in the report to give assurance. **CJ to note and take forward.** PE noted that the improvements set out in the paper reflected the recently published Penny Dash review of patient safety which will have an impact on these areas and so should be included in future reports, alongside triangulation from the patient safety and learning report to provide assurance of the quality position. CJ agreed that it is reassuring that the direction of travel and improvement in governance is aligned with the Penny Dash report. BS commended the focus on care environments and the Trust's strong performance in the '15 Steps Challenge', indicating safe, welcoming, and well-organised environments. Suggesting

	future work includes therapeutic environments for neurodivergent service users, includes neurodivergent voices to ensure their experience is considered and gives assurance of co-production in the assessment of environment. **CJ to note and take forward.** HSm noted that feedback was received from the learning disability service pilot regarding suitable environments for neurodiverse service user. Adding, the Trust will have a neurodiverse lead, as a part of the team to provide additional support. It was noted that HSm has been liaising with governors looking at co-production in the development of the learning disability service. OFO noted the compliance for mandatory training, asking for assurance that engagement takes place with bank staff to ensure they are compliant. CJ noted that there has been a focus on RESPECT training for temporary staffing, with a plan in place to ensure that nobody goes on the ward prior to completing training and confirmed that sufficient training spaces were available to support this. The Chair noted that most services did not meet compliance targets for face-to-face mandatory training, particularly basic life support (BLS Level 2) and request an update on improvements in future **reports to note and take forward CP/CJ** **Approvals, recommendations, and actions:** The Chair noted the following: The Board **noted** the content of the report, and it was agreed that the following updates would be provide in future reports – **for CJ to note and take forward** Updates on improvement in mandatory training compliance including BSL. • The narrative in the report to reflect the current position as indicated by CJ, and to be included in future iterations. • Reflection of the recently published Penny Dash review alongside triangulation and evidence third-party assurances (GGI and CQC). • Assurance of production in the assessment of environment and the lived experience voice.
30/07/2025 Item 11	**Patient Safety and Learning Report for Quarter 4** Caroline Johnson (CJ), executive director of nursing, professions and quality provided an update on progress in embedding the patient safety incident response framework (PSIRF) and strengthening its learning and improvement culture. Key highlights: • A learning and improvement group has been launched to oversee the delivery of improvement initiatives aligned to patient safety priorities ensuring learning is systematically reviewed and acted upon. • The daily incident safety huddle (DISH) continues to provide real-time oversight and rapid learning, reviewing 100% of incidents within 24 hours. • High levels of incident reporting have been maintained, and most incidents are low or no harm. CJ noted that the format of the report has been revised to reflect the move to the patient safety incident response plan's priorities which have been developed utilising a range of data, including incident data, noting: • A comprehensive thematic review of unexpected deaths is currently underway examining all learning responses to identify recurring themes, assess the effectiveness of existing improvement work, and highlight any remaining gaps. Supported by the rollout of the personalised assessment of risk (PAR) tool and a new care planning format. • A reduction in self-harm incidents has been reported supported by improved post-incident reviews, and targeted staff training. Work is ongoing to embed trauma-informed care and improve understanding of self-harm triggers. • Improvement initiatives to support safer medication administration include the EDMET (el dorado medication error tool) programme to explore systemic causes of error, strengthened protocols for controlled drugs, and environmental changes. • A sustained reduction in seclusion and rapid tranquilisation has been achieved, particularly on Burbage ward and psychiatric intensive care unit (PICU), supported by cultural change, leadership stability, and revised Respect training. • A 44% reduction in falls has been achieved in older adult services through the

	implementation of HUSH (huddling up for safer care) huddles and the introduction of falls champions. • Freedom to speak up will act as an overarching culture piece in the report and findings will be triangulated to inform improvement. HS asked for assurance in the oversight of incidents. CJ confirmed that learning from patient safety incidents is being systematically identified, acted upon, and used to improve the quality and safety of services. The Chair requested examples of this sustainable improvement to be included in the next report. **CJ to note and take forward**. HSm added the trio (executive director of nursing quality and professions, executive medical director and chief operating officer) are working to enhance the quality improvement (QI) work across the organisation to close the learning loop and help reduce incidents. BS commended the use of the personalised assessment of risk (PAR) tool, which is being piloted across selected community and inpatient services, and requested that the non-executive director team to continue to monitor this, retiring the importance of a personalised approach to risk, allowing for improved understanding of individual service user needs. CJ agreed that personalised approach to risk assessments supports a fundamental approach in a shift of culture to delivering care. OMcL requested assurance on out of area (OOA) incidents. HSm advised that peer review will be introduced on OOA to look at expected dates of discharge and the care given to people in out of area, and incidents will be picked up in this review. It was agreed that would be included in future reports – **CJ to note and take forward.** PE reflected that national statistics suggest that service users are three times more likely to receive restrictive practice in the private sector, and OMcL reiterated the need to monitor OOA given the number of service users utilising OOA services. GA noted the link to IPQR, offering support to align these to provide additional assurance. OFO noted medication error has been discussed at the Board previously. CJ advised that there are clusters of incidents, suggesting that this is not a systemic issue and targeted work will help improve the number of medication errors. Noting the importance of ensuring that support is in place for less experienced staff, using practice educators and promoting a just and learning culture. SY agreed that medication management incidents encompass a range of issues and therefore improvement is required to ensure fundamental safety. It was agreed that the executive team would work together using QI models to understand and address the issues. **To note and take forward** - **executive team** The Chair noted the improvement in reporting learning, advising the Board that a staff governor had received positive feedback from a constituent regarding a violence and aggression incident, where they had been well supported by their manager. **Approvals, recommendations, and actions:** The Chair noted the following: The Board **noted** the content of the report, and it was agreed that the following updates would be provided in future reports – **for CJ to note and take forward**: • Examples of sustainable improvement in learning from patient safety incidents. • Monitoring of OOA incidents given the number of service users utilising OOA services • Review of medication management incidents using a QI approach • Freedom to Speak Up activity including data and case studies.
30/07/2025 Item 12	**Mortality Annual Report 2024/25** Professor Helen Crimlisk (HC), interim executive medical director provided an overview of the Trust's mortality processes and learning from mortality noting: During 2024/25, SHSC was fully compliant with the 2017 National Quality Board (NQB) standards for learning from deaths.

	There were 325 deaths that were incident reported and reviewed via mortality processes. Seventeen of which were learning disability deaths. A separate learning from lives and deaths of people with a learning disability and autistic people (LeDeR) process will be undertaken to review this. The Trust remains an active member of the national mortality and learning from deaths group, working with them to look at learning from death. In addition: • There is a process in place for structure of judgement reviews to enhance learning and doctors in the Trust have been trained to contribute to this. • Going forward there will be a focus on recording of protected characteristics. Mortality will be considered across all protected characteristics, not just ethnicity. • National statistics show that the Trust has more service users who live alone, who take their lives by suicide, than both the region and in England. With less service users who are unemployed, that complete suicide. There are a higher percentage of service users diagnosed with a personality disorder, who take their own lives, than regionally and nationally, and a higher proportion of service users with a substance dependence. SY noted that the period of benchmarking in this report covers a period where the Trust still had substance misuse service, therefore affecting the overall suicide rate. BS noted that middle aged men from disadvantaged backgrounds are more likely to die by suicide, posing challenges to normative assumptions about inequality. Adding, that voluntary sector organisations can support this at-risk group and asked the Board to consider signposting to support outside of statutory services. HC agreed noting that when moving to the personalised risk assessment, it will be important to utilise the data that is already known about certain demographics. SY added that the Trust is working towards the baton of hope workplace pledge which is designed to improve knowledge and training in relation to suicide prevention and emphasises the role of other organisations in reaching at risk people who may not access statutory services and will be working. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board noted the report which provided assurance. • It was agreed that future reports would include an update on the learning from lives and deaths of people with a learning disability and autistic people (LeDeR) process will be undertaken to review this. **HC to note and take forward.**
30/07/2025 Item 13	**Quality Improvement Biannual Progress Report** Professor Helen Crimlisk (HC), interim executive medical director highlighted the report covering the period January 2025 – July 2025: • The Trust has completed its first quality improvement (QI) collaborative programme focussed on waiting less and waiting well. An evaluation report is being completed, due August 2025. • The Trust have been involved in six strands of the culture of care national QI programme which launched in September 2024. • Three nominations have been shortlisted for the health service journal (HSJ) patient safety awards 2025 and various QI projects have been presented at conferences. • The two projects that were successful in obtaining QExchange funding last summer, the 'Qi4All Academy' and 'Improving the Psychiatric Decisions Unit', have continued and are due to conclude in December 2025. HS asked for an overview of benchmarking nationally and the impact of QI projects. HC noted that the Trust is on a journey of embedding QI, disseminating improvements across the organisation and acknowledged the need to evidence the impact of projects. SY noted that the Trust is building a strong infrastructure to embed QI into the organisation. Reminding the Board that external support from AQUA has also been commissioned to support improvement across the Trust. OMcL noted good progress in embedding QI and asked for clarity on next steps for the

	waiting less and waiting well project. SY noted that standardising work processes is the next phase, and this is something that will be undertaken for all projects across the Trust. HC added that the use of language and culture will support staff to approach QI in a continuous way instead of focusing on programmes closing. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **noted** the content of the report. • It was agreed that future reports would include a strategic approach to QI looking at the impact of projects next steps for each project and information on the dissemination of learning and improvements from projects – **HC to note and take forward.** [Zoe Dodd (ZD), peer support lead joined the meeting]
30/07/2025 Item 14	**Lived experience report** Dr Caroline Johnson (CJ), executive director of nursing, quality and professions noted strengthened engagement across inpatient and community services and with the support of Zoe Dodd (ZD), peer support lead ~~and~~ highlighted: • The Trust have been awarded a second star in the triangle of care. • Cultural advocacy workers have supported more than 240 service users over the last six months. • The 'Feedback February' campaign highlighted service users' desire for clearer communication and better information about available services. • There remains low volume of responses in the friends and family test (FFT) which will be a focus for improvement in the coming months. • An implementation plan agreed by the executive management team in July 2025 for reinstating the care opinion platform is underway. • As part of the review of governance processes and following feedback from service users and staff, the focus of the lived experience and co-production assurance group (LECAG) has been reviewed and reshaped. • A patient and carer race equality framework (PCREF) stakeholder delivery group has been established, with co-produced toolkits, and the development of community development roles. HS recommended combining and strengthening the many ways of monitoring feedback such as Friends and Family Test (FFT) response rates, standardising feedback mechanisms, and improving engagement with carers and community services. DP advised that the work that has taken place will be supported by a communications strategy, thanking ZD for her input on the draft communications, involvement and inclusion strategy which will be presented to the Board for approval in the autumn. DP recommended a focus on compliments in relation to the care opinion work to support learning to be had from positive stories. **CJ to note and take forward.** HSm added that ZD will be attending senior leadership team (SLT) meetings so that senior leaders can support the engagement work operationally. SY commended the implementation of the Triangle of Care across community services highlighting that this success story is not visible in the Trust communications. It was agreed that ZD will work with communications team to get key messages for this into the communications cascade. **To note and take forward ZD.** SY noted that feedback from service users and the community are key measures of the Trust's culture change and recommended that positive impact continues to be celebrated with partnership organisations. CP highlighted the work taking place with Sheffield Flourish to work collaboratively on recruitment of volunteers and to implement the policy which has been co-produced. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **noted** the content of the report.

	• Highlight the achievement of the second star of the Triangle of Care with support from the communication team. **CJ/ZD to note and take forward.** • Include reference in future reports to the engagement with the council of governors and highlight the partnership work taking place with organisations. **CJ/ZD to note and take forward.** [Zoe Dodd (ZD), peer support lead left the meeting].
30/07/2025 Item 15	**Annual Safeguarding Report 2024 – 2025** Dr Caroline Johnson (CJ), Executive director of nursing, quality and professions outlined key points: • Current compliance for safeguarding children level 3 training remains below national expectations. A recovery plan is in place and being monitored via a task & finish group. • Uptake has improved for safeguarding supervision; however, compliance remains below target. Further work is required to embed the cascade model and ensure consistent access across clinical teams. • A revised allocation process has been agreed and is being implemented with directorate support, working with operational colleagues to support delays in allocation and completion of section 42 enquiries. It is likely the corresponding corporate risk will be reduced following this. HS requested that feedback and comments from QAC and the focus on risks are reflected in this report. The Chair noted the improvement areas identified in relation to training compliance and it was confirmed that general and service managers have been asked to review training compliance at team-level governance meetings. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **approved** the safeguarding annual report 2024-2025. • It was agreed that clear links to risks associated with the paper and feedback from QAC will be incorporated into the report **CJ to note and take forward**.
30/07/2025 Item 16	**Annual Complaints Report 2024-2025** Dr Caroline Johnson (CJ), Executive director of nursing, quality and professions presented the complaints annual report, highlighting: • Performance has improved from 77% of complaint responses completed within agreed timescales in 2023/24 to 82% in 2024/25. • Additional assurance on learning has been introduced ensuring that all concern contacts are appropriately logged and categorised. The learning from complaints is fed into the patient safety incident response framework (PSIRF). • Key developments include post closure learning reviews, enhanced reporting regarding concerns and queries, and monthly online complaints training. • Complaints are signed off by the executive director of nursing, quality and professions and the Chief Executive. Improvements in quality have been seen. • The team are exploring a rebrand to become a patient advice and liaison service (PALS), because they already deliver this function under the complaints name and structure. • It was noted that care opinion has been used effectively in other organisations to support complaints, and this will be explored. • For the year 1 April 2024 to 31 March 2025, SHSC received a total of 133 formal complaints and 172 concerns. The highest number of complaints received were around access to treatment or drugs, communication, values, and behaviours. • The complaints team triangulate where complaints are coming from and identify any trends in complaints in particular areas to offer enhanced support. • There has been a very significant increase in formal complaints received on Burbage ward, more than what would typically be expected for this type of unit. This has been highlighted throughout the year via governance processes and there is ongoing improvement work being undertaken on the ward. • Sheffield talking therapies accounted for quarter of all concerns, though very few of these escalated formal complaints, confirming that these were dealt with locally. • 58% of complaints were partially upheld, 18% fully upheld and 24% not upheld. Engagement will continue with the ombudsman.

	HSm recommended learning from compliments to showcase in service area and to increase visibility. It was noted that visibility of compliments remains an area for improvement, with 382 compliments received. PE noted that complaints which promote improvement, such as in Burbage ward, should be highlighted as positive assurance and learning. DP noted that compliments are a strong driver for improvements, advising that work will take place on branding for compliments, working in coordination with the re-launch of care opinion. It was agreed that a slide of compliments would be included in a future cascade. **To note and take forward CJ/ DP** OMcL asked for clarity on the timeline for the publication of the communications and engagement strategy and it was confirmed that the first draft of the strategy will be presented to the confidential Board in September 2025. HS commended the progress in complaints team, and the leadership from the head of complaints for embedding improvement. The Chair agreed and recommended that future reports link complaints learning to PSIRF. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **approved the annual complaint report** • Compliments slide to be included in the communications cascade – **DP to note and take forward**. • Future reports to link learning to PSIRF – **CJ to note and take forward.**
30/07/2025 Item 17	**Winter plan** Helen Smart (HSm), chief operating officer summarised the workstreams that will be progressed following review at Senior Leadership Team (SLT) and Executive Leadership Team EMT, in partnership with other organisations, to provide resilient and high-quality services throughout winter. • The plan has been aligned with the home first programme. • An audit is being undertaken to provide assurance that service users are not being diverted to the emergency department. • Work is taking place to ensure vulnerable service users have a crisis care plan in place. • A deep dive look-back and learn has been scheduled with the ICB and local authority colleagues to learn from last year. • Business continuity plans have been reviewed to ensure all services have these in place and that they are of a high quality. This was also done during junior doctor strikes. • Review of the operational pressures escalation levels (OPEL) system is taking place to ensure traction. An executive lead will need to be allocated to this. • Audit of 'on call' rota is taking place to assess the confidence of people on this rota to ensure they are fully supported. • There is regular Chief Executive to Chief Executive meetings with the local authority, and monthly huddles with the local authority alongside these. Salma Yasmeen (SY) advised that there is a requirement for all Boards to be assured on their winter plans which feeds into the ICB system plan. In response to the Chair asking about key risks, HSm highlighted social worker recruitment as an ongoing key risk. The Trust are working closely with local authority colleagues on this. Learning from last year indicates that escalation meetings will need to be in place regarding this and ICB colleagues are supportive. CP added that increased workforce sickness absence is a risk, highlighting that the flu campaign and winter wellness support are included in the plan. It was noted that the highest area of staff sickness was due to cold and flu, therefore improving vaccination uptake will be critical. It was agreed that an insight, data driven communications campaign on vaccination would be considered **to note and take forward DP/HC/CJ/CP.**

	HS asked for assurance on the increased demand across the organisation, and the impact of measures being taken. GA explained that the data is being developed, starting with inpatient services and moving to community services. HS highlighted the importance of looking at the community data to measure the impact of initiatives such as primary care and the 24/7 services. It was suggested that this could be presented to Board during a strategy meeting, using a data approach to look at the impact from programmes such as home first and the primary care mental health teams. **To note for the work programme.** Owen McLellan (OMcL) recommended that a timeline associated with the winter plan is incorporated into future reporting to track actions taking place. **To note and take forward HSm** **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **approved** the 2025-2026 winter plan. • A timeline for actions incorporated into future reporting • using a data approach to look at the impact from programmes such as home first and the primary care mental health teams. **To note for the work programme**.
30/07/2025 Item 18	**Improvement and Change** Dawn Pearson (DP) associate director of communications and corporate governance provided an update: • AQUA have been engaged to support development of culture of continuous improvement, supporting existing work of improvement and change team. • Therapeutic environments programme is at amber status. Charitable funding has been secured to support the Maple refurbishment. Maple ward handover will take place in November 2025, and Dovedale 2 in February 2026 to allow for further works to take place. • Gleadless and Heeley neighbourhood mental health pilot is at amber status. There has been good progress, with phase 1 complete and Newfield Green clinic now open. There will be a revised timeline for phases 2 and 3, which Board will receive next month. • The Trust has undertaken a review of the learning disability programme to ensure that the assumptions underpinning our new model remain valid, recognising that there have been many changes across the system. • Home first is at amber status, progress being made but current impact on out of area bed use requires improvement, so further actions are being added with operational grip and control escalated. Key activities took place in July, including a 3-day sprint workshop with CMHT Leadership, VOT Health and partners including PCMHT and GPs. The intention is to finalise the service model and complete the GP referral work. • We are our values is at green status, with good engagement with staff. The first delivery group meeting was well attended by 43 people. The group have identified six areas of delivery focus, with the first priority being revised recruitment forms and associated collateral. • Older adults' improvement is at amber status. Good work has been taking place on engagement and co-production with service users, families and carers. Improvements have been made in reducing the number of people awaiting a first appointment with the memory service. Work continues to reform the memory assessment pathway so that the total time taken from referral to diagnosis will be shorter. • Rio optimisation is at green status; some areas require further scoping and have experienced delays. BS reflected on discussions had by the Board in relation to the Board story, noting that initiatives such as the STEP programme, Gleadless and Heeley neighbourhood mental health pilot are examples of innovative non-clinical programmes to help with people's mental health. BS noted that work was previously done with the Trust and partner organisations to look at educational exchanges or recovery colleagues. BS reflected on how education can be beneficial to mental health recovery and that the Trust should be looking at this in future, using previous learning. The opportunity of innovative ways of working, linking to pathways to work and working with the community was noted and HC suggested that this could be piloted within Gleadless and

	Heeley neighbourhood mental health pilot. HSm gave an update on learning disability services as senior responsible officer for the programme: • The six-month pilot demonstrated that there is no requirement for an 8am-8pm service. Feedback from service users and carers indicated that a flexible service, which services before 9am and after 5pm would be beneficial, and this will be accommodated. • Bed data has been reviewed, and the service offer has been designed and implemented around this, working with the learning disability population and with voluntary sector colleagues to test the service offer. • The team are about to be co-located • A 30-day consultation will take place • Outcome measures are also being introduced The Chair thanked HSm for her interaction with the governors, listening to their feedback on learning disability service and taking things forward. HS asked if there would be financial implications for the delay in upgrades to Maple ward. It was confirmed that this would be covered in the update on the capital plan during confidential Board. SY highlighted that programmes have milestones which should be noted in the report and recommended that priority programmes be reported as a part of the integrated performance quality report (IPQR). GA confirmed that these would be included in the updated IPQR. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board of Directors **noted** the content of the report. • Milestones to be included in future reports – **JD to note and take forward**.
30/07/2025 Item 19	**Integrated Performance and Quality Report (IPQR)** Phillip Easthope (PE), executive director of finance and digital noted that key areas such as supervision reporting, targets for sickness absence and the development of the IPQR have been discussed in previous items on the agenda. BS noted that discussion had taken place at QAC relating to the homeless assessment and support team (HAST) emphasising that the people using this service are vulnerable and it is important that this does not fall off the radar. HSm confirmed that there will be a communications plan, working with the voluntary sector to promote HAST so that people are aware that the service is still running. SY noted that learning from the outreach work undertaken by the HAST underpins key clinical principles that could be cascaded across all services. In addition, there is opportunity to reform community care and support the HAST team model of care through the Gleadless and Heeley neighbourhood mental health pilot. HSm recommended that the health inclusion team should be aligned with HAST team to assess what could be done differently. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **noted** the content of the report.
30/07/2025 Item 20	**Financial Performance report (month 2)** Phillip Easthope (PE), executive director of finance and digital provided an update on the financial position as of 31 May 2025. • At month 2, the year-to-date deficit £387k higher than planned. This is because of value improvement plans (VIPs) (efficiency savings) being behind plan by £450k. The plan was phased in equal 12ths; however, plans will likely deliver more savings later in the year. • Currently the Trust are forecasting delivery on plan, this forecast demonstrates assurance

	of the Trust's financial position. However, this required the need to transition the VIP plan into delivery. • Financial recovery executive meetings have been escalated to weekly to improve oversight. The action plan for VIP is beginning to deliver, and focus will be on expenditure run rate, to ensure plans are translating into cost reductions. • An aged debtor concern, which was circulated outside of the meeting to Board members, has now been resolved. • There is significant variance in the capital plan due to the implications of Fulwood sale, there is a year-to-date underspend on capital, which is behind plan and may result in some slippage. Further discussion will take place in the confidential session. AD reflected on conversation at FPC regarding the phasing of VIP savings, noting the importance of progressing the delivery of savings in the VIP plan. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board noted the financial position as of 31 May 2025. [Liam Casey (LC) associate director of estates and facilities joined the meeting]
30/07/2025 Item 21	**Fulwood estate update** Phillip Easthope (PE), executive director of finance and digital and Liam Casey (LC) associate director of estates and facilities presented an update to provide assurance regarding structural safety, environmental impact, and site security, following a recent fire at the derelict Fulwood House building. LC highlighted key updates: • There has been increasing system challenges with unauthorised access and vandalism of Fulwood House. This is likely due to the site's location, bordering woodland, giving easy access despite security measures in place. • The fire took place on 7 July 2025, LC attended that fire, along with the director on call and the estates on call representatives. • The Trust worked in line with the emergency services, supporting their response by providing building intelligence and entry points and utility status specialist information and building schematics. • The responsibility of the building for public safety during an incident of that nature sits with the emergency services. The Trust has worked in full support of their decisions throughout. • Immediate actions were taken after the fire such as: o The site was re-secured after the fire service had left. o Fire and the police departments were supported with their investigations. o An independent structural survey was commissioned. o A review of the fire and security risk assessments took place. o The incident was escalated to the executive team. o Fallout recommendations from the fire service were implemented. • Security measures have been reviewed, and the Trust has now moved to a new security advisor, the contract for this commences on 1 August 2025. • Following the structural review, the Tudor building was confirmed to have suffered catastrophic damage, the report recommends full demolition as the safest course of action. Costed options are being worked through for this. • The building had a small number of asbestoses containing materials. They were categorised as low risk when undisturbed and they were previously managed accordingly during occupation and site closure. • Following the fire, the Trust commissioned a UCAS accredited perimeter air monitoring and visual inspection of the area. All samples returned results below the limits of quantification, indicating no detectable airborne asbestos fibres. A second round of air testing was commissioned which also came back with no detectable asbestos risk. The Chair noted the assurance provided from the report and thanked the estates team for the work undertaken to manage this incident. **Approvals, recommendations, and actions:** The Chair noted the following:

	• The Board of Directors **noted** the content of the report. [Liam Casey (LC) associate director of estates and facilities left the meeting; Liz Johnson Head of equality and inclusion joined the meeting]
30/07/2025 Item 22	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2025 Reports** Caroline Parry (CP) executive director of people shared the annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2025 noting that the reports require Boards approval prior to publication on the website in the Autumn. Liz Johnson (LJ), Head of equality and inclusion highlighted: • The percentage of not known for ethnically diverse staff is now down to 3.5% • The percentage of not known for disabled staff is down to 13% after a long stagnant period and there are ongoing plans to reduce this. • Disciplinary data has seen positive improvement for ethnically diverse staff, despite figures being not statistically significant due to general low numbers of disciplinaries. • Staff survey results for people with disabilities in relation to the question 'does the Trust provide equal opportunity' has improved from the previous year. However, this needs to be balanced against concerns regarding staff engagement in the survey for this group. HS reflected that committee discussion had noted the worsening position such as harassment scores, the lack of progress in number of ethnically diverse staff in senior roles, and staff engagement for disabled staff taking part in the staff survey, an action plan has been requested in realtion to these areas. CP advised the Board of work taking place regarding reciprocal mentoring for ethnically diverse staff to support them in getting senior roles. Staff have been targeted, and their progress is being tracked. She explained the need to look at retention of staff in senior roles. In relation staff in senior roles, the Chair asked for clarification of benchmarking. LJ explained that the latest data has not yet been published, it is due in the Autumn, noting from the previous year that the Trust compared poorly in this area, particularly in realtion to disabled staff. GA noted that it was difficult to understand key headline messages from the report and recommended that a summary is provided **CP to note and take forward.** HC noted an inconsistency in the data on WRES for medical staff, highlighting that there are a high number of black and ethnically minority staff in the medical group, but the number of these in senior roles has deteriorated and the number unknown has increased. She noted that this did not seem accurate and challenged on the number of unknown staff members. OMcL reflected that discussion in People Committee relating to 'not known' about staff statistics had taken place which has not been reflected in the updated report to the Board. HS asked whether new staff could select prefer not to say when inputting their details and it was agreed that this would be checked. **CP to note and take forward.** It was agreed that further work would take place on the report prior to publication, and a revised version will be presented to EMT prior to approval at the Board. **Action: CP** **Approvals, recommendations, and actions:** The Chair noted the following: • Further work would take place on the report prior to publication, and a revised version will be presented to EMT prior to approval at the Board. Action: CP • Confirmation whether new staff could select prefer not to say when inputting their details **CP to note and take forward.** • A summary with key headline messages to be included **CP to note and take forward**. [Liz Johnson (LJ) head of equality and inclusion left the meeting and Jason Rowland deputy director of strategy and planning joined the meeting]

30/07/2025 Item 23	**Systems and partnerships update** Jason Rowland (JR) deputy director of strategy and planning gave an update on ongoing system working as part of the partnerships for Sheffield and for the South Yorkshire Integrated Care System (ICS). • Eating disorders joint committee has enabled progress to be made with the expansion of community eating disorder services in all parts of South Yorkshire. This is significant for SHSC as the provider of these services, and important for the joint committee as evidence of the ability to achieve impact through this mechanism. • Local partners in the Sheffield health and care partnership have agreed to work together to submit a bid to join the national neighbourhood health implementation programme. This will build upon existing strengths including the Gleadless and Heeley neighbourhood mental health centre programme. The Chair thanked the team for their work on the neighbourhood bid, which was done in a short timescale. SY noted that there is national interest in the pilot sites and how these will align to the new neighbourhood model, noting an opportunity to build on and provide national influence in this area. OFO asked for clarification relating to risks associated with partnership work. JR highlighted the importance of the Trust shaping the changing NHS system to deliver the Trust strategy. SY added the need to weigh up risk and opportunity, and reiterated that within the new landscape, reform is required both within and outside the Trust. The Chair noted that the Trust strategy is being revised to reflect the ten-year plan. This will be approved by e-governance so that the strategy will be ready to launch in September 2025 at the annual members meeting. **Action:** JD/DP **Approvals, recommendations, and actions:** The Chair noted the following: • The Board noted the update for assurance and information. • The Trust strategy will be circulated for approval via e-governance in preparation for its launch in September. [**post meeting note**: the Trust strategy as presented and approved at an extraordinary board on 3 September 2025]
30/07/2025 Item 24	**Board Assurance Framework (BAF)** Dawn Pearson (DP), associate director of communications and corporate governance provided an update on the development of the 2025-2026 BAF risk descriptions and score noting these been aligned to the refreshed Trust strategy, following discussions at the executive management team and Trust Board development sessions in June 2025. In addition, the risks being reviewed the risk appetite score was also discussed. Executive leads have reviewed and revised the risks which are presented for approval. DP highlighted that BAF risk 21 has been moved to sit underneath the ARC. This will be pulled out into a separate appendix for ARC risks, following approval of the BAF. Anne Dray (AD) noted that some of the new risk descriptions are correct but do not follow the standard format recommended in the risk management framework. She asked that risk descriptions be reviewed and amended to fit this format in the final version. **Action:** DP **Approvals, recommendations, and actions:** The Chair noted the following: • Subject to the changes noted above, the Board **approved** the Board assurance framework for 2025-26. • Risk descriptions amended to fit this format in the final version. **Action: DP**.
30/07/2025 Item 25	**Corporate Risk Register 2025- 2026** Dawn Pearson (DP), associate director of communications and corporate governance provided an update: • The corporate risk register has been lined up with the BAF to help with read across. • There is one corporate risk monitored at the audit and risk committee relating to cyber

	security which has no change to scoring. • One new corporate risk relating to access to specialist medical emergency eating disorders (MEED) support has been added to the register for monitoring at the quality assurance committee, approved by the executive lead. • One new corporate risk relating to medical cover in the health-based place of safety has been added to the register for monitoring at the mental health legislation committee, approved by the executive lead. • Risk 5438 has a revised risk description following discussion at the Board of Directors in May 2025 and risk oversight group in June 2025. • A new risk relating to the governance of artificial intelligence (AI) tools is proposed for the corporate risk register, approved by the executive lead. • There has been no movement on risk scores AD highlighted that there has been no movement on the top four risks, she asked for a summary to be included in future reports, to demonstrate how long risks have had no movement for. **To note and take forward**. HS noted the increased number of risks on the register and recommended that the summary also highlight how many risks the organisation is holding. **To note and take forward**. DP noted that training is being offered across the organisation, and the register is presented at SLT to support oversight of the risks. The Chair recommended a review of risk 5438 **Action: DPe/ HSm/CJ** **Approvals, recommendations, and actions:** **The Chair noted the following:** • The risk description for risk 5438 requires updating. • The Board **approved** the escalation of risks to the corporate risk register. • Summary highlighting the number of risks and their movement to be included in future reports.
30/07/2025 Item 26	**Risk Management Framework (RMF)** Dawn Pearson (DP), associate director of communications and corporate governance presented the updated risk management framework for approval. Noting, following the divisional risk management audit undertaken during 2025-2025 for defining organisational risk register responsibilities and risk management, all feedback has been incorporated into the revised framework. The current process to support oversight of directorate level risks and above, is currently being reviewed via the SLT with changes noted in the framework. Any further changes to this approach will be added as work takes place to revise governance arrangements. AD noted that an incorrect score in the risk appetite section and it was confirmed that this would be amended **Action**: DP The Chair noted that the board has not had risk appetite training and asked that this be picked up. **To note for the Board work programme DP** **Approvals, recommendations, and actions:** The Chair noted the following: • The Board of directors **approved** the Risk Management Framework subject to changes above. • Risk appetite training for the Board to be planned on the work programme **DP** • An incorrect score in the risk appetite section to be amended **Action**: DP
30/07/2025 Item 27	**Governance report** Dawn Pearson (DP), associate director of communications and corporate governance noted: • The annual process for receiving declarations of interests, gifts and hospitality for both the Board of directors, governors and staff below the Board was presented for final approval.

	There have been significant improvements from the year before and work is ongoing to call, in remaining declarations from staff with support from line managers and executives leads. • Governor elections opened for nominations on 28 March 2025. There were 20 vacant seats in the 2025 election process, and 14 seats have been filled bringing the total number of governors on the council to 34 subject to due diligence checks. • Irfan Khan has been confirmed as continuing in his role as appointed Governor for the Pakistan Muslim Centre. • The annual member meeting will be held on 25 September from 4.30pm-7.30pm. • The Trust appointed the good governance institute (GGI) to conduct a developmental well-led governance review. The insight from the report of findings has provided assurance as well as evidence of areas of improvement, the corporate assurance team are using a QI approach to progress this work with the Board. • The modern anti- slavery statement is presented for approval following receipt at the People Committee in July 2025. • The Trust Seal was used twice during 2024-25. The Chair noted that she had not signed the sealings off as stated in the report. PE confirmed that the register was accurate and based on this assurance the Chair confirmed she would sign off the sealings. • The assurance committee annual reports for 2024-2025 and updated terms of reference were presented for assurance. Noting that further work on the terms of reference following implementation of the GGI actions, these will be incorporated once completed and submitted to the Board for approval. It was noted that executive leads will receive an updated list of staff members to support 100% compliance, and an update will be provided to the board in September. **Action: DP** The Chair asked that the terms of reference were checked for consistency across each committee. **To note and take forward DP** The Chair queried the new addition to the terms of reference requiring the Chair and Chief Executive to attend the audit and risk committee when the annual governance statement is signed off. AD confirmed that this has always been a requirement for the Chief Executive and explained that the addition of the Chair attending is in line with the revised healthcare financial management association (HMFA) guidelines, but that this can be discussed further. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board noted the report • The modern anti- slavery statement 2024-25 was **approved** by the Board for publication • The Board **approved** the changes to the terms of reference subject to a check on consistency across the committees and checking that the Chair and Chief Executive are not required to attend ARC.
30/07/2025 Item 28	**Draft annual health and safety report April 2024 to March 2025** Dawn Pearson (DP), associate director of communications and corporate governance noted: • Several important areas of improvement have been implemented due to a serious incident which resulted in a health and safety executive (HSE) investigation. The improvements in place will be beneficial for the future management of health and safety at the Trust, including the implementation of a new policy. • The appointed authorised engineer (fire) conducted an audit of the fire safety risk management strategy arrangements for the Trust. • Physical assault (patient to staff) is consistently the highest reported event within the "abuse to staff", this supports the need to continue, engage and promote the work of the groups to reduce violence and aggression incidents across SHSC. OMcL asked whether the report could outline the actions for the year and the progress against them. SY noted the report is a look back on the previous year and there should not be any outstanding actions. Adding, the report should set out objectives clearly, what has been done and the impact. It was agreed that the report will be reviewed at EMT going forward. **To note and take forward JD**

	The Chair noted the following amendments required: • Paragraph 1.2 states that it should be read in conjunction with some quarterly reports. These, therefore, need to be linked or appended but to date have not been seen with the paper • Paragraph 1.8 states an action that will be completed by June 2025, this requires updating as the report was submitted in July 2025. • Paragraph 1.15 does not confirm if the Trust is compliant with the requirements for fire drills. • Assurance around the skill set of the team. It was noted that this version of the report was in draft form, and it will return to Board for approval. **Action:** to update the report to add to the work programme for EMT and Board. **Approvals, recommendations, and actions:** The Chair noted the following: • The report will be updated and will return to Board for approval. **Action JD** • The report should set out objectives clearly, what has been done and the impact. It was agreed that the report will be reviewed at EMT going forward. **To note and take forward JD**
30/07/2025 Item 29	**Annual update: Sheffield Hospitals Charity (SHC)** Dawn Pearson (DP), associate director of communications and corporate governance presented the annual update noting the summary of actions and their impact, details of fund received this year and outline case studies on impact of the charitable funds. Key projects for the year ahead include: • Staff wellbeing including development days and a digital inclusion and empowerment initiative. • Support for Maple ward refurbishment which will enable touch screen entertainment, communication and information systems in each bedroom, and an autism-friendly sensory de-escalation room. • Support for women's health inequalities including perinatal mental health. The Chair commended the work of the director of strategy in developing the relationship with SHC, noting that it would be helpful to understand how projects are being funded, referencing the SHSC charity funds and the general funds from the charity. **JD to note and take forward.** AD asked about the application process and whether it was adjusted based on the size of the charitable funds requested. SY gave assurance that the process for this has been strengthened, working to ensure bids reflect the Trust strategy. The Board acknowledged and thanked SHC for the support to the Maple ward refurbishments enhancing enhance the space for service users, over and above the work already planned by the Trust. **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **noted** the content of the report. • Detail of how projects are being funded, referencing the SHSC charity funds and the general funds from the charity to be included in future reporting. **JD to note and take forward.**
30/07/2025 Item 30	**SIRO & Caldicott Guardian Report** Phillip Easthope (PE), senior information risk owner (SIRO), executive director of finance and digital provided an update on the role of the SIRO and Caldicott Guardian, giving an overview of work that has been undertaken in the last 12 months: • There have been significant improvements in information management and cyber security at the Trust, a bi-monthly information governance cyber security and artificial intelligence group reports into ARC. • The report gives assurance around the risk management processes, identifying significant risks around cyber.

	• Subject access records and freedom to speak up are on an improving trend. HC recommended that this report no longer be presented to Board and instead be overseen by the Audit and Risk Committee. The Board approved the report having delegated oversight at Audit and Risk Committee, subject to confirmation that this is not a mandatory report for the Board. **To note and take forward HC** **Approvals, recommendations, and actions:** The Chair noted the following: • The Board **noted** the content of the report. • The Board approved the report being overseen by audit and risk committee going forward, subject to confirmation that this is not a mandatory report for the Board. **To note and take forward HC**
30/07/2025 Item 31	**Board work programme for 2025/26** The Board received the work programme and noted that the changes discussed in the meeting will be reflected for inclusion on the work programme.
30/07/2025 Item 32	**Any other urgent business** No additional business was raised at the meeting
30/07/2025 Item 33	**Reflections on the meeting effectiveness** Following discussions, members were asked to reflect on discussions and highlight any instance of unconscious bias: • AD reflected on the discussions at the Board on inclusivity, including the experience story, the mortality report and discussions relating to the communications, engagement and inclusivity strategy. • AD noted the ongoing work to improve recording of protected characteristics. • HS reflected on the need to focus on risks when discussing reports.SY agreed that although the front sheet contains information on risks linking to the report, further clarity is required to link movement of these to improvements. • AD noted that milestones in reports needs to be clearly marked, and actions should have dates associated with them, linking to how these mitigate risks. • DP noted discussions around ownership of risk by executive leads to ensure the papers are mindful of these. • The Chair noted the helpful discussions on using data insights to inform narrative. • The Chair commended the joined up working by the executive team with an agenda which focused on services user and carer experience. • The Chair noted that the service user story was reflected throughout the meeting, linking with each agenda item, creating focussed discussion with service user experience at the heart of these. The Chair thanked all those in attendance and closed the meeting.

Date and time of the next public Board of Directors:
Wednesday 24 September 2025