

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Chief Executive's Report

Introduction

I would hope that we can see through our Board's papers increasingly joined-up work across the Trust to deliver the very ambitious agenda we have, but also to put in place basic disciplines of practice that improve reliability and reduce strain.

The papers before the Board this month bring a conclusion to some important work done during 2023/24. We can confirm **delivery of our work to secure the Trust's underlying finances** by making a substantial savings programme happen – itself supporting necessary expenditure in the coming year which will enhance quality of care and move towards delivery of some of our promises. Elsewhere in the Board's papers is work on safe staffing, and the revised proposal to transform our flexible staffing arrangements via contracting bank workers through NHS Professionals. Improving fill rates through growing our bank numbers and shifts is an important step towards greater team consistency on our wards, as is work to reduce sickness, and to improve the rigour and equity of rota management. Implementing this latter discipline in Q1 will prepare us better to make a success of NHSP in Q3 (if the Board supports the case before it this month). Our finance plans see us continuing to make use of bank staff but **dramatically scaling back agency staffing**, not least through significantly more centralised and senior models of approval from May. These were outlined for CLE in our February internal operating guidance and are being reinforced through directorate reviews.

As we consider the 23/24 annual report work for the Trust, I would suggest we should especially note a handful of key improvements teams have led locally over the last twelve months:

- The closure of Goldcrest ward in Rotherham has allowed us to **expand the acute outreach team's hours and seven-day service**. This has led directly to a 50% growth in care volumes offered through the team, and the weekend service has improved crisis management.
- The completion of long-term work to create a **24/7 CAMHS on-call service** has introduced improved resilience in our response to crisis for children and young people, and improved equity between the places we serve.
- The major **expansion of our volunteering effort** (with a further big growth needed in Q2 and Q3 of 25/26) responds both to our strategy and to the priorities set by our Governing Body
- Our virtual ward service is gathering pace and scale, and its connection with teams within Doncaster Royal Infirmary has been widely acknowledged. Our **IV pathway pilot** has now been supported on an ongoing basis to improve care outside hospital.
- Our **employee incident response team** continues to support colleagues effected by trauma and difficulty at work, and a modest expansion of that team is now planned.

This is not intended to overlook the very positive educational attainment cited below, nor the research esteem indicated by our new role as a coordinating hub within local NIHR arrangements.

Our patients

Both our physical health teams and our older adult mental health services continue to **support patients with dementia**. At CLE in February, we agreed diagnostic pathway changes to tackle waiting time delays in Rotherham, and half of the backlog of confirmed cases has now been addressed. Risk management group is retaining oversight of the further work to improve. Meanwhile, changes including funding new roles, to create equity and sustainability in our older people's services have been prioritised. The new Doncaster joint services with Alzheimer's' UK has launched – alongside a strategy for the city.

In bringing together **learning disability services** across the Trust, within one management structure, it has become startlingly clear that there are imbalances of service offer and service safety, including staff safety between our sites. We are therefore progressing at pace emergency work to stabilise the service in North Lincolnshire, and to ensure that it has the bare minimum multi professional staffing that the client group requires. This step is within the 'bids' and cost pressure process that the Board is sighted on: we would expect by the summer to have a position of equity – meanwhile through delivery reviews we are moving forward with our STOMP compliance analysis including standardising data practices and pathways RDaSH-wide.

The Board is aware that in two respects service **waits in Rotherham Children's Services are outwith our Trust-wide position**. ICB investment in 22/23 to address neurodiversity waits has shown some benefit but concludes in March 2025. CAMHS waits were also an outlier, and the latest plans being presented through delivery reviews suggest that we can achieve our promise 19 4-week standard in this service from July. The number of children waiting too long has halved since January, which is encouraging work. There remains a focus on ensuring that our pathways across Children's services are consistent, but that the results of those changes improves rather than deteriorates patient experience, including waiting times.

Extensive work, led by Claire Klein, has taken place to re-examine **our Talking Therapy services**, with a new service manager in post, and clinical lead joining us next month. Even though the national access (volume) 'target' for the service has been abolished from April, we continue to measure against this standard, and are now clear that we have the capacity in 24/25 needed to meet it: for the first time. Revisiting our low banding of counsellors will help us to improve turnover, and this may aid recovery rates, which are now the nationally tracked data point for the service. It is very difficult to see that expanding Talking Therapies services is not the right step, in view of economic growth and benefits reduction plans in the wider public policy realm.

As reported last time, work was undertaken in Q3 to assess the **therapeutic quality of our inpatient mental health services**, mindful of CQC standards, and of our own promises within strategic objective 4. Richard Chillery has developed a proposed implementation model to take this work forward, alongside and integrated with, work to tackle long stay inpatient care, out of area placements, and the various parameters of the national Inpatient Mental Health Quality programme.

Graeme, Jude and Steve, will all take on specific workstreams. This integrated approach to ward improvement is exceptionally important as we seek to avoid myriad initiatives, monitoring regimes, and other suggestions, given national focus on these settings. I will work as executive sponsor for this safety work given its centrality to the agenda, we have for the Trust over the coming nine months. We have sought support from NHS England to peer review/inspect our wards in November, as a timely test of impact over the coming months. Laura Wiltshire joins us in June to take on the leadership role with the flow team, and Laura's experience in driving meaningful trauma informed improvement will help greatly in the work ahead.

Whilst our quality and safety plan remain in finalisation, I wanted to draw the Board's attention to **the Outcome Measures** that teams are proposing for initial work; they speak to the diversity of the Trust's portfolio but also the mindset shift being observed in our 'reach'. Our children's services teams are seeking to focus their attention on school readiness – and within that on toilet training among our clients. Readiness is the ICB's number one health inequalities priority. Across adult community services we will be looking to achieve a substantial improvement in the timeliness of wound healing, building perhaps on the notable success of the Wound Care Alliance over recent years. Within adult mental health services, the primary initial focus will be on exceeding national norms for patients within Early Intervention Psychosis services, albeit to do this will require us to invest in a missing pathway within our North Lincolnshire team.

Our people

Health Education England now sits within NHSE. In early February, their visit to inspect our educational work has produced a glowing and positive endorsement of the Trust's improvement. This review covered all disciplines except social work, and especially praised the greater profile and reach of our AHP/psychological professionals mentoring and educational support work. We discussed the role of PAs going forward, as well as the needs of peer support workers. It is helpful to have an outside-in view of the quality of support we are providing on placement, as expansion in numbers can sometimes come at the expense of this. We have agreed that in July we will spend some time as a Board exploring all of the educational roles and approaches taken across the Trust as we aim to more clearly lead and govern a tripartite mission of service, research and education.

Joining up our vacancies with our safety and finance has been a thread of these reports for several Board meetings. We are working to **establish vacancy numbers**, reconcile those to a vacancy factor of no more than 2.5%, and fill residual posts. Our workforce returns for 24/25 show a net decrease in establishment but a rise in staff in post. From May, as part of our move towards being, 'fully staffed' I will be providing a vacancy summary to the Board as an annex to this report.

Annex 3 includes a summary report provided by Nicola McIntosh on the September 2023 national staff survey, with data published in March 2024. More responses than ever before were submitted by RDASH colleagues, and whilst our results remain comparatively good, both within our 'sector' and locally, the results show three significant falls from the prior year. More troublingly **our WRES data** contains a large jump in the proportion of staff suggesting discriminatory behaviours by their line manager. The jump is substantial enough that I consider we need a targeted response during Q1 to hear from colleagues about which behaviours they experience and what needs to change. There is no concurrent rise in formal claims or grievances. NHS Providers' wider WRES report is included with the guidance annex (2) to provide some balance and context for Board members.

The prioritised **investment to support peer support workers**, as part of securing promise 1, creates an opportunity for us to test how such roles are best created and employed. We will look to compare our own employment model (used currently in CYP) with hosted arrangements through VCSE structures. In either model we need to ensure that we have the right support in place, and the executive need to review that infrastructure, as we employ more people with lived experience. Our historic wellbeing and support offer, whilst notable (for example in our staff survey) may not be sufficient or elegantly structured for a different clientele.

Overseas recruitment remains an important part of our work, and I reported on our accreditation last time. Up to **nine doctors from India** will join the Trust at below consultant grade this autumn, as part of their work towards CESR status. This significant change will help us to tackle longstanding vacancies and also contribute further medical time to our research work. Diarmid Sinclair is

supporting the transition of these new colleagues into each of our Care Groups. The Board is aware of wider work to support our internationally educated colleagues, and I have asked Steve Forsyth to review the effectiveness of that support before the end of the summer.

The Trust's **staff app** has now reached over 2,000 people. I would hope all Board members have downloaded it. During 24/25 it will become our dominant electronic communication model, as we look to scale back email channels, and introduce greater face to face communication linked to Learning Half Days. The need for messaging/translation work to be a much greater part of the management role is acknowledged in discussions being held within CLE about how we liberate leader's time from meetings and formal obligations – both inside the Trust and especially arising from “system working”.

Our population and partners

When the Board meets in May, we will bring work from the South Yorkshire Collaborative on **future use of section 136 suites**. This work tests the scale of current provision in Barnsley, Sheffield, Doncaster, Scunthorpe, and Rotherham. It is likely to suggest that the key improvement steps rely on suites being staffed (we have standardised our staffing model within RDaSH from Q1), but on length of stay being at 24 hours. This is a *huge* step from current state, albeit it is a timescale which accords with the expectation of the legislation. This work directly speaks to whether, as a South Yorkshire system, we have scaled our in-area beds and sub-specialist capacity, to what is needed.

We have agreed with Doncaster's Strategic Homelessness Executive, that it would be helpful for the Trust and primary care partners **to develop homeless health services at scale in the city**. These would compliment and sit within the Complex Lives structure led through the local authority. NICE guidance, and other related publications, will be followed to develop a final proposal during Q1. There is considerable energy and excitement about this possibility and it will be important to capitalise on this collective commitment, not only in itself but because of the relationships it nurtures of relevance to our wider pathways of care.

We have succeeded, with our partners, in retaining **the drug and alcohol service's Aspire contract**. This marks a 100% tender success rate during 23/24: a pleasing indicator albeit the time taken by procurement processes remains notable. We will look to operate constructively to compare dual diagnosis arrangements in Doncaster (where we run services) and Rotherham (where we do not). The latter remains an identified improvement priority for local primary care colleagues and is being added to the health and wellbeing board's mental health improvement plan.

The Ministry of Justice have confirmed their intent to contract with the Trust to develop and **expand our Rotherham based Trauma and Resilience service**, which developed initially to respond to operation stovewood. We are clear that this will offer not only South Yorkshire but also North Lincolnshire access.

ICB colleagues are currently leading a **“refresh” of last year's Joint Forward Plan**. The current expectation is of minimal change. Meanwhile, Place Plans are being tested for, among other things, their ability to contribute to financial balance. The structural financial imbalance in Doncaster is of note and considerable joint work continues to seek to find a route to balance working across primary and secondary care.

Concluding comments

I recognise that the sheer scale of change across many facets of the Trust's work can feel overwhelming. Whilst our ambition, through the promises, is an energising one, it remains **important to check-in and adjust as we go**. The fundamentals of good care planning and accurate waiting list management, the basics of good sickness support and effective appraisal, will underpin our ability to flex and change in different spaces implied by our strategic objectives. At the next Board when we consider our Well-Led position we need to examine how we are supporting our leaders to both lead and change. This will be timely as our procurement of leadership development support will have reached a decision point.

It has been helpful to begin to mobilise our work on health inequalities, and the Board's new committee for that purpose will help to ensure we keep pace and focus. There is pressing work to be done to ensure that during 24/25 **our IQPR and other key datasets routinely assess all our key indicators for protected characteristics and consider spatial and deprivation indices too**: a 'reasonable unreasonableness is needed now' to make a rapid step-change in expectations.

Nicola McIntosh steps down from the Board in late April, with our *thanks*, and mine. This meeting is her last with us. Successor arrangements are in place designed to maintain momentum in our work to improve people management across RDaSH. The 2023 staff survey annex illustrates some elements of the task ahead, but the key step is our journey to being Fully Staffed, and work to reduce vacancies and improve retention. The wider NHS desire for 'flat staffing' should not be confused with the need to address gaps and risk.

Annexes provide detail of our work on the (1) governors' key priorities, show the (2) latest guidance documents, including in detail a WRES summary, then set out the (3) key issues in our latest Staff Survey, and (4) precis the work of the CLE since the Board last met.

Toby Lewis, Chief Executive
22 March 2024

Chief Executive's Report

Introduction

Looking ahead to our Annual Members' Meeting on July 20th, we will want to both issue the obligated statutory reports and provide **a candid view of progress with our promises over their first few months**. I share here the largely upbeat view I put to the Clinical Leadership Executive this month:

“Our **promise one** values peer support workers as critical to care quality. Over £500,000 is being invested in 2024 to expand peer support work at the Trust in a variety of children and adult services. We have been investing too to cut waiting times. Waits for ADHD and ASD assessment will reduce sharply in 2024/5 after over £1m has been spent to recruit more staff to speed up diagnosis. Our CAMHS services are now meeting the four-week wait – two years before we promised (**promise 14**). The Trust has taken steps to meet our apprenticeship levy in full (**promise 9**) by moving all band 2 and 3 roles onto an apprentice-first model this summer. In May 2024 we have changed our entire approach to patient feedback, replacing historic systems with a widely well-regarded model called Patient Opinion used in other NHS organisations (**promise 4**). We are proud of the work done to expand virtual care and ward models at the Trust over the last nine months: in physical health the service has never been larger – and during 2024 we plan to launch mental health virtual wards (**promise 20**).

The start of our work on poverty proofing (**promise 6**) has kicked off in three services in each geography we serve: the programme to extend those audit-and-act arrangements is in hand Trustwide. And finally, the fundamental **promise 5**, which seeks to involve patients at every level of our decision making has started: initially with patients within our executive and Board committees, as an initial step to a much wider participation by the Trust within our local community. In total, a quarter of our 28 promises are very much underway – with work on volunteering, anti-racism and adopting the Real Living Wage (**3, 26, 25**) next to ‘go live’ – *bringing us up to ten promises moving into delivery.*”

We recognised last summer that the endeavour of our strategy was one that would happen in the face of other pressures: not only inevitable financial system challenges and operational scrutiny, but also other calls on time and attention for our senior and middle management. Looking to the risks we face in moving the promises forward over coming months, this “contest for attention” – as well, still, as delivery skills gaps – remains the nub of our challenge, one we must meet.

In 2023/24 the Doncaster coroner issued **a regulation 28 letter** about the Trust's services in respect of mental health “disengagement”, and another R28 letter to NHS England about eating disorder liaison services (both annexed to this report). Over the coming quarter we need to see decisive progress on both matters, recognising that both are local manifestations of national issues. I would hope in July's Quality Committee, and then in the Board, that we can spend time to consider whether we are on track.

The Board recognises that clinical risks extend pervasively across many services and often at the edge of ourselves and primary care partners. Nonetheless, **our inpatient mental health wards** reflect specific risk – whether that is in terms of sexual safety, discrimination, staffing, multi-professional working, or long lengths of stay with arguably abundant caution. A small very senior leadership team are overseeing the work we plan to do on our wards: and very deliberately making sure we are choiceful about ‘initiatives’ and projects. Our finance plan requires us to reduce inpatient bed numbers while, our **promise 10**, an out-of-area placements

Our patients

I want to begin the new public service year by recognising that our ambitions to address health inequalities rest, more than any other endeavour, on **our effectiveness in children's services**. Whether seen through the lens of Adverse Childhood Experiences (ACE), or through the lifelong cost consequence of school readiness, our effectiveness in early years matters most – and in North Lincolnshire and Doncaster we have an opportunity across physical and mental health to make that difference (in Rotherham, we provide mental health services with TRFT providing community children's care). Children's services within the Trust are generally seen very positively, with strong leadership, research engagement, and success in retaining contracts and relationships. We want to challenge ourselves to go beyond that good state and examine what outstanding looks like – the teams themselves are committed to meeting our wait time ambitions, to intervening in toilet training to support a radical view of promise 17 focused on narrowing school readiness gaps.

Our work on **section 136 access** was discussed in January's Board, and in a South Yorkshire basis in the collaborative too. That work suggests that in South Yorkshire, commissioners need to consider a sixth suite (in Sheffield), but also that applying a maximum length of stay of 24 hours reflects the obligations of the MHA, and the best interests of individual patients as against the access of a wider population otherwise defrayed to ED and custody. From July 1st we will be reporting this new local "measure" and treating delays inside one of our three suites as an adverse event. Of course, highlighting these issues elevates considerations like out of hours decision making, and admission avoidance effectiveness, and the Board may wish during Q2 to explore both issues in more detail.

As CLE over recent months, we have revisited our complaints process, its timeliness, and impact. Notwithstanding positive opinion proffered in 23/24 by internal audit, there remain concerns over whether we are learning effectively, whether those who wish to complaint can truly do so, and the pace of investigation. Our quality account does not testify to *substantial* change arising from complaints, and recent data difficulties suggest that our system is not yet working effectively. More positively **the move to Patient Opinion this quarter**, and retirement of paper-based systems and a backlogged PALs model, testify to a determination to make changes this spring and improve the situation.

This month's Board meeting marks the last phase of reports related to the domains of **the CQC framework**. The Trust last received an inspection in 2019, and this was only for some services. Our rating remains requires improvement. Looking forward we have significant work to do to meet the ambitions we have set to be rated as good and become outstanding in the caring domain. I would suggest the board's reports provided over some time, are most useful in conceptualising what good looks like (rather than offering 'assurance' on a current state) – over the next four to six months Steve Forsyth and a wider group will be responsible for both the evidence and actions needed to move forward our execution. I have asked NHS England's intensive support team to work with us later in 2024 to test our internal views, and I know that Steve will bring some external input into the team in coming weeks to help mobilise action. Rigour will be key: are our operating practices what we say they are, and do we apply that in practice? At June's CLE Jude Graham will set out work in terms of autism friendly care which I would suggest is crucial to these questions.

Eating disorders have been discussed more within our Board over the past year than any other clinical subject. On the one hand, our community children's team presented in July 2023 and their wait times were, and remain, outstanding. On the other, adult services are lacking

locally, MEED compliance is varied, and specialised services are twice the scale funding presently permits. Fundamental change, in our patch, and system wide, is needed, and the paper received by the Board privately speaks to that intent. Consistent with other issues in our field, we see (a) rising prevalence and (b) a reliance on contracted-out supply; able to raise thresholds and prices in exclusionary ways. It is to credit of our ICB and partners that there is real ambition to move this forward in 2024.

Work has taken place since the last Board on Oxevision and resus, and I will provide an oral update when we meet, further to delivery reviews which take place between paper issues and our session as a Board of Directors.

Our people

We know we have work to do to make appraisal truly outstanding at the Trust. This intervention should be both supportive and purposive. Linked to training needs, wellbeing, and objectives for improvement. Our staff tell us we do ok but could do better. We know that the clarity and fairness of routes to training funding needs work (and we have a CLE sub-group focused on that which we will discuss at July's "education" Board) – and want to do better to introduce objective-based working. Despite all these limitations, and mindful of the internal audit report imminently due, we should be pleased, I believe, at **the very high level of recorded PDRs in the Trust**. This is a foundational competence to build on – allied to supervision score which remain high which has been a focus in this month's delivery reviews (and June's in backbone services).

Induction, notably **local induction**, is an impactful 'HR' intervention that has a defined impact on performance. If we critically examine Trust turnover data, we find that we combine longstanding employees, with those who are with us less than a year (and the latter roles are to a degree predictable). We want to make sure that our induction approach welcomes and equips new joiners to contribute, and to speak up and tell us how we can do better. Care Groups and corporate directorates will be focusing in Q1 and Q2 on local induction, whilst Carlene Holden, and the wider executive group, works with partners to build a truly outstanding face to face induction system which not only introduces 600 colleagues a year to RDaSH but also embeds them in our local communities. A report on progress will be at the Board's meeting in September.

Today the Board has chance to review work done over several months, since last year's inaugural leaders' conference, on the leadership development offer (LDO). This is both a development space, and a way of doing work. The commitment of time by senior leaders (1.5 days a month) is significant – and intended to build shared skills and create chance for new relationships across our most senior 150 leaders – directorate, group, and executive colleagues. The paper outlines the wider support offer for leaders, and I should make clear that a **specific 'manager's induction' will be introduced not later than September 1st**: this is a key step because presently it is possible to become a team leader or line manager, even a budget holder, without necessary core training being in place. If the role of the most senior leadership, even the Board itself, is to influence managers to then influence our people, this is a missing piece – *and one we need to act to change*.

The commitment to the leadership development offer is a vital part of our strategy. Discussions within the Board over some months have surfaced longstanding capability and capacity concerns. They are hinted at too within the annexes of our well-led paper. We have been very successful in recruiting at executive, group, and directorate level some high potential leaders to

join talented longstanding colleagues. We still have gaps in medical leadership, but we have decisively altered the balance of clinical leaders with lead professionals recruited in all of our 13 directorates. Our professional advisory groups (PAGs) will be expanded in coming weeks to include administrative staff, so central to work we do with and for patients. **I would hope that the Board will support the LDO proposal led by Carlene Holden**, with input from Richard Chillery, myself, Jude Graham, and a cohort of other senior leaders – we will not endorse other bespoke leadership programmes if we endorse this proposal – we are *all in*...the coalition described must encompass our plans. This will restrict external programmes other senior leaders wish to attend.

During June we are conducting a review of our longstanding **‘staff’ networks**. Before our celebration in October of their work, and mindful of the huge opportunity of learning half days from September to increase their membership, we are looking to explore what they wish to achieve. Kath Lavery and I will meet with each network chair, and the new executive sponsors, to consider *one major achievement* that they wish to deliver over the balance of 2024/25 (we will summarise these in July). I suspect in developing our networks we will launch a fifth ‘carers’ network’ in Q3 as well, consistent with promise 2. I am thrilled that in 2023/24 our new central ‘reasonable adjustments’ budget for the DAWN network hugely overspent (budget 35k, spend 84k)! This is testimony to our work to make sure that new employees have support to start well. It was a key ask of the network when I started at the Trust and one that has been impactful and is being sustained – perhaps unusual to celebrate an overspend, but happy to do so.

Our population and partners

Our mental health, learning disabilities and autism **collaboratives** continue to play a role in the life of the organisation. In Humber and North Yorkshire, we would expect to see the collaborative change shape, with proposals to become from April 2025 a contractual joint venture. This will place the ICB at the forefront of work to delegate responsibility from that body into the collaborative, now led by Brent Kilmurray from TEVs. Proposals to create a joint committee in South Yorkshire are reflected in the private Board, while actions to deliver real patient-facing change are acknowledged in this report. The Board-related implications of such changes are less defined and we may wish to consider, through the chair, time to explore those on a future occasion, bearing in mind the 2022 Act.

Place plans remain, as is outlined elsewhere in the board pack, mildly elusive as ICBs strive to respond to national direction. In Doncaster there are exciting plans that recognise the need to reshape secondary care, not only at the Trust, but at the DRI too. Building on work done within our virtual ward, we are looking to create with primary care partners a step-up capability at Tickhill Road, aligned to a modified older peoples’/frailty bed base, which addresses the unacceptable current estate we have, and may conjoin with some services misplaced presently at the hospital. The key step is to move away from A&E ‘delivery’ or attendance as the route to emergency care – and there is a good prospect of a capability, building on the Jean Bishop Centre, that could be one anchor in redefining the Woodfield Park.

The forthcoming annual report records **a significant increase in VCSE expenditure** by the Trust in 2023/24. This is a welcome step to rebalancing local systems. We will work to consider in the relevant Board committee (PHPIP) how we maximise freedoms to move away from procurement constraints. We will want to revisit how we ensure such opportunities arise in each community, and smaller groups have access to funding, either through our Trust processes, or through the revised charity governance explored elsewhere in our agenda. We

agreed in January that increasingly the charity would be a route to partnership locally, and we need to make good on that commitment.

The afore mentioned annual report and Further to previous updates to the Audit Committee, Finance, Estates and Digital Committee and the Board of Directors the work on the Annual Report and Accounts 23/24 has continued. Draft Accounts were submitted to Deloitte (External Auditors) on 24 April 2024 in line with the national timetable. A draft Annual Report was submitted to Deloitte on Monday 20 May 2024. Deloitte have commenced their audit work and anticipate this to continue throughout the rest of the month and into June 2024. They will provide their first formal update to the Audit Committee on Wednesday 5 June 2024.

This meeting of the Audit Committee is too early in the timetable for it to be the final approval point from the Trust's point of view. Deloitte will keep the Chief Executive, Director of Finance and Estates and Audit Committee chair updated on further progress with the intention being that when the Board meets on Thursday 27 June 2024, for its next timeout session, that a proportion of the day is assigned to the formal approval of the Annual Report and Accounts, including the receipt of the audit opinion from Deloitte.

This will then afford the opportunity for the final submission of the required paperwork and final version of the Annual Report and Accounts to be made on Friday 28 June 2024.

Concluding comments

In 2023/24 we suggested that **tackling excessive agency profits** was important to our financial future – and a step in addressing our safety as well. We failed last year to reduce costs. A new regime and approach is in place for 2024/25 as a Trust (CLE agreed April) and it is important to be explicit about what it seeks to achieve:

- Agency use in backbone services is barred, absent the approval of the CEO
- Non-medical agency will be exceptional, with current use phased out by July
- Medical agency is reduced sharply: a handful of roles may remain into Q3

It will be important that interventions do not 'suppress' the ask. Instead, they stimulate firstly the transfer of longstanding agency staff to bank or substantive contracts, and they secondarily incentivise fresh thinking. I would suggest in November, we review the impact of the revised controls on safety and spend.

Earlier in this report, it was acknowledged that continued reductions in 'out of area' placements could sit askance to **reductions in bed numbers**. We need to recall that admission rates at the Trust are high, and long-stay patients are numerous. Our bed base on site(s) should be for those who truly need detention or informal admission. There is significant opportunity to work with housing associations and other partners to support alternatives to ward beds, and to reform our current 'rehab' offer. This was effective in Rotherham in 2023, paradoxically it may demand more provision in North Lincs in 2024, and reshaped delivery in the city of Doncaster too.

A year ago, the Board supported our endorsement of **Equally Well**. This national campaign seeks to tackle physical health deficits among mental health patients, exemplified by the presentation in January 2024 from South Scunthorpe. Our MUST assessment data testifies to the work to be done, but so does our SMI health check data, where we do comparatively well, but fall short our unreasonably ambitious 95% standard (the new national stretch measure is

75%). I would suggest we revisit in September, the seriousness of our commitment to this campaign and examine initiatives to deliver.

Toby Lewis, Chief Executive
22 May 2024