Pack B

2024/25 Annual Report and Associated Matters Annex paper:

- Promises and Priorities updates – January 2025

RDASH Membership – a revised approach (Promise 5) Annex paper:

- Membership survey responses and demographics

Chief Executive's Report to Council of Governors Annex papers:

- CEO Report to Board of Directors – November 2024
- CEO Report to Board of Directors – January 2025

Rotherham Doncaster and South Humber NHS Foundation Trust

Promises and Priorities – January 2025 updates
(Reported to the Board of Directors January 2025)

Context / method next steps

1.1 The format of the annex is as in the prior two reports. In February's timeout we will consider how we transition other Board/Trust reporting for 25/26 to a 'four colour' traffic lights and instil a distinction between planning quality and likelihood of delivery. This move to prospective analysis is increasingly becoming normed/colloquial inside the Trust having been at the core of our delivery review method since late 2023. We agreed to consider the implications of this mindset for our Board 'assurance' mindset effective from April 2025.

1.2 During February PFG are meeting with the author to explore how best to introduce a community feedback/assessment consideration into our promises analysis, mindful of the commitment to have this in place for our annual reporting and Annual Members' Meeting (AMM). That discussion needs to have validity with our governing body, and a proposal on that matter will be before the next Governing Body, as we move to full implementation of Promise 5. We will benefit in so doing from the internal audit review of this promise (alongside 3 and 4); and from use in the coming year of our Community Involvement Framework.

1.3 Over coming Board meetings we will continue to consider specific promises within the workplan. In November, we considered promises 6, 7, and 8. In this January's meeting, we explore 3 and 4, as well as an in-depth look at elements of promise 14. Execution of all elements of **promise 25** is appraised in the Chief Executive's private report to the Board.

1.4 During 25/26 all promises will be considered in this way, noting that strategic objective 2 was assessed in September as being most 'behind', and strategic objective 3 least progressed. HQTC discussions provide an overview of strategic objective 4: and the Public Health, Public Involvement and Partnerships (PHPIP) committee has asked for a final plan for Promise 21 not later than May. In the paragraphs of this report, there is mention of all elements of strategic objective 5 (**emboldened** for ease).

Two monthly update: scoring position

2.1 In the annex, the textual commentary has been changed materially. Where it has been changed, the textbox is greyed. Changes have only been made where there is something new to report. At the last meeting I outlined the intent to tackle next all 'plan reds', and work to conclude that inside Q4 is in hand, notwithstanding the paragraph above about the sole promise where we have not settled on success measures/finish lines.

2.2 Having agreed our approach to anti-racism, the Board in March will test the wider approach being taken within the Trust to **Promise 26.** An agreed success measure for this work was to eliminate our gender pay gap, and the latest assessment has seen that reduce from 11% to just above 4%. That gap should further benefit from implementation of the Real Living Wage from April 2025 – and the impact of that change is presently being analysed.

2.3 In September, this report discussed **promise 27**, and the challenges of meeting the net zero commitment. Last time the Board met, there was some suggestion that planning for delivery might be time-wasted. In reality, we are now successfully building a series of propositions for the investment needed nationally to allow us to change the heat sourcing of our main building sites. On February 12th we host our Climate Adaptation 'day': this will bring together internal

and external colleagues to consider how we need, for 2040, to reshape how we deliver care to meet the inevitable reality of our local landscape. This work will inform, among other things, the development of the Remote Working Framework we will look to adopt in Q1 – itself a key enabler for finalisation of our Estate Plan. We know that our travel and transport approach is journey intensive, and presently car dependent.

2.4 The Board considered our work on research when we last met. In July we explored our education position, as a learning theme for the whole meeting. In 2025/26, delivery reviews with Care Groups will increasingly see a better balance between consideration of service, education, and research, as we seek to make the latter two more equal partners in the management effort. In reality this is dependent on the shift to directorates for day-to-day operational matters, together with the up-skilling of senior leaders across CLE (clinical leadership executive) on the language and levers of both education and research. Delivering **promises 24 and 28**, does require some such broadening of leadership if it is to become truly embedded.

2.5 As an executive group, we continue to try and balance moving forward all promises, with delivering some – and transitioning them to 'business as usual'. Those arguably closest to that state – certainly by July 2025 – are perhaps promises 3, 4, 5, 9, 24, and 25. **Promise 6** may develop that character to time if we can meet the revised schedule of implementation agreed within CLE and shared in my last weekly 'vlog'. As the PHPIP committee outbrief makes clear, the benefit for the audit process was well illustrated by frontline managers' comments at that committee in support of one of the pilot reports. All poverty proofing reports will be published on the Trust's website and retained there – as we work to create accountability loops to implement the changes recommended. Our 2025/2026 annual report will also address the recommendations made in the reports completed by the end of 2025.

2.6 Delivering **promises 14 and 19** are the major operational task of the coming year. They will require support and input from experts across the Board, and from clinical leaders inside our care group SLTs, in particular. Either promise could be executed in a manner which frustrates/risks the real purpose of change. Patient experience must be enhanced by being looked after locally, and therapeutic quality and outcome must not be compromised in so doing. Similarly, in moving to a four-week maximum wait, we cannot create secondary waits, nor create either the practice or impression that 'contact' is being privileged over meaningful assessment and care planning. As a drive to deliver "kicks in" this inadvertent risk arises, and we will consider how best to address it in practice. The CAMHS four-week delivery journey of 2024 – now nearing completion with success will offer a case study from which to draw learning. During Q1 we will consider how to offer an opportunity for frontline clinicians, middle managers, and the Board to explore that 'case study'.

<u>Specific score influencers since the last Board last met (excluding 3-4)</u>

3.1 **Promise 9:** whilst work to fully expend the levy has previously been positively reported, and remains achievable, a recovery plan is due in February from the People and OD directorate. During Q4 a considerable number of high-cost apprentices will need to be commenced, alongside the welcome initiation of our apprentice first work.

3.2 **Promise 11:** part of the challenge of this promise has been marshalling the various interested parties to it and ensuring overwhelming focus on the success measures. A constructive effort to cohere those with an interest, and those needing to lean in has been held. The CLE E&I sub group will see in its May meeting the outcome of that work, which needs to best balance general access to services for veterans and families, together with veteran led peer based services.

3.3 **Promise 13:** work to deliver a community-based clozapine service in all three communities has returned to CLE in January, with clear progress in two of three care groups. We would expect to move to implementation during Q1 25/26.

Conclusion

4.1 It would be especially helpful for Board members to do two things in the discussion:

- Raise any specific promise queries of interest
  (as the lead governor did on promise 10 at COG)
- Comment on whether the level of detail and insight now provided three times is broadly sufficient and suitable for our current needs as a Board.
  (it is recognised that the format/language may not be accessible to all, and we are working through with the help of PFG and others how this might addressed)

Toby Lewis, Chief Executive
22 January 2025

Promises and priorities – delivery plan and delivery self-assessment

Annex 1

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
1. Employ peer support workers at the heart of every service that we offer by 2027.	Each clinical service in the Trust will have a peer support worker aligned to it and working with patients in their care.	Red	The developing delivery plan (now CEO owned) needs to consider how PSWs are best supported, and to confirm the services that will have such roles, and the timeline to do so. Specific provision in our Investment Fund for 25/6 has been made for the next steps with this work.	Amber red	The promise is hugely ambitious in number and reach. It is forecast that we can scale up, but are not yet confident of sufficient expansion.
2. Support unpaid carers in our communities and among our staff, developing the resilience of neighbourhoods to improve healthy life expectancy.	Achieve Carers Federation accreditation for the work that we do across the Trust.	Amber red	The delivery sequence to do this will be considered in the POD/N&F delivery reviews in February.	Amber green	As an input measure, we are confident that effort will produce compliance/adherence.
	Provide flexible, safe, timely access to all our inpatient areas for carers to spend time with their loved ones.	Amber green	To a timetable to be confirmed within the HQTC, we will move to a standard access offer across our wards and sites – removing variation.	Amber red	Putting into place what is needed is feasible – what has to be established is that it works – through the eyes of carers…
	Identify most and better support all unpaid carers in our workforce, recognising carers traditionally excluded.	Amber red	We can do more to systematise this. But our plan is likely to be incomplete given self-identification inhibition in early months.	Amber red	This cautious rating reflects the hidden scale of need and the work required to match that with support
	Identify all-age carers that use our services and ensure their rights under the carers act are recognised.	Red	This piece of work is a significant one and may require dedicated resourcing for a fixed term period.	Red	Until the planning work is done it is difficult to meaningfully estimate the LOD.
3. Work with over 350 volunteers by 2025 to go the extra mile in the quality of care that we offer	Have 350 volunteers registered to work with us or have equivalent to that figure volunteering time with us through another body.	Amber green	This is reported elsewhere. Delivery Reviews will focus on upping the numbers of North Lincolnshire and Rotherham Without that plan, we risk missing the point of the measure.	Amber red	Until we are more than a third of the way to the measure (having used 40% of the elapsed time), we need to see a sizeable uptick in take up to go AG.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	For that body of volunteers to reflect the diversity of our populations.	Amber red	This remains outstanding and the commitment to complete it is contained in the paper before the Board. As yet the plan colour remains unchanged.	Amber green	As with the COG measure which predated the strategy, improvement is very possible against the baseline: proportionality is much more challenging.
4. Put patient feedback at the heart of how care is delivered in the Trust, encouraging all staff to shape services around individuals' diverse needs.	Increase by 15% the scale of feedback received in the Trust versus 2024/25 baselines.	Amber green	We have a deployment plan for Care Opinion, which we believe will improve our reach, pace and analytical capability.	Green	This scale measure we would expect to meet during 2025/26.
	Ensure that feedback is sought and received from a diverse range of backgrounds including those subject to Mental Health Act detention.	Green	JG has overseen a very clear plan to put this into place in acute settings during 24/25.	Amber green	MHA will continue to support this important qualitative work and there is confidence we can meet the ask.
	Demonstrate that patient feedback at directorate level has resulted in meaningful change by 2026.	Amber red	It is too early to shift the plan level, but there is an expectation that this will move to amber-green from April.	Amber red	Given that 18 months+ exists, this can be delivered: but the meaningful change means we need to have achieved the push/pull use in mid 2025.
5. From 2024 systematically, involve our communities at every level of decision making in our Trust throughout the year, extending our membership offer, and delivering the annual priorities set by our staff and public governors.	Involve patient and community representatives fully in our board, executive and care group governance .	Green	This work is structured and is in hand: documenting the process of 2024 peer support and creation of 2025 shadow forums will take place in Q3.	Green	Board and CLE changes are in place – CG governance changes planned for Q1 25/26.
	Deliver the Board's community involvement framework in full.	Amber green	Work to refine this is well advanced but final documentation is needed, routed in, VCSE analysis which is presently being finalised.	Amber red	This remains AR until there is a clearer trajectory, which SRO, E&I sub, CLE and PHPIP have confidence in.
	Apply patient participation tests to new policies and plans developed within the Trust .	Amber green	This continues to be an acknowledged oversight and will be addressed in the revised policy of policies over coming weeks.	Green	Getting the required changes into place is not an onerous ask, but does require a structured approach.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Support active membership participation in the work of the Trust, implementing a new membership offer in 2024/25 and evaluating it in 2026/27.	Amber green	The proposal on this work will go to the Council of Governors in March.	Green	This work is on track and will be developed.
	Deliver the annual priorities set by our council of governors.	Amber green	Most priorities set with COG are in hand: there is work to do on the digital aid/MH work which needs resourcing.	Amber green	Within 24/25 we would expect to meet the measures we set in 23/24.
6. “Poverty proof” all our services by 2025 to tackle discrimination, including through digital exclusion	All our services to have completed poverty proofing and be able to evidence resultant change (including digital).	Amber green	A revised schedule has been agreed with Care Groups, as is reported within the board committee notes.	Amber green	E&I sub, and CLE, have supported the ‘pre-agreed/indicative’ changes we would expect to make for 25/26 based on initial analysis.
	Sustained reduction in service attendance gap (7%) in lower decile neighbourhoods.	Amber red	Our current plan is to poverty proof. It remains to be established in early 25/26 what other interventions are needed to achieve this measure.	Amber green	The lack of a final timescale for this improvement explains the positive rating – there is time in 2025 to iterate delivery over following months/years.
	Benefits and debt advice access to be routine within Trust services to tackle ‘claims gap’.	Amber green	An initial proposal is almost in place which has strong support among partners: it is likely that this will be dovetailed within DIALOG+	Amber green	There is further work to do to consider scope of coverage but the plan has flexibility to reflect that risk.
7. Deliver all 10 health improvements made in the Core20PLUS5 programme to address healthcare inequalities among children and adults: **achieving 95% coverage of health checks for citizens with serious mental illness and those with learning disabilities from 2024.**	Achieve measured goals for chronic obstructive pulmonary disease (COPD), hypertension, asthma, diabetes, epilepsy, oral health, and children and young people mental health by 2026/27.	Amber green	This plan is at risk of moving towards red because of data and reporting delays. A process across the executive to resolve this in February is in hand.	Green	Teams involve convey confidence within delivery reviews that they can meet these measures over the time period.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Achieve learning disability and serious mental illness health check measure in 2024/25 and recurrently.	Amber green	Significant and positive work has taken place over the last two months, on the initial step related to Trust held patient registers. Q1 sees migration to a focus on a single PCN register in both circumstances.	Amber red	Success relies on the Trust changing how we work and who we work with. During Q3 it will become clearer how feasible this is and over what timeframe.
8. Research, create and deliver 5 impactful changes to inequalities faced by our population in accessing and benefitting from our autism, learning disability and mental health services as part of our wider drive to tackle inequality (“the RDASH 5”). (next report will include neurodiversity measure and PCERF)	Increase access to health checks for minority ethnic citizens with Learning Disabilities.	Amber red (reduction)	Presentation to the E&I group illustrated material weaknesses in the delivery chain analysis behind this measure and further work is needed in Q4.	Amber green	Resource to support this work is in place: we now need to see whether we are able to reach those previously excluded.
	Increase diagnostic rates for dementia among minority ethnic citizens.	Amber green (improvement)	Good work has been done to develop a cogent plan based on an understanding of other places. This plan is due in E&I in March to sign off.	Red	This is not simply a supply side change, and clearer influencing strategies need defining to move the LOD assessment.
	Improve access rates to talking therapies among older adults.	Amber green	Teams have worked hard to establish how this can be done and a defined data point is agreed. Executing the plan is commencing and needs ramping up.	Amber red	Movement on the key metric is needed in early 2025 to establish confidence in the work we have done to date
9. Consistently exceed our apprentice levy requirements from 2025, and implement from 2024 specific tailored programmes of employment access focused on refugees, citizens with learning disabilities, care leavers and those from other excluded communities.	Achieve the levy requirements in 2024/25 and thereafter.	Amber green (reduction)	A revised plan is needed as outlined within the body of the cover report.	Green	We are meeting our trajectory YTD and expect to do so at year end
	In 2024/25 introduce tailored access scheme for veterans and for care leavers.	Amber green	Work to meet this measure is planned and in part deployed.	Amber red	The scale and sustainability of the work being done needs further stress testing during Q3
	In 2025/26 introduce tailored access scheme for refugees and homeless citizens.	Amber red	The timing of this measure remains feasible but further work is needed in 24/25 to cohere our plans	Amber red	The rating reflects the evolving picture of planning outlined

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	In 2026/27 introduce tailored access scheme for people with learning disabilities.	Red	This scheme needs further dedicated work and the right community based partnership. This remains to be planned and is not simply an extension of the schemes above	Amber red	This can be delivered, given not required until 26/27. But schemes elsewhere have sometimes struggled, and we may need to bring forward a trial scheme.
10. Be recognised by 2027 as an outstanding provider of inclusion health care, implementing NICE and NHSE guidance in full, in support of local GRT, sex workers, prisoners, people experiencing homelessness, and misusing substances, and forced migrants.	Meet standards set out in published guidance issued by NICE/NHS England (2022).	Amber red	The standards go beyond ourselves and a shared assessment is being documented presently.	Amber red	It will certainly require change to meet the standards, and the homeless health conference in Q3 will be used to kickstart those investments.
	Internal audit confirms access rates being met and feedback from specific communities corroborates that insight.	Red	Data completeness, as well as access itself, makes it very difficult to rate this measure at base. Consideration being given to ‘mystery shopper’ work.	Red	Rating reflects planning gaps identified.
	Specific service offers in place for all or most inclusion health groups by 2027.	Amber red	Plan not yet fully defined, including for refugee groups and sex workers. E&I sub needs to pick up thinking work over remainder of 24/25: this is due in March.	Amber green	Time assists this input metric. Over period possible to put in place what is needed.
11. Deliver in full the NHS’ commitment to veterans and those within our service communities, recognising the specific needs many have, especially for access to suitable mental health and	Achieve priority access to services for veterans (closing gap between prevalent population and identified attendees).	Amber green	Strong planning work has taken place and whilst the reasons for gaps are speculated, the right actions are in place.	Amber green	Over time, with trial and error, we are expecting to close the gap we presently see through a combination of data improvement and better performance.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
trauma responsive services	Introduce peer-led service support offer for local residents.	Amber green	This offer is in place in trial and further expansion is being into place. We'd expect this to be live at full scale during 25/26.	Amber green	This input and effort measure can be met, and is in fact ahead of expectations.
12. Work with community organisations and primary care teams to better recognise and respond to the specific needs of the rural communities and villages that we serve.	Use rural health and care proofing toolkit (National Centre for Rural Health) to identify needs and potential solutions to improving access.	Green	Good connections have been built to help us to think through what the issues and potential solutions may be. Care Group led work at this stage with buy in from other teams.	Amber green	A clear set of intended steps have been defined and agreed in principle through E&I. Further testing needed going into 25/26.
	Increase digital and outreach service solutions to village communities, starting in North Lincolnshire.	Amber red	Not yet meaningfully planned but will be accelerated in the context of the digital transformation plans we have during the balance of 25/26.	Amber red	Rating reflects planning comments made.
13. Substantially increase our Home First ethos which seeks to integrate physical and mental health provision to support residents to live well in their household, childrens', or care home.	Deliver over 130 care packages through our physical health virtual ward service.	Green	A strong plan exists, has been peer reviewed, and is being delivered.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Sustain and expand our IV provision in out-of-hospital settings.	Amber green	A little more work might be merited to document the plans and their trajectory, but the component parts of what is needed are well understood.	Green	Services were substantively funded going into 24/25. They are expanding month on month.
	Sustain and expand our Clozapine service in off ward settings.	Amber green	As reported in in the body of the text we need to move forward the plans that Care Groups have developed for 25/26.	Green	This measure can be met when we find released funding to make it happen.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Take annual opportunities to transfer services to homecare where safe to do so.	Amber red	In due course we need to find a planning route to go beyond the measures above and establish a broader drumbeat of left shift…	Green	This measure is ours, and others, and will see substantial emphasis in coming years – no doubt.
14. Assess people referred urgently inside 48 hours from 2025 (or under 4 where required) and deliver a 4-week maximum wait for all referrals from April 2026: maximising the use of technology and digital innovation to support our transformation.	Meet four hour wait standard in 2025/26, where it applies.	Amber green	This measure applies in only a handful of defined services. Monitoring suggests room for improvement but strong performance – focus on this is likely to yield delivery.	Amber green	A delivery priority for next financial year.
	Meet 48 hour wait standard in 2025/26 for all urgent referrals.	Red	Planning, visibility and emphasis on this measure is below where it needs to be: delivery review discussion in September to begin to cohere approaches.	Amber red	Comment reflects known unknowns outlined in planning segment.
	Make progress to reduce waiting lists and times and close supply gap in 2024/26.	Amber green	The report before the Board provides a strong basis for considering this key measure and assessed plans by Care Group not at Trust level.	Amber green	The scale of change remains significant. But initial data offers optimism that it could be accomplished.
	Meet 4 week standard from April 2026 across all services.	Amber green	As above	Amber green	As left.
15. Support the delivery of effective integrated neighbourhood teams within each of our places in 2024 as part of our wider effort to deliver parity of esteem between physical and mental health needs.	Support development of integrated neighbourhood teams (INTs) in 2024/5 in all three places.	Red	We have work to do, and partnerships to finalise, to move this goal forward and will not achieve it in 24/25.	Red	As left.
	Restructure Trust services into those INTs during 2025/26.	Red	This rating reflects comment on prior measure.	Amber red	As left.
	Evaluate and incrementally improve joint working achieved through these teams.	Amber red	Planning this work can follow from further definition of the INT plans we have.	Amber green	Once the above measures are met, this item is feasible!

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Meet 5 measures of community mental health transformation agreed in 2024 at the conclusion of the community transformation national programme.	Amber green	This work was defined in late 23/24 and a monitoring structure established. Indications remains positive that we are on track.	Amber green	As left.
16. Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.	Implement Dialog+ by 2026, collating individual outcomes from that work.	Amber green	The work has started (Sept 24) in the field in training teams, and a well-structured delivery plan exists. We will consider at May's Board our learning and trajectory as this is key to executing this promise over the next two years.	Amber green	This remains a challenging programme and one that can deliver, but will face competition from other priorities.
	Report and improve patient recorded outcome measures (PROMS) supported nationally.	Amber green	We report as we need to. Further clarity is needed about our completeness and whether we are maximising opportunities to go beyond minimum response.	Amber red	An improvement trajectory remains to be understood and defined.
	Ensure each Trust service is reporting one local or national outcome measure by 2025/26 as part of our quality plan.	Amber red (deterioration)	Delays and issues with our quality and safety plan have delayed this measure, and we will revisit the balance of top-down/bottom up associated with this measure during the balance of Q4.	Amber red	This has proved a difficult measure to establish despite work on it for over 12 months.
17. Embed our child and psychological health teams alongside schools, early years and nursery providers to help tackle poor educational and school readiness and structural inequalities.	Narrow the school readiness gap between our most deprived communities and average in each place in which we work.	Amber green (improve)	A strong plan is in place which has been widely praised. The target itself remains very challenging, but the input elements judged most key to execution are in place.	Amber red	Gap narrowing on school readiness has proved elusive: joint working with school is going to be needed to deliver any plan.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Seek to see 80% of children meet their own potential for school readiness by 2028.	Amber green (improved)	As above	Amber red	Improvement in SR has been consistently achieved over recent years, so there is good evidence in support of further improvement.
18. From 2023 invest, support and research the best models of therapeutic multi-disciplinary inpatient care, increasingly involving those with lived experience and expert carers in supporting our patients' recovery.	Meet guidance obligations from NHS England relevant to the quality of inpatient care, including safer staffing measures where they exist, and fully comply with the Mental Health Act.	Amber green	Current analysis for this measure appears positive. Work to improve MHA compliance is showing promise. We know what to do, we need to do it.	Amber green	With continued focus we have some confidence that this can be met over the balance of the year.
	Implement programme of multi-professional quality improvement across all inpatient services by April 2026 and routinely publish data on the care provided in each environment.	Amber red	The mobilisation plan is required for HQTC before we can further improve this rating. The Board report narrates that this is due in the next eight weeks.	Amber red	Mobilising this work will be a significant endeavour in Q1 25/26, after pilot phases over next two quarters.
	Work with patients and peers to assess the quality of services, including through peer reviews, and ensure that teams are able to act on that feedback and those evaluations.	Green	This work has progressed strongly through 2024/25, including now on an OOH basis. Peer involvement has added greatly to the product.	Green	We do need to be able to show impact from the work done in H1, and this will be reflected in our QA for 24/25.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
19. End out of area placements in 2024, as part of supporting people to be cared for as close to home as is safely possible.	Cease to place patients out of their home district except where that is their choice or in their best interests.	Amber green	We do know what we need to do. The plan gap is resourcing doing it, and securing our delivery chain internally around LOS.	Amber red	The scale of change required remains immense. Substantial improvement is possible, a revised timetable for elimination wil be assessed in Q1 25/26.
20. Deliver virtual care models in our mental and physical health services by 2025, providing a high-quality alternative to prolonged admission.	Deliver over 130 care packages through our physical health virtual ward service working. with partners.	Green	A strong plan exists, has been peer reviewed, and is being delivered.	Amber green	The leap of our community geriatric service becoming involved provides a high volume route to expand current volumes.
	Introduce and evaluate virtual ward pilot into our mental health services 2024/25.	Amber red	Other priorities have delayed this work, and AOT work has taken primacy. An assessment is being made of how/when this is best mobilised.	Amber red	This rating reflects comments on the left.
	Introduce and evaluate virtual ward pilot within our children's services 2025/26.	Amber red	The intent and commitment to do this is clear from the leadership team – documenting these ambitions needs attention in late Q3 as part of IF process.	Amber green	Evaluation in that time period may not be feasible, but deployment, if funded, will be.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
21. Actively support local primary care networks and voluntary sector representatives to improve the coordination of care provided to local residents – developing services on a hyper local basis.	There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise.		There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise. However, we have discussed what this needs to include and we would expect to move ratings/measurement forward from May.		There is further work to do to confirm the measures of success that best summarise partners' ambitions for this promise.
22. Develop consistent seven day a week service models across our intermediate care, mental health wards and hospice models from 2025 in order to improve quality of care.	Ensure that access to urgent and emergency services is equitably available through Saturday and Sunday (this must include crisis and safe space availability).	Amber green	This is not P14! This measure is mostly met in Trust delivered/commissioned services. The intention is to use the MHLDA programme for 25/26 to influence configuration.	Red	This is rated red to reflect the reality our patients face – where there is substantial variety in non-Trust services which we need to now influence. There is also a fragility to crisis services which needs continued attention.
	Support substantially increased discharge and admission capacity over weekends.	Red	We do not have a defined plan, delivery chain or implementation model in place as yet.	Amber green	There is very substantial executive emphasis on this work and over coming months we'd expect to see change.
	Assess and publish during 2025 an analysis of quality and safety risks specific to our pattern of weekend working in key services.	Amber red	This is not currently our priority, and we'd anticipate baseline data is scarce. N&F resourcing this work during 25/26.	Amber green	By the end of 2025 this input measure can be met.
23. Invest in residential care projects and programmes that support long-term care outside our wards: specifically supporting expansion of community forensic, step-down and step-up services.	Develop bed-based mental health services within each of our communities by 2028, as additions or alternatives to ward based practice: ideally delivering these services through partner organisations.	Amber green	Good work has taken place to build relationships and this then ties into the bed-plans outlined before the Board. Specific proposals are now being assessed in one of our three places.	Amber red	The challenges to implementation are outlined in another paper and remain significant.
	Expand the scale of our residential forensic rehabilitation service.	Amber green	Work has already taken place with this in mind. Further plan exist in our community teams, with scope for work alongside Cheswold.	Amber green	A 20% expansion has already taken place.- and we now need to consider what more is needed to match need.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Establish and support a step-up service for older peoples' care in Doncaster by 2027.	Amber green	Work advancing alongside partners: project resource defined and starts work shortly. Significant place support.	Amber green	This may be an optimistic rating given scale of change: but the pressing need to change gives this natural priority and we have 3 years to deliver.
24. Expand and improve our educational offer at undergraduate and postgraduate level, as part of supporting existing and new roles within services and teams while delivering the NHS Long Term Workforce Plan.	Student feedback to reach upper quintile when compared to peers.	Amber green	Strong baseline position, albeit varies annually. Some uncertainty over what drives positivity.	Green	If we retain good infrastructure and support our supervisors with time then performance is expected to be sustained
	Trust workforce plan for 2028 on track to be delivered.	Amber green	Plan, notwithstanding item below, developing well. Fully staffed is year 1.	Amber green	Persistent vacancies are not out principle difficulty (retention exemplar work needs to be effective to sustain seniority within disciplines over time) ie retirement risk.
	Trust meets expectations applied through national Long Term Workforce Plan roll out.	Red	We may pause monitoring of this measure unless the operating plan guidance sheds light on the national future of these plans.	Red	Rating reflects lack of clarity of ask/measure at this stage. May be clarified in 10 year plan (2025)
	NHS England assessment outcomes remain outstanding in all disciplines.	Amber green	Currently strong in all assessed disciplines (latest report just received)	Amber green	No identified reason why assessment outcomes would change over coming period.
25. Achieve Real Living Wage accreditation by 2025, whilst transitioning significantly more of our spend to local suppliers in our communities.	Obtain Real Living Wage Foundation accreditation in first half of 2025.	Green	Engagement started some time ago. Components required all being taken forward and visible within corporate delivery reviews.	Green	For summer 2025 we are confident of achieving accreditation unless external intrusion into our pay plans.
	Pay the Real Living Wage to our own employees from April 2025, or sooner.	Green	We know what needs to be done. Most complex issue is banding reviews of band 2/3 which is needed in Q3/4.	Green	As above.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Transfer more of our spend to local suppliers (shift of 25%+ compared to 2023/24).	Amber green	Clear plans developed during 2024. Implementation deadlines are clear and being met.	Green	Measure defined, suppliers aware, procurement on plan with transition by end of Q4.
26. Become an anti-racist organisation by 2025, as part of a wider commitment to fighting discrimination and positively promoting inclusion.	Implement suite of policies and practice to Kick Racism Out of our Trust.	Green	Clarity across CLE about what we plan to do, first policies change go live in Q3.	Amber green	Practice as well as policy change needed, but visible and compelling start made.
	Tackle and eliminate our workforce race equality standard (WRES) gap by 2026.	Amber red	We have work to do to translate our seven key actions, and wider staff survey response plans, into actionable insights.	Amber red	A complex and longstanding issue, which, as yet does not provide have a clear trajectory to success.
	Receive credible accreditation against frameworks of inclusion for all excluded protected characteristics, starting with global majority.	Amber green	There is strong commitment to the measures contained in NW accreditation: work needed now to look across excluded groups for relevant assessment tools.	Amber green	These frameworks tend to be input based, not outcome derived. Organisational commitment to compliance is not in question.

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
	Tackle our gender pay gap.	Amber green (improve)	Notwithstanding the need for localised plans, it seems most likely that the shift to the RLW will move the position on this measure to compliance.	Amber green (improve)	As left.
27. Deliver the NHS Green Plan and match commitments made by our local authorities to achieve net zero, whilst adapting our service models to climate change.	Reduce our carbon tonnage by 2000 (and offset balance).	Red	Excellent analysis has established the sheer scale of change/investment needed. Consideration of a route to success is to be considered alongside our forthcoming estate plan.	Red	Estimated £18m investment is not foreseeable, and we are working through what may be possible as an alternate to the heat pump route to gas reduction.
	Agree and deliver specific contribution to local authority climate change plans.	Amber red	Advancing this measure is a matter of time/priorities. Good engagement exists with each LA, and in dour course this work can be documented and reviewed.	Amber green	LA feedback on Trust engagement remains positive, and we are not not doing what is asked. The plan may give rise to a larger ask in time.
	Change service models for patients and staff to reduce travel required by 2027.	Amber red	A plan to achieve this, and to scale ‘this’, is being developed during Q4/Q1. Our ‘remote’ policy and practice will be crucial to success.	Amber green	The implementation of digital care alternatives is a national priority, and we would expect our own and others efforts to intensify in 25-26-27.
28. Extend the scale and reach of our research work every year: creating partnerships with industry and Universities that bring	Meet portfolio study recruitment targets each year.	Green	The Trust is consistently meeting the measures and has a process in place to support engagement where there are shortfalls	Amber green	This is very much a well led measure and we would expect to succeed again in 2024/25

Promise	Measures of success	Delivery plan Green (G) – Finalised and agreed Amber/Green (AG) – Developed and being refined Amber/Red (AR) – Understood but Not well documented Red (R) – Not constructed yet	Comments on delivery plan	Likelihood of delivery Green (G) – On track to succeed Amber/Green (AG) – Largely on track, and properly understood Amber/Red (AR) – Solutions known but implementation requires support Red (R) – Actions to succeed not yet known orfully elaborated	Comments on likelihood of delivery
investment and employment to our local community.	Deliver metrics contained in the Trust's Research and Innovation plan.	Amber red	Significant work is now needed to convert the research priorities we have agreed into a delivery plan owned across Care Groups	Amber red	The 2028 ambitions are deliverable, but a cultural shift is probably needed in how GR/CGs operate together
	Work to further increase the reach of research into excluded communities locally.	Amber green	This is a longstanding programme of work for grounded research. A more detailed delivery plan may be needed going into 25/26. This may include developing a community researchers' programme.	Amber green	This is an input measure which we are confident of sustaining focus on, without too much corporate input

Membership Survey Response and Demographics

Over the period of August 2024 to December 2024, a total of 92 responses were collected after the deletion of duplicate responses. Engagement with the survey was low - the postal mailout had an engagement rate of 0.5% (n = 28) and the Civica database an average of 2.6% (n = 47). The response rate with community partners was 17. We also captured feedback through discussions and engagement within services that are not reflected in the survey data but nevertheless contribute to these findings.

Before applying any of the findings of this report, it is crucial to note the limitation of the survey response. Respondents are from a 'highly selected' population, that is, those who were not only 'successful' in becoming members of the Trust but are also active enough to answer a survey. As a result, this sample is unlikely to provide insights on those who are not engaged or were 'selected out' of this population because of barriers to the volunteering process.

The age demographics of respondents are displayed in *Figure 1*. Most survey respondents (60%) are 51 years and older, 21% are between the ages of 16 to 30, and 13% between the ages of 31 and 50. There were 4 none responses.

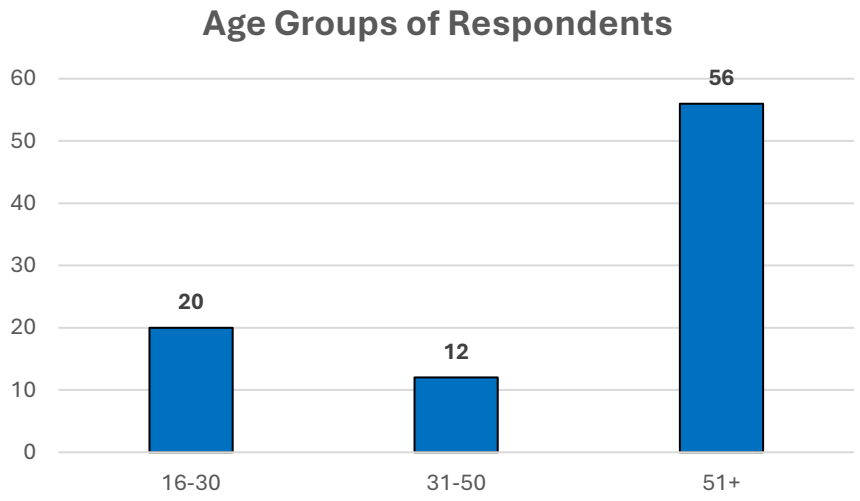

Figure 1: Bar Chart of Respondent Age Group

For the gender breakdown of respondents (*Figure 2*), self-reported survey data was prioritised over existing database information, as it is more recently reported, but where missing values existed database information was used. Most respondents identified as women (63%) and men (32%), two responses were received from individuals identifying as transgender or non-binary, and there was 1 none response.

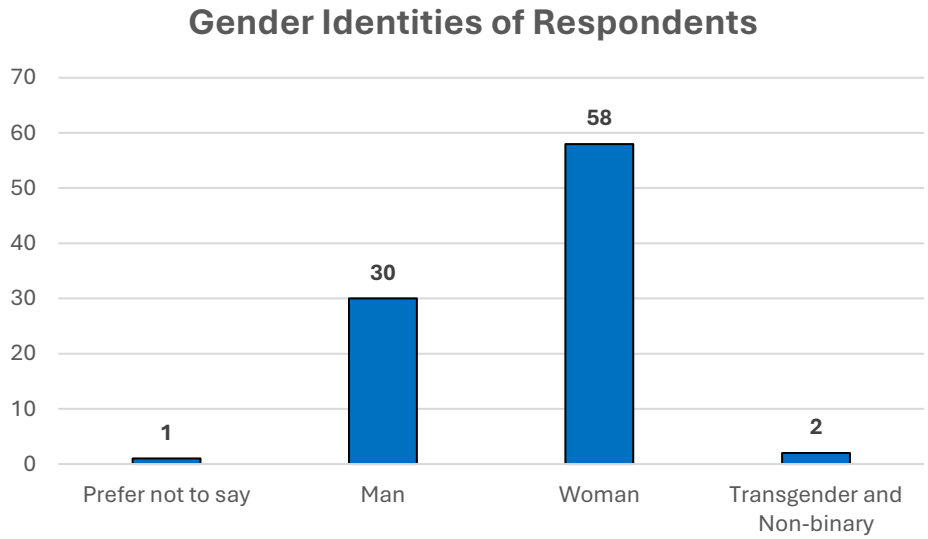

Figure 2: Bar Chart of Respondent Gender Identity

Most respondents to the survey reported living in Doncaster (60%) and Rotherham (27%), North Lincolnshire (8%) or 'Other' (5%).
Ethnicity data was not available for those who used *SurveyMonkey* to submit responses and was only available for 61% of the respondents of the Civica survey and is displayed visually in Figure 3.

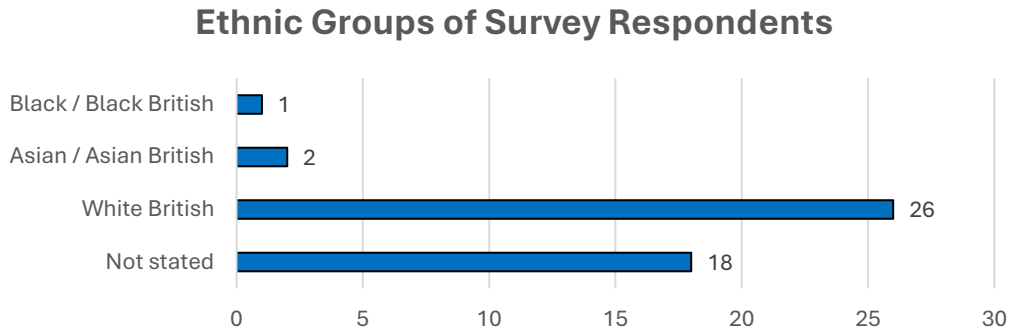

Figure 3: Ethnic Group Composition of Respondents

It is not possible to make any conclusions based on the ethnic groups of respondents as there are too few people in most categories and thus there is a risk of overgeneralising. In the future, it may be worth exploring ways to improve completeness of ethnicity recording for the members database as this is valuable information with respect to potential barriers to engagement.

Awareness and Interest in Involvement

Respondents were asked about their awareness of Promise 5 which seeks to involve the wider community in decision-making in the trust. As displayed in Figure 4 below, 44 respondents (47%) reported that they were unaware of Promise 5 and 47 (51%) reported awareness of Promise 5.

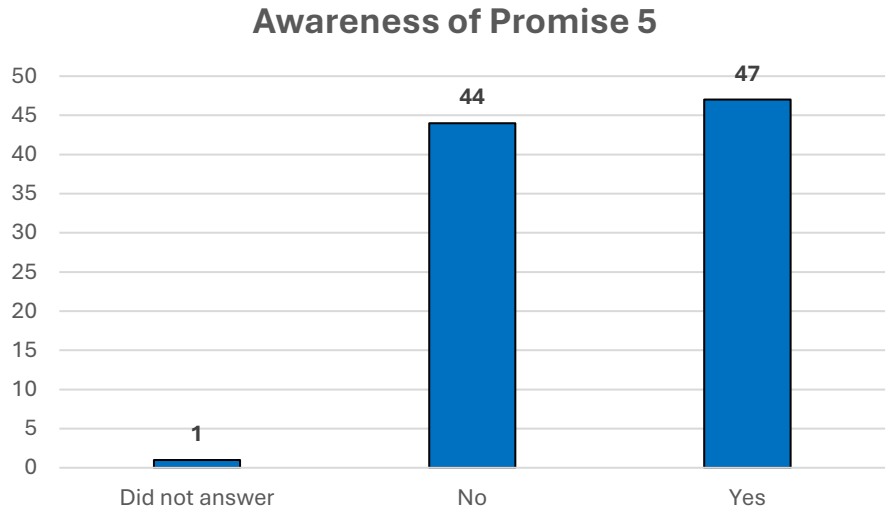

Figure 4: Awareness of Promise 5

While a large proportion of respondents were not aware of Promise 5, a large number (49%, n = 45) still reported an interest in getting involved in some way, with an additional 29% of respondents (n = 27) being undecided as to whether they would like to be involved.

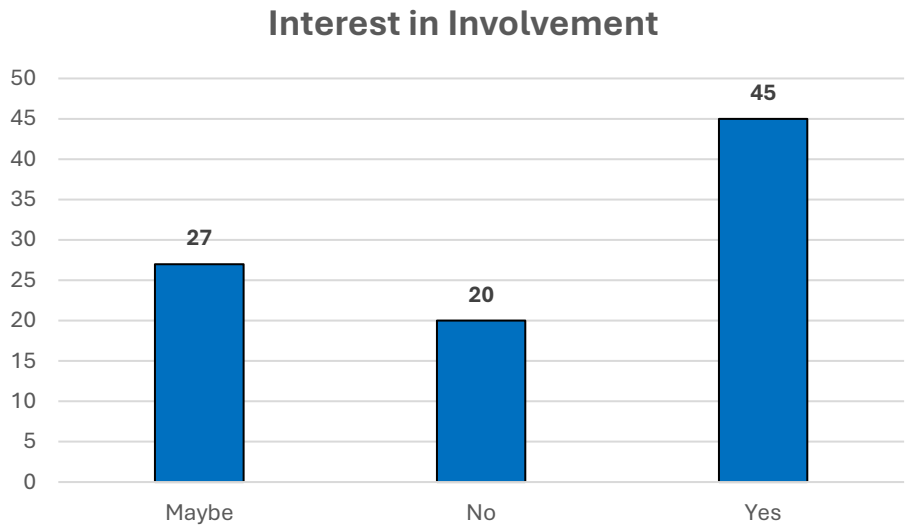

Figure 5: Interest in Involvement in RDaSH

The voluntary nature of the survey means that those who took time to respond to the survey are likely those who are most engaged with the trust and this lack of awareness means that much more must be done to make members aware of the trust's intentions and plans for community engagement.

Qualitative Findings

Involvement Preferences

The most frequently reported preferences for involvement were through shaping services and staff recruitment (29%, n = 27) and sharing lived experience of services and mental health (25%, n = 23). When asked about the ways in which they would like to be involved, respondents cited the opportunity to share their lived experience and helping to shape RDaSH services as their primary motivation for volunteering. This is illustrated by the following quotes:

> *Sharing my lived experience in my roles in research. Living with co-morbidities. To pass on my experience with mental health issues and other illnesses. I can offer advice to all concerned within RDASH.*

> *I like to be part of the positive changes with the mental health system through understanding that no one understands poor mental health better than the people who have experienced it and got through it.*

> *Sharing lived experience, provide ideas and shape and design services, contribute to interview panels and staff recruitment.*

Barriers to Involvement

The most frequently reported barriers to involvement were transport and disability and health (23%, n = 21; 16%, n = 15). For some respondents, living in the local area made it convenient to volunteer on the main site, and yet for others it was less convenient to rely on public transport:

> *I do not drive but have very easy access to St. Catherine's site and travel on public transport. Weekend time is not appropriate for me.*

For others, it was difficult to get involved in conventional ways because of their current or long-term health challenges:

> *Chronic fatigue and mobility issues mean I have to pace myself so would not be able to sit/stand for long periods of time or walk very far repeatedly.*

> *I do have difficulty in driving long distances and currently DVLA and my heart consultants are assessing my overall driving capability.*

At a more fundamental level, being unaware of the volunteering process or how to get involved served as barrier for involvement (12%, n = 11):

> *Not everyone knows about the opportunity to be involved.*

The process for finding out what avenues for being involved is off putting. I'm not too sure how to get involved.

One respondent suggested that the process is made easier and advertised prominently on the website rather than '*just being told to email whoever…*' and '*be more proactive. When someone shows an interest don't just leave it for them to follow this up'*. Another respondent reported a similar issue:

I tried to get involved once a year or so ago, the process was appalling and despite numerous attempts to get further information lit just didn't happen, so I am sceptical about trying again.

Having other commitments was an expected barrier to volunteering (25%, n = 23) with the most observed responses relating to childcare, finance, and full-time employment.

From the results of this question, it may be worthwhile to consider developing a system of alerts or email lists for registered members with opportunities in their area and in line with their preferences to enable involvement.

Incentives for Involvement

A few participants (9%, n = 8) suggested that incentives were not required as it was a 'chance to put something back into society' and 'contributing back to my community'. This, of course, may not be a sustainable way to recruit more volunteers and it is important to take into account the practical incentives for volunteering such as covering transport costs or providing car parking (16%, n = 15). The opportunity for personal growth and development was also reported by a number of respondents (21%, n = 19) exemplified well by the following quote:

I would be interested in opportunities for training or mentorship that could help me develop new skills. Connecting with other community members and professionals in the field would be valuable to me. The chance to contribute to positive change in my community is a strong motivator for me.

In addition to expenses and staff discounts, some respondents drew attention to non-tangible incentives such as meetings to create feelings of connectedness and feeling valued:

To be able feel valued (not 'just a volunteer'). Be able to access any training available for our roles in NHS. Staff discount also available to NHS staff. Meetings for volunteers so that they can share what works or what does not, many volunteers work in isolation and meetings would help them feel less isolated.

Almost foreshadowing the new member system, this respondent suggested that any incentives should be proportionate to the involvement.

Not necessarily for me but I think people should be appropriately rewarded in line with the role they are being asked to do - this will differ as filling in a survey is one thing but being involved as an expert by experience longer term and in a more official capacity is another. The incentive should be proportionate to the ask/ role.

Supporting Involvement

To support involvement, respondents most frequently reported practical and reasonable adjustments (20%, n = 18) such as easy read documents, access to toilets and safe spaces for taking medication, a single point of contact, transport, and information provided well in advance about volunteering opportunities relating to expectations and time commitments.

Having a mentor or guide to assist me in navigating the process would be helpful I would benefit from clear and concise information about the involvement opportunities, including expectations, time commitments.

All the above plus an induction to whatever team (introduced to team) or role they are in. Have a named person in whatever role they are in if any problems arise before they need to contact the volunteer coordinator.

It is unclear whether capacity is available for mentorship in this way, but it should be possible to stay connected with volunteer supervisors to report any concerns and individual departments may be able to put in place arrangements for volunteers to become familiar with staff.

Providing training and skills for the volunteer role was also reported (12%, n = 11) and a number of training courses are available on e-learning for health to those who have an NHS account, but it may be necessary to provide training on alternative platforms for users that do not have access to an NHS account. Moreover, role specific training may not exist and must be created so that those volunteering are able to feel confident in their role.

Otherwise, personal support was reported by respondents as an important part of supporting their involvement, with clear instructions and plans put in place to achieve tasks (13%, n = 12). Respondents highlighted the importance of peer support from experienced volunteers and having a point of contact that they can raise any issues with. One respondent suggested having their support worker with them while volunteering.

Rotherham, Doncaster and South Humber NHS Foundation Trust
Chief Executive's Report to the Board of Directors
November 2024

Introduction

1.1 Last month this report drew attention to the suite of cultural changes we are making to begin to develop the delivery culture the Board seeks, whilst retaining the kindness and compassion that has long been at the heart of RDaSH. These continue to progress, with this week marking our second week-long community-based induction programme, and widespread launch of local award schemes in October within the Trust, intended to create loops of gratitude. In February, we launch our high-volume QI Poster contest; and work has begun on both a significantly amended appraisal model and our long-term remote working policy, due by May. Whilst our high staff survey response rate will give us additional data from 2024 in Q4, from Q4 we will make much more high-profile use of the Pulse Survey method to build near-live update data on colleague feedback. At the second Trust People Council, we trialled **our 'voice' scorecard** which aims to bring together a range of sources of insight to identify both reg flags and great practice in how people and teams are experiencing the workplace (this was the substance of our Chester deaths response).

1.2 Equally significantly, the rollout of **Care Opinion** continues to be well-received. This is our principal, but not our only, promise 4 mechanism to put patient feedback into the heart of our work. In some teams, for example Long Covid, there is already evidence of high-volume use by patients and carers. All Care Groups have outlined an initial view of how they plan to use the material and, as a Board in February, we will have chance to explore the first few weeks' worth and hear from James Munro (company CE) about lessons from across the NHS over the last ten years - where this product has been deployed. Our ambition is to use this feedback to pinpoint and make changes; and I am optimistic that our Quality Account for 24/25 will begin to look and feel different in being able to identify how we are acting on what we hear.

1.3 I would hope we continue, as a Board, to give strong and visible support to **our flu vaccination programme**. At 59% of HCSW coverage, the Trust currently leads the NHS in NEY in the proportion achieved (3rd nationally: we were 8th last year). More importantly, with over 2,300 vaccinations completed among staff, and a higher figure with students, volunteers, and contractors, we are moving ever closer to our 3000 ambition, exceeded last year's best-ever 2,500 flu vaccines. The opportunity to protect ourselves and others is a significant one, and I'd hope managers are using this dynamic to renew health and wellbeing conversations with those they manage. A key part of supervision is that check-in, and we will consider how we test the prevalence of that approach – notwithstanding that during 25/26 all line managers will be subject to a 360-feedback process within the Trust.

1.4 The October **financial results** for the Trust show us £154k adverse to our plan, which is a stable position through Q2. Looking forward, our success will be hinged on two factors: very subtle titration of our recruitment and vacancy factor position. We have moved our requirements back from a vacancy factor of 2.5% to 3.3% temporarily to aid that balance. The second variable remains

delivery of repeated national assurances that the 24/25 pay award will be fully funded. Whilst in October staff were back-paid their due, and mid-point band 8-9 payments were made in November, no credible reconciliation of the assurances has yet been achieved either for the NHSE routed money (£1.25m additional) or the public health grant/LA funded contracts (£1m). The Board has always been explicit that such sums cannot come from cutting patient services. I am satisfied that everything possible has been done to fully explain the risks involved to ICB, regional, and national colleagues, and the position is well documented in our financial returns: a request to reflect it in an adjusted year end forecast was rejected externally pending further efforts to make a welcome differential allocation to mental health / community organisations.

Our patients

2.1 **Medication provision for people diagnosed with ADHD** has been discussed within the Board in the context of our promise 14 ambitions and, of course, based on a patient story last time we met in Rotherham. Our team have now completed their review of a distinct but important (inter)national issue, which is the unavailability of some medications. This position has been ongoing for over a year, and last year we derogated part of the national guidance in order to try and maintain services. Review of our current practice, noting revised guidance including this month, has been considered by the Clinical Leadership Executive (CLE) (see annex). We are complying with the guidance, but the impact for patients is threefold, with no estimated end date in sight. Some patients are needing to switch medication from one product to another, which takes time and causes distress; the time to supervise this is reducing by about 30 appointments a month, our service to achieve initial diagnosis; and some of our primary care shared care agreements, do not yet cover all products, including the new agreement due to start with Rotherham GPs in January.

2.2 The Integrated Quality Performance report continues to show a reasonable prospect of **meeting many of the national standards** set out in the 2024/25 planning guidance, together with additional measures our Board has prioritised. This builds on 2023/24, which was a step-change from prior positions. Whilst noting slightly lowered outcome data for Talking Therapies, we need to recognise that as we move to measuring the effectiveness of care, natural variation will need to be understood, and the Board is reminded that longitudinal study over ten years of these services would suggest that, in high-deprivation populations, any recovery position above 35% should be considered good performance. Our improvement, and work by others, is helping to lift the ICB-wide position, where recent review of ten indicators (a slightly different set to ours) suggest eight could plausibly be met for this year. Our failure to meet promise 19 stands out. Our work plan to substantially reduce out of area placements will be presented to the Board with our annual financial plan in March 2025, and pursuant to the last Board's approval, negotiations to take on 'risk' for funding inappropriate placements is nearing completion and remains within agreed parameters. In my report served in private, I consider some specific challenges our plan will pose, which are worth considering against the staff story, which begins our meeting.

2.3 The Board was briefed in September, and Quality Committee this month, on a **Regulation 28 letter** issued to us in respect of the death by suicide of an older adult (Carol). I can confirm that the actions contained in the Trust's response, overseen by myself, Steve Forsyth and Diarmid Sinclair, have been completed. The material step has been to move to equalise and standardise our approach to crisis assessment to a model already applied within North Lincolnshire. Wider work, to be completed by the end of Q1, to address age 'cut offs' in services is ongoing, let through the E&I group on behalf of the CLE. Discussions with local authorities and commissioners to recognise their complicity in existing arrangements have begun.

2.4 During Q4, we will implement new computer systems to cover **all our governance data and risks systems in the Trust**. This represents a significant opportunity to improve quality, because we will be able to operate with data on a near live-time basis. The selected system also allows much better integration of different sources of safety and quality intelligence drawn from key data collection points, like our risk register, policies, and incidents. The 2025/26 vision is for this system to also allow us to track, at individual employee level, policy awareness, and major renovation to rationalise our present 338 policies is underway.

2.5 Board members will recall my outline in May of our radically revised approach to **agency controls.** The scale of impact of the changes in Q2, and so far in Q3 is dramatic, with a 90% reduction in spend and shifts vs. peak. My briefing at the Quality Committee (QC) this month outlined the real-world changes made by teams, and especially leaders, to implement such a huge transformation. The Executive Group are clear that no identified harms have arisen so far from the programme, and some anticipated risks have been met through mitigation. I asked QC to advise on any key lines of enquiry beyond the two I proposed (spot study of declined requests and feedback study among prior high requesters). My recommendation is to remain *fiercely curious*, as now that the system we have put in place is 'normalised' the benefits of attention fade, and we may see atrophy of vigilance and consequent harms. QC asked for sight of some specific data, which will be notified in January.

2.6 Whilst inpatient care, and risk, is very much not the only issue we face as a Trust, the care of those we detain, and those we support, is a critical matter for us, as for many other similar sectoral organisations. **Strategic objective 4**, debated at the last Board meeting, and amplified by the stories we heard, testifies to our belief, as a Board, that therapeutically, we could do better. After six-month genuine debate and consideration across the executive, and several sessions across the CLE, we have adopted a three-part approach now to change. The scope of that change within our wards is 'everything', in order to balance matters of staffing, flow, safety plan, and culture. Kicking off from January and running for twelve months, we will:

- Introduce a 17-person taskforce [1](High Quality Therapeutic Care – HQTC) to oversee the reform design and implementation,

[1] CNO, Med Director, COO, Dir of Psych Prof, Patient Rep, Patient Flow Manager, Community directorate rep, DAS, Chief Executive, Care Group DON, Acute directorate medical lead, acute directorate AHP, acute directorate

- Create a ‘help team’ (other names are available) to actively support the pilot and phased ward deployment of our work, led by Jon Rouston,
- Move to wards led on a multi-professional basis, by a genuine multi-professional leadership team (or MPLT).

I am happy to amplify orally the work to be done or bring a focused paper in January to the Board of Directors. I would venture that the third change is the critical one, and that reflects some of the ‘what’s difficult’ briefing in the paper we debated in September.

Significantly, the frontline leaders within the taskforce will be predominantly drawn from the clinical directorates we created in 2023, rather than from our Care Groups, as we begin to prepare for a more devolved model in 2025/26. Conversely, five executive directors will serve on the taskforce, as will a patient representative, and to ensure organisational mobilisation, I have agreed to colleagues’ request that I chair the body.

<u>Our people</u>

3.1 Once again an annex is supplied with the extant vacancy position of the Trust, and each of our directorates. Whilst recruitment, and new starters, continues to progress well, the figures reflect investments made, including national funding for roles in local schools. As outlined above, we have extended our vacancy factor mid-year to ensure we manage to budget, albeit our base plan is to return to 2.5% in 2025/26. The focus remains on under one-year leavers. We are also working on a tweak to the national turnover data item (which essentially measures those leaving) to **add a turbulence measure**, which shows anyone exiting a team, even internally. This is because our quality and cultural focus remains on stability to nurture learning, and the turnover measure may well undercount the extent of transition being managed within teams.

3.2 Launch of the **acceptable behaviour policy** has now taken place, and we need to persistently reinforce the new arrangements. The policy provides for implementation review led through our director of corporate assurance (paper to People and OD – March 2025). The policy is one part of our anti-racism plan, agreed as a Board, and a key step in tackling wider discriminatory behaviours. It is to be hoped that the four stages of exclusion are rarely fully needed, and it will be important to ensure that we use the lower stages well to educate and inform.

3.3 Consistent with the Board’s voted decision (March 2024) to **transfer flexible working bank arrangements** to NHS Professionals (NHSP), October 21st saw the move to a new employer for many of our people (on time, budget). A first full month’s performance data will arrive at the end of November, but published interim data for last week saw almost 600 shifts requests and a 90% fill rate. It was always understood that NHSP would need to grow their mental health staffing from a predominantly physical health base, and that some existing RDaSH bank staff may choose not to move. On balance, go-live has gone well and we now begin the process of growing our temporary workforce. Roster

---

psych prof lead, acute directorate matron, acute direction service manager, resident doctor, and director of therapies

discipline remains a key competency for us and featured strongly in the latest delivery review cycle.

3.4 Because of our strong tradition of educational excellence, promise 24 is among our latest discussed pledges at times. Part of that work was to build meaningful bottom-up **training plans by directorate**, in time linked to reformed appraisal processes. These plans are beginning to gain traction, and shortly we will be able to evaluate the protected characteristics of past training spend. The ringfenced nature of training spend as a whole, and a commitment to annual growth, is crucial to the ambitions we have as a Trust. Appraisal of 25/26 training plans will face as much rigour as budget sign off, because of that significance.

3.5 The **leadership development offer** (LDO) launches formally in mid-January and late- April. We remain excited by our collaboration with Virginia Mason, PSC, Mokita, and others to support as one cadre our care group, executive, corporate and directorate leadership teams, alongside community partners. A readiness assessment check will take place at the very start of 2025. Grounded Research are working to build a rigorous evaluation, and the commitment to involve the wider board in in-flight assessment of impact on the leadership capability of the Trust is worth reiterating. Of course, the NHS-wide project of NHS Impact, and now a college of management education, are noted, and the pathways for our people into that wider work will be explored.

<u>Our population</u>

4.1 One of our most ambitious promises is the **school readiness** commitment given at promise 17. Poor school readiness and, in particular, predictable inequalities of achievement at school entry, are exceptionally expensive and difficult to retrospectively impact feature of a civil society. They are also the ICB's first inequalities priority in South Yorkshire. A cogent proposal to play our part in trying to improve matters has now been considered by CLE's Equity and Inclusion sub-group, and also explored with the Board's committee (PHPIP). We will work in Q4 to make sure that this work, in North Lincolnshire and Doncaster, is well-embedded as part of wider partnership efforts.

4.2 It was a privilege to attend the review by NHS England of PCN pilots in South Yorkshire, led by Claire Fuller and Stella Vig. Whilst the model focused much on practice in Sheffield, it was clear that the area had significantly outperformed many in the country in the work done so far. Helen Crimlisk focused on **neighbourhood health work** done in the city by SHSC, which we need to consider seriously within RDaSH. As we discussed in our timeout, this 'Trieste model' challenges sub-specialisation in much of our practice; and asks our three community directorates to look beyond review of existing arrangements and work differently with VCSE, patient, and primary care leaders.

4.3 On the occasion of Dawn Leese's retirement from the Board, it is pleasing to reflect the continued progress being made with creating an **all age eating disorders collaborative** across our places. There remains huge potential to level up community-based services, to replace long-term private sector provision for inpatients and to develop MEED near-compliant services with acute hospitals. All three ideas feel realisable over the coming eighteen months

with goodwill and focus. The specialised service contract we host continues to present a financial pressure in want of those changes, and we need to continue to drive forward this agenda in the opening months of 2025, if we are to meet the underlying needs of our population.

4.4 A major conversation within today's Board explores **our research collaborations**. The Trust benefits from strong NIHR networks, and well developed international commercial collaborations. Promise 28 invites us to go much further, both locally with business, and in how we work with local people. New areas of potential alignment are considered in private papers. As we look to develop the priorities we have built through CLE, our HSR work needs refinement and, before the moment is missed, we need to conceptualise how that objectives may be best progressed.

4.5 We have work to do to deliver **350 volunteers by autumn 2025**, and 250 by March. We have developed some useful partnerships in a number of local communities, as well as an increasing recognition inside all six groups that this is core work for the Trust. As we refine the voice scorecard outlined in the introduction to this report, and indeed the Pulse quarterly survey mentioned herein, we need to always ask ourselves the question of how volunteers find their place in our story. We are next due to have a 'staff story' in March's Board meeting, and it may be timely to hear from some of our newer volunteers, perhaps with video messaging

Concluding comments

5.1 The very welcome emphasis of the incoming government on **employment and fitness to work** is hugely relevant to the mission of the Trust. We would expect SYMA to be a major pilot site for this work, building on the Pathways to Work programme in Barnsley, annexed to my report in September. Over coming weeks, it is to be hoped that the Trust can contribute further to these considerations which need to blend the scale of system work, with the nuance of place considerations. What RDaSH can contribute is very clear: too often such programmes, at the margin of welfare and work, attract clinical expertise disconnected from services of continuity, and sometimes not able to attract the brightest and best (examples abound from prison healthcare, to Serco cancelled contracts). We can do this differently, and we have motivated clinicians keen to operate in this space.

5.2 Further to the Board's private session two months ago, and our timeout in Scunthorpe in October, work continues to refine the questions, and process to complete **our estate plan**. We are in the final stages of acquiring the Elizabeth Quarter lease to create the so-called Scunthorpe-triangle (St Nicholas, Great Oaks, and EQ). The Board meets in Barton, as we have in Brigg, in January, and can consider promise 12, and the very different village dynamic we need to pay attention to. In Rotherham, we have a series of town options and know too that we need to make Swallownest a fantastic place to work with staff amenities, and meaningful meeting spaces. Work to finalise the FDE-approved Waterdale scheme for children's mental health is advancing positively: and potential development partners have begun a structured process of visiting the Tickhill site, as we look to reorientate the site to Loversall, and realise the social and commercial value of the park. In April, we would expect to have a plausible

sequenced masterplan to consider, to accompany the clinical model and patient feedback we set out to build from September's papers.

5.3 I understand that the South Yorkshire MHLDA provider collaborative's proposal on *health-based place of safety* will be considered by the ICB on Wednesday 20th November. Meanwhile, HNY ICB have, in principle, supported the creation of a *community rehabilitation proposition* from ourselves and North Lincolnshire local authority – which has the potential to return local residents closer to home from out of area care. These are both very tangible steps of improvement, both arising from the dedication of RDaSH local leaders to coordinate the work of others. In January, we will consider how our partnership scorecard can reflect these contributions, acknowledging that the public health, patient involvement and partnerships committee is tasked with tracking our journey to reduce NHS meetings and committees, and transition the leadership effort into neighbourhoods and the voluntary sector.

Toby Lewis, Chief Executive
21 November 2024

Rotherham, Doncaster and South Humber NHS Foundation Trust
Chief Executive's Report to the Board of Directors
January 2025

1.1 It should be evident that much of the agenda before the Board today is about getting ready to **start 2025/2026 at the very beginning of Q1**. Consistent with our strategy, agreed in July 2023, we are working in quarters of the year, not on an annualised basis. There is a strong measure of continuity of effort, learning from what has and has not worked, and moving forward determinedly. The capital plan agreed in May 2024 is renewed for the year ahead, we revisit the work done to reduce vacancies and maintain a near-agency free staffing model, and we review updates on our volunteer expansion and patient voice work.

1.2 There are some nuances or point of re-emphasis: for the third meeting in a row, we discussed work to deliver strategic objective four, and within that to re-imagine our bed-base. The **High-Quality Therapeutic Care taskforce starts work on February 12th**. In light of the emergency closure of an older people's ward in Rotherham in early January, this is timely – as the intent to provide three-year clarity on the scale, and shape, of those beds is important to confidence.

1.3 The financial forward look regionally makes a difficult backdrop to these ambitious plans. In 24/25, the Trust, in effect, received no growth funding of any form. This led to a deficit plan, despite successful delivery of our largest ever cost improvement programme (£16m over 18 months). Moving into 25/26, this lack of any funding for growth, **or tariff equivalent adjustment for new costs like NICS or national pay awards in full**, produces a likely near-standstill deficit position for the year ahead, equivalent to just over 1% of turnover. ICB-wide discussions continue about how to best support left-shift policies, match prevalence changes in our population, and deliver wait time reductions that staff want and local people need and deserve.

1.4 It is important to note the moves to local devolution in both North/Greater Lincolnshire and across South Yorkshire. This is accompanied by a welcome focus on worklessness, to which the Trust can contribute in two ways: as an employer able to reach deep into traditionally marginalised communities, including older adults wanting second or third careers, and a provider of services to those out of work. Of note **the SY Mayoral Combined Authority has acknowledged a lack of support for neurodivergent younger adults as a significant barrier to employment** – a description that must be met by a constructive and impactful offer from the local NHS and wider provider partners.

Our patients

2.1 The Trust continues to be at the forefront of work to improve care for **those with eating disorders**. The Trust's children's service has a standout short-wait offer (consistently below four weeks and routinely within days). As a commissioner of adult services, we continue to seek to improve care and provide more community-based care. We welcome the commitment of the ICB to continued investment to 'level up' services, and the development of new services in North Lincolnshire. At Annex 5 are draft terms of reference/schedule to support to the go-live of a delegated Joint Committee of four Trusts and the ICB to create what appears to be the country's first all-age eating disorders pathway commissioning model. The Board has agreed repeatedly, during 2024, that this is a necessary condition for sustained change and is requested to offer formal endorsement for the proposal.

2.2 With the news that the sixth '**health-based place of safety'** suite is now funded in Sheffield, we are well placed to press on with our programme to ensure that S136 suites are open and available, and that no-one resides within one for longer than twenty-four hours. There is a continued downward trend since the commitment to this goal in July 2024, and we need to ensure that, when the suite is damaged, it can be rapidly refurbished.

Throughput in the suite in Barnsley and Sheffield is now subject to the same dataset and monitoring as our own approach and our interdependence is understood.

2.3 The Board discussed **restrictive practices** (RRI) at its last meeting. Analysis of our seclusion suites suggests that average length of use is just above one day, and that there is no spike in use, for example as bed closures occur. The likely rise in use with the move away from out of area placements from July 2025 is acknowledged. The MHA Committee did note some concerns over MDT review, where we have made a subsequent change to policy, which should clarify multi-professional engagement. The wider plan of work to address RRI during 2025/26 will be addressed in my report at the next meeting, as indicated in November.

2.4 The continued expansion of **virtual ward occupancy**, and use of our community based IV service, are perhaps our most significant contribution (other than flu vaccination) to the wider system 'winter' effort. We have again recorded our best ever volume of virtual ward care, and the move to recruit to two community geriatrician roles provides a strong basis for implementing 'step up' care as part of the capability: the key game changing initiative advised to local partners by external review of the service late last year.

2.5 Within this month's delivery reviews, we will again focus on **waiting times for children and young people needing mental health support.** The Trust has invested to reduce to no more than a few weeks neurodiversity diagnostic assessments in 2026, and our other CAMHS services have been seeking to deliver and sustain four weeks for some months. We are certainly on the cusp of doing so, which is welcome, and we will stress-test in Q4 staff and patient perceptions of the experience of using the getting help and getting advice service. This service is perhaps at the forefront of some of the genuine challenges of the promise 14 commitment that we gave – one addressed on a much broader scale within today's papers and expected to be the focus for much of our investment funding going into the year ahead.

2.6 We have spoken extensively about work to improve services for older adults across both our physical and mental health services. Moving to services without birth-date restriction remains a priority for the clinical leadership executive. The implementation of **changes within our crisis services** to create a consistent approach Trust-wide , whilst not without disquiet about pace, was cited by the coroner subsequently for its importance. Monitoring of the workload arising from the changes continues monthly. In these changes, and others to come, we need to make a reality of enhanced support and training to colleagues more used in their practice to supporting working age adults – and Dr Gemma Graham will lead a session with the Board on that subject, as she did with CLE last summer, in February 2025.

Our people

3.1 Recognising our focus on developing our directorates, as managers of today, and liberating care group leaders to focus with the executive and partners of tomorrow, we continue to consider how best to develop those teams. The creation of directorates in late 2023 provides a basis for bringing service teams together at a local level, but also requires those directorates to either work cross-trust (as in learning disabilities and forensics) or to collaborate with peer directorates in different places. For corporate teams, a shift to understanding the needs of all thirteen teams may feel more challenging on occasion than working solely with five care groups. **The intent, and the prize, remains a deeper, broader and more responsive management model – and on that, better reflects the diversity of our services** (only five of the directorates – three in mental health, and two within physical health services contain a bed-base).

3.2 The various leadership development (LDO) programmes that mark 2025 have now started. The first half of our 'LDO' with the top leaders' cadre kicked off in mid-January at the Doncaster Knights rugby club. Programmes to support first line manager, and clinical leaders in thought leadership roles, commence in Q1 25/26. We know that the move to a more responsive leadership model, **including 360-feedback as routine for line**

managers, represents another major cultural change in the organisation. This will support the wider work we need to do on employee feedback through the quarterly pulse surveys and the latest 2024 annual staff survey.

3.3 The Trust People Council has been established to provide a real focus on the current and future culture of our organisation. The successful election of **a full suite of staff governors (6)** offers another important voice to that body (and to the council of governors), alongside trade union representatives and those drawn from staff networks. Our staff networks grow again in February with the launch of the carer's network, which is one part of our Promise 2 efforts.

3.4 Whilst the focus of the senior leadership of moving away from the use of agency staffing has been widely discussed, and reviewed, and remains a focus of work, it is important to recognise other major shifts in people-practice. One of those is the intent to ensure that structured and agreed job plans exist annually – and **that 'SPA time' is both protected and purposive**. While that language is traditionally associated with the medical contract, Jon Rouston, Jude Graham and others have been leading work to embed similar disciplines into AHP roles, psychological professionals and roles including nurse consultants. In the main, such SPA time (apart from the element devoted to CPD) will support education, research or leadership, and the transition to these expectations may, understandably, represent a shift – as such the Trust is working closely with neighbouring organisations to compare approaches and paths of change.

3.5 Opening up research to a wider cohort of employees is very much part of our work in the year ahead. The Board reviewed the research arrangements of the Trust last time, as we did education in July, and it is clear there is **more to do to make research accessible to a broader group of professionals**. Both our portfolio practice and our commercial work are significant, and we look forward to collaborating with partners at Sheffield Children's Hospital on their groundbreaking new child health technology centre. Our Children's Care Group are leading the way internally with their focus on multi-professional research – and other teams are seeking to borrow some of their techniques as we make research governance and scaling up part of the mainstream management model for 25/26.

3.6 The clinical leadership executive discussed **sickness absence rates** at its last meeting. We know that these vary among teams, services, and professions. The right approach must prioritise care for the individual, and nothing in this work should be construed as seeking to push people back into work before they are ready. Our focus on reducing turnover and 'turbulence' within teams carries with it an expectation that we support employees over the medium term. It is, however, the case that sickness does drive use of temporary staffing and sometimes places significant pressure onto smaller teams, or shifts. During Q4 the focus is on better understanding our current patterning, before working through the right adjustments to make to try to create a fairer approach over coming months.

Our population and partners

4.1 Over recent weeks, we have completed work at executive and full board level within the South Yorkshire Mental Health LD&A Collaborative. These efforts have been informed by the Care Professionals Assembly, created last year, as well as by active patient and community involvement. The **likely future direction for the collaborative's programme will see greater focus in 2025/26 on dementia care** across South Yorkshire, as we look to recognise the rising need, and the potential to support both younger adults and older adults with diagnosis and support.

4.2 In Humber and NY, discussions continue about a move to a risk-bearing vehicle for mental health provision across the ICB. Such a proposition will depend on a multi-year funding agreement prior to any go-live proposal, and understandably such important work is taking time. In the meantime, there has been investment to **develop a specialist community rehabilitation service in North Lincolnshire**.

4.3 In terms of our strategy (promises 15/21) and our Strategic Delivery Risks (SDR/BAF), the Trust aims to develop more consistent links with local general practice. This is very much a localised development through our care groups, but with central support through the new primary care liaison manager within strategic development. Whether in terms of ARS roles, or in **delivering the four liaison priorities agreed for 25/26 through CLE**, we need to retain focus on this critical relationship: and to reduce paper-based processes and inter-sectoral handoffs.

4.4 At the latest public health, patient involvement and partnerships committee we discussed again ongoing work, under promise 5, to work better with the third sector. Projects like the charity's small grants programme will help to build relationships. The future structure of **a more strategic relationship with VCSE bodies will vary by place**, and again, like primary care collaboration, will be locally driven with some corporate support (in this case via nursing and facilities).

4.5 Alliances and shared intent continue to matter very much, perhaps especially in making sure that a 'neighbourhood led' NHS is just that. It is welcome, for example, to have strong support from North Lincolnshire Council to develop and secure the Elizabeth Quarter site**, as one part of our Scunthorpe triangle**. Investment in St Nicholas House took place in 24/25, and the Great Oaks redevelopment will be completed during 25/26. When we conduct our team-to-team with the local authority's senior leaders in February, we will then discuss our focus across the district's villages.

Toby Lewis, Chief Executive
January 21st 2025