The Rotherham NHS Foundation Trust

Board of Directors
Public AGENDA

Date: **Friday 04 March 2022**
Time: **0900hrs – 1130hrs**

The Trust's Constitution states that:

31.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

In view of the current coronavirus pandemic and governmental advice, the Board of Directors has taken the decision that members of the public are excluded from this meeting for special reasons, i.e. governmental advice re social distancing.

However, should members of the public have any questions relating to the items on the agenda, please forward these to dawn.stewart4@nhs.net by 1pm on Thursday 03 March 2022

Time	Item no.			Page	Required Actions	Lead
		Procedural Items				
0900	*P29/22*	*Chairman's welcome and apologies for absence*	*Verbal*	*-*	*For information*	*Martin Havenhand, Chairman*
	P30/22	*Quoracy Check*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P31/22	*Declaration of conflicts of interest*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P32/22	*Minutes of the previous meeting held on 07 January 2022*	*Enc.*	*4*	*For decision*	*Martin Havenhand, Chairman*
	P33/22	*Matters arising from the previous minutes (not covered elsewhere on the agenda)*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P34/22	*Action Log*	*Enc.*	*17*	*For assurance*	*Martin Havenhand, Chairman*
		Overview and Context				
0910	*P35/22*	***Patient** Story*	*Pres*	*19*	*For information*	*Helen Dobson, Interim Chief Nurse*
0920	*P36/22*	*Report from the Chairman*	*Enc.*	*23*	*For information*	*Martin Havenhand, Chairman*
0925	*P37/22*	*Report from the Interim Chief Executive*	*Enc.*	*26*	*For information*	*Dr Richard Jenkins, Interim Chief Executive*
		Culture				
0930	*P38/22*	*Responsible Officer – Quarterly Report*	*Enc.*	*62*	*For assurance*	*Dr Callum Gardner, Executive Medical Director*

0935	*P39/22*	*Guardian for Safe Working – Quarterly Report*	*Enc.*	*67*	*For assurance*	*Dr Gerry Lynch, Guardian of Safe Working*
0940	*P40/22*	*Freedom to Speak up Guardian – Quarterly Report*	*Enc.*	*71*	*For assurance*	*Anthony Bennett, Lead Freedom to Speak Up Guardian*
0945	*P41/22*	*Policy for Safeguarding Children Supervision*	*Enc.*	*76*	*For decision*	*Helen Dobson, Interim Chief Nurse*
0950	*P42/22*	*Safeguarding and Vulnerabilities Team Annual Report 2020/2021*	*Enc.*	*113*	*For assurance*	*Helen Dobson, Interim Chief Nurse*
		Strategy				
0955	*P43/22*	*National, Integrated Care System and Integrated Care Partnership Report*	*Enc.*	*152*	*For assurance*	*Michael Wright, Deputy Chief Executive*
1000	*P44/22*	*Operational Objectives 2021/22 Review*	*Enc.*	*182*	*For assurance*	*Michael Wright, Deputy Chief Executive*
1005	*P45/22*	*Acute Care Transformation*	*Enc.*	*210*	*For assurance*	*George Briggs, Chief Operating Officer*
1010	*P46/22*	*Green Plan*	*Enc.*	*215*	*For information*	*Steven Hackett, Director of Finance*
		Assurance				
1015	*P47/22*	*Board Committees Chairs Assurance Logs* *i. Finance and Performance Committee (23/02/2022)* *ii. Quality Committee (26/01/2022 & 23/02/2022)* *iii. People Committee (18/02/2022)* *iv. Audit Committee (09/02/2022)*	*Enc.*	*241* *245 & 248* *251* *256*	*For assurance*	*Committee Chairs and Lead Executives*
1025	***Break***					
1030	*P48/22*	*Care Quality Commission Assurance Report*	*Enc.*	*263*	*For assurance*	*Helen Dobson, Interim Chief Nurse*
1035	*P49/22*	*Monthly Integrated Performance Report*	*Enc.*	*269*	*For assurance*	*Michael Wright, Deputy Chief Executive*
1040	*P50/22*	*Reset and Recovery Operational Report*	*Enc.*	*289*	*For assurance*	*George Briggs, Chief Operating Officer*
1045	*P51/22*	*Finance Report*	*Enc.*	*297*	*For assurance*	*Steven Hackett, Director of Finance*
1050	*P52/22*	*Ockenden Monthly Report*	*Enc.*	*309*	*For assurance*	*Helen Dobson, Interim Chief Nurse*
1055	*P53/22*	*Mortality and Learning From Deaths Report*	*Enc.*	*345*	*For assurance*	*Dr Callum Gardner, Executive Medical Director*
1100	*P54/22*	*Medical Workforce Quarterly Report*	*Enc.*	*382*	*For assurance*	*Dr Callum Gardner, Executive Medical Director*

		Regulatory Compliance Risk and Assurance				
1105	*P55/22*	*Board Assurance Framework: Quarter 4*	*Enc.*	*385*	*For decision / For assurance*	*Angela Wendzicha, Director of Corporate Affairs*
1115	*P56/22*	*Annual Report and Accounts 2021/22* *i. Accounting Policies* *ii. Going Concern* *iii. Operating Segments*	*Enc.*	*411* *437* *443*	*For decision*	*Steven Hackett, Director of Finance*
		Board Governance				
1125	*P57/22*	*Register of Sealing – Bi Annual Report*	*Enc.*	*450*	*For assurance*	*Angela Wendzicha, Director of Corporate Affairs*
	P58/22	*Register of Interests – Bi Annual Report*	*Enc.*	*452*	*For assurance*	*Angela Wendzicha, Director of Corporate Affairs*
	P59/22	*Escalations from Council of Governors – 09/02/2022 meeting*	*verbal*	*-*	*For noting*	*Martin Havenhand, Chairman*
		For Information				
	P60/22	*Any other business*	*-*	*-*	*For noting*	*Martin Havenhand, Chairman*
	P61/22	*Date of next meeting:* *06 May 2022*	*-*	*-*	*For noting*	*Martin Havenhand, Chairman*
1130	*Close of meeting.*					

In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD VIRTUALLY ON FRIDAY 07 JANUARY 2022

Present:
Ms L Hagger, Non-Executive Director / Vice Chair
Miss N Bancroft, Non-Executive Director
Dr J Bibby, Non-Executive Director
Mr G Briggs, Chief Operating Officer
Mrs H Craven, Non-Executive Director
Mrs H Dobson, Interim Chief Nurse
Dr C Gardner, Executive Medical Director
Mr S Hackett, Director of Finance
Dr R Jenkins, Interim Chief Executive
Mr K Malik, Non-Executive Director
Mr S Ned, Director of Workforce
Dr R Shah, Non-Executive Director
Mr M Smith, Non-Executive Director
Mr M Wright, Deputy Chief Executive

In attendance:
Mr I Hinitt, Director of Estates and Facilities
Mr J Rawlinson, Director of Health Informatics
Miss D Stewart, Corporate Governance Manager (minutes)
Mrs L Tuckett, Director of Strategy Planning and Performance

Apologies:
Mr M Havenhand, Chairman
Mrs S Kilgariff, Director of Operations / Deputy Chief Operating Officer
Ms A Wendzicha, Director of Corporate Affairs

PROCEDURAL ITEMS

P01/22 CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE

Ms Hagger welcomed all present to the meeting with apologies for absence noted.

P02/22 QUORACY CHECK

The meeting was confirmed to be quorate.

P03/22 DECLARATIONS OF CONFLICTS OF INTERESTS

Dr Jenkins' interest in terms of his joint role as Interim Chief Executive of the Trust and substantive Chief Executive of Barnsley Hospital NHS Foundation Trust, was noted.

Mr Ned's interest, in terms of his joint role as Director of Workforce of both the Trust and Barnsley Hospital NHS Foundation Trust, was noted.

Colleagues were asked that should any further conflicts of interest become apparent during discussions that they were highlighted.

P04/22 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 05 November 2021 were agreed as a correct record, subject to the following amendment.

Responsible Officer's Report Q1 2021/22 Review (minute P212/21)

Clarification that Dr Shekar had been appointed as Associate Medical Director for Appraisal, Revalidation and Mentorship.

P05/22 MATTERS ARISING FROM THE PREVIOUS MEETING

i. Report from the Interim Chief Executive (minute P211/21)

Dr Jenkins confirmed in response to a question from Dr Shah that a meeting had yet to be held with the regulator as to the additional support and resources accessible to the Trust as a result of being placed in Segmentation 3. The Board would remain updated on the discussions.

ACTION – Interim Chief Executive

P06/22 ACTION LOG

The Board of Directors reviewed the action log and agreed that log numbers 47 to 51 would be closed. The remaining open actions were 35, 41 and 44 scheduled to be reported to future meetings.

OVERVIEW AND CONTEXT

P07/22 STAFF STORY

In introducing the Staff Story, the Board of Directors welcomed to the meeting Ms Rathbone, Employer Engagement Executive at Wayfinder Specialist Employment Service.

Mr Ned informed the Board that the Trust was actively supporting internships for those aged 16 – 24 with education and health care needs. The presentation by Ms Rathbone would highlight the services provided by Wayfinder to provide a structured work placement to support Lewis, the Trust's first intern, and the ongoing work with the Trust.

Ms Rathbone provided a short PowerPoint presentation outlining the work of Wayfinder, the diverse range of work place opportunities and the initial and ongoing support provided to interns as part of the placement. The presentation was followed by a short video from Lewis.

In response to a question from Dr Jenkins, the Board noted that the Trust had agreed to support five placements across a range of services including health records and patient support services. It was anticipated that as the relationship with the Trust grew through the Head of Equality Diversity and Inclusion, further placements would be established. Mrs Tuckett took the opportunity to

advise the Board that the Trust was also actively participating in the Government's Kickstart Scheme.

Ms Hagger indicated that the development and success of such schemes would be monitored through the People Committee.

The Board of Directors thanked Ms Rathbone for the uplifting presentation.

P08/22 **REPORT FROM THE CHAIRMAN**

The Board of Directors received and noted the Chairman's Report.

P09/22 **REPORT FROM THE INTERIM CHIEF EXECUTIVE**

The Board of Directors received the report from the Interim Chief Executive.

Firstly, the Board of Directors congratulated Mrs Kilgariff, current Director of Operations, on her appointment as Chief Operating Officer.

With regards to the new Acute Care Transformation programme to be led by the Chief Executive and Chief Operating Officer, Dr Jenkins confirmed that the Executive Team had discussed the requirements of the Programme Management Office (PMO). The PMO would be required to support schemes both trust-wide and service specific, including transformation and cost improvement programmes. The information discussed by the Executive Team would in due course be shared with the Board Assurance Committees.

Mrs Tuckett further added that resources available to the PMO had been increased, with recruitment underway, with the aim being that there would be one programme of work, with no separation in terms of efficiency and transformation.

In response to a question from Mrs Craven regarding the process of decision making by the Integrated Care System (ICS) in allocating additional resources, Dr Jenkins confirmed that the ICS Directors of Finance collectively directed the allocations based upon know organisational requirements. It was anticipated that the new Integrated Care Board would develop a structured approach moving forward.

Dr Gardner acknowledged the dedicated work of the Trust's staff, working in challenging circumstances, which had resulted in the Trust being in the national top ten for overall Referral to Treatment (RTT) performance in October 2021 delivering the best rate of improvement in this key elective care metric over the 12 months to August 2021. Additionally, the number of year-long waiters was under 40 as of mid-December 2021.

With regards to the ICS Chief Executive Report to the Health Executive Group, appended to the report, Dr Shah questioned the role to be played by Rotherham in the ICS piloting the new childhood obesity programme. Dr Jenkins agreed to obtain further detail in this matter.

ACTION – Interim Chief Executive

Dr Jenkins took the opportunity, supported by a number of Executive Directors to provide a comprehensive update as to the operational challenges as a result of the current wave of COVID.

The number of admitted cases continued to progressively rise, with Omicron now the dominate virus across the north of England in adults. Currently, the figure for Rotherham was circa 2300 per 100,000 with high incidence rates in the over 60 age group of over 1000 per 100,000. It was considered that Rotherham had yet to reach the peak in cases.

Staff absences regionally were in the range of 10% to 15%, and were anticipated to continue to rise.

Nationally a level four incident level was in force, and locally the Integrated Care System had declared a critical incident on behalf of all organisations. The ICS met weekly to monitor the position, with the Trust holding daily Gold and Silver Command meetings.

Mr Briggs confirmed that for the Trust circa 500 colleagues were absent, in the main COVID related. There were a rising number of admissions, with 76 patients in hospital with COVID. However, compared to previous waves there were a smaller number in critical care beds.

Emergency admissions due to other reasons also continued, with a decision having been taken to reduce elective admissions. Only emergency surgery, complex cases and cancer surgery was being maintained. However, this was reviewed on a daily basis due to the availability of beds and staffing levels.

Also, a number of non-essential services had ceased, to facilitate staff relocated to support other areas.

Mr Briggs confirmed that the Discharge Lounge had been underutilised due to recruitment difficulties, redeployment of staff to support other areas and a reduction in the elective programme. However, it was anticipated that it would be fully operational within the month.

Furthermore the number of long stay patients had increased due to pressures being seen by the Local Authority. A number of complex ill patients required additional support in their own homes, and a number of Care Homes had closed to new clients as a consequence of their own pressures. The Board thanked RMBC colleagues for the enhanced support they had provided were possible.

Mrs Dobson reported that the position with regard to nurse staffing level was monitored daily to ensure safe levels. As a result it had been necessary to redeploy nursing staff to areas that they may be unfamiliar with, but the Board were assured that it would be within their level of competency. Additionally, non-front line staff had been utilised for some activities to support patient care.

Daily assurance audits, undertaken by the Matrons, had been maintained to assess patient experience, the environment and infection control. Due to the

operational challenges standards had been lower than would be the norm; however action had been taken as necessary.

To provide further staff numbers, bank had been utilised and the registration for recent oversea nurse recruits had been fast tracked.

The difficult decision to restrict visiting had been taken. However, alternative measures had been established to ensure patients and relatives could stay in touch.

Similarly, the position was challenging for medical and dental colleagues, with Dr Gardner reporting that additional hours had been necessary, shift patterns reviewed, outpatient clinics suspended and training stood down. Middle grade doctors had also been asked, within their competency levels, to support other Divisions. Dialogue remained open with the medical and dental staff to address any additional support they may require.

It was clear that Omicron was having a significant impact on staff which as commented by Mr Ned, reinforced the requirement to maintain the health and wellbeing support available to colleagues.

It was confirmed that quarter four would require balance in ensuring staff did not work excessive hours and took their annual leave, whilst maintaining patient safety and operational services. These factors had all been taken into consideration in making the difficult decisions over recent weeks.

In terms of the requirement for vaccination as a condition of deployment, it was known that 92% of staff had been double vaccinated. The status of the remaining 8% was being ascertained. Once the exact position was known the options available would be discussed with the individuals.

Dr Shah questioned whether proactive communication with the Rotherham population as to the challenges and the possibility that the patient experience may be affected. However, Dr Jenkins clarified that national level 4 status required approval of any communication by the ICS, who themselves were preparing a press release on behalf of all South Yorkshire system.

The Board of Directors noted the interim Chief Executive report and the comprehensive position statement with regard to the operational challenges due to the impact of COVID.

STRATEGY

P10/22 **OPERATIONAL OBJECTIVES 2021/22**

The Board of Directors received the month eight position against the Operational Objectives 2021/22 presented by the Deputy Chief Executive.

Mr Wright highlighted that of the ten operational objectives for 2021/22, one was rated Blue (complete), one was rated Green (on plan), seven were rated Amber (behind plan with mitigation or actions in place to recover) and one was rated Red (behind plan with more significant action required).

Progress against all objectives had been considered during the December 2021 cycle of Board Assurance Committee meetings.

In terms of the Learning from Deaths programme, Dr Gardner took the opportunity to confirm that the Trust had established an interim solution to address the requirements in the National Medical Examiner's directive relating to Medical Examiner's independent scrutiny of deaths. The directive had stated that 'Stage 1/Medical Examiner independent 'scrutiny' reviews should not form part of patient records (i.e. Meditech)' this had resulted in the Trust's Medical Examiner's processing of Stage 1/scrutiny documentation, reverting to a paper-based system. The retrograde nature of the directive had been discussed with the Regional Medical Examiner.

It was noted that the Trust was in contact with the national team regarding the implementation timeframe for Rotherham of the new medical examiner system being rolled-out across England and Wales which would to provide greater scrutiny of deaths.

Dr Gardner further confirmed that progress was now being made with regards to mandatory Sepsis training, which also formed part of the Learning from Deaths programme.

In support of the Employer of Choice programme, it was noted that the People Committee, at its February 2022 meeting, would be considering a revised recruitment pack which would be based upon examples from other organisations.

In responding to a question from Dr Shah as to the reasons for the delay in the relaunch of the Quality Strategy which formed part of the Standards of Care and Quality Improvement programme, Mrs Dobson confirmed that the current Strategy remained in date. However, a refresh was underway and would be completed in quarter 4.

As part of the same programme, it was noted that the development of a Quality Academy would be a longer term project which would require development of a number of supporting business cases.

With regard to the development of the Same Day Emergency Care (SDEC) business case to support the Admission Avoidance programme, which was rated red, Mr Hackett reported that in conjunction with the Director of Operations, discussions had been held with the Division of Medicine. These discussions would be complex, as the opportunity to right size the organisation would be undertaken at the same time. As this would require full consideration by the Executive Team, it may be some time before the proposals, which may require significant investment, were brought to the Finance and Performance Committee and to the Board of Directors.

Miss Bancroft suggested that as there were a number of schemes amber rated, it would be prudent that during quarter four an assessment be made as to whether those programmes would be delivered, or whether they would need to be included as objectives for 2022/23.

The Board of Directors noted the Operational Objectives Report.

P11/22 **COUNCIL OF GOVERNORS APPROVED MEMBERSHIP AND ENGAGEMENT STRATEGY**

The Board of Directors received the Membership and Engagement Strategy 2022 – 2025 which had been approved by the Council of Governors at their meeting held on 10 November 2022.

Additionally, the report detailed the exercise undertaken to commence cleansing of the Membership database, and the provision of additional resources to implement the Strategy and support engagement activities with the membership.

In welcoming the Strategy, Dr Bibby commented that another measure of success would be areas which would be better as a result of an engaged membership. Ms Hagger suggested that the Trust Chair should discuss this further with the Lead Governor and Director of Corporate Services.

ACTION – Chairman

The Board of Directors approved the Council of Governors Membership and Engagement Strategy 2022 - 2025.

P12/22 **NATIONAL, INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP REPORT**

The Board of Directors received and noted the National, Integrated Care System (ICS) and Integrated Care Partnership (Place) Report presented by the Deputy Chief Executive. The Board had no questions in relation to the report.

ASSURANCE

P13/22 **BOARD COMMITTEES CHAIRS ASSURANCE LOGS**

The Board of Directors received and noted the Chairs logs from the following Board Assurance Committees held in November and December 2021:

i. Finance and Performance Committee
ii. Quality Committee
iii. People Committee
iv. Audit Committee

The Board discussed the position regarding agency spend. It was confirmed that the Medical Agency Group had operational oversight to approve requests to utilise external agencies. Additionally, to reduce the use of external agencies the Recruitment Panel had increased the frequency of its meeting to facilitate recruitment not being delayed. Agency usage was overseen on behalf of the Board by both the Finance and Performance Committee and the People Committee.

Dr Jenkins acknowledged that there could be further efficiencies to reduce agency spend which would be undertaken in in 2022/23, ultimately improving vacancies levels would reduce the requirement to utilise external agencies.

P14/22 **CARE QUALITY COMMISSION REPORT**

The Board of Directors received the Care Quality Commission (CQC) Report presented by the Interim Chief Nurse.

Mrs Dobson confirmed that the Trust's action plans in relation to the Section 29a Warning Notifications for Urgent and Emergency Care and the Acute Medical Unit, had been submitted to the CQC. This was in addition to the Must Do and Should Do actions plans following the 2021 inspection.

As the CQC had been assured of the position with regards to the Acute Medical Unit, which had been supported by an informal visit, the Section 29a Warning Notification had been removed.

The report further detailed the position with regards to the Section 31 received by the Urgent and Emergency Care following the 2018 inspection. Due to the progress which had been seen, the Trust in quarter four would begin the process to apply to have the conditions lifted. The CQC Delivery Group would be reviewing the evidence to support the application provided by the Division at its January meeting.

It was noted that information on the proposed operating framework in response to the CQCs 'A new strategy for the changing world of health and social care' and their risk based approach for future inspections would be released in quarter four. As detailed within the report, further information on the requirements would be provided as part of the next CQC report.

The Board of Directors noted the CQC Report.

P15/22 **MONTHLY INTEGRATED PERFORMANCE REPORT**

The Board of Directors received the Integrated Performance Report (IPR), presented by the Deputy Chief Executive.

The relevant Executive Director highlighted the following matters as at the end of November 2021:

- Referral to Treatment (RTT) times had improved, albeit with some challenges. However, the latest position as a consequence of the Omicron variant had been discussed earlier in the meeting;
- Mortality data was from July and August 2021 due to continued data delays. A separate report outlined the position;
- To utilise recent non-recurrent allocations a number of schemes or items of expenditure planned for 2022/23 were being brought forward;
- The current sickness absence rates had been detailed earlier in the meeting.

Dr Bibby questioned as to whether the target of zero was correct with regard to target PS1 - patient safety incidents severe or above. Mrs Dobson in confirming that the Trust promoted the reporting of incidents and near misses, agreed that the target would be amended.

ACTION – Interim Chief Nurse

In terms of cancer waiting times it was confirmed that patients waiting beyond the 62 day target continued to be monitored by both the Trust and the Integrated Care System. Currently no patient was waiting longer than 3½ months.

Improvements were being seen within Urology, supported by substantive Consultant recruitment, review of the patient pathways, allocation of additional resources and theatre efficiencies.

The Board of Directors noted the Integrated Performance Report.

P16/22 **RESET AND RECOVERY OPERATIONAL REPORT (INCLUDING COVID-19 UPDATE)**

The Board of Directors received for assurance the Reset and Recovery Operational Report which included an update on COVID-19 presented by the Chief Operating Officer.

Mr Briggs indicated that the Board had already discussed a number of the operational challenges detailed within the report. However, he wished to specifically highlight the deterioration in RTT (referral to treatment time), with patients waiting longer than the norm. Although not increasing to the levels being seen by some Trusts, it was not where the Trust had planned to be

The Board of Directors noted the report.

P17/22 **FINANCE REPORT**

The Board of Directors received the month eight Finance Report presented by the Director of Finance.

Mr Hackett reported that in month there had been an income and expenditure surplus to plan of £630K and £1,030K surplus to plan year to date. The forecast out-turn was an under-spend against plan of £512K.

In terms of capital expenditure, month eight had seen expenditure of £1,105K and £4,517K year to date. Although under plan, both in month and year to date, the forecast year end out turn was delivery of £13,581K. This planned underspend of circa £1,000K would be the Trust's contribution to the South Yorkshire and Bassetlaw Integrated Care System.

The Capital Monitoring Group, in discussion with the Divisions, had agreed the medical equipment requirements for 2022/23, with the five year equipment replacement programme enabling schemes to be brought forward when additional monies became available.

The Finance and Performance Committee continued to monitor delivery of the capital programme.

The cash position at the end of November 2021 remained strong, standing at circa £30,000K with the forecast year end position being circa £15,000K.

The Board of Directors noted the month eight finance report.

P18/22 **OCKENDEN MONTHLY REPORT**

The Board of Directors received the monthly report which provided oversight and assurance on the Maternity Service's compliance with the Ockenden Independent Review into maternity services.

Mrs Dobson reported that from a regional perspective the Trust was deemed to be performing positively against the requirements. Although the reporting of some national data had been paused for a three month period at the end of December, to maintain transparency to the Board, this would continue to be monitored.

The Board of Directors noted the Ockenden Monthly Report.

P19/22 **DEFAULT MIDWIFERY CONTINUITY OF CARER**

The Board of Directors received the report presented by the Interim Chief Nurse which detailed the Trust's ambition to deliver Midwifery Continuity of Carer by March 2023.

As explained within the report, Midwifery Continuity of Carer was a proven model to deliver safer and more personalised maternity care. It built upon the recommendations of Better Births and the commitments of the NHS Long Term Plan. The ambition for the NHS in England was for Continuity of Carer to be the default model of care for maternity services.

For the Trust to be compliant by 2023 would require an additional 15 WTE midwives, with the report detailing the actions to be taken to achieve this target. Dr Jenkins supported the improvements in care and patient experience resulting from the proposed model, stating that it would be important that the Trust's midwifery services were actively involved in the transition.

The Board of Directors noted the report.

P20/22 **MORTALITY AND LEARNING FROM DEATHS REPORT**

The Board of Directors received the report presented by the Executive Medical Director providing an update on both mortality data and the actions being taken to support learning from deaths.

Dr Gardner reported that Hospital Standardised Mortality Ratio (HSMR) stood at 114.0 (September 2020 - August 2021) which remained higher than expected. When secondary COVID-19 codes were excluded, the position was 101.7 which was within the 'expected range'.

The Summary Hospital-level Mortality Indicator (SHMI) stood at 112.6 for the period August 2020 - July 2021, moving the Trust back into the 'higher than expected' band.

Dr Gardner confirmed that the Internal Auditors following receipt of the required evidence had closed the outstanding recommendations from their review of Learning from Deaths. The audit would be repeated in quarter four, and at the request of Dr Gardner would focus on the Medical and Surgical Divisions.

The Board of Directors noted the report which provided assurance on the significant actions being taken to address the Trust's mortality position.

P21/22 **HEALTH INEQUALITIES TASK AND FINISH GROUP**

The Board of Directors received the report presented by the Deputy Chief Executive which provided an update on the activities of the Board's Health Inequalities Task & Finish Group.

Mr Wright reported that an operational group, which he would chair, had now been established to support the work streams identified by the Task and Finish Group. The operational group would be utilising available data in its activities. It was confirmed that the Indices of Multiple Deprivation would continue to be utilised as this was an analytical tool used both nationally and regionally.

Dr Bibby, chair of the Task and Finish Group, confirmed that the Trust was committed to address the identified health inequalities, with the priorities being the areas which would have the most significant and measurable impact.

Until the Board was assured that the health inequalities work was operationally embedded, the Task and Finish Group would continue to meet.

The Board of Directors noted the report from the Health Inequalities Task and Finish Group.

P22/22 **NATIONAL CQC PATIENT EXPERIENCE SURVEYS**

The Board of Directors received the report presented by the Interim Chief Nurse which detailed the findings of three national CQC Patient Experience Surveys undertaken in 2020 and early 2021.

The surveys related to:

- Urgent and Emergency Care
- Inpatient pathway
- Young People's Service

Each survey had produced results worse than had been expected. Action plans had been developed by the relevant Divisions to address the matters raised to improve responses by patients as part of future surveys. Progress against these action plans would be monitored through the Divisions, the Patient Experience Group and the Quality Committee.

Although the surveys had been undertaken during a challenging time due to the pandemic, Dr Jenkins considered the results unacceptable. Although robust actions would need to be implemented, due to the timing of the CQC surveys this may not have a positive impact on surveys currently underway. More frequent and real time patient feedback was required led by the Trust, which he would discuss further with Mrs Dobson.

ACTION – Interim Chief Executive

Across all the surveys had been comments relating to nurse staffing levels with the position in terms of the impact on the patient experience being monitored by the Quality Committee and the Nurse Strategy in terms of actual nursing numbers progressed through the People Committee.

The Board of Directors noted the report and the actions being taken to improve the patient experience.

REGULATORY COMPLIANCE RISK AND ASSURANCE

P23/22 HEALTH AND SAFETY ANNUAL REPORT 2020/21

The Board of Directors received and noted the Health and Safety Annual Report 2020/21.

Mr Hinitt confirmed that the Annual Report demonstrated that the organisation was not an outlier in terms of health and safety, supporting the Trust being awarded an 8th consecutive RoSPA (Royal Society for the Prevention of Accidents) Gold Award for Occupational Health and Safety.

BOARD GOVERNANCE

P24/22 BOARD ASSURANCE FRAMEWORK QUARTER 3

The Board of Directors received the report detailing the outcome of the discussions held by each Board Assurance Committees during the December 2021 cycle of meetings in relation to the quarter three Board Assurance Framework.

Prior to the Board, the quarter three position had also been considered by the Audit Committee at a meeting convened specifically to discuss the outcome of the discussions by each Committee. The Audit Committee would endorse approval by the Board of the recommendations contained within the report.

The Board of Directors approved the Board Assurance Framework quarter three recommendations.

P25/22 ENHANCING BOARD OVERSIGHT: A NEW APPROACH TO NON-EXECUTIVE DIRECTOR CHAMPION ROLES

The Board of Directors received the report detailing the outcome of the review of the Non-Executive Director Champion roles.

As detailed within the report, the proposal for consideration was a reduction in the number of Non-Executive Director Champions. The retained roles would have a strengthened remit and the areas no longer championed by a Non-

Executive Director would instead be aligned to a Board Assurance Committee to maintain focus on the matters.

The Board of Directors approved the revised approach for the role of Non-Executive Director Champion.

P26/22 **ESCALATIONS FROM COUNCIL OF GOVERNORS' - 10/11/2021 MEETING**

There were no escalations to the Board of Directors following the Council of Governors meeting held on 10 November 2021.

FOR INFORMATION

P27/22 **ANY OTHER BUSINESS**

There were no items of any other business.

P28/22 **DATE OF NEXT MEETING**

The next meeting of the Board of Directors would be held on Friday, 4 March 2022, commencing at 9am.

The meeting was declared closed.

Lynn Hagger
Non-Executive Director / Vice Chair **Date:**

Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
2020								
		2021						
35	09-Jul-21	National ICS and ICP Report	P154/21	Rotherham Place Development Plan, The Rotherham Integrated Care Agreement and Rotherham Place Plan to be submitted to Board when finalised	DCEO	~~05/12/2021~~ 04/03/2022	The Rotherham Place Development Plan and the Rotherham Integrated Care Agreement will be included in the Deputy CEO's report to Board in September 2021 (P181/21). The Place Plan however is going to the Place Board week commencing 30/08/21 and therefore will not be available for the Board of Directors until the November 2021 Board meeting. The Rotherham Place Development Plan and the Rotherham Integrated Care Agreement were included in the Deputy CEO's report to Board in September 2021 (P181/21). October 2021: The Place Priorities have been agreed by Place Board colleagues and are included within the Deputy CEOs report. There is action plan for quarter 2 that supports the priorities. This is currently being reviewed and updated with a view to being presented to the confidential Place Board in November and public Place Board in December. December 2021 - Place Objectives yet to be considered by Place Board. Current version circulated to Board members for information at this time.	Open
41	09-Jul-21	Governance Report	P161/21	Core Trust governing documents requiring review in light of the Health and Care Bill to be documented within Board forward work plan	DoCA	Apr-22	The forward planner will be updated as and when further ICS guidance is issued. It is anticipated that key governance documents will be revised by end of Q3 beg Q4.	**Open**
44	10-Sep-21	Five Year Strategy	P180/21	Analysis of the risks to be undertaken in parallel to the next stages, with these to be presented to the November 2021 Board meeting.	DoCA	~~01/12/2021~~ ~~01/02/2022~~ April 2022	Meeting with Executive Team and individual NEDs throughout March in preparation for presentation of new BAF at April 2022 Board	**Open**
		2022						

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
1	07-Jan-22	Matters arising	P05/22	To inform Board of outcome of discussions with the Regulator in accessing additional resources due to Segmentation 3 status	ICEO		Meeting took place on 27.01.22 and update provided in March CEO Report along with copy of outcome letter.	Recommend to Close
2	07-Jan-22	Chief Executive Report	P09/22	Obtain further information regarding the childhood obesity programme and any role for Rotherham	ICEO		Update from RCCG: very small allocation less than £30k	Recommend to Close
3	07-Jan-22	Member Engagement Strategy	P11/22	Further discussion to be held with Lead Governor and DoCA as to the benefits to be gained from implementation of the Strategy	Chair		To be discussed at Governor Member Engagement Group on 01/03/2022 and with Lead Governor	Recommend to Close
4	07-Jan-22	Integrated Performaance report	P15/22	Amend target for PS1	ICN		Developing a new target from April onwards to reflect annual average rather than monthly fluctuations	Recommend to Close
5	07-Jan-22	CQC National Surveys	P22/22	To discuss with the ICN options in relation to real time patient feedback	ICEO		Discussed with Interim Chief Nurse and the Trust will have Patient Experience Pulse in place within 3 months	Recommend to Close

Open
Recommend to close
Complete

Open
Recommend to Close
Complete

Patient Story

Michelle Fletcher
Macmillan Lead Cancer Nurse

Back ground to story

- Non surgical oncology (breast) changes
- National shortage of oncologists
- Changes to previous model
- Moving to a possible two hub model

My experience at clinic in Rotherham and the move to Western park .
It's is without doubt that the absence of my nurse specialist made such a huge impact on me at my appointment at Western park.
She has been with me from day 1 and I find her presence invaluable, not only in a supportive role but in helping to explain medical jargon used by so many doctors . When a doctor gives you a diagnosis/prognosis you need time to process the information but they've generally already left the room by the time questions start in your head. I appreciate their time is precious n they're very busy.
This is where my specialist nurse comes in she's heard the same news as you, she puts the bits together you've not taken in and goes over things with you in a clear and compassionate manner. Talking to her at this time is what I needed and I really missed that. I came home feeling confused. I needed my sounding board and she wasn't there like she'd been when I attended the clinic at Rotherham .
It is without doubt that in clinic they are needed on a personal level for patients n carers to fill in the gaps , support and give there time to listen n help at what is a very difficult point in many people's life.

What are we doing to address this?

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P36/22
Report	**Chairman's Report**
Executive Lead	Presenter: Martin Havenhand, Chairman
Link with the BAF	The Chairman's report reflects various elements of the BAF
How does this paper support Trust Values	This report supports the core values of Ambitious and Together through the various updates included relating to improving corporate governance and working collaboratively with key partners
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	This report provides a brief update on a number of issues since our January Board meeting.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report has not been received elsewhere prior to its presentation to the Board of Directors
Board powers to make this decision	The Trust's Matters Reserved document details that approving the membership and Chairmanship of Board Committees is a matter which it has reserved unto itself.
Who, What and When	Actions required will be led by the relevant Executive or Non-Executive Director.
Recommendations	It is recommended that the Board of Directors notes the report.

1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 07 January 2022.

2.0 Council of Governors

2.1 The Council of Governors held its public meeting virtually on 09 February.

2.2 Key issues addressed at the meeting were:

- An update on development of the Integrated Care System
- The long list of proposed 2022/23 Quality Priorities
- The Council of Governors received a number of reports from the Executive Team showing the elective recovery programme and the continuing impact of COVID-19 on the operation of the Trust.

3.0 Strategic Board Meeting 04 February 2022

3.1 The Board of Directors addressed two issues, firstly how we are to promote and implement our recently approved Five Year Strategy and secondly the emerging governance arrangements for the South Yorkshire and Bassetlaw Acute Federation (Provider Collaborative).

4.0 Ambition Rotherham Board

4.1 The Board has met on the 6th January and on 16th February. A key part of the meetings was devoted to the planned "Children's Capital of Culture" in Rotherham in 2025.

4.2 Rotherham will be the first Children's Capital of Culture, 365 days of arts and culture in partnership with local young people/school children. Festivals, artworks, cultural celebrations, and events will be happening all the way up to 2025.

4.3 Julie Dalton (Gullivers) is the Chair of the organising committee and is keen that the programme of events from the launch in February 2022 (during school half term) will change the image of Rotherham positively.

5.0 Lead Non-Executive Director (Michael Smith)

5.1 Michael Smith met with Dr Amanda Hendry, consultant liaison psychiatrist at Rotherham Doncaster and South Humber NHS FT concerning general liaison work for patients with mental health issues attending the Trust. This is part of his role as a member of the recently formed Mental Health Steering Group which has now met on 4 occasions and is working on a mental health strategy.

6.0 Lead Non-Executive Director (Lynn Hagger)

6.1 On 18 January 2022 and 15 February 2022 Lynn attended the Maternity and Neonate Safety Champions' meetings. On the 18 January she met with the Community Midwives. It was very encouraging to hear how they felt empowered to speak up to voice their concerns.

6.2 The Organ Donation Committee met on 20 January 2022 where good performance with respect to donation and training was highlighted and the Committee was pleased to welcome a chaplain as a new member. An anonymous (or consented) donation story will be used at a future meeting to make the issue more 'real' for those not directly involved in

donations. NHS Blood and Transplant at regional level continue to discuss the provision of an ambassador for South Yorkshire.

6.3 On 21 January 2022 Lynn joined some members of the Executive team and the Head of Midwifery to meet the national midwifery team who wanted to showcase a new toolkit to ensure best practice; it was pleasing to note that our maternity services are already using this tool.

6.4 On 14 February, Lynn met Alison Cowie, Head of Nursing, Children's Services and Dr Naveen Naganna, Paediatric consultant to visit the Urgent and Emergency Care Centre and discuss the new paediatric emergency pathway. While staffing and cultural issues remain, a significant amount of work has been undertaken to improve matters and there is confidence that current initiatives will come to fruition in the next 6 months. Lynn took the opportunity to also visit the Children's ward and Special Care Baby Unit.

Martin Havenhand
Chairman
February 2022

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P37/22
Report	**Chief Executive Report**
Executive Lead	Dr Richard Jenkins, Interim Chief Executive
Link with the BAF	The Chief Executive's report reflects various elements of the BAF
How does this paper support Trust Values	The contents of the report have bearing on all three Trust values.
Purpose	**For decision ☐ For assurance ☐ For information ☒**
Executive Summary (including reason for the report, background, key issues and risks)	This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest including: • Covid-19/Recovery • ICS and Rotherham Place • CQC • Staffing The items are not reported in any order of priority
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper reports directly to the Board of Directors.
Board powers to make this decision	No decision is required.
Who, What and When (what action is required, who is the lead and when should it be completed?)	No action is required.
Recommendations	It is recommended that the Board note the contents of the report.
Appendices	1. Update from Chief Executive designate NHS South Yorkshire Integrated Care Board for Feb 2022. 2. Letter from NHSE/I regarding System Oversight Framework rating for TRFT.

1.0 Covid-19

1.1 **Activity:** January saw a sharp increase in the number of cases of the Omicron Covid-19 variant both in the Trust and in the community. Alongside this, the Trust also saw an increase in Covid-19 related staff absence resulting in a significant increase in operational pressures. Strategic and Tactical Command meetings were stepped up to manage the pressures during the period. The last couple of weeks have seen a marked improvement in the numbers with a continuing decline in cases and staff absence being noted.

1.2 **Vaccination:** Following the 'Vaccination as a Condition of Deployment (VCOD) notification that vaccination for front-line colleagues will become mandated on 1st April 2022, work has continued to work with individuals to provide supportive conversations in order to support colleagues to make an informed choice. However, the Government has now announced that it intends to revoke the legislation following a consultation exercise conducted about the proposed change which ended on 16th February 2022 and therefore the Trust is awaiting further national guidance. The Trust does still believe that vaccination remains the best way of protecting staff and patients against Covid-19 infection.

1.2.1 At the time of writing this paper, the Covid-19 Vaccination Service, Hospital Hub team have delivered approximately 38,000 vaccines and the Trust is rated second in Acute Trusts in terms of performance at 90% (national performance being 84%).

1.2.2 Whilst it is worth noting that the incidence of flu in circulation remains very low currently, and the general uptake of Influenza vaccination in the Trust is lower than previous years, the Trust remains in the top two of Acute Trusts having 70% of its workforce vaccinated. This figure exceeds the National Flu uptake of 55%.

1.3 **Recovery**: The work to recover the accumulated long waiting times has slowed in recent months, due in part to the intense site pressures from the latest Covid-19 wave, which ultimately led to the temporary closure of our elective orthopaedic ward, and a reduction in the number of beds available for other elective surgical procedures. We have also experienced medical workforce shortages in particular areas over Q3, which has exacerbated the demand and capacity challenge within some specialties. SYB providers have made a decision to not anticipate any additional Elective Recovery Funding (ERF) within H2, given the increased expectation of 95% delivery against 2019/20 baselines. The growth in our overall waiting list has continued, with over 22,000 patients on the waiting list at the end of January, a more than 30% increase compared to the start of the year. We have seen an increase in the number of 18+ week waiters over the last 6 months, from under 3,000 patients in July 2021 to over 5,000 patients in the latest national submission (January). Within these figures, there are a handful of significant pressure points, with 3 specialties accounting for almost half of the long waiters (ENT, Trauma & Orthopaedics and Gynaecology). We are maximising opportunities to introduce new ways of working in order to better manage the demand and to maximise our capacity, and this should support some of the most challenged specialties in Q4. Whilst all Trusts are facing similar elective care challenges, TRFT was in the top eight acute or combined Trusts in the country for overall Referral to Treatment (RTT) performance in December (latest national data). The number of year-long waiters has increased to over 60 as of mid-February, which is still a more than 90% reduction on the peak of February 2021.

1.4 **Urgent and Emergency Care Activity (UECC):** The Trust continues to see and treat a consistent number of attendances through our Urgent and Emergency Care Centre (UECC) with some unexpected high attendance days over the last few weeks. Admissions and Ambulance attendances have remained high with Yorkshire Ambulance Service reporting an increase in acuity of patients by 20-30% over previous years, despite a gradual reduction in patients within our beds who are suffering from Covid-19. The Trust has seen a sustained period of high numbers of Covid-19 patients and complex long wait patients within our acute beds which has severely affected our overall bed capacity. Since early February occupancy in our beds has gradually reduced with complex patients and Covid-19 numbers reducing to more expected numbers, which has supported the reopening of all of our elective bed capacity.

1.5 The Trust has reviewed its visiting restrictions and agreed to re-instate visiting in all areas starting week commencing 14th February 2022. There will be a maximum of one visitor per patient at any time and visitors will need to comply with PPE requirements and expected to be asymptomatic. There are a number of areas however, where this will not be the case, those being UECC, Covid-19 positive wards and specific areas where there is limited capacity to main social distancing. Further changes to return to more normal arrangements are under active consideration as the pandemic

2.0 Integrated Care System (ICS) and Rotherham Place Development

2.1 Appendix one is the update from the ICB Chief Executive Designate, which is provided for information.

2.2 Rotherham Place continues to focus on the Rotherham Health and Social Care Partnership and the Rotherham Place Plan. All partners across the Place have reported significant staffing pressures in the reporting period but they continue to work together and support each other.

2.3 Representatives from the Trust have attended a number of Place meetings including the Health and Well-Being Board, the Health Select Commission and the Place Board.

3.0 NHS England and NHS Improvement

3.1 A number of Directors and I met with Alison Knowles, Locality Director and other colleagues from NHSE/I to review the Trusts System Oversight Framework (SOF) rating. The review was to discuss whether there had been sufficient improvement in the Trust's quality governance and outcomes to warrant moving the Trust from its current segment (3) to segment 2. We have received formal notification (appendix 2) which highlights the improvements and progress made and confirmation that subject to the lifting of the Section 31 notice, a recommendation will be made to move the Trust from SOF3 to SOF2.

4.0 Care Quality Commission Update

4.1 The Trust has been informed of its new CQC relationship team as of February 2022, Mr Chris Storton, Relationship Manager/Inspector and Ms Tony Preston, Relationship Owner/Inspector. The focus on improvement work to address the CQC findings following the inspection in summer continues, led by the Interim Chief Nurse. Work continues to provide evidence on the application process for the lifting of the Section 31 notice and it is hoped to be able to submit this for consideration by the end of February 2022 following a review of the evidence at the scheduled CQC engagement group meeting. Further detail on the work associated with the CQC can be found in the Interim Chief Nurse's report.

5.0 Staffing

5.1 I am pleased to report that, following an interview process, an offer has been made to the post of Director of Operations/Deputy Chief Operating Officer, successor to Sally Kilgariff, following her successful appointment to the Chief Operating Officer commencing in June 2022.

Dr Richard Jenkins
Interim Chief Executive
March 2022

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

8 February 2022

Author(s)	**Gavin Boyle** **Chief Executive designate NHS South Yorkshire Integrated Care Board**
Sponsor	
Is your report for Approval / Consideration / Noting	
For noting and discussion	
Links to the ICS Five Year Plan (please tick)	

Developing a population health system

- ☑ **Understanding health in SYB including prevention, health inequalities and population health management**
- ☑ **Getting the best start in life**
- ☑ **Better care for major health conditions**
- ☑ **Reshaping and rethinking how we flex resources**

Strengthening our foundations

- ☑ **Working with patients and the public**
- ☑ **Empowering our workforce**
- ☑ **Digitally enabling our system**
- ☑ **Innovation and improvement**

Building a sustainable health and care system

- ☑ **Delivering a new service model**
- ☑ **Transforming**
- ☑ **Making the best use of resources**

Broadening and strengthening our partnerships to increase our opportunity

- ☑ **Partnership with the Sheffield City Region**
- ☑ **Anchor institutions and wider contributions**
- ☑ **Partnership with the voluntary sector**
- ☑ **Committment to work together**

Where has the paper already been discussed?	
Sub groups reporting to the HEG:	**System governance groups:**
☐ **Quality Group**	☐ **Joint Committee CCGs**
☐ **Strategic Workforce Group**	☐ **Acute Federation**
☐ **Performance Group**	☐ **Mental Health Alliance**
	☐ **Place Partnership**
☐ **Finance and Activity Group**	
☐ **Transformation and Delivery Group**	

Are there any resource implications (including Financial, Staffing etc)?

N/A

Summary of key issues

This monthly paper from the System Lead of the South Yorkshire and Bassetlaw Integrated Care System provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the months of December 2021 and January 2022. The Health Executive Group adapted in December to become the Health Cell of the LRF in response to the new Omicron variant of Covid-19.

Recommendations

The SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees as appropriate.

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

Health Executive Group

08 February 2022

1. Purpose

This paper from the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) designate Chief Executive Officer provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the months of December 2021 and January 2022. The Health Executive Group meeting was adapted from December 202, becoming the health cell of the LRF to support leaders across the system with coming together to respond to the Omicron variant of Covid-19.

2. Summary update for activity during December/January

2.1 Coronavirus (COVID-19): The South Yorkshire and Bassetlaw position

2.1.1 Covid cases

December and January were particularly challenging across SYB ICS, as they were in the rest of the country. In December, following the announcement of a UK-wide Level 4 covid alert, the NHS declared a national Level 4 Incident, which currently remains in place. At the time the last CEO report was written in late November, there were no cases of Omicron in SYB, but this situation changed rapidly during December. Omicron became the dominant strain of the virus in most of the population, except for under 15s where numbers of the Delta variant were initially similar. By 10 January, cases of Covid had risen to 2000 per 100,000; the highest rate seen during the pandemic. The number of children under 12 with Covid are at levels 20 times higher than previously seen with a notable spike in cases when schools reopened in January.

Although the overall numbers of new cases are now decreasing, we are still expecting a peak in bed occupancy to follow at the end of January into early February but do not anticipate that this will be on the scale of the previous waves. Bed occupancy will also be affected by hospital discharge figures and the numbers/levels of local outbreaks in care homes and assisted care accommodation sites. However, at the end of January bed occupancy numbers are stable and encouragingly, there continue to be fewer admissions to intensive care units. This reflects the impact of the booster programme and new treatments which are helping to reduce severe illness and death.

2.1.2 Staff absences

The emergence of the Covid Omicron variant in November 2021 led to predictions of a sharp increase in numbers of people affected nationally due to the high transmissibility of the virus. This proved to be the case, with very high levels of community infection, which in turn led to an increase in hospital admissions but fortunately not at the same rate as previous waves due to the impact of the vaccine. Because of the number of people infected with Omicron, high levels of staff absence were anticipated and as a system we put plans in place to mitigate against this. Despite this, mid-December to mid-January proved to be extremely challenging with higher rates of staff absence than would normally be seen at this time of year creating pressures across the system. Although some staff had Covid, many were absent because they were caring for relatives with Covid or were required to self-isolate.

However, I am pleased to report that by the end of January, the situation had improved considerably. We anticipate that the Heath Secretary's announcement on 14 January reducing isolation from seven days to five days following consecutive negative tests will also help to reduce staff absences. But as the level among school children under 12 remains high, the virus will continue to circulate in the community, potentially causing reinfection which is passed on to parents and carers which in turn can translate into further staff absences.

I would like to take this opportunity on behalf of the ICS to record our heartfelt thanks to all our staff, who yet again have risen to another challenge with great dedication, courage and professionalism.

2.1.3 Reducing Covid hospital admissions

SYB has successfully established five Covid Medicine Delivery Units, which can provide treatment with neutralising monoclonal antibodies (nMABs) to patients who are at high risk if they contract Covid. Each patient is individually assessed by a clinician, which means that they get rapid treatment to help ensure they don't become very unwell with the virus. nMABs are highly recommended as a treatment option for non-hospitalised adults and children (aged 12 years and above) in the highest risk patient groups. This service is also helping to reduce the number of admissions to hospital.

The government has also announced details on PANORAMIC, a new national Covid study which aims to recruit 10,000 UK patients at greatest risk of serious illness to a trial the drug Molnupiravir at home. This is a new antiviral which has proved to be successful in clinical trials in reducing the risk of hospitalisation and death among the most vulnerable of non-hospitalised adults by 30 per cent.

2.1.4 System pressures and recovery

Ongoing pressures to SYB's urgent and emergency services have required some adaptions to patient-facing services, mostly connected to elective care and non-urgent services, to redeploy staff to the most in need services.

The impact of Omicron on staff absence resulted in specific pressures for the Yorkshire Ambulance Service (YAS), which had to put temporary measures in place to prioritise its most important services. For a short period in January, YAS had to suspend its Patient Transport Services (PTS). But following support from military colleagues and the number of YAS staff able to return to work, the service recommenced for all eligible patients requiring PTS services from 24 January.

The on-going infection control measures for Covid have also helped to ensure that the numbers of cases of flu remain well below normal seasonal levels with few admissions to hospital, and no admissions to intensive care. Cases of norovirus also continues to be very low.

2.1.5 Vaccination programme

The drive for booster vaccinations to help protect people against the Omicron variant was ramped up across the country in December. Vaccination teams did an amazing job in SYB and vaccination centre hours were extended to 12 hours a day seven days a week and we worked with local authority partners on additional sites and pop-up centres. Currently, over 80 per cent of the eligible population in SYB have now received their booster, which is an extraordinary achievement in such a short time scale, and I would like to offer my thanks on behalf of the ICS.

During January the number of people coming forward for their Covid vaccinations has been falling and currently we are vaccinating around 2000 people a day. To counteract this, SYB's Covid Vaccination Programme has been redoubling efforts to increase uptake of the booster programme to support the immunisation of all over-18's in the region. We have been offering popup vaccination sites and arranging vaccination sessions at places of employment for example Amazon.

Work has begun to look at how we can best use the vaccination capability which has been built up since January 2021 going forward, which will be shaped by the vaccination requirement over the next 12 months.

From 31 January we will also be offering vaccinations to children aged 5 - 12 who are clinically vulnerable or live in a household with someone who is immunosuppressed.

2.1.6 Vaccination as a condition of deployment (VCOD)
Following an announcement from the Department of Health and Social Care (DHSC), all staff who undertake CQC regulated activities and have direct contact with patients must be fully vaccinated against Covid 19 by 1 April 2022. This applies to the NHS and independent sector and follows a similar requirement for those working in social care. Across the system we are doing everything possible to support staff who are currently unvaccinated who want to be vaccinated before the deadline.

2.2 Regional update

2.2.1 Leaders meeting
The North East and Yorkshire (NEY) Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During December and January discussions focused on the ongoing Covid response and vaccination programme, urgent and emergency care, winter resilience, planning and recovery and ICS development. Specific pressures on the system, particularly in the ambulance service due to staff sickness levels and the impact of delayed discharge from hospital.

2.3. National updates

2.3.1 Planning guidance
On 24 December, NHS England and NHS Improvement (NHS E/I) released new operational planning guidance for 2022/23, outlining 10 clear priorities for health and care systems to enact over the next two years. Key elements of the guidance include reinforcing and strengthening our workforce, enhancing our access and capacity across primary care networks (PCN's) and continuing with transformation to reduce health inequalities through data and analytics. Covid response and treatment (including vaccination) is also firmly embedded within these priorities aligning this more closely with business-as-usual activities.

These plans are all set against the proposed Integrated Care Board (ICB) formation, which although subject to the Health and Care Bill passage - provides both stability and assurances of the direction of travel for health and care systems in their future operational planning.

2.3.2 GP patient survey
The 2022 GP patient survey was launched on 10 January. The Survey is a key source of information about primary care in England. Last year, more than 850,000 people gave feedback on around 6,700 GP practices. The 2021 results are available on the website, and this year for the first time, ICS slide packs have been produced which provide an ICS level view of the results for key questions from the survey with comparative 2020 data where available.

2.3.3 Weight loss support on the High Street
People struggling to lose weight will now be offered help from their local high street pharmacy in the latest drive to tackle rising obesity levels and type 2 diabetes. Community pharmacy teams can now refer adults living with obesity, and other conditions, to the 12-week online NHS weight management programme. GPs have already referred 50,000 adults to the programme. Adults living with obesity plus hypertension or diabetes will qualify for the service, which people can access via an app on their smartphone.

2.3.4 Childhood MMR Campaign

A new national campaign launches on 1 February 2022 encouraging parents to get their children vaccinated against measles, mumps, and rubella. The goal is to boost parents' confidence that getting their children vaccinated is the right thing to do, by providing information on the risk of measles, mumps, and rubella. The campaign's call-to-action tells parents and carers whose children have missed one of their two MMR doses to contact their GPs and book their vaccine.

2.4 Integrated Care System update

2.4.1 Establishing ICBs postponed until 1 July 2022

In December, the government announced a revised target date for the establishment of ICBs to 1 July 2022 from 1 April as originally planned. The decision was taken based on the anticipated passage of the Health and Care Bill through Parliament. NHS South Yorkshire, the confirmed public facing name for the ICB in South Yorkshire, will now formally establish on 1st July. National and local plans are being adjusted to reflect the new target date.

The change in date does not change our direction but gives more time to deepen preparations and continue to develop more integrated services in our Places and in our Provider Collaboratives and Alliances. The ICB provides the best opportunity to address unfair, avoidable and systematic differences in the opportunity for all our citizens to live healthily and well.

Until 1 July, CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business (collaboratively in cases where there are multiple CCGs within an ICS footprint), through existing governing bodies. CCG leaders will be working closely with designate ICB leaders in key decisions which will affect the future ICB, notably commissioning and contracting. NHSEI will retain all direct commissioning responsibilities not already delegated to CCGs.

However, boundary changes will go ahead on 1 April. This means that Bassetlaw CCG will become part of Nottingham and Nottinghamshire ICS on that date. We are currently developing a Memorandum of Understanding between South Yorkshire and Nottinghamshire to ensure the continuation of joint working between Bassetlaw and South Yorkshire given the important of this to the population of Bassetlaw who access almost all their secondary and specialised care in South Yorkshire.

2.4.2 ICB constitution and establishing ICB Board

The ICB draft Constitution, which set out our Board size, its make-up and approach to our eligibility, nomination and selection criteria was approved by NHS England on 23 December 2021 England.

We began the process for recruiting new executive and non-executive appointments in December with closing dates in January. We have had very encouraging responses so far and particularly from non-executive roles representing local community interests. Interviews are scheduled for February and March. We are continuing advertise for non-executives with specific areas of expertise in finance and strategy.

Over the next couple of months as the new Board is recruited, we will be focusing on discussions with our partners on co-production work to inform wider governance and how NHS South Yorkshire can best support the ambitions and priorities of our Places, Provider Collaboratives and Alliances. We will also be revisiting our current ICS governance in advance of the new statutory arrangements. The new target date of 1 July gives us more time to get the new shadow Board up and running in the first quarter.

The development work in our Places and Provider Collaboratives also continues to progress focussing on ambition and priorities and the arrangements needed to continue to work well together. We are considering the relationship and arrangements needed between these and the future ICB / ICP to continue to support thriving Places and strong and vibrant Provider Collaborates and Alliances.

2.4.3 Organisational development work on functional design

The organisational development work on functional design of the emerging new organisation is now well underway, although some workshops were delayed by a month because of the declaration of a level 4 incident and the need focus on system pressures. Workshops are now rescheduled and are back on track. The process began with the staff most affected by the changes who will become employees of NHS South Yorkshire (ICB) but will now involve the wider one workforce of the ICS and partners. A key objective of the work is to ensure there an understanding of the transferring functions and good practice supporting integration and opportunities.
We have also published a formal response to the Consultation on the proposed new executive board level roles in SY ICB Integrated Care Board. A copy of the report is available to all staff on the SYB Hub. I hosted a webinar for staff to go over the feedback received and answer questions.

2.4.4 ICCS £57.5m capital investment from treasury

SYB ICS have secured £57.5m from the Treasury to invest in primary and community facilities across our region. Only two areas in the country were selected and we will see over 20 projects delivered by the end of 2023 which will be instrumental in allowing us to provide seamless services, improve service quality, improve patient experience and deliver value for money.

2.5. Finance

The system had a £28.7m surplus at Month 8 which was £28.8m favourable to plan. The surplus all sits with provider organisations. The forecast position is a £0.3m surplus which is £0.3m favourable to plan. Organisations have been asked to undertake a detailed review of forecasts at Month 9 and revise forecast accordingly. This exercise is expected to increase the forecast surplus.

Capital spend at Month 8 showed a spend of £57.6m which was £7.4m or 12.8 per cent behind plan. The forecast adjusted performance is break even against plan. Providers have been asked to undertake a detailed review of the forecast at Month 9 and revise the forecast accordingly.

Final draft system allocations have been issued that shows that the system will receive £40.3m additional net resource compared to the opening baseline allocation (1.2 per cent increase). This includes allocation reductions of £147.2m or 4.5 per cent.

2.6 Retirement of Sir Andrew Cash

I would like to formally record my thanks to Sir Andrew Cash on behalf of SYB ICS on his retirement as System Lead for the ICS at the end of January 2022. Andrew has had a long and very distinguished career dedicated to improving patient care. He has made an enormous contribution to the development of the NHS in South Yorkshire and Bassetlaw and the wider NHS over the last six years in developing the ICS and prior to that as CEO of Sheffield Teaching Hospitals NHS Trust from 2004 to 2018. He has also championed partnership working which has been hugely instrumental in ensuring we have become one of the leading ICSs in the country. The transformational work across SYB has touched the lives of many thousands of people improving health and care services and addressing health inequalities.

I know that colleagues within the NHS locally and nationally, local authorities and the voluntary and community sector will join me in thanking him and wishing him well in his retirement. ‘Although Andrew has stepped down as SYB ICS executive lead at the end of January 2022 he will remain involved on a part time basis in helping lead the transition to the new ways of working across the wider NHS , in the North East and in the Yorkshire and Humber (NE and Y and H) for a while yet. He will chair the NE and Yorkshire and Humber Transition Oversight Group for the four ICSs and

Region. I know that he will continue to contribute his wisdom and energies to health and care both locally and nationally'.

Gavin Boyle
Chief Executive designate NHS South Yorkshire Integrated Care Board
Date: 01 February 2022

Richard Jenkins, Chief Executive
The Rotherham NHS Foundation Trust

Oak House, Moorhead Way
Bramley
Rotherham
S66 1YY
07876851849
alison.knowles1@nhs.net
2nd February 2022

Review of TRFT SOF Rating

Dear Richard,

Thank you for meeting with David Purdue and myself to review the Trust's SOF rating. The slides presented by your team provided a helpful update to the Trust's position and are attached to this letter as a reference point.

As background, we noted the removal of the licence undertakings and condition in July 2021 and the NHSEI decision at the same time to remove enhanced oversight in relation the Trust's financial governance and underlying financial position. NHSEI determined that the Trust should remain in SOF3 as the outcome of the CQC re-inspection from summer 2021 had not been published. The CQC report was published in September 2021 with the Trust receiving an overall rating of Requires Improvement and having two s29a notices (Adult Medicine (new) and Emergency Care (existing)) and the extant s31 notice in relation to safeguarding.

The national Oversight Framework does not draw a direct line between CQC ratings and the SOF category for a Trust so the purpose of this review meeting was to discuss whether there had been sufficient improvement in the Trust's quality governance and outcomes to warrant moving the Trust to SOF2.

We used the Trust's slides to discuss the four areas of focus which remain from the Trust's improvement plan. Key points from the discussion included:

I. Staff engagement – the work on culture and engagement continues to show improvement. In the 2021 staff survey (yet to be published) the Trust's position has remained around the median for Picker Trusts with a response rate of 60%, well above the average for similar Trusts of 52%.

II. Mortality – the SHMI score for the Trust is now within the expected range and HSMR is showing a downward trend. Excluding COVID deaths, the Trust's internal calculation is that HSMR is at 101. For COVID deaths, the regional range is 109 – 121 with TRFT at 114. Callum Gardner, Medical Director, reported that the investment in additional consultant posts is having a beneficial impact on the culture and the engagement of consultants in the improvement work. Work continues on individual pathways and the Trust is introducing a "new consultant" development programme to embed new ways

of working. Subsequent to the meeting, Professor Chris Welsh has also confirmed that the Trust has made significant progress on improving mortality.

III. CQC

a. The s29a in relation to acute medicine has been lifted by CQC.

b. In February, the Trust will submit the evidence required to lift the s31 notice on safeguarding. All actions have been completed with the focus principally on paediatric staffing and services but improvements also evidenced in adult safeguarding. Helen Dobson, Chief Nurse, described the much improved front-line engagement in safeguarding huddles from a nursing and medical perspective.

c. The actions in regards to the s29a notice on emergency care have either been completed or are on track to be completed in line with the agreed CQC action plan. The Trust is now reviewing actions to confirm that they are embedded and delivering the anticipated improvement in care and outcomes.

d. The Trust continues to work on improving staffing levels with single figure vacancies at a Trust level. Helen Dobson noted that surgical specialities are better placed than medicine for staffing levels but that, throughout the current period of COVID pressures, the Trust has maintained 2 registered nurses on every shift. The second cohort of nurses through international recruitment arrives imminently and the Trust is participating in the SYB work on HCA recruitment and retention given the turnover in this section of its workforce. The next Board review of Safer Staffing is scheduled for April 2022.

e. The CQC Action Board is chaired by Richard Jenkins and has a plan to revisit all actions in the improvement plan on a rolling basis.

f. The SYB QSG confirmed that the Trust would move back to routine surveillance (from enhanced) in December 2021.

g. The Trust is restructuring its approach to quality governance and developing a business case to support a new approach to Quality Improvement that will be rolled out over the next two years.

IV. UEC Delivery – the Trust's Acute Transformation Programme continues to progress. The strengthening of the Rapid Assessment process has reduced ambulance handovers and the new command centre allows oversight of the whole Trust capacity to facilitate flow.

Alongside the discussion of the improvement areas, we congratulated the Trust on its early achievement of the 104 week RTT ambition for 2021/22 and the progress that has been made towards treating all patients over 52 weeks.

Our conclusion is that the Trust is able to evidence on-going improvement in all areas. The lifting of the s31 notice on safeguarding will be an important next step

and, subject to this, a recommendation will be made to the NEY RSG to move the Trust from SOF3 to SOF2.

Thank you to you and your team for your leadership of the Trust. It is positive to see the on-going improvements and the continued focus on better care for your patients.

Yours sincerely,

Alison Knowles

Locality Director – South Yorkshire & Bassetlaw

NHS England & NHS Improvement | North East & Yorkshire

Cc David Purdue

Appendix 1

Strategic Oversight Framework Meeting

27th January 2022

Contents

- **Context and current position**
- Progress against key areas of focus
  - Staff Engagement
  - Mortality
  - Quality of care as assessed by the CQC
  - Urgent and Emergency Care
- Strategic Oversight Framework Rating Discussion

Our challenges

- At the start of the pandemic, the Board supported six priority areas needing significant improvement which formed the basis for the TRFT Improvement plan, as agreed with NHS E/I:
    - Staff Engagement
    - Mortality
    - Quality of care as assessed by the CQC
    - Urgent and Emergency Care
    - Well Led
    - Financial Improvement
- Our Ambition was to have the Trust's long-standing breach of licence removed, which was achieved in July 2021.

Where we are now

- **Staff Engagement** – 2020 staff survey significantly improved. The embargoed 2021 staff survey demonstrates that the Trust's position has remained around the median (Picker Trusts) whilst being one of the most COVID-19 impacted Trusts in the country. The response rate increased significantly – to 60% - well above the average for similar Trusts of 52%.
- **Mortality** – The Mortality Improvement Group has undertaken significant work and the Trust's SHMI is now within the 'as expected' range. The latest HSMR (excluding Covid) is 101.7.
- **Quality of care as assessed by the CQC** – Whilst the Trust remained RI, Maternity Services were rated as good which is significant.
- **Urgent and Emergency Care** – Whilst our site remains challenged due to the proportion of beds occupied by Covid patients and patients with no right to reside, we have seen very positive results with regards to the management of ambulance handovers and we have frequently supported our partners by taking diverts over the last few months.
- **Well Led** – Significant changes with the CQC noting the improvements in both leadership and culture.
- **Financial Improvement** – major work has been undertaken on financial governance following the challenges relating to the 2019/20 year end adverse movements. Since then, financial plans were delivered for 2020/21 and a favourable outturn is forecasted for 2021/22. The NHS E/I led monthly financial monitoring meeting was stood down in May 2021. It was noted that the positive improvement demonstrated in financial governance and delivery by the Trust during the period of escalated oversight, had improved the level assurance for NHSEI and SY&B ICS. Later in 2021, the ambition to remove the long standing breach of license was achieved.

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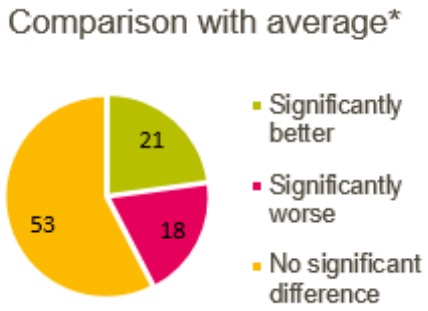
Staff Engagement

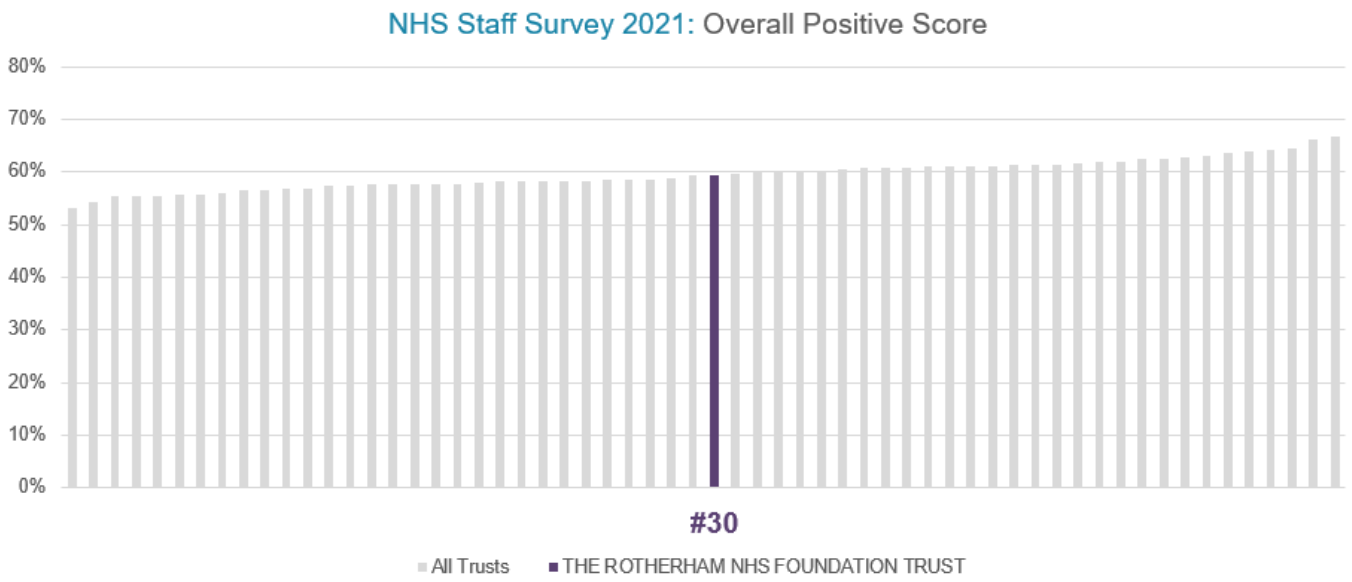
Our response rate was 60% which is a significant improvement on last year, and well above the average response rate

60%	52%	52%
TRFT response rate 2021	TRFT response rate 2020	Average response rate 2021

The majority of responses were similar to other Trusts, although a greater number were significantly better rather than significant worse



Early indications from the benchmarking from Picker suggests our staff survey results will put us around the median of all acute or acute and community trusts

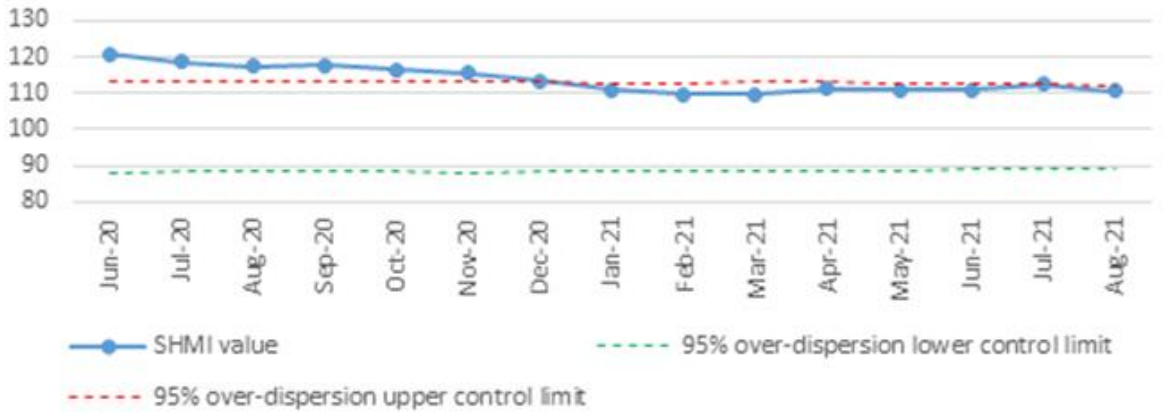


Mortality

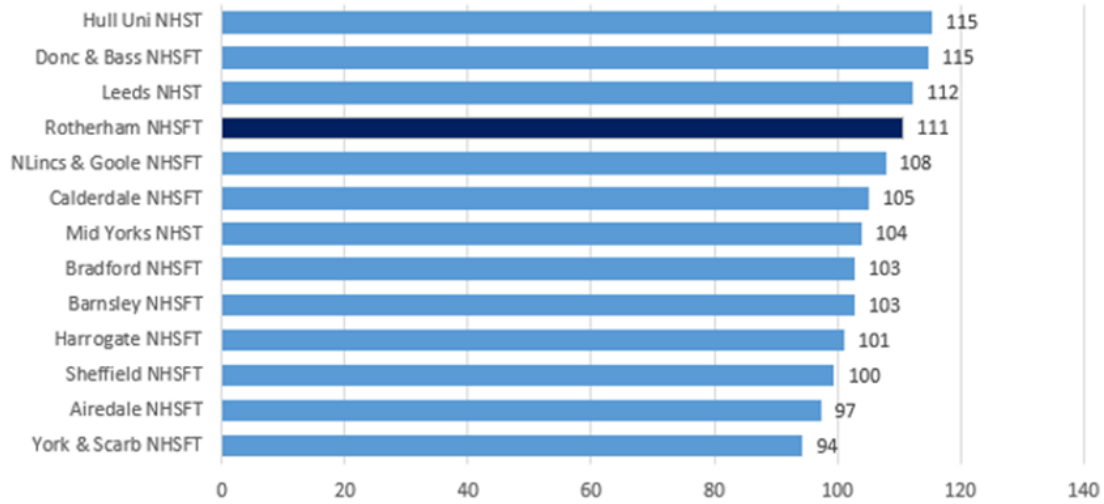
The Rotherham NHS Foundation Trust

The Trust is now within the 'as expected' category for SHMI, and TRFT is no longer an outlier in our region on mortality

SHMI 12-month rolling figure, June 2020 – August 2021



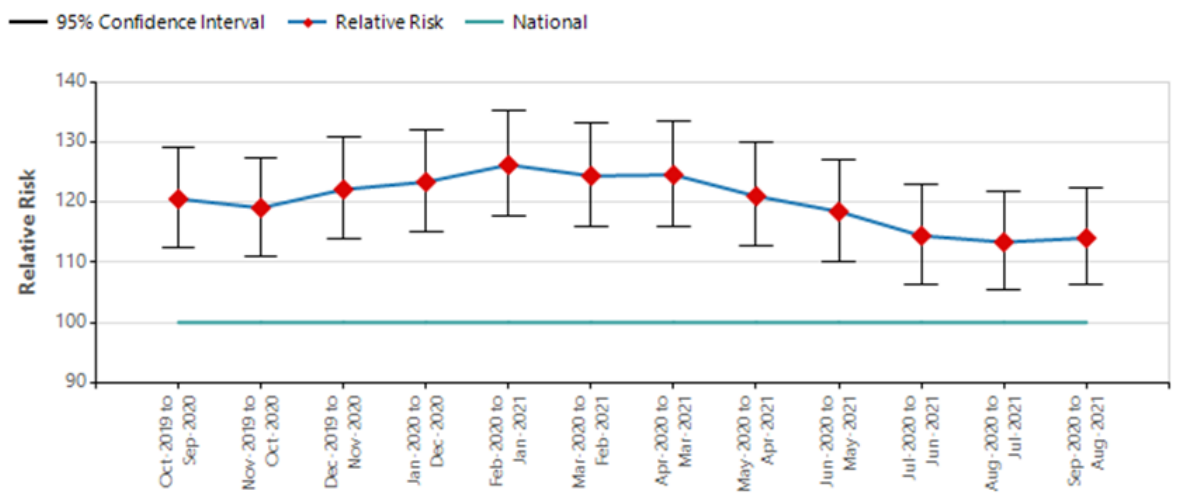
SHMI 12-month rolling figure, August 2021, compared to Yorkshire & Humber Acute Trusts



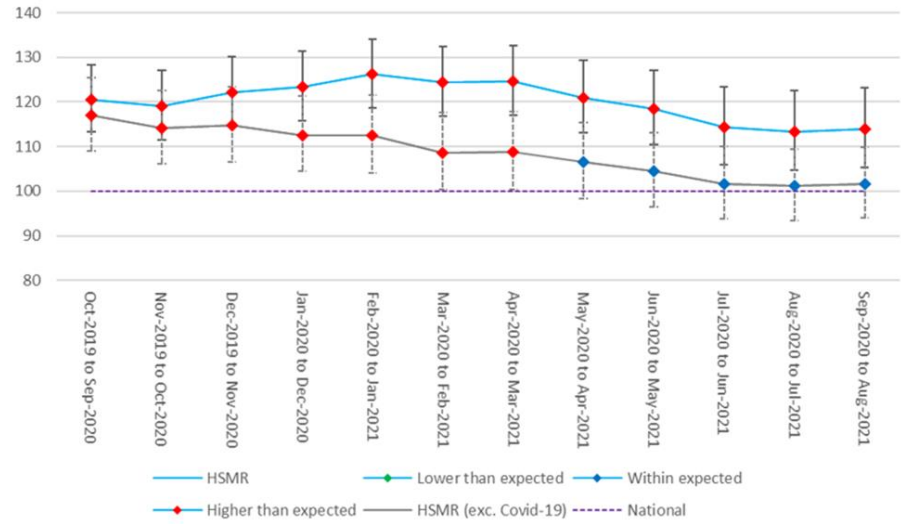
Mortality

Our HSMR has been falling across the same time period, and when the Covid-19 impact is stripped out, our performance is close to the 100 baseline

HSMR 12-month rolling figure, September 2020 – August 2021



HSMR 12-month rolling figure including and excluding Covid, September 2020 – August 2021



Once the 12-month rolling HSMR figure no longer captures the peak Covid period of Winter 2020 (in approximately 6 months' time), the Trust's HSMR value should fall significantly

CQC Assurance

The Trust is currently managing a number of retrospective Action Plans relating to each of the CQC Inspections that occurred between 2018 and 2021. The Action Plans are set out below:

- Section 31 Action Plan (October 2018) – Urgent and Emergency Care
- Section 29a Action Plan – (November 2020) – Acute Medical Unit
- Section 29a Action Plan – (August 2021) – Urgent and Emergency Care
- Must/Should take Action Plan – (September 2021) CQC Inspection

The Trust CQC Delivery Group – led by the Chief Executive - provides the operational oversight on progress against the plans. The group meets on the second week of each month to facilitate timely reporting to the Trust Quality Committee and Board of Directors. Each clinical area presents progress against their actions, providing mitigation for any action 'off track' and evidence where actions are deemed to be sustained and embedded into business as usual processes.

Updated versions of three of these Action Plans were submitted to the CQC within their agreed timeframe on 1 December 2021:

- Section 29a Acute Medical Unit
- Section 29a Urgent and Emergency Care
- Must/Should Take Action Plan from the 2021 CQC Report

CQC also receive the Minutes and Chair's Log from the CQC Delivery Group and the Quality Committee CQC Assurance Report each month. This stimulates further discussion at the routine CQC Engagement meetings.

CQC Assurance: Section 31 – Urgent and Emergency Care (2018)

- Received following the 2018 Comprehensive CQC Inspection due to concerns regarding safe care and treatment of children attending the paediatric emergency department, resulting in a condition being imposed on the Trust's Certificate of Registration. The condition set out the requirement to ensure the provision of two sick children's nurses and oversight by a medical consultant 24 hours a day, seven days per week.
- The Trust can demonstrate there are robust systems and processes in place to identify and escalate any staffing shortfalls in this area and take appropriate and timely remedial action. Actions included new roles, recruitment to full establishment and active training programme.
- Nursing leadership changed on the 10 January 2022, to formally integrate the Paediatric Emergency Service with the overall Children and Young People's Core Service. This will facilitate greater flexibility, skills and competencies of the workforce, leading to increased recruitment, staff satisfaction and patient safety.
- A Paediatric Safeguarding Action Plan linked to the section 31 was closed last year following completion of all actions and has recently been assessed to confirm actions are now embedded.

"As Designated Nurse for Safeguarding and Looked After Children my role has been made more effective due to staff willingness in TRFT to 'think the unthinkable' to 'see, hear and report' and to maintain, during challenging times, the capacity to 'professionally challenge' and be 'curious'. Whilst these are all clichés, the dedication of the staff to protect and promote wellbeing isn't, its innovative, refreshing and proactive. I am proud to work alongside TRFT staff. Yes there is always more we can do – but the energy to do more is there."

Catherine Hall, Rotherham CCG

The Trust is on track to formally apply to have the condition of the Section 31 lifted in Quarter 4, with submission of the application scheduled for January 2022.

CQC Assurance: Section 29a - Acute Medical Unit (2020)

In response to the Section 29a Warning Notification imposed on the Acute Medical Unit (AMU) in November 2020, the Trust were required to submit progress against the Action Plan monthly.

CQC visited the Unit as part of their routine Engagement meeting on 8 December. They met with a number of staff, including the Medicine Triumvirate, the Matron and Ward Manager and spoke to a number of staff. The Unit was included in the inspection of the Medical Care Core Service in May 2021 where no further concerns were raised.

CQC colleagues confirmed that the Section 29a is now closed. Continued monitoring of the improvements made will be via periodic reporting through to CQC Delivery Group to ensure the Unit maintains their improved position. This is a very positive step for the Trust, but in particular is testament to the commitment and engagement of the AMU team to deliver consistently safe, high quality care.

CQC Assurance: Section 29a – Urgent & Emergency Care (2021)

UECC received a Section 29a Warning Notification as part of the 2021 Inspection cycle, raising 48 individual concerns. As with the Must and Should take Action Plan a number of sub-actions (106) have been identified against each of the elements of the Warning Notice. The table below illustrates progress to date as of 11 January.

During the on-site CQC Engagement meeting on 8 December, CQC colleagues visited the UECC and met with a number of staff. They were pleased to note the work that is being undertaken and in particular, the specific focus on staff engagement demonstrating that the concerns raised during the May/June visit are being addressed and that staff across the department are being actively encouraged to be fully involved in the improvement journey.

Core Service Area	No of issues	No of actions	Red	Amber	Green	Blue	Grey
Within the UECC, there was evidence that patients were not always receiving safe care and treatment	21	62		9 (14.5%)	53 (85.5%)		
There were issues around the safeguarding processes for both adults and children, which could increase the risk of harm	7	18		4 (22.2%)	14 77.8%)		
There was evidence to show that not all patients received appropriate patient centred care	8	14		2 (14.2%)	12 (85.8%)		
Leadership, systems and processes were in place within the Department that were not being consistently applied. Audits were not consistently completed appropriately. Issues, whilst identified were not being addressed in a timely manner	12	12			12 (100%)		
Total	48	106	0 (0%)	15 (14.2%)	91 (85.8%)	0 (0%)	0 (0%)

CQC Assurance: Must Take Action Plan (2021)

82 Must and Should take issues were identified within the 2021 Inspection Report. In order to fully address each concern a number of sub-actions (229) have been agreed to ensure delivery of the required improvements. The table indicates the total number of actions per core service area and it is against this number that progress is monitored via the CQC Delivery Group. The table illustrates progress against the actions as of 11 January.

To note: Actions in the 'Blue' column denote those that have been approved as embedded by CQC Delivery Group. Actions in the 'Grey' column denote those actions where final completion is dependent on external stakeholder input.

Core Service Area	No of issues	No of Action	Red	Amber	Green	Blue	Grey
Trustwide	4	9			9 (100%)		
Urgent and Emergency Care	30	93		17 (18.3%)	76 (81.7%)		
Medical Care	18	72		1 (1.4%)	70 (97.2%)		1 (1.3%)
Maternity	6	10			10 (100%)		
Children and Young People	24	45	0 (0%)	22 (49%)	7 (15.5%)	15 (33.3%)	1 (2.2%)
Total			0 (0%)	40 (17.5%)	172 (75.2%)	15 (6.5%)	2 (0.8%)

Outputs from the Stakeholder Quality Meeting CQC

- Stakeholder Meeting (23/11/2021) and QRP outcome at QSG (December 2021)

  - Excellent engagement and ownership from TRFT who acknowledge CQC's inspection findings, with positive progress now evident
  - Rotherham CCG noted that Contract Quality Meetings, the Clinical Governance Committee and Safeguarding Strategic Meeting routinely discussed progress, sharing information and escalating as needed
  - Enhanced surveillance no longer required due to the positive and embedded changes required to continually strive for improved patient safety, quality of services and outcomes.
  - QSG approved the move to Routine Surveillance for TRFT in Dec 2021

  Kirsty Leahy, Head of Quality, Rotherham CCG

Urgent and Emergency Care

The Rotherham NHS Foundation Trust

Whilst there has been a significant regional and national challenge on ambulance handovers, TRFT has performed relatively well, and this is an improving picture

SYB Ambulance handover performance, 1st December 2021 – 26th January 2022

Cluster	Conveyances	Attends w Hand over Time	Avg Arrive To Notify Time (hh:mm:ss)	Average Hand over & RAG (hh:mm:ss)	Average Turn around (hh:mm:ss)	HO <15m	HO <15m %	HO 15-30m	HO 30m-1Hr	HO 1-2Hrs	HO >2Hrs	HO >1Hr%	Longest Handover Duration* (hh:mm:ss)	Lost HO Time (hrs)	Avg HO Lost Time (mins)
South Yorkshire	**18,170**	**15,055**	**00:03:58**	**00:33:16**	**00:50:50**	**5,165**	**34%**	**4,718**	**2,999**	**1,582**	**591**	**14.43%**	**05:59:56**	**5,108.4**	**31.0**
Barnsley District General	3,807	3,369	00:03:33	00:20:18 ✗	00:38:56	1,588	47%	1,183	489	102	7	3.24%	02:49:21	442.2	14.9
Doncaster Royal Infirmary	4,430	3,635	00:04:53	00:40:59 ✗	00:57:01	1,113	31%	1,016	724	532	250	21.51%	05:18:14	1,701.0	40.5
Northern General Hospital	6,031	4,525	00:03:51	00:41:36 ✗	00:58:03	846	19%	1,440	1,328	680	231	20.13%	05:59:56	2,090.5	34.1
Rotherham District General Hospital	3,902	3,526	00:03:31	00:27:02 ✗	00:44:14	1,618	46%	1,079	458	268	103	10.52%	04:17:28	874.8	27.5
Total	**18,170**	**15,055**	**00:03:58**	**00:33:16**	**00:50:50**	**5,165**	**34%**	**4,718**	**2,999**	**1,582**	**591**	**14.43%**	**05:59:56**	**5,108.4**	**31.0**

❶ Whilst turnover times are above target, we have got the 2nd lowest turnaround time in SYB, 6 minutes below the SYB average. Across the latest period, that has saved 430 hours of ambulance crew time, which is the equivalent of 18 days

❷ Almost 1 in 2 of our ambulance handovers occur within the 15 minute target, compared to 1 in 3 across SYB overall

❸ 10% of handovers are taking over an hour, but this is an improvement on the August to January data, where the equivalent figure was 18%.

Acute Care Transformation Programme (ACT)

We have established a new large-scale transformation programme to focus on developing more effective non-elective pathways, improving patient care, implementing the right workforce model and developing a cohesive and effective team.

ACT Steering Group
Chair: Richard Jenkins
Executive Lead: George Briggs

THEME 1: Workforce
Local Lead: Jez Reynard
Executive Lead: Steve Ned

- Review and benchmark staffing establishments
- Right staff, right place, right time
- Opportunity for new roles

THEME 2: Leadership & Staff Engagement
Local Lead: Lesley Hammond
Executive Lead: Michael Wright

- Leadership structures in place to engage with staff
- Development of individuals and teams
- Communication and engagement plans

THEME 3: Pathways
Local Lead: Kay Stanton
Executive Lead: George Briggs

- Ambulatory pathways out of UECC
- Avoid use of UECC where possible
- Condition-specific pathways

THEME 4: Patient Experience
Local Lead: Fiona Middleton
Executive Lead: Helen Dobson

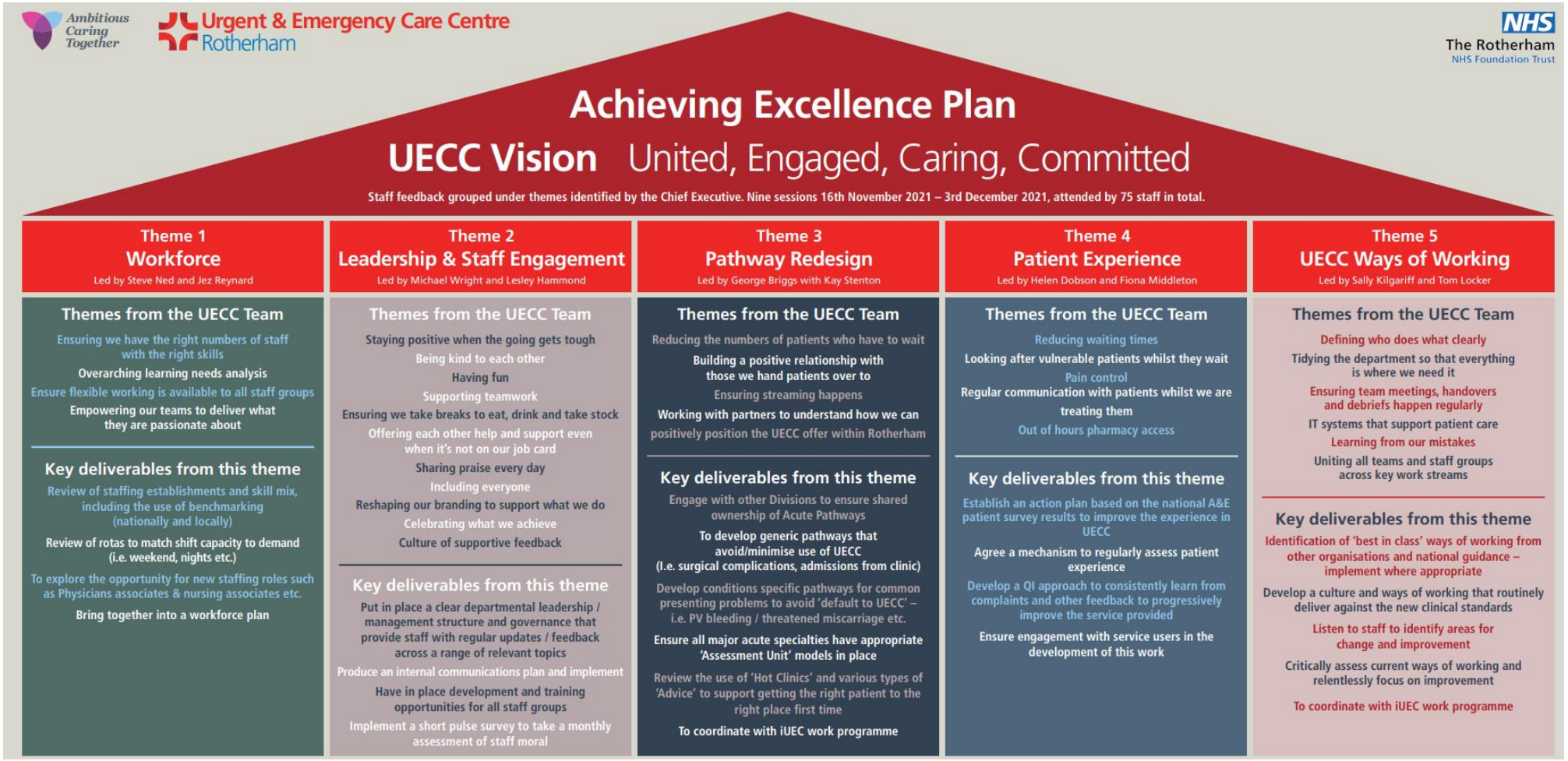
- Actions from A&E national survey
- Mechanism to regularly assess feedback
- QI process to learn from patient feedback

THEME 5: UECC Ways of Working
Local Lead: Tom Locker
Executive Lead: Sally Kilgariff

- 'Best in class' ways of working
- Culture to deliver constant improvements
- Critically assess current ways of working

Acute Care Transformation Programme (ACT)

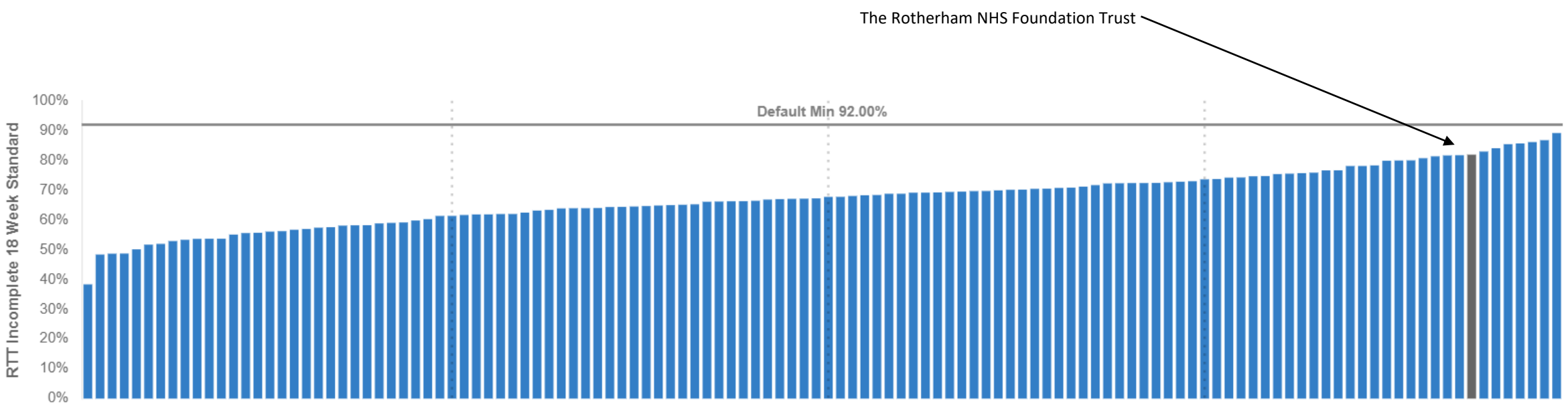
Following a series of listening events with the UECC teams, a 'plan on a page' has been developed to give the team purpose, direction and clarity of focus for the coming months



Elective Recovery

Whilst it wasn't part of our initial improvement plan, it is worth recognising the significant achievements of the Trust around elective recovery, with the Trust the 8th best acute or combined trust in the country in the latest national data

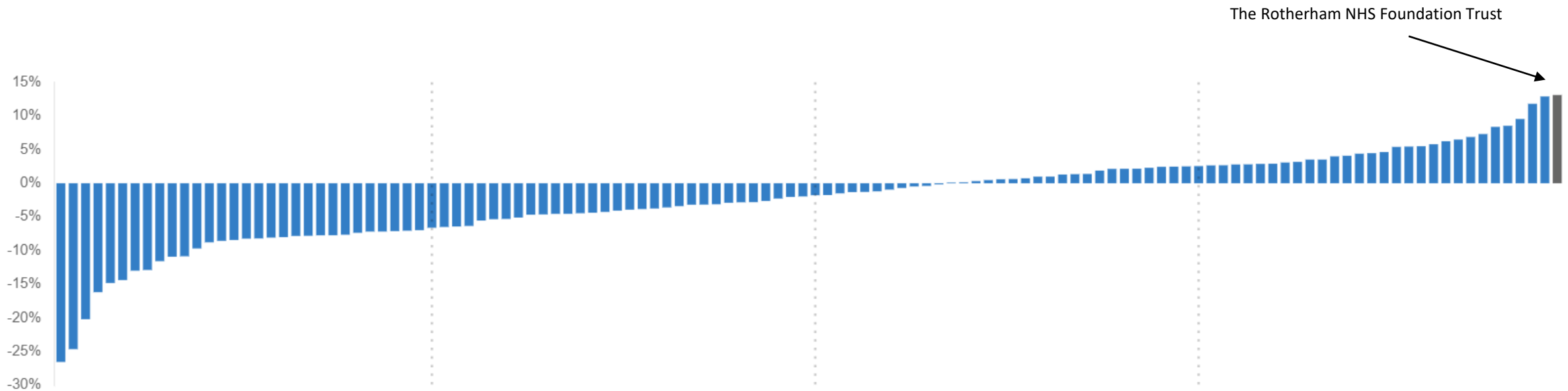
RTT Incomplete Standard for all acute or combined providers, November 2021



Elective Recovery

And this is on the back of delivering the most improved RTT position in the country over the last 12 months for the second consecutive month, demonstrating how teams have delivered following the intense and prolonged Covid pressures that the Trust experienced in 2020

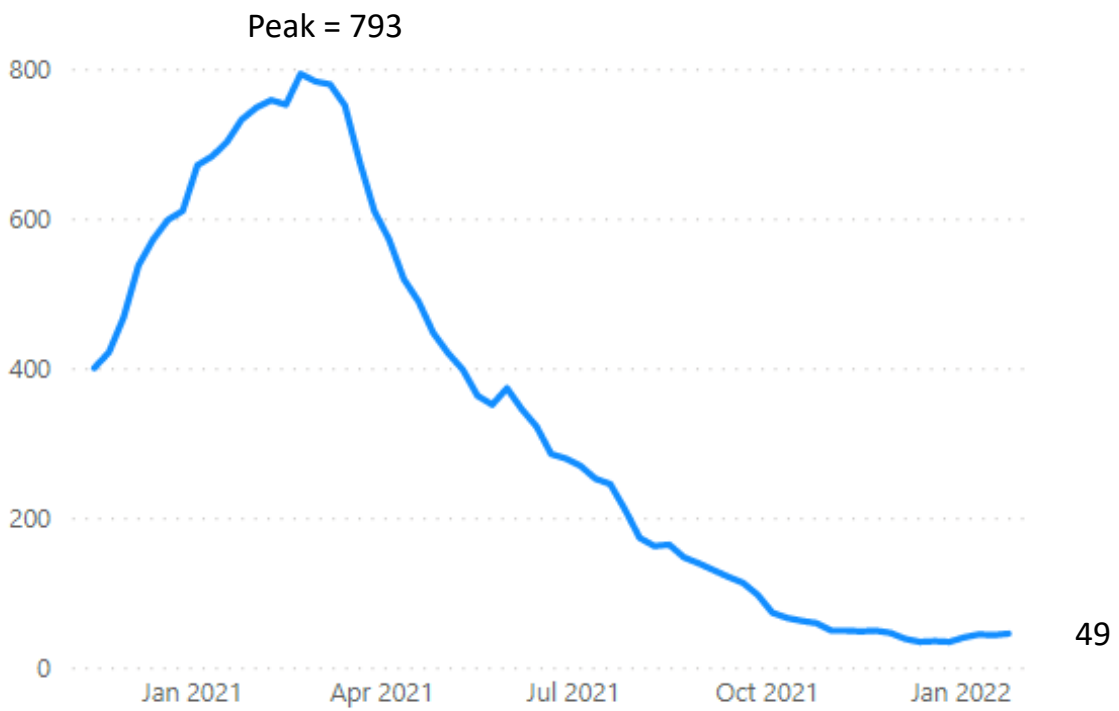
RTT change in incomplete standard performance, November 2020 – November 2021



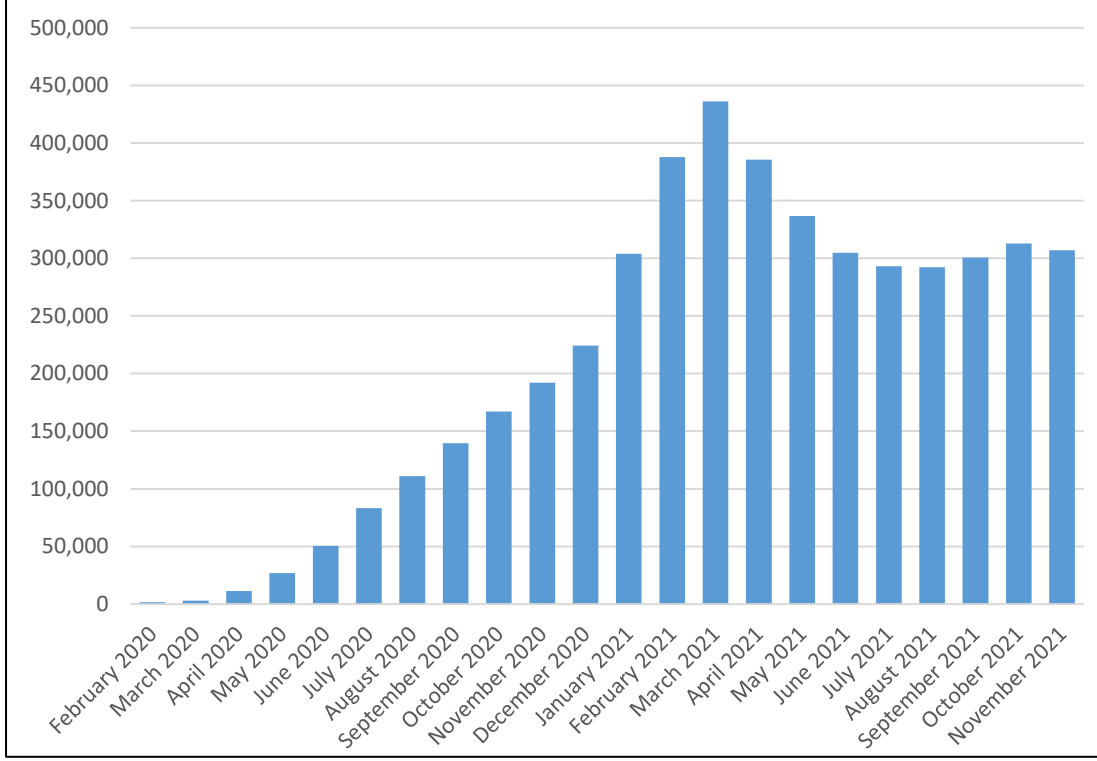
Elective Recovery

We have reduced the number of patients waiting over a year by over 95% from the peak in February, which is a very different profile to the national picture

Numbers of patients waiting 52 weeks or longer, The Rotherham NHS Foundation Trust, Nov 2020 – January 2021



Numbers of patients waiting 52 weeks or longer, England total, Feb 2020 – Nov 2021



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Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P38/22
Report	**Responsible Officer Quarterly Report**
Executive Lead	Dr Callum Gardner, Executive Medical Director & Responsible Officer
Link with the BAF	B1; B4; B5; B7
How does this paper support Trust Values	Demonstrates that medical staff are supported and engaged by the Trust to ensure that they have opportunity to reflect on clinical practice.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐

Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to present to the Board details of activity related to Medical Appraisal and Revalidation, as per NHS England and GMC regulations.
	
	Key points:
	• NHS England guidance has not changed and focus is on being supportive. At The Rotherham NHS Foundation Trust (TRFT), we ensure that appraisals are supportive but do not use the abridged form. GMC has encouraged colleagues to discuss feedback from all sources at each appraisal.
	• All the appraisals for the second quarter have been completed.
	• Patient feedback continues to be an issue and has been the cause for a couple of deferrals for recommendation of Revalidation in the third quarter.
	• The Appraisal team have had relevant training and are working on the Allocate eAppraisal platform for all new appraisals. All appraisers have now been trained and are being supported.
	• Quarter 3 2021/22 appraisal performance:
	  • 75 doctors were due their appraisal in Quarter 3. Of these:
	  o 74 have completed and one has been booked for 22/2/22; this colleague is being supported.
	  o There are no doctors who are a current cause for concern with non-engagement.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Not applicable - presented to the Board on a quarterly basis, but no other Committee. However, this report will be presented to the quarterly Responsible Officer's Advisory Group (ROAG) moving forward and has been discussed and approved.
Board powers to make this decision	N/A

Who, What and When (what action is required, who is the lead and when should it be completed?)	Continued weekly oversight by the Medical Director/Responsible Officer, and quarterly oversight by the Responsible Officer's Advisory Group (ROAG).
Recommendations	It is recommended that the Board notes the quarterly data.
Appendices	1. Medical Appraisal Figures for Q3 2021/22

1.0 Introduction

1.1 NHS England has continued to focus on appraisal as being supportive and reflective conversations, with less emphasis on written documentation. Revalidation recommendations have been deferred in a few cases due to difficulties with obtaining patient feedback, predominantly due to the impact of the pandemic.

2.0 Performance

2.1 The processes of Appraisal and Revalidation has embraced the new Allocate eAppraisal system. All appraisals from February 2022 are on this system. This has required a steep learning curve for the appraisal team and clinicians/appraisers involved, compounded by some challenges in gaining adequate Allocate support in a timely manner, which has been picked up and supported by the Medical Director. The figures for 2021-2022 will not be accurate on the reports run via Allocate, as it has only been in place for the last quarter.

2.2 We currently have 19 appraisers, with a target of 26. A few appraiser have retired from the Trust and from this role. One colleague was appointed at the last interview and is due to be trained on 25/3/22. Further interviews are booked for March 2022.

2.3 The AMD for Appraisal, Revalidation and Mentorship has been in role from September 2021 and has completed his Responsible Officer (RO) training.

2.4 A new, purpose-built appraisal room was inaugurated by Dr Cooper, previous Interim RO, that has been set up to provide a private confidential space for these meetings to take place. Almost all appraisal meetings are now taking place in this room and the feedback both from appraisers and appraises is positive.

2.5 Feedback from completed appraisals for 2020/21 is extremely positive, and this has been shared with all appraisers. Feedback is now mandatory on the Allocate system for the appraisal document to be locked down, and so far has been overwhelmingly positive.

2.6 Flows of information to doctors regarding complaints, compliments and incidents remains variable and some doctors have highlighted the difficulty in easily accessing this information. The Medical Director and his new Business Manager are reviewing how this data flows to Trust Doctors and it is envisaged that we will move to an appraisal ‘data pack’ for each Doctor. This data pack should incorporate all of the elements mentioned above, but this should also be ‘no surprise’ to the Doctor receiving it. The data pack should administratively support the Doctor in collating all the relevant information required for appraisal to aid their reflection and learning. This should also avoid the Doctor having to contact multiple departments for this information. This has not yet been completed but it is the intention to introduce this from the beginning of the next Financial Year.

2.7 The Appraisal Policy was ratified in August 2021 and is now ‘live’ on the Hub. However, this policy will now be subject to a substantial rewrite as we move to e-Appraisal, with the intention of approval in Quarter 1 of 2022/23.

2.8 The NHS England Revalidation checklist is in now use at TRFT, with some additional fields added by the Trust’s Responsible Officer. The form ensures that each Revalidation review follows the same checks and balances prior to a recommendation being made to the GMC and that there is an auditable trail of these decisions. The

document is populated and checked by the AMD for Appraisal, Revalidation and Mentorship and then sent to the RO for checking and approval. This is then filed.

2.9 Communication with the GMC regarding concerns has continued throughout this time via the Employer Liaison Adviser (ELA) network.

2.10 Although the General Dental Council does not require dentists to have an appraisal separate from job planning, the Trust's Clinical Director for Dentistry has agreed, at the request of the Medical Director, to use a supportive appraisal document for TRFT's community dentists and to send a copy to the appraisal office to be filed thereafter, which will also be shared with the RO.

3.0 Conclusion

3.1 Despite the pandemic, good performance has been maintained, although there have been some last-minute postponements due to Colleagues being asked to do clinical work or colleagues having to isolate with SARS-COV2.

3.2 The highly personalised approach we have taken in appraisal has helped to support Doctors during times of great challenge, and feedback suggests that it has been valued and appreciated.

3.3 The e-Appraisal system is progressing well, with the first cohort of Doctors now undertaking their appraisals on the system.

Dr Callum Gardner
Executive Medical Director & Responsible Officer
February 2022

Appendix 1

Indicator		Q2 01/010/2021 – 31/12/2021
1	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	75
1.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period	74
1.2	Number of those within ♯3 above who **did not hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	1 RO aware
1.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	1 RO aware
1.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**	0

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P39/22
Report	**Guardian for Safe Working Quarterly Report**
Executive Lead	Dr Callum Gardner, Executive Medical Director
Link with the BAF	B1, B2 & B4
How does this paper support Trust Values	**Ambitious** - for improvement in working conditions and patient safety. **Caring** - for colleagues and patients. **Together** - solutions are proposed after discussion has identified problems.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	Under the 2016 Junior Doctor Contract, a quarterly report from the Guardian of Safe Working is required to provide assurance to the Board that working in the Trust is safe. The Contract specifies maximal shift durations, total hours per week, and hours worked without breaks. Since last quarter's report, Exception Reports from Surgery have fallen, owing to new substantive staff starting in November. In Medicine, Exception Reports have accelerated towards the end of the quarter due to winter pressures and COVID absences. The intensity of working remains high and is sometimes flagged as unsafe by the most junior trainees in Medicine. Overall hours worked are not unsafe. Re-deployment of trainees to address rota gaps has been approved, if necessary.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Report collates information from the Allocate system for exception reporting, the Junior Doctors' Forum (JDF) monthly meetings, the Datix system, personal communication, and assorted email correspondence. It has been prepared by Dr Gerry Lynch, The Rotherham NHS Foundation Trust's Guardian of Safe Working, and sponsored by Dr Callum Gardner, Executive Medical Director.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	Dealing with the issues raised in the Junior Doctor Forum (JDF), which takes place monthly (JDF attendees include medical staffing, the Medical Director, Director of Medical Education and the Trust's Guardian of Safe Working).

Recommendations	It is recommended that the Board notes this report.
Appendices	None

1 Exception Report (ER) Quarterly update

1.1 In the last quarter, as of 8th January 2022, 29 doctors, (14 FY1, 4 FY2, 5 CT/ST1, 1 CT3 and 5 ST2's) submitted 102 Exception Reports related to hours worked. There were 17 Exception Reports related to education, 10 to service support, 1 to pattern and 5 to rest/breaks.

1.2 Total overtime hours claimed for were 107.5 for normal time hours and 1 for premium time hours.

1.3 Five reports cited an immediate risk to safety:

- 1 from Obstetrics and Gynaecology involving a long day without breaks for a Registrar.
- 2 from Cardiology relating to the same day with poor cover for CCU and A1.
- 1 from Care of the Elderly had a very large number of patients across 2 Wards being looked after by 2 Junior Doctors.
- 1 from AMU related to a 1.5 hour overstay for a Junior Doctor.

1.4 Educational Supervisors have again struggled to keep pace with the volume of Exception Reports, and the Guardian for Safe Working has dealt with the majority for payment.

1.5 No fines have been issued for persistent hours worked over contractual maxima or missed breaks.

2 Exception Report Quarterly details (as of 8/01/22)

Working hours:

(Sub) Specialty	Exceptions	Daytime Hours	Night time hours
General Medicine	48	52	
Cardiology	3	1.5	
Respiratory	9	13.5	
Care of the Elderly	17	20.25	.75
Acute Medicine	6	5.25	
Diabetes	3	3.25	
Medical Division Total	86	95.75	
Orthopaedics	2	1.25	
General surgery	6	3.75	.25
Paediatrics	1	2	
ED	0	0	
Obstetrics/Gynaecology	7	4.75	
Trust total	**102**	**107.5**	**1**

3 Qualitative Examples From Exception Reports

"*Didn't get to have any break during my shift from 8:00 to 16:00 and stayed late."*

"72 patients on 4 different wards but only 2 juniors allocated. One locum sent but ratio of patients to juniors still unsafe."

"Specialist reviews occurring near or after 4pm (end of shift). Jobs not completed by specialists and asked to in notes."

4 Actions Taken To Mitigate

4.1 Medical & Dental Workforce manage rota gaps and source Locums to the best of their ability, moving trainee doctors to where need is greatest on a daily basis, factoring in absences and patient numbers. This is challenging, especially as COVID absences increase.

4.2 The Guardian for Safe Working has raised any serious problems highlighted in Exception Reports as soon as possible to the divisional leadership in Medicine, as well as to Medical & Dental Workforce where appropriate; in particular, any which might pose genuine immediate threats to safety.

4.3 In response to COVID-19 absences in Medicine, redeployment of doctors has been approved by HEE, Medical & Dental Workforce and the Director of Medical Education, if absolutely necessary, to strengthen the medical teams.

4.4 Regular discussion of all concerns at the Junior Doctors Forum, attended by representatives from Medical & Dental Workforce, Divisions, the Medical Director, Director of Medical Education and the Guardian for Safe Working.

4.5 The exception in Obstetrics and Gynaecology was investigated by the trainee's Educational Supervisor and improved communication at handover put in place to guard against recurrence, along with active check-in by other team members within the SHO tier.

4.6 The Director of Medical Education and Foundation Director are also instrumental in raising issues coming to their attention and all are available to trainees for support.

4.7 The Medical Director continues to have fortnightly diary time set aside to meet with Junior Doctors.

Dr Gerry Lynch
Guardian for Safe Working
February 2022

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P40/22
Report	**Freedom to Speak up Guardian Quarterly Report**
Executive Lead	Helen Dobson, Interim Chief Nurse
Link with the BAF	B1, B4
How does this paper support Trust Values	Promoting a culture of Speaking up within TRFT supports all three of the Trust values of ambitious, Caring and Together
Purpose	**For decision ☐ For assurance ☒ For information ☐**
Executive Summary (including reason for the report, background, key issues and risks)	To provide the Board with an update of concerns which would be deemed whistleblowing, raised both to the Freedom to Speak Up Guardian and through other official routes and offer a comparison for TRFT against other local and similar sized organisations To provide an update of how the profile of the Speaking Up agenda is being raised and embedded within The Rotherham NHS Foundation Trust. **Summary of Key Points:** The key points arising from the report are • 7 concerns raised during Q3, two of which relate to patient safety • Update on concerns raised by overseas nurses during Q2 • West Suffolk NHS Foundation Trust Review – NHSE/I • New National Guardian appointed Dr Jayne Chidgey-Clark • TRFT circulated 5in5 in relation to open and honest safety culture December 2021 • Awaiting the National Guardians Office (NGO) final e-learning package for senior manager package (expected in Q4) • TRFT FTSU Policy reviewed • Quarterly Trust Guardians report sent to NGO • Regional NGO meeting attended • MaST E-learning now fully rolled out (Trust Compliance of 97.02%). Awaiting agreement from Operational Workforce Group (OWG) March 2022 meeting on refresher periods • One FTSU ambassador has left the Trust

	• NGO published self-review for Lead Guardian skills/training • NGO are looking at a national register for FTSUG there will be a training programme that comes out and a pass or fail questions at the end. • NGO are going to be looking for guardian mentors to help support new FTSUG. • FTSU index has gone not replaced with anything.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper does not go through any other processes as it is prepared for the Board's information only
Board powers to make this decision	N/a
Who, What and When (what action is required, who is the lead and when should it be completed?)	No further action required from the Board
Recommendations	It is recommended that the Board note the Q3 report.
Appendices	None

1. Introduction

1.1 The FTSU Guardians initiative was implemented following the Francis Report (2015). The aim of Freedom to Speak Up Guardians (FTSU) is to help create a culture of openness within the NHS, where staff are encouraged to speak up, lessons are learnt and care improves as a result.

1.2 The Trust introduced FTSU Guardians (FTSUG) in 2015, with a FTSUG lead appointed in October 2016. The NGO have now appointed Dr Jayne Chidgey-Clark as the new National Guardian.

1.3 The report aims to provide the Board with a high-level overview of the activity undertaken by the FTSUG during quarter one 2021, highlighting the number of concerns raised, actions taken and resultant learning.

2. Background

2.1 This paper provides a review of FTSU concerns raised within the Trust during quarter three 2021/22 and an update following the last quarterly report in October 2021. The report also details extracts of the data collated by the National Guardians Office (NGO), including national and regional comparative data in order to contextualise the FTSUG agenda within TRFT.

3. Reporting and Governance

3.1 The FTSUG lead has remained the responsibility of the Chief Nurse. The FTSUG lead is Tony Bennett who covers the role on a 0.2 WTE.

3.2 During quarter three there were seven concerns raised with the FTSU lead, which is a decrease of one from quarter three 2020/21. Two concerns directly relate to patient safety in the Trust's community bed base. These are being monitored and the respective heads of service have provided unequivocal support to the FTSU lead.

3.3 The other concerns raised related to culture, an allegation of fraud and one in relation to meditech. These were all signposted and where necessary escalated to the relevant areas for further investigation. The allegation of fraud was quickly negated with no requirement to involve 360 assurance.

3.4 In quarter two nine concerns were raised by international nurses based across the Trust, which related to attitudes and behaviour. They have all been supported and are now reporting improvements in culture. The FTSU and equality and diversity leads will continue to monitor and engage.

3.5 The FTSUG lead continues to meet quarterly with the Chief Executive, Chief Nurse and Director of Workforce which provides an opportunity for discussion regarding issues raised and potential learning opportunities. The FTSUG lead has also had regular support from the Senior Independent Director (SID) regarding issues and themes.

3.6 The Trust has an overall compliance rating of 97.02% for FTSU MaST e-learning training with every Division being above the target of 85%.

Division	165|LOCAL|Freedom to Speak Up 1 - Raising a Concern (Whistleblowing) - No Specified Renewal|
165 Clinical Support Services L3	97.55%
165 Community Services L3	98.40%
165 Corporate Operations L3	97.87%
165 Corporate Services L3	97.76%
165 Emergency Care L3	96.37%
165 Family Health L3	97.94%
165 Medicine L3	93.17%
165 Surgery L3	96.76%

3.7 Learning and development will be discussing what constitutes regular training with the Trust Workforce Committee during quarter 4 with the view to increasing the regularity of FTSU training.

3.8 Due to delays in the circulation of the New NGO Policy template, the existing TRFT policy has been reviewed and is being circulated amongst stakeholders for comment. The policy will be further reviewed when the national document is published.

3.9 The NGO have published self-review for Lead Guardians to monitor their own skills/training against nationally agreed standards. They are also considering creating a national register for FTSUG that will be contain a training programme that comes with a pass or fail.

4. National Guardian Office Data

4.1 The Trust has submitted data on a quarterly basis to the National Guardian's Office. The portal for submitting quarter three data has just closed.

4.2 The publication of the NGO index has ceased and as yet there are no plans to replace it.

5. TRFT Comparison with National Data

5.1 TRFT data will be assessed against national data gathered from the staff survey and reported in the quarter 4 FTSU report.

6. National Guardian Office Case Reviews

6.1 The NGO have circulated a new gap analysis tool based on the recommendations of previous case reviews. TRFT previously conducted its own gap analysis and incorporated these recommendations into our FTSU approach. The new national gap analysis template will be completed during Quarter 4.

6.2 The link below is the report from NHSE/I in relation to the West Suffolk NHS Foundation Trust and its investigation into an anonymous letter sent to a deceased patients next of kin in 2018.
https://www.england.nhs.uk/east-of-england/wp-content/uploads/sites/47/2021/12/west-suffolk-review-081221.pdf .

6.3 The review into the events at West Suffolk are a reminder to all organisations to respond in the spirit of the principles of Freedom to Speak Up when workers speak up – wherever, however and whoever they speak up to.

6.4 The NGO published a case review on Blackpool Teaching Hospitals NHS Foundation Trust during quarter two. After reviewing, the recommendations made within the report there were no additional gaps identified in TRFT's approach to speaking up

7. Conclusion

7.1 The culture towards speaking up is improving at TRFT and it is apparent from speaking to managers that they now welcome staff raising concerns with the FTSU lead that would otherwise have gone unheard.

7.2 Our aim is to be a Trust where everyone from front line care to Board level is committed to supporting a transparent and open culture, where all staff including: agency workers, temporary workers, students, volunteers, governors and other stakeholders are encouraged and confident that they are able to 'Speak Up'.

Anthony Bennett
Lead Freedom to Speak Up Guardian
February 2022

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P41/22
Report	**Policy for Safeguarding Children Supervision**
Executive Lead	Helen Dobson, Interim Chief Nurse
Link with the BAF	B1 - Standards and quality of care B6 – Robust Trust-wide quality and clinical governance.
How does this paper support Trust Values	This paper supports the Trust's ambition to continually improve the quality of care that is delivered and supports the Trust's Ambitious value through the management of quality standards and delivery of robust safeguarding arrangements. Caring is demonstrated by the activity to provide safe care to our patients and Together shown by our partnership working, both within and external to the Trust.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Policy describes the arrangements implemented within the Trust for the delivery of Safeguarding Children supervision. The Policy sets out clearly the different requirements for professionals dependent on their role and contact with children.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This Policy was presented and approved at the Quality Committee in January 2022. It will be uploaded to The Hub when finally ratified at Document Ratification Group (DRG).
Board powers to make this decision	Matters Reserved to the Board requires this policy to be approved by the Board of Directors.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The action is for the Board to approve the content of the Policy. The Executive Lead for this policy is the Interim Chief Nurse.
Recommendations	It is recommended that the Board of Directors approve the Policy.
Appendices	i. Policy for Safeguarding Children Supervision

Ref No: 165

POLICY FOR SAFEGUARDING CHILDREN SUPERVISION

SECTION 1
PROCEDURAL INFORMATION

Version:	6
Ratified by:	Trust Document Ratification Group
Date ratified:	February 2022
Title of originator/author:	Named Nurse Safeguarding Children Named Midwife Safeguarding Children
Title of responsible committee/individual:	Strategic Safeguarding Group
Date issued:	October 2019 (Reissued November 2020)
Review date:	22 February 2025
Target audience:	Trust Wide

Document History Summary

Version	Date	Author	Status	Comment
1	Aug 10		Final	
2	Dec 12		Final	
3a	20/7/13	S Pagdin	Draft	Review of document to update following changes in legislation
3b	21/10/13	S Pagdin	Draft	Circulated for comment
3	Dec 13	S Pagdin	Final	Ratified
4a	Oct 2015	C Whelan	Draft	
4b	Nov 2015	B Mitchell S Pagdin	Draft	
4c	Dec 2015	B Mitchell S Pagdin	Final Draft	Circulated for comment Safeguarding Operational Meeting 9.12.15
4d	Jan 2016	B Mitchell S Pagdin	Final Draft	Comments received, amendments made. Forwarded to Trust Document Ratification Group.
4e	Feb 2016	B Mitchell S Pagdin	Final Draft	Amended following comments at Trust Document Ratification Group
4	Feb 2016	B Mitchell S Pagdin	Final	Ratified by Trust Document Ratification Group
5a	Feb 19	Named Nurse Safeguarding Children Named Midwife Safeguarding Children	Draft	Triennial Review of Document
5	Feb 19	Named Nurse Safeguarding Children Named Midwife Safeguarding Children	Final	Ratified by Trust Document Ratification Group
5	Aug 19	Named Nurse Safeguarding Children Named Midwife Safeguarding Children	Final	Minor amendments ratified by Trust Document Ratification Group
5	Sep 2020	Named Midwife Safeguarding Children	Final	Minor amendments ratified by Trust

				Document Ratification Group
Version 6	Nov 2021	Named Nurses and Named Midwife Safeguarding Children	Draft	Reviewed and amended
V 6	Nov 2021	Named Nurse Safeguarding Children Named Midwife Safeguarding Children	Final	Circulated for comments with Safeguarding Operational Group November 2021 Approved at Strategic Safeguarding Group January 2022

Section 1 Contents

Section 1 Appendices

Section 2 Contents

Section 2 Appendices

1. INTRODUCTION

For many practitioners involved in day-to-day work with children and families, effective supervision is important to promote good standards of practice and to supporting individual members (Working Together to Safeguard Children).

Safeguarding children supervision is a formal, accountable process, which supports, assures and develops the knowledge, skills and values of an individual, group or team. Reflective, restorative supervision must aim to improve the quality of a practitioner's work, achieve agreed objectives and outcomes, ultimately promoting good standards of practice to ensure children and young people are safe and protected from harm through sound professional judgements.

All healthcare practitioners have a significant role in relation to ensuring that children, young people and other vulnerable groups are safeguarded from harm, and therefore require a clear structure of safeguarding supervision to support their practice.

The Rotherham NHS Foundation Trust (TRFT) is committed to providing a robust safeguarding supervision structure, which is entirely different to 1 to 1 practitioner/manager meetings and additional to clinical supervision.

Safeguarding supervision should actively contribute to the development of a learning culture, and support practitioners in making sound professional decisions; ultimately providing a level of assurance that the Trust meets its statutory requirements to safeguard children.

All staff working in safeguarding children should receive regular supervision and support from a safeguarding supervisor either individual or group supervision and support should be available for anyone to access on a monthly or more frequent basis if necessary.

2. PURPOSE & SCOPE

2.1 Purpose

The purpose of this policy is to provide a framework for the practice of safeguarding children's supervision for all TRFT staff. It will ensure that Trust staff are aware of the appropriate level and type of safeguarding supervision that they should access / deliver when working with children and families where there are concerns about the welfare of a child.

This policy will also clarify practitioners' access to identified safeguarding supervisors within individual practice areas and the designated / named safeguarding professionals in accordance with identified role requirements (see appendix 1 – Supervision Frequency Tool in Relation to Staff Role). "Bespoke" safeguarding supervision will also be offered when necessary, to individuals or groups by the safeguarding team in circumstances where caring

for children is not the staff member's prime responsibility but there are safeguarding concerns.

The policy aims to build on the development of effective, competent and confident practitioners and provides a planned systematic approach to the care provided and delivered to children and families taking into account the broader definition of safeguarding as defined in Working Together 2018 (pages 6-7).

- Protecting children from maltreatment
- Preventing impairment of children's health and development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes.

This policy is written with the intention of providing practitioners with guidance and structure, it is not intended to remove professional judgement. Individual practitioners remain accountable and as such need to be able to justify their decisions at all times. Safeguarding supervision does not replace nor should it delay the individual's responsibility to refer concerns about children to statutory agencies where there are concerns that a child may be at risk of significant harm.

a. Scope

This policy **MUST** be followed by all staff employed by TRFT: including those on temporary contracts, honorary contracts, volunteer contracts, secondments, Bank/Agency staff and students.

All identified staff must receive effective supervision according to the requirements of their job role (see appendix 1). The safeguarding children team take a professional lead for the safeguarding supervision arrangements, development and coordination within the Trust.

The safeguarding children's team are also available to offer safeguarding guidance, support and advice relating to any safeguarding issue, to any member of staff within the Trust: this however is separate to and in addition to the provision of specific safeguarding supervision.

3. ROLES & RESPONSIBILITIES

Roles	Responsibilities
Chief Executive	Responsibility for ensuring that Trust policies comply with all legal, statutory and good practice requirements and that response is based on the principles of risk assessment, co-operation with partners, communicating with the public and sharing information.

Head of Nursing, Head of Midwifery, Head of Professions and Matron	To ensure staff are aware of this policy To ensure that staff are familiar with the plans for their work area.
Safeguarding Children Team	To offer safeguarding guidance, support and advice relating to any safeguarding issue, to any member of staff within the Trust
Safeguarding Children Supervisors	To ensure they achieve the required competencies (see appendix 3) and thereafter adhere to this policy in terms of the requirements of the safeguarding children supervisor.

4. PROCEDURAL INFORMATION

All staff will be informed by their Line Manager at induction of the organisation's supervision framework, including specific children's safeguarding supervision and the expectations on them to engage in supervision.

Those providing safeguarding children supervision should be trained in safeguarding supervision skills and have an up-to-date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of children (Working Together to safeguard children, 2018).

All safeguarding supervisors that are new to the Trust will be expected to undertake a competence indicator self-check list (appendix 3). In order to assure the safeguarding children team and the Trust that their knowledge, management skills, intervention skills, attributes/qualities and commitment to their own development meets the required standard of the self-check list tool.

All supervisors should be committed to ensure their knowledge, skills and practice are current and evidence based.

Safeguarding supervision for those practitioners who are caseload holders should take place on a 1-1 basis every quarter (Q1 April-June, Q2 July-September, Q3 October-December, Q4 Jan-March) each session should aim to not exceed 2 hours duration.

For non-caseload holders working with children, young people and their families' practitioners should attend a safeguarding group supervision session twice a year. Each session should aim to not exceed 2 hours duration.

Any practitioner needing additional safeguarding supervision should contact TRFT children safeguarding team.

a. <u>Fundamentals of supervision</u>

Safeguarding Supervision will:

- Be supportive and facilitate staff in their development from 'novice to expert', and address practice issues.
- Be practitioner led, as it is intended to support the practitioner to prioritise and manage safeguarding casework.
- Where there are children of concern, it will ensure concerns are escalated to the appropriate level e.g. Early Help or referral to Children's Social Care.
- Enable staff to reflect on practice and escalate safeguarding issues where single agency intervention has not resolved concern, or where partner organisations do not recognise the level of concern raised by the health practitioner.
- Complement existing safeguarding policies and procedures by providing practitioners with a further opportunity to develop skills, knowledge and understanding to aid continuous professional development and learning, and to identify training needs and signpost to appropriate resources.
- Support practitioners and empower them to cope with emotions and possible stress relating to safeguarding duties and responsibilities.
- Facilitate a communication channel between the staff member and their team leader/manager/supervisor and/or member of the safeguarding children team

4.2 Safeguarding supervision contract for 1-1sessions

Safeguarding supervision is a formal process, and a contract must be agreed between the supervisee and supervisor, both of whom must discuss and agree the arrangements for supervision sessions at their first meeting.

The contract must be signed at the commencement of a new supervision relationship or change in supervisee's role (see appendix 4) Supervision agreements or contracts must clearly define:

- The purpose of supervision and any limitations
- The roles and responsibilities of both supervisor and supervisee
- The frequency of supervision
- Confidentiality limits within the supervision relationship
- How discussions about individual children and their families are recorded

4.3 Roles and Responsibilities

The Supervisee should:

- Participate fully in reflection, exploring issues and the development of action plans.
- Implement the actions identified in the supervision session and monitor the progress of the desired outcome(s) for the child.
- Bring to the attention of the supervisor when experiencing any difficulties/ unable to implement action plans agreed.

- Take responsibility for own personal and practice development.
- Have an explanation of confidentiality expectations within the terms of this agreement.
- Discuss stressful aspects of the work, be given support and be directed to further source of support if he/she wishes.
- Have protected time for supervision.

The supervisor should:

- Agree the supervision contract with the supervisee.
- Assist the supervisee to reflect on practice using a reflective model (e.g. Tony Morrison) and provide constructive feedback to enable best outcomes for children.
- Ensure the safeguarding supervisee has a clear understanding of his/her role and responsibilities in relation to promoting the wellbeing and safety of children.
- Acknowledge the stressful nature of working with vulnerable children and ensure that any necessary support available is offered to minimise the risk to the child/ren, the supervisee and TRFT.
- Identify with supervisees any children or families who should be discussed with the Line Manager in order to provide additional support where appropriate and to ensure the protection of children.
- Support the supervisee with issues arising from the reflection in relation to beliefs, values and past experiences.
- Inform the appropriate manager if a supervisee is unable to engage in the minimum number of supervision sessions due to a lack of cooperation, sickness or concerns about practice.
- Promote adherence to relevant policies and procedures e.g. child protection or record keeping.
- Discuss openly with the supervisee any concerns about their performance and agree/inform of action to be taken.
- See the professional's record of supervision discussion in SystmOne in all cases.

4.4 Preparing for 1:1 supervision session

Cases to be discussed within safeguarding supervision may be identified through direct working with a woman during pregnancy, the child or young person or through the care interventions with the parent and/or carer or following discussion with the practitioner's manager/team leader.

The supervisee should consider in advance of their session issues and relevant cases that will require discussion.

4.5 The content of safeguarding children 1:1 supervision

Cases that should be prioritised and considered by the supervisee for discussion at supervision:

- All children that that have been on a plan of protection for over 15 months
- Cases where there has been a request for a change of allocated worker **prior to the change**
- TRFT staff that are involved in a case which is subject to a complaint by the family (whether the complaint is informal or formal)
- Any cases where a family member is subject to MARAC (victim or perpetrator) and where areas of concern remain
- Any cases where a staff member has not been able to complete an action on a child protection plan
- Any cases where there is concern that the child protection plan may not meet the child's needs (born or unborn)
- Any cases where there are professional differences of opinion regarding protection planning and how this was resolved
- Any cases that are particularly traumatic and the staff member may need further support
- Any cases where the practitioner has concerns they wish to discuss
- Mental capacity concerns (parents and children 16 and over apply MCA). Under 16 Fraser competency principles' apply
- Any significant learning disabilities or barriers to communication
- Any case identified for discussion by either the supervisor or supervisee
- Any case that has been identified for discussion at MASH baby clinic

Please note this is not an exhaustive list.

Discussion should also take place to:

- Address personal safety issues for the practitioner/other services.
- Agree roles and actions to safeguard the unborn/child/family.
- Identify additional training needs.
- Identify potential wider unresolved issues for families and practitioners.
- Explore ways to minimise these and improve care delivery.
- Aim to be supportive and reduce stress.
- Ensure Plans are consistent with Rotherham Local Safeguarding Children Board (RLSCB) procedures.

- Consider safeguarding adult procedures where required and the use of other risk management solutions and forums e.g. Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conferences (MARAC).
- Consider risk utilising *"Ten Pitfalls and how to avoid them – what research tells us",* (NSPCC 2010). This can be accessed at

  https://www.nspcc.org.uk/globalassets/documents/research-reports/10-pitfalls-initial-assessments-report.pdf

4.6 Recording the safeguarding supervision session

4.6.1 1:1 Safeguarding Supervision Caseload holders with access to SystmOne

Key decisions reached regarding individual children should be recorded within the child's/ pregnant woman's health record. Appendices 5 – 8 are useful tools which may support reflective discussion and the evidence thinking process during safeguarding supervision. Such documents can be scanned into SystmOne if used during the supervision session or added as record attachments.

In accordance with the Trusts 'Policy for Record Keeping', the session must be recorded in the SystmOne record. Additionally, during the supervision session the practitioner must access the record for the safeguarding supervisor to view and in doing so they must update the record during the supervision session.

The Supervisee must record the discussion and the outcome in the child/pregnant woman SystmOne record using the supervision tab in the safeguarding children template (see diagram 1). The discussion must be documented followed by the recording of the action plan. The entry should always start; "*Safeguarding supervision with safeguarding supervisor" (name).*

Discussion in safeguarding supervision which is not appropriate to record directly in a child/pregnant woman's record e.g. personal reflection and learning, will be recorded on the Supervision Discussion Template (see appendix 10) a copy should be available to the supervisee and a copy retained by the supervisor.

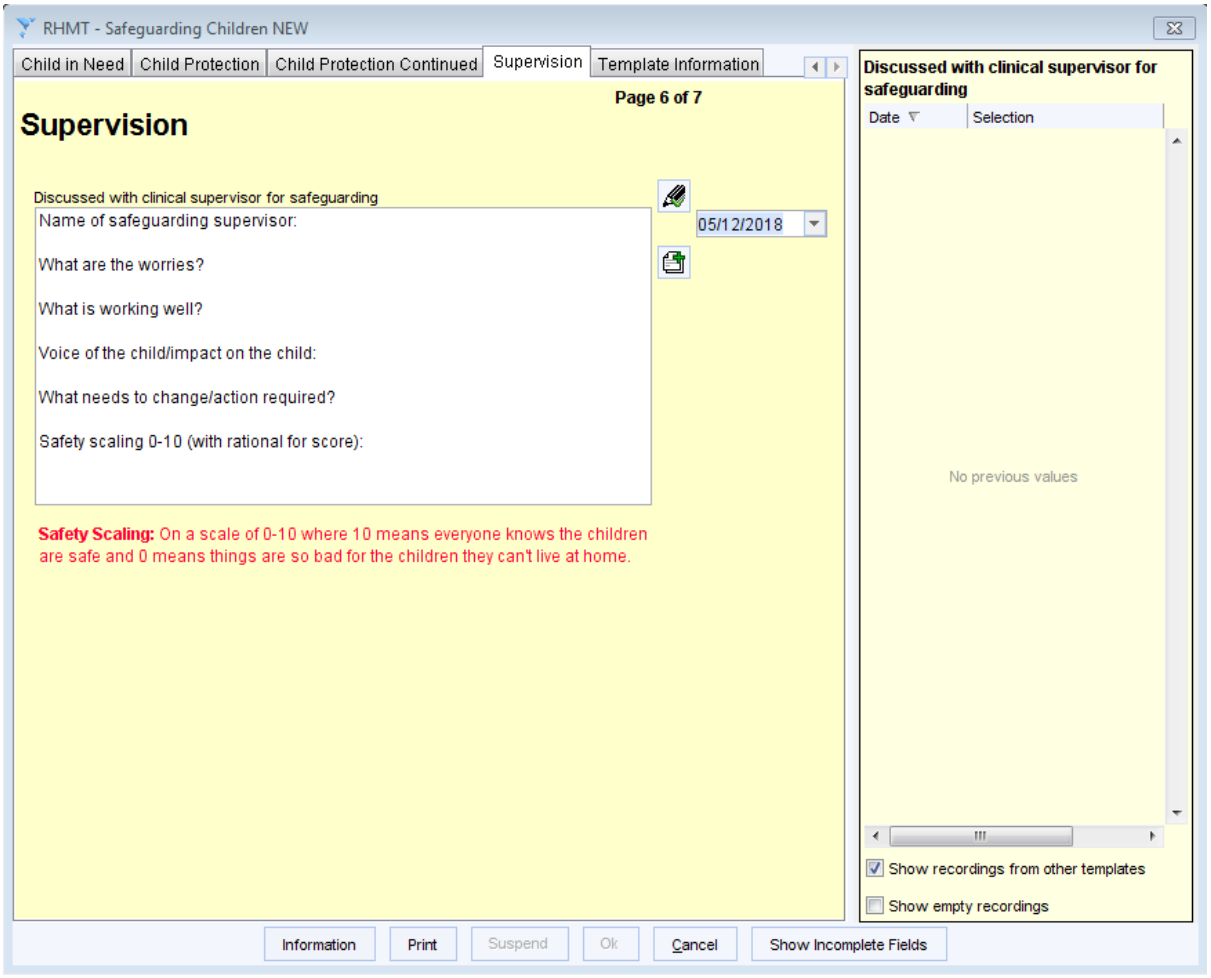


Diagram 1 – SystmOne Template for recording safeguarding supervision

The record must be saved by completing the event details as shown below in Diagram 2

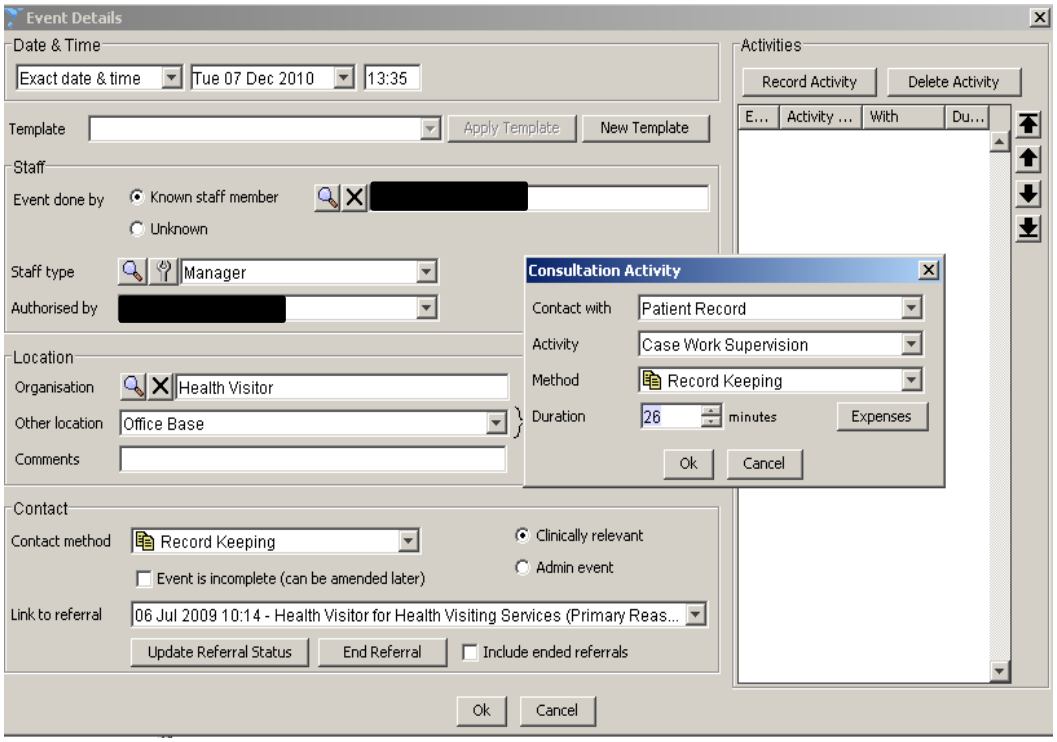


Diagram 2: SystmOne event screen to record and save the safeguarding supervision

For **all** supervision (CPP, CIN, LAC etc.) undertaken **by practitioners and managers/team leaders,** it is recorded as:

Contact method: Record Keeping
Contact with: Patient Record
Activity: Casework Supervision

For all supervision undertaken by the **safeguarding team** it is recorded as:

Contact method: Liaison
Contact with: Other Professional
Activity: Child Protection Supervision

It is the supervisee's responsibility to ensure any relevant action plan is entered in the pregnant woman's/new-born's/child's health record. This should include an analysis of the discussion that has taken place, the risks to and the needs of the child/unborn, parental stressors and also risks identified that may affect other professionals in contact with the family. Ongoing health/multi-agency plans should also be updated.

Following supervision the Supervisor should keep a log of cases discussed utilising appendix 10

4.6.2 For staff who are Meditech users (1:1 Ad hoc or Group)

The Meditech records should be available to the supervisor and supervisee during the session to refer to when discussion and reflecting on the case.It is the responsibility of the supervisee to clearly document a summary of the supervision discussion, the risks and actions as detailed above within the Meditech patient record.

The supervisor will be responsible for ensuring the staff compliance for supervision is notified to ESR and safeguarding admin.

4.6.3 Appendices 5-8 are useful tools which may support reflective discussion and evidence the thinking process during supervision.

4.7 <u>Group Supervision:</u>

'Group Supervision is a negotiated process whereby members come together in an agreed format, to reflect on their work by pooling their skills, experience and knowledge in order to improve both individual and group capacities' (Staff Supervision in Social Care, Morrison, 2005).

It is most appropriate for staff in acute services, who are not caseload holders; for example, those working in the Urgent and Emergency Care Centre (UECC), Paediatric wards, Dental services, Integrated Sexual health Services (ISHS) acute Maternity services, Medical staff, Therapy services and any other acute/community service that a child or young person may access. 0-19 Practitioners, Midwives, Continuity of Carer Midwives from Willow Team who caseload women with no known safeguarding concerns, Children's Community Nurses, may also find group supervision beneficial, particularly if several disciplines are delivering services to a family/child and the case is complex.

Ideally there will be six or eight in a group up to a maximum of 20.

Safeguarding Supervision Peer review
A monthly session is specifically offered for medical colleagues and is facilitated by the Named Doctor supported by safeguarding team. Attendance is logged and monitored via ESR. The assigned practitioner presenting the case will have the Meditech records available and is responsible for clearly documenting a summary of the supervision discussion, the risks and actions within the Meditech patient record.

The supervisor Safeguarding team will be responsible for ensuring the learning is summarised on a page and disseminated to the group and the wider group of Paediatrician

4.7.1 A framework for group supervision should include the following:

1. Frequency and length of time of supervision sessions, minimum twice yearly and each session should aim to not exceed 2 hour's duration

2. Consultation on urgent cases.

3. Content of supervision sessions, e.g. safeguarding children cases, practice development, personal issues which may impact on practice, interagency and inter-disciplinary work.

4. A record of attendance must be recorded and sent to learning and development department to update ESR. The safeguarding team maintain overview of TRFT compliance.

5. Learning from Serious Case Reviews / local and national issues

6. Child Protection Legislation e.g. The Children Act 1989 / 2004: The purpose and effect of various Children Act Orders: Interim Care Order (ICO), Care Order (CO). Child Arrangement Order, Police Protection Order (PPO), Emergency Protection Order (EPO); the requirements of health in relation to Children Act 2004 Section 11 and the related RLSCB Audits.

The expected outcomes of Group Supervision:

1. Reflect on feelings and attitudes discussed
2. Identify any area of practice that needs to be changed and implemented as a result of supervision
3. Learn from colleagues areas of good practice and recognition of areas of practice which need to improve.

5. DEFINITIONS AND ABBREVIATIONS

a. Definitions

Supervision: For the purpose of this policy supervision can be defined as 'an accountable process which supports, assures and develops the knowledge, skills and values of an individual, group or team the purpose being to improve the quality of their work to achieve agreed outcomes'.

Group Supervision: Group Supervision is a negotiated process whereby members come together in an agreed format, to reflect on their work by pooling their skills, experience and knowledge in order to improve both individual and group capacities

b. Abbreviations

CCG	Clinical Commissioning Group
CIN	Child in Need
CO	Care Order
CPP	Child Protection Plan
CQC	Care Quality Commission
DfE	Department for Education
DOH	Department of Health
EPO	Emergency Protection Order
ESR	Electronic Staff Record

ICO	Interim Care Order
ISHS	Integrated Sexual Health Services
LAC	Looked after Child
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conferences
MCA	Mental Capacity Act
NHS	National Health Service
NSPCC	National Society Prevention Cruelty to Children
PPO	Police Protection Order
RCN	Royal College of Nursing
RLSCB	Rotherham Local Safeguarding Children Board
SCR	Serious Case Review
TRFT	The Rotherham NHS Foundation Trust
UECC	Urgent and Emergency Care Centre

6. REFERENCES

- Staff Supervision in Social Care: *Making a real difference to staff and service users.* Morrison, T. (2006) Brighton Pavilion
- Laming, Lord (2009) The protection of Children in England: A Progress Report. London, HMSO
- Safeguarding Children. A review of arrangements in the NHS for safeguarding children. CQC (2009)
- Working Together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. DfE (2018)
- The Children Act 2004, London, HMSO
- Safeguarding Children &Young People: Every nurse's responsibility RCN (2014)

7. ASSOCIATED DOCUMENTATION

- Rotherham Safeguarding Children Board Procedures, can be accessed at: http://rotherhamscb.proceduresonline.com/index.htm
- TRFT Safeguarding Children Policy
- Ten Pitfalls and how to avoid them – what research tells us", (NSPCC 2010), can be accessed at:

  https://www.nspcc.org.uk/globalassets/documents/research-reports/10-pitfalls-initial-assessments-report.pdf

APPENDIX 1

The Rotherham NHS Foundation Trust

Safeguarding Children Supervision Frequency Tool in relation to Staff Role

Safeguarding supervision is separate and additional to clinical supervision and does not replace it.

It is clearly indicated within **Working Together to Safeguard Children (2018),** that employers have a responsibility to ensure that staff feel supported within their safeguarding role including having access to advice, expertise and guidance with decision making when working to safeguard children and families.

Supervision is dedicated time for the discussion of case studies or individual cases of concern about safeguarding children. It is considered to be best practice in the development of knowledge, skills and competencies.

It:

- Ensures that practice is soundly based and consistent with Local Safeguarding Children Board and organisational procedures
- Ensures that practitioners fully understand their roles and responsibilities and the scope of their professional discretion and authority.
- Identifies the training and development needs of individual practitioners to ensure that they have the appropriate skills to provide an effective service.

Working Together to Safeguarding Children (2018) suggests good quality safeguarding children supervision should:

- Ensure that the focus is maintained on the child.
- Avoid drift.
- Maintain a degree of objectivity and challenge fixed views.
- Test and assess the evidence base for assessment decisions.
- Address the emotional impact of safeguarding work.
- Be available as a source of advice and experience to practitioners
- Support professional development

Working Together to Safeguard Children (2018) also states that for practitioners working with children and families, effective supervision is important to promote good standards of practice and to support individual staff members.

It is even more important that professionals adopt practices of critical reflection, and that appropriate supervision is provided to facilitate this (Triennial Analysis 2011-2014, P191)

The process of supervision is underpinned by the principle that each practitioner remains accountable for his/her own practice and as such his or her own actions within supervision. Safeguarding supervision does not replace nor should it delay the individual's responsibility to refer concerns about children or vulnerable adults to statutory agencies where there are concerns that a child or adult may be at risk of significant harm.

Supervision in line with staff role

Staff Role	Recommended Supervision Frequency	Individual	Group	Suitable Supervisors
Safeguarding Named Nurses/Midwife/Dr	Quarterly	Yes		Designated Nurse/Dr (CCG)
Safeguarding Nurse Advisors/Practitioner including MASH advisor	Twice yearly		Yes	Named Safeguarding Professionals within the Trust
Safeguarding Children Supervisors	Twice Yearly	On an ad hoc basis as and when required	Yes	Safeguarding professionals within the Trust
Staff working predominantly with children & families who hold a child/family caseload	Quarterly	Yes	Yes	Safeguarding supervisors within the Trust
Acute/Community based qualified staff predominantly working with children & families that don't hold a child/family caseload	Twice yearly	On an ad hoc basis as and when required	Yes	Safeguarding supervisors within the Trust /clinical areas
Role involves working with adults and those who may see children/young people intermittently	On an ad hoc basis as and when required	On an ad hoc basis as and when required	On an ad hoc basis as and when required	Safeguarding Supervisors within the Trust
Non Clinical staff Will **NOT** be monitored through ESR	On an ad hoc basis as and when required *	On an ad hoc basis as and when required	On an ad hoc basis as and when required	Safeguarding Supervisors within the Trust

It is recognised that staff will often require advice or support in relation to safeguarding outside of formal supervision sessions.

***Staff such as health care staff, nursery nurses , maternity support workers should access group supervision for their own learning**

APPENDIX 2

The Rotherham NHS Foundation Trust

The Kolb Supervision Cycle

Experience
(engaging and observing)
The story – what happened?

Reflection
(investigating experience)
What was it like?

Analysis
(seeking to understand, hypothesising, asking why, what does this mean?)

Action Plans
(preparing for action, trying things out)
What next?

Morrison, 2005

APPENDIX 3

The Rotherham NHS Foundation Trust

Competence indicators for supervisor – check list

INDICATOR	YES/NO	COMMENTS
Understands purpose and key task of supervision		
Understands and can explain TRFT's supervision policy		
Understands and can explain the boundaries of supervision (as outlined in the supervision contract)		
Understands and can explain the 4 functions of supervision (management/support/development/mediation)		
Understands and can explain the purpose of supervision to supervisees		
Understands and can escalate persistent non-engagement by the supervisee		
Understands an appropriate environment conducive to a positive supervision session		
Understands and can support accurate recording of supervision		
Understands that the supervision process is child focussed		
Understands and can enable the supervisee to identify and explain evidence, risks, needs strengths, values, attitudes, feelings policies, and professional knowledge underpinning their practice and decision making		

Effective Supervision

INDICATOR	YES/NO	COMMENTS
Understands and can identify/analyse poor or blocked behaviour and establish a strategy to address the issues		
Understands and can professionally challenge concerns, discriminatory attitudes and behaviour		
Demonstrates understanding of practice resolution and support within TRFT		
Demonstrates an awareness of the benefits of effective supervision for the key stakeholders (child/practitioner/organisation/partner organisations		

	Name/Designation	Date
Self-Assessment		
Assessor		

Comments

Signed Safe and Effective	Designation	Date

APPENDIX 4

The Rotherham NHS Foundation Trust

Casework Supervision Contract

1. Ground Rules

Punctuality – time keeping important.

Uninterrupted time – not exceeding 2 hours.

Commitment – must be given high priority and should only be cancelled in exceptional and unforeseen circumstances. Every effort will be made to reconvene a cancelled meeting within 2 weeks.

Reciprocity and Respect – mutual interaction and respect are important. If disagreements occur that cannot be resolved within the supervision meeting to both parties satisfaction, it will be referred to the supervisors line Manager for consideration.

2. Frequency of supervision

Supervision will be accessed a **minimum** of once every quarter. At each supervision session a mutual agreeable date will be made for the next supervision session.

3. Agenda Preparation

The cases for supervision should include:

- All children that have been on a plan of protection for over 15 months
- Cases where there has been a request for a change of allocated worker

Whilst not an exhaustive list the following should be considered in safeguarding supervision:

- Any cases where a family member is subject to MARAC (victim or perpetrator) and where areas of concern remain
- Any cases where a staff member has not been able to complete an action on a child protection plan
- Any cases where there is concern that the child protection plan may not meet the child's needs (born or unborn)
- Any cases where there are professional differences of opinion regarding protection planning and how this was resolved
- Any cases that are particularly traumatic and the staff member may need further support
- Any cases where the practitioner has concerns they wish to discuss

- Mental capacity concerns (parents and children 16 and over apply MCA). Under 16 Frasier competency principles' apply
- Any significant learning disabilities or barriers to communication
- Any case identified for discussion by either the supervisor or supervisee

4. Issues of Confidentiality

Supervision records made during session which are not related to a child will be recorded on the supervision session/discussion sheet and a copy retained by the supervisor.

All employees are responsible for maintaining confidentiality in respect of colleagues and service users.

5. Date to Review Agreement

Annually.

6. Recording Method

Discussions about individual children and families will be recorded directly into SystmOne during the supervision session as per Supervision Policy.

Any personal information will be treated as confidential unless such disclosures directly affect the work of the supervisee or implementation of TRFT policies and procedure.

Signed ……Date…….

Signed ……Date…….
Copy for supervisor and supervisee

APPENDIX 5

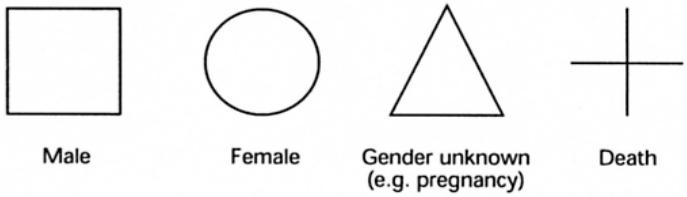
The Rotherham NHS Foundation Trust

Useful tool 1- What Do You Know?

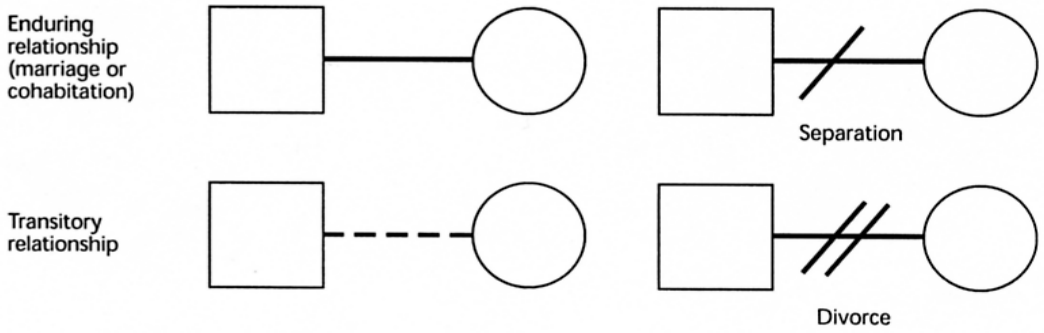
WHAT DO YOU KNOW?	WHAT DO YOU 'THINK' YOU KNOW?
WHAT DO YOU NEED TO KNOW?	**WHAT ACTIONS ARE NEEDED?**

GENOGRAM taken from Assessing Children In Need and their Families. Practice Guidance (DOH 2000)

Genogram symbols



Genogram symbols



A dotted line should be drawn around the people who currently live in the same house.

Compiling a genogram

A genogram of family tree covering three or more generations may be compiled using these symbols. Other relatives in addition to parents and children can be involved in compiling the genogram. More than one session may be needed if the exercise is used to discuss the family's history in detail and to enter significant dates and other information. Working on a genogram also provides the practitioner with an opportunity to observe family relationships, for example how open family members are with each other, how well they respond to each other's needs, how flexible they are and how much they know about each other.

APPENDIX 7

The Rotherham NHS Foundation Trust

Resilience and Vulnerability Matrix

Resilience

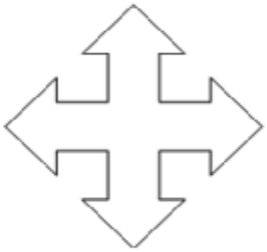
Characteristics that enhance normal development under difficult conditions

Good attachment,
Good self esteem
Sociability,
High IQ ,
Flexible temperament
Good problem solving skills
Positive parenting
Attractive child

Adversity

Life events or circumstances posing a threat to healthy development

Serious life events/crises
Illness/loss/bereavement
Separation/family breakdown
Domestic violence
Asylum seeking status
Serious parental difficulties
Parental substance misuse
Parental mental illness
Parental learning difficulty



Protective environment

Factors in the child's environment acting as buffers to the negative effects of adverse experience

Good school environment
One supportive adult
Special help with behavioural problems
Good community networks
Leisure activities
Talents and interests
Good community networks
Leisure activities
Talents and interests

Vulnerability

Characteristics of the child, the family circle and wider community which might threaten or challenge healthy development

Poor attachment
Minority status
Young age
Disability
History of abuse
Institutional care
Early child hood trauma

Communication differences
Innate characteristics in the child/family which threaten or challenge development

From Children's World

Assessing Children in Need

APPENDIX 8

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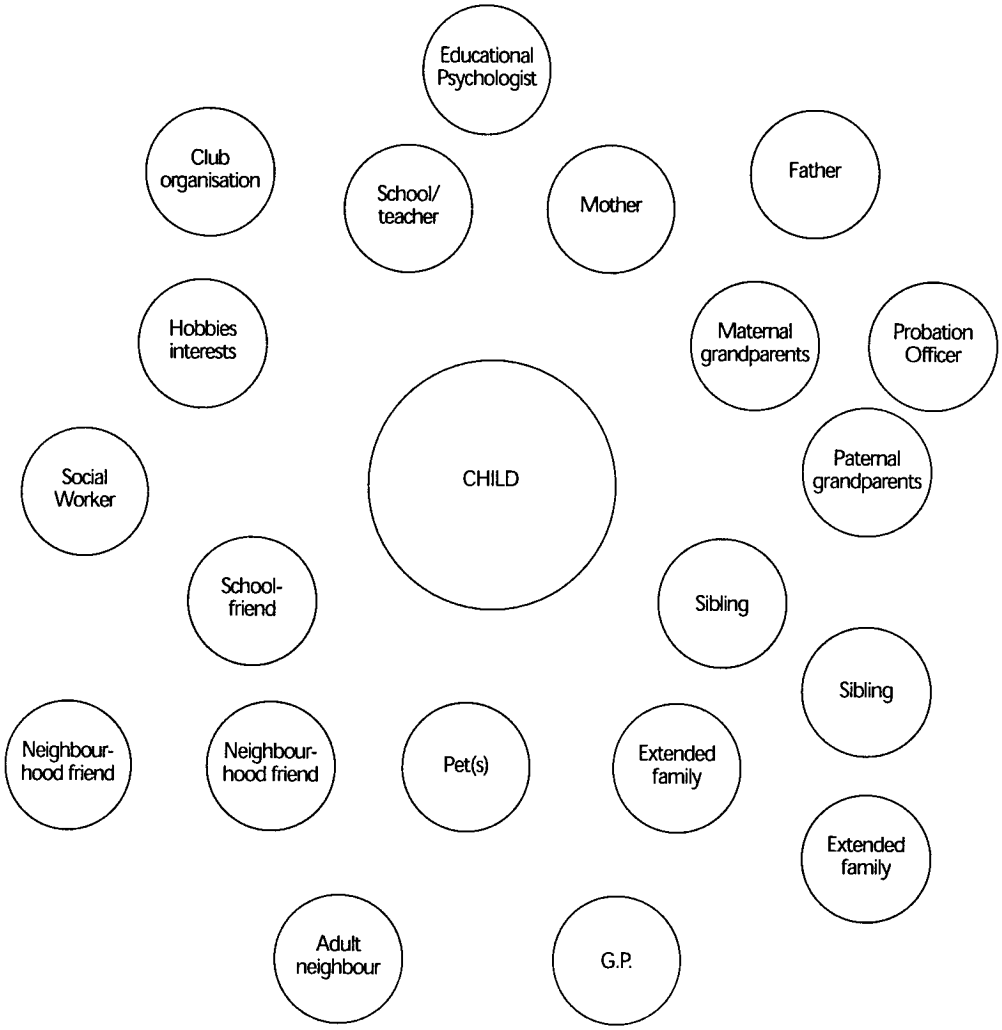
Eco Map



- Place child or couple or family in central circle.
- Identify important people or organisations and draw circles as needed
- Draw lines between circles where connections exist
- Use different types of lines to indicate the nature of the link or relationship

——— = strong

- - - - = weak

····· = stressful

APPENDIX 9

The Rotherham NHS Foundation Trust

Signs of Safety tool

What needs to change?	***What's Working well?***	***What are we worried about?***
Child's Voice	***Child's Eco Map (Family and Support)***	***Safety Scale 0 – 10*** 0 no signs of safety 10 lots of signs safety

APPENDIX 10

The Rotherham NHS Foundation Trust

Supervision Session/Discussion

Date of Session: …….. **Date of Last Session: ……**

Supervisor: …….. **Supervisee: ……**

Issues Discussed	Actions	Who and when
Agenda AOB		

Issues Discussed	Actions	Who and when

APPENDIX 11

The Rotherham NHS Foundation Trust

Supervision log sheet

Name/DOB child	Date discussed at supervision										

POLICY FOR SAFEGUARDING CHILDREN SUPERVISION

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

- TRFT Safeguarding Operational Group
- Rotherham Local Safeguarding Children Board

9. APPROVAL OF THE DOCUMENT

This document was approved by TRFT Strategic Safeguarding Group.

10. RATIFICATION OF THE DOCUMENT

This document was ratified by the Trust Document Ratification Group.

11. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

12. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years by the Safeguarding Children Team unless such changes occur as to require an earlier review.

13. DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
DRG Admin Support via policies email	Author	Email	Within 1 week of ratification	Remove watermark from ratified document and inform DRG Admin Support if a revision and which document it replaces and where it should be located on the intranet. Ensure all documents templates are uploaded as word documents.
Communication Team (documents ratified by the Document Ratification Group)	DRG Admin Support	Email	Within 1 week of ratification	Communication team to inform all email users of the location of the document.
All email users	Communication Team	Email	Within 1 week of ratification	Communication team will inform all email users of the policy and provide a link to the policy.
Key individuals	Author	Meeting / Email as appropriate	When final version completed	The author must inform staff of their duties in relation to the document.

To be disseminated to	Disseminated by	How	When	Comments
Staff with a role/responsibility within the document Heads of Departments / Matrons				
All staff within area of management	Heads of Departments /Matrons	Meeting / Email as appropriate	As soon as received from the author	Ensure evidence of dissemination to staff is maintained. Request removal of paper copies Instruct them to inform all staff of the policy including those without access to emails

14. IMPLEMENTATION AND TRAINING PLAN

Existing and newly trained supervisors are aware of this document and have accessed the required training in order to undertake their responsibilities in line with this policy.

The safeguarding Team, Managers and Team Leaders support colleagues to access safeguarding children supervision in line with this policy.

What	How	Associated action	Lead	Timeframe
Whole document	All newly appointed staff	Discussion at team induction	Line Manager / Team Leader	ongoing
Whole document	Appointment of staff who have supervisory role	Discussion at induction to identify assets and gaps delivering safeguarding supervision	Line Manager Safeguarding Children Team	ongoing
Development of supervisory role	Promote opportunities which will support experiential learning for all staff in supervisory role	Regular workshops for supervisors Yearly update	Safeguarding Children Team	ongoing

15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

Audit / Monitoring Criteria	Process for monitoring e.g. audit, survey	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Adherence to policy	Via KPI	Safeguarding Team	Quarterly	Safeguarding Operational Group Safeguarding Strategic Group	Safeguarding Strategic Group

15.2 Standards/Key Performance Indicators (KPIs)

Through Safeguarding KPI quarterly

SECTION 2
APPENDIX 1

NHS
The Rotherham
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name:	Policy For Safeguarding Children Supervision	Date/Period of Document:	
Lead Officer:	Safeguarding Children Named Nurse/Named Midwife	Job title:	Safeguarding Children Named Nurse/Midwife

☐ Function	☒ Policy	☐ Procedure	☐ Strategy	☐ Other: (*State*)_____

Describe the overall purpose / intended outcomes of the above: To provide a framework for the practice of safeguarding children's supervision for all TFRT hospital based and community staff. It will ensure that Trust staff are aware of the appropriate level and type of safeguarding supervision that they should access / deliver when working with children and families where there are concerns about the welfare of a child.

*You must assess **each** of the 9 areas separately and consider how your policy may affect people of different groups within those areas.*

1. Assessment of possible adverse (negative) impact against a protected characteristic				
Does this have a **significant** negative impact on equality in relation to each area?		Response		If yes, please state why and the evidence used in your assessment
		Yes	No	
1	Age		✓	
2	Disability		✓	
3	Gender reassignment		✓	
4	Marriage and civil partnership		✓	
5	Pregnancy and maternity		✓	
6	Race		✓	
7	Religion and belief		✓	
8	Sex		✓	
9	Sexual Orientation		✓	

You need to ask yourself:

- Will the policy create any **problems** or **barriers** to any community or group? No
- Will any group be **excluded** because of the policy? No
- Will the policy have a negative impact on **community relations**? No

If the answer to any of these questions is Yes, you must complete a full Equality Impact Assessment

2. Positive impact:				
Could the policy have a **significant** positive impact on equality by reducing inequalities that already exist? Explain how will it meet our duty to:		Response		If yes, please state why and the evidence used in your assessment
		Yes	No	
1	Eliminate discrimination, harassment and / or victimisation		✓	
2	Advance the equality of opportunity of different groups		✓	
3	Foster good relationships between different groups		✓	

3. Summary

On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?

Positive						Negative
HIGH ☒	MEDIUM ☐	LOW ☐	NEUTRAL ☐	LOW ☐	MEDIUM ☐	HIGH ☐

Date assessment completed: 9-11-21	Is a full equality impact assessment required?	☐ Yes ☒ No
Date EIA approved by Equality and Diversity Steering Group:		

Board of Directors' Meeting
04 March2022

The Rotherham NHS Foundation Trust

Agenda item	P42/22
Report	**Safeguarding & Vulnerabilities Team Annual Report**
Executive Lead	Helen Dobson, Interim Chief Nurse
Link with the BAF	B1 - Standards and quality of care B6 – Robust Trust-wide quality and clinical governance.
How does this paper support Trust Values	This paper supports the Trust's ambition to continually improve the quality of care that is delivered and supports the Trust's Ambitious value through the management of quality standards and delivery of robust safeguarding arrangements. Caring is demonstrated by the activity to provide safe care to our patients and Together shown by our partnership working, both within and external to the Trust.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report summarises the key activities of the Safeguarding & Vulnerabilities Team during 2020-2021. The report contains information on safeguarding activity, safeguarding key performance indicators and standards as well as summarising partnership activity and key developments throughout the year. The report details the risks and mitigations over the year and ends by focusing on the future priorities of the safeguarding team to support the delivery of robust safeguarding arrangements throughout the Trust.
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	This paper was presented to the Strategic Safeguarding Group on 12 August 2021 and to the Quality Committee on 27 October 2021. A recommendation was made to add further detail to the report. The report was returned to the Quality Committee on 26 January 2022 and approved.
Powers to make this decision	No decision required.
Who, What and When (what action is required, who is the lead and when should it be completed?)	For assurance.
Recommendations	It is recommended that the Board note the report.
Appendices	i. Safeguarding and Vulnerabilities Team Annual Report 2020/2021

Safeguarding & Vulnerabilities Team

Annual Report

2020 / 2021

CONTENTS

INTRODUCTION AND OVERVIEW

This Annual Report seeks to inform the Trust Board of the safeguarding activity within The Rotherham NHS Foundation Trust (TRFT) during the period 2020/2021. Additionally the report aims to:

- Provide assurance to the Trust Board that the Trust is fulfilling its statutory obligations
- Assure service commissioners and regulatory bodies that the Trust's activity over the year has developed in terms of preventing abuse and reducing harm to vulnerable service users
- To inform the Board and wider Trust staff of the activities and function of the Safeguarding & Vulnerabilities Team, and of the progress with the Safeguarding work plan, which enables the TRFT Strategy for Safeguarding Vulnerable Services Users (Appendix 1) to be fully realised and embedded within the organisation.

The Report incorporates Adult and Children Safeguarding. The Named Professional from each specialist area has inputted to the content. The Integrated Safeguarding Team is managed by the Head of Safeguarding with executive leadership of the Chief Nurse and Deputy Chief Nurse (Refer to Appendix 2 - Management and Professional Leadership Chart). The governance and assurance arrangements within Safeguarding remain robust and are outlined within Appendix 3 (TRFT and Partnership Organisational Governance Structure).

This has been a challenging year, with Covid-19 impacting on services Trustwide and the CQC inspection in July 2020, resulting in a comprehensive and detailed improvement plan.

This Annual Report sets out to identify and describe the key risks that were managed during the year and provides a summary of some the key activities undertaken each quarter. In addition, as part of the summary and conclusion, it describes the key priorities and areas identified for improvement in relation to safeguarding activity for implementation during 2021/2022.

The Report provides an overview of activities over the last 12 months in relation to:

Adult Safeguarding Activity

Learning Disability Service

Child Death Review

Children Safeguarding Activity

Looked after Children

Governance

Risks and Mitigations

Partnership Working

Jean Summerfield, Head of Safeguarding

Safeguarding & Vulnerabilities Team

Lynda Briggs, LAC Lead Nurse

ADULT SAFEGUARDING ACTIVITY

A blended approach to training delivery continues to be used, with the offering of internal face-to-face training, e-learning and external taught sessions with Rotherham Metropolitan Borough Council (RMBC).

Bespoke sessions have been delivered throughout the Trust to medical, nursing and allied health colleagues, in both adult and children's specialities, acute and community services. Mental Health training is provided in partnership with RDaSH.

A robust training programme is in place for Prevent; This is included in the Trust Induction programme. Training arrangements for this are regularly updated, in line with Government guidance.

There is ongoing review of training requirements allocated to staff, in line with the Safeguarding Adults Intercollegiate document. This is done in partnership with our colleagues in Learning & Development to ensure that TRFT staff MaST requirements appropriately reflect their roles.

Training compliance is monitored via Safeguarding Key Performance Indicators and the Safeguarding Standards set by the Clinical Commissioning Group (CCG). These are reviewed at the monthly Operational Safeguarding Group which reports to the Strategic Safeguarding Group, held quarterly.

2020/21 saw an increase in patients admitted due to poor mental health. TRFT have continued to work in partnership with RDaSH to ensure that, for this group of patient, there is parity of esteem between their mental and physical health needs.

Adult Safeguarding Training Compliance – Figures at 31/03/2021

Adult Safeguarding Training	Rag Rating	Percentage Achieved 2020/2021	Percentage Achieved 2019/2020
Level 1	Amber	80%	100%
Level 2	Green	90%	82.42%
Level 3	Green	100%	100%
Level 4	Green	100%	100%
Prevent Level 1 & 2	Green	92%	91.13%
Prevent Level 3	Green	94%	89.72%
Dementia	Green	98%	97.36%
Mental Health L1	Green	90%	
Mental Health L3	Amber	70%	26.09%

KEY PERFORMANCE INDICATORS (KPI) & STANDARDS

Adult Safeguarding are required to satisfy the requirements of KPIs and Safeguarding Standards, as set by the Clinical Commissioning Group (CCG). These

include offering assurance on a diverse range of safeguarding activity throughout the Trust.

Both the Safeguarding Standards and the Key Performance Indicators are reported quarterly to the Trust Safeguarding Strategic Group and Partners, including representation from the Clinical Commissioning Group, RMBC, Rotherham Children Safeguarding Partnership and Rotherham Safeguarding Adult Board are members.

An exception report is included at Appendix 4.

SAFEGUARDING ADULTS REVIEWS (SAR)

One SAR was conducted in 20/21. Sadly this was linked to a SAR completed in 19/20. The action plan for this was completed. The multi-agency action plan will be developed when the RSAB review is complete. All learning from reviews is shared appropriately across the Trust, either by being incorporated into training or by the use of 7-minute briefings.

DOMESTIC HOMICIDE REVIEWS

The statutory requirement related to domestic homicide reviews came into force in April 2011. The focus is a multiagency approach with the purpose of identifying learning.

One case went forward as a Domestic Homicide Review (DHR) in the 2020/2021 period. There were no internal recommendations for TRFT from this review. The multi-agency report is in progress. Any actions from this will be monitored through the Operational Safeguarding Group.

The Trust is represented at the Domestic & Sexual Abuse Priority Group by the Head of Safeguarding.

PARTNERSHIP WORKING – ADULT SAFEGUARDING

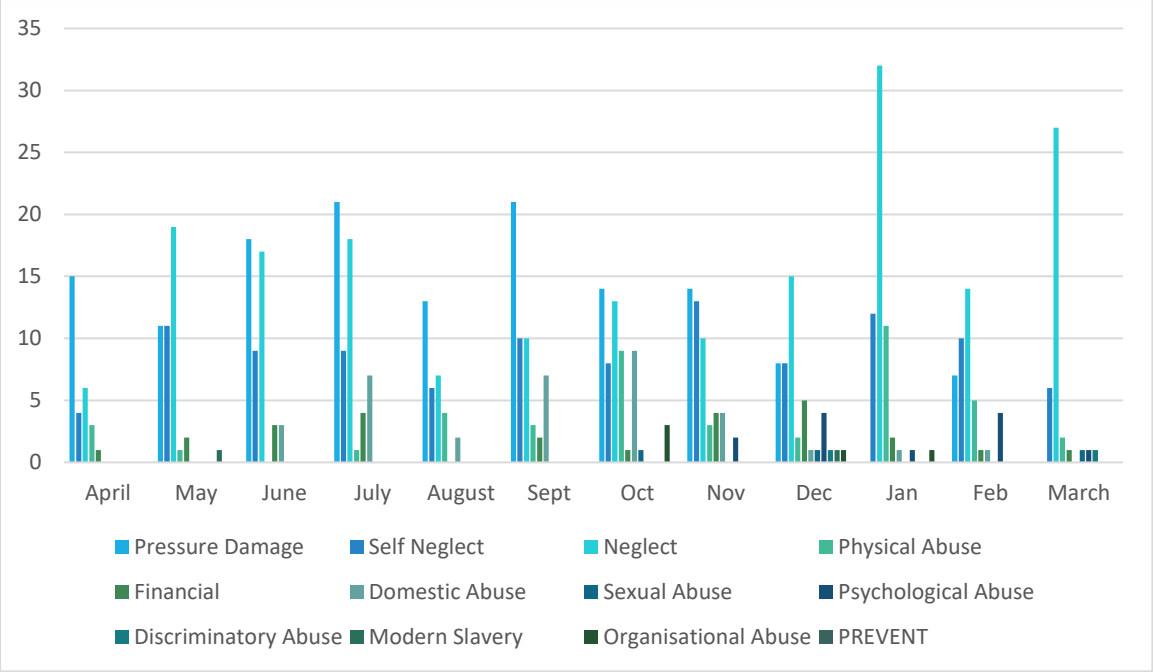
The Trust is represented at the Rotherham Safeguarding Adult Board by the Chief Nurse. Her deputy is the Head of Safeguarding.

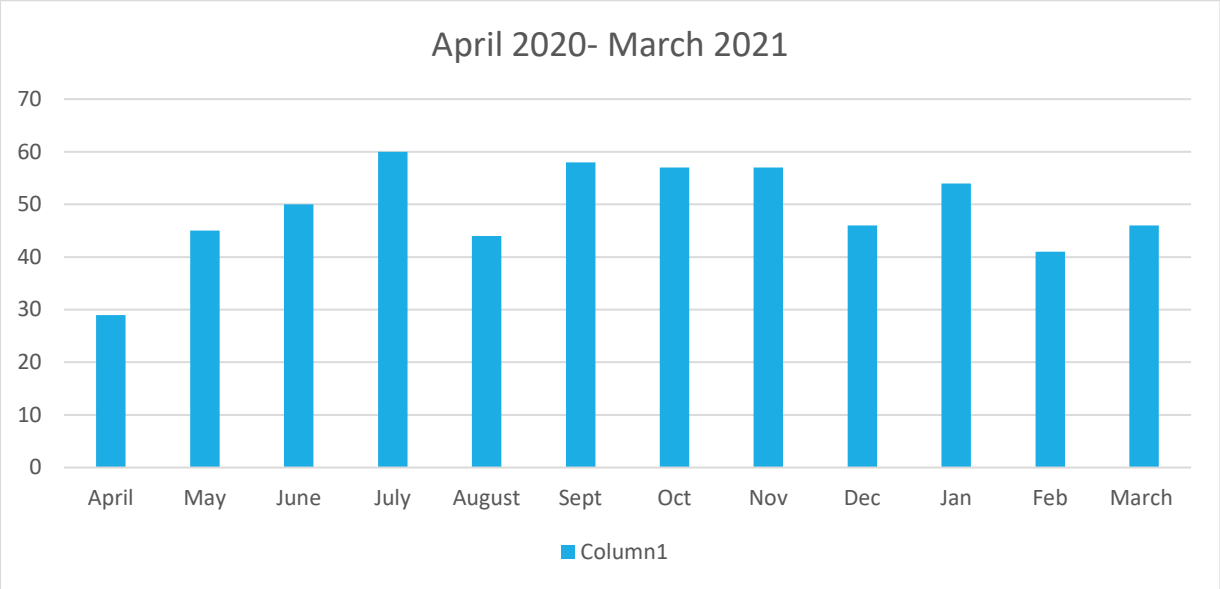
There is representation at all four sub-groups of the Board to ensure that TRFT has a voice in shaping Adult Safeguarding arrangements across Rotherham.

The Adult Safeguarding Team continues to work in partnership with RMBC to provide ‘health’ input for safeguarding investigations. This involves offering support to RMBC colleagues around investigations, Decision Making Meetings and preparations for Outcomes Meetings, even where there is no TRFT involvement. This represents the Trust’s continued commitment to partnership working.

In 2020/2021 no safeguarding concerns involving Trust services required progression to an Outcomes Meeting. This means that these concerns were managed and resolved in the initial concern stage.

As per Rotherham Adult Safeguarding Procedures, the Trust receives concerns raised about the safety and well-being of adults at risk (of neglect or abuse). For 2020/2021, 603 were received, equating to approximately 50 per month. This represents a 20% increase on figures for last year (508). Of these, a proportion (371) were passed to partner organisations to screen. These are cases where the concerns did not involve care delivered by TRFT, or which required joint-screening.





The Trust is represented at the Rotherham Multi-Agency Risk Assessment (MARAC) meetings. The HARK (Harassment, attack, rape, kick) form is now established in UECC and has been positively received. This was a specific measure taken to abbreviate the form which has resulted in better reporting within UECC.

A total of 936 cases were brought to MARAC, approximately 39 cases per fortnightly meeting, and information about the family reviewed and shared to enable the multi-

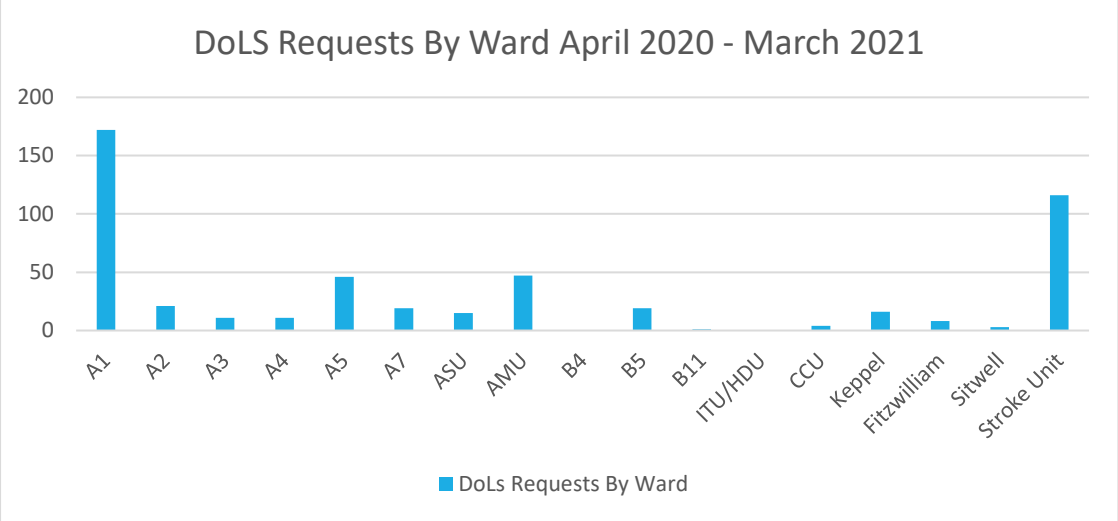
agency management of the risk related to each case. This represents a 4% increase on last year's figures. The local area increase reflects the national increase at the time during the early weeks of the Covid 19 pandemic and subsequent lockdown. MARAC meetings have been maintained virtually through 'Teams' meetings to ensure continuity of risk assessment and safety planning for the high-risk cases. In addition, MATAC (Multiagency Tasking and Co-ordination Meetings) commenced in February 2021 to review high risk and serial perpetrators of domestic abuse with interventions to address support, prevention, diversion, disruption and enforcement in order to reduce harm. The safeguarding team are represented at these meetings.

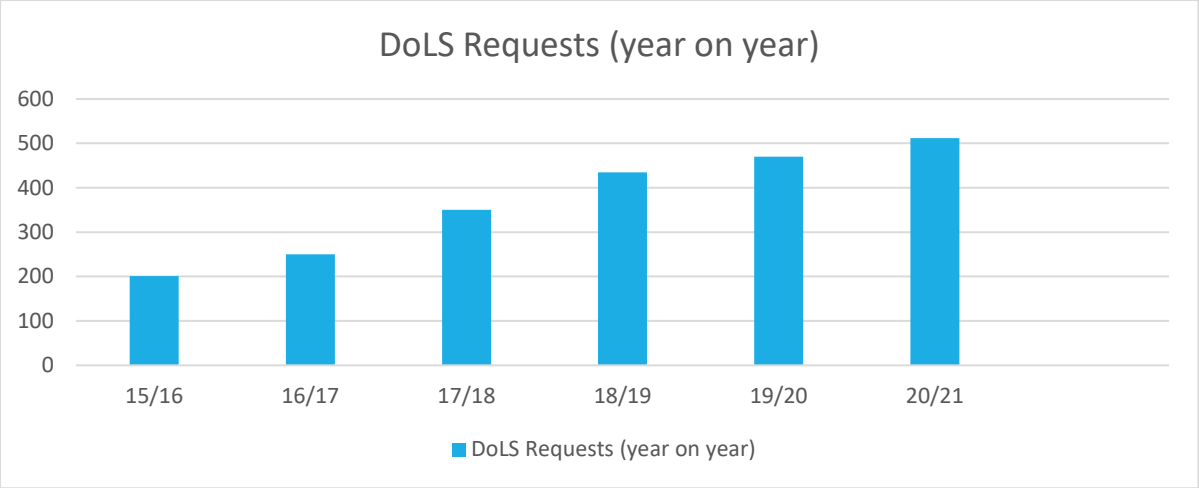
The management of patients who lack capacity to consent to care and treatment within the hospital continues to be a priority for TRFT. Work continues to embed improvements made regarding the implementation of the MCA. Requests for Deprivation of Liberty Safeguards (DoLS) continue to follow the year-on-year upward trend, demonstrating evidence of the continued application of the MCA in practice.

Adult Safeguarding again saw an increase in activity of 8% in DoLS applications to 510. Of the DoLS requests, none were authorised by RMBC. The Adult Safeguarding Team continue to provide leadership and support to ensure the processes are embedded fully across the Trust.

The Mental Capacity Act has been reviewed and amended. The expected change from DoLS to Liberty Protection Standards (LPS) was delayed and is now expected to be implemented in April 2022.

TRFT has recruited to a 1WTE Band 8A MCA Lead/Named Nurse Adult Safeguarding post, leading the LPS project plan and ensuring that we are prepared for the coming changes and will be able to meet the statutory requirements.





LEARNING DISABILITY SERVICE

The Learning Disability (LD) Team at TRFT continues to grow and strive to deliver excellent standards of care for people with LD and/or Autism. Within the Team we now have two Trainee Nursing Associates, who are specialising in LD. Following their two-year training, which completes later this year, they will have substantive positions within the LD Team.

This growth in the team allows us to visit, review and assist more people who are using the Trust facilities, in turn, improving the standard of care they receive and improving the experience for them. We continue as a Team and Trust to develop bespoke pathways, making individual 'reasonable adjustments' for people coming into the Trust. These are especially successful with patients coming through on our day surgery pathways, with patients and their teams/families giving excellent feedback.

The Team also visits people who have been discharged from hospital, to look to plan, prevent or minimise repeat admissions to hospitals, working with primary care and RDaSH Trust.

A current project that the LD Team are supporting is within our Urgent and Emergency Care Centre (UECC). The Team is working with the department to gain Autism Accreditation. This scheme is through the National Autistic Society and will help to raise the standard of care and the experience we give to patients and visitors with Autism. All of the autism awareness training that will be associated with this programme will be delivered by 'experts with experience'. This is also a project that we hope to extend through all wards and departments.

We are continuing to progress how we develop from feedback given to us from our patients, families and carers. We now have representation on our LD and autism sub-group from the parent of an individual with neuro-diverse needs and Autism. We continue to develop and welcome new members to this group. It is vital that patient

experience directly shapes and improves the services within the Trust. This group feeds directly into the Trust Patient Experience Group.

Around the Trust, the LD Team have also increased the amount of information boards there are in relation to LD and/or Autism. These act as a visual reminder to staff and visitors to the Trust regarding the LD Team and give information about the hospital passport, how to contact the team, and how we can give help and support.

Our Team is involved with the LD Mortality Reviews (LeDeR). These are reviews of deaths of people with Learning Disabilities. This is positive for our Trust to be able to learn from the thematic data this produces and improve our services accordingly.

The LD Team at TRFT continues to work in partnership with local organisations within the third sector. We work closely with Speak Up, a Rotherham advocacy organisation which employs staff and has volunteers with Autism and LD, service providers such as Voyage, Exemplar, Mencap and our Local Authority.

We hope to appoint a medical lead from the Trust for the LD Team in the near future. Having expert medical oversight will be a hugely positive achievement for patient care at TRFT and will provide clinical guidance for the Team.

The Team offers bespoke training within the Trust around LD and Autism. This training offer also extends to our local universities, for both undergraduate adult nursing programmes, postgraduate nurse training and Trainee nursing associate programmes.

CHILD DEATH REVIEW

The child death review (CDR) service has developed at a fast pace during the last year and has attracted interest from local and national Trusts to discuss and emulate the model we have embedded in Rotherham.

The CDR team aims to learn from all child deaths whilst delivering an excellent service for bereaved parents and carers.

What's working well in Rotherham?

- The Trust is represented at Rotherham Child Death Overview Panel (CDOP) and Regional CDOP.
- The introduction of the role of the Lead Nurse for Child Death within TRFT in April 2020 has proved fundamental in developing, embedding and supporting the CDR process in Rotherham. Learning from audit, local and national themes and trends is shared, and where appropriate, has influenced change in local practice.
- The appointment of the role of keyworker has proved invaluable in highlighting the need for the parental/carer voice to be heard during the CDR process. Parental /carer feedback has been crucial to identifying key learning, particularly in relation to service delivery in the first couple of weeks following

a child death. Bereaved parents/carers now have a single point of contact Mon-Friday, 9am-5pm to whom they can turn to for information on the CDR process. The keyworker discharges their care once parents/carers have been offered contact and seen by Designated Child Death Paediatrician, Lead Nurse and Keyworker following the child death review meeting.

- The CDR meetings for all child deaths have worked effectively in terms of attendance and participation. The keyworker attends the CDR meeting to ensure that the voice of parents/carer are heard and taken into account.
- Direct contact and liaison with the National Mortality Data Base (NCMD) has enabled CDOP to remain compliant with CDR guidance e.g. grading system used to identify modifiable factors.
- The CDOP and the CDR process has continued during the COVID pandemic and a number of outstanding historical cases have now been concluded at CDOP.
- There has been improved liaison with Leeds Children's Hospital, Sheffield Children's Hospital and Jessop Wing, leading to improved information sharing for deaths of children resident in Rotherham occurring outside of the area.
- The CDR meetings and use of the eCDOP system has enabled more focused discussion and evaluation of the case at CDOP, allowing more time to discuss learning points.
- There has been increased awareness of the CDR process in obstetrics and maternity services in TRFT resulting in timely initiation of relevant processes.
- The use of Rapid Response Meetings for relevant cases continues to offer an effective step at the early stages of a death to identify support for the family including siblings and schools.
- Safe Sleep in children's and maternity acute services audit has taken place. The audit identified excellent practice in SCBU and a good level of knowledge and understanding of national guidance amongst practitioners. However, national guidance was not always promoted when the baby/child was in receipt of care from TRFT. The audit included attendance at UECC and paediatric outpatient services.
- Developed links with LeDeR to ensure smooth referral of necessary cases.

What are our plans for 2021-2022

- Rotherham will host the South Yorkshire CDOP from September 2021. In conjunction with members, we will consider a number of thematic reviews to take place throughout the year.
- Improved liaison with the Coroner's Office in relation to role and function of coroner's officer and keyworker, and how they can work jointly to support families/carers.

- Audit and assurance of TRFT compliance with child death review statutory and operational guidance will take place.
- Embed child death review training on paediatric and obstetric registrar induction days and paediatric nurse training days.
- Consider and develop effective systems for cascading learning from CDOP to the wider partnership.
- Development session for CDOP members.
- Review Rotherham SUDI/C multi -agency safeguarding procedures.
- Consider the learning from National Reviews – eg NCMD Annual Report and webinars.
- TRFT will undertake self-assessment in relation to Bereavement Care Standards and identify actions, which may need to be addressed before the Trust can achieve National Care Pathways 2020, Bereavement Care Standards.

In 2020/2021 Rotherham recorded 11 child deaths in total; this is significantly below the average for years 2017-2020 (average 18 child deaths).

Rotherham CDOP cases discussed April 2020 – March 2021 (cases discussed do not collate to deaths occurred in 20-21 financial year).

Category of death	Number	Modifiable Factors
Perinatal/neonatal event	2	1
Sudden unexpected, unexplained death	3	0
Chromosomal, genetic and congenital anomalies	5	1
Infection	2	1
Acute medical or surgical condition	1	0
Trauma and other external factors	1	0
Chronic medical condition	0	-
Deliberately inflicted injury or neglect	0	-
Suicide or deliberately inflicted self-harm	0	-
Total	14	3

SAFEGUARDING CHILDREN ACTIVITY

Mandatory training remains a key priority. The development of our new training strategy, Think Family, commenced in the last quarter of 2020/21, with a focus on joint training for children's and adults competencies, meaning staff can acquire competencies in level 2 and level 3 at the same time, dependent on job role and requirements. This will be implemented and reviewed in 2021/2022. Overall figures for training compliance at levels 1, 2, and 3 have remained consistent, around the 85/90% compliance, which is all the more remarkable considering the additional pressures that the Trust has faced with COVID 19. The monitoring of training compliance continues via the Operational Safeguarding Group and Safeguarding

Strategic Group. Assurance is provided to the Quality Committee from the data provided by Electronic Staff Record (ESR).

Safeguarding Children Training Compliance - Figures at 31/03/2021

Children Safeguarding Training	Rag Rating	Percentage Achieved 2020/2021	Percentage Achieved 2019/2020
Level 1	Amber	76%	100%
Level 2	Amber	84%	84.64%
Level 3	Amber	84%	83.56%
Level 4	Amber	80%	100%

All TRFT E-learning packages and face to face training is compliant with intercollegiate requirements. There has been a continued emphasis on additional opportunities to support a blended approach to learning with 'bespoke' opportunities including attendance at safeguarding meetings, practitioner learning events, tailored feedback supervision sessions, incident review, 'stop the shift' presentations and Safeguarding Awareness Week with the key themes of Domestic Abuse, Child Sexual Exploitation and gender bias.

The Named Nurses conducted a joint review of staff MaST competencies with the Learning and development team. It was recognised that due to the variety of routes that staff can use to gain their competencies over the three year period as per Royal College of Paediatrics & Child Health (RCPCH) 'Intercollegiate Document' (2019), continual review and progression would be required to ensure the accuracy of the data obtained.

SAFEGUARDING CHILDREN DEVELOPMENTS

In 2020/2021 a key focus has continued to be the development and upskilling of the TRFT work force in order to increase practitioner confidence and competence in managing safeguarding children concerns.

The safeguarding team have implemented a number of 'Stop The Shifts' focusing on key messages e.g. Discharge Planning Meetings, Multi Agency Processes and Practice Resolution. During Covid all multi agency meetings have taken place via Teams which has benefited service users by having the right people at the right time to co-ordinate safe plans for discharge.

This has been progressed by the development of designated Safeguarding Children Champions across acute and community service areas. There has been expansion of standardised safeguarding children's competencies within key service areas to enhance level 3 skills and knowledge.

In addition to the Safeguarding Champions, the team have also been able to train additional staff in becoming Safeguarding Children's Supervisors to complement the safeguarding supervision offer across the Trust and support compliance for staff working with children.

Daily Safeguarding Children Huddles have been embedded in the acute children's services, maternity, UECC and children's ward which support meaningful case discussions and case escalations. This has emphasised that Safeguarding is a core business across the children's pathway. The huddles have also been extended to the fracture clinic and SCBU, with work ongoing to introduce the huddles within community children's services.

The use of paper safeguarding records was reviewed and Electronic safeguarding records for children and families were created through joint working with IT teams. Ward managers and paediatric practice educators agreed to implement these, with bespoke training delivered to staff.

Within maternity e-safeguarding care plans went live and staff were supported with six bespoke training sessions to support the transition to paperless. The plan was agreed with Children's ward areas to review 3 months after implementation.

Additional safeguarding alerts and prompts in UECC were expanded on the existing electronic templates. Further expansion of e-safeguarding templates in the acute Trust is planned e.g. community midwifery, SCBU, gynaecology wards and EPAU for 2021/22.

7-minute safeguarding briefings continue to be produced on a monthly basis, providing an opportunity to disseminate key current information across the Trust. Alongside these, appreciative enquiries are also produced which highlight areas of good practice to share across the workforce. This allows the safeguarding team to promote positive safeguarding messages to engage and encourage staff with the safeguarding processes.

The safeguarding team are responsible for reviewing and updating safeguarding policies. The Trust's Female Genital Mutilation (FGM) policy has been updated in line with recent changes to national guidance. Amendments were made to TRFT's Surrogacy Policy following changes to national guidance. These were reviewed by the Trust's legal team to support the transition. A Trust's Child Protection Medical Assessment Policy has also been developed in line with the national standards and a training package for medical colleagues developed in conjunction with new starter training to reinforce multiagency processes. This is co-delivered in conjunction with the RMBC children's social care, service manager and safeguarding team.

Partnership work has been undertaken to develop a Child Protection Medical Assessment 'surge plan' during Covid 19. It was anticipated that there could potentially be more children requiring child protection medical assessments (CPMA) and the surge plan would therefore ensure that all children who required a CPMA would receive one within the set partnership timescales. This was a direct result of

national networking and work to consider the priorities and demand that could be placed on the acute setting as a result of the Covid 19 situation.

Policy and processes have been implemented following the CQC inspection which identified the need for a more robust safeguarding system to identify vulnerable 16 and 17 year olds admitted to adult wards. The implementation involved building mandatory safeguarding checks into the Meditech patient record admission template. This prompted staff to request safeguarding checks which would provide information of known risks or vulnerabilities to support the assessment and ensure any emerging concerns are actioned appropriately.

The implementation involved the safeguarding team raising the awareness of child safeguarding processes across adult wards. It was key that, although infrequent, staff on adult wards were aware of who to go to for support and advice in the event of a vulnerable child being cared for on their ward.

In addition, arrangements were put in place for the safeguarding team have oversight of these admissions. IT built in a mechanism from admission of a 16 -17 year old which would trigger an email notification to the safeguarding team. It is acknowledged the workforce will need regular reinforcement of the safeguarding children's processes and review of the implementation.

KEY PERFORMANCE INDICATORS (KPI) & STANDARDS

Children's Safeguarding are required to provide assurance through the KPIs and Safeguarding Standards, as set by the Clinical Commissioning Group (CCG). These include offering assurance on a diverse range of safeguarding activity throughout the Trust, including supervision and training, division specific activity, e.g. LAC health assessments, CSE referrals and Child Protection Medicals.

Both the Safeguarding Standards and the Key Performance Indicators are reported quarterly to the Trust Safeguarding Strategic Group and Partners, including representation from the Clinical Commissioning Group, Local Authority, Local Children Safeguarding Partnership and Local Safeguarding Adult Board are members.

Following review of the terms of reference of the Operational and Strategic safeguarding meetings, plans were being implemented for the divisions to take ownership of their individual KPIs and standards with the requirement to report monthly to the Operational meeting to present their information.

SERIOUS CASE REVIEWS

Within this annual report year there have been two Serious Case Reviews (SCRs). Both were initiated by other Local Authorities, with no recommendations for Rotherham. TRFT has continued to contribute to multi-agency action plans from SCRs in the previous annual reporting period.

No Serious Incidents involving children have been identified in this reporting period however, action plans from serious incidents from the last reporting year have been

progressed and learning disseminated across the Trust. A practitioner thematic-review learning event for 3 cases was held September 2020 supported by the Rotherham Safeguarding Children Partnership (RSCP) which focussed on risks and vulnerabilities with teenage parents and bruising and injury in the non-mobile baby. While it would have been favourable to undertake such an event face-to-face Covid 19 proved to be a challenge and the event was undertaken virtually, via Teams.

SAFEGUARDING SUPERVISION

During 2020/21 the Supervision Model has continued to be embedded across the Trust. Within this annual reporting period, the Safeguarding Team have coordinated 1:1, group and adhoc safeguarding supervision sessions on a monthly basis. Due to the Covid 19 restrictions the sessions in lockdown were completed virtually.

The Children's Safeguarding Supervisors' training package continues to be delivered to colleagues from acute and community services. A training session was delivered in January 2021, with 5 further supervisors trained. Further dates for April 2021 and June 2021 are planned. This will support the offer of safeguarding supervision across the divisions with more scope for additional sessions within the departments, which will subsequently help to improve compliance. The challenge has been finding practitioners who have a keen interest but who will also be supported by their managers to undertake this additional role.

Compliance continues to be monitored through the Operational Safeguarding Group. In October 2020 there was a transfer of staff compliance from manual recording to Electronic Staff Records (ESR). There have been some difficulties with this related to the accuracy in recording staff who require supervision, resulting in manual database cross referencing against the workforce data, a time consuming exercise. This has been identified as an area that requires review and monitoring.

Due to COVID 19, an online safeguarding supervision video package was developed for staff to work through to enable them to maintain group compliance. This would allow staff to have time out for reflection and a requirement to complete the 'signs of safety' tool to demonstrate their learning. The safeguarding team implemented a process for reviewing and verifying the content of the learning record and then agreeing final compliance sign-off and then notifying the Learning and Development, who would record the achievement of this competency.

For those staff who required 1-1 supervision, sessions continued virtually.

PARTNERSHIP WORKING – SAFEGUARDING CHILDREN

Partnership working, as directed by Working Together to Safeguard Children (2018), and the Children Acts (1989 & 2004), underpins the ethos and values of the Safeguarding Children's Team.

The Trust is represented at executive level by the Chief Nurse, or her deputy, the Head of Safeguarding, who attend the Rotherham Safeguarding Children Partnership (RSCP) and Rotherham Adult Safeguarding Board (RSAB) meetings.

The Safeguarding Named Nurses and Named Midwife attend the safeguarding delivery groups of the RSCP, in line with Section 11 of the Children Act 2004 requirements. Actions and information is reported back to TRFT Safeguarding Operational Meeting with any future plans e.g. injuries in children, safeguarding risk assessment tool, parent/ carer child protection enquiries process leaflet.

Over the last 12 months the Children's Safeguarding Team have continued to work closely with our RSCP and Local Authority colleagues to improve the outcomes for children and young people. This has enabled joint priority setting, enabling the Partnership to respond to emerging themes, thereby ensuring safeguarding processes are robust and effective.

It has been recognised that communications and language between health and social care has not always been effective. From this joint discussions have taken place regularly which has given additional focus to improving and formalising the use of the practice resolution process, ensuing staff were aware of how to escalate and professionally challenge partners, with support where necessary.

The development of TRFT guidance on practice resolution was supported by walk-about sessions and stop-the-shift interventions across maternity, acute and community clinical areas. This links to the Rotherham Partnership Protocol. Further work is planned to develop the Multi-agency Safeguarding Hub (MASH) 'baby clinic' to consider information and multiagency planning for pregnant women.

TRFT Partnership arrangements are evidenced by TRFT's engagement with our Local Authority (LA) partners as well South Yorkshire Police (SYP), Rotherham Clinical Commissioning Group (RCCG) and other Health providers.

During Covid 19 lockdown an additional weekly vulnerabilities meeting was commenced to ensure partners were working effectively, able to respond to any new need and could consider new arrangements of working. In addition, the TRFT monthly Partnership Meeting (merged October 2020 with UECC Partnership Operational Meeting) continued with a virtual meeting to continue with the ethos of collective, joint solution-focused actions.

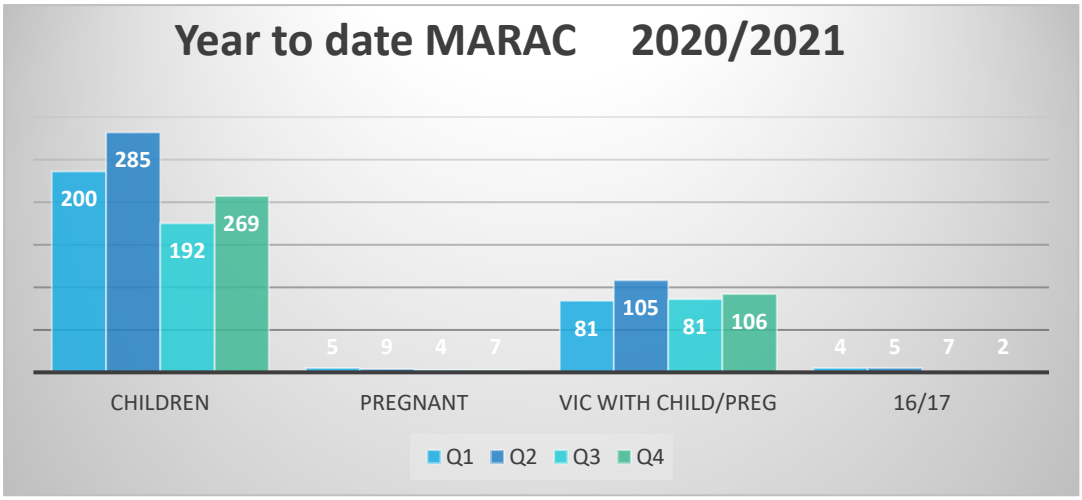
Active partnership working with the Multi-Agency Safeguarding Hub (MASH) continues. TRFT has a substantive post in MASH, and is represented at all relevant MASH meetings.

During this annual report period there have been 422 initial Child Protection Case Conferences (a 1% increase on the previous year) and 735 Review Child Protection Case Conferences (an 8.7% decrease) that health staff have contributed to.

- Legal statements were completed on 118 children by TRFT colleagues. Bespoke training, to support the staff with legal statements and quality-assuring skills has been delivered by the Safeguarding Children's Team with plans for further dates, COVID restrictions allowing.

The Trust is represented at MARAC for both adult and children's cases by the Safeguarding Children's Team, who provide health representation in high risk

domestic abuse cases which involve children, pregnant women and victims aged 16-17yrs. 373 cases of women with children (and/or pregnant) were discussed. The number of children discussed was 946. The number of pregnant women discussed showed an increase from 15 to 25, a 40% increase. The referrals for victims aged 16-17yrs rose from 12 to 18, an increase of 33%.



LOOKED AFTER CHILDREN

The Looked After Children and Care leavers service sits within Family Health, and is made up of a dedicated team of doctors, nurses and admin staff. There are strong, positive links with the safeguarding team, and performance reporting is provided for Strategic Safeguarding Committee.

This has been a further year of development and service improvement for the Looked After Children (LAC) and Care Leavers Service. A Named Doctor for Looked After Children has come into post during this report period, further nurses have joined the dedicated team, and additional admin staff are now in post.

- **Impact of the Covid 19 Pandemic**

The number of children coming into care increased over the financial year, which was expected when the country went into lockdown, reflecting the increased stress and pressures within vulnerable families due to the Covid 19 pandemic. Also, children in the adoption process were delayed in leaving care. This meant that caseloads and workloads significantly increased, and the amount of Initial Health Assessments (IHA) and Review Health Assessments (RHA) requiring completion increased. The trend is now declining with less children entering care each month and adoption processes now being finalised. Both IHAs and RHAs were undertaken virtually during the first lockdown period, but as soon as was safe to do so, assessments were returned to face to face with the use of PPE and social distancing. All staff adapted well to new ways of working to ensure a continuing safe service was delivered.

- **Performance**

The achievement of the 20 working day target is reliant on joint working with our partners, in particular, prompt notification of a child becoming looked after from Rotherham Metropolitan Borough Council (RMBC). Significant partnership work has taken place, and is on-going with partner agencies to support the timeliness of LAC accessing IHAs. Tables below show the % of IHAs completed within 20 days within the quarters, and the % completed excluding factors that were outside TRFTs control.

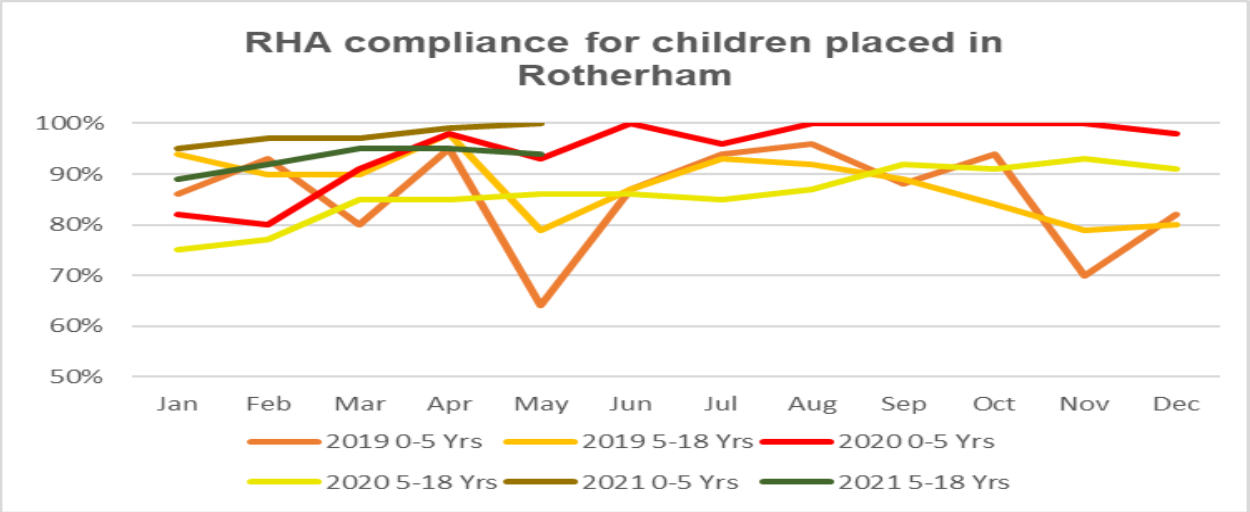
Q	Target	20/21 Achieved	20/21 excluding factors outside of TRFT's control
Q1	95%	84%	97%
Q2	95%	76%	94%
Q3	95%	82%	100%
Q4	95%	83%	100%

In Q1, the 1 IHA within TRFTs control and not completed was due to the medical practitioner's sickness. The appointment had been booked within timescale.

In Q2, of the 3 IHAs completed outside 20 day target that were within TRFTs control, 1 was due to the medical practitioner's sickness and 1 was due to the medical practitioner's IT failure although both were booked within timescale. The final IHA was delayed due to an oversight in LAC admin.

The data shows that TRFT has made significant improvements, and are performing well. There is commitment and working together from the whole service and management to improve and maintain performance, and pride is taken in the achievements made.

Throughout a child's time in care following the IHA, review health assessments (RHAs) are undertaken 6 monthly on those children under 5 years and annually for those over 5 years.



The above graph highlights the improvements made for those children placed in Rotherham, whose RHAs are undertaken by the TRFT LAC team. The nurses have shown adaptability, tenacity and a passion for our LAC throughout the pandemic, working in new ways and with restrictions. Despite these challenges, the team have improved and maintained performance as shown.

- **Service update**

The aim of the dedicated nursing team was to provide high quality, consistent health intervention with advice and support to children, young people, their carers and involved professionals, therefore providing a 'golden thread' of continuity.
A comment from the LAC Council (a group of Looked After Young People in Rotherham) during a consultation prior to the nursing team being developed was…

"***It would be more ideal that you could keep the same person so that nothing gets lost or forgotten in the process of changing, and having the same person can help us gain trust with them."***

However, at this year's Health Consultation at the LAC Council, young people indicated that health assessments have improved substantially, with young people being allowed to suggest having them at home where they feel more comfortable in a familiar environment and feel they have some control over what is happening to them rather than having the health assessment 'done to them' as they felt in the past. They had greater familiarity with the health assessor who they have met several times; only one young person wanted to change their health assessor.

This positive feedback from the young people at the heart of the service was welcomed by the team, and reinforces the need for the consistency and continuity of care, and its importance to young people in building positive relationships.

Carers have also provided email feedback regarding the positive impact of consistency and continuity…

"I wish to express how pleased I am with the help received from our LAC Nurse this year, she has consistently supported us, and has built a trusting relationship with my foster daughter."

It is reassuring that carers are identifying an improvement in the nursing service, and the positive impact this is having.

In order to support the nursing team 1:1 safeguarding supervision is integral to our work, alongside peer support and clinical supervision.

Following the successful South Yorkshire and Bassetlaw Looked After Children's Conference in March 2020, which was funded by NHSE Safeguarding North region and hosted by Rotherham CCG, planning has commenced via a task and finish group in relation to topics to be included in a further Conference later this year. Currently it is uncertain if this will be virtual or face to face.

The nursing team have commenced attendance at a support group for foster carers of babies and children under 5, where health support and advice can be shared with the foster carers. This has also now developed into health training sessions within this session in partnership with the Health Inclusion Team and the fostering service. Foster carers are finding this input very useful, and raises the profile of health and our team.

A significant project that the LAC nursing team and the Health Improvement Team have participated in is a dental project for Looked After Children. Due to the impact on dental services during the pandemic, access to dentists has been extremely challenging, therefore this project has enabled some of our most vulnerable children and young people to access this valued service.

This has been an exciting, challenging and positive year for the Looked After Children and Care Leavers Service, and we are passionate about the high quality care we deliver and are committed to continue to develop and improve in our service delivery.

SAFEGUARDING GOVERNANCE ARRANGEMENTS

Over the last 12 months the focus on a robust Trust safeguarding and external governance structure has remained a key priority (Refer to Appendix 3).

The responsibilities of all staff employed by the Trust for safeguarding children and adults are documented in the TRFT Safeguarding Policy. In addition to this there are a number of supporting policies and procedures which guide and support Trust staff.

The Chief Executive is the accountable officer. The Safeguarding Executive lead is the Chief Nurse and the Corporate/Operational Lead for Safeguarding is the Head of Safeguarding.

The Trust has two specific Safeguarding meetings: a monthly Operational Safeguarding Group chaired by the Head of Safeguarding and a quarterly Safeguarding Strategic Group, chaired by the Head of Safeguarding and latterly by the Chief Nurse, reporting to the Clinical Governance Committee. Arrangements for

the chairing and governance of both groups was reviewed in 2020 following CQC's inspection.

The role of the Strategic Safeguarding Group is to ensure processes within the Trust are in line with the current legal framework and national guidance, promoting the well-being and safeguarding of vulnerable patients whilst in the care of the Trust. In addition to Trust colleagues, membership includes representation from external partners from the Clinical Commissioning Group, the Rotherham Safeguarding Adult Board, the Local Safeguarding Children Partnership, RMBC Children and Adult Safeguarding and Public Health. This Group seeks to provide assurance on all matters relating to safeguarding and reports to the Board of Directors via the Quality Committee.

TRFT are represented on the Rotherham Safeguarding Adult Board and on the Rotherham Safeguarding Children Partnership by the Chief Nurse. The deputy for these meetings is the Head of Safeguarding.

There are a number of Safeguarding Board/Partnership delivery groups that have TRFT representation from named professionals within the team. The Performance and Quality Sub group of the Rotherham Safeguarding Adult Board is chaired by the Head of Safeguarding.

A summary report regarding key points from these delivery groups is submitted to the Operational Safeguarding Group to share information and to provide transparency and joined up working.

A 'Safeguarding Strategy on a page' is in place and sets out our strategic direction of Safeguarding. This is underpinned by a robust work plan. This was considered an excellent approach and the same approach is used for other Trust Service Strategies.

The Trust is required to satisfy the requirements of the Safeguarding Key Performance Indicators (KPI) and Safeguarding Standards, as set by the Clinical Commissioning Group. These include offering assurance on a diverse range of safeguarding activity throughout the Trust and are reported quarterly. Over the year the CCG has commended the Trust for the development of such a robust assurance system and process (Refer to Appendix 3).

In June 2019/20 NHS(E) led an inspection of the Trust's safeguarding team. This was a valuable exercise which led to a number of actions to progress the safeguarding team's work plan and supported the preparation of the Trust for the expected CQC inspection which took place in July 2020 and again in July 2021.

CQC IMPROVEMENT PLAN

In June 2020, CQC conducted an inspection across our children's pathway. From this a comprehensive CQC improvement plan was developed. This was completed on schedule, with over 180 actions specified. As a result of this, there have been significant improvements in practice within TRFT across all services linked to our children's pathway.

The improvement plan addressed a number of aspects of safeguarding arrangements including:

- **Governance**

TRFT's governance arrangements have been reviewed and strengthened to ensure that there is appropriate engagement at our specific safeguarding meetings, ensuring divisional ownership of safeguarding practice and better flow of information from ward to Board and back.

The ToR of both groups have been updated to ensure that these groups are effective in providing challenge across services, ensuring that safeguarding practice meets the required standards.

Safeguarding is now a standing agenda item on all divisional governance meetings and the safeguarding team are represented across the divisions' governance meetings.

- **Policy & Guidance**

All policies have been reviewed to ensure that they are in line with current legislation and guidance, and are relevant to practice.

Practice resolution has been of an awareness raising campaign and has been discussed through a variety of means, such as training, supervision, daily huddles, case discussions, peer reviews and advice calls.

A new TRFT guidance document has been developed and made available to all staff to ensure that they are familiar with the process and can easily access this if necessary. This links with the Partnership Practice Resolution Protocol. The safeguarding team have actively been developing staff skills to professionally challenge at the earliest opportunity seek a resolution using this process.

A training need was identified for paediatric staff in acute areas which led to the development of a bespoke training package on 'professional curiosity'.

- **Practice**

Safeguarding huddles have been embedded in maternity, UECC and paediatric wards, initially implemented five days per week but now held seven days per week to cover the risk area of weekends. This allows the teams to come together and discuss the management and planning for their safeguarding cases.

The safeguarding team support this Monday to Friday. These are audited monthly to provide assurance that safe planning is in place for children, and children are discharged safely with multiagency plans as required. Any cases for escalation can be taken to the additional case discussion meeting, or if necessary, the practice resolution process is utilised Any resulting themes are discussed at the partnership group meeting.

- **Safeguarding Supervision**

Safeguarding supervision is used to support reflection and learning across practitioners who work with children. Supervision arrangements now include peer-review for medical staff, 1:1 supervision for case-holders and group supervision. Compliance with supervision is monitored via ESR.

The safeguarding team have provided one training session with the plan for three additional training sessions in 2021/22 to increase the number of safeguarding supervisors across the children's pathway. This is in response to a number of existing supervisors having left the Trust or retired and in an attempt to improve compliance in departmental areas.

The additional supervisors, following sign-off of their competency, will be able to provide support within their area of work to complement the existing offer from the safeguarding team.

- **Training**

As a result of the CQC improvement plan, TRFT have developed and introduced a training strategy and programme using the TRFT Think Family principles. The newly combined children and adult training promotes staff to be more professionally curious, to contextualise information and to consider the wider picture rather than solely focus on the information the child or patient provide. This is in its early stages, however is evaluating well. It is supported by a practice 'toolkit'.

The training uses a Serious Adult Review for discussion, reflection and learning, focusing on various safeguarding elements, allowing for Trust processes and policies to be discussed as part of this training as well as wider partnership processes, with the aim to embed these within practice.

A refreshed, bespoke 'new-starter' programme has been developed aimed at medical colleagues, to ensure that they are familiar with TRFT process and able to discharge their accountability in safeguarding our patients. The training package is more robust with a practical application using case scenarios and is delivered in conjunction with Children's Social Care manager and safeguarding team to emphasise Working Together to Safeguard Children, thus reinforcing multiagency arrangements.

In addition, maternity services have responded to new starter need and provided four bespoke sessions to support the newly qualified staff acknowledging the pressures of qualifying during the pandemic.

In order to improve the quality of the children's referrals to children's social care, the safeguarding team have promoted the rolling training: Quality Child Safeguarding (eMARF) referrals. The training incorporates a practical application to the use of the Rotherham Multiagency Threshold Descriptors and importantly empower staff to consider and evidence "the voice of the child" when completing any referrals.

- **Audit**

A number of audits across the divisions were identified from the improvement plan. All were completed to schedule.

These included audit related to the quality of the electronic Child Safeguarding referrals (EMARF) referrals, effectiveness of the safeguarding huddles with discharge planning, Think Family documentation and assessment, 16 + 17year-old pathway, compliance with safeguarding checks, implementation of the MCA, Child Protection Medical Assessment process and the use of Body Maps. These audits all have action plans and the learning from each audit was cascaded out to the relevant area via a summary 'report on a page'. All audits are reported on either through the Operational Safeguarding meeting or divisional governance meetings and monitored by the clinical effectiveness department.

- **Patent Safety**

TRFT completed a thematic review of serious incidents, which allowed us to focus on the common themes and target additional resources in these areas.

Going forward, as there have been no safeguarding related Serious Incidents since February 2020, the safeguarding team will review all datix related to safeguarding issues, and use this to target our resources, providing support and training to ensure staff are developing confidence and competence.

RISKS AND MITIGATION

The following risks have been identified and managed throughout the last 12 months. Performance is reviewed and risks are monitored through the Operational Safeguarding Group and the Strategic Safeguarding Group.

All risks are included on the Chief Nurse Risk Register and managed accordingly.

1. Safeguarding Children Training Compliance
2. Child Protection E-MARF forms process
3. Implementation of the MCA
4. Management of injuries to infants under 2 years, including non-mobile babies

Description of Risk and Control Measures

1. Safeguarding MaST Training Compliance

The risk is in relation to TRFT colleagues not accessing the required level of safeguarding training, which may impact on their competence when required to assess safeguarding risk for children and adults. This is an approved risk with a score of 10 (High Risk).

Mitigations: The Safeguarding Team continue to receive monthly compliance reports. Colleagues receive a three-monthly reminder to complete their training from ESR.

The training offer during COVID has been made available, where possible, through Teams to ensure all staff can access training as normal. The E-learning package remains in place to provide core competency updates for safeguarding children, with the additional packages to support the additional hours required.

Training compliance is monitored and escalated via the Operational and Strategic Safeguarding Groups.

2. Child Protection E-MARF forms process

This risk is in relation to RMBC making changes to their domain address which has impacted upon the generation of an electronic referral receipt back to TRFT colleagues when making a 'worried about a child' referral (e-MARF). For TRFT colleagues this has meant that a copy of the referral was not provided for saving in the child's records. This is a managed risk with a score of 6 (Moderate Risk).

Mitigations: As an interim measure, TRFT colleagues were advised to record the reference number of the submitted referral and record the concerns on the safeguarding template (if a SystmOne user) or in the Child's health record (if not a SystmOne user).

There has been extensive liaison between TRFT and RMBC involving coordinated contact with NHS.net. There is now a temporary IT measure in place that allows a copy of the referral to be received within the TRFT Safeguarding Team, and further work is in progress to find a permanent solution.

3. Implementation of the MCA

The risk relates to providing evidence to support the continued and consistent implementation of the MCA & Deprivation of Liberty Safeguards (DoLS) throughout the Trust. This risk now includes Liberty Protection Safeguards (LPS) and how this will be implemented within the Trust.

Mitigations: There is continued input from the Adult Safeguarding Team to support and develop staff across the Trust to evidence their use of the MCA and DoLS in practice, and to be competent and confident in this. A variety of training has been provided throughout the period to support staff, as well as work progressed to ensure that the mental capacity assessments and best interest decisions can be recorded on the electronic patient record. This is a managed risk with a score of 6 (Moderate Risk).

The Adult Safeguarding Team have completed audit which demonstrated an overall baseline assurance that 87.5% of staff are completing MCA documentation. This audit will be repeated in 2021/22.

4. Management of injuries to infants under 2 years, including non-mobile babies

There is a risk of injuries in infants under two years, including non-mobile babies, being inappropriately clinically managed and not giving appropriate consideration to wider safeguarding issues which may be present. The concerns involve staff potentially failing to recognise wider concerns related to injuries in this group of patients and staff potentially failing to follow local policy and procedure when these cases present. This is particularly relevant where there may be temporary/Locum staff who are unfamiliar with TRFT policy and process for managing these issues. This carries a risk that appropriate single and multi-agency intervention to reduce risk and prevent further injuries to this group may be delayed.

Mitigations: The 'Bruising in non-mobile babies' pathway has been developed. This is now included in the Rotherham M/A procedures. A Child Safeguarding Risk assessment tool was developed within TRFT and has been approved for wider partnership use.

The safeguarding team has provided reinforcement of the appropriate management of these cases.

Case supervision and daily safeguarding Huddles have been implemented within UECC, Children's Ward, SCBU and Midwifery. Work is ongoing to embed the use of body-mapping across these services.

There has been development of the Child Protection Medical Assessment Policy and an increased focus on Partnership working, to ensure timely sharing of concerns and learning from cases.

TRFT new starter training has been refreshed for medical colleagues and use of case scenarios to reinforce multiagency safeguarding procedures.

This is an approved risk with a score of 8 (High Risk).

SUMMARY AND CONCLUSION

TRFT Safeguarding and Vulnerabilities Team continue to engage with Trust services and partner agencies throughout the Borough to develop and progress the safeguarding service to ensure our organisation, staff and patients are safe at all times. The workload has continued to increase across adults and children's work streams in relation to changes to legislation and national statutory guidance, but also due to the increased demand locally for safeguarding input across a wide range of areas, the actions required to implement the CQC Improvement Plan and accommodating the demands placed on our service, and the NHS by Covid-19.

In spite of these challenges, the Safeguarding & Vulnerabilities Team have continued to improve the support available across the Trust, assisting TRFT staff to incorporate safeguarding into their daily work load and ensuring good outcomes.

The Safeguarding team are committed to ensuring all systems and processes support the early identification of safeguarding concerns and promote an approach which has the voice of the child or adult at risk at the forefront of care delivery throughout the Trust. The positive impact of the CQC implementation plan is now evidencing the improved engagement and ownership of safeguarding matters across all divisions of the Trust.

Improvements in governance arrangements are set to continue, with review of the Terms of Reference of both Trust safeguarding groups to ensure that these meetings deliver on their objectives and can offer assurance on safeguarding activity throughout the Trust.

Covid-19 has forced a new way of working on services, which our team have adapted to positively, and used to progress the safeguarding agenda, both within our Trust and externally with our partners. It has resulted in some positive impacts, with improved attendance at meetings and stronger links with our LA partners to ensure that safeguarding arrangements are robust and continue to be developed and progressed as we move towards recovery.

Novel training approaches have been put in place, virtual safeguarding supervision and Teams meetings utilised to ensure that the business of safeguarding within TRFT did not lose any momentum in the circumstances.

The Safeguarding and Vulnerabilities Team have developed a robust work plan, which is monitored and updated regularly and will continue to support safeguarding practice in the coming year throughout our Trust.

FUTURE PRIORITIES

The Safeguarding Team have identified a number of key priorities for 2021-2022 to strengthen safeguarding arrangements for the Trust:

- To achieve all safeguarding contracting Standards and Key Performance Indicators.
- To improve the evidence available demonstrating compliance with the MCA & DoLS requirement and transition to the Liberty Protection Safeguards (LPS) arrangements.
- To progress towards Autism Accreditation for UECC to ensure that this patient group has access to high standards of care.
- To continue to support all staff to achieve compliance with safeguarding policy, procedure, training and supervision.
- To continue to work on improving the quality of safeguarding referrals to the local authority, both in children and adults.

- To develop a safeguarding referrals database providing opportunity to theme the topics of referrals in order to influence safeguarding training for the workforce.
- To develop a MASH Baby Clinic process to discuss any pregnant Mother's safeguarding risk and make the relevant referrals to children's social care in as timely a manner as possible.
- To work collaboratively with our Trust colleagues to manage the ongoing challenges of Covid-19, ensuring that staff continue to feel supported in keeping vulnerable people safe and the Trust is prepared to manage any increased demand on our services.
- To conduct a 'deep dive' of a range of the actions covered through the CQC improvement plan. This will allow for new practices to be tested and assessed, helping us to identify the impact of the changes made.
- To improve our care of patients who have poor mental health by partnership working with RDaSH.
- To continue to increase workforce competence through developing knowledge and skills within the adult and children's safeguarding champions.
- To continue to work with divisions and IT to develop the e-safeguarding templates on Meditech and support with the implementation for use in practice.

SAFEGUARDING PERFORMANCE SUMMARY ON A PAGE – INFORMATION FOR Q1 2020/2021

Risks and Management of Risks

- The Covid-19 arrangements have impacted on the Safeguarding team. A plan has been put in place to ensure the statutory functions are maintained.
- Issues regarding the new EMARF form continue. The Safeguarding team have worked with RMBC and the Trust's IT team to resolve this matter, which has also been escalated to the NHS.net national team. The implementation of the Mental Capacity Act across the Trust remains a high priority. There is good evidence that, even in the midst of Covid-19, staff are continuing to embed the principles of the MCA. DoLS requests have been relatively consistent during Q1.
- MaST training compliance remains a high priority. An escalation process has been agreed with the Chief Nurse and Medical Director which will ensure that staff are appropriately informed of non-compliance and that there is Divisional oversight of this issue.
- All risks are being actively managed and processes are in place to enable regular review and plan to improve the situation. 3 risks, MCA, MaST training compliance and the EMARF issues are on the Chief Nurse Risk Register and monitored via the Safeguarding Operational Group and Safeguarding Strategic Group.

Performance Assurance and Process

Assessment of the Safeguarding Standards and Key Performance Indicators will be presented at the Safeguarding Strategic Meeting on 22 July 2020. Actions are in place for on-going development.

Active Partnership Working – Partnership working has continued during Q1, in spite of Covid-19. Systems have been put in place, and many meetings and work streams have continued to be progressed virtually. TRFT have participated in a twice weekly 'Vulnerable Children – Multi-Agency' meeting to ensure that appropriate plans have been in place to manage throughout the Covid situation.

A Safeguarding Quarterly Report is provided to the Clinical Governance Committee and Quality Committee, presented by the Chief Nurse and Head of Safeguarding.

The report regarding the **Local Safeguarding Children Partnership & Rotherham Safeguarding Adult Board** joint assessment is expected in the near future.

The Children's Safeguarding Team have continued to offer support throughout the quarter, despite Covid. The Safeguarding Huddles have continued and demonstrated good outcomes. This process will continue to be developed through the coming quarter.

Some Key Developments and information during Q1 2020/2021

Completing a quality EMARF training: The Children's Safeguarding Team have continued to deliver focussed sessions to support staff to utilise Multi-Agency Threshold Descriptors, Signs of Safety Model and Practice Resolution Processes, in order to evidence risk to support case escalation. Work is now planned to ensure that all staff are aware of the Practice Resolution Process, which will support professional challenge where there may be disagreement in the management plans for children where there are safeguarding concerns.

Post-Covid Surge Plan – TRFT Safeguarding Team have been active partners in reviewing and planning for the expected Post Covid surge. This is likely to impact on all services who work with vulnerable people. Domestic abuse is likely to feature strongly in this. Regular multi-agency briefings have been shared, and a TRFT 7-minute briefing is currently being prepared to ensure staff are aware of this and know how to recognise and respond to such concerns.

Safeguarding Training Compliance: Quarter 1 has shown a continued slight general increase in compliance with MAST. Work is continuing across the Trust to ensure that this trend continues. E-learning is available to support MAST compliance during COVID-19 arrangements. In addition, face-to-face training is planned to resume within the coming quarter.

MCAA: No date has yet been provided for the publication of the new Code of Practice for the amended Act. Liaison with the LA and partners is on hold due to this and the Covid-19 situation.

TRFT has recruited an MCA Lead Nurse to drive forward the necessary changes within the Trust.

Safeguarding 7-minute briefings are being regularly produced to ensure staff have access to key messages and learning from investigations /reviews etc.in both adult and children's safeguarding. These are available through The Hub, and are also distributed via regular communications.

Safeguarding Supervision: Virtual Safeguarding supervision has evaluated well during Covid -19 arrangements. Plans are being considered to continue this method of supervision deliver.

Thematic Review of Injuries in non-mobile babies- The safeguarding team have completed a single-agency thematic review of all recent serious incidents involving injuries to non-mobile babies. This work has been welcomed by our partners and will now be extended to include our partner agencies who provide services across Rotherham.

Safeguarding Q1 Training Information

Children Safeguarding Training	Rag Rating	Percentage Achieved
Level 1	Green	100%
Level 2	Green	84.6% to 85.53%
Level 3	Green	86% to 86.1%
Level 4	Amber	75%
Induction Training	Green	100%

Adult Safeguarding Training	Rag Rating	Percentage Achieved
Level 1	Green	100%
Level 2	Green	82.4% to 85.04%
Level 3	Green	100%
Level 4	Green	100%
Prevent Level 1,2	Green	91% to 90.5%
Prevent Level 3.4.5	Green	89.7% to 92.7%
Induction Training	Green	100%

SAFEGUARDING PERFORMANCE SUMMARY ON A PAGE – INFORMATION FOR Q2 2020/21

Risks and Management of Risks

- The Safeguarding Team have been working with the Trust to ensure that normal safeguarding services are resumed, as Covid appears to be more controlled.
- Issues regarding the new EMARF form continue from Q1 with the same escalation strategies in place.
- Mental Capacity training sessions at ward level are taking place due to the expansion of the team, and increased visibility. DoLS applications have seen a small increase throughout the Trust.
- MaST training remains a high priority. Face to face training sessions have resumed in accordance with Covid regulations, and a virtual corporate induction session has commenced. For Children the highlighted areas for MaST training are with corporate services, this is mirrored is adults also.
- A new risk - Injuries in non-mobile babies - has been added to the 3 risks already on the Chief Nurse Risk Register. This risk, alongside our other risks, MCA, MaST training compliance and the EMARF issues are monitored via the Safeguarding Operational Group and Safeguarding Strategic Group.

Performance Assurance and Process

Assessment of the Safeguarding Standards and Key Performance Indicators will be presented at the Safeguarding Strategic Meeting on 28th October 2020. Actions are in place for on-going development.

Active Partnership Working – Partnership working has continued during Q2, in spite of Covid-19 for both Adults and Children. Systems have been put in place, and many meetings and work streams have continued to be progressed virtually.

A Safeguarding Quarterly Report is provided to the Clinical Governance Committee and Quality Committee, presented by the Chief Nurse and Head of Safeguarding.

LPS has been agreed as an operational objective for 2021 with support from PMO. We are awaiting the release of the Code of Practice for LPS, which will guide our ongoing actions.

The Daily Safeguarding Children's Huddles continue. The effectiveness of these and compliance with the Discharge Planning policy is being audited monthly and demonstrate good outcomes.

TRFT SI learning event has been supported by the Partnership. 3 cases were discussed and 'summaries on a page' produced for each. The learning is expected to be being cascaded by the safeguarding children's champions /leads to departments.

Some Key Developments and information during Q2 2020/2021

CQC 'targeted' inspection
CQC carried out a targeted inspection of children's services in June. From this a comprehensive improvement plan was agreed to ensure that TRFT continues to provide safe care to its children. The Safeguarding Team are working closely with all divisions to ensure that safe processes are agreed and embedded in practice.
Completing a quality EMARF training: The Children's Safeguarding Team have continued to deliver focussed sessions to support staff to utilise Multi-Agency Threshold Descriptors, Signs of Safety Model Practice Resolution Processes, in order to evidence risk assessment in order to support case escalation.
Stop the shift discharge planning and strategy meetings sessions in maternity and children's ward / SCBU have been held to reinforce and raise aware awareness of multiagency process and policy.
Regular Walk-about sessions have begun, supporting staff with embedding safeguarding processes and encouraging respectful professional challenge and prompt practice resolution in the management plans for safeguarding concerns.
Post-Covid Surge Plan – TRFT Safeguarding Team have been active partners in reviewing and planning for the expected second Covid surge. This is likely to impact on all services who work with vulnerable people. Domestic abuse is likely to feature strongly in this and we have seen this with an increase from Q1 =3 referrals to Q2 =16 referrals. Regular multi-agency briefings have been shared, and a TRFT 7-minute briefing is now circulated to staff to raise awareness of this and know how to recognise and respond to such concerns.
Safeguarding Training Compliance: Q2 has shown a continued slight general increase in compliance with MAST. Work is continuing across the Trust to ensure that this trend continues. E-learning is available to support MAST compliance during COVID-19 arrangements. Additional job-specific bespoke safeguarding training has resumed face-to-face and a number of "voice over presentations" with a staff work booklet will be available.
The **MCA** Lead Nurse is now in post and begins to drive forward the necessary changes within the Trust to implement the LPS arrangements.
Safeguarding 7-minute monthly briefings are being produced to ensure staff have access to key messages and learning from investigations /reviews etc.in both Adult and Children's safeguarding. These are available through The Hub, and are also distributed via regular communications.
Safeguarding children Supervision: Virtual Safeguarding supervision has evaluated well during Covid -19 arrangements. During Q2 these have continued to be provided virtually. In addition, group supervision Microsoft Teams sessions have recommenced.

Safeguarding Q2 Training Information

Children Safeguarding Training	Rag Rating	Percentage Achieved
Level 1	Green	100%
Level 2	Green	85.53% to 88.83%
Level 3	Green	86.1% to 91.25%
Level 4	Green	75% to 100%
Induction Training	Green	100%

Adult Safeguarding Training	Rag Rating	Percentage Achieved
Level 1	Green	100%
Level 2	Green	87% to 88.89%
Level 3	Green	100%
Level 4	Green	100%
Prevent Level 1,2	Green	91.23% to 100%
Prevent Level 3.4.5	Green	91% to 95.34%
Induction Training	Green	100%

SAFEGUARDING PERFORMANCE SUMMARY ON A PAGE – INFORMATION FOR Q3 2020/21

Risks and Management of Risks

- The Safeguarding Team have been working with the Trust to ensure that normal safeguarding services are maintained as Covid progresses along its second wave.
- Issues regarding the new EMARF form continue from Q2 with the same escalation strategies in place.
- Mental Capacity training sessions at ward level are taking place. Arrangements are in place to capture this activity. DoLS applications have again seen an increase across the Trust.
- MaST training remains a high priority. Face to face training sessions, which had been resumed, were again cancelled in favour of virtual sessions, reflecting the resurgence of Covid.
- There remain 4 risks on the Chief Nurse Risk Register. Injuries to non-mobile babies, implementation of the MCA, MaST training compliance and the EMARF issues continue to be monitored via the Safeguarding Operational Group and Safeguarding Strategic Group.

Performance Assurance and Process

Assessment of the Safeguarding Standards and Key Performance Indicators will be presented at the Safeguarding Strategic Meeting on 27th January 2021. Actions are in place for on-going development.

Active Partnership Working – Partnership working has continued during Q3, in spite of Covid-19 for both Adults and Children. Systems have been put in place, and many meetings and work streams have continued to be progressed virtually. The Adult Safeguarding Team are now attending AMU daily to support with safeguarding issues.

A Safeguarding Quarterly Report is provided to the Clinical Governance Committee and Quality Committee, presented by the Chief Nurse and Head of Safeguarding.

LPS has been agreed as an operational objective for 2021 with support from PMO. We are awaiting the release of the Code of Practice for LPS, which will guide our ongoing actions. This is expected in April 2021. Work has begun to develop the project plan to progress this.

The Daily Safeguarding Children's Huddles UECC, Childrens ward continue The effectiveness of these and compliance with the Discharge Planning policy is being audited monthly and demonstrate good outcomes with safe discharges.

There has been no serious incidents in TRFT since Feb2020

Admissions 16 & 17-Year-old Safeguarding processes have been reviewed and Policy developed for implementation

Some Key Developments and information during Q3 2020/2021

CQC 'targeted' inspection
The CQC improvement plan continues to be progressed. Work is ongoing to embed the changes across the Trust and ensure that TRFT continues to provide safe care to its children. The Safeguarding Team are working closely with all divisions to ensure that staff are supported to achieve this.

Post-Covid Surge Plan – TRFT Safeguarding Team have been active partners in reviewing and planning for the second Covid surge. This is likely to impact on all services who work with vulnerable people. Regular multi-agency briefings have been shared, and a TRFT 7-minute briefing has been circulated to support staff with MCA during COVID, as well as partnership 7-minutes briefings with RDaSH.

Safeguarding Training Compliance: Q3 has shown a slight decrease in compliance with MAST. Work is continuing across the Trust to ensure that this is rectified; this was expected due to the second wave of COVID 19. E-learning is available to support MAST compliance. Additional job-specific bespoke safeguarding training has resumed face-to-face and a number of "voice over" presentations; the joint (adult & children safeguarding) corporate induction with voice over is now available and will go live on 6th January 2021.

The **MCA** Lead Nurse is now in post and begins to drive forward the necessary changes within the Trust to implement the LPS arrangements. The latest to be distributed was a 7-minute briefing on Modern Slavery.

Completing a quality EMARF training: The Children's Safeguarding Team have continued to deliver sessions to support staff to utilise Multi-Agency Threshold Descriptors, to evidence level of concern /risk

TRFT Think Families approach is being embedded through updating Policies and processes and incorporated into training and Safeguarding 7 minute Briefings e.g. Adverse Child Hood experiences, working effectively with males /hidden males, domestic abuse

TRFT Safeguarding Childrens Risk Assessment Tool has been developed, used in training, shared with Partners

Safeguarding children Supervision: Safeguarding supervision has continued for 1:1 and those requiring group have offer of video cases or group sessions via teams during Covid -19 arrangements. This is being monitored via ESR Live from October 2020 Monthly Group supervision sessions Peer review for paediatric and UECC medical colleagues have been established.

Teenage Pregnancy rates have been noted to have significantly increased - 70 teenage parents as of December 20. A task and finish group has been created to consider how best to support this group.

E-Safeguarding care plan – came into effect on the 1st Nov, safeguarding documentation for maternity is now all electronic, making communication between practitioners easier.

Safeguarding Q3 Training Information

Children Safeguarding Training	Rag Rating	Percentage Achieved
Level 1	Amber	100% to 64.71%
Level 2	Green	88.83% to 86.41%
Level 3	Green	91.25% to 90.29%
Level 4	Green	100%
Induction Training	Green	100%

Adult Safeguarding Training	Rag Rating	Percentage Achieved
Level 1	Amber	100% to 65.76%
Level 2	Green	88.89% to 89.05%
Level 3	Green	100%
Level 4	Green	100%
Prevent Level 1,2	Green	100% to 89.28%
Prevent Level 3.4.5	Green	95.34% to 93.72%
Induction Training	Green	100%

SAFEGUARDING PERFORMANCE SUMMARY ON A PAGE – INFORMATION FOR Q4 2020/2021

Risks and Management of Risks

- The Safeguarding Team are continuing to work to ensure that normal safeguarding services are maintained as we continue to feel the impact of Covid.
- There has been no progress to resolve the issues regarding the EMARF form. The 'work-arounds' are still in place and are proving effective in managing the risk.
- Mental Capacity training sessions are continuing. DoLS applications are maintaining a steady level.
- MaST training remains a high priority. It is expected that the Trust will resume face-to-face sessions gradually as Covid becomes more controlled.
- There remain 4 risks on the Chief Nurse Risk Register. Injuries to non-mobile babies, implementation of the MCA, MaST training compliance and the EMARF issues continue to be monitored via the Safeguarding Operational Group and Safeguarding Strategic Group.

Performance Assurance and Process

Assessment of the Safeguarding Standards and Key Performance Indicators will be presented at the Safeguarding Strategic Meeting on 28th April 2021. Actions are in place for on-going development.

Active Partnership Working – Partnership working has continued during Q4, in spite of Covid-19 for both Adults and Children..

A **MASH baby clinic** has been set up to ensure multiagency planning for unborn and their families where there are historical and emerging concerns.

A Safeguarding Quarterly Report is provided to the Strategic Safeguarding Group and the Quality Committee, presented by the Chief Nurse and Head of Safeguarding.

LPS has been agreed as an operational objective for 2021 with support from PMO. The action plan is being progress, but is impacted by the delay in the publication of the Code of Practice.

The Daily Safeguarding Children's Huddles in UECC and Children's ward continue The effectiveness of these and compliance with the Discharge Planning policy is being audited monthly and demonstrate good outcomes with safe discharges. The adult Safeguarding Team have joined in with safeguarding huddles in UECC and are attending AMU daily. The integrated safeguarding team are working together to embed the THINK FAMILY Principles.

There have been no **Serious Incidents** in TRFT since Feb 2020.

Some Key Developments and information during Q4 2020/2021

CQC 'targeted' inspection
The CQC improvement plan continues to be progressed. We continue to work to embed the changes across the Trust and evidence the impact of the improvements.

CQC Improvement Plan Task & Finish Group: There has been a T&F group to provide clear information to staff throughout the Trust of the key changes related to the CQC inspection. The story-boards will be circulated via Communications and also displayed within work areas.

Post-Covid Surge Plan – TRFT Safeguarding Team continue to work with our partners to ensure appropriate plans are in place to manage provision as Covid progresses. There is likely to be a significant impact on all Trust services who work with vulnerable people.

Safeguarding Training Compliance: Q4 has shown a slight decrease in compliance with MAST. Work is continuing across the Trust to ensure that this is rectified; this was expected due to the second wave of COVID 19. E-learning is available to support MAST compliance. A rolling training programme has been developed to enhance the additional job-specific bespoke safeguarding training requirement offer with resumed face-to-face and virtual sessions ;

MCA & LPS: The publication of the new Code of Practice for the LPS changes has been delayed. This will impact on our project implementation, however, the MCA Lead Nurse is continuing to strengthen the implementation of the MCA to support any changes in the future.

Completing a quality EMARF audit: This has shown an improvement in the quality of the EMARFs completed and better evidenced the use of the multi-agency Threshold Descriptors.

TRFT Think Families approach: The training programme has been considered and discussed through the Operational Safeguarding Group. This will commence in April 2021.

TRFT Safeguarding Childrens Risk Assessment Tool has been developed, used in training and shared with Partners. This has been adopted by our partners and has been highly praised.

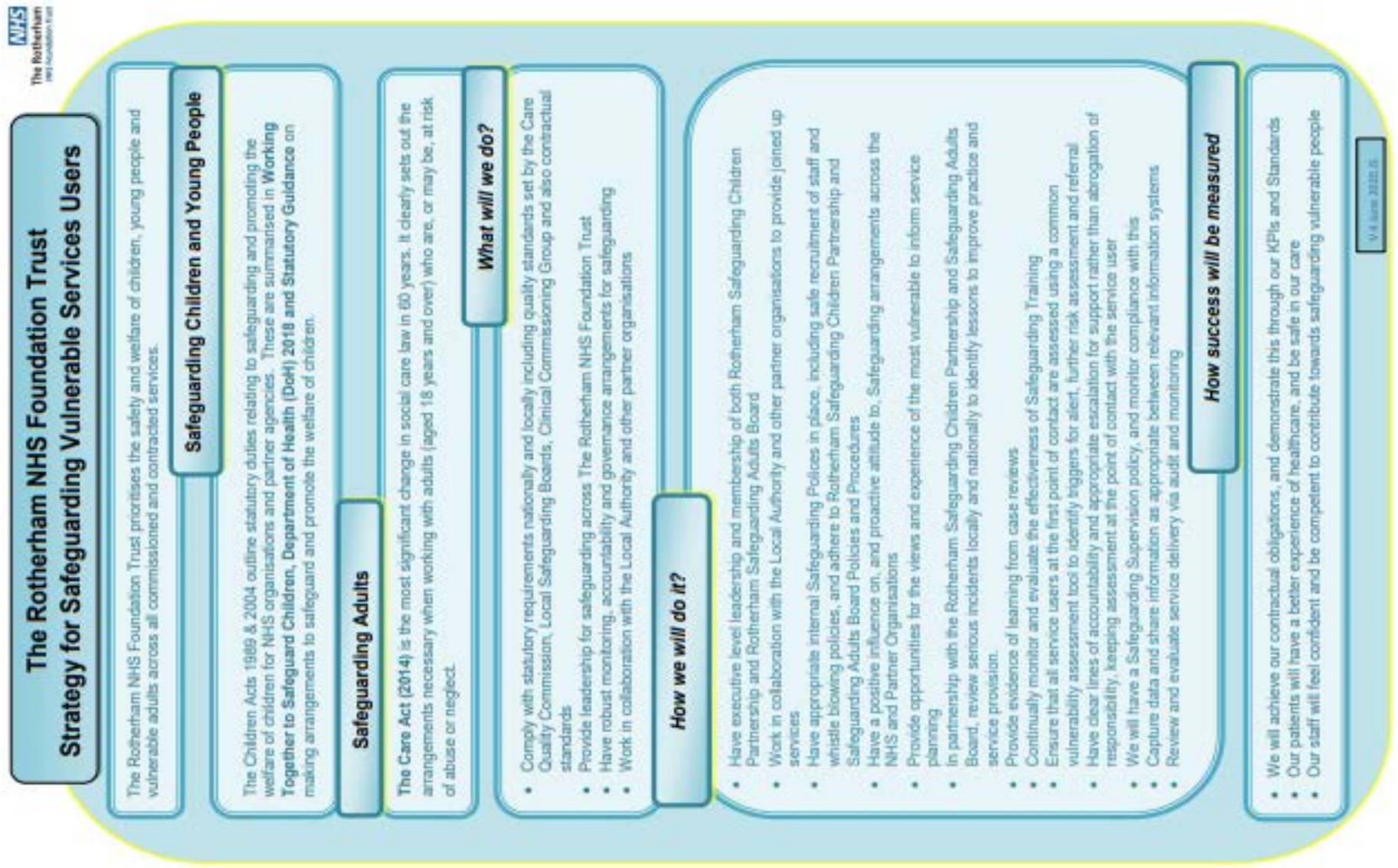
Safeguarding children Supervision: Safeguarding supervision has continued for 1:1 and is being offered by virtual group sessions. Peer review sessions for paediatric and UECC medical colleagues have been established.

E-Safeguarding care plan –safeguarding documentation for maternity and paediatric inpatient department is now all electronic, making communication between practitioners easier.

Safeguarding Q4 Training Information

Children Safeguarding Training	Rag Rating	Percentage Achieved
Level 1	Amber	64.71%to 76.14 %
Level 2	Amber	86.41% to 83.79 %
Level 3	Amber	90.29% to 83.7%
Level 4	Amber	80%
Induction Training	Green	100%

Adult Safeguarding Training	Rag Rating	Percentage Achieved
Level 1	Amber	65.76% to 79.76
Level 2	Green	89.05% to 90.25 %
Level 3	Green	100%
Level 4	Green	100%
Prevent Level 1,2	Green	91.79%
Prevent Level 3.4.5	Green	93.72% to 94.2 %
Induction Training	Green	100%


The Rotherham NHS Foundation Trust
Strategy for Safeguarding Vulnerable Services Users
The Rotherham NHS Foundation Trust prioritises the safety and welfare of children, young people and vulnerable adults across all commissioned and contracted services.
Safeguarding Children and Young People
The Children Acts 1989 & 2004 outline statutory duties relating to safeguarding and promoting the welfare of children for NHS organisations and partner agencies. These are summarised in Working Together to Safeguard Children, Department of Health (DoH) 2018 and Statutory Guidance on making arrangements to safeguard and promote the welfare of children.
Safeguarding Adults
The Care Act (2014) is the most significant change in social care law in 60 years. It clearly sets out the arrangements necessary when working with adults (aged 18 years and over) who are, or may be, at risk of abuse or neglect.
What will we do?
Comply with statutory requirements nationally and locally including quality standards set by the Care Quality Commission, Local Safeguarding Boards, Clinical Commissioning Group and also contractual standards
Provide leadership for safeguarding across The Rotherham NHS Foundation Trust
Have robust monitoring, accountability and governance arrangements for safeguarding
Work in collaboration with the Local Authority and other partner organisations
How we will do it?
Have executive level leadership and membership of both Rotherham Safeguarding Children Partnership and Rotherham Safeguarding Adults Board
Work in collaboration with the Local Authority and other partner organisations to provide joined up services
Have appropriate internal Safeguarding Polices in place, including safe recruitment of staff and whistle blowing policies, and adhere to Rotherham Safeguarding Children Partnership and Safeguarding Adults Board Policies and Procedures
Have a positive influence on, and proactive attitude to, Safeguarding arrangements across the NHS and Partner Organisations
Provide opportunities for the views and experience of the most vulnerable to inform service planning
In partnership with the Rotherham Safeguarding Children Partnership and Safeguarding Adults Board, review serious incidents locally and nationally to identify lessons to improve practice and service provision.
Provide evidence of learning from case reviews
Continually monitor and evaluate the effectiveness of Safeguarding Training
Ensure that all service users at the first point of contact are assessed using a common vulnerability assessment tool to identify triggers for alert, further risk assessment and referral
Have clear lines of accountability and appropriate escalation for support rather than abrogation of responsibility, keeping assessment at the point of contact with the service user
We will have a Safeguarding Supervision policy, and monitor compliance with this
Capture data and share information as appropriate between relevant information systems
Review and evaluate service delivery via audit and monitoring
How success will be measured
We will achieve our contractual obligations, and demonstrate this through our KPIs and Standards
Our patients will have a better experience of healthcare, and be safe in our care
Our staff will feel confident and be competent to contribute towards safeguarding vulnerable people

The Rotherham NHS Foundation Trust
Strategy for People with a Learning Disability/and or Autism

The Rotherham NHS Foundation Trust is committed to providing excellent standards of care to people with a Learning Disability/and or Autism. Providing person centered holistic care, based on individual needs.

What is a Learning Disability?

It can be defined as a significant reduced ability to understand new or complex information, to learn new skills (significantly impaired intelligence). Coupled with a reduced ability to cope independently (impaired social/adaptive functioning), which started before adulthood (onset before aged 18) – with a lasting effect on development.

National drivers

- **Progress on improving nursing for people with Learning Disabilities (DOH 2014)**
- **The Equalities Act 2010, MCA 2005, DOLS 2007 & The Bubb report 2014.**
- **NHSi Learning Disability Improvement Standards for NHS trusts 2018 & NHS long term plan 2019**

What we will do?

- We will comply with statutory requirements nationally and locally including quality standards set by the Care Quality Commission, Local Safeguarding Boards and Clinical Commissioning Groups.
- We will provide leadership and support for patients with a Learning Disabilities/and or Autism within The Rotherham NHS Foundation Trust
- We will ensure that our Learning Disability Service has robust performance monitoring systems, through the Safeguarding Groups, to ensure we are delivering a high quality service
- We will ensure reasonable adjustments are made for people with a Learning Disability and/or Autism

How we will do it?

- Have executive level leadership via the Chief Nurse as the Executive Lead for vulnerable people.
- Work in collaboration with the Local Authority and partner organisations such as RDaSH, Advocacy groups and provider services, enhancing joined up working.
- Have appropriate internal Safeguarding Polices in place including whistle blowing policies and adhere to the Trust Learning Disability/and or Autism policy.
- Have a positive influence and proactive attitude on improving health and well-being outcomes for people with Learning Disabilities/and or Autism across NHS and Partner Organisations
- Provide opportunities for the views and experience of people with a Learning Disability/and or Autism to inform service planning and development, linking in with partnership agencies.
- Ensure all individuals with a diagnosed Learning Disability have an Hospital Assessment in place and has input/advice on their individual care pathway from the Lead Nurse in Learning Disabilities
- Provide evidence of learning from serious case reviews associated with patients with a Learning Disability and/or Autism.
- Continually monitor and evaluate the effectiveness of Safeguarding Training
- Ensure that all service users at the first point of contact are ; identified as having a Learning disability/and or Autism, that reasonable adjustments are made, that risk assessments are completed and a that a referral to the Lead Nurse in Learning Disabilities is made.
- To continue to promote the role of the Learning Disability Champion on each ward and Department, to advocate for and ensure the additional needs of a person with Learning Disability/and or Autism are met.
- Provide regarding Learning Disabilities/and or Autism and monitor the effectiveness of this.
- To ensure the information we provide to people with a Learning disability/and or Autism is in an accessible /appropriate format for that individual.
- Review and evaluate service delivery via audit and monitoring to ensure we are providing a high quality service.

How success will be measured

- We will achieve our contractual obligations, and demonstrate this through our KPIs and Standards
- Our patients will have a better experience of healthcare, and be safe in our care
- Our staff will feel confident and be competent to care for patients who have a Learning Disability and/or Autism

V4 June 2020 IS & IT

The Rotherham NHS Foundation Trust Strategy for Supporting Vulnerable Services Users who have Poor Mental Health

The Rotherham NHS Foundation Trust prioritises the safety and welfare of children, young people and vulnerable adults across all commissioned and contracted services.

No health without Mental Health

The cross-government document 'No health without Mental Health' sets shared objectives to improve people's mental health. This document highlights its expectation of parity of esteem between mental and physical health services. Subsequent documents have progressed this work to improve outcomes for people with mental health problems.

Safeguarding Adults

The Care Act (2014) is the most significant change in social care law in 60 years. It provides a statutory framework for safeguarding adults who are, or may be, at risk of abuse or neglect and clearly sets out the arrangements necessary when working with adults (aged 18 years and over).

What we will do?

- Comply with statutory requirements nationally and locally including quality standards set by the Care Quality Commission, Local Safeguarding Boards, Clinical Commissioning Group and also contractual standards
- Provide leadership for safeguarding across The Rotherham NHS Foundation Trust
- Have robust monitoring, accountability and governance arrangements for safeguarding
- Work in collaboration with partner organisations to provide joined up services, implementing the Core 24 agenda within Urgent & Emergency Care service

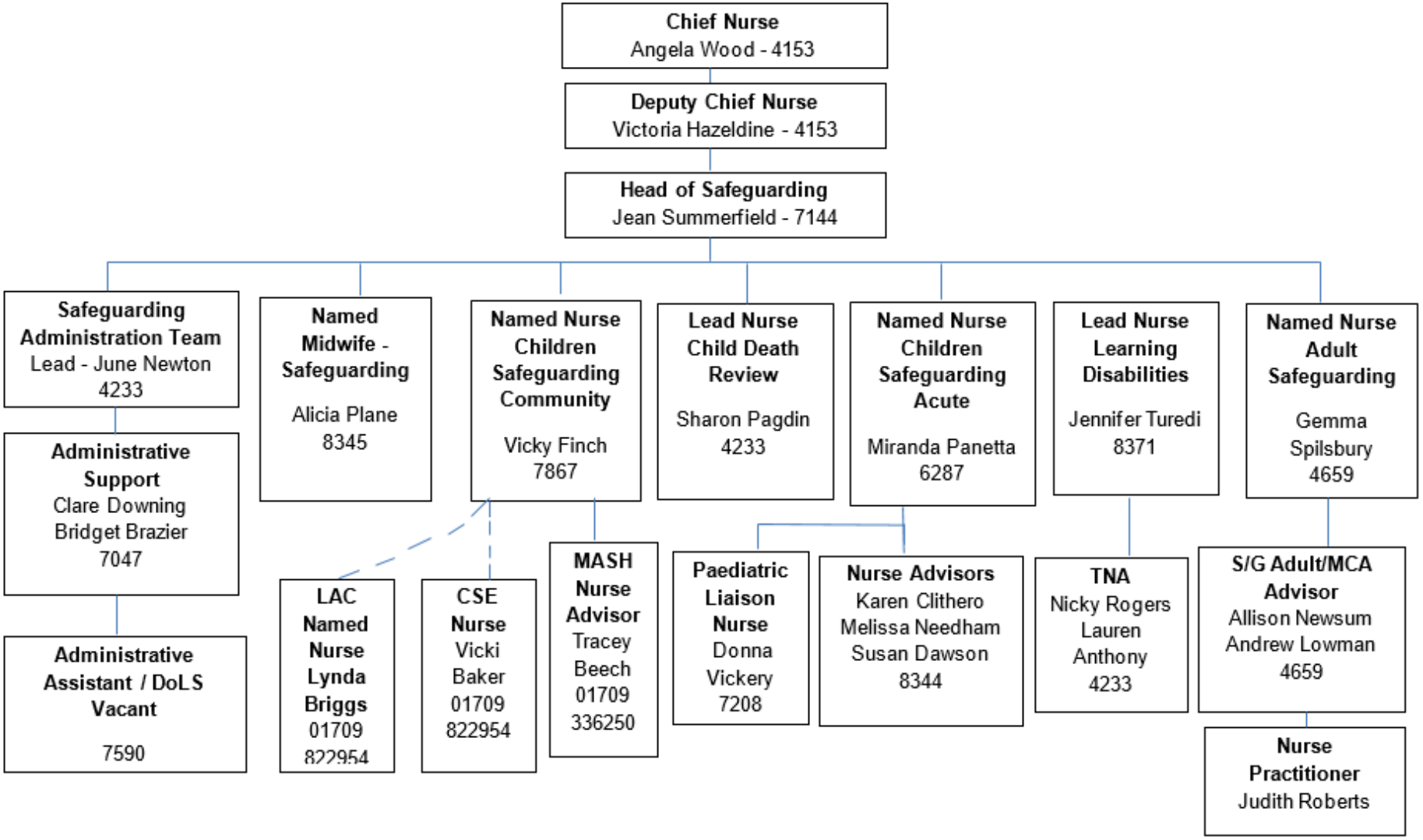
How we will do it?

- Have executive level leadership and membership of both Rotherham Safeguarding Children Partnership and Rotherham Safeguarding Adults Board
- Work in collaboration with the Rotherham, Doncaster and South Humber Mental Health Foundation Trust (RDaSH) to provide joined up services for people with an identified Mental Health need as identified in the Five Year Forward View for Mental Health
- Promote 'parity of esteem' across our services where there is an identified Mental Health need
- Have a positive influence on, and proactive attitude to, safeguarding arrangements across the NHS and partner organisations
- Provide opportunities for the views and experience of the most vulnerable to inform service planning
- In partnership with the Rotherham Safeguarding Children Partnership and Rotherham Safeguarding Adults Board, review serious incidents locally and nationally to identify lessons to improve practice and service provision
- Implement mandatory Mental Health awareness training for all staff across the Trust to improve understanding
- Ensure that all service users at the first point of contact are assessed using a common vulnerability assessment tool to identify triggers for alert, further risk assessment and referral and promote equity of service delivery
- Have clear lines of accountability and appropriate escalation for support rather than abrogation of responsibility, keeping assessment at the point of contact with the service user
- Capture data once and share information as appropriate between relevant information systems
- Work closely with our RDaSH colleagues to ensure that appropriate referral pathways are developed and utilised

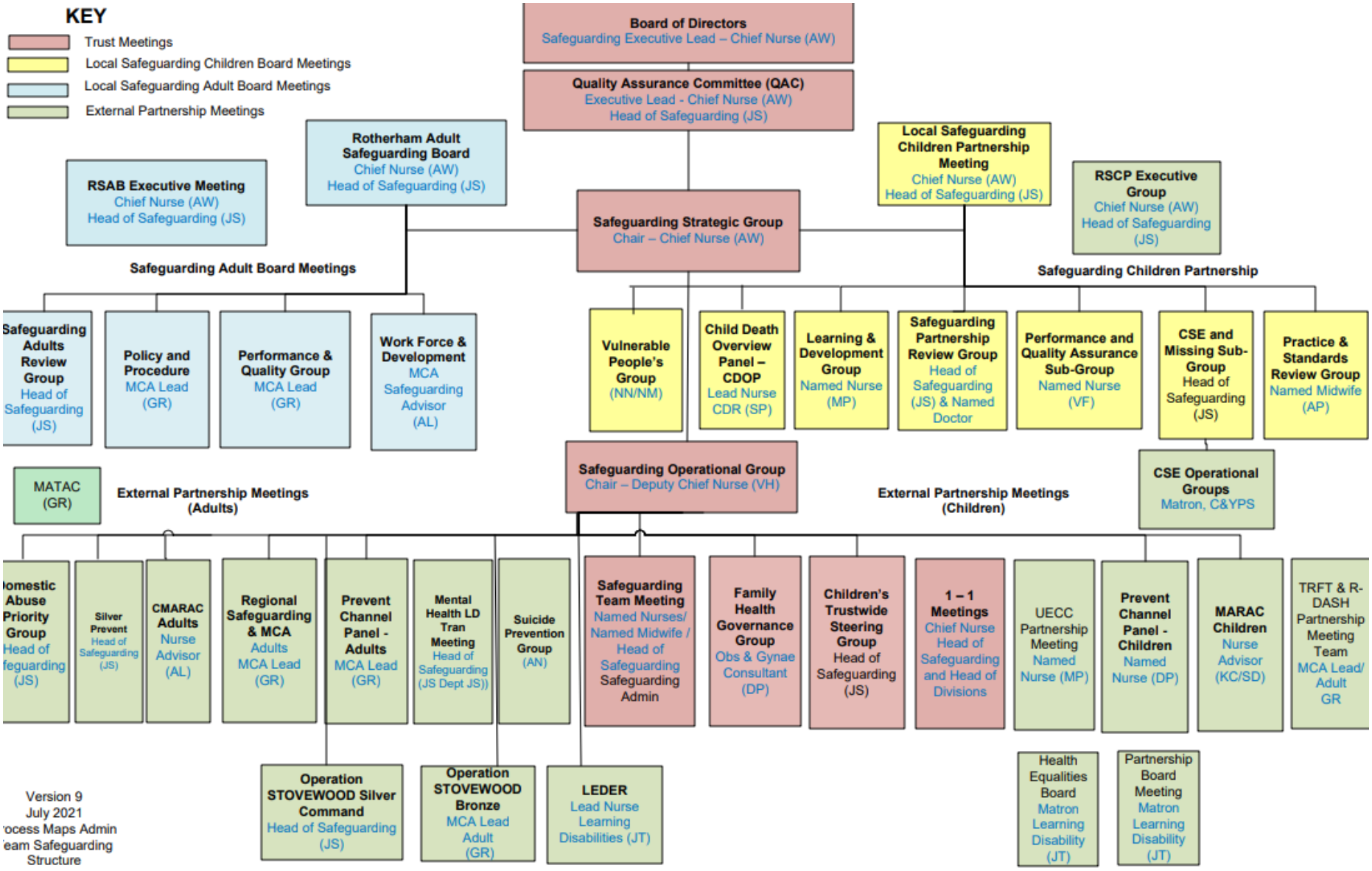
How success will be measured

- We will achieve our contractual obligations, and demonstrate this through our KPIs and Standards
- Our patients with poor mental health will have a better experience of healthcare, and be safe in our care
- Our staff will feel confident and be competent to care for patients who have poor mental health

MANAGEMENT AND PROFESSIONAL LEADERSHIP - SAFEGUARDING & VULNERABILITES TEAM Appendix 2



APPENDIX 3


KEY
Trust Meetings
Local Safeguarding Children Board Meetings
Local Safeguarding Adult Board Meetings
External Partnership Meetings
Board of Directors
Safeguarding Executive Lead – Chief Nurse (AW)
Quality Assurance Committee (QAC)
Executive Lead - Chief Nurse (AW)
Head of Safeguarding (JS)
Rotherham Adult Safeguarding Board
Chief Nurse (AW)
Head of Safeguarding (JS)
RSAB Executive Meeting
Chief Nurse (AW)
Head of Safeguarding (JS)
Safeguarding Strategic Group
Chair – Chief Nurse (AW)
Local Safeguarding Children Partnership Meeting
Chief Nurse (AW)
Head of Safeguarding (JS)
RSCP Executive Group
Chief Nurse (AW)
Head of Safeguarding (JS)
Safeguarding Adult Board Meetings
Safeguarding Children Partnership
Safeguarding Adults Review Group
Head of Safeguarding (JS)
Policy and Procedure
MCA Lead (GR)
Performance & Quality Group
MCA Lead (GR)
Work Force & Development
MCA Safeguarding Advisor (AL)
Vulnerable People's Group
(NN/NM)
Child Death Overview Panel – CDOP
Lead Nurse CDR (SP)
Learning & Development Group
Named Nurse (MP)
Safeguarding Partnership Review Group
Head of Safeguarding (JS) & Named Doctor
Performance and Quality Assurance Sub-Group
Named Nurse (VF)
CSE and Missing Sub-Group
Head of Safeguarding (JS)
Practice & Standards Review Group
Named Midwife (AP)
MATAC (GR)
External Partnership Meetings (Adults)
Safeguarding Operational Group
Chair – Deputy Chief Nurse (VH)
External Partnership Meetings (Children)
CSE Operational Groups
Matron, C&YPS
omestic Abuse Priority Group
Head of feguarding (JS)
Silver Prevent
Head of Safeguarding (JS)
CMARAC Adults
Nurse Advisor (AL)
Regional Safeguarding & MCA
Adults MCA Lead (GR)
Prevent Channel Panel - Adults
MCA Lead (GR)
Mental Health LD Tran Meeting
Head of Safeguarding (JS Dept JS))
Suicide Prevention Group
(AN)
Safeguarding Team Meeting
Named Nurses/ Named Midwife / Head of Safeguarding Safeguarding Admin
Family Health Governance Group
Obs & Gynae Consultant (DP)
Children's Trustwide Steering Group
Head of Safeguarding (JS)
1 – 1 Meetings
Chief Nurse Head of Safeguarding and Head of Divisions
UECC Partnership Meeting
Named Nurse (MP)
Prevent Channel Panel - Children
Named Nurse (DP)
MARAC Children
Nurse Advisor (KC/SD)
TRFT & R-DASH Partnership Meeting Team
MCA Lead/ Adult GR
Operation STOVEWOOD Silver Command
Head of Safeguarding (JS)
Operation STOVEWOOD Bronze
MCA Lead Adult (GR)
LEDER
Lead Nurse Learning Disabilities (JT)
Health Equalities Board
Matron Learning Disability (JT)
Partnership Board Meeting
Matron Learning Disability (JT)
Version 9
July 2021
ocess Maps Admin
eam Safeguarding Structure

SAFEGUARDING STANDARDS – EXCEPTION REPORT APPENDIX 4

This exception report includes areas of non-compliance over the financial year 20/21. It serves to demonstrate progression, and identifies areas for future development, which will be incorporated into the work streams.

Safeguarding Standards	Q1	Q2	Q3	Q4	
Standard 5 - Training					
5.1 The provider will ensure that all colleagues and volunteers undertake safeguarding training appropriate to their role and level of responsibility and that this will be identified in an organisational training needs analysis and training plan. This training needs to include: ● LAC . ● Prevent ● FGM ● CSE ● MCA/DoLS ● Domestic Abuse ● Modern Slavery (including Human Trafficking) ● Neglect & Self Neglect	Children & Adult				Ref 574 Safeguarding Vulnerable People Policy All new starters receive safeguarding introductory presentation with Q & A from safeguarding team on induction. New and existing staff receive an annual leaflet on safeguarding which satisfies level 1 training. Extensive collaborative work is ongoing to ensure that staff have the appropriate level of children's and adult's safeguarding training assigned to them which has been agreed by the subject matter expert and the local manager in line with the release of both the Adult and Children's Intercollegiate documents. In respect of level two safeguarding adults training, elearning options have been put in place and additional units attached for MCA. In respect of Level two and Level three children's training, eLearning modules are in place with the additional option for face to face multi-agency training at L3. Additional bespoke training is offered to support learning and any current topical themes. PREVENT training is aligned with Children's safeguarding training requirements in line with the most recent NHS England guidance. full review of training has taken place during March 2021
5.3 The Provider will ensure that all colleagues undertake safeguarding training in line with national and local expectations. This includes safeguarding updates as a minimum of 3 yearly and an annual written update. The provider will ensure that all Board level staff receive additional to the level 1 requirement, safeguarding training as per Intercollegiate documents (children & adults).					Provision is in place for all relevant training for all colleagues, however training figures although excellent in some areas need further progress (see KPI information) Training has been reviewed during March 2021 with a programme identified for the year for Level 2 Adults and Children, and Level 3 children and Levl 2 adults full day training

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P43/22
Report	**National, Integrated Care System and Integrated Care Partnership Report**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B10, B11
How does this paper support Trust Values	N/A
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to provide the Trust Board with an update on national developments and developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and Integrated Care Partnership (Rotherham Place). Key points to note from the report are: 1. National planning guidance and the Elective Recovery Plan were both published. These set out key priorities and expectations for the NHS over the coming years 2. As part of the elective recovery plan, it is expected that the elective waiting list will continue to grow for another 2 years 3. The Secretary of State for Health and Social Care visited Doncaster Hospital, touring the new extension to the Women's and Children's facility. 4. Rotherham ICP continued to move to a business-as-usual position with work across all key areas progressing. 5. The ICP Prevention and Health Inequalities Group has produced a draft strategy and an action plan. The Chair of the group (Ben Anderson) the Director of Public Health for Rotherham, is also working with the Trust's Health Inequality Task and Finish group.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Executive Team receives a weekly verbal update covering key Place and ICS level activities in addition to specific papers periodically, as and when required.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Board note the content of this report.

Appendices	Appendix 1 – ICP Priorities Update

1.0 Introduction

1.1 This report provides an update on national developments and developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and the Integrated Care Partnership (Rotherham Place).

2.0 National Update

2.1 On Christmas Eve the NHS published its annual Planning Guidance. The guidance is similar to the 2021/22 Half 2 guidance and asks Trusts to focus on:

A) Investment in workforce
B) COVID-19 Response and Vaccinations
C) Delivering more elective capacity
D) Improved responsiveness in urgent and emergency care
E) Improve access to primary care
F) Improve mental health services
G) Continue to develop a population health approach to address health inequalities
H) Exploit digital technologies
I) Make effective use of resources
J) Establish ICBs and collaborative system working

2.2 To complement the Planning Guidance, on 8 February 2022 the NHS and Government published its slightly delayed Elective Recovery Plan. The plan outlines how the NHS and Government will address the backlog built prior to and through the COVID pandemic and tackle long waits through increased capacity and prioritising treatments.

The plan is built around 4 main areas:

1) **Increasing capacity** though growing the workforce, using digital technologies, safely adapting infection and prevention control measures and the use of the independent sector
2) **Prioritising treatment** to ensure that patients are seen in order than reflects clinical judgement on need, targeting long waiters and increasing the number of cancer referrals, helping those to come forward who did not during the pandemic.
3) **Transforming how elective care is provided** through community diagnostic centres and surgical hubs, increasing access to specialist advice for referrers, personalising outpatients and reducing pathway complexity.
4) **Better information and support for patients** through the launch of 'My Planned Care' and supporting patients to prepare for surgery and

In setting out the recovery plan, it was made clear that the NHS elective waiting list would continue to increase until March 2024, despite the NHS committing to increasing capacity by 30% (of pre pandemic levels) over the next few years.

2.3 NHS services in the East of England have been affected by cases of Lassa fever. As of the 16th February, a total of three people have been treated for the disease, all of whom had recently travelled to West Africa. Several staff have needed to isolate causing disruption to some services.

2.4 Sir David Sloman was appointed to the role of Chief Operating Officer of NHS England on 14 December. He had previously been the London Regional Director and Group Chief Executive for the Royal Free London NHS Foundation Trust. Sir David is the substantive appointment to the role vacated when Amanda Pritchard was appointed as NHS Chief Executive.

3.0 South Yorkshire & Bassetlaw Integrated Care System (SYB ICS)

3.1 Mr Sajid Javid, Secretary of State for Health and Social Care visited Doncaster Royal Infirmary on 15 February. On the visit he toured the new development on the Women's and Children's hospital facility, which is in part a response to the damage caused last year.

3.2 The newly appointed ICS Chief Executive, Gavin Boyle continues to meet and engage with members of the ICS. In February, Gavin attended the Acute Federation, Chaired by Martin Havenhand, the Chairman of The Rotherham NHS Foundation Trust.

4.0 Rotherham Integrated Care Partnership (ICP)

4.1 The ICP continues to move towards 'business as usual' following significant COVID pressures in late December and January due to the Omicron wave. Place priorities which had previously been agreed (appendix one) will continue to guide work.

4.2 The Place Board received an update of the work of the ICP Prevention and Health Inequalities Group**.** The Trust has representation on this group. Work is gathering momentum, with progress on a draft strategy and an action plan. Six key priorities have been identified:

1. Strengthen our understanding of health inequalities
2. Harness partners' collective roles as anchor institutions
3. Develop the healthy lifestyles prevention pathway
4. Support the prevention and early diagnosis of chronic conditions
5. Tackle clinical variation and promote equity of access and care
6. Advocate for prevention across the system

To take forward the population health management/data aspects of the strategy a sub-group has also been established. Named Executive leads for health inequalities have been confirmed to ensure wider partnership input and leadership. The next steps will be to sign off the action plan; develop an outcomes framework and dashboard and hold a workshop in March with a focus on the anchor institution role. It should also be noted that the Director of Public Health for Rotherham who leads the ICP Prevention and Health Inequalities Group**,** also works with the Trust's Health Inequalities Task and Finish Group.

4.3 ICP Chief Executives collectively met with Gavin Boyle, SY ICB Chief Executive on the 16 February. The session commenced with a presentation explaining the challenges across Rotherham Place and the current priorities as well as how Rotherham views the future as an already well developed place. Members of the ICP were able to demonstrate the strength and maturity of the Rotherham partnership.

4.4 The ICP Delivery Team has appointed Executive Sponsors to the enabling groups within the place plan. This is to increase their support and exposure. The leads are as follows:

- Communications and Engagement – Ian Atkinson
- Estates – Michael Wright
- Organisational Development and Workforce – Suzanne Joyner
- Digital – Ian Spicer

4.5 The Health Select Commission met in February. This is a forum where local councillors receive updates on various health services delivered across Rotherham Place. Colleagues from the Trust attended two recent meetings, presenting on Maternity Services and discharge processes.

4.6 The Health and Wellbeing Board met at the end of January 2022. The key areas of focus included system pressures, housing, the Safeguarding Annual Report and Carers across Rotherham.

Michael Wright
Deputy Chief Executive
March 2022

Rotherham Place Reset: Assessment of Priorities

as at October 2021

In March 2020 the Rotherham Place Board agreed the revised Rotherham Integrated H&SC Place Plan, significant work by all partners went into setting and agreeing the priorities for the Rotherham Place.

As part of the system reset following the first wave of the pandemic the priorities were set for the remainder of the financial year 2020/21 and were received by Place Board in October and December 2020.

In March 2021 worked commenced once again to reaffirm the priorities following the subsequent wave of the pandemic and the winter period. Transformation Groups have spent significant time assessing and reconfirming priorities and the key actions associated.

This document provides a Q2 end of September position which was received at Place Board at their 3rd November Confidential meeting so enable members understand performance against revised target dates and any risks to delivery. As the public meetings in December and January were cancelled it is being received at February 2022 Public Place Board for completeness.

In this version of the priorities document the Enabling Groups have identified their key priorities, although further work is taking place to refined these, and this version also addresses the high number of acronyms identified.

Key

Red	Milestone significantly off target
Amber	Milestone slightly off target
Green	Milestone on target
Blue	Milestone complete
Purple	Milestone not due

Abbreviation	Organisation
CCG/RCCG	Rotherham Clinical Commissioning Group
RMBC	Rotherham Metropolitan Borough Council
VAR	Voluntary Action Rotherham
RDASH	Rotherham Doncaster and South Humber NHS Trust

Children and Young People

In the refreshed Rotherham Place Plan the following were identified as priority areas for this transformation area:

1. The first 1001 days
2. Special Education Needs and Disabilities
3. Looked After Children
4. Children & Young People's Mental Health and Emotional Wellbeing
5. Transition to Adulthood

Below are the milestones identified for each of these priorities and the assessment of post Covid impact.

Priority 1	The First 1001 Days	Lead Officer			Subgroup reporting to the C&YP Transformation Group with lead responsibility is:
		Alex Hawley			TBC
No.	Description	Target	RAG position as end June 2021	RAG position as at Oct 2021	Update / Key actions
CH 1	Local leadership and governance in place to deliver on the first 1001 days	Q2 2021			• A 0-19s re-commissioning project group continues to meet, chaired by the Director of Public Health, with subgroups to work to procurement timetable milestones. A needs assessment has been carried out. A draft specification is in place and will be finalised by end of November. A market engagement event took place early September. A co-production exercise will be undertaken with Rotherham Parent Carers Forum in Oct/Nov. A report will go to RMBC Cabinet in December, outlining good progress against timeline for tender in April 2022. A new contract will be in place by April 2023. • Public Health has restructured - to have 4 Consultant portfolios aligned to the 4 aims of the Health and Wellbeing Strategy. A new Best Start (Aim 1) portfolio has been in place since 1st July. A second Public Health Specialist post has been recruited to and will commence in January 2022. • A 'Best Start and Beyond strategy' will adopt a life-course structure and provide a context for priorities for 0-19s service and rest of children's workforce and will enable a 1001 Days sub-group to be established. A kick-off workshop with partners will take place on 11th October.
CH 2	Carry out a scoping exercise and gap analysis to identify services already contributing to the first 1001 days and what we need to develop	Q2 2021			• A scoping exercise took place with representatives from Health services on 10th August – a "jamboard" session to map commissioned services, and aspects of services provided. • A further exercise to better map non-healthcare services is still needed. • The Best Start and Beyond Strategy sub-groups will adopt a template for mapping pathways. May be adapted from pathway mapping tool already deployed by Speech, Language and Communication Network to map related pathways from 0 to 60 months. Will be informed by "Start for Life" user journeys, described in The Best Start for Life. A Vision for the 1,001 Critical Days.
CH 3	Development of a local action plan to deliver on the first 1001 days	Q2 2021			• The Best Start and Beyond Strategy will provide a Public Health-led evidence-based set of agreed priority outcomes for 1001 Days, and associated sub-group will agree an action plan. • Strategy will enable better links to actions of South Yorkshire and Bassetlaw Local Maternity and Neonatal System Prevention Group in respect of post-COVID recovery and maternity transformation. NHS England published Equity and equality: Guidance for local maternity systems in September, aimed at aligning Local Maternity Systems with the five health inequality priority areas set out in March operational guidance (Priority 1: Restore NHS services inclusively; Priority 2: Mitigate against digital exclusion; Priority 3: Ensure datasets are complete and timely; Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes; Priority 5: Strengthen leadership and accountability. South Yorkshire and Bassetlaw Local Maternity and Neonatal System Equity Analysis focuses on Priority 4a (Understand your population and co-produce interventions).

CH 4	To explore realigning commissioning pathways and commissioning arrangements in relation to 0-19 services	Q1 2023			• Preparations to re-commission the 0-19 service are well advanced and on track for Tender to open in Spring 2022. This milestone remains on track. • The specification for new 0-19s has been developed to optimize the ability of the service to adapt to the system and changes in needs and priorities, and to include co-production (based on Four Cornerstones) as an ongoing aspect of service development. The 0-19s Project Group is exploring evaluation models that acknowledge the importance of integration, adaptability, and additionality. • Public Health is commissioning Rotherham Parent Carers Forum to conduct a co-production exercise (October – December) to inform the specification, using the Four Cornerstones ethos. • The Best Start and Beyond strategy will provide a framework for the 0-19s to be integrated within a system (covering preconception through to transition to adulthood, but with a key focus on 1001 Days). • Discussions have commenced with 0-19s provider about developing the current service in light of the new Healthy Child Programme guidance, including optimising continuity of care between midwifery and 0-19s service.

Key Risks / Issues

- Pandemic is ongoing – Best Start portfolio within Public Health is resuming 'Business as Usual', but further surges or advent of vaccine-escape variants still present a risk to resource deployment, including commissioned healthcare resources, which might need to be redeployed (e.g. currently some disruption due to 12-15 vaccination programme).
- Risk of lack of adaptability to changing priorities of 0-19s service within a long term contract – a well designed specification is the mitigation for this, albeit always constrained by the available budget and the core Healthy Child Programme requirements. Central government thinking might lead to different expectations for local systems: e.g. Early Years review and ongoing Public Health England review of Healthy Child Programme.

Priority 2	**Special Educational Needs and Disabilities**	**Lead Officer**			**Subgroup reporting to the C&YP Transformation Group with lead responsibility is:**
		Julie Day			**TBC**
No.	**Description**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
CH 5	The Rotherham Sensory Model is implemented and embedded.	Q4 2020			• Progress against this had slowed down due to the limited school opening arrangements between January and March 2021. However, progress work has been made over the last 6 months and the sensory model forms part of the work associated with the Special Educational Needs toolkit.
CH 6	Roles and responsibilities to support children with Special Educational Needs and Disabilities in school are clearly understood	Q1 2021			• There will be a focus on roles and responsibilities as part of the Written Statement of Action related to the graduated response which will have oversight by the Special Educational Needs and Disabilities Strategic Board. Representatives from a variety of schools and settings will be expected to form part of any appropriate working party or sub-group. • There is a core group in place with school representatives to help design and facilitate Continuous Professional Development (CPD) opportunities and networking with all Special Educational Needs Co-ordinators. This will allow for a greater understanding of roles and responsibilities when meeting the needs of those with Special Educational Needs and Disabilities.
CH 7	A Special Educational Needs Toolkit is developed, launched and implemented across education settings	Q4 2020			• The Special Educational Needs toolkit is in place and an official launch is taking place with Special Educational Needs Co-ordinators on 3rd November. • The work is to now embed and implement its use across the system, reference it in the Local Offer and continue to develop as part of implementing the graduated response. This will fulfil an expectation in relation to the Written Statement of Action.
CH 8	Develop an understanding of the impact of Covid and related changes to service provision on outcomes for children with Special Educational Needs and Disabilities	Q1 2021			• Special Educational Needs and Disabilities Strategic Board and Education Recovery Cell have clear oversight with regular reporting regarding outcomes for children. The Cell has made an Innovative bid which has been successful to pilot a Team Around the School approach to prompt practitioner delivery and model for support in school. This will be monitored closely as part of implementation to establish the impact.

Key Risks / Issues

- The toolkit needs to be part of wider cultural transformation and review of support to schools to support inclusion.
- The challenge is in relation to schools refusing to offer placements to children with challenging Social, emotional and mental health and cognitive issues. The toolkit needs to be set in wider transformation, including increased capacity for service delivery and work within the whole school context.

Priority 3	Looked After Children and Vulnerable Children and Young People	Lead Officer			Subgroup reporting to the C&YP Transformation Group with lead responsibility is:
		Ailsa Barr			TBC
No.	Description	Target	RAG position as end June 2021	RAG position as at Oct 2021	Update / Key actions
CH 9	Refreshed commissioning arrangements are in place to complete Looked After Children health assessments.	Q3 20/21			• The new arrangements for enhanced Looked After Children health assessments are in place and are now complete. These arrangements are detailed in the Looked After Children Service Specification, further monitoring will continue as the timescales for completion are currently lower than we would like.
CH 10	A review of therapeutic services includes key recommendations to support the social, emotional, and mental health needs of Looked After Children.	Q4 20/21			• Paper presented April 2021 provided key recommendations which suggested focus on developing arrangements for children with complex needs including looked after children with social, emotional and mental health needs, where current service provision is not meeting their needs.
CH 11	Implementation of review recommendations to support the social, emotional, and mental health needs of Looked After Children.	Q4 2022			• The new Assistant Director starts in post on 1st November and will prioritise activity across RMBC and RCCG to understand the current arrangements to inform proposals to deliver the recommendations.
CH 12	New milestones to be identified by the Multi-Agency Vulnerable Children's Group.	Q4 2020			• This group is now meeting regularly and is business as usual and can be closed as an action.
Key Risks / Issues					

Priority 4	Children and Young People's Mental Health and Emotional Wellbeing	Lead Officer			Subgroup reporting to the C&YP Transformation Group with lead responsibility is:
		Christina Harrison			TBC
No.	Description	Target	RAG position as end June 2021	RAG position as at Oct 2021	Update / Key actions
CH 13	Children in Rotherham will have timely access to an assessment and intervention for neurodevelopment disorders when a need has been identified. Business Case submitted and funded by the CCG to reduce waiting lists over a 3-year period	Q1- 2024			• The Special Educational Needs Toolkit with resources for school-based workforce was launched w/b 14.12.2020 • The digital offer provided by Healios has been well received by families and has been extended • The waiting list has currently plateaued and is reviewed weekly, identifying where the referrals are from, and support needed to wider services • A Neuro dashboard is updated on a weekly basis and shared with the Commissioners on a monthly basis • RDaSH are creating an implementation plan for the Business Case. This work will commence in 2022
CH 14	A programme of licensed training (Autism Education Trust) is rolled out to learning providers and GPs	Q4 20/21			• Autism Education Trust training is still being rolled out – We are identifying schools that have received this and where targeted training needs to be focused
CH 15	A multi-disciplinary team to respond to neuro-developmental difference is established	Q3 20/21			• The new pathway is now operational with multi-agency involvement and meet weekly.
CH 16	All children in Rotherham will have a first line of support for their mental health and emotional wellbeing available in their school or educational settings	Q1 2021			• Department of Education Wellbeing for Education Return has been rolled out • There is a pilot in place to provide supervision and consultation to the school workforce • Mental Health Support Teams are becoming established in pilot schools and an evaluation framework has been agreed

					• Two cohorts for the Anna Freud Link Programme have met and are using the Cascade framework to map whole system provision. • A further Mental Health Support Teams programme will go live in January 2022.
CH 17	Communicate the multi-agency offer to support children's mental health and emotional wellbeing to schools and ensure that it is accessible to all.	Q3 20/21			• Department of Education Wellbeing for Education Return is being rolled out through this term with input from the whole system • The social, emotional and mental health toolkit has been developed and available to schools which supports the graduated response
Key Risks / Issues					
• Pressures have emerged to meet the needs of children with eating disorders, and lack of specialist inpatient availability. Children are presenting later and with complex health needs. • Whilst we now have funding and a 3 year plan, some children will be waiting longer than desirable for a neurodevelopment assessment.					

Priority 5	**Transitions to Adulthood**	**Lead Officer**			**Subgroup reporting to the C&YP Transformation Group with lead responsibility is:**
		Paul Theaker			**TBC**
No.	**Description**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
CH 18	Local leadership and governance in place to deliver on transitions to adulthood for young people with long-term conditions and complex care needs	Q1 2021			• The Preparing for Adulthood Board is in place to provide local leadership and governance. The board is now meeting frequently with consistent attendance (after a period of inconsistent attendance as a result of conflicting covid-19 pressures.) • Transitions to adulthood remains a priority for all Place partners.
CH 19	Carry out a scoping exercise and gap analysis to identify where there is a need to develop pathways to support transitions to adulthood for young people with long-term conditions and complex care needs	Q1 2021			• A scoping exercise was undertaken and all current activity mapped, gap analysis informed the development of a story board and the Special Educational Needs and Disabilities Strategy Preparing for Adulthood Action Plan.
CH 20	Carry out further gap analysis to identify where to prioritise the development of pathways to support transitions to adulthood for young people with long-term conditions and complex care needs				• Despite the above activity described being achieved, the transitions to adulthood workstream have rag rated this action amber on reflection as further gap analysis and a prioritization exercise is now required • There were a number of key recommendations developed that outline a way forward and will result in a refreshed action plan and a restart of the work programme. • Following receipt of the Ofsted/Care Quality Commission Special Educational Needs and Disabilities Inspection feedback letter, discussions are now taking place with senior leaders within Health to consider how achievable the recommendations are and to ensure strategic buy-in from adult health colleagues. It is anticipated that a refreshed action plan will be in place by mid-November 2021.
CH 21	Develop, implement, and embed the pathway to support transitions to adulthood for young people with diabetes	Q1 2021			• Additional investment was secured to develop, implement and embed the pathway to support transitions to adulthood for young people with diabetes.
Any new milestones/actions as a result of Covid					
N/A					
Key Risks / Issues					

Mental Health, Learning Disabilities and Neurodevelopmental Care

In the refreshed Rotherham Place Plan the following were identified as priority areas for this transformation group:

1. Improving Access to Psychological Therapies (IAPT) service
2. Dementia diagnosis and post-diagnostic support
3. Adult Severe Mental Illnesses (SMI) in the Community including perinatal mental health
4. Mental Health Crisis and Liaison
5. Suicide prevention
6. Better Mental Health for All, including loneliness
7. Improving residential, community and housing support for people with Mental Health and/or Learning disability
8. Delivering the NHS Long Term Plan for people with a learning disabilities and / or autism (this includes Transforming Care)
9. Delivery of My Front Door transformation programme
10. Delivery of Autism Strategy and Neurological Pathway

Below are the milestones identified for each of these priorities and the assessment of post Covid impact.

Priority 1	**Improving Access to Psychological Therapies (IAPT) service**	**Lead Officer**			**Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:**
		Kate Tufnell			**Rotherham IAPT Provision Communications / Rotherham Health App – IAPT integration group,**
No.	Milestones PWPs = Psychological Wellbeing Practitioner HITs – High Intensity Trainers IAPT = Improving Access to Psychological Therapies CBT = Cognitive Behavior Therapy	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 1	RDaSH workforce IAPT trainee expansion in 20/21 & 21/22. Actions required:	Q2 21/22			• 3x trainee PWPs recruited and started for October intake. • 3x trainee CBT places allocated for March 2022 and recruitment due to commence for these in the next month (December).
	20/21 Improving Access to Psychological Therapies trainees complete training (Psychological Wellbeing Practitioner (PWPs) and High Intensity Trainers (HITs)	Q4 20/21			• 4x PWPs completed training on schedule. • 1x PWP delayed approx. 1-2 months • 2x CBT delayed approx. 1-2 months • 2x CBT delayed approx.. 8-10 months • 1x CBT completed in July (9 months delayed)
	Recruitment of 2 PWPs in 2021/22	Q4 21/22			• None recruited to date
	Recruitment of 4 High intensity Therapists – HITs in 21/22	Q4 21/22			• None recruited to date
MH/LD 2	Reduction in the RDaSH IAPT CBT waiting times.	Q2 21/22			• During this period the CBT waiting list has decreased, due to the implementation of the RDASH/IESO waiting list initiative. It is, however, still above the trajectory– July 408, August 442, September 385 (trajectory 321) people waiting • Work is underway to support the reduction of the waiting list over the next reporting period • Additional capacity commissioned to support IESO / RDaSH waiting list initiative
	Mobilisation of IESO/RDaSH waiting list initiative (due to commence July 2021)	Q3 21/22			• Additional capacity commissioned to support IESO / RDaSH waiting list initiative • CBT waiting list preparation underway between RDaSH & IESO • CBT waiting list initiative commenced July 2021 and it almost complete.

	CBT trainee recruitment and commence training (21/22 cohort)	Q4 21/22			• As above October trainees x3 PWP recruited as planned on schedule. • March 2022 trainees x3 CBT on track
	CBT (qualified posts) vacancies recruitment completed or alternative explored - to be agreed with RDaSH	Q2 21/22			Employment Checks completed and posts advertised.
MH/LD 3	Recruitment of 2 PWPs in 2021/22	Q4 20/21			• None recruited to date
MH/LD 4	Develop an action plan to enhance access for Black and Minority Ethnic groups, older people, unemployed and those who are post COVID	Q4 21/22			• Work underway to develop an action plan - discussions ongoing with a number of partner's organisations. • RDaSH IAPT service is part of the Rotherham Long-Covid pathway
MH/LD 5	Increase digitalization of IAPT / low level psychology provision. Actions required	Q4 21/22			• Work is underway to include the referral to the Rotherham IAPT service a as part of the Rotherham Health App functionality. Initial testing has been completed. This has highlighted a few adjustments will need to be made to extend further rollout. • Referrals to both RDASH IAPT and IESO can be made via the Rotherhive site • IESO digital offer in place • RDaSH IAPT services can be accessed video, telephone and face-to- face. is provide
MH/LD 6	Increase awareness of IAPT Provision and low-level psychological support available in Rotherham. Actions required:	Q3 21/22			• Joint IAPT Communications meeting in place (RCCG, DCCG, RDaSH & IESO) • Ongoing communication plans in place for RDaSH, IESO and RCCG • Further work undertaken to promote the Mental Health offer leaflets across the borough
MH/LD 7	Rotherham IAPT Provision Communications plan delivered	Q4 21/22			
MH/LD 8	Development and agreements of mental health themed communications campaign • Anxiety campaign launched Q.3 2021/22	Q3 21/22			• Rotherham Anxiety Campaign has been launched. This is a partner campaign that will be rolled out over the next 3 months. • CCG promoted World Mental Health Day via social media • A resource library of self-help leaflet to support the Rotherhive and Wellness Hive are under-development / due to be launched shortly. • A Rotherhive professional page is underdevelopment and will be launched shortly • A Rotherhive Sleep section is being developed and will be launched shortly
MH/LD 9	Continued development of RotherHIve and Wellness Hive digital platform https://rotherhive.co.uk/	Q4 21/22			• Wellness Hive number of visitors continue to increase 616,957 page visits https://rotherhive.co.uk/wellness-hive/ • RotherHive site visits 2 million. • A Professional section – developed and product tested with a range of key stakeholder. This section of the sight is due to be launched shortly. • Rotherhive – new sleep section developed and product tested – due to launched shortly • A range of self-help leaflets to support Rotherhive and Wellness Hive site are currently under-development and will be launched shortly. Once available these will be made available electronically and as hard copies (as appropriate).
MH/LD 10	Integration of Rotherham Health App and RDaSH IAPT provision	Q3 21/22			Awaiting further testing and roll out following initial release and challenges identified.
MH/LD 11	Recruitment of 4 High intensity Therapists – HITs in 20/21		Complete	Complete	
Key Risks / Issues:					

Priority 2	Improving Dementia diagnosis and post-diagnostic support	Lead Officer			Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:
		Kate Tufnell			TBC
No.	**Milestones**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 12	National Institute for Clinical Excellence (NICE) compliant dementia diagnostic pathway to be agreed	Q4 21/22			• Funding identified as part of 21/22 Finance agreement to support diagnostic/post-diagnostic recovery plan • Work re- commenced to review pathway
MH/LD 13	National Institute for Clinical Excellence (NICE) compliant dementia post-diagnosis pathway to be agreed	Q4 21/22			• Funding identified as part of 21/22 Finance agreement to support diagnostic/post-diagnostic recovery plan • Work re- commenced to review pathway
MH/LD 14	To implement the new dementia pathway across the Rotherham place	Q4 20/21			• Funding identified as part of 21/22 Finance agreement to support diagnostic/post-diagnostic recovery plan • Work re- commenced to review pathway
MH/LD 15	**To rollout** a programme of training sessions to support people with dementia and their unpaid carers	Q3 20/21			• Rollout of the training programme is now ongoing. Training offer will be reviewed on an annual basis. Four Herbert Protocol and This is Me sessions have been delivered for carers in Quarter 2
Any new milestones/actions as a result of Covid					
	N/A				
Key Risks / Issues					
• Agreed dementia pathway to be reviewed in light of new guidance • Delivery of elements of the dementia pathway has been impacted by COVID.					

Priority 3	Adult Severe Mental Illnesses (SMI) in the Community	Lead Officer			Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:
		Kate Tufnell			ICS Individual Placement and Support Group, Community Mental Health Transformation Group (inc. MH ARRS) / Rotherham SMI Register – Data Cleansing Group / ICS Perinatal Group
No.	**Milestones** SMI = Serious Mental Illness	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 16	Delivery of all of the SMI Health check long-term plan requirement. Action required:	Q3 20/21			• Work on-going – some delay due to workforce capacity issues
	Complete secondary / primary care SMI register validation	TBC			• Work on-going – some delay due to workforce capacity issues
	Development of single live SMI register across primary and secondary care	21/22			• Work on-going – some delay due to workforce capacity issues
	Development of digital offer to support primary care SMI Locally Enhanced Service (LES) deliver	Q3 21/22			• Work on-going – some delay due to workforce capacity issues
	Increase the number of primary care SMI health checks completed in 2021/22 (against 2021/2, q.4 baseline – 31%)	Q4 21/22			• SMI Locally Enhanced Services (LES) is mandatory across all practices • Number of health checks completed continues to increase. **In quarter 2 Rotherham reported 42.1% of annual health checks completed.** • Rotherham partners across Primary Care, RCCG and RDaSH continue to work together to increase the uptake of annual health checks across Place.

<table>
<tr><td>MH/LD 17</td><td>Maintain 60% target of patients requiring Early Intervention for Psychosis (EIP) receiving National Institute for Clinical Excellence (NICE) concordant care within two weeks, and service graded at level 3 for NICE concordance</td><td>Q4 21/22</td><td></td><td></td><td>• National target 60% has not been achieved In July and August 21 the Rotherham service reported 50% of patients receiving National Institute for Clinical Excellence (NICE) concordat care within 2 weeks
• The service is currently rated as level 3 National Institute for Clinical Excellence (NICE) concordance</td></tr>
<tr><td>MH/LD 18</td><td>Support the delivery of the ICS Individual Placement Support programme</td><td>Q4 20/21</td><td></td><td></td><td>• ICS evaluation of the Individual Placement and Support (IPS) service completed / Rotherham input into the evaluation
• Draft evaluation report produced for consideration
• October 21- March 22 mainstream funding for Individual Placement and Support (IPS) workers funded by NHS England Transformation pilot identified and agreed
• Sheffield CCG commenced procurement development for service provision from April 22 onwards</td></tr>
<tr><td>MH/LD 19</td><td>Delivery of the 2021/22 Adult SMI in the Community Workforce year 1 plan.</td><td>Q4 21/22</td><td></td><td></td><td>
<table>
<tr><th>Post</th><th>Recruiting organisation</th><th>status</th></tr>
<tr><td>Programme Manager</td><td>RDaSH</td><td>Contract documentation issued
Recruitment process completed 9/21 - unsuccessful</td></tr>
<tr><td>Specialist/Clinical Input - Social Care</td><td>RMBC</td><td>Contract documentation drafted
Recruitment process commenced</td></tr>
<tr><td>Specialist/Clinical Input - Primary Care</td><td>Primary Care</td><td>Contract documentation drafted
Marketing of post commenced</td></tr>
<tr><td>Specialist/Clinical Input – Secondary Care</td><td>RDaSH</td><td>Contract documentation issued
Expression of interest received May 21 – on hold waiting funding approval</td></tr>
<tr><td>Admin/Project Support</td><td>RDaSH</td><td>Contract documents issued
Recruitment process completed 8/2 – candidate withdrew
Second recruitment round underway</td></tr>
<tr><td>Older People's community mental health teamSupport Worker</td><td>RDaSH</td><td>Contract document drafted</td></tr>
<tr><td>Reablement Worker</td><td>RDaSH</td><td>Contract document drafted</td></tr>
<tr><td>Occupational Therapy Clinical Lead</td><td>RDaSH</td><td>Contract document drafted</td></tr>
<tr><td>Clinical Associate Psychologists (CAPS)Workers (Adults and Older Adults)</td><td>RDaSH</td><td>Contract documents drafted
University/RDaSH Interviews complete Recruitment successful – start date to be confirmed</td></tr>
<tr><td>Peer Support/Lived Experience Worker</td><td>VAR</td><td>Development commenced – further discussions required</td></tr>
</table>
</td></tr>
<tr><td>MH/LD 20</td><td>Workforce expansion of community mental health team in line with 21/22 planning agreement</td><td>Q3 21/22</td><td></td><td></td><td>• community mental health team specialist social care input – recruitment underway
• community mental health team specialist secondary care input – service specification / contract change documents approved
• community mental health team specialist primary care input – service specification shared for comments
Waiting information on RDaSH specific roles</td></tr>
<tr><td>MH/LD 21</td><td>Expansion of peer support /living experience workers to support the provision of community Mental health provision (bid requirement – Voluntary / Community Sector posts)</td><td>Q3 21/22</td><td></td><td></td><td>• Initial discussions commenced</td></tr>
</table>

MH/LD 22	Support the delivery of the perinatal Mental Health long-term plan requirements: Action required: RCCG to work with Sheffield and Doncaster to review the perinatal mental health service	Q2 21/22			• Funding identified to support the expansion of the service in Rotherham, in line with long-term plan and Sheffield / Doncaster developments. • Review and discussions on going
MH/LD 23	Support the further expansion of the Rotherham service (in line with 2021/22 contract agreement) q.4	TBC			Some uplift posts appointed to and some under recruitment
MH/LD 24	Complete an Early Intervention for Psychosis (EIP) profile scoping exercise to inform service development and ensure the service is ○ Culturally appropriate to address disparities in access and experience of ○ Black and Minority Ethnic (BAME) people with psychosis. Delivering to full recommended age range of 14-65 to reduce inequalities in access for age groups.	Q3 21/22			The Early Intervention for Psychosis (EIP) scoping analysis was completed. However, owing to the numbers involved in Early Intervention for Psychosis (EIP) for a relatively small geography such as Rotherham, make any prediction of future trends challenging.
MH/LD 25	Expansion of Early Intervention for Psychosis (EIP) workforce, in line 21/22 with local contract agreement	Q3 21/22			• Recruited to the following posts with the new investment • fte Band 6 First Episode Psychosis (FEP) pathway (commenced in post November 2021) • fte Band 6 First Episode Psychosis (FEP) (awaiting DBS expected to start in January 2022) • fte Band 3 Support time and Recovery (STR) • Jill Fairbank is currently discussing post to lead on family interventions.
MH/LD 26	Delivery of Community Mental Health Transformation programme (21/22). Action required:	Q4 21/22			• Programme manager post realigned out to advert imminently • RMBC have appointed to social care 0.2 post • Primary Care Network (PCN) leads progressing recruitment to Primary Care 0.2 post • 6 x B7 Mental Health Additional Roles Reimbursement Scheme (ARRS) roles out to recruitment – 1 for each Primary Care Network (PCN) • Clinical Associate Psychologists (CAPs workers appointed for university placement • Rapid development day for partnership being planned in December
MH/LD 27	Enhance eating disorder offer across Rotherham – South Yorkshire Eating Disorder Association (SYEDA), Physical Health shared care protocol, RotherHive development	Q4 21/22			• RotherHive eating disorder page developed and Launched May 21. In its first month this page reported 2167 hits. https://rotherhive.co.uk/eating-disorders/ • Further expansion of South Yorkshire Eating Disorder Association SYEDA commissioned to increase both children and young people and Adult eating disorder capacity in Rotherham from March 2021 • Work commenced on medical monitoring of Physical Health shared care protocol
MH/LD 28	Development and implementation of the Mental Health Additional Roles Reimbursement Scheme (ARRS) 21/22 requirements. Action required:	Q1 21/22			• Mental Health Additional Roles Reimbursement Scheme (ARRS) operational group in place • Job description produced / reviewed and banded by RDaSH • Discussions on-going re recruitment
MH/LD 29	All contract mechanisms in place CCG/RDaSH	Q2 21/22		Complete	• CCG /RDaSH Schedule 2ii signed • CCG/RDaSH Mental Health Additional Roles Reimbursement Scheme (ARRS) signed

MH/LD 30	All contract mechanisms in place RDaSH with each of 6 Primary Care Networks (PCNs)	Q2 21/22			• No contracts in place
MH/LD 31	Recruitment of mental health Mental Health Additional Roles Reimbursement Scheme (ARRS) across all 6 Primary Care Networks (PCNs)	Q2 21/22			• Primary Care Network (PCN) / RDaSH clinician discussions underway to inform post requirements. • Primary Care Network (PCN) are keen to commence Mental Health Additional Roles Reimbursement Scheme (ARRS) • RDaSH are not in a position to recruit until contracts are signed
MH/LD 32	Embed Mental Health Additional Roles Reimbursement Scheme (ARRS) posts within Primary Care Networks (PCNs), in line with GP and standard contract requirements	Q3 21/22			• Not due yet
MH/LD 33	Year 2 Mental Health Additional Roles Reimbursement Scheme (ARRS) plans in place to support recruitment of posts	Q1 22/23			• Not due yet
MH/LD 34	Ensure delivery of the Early Intervention in psychosis 21/22, in line with LTP requirement. Action required	Q4 21/22	Complete	Complete	• Level 3 achieved. Note that if the service had achieved a level 3 rating for the physical health rating (missed by 0.8%) the service would have achieved an overall level 4 rating. • National target 60% achieved
MH/LD 35	Establish community mental health team group (q.1)	Q.2 21/22	Complete	Complete	• Mental Health Additional Roles Reimbursement Scheme (ARRS) groups established. This will expanded to become the community mental health team group, once initial work on Mental Health Additional Roles Reimbursement Scheme (ARRS completed
MH/LD 36	Establish a mechanism to develop the Mental Health Additional Roles Reimbursement Scheme (ARRS) roles contract and finance processes	Q1 21/22	Complete	Complete	• Mental Health Additional Roles Reimbursement Scheme (ARRS) Finance and Contract Task and Finish group established. • Contract /Finance process developed and available to be implemented.
Key Risks / Issues					
• Further waves of COVID 19 will have an impact in primary care capacity potential impact on MH/LD13 (Risk mitigation: development of digital mechanism and alternative ways to support process – under-development). • Perinatal Mental health – increase in demand (Risk mitigation: 21/22 Mental Health Investment Standard (MHIS) funding agreed to support expansion of service). • Perinatal Mental Health – difficulties recruiting expansion workforce especially perinatal psychiatrists • Mental Health Additional Roles Reimbursement Scheme (ARRS) – RDaSH experiencing difficulties in recruiting 6 X band 7 posts (Risk mitigations: exploring different recruitment options, such as band 6 /7 development posts). • Eating disorders – demand for the service continues to increase (Risk mitigation – additional capacity commissioned, performance monitoring mechanisms in place, preventative work underway – training, RotherHive etc.)				

Priority 4	Mental Health Crisis and Liaison	Lead Officer			Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:
		TBC			S. Yorkshire S12 Solutions Prelaunch Project Group / ICS Adult Crisis Meeting
No.	**Milestones**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 37	Review of the social care delivery model (increase social care capacity / improve care act compliance)	Q4 20/21			• A meeting is planned early November to take stock of the review, look at how to address operational pressures and set out next steps. A delivery plan with timescales will be developed.
MH/LD 38	Workforce development of the Crisis Resolution and Home Treatment Teams (CRHTT) and increase social care capacity	Q4 21/22			• Initial discussions commenced
MH/LD 39	Establish a Crisis Resolution and Home Treatment Teams (CRHTT) service that operates in line with best practice	Q4 20/21			• Crisis Resolution and Home Treatment Teams (CRHTT) will need to a further review once the RMBC Social Care review is completed – to ensure alignment of both processes.

MH/LD 40	Develop at least one alternative crisis service to hospital admission. Actions required:	Q3 20/21			• Stakeholder engagement to develop the model (inc. stakeholder survey)
					• Further research on best practice from other areas
					• Gathering of Equalities data and identifying data gaps
					• Service Specification & Equality Impact Assessment completed
					• Procurement commenced Q3: High Level timeline
					  ○ Invitation to Tender issued 29.10.21
					  ○ Invitation to Tender closes 26.11.21
					  ○ Evaluation Panel will meet w/c 10.12.21
					  ○ Contract award planned w/c 07.01.21
					  ○ Contract commences 01.02.22
					• Crisis prevention / alternative communication work commenced

MH/LD 41	Reduction in the number of out of area placements. Action required: • Implementation of the Out of Area Treatment Services (OATS) agreement (end of q.2)	Q4 22/23		TBC	Waiting for information
MH/LD 42	Hospital Discharge fund initiatives identified and mobilised – Delivery plan on track	TBC			Waiting for information
MH/LD 43	Outcome report of PITT training and impact on delivery	Q2 21/22			Waiting for information
MH/LD 42	Implementation of the new social care delivery model commenced	Q3 21/22			• Discussion commenced, but timescales for delivery still to be agreed.
MH/LD 43	Support the ICS S12 App extended pilot. Action required:	TBC		Complete	• Pilot extension completed End of September 2021. Future commissioning intensions agreed by SYB Commissioners
MH/LD 44	Improve IT connectivity at Swallownest (q.2)	TBC		Complete	• IT connectivity issues have been resolved
MH/LD 45	Ensure all Rotherham Approved Mental Health Professional (AMPs) are signed	Q2 21/22		Complete	• Local S12 solutions champion established. • All Rotherham Rotherham **Approved Mental Health Professional** (AMPs) have been trained and are using the platform

	up to the S12 App and trained to use it (end July 2021)				
	Mobilise S12 App only model (as agreed across the ICS) August – October 2021	TBC		Complete	• Rotherham worked in partnership to support the move toward S12 App only model, in line with pilot criteria.
	Support ICS evaluation of the pilot to inform future commissioning intentions (q.3)	TBC	Q2.21/22	Complete	• ICS S12 solution pilot evaluation completed. Recommendation: continued use of the S12 solution app across SYB ICS. • Sheffield CCG have issued a further 12 month contract for the S12 solutions app. Rotherham Place is part of this agreement.
MH/LD 46	Workforce development training (PITT	Q3 19/20	Complete	Complete	• RDaSH identified staff team has attended the PITT development training.
MH/LD 47	Establish a social worker co-ordinator post to operate across the mental health wards	Q4 19/20	Complete	Complete	• Social worker co-ordinator post now established.
MH/LD 48	Maintain Mental Health Liaison (Core 24 compliant) service	Q4 20/21	Complete	Complete	• Now part of mainstream provision
Key Risks / Issues					

Priority 5	**Improving residential, community and housing support for people with Mental Health and/or Learning disability**	**Lead Officer**			**Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:**
		Garry Parvin			**TBC**
No.	**Milestones**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 49	Co-production of a vision for recovery	Q2 21/22			• New service specifications have been completed that reflect the ideas and learnings from the market engagement work detailed above as well as good examples from other local authorities. • This approach identified that there were issues with the current requirement to sign up to the Councils Social Value Portal and work commenced to resolve this in order that it can be utilised with smaller/lower value placements alongside larger contract awards. This has, by necessity, delayed the procurement of the new flexible procurement system to ensure we are able to capture and monitor Social Value without this being a substantial burden to the smaller organisations and contracted providers. • Although the work to develop the Social Value Portal is still ongoing once this is resolved the procurement of the flexible procurement system can proceed with confidence that the Social Value for Rotherham brought by the increased provider base can be appropriately captured and monitored.
MH/LD 50	Service transformation model to be agreed	Q4 21/22			• A cabinet report has been drafted and is being consulted on. The report will give an update on progress and it is being planned to be presented (subject to Director approval) in December 2021
MH/LD 51	Scoping the current system to identify challenges and opportunities within a recovery model	Q1 21/22	Complete	Complete	Completed. Scoping has occurred via: 1. Housing needs assessment completed by Campbell Tickell led by RMBC Housing on behalf of the South Yorkshire Transforming Care Partnership (SYTCP) 2. Care home research undertaken on behalf of RMBC by Cordis Bright 3. Development of a supported living plan by Atlantic
Key Risks / Issues					
Place Board is asked to note the developments in relation to Social Value and Flexible Purchasing Systems being developed.					

Priority 6	Suicide prevention	Lead Officer			Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:
		Ruth Fletcher-Brown			Rotherham Suicide Prevention and Self-harm Group, SYB ICS Suicide Prevention Meeting, ICS Suicide Bereavement Group
No.	**Milestones**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 52	Delivery of 20/21 actions within local plan	Q2 21/22			• Cohort 2 training for the self-harm train the trainer project has been delivered and trainers are being signed off
MH/LD 54	Delivery of self-harm awareness training programme to commence. Action required: • Cohort two Train-the-trainer training complete (q.1) • Rollout of self-harm awareness course across the borough	Q4 21/22			• Some of the trainers from Cohort 1 are still delivering courses, Early Help for example • Cohort 2 trainers are expected to complete signed off delivery courses.by September Cohort 2 training delivery will be rolled out October onwards.
MH/LD 55	Refresh of the Suicide prevention and self-harm plan in line with national recommendations	Q3 21/22			• The Suicide Prevention Symposium was held on the 12th October and this workshop will inform a one year action plan • Action plan will go out to partners for consultation by end of 2021. • Action plan will be signed off by the Health and Wellbeing Board in Feb 2022. Updates on progress will be reported to the Health and Wellbeing Board twice a year.
MH/LD 56	Evidence of impact of the Be the One campaign	Q4 20/21			• Women's campaign launched on the 10th September • Healthwatch held a 'Be the One' promotional event on 22nd September • Continue to promote and evaluate next year. Monitoring website activity https://www.be-the-one.co.uk/ • The 'Be the One' website will be promoted during Safeguarding awareness week w/c 15th November 2021 • Included in various publications circulated across the borough
MH/LD 57	Delivery of Year 3 NHSE funded projects	Q2 21/22			• End of year report to be completed (delayed due to capacity issues, which delayed return of evaluation information). To be completed by end q.2 21/22 • Self-harm train the trainer course has been delivered.
MH/LD 58	Review the suicide prevention and self-harm action plan, in light of emerging at risks / inequalities	Q3 21/22			• The Suicide Prevention Operational Group update their action plan regularly following Covid guidance and informed by real time data.
MH/LD 53	Review of the delivery of Suicide Prevention training in view of Covid	Q3 20/21			• Programme of training being delivered including; • Promotion of Zero Suicide Alliance training across the partnership • Face to face training being delivered for staff across the partnership but with a particular focus on Voluntary and Community Sector, primary care and South Yorkshire Police Training accessed through RMBC Learning and Development. • 'Be the One' promoted through various events • Training planned for SYP Rotherham District and frontline staff RMBC delivered by PH Suicide Prevention Lead, South Yorkshire Police mental health single point of contact and RDASH
MH/LD 59	Coroners Audit Report recommendations - delivery plan to be developed	Q3 21/2			• Report published September 2021, initial findings shared at symposium. Looking at a programme of events/training to share findings
MH/LD 53	Rotherham Suicide prevention Symposium (September 2021)	Q2. 21/22		Complete	• Symposium held 12th October 2021
MH/LD 60	Be the One Campaign. Action required:	Q2 21/22		Complete	

MH/LD 61	• Development and mobilisation of the Be the One Campaign to be launched September 2021.				• Targeted promotion at women. Monitoring Facebook and Website activity. – launched September 2021.https://www.be-the-one.co.uk/
MH/LD 62	Delivery of 20/21 actions within local plan		Complete	Complete	• The current action plan has been completed
MH/LD 63	Delivery of Self-harm train the trainer course (cohort 2)	Q2 20/21	Complete	Complete	• Training for Cohort 2 was delayed due to Covid. This has now and been delivered 7 participants completed. • The trainers are now preparing to commence delivery of self-harm awareness training.
MH/LD 64	Delivery of Self-harm awareness training to be reviewed in light of COVID (social distancing etc.)	Q3 20/21	Complete	Complete	• The course has been adapted to enable be delivered both virtually and face to face. • The Trainers have received fresher training to support them in the delivery of the course in a virtual format.
Key Risks / Issues					
• Research would suggest increase in suicide risk , as a result of COVID 19. This has not been seen during the first year of the pandemic but many of the protective factors are no longer available. • Discussions with REMA (Rotherham Ethnic Minority Association) have highlighted the need to review suicide prevention training regarding Black and Minority Ethnic Groups Groups • Limited or lack of focus on preventative initiatives • Need to have a training plan which is funded to target not only staff but the general public					

Priority 7	**Better Mental Health for All, including loneliness**	**Lead Officer**			**Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:**
		Ruth Fletcher-Brown			**Mental Health & Well Being Recovery Cell**
No.	**Milestones**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
Better Mental Health for All					
MH/LD 65	Delivery of Better Mental Health for All Action plan	Q4 20/21			• Rotherham Mental Health and Wellbeing Recovery Cell continues to meet with representation from Health and Wellbeing partners. • The action plan is focusing on the recovery phase and has adapted the action plan accordingly. • Groups meets every 6 weeks • Recovery and the impact on vulnerable and at risk groups is referenced in the action plan. • Plan updates reported to RMBC Gold and Mental Health and Learning Disability Transformation Group • Comms and Engagement – launched the Great Big Rotherham To Do List in July 2021, now looking at how this can be embedded into working practice with tenants, clients and patients. RCCG leading on anxiety campaign with input from partner organisations. • Rotherham' s has 3 projects funded as part of Office For Health Improvement and Disparities (Formally PHE) Prevention and Promotion of Better Mental Health Fund. Implementation has commenced with the first monitoring due 22nd October 2021. The three projects are; Team around the school, Workplace mental health working with Small and Medium Enterprises and Befriending project led by the Voluntary and Community Sector.
Loneliness					
MH/LD 66	To launch the Health and Wellbeing Board partnership action plan	Q2 20/21			**Impact of COVID:** • Action plan approved • Emerging research through COVID period identify loneliness and social isolation as a big issue **Action:** • Loneliness is addressed within the wider mental health and Recovery action plans plan which has officers representing HWB partner organisations- group meets every 6 weeks and this is an item on the agenda. Public health leads also sits on Voluntary and community sector Befriending group.

					• Comms and engagement plan developed to raise awareness around loneliness and befriending, including use of Five Ways to Wellbeing messages as a tool to raise awareness. • Voluntary and community sector Befriending group meets monthly to share good practice and support each other with this work. • Plan updates to be received by the HWB annually. • OHID funded Befriending project has commenced led by the Voluntary and community sector • Making Every Contact Count Training has been launched and is being delivered staff across the partnership.
MH/LD 67	Implementation and delivery of 20/21 loneliness action plan	Q4 20/21			• Elements of the action plan are being delivered through the Mental health & Wellbeing Recovery Cell action plan • Comms and engagement work • Making Every Contact Count and loneliness training
MH/LD 68	Build on the learning from the pilot and roll out 'Making Every Contact Count' and loneliness across the borough	Q4 20/21			• Commencement of Making Every Contact Count training around loneliness, deliver key messages to staff groups in a COVID secure way.
Any new milestones/actions as a result of Covid					
	N/A				
Key Risks / Issues					
• Impact of loneliness and social isolation on mental health and wellbeing has increased during COVID and further evidence to support that this is an issue across the life course • It is expected that there will be an increase for low level psychological support, as a result of COVID • Organisations like those in the Voluntary and Community Sector reporting higher levels of anxiety • Impact of COVID on vulnerable groups to be reflected in action plan					

Priority 8	**Delivering the NHS Long Term Plan for people with a learning disabilities and / or autism (this includes Transforming Care**	**Lead Officer**			**Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:**
		Garry Parvin / Andrew Wells			**Strategic Transforming Care Group**
No.	**Description**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 69	CCG Governance sign-off of joint S117 documentation	Q2 21/22			• Operational Executive (OE) paper produced. Considered at OE 15.10.21 and agreed in principle subject to full policy ratification by CCG. Next Steps paper to be considered at Strategic Clinical Executive, Audit and Quality & Governing Body in November. • The first S117 mobilisation meeting of partners (RMBC, RCCG and RDaSH) was held 13 October. The operational launch of the will be arranged once agreed. Further monthly meetings to be established
MH/LD 70	Commissioning solutions to be in place to meet individual trajectories	Q4 21/22			• This has been completed for all people in CCG commissioned beds. Plans are in place for all patients.
MH/LD 71	Ensure no more than 3 people are detained in CCG hospital beds at one time, during 21/22	Q4 21/22			• Maintained. Rotherham has met target and is below Transforming Care Partnership (2021/22) planning target of 3 people. Currently there are 2 people with a learning disability detained in Rotherham CCG commissioned beds • Continues to be on target.
MH/LD 72	Ensure that Rotherham meets the national target of 75%% of annual health check completed (as a minimum)	Q4 21/22			• The table above shows the Q1 data in relation to completed Annual Health Checks in Q1 2021/22. The Place Board should note that Rotherham has typically completed most of its Annual Health checks in Q3 and Q4.

CCG	Q1 Checks Claimed	Q1 Trajectory	% claimed vs Q1 trajectory
NHS BARNSLEY CCG	105	100	105%
NHS SHEFFIELD CCG	235	346	68%
NHS ROTHERHAM CCG	90	420	21%
NHS DONCASTER CCG	79	270	29%
South Yorkshire	**509**	**1136**	**45%**

MH/LD 73	RMBC and CCG to agree process for funding learning disability joint placements. Actions required:	Q2 20/21	Complete	Complete	• Joint policy between RMBC and CCG has been developed led by Andrew Wells/ Marie Staves and Sally– Anne Redhead.
MH/LD 74	RMBC Governance sign-off of joint S117 documentation	Q2 21/22		Complete	• Policy approved
MH/LD 75	RMBC and CCG to agree process for funding learning disability joint placements. Actions required:	Q2 20/21	Complete	Complete	• Joint policy between RMBC and CCG has been developed led by Andrew Wells/ Marie Staves and Sally– Anne Redhead. • Draft document is now available for sign-off via RMBC and CCG Governance routes.
MH/LD 76	RMBC Governance sign-off of joint S117 documentation	Q2 21/22		Complete	• Policy approved
Key Risks / Issues					
• Not successful for Sensory Ward bid. • Increase number of people requiring admission					

Priority 9	**Delivery of Learning Disability Transformation (My Front Door)**	**Lead Officer**			**Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:**
		Garry Parvin			Adult Social Care Project Assurance Board
No.	**Description**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 77	Delivery of Learning Disability Transformation (My Front Door) – Work Stream 1: *Scope: Completion of the changes set out in the Transformation of Services and Support for People with a Learning Disability - Cabinet and Commissioner's Decision-Making Meeting 21st May 2018*	Q4 21/22		TBC	1. Supported Living Redesign: to create a flexible commissioning system to ensure that high quality supported living homes are created. Service specifications completed. Awaiting confirmation of Social Value methodology to be applied. 2. Day Opportunities Flexible framework: business case nearly completed. Awaiting confirmation of Social Value methodology to be applied 3. Microenterprise program – implement program by December 2021- Completed 4. CIC/ Key ring retender: re tender complete, new service in place by November 2021 (action from Decisions approved by Cabinet October 2020). Completed 5. Supported Living Redesign: to create a flexible commissioning system to ensure that high quality supported living homes are created. Service specifications completed. Awaiting confirmation of Social Value methodology to be applied. 6. Day Opportunities Flexible framework: business case nearly completed. Awaiting confirmation of Social Value methodology to be applied 7. Microenterprise program – implement program by December 2021- Completed 8. Community Interest Company/ Key ring retender: re tender complete, new service in place by November 2021 (action from Decisions approved by Cabinet October 2020). Completed
MH/LD 78	Learning Disability The Future Offer – this will include adults with a learning disability into paid employment	Q4 21/22	TBC	TBC	• Preparing for Adulthood (PFA) work is continuing as part of the employment element pathway. • Scoping work is still outstanding about the target. This has been delayed due to C-19 • The Future Offer work will commence from December 2021. • Preparing for Adulthood (PFA) work is continuing as part of the employment element pathway. • Scoping work is still outstanding about the target. This has been delayed due to C-19 • The Future Offer work will commence from December 2021.
Any new milestones/actions as a result of Covid					
	N/A				
Key Risks / Issues					
• Delivery of key projects associated with My Front Door. The project reports to Adult Social Care Project Assurance Board					

Priority 10	– Delivery of Autism Strategy and Neurological Pathway	Lead Officer			Subgroup reporting to the MH & LD Transformation Group with lead responsibility is:
		Garry Parvin / Kate Tufnell			Rotherham Adult Neurodevelopment Meeting
No.	**Description**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
MH/LD 79	Delivery of the Rotherham Autism Strategy Delivery plan 21/22 targets. Need to still include a milestone re: refresh of the autism strategy in light of new publication	Q. 4 21/22 REVISED		TBC	• Review of Autism strategy targets is being undertaken in light of publication of National (England) strategy. • Removed
MH/LD 80	Ensure all staff working in mental health inpatient settings have access to autism awareness training	Q4 21/22	TBC	Not due	• Not yet commenced. A commitment in the national strategy for autistic children, young people and adults: 2021 -2026 in line with tier 3 of the Core Capabilities Framework for supporting autistic people.
MH/LD 81	Creation of Sensory Friendly Mental Health Inpatient Environments (Adult/children and yount people, learning disability, autism or both)	Q4 21/22	TBC	Not due	• Not yet commenced. Metric as outlined in the National Strategy for autistic children, young people and adults: 2021 -2026 Plans agreed with RDaSH, with anticipated timescales. • Bid submitted
MH/LD 82	Autism awareness training sessions for all South Yorkshire Police officers and Rotherham elected Members (October 2021).	Q4 21/22	TBC	TBC	• To review with South Yorkshire police
MH/LD 83	95% of All schools, colleges and GP's / primary care staff to have autism awareness training. Autism education trust.	Q4 21/22	TBC	TBC	• To review with school leads
MH/LD 84	Delivery of the Rotherham Autism Strategy Delivery plan 21/22 targets. Need to still include a milestone re: refresh of the autism strategy in light of new publication	Q. 4 21/22 REVISED		TBC	• Review of Autism strategy targets is being undertaken in light of publication of National (England) strategy. • Review of Autism strategy targets is being undertaken in light of publication of National (England) strategy.
MH/LD 85	Ensure all staff working in mental health inpatient settings have access to autism awareness training	Q4 21/22	TBC	Not yet commenced	• Not yet commenced. A commitment in the national strategy for autistic children, young people and adults: 2021 -2026 in line with tier 3 of the Core Capabilities Framework for supporting autistic people.
MH/LD 86	Creation of Sensory Friendly Mental Health Inpatient Environments (Adult/Children and young people, learning disability, autism or both)	Q4 21/22	TBC	Not yet commenced	• Not yet commenced. Metric as outlined in the National Strategy for autistic children, young people and adults: 2021 -2026 Plans agreed with RDaSH, with anticipated timescales. • Bid submitted
Key Risks / Issues					
• Difficulties in recruiting staffing to support the RDaSH (diagnostic and post-diagnosis) element of the pathway (Risk mitigation: alternatives will be explored to ensure delivery of commissioned activity) • Post-diagnostics currently delivered by Professional Capabilities Framework (PCF), but expansion will be subject to a Voluntary Ex ante Transparency Notice (VEAT).					

Urgent and Community Care

In the refreshed Rotherham Place Reset Plan the following were identified as priority areas for this transformation group:

Workstream 1: Prevention and Urgent Response

1. Front Door **(priority 1)**
2. Urgent Response Standards **(priority 2)**
3. Prevention and anticipatory care in localities: long term conditions and unplanned **(priority 3)**

Workstream 2: Integrating a sustainable discharge to assess model (priority 4)

Workstream 3: Enhanced Health in Care Homes (priority 5)

Below are the milestones identified for each of these priorities and the assessment of post Covid impact.

Priority 1	Front Door	Lead Officer			Subgroup reporting to the U&C Transformation Group with lead responsibility:
		Penny Fisher/Claire Smith			Prevention and Urgent Response
No.	Description	Target	RAG position as end June 2021	RAG position as at Oct 2021	Update / Key actions
UC 1	**Clinical assessment services** (CAS) emergency care working with 111 and 999 to ensure urgent services are effectively managed through the Directory of Services (DOS) to reduce unnecessary conveyances to hospital and avoidable admissions	Q1 21/22	Green	Complete	The Directory of Services (DOS) has been aligned with Rotherham access points and a review carried out. A collaborative approach has been established between the YAS Emergency Care Practitioner service and Rapid Response to develop the hospital avoidance pathway through Care Co-ordination Centre (CCC). A further meeting is arranged to widen scope to 111/999. An identified pathway is under development to support referrals via 111/999 to the Care Home Advanced Nurse Practitioner (ANP) service in the hours of 8-8pm – this stalled due to Covid and requires development of the final process and agreement across partners.
UC 2	To pilot an integrated community hub for the triage of complex urgent and intermediate care and reablement	Q1 21/22	Green	Complete	An initial pilot has been carried out but the model of 3 Multi Disciplinary Team meetings per week was not responsive enough. An alternative model is being implemented to co-locate nursing, therapy and reablement to enable an Multi Disciplinary Team response in real time 5 days a week. Nursing cover is provided 24 hour /7 days which will refer out of hours cases to the as required. This will inform UC3
UC 3	Expand the local 111 Clinical assessment Services (CAS) offer and develop directory of services (DOS) profiles for admission avoidance	Q4	n/a	Green	Work is underway through the Urgent and Emergency Care Centre work stream with the ICS to expand the local clinical assessment services offer, with mental health and social care resource & develop additional directory of services profiles for hospital avoidance linked to cohorts such as frailty & Same Day Elective Care (SDEC) pathway
UC 4	Implementation of the approved model	Q4 21/22	Not yet due	Not yet due	

Priority 2	Urgent Response Standards	Lead Officer			Subgroup reporting to the U&C Transformation Group with lead responsibility:
		Penny Fisher/Claire Smith			Prevention and Urgent Response
No.	Description	Target	RAG position as end June 2021	RAG position as at Oct 2021	Update / Key actions
UC 5	Organisational approval of intermediate care and reablement service specs	Q2 21/22	green	Complete	A suite of draft specifications has been approved by health and social care. These are aligned to the Place intermediate care and reablement strategy and national community and discharge to assess models to increase the numbers of people supported at home.
UC 6	Developing and embedding the urgent 2 hour and reablement 2 day urgent standard and mandatory reporting Note - Reablement 2024 (nationally mandated timeline)	Q4 21/22 (for urgent)	Green	Green	Data requirements are mapped. Development of a community capacity and demand tool has been commissioned which will identify steady state and scenario based predictive requirements. This will also assist discharge planning and contribute to the cross system escalation model.

Priority 3	Prevention and anticipatory care in localities: long term conditions and unplanned	Lead Officer			Subgroup reporting to the U&C Transformation Group with lead responsibility:
		Penny Fisher/Claire Smith			Prevention and Urgent Response
No.	Description	Target	RAG position as end June 2021	RAG position as at Oct 2021	Update / Key actions
UC 7	Pre scoping analysis of population health information (aligned to national project)	Q2 21/22	Green	Complete	Initial identification and analysis of frailty indicators has been completed. The national model due in quarter 2 has not yet been published. Further analysis will be carried out as part of the development work.
UC 8	Articulation of Place ambitions	Q2 2022	Not yet due	Green	The national milestone has been deferred to September 2022 due to system pressures on Primary Care Networks. Systems are encouraged to progress work in the interim. See UC 9 below
UC9	Pilot a frailty model to inform ambitions	Q4 21/2	Not yet due	Green	A draft pilot has been proposed to support people living with severe frailty by providing a comprehensive geriatric assessment which will provide them with a holistic plan and reduce avoidable conveyances and admissions.
UC 10	Implementation of Place ambitions	Phase 2 2022-23	Not yet due	Not yet due	

Priority 4	Integrating a sustainable discharge to assess model	Lead Officer			Subgroup reporting to the U&C Transformation Group with lead responsibility:
		Jayne Metcalfe, Emma Roberts			Sustainable Discharge Model
No.	Description	Target	RAG position as end June 2021	RAG position as at Oct 2021	Update / Key actions
UC 11	Approval of a discharge to assess community unit with nursing	Q2 21/22	Green	Complete	A business case for a 24 bedded community unit was approved by Place partners in July 2021
UC 12	Implementation of a discharge to assess community unit with nursing	Q3 21/22	Not yet due	Green	An Official Journal of the European Union procurement process has been carried out with a preferred provider identified. The governance process is due to complete in October with implementation in time for the end of the current contract in November.

UC 13	Review current discharge pathways and processes to remove barriers to flow	Q3 21/22	Green	Green	A review has been carried out and an acute and community action plan developed and underway.
UC 14	Develop a Business case for sustainable model	Q3 21/22	Not yet due	Green	Extensive work has been carried out to develop new ways of working to support same day/7 day discharge planning. National Covid monies have been used to facilitate discharge. There has been a drive to fill vacant posts and absence cover in the discharge team. A business case to fund some temporary social care roles substantively is under consideration. Further work will be done to review weekend discharges. However, when built, the capacity and demand model will inform future requirements and changes to the model need time to embed before the impact can be assessed. Further consideration will be given to if and when a business case may be required.

Priority 5	**Enhanced Health in Care Homes**	**Lead Officer**			**Subgroup reporting to the U&C Transformation Group with lead responsibility:**
		Claire Smith			**Enhanced Health in Care Homes**
No.	**Description**	**Target**	**RAG position as end June 2021**	**RAG position as at Oct 2021**	**Update / Key actions**
UC 15	Integrating Multi Disciplinary Teams: review of referral routes and signposting for residents and families	Q4 21/22	Green	Green	A GP lead has been identified who has held wider discussions with primary care. A quality standard will be agreed with targeted work to support where required
UC 16	Review of physical and mental health care homes team	Q4 21/22	Not yet due	Not yet due	Work will commence later in the year following outcomes from the multi disciplinary team work
UC 17	Development of the Rotherham Health Record for Care Homes (following 4 milestones)				**Note**: phase 1 has been funded by the ICS Aging Well programme. Phase 2-4 are dependent on securing external funding (potentially further monies from Aging Well Enhanced Health in Care Homes or digital solutions to support roll out of community operational plan)
UC 18	Care home view of existing information for health and social care practitioners	Q1 21/22	Green	Amber	The build has been completed. Planned roll out was delayed due to competing resource pressures as a result of Covid and work required on access rights for social care information governance.
UC 19	Expansion of information for health and social care practitioners	Q3 21/22	Green	Green	Requirements have been identified.
UC 20	Pilot and roll out of care home view to care homes	Q4 21/22	Green	Green	Discussions with care homes have been positive with clear benefits identified for residents, care homes, health and social care. A number of pilot sites have been identified. Funding has been secured.
UC 21	Pilot and roll out electronic information capture by care homes to feed the Rotherham Health Record care home view	2022-24	Green	**Defer dependent on funding**	This is a complex piece of work and is currently unfunded The health record is a read only system which interfaces with organisations record systems. Care homes use multiple different systems and many are still paper based. Due to the scale and complexity of the work it has been agreed this should be managed as a discrete project if funding can be secured. This milestone is therefore deferred until funding can be secured
UC 22	Joined up commissioning	Q4 21/22	Not yet due	Not yet due	A review of the Care Home market sustainability was commissioned by the Council. This has provided a framework to develop a robust action plan in which the joint review of service specifications for residential/nursing care has been highlighted. The contract will be reviewed and amended to ensure there is a health and social care approach to commissioning of services in line with the guidelines set out in the Enhanced Health in Care Homes framework.
UC 23	Holistic care in care homes i. medicines management ii. continence	Q4 21/22	Green	Green	An multi disciplinary team project group has been established including medicines management, dietetics, Continence, Wound Care, Care home team, RMBC. Progress to date includes development of a virtual/face to face training package care homes. Using ambulance data four care homes have been identified for intensive training support from the multi disciplinary team Prescribing data will be monitored. Expected outcomes include a reduction in the number of ambulance call outs and improved prescribing data

Organisational Development and Workforce

***Note that the delay in securing the place-based workforce role has impacted on capacity to drive forward some of the actions**

	Priority	Timescales	RAG	Action/Notes
1	Development of agreed Place values and behaviours, and the approach to embedding these across the Place workforce	August 2021 – March 2022		WF Group have shared all organisational values and are looking at the synergies between these, anticipated that work will take longer than expected so extended the timescale. A number of ongoing initiatives will be developed and implemented as part of the approach to embedding the values and behaviours following initial activity.
2	Development of a shared learning approach across the Place. This will include identifying existing shared learning opportunities and scoping out options for a programme to support and enable future system leaders	December 2021- March 2022	Not due	SYB ICS Development Matrix action is in relation to the development of a shared learning culture. This will be a longer-term outcome and an ongoing priority for the Workforce Enabling Group. Potential to look at opportunities available via apprenticeships
3	Development of an applied approach to OD which can be used where opportunities are identified to develop the workforce who are working across partner organisations	November 2021- March 2022	Not due	Anticipated that the approach will broadly follow the Burke-Litwin model and Making Every Contact Count (MECC) behaviour change approach.
4	Identify opportunities and prioritise teams who are working across partner organisations to participate in the application of the applied OD approach/development	January 2022 onwards	Not due	Anticipated that this activity will be delivered jointly by the Workforce Enabling Group members (or reps) alongside the ICS Place Based Role
5	Provision of ongoing support to the Transformational Groups in line with their agreed priorities in relation to the Place workforce	October 2021 onwards		Anticipated that the ICS Placed Based Role will play a key part in developing and maintaining the conversations about priority support between the Transformational Groups and the Workforce Enabling Group
6	Identify further opportunities for workforce/organisational development activities in line with associated networks and existing groups. e.g. LWAB, ICS Workforce Hub, Place Based Leads Meeting	December 2021 onwards	Not due	Anticipated that the ICS Placed Based Role will play key part in attending these meetings and feedback to the Workforce Enabling Group. Examples may include how we: • develop Rotherham Place to become an employer of choice and promote career opportunities to young people/schools • review the approach to equality and diversity and how this may link across Transformational and Enabling Groups priorities

Communication and Engagement

	Priority	Timescale	RAG	Action/Notes
1	Mental Health support and advice	July to September December to February 2022		Activity based on mental health themes (including suicide prevention, anxiety and depression amongst others) that promote the full spectrum including service provision, prevention, resilience and self-management. Work progressing as per plans 5 themed campaigns for MH
2	System Recovery/Pressures	June to September 2021 November 2021 to February 2022		Communication and engagement across the health and care system to support patients to get the most efficient and effective care they need, whilst supporting the services to recover and manage pressures. Encourage people of Rotherham to take care of themselves, making healthy choices. We want people to be active, happy and comfortable in their own homes where possible. Messages are being communicated to Rotherham public and are in line winter communications plan which was approved at AEDB in October – this a live document and subject to change
3	Enabling Workstream Transformation	Aligned to workstream requirements		Ensuring the public engagement and consultation requirements are met for service change/transformation. Clear and concise messages to be communicated in a relevant and appropriate way. TG have updated their priorities over the summer and are reporting on Q2 position at November board – following this an assessment of coms and engagement requirements will be made including individual meetings with leads.
4	ICS/ICP future development	October to March 2021		Public engagement and communications on future system changes. Activity will focus on informing, sharing, listening and responding. Awaiting further national and local guidance on future ways of working

Digital

No.	Priority Area	Timescale	RAG	Action/Notes
1	Rotherham Health Record (RHR)	July to September 2021		RDASH data received and development underway to display inside the RHR. Discussions with RMBC re additional ASC data items commenced.
2	Rotherham Health Record (RHR)	July to December 2021		Onboarding of social care staff onto the RHR system. IG issues re system use by SC staff resolved. Collection of user data ongoing. Training and implementation plan developed.
3	Rotherham Health App (RHA)	July to September 2021		Integration to display outpatient appointments completed. Work to display community appointments still ongoing.
4	Rotherham Health App (RHA)	July to August 2021		12 month contract agreed with supplier. Contract still under development.
5	Rotherham Health App (RHA)	July to December 2021		Formal SY task and finish group established to lead procurement of the Digital Services for our Public Solution.
6	Population Health Management (PHM)	July to March 2022		Establishment of Rotherham Office of Data Analytics (RODA) underway.
7	Population Health Management (PHM)	August to March 2022		Key forums established such as RODA steering group and ICS discussion group to ensure strong links across the place and the ICS to support the PHM approach.
8	Digital Literacy & Digital Inclusion	June 2021 to August 2022		Digital Inclusion Delivery Manager now been appointed. Reviewing proposal from provider for place digital inclusion baseline.
10	Digital Literacy & Digital Inclusion	July to March 2022		Literature review completed. Focus groups planned for Nov/Dec 2021.For place wide review of nursing/AHP digital capabilities.

Prevention and health inequalities

No.	Priority Area	Timescale	RAG	Action/Notes
1	Develop the prevention pathway to reduce the harms from smoking, obesity and alcohol and support healthy ageing.	November 2021 onwards		Six programme priorities were agreed at the ICP Prevention and Health Inequalities Enabler Group in November. A first draft of the strategy and action plan is scheduled to be reviewed by the group in January 2022, which will include milestones and KPIs aligned with these priorities.
2	Support the prevention and early diagnosis of chronic conditions (including mental health conditions).	November 2021 onwards		As above.
3	Tackle clinical variation and promote equity of access and care for underserved groups.	November 2021 onwards		As above.
4	Harness partners' collective roles as anchor institutions to address health inequalities.	November 2021 onwards		As above.
5	Strengthen our understanding of health inequalities through data and intelligence.	November 2021 onwards		As above. It has also been agreed that a Health Inequalities Data Sub-group will be established. The Terms of Reference for this group has now been agreed and a meeting is in the process of being setting up.
6	Advocate for prevention across the system.	November 2021 onwards		As above.

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P44/22
Report	**Operational Objectives 2021/22 Review**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B1, B4, B5, B7, B8, B9, B10, B12
How does this paper support Trust Values	Ambitious – The paper provides detail of the delivery of the ambitious operational objectives for 2021/22 as at the end of Month 8. Together – colleagues work together to ensure that the continual monitoring and assurance of operational objectives is underpinned by robust governance arrangements.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	The purpose of this paper is to present to the Board of Directors a review of progress against the 2021/22 Operational Plan priorities and associated programmes as at Month 10. At the end of Month 10, two of the ten programmes are rag rated blue (completed/closed) one is rag rated green (on plan), six are rag rated amber (behind plan with mitigation or actions in place to recover) and one is rag rated red (behind plan with more significant action required). Mitigation and recommendations for action against programmes that are rag rated amber and/or red are described in the body of this report. Throughout the life cycle of each programme, the risks to overall delivery are closely monitored. Of the thirty one risks logged at the start of this year, fifteen still remain open, despite resolute efforts to find means of mitigation. It is unlikely that the status of the open risks will change in the final two months of this year as their potential closure is persistently aggravated by the impact of the pandemic and ongoing site pressures. Details on each of the risk descriptions and status can be found in the assurance committee sections of this report.
Due Diligence	The content of individual monthly highlight reports has been presented to People Committee, Quality Committee and Finance and Performance Committee meetings held in February 2022.
Board powers to make this decision	The principal purpose of the Board is to support the timely delivery of the Trust's strategic objectives / Annual Operational Plan, whilst being assured as to compliance with appropriate statutory and legislative requirements, such as those determined, inter alia, by the Care Quality Commission (CQC).

Who, What and When	Individual Executive Directors act as Executive SROs (Senior Responsible Officers) for each area for ensuring achievement of the Operational Objectives and priorities and are responsible for realising the relevant milestones.
Recommendations	It is recommended that Board consider any actions or additional assurance required as a result of this report.
Appendices	1: Operational Objectives 2021-22 Programme Highlight Reports (December 2021 – January 2022)

1.0 Introduction

1.1. The Operational Plan for 2021/22 is built around six key themes:-

- Safely exit the Covid-19 pandemic
- Focus on the fundamentals of care
- Deliver elective recovery for patients
- Empower and enable staff to deliver
- Deliver a step change improvement in flow
- Drive the organisation forwards

1.2. The ten priorities that derive from the above themes are supported by 10 operational programmes that are set out to deliver the organisational objectives for the Trust this year.

1.3. The delivery and monitoring of the programmes utilises a standardised Highlight Report (see Appendix 1) so that the Trust can maintain a clear line of sight on progress.

1.4. The Highlight Reports incorporate two Red, Amber, Green (RAG) indicators to assist assurance. The first looking at the progress of the plan of delivery (achievement of milestones) and the second examining the impact of that progress (realisation of the metrics).

1.5. This paper presents a high level update on progress during Months 9 and 10, against each of the programmes of work and reports, by exception, any areas of concern with recommendations for continuance into the next planning cycle.

2.0 Progress against Operational Objectives and Priorities

2.1 Each of the programmes supporting the delivery of the Trust's Operational Objectives and Priorities have been BRAG (Blue, Red, Amber, Green) rated as to their status at the end of January 2022 as illustrated below:

- Completed/Closed
- On plan
- Behind plan with mitigation or actions in place to recover
- Behind plan, no mitigation or more significant action required

2.2 The following tables provide the summary position at Months 9 and 10 on each of the programmes of work with their respective BRAG rating. More detailed highlight reports are attached at Appendix 1.

Theme: Safely Exit the Covid-19 Pandemic

Programme	Scope	Summary Position	Status
01.1 Health and Wellbeing (Executive Director of Workforce and Organisational Development)	To deliver the full programme of health and wellbeing initiatives for staff	A Working group has been set up to progress the "Covid Vaccination as a Condition of Employment" (VCOD) programme. The Occupational Health tender was awarded to Sheffield Teaching Hospitals. The new South Yorkshire & Bassetlaw Health and Wellbeing Hub has been launched. Joint arrangements with Barnsley are in place to provide occupational psychology support to staff.	**Green**
01.2 Identify new practices to embed (Director of Strategy, Planning and Performance)	Support to clinical and corporate areas to understand what positive changes made through Covid-19 would want to be maintained / developed / embedded	The Programme has closed earlier than originally planned due to the decision taken to move activities into the operational planning rounds for 2022/23, following the publication of the national operational planning guidance for next year.	**Closed**

Theme: Focus on the Fundamentals of Care

Programme	Scope	Summary Position	Status
02.1 Standards of Care and Quality Improvement (Executive Chief Nurse and Director of Infection, Prevention, Control (DIPC)	Embed agreed standards of care and support teams to deliver and embed quality improvement	An outline Quality Strategy is planned for completion at the end of the year. The Enhanced Patient Care through Improvements in Quality (EPIQ) projects are continuing to deliver sustainable improvements.	**Amber**
02.2 Learning from Deaths (Executive Medical Director)	Embed effective learning from deaths practices and deliver improved mortality rate	Hospital mortality statistics are improving. Work is continuing to improve governance around mortality sub group meetings. Formal training is to be provided on structured judgement reviews. Clinical coding training and education is impacting on accuracy which is now around 98%.	**Amber**

Theme: Deliver Elective Recovery for Patients

Programme	Scope	Summary Position	Status
03 Plan the long-term recovery of Elective Care / Operational Excellence (Chief Operating Officer)	Achieve nationally defined targets and requirements with access to Elective Recovery funds, provide staff training on recording elective care pathways	Elective recovery is behind 2019/20 levels and has declined. 52 week waits are increasing. Patient initiated follow-ups will be initiated in 5 major specialities by year end in accordance with national directives. Orthopaedic Planned Care Citizens' panel meetings now scheduled monthly. Referral to Treatment training to be rolled out by end March 2022.	Amber

Theme: Empower and Enable Staff to Deliver

Programme	Scope	Summary Position	Status
04.1 Organisational Development Programme (Director of Workforce and Organisational Development)	Design and launch organisational development programme for divisional teams	The divisional leadership team programme which started 12 months ago is under review. Not all sessions have been well attended due to operational pressures. Initial feedback is positive however further diagnostics will need to be undertaken in February/March to inform next steps.	Amber
04.2 Employer of Choice (Director of Workforce and Organisational Development)	Build a culture so the Trust is seen as an employer of choice, appointing to key clinical leadership vacancies	The Medical and Dental recruitment strategy update has been postponed to end of March due to capacity issues caused by the national Covid vaccination programme (VCOD). Trust branding and marketing for consultant vacancies will be enhanced through a new advertising campaign to be published in the British Medical Journal. Medical locum expenditure has increased.	Amber

Theme: Deliver a Step Change Improvement in Flow

Programme	Scope	Summary Position	Status
05.1 Best Practice Discharge Processes (Deputy Chief Operating Officer/Director of Operations)	Ensure best practice discharge solutions. Includes digital patient flow/command centre	The five work streams within the programme are progressing with plans in place to make significant improvements in flow in the coming weeks despite ongoing site pressures and high levels of disruption across services. The Deputy Chief Nurse has been appointed to replace the Senior Responsible Officer that left the Trust in January.	Amber

Theme: Deliver a Step Change Improvement in Flow (continued)

Programme	Scope	Summary Position	Status
05.2 Admission Avoidance (Deputy Chief Operating Officer/Director of Operations)	Implementation of an appropriate Same Day Emergency Care (SDEC) service at acute site and ensure effective ambulatory frailty pathways are in place	An expanded business case is still under discussion and will require further meetings with Executives before a decision can be reached. The outline frailty pathway model is developed and is supported by the division of medicine. Progress to embed the model will continue into next year.	**Red**

Theme: Drive the Organisation Forwards

Programme	Scope	Summary Position	Status
06 Removal of Breach of Licence/5 Year Strategy (Deputy Chief Executive)	To have long standing breach of license lifted by March 2022 and to publish a new 5 Year Trust Strategy by the end of September 2021	Programme completed.	**Completed**

3.0 Conclusions

3.1 The Board Assurance Committees play a key role in ensuring effective oversight and delivery of the Operational Plan. In February, the People Committee, Quality Committee and Finance and Performance Committee considered reports on progress in all areas and confirmed the following assertions with recommendations for action as deemed applicable.

4.0 Quality Committee

4.1 The Standards of Care and Quality Improvement programme continues to deliver on the objectives set out in the original mandate due to the sustained improvements being made through the work undertaken by the Quality Matrons and other colleagues throughout the Trust that are embracing the continuous improvement methodology that has been introduced. This is evident from the performance metrics.

4.2 Changes have been agreed internally to move the milestone to relaunch the Safe and Sound Quality Strategy to the end of the year, at which point the outline version of the strategy will be completed for presentation at Trust Board.

4.3 If the proposal to establish a Quality Academy is supported through the appropriate business case approval processes in 2022-23, the Quality Strategy will need to be reviewed again next year.

4.4 The following provides an update on the key risks to delivery registered at the start of this programme and the likely status of the risk at the end of the year:-

Description	Status/mitigation
A resurgence of COVID 19 cases across the Trust	**Closed** No longer a risk to delivery. Significant progress has been made despite staff shortages and restrictions due to COVID.
Lack of engagement from staff in the concept of the Safe and Sound Strategy	**Closed** Engagement from staff is evident from the outcomes of the EPIQ projects and the transfer of learning into business as usual processes.
Lack of resource to support implementation of the relaunch	**Closed** Due to movement of the key milestone to relaunch the strategy, there is no resource impact on delivery this year
Unable to secure quality improvement resource to embed quality improvement and encourage continuous improvement as BAU	**Closed** Significant progress has been made this year through the deployment of Quality Matrons

4.5 The overall rag rating of the Standards of Care and Quality Improvement programme is at amber status due to the decision taken to postpone the relaunch of the Quality Strategy into next year.

4.7 The Learning from Deaths programme has now completed all key milestones on this year's plan. However, due to the number of performance metrics that have not achieved target levels so far, the programme remains in amber rag status. Due to the time lag between Dr Foster reports the data will not show signs of improvement for some months and until such time as COVID is no longer a complicating factor.

4.8 Work is continuing to improve quality of care and reduce excess mortality in the trust. This work is supported by the development of new templates for operational governance purposes and for promoting learning from deaths within divisions. The trust will be also be participating in a Mortality Review/Improvement Programme with NHS England/Improvement.

4.9 To improve the quality and consistency of structured judgement reviews and to support clinicians in their endeavours to complete the reviews in line with internal key performance indicators, training courses have now been resourced. The impact of the training is unlikely to be realised until next year therefore the completion of structured judgement reviews within 60 days will remain a challenge.

4.10 The ongoing education and training of clinicians in terms of clinical coding practice has resulted in significant improvements in accuracy. A training video is due to be launched which will support clinicans to undertake training and/or refresher training at a time more convenient to them.

4.11 Limited progress has been made during the year in relation to launching Sepsis Mandatory Training however the training package which has now been installed in the Electronic Staff Records system is in the process of being tested by end users. The performance metric against compliance for Sepsis is therefore rag rated red due to their being no reportable data up to the end of this year.

4.12 The work undertaken by the Improvement Academy in Urgent and Emergency Care on the community acquired pneumonia care bundle has been completed. The reporting functionality available on the Mortality Insights dashboard requires further work to understand accurate utilisation, albeit there is evidence in Meditech that the care bundle is being utilised as planned.

4.13 The following provides an update on the key risks to delivery registered at the start of this programme and the likely status of the risk at the end of the year:-

Description	Status/mitigation
Impact of COVID-19 on our mortality indicators and an inability to understand our position excluding COVID-19.	**Closed** No longer a risk due to improvements in Dr Foster reporting showing the separation of COVID-19 metrics and the impact on key performance indicators where COVID is removed
Inability to appoint an AMD – Mortality & Learning From Deaths for the Trust	**Closed** The decision was taken to place recruitment on hold earlier this year. The appointment of the new Learning from Deaths Manager post was therefore prioritised.
Inability to appoint a mortality lead within the division of medicine	**Open** The division of medicine is reliant on the divisional director and governance lead to attend Safe and Sound Mortality Group meetings where key decisions take place. Dissemination of learning from the Mortality Group to the division is therefore inconsistent and medicine sub group meetings are seldom quorate.
Leadership and capacity within the division of medicine	**Open** The Divisional Director in Medicine has taken responsibility for leading the divisional mortality agenda however this is not a long term solution. Medical capacity within the division remains low therefore it is unlikely given ongoing site pressures that this situation will change before the end of the year.

4.9 At the Quality Committee meeting held on 23rd February, the Executive Leads confirmed that positive progress continues to made even though this has been slower in some areas than originally anticipated. The Standards of Care and Quality Improvement Programme is linked to the quality improvement action plan primarily through its Enhanced Patient Care through Continued Quality (EPIQ) project work. The projects are introducing new ways of working and have received positive buy in from the clinical areas involved. In Learning from Deaths, the Committee agreed that the mortality figures are going in the right direction but it will take some time to achieve internal performance targets. Quoracy at Mortality Sub Group Meetings is improving and remains a priority for divisions. Surgery, for example, regularly have good attendance but their terms of reference do not reflect adequate quoracy due to the unfeasible high numbers required in attendance and whilst there are signs of improvement in Medicine the division must respond to the management of patient outliers and dealing with the impact of high staff absence levels. The Mortality and Learning from Deaths Manager is making progress to improve the Sub Group governance arrangements and ways in which dissemination of learning from deaths takes place.

4.10 The Quality Committee were therefore assured around processes in place but with limited assurance assigned to the Learning from Deaths Programme specifically.

5.0 People Committee

5.1 The Health and Wellbeing programme is delivering on all key objectives as set out in the original mandate with milestones and metrics on track to deliver by the end of March 2022.

5.2 The following provides an update on the key risks to delivery registered at the start of this programme and the likely status of the risk at the end of the year:-

Description	Status/mitigation
Colleagues do not fully access or participate in the Health and Wellbeing offer	**Open** Colleagues have responded positively to the whole range of support systems now in place. This is expected to continue to the end of the year at which point this risk will be closed.
Operational pressures result in delays to appraisals being undertaken which may have potential impacts on any health and wellbeing recorded conversations taking place	**Open.** Target for completion of appraisals has been exceeded during the last 6 months. 90% may not be achievable by the end of the year however training sessions are continuing and staff will be encouraged to undertake their appraisals before the end of the year. Progress has been extremely positive this year despite operational pressures and staff shortages. Good progress is expected to continue to the end of the year at which point this risk will be closed.

National guidance not timely or responsive in relation to future vaccinations (Covid / Flu)	**Open.** Staff may not receive their first vaccination by 3rd February in line with the vaccination as a condition of employment regulations (April 2022) Note: Guidance on COVID vaccinations for NHS staff may change before the end of the year at which point this risk will be closed.
The trust has a varied health and wellbeing approach with different directorates engaged with health and wellbeing activity; therefore, potential for duplication or gaps in the HWB portfolio	**Closed** The health and wellbeing portfolio has been developed this year in conjunction with partners in order to avoid duplication offering equal access to the full range of support services applicable to all staff when they need it the most.
Prospective providers may not be able to fully meet the Occupational Health/Health and Wellbeing requirements contained in the service specification	**Closed** New contract has now been awarded that fully meets trust requirements

5.3 The Organisational Development Programme will remain in amber rag status for this reporting period due to set backs mainly caused by lack of capacity within the divisional triumvirates to attend the leadership "Team at the Top" development sessions, facilitated by the existing provider Fiona Reed Associates. It is therefore highly unlikely that the programme will be able to demonstrate the achievement of the following objectives, as set out in the original mandate, by the end of the year despite best efforts of all colleagues to participate in the learning and coaching events and to have the opportunity to practice their learning as a team:-

- Look at ways to improve the effectiveness of the Divisional management and leadership function
- Improve the senior leadership teams integrated performance, within their own Division and wider afield across The Trust
- Develop and integrate an effective coaching and mentoring framework into the fabric of Divisions, to support and underpin improvements in individual and team performance and effectiveness.
- Enhance leadership behaviours and safe practice intentions and actions within the Divisional teams.
- Further improve patient care, safe practice, safe and effective management and leadership.
- Develop a far-reaching Organisation Development Plan that aids the sustained improvement of the Divisions operating principles.

The intention therefore is to commission a further Organisational Development programme that will build on this year's work, exploring how teams can work better together and be more effective in delivering divisional performance.

The following provides an update on the key risks to delivery registered at the start of this programme and the likely prediction of risk status at the end of the year:-

Description	Status/mitigation
There is not full participation from Divisional Leadership Teams across the whole programme	**Open** Capacity issues have prevented full attendance on scheduled training sessions. 360 appraisal process is linked to delivery of the Organisatioinal Development/Leadership programme. 360 appraisal facilitators are in place and ready to commence when the programmes are aligned
External provider costs high; therefore there is dilution of the programme to fit within budget	**Closed** Existing provider costs approved (£40k) albeit incurring additional costs where training sessions are not fully attended
Preferred supplier is not able to commence programme if cost to deliver the programme is outside budget	**Closed** Schedule of training sessions set up to cover all divisions at an agreed cost of £40k)
Operational pressures result in individuals not being available to attend on the day / or only for part days.	**Open** Capacity issues have prevented full attendance and learning is then not applied equally across the whole team

5.4 The two benefit metrics assigned to this programme have not yet started due to the delay in implementing the 360 appraisal programme and the embargo on releasing the national staff survey results.

5.5 The Employer of Choice programme is rag rated amber due to the key milestone to complete the updated Medical and Dental Strategy having been extended again to the end of March.

The programme is, however, predicted to achieve the majority of its objectives set out in the original mandate with the exception of the bullet points below which have been delayed mainly due to re-prioritisation of graphics capacity within the trust subsequently causing delays in the production of new recruitment packs and the re-design of the trusts recruitment web site.

- Build and maintain our reputation externally, improving our brand as an employer of choice.
- Review of how we sell the trust as a place to work, such as an updated website.

Improvements are expected to materialise however once the new Digital Communication post holder joins the trust in a few weeks time and the positive impact of the new job advertisement contract with the British Medical Journal becomes evident.

The following provides an update on the key risks to delivery registered at the start of this programme and the likely prediction of risk status at the end of the year:-

Description	Status/mitigation
Failure to attract suitable applicants	**Open** To be rectified by new advertising campaign in the BMJ and updated job packs. Effects will not materialise until next year therefore the risk will remain open
Candidates once interviewed are not appointable	**Open** Linked to above risk. Wider applicant pool attracted by updated job packs and recruitment advertising. Effects will not materialise until next year therefore the risk will remain open
Delays in identifying recruitment to vacant posts e.g. retirements	**Open** Reliant on process improvements which may not impact on delays this year therefore the risk will remain open.
Retention of those appointed	**Open** Impacted by leadership, peer support, team working, environment, education opportunities, rostering etc. not directly attributed to the recruitment strategy therefore the risk will remain open
Clinical leaders can not be identified	**Closed** Clinical leaders have remained in post so far this year

5.6 The People Committee held on 18th February recognised the extensive work that has been undertaken regarding the mandatory Covid vaccination programme for NHS staff. The appointment of three consultants in the Urgent and Emergency Care Centre is strengthening the medical establishment. The Committee also recognised that the organisational development work around leadership has been consistently delayed due to Covid and the resultant capacity problems preventing staff from participating in the planned learning events. The People Committee therefore assigned limited assurance to the programme overall.

6.0 Finance and Performance Committee

6.1 The Identify New Practices to Embed Programme was closed in January due to the internal decision taken to move key activities into the operational planning rounds for 2022/23. Whilst this means that any associated risks and benefit metrics identified in the original mandate will not be monitored for the remainder of the year, the following provides a formal status of the risk log as at December 2021.

Description	Status/mitigation
Another wave of Covid-19 would likely put delivery at risk, as teams would need to focus their efforts on managing the clinical challenges.	**Closed** Learning from COVID packs were drafted in September/October. However, due to site pressures and the tighter restrictions around COVID throughout December, the completion of the packs was placed on hold and the decision taken to move the work into 2022-23 operational planning rounds, following the publication of the national operational planning guidance for next year.
Overall staff availability and willingness to engage with this programme of work.	**Closed** Staff availability has been inconsistent throughout the two year pandemic however as the learning from COVID packs have been moved into next year's plans, evidence of staff engagement to deliver the work has not been formally documented as part of this programme. Staff engagement is however being measured through national and local surveys under the Health and Wellbeing programme as well as through Pulse surveys which cover the impact of COVID on individuals and teams.

6.2 The Plan for the long-term recovery of Elective Care / Operational Excellence Programme is divided into two key work streams namely Elective Care and Operational Excellence.

In Elective Care, closure of the orthopaedic elective beds and restrictions on the main elective beds for seven weeks in Quarter 4, on top of the two-week closure in Quarter 3, has prevented the Trust from achieving key objectives and performance indicators aligned to this programme. Elective recovery is still behind 2019/20 levels and waiting lists continue to grow with more than 22,500 patients waiting at the end of January.

Implementation of patient initiated follow up pathways (PIFU) is an initiative that has been driven across partners through the Integrated Care System (ICS). The target to implement five major specialties by the end of the year is ambitious; however the Trust now has Sleep Studies, Ophthalmology, Gastroenterology, Ear Nose and Throat in implementation, with General Surgery to complete in the next few weeks and discussions are in place to on board Urology by the end of the year. This initiative – which gives patients and their carers the flexibility to arrange their follow up appointments as and when they need them – will help the Trust manage its demand appropriately, and see patients in need more quickly.

The patient voice element of the Operational Excellence work stream is supported by the Orthopaedic Planned Care Citizens' Panel which is now scheduled to meet each month and is already well received by participants. Ideas generated by the group will be formulated into action plans that will improve quality of care and provide ongoing support to patients that might otherwise feel that they have been forgotten due to the long delays caused by the pandemic (infection prevention control measures and staff shortages included) and the ensuing backlog of patients waiting for surgery.

Good progress has also been made to deliver against the objective outlined in the original mandate to ensure that there is a robust training package around elective care and to achieve the Referral to Treatment (RTT) incomplete standard targets. Training is now in place and will be rolled out to all relevant staff by the end of March.

6.3 The following provides an update on the key risks/issues to delivery registered at the start of this programme and the likely status of the risk by the end of the year:-

Description	Status/Mitigation
If there is a 3rd Covid wave, delivery of elective recovery will be at risk.	**Open** A better infrastructure is now in place to manage the impact of future waves of COVID. The impact of the pandemic will continue to be monitored up to the end of March when the status of this risk will be finalised.
The rollover of annual leave which has been allowed and encouraged into 2021/22 will reduce our clinical resources at a time when we are trying to deliver additional activity. Careful management of this annual leave is critical.	**Open** Roll over of annual leave and high levels of sickness absence and isolation due to Covid has reduced capacity across the trust. Status of annual leave planned/taken during the year is monitored under the separate Health and Wellbeing programme however full status will not be known until carry over for next year's requests are submitted and management of leave is more widely understood therefore the status of this risk will be finalised at the end of March.
Some of the recovery programme will require changes to ways of working and potentially pathway redesign. Resistance to this from partners could create significant challenges.	**Closed** The Trust has supported the Integrated Care System partners new ways of working and pathway re-design through the implementation of virtual consultations, patient initiated follow ups and advice and guidance. This work will continue into next year under a renewed outpatient efficiency programme.

6.4 The Best Practice Discharge Processes programme comprises five key work streams namely:-

- Digital solutions
- Discharge Lounge Utilisation
- Prescriptions to take out (TTOs)
- Integrated Discharge Team (IDT) Review
- Ward by Ward programme of improvement

With the exception of the Integrated Discharge Team (IDT) Review, which has proven difficult to arrange in the last six months on account of unyielding work pressures across the service and the wider system, all work streams are delivering, particularly in the case of the planned, digital solutions which are now live in the operational command centre. Through the tailoring of the "plan, do, study, act" approach identified improvements are also being piloted in other areas with performance metrics being put into place with a view to studying the outcomes before any wider roll outs are undertaken.

This methodology has led to an early promising outcome in the trialling of an Advanced Clinical Practitioner (ACP) based in the discharge lounge which has seen a plateau in its utilisation. The expectation is that with further promotion of the discharge lounge as well as engagement with teams to understand blockages to its usage, utilisation will exceed original base line metrics before the end of the year. It is acknowledged that use of the service is constrained by essential infection control prevention measures, particularly in the face of a surge in Covid infections in January that prevented an increase in its use. The Discharge Re-set week also identified a number of changes that will improve utilisation of the lounge including transition to a ward based discharge co-ordinator model.

A pilot approach is also being undertaken in relation to changing working practices by providing training to staff on good practice in processing of medicines to take out (TTOs). The effects of the training will be studied to ensure that is has had the desired effect after which an appropriate trust wide implementation plan will be put into place.

The Ward by Ward improvement work has commenced in Medicine and Surgery with a view to providing support in order to exceed baseline internal key performance indicators relating to Expected Discharge Dates (EDD) for patients.

It is recognised that to progress delivery the work streams require ongoing support for staff with regular communication and feedback from operational leads in order to strengthen staff engagement and consolidate the improvement work across the trust as agreed in the original mandate where the focus of the work has remained trust-related and as defined by the following priorities:

- Deliver efficient and appropriate discharge arrangements that support optimum flow and in line with best practise and national guidance
- Deliver digital patient flow programme, including command centre, escalation management and tele-tracking

In order to reinforce the links between this programme and Place, a review of discharge priorities and the interface with partners is due to commence before the end of this financial year.

6.5 The following provides an update on the key risks/issues to delivery registered at the start of this programme and the likely status of the risk by the end of the year:-

Description	Status/mitigation
Risk -Impact of Covid - future surges will impact on patient flow and metrics.	**Open** 3 out of 6 performance metrics are rag rated red at the end of January, albeit this is not entirely attributed to Covid which has impacted on both patients as well as availability of staff needed to provide care.
National guidance changes that alters the direction of travel.	**Closed** National guidance identified at the start of the project is factored into the programme work streams along with any changes in direction to accommodate the pandemic - Hospital Discharge Service Policy and Operating Model outlines key principles of discharge. Reducing Length of Stay (RLOS) programme - national ambition announced in June 2018.

6.6 The Admission Avoidance programme remains in red rag status as at the end of January due to the unsuccessful achievement of two key milestones and the impact this has had on the objectives of this programme to (a) ensure that effective ambulatory and frailty pathways are in place and (b) the need to implement an appropriate Same Day Emergency Care (SDEC) service at the acute site.

Until such time as there is a consensus on the future operating model and the presentation of the financial aspect of the SDEC business case is reviewed, the business case cannot be re-submitted for Executive Management Team discussion, and, whilst the frailty pathway model is already supported by Medicine, it will take some time to formally establish. However, recent metrics suggest that the way in which frail patients are now being assessed is avoiding hospital admission and reducing length of stay for those patients that might otherwise have resided in hospital for more than three days.

The Acute Care Transformation Programme (ACT) has subsequently identified pathway re-design as one of its key themes for next year starting in the Urgent and Emergency Care Centre (UECC) therefore progress on SDEC and frailty pathways will now be transitioned into the ACT Programme in order to find ways to stream patients to the most appropriate specialty and where possible circumvent the emergency department.

6.7 The following provides an update on the key risks/issues to delivery registered at the start of this programme and the likely status of the risk by the end of the year:-

.Description	Status/mitigation
Impact of Covid - future surges will impact on patient flow and metrics.	**Open** Changes in frailty and SDEC will not be embedded by the end of the year therefore the services will manage the impact of Covid as they do currently. Lessons learned from the pandemic will be factored into pathway re-design in the future.
Recruitment to key roles to support pathways, particularly frailty.	**Closed** Consultant Geriatrician/lead frailty specialist commenced in September and is making a significant impact. The Frailty specialist nurse development plan to achieve ANP status with prescribing will take longer than the timeline attached to this programme. Acute medical vacancies remain hard to fill. SDEC is reliant on its nurse led model currently. Expansion will require additional medical input which will transfer to next year's plans and options to support a revised business case.

6.8 Given the position around recovery and admission avoidance, the Finance and Performance Committee assigned limited assurance at their meeting held on 23rd February. The Finance and Performance Committee is keen to ensure that the work around learning from Covid is undertaken as part of operational planning, along with service sustainability reviews. With reference to the Same Day Emergency Care Business Case, the Committee supported the phased approach that is being adopted with the first phase being to agree to fund the additional capacity already open across the organisation in 2022-23. The positive progress on Frailty was recognised with the recruitment of additional consultants noted as a particularly positive step.

6.9 The Board of Directors is asked to note the content of this report.

Michael Wright
Deputy Chief Executive
March 2022

Operational Objectives 2021-22

December 2021 – January 2022

Appendix 1: Programme Highlight Reports

Board of Directors Meeting

4th March 2022

Operational Plan 21/22 Programme Highlight Report – Dec 21 – Jan 22

NHS
The Rotherham
NHS Foundation Trust

Programme: O1.1	Health & Well Being (HWB)		
Exec Lead:	Director of Workforce & OD	**Impact**	People
SRO:	Deputy Director of HR		

R A G

Current Progress — Red / Amber / Green — **Previous**

Overview:	To deliver a full programme of HWB initiatives available for all TRFT staff to access. This will include key priorities contained in the NHS People Plan /P&PG :- maintain national HWB offer and access regional mental health hubs (SYB); enhanced OH & HWB offer (review of OH service specification); encourage and embed health and wellbeing conversations (including training and support to line managers and a means of tracking delivery); continue to offer colleagues risk assessments; facilitate the process for Covid (and flu) vaccinations / booster jabs in line with national guidance; access to psychological and physical support for colleagues; improve usage of effective e-rostering to support flexibility, planning annual leave, work-life balance.
Summary Position:	Apply VCOD national guidance/legislation - a working group has been set up to progress Vaccination as a Condition of Deployment (VCOD) requirements by April 2022. The new SYB HWB Hub website has been launched and will provide 24/7, 365 support, self help information and fast track access to therapy services. National charitable funding has also been secured to provide (1) occupational psychology support to both Rotherham and Barnsley Trusts jointly; (2) a schedule of inclusive events that will reach out to both staff and local communities will start in March with a 5-a-side football competition being the first venture; (3) art therapy pilot will be undertaken during 22/23. The new Occupational Health tender was awarded to Sheffield Teaching Hospitals with the contract due to commence on 01 March 2022. The embargo on the publication of the national Staff Survey results is still in place but results have been shared with Divisions to support action plan development. The quarterly NHS People Pulse Survey has now been launched with initial results expected early next year.
Activities completed December/January	▪ Develop plans to complete NHS Wellbeing Framework (final end date end of Quarter 4 2022/23) to include staff engagement, people pulse data and staff survey information. ▪ ICS Mental Health First funding acquired to train the trainer – aiming for 75 colleagues Trust wide. ▪ Continue to seek out opportunities to bid for a variety of wellbeing opportunities such as complimentary therapies and weight loss ▪ Successful bid for extended funding to support ongoing dissemination of the healthy minds, health eating, healthy body pilot ▪ ICS Funded staff health 12 month initiative 'Know your numbers'- staff health surveillance/lifestyle- planned recruitment underway ▪ Continual development of roll out of behavioural framework and implementation of services behavioural charters
Activities planned for February/March	▪ Identify all staff that have not had their first COVID vaccine by 3rd February deadline ▪ Continue COVID vaccine sessions and hold discussions with staff requiring individual support and advice ▪ Sheffield Teaching Hospitals Occupational Health contract will commence 01 March 2022. ▪ Implement plans to complete the NHS Wellbeing Framework by end of March (5 Ways to Wellbeing) ▪ Publish national Staff Survey results

Operational Plan 21/22 Programme Highlight Report – Dec 21 – Jan 22

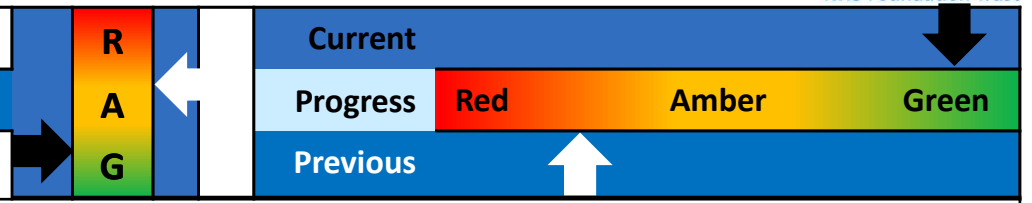
The Rotherham NHS Foundation Trust

Programme: O1.2	Identify new practices to embed		CLOSED	R A G	**Current** CLOSED **Progress** Red / Amber / Green **Previous**
Exec Lead:	Director of Strategy, Planning & Performance	**Impact**			
SRO:	Assistant Director of Strategy, Planning & Delivery	F&PC			
Overview:	Understand the current sustainability of services post COVID. Identify key actions / areas for focus for unsustainable services Identification of changes made through COVID which services / corporate teams want / hope to maintain Support services / corporate teams to maintain the positive changes made through COVID				
Summary Position:	The programme was closed in December due to the transfer of any further activity into 2022-23 Operational Planning rounds, following the publication of the national operational planning guidance in late December.				
Activities completed December/January	▪ Commencement of operational planning cycle ▪ Programme closed				
Activities planned for February/March	▪ None				
Key risks to overall delivery	▪ Continued uncertainty around national operational planning guidance (no longer a risk to delivery of the programme in the current financial year, however, its impact will be factored into next year's plans as required.				
Key issues	▪ None				

Operational Plan 21/22 Programme Highlight Report – Dec 21 – Jan 22

NHS The Rotherham NHS Foundation Trust

Programme: O2.1	Standards of Care & Quality Improvement		
Exec Lead:	Executive Chief Nurse & DIPC	**Impact**	
SRO:	Dep. Chief Nurse (Safety, Safeguarding, Risk Management)	Quality	



Overview:	Review and relaunch the Safe and Sound Quality Strategy. Articulate and embed agreed standards of care across the organisation consistently. Identify clear quality improvement methodology and resources. Support teams to deliver and embed continuous quality improvement
Summary Position:	Refinements to the existing quality strategy have already been completed and having worked alongside NHS Improvement a standardised approach to quality improvement is now in place. However, there will now be a proposal to establish a Quality Improvement Faculty, supported by the Trust. If supported, this will mean the strategy will be required to be reviewed next year, albeit subject to Trust Board approval and development of any associated business case. An outline strategy is planned for completion by the end of the year which will then be presented to Trust Board. The Quality Matrons continue to progress Enhanced Patient Care through Continued Quality (EPIQ) projects. The EPIQ projects have delivered a wide range of sustainable improvements in standards of care particularly in falls, pressure ulcers and deteriorating patients. The positive impact of the EPIQ projects this year is evident from the performance metrics despite prevailing capacity issues and operational pressures. The process for managing Serious Incidents and Red reports continues to be refined with patient safety leads working more closely with the divisions. This will allow the trust to gain a renewed focus on the early implementation of the required learning.
Activities completed December/January	▪ Seek Executive approval to close the programme two months early (end January) due to postponement of the re-launch of the quality strategy and associated toolkit until next year. Early closure was not supported by the Quality Committee in December due to limited assurance and acceptance that work will continue into next year given the proposal to establish a quality improvement faculty. ▪ Continue to embed improvements identified during implementation of the 5 Quality Improvement Projects already started this year
Activities planned for February/March	▪ Complete outline quality strategy
Key risks to overall delivery	▪ Insufficient time to prepare the updated strategy in full and present to Trust Board during quarter four.
Key issues	▪ None

Blue	Achieved / Completed	Green	On Target / Plan	202 Amber	Behind plan with mitigation or actions in place to recover	Red	Behind plan no mitigation or more significant action required

Operational Plan 21/22 Programme Highlight Report – Dec 21 – Jan 22

NHS
The Rotherham
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Programme: O2.2	Learning from Deaths		
Exec Lead:	Executive Medical Director	**Impact**	R A G
SRO:	Deputy Medical Director for Professional Standards	Quality	

Current Progress: Red – Amber – Green

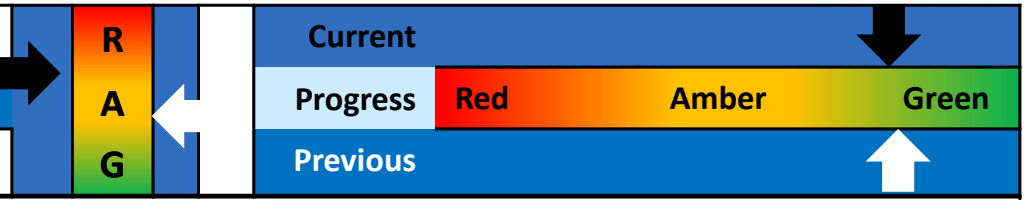
Previous

Overview:	Improve the quality of care provided within the Trust. Reduce the level of excess mortality within the Trust. Improve the quality and accuracy of our clinical coding (including documentation) so that it fully reflects our patient cohort and standard of care provided. Support the clinical, quality and operational governance structures to support and promote learning and improvements in the quality of care.
Summary Position:	The trust is one of 9 in the region that remains in the higher than expected category with a Hospital Standardised Mortality Ratio score of 114.6 (September 2021 data). This is a notable reduction, however, from the programme's baseline in June 2021 of 125.6. The Summary Hospital Mortality Indicator (SHMI) (August 2021 data) remains within the expected range at 110.66. To improve quality of care and reduce excess mortality in the trust a new template has been developed to support operational governance and promote learning from deaths within divisions. A new procedure is also in development to co-ordinate and deal with Dr Foster alerts in a more timely manner. To improve the quality and consistency of TRFT's SJRs, training opportunities are being sourced. The mortality leads from Medicine, Surgery and Family Services have been allocated a place on an SJR Training Event in March run by the Quality Academy. The trust is participating in a Mortality Review/Improvement Programme with NHSI/E National Mortality leads which will more likely involve wide scale SJR training for clinicians, later in 2022.Ongoing education and support from the Clinical Coding team has resulted in achieving 98.97% coding accuracy as published in a recent audit. No further work is expected to be undertaken by the Improvement Academy in relation to UECC and the pneumonia care bundle which is now live in Meditech. The Adult Sepsis mandatory training package is live in the electronic staff records system after long delays however compliance reporting will not be in place until after April when final system adjustments have been made.
Activities completed December/January	▪ Identify divisional learning and actions associated with Dr Foster alerts for alcoholic liver disease and congestive heart failure ▪ New Mortality & Learning from Deaths Manager to begin to review processes and make recommendations for further improvements. ▪ Clinical coding training video in place ▪ Adult Sepsis e-learning package installed in ESR and all relevant staff have been informed of the requirement to complete the MAST
Activities planned for February/March	▪ Launch Clinical Coding Video ▪ Strengthen SJR review process and commence Quality Academy SJR training sessions
Key risks to overall delivery	▪ Clinician capacity and operational pressures leads to non-quorate mortality meetings where key decisions are then deferred ▪ 85% compliance target at risk due to installation issues related to Sepsis e-learning training package ▪ Timeliness of junior doctors attending bereavement centre to complete death certificates impacts on S1 and SJR KPIs (30, 60 days). ▪ National ME directive that Stage 1/ME 'scrutiny' reviews should not form part of Meditech/patient records.

Operational Plan 21/22 Programme Highlight Report – Dec 21 – Jan 22

The Rotherham NHS Foundation Trust

Programme: O3	Plan the long-term recovery of Elective Care / Operational Excellence		
Exec Lead:	Chief Operating Officer	**Impact**	
SRO:	Director of Strategy, Planning and Performance	F&PC	



Overview:	**Elective Care Recovery** will aim to achieve a) a set of defined targets against the national constitutional standards b) adherence to the key requirements in the national planning guidance, relating to a system's ability to access the Elective Recovery Fund. **Operational Excellence** will aim to achieve a) a robust and accessible package of training for colleagues around elective care and b) clear guidance for staff on how to record elective care pathways in our systems.
Summary Position:	**Elective recovery** activity has fallen further behind 19/20 levels, and closure of the majority of the elective beds for 7 weeks has significantly affected our ability to deliver the recovery programme. The number of 52 week waits has started to increase for the first time in nearly a year, and the waiting list size also continues to grow (approx. 22.7k, 33% increase on April 2021). **Patient Initiated Follow up (PIFU)** - National expectation is that the Trust will have PIFU in place for at least 5 major outpatient specialties, moving or discharging 1.5% of all outpatient attendances to PIFU pathways by December 2021, and 2% by March 2022. Dec data tracks at 0.3%. Ophthalmology already implemented. Gastro Phase 1 went live 4th Jan and Phase 2 is planned for early March. ENT planned for go live by March. General Surgery protocols are being written with plan for go live by end of March. Urology is also in early stage discussions with clinicians. **Orthopaedic Planned Care Citizens' Panel** - 3 of the 6 scheduled monthly meetings have taken place, and an action plan to capture and manage panel feedback is in progress, with several quick wins identified. The panel has also focussed on some medium term actions including modernising and improving the Orthopaedics web page to include more patient-friendly information (for example consultant names and photos, where to find exercise classes, and average waiting times.) We plan to issue a patient communication in Q4 across most specialties to all patients currently on the waiting list, to provide reassurance that they haven't been forgotten, and to offer advice and sign-posting. **Operational Excellence –** The Referral to Treatment training is designed, with internal trainers now fully trained. To be rolled-out across the organisation in March 22.
Activities completed December/January	▪ PIFU – Gastro Phase 1 go-live ▪ Orthopaedic Planned Care Citizens Panel – December and January meetings
Activities planned for February/March	▪ Orthopaedic Planned Care Patient Panel – February and March meetings and issue holding letter to all patients on the waiting list ▪ PIFU – Gastro phase 2 roll-out ▪ RTT training roll-out
Key risks to overall delivery	▪ Winter pressures are likely to make increases in activity more challenging, especially if the ring-fenced bed base is lost at any future point
Key issues	▪ Elective beds lost for 7 weeks, significantly affecting our ability to deliver the recovery programme.

Operational Plan 21/22 Programme Highlight Report – Dec 21 – Jan 22

NHS
The Rotherham
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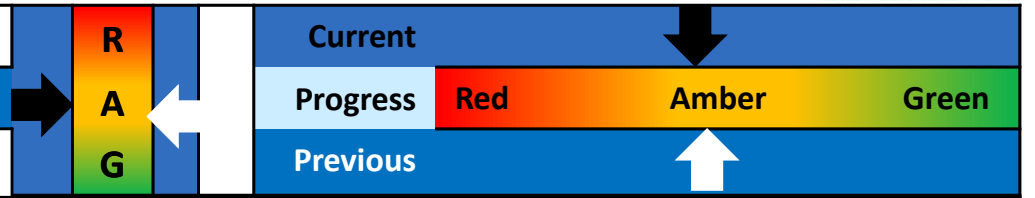
Programme: O4.1	Organisational Development Programme		
Exec Lead:	Director of Workforce & OD	**Impact**	People
SRO:	Deputy Director of HR		



Overview:	Ascertain how Divisions operate: challenges, successes, areas for continuous improvement; Look at ways to improve effectiveness of Divisional management and leadership; Generate rich picture of good stories and not-so-good stories; Improve senior leadership teams' integrated performance; Develop and integrate effective coaching and mentoring framework to improve individual and team performance and effectiveness; Enhance leadership behaviours and safe practice intentions and actions; Further improve patient care, safe practice, safe and effective management and leadership; Develop far-reaching OD Plan that aids the sustained improvement of the Divisions operating principles; Further embed The Trust's values, mission and strategy; Increase levels of Transparency, Communication and Participation.
Summary Position:	During the last 12 months the existing provider (Fiona Reed Associates) has continued to roll out the "Team at the Top" programme to divisional triumvirates supported by the Chief Operating Officer. Due to operational pressures and changes in divisional appointments throughout the year, several sessions have been rescheduled at short notice. Family Health and Surgery were however able to complete their planned sessions in December. Initial feedback from participants so far has been positive, however, further diagnostics will need to be undertaken in February in order to inform next steps. The intention is to commission a further OD programme to build on this year's work but explore how teams can work better together and be more effective in delivering divisional performance.
Activities completed December/January	▪ Existing provider to continue roll out of Team at the Top leadership programme ▪ Facilitate 360 appraisals (deferred until next year's leadership programme is confirmed) – 11 360 facilitators have been trained in 21/22.
Activities planned February/March	▪ Complete participant feedback/diagnostic exercise on Team at the Top provision ▪ Continue development of 2022-23 Organisational Development Programme
Key risks to overall delivery	▪ 360 appraisals delayed until the OD programme is implemented for 22/23. ▪ Embargo on sharing National staff survey scores (quality of care/safety culture) delays publication of metrics that are intended to provide measures of success in effective management and leadership, safe practice intentions and actions.
Key issues	▪ None

Blue – Achieved / Completed

Green – On Target / Plan

Amber – Behind plan with mitigation or actions in place to recover

Red – Behind plan no mitigation or more significant action required

Operational Plan 21/22 Programme Highlight Report – Dec 21 – Jan 22

NHS
The Rotherham
NHS Foundation Trust

Programme: O4.2	Employer of Choice		
Exec Lead:	Director of Workforce & OD	**Impact**	
SRO:	Head of Medical & Dental Workforce	People	

R A G

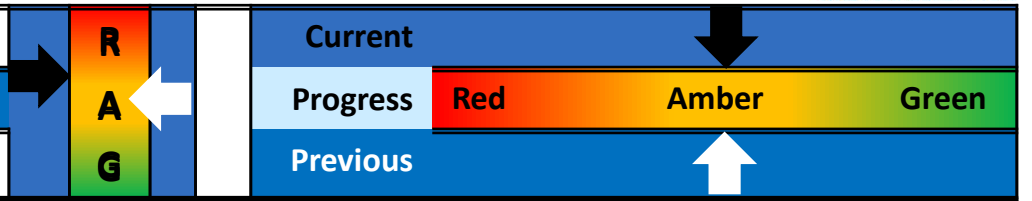
Current / **Progress** / **Previous**: Red | Amber | Green

Overview:	Identify and recruit to key posts, including through the exploration of alternative markets & new roles and have mitigation plans in place if roles not filled. Build and maintain our reputation externally, improving our brand as an employer of choice. Review of how we sell TRFT as a place to work, such as an updated website. Develop our own M&D staff to become Clinical Leaders. Attract external applicants to undertake leadership roles. Encourage trainees to apply for consultant posts upon completion of training. Retain staff once recruited. Recruitment strategy of direct advertisement, liaising with recruitment agencies when this route has been unsuccessful or a dual strategy of both concurrently.
Summary Position:	The key milestone to complete the updated Medical and Dental Strategy has been extended to the end of March. This is largely due to the re-direction of resources that were needed to support divisions to concentrate on mandatory COVID vaccinations. Medical and Dental vacancy rates remain stable, however, expenditure on locums continues to rise, mainly due to fluctuations in agency supply and continued supply of 8 or 9 long term locums to cover long-standing vacancies. To support the trust in improving its employer brand and move away from in-house graphics, the BMJ will be contracted to provide eighteen, full colour, quarter page adverts per annum for a negotiated price of £20,500, along with enhanced on-line content and exposure on BMJ Careers. Ten recruitment agencies are now engaged to assist with the marketing and recruitment of medical staff, with Rheumatology Consultant vacancies being the first to go ahead on an Executive search basis. Three Higher Level trainees have applied for Consultant vacancies in UECC with interviews taking place on 9th February. Re-vamp of the trusts recruitment pages on the Hub will be completed following the commencement of the new Digital Communications Assistant.
Activities completed December/January	▪ Commence Digital Communications Assistant recruitment (appointment confirmed)
Activities planned for February/March	▪ Review and redraft Consultant Job Descriptions ▪ Present paper to Executives to support request for annual subscription to BMJ (£20,500 per annum) ▪ Request narrative from Divisions to complete strategy documentation ▪ Re-draft medical and dental recruitment policy ▪ Interview 3 higher level trainees for Consultant vacancies in the Urgent and Emergency Care Centre
Key risks to overall delivery	▪ Candidates once interviewed are not appointable ▪ COVID continues to impact on international recruitment and locum expenditure ▪ Capacity to overhaul job packs (medical & non-medical) in graphics design services and medical staffing team

Operational Plan 21/22 Programme Highlight Report – Dec 21 – Jan 22

The Rotherham NHS Foundation Trust

Programme: O5.1	Best Practice Discharge Processes		
Exec Lead:	Deputy Chief Operating Officer / Director of Operations	**Impact**	
SRO:	Deputy Chief Nurse	F&PC	



Overview:	Ensure best practice discharge processes are implemented. Ensure appropriate digital solutions and processes are implemented (to include escalation system, teletracking, command centre).
Summary Position:	The Deputy Chief Nurse was appointed in Jan as SRO for this programme due to the previous postholder leaving the organisation. The Discharge T&F Group is currently being refreshed and reconfigured, to encourage greater engagement and ownership of the work programme and tighter reporting. **Discharge Lounge utilisation** has improved from the original baseline, but is now plateauing. To address this, engagement with teams to understand blockages is taking place, and promotion of the lounge is under review. The Trust has recently trialled an Advanced Clinical Practitioner in the discharge lounge to provide senior clinical support that reassures medical colleagues of a final review, TTO (to take out) prescribing and clinically led discharge letter/summary - the initial results appear very promising. Some challenges remain due to IPC measures restricting use of the lounge - there was a sharp rise in Infection, Prevention Control rates in late December through January (In January, 30 (49.7%) of patients were not able to utilise the lounge for this reason. **TTOs -** In order to promote an increase in accurate TTO prescribing, Pharmacy have delivered pilot training on 2 wards initially. A review of the impact of the training is in progress, before a wider roll-out. **Integrated Discharge Team (IDT) Review -** Process mapping to identify any efficiencies within IDT, has proven difficult to arrange due to ongoing pressures within the team and wider system pressures; however, there is a firm commitment to progress the review from early March. **Ward by ward programme of improvement** – all wards in Medicine are in progress, with initial support provided and plans agreed to revisit (hitting 85-95% in Expected Discharge Date (EDD) planning across the division). Improvement work in Surgery has also now started with an initial focus on equipping the team with patient information tools (hitting 95-100% in EDD planning). In addition, a **Discharge Reset Week** was undertaken during January with a focus on no right to reside (R2R) including transition to ward-based discharge co-ordinator model, improved usage of the discharge lounge, improved patient / staff communications and engagement with long length of stay processes.
Activities completed December/January	▪ Discharge Focus Week on A4 – December; Discharge Reset Week – January ▪ TTO pilot training
Activities planned for February/March	▪ Review of discharge priorities and interface with Place ▪ IDT review
Key risks to overall delivery	▪ Ongoing system pressures causing disruption to the Discharge T&F Group progress and significantly impacting adversely on length of stay
Key issues	▪ See risks

Operational Plan 21/22 Programme Highlight Report – Dec 21 - Jan 22

NHS The Rotherham NHS Foundation Trust

Programme: O5.2	Admission Avoidance	**Impact**	R A G
Exec Lead:	Chief Operating Officer		
SRO:	General Manager Medicine	F&PC	

Current Progress — Red / Amber / Green — **Previous**

Overview:	Implementation of an appropriate SDEC service at acute site. Ensure effective ambulatory and frailty pathways are in place.
Summary Position:	**SDEC -** The expanded business case is still under discussion to ensure that we are capturing the unfunded areas in Medicine alongside the enhancement and expansion of Same Day Emergency Care (SDEC), and also reviewing the presentation of the financial aspect of the case. A further meeting will follow (timing to be confirmed) with Executive Team colleagues once this has been completed. **Frailty pathway -** The preferred frailty pathway model has been outlined by the lead Consultant for Frailty and the Division of Medicine is on board. Progress to embed the model will continue into next year through the Acute Care Transformation framework.
Activities completed December/January	▪ Draft SDEC/AMU business case issued to the Exec Team and ongoing discussions throughout the reporting period
Activities planned for February/March	▪ N/A
Key risks to overall delivery	▪ Consensus on the future operating model for SDEC cannot currently be reached
Key issues	▪ See above

Operational Plan 21/22 Programme Highlight Report – Dec – Jan 2022

The Rotherham NHS Foundation Trust

Programme: O6	Removal of Breach of Licence / Five Year Strategy		COMPLETED	**Current**	**COMPLETED**
Exec Lead:	Deputy Chief Executive	**Impact**		**Progress**	
SRO:	Dir. of Finance / Dir. of Strategy, Planning & Performance	F&PC		**Previous**	

Overview:	To have the longstanding breach of licence lifted by March 2022 and to publish a new Trust Strategy by the end of September 2021.
Summary Position:	As previously reported the Breach of licence and undertakings have been removed ahead of plan. The Trust Strategy was approved at the Trust Board in September subject to minor amendments and was published slightly later than planned in December following a Board development session on 10/12/21. This now completes the activities aligned to the programme which is now closed.
Activities completed December/January	▪ Board development session on Trust's strategy delivery plan 10/12/21 ▪ New Trust Strategy published
Activities planned for February / March	▪ None programme closed
Key risks to overall delivery	▪ None
Key issues	▪ None

Blue – Achieved / Completed

Green – On Target / Plan

Amber – Behind plan with mitigation or actions in place to recover

Red – Behind plan no mitigation or more significant action required

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P45/22
Report	**Acute Care Transformation (ACT)**
Executive Lead	George Briggs, Chief Operating Officer
Link with the BAF	B1 and B2
How does this paper support Trust Values	Ambitious: Ensuring the Trust is delivering high quality services Caring: Ensuring patients are seen within the appropriate time frames Together: Working collaboratively with partners to achieve standards
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report provides an outline of the Acute Care Transformation (ACT) programme established by the Trust in late 2021. The report outlines the background to the establishment of the group, the currently agreed work programme and the progress / work undertaken to date. The ACT programme will make improvements across our emergency and acute care pathways across key themes. The five agreed themes are as follows: 1. Urgent and Emergency Care Centre (UECC) Workforce 2. UECC Leadership and Staff Engagement 3. Acute Pathways 4. UECC Patient Experience 5. UECC Ways of Working
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report is for information and is taken from the initial scoping meetings and the subsequent transformation program.
Board powers to make this decision	The Board has delegated authority to the Chief Operating Officer to review and feedback to the board any improvement and transformation issues, and actions required to ensure we meet our vision and aims.
Who, What and When (what action is required, who is the lead and when should it be completed?)	A report is provided to the Trust Board to inform the Directors of the ACT program. The program is chaired by the Chief Executive with the Chief Operating Officer with support from PMO colleagues acting as executive lead.
Recommendations	It is recommended that the Board note the report.
Appendices	1. Acute Care Transformation Program

1.0 Introduction

1.1 This report provides an outline of the Acute Care Transformation (ACT) programme established by the Trust in late 2021. The report outlines the background to the establishment of the group, the currently agreed work programme and the progress / work undertaken to date.

2.0 Background

2.1 In November 2021, the Trust launched the Acute Care Transformation (ACT) programme of improvement. The programme, which is led by Dr Richard Jenkins (Interim CEO) and George Briggs (COO) will focus on improvements to the Trusts emergency care and acute pathways.

2.2 This establishment of this work and focus on our emergency care services is in direct response to the challenges the Trust has within this area currently as well as challenges faced during and before the COVID-19 pandemic. This includes issues such as our compliance with national performance standards, poor staff satisfaction and engagement within the UECC department, disappointing patient feedback and concerns raised through Care Quality Commission (CQC) inspections.

3.0 Current Work

3.1 In establishing the ACT programme, it was recognised that significant work has already taken place. This is through a variety of sources including our CQC action plan as well as proactive developments by the new local leadership within UECC.

3.2 One of the key objectives of the ACT is to compliment the good work already taking place. However, it should also stretch the ambition of this work, support higher standards of delivery and support and empower local leadership to move into a culture of continuous improvement. ACT will provide framework for this to happen.

4.0 Scope of the ACT Programme

4.1 The ACT programme will look to make improvements across our emergency and acute care pathways. This will cover a significant amount of the Trust and cut across our clinical divisions. However, while recognising that resolving some the challenges will require this wider Trust response, the programme is deliberately focused predominantly on our Urgent and Community Care Centre (UECC) – both from a work plan, but also from a leadership and engagement position.

4.2 Additionally, the work will focus on the internal, TRFT influence able factors. Again, the work recognises that there is a significant role that place partners and external influences have on our acute pathways (i.e., who arrives at the UECC front door) and will ensure that links are maintained into the Place governance to which TRFT is an active participant.

5.0 The Work Programme

5.1 The work programme developed, as well as the governance, has been designed to be light touch, flexible and responsive. This is to maximise the 'delivery time' of staff engaged with the programme, as well as ensure that we continue to focus on the right things, regardless of how and when they are identified.

6.0 Themes of Work

6.1 Five themes of work have been agreed within the programme. These have been developed initially from feedback received from staff engagement via listening exercises undertaken by the CEO and COO (and subsequently much wider UECC engagement from the leadership team) and refined through the inclusion of our known challenges and discussion with the programme leads.

The five agreed themes are as follows:

1) UECC Workforce
2) UECC Leadership and Staff Engagement
3) Acute Pathways
4) UECC Patient Experience
5) UECC Ways of Working

6.2 The outline objectives for each of these are set out within figure 1 and have been agreed with the Steering Group.

6.3 In setting out these objectives, it is thought that the 'length' of each theme within the ACT programme may be variable – for example, the assurance needed on Leadership and Staff Engagement may take less time that the development of key pathways. Therefore, as each group is established, they have been asked to consider the 'exit criteria' from the ACT programme into business as usual, so that the Steering Group have assurance that the required, sustainable change, has been made.

7.0 Leadership

7.1 Each of the five themes outlined above have a 'local' lead from the UECC and an Executive Lead from the Trust Executive Team. There is positive clinical (with 4 of 5 local leads clinical) and UECC leadership team engagement (Divisional Director, Clinical Lead, General Manager and Head of Nursing are all leads).

7.2 The including of senior local and executive team leadership is a significant resource and emphasises the importance of this work to the Trust.

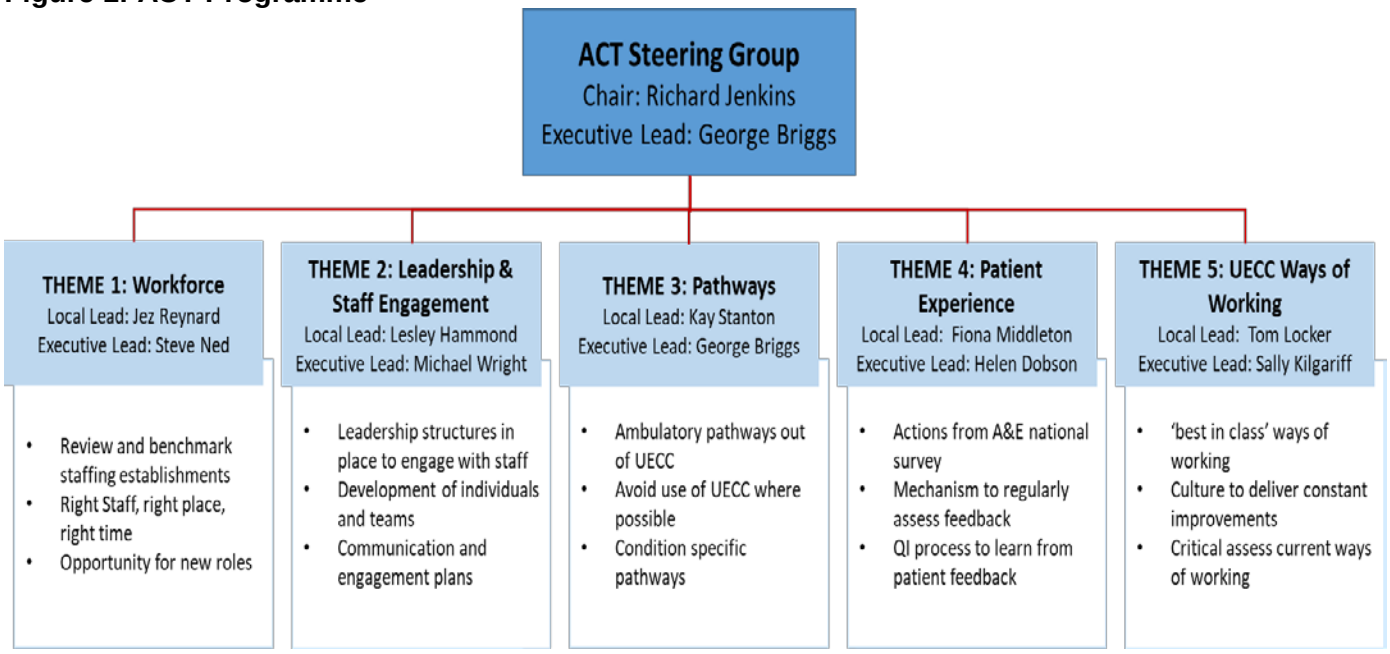
8.0 Work to Date

8.1 The work to date has focused on the establishment of the programme of work, engagement with leads and establishment of initial actions. It is felt that good progress has been made given the pressures faced by UECC and the Trust in general over the last 2 months and the impact of the Omicron wave on the Trust. Some of the high level actions started and undertaken are as follows:

- Information analysis of doctor productivity within the UECC has commenced supported by the Health Informatics department
- A ‘visionary board’ has been developed for display within the UECC – this will support staff interaction and idea generation.
- Staff focus group is now meeting regularly within the UECC to look at good practice and develop an action plan
- Family Health presented an outline of the options for ambulatory gynaecology pathways out of UECC for discussion and input
- Cross referencing of patient feedback from patient survey and the CQC action plan has taken place with many of the concerns raised also present raised by the 2021 inspection.
- Agreement on these key streams within the UECC ways of working theme – looking at stock management, digital and ‘if only I could change’. Initial action plan developed.

George Briggs
Chief Operating Officer
February 2022

Figure 1: ACT Programme



Board of Directors' Meeting
04 March 2021

NHS
The Rotherham
NHS Foundation Trust

Agenda item	P46/22
Report	**Green Plan**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	B1 – Standards and quality of care B3 – Engagement with service users B11- Joint working with key partners
How does this paper support Trust Values	Ambitious – The Trust is working to achieve its Net Zero targets. Caring – The Trust is working to reduce its climate change impact in the South Yorkshire region. Together – The Trust is working together with senior leaders, clinical teams and external stakeholders to mitigate the impact of climate change for the population of Rotherham.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this paper is to present the Green Plan 2022 – 2025, to the Board for information. The Rotherham NHS Foundation Trust's Green Plan sets out how the trust will address Sir Simon Stevens Net Zero challenge, for the NHS to reduce the environmental impact arising from carbon emissions with a view to achieving 80% net zero by 2032 and totally emissions free on site by 2040. The Green Plan replaces the TRFT Sustainable Development Management Plan 2017 – 2022. Green Plans provide a structured way for each trust and ICS to set out the carbon reduction initiatives that are already underway and their plans for the subsequent three years. Every trust and every ICS are expected to have a Green Plan approved by that organisations Board. For trusts, these should be finalised and submitted to the ICCS by 14th January 2022. Each ICS is then required to develop a consolidated system-wide Green Plan by 31st March 2022, to be peer reviewed regionally and subsequently published. The Green Plan, attached as Appendix 1, intends to enable TRFT to: • Achieve at least an 80% reduction in emissions from on-site sources by 2032 • Achieve a further 5% reduction in general waste, based on 2020's levels • Reduce patient service mileage by 25% based on 2020 by 2032, by delivering care closer to home and in the community settings

	• Cease use of all single use plastics • Reduce water consumption by 10% by 2025 The approved Green Plan has been disseminated to the South Yorkshire ICS on 14th January 2022 as required by NHSE/I and will be a document which is available to the public, in due course.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Green Plan has been developed through full consultation with reference to the NHS Guidance report entitled 'How to produce a Green Plan: A three-year strategy towards net zero'. The draft Green Plan has been presented to the Executive Team Meeting and approved at the Private Board on 23rd January 2021.
Board powers to make this decision	It is one of the Board's key responsibilities to have a current Green Plan.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Director of Estates and Facilities - Ian Hinitt, is the Lead Executive for ensuring the development of a Board approved Green Plan, for dissemination to the ICS by 14th January 2022, in supporting the NHSE/I Net Zero objectives.
Recommendations	It is recommended that the Board of Directors receive the Green Plan for information
Appendices	1) TRFT Green Plan

The Rotherham NHS Foundation Trust

Green Plan 2022 - 2025

Executive Summary

The Rotherham NHS Foundation Trust's Green Plan sets out how the Trust will address Sir Simon Stevens Net Zero challenge, for the NHS to reduce the environmental impact arising from carbon emissions with a view to achieving 80% net zero by 2032 and totally emissions free on site by 2040.

Our Green Plan is in response to the climate change emergency. If the matter is not addressed, the consequences of poorer air quality and environmental stress may significantly impact on our wellbeing and result in an increase in diseases such as cardiac issues, respiratory disease and cancer, which may affect us all and our future generations.

In 2021 we made significant progress in reducing our carbon footprint through the successful completion of an £11m investment through a range of energy savings projects, including the replacement of our Combined Heat and Power Plant and primary heating boilers at The Rotherham Hospital and widescale replacement of lighting with LED fittings across our sites.

Our Estates Strategy 2022 – 2027 is wholly aligned to the Green Plan, ensuring that over the next five years we will continue to invest in further carbon reduction targets in the areas of Built Environment and Infrastructure; Estates and Facilities Management; Medicines Management; Supply Chain & Procurement; Food & Nutrition and Climate Change Adaptation.

Our Green Plan intends to exceed the current NHS commitments towards environmental sustainability, by:

- Achieving at least an 80% reduction in emissions from on-site sources by 2032
- Achieving a further 5% reduction in general waste, based on 2020's levels
- Reducing patient service mileage by 25% based on 2020 by 2032, by delivering care closer to home and in the community settings
- Ceasing use of all single use plastics
- Reducing water consumption by 10% by 2025

We pledge to adhere to the NHS CO_2 reduction targets to eliminate our CO_2 footprint through this plan, as approved by our Board of Directors.

By working collaboratively with our peer organisations within the Integrated Care System in South Yorkshire and as an Anchor organisation within our community, we will uphold our corporate and social responsibilities. We will minimise our environmental impact and work to provide sustainable healthcare services, in contribution to the global effort to mitigate climate change impact.

CONTENTS

1.0 INTRODUCTION

1.1 THE ROTHERHAM NHS FOUNDATION TRUST

The Rotherham NHS Foundation Trust (TRFT) is a combined acute and community Trust providing services at Rotherham Hospital and across the borough to a population of 264,700 people.

The 430+ bed Rotherham Hospital first opened in March 1978 with Rotherham community services integrating with the TRFT in 2011.

Today, TRFT provides a full range of district hospital and community services to Rotherham and the surrounding area alongside partner organisations.

The Urgent and Emergency Care Centre (UECC) opened in 2017 and sees approximately 75,000 attendees per year, and there are approximately 55,000 inpatients and 250,000 outpatient attendances each year.

TRFT is an Associate Teaching Hospital of the University of Sheffield and has an active research programme delivered through local, regional, national and international research networks and consortia.

1.2 DEMOGRAPHIC & SOCIOECONOMIC DETAILS

Rotherham and borough's 265,000 inhabitants are spread over an area of 287 km². Certain factors may impact on the populace to a greater degree than found nationally in terms of age; economic background and environment.

Approximately 33% of the populace are over the age of 55[1] (compared with 26% of the national average for England and Wales). In addition, child poverty in some areas of the borough is over twice the national average[2].

Air quality in Rotherham[3] was 21.3 to 50 µg/m³ NO_2; 22.4 µg/m³ PM10 & 12.6 µg/m³ PM2.5 particulates This can be compared to national averages[4] of 23 µg/m³ NO_2; 16.3 µg/m³ PM10; 8.1µg/m³ PM2.5, which indicates that the air quality is worse than the national average. It is noted that two of the heaviest influences in pollution relate to steep hills (with heavy fuel use required to climb) in the vicinity of Rotherham and the M1 motorway, which lie largely beyond much of the borough's control.

Clearly, pollution at low atmospheric level has a significant effect on health and any impact that TRFT can make in reducing this through reduced road travel and fuel combustion is to be welcomed.

[1] https://ugeo.urbistat.com/AdminStat/en/uk/demografia/dati-sintesi/rotherham/58/4
[2] https://www.rotherham.gov.uk/downloads/file/608/rotherham-east-ward-profile#:~:text=Deprivation%20in%20Rotherham%20East%20is,most%20deprived%202%25%20of%20England.
[3] https://www.rotherham.gov.uk/downloads/file/2570/2020-air-quality-annual-status-report
[4] https://www.gov.uk/government/statistics/air-quality-statistics/summary

2.0 ORGANISATIONAL VISION

TRFT aims to build a healthier future for patients, their carers and families, staff, and for anyone else that TRFT cares for. TRFT is committed to implementing a vision that integrates hospital and community services and empowers clinicians and managers to deliver real benefits to patients and their carers. This is actioned by providing healthcare services where they are most convenient and best suit patients' needs.

With respect to carbon reduction, TRFT is committed to playing its full part in achieving the NHS aims to reduce its own emissions to net zero by 2040.

2.1 SUSTAINABILITY IN HEALTHCARE

The NHS has been identified as a generator of 5% of all the UK total emissions. This is despite a successful campaign to reduce overall emissions by an impressive 18% over the past decade. However, along with the rest of the UK, greater effort than ever is being called upon to now reduce the NHS emissions to net zero by 2040[5].

2.1.1 Climate Change Act 2008

The Climate Change Act 2008 sets legally binding targets for the UK to cut greenhouse gas emissions by 80% by 2050 (based on a 1990 baseline). This is split into interim reductions of 34% by 2020 and 50% by 2025. Emissions include those from building energy use, travel, waste and the procurement of goods and services. This is the principal driving legislative act in place.

2.1.2 Net Zero

Since the Climate Change Act, the term “Net Zero” has come into common parlance. This essentially signifies that, on balance, no CO_2 emissions must be attributable to any activity. This is generally to be achieved by a reduction in energy use by improved technology and efficiency gains.

Net zero is reached when the amount we add is no more than the amount taken away.

Net zero means achieving a balance between the greenhouse gasses put into the atmosphere and those taken out.

Another factor is the restoration of the environment in areas such as forestry; peat bogs and oceanic protection, which increases CO_2 absorption capacity of the planet. Unfortunately, industrialisation and environmental degradation has already created enough emissions to the atmosphere that have set in train a global temperature rise.

It has been realised by the world’s governance that a drastic cut in emissions, globally, is required to avoid the worst of catastrophic climate change, by limiting this temperature rise. To this end, in the Paris COP 25, a limit was set of 2°C increase in global temperatures by 2050. However, science has shown that this is an insufficient limit. Therefore, the recent COP 26 talks in Glasgow have endeavoured to reduce this to 1.5°C. This essentially requires CO_2 emissions to cease by 2050.

[5] “Delivering a ‘Net Zero’ National Health Service”; NHS England & NHS Improvement; October 2020

Without action to limit temperature rises, the current severities of extreme weather events seen in the UK and elsewhere over the last ten years, will become more prevalent. Extremes of cold and heat will be more likely, and this will inevitably impact on the health of citizens. Action must be taken to prevent this from all elements of society. The NHS is no exception and may even be considered as a leading influence in societal behavioural change to reduce emissions and limit global temperature increase.

The NHS has issued its own target as part of its contribution to climate action. The "Delivery of a 'Net Zero' National Health Service", sets forward the requirements that the NHS be net zero by 2040. It is divided into two areas. The "NHS Carbon Footprint" concerns emissions over which the NHS has direct ownership (e.g. gas and electricity use; road transport). There is an ambition to have 80% of the reduction achieved over the period 2028 to 2032. The second area is known as "NHS Carbon Footprint Plus". This pertains to emissions over which the NHS has influence (for example: embedded emissions in suppliers' services and products). These must be at zero by 2045, with the ambition of 80% of the reduction to take place over 2036 – 39.

The emitters of carbon dioxide are wide and various, and the two above areas are summarised in Figure 1 below:

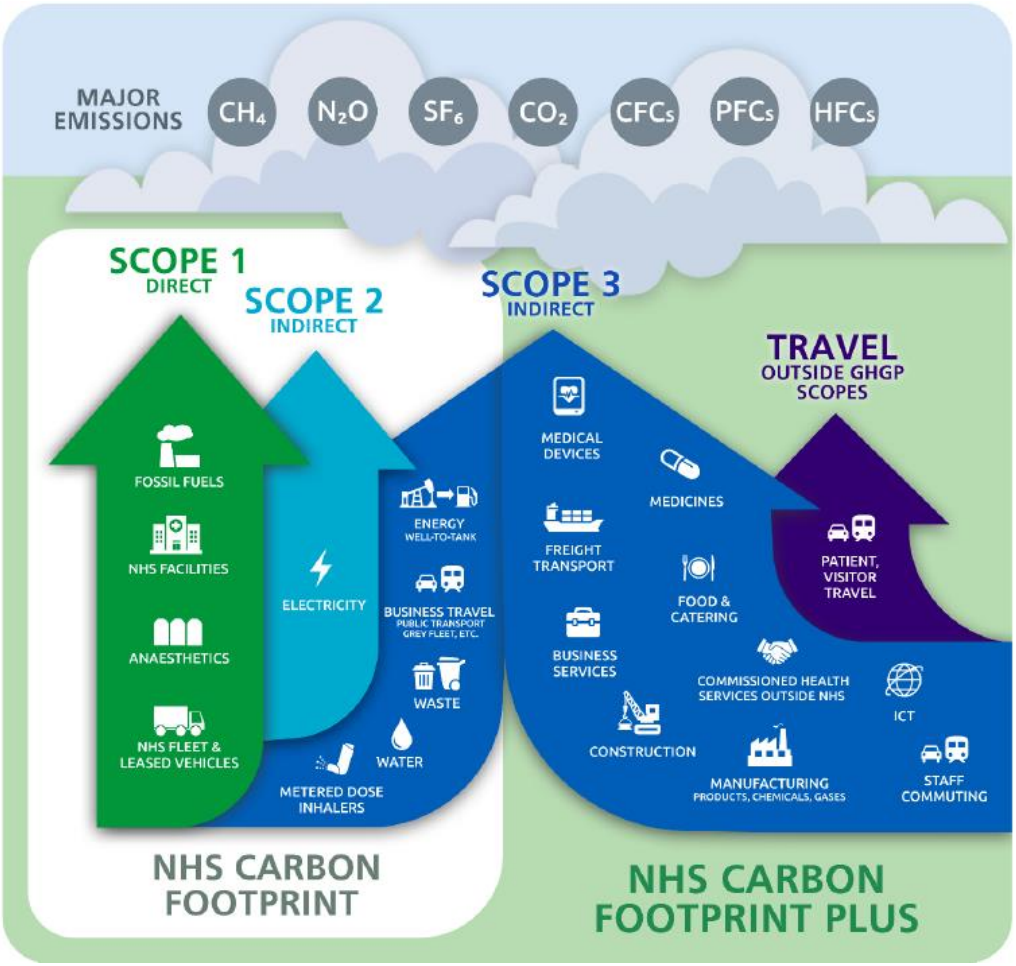


Figure 1 - NHS Carbon Footprint Sources

To explain the various "Scopes":

- Scope 1 – Emissions arising from direct combustion (natural gas; hospital owned vehicle use); fugitive emissions from refrigerants
- Scope 2 – Grid Electricity
- Scope 3 – Indirect emissions such as those arising from water supply and treatment; general and specialist waste treatment, transportation and procurement of goods and medicines

3.0 PREVIOUS SUSTAINABLE DEVELOPMENT MANAGEMENT PLAN

The trust's Sustainable Development Management Plan (SDMP) detailed TRFT's 2017-2022 five-year plan to address climate and sustainable matters over which it had control.

It's strategy to combat sustainability issues was to adhere to the following high-level action plan:

Area	**Priority**	**High Level Actions**
Energy & Water	1	Implement the annual "Energy and Carbon Spend to Save" programme, dependent on availability of finance
	2	Promote energy and water efficient behavior amongst employees, patients and visitors
	Progress	*Battery energy storage; LED lighting; Boiler improvements; new CHP (tri-generation); general insulation; BMS improvements; Chilled water control improvements. 100% electricity purchased from the grid is renewably sourced and will continue to be so.*
Procurement	3	Produce a Sustainable Procurement Policy
	4	Adopt the Procuring for Carbon Reduction (P4CR) programme
	Progress	*Sustainable Procurement is referenced in TRFT Procurement policy*
Travel	5	Work with external organisations to raise awareness of the health benefits from utilising active travel modes
	6	*Promote sustainable travel behavior amongst staff, patients and visitors*
	Progress	*Implementation of Cycle to Work and ULEV purchase schemes via salary sacrifice methods; Dr Bike monthly visits and loan bikes provision; reduced rate bus season tickets; Car share scheme; Launch of sustainable travel group*
Waste	7	Ensure high and compliant standards for waste management from the point of generation to the point of disposal
	8	Promote effective waste segregation and waste management behaviors amongst employees, patients and visitors
	Progress	*94.7% of all waste is recycled or recovered*
Food	9	Achieve the Soil Association "Food for Life" Silver and Gold Catering Mark

	10	Encourage healthy eating amongst employees, patients & visitors
	Progress	*TRFT staff wellbeing programme promotes healthy eating and runs healthy eating cookery courses for staff*
Pharmaceuticals	11	Improve processes for the issuing and transfer of medicines
	12	Maximise the use of Patient Own Drugs (PODs) Building healthy, sustainable and resilient services and communities
	Progress	*Investigation into reduction of desflurane anaesthetics in favour of sevoflurane.*
Designing the Built Environment	13	Ensure that buildings are designed to encourage sustainability and resilience to climate change
	14	Ensure that sustainability design and construction considerations are explicit in Contractor Briefing Documents Workforce development and community engagement
	Progress	*Environmentally sustainable design objectives briefed at design stage to design team consultants. Construction developments meet current Building Regulations standards for environmental sustainability.*
Workforce development and community engagement	15	Ensure sustainability responsibilities are included within all job descriptions, and embed sustainability delivery into Executive and Senior Managers appraisals
	16	Review existing training provision to introduce a more structured and coherent training programme around how staff can contribute towards the reduction of carbon emissions across all key areas
	17	Work in partnership with public health professionals to support employees in improving health and wellbeing Climate change adaptation
	Progress	*The Sustainable Development Management Group are supported by several key influencers and stakeholder environmental champions, in embedding environmental sustainability within TRFT culture. An outdoor wellbeing garden, staff gym and woodland walk have been delivered in 2021 in supporting staff wellbeing. Chilled water infrastructure pipework has been installed to serve all future ward upgrades, in providing comfort cooling capabilities for staff and patient areas.*
Climate change adaption	18	Produce a Climate Change Adaptation Plan
	19	Work in partnership with local organisations to build resilience and adaption to climate change Embedding sustainable clinical and care models Sustainable clinical and care models

	Progress	*Climate Change Adaptation Plan scheduled for Q2- 2022. TRFT will be collaborating with the ICB in embedding an ICS wide plan in Q1 – 2022.*
Sustainable clinical and care models	20	Investigate mechanisms to facilitate a movement towards more sustainable models of care
	21	Assess the sustainability impacts of new service models
	Progress	*The Trust Strategy "Our new journey, together" incorporates movement towards a more sustainable model of care in minimizing impact on environmental sustainability.*

Table 1 - 2016-21 Sustainable Development Management Plan - High Level Actions

Ongoing progress of actions, detailed in

	Progress	*The Trust Strategy "Our new journey, together" incorporates movement towards a more sustainable model of care in minimizing impact on environmental sustainability.*

Table 1, to be monitored through the Sustainable Development Management Group.

The impact of actions in

	Progress	*The Trust Strategy "Our new journey, together" incorporates movement towards a more sustainable model of care in minimizing impact on environmental sustainability.*

Table 1 is described in Figure 2 to Figure 4 below:

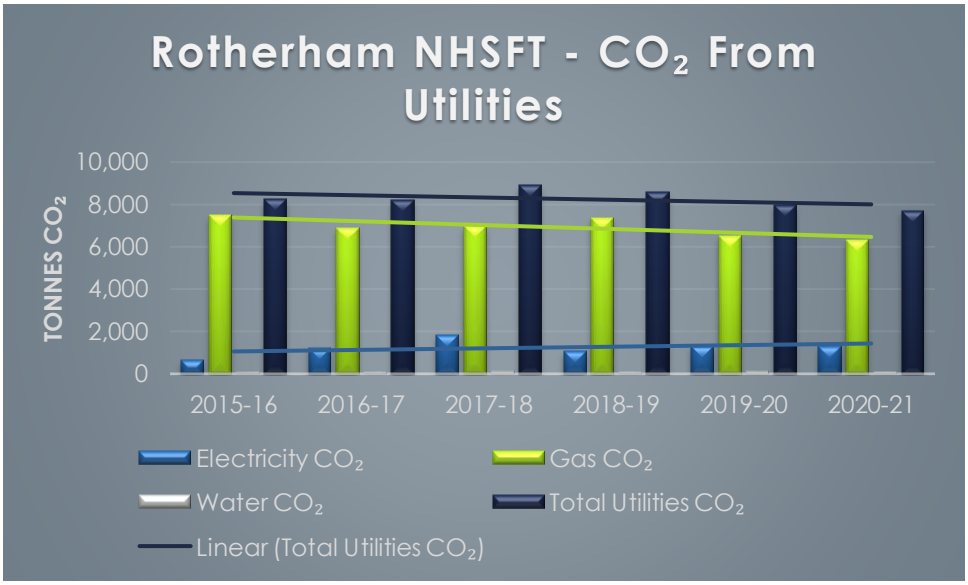


Figure 2 - Rotherham Foundation Trust - Emissions from Utilities

Emissions from electricity rose slightly over the last five years, whilst gas use fell. It was reported that a Combined Heat and Power (CHP) unit, installed in 2009, did not provide savings in emissions predicted owing to poor reliability delivery. In normal circumstances it would have been anticipated that gas emissions would rise as electricity use fell. However, gas use fell as less than predicted was used by the CHP, as a result reliability issues experienced.

Latterly, much less emissions savings from CHP are seen owing to the rapid decarbonisation of the National Grid. This latter factor also contributes to the overall slight reduction in emissions from all sources.

In 2021, the CHP and primary heating boilers were replaced under an Energy Services Contract with the Carbon and Energy Fund, which guarantees carbon reductions over the 20-year life of the contract.

Clearly, emissions from water supply are negligible in comparison to gas and electricity. Nonetheless, good water management is considered by TRFT as an important element of carbon management and emissions reduction and is aligned to the Trust's corporate and social responsibilities.

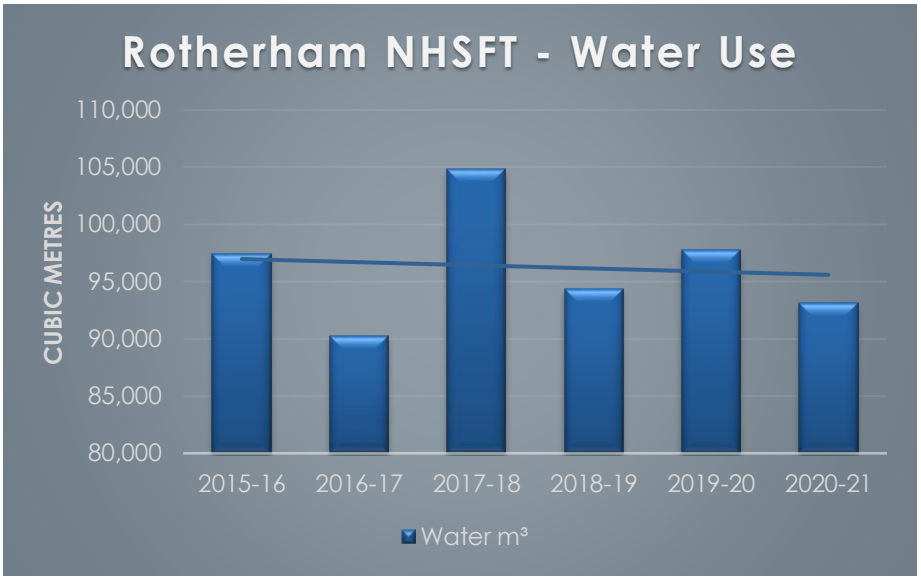


Figure 3 - Rotherham Foundation Trust Water & Treatment

Water use showed a slight decrease over the last five years. This is good news especially in the light of even higher levels of cleanliness required by infection prevention and control measures, including those to combat coronavirus and the associated increase in water use.

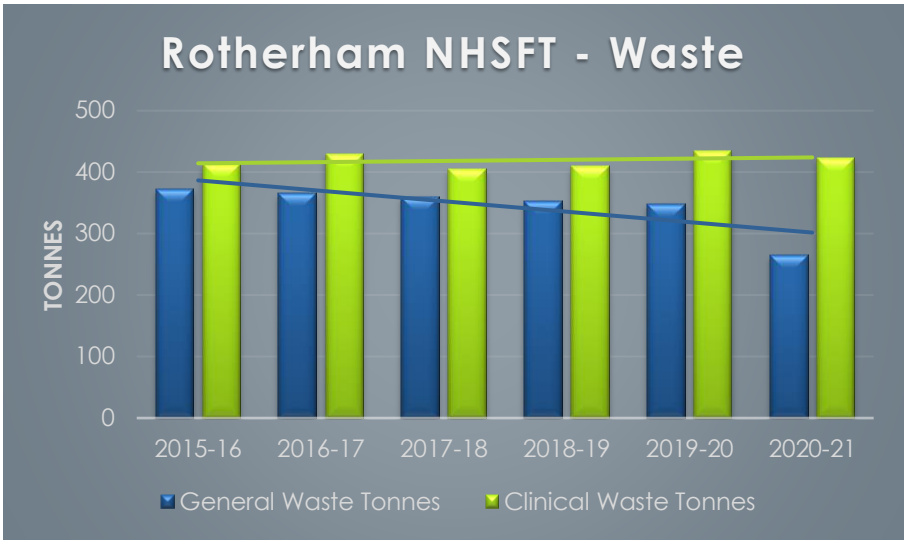


Figure 4 - Rotherham Foundation Trust – Waste

With respect to waste, clinical waste has shown a slight increase. This requires further work to reduce. However, general waste control is a success story showing a significant decline in general waste generation.

4.0 THE GREEN PLAN

The TRFT Green Plan will inform our vision for environmental sustainability and objectives to become a Net Zero healthcare provider, through the following staged objectives:

- Stage 1 – Carbon Footprint – review and validate the carbon footprint of TRFT's emissions (covering Scope 1 and 2 and selected Scope 3 emissions)
- Stage 2 – Action Identification – identification and assessment of opportunities for reducing emissions from energy and staff travel
- Stage 3 – Decarbonisation Action Plan – develop a Decarbonisation Action Plan. This will bring together the analysis from Stage 1 and Stage 2 to provide a roadmap of decarbonisation activities, including detail on specific energy and carbon saving interventions and impact.

4.1 WORKFORCE AND SYSTEM LEADERSHIP

TRFT's workforce are central to enabling us to deliver the Green Plan. The decisions that our workforce makes in energy use are key to this. Therefore, we will ensure that our staff teams are provided with the knowledge and tools to make the right environmental decisions. This will focus on the best use of powered equipment such as lighting; IT; heating and cooling controls. We will also maximise the best use of energy in our support services such as food provision in canteens and patient meals.

In order to do this, a board endorsed policy will drive this with target setting and appropriate monitoring. Our leadership will actively promote the Green Plan by direction and example.

4.2 ESTATES & FACILITIES

4.2.1 Energy & Water

The Estates and Facilities team has ultimate responsibility for the procurement and use of energy and utilities across all sites occupied by TRFT, including the main hospital and all community-based sites and services. As such, we will ensure that energy and utilities are consumed in as efficient a manner as possible. A programme of savings proposals has been completed as part of an Energy Performance Contract. These are summarised in the progress details in Table 1.

	Progress	*The Trust Strategy "Our new journey, together" incorporates movement towards a more sustainable model of care in minimizing impact on environmental sustainability.*

Table 1.

We will continue to explore other opportunities for saving energy and reducing waste and carbon emissions and we will endeavour to ensure that maintenance operations are equally focused on continued reliable functionality.

We will ensure that the carbon embodied in the procurement of goods, services, equipment and facilities, adopts best practice in the most efficient use of energy and carbon and in minimising carbon emissions and waste. Examples would be to ensure that insulation is replaced after work is completed and a low carbon alternative is considered and installed where feasible (for example; LED lighting; high efficiency motors).

We will also continue to examine other areas where energy use can be minimised utilising capital or revenue funded projects, which derive a financial return on investment focusing, reduce backlog maintenance and yield carbon emission reductions on, for example:

- Heat recovery (from AHUs; chiller condensers; economisers)
- Decarbonised heat (heat pump technology; hydrogen ready combustion appliances - subject to bid under PSDF3 for funding)
- Photovoltaics
- Draft proofing
- Double glazing

- Local mechanical ventilation heat recovery
- Underfloor heating
- Grey water recycling

We will use grey water recycling and general water efficiency improvements to save 10% of our water use, based on 2020 consumption.

4.2.2 Transport

We have an active programme to address transportation issues including a reduced rate public transport season ticket and bike to work scheme. We will build on this work with recently commissioned secure bicycle storage enabling our cycling commuters to confidently store their bikes. In 2022, we will be building additional staff shower/changing facilities for cyclists as added inducement to leave the car at home, in favour of environmentally sustainable modes of transport, such as cycling, running and walking.

A new park and ride scheme is planned in conjunction with local supermarkets so that motorist commuters can park part way along their journey and then continue on foot or by bike to the hospital.

We will also be shifting to electric vehicles, with a plan for a network of charging points over the coming years, increasing our electric vehicle charging capacity to at least 10% of all car parking spaces.

4.2.3 Waste and Recycling

At present, 94.7% of all waste generated by the hospital is recycled or recovered. 30% of this amount is fully recycled, which is a 4.4% improvement on the previous year (2019/20). 37.3% of waste is sent for energy recovery (conversion of non-recyclables into combustible material in place of fossil fuels); 26.4% goes to energy from waste power plants as a direct fuel.

The impact of coronavirus has impacted on several areas including the disposal of clinical and offensive wastes. In some ways, this has reduced recycling rates whilst in others, the amount of waste has reduced owing to working from home practices and reduced patient numbers.

We will build on this progress and continue to work towards yet further improvements. To this end, we will plan for a further 5% reduction in overall waste generation.

4.3 MEDICINES

TRFT will work to reduce the carbon footprint associated with medicines and anaesthetics.

4.3.1 Anaesthetics

The most common anaesthetic is desflurane, which has 20 x more Global Warming Potential than CO_2. We will work to reduce the use of this in favour of the lower GWP gas, sevoflurane.

4.3.2 Medicines Use; Procurement and Wastage

A study for the Department of Health revealed prescription drug wastage costs NHS England at least £300 million a year - and that £150 million is avoidable. In 2015/16, 9.5% of TRFT's carbon emissions were attributable to the procurement of pharmaceuticals.

TRFT is committed to tackling avoidable medicines wastage and taking necessary best practice pathways towards minimising medicine waste.

We will utilise the Procuring for Carbon Reduction (P4CR) Flexible Framework to facilitate the procurement of pharmaceuticals in a more innovative, sustainable manner.

In summary, TRFT will:

- Carry out regular audits of medicines returned to the pharmacy from the wards, Urgent and Emergency Care Centre and other clinical areas to identify any opportunities for re-use. The audit will differentiate the type of medicines that are being returned (Patient Own Drugs, discharge medicines not given to a patient, medicines dispensed during an inpatient stay that are no longer required and medicines that were not transferred with a patient when they moved to another clinical area).
- Improve processes for the issuing and transfer of medicines, when patients are moved from one clinical area to another within the hospital.
- Where appropriate, maximise the use of Patient Own Drugs (PODs) that are brought into the hospital.
- Reduce pharmaceutical waste through improved prescribing, re-use of medicines, compliance and stock management.
- Explore what can be done to encourage patients to bring their own medicines into hospital for use during their stay, including an awareness campaign with the Yorkshire Ambulance Service.
- Regularly review the approach to discharge prescriptions to examine efficiencies, convenience for patients and contribution to better outcomes through integrated care.
- Investigate options to introduce a temperature controlled cold room in pharmacy.

This will be measured by:

- Annual progress of the pharmaceuticals section of the SDAP will be reviewed against achieving the SDMP's vision and priorities.
- Reduction in medicine wastage.

4.4 SUPPLY CHAIN AND PROCUREMENT

It is likely that Procurement/Supply Chain emissions represent more than 60% of the Trust's overall emissions and this can be addressed by Sustainable Procurement of goods and services initiatives.

Sustainable Procurement is defined as a process whereby organisations meet their needs for goods, services, works and utilities in a way that achieves value for money on a whole life basis in terms of generating benefits not only to the organisation, but also to society and the economy, whilst minimising negative impact on the environment.

We will carry out a carbon foot-printing exercise to provide an emissions assessment for TRFT to have a greater insight of the opportunities for us to reach net zero. Our Procurement team will identify and engage key suppliers, aiming to improve reporting, encourage information sharing and support alignment to NHS and TRFT carbon and emissions reduction targets.

Suppliers will be required to meet key criteria such as estimated emissions contributions, TRFT's ability to influence supplier's sustainability credentials, their existing approach to decarbonisation; e.g. low emission company vehicles, product packaging, etc., and their willingness to engage with TRFT.

We will utilise the Procuring for Carbon Reduction (P4CR) Flexible Framework to facilitate the procurement of goods and services in a more innovative, sustainable manner:

- Purchase more goods from sustainable sources, with a focus on those from local, ethical and fair-trade suppliers.
- Work with suppliers to encourage them to hold an Environmental Management Standard (e.g. ISO 14001) and to disclose their carbon emissions.
- P4CR Practice (Level 3) by 2025.

4.5 FOOD & NUTRITION

The NHS is one of the largest purchasers and providers of food in the UK. Working in partnership with our supply chain and service partnerships, TRFT will continue to promote and expand the procurement and delivery of sustainable foods and nutrition.

The annual Green Plan will detail the actions to ensure that TRFT procures sustainable, health and low carbon food and promotes healthy food choices. Working in partnership with our supply chain and service partnerships, TRFT will:

- Encourage healthy eating amongst staff, patients and visitors through the promotion of the Food for Life programme through the TRFT Wellbeing programme.
- Continue to work in partnership with ReFood and reduce food waste across the food supply chain through improvements to food storage, preparation, ordering and meal service procedures.
- Work in partnership with food suppliers to increase the availability of locally sourced, seasonal, sustainably grown food.
- Work in partnership with food suppliers to reduce the number of transport deliveries to the Rotherham Hospital site.

- Support and enhance education in food, nutrition and sustainable food production through our Staff Wellbeing scheme and in partnership working to facilitate local growing projects (e.g. chef herb garden, patient allotment, supporting local allotments and grower's associations), when opportunities arise post pandemic.
- Continue to work closely with clinicians and dieticians in order to adopt well-balanced and appropriately portioned menus for both patients and staff.
- Continue to deliver a staff behavioural change programme to catering staff to encourage resource efficient behaviours.
- Influence consumer behaviour to reduce food waste in the home through the promotion of the Love Food Hate Waste campaign.
- Food waste data will continue to be regularly monitored and reported.
- Annual progress of the food & nutrition section of the Green Plan will be reviewed against achieving the TRFT's vision and priorities.
- Ongoing reduction in food transport mileage.

4.6 CLIMATE CHANGE ADAPTION

Extreme weather can represent a threat to the effective delivery of health and care services. In addition, a rapid increase in service users during extreme weather events can increase pressure on staff dealing with elevated workloads and potential staff shortages.

TRFT recognises that it must become resilient to the effects of climate change and adopt adaptation measures to prepare for, and reduce, the impacts of a changing climate on healthcare services. Climate change adaptation is the understanding and implementation of resilience measures to enable TRFT to prepare for the effects of climate change.

Our Emergency Preparedness, Resilience and Response Group will work to improve the resilience of services and the built environment, ensuring they are fit to meet Net Zero objectives by ensuring:

- Services and infrastructures are prepared and resilient to severe weather events and other disruptions.
- We work together with other public services and local organisations within a framework for sustainable development.
- Current and future risks to health and wellbeing from a changing climate are understood and minimised.

TRFT needs to understand the health and wellbeing implications of current and projected changes in climate and adapt services accordingly. An important component of this is ensuring TRFT's infrastructure (including buildings, vehicles and the supply chain for fuel, food and key products) is prepared for, and resilient to, severe weather events and other disruptions.

Additionally, as many health and care services are increasingly being delivered in people's own homes, there is a growing need to ensure that domestic settings, as well as healthcare settings, are adapted, resilient and accessible.

TRFT's Major Incident Plan and Local Service Business Continuity Plans describe the operational command, control and communication structures required to manage the effects of a significant or major incident. This includes flooding and severe weather conditions (e.g. excessive rain, snow, wind, ice, extreme cold or heat). As a Category One responder under the Civil Contingencies Act 2004, TRFT is a member of the South Yorkshire Local Health Resilience Partnership, with direct links to the South Yorkshire Local Resilience Forum.

The annual Sustainable Development Action Plan will detail the actions to ensure the resilience of TRFT's services and buildings. In summary, TRFT will:

- Employ the UK Climate Change Risk Assessment tools and guidance to assess local risks to patients and staff, infrastructure, supply chain and clinical services, and inform Emergency Planning & Business Continuity procedures.
- Conduct regular climate change impact risk assessments to ensure that high level risks are registered on TRFT's Risk Register.
- Produce a Climate Change Adaptation Plan to ensure continuation of care for the most vulnerable patients during heat waves, floods and other extreme weather events.
- Design all new buildings, and ensure all existing infrastructure, has ability to cope with rising temperatures and floods.
- Assess the risk that disruptive climate changes pose to the supply chain and develop appropriate management strategies to ensure continuity of services.
- Identify risks of disruption to transport operations and put in place contingency plans to cope with extreme or unexpected events.

We will monitor progress by:

- Reporting annual progress of the climate change adaptation section of the Green Plan, reviewed against achieving the Trust's vision and priorities.
- Development of a Climate Change Adaptation Plan.

4.7 SUSTAINABLE MODELS OF CARE

Provision of care brings with it its own environmental issues. To address this, we will examine routes to reduce environmental impact by our delivery of care. We will examine the opportunities for delivering care closer to the patient's home and in the community setting and thus avoid longer journeys to and from the main hospital and treatment centres. We will explore the low carbon alternatives to existing interventions and avoid unnecessary changes to care delivery.

4.8 DIGITAL TRANSFORMATION

TRFT is making significant investment in digital infrastructure and in 2020 were named as one of 23 NHS trusts as the first sites to participate in the NHS Digital Aspirant programme, which helps NHS trusts raise their digital maturity to deliver a set of core capabilities, reducing the gap between the levels of digitisation across the NHS, thereby improving organisational efficiency. Using this investment, TRFT has replaced all data network and Wi-Fi infrastructure with modern lower energy alternatives, is on track to replace it storage area network systems to very low energy consuming solid-state technology and all new PC equipment is small form factor devices. In addition, TRFT has commenced its journey to the cloud with an aspiration to have the majority if its computer workloads hosted in energy efficient data centres by 2025.

The digital revolution also has had wide-ranging impacts in domestic terms, whereby personal computers, tablets and smart phones now influence where and how our patients make and participate in online appointments. The coronavirus pandemic has accelerated primary patient consultation by means of telemedicine through the necessity to reduce contact time. Further, remote working for our staff creates new opportunities to rationalise and consolidate office accommodation and contributes to reduction in carbon emissions.

5.0 GREEN PLAN FOUNDATION

The steps below will form the core of our Green Plan going forward:

- The designated executive Board member champions our net zero targets and Green Plan.
- The designated Board lead oversees our Green Plan development.
- Reduce our carbon footprint from fixed assets by continued investment in low and zero carbon solutions in building services.
- All new build and refurbishments to be completed to surpass those dictated by Part L of the building regulations.
- All new builds to achieve an EPC of A.
- All new builds to achieve a DEC of at least B on first 12-month anniversary of handover.
- Reduce our use of desflurane in surgery to less than 10% of its total volatile anaesthetic gas use, by volume.
- Develop plans for clinically appropriate prescribing of lower carbon inhalers.
- Ensure that, for new purchases and lease arrangements, we solely purchase and lease cars that are ultra-low emissions vehicles (ULEV's) or zero emissions vehicles (ZEV's).
- Develop our green travel plan to support active travel and public transport for staff, patients and visitors.
- Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.

6.0 TRACKING & REPORTING PROGRESS

The Good Corporate Citizenship (GCC) Tool has been developed by the NHS Sustainable Development Unit as a methodology for NHS organisations to measure and monitor their progress on sustainable development. The tool provides organisations with the means to monitor progress on the less easily quantifiable aspects of sustainable development in financial, social and environmental terms. The GCC Tool allows NHS organisations to assess their sustainable development performance across key areas and compare the result with national and regional averages.

TRFT will use the GCC Tool as a key metric to monitor the impacts from the implementation of the Green Plan. TRFT will undertake a baseline assessment for the GCC Tool in 2022, and an internal procedure will be developed to ensure the GCC Tool is completed as fully and accurately as possible and reviewed on an annual basis.

The Department of Health requires all NHS Trusts to report ERIC (Estates Return Information Collection) data. ERIC data comprises essential statistics on waste, energy and water (amongst other data sets) from Estates and Facilities. TRFT will benchmark performance with other acute Trusts, using ERIC Median Performance and relevant datasets from the Health Estates and Facilities Management Association (HEFMA), with a view to informing our performance within our peer group and in identifying further opportunities and best practice in energy and emissions reduction.

Progress on the implementation of the Green Plan will be reported annually through the Energy & Utilities Annual Report, the TRFT Emissions Baseline & Tracker, the Waste and Environmental Annual Report and TRFT's Annual Report.

7.0 SUPPORTING RESOURCES

7.1 TECHNICAL RESOURCES

TRFT will utilise one or more of the following technical resources in delivering the Green Plan:

- Delivering a net zero National Health Service report
- Greener NHS Dashboard
- Greener NHS Quarterly Data Collection documents
- Health Outcomes of Travel Tool (HOTT)
- Health Outcomes of Stationary Sources Tool (HOST)

7.2 FINANCIAL RESOURCE

7.2.1 Salix (Public Sector Decarbonisation Fund)

The Government backed Salix funding scheme for Public Sector Decarbonisation Fund (PSDF) will be explored to provide finance for projects to reduce carbon usage and emissions. We will put in place costed scheme submissions to enable appropriate applications for grant funding, to ensure the best opportunities materialise for TRFT. A bid was approved in January 2022 for £2.8M under the 3rd edition of this scheme and will include installation a 50kW Heat Pump to Old Greenoaks to replace the inefficient gas boilers, double glazing upgrades to the hospital, Insulation upgrades to numerous communities buildings and upgrade to heating controls.

7.2.2 Net Zero Hydrogen Fund

This scheme is set to launch in 2022, pending the results of a now closed, consultation.

7.2.3 Internal Capital

Funding for energy and sustainability initiatives can also be considered by business case approval via internal Trust funding.

8.0 EQUALITY & DIVERSITY

In applying this plan, the Rotherham NHS Foundation Trust will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following nine protected characteristics by the Equality Act (2010); age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, and sexual orientation.

Alongside this, the Trust will seek to reduce health inequalities, and avoid exacerbating economic inequalities.

The application of this plan will include careful consideration of the access needs of disabled staff, patients and visitors.

9.0 MONITORING & REVIEW

This plan will be reviewed every three years as well as in accordance with any changes to relevant legislation, good practice guidelines or after a significant change in organisational structure. Where review is necessary due to legislative change, this will happen as soon as practicable after the change. Once ratified, the Green Plan will be disseminated to colleagues by way of the Hub.

Subject:	**Finance and Performance Committee 23 February 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P47/22(i)	**BoD: 04/02/2022**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group:	**Date:**	**Chair:**

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Risk and Assurance: Board Assurance Framework (BAF) and Risk Register	The Committee received the latest position in quarter 4, acknowledging the ongoing work around the BAF. The Committee discussed the 3 BAF risks aligned to the Committee, noting that a review of the risks aligned to each BAF risk had been undertaken resulting in a number having a reduction in score or being closed. The Committee discussed the static position in relation to BAF8 and BAF9 concluding that they remained managed risks. The Committee requested that the implementation risk around capital expenditure and the need to have sufficient human resources capacity should be discussed at the next Risk Management Committee. The Committee noted the additional narrative to BAF8 confirming the budget setting process has commenced. Once the draft financial plans have been submitted, this will move into a control. The Committee discussed the two risks on the Trust Risk Register rated 15 and above assigned to the Committee. The Committee further noted the high level action plans setting out the mitigations for each risk.	Board of Directors	Assured in relation to the assessment of the BAF risks and the process to link the new BAF with the 2022/23 planning process.

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee welcomed sight of the latest action plan produced as a result of the internal review of the risk register and risk management process noting that progress against this will be monitored at the Quality Committee.		
2	Operational Plan Priorities Update	The Committee received and discussed the progress against the 2021/22 Operational Priorities noting that one programme (Identify new practices to embed) had closed since the last review. The Committee noted that the programme relating to the long term recovery of elective care is anticipated to move from amber to red by the year end. The Committee requested that the proposed plan for completion of the service sustainability reviews be reassessed given their importance for meeting planning commitments in the new financial year. The Committee discussed the programme that is currently behind plan, Admission Avoidance, and completion of the associated Same Day Emergency Care Business Case. The Committee requested visibility of the timetable for submission of the proposed business case(s) for a staged approach to patient improvement to the Executive Team. The Committee concluded that despite the positive work completed, the Committee was not assured on the overall delivery of the operational plan and sought clarity on the plan for those priorities being carried forward to 2022/23.	Board of Directors	Limited Assurance.
3	Operational Performance	The Committee received and discussed the Integrated Performance Report and associated operational update noting the following key issues:	Board of Directors	Limited Assurance.

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• Increasing waiting lists continue to be a concern with no elective work carried out during December and January. • Increasing waiting times in UECC with a step up in the number of patients waiting more than 12 hours with the acknowledgment that the Trust sees and treats within UECC whereas some organisations have a clinical decision unit. • Improvement has been seen in cancer waits overall but some issues around capacity remain. • The appointment of additional consultants in UECC is expected to assist considerably with recovery. The Committee noted that benchmarking around compliance against national standards will be included in reporting from April onwards. The Committee acknowledged and recognised the progress made, however there was limited assurance on delivery against key targets.		
4	Integrated Financial Performance Report and Balance Sheet Review	The Committee received and discussed the financial position as at Month 10 noting the following: • A deficit to plan of £264K in month and £1,290K surplus to plan year to date. • Cost improvement programme forecast remains on track, albeit driven by non-recurrent savings. • The Trust does not foresee any difficulty in signing off as a "Going Concern" at the end of the year with a report presented to the Board in March 2022. • Stock counts have been taking place throughout January and February and whilst some remained outstanding there	Board of Directors	Assured – performance to date and year-end forecast.

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		was confidence on meeting the year end requirements for audit purposes. • Accounting treatment for the Carbon Energy Fund is being reviewed with the external auditors and NHSE/I in advance of the year end given the material nature of the transaction. • The quarterly balanced sheet review highlighted no issues.		
5	Finance Governance Action Plan – Learning Review	The Committee welcomed the post implementation learning review undertaken by Steve Hackett, Director of Finance and Nicola Bancroft, Chair of FPC, alongside senior Finance colleagues. The Committee was assured that the action plan had been embedded and was supportive of the continuous improvement opportunities for 2022. The Committee requested a review every 6 months to ensure the improvement is being sustained.	Board of Directors	Assured.

Subject:	**Quality Committee held on Wednesday 26 January 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P47/22(ii)	**BoD: 04/03/2022**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group:	**Date:**	**Chair:**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Risk Register	The Committee reviewed the risk register aligned to the Quality Committee and acknowledged the ongoing work in relation to the risk register. The Committee welcomed the detail set out in the high level improvement plan in order to improve the quality and visibility of the Trust risk register. The Committee concluded that limited assurance remained on the risk register until further progress has been delivered on the improvement plan especially in relation to oversight of delivery against action plans for individual risks.	Board of Directors	Limited Assurance
2	Board Assurance Framework (BAF) Quarter 4 (ongoing).	The Committee discussed in detail the BAF Risks and agreed the proposed risk scores for the beginning of Quarter 4. The Committee welcomed the strengthening alignment between the risk register and the Board Assurance Framework noting is remains work in progress. The Committee agreed that overall the BAF has been strengthened insofar as how the risks are reviewed and updated acknowledging the ongoing work to align with the risk register.	Board of Directors	Assured on the process of reviewing the BAF.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
3	Clinical Governance Committee Chair's Log	The Committee received and discussed the Clinical Governance Chair's Log and highlighted a number of concerns whereby limited assurance had been noted by the Clinical Governance Committee such as sepsis management, care of people with dementia and the concerns from the Major Trauma Group. The Committee expressed specific concern in relation to Sepsis, requesting a deep dive into management of sepsis in the Trust.	Board of Directors	Not Assured in relation to management of sepsis.
4	CQC Delivery Group Chair's Log	The Committee noted the update on the progress made on the current CQC delivery action plan highlighting those action that were 'off track' and noting the commitment sought to ensure the actions were back on track. The Committee noted the role of the CQC Delivery Group in signing off evidence that actions have been completed and embedded.	Board of Directors	Assured of the processes in place for the CQC readiness.
5	Health and Safety Committee Chair's Log	The Committee noted that the Health and Safety Committee had not met. A verbal update was provided in relation to responding to the Health and Safety Executive and that the draft response and action plan had been sent to the Executive Team Meeting for comment.	Board of Directors	Noted the draft response currently with the Executive Team.
6	Safe and Sound Quality Scorecard	The Committee received and discussed the work in relation to medicine management and the use of the barcode system. In addition, the Committee discussed the nurse staffing levels and the potential impact this had on the overall quality of care. The Committee acknowledged the improvements seen in relation to mandatory training compliance and patient experience but concluded that overall there was limited assurance due to the ongoing issues around nurse staffing.	Board of Directors	Limited Assurance
7	Safeguarding Annual Report	The Committee received and discussed the Safeguarding Annual Report noting that the actions previously requested had been	Board of Directors	Recommend that the Trust Board approve the

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		completed and as a result recommend the Annual Report to the Trust Board for approval.		Safeguarding Annual Report.
8	Mortality and Learning from Deaths	The Committee received the monthly report and confirmed there was assurance in relation to the processes in place around mortality, limited assurance remained in terms of learning from deaths at Divisional level as Structured Judgement Reviews were not consistently completed.	Board of Directors	Limited Assurance
9	Serious Incident Report	The Committee discussed the report noting there had been an increase in the number of Serious Incidents declared. The Committee received assurance that all actions relating to serious incident investigations are now included in the OLAF action tracker. The Committee requested clarity on the impact of training that has been carried out as an action following an incident.	Board of Directors	Assured that all actions are included on the OLAF tracker.
10	Tendable (Previously perfect ward) Quarterly Report	The Committee received and discussed the report highlighting the importance of the Enhancing Patient Care through Improvements in Quality (EPIQ) programmes. The Committee noted that progress had been made on the current work streams relating to falls, pressure ulcer prevention, medication, deteriorating patients and admissions and discharges. The Committee acknowledged the progress made but concluded there was limited assurance due to the ongoing work required relating to the above work streams.	Board of Directors	Limited Assurance

Subject:	**Quality Committee held on 23 February 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P47/22(ii)	**BoD: 04/02/2022**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group:	**Date:**	**Chair:**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Risk and Assurance	The Committee reviewed the risk register aligned to the Quality Committee in addition to the ongoing Quarter 4 position for the Board Assurance Framework (BAF). The Committee welcomed sight of the action plans associated with the risks aligned to the Committee noting that the development of the report remains work in progress. The Committee acknowledged that progress against the action plan would be monitored via the Risk Management Committee and Quality Committee. The Committee discussed and agreed the BAF risk scores remained the same and noted that work had commenced on drafting the new BAF in preparation for April 2022. Lead: Director of Corporate Affairs	Board of Directors	Assured on the process for reviewing the BAF risks and the ongoing progress against the improvement plan for the risk register.
2	Infection, Prevention and Control Monthly Report	The Committee received and discussed the report noting the increase in Carbapenamase producing enterobacteriaceae (CPE) noting a review of the cases remain ongoing with support from the regional filed epidemiology team.	Board of Directors	Assured on the processes around infection prevention and control.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		Lead: Interim Chief Nurse		
3	Clinical Governance Committee Chair's Log	The Committee noted that whilst the core Mandatory Training compliance for Medical and Dental staff had increased to 87%, there was limited assurance around Safeguarding Mandatory Training and the committee requested a deep dive report back to the April Committee. The Committee noted the increase in the number of Serious Incidents declared and welcomed the ongoing deep dive to review in more detail the reasons for the increase. The Committee welcomed the establishment of a task and finish group to review the management of sepsis and requested a report of the outputs from that group to the April Committee. Leads: Medical Director and Interim Chief Nurse	Board of Directors	Limited Assurance
4	Operational Plan 2021/22: Update	The Committee received and discussed the report noting the amber status of the two programmes aligned to the Quality Committee. Standards of Care and Quality Improvement: The Committee acknowledged that the Enhanced Patient Care through Improvements in Quality (EPIQ) projects continue to deliver sustainable improvements, the draft Quality Strategy is planned for the end of the year. Learning from Deaths: The Committee noted that whilst the milestones had been met, work remains ongoing to strengthen the governance around the mortality sub-groups further noting that 360 Assurance are currently re-doing the Learning from Deaths Audit. Leads: Medical Director and Interim Chief Nurse	Board of Directors	Limited Assurance.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
5	Strategic Safeguarding Group Chair's Log	The Committee received the Strategic Safeguarding Group Chair's log and sought assurance in relation to the audits carried out relating to completion of body mapping. Assurance was requested to be circulated to Committee members before the next Quality Committee meeting in March 2022. Lead: Interim Chief Nurse	Board of Directors	Limited Assurance relating to the completion of Body Mapping Audits.
6	Look After Children	The Committee received the quarterly report and commended the work carried out by the Looked After Children team to ensure the children receive all statutory and universal health care in a timely manner. Lead: Interim Chief Nurse	Board of Directors	Assured.
7	Children and Adolescent Mental Health Report	The Committee received and discussed the increasing number of young people presenting in acute crisis. The Trust has seen a significant increase in the number of children admitted with eating disorders/disordered eating as a result of the national challenges in relation to availability of Tier 4 beds. The Committee commended the work carried out by the Division in relation to these challenges. Lead: Interim Chief Nurse	Board of Directors	Assured.

Subject:	**People Committee: 18 February 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P47/22(iii)	**BoD:04/03/2022**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: People Committee	**Date:** 18 February 2022	**Chair: Lynn Hagger**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Divisional Attendance- Surgery	The Committee welcomed the leadership team from the Division of Surgery who provided an overview of The Committee noted some of the key workforce successes relating to the following: • The leadership team follow the 'Getting it Right in Leadership' model; • Developed a healthy working environment where staff can contribute and challenge the senior management team; • Excellent progress has been made in relation to roster management using the E-roster system; • Appraisals: A total of 92% of staff have completed their appraisals which is a significant achievement; • Mandatory training: The Division has maintained the Trust target and set itself a stretch target of 95% by the end March 2022; • Sickness absence: Overall at 8.37% with 2.8% short term and 5.57% accounting for long term sickness. All staff on long term sickness have supportive plans in place;	Board of Directors	Assured.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• All staff were encouraged to complete the recent staff with 70% doing so. The Committee acknowledged the excellent work ongoing within the Division and in particular the level of ownership and accountability within the Division.		
	Divisional Attendance - Community	The Committee welcomed the leadership team from Community and noted the following: • Recruitment for the Head of Nursing has been temporarily paused; • Sickness absence: Short term sickness has increased due to the Omicron variant (4.07%) with long term sickness below the Trust average at 3.79%; • Appraisals: Currently at 74% which is below the Trust average; • Staff Survey: The response rate was lower than expected with key areas of concern being health, wellbeing and safety at work. There is support from the management team around safety during home visits; • Successful recruitment programme for Associate Nurses with a further plan to develop a District Nurse competency framework; • Plans to develop a Community Compass Programme, increase Apprenticeships and develop the Health Care Assistant role. The Committee commended the number of initiatives within the Division to assist in addressing the challenges within the Division.	Board of Directors	Limited Assurance due to performance around the workforce metrics.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
2	Risk Register	The People Committee received the risks that are currently aligned to the Committee noting that no risks rated 15 and above are currently aligned however, the Committee discussed five risks that relate to staffing but are currently linked to the Quality Committee. The Committee further noted the action plans highlighted for the gaps in the controls for each risk acknowledging that whilst there is more work to do, the Committee commended the work that is being undertaken with the risk register.	Board of Directors	Assured in relation to the plan to improve the risk register.
3	Board Assurance Framework	The Committee received and discussed the ongoing Quarter 4 position for the Board Assurance Risks aligned to the People Committee noting and agreeing with the current position that there has been no change. The Committee agreed that progress is being made with the BAF Risks aligned to the Committee and acknowledged that work has begun in developing the new BAF in preparation for April 2022.	Board of Directors	Assured in relation to the process around the BAF but limited in relation to the alignment of the risk register.
4	Workforce Report	The Committee discussed the Workforce Report highlighting the following: • Sickness absence: Remains high across the Trust at 9.13% which is 5.18% above the Trust target. • Mandatory training: Overall core mandatory training compliance remains above the Trust target at 90% with job specific below target at 80%. • Appraisal rate: The 12 month rolling compliance rate remains at 82% will all Divisions being below the Trust target with the exception of the Surgical Division. Revised appraisal paperwork is currently at the final consultation stage prior to launch in time for the new appraisal season from April 2022.	Board of Directors	Limited Assurance due to the pressures experienced by the workforce but Assured in relation to the steps that are being taken to support.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• The ICS Workforce Team are engaging with organisations to agree priorities for 2022/23 in addition to a People Dashboard. The Committee acknowledged the good work that is being undertaken but agreed limited assurance due to the performance around the workforce metrics.		
5	Health and Wellbeing Update	The Committee received and commended the work carried out in relation to the health and wellbeing offer within the Trust despite the recent challenges relating to the ongoing pandemic. The Committee was assured in relation to progress around the 5 Ways to Wellbeing in addition to the increase in the number of Health and Wellbeing Champions.	Board of Directors	Assured
6	Staff Survey Update	The Committee noted the final overall response rate to the Staff Survey being 59.6% with an improving trend in response rates from previous years. The Committee requested further analysis on the data and actions that are required especially around health and wellbeing which is a surprising outcome given the ongoing work around health and wellbeing within the Trust.	Board of Directors	Limited Assurance
7	Learning and Development Update	The Committee received and commended the ongoing work around learning and development in particular: • Centralised single point of contact for learning and development with senior representatives from the Learning and Development team now aligned with Divisions;	Board of Directors	Assured

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• From January 2022, new 'job specific' competencies introduced for Medicine Management, Sepsis and EPR Mastery all of which require managerial oversight; • Increase in the Leadership Academy 360 appraisal capacity to support team and individual leadership development; • Celebration of National Apprentice Week with 187 currently on the programme at the Trust.		
8	E-Roster Deep Dive	The Committee received the updated report following reviews carried out by Internal Audit noting the following updates: • Rostering Policy: The Policy has been updated to incorporate recommended practice; • The following has been implemented following the audit; review and approve meetings, Divisional oversight meeting in addition to the creation of a Trust roster workforce group. The Committee recognised the ongoing work remaining concluding that limited assurance remains around the e-roster system.	Board of Directors	Limited Assurance
9	Medical Consultant Job Pack	The Committee received and discussed the draft Medical Consultant Job Pack commending this ongoing work. The Committee requested an update at the May 2022 Committee.	Board of Directors	Assured.

Subject:	Audit Committee 09 February 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA Quorate: Yes	Ref:P47/22(iv)	BoD: 04/03/2022

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Audit Committee	**Date:** 30/12/2021	**Chair: Kamran Malik**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Risk Management Report (including Risk register	The Committee received the report detailing the 13 approved risks scoring 15 or above at the end of quarter three. The Committee noted and discussed the findings of the initial review of the risk register and risk management processes. The Committee welcomed the detailed action plan supporting the improvement plan generated as a result of the review. The Committee acknowledged that the Risk Management Action Plan, presented to the Committee, would strengthen systems and processes, improve terminology and context when describing and reporting risks on Datix. The improvement plan includes strengthening of the Risk Management Committee including a revised Terms of Reference and increase scrutiny of actions to mitigate risks.	Board of Directors	Assured that plans were in place to address identified gaps and areas for improvement, acknowledging that further work was required

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
2	Board Assurance Framework	The Committee received the Board Assurance Framework (BAF) report outlining the current position. It was noted that the report detailed the discussions held at the Quality Committee in January 2022. As the meetings of the Finance and Performance Committee and People Committee had been stood down as a result of operational pressures, the report detailed the outcome of the discussions held with the lead Executives for the BAF risks which would have been presented to those Committees. The Committee acknowledged the focus now being given to the BAF, and particularly in relation to the gaps in control and assurance.	Board of Directors	Assured that plans were in place to address identified gaps and areas for improvement, acknowledging that further work was required. Assured on ratings and how assessing BAF positions and supportive of plans going forward.
3	Progress Report from Internal Auditor	The Committee received the progress report which provided an update on activities as part of the Internal Audit Plan 2021/22. An advisory review of legal services (claims and inquest management) had been completed, with two high risk and two medium risk findings. The Committee noted that an action/improvement plan had been developed to ensure correct and robust processes are in place to manage the Trusts' Inquest and Litigation profile. The Committee had noted the common theme in the reviews completed to date had been identification of learning, actions taken and dissemination.	Board of Directors	

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The implementation rate for recommendations is currently 64%, with the threshold for significant assurance at first follow up being 75%. Five actions were overdue at the time of reporting to the Committee, with the Internal Auditor confirming that once evidence that the action had been implemented on time had been received the action would be closed and backdated so not to adversely impact on the Head of Internal Audit Opinion. Appended to the report had been the Head of Internal Audit Opinion Stage 2 memorandum. The Internal Auditor has confirmed that the 2021/22 Audit Plan would be delivered to enable delivery of the final Head of Internal Audit Opinion. The Committee had approved a number of changes to the 2021/22 plan in relation to: • Performance management framework • Consultant Job Planning • Governance and Risk Management		
4	Progress Report from External Auditor	The Committee received the report from the External Auditor. The report detailed the timeline for the accounts and a number of national publications including the Financial Reporting Council (FRC) - Major Local Audits Audit Quality Inspection, October 2021. In respect of Mazars, the FRC had concluded that "*the audit quality results for our inspection of the four*	Board of Directors	

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		audits showed significant improvement compared to the prior years, with all audits assessed as requiring no more than limited improvements". In addition, the Committee was informed of the substantial fine issued by FRC against Mazars for the failure to comply with the Regulatory Framework for Auditing in its audit of a local government authority's 2019 financial statements. The Committee received assurance that systems had been subsequently strengthened across all the company's portfolios as demonstrated by the FRC findings in October 2021. As the Governors appoint the External Auditor, the matter was reported and discussed at the Council of Governors meeting held on 09 February 2022.		
5	Draft Audit Strategy Memorandum 2021/22	The Committee received the Audit Strategy Memorandum which detailed the approach and timeline to complete the end of year audit. Planning would take place January to March, with the deadline for completion of the work by 22 June 2022. The report had provided information across a range of matters to be completed and reviewed and highlighted significant risks and key judgements. The Committee had noted that the initial overall materiality threshold had been established at circa £6.5m.	Board of Directors	

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The fee to undertake the work, would be £90,000 plus VAT.		
6	Counter Fraud Progress Report	The Committee received the routine Counter Fraud Progress report. The Committee had been informed of the steps being taken to ensure full compliance against the thirteen components of the of the 2021 Counter Fraud Functional Standard Return. The Committee was informed of the national investigation in relation to potential vaccine fraud and falsification of records.		
7	2021/22 Annual Report and Accounts i. Timetable	The Committee in noting the timetable for the Annual Report and Accounts, were informed that the draft accounts were due for submission on 26 April 2022, with the audited Accounts and Annual Report to be submitted by 22 June 2022. It was noted that the Quality Report is not required to form part of the Annual Report, and would be subject to a different reporting deadline of 30 June 2022. The Annual Reporting Manual (ARM) guidance had yet to be published by NHS England / Improvement.	Board of Directors	
	ii. Accounting Policies	The Committee received the report outlining the changes required to the Trust's Accounting Policies, which would form Note 1 to the 2021/22 Accounts. Whilst there were no significant or material changes required the Committee noted the main changes in relation to: • Note 1.15 Provisions, Early Retirement Provisions	Board of Directors	

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• Note 1.3 Critical accounting judgements and key sources of estimation uncertainty. The Committee had endorsed the changes to the Accounting Policies and would recommend approval by the Board of Directors when considered at their meeting on 04 March 2022.		
	iii. Operating Segments	The Committee had received the report detailing the Operating Segments disclosure note required under IFRS 8 in the 2021/22 Annual Reports and Accounts. The Committee endorsed the recommendation that the Trust should have one reporting segment, namely the provision of healthcare for the purpose of disclosure in the 2021/22 Annual Accounts. The Audit Committee would recommend approval by the Board of Directors when considered at their meeting on 04 March 2022.	Board of Directors	
	iv. Going Concern	The Committee had received and endorsed the recommended that the 2021/22 annual accounts were prepared on a “Going Concern” basis and would recommend approval by the Board of Directors when considered at their meeting on 04 March 2022.	Board of Directors	
8	Standing Financial Instruction Breach Report	The Committee received the report identifying breaches of financial governance as defined by the Standing Financial Instructions (SFIs) for the period 1 October 2021 to 31 December 2021.	Board of Directors	

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee had noted that: • 89% of invoices had been paid within 30 days; • There had been no staffing breaches during the period; • 2% of invoices received, equating to £280k, had been received without a purchase order having been in place.		
9	Losses and Special Payments	The Committee received the Losses and Special Payments Report for the cumulative period 01 April to 31 December 2021, with losses and special payments during quarter three equating to £19,000.	Board of Directors	Assured of the processes in place regarding losses and special payments
10	Tender Waivers	The Committee received the report which detailed the three single tender waivers approved since the last meeting.	Board of Directors	Assured of the processes in place regarding tender waivers
11	Audit Completion report Progress against recommendations	The Committee received the second follow up report on progress against the three recommendations detailed in the 2020/21 External Audit Completion Report, and subsequent follow up letter. The Committee noted progress against all three recommendations, all of which were considered to have been completed and would be closed. The External Auditor would assess the position when reviewing the 2021/22 accounts. .	Board of Directors	
12	Annual Review of Freedom to Speak Up Strategy	The Committee received a copy of the Freedom to Speak Up Strategy 2021 -2023 and associated work plan which had been the subject of its annual review.	Board of Directors	

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee noted the rollout of further national e-learning packages and that the Trust would be collaborating with a local Trust to undertake a peer review. The Committee had further noted the Trust working in collaboration with South Yorkshire Police to establish a racism reporting centre. The Committee Chair as Non-Executive Director Champion for Freedom to Speak Up, will be holding quarterly meetings with the Lead Freedom to Speak up guardian.		

The Audit Committee met on 09 February 2022 and considered the following agenda items:

- Risk Register and BAF
- Progress report from Internal Auditor
- Progress report and Draft Audit Strategy Memorandum from External Auditor
- Counter Fraud Progress Report
- Annual Report and Accounts Timetable
- Accounting policies
- Operating Segments
- Going Concern
- Standing Financial Instructions Breach report
- Losses and Special Payments report
- Tender Waivers report
- Audit Completion report Progress against recommendations
- Annual Review of Freedom to Speak Up Strategy

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P48/22
Report	**Care Quality Commission (CQC) Assurance Report**
Executive Lead	Helen Dobson, Interim Chief Nurse
Link with the BAF	B1
How does this paper support Trust Values	Ambitious – The Trust is working to achieve a CQC rating of Good and beyond. Caring – The Trust is working to achieve a CQC rating of Outstanding for the Caring Domain Together – The Trust is working together with senior leaders, clinical teams and external stakeholders to deliver safe, high quality care for the population of Rotherham
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This paper provides a brief overview of the activity in relation to compliance and regulation. This includes: • CQC Assurance – January Cycle 2022 • Changes to the CQC Relationship Team • Current performance against CQC Insight Indicators
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	Individual elements of this report have been presented to the following: Chief Nurse Governance and Performance Group on 14 February Clinical Governance Committee on 17 February Quality Committee on 23 February
Powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	The action is for the Board to note the content of the Report, be assured that robust plans are in place and that progress is being made to address the issues identified through the 2021 Inspection process. The Interim Chief Nurse is the Board lead for Regulatory Compliance.
Recommendations	It is recommended that Board: • Note the content of the Report

	• Note the submission of the application to CQC to consider the removal of the Section 31 condition in Urgent and Emergency Care • Note the ongoing requirements for monitoring the CQC Action Plans
Appendices	N/A

1. CQC Assurance

1.1 The CQC Delivery Group was held on 8 February, chaired by Michael Wright, Deputy Chief Executive. Each core service provided an update on progress made through the January Cycle. The progress update is set out below:

2. Section 31 (2018) - Urgent and Emergency Care (UECC)

2.1 As reported previously, the Trust believes it is now in a position to submit an application to the CQC to have the regulatory condition imposed on the Urgent and Emergency Care Centre in October 2018 removed. The condition against the Certificate of Registration relates to inadequate sick children's nurse staffing and oversight of a senior medical doctor within the Paediatric Emergency Department.

2.2 The application and supporting evidence was presented to the CQC Delivery Group on 8 February and approved at the Executive Team Meeting on 17 February. This has been further discussed with CQC colleagues at the Engagement Meeting on 24 February and the application was subsequently submitted.

3. Urgent and Emergency Care - Section 29a warning Notice (2021)

3.1 The monthly review of the Urgent and Emergency Care (UECC) Section 29a Improvement Plan was presented to CQC Delivery Group.

3.2 Table 1 confirms the performance against the 48 issues (106 individual actions) as of 8 February.

3.3 This demonstrates a positive movement of six actions within section one of the table rated as amber in January, now rated as green as the remedial action taken has brought progress back on track. There has been a slippage of three actions in month within section two with all three now rated as amber. One action in section three has also been rated as amber from green through the January Cycle.

3.4 Section four, reflects the overall leadership of UECC, where considerable progress is continuing with respect to staff engagement and involvement in the transformation programme and culture of the department. Specific progress includes:

- Second round of engagement sessions planned for week commencing 14 February, with shop floor conversations starting Tuesday 15 February
- "Art of Being Brilliant" agreed and dates to be confirmed, this will also be recorded so every member of UECC will have the opportunity to be involved.
- PRINT sessions for the Leadership Team takes place on 22 February
- PRINT session was completed for Band 7 staff on 4 February

Core Service Area	No of issues	No of actions	R	A	G	B	G
Within the UECC, there was evidence that patients were not always receiving safe care and treatment.	21	62		3 (4.8%)	59 (95.2%)		
There were issues around the safeguarding processes for both adults and children, which could increase the risk of harm.	7	18		7 (38.8%)	11 (61.2%)		

There was evidence to show that not all patients received appropriate patient centred care.	8	14		3 (21.5%)	11 (78.5%)		
Leadership, systems and processes were in place within the Department that were not being consistently applied. Audits were not consistently completed appropriately. Issues, whilst identified were not being addressed in a timely manner	12	12			12 (100%)		
Total	48	106	0 (0%)	13 (12.2%)	93 (87.8%)	0 (0%)	0 (0%)

Table 1

4. The MUST take Action Plan (2021)

4.1 82 Must and Should take issues were identified within the 2021 Inspection Report. In order to fully address each concern a number of sub-actions (232 – note an addition of three actions from the January position) have been agreed to ensure delivery of the required improvements. Table 2 indicates the total number of actions per core service area. The table illustrates progress against the actions as of 8 February.

4.2 This is a positive movement in month, in particular the increase of 12 sub-actions (6 Blue Forms) approved as embedded.

4.3 The Division of Medicine submitted three Blue Forms for consideration; however, these require further work and as such were not approved.

4.4 As previously reported, these Action Plans initially comprised of issues and concerns identified by CQC, are dynamic documents that provide clinical services the opportunity to add further actions and improvements. It is expected that each service will continue to grow and develop their plans further and as an example Urgent and Emergency Care have added issues resulting from their recent Patient Experience Survey, thus ensuring all improvement work is managed in a robust manner with the same level of scrutiny and assurance on delivery required.

Core Service Area	No of issues	No of actions	R	A	G	B	G
Trustwide	4	12			7 (58%)	5 (42%)	
Urgent and Emergency Care	30	93		17 (18.3%)	76 (81.7%)		
Medical Care	18	72		1 (1.4%)	70 (97.2%)		1 (1.4%)
Maternity	6	10			7 (70%)	3 (30%)	
Children and Young People	24	45	0 (0%)	11 (24.4%)	14 (31.2%)	19 (42.2%)	1 (2.2%)
Total	82	232	0 (0.0%)	29 (12.5%)	174 (75%)	27 (11.7%)	2 (0.8%)

5 CQC Relationship

5.6 Following a reconfiguration within CQC there has been a change in the Trust CQC relationship colleagues. The Trust Relationship Officer is now Toni Preston, replacing Amy Harris and the Inspection Manager is Chris Storton, replacing Wendy Dixon. An initial introductory meeting has taken place to set out the relationship details going forward.

5.7 From February, the routine Engagement meeting will take place on the last Thursday afternoon of each month. The meeting will be extended to a minimum of two hours, to provide an opportunity for clinical teams to become more involved in the discussions. Regardless of whether the meeting is held on site or virtually, the agenda will be planned to ensure a balance between key issues and risks and teams presenting the positive improvements that are taking place across the organisation.

5.8 We are very much looking forward to continuing to build a productive and mutually supportive working relationship with the new team.

Elaine Jeffers
Deputy Director of Quality Assurance
February 2022

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P49/22
Report	**Integrated Performance Report – January 2022**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B1, B2, B9
How does this paper support Trust Values	The Integrated Performance Report supports the Trust's *Ambitious* value in ensuring we are constantly striving to deliver stronger performance across all of the core domains.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Integrated Performance Report is the monthly summary of Trust performance across the four domains of Operational Delivery, Quality, Finance and Workforce. This month's report relates to January 2022 data wherever it is available. It highlights performance against agreed national, local or benchmarked targets. Statistical Process Control charts are included against key metrics.
Due Diligence	Each of the Assurance Committees have received the relevant elements of the Integrated Performance Report or identical information, with the Executive Directors approving the content for their domain.
Board powers to make this decision	In order to be assured of the performance of the organisation, the Board needs to have visibility of the Trust's performance against core metrics.
Who, What and When	The Deputy Chief Executive is the Lead Executive for reporting on the performance of the organisation through the Integrated Performance Report on a monthly basis.
Recommendations	It is recommended that the Board of Directors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.
Appendices	i. Integrated Performance Report – January 2022 ii. Integrated Performance Report Commentary – January 2022

Board of Directors

Integrated Performance Report - January 2022

Provided by

Business Intelligence Analytics, Health Informatics

PERFORMANCE SUMMARY

Quality	Operational Delivery	Finance	Workforce	Activity
Mortality	Planned Patient Care	Financial Position	Workforce Position	Acute
Infection Prevention & Control	Emergency Performance			Community Services
Patient Safety	Cancer Care			
Maternity	Inpatient Care			
Patient Feedback	Community Care			

CQC DOMAINS

Responsive	Effective	Safe	Caring	Well Led
Planned Patient Care	Mortality	Infection Prevention & Control	Patient Feedback	Workforce position
Emergency Performance	Inpatient Care	Patient Safety		Financial Position
Cancer Care		Maternity		
Community Care				

Trust Integrated Performance Dashboard - Operations

KPI		Reporting Period	Type of Standard	Target	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD 21/22	Same Month Prev. Yr	Forecast - Year End	Trend	Data Quality
Planned Patient Care													
P1	Waiting List Size	Jan 2022	L	**19,705**	20,478	20,489	21,496	22,333	22,333	14,012			
P1A	Number of RTT Patients with a Decision to Admit	Jan 2022			2,914	3,038	3,127	3,462	3,462	3,738			
P2	Referral to Treatment (RTT) Performance	Jan 2022	N	**92%**	83.2%	81.9%	80.4%	77.2%	82.4%	70%			
P3	Number of 52+ Weeks	Jan 2022			47	44	35	48	48	721			
P3A	Number of 104+ Weeks	Jan 2022	N	**0**	0	0	0	0	0	0			
P4	Overdue Follow-Ups	Jan 2022	L	**10,773**	9,754	10,340	11,268	12,458	12,458	12,449			
P5	First to follow-up ratio	Jan 2022	B	**2.5**	2.97	2.92	2.94	2.67	2.95	3.39			
P6	Day case rate (%)	Jan 2022	B	**80%**	85.1%	87.3%	84.7%	89.5%	84.0%	90%			
P7	Diagnostic Waiting Times (DM01)	Jan 2022	N	**1%**	17.4%	11.1%	10.0%	9.8%	20.6%	39%			
P8	Diagnostic Activity Levels												
Emergency Performance													
E1	Number of Ambulance Handovers > 60 mins	Jan 2022	CQC	**0**	190	307	327	100	1,753	72			
E1A	Number of Ambulance Handovers > 30 mins	Jan 2022	CQC	**0**	438	579	608	314	3,960	249			
E2	Average Time to Initial Assesment in ED (Mins)	Jan 2022	N	**15**	25	28	25	24	23	20			
E3	Proportion of patients spending more than 12 hours in A&E from time of arrival	Jan 2022			7.89%	10.06%	9.43%	7.19%	5.96%				
E4	Number of 12 hour trolley waits	Jan 2022	N	**0**	0	0	0	0	0	0			
E5	Conversion rate from A&E (not including Observations)	Jan 2022			22.1%	21.5%	23.3%	23.5%	21.6%	29%			
E6	Proportion of same day emergency care	Jan 2022	L	**33%**	39.4%	41.6%	38.3%	39.0%	40.1%	30%			
Cancer Care													
Ca1	2 Week Wait Cancer Performance	Dec 2021	N	**93%**	92.4%	94.2%	95.1%	93.8%	94.4%	96%			
Ca2	2 Week Wait Breast Symptoms	Dec 2021	N	**93%**	96.2%	94.7%	84.8%	86.7%	90.0%	82%			
Ca3	31 day first treatment	Dec 2021	N	**96%**	95.6%	96.9%	95.5%	96.6%	95.9%	99%			
Ca4	62 Day Performance	Dec 2021	N	**85%**	67.9%	75.2%	68.2%	72.3%	73.0%	66%			
Ca5	Patients waiting longer than 62 days on the PTL	Jan 2022	L	**75**	86	70	72	89	89				
Ca6	28 day faster diagnosis standard	Dec 2021	N	**75%**	71.0%	73.0%	75.6%	79.7%	74.0%	58%			
Inpatient Care													
I1	Mean Length of Stay - Elective (excluding Day Cases)	Jan 2022			0.32	0.33	0.29	0.21	3.23	2.76			
I2	Mean Length of Stay - Non-Elective	Jan 2022			0.18	0.18	0.17	0.18	5.35	6.33			
I3	Length of Stay > 7 days (Snapshot Numbers)	Jan 2022	L	**142**	192	204	192	218	218	183			
I4	Length of Stay > 21 days (Snapshot Numbers)	Jan 2022	L	**42**	51	66	50	84	84	44			
I5	Right to Reside - % not recorded (Internal Performance from May)	Jan 2022	B	**0%**	8.6%	7.2%	7.4%	6.2%	6.2%	13%			
I6	Discharges before 5pm (inc transfers to Dis Lounge)	Jan 2022	L	**70%**	53.7%	54.8%	56.8%	55.1%	56.6%	54%			
Outpatient Care													
O1	Did Not Attend Rate (OutPatients)	Jan 2022	B	**7%**	8.7%	8.9%	8.4%	8.2%	8.1%	9%			
O2	Appointment Slot Issues	Jul 2021	N	**4%**	80.2%	82.7%	96.9%	88.0%	88.0%	91%			
O4	% of all Outpatient activity delivered remotely via telephone or video consultation	Jan 2022	N	**25%**	16.3%	17.4%	16.3%	16.1%	17.5%				
O5	Advice and Guidance - Metric still being worked up												
O6	Number of patient pathways moved or discharged to PIFU, expressed as a proportion of all outpatient activity.	Jan 2022			0.03%	0.14%	0.30%	0.28%	0.14%				
Community Care													
CC1	MusculoSkeletal Physio <4 weeks	Jan 2022	L	**80%**	11.5%	16.1%	13.9%	13.6%	15.1%	11%			
CC2	% urgent referrals contacted within 2 working days by specialist nurse (Continence)	Jan 2022	L	**95%**	65.1%	79.2%	76.0%	64.7%	66.1%	92%			
CC3	A&E attendances from Care Homes	Jan 2022	L	**144**	143	159	134	124	124	107			
CC4	Admissions from Care Homes	Jan 2022	L	**74**	62	72	61	85	85	57			
CC5	Patients assessed within 5 working days from referral (Diabetes)	Jan 2022	L	**95%**	100.0%	87.5%	50.0%	100.0%	88.5%	98%			

Trust Integrated Performance Dashboard - Quality

KPI		Reporting Period	Type of Standard	Target	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD 21/22	Same Month Prev. Yr	Forecast - Year End	Trend	Data Quality
Mortality													
M1	Mortality index - SHMI	Aug 2021	B	**100**	111.0	111.0	112.6	110.7	--	117.3			
M2	Mortality index - HSMR (Rolling 12 months)	Sep 2021	B	**100**	112.6	113.4	114.0	114.6	--	118.3			
M3	Number of deaths (crude mortality)	Jan 2022		-	84	110	98	102	859	157			
Infection, Prevention and Control													
In1	Clostridium-difficile Infections	Jan 2022		-	2	2	6	3	22	2			
In1a	Clostridium-difficile Infections (rate)	Jan 2022		-	14.8	14.1	15.4	16.1	15.4	22.6			
In2	MRSA Infections (Methicillin-resistant Staphylococcus Aureus)	Jan 2022	L	**0**	0	0	0	0	1	0			
In2a	MRSA Infections (Methicillin-resistant Staphylococcus Aureus) (Rate)	Jan 2022		-	0.71	0.70	0.70	0.70	0.70	0.0	**0**		
In3	E.coli blood bactertaemica, hospital acquired	Jan 2022		-	4	6	4	1	34	0	**0**		
In4	CPE Infections, Hospital Provider	Jan 2022		-	0	0	1	2	4	-	**0**		
In5	GRE Infections - data collection to commence from April 2022												
Patient Safety													
PS1	Incidents - severe or above (one month behind)	Dec 2021	L	**0**	3	3	7	6	43	3			
PS2	% Potential of Under Reporting of Pt Safety Incidents	Jan 2022		-	51.2	51.7	52.2	52.5	50.3	0			
PS3	Never Events	Jan 2022	L	**0**	0	0	0	0	0	0			
PS4	Number of Patient Harms	Jan 2022		-	588	633	713	677	6,250	544			
PS5	Number of Patient Harms (Moderate and above)	Jan 2022		-	20	33	28	39	263	23			
PS6	Number of Patient Falls	Jan 2022		-	91	83	101	119	931	102			
PS7	Number of Pressure Ulcers (G3 and above)	Jan 2022		-	0	2	1	0	6	0			
PS8	Medication Incidents	Jan 2022		-	114	96	116	91	1049	78			
PS9	Readmission Rates (one month behind)	Dec 2021	L	**7.6%**	6.8%	8.6%	8.0%	8.5%	8.1%	7.0%			
PS10	Venous Thromboembolism (VTE) Risk Assessment	Jan 2022	N	**95.0%**	95.4%	93.0%	93.6%	94.6%	95.5%	94.4%			
PS11	Number of complaints per 10,000 patient contacts	Jan 2022	L	**8**	9.26	10.45	3.50	11.93	7.90	9.2374874			
PS12	Proportion of complaints closed within 30 days	Jan 2022	L	**100.0%**	100.0%	100.0%	100.0%	100.0%	98.2%	100.0%			
PS13	Hip Fracture Best Compliance	Jan 2022	L	**65.0%**	74.1%	79.2%	76.2%	39.1%	68.4%	55.6%			
PS14	F&F Postive Score - Inpatients & Day Cases	Jan 2022	N	**95.0%**	98.0%	97.6%	97.7%	98.5%	97.9%	97.9%			
PS15	F&F Postive Score - Outpatients	Jan 2022	N	**95.0%**	98.7%	98.1%	98.0%	97.9%	97.9%	97.9%			
PS16	F&F Postive Score - Maternity	Jan 2022	N	**95.0%**	100.0%	96.9%	100.0%	100.0%	98.8%	98.9%			
PS17	Care Hours per Patient Day	Jan 2022	L	**7.3**	6.50	6.40	6.50	6.20	6.20	6.3			
Maternit Maternity													
Ma1	Bookings by 12 Week 6 Days	Jan 2022	N	**90.0%**	91.0%	92.6%	94.0%	91.7%	93.4%	91.3%			
Ma2	% of emergency Caesarean-sections	Jan 2022	L	**16.5%**	20.2%	14.8%	15.8%	18.8%	17.3%	16.3%			
Ma3	Breast Feeding Initiation Rate	Jan 2022	N	**66.0%**	67.1%	70.5%	64.0%	64.9%	68.0%	63.1%			
Ma4	Stillbirth Rate per 1000 live births (Rolling 12 months)	Jan 2022	L	**4.66**	4.08	3.62	3.58	3.57	3.57	4.89			
Ma4a	Number of Stillbirths	Jan 2022		-	0	0	1	0	2	0			
Ma5	1:1 care in labour	Jan 2022	L	**75.0%**	95.4%	96.4%	95.0%	97.1%	96.0%	95.5%			
Ma6	Serious Incidents (Maternity)	Dec 2021	L	**0**	0	0	0	1	5	0			
Ma7	Moderate and above Incidents (Harm Free)	Dec 2021		-	0	0	0	0	0				
Ma8	Cases Referred to HSIB	Jan 2022	L	**5**	0	0	1	0	2	0			
Ma9	Consultants on labour (Hours on Ward)	Jan 2022		-	62.50	62.50	62.50	62.50	62.50	--			
Ma10	% women on continuity of care pathway	--											

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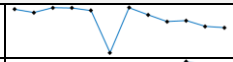
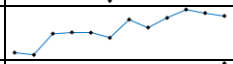
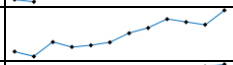
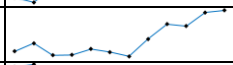
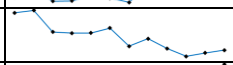
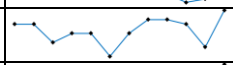
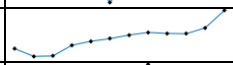
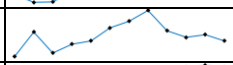
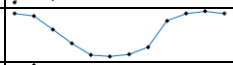
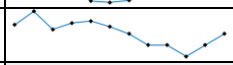
Trust Integrated Performance Dashboard - Workforce

KPI		Reporting Period	Type of Standard	Target	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD 20/21	Same Month Prev. Yr	Forecast - Year End	Trend	Data Quality
Workforce													
W1	Whole Time Equivalent against plan - Total	Jan 2022	L	**-164**	-285.00	-278.86	-314.96	-322.85	-322.85	-226.00			
W2	Whole Time Equivalent plan - Nursing	Jan 2022	L	**-102**	-39.00	-23.48	-30.21	-35.53	-35.53	-110.00			
W3	Total Headcount	Jan 2022		-	4,911	4,905	4,899	4,930	4,930	4,825			
W4	Vacancy Rate - TOTAL	Jan 2022	L	**3.90%**	6.51%	6.39%	7.17%	7.30%	7.30%	5.38%			
W5	Vacancy Rate - Nursing	Jan 2022	L	**7.90%**	2.93%	1.79%	2.29%	2.69%	2.69%	8.56%			
W6	Time to Recruit	Jan 2022	L	**34**	31	30	25	33	33	32			
W8	Sickness Rates (%) - inc COVID related	Jan 2022	L	**3.95%**	6.84%	6.83%	7.40%	9.13%	6.37%	5.23%			
W9	Turnover	Jan 2022		**0.63%**	0.90%	0.80%	0.84%	0.75%	0.85%	0.80%			
W10	Appraisals complete (%)	Jan 2022	L	**90.00%**	79.00%	82.00%	83.00%	82.00%	82.00%	80.90%			
W11	MAST (% of staff up to date)	Jan 2022	L	**85.00%**	89.00%	88.00%	89.00%	90.00%	90.00%	90.81%			
W12	% of jobs advertised as flexible	Jan 2022		-	-	-	53.57%	41.67%	-	-			

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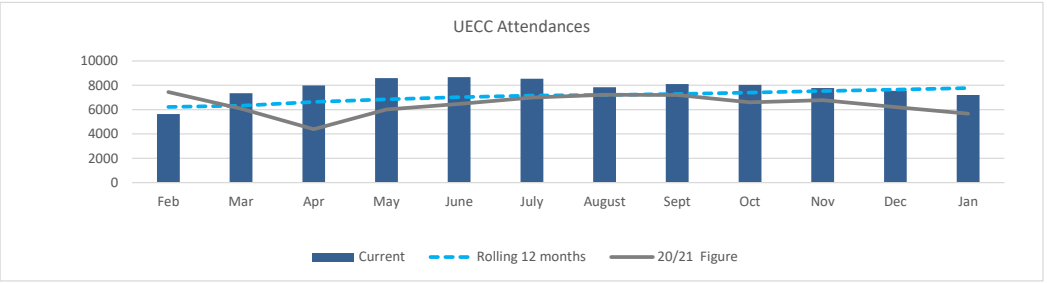
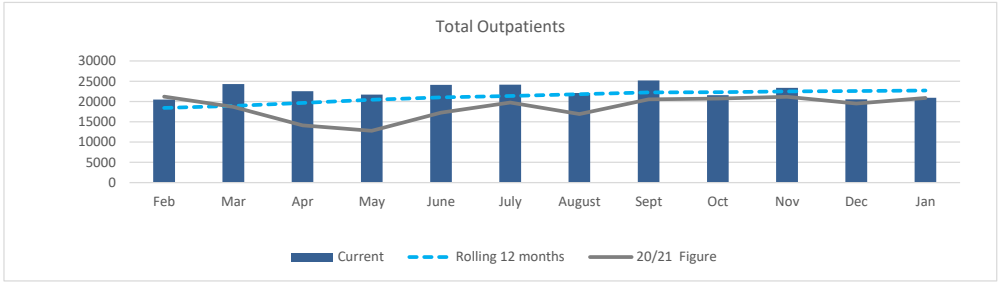
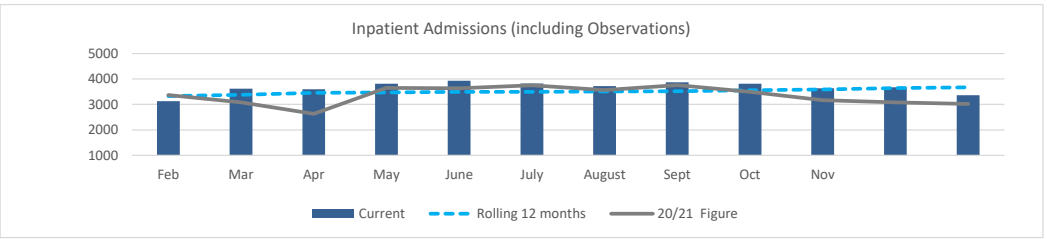
Trust Integrated Performance Dashboard - Finance

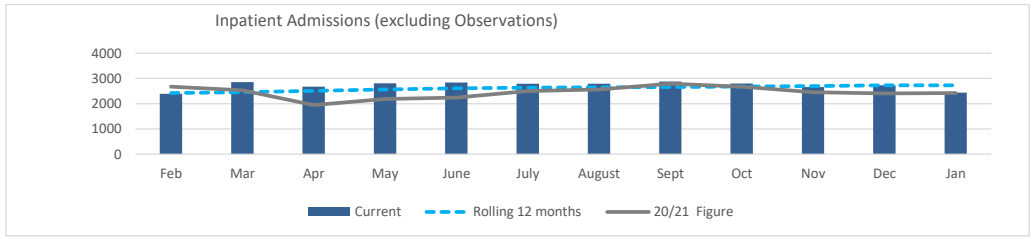
	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast Variance £000s	Prior Month Forecast £000s
I&E Performance (Actual)	(79)	(343)	(264)	(539)	752	1,290	1,683	1,834
I&E Performance (Control Total)	(42)	(306)	(264)	(166)	1,123	1,289	1,684	1,835
iency Programme (CIP) - Risk Adjusted	586	796	210	3,850	4,672	822	708	400
Capital Expenditure	1,460	542	918	9,968	5,069	4,899	1,415	1,553
Cash Balance	0	2,734	2,734	1,357	30,811	29,454	14,952	14,952

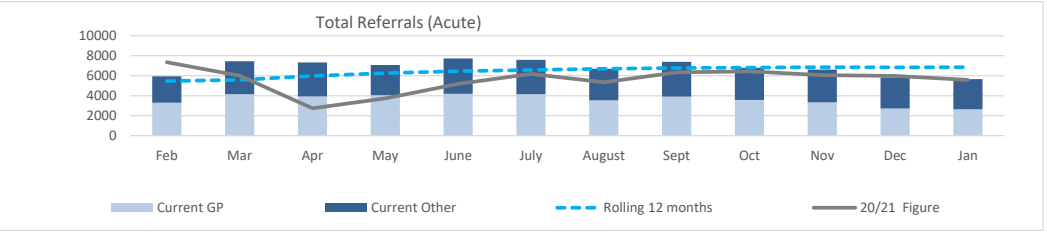
Trust Integrated Performance Dashboard - Activity

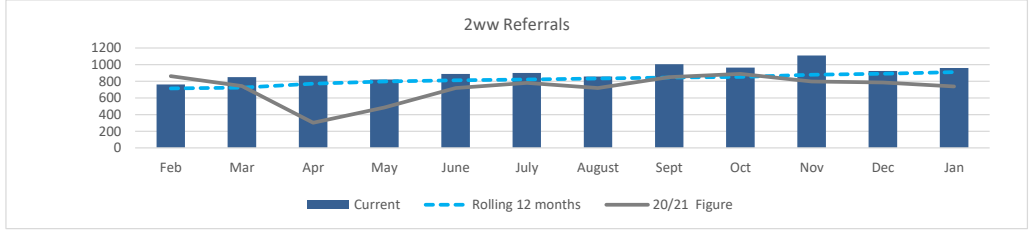












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Trust Integrated Performance Dashboard - Activity

ACTIVITY

OUTPATIENTS

	Activity 20/21	Activity 19/20 (WDA)	As % of 2019/20 WDA
January	17,673	21,779	-18.9%
M7-12 YTD monthly average	20,412	22,171	-7.9%

DAYCASES

	Activity 20/21	Activity 19/20 (WDA)	As % of 2019/20 WDA
January	1,697	2,034	-16.6%
M7-12 YTD monthly average	1,772	2,117	-16.3%

ELECTIVE ACTIVITY

	Activity 20/21	Activity 19/20 (WDA)	As % of 2019/20 WDA
January	192	275	-30.2%
M7-12 YTD monthly average	257	389	-33.9%

CLOCK STOPS - RTT

Clock Starts

	Clock Starts 2021* includes ASIs	Clock Starts 19/20	As % of 2019/20 WDA
January	6,215	7,380	-15.8%
M7-12 YTD monthly average	6,722	6,910	-2.7%

Clock Stops Admitted

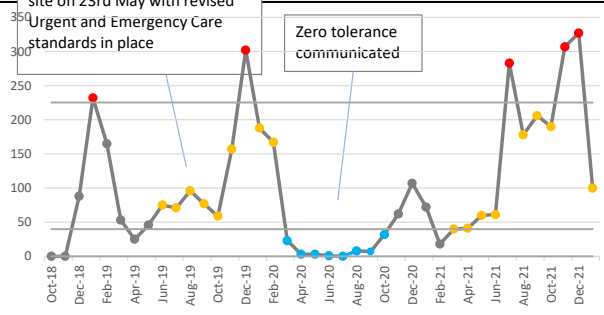
	Clock Stops 2021	Clock Starts 19/20	As % of 2019/20 WDA
January	951	1,580	-39.8%
M7-12 YTD monthly average	1,162	1,534	-24.3%

Clock Stops Non-Admitted

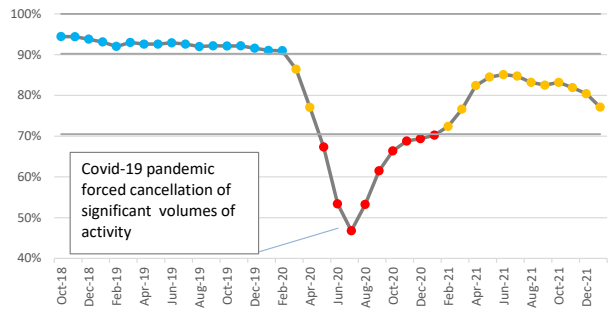
	Clock Stops 2021	Clock Starts 19/20	As % of 2019/20 WDA
January	3,555	4,312	-17.6%
M7-12 YTD monthly average	3,618	4,183	-13.5%

Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (1)

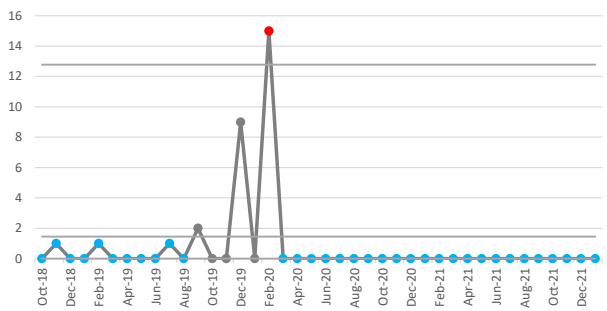
...rs - % of handovers > 60 minutes



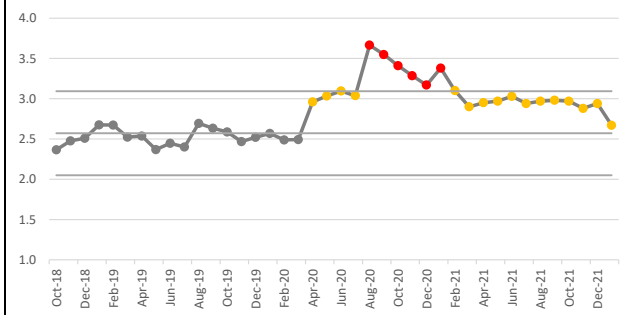
Referral to Treatment - % of patients waiting less than 18 weeks for treatment



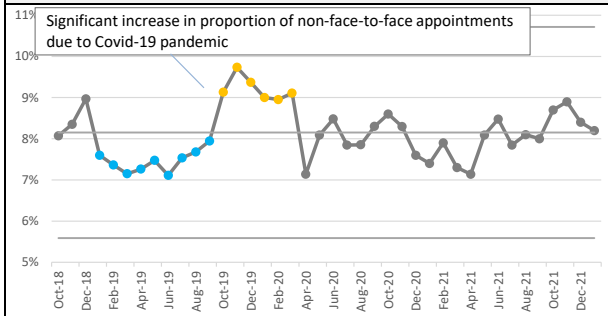
12 hour trolley waits - per month



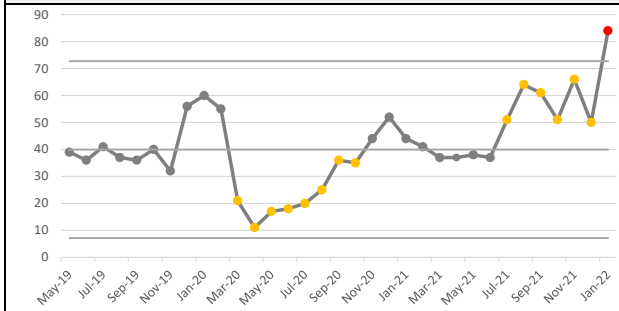
First to Follow-Up Ratio



Did Not Attends (DNAs) % of appointments

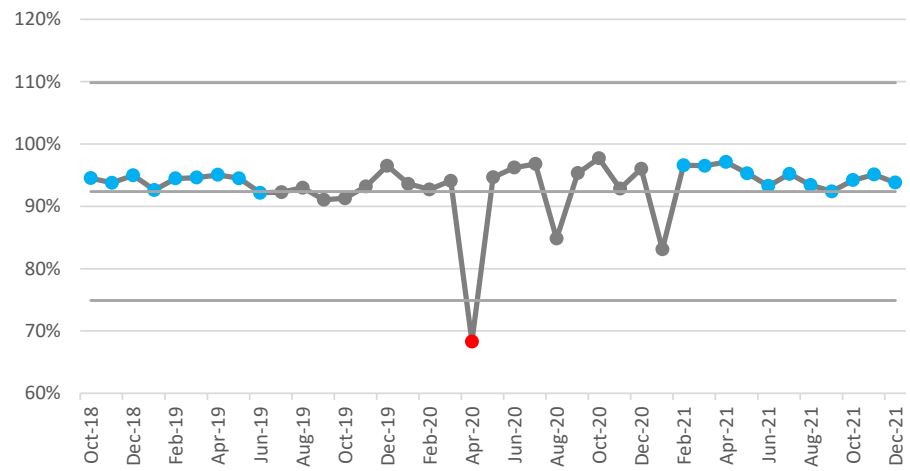


Length of Stay > 21 days (Snapshot Numbers)

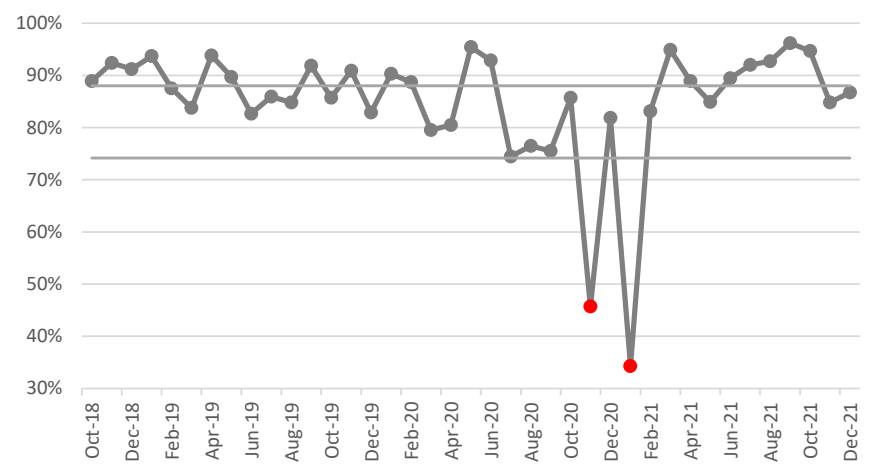


Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (2)

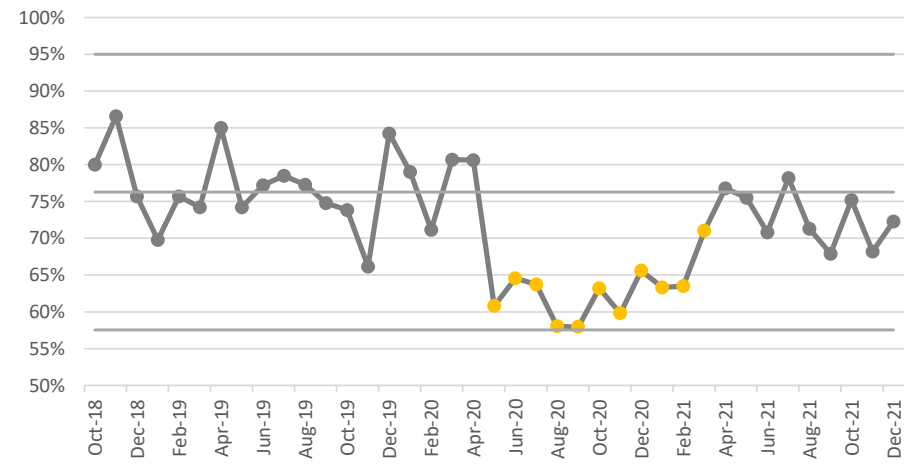
Cancer 2 week wait standard



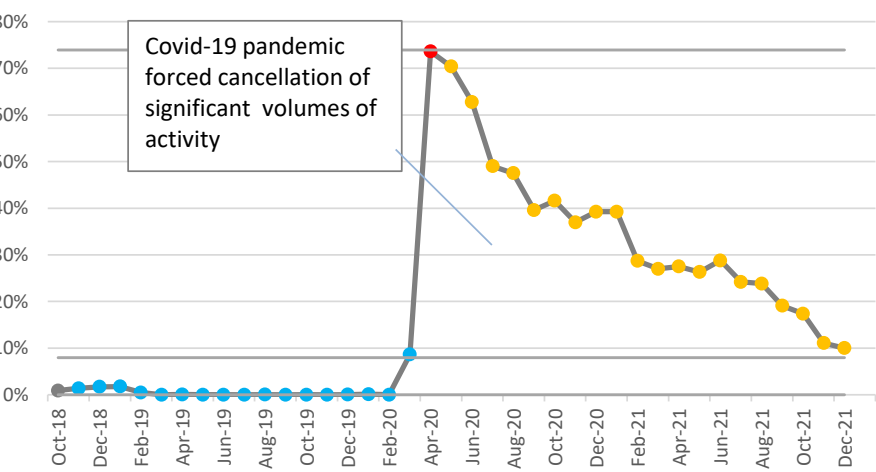
Cancer 2 week wait breast symptoms standard



Cancer 62 day first treatment standard

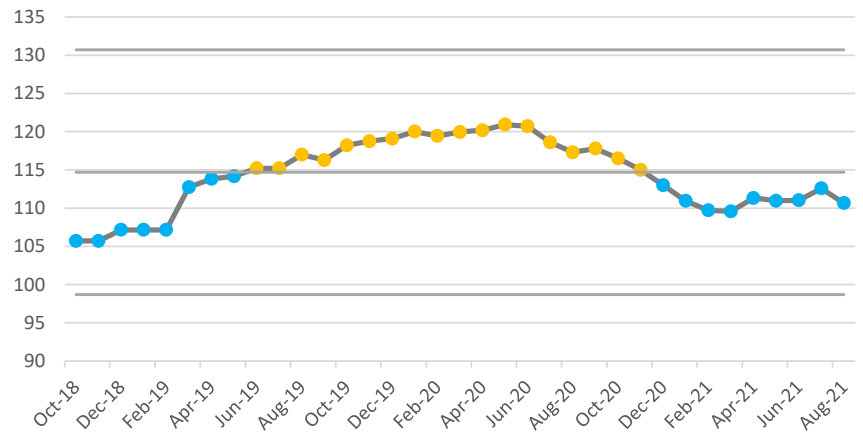


Diagnostics - % of breaches over 6 weeks (DM01)

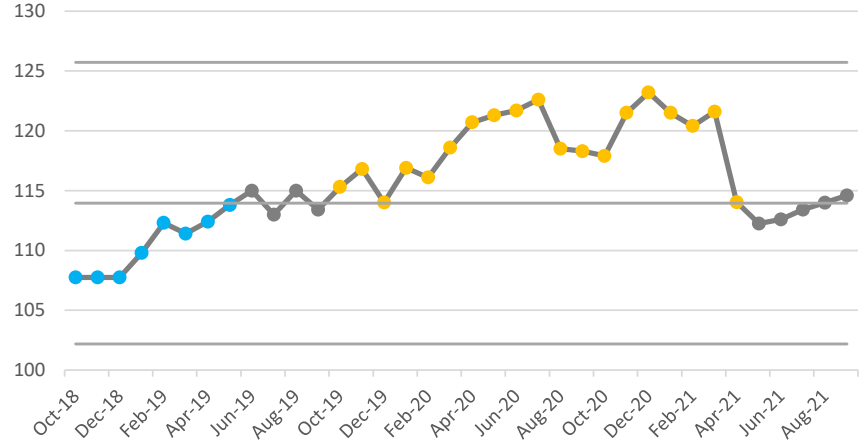


Trust Integrated Performance Dashboard - SPC Charts - Quality (1)

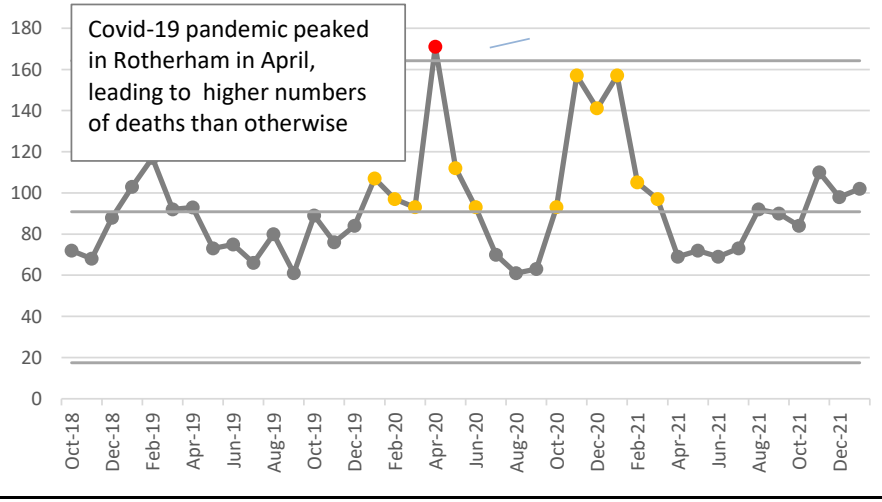
Standardised Hospital Mortality Indicator (SHMI)



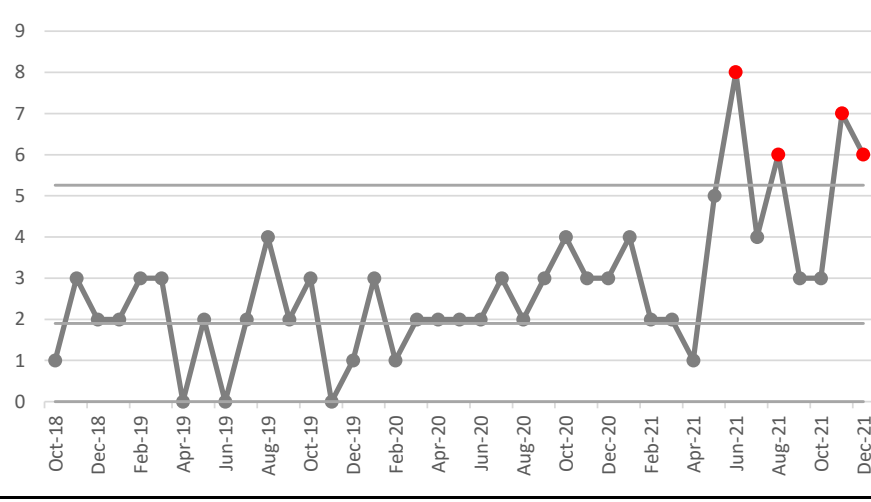
Hospital Standardised Mortality Ratio (HSMR)



Crude Mortality (number of deaths)

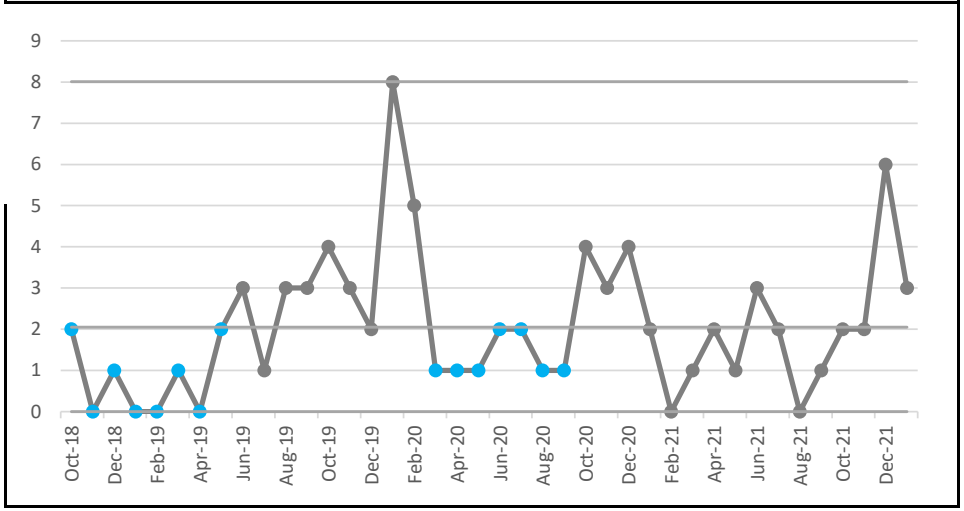


Incidents (severe or above)

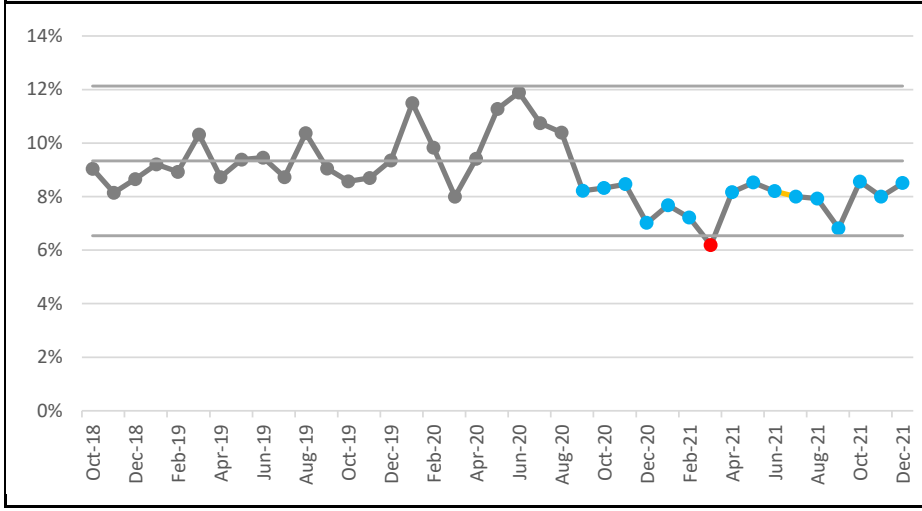


Trust Integrated Performance Dashboard - SPC Charts - Quality (2)

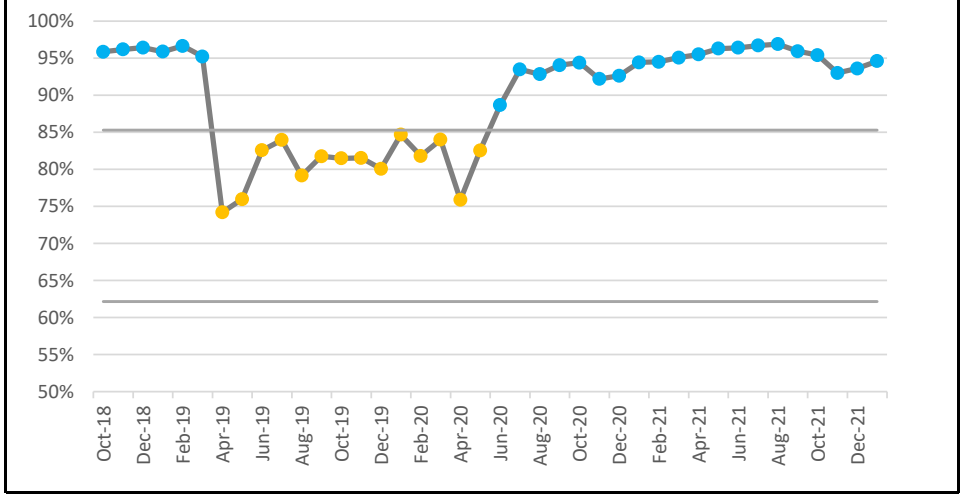
Clostridium difficile infections (number)



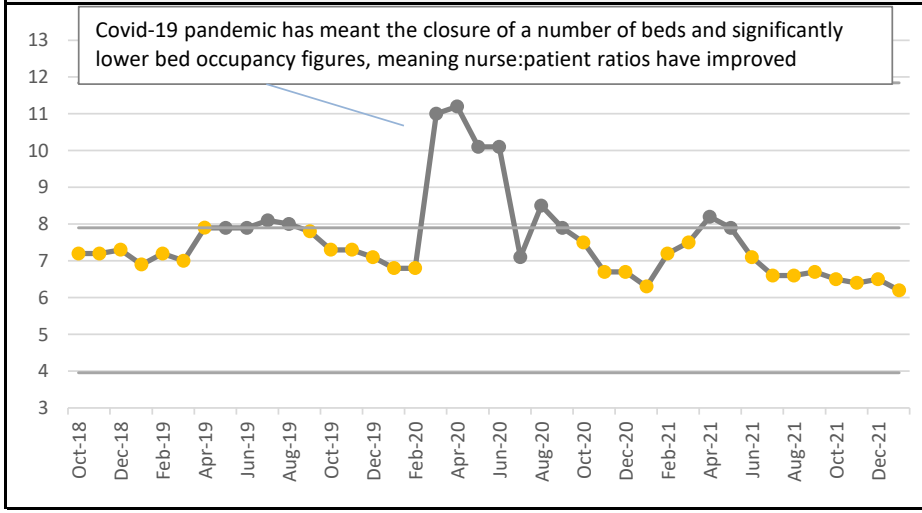
Readmissions (%)



Venous Thrombous Embolism compliance (%)

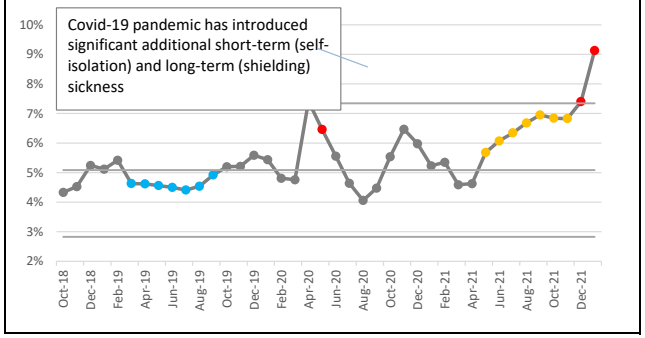


Care Hours per Patient Day

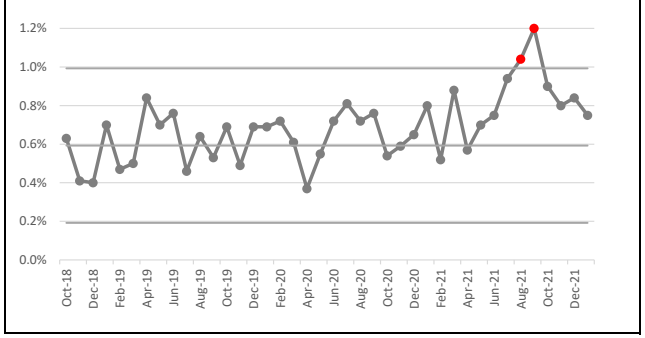


Trust Integrated Performance Dashboard - SPC Charts - Workforce

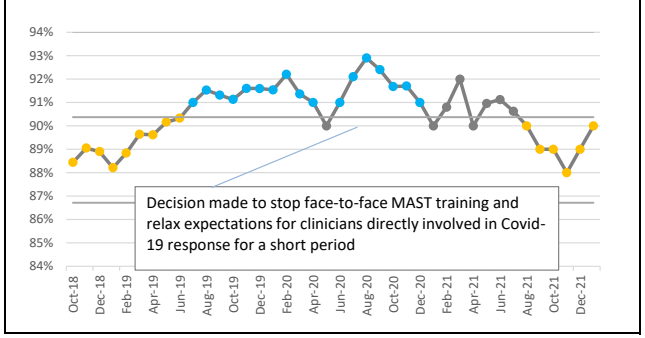
Sickness (%)



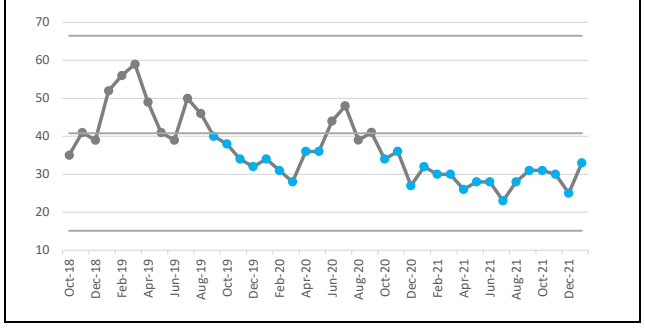
Turnover (%)



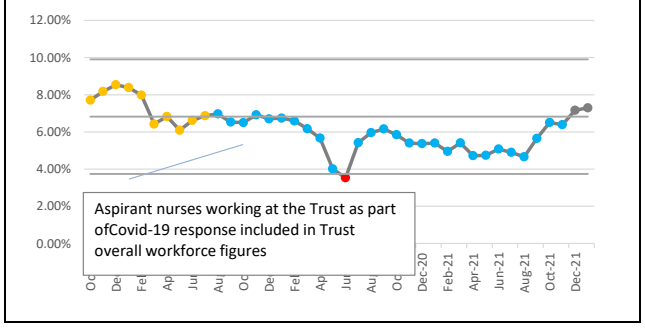
Mandatory and Statutory Training (MAST)



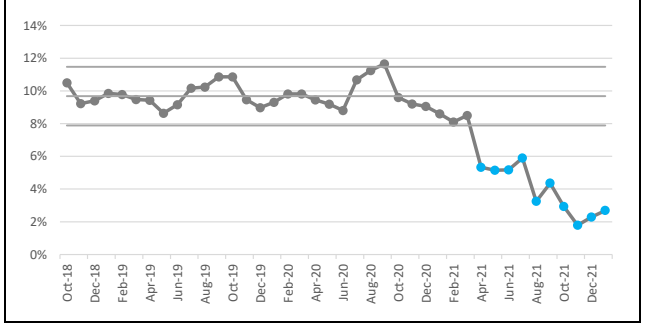
Time to Recruit - days



Vacancy Rate (TOTAL)



Vacancy Rate (Nursing)



Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Daily staffing -actual trained staff v planned (Days)	88.00%	88.25%	86.51%	87.67%	89.80%	85.40%	82.55%	84.17%	87.39%	85.51%	86.74%	89.65%	87.75%
Daily staffing -actual trained staff v planned (Nights)	87.21%	85.24%	85.30%	88.23%	87.10%	89.95%	86.37%	83.00%	83.93%	82.94%	86.32%	87.50%	87.06%
Daily staffing - actual HCA v planned (Days)	101.69%	102.86%	105.41%	111.97%	129.70%	108.39%	104.30%	103.18%	100.43%	99.16%	101.90%	94.90%	90.63%
Daily staffing - actual HCA v planned (Nights)	99.1`%	1.0071	120.72%	108.47%	113.20%	105.09%	101.02%	101.69%	98.49%	89.90%	95.29%	90.95%	89.28%
Care Hours per Patient per Day (CHPPD)	6.3	7.2	7.5	8.2	7.9	7.1	6.6	6.6	6.7	6.5	6.4	6.5	6.2

Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- Site pressures increased significantly in the second half of December and through January, in large part due to the Omicron variant peak occurring in Rotherham, with 80-110 Covid-19 positive inpatients for a more-than three week period. UECC Attendances over the latest two-month period were back to 2019/20 levels (100%), but admissions were significantly above pre-Covid levels, at 109% of 2019/20 volumes.
- The number of super-stranded patients (21 day+ length of stay) rose significantly during January, and remained high throughout the month, only falling in mid-February. Some of the challenges arose from significant proportions of care home beds being closed for IPC reasons, with 33 care homes in Rotherham closed to new patients at certain points in January.
- The increased challenges with flow through the organisation led to another difficult month in December regarding ambulance handover delays over 60 minutes, with over 300 'black breaches' in the month, but this reduced to its lowest level since June 2021 in January, with 100 of these recorded delays. The number of patients waiting 12 hours in department also reduced considerably, down to just over 500 in January, from the peak of over 750 in November. This will be a key focus for the Trust moving forward given the new national expectations around this metric.
- These figures demonstrate the intense challenges experienced in the Trust in this month, through the combination of high demand at the front door, the ongoing need to cohort Covid-19 patients appropriately and high levels of staff sickness due to the prevalence of Covid-19 in the community.

Elective Care

- The size of the waiting list has increased further, with the total growth now at over 30% over this year. Despite the increase in the number of patients waiting, the RTT position has deteriorated significantly, driven in part by capacity challenges within a few of the larger specialties. However, the most significant impact has come from the closure of our orthopaedic elective ward for a further 7 weeks (following the closure in November) and a reduction in the number of general elective beds. This was driven by the level of emergency demand which required us to convert these beds into non-elective capacity. Inpatient activity has fallen to just over 70% of 2019/20 levels for the latest 3 months

of activity, reflecting this switch in our capacity. With the closure of the elective beds, we have now seen an increase in the number of 52+ week waiters for the first time in almost a year since the peak in February 2021. Our elective beds have now re-opened (as of 21st February 2022) and teams have put plans in place to ensure as many as possible of these long-waiting patients are treated by the end of the year.

Cancer

- Following a reduction in the size of the Cancer Patient Tracking List (PTL) through December, it has gradually increased since then, to the highest level since November 2020. This has been driven by increases in the Upper GI and Skin PTLs, with Lower GI also increasing following the recent significant reductions.
- 62-day performance was well below the national standard again despite improving on the prior month, with 20.5 breaches in the month (of which 8.5 were in Urological cancers and 4 in Lower GI). We continue to see more patients waiting longer for their treatment due to being unfit, or due to poor engagement in their pathway. The additional time added to pathways due to IPC controls is also lengthening pathways, but the implementation of the UKHSA guidance in the next few weeks should immediately reduce some pathways by 3-6 days. The re-introduction of the straight to test pathway in Lower GI has supported a significant improvement in Faster Diagnosis Standard (FDS) performance throughout Q3, with the Trust now ranking 20th of all trusts for FDS, compared to 3rd quartile performance just a few months earlier.

QUALITY SUMMARY

Mortality

- The latest Dr Foster data has now been updated to September 2021. As per the previous position, the HSMR is currently within the 'above expected' category. However, when all Covid-19 activity is excluded from the HSMR, the figure falls to 101.5, well within the 'as expected' category. This significant difference in index score demonstrates the impact that Covid-19 is having on our mortality indicator, and given the unprecedented nature of such a pandemic, it is helpful to consider multiple mortality indicators at this time, whilst the mortality models continue to be adapted. The in-month HSMR for September 2021 was 104.1 statistically within the 'as expected' band.
- Crude mortality was 3.1% over the 12-month period, compared to 3.3% regional average (acute, non-specialist Trusts) and 3.2% nationally (acute, non-specialist).

Patient Safety

- There were 6 incidents deemed to be severe or above in January, and these have all been investigated at Harm Free Care and Serious Incident (SI) panels as appropriate. Staffing levels have been significantly affected over the last two months due to the Covid-19 pandemic, which may be a contributory factor to the increase in the number of falls seen in these two months. There was an increase in the total number of patient harms reported, but with 95% of these considered to cause either low harm or no harm.
- The Trust failed to meet the national Venous Thromboembolism (VTE) assessment target for the third consecutive month, and this is being addressed with the relevant specialties via their Clinical Leads.
- Complaints per 10,000 contacts increased significantly in January, although a number of these related to December 2021 activity, with visiting restrictions being one of the main issues identified. However, Friends and Family Test (FFT) results continued to be positive, with all scores well above the national target.
- Care Hours per Patient Day continued to be well below the benchmark, with a noticeable deterioration in unregistered fill rates over the course of this year. This is being addressed through recruitment of additional HCAs, with a new international nursing campaign also due to start in the coming months. The prevalence of Covid-19 in the community led to much higher staff sickness rates, which affected our ability to fill all shifts as planned. It is anticipated that this will improve in February now the infection rate is much lower.

Maternity

- Maternity performance saw a further improvement in 1:1 care in labour and the rolling stillbirth rate. Whilst there was a deterioration in the emergency Caesarean-section rates, the recent Ockenden report has led to this target being removed from the national standards, in order to ensure the clinical assessment of risk to pregnant ladies is not inappropriately driven by this target. Moving forward therefore, this indicator will no longer be RAG-rated within our report.
- CNST Update – The Trust has recently received notification that we have received the discretionary payment for year 3 and year 4 is currently paused but we continue to work towards all 10 safety actions.
- Ockenden – An initial report has been received from the national team regarding our submission, and an action plan is in the process of being developed by maternity services as a response to this preliminary feedback. The Board of Directors was updated on this progress in February.

WORKFORCE SUMMARY

Recruitment and Retention

- The Trust welcomed over 67 WTE in January 2021, with Corporate Operations and the Division of Surgery seeing the highest number of new starters in the month. These Trust figures included 11 new Nursing & Midwifery colleagues.
- Total Trust turnover rate was at 10.8% which is a 2.35% increase on January 2021. Turnover was particularly high within the Medical and Dental staff group, at 1.77% in December, compared to 0.68% nationally (latest comparative benchmarking data). However, the Nursing and Midwifery turnover rate remained relatively low at 0.89% in-month, with the number of nursing vacancies rising slightly in-month (although note that this includes a number of candidates going through the external recruitment process and awaiting PIN numbers).
- Of the 37 leavers in January, 10 colleagues left for reasons relating to relocation.
- There were promotions for over 40 WTE in-month, with more than 11 WTE relating to band 6 clinical staff. This will support our efforts to 'grow our own' and retain and develop our most talented colleagues with the greatest potential.

Sickness

- The monthly sickness rate increased significantly in December and January, to 9.13% in the latest month, well above the Trust target of under 4%. This trend was driven by an increase in short-term sickness, with Covid-19 sickness absence the primary driver of the sudden increase. Sickness absence was high across all divisions, although UECC saw the highest in-month figure of 12.2%, followed by the Division of Medicine at 10.8% and the Division of Surgery at 10.6%.
- 12-month rolling sickness rate is now up to 6.4% compared to 5.2% a year ago. Covid-19 sickness accounts for approximately a fifth of the current sickness absence, so excluding Covid-19 sickness, the Trust is still experiencing sickness rates well above pre-pandemic levels.

Appraisals and Mandatory Training

- Overall appraisal compliance rate is now at 82% which is a 1% decrease on prior year and the previous month. All divisions are below the Trust target of 90% excluding the Division of Surgery, who achieved the Trust target at the end of November. Divisions continue to focus on ensuring that colleagues are released to conduct their appraisals, and that the relevant information is recorded onto the system.
- Core Mandatory and Statutory Training (MaST) is above the Trust target at 90%, which is an improvement on the previous month's performance. All Divisions with the exception of Medicine are above the Trust target for both

core and job-specific MaST combined together. Compliance amongst Medical and Dental staff has increased significantly from previous months and is now above the Trust target at 85.6%; however, only 84.6% of Nursing & Midwifery colleagues are now compliant with their mandatory training requirements.

- Safeguarding Adults Level 3 (25%), Mental Health 1 year (53%) and Medicines Management (64%) remain key focus areas for improvement.

FINANCE SUMMARY

Income & Expenditure (I&E)

- The Trust month 10 financial report shows a slight deterioration in I&E performance in the month and year to date against the plan, with a still positive forecast variance for the year-end against the H2 2021/22 financial plan. The control total is what the Trust's performance is measured against with NHSE/I, having adjusted for depreciation on donated assets. The Trust is now reporting a £1,290k surplus to plan year-to-date, with a forecasted surplus of £1,683k by the end of the year.
- Cost Improvement Programme performance showed over-delivery in-month and the year-to-date positive variance to plan of over £800k has led to a forecast £700k over-deliver of CIP schemes against plan, based on the risk-adjusted schemes identified.
- However, a significant amount of this in year delivery is non-recurrent in nature, which will lead to ongoing cost containment challenges in 2022/23, especially given the financial pressures anticipated next year.
- Pay over-spent in month by £170k, with a substantial under-spend on substantive staff (£437k) but this was more-than-fully offset by increased expenditure on temporary bank and agency staff costs (£607k).
- The Trust is currently forecasting a surplus to plan of over £1,680k for the financial year 2021/22. Within this forecast is an assumption that pay costs will overspend significantly, with a forecast improvement in recruitment to substantive staff, but also an increased reliance on agency staff within medical and nursing staff groups.

Capital Expenditure

- Financial results for the first ten months of the 2021/22 financial year show expenditure of just under £5.1m year to date, representing an under-spend of approximately £4.9m year to date against plan. However, the forecast out-turn position shows a recovery of this compared to plan, with an under-spend of just over £1.4m by year-end. An under-spend of approximately £1m is required as the Trust's contribution to an SYB ICS potential over-commitment.
- There are a number of large and significant capital schemes planned for the last two months of the year which will lead to an increase in the run-rate. These include the purchase and installation of a new MRI scanner, ward refurbishment to allow for increased and more flexible elective bed capacity

and End User Device Refresh implementation.

Cash Flow

- The Trust's underlying residual cash position is still strong, when compared to the same position last year. However, due to the various uncertainties that have arisen since the plan was produced for H2 2021/22, it is highly probable that there could be significant changes (both positive and negative) that could impact upon the closing cash position, which at this stage are very difficult to forecast.
- However, the large capital schemes still to be delivered will drive up commitments in the latter months of the year, with a further £8,599k still to be incurred, although at this stage it is unclear how much will be paid in cash before 31st March 2022.

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P50/22
Report	**Reset and Recovery Operational Report**
Executive Lead	George Briggs, Chief Operating Officer
Link with the BAF	B1 and B2: Risk scores have remained static from the previous quarter based on the Trust receiving increased pressure from admissions and activity showing the operational activity is off course with national standards.
How does this paper support Trust Values	Ambitious: Ensuring the Trust is delivering high quality services Caring: Ensuring patients are seen within the appropriate time frames Together: Working collaboratively with partners to achieve standards
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	This report is presented to the board for information regarding the recovery actions and plans to deliver elective activity and emergency care during the ongoing phases of the pandemic and resulting challenging circumstances: • Updates on the recovery actions underway. • Provides an update on the Rotherham NHS Foundations Trust's (TRFT`s) response to the recovery from the effects of the Covid-19 pandemic • Describes the activity and actions the Trust has taken to deal with the pandemic, up to the month of January 2022.
Due Diligence (include the process the paper has gone to prior to presentation at FPC Meeting)	This report is taken from the daily dashboard, the monthly IPR and the regional updates, and the notes from the monthly recovery meetings
Board powers to make this decision	The Board has delegated authority to FPC to review and feedback to the board any assurance issues, and breaches in SO, SFIs, scheme of delegation etc.
Who, what and when (what action is required, who is the lead and when should it be completed?)	A monthly report is provided to the Finance and Performance Committee and to the Board of Directors and any actions required are the responsibility of the Chief Operating Officer with support from colleagues.
Recommendations	It is recommended that: The Board of Directors note the report.
Appendices	1. Operational update

Appendix 1

1.0 Introduction

1.1 This paper covers key operational indicators, an overview of Covid-19 related issues and the recovery plans as of January 2022.

1.2 Recovery has recommenced since the high numbers of positive Covid-19 inpatients started to settle from January 22 this has shown a slow improvement over the last few weeks.

1.3 Recovery plans have been submitted to the CCG and ICS in November 21.

1.4 The elective wards and surgical wards have been open and ring-fenced for elective patients, during the first half of this year. At times we have cancelled elective activity and utilised Keppel ward for non-electives. During December – January we had 3 elective wards which were utilised for Covid positive and resolved patients we are maintaining a reduced elective program.

1.5 Covid numbers of inpatients has flexed daily varying from 70 in June to 60-70 in November 21. And back up to over 100 in January.

1.6 Critical care have been under increasing pressure with numbers regularly going above funded beds TRFT has reported Critcon 1 (the network norm is level 0) consistently over the last 3 months. The number of available ICU beds has affected our elective capacity due to numbers of Covid and level 3 patients and staffing levels.

2.0 Recovery

2.1 The national and regional teams have implemented a recovery program, the CEO`s across the North East and Yorkshire were invited to a recovery forum led by Sir James Mackey “this North and East Yorkshire Recovery Taskforce”.

2.2 The key challenges and opportunities as identified by the regional team are detailed below:

- Without additional action, the overall waiting list size will continue to increase, as will the number of 52 and 104 weeklong waiters.
- The scale of the recovery challenge in each provider is different, with some providers experiencing much greater mismatch in capacity and demand than others.
- A significant part of the elective recovery challenge (including long waiters) is not about inpatient capacity, but about non-admitted pathways. The biggest volumes by specialty are in orthopaedics; ENT, ophthalmology and “other.”
- The data also identifies further potential opportunities to accelerate elective recovery

2.3 The Trust has been working on our internal recovery as below:

- Benchmark IPC practice as a Trust and as a region to make sure it is applied safely & consistently.
    - Review IPC / testing guidance for patients attending appointments.
- Opportunities to reduce DNA rates.
    - Utilising net call and patient initiated follow up.
- Increase day case activity

- Increase outpatient procedures.
- Waiting List Management - Longest Waits; Validation; RTT performance – an organisational focus on very long waits,
- Revisiting waiting list validation and clinical prioritisation of the list.
- Collaboration on Fast Track High Volume Pathways for Non-Admitted & Admitted – SOP in place and weekly mutual aid meetings.

3.0 Referral to Treatment October data

3.1 Referral to Treatment performance had improved between January to July 84.7% against the 92% standard. Since then we have seen a gradual levelling off performance with: - January 77.2% (Sept 82.5%)

- Total incomplete PTL size 22333
- (20478 November 21)
- 48x 52 breaches for incompletes (67 in September 21)

3.2 The specialty detail below shows delivery in 4 specialties.

Incompletes Performance

SpecialtyGroup	<18	>=18	Total	%
Cardiology	1146	235	1381	83.0%
Dermatology	1424	115	1539	92.5%
Ear, Nose & Throat	1666	1143	2809	59.3%
Gastroenterology	959	316	1275	75.2%
General Medicine	251	56	307	81.8%
General Surgery	1618	432	2050	78.9%
Geriatric Medicine	209	3	212	98.6%
Gynaecology	1508	489	1997	75.5%
Ophthalmology	2179	294	2473	88.1%
Oral Surgery	8	5	13	61.5%
Rheumatology	578	405	983	58.8%
Thoracic Medicine	898	139	1037	86.6%
Trauma & Orthopaedics	1545	691	2236	69.1%
Urology	1027	234	1261	81.4%
X01 - Clinical Haematology	179	16	195	91.8%
X01 - OMFS	1392	479	1871	74.4%
X01 - Paediatric	543	19	562	96.6%
X01 - Paediatric Cardiology	64	25	89	71.9%
X01 - Rehabilitation Medicine	40	3	43	93.0%
Total	**17234**	**5099**	**22333**	**77.2%**

3.3 The Trust has previously utilised the independent sector in H1 now that H2 funding has become available we are struggling getting capacity from the IS in South Yorkshire.

3.4 Over the previous 2 months we have gradually reduced our elective capacity reducing our ring-fenced elective ward capacity to support Covid and complex medical patients, the elective orthopaedic ward is due to come back online in February. We have achieved the plan to reduce the number of patients waiting more than 104 weeks to zero by March 22. 52 weeks is required to be at zero by the end of March 2023 we set a local target to hit this by April 22 we will not achieve this TRFT target.

3.5 The waiting list had grown to approximately 22,300 patients as of the end of January, compared to the 17,000 patients waiting at the end of April 21. There has been a noticeable increase in referral volumes since March 2021, which explains some of this waiting list pressure, for most specialties, OP activity is now close to 2019/20 volumes, which means this continued growth in the waiting list is linked to capacity. Demand and capacity plans have been submitted by all divisions, and overall activity plans submitted week of 15th November 21.

3.6 Within the waiting list are a number of very long-waiting patients, with divisional teams continuing to focus on bringing these patients in for treatment despite the ongoing capacity challenges. We aim to maintain zero 104 week waits and reduce our long waits

3.7 The recovery trajectories are monitored on a weekly and monthly basis, at the divisional Recovery Meetings. Operational teams continue to focus on ensuring clinically prioritised patients are treated within the appropriate timescales, and that long waiting patients are given treatment dates as soon as possible.

3.8 The present number of Complex delayed discharges, patients over 21 days has compromised capacity across the main wards, this has remained stubbornly high at around the 60 patient mark linked to community capacity brokerage and post Covid access.

3.9 The Delivery plan for tackling the Covid -19 backlog of elective care has been published on the 8th February 2022 we will process the requirements and formulate a operational response linked to the latest elective recovery support guidance (22nd February 22).

4.0 Cancer Recovery Performance

4.1 2 week waits (ww) numbers are on plan at 94% and 95% and on track to be sustained against a 93% target.

4.2 2ww breast is improving with Q3 on target despite November provisional figures.

4.3 Referral volumes are above the previous year's numbers, services have to manage more patients with restricted capacity, as well as patient engagement challenges and infection prevention and control measures.

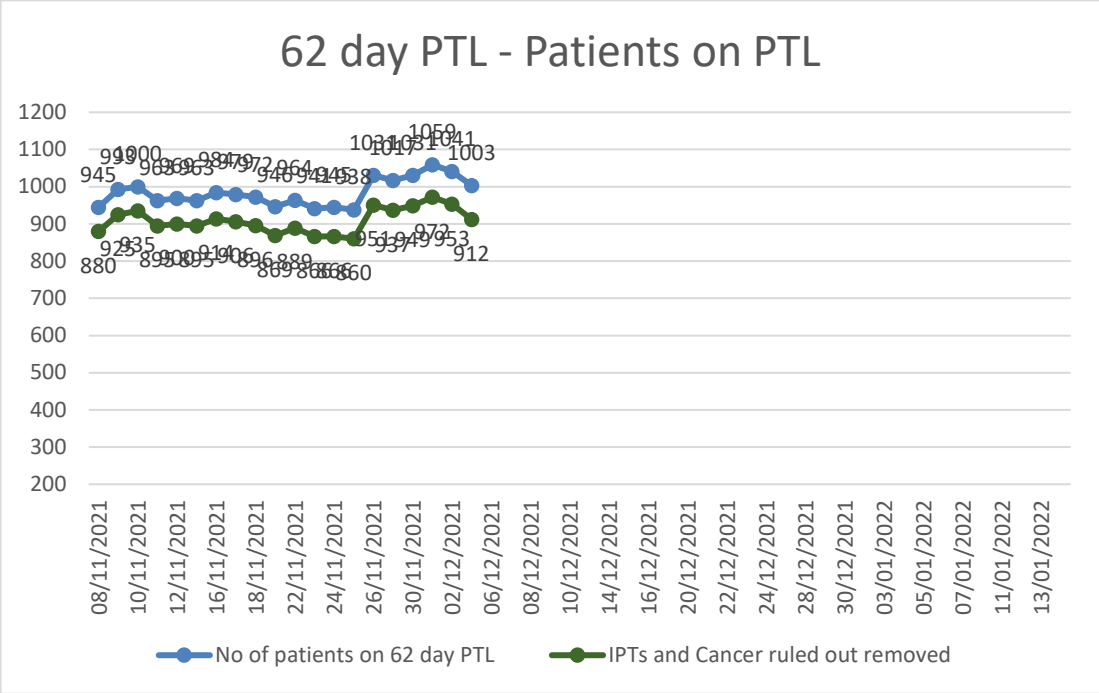
4.4 Existing performance improvement forums, including fortnightly Cancer Recovery meetings with operational teams and the monthly joint CCG and Trust Cancer Strategy & Improvement Committee are providing focus on the recovery plans.

Target	Operational Standard	Sep 2021 Final figures	Oct 2021 Provisional figures	Nov 2021 Provisional figures
2ww	93%	92.3%	94.2%	95.1%
31 Day First Definitive Treatment	96%	95.7%	96.9%	96.2%
62 Day from 2ww	85%	67.0%	76.1%	67.3%
Breast Symptoms 2ww	93%	96.2%	94.7%	84.8%
31 Day Subsequent Treatment				
Surgery	94%	100.0%	90.9%	100.0%
Drug	98%	100.0%	100.0%	100.0%
62 Day Screening	90%	87.5%	100.0%	100.0%
62 Day Consultant Upgrade	TBC	88.1%	85.7%	81.7%
28 Day Faster Diagnosis Standard	75%	71.0%	73.0%	76.4%

4.5 The faster diagnosis standard has a target of 75%, which as can be seen we are above for the November data although this un-validated Q3 is circa 74.3%.

5.0 Cancer 62-day focus

5.1 The Trust is achieving 70% in Q3 (indicative) which shows a deterioration in performance since Q1. Linked to high referrals reduction in capacity due to Covid and sickness and absence in key pathways, the key areas of failure are Head and neck GI and Urological pathways.



5.2 The numbers of patients on the PTL saw a hike over a number of days in late November the highest number for a while.

6.0 DM01 Performance

6.1 DM01 diagnostic performance had been a marked challenge throughout the pandemic. But showing positive improvements. I believe we will be on target ahead of the 22/23 national proposal.

- The formal performance is 9.38% (11.11% December 19.1% September) against a pre pandemic performance of under 1% this is a very slowly improving position.

- 256 breaches (September 930 breaches)

Diagnostics (DM01) - Patients Still Waiting at Month End
January 2022

Category	Investigation	<6 weeks	≥ 6 weeks	Performance (% breaches)	Total WL
Imaging	Magnetic Resonance Imaging	182	87	32.34%	269
	Computed Tomography	304	135	30.75%	439
	Non-obstetric ultrasound	720	0	0.00%	720
	Barium Enema	0	0		0
	DEXA Scan	71	0	0.00%	71
Physiological Measurement	Audiology - Audiology Assessments	296	26	8.07%	322
	Cardiology - echocardiography	101	0	0.00%	101
	Cardiology - electrophysiology	0	0		0
	Neurophysiology - peripheral neurophysiology	0	0		0
	Respiratory physiology - sleep studies	98	5	4.85%	103
	Urodynamics - pressures & flows	1	0	0.00%	1
Endoscopy	Colonoscopy	184	2	1.08%	186
	Flexi sigmoidoscopy	77	0	0.00%	77
	Cystoscopy	39	0	0.00%	39
	Gastroscopy	276	1	0.36%	277
	Total	2349	256	9.83%	2605

6.2 Key areas of compromised performance are

- Magnetic Resonance Imaging MRI additional Mobile days have not been available from the company Initially from July 21 now likely February 22 which means we will not recover until after May 22
- Respiratory Physiology on track to achieve in April 22 (initially January 22)
- Audiology assessments improved month on month plan to hit standard end May 22

6.3 The biggest area of concern is MRI with plans having to be reviewed, we should have had seventeen additional mobile days per month, and unfortunately, we have not seen the additional days so far due to national demand. Capital funding for a second MRI scanner has been included in the capital plans, which will support the sustainability of this service in the longer-term, especially given the breakdowns which continue to occur on the existing scanner.

6.4 Alongside this, our sleep study service saw a rapid growth in the waiting list and the backlog during Covid, due to the IPC guidance around Aerosol Generating Procedures (AGPs). Capacity has been increased recently and new referral guidelines have been agreed with primary care performance has improved from 20% to 5% in the last 2 months.

7.0 Emergency performance

7.1 The care of our elective and emergency patients is balanced between demand capacity and available resources we are reviewing emergency performance on a daily basis with performance remaining complex. Attendances have varied across SYB and we are now seeing high numbers of Yorkshire ambulance dispositions with up to 20% increases in category 1 (complex patients). Admissions have been increasing across SYB with Mondays proving very difficult. The pattern has also changed with lots of walk-in and minors patients attending in the afternoon this has manifested in very high numbers of patients in the UECC on numerous occasions over 100 in the evening. These numbers of patients are continuing to overwhelming the UECC staff, and causing concern and an inability to manage patients in a timely way. This is a national issue and not specific to TRFT although the long waits in UECC are some of the longest nationally.

7.2 Linked to the above, a shortage of middle grades and inexperienced junior doctors initial assessment times have deteriorated. Times to see a clinician are variable and have deteriorated, whilst overall time in the department has deteriorated (although we saw an improvement in January). Ambulance handover have deteriorated across South Yorkshire. TRFT has shown a consistent improvement in handovers and are no longer considered of concern from NHSEI and YAS.

7.3 There continues to be a marked increase in the number of long stay patients which is an indication of reduced capacity in non-acute settings to support patients to return to their usual place of residence. This then contributing to a restriction in flow through the emergency pathway. We are reporting up to 90 (60 in November/ December) long length of stay patients over 21 days with half of these awaiting social service support from packages of care to community beds (this time in 2019 it was 35). Early indications show a very slight improvement in February with care homes opening post Covid and packages of care remaining compromised.

7.4 Please find below the latest data.

	Rolling	Time to Initial Assessment (Mins)	Time to be seen by a Clinician (Mins)	Mean Total Wait (Mins)	12hrs in Department
Standard		**15**	**60**	**200**	**0**
Pre-Field Test (6wks)		**15**	**93**	**189**	**3 (per day)**
Thu	**20/01/2022**	19	183	321	7
Fri	**21/01/2022**	14	117	232	1
Sat	**22/01/2022**	19	139	300	6
Sun	**23/01/2022**	24	170	328	14
Mon	**24/01/2022**	31	201	365	30
Tue	**25/01/2022**	31	219	371	30
Wed	**26/01/2022**	21	197	348	15
	Rolling 7 Days	**23**	**175**	**324**	**103 (15 per day)**
Year to Date (21/22)		**23**	**157**	**302**	**16 (per day)**

May 21	**18**	**131**	**246**	**2 (per day)**

7.5 As above, the deterioration across all indicators since May 2021 is more marked in long 12 hour waits in UECC. Averaging 16 patients per day at 12 or more hours in the department. It is worth mentioning that as an organisation we no longer discharge or admit at 4 hours which compromises the overall number of long waits as we purposefully aim to review get results and commence treatment within the UECC often patients wait until this is complete before discharge or admission, we often keep patients in UECC overnight before discharge with transport as a example. Other organisations utilise clinical decisions units for these patients TRFT does not have a CDU.

8.0 Conclusion and winter update

8.1 The recovery of performance was fairly rapid initially during the first half of the year with an accelerated performance in June – July. The developments in the last months shows a reduction in RTT. Linked to no acute elective capacity on the hospital site.

8.2 Trauma and Orthopaedics are planning to recommenced elective activity at the end of February 22. This remains at considerable risk due to emergency demand and the next phase of the Covid Omicron variant.

8.3 Whilst we had planned to retain our ring-fenced orthopaedic ward over winter, non-elective pressures at the start of winter made it impossible to maintain the ward, we have recently reopened it to elective patients and are attempting to maintain that stance over the next 3 months. We have also enacted the additional second phase of winter beds by utilising beds on B10 (decant facility).

8.4 DMO1 performance has shown a remarkable improvement thanks to the CSS team and particularly cardiac echo, MRI and respiratory improvements.

8.5 Emergency performance had deteriorated markedly and has necessitated command and control with some improvements in flow. Ambulance dispositions and UECC attends are moving to a later period in the day putting pressure on the departments evening resources and creating long waits overnight. We are now looking at additional private sector community beds, to help reduce the complex patients with no right to reside, partnership working across the place is vital to get TRFT through the next few months.

8.6 This performance continues to show an organisation and a department under increased demand and stress with flow across the organisation compromised at key times of the week.

8.7 As a Trust we pre-emptively moved to a command and control footing with daily operational meeting and three times a week strategic gold meetings, these are easing in February but we are still planning for staffing shortages and additional capacity requirements specifically in Critical Care.

George Briggs
Chief Operating Officer
February 2022

Board of Directors' Meeting
04 March 2022

Agenda item	P51/22
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	B8 and B9: This report provides assurance regarding the financial results for April 2021 to January 2022 of the financial year 2021/22 against the Trust's approved financial plan for its income and expenditure account and capital programme, together with an update on cash management. A forecast out-turn position is provided up to the end of March 2022 on all of these areas.
How does this paper support Trust Values	This report supports the Trust's core values – (A)mbitious, (C)aring and (T)ogether by specifically focussing on two strategic themes: (a) Governance: Trusted, open governance: • Have an effective performance framework to help deliver outstanding results; • Be outstanding on the Care Quality Commission "well-led" framework across the Trust; • Have high quality data to provide robust information and support key decision making; • Ensure all teams have regular reviews and updates around key issues and opportunities to learn. (b) Finances: Strong financial foundations • Manage within approved budgets at all times; • Improve our efficiency and productivity and invest in our estates and facilities; • Use our money and resources wisely – only spend what we can afford.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This detailed report provides the Board of Directors with an update on: • Section 1 – Financial Summary in month and year to date – April 2021 to January 2022: o A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management.

	• Section 2 – Income & Expenditure Account in month and year to date April 2021 to January 2022: o Financial results for the first ten months of the 2021/22 financial year. - A deficit to plan of £264K in month and £1,290K surplus to plan year to date; - A similar deficit to the (external) control total in month and £1,289K surplus year to date. This external control total performance is calculated after adjusting for depreciation on donated assets - £37K in month and £371K year to date, which does not form part of NHS funding. o A forecast out-turn position for the financial year showing an under-spend against plan of £1,683K (£1,684K against the external control total). • Section 3 – Capital Expenditure 2021/22 o Financial results for the first ten months of the 2021/22 financial year show expenditure of £542K in month and £5,069K year to date representing an under-spend of £918K in month and £4,899K year to date respectively against plan. o A forecast out-turn position for the full financial year is showing an expectation of delivering total expenditure of £13,668K leading to an under-spend of £1,415K. An under-spend of c. £1,000K is required as the Trust's contribution to an SYB ICS initial over-commitment of £12,400K. • Section 4 – Cash Flow 2021/22 o A cash flow statement for the first ten months of the 2021/22 financial year showing a decrease in cash of £99K to a closing balance of £30,811K as at 31st January 2022. o An indication of forecast cash balances for the remainder of the financial year 2021/22 showing a further decrease in cash of £15,859K to a prudent closing balance of £14,952K as at 31st March 2022.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report to the Board of Directors has been prepared directly from information contained in the Trust's ledgers and is consistent with information reported externally to NHSE/I. o The overall financial positions for Income and Expenditure (I&E) (both actual and forecast out-turns) have been reviewed collectively by and agreed with the senior Finance Team together with the Director of Finance. o Cost Improvement Programme (CIP) performance has been discussed with the CIP (Efficiency) Board chaired by the Deputy Chief Executive.

	o The capital expenditure positions (both actual and forecast out-turns) have been discussed and reviewed by the Capital Planning & Monitoring Group, chaired by the Director of Finance. o A more comprehensive and detailed report of the financial results in month, year to date and forecast out-turn has been presented to Finance & Performance Committee. o A summarised position of the information contained in this report has also been presented to the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*
Who, What and When (What action is required, who is the lead and when should it be completed?)	No action to be taken given the overall satisfactory position being reported year to date and forecast out-turn positions in line with or better than plans.
Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	1. Income & Expenditure Account Analysis for Month 10 2021/22 (January 2022) 2. Income & Expenditure Account Analysis Forecast Out-Turn Position for the Financial Year 2021/22 3. Capital Expenditure for the Ten Months Ending 31st January 2022 4. Capital Expenditure Forecast Out-Turn Position for the Financial Year 2021/22 5. Cash Flow Statement for the Ten Months Ending 31st January 2022

1. Key Financial Headlines

1.1 The key financial metrics for the Trust are shown in the table below. These are:

- Performance against the monthly income and expenditure plan;
- Capital expenditure;
- Cash management.

Key Headlines	Month P £000s	Month A £000s	Month V £000s	YTD P £000s	YTD A £000s	YTD V £000s	Forecast V £000s	Prior Month FV £00s
I&E Performance (Actual)	(79)	(343)	(264)	(539)	752	1,290	1,683	1,834
I&E Performance (Control Total)	(42)	(306)	(264)	(166)	1,123	1,289	1,684	1,835
Capital Expenditure	1,460	542	918	9,968	5,069	4,899	1,415	1,553
Cash Balance	0	2,734	2,734	1,357	30,811	29,454	14,952	14,952

1.2 There is a deterioration in Income and Expenditure (I&E) performance in month and year to date against the plan but still with a very positive forecast variance for the year-end having released £1,000K from contingency, which is still deemed to be prudent by the Director of Finance. The control total is what the Trust's performance is measured against with NHSE/I, having adjusted for depreciation on donated assets.

1.4 Capital expenditure is behind plan at present, both in month and year to date. In month is being influenced by a further £404K capital to revenue transfers adding to the £841K transacted in the prior month. This is being transacted in order to reduce the level of excess I&E reserves and minimise the impact upon capital charges going forward. A significant amount of expenditure still has to be incurred in the final two months of the financial year - £8,599K or 57% of the overall annual programme if the Trust is to deliver its planned year-end under-spend of £1,415K.

1.5 The cash position year to date is still very strong and is forecast to remain as such during the remainder of H2 2021/22, despite a planned reducing cash balance throughout the remaining two months.

2. Income & Expenditure Account

2.1 Financial Performance for the Ten Months Ending 31st January 2022

2.1.1 Appendix 1 shows the in-month and year to date position. The overall position at Month 10 is an in-month deficit to plan of £264K and a year to date surplus to plan of £1,290K.

2.1.2 Clinical income has remained consistent with the plan in month. Cumulative year to date over-performance is mainly driven by the funding for national pay awards that was accrued at the end of September 2021 and not previously budgeted for, which was paid by commissioners in October 2021. Income is forecast to improve throughout the remainder of the financial year, with improved recovery of costs associated with excluded drugs recharged to commissioners.

2.1.3 Other operating income is above plan in month, with the major variance being on education and training (+£73K) and staff recharges (+£97K), with the latter being a direct offset to pay expenditure. This is being offset by reduced income from car parking charges (-£28K) and non-clinical non-SLA income recharges (-£26K). Year to date is a mixture of over and under performance on various line items but is predominantly related

to the two same issues being over-recovered by £369K and £571K respectively. The further improvement in the forecast out-turn position reflects similar movements.

2.1.4 Pay is over-spending in month by £170K, with a substantial under-spend on substantive staff (£437K) being more than offset by increased expenditure on temporary bank and agency staff costs (+£607K). This is similar to the year to date position, which is being skewed by the over-commitment on reserves during September 2021 to fund previously unbudgeted national pay awards. This over-spend is forecast to stabilise over the remainder of the year with a reduced reliance on temporary staff costs as COVID-19 related absences continue to decrease.

2.1.5 Non-Pay costs are over-spending against budget in month by £444K, which is being primarily driven by increased costs for clinical supplies (+£164K) and premises costs (+£176K). The year to date overspend includes the aforementioned items collectively @ £1,651K. Expenditure in the final two months of the year is forecast to be managed more or less within budget.

2.1.6 Non-Operating costs are under-spending in month and year to date, relating to reduced depreciation charges and PDC dividends payable due to continued slippage on the Trust's capital programme. This is replicated in the year to date performance.

2.2 Financial Performance Forecast Out-Turn Position for the Financial Year 2021/22

2.2.1 Appendix 3 shows the forecast out-turn position. The Trust is currently forecasting a surplus to plan of £1,683K for the financial year 2021/22, which still represents a prudent position when considering the values remaining in reserves and contingency.

2.2.2 Clinical income is showing an improvement in performance for Months 11 and 12 due to increased recovery of costs for excluded drugs. The Trust has set itself a zero budget for excluded drugs income in H2 2021/22 due to the variability of income receivable from commissioners (particularly NHSI) during H1 2021/22.

2.2.3 Other operating income is being bolstered by anticipated receipts for education & training (£135K) and increased income from staff recharges (£199K).

2.2.4 Pay costs are expected to remain more or less within budget during the remaining 2 months, although there is still an increasing reliance upon bank and agency staff.

2.2.5 Non-pay costs are similarly only expected to be marginally above budget during February and March 2022, with the impact of reserves helping to improve performance.

2.2.6 Non-operating costs assume depreciation charges in line with plan for the remainder of the financial year but a forecast reduction in PDC dividends payable further improving the forecast variance as at 31st March 2022, due to the significantly higher than planned cash balances currently being experienced.

3. Capital Programme

3.1 Capital Expenditure for the Ten Months Ending 31st January 2022

3.1.1 During January 2022 the Trust incurred costs of only £542K against a budget of £1,460K - an under-spend of £918K. This is due to a further £404K capital to revenue transfers to add to the £841K transacted last month. This has been agreed by the Director of Finance in order to reduce the level of excess I&E reserves and minimise the impact upon capital charges going forward.

3.1.2 Year to date the programme is still significantly under-spending by £4,899K, with a significant amount of expenditure still to be incurred in the final two months of the financial year - £8,599K or 57% of the overall annual programme if the Trust is to deliver its planned year-end under-spend of £1,415K.

3.1.3 The overall position is being closely monitored by the Director of Finance via the Capital Planning & Monitoring Group with the intention of trying to commit additional expenditure where it is reasonable and practical to do so, with guaranteed delivery and/or completion before 31st March 2022. Any under-spend represents a lost opportunity to the Trust as it cannot be carried forward across the financial year end, although as previously reported, the Trust is expected to deliver c. £1,000K under-spend, as requested by SYB ICS.

3.2 Capital Expenditure Forecast Out-Turn Position for the Financial Year 2021/22

3.2.1 As a result of the flood and subsequent fire at Doncaster Royal Infirmary, the SYB ICS has been told that it is required to meet the cost of the repairs from within its overall capital allocation across the system. At present, it is expected that the Trust will be expected to under-spend its capital envelope in the region of c. £1,000K, which is all being planned for in the figures reported.

3.2.2 Despite having now transferred £1,245K to revenue, the Trust is still only forecasting a year-end under-spend of £1,415K as additional expenditure has been approved against medical equipment (£467K) and information technology (£615K).

3.2.3 The late notification of PDC funding awards, with further amounts still expected, poses a serious risk to planning and delivering expenditure before the end of the financial year, with any under-spend above that currently being forecast representing a real terms decrease in the Trust's spending power as a result of the way national NHS capital controls are applied. Any increased under-spend will effectively represent a pre-commitment against available capital resources in 2022/23.

3.2.4 Overall performance is being managed on a monthly basis by the Capital Planning and Monitoring Group, which is already bringing forward priorities from 2022/23 to offset any potential slippage in 2021/22, as referred to above.

4. <u>Cash Management</u>

4.1 A cash flow statement for the first ten months of the financial year is included in Appendix 8 and shows a significant closing cash balance as at 31st January 2022 of £30,811K.

4.2 Net overall reductions in working capital have effectively reduced the overall cash balance in the first ten months by only £99K and hence, cash is much higher than was originally forecast. However, the cash balance will continue to reduce as financial provisions are released:

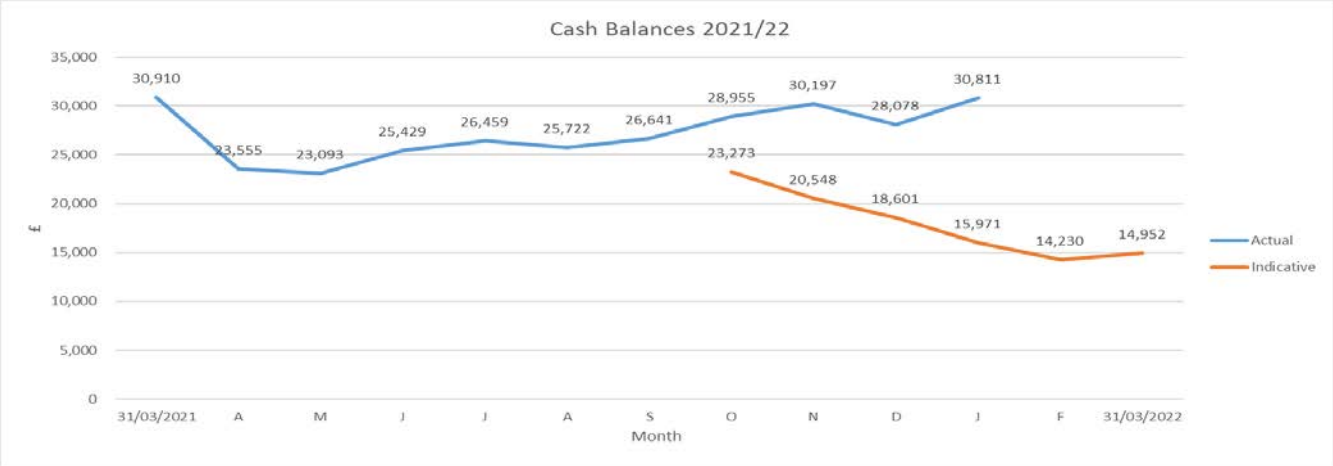
(a) Settlement of creditors, accruals and estimates made in year;

(b) Utilisation of deferred income balances that have arisen in year; and

(c) Release of reserves provided for during H1 2021/22.

4.3 Additionally, capital expenditure will significantly increase in the final two months of the year, with a further £8,599K still to be incurred, although at this stage it is unclear how much will be paid in cash before 31st March 2022.

4.4 The Trust's underlying residual cash position is still strong, when compared to the same position last year. However, due to the various uncertainties that have arisen since the plan was produced for H2 2021/22, it is highly probable that there could be significant changes (both positive and negative) that could impact upon the closing cash position, which at this stage are very difficult to forecast. However, the cash position is not expected to be any lower than that produced for the plan as shown in the graph below.



Steve Hackett
Director of Finance
21st February 2022

Appendix 1

Income & Expenditure Account Analysis for Month 10 2021/22 (January 2022)

Summary Income and Expenditure Position	AP	Month			YTD			21/22
		P	A	V	P	A	V	Monthly Trend / Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	
Clinical Income	301,811	27,172	27,194	22	251,266	254,294	3,029	
Other Operating Income	21,404	1,691	1,816	125	17,962	18,708	747	
Pay	(222,423)	(20,311)	(20,481)	(170)	(185,232)	(186,948)	(1,717)	
Non Pay	(86,902)	(7,385)	(7,829)	(444)	(72,435)	(74,065)	(1,629)	
Non Operating Costs	(14,587)	(1,246)	(1,043)	203	(12,099)	(11,238)	861	
RETAINED SURPLUS / (DEFICIT)	(697)	(79)	(343)	(264)	(539)	752	1,290	

Appendix 2

Income & Expenditure Account Analysis Forecast Out-Turn for the Financial Year 2021/22

Summary Income and Expenditure Position	AP £000s	21/22 FO £000s	21/22 FV £000s	M1-M6 AV £000s	M7-M10 AV £000s	M11-M12 FV £000s	21/22 Total FV £000s	21/22 Monthly Trend / Variance
Clinical Income	301,811	304,960	3,148	2,280	749	120	3,148	
Other Operating Income	21,404	22,454	1,050	183	564	303	1,050	
Pay	(222,423)	(224,210)	(1,787)	(1,622)	(95)	(70)	(1,787)	
Non Pay	(86,902)	(88,591)	(1,690)	(966)	(663)	(61)	(1,690)	
Non Operating Costs	(14,587)	(13,626)	961	374	487	101	961	
RETAINED SURPLUS / (DEFICIT)	(697)	986	1,683	250	1,040	392	1,683	

Appendix 3

Capital Expenditure for the Ten Months Ending 31st January 2022

Scheme Categories	AP	Month 10			YTD		
		P	A	V	P	A	V
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Carbon Energy Fund	661	0	0	0	661	581	80
Estates Strategy	4,300	650	6	644	2,500	1,564	936
Estates Maintenance	2,656	256	(6)	262	2,213	1,139	1,074
Information Technology	2,162	174	255	(81)	1,621	1,121	500
Medical & Other Equipment	4,881	330	288	42	1,791	975	816
Contingency	423	50	0	50	1,182	(312)	1,494
Surplus/(Deficit)	**15,083**	**1,460**	**542**	**918**	**9,968**	**5,069**	**4,899**

Appendix 4

Capital Expenditure Forecast Out-Turn Position for the Financial Year 2021/22

Scheme Categories	AP £000s	A M1 - M10 £000s	F M11 £000s	F M12 £000s	FOT A £000s	FOT V £000s
Carbon Energy Fund	661	581	0	0	581	80
Estates Strategy	4,300	1,564	381	1,160	3,105	1,195
Estates Maintenance	2,656	1,139	239	367	1,745	911
Information Technology	2,162	1,121	480	1,176	2,777	(615)
Medical & Other Equipment	4,881	975	1,599	3,197	5,771	(890)
Contingency	423	(312)	0	0	(312)	735
Surplus/(Deficit)	**15,083**	**5,069**	**2,699**	**5,900**	**13,668**	**1,415**

Cash Flow Statement for the Ten Months Ending 31st January 2022

	31st January 2022 £000s
Cash flows from operating activities	
Operating surplus/(deficit)	4,186
Depreciation and amortisation	7,806
(Increase)/decrease in receivables	(3,378)
(Increase)/decrease in inventories	150
Increase/(decrease) in trade and other payables	(209)
Increase/(decrease) in other liabilities	3,434
Increase/(decrease) in provisions	43
Net cash generated from / (used in) operations	**12,032**
Cash flows from investing activities	
Interest received	3
Purchase of intangible assets	(53)
Purchase of property, plant and equipment and investment property	(8,479)
Net cash generated from/(used in) investing activities	**(8,529)**
Cash flows from financing activities	
Public Dividend Capital received	0
Loans from Department of Health and Social Care - repaid	(1,000)
Capital element of finance lease rental payments	(334)
Interest paid	(265)
Interest element of finance lease	(187)
PDC dividend paid	(1,618)
Net cash generated from/(used in) financing activities	**(3,404)**
Increase/(decrease) in cash and cash equivalents	**99**
Cash and cash equivalents at start of year	**30,910**
Cash and cash equivalents at end of period	**30,811**

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P52/22
Report	**Ockenden Monthly Report**
Executive Lead	Helen Dobson, Interim Chief Nurse
Link with the BAF	B1 and B9
How does this paper support Trust Values	High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	All Trusts received a letter dated 25th January 2022 from Ruth May, The Chief Nursing officer for England requesting that the progress with the Ockenden review is discussed at public Board by the end of March 2022, ensuring that the following areas be updated. (Appendix 1). • Progress with the Morecambe Bay (Kirkup 2015) action plan. This was shared with the LMS in December 2020 and all the actions are now completed (Appendix 2) • Status of the completion of the self-assessment assurance tool kit: This was completed In December 2020 and shared with Trust Board in January 2021 subsequently, the results of the evidence submission has been shared along with the action plan for areas of Non Compliance. This was, presented in the February 2022 Board paper. Following this, Maternity Services in South Yorkshire and Bassetlaw received a further Ockenden progress-benchmarking tool and the team at TRFT have completed this (Appendix 3). • The Current Maternity workforce plan. **Workforce plan** The Birth-rate plus Workforce planning tool assessment was completed in October 2020 and the report at the time worked on the caseload mix for 2019/20. The table below highlights the recommended WTE Midwives and Band 3 support staff and the requirements to achieve continuity of carer (CoC). At the time of the assessment TRFT were achieving 35 % and the national ambition was 51%. The current establishment therefore meets the birth rate plus recommendations for safe staffing and our current continuity point prevalence. However, to meet the revised NHS England Ambition for COC to be the default model for all women by March 2023, a further 14.46 WTE midwives are required. This is based on the NHS England workforce tool: https://www.maternityandmidwifery.co.uk/continuity-of-carer-

workplace-toolkit. The Regional Chief Midwife for Yorkshire and the North East recommended this during the Continuity of Carer assurance visit in August 2021. A business case is being developed by the Division to request support to fund the additional midwife requirement to meet this ambition.

	RM WTE	MSW WTE	Staff in post RMWTE	Staff in post Band 3 WTE
Birthrate plus recommendation based on case mix	110.59	11.17	112.63	12.93
Birth rate plus recommendation based on case mix and COC 35%	112.60	11.35	112.63	12.93
NHS England Continuity tool	127.09	Based on Midwives only	112.63 -14.46	Based on Midwife requirement only

The Service continues to report monthly on the Divisional IPR and commentary for the Perinatal Safety dashboard data. Please see the Summary below for January 2022:

Obstetric cover gaps	0	
Maternity unit closures	0	
Utilisation of on call midwife to staff labour ward	0	Birthrate plus data
1-1 care in labour	100%	Data from birth-rate plus acuity tool reflects 100%
Continuity team midwife present for continuity birth	83%	Data from Birth rate plus acuity tool
Supernumerary labour ward co-ordinator	97%	Data from Birth rate plus acuity tool
Staff absence	9%	
Shifts unfilled	21%	
Number of stillbirths	0	
Stillbirth rate per 1000 births Rolling 12 months	3.57	

There were five red flags for Supernumerary status of the Labour ward coordinator. This was acuity related and was not for care in labour but supporting triage during a period of high acuity.

	CNST –Although the scheme is currently paused, the division continue to work on all the safety actions. It is anticipated in 2022 that the Regional Teams with the engagement of the Chief and Deputy Midwifery Officer for England will commence the Perinatal Safety quality assurance visits. Maternity services are awaiting the follow up report for Ockenden, which is due to be published in March 2022.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper has been completed by the Head of Midwifery and will be shared through Maternity and Divisional Governance. The paper is shared with the Executive Maternity Safety Champion.
Board powers to make this decision	The Board is required to have oversight on the Maternity Service's compliance with Ockenden and this paper provides assurance of the current progress.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Helen Dobson, Interim Chief Nurse, is the Board lead and will provide a monthly update to Board on the compliance with the Ockenden IEAS
Recommendations	It is recommended that the Board is assured by the progress and compliance to date.
Appendices	1. Letter from Ruth May 2. Morecambe Bay Action plan 3. Ockenden Progress TRFT

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To: NHS Trust and Foundation Trust Chief Executives

cc. Trust Chairs and Directors of Nursing
ICS, CCG, LMS Leaders,
Regional Directors,
Regional Chief Nurses,
Regional Chief Midwives,
and Regional Obstetricians

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

25 January 2022

Dear colleagues,

Ockenden review of maternity services – one year on

Thank you for all your efforts in response to the Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust published in December 2020, and for your continued focus on the Immediate and Essential Actions (IEAs) despite the sustained pressure on your services throughout the pandemic. As well as ensuring progress continues, we need to prepare for the publication of further reports into maternity services during 2022.

The national response to the Ockenden report included a £95.6M investment into maternity services across England including funding for:

- 1200 additional midwifery roles,
- 100 wte equivalent consultant obstetricians,
- backfill for MDT training
- International recruitment programme for midwives
- Support to the recruitment and retention of maternity support workers

In our letter of 14 December 2020, we asked you to use the Assurance Assessment Tool, which includes the recommendations from the Morecambe Bay investigation report and the Ockenden report, to support a discussion at your trust public Board. One year on, we are asking that you again discuss progress at your public Board before the end of March 2022.

We expect the discussion to cover:

- Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance,
- Maternity services workforce plans,

Ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore you should ensure progress is shared and discussed with your LMS and ICS. Progress must also be reported to your regional maternity team by 15 April 2022.

As you will no doubt agree, women and families using our maternity services deserve the best of NHS care. We recognise the huge efforts being made across the system and thank you for your continued commitment and support in driving the improvements required.

Yours faithfully

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer, England
NHS England and NHS Improvement

South Yorkshire and Bassetlaw
Local Maternity System
Transforming your maternity services together

Actions should be rag rated Red/Amber/Green
Responsible Persons should be identified with proposed timelines
All recommendations should be regularly reviewed in line with recommendations.

December 2020

Kirkup Report Gap Analysis – 44 Recommendations

Trust:

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for	I. When an incident occurs the doctors involved, often led by the on call consultant with a senior midwife, explain to the parents at the time what occurred and apologise that this happened	As the team of Lead Investigators expands, the governance Lead needs to make the team aware of the processes in place. These to be kept on the drive where authors have access.	Ongoing

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.	thereby carrying out their duty of candour. II. A senior member of the midwifery team, either the Governance Midwife Lead, Matron or Ward Lead would speak to the woman/parents and let them know that a Trust investigation will take place. III. Prior to the investigation the Lead Investigator of the report will make contact with the family so they have any concerns or questions that they would like answered as part of the report. IV. A formal letter of Duty of Candour to the family then follows this telephone contact. V. Any questions raised by the family are answered as part of the report. VI. For a Stillbirth and Neonatal Death the National Perinatal Mortality Review Tool (PMRT) and documentation are used. VII. If this fulfils the criteria parents are also informed about the referral to HSIB, MBRRACE & Early Notification Resolution(ENR)		
2	The University Hospitals of Morecambe Bay NHS Foundation	I. Prior to the pandemic, there was a 3 day multidisciplinary mandatory	Work on getting the anaesthetic staff back and 90% compliance.	SJP, SP. Lm VG, CS May 2021

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review should be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere.	training in place. Day 1 involved MSW's Day 2 & 3 involved all Doctors & anaesthetists/ ODP. II. During the first wave of the pandemic, covid essential F2F training continued in appropriate PPE and social distancing supported by on line work. III. At present training is done remotely using resources provided by PROMPT as well as K2 and mandatory training. IV. 2016- Compliance rate of for CNST at 75% was achieved	Action plan with anaesthetics and ODP staff to achieve compliance for CNST.	
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.	I. Plans are in place for a yearly programme of Band 6 to Band 7 development to start. As part of that process, those on that programme will have experience in a larger unit. The MDT involvement II. Perinatal mortality meetings, annual conference III. LMS sharing IV. Debriefing meetings V. ATAIN Reviews shared with the LMS	I. Now that the new managerial team is in place a review of the vision for the unit. II. A training needs analysis for the whole unit including Midwifery Support workers starting on their Framework and Managers accessing Masters Programmes including midwives having all the skills to deliver continuity of care and the work needed within Transformation of the maternity services. Explore that the recovery care post caesarean section for women is robust and meets with the anaesthetic standards	Ongoing SJP/SP

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
		VI. Risk Incident meetings (Datix) VII. Safety Forums with the LMS and exception reporting VIII. MatNeoSIP	III. Staff will then be aware of the direction of the service and what training is likely to gain investment as well as what is expected of all groups of staff. To buddy with a local hospital **DCS**	
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.	i. CPD is discussed at appraisals. These mainly focus on the following courses: • Newborn Infant Physical Examination • Non- medical Prescribing • Professional Midwifery Advocate • Band 5-6 development with a robust preceptorship package. A Preceptorship package across the LMS is being considered • The new Band 6 to Band 7 development • NLS • LMS wide MSW framework • Process for revalidation embedded	Participate in any LMS developments	Ongoing
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote	I. Joint training is in place and plans to cover the wider team. II. Neonatal attendance at Labour Ward forum	I. Reinstate the CTG meetings that took II. place pre Covid	Ongoing SJP,SP, NB,VG,LM

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	effective multidisciplinary team working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.	III. Remote learning covers the team learning together IV. Meetings that bring the MDT team together • Divisional Governance meetings monthly • ATAIN reviews monthly • Perinatal Mortality & Morbidity meeting • PMRT Review • Annual PM&M conference • Panel Reviews when serious Incidents occur • Policies are circulated around Family Health for approval • Clinical Risk Incident reviews weekly • Maternity & Neonatal Safety Champions meeting • Network meetings in SYB attendance • LMS guidelines are being considered	III. Paediatric medical staff presence for the ATAIN reviews IV. Improve the attendance of the anaesthetic and theatre team in the MDT Training as per plans V. Ensure continued attendance of staff at all levels VI. Ensure decisions / key points communicated VII. Ensure learning disseminated widely through newsletter VIII. Continue to maintain on-going review	
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which	i. TRFT follow the pathways within the Local Maternity System (LMS) for births and report exceptions. ii. Risk assessments undertaken at booking. Consultant / Midwifery led care. Home birth Assessments iii. Better Births personal care plans (PCP)and Continuity of Carer	Look at the informed choice leaflet for women need to developed Continue published guidance disseminated / policies / practice reviewed	SJP/VG March 2021 Feb 22 Patient info updated and trust website all co produced with MVP

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.	iv. Women are offered homebirths as part of their choice and they can chose any unit within the LMS		
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.	i. This is in place at present and since the pandemic. It is becoming the norm to have MDT remote discussions when decisions regarding transfer are challenging and controversial. ii. Clinical Network guidelines are embedded. iii. Exception reporting via the LMS	None Required	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.	iv. Flexible working to support the work life balance are encouraged. v. Recruitment practices have improved across the last 9 months. All the student midwives who were aspirant midwives who wanted posts were employed. vi. The LMS are exploring joint recruitment for newly qualified midwives vii. The transition from Band 5 – Band 6 has been made more open and transparent by involving the leadership team.	None Required	
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other	i. Split site issues do not apply. As most of the issues appear to be more challenging when across split sites. Any moves to make Rotherham a split site should be carefully considered.	None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.			
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.	i. The support of the LMS has made this easier for units to work together. This has strengthened partnership working and Shared learning across SYB	None	
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement	i. This is well established as described in number 1.	None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy. This should be begun with maternity staff by April 2015 and rolled out to other staff by April 2016.	ii. Systems are being put in place at present to make the processes more robust.		
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing	I. The Trust has provided updated training in the past year and 12 staff have had training on RCA System Based approach training to give them the report writing skills and improve the reports written. II. The trust provides a template for reports and these are proof read and quality assured before going to the Trust Board. III. The action plans are regularly updated. They go to the midwifery leadership meeting, governance meetings and Safety Champions meeting. IV. Debriefing meetings are standard when there is an unexpected death and staff are sign posted to pastoral support. Staff are also given feedback following a rapid panel review to identify early learning.	None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.			
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.	i. Complaints are used as a source of learning. ii. Action plans are now developed and tracked for improvement iii. Work with the MVP as a source of co-production is planned iv. Divisional Governance meetings and the Trust Clinical Governance meetings track the complaints, concerns and learning from these	None	
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change	I. There is a Clinical Lead for Obstetrics. There is a Divisional Director, as an appointment II. There is an Obstetric Governance Lead and a Clinical Effectiveness Lead. III. In Midwifery there is a Head of Midwifery supported by x3 Matrons for Acute, community and outpatients, A	Review current evidence for Leadership training in the division. Leadership opportunities for all leads and matrons	On going

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.	deputy head of Midwifery was appointed and commenced in post in August 2021 IV. Leadership training is facilitated and staff are supported to undertake Leadership training. V. There is an executive lead for Maternity and Neonatal safety Champion.		
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.	I. The responsible person for Governance and quality standards is the Head of Midwifery who attends Clinical Governance Committee and Quality Committee II. Maternity safety is also monitored through the Maternity Safety Champion agenda chaired by the chief nurse. III. Maternity dashboards and audits monitor safety and outcomes, these are monitored through local and regional dashboards. IV. Si and incidents are monitored through the governance processes.	None	
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe	I. All staff who attend Governance meetings should complete the Risk		

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.	Management training eLearning package. This needs to be completed now.		
17	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017.	I. The arrangements for a covid theatre are continually being renegotiated. II. ?All rooms are en-suite in the labour ward	None	
18	All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In	2016 - In place: benchmarking exercises in place. Excellent networking regionally via SCN Matneosip/ LMS.	None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.			
These recommendations are for other Trusts, but we have generally indicated the bodies responsible for leading and ensuring that action is completed.				
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. **Action: the General Medical Council, the Nursing and Midwifery Council.**		None	
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. **Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.**			
21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. **Action: NHS England**.		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. **Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.**		None	
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. **Action: the Care Quality Commission, NHS England, the Department of Health.**			
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. **Action: the Care Quality Commission, NHS England**		None	
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	Commission should develop a system to disseminate learning from investigations to other Trusts. **Action: the Department of Health, the Care Quality Commission.**			
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. **Action: the Department of Health.**		None	
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. **Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.**		None	
28	Clear national standards should be drawn up setting out the professional duties and expectations		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. **Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.**			
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. **Action: NHS England, the Care Quality Commission, all Trusts.**		None	
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. **Action: NHS England, the Care Quality Commission.**			
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	Ombudsman to intervene in unresolved complaints. **Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.**			
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. **Action: the Department of Health, NHS England, the Nursing and Midwifery Council.**		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. **Action: Monitor, the Care Quality Commission, the Department of Health.**		None	
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. **Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.**			
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. **Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.**		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. **Action: the Department of Health**.		None	
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. **Action: the Department of Health.**			
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts**. Action: NHS England.**		None	
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. **Action: the Department of Health.**			
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	following neonatal transfer. **Action: the Department of Health.**			
41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. **Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.**		None	
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. **Action: the Care Quality Commission, Monitor.**		None	
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All*,		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. **Action: NHS England, the Department of Health.**			
44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that		None	

	Recommendation	Benchmark/assurance	Actions	Responsibility and Timeline
	this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current and former health service staff to cooperate. **Action: the Department of Health.**			

Rotherham Ockenden Progress

				Assessment Criteria	London Regional narrative on process and ratings & asks for clarify from national team	Requirements	Minimum Evidence Requirements	Rotherham			
								Self Assessment (June 2021)	NHS England Feedback (Results of Phase 2 Audit, December 2021)	Self Assessment (March 2022)	Notes from meeting with LMNS
Immediate and Essential Action 1: Enhanced Safety											
Q1		Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.		**Confirmation of a Maternity Services Dashboard** **Confirmation this is seen by the LMNS at least Quarterly**	All Trusts already had a dashboard they review regularly but most trusts reported starting this work in January 2021 with reference to the LMS. This was accepted as demonstrating compliance. However on submission they will need to demonstrate that this process is actively in place. It was noted that some LMS had an LMS specific dashboard and it would be expected that this was considered in the light of the new quality surveillance principles and models in development.	Trusts will need to demonstrate that the process with LMS is actively in place. It was noted that some LMS had a specific dashboard we would expect evidence that to be considered in the light of the new quality surveillance principles and models in development. Confirmation from the LMS implementation Leads along with evidence of the dashboards and discussion and challenge at the LMS Evidence of LMS reviews and shared learning from dashboard oversight Evidence of adaptation to the dashboard based on national and local drivers.	**SOP required which demonstrates how the trust reports this both internally and externally through the LMS.**	Minutes available - SOP to be updated to include Trust process	100%		
							Submission of minutes and organogram, that shows how this takes place.		100%		
							Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.		100%		
							Dashboard to be shared as evidence.		100%		
Q2		External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.		**Confirmation of external specialist opinion on reviews**	Trusts needed to confirm that this happens in 100% of cases. Some LMS are working on this already which is commendable. **NATIONAL ASK:** Further clarification on whether external review is needed on cases where sadly there is no expectation that life is possible such as anophaly would be welcomed by trusts.	Trusts will need to demonstrate that if there is a process with their LMS that it is actively in place? Audit Could ask LMS to submit the process approved for creating/managing the panel and how / when it is instigated. This will ensure consistency and collaboration in the LMS to have a transparent process.	**Policy or SOP which is in place for involving external clinical specialists in reviews.**	Audit available	0%		
							Audit to demonstrate this takes place.		100%		
Q3		All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months		Confirmation that SI **GO TO Trust Board** (nab not a sub group of board such as Quality group) Confirmation that a SUMMARY of SI key issues goes to Trust Board Confirmation that SI **GO TO LMNS Board** Confirmation that a **SUMMARY** of SI key issues goes to LMNS Board Each of the above happen **quarterly**	Consideration of the full SI reports at a trust sub-board was very common, often chaired by an member of the executive. The minimum for this action to achieve compliance was the expectation that there is a summary sent to the trust board. We would also expect the trust board to have access to full reports as needed, bearing in mind that full reports should not be sent to a public board.	Would evidence be that the item of maternity S I being on the trust agenda be sufficient? Or would there need to be minutes of them being discussed? Questions were asked about what consideration by the trust board should look like. Should include examples of any discussion at sub-group and any summaries sent to the board. LMS to provide evidence of receipt and method of scrutiny/oversight/transparency of all SI reports. Perhaps a quarterly report from the monthly SI meetings? Inc no of Sis, key themes and system wide actions resulting.	**Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion..**	Minutes available	100%		
							Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed.		100%		
							Submit SOP.		100%		
Link to Maternity Safety actions:											
Q4	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		**Confirmation that PMRT is undertaken** see PMRT Tab	The expectation was that trusts were meeting the CNST standards	PMRT Trust board report - this should already in place as it is a requirement with the CNST requirement Local PMRT Reports Confirmation from the central PMRT leads	**Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.**	Audit available	0%		
							Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.		100%		
Q5	Action 2	Are you submitting data to the Maternity Services Dataset to the required standard?		**Confirmation that Monthly score card completed** (13 mandatory criteria)	This was passed by all trusts in London so rated compliant	Cross reference with MSDS submission score card data	**Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.**	CNST Evidence	100%		
Q6	Action 10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?		Confirmation that **100% of** cases are reported to HSIB & NHS Resolution	The standards for this were clear	Local checking and auditing Evidence of a local Assurance Process	**Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Schems.**	CNST Evidence	100%		
Link to urgent clinical priorities:											
Q7	(a)	A plan to implement the Perinatal Clinical Quality Surveillance Model		Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented	REGIONAL NARRATIVE ON RATING: The new principles for quality surveillance remain in development in London, although are nearly finalised. Similarly the ICS' and related LMS' are also in the process of working up their new approaches. In this environment it is therefore difficult for any trust to be fully compliant. However all have shown willingness and are planning to be engaged with the new approaches so are therefore moved to a regional amber/green rating for all trusts.	Trusts given evidence against the relevant principles from the QS document: Regular (monthly-quarterly) board review of perinatal safety Development of a board level set of measures Non-exec director to work with the safety champion Formalised perinatal governance processes up to trust Board (CNST MIS 5A9) Description and evidence of processes in relation to the ICS and LMS Evidence from LMS level would make sense here to. Diagram of the governance structure for reporting from Trust to Regional level.	**Full evidence of full implementation of the perinatal surveillance framework by June 2021.**	Minutes available - SOP to be updated to include Trust process	0%		
							LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.		100%		
							Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.		100%		
Q8	(b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB		Confirmation that SI go to Trust Board (nab not a sub group of board such as Quality group) **Confirmation that SI go to LMNS Board** **Each of the above happen Monthly**	Consideration of the full SI reports at a trust sub-board was very common, often chaired by an member of the executive. The minimum for this action to achieve compliance was the expectation that there is a summary sent to the trust board. We would also expect the trust board to have access to full reports as needed, bearing in mind that full reports should not be sent to a public board. **NATIONAL ASK:** Removal of the duplication with question 3 - combine the questions intelligently and please introduce clarity on whether a monthly or quarterly ask is required.	Would evidence be that the item of maternity S I being on the trust/LMS agenda be sufficient? Or would there need to be minutes of them being discussed? Questions were asked about what consideration by the trust board should look like. Should include examples of any discussion at sub-group and any summaries sent to the board. Is an LMS sub-group sufficient?	**Submit SOP.**	Minutes available - SOP to be updated to include Trust process	No NHS England feedback available for this.		
							Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed.		No NHS England feedback available for this.		
							Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion.		No NHS England feedback available for this.		
Immediate and Essential Action 2: Listening to Women and Families											
Q9		Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.		No expectation that this action is met - national guidance awaited	REGIONAL NARRATIVE ON RATING: In the absence of national guidance on this item we did not ask for any submission.						
Q10		The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.		No expectation that this action is met - national guidance awaited	REGIONAL NARRATIVE ON RATING: In the absence of national guidance on this item we did not ask for any submission.						
Q11		Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.		Confirmation of an identified Trust Board Non Exec.	The standards for this were clear.	Evidence of participation and contribution of the NED Name and date of appointment. Evidence of how all voices are represented: how linked in to MVP; any other mechanisms NED JD	**Evidence of how all voices are represented.**	NED JD available. Meeting minutes available. MVP evidence and evidence of coproduction. Safety champion attended MVP.	100%		
							Evidence of link in to MVP; any other mechanisms.		100%		
							Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed.		100%		
							Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions.		100%		
							Name of NED and date of appointment.		100%		
							NED JD.		0%		
Link to Maternity Safety actions:											
Q12	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		Confirmation that PMRT is undertaken Confirmation that Parents are involved	**NATIONAL ASK:** Definition of what the offer of parents being involved should look like in practice would be welcome. Whilst accepting that this will be guided by the parents themselves on an individual basis there is a need to ensure that Trusts actively offer the maximum level of involvement such as being able to attend meetings, comment on drafts of the report, named contact etc.	Evidence will follow from greater definition as described in adjoining box Evidence of engagement with parents - emails etc or other communication	**Local PMRT report.**	LMNS SOP and Audit available	No NHS England feedback available for this.		
							PMRT trust board report.		No NHS England feedback available for this.		
							Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.		No NHS England feedback available for this.		
							Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.		No NHS England feedback available for this.		
Q13	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?		Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) **AND** MVP in place that **COPRODUCES** services	**NATIONAL ASK:** Definition of the minimum standard of "co-produces services" would be welcome. There is a huge gap between the two ratings of 'confirmation of an MVP' and 'co-produces services'. Would suggest that Lisa Ramsay and other MVP chairs formulate this question to increase clarity of definition and that the two elements are service user feedback and co-production are separated out. This might include criteria of what a minimum MVP looks like (e.g. proof of remunerated lay chair, ability to claim expenses (as CNST), or more?	At a minimum would expect a submission from the MVP chair that rates the trust on the two elements - gathering service user feedback and co-production with examples. One of our MVP leads commented *'Are we simply relying on written evidence or is there scope (resources permitting) to set up a minutes interview/meeting between the MVP and an 'evidence collector' (perhaps a member from another MVP) as potentially the nuances of a MVP/Trust relationship, in terms of co-production, could be lost in simply having a written report. It could be problematic if evidence from the MVP/women is gathered through the Trust. Ideally the MVP would be approached independent of the Trust's involvement so that they can speak candidly. This is an amazing opportunity, at national level, for this evidence to be used as a springboard for a follow-on, structured and time-lined piece of work around strengthening the impact of the voice of the MVP/women in Trust policy and the production of resources – perhaps one for Lisa Ramsay and the NMV* Other suggestions included: Terms of reference; Minutes of meetings; Co-produced action plans; Presentations of feedback events; Involvement in pathway development; Quality improvement initiatives with MVP involvement; FFT reports - not considered very valuable by MVP chairs in general - so should standard of what good is be defined; 15 steps or walk the patch reports etc; Escalation and responses of comments/ concerns on trust social media; UNICEF baby friendly assessments; Review and action of NHS CHOICES feedback; From LMS perspective, evidence of co-production on LMS projects also.	**Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.**	To include CNST evidence.	100%		
							Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps).		100%		
							Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.		100%		
Q14	Action 9	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?		Identified Safety Champions **WORKING WITH** Exec and Non Exec Board Leads for Maternity	**NATIONAL ASK:** what if the maternity safety champions are working closely with the executive director but late with the Non executive director?	Evidence of meetings - minutes etc Process for escalation	**Action log and actions taken.**	Evidence available.	100%		
							Log of attendees and core membership.		100%		
							Minutes of the meeting and minutes of the LMS meeting where this is discussed.		100%		
							SOP that includes role descriptors for all key members who attend by-monthly safety meetings.		0%		
Link to urgent clinical priorities:											
Q15	A	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.		Same score as Q13	**NATIONAL ASK:** please remove this duplication		**Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.**	CNST MVP Evidence.	100%		
Q16	B	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.		Confirmation of an identified Trust Board Executive Director **AND** a Non Executive Director	**NATIONAL ASK:** Removal of the duplication with question 11. The two questions can be combined	Evidence of participation and contribution of the NED and Exec. NED and Exec JD	**Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken.**	Additional board of directors minutes.	100%		
							Name of ED and NED, and dates of appointments.		100%		
							Role descriptors.		0%		
Immediate and essential action 3: Staff Training and Working Together											
Q17		Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.		**Training together:** Confirmation of MDT training **AND** this is validated through the LMNS x 3 per year.	Most trusts reported starting this work in January 2021 with reference to the LMS. This was accepted as demonstrating compliance.	Education training compliance reports. Evidence of multi-system training sessions in line with CNST safety action 8. Trusts will need to demonstrate that if there is a process with their LMS that it is actively in place. Confirmation of what validation means	**A clear trajectory in place to meet and maintain compliance as articulated in the TNA.**	CNST discussion re MDT training.	100%		
							LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.		100%		
							Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.		100%		
							Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.		100%		
							Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.		0%		
Q18		Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.		**Working together:** Confirmation of **ALL** criteria requested.	London took as compliance if the evening ward round was at 5pm but no earlier in the day. **NATIONAL ASK:** Clarity on what timings would be considered acceptable either as defined times or principles.	Evidence will follow from greater definition as described in adjoining box Audit of compliance.	**Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night, 7 days a week (e.g. audit of compliance with SOP).**	Evidence from February. Audit evidence indicates non-compliance. Information logged in Medtech. **Evidence indicates non-compliance.**	100%		
							SOP created for consultant led ward rounds.		100%		
Q19		Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training)		Confirmation of ring fenced Maternity training budget	The standards for this were clear	Evidence of funding received and spent Confirmation from Directors of Finance Evidence from Budget statements. MTP spend reports to LMS	**Confirmation from Directors of Finance.**	Evidence available that funding will be ring-fenced (but funding not yet available) invoices from PROMPT.	100%		
							Evidence from Budget statements.		100%		
							Evidence of funding received and spent.		0%		
							Evidence that additional external funding has been spent on funding including staff can attend training in work time.		0%		
							MTP spend reports to LMS.		0%		
Link to Maternity Safety actions:											
Q20	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		See Section 2	This was rated based on the answer to Q45 on tab 2 of the spreadsheet. **NATIONAL ASK:** Please remove this question as it is addressed on tab 2 in detail this is unnecessary duplication.	Duplication see tab 2	See section 2.				
Q21	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?		90% achieved on MDT training of all Staff groups (Obstetrics / Anaesthetists / Maternity / Neonates / Support Workers)	The standards for this were clear	Attendance records - summarised Clarity on whether that request for 90% compliance is at the point of submission or by July 2021.	**A clear trajectory in place to meet and maintain compliance as articulated in the TNA.**	LMNS SOP and Audit tool. To be submitted to LMNS July Board Additional evidence of training sessions to be submitted	100%		
							Attendance records - summarised.		100%		
							LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.		100%		
							Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.		No NHS England feedback available for this.		

						Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.		No NHS England feedback available for this.		
Link to urgent clinical priorities:										
Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	See Q18	**NATIONAL ASK:** Removal of this duplication	Duplication.		**Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night, 7 days a week (E.G audit of compliance with SOP).**	Evidence from February. Audit evidence indicates non-compliance. Information logged on Medtech. **Evidence indicates non-compliance.**	100%		
						SOP created for consultant led ward rounds.		No NHS England feedback available for this.		
Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	See Q17	REGIONAL NARRATIVE ON RATING: This was given if a schedule/plan for MDT training was in place. NATIONAL ASK: Removal of this duplication.	Duplication.		**A clear trajectory in place to meet and maintain compliance as articulated in the TNA.**	LMNS SOP and Audit tool. To be submitted to LMNS July Board	100%		
						LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	Additional evidence of training sessions to be submitted TNA to be included	100%		
						Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.		No NHS England feedback available for this.		
						Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.		No NHS England feedback available for this.		
Immediate and essential action 4: Managing Complex Pregnancy										
Q24	Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	Agreement reached on Criteria for referral to Mat Med Specialist Centre	REGIONAL NARRATIVE ON RATING: London has a well established Maternal Medicine regional network that has been working on establishing pan-London pathways across all specialities and supporting the ICS and LMS in the formulation of the five centres. All trusts in London have been very actively involved. This is a work in progress and is in addition to the long standing informal arrangements that exist across the region. In view of this a London position of Green/Amber was adopted for all trusts.	Agreed pathways - should this be for a list of different specialities?		**Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians.**	**SOP not developed as Networked Maternal Medicine not yet established. Evidence of meetings to progress service development to be shared.**	0%		
						SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.		0%		
Q25	Women with complex pregnancies must have a named consultant lead.	Named consultant lead for all women identified + Yes.	The standards for this were clear	Guidelines with pathway for complex pregnancies Screenshot of maternity system ability to document named consultant Audits of compliance		**Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.**		0%		
						SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.		0%		
Q26	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.	Referenced to specialist involvement AND management plans developed.	**NATIONAL ASK:** This is a question that would very much benefit from further definition. Is a defined process for recording this satisfactory? Or audit of a plan following medical review which includes evidence of the woman's involvement? All reviewers found this question difficult to assess in the current format and asked for more guidance. Question is should this not reference PCSP? The element of specialist involvement probably requires audit ensuring that not only does it happen but that it is timely.	Probably requires audit of women's views and documentation audit on quality of planning.		**Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the cinical team in consulation with the woman.**		0%		
						SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.		0%		
Link to Maternity Safety actions:										
Q27	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Confirmation of compliance with **ALL** elements	The standards for this were clear and we took this to mean that they were compliant at the time of the peer review	SOP's Audits for each element Guidelines with evidence for each pathway	**Audits for each element.**	SOP plus CNST evidence.	100%		
						Guidelines with evidence for each pathway.		100%		
						SOP's.		100%		
Link to urgent clinical priorities:										
Q28	A	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Confirmation of consultant lead **AND** regular Audit of Compliance in place.	The standards for this were clear - duplication with Q25.	Duplication.	**SOP that states women with complex pregnancies must have a named consultant lead.**	LMNS SOP 008 and Audit plan	100%		
						Submission of an audit plan to regularly audit compliance.		100%		
Q29	B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Confirmation that Trust is developing their local actions as part of an agreed Network approach	REGIONAL NARRATIVE ON RATING: London has a well established Maternal Medicine regional network that has been working on establishing pan-London pathways across all specialities and supporting the ICS and LMS in the formulation of the five centres. All trusts in London have been very actively involved. This is a work in progress and is in addition to the long standing informal arrangements that exist across the region. In view of this a London position of Green was adopted for all trusts.	Agreed pathways - should this be for a list of different specialities and LMS arrangements		**Agreed pathways.**	MMM meeting minutes	0%		
						Criteria for referrals to MMC.		0%		
						The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.		0%		
Immediate and essential action 5: Risk Assessment Throughout Pregnancy										
Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Risk Assessment at **EVERY** AN Contact	The standard for compliance applied that there was a formal risk assessment process beyond the standard set-up of an antenatal visit. There were questions about attendance for unplanned care and the view taken was that this then entails a risk assessment by default as you have to assess the reason for attendance - this would benefit for a formalised approach **NATIONAL ASK:** Clarity on unplanned attendance for care	Risk assessment tools, Pathways for supporting choice, Information for women Guideline including risk assessment requirement Maternity system screenshot of ability to record this information Audits of compliance		**How this is achieved within the organisation.**	Spot check audits, to review compliance.	100%		
						Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.		100%		
						Review and discussed and documented intended place of birth at every visit.		100%		
						SOP that includes definition of antenatal risk assessment as per NICE guidance.		100%		
						What is being risk assessed.		100%		
Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Review of place of birth in risk assessment at **ALL** AN contacts.	REGIONAL NARRATIVE ON RATING: This question was felt by all reviewers and MVPs to be inappropriate in the assessment criteria. All agreed that conversations around place of birth need revisiting during pregnancy, but to have this at all contacts was not woman centred or personalised, and risked being harassing and heavy handed for the woman who has made a clear decision. The emphasis would be better placed from 36 weeks onwards NOT in starting the conversation which of course should start at booking, but in assessment of 'risk'. Two trusts had prompts in their risk assessment process that asked the clinician to review PCB to see if discussion was required. This was considered a good approach.	Guideline including review of intended place of birth Maternity system screenshot of ability to record this information Audits of compliance Out of birth guidance pathway Birth options clinics		**Evidence of referral to birth options clinics**	LMNS SOP 008/010 Audit evidence	100%		
						Out with guidance pathway.		100%		
						Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.		100%		
						SOP that includes review of intended place of birth.		100%		
Link to Maternity Safety actions:										
Q32	Action 5	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27.	**NATIONAL ASK:** Removal of this duplication.	Duplication.	**SOP's.**	LMNS SOP 007 Audit evidence	No NHS England feedback available for this.		
						Audits for each element.		No NHS England feedback available for this.		
						Guidelines with evidence for each pathway.		No NHS England feedback available for this.		
Link to urgent clinical priorities:										
Q33	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	Are PCSPs in place **AND** are they audited	REGIONAL NARRATIVE ON RATING: As the national guidance on PCSP is yet to be published we have no concerns about the low compliance on this item NATIONAL ASK: Please integrate PCSP into Q29 of consistency.	Audit standards need to be developed and this is duplication		**Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust).**	LMNS SOP 008 Example PCSP Ongoing Audit evidence	100%		
						How this is achieved in the organisation.		100%		
						Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.		100%		
						Review and discussed and documented intended place of birth at every visit.		100%		
						SOP to describe risk assessment being undertaken at every contact.		100%		
						What is being risk assessed.		100%		
Immediate and essential action 6: Monitoring Fetal Wellbeing										
Q34	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.	**BOTH** MW and Obstetrician in place.	The standards for this were clear.	Training compliance Attendance at external fetal wellbeing events meeting minutes/ attendee lists incident investigations/ reviews Action plans		**Copies of rotas / off duties to demonstrate they are given dedicated time.**	Midwifery evidence available. Consultant JD available; role included in PA time. Rota evidence. Action plan for work plan.	100%		
						Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.		100%		
						Incident investigations and reviews.		0%		
						Name of dedicated Lead Midwife and Lead Obstetrician.		100%		
Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health.	JD fulfils **ALL** criteria	REGIONAL NARRATIVE ON RATING: As this was not clear in the assurance tool and Job descriptions were not to be submitted, we have few concerns about the partial compliance on this item. Trusts are aware now that this is the standard they need to meet and we will expect to see this in the evidence	JDs for roles and confirmation the roles are filled		**Consolidating existing knowledge of monitoring fetal wellbeing.**		0%		
						Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision.		0%		
						Improving the practice & raising the profile of fetal wellbeing monitoring.		0%		
						Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.		0%		
						Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post.		100%		
						Keeping abreast of developments in the field.		0%		
						Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.		0%		
						Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.		100%		
Link to Maternity Safety actions:										
Q36	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	**NATIONAL ASK:** Removal of this duplication	Duplication.	**Audits for each element.**	LMNS SOP 007 Audit evidence available Related guidelines to be included	100%		
						Guidelines with evidence for each pathway.		100%		
						SOP's.		100%		
Q37	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	See Q21	**NATIONAL ASK:** Removal of this duplication	Duplication.	**A clear trajectory in place to meet and maintain compliance as articulated in the TNA.**	CNST/Audit evidence	100%		
						Attendance records - summarised.		100%		
						Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.		100%		
						Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.		No NHS England feedback available for this.		
						LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.		No NHS England feedback available for this.		
						Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.		No NHS England feedback available for this.		
Q38	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	See Q34.	**NATIONAL ASK:** Removal of this duplication	Duplication.		**Name of dedicated Lead Midwife and Lead Obstetrician.**	Roles in place. **Roles available but won't identify specific SBL work.**	No NHS England feedback available for this.		
						Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.		No NHS England feedback available for this.		
						Incident investigations and reviews.		No NHS England feedback available for this.		
Immediate and essential action 7: Informed Consent										
Q39	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	**ALL** place of birth information easily accessible	London view was that information was on the website as assessed by MVP and was translatable easily **NATIONAL ASK:** All reviewers felt the criteria needed to be clearer to assess this. It is difficult to assess what 'all' means and in a post Montgomery era feels presumptuous to think that this is possible. Rather we need definition on minimum standards - suggest this is led by MVP leads such as Lisa Ramsay. Also needs to include consideration of those who do not have English as a first language.	At a minimum would expect a submission from the MVP chair that raises the trust information (e.g. website, apps etc) in terms of accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) and includes reference to their own involvement in the information's production. This should also include how easy it is to find the information - important that service users are able to access information if they choose, without relying on care givers to provide it. In future MVPs could have an ongoing survey asking women if/how they had access to this information. This should be assessed by MVP chairs external to the trust and ideally submitted by the MVP chair and not 'via' the trust One of our MVP leads commented *'Are we simply relying on written evidence or is there scope (resources permitting) to set up a minutes interview/meeting between the MVP and an 'evidence collector' (perhaps a member from another MVP) as potentially the*	**Information on maternal choice including choice for caesarean delivery.**	Feedback in process from MVP chair.	100%		

				evidence of a MVP/Trust relationship, in terms of co-production, could be lost in simply having a written report. It could be problematic if evidence from the MVP/women is gathered through the Trust. Ideally the MVP would be approached independent of the Trust's involvement so that they can speak candidly. This is an amazing opportunity, at national level, for this evidence to be used as a springboard for a follow-on, structured and time-lined piece of work around strengthening the impact of the voice of the MVP/women in Trust policy and the production of resources – perhaps one for Lisa Ramsey and the NMV." Other suggestions included: Patient information leaflets; Apps for example Mum and Baby; Website information; Social media content; MVP involvement in quality improvement initiatives; Information in different languages; Antenatal education; Guidelines/ SOP's birth outside of guidance.	**Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.**		0%		
Q40	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	**ALL** information is easily accessible	NATIONAL ASK: All reviewers felt the criteria needed to be clearer to assess this. It is difficult to assess what 'all' means and in a post Montgomery era feels presumptuous to think that this is possible. Rather we need definition on minimum standards - suggest this is led by MVP leads such as Lisa Ramsay. Also needs to include consideration of those who do not have English as a first language. REGIONAL NARRATIVE ON RATING: Without further definition this was regarded as an impossible ask to define so all trusts were rated amber on this question.	At a minimum would expect a submission from the MVP chair that raises the trust and includes reference to their own involvement in the information's production. This should be assessed by MVP chairs external to the trust and ideally submitted by the MVP chair and not 'via' the trust One of our MVP leads commented *'Are we simply relying on written evidence or is there scope (resources permitting) to set up a minutes interview/meeting between the MVP and an evidence collector' (perhaps a member from another MVP) as potentially the nuances of a MVP/Trust relationship, in terms of co-production, could be lost in simply having a written report. It could be problematic if evidence from the MVP/women is gathered through the Trust. Ideally the MVP would be approached independent of the Trust's involvement so that they can speak candidly. This is an amazing opportunity, at national level, for this evidence to be used as a springboard for a follow-on, structured and time-lined piece of work around strengthening the impact of the voice of the MVP/women in Trust policy and the production of resources – perhaps one for Lisa Ramsey and the NMV"* As above rate in terms of ease of finding anything you want (or a minimum set?) and how good the information is when found. And in future, MVPs could have an ongoing survey which asks whether women could find the information they wanted when they wanted.	**Information on maternal choice including choice for caesarean delivery.**		No NHS England feedback available for this.		
					Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.		No NHS England feedback available for this.		
Q41	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	Confirmation that trust **HAS** a method of recording decision making processes that includes women's participation & informed choice	**NATIONAL ASK:** This appears to be a duplication with questions Q26 and Q33 - it is not clear why this does not reference PCSP's which surely form the basis of the approach going forward	Will need some kind of audit process that asks women	**An audit of 1% of notes demonstrating compliance.**	LMNS SOP 010 Additional Audit/CQC evidence	100%		
					CQC survey and associated action plans.		100%		
					SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.		100%		
Q42	Women's choices following a shared and informed decision-making process must be respected	Reference made to how Women's choices are respected and evidenced	Regionally due to the unclear nature of the criteria we accepted the presence of a birth options clinic but all felt further clarity was required. **NATIONAL ASK:** All reviewers felt the criteria needed to be clearer to assess this. Definition on minimum standards or principles required. Suggest this is led by MVP leads such as Lisa Ramsey	Birth options clinic (or equivalent) evidence. Training and support and tools used to support women's choices - should be mainstream not just in specialist clinics. SUV commented *'I feel that presence of a birth choices clinic is not enough - unless any/all woman and birthing people can find out about and access it) And how can this be measured? If 1 woman's decision isn't respected, does that mean no? Perhaps future evidence is from an ongoing MVP-lead survey asking women and birthing people whether they were equal partners in an informed decision making process; and whether those decisions were respected; I can see lots of challenges to this, but I don't know how you demonstrate this without asking service users'*	**An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.**	LMNS SOP 010 Additional Audit evidence	0%		
					SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.		100%		
					CQC survey and associated action plans.		No NHS England feedback available for this.		
Link to Maternity Safety actions:									
Q43	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	See Q13.	**NATIONAL ASK:** Removal of this duplication		**Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.**	CNST Evidence	100%		
						Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps).		100%		
						Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.		100%		
Link to urgent clinical priorities:									
Q44	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	All information **ON** trust website	**NATIONAL ASK:** This is a duplication with Q40 but is equally unclear on what the core principles and standards should be - suggest the two are combined.	At a minimum would expect a submission from the MVP chair that raises the trust and includes reference to their own involvement in the information's production. Would like this to be assessed by MVP chairs external to the trust And as comments above in terms of looking at criteria for the quality of information (Qs 40/41/42 etc)	**Co-produced action plan to address gaps identified.**	Feedback in process from MVP chair.	0%		
					Gap analysis of website against Chelsea & Westminster conducted by the MVP.		0%		
					Information on maternal choice including choice for caesarean delivery.		100%		
					Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.		0%		
Workforce Planning									
Link to Maternity Safety Actions:									
Q45	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard.	Midwifery workforce planning system **in PLACE.**	N/A	N/A	**Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan.**	Evidence available.	100%		
						Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.		100%		
						Most recent BR+ report and board minutes agreeing to fund.		100%		
Q46	Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Confirmation of a maternity workforce gap analysis **AND** a plan in place (with confirmed timescales) to meet BR+ standards.	N/A	N/A	**Most recent BR+ report and board minutes agreeing to fund.**		100%		
Midwifery Leadership:									
Q47	Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director.	Evidence the Director/Head of Midwifery responsible and accountable to an executive Director.	N/A	N/A	**RoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director.**	JD available, SP to check accountability in current structure. To confirm line of accountability.	100%		
Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders	**Meets ALL** that apply **Note - Trusts would not lead on actioning all seven steps.**	N/A	N/A	**Action plan where manifesto is not met.**	**Gap analysis to be undertaken.**	100%		
					Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care.		0%		
NICE Guidance related to maternity:									
Q49	We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	**ALL** guidance assessed & implemented = Yes (GREEN).	N/A	N/A	**Audit to demonstrate all guidelines are in date.**	Process established and linked to local governance. Policy for implementation of NICE guidelines.	100%		
					Evidence of risk assessment where guidance is not implemented.		0%		
					SOP in place for all guidelines with a demonstrable process for ongoing review.		100%		

Board of Directors' Meeting
04 March 2022

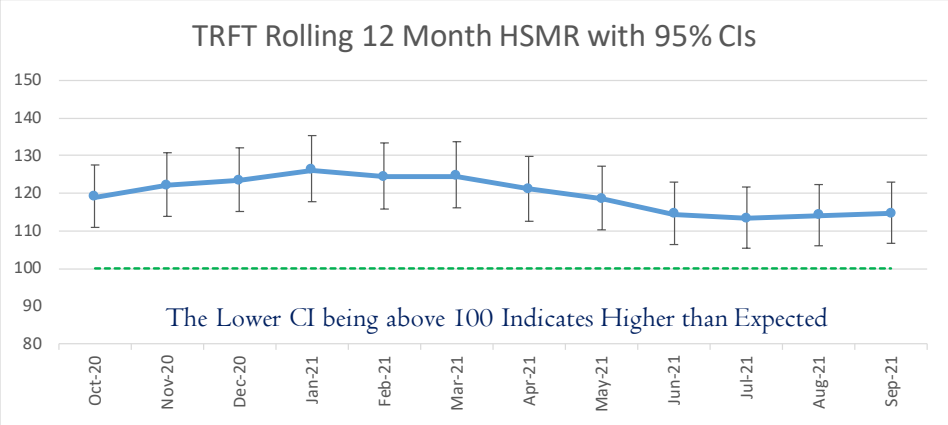
Agenda item	P53/22
Report	**Mortality and Learning From Deaths Report**
Executive Lead	Dr Callum Gardner, Executive Medical Director
Link with the BAF	B1 – Standards and quality of care not being met B2 – Demand for care exceeds the resources available B7 – Insufficiently robust quality and clinical governance
How does this paper support Trust Values	**Ambitious** – demonstrates that the Trust strives to deliver the highest standards and quality of care possible and to have a Hospital Standardised Mortality Ratio (HSMR)/Summary Hospital Level Mortality Indicator (SHMI) below 100. **Caring** – demonstrates that the Trust strives to give outstanding, compassionate care, including around end of life care. **Together** – demonstrates that the Trust strives to ensure that quality improvement and the learning from deaths is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report provides the Board with the monthly mortality data and an update around changes and quality improvements being made as part of the Trust's Learning from Deaths Programme. Summary of key points: **HSMR**: The Rotherham NHS Foundation Trust's (TRFT) latest rolling 12 Month HSMR value is 114.6; TRFT remain in the 'Higher than Expected' band. This is a slight increase from the last value, which was 114.0. 6 of the 13 Yorkshire & Humber Non Specialist Trusts are in the ' Higher than Expected' band. **Diagnosis Code Alerts:** For the latest 12 month period, there are 4 HSMR diagnosis groups with 'Higher than Expected' Relative Risks (RR): • Acute Bronchitis (RR – 260.7) • Syncope (RR – 352.0) • Liver disease, alcohol-related (RR – 164.9) • Other perinatal conditions (RR – 247.3)

	SHMI: TRFT's latest Rolling 12 Month SHMI Value is 110.7. TRFT are in the Band 2 'As Expected' band. This is a reduction from the last value, which was 112.6. The reduction has moved TRFT out of Band 1 'Higher than Expected'. 3 of the 13 Yorkshire & Humber Non Specialist Trusts are in Band 1. TRFT is Alerting for 1 Diagnosis Group: • Acute Bronchitis
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	This data has been presented to the Trust's Clinical Governance Committee, the Quality Committee, the Safe & Sound Mortality Improvement Group, and to the Mortality Improvement Group.
Board Powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Trust is working extremely hard to understand and quickly improve the HSMR/SHMI and learning from deaths, co-ordinated through the Trust's Mortality Improvement Group (MIG), chaired by the Chief Executive Officer, with the Medical Director as the Senior Responsible Officer. This Group is now moving to quarterly, and is likely to be stood down in the next 3-6 months; thereafter, 'Business as Usual' will continue to be picked up through the Trust's Safe & Sound Mortality Group, chaired by the Medical Director, with oversight and assurance through the Trust's new Clinical Effectiveness Committee (from April 2022) and Quality Committee.
Recommendations	It is recommended that the Board notes the mortality position and the significant actions being taken to make improvements.
Appendices	1. Dr Foster Mortality Report

1.0 Quality of Care

1.1 This section will focus on HSMR data published on 20 January 2022. The latest 12 month data period is 01/10/2020 – 30/09/2021. TRFT's current 12 month rolling value is 114.6.

1.2 TRFT remain in the 'higher than expected' band. The chart below tells us that, since January 2021, there had been a sustained reduction then a levelling off. 6 of the 13 Yorkshire and Humber General Trusts are in the 'higher than expected' band.



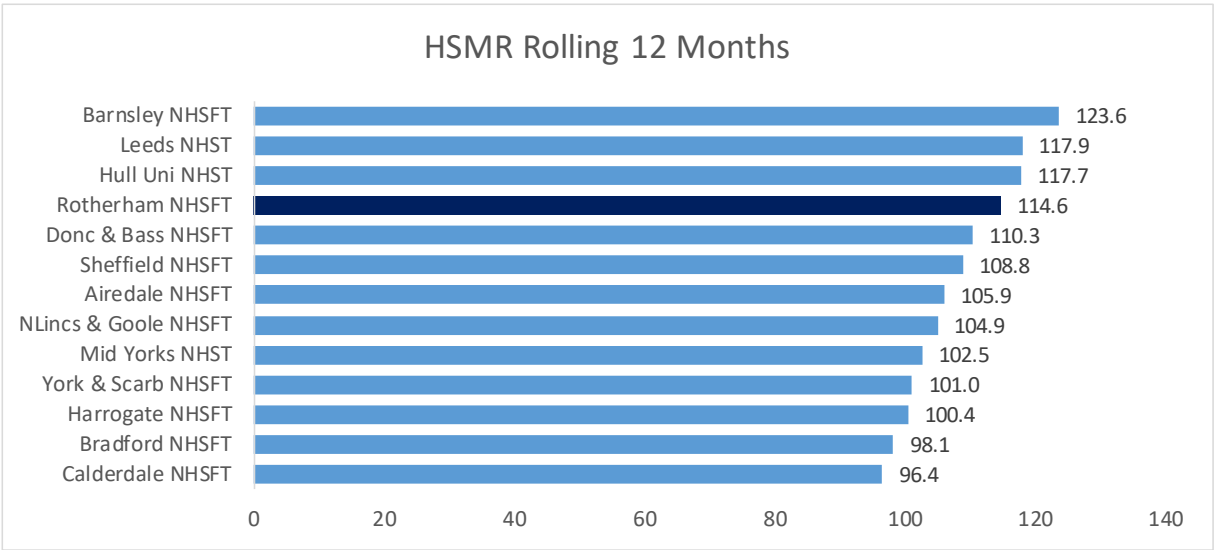
1.3 COVID Effect

COVID patients are excluded from the HSMR only when they had a COVID diagnosis code in the first or second episode of their inpatient stay. This means that some COVID deaths feature in HSMR data.

During the COVID peaks, data suggests that TRFT had a relatively high percentage of its beds occupied by COVID patients, indicating that TRFT's HSMR would be more affected by COVID.

TRFT's latest HSMR with COVID patients fully excluded is 101.5.

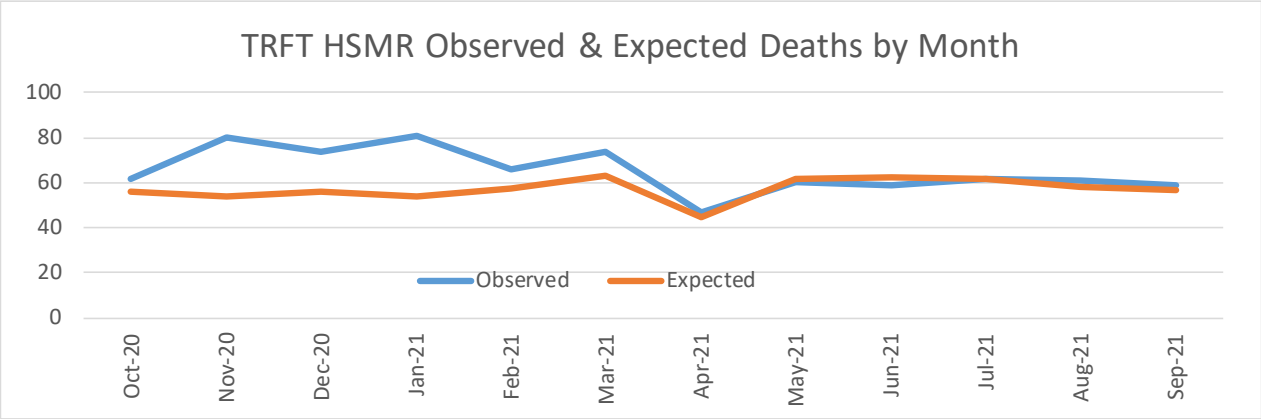
1.4 Yorkshire & Humber Regions General Trusts, HSMR Oct 2020 – Sept 2021:



1.5 Future Direction of Mortality Metrics

This chart details the expected and observed number of HSMR deaths by individual month. The HSMR value is a ratio of the two. This tells us that, for the last 5 months, TRFT's HSMR has been very close to 100.

The months of November 2020 – January 2021 inclusive are driving the current high rolling 12 month HSMR. TRFT's rolling 12 Month HSMR is likely to decrease for data releases in the first Quarter of 2022/23, but is then likely to increase again due to the further COVID peaks seen in November 2021 onwards.



2.0 SHMI Coding Indicators

2.1 NHS Digital's SHMI Coding/Data Quality indicate that TRFT is coding a high number of Co-Morbidities per Non-Elective admission.

2.2 TRFT has the highest rates of Signs and Symptoms recorded in the Primary Diagnosis. This could indicate a problem with data quality or timely diagnosis of patients. Our 12 month rate is affected by spikes in this metric during March and April 2022 when there were staffing shortages in Clinical Coding.

TRFT Rank of 13	1st Highest	1st Highest	2nd Highest	10th Highest
Yorks & Humber Region Non Spec Provider Trusts	**% of Spells: Primary Diagnosis is a Sign & Symptom**	**% of Spells: Invalid primary diagnosis code**	**MEAN Secondary Diagnoses per Spell Non Elective**	**% of Spells with palliative care (spec or Diag)**
Rotherham NHSFT	18.3	4.6	7.4	1.4
Airedale NHSFT	16.1	*	4.9	1.0
Harrogate NHSFT	15.4	*	5.0	1.9
England	14.4	0.8	5.9	1.9
York & Scarb NHSFT	14.3	0.0	5.6	1.3
NLincs & Goole NHSFT	14.3	0.1	6.2	1.6
Barnsley NHSFT	12.8	0.2	7.5	1.6
Bradford NHSFT	12.0	0.4	4.6	1.0
Donc & Bass NHSFT	11.8	0.0	5.5	2.3
Calderdale NHSFT	9.9	*	6.2	1.8
Sheffield NHSFT	9.8	0.0	5.7	2.0
Mid Yorks NHST	9.7	0.7	6.6	1.7
Leeds NHST	7.9	*	6.7	1.8
Hull Uni NHST	5.4	0.0	6.5	2.5

2.3 The Palliative Care metrics indicate that our Palliative Care overall coding rate for all spells is relatively low. However, for patients who die at the Trust, the proportion with the palliative care code is average compared with the region, although below national averages.

2.4 A relatively low Palliative Care coding rate and high incidence of Signs and Symptoms coding, could lower TRFT's Expected Rate for both SHMI and HSMR.

3.0 Coding Update

3.1 For both the HSMR and SHMI, allocation to the Diagnosis Group and calculation of the Co-Morbidity score relies on diagnoses being coded in the First and sometimes second Consultant Episode (FCE). Any diagnoses coded in further episodes are not included.

3.2 Measures are in place and being considered at TRFT to make sure diagnoses are recorded in these episodes, where appropriate. The Medical Director has also asked the Divisional Director for Medicine, the Trust's Learning from Deaths and Mortality Manager, and the Head of Clinical Coding & Data Quality to work together to look at what process improvements can be made to reduce the number of unnecessary Consultant transfers. This will mean more spell diagnoses are included in the Expected Risk calculation.

3.3 TRFT is using a 3M coding analytics product to support this. This product flags diagnoses relevant to the HSMR and SHMI, which could be considered for including in all episodes. Feedback from the Head of Clinical Coding & Data Quality suggests that this is having a positive effect on coding practices.

3.4 Changes have been made in MediTech in order to clearly highlight when a patient has been by the specialist palliative care team. The Dr Foster process which looks for Palliative Care Coding now looks at 19 diagnostic positions, rather than 14. This may result in more palliative care codes being picked up, and included in HSMR expected death risk calculations.

4.0 Medicine's 360 Audit Response

4.1 360 Internal Assurance are in the process of completing their re-audit. Their auditor is viewing TRFT's documents and attending various mortality related group meetings. Feedback is expected in March 2022.

5.0 Learning From Deaths

5.1 Obtaining figures for the number and timeliness of completed Medical Examiner (ME) Scrutinies and Structured Judgement Reviews (SJRs) remains difficult. Since August 2021, ME Scrutinies have not been input onto MediTech. SJRs continue to be input onto MediTech, however those completed more than 90 days after death do not count as complete on the Mortality Insights Dashboard. Fixes continue to be worked on.

5.2 Work between the ME office, the Learning From Deaths and Mortality Manager, and Health Informatics colleagues is being undertaken to re-populate the Mortality Insights Report, with ME Scrutiny figures.

Month of Discharge	Adult IP Deaths	ME Scrutiny (Recorded on MediTech)	% ME Scrunity	SJRs Completed **
Jan-21	157	125	79.6%	11
Feb-21	105	88	83.8%	12
Mar-21	97	76	78.4%	10
Apr-21	69	57	82.6%	7
May-21	72	62	86.1%	9
Jun-21	69	44	63.8%	8
Jul-21	73	28	38.4%	8
Aug-21	92	7	7.6%	10
Sep-21	90	7	7.8%	11
Oct-21	83	11	13.3%	7
Nov-21	108	0	0.0%	11
Dec-21	97	1	1.0%	4

* ME Scrutinies stopped routinely being inputted onto MediTech
** Doesn't include those completed > 90 days after death

6.0 SJRs Learning In the Divisions

6.1 Deaths are being reviewed and discussed in Divisional Safe & Sound Mortality Sub Group meetings. However, they are not in the SJR format and therefore are not feeding into the learning from deaths data collection, and this is impeding our ability to maintain an overview and identify themes.

6.2 Learning from these local reviews cannot be aggregated and used in any thematic or trend analysis.

6.3 No trend or thematic analysis of completed SJRs is being completed in the Trust. The Learning from Deaths & Mortality Manager will complete an analytical review of SJR completed by Medicine in 2021.

7.0 So What?

7.1 TRFT has arranged to take part in a Mortality Review and Improvement Programme with NHSI/E Mortality Leads. This will be complementary to the 360 Internal Assurance Audit and focuses more on the operational implementation. A key part of this programme will be SJR awareness and training for TRFT Clinicians.

7.2 A key outcome of the NHSI/E Review programme is that TRFT will complete SJRs consistently to the required standard, in a format that can be analysed for trends and Thematic Analysis (structured analysis of Free Text) performed. It is to the intention to embed the SJR process within the Divisions and establish SJRs as the method for case note reviews of deaths.

7.3 Work in Coding continues, to promote thorough and timely diagnosis and Palliative care recording, and these need to appear in the 1st or 2nd Episodes in the patient's Spell to enable the clinical coders to appropriately code the diagnoses.

7.4 Coding have finalised a Clinical Coding Educational Video for Clinicians, which is due to be published in February 2022.

8.0 Conclusion

8.1 A significant amount of work and effort continues to be focused on improving mortality and the Trust's Learning from Deaths programme.

8.2 Mortality and the Learning from Deaths will continue to remain one of the Trust's top Quality Improvement priorities next financial year.

John Taylor
Learning from Deaths & Mortality Manager
On behalf of Dr Callum Gardner, Executive Medical Director
February 2022

MORTALITY SUMMARY REPORT

Trust	THE ROTHERHAM NHS FOUNDATION TRUST
Report Date	Saturday, 29 January 2022
Senior Consultant	Robert Douce
Area	Consultancy
Contact Details	robert.douce@health.telstra.com
Data Period	Oct 2020 - Sep 2021

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REPORT OUTLINE

Background

The report provides an overview of mortality using the Hospital Standardised Mortality Ratio and the Standardised Mortality Ratio. The report presents intelligence with potential recommendations for further investigation. This report should be used as an adjunct to supplement other pieces of work completed within the Trust and not used in isolation.

Methods

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and analysing in the Healthcare Intelligence Portal tool, this report examines in-hospital mortality, for all inpatient admissions for the 12 month time period Oct 2020 - Sep 2021.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including July 2021(unless otherwise stated). This is the most recent benchmark period available. Statistical significance is determined using 95% confidence intervals unless otherwise stated.

SHMI data for the time period Sep-20 to Aug-21 was obtained from NHS Digital's Indicator Portal. SHMI is updated and rebased monthly.

REPORT HEADLINES

Data Period: Oct 2020 - Sep 2021

Metric	Result

HSMR	• HSMR = 114.6 and banded as statistically 'higher than expected'.
	  o Excluding spells with secondary COVID-19 codes the Trusts HSMR for the period was 101.5 and banded as statistically 'within expected'.
	  ▪ For the last available 12 months patients with secondary Covid-19 within the HSMR basket represented 2.9% of admissions (635 super-spells, 155 deaths) at the Trust.
	• The latest month HSMR value (Sep-21) = 104.1 and banded as statistically 'within expected'.
	• Crude mortality (all diagnosis) was 3.1% over the 12 month period compared to 3.3% regional average (acute, non-specialist) and 3.2% national average (acute, non-specialist).
	• For the 12 month period there were four HSMR diagnosis groups with a relative risk banded as statistically 'higher than expected':
	  o Acute bronchitis
	  o Other perinatal conditions
	  o Syncope
	  o Liver disease, alcohol-related

HSMR position vs. peers	• The Trust is 1 of 9 within the regional peer group with an HSMR banded as statistically 'higher than expected' over the 12 month period. If the regional HSMR values are ranked (lowest to highest) the Trusts HMR is 16th of 21 acute, non-specialist Trusts.

SMR outlying groups	• For the 12 month period (Oct-20 to Sep-21) there were 7 diagnosis groups with a relative risk banded as statistically 'higher than expected':
	  o Nonspecific chest pain*
	  o Acute bronchitis
	  o Other perinatal conditions
	  o Syncope
	  o Poisoning by other medications and drugs*
	  o Liver disease, alcohol-related
	  o Nervous system congenital anomalies

All Diagnosis SMR	• SMR = 112.0 and banded as statistically 'higher than expected'.

	o Excluding spells with both primary and secondary COVID-19 codes the Trusts SMR for the period was 99.7 and banded as statistically 'within expected'. ▪ For the last available 12 months patients with either primary or secondary Covid-19 represented 3.8% of admissions (2,478 super-spells, 474 deaths) at the Trust. • The latest month (Sep-21) SMR = 109.5 banded as statistically 'within expected'. • Crude mortality (all diagnosis) was 1.7% over the 12 month period compared to 1.6% regional average (acute, non-specialist) and 1.7% national average. • The Trust is 1 of 11 within the regional peer group with an SMR banded as statistically 'higher than expected' over the 12 month period. • If the 12 month (Oct-20 to Sep-21) SMR values for the regions acute, non-specialist Trusts are ranked (lowest to highest) The Rotherham NHD FT ranks 16th of 21 Trusts.
CUSUM breaches	• Over the 12 month period (Oct-20 to Sep-21) there were CUSUM alerts (using 99% detection threshold criteria) in the following 12 diagnosis groups: o Nonspecific chest pain o Congestive heart failure, nonhypertensive o Acute bronchitis o Other upper respiratory disease o Biliary tract disease o Liver disease, alcohol-related o Other connective tissue disease o Nervous system congenital anomalies o Other perinatal conditions o Fever of unknown origin o Other psychoses o Anxiety, somatoform, dissociative, and personality disorders
SHMI position	• SHMI for The Rotherham NHS FT = 110.66 banded as statistically 'within expected' using the 95% control limits (adjusted for over dispersion) published by NHS digital. o During the 12 month period (Sep-20 to Aug-21) there were 745 in-hospital deaths and 435 out of hospital deaths recorded within the metric. o The Trust is one of 11 within the NHS England (Yorkshire and Humber) region with a SHMI banded in the statistically 'within expected' range.

HOSPITAL STANDARDISED MORTALITY RATIO OVERVIEW

Key points

- HSMR = 114.6 and banded as statistically 'higher than expected'.
  - Excluding spells with secondary COVID-19 codes the Trusts HSMR for the period was 101.5 and banded as statistically 'within expected'.
    - For the last available 12 months patients with secondary Covid-19 within the HSMR basket represented 2.9% of admissions (635 super-spells, 155 deaths) at the Trust.
- The latest month HSMR value (Sep-21) = 104.1 and banded as statistically 'within expected'.
- Crude mortality (all diagnosis) was 3.1% over the 12 month period compared to 3.3% regional average (acute, non-specialist) and 3.2% national average (acute, non-specialist).
- For the 12 month period there were four HSMR diagnosis groups with a relative risk banded as statistically 'higher than expected':
  - Acute bronchitis
  - Other perinatal conditions
  - Syncope
  - Liver disease, alcohol-related

Diagnoses - HSMR | Mortality (in-hospital) | Oct-20 to Sep-21 | Diagnosis group

Diagnosis group: Acute bronchitis, Liver disease, alcohol-related, Other perinatal conditions, Syncope

Analyse by: Diagnosis group | Measure: Relative risk | Show: All

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	1,291	100.0%	1,295	73	5.7%	34.0	2.6%	39.0	214.6	168.2	269.8
Acute bronchitis	529	41.0%	530	25	4.7%	9.6	1.8%	15.4	260.7	168.7	384.9
Other perinatal conditions	349	27.0%	352	12	3.4%	4.9	1.4%	7.1	247.3	127.7	432.1
Syncope	283	21.9%	283	7	2.5%	2.0	0.7%	5.0	352.0	141.0	725.3
Liver disease, alcohol-related	130	10.1%	130	29	22.3%	17.6	13.5%	11.4	164.9	110.4	236.8

- The Trust is 1 of 9 within the regional peer group with an HSMR banded as statistically 'higher than expected' over the 12 month period. If the regional HSMR values are ranked (lowest to highest) the Trusts HMR is 16th of 21 acute, non-specialist Trusts.

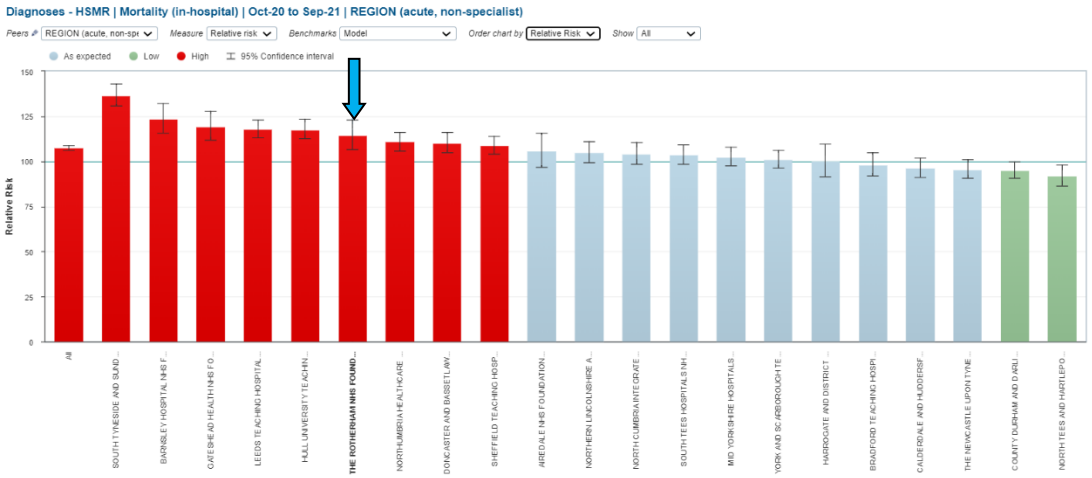


Figure 1 – HSMR Monthly Trend

Diagnoses - HSMR | Mortality (in-hospital) | Oct-20 to Sep-21 | Trend (month)

Analyse by: Trend (month) | Measure: Relative risk | Show: All

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	22,137	100.0%	22,176	785	3.5%	685.1	3.1%	99.9	114.6	106.7	122.9
Oct-20	1,841	8.3%	1,842	62	3.4%	55.7	3.0%	6.3	111.3	85.3	142.7
Nov-20	1,762	8.0%	1,767	80	4.5%	53.9	3.1%	26.1	148.5	117.7	184.8
Dec-20	1,768	8.0%	1,771	74	4.2%	55.9	3.2%	18.1	132.3	103.8	166.1
Jan-21	1,690	7.6%	1,694	81	4.8%	54.1	3.2%	26.9	149.7	118.9	186.1
Feb-21	1,733	7.8%	1,737	66	3.8%	57.1	3.3%	8.9	115.6	89.4	147.0
Mar-21	1,825	8.2%	1,827	74	4.1%	62.8	3.4%	11.2	117.9	92.6	148.0
Apr-21	1,528	6.9%	1,530	47	3.1%	44.9	2.9%	2.1	104.8	77.0	139.3
May-21	1,908	8.6%	1,910	60	3.1%	61.4	3.2%	-1.4	97.8	74.6	125.9
Jun-21	2,117	9.6%	2,119	59	2.8%	62.3	2.9%	-3.3	94.6	72.0	122.1
Jul-21	2,049	9.3%	2,052	62	3.0%	62.0	3.0%	-0.0	100.0	76.6	128.1
Aug-21	1,894	8.6%	1,898	61	3.2%	58.4	3.1%	2.6	104.5	80.0	134.3
Sep-21	2,022	9.1%	2,029	59	2.9%	56.7	2.8%	2.3	104.1	79.2	134.3

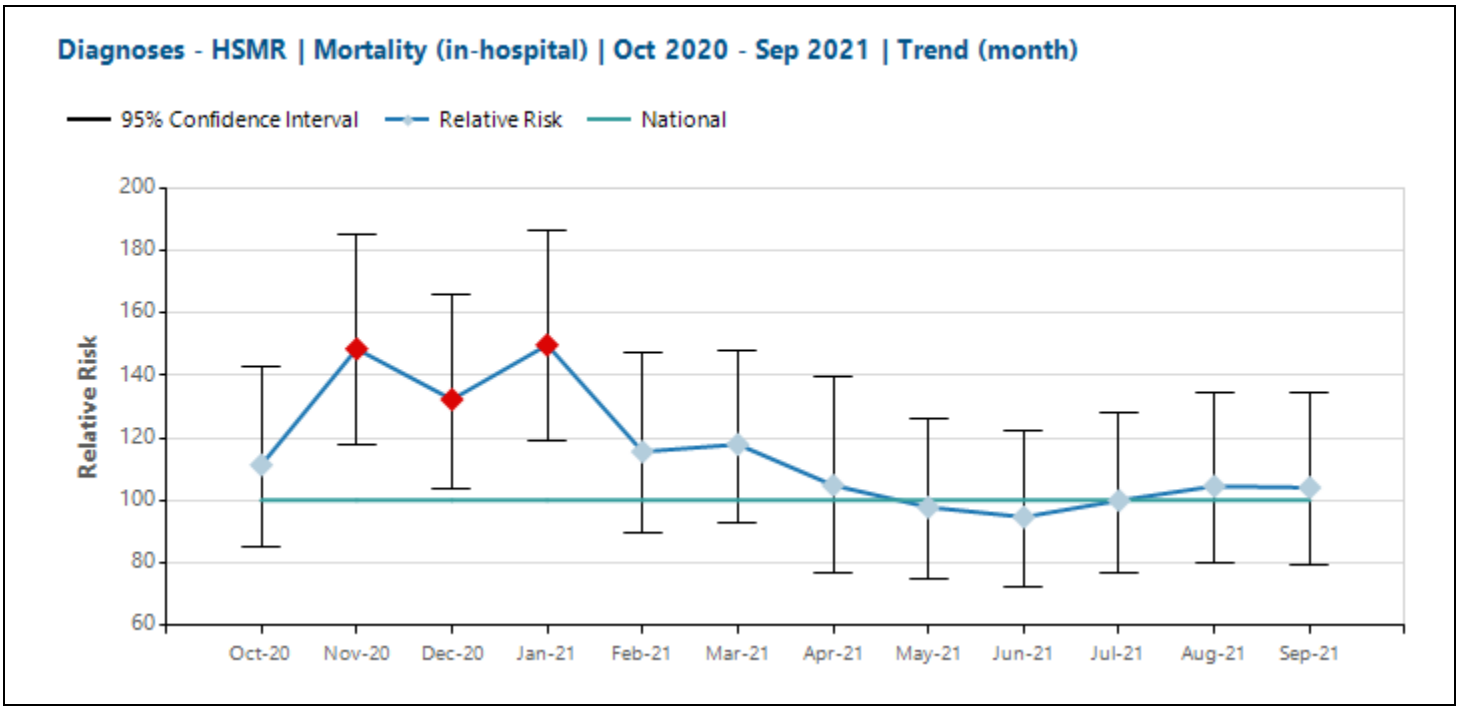
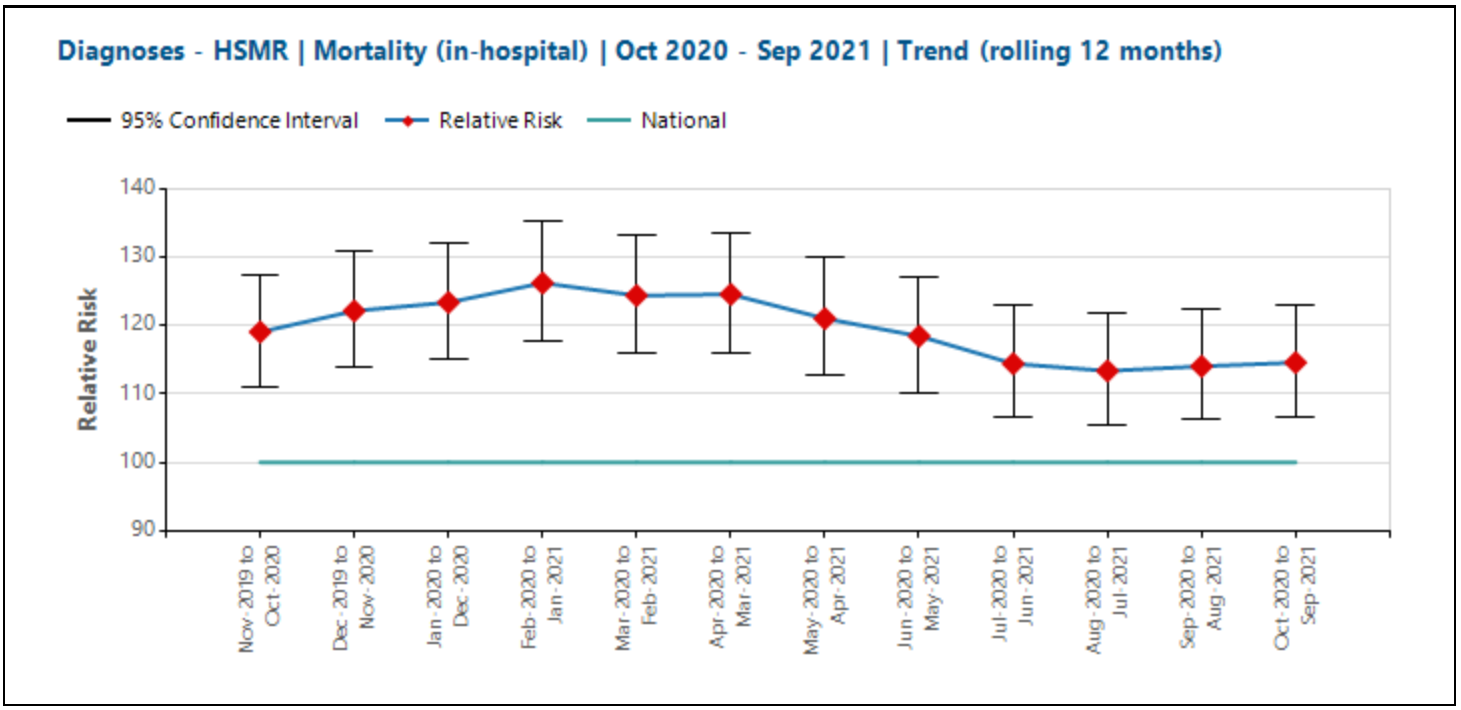
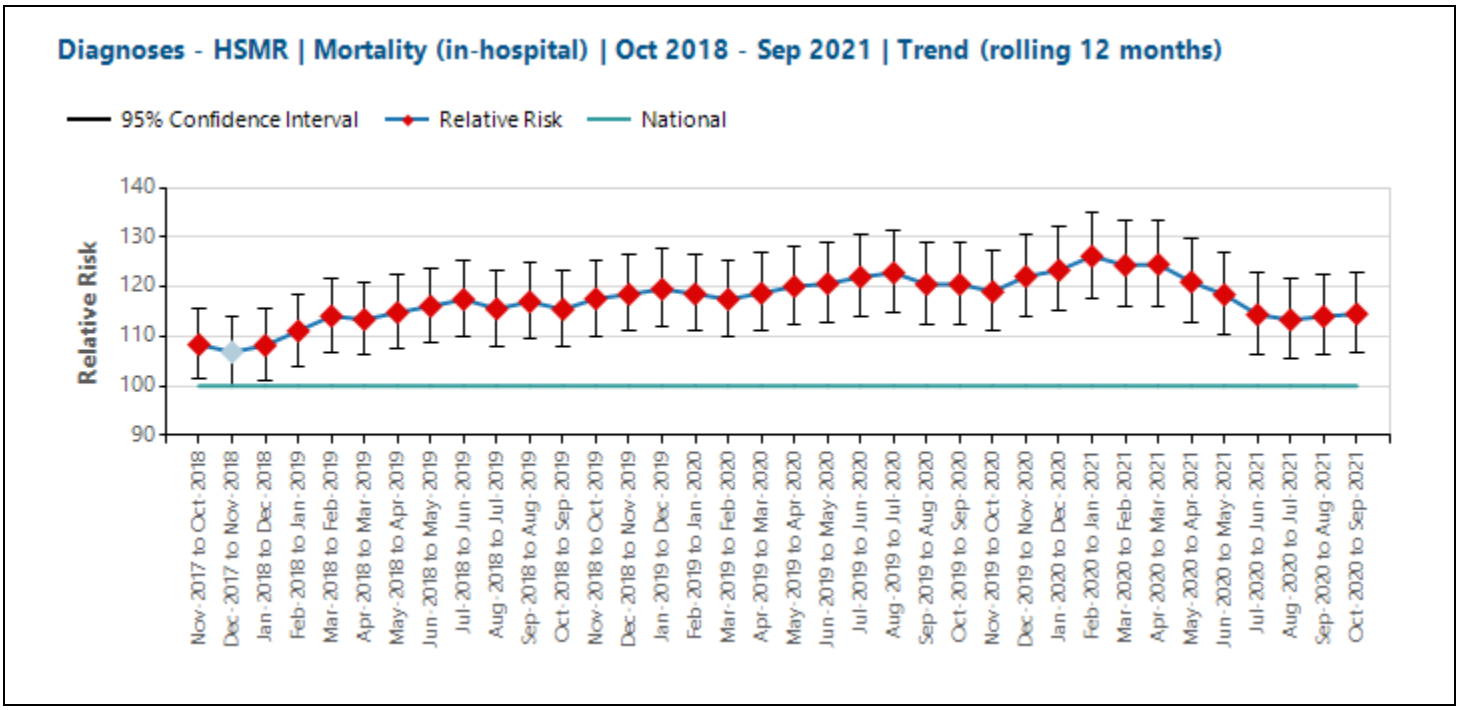


Figure 2 – HSMR 12 Month Rolling Trend




Diagnoses - HSMR | Mortality (in-hospital) | Oct 2018 - Sep 2021 | Trend (rolling 12 months)
95% Confidence Interval
Relative Risk
National
Relative Risk
140
130
120
110
100
90
Nov 2017 to Oct 2018
Dec 2017 to Nov 2018
Jan 2018 to Dec 2018
Feb 2018 to Jan 2019
Mar 2018 to Feb 2019
Apr 2018 to Mar 2019
May 2018 to Apr 2019
Jun 2018 to May 2019
Jul 2018 to Jun 2019
Aug 2018 to Jul 2019
Sep 2018 to Aug 2019
Oct 2018 to Sep 2019
Nov 2018 to Oct 2019
Dec 2018 to Nov 2019
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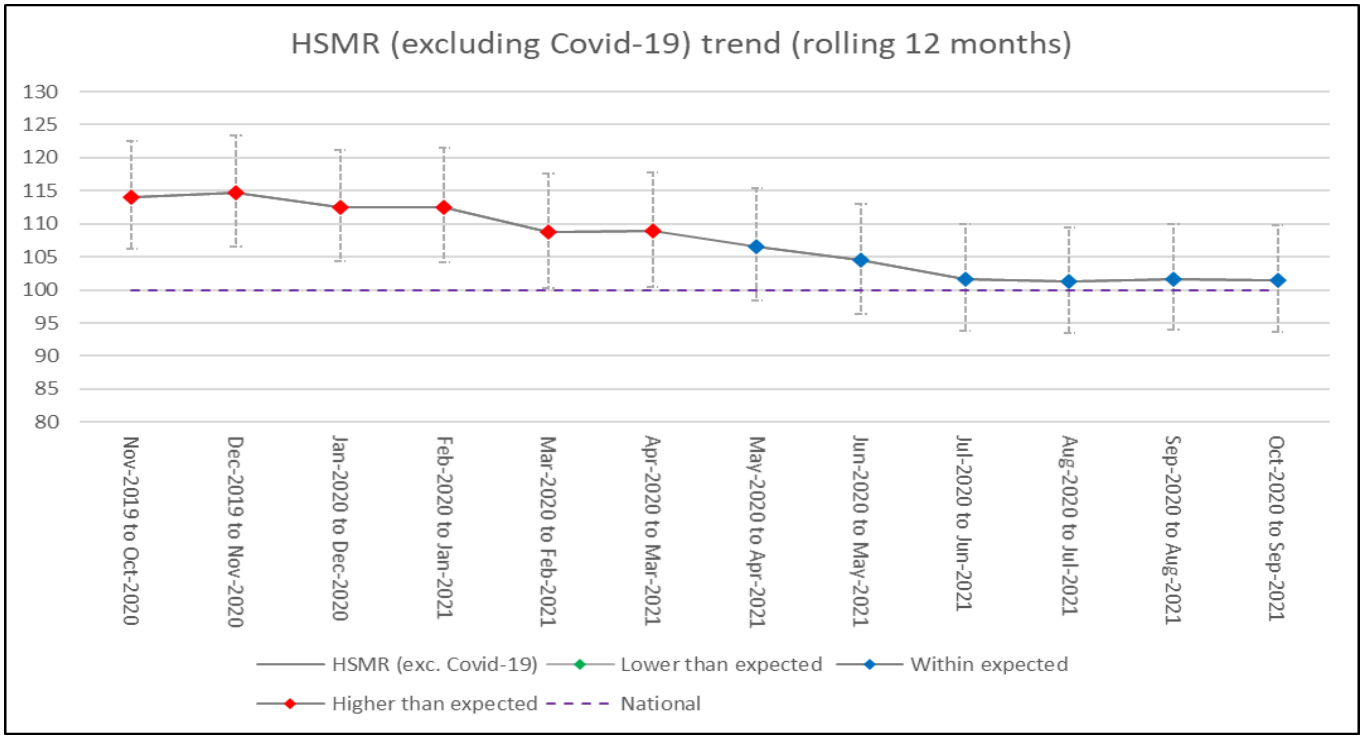
Nov 2019 to Oct 2020
Dec 2019 to Nov 2020
Jan 2020 to Dec 2020
Feb 2020 to Jan 2021
Mar 2020 to Feb 2021
Apr 2020 to Mar 2021
May 2020 to Apr 2021
Jun 2020 to May 2021
Jul 2020 to Jun 2021
Aug 2020 to Jul 2021
Sep 2020 to Aug 2021
Oct 2020 to Sep 2021

Figure 2.1 – HSMR vs HSMR (Exc. Covid-19) trend (rolling 12 months)

- The HSMR metric doesn't include any patients with a primary diagnosis of Covid-19 (ICD-10 U07) instead these patients are housed in the 'viral infections' diagnosis group that forms part of your SMR (all diagnosis).
- It is however important to note that patients with a Covid-19 code in a secondary position will be included in the HSMR basket.
    - For the last available 12 months patients with a secondary Covid-19 diagnosis within the HSMR basket represented 2.6% of admissions (580 super-spells, 145 deaths, 25% crude mortality rate) at The Rotherham NHS Foundation Trust.
- The following charts provide comparative trends showing the rolling 12 month HSMR vs HSMR (excluding Covid-19) to highlight the impact of these patients on the HSMR metric.



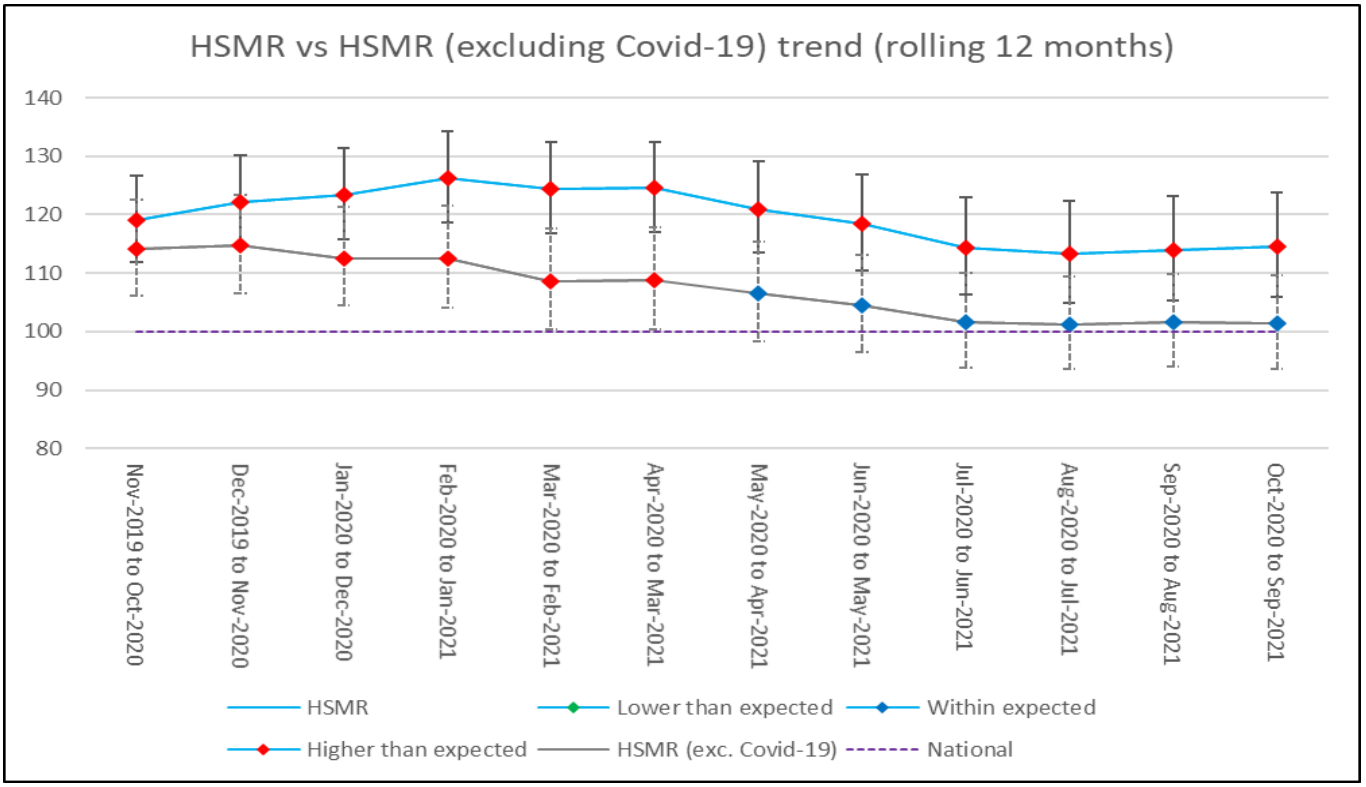
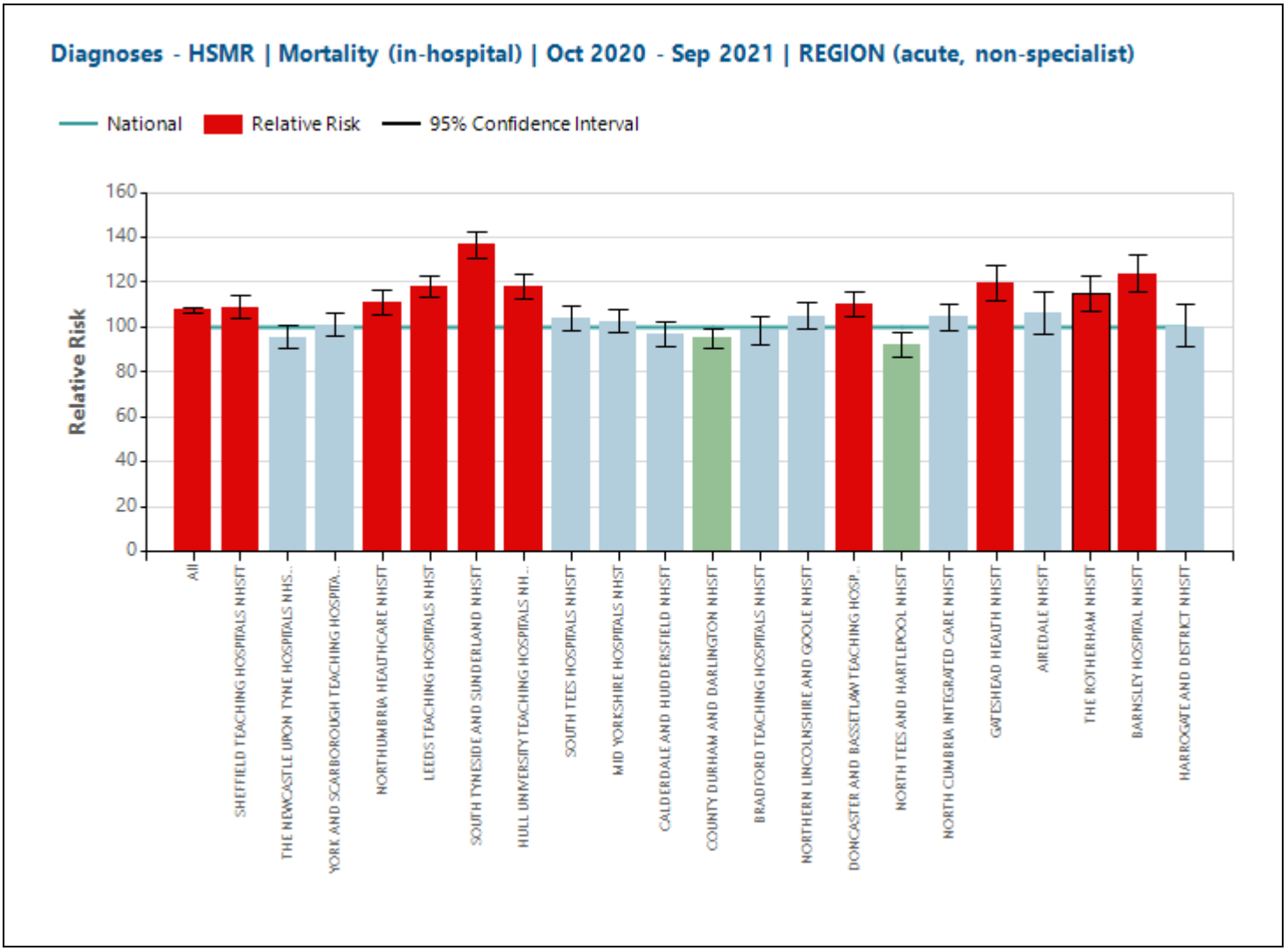


Figure 3 – HSMR 12 Month Peer Comparison



REGION (acute, non-specialist)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		839,365	100.0 %	849,825	27,795	3.3 %	25,845.1	3.1 %	1,949.9	107.5	106.3	108.8
SHEFFIELD TEACHING HOSPITALS NHSFT	RHQ	81,410	9.7 %	82,630	1,890	2.3 %	1,737.8	2.1 %	152.2	108.8	103.9	113.8
THE NEWCASTLE UPON TYNE HOSPITALS NHSFT	RTD	66,755	8.0 %	68,865	1,305	2.0 %	1,365.5	2.0 %	-60.5	95.6	90.5	100.9
YORK AND SCARBOROUGH TEACHING HOSPITALS NHSFT	RCB	54,245	6.5 %	54,790	1,600	3.0 %	1,583.8	2.9 %	16.2	101.0	96.1	106.1
NORTHUMBRIA HEALTHCARE NHSFT	RTF	52,095	6.2 %	52,450	1,750	3.4 %	1,578.0	3.0 %	172.0	110.9	105.8	116.2
LEEDS TEACHING HOSPITALS NHST	RR8	51,640	6.2 %	52,920	2,250	4.4 %	1,908.6	3.7 %	341.4	117.9	113.1	122.9
SOUTH TYNESIDE AND SUNDERLAND NHSFT	R0B	49,350	5.9 %	49,660	1,975	4.0 %	1,446.5	2.9 %	528.5	136.5	130.6	142.7
HULL UNIVERSITY TEACHING HOSPITALS NHST	RWA	49,095	5.8 %	49,775	1,835	3.7 %	1,558.5	3.2 %	276.5	117.7	112.4	123.3
SOUTH TEES HOSPITALS NHSFT	RTR	44,705	5.3 %	45,920	1,395	3.1 %	1,345.1	3.0 %	49.9	103.7	98.3	109.3
MID YORKSHIRE HOSPITALS NHST	RXF	43,895	5.2 %	44,290	1,500	3.4 %	1,462.9	3.3 %	37.1	102.5	97.4	107.9
CALDERDALE AND HUDDERSFIELD NHSFT	RWY	39,370	4.7 %	39,685	1,240	3.1 %	1,285.9	3.3 %	-45.9	96.4	91.1	102.0
COUNTY DURHAM AND DARLINGTON NHSFT	RXP	39,120	4.7 %	39,255	1,755	4.5 %	1,848.5	4.7 %	-93.5	94.9	90.6	99.5
BRADFORD TEACHING HOSPITALS NHSFT	RAE	33,960	4.0 %	34,330	885	2.6 %	902.0	2.7 %	-17.0	98.1	91.8	104.8
NORTHERN LINCOLNSHIRE AND GOOLE NHSFT	RJL	32,795	3.9 %	32,900	1,255	3.8 %	1,196.5	3.7 %	58.5	104.9	99.2	110.9
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHSFT	RP5	31,775	3.8 %	31,985	1,515	4.8 %	1,373.4	4.3 %	141.6	110.3	104.8	116.0
NORTH TEES AND HARTLEPOOL NHSFT	RVW	30,955	3.7 %	31,015	1,015	3.3 %	1,103.8	3.6 %	-88.8	92.0	86.4	97.8
NORTH CUMBRIA INTEGRATED CARE NHSFT	RNN	26,315	3.1 %	26,380	1,155	4.4 %	1,107.1	4.2 %	47.9	104.3	98.4	110.5

GATESHEAD HEALTH NHSFT	RR7	24,180	2.9 %	24,405	845	3.5 %	707.2	2.9 %	137.8	**119.5**	111.6	127.8
AIREDALE NHSFT	RCF	23,390	2.8 %	23,665	495	2.1 %	467.4	2.0 %	27.6	105.9	96.8	115.6
THE ROTHERHAM NHSFT	RFR	22,137	2.6 %	22,176	785	3.5 %	685.1	3.1 %	99.9	**114.6**	106.7	122.9
BARNSLEY HOSPITAL NHSFT	RFF	21,585	2.6 %	21,870	880	4.1 %	712.3	3.3 %	167.7	**123.6**	115.5	132.0
HARROGATE AND DISTRICT NHSFT	RCD	20,595	2.5 %	20,860	465	2.3 %	463.8	2.3 %	1.2	100.3	91.4	109.8

STANDARDISED MORTALITY RATIO OVERVIEW

Key points

- SMR = 112.0 and banded as statistically 'higher than expected'.
  - Excluding spells with both primary and secondary COVID-19 codes the Trusts SMR for the period was 99.7 and banded as statistically 'within expected'.
    - For the last available 12 months patients with either primary or secondary Covid-19 represented 3.8% of admissions (2,478 super-spells, 474 deaths) at the Trust.
- The latest month (Sep-21) SMR = 109.5 banded as statistically 'within expected'.
- Crude mortality (all diagnosis) was 1.7% over the 12 month period compared to 1.6% regional average (acute, non-specialist) and 1.7% national average.
- For the 12 month period (Oct-20 to Sep-21) there were 7 diagnosis groups with a relative risk banded as statistically 'higher than expected':
  - Nonspecific chest pain*
  - Acute bronchitis
  - Other perinatal conditions
  - Syncope
  - Poisoning by other medications and drugs*
  - Liver disease, alcohol-related
  - Nervous system congenital anomalies
- The Trust is 1 of 11 within the regional peer group with an SMR banded as statistically 'higher than expected' over the 12 month period.
- If the 12 month (Oct-20 to Sep-21) SMR values for the regions acute, non-specialist Trusts are ranked (lowest to highest) The Rotherham NHD FT ranks 16th of 21 Trusts.

Figure 4 – SMR Monthly Trend

Diagnoses | Mortality (in-hospital) | Oct-20 to Sep-21 | Trend (month)

Analyse by: Trend (month) Measure: Relative risk Show: All

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	64,191	100.0%	64,338	1,260	2.0%	1122.7	1.7%	137.3	112.2	106.1	118.6
Oct-20	5,222	8.1%	5,231	98	1.9%	92.3	1.8%	5.7	106.1	86.2	129.3
Nov-20	5,036	7.8%	5,055	163	3.2%	117.5	2.3%	45.5	138.7	118.2	161.7
Dec-20	4,869	7.6%	4,876	144	3.0%	115.8	2.4%	28.2	124.3	104.8	146.4
Jan-21	4,689	7.3%	4,708	160	3.4%	120.1	2.6%	39.9	133.2	113.4	155.5
Feb-21	4,903	7.6%	4,917	109	2.2%	103.4	2.1%	5.6	105.4	86.5	127.1
Mar-21	5,571	8.7%	5,585	100	1.8%	99.4	1.8%	0.6	100.6	81.9	122.4
Apr-21	5,298	8.3%	5,312	72	1.4%	70.1	1.3%	1.9	102.7	80.4	129.4
May-21	5,466	8.5%	5,475	75	1.4%	75.2	1.4%	-0.2	99.8	78.5	125.1
Jun-21	5,880	9.2%	5,889	72	1.2%	75.8	1.3%	-3.8	95.0	74.3	119.6
Jul-21	5,731	8.9%	5,741	74	1.3%	77.9	1.4%	-3.9	95.0	74.6	119.3
Aug-21	5,559	8.7%	5,569	95	1.7%	85.6	1.5%	9.4	110.9	89.8	135.6
Sep-21	5,967	9.3%	5,980	98	1.6%	89.5	1.5%	8.5	109.5	88.9	133.5

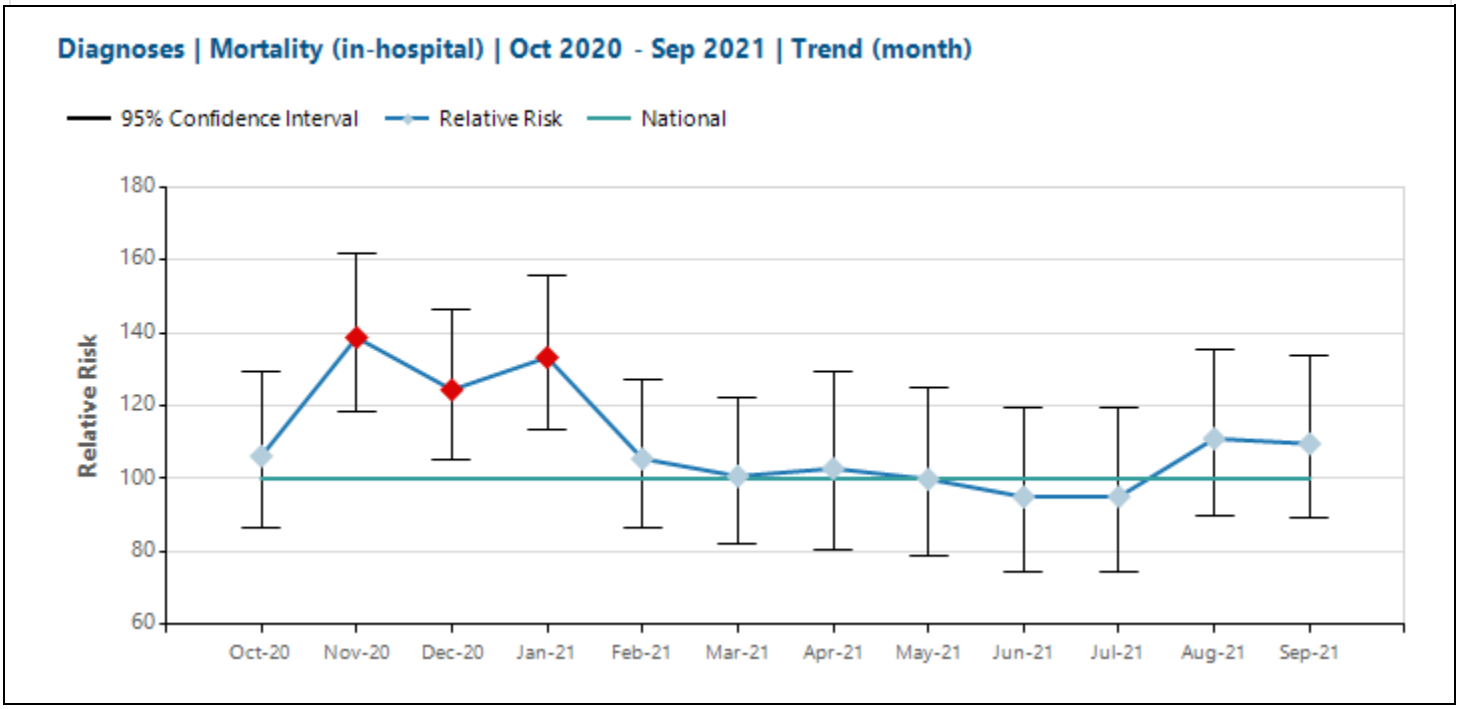
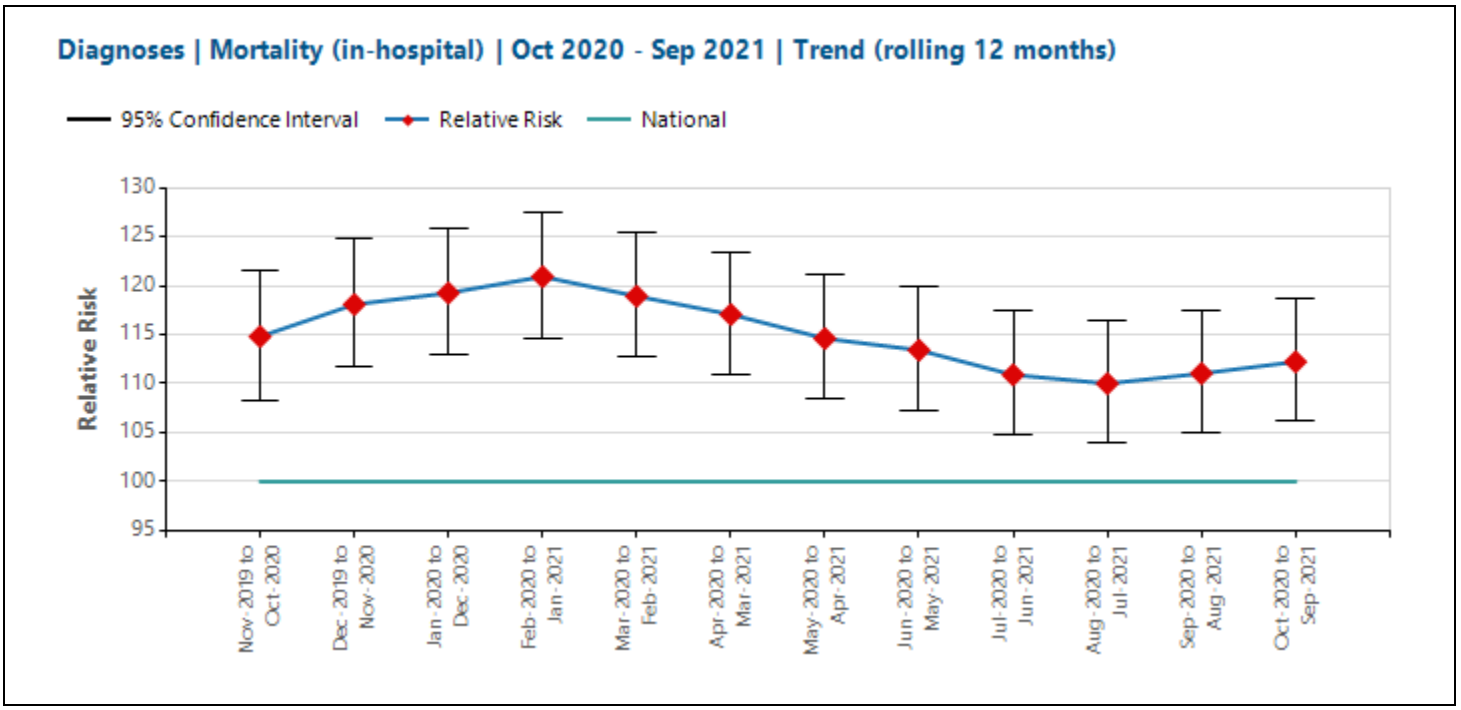
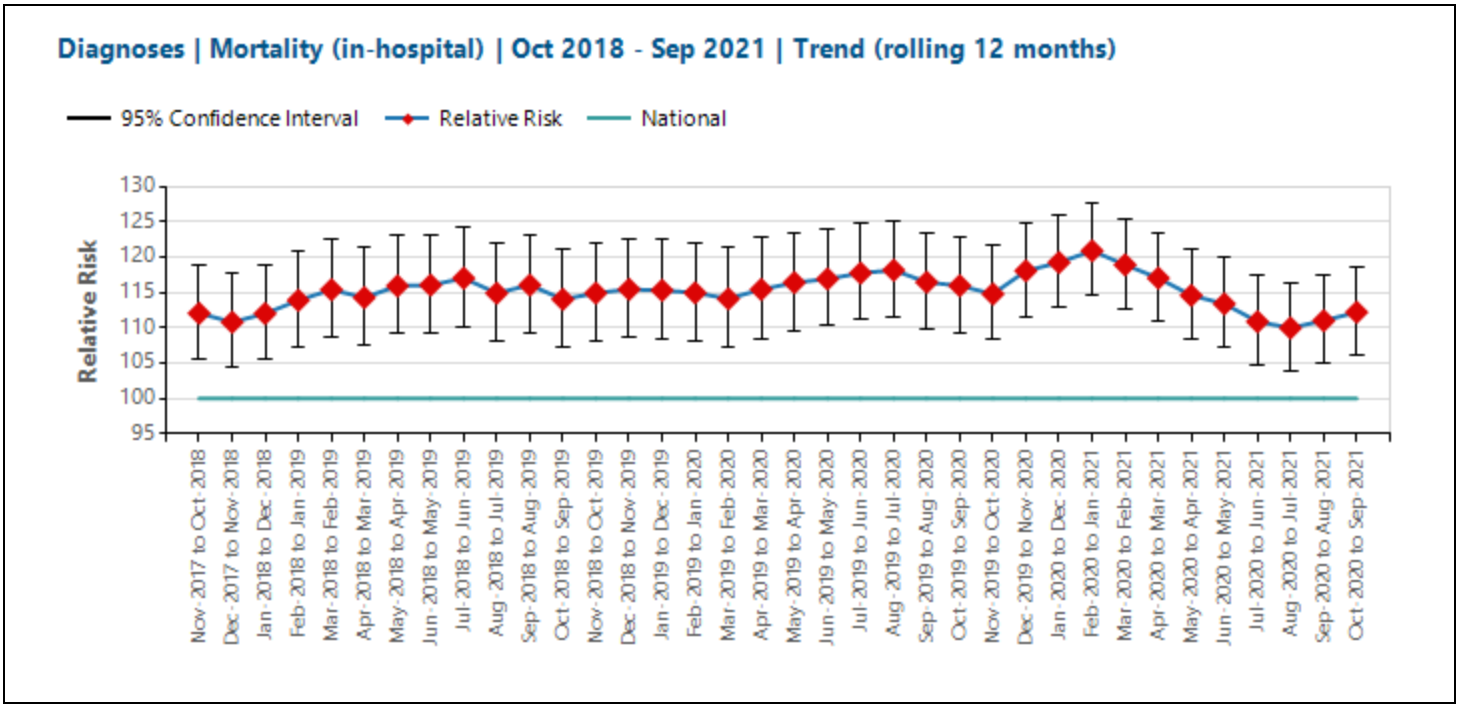


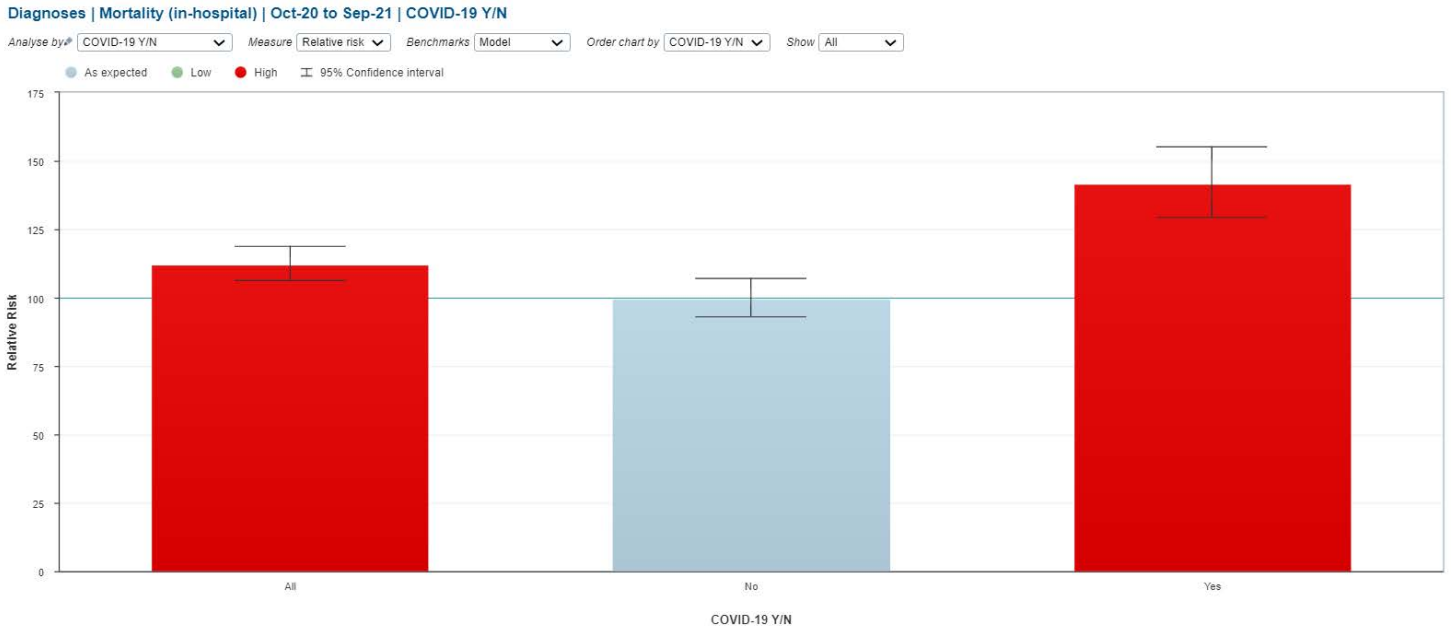
Figure 5 – SMR All Diagnoses Rolling Trend





Impact of Covid-19 within the SMR (all diagnosis) metric

- Excluding spells with both primary and secondary COVID-19 codes the SMR for the 12 month period was 99.7 and banded as statistically 'within expected'.
    - For the last available 12 months patients with either primary or secondary Covid-19 represented 3.5% of admissions (2,242 super-spells, 445 deaths) at the Trust.

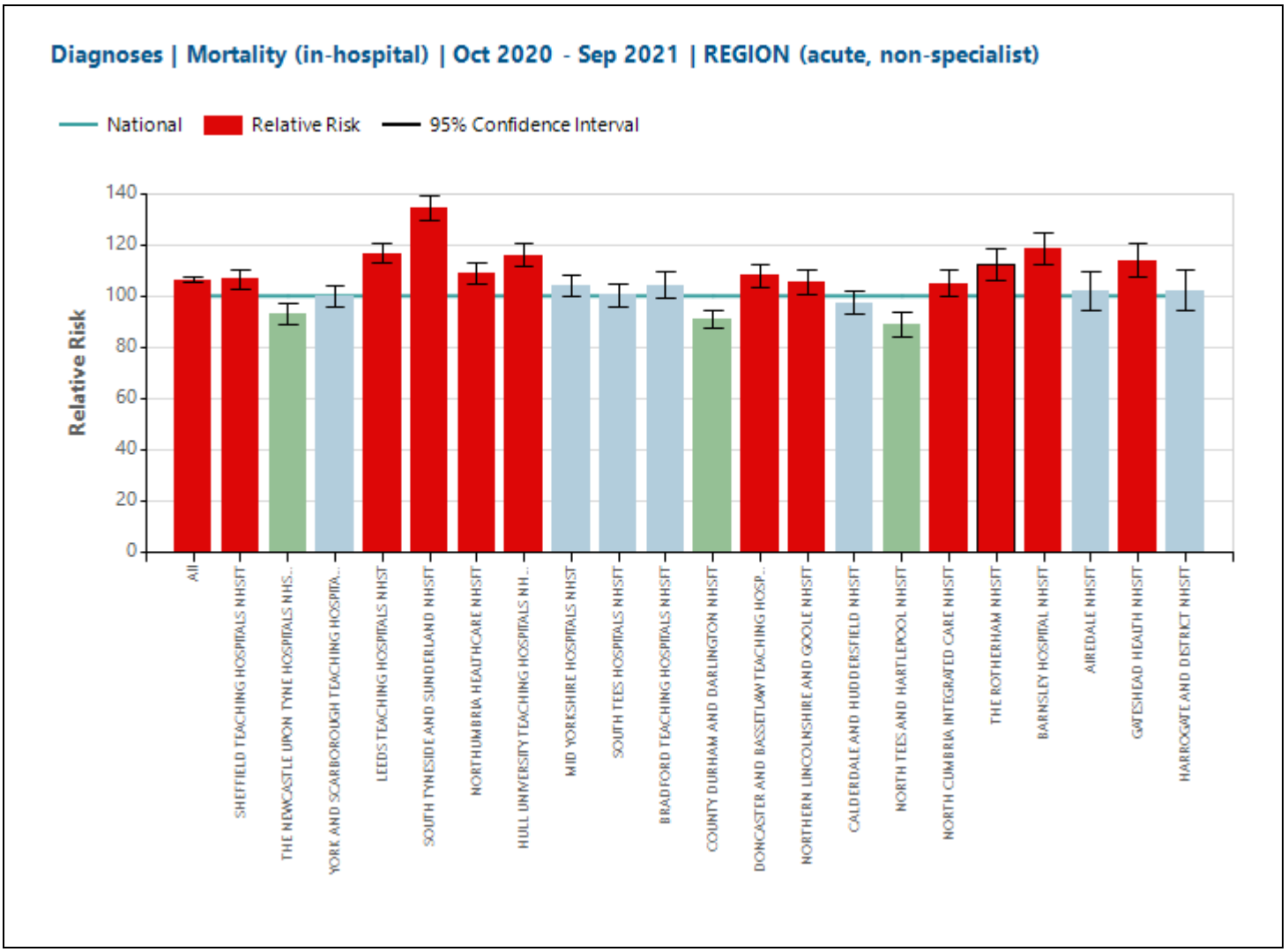


Diagnoses | Mortality (in-hospital) | Oct-20 to Sep-21 | COVID-19 Y/N

Analyse by COVID-19 Y/N Analyse by Trend (month)

COVID-19 Y/N	Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		64,191	100.0%	64,338	1,260	2.0%	1122.7	1.7%	137.3	112.2	106.1	118.6
No		61,733	96.2%	61,860	786	1.3%	788.2	1.3%	-2.2	99.7	92.9	106.9
	Oct-20	5,022	7.8%	5,029	60	1.2%	62.9	1.3%	-2.9	95.3	72.7	122.7
	Nov-20	4,609	7.2%	4,620	58	1.3%	49.6	1.1%	8.4	117.0	88.9	151.3
	Dec-20	4,467	7.0%	4,473	44	1.0%	49.4	1.1%	-5.4	89.0	64.7	119.5
	Jan-21	4,285	6.7%	4,303	66	1.5%	53.4	1.2%	12.6	123.6	95.6	157.2
	Feb-21	4,635	7.2%	4,645	59	1.3%	65.4	1.4%	-6.4	90.2	68.7	116.4
	Mar-21	5,432	8.5%	5,445	82	1.5%	81.3	1.5%	0.7	100.9	80.2	125.2
	Apr-21	5,245	8.2%	5,258	69	1.3%	64.9	1.2%	4.1	106.3	82.7	134.5
	May-21	5,438	8.5%	5,446	73	1.3%	73.9	1.4%	-0.9	98.8	77.4	124.2
	Jun-21	5,858	9.1%	5,866	72	1.2%	75.0	1.3%	-3.0	96.0	75.1	120.9
	Jul-21	5,654	8.8%	5,664	70	1.2%	75.0	1.3%	-5.0	93.3	72.7	117.9
	Aug-21	5,368	8.4%	5,378	66	1.2%	71.6	1.3%	-5.6	92.2	71.3	117.3
	Sep-21	5,720	8.9%	5,733	67	1.2%	65.7	1.1%	1.3	102.0	79.0	129.5
Yes		2,458	3.8%	2,478	474	19.3%	334.5	13.6%	139.5	141.7	129.3	155.1
	Oct-20	200	0.3%	202	38	19.0%	29.4	14.7%	8.6	129.3	91.5	177.4
	Nov-20	427	0.7%	435	105	24.6%	68.0	15.9%	37.0	154.5	126.3	187.0
	Dec-20	402	0.6%	403	100	24.9%	66.4	16.5%	33.6	150.6	122.5	183.2
	Jan-21	404	0.6%	405	94	23.3%	66.7	16.5%	27.3	141.0	113.9	172.5
	Feb-21	268	0.4%	272	50	18.7%	38.0	14.2%	12.0	131.5	97.6	173.4
	Mar-21	139	0.2%	140	18	12.9%	18.1	13.0%	-0.1	99.6	59.0	157.4
	Apr-21	53	0.1%	54	3	5.7%	5.2	9.7%	-2.2	58.2	11.7	170.1
	May-21	28	0.0%	29	2	7.1%	1.3	4.5%	0.7	159.5	17.9	576.0
	Jun-21	22	0.0%	23	0	0.0%	0.8	3.6%	-0.8	0.0	0.0	457.9
	Jul-21	77	0.1%	77	4	5.2%	2.9	3.7%	1.1	140.0	37.7	358.4
	Aug-21	191	0.3%	191	29	15.2%	14.1	7.4%	14.9	206.2	138.1	296.2
	Sep-21	247	0.4%	247	31	12.6%	23.8	9.6%	7.2	130.4	88.6	185.1

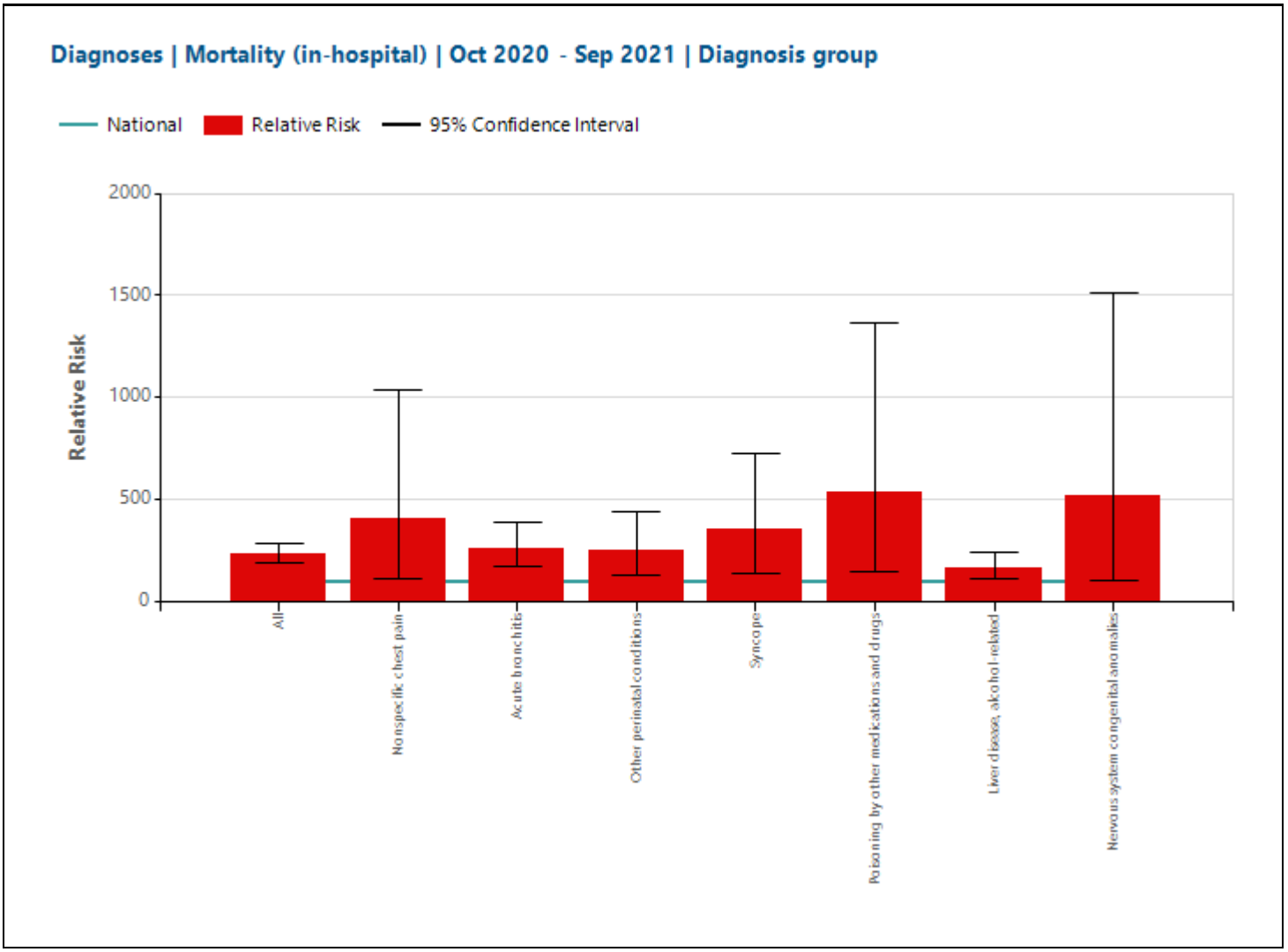
Figure 6 – SMR 12 Month Peer Comparison



REGION (acute, non-specialist)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		2,329,575	100.0 %	2,352,460	40,285	1.7 %	37,981.3	1.6 %	2,303.7	106.1	105.0	107.1
SHEFFIELD TEACHING HOSPITALS NHSFT	RHQ	214,280	9.2 %	216,640	2,785	1.3 %	2,616.5	1.2 %	168.5	106.4	102.5	110.5
THE NEWCASTLE UPON TYNE HOSPITALS NHSFT	RTD	198,495	8.5 %	203,140	1,835	0.9 %	1,980.5	1.0 %	-145.5	92.7	88.5	97.0
YORK AND SCARBOROUGH TEACHING HOSPITALS NHSFT	RCB	151,130	6.5 %	152,420	2,175	1.4 %	2,182.6	1.4 %	-7.6	99.7	95.5	103.9
LEEDS TEACHING HOSPITALS NHST	RR8	148,255	6.4 %	151,075	3,285	2.2 %	2,816.3	1.9 %	468.7	116.6	112.7	120.7
SOUTH TYNESIDE AND SUNDERLAND NHSFT	R0B	136,850	5.9 %	137,685	2,950	2.2 %	2,196.2	1.6 %	753.8	134.3	129.5	139.3
NORTHUMBRIA HEALTHCARE NHSFT	RTF	136,545	5.9 %	137,290	2,465	1.8 %	2,267.6	1.7 %	197.4	108.7	104.5	113.1
HULL UNIVERSITY TEACHING HOSPITALS NHST	RWA	129,045	5.5 %	130,600	2,580	2.0 %	2,228.4	1.7 %	351.6	115.8	111.4	120.3
MID YORKSHIRE HOSPITALS NHST	RXF	128,390	5.5 %	129,655	2,365	1.8 %	2,272.3	1.8 %	92.7	104.1	99.9	108.4
SOUTH TEES HOSPITALS NHSFT	RTR	126,065	5.4 %	128,115	1,945	1.5 %	1,937.5	1.5 %	7.5	100.4	96.0	104.9
BRADFORD TEACHING HOSPITALS NHSFT	RAE	108,345	4.7 %	109,630	1,480	1.4 %	1,421.9	1.3 %	58.1	104.1	98.8	109.5
COUNTY DURHAM AND DARLINGTON NHSFT	RXP	107,380	4.6 %	107,805	2,470	2.3 %	2,722.4	2.5 %	-252.4	90.7	87.2	94.4
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHSFT	RP5	102,870	4.4 %	103,295	2,140	2.1 %	1,984.5	1.9 %	155.5	107.8	103.3	112.5
NORTHERN LINCOLNSHIRE AND GOOLE NHSFT	RJL	102,370	4.4 %	102,650	1,740	1.7 %	1,653.1	1.6 %	86.9	105.3	100.4	110.3
CALDERDALE AND HUDDERSFIELD NHSFT	RWY	97,615	4.2 %	98,180	1,790	1.8 %	1,842.4	1.9 %	-52.4	97.2	92.7	101.8
NORTH TEES AND HARTLEPOOL NHSFT	RVW	79,225	3.4 %	79,415	1,405	1.8 %	1,583.5	2.0 %	-178.5	88.7	84.2	93.5
NORTH CUMBRIA INTEGRATED CARE NHSFT	RNN	70,785	3.0 %	70,985	1,680	2.4 %	1,600.4	2.3 %	79.6	105.0	100.0	110.1

THE ROTHERHAM NHSFT	RFR	64,191	2.8 %	64,338	1,260	2.0 %	1,122.7	1.7 %	137.3	**112.2**	106.1	118.6
BARNSLEY HOSPITAL NHSFT	RFF	63,165	2.7 %	63,725	1,390	2.2 %	1,175.4	1.9 %	214.6	**118.3**	112.1	124.6
AIREDALE NHSFT	RCF	57,560	2.5 %	57,975	710	1.2 %	697.7	1.2 %	12.3	101.8	94.4	109.5
GATESHEAD HEALTH NHSFT	RR7	56,140	2.4 %	56,550	1,185	2.1 %	1,041.6	1.9 %	143.4	**113.8**	107.4	120.4
HARROGATE AND DISTRICT NHSFT	RCD	50,865	2.2 %	51,295	645	1.3 %	632.6	1.2 %	12.4	102.0	94.2	110.2

Figure 7 – SMR Statistically Significant Diagnosis Groups



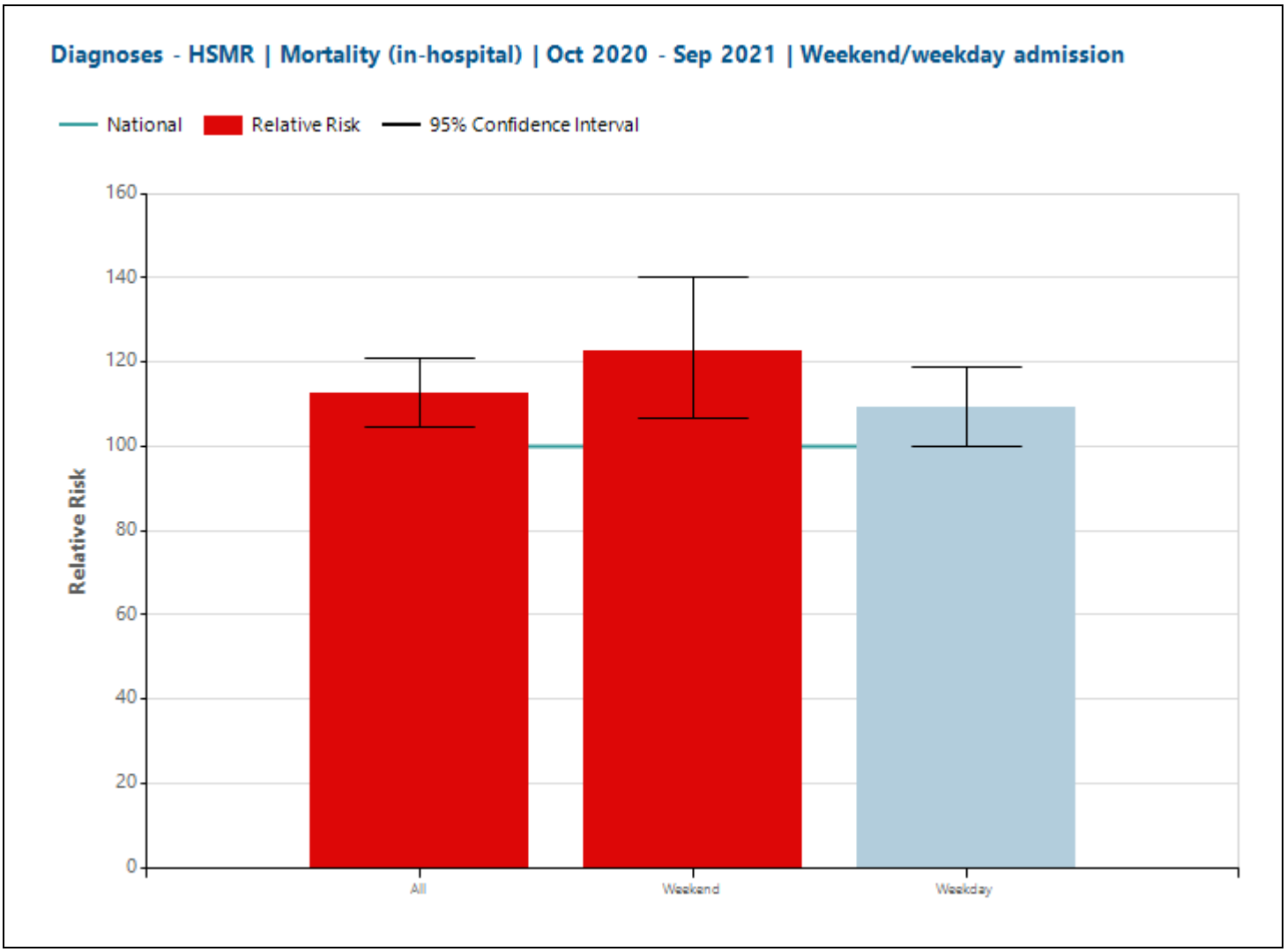
Diagnosis group	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		2,412	100.0 %	2,420	84	3.5 %	36.2	1.5 %	47.8	**232.0**	185.0	287.2
Nonspecific chest pain	102	882	36.6 %	882	4	0.5 %	1.0	0.1 %	3.0	**405.6**	109.1	1,038.5
Acute bronchitis	125	528	21.9 %	530	25	4.7 %	9.6	1.8 %	15.4	**261.2**	169.0	385.6
Other perinatal conditions	224	347	14.4 %	352	12	3.5 %	4.7	1.4 %	7.3	**252.6**	130.4	441.3
Syncope	245	282	11.7 %	283	7	2.5 %	2.0	0.7 %	5.0	**352.2**	141.1	725.7
Poisoning by other medications and drugs	242	239	9.9 %	239	4	1.7 %	.7	0.3 %	3.3	**533.6**	143.6	1,366.2
Liver disease, alcohol-related	150	130	5.4 %	130	29	22.3 %	17.6	13.5 %	11.4	**164.9**	110.4	236.8
Nervous system congenital anomalies	216	4	0.2 %	4	3	75.0 %	.6	14.4 %	2.4	**519.2**	104.3	1,516.9

HSMR WEEKEND/WEEKDAY ANALYSIS

Key points

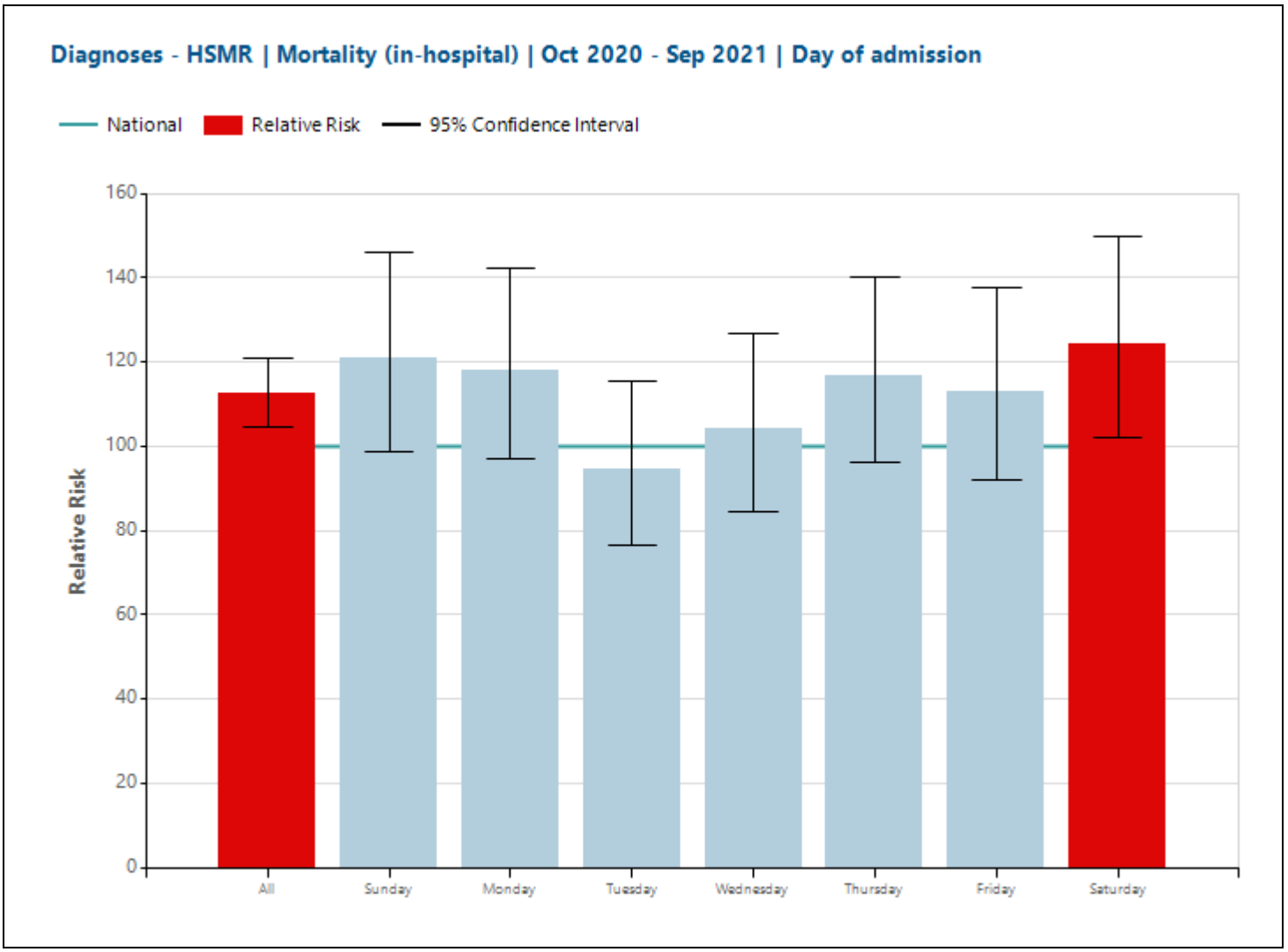
- For the 12 month period Weekend (non-elective) HSMR = 122.5 banded as statistically 'higher than expected'.
- For the 12 month period Weekday (non-elective) HSMR = 109.0 banded as statistically 'within expected'.
  - Of the individual days of admission for non-elective spells within the HSMR basket only Saturday (124.3) has a relative risk that is banded as statistically 'higher than expected'.

Figure 8 – HSMR Weekend/Weekday Admissions Emergency only



Weekend/weekday admission	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		13,164	100.0 %	13,176	733	5.6 %	650.7	4.9 %	82.3	112.6	104.6	121.1
Weekend	1	3,225	24.5 %	3,227	216	6.7 %	176.3	5.5 %	39.7	122.5	106.7	140.0
Weekday	2	9,939	75.5 %	9,949	517	5.2 %	474.4	4.8 %	42.6	109.0	99.8	118.8

Figure 9 – HSMR Day of admission - Emergency only



Day of admission	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		13,164	100.0 %	13,176	733	5.6 %	650.7	4.9 %	82.3	**112.6**	104.6	121.1
Sunday	1	1,534	11.7 %	1,535	105	6.8 %	87.0	5.7 %	18.0	120.7	98.7	146.1
Monday	2	1,981	15.0 %	1,982	110	5.6 %	93.3	4.7 %	16.7	117.9	96.9	142.1
Tuesday	3	2,005	15.2 %	2,008	96	4.8 %	101.5	5.1 %	-5.5	94.6	76.6	115.5
Wednesday	4	1,996	15.2 %	1,996	99	5.0 %	95.2	4.8 %	3.8	104.0	84.6	126.7
Thursday	5	1,978	15.0 %	1,979	113	5.7 %	96.9	4.9 %	16.1	116.6	96.1	140.2
Friday	6	1,979	15.0 %	1,984	99	5.0 %	87.6	4.4 %	11.4	113.0	91.8	137.5
Saturday	7	1,691	12.8 %	1,692	111	6.6 %	89.3	5.3 %	21.7	**124.3**	102.2	149.7

TRENDS IN CODING

Key points

- The proportion of both non-elective spells and deaths within the HSMR basket coded as receiving specialist palliative care is below regional and national averages over the 12 month period.
- The proportion of non-elective spells with a 0 comorbidity score within the HSMR basket (41.3%) is slightly higher than the regional average (39.2%) and national average (40.9%).
- The proportion of non-elective spells with a 20+ comorbidity score within the HSMR basket (17%) is above the regional average (15.9%) and national average (15.7%).

Figure 10 – Palliative Care Coding Rate Vs National

Trend (financial year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2017/2018	26,378	428	1.62%	2.00%	1.97%
2018/2019	31,232	734	2.35%	2.07%	2.05%
2019/2020	29,165	678	2.32%	2.18%	2.21%
2020/2021	37,334	705	1.89%	2.60%	2.58%
2021/2022	23,821	399	1.67%	2.16%	2.11%

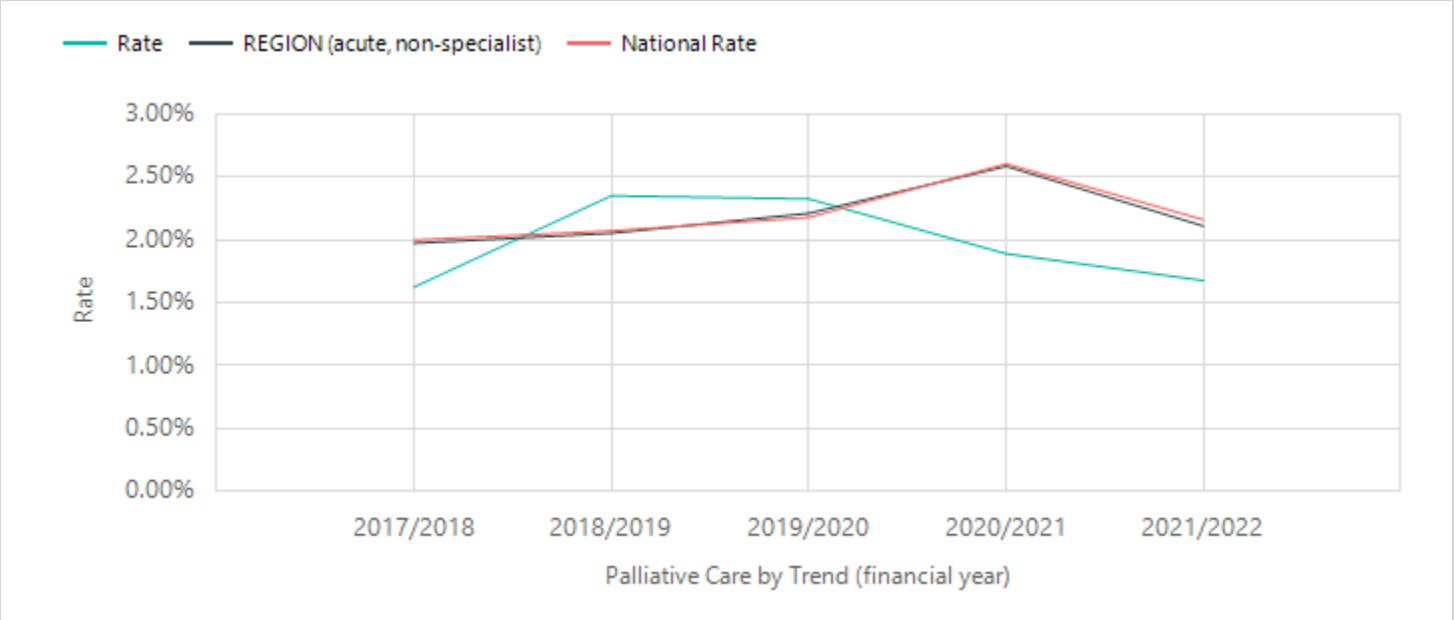


Figure 11 – HSMR and Influencers

Performance	Trust	Peer	National
HSMR	114.6	107.5	100.9
SMR	112.2	106.0	101.3
Non-elective (HSMR)	113.3	106.9	100.5
Weekday, emergency (HSMR)	109.0	105.5	98.8
Weekend, emergency (HSMR)	122.5	111.7	105.5
Saturday, emergency (HSMR)	124.3	110.3	105.0
Sunday, emergency (HSMR)	120.7	113.3	105.9

Coding / Casemix	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)	31.3%	34.6%	38.3%
% Non-elective spells with palliative care (HSMR)	3.7%	4.6%	5.0%
% Spells in Symptoms & Signs chapter	10.8%	5.5%	6.6%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	41.3%	39.2%	40.9%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	17.0%	15.9%	15.7%
% Non-elective spells in Risk Band (0-10%) (HSMR)	86.2%	84.4%	84.3%

Figure 12 – Palliative Care Coding (Palliative Observed Mortality v Superspell Count)

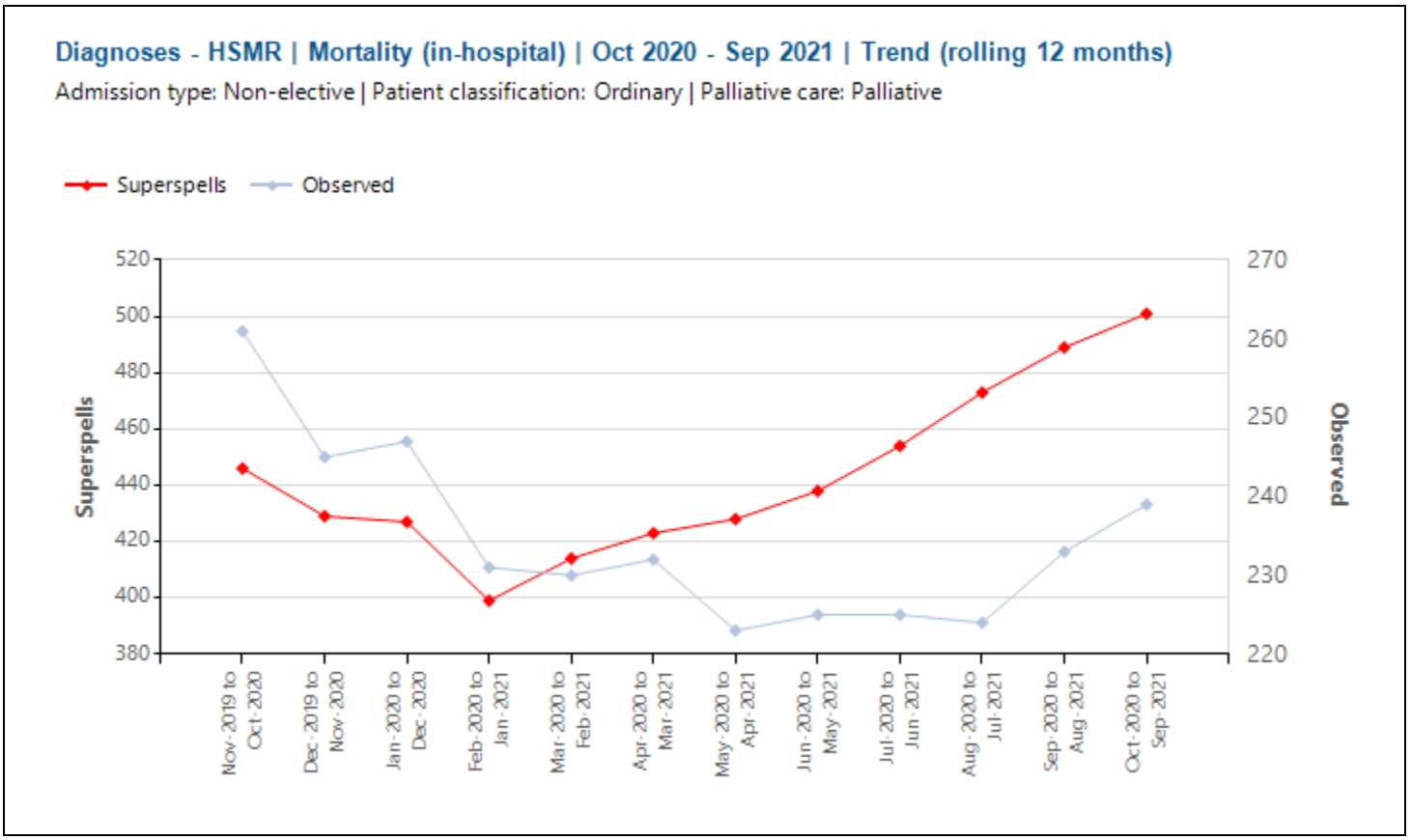


Figure 13 – Charlson Index Co-morbidity Coding Rates Vs National

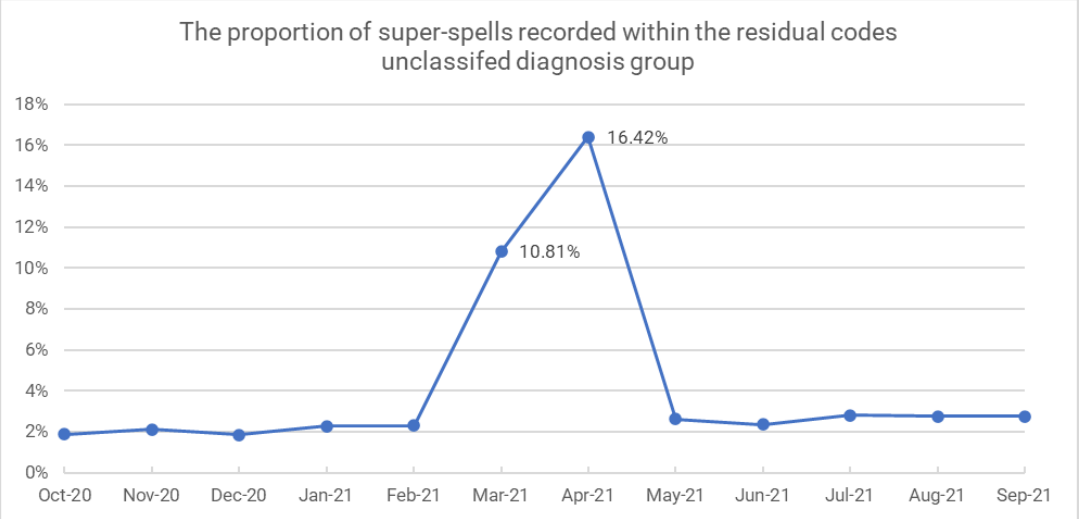
Vol	Mean number of codes				
20/21	20/21	19/20	*England Nov 20 - Oct 21*		
Nov-Oct	Nov-Oct	Nov-Oct	*P25*	*P50*	*P75*
65,124	**6.3**	5.5	**3.1**	**4.4**	**5.1**

Vol	No codes (%)				
20/21	20/21	19/20	*England Nov 20 - Oct 21*		
Nov-Oct	Nov-Oct	Nov-Oct	*P25*	*P50*	*P75*
65,124	**13.8%**	9.8%	**10.5%**	**14.2%**	**23.0%**

Vol	No comorbidity (%)				
20/21	20/21	19/20	*England Nov 20 - Oct 21*		
Nov-Oct	Nov-Oct	Nov-Oct	*P25*	*P50*	*P75*
65,124	**60.9%**	62.0%	**59.4%**	**65.8%**	**78.8%**

Residual Codes, unclassified Monthly Trend

- Following the peak months of Mar-21 (602 spells) and Apr-21 (870 spells) the proprtion of spells within the residual codes, unclassified diagnosis group has returned to the usual range of 2-3% (of all admissions).



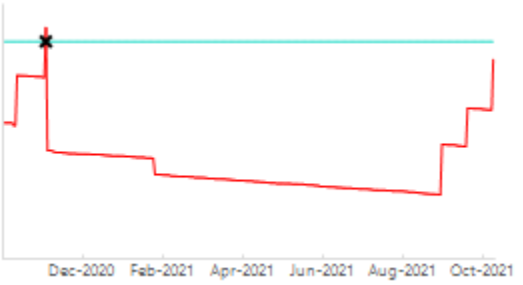
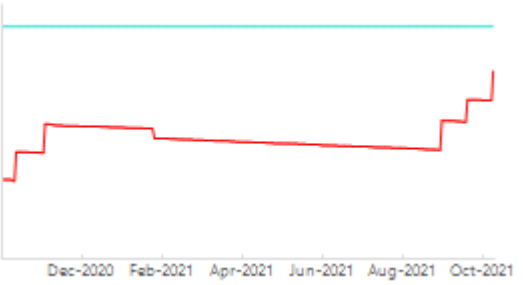
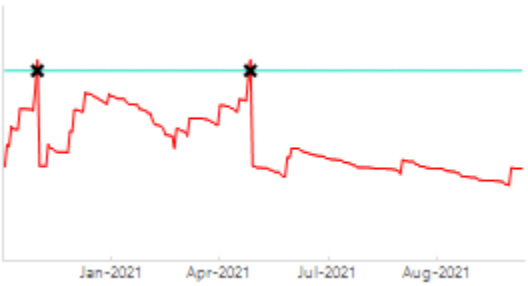
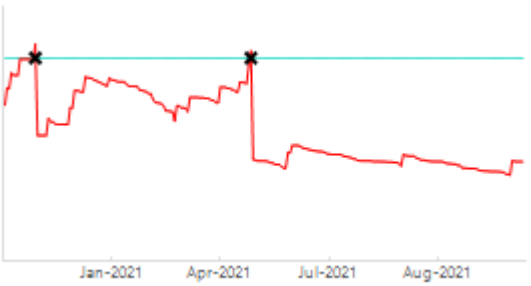
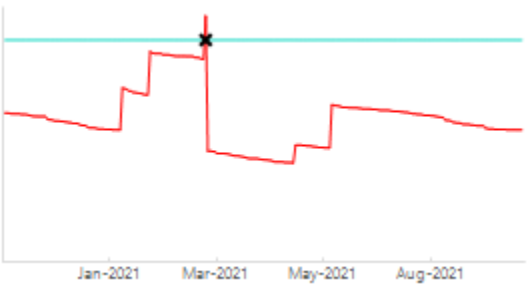
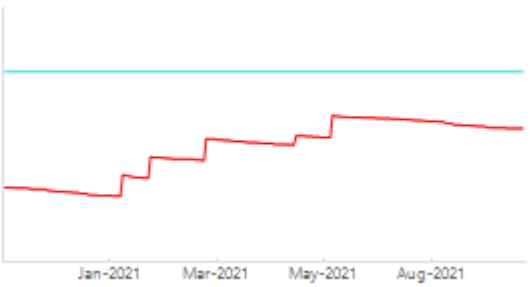
Trend (month)	Super-spells	Spells	Super-spells in the 'residual codes, unclassified' diagnosis group	% of ALL
Oct-20	4,432	5222	98	1.88%
Nov-20	5,035	5036	107	2.12%
Dec-20	4,857	4869	91	1.87%
Jan-21	5,404	4689	107	2.28%
Feb-21	5,218	4903	113	2.30%
Mar-21	5,036	5571	602	10.81%
Apr-21	4,869	5298	870	16.42%
May-21	4,689	5466	144	2.63%
Jun-21	4,903	5880	139	2.36%
Jul-21	5,571	5731	161	2.81%
Aug-21	5,298	5559	153	2.75%
Sep-21	5,474	5967	165	2.77%

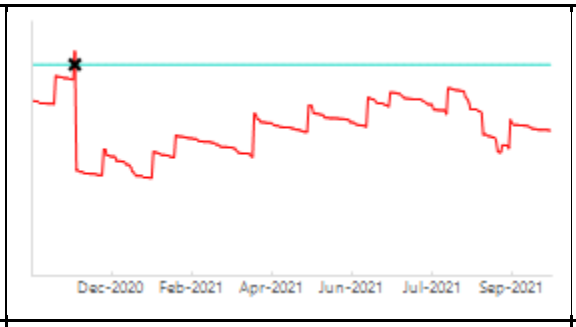
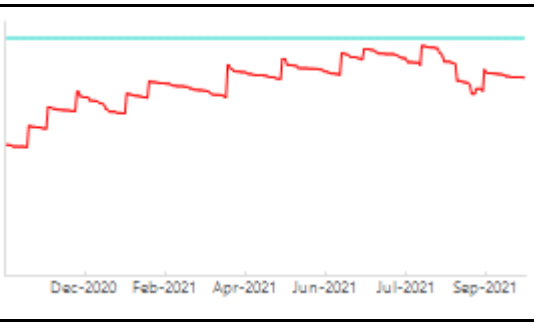
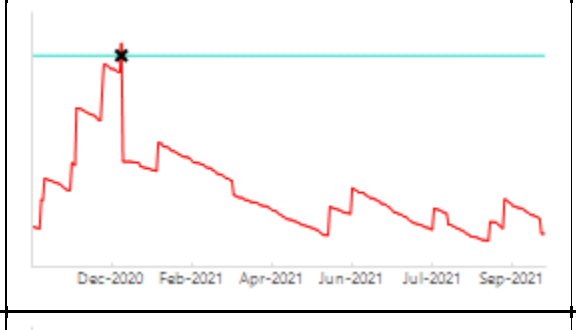
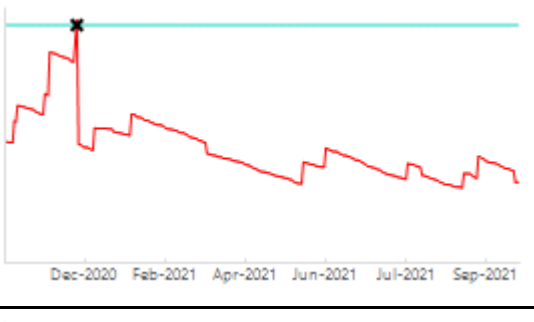
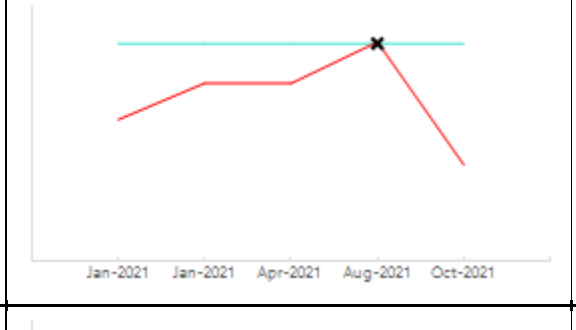
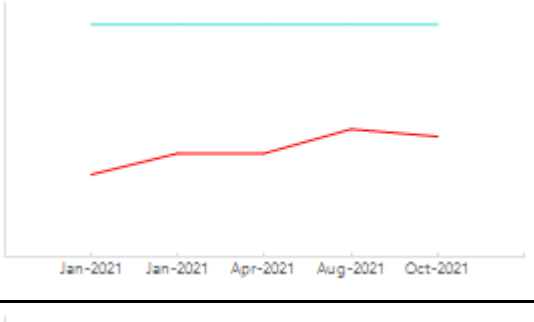
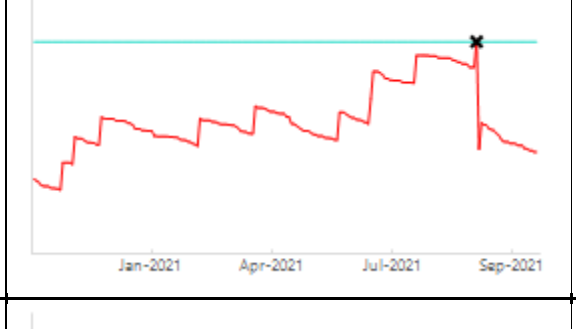
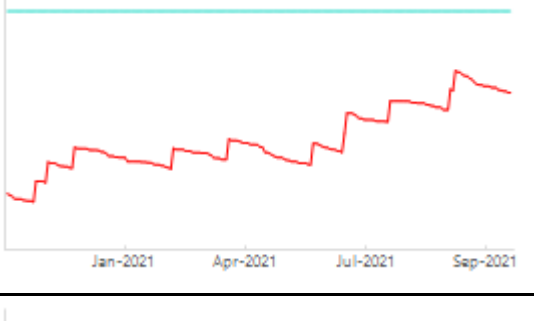
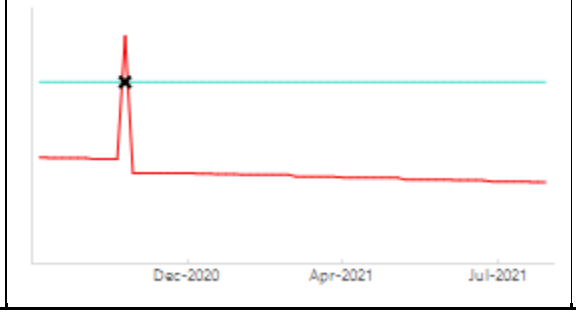
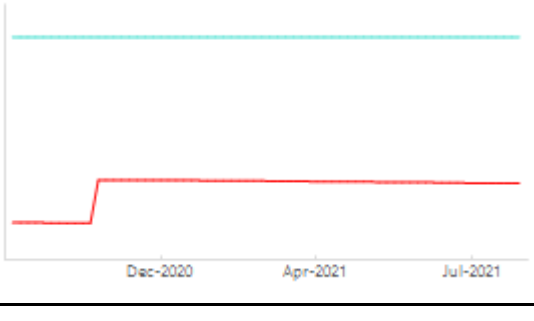
CUSUM ALERTS

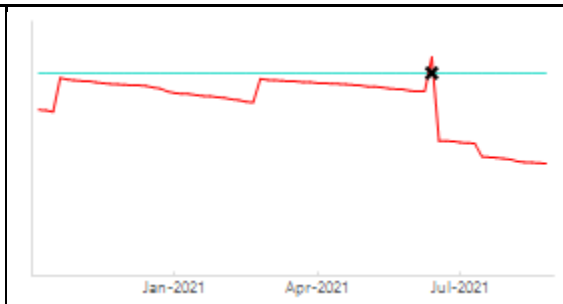
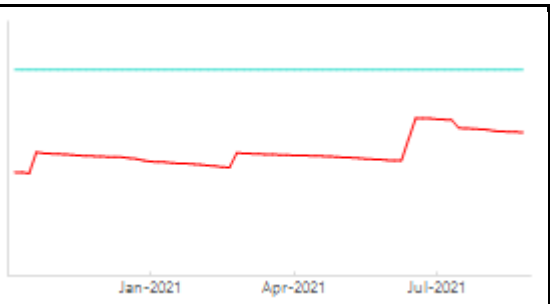
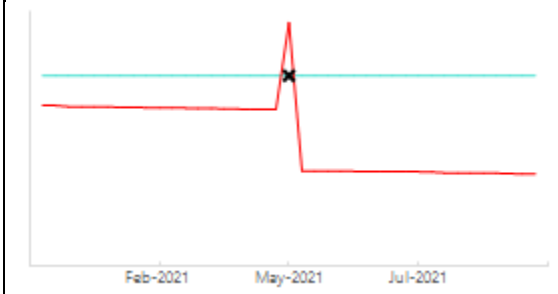
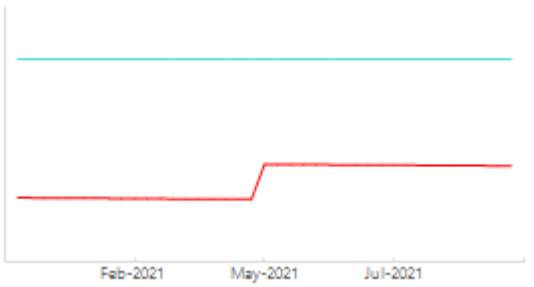
Key points

- Over the 12 month period (Oct-20 to Sep-21) there were CUSUM alerts (using 99% detection threshold criteria) in the following 12 diagnosis groups:
  - Nonspecific chest pain
  - Congestive heart failure, nonhypertensive
  - Acute bronchitis
  - Other upper respiratory disease
  - Biliary tract disease
  - Liver disease, alcohol-related
  - Other connective tissue disease
  - Nervous system congenital anomalies
  - Other perinatal conditions
  - Fever of unknown origin
  - Other psychoses
  - Anxiety, somatoform, dissociative, and personality disorders

Figure 14 – Relative Risk and CUSUM Alerts (Oct 2020 - Sep 2021)

	99% Detection Threshold	99.9% Detection Threshold
Nonspecific chest pain		
Congestive heart failure, nonhypertensive		
Acute bronchitis		
Other upper respiratory disease		

Biliary tract disease		
Liver disease, alcohol-related		
Other connective tissue disease		
Nervous system congenital anomalies		
Other perinatal conditions		
Fever of unknown origin		

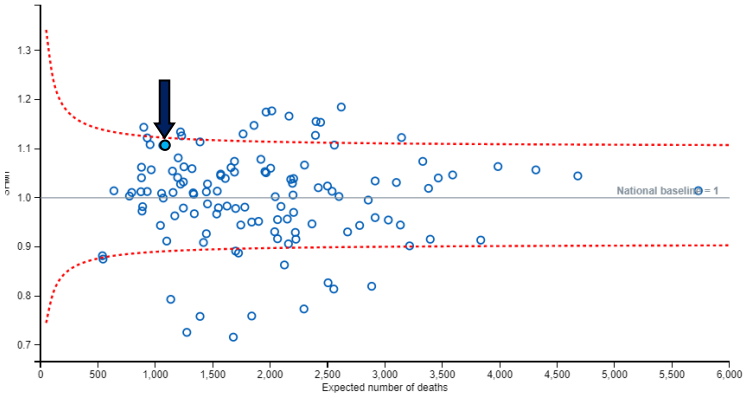
Other psychoses		
Anxiety, somatoform, dissociative, and personality disorders		

MONTHLY SHMI

Key points

- SHMI for The Rotherham NHS FT = 110.66 banded as statistically 'within expected' using the 95% control limits (adjusted for over dispersion) published by NHS digital.
  - During the 12 month period (Sep-20 to Aug-21) there were 745 in-hospital deaths and 435 out of hospital deaths recorded within the metric.
  - The Trust is one of 11 within the NHS England (Yorkshire and Humber) region with a SHMI banded in the statistically 'within expected' range.

SHMI Funnel Plot (Sep-20 to Aug-21)



SHMI - Summary Hospital Mortality Indicator

Period: Sep 20 - Aug 21

Provider: RFR - THE ROTHERHAM NHS FOUNDATION TRUST

Region: NHS ENGLAND NORTH (YORKSHIRE AND HUMBER)

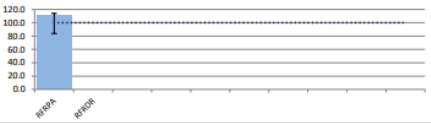
Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

click group name to filter; click header title to clear

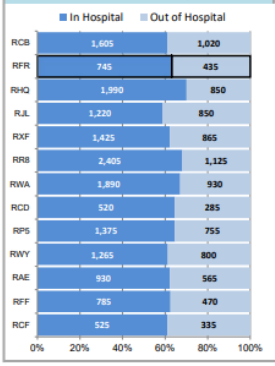
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RCF	Airedale NHS Foundation Trust	28,590	860	885	-25	97.29	88.80	112.61
RFF	Barnsley Hospital NHS Foundation Trust	39,470	1,255	1,220	35	102.78	89.26	112.04
RAE	Bradford Teaching Hospitals NHS Foundation Trust	71,570	1,495	1,455	40	102.81	89.46	111.78
RWY	Calderdale And Huddersfield NHS Foundation Trust	56,760	2,065	1,965	100	105.10	89.74	111.44
RP5	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trus	57,085	2,130	1,860	270	114.74	89.69	111.49
RCD	Harrogate And District NHS Foundation Trust	24,030	805	795	10	101.08	88.62	112.84
RWA	Hull University Teaching Hospitals NHS Trust	64,755	2,815	2,440	375	115.37	89.90	111.24
RR8	Leeds Teaching Hospitals NHS Trust	93,830	3,530	3,145	385	112.27	90.05	111.05
RXF	Mid Yorkshire Hospitals NHS Trust	73,140	2,290	2,205	85	103.91	89.83	111.32
RJL	Northern Lincolnshire And Goole NHS Foundation Trust	53,710	2,070	1,920	150	107.83	89.72	111.46
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	98,680	2,840	2,855	-15	99.53	90.00	111.12
RFR	The Rotherham NHS Foundation Trust	39,690	1,180	1,065	115	110.66	89.08	112.26
RCB	York And Scarborough Teaching Hospitals NHS Foundation Trust	82,310	2,625	2,780	-155	94.36	89.98	111.14
Group		783,620	25,960	24,590	1,370	105.57		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
ROTHERHAM DISTRICT GENERAL	39,315	1,175	1,060	110.70	86.19	116.02
DONCASTER & BASSETLAW	375	*	*			

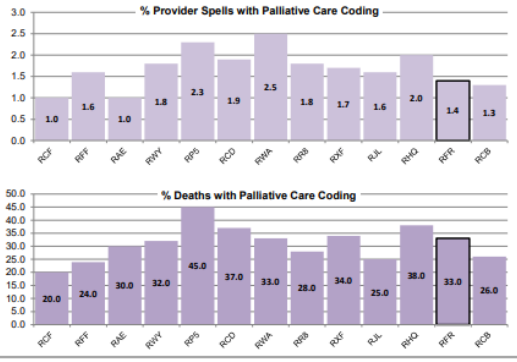


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	110	95.00	114.80	79.07 126.47
Cancer of bronchus, lung	10	10.00	*	*
Secondary malignancies	10	20.00	51.93	63.98 156.31
Fluid and electrolyte disorders	25	15.00	161.77	60.62 164.95
Acute myocardial infarction	25	25.00	103.79	67.62 147.88
Pneumonia	190	175.00	107.91	84.40 118.49
Acute bronchitis	25	15.00	177.19	59.35 168.50
Gastrointestinal haemorrhage	20	15.00	107.62	61.93 161.48
Urinary tract infections	40	30.00	131.61	67.13 148.97
Fracture of neck of femur (hip)	15	20.00	75.47	63.44 157.63

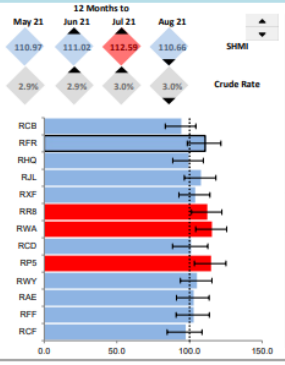
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(93) Liver disease, alcohol-related	25	15	166.67	107.83 246.04
(65) Congestive heart failure, nonhypertensive	55	45	122.22	92.07 159.09
(94) Other liver diseases	15	10	150.00	83.89 247.42
(92) Biliary tract disease	15	10	150.00	83.89 247.42
(99) Acute and unspecified renal failure	40	35	114.29	81.64 155.63
(66) Acute cerebrovascular disease	40	35	114.29	81.64 155.63
(113) Other connective tissue disease	20	15	133.33	81.41 205.93
(89) Intestinal obstruction without hernia	20	15	133.33	81.41 205.93

*Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's

APPENDICES

Nonspecific chest pain diagnosis group

- New alert for this time period.
- 882 super-spells and 4 observed outcomes over the 12 month period. RR= 405.6 banded as statistically 'higher than expected'.
- Link to the records of the 4 observed outcomes: https://one.drfoster.com/Query/?id=2199892

Age Profile

Nonspecific chest pain | Mortality (in-hospital) | Oct-20 to Sep-21 | Age (broad bands)
Diagnosis group: Nonspecific chest pain

Analyse by Age (broad bands) *Measure* Relative risk *Show* All

Age (broad bands)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	882	100.0%	882	4	0.5%	1.0	0.1%	3.0	405.6	109.1	1038.5
0-17	23	2.6%	23	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	2.29e+5
18-29	82	9.3%	82	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	91596.6
30-49	232	26.3%	232	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	25763.6
50-64	241	27.3%	241	0	0.0%	0.1	0.0%	-0.1	0.0	0.0	3287.4
65-74	131	14.9%	131	0	0.0%	0.1	0.1%	-0.1	0.0	0.0	4030.8
75-84	133	15.1%	133	1	0.8%	0.5	0.3%	0.5	219.8	2.9	1222.9
85+	40	4.5%	40	3	7.5%	0.3	0.8%	2.7	971.6	195.3	2839.0

Specialty (of diagnosis)

Nonspecific chest pain | Mortality (in-hospital) | Oct-20 to Sep-21 | Specialty (of diagnosis)
Diagnosis group: Nonspecific chest pain

Analyse by Specialty (of diagnosis) *Measure* Relative risk *Show* All

Specialty (of diagnosis)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	882	100.0%	882	4	0.5%	1.0	0.1%	3.0	405.6	109.1	1038.5
ACUTE INTERNAL MEDICINE	398	45.1%	398	2	0.5%	0.4	0.1%	1.6	475.9	53.5	1718.3
GENERAL MEDICINE	388	44.0%	388	2	0.5%	0.5	0.1%	1.5	378.1	42.5	1365.2
CARDIOLOGY	35	4.0%	35	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	35251.8
GENERAL SURGERY	20	2.3%	20	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	40780.6
PAEDIATRICS	19	2.2%	19	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	2.80e+5
ACCIDENT & EMERGENCY	5	0.6%	5	0	0.0%	0.0	0.2%	-0.0	0.0	0.0	41047.1
GERIATRIC MEDICINE	4	0.5%	4	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	1.49e+5
RESPIRATORY MEDICINE (also known as thoracic medicine)	4	0.5%	4	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	2.57e+5
GYNAECOLOGY	3	0.3%	3	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	3.89e+5
CLINICAL HAEMATOLOGY	2	0.2%	2	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	4.27e+5
ENDOCRINOLOGY	2	0.2%	2	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	8.15e+5
TRAUMA & ORTHOPAEDICS	1	0.1%	1	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	4.10e+5
UROLOGY	1	0.1%	1	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	1.41e+6

LOS

Nonspecific chest pain | Mortality (in-hospital) | Oct-20 to Sep-21 | LOS (6 bands)
Diagnosis group: Nonspecific chest pain

Analyse by LOS (6 bands) *Measure* Relative risk *Show* All

LOS (6 bands)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	882	100.0%	882	4	0.5%	1.0	0.1%	3.0	405.6	109.1	1038.5
0 Days	590	66.9%	590	0	0.0%	0.3	0.0%	-0.3	0.0	0.0	1434.5
1-6 Days	263	29.8%	263	1	0.4%	0.5	0.2%	0.5	200.2	2.6	1113.6
7-13 Days	22	2.5%	22	1	4.5%	0.0	0.1%	1.0	3378.3	44.2	18796.5
14-20 Days	6	0.7%	6	2	33.3%	0.2	3.3%	1.8	996.7	111.9	3598.5
21-27 Days	1	0.1%	1	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	6.72e+5

Comorbidity score

Nonspecific chest pain | Mortality (in-hospital) | Oct-20 to Sep-21 | Comorbidity score
Diagnosis group: Nonspecific chest pain

Analyse by Comorbidity score *Measure* Relative risk *Show* All

Comorbidity score	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	882	100.0%	882	4	0.5%	1.0	0.1%	3.0	405.6	109.1	1038.5
0 (none)	440	49.9%	440	0	0.0%	0.1	0.0%	-0.1	0.0	0.0	4577.1
1	1	0.1%	1	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	4.93e+5
3	34	3.9%	34	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	34071.1
4	121	13.7%	121	1	0.8%	0.0	0.0%	1.0	2515.3	32.9	13994.9
5	41	4.6%	41	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	20040.4
6-9	55	6.2%	55	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	9918.1
10-19	108	12.2%	108	1	0.9%	0.1	0.1%	0.9	812.5	10.6	4520.5
20-49	79	9.0%	79	2	2.5%	0.7	0.8%	1.3	305.3	34.3	1102.2
50+	3	0.3%	3	0	0.0%	0.0	0.7%	-0.0	0.0	0.0	17272.0

Primary diagnosis

Nonspecific chest pain | Mortality (in-hospital) | Oct-20 to Sep-21 | ICD10 (4-char)
Diagnosis group: Nonspecific chest pain

Analyse by: ICD10 (4-char) Measure: Relative risk Show: All

ICD10 (4-char)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	882	100.0%	882	4	0.5%	1.0	0.1%	3.0	405.6	109.1	1038.5
R07.3 Other chest pain	348	39.5%	348	1	0.3%	0.4	0.1%	0.6	236.7	3.1	1316.9
R07.4 Chest pain, unspecified	300	34.0%	300	1	0.3%	0.4	0.1%	0.6	247.4	3.2	1376.7
R07.2 Precordial pain	211	23.9%	211	2	0.9%	0.2	0.1%	1.8	1311.1	147.3	4733.7
R07.1 Chest pain on breathing	23	2.6%	23	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	52838.6

Covid-19

Nonspecific chest pain | Mortality (in-hospital) | Oct-20 to Sep-21 | COVID-19 Y/N
Diagnosis group: Nonspecific chest pain

Analyse by: COVID-19 Y/N Measure: Relative risk Show: All

COVID-19 Y/N	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	882	100.0%	882	4	0.5%	1.0	0.1%	3.0	405.6	109.1	1038.5
No	871	98.8%	871	3	0.3%	1.0	0.1%	2.0	307.0	61.7	896.9
Yes	11	1.2%	11	1	9.1%	0.0	0.1%	1.0	11283.4	147.5	62779.2

Palliative care

Nonspecific chest pain | Mortality (in-hospital) | Oct-20 to Sep-21 | Palliative care
Diagnosis group: Nonspecific chest pain

Analyse by: Palliative care Measure: Relative risk Show: All

Palliative care	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	882	100.0%	882	4	0.5%	1.0	0.1%	3.0	405.6	109.1	1038.5
Non-palliative	879	99.7%	879	3	0.3%	0.5	0.1%	2.5	575.3	115.6	1680.9
Palliative	3	0.3%	3	1	33.3%	0.5	15.5%	0.5	215.2	2.8	1197.4

Procedures

Nonspecific chest pain | Mortality (in-hospital) | Oct-20 to Sep-21 | Procedure group
Diagnosis group: Nonspecific chest pain

Analyse by: Procedure group Measure: Relative risk Show: All

Procedure group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	882	100.0%	882	4	0.5%	1.0	0.1%	3.0	405.6	109.1	1038.5
Diagnostic imaging (except heart)	396	44.9%	396	2	0.5%	0.3	0.1%	1.7	588.4	66.1	2124.5
No Procedure	376	42.6%	376	1	0.3%	0.6	0.2%	0.4	164.8	2.1	917.1
Diagnostic imaging of heart	40	4.5%	40	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	21822.1
Contrast radiology or catheterisation of heart	32	3.6%	32	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	69556.0
Rest of Miscellaneous operations	30	3.4%	30	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	40339.7
Rest of Arteries and veins (diagnostic/minor)	2	0.2%	2	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	3.44e+5
Urethral catheterisation of bladder	2	0.2%	2	1	50.0%	0.0	0.3%	1.0	19281.6	252.0	1.07e+5
Diagnostic tests	1	0.1%	1	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	1.79e+6
Liver biopsy	1	0.1%	1	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	4.70e+5
Rest of Heart	1	0.1%	1	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	3.99e+5
Rest of Upper GI	1	0.1%	1	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	1.39e+6

Poisoning by other medications and drugs diagnosis group

- Over the 12 month period 229 super-spells and 4 observed outcomes under the following primary diagnosis codes:
  - T39.1 Poisoning: 4-Aminophenol derivatives (28 years old, 48 years old)
  - T44.7 Poisoning: Beta-adrenoreceptor antagonists, not elsewhere classified (88 years old)
  - T38.3 Poisoning: Insulin and oral hypoglycaemic [antidiabetic] drugs (66 years old)
- RR= 533.6 (4 observed, 0.7 expected) banded as statistically 'higher than expected'.
- Link to the 4 outcome records: https://one.drfoster.com/Query/?id=2200042

Primary diagnosis (ICD-10)

Poisoning by other medications and drugs | Mortality (in-hospital) | Oct-20 to Sep-21 | ICD10 (3-char)
Diagnosis group: Poisoning by other medications and drugs

Analyse by: ICD10 (3-char) Measure: Relative risk Show: All

ICD10 (3-char)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	239	100.0%	239	4	1.7%	0.7	0.3%	3.3	533.6	143.6	1366.2
T39 Poisoning by nonopioid analgesics, antipyretics and antir…	177	74.1%	177	2	1.1%	0.5	0.3%	1.5	413.8	46.5	1494.1
T38 Poisoning by hormones and their synthetic substitutes an…	22	9.2%	22	1	4.5%	0.1	0.4%	0.9	1218.2	15.9	6777.8
T44 Poisoning by drugs primarily affecting the autonomic nerv…	17	7.1%	17	1	5.9%	0.1	0.4%	0.9	1448.5	18.9	8059.3
T50 Poisoning by diuretics and other and unspecified drugs, …	10	4.2%	10	0	0.0%	0.1	0.7%	-0.1	0.0	0.0	5326.1
T46 Poisoning by agents primarily affecting the cardiovascula…	7	2.9%	7	0	0.0%	0.0	0.5%	-0.0	0.0	0.0	9867.2
T45 Poisoning by primarily systemic and haematological agen…	5	2.1%	5	0	0.0%	0.0	0.2%	-0.0	0.0	0.0	40971.6
T41 Poisoning by anaesthetics and therapeutic gases	1	0.4%	1	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	2.42e+6

Age profile

Poisoning by other medications and drugs | Mortality (in-hospital) | Oct-20 to Sep-21 | Age (broad bands)

Diagnosis group: Poisoning by other medications and drugs

Analyse by: Age (broad bands) | Measure: Relative risk | Show: All

Age (broad bands)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	239	100.0%	239	4	1.7%	0.7	0.3%	3.3	533.6	143.6	1366.2
30-49	71	29.7%	71	1	1.4%	0.2	0.2%	0.8	574.1	7.5	3194.4
18-29	61	25.5%	61	1	1.6%	0.1	0.1%	0.9	1302.2	17.0	7245.1
0-17	57	23.8%	57	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	60500.3
50-64	31	13.0%	31	0	0.0%	0.2	0.6%	-0.2	0.0	0.0	2118.6
65-74	8	3.3%	8	1	12.5%	0.1	1.2%	0.9	1050.5	13.7	5845.1
75-84	7	2.9%	7	0	0.0%	0.1	1.8%	-0.1	0.0	0.0	2843.1
85+	4	1.7%	4	1	25.0%	0.1	2.4%	0.9	1050.4	13.7	5844.4

Admission method

Poisoning by other medications and drugs | Mortality (in-hospital) | Oct-20 to Sep-21 | Admission method

Diagnosis group: Poisoning by other medications and drugs

Analyse by: Admission method | Measure: Relative risk | Show: All

Admission method	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	239	100.0%	239	4	1.7%	0.7	0.3%	3.3	533.6	143.6	1366.2
Emergency - via A&E	236	98.7%	236	4	1.7%	0.7	0.3%	3.3	534.9	143.9	1369.4
Elective - booked	1	0.4%	1	0	0.0%	0.0	0.2%	-0.0	0.0	0.0	2.29e+5
Emergency - via A&E another provider	1	0.4%	1	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	4.51e+6
Emergency - via GP	1	0.4%	1	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	4.82e+6

Specialty (of diagnosis)

Poisoning by other medications and drugs | Mortality (in-hospital) | Oct-20 to Sep-21 | Specialty (of diagnosis)

Diagnosis group: Poisoning by other medications and drugs

Analyse by: Specialty (of diagnosis) | Measure: Relative risk | Show: All

Specialty (of diagnosis)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	239	100.0%	239	4	1.7%	0.7	0.3%	3.3	533.6	143.6	1366.2
ACUTE INTERNAL MEDICINE	106	44.4%	106	3	2.8%	0.5	0.4%	2.5	642.1	129.1	1876.1
GENERAL MEDICINE	71	29.7%	71	0	0.0%	0.2	0.3%	-0.2	0.0	0.0	1792.8
PAEDIATRICS	43	18.0%	43	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	85389.6
GERIATRIC MEDICINE	7	2.9%	7	0	0.0%	0.0	0.2%	-0.0	0.0	0.0	31344.5
RESPIRATORY MEDICINE (also known as thoracic medicine)	4	1.7%	4	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	8.24e+5
ENDOCRINOLOGY	3	1.3%	3	0	0.0%	0.0	0.7%	-0.0	0.0	0.0	18422.7
CARDIOLOGY	2	0.8%	2	0	0.0%	0.0	1.1%	-0.0	0.0	0.0	16992.2
GENERAL SURGERY	2	0.8%	2	0	0.0%	0.0	0.6%	-0.0	0.0	0.0	32608.2
ACCIDENT & EMERGENCY	1	0.4%	1	1	100.0%	0.0	0.9%	1.0	11688.4	152.8	65032.3

Previous emergency admissions (within last 12 months)

Poisoning by other medications and drugs | Mortality (in-hospital) | Oct-20 to Sep-21 | A&E Attendance history (1 yr)

Diagnosis group: Poisoning by other medications and drugs

Analyse by: A&E Attendance history | Measure: Relative risk | Show: All

A&E Attendance history (1 yr)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	239	100.0%	239	4	1.7%	0.7	0.3%	3.3	533.6	143.6	1366.2
No previous attendances	222	92.9%	222	4	1.8%	0.7	0.3%	3.3	561.8	151.2	1438.4
One previous attendance	12	5.0%	12	0	0.0%	0.0	0.3%	-0.0	0.0	0.0	12157.2
Two previous attendances	4	1.7%	4	0	0.0%	0.0	0.2%	-0.0	0.0	0.0	52212.2
Three or more previous attendances	1	0.4%	1	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	9.00e+5

Risk band

Poisoning by other medications and drugs | Mortality (in-hospital) | Oct-20 to Sep-21 | Risk band

Diagnosis group: Poisoning by other medications and drugs

Analyse by: Risk band | Measure: Relative risk | Show: All

Risk band	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	239	100.0%	239	4	1.7%	0.7	0.3%	3.3	533.6	143.6	1366.2
0-10%	239	100.0%	239	4	1.7%	0.7	0.3%	3.3	533.6	143.6	1366.2

Comorbidity Score

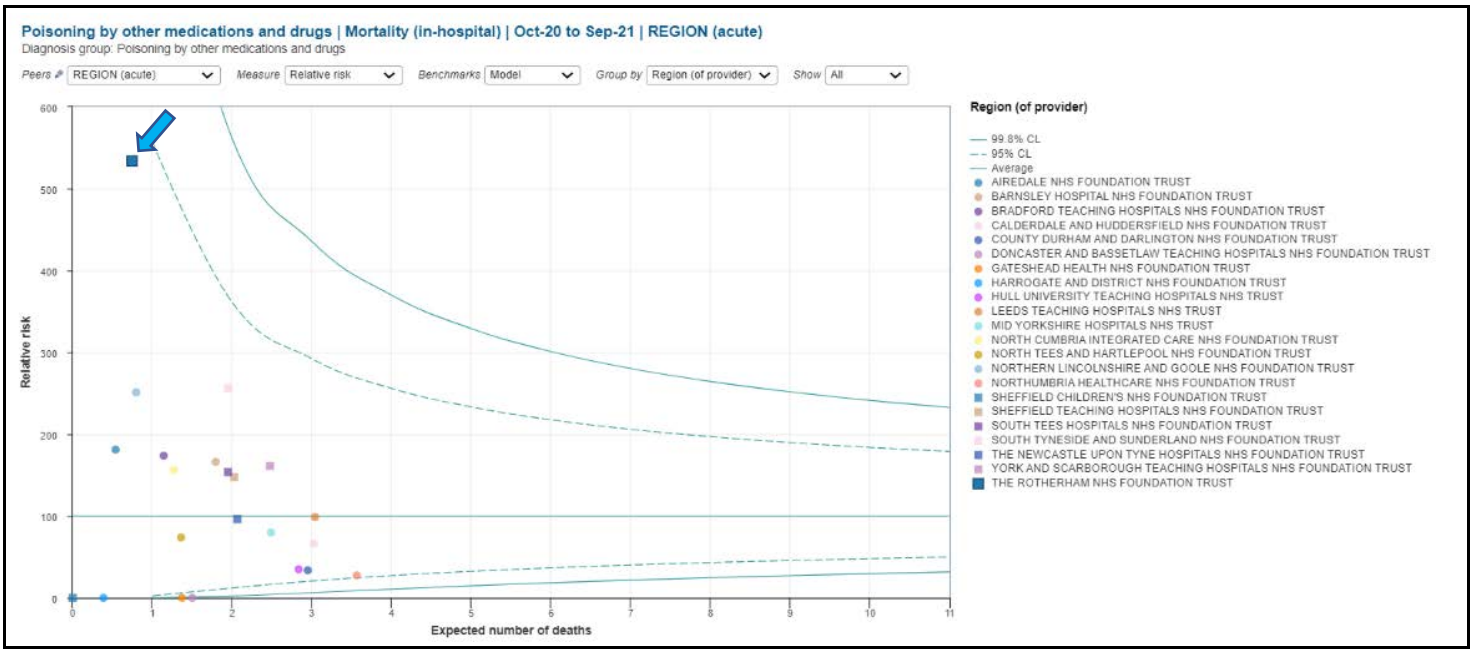
Poisoning by other medications and drugs | Mortality (in-hospital) | Oct-20 to Sep-21 | Comorbidity score

Diagnosis group: Poisoning by other medications and drugs

Analyse by: Comorbidity score | Measure: Relative risk | Show: All

Comorbidity score	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	239	100.0%	239	4	1.7%	0.7	0.3%	3.3	533.6	143.6	1366.2
0 (none)	161	67.4%	161	0	0.0%	0.3	0.2%	-0.3	0.0	0.0	1463.5
3	17	7.1%	17	0	0.0%	0.1	0.3%	-0.1	0.0	0.0	6638.6
4	26	10.9%	26	1	3.8%	0.1	0.2%	0.9	1742.8	22.8	9696.5
6-9	15	6.3%	15	0	0.0%	0.1	0.6%	-0.1	0.0	0.0	3859.5
10-19	14	5.9%	14	2	14.3%	0.1	0.9%	1.9	1518.9	170.6	5484.1
20-49	6	2.5%	6	1	16.7%	0.2	2.7%	0.8	626.6	8.2	3486.3

Comparative funnel plot (region)


Poisoning by other medications and drugs | Mortality (in-hospital) | Oct-20 to Sep-21 | REGION (acute)
Diagnosis group: Poisoning by other medications and drugs
Peers REGION (acute)
Measure Relative risk
Benchmarks Model
Group by Region (of provider)
Show All
Relative risk
Expected number of deaths
Region (of provider)
99.8% CL
95% CL
Average
AIREDALE NHS FOUNDATION TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
GATESHEAD HEALTH NHS FOUNDATION TRUST
HARROGATE AND DISTRICT NHS FOUNDATION TRUST
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
LEEDS TEACHING HOSPITALS NHS TRUST
MID YORKSHIRE HOSPITALS NHS TRUST
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST
THE ROTHERHAM NHS FOUNDATION TRUST

REFERENCES

SMR

A calculation used to monitor death rates. The standardised mortality ratio is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

HSMR

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity. Further information can be found at http://www.drfoster.com/about-us/our-approach/metrics-methodologies-and-models-library/

Benchmark

The benchmark used in this analysis is the monthly benchmark available within the Healthcare Intelligence Tool.

CUSUM

A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers, whereas the default on the HIP dashboard is set at 99%, to provide trusts with an early warning of potential areas of alert for investigation.

HSMR Comparison

In order to give an indication of how performance for the current incomplete year compares to the national average we show a rebased HSMR for the current year. This is estimated for each of the 56 diagnoses by dividing the trust's SMR (using the existing benchmark) by the national SMR and multiplying by 100. The 56 rebased SMRs are then aggregated to produce the estimated rebased HSMR.

Charlson Index of Comorbidities

The original Charlson weights were derived 25 years ago in the USA. We have updated them (e.g. HIV had the highest weight then but its mortality has fallen greatly since) and calibrated them on English data due to differences in coding practice and hospital patient population characteristics. We had advice from some clinical coders on current English coding practice and, where possible, also assessed the consistency of comorbidity recording among admissions for the same patient.

Charlson Upper-Quartile Rate

For each financial year we calculate the proportion of a trust's HSMR spells where the Charlson index for the diagnosis-dominant episode is in the national upper quartile for that diagnosis and admission type, this is the observed value. The expected value is the equivalent proportion nationally i.e. 25%. The trust's index value is calculated as the observed/expected x 100.

Palliative Care Coding Rate

For each financial year we calculate the proportion of a trust's HSMR superspells excluding day cases which are coded as having palliative care, this is the observed value shown. The expected value is the proportion nationally for the equivalent mix of diagnosis and admission type. The trust's index value is calculated as observed/expected x 100

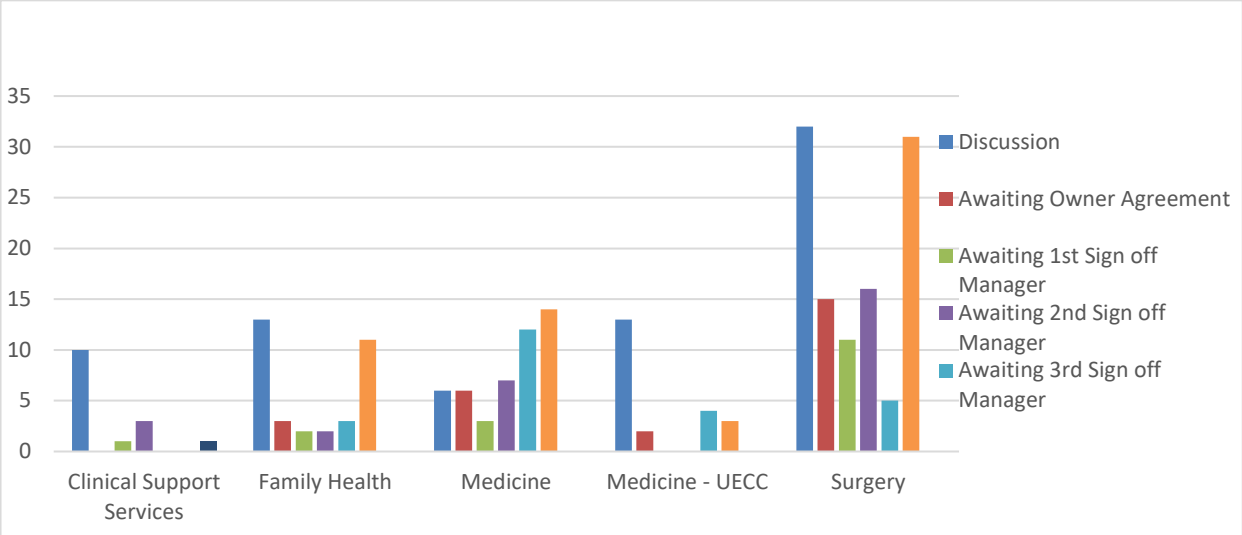
Board of Directors' Meeting
04 March 2022

Agenda item	P54/22
Report	**Medical Workforce Report – Q4 2021/22 Review**
Executive Lead	Dr Callum Gardner, Executive Medical Director
Link with the BAF	B4, B5
How does this paper support Trust Values	**Ambitious** – to be an employer of choice. **Caring** – to ensure job plans meet the needs of our patients. **Together** – to ensure a MDT approach to patient care
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	To provide the Board with an update on job planning progress along with a summary of recent Consultant recruitment.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	N/A
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	No action is required. The report is for information only.
Recommendations	It is recommended that the summary and update are noted.
Appendices	None

Job Planning

1. The Trust utilises Allocate e-Job Plan software and the table below shows the current situation on progress of job plans as at 21 Feb 22:

Trust Overview



Consultant	Discussion	Awaiting Owners Agreement	Awaiting 1st Managerial Sign Off	Awaiting 2nd Managerial Sign Off	Awaiting 3rd Managerial sign Off	Signed off	Locked Down	Grand Total
CSS	10		1	3			1	15
Family Health	12	2	2	2	3	9		30
Medicine	6	3	3	6	5	12		35
UECC	4	2			4	3		13
Surgery	19	12	7	10	3	25		76
Grand Total	**51**	**19**	**13**	**21**	**15**	**49**	**1**	**169**

SAS Grades	Discussion	Awaiting Owners Agreement	Awaiting 1st Managerial Sign Off	Awaiting 2nd Managerial Sign Off	Awaiting 3rd Managerial sign Off	Signed off	Grand Total
CSS							
Family Health	1	1				2	4
Medicine		3		1	7	2	13
UECC	9						9
Surgery	13	3	4	6	2	6	34
Grand Total	**23**	**7**	**4**	**7**	**9**	**10**	**60**

2. The Job Planning Policy is in the process of being reviewed and there will be Job Planning Consistency Panels set up to review the content, ensuring they are fit for purpose and can deliver planned clinical activity. Now we are moving more towards BAU, scrutiny of job plans will be crucial to make sure we deliver against targets.

Consultant Recruitment

3. A summary of consultant establishment is provided below; we are trending in the right direction, with substantive vacancies reduced by 6 since the previous reported position:

Consultants – 18 Oct 21	
Consultant Establishment (wte)	180.18
Cons Sub Vacancies (excl. NHS Locums / temp staff)	47.24
Cons Substantive Fill %	73.8%
Cons Vacancies (incl. NHS Locum / Acting Up in post)	25.9
Cons Fill % (incl. NHS Locum / Acting Up in post)	85.6%
Cons Sub Vacancies (incl. NHS Locums / temp staff)	21.94
Cons Total Fill as Percentage	87.8%

Consultants – 21 Feb 22	
Consultant Establishment (wte)	183.85
Cons Sub Vacancies (excl. NHS Locums / temp staff)	41.54
Cons Substantive Fill %	77.4%
Cons Vacancies (incl. NHS Locum / Acting Up in post)	24.2
Cons Fill % (incl. NHS Locum / Acting Up in post)	86.8%
Cons Sub Vacancies (incl. NHS Locums / temp staff)	15.24
Cons Total Fill as Percentage	91.7%

4. An update on recent consultant recruitment, since the last report, is provided below (L = Locum); of particular note is the appointment of 3 Consultants to the UECC, all of whom are Higher Level trainees on the South Yorkshire rotation:

Specialty	Name	Start Date
Obs & Gynae	Miss Hannah Mistry	16 Feb 22
Gastro	Dr Abdel Alsawaf (L)	4 Jan 22
HCOP	Dr Sunil Punnoose	14 Mar 22
Respiratory	Dr Nitish Marathe	7 Feb 22
Anaesthetics	Dr Tharaka Wijerthne	TBC
Ophthalmology	Miss Hibba Quhill	7 Mar 22
Rheumatology	Dr Leticia Garcia-Montoya	3 May 22
Urology	Mr Panagiotis Apalidis	16 Feb 22
Emergency Medicine	Dr George Kay	TBC
Emergency Medicine	Dr Eamon Staunton	TBC
Emergency Medicine	Dr Akinola Olaniyan	TBC

5. There have been 2 joint appointments, with Barnsley Hospital Foundation Trust (BHFT), in Gastro and we await confirmation of start dates and clinical sessions at TRFT. The Consultant Job Pack is in the process of being completely overhauled and refreshed, with a target to utilise the revised version from April onwards. As part of our strategy, the Trust has signed up to the BMJ's subscription service to provide enhanced exposure and highlight our vacancies; this will ensure TRFT is in the spotlight for potential candidates.

Derek Thomas
Head of Medical & Dental Workforce
February 2022

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P55/22
Report	**Board Assurance Framework: Quarter 4 (ongoing)**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The paper links with the entire Board Assurance Framework
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Board Assurance Committees discussed the Quarter 4 position in relation to the Board Assurance Framework and their respective BAF risks during the meetings scheduled in February 2022 as follows: **People Committee:** Discussed and approved the position in relation to BAF Risk 4 and BAF Risk 5. **Finance and Performance Committee:** Discussed and approved the position in relation to BAF Risk 2, BAF Risk 8 and BAF Risk 9. **Quality Committee:** Discussed and approved the position in relation to BAF Risk 1, BAF Risk 2, BAF Risk 3 and BAF Risk 6. The Audit Committee met on 9 February 2022, discussed the ongoing Quarter 4 position and remained assured in relation to the process and assessment of the risks as appropriate. The Audit Committee subsequently agreed to recommend that the Board approve the Quarter 4 position in relation to the Board Assurance Framework.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Board Assurance Framework ongoing position for Quarter 4 has been discussed at the relevant Board Committees prior to further scrutiny at the Audit Committee on 9 February 2022.
Board powers to make this decision	In accordance with the approved Matters Reserved to the Board, Internal Controls- the Board is required to ensure the maintenance of a sound system of internal control and risk management, including "*Approval of the Board Assurance Framework".*
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Director of Corporate Affairs continues to work with Executive colleagues in order to develop the revised Board Assurance Framework that will align with the new approve 5 Year Strategy in preparation for April 2022. This will include a full review of the Trust's Risk Appetite Statement.

Recommendations	The Board is requested to discuss and approve the position in relation to the Board Assurance Framework for Quarter 4.
Appendices	Board Assurance Framework

1. Introduction

1.1 The Board Assurance Framework has been discussed at the Board Assurance Committees during February 2022. The following report provides the Trust Board with the ongoing position in relation to the Board Assurance Framework for Quarter 4.

2. Quarter 4 Outcome

2.1.1 **The People Committee** discussed the following Board Assurance Risks at the meeting convened on Friday :

2.1.2 **BAF Risk 4**: Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's plan.

The People Committee discussed the BAF Risk and concluded there were no changes to the position and the score remained. As such the Board is asked to concur with the scoring of **12 (L=3 x C=4)** for BAF Risk 4.

2.1.3 **BAF Risk 5:** Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs.
The People Committee discussed the risk and following consideration concluded the risk score should remain the same at **12 (L=3xC=4)** as there have been no additional controls or assurances identified. The People Committee concluded the target score was appropriate. The Board is asked to concur with the aforementioned conclusion.

2.1.4 **The Finance and Performance Committee** discussed the following Board Assurance Risks at the meeting convened on Wednesday 23 February 2022:

2.1.5 **BAF Risk 2:** Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes.

The Finance and Performance Committee agreed at the February Committee that the score remained at **16 (L=4xC=4).**

2.1.6 **BAF Risk 8**: The financial plan is not delivered.

The Finance and Performance Committee discussed the risk score and agreed the score remained at **3 (L=1xC+3).** The Board will note the additional narrative for Gap 6 (G6) relates to confirmation that the budget setting process has commenced with draft financial plans to be submitted by 15 March 2022. Once this is complete, the gap will move into a control.

The Finance and Performance Committee agreed this remained a managed risk and within agreed risk appetite.

2.1.7 **BAF Risk 9:** The lack of capital investment may affect the delivery of some services.
The proposed risk score for Q4 has remained unchanged at **4 (L=1xC=4)** thus remaining a managed risk within the target risk and agreed risk appetite.

The Board will note that risk reference 6198 (Loss of MRI service due to re-aligned failure of MRI scanner) has been reviewed and reduced to a score of 12.

2.1.8 **The Quality Committee** discussed the following Board Assurance Risks at the meeting convened on Wednesday 22 December 2021:

2.1.9 **BAF Risk 1:** Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements.

The Quality Committee agreed that to retain a risk score of **20 (L=4xC=5)** given that the CQC Warning Notices remain in place albeit one has now been removed. The Board will note the further review of the narrative to Gap16 providing further clarification to the rationale for moving the serious incident process from a control to a gap in control due to embedding and learning from actions not being consistently demonstrated in all cases.

2.1.10 **BAF Risk 2:** Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes.

The Quality Committee agreed to retain a risk score of **16 (L=4xC=4**) as no changes have been seen relating to controls, assurance or gaps in controls.

2.1.11 **BAF Risk 3:** Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services.

The Quality Committee agreed to retain a risk score of **16 (L=4xC=4)** due to no changes in gaps or controls for BAF Risk 3 but noted the following changes:

- There are currently no risks on the register rated 15 and above relating to patient experience.
- The Deputy Chief Nurse with a remit for staffing and patient experience has now commenced and added as a new control (C9).
- There is an expectation that the gap in relation to public access to up to date information via the Trust website will be closed during Quarter 4 due to the work commenced by the newly appointed Deputy Chief Nurse.
- A new gap (Gap7) has been added to reflect that the Patient and Public Involvement Strategy requires approval.
- A new gap (Gap8) has been added to reflect the need for centralised oversight of the clinical governance function which will be incorporated into the work steam relating to quality governance supported by external support.

2.1.12 **BAF Risk 6:** Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans/objectives.

The Quality Committee agreed to retain a risk score of **20 (L=4xC=5)** due to the ongoing work around the quality governance agenda and noted the following revisions to the controls and gaps as follows:

- The narrative to Gap 19 has been amended to reflect the narrative to Gap 16 for BAF Risk 1.
- The risks aligned to this BAF Risk 6 have been reviewed and updated. Risk 5169 has been closed and separated into two separate risks; Risk 6545 relates to a significantly raised HSMR meaning higher mortality rates than expected is linked and is currently scored at 16. The risk relating to the SHMI is rated below 15 and therefore not visible on the BAF Risk.

3. Risks for Discussion by the Board

The following BAF Risks are allocated to the Board of Directors for discussion and agreeing the risk scores:

BAF Risk 10: There is a risk that the Trust has insufficient governance in place with partners in the South Yorkshire and Bassetlaw ICS which will impact on the Trust's ability to contribute effectively to the partnerships in Place, Provider Collaborative.

The risk score is currently at **8** (L=2xC=4).

BAF Risk 11: Joint working with key partners is developing steadily and relationships are in formative periods. Unless these relationships continue to develop, there is a risk to continuity and poor service configuration across the Rotherham Place.

The risk score is currently at **8** (L=2xC=4).

4. Next Steps

The Director of Corporate Affairs will continue to work in conjunction with Executive colleagues to further strengthen the process around the Board Assurance Framework and aligning the risk register to the Board Assurance Risks.

In addition, work has commenced in order to develop the revised Board Assurance Framework to align with the new 5 Year Strategy.

5. Recommendations

The Board is requested to discuss the outcomes following review of the Board Assurance Framework for Quarter 4 and approve the current positions as recommended by the Board Assurance Committees.

In addition, the Board is asked to note the development of a revised Board Assurance Framework to align with the new 5 Year Strategy for discussion at the Strategic Board in April 2022.

Angela Wendzicha
Director of Corporate Affairs
25 February 2022

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			Q4 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C		L	C	
PATIENTS: Excellence in healthcare Which means…	**B1**	**Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements**	**Focus on the fundamentals of care** - Embed agreed standards of care and support teams to deliver and embed quality improvement - Implement effective learning from deaths practices and deliver improved mortality rate	4174, 5169, 5442, 5761, 5950, 6119, 6296, 6386	**CN / MD**	**All to QC -** BAF Risk2 also to F&P	**28-Apr-21**	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	**3**	**5**	**15**
PATIENTS: Excellence in healthcare Which means… - Deliver high quality care to our patients every day - Put patients at the centre of what we do - Continuously improve the quality of care and services we provide - Develop and implement new models of care for the future	**B2**	**Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes**	**Deliver elective recovery for patients:** - Plan the long term recovery of elective care and deliver 2021/22 recovery plan - Implement programme of ensuring operational excellence in elective care	5715, 5779, 6127, 4514, 6119, 6198, 6199, 6213, 6215, 6226, 6417	**COO**		**28-Apr-21**	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	**3**	**4**	**12**
	B3	**Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services**	**Focus on the fundamentals of care** - Embed agreed standards of care and support teams to deliver and embed quality improvement - Implement effective learning from deaths practices and deliver improved mortality rate	No risks	**CN / MD**		**28-Apr-21**	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	**3**	**4**	**12**

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			Q4 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C		L	C	
COLLEAGUES: Engaged, accountable colleagues Which means… - Recruit, retain and develop a high performing, effective and motivated workforce - Be a learning organisation with a culture of continuous improvement - Engage with colleagues and communicate effectively - Develop strong leadership at all levels of the organisation	**B4**	**Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's plan**	**Safely exit the COVID-19 pandemic:** deliver full programme of Health & Wellbeing initiatives for staff **Empower and enable staff to deliver:** - design and launch organisational development programme for divisional teams	No risks	**DoW**	**PC**	**30-Apr-21**	3	4	12	3	4	12	3	4	12	3	4	12	3	4	12	**3**	**4**	**12**
	B5	**Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs**	**Safely exit the COVID-19 pandemic:** identify new practices from COVID--19 to embed in the long term and implement new ways of working **Empower and enable staff to deliver:** - Build a culture so that the trust is seen as an employer of choice, appointing to key clinical leadership vacancies	4959, 5442, 4514, 5715, 6417				3	4	12	3	4	12	3	4	12	3	4	12	3	4	12	**3**	**4**	**12**

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			Q4 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C		L	C	
GOVERNANCE: Trusted, open governance Which means… - Have an effective performance framework to help deliver outstanding results - Be outstanding on the CQC 'well-led' framework across the Trust - Have high quality data to provide robust information and support decision making - Ensure all teams have regular reviews and updates around key issues and opportunities to learn	**B6**	**Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives**	**Focus on the fundamentals of care** - Embed agreed standards of care and support teams to deliver and embed quality improvement - Implement effective learning from deaths practices and deliver improved mortality rate	4174, 5169	**CN / MD**	**QC**	**28-Apr-21**	4	4	16	4	5	20	4	5	20	4	5	20	4	5	20	**3**	**5**	**15**
	B7	**There is a risk that robust financial governance arrangements are not embedded across the Trust which could impact on the achievement of Trust plans / objectives, and subsequent removal of the financial planning undertakings and breach of the provider licence**	**Drive the organisation forwards:** - Deliver on our financial commitments and ensure removal of breach of licence	No risks	**DCE / DoF**	**Audit**	**N/A**	N/A			3	4	12	3	4	12	2	4	8	2	4	8	**3**	**4**	**12**

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			Q4 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C		L	C	
FINANCES: Strong financial foundations Deliver strong financial foundations through: - Improving liquidity whilst ensuring appropriate investment in estates and assets - Managing within the approved budget and reduce the underlying deficit - Improving financial performance through service transformation and cost improvement.	**B8**	**The financial plan is not delivered**	**Drive the organisation forwards:** - Deliver on our financial commitments and ensure removal of breach of licence	5779	**DoF**	**F&PC**	**28-Apr-21**	1	3	3	1	3	3	1	3	3	1	3	3	1	3	3	**3**	**3**	**9**
	B9	**The lack of capital investment may affect the delivery of some services**		6198				2	5	10	2	4	8	1	4	4	1	4	4	1	4	4	**2**	**4**	**8**

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			Q4 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C		L	C	

PARTNERS: Securing the future together Which means… - Work with our partners to provide sustainable health and care services for the population of Rotherham - Be open to new ideas and innovations and adopt these wherever we can - Collaborate with partners across South Yorkshire & Bassetlaw on key services to improve service resilience and sustainability	**B10**	~~Misaligned governance and decision-making may arise from divergent Trust and ICS interests and objectives~~ There is a risk that the Trust has insufficient governance in place with partners in the South Yorkshire and Bassetlaw ICS which will impact on the Trust's ability to contribute effectively to the partnerships in place, provider collaboratives, and digital and data to drive systems	**Drive the organisation forwards:** - Publish a new five year strategy and support partners with re-organisation	No risks	**DCE**	**BoD**	**N/A**	N/A	2	4	8	2	4	8	2	4	8	2	4	8	**2**	**4**	**8**
	B11	~~Ineffective relationships with key partners may lead to a lack of integrated working and poor service configuration across the Rotherham Place~~ Joint working with key partners is developing steadily and relationships are in formative periods. Unless these relationships continue to develop there is a risk to continuity and poor service configuration across the Rotherham Place		6226, 6386	**COO**	**BoD**		N/A	2	4	8	2	4	8	2	4	8	2	4	8	**1**	**4**	**4**

DCE	Deputy Chief Executive
CN	Chief Nurse
MD	Medical Director
DoW	Director of Workforce
DoF	Interim Director of Finance
COO	Chief Operating Officer
Co Sec	Company Secretary
BoD	Board of Directors
QC	Quality Committee
Audit	Audit Committee
F&PC	Finance & Performance Committee
PC	People Committee

Risk Matrix:

	Likelihood				
Consequence	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)	**5**	**10**	**15**	**20**	**25**
Major (4)	**4**	**8**	**12**	**16**	**20**
Moderate (3)	**3**	**6**	**9**	**12**	**15**
Minor (2)	**2**	**4**	**6**	**8**	**10**
Negligible (1)	**1**	**2**	**3**	**4**	**5**

PATIENTS: Excellence in healthcare

BAF Item B1: Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements *Risk Owner: Interim Chief Nurse & Medical Director* *Board Committee: Quality Committee* *Date the risk last reviewed: 08 Febraury 2022*	**Link to 2021/22 Operational Plan** **Focus on the fundamentals of care** **- Embed agreed standards of care and support teams to deliver and embed quality improvement** **- Implement effective learning from deaths practices and deliver improved mortality rate**	**Link to Operational Risks (scoring 15+):** **4174:** Clinicians do not always recognise the deteriorating patient: Feb 2022: Remains scored at 15 **5169:** Significantly raised HSMR and SHMI meaning higher mortality rates than expected: Closed **5442:** Inability to fill high number of registered nurse vacancies leading to potentially a reduction in patient experience and safety: Closed **5761**: UECC patient safety due to overcrowding: February 2022: Scored 20 **5950:** Lack of consistent triage through a single overnight service (streaming undertaken during COVID-19 and impact on having split clinical areas in UECC): February 2022 scored 16 **6119:** Management of the department during COVID-19 (UECC): Reduced to 8 **6296:** Overcrowding in the UECC waiting room relating to concerns with COVID: Reduced to 12 **6386:** CAMHs inpatients on Children's Ward and Children's Assessment Unit (CAU): Reduced to 12

STRATEGIC OBJECTIVE:
PATIENTS: Excellence in healthcare
Which means…
- Deliver high quality care to our patients every day
- Put patients at the centre of what we do
- Continuously improve the quality of care and services we provide
- Develop and implement new models of care for the future

Executive Summary - Quarterly Update:
Q1: Not appropriate to reduce current risk score whilst CQC warning notice still in place and report from most recent CQC inspections awaited.

Q2: Not considered appropriate to reduce risk score whilst CQC inspection report is still awaited and whilst CQC warning notices are in effect.
Q3 Update: CQC report recieved and warning notices remain in place therefore score remains the same. January 2022 - score remains the same. February 2022 review: Score remains the same. Two out of three warning notices remain in place. External support has been sourced to support reviewing the Quality Governance processes within the Trust with a report scheduled for Trust Board in March 2022.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
4 x 5 = 20 L (likely) x C (catastrophic)	**4 x 5 = 20 L (likely) x C (catastrophic)**	**4 x 5 = 20 L (likely) x C (catastrophic)**	**4 x 5 = 20 L (likely) x C (catastrophic)**	**4 x 5 = 20 L (likely) x C (catastrophic)**	➔	3 x 5 = 15 L (possible) x C (catastrophic)

Risk Appetite:
TRFT has a **VERY LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users (score of 1 - 5)
TRFT has a **LOW** risk appetite for risks that may affect the experience of our service users (score of 6 -10)
TRFT has a **VERY LOW** risk appetite for risks that may compromise safety (1-5)
TRFT has a **VERY LOW** risk appetite for Compliance / Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements (1-5)

Current Risk Appetite (based on current risk score):
High (16 - 25)

Target Risk Appetite (based on target risk score):
In line with / below appetite of MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Achievement and embedding of Quality Priorities
C2	Regular monitoring of quality indicators and instigation and implementation of remedial action by Quality Committee, Clinical Governance Committee and sub-groups, Risk Management Committee and sub-group
C3	Oversight of implementation of 'must do' and 'should do' actions and responsiveness to warning notices by Divisional, pathway and Trust-wide CQC Action Plan Steering Groups including escalation of issues and implementation of remedial action. Regulatory compliance against section 29A and section 31 warning notices in place.
C4	Reintroduction of Trust's professional standards entitled *'Who goes where'* at the beginning of June 2021 to ensure that patients go to the most appropriate specialty and that flow is optimised within the organisation
C5	Review of risk assessments by Risk Management Committee and sub-group and Divisions on a monthly basis complemented by quarterly review of risk scoring 15+ by Board Assurance Committees. All new risks scoring 15+ reviewed on a weekly basis at Executive Team Meeting.
C6	Serious Incident process in place.
C7	Coordinated approach to monitoring and learning from morbidity and mortality in accordance with agreed processes

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Monthly reporting of HSMR and SHMI at CGC, QC and Trust Board and via monthly IPR at Perf Meetings (monthly, negative: SHMI 109 and Trust is no longer an outlier; HSMR at 125; Jan-21 data). Q3 Update: Delay in receiving data from Dr Foster, last data received in May 2021.			✓	**Quality Committee and Clinical Governance Committee Dec-21**
A2	Monthly contact between Chief Nurse and CQC to provide assurance relating to implementation of 'must do' and 'should do' actions arising from inspections as well as any other quality concerns. Regulatory compliance against section 29A and section 31 warning notices in place. (monthly, negative)			✓	**Sep-21**
A3	Incident management and escalation enacted by senior leaders in accordance with acuity of situation across the Trust (e.g. Gold, silver or bronze meetings as required) (regular, mixed assurance)	✓			**Jun-21**
A4	Assurances in relation to mortality A) 2 Medical Examiners (ME) in post, ME officers now fully recruited. Clinical coding staff member based in ME office (ongoing, positive) B) Monthly Safe & Sound mortality group meeting in place with Divisional representation including Health Informatics and Divisional mortality sub-groups being aligned to Terms of Reference. All Divisional mortality sub-groups are in place including in Medicine and Surgery Divisions (monthly, mixed assurance) C) Monthly mortality Task & Finish Group chaired by Chief Executive with parallel insight mortality group reporting into Task & Finish group (started Dec-20). Overarching mortality improvement action plan in place and reported to Clinical Governance Committee, Quality Committee and Board monthly (monthly, mixed assurance) Q3 Gap due to long term sickness in the ME service. **Q4 gap remains ongoing in ME service**	✓			**Jun-21**
A5	Reports on Quality Priorities 2020/21 Monthly updates to Clinical Governance Committee and Quality Committee (monthly, Mixed assurance)		✓		**Jun-21**
A6	CQC Insight for Acute NHS Trusts reports (periodic, mixed assurance)			✓	**Aug-21**
A7	360 Assurance 'Learning from deaths review - stage 1 mortality reviews' report (Sept 20) gave 'limited assurance' rating and made 4 medium actions (ad hoc, negative) See BAF item B6 G14 for action plan 360 Assurance Learning from Deaths Governance review Apr-21 gave 'limited assurance rating and made 2 high and 9 medium recommendations (ad hoc, negative) See BAF item B6 G13 for action plan			✓	**Sep-21** **Apr-21**

GAPS IN CONTROL (C) or ASSURANCE (A)
gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Standards of Care & Quality Improvement (Mandate 2A) **(C&A)**	1. Establish a Quality Strategy Working Group 2. Identify the Quality Improvement Methodology (Toolkit)to be utilised across the Trust and its method of support and implementation - *revised timescale TBC as need to ensure refreshed Quality Strategy links to Trust strategy. Q2 Update: Methodology still being worked on. Will complete in Q3* 3. Identify and agree the standards of care required and measurement for improvement - *revised timescale Q3 as need to ensure refreshed Quality Strategy links to Trust strategy* 4. Refine Quality Strategy and present for Board sign off 5. Relaunch the Safe and Sound Quality Strategy *Q2 Update: delayed by 2 months* 6. Refresh of the Safe and Sound Quality Scorecard using the metrics identified in the strategy 7. Launch the KPIs data collection of perfect ward - completed 8. Develop Quality Improvement Methodology (Toolkit)and launch it 9. Embed Quality Improvement and encourage continuous improvement as BAU Q3: Quality Governance Structure under review and continues into Q4.	Chief Nurse	**1. 31-May-21** - completed **2. ~~30-Jun-21~~** - revised timescale to Q3 **3. ~~30-Jun-21~~** - revised timescale to Q3 **4. ~~9-Jul-21~~ Q3** **5. ~~31-Jul-21~~ Q3** **6. ~~31-Jul-21~~ Q3** **7. 31-Jul-21 - completed** **8. 30-Sep-21** **9. 31-Mar-22**
G2	Learning from Deaths (Mandate 2B) **(A)**	1. Completion of investigation and initial actions into Palliative Care processes and coding 2. Completion of actions identified by Internal Audit review of Governance 3. Transfer of work from MIG and MAG into Business-as-Usual governance and ways of working 4. Appointment to Associate Medical Director Mortality and Learning from Deaths and Mortality Manager posts 5. Implement Community Acquired Pneumonia (CAP) policy 6. Completion and learning from Improvement Academy work in the Urgent and Emergency Care Centre (UECC)	Medical Director	**Q2** **Q3** **Q3** **Q2** **Q1** **Q4**
G3	Ensuring all actions from SI and red incident investigations are completed and sustained **(A)**	**Q4 Update:** Currently 24 red incident investigations and 4 SI investigations are overdue. In order to close gap would need to have overdue red incidents under 10 and overdue SIs under 5. **Q1 Update**: as at end May-21 5 overdue SIs and 21 overdue red incidents **Q2 Update:** as at Aug-21 QC report zero overdue SIs, 3 overdue incidenrs (all HSIB investigations) and 14 overdue red incidents therefore gap remains.	Deputy Chief Nurse	**Q4**
G4	CQC issued section 29A warning notice on 11 February 2021 **(C&A)**	Preliminary response sent to CQC on 11-Dec-10, feedback awaited. Work has commenced on the required action plan. Submission date 19 Feb 2021 **Q1 Update:** Only a small number of actions are still open and all are due for completion in Q2 2021/22 **Q2 Update:** 1 action is outstanding, due to complete in Q3	Chief Nurse	**Q2** Q3
G5	Lack of Trust-wide consistent and robust quality governance arrangements **(C&A)**	**Q4 Update:** Sufficient assurance in place regarding Divisional governance meetings. Less assurance available regarding CSU meetings so a member of Chief Nurse / Medical Director team will start attending CSU level meetings. Assurance should be in place by end Q1 2021/22. Medical Director now chairing Clinical Effectiveness Group with enhanced focus on NICE compliance plus revised ToR to include policy compliance moving forward. **Q1 Update:** 360 Assurance Strategic Quality Assurance review (Jun-21) gave 'Significant Assurance' rating and made 4 medium recommendations (see BAF item B6 G16 for action plan). There has been a sustained improvement in policy compliance and NICE compliance. There needs to be evidence of discussion and dissemination of learning from deaths and SJRs happening at Divisional and CSU level before this gap can be closed. **Q2 Update:** gap remains. Learning from Deaths Manager recruitment is underway.	Medical Director & Chief Nurse	**Q2 2021/22**
G6	Gap in assurance and control relating to: - medication safety / medicines management at Divisional and Pharmacy level **(C&A)** - delayed administration of critical medications and controlled drugs **(C&A)**	Medication Safety Group with be chaired by Medical Director in Q2 Rotherham Medicines Optimisation Group (RMOG) to be chaired by Deputy Medical Director during Q2 Working to arrange NHS E/I external review of medicines management to take place in Q2 Ongoing challenge of getting the SCRIPT training module onto the ESR system working with Learning & Development department and Chief Pharmacist. **Q2 Update:** External review has not yet taken place. SCRIPT is not on ESRas yet. ***Medical Safety Officer role with direct link to Medical Director.***	Medical Director	**Q2**
G7	Out of hours resilience and capacity to respond to deteriorating or acutely ill patients **(C)**	**Q4 Update:** Medical Director has liaised with Director of Workforce to ensure consultation process is in train. Current mitigation by NHS Professionals to strengthen current workforce pending substantive recruitment in line with business case. NEWS2: revisions made to fluid balance monitoring and AKI policy. NEWS2 and urine output continues to be a standing agenda item for Deteriorating Patient and Sepsis Group. **Q1 Update:** Acute Response Team (ART) business case has been approved and staff consultation in progress. The fact that NEWS 2 does not incorporate urine output is a national issue and remains a gap which is being progressed via the Deteriorating patient and sepsis group. **Q2 Update:** staff consultation will start in Sep-21. Quality Improvement Matron working on deteriorating patient work stream. Escalation proforma in Meditech and now live and fully compliant. Also working with Portsmouth Foundation Trust and with support from NHSE/I around mangement of deteriorating patients.	Medical Director	**Q1 2021/22 - advertise** **Q2 2021/22 - staff in post** **Q1 2021/22 - NEWS2** **Q4 2021/22**

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C8	Annual Clinical Audit Plan completion monitored via quarterly reports to Clinical Governance Committee and via monthly Clinical Effectiveness and Research Group
C9	Monthly Safe & Sound mortality group continues to meet; Deteriorating patient and sepsis group and clinical leads Safe & Sound Internal Professional Standards meeting are also continuing to meet. Other Safe & Sound workstreams are being reviewed as part of the refresh of the Quality Strategy and identification of quality improvement methodology (links to G1)
C10	Organisational Learning Action Forum (OLAF) introduced in late September 2020 to ensure that learning from claims, complaints, incidents and inquests can be used to positively impact on quality of care to close the loop with the clinical audit process to provide assurance.
C11	Existing Mental Health strategy in place to ensure best practice care is provided
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A8	CQC have reduced the frequency of quality assurance meetings				
A9	CQC section 31 warning notice;(See G14 for action plan) CQC issued section 29A warning notice on 11 February 2021; Section 29A improvement action plan in place (see G4 for action plan) CQC Children's Safeguarding action plan. All actions now completed and Deputy Chief Nurse for Safeguarding is undertaking a review to ensure that all actions are sustained. (ad hoc, positive)			✓	**Feb-21** **Jun-21**
A10	NHS England qualitative risk profile (QRP) assessment undertaken in conjunction with RCCG: submission of a self-assessment of risk score and evidence. Follow on meeting concluded no need to escalate to single item quality surveillance group or risk summit (ad hoc, positive outcome) NHSE/I attending monthly RCCG Contract Quality Meetings			✓	**Sep-21**
A11	Executive Directors' weekly walkarounds (weekly, positive) Chief Nurse and Medical Director clinics (twice monthly, positive)	✓			**Jun-21**
A12	Senior Nurse and AHP 'Back to the floor' monthly sessions to be reinstated in July and August 2021 (monthly, mixed assurance)	✓			**Q2 2021/22**
A13	NHS E/I external review of medicines management (ad hic, mixed assurance)			✓	**Q2 2021/22**
A14	Deprivation of Liberty Safeguards (DoLS) performance is included in Safeguarding quarterly report to Quaity Committee and also reviewed at Startegic Safeguarding Group (quarterly, mixed assurance)		✓		**Aug-21**
A15	Serious Incident reports to Clinical Governance Commmittee and Quality Committee (Monthly, mixed assurance)				

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G8	Assurance re: compliance with NICE guidance and /or policies is lacking **(C&A)**	**Q4 Update:** Medical Director now chairing Clinical Effectiveness Group with enhanced focus on NICE compliance plus revised ToR to include policy compliance moving forward. Clinical Effectiveness and Research Group being split into Clinical Effectiveness Group and separate Research and Innovation Group. Draft ToR being revised. **Q1 Update:** Deputy Medical Director of Professional Standards is now chairing the Clinical Effectiveness Group. The Clinical Effectiveness and Research Group has not yet been split as the business case was unsuccessful at its first submission. NICE non-compliance is now at its lowest level in several years. The targets that have been set are to have no NICE guidance over 6 months overdue by end Jun-21; between 3 and 5 months overdue by end Jul-21 and over 3 months overdue by end Aug-21. **Q2 Update:** Policy compliance is now at 94% complaince in relation to overdue policies. New process in Document Ratification Group whereby all policies due for review in 6 months and 3 months' time will be communicated to Divisions.	Medical Director	**Q2**
G9	Safe & Sound work streams not yet having breadth of representation and limitation of bandwidth to complete all required actions **(C)**	**Q3 Update:** Deteriorating patient and sepsis group; Mortality Group and Medicine Management group continuing to meet and are well attended. Other workstreams have been reviewed and proposals created which require sign off by Interim Chief Executive. **Q4 Update:** as for Q3 **Q1 Update:** Deteriorating patient and sepsis group continues to meet and is well attended. Addition of internal Safe & Sound Internal Professional Standards meeting on a monthly basis. Reviewing current ToR and chairmanship of Medicines Safety Group and Rotherham Medicines Optimisation Group. Other Safe & Sound workstreams are being reviewed as part of the refresh of the Quality Strategy and identification of quality improvement methodology.	Medical Director & Chief Nurse	**Q2** **Q3** **Q4** **Q2 and ongoing**
G10	Impact of COVID-19 on the Trust's capacity (staffing and / or conflicting prioritisation) to maintain focus on quality and ability to adhere to national standards if resources are overwhelmed **(C)**	**Q1 Update:** During Q1 COVID-19 numbers and impact had improved however local, regional and national levels started to increase at end of Q1 again with consequent impact on capacity and staffing. Mitigations for staff absence include use of PPE and lateral flow tests etc. **Q2 Update:** recognition that this is going to be a long term issue. There has been some improvement in line with relaxation of national guidance following successful vaccination and self-isolation however it remains a significant concern.	Medical Director & Chief Nurse	**Update at Q2 2021/22**
G11	Lack of assurance that estate is conducive to prevention of cross infection of COVID-19 **(A)**	**Q1 Update:** discharge lounge complete, Resus complete, in the main work detailed in Q4 update that needed to be done has been done with only minor snagging issues remaining. However new issues emerged during Q1 e.g. overcrowding in UECC waiting room (looking to implement screens) and a large number of side rooms do not have en-suite facilities. The issue of en suite facilities is being picked up as part of view of Trust's estate strategy refresh which is in train (due to complete Nov-21) and which will tie into the Trust's revised strategy to be approved in Sep-21. **Q2 Update:** discussions have commenced about what long term estate facilities are required to manage future COVID-19 situations. This may include a designated Infection Control ward and potential reduction the number of beds in all bays down to 4. Work on ward B6 to increase capacity to care for critically ill patients by creating additional intensive care facilities now complete.	Chief Nurse	~~**Q3 and Q3 2021/22**~~ **Q4 2021/22**
G12	Change in regulation meaning that Deprivation of Liberty Safeguards (DoLS) will be replaced with Liberty & Protection Safeguards **(C&A)**	Trust is working on Liberty & Protection Safeguards (LPS) standards and implementation in line with national mandate. Have also commisioned 360 Assurance to undertake a benchmarking and external assurance review.	Chief Nurse (Deputy Chief Nurse)	**National deadline was Apr-22 . Is now likely to be Sep 22**
G13	Implementation of Patient Safety Incident Response Framework (PSIRF) which is a new national process to oversee patient safety incidents **(C&A)**	Trust has already started and a project mandate is in place in order to achieve the key milestones set nationally. Mandate to be presented to Executive Team Meeting. Meeting taken place with HM Coroner and Trust now has 3 Patient Safety Specialists in post.	Chief Nurse (Deputy Chief Nurse)	**National launch delayed until Mar-22**
G14	Section 31 warning notice action plan **(A)**	Action plan is presented and monitored via the CQC Delivery Group.		
G15	Stage 1 mortaltiy review impacted by ability to put on meditech			
G16	**Serious Incident Process moved from a control to a gap. Embedding and learning from actions is not consistently demonstrated in all cases.**	**The current SI policy is in date but under review. Current review of how action plans are embedded. Review of clinical governance structure with external support.**	**Chief Nurse**	**Q4**
G17	Streamlining of Committee structure	Process commenced. Consulted with Executives and Board in December for further development Jan, Feb and March. Presentation at the April Board with comencement from April 2022.	Director of Corporate Affairs	Q1 2022-23

PATIENTS: Excellence in healthcare

BAF Item B2: Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes

Risk Owner: Chief Operating Officer
Board Committee: Quality Committee & Finance & Performance from Q3.
Date the risk last reviewed: **8 February 2022**

Link to 2021/22 Operational Plan	Link to Operational Risks (scoring 15+):
Deliver elective recovery for patients: **- Plan the long term recovery of elective care and deliver 2021/22 recovery plan** **- Implement programme of ensuring operational excellence in elective care**	**4514:** The Division's ability to deliver the full range of gastroenterology services by substantive Consultant workforce challenges: **Reduced to 12** **5715:** Ability to treat deteriorating patients in a timely manner due to lack of capacity within the Hospital at Night team **Reduced to 9** **5779:** Opening additional capacity on AMU above the funded 44 bed base **Remains 15** **6119:** Management of the department during COVID-19 (UECC) **Reduced to 8** **6127:** Inability to deliver planned and emergency services due to national pandemic **Closed** **6198:** Loss of the MRI service due to age-related failure of the MRI scanner **Reduced to 12** **6199:** Increased respiratory workload due to COVID-19 (Breathing Space) **Reduced to 12** **6213:** COVID-19 - threat to Business as Usual **Closed** **6215:** COVID-19 - procurement of clinical equipment **Reduced to 8** **6226:** COVID-19 - organisational recovery **Remains at 15** **6417:** The Division of Medicine's ability to deliver the full range of inpatient (Nursing) Diabetes Specialist Care **Reduced to 6 now a managed risk**

STRATEGIC OBJECTIVE
PATIENTS: Excellence in healthcare
Which means…
- Deliver high quality care to our patients every day
- Put patients at the centre of what we do
- Continuously improve the quality of care and services we provide
- Develop and implement new models of care for the future

Executive Summary - Quarterly Update:
Q4: There has been a significant improvement in nursing staff recruitment and improvements in patient flow hence the proposed reduction in risk score to 4x4=16

Q1: A degree of good progress has been achieved during the quarter. Good progress has been achieved in elective care recovery and in patient flow. However challenges were experienced in non-elective demand during Q1. The Command Centre and Discharge Lounge were opened in April and May 2021 respectively. This has contributed to the Trust improving RTT to the fifth best in the country supporting elective recovery and patient flow. However demand for emergency care has increased to 15 - 20% above pre pandemic levels. Quality Committee on 28-Jul-21 noted that this BAF risk was overseen by Quality Committee as opposed to Finance & Performance Committee since it focussed on quality levels due to COVID-19 impact. Q2 review - score remains the same at 16 but likely to increase in Q3 due to capacity issues.
January 2022 - risk score remains at 16 due to capacity demands. Q4 ongoing risk remains the same. A review of the risks aligned to this BAF risk have been reveiwed and updated.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
4 x 4 = 16 L (likely) x C (major)	4 x 4 = 16 L (likely) x C (major)	4 x 4 = 16 L (likely) x C (major)	4 x 4 = 16 L (likely) x C (major)	**4 x 4 = 16 L (likely) x C (major)**	➔	3 x 4 = 12 L (possible) x C (major)

Risk Appetite:
TRFT has a LOW risk appetite for Compliance / Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements (6-10)

Current Risk Appetite (based on current risk score):
High (16 - 25)

Target Risk Appetite (based on target risk score):
In line with MODERATE (12 - 15)

Executive Summary - Quarterly Update:

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Daily monitoring of: mean time of patients in UECC; initial time to be seen; time to be seen by a clinician and all patients waiting 12hrs+ . During Q1 began recording patients who had been waiting for 4 hours since their decision to admit.
C2	A&E Delivery Group. This is a monthly meeting responsible for developing winter plans, implementing Place-wide policies and programmes and reviewing Place-wide risks and mitigations. Involves Deputy Chief Operating Officer, Head of UECC, Head of Nursing for UECC as well as Rotherham CCG representatives and RMBC Deputy Heads. During Dec-20, Jan-21 and Feb-21 moved to weekly meetings due to winter plan
C3	Weekly PTL meetings for 18-week target
C4	Divisional performance meetings chaired by the Deputy Chief Executive or Chief Operating Officer on a monthly basis and corporate directorate performance meetings on a quarterly basis. Meetings use a set agenda and updated Integrated Performance Report and focus on all activity and quality indicators. They are used to work through anything that is off track and identify key risks, actions and mitigations.
C5	Cancer Recovery Group Meetings (weekly) track progress with the PTL and feed into the COVID-19 recovery programme. Clinical representatives responsible for reviewing long-waiting individual patients to minimise risk to each patient

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE: 1. Internal (operational)	2. Internal: (oversight)	3. External	DATE LAST ASSURANCE PROVIDED
A1	Still part of national program on emergency care standards reporting weekly and daily (Q3: moving to consultation) - **The National Team have confirmed this remains on hold. - this will now move to a gap in control**	✓			~~Nov-21~~ July 2022
A2	Continued marked improvement in initial assessment, time to see clinician and mean waiting time in A&E, now well below national standard and maintained since February 2020. Q2 Update Increase in attendance to UECC with increase in acuity and ambulance dispositions; marked deterioration in mean time in dept, time to initial assessment and time to be seen by doctor - this is likely to remain the same in Q3.	✓			~~Nov-21~~ January 2022
A3	National drive on 'right to reside' (whether a patient should be in a hospital bed or not). New requirement to record daily and weekly began in April 2020. Significant reduction in Delayed Transfers of Care and whole programme of inpatient acute and inpatient community bed reviews. Patients who are medically fit for discharge are number in the 20s rather than between 60 -80 (30s at mid-Sep-20; 39 as at 31-Dec-20; mid-20s as at end Mar-21). Q2 update deterioration to mid 40's and expected to deteriorate further.	✓			~~Nov-21~~ January 2022
A4	<61 and <91 cumulative ambulance handover delay targets met in May and June 2020. Targets met in Oct-20 and Nov-20. Deteriorated in Dec-20 due to COVID-19 **Q4 Update:** Trust is best performing Trust in South Yorkshire against these indicators. Since Dec-20 targets have been met and feedback from YAS very positive. Letter from NHSE actions across each ICS to reduce handover delays. Q3 update: Position documentated on a daily basis.	✓			Q4
A5	Rotherham Reset Week ran from Wednesday to Wednesday from 03-Feb-21 and was very positive creating a reduction in long waits for patients in A&E; an increase in discharges and flow across the organisation and improvement in morale across key areas. Learning from the Reset Week has been reviewed and now there is a programme of Mini Reset Weeks in place throughout 2021/22 (e.g. focus on golden patient 05-Apr-21). Additional reset week planned for November. Reset week completed.		✓		Nov-21

GAPS IN CONTROL (C) or ASSURANCE (A)
gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Plan the long-term recovery of Elective Care / Operational Excellence (Mandate 3) **(C&A)**	1. Convert existing red theatre into green theatre and utilise additional capacity ***Q1 Update:*** *Complete, operational from May-21.* 2. Complete waiting list analysis based on deprivation and BAME cohort and identify any issues to be addressed Q2 completed 3. Complete outpatient productivity project (with support from external provider) and develop plan from outputs Q2 completed 4. Deliver planned H1 activity on monthly basis Q2 Achieved 5. Implement MS Teams Ox.wr single IT solution across all appropriate sub-specialties Using MTeams or telephone now for consultations. 6. Implement waiting list analysis by WL and BAME cohort in standard internal reporting. Completed and shared with ICS and CCG. 7. Rollout PIFU pathway to a further two specialties On track 8. Increase use of advice and guidance across 3 key specialties 9. Define relevant processes, procedures and responsibilities for elective care operational management across the Trust 10. Implement full RTT training package, and ensure appropriate policy and procedure documents are in place across the Trust (SOPs etc)	Chief Operating Officer	**Jun-21 - complete** **Jul-21** **Sep-21** **Sep-21** **Sep-21** **Oct-21** **Oct-21** **Mar-22** **Mar-22** **Mar-22**
G2	Insufficient acute inpatient beds leading to delays in accessing beds **(C)**	Trust has recently participated in a review undertaken by ECIST utilising the ECIST bed modelling tool. The review shows an ongoing gap of 60+ beds. Business case to be developed for development of a short stay unit, frailty ward and same day emergency care service. **Q2 Update:** Business case has been written and is linked to the new transformation programme which began in September 2020 until January 2021 and has 7 work streams: • UECC processes • Ward processes • SDEC, AMU and short stay • Minor injuries • Frailty • Speciality medical wards • ASU. Business case is for confirmation and challenge during Q3. **Q3 Update:** paused due to COVID-19 **Q4 Update:** restarted the work re: short stay AMU and SDEC and frailty unit. Number of meetings held and opened a short stay ward. Piloting the frailty unit in May-21. **Q1 Update** - Paper regarding reconfiguration of medicine ward bed base submitted to Transformation Meeting and work continues to refine further. Short AMU operational and working well. Q2 update: Business case completed part funded for 2020/21 - will require updated business case for March 2022.	Chief Operating Officer	**Q2 Q4** **Transformation Programme:** **Jan-21 March 2022**
G3	Lack of capacity in same day emergency service **(C)**	Double the capacity of same day emergency care in AMU. This is a 2 year project led by Head of Nursing for Surgical Division. ECIST supporting the Trust in this project. Project overseen by Deputy Chief Executive **Q2 Update:** linked to the new transformation programme which began in September 2020 until January 2021 as business case mentioned in G2 includes capacity for SDEC. **Q3 Update:** have increased capacity in SDEC. Business cases are completed and will be reviewed in Jan-21 based feedback received ETM in Dec-20. **Q4 Update:** SDEC business case has been reviewed and will be rewritten to take into account comments from ETM and colleagues. **Q1 Update:** Medical input into SDEC continues to be progressed in order to increase streaming of patients via the service. I consultant appointed 2 still required.	Deputy Chief Executive / Chief Operating Officer	~~**Jan-22**~~ ~~**Apr-21**~~ ~~**Q1 2021/22**~~ **Sept 2022**
G4	Vacancies in key posts (e.g. General Medical Consultants **(C)**	Number of vacancies has reduced since 2019/20. Develop joint posts with Barnsley NHS FT and Doncaster & Bassetlaw NHS FT. Recruitment to key posts led by TRFT Medical Director, and exploring other workforce solutions. **Q2 Update:** ongoing, still pursuing joint posts with Barnsley as well as TRFT posts **Q3 Update:** deteriorated due to both vacancies and sickness absence. During Q3 vacancies continued to increase in key areas. **Q4 Update:** minimal changes since Q3. Now have a joint Gastro lead with Barnsley FT in place (2 days a week on site). Q2 update joint lead resigned now have 1 year interim Gastro lead in place.	Chief Operating Officer and Medical Director	~~**Jul-20**~~ ~~**Apr-21**~~ ~~**Q3 2021/22**~~ **April 2022**
G5	Best Practice Discharge Processes (Mandate 5A) **(C)**	1. Command centre build delivered - ***Q1 Update*** *- Complete operational from April 2021* 2. Discharge lounge open - ***Q1 Update*** *- Complete operational from 31 May 2021* 3. Agree best practice for ward led discharge processes - ***Q1 Update*** - Task and Finish Group established. Deputy Chief Operating Officer Executive Lead. Q2 update best practice agreed and presented to CQC completed Q3 completed 4. Commenced Ward Programme of Improvement - ***Q1 Update*** *- Remit of T & G Group, see above. Trust wide plan developed on a ward by ward basis to provide intensive support. At Q1 workshops have been held with the Medicine Division x 2 and independently the Acute Medical Unit (AMU) and Surgical Division. A QI process has been adopted involving Heads of Nursing and key members of the MDTs to undertake process mapping including TTO medication.* Q2 update paused due to covid and reinstatement dependant upon pandemic. 5. Centralised discharge support agreed Q2 - completed and agreed and recruiting. 6. Escalation management tool tested Q2 - In place 7. IDT review completed - Q2 - completed 8. Centralised discharge support structure in place 9. Commence auditing ward processes and practice. Q2 update - commenced. 10. Go live for escalation management 11. Go live for ward requests via tele tracking Q2 update - now in pilot Nov 21. 12. Embed reporting arrangements to replace DTOC –in line with national guidance once received (date TBC) 13. Evaluate impact of all changes	Chief Operating Officer	**Apr-21 - complete** **Jun-21 - complete** **Jun-21** **Jun-21** **Jul-21** **Jul-21** **Aug-21** **Sep-21** **Oct-21** **Sep-21** **Oct-21** **TBC** **Mar-22**

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C6	Monthly COVID-19 Recovery Programme Meeting introduced in May 2020 and chaired by Chief Operating Officer. Consists of cancer recovery, waiting list and capacity recovery, PPE management process, outpatient recovery programme and operational management. Split into work streams and each has a recovery meeting in place with an identified lead (e.g. Chief Nurse for PPE, Chief Operating Officer for outpatient activity and Director of Strategy, Planning & Performance for waiting list and cancer). Q3: moved into business as usual and meetings now three times a week linked to Gold Command from Oct-20. **Q4:** Appointed Recovery Director who also attends this meeting which is chaired by the Chief Operating Officer
C7	Gold, Silver and Bronze Command meetings as required by site pressures
C8	Daily record of length of stay obtained.
C9	**No Right to Reside' tracker introduced January 2022.**
C10	
C11	
C12	
C13	
C14	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A6	New Frailty Consultant in post.	✓			**Nov-21**
A7					
A8					
A9					
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G6	Nurse staffing on medical wards **(C)**	International recruitment: the Trust made a commitment to recruit 40 international nurses using NHS Professionals' international arm as part of an ICS wide-initiative. COVID-19 delayed the plan however the first 7 nurses arrived in the UK on July 2020 and the second cohort of 11 nurses will arrive on 29 October 2020. All of these nurses have been recruited from India. **Q2 Update:** first 7 nurses are in post and part of the teams. Deputy Chief Nurse is planning further recruitment. Gap remains as 50 nurses are required to close the current gap in control. **Q3 Update:** ongoing, gaps are similar however next phase of international recruitment for nurses has been agreed. **Q4 Update:** agreement to continue with international nurse recruitment plans to recruit a further 50 nurses during 2021/22. Another 10 nurses arriving in next few weeks. Plan is to have only minimal vacancies by end of 2021/22. Q2 update new starters commencing by end September and on a phased approach up to April 2022.	Chief Nurse	~~**Jul-20**~~ **Sep-21** **April 2022**
G7	Consultant cover in AMU currently provided by agency Consultants **(C)**	See actions for G4. **Q3 Update:** have lost agency Consultants **Q4 Update:** still being covered by agency as and when available. **Q1** **Update:** 3 Substantive Consultants appointed to AMU and one long term locum. Q2 update - 2 substantive recruited with 1 to recruit.	Chief Operating Officer and Medical Director	~~**Jul-20**~~ ~~**Apr-21**~~ **Update in Q1 2021/22** **Sept 2022**
G8	Due to COVID-19 pandemic the Trust has seen a large increase in its waiting list and the ability to undertake routine elective work has been reduced. Had to reduce capacity across inpatient and outpatient services **(C)**	Recovery action plan in place and following national guidance. Envisage compliance with new national guidance relating to waiting lists by September 2021. **Q2 Update:** Phase 3 letter received in Q2, plan to be compliant after April 2021, on track for September 2021. **Q3 Update:** phase 3 letter actions put on hold due to wave 2 of COVID-19 pandemic - Expect further adjustments due to omnicon variant. **Q4 Update:** recovery programme agreed and shared with ICS. National trajectories advised, plan to achieve trajectory by Q3 2021/22. **Q1 Update:** An update to mitigations due in Q1 regarding elective care are included in G1.1. Currently it is not advised to absorb or recommend closure of the gap and await Q2 update. Q2 update- H1 recovery plan completed and met above expectations. H2 recovery plan data submitted in November 2021.	Chief Operating Officer	**Sep-21** **Q3 2021/22**
G9	Admission Avoidance (Mandate 5B) **(C)**	1. Run pilot for frailty pathway from ED (will go live 24 May for 4 weeks). 2. Agree next steps following review of pilot –including medical input to the combined assessment of frail patients in SDEC. Q2 Pilot reamins ongoing 3. Agree frailty pathway model and embed in working practice	Chief Operating Officer	**Jul-21** **Oct-21** **Jan-22**
G10	National Programme re 'right to reside' on hold.	Work ongoing in relation to dealyed transfere of care.	Chief Operating Officer	**Ongoing to due external factors**
G11				
G12				
G13				

PATIENTS: Excellence in healthcare

BAF Item B3: Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services *Risk Owner: Interim Chief Nurse / Medical Director* *Board Committee: Quality Committee* *Date the risk last reviewed: 8 February 2022*	**Link to 2021/22 Operational Plan** **Focus on the fundamentals of care** **- Embed agreed standards of care and support teams to deliver and embed quality improvement** **- Implement effective learning from deaths practices and deliver improved mortality rate**	**Link to Operational Risks (scoring 15+):** **There are no risks on the risk register as at 22 February 2022 rated 15 and above relevant to patient experience.**

STRATEGIC OBJECTIVE
PATIENTS: Excellence in healthcare
Which means…
- Deliver high quality care to our patients every day
- Put patients at the centre of what we do
- Continuously improve the quality of care and services we provide
- Develop and implement new models of care for the future

Executive Summary - Quarterly Update:
Q1: Until arrangements for visiting are back to normal and there has been a reduction in the number of concerns and complaints linked to visiting it is not considered appropriate to reduce the risk score. In addition new gap identified during Q1 relating to staff shortages leading to reduced opportunity to communicate with clinical teams.

Q2: The Trust managed to reintroduce some visiting in Q2. The visiting hotline was very successful. Insufficient reduction in complaints and concerns sufficient to reduce risk score in Q2. Q3 unchanged. Q4 ongoing review: full review of the current position.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
4 x 4 = 16 L (likely) x C (major)	**4 x 4 = 16 L (likely) x C (major)**	**4 x 4 = 16 L (likely) x C (major)**	**4 x 4 = 16 L (likely) x C (major)**	**4 x 4 = 16 L (likely) x C (major)**	➔	3 x 4 = 12 L (possible) x C (major)

Risk Appetite:
TRFT has a **VERY LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users (score of 1 - 5)
TRFT has a **LOW** risk appetite for risks that may affect the experience of our service users (score of 6 -10)
TRFT has a **VERY LOW** risk appetite for risks that may compromise safety (1-5)

Current Risk Appetite (based on current risk score):
High (16 - 25)

Target Risk Appetite (based on target risk score):
In line with / below appetite of MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Implementation of actions based on the outcomes of the national patient surveys (annual Inpatient, Maternity and UECC surveys and bi-annual C&YPS survey).
C2	External benchmarking to ensure the Trust is employing best practice to responded to the outcomes of patient surveys, some of which may be facilitated by Picker
C3	All patient survey action plans monitored quarterly at Patient Experience Group and within the Divisions to ensure completion of actions. Also monitored to completion by Clinical Governance Committee via register for Action Plans.
C4	Responding to national guidance to ensure visiting and communication with families is optimised as far as it is safe to do so.
C5	Organisational Learning Action Forum (OLAF) to ensure that learning from claims, complaints, incidents and inquests can be used to positively impact on quality of care to close the loop with the clinical audit process to provide assurance.
C6	Driving the implementation of the Engagement and Inclusion strategy to ensure that the voices of service users are heard and acted upon in a meaningful way.
C7	Ongoing compliance with the Complaints Strategy to ensure that learning from complaints is embedded and action from in a meaningful way

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE: 1. Internal (operational)	2. Internal: (oversight)	3. External	DATE LAST ASSURANCE PROVIDED
A1	Findings of national patient surveys (annual or bi-annual, mixed assurance) Surveys have been delayed during COVID-19 so the Trust has not received other results this year although the surveys have now started to collect data. Publication dates as follows: UECC: Sep-21 C&YPS (bi-annual): Nov-21 Maternity: **Jan-22** Inpatients: Nov-21	✓	✓	✓	UECC: **Oct-19** C&YPS: **Nov-19** (bi-annual) **Maternity: Jan-22** Inpatients: **Jul-20**
A2	Friends & Family Test reinstated with a new process which places greater emphasis on qualitative responses rather than response rates. Monitored via monthly report reviewed at Friends & Family Test Group and Patient Experience Group and is summarised quarterly within Patient Experience report for Clinical Governance Committee and Quality Committee (monthly, mixed assurance)	✓	✓		**Feb-22**
A3	Quality Boards in all ward areas including 'You said, We did' section based on Friends & Family Test or patient survey feedback The perfect ward audits are ensuring that up to date Friends & Family Test feedback is displayed on Quality Boards in all clinical areas (monthly, positive). Quarterly reports on Tendable (previously)Perfect Ward to Clinical Governance Comittee and Quality Committee (quarterly, positive)	✓			**Feb-22**
A4	Compliance with timeliness of responses to complaints monitored monthly via reports to Clinical Governance Committee and Quality Committee (monthly, positive) Quality of the complaints responses and robustness of action plans is reported quarterly to Clinical Governance Committee and Quality Committee (quarterly, mixed) Annual Complaints Report to Board of Directors and included in the Trust's Quality Account (annual, positive)	✓	✓		**January 2022** **February 2022** **Jun-21**
A5	Engagement and inclusion update included in quarterly Patient Experience report for Clinical Governance Committee and Quality Committee (quarterly, positive)	✓	✓		**Feb-22**
A6	Regular Tendable audits relating to patient experience began in Q11 (monthly, mixed assurance)	✓			**January 2022**
A7	360 Assurance audit of complaints management (Jul-21) save 'significant assurance' rating for complaint handling and 'limited assurance' for learning from complaints (ad hoc, mixed) (See G2 for action plan)			✓	**Jul-21**

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	TRFT is the only Trust in ICS to not run Friends & Family Test via text message leading to a lack of choice for patients about how to respond **(A)**	**Q1 Update:** now a choice of ways for people to complete test including electronically via a QR code. To discuss at Executive Team Meeting and determine whether there is an appetite to launch text messaging.	Chief Nurse (Head of Patient Experience)	**Update in Q2**
G2	360 Assurance audit of complaints management (Jul-21) save 'significant assurance' rating for complainst handling and 'limited assurance' for learning from complaints **(C)**	Audit made 3 medium and 1 low recommendations: 1.1 and 1.2 (Medium) Deadline: 31-Mar-22 2.0 (Low) Deadline: 31-Mar-22 3.0 (Medium) Deadline: 31-Mar-22	Chief Nurse (Deputy Chief Nurse)	**Q4 2021/22**
G3	Public having access to up to date information via the Trust's website **(A)**	**Q4 update: New Deputy Chief Nurse workinging with communications team to ensure new resources for patients are available on the website and in clincial areas.**	Chief Nurse & Deputy Chief Nurse	~~**Q1 2021/22**~~ **Q4 2021/22**
G4	COVID-19 restrictions have negatively impacted on the communication between ward staff and patient's families leading to concerns being raised with complaints team **(C)**	**Q1 Update:** Development of a visiting' hot line' allowing one visitor per patient to visit at an agreed time for 50mins to maintain safety and enable cleaning between visitors. Pre-bookable slots are managed through a centralised admin / volunteer team. Special circumstances enabling enhanced visiting are still in operation e.g. for patients at end of life of paediatric patients as per the SOP. Q2 Update: In line with national guidance The Trust has relaxed some visiting rules, SOP in place to support arrangements. Closure of visiting hotline and although restrictions remain in place they are now managed locally at ward level. Gap remains as the Trust goes into winter as may need to impose visiting restrictions again. Jan 2022 - Restrictions in visiting re-instated due to increase in Omicron varient but visiting helpline established. February 2022: Production of an ongoing business as usual plan to ensure relatives are kept informed.	Chief Nurse (Deputy Chief Nurse)	**Q1 for SOP -** complete **Gap will remain until all visiting restrictions are removed**
G5	Staff shortages leading to reduced opportunity for relatives to communicate with clinical teams **(C&A)**	Work to support the teams with extra resources (non-clinical) to look to a method to enable communication to increase Q2 Update: Relaxation on visiting has improved the situation but will need to be monitored for one more quarter before the gap can be considered closed. Concerns data acts as a barometer for whether or not communication is improving.	Chief Nurse and Medical Director	**Q3**
G6	How to safely reintroduce volunteer workforce back into the Trust **(A)**	Additional members of staff to support volunteer coordinator to enable one to one conversations with all existing volunteers to identify safe roles they would be comfortable returning to and beginning to look to actively recruit new volunteers. One to one conversations will be complete in early Q3. Looking to increase volunteer presence on site by end of Q3 providing it is safe to do so.	Chief Nurse	**Extended to Q2 2022-23**
G7	**Patient and Public Involvement Strategy requires approval.**	**Approval scheduled by the end Quarter 4.**	Chief Nurse	Q4 2021/22

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C8	Acute Care Transformation Steering Group
C9	**New Deputy Chief Nurse in post with specific remit for staffing and experience.**
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A8	Ongoing work of Engagement and Inclusion Lead with hard to reach communities. Evidenced through quarterly Patient Expereince Report report for Clinical Governance Committee and Quality Committee (quarterly, positive)		✓		**Aug-21**
A9	Monthy reports recevied from the Acute Care Transformation Steering Group.				
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G8	**Centralised corporate oversight of the clinical governance function.**	**Incorporated in the work stream realting to quality governance supported by external support. Paper to the Executive Team Meeting in Quarter 4 with a proposed implementation within Q1.**	Interim Chief Nurse and Deputy Chief Nurse	Q1 2022-23
G9				
G10				
G11				
G12				
G13				

COLLEAGUES: Engaged, accountable colleagues

BAF Item B4: Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's plan *Risk Owner: Director of Workforce* *Board Committee: People Committee* *Date the risk last reviewed: 30-Apr-21*	**Link to 2021/22 Operational Plan** **Safely exit the COVID-19 pandemic: deliver full programme of Health & Wellbeing initiatives for staff** **Empower and enable staff to deliver:** **- design and launch organisational development programme for divisional teams**	**Link to Operational Risks (scoring 15+):** **No risks**

STRATEGIC OBJECTIVE:
COLLEAGUES: Engaged, accountable colleagues
Which means…
- Recruit, retain and develop a high performing, effective and motivated workforce
- Be a learning organisation with a culture of continuous improvement
- Engage with colleagues and communicate effectively
- Develop strong leadership at all levels of the organisation

Executive Summary - Quarterly Update:
Q4: 2020 staff survey results have revealed that the Trust scored an average of 6.9 for staff engagement and comparator Trusts scored 7.0. In addition TRFT was 5th most improved trust in the country; of the 10 themes measured 9 have improved from previous year hence proposed reduction in score to 3(L) x 5(C) = 12

Q1 Update: Positive progress made during Q1 in relation to opening of staff gardens, Executive Director walkarounds across both hospital and community locations and NHS Big Tea Party. Challenges encountered in relation to capacity to undertake further staff engagement work due to requirement for Health & Wellbeing team to support COVID-19 and 'flu vaccination programme between September and December 2021. Q2 Update: Despite anticipated challenges, TRFT has delivered a sucessful flu and Covid booster vaccination programme. Ongoing Q4 update: position remains unchanged.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
3 x 4 = 12 L (possible) x C (major)	3 x 4 = 12 L (possible) x C (major)	**3 x 4 = 12 L (possible) x C (major)**	**3 x 4 = 12 L (possible) x C (major)**	**3 x 4 = 12 L (possible) x C (major)**	➔	**3 x 4 = 8 L (possible) x C (major)**

Risk Appetite:
TRFT has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce (12 - 15)

Current Risk Appetite (based on current risk score):
Moderate (12 - 15)

Target Risk Appetite (based on target risk score):
In line with appetite of LOW (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Trust has organised staff inclusion networks (BAME, LGBTQI, Disability) and work continues to develop these networks and increase staff engagement from those with protected characteristics
C2	Risk assessment process for COVID-19 aimed specifically at supporting staff who were shielding and those staff who may be suffering from Long COVID
C3	Equality, Diversity & Inclusion Steering Group designed to address issues of equality at a corporate and policy level from an Equality, Diversity & Inclusion perspective
C4	Established regular meetings with Trade Union colleagues in order to ensure Trade Unions are informed, engaged and updated regarding changes within the organisation
C5	Revised national approach to staff survey including additional quarterly local staff surveys and a revised annual national staff survey
C6	Divisional attendance at People Committee to provide assurance around staff engagement activities
C7	Proactive well-being programme publicised through the Trust via 'Your People Pack' on intranet
C8	Reviewed Personal Development Review (PDR) process and documentation to facilitate better appraisal conversations including conversations about health and wellbeing
C9	Continued implementation of People Strategy approved by Board of Directors in June 2020 of which staff engagement is a key factor
C10	People Committee seeks assurance that staff engagement is sufficiently effective, resulting in improved staff survey results
C11	Continued implementation of local staff survey action plans by Divisions monitored through Divisional performance meetings from March 2021 onward
C12	Proud award process including the event and monthly excellence awards
C13	**Trust has launched the Behavioural Framework in Q3.**
C14	**The tender process for Occupational Health Service has completed with a view to the new service from April 2022.**
C15	**Additional resources approved to deliver the Health and Wellbeing Initiative and is now in place.**

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	People Strategy approved by Board of Directors of which staff engagement is a key factor (positive)		✓		**Jun-20**
A2	National Staff Survey 2020: - Response rate of 52.2% compared to average national response rate of 47.3%. Improved rate compared to last year and is evidence of increased engagement in staff survey - 3rd most improved trust in the country; of the 10 themes measured 9 have improved from previous year (positive, annual) **2021 response rates 59.6% which is an increase of 7.4%. We are 8.5% above the national average.**			✓	**Nov-20 Mar-21**
A3	Individual meetings have taken place between Board members and members of staff as part of reciprocal mentoring scheme Also commenced meetings with Leadership Academy to take forward reciprocal mentioning scheme (positive, ad hoc)			✓	**May-21**
A4	Current completion rate of PDR is 70% against target of 90% New window for appraisals commenced Apr-21 to Aug-21 (negative, monthly)		✓		**May-21**
A5	During pandemic managed to stage Proud Awards and Recognition of Learning Event virtually which led to positive engagement with staff in terms of viewing on YouTube (positive, annual)		✓		**Nov-20**
A6	NHS Tea Party held on 5 July 2021 to support engagement with Trust staff (both hospital and community).		✓		**Jul-21**
A7	Charitable funding utilised to develop hospital garden including outdoor gym facility and to create a woodland walk for staff		✓		**Q1 2021/22**
A8	Established programme of Executive Director weekly walkarounds (hospital and community) which are reported back through Executive Team Meeting		✓		**Q1 2021/22**
A9	Delivered Flu and Covid booster vaccinaion programme within TRFT the best performing within the North East and Yorkshire for Flu vaccinations.		✓	✓	**Q2 2021/22**
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	**BAF deep dive at People Committee in April said that we needed to detail what actions have actually made the difference in terms of staff engagement. Steve to speak to Lynn about what additional assurance is needed. Need to prove we do know what has made the difference.**	**Q4: Revised BAF will be developed February and March 2022.**		
G2				
G3	Heath & Wellbeing (Mandate 1A) **(C&A)**	1. Individual health & well-being conversations to take place: 1a. employee / manager training available - completed 1b. HWB conversations to be completed/recorded as part of the appraisal during the first half of the year 2. Stakeholder group established for review of Our People Pack - completed 2a. new version available for colleagues to access 3. Occupational health & wellbeing support available to all staff including rapid access to psychological and specialist support - completed 4. E-Roster governance meeting established 5. Encourage maximum uptake for Covid(and flu) vaccinations / booster jabs inline with national guidance	Director of Workforce	**Apr-21 Aug-21 Jun-21 Sep-21 May-21 May-21 Mar-22**
G4	Organisational Development Programme (Mandate 4A) **(C&A)**	1. Appoint an external company to deliver the Divisional Leadership Team (DLT) Programme 2. Outline a scope of works / statement of requirements for the DLT Programme. 3. Completion of DLT OD programme 4. Post programme diagnostic	Director of Workforce	**31-May-21 31-May-21 30-Nov-21 28-Feb-22**
G5	~~Capacity to support Health and Wellbeing initiatives caused by team having to support COVID-19 booster and annual 'flu vaccination programme between Sep-21 and Dec-21. (C&A).~~	~~Identify additional resources to support Health and Wellbeing programme.~~	Director of Workforce	**~~Q2 2021/22~~ - Moved to assurance**
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

COLLEAGUES: Engaged, accountable colleagues

BAF Item B5: Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs *Risk Owner: Director of Workforce* *Board Committee: People Committee* *Date the risk last reviewed: 30-Apr-21*	**Link to 2021/22 Operational Plan**	**Link to Operational Risks (scoring 15+):**
	Safely exit the COVID-19 pandemic: identify new practices from COVID-19 to embed in the long term and implement new ways of working **Empower and enable staff to deliver:** **- Build a culture so that the trust is seen as an employer of choice, appointing to key clinical leadership vacancies**	**4514:** The Division's ability to deliver the full range of gastroenterology services by substantive Consultant workforce challenges **4959:** The Divisions (Acute CSU) ability to ensure that there are adequate numbers of suitably qualified, competent and experienced nurses **5442:** Inability to fill high number of registered nurse vacancies leading to potentially a reduction in patient experience and safety **5715:** Ability to treat deteriorating patients in a timely manner due to lack of capacity within the Hospital at Night team **6417:** The Division of Medicine's ability to deliver the full range of inpatient (Nursing) Diabetes Specialist Care

STRATEGIC OBJECTIVE:
COLLEAGUES: Engaged, accountable colleagues
Which means…
- Recruit, retain and develop a high performing, effective and motivated workforce
- Be a learning organisation with a culture of continuous improvement
- Engage with colleagues and communicate effectively
- Develop strong leadership at all levels of the organisation

Executive Summary - Quarterly Update:
Q4: There has been no deterioration in the position during Q4 although there have also been no significant gaps closed hence recommend no change in risk score for Q4. Q4: ongoing during Quarter 4; no change

Q1 Update: The Trust has the lowest level of nursing and midwifery vacancies it has had for a long time. However, more needs to be embedded before a reduction in risk score is proposed.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
3 x 4 = 12 L (possible) x C (major)	**3 x 4 = 12** **L (possible) x** **C (major)**	**3 x 4 = 12** **L (possible) x** **C (major)**	**3 x 4 = 12** **L (possible) x** **C (major)**	**3 x 4 = 12** **L (possible) x** **C (major)**	➔	3 x 4 = 12 L (possible) x C (major)

Risk Appetite:
TRFT has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce (12 - 15)

Current Risk Appetite (based on current risk score):
Moderate (12 - 15)

Target Risk Appetite (based on target risk score):
In line with MODERATE (12 - 15)

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Operational Workforce Group reviews with Divisions key operational workforce metrics to understand performance and areas of assurance. People Committee seeks assurance that staff recruitment and retention is effective and supports a decrease in temporary staffing costs
C2	Implementation of People Strategy approved at Board of Directors in June 2020
C3	Medical workforce job plans to ensure that the Trust has sufficient capacity of medical workforce to meet service demand.
C4	Medical agency sign off process to ensure that the Trust tries to minimise additional temporary staff costs by having a rigorous process of control
C5	Vacancy control process established: Panel of Executive Directors reviews and scrutinises vacancies when they occur in order to control workforce costs on a weekly basis.
C6	Ongoing recruitment campaigns including participation in South Yorkshire & Bassetlaw international nurse recruitment programme

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE: 1. Internal (operational)	2. Internal: (oversight)	3. External	DATE LAST ASSURANCE PROVIDED
A1	People Strategy approved by Board of Directors which includes focus on recruitment and retention (positive) People Committee endorsed Talent Management Framework for the Trust at the Oct-20 meeting (positive, ad hoc)		✓		**Jun-20** **Oct-20**
A2	A number of simultaneous strategies to increase recruitment for registered nurses have been successful during 2020/21 and have all achieved the desired outcomes. This includes: newly qualified recruitment, return to practice and international recruitment and links to G3 (positive)	✓			**Feb-21**
A3	Increased number of nurse staffing placements to accommodate increased take up of nurse training (positive)	✓			**Jun-21**
A4	360 Assurance Integrity of e-rostering gave a 'limited assurance' rating and made 3 high and 3 medium recommendations (negative) All actions completed as at Q2 2020/21 *360 Assurance e-rostering audit planned for Q3/4 2021/22*			✓	**Oct-20** ***Q3/4 2021/22***
A5	*360 Assurance Consultant job planning internal audit planned for ~~Q3/Q4 2020/21~~ Q4 2021/22*			✓	**Q4 2021/22**
A6	People Committee undertook a 'deep dive' on Medical workforce job plans in Q4		✓		**Q4 2020/21**

GAPS IN CONTROL (C) or ASSURANCE (A)
gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Employer of Choice (Mandate 4B) High Level milestones….not included in report to Board in June 2021	**To be confirmed**	Director of Workforce	TBC
G2	Lack of coverage for relevant Medical & Dental staff groups in relation to electronic rostering **(C)**	The Trust has secured regional funding to implement rostering for medical and dental staff	Director of Workforce	**~~Jul-21~~** **Q4 2021/22**
G3	~~Trust's inability to recruit to vacancies across the organisation **(C)**~~ Significant staffing gaps still exist in some specific areas **(C)**	Registered nurse vacancy rate has reduced form 11% to 5% over last 12 months hence gap in control has been reworded. With recruited registered nurse staff currently in the pipeline it is anticipated that the overall gap will be eradicated by end Q3 2021/22. Sideways transfer policy is being utilised to smooth out discrepancies between areas such as supporting community nursing. In line with NHS E/I target Health Care Support worker has reduced from 37 WTE in Oct-20 to an over recruited position in Apr-21. **Q2 Update:** as for Q1 except that the vacancy rate for the substantive funded beds is now down to 3.25% , the lowest it has ever been. The sideways transfer plan for Community has had positive results. All other plans continue on track.	Chief Nurse and Chief Nurses of SY&B ICS	**Q3 2021/22**
G4	Medical Workforce job Plans **(C)**	Job Planning for 2021/22: A 'light touch' to job planning has been adopted throughout the period of COVID; however, job plans have been reviewed and updated as and when required, particularly where there are pay affecting changes. The Medical Director has sent out communication to the Divisional Directors (DDs) (including General Managers) on 17-Jun-21 asking that they liaise with the respective Clinical Leads in order to ensure that they are progressing job plans through and that DDs are also signing off those job plans that are awaiting 3rd Managerial Sign off. The percentage figures for Q1 reflect the job planning status for 2020/21: Total number of the Consultants in post as of 8 July 2021 = 166 / Total number of SAS Grades in post as of 8 July 2021 = 59 12% of Consultant job plans are now signed off on the e-Job Plan System / 65% of Consultant Job Plans are awaiting Consultant or managerial sign off / 23% of Consultant job plans have not been submitted for sign off and are still at the Discussion stage 5% of SAS doctor job plans are signed off / 49% are awaiting manager approval / 46% of job plans have not been submitted for sign off and are still at the Discussion stage. The Medical Director has hastened Divisional Directors to ensure job planning is completed by 31 July 2021. The Medical Workforce Manager (Quality and Standards) continues to support the Divisions with the job planning process	Medical Director	**31-Jul-21**
G5	Identify new practices to embed (Mandate 1B) **(C)**	1. Publish two 'Learning from Covid-19' Team Completion Packs for use across the organisation 2. Begin engagement with services around Service Sustainability Reviews 3. Complete second round of Service Sustainability Reviews 4. Consolidate key actions from Service Sustainability Reviews and ensure these are built into plans for the following year	Director of Strategy, Planning and Performance	**Sep-21** **Oct-21** **Dec-21** **Mar-22**
G6				

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C7	NHS Professionals in place to ensure value for money supply of temporary staff
C8	Interface for interaction between NHS Professionals and e-roster
C9	E-roster Implementation Group established in Q1 to oversee appropriate implementation of e-roster system across the Trust
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A7	In 2020/21 Trust began a career development programme for disabled staff in partnership with Disability Rights UK, funded by the £10K the Trust has been awarded from the WDES Innovation fund (ad hoc, positive)		✓		**Q1 - Q4 2021/22**
A8	Reciprocal mentorship participation in Leadership Academy program in (ad hoc, positive)			✓	**Jun-21**
A9	Monthly workforce report scrutinised by Operational Workforce Group, Executive Team Meeting and People Committee to obtain assurance on recruitment and retention metrics	✓	✓		**Jun-21**
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G7				
G8				
G9				
G10				
G11				
G12				
G13				

GOVERNANCE: trusted, open governance

BAF Item B6: Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives

Risk Owner: Interim Chief Nurse & Medical Director
Board Committee: Quality Committee
Date the risk last reviewed: 8 February 2022

Link to 2021/22 Operational Plan

Focus on the fundamentals of care
- Embed agreed standards of care and support teams to deliver and embed quality improvement
- Implement effective learning from deaths practices and deliver improved mortality rate

Link to Operational Risks (scoring 15+):

4174: Clinicians do not always recognise the deteriorating patient: February 2022: Score remains 15
5169: Significantly raised HSMR and SHMI meaning higher mortality rates than expected: Risk closed
6545: Significantly raised HSMR meaning higher mortality rates than expected - scored at 16.

STRATEGIC OBJECTIVE:
GOVERNANCE: Trusted, open governance
Which means…
- Have an effective performance framework to help deliver outstanding results
- Be outstanding on the CQC 'well-led' framework across the Trust
- Have high quality data to provide robust information and support decision making
- Ensure all teams have regular reviews and updates around key issues and opportunities to learn

Executive Summary - Quarterly Update:
Q4: Consider the current risk score cannot be reduced given current level of CQC scrutiny and qualitative risk profile (QRP) undertaken during Q4.

Q1: Not appropriate to reduce current risk score whilst CQC warning notice still in place and report from most recent CQC inspections awaited.

Q2: Not considered appropriate to reduce risk score whilst CQC warning notices are in place. Q3: Position remained the same

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
4 x 4 = 16 L (likely) x C (major)	4 x 5 = 20 L (likely) x C (major)	**3 x 5 = 20 L (likely) x C (major)**	**3 x 5 = 20 L (likely) x C (major)**	**3 x 5 = 20 L (likely) x C (major)**	➔	3 x 5 = 15 L (possible) x C (catastrophic)

Risk Appetite:
TRFT has a **VERY LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users (score of 1 - 5)
TRFT has a **LOW** risk appetite for risks that may affect the experience of our service users (score of 6 -10)
TRFT has a **VERY LOW** risk appetite for risks that may compromise safety (1-5)
TRFT has a **VERY LOW** risk appetite for Compliance / Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements (1-5)

Current Risk Appetite (based on current risk score):
High (16 - 25)

Target Risk Appetite (based on target risk score):
In line with / below appetite of MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Reporting on results of external reviews (e.g. Cancer Peer Review, JAG accreditation, GIRFT) to Clinical Governance Committee on a monthly basis with appropriate challenge and escalation as necessary. Remedial action plans monitored to conclusion by Clinical Governance Committee.
C2	The refreshing and embedding of Quality Strategy (previously known as Safe & Sound framework). Being refreshed to incorporate more emphasis on quality improvement
C3	Implementing and embedding Safeguarding Strategy including appropriate governance
C4	Robust Serious Incident process in place in accordance with the Incident and Serious Incident Management Policy
C5	Implementation of the Risk Management Strategy and ongoing education programme
C6	Monthly Safe & Sound mortality group continues to meet; Deteriorating patient and sepsis group and clinical leads Safe & Sound Internal Professional Standards meeting are also continuing to meet. Other Safe & Sound workstreams are being reviewed as part of the refresh of the Quality Strategy and identification of quality improvement methodology (links to G1)
C7	Regular monitoring of quality indicators and instigation and implementation of remedial action by Quality Committee, Clinical Governance Committee and sub-groups, Risk Management Committee and sub-group
C8	Annual Clinical Audit Plan completion monitored via quarterly reports to Clinical Governance Committee and via monthly Clinical Effectiveness and Research Group
C9	Executive Team Meeting (ETM) covers quality governance and operational performance with wider stakeholder input than previous ETM. All new risks scoring 15+ reviewed on a weekly basis at Executive Team Meeting. Action plans arising from CQC inspections receive scrutiny confirmation and challenge at ETM.

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE: 1. Internal (operational)	2. Internal: (oversight)	3. External	DATE LAST ASSURANCE PROVIDED
A1	Monthly reporting of HSMR and SHMI at CGC, QC and Trust Board and via monthly IPR at Perf Meetings (negative: SHMI 109 and Trust is no longer an outlier; HSMR at 125, Jan-21 data).			✓	**Quality Committee and Clinical Governance Committee Jan-21**
A2	Monthly contact between Chief Nurse and CQC to provide assurance relating to implementation of 'must do' and 'should do' actions arising from inspections as well as any other quality concerns. Regulatory compliance against section 29A and section 31 warning notices in place. (monthly, positive)			✓	**Sep-21**
A3	CQC Children's Safeguarding action plan. Q1 2021/22: All actions now completed and Deputy Chief Nurse for Safeguarding is undertaking a review to ensure that all actions are sustained (ad hoc, positive)			✓	**Jun-21**
A4	360 Assurance 'Learning from deaths review - stage 1 mortality reviews' report (Sept 20) gave 'limited assurance' rating and made 4 medium actions (negative) See G14 for action plan 360 Assurance Learning from Deaths Governance review Apr-21 gave 'limited assurance rating and made 2 high and 9 medium recommendations (ad hoc, negative) See G13 for action plan *360 Assurance Learning from deaths governance review scheduled for Q3 2021/22*			✓	**Sep-20** **Apr-21**
A5	360 Assurance Policy management framework internal audit (Sept 20) gave 'limited assurance' rating and made 4 medium and 2 low recommendations (negative). **Q1 2021/22:** all recommendations have now been implemented.			✓	**Sep-20**
A6	360 Assurance CSU-level risk management internal audit (Jan-21) gave 'significant assurance' rating. All recommendations completed in Q4 2020/21			✓	**Jan-21**
A7	360 Assurance Strategic Quality Assurance review (Jun-21) gave 'Significant Assurance' rating and made 4 medium recommendations (ad hoc, positive)			✓	**Jun-21**
A8	360 Assurance CQC Action Plan – advisory work June 2021 reported 19 findings with associated actions (ad hoc, mixed assurance). Findings added to Trust's CQC action plan.			✓	**Jun-21**
A9	CQC section 31 warning notice (ad hoc, negative)(See G15 for action plan) CQC issued section 29A warning notice on 11 February 2021 (negative, ad hoc) Section 29A improvement action plan in place (see G4 for action plan)			✓	**Feb-21**

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Standards of Care & Quality Improvement (Mandate 2A) **(C&A)**	1. Establish a Quality Strategy Working Group 2. Identify the Quality Improvement Methodology (Toolkit)to be utilised across the Trust and its method of support and implementation - *revised timescale TBC as need to ensure refreshed Quality Strategy links to Trust strategy. Q2 Update: Methodology still being worked on. Will complete in Q3* 3. Identify and agree the standards of care required and measurement for improvement - *revised timescale Q3 as need to ensure refreshed Quality Strategy links to Trust strategy* 4. Refine Quality Strategy and present for Board sign off 5. Relaunch the Safe and Sound Quality Strategy *Q2 Update: delayed by 2 months* 6. Refresh of the Safe and Sound Quality Scorecard using the metrics identified in the strategy 7. Launch the KPIs data collection of perfect ward - completed 8. Develop Quality Improvement Methodology (Toolkit)and launch it 9. Embed Quality Improvement and encourage continuous improvement as BAU	Chief Nurse	**1. 31-May-21** - completed **2. ~~30-Jun-21~~** - revised timescale to Q3 **3. ~~30-Jun-21~~** - revised timescale to Q3 **4. ~~9-Jul-21~~ Q3** **5. ~~31-Jul-21~~ Q3** **6. ~~31-Jul-21~~ Q3** **7. 31-Jul-21 - completed** **8. 30-Sep-21** **9. 31-Mar-22**
G2	Learning from Deaths (Mandate 2B) **(A)**	1. Completion of investigation and initial actions into Palliative Care processes and coding 2. Completion of actions identified by Internal Audit review of Governance 3. Transfer of work from monthly Mortality Improvement Group and Mortality Analytical Group into Business-as-Usual governance and ways of working 4. Appointment to Associate Medical Director Mortality and Learning from Deaths and Mortality Manager posts 5. Implement Community Acquired Pneumonia (CAP) policy 6. Completion and learning from Improvement Academy work in the Urgent and Emergency Care Centre (UECC)	Medical Director	**Q2** **Q3** **Q3** **Q2** **Q1** **Q4**
G3	Gaps remain in Medical Director and Chief Nurse structures ©	**Q4 Update:** Chief Nurse team: temporary additional posts to support CQC process. Gap remains for Chief Nurse teams. Medical Director team: Medical Director structure has been strengthened by appointment and commencement of first Deputy Medical Director in Apr-21 whose focus includes professional standards. Second Deputy Medical Director and Business Manager have been appointed (start dates TBC). New Associate Medical Director for learning from deaths was not appointed therefore going back out to recruit for this post. **Q1 Update:** Medical Director team: Deputy Medical Director for Quality and Business Manager have been recruited but are not yet in post. Business Manager starts in Aug-21 and Deputy Medical Director for Quality in mid-Sep-21. Unsuccessful in recruiting to Associate Medical Director for Learning From Deaths role, currently under Deputy Medical Director for Professional Standards. Clinical Lead for Mortality and Learning From Deaths to be advertised and open to all colleagues at band 8A and above to apply. No gaps in Chief Nurse structure.	Chief Nurse & Medical Director	MD:**Q2 2021/22** CN: **Q2** for advert, **Q3 / Q4** before in post
G4	CQC issued section 29A warning notice on 11 February 2021 **(C&A)**	Preliminary response sent to CQC on 11-Dec-10, feedback awaited. Work has commenced on the required action plan. Submission date 19 Feb 2021 **Q1 Update:** Only a small number of actions are still open and all are due for completion in Q2 2021/22 **Q2 Update:** 1 action is outstanding, due to complete in Q3	Chief Nurse	**~~Q2~~** **Q3**
G5	Gap in assurance and control relating to: - medication safety / medicines management at Divisional and Pharmacy level **(C&A)** - delayed administration of critical medications and controlled drugs **(C&A)**	Medication Safety Group with be chaired by Medical Director in Q2 Rotherham Medicines Optimisation Group (RMOG) to be chaired by Deputy Medical Director during Q2 Working to arrange NHS E/I external review of medicines management to take place in Q2 Ongoing challenge of getting the SCRIPT training module onto the ESR system working with Learning & Development department and Chief Pharmacist. **Q2 Update:** External review has not yet taken place. SCRIPT is not on ESRas yet. ***Medical Safety Officer role with direct link to Medical Director***	Medical Director	**Q2**
G6	Lack of standardised SJR and morbidity meetings in Integrated Medicine Division **(C&A)**	**Q4 Update:** Safe & Sound Mortality subgroups now in place in Medicine Division. Anticipate that this gap can be closed when the Trust can evidence it is doing 100% of SJR within two months. **Q1 Update:** Safe & Sound Mortality subgroups in place Medicine and Surgery and meeting monthly. Need increased evidence that outputs form SJRs are being routinely discussed at these meetings. Gap can be closed when there is evidence of 100% completion of SJRs within 2 months and evidence of dissemination of learning from these reviews.	Medical Director (Divisional Director for Integrated Medicine)	**Q2**
G7	Lack of Trust-wide consistent and robust quality governance arrangements **(C&A)**	**Q4 Update:** Sufficient assurance in place regarding Divisional governance meetings. Less assurance available regarding CSU meetings so a member of Chief Nurse / Medical Director team will start attending CSU level meetings. Assurance should be in place by end Q1 2021/22. Medical Director now chairing Clinical Effectiveness Group with enhanced focus on NICE compliance plus revised ToR to include policy compliance moving forward. **Q1 Update:** 360 Assurance Strategic Quality Assurance review (Jun-21) gave 'Significant Assurance' rating and made 4 medium recommendations (see BAF item B6 G16 for action plan). There has been a sustained improvement in policy compliance and NICE compliance. There needs to be evidence of discussion and dissemination of learning from deaths and SJRs happening at Divisional and CSU level before this gap can be closed **Q2 Update:** gap remains. Learning from Deaths Manager recruitment is underway. Q3 Learning from Deaths manager now in post move to an assurance level.	Medical Director & Chief Nurse	**Q2 2021/22**
G8	Assurance re: compliance with NICE guidance and /or policies is lacking **(C&A)**	**Q4 Update:** Medical Director now chairing Clinical Effectiveness Group with enhanced focus on NICE compliance plus revised ToR to include policy compliance moving forward. Clinical Effectiveness and Research Group being split into Clinical Effectiveness Group and separate Research and Innovation Group. Draft ToR being revised. **Q1 Update:** Deputy Medical Director of Professional Standards is now chairing the Clinical Effectiveness Group. The Clinical Effectiveness and Research Group has not yet been split as the business case was unsuccessful at its first submission. NICE non-compliance is now at its lowest level in several years. The targets that have been set are to have no NICE guidance over 6 months overdue by end Jun-21; between 3 and 5 months overdue by end Jul-21 and over 3 months overdue by end Aug-21. **Q2 Update:** Policy compliance is now at 94% complaince in relation to overdue policies. New process in Document Ratification Group whereby all policies due for review in 6 months and 3 months' time will be communicated to Divisions.	Medical Director	**Q2**
G9	Safe & Sound work streams not yet having breadth of representation and limitation of bandwidth to complete all required actions **(C)**	**Q3 Update:** Deteriorating patient and sepsis group; Mortality Group and Medicine Management group continuing to meet and are well attended. Other workstreams have been reviewed and proposals created which require sign off by Interim Chief Executive. **Q4 Update:** as for Q3 **Q1 Update:** Deteriorating patient and sepsis group continues to meet and is well attended. Addition of internal Safe & Sound Internal Professional Standards meeting on a monthly basis. Reviewing current ToR and chairmanship of Medicines Safety Group and Rotherham Medicines Optimisation Group. Other Safe & Sound workstreams are being reviewed as part of the refresh of the Quality Strategy and identification of quality improvement methodology.	Medical Director & Chief Nurse	**Q3** **~~Q3~~** **Q4** **Q2 and ongoing**

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C10	Most deaths reviewed by Medical Examiner within 1 month and standing mortality section as part of Clinical Governance Committee Separate Safe & Sound mortality group meeting (monthly). Mortality will remain a standing agenda item on Clinical Governance Committee agenda until HSMR / SHMI below 100
C11	Effective quality governance structure at Divisional level with regular spot checks undertaken by members of Chief Nurse / Medical Director team
C12	Organisational Learning Action Forum (OLAF) introduced in late September 2020 to ensure that learning from claims, complaints, incidents and inquests can be used to positively impact on quality of care to close the loop with the clinical audit process to provide assurance.
C13	Medical Director chairing Clinical Effectiveness Group during Q3 & Q4 Deputy Medical Director assumed chairmanship in Q1
C14	Existing Mental Health strategy in place to ensure best practice care is provided
C15	
C16	
C17	
C18	
C19	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A10	Safeguarding Strategic Board (quarterly) and Safeguarding Operational meeting review assurances provided across safeguarding and institage remedial actions where required. Monthly, quorate and meeting (monthly, mixed)	✓	✓		**Q1**
A11	NHS England qualitative risk profile (QRP) assessment undertaken in conjunction with RCCG: submission of a self-assessment of risk score and evidence. Follow on meeting concluded no need to escalate to single item quality surveillance group or risk summit (ad hoc, positive outcome) NHSE/I attending monthly RCCG Contract Quality Meetings			✓	**Sep-21**
A12	Weekly Harm Free Care meetings chaired by Medical Director or Chief Nurse review prpvision of safe care on a weekly basis and determine remeidal action to be take where required (weekly, positive) Weekly Serious Incident Panel chaired by Medical Director or Chief Nurse to ensure robust reveiw of SI and progerss with investigations (weekly, positive)	✓			**Jun-21**
A13	360 Assurance Learning from Incidents review (Sep-21) gave 'signficant assurance' for evidence of learning from incidents and 'limited assurance' for Organisational Learning Action Tracker (ad hoc, mixed) (See G12 for action plan)			✓	**Sep-21**
A14	*360 Assurance Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019 (client wide review) scheduled for Q1-4 2021/22* *360 Assurance Governance & Risk Management review scheduled for Q2/Q3 2021/22*			✓	**Q1 - Q4 2021/22**

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G10	Chief Nurse and Medical Director Clinics not having the desired impact **(C&A)**	**Q3 Update:** Looking to have a session similar to Team Brief once a month, during Q4. Medical Director liaising with Interim Director of Communications to increase awareness and convert to virtual clinics in late Q3 and Q4. **Q4 Update**: Restarting virtually in Q1 **Q1 Update:** Clinics are running virtually, ongoing communications required to increase attendance and effectiveness.	Medical Director & Chief Nurse	~~**Sep-20**~~ ~~**Q3**~~ ~~**Q4**~~ **Q1 2021/22**
G11	Ensuring all actions from SI and red incident investigations are completed and sustained **(A)**	**Q4 Update:** Currently 24 red incident investigations and 4 SI investigations are overdue. In order to close gap would need to have overdue red incidents under 10 and overdue SIs under 5. **Q1 Update**: as at end May-21 5 overdue SIs and 21 overdue red incidents **Q2 Update:** as at Aug-21 QC report zero overdue SIs, 3 overdue incidenrs (all HSIB investigations) and 14 overdue red incidents therefore gap remains.	Medical Director & Chief Nurse	**Q4**
G12	360 Assurance Learning from Incidents review (Sep-21) gave 'signficant assurance' for evidence of learning from incidents and 'limited assurance' for Organisational Learning Action Tracker **(C)**	Review made 2 High, 2 Medium and 2 Low recommendations: 1.1 (High) deadline 31-Dec-21 1.2 (High) deadline 31-Mar-22 2.0 (Low) deadline 30-Sep-21 (Check with 360, not on portal) 3.0 (Low) deadline 31-Oct-21 4.0 (Medium) deadline 31-Mar-21 5.0 (Medium) deadline 31-Mar-21	Chief Nurse & Division of Surgery	**Q4 2021/22**
G13	360 Assurance Learning from Deaths Governance review Apr-21 gave 'limited assurance rating and made 2 high and 9 medium recommendations **(A&C)**	1.1 and 1.2 (Medium) deadline 30-Sept-21 2.1 (Medium) deadline 30- Sep-21 completed and 2.2 (Medium) deadline 30-Oct-21 completed 3.1 and 3.2 (High) deadline 30-Jun-21 both in progress revsied deadline of 30-Nov-21 4.1 (Medium) deadline 30-Sep-21 outstanding 4.2 (Medium) deadline 30-Sep-21 completed 5.1 (Medium) deadline 30-Sep-21 and 5.2 (Medium) deadline 30-Jun-21 revsied deadline 39-Nov-21 6.1 (Medium) deadline 30-Sep-21 outstanding check with Callum	Medical Director	**Q2 2021/22**
G14	360 Assurance 'Learning from deaths review - stage 1 mortality reviews' report (Sept 20) gave 'limited assurance' rating and made 4 medium actions **(C)**	Action plan in place. **Q3 Update:** as at 31-Dec-20 all four recommendations are outstanding. **Q4 Update:** 3 recommendations have been completed with the remaining recommendation being in progress with a deadline of 31-Jul-21 **Q1 Update:** as for Q4. **Q2 Update:** all recomendations now implemented	Medical Director	**Gap closed**
G15	Section 31 warning notice action plan **(A)**			
G16	360 Assurance Strategic Quality Assurance review (Jun-21) gave 'Significant Assurance' rating and made 4 medium recommendations **(C&A)**	1.1 and 1.2 Medium deadline 30-Sep-21 Chief Nurse both completed 2.1 and 2.2 Medium deadline 30-Sep-21 Director of Corporate Affairs - Committee structure agreed.	Chief Nurse (Deputy Chief Nurse) Director of Corporate Affairs	**01/09/2021 - for implementation from 01 April 2022**
G17	Insufficient current resource in Clinical Effectiveness team to manage national and local audits, NICE, CQUINS and TARN **(C&A)**	Business case in progress to increase establishment. First pass of business case was not approved, therefore business case being revised. January 2022 - 360 Assurance carryiong out a review of the department.	Medical Director	**Update in Q2**
G18	Gap in control due to increase in mental health demand post-COVID for all ages but especially in relation to Children and Adolescent Mental Health Services (CAMHS) **(C)**	Establishing a Mental Health Steering Group and refreshing the Trust's existing Mental Health strategy. First meeting of Steering Group scheduled for Jul-21, refresh of strategy due for completion in Q3	Chief Nurse	**Steering Group: Jul-21** **Refreshed strategy: Q3**
G19	**Embedding and learning from actions from Serious Incidents is not consistently demonstrated in all cases. (Gap16BAF1)**	**Review of the current SI policy commenced.**	Interim Chief Nurse/ Medical Director	**Q4**

GOVERNANCE: trusted, open governance

BAF Item B7: There is a risk that robust financial governance arrangements are not embedded across the Trust which could impact on the achievement of Trust plans / objectives, and subsequent removal of the financial planning undertakings and breach of the provider licence *Risk Owner: Deputy Chief Executive / Director of Finance* *Board Committee: Audit Committee* *Date the risk last reviewed: 30-Apr-21*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Deliver on our financial commitments and ensure removal of breach of licence**	**Link to Operational Risks (scoring 15+):** **No risks**

STRATEGIC OBJECTIVE:
GOVERNANCE: Trusted, open governance
Which means…
- Have an effective performance framework to help deliver outstanding results
- Be outstanding on the CQC 'well-led' framework across the Trust
- Have high quality data to provide robust information and support decision making
- Ensure all teams have regular reviews and updates around key issues and opportunities to learn

Executive Summary - Quarterly Update:
Q1: Financial governance processes are now well embedded. Further work required across corporate areas and harmonisation of financial reporting to Divisional performance meetings. All improvements materially completed in Q1 and the organisation is receiving clarity in terms of the messages relating to financial governance.

Q2: On 13 August 2021, formal confirmation was received from NHS England / Improvement, North East and Yorkshire Regional Provider Support Group (RSG), that the Trust was no longer in breach of its provider licence.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
N/A	**3 x 4 = 12 L (possible) x C (major)**	**3 x 4 = 12 L (possible) x C (major)**	**2x4=8**		↓	3 x 4 = 12 L (possible) x C (major)

Risk Appetite:
TRFT has a **VERY LOW** risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements (1-5)
TRFT has a **LOW** risk appetite for actions and decisions taken in relation to Information Governance / IT. (6-10)
TRFT has a **LOW** Risk appetite for financial/VFM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements. (6 - 10).

Current Risk Appetite (based on current risk score):
Moderate (12 - 15)

Target Risk Appetite (based on target risk score):
In line with MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Financial control and scrutiny of financial performance through the hierarchical structure from Divisions through to Board of Directors (monthly / bimonthly meetings)
C2	Suite of Board documentation in place (SFIs, SO's, Standards of Business Conduct, Constitution, Matters Reserved). SFIs are being updated in relation to Executive Management Team (see G3)
C3	Outstanding recommendations from internal audits reviewed at every Audit Committee meeting and Executive Directors invited to attend as necessary. From Nov-20 also reviewed at ETM on a bi-monthly basis.
C4	Overview and scrutiny of Trust's financial performance by the ICS and NHSE/I regional finance team
C5	Contract Performance Meeting ensures adherence to contracts and financial goals (N.B. These meetings were stood down during the pandemic but recommenced from September 2020 and have been held monthly since. The agenda has been changed slightly to focus on waiting list recovery as opposed to the traditional activity / income volume variances).

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	360 Assurance Integrity of General Ledger and Financial Reporting audit April 2021 gave indicative opinion of 'significant assurance' rating (annual, positive)			✓	**Apr-21**
A2	Final Head of Internal Audit Opinion detailed that The Trust has implemented a total of 96% of all internal audit actions due in-year and gave a 'moderate assurance' opinion overall (annual, positive)			✓	**Jun-21**
A3	2020/21 External Auditors' ISA 260 issued unqualified opinion, without modification, on the financial statements (annual, positive)			✓	**11-Jun-21**
A4	360 Assurance Payroll internal audit July 2020 gave 'significant assurance' rating (ad hoc, positive)			✓	**Jul-20**
A5	360 Assurance Advisory review re: leases (Oct 20) - no assurance rating assigned (ad hoc, mixed assurance)			✓	**Oct-20**

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Removal of breach of licence / Five Year Strategy (Mandate 6) (C&A)	1. Delivery the financial plan for 2020/21 (post audit). Break even position on plan at Q1 and forecast to achieve at month 6 of 21/22 2. Break even position achieved at month 6 (H1), Capital Plan delivered at end of month 6 (H1), Financial Governance Plan implemented 3. Breach of licence removed - achieved	Director of Finance	**Jun-21** - achieved and Q1 on plan **Oct-21** **Mar-22** - **achieved**
G2	Carbon Energy Fund and Financial Governance external reviews led to recommendations for actions to be taken **(C)**	One combined action plan has been robustly developed with actions led by members of the Board of Directors. A significant number of actions are already complete or in progress, with the vast majority scheduled to be implemented before the end of March 2021. **Q4 Update:** Acton plan has been substantially completed as at Q4. **Q1 Update:** materially completed all actions with completion dates in Q1	Board of Directors	**Jun-21** - materially completed all actions scheduled for completion **Sep-21** - for completion of all actions
G3	Standing Financial Instructions to be reviewed to ensure that Executive Team Meeting has appropriate delegated authority via lead officers **(C)**	SFIs to be updated. **Q2 Update:** SFIs will be updated by end March 2021 **Q4 Update:** SFIs will be updated by end June 2021 **Q1 Update:** Agreed with Finance & Performance Committee and Audit Committee that a summary document of the proposed changes to SFI's will be made available at the Committees along with a proposal to Business Case approvals. The final suite of documents will go to Oct-21 Audit Committee Q2 Update: At Sep-21 Board of Directors' meeting approval was given to the proposed wording changes to the AFIs and the prposed changes to the 'Authorisation Limits For In Year Changes To Budgets'. Revised SFIs to be presented for approval to Nov-21 Board meeting. Q3 update - approved therefoer move to an assurance	Interim Deputy Director of Finance (Deputy Director of Finance) and Company Secretary	~~**Q2 Q4**~~ ~~**Q1 2021/22**~~ **Q3 2021/22**
G4				
G5				

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C6	CIP Efficiency Board (monthly) holding Divisions to account for development and delivery the Cost Improvement Plan and subsequent delivery of financial benefit
C7	Implementation of Internal Audit, External Audit and Counter Fraud report recommendations
C8	
C9	
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A6	Carbon Energy Fund external review (negative, ad hoc) Financial governance external review (negative, ad hoc) See G2 for action plan..			✓	**Jul-21**
A7	Financial governance improvement plan progress reported to Confidential Board of Directors' meetings on a monthly basis (monthly, positive)		✓		**Jul-21**
A8	Correspondence from Director of Operational Finance at NHS E/I noted the Trust had demonstrated a positive improvement in financial governance and delivery which had improved the level assurance for NHSE/I and SY&B ICS leading to the decision by NHSE/I that the monthly finance review meetings would cease with immediate effect (ad hoc, positive)			✓	**May-21**
A9	Undertakings and license condition: The progress made on the Governance Improvement Plan has been recognised by NHSE/I. As a result, there has been an indication that the lifting of the undertakings will be considered. This would need to be approved at a regional level. Further feedback on this and the outcome will be received in the near future. Additionally, consideration on the lifting of the legacy licence conditions will also be considered, although this must be undertaken at a national rather than regional level (ad hoc, positive)			✓	**Q1 2021/22**
A10	Formal confirmation received from NHS England / Improvement, North East and Yorkshire Regional Provider Support Group (RSG), that the Trust was no longer in breach of its provider licence (ad hoc, positive)			✓	**13-Aug-21**
A11					
A12	*Finance & Performance Committee Annual Report to Board of Directors for 2020/21*				
A13					
A14					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

FINANCE: Strong financial foundations

BAF Item B8: The financial plan is not delivered *Risk Owner: Director of Finance* *Board Committee: Finance & Performance Committee* *Date the risk last reviewed: 8 February 2022*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Deliver on our financial commitments and ensure removal of breach of licence**	**Link to Operational Risks (scoring 15+):** **5779:** Opening additional capacity on AMU above the funded 44 bed base **Risk Closed**

STRATEGIC OBJECTIVE:
Deliver strong financial foundations through:
- Improving liquidity whilst ensuring appropriate investment in estates and assets
- Managing within the approved budget and reduce the underlying deficit
- Improving financial performance through service transformation and cost improvement.

Source: Five Year Strategy 2017 - 2022

Executive Summary - Quarterly Update:
Q4 Update: Financial plan will be delivered by end of Q4 2020/21 hence proposal to reduce risk score for Q4 to 1(L) x 3(C) = 3. The only risk that remains is the potential for adjustments which arise from completion of the external audit.

Q1 Update: Trust is reasonably confident it will be able to deliver the first half plan for 2021/22. Half 2 financial regime currently unknown. Challenges expected from second half financial regime may be mitigated by non recurrent support. Q2 update H1 plan achieved.
Q3 Update: Three gaps in controls have been closed (G3, G4 and G7) therefore following overall review of the risk score the recommendation is that this BAF risk 8 is now a mananged risk. Q4 ongoing managed risk.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
1 x 3 = 3 L (Rare) x C (moderate)	1 x 3 = 3 L (Rare) x C (moderate)	1 x 3 = 3 L (Rare) x C (moderate)	1 x 3 = 3 L (Rare) x C (moderate)	**1 x 3 = 3 L (Rare) x C (moderate)**	➔	2 x 3 = 6 L (possible) x C (moderate)

Risk Appetite:
TRFT has a **LOW** Risk appetite for financial/VFM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements (6 - 10).

Current Risk Appetite (based on current risk score):
Very Low (1 - 5)

Target Risk Appetite (based on target risk score):
In line with appetite of LOW (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Key committees in place which receive reports and subsequently monitor implementation of action plans: - Executive team meeting receives monthly financial performance data and project mandate updates reviewing progress (monthly) - Divisional performance management meetings chaired by Deputy Chief Executive receives latest performance data by Division (monthly) - Finance Oversight Meetings for Divisions - Finance and Performance Committee scrutinises financial performance and progress with project mandates in addition revised forecast positions (monthly) - Workforce control groups review progress against trajectory (weekly) - Capital planning and monitoring group scrutinises progress against capital plan (monthly) (See B9 for further detail) - Cash review meeting scrutinises cash flow forecast (monthly) - ETM receives monthly update on financial position
C2	Project mandate are in place for Removal of Breach of Licence and Five Year Strategy (see G1) Mandate has been signed off and monthly progress will be reported against the mandate.
C3	Business cases scrutinised by FPC with recommendation made to Board of Directors (N.B. all business cases are scrutinised first by ETM then by F&PC and finally by Board of Directors where they are above £250K in value plus in exceptional and urgent circumstances e.g. early stages of a pandemic, ETM approval can be up to £1M)
C4	Plan submitted to NHSE/I and ICS with transparent assumptions owned by all budget holders. This will be closely monitored and overseen at meetings detailed in C1.
C5	Monitoring of individual budgetary control positions against budget holder accountabilities
C6	Maximisation of income opportunities with Commissioners where appropriate given current planning guidance
C7	Dedicated finance and PMO support to the Divisions and Corporate Directorates
C8	Monthly Rotherham CCG Contract Performance Meetings (N.B. These meetings were stood down during the pandemic but recommenced from September 2020 and have been held monthly since. The agenda has been changed slightly to focus on waiting list recovery as opposed to the traditional activity / income volume variances).
C9	Overview and scrutiny of Trust's financial performance by the ICS and NHSE/I regional finance team

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	2020/21 External Auditors' ISA 260 issued unqualified opinion, without any adjusted or unadjusted misstatements, on the financial statements			✓	**11-Jun-21**
A2	360 Assurance Payroll internal audit July 2020 gave 'significant assurance' rating (positive) All actions completed as at Q1 2021/22 360 Assurance Integrity of e-rostering (Oct-20) gave a 'limited assurance' rating and made 3 high and 3 medium recommendations (negative) All actions completed as at Q4 2020/21			✓	**Jul-20** **Oct-20**
A3	Q1 favourable to plan at Jun-21 and forecasting for H1 to be favourable to plan.	✓			**Jun-21**
A4	Integrated financial performance report (monthly) (positive / negative)		✓		**Jan-22**
A5	Detailed forecast (quarterly) (positive assurance)		✓		**Dec-21**
A6	Divisional performance management log of issues and actions (monthly) (positive / negative)	✓			**Jun-21**
A7	Monthly financial escalation meetings with NHS E/I regional team stood down from May-21 because Trust's financial performance is to plan and future forecasts have been achieved (positive)			✓	**May-21**
A8	360 Assurance Integrity of the general ledger and financial reporting review April 2021 gave 'significant assurance' rating and made 1 medium and 3 low recommendations (annual, positive) 360 Assurance Procurement review (May 2021) gave 'significant assurance' rating and made 2 medium and 2 low recommendations (ad hoc, positive)			✓	**Apr-21** **May-21**
A9					

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Removal of breach of licence / Five Year Strategy (C&A)	1. Delivery the financial plan for 2020/21 (post audit). Break even position on plan at Q1 and forecast to achieve at month 6 of 21/22 2. Break even position achieved at month 6 (H1), Capital Plan delivered at end of month 6 (H1), Financial Governance Plan implemented 3. Breach of licence removed	Director of Finance	Jun-21 - achieved and Q1 on plan Oct-21 Mar-22
G2	Insufficient workforce to deliver the Operational Plan and therefore being overly reliant on agency **(C)**	See Employer of Choice Mandate detailed at G5 on BAF item B5	Executive Team	**Q4**
G3	360 Assurance Integrity of the general ledger and financial reporting review April 2021 gave 'significant assurance' rating and made 1 medium and 3 low recommendations **(C)**	1.0 (Low) completed 2.0 (Medium) deadline Sep-21 3.0 (Low) deadline Jun-21 - completed 4.0 (Low) deadline Jun-21 - completed	Director of Finance	**Gap closed Q3.**
G4	Unknown financial regime from 1 October 2021 (C&A)	NHS E/I to publish financial regime for Half 2.	NHS E/I	**Gap closed Q3.**
G5	360 Assurance Payroll internal audit July 2020 gave 'significant assurance' rating and made 2 medium and 7 low recommendations **(C)**	Action plan in place. **Q2 Update**: 6 recommendations have been implemented, 3 recommendations outstanding. **Q3 Update:** 2 medium and 5 low recommendations implemented. 2 low recommendations in progress with due dates of 31-Mar-21 and 31-Oct-20 **Q4 Update:** 1 low recommendation outstanding with due date of 31-May-21 **Q1 Update:** All recommendations have now been implemented	Director of Workforce	**Gap closed**
G6	Lack of assurance relating to budget setting and budgetary control processes across the organisation using forecasting methodology and links to recovery plans **(C&A)**	More robust process used for budget development for Half 1 2021/22. Specific budget sign off requests from all Divisions and corporate directorates. Zero based budgets to be developed for 2022/23 budgeting process linked to activity requirements and underpinning capacity. Feb Update: budget setting process has commenced with draft financial plans to be submitted natioanlly by 15 March 2022.	Director of Finance	**Q4**
G7	360 Assurance Procurement review (May 2021) gave 'significant assurance' rating and made 2 medium and 2 low recommendations **(C)**	1 (Low) deadline 31-Jul-21 2.1 and 2.2 (Medium) deadline 31-Jul-21 3 (Low) implemented	Director of Finance	**Gap closed Q3.**
G8				
G9				

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C10	Implementation of Internal Audit, External Audit and Counter Fraud report recommendations
C11	CIP Efficiency Board (monthly) holding Divisions to account for development and delivery the Cost Improvement Plan and subsequent delivery of financial benefit
C12	3 workforce meetings (medical agency, substantive vacancy control and NHS Professionals agency and bank) all chaired by DCEO with Director of Finance and / or Deputy Director of Workforce also attending have oversight of staffing levels within the Trust to control pay cost
C13	Director of Finance now participates in the development and review of the monthly financial results and preparation of forecast outturn to the year end

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A10					
A11	*Internal Audits relating to finance controls in 2020/21: Integrity of general ledger and financial reporting scheduled for Q3 2021/22 Key Financial Systems scheduled for Q3 2021/22 Estates Procurement scheduled for Q2 2021/22*			✓	***Q2 and Q3 2021/22***
A12	*360 Assurance Review of Performance Management scheduled for Q2 2021/22*			✓	***Q2 2021/22***
A13	*Post investment reviews (positive / negative)*		✓		

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G10				
G11				
G12				
G13				

FINANCE: Strong financial foundations

BAF Item B9: The lack of capital investment may affect the delivery of some services *Risk Owner: Director of Finance* *Board Committee: Finance & Performance Committee* *Date the risk last reviewed: 8 February 2022*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Deliver on our financial commitments and ensure removal of breach of licence**	**Link to Operational Risks (scoring 15+):** **6198:** Loss of the MRI service due to age-related failure of the MRI scanner: **Risk Closed**

STRATEGIC OBJECTIVE:
Deliver strong financial foundations through:
- Improving liquidity whilst ensuring appropriate investment in estates and assets
- Managing within the approved budget and reduce the underlying deficit
- Improving financial performance through service transformation and cost improvement.

Source: Five Year Strategy 2017 - 2022

Executive Summary - Quarterly Update:
Q4: It is now considered unlikely that the Trust will experience an event that leads to the death of a patient or staff member due to a lack of capital investment hence proposal to reduce Q4 risk score to 2(L) x 5(C) = 10

Q1 Update: Capital plan has been recently set and includes a £500k contingency as well as the ability to vire expenditure from other schemes that may be seen as lower priority should a major risk arise. Hence proposed Q1 risk score of 2(L) x 4(C) = 8. Following Deep Dive review at Finance & Performance Committee on 28-Jul-21 it was agreed to add reference to the fact that during Q1 the Trust had reacted to a high risk issue and had reallocated the capital plan accordingly which it was envisaged would be formally approved in Q2. D&BHFT have experienced an emergency issue which has resulted in a 12.4m capital requirement in addiiton to their normal capital spend. All partners across the STB ICS will be required to underspend their capital limits to match additional expenditure. TRFT is estimated to be impacted by £1m whcih does not adversely impact on patient care hence maintenance of the risk score. Discussion at November F&P Committee reduce the score to 4. Q3 update: The risk score is below the target score and within the risk appetite and therefore a managed risk. Q4 ongoing managed risk

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
2 x 5 = 10 L (unlikely) x C (catastrophic)	2 x 4 = 8 L (unlikely) x C (major)	1 x 4 =4 L (unlikely) x C (major)	1 x 4 =4 L (unlikely) x C (major)		➔	2 x 4 = 8 L (possible) x C (major)

Risk Appetite:
TRFT has a **LOW** Risk appetite for financial / VFM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements. (6 - 10).

Current Risk Appetite (based on current risk score):
Low (6 - 10)

Target Risk Appetite (based on target risk score):
In line with appetite of **LOW** (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Establishment of appropriate capital plan which is funded either through depreciation, cash balance in organisation or loans / PDC from Department of Health & Social Care
C2	Strategic review of lease options and clarity on treatment as revenue or finance leases that count against capital delegated limits
C3	Capital Monitoring Group in place to monitor capital expenditure and propose either corrective actions or new schemes to spend capital. Fit for purpose membership and delegated powers. Feeds into the hierarchy of Finance & Performance Committee and Board of Directors meetings. This is the key control for IT capital investment with all updates on progress with the capital plan containing these themes: Estates, Digital and Medical Equipment
C4	Standing Financial Instructions which clearly detail the scheme of delegation

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Clarity that Trust has no surplus land, building or assets for disposal and declaration to this effect made to NHS Improvement annually. Link to action detailed in G2. Trust is required to make a surplus land declaration to NHS Surplus Land Collection on a quarterly basis	✓			**Q1 2021/22** **Jul-21 for quarterly declaration**
A2	Capital programme delivered to plan at Q1 (positive)	✓			**Jun-21**
A3	Six facet survey undertaken during Q2 2020/21 by external company (NIFES) which will enable the Trust to articulate an accurate response to annual ERIC to NHS Improvement in 2021/22 and to develop Estates Strategy (positive, ad hoc)			✓	**Sep-20**
A4	Measured term contract independent review undertaken by DKP (negative assurance) See G1 for action plan			✓	**Sep-20**

GAPS IN CONTROL (C) or ASSURANCE (A)
gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Gap in assurance from measured term contract arising from out of scope use. Independent review undertaken by DKP in scoping value for money of MTC **(A)**	Trust has reasserted the maximum single tender order value as £200K in accordance with SFIs. Trust is looking to redefine the measured term contract and retender this via the north of England procurement framework collaborative. **Q4 Update:** Action plan is to redesign the MTC framework and to retender the MTC. Looking to appoint quantity surveyor to help write specification. Expressions of interest to be issued during Q4 2020/21 with a view to MTC tender specification being generated and tendered in Q2 2021/22 via NHS SBS framework. Maximum single tender order values of £200k asserted in Q3. **Q1 Update:** continuing to reassert maximum value of £200K. MTC will be re-tendered in Q3 this year. **Q2 Update:** Will be re-tendered in Q4. **Q3 update:** Paper to Finance and Performance Committee in October 2021 supporting re-procurement with 8 month extension to existing contract.	Chief Operating Officer (Director of Estates & Facilities)	**Retender ~~Q2~~ ~~Q3~~ Q4 21/22**
G2	The Trust does not have a suite of schemes already developed ready to use for short-notice announcements of capital funding **(C)**	**Estates & Facilities:** Work planned to develop such schemes. Would require expenditure in order to appoint a design team to establish preferred options and a defendable cost. Approval for such development costs to be sought for schemes that are highly likely to be progressed. **Q4 Update:** Envisage will have a suite of prospective business cases by ~~Q2~~ Q4 2021/22. **Q2 Update:** these business cases will be informed by the revised Estates Strategy which is under development and is scheduled for completion by end of Nov-21 **Digital:** Creation of well prepared and approved business cases ready to use at short notice. Q3 update the Trust is in a stronger position and has a targeted investment scheme in place. **Q4 ongoing improving position**	Chief Operating Officer (Director of Estates & Facilities) Deputy Chief Executive (Director of Health Informatics)	**~~Q2~~ Q4 2021/22**
G3	The time taken from a successful business case to procurement can result in changes in cost base (A)	If there a significant difference in costs the business case is taken back through the approval process via the Capital Monitoring Group then Finance & Performance Committee and Board of Directors (if required) to seek approval for actual costs. Other mitigations include: - contingency allowances included within business cases - improvement in cost estimates - engagement with Procurement as soon as possible - use of national frameworks where applicable - creation of the highest quality of specification possible to reduce risk of unexpected issues arising when contact awarded to suppliers Action to be taken: look to reduction in friction between approval of business case and procurement. Measure will be the number of times digital business cases have to be taken back to CMG and FPC.	Deputy Chief Executive (Director of Health Informatics)	Q4 2021/22
G4	Inability to implement agreed and approved digital capital work due to reasons outside of control e.g. COVID-19 or operational pressures causing suppliers to not bill the Trust within anticipated timeframes **(C)**	Creation of accruals by Finance team. Monitored through Capital Monitoring Group and Finance & Performance Committee. Work underway to try to achieve zero accruals which will be assessed year end.	Deputy Chief Executive (Director of Health Informatics)	**Q4 2021/22**

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C5	Revised business case process captures all necessary capital projects ensuring proper approvals
C6	The organisation's yearly business planning cycle means that digital developments requiring capital expenditure are forecast and funding is allocated dependent on prioritisation
C7	
C8	
C9	
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A5	Digital Transformation Committee receive digital programme updates which include capital expenditure. The Committee seeks assurance as to whether the digital capital programme is on track and achieving its objectives (positive, monthly)	✓			**Sep-21**
A6	ICS Digital Transformation Strategy 2021-2024 provides a level of assurance that the Trust is spending digital capital on the right things to maximise interoperability and achievement of the paper-free agenda, as well as a stable digital infrastructure (5 yearly, positive)			✓	Endorsed by Board of Directors Sep-21
A7					
A8					
A9					
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G5				
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

PARTNERS: Securing the future together

BAF Item B10: There is a risk that the Trust has insufficient governance in place with partners in the South Yorkshire and Bassetlaw ICS which will impact on the Trust's ability to contribute effectively to the partnerships in place, provider collaboratives, and digital and data to drive systems *Risk Owner: Deputy Chief Executive* *Board Committee: Board of Directors* *Date the risk last reviewed: January 2022*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Publish a new five year strategy and support partners with re-organisation**	**Link to Operational Risks (scoring 15+):** **No risks**

STRATEGIC OBJECTIVE:
PARTNERS: Securing the future together
Which means…
- Work with our partners to provide sustainable health and care services for the population of Rotherham
- Be open to new ideas and innovations and adopt these wherever we can
- Collaborate with partners across South Yorkshire & Bassetlaw on key services to improve service resilience and sustainability

Executive Summary - Quarterly Update:

Q1: Trust has strong representation across the various system-related groups and the position has been maintained during Q1.
January 2022 - the Board agreed for the scoring to remain the same.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
N/A	**2 x 4 = 8 L (unlikely) x C (major)**	**1 x 4 = 8 L (unlikely) x C (major)**	**1 x 4 = 8 L (unlikely) x C (major)**	**1 x 4 = 8 L (unlikely) x C (major)**	N/A	2 x 4 = 8 L (unlikely) x C (major)

Risk Appetite:
TRFT has a **MODERATE** risk appetite for partnerships which may support and benefit the people we serve (12 - 15)

Current Risk Appetite (based on current risk score):
Moderate (12 - 15) / Low (6-10) / Very Low (1-5)

Target Risk Appetite (based on target risk score):
In line with / below appetite of / LOW (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Clear governance structures are in place to support decision making for the ICS (although COVID-19 remains a key focus)
C2	TRFT Committee (in Common) in place
C3	Regular attendance at ICS governance fora e.g. Health Executive Group (HEG)
C4	Change proposals are circulated to all providers prior to adoption
C5	The Trust is taking a lead role in a number of ICS-wide developments (e.g. hosted network)
C6	Collaboration across ICS in relation to response to COVID-19
C7	
C8	
C9	
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Monthly ICS update provided to Board of Directors by Interim Chief Executive as appendix to Chief Executive's report including ICS Health Executive Group and sub-group reporting to Board of Directors (monthly, positive)	✓			**Jun-21**
A2	Updates relating to the ICS is a standing agenda item on the Executive Team Meeting agenda (monthly, positive)	✓			**Jun-21**
A3	Deputy Chief Executive also provides monthly update on ICS to the public Board of Directors meetings (monthly, positive)		✓		**Jun-21**
A4	Trust is part of SYB ICS Acute Federation in which the Interim Chief Executive is heavily involved thereby giving the Trust the opportunity to influence the development of the way forward for the ICS (monthly, positive)		✓		**Jun-21**
A5					
A6	360 Assurance 'System and joint Working' review scheduled fro Q1-Q4 2021/22			✓	Q1 - Q4 2021/22
A7					
A8					
A9					
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Collaborative governance arrangements across SYB ICS still do not have a statutory / regulatory framework in place (and remain subject to legal challenge) and are not legally binding **(C&A)**	NHSE/I published the Integrated Care System (ICS) Design Framework on 16 June 2021 which sets out the operating model for ICS from April 2022 onwards. Once the Health and Care Bill has been enacted, ICS will be placed on a statutory footing. The Design Framework document sets out how ICS should develop and prepare for their new statutory status between June 2021 and March 2022. In SYB the ICS Development Steering Group is focussing on the work of the provider collaboratives and the main transition commitments for 2021.	Interim Chief Executive and Deputy Chief Executive	**Mar-22**
G2				
G3				
G4				
G5				
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

PARTNERS: Securing the future together

BAF Item B11: Joint working with key partners is developing steadily and relationships are in formative periods. Unless these relationships continue to develop there is a risk to continuity and poor service configuration across the Rotherham Place *Risk Owner: Chief Operating Officer* *Board Committee: Board of Directors* *Date the risk last reviewed: January 2022*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Publish a new five year strategy and support partners with re-organisation**	**Link to Operational Risks (scoring 15+):** **6226:** COVID-19 - organisational recovery -Remains scored at 15. **6386:** CAMHs inpatients on Children's Ward and Children's Assessment Unit (CAU) The risk is now closed

STRATEGIC OBJECTIVE
PARTNERS: Securing the future together
Which means…
- Work with our partners to provide sustainable health and care services for the population of Rotherham
- Be open to new ideas and innovations and adopt these wherever we can
- Collaborate with partners across South Yorkshire & Bassetlaw on key services to improve service resilience and sustainability

Executive Summary - Quarterly Update:
Q1: still on track to develop integrated performance plans and services and most of the controls in place have restarted post COVID-19. Q2 score remains the same but likely to decrease in Q3/4 due to increasing partnership working. January 2022 the Board agreed for the score to remain the same.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
N/A	2 x 4 = 8 L (unlikely) x C (major)	1 x 4 = 8 L (unlikely) x C (major)	1 x 4 = 8 L (unlikely) x C (major)	1 x 4 = 8 L (unlikely) x C (major)	N/A	1 x 4 = 8 L (rare) x C (major)

Risk Appetite:
TRFT has a **MODERATE** risk appetite for partnerships which may support and benefit the people we serve (12 - 15)

Current Risk Appetite (based on current risk score):
Moderate (12 - 15)

Target Risk Appetite (based on target risk score):
In line with / below appetite of LOW (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Trust engages at a senior level with Rotherham Place e.g. Deputy Chief Executive sits on Integrated Care and Reablement Project. This enables the sharing of developments and agreeing across the Place how any developments are taken forward.
C2	Clear governance structures are in place to support decision making for the Place
C3	Delivery Oversight Group (DOG) is a new control added in Q1 2020/21. The purpose of the DOG is to ensure that Directors at the Trust and Rotherham CCG agree the initiatives to be focussed upon by each organisation and to avoid project workstreams being initiated without the relevant Director input / support and governance being in place. The Deputy Chief Executive, Chief Operating Officer and Interim Director of Finance represent the Trust at the DOG.
C4	Operational Partnership Board (weekly) chaired by TRFT's Deputy COO and Deputy Director of Commissioning from RMBC and CCG. This Board operationally manages issues of concern e.g. operationally writes the winter plan for the Rotherham Place. Also feeds into A&E Delivery Board.
C5	Rotherham Place COVID-19 Bronze response meeting led by Rotherham CCG to align and prioritise actions (met weekly for most of Q1 then twice weekly at end of Q1)
C6	Restarted monthly Contract Monitoring Group with Rotherham CCG in Dec-20 reviewing performance against the whole contract
C7	A&E Oversight Board chaired by Interim Chief Executive. This is the oversight board for whole of SY&B ICS and ensures that Place discussions and debate are aligned to S&YB ICS.
C8	
C9	
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Rotherham Integrated Health & Social Care Plan 2020 to 2022 (positive) Updated fro 2021/22		✓		**Jun-21**
A2	Place Executive Meeting oversees Place performance and is attended by Deputy Chief Executive (weekly, mixed assurance)			✓	**Jun-21**
A3	A&E Delivery Board. Place-led meeting chaired by Rotherham CCG Chief Officer with representation from RMBC, TRFT, GP Federation, Yorkshire Ambulance Service and voluntary groups. Receives reports on performance (monthly, mixed assurance)			✓	**Jul-21**
A4	Deputy Chief Executive also provides monthly update on Place and ICS to the public Board of Directors meetings (monthly, positive)		✓		**Jun-21**
A5	Refreshed Rotherham Integrated Care Partnership Agreement received at Board of Directors in Sep-21		✓		**Sep-21**
A6	Rotherham Integrated Care Development Plan received at Board of Directors in Sep-21		✓		**Sep-21**
A7					
A8					
A9					
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	All activity delivered is appropriately reimbursed **(C)**	Accurately capture all activity undertaken and ensure it feeds into contract discussion **Q2 Update:** COVID -19 fixed national contact for months 1 - 6. Months 7 - 12 guidance now released. **Q3 Update:** now on block national contract therefore progress cannot be made against this gap at present. **Q1 Update**: block contract continuing for H1. Further detail will be available in Q2 relating to H2	Deputy Chief Executive	Q4 2020/21 - paused due to current block contract arrangements **Q2 2021/22**
G2	Trust does not have a substantive Executive Team in place **(C&A)**	Interim Chief Executive, Deputy Chief Executive and Interim Director of Finance. New appointments to Executive Team will require time to embed. **Q3 Update**: substantive Deputy Chief Executive in post and substantive Director of Finance appointed. **Q4 Update**: as for Q3 **Q1 Update:** Substantive Director of Finance in post.	Chairman and Interim Chief Executive	~~**Q2 Q4 2020/21**~~ **Q2 2021/22**
G3	Five Year Strategy (Mandate 6) **(C&A)**	2. Publication of a Trust Strategy following robust engagement.	Director of Strategy, Planning and Performance	**Sep-21**
G4				
G5				
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P56/22(i)
Report	**2021/2022 Accounts: Accounting Policies**
Executive Lead	Steve Hackett - Director of Finance
Link with the BAF	B7 & B8
How does this paper support Trust Values	Effective financial management assists the Trust in achieving all of its values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to brief the Committee on changes required to the Trust's Accounting Policies, which form Note 1 to its accounts, and on changes to the accounting requirements when preparing the 2021/2022 financial year annual accounts. There have been no significant changes to the draft 2021/2022 Accounting Policies compared to the previous year's approved Accounting Policies. The Accounting Policies still need to be updated in respect of the wording around the NHS Pension Scheme (at note 1.6, Expenditure on Employee Benefits) once confirmed with DHSC. References to income received for open spells / partially completed spells of healthcare have been removed to reflect the current financial regime of block contracts. There have been no new standards implemented during 2021/2022. A copy of the draft Accounting Policies for the 2021/2022 annual accounts have been attached at Appendix 1; amendments from the 2020/2021 Accounting Policies have been highlighted through the use of tracked changes.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Accounting Polices for the 2021/2022 financial year have been reviewed against the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) for 2021/2022, which interprets the Financial Reporting Manual (FReM) for the NHS sector. This report was presented at the Trust's Audit Committee for endorsement on 9 February 2022 prior to it being put on the agenda for Board Approval.

	The Director of Finance and Deputy Director of Finance received a copy of the report for review and consideration prior to it being presented to the Audit Committee.
Board powers to make this decision	This report complies with the Trust's Constitution: 40. Accounts 40.1 The Trust must keep proper accounts and proper records in relation to the accounts. 40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to— (a) the methods and principles according to which the accounts must be prepared, (b) the information to be given in the accounts. Accounting standards require the Trust's Board of Directors to review the Accounting Principles which underpin the way in which the Trust's accounts are prepared, as set out in the Accounting Policies.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Once approved, these Accounting Policies will form the basis upon which the accounts are prepared, and will be included within the Trust's annual accounts at note 1. Audit Committee endorsed this report at their meeting on 9 February 2022. Trust Board need to approve the Accounting Policies prior to the end of the financial year in order to ensure the timely preparation of the annual accounts.
Recommendations	It is recommended that: Trust Board approve the changes to the 2020/2021 Accounting policies made in preparing the 2021/2022 Accounting Policies disclosures, having noted the changes in the Annual Report and Accounting guidance and the Accounting Standards this year and the impact of these for the Trust's Annual Report and Accounts. A copy of the draft Accounting Policies, which will form Note 1 to the 2021/2022 annual accounts are included at Appendix 1 to this report. The NHS Pension Scheme mandated wording will need to be updated when received from the DHSC and the final cross references to accounting notes will be re-checked once the accounts are complete. Any changes that are required to the Accounting Policies upon completion of the Trust's annual accounts will be brought to the Board's attention when the annual accounts are presented for approval at it's meeting.
Appendices	1. Note 1 Accounting Policies and Other Information

2020/2021 Accounts: Accounting Policies

1 Introduction

1.1 This report sets out the Accounting Policies which will be adopted in the preparation of the 2021/2022 annual accounts.

2 Background

2.1 The Trust's Accounting Policies, which are contained within Note 1 to the Trust's accounts have been reviewed in line with changes made to the Department of Health and Social Care's (DHSC) Group Accounting Manual (GAM) 2021/2022.

2.2 On the whole there has been very little change to the Group Accounting Manual for 2021/2022 compared to the 2020/2021 financial year. A copy of the proposed Accounting Policies have been included at Appendix 1, with proposed changes shown using tracked changes.

2.3 The main changes includes:

Note 1.15 Provisions, Early Retirement Provisions: the inflation adjusted expected cash flow discount rates have been updated for 2021/2022.

Note 1.3 Critical accounting judgements and key sources of estimation uncertainty: references to income received for open spells / partially completed spells of healthcare have been removed to reflect the current financial regime of block contracts.

2.4 There have been no new standards implemented during the 2021/2022 financial year.

2.5 Whilst this report recommends the approval of the Accounting Policies which are contained within Appendix 1, some changes will be required at the point at which the accounts are prepared, these include (but not may not be restricted to):

- The NHS Pension Scheme mandated wording will need to be updated when received from the Department of Health and Social Care (DHSC).

2.6 Any further changes that are required to the Accounting Policies as part of revisions to the DHSC's GAM and Foundation Trust's Annual Reporting Manual (FT ARM) will be bought to the Audit Committee's attention when the draft report is presented at it's meeting.

Steve Hackett
Director of Finance
February 2022

Appendix 1 Accounting Policies

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Rotherham NHS Foundation Trust ('the Trust') is a public benefit corporation authorised, in England, by Monitor (trading as NHS Improvement) in accordance with the National Health Service Act 2006. The Trust provides healthcare mainly to the region. The address of the Trust is Moorgate Road, Rotherham, S60 2UD.

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation Trust shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

Consequently, the following financial statements have been prepared in accordance with the GAM issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

Note 1.2 Going Concern

The Rotherham NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The Trust is not aware of any material uncertainties in respect of events or conditions that would bring into question the going concern ability of the entity.

Note 1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of The Rotherham NHS Foundation Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.3.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying The Rotherham NHS Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- Management make judgements in determining when substantially all the significant risks and rewards of ownership of financial assets and lease assets are transferred to other entities.

1.3.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Income estimates
In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

Expense accruals
In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

Impairment of property, plant and equipment
The Trust has undertaken an annual impairment exercise of its Property, Plant and Equipment. Following an interim professional valuation carried out at 31 March 2021, the Trust has considered items such as: indices movements; deterioration of assets and its further estates plans to support its impairment assessment. It is the judgement of management following this review that there is not an indication of impairment.

Recoverability of receivables
In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables and made appropriate adjustments to the existing allowance account for expected credit losses.

Provisions
In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

Note 1.4 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within The Rotherham NHS Foundation Trust.

Note 1.5 Income (Revenue from Contracts with Customers)

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- the Trust is not required to disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less
- the Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard where the right to consideration corresponds directly with value of the performance completed to date
- the Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery

of a series of goods or services that are substantially the same and have a similar pattern of transfer.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Note 1.6 Expenditure on Employee Benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.6.2 Retirement Benefit Costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore,

each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control

mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

NEST Pension Scheme

The Trust is a member of the National Employment Savings Trust (NEST) pension scheme which operates as a defined contribution plan. The Trust pays contributions into a fund but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore limited to the amount it agrees to contribute to the fund and effectively place actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

1.8.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and either
- the item has cost of at least £5,000, or collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, for example, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use and where there are no restrictions preventing access to the market at the reporting date, are valued at fair value under IFRS 13.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings - market value for existing use
- Specialised buildings - depreciated replacement cost, modern equivalent asset basis

Where applicable, assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.8.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.8.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position Public Finance Initiative (PFI) contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless there is an expectation that the asset will be acquired at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.8.5 Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

1.8.6 Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.8.7 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met;

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable, that is:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued except where 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.8.8 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8.9 Useful Economic lives of property, plant and equipment

Plant, Property and Equipment	Minimum life (Years)	Maximum life (Years)
Land	-	-
Buildings (excluding dwellings)	3	90
Plant and machinery	5	15
Transport equipment	7	9
Information technology	5	20
Furniture and fittings	10	10

Note 1.9 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.10 Intangible assets

1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are only recognised if, and only if, all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset
- the Trust can measure reliably the expenses attributable to the asset during development

Software
Software which is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.10.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

1.10.3 Subsequent Expenditure

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

1.10.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.10.5 Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

Intangible assets	Minimum life (Years)	Maximum life (Years)
Purchased software	2	20

Note 1.11 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020/21 and 2021/2022, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.14 Financial assets and financial liabilities

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or would be otherwise determined by reference to quoted market prices, where possible, or by valuation techniques where relevant. (See IFRS 9 B5.1.2A.).

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.14.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.14.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

At present the Trust does not hold any financial assets or financial liabilities held for trading.

1.14.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive

income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.14.4 Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

A provision matrix approach is adopted, as one of the recommended methodologies, to calculate lifetime expected credit losses of trade receivables at the reporting date. The Trust does not currently hold any lease receivables or contract assets.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

Additionally, the DHSC provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.14.5 Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished - that is, the obligation has been discharged or cancelled or has expired.

1.14.6 Financial Liabilities at fair value through profit and loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

The Trust has reviewed all its main contracts and concluded that any derivatives the contracts may have are 'closely related' and therefore do not warrant separate disclosure or accounting.

1.14.7 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.15 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is apportioned between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Contingent rents are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Private Finance Initiative (PFI) transactions
PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

1. payment for the fair value of services received - the cost of the services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

2. repayment of the finance lease liability, including finance costs - The Public Finance Initiative (PFI) assets are recognised as Plant, Property and Equipment when they come into use.

A PFI liability equal to the capital value of the contract is recognised at the same time as the PFI assets are recognised. This does not include service elements and interest charges within the PFI contract which are expensed in accordance with IFRIC 12 as adapted and interpreted by the FReM, and as detailed below.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

3. payment for the replacement of components of the asset during the contract 'lifecycle replacement' - Components of the asset replaced by the operator during the contract (lifecycle replacement) are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalise at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the trust to the operator for use in the PFI scheme: Assets contributed for use in the scheme continue to be recognised as items of Plant, Property and Equipment in the Trust's Statement of Financial Position.

Other assets contributed by the trust to the operator: Other assets contributed (e.g. Cash payments, surplus property) by the Trust to the operator before the asset is brought into use, where these are intended to defray the operators capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This applies to early retirements and injury benefits provisions.

Clinical negligence costs

NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in the notes to the Accounts but is not recognised within the Trust’s Accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHSR and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Early Retirement Provisions

Early retirement provisions are discounted using the HM Treasury's pension discount rate of negative 1.30% (negative 0.95% in 2020/2021) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

A nominal short-term rate of 0.47% (negative 0.02% in 2020/2021) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

A nominal medium-term rate of 0.7% (positive 0.18% in 2020/2021) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

A nominal long-term rate of 0.95% (positive 1.99% in 2020/2021) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term date of 0.66% (positive 1.99% in 2020/2021) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in the notes to the Accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the notes, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

Note 1.18 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. It represents the DHSC investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time the Secretary of State can issue new PDC to, and requirement repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
- assets under construction for nationally directed schemes
- any PDC dividend balance receivable or payable
- Approved expenditure on COVID-19 capital assets

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts.

The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. PDC dividend calculation is based upon the Trust's group accounts (that is, including subsidiaries), but excluding consolidated charitable funds.

As part of the reforms to the NHS cash regime effective from 1 April 2020, any interim revenue loans, including specified working capital facilities, and interim capital debt at 31 March 2020 were extinguished during the 2020/2021 financial year. £67.459million of PDC was provided to the Trust to enable the principal repayment of the outstanding balance.

Note 1.19 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax

The Finance Act 2004 amended section 519A of the Income and Corporation Tax Act 1998 to provide power to HM Treasury to make certain non-core activities of NHS Foundation Trusts potentially subject to corporation tax.

However, the Trust has evaluated that it is has no Corporation Tax Liability, as all activities are either ancillary to healthcare or below the de minimis level of profit at which tax becomes payable.

Note 1.21 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However,

they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Transfers of functions to / from other NHS bodies / local government bodies

As public sector bodies are deemed to operate under common control, business reconfigurations with the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place.

For functions that have been transferred to the Trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust

makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/2022.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2021/2022. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/2023, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases: The standard is effective 1st April 2022 as adapted and interpreted by the FReM.

IFRS 17 Insurance Contracts: Application required for accounting periods beginning on or after 1st January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

The Trust has considered the above new standards, interpretation and amendments to published standards that are not yet effective and concluded that, with the exception of IFRS 16 that is dealt with below, they are currently either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

This conforms with the Foundation Trust Annual Reporting Manual (FT ARM) which requires that any amendments to standards are applied in accordance with the applicable timetable, with early adoption not permitted.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting

model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.95% (0.91% in 2020/2021) but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/2023, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P56/22(ii)
Report	**2021/2022 Annual Accounts: Going Concern**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	B7 & B8
How does this paper support Trust Values	Effective financial management assists the Trust in achieving all of its values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	Accounting standards require the Trust's Board of Directors to assess and satisfy itself that it is appropriate to prepare the Trust's financial statements on a Going Concern basis for at least 12 months from the date of the accounts. This purpose of this report is to set out the arguments for supporting the going concern concept for the Trust, mainly being: • The management of the Trust has not, nor does it intend to, apply to the Secretary of State for the dissolution of the Trust. • The Secretary of State has not informed the Trust that it intends to dissolve the Trust. • Management is not aware of any operating or other issues that would prevent the annual accounts for 2021/2022 being prepared on a going concern basis.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was presented at the Trust's Audit Committee for endorsement on 9 February 2022 prior to it being put on the agenda for Board Approval. The report was submitted to the Director of Finance and Deputy Director of Finance for pre-approval prior to being presented to the Audit Committee for review and comment.
Board powers to make this decision	This report complies with the Trust's Constitution: 40. Accounts

	40.1 The Trust must keep proper accounts and proper records in relation to the accounts. 40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to— (a) the methods and principles according to which the accounts must be prepared, (b) the information to be given in the accounts. Accounting standards require the Trust's Board of Directors to assess and satisfy itself that it is appropriate to prepare the Trust's financial statements on a going concern basis for at least 12 months from the date of the accounts.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Audit Committee endorsed this report at their meeting on 9 February 2022. This report needs to be ratified by Trust Board prior to the end of the financial year to enable the timely preparation of the Trust's annual accounts.
Recommendations	It is recommended that: Trust Board approve that the going concern concept is applied to The Rotherham Foundation Trust before the end of the financial year to ensure the timely preparation of the annual accounts.
Appendices	Appendix 1 – Going Concern in the Public Sector / NHS Context

2021/2022 Annual Accounts: Going Concern

1 Introduction

1.1 The accounting concept of Going Concern is fundamental to the way in which the assets and liabilities of an organisation are recorded within its accounts. Under this concept an entity is usually expected to continue to operate for the foreseeable future with the assets and liabilities being valued on this basis.

1.2 If the entity is not expected to continue to operate the assets and liabilities would be recorded in the accounts on the basis of their value on the winding up of the entity. As a result, the assets would be recorded at a lower break-up value and medium/long-term liabilities would become short term. It is important to note that the Going Concern consideration applies to The Rotherham NHS Foundation Trust as an entity and not to the hospitals or services which it runs.

1.3 NHS Foundation Trusts (FTs) are required to prepare their accounts in accordance with International Financial Reporting Standards (IFRSs) as interpreted by the Department of Health and Social Care's (DHSC) Group Accounting Manual (GAM). The requirement to prepare accounts on a Going Concern basis is set out in International Accounting Standard (IAS) 1: Presentation of Financial Statements, which states:

- When preparing financial statements, management shall make an assessment of an entity's ability to continue as a going concern,
- An entity shall prepare financial statements on a going concern basis unless management intends to liquidate the entity or to cease trading, or has no realistic alternative but to do so,
- In assessing whether the going concern assumption is appropriate, management takes into account all available information about the future, which is at least, but is not limited to, twelve months from the end of the reporting period,
- When management is aware, in making its assessment, of material uncertainties related to events or conditions which may cast significant doubt upon the entity's ability to continue as a going concern, the entity shall disclose those uncertainties

1.4 External Audit will consider what the Trust's Board has done to satisfy itself that the accounts should be prepared on a Going Concern basis. This paper considers the basis on which the 2021/2022 accounts should be prepared and the conclusion reached on the Going Concern issue.

2 Going Concern in the Public Sector / NHS Context

2.1 The concept of Going Concern is set out in both the Group Accounting Manual (GAM) and the Foundation Trust Annual Reporting Manual (FT ARM); the relevant extracts have been included in Appendix 1 which explains how this principle applies to the NHS specifically.

2.2 The main points which need to be considered by the Trust are:

"4.24 Department of Health and Social Care (DHSC) group bodies should therefore prepare their accounts on a going concern basis unless informed by the relevant national body or Department of Health and Social Care (DHSC) sponsor of the intention for dissolution without transfer of services or function to another entity.

4.25 Where a Department of Health and Social Care (DHSC) group body is aware of material uncertainties in respect of events or conditions that may bring into question the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved.

4.27 Should a Department of Health and Social Care (DHSC) group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances) it must raise the issue with its sponsor division or relevant national body as soon as possible."

2.3 The requirement to consider the Trust's Going Concern status has slightly changed from previous years in that making its assessment:

"4.28 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment."

3 Assessment of Going Concern for the Trust's 2021/2022 Annual Accounts

3.1 In making an assessment of the Trust's going concern status, the following points are noted:

- The management of the Trust has not, nor does it intend to, apply to the Secretary of State for the dissolution of the Trust.
- The Secretary of State has not informed the Trust that it intends to dissolve the Trust. It is most unlikely that a Foundation Trust would be disestablished without a major process over some time, particularly given the absolute requirement for the services it provides. None of this would suggest any immediate likelihood of the Trust ceasing to be a going concern.
- Management is not aware of any operating or other issues that would prevent the annual accounts for 2021/2022 being prepared on a going concern basis.

3.2 On the basis of the above considerations, and in line with the Group Accounting Manual (GAM) which states that NHS providers should prepare their accounts on a going concern basis unless told otherwise (see paragraph 3, of section 2.1), it is recommended that the Rotherham Foundation Trust's annual accounts for the 2021/2022 financial year are prepared as such.

Appendix 1

Going Concern in the Public Sector / NHS Context

The following provide extracts from the GAM and FT ARM regarding the Going Concern Principles and how they apply to the NHS.

DHSC Group Accounting Manual (GAM)

It is important to consider the guidance stated in the Group Accounting Manual (GAM), which sets the requirements of IAS 1 in the context of a public sector organisation. The key extracts are as follows:

Going Concern

4.18 The Financial Reporting Manual (FReM) notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.

4.19 For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

4.20 A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.21 Sponsored entities whose statements of financial position show total net liabilities should prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.

4.22 Where an entity ceases to exist, it should consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.23 While an entity will disclose its demise in various areas of its Annual Report and Accounts such as in the Performance Report and cross reference this in its going concern disclosure, this event does not prevent the accounts being prepared on a going concern basis or give rise to a material uncertainty in relation to the going concern of the entity.

4.24 Department of Health and Social Care (DHSC) group bodies should therefore prepare their accounts on a going concern basis unless informed by the relevant national body or Department of Health and Social Care (DHSC) sponsor of the intention for dissolution without transfer of services or function to another entity.

4.25 Where a Department of Health and Social Care (DHSC) group body is aware of material uncertainties in respect of events or conditions that may bring into question the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved.

4.26 As the continued provision of service approach, per paragraph 4.22, applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.

4.27 Should a Department of Health and Social Care (DHSC) group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances) it must raise the issue with its sponsor division or relevant national body as soon as possible. "

4.28 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment.

Foundation Trust Annual Reporting Manual (FT ARM)

The Foundation Trust Annual Reporting Manual (FT ARM) also provides guidance and it states:

Overview: Going Concern

2.13 There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis.

2.14 In making this assessment NHS foundation trusts should also be mindful of the Financial Reporting Manual (FReM), which emphasises that:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

"Where an entity ceases to exist, it should consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements."

2.15 An NHS foundation trust's assessment of whether the going concern basis is appropriate for its accounts should therefore only be based on whether it is anticipated that the services it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise; these should be discussed with NHS England and NHS Improvement. Where the continued provision of services in the public sector is anticipated to apply, there will not be any material uncertainties over going concern requiring disclosure.

2.16 Where an NHS foundation trust has or is expected to demise in its current organisational form but its services (and accompanying assets) are transferring to another NHS body, this would not prevent the going concern basis for accounts being adopted, and would also not be a material uncertainty on going concern. Clearly the changes to organisational form are important to the user of the annual report and accounts; in this scenario the going concern disclosure should cross reference to the relevant disclosures elsewhere in the annual report and accounts.

Steve Hackett
Director of Finance
February 2022

Board of Directors' Meeting
04 March 2022

Agenda item	P56/22(iii)
Report	**2021/2022 Annual Accounts: Operating Segments**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	B7 and B8
How does this paper support Trust Values	Effective financial management assists the Trust in achieving all of its values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	**Purpose of this paper:** The purpose of this paper is to present the Operating Segments disclosure note required under IFRS 8 in the Trust's 2021/2022 Annual Report and Accounts. **Summary of Key Points:** This paper specifically deals with the area of segmental reporting for the Trust under IFRS and requests ratification of assumptions and disclosures required under IFRS 8 - Operating Segments. There have been no changes to assumptions and disclosures required for the 2021/2022 operational year compared to the 2020/2021 financial year: • The Chief Operating Decision Maker remains the Board of Directors. • The Board continues to review the financial position of the Foundation Trust as a whole in their decision making process, rather than reviewing individual components included in the totals; therefore the Board continues to only consider the one segment of healthcare in its decision-making process. • Per the criteria laid out in IFRS 8, all of the operating segments can be aggregated together to form one reporting segment – the provision of healthcare. In conclusion, the Trust has one "reporting" segment for the 2021/2022 financial year as per previous years, namely the provision of healthcare, and the accounts will be prepared on that basis.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was presented at the Trust's Audit Committee for endorsement on 9 February 2022 prior to it being put on the agenda for Board Approval. The Director of Finance received a copy of the report for review and consideration prior to it being presented to the Audit Committee.
Board powers to make this decision	This report complies with the Trust's Constitution: 40. Accounts 40.1 The Trust must keep proper accounts and proper records in relation to the accounts. 40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to— (a) the methods and principles according to which the accounts must be prepared, (b) the information to be given in the accounts. Accounting Standards require the Trust to consider its operating segments, as per IFRS 8 and as interpreted by the Department of Health and Social Care's (DHSC) Group Accounting Manual (GAM).
Who, What and When (what action is required, who is the lead and when should it be completed?)	Audit Committee endorsed this report at their meeting on 9 February 2022. Board need to approve the operating segments prior to the end of the financial year in order to ensure the timely preparation of the annual accounts.
Recommendations	It is recommended that: Trust Board approve the following Note 2 for inclusion within the 2021/2022 annual accounts: "All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the healthcare services provided occur at the one geographical main site. Trust revenue derives within the UK. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate. The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Foundation Trust Board of Directors, which includes senior professional non-executive

directors. The Board of Directors review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Board of Directors contains summary figures for the whole Trust together with directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cash flow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		**Total**	
	2020/21	2019/20	**2020/21**	2019/20
	£000	£000	**£000**	£000
Income	**324,099**	**288,614**	**324,099**	288,614
Retained Earnings / (Accumulated Deficit)	**(1,712)**	**9**	**(1,712)**	9
Segment net assets	**131,549**	**43,654**	**131,549**	43,654

(The figures above are those included within the 2020/2021 accounts, the numbers will be updated on production of the 2021/2022 accounts, with reference to appropriate year's updated at that point.)

Appendices	Not applicable

2021/2022 Annual Accounts: Operating Segments

1.1 Introduction

This paper deals with segmental reporting for the Trust under IFRS and requests ratification of assumptions and disclosures required under IFRS 8 - Operating Segments.

1.2 Background

1.2.1 The objective of IFRS 8 is to require the Trust to disclose information, within a note to the annual accounts, to enable users of these financial statements to evaluate the nature and financial effects of the activities in which it engages and the economic environment in which it operates. This relates to both Statement of Comprehensive Income and the Statement of Financial Position.

1.2.2 An annual review should be made of the core principle above when forming a judgement about how and what information should be disclosed.

1.3 Key Issues Relating to IFRS 8

IFRS 8 places emphasis on reporting disclosures in the annual accounts that reflect the way that senior management runs the Trust. This involves:

1.3.1 **Identifying the Chief Operating Decision Maker (CODM)**
This is the person or persons who receive NHSI financial information analysed by internal segments and uses that information to allocate resources. Following a detailed review undertaken on the introduction of IFRS 2009/2010 and each review since, this was determined to be the Board of Directors. No changes to the organisation have since affected this, and the CODM therefore remains the Trust Board.

1.3.2 **Determining the Internal Operating Segments**
These are the segments reported to the CODM internally and are primarily the Trust's Clinical and Corporate Divisions.

In terms of allocating resources, the Board reviews the financial position of the Foundation Trust as a whole in their decision making process, rather than reviewing individual components included in the totals.

The finance report considered monthly by the Board contains summary figures for the whole Trust, although some subsidiary divisional performance data regarding budgets and cost improvement positions is included.

Importantly, only the trust-wide detailed and itemised Income and Expenditure performance is reported upon. Likewise, only the trust-wide total Statement of Financial Position and Statement of Cash flows are reported. Finally, the trust's Annual Financial Plan is considered on a whole Trust basis.

The Board, therefore, only considers the one segment of healthcare in its decision-making process.

Following reviews in previous years, it has been ratified that the Trust has one "reporting" segment, namely the provision of healthcare. This remains the position for the 2021/2022 year.

1.3.3 **Determining the 'Significant' Operating Segments to be Disclosed (i.e. the Reporting Segments)**

In accordance with IFRS 8, a 'significant segment' is one whose revenue is at least 10% of the entity's overall revenues. However, two or more operating segments may be aggregated if:

(i) The segments have similar economic characteristics
(ii) Aggregation allows the users of the financial statements to evaluate the nature and financial effects of the business activities
(iii) Segments are similar in each of the following respects
   a. The nature of the products and services
   b. Nature of the production processes
   c. The type or class of customer for their products and services
   d. The methods used to distribute their products or provide their services and
   e. If applicable the nature of the regulatory environment

These points are considered in detail on an individual basis:

(i) Economic Characteristics

The funding of the services provided by the Trust, and reported through these operating segments, is provided by Government backed organisations, demonstrating a common funding profile and risk.

The operating segments within the Trust have similar economic characteristics in that the operational goal of the clinical and corporate divisions is to break-even on an annualised basis. The operational aim of all of the divisions is to provide health care, in accordance with the Trust's objectives.

(ii) Evaluation of Organisational Activities

The aggregation of all of the operating segments allows users of the financial statements to evaluate the nature and financial effects of the Trust's activities – being the provision of healthcare. Non aggregation of the Trust's performance would cause confusion to the readers of the annual accounts, rather than provide any clarification of the Trust's internal decision making process.

(iii) Other Characteristics

Characteristic	Similarity
Nature of service provided	The services provided by the Trust are all concerned with the core mission of the Trust – "to improve the health and wellbeing of the population we serve, building a healthier future together".
Nature of production processes	Not applicable for the Trust
Type / class of customer for services	Whilst the funding for the provision of the Trust's services are from different areas (for example, NHS bodies, Local Authorities and other Governmental bodies), fundamentally the 'customers' for all of the Trust's service areas are from those in the population requiring healthcare.
Methods used to provide services	The methods and associated risks of service provision are similar through inpatient provision and community teams.
Nature of regulatory environment	Service areas within the Trust are subject to regulation in the provision of healthcare services by the Care Quality Commission.

In view of the similarities noted above, the Trust therefore considers that the aggregation criteria of IFRS 8 is satisfied and therefore all of the operating segments can be aggregated together to form one reporting segment – the provision of healthcare.

Consequently, one reporting segment will be disclosed in the 2021/2022 annual accounts. This also reflects the fact that the risks and economic characteristics of the operating segments fall within the provision of healthcare and these are not significantly different for each of the segments.

This reporting segment (that is, the provision of healthcare) mirrors the way that the organisation is managed by the Board of Directors as Chief Operating Decision Maker. The operational management of the Trust is concentrated on the provision healthcare. The Board reviews the trust-wide position initially from an Income and Expenditure, Statement of Financial Position and cash flow basis. The review of divisional performance is secondary. It also reflects the core purpose of the Trust - to improve the health and wellbeing of the population we serve, building a healthier future together.

1.3.4 **Determining the Disclosures required for the 'Significant' Operating Segments (that is, Reporting Segment)**

As the Trust has determined that there is only one reporting segment (that is, the provision of healthcare), the following disclosures are required under IFRS 8 for all entities, including those that have a single reportable segment:

(i) Information about services:
- Revenue from external customers for each service provided

(ii) Information about geographical areas:
- Split of revenues from customers by country

(iii) Information about major customers:
- Revenues from transactions with one major customer is in excess of 10% of total revenue

The vast majority of these disclosures are covered by the disclosures already required in the annual accounts for related parties and the analysis of income from activities. The geographical information disclosure will simply state that all revenues are derived within the UK within Note 2 of the accounts.

Steve Hackett
Director of Finance
February 2022

Board of Directors' Meeting
04 March 2022

Agenda item	P57/21
Report	**Register of Seal Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	
How does this paper support Trust Values	This report supports the core value of Ambitious ensuring the Board complies with the requirements it sets out in its Constitution in relation to the signing and sealing of documents with third parties
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The flowing report sets out the detail for which the Trust Seal has been used since the last report in March 2021. The Board is asked to note that the Trust Seal has been used on two occasions as detailed in the table at Appendix 1.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report has not been considered by any other Committee.
Board powers to make this decision	**Standing Orders (Section 10)** **10.3 Register of Sealing** An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least bi-annually. (The report shall contain details of the seal number, the description of the document and date of sealing). The book will be held by the Secretary.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Director of Corporate Affairs will be charged with compliance with the relevant procedures and will be supported by the Head of Governance and Corporate Governance Manager.
Recommendations	It is recommended that the Board receives and notes the content of the report.
Appendices	Appendix 1 - Details of documents sealed on behalf of The Rotherham NHS Foundation Trust

Appendix 1

Details of documents sealed on behalf of The Rotherham NHS Foundation Trust for the period 01 April 2021 to 28 February 2022

Seal number	Description of documents	Date of Seal	Signatories
237	Under lease for part of the Vermuyden Centre, Thorne, Doncaster at a rental value of £68,515.63 between Community Health Partnership and the Trust	07 May 2021	Michael Wright, Deputy Chief Executive and George Briggs, Chief Operating Officer
238	Licence to assign Busy Bees Nurseries Limited to Busy Bees Day Nurseries Limited	11 January 2022	Michael Wright, Deputy Chief Executive and Steven Hackett, Director of Finance

Board of Directors' Meeting
04 March 2022

The Rotherham NHS Foundation Trust

Agenda item	P58/22
Report	**Register of Interest Report: Bi-Annual Review**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	**B7**
How does this paper support Trust Values	Good governance underpins all Trust values and supports delivery of them
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	In accordance with Section 20(1)(d), Schedule 7, National Health Service Act 2006 (as amended), the Trust, as a public benefit corporation is required to maintain a Register of Interests of Directors (including a nil return) that is available to the public. The attached Register of Interests reflects the recent due diligence checks carried out as part of the bi-annual check. New declarations have been made by the Interim Chief Nurse and Director of Strategy, Planning and Performance.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Any breaches relating to Declarations of Interest will be reported to the Audit Committee
Board powers to make this decision	Standing Orders Section 7 – Declarations of Interest
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Register of Interests will be published on the Trust's public facing website and a copy provided to our External Auditors as part of the annual audit requirements.
Recommendations	It is recommended that the Board of Directors note for information the Register of Interest and receive assurance in relation to compliance with Section 20(1)(d), Schedule 7 National Health Service Act 2006 (as amended).
Appendices	1. Register of Interest

The Rotherham NHS Foundation Trust

Register of Interests of the Board of Directors – March 2022

Non-Executive Directors	
Name	**Interests Declared**
Martin Havenhand Chairman	▪ Niece is Associate Operations Director of One Health ▪ Member of Rotherham Together Partnership Board ▪ Chair of Ambition Rotherham Board of Directors ▪ Director of Corporate Trustee
Alphabetical order	
Nicola Bancroft	▪ Business in the Community Member of Finance and Risk Committee ▪ Sister employed by Sheffield Teaching Hospitals NHS Foundation Trust ▪ Director of Corporate Trustee
Joanna Bibby	▪ Director of Health, Health Foundation ▪ Trustee, Centre for Homeless Impact ▪ Director, Business for Health Community Interest Company ▪ Director of Corporate Trustee
Heather Craven	▪ No general interests to declare ▪ Director of Corporate Trustee
Lynn Hagger	▪ Company Secretary, Suburbaret Ltd ▪ Director of Corporate Trustee
Kamran Malik,	▪ No general interests to declare ▪ Director of Corporate Trustee
Dr Rumit Shah	▪ Principal GP in Hatfield, Doncaster ▪ Local Medical Committee Chair, Doncaster ▪ Managing Director Beckingham Medical Services Ltd ▪ Director of Corporate Trustee
Michael John Smith	▪ Non-Executive Director Humber Teaching NHS Foundation Trust ▪ Associate Hospital Manager (under S.23 of Mental Health Act 1983): o Rotherham Doncaster and South Humber NHS Foundation Trust o John Munroe Hospital Group ▪ Owner/Director MJS Business Consultancy Ltd ▪ Trustee, The Rotherham Minster Development Trust ▪ Director/Trustee Magna Science Adventure Centre ▪ Director/Trustee Magna Enterprises Ltd ▪ Director of Corporate Trustee

Executive Directors	
Dr Richard Jenkins, Interim Chief Executive	▪ Chief Executive at Barnsley Hospital NHS Foundation Trust ▪ Director of Corporate Trustee Barnsley Hospital NHS Foundation Trust ▪ Executive Reviewer (Well-led Reviews) for the Care Quality Commission ▪ Fellow of The Royal College of Physicians ▪ Member of the British Humanist Association ▪ Wife employed as a Nurse at York Teaching Hospital NHS Foundation Trust ▪ Director of Corporate Trustee
Alphabetical order	
George Briggs, Chief Operating Officer	▪ Shareholder in Briggs Health Ltd ▪ Director of Corporate Trustee
Helen Dobson, Interim Chief Nurse	▪ Husband is employed at Sheffield Children's NHS Foundation Trust ▪ Director of Corporate Trustee
Dr Callum Gardner, Executive Medical Director	▪ Owner & Director of Innovative Medicine Ltd ▪ Director of Corporate Trustee
Steven Hackett, Director of Finance	▪ No general interests to declare ▪ Director of Corporate Trustee
Steven Ned, Director of Workforce	▪ Director of Steven Ned Ltd ▪ Workforce Director at Barnsley NHS Foundation Trust ▪ Director of Corporate Trustee ▪ Niece is a Nurse at The Rotherham NHS Foundation Trust ▪ Trustee of St. Luke's Hospice, Sheffield
Michael Wright, Deputy Chief Executive	▪ No general interests to declare ▪ Director of Corporate Trustee
Non-voting Members	
Angela Wendzicha, Director of Corporate Affairs	▪ No general interests to declare
Ian Hinitt, Directors of Estates and Facilities	▪ Trustee, Director and immediate past President of The Institute of Healthcare Engineering and Estates Management (IHEEM)
Sally Kilgariff, Director of Operations	▪ Sister is Group Finance Director at Marks and Spencer.
James Rawlinson, Director of Health Informatics	▪ Elected member of a UK-wide Chief Information Officer (CIO) Advisory Panel
Louise Tuckett, Director of Strategy, Planning & Performance	▪ Husband is Director of Strategy and Planning at Sheffield Teaching Hospitals NHS Foundation Trust (effective April 2022).