Board of Directors
Public AGENDA

Date: **Friday 06 May 2022**
Time: **0930hrs – 1200hrs**

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.

Time	Item no.			Page	Required Actions	Lead
		Procedural Items				
0930	*P62/22*	*Chairman's welcome and apologies for absence*	*Verbal*	*-*	*For information*	*Martin Havenhand, Chairman*
	P63/22	*Quoracy Check*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P64/22	*Declaration of conflicts of interest*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P65/22	*Minutes of the previous meeting held on 04 March 2022*	*Enc.*	*4*	*For decision*	*Martin Havenhand, Chairman*
	P66/22	*Matters arising from the previous minutes (not covered elsewhere on the agenda)*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P67/22	*Action Log*	*Enc.*	*19*	*For assurance*	*Martin Havenhand, Chairman*
		Overview and Context				
0940	*P68/22*	***Staff** Story*	*verbal*	*-*	*For information*	*Steve Ned, Director of Workforce*
0950	*P69/22*	*Report from the Chairman*	*Enc.*	*20*	*For information*	*Martin Havenhand, Chairman*
0955	*P70/22*	*Report from the Chief Executive*	*Enc.*	*23*	*For information*	*Dr Richard Jenkins, Interim Chief Executive*
		Culture				
1000	*P71/22*	*Guardian for Safe Working – Annual Report*	*Enc.*	*27*	*For assurance*	*Dr Gerry Lynch, Guardian of Safe Working*
1005	*P72/22*	*Freedom to Speak Up Policy*	*Enc.*	*30*	*For decision*	*Helen Dobson, Chief Nurse*
1010	*P73/22*	*Freedom to Speak Up Annual Report*	*Enc.*	*55*	*For assurance*	*Anthony Bennett, Lead Freedom to Speak Up Guardian*

1015	*P74/22*	*Complaints Annual Report*	*Enc.*	*64*	*For decision*	*Helen Dobson, Chief Nurse*
1020	*P75/22*	*Gender Pay Gap Report*	*Enc.*	*84*	*For information*	*Steve Ned, Director of Workforce*
1025		***Strategy***				
	P76/22	*National, Integrated Care System and Integrated Care Partnership Report*	*Enc.*	*94*	*For assurance*	*Michael Wright, Deputy Chief Executive*
	P77/22	*Operational Objectives 2021/22 Review*	*Enc.*	*97*	*For assurance*	*Michael Wright, Deputy Chief Executive*
	P78/22	*Operational Objectives 2022/23 - Mandates to deliver 5 key priorities*	*Enc.*	*122*	*For decision*	*Dr Richard Jenkins, Chief Executive*
	P79/22	*Target Operating Model South Yorkshire and Bassetlaw – Pathology Partnership Agreement*	*Enc.*	*139*	*For decision*	*Michael Wright, Deputy Chief Executive*
1100		***Break***				
1105		***Assurance***				
	P80/22	*Board Committees Chairs Assurance Logs* *i. Finance and Performance Committee (23.03.22 & 27.04.22)* *ii. Quality Committee (30.03.22 & 27.04.22)* *iii. People Committee (18.3.22 & 22.04.22)* *iv. Audit Committee (29.04.22)*	*Enc.*	*194* *200* *206* *214*	*For assurance*	*Committee Chairs and Lead Executives*
	P81/22	*Care Quality Commission Assurance Report*	*Enc.*	*219*	*For assurance*	*Helen Dobson, Chief Nurse*
	P82/22	*Monthly Integrated Performance Report*	*Enc.*	*230*	*For assurance*	*Michael Wright, Deputy Chief Executive*
	P83/22	*Reset and Recovery Operational Report*	*Enc.*	*249*	*For assurance*	*George Briggs, Chief Operating Officer*
	P84/22	*Finance Report*	*Enc.*	*257*	*For assurance*	*Steven Hackett, Director of Finance*
	P85/22	*Safe Nurse Staffing – six month review March 2022*	*Enc.*	*265*	*For assurance*	*Helen Dobson, Chief Nurse*
	P86/22	*Ockenden Monthly Report*	*Enc.*	*283*	*For assurance*	*Helen Dobson, Chief Nurse*
	P87/22	*Mortality and Learning From Deaths Report*	*Enc.*	*305*	*For decision & assurance*	*Dr Callum Gardner, Executive Medical Director*
	P88/22	*Digital Strategy and Data Quality Report*	*Enc.*	*340*	*For information*	*Michael Wright, Deputy Chief Executive*
1140		***Regulatory Compliance Risk and Assurance***				

	P89/22	*Board Assurance Framework:*	*Enc.*	*357*	*For decision*	*Angela Wendzicha, Director of Corporate Affairs*
1155		***Board Governance***				
	P90/22	*Governance Report*	*Enc.*	*360*	*For information*	*Angela Wendzicha, Director of Corporate Affairs*
1200		***Closing matters***				
	P91/22	*Any other business*	*-*	*-*	*For noting*	*Martin Havenhand, Chairman*
	P92/22	*Date of next meeting: 08 July 2022*	*-*	*-*	*For noting*	*Martin Havenhand, Chairman*
	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 04 MARCH 2022

Present:
Mr M Havenhand, Chairman
Miss N Bancroft, 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
Ms L Hagger, Non-Executive Director
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 A Bennett, Lead Freedom to Speak up Guardian (minute P40/22 only)
Ms M Fletcher, Lead Cancer Macmillan Nurse (minute P35/22 only)
Mr I Hinitt, Director of Estates and Facilities
Mrs S Kilgariff, Director of Operations / Deputy Chief Operating Officer
Dr G Lynch, Guardian of Safe Working (minute P39/22 only)
Miss D Stewart, Corporate Governance Manager (minutes)
Mrs L Tuckett, Director of Strategy Planning and Performance
Ms A Wendzicha, Director of Corporate Affairs

Apologies:
Mr J Rawlinson, Director of Health Informatics
Dr J Bibby, Non-Executive Director

Prior to commencement of the meeting the Board of Directors held a minutes silence to reflect on the position in Ukraine, and those Trust colleagues who continued to provide services to patients whilst facing personal challenges at this time.

PROCEDURAL ITEMS

P29/22 CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE

Mr Havenhand welcomed all present to the meeting with apologies for absence noted.

P30/22 QUORACY CHECK

The meeting was confirmed to be quorate.

P31/22 **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.

P32/22 **MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 07 January 2022 were agreed as a correct record.

P33/22 **MATTERS ARISING FROM THE PREVIOUS MEETING**

There were no matters arising from the previous meetings that were not either covered by the action log or agenda items.

P34/22 **ACTION LOG**

The Board of Directors reviewed the action log and agreed that with the exception of log numbers 41 and 44 (from 2021) all actions would be closed.

OVERVIEW AND CONTEXT

P35/22 **PATIENT STORY**

The Board of Directors welcomed to the meeting Ms Fletcher, Lead Macmillan Cancer Nurse to present the patient story.

In providing background to the patient story, Ms Fletcher explained that it reflected changes to the non-surgical oncology breast provision service. As a consequence of national staff shortages in the oncology speciality and specific challenges at Weston Park who provided the service to Rotherham, from October / November 2021 the service model had been reduced from a five hub, one of which was Rotherham, to a three hub approach.

This had resulted in Rotherham patients having to travel to Weston Park for their appointments; however patients were not supported by the Clinical Nurse Specialist as would have been the norm if the appointment had been in Rotherham.

The patient explained in her own words, as detailed within the meeting papers and read out by Ms Fletcher, her thoughts and experience without the Clinical Nurse Specialist being present for the appointment. The Board noted that similar experiences had been relayed from other patients.

Further changes to the service model had now taken place with a hub being provided from Breathing Space (Rotherham), which provided improved access for the Trust's patients.

In order to ensure patients continued to receive the valued support of the Clinical Nurse Specialist, pop-up sessions were being explored and pilots of virtual consultations. Additionally, the Breast Cancer Now pledge which aimed to remove service variation was being renewed. There was also closer collaboration from across South Yorkshire and Bassetlaw with the Cancer Alliance.

Mrs Kilgariff commented that the feedback from the patient was a powerful message which she would share in the discussions regarding future delivery models.

The Board of Directors thanked Ms Fletcher for her attendance and for sharing the patient story.

P36/22 **REPORT FROM THE CHAIRMAN**

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

P37/22 **REPORT FROM THE INTERIM CHIEF EXECUTIVE**

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

The report provided an update with regards to COVID, the Care Quality Commission, the Integrated Care System (ICS) and NHS England /Improvement (NHSE/I).

Further appended to the report were a number of supporting documents including ICS activities and the review by NHSE/I of the Trust's System Oversight Framework rating. The latter detailed the actions required to support improvement of the rating from the current 3 to 2.

With regards to COVID, Dr Jenkins reported that the number of in-patient cases continued to reduce, averaging 20 per day. As detailed within the report the requirement for vaccination as a condition of deployment legislation had been revoked by the Government; however, the Trust still considered vaccination remained the effective means in protecting staff and patients.

Ms Hagger questioned the Trust's position following the announcement that the NHS should reduce its reliance on gas supplies from Russia as part of the sanction regime. Whilst the Director of Estates and Facilities confirmed that the Trust's contract for gas provision was with EDF, it was unknown if they traded directly with Russia. However, it was inevitable that the already rising wholesale gas prices and now the conflict would lead to increased expenditure by the Trust in terms of its energy requirements.

In terms of the conflict in Ukraine, the Board thanked Dr Jenkins for his communication to all Trust staff earlier in the week and noted that as

necessary personal discussions were being held with colleagues who may be directly affected.

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

CULTURE

P38/22 **RESPONSIBLE OFFICER – QUARTERLY REPORT**

The Board of Directors received the Responsible Officer quarterly report presented by Dr Gardner in his role as Responsible Officer.

The key areas from the report were:

- Appraisals continued to be supportive; however the Trust was not utilising the abridged form.
- All the appraisals for the second quarter had been completed.
- Patient feedback continued to be an issue, resulting in a number of deferrals for recommendation of Revalidation in the third quarter.
- The Appraisal team had received relevant training and were utilising the Allocate eAppraisal platform for all new appraisals.
- 75 doctors were due their appraisal in Quarter 3. Of these 74 had been completed, with the final booked. There were no doctors who are a current cause for concern with non-engagement.

The Board of Directors noted the Responsible Officer quarterly report.

P39/22 **GUARDIAN FOR SAFE WORKING – QUARTERLY REPORT**

The Board of Directors welcomed to the meeting Dr Lynch, Guardian for Safe Working, to present his quarter three report.

Dr Lynch confirmed that the data covered the period up to the beginning of January 2022. This had been a challenging period as demonstrated by the report and would undoubtedly have deteriorated further when the quarter four position was reported due to the Omicron wave of the pandemic.

Both periods had seen staffing pressures due to short term absence and a requirement for Junior Doctors to be relocated across services to fill any rota gaps.

The steps taken to mitigate the position for the junior doctors were detailed within the report and included proactive and frequent meetings such as the Junior Doctors Forum and the fortnightly opportunities to meet with the Executive Medical Director

It was questioned as to whether the five occasions when the junior doctors had reported an immediate risk to safety whether it had also correlated to any harm to patients. Dr Lynch commented that he did not have access to the level of detail to be able to answer; however he would presume that any serious incident investigation would have ascertained any links to staffing.

The Board of Directors noted the report from the Guardian of Safe Working and thanked Dr Lynch for the continued support provided to the Junior Doctors.

P40/22 **FREEDOM TO SPEAK UP GUARDIAN – QUARTERLY REPORT**

The Board of Directors welcomed to the meeting Mr Bennett, Lead Freedom to Speak up Guardian.

The Board of Directors received the quarter three report from the Freedom to Speak up Guardian, which was introduced by Mrs Dobson as lead Executive Director.

Mrs Dobson commented that it was pleasing to report that colleagues continued to engage with the Freedom to Speak up Guardians and the matters raised by the international nurses in quarter two were being resolved, with the nurses feeding back that the position was greatly improved.

Mr Bennett took the opportunity to highlight key matters from his report, including:

- Appointment of Dr Jayne Chidgey-Clark as the new national Guardian.
- Seven concerns having been raised in quarter three, two of which related to patient safety. Areas of concern had been the bed base and Meditec.
- There had been a noticeable increase in staff speaking directly to their line managers in relation to bullying and harassment, which was more appropriate. Matters now raised with the Freedom to Speak up Guardians related to patient safety, which was the reason for the guardian roles having been established.
- The national index, which had been a valuable source of data and had enabled peer comparison, had been removed by the National Guardians Office
- As indicated by Mrs Dobson, there had been positive improvement in terms of the matters raised by the international nurses, with Mr Bennett describing some of the steps taken to date in conjunction with the Head of Equality, Diversity and Inclusion. The position would continue to be monitored.

The Board of Directors noted the Freedom to Speak Up Guardian quarterly report which provided a valuable source of information and enabled triangulation with information from other sources.

P41/22 **POLICY FOR SAFEGUARDING CHILDREN SUPERVISION**

The Board of Directors received the Policy for Safeguarding Children Supervision, which had been considered by the Quality Committee at its January 2022 meeting and who would recommend its approval by the Board.

The Board of Directors approved the policy.

P42/22 **SAFEGUARDING AND VULNERABILITIES TEAM ANNUAL REPORT 2020/2021**

The Board of Directors received the Safeguarding and Vulnerabilities Team Annual Report 2020/21.

Mrs Dobson explained that the annual report had originally been considered at the October 2021 Quality Committee. Having requested areas to be further strengthened, the Annual Report had been reconsidered through the governance committees and finally approved by the Quality Committee at the January 2022 meeting.

The areas which had been strengthened related to learning from incidents, the meeting structure and training and accountability. Although improvements had been made, the Trust was not complacent and there was more to be undertaken.

It was noted that the Annual Report had referenced the challenges in terms of attendance and quoracy of both the strategic and operational safeguarding meetings. Dr Jenkins indicated that when the position had been reviewed it had been noted that the quoracy requirements had been too stringent. This and the reporting arrangements between both Committees formed part of the quality governance improvement plan.

In noting that the Learning Disability Service was involved in reviews of deaths of people with learning disabilities, Dr Gardner confirmed that the Trust had taken the decision to go over and above the mortality review requirements by ensuring that all deaths relating to this client group were reviewed to ensure learning opportunities were taken forward.

Additionally, Mrs Dobson explained that the Trust had a proactive Learning Disability lead nurse, who actively worked to support individual patients and provide training and advice to colleagues.

The Board of Directors noted the Safeguarding and Vulnerabilities Team Annual Report 2020/21.

STRATEGY

P43/22 **NATIONAL, INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP REPORT**

The Board of Directors received the National, Integrated Care System (ICS) and Integrated Care Partnership (Place) Report presented by the Deputy Chief Executive.

Mr Wright, in taking the report as read, highlighted the continued focus by Rotherham Place on addressing health inequalities and attendance by Trust officers to the Health Select Commission. At the latter presentations on maternity services, discharge processes and progress against the winter plan had been shared.

Additionally, appended to the report was the Rotherham Place Reset: Assessment of Priorities position as at October 2021. In noting the quarter two position, it was confirmed that recent changes to Trust officers would be reflected in the quarter three position report.

Mrs Kilgariff confirmed positive progress was being seen across the Place in terms of urgent and community services, as detailed within the report and supporting appendix. Focus was now being given to improvements required to maximise benefits linked to the workforce group.

The Board of Directors noted the report.

P44/22 **OPERATIONAL OBJECTIVES 2021/22 REVIEW**

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

Mr Wright indicated that of the ten programmes, two were rated blue (completed/closed), one was rated green (on plan), six 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). The report further detailed the forecast year end outturn.

It was confirmed that the Board Assurance Committee's had reviewed the position for each programme assigned to them for monitoring. Detail of the outcome of these discussions had been included both within the report and the Chairs assurance logs to be considered later in the meeting.

With regard to the Admission Avoidance programme, and specifically implementation of an appropriate Same Day Emergency Care (SDEC) service, Mrs Craven questioned the approach to be taken to ensure a cross divisional approach when considering and implementing the pathways/ models of care. On this matter, Mrs Kilgariff confirmed that there were a number of discussions ensuing regarding this programme, at service level, Divisional and Place level, with the work streams including required resources and patient pathways.

The programme to identify new practices, and specifically that the positive changes made through COVID 19 would be either maintained, developed or embedded, had been closed with the activities having moved into the 2022/23 planning process. Mrs Tuckett outlined the process to be undertaken to ensure that the lessons learnt were not lost including discussions having been held with the General Managers. Mr Havenhand suggested that the Board should have further oversight of the position.

ACTION - Director of Strategy, Planning and Performance

In development of the 2022/23 Operational Plan and its objectives, those programmes not delivered in 2021/22 would be reviewed to ascertain if they would be included, or taken forward through a different process.

The Board of Directors noted the month ten Operational Objectives 2021/22 Report.

P45/22 **ACUTE CARE TRANSFORMATION**

The Board of Directors received the report presented by the Chief Operating Officer providing an update on the Acute Care Transformation (ACT) Programme.

The programme established in late 2021 aimed to make improvements across the emergency and acute care pathways in the five key areas of:

i. Urgent and Emergency Care Centre (UECC) Workforce
ii. UECC Leadership and Staff Engagement
iii. Acute Pathways
iv. UECC Patient Experience
v. UECC Ways of Working

Miss Bancroft confirmed that the programme had been discussed in detail by the Finance and Performance Committee, with Mr Briggs outlining to the Board the areas he considered may initially see greatest impact or benefit realisation.

Mr Briggs confirmed that discussions relating to patient pathways would be considered across all relevant Divisions, working as one on the solution, rather than in silos.

In terms of any associated business cases to support the programmes of work, Mr Briggs envisaged that the focus would be on reviewing models of care rather than additional investment. However, should there be any further resource requirements, these would be considered as part of the planning process. Mrs Kilgariff confirmed that the General Managers had already been requested to submit indicative costs as part of this process.

The Board of Directors noted the Acute Care Transformation report.

P46/22 **GREEN PLAN**

The Board of Directors received the Trust's Green Plan 2022 – 2025 which would replace the Sustainable Development Management Plan 2017 – 2022.

The Board was informed that the plan would be central in setting out how the Trust would achieve Sir Simon Stevens Net Zero challenge of the NHS reducing the environmental impact arising from its carbon emissions. As detailed within the Green Plan, the Trust's aim would be to achieve 80% net zero by 2032, and be totally emission free by 2040. It was noted that the Trust had access to data against which it could measure delivery.

Mr Hinitt confirmed that grant funding from the Public Sector Decarbonisation Fund had been approved, with £2.8m available to support a number of carbon reduction schemes.

The Green Plan had been approved by the Board at its January 2022 confidential meeting, and submitted to the ICS in order that a system-wide Green Plan could be developed.

The Board of Directors received for information the Green Plan 2022 – 2025.

ASSURANCE

P47/22 BOARD COMMITTEES CHAIRS ASSURANCE LOGS

The Board of Directors received and noted the Chairs logs from the following Board Assurance Committees:

i. Finance and Performance Committee (23 February 2022 meeting)

Miss Bancroft highlighted that the Committee had discussed progress against its 2021/22 operational priorities. As documented within the log, the Committee had not been assured on overall delivery of the operational plan and had sought clarity on the priorities which would be carried forward into 2022/23.

On other matters, the quarterly review of the balance sheet had been undertaken by the Head of Financial Services and Mr Hackett, with no matters identified which required reporting to the Board.

The Committee had received the report detailing the outcome of the review of implementation of the financial governance improvement plan. The Committee had been assured that the required actions had been embedded; however they would seek a further review of the position on a six monthly basis.

In terms of the operational performance section of the log, Mrs Kilgariff wished to clarify that the statement 'Increasing waiting lists continue to be a concern with no elective work carried out during December and January' should read limited elective work had been undertaken rather than no elective work. This was noted by the Board.

ii. Quality Committee (26 January and 23 February 2022 meetings)

Dr Shah highlighted receipt by the Committee of the Children and Adolescent Mental Health Report. This had identified the 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. This matter had previously been discussed by the Board and was being discussed by the ICS Chief Executive's to ensure appropriate services were in place for this client group.

As part of the operational plan and specifically the Learning from Deaths programme, the Committee had noted that the Internal Auditor had commended their review of the Learning from Deaths Audit originally undertaken in 2020/21.

It was noted that a task and finish group had been established to review the management of sepsis, with a report of the outputs from that group to be presented to the April Quality Committee. Dr Gardner acknowledged that there was further work to be undertaken in this area; however, there had been no serious incidents nor any adverse impact to patients specifically relating to any areas of this work.

iii. People Committee (18 February 2022 meeting)

Ms Hagger reported that due to the cancellation of the January 2022 meeting due to the operational pressures there had been two Divisional presentations at the February meeting. The positive outputs from these were detailed in the report.

The Committee had noted that the overall response rate to the Staff Survey had been 59.6% demonstrating continued engagement by staff despite the challenging period for staff when the survey was undertaken.

The Committee had also received and discussed the draft medical consultant job pack.

iv. Audit Committee (9 February 2022 meeting)

Mr Malik confirmed that the Committee were assured of the work being undertaken to strengthen the management and reporting of both operational risks and the Board Assurance Framework.

The Committee in noting the advisory review of legal services (claims and inquest management) undertaken by the Internal Auditor had noted that the common theme emanating from reviews in 2021/22 had been identification of learning, actions taken and dissemination.

The Committee had been informed of the fine imposed against Mazars, the Trust's External Auditor, by the Financial Reporting Council for failure to comply with the regulatory Framework for Auditing in its audit of a local authority in 2019. The Committee had been assured of the steps taken by Mazars to strengthen its systems and processes. The matter had been reported to the Council of Governors at their February 2022 meeting.

P48/22 **CARE QUALITY COMMISSION ASSURANCE REPORT**

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

Mrs Dobson confirmed that the report, which had been considered by a number of Committees in February, including the Quality Committee on 23 February, detailed the position against the action plans resulting from previous inspections by the CQC.

The report further confirmed that the application had been submitted to seek removal of the Section 31 regulatory condition relating to Urgent and Emergency Care (UECC) dating back to 2018.

In terms of the Section 29a warning notice issued in 2021, it was noted that the CQC had undertaken a one day unannounced inspection of the UECC to review progress against the action plan for this service. A number of matters had been identified during the visit, with progress underway for them to be addressed. The CQC had yet to meet with the Divisional leadership team before they would be able to issue any report following the visit.

Dr Jenkins commented that in attending a round table discussion with leaders from the CQC there would be a requirement to consider the proposed new risk based CQC operating framework. **ACTION – Interim Chief Nurse**

The Board of Directors noted the report.

P49/22 **MONTHLY INTEGRATED PERFORMANCE REPORT**

The Board of Directors received and noted the Integrated Performance Report (IPR). The Deputy Chief Executive commented that the report reflected the operational pressures over recent months due to the pandemic and the resulting impact on achievement of targets. Whilst challenging, the Trust had been able to manage the position.

P50/22 **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.

The report provided a detailed update in relation to recovery, referral to treatment, cancer waiting times, diagnostic waiting times, emergency performance and an update on winter. The Trust had, despite the challenges, been able to maintain its relative position as one of the best performing Trusts over the period.

Recovery continued, with the next phase to fully reintroduce the elective surgery programme.

Mr Briggs confirmed that the pressures previously reported in relation to long stay patients was easing, with the Local Authority now in a position to take new clients. This was supporting gradual improvement of patient flow; however, the position remained challenging.

The Board of Directors noted the report, acknowledging its appreciation to Trust staff for their commitment to maintain services to patients as demonstrated within the report.

P51/22 **FINANCE REPORT**

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

It was noted that the financial position had been considered in detail by the Finance and Performance Committee at its meeting held on 23 February 2022.

In summary the key points were:

- 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.
- A forecast out-turn position for the financial year showed an under-spend against plan of £1,683K (£1,684K against the external control total).
- Capital 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.
- A forecast capital out-turn position for the full financial year showed an expectation of delivering total expenditure of £13,668K leading to an under-spend of £1,415K. With an under-spend of circa £1,000K required as the Trust's contribution to the ICS.
- The cost improvement position remained challenging, but continued to reduce month on month.

The Board of Directors noted the month ten finance report and noted the due diligence of the Executive Team and Trust officers in managing the financial position which remained on plan

P52/22 **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 the Trust continued to receive positive feedback in terms of the progress it was making against the requirements. However, increased requests for data and reporting was being seen as demonstrated by the report and appendices.

In updating the information provided to the Board, Mrs Dobson took the opportunity to highlight a number of changes to the Kirkup Report Gap Analysis following external review by the Local Maternity System. These were in relation to recommendation number 24 where both had initially been rated red but were now assessed as the first to remain red with the second rated amber. Additionally, recommendation 29 of the three initially red rated, the first two were now rated amber and the third rated green.

As Maternity Board Safety Champion, Ms Hagger confirmed that she had nothing further to add to the discussion, other than to confirm her satisfaction with the work being undertaken and the plans with regards to maternity services. Dr Gardner further commented that as host for the maternity network he could confirm that Ockenden had been discussed, with Rotherham benchmarking favourably against peer organisations.

The Board of Directors noted the Ockenden Monthly Report and the continued positive progress which was being achieved and plans in place.

P53/22 **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 the Summary Hospital-level Mortality Indicator (SHMI) stood at 110.7 which was within the 'As Expected' band. With the Hospital Standardised Mortality Ratio (HSMR) latest rolling 12 Month value standing at 114.6, which remained in the 'Higher than Expected' band.

In terms of the Mortality Improvement Group, established as a task and finish group, it was reported that the frequency of meetings had now been reduced. Dr Jenkins as Chair of the Group further explained that once a number of criterion had been achieved, its work would be deemed to have been completed. To support the positive progress which was being seen, it was reported that Professor Chris Welch, who had been an external advisory member representing NHSE, had submitted his report and had stepped down from the Group.

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

P54/22 **MEDICAL WORKFORCE QUARTERLY REPORT**

The Board of Directors received the Medical Workforce Report for quarter four presented by the Executive Medical Director.

The report provided an update with regard to job planning and consultant recruitment. It was noted that although the Trust had traditionally found it challenging in completing the job planning process, Rotherham was not unique in the matter, with the position considered by Dr Gardner to be improving.

Additionally, it was reported that Consultant recruitment also continued to improve, with a number of recent appointments detailed within the report. Notably three Consultants appointments had been made to UECC, all of whom were Higher Level trainees on the South Yorkshire rotation. It was pleasing to see that previous trainees were choosing Rotherham.

To support recruitment the Consultant Job Pack was being renewed, with the Trusts reputation being key in promoting the Trust as the employer of choice to potential applicants. However, there remained some specialities where recruitment continued to be challenged.

The Board of Directors noted the report.

REGULATORY COMPLIANCE RISK AND ASSURANCE

P55/22 BOARD ASSURANCE FRAMEWORK QUARTER 4

The Board of Directors received the report detailing the Board Assurance Framework (BAF), following the ongoing discussions held with the Executive Director leads and the Board Assurance Committees.

Monthly reporting, and constructive discussion of both the BAF and risk register continued by all Committees, with discussions commencing to develop the 2022/23 BAF linked to the Five Year Strategy. There would be a further opportunity for the Board to consider the position prior to formalisation at the May 2022 Board of Directors meeting.

The Board of Directors noted the Board Assurance Framework Report.

P56/22 ANNUAL REPORTS AND ACCOUNTS 2021/22

The Board of Directors received and considered the following reports, all relating to the preparation of the 2021/22 financial accounts.

All three matters had been considered by the Audit Committee at their meeting held on 9 February 2022, with the Committee recommending their approval.

i. Accounting Policies

In noting the report, the Board of Directors approved the changes required to the Trust's Accounting Policies, which would form Note 1 to the Accounts, and the additional requirements for 2021/22 in preparing the Annual Accounts.

ii. Going Concern

In noting the report, the Board of Directors agreed that the Trust should have one reporting segment, namely the provision of healthcare, for the purpose of disclosure in the 2021/22 Annual Accounts.

iii. Operating Segments

In noting the report, the Board of Directors agreed that the 2021/22 Annual Accounts should be prepared on a "Going Concern" basis.

BOARD GOVERNANCE

P57/22 REGISTER OF SEALING

The Board of Directors received and noted for information the report detailing the use of the Trust Seal.

P58/22 REGISTER OF INTERESTS

The Board of Directors received and noted for information the review of the Register of Interest.

P59/22 **ESCALATIONS FROM COUNCIL OF GOVERNORS' - 09/02/2022 MEETING**

There were no escalations to the Board following the Council of Governors meeting held on 9 February 2022.

FOR INFORMATION

P60/22 **ANY OTHER BUSINESS**

There were no items of any other business.

P61/22 **DATE OF NEXT MEETING**

The next meeting of the Board of Directors would be held on Friday, 6 May 2022, commencing at 9am.

The meeting was declared closed.

Martin Havenhand
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
		2021						
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	~~01/04/2022~~ 08/07/22	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~~ 06/05/22	Meeting with Executive Team and individual NEDs throughout March in preparation for presentation of new BAF at April 2022 Board. 2022/23 BAF agenda item P89/22	Recommend to close
		2022						
6	04-Mar-22	Operational Objectives	P44/22	Board should have further oversight of the position with regards to the positive changes made through COVID 19 would be either maintained, developed or embedded, .	DoSPP	Jul-22	It is proposed that a paper is brought to the next Public Board Meeting (in July 2022) which outlines these changes so the Board are sighted as appropriate. Internal discussions at a more detailed and operational level will continue in the meantime.	Open
7	04-Mar-22	Care Quality Commission Report	P48/22	Requirement to consider the proposed new CQC operating framework, which would be a risk based approach.	CN	Jul-22	To date we have not received documentation as to what standards are being looked at or where the Trust may feature.	Open
8								
9								

Open
Recommend to close
Complete

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P69/22
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 March 2022 Board meeting: • Strategic Board Meeting 08 April 2022 • Chief Nurse Appointment • NED Appraisals • South Yorkshire and Bassetlaw Acute Federation • Lead Non-Executive Director reports
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 04 March 2022.

2.0 Strategic Board Meeting 08 April 2022

2.1 The Board of Directors addressed two issues, firstly developing the themes for the Operational Plan for 2022/23 and secondly the Board Assurance Framework review to take account of the new 5 Year Strategy.

3.0 Chief Nurse Appointment

3.1 Interviews for the substantive Chief Nurse were held on 24 March 2022.

3.2 The role had been externally advertising, with a recruitment process involving stakeholder groups and a panel interview involving The Chair, Chief Executive, Non-Executive Directors and an external assessor.

3.3 Four candidates were shortlisted and interviewed and I am pleased to report that Mrs Helen Dobson, who had been interim Chief Nurse, has been substantively appointed as our Chief Nurse.

4.0 NED Appraisals

4.1 During April 2022, the annual appraisal of the Non-Executive Directors was undertaken, by myself and Mr Rimmer, Lead Governor.

4.2 My annual appraisal was undertaken by Ms Hagger, Senior Independent Director and the Lead Governor.

4.3 The feedback from these appraisal discussions and objectives for 2022/23 will be discussed by the Governors Nomination Committee.

5.0 South Yorkshire and Bassetlaw Acute Federation

5.1 Legislation is currently going through parliament to establish an Integrated Care Board (ICB) which will be the statutory organisation leading the Integrated Care System. As part of that process a number of provider collaboratives are being established and the acute collaborative for South Yorkshire and Bassetlaw is the Acute Federation which has been operating in shadow form until its April meeting when it met as a full Board.

5.2 The Acute Federation is working with the ICB as an integral part of system working and will be providing collaborative acute services across the system.

5.3 The ICB is scheduled to become a statutory body on the 1 July 2022.

6.0 Lead Non-Executive Director (Lynn Hagger)

6.1 On 9 March 2022 Lynn deputised for the Chair at the South Yorkshire and Bassetlaw ICB and Trust Chairs' monthly meeting. An update on Executive and Non-Executive Director appointments was provided.

6.2 Lynn attended the Ockenden Final Report webinar on 7 April 2022 where senior leaders acknowledged the importance of the Report. It was noted that Boards needed to focus on risk, the breadth/depth of maternity services, listen to clinical leaders and look at their skill set. Although more funding has been provided this is insufficient to address key concerns such as adequate levels of staffing. A working group of the relevant Royal Colleges will be guiding the maternity transformation programme. In the meantime, Boards should ensure their maternity services are well-staffed (with the Continuity of Carer programme paused if necessary), well-trained and learn from incidents, that the Trust listens to families and 'doubles down' on Freedom To Speak Up by, for example, linking up with the maternity services Freedom To Speak Up Guardian.

6.3 On 19 April 2022 Lynn attended the Maternity and Neonate Safety Champions formal meeting. As part of the usual review of key metrics, the bid to pilot an initiative to address safe staffing levels in the Trust while maintaining the Continuity of Carer approach in the community was noted.

Martin Havenhand
Chairman
May 2022

Board of Directors' Meeting
06 May 2022

Agenda item	P70/22
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	N/A

1.0 Covid-19

1.1 **Activity:** The Trust has seen a sustained period of high numbers of positive Covid-19 patients with numbers now at the same level as in mid-winter, peaking over January and again in March to over 100. This is also reflected in the increase of infections in the Community, the number of staff absent from work due to Covid-19 related issues and the rise in the number of infections across the country. In the last few days a reduction in the numbers of Covid-19 positive patients has been seen in TRFT and other local Trusts.

1.2 **Vaccination:** Following national guidance, the Trust is making preparations to deliver vaccinations for both Covid-19 and Flu in the autumn, should it be required to do so. It should be noted that there is likely to be an increased ask on the Trust and Place Partners, which is likely to require more resource but clarity is still required on the detail.

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 has led to another temporary closure of our elective orthopaedic ward, and a significant reduction in the number of beds available for other elective surgical procedures. We have also continued to experience medical workforce shortages in particular areas, particularly in Anaesthetics, which has exacerbated the demand and capacity challenge we are facing. The growth in our overall waiting list has stabilised in recent months, remaining at just over 22,000 patients on the waiting list at the end of March, although this is just over a 30% increase compared to the start of the year. The number of 26+ week waiters have more than doubled since the start of November, from approximately 1,200 patients to over 2,700 patients in the latest weekly data. Within these figures, there are a handful of significant pressure points, with 4 specialties accounting for over half of the long waiters (ENT, OMFS, Trauma & Orthopaedics and Rheumatology). The Trust is working across the system to see how we can resolve these where there are no internal solutions, particularly within Rheumatology. We are also taking opportunities to introduce new ways of working in order to better manage the demand and to maximise our capacity, but it will take significant time to recover these positions. Whilst all Trusts are facing similar elective care challenges, TRFT was in the top fifteen acute or combined Trusts in the country for overall Referral to Treatment (RTT) performance in February (latest national data). The number of year-long waiters has increased to over 85 as of mid-April, up from the low of 34 from four months' previously.

1.4 **Urgent and Emergency Care Activity (UECC):** The Trust has continued to see and treat an increasing number of attendances through our Urgent and Emergency Care Centre (UECC) with some unexpected high attendance days over the last few weeks. Admissions have stabilised with similar numbers for the past few months but Ambulance attendances have remained high across South Yorkshire with Yorkshire Ambulance Service reporting an increase in acuity of patients over previous years.

1.5 The South Yorkshire ICS CEO has requested each Trust to support a regional approach to the management of a sustained increase in attendances to the Emergency Department together with improved ambulance handovers, mental health assessments, patient discharges and access to GP services. Work is currently being undertaken to respond in support of this and within the already established Acute Care Transformation work.

1.6 The high numbers of Covid-19 patients and complex long stay patients within our beds has severely affected our overall bed capacity affecting patient flow and limiting our ability to move patients into specialty beds. This has also reduced our elective capacity and meant elective cancellations have peaked again in March and early April. Initially we had reopened of all of our elective bed capacity unfortunately this was short lived and over

the past month we have at times converted all of our elective capacity to support emergency care, although we have managed to maintain elective diagnostics and day care services.

1.7 The Trust has reviewed its visiting restrictions again and as a result, Covid-19 positive patients and patients on the red Covid-19 wards will now be able to have one named visitor. The visitor must be well and not have any symptoms of Covid-19 and they will be advised that if they choose to visit they do so at their own risk. They will also be required to wear a surgical mask for the duration of the visit and be strongly advised to be fully vaccinated. It has also been stipulated that a visitor must not be present when a Covid-19 positive patient is undergoing an aerosol generating procedure.

2.0 Integrated Care System (ICS) and Rotherham Place Development

2.1 The ICB CEO has introduced an alternate week Senior Leaders Group meeting to replace the previous approach. Work is in progress to complete the appointment of the ICB Board members with three Non-Executive Directors having recently been appointed and a fourth post out to recruitment. There have been a number of ICB development sessions over the last few weeks to consider new structures going forward.

2.2 Interviews for the roles of Place Director across the other South Yorkshire Places are due to take place week coming 25th April 2022; Chris Edwards, Accountable Officer for Rotherham CCG, has already been appointed to the role of Rotherham Place Director. The recruitment to the role of Managing Director for the Acute Federation, has been paused with the intention of advertising again in the next few months.

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.

2.4 There has been lots of discussion with regional teams on the planning process for 2022/23. All Trusts in the region have been asked to review plans, compare approaches and identify opportunities for efficiencies in the year ahead. The submission date for the final plan is 28th April 2022 and further detail is available in the Board report from the Director of Finance.

3.0 Care Quality Commission Update

3.1 The Trust has now submitted applications for the lifting of the Section 31 notice and the Section 29 (UECC) notice and is currently waiting on confirmation with regard to whether these have been successful or not. Further detail on the work associated with the CQC can be found in the Chief Nurse's report.

4.0 Staffing

4.1 I am delighted to report that, following a successful interview process, our current Interim Chief Nurse, Helen Dobson has been offered and accepted the post of Chief Nurse. This is great news and I am sure you will join me in wishing Helen every success in this important role and her first Executive Director position.

4.2 The Trust will be reinstating charges for staff car parking as from 1st May 2022 following the announcement by the Department of Health and Social Care that the free parking arrangements for NHS staff would come to an end on 31st March 2022. The Trust would also maintain charges for the public to park at the hospital site as well as introduce charges for parking, for both the public and members of staff, at the Rotherham Community Health Centre.

4.3 The National NHS Staff Survey for 2021/22 has now been published and is split into nine themes, based on the seven elements of the People Promise plus staff engagement and morale. Out of a total of 117 questions, 92 were scored positively. Of the 12 acute Trusts in the Yorkshire and Humber region, our aggregate scores against the nine themes were the 4th best and also 2nd best of the four South Yorkshire Acute Trusts. The Trust will now need to use the results to guide further progress over the next 12 months.

4.4 I am very pleased to also report that after a two year absence, the Trust's Proud Awards ceremony will take place on Friday 15 July 2022 at Magna. The closing date for nominations was Friday 22nd April 2022 and preparations are on-going to make the event as special as possible.

4.5 The Trust will also be celebrating the Queens Platinum Jubilee with a garden party celebration due to take place on Monday 6th June 2022, in the well-being garden, from 11:30am to 2:00pm. Further details will be provided to colleagues.

Dr Richard Jenkins
Interim Chief Executive
May 2022

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P71/22
Report	**Guardian of Safe Working Annual Report 2021/22**
Executive Lead	Dr Callum Gardner, Executive Medical Director
Link with the BAF	B1, B2 and 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, an annual 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. In the Division of Medicine, overall hours worked are not unsafe, but an increasing trend is noted. The intensity of working in medicine is consistently high and is sometimes flagged as unsafe by the most junior medical trainees, whose morale is often poor. Understaffing is frequently present on medical wards and rota gaps have caused many problems. The potential risks to doctors and patients of poor staffing ratios is clear. The Medical & Dental Workforce Team make huge efforts on a daily basis to move trainees in Medicine to wards where the need is greatest. This is challenging and very often results in a "least bad case" scenario. Durable solutions for workload and intensity are difficult for the division to find owing to problems recruiting staff, which is not unique to TRFT, and the efforts in place will take time. The Junior Doctor Forum (JDF) functions well for other issues. The overall situation in other specialties does not give grounds for concern.

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 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 for 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 Doctors' Forum, which takes place monthly. JDF attendees include medical staffing, Medical Director, Director of Medical Education and Guardian for Safe Working.
Recommendations	The Board is asked to continue to support efforts to improve working conditions for Junior Doctors by: • supporting recruitment to medical specialties at Trust doctor level; • investing in professions allied to Medicine to share workload and improve safe working; • having a recruitment strategy for Consultants in Medicine to provide leadership and direction in the coming years; and • assisting divisional leaders in Medicine to ensure Consultants in Medicine are appropriately job-planned allowing them to support their trainees on the Wards.
Appendices	N/A

1.0 Exception Report Annual details (as of 8/04/22)

Working hours:

(Sub) Specialty	Exceptions	Daytime Hours	Nightime hours
General Medicine	166	209.5	
Cardiology	38	51.25	
Respiratory	60	79	
Care of the elderly (HCOP)	69	95.75	0.75
Acute Medicine	70	70.5	
Medical Division total	403	506	
Orthopaedics	27	22	
General surgery	86	66.25	8.25
Paediatrics	7	9.75	
ED	1	1.25	
Obstetrics/Gynaecology	12	7.25	
Maxillofacial Surgery	3	8	
Total	539	620.5	9

2.0 Actions to mitigate

Medical & Dental Workforce manage rota gaps (apart from currently Family Health) and source Locums to the best of their ability, moving Trainee Doctors to where the need is greatest on a daily basis, factoring in absences and patient numbers.

A review of trainee staffing across the Medical Division, led by one of the Consultant Physicians, has begun.

The Trust is investing in recruiting Advanced Clinical Practitioners (ACPs) to reduce the workload of trainees, although there is a long lead time before these practitioners will be in post.

Two additional Middle Grade Doctors have been recruited to the Division of Medicine and efforts to recruit Consultants are ongoing, with some key success, particular in stroke, gastroenterology and HCOP.

In response to Covid-19 absences in Medicine, redeployment of Doctors from other specialties has been approved by Health Education England (HEE), Medical & Dental Workforce and the Director of Medical Education, if absolutely necessary to strengthen the medical teams.

Dr Gerry Lynch
Guardian of Safe Working
April 2022

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P72/22
Report	**Review of Freedom to Speak Up Policy**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	B4
How does this paper support Trust Values	The Freedom To Speak Up (FTSU) Policy supports all aspects of the Trusts core values of ambitious, caring and together by helping create a culture where honesty, transparency and accountability are valued
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This FTSU Policy attached outlines the commitment of the Trust to honesty, openness and accountability within the organisation. It has been written with due consideration of the NHS Constitution, the law, the recommendations of the Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Frances, 2013) and the Freedom To Speak Up Review (Frances 2015) to outline clearly the process employees must follow in order to raise genuine concerns.
Due Diligence (include the process the paper has gone through prior to presentation at the meeting)	As part of consultation this policy has received comments from the Joint Partnership Forum, Audit Committee, People Committee and the Executive Team Meeting. The Policy is now being presented to the Board of Directors and Document Ratification Group, prior to publication.
Board powers to make this decision	The Board of Directors have overall responsibility for ratification of this policy.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The policy was previously given an extension in anticipation of the new national template being available in 2021-2022. Due to the delay in publication of this template it was deemed prudent to review it in its current guise. The FTSU Lead will review the policy in full once the new template is available.
Recommendations	It is recommended that the policy is submitted for approval, it should be noted that it is anticipated that the National Guardians Office will issue a new national policy template during 2022-2023 and as such this policy will require a further comprehensive review.
Appendices	i. Freedom to Speak Up Policy

Ref No: 194

FREEDOM TO SPEAK UP: RAISING CONCERNS (WHISTLE BLOWING) POLICY

SECTION 1
PROCEDURAL INFORMATION

Version:	3
Ratified by:	Trust Document Ratification Group
Date ratified:	
Name of originator/author:	Lead Freedom to Speak Up Guardian
Name of responsible committee/individual:	Board of Directors
Date issued:	
Review date:	31 January 2022 (2nd DRG Approved Extension)
Target audience:	All Trust Employees

Document History Summary

Version	Date	Author	Status	Comment
1a	13 June 2014	Jennifer Smith	Draft	Review by People Committee. Whistleblowing Policy is superseded by this document.
1b	July 2014	Jennifer Smith		Review by Joint Policy Group
1c	October 2014	Jennifer Thornley	Draft	Final Review. Amendments incorporated following feedback from Chief Executive, HRD & DRG.
1d	November 2014	Lynne Waters	Final	Final amendments following TRFT Board feedback
1	November 2014	Lynne Waters	Final	Ratified by TRFT Board
2a	June 2015	Jennifer Thornley	Amended	Updated to reflect minor changes in legislation and implementation of Speak up Guardians
2	July 2015	Jennifer Thornley	Final	Ratified by Trust Document Ratification Group
3a	October 2017	Sarah Cooper	Draft	Updated & Reviewed
3	March 2018	Sarah Cooper	Final	Ratified by Trust Document Ratification Group
3	June 2021	Sarah Cooper	Final	Review date extension to Sep 21 approved by DRG
3	July 2021	Sarah Cooper	Final	Minor amendment

Section 1 Contents

Section 1 Appendices

Section 2 Contents

Section 2 Appendices

1. INTRODUCTION

The Rotherham NHS Foundation Trust (TRFT) referred to in the policy as the Trust is wholly committed to honesty, openness and accountability. We support and endorse the findings and recommendations of the independent Freedom to Speak Up Review 2015 (Francis, 2015).

Having an open reporting culture is key to the delivery of safe and compassionate care. For it to be effective, the raising of concerns (often referred to as "whistleblowing") should be embraced as a normal part of employment practice, where employees feel confident and safe to speak up without fear of any repercussion or reprisal.

Speaking up about any concern is really important. In fact, it is vital as it can save lives, jobs, money and the reputation of professionals and organisations. It is a valuable early alert system, which when communicated and dealt with properly, contributes towards quality care and compassion along with colleague and patient well-being.

The Trust will not tolerate an organisational culture where poor patient care is accepted and ignored.

This policy supports the principles of the Public Interest Disclosure Act 1998 that no employee will be victimised for raising genuine concerns internally.

This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS.

It is crucial that all Trust employees understand the principles of raising concerns. Research has shown that a large number of employees will raise a concern at least twice internally before raising the concern externally.

2. PURPOSE AND SCOPE

2.1 Purpose

This policy outlines the commitment of the Trust to honesty, openness and accountability within the organisation. It has been written with due consideration of the NHS Constitution, the law, the recommendations of the Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Frances, 2013) and The Freedom to speak up review (Frances 2015) to outline clearly the process employees must follow in order to raise genuine concerns.

The Trust recognises that it is sometimes not easy for employees to raise concerns and has established an appropriate and safe framework for employees to understand when and how to raise concerns.

The Trust aims to provide a working environment where employees feel empowered, confident and safe to raise issues internally.

Any action taken as a result of an employee raising a concern will be treated in the strictest of confidence accepting that dealing with concerns may require some information being used.

Any concern will be investigated swiftly and effectively to minimise any risk to patients or employees.

It is the responsibility of every employee to raise concerns when there is a possibility of risk to patients or employees. We encourage employees to raise concerns first via their line manager or supervisor. If it cannot be resolved at this level or if employees do not feel able to raise with their line manager or supervisor, ethe Freedom to Speak Up process should be accessed.

2.2 Scope

This policy applies to all Trust employees and is also inclusive of contractors', bank/agency workers, volunteers, students and governors. Any employees working at The Trust from another organisation should adopt the principles of this policy if raising a concern in relation to The Trust.

3 ROLES & RESPONSIBILITIES

Board of Directors	The Board of Directors have overall responsibility for ratification of this policy
Chief Executive	Executive Lead and accountable to the Board of Directors for ensuring compliance with this policy across the Trust.
The Senior Independent Director	The **Senior Independent Non-Executive Director**, will have oversight of the Policy. They will provide assurance regarding arrangements through the annual report to the Trust Board. The designated Non-Executive will also be available as an independent route to review cases where concerns have been raised with a line manager or Trust Freedom to Speak up Guardian or Freedom To Speak Up Lead and appropriate action has not been taken.
Director of Workforce	Has responsibility for ensuring that this policy is applied fairly, consistently and in a non-discriminatory manner
People Committee	Receives assurance regarding compliance with the policy and receives regular reports from the FTSUG regarding concerns raised and monitoring performance against KPI's
Managers	Managers are responsible for ensuring this policy is applied fairly, consistently and in a non-discriminatory manner and that all employees are aware of this policy. Managers will refer new

	employees to this document as part of their local induction, and encourage them to familiarise themselves with its contents.
Freedom To Speak Up Guardian Lead	The Freedom to Speak up Guardian Lead (FTSUG Lead) is responsible for raising the profile of the 'speak up' agenda across the organisation. They will support employees to raise concerns ensuring timely investigation of the concerns raised and provide feedback to the individual reporting the concern. They will also seek feedback from employees raising concerns regarding their experience and ensure employees have not suffered detriment as a result of raising their concern. They are also responsible for providing high level reports to the Board regarding the 'speak up' agenda within the Trust.
Freedom to Speak Up Guardians	Are responsible for supporting employees to raise concerns regarding patients' safety and to ensure timely investigation of concerns raised, providing feedback to the individual reporting the concern. They will also support the FTSUG Lead to raise the profile of the speak up agenda across the organisation
Employees	Employees are responsible for either raising concerns via their manager or the FTSU guardians in accordance with Trust policies and procedures, and to familiarise themselves with these documents and to undertake training as required
Staff Side/Professional Organisation Representatives	Trade union/professional organisation representatives will: - ensure that they familiarise themselves with this policy and procedure. - advise members in accordance with the policy and procedure**.**

4 PROCEDURAL INSTRUCTIONS

Full details regarding the process for raising a concern can be found in Appendix 1 - Example process for raising and escalating a concern

4.1 What concerns can be raised?

Employees can raise a concern about risk, malpractice or wrongdoing they think is harming the service the Trust delivers. Some examples of this might include (but are by no means restricted to):

- Unsafe patient care
- Unsafe working conditions
- Inadequate induction or training for employees
- Lack of, or poor, response to a reported patient safety incident

- Suspicions of fraud (which must be reported to the Trusts counter-fraud Specialist 01709 428701 or Amanda.smith61@nhs.net

- A bullying culture (across a team or organisation rather than individual instances of bullying).

For further examples, please see the Health Education England Video

It is important to remember that healthcare professionals may have a professional duty to report a concern, (**Being Open And Duty Of Candour Policy)**. If in doubt, employees must raise their concerns, they should not wait for proof. The Trust would prefer employees to raise the matter while it is still a concern. It does not matter if employees turn out to be mistaken as long as they are genuinely troubled.

This policy is not for people with concerns about their employment that affect only them – that type of concern is better suited to the Trust's grievance policy.

4.2 Feel safe to raise concerns

If employees raise a genuine concern under this policy, they will not be at risk of losing their job or suffering any form of reprisal as a result. The harassment or victimisation of anyone raising a concern will not be tolerated. Nor will any attempt to bully employees into not raising any such concern be tolerated. Any such behaviour is a breach of the Trust's values as an organisation and, if upheld following investigation, could result in disciplinary action as per the Trusts Disciplinary Policy.

In the event an employee feels that they are being subjected to detriment, having raised a concern that would be considered within this policy, they are encouraged to speak to their line manager, the FTSUG or union representative in order for appropriate action to be taken

Provided employees are acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns.

Anyone found to have raised a concern maliciously would be subject to disciplinary action.

4.3 Confidentiality

The Trust encourages employees to raise concerns openly; it is however appreciated that individuals may want to raise their concern confidentially. This means that whilst the individual is willing for their identity to be known to the person they report their

concern to, they do not want anyone else to know their identity. In such instances the individuals will be kept confidential. There are some occasions whereby it would be preferable to identify where the concern has originated, for example if the evidence provided is to be used in a formal hearing, on rare occasions disclosure is required by law for example, police investigation. In any instance where information provided in the context of this policy is to be used within a formal process, leading to an inability to maintain an individual's confidentiality this will be explained to the individual raising the concern prior to this occurring.

A concern can be raised anonymously; although this may make it more difficult for a thorough investigation or to provide feedback on the outcome.

4.4 Who can raise concerns?

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

4.5 Who should employees raise their concerns with?

In many circumstances the easiest way to get a concern resolved is for it to be raised either formally or informally with the employee's line manager or any manager, lead clinician or tutor that they feel comfortable to talk to.

Where a colleague does not think it is appropriate to do this, or if they feel having raised the concern with their line manager or other person the issue remains unresolved, they can use any of the options set out below.

If your concern is in relation to fraud, bribery or corruption you need to report this in line with the Trust's Counter Fraud, Bribery and Corruption Policy.

- The Trust's Freedom to Speak Up Guardian at either rgh-tr.freedomtospeakupguardians@nhs.net or 01709 42(7009) – this is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to employees at any stage of raising a concern, with access to anyone in the organisation, including the Chief Executive, or if necessary, outside the organisation.

- The Trust's Patient Safety Team: 01709 42(7362).

If employees still remain concerned after this, they can contact:

- The Executive Director with responsibility for whistleblowing, the Chief Executive Officer 01709 424001

- The Senior Independent Director has been delegated responsibilities by the board relating to whistleblowing please see inSite Freedom To Speak Up

All these people have been trained in receiving concerns and will give employees information about where they can go for more support. If for any reason employees do not feel comfortable raising their concern internally, they can raise concerns with external bodies, detailed in 4.13.

4.6 Advice and support

Details on the local support available to employees can be found here Freedom To Speak Up. However, employees can also contact the Whistleblowing Helpline for the NHS and social care, their professional body or trade union representative.

4.7 How should employees raise their concerns?

Employees can raise their concerns with any of the people listed above in person, by phone or in writing (including email FreedomToSpeakUpGuardians Whichever route is chosen, please be ready to explain as fully as possible the information and circumstances that gave rise to the concern.

4.8 What will the Trust do?

The Trust is committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will respond in line with them (see Appendix 2). The Trust is committed to listening to employees, learning lessons and improving patient care. On receipt by the FTSUG, the concern will be recorded and the colleague raising the concern will receive an acknowledgement within two working days. The central record will record the date the concern was received, whether the colleague has requested confidentiality, a summary of the concerns and dates when updates or feedback have been provided to the colleague who raised the concern.

4.9 Investigation

Where a colleague has been unable to resolve the matter quickly (usually within a few days) with their line manager, and where appropriate the Trust will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and will reach a conclusion within a reasonable timescale (which will be notified to the colleague involved). Wherever possible the Trust will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, the Trust will usually undertake a single investigation that looks at the concern and the wider circumstances of the incident. If the issue is considered to be of moderate harm or above this will be referred to the Trusts Serious Incident panel and an investigation will be undertaken in line with the Trust Incident and Serious Incident Management Policy

The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

There will be a right to comment on the final investigation report

The Trust may decide that the concern would be better looked at under another process; for example, the process for dealing with bullying and harassment. If so, this will be discussed with the individual raising the concern and the appropriate policy/process followed.

If your concern highlights any suspicions of fraud, bribery or corruption, a referral will be made to the Trust's Local Counter Fraud Specialist.

Any employment issues (that affect only the individual and not others) identified during the investigation will be considered separately and managed in line with the appropriate policy /procedure.

4.10 Communicating with employees who raise concerns

The Trust will treat employees who raise concerns with respect at all times and will thank them for raising their concerns. The Trust will discuss employees' concerns with them to ensure the exact concern is understood. Employees will be told how long the investigation is expected to take and will keep the individual up to date with its progress. Wherever possible, the Trust will share the full investigation report with the individual who raised the concern (while respecting the confidentiality of others).

4.11 How will we learn from concerns raised?

The focus of the investigation will be on improving the service provided for patients. Where it identifies improvements that can be made, the Trust will track them to ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate. Action plans will be monitored and closed by the relevant committee.

4.12 Board oversight

The Board will be given anonymised high level information about all concerns raised by employees through this policy and what is being done to address any problems. Similar high level information will be included in our annual report. The Board supports employees raising concerns and wants them to feel free to speak up.

4.13 Raising a concern with an outside body

Through this Policy the Trust will respond to concerns via a thorough and transparent process. The provisions of this Policy will allow any concerns felt by employees to be adequately addressed; however, in exceptional circumstances, if an individual has exhausted the internal procedure and is dissatisfied with the response they may wish to go to an external organisation.

External organisations which individuals may wish to contact in regard to raising a concern are detailed below:

NHSEi for concerns about:

- How NHS trusts and Foundation Trusts are being run
- Other providers with an NHS provider license
- NHS procurement, choice and competition
- The national tariff
- Primary medical services (general practice)
- Primary dental services
- Primary ophthalmic services
- Local pharmaceutical services
-

Care Quality Commission for quality and safety concerns

Health Education England for education and training in the NHS

NHS Protect for concerns about fraud bribery and corruption

NHS & Social Care Whistleblowing Helpline
The Whistleblowing Helpline is a free-phone service for employees, and organisations working within the NHS and social care sector.

Telephone: 08000 724 725 | Web: Speak Up.direct

4.14 Making a 'protected disclosure'

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of 'prescribed persons', similar to the list of outside bodies in section 4.13, to whom employees can make a protected disclosure to. To help employees consider whether they might meet these criteria, independent advice may be sought from the whistleblowing helpline for the NHS and social care, Protect-advice.org.ukor a legal representative.

4.15 National Freedom to Speak Up Guardians Office

The role of National Guardian was established following the Francis Freedom to Speak Up Review in 2015, which looked into how NHS workers should be better supported to raise concerns.

The National Guardian is independent and responsible for leading a change in the culture in NHS trusts, so that speaking up becomes business as usual.

The National Guardian's role includes providing guidance and training to Freedom to Speak Up Guardians appointed to each NHS trust. In addition, the National Guardian is responsible for reviewing the handling of concerns raised in Trusts

where there is evidence that this did not meet with good practice. This process is known as the 'case review process'.

4.16 National Guardians Office Case Review Process

The purpose of a case review is to identify any areas where the handling of NHS employees' concerns does not meet the standards of accepted good practice in supporting speaking up in NHS trusts. The emphasis of a case review will be on learning, not blaming.

Where a review finds that good practice was not followed the National Guardian will make recommendations about how this can be improved.

Case reviews will also identify where NHS Trusts have demonstrated good practice in supporting their employees to raise concerns, to help develop a positive culture of speaking up.

Where the National Guardian makes recommendations to support speaking up they will ask the Trust in question to provide an action plan for their implementation. The National Guardian will then monitor how the action plan is put into effect. This will include liaising with the local Freedom to Speak Guardian, as well as Trust staff to verify the plan has been implemented.

For more information please see: **Case Review Referral Guidance**

4.17 Making a referral to the National Guardian

The National Guardian will consider referrals from a variety of persons and bodies, including those currently working for the NHS, former employees who worked in the NHS up to two years prior to the referral and bodies responsible for regulating the work of trusts. This includes bank, agency and locum staff, as well as students.

The National Guardian can also exercise discretion to accept a referral from any other source they deem appropriate.

4.18 Types of cases that cannot be reviewed by the National Guardians Office

The National Guardian will only consider reviewing those cases where it practicable to do so. Cases which may not be practicable to review could include those where it is difficult to obtain evidence about the original concern due to the length of time which has elapsed since it took place.

The National Guardian is not able to investigate the merits of the original concern to determine whether there was evidence to support that concern or not. Such an investigation is the responsibility of other bodies, including the relevant NHS trust.

The National Guardian cannot review cases that are the subject of a criminal investigation or an investigation by NHS Protect.

4.19 Case Referral Process to the National Guardian

Case review referrals can be sent to the National Guardian's Office by email to: casereviews@nationalguardianoffice.org.uk

When referring by email we recommend that you use the downloadable referral form available on their webpages. Using this form will assist the NGO in promptly processing the referral:

http://www.cqc.org.uk/content/national-guardians-office

If referrers have any questions or difficulties making a referral contact on:
0300 067 9000

All referrals are treated in the strictest confidence. The National Guardian's Office will only share information it receives in exceptional circumstances, where it is necessary to protect the welfare of individuals, for example where the information relates to a child or adult safeguarding matter.

4.20 Complaints regarding Trust FTSU Guardians

The National Guardian's Office (NGO) will deal with issues raised about Freedom to Speak Up Guardians (FTSUGs). It includes details of the process that will be used and the principles that will be upheld (appendix 3).

If concerns were to be raised regarding the capability or conduct of a FTSUG, the FTSUG may be asked to step down from their role as FTSUG temporarily whilst any necessary HR process is completed.

4.21 Re-Building Relationships and Teams

After a concern has been raised, it may be appropriate to spend time with all those concerned, to help re-build relationships and teams with support from HR and trade unions if needed.

The emotional impact on all those directly involved cannot be underestimated. Having access to external mediation and early reconciliation can be helpful in managing any breakdown of relationships within teams and in continuing to support individuals who have raised concerns.

On occasion the employment relationship breaks down irretrievably, it is important for managers to explore options for redeployment where the person raising concerns feels unable to return to their post or team. In these situations, advice should always be sought from Human Resources.

Having clear processes in place reduces:

• Sickness absence
• Low morale amongst employees
• Poor relations/performance
• Time consuming formal proceedings such as grievances or tribunals

In cases where a colleague subjects another colleague to any form of victimisation as a result of raising a concern and where the employer cannot evidence that all reasonable measures were put in place to minimise the risk of any such victimisation – then the employer may be held vicariously liable (see definition section 5.1 for explanation of this term).

5 DEFINITIONS AND ABBREVIATIONS

5.1 Definitions

Whistleblowing - Whistleblowing is when a colleague reports suspected "wrongdoing" at work in the public's interest. Officially this is called 'making a disclosure in the public interest'.

To be covered by whistleblowing law when a concern is raised (to be able to claim the protection that accompanies it) a colleague must reasonably believe two things:

They are acting in the public interest (so the concern needs to be more than a personal grievance) and

Their disclosure tends to show past, present or future wrongdoing that falls into one or more of the following categories:

i. Where a criminal offence has been, or is about to be, committed;
ii. A person has failed, is failing or is likely to fail, to comply with a required legal obligation;
iii. A miscarriage of justice has occurred or is likely to occur;
iv. The health and safety of an individual (inclusive of patients, employees and members of the public) has been or is likely to be endangered;
v. The environment has been, or is likely to be, endangered (inclusive of poorly organised systems, inadequate or broken equipment);
vi. Any attempts to deliberately conceal information about any of the above

Duty of Candour (DoC) – introduced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this relates to the statutory Duty of Candour placed on all health service bodies, and, from 1 April 2015, all other care providers registered with the CQC. This duty requires providers to be open and honest with patients, or their representatives, when unintended or unexpected harm has occurred during their treatment.

Detriment – a loss, damage or disadvantage specifically in relation having raised a concern.

Grievance - a complaint relating to an employee's own personal terms and conditions or about a decision affecting an employee at work. There is a separate TRFT grievance policy available.

Protected Disclosure - A qualifying disclosure which is made by a worker and fulfils certain requirements under the Public Interest Disclosure Act 1998 (known as the whistleblowing legislation). Employees who make a protected disclosure are protected against dismissal and victimisation in respect of the disclosure.

Raising a concern – reporting a concern, usually relating to patient safety or the integrity of the system, including concerns about bullying or dysfunctional working relationships.

Vicarious liability- refers to a situation where someone is held responsible for the actions or omissions of another person. In a workplace context, an employer can be **liable** for the acts or omissions of its employees, provided it can be shown that they took place in the course of their employment.

Whistle-blower – a person who raises concerns in the public interest. For the purpose of concerns relating to the NHS, and in particular patient safety concerns, the term 'whistle-blower' is used in this policy to apply to those who speak up when they see something wrong usually relating to patient safety but also to the integrity of the system.

5.2 Abbreviations

CQC	Care Quality Commission
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
NHS	National Health Service
PIDA	Public Interest Disclosure Act 1998
TRFT	The Rotherham NHS Foundation Trust

6 REFERENCES

Freedom to Speak up Report –Francis 2015
Public Interested Disclosure Act (PIDA) 1998
NHSEi

7 ASSOCIATED DOCUMENTATION

Counter Fraud Bribery and Corruption policy
Grievance Procedure
Disciplinary Policy
Being Open and Duty of Candour Policy
Incident and Serious Incident Management Policy

Example process for raising and escalating a concern

Step one
If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your Line Manager, Lead Clinician or tutor (for students).

This may be done verbally or in writing.

Step two

If you feel unable to raise the matter with your Line Manager, Lead Clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak Up Guardian: 01709 42(7009)

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed
- ensure you receive timely support to progress your concern
- escalate to the Board any indications that you are being subjected to detriment for raising your concern
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- ensure you have access to personal support since raising your concern may be stressful.

If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

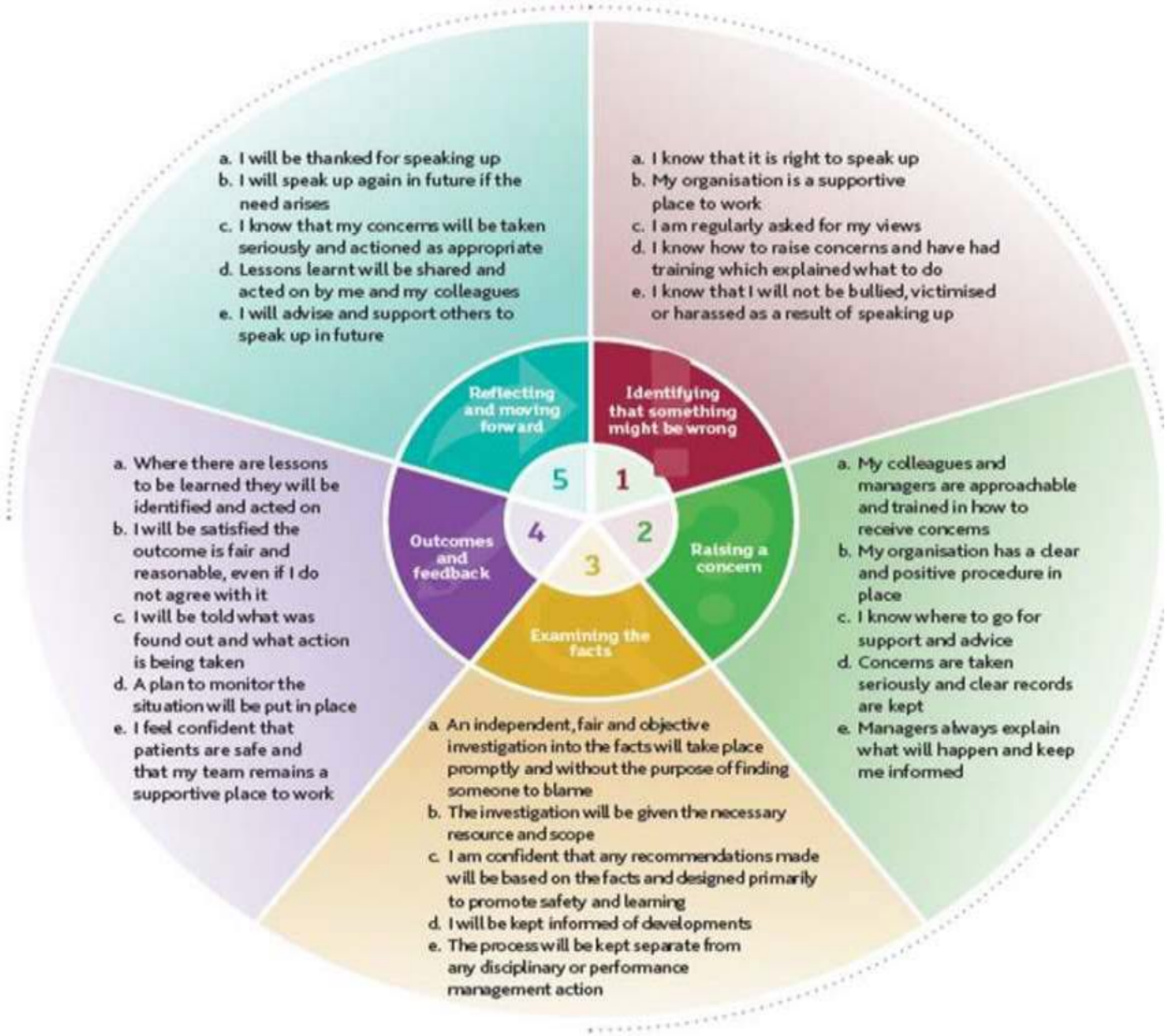
Step three
If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:
The Chief Executive Richard.Jenkins8@nhs.net

Or

Senior Independent Non-Executive Director. Please see details on the FTSU page on the Trust intranet

Step four
You can raise concerns formally with external bodies in section 4.13.

A vision for raising concerns
Source: Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS*



Step 1 -

The NGO will endeavour to seek as much relevant information related to the concern as possible from the person who is speaking up.

The NGO will ascertain whether the person speaking up wishes their identity to remain confidential, and discuss the level of confidentiality that can practically be preserved. It is likely to be easier for a trust to conduct a more thorough investigation into issues that are raised if the person speaking up is willing to have their identity revealed, but confidentiality will be preserved where this is requested, unless this would result in an immediate risk to patient or staff safety, or there would be a legal obligation for the individual's identity to be disclosed.

Matters raised anonymously will proceed directly to Step 2.

Step 2 –

The NGO will raise the issue with the trust Chief Executive. The NGO will provide as much relevant information as possible to enable the trust to respond fully to the issue being raised, whilst preserving the confidentiality of the person speaking up (subject to the constraints set out above). The NGO will ask for assurance that the FTSUG role is being implemented in a way that meets the needs of workers in the organisation and the expectations of the role set out by the NGO. The NGO will also ask the trust to respond to any particular areas of concern that the issue raised highlights. The trust will be given a 2-week timeframe in which to respond.

Where possible, the NGO will notify the FTSUG that an issue has been raised at the same time as the Chief Executive is notified. However, this will not be done if it appears that, by doing so, the confidentiality of someone raising an issue, or any likely investigation or other action that a trust may wish to take, may be compromised.

The person raising the issue will be informed of the action that the NGO takes.

Step 3 –

On receiving a response from the trust the NGO will consider whether further action is needed or not. Details of the response received from the trust and the action (if any) that the NGO proposes will be fed back to the person speaking up. The response received from the trust will be disclosed in its entirety to the person who has spoken up unless, by doing so, confidentiality will be breached or if it appears that any actions that are proposed may be compromised.

If the NGO receives no response from the trust or the response appears in any way inadequate, and the trust cannot provide any other means of assurance that the matter has been dealt with appropriately, the matter will be escalated to NHS Improvement or the CQC as appropriate.

FREEDOM TO SPEAK UP: RAISING CONCERNS (WHISTLEBLOWING) POLICY

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8 CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

People Committee
The Joint Partnership Forum
Executive Trust Management
Board of Directors

9 APPROVAL OF THE DOCUMENT

This document was approved by:
People Committee
Executive Trust Management
Joint Partnership Forum
Document Ratification Group

10 RATIFICATION OF THE DOCUMENT

This document was ratified by the Trust Board of Directors.

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.

Once the document has been ratified the author will make arrangements for the Website Summary Form to be published to the Trust's Internet

12 REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years unless such changes occur as to require an earlier review.

The Freedom to Speak up Guardian lead is responsible for the review of this document.

13 DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
All Employees	DRG Admin Support	As a bulletin via the Communications Team	Within 2 weeks of ratification	Managers to inform employees without readily available e-mail access of the policy
All Employees	DRG Admin Support	Placed on Trust intranet site for employees to access	Within 2 weeks of ratification	
All Employees	Line Managers	Via Team Meetings	As soon as possible following ratification and publication on Trust intranet	

14 IMPLEMENTATION AND TRAINING PLAN

What (specific section of the document)	**How** (e.g. production and completion of documentation)	**Associated action** (e.g. where are forms kept, who restocks them?)	**Lead**	**Timeframe**
All employees to complete HEE freedom to speak up training	Electronically	N/A	Line managers	Within 3 years of commencement or ratification of this policy

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
Number and types of concerns raised and the outcomes of investigations including feedback / complaints of victimisation / confidentiality compliance	Via Agenda on People Committee (PC)	Non-Exec Chair and Exec Lead of PC	Quarterly	Chairman, CEO, Non-Execs and Exec Directors	Non-Exec of PC
Policy effectiveness including a review colleague awareness, trust and confidence in the arrangements	Feedback from employees raising concerns	FTSUG lead	Annually	Director of HR	Director of HR
Record of any identified risks	Audit	FTSUG lead	Annually	Director of HR	Director of HR

15.2 Standards/Key Performance Indicators (KPIs)

The required standard is compliance with the policy with 85% of action plans are closed within the agreed timeframes and learning imbedded within the organisation.

85% of all employees to have completed HEE training implemented over a 3 year phased basis from April 2018

85% of employees and line managers are aware of their responsibilities, feel able to raise a concern and that this would be dealt with appropriately, as identified through the responses to the NHS staff survey and an annual trust wide survey

The Rotherham NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name:	Freedom to speak up: Raising Concerns (Whistleblowing) Policy			Date/Period of Document:	Dec 2017 – Dec 2020
Lead Officer:	Freedom to Speak up Guardian Lead	Directorate:	HR	Reviewing Officers:	Freedom to Speak up Guardian Lead

❑ Function	☑ Policy	❑ Procedure	❑ Strategy	❑ Joint Document, with whom?

Describe the main aim, objectives and intended outcomes of the above: This policy has been developed to provide guidance for employees and contractors on how to raise genuine concerns about conduct, malpractice, that is: crime, failure to comply with any legal duty (e.g. negligence, breach of contract), a miscarriage of justice, danger to health and safety or the environment and the attempt to cover up these issues. Examples may include fraud and corruption, abuse of patients/service users or unsafe practices.

*You must assess **each** of the 7 areas separately and consider how your policy may affect people's human rights.*

1. Assessment of possible adverse impact against any minority group

	How could the policy 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?		X	
2	Gender (Male, Female and Transgender)?		X	
3	Disability (Learning Difficulties/Physical or Sensory Disability)?		X	
4	Race or Ethnicity?		X	
5	Religious, Spiritual Belief?		X	
6	Sexual Orientation?		X	
7	Socio-economic groups?		X	

You need to ask yourself:

- Will the policy create any **problems** or **barriers** to any community of 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	Promote **equal opportunities**	X		
2	Get rid of **discrimination**	X		
3	Get rid of **harassment**	X		
4	Promote **good community relations**		X	
5	Promote **positive attitudes** towards disabled people		X	
6	Encourage **participation** by disabled people		X	
7	Consider **more favourable treatment** of disabled people		X	
8	Promote and protect **human rights**	X		

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	*Please rate, by circling, the level of impact*					Negative
HIGH	MEDIUM	LOW	☑ NIL	LOW	MEDIUM	HIGH

Date assessment completed: 14 Dec 2017	Is a full equality impact assessment required?	❑ Yes (documentation on the intranet)	☑ No

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P73/22
Report	**Freedom To Speak Up (FTSU) Annual Review**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	B1
How does this paper support Trust Values	The FTSU underpins all aspects of the trusts core values of ambitious, caring and together by helping create a culture where honesty, transparency and accountability are valued
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	To provide the Board of Directors with an overview 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 Summary of Key Points: • 45 concerns raised during 2021-22 (up from 34 in 2020- 21) • FTSU interviewed during CQC Inspection • Recommendation to increase hours for FTSU lead • Concerns raised by ophthalmology staff • Henrietta Hughes steps down as of the Head National Guardian Office, New National Guardian appointed Dr Jayne Chidgey-Clark • National Guardians Office (NGO) has published new e-learning packages in 2021/22, awaiting the final senior manager package. • New FTSU self-review published & completed • Lead Guardian working with Head of Equality, Diversity and Inclusion to increase reporting – 'Call it out, Work it out' • Regional NGO meeting now monthly via teams • Mast E-learning now fully rolled out (Trust Compliance of 97.23%). Awaiting agreement on refresher periods • The Second and final NGO Index was published which was based on Data from the 2020 staff survey. The national average was 79.2% The TRFT score was 78.9% satisfaction, which is up 2.8% on the 2019 survey • Reference to FTSU Lead to be included in review of Leavers Policy. • TRFT FTSU Policy reviewed
Due Diligence (include the process the paper has gone through prior to presentation at the meeting)	This report was provided to the Audit Committee on 29 April 2022 prior to submission to the Board of Directors.

Board powers to make this decision	The Trust's Chief Executive will be responsible for ensuring that Freedom to Speak Up concerns are assessed and addressed and all data reported nationally.
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	The Board is asked to note the Freedom to Speak Up Annual Report
Appendices	Freedom to Speak Up Annual Report

1. Introduction

The FTSU Guardians 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.

The Trust introduced FTSU Guardians in 2015 with a FTSUG Lead appointed in October 2016.

The report aims to provide the Board with a high-level overview of the activity undertaken by the FTSUG in 2021/22, highlighting the number of concerns raised.

2. Background

This paper provides a review of FTSU concerns raised within TRFT in 2021/22 and an update following the last report in May 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

Since the last annual board report in May 2021 the FTSUG Lead has remained the responsibility of the Chief Nurse. The FTSUG lead is Tony Bennett who covers the role on a 0.4 WTE. In order to increase access to the FTSU lead a recommendation has been made to increase this to 0.6.

A number of patient safety and bullying & harassment concerns have been raised which have included:

- Staffing levels &
- Cultural issues

The majority of the issues are now closed with satisfactory outcomes for the individual raising the concern.

The FTSUG Lead meets 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 regarding issues and themes.
The Trust has an overall compliance rating of 97.23% 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	98.22%
165 Community Services L3	98.54%
165 Corporate Operations L3	97.48%
165 Corporate Services L3	96.50%
165 Emergency Care L3	96.65%
165 Family Health L3	97.59%
165 Medicine L3	94.20%
165 Surgery L3	97.51%

National guidelines on Freedom to Speak Up training in the health sector in England were published in August 2018. These guidelines are set out in three parts covering three broad groups of workers: *including volunteers, learners, students and those in training regardless of their terms of contract

Section	Workers
Core training	All workers*
	Line and middle managers**
	Senior leaders***
Line and middle management training	Line and middle managers
	Senior leaders
Senior Leader training	Senior leaders

The principles set out in the document include the need for the training to be regular. TRFT has proposed that this will move to every three years, as it is currently a one off session. The NGO has now launched e-learning packages for each of the groups.

The NGO published a national Index based on the responses to questions 17a&b and 18a&b of the 2020 national staff survey. The national average was 79.2% The TRFT score was 78.9% satisfaction, which is up 2.8% on the 2019 survey, locally only 2.7% points divided the Trusts;

Sheffield Teaching Hospitals	79.7%
Barnsley	79.9%
RDASH	81.5%
Doncaster –	78.8

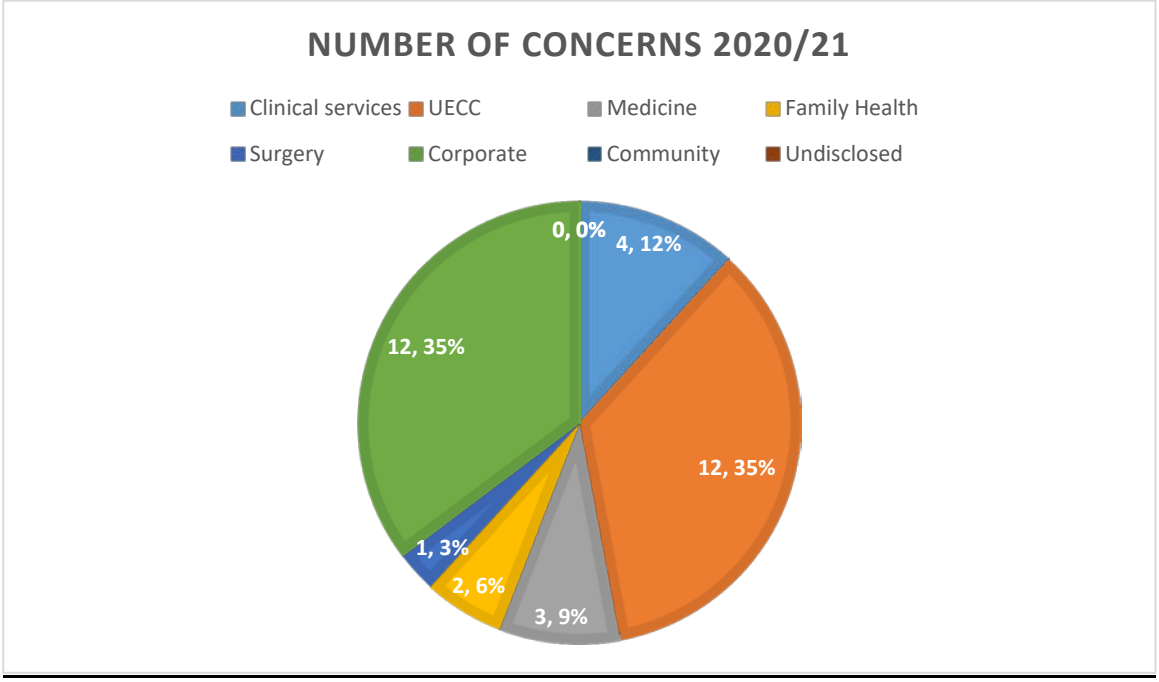
In addition to the Lead Guardian, there are 11 Freedom to Speak Up Ambassadors within the Trust, one of which has also attended the National Guardians training session. In the last twelve months, there has been one change, due to an Ambassador leaving the Trust.

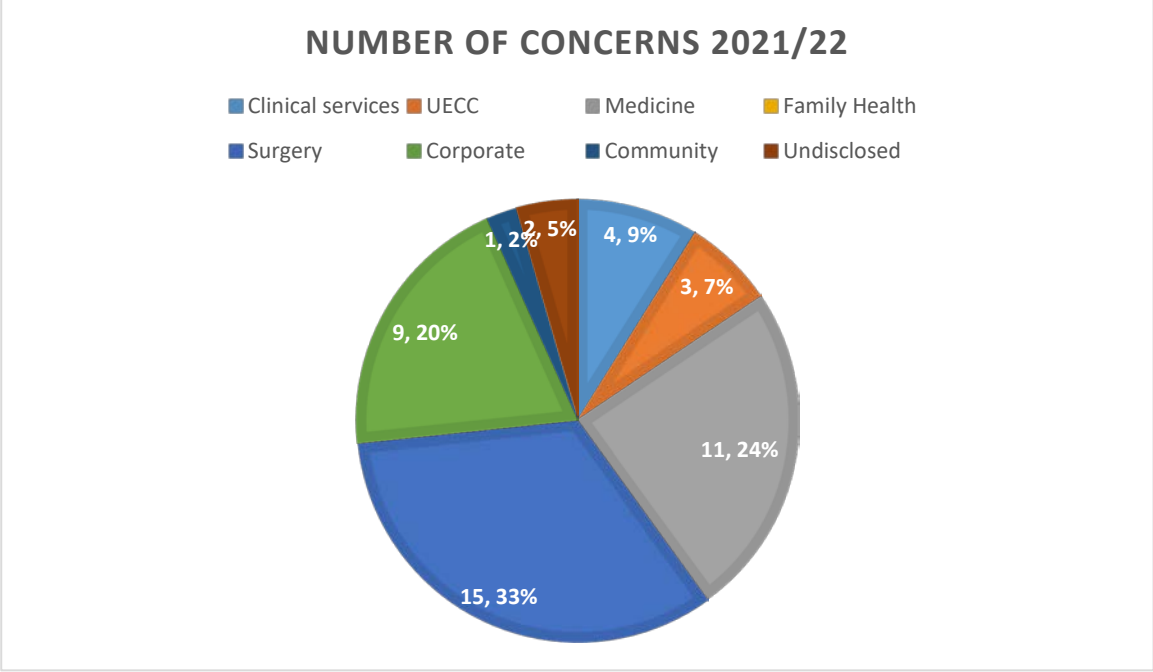
3.1 Summary of FTSU Concerns for TRFT

Table 1: FTSU Concerns 2021/22

Quarter	Number of concerns	Nature of concern	Investigations completed	Detriment
1	11	Patient safety 7 Attitudes and behaviours 1 Bullying & harassment 2 Staffing 1	10	0
2	19	Attitudes and behaviours 13 Policies and procedures 3 Patient safety 3	19	0
3	7	Patient safety 2 Fraud 1 Attitudes and behaviours 3 Policies and procedures 1	6	0
4	8	Patient safety 4 Attitudes and behaviours 3 Staffing 2	5	0
Total	45		40	

Graph 1: FTSU Concerns per Division

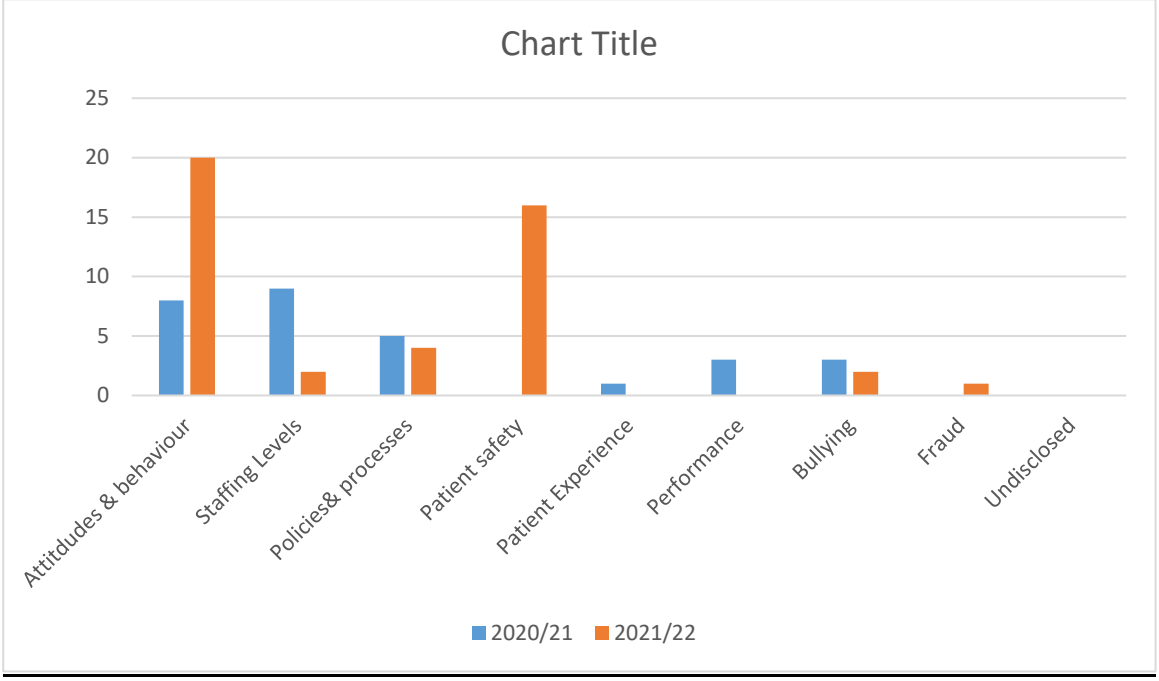




Graph 1 details the divisions that staff raising concerns and the division the concern related too. Surgery had the highest number of FTSU concerns raised, due to the concerns being connected to the same issue.

A significant proportion (36%) of cases have related to patient safety, the response to these concerns has been extremely encouraging.

Graph 2: Nature of concerns Raised



3.2 Feedback following Raising a FTSU concern

It has been difficult to get feedback from staff who have raised concerns via the questionnaires, as there is a reluctance to respond once the concerns have been addressed. We are currently looking at other options such as a series of text questions to raise the response rate.

3.3 Raising the Profile of FTSU within TRFT

Due to the Covid pandemic, it has been difficult to promote the role of the guardians in person. However, work has continued to increase the visibility of FTSU within the Trust. This has included development of promotional information on the role of the guardians.

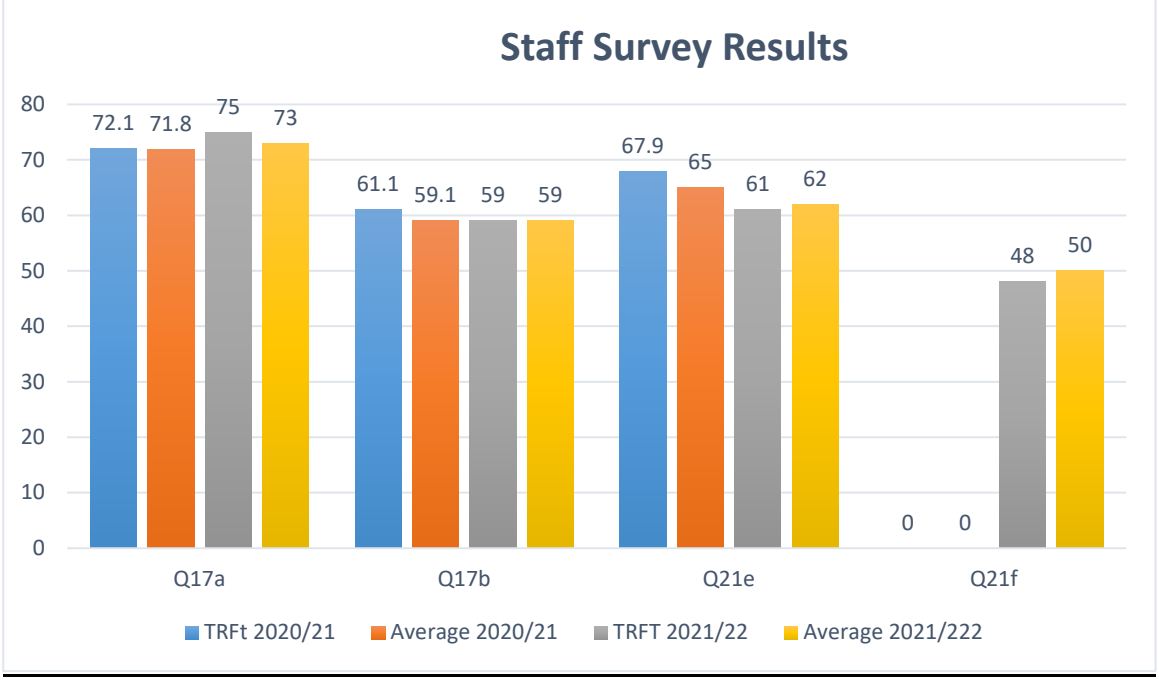
The FTSU Ambassadors' have highlighted the role and associated agenda through various forms. The FTSUG Lead is continuing to work with the Equality and Diversity Lead to increase awareness amongst all staff groups.

3.4 NHS staff survey results

As can be seen within table 6 there has been a further increase in relation to q17a and TRFT is now above the national average. There has been a slight deterioration in responses to Q17 & Q21E. This may be due to an increased response rate, and as such provides a more indicative picture.

Graph 3 – Staff Survey results relating to

- Q17a -I would feel secure raising concerns about unsafe clinical practice?
- Q17b - I am confident that my organisation would address my concern?
- Q21E - Feel safe to speak up about anything that concerns me in this organisation?
- New Q21f - Feel organisation would address any concerns I raised?



4. National Guardian Office Data

The Trust has submitted data on a quarterly basis to the National Guardian's Office.

4.1 TRFT Comparison with National Data

The value of comparison between Trusts is difficult to determine as a high or low number of concerns does not necessarily provide assurance regarding the speaking up culture of the Trust. The NGO remains keen for trusts to avoid comparison.

The key performance indicator for organisation is that the NGO receive a data return each quarter, which contains some data. The full year's data will be available later in quarter one 2022/23.

4.2 National Guardian Office Case Reviews

The NGO have issued numerous recommendations as a result of case reviews, a gap analysis of these has been conducted and TRFT is well placed to have incorporated all of these. Two that require further work are;

- Development of a communication strategy for FTSU
- Does your organisation's exit process (Questionnaire/Interview) include reference to the FTSU support available?

The second recommendation has now been incorporated into the Leaver's Policy, which is currently progressing through ratification.

During 2021/22 the NGO have published two case reviews at Blackpool and Whittington NHS Trusts. These highlighted a number of actions required for the organisations reviewed. These reports have been reviewed with no additional actions for TRFT

5. Conclusion

There has been an increase in the number of concerns that have been raised during 2021/22, however benchmarking the Trust against peers remains a challenge due to the nature of the subject. Historically of concern locally has been the lack of individuals who are from BAME & LGBTQ+ backgrounds. This has improved considerably during 2021/22, which illustrates the targeted promotion of FTSU has had a positive impact. The guardians will continue to promote a positive speaking-up culture, to prevent harm and improve outcomes for both colleagues and patients.

It is vital, not only to encourage colleagues to raise issues, but to foster an environment where staff are truly supported to speak up. Managers have an important role to play in supporting a culture within their teams so that speaking up becomes business as usual.

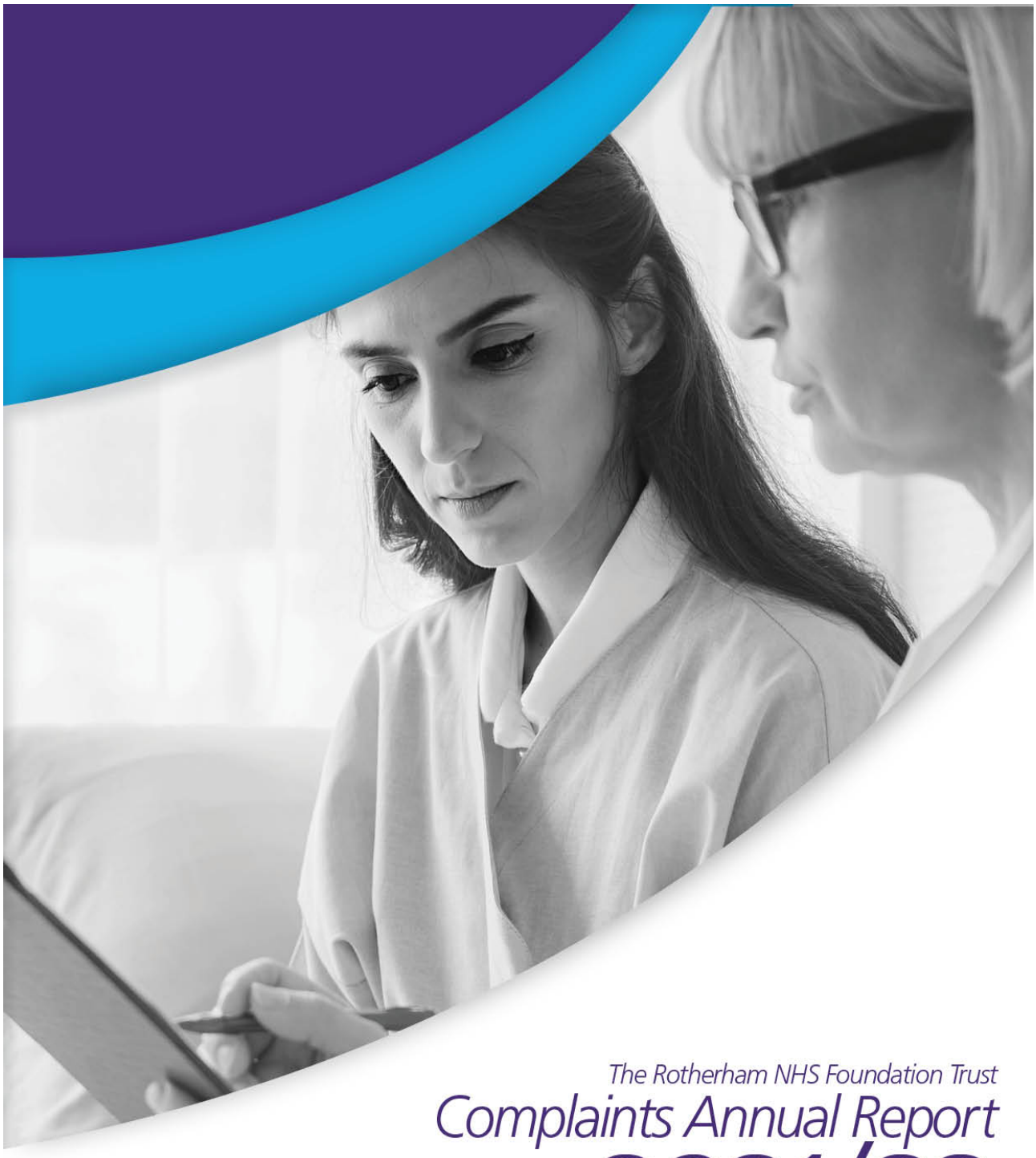
Our aim is to be a Trust where everyone from front line care to Board level is committed to supporting a transparent and open culture, where all staff including: agency workers, temporary workers, contractors, students, volunteers, governors and other stakeholders are encouraged and confident that they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

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P74/22
Report	**Complaints Annual Report**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	B1 and B3
How does this paper support Trust Values	The Trust has an ambition to ensure that all complaints are responded to appropriately and within agreed timescales. This helps to demonstrate that we are a caring organisation and promotes effective engagement with service users.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	In accordance with Statutory Instrument 309, NHS Complaint Regulation 2009, this annual report provides a summary of the concerns and complaints activity between 1 April 2021 and 31 March 2022 The aim of this report is to provide assurance to the Board of Directors that the Trust follows its Complaints Policy and Procedures when investigating and responding to formal complaints addressed to The Rotherham NHS Foundation Trust. In addition this report aims to: • Provide information and assurance in relation to the management of complaints and performance against its policy. • Provide information on the development and enhancement of the complaints process. • Share the priorities for 2022/23 The key points are: • 2,437 concerns and complaints were received in 2021/22 representing a 37.92**%** overall increase in total from 2020/21 (1,767). • Formal complaints increased within the year 266 compared to 2020/21 (234), representing a 13.68% overall increase. • Concerns increased significantly by 41.62% (2171) when the figures are compared to 2020/21 (1533) again reflecting the emphasis on

	immediate resolution embedded within the Trust when dealing with in-patient issues and during the Covid-19 Pandemic in real time. • The Division with the highest incidence of complaints and concerns was the Division of Surgery. This increase is linked to the Covid-19 pandemic due to visiting restrictions and lack of communication. • There was a decrease in the number of complaints closed and re-opened in 2021/22 by 3.1%. It should be noted that this data is dynamic as a complainant may return many months after the response has been received and the initial complaint closed. • During the financial year the Parliamentary and Health Service Ombudsman (PHSO) did not accepted any complaints for investigation. However, it should be noted that one is still ongoing which was opened in 2020. • With regard to benchmarking against other organisations, at the time this report was produced the annual data for 2021/22 has not yet been published by the Health and Social Care Information Centre (which produces annual statistics on complaints). • It should be noted that when the Board considered the complaints annual report for 2019/20 it was agreed that the quarterly complaints review reports from the Non-Executive Directors form part of the Complaints Annual Report. However, due to the Covid-19 pandemic these reviews did not take place in 2020/21. Therefore this report includes the reviews undertaken in 2021/22.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper was presented to the Quality Committee on 27 April 2022.
Board powers to make this decision	The Board of Directors are authorised to make this decision
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Board are asked to approve this report prior to inclusion in the Quality Account.
Recommendations	The Board are asked to approve this report.



The Rotherham NHS Foundation Trust

Complaints Annual Report 2021/22

Ambitious Caring Together

NHS The Rotherham NHS Foundation Trust

1. Introduction

This report provides a summary of patient complaints received between 1 April 2021 and 31 March 2022 and includes details of the numbers of concerns received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman (PHSO) investigations and action taken by the Trust in response.

The report aims to provide assurance that the Trust is responding to patients, relatives and carers complaints in line with its procedures, Department of Health legislation and standards expected by the PHSO.

In the vast majority of cases patients, relatives and carers are satisfied with the care, treatment and services they receive. On the occasions where a patient, relative or carer is dissatisfied, it is important that they feel comfortable in raising their concerns so that the Trust can resolve any misunderstandings or failings and ensure that learning and improvements take place. Complaints are considered a vital source for identifying how services can improve.

The Trust has had a strong focus on improving patient experience and this continues to develop and evolve. The Trust is committed to resolving any concerns at the earliest opportunity and all colleagues are encouraged to manage concerns raised in an effective and timely manner rather than letting them escalate to a formal complaint. This is often achieved through the patient, relative or carer discussing their concerns directly with the service. Patient care is at the heart of what we do and we are committed to improving the experience of our patients but we know that we do not always get it right. It is important to us that people find it easy to raise their concerns and complaints with us and that they feel their feedback is welcomed and dealt with in a timely manner.

Should the patient or carer feel that their concern should be formally investigated, they are able to make a formal complaint. The Trust's Patient Experience Team is accessible through email, in writing, telephone, NHS UK, Care Opinion and in normal circumstance person. The Trust aims to provide a response in as timely a manner as possible, setting an internal benchmark of 30 working days. The Trust aims to remedy complaints locally through investigation and conciliation meetings, when appropriate. However, if the complainant remains dissatisfied, they have the right to refer their complaint to the PHSO as the second stage of the complaint process.

2. Context

The Trust's Concerns and Complaints policy describes the roles and responsibilities of colleagues in ensuring all concerns and complaints are handled as quickly as possible and in line with appropriate national guidance. The policy applies to all hospital and community services, sites, departments and areas within the organisation, buildings or the environment and to all permanent and temporary staff working within the Trust.

The Trust's procedure invites both concerns and formal complaints and in line with national guidance uses the following definitions:

Concerns: A concern can be defined as a matter of interest, importance or anxiety which can be resolved to the individual's satisfaction within a short period of time without the need for formal investigation and formal correspondence. These are dealt with as proactively and as quickly as possible "real time".

This may include meetings or telephone calls with an appropriate senior manager. We aim to resolve a concern within 10 working days although the vast majority can be resolved in a much shorter timescale.

Formal complaints: A complaint can be defined as an expression of dissatisfaction with the service provided or not provided or the circumstances associated with its provision which requires an investigation and a formal response in order to promote resolution between the parties concerned. They are processed through a formal procedure which involves a written acknowledgement, conciliation meeting or written response from the head of the relevant service, together with a cover letter from the Chief Executive. We aim to respond to all formal complaints within 30 working days. If the complaint is complex, multi-faceted or involves a number of organisations a timescale of 40 or 60 working days can be allocated.

3. The Patient Experience Team and Complaint handling

The Patient Experience Team (PET) has a dedicated team of 3.4 Whole Time Equivalent (WTE) staff – 1 Complaints Manager, 2 Patient Advisor's (1.6 WTE) and 1 Administrative Assistant (0.6 WTE). The team encompass both the complaints and concerns functions and is responsible for co-ordinating and managing the complaints process centrally for the Trust. This provides a central point of contact for patients and their family/carer with the Trust.

All complaint investigations and draft responses are devolved to a principal Division regardless of other specialities that may be involved in another aspect of the complaint. On completion of the investigation and draft response the Divisional Head of Nursing, Head of Midwifery, Clinical Lead or Governance Lead will be responsible for its sign off by way of reviewing the complaint investigation to ensure that it has been thorough and addresses all the issues raised by the complainant and that appropriate action and lessons learnt have been identified. This enables the division to strengthen the role of divisional governance.

If a complaint relates to a corporate team and sits outside of a Clinical Divisional structure the sign off of the complaint will be the responsibility of the appropriate Director for that area.

The PET liaises with the divisions to ensure complaints are investigated and responded to in a timely manner and provide support/expertise as appropriate.

A weekly report is provided to the Chief Nurse, Deputy Chief and Assistant Chief Nurse, Heads of Nursing and Governance Leads highlighting performance against agreed dates, escalation and potential breaches.

Complaints are responded to either in writing or by holding a Local Resolution Meeting (LRM). The recommendations from The Clwyd/Hart[1] report outlined the importance of negotiating a timeframe for completion of an investigation with the complainant as there is currently no national mandatory timeframe. However, the Trust aims to respond within 30 working days currently. In 2021/22 the Trust set a target that 95% of complaints would be replied to within the timeframe.

As well as providing a written response, complainants can agree to meet face to face with Trust staff as part of the investigation and local resolution process. This option is pursued where appropriate and complainants are also given the opportunity to bring their family, friends or advocate to the meeting.

[1] Clwyd/Hart Report 2013 – Review of the NHS Hospitals complaints system: Putting Patients back in the Picture.

The date and time and venue are agreed with the complainant. Any meetings held are digitally recorded and a copy of the recording is provided to the complainant so all parties can refer to this at a later date if required to clarify any issues discussed and specific details. Due to the Covid -19 pandemic and the restrictions on face to face meetings, only 50 Local Resolution Meetings were held in respect of complaints during 2021/22. This approach continues to be received positively as meetings can provide openness and transparency, many families have requested that the LRM meetings be scheduled once restrictions were lifted.

4. Data Collection, Analysis and Reporting

Data is recorded on the 'Complaints' module within Datix which allows for analysis against a defined set of categories. As part of the Trusts reporting mechanisms a quarterly Patient Experience Report is provided to the Clinical Governance Committee, Quality Committee and NHS Rotherham Clinical Commissioning Group (RCCG). Complaints are also a monthly standing agenda item on the Divisional Performance dashboard, Patient Experience Group[2] (PEG) and Organisational Learning Actions Forum (OLAF). A sample of complaint files are also reviewed on a quarterly basis by a Non-Executive Director which also forms part of this annual report.

5. Complaints and Concerns activity

In 2021-22 the Trust has continued to welcome patient feedback. During the year we received 266 formal complaints and 2,171 concerns. The table below compares the number of complaints and concerns received in the last three financial years.

Figure 1: Number of Complaints and Concerns received

	2019/20	2020/21	2021/22
Formal complaints	279	234	266
Concerns	1139	1533	2171
Total	1418	1767	2,437

In total 2,437 complaints and concerns were received in 2021-22 in comparison with 1,767 in 2020-21, representing a significant increase overall of 37.92% on the previous year. Data shows there has been a significant increase of 13.68% in formal complaints and a significant increase in the number of concerns 41.62% received. This increase in concerns can be directly linked to the Covid-19 pandemic and required an immediate response and was primarily linked to the lack of communication and information provided.

The majority of issues centred around the lack of access for visitors and clinical updates to families, with the consequences they felt from that exclusion in relation to communication and information issues especially when alternative communication was not proactively addressed at ward level.

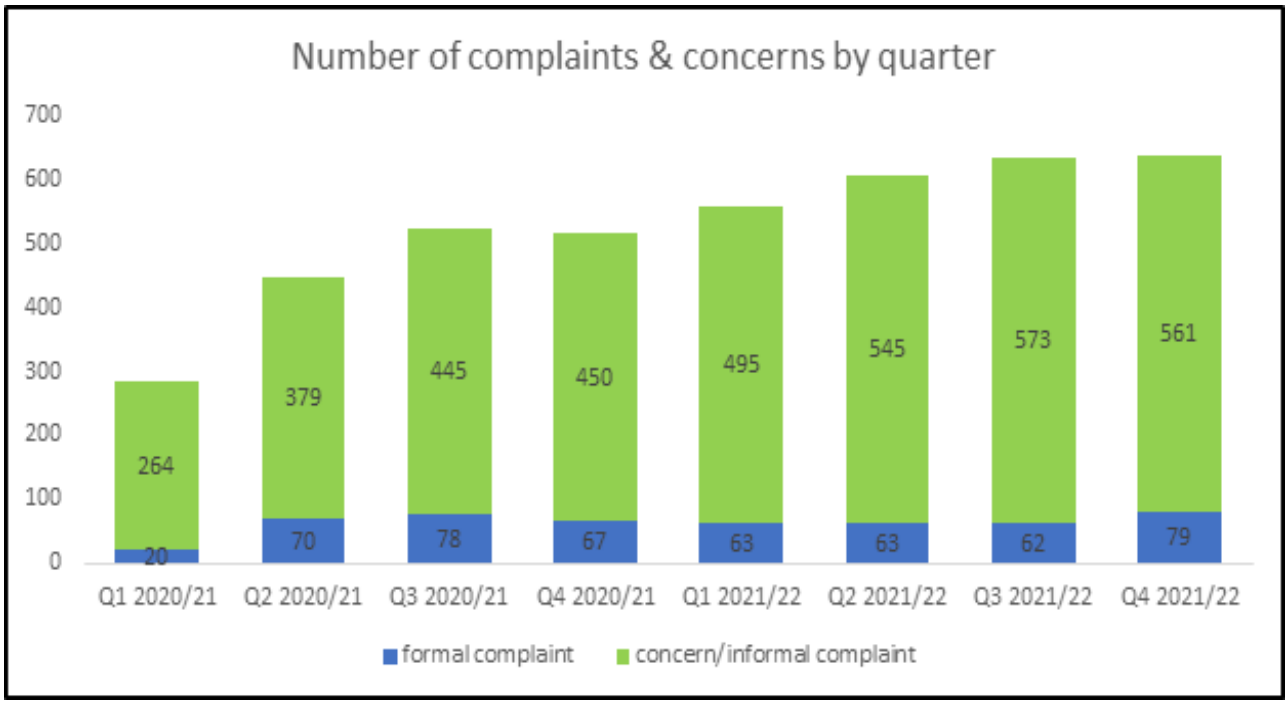
Other factors also influenced the number received, such as the discharge process, appointment waits, patient and carers being more comfortable in raising a concern with the continued proactive use of the concerns process by the PET, the divisions trying to resolve concerns in real time and that staff are more aware of the PET.

[2] PEG is accountable to the Clinical Governance Committee which reports directly to the Quality Committee.

The graph below compares the combined number of complaints and concerns received for each quarter in 2020-21 and 2021-22. In 2021-22 the greatest number of complaints and concerns received were in quarter three and is identified below. This increase continued quarter on quarter.

It is important to note that both concerns and formal complaints are not always made in the same month that the issue occurred, with some complaints being raised many months later. However, this year the majority of concerns were being raised in real time.

Figure 2: Number of Complaints and Concerns received (quarter and year)



Of the formal complaints closed[3] in 2021-22 (258) 24% (62) were upheld, 54% (138) partially upheld and 22% (58) not upheld. (Partially upheld means that the complaint investigation identified areas for improvement).

6. Complaints by Division and Speciality

Figure 3 overleaf illustrates the number of formal complaints received by each division in 2021-22 in comparison to 2020-21. On this occasion Surgery received the most number of formal complaints, in comparison and similar in numbers to that of 2020-21. Urgent and Emergency Care (UECC) received significantly more complaints and Clinical Support, Family Health and Corporate Functions experienced a slight increase. However, it should be noted that Integrated Medicine experienced a decrease in the number received.

[3] The numbers in brackets relate to the number of complaints closed during the year and therefore will not total to the same number as received during 2021-22.

Figure 3: Number of complaints received by each division

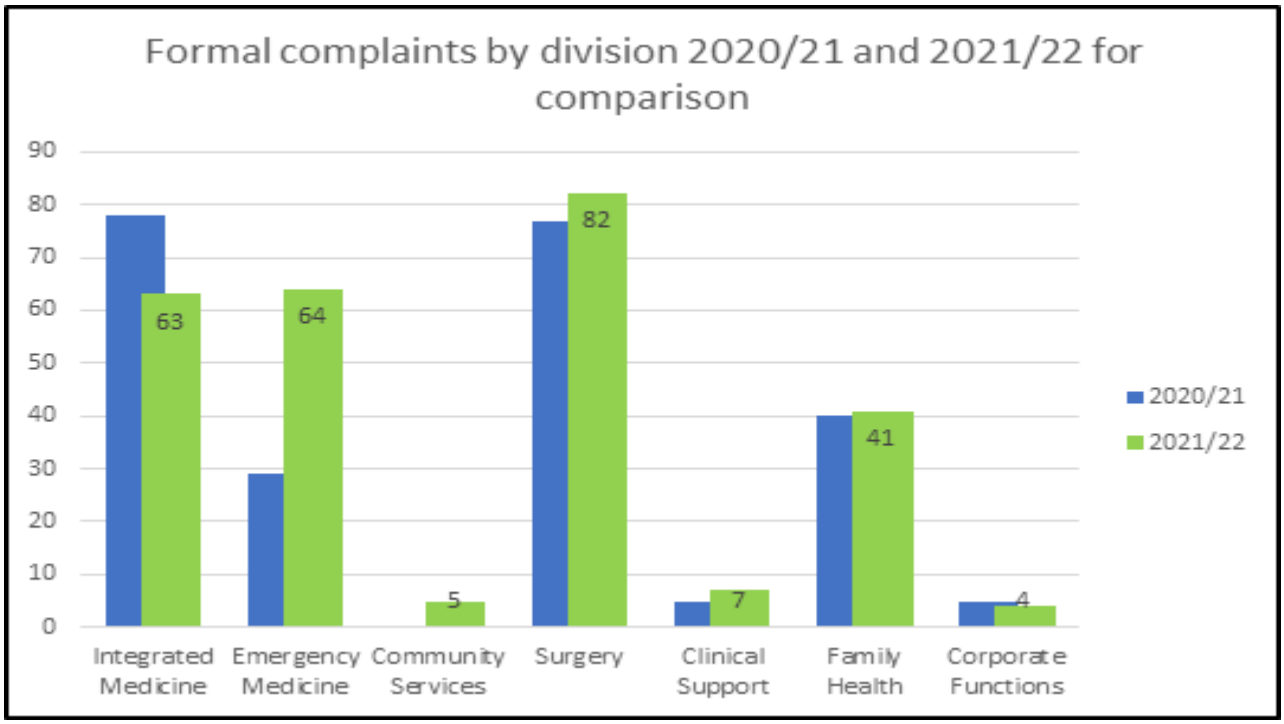


Figure 4: Number of complaints received by Speciality

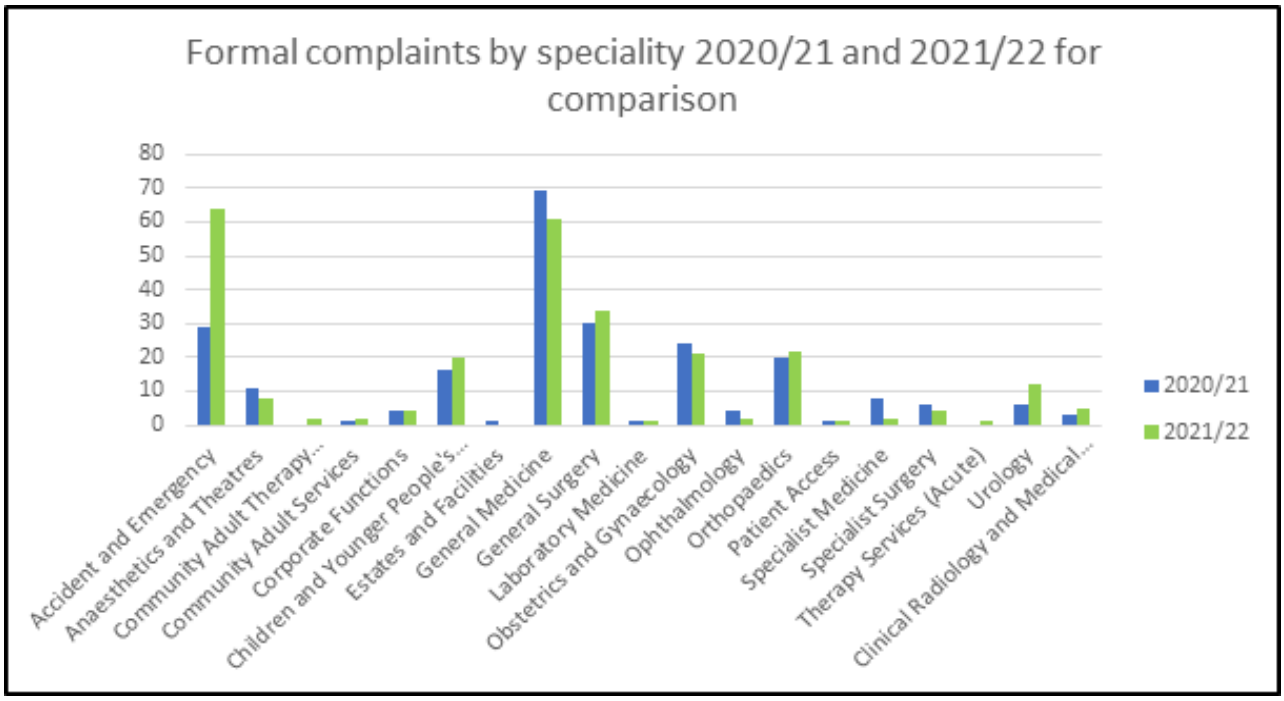


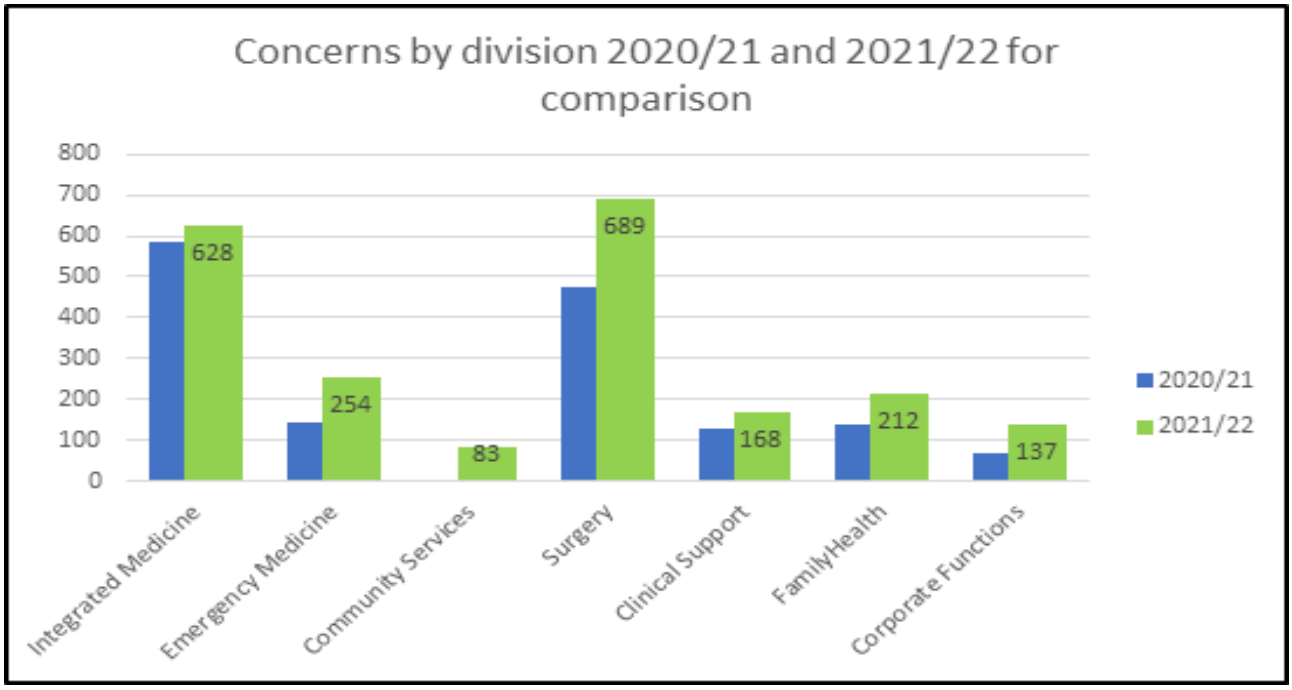
Figure 4 above shows the number of complaints by speciality in comparison. It can be observed that in general complaints followed a similar distribution across the specialities year on year with the specialities of General Medicine[4] and UECC reporting the highest numbers of formal complaints.

[4] This includes all Integrated Medicine i.e. General Medicine, Gastroenterology, Cardiology and Health Care for Older People (HCOP) but excludes Specialist Medicine.

It should be noted that General Medicine speciality also represents the largest activity in terms of patient episodes.

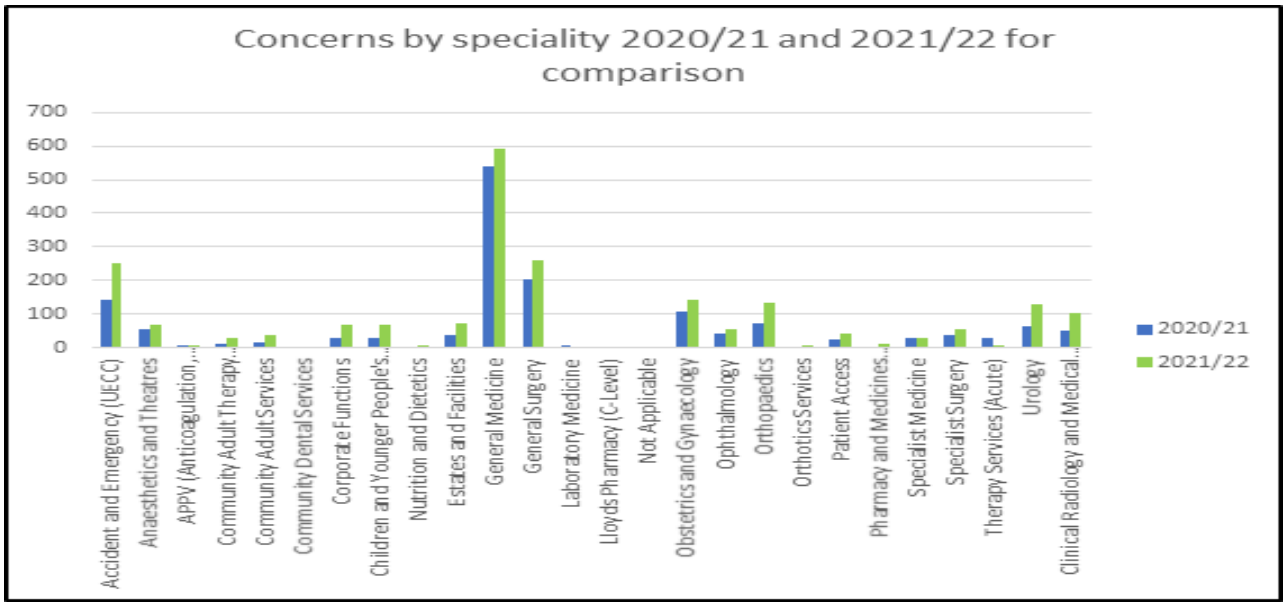
7. Concerns by Division and Speciality

Figure 5: Number of Concerns received by Division



As with formal complaints Surgery received the highest number of concerns followed by Integrated Medicine. As with formal complaints the divisions of Clinical Support, UECC, Family Health, Corporate Functions and Community Services all experienced an increase in 2021-22.

Figure 6: Number of Concerns received by Speciality



It should be noted that in comparison with 2020-21 there has been a significant increase in the number of concerns received by UECC. This increase is also evident in General Medicine, General Surgery, and several other of the specialities.

7. Grading and risk rating

Complaints are triaged on receipt using the National Patient Safety Agency (NPSA) risk rating matrix guidance. This is a systematic and effective method of identifying risks and it is an essential part of any risk management programme.

It also encompasses the processes of risk analysis and risk evaluation with colour rated scoring, green being minor through to red being major.

The initial grading is determined by the Patient Experience Team based on the content of the complaint and is reviewed by the division for appropriateness. As part of this triage, complaints that highlight potentially Serious Incidents (red rated) or have Care Quality Commission (CQC) involvement are discussed with the Deputy Chief Nurse upon receipt, and are routinely reviewed by colleagues and are linked to a patient safety investigation under the Duty of Candour (DoC).

Figure 7 below summarises the percentage breakdown of formal complaints by risk grade and compares the last three financial years. Throughout the financial year, two were risk rated as green. It should be noted that these were MP enquiries which the CEO required registering formally. Percentage rates of risk evaluation and colour rated scoring have reduced with the exception of an increase in yellow rated complaints.

Figure 7: Complaints by Risk rating over the last three years

Year	Green	Yellow	Amber	Red
2019/20	0.0%	74.9%	25.1%	0.0%
2020/21	2.1%	65.0%	32.5%	0.4%
2021/22	0.8%	69.9%	29.3%	0.0%

There were no red complaints. It should be noted that a red incident or Serious Incident (SI) investigation will take precedence over the complaints process. An explanatory letter is sent to all complainants in these circumstances to explain that their complaint is being addressed through a different process.

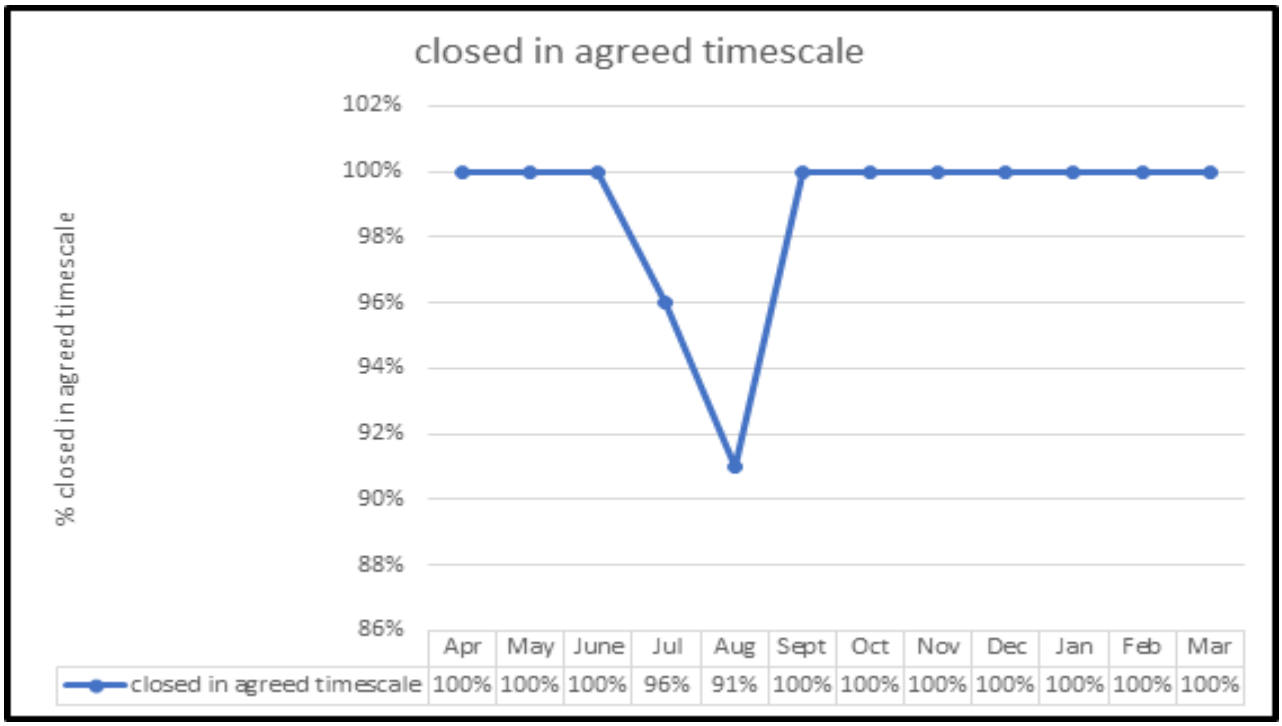
8. Responding to Complaints within the agreed timescale

The Trust complaints policy aims to respond to all formal complaints within 30 working days and the responsibility for ensuring timely responses is shared between the PET and the divisions. If the complaint is complex multi-faceted or involves a number of organisations a timescale of 40 or 60 working days can be allocated. This timescale does not apply to complaints where local resolution meetings are being arranged as this is in negotiation with the complainant.

In 2021-22 the Trusts target remained unchanged to respond to 95% of complaints within the timeframe.

It should be noted that for several consecutive months the Trust exceeded this target by reaching 100%. However, the overall performance for the year was 98.58% which was an increase from 2020-21 which was 91.86%, The Trust will continue with the progress made to ensure that for the year 2022-23, 95% of complaints are closed in the agreed timescale.

Figure 8: Complaint response timescale



9. Ethnicity, age and access

In order to enable all patients and or their family to raise concerns or provide feedback we sign post patients/carers to free NHS Advocacy Services (Absolute Advocacy Rotherham) where support may be required. Easy read literature and translation services are also available. Data is recorded on the 'Complaints' module within Datix which allows for analysis against a defined set of categories. The Trust monitors the age and ethnicity of patients involved in complaints. It should be noted that this data is linked to the patient not the complainant as per Department of Health guidance.

Figure's 9 and 10 overleaf show that the age of the patients involved in complaints in the majority of formal complaints was between 26-55 and the over 75's with the majority of patients involved in complaints being of white British ethnicity 50%. However, it should be noted that 46% did not state their ethnicity.

Figure 9: Patient age

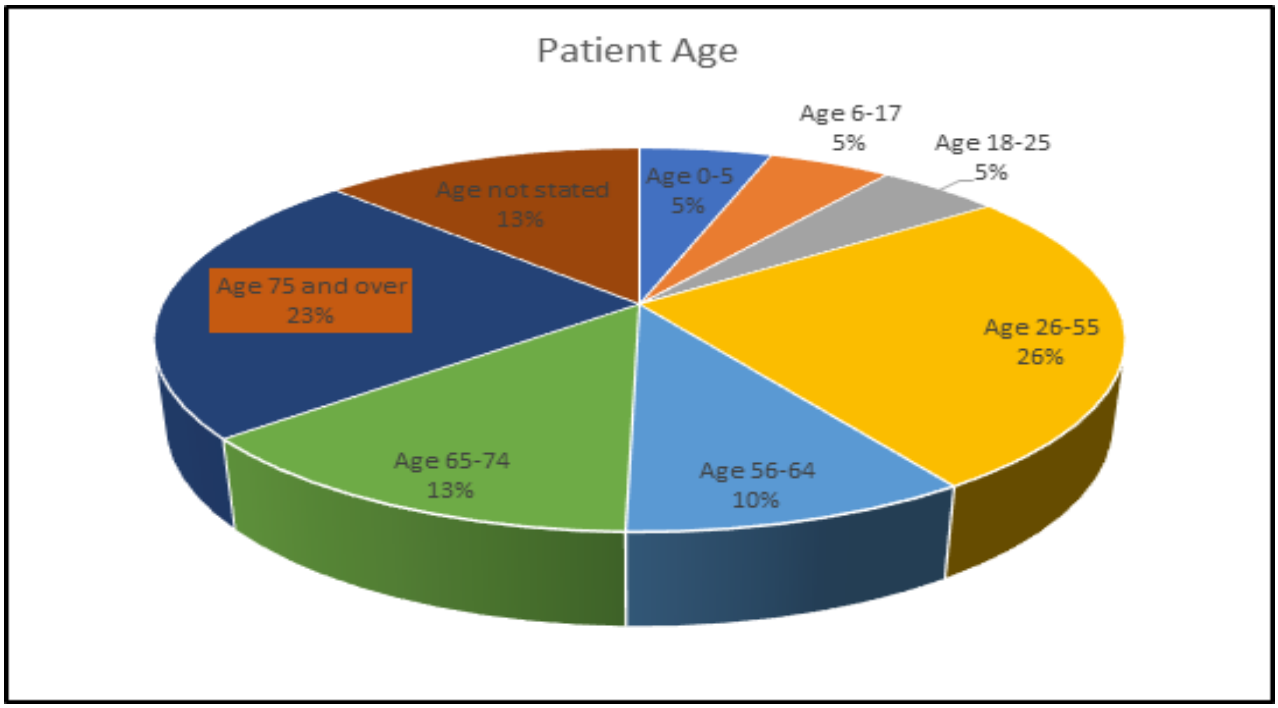
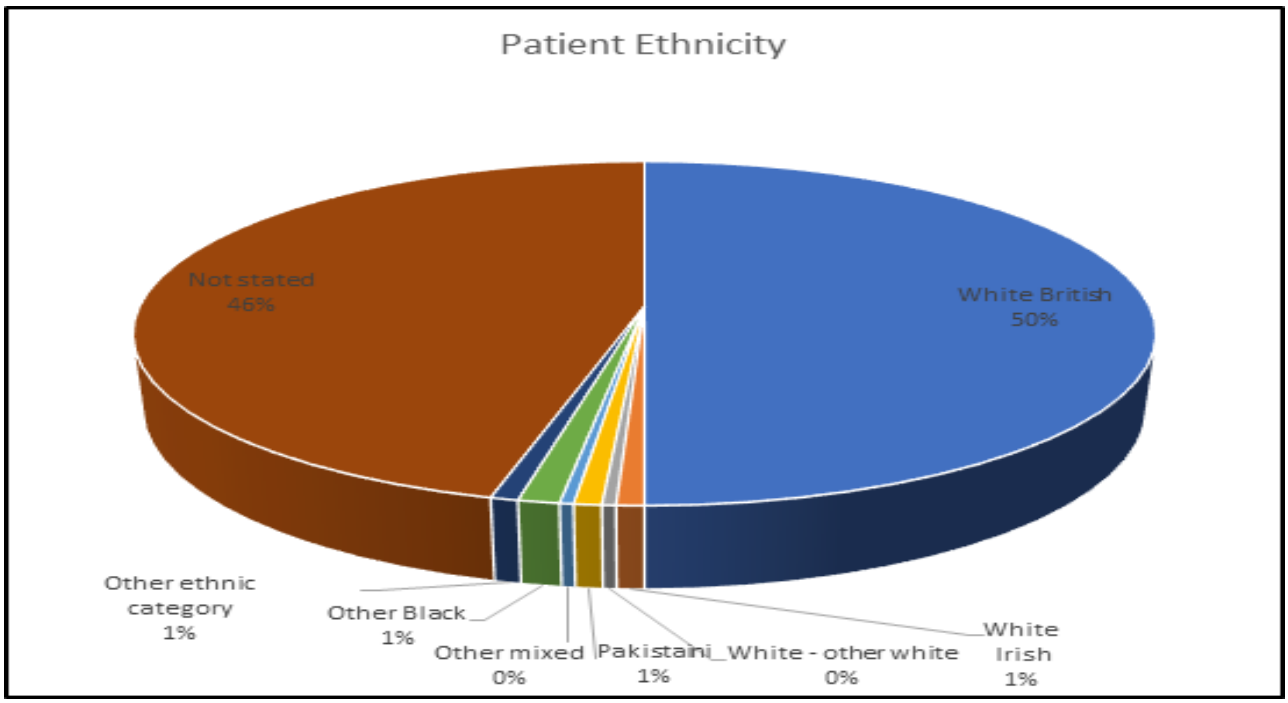


Figure 10: Patient ethnicity



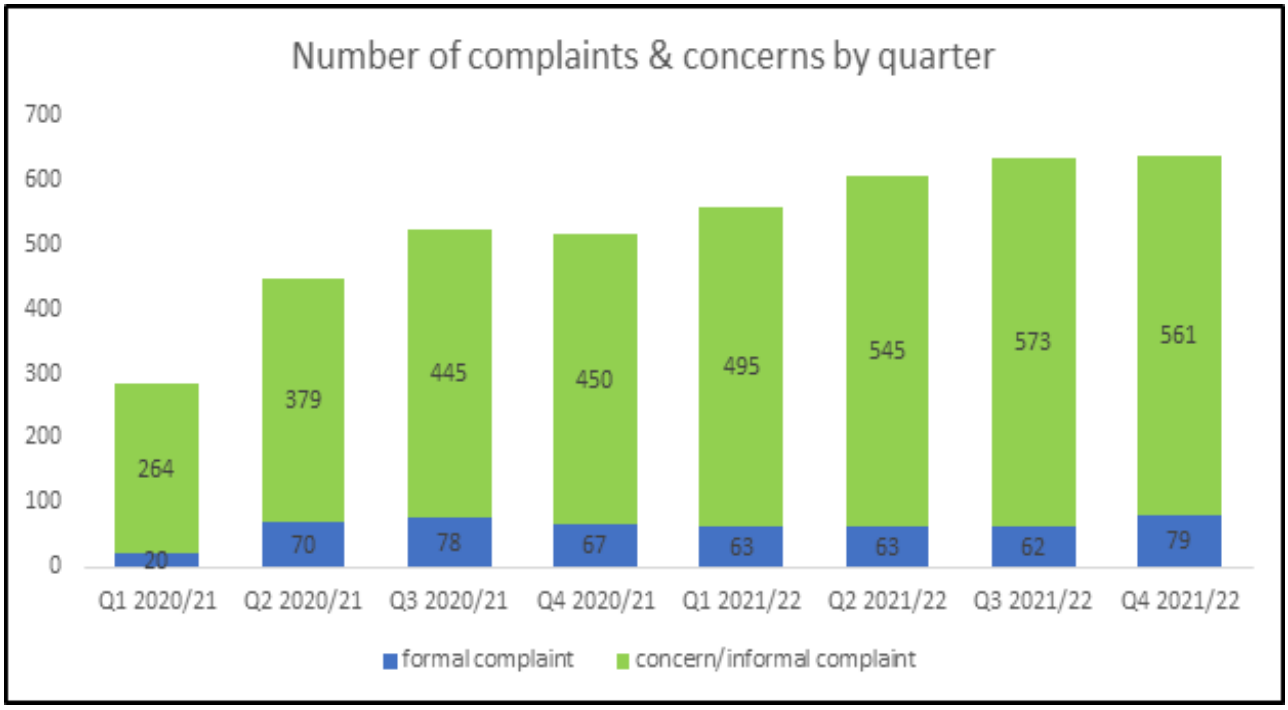
10. Themes and Trends

The data recorded allows for analysis against a defined set of categories. Monthly and quarterly reports are produced to enable the Trust to monitor the categories of complaints and concerns so that issues can be addressed accordingly at divisional and Trust wide level.

For the purpose of this report Figure 11 below highlights the top five themes of complaints and concerns during the year. The data identifies that Medical care received the highest number of formal complaints. However, this is not reflected in the concerns raised as the lack of information significantly received the highest proportion followed by waiting times.

Once again this increase in concerns can be directly linked to the Covid-19 pandemic and the exclusion in relation to communication with family members for clinical updates at ward level.

Figure 11: Top five Subjects of formal complaints and concerns



Complaints provide valuable feedback and should be viewed by staff and the Trust as positive agents for change. However, because complaints reflect a personal experience, it is difficult to be precise about any common themes but some of the issues raised included a perceived failure or delay in treatment, inappropriate discharge, transfer, a procedure (medical and surgical), post-operative management either a developed complication or outcome not as expected, inappropriate surgical management, obstetric management (labour) and DNACPR.

As with past years there are underlying themes relating to information and communication issues and the negative impact this has had. In general, there was evidence from complaints that attitude or behaviour and communication may be the trigger for a much broader complaint about their experience of healthcare provided. Therefore, appropriate attitude and behaviour of our staff, and their responsiveness to patients continues to remain a priority for the Trust.

11. Complaints returned for further local resolution

Out of the 258 formal complaints closed, 31 (12.0%) were returned for further local resolution, this was a decrease compared to the financial year of 2020-21 of 36. It should be noted that this data is dynamic as a complainant may return many months after the response has been received and the initial complaint closed.

12. Formal Complaints numbers measured against Trust activity

Figure 12: Complaints measured against Trust activity

Figure 12 below illustrates the proportion of patient complaints to actual patient attendances over the past three years. Of note, there has been an increase in the overall total numbers of formal complaints, driven by UECC.

	2019/20	2020/21	2021/22
Inpatient Episodes			
Number of inpatient complaints	140	147	133
Inpatient Episodes	70,318	59,679	69,128
Complaints per 1000 episodes	1.99	2.46	1.92
Outpatient Attendances			
Number of outpatient complaints	80	51	48
Outpatient Attendances	259,506	226,770	272,257
Complaints per 1000 attendances	0.31	0.22	0.18
ED Patient Attendances			
Number of ED complaints	39	20	67
ED Attendances	99,069	75,889	95,438
Complaints per 1000 attendances	0.39	0.26	0.70

It should be noted that In-patient episodes, Out-patient and UECC attendances have all significantly increased in the last year, although In-patient and Out-patient complaints decreased slightly over the same period. However, UECC data shows that complaints per 1000 is significantly higher compared to 2019-20 when we had higher attendances, therefore overall this shows a deterioration in satisfaction for this service.

The remaining 16 complaints this year did not fit specifically into these categories for example corporate functions or Community Care.

13. Parliamentary Health Service Ombudsman (PHSO)

Although we aim to resolve all complaints at a Trust level, once local complaints resolution is complete, if the complainant remains dissatisfied they may ask the PHSO for consideration of their case by providing details of the way in which they consider that the Trust has failed to answer the issues.

Following full investigation, the PHSO will either uphold the complaint and recommend action to take place for resolution to occur; partially uphold or not uphold the complaint and no further action required.

There are many factors that influence the number of complaints and the PHSO advises that this data should not be treated as an attempt to rank the performance of Trusts across England. Organisational size, specialities, and patient demographics all have an impact on the number of complaints about different Trusts. The accessibility of each Trust's complaints service and how well a Trust signposts to the PHSO service, may also have had an impact.

Figure 13 below shows that four cases were received for investigation by the PHSO in 2020. Three of the cases were closed in the current financial year. The fourth remains ongoing. It should be noted that no investigations were opened this financial year.

Figure 13 PHSO Investigations

Speciality	Primary subject matter	Outcome	Recommendations
General Medicine	Complaint made regarding the lack of information, care and treatment received in conjunction with the Local Authority.	Closed	Not upheld
General Medicine	Complaint made regarding the care and treatment received.	Ongoing	
General Surgery	Complaint made regarding the care and treatment received.	Closed	Partially upheld
Corporate Integrated Discharge Team	Concerns regarding discharge of patient to home	closed	Partially upheld

The PHSO publishes their data online on a quarterly basis which is limited to purely numerical information. The Trust also seeks to learn from the reports that the PHSO produce throughout the year. However, at the time of this report this data had not yet been published.

14. Listening and Learning from Complaints

Complaints present an opportunity to review patient care and our services, and the way we interact and provide information to patients. Once we have investigated a complaint, we tell the complainant where we will be taking action to ensure the events leading to their experience are put right.

Often this may involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study.

The lessons learnt are discussed at Divisional Clinical Governance meetings. This enables those staff not directly involved in the complaint or the care of the patient to understand what has happened and to reflect on whether a similar situation could occur in their service. It ensures that any lessons are shared and considered by other services enabling pro-active action to be taken in order to drive improvement in learning from complaints across the organisation.

The work with Divisions to support their provision of detailed and robust action plans continues and the requirement for explicit evidence of learning from complaints remains ongoing.

To ensure that the learning from complaints is occurring at a Divisional level, the Interim Assistant Chief Nurse for Patient Experience continues to work with the Divisional Governance Leads to support action plan completion and progression.

The purpose of the corporate meeting with the Divisions the Organisational Learning Action Forum (OLAF) continues to ensure that robust and consistent shared learning is occurring, across clinical services within the organisation.

The forum correlates information and supports Divisions to identify the themes that they need to focus upon to address adverse outcomes, avoid repetition of similar events and to enable staff learning to become embedded across the organisation. The aim therefore is to reduce the incidences of patient harm and complaints whilst positively and proactively contributing to the Trust's Quality Improvement initiatives.

Further to this within the OLAF process, each Division is asked to present the specific learning activities that they have undertaken following a patient safety or experience event, to the forum each month. The format of the presentation is standardised, so that the themes for learning are explicit and can be readily shared for the education of all attendees. The slides are then available for all participants to share with their own teams, through their Divisional Governance meetings and staff huddles.

Some Divisions also build upon their local shared learning, by using other mechanisms such as a monthly newsletter, which includes 'Learning from Complaints', sent to all clinical staff to highlight the prior months' concerns and the actions taken.

Below are examples of some of the actions that have been taken as a result of the complaints presented to the Trust.

- Due to concerns raised that a patient had lost trust in the clinical team, following patient safety issues. The Division of Surgery introduced a new question to staff's ward rotation interview package, offering new nursing employees the option to rotate through the three surgical areas. This will ensure that staff are familiar with different care settings and clinical practices and they will gain the wider experience of working with diverse qualified nurses.

- One of the key achievements for the Division of Family Health following concerns raised by a patient regarding their birth story and the impact this had was the introduction of the Birth in Minds service. The Trust has a dedicated maternity mental health midwife and the existing service has been strengthened further with the introduction of a dedicated midwife and psychologist so that women suffering birth trauma can be referred and receive the appropriate psychological and therapeutic intervention.

- Between May and September 2021, as part of the Trust's operational recovery plan following the 2020/21 COVID-19 pandemic, the Medical Imaging CSU faced a very challenging time due to the large number of patients awaiting diagnostics.

  Despite all efforts to communicate well with patients, the CSU unfortunately received several concerns. These related to difficulties encountered when trying to contact the Medical Physics or Radiology Departments by telephone when attempting to book, cancel or discuss appointments.

Following a review of the situation by the CSU management team, the root cause of the problems appeared to be exacerbated by the increased demand for imaging and insufficient staff being available to answer the telephone calls. The CSU therefore improved their practice by:

- Medical imaging clerical staff put in place actions to ensure that the voicemail systems were checked numerous times per day and, following return of calls to patients, the systems were cleared.
- Netcall system (currently used by the Patient Access CSU), could be utilised within Medical Imaging by placing the caller in a queue system, allowing them to remain on the telephone to await their call being answered.
- Netcall system also has the functionality to allow a patient to make an appointment without having to talk to someone.
- The Medical Imaging CSU has been granted approval to install Netcall.
- Netcall will also record calls which will help when investigating any future concerns which may be raised and assist staff training. Meetings are planned to agree dates for when the system will be introduced.
- Until Netcall is in place, the CSU has put in place further mitigating actions to reduce the likelihood of such incidents recurring including the training of an apprentice colleague to assist with the answering of calls at busy periods and a message has now also been recorded requesting patients to leave just one message (not several). Staff will contact them as soon as possible the same day.

- Due to concerns raised following a patient with diabetes attending UECC, the department completed a process-mapping event to review whether patients are receiving the right care in the right place and first time. As a consequence, the department implemented an action plan which included:

  - UECC summit held to focus on the issues identified.
  - Monitoring of Professional Standards within the department.
  - Ensuring safe patient discharges.
  - Diabetes management updating and training sessions provided.
  - Review of the continuous access to refreshments and food within the department.
  - Pagers provided for Patients temporarily leaving the department for example to visit food outlets etc.

- For the Divison of Medicine listening to the feedback they received from patients and their relatives has been essential. Acting upon the concerns raised has been a key priority to ensure that we learn from these and continue to improve the quality, experience and safety of care our patients receive.

  The standard of communication and professional behaviours/ interactions portrayed has been a theme within the complaints received across the Division. In order to address this the Divison introduced a number of measures:

  - The Acute Medical Unit introduced daily calls to the patients next of kin or nominated person to notify, to provide them with an update of the patients condition and clinical management plan.
  - Ward A5 introduced ‘Huddle Up for Safer Healthcare’ (HUSH) huddles to improve communication, patient safety and well-being of staff.

- Ward A1 developed ‘A fundementals of care package’ which is completed by all nursing staff.
- The Stroke Unit are developing a leaflet for patients which explains the wards daily routines and expectaions.
- Ward A2 have introduced ‘Planning your discharge from hospital Cards’ to faciliate communication with patients’ relatives specifically relating to discharge planning arrangements.
- A monthly Medical Nurses Education day has also been introduced from February for all Registered Nurses within the Division, which includes a session on communication.

These initiatives were also shared within the Divisional newsletter, Divisional/ CSU Governance meetings, Band 7 and Matron huddles.

15. Non-Executive Director review of closed complaints

A quarterly basis a review of the complaints closed within the financial year is undertaken by one of the Non-Executive Directors (NED) of the Board on a rotating basis. The NED randomly selects several files from the complaints closed, by Datix number. The analysis includes subject areas, structure and content of the complaint files, timeliness and quality and actions of the investigation.

From the reviews undertaken is was evident the timeliness of handling and responding to the complaints was compliant with the Trust complaints policy. The files managed by the PET were well organised and contained copies of all correspondence and the letters of response were generally of good quality. However, it should be noted that there were missing key documents from the Divisions.

Many complaints trigger an action plan requiring execution and monitoring. Some complaints rightly require one-off action to improve and learn. However, there were common themes to many of the complaints reviewed and consideration should be given to how those themes feed into the quality themes and objectives and whether the plan on those quality themes, pick up the issue or a separate plan for that complaint is required. If the themed complaints were measured by the Division, it would be possible to see if the quality improvement plan was resulting in fewer complaints and issues. Currently there is no mechanism to see if the learning from the complaint via the action plan is embedded by the Division, or if the complaint is the same or similar to one that had previously been addressed. It is recognised that some actions may take some time to complete, but there should be an evidence chain to show completeness in place provided by the Divisions. There were action plans which were incomplete and where complete, the files contained no evidence of the action being executed or of learning where completion dates had been provided.

The process of handling complaints was clear and well executed by the PET. The issues relate to the incomplete action plans and the lack of evidence to support them. There is an opportunity to review the approach to action plans and the link into the quality journey.

As a consequence, it has been agreed that the PET to take responsibility for all Divisional complaint actions plans to be uploaded to the master OLAF database. This will enable the oversight of evidence completion and allow themes and trends to be identified across the three key areas which are:

- Patient Safety
- Complaints

- Claims

This will also contribute to quality improvements, learning and practice development whilst holding the Divisions to account.

16. Key Achievements of 2021-22

- 100% of complaints were acknowledged within the 3 working day target.
- 100% of complaints were risk graded upon receipt.
- Exceeded the Trust's internal response rate of 95% by 3.8%.
- The Head of Patient Experience continued to support Governance Leads with the monitoring of complaints to ensure performance.
- The Patient Engagement and Inclusion Lead established a range of user engagement and inclusion activities with patients, families, carers.

17. Further developments for 2022-23

- To continue to deliver against Key Performance Indicators (KPI's) including agreed response times.
- The Patient Engagement and Inclusion Lead to continue nurture a range of user engagement and inclusion activities with patients, families, carers and the wider communities of interest where services are provided by the Trust following the lifting of pandemic restrictions.
- The PET to take responsibility for all Divisional complaint actions plans to be uploaded to the master OLAF database. This will enable the oversight of evidence completion and allow themes and trends to be identified across the three key areas which are:

    - Patient Safety
    - Complaints
    - Claims

    This will also contribute to quality improvements, learning and practice development whilst holding the Divisions to account.

- Following on from the 360 Assurance audit on complaints, the initial feedback from the interim Director of Quality Governance and the clear messages from Ockenden, a review of the complaints process will be undertaken by the Deputy Chief Nurse. Identified required improvements will be implemented within the 2022-3 year and reported quarterly through the newly formed Patient Experience and Inclusion Committee.
- Work in line with the Parliamentary and Health Service Ombudsman National NHS Complaint Standards due to be introduced across the NHS in 2022. The Standards are guidelines to provide a unified approach that will benefit complaint staff and complainants alike.

18. Conclusion

The Rotherham NHS Foundation Trust remain committed to investigating, learning from and taking action as a result of individual complaints where mistakes have been made or where services can be improved.

Our vision is to be an outstanding Trust delivering excellent healthcare, in our community and in hospital. To achieve this, every colleague, at an individual level and every team need to be involved in quality improvement and see it as part of everyday business.

This report highlights the ongoing work being done within the compact and dedicated PET and more significantly during the ongoing Covid-19 pandemic to ensure that the Trust's complaints procedure continues to be managed effectively and performance compliant in actioning and responding to complaints is in line with the regulations.

It provides a summary of formal complaints and concerns received during the financial year of 2021-22 and associated patterns and themes.

Samantha Robinson
Head of Patient Experience
April 2022

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P75/22
Report	**Gender Pay Gap Report**
Executive Lead	Steven Ned, Executive Director of Workforce
Link with the BAF	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 B5: Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs
How does this paper support Trust Values	Ambitious – the Trust is ambitious to improve its equality and diversity performance and become an employer of choice within the local area Caring – the Trust is committed to improving staff experience
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary	This is the Trust's Annual Gender Pay Gap report, which the Trust is legally required to produce and publish. It is based on data as at 31st March 2021.
Due Diligence	This paper was discussed at Operational Workforce Group on 3rd March This paper has been discussed at Executive Team meeting (10th March) and the Executive Team were supportive of the recommendations contained in the paper. This paper was presented to People Committee on 18 March. The paper is also published on the Trust website.
Board powers to make this decision	N/A – no decision is required
Who, What and When	The recommendations of this report will be taken forward via Operational Workforce Group
Recommendations	The Board of Directors is asked to note the report.
Appendices	i. Gender Pay Gap Report

The Rotherham NHS Foundation Trust

Gender Pay Gap Report

Data as at 31st March 2021

Publication date: 18th March 2022

Contents

Introduction

The gender pay gap report shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 15% less than men.

The mean and median are different ways of expressing an average. Mean hourly pay for a group of ten people would be calculated by adding together the hourly rates of all ten people, and then dividing the result by 10. To find the median hourly rate for the same ten people, you would put the hourly rates in order, from lowest to highest, and the median would be a value halfway between the 5th and 6th rate. When used in relation to pay, the mean can be significantly affected by a small number of very high earning staff.

The gender pay gap differs from equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

As a public body employing over 250 staff the Trust is required to publish the following gender pay gap information:

a) Mean gender pay gap
b) Median gender pay gap
c) Mean bonus gender pay gap
d) Median bonus gender pay gap
e) Proportion of males receiving a bonus payment
f) Proportion of females receiving a bonus payment
g) Proportion of males and females in each quartile pay band

Gender Pay Gap Reporting

Data and statistics provided for this report have been created using the national Electronic Staff Records System Business Intelligence reporting tool, specifically designed to allow NHS Trusts to meet the statutory reporting requirements.

As at 31st March 2021, the Trust's workforce included 4029 women, and 835 men. Men made up 17.2% of the overall workforce. The numbers of both male and female employees have increased over the last year, however the proportion of the Trust's workforce who are male has decreased very slightly. The national NHS Electronic Staff Record system does not facilitate the recording of genders other than male or female.

As at 31st March 2021, the Trust employed 4571 full-pay relevant employees. Of these, 3771 were women and 800 were men. 17.5% of full-pay relevant employees were men. Employees who are on maternity, maternity support, adoption or sick leave, or on a career break are not full-pay relevant employees.

Mean Gender Pay Gap and Median Gender Pay Gap

Gender	Mean Hourly Rate	*Median Hourly Rate
Female	£16.02	£14.08
Male	£22.76	£17.83
Difference	£6.74	£3.75
Pay Gap %	29.61%	21.01%

The Trust's Gender Pay Gap (median) as at 31st March 2021 is 21.01%. This has deteriorated every year since 2018, when it stood at 10.58%. There does not appear to be a single explanation for this change, but some of the reasons are explored further in this report.

Mean Bonus Gender Pay Gap and Median Bonus Gender Pay Gap

Gender	Mean Bonus Pay	Median Bonus Pay
Female	£7,709.68	£7,238.40
Male	£11,205.27	£9,048.00
Difference	£3,495.60	£1,809.60
Pay Gap %	31.20%	20.00%

* This data excludes Long Service Awards

Bonus pay is made up of Clinical Excellence Awards (CEAs) which are paid only to medical staff. No additional CEAs were awarded during the relevant period as temporary arrangements introduced during the Covid-19 pandemic continued (these involved the amount available for new CEAs being split between all eligible consultants and paid as a non-pensionable lump sum, rather than a bonus). Pre-existing CEAs continued to be paid, although there was a slight reduction in the number of staff receiving them due to retirements and resignations. This has significantly impacted the figures around mean and median bonus pay, as previously females had a higher mean average than males, with a fairly small median pay gap (in favour of males), whereas there is now a significant mean and median bonus pay gap, which favours males. In common with previous years, a significantly larger number of males than females received CEAs.

Proportion of Males Receiving a Bonus Payment and Proportion of Females Receiving a Bonus Payment

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	12	3933	0.31%
Male	43	876	4.91%

A significantly larger number of males than females are paid CEAs. There are also much smaller numbers of males than females in the overall workforce, so the proportion of males receiving bonus payments is significantly higher than the proportion of females receiving bonus payments.

Taking into account the numbers of male and female medical staff within the Consultant workforce (approximately 61% of the consultant workforce are male, and this proportion has seen a steady slow decline over recent years), male consultants are significantly more likely than female to be paid CEAs. CEAs have to be applied for, and nationally, male consultants are significantly more likely than female consultants to apply for CEAs.

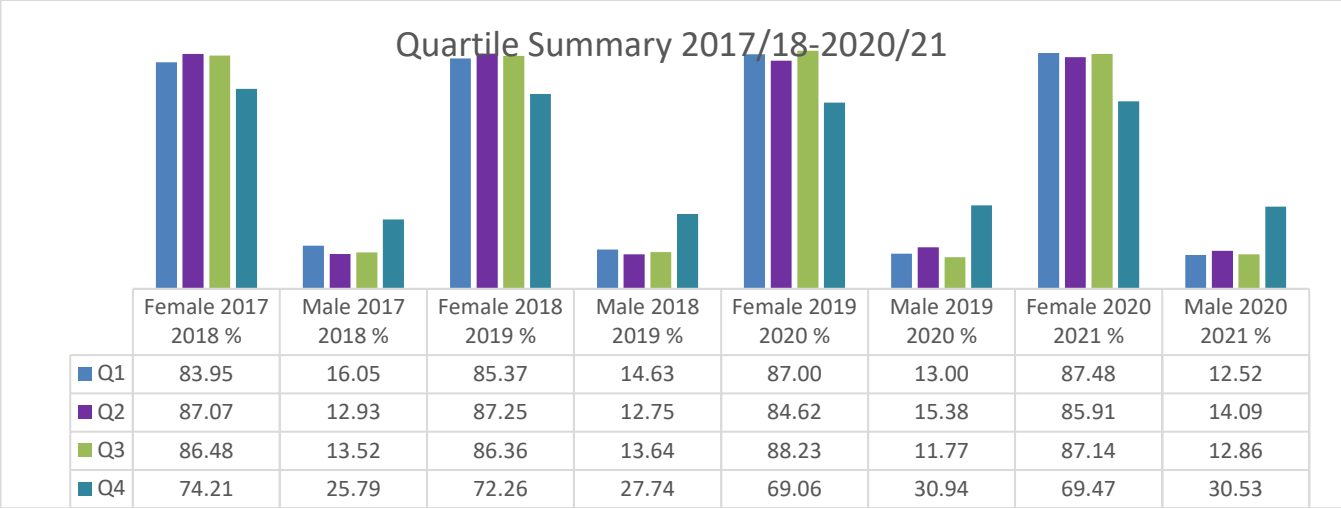
Current CEAs are retained once awarded; however the CEA process is changing, and Trusts are now required to develop processes for Local Clinical Excellence Awards (LCEAs), which will have to be reapplied for periodically. In designing and implementing a process for LCEAs, the Trust will devote time, energy and effort into devising an equitable process that supports and encourages female consultants to apply for awards. All elements of the process will be subjected to a rigorous Equality Impact Assessment, and the results of awards rounds will be very closely monitored.

Proportion of Males and Females in each Quartile Pay Band

Quartile 1 - lowest paid and quartile 4 - highest paid employees.

Quartile	Female	Male	Female %	Male %
1	999	143	87.48%	12.52%
2	982	161	85.91%	14.09%
3	996	147	87.14%	12.86%
4	794	349	69.47%	30.53%

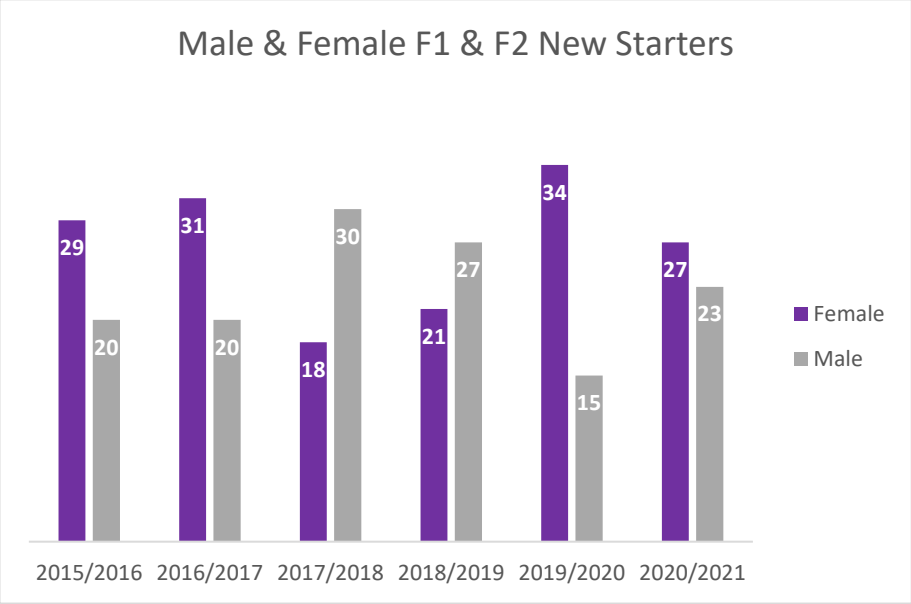
The graph below shows a slight increase in the proportion of staff within quartile 4 who are female over the last year, following a steady decline over the previous three years.



	Female 2017 2018 %	Male 2017 2018 %	Female 2018 2019 %	Male 2018 2019 %	Female 2019 2020 %	Male 2019 2020 %	Female 2020 2021 %	Male 2020 2021 %
Q1	83.95	16.05	85.37	14.63	87.00	13.00	87.48	12.52
Q2	87.07	12.93	87.25	12.75	84.62	15.38	85.91	14.09
Q3	86.48	13.52	86.36	13.64	88.23	11.77	87.14	12.86
Q4	74.21	25.79	72.26	27.74	69.06	30.94	69.47	30.53

The data shows that statistically the Trust pays the male workforce more than the female workforce. After further analysis, this is believed to be partly as a result of the highest earners being within the medical workforce, which is a predominantly male workforce. It takes up to 14 years of under and postgraduate training for individuals to achieve the highest grade of consultant and a further 20 years to achieve the top of the consultant salary scale.

The table below shows number of female and male trainee Foundation Years 1 and 2 new starters for all years since 2015/2016. Over the period, there have been 160 female new starters within this group, compared to 135 male new starters. Coupled with long-term trends showing increased numbers of female medical students, it is likely that the gender balance of the medical workforce will shift over time, however this may be significantly influenced by the availability or otherwise of flexible working opportunities within hospital medical posts.



Comparison of hourly pay rates amongst medical and non-medical staff groups

Non-medical

Non-Medical Average & Median Hourly Rates

Gender	Mean Hourly Rate	*Median Hourly Rate
Female	£15.12	£13.82
Male	£16.80	£14.68
Difference	£1.67	£0.86
Pay Gap %	9.96%	5.86%

The gender pay gap amongst non-medical staff is relatively small compared to the Trust's overall gender pay gap, although the mean gender pay gap for non-medical staff has increased slightly over the last year. The median pay gap for non-medical staff has increased by over 2.5 percentage points, equating to an additional 40p per hour (for a full-time staff member, this would equate to an additional median pay gap of £782.13 per year and a total median pay gap of £1681.58 per year).

Medical and dental

Gender	Mean Hourly Rate	*Median Hourly Rate
Female	£34.25	£31.09
Male	£39.96	£41.81
Difference	£5.71	£10.72
Pay Gap %	14.30%	25.64%

There is a significant pay gap within the medical and dental workforce. Over the last year, the mean hourly pay gap within medical workforce has decreased slightly, whilst the median has increased slightly.

Comparison of proportion of medical and non-medical staff in each pay quartile

Non-medical

Non Medical No. of employees
Q1 = Low, Q4 = High

Quartile	Female	Male	Female %	Male %
1	998	143	87.47%	12.53%
2	978	155	86.32%	13.68%
3	969	132	88.01%	11.99%
4	649	164	79.83%	20.17%

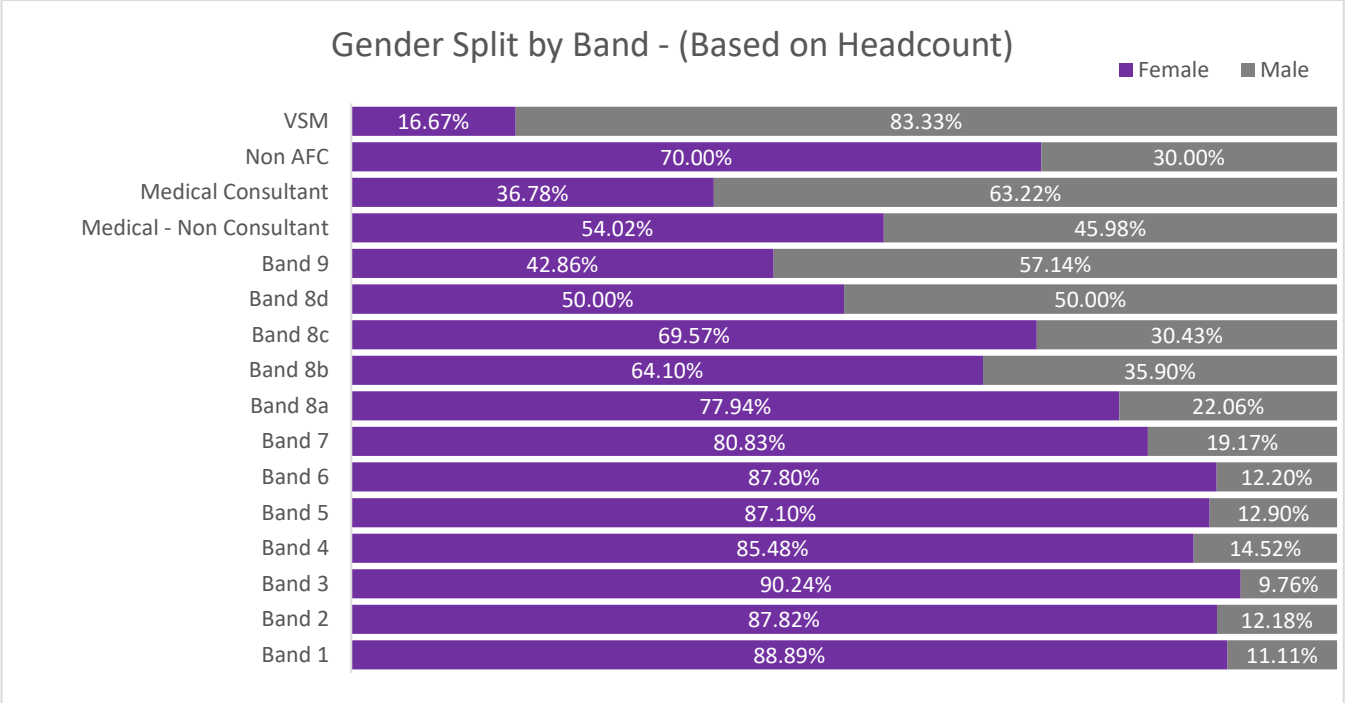
Medical

Medical No. of employees
Q1 = Low, Q4 = High

Quartile	Female	Male	Female %	Male %
1	1	0	100.00%	0.00%
2	4	6	40.00%	60.00%
3	27	15	64.29%	35.71%
4	145	185	43.94%	56.06%

Over the last year, there has been a significant increase in the number of medical staff within Quartile 3 who are male (from 5 to 15). There has been a slight increase (3) in the number of male medical staff in Quartile 4, and a bigger increase (8) in the number of female medical staff in Q4.

Gender split by pay band



Gender pay gap by staff group

Staff Group	Headcount		Pay Gap
	Female	Male	
Add Prof Scientific & Technic	99	32	17.04%
Additional Clinical Services	882	94	5.93%
Administrative & Clerical	777	164	43.84%
Allied Health Professionals	308	79	13.64%
Estates & Ancillary	228	103	40.64%
Healthcare Scientists	74	37	16.50%
Medical & Dental	177	206	24.26%
Nursing & Midwifery	1222	85	12.41%
Students	4	0	0

The largest pay gaps are within the administrative and clerical and estates and ancillary staff groups.

Suggestions for action

Whilst many of the factors underlying the gender pay gap are societal, rather than organisational, the Trust Executive Team have agreed to implement the following suggested actions. These will be progressed via the Operational Workforce Group and relevant steering groups:

- Reviewing person specifications to ensure that criteria listed as essential are genuinely essential (research has shown that women are less likely to apply for jobs where they do not meet every item on the person specification than men)
- Reviewing and equality impact assessing existing scrutiny arrangements for job re-gradings, job evaluation, recruitment and retention premia, accelerated pay progression etc.
- Reviewing and de-biasing recruitment processes. A first step could be to begin monitoring interview panel composition, and prevent the use of all-male interview panels.
- Ensuring that flexible working opportunities are available at every level of the organisation and that flexible working is actively promoted and role-modelled.

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P76/22
Report	**National, Integrated Care System and Integrated Care Partnership Report**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B11, B12
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: • The Ockenden report into maternity care at Shrewsbury and Telford NHS Trust was published and outlined serious failing within the service. • The country moved further into the 'living with COVID' phase with the removal of free mass testing and the requirement for symptomatic people to isolate moved to a 'personal judgement' approach. • Guidance was published which outlined that all Integrated Care Systems must break even in 2022/23. This will be a significant challenge nationally. • A place development programme, provided through NHS England, is taking place across Rotherham as part of the programme to support the ICS and place leadership to deliver the best value population health segments in specific neighbourhoods.
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	N/A
Recommendations	It is recommended that the Board note the content of this paper
Appendices	N/A

1. Introduction

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

2. National Update

2.1. Sir Andrew Morris, the former Chief Executive Officer of Frimley Health Foundation Trust and current NHS Improvement non-executive director will become the joint Deputy Chair of NHS England when it takes over the powers of NHS Improvement later this year.

2.2. The report into maternity practices at Shrewsbury and Telford NHS Trust (SaTH) led by Donna Ockenden has been published. It outlined 'catastrophic' failures at SaTH which may have led to the death of more than 200 babies, 9 mothers and left other infants with life-changing injuries. Among the key findings was a culture where mistakes were not learnt from, parents not listened to, a lack of transparency and honest when mistakes were found, a culture of bullying amongst staff and a discouragement of caesarean sections.

2.3. The country moved into its next phase of its 'living with COVID' plan with the end of free mass testing and a move to 'personal judgement' for people who have COVID symptoms and the need to self-isolate coming into place on the 1st April. However COVID has continued to have an impact on health services with the Trust experiencing a significant and sustained peak of over a 100 COVID positive patients through late March and early April

3. South Yorkshire & Bassetlaw Integrated Care System (SYB ICS)

3.0. Guidance published by NHSE/I at the end of March included a requirement for all ICS' to breakeven for 2022/23. During April, members of the SYBICS have been developing and reviewing financial plans with a view to submitting final plans by the 28th April.

3.1. SYBICS celebrated their 'finalist' position at the HSJ partnership awards for their staffing solution. This was in partnership with NHS Professionals International around the work undertaken for International Recruitment of which the Trust played an integral role.

3.2. The following people have been appointed to the Integrated Care Board:

- Cathy Winfield MBE has been appointed to the position of Chief Nursing Officer.
- Chris Edwards has been appointed to the position of Place Director for Rotherham and SYICB Deputy Chief Executive.
- Christine Joy has been appointed to the position of Chief People Officer.
- Dr David Crichton has been appointed to the position of Chief Medical Officer.
- Lee Outhwaite has been appointed to the position of Chief Financial Officer.
- Will Cleary-Gray has been appointed to the position of Executive Director of Strategy and Partnerships.

4. Rotherham Integrated Care Partnership (ICP)

4.1. The Trust is working with Thomas Rotherham College as a partner to understand what careers engagement and work experience is required by pupils to help them make a choice to follow a path into health and social care. The data produced from an initial survey will be used across Rotherham Place to plan careers engagement to increase update in young adults wanting to work in the Trust or partners across Rotherham.

4.2. Rotherham had received an offer from NHS England to be part of a programme to support ICS and Place Leaders across regions to deliver the best value to population health segments in specific neighbourhoods.

The programme consists of four modules:

- Module A – Ambition, Vision and Leadership
- Module B – Governance, Functions and Finance
- Module C – Public Health Management & Integrated Transformation
- Module D – Digital Data and Analytics

Members agreed to take part in the programme which supported our direction of travel and acknowledged that leadership level input will be required from Place Board membership.

The programme commenced on Wednesday 28 March and will take place over the next few months ending in July.

4.3. The Place Board approved the Prevention and Health Inequalities Strategy and Action Plan, noting the five key priorities are:

- Strengthen our understanding of health inequalities
- Develop the healthy lifestyles prevention pathway
- Support the prevention and early diagnosis of chronic conditions
- Tackle clinical variation and promote equity of access and care
- Harness partners' roles as anchor institutions

The strategy will run to 2025 and the action plan will be reviewed and updated by the Prevention and Health Inequalities Enabler Group on an annual basis.

Michael Wright
Deputy Chief Executive
May 2022

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P77/22
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. 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	This paper presents a high level update on progress at the end of the year against each of the 2021-22 Operational Plan priorities and reports, by exception, any areas of concern with recommendations for continuance into next year's planning cycle where applicable. The Highlight Reports attached at Appendix 1 incorporate two (BRAG) Blue/Red/Amber/Green indicators – 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) during the period February to March 2022. At the end of Month 12, two of the ten programmes are BRAG rated blue (completed/closed) one is BRAG rated green (on plan), six are rag rated amber (behind plan) and one is BRAG rated red (significantly behind plan). There has been a continued risk to delivery of the programmes of work throughout the year as a result of our response to the ongoing COVID-19 pandemic and the changing requirements of the Department of Health, NHS England / Improvement and our system partners. Without the impact of the pandemic a much greater level of progress would have been made in delivery of the projects and consequently a higher number of projects would have successfully completed. Progress has, however, been overseen throughout the year by Board Assurance Committees for Quality, People and Finance and Performance through bi-monthly reporting. Only those programmes that are BRAG rated green would have full assurance from their associated Committees on delivery. Amber BRAG status denotes limited assurance, subsequently Red BRAG status renders the programme without assurance due to significant slippage from plan and

	any perceived ability to achieve its objectives and realisation of benefit metrics during the reporting period. An update on the year end position regarding overall achievement of objectives, milestones and benefit metrics for each programme along with the closure of risks and issues is summarised in the supplementary 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 April 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 and benefit metrics.
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 (February to March 2022)

1.0 Introduction

1.1. The Operational Plan for 2021/22 was 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 have been supported by ten operational programmes that set out to deliver the organisational objectives for the Trust during the 12 months ending March 2022.

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 March 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 delivery and monitoring of the programmes has utilised a standardised Highlight Report (see Appendix 1) throughout the year so that the Trust can maintain a clear line of sight on progress.

2.3 The following tables provide the summary position as at Months 10 and 11 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	Covid-19 mandatory vaccination programmed was revoked on 15th March. Sheffield Teaching hospital occupational health services contract commenced on 1st March.	Green

Programme	Scope	Summary Position	Status
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	Programme closed	**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	The updated Quality Strategy will not be presented to Trust Board until the business case for the proposed Quality Faculty is signed off in the new financial year. Four new quality improvement projects have started implementation.	**Amber**
02.2 Learning from Deaths (Executive Medical Director)	Embed effective learning from deaths practices and deliver improved mortality rate	The Hospital Standardised Mortality Ratio score has consistently reduced, standing at 107.0 (November 2021 data) at the end of the year. The Summary Hospital Mortality Indicator (SHMI) (November 2021 data) has been recorded as "within the expected range at 107.71. Clinical coding now more accurately reflects our patient cohort and the standard of care provided. Governance arrangements, reporting and associated learning from deaths have continued to improve.	**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 activity has fallen behind 2019-20 levels. Number of patients waiting 52 weeks has increased.	**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	Feedback from participants in the Team at the Top leadership programme has been positive. Key elements of the original specification will be factored into next year's bid to locate a new provider.	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	Trust branding and marketing for consultant vacancies will be enhanced through the new contract with the British Medical Journal. Three new consultants are on track to commence in Urgent and Emergency care later this year.	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 command centre is now established with all digital requirements in place. Best practice discharge solutions are partly in place.	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	The outcome of the Same Day Emergency Care SDEC business case has not been decided. The preferred frailty pathway and operating model has not been finalised	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 April 2022 the People Committee, Quality Committee and Finance and Performance Committee considered reports on progress in all areas and made recommendations for further action as deemed applicable.

4.0 Quality Committee

4.1 **The Standards of Care and Quality Improvement Programme** has remained in green/amber status throughout this year and, with the exception of formally launching the revised Quality Strategy, has delivered on the trusts priority entitled "Focus on the Fundamentals of Care" as agreed at Trust Board in June 2021.

4.2 A summary of the programme delivery up to the end of March 2022 is provided below:

- Objectives met 75%
- Milestones achieved 75%
- Metrics achieved target 80%
- Risks Closed 100%

4.3 The positive impact of the programme on standards of patient care is evidenced largely through the work undertaken by the Quality Matrons and the five Enhanced patient Care through Continued Quality (EPIQ) projects which commenced this year. Four new projects including sepsis, champion workshops, band 6 leadership programme and safety huddles will continue into next year, some of which will be supported by the NHS Improvement Academy. This work will lead to further benefits realisation around the provision of clinically effective and reliable care, informed by best practice.

4.4 To continue the positive outcomes from this year's work and achieve longer term benefits particularly in relation to the requirement to improve our CQC rating, the trust will progress its proposal to establish a Quality Improvement Faculty, starting with a business case presentation to Trust board early in the new financial year. The Quality Faculty will further cultivate improvement values across the trust and in doing so ensure that staff are equipped with the appropriate tools and techniques to bring their ideas to life as well as applying a consistent approach to quality improvement across the board.

4.5 **The Learning from Deaths Programme** has completed the reporting period in green rag status and has shown steady progress during the last twelve months in delivering on the Trust's priority entitled "Focus on the Fundamentals of Care" as agreed at Trust Board in June 2021.

A summary of the programme's delivery up to the end of March 2022 is provided below:-

- Objectives met 100%
- Milestones achieved 100%
- Metrics achieved target 80%
- Risks Closed 100%

4.6 The Learning from Deaths programme completed ahead of plan on all key milestones and due to the significant improvement in Hospital Mortality Ratios Scores (HSMR) and Summary Hospital Mortality indicators (SHMI) has ended the year in a positive position.

4.7 The capture and coding of clinical data has improved significantly and this has directly impacted on the reduction of HSMR and SHMI which are now at their lowest compared to base line twelve months ago. The clinical coding team are now firmly established and have poured resources into supporting clinicians through scheduled education sessions, the introduction of clinical champions and clinical coding education videos and importantly responding as quickly as possible to Dr Foster alerts, engaging with clinicians and undertaking regular audits in order to improve coding practice and learning which can then be translated into improvements in clinical practice and quality of patient care.

4.8 Whilst the Safe and Sound Mortality Group has taken several months to get off the ground it is now firmly established and regularly quorate. The divisional mortality sub groups have suffered a number of set backs, however, during the last year largely due to cancellation of meetings due to site pressures, staffing shortages and COVID.

4.9 The 360 governance audits commissioned by the trust have made recommendations around improvements to the mortality sub groups terms of reference particularly in relation to Medicine. The new Learning from Deaths and Mortality Manager is working closely with the divisions to make the desired changes and monitor progress through the monthly Safe and Sound Mortality Group meetings chaired by the Executive Medical Director.

4.10 The 360 governance re-audit undertaken in January 2022 made further recommendations around internal communication processes between the Medical Examiner and Learning from Deaths Manager to ensure that the divisions receive notifications of death which are recommended for a Structured Judgement Review (SJR). In conjunction with this the process for improving learning from deaths arising from Structured Judgement Reviews is under review. Some Rotherham clinicians attended SJR training provided by the NHS Yorkshire and Humber Improvement Academy. A wider SJR training programme is being agreed as part of a Learning from Deaths improvement plan with NHSI/E. This will promote the quality and consistency of Rotherham's SJRs.

4.11 The Mortality Insights Dashboard will be further developed next year to ensure that data on Medical Examiner scrutinies and completion and outcomes of Structured Judgement Reviews is shared with divisional sub mortality groups. Learning from themes and trends arising from SJRs, Dr Foster alerts and inquests are topics for discussion at the Safe and Sound Mortality Group and the agenda for this meeting is regularly adjusted to ensure that priority topics are covered for discussion and actions delegated and monitored.

4.12 At the Quality Committee meeting held on 27th April there was some discussion around the achievement of objectives and metrics in relation to the Standards of Care and Quality Improvement programme. The Committee were informed that there had been an unexpected delay in receiving the March falls data due to re-validation issues and that, had the information been included on the metrics tracker supplied to the Committee as an appendix to their report, it would have been assigned red BRAG status due to the number of falls which subsequently exceeds target levels as described in the original mandate as : "Reduction in patient falls with harm based on last year's number (relative to activity) by a minimum of 50%". This metric was profiled last year to cover a monthly target of no more than one fall each month in the moderate or higher categories.

4.13 The Chair of the Quality Committee subsequently confirmed approval of the amber rating against delivery of both programmes relating to this committee.

5.0 People Committee

5.1 **The Health and Wellbeing programme** has remained in green rag status throughout the year which is commendable and has delivered the trusts priority as set out in the mandate entitled "Safely Exit the Covid Pandemic" as agreed at Trust Board in June 2021. The purpose of the programme has been to deliver long lasting initiatives that will support people to stay physically and mentally healthy during and after the pandemic and to help people in their recovery by promoting proactive health and wellbeing initiatives. This programme has also supported delivery of the national 21/22 Operational Planning Guidance 'Looking after our people'.

A summary of the programme delivery up to year end is provided below:

- Objectives met 100%
- Milestones achieved 100%
- Metrics achieved target 80%
- Risks Closed 100%

The benefit metrics are affected by the late publication of the national Pulse survey and results are not expected now until quarter one of 2022-23.

5.2 There has also been a slight shortfall in the target to achieve 90% appraisals/health and wellbeing conversations by the end of March. However, on average, uptake is around 80% each month which is positive considering the impact of COVID on staff attendance and individuals' capacity to participate in meetings. The training provided to managers to undertake health and wellbeing conversations is ongoing and following feedback from participants changes will be made next year to the format of the appraisal to ensure that the participant experience is enhanced and continuously improving.

5.3 During February and March the trust was on track to deliver the mandatory COVID-19 vaccination programme in accordance with the national regulations and support was put into place for managers who needed to hold a difficult conversation with staff members who had not received their first jab in line with legal requirements. Whilst the government has now retracted the mandate the trust will continue to offer appropriate flu and COVID-19 vaccinations in a timely way that will provide the best protection to patients, staff and their families. Further campaigns will take place

throughout the year to ensure uptake remains high. The trust has remained in the top two in the region for flu and COVID vaccinations throughout the year.

5.4 In line with the NHS Wellbeing framework the trust continues to provide psychological, physical and emotional support to staff and has introduced several new initiatives through local partnership working and through the installation of a new occupational health service provider which started on 1st March 2022.

5.5 The number of rosters approved within fourty-two days has exceeded target each month this year, however, disappointingly the 2021 staff survey results indicate a low score again in the "we work flexibly" People Promise domain as well as in "morale" with only half of respondents stating they achieve a good work-life balance. The divisions are required to put improvement plans into place in order to turn this outcome around next year and bring about the desired change in culture.

5.6 Learning from this programme and from formal staff feedback/informal listening events will support the development of facilities to deliver the proposed mandate for 2022-23 Operational Plan priorities with the proposed title "Focus on a commitment to workplace wellbeing and compassionate leadership". The trust will look to secure external funding available to continue some if its initiatives which started this year, such as those with a recreational/fun bias e.g. the inter-departmental football league.

5.7 **The Organisational Development Programme** has remained in amber status throughout the year. The original mandate was developed to deliver the trust priority entitled "Empower and Enable Staff" as agreed at trust Board in June 2021.

The programme has delivered the following:

- Objectives met 40%
- Milestones achieved 100%
- Metrics achieved target 50%
- Risks Closed 30%

5.8 The programme set out to deliver ten objectives, however, after a challenging year only 40% have been delivered despite achievement of milestones. The expected outcomes related primarily to the desired changes in leadership behaviours and the resultant effect on improvements in individual and team performance and effectiveness. This also related to integrated performance within the leader's own divisions and wider afield across the trust with a view to ascertaining a real picture of how the divisions currently operate, their challenges and successes as well as areas for continuous improvement.

5.9 The trust secured a suitable provider, namely Fiona Reed Associates to ensure delivery of a bespoke leadership programme entitled "Team at the Top" to support the divisional triumvirate in achieving the programme objectives. However due to inconsistent attendance caused mainly by site pressures and staff absence it has not been possible, having undertaken participant feedback sessions in February/March, to solely attribute the learning taken from the programme to any specific behavioural or service improvement. A specification for a new, far reaching leadership programme has therefore been developed for delivery as part of the proposed 2022-23 operational plan priority "Commit to a focus on Workplace Wellbeing and Compassionate Leadership".

5.10 **The Employer of Choice programme** has remained in amber status for several months of the year due to capacity issues, unforeseen delays in developing the medical and dental recruitment strategy and slower than expected progress in assessing options to explore alternative markets which will improve our employer branding, particularly relating to how we promote the trust as a great place to work.

5.11 Nonetheless despite setbacks, the programme has delivered on the majority of its objectives and milestones which were set out in the original mandate entitled "Empower and Enable Staff to deliver" agreed at trust Board in June 2021. Achievement of metrics and closure of risks has been an ongoing challenge as shown in the results provided below:

- Objectives met 80%
- Milestones achieved 80%
- Metrics achieved target 30%
- Risks Closed 20%

5.12 The desired reduction in locum expenditure has not been achieved again in February and March due to there being no less than seven doctors at any one time required to provide adequate cover across the trust.

However, significant progress has been made in the urgent and emergency care service whereby three consultants have now been appointed and are scheduled to join the team in August. This will reduce locum expenditure next year providing there is no significant rise in medical and dental staff attrition rates. These appointments will impact positively on the medical vacancy metric overall.

5.13 The People Committee held on 22nd April assigned limited assurance due to the amber BRAG status of the Organisational Development and Employer of Choice Programmes.

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.

A summary of the programme's delivery in 2021-22 is provided below:-

- Objectives met 25%
- Milestones achieved 66%
- Metrics achieved target 0%
- Risks Closed 100%

6.2 **The Plan the long-term recovery of Elective Care / Operational Excellence Programme** has remained in amber status during for the majority of this financial year. A summary of the programme's delivery in 2021-22 is provided below:-

- Objectives met 70%
- Milestones achieved 70%
- Metrics achieved target 66%
- Risks Closed 80%

The risk relating to the continuation of COVID and the impact on elective recovery has remained open up to the end of the year. The impact of COVID and the requirement to uphold essential infection control measures has placed an unprecedented strain on resources and staff absence to deliver the programme. Vacancy rates have also remained high.

6.3 **Elective Care** - Despite getting off to a good start earlier this year the national target of 2% of outpatient attendances moving or discharging to patient initiated follow up (PIFU) pathways by March 2022 for at least 5 major outpatient specialties has not been achieved, however, there are three services (Sleep Studies, Ophthalmology, Gastroenterology) currently moving patients on to PIFU pathways with Ear Nose and Throat and General Surgery moving in April. By the end of June three additional services - Urology, Dermatology and Cardiology will be rolled out. The ambition is to implement PIFU across all other specialties to ensure the trust meets the national target of 5% by March 2023. Further activity relating to this work stream will be transferred for delivery as part of 2022-23 Operational Plan priority encompassing outpatient efficiencies that will shorten elective waiting times and improve theatre throughput.

6.4 The Orthopaedic Patient Panel is progressing extremely well with five of the six scheduled monthly meetings having already taken place. The Orthopaedic web page has been modernised and is much improved as a result of patient feedback. A 'holding letter' has been issued to all current Orthopaedic waiting list patients to provide reassurance that they have not been 'forgotten', and to sign-post them to the Orthopaedics web page for further advice and guidance. The patient panel meetings will continue next year on a bi-monthly basis with support from the existing orthopaedic team.

6.5 **Operational Excellence** - Referral to Treatment training courses have been delayed slightly into next year however all training officers have completed full training and are ready to start delivery as soon as the departmental schedules are in place.

6.6 **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

6.7 This programme has remained in amber status for the majority of this financial year. This is evident from the benefit metrics which have not achieved target for several months with four out of six in February/March being reported as red BRAG status. A summary of the programme's delivery in 2021-22 is provided below:-

- Objectives met 75%
- Milestones achieved 80%
- Metrics achieved target 40%
- Risks Closed 50%

6.8 Through the five key work streams the programme set out to deliver "efficient and appropriate discharge arrangements that support optimum flow and in line with best practice and national guidance (Hospital Discharge Service Policy and Operating Model). The establishment of the new digital command centre has achieved this objective in terms of supporting optimisation of patient flow and information management through enhanced IT solutions primarily relating to escalation management and the electronic interface with the Teletracking/portering staff system.

6.9 However, the significant impact of the pandemic on staffing, patient flow and day to day bed management has led to long delays in completing the Integrated Discharge Team process mapping events. The "future state" mapping event is not due to take place until early 2022-23.

6.10 Utilisation of the Discharge Lounge has also been adversely affected by the pandemic, partly due to the continuation of essential infection prevention control measures. However, the purpose and benefits of utilising the Discharge Lounge will continue to be promoted throughout the Trust and Place via video/presentation events such as the recent promotion event that took place on 29th March.

6.11 The work around TTOs (prescriptions to take out) will progress through regular staff training and awareness/feedback events that will cover topics including understanding causes for inaccurate prescribing, expanding teaching across junior doctors as well as Place partners and dealing with common issues raised by staff that prevent timely issuance of TTOs such as faulty IT equipment which ultimately cause unnecessary delays in discharging patients.

6.12 The Ward by Ward programme of improvement has progressed well this year, particularly in Medicine where the division is regularly achieving between 85 and 95% Expected Date of Discharge planning. The programme will continue into next year with Surgery, initially equipping the team with patient information tools. This work will be further enhanced through the development of a Discharge Induction Package which will be delivered next year to relevant new members of staff.

6.13 To celebrate the overall success of the programme and plan the future model an "Admission Avoidance & Discharge Day was held in March. Seventy one people from across health and social care, the voluntary sector and NHS Improvement attended the event and their feedback has been extremely positive. Outputs from the event and further, planned activity will be transferred for delivery as part of next year's Operational Plan priority associated with embedding the necessary actions and ways of working from the discharge priorities identified across Place.

6.14 **The Admission Avoidance Programme** remains in red BRAG status at the end of the year due to the unsuccessful achievement of two key milestones and the impact this has had on achieving the objectives of this programme (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.

A summary of the programme's delivery in 2021-22 is provided below:-

- Objectives met 30%
- Milestones achieved 50%
- Metrics achieved target 100%
- Risks Closed 50%

6.15 The objective to implement an appropriate Same Day Emergency Care service requires a robust business case that will capture the unfunded areas in Medicine as well as the need to expand and enhance the SDEC environment suitable for the high number of patients in need of this service. The Frailty Pilot which completed last year (6 months duration) paved the way for an updated frailty pathway model to be established, however, due to fluctuations in demand for short stay beds and COVID patients requiring medical beds it has not been possible to consistently ring fence beds for frail patients.

6.16 Medical capacity within the Acute Medical Unit and Health Care for Older People is improving and further recruitment will take place in the new financial year. Nonetheless, by the end of March there has been no final agreement reached on the preferred operating model for both SDEC and the frailty pathway albeit the expanded SDEC business case has been reformulated to incorporate unfunded areas in medicine and includes a renewed presentation of the financial case that will offer a sensible, phased approach to implementation in 2022-23.

6.17 The programme has been further progressed during the last six months as part of the Acute Care Transformation Programme (ACT) and its Steering Group led by the Chief Executive. The Steering Group focusses on five key, operational themes with a view to reducing reliance and pressure on emergency services. This will predominantly be achieved through pathway re-design and appropriate streaming to Same Day Emergency Care (SDEC), Acute Surgical Assessment Unit and/or Acute Gynaecological Assessment Unit. Discussions are continuing around the appropriateness of establishing a "right sized" independent frailty unit or to flex frailty services around existing capacity and demand as part of the acute medical assessment function. An options appraisal will be developed in the new financial year and incorporated into the enhanced SDEC business case.

6.18 The programme will therefore be transferred for delivery as part of next year's Operational Plan priority around Acute Care Transformation with a view to implementing sustainable change to delivery of high quality, timely and affordable care.

6.19 At the Finance and Performance Committee meeting held on 27th April, the Committee confirmed assurance on governance and process but were not assured on delivery where milestones and metrics were reported as amber and/or red status.

6.20 The Board of Directors is asked to note the content of this report.

Michael Wright
Deputy Chief Executive
May 2022

Operational Objectives 2021-22

February to March 2022

Appendix 1: Programme Highlight Reports

Board of Directors Meeting

6th May 2022

Operational Plan 21/22 Programme Highlight Report – Feb – Mar 22

The Rotherham NHS Foundation Trust

Programme: O1.1	Health & Well Being (HWB)		
Exec Lead:	Director of Workforce & OD	**Impact**	
SRO:	Deputy Director of HR	People	

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 and Promise guidance :- 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:	Plans in place to ensure that all relevant staff received their first COVID vaccine by 3rd February were cancelled following the national directive to revoke VCOD (Covid-19 mandatory vaccination programme for health and social care staff) on 15th March. In line with the NHS Wellbeing framework the trust continues to provide psychological, physical and emotional support to staff and has introduced new initiatives through local partnership working and new occupational health service provider . Healthy lifestyle opportunities have also been promoted. End user feedback on the format of the appraisal/wellbeing conversation has resulted in amendments that will be operationalised following the relaunch early next year. Despite exceeding the internal target for the number of rosters signed off within 42 days again this period, the 2021 national staff survey results indicate dissatisfaction in the "we work flexibly" People Promise domain with only around half of respondents stating they achieve a good work-life balance. The divisions are required to put improvement plans into place to recover from this position next year.
Activities completed 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 ▪ Train a menopause champion - this will then be linked to an ICS faculty ▪ A number of TRFT colleagues undertaking the ICS Compassionate Leadership Course who will then form an alumni to share good practice.
Activities recommended for completion in 2022/23	▪ Re-launch updated Appraisal/health and wellbeing documentation ▪ Progress action plans arising from the outcomes of the national staff survey results relating to workplace wellbeing and leadership
Key risks to overall delivery	▪ None (final report for 2021-22)

Operational Plan 21/22 Programme Highlight Report –Feb – Mar 22

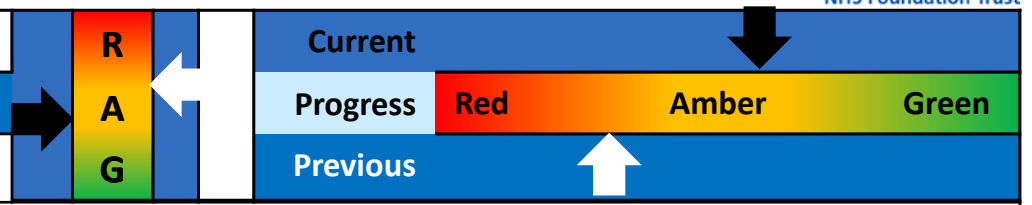
The Rotherham NHS Foundation Trust

Programme: O1.2	Identify new practices to embed		CLOSED	R		**Current**	**CLOSED**
Exec Lead:	Director of Strategy, Planning & Performance	**Impact**		A		**Progress**	**Red / Amber / Green**
SRO:	Assistant Director of Strategy, Planning & Delivery	F&PC		G		**Previous**	**CLOSED**

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.
Activities completed February/March	▪ None – programme closed
Activities planned for completion 2022-23	▪ None – programme closed
Key risks to overall delivery	▪ None
Key issues	▪ None

Operational Plan 21/22 Programme Highlight Report – Feb – Mar 22

Programme: O2.1	Standards of Care & Quality Improvement		
Exec Lead:	Executive Chief Nurse & DIPC	**Impact**	
SRO:	Dep. Chief Nurse (Safety, Safeguarding, Risk Management)	Quality	

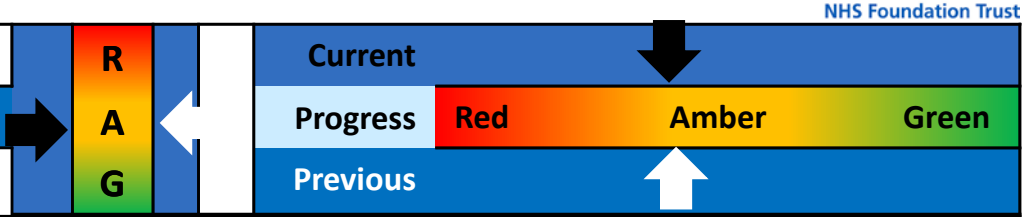


Overview:	Review and relaunch the Safe and Sound Quality Strategy. Articulate and embed agreed standards of care across the organisation consistently. Identify clear quality improvement methodology and resources. Support teams to deliver and embed continuous quality improvement
Summary Position:	The business case for the Quality Improvement faculty will be completed in April 2022. The updated Quality Strategy will not be presented to Trust Board until the outcome of the business case is confirmed. Additional Enhanced Patient Care through Continued Quality (EPIQ) projects started before the end of the year include Sepsis, champions workshops, band 6 leadership programme and safety huddles supported. These will continue into next year with some of the work streams being supported by the Improvement Academy. There has been a commissioned piece of work supported by the Interim Director of Quality Governance Improvement to review the serious incident process and triangulation of learning directly aligned to the patient safety incidence response framework.
Activities completed February/March	• Complete outline quality strategy
Activities planned for completion 2022-23	• Completion of the Quality Improvement Faculty business case.
Key risks to overall delivery	• None
Key issues	• None

Operational Plan 21/22 Programme Highlight Report – Feb - Mar 22

The Rotherham NHS Foundation Trust

Programme: O2.2	Learning from Deaths		
Exec Lead:	Executive Medical Director	**Impact**	
SRO:	Deputy Medical Director for Professional Standards	Quality	



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 10 in the region that falls within the "as expected category" with a Hospital Standardised Mortality Ratio score of 107.0 (November 2021 data). This is a notable reduction from the programme's baseline in June 2021 of 125.6. The Summary Hospital Mortality Indicator (SHMI) (November 2021 data) remains within the expected range at 107.71. The results are indicative of a vast improvement in clinical coding which now more accurately reflects our patient cohort and the standard of care provided. Revision of Structured Judgement Review (SJR) processes and documentation has been completed and improvements identified including arrangements for Sepsis. Changes are to be made to the Mortality Dashboard that will reflect national recommendations. Quality Academy SJR training has been completed in Surgery. An additional Medical Examiner post has been advertised. Promotion of learning from deaths within divisional mortality governance meetings continues through monthly mortality sub-groups. 360 audit has identified standardisation of terms of reference as a key area of focus next year. All divisions continue to provide mortality updates at the monthly Safe and Sound Mortality Group meetings where delegated actions are monitored by the Executive Medical Director.
Activities completed February/March	▪ Launch clinical coding video ▪ Strengthen SJR review process and commence Quality Academy SJR training sessions
Activities planned for completion 2022-23	▪ Complete the 360 Assurance LFD Governance Jan 2022 re-audit agreed action plan points ▪ Engage with the NHSI/E Learning from Deaths Improvement Programme and enact agreed recommendations ▪ Fill Medical Examiner vacancy (this will support the requirement to scrutinize deaths in a community setting) ▪ Enhancements to the Mortality Dashboard - ongoing
Key risks to overall delivery	▪ None – all milestones completed
Key issues	▪ Quoracy at sub group meetings can be challenging (particularly surgery) – to be resolved next year through standardization of terms of reference

Operational Plan 21/22 Programme Highlight Report – Feb – Mar 22

The Rotherham NHS Foundation Trust

Programme: O3	Plan the long term recovery of Elective Care/Operational Excellence		R
Exec Lead:	Chief Operating Officer	**Impact**	A
SRO:	Director of Strategy, Planning and Performance	F&PC	G

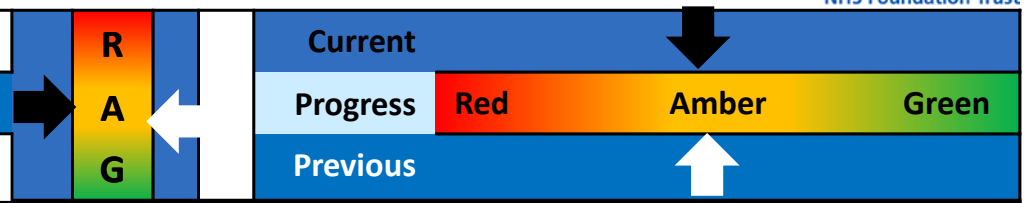
Current ↓ **Progress** — Red — Amber — Green — **Previous** ↑

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 a**ctivity has fallen further behind 19/20 levels, and closure of some of the elective beds in Quarter 3 and Quarter 4 has significantly affected our ability to deliver the recovery programme. The number of 52 week waiters has increased, although the waiting list size has remained relatively consistent. The impact of continued IPC challenges, high levels of sickness relating to the most recent COVID wave, and key vacancies in key areas continue to affect the Trusts recovery success. There is however some good progress in other areas: **PIFU (Patient Initiated Follow Up)** - The national target of 2% of outpatient attendances moving or discharging to PIFU pathways by March 2022 for at least 5 major outpatient specialties, will not be achieved. December data tracks at 0.3%, with 3 services (Sleep Studies, Ophthalmology, Gastro) currently live. Ear, nose and throat and General Surgery have been pushed back to April for go live. Urology, Dermatology and Cardiology will roll out by end June 2022. Expectation is that all other specialties will follow during Quarter 2/Quarter 3 to ensure we meet target of 5% by March 2023. **Orthopaedic Planned Care Citizens Panel (OPCCP)** - 5 of the 6 scheduled monthly meetings have taken place, and several quick wins have been identified. In addition, the Orthopaedic web page has been modernised and improved, and a 'holding letter' issued to all current Orthopaedic waiting list patients, to provide reassurance that they haven't been 'forgotten', and to sign-post them to the Orthopaedics web page. Orthopaedics to continue with the panel as BAU bi-monthly. **Operational Excellence –** The referral to treatment (RTT) training is designed, and internal trainers have been identified and trained. 2 x training courses will be run in April and a further 2 x courses will be run in May.
Activities completed February/March	• PIFU – Gastro Phase 2 live • OPCCP – February and March meetings • OPCCP – Holding letter issued to patients on the Orthopaedic waiting list
Activities planned for completion 2022/23	• PIFU – All other specialities rolled out by Q2/Q3 • RTT training rolled-out across the organisation in April and May
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

Operational Plan 21/22 Programme Highlight Report – Feb – Mar 22

The Rotherham NHS Foundation Trust

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:	The analysis of feedback from participants involved in the Team and the Top leadership development programme has commenced. This will be incorporated into a revised specification next year for potential providers to expand on how their programme will be delivered with a breakdown of the time to be invested by participants and associated costings. The programme will be supported by a new psychometric profile PRINT © and an expansion of the 360 feedback model. Due to ongoing site pressures and availability of senior leaders to attend the development workshops the programme will require full evaluation next year in order to determine its impact on key objectives around improving leadership team behaviours, effective management and safe practice intentions and actions. The measure of success for this programme aligned to the national staff survey results "We are Safe and Healthy" has not achieved target as there is no change in this "culture" measure from last year's result.
Activities completed February/March	▪ Complete participant feedback/diagnostic exercise on Team at the Top provision ▪ Continue development of 2022-23 Organisational Development Programme
Activities planned for completion 2022/23	▪ Finalise new leadership development programme specification and source suitable provider
Key risks to overall delivery	▪ None (Final report for 2021-22)
Key issues	▪ None (Final report for 2021-22)

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 – Feb – Mar 22

The Rotherham NHS Foundation Trust

Programme: O4.2	Employer of Choice		
Exec Lead:	Director of Workforce & OD	**Impact**	**R** / **A** / **G**
SRO:	Head of Medical & Dental Workforce	People	

Current Progress: Red | Amber | Green

Previous

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:	Good progress has been made to review and redraft Consultant Job Descriptions which will enhance the revised consultant job packs. Executives have supported the request to purchase an annual subscription for the British Medical Journal which is aimed at improving our brand as an employer of choice. The Medical and Dental recruitment strategy has not been completed as planned due to awaiting further narrative from divisions. The strategy will therefore be finalised in early 2022/23. Three new Consultants have been appointed in Urgent and Emergency Care.
Activities completed February/March	▪ Present paper to Executives to support request for annual subscription to British Medical Journal (BMJ) (£20,500 per annum) ▪ Request narrative from Divisions to complete strategy documentation ▪ Interview 3 higher level trainees for Consultant vacancies in the Urgent and Emergency Care Centre
Activities planned for completion 2022/23	▪ Continue to review and redraft Consultant Job Descriptions ▪ Complete Medical and Dental Recruitment Strategy
Key risks to overall delivery	▪ None (final report for 2021-22)
Key issues	▪ None (final report for 2021-22)

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 – Feb – Mar 22

The Rotherham NHS Foundation Trust

Programme: 05.1	Best Practice Discharge Processes		
Exec Lead:	Deputy Chief Operating Officer	**Impact**	
SRO:	Deputy Chief Nurse	F&PC	

R A G

Current ↓

Progress Red | Amber | Green

Previous ↑

Overview:	Ensure best practice discharge processes are implemented. Ensure appropriate digital solutions and processes are implemented (to include escalation system, teletracking, command center).
Summary Position:	**Digital solutions** - The Command Centre and Discharge Lounge builds were completed and became operational during Quarter1. The Escalation Wheel has been rolled-out and is in full operational use. The project to build an interface between Meditec and Teletracking is complete, meaning all ward and clinical department teams are able to request porters via Meditec/Teletracking. The next part of the project, to request all patient movement from UECC via Meditec/Teletracking, is progressing with Information Technology. **Discharge Lounge** - Whilst some challenges remain due to under-use of the lounge (including IPC measures restricting use of the lounge), utilisation has improved from the original baseline. Engagement with teams to understand blockages is taking place, and promotion of the lounge is progressing with a key presentation/video tour of the lounge delivered on 29th March to staff from across the Place. **TTOs (prescriptions to take out)** - Pharmacy have delivered pilot training on 3 wards, with an initial positive impact that hasn't been sustained. A presentation was delivered by Pharmacy on 29th March to key staff from across the Place highlighting next steps including a) understanding causes for inaccurate prescribing b) considering expansion of teaching to include all junior doctors and c) working with HI and IT colleagues to address commonly raised issues (e.g. Junior doctors say they are unable to access printers). **IDT (Integrated Discharge Team) Review** - Process mapping, to identify any efficiencies within IDT, has proven difficult to arrange due to ongoing pressure of work within the team and wider system pressures; however, mapping of the 'current state' has now been undertaken and mapping and implementation of the 'future state' will continue through into April/May 23. **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 EDD planning across the division). Medicine also has Discharge Co-ordinators appointed to all wards (except Acute Medical Unit). Improvement work in Surgery has also now started with an initial focus on equipping the team with patient information tools (consistently hitting 90% in Estimated Discharge Date planning). A Discharge Induction Package is under development for new starters. 71 people from health, care, the voluntary sector and NHS England/Improvement attended the **Admission Avoidance & Discharge Day** (face to face and virtually) to celebrate success and plan the future model. Feedback was overwhelmingly positive including increased awareness of partnership working and wellbeing strategies.
Activities completed February/March	▪ Admission Avoidance and Discharge Day 29th March ▪ Discharge Lounge and Pharmacy presentations at the Admission Avoidance and Discharge Day ▪ IDT process mapping of the 'current state'

Operational Plan 21/22 Programme Highlight Report – Feb – Mar 22

The Rotherham NHS Foundation Trust

Programme: 05.2	Admission Avoidance		
Exec Lead:	Chief Operating Officer	**Impact**	
SRO:	General Manager Medicine	F&PC	

RAG

Current			
Progress	**Red**	**Amber**	**Green**
Previous			

Overview:	Implementation of an appropriate SDEC (Same Day Emergency Service) at acute site. Ensure effective ambulatory and frailty pathways are in place.
Summary Position:	**SDEC** - The expanded business case has been reformulated to incorporate unfunded areas in medicine alongside the enhancement and expansion of SDEC, this also includes a renewed presentation of the finances to offer a phased approach to implementation. A further meeting will follow with Executive Team colleagues once this has been completed. **Frailty pathway** - Progress to establish the preferred model will continue into next year through the Acute Care Transformation pathway re-design work. A number of pilots have been planned to test the theories.
Activities completed February/March	▪ Expanded SDEC business case reformulated
Activities planned for completion 2022/23	▪ Expanded and reformulated SDEC business case to be renewed with finances and presented back to the Executive Team ▪ Establish acute frailty pathway
Key risks to overall delivery	▪ Consensus on the future operating model for SDEC cannot currently be reached
Key issues	▪ See above

Blue – Achieved / Completed

Green – On Target / Plan

120 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 – Feb – Mar 22

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**	**Completed**

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 February/ March	▪ None programme closed
Activities planned for completion 2022/23	▪ None programme closed
Key risks to overall delivery	▪ None
Key issues	▪ None

Blue Achieved / Completed

Green On Target / Plan

121 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
06 May 2022

Agenda item	P78/22
Report	**Operational Objectives 2022/23 - Mandates to deliver 5 key priorities**
Executive Lead	Richard Jenkins, Interim 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 plan for 2022/23. 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	Following the publication of the NHS National Planning Guidance 2022/23 and the launch of the Trust's 5 Year Strategy 2022 – 2027 the Trust Board have developed five key priorities for delivery under this year's Operational Plan. The working titles for this year's priorities are listed below and have been specifically linked to the Trust's P-R-O-U-D Strategic Ambitions. Further details can be found in the diagram attached at Appendix 1. 1. **Patients** : Empower our teams to deliver improvements in care 2. **Rotherham** – Ensure equal access to services 3. **Our Partners** – Work together to succeed for our communities 4. **Us** – Commit to a focus on Workplace Wellbeing and Compassionate Leadership 5. **Delivery** – Implement sustainable change to deliver high quality, timely and affordable care These priorities were developed over a number of weeks, following engagement with colleagues through the Trust Senior Leaders meeting, the Executive Team meeting and at a Board Development Session in early April. These contributions were brought together, with consistent ideas identified and prioritised for the coming year. It should be noted that the Trust's Operational Plan is not a mutually exhaustive list of everything the Trust will deliver this year, nor is it designed to encompass all the 'business as usual' activities within our remit. Rather, it is a collection of the biggest priority areas of focus for 2022-23, with a small number of specific objectives identified within each of these areas.

	To ensure clarity over delivery expectations and the programme's success, the production of a set of appropriate mandates is required, in order to set out the main objectives and deliverables for each priority and include measures of success, high level activities and key milestones. These are enclosed in Appendix 2. Executive Leads and Senior Responsible Officers have been assigned to develop the mandates which have been presented for review at the relevant Trust Board Assurance Committees in April. Where the Assurance Committees requested amendment or inclusion of further information, the details have been factored into the final drafts which are attached at Appendix 2. The Strategy, Planning and Delivery team will support the Executive Leads and Senior Responsible Officers in expediting the enabling projects and actions to complete delivery and in doing so will ensure that bi-monthly updates are provided to Board Assurance Committees in June, followed by at the next Board of Directors meeting in July. The Executive Management Team will be sighted in advance of any fundamental changes required to plans or for the purpose of mitigating significant risk to delivery as part of the process of managing change control and exception reporting to Assurance Committees. The expectation is that project administration will be tailored to a minimum where possible and in a way so as to optimise resources available to support delivery of the priorities and to learn from the pandemic in a positive way by empowering staff across the trust to contribute to delivering this year's priorities without feeling over-burdened by bureaucracy.
Due Diligence	The mandates have been presented to People Committee, Quality Committee and Finance and Performance Committee meetings held in April 2022. Comments have been incorporated as appropriate into these final drafts.
Board powers to make this decision	The principal purpose of the Board is to support the timely delivery of the Trust's strategic objectives and annual Operational Plan, whilst being assured as to compliance with appropriate statutory and legislative requirements.
Who, What and When	Individual Executive Directors act as Executive Leads and have designated SROs (Senior Responsible Officers) for each priority to ensure achievement of the Operational Plan and are ultimately responsible for realising the relevant objectives, milestones and benefit metrics.
Recommendations	It is recommended that the Board approves the Operational Plan for 2022-23 with the five priorities as described, and agrees with the details as provided in the enclosed mandates, confirming any actions or additional assurance required as a result of this report.
Appendices	1: Operational Plan 2022-23 – 5 Key Priorities 2. Operational Plan 2022-23 – Proposed Mandates (5 Key Priorities)

Introduction

1.1. The Operational Plan for 2022/23 is built around five key priorities, underpinned by thirteen key enablers as described in the table below.:-

Strategic Ambition/Priority	Mandate Title	Summary of enablers	Executive Lead	Assurance Committee
1.0 Patients	1.1 Empower our teams to deliver improvements in care	1.1(a) Quality Improvement methodology 1.1(b) Quality governance processes and practices 1.1(c) Quality priorities	Chief Nurse	Quality Committee
2.0 Rotherham	2.1 Ensure equal access to services	2.1(a) Reduce Health Inequalities 2.1(b) Start to implement our Green Plan 2.1(c) Enhance digital services for patients and families	Deputy Chief Executive	Finance & Performance Committee
3.0 Our Partners	3.1 Work together to succeed for our Communities	3.1(a) Deliver the new Urgent and Community Response 2-hour standard 3.1(b) Ensure discharge arrangements are highly effective and sustainable	Deputy Chief Executive	Finance & Performance Committee
4.0 Us	4.1 Commit to a focus on Workplace Wellbeing and Compassionate Leadership	4.1(a) Improve staff facilities and increase wellbeing support 4.1(b) Divisional Leadership teams undertake a bespoke leadership development programme	Director of People and Organisation Development	People Committee
5.0 Delivery	5.1 Implement sustainable change to deliver high quality, timely and affordable care	5.1(a) Shorten elective waiting times 5.1(b) Increase use of same day emergency care/shorten waiting times in Urgent and Emergency Care Centre 5.1(c) Implement new systems to better understand the cost of service delivery at patient level	Chief Operating Officer	Finance & Performance Committee

2.0 Trust Board Assurance Committee Feedback and Recommendations

2.1 People Committee

The People Committee held on 22nd April 2022 reviewed the Mandates prepared in relation to Priority 4 and asked for clarification from the Executive Lead on how staff survey results will be used to track the desired change in leadership behaviour and other working practices. The Executive Lead advised that through discussion with Executives a decision had been taken to change the title of the priority from "strong" leadership to "compassionate" leadership which will ensure that learning is focussed on the trusts preferred management style. The impact on the new Leadership Development programme will be measured primarily through evidence gathered from the quarterly staff Pulse survey as well as the national staff survey the results both of which can be influenced during the next five to six months.

The Committee were in agreement that plans to improve workplace wellbeing facilities would be beneficial to staff however their reservations were around whether or not staff would feel able to take time out and away from their work place due to reduced capacity and periods of high escalation.

Feedback from the People Committee has been factored into the attached Mandate to enhance the measures of success and to incorporate the issue around staff availability to take time out in order to feel the benefit of any new relaxation space made available.

2.2 Quality Committee

The Quality Committee held on 27th April reviewed the mandates prepared in relation to Priorities 1 and 2. Feedback was provided by the Non-Executive Directors outside of the meeting regarding Priority 1, with changes made to the mandate as appropriate in discussion with the Executive Lead.

In addition to this detailed feedback, a discussion was held at the Quality Committee meeting around the most appropriate Assurance Committee to maintain oversight of Priority 2, and subsequently, it was agreed with the Chairs of both the Quality Committee and the Finance and Performance Committee, that Priority 2 was more closely aligned with the latter of these two, and therefore this Priority would move to report into the Finance and Performance Committee. Members of the Finance and Performance Committee were therefore given an opportunity to provide feedback on this mandate outside of the meeting forum.

2.3 Finance and Performance Committee

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The Finance Committee held on 27th April reviewed the Mandates prepared in relation to Priorities 3 and 5 and members agreed to support their submission to Board in May. A request to amend the Executive Leads and SROs on two mandates was agreed, and these changes have been made in the mandates for approval at the Board meeting. A few minor comments from members on the mandate content were also incorporated into the mandates outside of the meeting.

3.0 The Board of Directors is asked to note the content of this report and confirm their decision to proceed to implementation of this year's Operational Plan priorities through the mechanisms as described in this report and associated mandates.

Richard Jenkins
Interim Chief Executive
April 2022

The Rotherham NHS Foundation Trust

Appendix 1: Operational Plan Priorities 1 – 5 and Mandates

Priority 1:	Patients	Empower our teams to deliver improvements in the care they strive to provide
Priority 2:	Rotherham	Ensure equal access to Services
Priority 3:	Our Partners	Work together to succeed for our Communities
Priority 4:	Us	Commit to a focus on workplace wellbeing and compassionate leadership
Priority 5:	Delivery	Implement sustainable change to deliver high quality, timely and affordable care

2022-23 Operational Plan Priorities

The Rotherham NHS Foundation Trust

Patients: Empower our teams to deliver improvements in the care they strive to provide

- Implement a **quality improvement** methodology in the organisation
- Embed effective **quality governance** processes and practices across our organisation
- Deliver the Trust **Quality Priorities**

Rotherham: Ensure equal access to services

- Ensure equal access to services and reduce **health inequalities** in Rotherham
- Implement year one of our **Green Plan**
- Enhance our **digital services** to support patients and their families across Rotherham

Our Partners: Work together to succeed for our communities

- Deliver the new **Urgent Community Response** 2-hour standard
- Ensure **discharge arrangements** are highly effective and sustainable through working with partners in Rotherham

Us: Commit to a focus on workplace wellbeing and compassionate leadership

- Improve our staff facilities and increase the **wellbeing support** available to our staff
- Divisional leadership teams will undertake a bespoke **leadership development programme**

Delivery: Implement sustainable change to deliver high quality, timely and affordable care

- **Shorten elective waiting times** for patients, modernise our outpatient services and improve theatre throughput
- Increase the use of **same day emergency care** and shorten waiting times for patients in **UECC**
- Implement new systems to better understand the **costs of our service delivery** at patient level

22/23 OPERATIONAL PLAN

P1 Empower our teams to deliver improvements in care

SCHEME OWNERSHIP	
Executive Lead	Helen Dobson
SRO	Victoria Hazeldine
Reporting Forum	Quality Committee

The Rotherham NHS Foundation Trust

OUTLINE / OVERVIEW

This Priority is aligned to the Trust's Strategic Ambition "Patients" as well as the Trust's Quality Strategy. It seeks to deliver improvements in our care for patients and is divided into the following key areas of work:

1. Agree our organisational approach to quality improvement by evaluating and agreeing the Trust model to be used, launch our new Quality Improvement approach across the Trust and begin implementation. Current options include:

- Model for Improvement a) Sheffield Microsystem Academy b) Institute of Health Care Improvement c) QSIR
- Lean a) Doncaster Quality Improvement b) Virginia Mason Institute
- Six Sigma a) Improvement Academy Bradford b) NHS Improvement Academy Leeds

2. Reset our quality governance expectations and embed revised, effective practices and processes across our organization, restructuring relevant teams as appropriate.

3. Deliver the 9 Quality Priorities.

OBJECTIVES / PURPOSE

Standardise our Quality Improvement approach and implement this in order to improve our quality of care for patients:

- Agree a suitable QI methodology for TRFT
- Commence the establishment a QI Faculty for TRFT
- Commence the implementation of QI practices and processes across TRFT (using agreed methodology)
- Improve on national staff survey results Q3d "I am able to make suggestions to improve the work of my Team/Department and Q3e "I am involved in deciding on changes introduced that affect my work area/team/Department

Revise our internal Quality Governance structures and processes:

- Review of clinical governance and quality assurance structures across TRFT
- Restructure our resources to establish a corporate clinical governance and assurance team at TRFT

Deliver our Quality Priorities:

- This will be out of scope for Operational Plan highlight reporting to Quality Committee (reported directly at agreed frequencies)

SCOPE

IN SCOPE	OUT OF SCOPE
Trust wide.	National staff survey results relating to autonomy and control Question 3f "I am able to make improvements in my area of work" to be postponed to 2023-24 allow sufficient time to embed model for improvement

DELIVERY PLAN

TIME	KEY ACTIVITIES		OUTPUTS / DELIVERABLES / KEY MILESTONES
Q1	<u>Improvement</u> • Complete the business case for Quality Improvement Faculty • Agree Quality Improvement methodology	<u>Governance</u> • Review current infrastructure behind clinical governance and assurance • Establish and agree clinical governance and assurance key roles	• Agreed business cases for QI and Clinical Governance (output and milestone) • Agreed QI methodology (output & methodology) • Key clinical governance and assurance roles agreed (milestone)
Q2	• Recruitment to key posts • Provide key training on agreed methodology (Faculty and other key staff) • Policy for Quality Improvement approved	• Recruitment to key roles • Realignment of existing posts	• Key posts recruited and existing realigned (milestone) • QI methodology training delivered to key staff (output and milestone)
Q3	• Ongoing recruitment to key posts • Identification of Quality Improvement initiatives	• Standardisation of processes including QI policy and guidance • Finalised recruitment to key roles	• Standardised Policy and Guidance (output and milestone) • Key posts recruited (milestone)
Q4	• Ongoing recruitment to key posts • Delivery of Quality Improvement initiatives • Milestone plan for 2023/24 (2 year programme)		• QI initiatives delivered (output and milestone) • 23/23 Milestone Plan (output and milestone)

ANTICIPATED IMPACT

IMPACT	DOMAIN
Improved workforce views on quality of care offered	Workforce
Core quality of care metrics meet expectations from Quality Priorities. To include nutrition & hydration, numbers of falls, numbers of pressure ulcers etc.	Quarterly
Improved Tendable audits (Patient Safety) (positive)	Quality
Improvement in inpatient experience (internal survey)	Quality

MEASUREMENT OF SUCCESS

MEASUREMENT / KPI	TARGET
All Divisions have x number of staff trained on QI methodology	TBD once methodology is agreed
Number of QI projects successfully delivered	5+
Staff survey results relating to autonomy/control, morale and friends/family treated at Trust improve on last year's baseline	Q3d (2021-22 = 69.8%) Q3e (2021-22 = 22.4%) Q21d (2021-22 = 51.5%)
Improvement in inpatient survey scores – internal survey	Overall experience in hospital = 80%+

RISKS

- Funding of the business case
- Unable to recruit to key posts on time
- Unable to support QI priorities for 22/23

ISSUES

- Current multiple methodologies used throughout the Trust
- Staff in post on secondment only that are managing QI initiatives

22/23 OPERATIONAL PLAN

P2 Rotherham – Ensure equal access to services

SCHEME OWNERSHIP	
Executive Lead	Michael Wright, Deputy Chief Executive
SROs	Louise Tuckett, Director of Strategy, Planning & Performance
Reporting Forum	Finance and Performance Committee

The Rotherham NHS Foundation Trust

OUTLINE / OVERVIEW

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society, which lead to inequality of access to services. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

As such, we must ensure that:

- We uphold the requirements set out in the NHS national planning guidance 2022-23 and NHS Long Term plan in relation to health inequalities and service provision
- We take proactive action to improve health equity across Rotherham, building our services to be inclusive and accessible for those that need them and encouraging our colleagues to instill positive health behaviors in themselves and our patients.
- We implement the ambitions set out within our Green Plan and move the organisation towards delivering on the NHS net Zero Challenge reducing the environmental impact of the Trust.
- We advance our digital offer to patients and their families, and ensure this supports our communities to better manage their interactions with us

OBJECTIVES / PURPOSE

- Deliver tailored, patient-centred care, adapted to individual patient needs with a particular focus on patient populations for whom accessing our services is particularly difficult.
- Influence the wider health and social care system to deliver more targeted preventative activities where we identify a need to support patients and staff, with particular focus on our most deprived communities.
- Work with our colleagues to encourage more role modelling of positive health behaviours, and support our staff to access the support they need to do this.
- As an 'Anchor' institution, act as a leader in Rotherham, building healthier communities and offering opportunities that support improved lifestyle choices to our population.
- Implement year one of our Green Plan, continuing the decarbonization of the Trust
- Functionality in Rotherham Health App enhanced, so patients can amend or cancel appointments online
- Prospective parents will be able to interact with maternity services online
- Complete rollout of digital correspondence services

SCOPE

IN SCOPE	OUT OF SCOPE
Health inequalities across the Trust and wider community Existing Rotherham Health App and Patient Hub	Development of entirely new digital tools

DELIVERY PLAN

TIME	KEY ACTIVITIES	OUTPUTS / DELIVERABLES / KEY MILESTONES
Q1	Complete full data driven identification of Health Inequalities across non-elective and elective pathways, with focus on deprivation and ethnicity. Development of the Delivery Plan for the implementation of the Green Plan	Baselines and targets determined to achieve (deliverable/metric): • Reduction in conversion from elective to emergency procedure. • Reduction in elective waiting list by deprivation and ethnicity. • Reduction in frequent attenders to non-elective pathways
Q2	Fully deploy Communication Stations across the Trust to support inclusion for all patients	• Communication stations embedded to include translation materials (milestone) • Delivery Plan agreed (Deliverable) • Impaired hearing materials, learning disability and autism resources (milestone)
Q3	Expansion of health improvement programmes including waiting well/pre-habilitation programme Work with communities/partners to reduce barriers to outpatient access Roll out maternity digital offer so prospective parents can interact directly with us	• Increase in patients/staff referred to QUIT programme (output) • Expansion of QUIT into emergency care/paediatrics (output) • Implementation of waiting well offer (milestone) • Reduction in outpatient DNAs through improved communication with migrant/homeless/non-English speaking communities (deliverable/metric)
Q4	Implement preferred waiting list segmentation model and corresponding tailored patient offers across at least 2 specialties Enhance Rotherham Health App so that patients can cancel and amend appointments online Full rollout of digital correspondence services	• Waiting list segmentation model implemented (milestone)

ANTICIPATED IMPACT

IMPACT	DOMAIN
Increase in Rotherham Health App users	Finance
Equity of access to services for all service users	Quality
Increased opportunity of access to services	Quality
Decarbonisation of the Trust	Quality

MEASUREMENT OF SUCCESS

MEASUREMENT / KPI	TARGET
RTT Admitted Waiting List - total (median) length of wait based on deprivation (deciles 1&2 versus deciles 3+	Sustain or reduce gap from 0.08
Proportion of patients cancelled for clinical reasons by deprivation quintile (12 month rolling)	Reduction from baseline (TBC)
Outpatient DNA rate by deprivation and ethnicity	Reduction from baseline
QUIT - INPATIENT smokers with LOS ≥ 1 who have a Tobacco Treatment Advisor Specialist Assessment as an inpatient or within 5 days of discharge	=>118 per month
Number of Rotherham Health App users	10% increase over year

RISKS	ISSUES
• Lack of engagement from deprived communities across Rotherham. • A further Covid outbreak could reduce opportunity to engage with communities • Capacity of staff to deliver additional work required • Lack of investment available to deliver necessary improvements	

22/23 OPERATIONAL PLAN

P3 Our Partners: Work together to succeed for our communities

SCHEME OWNERSHIP	
Executive Lead	Michael Wright, Deputy Chief Executive
SRO	Sally Kilgariff, Deputy COO
Reporting Forum	Finance and Performance Committee and Rotherham Place Governance Framework

The Rotherham NHS Foundation Trust

OUTLINE / OVERVIEW

The Rotherham Urgent and Community Transformation programme is part of the Rotherham Integrated Health and Social Care plan which aims to support people and families to live independently in the community, with prevention and self-management at the heart of delivery. The Trust is working in partnership with the Rotherham Clinical Commissioning Group, the Council, Primary Care, Mental Health and the Voluntary Sector to develop and deliver more integrated health and care. The current priorities are aligned to the NHS Long Term Plan, Better Care Fund objectives and the Aging Well projects which sit within this. These include the nationally mandated standards to

- Deliver the new **Urgent Community Response** 2-hour standard
- Embed the necessary actions and ways of working from the **discharge priorities** across Place

OBJECTIVES / PURPOSE

To work with partners to develop an affordable 7 day model which supports avoidable admission and timely discharge to the right place providing the right treatment, care and support for individuals. The model will provide choice, taking account of patient and carer wishes whilst meeting the needs of system flow.

Urgent Community Response:
Respond within 2 hours of receipt to urgent community referrals at least 70% of the time by December 2022 providing geographical cover across the borough at minimum 8am to 8pm.
Submit a monthly national data set according to the agreed criteria.

Discharge Priorities:
Early discharge planning and allocation of resource to assess/support individuals in their own home wherever possible
Develop and embed clear protocols, accountability, roles, responsibilities and escalation routes based on home first principles
Acute discharge improvement plan – ward level programme of work to include ward discharge processes including length of stay, right to reside and use of discharge lounge

SCOPE

IN SCOPE	OUT OF SCOPE
Acute and community discharge pathways Admission avoidance pathways and activity in relation to UECC, AMU, ASU and SDEC including frailty where this can result in the patient returning home Health and care intermediate care pathways Commissioned community bed base, therapy provision Care homes where it is the patients normal place of residence	UECC transformation programme SDEC development Acute frailty ward following an unavoidable admission

DELIVERY PLAN		
TIME	**KEY ACTIVITIES**	**OUTPUTS / DELIVERABLES / KEY MILESTONES**
Q1	Place priorities and milestones for 2022-3 to be discussed with partners at Exec place meeting on 27/04/22	
Q2		
Q3		
Q4		

ANTICIPATED IMPACT	
IMPACT	**DOMAIN**
Potential reduction in avoidable admissions	Quality/operational
Reduction in number of surge beds	Operational/finance
Improvement in national discharge measures	Quality/operational /finance

MEASUREMENT OF SUCCESS	
MEASUREMENT / KPI	**TARGET**
National 2 hour urgent response standard met	70%
Improvement in discharge measures including Long length of stay /right to reside, discharge before 5pm & use of discharge lounge. Community bed base occupancy levels (90%)	tbc
Reduced use of community surge bed base	tbc

RISKS	ISSUES
Commissioners are unable to agree a joint risk approach to short term funding resulting in delays to discharge decision making. Mitigation: discussion of proposals are underway Acute and community accountability is not agreed to support the virtual ward. Mitigation: accountability to be agreed and monitored through clinical/project governance Barriers to cross organization/team working cannot be overcome. Mitigation: high level exec lead support / joint design and development work	National funding is reduced to support aging well projects. Mitigation: funding to be clarified by ICS. Virtual ward funding may mitigate impact There is insufficient capacity to support people at home due to recruitment issues and staff sickness. Mitigation: a joint approach to recruitment is being proactively pursued through the Place workforce enabler group

22/23 OPERATIONAL PLAN

P4 Commit to a focus on workplace wellbeing and compassionate leadership

SCHEME OWNERSHIP	
Executive Lead	Steve Ned, Director of Workforce & OD
SRO	Paul Ferrie, Deputy Director of HR
Reporting Forum	People Committee

The Rotherham NHS Foundation Trust

OUTLINE / OVERVIEW

2.1 Workplace Wellbeing - Staff health and wellbeing remains a key area of focus for the Trust as outlined in the People Strategy 2020-2023 Staff Engagement objectives. Wellbeing initiatives implemented last year, particularly building on experience learned through Covid, are set to continue with a view to providing a supportive and holistic approach to staff wellbeing across the trust. Through staff survey results and listening to staff in open discussions about what is important and what effect the workplace has on their overall wellbeing it is apparent that there is a lack of local facilities which would enable staff to take time out from their place of work, not only for refreshment breaks but also to have the option to step into a "calmer" space that will help them re-balance and return to their work location feeling re-energised.

2.2 Compassionate Leadership - The Trust aims for senior leaders within its six divisions to take greater responsibility for the continuous improvement of employee welfare and engagement, communication and performance ownership as well as partnership development and working better together. The investment in a development programme again this year will enable the trust to meet the objectives set out in this mandate and through a formal tender process engage a new provider, building on last year's work provided by Team at the Top.

OBJECTIVES / PURPOSE

- Improve our recreation/wellbeing offer with support from NHS Charities Together Funding
- Improve our day-to-day offer i.e. break out areas, "staff sanctuary" that will provide a safe space for staff to unwind with access to professional support through employee assistance programmes including the SYB Viv-up network.
- Implement a leadership development programme for senior teams that will enhance leadership behaviours and cross divisional working, embed a coaching approach that will empower other team members to improve their performance and effectiveness and allow senior leaders to concentrate on their strategic objectives and operate within the wider healthcare system
- To improve staff engagement

SCOPE

IN SCOPE	OUT OF SCOPE
• Existing facilities located within hospital grounds suitable for health and wellbeing services • NHS Charities Together funding • SYB provision (e.g. Viv-up network) • Senior leaders (all six divisions)	Woodside, community locations

DELIVERY PLAN

TIME	KEY ACTIVITIES	OUTPUTS / DELIVERABLES / KEY MILESTONES
Q1	1. Run staff engagement/listening events 2. Review hospital estate to identify locations for health and wellbeing services 3. Submit application for NHS Charities Together funding for psychological support and inter-divisional sports leagues 4. Identify suitable leadership development programme provider	1. When inventory of estate locations is completed (milestone) 2. When staff engagement sessions completed/feedback analysed (milestone) 2. When Leadership Programme specification is signed off (milestone)
Q2	1. Schedule leadership programme sessions 2. Present Business case to Executives for estates refurbishment/sanctuary location (includes reconfiguration schedule/priorities) 3. Seek expressions of interest from suitable healthcare providers for sessional work	1. When leadership development programme starts (milestone) 2. Draft business case – estates refurbishment (output) 3. When Cohorts 1 and 2 Leadership Programme completes (milestone) 4. When NHS Charities Together funding is in place (Milestone)
Q3	1. Create communication plan (informing staff of timescales etc. on estates reconfiguration plans, Open Days, launch event plans) 2. Continue leadership programme sessions	1. When business case – estates refurbishment is signed off (milestone) 2. When cohorts 3 and 4 Leadership Programme completes (milestone) 3. When wellbeing sessional providers are confirmed (milestone)
Q4	1. Estates refurbishment plans implemented 2. Prepare evaluation/staff feedback following estates refurbishment 3. Prepare evaluation/staff feedback following leadership development programme	1. When all refurbished estate is in place and health and wellbeing locations/sanctuary are being utilised (milestone) 2. When cohorts 5 and 6 Leadership Programme completes (milestone)

ANTICIPATED IMPACT

IMPACT	DOMAIN
Improvement in well led domain (CQC) (positive)	Quality
Improvement in staff engagement (positive)	Workforce
Value for money - staff wellbeing/patient care improves/leaders operating at the level for their grade (positive)	Finance

MEASUREMENT OF SUCCESS

MEASUREMENT / KPI	TARGET
Staff survey results improve in the People Promise – Compassionate Leadership domain (questions – Q9f, Q9g, Q9h, Q9i)	Baseline 2021/22:- Q9f = 67.8%, Q9g = 69.7%, Q9h = 69.1%, Q9i = 65.6%
Senior managers complete leadership programme	100% by Dec 2022
Estates refurbishments implemented within budget	Budget TBC by end Q2
Staff survey results improve in the staff engagement domain (questions Q2a and Q21c)	Baseline 2021/22 = Q2a = 49.4%, Q21c = 54.3%

RISKS	ISSUES
Insufficient capital available to meet estates refurbishment plans	Availability of senior leaders to consistently attend development sessions

22/23 OPERATIONAL PLAN

P5 Delivery: Implement sustainable change to deliver high quality, timely and affordable care

SCHEME OWNERSHIP	
Executive Lead	George Briggs, Chief Operating Officer
SRO	Sally Kilgariff, Deputy COO; Louise Tuckett, Director of Strategy, Planning and Performance; Mark Bloy, Deputy Director of Finance
Reporting Forum	Finance and Performance Committee

NHS
The Rotherham NHS Foundation Trust

OUTLINE / OVERVIEW

Implement a consistent approach to Same Day Emergency Care and take action to relieve the pressure in our UECC:

- Through delivery of the Acute Care Transformation Programme, starting in UECC, we will deliver change and improvement through 5 key work themes; Ways of Working (Storage and Stock Control, Health Informatics and 'If only I could change workstreams'), Patient Experience, Workforce, Leadership and Staff Engagement and Pathway Redesign.

Drive forward our elective recovery, realigning our outpatient capacity and improving the efficiency of our theatres:

Elective recovery is a key priority for the NHS, but there will be significant challenge in meeting the expectations set out within the NHS planning guidance unless we make fundamental changes to our services and ways of working. As well as our day-to-day delivery of the recovery programme, we will need to:

- Restore and improve the efficiency of our theatre pathways, through innovation and improvement including waste reduction where possible
- Realign our Outpatient (OP) capacity, growing our use of tools such as Advice and Guidance and improve our efficiency

Build the sustainability of the organisation through a refreshed approach to delivering efficiencies and by improving our understanding of sustainability of services. This priority is focused on delivering the financial plan and gaining the tools to make long term change, by:

- **Redesigning our approach to transformational efficiency** – implement a greater focus on a longer term, transformational approach to efficiency to deliver our financial savings
- **Sustainability of services** - Undertake the preliminary work to allow for a better and 'live' understanding of the financial viability of our services through patient level information so that we can gain a clear understanding of those that provide a contribution / benchmark well to the organisation and those that do not.

OBJECTIVES / PURPOSE

- Release pressure on UECC services by ensuring care is provided in the right place in, at the right time and by delivering improved ways of working.
- Improve the perception of patients and staff on the provision of emergency and acute services and improve patient experience.
- Develop the UECC workforce plan and improve engagement with colleagues whilst embedding a quality improvement culture.
- Develop a transformational, cross-cutting approach to efficiency
- Implement changes to our OP pathways which result in increased efficiency, such as patient-initiated follow-up and full clinical triage of referrals, and increase our capacity in clinics
- Utilise our new data dashboards to increase theatre throughput, ensuring we are working efficiently with our teams and improving satisfaction at work
- Understand the level of financial contribution to the Trust at service level
- Produce 'live' contribution and benchmarking information on a regular basis (ie monthly) through the use of PLICs, SLR and reference costs

SCOPE

IN SCOPE	OUT OF SCOPE
• UECC, Same Day Emergency Care and Assessments Units for Gynaecology and Surgery. • Digital transformation and Estates work. • Patient and public involvement • Outpatients • Theatres – full theatre pathway	• Existing SDEC business case, IV Pilot. • Any community clinical pathways. • Implementation of the decisions based on the 'live' contribution information / benchmarks produced

DELIVERY PLAN

TIME	KEY ACTIVITIES	OUTPUTS / DELIVERABLES / KEY MILESTONES
Q1	Finalise AGU Business Case Ring-fence interim frailty assessment beds e.g. 'AMU2' UECC Comms and Engagement plan developed Complete initial theatres deep-dive and agree resulting priorities Identify, scope out and agree medium to large scale efficiency schemes	Decision made on AGU Business Case (milestone) ICS SDEC pathways confirmed (milestone) UECC Communications and Engagement plan agreed (milestone) Medium to large scale schemes signed off (milestone)
Q2	Plan phasing of assessment areas (priority frailty) and adapt SDEC business case UECC workforce plan finalised Initiate and commence 3 transformational / medium to large scale schemes	Patient involvement events take place (milestone) UECC workforce plan agreed (milestone) Service specifications reviewed against services provided (milestone)
Q3	Develop assessment unit pathways in line with plan Implement phase 1 of SDEC pathways Discuss initial ' live' report at October CIP Board and agree priorities for next 6 months	Medical staff recruitment confirmed (milestone) Live Contribution Report in place Priorities agreed for better understanding of services (Milestone)
Q4	Continue pathway redesign work Review of services provided by division against service specifications	Frailty unit and AGU pathways established (milestone) Acute Surgical assessment pathways re-designed (milestone) Efficiency /service priorities for 23/24 agreed (Milestone)

ANTICIPATED IMPACT

IMPACT	DOMAIN
Costs associated with Acute Gynaecology Unit and SDEC Business cases	Finance
Positive impact on patient and staff experience in UECC	Quality/Workforce
Reduced pressure and more appropriate utilisation of UECC and efficient, high quality same day emergency care.	Operational
Financial / Quality impact of transformational approach to efficiency / waste programme (Positive)	

MEASUREMENT OF SUCCESS

MEASUREMENT / KPI	TARGET
Improvement in patient and staff survey results	**What by when**
Zero length of stay for patients following re-designed pathways	
Efficiency target delivered in full (by year end)	
22/23 financial plan delivered (year-end)	

RISKS

- Specialties do not buy into the "pull" pathway processes that will circumvent UECC
- Staff recruited for UECC are not appointable / workforce model not affordable
- Capacity of staff to deliver change and improvements
- Not having capacity to deliver Trust transformational schemes (corporate and divisional)
- Lack of clinical / divisional engagement to make efficiency savings and service change
- Agreement on strengthening team / system to be used for PLICs takes longer than plan
- Challenge in identifying income at service level given current contracts

ISSUES

- Lack of shared ownership of acute pathways
- Support services capacity to work with UECC, eg Health Informatics
- Unfilled (hard to fill) vacancies
- Not having capacity within the finance & contracting team to deliver 'live ' contribution information / benchmarking

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P79/22
Report	**Target Operating Model South Yorkshire and Bassetlaw – Pathology Partnership Agreement.**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B2, B10
How does this paper support Trust Values	Together: Colleagues are working together across the Integrated Care System to develop a resilient and efficient joint Pathology Service. Ambitious: An ambition to deliver high quality, innovate laboratory solutions.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	In April 2018 the Trusts across the South Yorkshire and Bassetlaw signed a Memorandum of Understanding to agree to develop a network pathology service and to work together to provide a single pathology service for South Yorkshire and Bassetlaw with the aim of improving sustainability and ensuring that services are as cost effective as possible while maintaining high quality patient care. The Trusts now wish to consolidate pathology services and related services across the South Yorkshire and Bassetlaw Integrated Care System to create a single pathology service. The South Yorkshire and Bassetlaw Clinical Strategy provides a framework and direction for the reconfigured pathology services that will ensure the local region has an innovative and sustainable pathology service, capable of adapting to the changing needs of clinicians and patients. An Outline Business Case that articulated the case for change with a proposed Target Operating Model for Pathology services has been approved by the Boards of the five Trusts within South Yorkshire and Bassetlaw. As a result, a full Business Case is now in development. The services offered will support the national and local clinical priorities and support the needs of the local population. This will be effected through the establishment of a contractual joint venture, through which the pathology services will be delivered, which is in effect, a Partnership. The Partnership Agreement sets out the arrangements of the pathology network, how the Trusts have agreed to contribute resources, collaborate, work together to optimise benefits and efficiencies across the Trusts, and manage and apportion risk and liability on a

	proportionate and equitable basis. The Pathology Agreement is the legal underpinning of the agreed Partnership between the Trusts.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Partnership Agreement has previously been to the Executive Team at the Trust and also the Acute Federation.
Board powers to make this decision	In accordance with the current Standing Financial Instructions and Standing Orders, the Trust Board has the power to consider and make this decision.
Who, What and When (what action is required, who is the lead and when should it be completed?)	If supported, by the Board and also the other Provider Trust Boards within the South Yorkshire Integrated Care System, the partnership agreement will be operationalised.
Recommendations	It is recommended that the Board of Directors approve the Partnership Agreement for Trust sign off and in doing so support the decision for the formal establishment of the SYB Pathology Network allowing the network governance arrangements to be operationalised immediately (subject to Board approval being obtained at all the five Acute Trust members), whilst the development of the Full Business is completed.
Appendices	The Pathology Partnership Agreement

Dated 2021

(1) Barnsley Hospital NHS Foundation Trust

(2) Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

(3) The Rotherham NHS Foundation Trust

(4) Sheffield Children's NHS Foundation Trust

(5) Sheffield Teaching Hospitals NHS Foundation Trust

SYB Pathology Partnership Agreement

Table of contents

Clause heading and number — Page number

THIS AGREEMENT IS MADE THE [ ] DAY OF 2022

BETWEEN:

1. Barnsley Hospital NHS Foundation Trust of Gawber Road, Barnsley, South Yorkshire, S75 2EP **("BHFT")**

2. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust of Armthorpe Rd, Doncaster DN2 5LT **("DBTHFT")**

3. The Rotherham NHS Foundation Trust of Rotherham Hospital, Moorgate Road, Rotherham, S60 2UD **("TRTF")**

4. Sheffield Children's NHS Foundation Trust of Western Bank, Sheffield, South Yorkshire, S10 2TH **("SCFT")**; and

5. Sheffield Teaching Hospitals NHS Foundation Trust of Northern General Hospital, Herries Road, Sheffield, South Yorkshire, S5 7AT **("STHFT")**

together the **"Trusts"**

BACKGROUND

(A) Pathology is a fundamental diagnostic and prognostic service that supports every aspect of patient care pathology services across the South Yorkshire and Bassetlaw Integrated Care System ('**SYB**'). SYB provide a wide range of both routine and specialist services, and offer an extensively recognised portfolio of services and expertise, both nationally and internationally.

(B) The NHS Five Year Forward View and the NHS Long Term Plan, have both identified a need to improve efficiency and productivity across the NHS. In recent years there has also been national reports on pathology services, including Lord Carter's Independent Review of NHS Pathology Services in England (2008), and the Review of Unwarranted Variation in Operational Performance and Productivity in English Acute Trusts (2016). These reports advocate the consolidation of pathology services across England as a means of improving both service quality and cost effectiveness.

(C) Following these reports, National Health Service Improvement ('**NHSI'**) recommended the formation of pathology networks across England with pathology services delivered within each of the networks, on a 'hub and spoke' basis and estimated £200m of savings which could be achieved by implementation of this model. NHSI proposed that a 'North 6' network should be established corresponding to the footprint of SYB. There is an expectation that all 29 networks are established and maturing during the 2024/25 financial year.

(D) In April 2018 the Trusts signed a Memorandum of Understanding to agree to develop a network pathology service and to work together to provide a single pathology service for SYB with the aim of improving sustainability and ensuring that services are as cost effective as possible while maintaining high quality patient care. An appropriate governance structure and expert reference groups were established to consider the model and other possible options for service delivery across SYB. A shared vision was agreed as well as guiding principles against which to evaluate reconfiguration options and a number of key enablers were identified which are critical dependencies for reconfiguration.

(E) A number of options were considered for the organisational form of the SYB network. In January 2020, after seeking legal advice, the Trust decided that STHFT will act as the Host Trust. This organisational form was perceived to be the most cost efficient model from a tax perspective, and would allow staff to remain within the NHS. The expert reference groups have considered the

options for service delivery and have recommended a target operating model with an associated workforce model.

(F) The Trusts now wish to consolidate pathology services and related services across the South Yorkshire and Bassetlaw Integrated Care System to create a single pathology service. The SYB Clinical Strategy provides a framework and direction for the reconfigured pathology services that will ensure the local region has an innovative and sustainable pathology service, capable of adapting to the changing needs of clinicians and patients. The services offered will support the national and local clinical priorities and support the needs of the local population. This will be effected through the establishment of a contractual joint venture, through which the pathology services will be delivered (known as the "**Partnership**").

(G) The Partnership will be hosted by the Partnership Host on behalf of the Trusts. The Trusts shall share control of the Partnership fairly.

(H) This Agreement sets out the Partnership arrangements of the pathology network, how the Trusts have agreed to contribute resources, collaborate, work together to optimise benefits and efficiencies across the Trusts, and manage and apportion risk and liability on a proportionate and equitable basis. This Pathology Agreement is the legal underpinning of the agreed Partnership between the Trusts.

(I) As at the date of this Agreement, the Trusts are preparing to participate in a collaborative Procurement Processes for pathology services and related services, including a pan pathology Managed Service Contract (MSC), a single Laboratory Information Management System (LIMS), Digital Pathology, and logistics services to support the delivery of the Partnership.

(J) The Trusts vision for pathology is to improve lives and safeguard best clinical outcomes by delivering high-quality, innovative laboratory medicine solutions. The agreed guiding principles include making the best use of taxpayers money and to deliver efficiencies from economies of scale and scope.

(K) The Trusts acknowledge and confirm that the way in which the collaboration is to be structured, establishes a cooperation between the Trusts pursuant to Regulation 12(7) of the Public Contracts Regulations 2015 ("PCR") and the Trusts will adhere to the conditions of Regulation 12(7) PCR throughout the term of this Agreement.

IT IS HEREBY AGREED as follows:

1. **DEFINITIONS**

1.1 In this Agreement, the words and expressions defined in SCHEDULE 1 shall have the meanings attached thereto.

1.2 This Agreement shall be interpreted in accordance with the following provisions unless the context requires a different meaning:

1.2.1 unless otherwise specified, references to Clauses and Schedules are to the Clauses of and Schedules to this Agreement;

1.2.2 the Schedules to this Agreement are an integral part of this Agreement and any reference to this Agreement includes a reference to the Schedules; and

1.2.3 where the context requires, words importing the singular shall be construed as importing the plural and vice versa and words importing the masculine shall be construed as importing the feminine or the neuter or vice versa.

1.3 In relation to any conflict and/or inconsistency relating to the provisions of this Agreement, the following shall apply:

1.3.1 for any conflict and/or inconsistency between the Clauses and the Schedules to this Agreement, the Clauses shall take precedence;

1.3.2 for any conflict and/or inconsistency between the Schedules, the following order of precedence shall apply:

(a) this Agreement;

(b) SCHEDULE 2 (Terms of Reference and Trust Delegations);

(c) SCHEDULE 3 (Procurement Resources and Project Delivery Costs)

(d) SCHEDULE 4 (Hosting Obligations and Hosting Standards); and

(e) the order in which all subsequent schedules appear.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 This Agreement sets out the Trusts' intentions to work together during the Term.

2.2 The Trusts acknowledge that this Agreement is between NHS Foundation Trusts and is intended to be legally binding.

2.3 The Trusts confirm to each other that they have and will continue to have all relevant and necessary authority and permissions to participate in this Agreement and any associated documentation in due course.

2.4 The Trusts acknowledge and agree that, as at the date of this Agreement, each Trust has obtained approval in accordance with its internal governance arrangements to enter into this Agreement.

3. TERM

3.1 This Agreement will commence on the Commencement Date and shall continue for the Initial Term unless terminated earlier in accordance with this Agreement.

3.2 On the expiry of the Initial Term this Agreement will expire automatically without notice unless, no later than 12 months before the end of the Initial Term, the Trusts agree in writing that the term of this Agreement will be extended for a further term to be agreed between them (the "**Extended Term**").

4. PARTNERSHIP ARRANGEMENTS

4.1 The Trusts shall work together to deliver:

4.1.1 the Target Operating Model;

4.1.2 each Procurement Process; and

4.1.3 the Pathology Services.

4.2 The Trusts have established the SYB Pathology Partnership Board with representation from each Trust which, subject to Clause 8 and SCHEDULE 2, shall be responsible for the:

4.2.1 oversight and control of the Partnership, including the Project, the Pathology Services, the Partnership Business and this Agreement;

4.2.2 making decisions relating to the Partnership, including but not limited to decisions regarding SYB Pathology Partnership Board Reserved Matters;

4.2.3 appointment of members to and oversight of the SYB Pathology Network Operational Management Team; and

4.2.4 reporting to the Acute Federation Collaborative at a frequency which is to be agreed by the Trusts.

4.3 Each Trust shall provide to the Partnership Host a complete list of Transferring Employees and all information set out in SCHEDULE 8 within the timeframes specified and in any event before the relevant contract Commencement Date.

4.4 During the first six (6) months following the Commencement Date, the Trusts shall develop an agreed list and content of the Partnership Policies in accordance with Clause 8.7.

4.5 The Trusts agree that:

4.5.1 the Transferring Assets and Equipment will transfer to the Partnership Host in accordance with Part 1 of SCHEDULE 7;

4.5.2 the Retained Assets and Equipment will be retained by the Trusts and made available to the Partnership Host in accordance with Part 2 of SCHEDULE 7;

4.5.3 the Transferring Employees will transfer from the Trusts to the Partnership Host in accordance with SCHEDULE 8;

5. THE PARTNERSHIP HOST

5.1 The Trusts agree that STHFT shall be the host of the Partnership (**"Partnership Host"**).

5.2 Subject to Clause 5.3, the Partnership Host shall carry out the Hosting Obligations in accordance with the Hosting Standards.

5.3 Notwithstanding Clause 5.2, the Partnership Host shall not be obliged to carry out or perform any act (or omission) that it reasonably considers:

5.3.1 would conflict with legislation, regulations, the Partnership Host's constitutional documents, the standing orders and standing financial instructions governing the Partnership Host from time to time; or

5.3.2 would put the Partnership Host's business or assets or reputation at risk.

5.4 The costs incurred in fulfilling the Hosting Obligations shall be:

5.4.1 calculated; and

5.4.2 paid;

in accordance with SCHEDULE 4 and any deviation therefrom is a SYB Pathology Partnership Board Reserved Matter and shall require approval by the SYB Pathology Partnership Board.

5.5 STHFT shall remain the Partnership Host until the expiry or early termination of this Agreement unless or until STHFT is unable or unwilling to comply with the requirements or recommendations of a regulatory body in relation to the performance of its obligations as Partnership Host.

5.6 Where STHFT can no longer fulfil its obligations as the Partnership Host, in accordance with Clause 5.5, the remaining Trusts shall agree a replacement Partnership Host which shall provide the Hosting Obligations in accordance with the Hosting Standards from the leaving date of STHFT until this Agreement is terminated in accordance with Clause 3.

6. PROCUREMENT PROCESS

6.1 Each Trust commits to funding its share of the Project Delivery Costs, and providing the Procurement Resources required to successfully deliver each Procurement Process in accordance with SCHEDULE 3.

6.2 The Partnership Host shall manage each Procurement Process on behalf of the Trusts. Each other Trust shall provide such information and assistance to the Partnership Host as may be required by the Partnership Host in order to fulfil its obligations under this Clause 6.2, Clause 5 and SCHEDULE 3. The Partnership Host shall bill the Project Delivery Costs based on actual costs incurred and shall issue invoices to the Trusts on a quarterly basis accompanied by a reconciliation of current Project Delivery Costs. Any significant variance in actual Project Delivery Costs against estimated Project Delivery Costs, which could lead to cost pressures, will be notified to Trusts following discussion at SYB Pathology Partnership Board to assess mitigation options. Any deviation from the Project Delivery Costs is a SYB Pathology Partnership Board Reserved Matter and shall require approval by the SYB Pathology Partnership Board.

6.3 Any other costs relating to each Procurement Process shall be borne by each Trust as they are incurred unless otherwise expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by all Trusts.

7. CONTRACT RESOURCE PROVISION AND CONTRACT COSTS

7.1 Each Trust commits to funding its share of the Contract Costs, and providing the Contract Resources required to ensure compliance with the Partnership Host's obligations under each Contract.

7.2 The Partnership Host shall bill the Contract Costs based on invoices received from the relevant Contract Provider and in accordance with the procedure for invoicing at SCHEDULE 4.

7.3 Each Trust shall ensure that the Contract Costs are paid to the Partnership Host in a timely manner and in accordance with the procedure for payment as set out in SCHEDULE 4.

7.4 Any other costs relating to each Contract shall be borne by each Trust as they are incurred unless otherwise expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by all Trusts.

8. MANAGEMENT AND GOVERNANCE OF THE PARTNERSHIP

8.1 The SYB Pathology Partnership Board is responsible for oversight, control and decision making of the Partnership in accordance with Clause 4.2.

8.2 The SYB Pathology Network Operational Management Team shall report to the SYB Pathology Partnership Board in accordance with SCHEDULE 2.

8.3 Each Trust shall fully support the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team in their roles which are set out in SCHEDULE 2 including:

8.3.1 by way of approval of the OBC/FBC and execution of this Agreement, confirmation that it authorises the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team under their respective Terms of Reference;

8.3.2 participation in the decision making process via each Trust's Board in a timely (as referenced in Schedule 2, Governance Structure, of this Agreement) and appropriate manner in line with the SYB Pathology Partnership Board's, and the SYB Pathology Operational Management Team's requirements. Each Trust has agreed that at the Commencement Date the delegation at Part 3 of SCHEDULE 2 shall be made to Chair/CEO on behalf of Trust Boards of the relevant organisation to enable parallel decision making;

8.3.3 establishment of its own Trust specific project team (as required) to manage the Trust's participation in each Procurement Process and the implementation and transition of the Trust's relevant existing contract during the final phase of the relevant Procurement Process and the commencement of the relevant Contract;

8.3.4 active participation in each Procurement Process when identified by the SYB Pathology Partnership Board or the SYB Pathology Network Operational Management Team as necessary;

8.3.5 adherence to principles of openness and transparency in relation to each Trust;

8.3.6 thorough reviews and checks of final draft documents prior to publication as may be notified as required by the Programme and Project Managers, the SYB Pathology Partnership Board, or the SYB Pathology Operational Management Team;

8.3.7 use of reasonable endeavours to co-operate with and provide assistance to each Trust as requested by the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team;

8.3.8 confirmation of the provisions relating to decision making, quorum and dispute resolution as set out in SCHEDULE 2 and Clause 23 respectively;

8.3.9 confirmation of its support (and any required participation) in respect of the Deliverables (as required by the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team), including but not limited to:

(a) ensuring the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team are fully aware of any relevant policies and procedures with which they must comply;

(b) co-operating and participating in the approval process required by the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team in a timely and transparent manner;

8.3.10 the set up and confirmation of all internal governance procedures; and

8.3.11 ensuring that appointments to the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team are made openly and transparently.

8.4 The Trusts agree that:

8.4.1 neither the SYB Pathology Partnership Board nor the SYB Pathology Operational Management Team shall have any delegated statutory powers or functions of the Trusts;

8.4.2 SYB Pathology Operational Management Team is not a committee of any Trust's board. The SYB Pathology Partnership Board members will be made up of Executive and/or Corporate Directors of the Trusts with delegations as set out at Clause 8.3.2;

8.4.3 nothing in this Agreement shall be construed as a delegation of its statutory powers by any of the Trusts to the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team and nor shall any Trust be deemed to have delegated any powers to the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team;

8.4.4 the operation and decision making of the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team shall be governed by the principles of contract law and not public law;

8.4.5 nothing in this Agreement shall be construed as fettering the statutory powers of the Trusts;

8.4.6 acts and decisions in relation to the Partnership Business shall be taken or made (as the case may be) in the manner described in SCHEDULE 2 and, when a decision has been made in accordance with SCHEDULE 2, then such decision shall bind the Trusts under contract law;

8.4.7 if the Partnership Host fails to act in accordance with the decisions of the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team (in circumstances where such decisions have been made in accordance with SCHEDULE 2), then the Partnership Host shall be in breach of the contractual terms of this Agreement; and

~~8.4.8~~ actions of the Partnership will be taken by the Partnership Host acting on behalf of the Partnership.

8.5 In this Agreement, any reference to a decision or resolution of the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team shall be taken in accordance with SCHEDULE 2 and/or this Agreement (as the context so requires).

8.6 The Trusts acknowledge and agree that they shall comply with all Partnership Host Policies in place from time to time. A list and copies of the Partnership Host Policies that are in place at the Commencement Date have been provided by STHFT to the Trusts prior to the date of this Agreement.

8.7 During the first twelve (12) months following the Commencement Date, the Trusts will develop a list and the content of relevant operational policies that are specific to the Partnership (the "**Partnership Policies**"). The Partnership Policies:

8.7.1 are subject to ratification by the [Policy Ratification Group] (or any equivalent committee or group) of the Partnership Host;

8.7.2 may not contradict the Partnership Host Policies;

8.7.3 shall supplement but not replace the Partnership Host Policies; and

8.7.4 shall include but are not limited to innovation, quality improvement and education and research policies.

8.8 All changes to the Partnership Policies shall be implemented by the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team.

8.9 The SYB Pathology Operational Management Team shall develop an annual Business Plan which shall be approved by the SYB Pathology Partnership Board, The Business Plan will be annexed to this Agreement at each annual review and shall include:

8.9.1 the proposed annual activity (and details of service/pathway developments and how they may be managed) for SYB Pathology;

8.9.2 a financial assessment of the Partnership, including financial modelling assumptions;

8.9.3 agreeing the pricing strategy and the apportionment of costs relating to the Partnership, including any changes to the Project Delivery Costs, the Contract Costs, and the Risk and Gain Share Principles;

8.9.4 financial monitoring and management accounting of the Partnership;

8.9.5 annual planning, schemes of delegation and accounting principles that will apply to the Partnership;

8.9.6 efficiency targets applicable to the Partnership;

8.9.7 quality and improvement targets applicable to the Partnership and any processes required to ensure compliance with these;

8.9.8 contract monitoring arrangements;

8.9.9 facilities and estates arrangements relating to the Partnership;

8.9.10 the purchase of new and/or transfer of existing assets and equipment for use by the Partnership and the management of the assets and equipment used by the Partnership;

8.9.11 arrangements and approvals for the bidding and delivery of additional pathology services to non-Trust organisations;

8.9.12 additional funding or investments (including capital investments) relating to the Partnership; and

8.9.13 requirements and arrangements for the delivery of corporate services relating to the Partnership.

8.10 The Business Plan for the first Financial Year has been adopted by the SYB Pathology Partnership Board.

8.11 Any variations to the Business Plan shall be approved and adopted in writing by the SYB Pathology Partnership Board before 1 April of the Financial Year to which it applies.

8.12 To the extent that a Business Plan is not approved and adopted in any Financial Year, the Business Plan for the preceding Financial Year shall be rolled forward, subject to updating the costs detailed in such Business Plan to reflect indexation by reference to national NHS guidance.

9. REVIEW AND AUDIT OF THE AGREEMENT

9.1 This Agreement shall be reviewed annually by the SYB Pathology Partnership Board.

9.2 The purpose of each review undertaken pursuant to Clause 9.1 is to ensure that the arrangements detailed within this Agreement are operating as envisaged and that each Trust can raise any issues through the SYB Pathology Partnership Board.

9.3 Any proposed changes to this Agreement must be agreed by all Partnership Trust Boards in writing.

10. RESPONSIBILITIES

10.1 Each Trust shall:

10.1.1 at all times, act in good faith towards the other Trusts;

10.1.2 act in a timely manner (including by paying any costs within [30 days] of production of a valid invoice issued by the Partnership Host);

10.1.3 generally do all things necessary, where reasonable and practical to do so, to give effect to the terms of this Agreement and each Contract;

10.1.4 take all reasonable steps to ensure, so far as it is able, that any meeting of the SYB Pathology Partnership Board has the necessary quorum throughout;

10.1.5 share information, experience, skills and work collaboratively with each other to identify solutions, eliminate duplication of effort, mitigate risk and reduce costs; and

10.1.6 adhere to statutory requirements and best practice.

11. LIABILITY

11.1 No Trust limits its liability for:

11.1.1 death or personal injury caused by its negligence;

11.1.2 fraudulent misrepresentation; or

11.1.3 any other liability which cannot be excluded or limited by Applicable Law.

11.2 In consideration of the Hosting Obligations of the Partnership Host the Trusts agree that:

11.2.1 save in the case of the Partnership Host's fraud or wilful default, irrespective of the subject matter (whether in breach of contract, under any indemnity in any agreement, contracts (including each Contract) or arrangements, tort, breach of statute or otherwise), all losses, liabilities, expenses, costs and claims, including liabilities incurred in the event of a termination of any Contract incurred by the Partnership Host in carrying out its role as Partnership Host ("**Liabilities**") should be borne by all Trusts divided by the Trusts in the proportions equivalent to the agreed shares determined by the SYB Pathology Partnership Board as at the date such Liabilities were incurred;

11.2.2 they hereby indemnify and keep indemnified the Partnership Host from and against all unavoidable Liabilities whatsoever resulting from or in connection with its role as Partnership Host, including for the avoidance of doubt, its liability under any Contract; and

11.2.3 each Trust shall, upon request to do so by the Partnership Host in writing, meet its share of any and all unavoidable Liabilities or reimburse the Partnership Host if it has already met such unavoidable Liabilities on demand.

11.3 Subject to Clauses 11.4 and 11.5, each Trust shall be severally liable for costs and/or losses incurred by one or more of the other Trusts to the extent that they arise or result from that Trust's deliberate or negligent acts or omissions and/or breach of this Agreement except to the extent that such costs and/or losses have been caused by any deliberate or negligent act or omission by, or on behalf of, or in accordance with the instructions of the SYB Pathology Partnership Board or the Trust claiming costs and/or losses.

11.4 No Trust shall be liable under Clause 11.3 to the extent that the costs are already covered in the Contract Costs.

11.5 No Trust shall be liable for any Indirect Losses.

11.6 It is agreed that each Trust has reviewed and agreed to the terms of each Contract prior to the Partnership Host entering into each Contract on behalf of the Trusts.

12. TERMINATION

12.1 This Agreement shall terminate:

12.1.1 where a material dispute cannot be resolved pursuant to Clause 23 and all Trusts agree to its termination;

12.1.2 upon the termination of each and every Contract; or

12.1.3 during the Term, if:

(a) a Trust fails to obtain or loses any regulatory consent, licence or approval necessary for its compliance to this Agreement and/or the continuation of this Agreement or incurs any other restriction, the effect of which might reasonably be considered to have a material adverse impact on the continuance of this Agreement;

(b) a Trust commits an illegal act which is relevant to or connected with this Agreement;

(c) a Trust causes significant reputational damage to any other Trust due to a material breach (whether or not capable of remedy); or

(d) a Trust is deemed to be incapable of carrying on its business by a relevant regulatory or professional body, or substantially the whole of its business, including in relation to its ability to award and/or enter into a Contract;

then the other Trusts shall be entitled to immediately terminate the relevant Trust's participation in the Agreement by joint written notice. Such decision by the Trusts shall be approved by the SYB Pathology Partnership Board.

12.2 Where this Agreement is terminated pursuant to Clause 12.1.1 or Clause 12.1.2 then the Trusts shall pay any outstanding proportion of the Project Delivery Costs and any other costs (not included in the foregoing) directly arising pursuant to Clause 12.1.1 or 12.1.2. Each Trust shall be responsible for any outstanding proportion of the Contract Costs owed by it at the time of the Termination as identified by the Partnership Host. Any Dispute between the Trusts regarding whether any such costs should be apportioned shall be referred to the Dispute Resolution Procedure (Clause 23) for resolution without prejudice to the Trusts' obligations to make payments of Contract Costs accrued to the date of termination or expiry as well as any termination payments payable under the relevant Contract on demand by the Partnership Host. Subject to the foregoing, each Trust shall bear their own costs where they fall due.

12.3 If notice is served pursuant to Clause 12.1.3, then the Trust that is in default or that wishes to withdraw or otherwise leaves the Agreement shall pay any outstanding proportion of the Project Delivery Costs and any other costs (not included in the foregoing) directly arising pursuant to Clause 12.1.3. The Trust that is in default or that wishes to withdraw or otherwise leaves the Agreement shall be responsible for any outstanding proportion of the Contract Costs owed by it at the time of the Termination as identified by the Partnership Host. Any Dispute between the Trusts regarding whether any such costs should be apportioned shall be referred to the Dispute Resolution Procedure (Clause 23) for resolution without prejudice to the Trusts' obligations to make payments of Contract Costs accrued to the date of termination or expiry as well as any termination payments payable under the relevant Contract on demand by the Partnership Host. Subject to the foregoing, each Trust shall bear their own costs where they fall due.

12.4 Where the Partnership Host is the Trust that is the subject of Clause 12.1.3 (a) to (e), then the outstanding proportion of the Contract Costs owed at the time of the Termination shall be calculated by the Partnership Host and approved by the SYB Pathology Partnership Board.

13. CONSEQUENCES OF TERMINATION

13.1 On termination of this Agreement, the following Clauses shall continue in force: Responsibilities (Clause 10), Clause 12 (Termination), this Clause 13 (Consequence of Termination), Clause 144 (Confidentiality), Clause 155 (Information Governance and Sharing of Data), Clause 16 (Data Protection), Clause 18 (Bribery and Corruption), Clause 23 (Dispute Resolution), Clause 25 (Status of Agreement), SCHEDULE 1 (Definitions and Interpretation) and SCHEDULE 3 (Procurement Resources and Project Delivery Costs).

13.2 Termination of this Agreement shall not affect any rights, remedies, obligations or liabilities of the Trusts that have accrued up to the date of termination.

13.3 Each Trust shall act reasonably and in good faith with regards to mitigating any adverse consequences on each other to the extent it is reasonable and within the control of each Trust to do so.

14. CONFIDENTIALITY

14.1 Each Trust:

14.1.1 shall treat all Confidential Information belonging to any other Trust or any Contract Provider as confidential and safeguard it accordingly; and

14.1.2 shall not disclose any Confidential Information belonging to any other Trust or any Contract Provider to any other person without the prior written consent of the other Trust or the relevant Contract Provider, except to such persons and to such extent as may be necessary for the performance of this Agreement or except where disclosure is otherwise expressly permitted by the provisions of this Agreement including Applicable Law.

14.2 Each Trust shall take all necessary precautions to ensure that all Confidential Information obtained from any other Trust under or in connection with this Agreement:

14.2.1 is given only to such of the employees and professional advisers or consultants engaged to advise it in connection with this Agreement and as is strictly necessary for the performance of this Agreement;

14.2.2 is, if it is Special Category Data or Personal Data, kept secure in accordance with the requirements of the Data Protection Legislation and only used in accordance with the disclosing Trust's instructions;

14.2.3 is treated as confidential and not disclosed (without written prior consent) or used by any employees or professional advisers or consultants otherwise than for the purposes of performing its obligations under this Agreement.

14.3 The provisions of Clauses 14.1 to 14.3 (inclusive) shall not apply to any Confidential Information received by one Trust from the other which:

14.3.1 is or becomes public knowledge (otherwise than by breach of this Clause 1414 or through act of default on the part of the receiving Trust or the receiving Trust's agents or employees);

14.3.2 the receiving Trust lawfully obtained from a third party who:

(a) lawfully acquired it;

(b) did not derive it directly or indirectly from the disclosing Trust; and

(c) is under no obligation restricting its disclosure;

14.3.3 must be disclosed pursuant to a statutory, legal or parliamentary obligation placed upon the Trust making the disclosure, including any requirements for disclosure pursuant to Clause 1515, or otherwise in accordance with a court order, or the recommendation, notice or decision of a competent authority.

14.4 On termination of this Agreement or the participation of a Trust, each Trust (or in the event that the Agreement is terminated in relation to one Trust, that Trust) shall:

14.4.1 Subject to the Public Records Act 1958 as amended, destroy or return to the other Trusts, as applicable, all documents and materials (and any copies) containing, reflecting, incorporating or based on the other Trusts' Confidential Information;

14.4.2 erase all Confidential Information belonging to the other Trusts from computer and communications systems and devices used by it, including such systems and data storage services provided by third parties (to the extent technically and legally practicable); and

14.4.3 certify in writing to the other Trusts that it has complied with the requirements of this Clause and any relevant provision of each Contract notified to it by the Partnership Host, provided that a recipient Trust may retain documents and materials containing, reflecting, incorporating or based on the Confidential Information of the other Trusts to the extent required by Applicable Laws or any applicable governmental or regulatory authority.

14.5 Except as expressly stated in this Agreement, no Trust makes any express or implied warranty or representation concerning its Confidential Information.

14.6 The Trusts agree that the provisions of this Clause 14 shall continue following expiry or termination for any reason of this Agreement for a period of three (3) years.

15. INFORMATION GOVERNANCE AND SHARING OF DATA

15.1 The Trusts acknowledge that they are subject to the requirements of the FOIA, the EIRs and the Data Protection Legislation and the Trusts shall assist and co-operate with each other to enable them to comply with these requirements.

15.2 The Trusts shall procure that any of their agreed sub-contractors shall:

15.2.1 transfer any Request for Information to the relevant Trust which is the subject of the Request for Information (the "**Disclosing Trust**") as the case may be as soon as practicable after receipt and in any event within two (2) Working Days of receiving that Request for Information;

15.2.2 provide the Disclosing Trust with a copy of all Information in its possession or power in the form that the Disclosing Trust requires as soon as practicable and in any event within five (5) Working Days (or such other period as the Disclosing Trust may specify) of the Disclosing Trust requesting that Information; and

15.2.3 provide all necessary assistance as reasonably requested by the Disclosing Trust to enable it to respond to a Request for Information within the time for compliance set out in the FOIA and regulation 5 of the EIRs.

15.3 Each Trust shall maintain an adequate records management system to enable it to retrieve the Information within the time limits prescribed in the FOIA and/or EIRs as applicable.

15.4 In considering whether Information is exempt from disclosure, the Disclosing Trust shall reasonably consider the nature of such Information and in particular whether any information has been identified by the other Trust as being commercially sensitive; however, for the avoidance of doubt, the Disclosing Trust shall be responsible for determining in its absolute discretion whether the Information should be disclosed in response to a Request for Information.

15.5 Each Trust acknowledges that the other Trusts may, acting in accordance with the Secretary of State for Constitutional Affairs' Code of Practice on the discharge of public authorities' functions under Part 1 of FOIA (issued under section 45 of the FOIA, November 2004), be obliged under the FOIA or the EIR to disclose Information:

15.5.1 without consulting with the other Trusts, or

15.5.2 following consultation with the other Trusts and having taken their views into account.

15.6 The Disclosing Trust agrees to keep the other Trusts fully informed of any FOIA requests received and processed in relation to this Agreement.

15.7 The Trusts shall ensure that all Information produced in the course of this Agreement or relating to this Agreement is retained for disclosure and each Trust shall permit the other to inspect such Information and documents and records containing such Information as that other Trusts may reasonably request from time to time.

15.8 It is agreed that SYB Pathology Partnership Board and any SYB Pathology Operational Management Team minutes and any documents related to each Procurement Process and each Contract may contain commercially sensitive information, and that the Disclosing Trust shall, where reasonably practicable and appropriate, seek the other Trusts' opinion on whether such information is exempt from disclosure in accordance with the provisions of the FOIA or the EIRs save that the decision on disclosure shall remain the sole responsibility of the Disclosing Trust.

15.9 Any costs charged for FOIA requests received and processed in relation to this Agreement will be split proportionately between the Trusts.

16. DATA PROTECTION

16.1 Each Trust shall comply with the Data Protection Legislation. Without prejudice to the foregoing, when a Trust (the "**Processing Trust**") is acting as a Processor by Processing Personal Data on behalf of another Trust (the "**Controlling Trust**") under or in connection with this Agreement, the Processing Trust shall:

16.1.1 only Process Agreement Data in accordance with the instructions of the Controlling Trust as set out in this Agreement or as provided in writing by the Controlling Trust to the Processing Trust from time to time;

16.1.2 not transfer data outside of the UK; and

16.1.3 assist and fully co-operate with the Controlling Trust as requested by the Controlling Trust from time to time to ensure the Controlling Trust's compliance with its obligations under the Data Protection Legislation which shall include, but not be limited to:

(a) completing and reviewing data protection impact assessments;

(b) implementing measures to mitigate against any data protection risks; and

(c) implementing such technical and organisational measures to enable the Controlling Trust to respond to requests from Data Subjects exercising their rights under the Data Protection Legislation.

16.2 The Processing Trust shall notify the Controlling Trust promptly (but in any event within 24 hours) should it:

16.2.1 be under a legal obligation to Process the Agreement Data, other than under the instructions of the Controlling Trust, in which case it shall inform the Controlling Trust of the legal obligation, unless the law prohibits such information being shared on important grounds of public interest; and

16.2.2 become aware that in following the instructions of the Controlling Trust, it shall be breaching Data Protection Legislation.

16.3 When Processing Agreement Data under this Agreement the Processing Trust shall take all necessary technical and organisational precautions and measures to preserve the confidentiality and integrity of Agreement Data and prevent any unlawful Processing or disclosure, taking into account the state of the art, the costs of implementation, the nature, scope, context and purposes of Processing as well as the risk of varying likelihood and severity for the rights and freedoms of the Data Subjects. These shall include, but not be limited to:

16.3.1 encrypting the Agreement Data stored on any mobile media or transmitted over public or wireless networks;

16.3.2 implementing and maintaining business continuity, disaster recovery and other relevant policies and procedures to ensure:

(a) the confidentiality, integrity, availability and resilience of Processing systems and services;

(b) the availability and access to Agreement Data in a timely manner in the event of a physical or technical incident;

(c) that all employees and contractors who are involved in the Processing of Agreement Data are trained in the policies and procedures set out in Clause 16.3 and are under contractual or statutory obligations of confidentiality concerning Agreement Data; and

16.3.3 pseudonymising the Agreement Data on request by the Controlling Trust,

(the "**Security Measures**").

16.4 The Security Measures shall be regularly tested by the Processing Trust to assess the effectiveness of the measures in ensuring the security, confidentiality, integrity, availability and resilience of the Agreement Data and shall maintain records of the testing.

16.5 The Processing Trust shall notify the Controlling Trust promptly (and in any event no later than 24 hours of discovery) if it becomes aware of any actual, suspected or threatened unauthorised exposure, access, disclosure, Processing, use, communication, deletion, revision, encryption, reproduction or transmission of any component of the Agreement Data, unauthorised access or attempted access or apparent attempted access (physical or otherwise) to the Agreement Data or any loss of, damage to, corruption of or destruction of such Personal Data ("**Security Incident**").

16.6 The notification in Clause 16.5 shall include:

16.6.1 the nature of the breach, including the categories and approximate number of Data Subjects and records concerned;

16.6.2 the contact at the Processing Trust who will liaise with the Controlling Trust concerning the breach; and

16.6.3 the remediation measures being taken to mitigate and contain the breach.

16.7 The Processing Trust shall not provide any third party with access to Agreement Data or sub-contract any of its obligations under this Agreement without the prior written approval of the Controlling Trust. Where approval has been granted by the Controlling Trust to the Processing Trust pursuant to this Clause 16.7, the Processing Trust shall:

16.7.1 undertake due diligence on the sub-contractor equivalent to the due diligence undertaken on the Processing Trust by the Controlling Trust under this Agreement;

16.7.2 put in place contractual data processing provisions equivalent to those in place between the Processing Trust and the Controlling Trust under this Agreement; and

16.7.3 remain liable for the Processing activities of such sub-contractor.

16.8 The Processing Trust shall provide all necessary information and assistance to the Controlling Trust in order for the Controlling Trust to verify the Processing Trust's compliance with its obligations under this Agreement and the Data Protection Legislation including:

16.8.1 allowing the Controlling Trust and its advisors to inspect and make copies of the records required under this Clause 16.8; and

16.8.2 allowing access to Processing Trust premises on reasonable notice and provide all reasonable assistance to the Controlling Trust to enable the Controlling Trust to audit the Processing Trust's compliance with the Security Measures.

16.9 Unless required by law, the Processing Trust shall, upon termination or earlier expiry of the Agreement for whatever reason, at the option of the Controlling Trust, either securely delete or return all Agreement Data to the Controlling Trust. If required by law to retain a copy, the Processing Trust shall inform the Controlling Trust what it is retaining and the legal reason why it needs to be retained.

16.10 The Trusts agree to use all reasonable efforts to assist each other to comply with the Data Protection Legislation. This includes (but is not limited to) the Trusts providing each other with reasonable assistance in complying with Data Subject access requests served on an Trust under the Data Protection Legislation and always consulting with each other prior to the disclosure by any Trust of any Personal Data in relation to such requests.

16.11 The provisions of this Clause shall apply during the continuance of the Agreement and indefinitely after its expiry or termination.

Agency under each Contract

16.12 The Trusts acknowledge that the Partnership Host will act as an agent on behalf of the Trusts under each Contract in respect of their obligations as Controllers. In recognition of this arrangement the Trusts agree to follow the provisions of SCHEDULE 5.

16.13 In the event that the agency position is deemed unlawful by a competent authority, the Trusts will, without undue delay, and as soon as reasonably practicable, enter into data

processing agreements with the relevant Contract Provider [on the same terms as those set out in the relevant Contract.]

17. **FORCE MAJEURE**

17.1 If an Event of Force Majeure occurs, the affected Trust must:

17.1.1 take all reasonable steps to mitigate the consequences of that event;

17.1.2 resume performance of its obligations as soon as practicable; and

17.1.3 use all reasonable efforts to remedy its failure to perform its obligations under this Agreement.

17.2 The affected Trust must notify the other Trusts immediately when it becomes aware of the Event of Force Majeure, giving detail of the Event of Force Majeure and its likely impact on the delivery of its obligations in accordance with this Agreement.

17.3 If it has complied with its obligations under Clause 17.1 and Clause 17.2, the affected Trust will be relieved from liability under this Contract if and to the extent that it is not able to perform its obligations under this Agreement due to the Event of Force Majeure.

18. **BRIBERY AND CORRUPTION**

18.1 For the purposes of this Clause 18 the expressions "**adequate procedures**" and "**associated with**" shall be construed in accordance with the Bribery Laws.

18.2 Each Trust shall ensure that it does not, by any act or omission, place any other in breach of any Bribery Laws. Each Trust shall comply with all applicable Bribery Laws and ensure that they have in place adequate procedures to prevent any breach of this Clause 18 and ensure that no Trust shall make or receive any bribe (which term shall be construed in accordance with the Bribery Laws) or other improper payment or advantage, or allow any such to be made or received on its behalf, either in the United Kingdom or elsewhere, and will implement and maintain adequate procedures to ensure that such bribes or improper payments or advantages are not made or received directly or indirectly on its behalf.

18.3 Each Trust shall immediately notify the other Trusts, the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team as soon as they become aware of a breach or possible breach of any of the requirements in this Clause 18.

19. **EQUALITY ACT**

19.1 Each Trust shall not unlawfully discriminate within the meaning and scope of the provisions of the Equality Act 2010 or any statutory modification or re-enactment of that Act or analogous legislation which has been, or may be, enacted from time to time relating to discrimination in employment or discrimination in the delivery of public services.

19.2 Each Trust shall take all reasonable steps to secure that all their servants, employees or agents and all sub-contractors employed in the performance of the sub-contract do not unlawfully discriminate as set out in Clause 19.1.

20. **SUB-CONTRACTING AND ASSIGNMENT**

20.1 No Trust shall be entitled to sub-contract or assign its rights or obligations under this Agreement without the consent of each of the other Trusts, such consent not to be unreasonably withheld or delayed unless such assignment, sub-contracting, novation or transfer is to a statutory successor in which case no consent shall be required.

21. **INTELLECTUAL PROPERTY RIGHTS**

21.1 All existing Intellectual Property of each Trust that is used by the Trusts in connection with this Agreement shall remain the exclusive property of the Trust that owned such Intellectual Property on the commencement of this Agreement. Each Trust hereby grants to each other a non-exclusive, royalty free licence to use any such existing Intellectual Property solely for the purposes of participating in the relevant Procurement Process.

21.2 Any Intellectual Property created by a Trust as part of or arising out of this Agreement shall belong to the Trust who created it (the "**Owning Trust**"). The Owning Trust hereby grants to the other Trusts a non-exclusive, royalty free licence to use any such new Intellectual Property for the purposes of collaborating in relation to this Agreement.

21.3 Where Intellectual Property is developed jointly by the Parties and there is no single clear developer, the Trusts will jointly own any such Intellectual Property and no Trust will be entitled to independently use such Intellectual Property other than in conjunction with the relevant Procurement Process without the written consent of the other Trusts.

21.4 The Trusts hereby agree that any benefit accruing to any Trust in relation to the exploitation of the Intellectual Property arising under Clause 21.2 and/or 21.3 shall be shared between the Parties on terms to be agreed by the SYB Pathology Partnership Board.

21.5 Any dispute as to the ownership of any Intellectual Property shall be determined in accordance with Clause 23 (Dispute Resolution Procedure).]

22. NOTICES

22.1 Any notice required to be given under this Agreement may be delivered personally or sent by first class post, courier or transmitted by email to the Chief Executive (or equivalent) of each other Trust at the address given at the beginning of this Agreement, or such other addresses as may be notified in accordance with this Clause 22 from time to time.

22.2 Any notice so sent shall be deemed to have been duly given if sent by:

22.2.1 personal delivery or courier – on delivery at the address of the relevant Trust; or

22.2.2 prepaid first class post – five (5) days after the date of posting; or

22.2.3 transmitted by email – when able to be read as received on recipient's email server.

22.3 This Clause does not apply to the service of any proceedings or other documents in any legal action or, where applicable, any arbitration or other method of dispute resolution.

23. DISPUTE RESOLUTION PROCEDURE

23.1 In the event of any dispute arising in relation to this Agreement ("**Dispute**"), the matter shall first be considered by the SYB Pathology Operational Management Team. In the event that the SYB Pathology Operational Management Team is not able to resolve the dispute within ten (10) Working Days of the matter arising, the SYB Pathology Operational Management Team shall escalate the matter by referring it (in the first instance), to the SYB Pathology Partnership Board.

23.2 In the event that the SYB Pathology Partnership Board is unable to settle the dispute within ten (10) Working Days of referral to it detailed in Clause 23.1, they shall within five (5) Working Days after the end of that negotiation period submit the dispute for consideration by the Acute Federation Collaborative.

23.3 In the event that the Acute Federation Collaborative is unable to settle the dispute within ten (10) Working Days of referral to it detailed in Clause 23.2, they shall within five (5)

Working Days after the end of that negotiation period submit the dispute to mediation by a mediator to be agreed between the Trusts.

23.4 If the matter is not resolved following the process referred to in Clauses 23.1 to 23.3, the Trusts shall attempt to settle it by mediation in accordance with Centre for Effective Dispute Resolution ("**CEDR**") Model Mediation Procedure. To initiate a mediation, a Trust may give notice in writing ("**Mediation Notice**") to the others requesting mediation of the dispute and shall send a copy thereof to CEDR asking CEDR to nominate a mediator. The mediation shall commence within 28 days of the Mediation Notice being served. No Trust will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one hour or one Trust has failed to participate in the mediation process. No Trust will commence legal proceedings against the other until thirty (30) days after such mediation of the dispute in question has failed to resolve the dispute. The Trusts shall co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay the mediator's costs, as the mediator shall determine or in the absence of such determination such costs shall be shared equally.

23.5 During the mediation phase and in advance of the mediation session, each Trust must submit to the mediator within five (5) Working Days of the mediator's request a signed position statement describing the precise points on which the Trusts disagree, and describing its own solution to the dispute.

23.6 No Trust may commence any court proceedings in relation to any Dispute arising out of this Agreement until it has attempted to settle the Dispute by mediation and either the mediation has terminated or the other Trust has failed to participate in the mediation, provided that the right to issue proceedings is not prejudiced by a delay.

23.7 Nothing in this Agreement shall prevent a Trust seeking from any court any interim or provisional relief that may be necessary to protect the rights or property of that Trust or the security of Confidential Information, pending resolution of the relevant dispute in accordance with the process set out in this Clause 23.

24. GENERAL

24.1 No variation of this Agreement or the Terms of Reference shall be effective unless it is in writing and signed by each Trust.

24.2 Failure of any Trust to enforce or exercise, at any time or for any period, any term of this Agreement does not constitute, and shall not be construed as, a waiver of any term and shall not affect the right to enforce such term, or any other term contained in this Agreement, at a later date.

24.3 Nothing in this Agreement shall constitute, or be deemed to constitute, a legal partnership between the Trusts, or shall constitute any Trust as the agent, employee or representative of the other(s).

24.4 The Trusts hereby agree that this Agreement shall be binding on any successors in title.

24.5 No one other than a party to this Agreement, their successors and/or permitted assignees, shall have any right to enforce any of its terms whether by virtue of the Contracts (Rights of Third Parties) Act 1999 or otherwise.

24.6 If any part of this Agreement is declared invalid or otherwise unenforceable, it shall be severed from this Agreement and the Trusts shall work together to agree a variation to this Agreement to ensure their continuation and achieve so far as possible their original intent. In the event that the Trusts cannot agree an appropriate variation, any Trust may terminate its participation from this Agreement with immediate effect.

24.7 No publicity or advertising regarding the relationship between the Trusts concerning any Procurement Process, any Contract or this Agreement shall be released by any Trust without the prior written approval of the other Trusts, which shall not be unreasonably withheld.

24.8 The Trusts shall do and execute all such further acts and things as are reasonably required to give full effect to the rights given and the matters contemplated by this Agreement.

24.9 This Agreement may be executed and delivered in any number of counterparts, each of which is an original and which, together, have the same effect as if each Trust had signed the same document.

24.10 This Agreement constitutes the entire agreement and understanding between the Trusts with respect to the subject matter of this Agreement and supersedes any prior agreement, understanding or arrangement between the Trusts with respect to the subject matter of this Agreement, whether oral or in writing.

25. STATUS OF AGREEMENT

This Agreement is governed in accordance with this Clause 25.

25.1 This Agreement and any dispute or claim arising out of, or in connection with, it, its subject matter or formation (including non-contractual disputes or claims) shall be governed by, and construed in accordance with, the laws of England.

25.2 The Trusts irrevocably agree that the Courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

SCHEDULE 1

Definitions

Acute Federation Collaborative	means the collaboration of Chief Executives and Chairs of all SYB Acute Trusts with a common aim of improving quality, safety, sustainability of services and the patient experience by sharing collective expertise and collaborating on specific projects;
Agreement	means this agreement, including its Schedules;
Agreement Data	means Personal Data and/or Special Category Data Processed by a Processing Trust on behalf of the Controlling Trust under or in connection with this Agreement;
Applicable Laws	all laws, rules, regulations, codes of practice, research governance or ethical guidelines or other requirements of regulatory authorities, as amended from time to time;
Bribery Laws	means the Bribery Act 2010 and associated guidance published by the Secretary of State for Justice under the Bribery Act 2010 and all other applicable United Kingdom laws, legislation, statutory instruments and regulations in relation to bribery or corruption;
Business Plan	means [insert];
Commencement Date	means [insert date];
Confidential Information	means information, the disclosure of which would constitute an actionable breach of confidence, which has either been designated as confidential by an Trust in writing or that ought to be considered as confidential (however it is conveyed or on whatever media it is stored), including commercially sensitive information, information which relates to the finances, business, affairs, properties, assets, trading practices, goods/services, developments, trade secrets, Intellectual Property rights, know-how, employees and other workers, customers and suppliers of an Trust and all Personal Data and Special Category Data.;
Contract	means each contract for the provision of the different elements of the Pathology Services entered into by the Partnership Host with each Selected Supplier for the delivery of the Pathology Services;
Contract Award Criteria	means the agreed contract award criteria applied during each Procurement Process;
Contract Commencement Date	means the commencement date of the relevant Contract;
Contract Costs	means the costs payable under or in connection with the Contracts, including any such costs arising on termination or expiry of the Contracts, however that arises, to be apportioned between the Trusts as set out in Schedule [3 OR x];

Contract Manager	means [an individual appointed by the Partnership Host in accordance with paragraph 2 of SCHEDULE 4 of the Agreement];
Contract Provider	means [insert for each of the Contracts];
Contract Resources	means the human resources that must be supplied by each Trust as set out in Schedule [3 OR x] (Contract Resources and Project Delivery Costs);
Contract Term	means the period of time equivalent to the duration of the relevant Contract as set out and determined therein;
Controller	has the meaning given in the Data Protection Legislation;
Controlling Trust	has the meaning given in Clause 16.1;
Data Protection Legislation	means all applicable data protection and privacy legislation, regulations and guidance, including: the General Data Protection Regulation (Regulation (EU) 2016/679), as incorporated into UK legislation by way of the European Union (Withdrawal Agreement) Act 2020 and as amended by the Data Protection, Privacy and Electronic Communications (Amendments etc) (EU Exit) Regulations 2019 ; the Data Protection Act 2018; and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Subject	has the meaning given in the Data Protection Legislation;
Deliverables	means deliverables set out in SCHEDULE 2;
Direct Losses	means amounts recoverable under Clause 11.3 or any Project Delivery Costs, excluding Indirect Losses;
Dispute Resolution Procedure	means the procedure set out in Clause 23 of this Agreement;
EIRs	means the Environmental Information Regulations 2004 together with any code of practice made pursuant to those Regulations and any related guidance issued by the Secretary of State for the Department for Environment, Food and Rural Affairs, the Information Commissioner or the Secretary of State for the Department of Constitutional Affairs;
Evaluation Process	means the process identified as such in SCHEDULE 3 (Evaluation Process Compliance);
Event of Force Majeure Event	an event or circumstance which is beyond the reasonable control of the Trust claiming relief under Clause 17, including war, civil war, armed conflict or terrorism, strikes or lock outs, riot, fire, flood or earthquake, and which directly causes that Trust to be unable to comply with all or a material part of its obligations under this Agreement;
Expiry Date	means [insert];

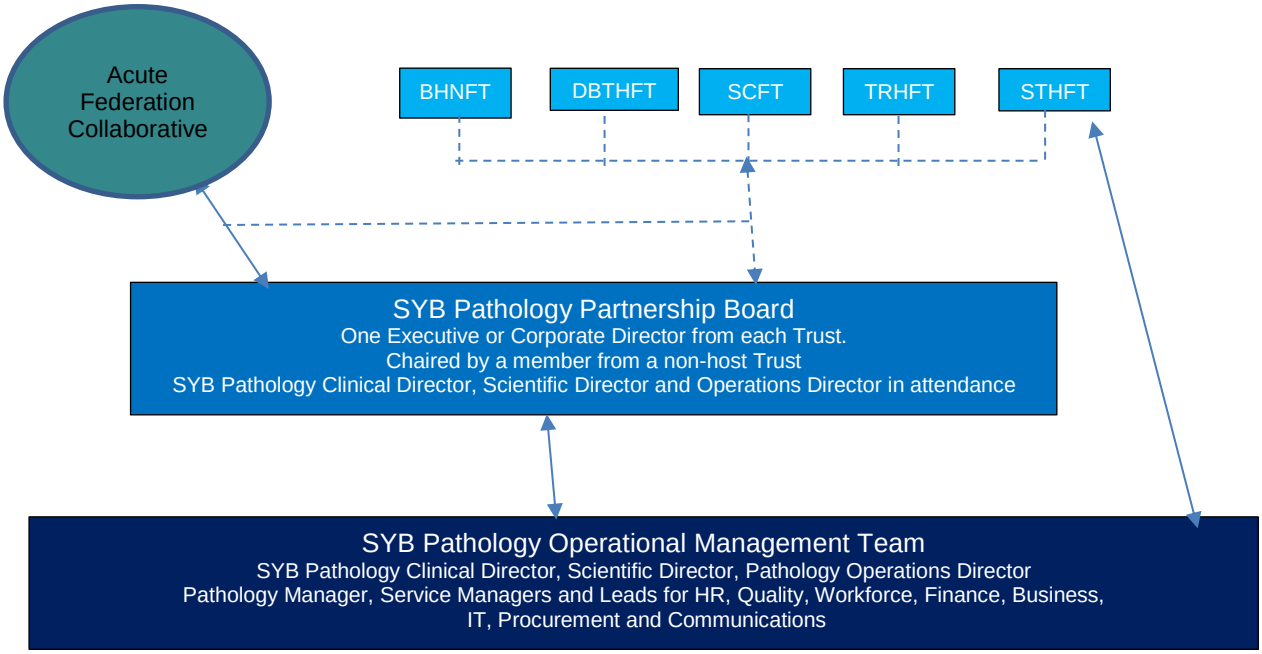
Financial Year	the period starting on the Commencement Date and ending on the following 31 March and each subsequent period of 12 calendar months starting on 1 April, provided that the final Financial Year will be the period starting on the relevant 1 April and ending on the Expiry Date or date of earlier termination of this Agreement;
FOIA	means the Freedom of Information Act 2000 and any subordinate legislation (as defined in the Interpretation Act 1978), but excluding the EIRs, as amended modified or re-enacted from time to time, together with all codes of practice made pursuant to that Act or pursuant to that subordinate legislation from time to time, and together with any related guidance issued by the Information Commissioner or the Secretary of State for the Department of Constitutional Affairs;
Full Business Case or **FBC**	means the full business case that has been approved in relation to the Project;
Health Service Body	has the meaning set out at section 9(4) of the NHS Act 2006;
Hosting Obligations	means the obligations set out in SCHEDULE 4;
Hosting Standards	means the standards set out in SCHEDULE 4;
Indirect Losses	means any loss of profits, loss of business or loss of business opportunity (whether such losses arise directly or indirectly) and any other consequential or indirect loss of any nature, but excluding Direct Losses;
Initial Term	means a period from the date of this Agreement until the Expiry of the Contract Term of each Contract unless terminated earlier in accordance with Clause 12 (Termination) or extended in accordance with Clause 3.2 (Term);
Information	shall have the meaning given under section 84 of the Freedom of Information Act 2000 including but not limited to environmental information as defined in regulation 2 of the EIRs and Personal Data and data as defined in the Data Protection Legislation;
Intellectual Property	means any patents, rights to inventions, registered designs, copyright and related rights, database rights, design rights, topography rights, trademarks, service marks, trade names and domain names, trade secrets, rights in unpatented know-how, rights of confidence and any other intellectual or industrial property rights of any nature, including all applications (or rights to apply) for and renewals or extensions of such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world;
NHS Act 2006	means the National Health Service Act 2006;
NHS Contract	shall have the meaning set out in section 9 of the NHS Act 2006;
Outline Business Case or **OBC**	means the outline business case that has been approved in relation to the Project;
Partnership	means the contractual joint venture established pursuant to this

	Agreement between the Trusts for the provision of the Pathology Services which the Trusts agree will be collaborative and inclusive venture;
Partnership Business	means [the arrangements set out in the Business Plan];
Partnership Host	has the meaning set out in Clause 5.1;
Partnership Host Policies	means [insert a list of Partnership Host policies];
Partnership Policies	has the meaning set out in Clause 8.7;
Pathology Services	[means the pathology services and related services, including a single laboratory information management system, transport services to support the delivery of the pathology services, and digital pathology [services and equipment], procured in accordance with the relevant Procurement Process and set out within the relevant Contract;
Personal Data	has the meaning given in the Data Protection Legislation;
Process	has the meaning given in the Data Protection Legislation (and **"Processed"** and **"Processing"** shall be construed accordingly);
Processing Trust	has the meaning given in Clause 16.1;
Processor	has the meaning given in the Data Protection Legislation;
Procurement Decision Making Group	means the group made up of members of each Trust and governed in accordance with its agreed terms of reference;
Procurement Process	means each of the procurement processes as more particularly set out in SCHEDULE 3;
Procurement Resources	means the human resources that must be supplied by each Trust as set out in SCHEDULE 3 (Procurement Resources and Project Delivery Costs);
Procurement Timetable	means the timetable included in SCHEDULE 3 (Procurement Timetable) as the same may be amended from time to time by the SYB Pathology Partnership Board;
Project	means the project for the provision of the pathology laboratory services, a laboratory information management system, transport services, and digital pathology [services and equipment] that are required by each Trust and which are being provided or procured pursuant to each Procurement Process;
Project Delivery Costs	means the project delivery costs to be incurred by the Trusts and apportioned as set out in SCHEDULE 3;
Request for Information	shall have the meaning set out in FOIA;
Retained Assets and Equipment	means the assets and equipment listed in Part 2 of SCHEDULE 7;

Risk and Gain Share Principles	means the risk and gain share principles set out in SCHEDULE 4;
Selected Supplier	means the supplier (or suppliers, if applicable, on the basis of multiple lots) appointed by the Trusts pursuant to the application of the Contract Award Criteria during each Procurement Process;
Special Category Data	has the meaning given in the Data Protection Legislation;
SYB Pathology Operational Management Team	means the SYB Pathology Operational Management Team established in accordance with the SYB Pathology Operational Management Team Terms of Reference at Part 2 of SCHEDULE 2;
SYB Pathology Operational Management Team Terms of Reference	means the terms of reference that govern the set-up, management, roles and responsibilities of the SYB Pathology Operational Management Team (as updated from time to time), a copy of which (as at the date of this Agreement) is set out in Part 2 of SCHEDULE 2;
SYB Pathology Partnership Board	means the SYB Pathology Partnership Board established in accordance with the SYB Pathology Partnership Board Terms of Reference at Part 1 of SCHEDULE 2;
SYB Pathology Partnership Board Reserved Matter	means matters reserved for decision by the SYB Pathology Partnership Board as set out at Part 2 or SCHEDULE 2;
SYB Pathology Partnership Board Terms of Reference	means the terms of reference that govern the set-up, management, roles and responsibilities of the SYB Pathology Partnership Board (as updated from time to time), a copy of which (as at the date of this Agreement) is set out in Part 1 of SCHEDULE 2;
SYB Pathology Workforce Group	means the group made up of members of each Trust and governed in accordance with its agreed terms of reference;
Target Operating Model or TOM	means the target operating model set out in SCHEDULE 6;
Term	means the Initial Term of this Agreement plus any Extended Term(s) agreed between the Trusts;
Transferring Assets and Equipment	means the assets and equipment listed in Part 1 of SCHEDULE 7;
Trust(s)	means each and any or all (as the context so requires) of the organisations listed at the start of this Agreement (numbers 1 to 6);
Working Day	means any day other than a Saturday, a Sunday, Christmas Day, Good Friday or a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in any part of the United Kingdom and "**Working Days**" shall be construed accordingly.

SCHEDULE 2

Terms of Reference and Trust Delegations



SCHEDULE 2

Terms of Reference and Trust Delegations

Part 1

South Yorkshire and Bassetlaw (SYB)

Pathology Partnership Board (PPB)

Terms of Reference

NAME OF GROUP:	SYB Pathology Partnership Board
ACCOUNTABLE TO:	Chairs and Chief Executives - Acute Federation Collaborative
REPORTING THROUGH:	Chief Executives – Acute Federation Collaborative
PRIMARY PURPOSE:	To oversee delivery of, and maximise the sustainability, safety and efficiency, of the Partnership. The vision is to improve lives and safeguard the best clinical outcomes by delivering high quality, innovative laboratory medicine solutions making best use of taxpayers money to deliver efficiencies form economies of scale and scope.
COMPOSITION OF GROUP/ MEMBERSHIP:	A non-host Chief Executive will act as the Chair of the SYB Pathology Partnership Board. The membership of the Partnership Board will comprise one of each of the following:- • Executive or Corporate Director (Barnsley Hospital NHS FT) • Executive or Corporate Director (Doncaster & Bassetlaw Teaching Hospitals NHS FT) • Executive or Corporate Director (Sheffield Children's NHS FT) • Executive or Corporate Director (Sheffield Teaching Hospitals NHS FT) • Executive or Corporate Director (The Rotherham Hospital NHS FT) In appointing individuals to the SYB Pathology Partnership Board, the participating Trusts will act with a view to ensuring that the makeup of the board reflects the breadth of the provision across both general and specialist care, with an appropriate mix of skills and expertise.
IN ATTENDANCE	• SYB Pathology Clinical Director • SYB Pathology Scientific Director • SYB Pathology Operations Director Attendance by other relevant officers outside of the Membership will be agreed in advance of each meeting.

RESPONSIBILITIES OF PARTNERSHIP BOARD MEMBERS	1. To review the Agreement on an annual basis with any variations to be approved by each Trust Board in writing. 2. To provide leadership, create a culture of collaboration across the Partnership and effectively manage any challenges that arise in an open and constructive way. 3. To ensure appropriate governance and management arrangements are in place across the Partnership. 4. To agree the overall strategy for the Partnerships on behalf of the Trusts and report to the Acute Federation Collaborative and Trust Boards as required. 5. To provide oversight to annual planning, tenders and business case processes including planning, delivery of milestones, and risk and issue management. 6. To approve the annual Business Plan and to oversee its implementation. 7. To agree plans ensuring that measurable outcome criteria are in place for each initiative / project. 8. On an annual basis, to agree the contribution to the running of the Partnership to be made by the Trusts and the outcomes and benefits that are required as a result from that investment. 9. To ensure the principles of this Agreement are adhered to by all of the participating Trusts. 10. To ensure successful delivery and implementation of the Full Business Case for the Partnership. 11. To review and endorse any proposed changes to the agreed Target Operating Model, ensuring operational, clinical and financial sustainability of such changes prior to approval by all Trust Boards. 12. To refer any Reserved Matters, as defined in this Agreement, to individual Trust Boards. 13. To agree the structure and objectives of the SYB Pathology Operational Management Team. 14. To provide oversight and direction to the SYB Pathology Operational Management Team, holding the Clinical Director and team accountable for service delivery and performance. 15. On behalf of the Trusts, and customers, assure the delivery of the agreed outcomes. 16. To monitor delivery and performance of the expected outcomes, agreeing mitigations and corrective actions with the SYB Pathology Operational Management Team. 17. To make business case recommendations to individual Trust Boards and approve business cases and plans within the limits of the Hosts SFIs. 18. To receive, review and approve the annual accounts as provided by the Host Department of Finance. 19. To have oversight of all relevant external contracts. 20. To abide by the agreed guiding principles including making the best use of taxpayers money and to deliver efficiencies from economies of scale and scope. 21. To agree any financial implications for the Partnership as a result of the annual Business Plan e.g. fluctuations to test pricing, expected annual Cost Improvement Plan.

	22. To provide effective support in the identification and mitigation of the Partnership's risks and issues. 23. To agree and support the Partnership's communication and engagement plans at system and local level. 24. To ensure appropriate communication and engagement with stakeholders across the Integrated Care System, acting as points of contact for local teams and services. 25. To hold any external advisors to account for their performance against agreed objectives and in accordance with any contract. 26. To undertake any other duties required of it by the Trust Boards. 27. To ensure that organisational, professional or personal conflicts of interest are effectively managed in an open and constructive way 28. To seek to resolve any disputes between the Trusts in accordance with Clause 23 of this Agreement.
SERVICED BY:	SYB Pathology Operations Director
FREQUENCY OF MEETINGS:	Monthly for the first 12 months and then as agreed by the Partnership Board
REQUIRED ATTENDANCE:	Attendance of the Director representative from each participating Trust at scheduled meetings will be critical to successful delivery of the SYB Pathology Network. Therefore, notwithstanding the quoracy requirements below, each Trust will endeavour to have representation at each meeting. A nominated executive or corporate deputy may represent Trusts where necessary.
QUORACY:	In line with this Agreement, each of the five Trusts will have equal participation in this forum. Meetings will be quorate based on attendance of Executive representatives from three out of five Trusts. Proposed decisions will be shared with any participating Trust not represented within a week of the meeting to enable feedback from that Trust. Where a unanimous agreement cannot be reached, the proposal will be discussed via email and at the next meeting. Each Trust must be present at the meeting where a material decision is required.
MINUTES CIRCULATED TO:	Acute Federation Collaborative Trust Boards SYB Pathology Operational Team Other Groups as required
REVIEW DATE:	April 2023
DATE APPROVED:	

SCHEDULE 2

Terms of Reference and Trust Delegations

Part 2

South Yorkshire and Bassetlaw (SYB)

Pathology Operational Management Team (OMT)

Terms of Reference

NAME OF GROUP:	SYB Pathology Operational Management Team
ACCOUNTABLE TO:	Acute Federation Collaborative
REPORTING THROUGH:	SYB Pathology Partnership Board (PPB)
PRIMARY PURPOSE:	To oversee the general pathology service delivery and to maximise sustainability, safety and efficiency of the Partnership. The vision is to improve lives and safeguard the best clinical outcomes by delivering high quality, innovative laboratory medicine solutions making best use of taxpayers money to deliver efficiencies form economies of scale and scope.
COMPOSITION OF GROUP/ MEMBERSHIP:	• SYB Clinical Director (CD) • SYB Scientific Director (SD) • SYB Operations Director (OD) • SYB Pathology Manager • Pathology Clinical Lead for each Pathology Discipline • Pathology Laboratory Manager for each Pathology Discipline • Quality Lead • Workforce Lead • Business Lead • Finance Lead • Procurement Lead • IT Lead • HR Business Partner • Communications Lead The SYB Clinical Director will act as Chair of the Pathology Operational Team. The Clinical Lead and Laboratory Manager Lead representation for each discipline must ensure that all partner Trusts are adequately represented.
IN ATTENDANCE	NHSI North of England regional lead for diagnostic transformation programmes. Other relevant officers outside of the Membership will be agreed in advance of each meeting.

RESPONSIBILITIES OF SYB PATHOLOGY OPERATIONAL MANAGEMENT TEAM MEMBERS	1. To develop and recommend the overall strategy for the Partnership and provide medical, scientific, technical and support expertise to the SYB Pathology Partnership Board. 2. To develop the annual Business Plan for the Partnership, including measurable outcomes, for recommendation to the SYB PPB. 3. To prepare associated business cases, procurement plans and other and projects for recommendation to the SYB PPB, and individual Trust Boards where required. 4. To support the successful delivery of the business cases or projects arising from the annual Business Plan, monitoring and leading on any corrective action needed to deliver the agreed outcome/success criteria including delivery of milestones and risk and issue management. 5. To report the measurable outcome criteria to the PPB on a monthly basis. 6. To establish and monitor an agreed set of KPIs across SYB Pathology, reporting compliance by exception to the PPB on a monthly basis. 7. To provide effective support in the identification and mitigation of SYB Pathology risks and issues. 8. To take action to ensure the Trusts compliance with the principles of this Agreement including tenders, investment and recruitment decisions. 9. To provide leadership in driving a collaborative culture across the Partnership. 10. To provide oversight and direction to working teams. 11. To provide oversight to the recruitment of posts. 12. To provide support to the Host finance and business teams to enable a common pricing strategy which can be implemented across the Partnership. 13. To monitor activity and income of all external contracts. 14. To ensure appropriate communication and engagement with stakeholders across the Integrated Care System, acting as points of contact for local teams and services. 15. To recommend SYB Pathology communication to the PPB and support engagement plans at both system and local level. 16. To ensure that organisational, professional or personal, conflicts of interest are effectively managed in an open and constructive way. 17. To ensure appropriate governance and management arrangements are in place. 18. To undertake any other duties required of it by the PPB and Trust Boards.
SERVICED BY:	SYB Pathology Manager

FREQUENCY OF MEETINGS:	Monthly
REQUIRED ATTENDANCE:	It is expected that, as a minimum, two members of the SYB Senior Management Team (CD, SD or OD) will be in attendance. It is expected that the Clinical Lead and / or Laboratory Manager from each Pathology Discipline (Automated Blood Sciences, Specialist Blood Sciences, Histology, Microbiology) will attend each meeting such that all partner sites are adequately represented. Senior nominated deputies may represent Disciplines and Sites where necessary.
QUORACY:	Meetings will be quorate based on attendance of representatives from three out of the four Pathology Disciplines (Automated Blood Sciences, Specialist Blood Sciences, Histology, Microbiology) with adequate representation of 3 out of the 5 partner Trusts. Recommendations will be shared with any discipline and Trust not present within a week of the meeting to enable feedback, from that Trust. Where a unanimous agreement cannot be reached the proposal will be discussed via email and at the next meeting.
MINUTES CIRCULATED TO:	Pathology Partnership Board Other Groups as required Minutes to be communicated to all SYB Pathology staff via agreed communication channels.
REVIEW DATE:	April 2023
DATE APPROVED:	

SCHEDULE 2

Terms of Reference and Trust Delegations

Part 3

Trust Delegations

Trust Boards will not delegate their statutory responsibilities to the SYB Pathology Partnership Board.

Any proposed changes to this Agreement must be approved by all Trust Boards in writing.

Any proposed changes to Terms of Reference must be approved by all Trust Boards in writing.

Pathology Board Reserved Matters are any changes to the agreed Target Operating Model and Workforce Models which must be approved by the Trust Boards with consideration by the Acute Federation Collaborative.

Reserved Matters as at the Commencement Date include:

- Changes to the Partnership Agreement
- Changes to the Target Operating Model
- Financial decisions in line with Host SFIs
- Changes to the Workforce Model

SCHEDULE 3

Procurement Resources and Project Delivery Cost

All procurements undertaken in accordance with this Agreement will be in accordance with:

- procurement legislation;
- the Partnership Host Standing Financial Instructions, Standing Orders and Procurement Policy; and
- the Pathology Network Outline Business Case ('OBC') and when agreed, the Full Business Case ('FBC');

Any procurement requiring competition, not included in the Pathology Network OBC or FBC, may be recommended by the SYB Pathology Operational Management Team and approved by the SYB Pathology Partnership Board.

A) Procurement Process – General Compliance

In order for the Partnership Host to carry out the Procurement Processes on behalf of the Partnership that are both, compliant with the relevant legislative framework and minimise the risk of a challenge being brought, the below process will be adhered to (in accordance with the relevant Host decision making process, for each Procurement Process);

The SYB Operational Management Team will:

- Establish a Procurement Decision Making Group. For larger projects this will require a project board with a representative from each Trust;
- Establish a Pathology Project Lead/Manager;
- Establish a lead for the development of the OBC and FBC (if required);
- Agree the overall timetable of the procurement;
- Agree the procurement route and put the recommendation forward to the Procurement Decision Making Group;
- Draft the tender documentation;
- Agree the contract award criteria (this will include adherence to the evaluation guidance as provided and directed by STHFT as the Partnership Host) and make a recommendation to the Procurement Decision Making Group;
- Carry out the commitments in the OBC and FBC;
- Provide support to the team leading the Procurement Process on their behalf;
- Make contract recommendations to the Procurement Decision Making Group and where required the SYB Pathology Partnership Board; and
- Approve the Regulation 84 Procurement Report.

The Partnership Host will, in conjunction with the SYB Pathology Operational Management Team, provide advice via the SYB Pathology Partnership Board to ensure all Trusts, as a collective group, mitigate the risk of non-compliance and supplier challenge. Any deviation from the advice may compromise the process, therefore all Trusts must raise any potential issues including potential conflicts of interest to the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team as soon as they are aware of the issues or conflicts.

B) Contract Award and Contract Management

The Partnership Host will enter into all the contracts with the supplier on behalf of the Trusts.

The Partnership Host will be responsible for the contract management of all contracts with the supplier awarded on behalf of the Partnership.

C) Finances

The Partnership Host will deal with the financial elements of the contracts following contract award and costs will be recovered from the Trusts via a routine monthly/quarterly recharge (TBC). The authorised 'risk and gain share' document will be used as the default principle for distributing costs and income between the Trusts. Costs will be signed off by the SYB Pathology Partnership Board and will reflect the values in each Outline Business Case.

Where any procurements exceed the scope of this Agreement, these would be considered on an individual basis. When the Target Operating Model is reached, Trusts will be recharged on an equalised cost per unit basis. Unit costs will include the costs of any procurement.

D) Slippage and Delays

The project timelines will be managed by the SYB Pathology Operational Management Team and any delays that have a financial impact will be reported to the Pathology Partnership Board. Any delays that cause a financial risk to a Trust(s) will be shared proportionally between all Trusts in accordance with the agreed risk and gain share arrangement.

SCHEDULE 4

Hosting Obligations and Hosting Standards

Part 1

1. GENERAL OBLIGATIONS

1.1 The Partnership Host shall:

1.1.1 comply with SCHEDULE 8 (TUPE), employ the staff of the Partnership in accordance with SCHEDULE 4 Part 2) (Hosting Standards) and ensure there are no compulsory redundancies;

1.1.2 in all matters regarding legal personality act on behalf of the Partnership, including, without limitation, entering into all contracts, agreements and arrangements (including each Contract) in relation to the Partnership;

1.1.3 be responsible for all regulatory matters including:

(a) registration with the Care Quality Commission (or its successor body);

(b) registration with the Medicines and Healthcare products Regulatory Agency (or its successor body);

(c) registration with the Human Tissue Authority and registration with the Clinical Pathology Accreditation UK Limited;

(d) meeting the requirements of NHS Improvement and any relevant Clinical Commissioning Groups and any other commissioning organisations; and

(e) any relevant UKAS accreditation;

1.1.4 set up separate accounting records in relation to the Partnership including maintaining accurate and complete statements and records of all transactions in relation to the Partnership;

1.1.5 prepare financial reports and accounts for the Partnership records for each year in accordance with the requirements of all Applicable Laws and generally accepted accounting practices applicable in the United Kingdom in relation to this Agreement;

1.1.6 supply each Trust with the financial and other information necessary to keep the party informed about how effectively the business of the Partnership is performing and in particular shall supply each Partner with:

(f) a copy of each year's Business Plan for approval in accordance with Clause 8.9;

(g) monthly income and expenditure accounts of the Partnership to be supplied within fifteen (15) Working Days of the end of the Month to which they relate (the first Working Day being the first Working Day of the following month) and the accounts shall include activity report, a surplus and loss account, a balance sheet and a cashflow statement;

1.1.7 promptly notify the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team of any liabilities which it considers it is entitled

to seek indemnity protection or reimbursement from the other Trusts under this Agreement such notice to include:

(a) the quantum and nature of such liability;

(b) details of the circumstances causing such liability;

(c) any steps it has taken to minimise such liability (to the extent that such steps are appropriate) acknowledging the Partnership Host acts in accordance with the terms of this Agreement and the decisions of the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team; and

(d) other details regarding the liability, including details of any litigation;

1.1.8 operate the Partnership as the legal host on behalf of the Trusts in accordance with the decisions of and directions of the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team;

1.1.9 must put into place and maintain in force appropriate insurance (or membership of an NHS Resolution risk sharing scheme) in respect of:

(a) employers liability;

(b) clinical negligence, where the provision or non-provision of any part of the Services to be provided from time to time pursuant to the relevant Contract may result in a clinical negligence claim;

(c) public liability; and

(d) professional negligence; and

1.1.10 on a Trust's request, produce both the insurance certificate giving details of cover and the receipt for the current year's premium in respect of each insurance; and

1.1.11 perform the Hosting Obligations to the Hosting Standards (as applicable).

2. CONTRACT MANAGEMENT

2.1 The Partnership Host shall be responsible for managing each Contract under the terms of the relevant Contract.

2.2 [The Partnership Host has appointed a Contract Manager who will act as the representative of the Partnership in connection with each Contract. The role description of the Contract Manager will be agreed between the Trusts through the SYB Pathology Partnership Board. The Contract Manager will, notwithstanding that he/she is employed by the Partnership Host, be expected to act equally in the best interests of all of the Trusts and in accordance with their joint instructions through the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team. Where any Trust has concerns that the Contract Manager is not acting in their best interests the matter shall be referred to the dispute resolution procedure.]

SCHEDULE 4

Hosting Obligations and Hosting Standards

Part 2

Hosting Standards

1. HOSTING STANDARDS

1.1 In its performance of the Hosting Obligations, the Partnership Host shall:

1.1.1 comply with all instructions of the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team in relation to the Partnership Business;

1.1.2 perform the Hosting Obligations with the best care, skill and diligence in accordance with best practice in the supplier's industry, profession or trade;

1.1.3 use personnel who are suitably skilled and experienced to perform tasks assigned to them, and in sufficient number to ensure that the Hosting Obligations are fulfilled in accordance with this Agreement;

1.1.4 ensure that the Hosting Obligations conform with all descriptions and specifications set out in any reasonable written specification provided by the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team;

1.1.5 provide all equipment, tools and vehicles and such other items as are required to perform the relevant Hosting Obligations;

1.1.6 use the best value goods, materials, standards and techniques, and ensure that all goods and materials supplied and used will be free from defects in workmanship, installation and design;

1.1.7 obtain and at all times maintain all necessary licences and consents, and comply with all applicable laws and regulations, in respect of the Hosting Obligations;

1.1.8 observe all health and safety rules and regulations and any other security requirements that apply at any of the premises from which the Pathology Services or the Hosting Obligations are provided; and

1.1.9 not do or omit to do anything which may cause any Trust to lose any licence, authority, consent or permission on which it relies for the purposes of conducting its business.

SCHEDULE 4

Hosting Obligations and Hosting Standards

Part 3

Contract and Costs Management

Risk and Gain Share

In February 2020 the Risk and Gain Share financial principles were agreed by the Finance Work Group for inclusion in the OBC and Partnership Agreement in support of a 'Fair Share Partnership' arrangement for SYB Pathology. The Finance Work Group considered options using both the costs and activity of the current Pathology services within SYB based on the NHSI returns collated by the Programme Team.

Consensus was reached that cost information, following agreed adjustments (baseline costs), should be used to accurately reflect the current level of Investment by each Trust in Pathology services and this was approved by SYB Directors of Finance at their meeting on 22nd April 2021.

In debating the Risk and Gain Share proposals it was noted that using the current cost methodology could penalise organisations that that have been the most effective in implementing efficiency initiatives as the cost base would be lower, however this is negated by the opportunity to share in any future savings by joining a consolidated pathology network. Agreed percentages will be used to distribute savings / surplus income within the Partnership as a consequence of implementing the Full Business Case.

Risk and Gain Share Proposals which reflect the existing investment in Pathology Services (19/20)

	BRILS	DBTH	SCH	STH
Baseline cost for OBC (£m)	**£17,052**	**£12,997**	**£4,912**	**£37,476**
% Share	**24.0**	**17.8**	**6.8**	**51.4**

- Note the above percentage values have been rounded.
- The current BRILS agreement between BHFT and TRHFT is a 50:50 split

All future investments / service improvements following the establishment of SYB Pathology will be considered on an 'individual basis' based on the merits of the proposal.

SCHEDULE 5

Agency Arrangements

Text only to be included if agency arrangements apply.

SCHEDULE 6

Target Operating Model

Recommended SYB Pathology TOM - August 2021

Hospital Site	Type of Lab	Range of Services
Northern General Hospital, Sheffield	CSL for Blood Sciences and Microbiology Sp	Main automated lab for Blood Sciences Specialist centre for Blood Sciences All Immunology Main 24/7 lab for Microbiology Specialist centre for Microbiology All Virology Frozen sections Andrology POCT
Royal Hallamshire Hospital, Sheffield	ESL * Sp **	ESL for Blood Sciences Specialist centre for Haematology and Coagulation Specialist centre or Gestational Trophoblastic Disease Frozen sections POCT
Sheffield Children's	ESL * Sp Paediatric PM **	ESL for Blood Sciences Specialist centre for paediatric biochemistry Paediatric PM Frozen sections Brain smears POCT
Doncaster Royal Infirmary	Ext ESL Mini CSL	Extended ESL for Blood Sciences Secondary lab for Microbiology (not 24/7) Frozen sections Andrology POCT
Rotherham Hospital	ESL	ESL for Blood Sciences Frozen sections Andrology POCT
Barnsley Hospital	ESL	ESL for blood sciences POCT
Bassetlaw Hospital	ESL	ESL for Blood Sciences POCT
Chesterfield Royal Infirmary		Frozen sections

* A quality impact assessment is being completed to understand whether, to meet all of the critical Requirements, an ESL is required at both the RHH and SCH sites.

** Two sites (Royal Hallamshire Hospital and Sheffield Children's) are being evaluated for the site of a single Histopathology CSL.

Key:

CSL	Central Service Laboratory
ESL	Essential Service Laboratory
EESL	Extended Essential Service Laboratory undertaking a wider repertoire of automated tests than an ESL (but on ESL equipment) and/or a proportion of primary care work
Mini CSL	Ext ESL for Blood Sciences plus a secondary Microbiology Laboratory
Sp	Specialist Centre

SCHEDULE 7

Assets and Equipment

Part 1

Transferring Assets and Equipment

Current Assets (primarily stocks)

Non-host stocks to be sold to the host Trust at cost.

Fixed Assets

Non-host Trust laboratory buildings, plant, and non-clinical equipment that are still to be used as part of the SYB Pathology operational model will be retained by the non-host Trusts and a charge made to the host Trust.

Clinical equipment acquired through existing Managed Service Contracts (MSC) will be novated into the single SYB MSC where appropriate.

It is anticipated that Pathology clinical equipment assets will transfer to the balance sheet of the Host Organisation as they will be deemed to be in control of these assets. Donated Assets will be subject to individual agreement.

New/replacement assets will be subject to an agreed business case process as defined by the Partnership Agreement; this will be aligned with the host Trust's policies and processes.

Trust Asset Lists

Trust asset lists are attached. These lists are accurate as of 1st Jan 2022 but are subject to continual review and update.

SCHEDULE 7

Assets and Equipment

Part 2

Retained Assets and Equipment

Details of any assets and equipment that will not transfer to the Partnership Host but will be made available by the Trusts for use by the Partnership Host are be inserted once finalised and confirmed. This should also include details of any charges for making such assets and equipment available as required.

SCHEDULE 8

Transferring Partnership Employees

Part 1

1. INTERPRETATION

1.1 The definitions in this paragraph apply in this Schedule.

Directive: the Council of the European Union Directive 2001/23/EC;

Employee Liability Information: the employee liability information to be provided pursuant to regulation 11 of the Transfer Regulations;

Losses: all losses, claims, actions, costs, liabilities, damages or expenses, (including all reasonable legal and professional costs and expenses), proceedings, demands and charges whether arising under statute, contract or at common law but excluding loss of profits, loss of use, loss of production, loss of business, loss of business opportunity, or any claim for consequential loss or for indirect loss of any nature but excluding any of the same that relate to loss of revenue;

Resource Transfer Date means the date the Partnership Host takes responsibility for the provision of the Services or any part of the Services and the resources relating to the Services or any part of the Services are transferred to it by a Trust.

Redundancy Costs means notice pay (including any payment in lieu of notice), redundancy payments payable on termination of employment pursuant to any arrangement (including voluntary redundancy) whether contractual or statutory, any entitlement to early benefits on redundancy or early retirement benefits pursuant to the employee's terms and conditions of employment, any increased employment costs arising due to the application of a relevant pay protection policy and any employer national insurance liabilities associated with such payments and costs;

Relevant Transfer: a relevant transfer for purposes of the Transfer Regulations;

Services: means the Pathology Services as defined in SCHEDULE 1

Transferring Employees: the persons employed by BHFT, DBTHFT, TRTF, SCFT (or a supplier or sub-contractor of the same) who are wholly or mainly engaged in the activities of the Services immediately before the Resource Transfer Date.

Transferor Trusts means BHFT, DBTHFT, TRTF, and/ or SCFT, as the context determines;

Transfer Regulations: the Transfer of Undertakings (Protection of Employment) Regulations 2006.

2. RELEVANT TRANSFERS

2.1 The parties anticipate that the transfer of the Services to the Partnership Host will constitute a Relevant Transfer and that the contracts of employment (together with any collective agreements) of the Transferring Employees shall have effect (subject to Regulation 4(7) of the Transfer Regulations) thereafter as if originally made between the Transferring Employees and the Partnership Host except insofar as such contracts relate to any benefits for old age, invalidity or survivors under any occupational pension scheme (save as required under sections 257 and 258 of the Pensions Act 2004), however staff who are eligible to participate in, or who immediately before such Relevant Transfer are participating

in, the NHS Pension Scheme shall continue to be provided with access or continued membership in the NHS Pension Scheme. On the occasion of a Relevant Transfer to any sub-contractor or supplier the Partnership Host shall procure that the former and any new sub-contractor or supplier shall comply with their obligations under the Transfer Regulations and with the provisions of Fair Deal for staff pensions: staff transfer from central government (October 2013).

3. EMPLOYEE LIABILITY INFORMATION AND MEASURES

3.1 Each Transferor Trust shall promptly respond to any reasonable requests from the Partnership Host for information about the workforce and working arrangements for purposes of determining the number and job titles of the individuals assigned to the Services for purposes of the Transfer Regulations and details of all unfilled vacancies in the Services and details of all roles currently filled by agency or bank staff working in the Services.

3.2 Each Transferor Trust has supplied to the Partnership Host the Employee Liability Information as at the date of this Agreement, which is contained in Part 2 of this SCHEDULE 8, relating to each of those employees of the respective Transferor Trust who it is expected, if they remain in the employment of the relevant Transferor Trust or its sub-contractor or supplier until immediately before the Resource Transfer Date, would be Transferring Employees.

3.3 Each Transferor Trust warrants that the information it has supplied is accurate and complete. Each Transferor Trust shall severally indemnify and keep indemnified the Partnership Host in respect of any Losses:

3.3.1 which the Partnership Host incurs and which are reasonably attributable to a breach of this warranty, including but not limited to where the incompleteness or inaccuracies in such information resulted in the Partnership Host agreeing a lower fee or payment from the Transferor Trusts under this Agreement; and

3.3.2 arising from any claim by any party as a result of the Transferor Trust (or sub-contractor or supplier) failing to provide or promptly provide the Partnership Host where requested by the Partnership Host, the Employee Liability Information or to provide full Employee Liability Information or as a result of any material inaccuracy in, or omission, from the Employee Liability Information.

3.4 Without prejudice to their obligations under this Schedule, the Transferor Trusts will provide the Employee Liability Information to the Partnership Host at such time or times as are required by the Transfer Regulations and update the Employee Liability Information to take account of any changes as required by the Transfer Regulations.

3.5 The parties agree to take all reasonable steps, including co-operation with reasonable requests for information to ensure that the Relevant Transfer takes place smoothly with the least possible disruption to the Services and to the Transferring Employees.

3.6 The Partnership Host shall immediately and in any event within five (5) Working Days following a written request by a Transferor Trust, provide to the relevant Transferor Trust details of any measures which the Partnership Host or any sub-contractor or supplier envisages it or they will take in relation to any Transferring Employees who are or who will be the subject of a Relevant Transfer, and if there are no measures, confirmation of that fact.

4. INDEMNITIES

4.1 The Transferor Trusts shall severally indemnify and keep indemnified in full the Partnership Host against all Losses incurred by the Partnership Host in connection with or as a result of any claim or demand by (i) a Transferring Employee of the Transferor Trust or by (ii) any

trade union or staff association or employee representative in respect of all or any of the Transferring Employees, in either case that arises out of the employment or termination of the employment of any Transferring Employee of the Transferor Trust or its sub-contractor or supplier, provided that this arises from any act, fault or omission of the relevant Transferor Trust or its sub-contractor or supplier in relation to such employee prior to the Resource Transfer Date.

4.2 The Transferor Trusts shall remain (and procure that any sub-contractor or supplier shall remain) responsible for all their (or as relevant, sub-contractor's or supplier's) employees (other than the Transferring Employees) on or after the Resource Transfer Date and shall severally indemnify and keep indemnified the Partnership Host against all Losses incurred by the Partnership Host resulting from any allegation or claim whatsoever, whether arising before on or after the Resource Transfer Date by or on behalf of any of the relevant Transferor Trust's employees or sub-contractor's or supplier's employees or persons engaged by the Transferor Trust or its sub-contractor or supplier who do not constitute the Transferring Employees.

4.3 Where any liability in relation to any of the Transferring Employees or former employee of the Transferor Trust or its sub-contractor or supplier in respect of their employment or its termination by the relevant Transferor Trust or its sub-contractor or supplier which transfers in accordance with the Transfer Regulations arises partly as a result of an act or omission occurring before the Resource Transfer Date and partly as a result of an act or omission occurring after the Resource Transfer Date, the relevant Transferor Trust shall severally indemnify and keep indemnified in full the Partnership Host against only such part of the Losses sustained by the Partnership Host as is reasonably attributable to an act fault or omission of the relevant Transferor Trust or its sub-contractor or supplier prior to the Resource Transfer Date.

4.4 The indemnities contained in paragraphs 4.1 shall apply as if references in that paragraph to any act, fault or omission of the Transferor Trust also included a reference to a sub-contractor or supplier employer of any Transferring Employee prior to the Resource Transfer Date.

4.5 The Partnership Host shall indemnify and keep indemnified in full the Transferor Trusts against:

4.5.1 all Losses incurred by a Transferor Trust in connection with or as a result of any claim or demand against a Transferor Trust by (i) any person who is, or has been, employed or engaged by the Partnership Host or any sub-contractor or supplier in connection with the provision of the Services or (ii) any trade union or staff association or employee representative in respect of such person, in either case where such claim arises as a result of any act, fault or omission of the Partnership Host or any sub-contractor or supplier on or after the Resource Transfer Date;

4.5.2 all Losses incurred by the Transferor Trusts in connection with, or as a result of, any claim by any employee, trade union or staff association or employee representative (whether or not recognised by the Partnership Host or any relevant sub-contractor or supplier in respect of all or any of the Transferring Employees) arising from, or connected with any failure by the Partnership Host and/or any sub-contractor or supplier to comply with any legal obligation to such trade union, staff association or other employee representative whether under Regulation 13 of the Transfer Regulations, under the Directive or otherwise and, whether any such claim arises or has its origin before on or after the Resource Transfer Date.

4.6 The Trusts agree to jointly and severally indemnify each other against all Losses incurred by the Transferor Trusts in connection with or as a result of:

4.6.1 any claim by any Transferring Employee that any proposed or actual substantial change by the Partnership Host to the Transferring Employees' working conditions, or any proposed measures of the Partnership Host or any relevant sub-contractor or supplier are to that employee's material detriment or to the material detriment of any person who would have been a Transferring Employee but for their resignation (or decision to treat their employment as terminated under Regulation 4(9) of the Transfer Regulations) whether such claim arises before on or after the Resource Transfer Date; and

4.6.2 any claim arising out of any misrepresentation or mis-statement made by the Partnership Host or any sub-contractor or supplier (except where the Partnership Host is negligent) to the Transferring Employees or their representatives whether before, on or after the Resource Transfer Date and whether liability for any such claim arises before on or after the Resource Transfer Date.

5. PAY AND BENEFITS (INCLUDING REDUNDANCY PAY)

5.1 Each Trust shall and shall procure that its sub-contractor or supplier shall be responsible for all remuneration, benefits, entitlements and outgoings in respect of its Transferring Employees, including without limitation all wages, holiday pay, bonuses, commission, payment of PAYE, national insurance contributions, pension contributions, statutory redundancy payments, contractual redundancy payments, payments on early retirement and otherwise, prior to the Resource Transfer Date.

5.2 The Partnership Host shall be responsible or shall procure that any relevant sub-contractor or supplier is responsible, for all remuneration, benefits, entitlements and outgoings in respect of the Transferring Employees and any other person who is or will be employed or engaged by the Partnership Host or any sub-contractor or supplier in connection with the provision of the Services, including without limitation all wages, holiday pay, bonuses, commission, payment of PAYE, national insurance contributions, pension contributions, payments on early retirement and otherwise, on or after the Resource Transfer Date.

5.3 The Trusts agree to jointly and severally indemnify the Partnership Host for any and all Redundancy Costs arising from a redundancy of any Transferring Employee on or after the Resource Transfer Date. For the avoidance of doubt, each Trust including the Partnership Host will pay an equal share of the Redundancy Costs. No redundancies will be made without the agreement of the SYB Pathology Partnership Board.

6. OFFER OF EMPLOYMENT TO OBJECTING EMPLOYEES

6.1 If any Transferring Employee objects to the transfer, the Trusts will take all necessary steps to offer employment to such employees and will seek to preserve continuity of employment. The Transferor Trust which employs the relevant Transferring Employee will take primary responsibility for searching for alternative employment, however, all Trusts must cooperate to search for employment and offer employment on the same terms as the relevant Transferring Employee was afforded immediately prior to the Resource Transfer Date.

7. CLAIMS AND GRIEVANCES

7.1 The Trusts agree to take all reasonable steps to conclude internal grievance, disciplinary and appeal processes prior to the Resource Transfer Date.

7.2 In the event that any of the Transferring Employees bring or raise claims, grievances or appeals on or after the Resource Transfer Date that relate in whole or in part to their employment prior to the Resource Transfer Date, the Trusts agree to cooperate with the Partnership Host and to promptly comply with all reasonable requests for information and to afford the Partnership Host access to any of their employees who may be relevant

witnesses in order to assist the Partnership Host in defending, responding to and investigating any such claims, grievances or appeals.

8. RECRUITMENT

8.1 Between the date of this Agreement and transfer of the Services under TUPE the Trusts agree:

8.1.1 not to appoint to any existing vacancy within the Services without the agreement of the SYB Pathology Partnership Board;

8.1.2 not to advertise any new vacancy within the Services without the agreement of the SYB Pathology Partnership Board; and

8.1.3 to undertake all approved recruitment to the Services in accordance with the SYB Pathology Workforce Group vacancy control procedure.

9. EXIT ARRANGEMENTS

9.1 In the event of a change of Partnership Host, termination of the Partnership, or any other event giving rise to a subsequent transfer under TUPE, the Trusts will agree exit terms and arrangements via the SYB Pathology Partnership Board at least two months in advance of the subsequent transfer of the Services (or as soon as reasonably practicable where two months is not possible).

Part 2

Employee Liability Information

Each Transferor Trust will supply the Partnership Host the Employee Liability Information as soon as finalised and confirmed. This is Information relating to each of those employees of the respective Transferor Trust who it is expected, if they remain in the employment of the relevant Transferor Trust or its sub-contractor or supplier until immediately before the Resource Transfer Date, would be Transferring Employees.

SIGNATURE PAGE

SIGNED by ....
(Signature)

(Role) ……..
.....
for and on behalf of (Date)

Barnsley Hospital NHS Foundation Trust

SIGNED by ....
(Signature)

(Role) ……..
.....
for and on behalf of (Date)
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

SIGNED by ....
(Signature)

(Role) ……..
for and on behalf of .....
The Rotherham NHS Foundation Trust (Date)

SIGNED by ....
(Signature)

(Role) ……..
.....
for and on behalf of (Date)
Sheffield Children's NHS Foundation Trust

SIGNED by ....

(Signature)

(Role) ……..

for and on behalf of

Sheffield Teaching Hospitals NHS Foundation Trust

.....

(Date)

Subject:	**Finance and Performance Committee 23 March 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	**Ref:P80/22i**	**BoD:06/05/2022**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Finance and Performance Committee	**Date:** 23 March 2022	**Chair:** Nicola Bancroft

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Divisional Performance Update: Surgery	The Committee welcomed representatives from the Senior Management Team from the Division of Surgery who provided an overview of the Divisional structure and further highlighted the following: • At Month 11 the Division was carrying £70K deficit in month with an agreed control total of £2.75m for the full year. • Cost Improvement Programme (CIP): Schemes had been identified for 2022/23 acknowledging that additional engagement with larger transformational schemes was still required. • There are ongoing challenges relating to staffing with agency spend projected to increase by £143K due to recovery work, impact of Covid-19 and sickness. A robust process is in place to ensure managerial oversight of staffing vacancies and agency usage. The Committee was assured that the Division was improving in relation to performance around operational and financial performance targets but mindful of the requirements to deliver against what has been committed to for the next 12 months.	Board of Directors	Assured

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
2	Risk and Assurance: Board Assurance Framework (BAF) and Risk Register	The Committee received and discussed the position for quarter 4 acknowledging the ongoing work around the BAF noting the year end position. The Committee discussed the three BAF risks aligned to the Committee noting that two are currently managed risks. The Committee discussed the one risk rated 15 and above assigned to the Finance and Performance Committee and noted the visibility of the high level action plan associated with the risk further acknowledging that actions aligned to risks on the risk register remain in development. The Committee noted the plan to receive both the BAF and the Risk Register on a monthly basis to ensure the Committee remains sighted on the risk profile. In addition, operational risks would be part of the review at the next Committee.	Board of Directors	Assured – BAF assessment as at Quarter 4 Assured re process for Risk Register
3	Integrated Performance Report	The Committee received and discussed the Integrated Performance Report noting the following: • Challenges continue with the emergency pathways due to the increasing number of COVID positive patients and increasing staff absences with revised Infection Prevention and Control guidance expected. • Discussions continue within the Executive Team in relation to the expected challenges around the activity uplift for 2022-23. The Committee noted limited assurance whilst recognising the challenges on the emergency pathways and performance of elective recovery the Committee sought further clarity and assurance on how delivery on performance will be managed going forward into the new financial year.	Board of Directors	Limited Assurance

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
4	Integrated Financial Performance Report	The Committee received and discussed the financial position noting the following: • At Month 11 financial position better than plan at £144K, year to date position was reported at £1.4M better than plan, forecasting to be £1.9M better than plan. • One risk highlighted related to the expected delivery of the MRI scanner which is due to be delivered just prior to the year end. • Work continues with Division on agreeing control totals for the next financial year. • There is an under spend on pay in month by £228K with an over spend on non-pay costs against budget primarily driven by increased costs for clinical supplies. • Currently the Trust is in a strong cash position which is expected to reduce as invoices are paid by the end of the financial year. The Committee was assured that the Trust would deliver on the financial plans at year end.	Board of Directors	Assured

Subject:	**Finance and Performance Committee 27 April 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	**Ref:P80/22i**	**BoD: 06/05/2022**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Finance and Performance Committee	**Date:** 27 April 2022	**Chair:** Nicola Bancroft

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Divisional Performance Update: Community	The Committee welcomed representatives from the Senior Management Team from the Community Division who provided an overview of the Divisional structure highlighting that the Head of Nursing post remains vacant. In addition, the Committee noted the following: • Staffing levels: A significant number of nurses left during the pandemic with the Division starting to recover with increased numbers of support workers. • Cost Improvement: Over achieved by £419K with non-recurrent CIPs with 100% recurrent CIP achieved. • A number of new externally approved schemes have supported income generation such as 'Physio First funding which will be continued into 2022-23. • Levels of activity within the Community have grown significantly resulting in the number of visits per day increasing. • Performance against the urgent community response two hour target is at 85% which is above the national target of 70%.	Board of Directors	Assured

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee concluded the presentation provided good insight into the challenges faced by the Division and was assured that the leadership team addressing the issues raised.		
2	Risk and Assurance: Board Assurance Framework (BAF) and Risk Register	The Committee discussed the risk register noting the one risk aligned to the Committee rated 15. The Committee further noted the ongoing work to strengthen the risk register. The Committee discussed the year end position in relation to the BAF noting that the new BAF risks were in development to align with the new 5 Year Strategy.	Board of Directors	Assured re process for Risk Register
3	Operational Plan Priorities 2021-22	The Committee reviewed the year end position in relation to progress against the operation plan 2022-22 highlighting the following: • Of the five programmes one closed, one completed, two remain amber and one remains red. • Discussions have taken place in relation to ring fencing resources to enable delivery on agreed priorities. The Committee acknowledged that the last financial year had been challenging from an operational perspective and whilst there is assurance on the governance process around the operational plan, the Committee was not assured on delivery.	Board of Directors	Assured on the processes around the operational priorities but not assured on delivery.
4	Operational Performance	The Committee received and discussed the Performance Report highlighting the following: • Recovery of performance continues with a reduction seen in Referral To Treatment (RTT) times reduced.	Board of Directors	Limited Assurance

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• Elective activity within Trauma and Orthopaedics has recommenced with our dedicated orthopaedic ward re-opened to elective patients. • There is a marginal improvement in performance within Emergency Care but remains under pressure due to compromised flow of patients within the Trust. The Committee welcomed the additional narrative within the report which provided good insight into the demands on performance generally across the Trust. However, the Committee concluded there was limited assurance as we were not delivering on all aspects of performance due to the ongoing challenges that remain.		
5	Integrated Financial Performance Report	The Committee received and noted the Integrated Financial report highlighting the following: • The Trust delivered a deficit to plan in March of £276K • There has been an overspend in pay costs against an overspend in non-pay costs • Expenditure on drugs and clinical supplies continue to increase in month with increasing energy and utility costs seen in month. • CIP: Over performance in year of non-recurrent cost improvement programmes • The Trust has a healthy cash balance in month. The Committee commended the Trust on delivery of the financial plan at year end.	Board of Directors	Assured.

Subject:	Quality Committee 30 March 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA Quorate: Yes	Ref:P80/22ii	BoD: 06/05/2022

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality Committee	**Date:** 30 March 2022	**Chair: Dr J Bibby**

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Risk Register and Board Assurance Framework	The Committee received and discussed the risks scoring 15 and above aligned to the Quality Committee highlighting the following: • The Committee considered 17 risks aligned to one Committee too many to allow for scrutiny. Work remains ongoing to ensure the correct level of risks are aligned to the correct Committee. The Committee discussed the Board Assurance Framework highlighting the format remains challenging to read and that little progress had been made in the last year with no risk targets being achieved. The Committee concluded there was limited assurance in relation to the risk register and the Board Assurance Framework with recognition of the work that remains to be completed.	Board of Directors	Limited Assurance
2	Infection Control Chair's Log	The Committee received the report receiving additional clarification that vulnerable patients are protected by reverse barrier nursing in side rooms where available in addition to preventing admissions of clinically vulnerable patients is clinically possible.	Board of Directors	Assured
3	CQC Assurance Report	The Committee received the report highlighting the application to the CQC for consideration of lifting the Section 31 Regulatory	Board of Directors	Limited Assurance

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		sanction in UECC from 2018 with the outcome of their decision awaited. The Committee in discussing the report concluded there was limited assurance and requested additional information to be included in the next report.		
4	Safeguarding Mandatory Training Compliance Report	The Committee received and discussed the report noting some areas of training compliance were lower than required with some red rated. The Committee requested additional information to come back to the Committee detailing actions taken in areas where compliance was lower than required.	Board of Directors	Limited Assurance
5	Clinical Negligence Scheme for Trusts (CNST) - Maternity	The Committee discussed the content of the report noting an external review is planned to take place on 25 May 2022.	Board of Directors	Assured
6	Safe and Sound Quality Scorecard	The Committee noted the content of the report highlighting an increase in falls had been reported last month which is now an improving position. A focused piece of work will take place with Tissue Viability in the Community during May 2022. The Committee concluded that whilst some improvements have been seen, a number of areas of concern remain.	Board of Directors	Limited Assurance
7	Mortality and Learning from Deaths	The Committee noted the mortality figures reducing with triangulation now taking place with Serious Incidents and Inquests.	Board of Directors	Assured
8	Serious Incident Report	The Committee received the report noting the increased number of Serious Incidents reported during February. The Committee concluded there was limited assurance currently with an expectation of an improving position for the next report.	Board of Directors	Limited Assurance

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
9	Nutrition Report (Annual)	The Committee received and discussed the Nutrition Annual Report commending the work that had taken place during the last year with the expectation that measures put in place will improve the avoidance of harm.	Board of Directors	Assured
10	MHRA Inspection – Medical Physics: Update on Action Plan	The Committee discussed the content of the report receiving assurance that as the national review remains ongoing, the business case will not progress until the guidance has been received. Confirmation has been received that the Trust has made the environment safe.	Board of Directors	Assured

Subject:	Quality Committee 27 April 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA Quorate: Yes	Ref:P80/22ii	BoD:06/05/2022

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality Committee	**Date:** 27 April 2022	**Chair: Rumit Shah**

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Risk Register and Board Assurance Framework	The Committee received and discussed the risks graded 15 and above aligned to the Committee noting the ongoing developments in relation to the high level action plan to strengthen the risk register and alignment to the Board Assurance Framework. The Committee further noted the ongoing development of the new Board Assurance Framework noting the revised strategic risks will be discussed at Board in May 2022.	Board of Directors	Assured on the processes currently in place to strengthen the risk register.
2	Medication Safety Committee Quarterly Report	The Committee received the Medication Safety Committee highlighting the number of medication related incidents including the level of harm. The Committee noted the ongoing overarching Medicines Management Quality Improvement Plan. The Committee concluded that due to the lack of detail within the report there was limited assurance noting the annual report will be presented at the Committee in June 2022.	Board of Directors	Limited Assurance
3	Infection Prevention and Control	The Committee received and discussed the year end position in relation to Health Care Associated Infections (HCAI) highlighting the following: • Clostridium difficile trajectory for 2021-22 was breached as was the Klebsiella trajectory	Board of Directors	Assured on processes in place

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• The Trust saw an increase in COVID-19 cases which was expected when the legal requirement to test and isolate if positive was removed. • Carbapenamase producing enterobacteriaceae (CPE) cases have increased with reviews of cases ongoing with support from the regional field epidemiology team at UKHSA. Despite the increasing cases, the Committee noted the positive feedback from the external team at NHSI/E and therefore concluded it was assured around the infection prevention and control processes within the Trust.		
4	Operational Plan 2021-22: Year End Position	The Committee received and discussed the year end position in relation to the two programmes aligned to the Committee, namely Standards of Care and Quality Improvement and Learning from Deaths. Following a detailed discussion, the Committee concluded there was insufficient evidence presented within the report to sign off the objectives at year end and requested more detail to be presented to the May Committee.	Board of Directors	Limited Assurance to enable sign off at year end.
5	Operational Plan 2022-23	The Committee discussed the two mandates proposed as aligned to the Quality Committee concluding they required further consideration and drafting before presentation at Board in May.	Board of Directors	Noted
6	Mortality and Learning from Deaths Report	The Committee received and discussed the report noting the rolling 12 month HSMR value is 107 decreasing from 111.4 and therefore the Trust is now in the 'as expected' band for the first time since 2018. In addition the SHMI was noted to be 107.7, a reduction from 109.4 therefore the Trust remains in the 'as expected' band.	Board of Directors	Assured on the process with limited assurance on thematic reviews of deaths.

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee was assured on the process for review of deaths further concluding there was limited assurance around the thematic review of learning from deaths.		
8	Tendable Quarterly Report	The Committee received the first quarterly report relating to the Tendable Audit Programme. The Committee acknowledged that the digital tool introduces a revised auditing programme and provides a rich source of information. The Committee requested that additional detail be added in relation to actions that have been identified as areas of concern.	Board of Directors	Noted
9	Quality Improvement Priorities 2022-23	The Committee discussed and supported the nine Quality Improvement Priorities for 2022-23 concluding that additional work was required to ensure clarity on the objective and what quality improvement is expected as a result.	Board of Directors	Noted
10	Complaints Annual Report	The Committee discussed the content of the Complaints Annual Report recommending review of a number of sections prior to presentation at Board in May.	Board of Directors	Noted

Subject:	People Committee: 18 March 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA Quorate: Yes	Ref:P80/22iii	BoD:06/05/2022

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: People Committee	**Date:** 18 March 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- Estates	The Committee welcomed the leadership team from the Estates Department who provided an overview of the leadership team and further noted the following: • Sickness absence: Sickness absence rates within the department are higher with higher than normal level of complex long term sickness cases whilst working closely with Occupational Health to manage cases; • The team are promoting the health and wellbeing offer that is bespoke to the department; • Challenges around completion of appraisals with good compliance with mandatory training overall. • Key successes for the department include exceeding CIP targets, the Gold RoSPA award and a national leader on the NHS Premises Assurance Model and developing staff through the apprenticeship model. • Key issues and risks highlighted as long term sickness, and aging workforce and succession planning in addition for the need to improve on our staff survey.	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
		The Committee acknowledged the hard work ongoing within the Estates department but concluded limited assurance due to the workforce metrics.		
2	Workforce Report	The Committee received and discussed the Workforce Report highlighting the following: • Covid-19: The Trust had moved into the 'living with Covid' stage recognising that although the numbers of positive cases amongst staff remained high, staff were reporting not as serious as with previous waves. However this was still adversely impacting the ability to deliver services. • A successful Health Care Support Worker recruitment event had been held using values based interview techniques. • Sickness absence: Currently at high levels generally. The Committee noted the ongoing positive work but concluded limited assurance due to the workforce metrics.	Board of Directors	Limited Assurance
3	Covid/Flu Vaccinations: Update	The Committee received the updated position in relation to Covid/Flu vaccinations noting the following: • The Trust remains in a strong positon for update of Covid and Flu vaccinations with the Trust at 70% for Flu vaccinations (nationally the uptake for Flu vaccination has been poor) • There is an expectation that the Trust will support the vaccination programmes at Rotherham PLACE and the wider South Yorkshire area which will require resources to continue to deliver. The Committee concluded it was assured on the current situation	Board of Directors	Assured.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		and commended the team for delivery of the programme to date noting that discussions will take place with the Executive team in relation to resources required for future delivery.		
4	National Staff Survey	The Committee received an update on the National Staff Survey as follows: • National reports had now been received (embargoed until end March 2022) and had been shared with the Executive Team and the Divisional Leadership Teams. • Themes from the survey relate to flexible working options, health and wellbeing and work life balance. The Committee acknowledged that more detail would be available in due course and there was assurance around the process for managing this going forward.	Board of Directors	Assured on the process
5	Freedom to Speak Up Policy	The Committee received the updated Freedom to Speak Up Policy as part of the consultation process. The Committee noted that the revised National template was still outstanding but there was a need to update the Trust's current Policy with a caveat it may require further updates once the National template Policy has been received. The Committee was assured on the process being carried out to approve the updated Policy prior to sign off at Board.	Board of Directors	Assured on the process.
6	Gender Pay Gap Annual Report	The Committee received and discussed the Annual Report noting the gender pay gap had increased again in year. It was noted that the Clinical Excellence Awards affect the pay gap as historically an increased number of male clinicians applied than females.	Board of Directors	Assured.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee noted the requirement to publish the report on the Trust's public website by 31 March 2022 and recommended the report for publication.		
7	Risk Register	The Committee discussed the report noting there are currently no risks aligned to the Committee however, the Committee discussed four 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 in ensuring the correct alignment of risks assurance was received on the processes.	Board of Directors	Assured in relation to the plan to improve the risk register but currently Limited Assurance overall.
8	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.

Subject:	**People Committee: 22 April 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P80/22ii	**BoD: 06/05/2022**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: People Committee	**Date:** 22 April 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- Finance Department	The Committee welcomed the leadership team from the Finance Department who provided an overview of the Senior Management Team highlighting the following: • Mandatory training and Appraisal compliance will be the focus for the department for the following 12 months to improve compliance percentages. • The Finance Governance Action Plan commenced with the Interim Director of Finance in 2020/21 has been further embedded with the appointment of the substantive Director of Finance with all nine recommendations implemented overall. • Staff Survey results are positive across the department with an increase in response rate from 61.9% to 81.4% with increased morale within the team. • Workforce successes include flexible working arrangements whilst still maintaining performance against key deliverables. • Continued improvement in communication with an improvement in openness and transparency within the	Board of Directors	Assured.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		team. • Succession planning will be a key issue in the coming year both short term and long term planning required. The Committee noted the positive messages from the Finance Department despite ongoing challenges and was assured around the plan to address the risks and issues.		
2	People Objectives 2021-22 Operational Plan 2022-23	The Committee received the end of year position in relation to the progress against the Operational Objectives and Priorities noting the following: • Health and Wellbeing Programme is delivering on all key objectives as set out in the original mandate with some actions carried over into the new Operational Plan for 2022-23. • Employer of Choice remains 'amber' due to the postponement of the Medical and Dental Recruitment Strategy. • Organisational Development remains 'amber' as progress against this mandate has been adversely affected by the pandemic. The Committee noted the draft Operational Plan for 2022-23 relevant for the People Committee noting the additional work to be carried out prior to presentation at Board in May 2022.	Board of Directors	Limited Assurance
3	Workforce Report	The Committee received and noted the Workforce report highlighting the following: • Overall 12 month rolling appraisal compliance is 80% for March 2022 • Core MaST compliance has increased to 91% and is	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

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		currently 6% above the Trust's overall target of 85% • Sickness absence remains above target across all Divisions with a rolling sickness absence of 6.66& at the end March with the exception of Corporate Services. The Committee noted the key workforce metrics acknowledging the ongoing hard work across all staff groups.		support.
4	Health and Wellbeing Annual Update	The Committee received and commended the work carried out in relation to the health and wellbeing activity within the Trust despite the recent challenges relating to the ongoing pandemic and in particular noting the introduction of a Behavioural Therapist providing support to staff, previously investing in training 40 trauma resilience practitioners in addition to the introduction of mindfulness sessions. Funding has been secured through the ICS to pilot an innovative weight loss programme with positive uptake. 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 and the anticipated programme of work for the new financial year.	Board of Directors	Assured
5	National People Plan	The Committee received the final update against the Employer action statements contained within the NHS People Plan noting that the majority of actions had been closed with existing gaps relating to system wide activities or central policy activities.	Board of Directors	Assured
6	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 four risks that relate to staffing but are currently linked to the Quality	Board of Directors	Assured in relation to the plan to improve the risk register.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		Committee. The Committee noted the progress with the inclusion of the actions relevant to each risk but noting more detailed work is required on the risk register generally.		
7	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 that will align with the new 5 Year Strategy.	Board of Directors	Assured in relation to the process around the BAF but limited in relation to the alignment of the risk register.

Subject:	Audit Committee 29 April 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA Quorate: Yes	Ref:P80/22(iv)	BoD: 06/05/2022

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Audit Committee	**Date:** 29 April 2022	**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 received information on these risk by Division and noted that positive engagement continued with the Divisions on the risk management process. The review by the Internal Auditors of Strategic Risk Management had received a limited assurance assessment. Trust Officers indicated that this review concurred with their own findings. The Risk Management action plan was progressing; however the Committee noted that there had been an underestimation as to what was required in terms of organizational training and the functionality of Datix. Therefore, completion of the action plan may take longer than anticipated.	Board of Directors	Limited in terms of risk management process. Assured that a plan in place to address

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Risk Management Committee (RMC) had stood down the Risk Analysis Group, with the emphasis for local discussions to be held at Divisional level. The RMC was seeking improved articulation of risks and was horizon scanning risks currently scored below 15 as to whether they would increase. This would improve visibility to the Board		
2	Board Assurance Framework (BAF)	The Committee had noted that discussions had commenced in development of the 2022/23 BAF, firstly by the Board of Directors, and secondly with the support of a focus group. The proposals would be considered by the Board on 06/05/2022. The Committee consider that the agenda for each of the Board Assurance Committees' should be instrumental in supporting progressing the BAF risks.	Board of Directors	Assured that development of the 2022/23 BAF was in progress
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. Five audit reports have been issued: • Estates Procurement – Significant Assurance • General Ledger and Financial Reporting Arrangements – Significant Assurance • Learning from Deaths – Governance (revisit) –Limited Assurance • Performance Management – Significant Assurance • Strategic risk management – Limited Assurance. Whilst the revisit of Learning from Deaths Governance has seen some areas of improvements, some new risks had been identified resulting in no change to the assurance rating.	Board of Directors	

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		Areas of concern were identification of trends and learning opportunities through the Structured Judgement Reviews, and reports to such as the Board not providing data in relation to deaths in patients with learning disabilities. **The Audit Committee sought assurance that the Quality Committee will monitor progress against the recommendations from the Learning from Deaths Governance review through to implementation.**		
4	Interim Head of Internal Audit Opinion	The Committee received the interim Head of Internal Audit Opinion as follows: "An interim opinion of significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently." The Committee considered that the interim opinion was balanced and a fair assessment of the year on year improvement. The final opinion would be made available in June 2022.		
5	Internal Audit Plan 2022/23	The Committee approved the 2022/23 Internal Audit Plan, which had been developed following discussion with the Executive Directors. The Plan would remain dynamic during the year to address any matters requiring further investigation by the Trust or the Committee.		

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee agreed that the number of contingency days should be increased from 2 to 10, with a total 220 day allocated.		
6	Counter Fraud	The Committee received the routine Counter Fraud Progress report and approved the Counter Fraud Annual Workplan of 75 days of work.		
7	Standing Financial Instruction (SFI) Breach Report	The Committee received the report identifying breaches of financial governance as defined by the Standing Financial Instructions (SFIs) for the period 1 January 2022 to 31 March 2022. The Committee had noted that: • 88.9% of invoices (by number) received within 30days, year to date as at March 2022 • There were no staffing breaches to report between January to March 2022, where staffing invoices were outside the NHS Secondment / agreed framework. • of the 9,724 invoices received by the Trust, 2% didn't have a purchase order raised at the point at which goods and services were ordered, which amounted to £656k of the Trust's spend of £27.564million for the period January to March 2022.	Board of Directors	Assured of the processes in place regarding breaches of SFIs
8	Losses and Special Payments	The Committee received the Losses and Special Payments Report 1, losses and Special Payments for the fourth quarter were £123k.	Board of Directors	Assured of the processes in place regarding losses and special payments
9	Tender Waivers	The Committee received the report which detailed the five single tender waivers approved since the last meeting.	Board of Directors	Assured of the processes in place regarding tender waivers

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
10	Whistleblowing	The Committee considered the revised Whistleblowing Policy and would recommend its approval by the Board of Directors. The Committee also received the annual report from the Lead Freedom to Speak Up Guardian. Common themes, similar to the national position, remained attitude and behaviours. It was noted that there had been an increase in patient safety in 2021/22 due to the pandemic, with any clinical issues anonymously brought to the attention of the Chief Nurse by the Freedom to Speak Up Guardian.	Board of Directors	Assured that the processes in speaking up were effective.
11	Annual Report and Accounts	The Committee has received the draft unaudited Annual Accounts 2021/22 and noted that they had been submitted to NHSE/I, and the External Auditors on 26 April 2022. In terms of the Annual Report, work had commenced in collating the information required with acknowledgement that this will be drafted during May 2022. The draft Annual Governance Statement had been presented with additional information still required to be submitted prior to approval in June 2022. The External Auditors had already started their review, with the Committee next meeting on 13 June to consider all documentation relating to the Annual Report and Accounts 2021/22.	Board of Directors	Noted

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P81/22
Report	**Care Quality Commission (CQC) Assurance Report**
Executive Lead	Helen Dobson, 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 – March Cycle 2022 • The unannounced inspection to the Urgent and Emergency Care Centre on 2 and 8 March 2022 • A summary of the Confirm and Challenge Sessions held through March 2022 • CQC Engagement April 2022
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	A version of this paper was presented to the CQC Delivery Group on 12 April and to the Quality Committee on 27 April 2022
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 for Board is to note the content of the Report and be assured that robust plans are in place and that progress is being made to address the issues identified through the 2021/22 Inspection process. The Chief Nurse is the Board lead for Regulatory Compliance.

Recommendations	It is recommended that the Board of Directors: • Note the content of the Report
Appendices	• Appendix 1– Response to the formal feedback letter following the unannounced CQC Inspection of the Urgent and Emergency Care Centre on 2 and 8 March 2022

1. CQC Visit – Urgent and Emergency Care – March 2022

1.1 As reported to the March CQC Delivery Group, Urgent and Emergency Care (UECC) received an unannounced visit on the 2 and 8 March from a small CQC team. The purpose of the visit was primarily to determine whether 'significant' progress had been made in relation to the actions identified in the Section 29a issued to the Trust in August 2021 following the formal inspection in May/June 2021.

1.2 The team recognised that progress had been made and saw evidence of good practice. They were complimentary about the engagement and professionalism of a number of staff who were personally named in their formal feedback.

1.3 However, some concerns were raised at the first visit on 2 March, which the department responded to immediately. This response was acknowledged in the follow up visit on 8 March.

1.4 The Trust submitted the reply to the formal feedback letter on the 18 March, which included additional supporting evidence. The response letter is attached at Appendix 1.

1.5 The key areas of continuing concern refer to the accurate and timely completion of relevant risk assessments, in particular the assessment for a patient with a mental health need. In the risk assessments reviewed, CQC colleagues noted that, although the Trust Mental Health Risk Assessment document was fit for purpose there was a lack of documentation in the patient record confirming appropriate action had been taken and staff were acting on the output of the assessment. This continues to be a challenge but actions are being undertaken to address this.

1.6 Body mapping for children who present with a physical injury was also raised as a concern. Five sets of patient notes were reviewed; with inspectors noting only one set contained a documented body map. The Trust reviewed all five cases following the visit and confirmed that none of the cases met the criteria for completion of a body map. We provided a significant amount of evidence to support the Trust body mapping process, including documented guidance on the criteria of when a body map is mandated.

1.7 Failure of some staff to follow required Infection, Prevention & Control measures, including the correct wearing of PPE was raised. The Chief Nurse issued a Trustwide brief reiterating the importance of adhering to these standards, emphasising the responsibility of all staff to challenge bad practice.

1.8 Finally, concerns were noted with the general cleanliness and clutter in the department. There are current challenges with storage facilities, which will be resolved via the work underway, through the Acute Care Transformation (ACT) programme. Increased focus on the safe storage of medicines is also required.

1.9 CQC have confirmed that the Draft Report following the visit will be received in May. Confirmation was received at the CQC Engagement meeting on 21 April, that the response made by the Trust was robust and had positively influenced the potential outcome.

2. CQC Assurance

2.1 Confirm and Challenge meetings have been held with Children and Young people, Maternity, Urgent and Emergency Care and Medicine throughout March/April. The Must and Should take and Section 29a Action Plans have been updated accordingly.

2.2. Table 1 illustrates the position against the Must and Should take actions for Children and Young People, Maternity and Medical Care Core Services following the CQC Delivery Group meeting on 12 April.

In summary:

- Children and Young people – one action re-rated from Amber to Red relating to the unavailability of the required level of Resus training (PILS) for Paediatric staff. The Group agreed this is a continuing challenge.
- Maternity - no change in the rating of actions; however good progress continues to be made with the service collating the evidence to demonstrate actions taken are not only achieved but sustainable and embedded into business as usual.
- Medical Care – the Group approved six actions (25 sub actions) as 'Blue' (embedded) following discussion regarding the supporting evidence.

Core Service Area	No of issues	No of actions	R	A	G	B	G
Children and Young People	24	45	1	9	12	21	2
Maternity	6	10	0	0	7	3	0
Medical Care	18	72	0	0	46	25	1

Table 1

3. Urgent and Emergency Care – Section 29a Assurance

3.1 Table 2 illustrates the position against the UECC Section 29a actions. The March confirm and challenge sessions focussed, in the main, on section 1-3 of the Action Plan.

3.2 Section 4 of the plan focuses on the leadership of the department. The actions within this section have been aligned to the Trust Acute Transformation Programme (ACT), where progress is monitored via the ACT Steering Group, chaired by the Chief Executive.

3.3 Key issues discussed:

- S29a Action 1.1 – *'Risk assessments were not completed in line with Trust Policy and we saw evidence of this in records'*. Although it is acknowledged that work has been undertaken, in particular to improve risk assessment documentation, in light of the unannounced CQC inspection in March, CQC Delivery Group agreed that this action is re-rated from Green to Amber as it was identified there remain gaps in assurance.
- S29a Action 1.1.1 – *'20 sets of patient records were reviewed with 50% with no evidence of any risk assessments being completed'*. Again, in light of the

unannounced CQC inspection CQC Delivery Group agreed that this action is re-rated from Green to Amber as above.

- S29a Action 2.1 – *'Safeguarding processes were not always followed to protect patients from the risk of harm'*. Following a robust discussion re the supporting evidence to demonstrate the action is now embedded, CQC Delivery Group approved the action as Blue.
- S29a Action 2.1.1 – *'Although there was a process in place, staff did not always review adult safeguarding referrals to ensure they had been completed appropriately'*. CQC Delivery Group approved the action as Blue in response to the evidence presented.

Urgent and Emergency Care	No of issues	No of actions	R	A	G	B	G
Section 1 Within the UECC, there was evidence that patients were not always receiving safe care and treatment.	21	62	0	13	48	1	0
Section 2 There were issues around the safeguarding processes for both adults and children, which could increase the risk of harm.	7	19	0	7	4	8	0
Section 3 There was evidence to show that not all patients received appropriate patient centred care.	8	14	0	3	11	0	0
Section 4 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	0	0	12	0	0

Table 2

3.4 Progress against the Action Plans continues. For the Core Services of Maternity and Children and Young People, evidence of progress against their actions is where it is expected to be. Medical Care have continued to make progress against their actions, with all actions completed. The Division are in the process of collating robust evidence to demonstrate that the improvements made are sustained and embedded into practice. It is expected that an increased number of actions will be 'Blue' within quarter one 2022/23.

3.5 The actions within the Section 29a for Urgent and Emergency Care (sections 1-3) have not progressed as rapidly as originally planned. Lack of significant improvement in some key result areas was identified during the recent CQC visit as described above. A significant amount of groundwork has been required to ensure staff across the department fully understand and are engaged in the improvement work. Many core systems and processes have required systemic review in order to provide the strong foundations required to sustain lasting change.

3.6 The continued operational pressures and staffing challenges within the department have been a contributory factor; however there has been a considerable shift in focus through March and April resulting in an improved grip on the work that needs to be undertaken

and the accountability for delivery. It is expected that this will be reflected in the CQC Delivery Group Assurance Report going forward.

4. Medicines Management Improvement Plan

4.1 The Medicines Management Improvement Plan was reviewed throughout March. As part of the review the actions have been cross-referenced with corresponding actions within the Must/Should take Plan to ensure consistency.

5. CQC Engagement

5.1 The CQC Engagement meeting took place on the 21 April. The key agenda items included current operational pressures and recovery plans, serious incidents declared since the last meeting and progress against the Regulation 28 'Prevent Future Deaths' notifications.

5.2 CQC are arranging a separate session with the CQC Lead Pharmacist to review progress against the Trust Medicines Management Improvement Plan. In preparation, the Chief Pharmacist and Deputy Director of Quality Assurance have met to ensure the actions and progress identified in the Medicines Plan aligns with the medicine-related actions within the overall Must/Should Take Plan. A date for the CQC medicines meeting has yet to be agreed.

5.3 We have received information that CQC have commenced their inspection of 'Systems'. To date we have not received documentation as to what standards are being looked at or where the Trust may feature.

5.4 For information – we have received a number of CQC Enquiries through March and April. Responses to all have been submitted within time. There are no specific themes and trends evident through the enquiries.

5.5 At the CQC Engagement on 21 April, confirmation was received that the application to have the Section 31 Condition in the Urgent and Emergency Care Centre removed was in process. CQC reported that the application was strong. It is currently with the Deputy Chief Inspector for final approval.

5.6 The Engagement meeting dates for the remainder of the year have been set, with the meeting planned for the 30 June to be a site visit. The Trust will agree a programme of activities to provide opportunities to display good practice, whilst demonstrating where improvements have been made in those areas where previous concern has been raised.

Elaine Jeffers
Deputy Director of Quality Assurance
May 2022

Michael Wright
Deputy Chief Executive

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Ref: MW/ej/mp/042

The Rotherham NHS Foundation Trust

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Chris Storton
Inspection Manager
South Yorkshire and Bassetlaw
North East Acute team
Care Quality Commission
Citygate
Gallowgate
Newcastle-upon-Tyne

18/03/2022

Care Quality Commission
Health and Social Care Act
Response to Inspection Feedback 09/03/2022
Provider ID: RFR. The Rotherham NHS Foundation Trust
Inspection ID: INS2-11723930501

Dear Chris,

Thank you for your letter dated 09/03/2022 providing the written feedback following the inspection of the Urgent and Emergency Care Centre (UECC) on 02/03/2022 and 08/03/2022. Please see the Trust response to the areas for improvement identified below:

1. **Safeguarding –** specifically in relation to body mapping of a child presenting with a physical injury

1.1 The Trust 'Guidance for documentation of injury and body maps' sets out the criteria for when a body map for a child presenting with a physical injury must be completed. The Guidance Document is attached at Enclosure 1.1.

The Safeguarding Team have benchmarked the Body Mapping Guidance with other acute providers and confirm it is in line with national requirements. The Body Mapping Guidance can be accessed via the Safeguarding section of the Trust Intranet site.

Staff within the Urgent and Emergency Care Centre are familiar with this guidance, which is available across the department. Compliance against the guidance is audited on a regular basis, both by an Emergency Medicine Consultant and the Safeguarding Team who carry out an independent audit quarterly. The Audit proposal form setting out the requirement and frequency of the Body mapping Audit is attached at Enclosure 1.2. Two examples of the UECC Audits are attached at Enclosure 1.3 and 1.4 covering the periods 2020-

2021 and June to August 2021, with the February 2022 independent Safeguarding Audit attached at Enclosure 1.5.

The outcome of each audit is discussed through the departmental governance process with learning disseminated. In addition, body mapping is a regular agenda item at the Safeguarding Operational Group and the Clinical Audit and Effectiveness Committee. The Safeguarding Team also provide additional support, advice and guidance to UECC. A '7 Minute Briefing,' highlighting awareness of injuries in non-mobile babies, including a reference to the Trust Body Mapping Guidance, produced by Safeguarding and circulated across the Department is attached at Enclosure 1.6 to further support the focus on the importance of recording injuries where concerns have been raised.

The five cases identified through the CQC Inspection, where four children had not had a body map completed have been reviewed by UECC since the visit in March. The review concluded that none of the five cases met the criteria for the completion of a body map – as defined in the Trust Guidance. One case had been referred to the Maxillofacial Team who had documented the child's injury on the standard Max Fac Template within Meditech. This is a standard template used for all Max Fac cases and does not replace a formal body map should a concern re a non-accidental injury be raised. The review of each case are attached at Enclosures 1.7-1.11.

2. Risk Assessments

2.1 Following the CQC Inspection in May/June 2021 a significant amount of work has been undertaken in relation to the importance of recognising those patients who require a risk assessment in order to ensure their safety.

There are a number of risk assessments carried out in UECC, including patients who may be at risk of a fall, developing a pressure ulcer, those who may not have capacity to make informed decisions about their care and treatment and those patients presenting with a possible or actual mental health condition.

We recognise that during the visit, errors and omissions were identified within the risk assessment documentation reviewed. Immediate action was taken following the visit on 2 March, which was acknowledged during the second visit on 8 March.

There is a weekly 'Tendable' Audit programme for falls and pressure ulcer risk assessments. In addition, the daily Quality Assurance Tool, undertaken by the Matron and now Band 7 senior nurses, focusing on key care issues such as the departmental environment, patient safety, safe staffing and medication management, provides an opportunity for real time feedback to staff on any gaps and omissions. Including the Band 7 team in this assurance process, increases senior nurse accountability and visibility of sub-optimal performance and allows for further training opportunities for their teams.

2.2 The medical records for the patient identified as having been left in the waiting area during the inspection without appropriate escalation to the Nurse in Charge have been reviewed. We can confirm that the patient had been escalated to the Consultant in Charge as the Nurse in Charge was speaking to a CQC colleague. The Consultant had reviewed the patient and prescribed

appropriate medications. A treatment plan was put in place, although at the time, due to departmental pressures, it was not possible to move the patient to a bed space.

2.3 Ensuring all patients have access to a call bell to summon assistance has been built into the Quality Assurance Tool. This further supports the departmental Intentional Rounding undertaken by nursing teams. The importance of ensuring patients can easily call for assistance has been reiterated across the department and is included in the Matron's Newsletter for Friday 18 March. The Newsletter is attached at Enclosure 2.1.

3. Assessment and management of patients presenting with mental ill-health

3.1 There has been an intense focus on improving the assessment process for patients presenting with a mental ill health. A Trust Mental Health Steering Group, chaired by the Deputy Chief Nurse is in place, in addition to support from the Mental Health Liaison team. Oversight of this is through the Strategic Safeguarding Committee, chaired by the Interim Chief Nurse.

The first iteration of the Mental Health Risk Assessment Documentation was launched in December 2021, which supplements the Manchester Triage Tool currently in operation. It was immediately identified that it was too complex and version two was produced. It was originally planned to begin using this after ratification through the Mental Health Steering Group on 9 March; however following feedback from the inspection on 2 March this was expedited with virtual approval from the Chief Nurse and Medical Director, a rapid 'Stop the Shift' training programme and implemented on 4 March 2022. Thus at the time of the visit on 8 March you observed the document in use. We can confirm that adherence with the Policy has continued since this date.

It is acknowledged that there are further improvements to be made to the actions taken following completion of the Mental Health Risk Assessment. To achieve this the timely and accurate completion of the Mental Health Risk Assessment is monitored as part of the senior nurse daily assurance and will be strengthened by a specific weekly 'Tendable' Audit to monitor compliance. This is currently being built and will be launched 01 April. The outcome of the Mental Health Audits will be reported through the Trust Mental Health Steering Group in addition to UECC Governance.

The Quality Assurance Tool, used by the Nurse in Charge during their regular formal 'walkabouts', has been strengthened to ensure that each patient who needs a Mental Health Risk Assessment has been identified and specifically, where an assessment has been completed, it is accurate and that all identified actions have been enacted. The UECC Matron carries out a daily case note retrospective review of risk assessments to ensure compliance and identify immediate learning needs.

As additional assurance, the Chief Nurse and Deputy Director of Quality Assurance are conducting weekly random spot checks of compliance with Mental Health Risk Assessments in real time. Any good practice or poor

performance will be shared immediately with the individual staff member and senior management team.

3.2 Ligature Risk Assessments have been undertaken on the cubicles in the Red and Blue areas of the Emergency Department, the Interview Room, the Paediatric area, the Waiting Room, Resus and Rapid Assessment and Treatment (RAT). The Assessments are now displayed in each area. The Risk Assessment documentation is attached at Enclosure 3.1.

Cubicles 1, 2 and 3 in the Red area are the first line choice for patients who require close observation; however, it is recognised that it is not always possible to allocate these cubicles when the department is under pressure. It is therefore important to ensure that the assessment of the patient also includes consideration of whether they are at risk of self-harm from a ligature and take all necessary steps to document and mitigate this. Again, this forms part of the daily patient safety checks.

4. Infection, Prevention and Control

4.1 We acknowledge the non-compliance observed in relation to the correct wearing of personal protective equipment (PPE) and a message reiterating the importance of adhering to required PPE standards has been delivered across the Trust by the Chief Nurse. This is attached at Enclosure 4.1.

The daily Quality Assurance Tool also identifies staff who are not adhering to infection control standards, including the appropriate use of PPE. This is everyone's responsibility and staff are expected to challenge colleagues where necessary.

5. Safe and Clean Environments

5.1 The storage and supply of oxygen cylinders to UECC has been raised with the Chief Pharmacist and the Estates Department. A review of the oxygen supply and storage has taken place with excess oxygen returned to the oxygen store. The daily checks ensure that oxygen within the department is safely secured at all times and agreed stock levels are maintained. A Band 6 nurse has taken responsibility for ensuring this is maintained on a daily basis.

5.2 As part of the Acute Care Transformation programme the storage and stock management across UECC is being reviewed. It is recognised storage space is limited and creative solutions are required to ensure the department remains free from clutter.

5.3 The security of medicines is part of the daily senior nurse assurance checks and all staff have been asked to ensure cupboards containing medicines are locked at all times. Further discussions are taking place with Estates and Pharmacy as to whether a different type of cupboard or locking mechanism can be sourced to reduce the risk. There are examples across the organisation for consideration.

6. X-ray Staffing

We acknowledge the comments raised at the time of the visit relating to concerns re availability of staff to supervise patients being transferred to the X-ray Department. To provide an opportunity for staff to discuss their worries a listening event with portering and patient transfer staff has been organised for 08 April 2022.

7. Summary

We would like to thank you once again for your constructive feedback, highlighting those areas where further improvement is required. We are pleased that you acknowledged the immediate actions taken between the 2 and 8 March and hope you feel we responded appropriately.

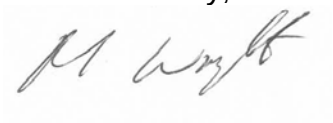
We are committed to ensuring all patients who attend the Urgent and Emergency Care Centre are treated in a safe and compassionate manner and are able to receive the care and treatment they deserve.

Since the inspection in May 2021 UECC have worked hard to make improvements and address the concerns raised, despite continued operational and staffing pressures. There have been changes to the leadership team and there is a palpable increase in the engagement of staff to be involved and lead the changes required.

8. Supporting Evidence

Supporting Evidence	
Enclosure 1.1	Guidance for documentation of injury and body maps
Enclosure 1.2	Clinical Audit Proposal Form
Enclosure 1.3	Body Mapping Audit 2020-2021
Enclosure 1.4	Body Mapping Audit June-August 2021
Enclosure 1.5	Body Mapping Audit – Safeguarding February 2022
Enclosure 1.6	Safeguarding '7 Minute' Briefing (including reference to Body Mapping)
Enclosure 1.7	Chronology time line – Case 1
Enclosure 1.8	Chronology time line – Case 2
Enclosure 1.9	Chronology time line – Case 3
Enclosure 1.10	Chronology time line – Case 4
Enclosure 1.11	Chronology time line – Case 5
Enclosure 2.1	UECC Matron Newsletter 18/03/22
Enclosure 3.1	Ligature Risk Assessments
Enclosure 4.1	Message from Chief Nurse re appropriate use of PPE

Yours sincerely,



Michael Wright
Deputy Chief Executive
The Rotherham NHS Foundation Trust

Board of Directors Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P82/22
Report	**Integrated Performance Report – March 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 March 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	Integrated Performance Report – March 2022

Board of Directors

Integrated Performance Report - March 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	Mar 2022	L	**19,705**	21,496	22,333	22,486	22,378	22,378	13,040			
P1A	Number of RTT Patients with a Decision to Admit	Mar 2022			3,127	3,462	3,569	3,687	3,687	3,464			
P2	Referral to Treatment (RTT) Performance	Mar 2022	N	**92%**	80.4%	77.2%	76.2%	74.8%	81.1%	77%			
P3	Number of 52+ Weeks	Mar 2022			35	48	59	62	62	559			
P3A	Number of 104+ Weeks	Mar 2022	N	**0**	0	0	0	0	0	0			
P4	Overdue Follow-Ups	Mar 2022	L	**10,773**	11,268	12,458	11,622	12,517	12,517	11,810			
P5	First to follow-up ratio	Mar 2022	B	**2.5**	2.94	2.69	2.52	2.31	2.85	2.95			
P6	Day case rate (%)	Mar 2022	B	**80%**	84.7%	89.5%	87.6%	85.0%	84.4%	84%			
P7	Diagnostic Waiting Times (DM01)	Mar 2022	N	**1%**	10.0%	9.8%	6.1%	5.8%	18.2%	27%			
P8	Diagnostic Activity Levels												
Emergency Performance													
E1	Number of Ambulance Handovers > 60 mins	Mar 2022	CQC	**0**	327	100	109	270	2,132	40			
E1A	Number of Ambulance Handovers > 30 mins	Mar 2022	CQC	**0**	608	314	341	531	4,832	165			
E2	Average Time to Initial Assesment in ED (Mins)	Mar 2022	N	**15**	25	24	23	26	24	20			
E3	Proportion of patients spending more than 12 hours in A&E from time of arrival	Mar 2022			9.43%	7.19%	7.99%	9.74%	6.43%				
E4	Number of 12 hour trolley waits	Mar 2022	N	**0**	0	0	0	0	0	0			
E5	Conversion rate from A&E (not including Observations)	Mar 2022			23.3%	23.5%	22.7%	20.5%	21.6%	24%			
E6	Proportion of same day emergency care	Mar 2022	L	**33%**	38.3%	39.0%	42.3%	41.1%	40.3%	35%			
Cancer Care													
Ca1	2 Week Wait Cancer Performance	Feb 2022	N	**93%**	95.1%	93.8%	91.0%	92.0%	93.9%	97%			
Ca2	2 Week Wait Breast Symptoms	Feb 2022	N	**93%**	84.8%	86.7%	78.0%	88.9%	88.8%	83%			
Ca3	31 day first treatment	Feb 2022	N	**96%**	95.5%	96.6%	94.8%	92.9%	95.6%	99%			
Ca4	62 Day Performance	Feb 2022	N	**85%**	68.6%	71.5%	74.2%	74.5%	73.2%	64%			
Ca5	Patients waiting longer than 62 days on the PTL	Mar 2022	L	**75**	72	89	82	65	65				
Ca6	28 day faster diagnosis standard	Feb 2022	N	**75%**	75.7%	79.7%	72.2%	76.5%	74.1%	66%			
Inpatient Care													
I1	Mean Length of Stay - Elective (excluding Day Cases)	Mar 2022			3.48	4.75	2.81	2.64	3.16	2.85			
I2	Mean Length of Stay - Non-Elective	Mar 2022			5.87	5.63	6.16	5.66	5.44	5.01			
I3	Length of Stay > 7 days (Snapshot Numbers)	Mar 2022	L	**142**	192	218	187	217	217	136			
I4	Length of Stay > 21 days (Snapshot Numbers)	Mar 2022	L	**42**	50	84	56	80	80	37			
I5	Right to Reside - % not recorded (Internal Performance from May)	Mar 2022	B	**0%**	7.4%	6.2%	4.6%	3.8%	3.8%	11%			
I6	Discharges before 5pm (inc transfers to Dis Lounge)	Mar 2022	L	**70%**	56.8%	55.1%	54.0%	50.2%	55.9%	52%			
Outpatient Care													
O1	Did Not Attend Rate (OutPatients)	Mar 2022	B	**7%**	9.3%	7.7%	7.6%	9.2%	8.5%	7%			
O4	% of all Outpatient activity delivered remotely via telephone or video consultation	Mar 2022	N	**25%**	16.5%	17.1%	15.6%	16.5%	17.4%				
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.	Mar 2022			0.30%	0.28%	0.32%	0.23%	0.17%				
Community Care													
CC1	MusculoSkeletal Physio <4 weeks	Mar 2022	L	**80%**	13.9%	13.6%	19.9%	20.9%	16.0%	12%			
CC2	% urgent referrals contacted within 2 working days by specialist nurse (Continence)	Mar 2022	L	**95%**	76.0%	64.7%	63.6%	62.7%	65.5%	71%			
CC3	A&E attendances from Care Homes	Mar 2022	L	**144**	134	124	138	142	142	112			
CC4	Admissions from Care Homes	Mar 2022	L	**74**	61	85	60	69	69	64			
CC5	Patients assessed within 5 working days from referral (Diabetes)	Mar 2022	L	**95%**	100.0%	100.0%	83.3%	90.9%	88.2%	73%			

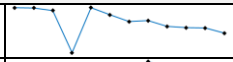
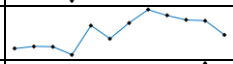
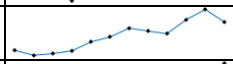
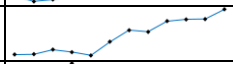
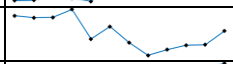
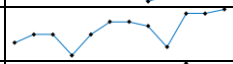
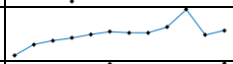
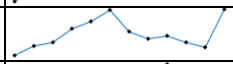
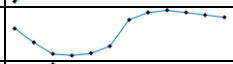
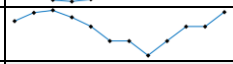
The Rotherham NHS
NHS Foundation Trust

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	Oct 2021	B	-	110.7	109.5	107.7	107.7	--	116.50			
M2	Mortality index - HSMR (Rolling 12 months)	Dec 2021	B	-	114.6	111.5	107.0	102.6	--	121.50			
M3	Number of deaths (crude mortality)	Mar 2022		-	98	101	82	83	1,023	97			
Infection, Prevention and Control													
In1	Clostridium-difficile Infections	Mar 2022		-	6	3	2	2	26	1			
In1a	Clostridium-difficile Infections (rate)	Mar 2022		-	15.4	16.1	17.5	18.0	15.4	18.4			
In2	MRSA Infections (Methicillin-resistant Staphylococcus Aureus)	Mar 2022	L	**0**	0	0	0	0	1	0			
In2a	MRSA Infections (Methicillin-resistant Staphylococcus Aureus) (Rate)	Mar 2022		-	0.70	0.70	0.70	0.69	0.70	0.0	**0**		
In3	E.coli blood bactertaemica, hospital acquired	Mar 2022		-	4	1	4	2	40	2	**0**		
In4	CPE Infections, Hospital Provider	Mar 2022		-	1	2	1	0	5	-	**0**		
In5	GRE Infections - data collection to commence from April 2022												
Patient Safety													
PS1	Incidents - severe or above (one month behind)	Feb 2022	L	**0**	7	6	7	4	54	2			
PS2	% Potential of Under Reporting of Pt Safety Incidents	Mar 2022		-	52.1	52.4	52.5	51.8	50.6	46.1			
PS3	Never Events	Mar 2022	L	**0**	0	0	0	0	0	0			
PS4	Number of Patient Harms	Mar 2022		-	713	673	624	604	7,467	555			
PS5	Number of Patient Harms (Moderate and above)	Mar 2022		-	27	36	34	23	317	19			
PS6	Number of Patient Falls	Mar 2022		-	101	119	80	91	1102	38			
PS7	Number of Pressure Ulcers (G3 and above)	Mar 2022		-	0	1	0	0	4	1			
PS8	Medication Incidents	Mar 2022		-	116	91	106	107	1262	89			
PS9	Readmission Rates (one month behind)	Feb 2022	L	**7.6%**	7.9%	8.5%	8.1%	7.3%	8.0%	7.2%			
PS10	Venous Thromboembolism (VTE) Risk Assessment	Mar 2022	N	**95.0%**	93.6%	94.6%	94.5%	95.3%	95.4%	95.1%			
PS11	Number of complaints per 10,000 patient contacts	Mar 2022	L	**8**	3.50	11.93	8.08	10.49	8.12	9.40733772			
PS12	Proportion of complaints closed within 30 days	Mar 2022	L	**100.0%**	100.0%	100.0%	100.0%	100.0%	98.5%	100.0%			
PS13	Hip Fracture Best Compliance	Mar 2022	L	**65.0%**	66.7%	41.7%	64.3%	86.7%	63.4%	75.0%			
PS14	F&F Postive Score - Inpatients & Day Cases	Mar 2022	N	**95.0%**	97.7%	98.5%	97.3%	97.0%	97.8%	97.9%			
PS15	F&F Postive Score - Outpatients	Mar 2022	N	**95.0%**	98.0%	97.9%	98.6%	96.9%	97.8%	97.9%			
PS16	F&F Postive Score - Maternity	Mar 2022	N	**95.0%**	100.0%	100.0%	96.9%	98.1%	98.6%	98.9%			
PS17	Care Hours per Patient Day	Mar 2022	L	**7.3**	6.50	6.20	6.50	6.20	6.20	7.5			
Maternity													
Ma1	Bookings by 12 Week 6 Days	Mar 2022	N	**90.0%**	94.0%	91.7%	87.4%	93.7%	92.9%	93.7%			
Ma2	% of emergency Caesarean-sections	Mar 2022	L		15.8%	18.8%	22.7%	17.5%	17.8%	8.1%			
Ma3	Breast Feeding Initiation Rate	Mar 2022	N	**66.0%**	64.0%	64.9%	67.9%	63.6%	67.6%	68.9%			
Ma4	Stillbirth Rate per 1000 live births (Rolling 12 months)	Mar 2022	L	**4.66**	3.58	3.57	3.14	2.35	2.35	6.15			
Ma4a	Number of Stillbirths	Mar 2022		-	1	0	0	1	3	3			
Ma5	1:1 care in labour	Mar 2022	L	**75.0%**	95.0%	97.1%	98.6%	97.2%	96.3%	93.0%			
Ma6	Serious Incidents (Maternity)	Feb 2022	L	**0**	0	1	0	0	5	0			
Ma7	Moderate and above Incidents (Harm Free)	Feb 2022		-	0	0	0	0	0	0			
Ma8	Cases Referred to HSIB	Mar 2022	L	**5**	1	0	0	0	2	0			
Ma9	Consultants on labour (Hours on Ward)	Mar 2022		-	62.50	62.50	62.50	62.50	62.50	--			
Ma10	% women on continuity of care pathway	--											

The Rotherham NHS
NHS Foundation Trust

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	Mar 2022	L	**-164**	-315	-323	-325	-357	-357	-229			
W2	Whole Time Equivalent plan - Nursing	Mar 2022	L	**-102**	-30	-36	-37	-53	-53	-109			
W3	Total Headcount	Mar 2022		-	4,899	4,930	4,953	4,925	4,925	4,831			
W4	Vacancy Rate - TOTAL	Mar 2022	L	**3.90%**	7.17%	7.30%	7.32%	8.04%	8.04%	5.41%			
W5	Vacancy Rate - Nursing	Mar 2022	L	**7.90%**	2.29%	2.69%	2.73%	3.96%	3.96%	8.47%			
W6	Time to Recruit	Mar 2022	L	**34**	25	33	33	34	34	30			
W8	Sickness Rates (%) - inc COVID related	Mar 2022	L	**3.95%**	7.40%	9.13%	6.63%	7.05%	6.66%	4.59%			
W9	Turnover	Mar 2022		**0.63%**	0.84%	0.75%	0.68%	1.21%	0.83%	0.88%			
W10	Appraisals complete (%)	Mar 2022	L	**90.00%**	83.00%	82.00%	81.00%	80.00%	80.00%	81.00%			
W11	MAST (% of staff up to date)	Mar 2022	L	**85.00%**	89.00%	90.00%	90.00%	91.00%	91.00%	92.00%			
W12	% of jobs advertised as flexible	Mar 2022		-	53.57%	41.67%	46.46%	51.43%	48.28%	-			

The Rotherham NHS
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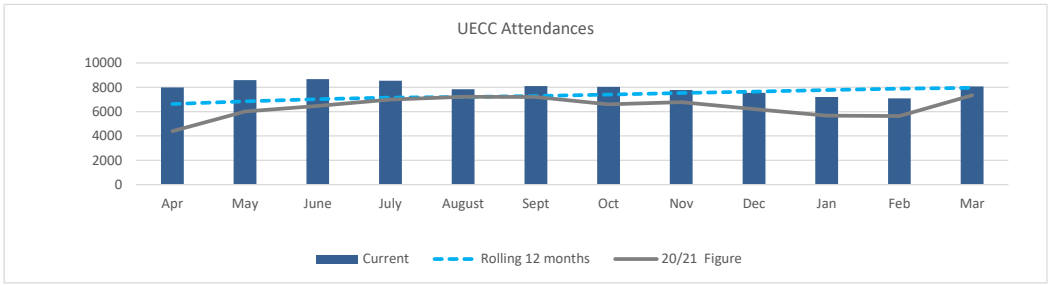
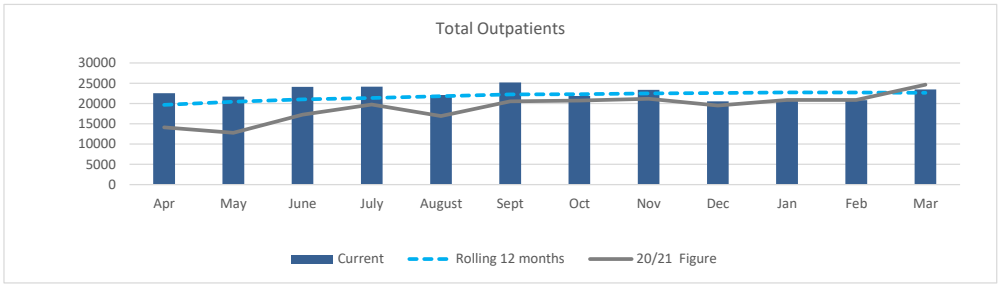
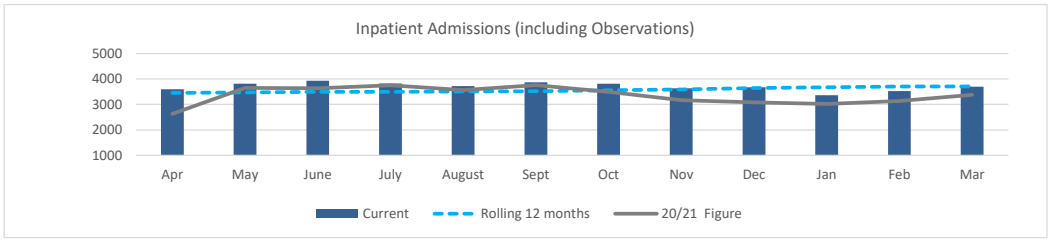
Trust Integrated Performance Dashboard - Finance

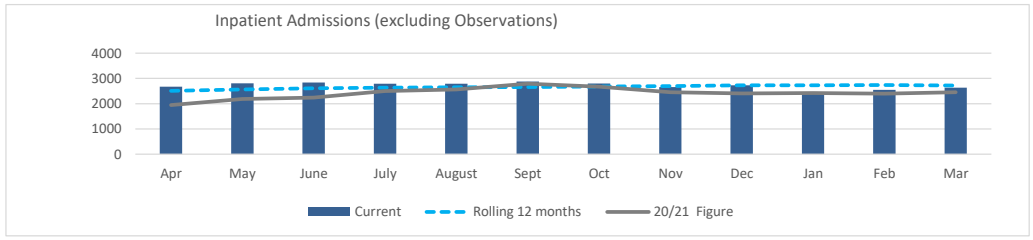
	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Prior Month Forecast £000s
I&E Performance (Actual)	(79)	(355)	(276)	(697)	461	1,158	1,912
I&E Performance (Control Total)	(42)	(332)	(290)	(249)	1,478	1,727	1,913
iency Programme (CIP) - Risk Adjusted	585	757	172	5,022	6,099	1,077	976
Capital Expenditure	4,271	8,617	(4,346)	15,717	15,024	693	835
Cash Balance	722	(2,138)	(2,860)	14,952	33,303	18,351	0

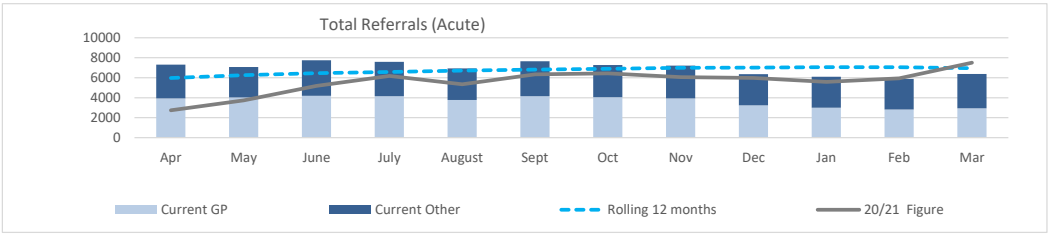
Trust Integrated Performance Dashboard - Activity

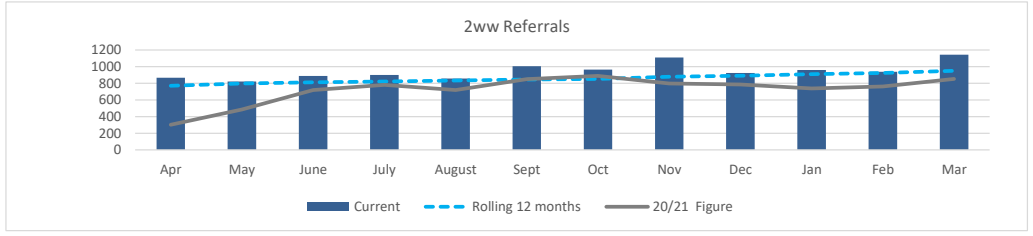












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Trust Integrated Performance Dashboard - Activity

ACTIVITY

OUTPATIENTS

	Activity 20/21	Activity 19/20 (WDA)	As % of 2019/20 WDA
March	22,066	19,488	13.2%
M7-12 YTD monthly average	20,571	21,608	-4.8%

DAYCASES

	Activity 20/21	Activity 19/20 (WDA)	As % of 2019/20 WDA
March	1,902	1,747	8.9%
M7-12 YTD monthly average	1,768	2,040	-13.3%

INPATIENT ACTIVITY

	Activity 20/21	Activity 19/20 (WDA)	As % of 2019/20 WDA
March	338	365	-7.4%
M7-12 YTD monthly average	267	382	-30.1%

CLOCK STOPS - RTT

Clock Starts

	Clock Starts 2021* includes ASIs	Clock Starts 19/20	As % of 2019/20 WDA
March	7,450	4,679	59.2%
M7-12 YTD monthly average	6,792	6,527	4.1%

Clock Stops Admitted

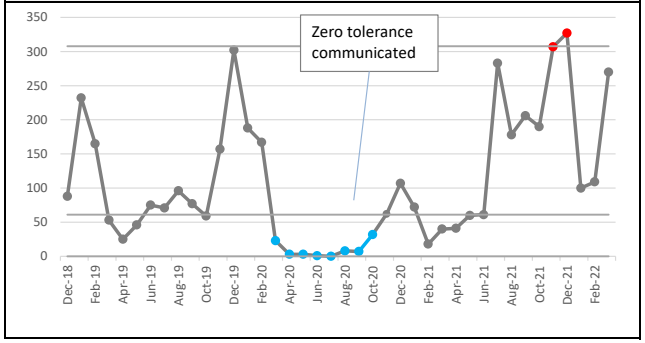
	Clock Stops 2021	Clock Starts 19/20	As % of 2019/20 WDA
March	1,358	1,097	23.8%
M7-12 YTD monthly average	1,201	1,437	-16.4%

Clock Stops Non-Admitted

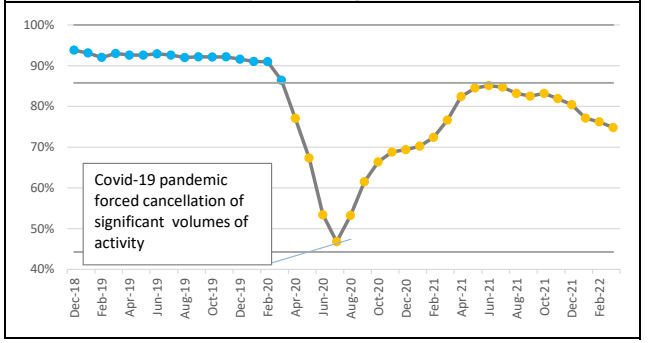
	Clock Stops 2021	Clock Starts 19/20	As % of 2019/20 WDA
March	4,381	3,357	30.5%
M7-12 YTD monthly average	3,800	4,018	-5.4%

Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (1)

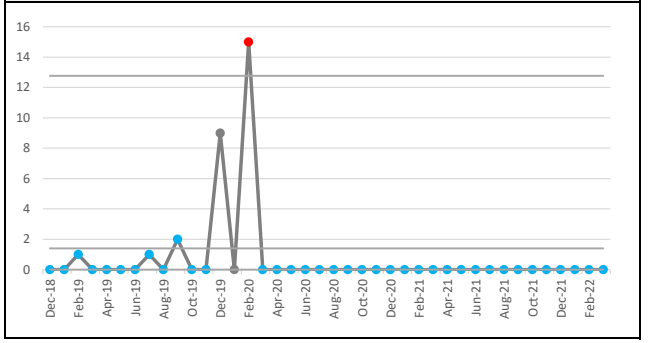
Ambulance Handovers - % of handovers > 60 minutes



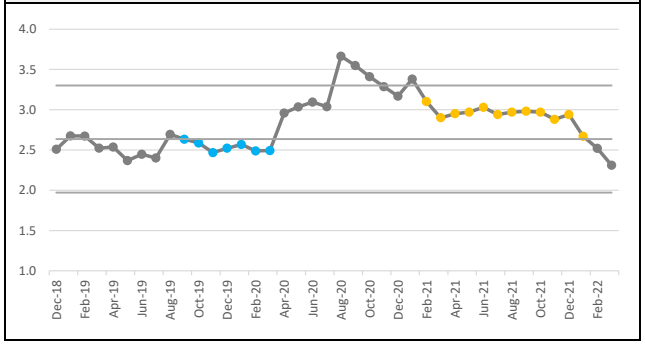
Referral to Treatment - % of patients waiting less than 18 weeks for treatment



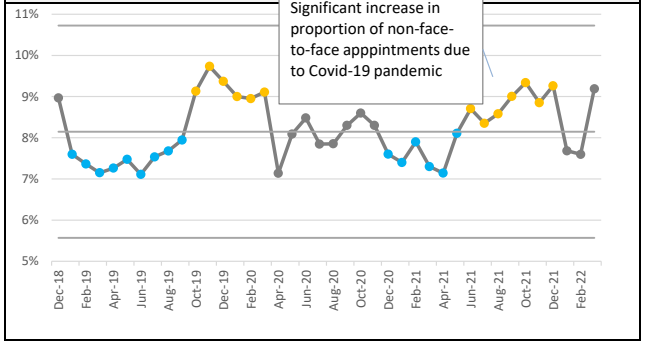
12 hour trolley waits - per month



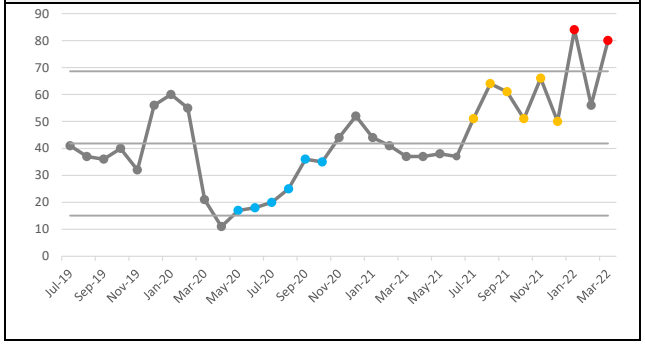
First to Follow-Up Ratio



Did Not Attends (DNAs) % of appointments

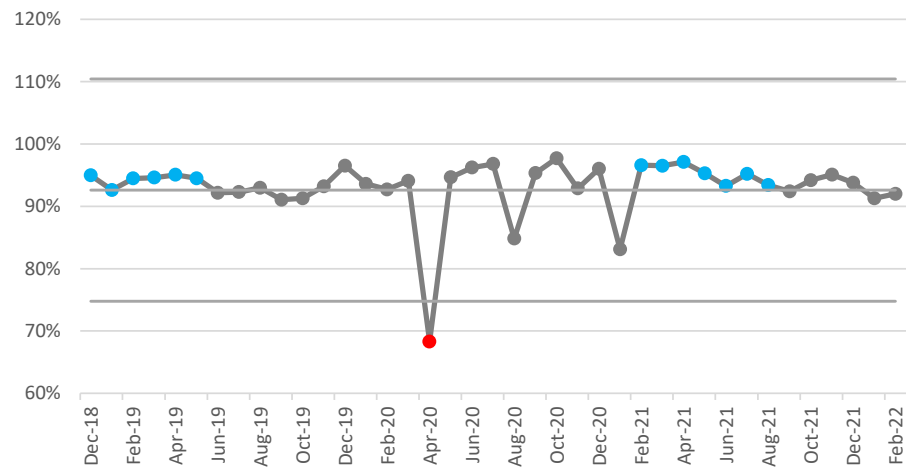


Length of Stay > 21 days (Snapshot Numbers)

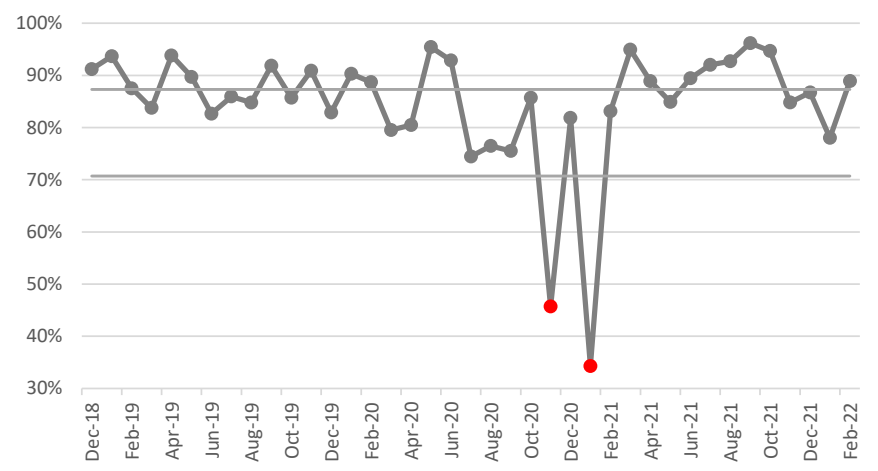


Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (2)

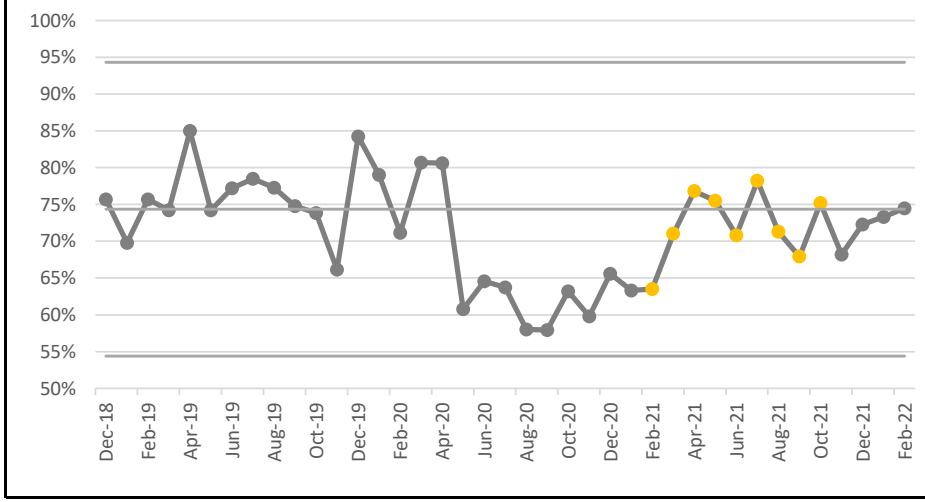
Cancer 2 week wait standard



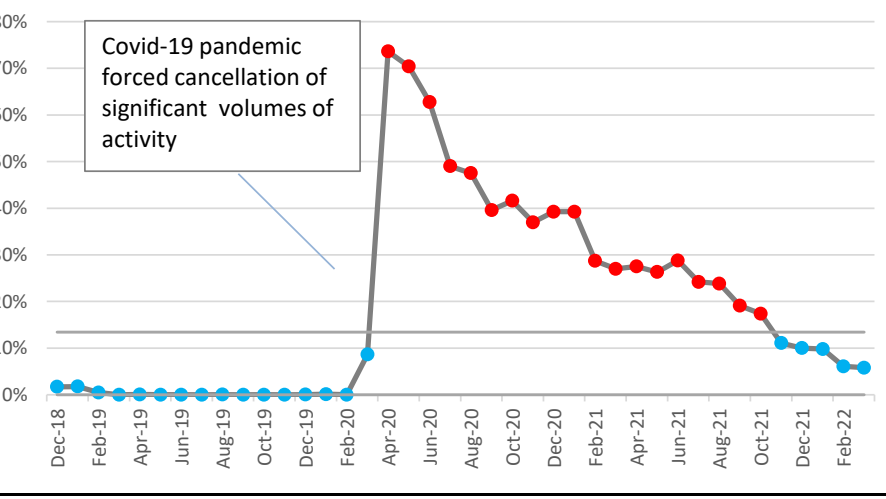
Cancer 2 week wait breast symptoms standard



Cancer 62 day first treatment standard

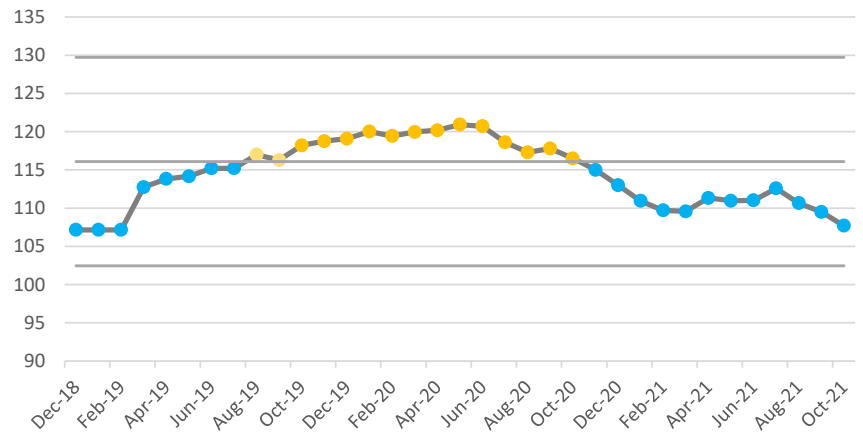


Diagnostics - % of breaches over 6 weeks (DM01)

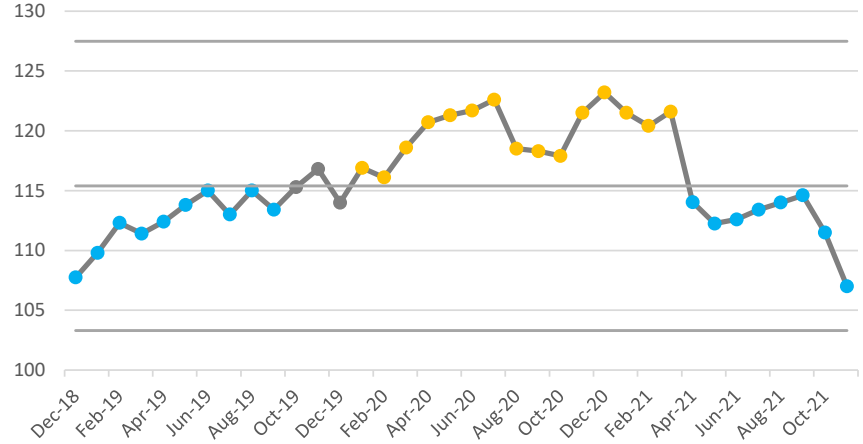


Trust Integrated Performance Dashboard - SPC Charts - Quality (1)

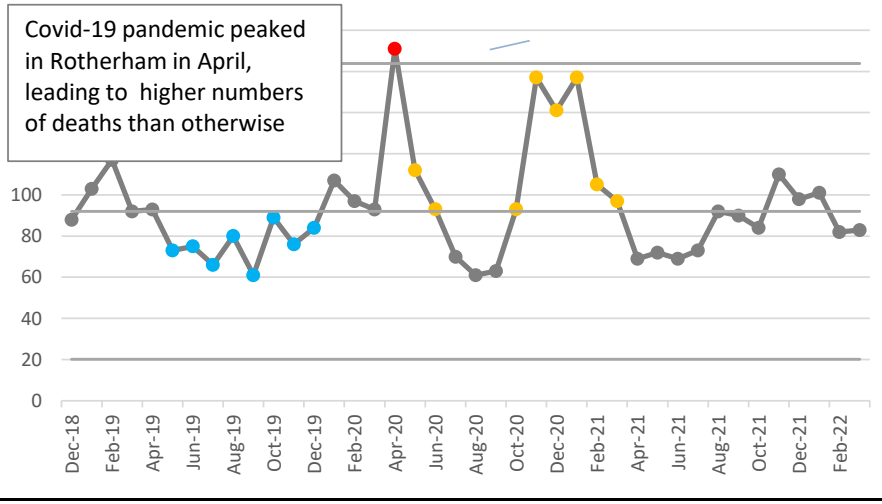
Standardised Hospital Mortality Indicator (SHMI)



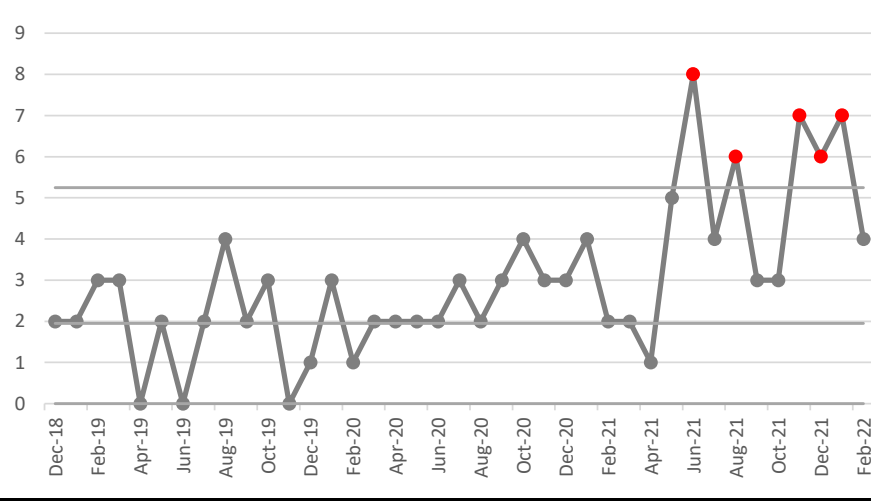
Hospital Standardised Mortality Ratio (HSMR)



Crude Mortality (number of deaths)

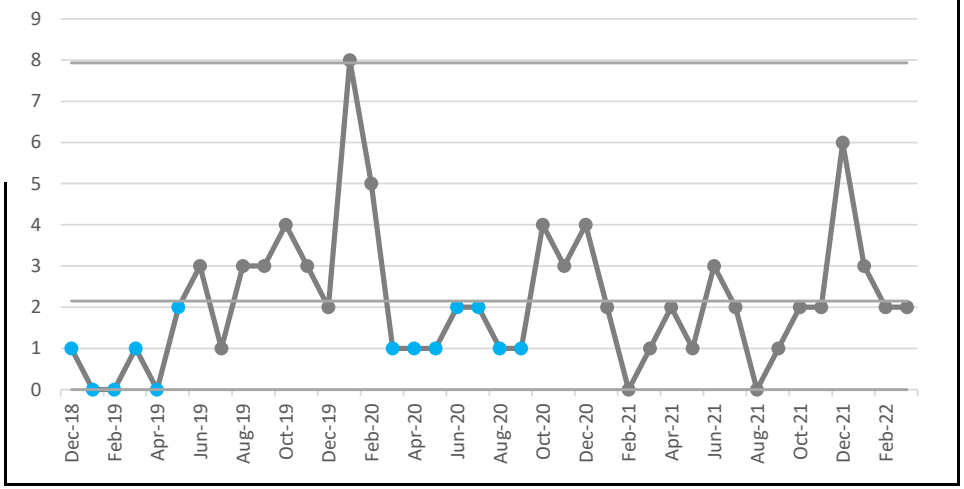


Incidents (severe or above)

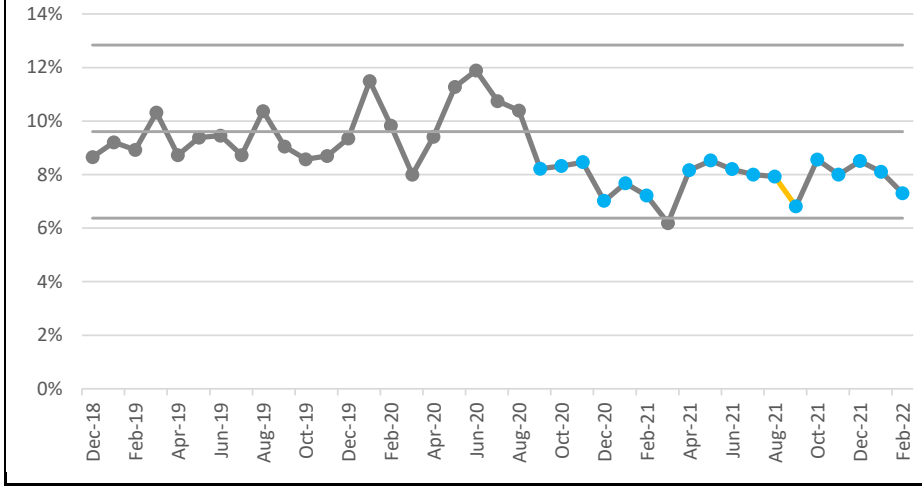


Trust Integrated Performance Dashboard - SPC Charts - Quality (2)

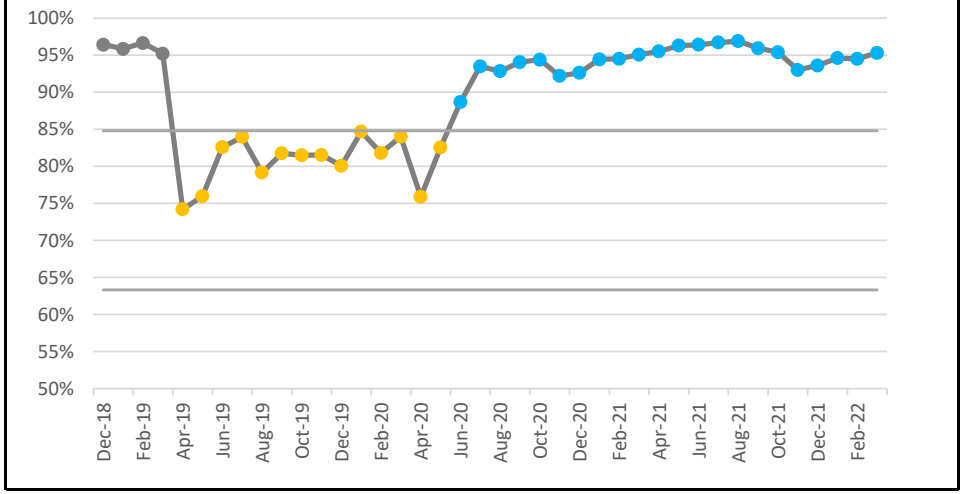
Clostridium difficile infections (number)



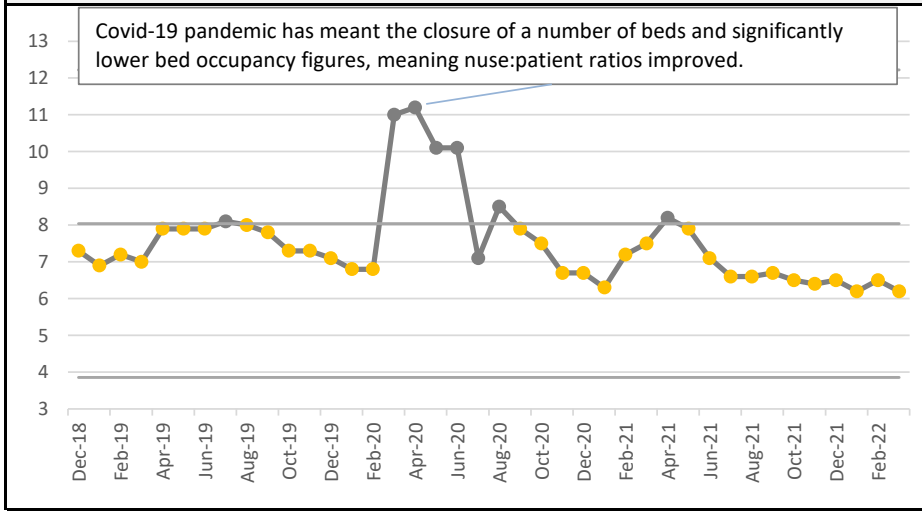
Readmissions (%)



Venous Thrombous Embolism compliance (%)

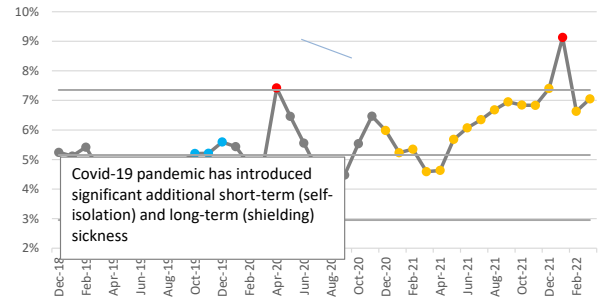


Care Hours per Patient Day

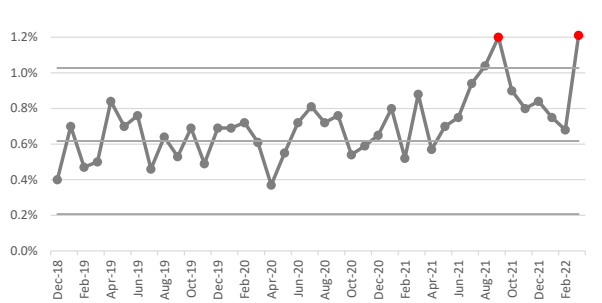


Trust Integrated Performance Dashboard - SPC Charts - Workforce

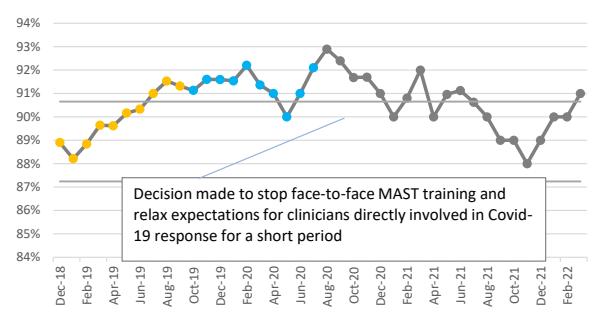
Sickness (%)



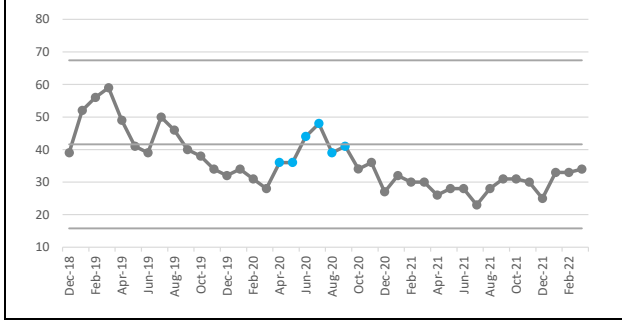
Turnover (%)



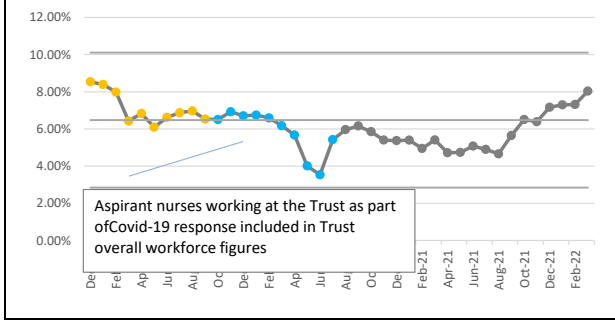
Mandatory and Statutory Training (MAST)



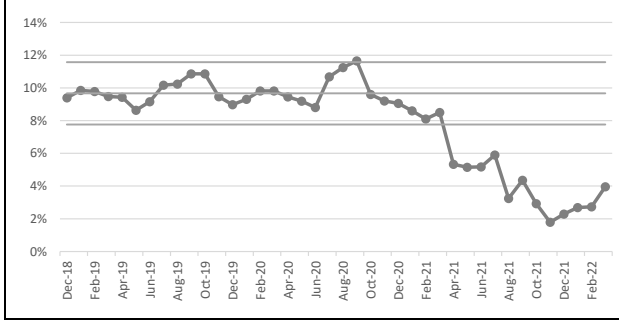
Time to Recruit - days



Vacancy Rate (TOTAL)



Vacancy Rate (Nursing)



Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Daily staffing -actual trained staff v planned (Days)	86.51%	87.67%	89.80%	85.40%	82.55%	84.17%	87.39%	85.51%	86.74%	89.65%	87.75%	87.62%	86.48%
Daily staffing -actual trained staff v planned (Nights)	85.30%	88.23%	87.10%	89.95%	86.37%	83.00%	83.93%	82.94%	86.32%	87.50%	87.06%	86.41%	84.29%
Daily staffing - actual HCA v planned (Days)	105.41%	111.97%	129.70%	108.39%	104.30%	103.18%	100.43%	99.16%	101.90%	94.90%	90.63%	89.55%	89.47%
Daily staffing - actual HCA v planned (Nights)	1.2072	108.47%	113.20%	105.09%	101.02%	101.69%	98.49%	89.90%	95.29%	90.95%	89.28%	89.06%	92.35%
Care Hours per Patient per Day (CHPPD)	7.5	8.2	7.9	7.1	6.6	6.6	6.7	6.5	6.4	6.5	6.2	6.5	6.2

Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- Site pressures remained high in February and March, and whilst Covid-19 patient volumes fell in February, this preceded a sudden resurgence in March, with an even higher Omicron variant peak occurring in Rotherham during the month, with 80-110 Covid-19 positive inpatients for a more-than three week period. UECC Attendances over the latest two-month period were 16% above 2021 levels, with admissions just slightly above the levels from the previous year (104%).
- Related to this, the number of super-stranded patients (21 day+ length of stay) rose significantly during March, back to the levels seen in January. Some of the challenges arose from care home beds being closed for IPC reasons.
- The increased challenges with flow through the organisation led to another difficult month in March regarding ambulance handover delays over 60 minutes, with 270 'black breaches' in the month, but this followed relatively positive performance against this metric in February, when the site position wasn't quite as stretched. The propotion of patients waiting 12 hours in department was still well above the national targets that have now been set for 2022/23 (2%), with close to 10% of patients spending at least 12 hours in the UECC in March. 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. With the changes in IPC guidance recently announced and implemented within the Trust, we expect to see these pressures ease given the reduced need for additional cohorting and the ward moves this requires.

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

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).

indicator, and given the unprecedented nature of such a pandemic, it is helpful to review other mortality indicators to ensure the full picture is being presented. The in-month HSMR for December 2021 was 87.4, which is statistically within the 'as expected' band.

- Crude mortality was 3.5% over the 12-month period, compared to 3.1% regional average (acute, non-specialist Trusts) and 3.2% nationally (acute, non-specialist Trusts).

Patient Safety

- There were 4 incidents deemed to be severe or above in March, and these have all been investigated at Harm Free Care and Serious Incident (SI) panels as appropriate. Staffing levels continued to be affected in the last two months due to the Covid-19 pandemic, although we saw a reduction in the number of falls despite this. There was also a reduction in the total number of patient harms reported across these two months, with more than 95% of these considered to cause either low harm or no harm.
- The Trust re-met the national Venous Thromboembolism (VTE) assessment target again in March, following a further focus internally to ensure the relevant documentation is completed and recorded as required.
- Complaints per 10,000 contacts were above target in February and March, although a number of these related to issues that will be resolved by changes to IPC guidance, with visiting restrictions being one of the main issues identified. 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 deterioration in trained fill rates in the most recent two months. 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, as well as an increase in annual leave taken in March as the financial year ended, which affected our ability to fill all shifts as planned. It is anticipated that this will improve in May once the infection rate is lower.

Maternity

- Maternity performance saw a further improvement in bookings within 13 weeks and the rolling stillbirth rate.
- CNST Update – There has been no further update received since the Trust was informed that the discretionary payment for year 4 is currently paused, but we continue to work towards all 10 safety actions.

There are some challenges with the maternity service dataset and carbon monoxide monitoring which the team are focussing on.

- Ockenden – An Ockenden visit is planned for late May, which the team are preparing for. This is part of the national visits to all acute sites following the publication of the latest report.

WORKFORCE SUMMARY

Recruitment and Retention

- The number of new starters for March 2022 decreased slightly (~45 WTE) compared with previous month (~56 WTE), and represents a ~12 WTE decrease compared with March 2021. Surgery have seen the highest number of new starters for March 2022 (17) followed by Community Services, (9). The Trust welcomed 6 qualified Nursing & Midwifery staff in March 2022, 2 of whom were attributed to the Community Services Division.
- Overall vacancies for Nursing & Midwifery and support to Nursing & Midwifery was ~112 WTE for the month of March. This is reduced to 36 WTE when taking into consideration the candidates going through the external recruitment process. There are currently 41 WTE newly qualified nurses/midwives who are currently awaiting confirmation of registration who have been included in the above figures.
- 12 month rolling turnover (voluntary leavers only) for the Trust was 11.3%, and represents a 2.9% increase compared to March 2021. The Nursing & Midwifery turnover (12 month rolling rate) for the month of March 2022 was 10.5% and represents an increase of 0.55% compared with previous month.
- Of the 37 leavers in January, 10 colleagues left for reasons relating to relocation.
- Promotions, both permanent and temporary taken place over the month of March 2022 equate to over 15 WTE with just under 5 WTE attributing 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 absence rate (inc COVID-19) increased by 0.4% to 7%, which is above the Trust target by 3%. The increase in the overall Trust sickness rate was driven by short-term sickness (3.2%), a 0.5% increase compared with previous month.
- Sickness absence (inc COVID-19) remains above target in all Divisions with the exception of Corporate Services for the month of March with Medicine being the highest (8.9%). 12 month rolling sickness absence for March 2022 was 6.7% and represents a 0.2% increase compared to previous month.

- Compared with March 2021, rolling sickness absence has increase by 2.84%. 12 month rolling sickness absence excluding Covid-19 is 5.36% which is a 0.08% increase compared with previous month

Appraisals and Mandatory Training

- Overall appraisal rolling 12 month compliance rate for the month of March is 80% which is a 1% decrease compared to March 2021. The rolling 12 month appraisal rate has decreased by 1% compared to previous month.
- All Divisions remain below the Trust target of 90%
- Core MaST compliance has increased by 1% (91%), compared to previous month and is 6% above the Trust target (85%). Hand Hygiene compliance has increased by 2.5% (74%), compared to previous month (72%), and is still below the Trust target. Information Governance compliance has fallen to 87%, which is below the CQUINN target of 95%. Mental Health Act (1yr) has the lowest compliance rate at 53%.
- All Divisions with the exception of Medicine and Urgent & Emergency Care are above the Trust target for both core and job-specific combined together. The Nursing and Midwifery staff group has the lowest compliance rate overall for both Core and Job Specific combined together with 86% compliance.

FINANCE SUMMARY

The Finance summary commentary is included within the separate Finance Report.

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P83/22
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 of Directors 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 the Board of Directors 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 March 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 Chief Operating Officer and the Finance and Performance Committee has delegated authority to review and feedback to the Board of Directors 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 March 2022.

1.2 Recovery had recommenced since the high numbers of positive Covid-19 inpatients started to settle from January 2022 and this has shown a reduction over the last 2 months due to high numbers of Covid-19 and complex long length of stay patients in our beds.

1.3 The elective wards and surgical wards had 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-19 positive and resolved patients. The Trust managed to reopen these for a month in February but during March we have seen a reduction in elective capacity forcing us to run a reduced elective programme.

1.4 Covid-19 numbers of inpatients has flexed daily varying from 70 in June to over 100 in January. Recent weeks have seen a spike in numbers again up to 115 in March 2022.

1.5 Critical Care has constantly been under pressure with demand above the expected numbers. This has seen a settling over the last 2 months. During the latter part of 2021 a number of outpatient letters did not appear to have been sent via our automatic service.

1.6 On investigation, the majority of these have been sent electronically as per our normal processes but in a small number of cases the letters were not sent. These have all been identified and a harm review undertaken to ensure that no ill effects have been experienced by patients. Seven reviews are outstanding in Urology and will be complete this month. A new audit system and review of letters has been instigated by the Patient Administration teams to ensure the confusion does not arise again. This has encouraged us to review other systems of electronic delivery which has commenced.

2.0 Recovery

2.1 TRFT has been working on its internal recovery as previously discussed below:

- Benchmark IPC practice as a Trust and as a region to make sure it is applied safely and 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 capacity clinic and treatment rooms
- **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
- Reopen ring-fenced elective wards

3.0 **Referral to Treatment.**

3.1 Referral to Treatment performance had improved between January to July 84.7% against the 92% standard.

3.2 Since then we have seen a gradual deterioration of performance with; (September 82.5%, January 77.2%, February 76.2%**) March at 74.8%**

3.3 **The waiting list size has come down slightly the first time in 6 months:**

- Total incomplete PTL size **22378**
  - (**20,478** November 2021 and **22,486** February 2022)
- 75 x 52 week breaches for incompletes (67 in September 2021, 48 in January 2022)

3.4 Long wait patients ie the 75 over 1 year waits although the best in SYB is deteriorating monthly linked to capacity in beds and operators. TRFT does not have any 2 year waits and nobody waiting over 78 weeks we are now focusing by specialty on reducing the long waits and reducing the size of the waiting list.

3.5 Incompletes - 13 March 2022

Specialty Group	<18	>=18	Total	%
Cardiology	1193	308	1501	79.5%
Dermatology	1506	247	1753	85.9%
Ear, Nose & Throat	1671	687	2358	70.9%
Gastroenterology	912	390	1302	70.0%
General Medicine	334	37	371	90.0%
General Surgery	1427	406	1833	77.9%
Geriatric Medicine	96	4	100	96.0%
Gynaecology	1266	494	1760	71.9%
Ophthalmology	2114	540	2654	79.7%
Oral Surgery	9	7	16	56.3%
Rheumatology	534	441	975	54.8%
Thoracic Medicine	917	174	1091	84.1%
Trauma & Orthopaedics	1438	809	2247	64.0%
Urology	982	353	1335	73.6%
X01 - Clinical Haematology	226	5	231	97.8%
X01 - OMFS	1428	671	2099	68.0%
X01 – Paediatric	560	28	588	95.2%
X01 - Paediatric Cardiology	82	38	120	68.3%
X01 - Rehabilitation Medicine	40	4	44	90.9%
Totals	**16735**	**5643**	**22378**	**74.8%**

3.6 Over the previous months we had gradually reduced our elective capacity reducing our ring-fenced elective ward capacity to support Covid-19 and complex medical patients, the elective Orthopaedic ward came back on line in February. Unfortunately, during March and April numbers of Covid-19 and complex delays increased considerably, this necessitated closing some elective capacity again to accommodate emergency flow.

- We have achieved the plan to reduce the number of patients waiting more than 104 weeks to zero by March 2022

- 52 weeks is required to be at zero by the end of March 2023. The numbers of 52 weeks have increased over the last few months and we are expecting to see a spike of over 200 in the next 2 months which will require focused management over the next 6 months. Rheumatology and ENT are proving to be complex and staffing levels as well as demand are causing difficulties.

3.7 The waiting list had grown to approximately 22,500 patients as of the end of February, compared to the 17,000 patients waiting at the end of April 2021. There has been a noticeable increase in referral volumes since March 2021, which explains some of this waiting list pressure. For the first time we have seen a steadying of the patient numbers on the list with a slight reduction this month.

3.8 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 52 week long waits as per the national requirements March 2025. Whilst we are clear on the overall reduction we will see a slight increase to 160-200 52 week waits in the next 2 months whilst activity and recruitment plans are enacted.

3.9 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 80 patient mark linked to community capacity brokerage and post Covid-19 access.

4.0 Cancer Recovery Performance

4.1 2 week waits numbers are on plan at 94% and 93% and on track to be sustained against a 93% target. For quarter 3 provisional figures for month of December remain above target with January and February figure only partially validated.

4.2 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.

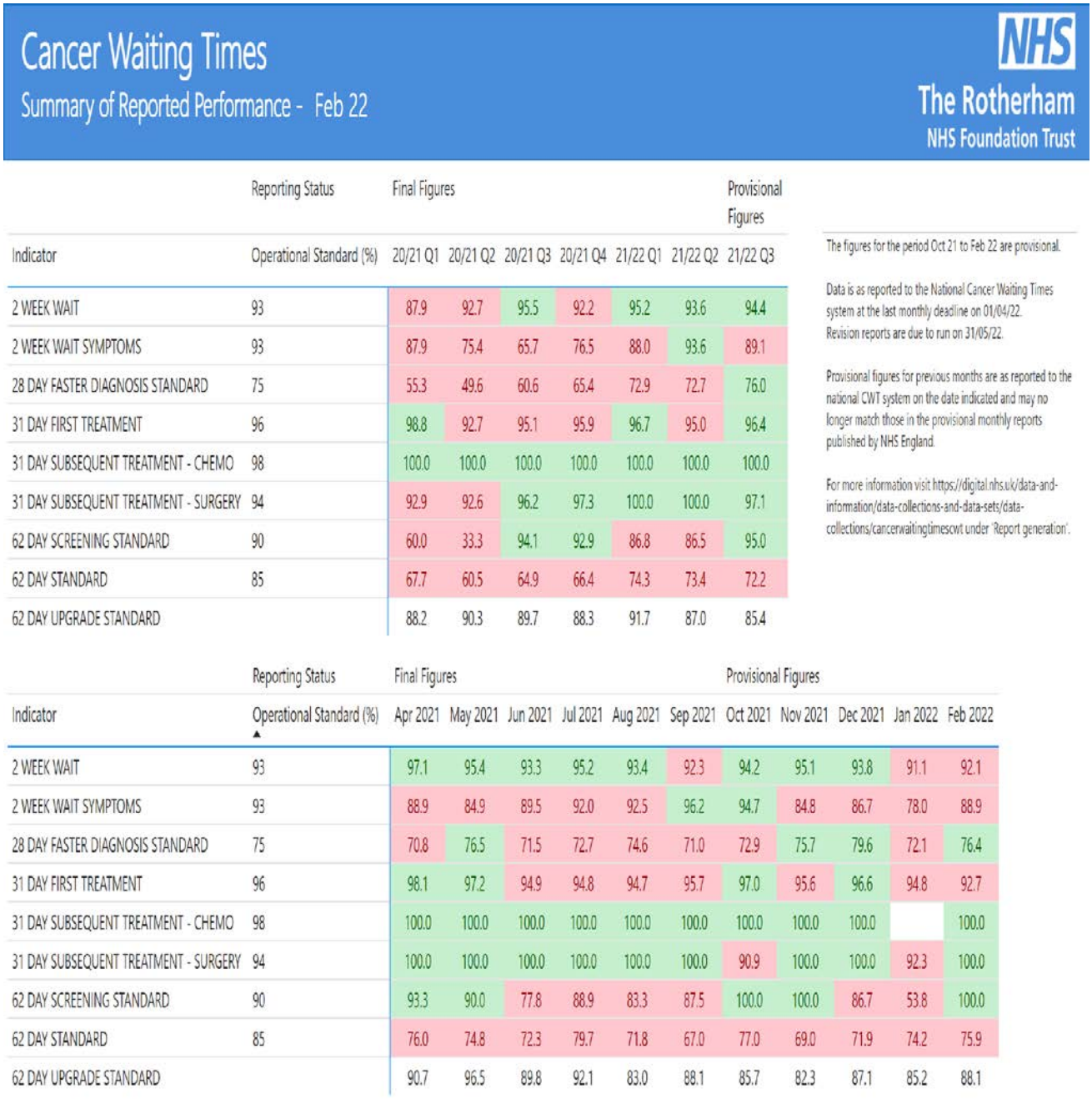
4.3 Fortnightly Cancer Recovery meetings with operational teams and the monthly joint Clinical Commissioning Group (CCG) and Trust Cancer Strategy & Improvement Committee are providing focus on the recovery plans.

4.4 The faster diagnosis standard (FDS) has a target of 75%, which as can be seen we are above for the Q3 data circa 76.1%. February and January are un-validated but are showing above the FDS at 76.4%

5.0 Cancer 62-day focus

5.1 Although the national standard is moving to faster diagnosis and combining Screening and the standard 62 days (which will show a marked improvement in our performance), we are achieving 72% in Q3 (indicative) linked to high referrals reduction in capacity

Due to Covid-19 and sickness and absence in key pathways, the key areas of failure are Head and neck GI and Urological pathways.



Cancer Waiting Times

Summary of Reported Performance - Feb 22

NHS

The Rotherham NHS Foundation Trust

	Reporting Status	Final Figures						Provisional Figures
Indicator	Operational Standard (%)	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
2 WEEK WAIT	93	87.9	92.7	95.5	92.2	95.2	93.6	94.4
2 WEEK WAIT SYMPTOMS	93	87.9	75.4	65.7	76.5	88.0	93.6	89.1
28 DAY FASTER DIAGNOSIS STANDARD	75	55.3	49.6	60.6	65.4	72.9	72.7	76.0
31 DAY FIRST TREATMENT	96	98.8	92.7	95.1	95.9	96.7	95.0	96.4
31 DAY SUBSEQUENT TREATMENT - CHEMO	98	100.0	100.0	100.0	100.0	100.0	100.0	100.0
31 DAY SUBSEQUENT TREATMENT - SURGERY	94	92.9	92.6	96.2	97.3	100.0	100.0	97.1
62 DAY SCREENING STANDARD	90	60.0	33.3	94.1	92.9	86.8	86.5	95.0
62 DAY STANDARD	85	67.7	60.5	64.9	66.4	74.3	73.4	72.2
62 DAY UPGRADE STANDARD		88.2	90.3	89.7	88.3	91.7	87.0	85.4

The figures for the period Oct 21 to Feb 22 are provisional.

Data is as reported to the National Cancer Waiting Times system at the last monthly deadline on 01/04/22. Revision reports are due to run on 31/05/22.

Provisional figures for previous months are as reported to the national CWT system on the date indicated and may no longer match those in the provisional monthly reports published by NHS England.

For more information visit https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt under 'Report generation'.

	Reporting Status	Final Figures						Provisional Figures			
Indicator	Operational Standard (%) ▲	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022
2 WEEK WAIT	93	97.1	95.4	93.3	95.2	93.4	92.3	94.2	95.1	93.8	91.1	92.1
2 WEEK WAIT SYMPTOMS	93	88.9	84.9	89.5	92.0	92.5	96.2	94.7	84.8	86.7	78.0	88.9
28 DAY FASTER DIAGNOSIS STANDARD	75	70.8	76.5	71.5	72.7	74.6	71.0	72.9	75.7	79.6	72.1	76.4
31 DAY FIRST TREATMENT	96	98.1	97.2	94.9	94.8	94.7	95.7	97.0	95.6	96.6	94.8	92.7
31 DAY SUBSEQUENT TREATMENT - CHEMO	98	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		100.0
31 DAY SUBSEQUENT TREATMENT - SURGERY	94	100.0	100.0	100.0	100.0	100.0	100.0	90.9	100.0	100.0	92.3	100.0
62 DAY SCREENING STANDARD	90	93.3	90.0	77.8	88.9	83.3	87.5	100.0	100.0	86.7	53.8	100.0
62 DAY STANDARD	85	76.0	74.8	72.3	79.7	71.8	67.0	77.0	69.0	71.9	74.2	75.9
62 DAY UPGRADE STANDARD		90.7	96.5	89.8	92.1	83.0	88.1	85.7	82.3	87.1	85.2	88.1

5.2 Cancer type shows 3 key specialisms that are not delivering the new main FDS standard specifically Urology and GI with Haematology tiny numbers

6.0 DM01 Performance

6.1 DM01 diagnostic performance had been a marked challenge throughout the pandemic. We are showing positive improvements and I believe we will be on target ahead of the 2022/23 national proposal 95% March 2025. (93.47% for March 2022).

6.2 The validated performance is 5.76% (9.38% January, 19.1% September) against a pre pandemic performance of under 1% and this is a very slowly improving position. 303 breaches (September 930 breaches).

Diagnostics (DM01) - Patients Still Waiting at Month End
March 2022

Category	Investigation	<6 weeks	≥ 6 weeks	Performance (% breaches)	Total WL
Imaging	Magnetic Resonance Imaging	647	29	4.29%	676
	Computed Tomography	829	158	16.01%	987
	Non-obstetric ultrasound	1568	1	0.06%	1569
	Barium Enema	0	0		0
	DEXA Scan	168	0	0.00%	168
Physiological Measurement	Audiology - Audiology Assessments	377	25	6.22%	402
	Cardiology - echocardiography	296	1	0.34%	297
	Cardiology - electrophysiology	0	0		0
	Neurophysiology - peripheral neurophysiology	0	0		0
	Respiratory physiology - sleep studies	280	86	23.50%	366
	Urodynamics - pressures & flows	3	0	0.00%	3
Endoscopy	Colonoscopy	274	2	0.72%	276
	Flexi sigmoidoscopy	84	0	0.00%	84
	Cystoscopy	85	1	1.16%	86
	Gastroscopy	345	0	0.00%	345
	Total	4956	303	5.76%	5259

6.3 The biggest area of concern is CT with plans to utilise the CT in a box being reviewed and cardiac CT an area for concern.

6.4 Alongside this, our Sleep Study Service saw a rapid growth in the waiting list and the backlog during Covid-19, 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.

7.0 Emergency Performance

7.1 The care of our elective and emergency patients is balanced between demand capacity and available resources and 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 20-25% increases in category 1 (complex patients). Admissions have been increasing across SYB with Mondays proving very difficult.

7.2 The numbers of patients at times 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. This links to TRFT being one of the 14 national pilot sites and the change in ways of working this has brought about ie we do not admit patients at 4 hours and a number are in the department a long time whilst they are assessed, treated and reviewed. This is just under 50% of our long wait patients which is indicative of the new ways of working.

7.3 The other 50% are clearly for admission and waiting far too long for access to a bed, although in UECC the patients have individual rooms with beds and access to amenities we have ensured these patients are appropriately cared for whilst we work on improving the emergency flow.

7.4 An increase in staff with Covid-19 specifically shortage of Consultants and middle grades and junior doctors has meant initial assessment times have deteriorated. Times to see a clinician are variable, whilst overall time in the department has deteriorated. Ambulance handover have deteriorated across South Yorkshire.

7.5 There continues to be a marked concern 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 is contributing to a restriction in flow through the emergency pathway. We are reporting up to 80 patients with long lengths of stay at over 21 days with half of these awaiting social service support from packages of care to community beds (In 2019 it was 35). Early indications showed a slight improvement in February but with care homes reclosing again due to community Covid-19 numbers have deteriorated again. The sought after reduction had got to around the 60 patient mark but this quickly deteriorated when we saw the increase in numbers of homes with Covid-19 close.

7.6 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)**
Mon	**14/03/2022**	20	114	305	28
Tue	**15/03/2022**	24	179	349	33
Wed	**16/03/2022**	30	189	345	28
Thu	**17/03/2022**	28	156	349	28
Fri	**18/03/2022**	26	171	321	12
Sat	**19/03/2022**	22	193	357	42
Thu	**20/03/2022**	18	133	297	17
	Rolling 7 Days	**24**	**162**	**332**	**188 (27 per day)**
Year to Date (21/22)		**23**	**160**	**305**	**16 (per day)**

May 21	**18**	**131**	**246**	**2 (per day)**

7.7 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. 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 and we often keep patients in UECC overnight before discharge with transport. Other organisations utilise clinical decisions units for these patients TRFT does not have a CDU.

8.0 Conclusion

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 recommenced elective activity at the end of February 2022. This remained at considerable risk due to emergency demand and the next phase of the Covid-19 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. The ward has closed over the Easter period due to demand and high numbers of emergency patients across all pathways.

8.4 DMO1 performance has shown a remarkable improvement thanks to the CSS team and particularly, MRI and respiratory improvements.

8.5 Emergency performance had shown a very slight improvement but this is marginal. Performance overall 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 utilising additional private sector community beds, to help reduce the complex patients with no right to reside,

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.

George Briggs
Chief Operating Officer

Sally Kilgariff
Deputy Chief Operating Officer

April 2022

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda Item	P84/22
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	B9 and B10: This report provides assurance regarding the financial results for the financial year 2021/22 against the Trust's approved financial plans for its income and expenditure account and capital programme, together with an update on cash management.
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 March 2022: o A summary of the key performance metrics linked to income and expenditure (including cost improvement performance), capital expenditure and cash management. • Section 2 – Income & Expenditure Account in month and year to date April 2021 to March 2022:

	o Financial results for the twelve months period. - A deficit to plan of £276K in month and £1,158K surplus to plan cumulatively; - A deficit to the (external) control total in month of £290K £1,727K surplus year to date. This external control total performance is calculated after adjusting for for income and expenditure on donated assets, including the write-down of £583K PPE stock purchased nationally in 2020/21. • Section 3 – Capital Expenditure 2021/22 o Financial results for the financial year 2021/22 show expenditure of £8,617K in month and £15,024K year to date representing an over-spend of £4,346K in month and an under-spend of £693K year to date respectively against plan. • Section 4 – Cash Flow Position 2021/22 o A cash flow position for the financial year 2021/22 showing an increase in cash of £2,393K throughout the twelve months period to a closing balance of £33,303K 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 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 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 More comprehensive and detailed reports on these financial results have been presented to both the Executive Team and Finance & Performance Committee.
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.

Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	1. Income & Expenditure Account Analysis for Month 12 2021/22 (March 2022) 2. Capital Expenditure for the Twelve Months Ending 31st March 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	Prior Month FV £00s
I&E Performance (Actual)	(79)	(355)	(276)	(697)	461	1,158	1,912
I&E Performance (Control Total)	(42)	(332)	(290)	(249)	1,478	1,727	1,913
Capital Expenditure	4,271	8,617	(4,346)	15,717	15,024	693	835
Cash Balance	722	(2,138)	(2,860)	14,952	33,303	18,351	0

1.2 There has been a slight deterioration in month and in the year–end out-turn that is £754K worse than forecast. However, this is after transacting £697K of previously unplanned capital to revenue transfers. The control total is what the Trust's performance is measured against with NHSE/I, having adjusted for income and expenditure on donated assets, including the write-down of PPE stock purchased nationally in 2020/21.

1.3 Capital expenditure has significantly over-spent in month as was previously forecast and has an out-turn for the year end of £693K underspent, which is very much in line with the previous month's forecast.

1.4 Whilst the cash position has reduced by £2,138K in month the out-turn position at 31st March 2022 is still a healthy £33,303K.

2. Income & Expenditure Account Performance for the Twelve Months Ending 31st March 2022

2.1 Appendix 1 shows the in-month and year to date position. The overall position at Month 12 is an in-month deficit to plan of £276K. This gives a cumulative out-turn year to date of £1,158K favourable to plan, which is after accounting for £697K of capital to revenue transfers.

2.2 Clinical income is better than plan in month due to:

(a) Increased expenditure on excluded drugs reclaimable from NHSE/I (£254K);
(b) Release of deferred income to match expenditure (£168K) mainly associated with the digital aspirant programme and cancer alliance; and
(c) Increased non-commissioned non-NHS activity (£43K).

2.3 Other operating income is above plan in month due mainly to increased research, education and training income (£194K) together with increased staff recharges (£335K), with the latter being a direct offset to pay expenditure.

2.4 Pay is significantly under-spending in month, whereas non-pay is significantly over-spending. This represents a realignment of reserves to fund expenditure where it has been incurred rather than where it has been originally budgeted. Therefore, Reserves is

now showing a positive variance on pay of £5,202K in month and a negative variance of £4,999K on non-pay.

2.5 Expenditure on drugs and clinical supplies continues to increase in month (£736K over-spend) although much of the decrease in year-end stock (£304K) can be attributed to this area. Additionally, there has also been a further increase in premises expenditure in month (£511K over-spend), which includes energy & utility costs, computer equipment and building & engineering costs.

2.6 Non-operating costs have over-spent in month due to the capitalisation of expenditure into previous months, which has resulted in increased depreciation charges during March 2022.

3. Capital Expenditure 2021/22

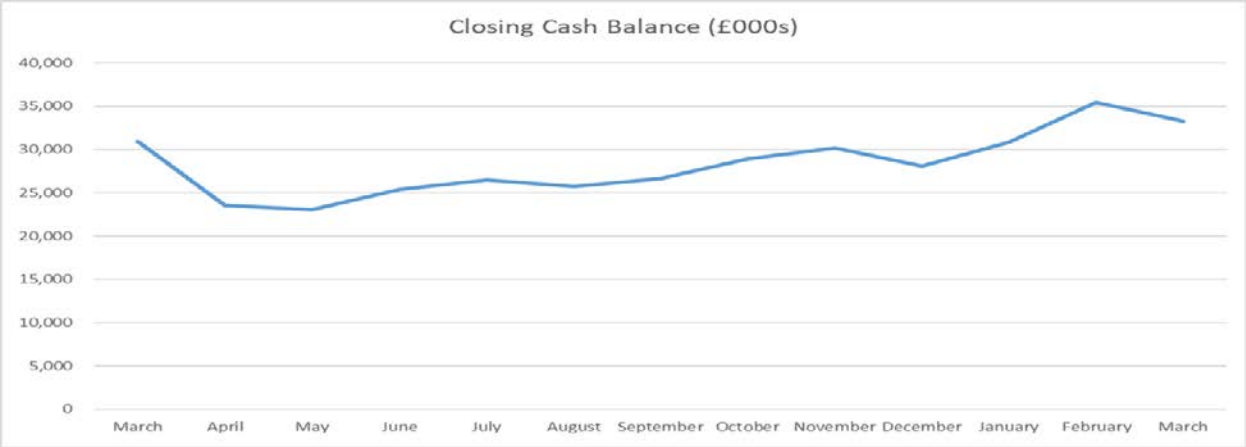
3.1 During March 2022, the Trust incurred significant costs of £8,617K against a budget of £4,271K to deliver a year to date out-turn of £693K under-spend, which is very much in line with the previous month's forecast (See Appendix 2).

3.2 During the last quarter of the financial year, the Trust has made significant additional capital commitments against both internal and external resources, which have been managed via further capital to revenue expenditure transfers during the month. However, certain of those commitments have not been delivered before 31st March 2022 and will be carried forward into the next financial year. These will be closely monitored and controlled by the Capital Planning & Monitoring Group within the totality of resources available to it.

3.3 Overall a very satisfactory out-turn position.

4. Cash Flow Position 2021/22

4.1 A cash flow position below, for the financial year 2021/22 is showing an increase in cash of £2,393K throughout the twelve months period to a closing balance of £33,303K as at 31st March 2022.



5. Financial Plan 2022/23

With regards to the financial plan for 2022/23 this will be shared at the next public Board of Directors meeting following submission to NHSE/I.

Steve Hackett
Director of Finance
20th April 2022

Appendix 1

Income & Expenditure Account Analysis for Month 12 2021/22 (March 2022)

Summary Income and Expenditure Position	AP	Month			YTD			21/22
		P	A	V	P	A	V	Monthly Trend /
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	Variance
Clinical Income	302,319	26,025	26,523	498	302,319	305,780	3,461	
Other Operating Income	22,812	2,827	3,522	695	22,812	24,315	1,503	
Pay	(223,211)	(19,014)	(13,888)	5,127	(223,211)	(219,572)	3,638	
Non Pay	(88,030)	(8,675)	(15,144)	(6,469)	(88,030)	(96,346)	(8,316)	
Non Operating Costs	(14,587)	(1,242)	(1,370)	(127)	(14,587)	(13,715)	872	
RETAINED SURPLUS / (DEFICIT)	(697)	(79)	(355)	(276)	(697)	461	1,158	

Appendix 2

Capital Expenditure for the Twelve Months Ending 31st March 2022

Scheme Categories	AP	Month 12			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	1,100	1,256	(156)	4,300	3,420	880
Estates Maintenance	2,656	220	1,150	(930)	2,656	2,168	488
Information Technology	2,763	968	1,529	(561)	2,763	3,188	(425)
Medical & Other Equipment	4,914	2,792	4,631	(1,839)	4,914	5,922	(1,008)
Contingency	423	(809)	51	(860)	423	(256)	679
Surplus/(Deficit)	**15,717**	**4,271**	**8,617**	**(4,346)**	**15,717**	**15,024**	**693**

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P85/22
Report	**Safer Staffing – Six Month Review March 2022**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	B1, B2, B5 & B6
How does this paper support Trust Values	By demonstrating the scrutiny of staffing levels to ensure staff are safe and appropriately care for patients, working together to ensure appropriate staffing is in place.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Nurse and Midwife staffing review for the Divisions of Medicine, Planned Care and Surgery, Family Health and the Urgent and Emergency care Centre (UECC) takes place every six months. This review forms part of the Trust's approach to the systematic review of staffing resources to ensure safe staffing levels meet patient care needs. The review in March 2022 identified that some investment is required within the Division of Planned Care and Surgery.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Divisions presented their establishment reviews and proposals to a panel consisting of Deputy Chief Nurse, Deputy Director of Human Resources and Assistant Chief Nurse. This paper was presented to Quality Committee 27 April 2022.
Board powers to make this decision	The Board of Directors is required to have oversight of the Safer Staffing review for inpatient areas twice per year prior to publication on the Trust website.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Chief Nurse will continue to review staffing levels and present the findings on a 6 monthly basis reporting again to November 2022 Board of Directors.
Recommendations	It is recommended that: The Board note the current staffing levels are appropriate and staffing is being planned as per establishments. There is support to progress a Business Case from the Division of Planned Care and Surgery to increase establishment in line with their proposal at the review. The business case will then proceed to FPC and Board of Directors in due course.

Appendices	Appendix 1 – Ward by Ward Findings Appendix 2 – Safer Staffing Review Outcomes

Safer Staffing Review – March 2022

1. Introduction

1.1 The purpose of this paper is to report the outcome of the nurse and midwife staffing review for March 2022 for the Divisions of Medicine, Planned Care and Surgery, Family Health and the Urgent and Emergency Care Centre (UECC). This review forms part of the Trust's approach to the systematic review of staffing resources to ensure safe staffing levels meet patient care needs.

1.2 The review is undertaken to ensure all stakeholders including patients, staff and the Board of Directors understand the risks and assurances associated with current nurse and midwife staffing levels and the actions required to ensure care is provided safely ensuring the Trust is care effective and cost effective.

1.3 It describes the methodology used and the recommendations made by the Divisional Management Teams following deployment of the Safer Nursing Care Tool (SNCT) across in-patient areas and Birthrate plus (BR+) in Maternity services and the subsequent analysis and triangulation of relevant nursing/midwifery quality indicators and Professional Judgement (Telford).

1.4 The report fulfils expectation 1 and 2 of the NQB requirements for trusts in relation to safe nurse staffing.

2 National Guidance

2.1 In 2013 as part of the response to the Francis Enquiry the National Quality Board (NQB) published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place, at the right time'.

2.2 This guidance was refreshed, broadened to include all staff groups and re-issued in July 2016 to include the need to focus on safe, sustainable and productive staffing. The principles of this guidance are identified below:

<table>
<tr><th colspan="3">Safe, Effective, Caring, Responsive and Well-Led Care</th></tr>
<tr><td colspan="3">Measure and Improve
-patient outcomes, people productivity and financial sustainability -- report investigate and act on incidents (including red flags) -
- patient, carer and staff feedback -</td></tr>
<tr><td colspan="3">- Implementation Care Hours per Patient Day (CHPPD) -
- develop local quality dashboard for safe sustainable staffing -</td></tr>
<tr><th>Expectation 1</th><th>Expectation 2</th><th>Expectation 3</th></tr>
<tr><td>Right Staff
1.1 evidence-based workforce planning
1.2 professional judgement
1.3 compare staffing with peers</td><td>Right Skills
2.1 mandatory training, development and education
2.2 working as a multi-professional team
2.3 recruitment and retention</td><td>Right Place and Time
3.1 productive working and eliminating waste
3.2 efficient deployment and flexibility
3.3 efficient employment and minimising agency</td></tr>
</table>

2.3 There is also a suite of improvement resources available, developed and designed to support the approved NQB guidance on safe, sustainable and productive staffing.

2.4 The resources applicable to the Trust are:

- In-patient Wards for Adult Acute Hospitals - is aimed at wards that provide overnight care for adult in-patients and excludes intensive care, high dependency, acute admissions and assessment units
- Urgent and Emergency Care
- Maternity Services
- Children's Services
- Deployment of nursing associates in secondary care

2.5 These resources have been included within the process for the skill mix reviews and assessing compliance against them.

2.6 This review is compliant with the requirements of the NQB and will ensure that Trust Board have assurance that staffing models in the Trust are developed and reviewed annually using a triangulated approach using evidence based tools and professional judgement (NQB, 2018).

2.7 In October 2018 NHSI published 'Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing'. This identified that when triangulating data, a minimum of 20 days of acuity data should be used. The first staffing review of 2022 has acknowledged this requirement and used 28 days of data in the collection period of 7 February – 6 March 2022. The Department of Health and Social Care's accounting manual requires NHS Trusts to include an annual governance statement specifically about staffing governance processes in their annual report.

2.8 Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the high standards of safe and personal care to women, babies and families. Central to this has been the overarching policy publication of the National Maternity Review (2016) *Better Births: improving outcomes of maternity services in England – a five year forward view for maternity care.*

2.9 This has informed the work streams for the Maternity Transformation Programme, with Maternity workforce being a key deliverable, implementing the Midwifery Continuity of Carer (MCOC) workforce model as the default model of care for most women by March 2023. Prioritising those women most likely to experience poorer outcomes first, including those from Black, Asian and Mixed Ethnicity backgrounds as well as those women from the most deprived areas. With a plan to develop an enhanced model of care for the most deprived which provides more midwifery team to support these families.

2.10 Critical to delivering the Better Births agenda is the safe, sustainable and productive staffing of maternity services. NHS provider boards are accountable for assuring themselves that appropriate tools such as the Birthrate Plus (BR+) tool recommended by NICE (2015) NG4 guideline: Safe midwifery staffing for maternity settings. BR+ is also endorsed by the Royal College of Midwives (RCM) as a robust and credible workforce planning tool for midwives and the National Quality Board (NQB) (2018)

publication: Safe, sustainable and productive staffing: An improvement resource for maternity services. The Maternity incentive scheme safety action 5: includes the required standard (table 1) to be evidenced.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	1. a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete. 2. b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service 3. c) All women in active labour receive one-to-one midwifery care 4. d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.

Table 1.

2.11 The publication of the final Ockenden report (March 2022) has highlighted Safe staffing in Maternity services as a key pillar and has a specific action that " All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer MCoC, unless they can demonstrate staffing meets safe minimum requirements on all Shifts". This action has been mandated further following a letter received by the Trust on the 1st April 2022, recommending that Trusts should immediately assess that safe staffing plans are in place making the following decisions for their Maternity service:

- Trusts that can demonstrate staffing meets safe minimum requirements can continue existing Midwifery Continuity of Carer (MCoC) provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision

2.12 The Final Ockenden Report March 2022 recommends that all professional bodies review the feasibility and accuracy of the Birth Rate Plus tool and associated methodology nationally.

Expectation 1: Right Staff

2.13 Safer Nursing Care data is input daily at an acute ward level to reflect the acuity and dependency of patients each day, this data is then utilised to determine the Care Hours per Patient Per Day (CHpPD) data.

2.14 In order to obtain data to support the triangulated annual strategic review of staffing, a structured twice yearly acuity and dependency data collection process is undertaken; this has been undertaken twice a year since January 2015, for all wards across the Divisions of Medicine and Surgery and ward B11 and Children's wards in the Division of Family Health with the exception of 2020 whereby emergency staffing plans were introduced in response to the COVID 19 pandemic.

2.15 The Division of Family Health commissioned a BR+ re-assessment (last completed 2017) during August 2020, which highlighted an opportunity for betterment in reference to the number of midwives and specialist roles and management. The Maternity escalation guideline for closure of the maternity unit has been aligned to the acuity tool, ensuring that there is standardised approach to escalation if required at times of high acuity. During October – March 2022 there have been no unit closures at TRFT.

2.16 On a day to day basis professional judgement is applied by Registered Practitioners in relation to ensuring that safe and sustainable staffing is maintained across the Divisions.

Expectation 2: Right Skills

2.17 The Organisation provides colleagues with a suite of blended approaches to Mandatory and Statutory training (MAST) across the organisation.

2.18 The Divisions undertake a review of education and training through the availability of funding for continuous professional development (CPD) via Health Education England, this allows colleagues to be supported on the most appropriate CPD to enhance their professional development, their knowledge and skills for the care, treatment and management of patients as well as sharing this with their wider multi professional teams.

2.19 The whole pathway for patients across the Divisions is Multi professional led and inclusive of patients, their families and carers.

2.20 In acknowledging the national shortage of Registered Nurses, all recruitment and retention opportunities are actively being pursued, including alternative workforce models. Registered Nursing Associate (RNA) and Trainee Nursing Associate (TNA) recruitment and workforce models are in place across the Divisions and active recruitment of return to practice nurses, international nurses and overseas nurses that currently hold HCSW positions in the UK continues to be progressed.

2.21 The Maternity services have implemented specialist training in line with the CNST TNA Minimum Data Set and recommendations from The Royal College of Obstetricians and Gynaecologists (RCOG) Green Top Guidelines, MBRRACE 2019,

Saving Babies Lives and the nationally recognised course PROMPT endorsed and accredited by the RCOG, RCM & Health Education England (HEE).

Expectation 3: Right Place and Time

2.22 The Trust actively encourages the efficient utilisation of colleagues, eRoster is applied across the wards and departments in line with the roster calendar, this ensures effective planning of rotas aligned with the resources available.

2.23 A Matron rota has been introduced to provide daily senior cover until 21:00 to ensure that staffing is deployed to areas as safely and effectively as possible with the resources available.

2.24 There is a daily (Monday to Friday) Senior Nurse Huddle that operates led by one of the Heads of Nursing / Deputy Chief Nurse to review staffing across the Divisions, to provide a Trust view of staffing and re-deployment of staffing across the Trust to support ward areas to ensure safe and sustainable staffing in line with the resources across the organisation. At weekends this is undertaken by the Divisional bleep holders, the Site Manager or Duty Matron

2.25 NHS Professionals and Agency colleagues are utilised to support the delivery of safe staffing. There is a daily check in and assurance process for the deployment of Agency staffing across the divisions, this is led each evening at 19.00 hours by the Matron on duty. In addition there is the use of the Trusts Allocate on Arrival Team.

2.26 Weekend staffing plans are prepared in advance to support the senior nurse / matron staffing representative, in order to strengthen the support out of hours a weekend Duty Matron Rota in in place on Saturday and Sundays 1-9pm, this role offers professional support and leadership across the organisation out of hours.

2.27 Rotational opportunities are in place for colleagues (Compass Programme) and a sideways transfer programme for nursing colleagues should they be interested in moving areas, flexible working opportunities are also supported, whilst ensuring service delivery.

2.28 Following the Ockenden report NHSE/I has offered investment for Trusts to bid for service improvement to focus on retention and pastoral support for midwives. TRFT have successfully achieved £50k for 12 months to support an additional 1 WTE clinical educator midwife to provide this support in clinical practice.

3 Ward Staffing Review Methodology

3.1 The Trust has in place a systematic, evidence-based and triangulated methodological approach to reviewing ward staffing levels on a 6-monthly basis, taking proposals for changes to establishment to the Board of Directors to be approved and implemented via a budget setting process. The aim of this process is to provide safe, competent and fit for purpose staffing to ensure delivery of efficient, effective and high quality care.

3.2 The current process for review now includes a full annual skill mix review presented to Board in May, followed up by an update review 6 months later to ensure plans are still appropriate.

3.3 The approach taken for the staffing review utilises the following methodologies:

- Shelford Safer Nursing Care Tool Acuity/Dependency staffing multiplier (a nationally validated tool)
- Care Hours per Patient Day
- Professional judgement
- Benchmarking and review of national guidance
- Review of e-rostering data
- Review of ward nurse sensitive indicator data
- Review of HR indicators and finance metrics
- Birthrate plus (Maternity services)

3.4 Triangulation of this data allows a full picture to be drawn that can determine if the correct staffing levels are being deployed across the wards.

3.5 The Divisional Management Teams for Medicine, Surgery and Family Health attend a review panel to present their review and any proposals. Any proposed changes must have already been agreed within the Divisional Management Team.

4 Six-monthly Ward Staffing Review

4.1 The review was carried out with each in-patient ward during Q4, assessing data from 7 February to 6 March 2022.

4.2 The reviews were undertaken as a two-step approach with the SNCT data presented to the Division for review. The Divisions were then invited to attend a review panel consisting of the Deputy Chief Nurse, Assistant Chief Nurse (Workforce and Education), HR Systems manager and the Head of HR Systems and Workforce Information.

4.3 The Ward Manager and Matron for each ward / unit attended with the Divisional Management Team to confirm current establishment, budget and alignment with roster template. In the main, ward budgeted establishment matched ESR and eRoster templates. Where anomalies were identified corrections were agreed to take place within one month.

4.4 The triangulated methodology was utilised as in previous reviews – a review of nurse sensitive indicators, SNCT data, HR data, nurse-patient ratios and professional judgement.

4.5 The spreadsheet with ward by ward findings are included in Appendix 1. This provides detailed information on the establishment levels for each ward and vacancies at the time of ward reviews; nurse sensitive quality and HR outcome data and detailing acuity and dependency information from the Safer Nursing Care Tool reviewed by ward.

4.6 The ward establishments allow for registered nurse to adult patient ratios during the day across the Trust to be based at a level of 1:8. These ratios are set against establishment and can regularly increase when wards are not fully established. Planned staffing ratios at night require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours. Ratios aim to achieve 1:11 registered nurse to patient. All areas with lower ratios have been reviewed to ensure the registered nurse to patient ratio is appropriate for the acuity of the ward and is offset by higher total staff to patient ratios.

4.7 The Safer Nursing Care tool (acuity/dependency model) has been used to model required staffing based on the national recommended nurse to patient ratios for each category of patient in all the adult areas. When predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the specialty and number of beds. The data is reviewed at each skill mix review as well as being used to review staffing levels on a daily basis.

4.8 Similarly the Safer Nursing Care Tool for Children's and & Young People was utilised for the Children's wards.

4.9 The Division of Family Health commissioned a BR+ plus reassessment during August 2020 to assess the midwife and support staff requirements in real time based on the acuity of the workload. It is recorded 4 hourly and enables the lead midwives to deploy staff to areas of need based on the BR+ evidence based methodology rather than the thresholds of the Labour ward co-ordinator.

4.10 The Trust continues to run a supervisory model for ward sisters/charge nurses. Full benefits of the supervisory model will not be realised until substantive staffing levels improve but where implemented, mostly within the surgical division, the model demonstrates benefits to the patient experience and safety outcomes at ward level, as well as reducing temporary staffing usage and patient flow.

4.11 A reduction in supervisory time given particularly in the Division of Medicine has been due to the high level of vacancies and ward leaders needing to fill vacant shifts, it is anticipated that as vacancies improve this will to improve also.

5 Safer Staffing Requirements

5.1 Division of Medicine;

5.1.1 During the COVID 19 Pandemic (from February 2020) the Division of Medicine has responded to the ever changing landscape of the pandemic in response to national, regional and local guidance. This has meant a significant change in the way pathways, services and wards work for example, how patients are segregated and cared for at ward level meaning that wards, services and departments have had to adapt and work in new ways of working, many of these new ways of working have been sustained and embedded as `business as usual`. In relation to the establishment reviews this has meant that the data has also been triangulated with previous safe care results and nurse sensitive indicators.

5.1.2 As part of the triangulated review the division have reviewed the impact of COVID 19 on the ward bases as the impact of COVID 19 has been felt across all pathways, wards and services, Ward A3 and A5 remained for the largest part of the pandemic the COVID positive ward areas with this escalating into A2 for periods of time. A2 was also for 5 months of the pandemic caring for patients at the end of their life / last few days of their life.

5.1.3 The Acute Medical Unit (AMU) has also been impacted in the segregation of patients through the pathway of symptomatic and asymptomatic. This pathway was changed with the introduction of Point of Care (POC) testing on the 22nd February 2021 for all admitted patients from the UECC allowing AMU to become a `green` assessment area and the introduction of Short Stay Medicine on the 24th February 2021.

5.1.4 The staffing levels for AMU and Short Stay Unit were agreed by the Chief Nurse in January 2021, and it is important to note that the funding for these established levels remains non-recurrent and has been funded through accelerator programme for 6 months and the winter funding for 6 months. The Division have been given executive approval to recruit permanently but only have budgets put in on a monthly basis to reflect the monthly spend, this is also the same situation for ward A4.

5.1.5 Ward A3 has also been above its funded establishment of 26 Beds and has been operating at 33 beds, the establishment for this ward was set in line with the requirements for Respiratory Support Unit. As this has not been operational, their planned staffing levels have remained the same due to an increase in the bed base.

5.1.6 The Division have also seen an increase in short term and long term sickness, some of this has been associated with `long COVID` and also associated anxiety and stress. The Division has worked closely with palliative care colleagues to offer individual and group support and have actively encouraged colleagues to access the suite of services available to support them through this challenging period such as de-brief sessions, psychology support on a 1:1/team level, support from Line Manager and Senior Divisional Management Team.

5.1.7 The Band 7 Ward Manager works both in a supervisory capacity as well as providing direct care to patients in the planned staffing levels. The amount of supervisory time for Ward Managers across the Division of Medicine is compromised as they are frequently required to work as part of the ward numbers, this impacts on the ability of the Ward Manager to undertake other managerial duties for example appraisals, timely investigation of incidents/incident management and the support of quality improvement projects.

5.1.8 From March 2022 the Division has reviewed the oversight and assurance of e-rostering KPI and compliance and have introduced a monthly oversight and assurance meeting from April 2022 for ward based rotas, this is supported by E Rostering, HR, Finance and NHSP Colleagues.

5.1.9 The Division of Medicine is not proposing any changes to the funded establishments at this stage following the review undertaken, it will continue to actively recruit to RN and HCA vacancies to increase RN and HCA fill rate across the division.

5.1.10 The Division is in support of the Chief Nurse reviewing the uplift of ward establishments to reflect the current sickness levels, and continued increase in MAST, role Specific MAST and CPD for colleagues.

5.1.11 The Division is in support of a review by the Chief Nurse of a trust wide approach to Practice Development to support `bed side` clinical education and supervision.

5.2 Division of Planned Care and Surgery

5.2.1 Existing establishments in the Division are currently over recruited at Registered Nurse level due to International Nursing and Newly Qualified Nursing allocations that have been co-ordinated and agreed centrally in anticipation of leavers.

5.2.2 The Acute Surgical Unit's agreed staffing model is for 4 HCSW's in the day and 3 at night. This staffing model is to support the delivery of safe effective care to 33 inpatients admitted through the non-elective surgical pathways. In the day there is an additional function of the Surgical Same Day Emergency Care (SDEC) waiting room which supports admission avoidance and UECC patient flow. Since its introduction the staffing model has not changed to reflect this activity and as a result the ward is depleted to 3 HCSW's whilst one supports the SDEC function. This leaves ASU with a depleted staffing model that is not consistent with other departments in the Division with a similar sized bed model.

5.2.3 The provision of safe staffing levels for HCSW'S on ASU was subject to a recent CQC enquiry that attributed delays in care to the acuity and low numbers of HCSW's on the ward. There are delays in patient observations completed on time with the department only achieving c85% compliance with observations on time over the last 8 months.

5.2.4 In the 2021 staff survey, only 7.1% of staff felt there was enough staff to undertake their job properly, this is the second lowest score within the Division. These results were based on a 97% response rate for the department and compares negatively to the overall organisational comparator where 25.7% of staff felt there was enough staff to undertake this role.

5.2.5 The increased band 2 HCSW for ASU equates to 2.71 wte at a cost of £78,522.

5.2.6 Details of the proposed changes are identified in the table at Appendix 2.

5.2.7 There is currently a recurrent vacancy factor within the Division of Surgery, specifically relating to Registered Nurses and HCSWs, totalling £863,967.00. This is following any premium spend allowance being netted off against. Unfortunately, the vacancy factor pressure was not supported through the Trust's cost pressure approval process and consequently presents a significant risk to the Division's financial position.

5.2.8 The financial risk associated will be included on the Division's risk register but may be incorporated within a more overarching risk. This, however, is dependent on the agreed 22/23 budget sign off process, which has yet to be finalised.

5.2.9 There are potential options to mitigate the financial risk in line with the expectation of a vacancy factor, which the Division would welcome further discussion on:

- Hold recruitment once the substantive recruited position of band 2 is below the overall expected establishments
- Reduce rostered numbers per shift to account for a reduction in 21.78 WTE RN's or 33.12 WTE band 2
- Reduce bank and agency cover for selected rostered shifts

5.3 Division of Family Health

5.3.1 **Children's Wards;** Across the floor, the planned staffing is 5 Registered and 2 HCSW per shift, this provides a 71:29 percent registered to unregistered split. This meets the Royal College of Nursing (RCN) 'Defining staffing levels for children and young people's services' (2013), minimum core standard of 70:30 percent registered to unregistered staff. As per RCN guidance 1.00 wte Band 7 is supervisory. No changes are proposed to the current establishment.

5.3.2 **Special Care Baby Unit;** British Association of Perinatal Medicine (BAPM) (2019) states "the nurse staffing establishment should be calculated using BAPM standards, calculated on the basis of an average 80% cot occupancy and with the help of the appropriate staffing tool". Based upon the Royal College of Nursing (RCN) guidance - Defining staffing levels for children and young people's services (2013), 70% of registered nurses in Neonatal units should be Qualified in Speciality (QIS) to ensure appropriate skill mix. Although no changes to the current established are proposed, it is acknowledged that there is a need to support increased training to achieve 18.9 wte Qualified in Speciality.

5.3.3 **Ward B11;** The ward continues to be used on a regular basis for medical and surgical outliers. The funded establishment includes staffing for the Acute Gynaecological Unit (AGU) and Early Pregnancy Assessment Unit (EPAU). One (0.92 wte) Registered Nursing Associate is included in the establishment, however this is now a vacant post. The SNCT typically suggests an establishment below the funded establishment in this area, however reducing the establishment would take the planned registered nurse staffing below two registered nurses per shift, and therefore no changes are proposed to the current establishment.

5.3.4 **Maternity;** The Maternity Service at TRFT has embraced the Better Birth ambition of implementing Continuity of Carer to improve outcomes and choice for women. Three geographical continuity teams have been established with a mix of midwives from the hospital and community service who opted to work in the Continuity of Care model. The point prevalence rate for 2021 has been between 37- 45 % as this model of care was maintained throughout the pandemic. Plans to fully implement this model at TRFT were submitted to Trust Board in December 2021.

5.3.5 Recommendations from the first Ockenden report (December 2020) have strengthened further the need for providers and local maternity systems to redouble their efforts to provide safe high quality care; with workforce been included as an immediate and essential action for staff training and working together. The NHS Planning guidance March 2020/21 has reset these priorities with a focus on local

Maternity systems continuing to drive the Better Births (2016) ambitions including an emphasis on the health and wellbeing of the workforce taking action to recruit and retain staff.

5.3.6 BR+ recommends a skill mix of 90% midwives and 10% band 3/4 support workers, at the time of the assessment this was 88%:12%. Currently, the workforce split is in line with the BR+ recommendations.

5.3.7 The current establishment meets the BR+ recommendations for safe staffing and the current continuity point prevalence of around 35%. However, to meet the revised NHS England Ambition for MCoC to be the default model for all women by March 2023, a further 12.26 WTE midwives would be required. This is based on the NHS England Continuity of Carer Workplace Toolkit.

5.3.8 This was also recommended by the Regional Chief Midwife for Yorkshire and the North East during the Continuity of Carer assurance visit in August 2021. Subsequently, following the recommended actions following the Ockenden Final report as described earlier, the Family Health Division are currently reviewing their position on MCoC to ensure that safe staffing is maintained on every shift.

5.3.9 The Division will review commissioning a refresh of Birth rate plus workforce acuity baseline assessment to inform any future business cases to support additional funding for the establishment.

5.3.10 The Division will review the Trust position on the MCoC model of care and will review the headroom requirements based on the Final Ockenden Report action for safe staffing, reviewing the last 3 years sickness, maternity leave and MAST training requirements.

5.4 Urgent and Emergency Care

5.4.1 A review of the nursing workforce was undertaken during 2019 with Emergency Care Improvement Support Team (ECIST) using an NHS Improvement recognised staffing tool following a Care Quality Commission (CQC) assessment.

5.4.2 The Shelford Group have launched a licensed Emergency Department (ED) Safer Nursing Care Tool. This is an evidence-based tool that calculates nurse staffing requirements for emergency departments based on patients' needs (acuity and dependency) which, together with professional judgement, supports Emergency Department Managers and Chief Nurses in their safe staffing decisions.

5.4.3 The tool provides the following:

- Establishment set by Annual Attendance as well as Acuity and Dependency
- Care Hours to Contact metrics on the current and recommended establishments
- A deployment arm showing the hourly staffing requirement aligned to the acuity and dependency.

5.4.4 Users are required to attend two training sessions delivered by NHS England and Improvement prior to using the tool. The first session was attended by Trust colleagues on 17 March 2022, a second date has yet to be issued.

5.4.5 It is recommended to run the data collection for two periods prior to using the data to inform decisions regarding staffing establishments. The UECC plan to run the first data collection during June 2022.

6 Issues considered in the review

6.1 The Principles applied to the planned establishments are a ratio of nurse; patient of 1:8 Days and 1:11 nights with the exception of specialist medical areas of Ward A7 and Coronary Care Unit as well as the Acute Medicine Area (which includes Short Stay).The Society of Acute Medicine also recommends a ratio of 1:6 in Acute Assessment Areas.

6.2 The SNCT does not capture the monitoring of the remote telemetry units which are monitored centrally on CCU and also is not sensitive to the requirements of ward A7 Haematology ward, hence the division are not proposing a change to their establishment.

6.3 The Division of Medicine acknowledges the lack of supervisory time the Ward Managers have been able to undertake due to the need to support clinically within their ward areas as part of the establishment, this provides a challenge to the division in relation to the competing priorities of Ward Managers eg Appraisals, Incident investigation, and is currently reviewing the options available to support supervisory time for our Ward Managers.

6.4 The reviews have been approved by the Divisional Management Team and recommended changes to staffing templates approved following assessment against triangulated SNCT requirement, agreed nursing quality indicators and clinical judgement. The ward staffing templates are agreed by the Head of Nursing.

6.5 The proposed templates assume the ward is fully established for the template to meet the demand requirement of that ward and additional hours required are based on the acuity of the patients exceeding the pre agreed parameters.

6.6 Focused recruitment campaigns continue to increase the numbers of substantive staff with the intention of eliminating agency expenditure.

6.7 Nationally there has been an increased focus, to increase nursing establishments and improve nurse staffing levels on the wards. As a result, the majority of NHS Trusts are undertaking major recruitment initiatives for nursing positions. The Trust acknowledges the national nurse recruitment difficulties and the turnover realities of a profession where staff move organisations in order to progress.

6.8 Detailed work continues on recruitment initiatives in all Divisions in close partnership with the recruitment team. Further work is being undertaken in developing retention initiatives to ensure that staff recruited into the organisation are retained and develop their careers within the organisation.

7 Conclusions

7.1 Although improvements have been made in recruitment, retention continues to remain a significant area of challenge in the provision of safe staffing levels across the ward areas, and thus a formal recruitment and retention group is to be established led by the Deputy Director of Workforce. Focus needs to be maintained on continuing recruitment and retention initiatives as priority areas.

7.2 There is a requirement to review the Discharge co-ordinator role included in some ward establishments and agreement to where these roles will sit.

7.3 For clarity, there needs to be standardisation of job titles, aligned to roles, particularly at Band 6 where there are large number of job titles in existence relating to the same job role.

7.4 Divisional roster management has improved particularly in the Division of Surgery. This will be strengthened further in the Division of Medicine with the establishment of monthly review meetings supported by the Deputy Chief Nurse.

7.5 A review of the uplift (currently set at 21%) to cover absence relating to study leave, sickness and maternity is recommended.

7.6 Overall quality of care continues to be maintained according to reportable nurse sensitive indicators despite the challenging environment of vacancies, temporary staffing and increasing acuity and dependency.

7.7 The Chief Nurse on acceptance of the recommendations considers the nurse staffing model to be safe, effective and sustainable and reflective of current levels of acuity and dependency – this will be subject to an annual review.

8 Recommendations

8.1 To note the findings of the nurse and midwifery establishment review and the Trust position in relation to adherence to the monitored metrics on nurse/midwife staffing levels, specifically:

- TRFT nursing establishments are set to achieve a rate of no more than 1:8 registered nurses to patients during the day; and no more than 1:11 registered nurses to patients at night, areas not achieving have been reviewed.
- To note the on-going progress with compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing and Developing Workforce Safeguards.
- To continue momentum of actions to fill vacancies and improve retention to impact on the reliance on high cost agency against the backdrop of agency control from NHS Improvement.
- To discuss the report at public Board of Directors as an ongoing requirement of the National Quality Board expectations around safe staffing assurance.
- To agree the additional investment into staffing as outlined in the table at Appendix 2.

9 Summary and next steps

9.1 In line with national recommendations, the review of adult inpatient ward nurse staffing levels has been undertaken. The information gathered has been triangulated against nursing quality indicators and professional judgment. To ensure the Trust provides safe and efficient care, it is vital that the Trust remains responsive to patient needs and explores innovative ways of working and delivering workforce models and role development, which is in line with the NQB recommendations (2018). The Board of Directors is asked to accept the information contained in this summary and work undertaken to maintain safe staffing levels and are asked to support the nurse staffing recommendations approved within the Divisions and by the staffing review panel.

9.2 All proposals agreed by the Board of Directors and Finance and Performance Committee need to be communicated to Divisional management teams to ensure relevant amendments are made to budgets, establishments and Healthroster.

Appendix 1

Area	Core Beds	Current Funded Establishment (inc Band 7 Wd Manager)	Total Jan 2021	Total July 2021	Total Feb 2022	Average	Variation Current Funded vs Average	% Registeredstaff to plan FEB 22	% Non-Registeredstaff to Plan FEB 22	Net Vacancies as of 28 Feb 22	Sum of external in recruitment process as of 28 Feb 22	Falls - Moderate and above	Pressure Ulcers - Grade 2 - 4	Medication Errors	Complaints	Notes
A1	33	39.68	40.82	42.18	39.34	40.78	-1.1	86.2	81.3	Registered +0.06 Unregistered +0.13	Registered 0 Unregistered 1.0	0	1	2	0	1.0 wte Discharge Liaison Facilitator not included
A2	24	35.47	38.68	36.13	34.39	36.4	-0.93	99.3	76.5	Registered +0.69 Unregistered -1.86	Registered 0 Unregistered 0	0	6	2	0	
A3	33	46.56	41.4	42.77	41.78	41.98	4.58	72.6	77.3	Registered -1.05 Unregistered -6.54	Registered 0 Unregistered 0.61	0	2	1	3	
A4	33	32.99	47.35	44.01	41.82	44.39	-11.4	90	81.1	Registered +4.32 Unregistered +3.61	Registered 1.0 Unregistered 5.03	0	6	7	1	
A5	33	39.28	41.12	44.63	43.33	43.03	-3.75	82	72.8	Registered +1.35 Unregistered -1.51	Registered 1.0 Unregistered 1.23	0	2	2	2	1.0 wte Discharge Liaison Facilitator not included
A7	12	20.87	16.32	13.46	14.67	14.82	6.05	87.3	74	Registered -1.06 Unregistered +1.1	Registered 0 Unregistered 0	0	0	2	0	
Stroke and Neuro Rehab	27	44.1	42.35	39.11	38.97	40.14	3.96	77.2	74.2	Registered +2.02 Unregistered -9.13	Registered 0 Unregistered 1.0	0	4	5	2	6.80 wte specialist nurse practitoner not included 1.69 wte discharge liaison facilitator
CCU	8	20.31	12.08	11.31	11.52	11.64	8.67	77.2	234.3	Registered -0.69 Unregistered +0.33	Registered 0 Unregistered 0	0	2	0	0	
AMU and Short Stay Unit	39 AMU + 17 SSU	71.23	105.78	94.46	81.78	94	-22.77	103.8	74.2	Registered +7.91 Unregistered -2.24	Registered 1.0 Unregistered 2.0	0	4	3	0	Includes short stay unit + 10 unfunded beds on SSU, note AMU multiplier used for all.
Fitz	28	39.74	45.81	42.19	38.26	42.09	-2.35	74.6	115.6	Registered +0.63 Unregistered -1.38	Registered 0 Unregistered 2.0	0	1	0	1	
Keppel	22	29.81	38.71	29.53	27.88	32.04	-2.23	92.9	102.4	Registered -0.91 Unregistered -0.26	Registered 0 Unregistered 2.0	0	3	3	0	
Sitwell	14	20.77	20.36	13.81	13.61	15.93	4.84	90.3	57.2	Registered +0.63 Unregistered -0.04	Registered 0 Unregistered 0.61	0	0	2	0	
B5	33	41.36	No Data	No Data	46.84	46.84	-5.48	77.3	105.5	Registered -0.48 Unregistered -0.46	Registered 0 Unregistered 4.0	0	3	3	3	
ASU	33	46.27	49.6	51.38	52.82	51.27	-5	79.7	87	Registered -2.81 Unregistered -1.13	Registered 1.0 Unregistered 1.0	0	1	6	0	
B11	14	17.57	9.83	12	16.32	12.72	4.85	111.9	102.2	Registered +1.21 Unregistered -1.47	Registered 1.61 Unregistered 0	0	0	0	0	
Children's	22	41.09	29.88	41.6	30.71	34.06	7.03	94.4	97.1	Registered -1.87 Unregistered -0.08	Registered 1.53 Unregistered 0	0	0	5	0	

Notes

Vacancies as at 28 February 2022. Non-registered vacancies reduced by the inclusion of nurse no PIN (RtP, International) who will move to Registered.

Column F shows the recommended staffing establishment allied to the average acuity and dependency measurement for each ward during February 2022.

Column G shows the average of the last three SNCT results for each ward.

The Safer Nursing Care Tool for Children's & Young People's In-patient Wards was used for the acuity and dependancy measurement in Children's.

The Shelford Safer Nursing Care Tool multiplier includes a headroom of 22%, TRFT headroom is 21%

Appendix 2

Proposed Establishment changes for 2021	Comments
Acute Surgical unit **Increase Band 2 (2.71 wte)**	The Division requests funding to increase Band 2 by 2.71 wte to provide appropriate staffing for the SDEC waiting room. The current staffing model has not changed to reflect SDEC activity and as a result ASU is depleted to 3 HCSW's whilst one supports the SDEC function. Financial cost £78,522.

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P86/22
Report	**Ockenden Monthly Report**
Executive Lead	Helen Dobson, 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)	The Ockenden final report, *Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust*, was published on 30th March 2022. 1,592 clinical incidents involving mothers and babies have been reviewed. The review identified poor practice, leading to poor outcomes for women and babies and in some cases unfortunately death. Investigatory processes were not followed appropriately, and serious incidents were inappropriately downgraded. As a result, lessons were not learned, and opportunities were missed to prevent harm to other women and babies. The report identifies ongoing concern that NHS maternity services and their Trust Boards continue to inadequately address and learn lessons from serious maternity events. The review also found concerns that false reassurance was provided to the CCG and other external bodies, despite repeated concerns raised by families. As such the review categorises a further fifteen areas as Immediate and Essential Actions (IEAS) which should be implemented by all Trusts in England providing maternity services. TRFT have responded to the report sharing a comment to reassure the public via communications on 1st April 2022. The Maternity service has shared the report with all teams including Anaesthetists and Neonatal colleagues and the infographic (Appendix 1) has been shared to illustrate the fifteen IEA'S. All Trusts received a letter from NHS England on the 1st April 2022 (Appendix 2) requesting that Trusts immediately assess their staffing position to inform a decision regarding the position for Midwifery Continuity of Carer (MCoC). TRFT have assessed their position following engagement with teams as:

Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

The Head of Midwifery and Community Midwifery Matron have met with the regional and national midwifery continuity leads to discuss proposals for a pilot to support the Trust with a more sustainable staffing model for MCoC and this is currently been developed with teams and will be shared with the Maternity Voice Partnership and Trust Board once finalised.

A benchmarking exercise has subsequently been undertaken by the Maternity Service to review the current position against the fifteen IEAs (Appendix 3). The non-complaint and partially complaint actions will inform the service improvement plan for Ockenden. Regionally this information has not been requested as it is anticipated that a Trust response will be requested when the East Kent report is published in June 22.

The Maternity Service at TRFT report monthly to Trust Board the progress with the 7 IEA'S from the First Ockenden Report (December 2020). At the April 2022 Board of directors meeting, compliance with the IEAs following the Local Maternity System review meeting on the 4th March 2022 was reported with a total aggregate compliance score of 93%.
The regional assurance visit is planned for the 25th May 2022 and the Division is currently preparing for this visit.

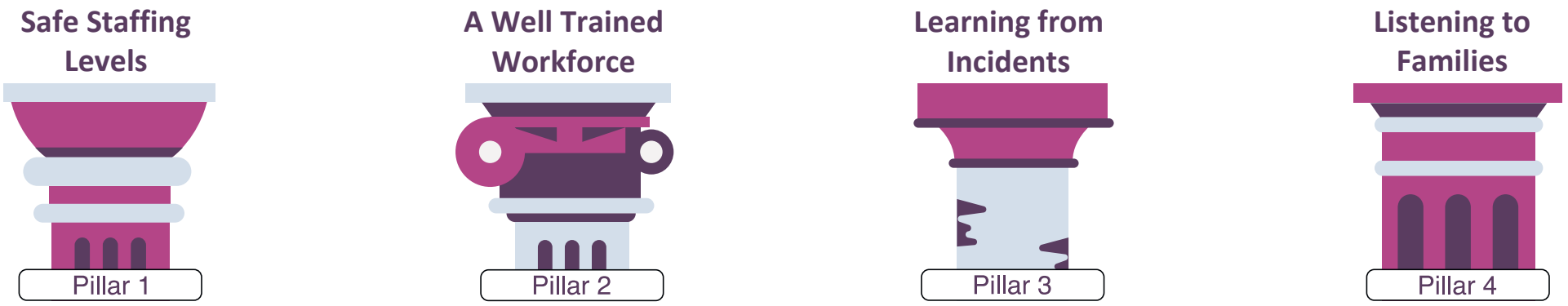
The Service continues to report monthly on the Divisional IPR and commentary for the Perinatal Safety dashboard data. Please see the Summary below for March 2022:

Obstetric cover gaps	31	Dashboard data
Maternity unit closures	0	
Utilisation of on call midwife to staff labour ward	3	Birthrate plus data
1-1 care in labour	98%	Data from birth-rate plus acuity tool reflects 100%
Continuity team midwife present for continuity birth	96%	Data from Birth rate plus acuity tool
Supernumerary labour ward co-ordinator	97%	Data from Birth rate plus acuity tool
Staff absence	9%	HR data
Shifts unfilled	56	Data from birth rate plus acuity tool
Number of stillbirths	1	
Stillbirth rate per 1000 births Rolling 12 months	2.35	
MDT Training	76%	Feb 22 data

	MDT training is currently below the trajectory of 90%, however, CNST is currently paused due to the recognition of operational pressures due to the pandemic and increased sickness and absence rates. Therefore the threshold to cancel training remains low to maintaining safe staffing.
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 IEA'S 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, 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. Infographic Immediate and Essential Actions 2. Letter from NHS England 3. TRFT Benchmarking

Key Pillars and Immediate and Essential Actions from the Ockenden Report

The final Ockenden Report was published in March 2022 and contained 4 key pillars and 15 Immediate and Essential Actions for all Maternity Trusts.



ESSENTIAL ACTION 1

Workforce Planning & Sustainability

- **Financing a safe Maternity workforce:** the recommendation from the Health and Social Care (HSC) Committee Report: the safety of maternity services in England must be implemented
- **Training:** we state that the HSC Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented

ESSENTIAL ACTION 2

Safe Staffing

- **Safe staffing:** All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals

ESSENTIAL ACTION 3

Escalation and Accountability

- **Escalation:** staff must be able to escalate concerns if necessary
- **Appropriate:** there must be clear processes for ensuring obstetric units are staffed by appropriately trained staff at all times
- **Guidelines:** if not resident there must be clear guidelines for when a consultant obstetrician should attend

ESSENTIAL ACTION 4

Clinical Governance-Leadership

- **Oversight:** trust boards must have oversight of the quality and performance of their maternity services
- **Accountable:** in all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems

ESSENTIAL ACTION 5

Clinical Governance: Incident Investigation and Complaints

- **Investigations:** incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner

ESSENTIAL ACTION 6

Learning from Maternal Deaths

- **Post-mortem:** nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies
- **Review:** in the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings

ESSENTIAL ACTION 7

Multidisciplinary Training

- **Together: staff who work together must train together**
- **Mandatory Training:** staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend
- **CTG training:** clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training

ESSENTIAL ACTION 8

Complex Antenatal Care

- **Pre-conception care:** Local Maternity systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care
- **Multiple pregnancy:** trusts must provide services for women with multiple pregnancy in line with national guidance
- **National guidance:** trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

ESSENTIAL ACTION 9

Preterm Birth

- **Preterm birth:** the Local Maternity and Neonatal System (LMNS), commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth
- **Saving Babies** Lives: trusts must implement NHS Saving Babies Lives Version 2

ESSENTIAL ACTION 10

Labour and Birth

- **Transfer:** women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary
- **CTG Monitoring:** centralised CTG monitoring systems should be mandatory in obstetric units

ESSENTIAL ACTION 11

Obstetric Anaesthesia

- **Follow-up:** Pathways for outpatient postnatal follow-up and routine inpatient obstetric anaesthesia review must be available to address incidences of physical and psychological harm
- **Record-keeping:** documentation of patient assessments and interactions by obstetric anaesthetists must improve. Core datasets must be recorded during every obstetric anaesthetic intervention to reflect more accurate record-keeping to reflects events
- **Safe:** Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services must be developed

ESSENTIAL ACTION 12

Postnatal Care

- **Readmission**: trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review
- **Staffed:** postnatal wards must be adequately staffed at all times

ESSENTIAL ACTION 13

Bereavement Care

- **Bereavement services:** trusts must ensure that women who have suffered pregnancy loss have the appropriate bereavement care services

ESSENTIAL ACTION 14

Neonatal Care

- **Pathways:** there must be clear pathways of care for provision of neonatal care
- **Recommendation:** the review endorses the recommendations from the Neonatal Critical Care Review to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must progress at pace

ESSENTIAL ACTION 15

Supporting Families

- **Wellbeing:** care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision
- **Engage:** maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care

Official
Publication approval reference: B1523

To:

- NHS Trust and Foundation Trust:
  - Chief Executives
  - Chairs
  - Chief Nurses
  - Chief Midwives
  - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

CC:

- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared

with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard

NHS Chief Executive

Ruth May

Chief Nursing Officer

Professor Stephen Powis

National Medical Director

Final Ockenden Report

Benchmarking Against 15 Immediate and Essential Actions

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
Essential Action 1 – Workforce Planning and Sustainability			
The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	Ockenden Funding received. For 2022/23, we have received the funding	GREEN
	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	BirthRate Plus workplace assessment completed August 2020. BirthRate workplace assessment to be considered for a refresh. Professional Judgement exercise on all areas. Birth rate plus acuity tool to ensure safe staffing and 1:1 care in labour.	GREEN
	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	Data has been requested from workforce for sickness and Maternity.	RED
	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	Awaiting national guidance	RED
We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	LMNS preceptorship and TRFT welcome package. The pastoral support midwives role is to support NQM and provide 1:1 support. Protected learning time NQM study days. Review training programme for NQM to aspire for a mini MAST programme.	AMBER

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Awaiting national guidance.	RED
	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Improvement work started as planned for April 2022 on culture, Situational awareness and human factors covered in MAST. Psychological support commissioned by the LMNS to support positive behaviours.	RED
	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Labour ward coordinator development package implemented in 2021.	AMBER
	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Review of care pathways for HDU patients in a DGH. Scoping the training available via MEACC.	RED
	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Maternity Workforce strategy required. Leadership has been strengthened and specialist roles.	RED
	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	TRFT involved in the regional development of Maternal Medicine Networks.	AMBER
Essential Action 2 – Safe Staffing			

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	Escalation policy. Daily Maternity and Trust Bronze staffing huddles. LMNS Escalation policy.	GREEN
	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	Risk assessment required for Consultant rota.	RED
	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Labour Ward Co-Ordinator JD reflects.	GREEN
	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	Self-assessment completed and engagement on going with teams. Agreed that TRFT 2 on the letter. Pause on rolling out further teams at this moment in time.	GREEN
	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.	Awaiting national guidance re further roll out of MCOC.	RED
	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	Training needs to be included into job plans to maintain consistency. Currently in SPA/study leave	AMBER
	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Clinical support midwives in post.	GREEN
	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Leadership development currently supported by the individual line manager who acts as pastoral support and mentor. Support available at a regional and LMNS level.	GREEN

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Pathways are integrated between community and the acute services. LMNS pathways and regional pathways for complex pregnancies and safeguarding.	GREEN
	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	Locum guidance in place to be reviewed in line with these recommendations.	AMBER
Essential Action 3 – Escalation and Accountability			
Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	Guideline developed in 2021 on women's birth choices outside of guidance. Review guideline to check that this covers conflict of clinical opinion	AMBER
	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Entrustability is fully implemented for trainees at TRFT. Currently the process is under review in respect of non-training grade doctors.	AMBER
	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Currently the Unit is covered 66 hours by a resident consultant. The process is under review to identify if there is a need to increase this cover.	AMBER
	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Medical Staffing Levels, Rotas and Handover of Care in Obs & Gynae Guideline (page 14) in place.	GREEN
	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Escalation policy	GREEN
Essential Action 4 – Clinical Governance - Leadership			
Trust boards must have oversight of the quality and performance of their maternity services.	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Head of Midwifery presents at Board meetings either face to face or via the Chief Nurse monthly on Ockenden assurance and any relevant maternity improvement and transformation plans including maternity safety	GREEN

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	The National Maternity Self-Assessment Tool has been completed and was shared via Maternity and Neonatal Safety Champions. This Tool was shared with the Executive team for the national maternity safety board visit. Action plan needs to be shared with Trust Board	AMBER
	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Lead Midwife for Governance for Maternity, Gynaecology and Rotherham Sexual Health Consultant Lead for Governance with identified PAs Deputy Head of Midwifery with patient safety within their portfolio The Division need to consider a patient safety specialist role	AMBER
	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Consultant Lead for Governance with identified PAs	GREEN
	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	HSIB Training and Baby Lifeline Training has been undertaken by the Deputy Head of Midwifery. Lead Midwife newly appointed will also undertake this training. Currently Consultant Lead for Governance has not had this training formally. Plans in place to address this.	AMBER
	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Guidelines are currently developed by Matrons, Leads and Consultants. There is no dedicated Midwife role at TRFT.	GREEN
	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	As above	AMBER
Essential Action 5 – Clinical Governance – Incident Investigation and Complaints			

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Investigation reports do use lay terms and all medical interventions and procedures are explained using diagrams where appropriate	GREEN
	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Investigation findings are integrated into the MAST training sessions	GREEN
	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Changes in practice are audited eg swab count. We also include changes in practice in the ward assurance audits. Mapping of audits to take place.	AMBER
	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	This happens through immediate changes to learning points and guidelines	GREEN
	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	Any complaints go through the Trust process and an investigation would be undertaken following review at Harm Free and SI Panel	GREEN
	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Service users are not currently involved in complaints response processes. MVP do signpost women to our services if they wish to make a complaint. We also encourage women to contact MVP when making a complaint	GREEN
	Complaints themes and trends must be monitored by the maternity governance team.	Complaints are on the monthly Governance meeting agenda and themes/trends are monitored	GREEN
Essential Action 6 – Learning from Maternal Deaths			
Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	Awaiting national guidance	RED
	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	Awaiting national guidance	RED
	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	Based on criteria certain maternal deaths are investigated through HSIB. The late maternal deaths are investigated through MBRRACE. At TRFT they are presented and discussed as a cohort.	AMBER

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Essential Action 7 – Multidisciplinary Training			
Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Staff are allocated on to MAST training. Governance meeting dates are shared within the division. The clinical effectiveness and audit meetings are included in SPA time for medical colleagues and all maternity staff are invited.	AMBER
	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	SBAR is included in the MAST curriculum for all scenarios	GREEN
	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Current MAST programme includes human factors training. The midwifery service has invested in psychological support training and improvement work around behaviours and values engaging with the Trust Equality and Diversity Leads. This needs evaluation for wider sharing including all MDT teams.	GREEN
	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	There are skills drills within the MAST programme and ad hoc skills drills are undertaken in all areas of Maternity Services.	GREEN
	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	PMA role is established at TRFT. Invested in psychological support for maternity teams. The Trust has team time and psychological support services available.	GREEN
	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Full foetal wellbeing programme included in mandatory training	GREEN
	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	MAST training is mandatory for all clinicians. Schedule in place allocating attendance at MAST training.	GREEN
Essential Action 8 – Complex Antenatal Care			

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Preconception care is undertaken by a Specialist Consultant	GREEN
	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Multiple pregnancy clinics undertaken by a dedicated consultant. There is currently no dedicated specialist midwife due to low numbers within a DGH. However, the core antenatal clinic staff are looking at having dedicated specialist interests.	AMBER
	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	All our care pathways follow NICE guidance. Any non-compliance is recorded on the risk register with a risk assessment.	AMBER
	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	All care is evidence based and women are offered informed choice in line with national guidance. Documentation is completed in the women's maternity records of all discussions. Notes are audited monthly.	GREEN
	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Women with chronic hypertension are cared for under a consultant and Aspirin guidance is followed.	GREEN
Essential Action 9 – Preterm Birth			
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	We have preterm clinics and women at risk of preterm birth are counselled by both obstetric and paediatric consultants	GREEN
	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Fetal monitoring and recommendations are included in birth plan and personalised care plan discussions. Guideline for Care for Women Choosing Care Outside of Guidance.	GREEN
	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	We collaborate with the ODN and network care pathways. Off pathway deliveries are audited through the LMNS.	GREEN

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Monitored by the ODN and LMNS. Exception reports are completed and shared at network and LMNS meetings as well as through the Perinatal meeting.	AMBER
Essential Action 10 – Labour and Birth			
Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	Risk assessments are undertaken throughout pregnancy and in early and established labour. Risks are reviewed and assessed. Women choosing birth outside guidance are offered fully informed discussions with risk assessments.	GREEN
	Midwifery-led units must complete yearly operational risk assessments.	Not applicable	
	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Not applicable	
	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	This is included in the homebirth risk assessment. Any ambulance delays would be datixed and investigated.	GREEN
	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Induction of labour guideline in place.	AMBER
	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Business case in development for the procurement of a centralised CTG	RED
Essential Action 11 – Obstetric Anaesthesia			
In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Currently all women with the mentioned issues get followed up in hospital as an inpatient postnatally, picked up through either Datix and / or midwife referral for review. An outpatient pathway is not in place currently.	AMBER

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Currently anaesthetists are proactive on an 'as required' basis as women present with anaesthetic issues for example previous traumatic experiences with GA or failed regional anaesthesia through the high risk anaesthetic antenatal clinic. An outpatient pathway for postnatal care for women with anaesthetic issues is not in place currently.	AMBER
	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC.	Currently a hybrid model of documentation exists. The medication review and WHO checklist takes place on the electronic patient record (Meditech). The anaesthetic chart and labour epidural documentation is on paper. Plans are in place to transfer this to an electronic version. This is currently with IT and pharmacy for development.	AMBER
	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	To confirm if national guidance is available	RED

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
	Obstetric anaesthesia staffing guidance to include: The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	There are 15 Consultant programmed activities (PAs) per week utilised by the Delivery Suite. Currently the Obstetric Anaesthetic Consultants are resident between 07.40 and 21.30 hours Monday to Friday. There are an additional 4 and 5 programmed activities on alternate weeks for a dedicated Consultant to undertake the elective caesarean section lists. In addition, there is also a nominated Consultant Anaesthetist available in Main Theatre who is instantly available should the need arise. A duty anaesthetist is available to attend the unit 24 hours a day, 7 days a week. There is always a non-resident Consultant Anaesthetist on call to provide prompt advice and assistance. Dedicated middle grade anaesthetic cover is provided 24 hours a day every day.	GREEN
	The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	Compliant with obstetric anaesthetic rota cover. Joint Clinical Effectiveness Meetings. Monthly Labour Ward Forums with anaesthetic representation in place. Involved in MDT teaching as faculty. The current compliance target for anaesthetics at multidisciplinary training has been challenged due to high sickness levels as clinical commitments have been prioritised.	AMBER
	The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	All staff covering labour ward are required to attend MDT Maternity MAST training. Current compliance at 76 % for all disciplines due to extreme staff shortages as a result of sickness	AMBER
	Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	Currently happens through handover and ward rounds.	GREEN
Essential Action 12 – Postnatal Care			

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.	All postnatal readmissions are reviewed by a consultant and obstetric team. Review current communication pathway for when women are admitted to a non-maternity ward.	AMBER
	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Reviewed as part of the twice daily medical ward round. Currently collating the evidence.	AMBER
	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	All postnatal readmissions receive a medical review as part of the twice daily medical ward rounds. On-call team would review and see postnatal admissions out of hours.	AMBER
	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Professional judgement has been used to ensure safe staffing on the antenatal / postnatal ward and the BirthRate Plus acuity tool is completed 8 hourly to ensure safe staffing.	GREEN
Essential Action 13 – Bereavement Care			
Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Bereavement care is offered 24/7 on Labour Ward. We have a dedicated Bereavement Midwife who provides training to all staff groups. There are pathways to support the care of families under bereavement services.	GREEN
	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Currently trainees have post-mortem training via the training programme. Consultants have received this training. Plan to be developed for non-training grade doctors.	AMBER
	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	All families are followed up and supported by the Bereavement Midwife and are offered Consultant follow-up debrief and consultation.	GREEN
	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	Benchmarking has taken place against the National Bereavement Care Pathway and Trust guidance follows these and national guidance.	GREEN
Essential Action 14 – Neonatal Care			

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Yorkshire and Humber ODN pathways for LMNS are followed in full.	GREEN
	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	Exception reports are completed on a case by case basis. This is triggered and picked up by the ODN and reports submitted and discussed at the clinical forum. This process is supported by the daily BADGER net entries. This then generates a report from the clinical forum and learning points are identified and areas of good practice. Reports are available on Future NHS Platform and the Yorkshire and Humberside ODN webpage. Off pathway papers info to be shared at CYPS governance, maternity and Neonatal and Maternity Safety Champions going foward.	AMBER
	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	NNAP data for reporting on this is included within Network NNAP standards for preterm babies and BIRP. Maternity services complete exception reports for these babies. The number for TRFT is <5 per year. TRFT follow the ODN LNU/SC pathway. Monthly report of off pathway babies are discussed at LW forum. (As above) off pathway babies to be discussed at CYPS governance.	GREEN

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	PAN Network Clinical Guidelines in place. Agenda item on all clinical forums for learning on serious incidents. Mortality review panels to share learning and good practice. Neonatal Executive Group bi monthly for collaborative ratification of guidance, EMBRACE and tertiary unit updates and activity reports. Adherence to National Guidance reviewed Advice from EMBRACE and tertiary units available as required to support day to day practice. Nursing staff seconded to tertiary centre for QIS training. As part of Medical trainee programme all Tier 4-8 medical staff rotate through training programme to tertiary centres Paediatric specific Tier 1-3 trainees also have access to tertiary placements Consultants have accessed in the past ODN clinical skills training – the ODN availability of these have decreased in last 18 months. Annual ODN conference and regular ODN learning events to support clinical skills.	GREEN
	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	TRFT submit data to ODN continuously through the BADGER net, and this data is then discussed at ODN Clinical EXEC which is attended by commissioners and unit representatives.	GREEN
	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	All consultants when off site need to be contacted via switchboard – immediate action is that all substantive consultants contact details are compiled and are available for staff so they can be contacted directly. Need to develop how to get immediate access to locum consultants as oppose to going through switchboard	AMBER

IEA Number and Action	Recommendation	TRFT Current Position	RAG Rating
	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	97.5% of nursing staff are NLS compliant. 50% medical consultants are NLS compliant. Rotating junior medical staff have NLS principles as part of their induction. Neonatal practice educator delivers neonatal resuscitation training to the midwifery team yearly and to the consultant team. NLS course does educate the use of 25cmH2O pressures in preterm infants	AMBER
	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	TRFT has a training plan for foundation course and QIS training. Current QIS registered nurses is 70.2% (BAPM guidance is 70%) Medical staffing does not currently meet the NNRC/BAPM guidance for tier 1 and 2 out of hours. The service has a business case currently awaiting approval.	AMBER
Essential Action 15 - Supporting Families			
Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Birth in Mind Service with a dedicated midwife, psychologist and psychotherapist. Care pathways support the referral and signposting to these services both during and after pregnancy.	GREEN
	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Referrals to the Birth in Mind Service do not require mental health diagnosis. Referrals are accepted from GPs, midwives, consultants and health visitors.	GREEN
	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	Clinicians in this service have the relevant specialist expertise and experience for maternity care.	GREEN

GREEN	Action Achieved	AMBER	Partial Compliance with Action	RED	Not Compliant with Action

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P87/22
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) both 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)	**HSMR –** The Rotherham NHS Foundation Trust's (TRFT) latest rolling 12-month HSMR value is 107.0. This is a decrease from the last value, which was 111.4. TRFT are now in the 'As Expected' band, for the first time since 2018. **SHMI –** TRFT's latest rolling 12-month SHMI value is 107.7. TRFT remain in the Band 2 'As Expected' band. This is a reduction from the last value, which was 109.4. **Learning From Deaths** The 360 full Learning from Deaths Governance re-audit report was presented to the Trust in March. An agreed Action Plan is in place and being worked on. Action point target dates range from April 2022 to March 2023, and are being tracked monthly at the Safe & Sound Mortality Group meetings. The Learning from Death Improvement project with NHS England & NHS Improvement (NHSE/I) is underway. The main aim is to improve the standard of Structured Judgement Reviews (SJRs) and the analysis/learning gained from them. The project outline is being presented to the S&S Mortality Group meeting in May, together with a presentation being arranged for Executive Directors.

	It is proposed that, moving forward, the Mortality & Learning from Deaths Report to the Board becomes a quarterly report, focussed on actions taken and progress made within the preceding quarter, and what actions are planned to be taken in the following quarter, supported by SPC charts where available. If approved, it is also proposed that the next report to the Board will go to the June Board, then quarterly thereafter.
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	This data is also presented to the Trust's Safe & Sound Mortality Group, Mortality Improvement Group and the Quality Committee.
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 hard to establish a Learning from Deaths process where both good and poor practice is identified. The purpose is to identify problems in care which might have contributed to the death, and to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon. Learning from Deaths is co-ordinated and run through the Trust's Safe & Sound Mortality Group, chaired by the Executive Medical Director, with oversight and assurance through the Trust's new Clinical Effectiveness Committee and Quality Committee. The Trust's Mortality Improvement Group (MIG) provides additional oversight for Learning from Deaths. MIG is chaired by the Chief Executive Officer, with the Medical Director as the Senior Responsible Officer. The Mortality Improvement Group outstanding actions are all completed or near to completion. The MIG group is likely to be stood down in 2022. The Trust aims to understand its Mortality Indicators and use them to assist the Learning from Deaths process, in order to indicate areas where TRFT may have problems in care and need to investigate.
Recommendations	It is recommended that the Board notes the mortality position and the significant actions being taken to make improvements. The Board is requested to approve the proposal to move to a quarterly Mortality & Learning from Deaths Report.
Appendices	1. Dr Foster Mortality Report

1.0 MORTALITY INDICATORS

1.1 Hospital Standardised Mortality Ratios (HSMR), produced by Dr Foster

Latest Month Available for The Rotherham NHS Foundation Trust (TRFT): November 2021

TRFT's latest rolling 12-month HSMR value is 107.0. TRFT are in the 'As Expected' band. This is a decrease from the last value which was 111.5, and has moved TRFT from the 'Higher than Expected' band.

1.2 Covid Effect

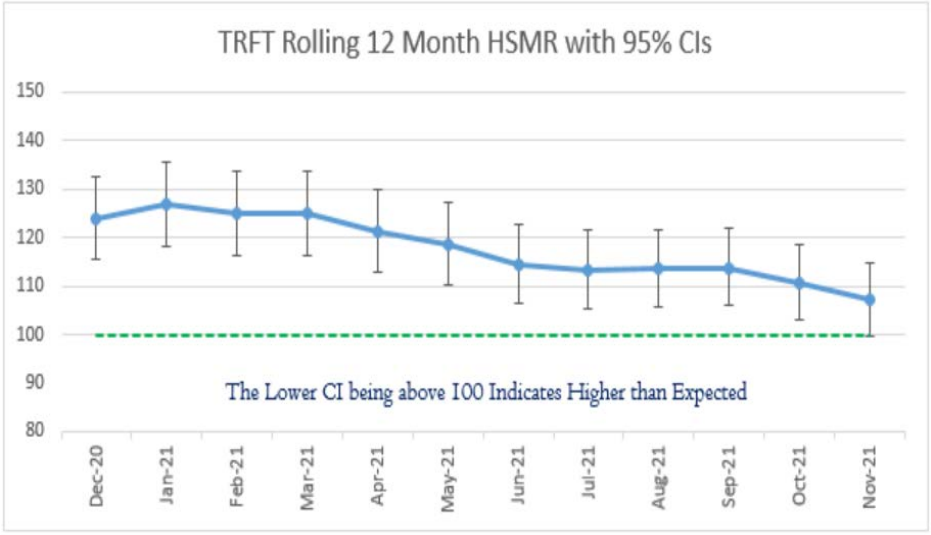
Covid patients are excluded from the HSMR only when they had a Covid diagnosis code in the 1st or 2nd Episode of their inpatient stay. This means that some Covid deaths feature in HSMR data.

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.

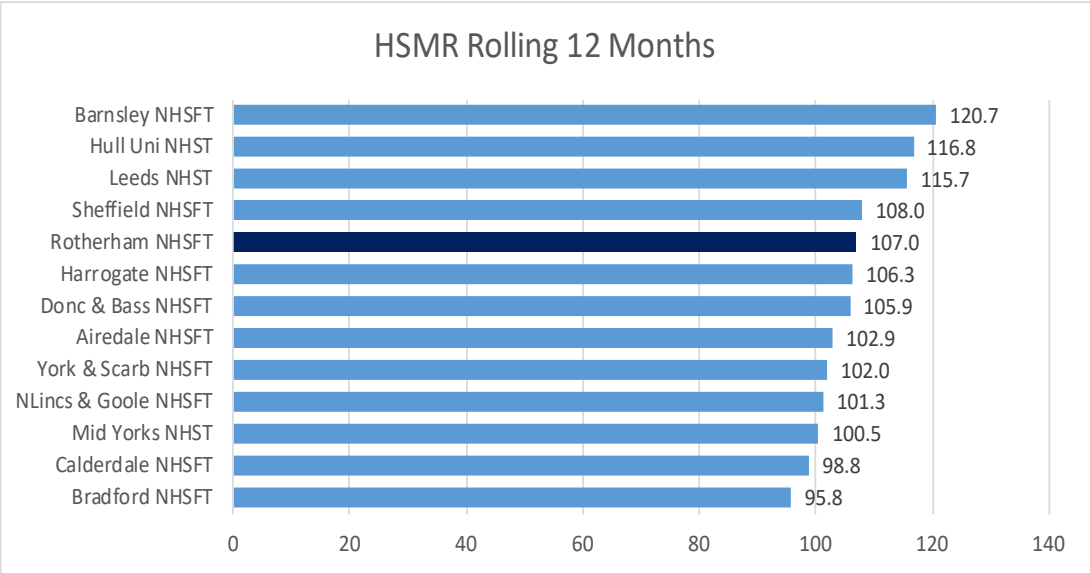
TRFT's latest HSMR with Covid patients fully excluded is 97.1.

1.3 HSMR Rolling 12-Month Trend

This chart shows that TRFT's rolling 12-month HSMR has followed a downward trend for the last few months.



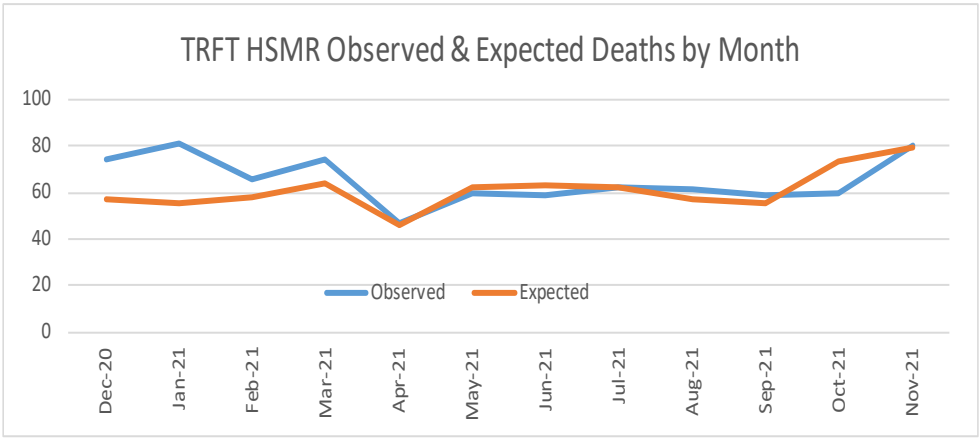
1.4 Yorkshire & Humber Regions General Trusts, HSMR Oct 2020 – Nov 2021



1.5 Future Direction of the HSMR

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 8 months, TRFT's HSMR has been very close to 100, and significantly below for October 2022.

The months of December 2020 and January 2021 (2nd Covid Peak) had high HSMRs. Local Crude Mortality Rates for months December 2021 and January 2022 suggest TRFT's rolling 12-month HSMR is likely to decrease for data releases in the 1st Quarter of 2022/23.



1.6 Summary Hospital-Level Mortality Indicator (SHMI), produced by NHS Digital

Latest Month Available for TRFT: September 2021

The main difference between the SHMI and the HSMR is that the SHMI includes deaths that occurred within 30 days of a Hospital Discharge. TRFT's latest rolling 12-month SHMI value is 107.7. TRFT are in the Band 2 'As Expected' band. This is a reduction from the last value, which was 109.4

2.0 RECORDING OF CORRECT DIAGNOSES AND PROCEDURES AND ITS CODING

Clinical coding is the process whereby information from the hospital case notes for each patient are expressed as codes. This includes the operation/treatment, diagnosis, complications and co-morbidities.

To ensure that the number of 'Expected Deaths' calculated in the HSMR and SHMI accurately reflects TRFT's inpatient case mix, the following clinical recording/coding factors are important:

- Recording of a definitive diagnosis in the 1st or 2nd Episode of care, where possible
- Capture of all relevant Co-Morbidities
- Capture of Palliative Care (HSMR Only)

2.1 SHMI Coding Indicators

NHS Digital's SHMI Coding/Data Quality indicate that TRFT is now coding a high number of Co-Morbidities per Non-Elective admission.

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.

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.

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.

TRFT Rank of 13	1st Highest	1st Highest	2nd Highest	8th Highest	4th 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**	**% of deaths with palliative care**
Rotherham NHSFT	18.3	4.8	7.4	1.5	35
Airedale NHSFT	16.5	0.0	4.9	1.1	22
Harrogate NHSFT	15.3	0.0	4.9	2.0	39
NLincs & Goole NHSFT	14.6	0.1	5.9	1.5	24
York & Scarb NHSFT	13.9	0.0	5.5	1.3	27
Barnsley NHSFT	13.0	0.2	7.5	1.5	24
Bradford NHSFT	12.4	0.5	4.5	1.1	31
Donc & Bass NHSFT	11.4	0.0	5.4	2.3	44
Calderdale NHSFT	10.0	*	6.1	1.8	33
Sheffield NHSFT	9.7	0.0	5.6	2.1	39
Mid Yorks NHST	9.6	0.7	6.4	1.6	35
Leeds NHST	7.7	*	6.6	1.8	29
Hull Uni NHST	5.3	0.0	6.3	2.5	33
England	14.3	0.8	5.9	1.9	39

3.0 CLINICAL CODING UPDATE (PROVIDED BY THE CLINICAL CODING MANAGER)

3.1 Learning From Deaths Related Work

Reducing Multi Short Duration Consultant Episodes (CEs) in AMU

A high number of short duration CEs is associated with a higher incidence of signs and symptoms codes assigned as the primary diagnosis in FCE 1 and 2, which is reflected in the Trust's overall position with signs and symptoms for HSMR and SHMI data.

The Clinical Coding Team is working with clinicians in AMU to gain a better understanding of the high prevalence of short duration CEs in the early part of the admission. A resolution to this issue must be clinically driven and subsequent actions must be based around the change being legitimate clinically.

There is a working group looking at resolutions. Local trusts have been contacted to determine if they have processes in place for this issue. Feedback has indicated that other trusts follow a process where the admitting Consultant remain as the responsible Consultant, unless there is a ward or Specialty change. Other Clinicians providing care or opinion at TRFT would record this as an 'Attending Clinician', rather than triggering a new CE.

A proposal is being tabled at the May 2022 S&S Mortality Group meeting.

Identifying Deaths Requiring an SJR

There are national criteria for deaths that require an SJR. In addition, trusts can determine their own groups. TRFT require SJRs for all Trauma and Asthma Deaths.

Clinical Coding have been assisting the Learning from Deaths and Mortality Manager and Health Informatics to identify these deaths via ICD10 Diagnosis Codes. These deaths are expected to be identified in the Mortality Insights Report by the end of May 2022.

3.2 Clinical Coding Performance

The Clinical Coding department has maintained the highest level of accuracy (Standards Exceeded) at external DSPT audit for the fifth consecutive year, with further improvements in primary diagnosis and primary procedure percentages.

RESULTS

TABLE 2 – OVERALL RESULTS – CODER AND NON-CODER ERRORS

Area audited	Number of FCEs	Primary Diagnosis accuracy	Secondary diagnosis Accuracy	Primary Procedure Accuracy	Secondary Procedure Accuracy
Overall	**200**	**98.50%**	**97.94%**	**100%**	**99.54%**

200 FCEs were audited – the accuracy percentages were as noted above.

These figures correspond to Standards Exceeded in the Data Security and Protection Toolkit requirements.

The auditor noted exceptional depth of coding in all areas and good attention to detail, with many audited cases having a high number of relevant comorbidities captured. There were some areas of potential improvement identified which are being worked on by the Team.

HSMR and SHMI data that includes coded data for discharges in March and April 2021 will be outliers for the Trust due to low coding staffing at that time leading to low data capture. This position will improve over time as this data drops off the yearly data snapshot.

4.0 LEARNING FROM DEATHS IMPROVEMENT PROGRAMMES

TRFT is involved in two Learning from Deaths Improvement Programmes, which complement each other. The review with 360 Assurance focuses on reporting and governance for the Learning from Deaths programme. The outcome is to maximise the transparency and competence of the governance process.

The 2nd review programme with NHS England/Improvement also focuses on the operational side. The key feature of this programme is to move TRFT to their SJR+ System. This system has an enhanced SJR form, and an analytical reporting tool. The anticipated outcome from this audit is better quality and complete SJRs from which learning can be extracted and disseminated.

4.1 UPDATE 360 RE AUDIT UPDATE

The 360 full Learning from Deaths governance re-audit report was presented to the Trust in March. An agreed action plan is in place and being worked on. Action point target dates range from April 2022 to March 2023, and are now being tracked monthly at the S&S Mortality Group Meetings.

4.2 Update NHS E/I Learning From Deaths Improvement Programme

The Learning from Death Improvement project with NHS E/I is underway. The main aim is to improve the standard of Structured Judgement Reviews and the analysis/learning gained from them. The project outline is being presented to the S&S Mortality Group Meeting in May, together with a presentation being arranged for Executive Directors.

5.0 LEARNING FROM DEATHS - PROGRESS

Actions/Progress in March April 2022	Why	Benefit
Process to identify deaths for Trauma and Asthma being set up	Request by the S&SMG Group, identified as potential areas of concerns	Provide intelligence to the Sepsis Group and S&SMG regarding the care of Sepsis patients
Process up & running for the ME to flag Sepsis Deaths (MCCD 1a) for SJRs - requested by Sepsis Group	Requested by Sepsis Group	Provide intelligence to the Sepsis Group and S&SMG regarding the care of these patients
S&S MG Agreed proposal for routine identification of elective, low frequency death specialties and patient on the Learning Difficulty Register - Process up & running	Previously reliant on the ME Service to identify SJRs., when many required SJRs can be identified from local data.	This will reduce the chance of SJRs being missed.
360 Action Plan Agreed, and early actions being worked on	Risks identified in the Governace process	Reduction of these identified risks
NHSI/E Arrangements for presentation to S&SMG and Execcutive Directors	TRFTs quality, consistency, completeness of its SJRs needs improving	Enhancing & improving the quality, and consistency and completeness of its SJRs. Be able to analyse and determine trends and themes from SJRs

5.1 SJR Report

SJRs All Adult Inpatient Deaths

Month of Discharge	No of Adult Inpatient Deaths	SJR Requested	SJRs Completed	SJRs Outstanding	Overall Care Score < 3	Avoidability Score < 4
Apr-21	69	18	not available	not available	2	0
May-21	71	21			0	0
Jun-21	66	13			1	1
Jul-21	72	19			0	0
Aug-21	91	23			0	0
Sep-21	89	21			0	0
Oct-21	83	33			1	0
Nov-21	109	21			1	0
Dec-21	96	18			0	0
Jan-22	100	30			0	0
Feb-22	80	14			0	0
Mar-22	81	7			0	0
FYTD Total	1007	238			5	1

Care Score	1 - Very Poor	2 - Poor	3 - Adequate	4 - Good	5 - Excellent

Avoidability Score	1 - Definitely avoidable	2 - Strong evidence	3 - Probably (more than 50:50)	4 - Possibly (less than 50:50)	5 - Slight evidence	6 - Definitely not avoidable

Timeliness of SJR Completions

Financial Quarter	SJR Requested	SJRs Completed	% Completed	Completed Within 60 Days of Death	% Completed Within 60 Days of Death
not available					

5.2 Learning From Deaths - Learning Disabilities and LeDer Reviews

The LeDer Programme is a Commissioner led review of deaths for patients with Learning Disabilities, regardless of the place of death. Provider Trusts are frequency asked to assist with a LeDer review when they have been involved in care provision for that patient. From 1 April 2022, this is also to include Autism.

In hospital, deaths for patients with Learning Disabilities are a group for which SJRs are recommended. From 1 April 2022, this is also to include Autism.

SJRs for Learning Disability deaths are identified and marked as priority for the Divisions to complete.

A new process has been established between the Matron in Learning Disabilities and Autism and the LFD & Mortality Manager. This process will identify where there is a completed SJR that could assist/enhance a LeDer review or where a LeDer request suggests an SJR would be beneficial for Trust learning, if the patient died in the community within 30 days of a TRFT discharge.

LeDer Requests and SJR for Adults with a Learning Disability

Month of Discharge	SJR Requests	SJRs Completed	SJRs Outstanding	Overall Care Score < 3	Avoidability Score < 4	LeDer Requests
Apr-21	0	not avail	not avail	0	0	0
May-21	0			0	0	0
Jun-21	2			0	0	2
Jul-21	1			0	0	1
Aug-21	4			0	0	1
Sep-21	0			0	0	0
Oct-21	0			0	0	1
Nov-21	2			0	0	3
Dec-21	3			0	0	2
Jan-22	6			0	0	6
Feb-22	2			0	0	2
Mar-22	1			0	0	1
FYTD Total	21			0	0	19

6.0 SJRS LEARNING IN THE TRUST AND DIVISIONS

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. This is impeding TRFT's ability to maintain an overview and identify themes.

Learning from these local reviews can't be aggregated and used in any thematic or trend analysis.

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.

TRFT's SJRs are being completed with very little free text judgement statements, which are crucial to enable learning from SJRs. This is in part due to the SJR form design which limits free text entry and due to a training issue. This should be solved once the Trust adopts the new SJR+ process.

7.0 CONCLUSION

A significant amount of work and effort continues to be focused on improving mortality and the Trust's Learning from Deaths programme.

Mortality and the Learning from Deaths will continue to remain one of the Trust's top Quality Improvement priorities next financial year.

Some required short term fixes have and are being put in place to deal with immediate issues such as Learning Difficulty Deaths not being reviewed. Changes to enhance TRFT's Learning from Deaths Programme will come from the Trust's implementation of the recommended actions from our 2 reviews programmes.

It is proposed that, moving forward, the Mortality & Learning from Deaths Report to the Board becomes a quarterly report, focussed on actions taken and progress made within the preceding quarter, and what actions are planned to be taken in the following quarter,

supported by SPC charts where available. If approved, it is also proposed that the next report to the Board will go to the June Board, then quarterly thereafter.

John Taylor
Learning From Deaths and Mortality Manager
April 2022

MORTALITY SUMMARY REPORT

Trust	THE ROTHERHAM NHS FOUNDATION TRUST
Report Date	Tuesday, 29 March 2022
Senior Consultant	Robert Douce
Area	Consultancy
Contact Details	Robert.douce@health.telstra.com
Data Period	Dec 2020 - Nov 2021

TABLE OF CONTENTS

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 Dec 2020 - Nov 2021.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including September 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 November 2020 to October 2021 was obtained from NHS Digital's Indicator Portal. SHMI is updated and rebased monthly.

REPORT HEADLINES

Data Period: Dec 2020 - Nov 2021

Metric	Result
HSMR	• HSMR = 107.0 and banded as statistically 'within expected'. o Excluding spells with secondary COVID-19 codes the Trusts HSMR for the period was 97.1 and banded as statistically 'within expected'. ▪ For the last available 12 months patients with secondary Covid-19 within the HSMR basket represented 2.6% of admissions (586 super-spells, 130 deaths) at the Trust. • The latest month HSMR value (Nov-21) = 101.1 and banded as statistically 'within expected'. • Crude mortality (all diagnosis) was 3.5% 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 2 HSMR diagnosis groups with a relative risk banded as statistically 'higher than expected': o Other upper respiratory disease * New Alert o Syncope
HSMR position vs. peers	• The Trust is 1 of 10 within the regional peer group with an HSMR banded as statistically 'within expected' over the 12 month period. If the regional HSMR values are ranked (lowest to highest) the Trusts HMR is 14th of 21 acute, non-specialist Trusts.
SMR outlying groups	• For the 12 month period (Dec-20 to Nov-21) there were 4 diagnosis groups with a relative risk banded as statistically 'higher than expected': o Other upper respiratory disease * New Alert o Syncope o Poisoning by other medications and drugs o Cancer of other GI organs, peritoneum
All Diagnosis SMR	• SMR = 104.5 and banded as statistically 'within expected'. o Excluding spells with both primary and secondary COVID-19 codes the Trusts SMR for the period was 94.9 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 (2,273 super-spells, 396 deaths) at the Trust.

	• The latest month (Nov-21) SMR = 97.2 banded as statistically 'within expected'. • Crude mortality (all diagnosis) was 1.8% over the 12 month period compared to 1.7% regional average (acute, non-specialist) and 1.7% national average. • The Trust is 1 of 10 within the regional peer group with an SMR banded as statistically 'within expected' over the 12 month period. • If the 12 month (Dec-20 to Nov-21) SMR values for the regions acute, non-specialist Trusts are ranked (lowest to highest) The Rotherham NHD FT ranks 14th of 21 Trusts.
CUSUM breaches	• Over the 12 month period there were 8 CUSUM alerts (using 99% detection threshold criteria) in the following diagnosis groups: o Acute bronchitis o Other upper respiratory disease o Biliary tract disease * New alert in Nov-21 o Liver disease, alcohol-related o Nervous system congenital anomalies o Other perinatal conditions o Other psychoses o Anxiety, somatoform, dissociative, and personality disorders
SHMI position	Time period: November 2020 to October 2021 • SHMI for The Rotherham NHS FT = 107.71 banded as statistically 'within expected' using the 95% control limits (adjusted for over dispersion) published by NHS digital. o During the 12 month period (Oct-20 to Sep-21) there were 745 in-hospital deaths and 425 out of hospital deaths (within 28 days of discharge) recorded within the summary metric. o The Trust is one of 10 within the NHS England (Yorkshire and Humber) region with a SHMI banded in the statistically 'within expected' range. • Of the SHMI diagnosis groups banded by NHS digital (using 95% control limits adjusted for over dispersion) there was a single outlying group: o Fluid and electrolyte disorders (30 observed deaths, 15 predicted by the modelling).

HOSPITAL STANDARDISED MORTALITY RATIO OVERVIEW

Key points

- HSMR = 107.0 and banded as statistically 'within expected'.
  - Excluding spells with secondary COVID-19 codes the Trusts HSMR for the period was 97.1 and banded as statistically 'within expected'.
    - For the last available 12 months patients with secondary Covid-19 within the HSMR basket represented 2.6% of admissions (586 super-spells, 130 deaths) at the Trust.

Diagnoses - HSMR | Mortality (in-hospital) | Dec-20 to Nov-21 | COVID-19 Y/N

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	22,561	100.0%	22,603	783	3.5%	731.5	3.2%	51.5	107.0	99.7	114.8
No	21,979	97.4%	22,017	653	3.0%	672.4	3.1%	-19.4	97.1	89.8	104.9
Yes	582	2.6%	586	130	22.3%	59.1	10.2%	70.9	220.0	183.8	261.3

- The latest month HSMR value (Nov-21) = 101.1 and banded as statistically 'within expected'.
- Crude mortality (all diagnosis) was 3.5% 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 2 HSMR diagnosis groups with a relative risk banded as statistically 'higher than expected':
  - Other upper respiratory disease * New Alert
  - Syncope

Diagnoses - HSMR | Mortality (in-hospital) | Dec-20 to Nov-21 | Diagnosis group

Diagnosis group: Other upper respiratory disease, Syncope

Analyse by: Diagnosis group Measure: Relative risk Show: All

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	743	100.0%	745	12	1.6%	3.6	0.5%	8.4	335.1	173.0	585.4
Other upper respiratory disease	460	61.9%	462	6	1.3%	1.8	0.4%	4.2	336.2	122.8	731.8
Syncope	283	38.1%	283	6	2.1%	1.8	0.6%	4.2	334.1	122.0	727.1

- The Trust is 1 of 10 within the regional peer group with an HSMR banded as statistically 'within expected' over the 12 month period. If the regional HSMR values are ranked (lowest to highest) the Trusts HMR is 14th of 21 acute, non-specialist Trusts.

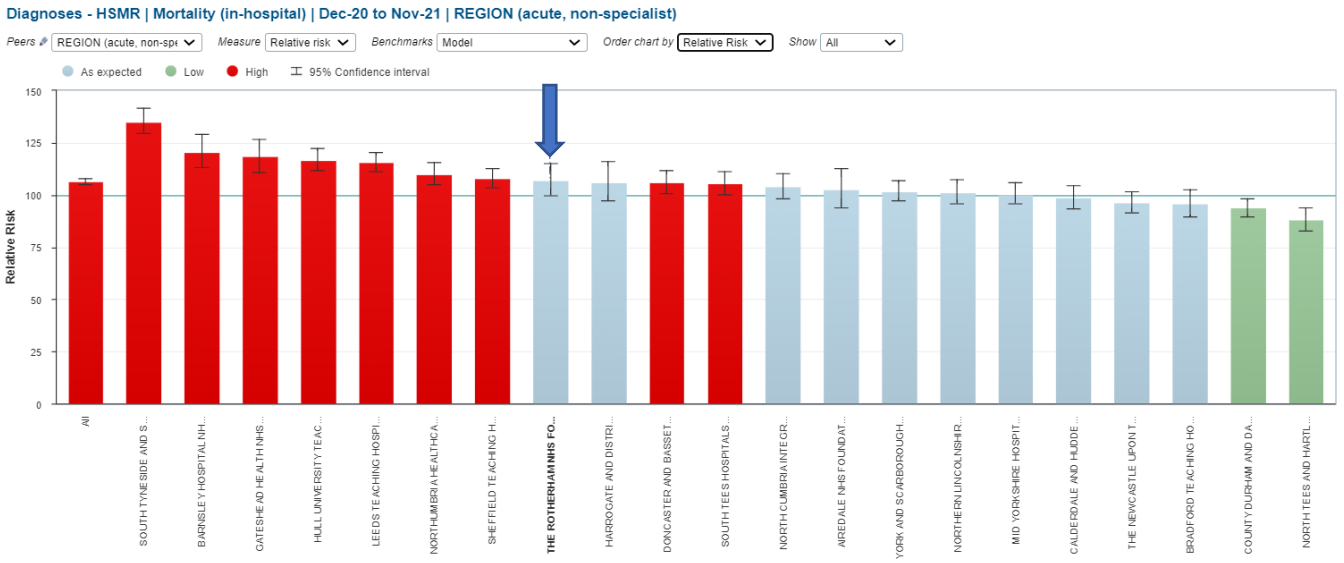


Figure 1 – HSMR Monthly Trend

Diagnoses - HSMR | Mortality (in-hospital) | Dec-20 to Nov-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	22,561	100.0%	22,603	783	3.5%	731.5	3.2%	51.5	107.0	99.7	114.8
Dec-20	1,768	7.8%	1,771	74	4.2%	56.8	3.2%	17.2	130.3	102.3	163.6
Jan-21	1,691	7.5%	1,694	81	4.8%	55.1	3.3%	25.9	147.0	116.7	182.7
Feb-21	1,733	7.7%	1,737	66	3.8%	58.0	3.3%	8.0	113.7	87.9	144.7
Mar-21	1,825	8.1%	1,827	74	4.1%	63.7	3.5%	10.3	116.1	91.2	145.8
Apr-21	1,527	6.8%	1,529	47	3.1%	45.6	3.0%	1.4	103.1	75.8	137.2
May-21	1,908	8.5%	1,910	60	3.1%	62.3	3.3%	-2.3	96.3	73.5	124.0
Jun-21	2,119	9.4%	2,121	59	2.8%	63.2	3.0%	-4.2	93.4	71.1	120.5
Jul-21	2,048	9.1%	2,051	62	3.0%	62.2	3.0%	-0.2	99.7	76.4	127.8
Aug-21	1,893	8.4%	1,897	61	3.2%	57.0	3.0%	4.0	107.0	81.9	137.5
Sep-21	2,022	9.0%	2,029	59	2.9%	55.6	2.7%	3.4	106.2	80.8	136.9
Oct-21	2,030	9.0%	2,038	60	3.0%	72.9	3.6%	-12.9	82.3	62.8	105.9
Nov-21	1,997	8.9%	1,999	80	4.0%	79.1	4.0%	0.9	101.1	80.2	125.9

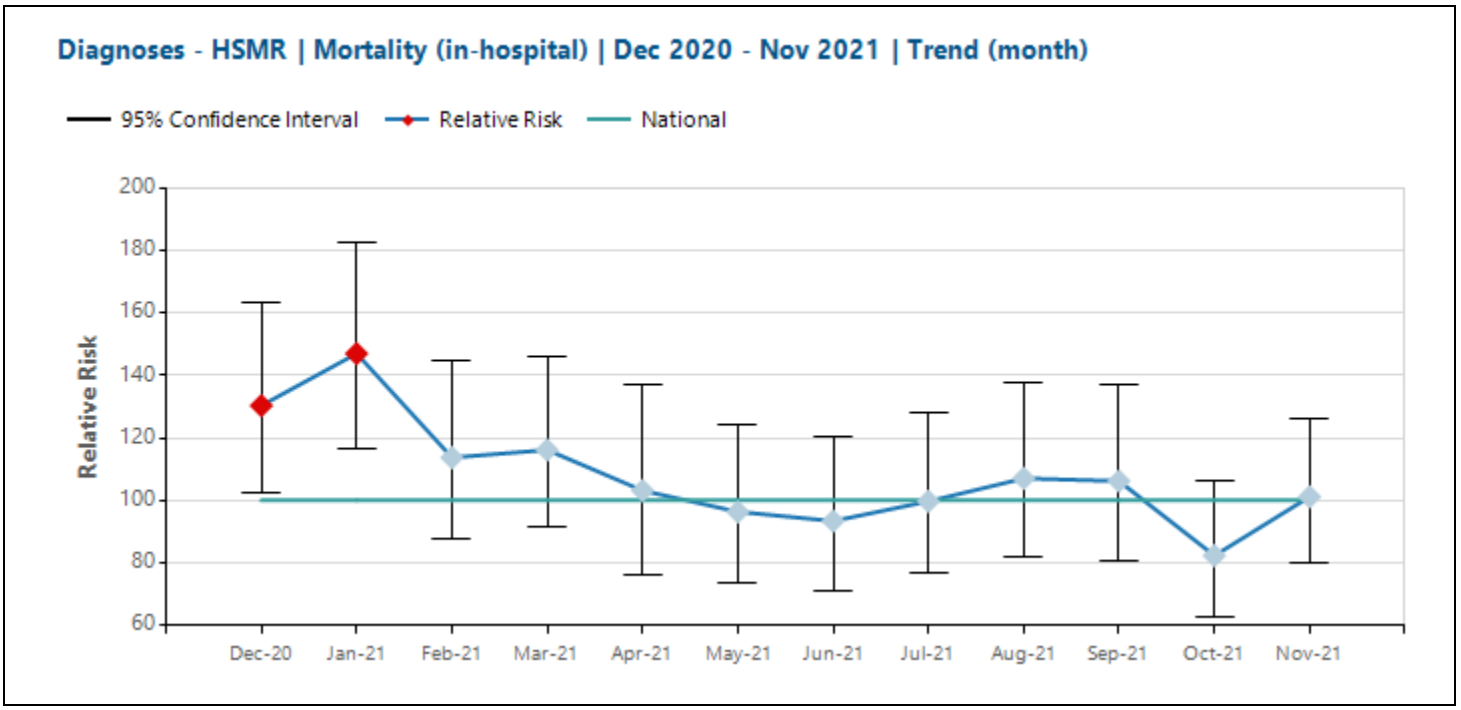
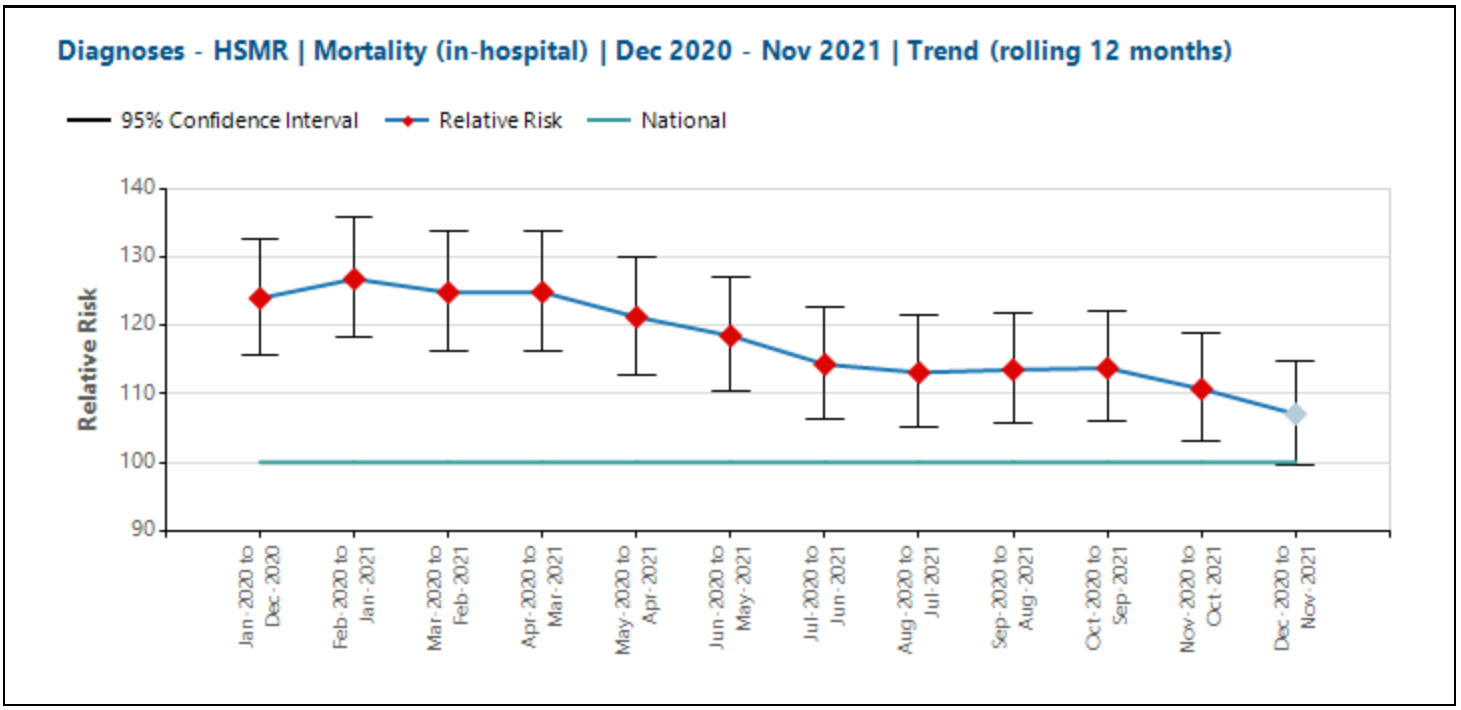
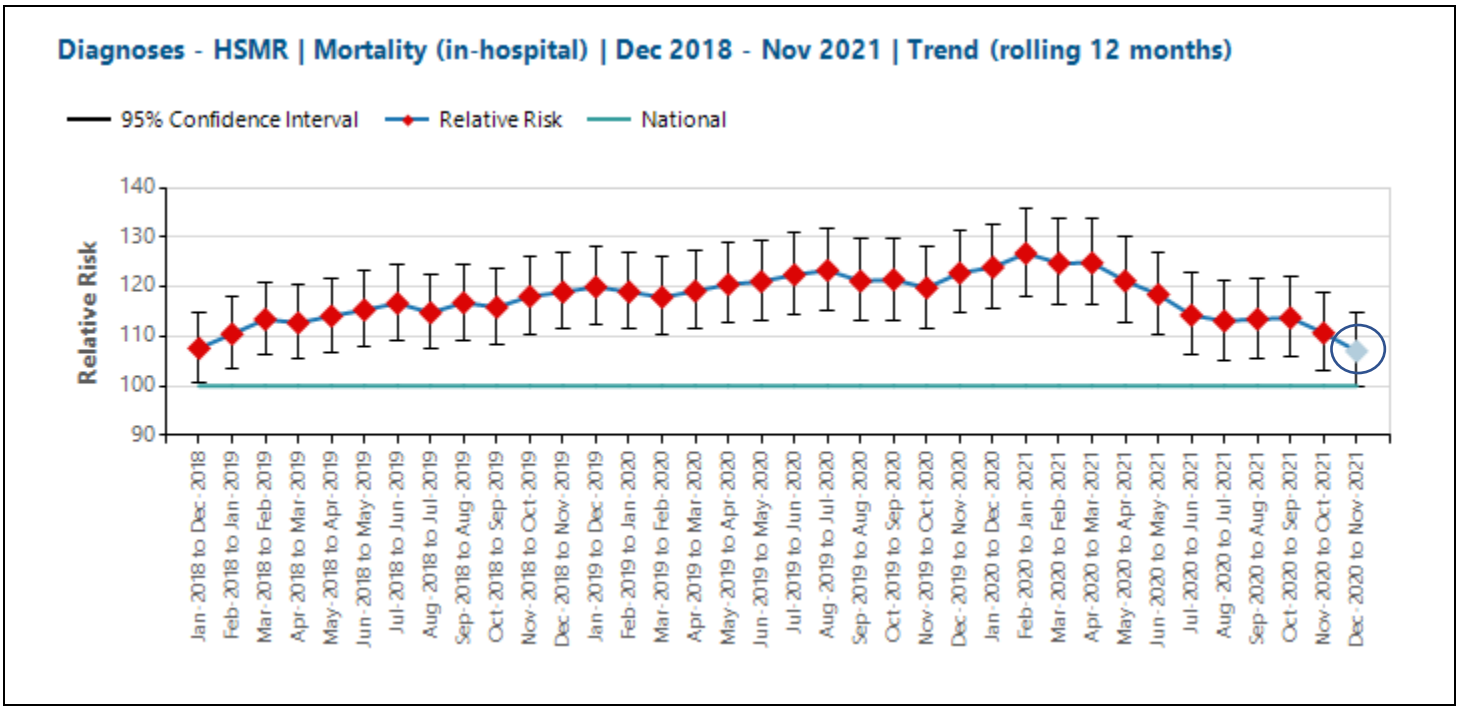
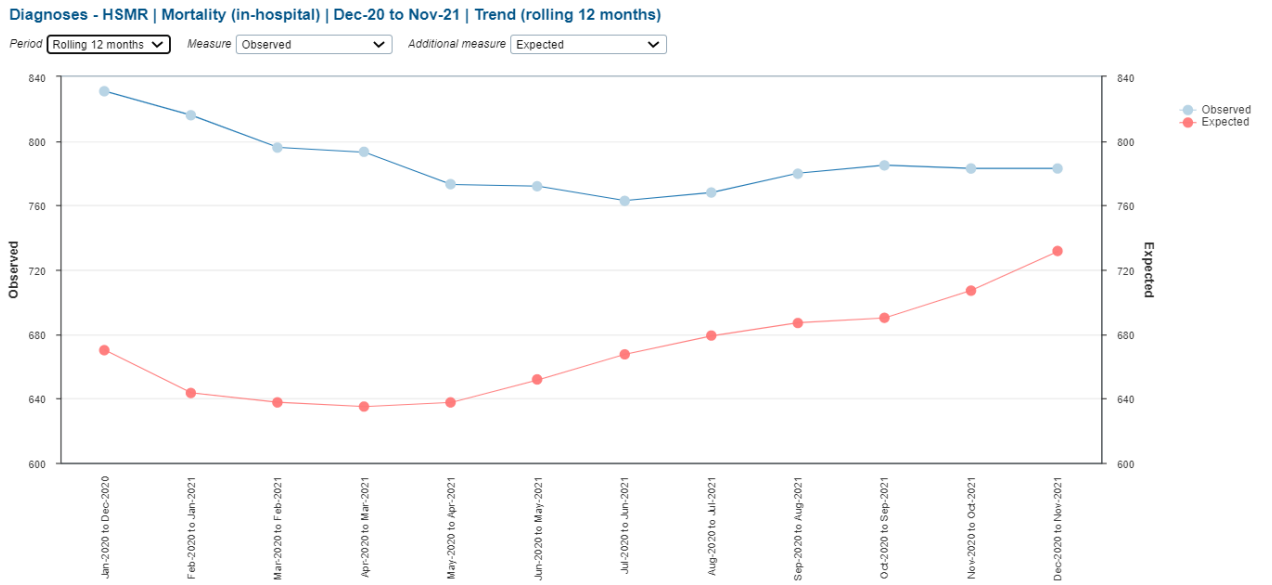


Figure 2 – HSMR 12 Month Rolling Trend





HSMR: Observed vs Expected (rolling 12 month trend)



HSMR: Crude mortality rate (%) vs Expected (%) rolling 12 month trend

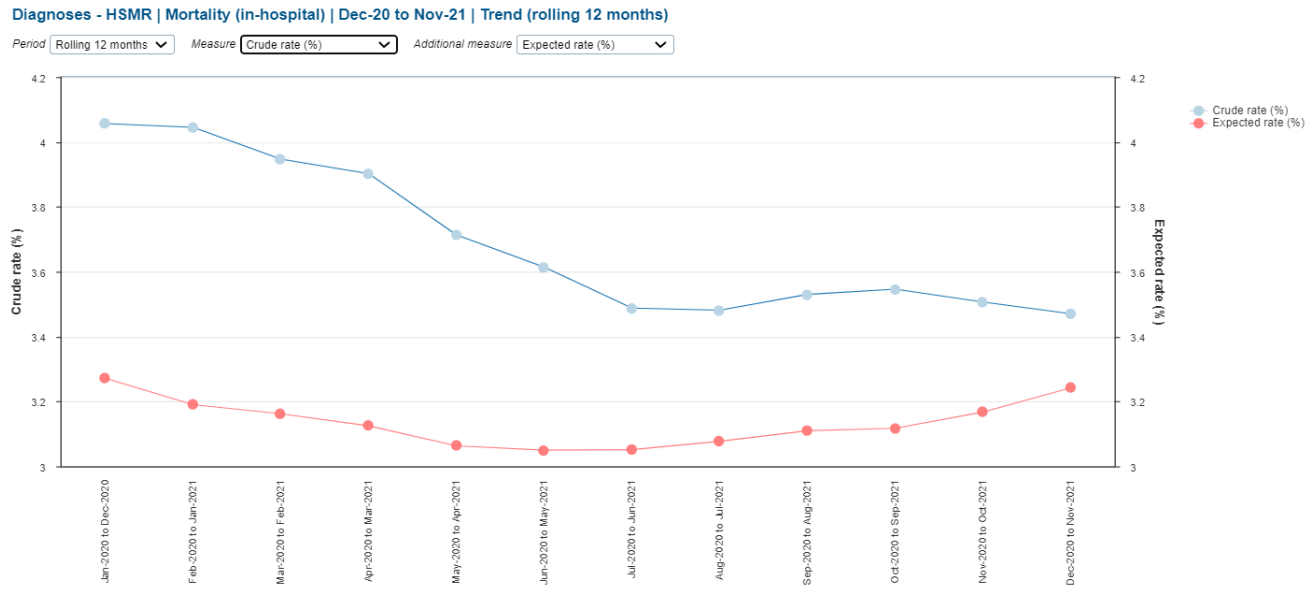
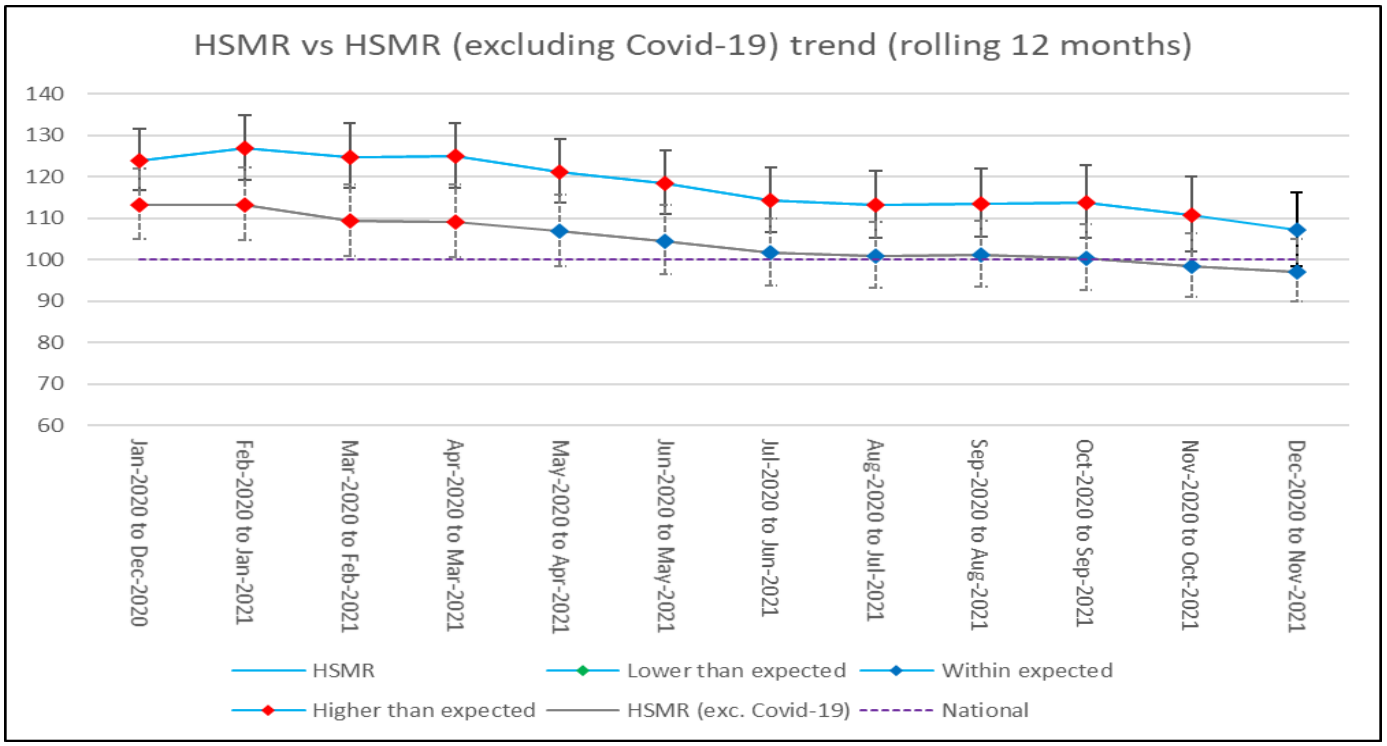


Figure 2.1 – HSMR vs HSMR (Exc. Covid-19) trend (rolling 12 months)

- 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.
    - Excluding spells with secondary COVID-19 codes the Trusts HSMR for the period was 97.1 and banded as statistically 'within expected'.
        - For the last available 12 months patients with secondary Covid-19 within the HSMR basket represented 2.6% of admissions (586 super-spells, 130 deaths) at the 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.



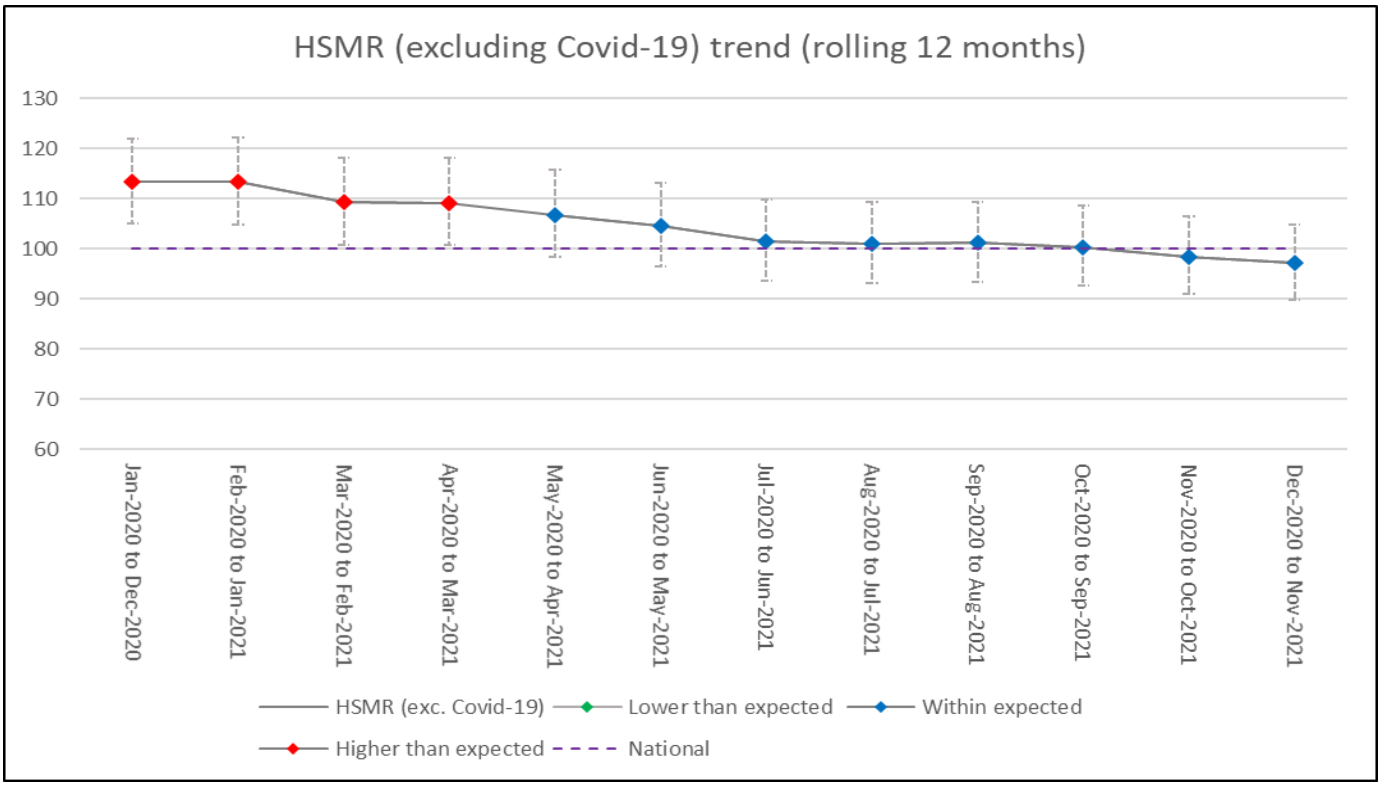
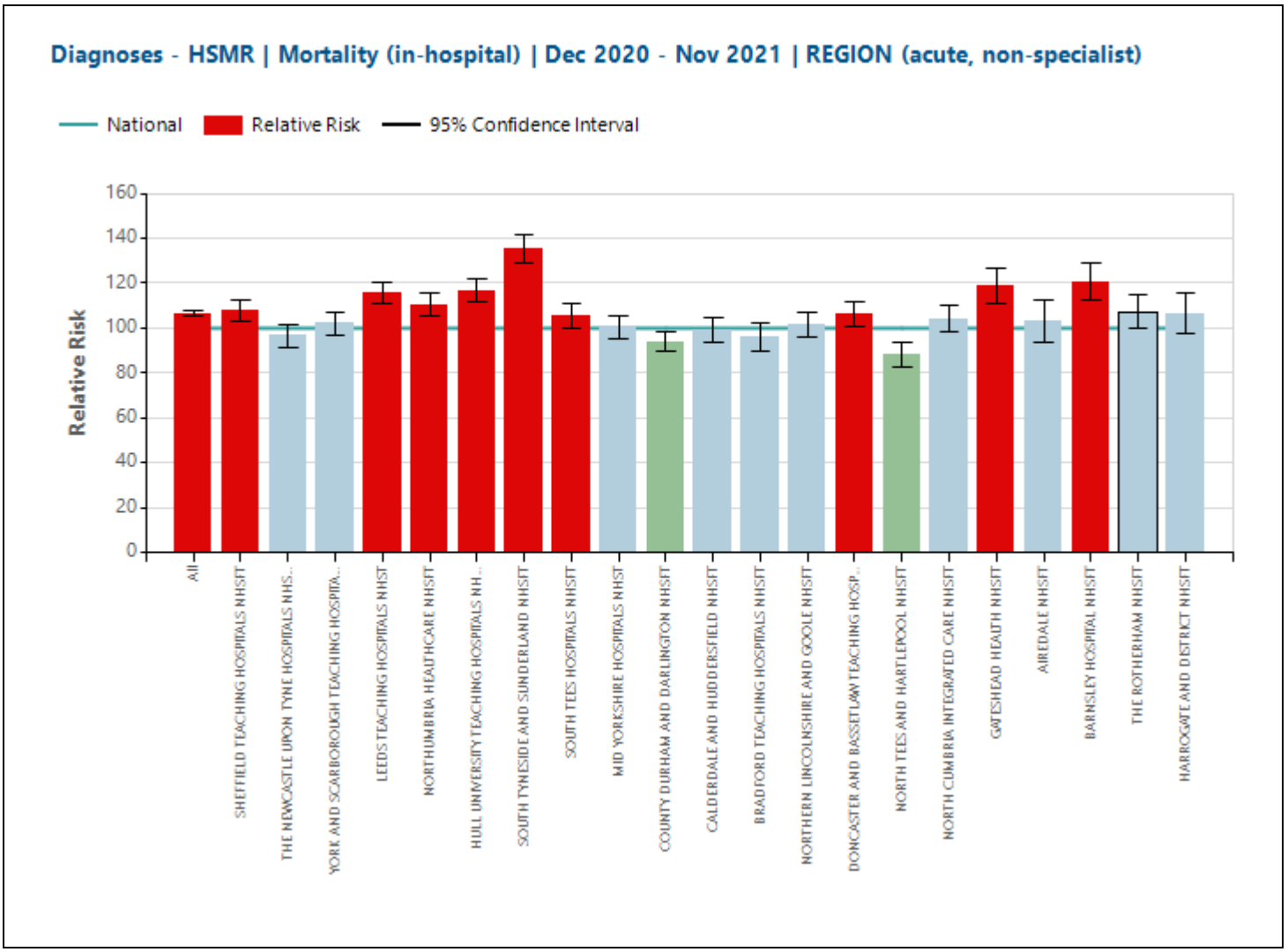


Figure 3 – HSMR 12 Month Peer Comparison



REGION (acute, non-specialist)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		861,015	100.0 %	871,760	28,270	3.3 %	26,575.8	3.1 %	1,694.2	106.4	105.1	107.6
SHEFFIELD TEACHING HOSPITALS NHSFT	RHQ	83,090	9.7 %	84,355	1,950	2.3 %	1,806.1	2.2 %	143.9	108.0	103.2	112.9
THE NEWCASTLE UPON TYNE HOSPITALS NHSFT	RTD	68,635	8.0 %	70,775	1,385	2.0 %	1,437.0	2.1 %	-52.0	96.4	91.4	101.6
YORK AND SCARBOROUGH TEACHING HOSPITALS NHSFT	RCB	55,245	6.4 %	55,820	1,660	3.0 %	1,628.0	2.9 %	32.0	102.0	97.1	107.0
LEEDS TEACHING HOSPITALS NHST	RR8	52,775	6.1 %	54,095	2,315	4.4 %	2,002.2	3.8 %	312.8	115.6	111.0	120.4
NORTHUMBRIA HEALTHCARE NHSFT	RTF	52,670	6.1 %	53,055	1,735	3.3 %	1,575.0	3.0 %	160.0	110.2	105.0	115.5
HULL UNIVERSITY TEACHING HOSPITALS NHST	RWA	50,650	5.9 %	51,345	1,860	3.7 %	1,593.1	3.1 %	266.9	116.8	111.5	122.2
SOUTH TYNESIDE AND SUNDERLAND NHSFT	R0B	50,445	5.9 %	50,780	2,005	4.0 %	1,482.1	2.9 %	522.9	135.3	129.4	141.3
SOUTH TEES HOSPITALS NHSFT	RTR	46,210	5.4 %	47,430	1,465	3.2 %	1,389.1	3.0 %	75.9	105.5	100.1	111.0
MID YORKSHIRE HOSPITALS NHST	RXF	44,100	5.1 %	44,525	1,515	3.4 %	1,507.2	3.4 %	7.8	100.5	95.5	105.7
COUNTY DURHAM AND DARLINGTON NHSFT	RXP	41,265	4.8 %	41,415	1,810	4.4 %	1,927.1	4.7 %	-117.1	93.9	89.6	98.4
CALDERDALE AND HUDDERSFIELD NHSFT	RWY	40,800	4.7 %	41,120	1,275	3.1 %	1,290.0	3.2 %	-15.0	98.8	93.5	104.4
BRADFORD TEACHING HOSPITALS NHSFT	RAE	35,095	4.1 %	35,490	880	2.5 %	918.7	2.6 %	-38.7	95.8	89.6	102.3
NORTHERN LINCOLNSHIRE AND GOOLE NHSFT	RJL	33,995	3.9 %	34,105	1,230	3.6 %	1,214.7	3.6 %	15.3	101.3	95.7	107.1
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHSFT	RP5	32,650	3.8 %	32,865	1,470	4.5 %	1,388.4	4.2 %	81.6	105.9	100.5	111.4
NORTH TEES AND HARTLEPOOL NHSFT	RVW	31,965	3.7 %	32,020	995	3.1 %	1,127.5	3.5 %	-132.5	88.2	82.8	93.9
NORTH CUMBRIA INTEGRATED CARE NHSFT	RNN	25,660	3.0 %	25,725	1,175	4.6 %	1,128.2	4.4 %	46.8	104.1	98.3	110.3

GATESHEAD HEALTH NHSFT	RR7	25,105	2.9 %	25,335	870	3.5 %	734.2	2.9 %	135.8	**118.5**	110.8	126.6
AIREDALE NHSFT	RCF	24,200	2.8 %	24,460	485	2.0 %	471.3	2.0 %	13.7	102.9	94.0	112.5
BARNSLEY HOSPITAL NHSFT	RFF	22,890	2.7 %	23,185	890	3.9 %	737.5	3.2 %	152.5	**120.7**	112.9	128.9
THE ROTHERHAM NHSFT	RFR	22,561	2.6 %	22,603	783	3.5 %	731.5	3.2 %	51.5	107.0	99.7	114.8
HARROGATE AND DISTRICT NHSFT	RCD	21,005	2.4 %	21,255	510	2.4 %	480.2	2.3 %	29.8	106.2	97.2	115.8

STANDARDISED MORTALITY RATIO OVERVIEW

Key points

- SMR = 104.5 and banded as statistically 'within expected'.
  - Excluding spells with both primary and secondary COVID-19 codes the Trusts SMR for the period was 94.9 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 (2,273 super-spells, 396 deaths) at the Trust.
- The latest month (Nov-21) SMR = 97.2 banded as statistically 'within expected'.
- Crude mortality (all diagnosis) was 1.8% over the 12 month period compared to 1.7% regional average (acute, non-specialist) and 1.7% national average.
- For the 12 month period (Dec-20 to Nov-21) there were 4 diagnosis groups with a relative risk banded as statistically 'higher than expected':
  - Other upper respiratory disease * New Alert
  - Syncope
  - Poisoning by other medications and drugs
  - Cancer of other GI organs, peritoneum
- The Trust is 1 of 10 within the regional peer group with an SMR banded as statistically 'within expected' over the 12 month period.
- If the 12 month (Dec-20 to Nov-21) SMR values for the regions acute, non-specialist Trusts are ranked (lowest to highest) The Rotherham NHD FT ranks 14th of 21 Trusts.

Figure 4 – SMR Monthly Trend

Diagnoses | Mortality (in-hospital) | Dec-20 to Nov-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	65,233	100.0%	65,380	1,203	1.8%	1151.6	1.8%	51.4	104.5	98.7	110.5
Dec-20	4,869	7.5%	4,876	144	3.0%	116.8	2.4%	27.2	123.2	103.9	145.1
Jan-21	4,692	7.2%	4,708	161	3.4%	121.5	2.6%	39.5	132.5	112.8	154.7
Feb-21	4,903	7.5%	4,917	109	2.2%	104.7	2.1%	4.3	104.1	85.5	125.6
Mar-21	5,571	8.5%	5,585	100	1.8%	101.0	1.8%	-1.0	99.0	80.5	120.4
Apr-21	5,298	8.1%	5,312	72	1.4%	71.5	1.3%	0.5	100.7	78.8	126.9
May-21	5,466	8.4%	5,475	75	1.4%	76.4	1.4%	-1.4	98.2	77.2	123.1
Jun-21	5,880	9.0%	5,889	72	1.2%	76.9	1.3%	-4.9	93.7	73.3	117.9
Jul-21	5,730	8.8%	5,740	74	1.3%	78.9	1.4%	-4.9	93.8	73.6	117.7
Aug-21	5,558	8.5%	5,568	95	1.7%	88.5	1.6%	6.5	107.3	86.8	131.2
Sep-21	5,962	9.1%	5,975	98	1.6%	89.2	1.5%	8.8	109.9	89.2	133.9
Oct-21	5,706	8.7%	5,727	88	1.5%	107.9	1.9%	-19.9	81.6	65.4	100.5
Nov-21	5,598	8.6%	5,608	115	2.1%	118.3	2.1%	-3.3	97.2	80.3	116.7

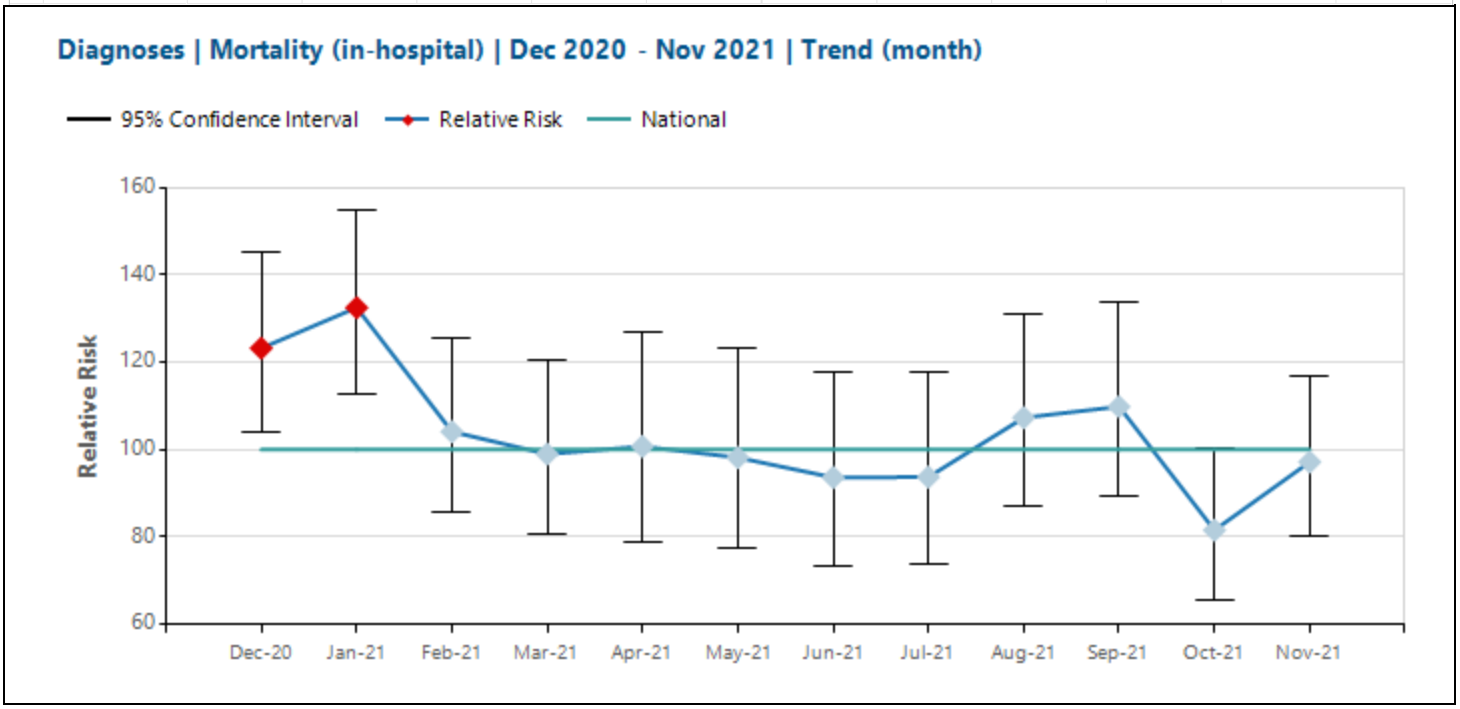
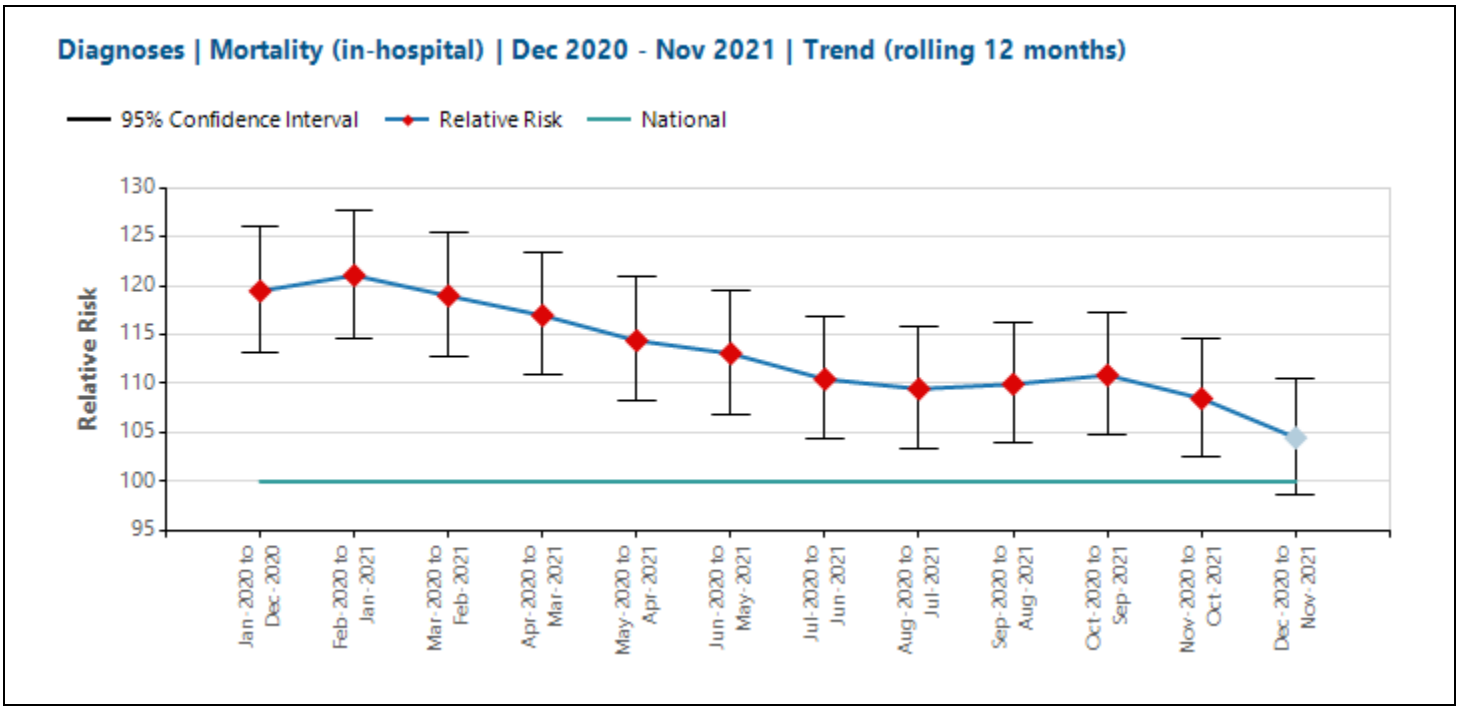


Figure 5 – SMR All Diagnoses Rolling Trend



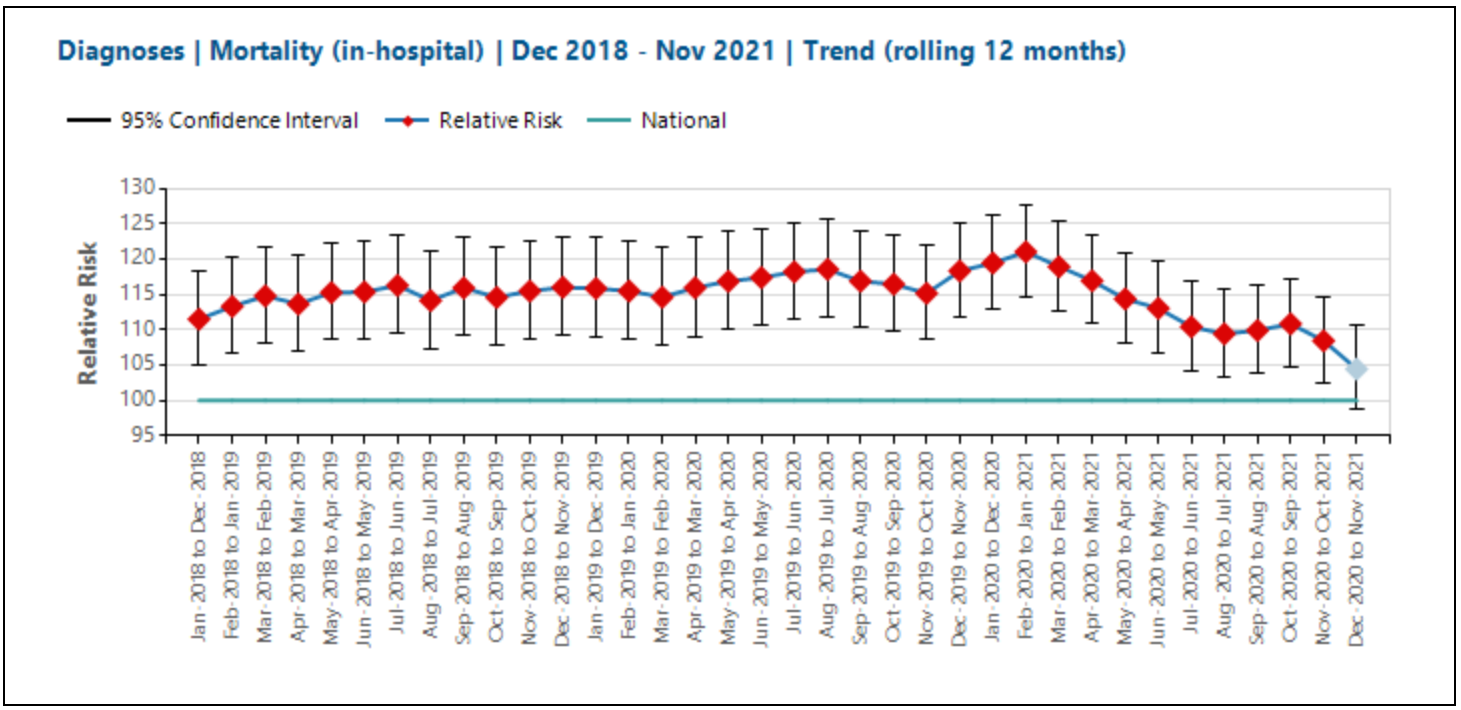
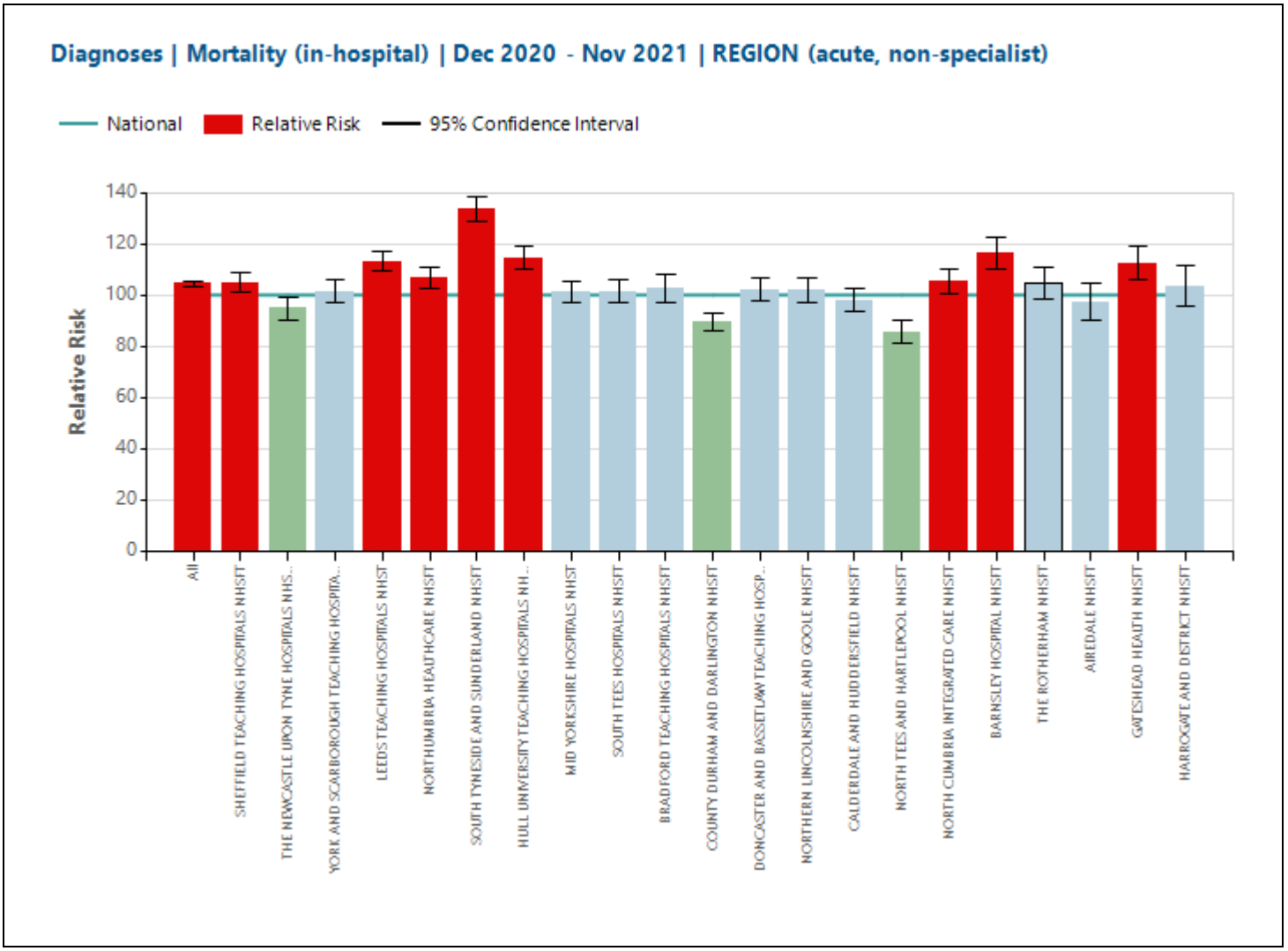


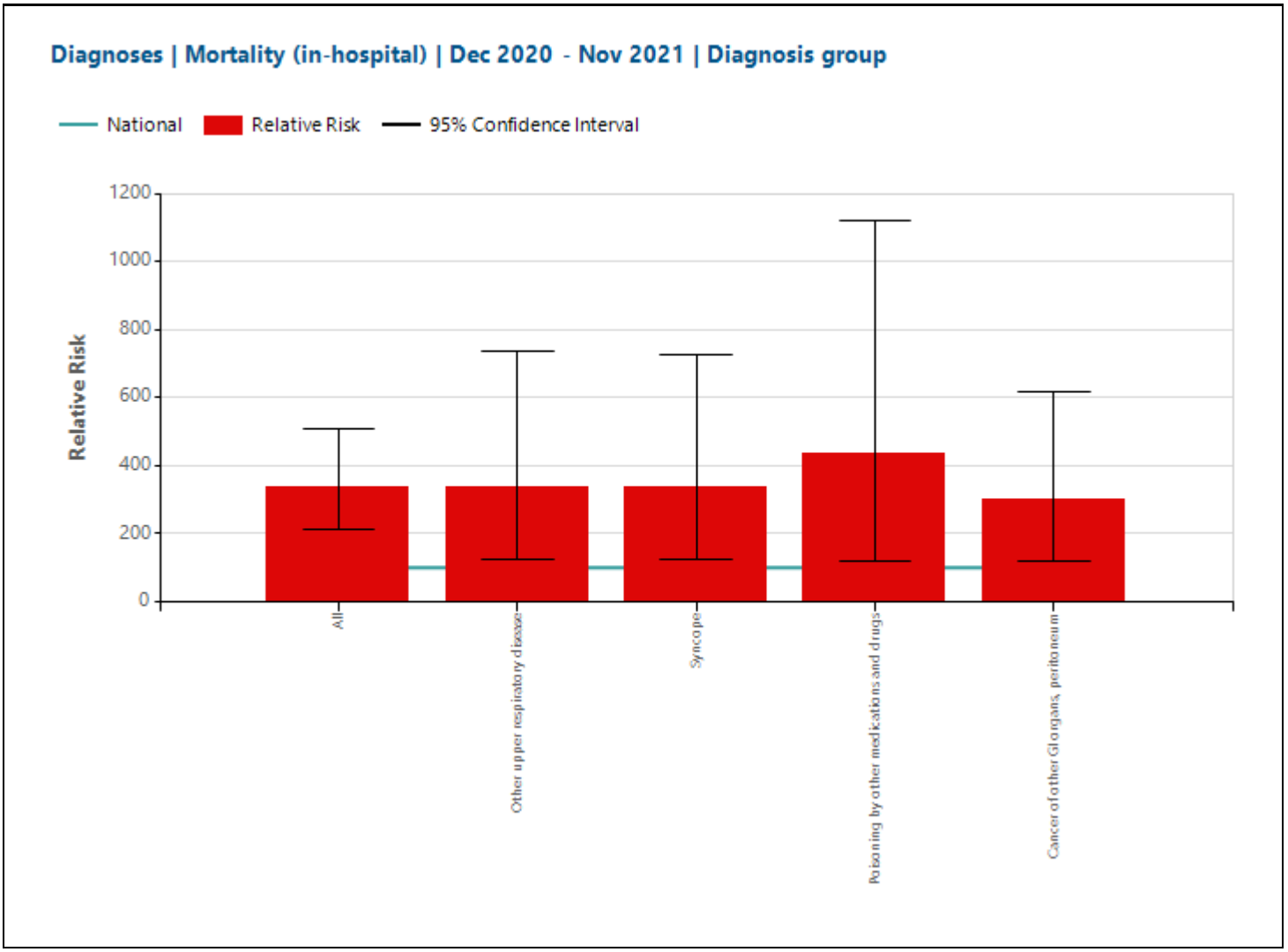
Figure 6 – SMR 12 Month Peer Comparison



REGION (acute, non-specialist)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		2,383,250	100.0 %	2,406,610	39,690	1.7 %	38,007.4	1.6 %	1,682.6	104.4	103.4	105.5
SHEFFIELD TEACHING HOSPITALS NHSFT	RHQ	218,050	9.1 %	220,480	2,750	1.3 %	2,622.1	1.2 %	127.9	104.9	101.0	108.9
THE NEWCASTLE UPON TYNE HOSPITALS NHSFT	RTD	203,070	8.5 %	207,825	1,915	0.9 %	2,021.9	1.0 %	-106.9	94.7	90.5	99.0
YORK AND SCARBOROUGH TEACHING HOSPITALS NHSFT	RCB	153,000	6.4 %	154,335	2,245	1.5 %	2,213.4	1.4 %	31.6	101.4	97.3	105.7
LEEDS TEACHING HOSPITALS NHST	RR8	149,950	6.3 %	152,845	3,200	2.1 %	2,828.1	1.9 %	371.9	113.2	109.3	117.1
NORTHUMBRIA HEALTHCARE NHSFT	RTF	139,700	5.9 %	140,520	2,410	1.7 %	2,257.9	1.6 %	152.1	106.7	102.5	111.1
SOUTH TYNESIDE AND SUNDERLAND NHSFT	R0B	138,980	5.8 %	139,865	2,950	2.1 %	2,208.6	1.6 %	741.4	133.6	128.8	138.5
HULL UNIVERSITY TEACHING HOSPITALS NHST	RWA	133,145	5.6 %	134,720	2,540	1.9 %	2,222.7	1.7 %	317.3	114.3	109.9	118.8
MID YORKSHIRE HOSPITALS NHST	RXF	129,790	5.4 %	131,095	2,250	1.7 %	2,224.1	1.7 %	25.9	101.2	97.0	105.4
SOUTH TEES HOSPITALS NHSFT	RTR	129,435	5.4 %	131,535	1,975	1.5 %	1,952.9	1.5 %	22.1	101.1	96.7	105.7
BRADFORD TEACHING HOSPITALS NHSFT	RAE	111,940	4.7 %	113,155	1,420	1.3 %	1,383.9	1.2 %	36.1	102.6	97.3	108.1
COUNTY DURHAM AND DARLINGTON NHSFT	RXP	111,375	4.7 %	111,825	2,470	2.2 %	2,759.3	2.5 %	-289.3	89.5	86.0	93.1
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHSFT	RP5	105,840	4.4 %	106,260	1,980	1.9 %	1,938.2	1.8 %	41.8	102.2	97.7	106.8
NORTHERN LINCOLNSHIRE AND GOOLE NHSFT	RJL	105,790	4.4 %	106,065	1,665	1.6 %	1,638.2	1.5 %	26.8	101.6	96.8	106.6
CALDERDALE AND HUDDERSFIELD NHSFT	RWY	101,775	4.3 %	102,355	1,780	1.7 %	1,818.9	1.8 %	-38.9	97.9	93.4	102.5
NORTH TEES AND HARTLEPOOL NHSFT	RVW	81,055	3.4 %	81,240	1,360	1.7 %	1,589.9	2.0 %	-229.9	85.5	81.1	90.2
NORTH CUMBRIA INTEGRATED CARE NHSFT	RNN	70,840	3.0 %	71,020	1,710	2.4 %	1,625.3	2.3 %	84.7	105.2	100.3	110.3

BARNSLEY HOSPITAL NHSFT	RFF	65,895	2.8 %	66,480	1,345	2.0 %	1,158.7	1.8 %	186.3	**116.1**	109.9	122.5
THE ROTHERHAM NHSFT	RFR	65,233	2.7 %	65,380	1,203	1.8 %	1,151.6	1.8 %	51.4	104.5	98.6	110.5
AIREDALE NHSFT	RCF	59,050	2.5 %	59,450	670	1.1 %	688.7	1.2 %	-18.7	97.3	90.1	104.9
GATESHEAD HEALTH NHSFT	RR7	58,000	2.4 %	58,420	1,170	2.0 %	1,041.0	1.8 %	129.0	**112.4**	106.0	119.0
HARROGATE AND DISTRICT NHSFT	RCD	51,330	2.2 %	51,740	675	1.3 %	654.7	1.3 %	20.3	103.1	95.5	111.2

Figure 7 – SMR Statistically Significant Diagnosis Groups



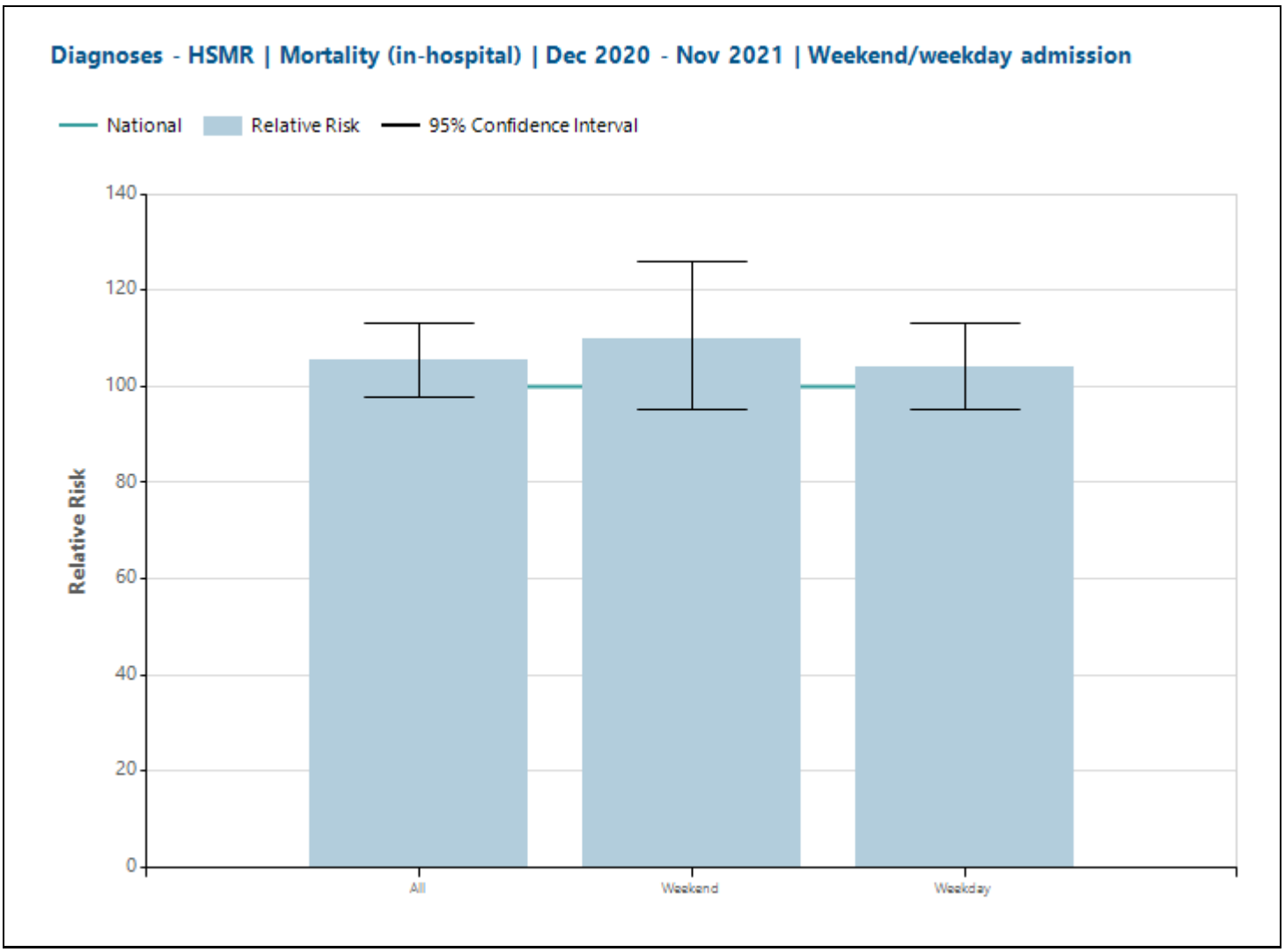
Diagnosis group	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		1,027	100.0 %	1,031	23	2.2 %	6.8	0.7 %	16.2	**337.4**	213.8	506.3
Other upper respiratory disease	134	459	44.7 %	462	6	1.3 %	1.8	0.4 %	4.2	**338.3**	123.5	736.3
Syncope	245	282	27.5 %	283	6	2.1 %	1.8	0.6 %	4.2	**334.3**	122.1	727.7
Poisoning by other medications and drugs	242	253	24.6 %	253	4	1.6 %	.9	0.4 %	3.1	**437.0**	117.6	1,118.7
Cancer of other GI organs, peritoneum	18	33	3.2 %	33	7	21.2 %	2.3	7.1 %	4.7	**300.1**	120.2	618.4

HSMR WEEKEND/WEEKDAY ANALYSIS

Key points

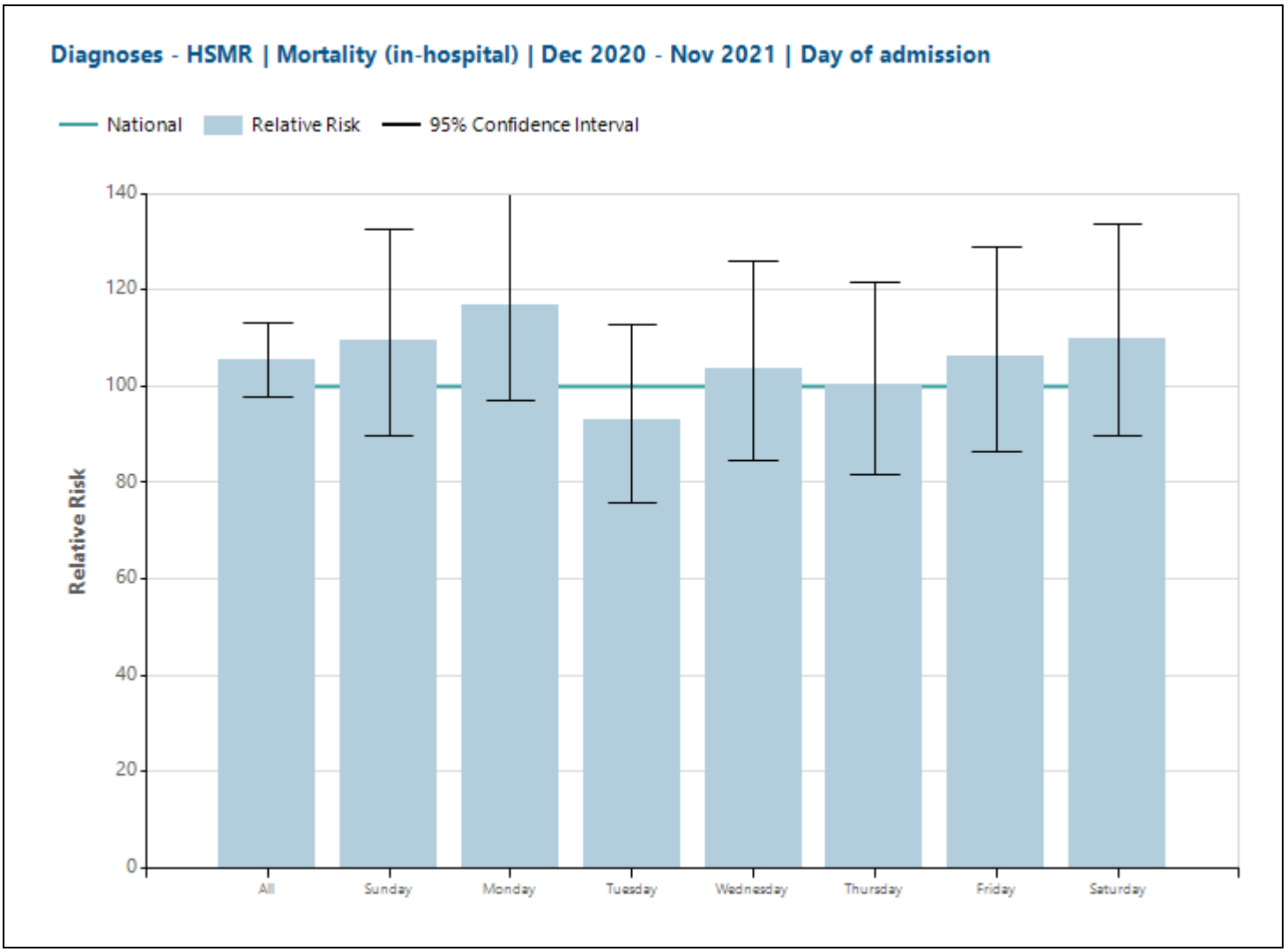
- For the 12 month period Weekend (non-elective) HSMR = 109.8 banded as statistically 'within expected'.
- For the 12 month period Weekday (non-elective) HSMR = 103.8 banded as statistically 'within expected'.
- For the 12 month period all individual days of admission are within the 'expected' range.

Figure 8 – HSMR Weekend/Weekday Admissions Emergency only



Weekend/weekday admission	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		13,490	100.0 %	13,502	735	5.4 %	697.4	5.2 %	37.6	105.4	97.9	113.3
Weekend	1	3,251	24.1 %	3,252	207	6.4 %	188.6	5.8 %	18.4	109.8	95.3	125.8
Weekday	2	10,239	75.9 %	10,250	528	5.2 %	508.8	5.0 %	19.2	103.8	95.1	113.0

Figure 9 – HSMR Day of admission - Emergency only



Day of admission	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		13,490	100.0 %	13,502	735	5.4 %	697.4	5.2 %	37.6	105.4	97.9	113.3
Sunday	1	1,553	11.5 %	1,554	105	6.8 %	95.9	6.2 %	9.1	109.5	89.6	132.6
Monday	2	2,040	15.1 %	2,042	120	5.9 %	102.6	5.0 %	17.4	117.0	97.0	139.9
Tuesday	3	2,055	15.2 %	2,057	102	5.0 %	109.8	5.3 %	-7.8	92.9	75.8	112.8
Wednesday	4	2,056	15.2 %	2,057	102	5.0 %	98.4	4.8 %	3.6	103.6	84.5	125.8
Thursday	5	2,032	15.1 %	2,033	103	5.1 %	102.8	5.1 %	0.2	100.2	81.8	121.5
Friday	6	2,056	15.2 %	2,061	101	4.9 %	95.2	4.6 %	5.8	106.1	86.4	128.9
Saturday	7	1,698	12.6 %	1,698	102	6.0 %	92.7	5.5 %	9.3	110.0	89.7	133.5

TRENDS IN CODING

Key points

- The proportion of both non-elective spells within the HSMR basket coded as receiving specialist palliative care is marginally above the regional average but below the national averages for this the 12 month period.
- The proportion of non-elective spells with a 0 comorbidity score within the HSMR basket (41.0%) is slightly higher than the regional average (39.8%) and national average (41.3%).
- The proportion of non-elective spells with a 20+ comorbidity score within the HSMR basket (17.5%) is above the regional average (15.7%) and national average (15.6%).

Figure 10 – Palliative Care Coding Rate Vs National

Trend (financial year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2017/2018	26,376	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	30,470	591	1.94%	2.22%	2.15%

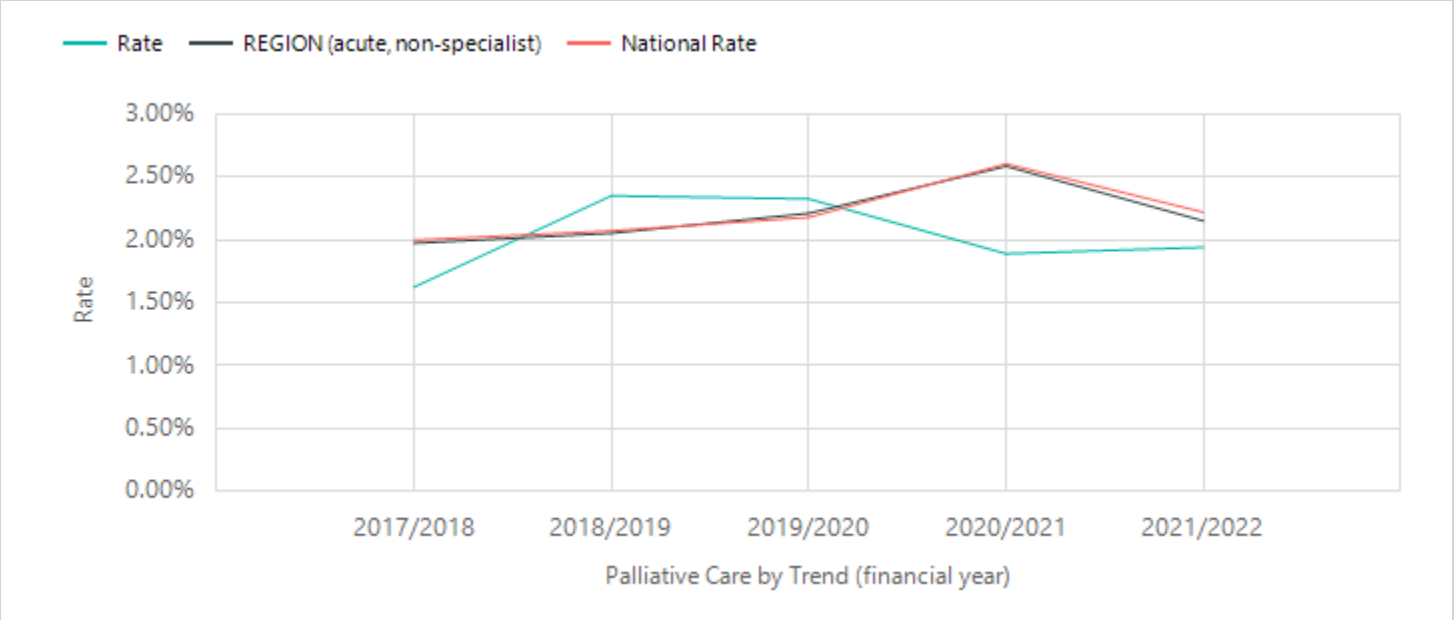


Figure 11 – HSMR and Influencers

Performance	Trust	Peer	National
HSMR	107.0	106.4	100.1
SMR	104.5	104.4	99.9
Non-elective (HSMR)	105.8	105.8	99.7
Weekday, emergency (HSMR)	103.8	104.6	98.1
Weekend, emergency (HSMR)	109.8	110.0	104.4
Saturday, emergency (HSMR)	110.0	108.6	103.8
Sunday, emergency (HSMR)	109.5	111.5	105.0

Coding / Casemix	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)	35.4%	35.0%	38.7%
% Non-elective spells with palliative care (HSMR)	4.0%	4.6%	4.9%
% Spells in Symptoms & Signs chapter	10.9%	5.5%	6.5%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	41.0%	39.8%	41.3%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	17.5%	15.7%	15.6%
% Non-elective spells in Risk Band (0-10%) (HSMR)	85.8%	84.5%	84.2%

Figure 12 – Palliative Care Coding (Palliative Observed Mortality v Superspell Count)

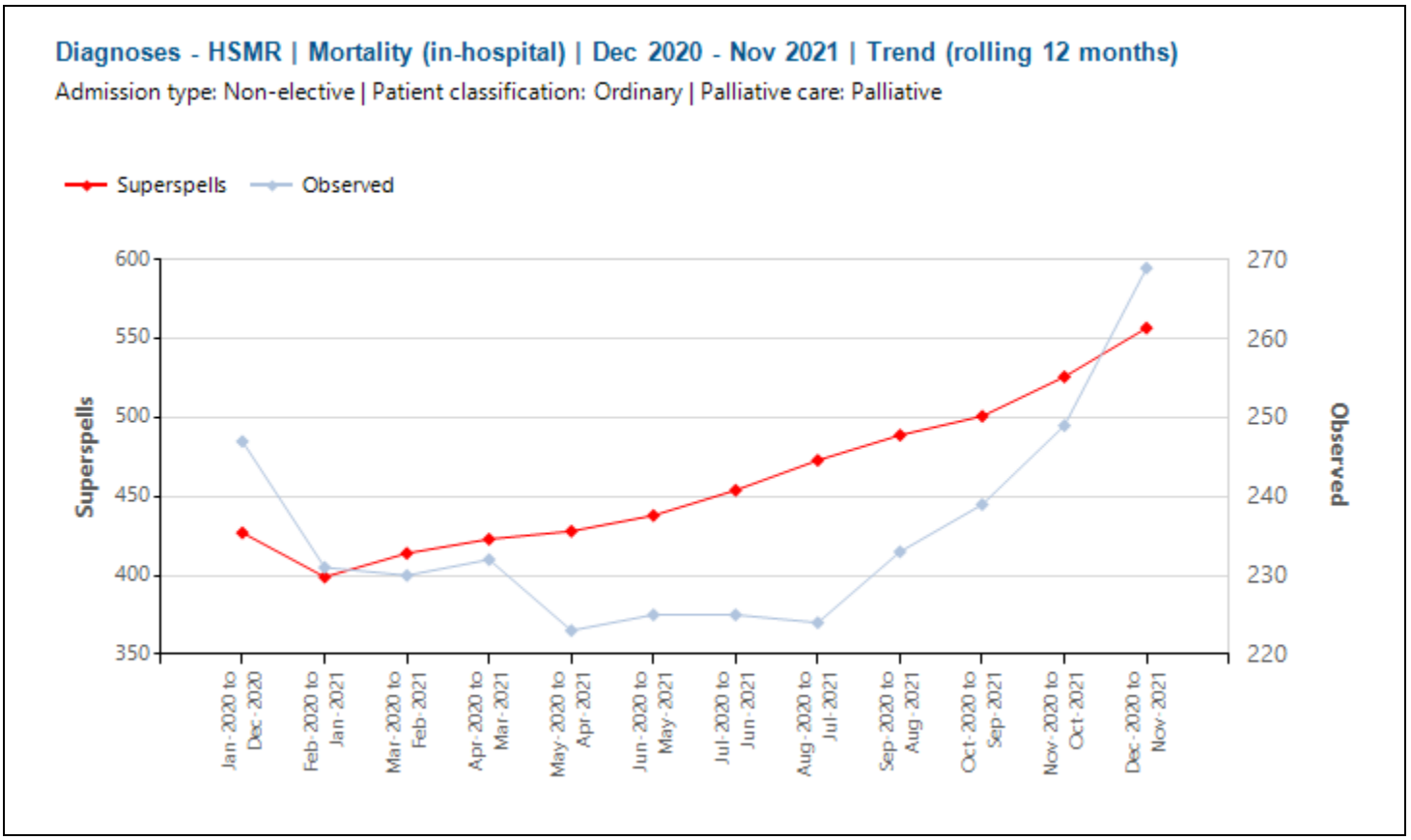


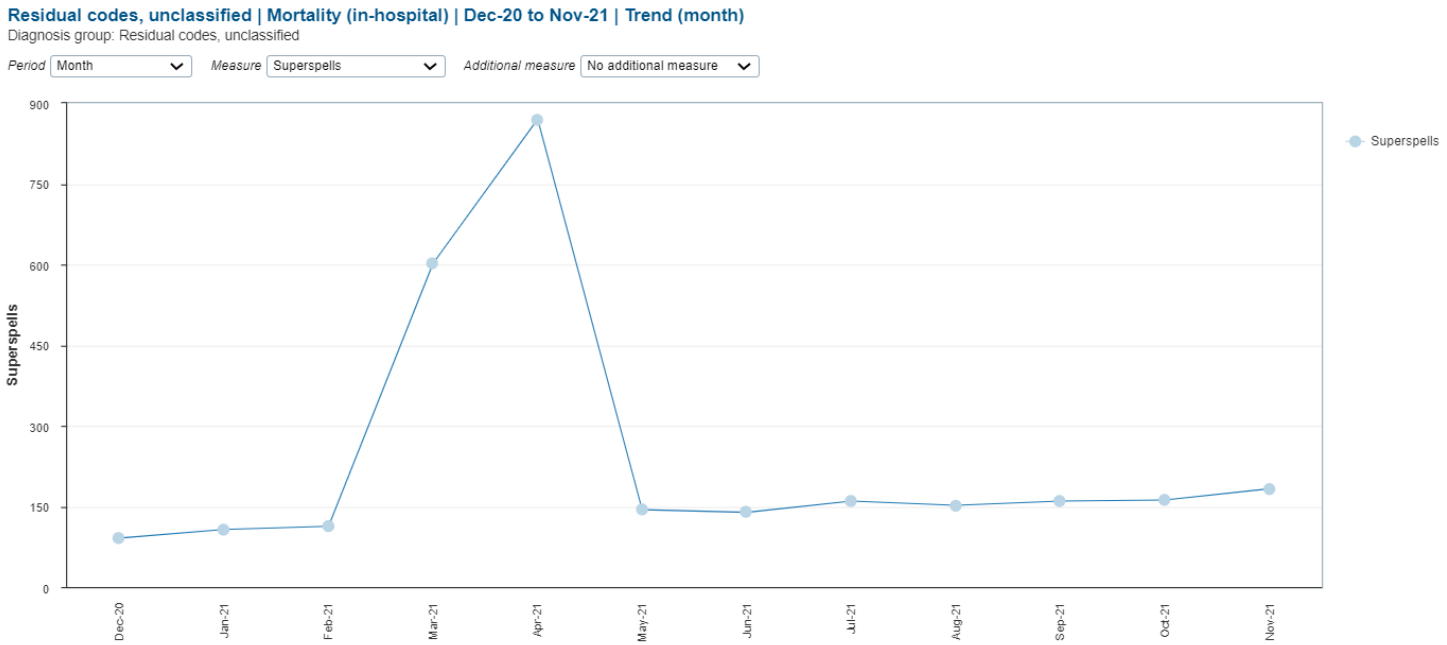
Figure 13 – Charlson Index Co-morbidity Coding Rates Vs National

Vol	Mean number of codes				
21/21	21/21	20/20	*England Jan 21 – Dec 21*		
Jan-Dec	Jan-Dec	Jan-Dec	*P25*	*P50*	*P75*
66,162	**6.3**	5.7	**3.1**	**4.4**	**5.1**

Vol	No codes (%)				
21/21	21/21	20/20	*England Jan 21 – Dec 21*		
Jan-Dec	Jan-Dec	Jan-Dec	*P25*	*P50*	*P75*
66,162	**12.9%**	9.4%	**10.5%**	**14.6%**	**22.7%**

Vol	No comorbidity (%)				
21/21	21/21	20/20	*England Jan 21 – Dec 21*		
Jan-Dec	Jan-Dec	Jan-Dec	*P25*	*P50*	*P75*
66,162	**60.1%**	61.6%	**59.9%**	**65.7%**	**78.9%**

Figure 13.5 - Volume (super-spells) within the Residual Codes, unclassified diagnosis group.

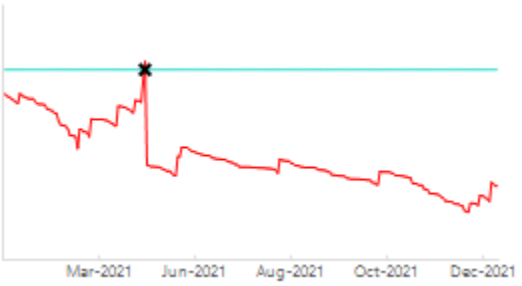
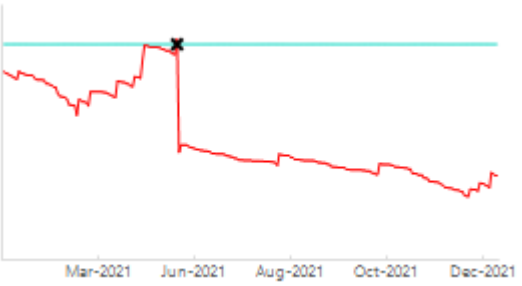
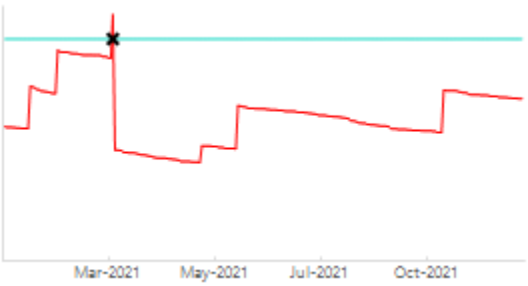
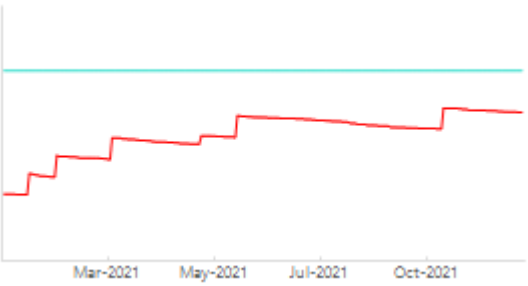
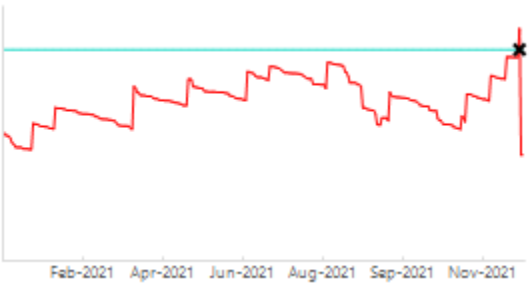
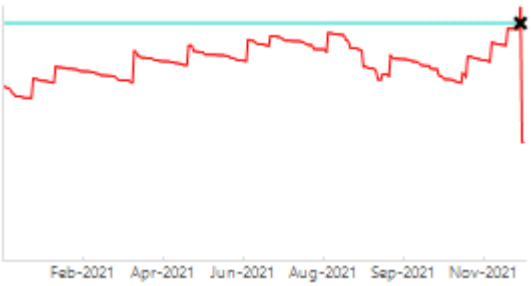


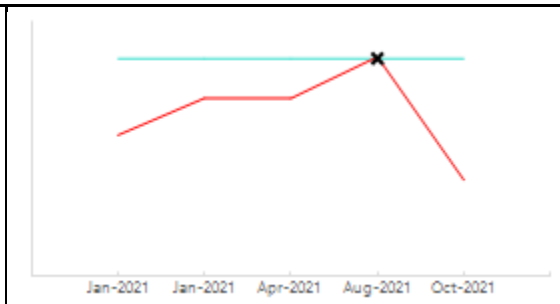
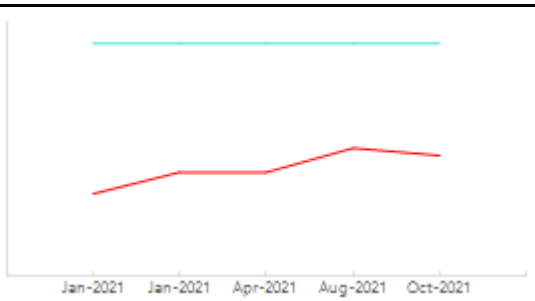
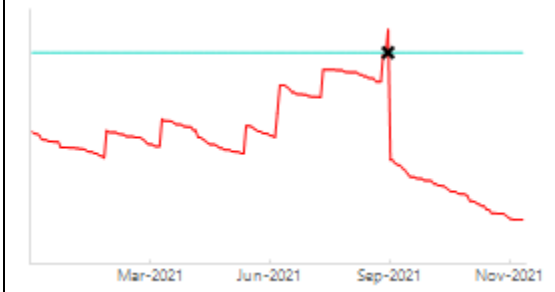
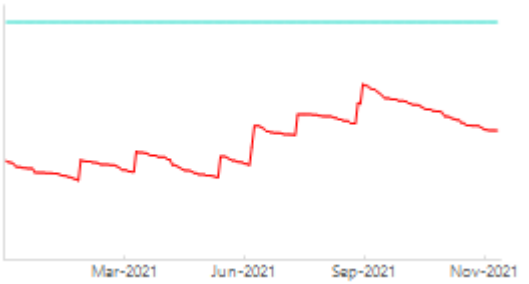
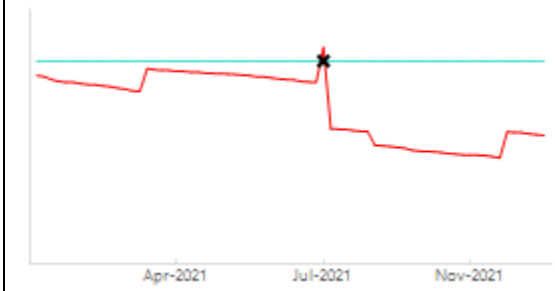
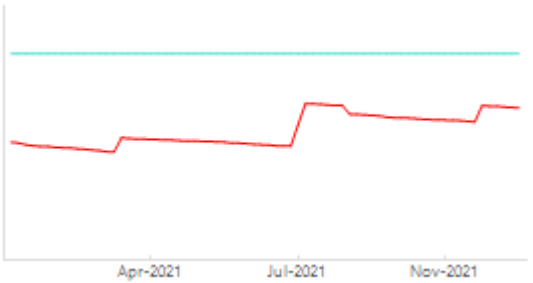
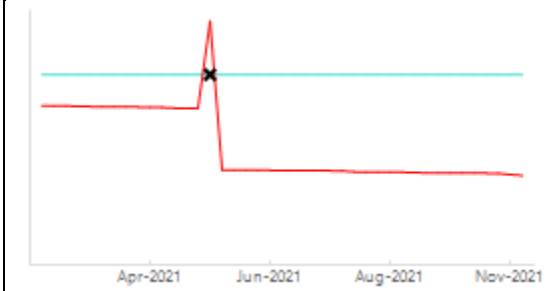
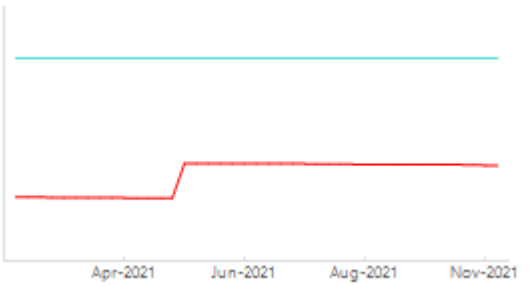
CUSUM ALERTS

Key points

- Over the 12 month period there were 8 CUSUM alerts (using 99% detection threshold criteria) in the following diagnosis groups:
  - Acute bronchitis
  - Other upper respiratory disease
  - Biliary tract disease * New alert in Nov-21
  - Liver disease, alcohol-related
  - Nervous system congenital anomalies
  - Other perinatal conditions
  - Other psychoses
  - Anxiety, somatoform, dissociative, and personality disorders

Figure 14 – Relative Risk and CUSUM Alerts (Dec 2020 - Nov 2021)

	99% Detection Threshold	99.9% Detection Threshold
Acute bronchitis		
Other upper respiratory disease		
Biliary tract disease		
Liver disease, alcohol-related		

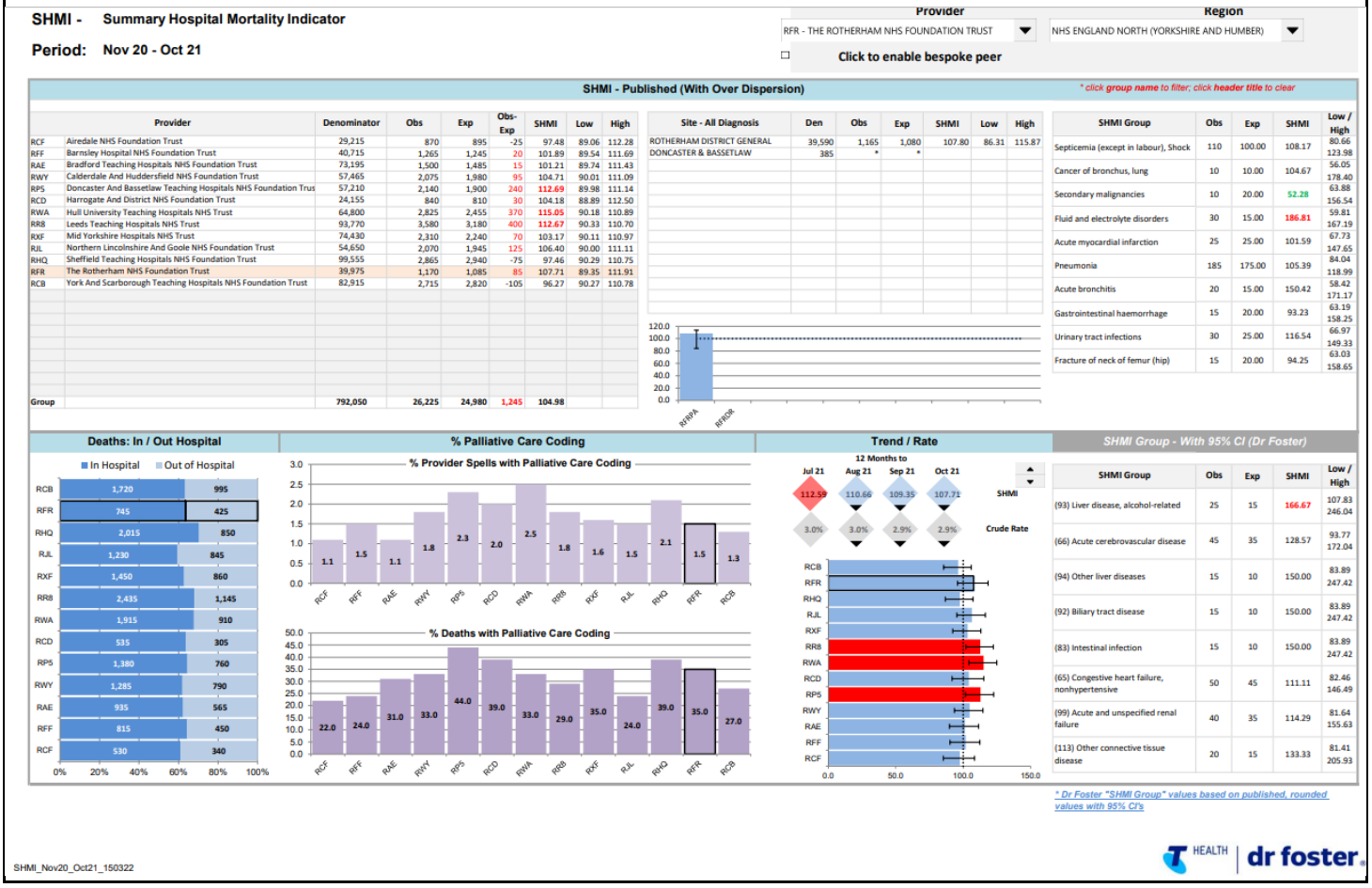
Nervous system congenital anomalies		
Other perinatal conditions		
Other psychoses		
Anxiety, somatoform, dissociative, and personality disorders		

MONTHLY SHMI

Key points

Time period: November 2020 to October 2021

- SHMI for The Rotherham NHS FT = 107.71 banded as statistically 'within expected' using the 95% control limits (adjusted for over dispersion) published by NHS digital.
  - During the 12 month period (Oct-20 to Sep-21) there were 745 in-hospital deaths and 425 out of hospital deaths (within 28 days of discharge) recorded within the summary metric.
  - The Trust is one of 10 within the NHS England (Yorkshire and Humber) region with a SHMI banded in the statistically 'within expected' range.
- Of the SHMI diagnosis groups banded by NHS digital (using 95% control limits adjusted for over dispersion) there was a single outlying group:
  - Fluid and electrolyte disorders (30 observed deaths, 15 predicted by the modelling).



APPENDICES

Key points

Other upper respiratory disease diagnosis group

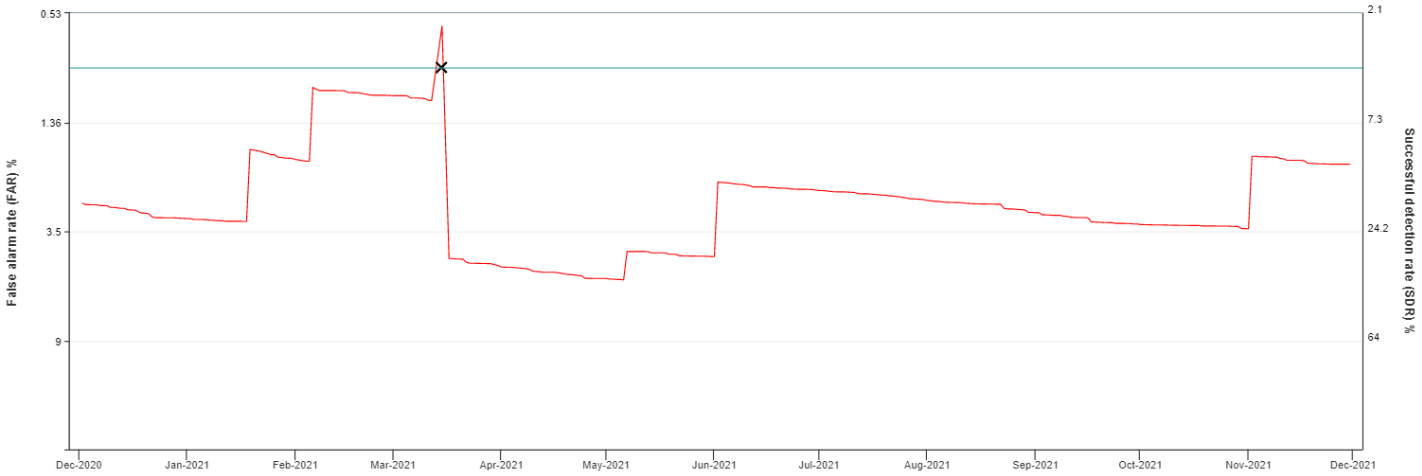
- 460 super-spells and 6 observed deaths over the 12 month period (1.8 'expected' by the modelling).
- RR = 336.2 banded as statistically 'higher than expected'. CUSUM alert in Mar-21 triggered by a run of three deaths (from Jan-21 to Mar-21).

CUSUM

Other upper respiratory disease | Mortality (in-hospital) | Dec-20 to Nov-21

Diagnosis group: Other upper respiratory disease

View: Negative | Reset on alert: To threshold / 2 | Start: Apr 2017 | Threshold: High (99%)



Trend (month)

Other upper respiratory disease | Mortality (in-hospital) | Dec-20 to Nov-21 | Trend (month)

Diagnosis group: Other upper respiratory disease

Analyse by: Trend (month) | Measure: Relative risk | Show: All

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	460	100.0%	462	6	1.3%	1.8	0.4%	4.2	336.2	122.8	731.8
Dec-20	40	8.7%	40	0	0.0%	0.1	0.3%	-0.1	0.0	0.0	2731.9
Jan-21	38	8.3%	38	1	2.6%	0.1	0.4%	0.9	669.5	8.8	3725.3
Feb-21	39	8.5%	40	1	2.6%	0.1	0.3%	0.9	868.3	11.3	4831.1
Mar-21	43	9.3%	43	1	2.3%	0.1	0.3%	0.9	729.9	9.5	4060.9
Apr-21	40	8.7%	40	0	0.0%	0.1	0.3%	-0.1	0.0	0.0	3498.9
May-21	45	9.8%	45	1	2.2%	0.6	1.3%	0.4	167.1	2.2	929.6
Jun-21	40	8.7%	40	1	2.5%	0.1	0.2%	0.9	1095.3	14.3	6094.3
Jul-21	40	8.7%	41	0	0.0%	0.1	0.2%	-0.1	0.0	0.0	4397.8
Aug-21	27	5.9%	27	0	0.0%	0.1	0.4%	-0.1	0.0	0.0	3030.1
Sep-21	43	9.3%	43	0	0.0%	0.1	0.3%	-0.1	0.0	0.0	3374.4
Oct-21	29	6.3%	29	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	9757.1
Nov-21	36	7.8%	36	1	2.8%	0.1	0.3%	0.9	966.4	12.6	5376.7

Primary diagnosis (assigned from one of the initial two episodes of care)

Other upper respiratory disease | Mortality (in-hospital) | Dec-20 to Nov-21 | ICD10 (3-char)

Diagnosis group: Other upper respiratory disease

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	460	100.0%	462	6	1.3%	1.8	0.4%	4.2	336.2	122.8	731.8
R06 Abnormalities of breathing	219	47.6%	219	5	2.3%	0.9	0.4%	4.1	587.1	189.2	1370.0
J34 Other disorders of nose and nasal sinuses	92	20.0%	92	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	58612.2
R04 Haemorrhage from respiratory passages	59	12.8%	60	1	1.7%	0.9	1.5%	0.1	116.3	1.5	647.2
J38 Diseases of vocal cords and larynx, not elsew…	33	7.2%	33	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	15001.8
J33 Nasal polyp	29	6.3%	29	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	1.66e+5
J39 Other diseases of upper respiratory tract	11	2.4%	12	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	26351.6
J31 Chronic rhinitis, nasopharyngitis and pharyngitis	4	0.9%	4	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	4.19e+5
J30 Vasomotor and allergic rhinitis	3	0.7%	3	0	0.0%	0.0	0.3%	-0.0	0.0	0.0	43783.8
J98 Other respiratory disorders	3	0.7%	3	0	0.0%	0.0	0.3%	-0.0	0.0	0.0	38127.7
R07 Pain in throat and chest	3	0.7%	3	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	87367.0
R49 Voice disturbances	3	0.7%	3	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	1.47e+5
J37 Chronic laryngitis and laryngotracheitis	1	0.2%	1	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	4.20e+5

Diagnosis (discharge)

Other upper respiratory disease | Mortality (in-hospital) | Dec-20 to Nov-21 | ICD10 on discharge (3-char)

Diagnosis group: Other upper respiratory disease

Analyse by ICD10 on discharge (3-c *Measure* Relative risk *Show* All

ICD10 on discharge (3-char)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	460	100.0%	462	6	1.3%	1.8	0.4%	4.2	336.2	122.8	731.8
J18 Pneumonia, organism unspecified	6	1.3%	6	2	33.3%	0.1	0.9%	1.9	3814.5	428.4	13772.4
K70 Alcoholic liver disease	2	0.4%	2	2	100.0%	0.6	28.5%	1.4	350.3	39.3	1264.6
J44 Other chronic obstructive pulmonary disease	4	0.9%	4	1	25.0%	0.0	1.2%	1.0	2098.6	27.4	11676.1
J84 Other interstitial pulmonary diseases	1	0.2%	1	1	100.0%	0.0	1.0%	1.0	10131.9	132.4	56372.2
A41 Other sepsis	1	0.2%	1	0	0.0%	0.0	3.0%	-0.0	0.0	0.0	12422.3
I27 Other pulmonary heart diseases	1	0.2%	1	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	1.03e+6
I48 Atrial fibrillation and flutter	1	0.2%	1	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	2.98e+5
I50 Heart failure	1	0.2%	1	0	0.0%	0.0	0.4%	-0.0	0.0	0.0	86722.7

Episodes in a spell

Other upper respiratory disease | Mortality (in-hospital) | Dec-20 to Nov-21 | Episodes in spell

Diagnosis group: Other upper respiratory disease

Analyse by Episodes in spell *Measure* Relative risk *Show* All

Episodes in spell	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	460	100.0%	462	6	1.3%	1.8	0.4%	4.2	336.2	122.8	731.8
1	407	88.5%	409	0	0.0%	0.8	0.2%	-0.8	0.0	0.0	437.4
2	27	5.9%	27	0	0.0%	0.2	0.6%	-0.2	0.0	0.0	2348.7
3	18	3.9%	18	3	16.7%	0.2	1.0%	2.8	1664.2	334.5	4862.4
4	4	0.9%	4	1	25.0%	0.6	13.8%	0.4	180.8	2.4	1005.9
5	2	0.4%	2	1	50.0%	0.0	1.1%	1.0	4418.0	57.7	24581.0
6	2	0.4%	2	1	50.0%	0.0	1.7%	1.0	2943.4	38.5	16376.6

Covid-19 (secondary)

Other upper respiratory disease | Mortality (in-hospital) | Dec-20 to Nov-21 | COVID-19 Y/N

Diagnosis group: Other upper respiratory disease

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	460	100.0%	462	6	1.3%	1.8	0.4%	4.2	336.2	122.8	731.8
No	455	98.9%	456	6	1.3%	1.8	0.4%	4.2	341.7	124.8	743.7
Yes	5	1.1%	6	0	0.0%	0.0	0.6%	-0.0	0.0	0.0	12819.3

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
06 May 2022

The Rotherham NHS Foundation Trust

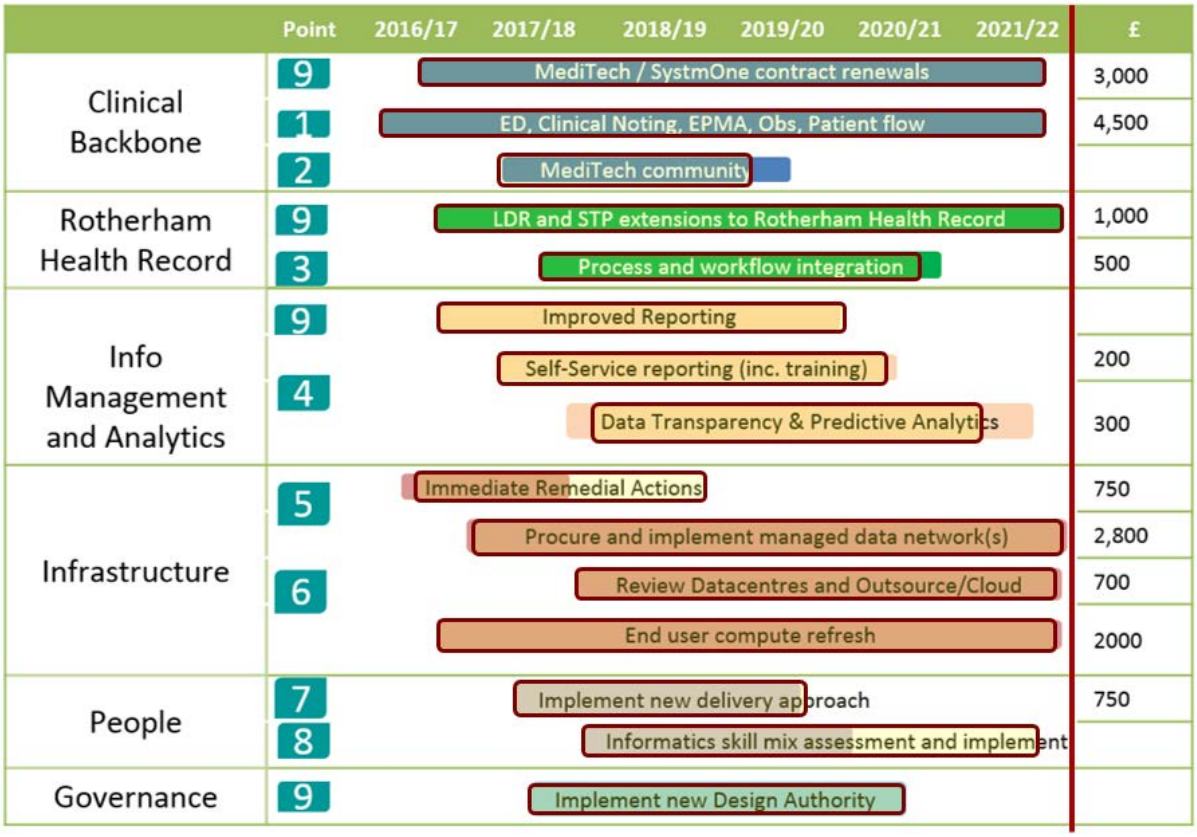
Agenda item	P88/22
Report	**Digital Strategy and Data Quality Report**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B1, B7, B8
How does this paper support Trust Values	Effective digital systems support the organisation and its patients in providing joined up high quality and safe care together.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues, and risks)	To provide a bi-annual update on progress towards the delivery of the Trust's Digital Strategy. Programme Highlights: • The Digital Aspirant Programme funding programme has now concluded, some systems are live, having being deployed such as Patient Letters or Cloud Dictation, and others are in their final phases of delivery. • A tremendous amount of effort, with exceptional close working with finance and procurement colleagues during January, February and March has enabled the bringing forward of a significant number of infrastructure and system investments into 2021/22, such as Maternity patient portal and End user device replacement programme. • All core and edge data network has been upgraded with Wi-Fi switchover now planned for June 2022. • A significant number of co-designed Analytical models have been produced and continued to be well received; demonstrating the ongoing shift to running and planning our services on near-live, accurate and insightful information. • We continue to strengthen our Cybersecurity position, by upgrading critical systems and removing outdated software, and received £125k external funding to strengthen our backup software. • The Rotherham Health App integration to TRFT appointment systems remain live, with over a 1000 views a week. • Despite challenges with Software development resource availability, we've overhauled the UI for SEPIA bed boards, and Mental Health assessments. National Digital strategy, has now pivoted towards 'EPR Convergence' across ICS, and we may need to consider implications of STH recent

	announcement of selecting an EPR provider not within our ICS on our future EPR direction.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper is comprised of elements of monthly updates provided to Digital Transformation Committee, its sub-committees and Clinical Governance committee.
Board powers to make this decision	
Who, What and When? (what action is required, who is the lead and when should it be completed?)	Board members continue to support the Trusts Digital strategy Board acknowledges consideration may need to be given to EPR convergence on our future EPR strategy.
Recommendations	It is recommended that: • Board note the contents of this report • Board acknowledges our Digital Board Seminar will be the 1st step in formulating our future Digital Strategy.
Appendices	Appendix 1 – What Good Looks Like Self-Assessment Appendix 2 – Informatics Digital Programme Plan

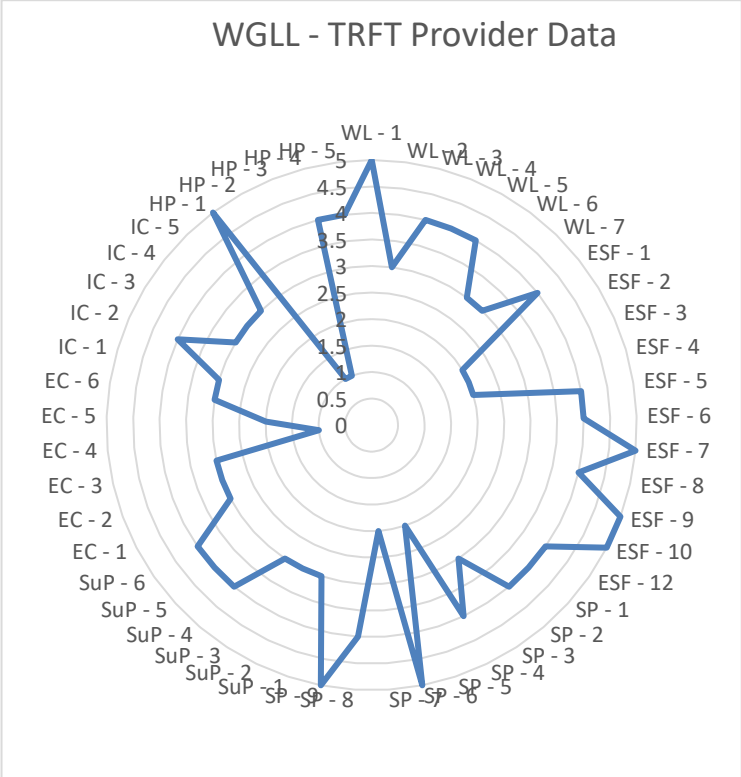
1.0 Introduction

1.1 In April 2017, the Trust board approved the 5-year, 9 point #DigitalByDefault strategy, which emphasized a "cloud-first" approach along with optimisation of existing Electronic Patient Record systems that are complemented by the award-winning Rotherham Health Record system (SEPIA).

1.2 This paper provides a summary update with respect to progress along each of these 6 dimensions up to April 2022, position shown graphically below.



1.3 We've self-assessed ourselves along with ICS colleagues against the What Good Looks Frameworks (Appendix 1) and, unsurprising score relatively highly in all domains, with some specific areas to focus around adequately resourced cybersecurity function, NetZero and carbon reduction, and patients contributing to their own health record



1.4 In January, NHSE pivoted national thinking towards

‘EPR convergence across ICS’ and levelling up EPR adoption across England. All Organisations were asked, to self-assess their level of EPR maturity using a 4-scale measuring system against a set of minimum set of digital capabilities. (0 being no EPR, 3 has EPR deployed within all capabilities. TRFT, along with ICS, assess ourselves at level 3. Organisations at Level 0 will be prioritised national funding.

1.5 In April, Sheffield Teaching Hospital, announced their intention to award their future EPR contract to a supplier that does not have a footprint in South Yorkshire, Nottinghamshire or Derbyshire, and we may have to consider if this decision will have implications on our future EPR strategy.

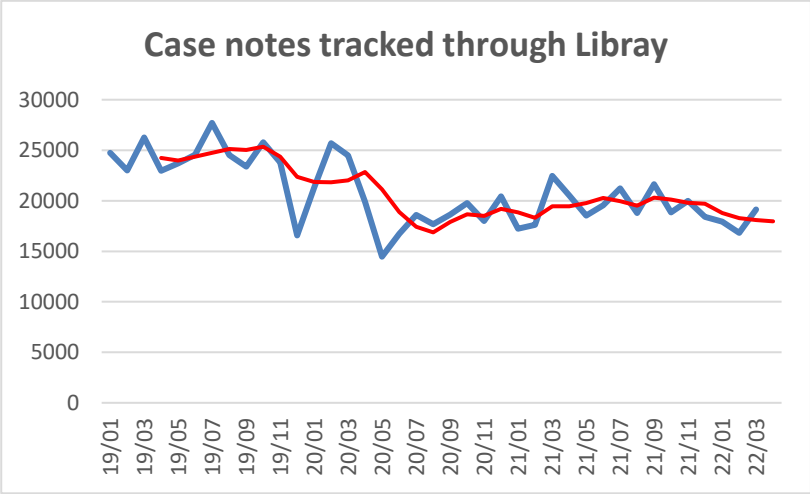
1.6 Doncaster and Bassetlaw are the only provider in the region without EPR capability (Level 0), and will shortly commence, supported by national funding, their EPR programme.

1.7 On May 13th, NHS Providers will be facilitating our Board Development day for us to collectively start thinking around our future Digital Strategy in the context of our own Digital Strategy, ICS digital strategy and NHE digital strategy. The outputs of this workshop will then enable the Informatics team to start developing the detail, along with Louise Tucketts team, with a view to come back to board around November for final approval.

1.8 A detailed digital strategy programme update is available in Appendix 2

2.0 Clinical Backbone

2.1 We continue to make progress with digitization of our clinical processes across the organisation and leveraging the capabilities of our EPR(s) to support implementation of standardised digital pathways and new ways of working. Using Digital Aspirant programme funding, we part funded a secondment from Medical Records to enable driving through reductions on 'paper dependency'. There is more work to do, but proxy analysis is showing a reduction of circa 20% on notes tracked through our libraries compared to pre-COVID levels (25,000 to 20,000 per month)



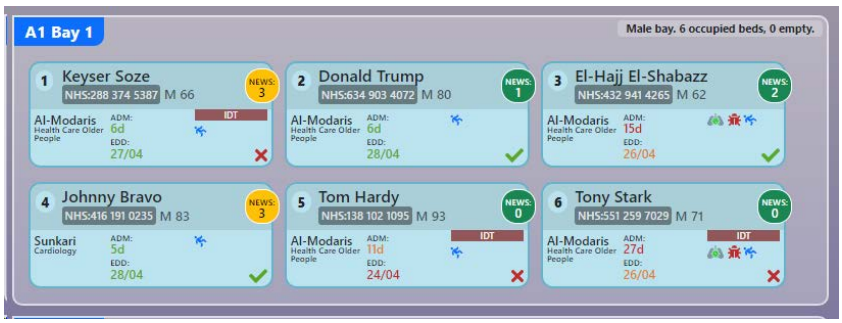
2.2 EPR 'digital' developments and Investments in the last 6 months include:

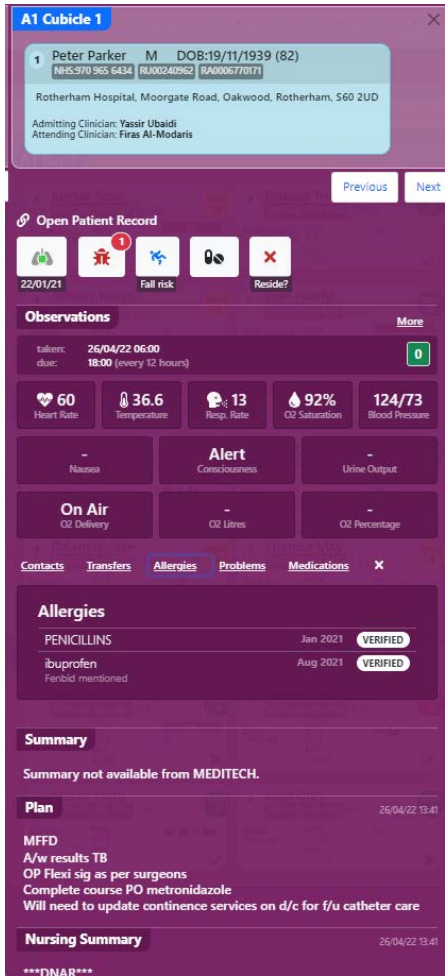
- Digital Patient Letters is live in several services and being deployed by Medical Records teams across the organisation.
- Steady progress continues with fully digitizing our outpatient services, with only Breast, Rheumatology, Urology and Gynaecology to be engaged in the programme.
- Cloud based, Digital Dictation Solution is in the final stages of testing
- Significant progress has now been made in moving Critical Care Services electronic, led by an ICU nurse who has been seconded into Health Informatics, nursing assessments have been digitized and Large format WoW have been procured to enable bedside digital charting

- Working with Pathology, we've significantly overhauled our approach to managing Lab Interfaces after clinicians had raised concerns re: timeliness of results and some results not appearing within MediTech.

- Co-designing with the Clinical Director of Medicine, we've deployed an Acute Take Tracker into SEDC/AMU to help with the flow of patients being admitted from ED.
- The **Trust Escalation and Management (TEAM)** tool is now embedded in the organisation and we've now added capability to automatically send text messages and teams notifications when the Trust Escalation Levels change.

2.3 We've updated SEPIA bed boards User Interface across the organisation, to be even more intuitive, with clearer icons, highlighted NEWS levels, with a comprehensive patient panel. At a recent site visit across our Medical Wards, I was able to see first-hand, clinical teams coming into their control rooms, and intuitively interacting with the new bed board interface.





2.4 In Q4 of 2021/22, we worked closely with finance and procurement colleagues to complete active procurement during the year, but also to bring forward from 2022/23 capital programme several investments. During this period, we concluded:

- Pre-op and eConsent solution, allow patients to commence pre-op pathway from home and manage their consent right through to surgery.
- MediTech Maternity clinical portal, allowing Mums to digitally interact and add data to their complete medical record
- Wifi Access Points for Nurses Home buildings
- Procurements of 415 laptops and 200 monitors
- 250 DECT replacement, Wifi handsets in preparation for our switchboard upgrade this summer.

- Low-code automation modules for our Contact system
- Upgrades to our Backup software
- In collaboration with BGH, a new cloud based modern website solution

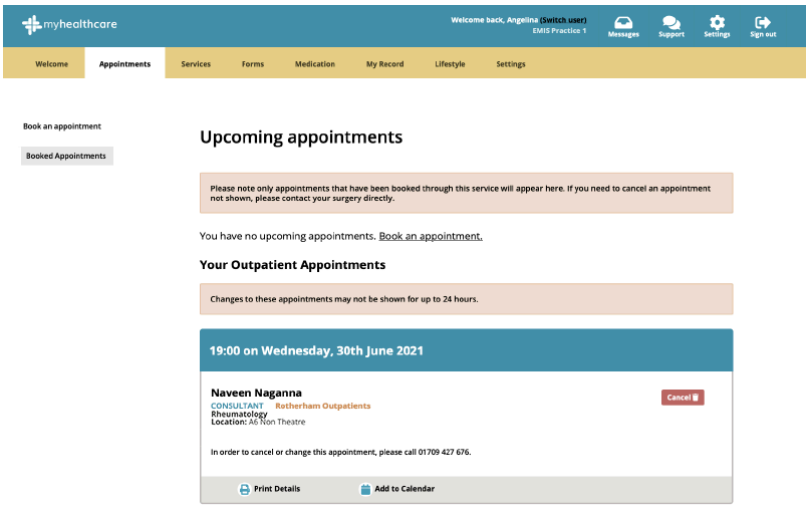
3.0 Rotherham Health Record

3.1 Development of the Rotherham Health Record have been slow over the past 6 months, predominately due to a lack of internal software development resource, despite multiple attempts to recruit.

3.2 A programme of work has been initiated to deploy access to the RHR for RMBC social services teams, and we have now circa 100+ RMBC staff trained and actively using https://rhr.care/

3.3 In addition, we've also started working with place partner to evaluate using RHR.CARE in care homes across the borough, this is early stages.

3.4 The Rotherham Health App continues to be well used, with over 40,000 people actively registered and over 1000 views a week of hospital appointments.
Sample screen shot below.



3.5 In January we went live with the 1st phase of improving Radiology booking processes, by moving the service on our Contact Centre solution, handling upwards of 150 calls a day. Future phases planned for 2022, include the ability for patients to directly book themselves using text message and chatbot technology.

3.6 We also continue to develop ad-hoc in-house solutions to support the organisation including:

- Automating texting of COVID swab results
- Development of new, 100%, digital approach to Child Vaccinations.
- EPPRF Automated hotline: 0113 868 4689

4.0 Information Management – Analytics, Data Quality and Coding

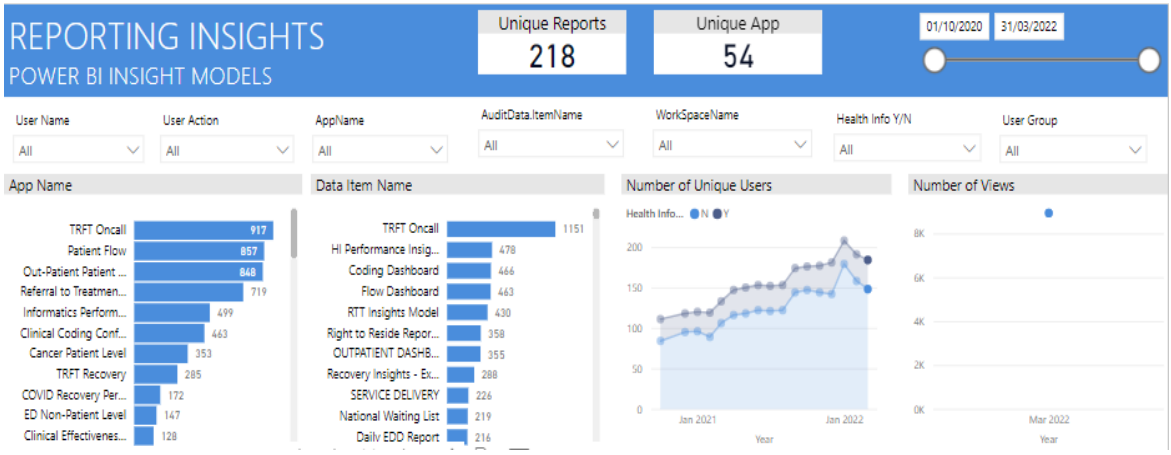
4.1 In support of data-driven decision making, Insight models continue to be built on our PowerBI platform. Leveraging data and information captured within our EPRs to provide actionable Insight models for many parts of the organisation. Specific developments and enhancements over the last period include:

- **Theatre Booking Assistant** – Significant development supporting the Trust's Elective Recovery Programme, bringing together future theatre lists, and active waiting list patient to identify where additional procedures could be accommodated

- **Nurse Observation Insights (NEWS/PEWS)** – Driven by the Trust's Quality Improvement nurse to establish baseline performance and seek to improve the timeliness of observations where needed.

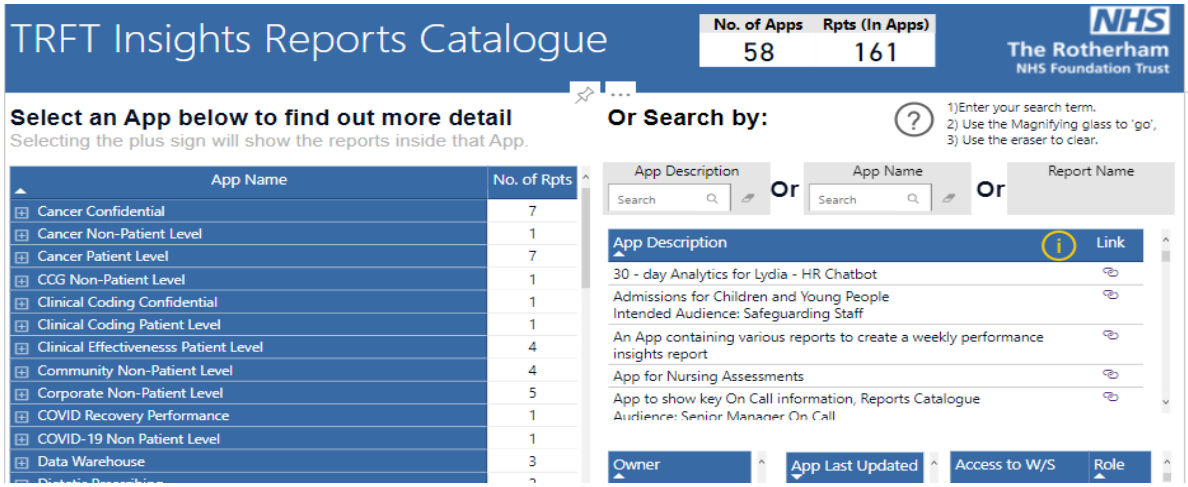
- **Health Inequalities RTT/UECC Overview** – As part of the Trust's commitment to the HI agenda, models have been created to understand the patterns of attendance and barriers to access by different demographics, including ethnicity and deprivation profiles

4.2 Uptake and production of online PowerBI models is increasingly embraced across the organisation, in January 2022 the highest number of unique users was noted, we recognise that a limitation is our clinicians and staff can only see models that they have permissions to see, and as such some models may be infrequently utilised.

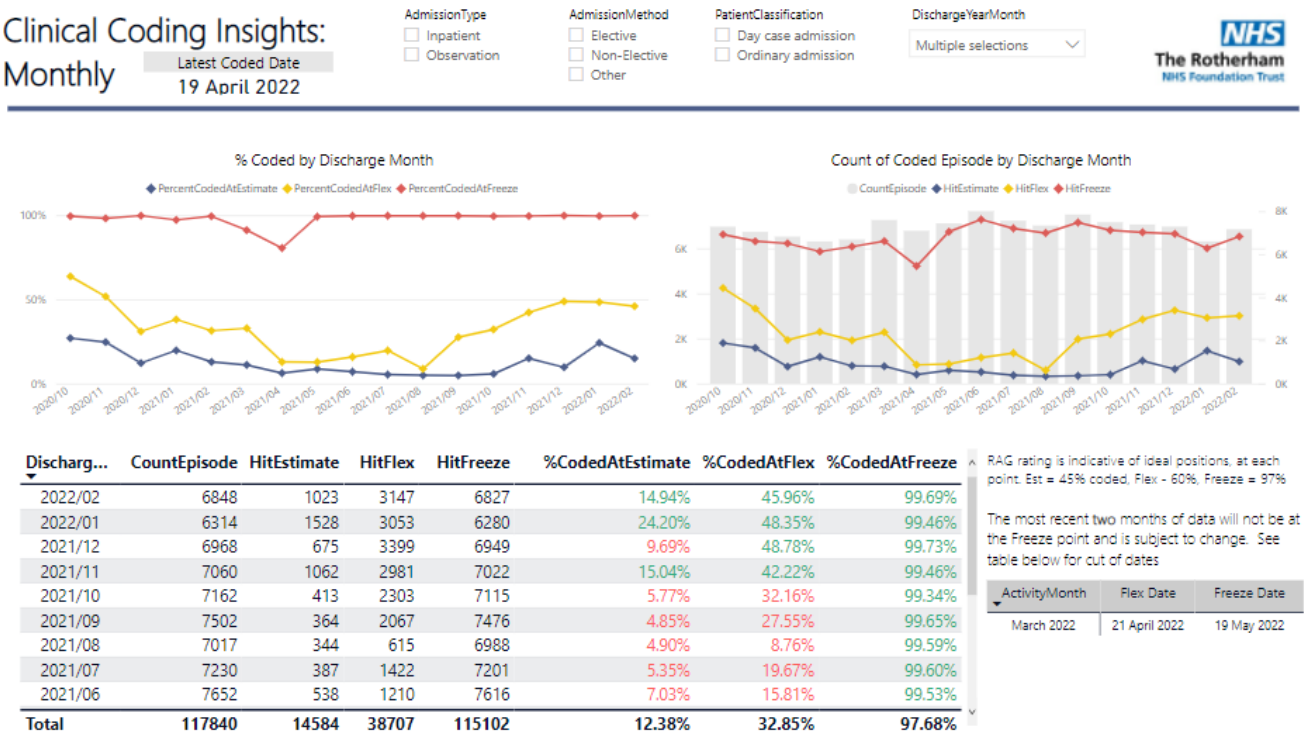


With of this in mind; two enhancements have been made this quarter:

- Catalogue and User Guides to ‘My Insights’ (PowerBI)
- PowerBI Icon rolled out to all staff on their MS Teams account



4.3 Whilst we continue to meet coding freeze targets, we are seeing improvements in recent time around achieving our flex targets. Weekly coding performance information is sent to the Director of Finance and Deputy Chief Executive. There remains some fragility within the team, as vacancies remain with some recent turnover in staff.



Discharg...	CountEpisode	HitEstimate	HitFlex	HitFreeze	%CodedAtEstimate	%CodedAtFlex	%CodedAtFreeze
2022/02	6848	1023	3147	6827	14.94%	45.96%	99.69%
2022/01	6314	1528	3053	6280	24.20%	48.35%	99.46%
2021/12	6968	675	3399	6949	9.69%	48.78%	99.73%
2021/11	7060	1062	2981	7022	15.04%	42.22%	99.46%
2021/10	7162	413	2303	7115	5.77%	32.16%	99.34%
2021/09	7502	364	2067	7476	4.85%	27.55%	99.65%
2021/08	7017	344	615	6988	4.90%	8.76%	99.59%
2021/07	7230	387	1422	7201	5.35%	19.67%	99.60%
2021/06	7652	538	1210	7616	7.03%	15.81%	99.53%
Total	**117840**	**14584**	**38707**	**115102**	**12.38%**	**32.85%**	**97.68%**

RAG rating is indicative of ideal positions, at each point. Est = 45% coded, Flex - 60%, Freeze = 97%

The most recent two months of data will not be at the Freeze point and is subject to change. See table below for cut of dates

ActivityMonth	Flex Date	Freeze Date
March 2022	21 April 2022	19 May 2022

4.4 The Clinical Coding team sustained the IG Level 3 accreditation, with The Trust remaining in the top quartile nationally.

4.5 December 2021 regional Data Quality Maturity Index data is shown below, we continue to perform well around Community (CSDS) and Maternity (MSDS) datasets.

Data Provider Name	APC	CSDS	ECDS	MHSDS	MSDS	OP
THE ROTHERHAM NHS FOUNDATION T...	98.90	89.40	72.50		99.70	99.40
NORTHERN LINCOLNSHIRE AND GOOL...	100.00	81.30	85.90		100.00	100.00
HARROGATE AND DISTRICT NHS FOUN...	97.60	81.00	89.60		99.60	99.40
DONCASTER AND BASSETLAW TEACHI...	99.70		84.50		99.90	99.30
CALDERDALE AND HUDDERSFIELD NH...	99.00	80.80	91.20		99.70	99.50
MID YORKSHIRE HOSPITALS NHS TRUST	99.80	84.00	91.80		99.50	98.50
SHEFFIELD TEACHING HOSPITALS NHS ...	99.70	84.00	91.80		99.90	99.60
BARNSLEY HOSPITAL NHS FOUNDATIO...	96.50		89.90		100.00	99.70
LEEDS TEACHING HOSPITALS NHS TRU...	99.70		93.10	89.40	99.70	99.30

4.6 Our Emergency Department continue to take a lead on ensuring we adapt systems to appropriately capture ECDSv3 information, which will then have a positive impact on the ECDS scores above.

5.0 Infrastructure and CyberSecurity.

5.1 All our data network infrastructure has now been upgraded, with WiFi switchover now scheduled for June 2022 (delays due to internal and external resource availability). This has contributed to reducing Risk 4630 (reliability of IT infrastructure).

5.2 Replacement of our switchboard telecommunications system is well underway and we are entering a phase of soak testing and configuration. Migration of desktop phones and DECT handsets is scheduled to commence in June with a 3-6-month rollout. Implementation of the much-needed upgrade to our Storage Area Network system has commenced as planned.

5.3 We took the opportunity to bring forward capital expenditure to purchase 415 laptops and 200 monitors, to meet requirements as part of our End User Device refresh programme business case, and expect to start this 5-year refresh programme in July 2022. This refresh programme will pick up those PC/Laptops that, due to age, we can no longer apply the latest Windows 10 patches to.

5.4 In December 2021 (on the same day as our Cyber Board Training), the Log4JShell was announced globally, this resulted in Informatics standing up a task and finish group, convening every 24 hours, and commenced a review of ALL our systems to assess exposure. This programme highlighted further work that, as an organisation, we need to undertake in educating Information Asset Owners on their responsibilities in this regard. No significant systems were affected.

5.5 In February, we hosted a visit by Phil Huggins, NHS England Chief Information Security Officer and his team. We had a frank conversation around what managing cybersecurity means at the sharp end of the NHS, especially around time to apply software patches and disruption this causes digitally advanced organisations and also levels of resource and time required to carry out full recovery EPR systems from backups. Phil, also shared some of the future offerings from NHS England, such as on-site assessments which we have put into our 2022 cyber plans.

6.0 People and Engagement

6.1 In March, NHS England Launched 2022 as the Year of the digital profession, the launch of a 5 year strategy and roadmap for building a sustainable digital and data workforce. - https://www.nhsx.nhs.uk/digitise-connect-transform/the-year-of-the-digital-profession-2022/ , where one of the top priorities for the year is to establish the professionalisation of the workforce. At Rotherham FT, we're slightly ahead of this intention, and used Digital Aspirant Programme funding to 'seed' fund professionalisation for all staff within Health Informatics. All Informatics staff have been encouraged and supported to join the British Computer Society, or other appropriate professional body and become members of the Federation of Informatics Professionals (Fed-IP). Our Director of Health Informatics was personally invited to the BCS launch event in March 2022, and is an Assessor for other FED-IP applications.

6.2 Led by our CCIO, Mr Richard Slater, we continue to support other professional groups across the organisation in digital leadership and digital co-design. For example, we have a Digital Midwife, a Digital ICU nurse, Practice Development team trained in Digital Clinical Safety, and secondments into Health Informatics from Pharmacy, Medical Records and Medical Secretaries. There is a clear relationship between

progress of change and implementation when these resources are committed to programmes.

6.3 Our 2021 staff survey, indicates that we still have work to do around our staff feeling valued by the wider organisation, seeing how the work they do fits into the broader organisation and inter-directorate team working. We already have a number of initiatives in place from Health and Wellbeing events, to HI 'extra mile award', and with the easing of COVID restrictions we're looking to organise a Directorate wide engagement event and have updated our 2022 informatics skills development plan to ensure every member of staff receives a 1:1 workplace stress risk assessment.

7.0 Recommendations

7.1 The Board is asked to note the contents of this report

James Rawlinson
Director of Health Informatics
May 2022

Appendix 1 – What Good Looks Like Self-Assessment

ID	Success Measure	Standard	Provider score	Rotherham NHS FT score (0-5)	please provide any notes which you feel relevant
WL - 1	Well Led	build digital and data leadership expertise and strong board-level accountability for digital transformation - this would include having a CIO or CCIO (or role within this function) as a member or attendee of the board	5	5 – Agree completely	
WL - 2	Well Led	establish board governance that regularly reviews digital and data strategy, cyber security, services, delivery and risks, underpinned by meaningful metrics and targets	3	3 – Neither agree or disagree	Board committees do regular review, not really discussed at Full board level
WL - 3	Well Led	ensure that your digital and data strategy has had wide input from clinical representatives from across the organisation	4	4 – Somewhat agree	
WL - 4	Well Led	ensure board ownership of a digital and data strategy that is linked to the Integrated Care System (ICS) strategy and underpinned by a sustainable financial plan	4	4 – Somewhat agree	
WL - 5	Well Led	identify digital and data solutions to improve care by regularly engaging with frontline users and citizens	4	4 – Somewhat agree	
WL - 6	Well Led	Invest in regular board development sessions to develop digital confidence, manage cyber security risk and achieve the sustainability agenda	3	3 – Neither agree or disagree	To date have held Board Cyber development sessions and plans *are* in place to have wider sessions
WL - 7	Well Led	Invest in a multidisciplinary CCIO and CNIO function	3	3 – Neither agree or disagree	Sustained investment is lacking for nurses/therapists/pharm/ etc.
ESF - 1	Ensure Smart Foundations	Invest in and build multidisciplinary teams with clinical, operational, informatics, design and technical expertise to deliver your digital and data ambitions	4	4 – Somewhat agree	
ESF - 2	Ensure Smart Foundations	ensure progress towards net zero carbon, sustainability and resilience ambitions by meeting the Sustainable ICT and Digital Services Strategy (2020 to 2025) objectives	2	2 – Somewhat disagree	
ESF - 3	Ensure Smart Foundations	Make sure that all projects and programmes meet the Technology Code of Practice and are cyber secure by design	2	2 – Somewhat disagree	
ESF - 4	Ensure Smart Foundations	Have a plan and move to cloud data hosting and management	2	2 – Somewhat disagree	
ESF - 5	Ensure Smart Foundations	Maintain a robust and secure network	4	4 – Somewhat agree	
ESF - 6	Ensure Smart Foundations	Ensure hardware, software and end user devices are all within the suggested supplier life cycle and fully supported	4	4 – Somewhat agree	
ESF - 7	Ensure Smart Foundations	Remove fax machines and non-emergency pagers, and maximize use of modern telephony and communication methods, for example, communications software	5	5 – Agree completely	
ESF - 8	Ensure Smart Foundations	Ensure staff have access to the technology and devices that best support their roles	4	4 – Somewhat agree	
ESF - 9	Ensure Smart Foundations	Maintain a central, organisation-wide, real-time electronic care record system	5	5 – Agree completely	
ESF - 10	Ensure Smart Foundations	Extend the use and scope of your electronic care record systems to all services, ensuring greater clinical functionality and links to diagnostic systems and electronic prescribing and medicines administration (EPMA)	5	5 – Agree completely	
ESF - 12	Ensure Smart Foundations	Contribute data to the ICS-wide shared care record in line with the Professional Records Standard Body's (PRSB) Core Information Standard	4	4 – Somewhat agree	
SP - 1	Safe Practice	comply with the requirements in the Data Security and Protection Toolkit which incorporates the Cyber Essentials Framework	4	4 – Somewhat agree	
SP - 2	Safe Practice	fully use national cyber services provided by NHS Digital	4	4 – Somewhat agree	
SP - 3	Safe Practice	have a secure and well-tested back-up, a plan to get off and stay off unsupported systems, and a rapid turn-around of High Severity Alerts	3	3 – Neither agree or disagree	Funding is an issue here
SP - 4	Safe Practice	establish a process for managing cyber risk with a cyber improvement strategy, investment and progress regularly reviewed at board level	4	4 – Somewhat agree	
SP - 5	Safe Practice	have an adequately resourced cyber security function, including a senior information risk owner and data protection officer (DPO)	2	2 – Somewhat disagree	Operational funding is an issue here

SP - 6	Safe Practice	have an adequately resourced clinical safety function, including a named CSO, to oversee digital and data development and deployment across all care services	5	5 – Agree completely	
SP - 7	Safe Practice	establish a clear process for reviewing and responding to relevant safety recommendations and alerts, including those from NHS Digital (cyber), NHS England and NHS Improvement, the Medicines and Healthcare Products Regulatory Agency (MHRA) and the Healthcare Service Investigation Branch (HSIB)	2	2 – Somewhat disagree	
SP - 8	Safe Practice	ensure clinical systems and tools meet clinical safety standards as set out by the Digital Technology and Assessment Criteria (DTAC) and DCB0129 and DCB0160	4	4 – Somewhat agree	
SP - 9	Safe Practice	ensure you are compliant with NHS national contract provisions related to technology-enabled delivery (for example, clinical correspondence and electronic discharge summaries)	5	5 – Agree completely	
SuP - 1	Support People	create and encourage a digital first approach and share innovative improvement ideas from frontline health and care staff	3	3 – Neither agree or disagree	COVID has made this problematic
SuP - 2	Support People	support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development	3	3 – Neither agree or disagree	Mastery programme is an example of good practice.
SuP - 3	Support People	ensure that the systems that your staff use are intuitive and easy to use	3	3 – Neither agree or disagree	
SuP - 4	Support People	support your staff to work flexibly, remotely, and across multiple wards or sites	4	4 – Somewhat agree	
SuP - 5	Support People	provide front-line staff with the information they need to do their job safely and efficiently at the point of care, for example ICS shared care record	4	4 – Somewhat agree	
SuP - 6	Support People	provide access to digital support services 24 hours per day, resulting in high first-time fixes	4	4 – Somewhat agree	
EC - 1	Empower Citizens	develop a single, coherent strategy, in conjunction with your ICS, for citizen engagement and citizen-facing digital services that is led by and has been co-designed with citizens	3	3 – Neither agree or disagree	
EC - 2	Empower Citizens	make use of national tools and services (the NHS website, NHS login and the NHS App), supplemented by complementary local digital services that provide a consistent and coherent user experience	3	3 – Neither agree or disagree	
EC - 3	Empower Citizens	use digital communication tools to enable self-service pathways such as self-triage, referral, condition management, advice and guidance	3	3 – Neither agree or disagree	
EC - 4	Empower Citizens	ensure that people can access and contribute to their health and care data	1	1 – Disagree completely	
EC - 5	Empower Citizens	ensure that citizens have access to care plans, test results, medications, history, correspondence, appointment management, screening alerts and tools	2	2 – Somewhat disagree	
EC - 6	Empower Citizens	have a clear digital inclusion strategy, incorporating initiatives to ensure digitally disempowered communities are better able to access and take advantage of digital opportunities	3	3 – Neither agree or disagree	
IC - 1	Improve Care	use data and digital solutions to redesign care pathways across Organisational boundaries to give patients the right care in the most appropriate setting	3	3 – Neither agree or disagree	
IC - 2	Improve Care	promote the use of digital tools and technologies that support safer care, such as EPMA and bar coding	4	4 – Somewhat agree	
IC - 3	Improve Care	provide decision support and other tools to help clinicians follow best practice and eliminate unwarranted variation across the entire care pathway	3	3 – Neither agree or disagree	
IC - 4	Improve Care	provide remote consultations, monitoring and care services, promoting patient choice and sustainability	3	3 – Neither agree or disagree	
IC - 5	Improve Care	enhance your collaborative and multidisciplinary care planning using an array of digital tools and services alongside PRSB standards	3	3 – Neither agree or disagree	
HP - 1	Healthy Populations	use data to inform care planning and decision making in your organisation	5	5 – Agree completely	
HP - 2	Healthy Populations	contribute data and resources to the ICS-wide population health management platform and use this intelligence to inform local care planning	1	1 – Disagree completely	current emphasis is at place
HP - 3	Healthy Populations	support the implementation of new ICS-led pathways and personalized care models that use digital platforms to coordinate care seamlessly across settings	1	1 – Disagree completely	
HP - 4	Healthy Populations	make data from your organisation available to support clinical trials, real-world evidencing and the development of AI tools	4	4 – Somewhat agree	
HP - 5	Healthy Populations	drive digital and data innovation through collaborations with academia, industry and other partners	4	4 – Somewhat agree	

Appendix 2 - APRIL 2022 – DIGITAL PROGRAMME STATUS TRACKER

Strategic Theme	Title	Status	RAG
Rotherham Health Record			
	HID10037 Rotherham Health Record	On-boarding workshop held to establish process for standard roll out to organisations and process document produced.	Green
	HID10172 Yorkshire & Humber Care Record	YAS Transfer of Care data feed into Meditech made live on 10/3/21. Some outstanding issues continue to be worked on.	Green
	HID10181 Back Office Digitization	HR Automatic emails ready to be enabled once a start date is agreed with service. Work underway on ED1 forms and linking to eRS via API.	Green
	HID10198 SALSA	Development team capacity increased to accelerate completion and 3rd party development also being utilised to upskill internal team. All components now in parallel development.	Green
Clinical Backbone			
	HID10126 Results Acknowledgement	Work is continuing the actions from the task and finish group. Histology has been reassigned to Jonathan Caudwell a meeting with Histology is planned for 31/3 to test and agree further actions. The process for Dexa scans has been agreed, this will go live once Bone Health can confirm the user information. Unknown clinician numbers have stabilised, the majority now are from clinics booked under generic accounts. A review of these generic accounts (clinicians) is taking place.	Green
	HID10173 Location Aware Hospital	Smart hospital is part of the trust Digital Aspirant programme which includes the tracking of medical equipment. POCs completed and now the trust is entering a tendering process • TENDER EVALUATION in final stage	Green
	HID10180 Elective Bed Planner	On hold due to service pressures	On Hold
	HID10182 Self Service Check-In	Hardware installation remains outstanding for maternity entrance.	Green
	HID10188 Digital Consultations Phase 2	All services with the exception Integrated Sexual Health (ISHS) are now off the Attend Anywhere platform, all user platforms have been suspended for use as per the Trust and SystmOne communications. ISHS will carry out adhoc appointments until the integration is completed. The 3rd party proxy functionality is now live following rigorous testing. HL7 work continues and the solution will be demonstrated on 28th April.	Green
	HID10191 Clinical Noting	The project is progressing with Cardiology, OMFS, Dermatology, Diabetes and Respiratory. Bone Health and HCOP have had their current processes completed but are yet to provide their build requirements. Whilst there are engagement issues with on boarding remaining services, currently the Apps team has no additional capacity to take on additional services.	Amber
	HID10192 Point of Care	Some of the Seca scales have been moved to the main site. The interface has been set up and initial testing has started. CTG order wasn't placed before the financial year deadline and a new business case is being developed.	Green
	HID10193	The remaining machines are now with Clinical Engineering to be built. They will be distributed to Fitzwilliam, Keppel	Amber

	Nursing Observations Phase 2	and A3. There has been a delay to the switch to the new Wi-Fi, this is now planned in for June so this project will be re-planned to fit in line with this.	
	HID10196 Digital Dictation	Testing ongoing with issue currently with Synertec; escalated to ensure a meeting is arranged to work through the issues.	Red
	HID10199 Netcall Patient Hub	The trust has procured the addition of the patient hub system to the already in use Netcall system. This system aims to reduce paper use by sending text/email reminders for appointments to patients. **Rollout Plan Continues**	Green
Infrastructure			
	HID10104 Desktop Infrastructure Strategy	The business case for a 5 year rolling replacement programme has been approved and a quantity of laptops (415) and monitors (200) were purchased in the 2021/22 financial year. Build and deployment processes have been reviewed and distribution is planned to begin in July.	Green
	HID10189 Network Managed Service	Switch over work is underway but has been delayed in some areas due to service pressures. Estimated completion of data and wifi upgrade now March 2022	Green
	Switchboard Replacement	This project will see the upgrade of the legacy telephony system along with the deployment of new IP handsets across the estate. The new telephony system will allow for new functionality and flexibility across the Trust along with better resilience. Delivery is currently delayed due to the over-runs with the dependent data and wifi upgrade.	Green
Information Management and Analytics			
	HID10183 SQL Reconfiguration	Physical servers received and in build and configuration process.	Green
	Rotherham Population Health	Business Case brief approved at Exec meeting.	Green

Appendix 2 – Informatics Digital Programme Plan

Informatics Digital Programme Plan	Work Type	2020/21 Q4 Jan	Feb	Mar	2021/22 Q1 Apl	May	Jun	Q2 Jul	Aug	Sep	Q3 Oct	Nov	Dec	Q4 Jan	Feb	Mar
Rotherham Health Record																
HID10037 - Rotherham Health Record	Workpackage															
HID10172 - Yorkshire and Humber Care Record	Workpackage															
HID10181 - Back Office Digitisation	Workpackage															
HID10198 - SALSA	Project															
Clinical Backbone																
HID1093 - Nursing Observations	Project															
HID10145 - Medical Physics - Respiratory Results	Workpackage															
HID10191 - Clinical Noting Programme	Project															
HID10173 - Location Aware Hospital	Project															
HID10188 - Digital Consultation	Project															
HID10180 - Elective Bed Planner	On Hold															
HID10182 - Outpatients Self-Service Check In	Project															
HID10196 - Digital Dictation Replacement	Project															
HID10199 - Netcall patient Hub	Project															
HID10203 - Anaesthetic Charting	Initiation															
Infrastructure																
HID10104 - Desktop Infrastructure Strategy	Project															
Network Managed Service	Project															
Switchboard Replacement	Project															
Information Management and Analytics																
HID10183 - SQL Reconfiguration	Project															
Rotherham Population Health	Project															

Board of Directors' Meeting
06 May 2022

Agenda item	P89/22
Report	**Board Assurance Framework**
Executive Lead	Angela Wendzicha Director of Corporate Affairs
Link with the BAF	Not applicable as this paper proposes the new Board Assurance Risks to align with the new 5 Year Strategy
How does this paper support Trust Values	
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The following paper sets out the proposed Board Assurance Framework Risk to align with the new approved 5 year Strategy.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The draft Board Assurance Framework risks were initially discussed at the Strategic Board session on 8 April 2022. A focus group comprising Non-Executive Directors, Executive Directors, Director of Corporate Affairs and the Quality Governance, Compliance and Risk Manager took place on 22 April 2022 resulting in the attached proposed BAF risks which have been circulated to the Executive Directors.
Board powers to make this decision	In accordance with the current Constitution, the Board agrees the Trust Strategy and therefore the strategic risks aligned to the same.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Subject to the decision of the Board, monthly one to one meetings are arranged with the relevant Executive Directors to progress the further development of the Board Assurance Framework to the final document.
Recommendations	It is recommended that the Board consider and approve the attached draft Board Assurance Framework Risks.
Appendices	None

1. Introduction

1.1 The Trust Board recently approved the Trust Strategy for the next five years. As a result, there is a need to review and re-focus the Board Assurance Framework to ensure the strategic risks therein are aligned to the new Strategic Ambitions.

2. Development of and Proposed new Risks

2.1 Discussions commenced at the Board Strategic session on 8 April 2022 in relation to the draft strategic risks aligned to the 5 Year Strategy. Following this, a focus group took place on 22 April 2022 with Non-Executive Directors, Executive Directors, Director of Corporate Affairs and the Quality, Governance, Compliance and Risk Manager.

2.2 The attached draft strategic risks at Appendix 1 resulted from the aforementioned discussions. Subject to Board approving the draft strategic risks, work will commence to finalise the current risk scores, agree the target score, the date the target score is expected to be achieved in addition to the detail around controls, assurance, gaps and mitigations.

3. Recommendation

3.1 The Board is asked to:

- Discuss the draft strategic risks and
- Approve and recommend they are used to develop the new Board Assurance Framework.

Angela Wendzicha
Director of Corporate Affairs
May 2022

Appendix 1

Draft Board Assurance Framework Overview: Version 2

Ambition	Strategic Risk			Original Score LxC	Current Score	Target Risk Score	Movement	Risk Appetite/ Risk Tolerance
	There is a Risk that….	Because…..	Leading to…..					
Patients: ***We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them.***	**P1: we will not embed care within the 5 year plan**	**..of lack of resource, capacity and capability**	**..poor clinical outcomes and patient experience for our patients**					
Rotherham: ***We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.***	**R2:we will not establish ourselves as leaders in improving the lives of the population we serve**	**..of insufficient influence at PLACE**	**..increased ill health and increased health inequalities**					
Our Partners: ***We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care.***	**OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system**	**..of lack of appetite for developing strong working relationships and mature governance processes**	**..poor patient outcomes**					
Us: ***We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.***	**U4: we do not develop and maintain a positive culture**	**..of insufficient resources and/or ineffective or inefficient processes and systems**	**..an inability to recruit and retain staff.**					
Delivery: ***We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation***	**D5: we will not deliver safe and excellent performance**	**..of insufficient resource (financial and human resource)**	**..an increase in our patient waiting list backlog and potential for patient deterioration and inability to deliver our Operational Plan.**					
	D6: we will not be able to deliver our services	**..we have not delivered on our Financial Plans for 2022-23 in line with national and system requirements**	**..financial instability and the need to seek additional support to deliver our services.**					

Board of Directors' Meeting
06 May 2022

The Rotherham NHS Foundation Trust

Agenda item	P90/22
Report	**Governance Update**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	
How does this paper support Trust Values	Supports the value 'Ambitious' and 'Together' as we evolve our governance processes in line with the new legislation
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The following report illustrates recent developments within the NHS that impact on the Corporate Governance agenda.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report has not been presented to any other Committee.
Board powers to make this decision	Not applicable, no decision required.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Further work to be carried out by the Director of Corporate Affairs as a result of the introduction of the Health and Care Act
Recommendations	It is recommended that the Board notes the content of the report.
Appendices	None attached.

1. Introduction

The following report provides a summary of updates relevant to the Governance Agenda.

2. Health and Care Act 2022

The Health and Care Bill received Royal Assent on 28 April 2022 resulting in the Health and Care Act 2022, putting Integrated Care Systems on a statutory footing. This is the most significant legislative change in health in over ten years setting up the structures and systems to reform how health and adult social care work together, tackle long waiting lists and address chronic conditions and inequalities in health outcomes.

It is anticipated that the Health and Care Act will ensure the NHS can rebuild from the pandemic and harness the best ways of working to ensure people are benefitting from more joined-up care.

The Health and Care Act introduces measure to tackle the backlog from Covid and rebuild health and social care services over the next three years backed by finances through the Health and Care Levy. In addition, the Health and Care Act builds on the proposals for legislative change as set out in the NHS Long Term Plan.

A separate briefing note will be circulated the Board in relation to the practical implications for the Trust and how we operate in the future. In addition, the Director of Corporate Affairs will commence reviewing the Trust's Corporate Governance documentation to ensure alignment with the new Act.

3. Healthcare Financial Management Association (HFMA)

The HFMA updated their NHS Corporate Governance Map in March 2022. The Corporate Governance Map is a useful tool that deals with four specific categories of corporate governance namely strategic framework, enabling good governance, specific areas of assurance and devolved nations. The updated NHS Corporate Governance Map will be used to review the corporate governance arrangements within the Trust and ensure it is supported by up to date published resources that support the development and maintenance of effective governance arrangements.

4. Recommendations

The Board is asked to note the updates provided above.

Angela Wendzicha
Director of Corporate Affairs