The Rotherham NHS Foundation Trust

Board of Directors
Public AGENDA

Date: **Friday 09 September 2022**
Time: **0900hrs – 1130hrs**
Venue: **Boardroom**

Time	Item no.			Page	Required Actions	Lead
		Procedural Items				
0900	*P124/22*	*Chairman's welcome and apologies for absence*	*Verbal*	*-*	*For information*	*Martin Havenhand, Chairman*
	P125/22	*Quoracy Check*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P126/22	*Declaration of conflicts of interest*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P127/22	*Minutes of the previous meeting held on 8 July 2022*	*Enc.*	*4*	*For decision*	*Martin Havenhand, Chairman*
	P128/22	*Matters arising from the previous minutes (not covered elsewhere on the agenda)*	*Verbal*		*For assurance*	*Martin Havenhand, Chairman*
	P129/22	*Action Log*	*Enc.*	*19*	*For assurance*	*Martin Havenhand, Chairman*
		Overview and Context				
0905	*P130/22*	*Report from the Chairman*	*Enc.*	*20*	*For information*	*Martin Havenhand, Chairman*
0910	*P131/22*	*Report from the Chief Executive*	*Enc.*	*24*	*For information*	*Dr Richard Jenkins, Chief Executive*
		Culture				
0915	*P132/22*	***Staff** Story*	*Verbal.*	*-*	*For information*	*Steve Ned, Director of Workforce*
0925	*P133/22*	*Responsible Officer Report*	*Enc.*	*46*	*For assurance*	*Dr Callum Gardner, Executive Medical Director*
0930	*P134/22*	*Guardian of Safe Working Report*	*Enc.*	*52*	*For assurance*	*Dr Gerry Lynch, Guardian of Safe Working*
0935	*P135/22*	*Freedom to Speak Up Guardian Report*	*Enc.*	*55*	*For assurance*	*Anthony Bennett, Lead Freedom to Speak up Guardian*
		System Working				
0940	*P136/22*	*National, Integrated Care Board and Integrated Care Partnership Report*	*Enc.*	*59*	*For information*	*Michael Wright, Deputy Chief Executive*
		Strategy				
0950	*P137/22*	*Operational Objectives 2022/23 Review Report*	*Enc.*	*109*	*For assurance*	*Michael Wright, Deputy Chief Executive*

Break: 5 mins						
		Assurance				
1005	*P138/22*	*Board Committees Chairs Assurance Logs* *i. Finance and Performance Committee* *ii. Quality Committee* *iii. Audit Committee* *iv. People Committee*	*Enc.*	*131* *134* *136* *139*	*For assurance*	*Committee Chairs and Lead Executives*
1015	*P139/22*	*Care Quality Commission Report*	*Enc.*	*141*	*For assurance*	*Helen Dobson, Chief Nurse*
1020	*P140/22*	*Monthly Integrated Performance Report*	*Enc.*	*151*	*For assurance*	*Michael Wright, Deputy Chief Executive*
1025	*P141/22*	*Urgent & Emergency Care; Performance Indicators - Presentation*	*Pres.*	*-*	*For assurance*	*Dr Richard Jenkins, Chief Executive/ Sally Kilgariff, Chief Operating Officer*
1030	*P142/22*	*Reset and Recovery Operational Report*	*Enc.*	*172*	*For assurance*	*Sally Kilgariff, Chief Operating Officer*
1035	*P143/22*	*Finance Report*	*Enc.*	*182*	*For assurance*	*Steve Hackett, Director of Finance*
1040	*P144/22*	*Maternity Safety including Ockenden monthly report*	*Enc.*	*189*	*For assurance*	*Helen Dobson, Chief Nurse*
		Regulatory Compliance Risk and Assurance				
1045	*P145/22*	*Board Assurance Framework*	*Enc.*	*217*	*For decision*	*Angela Wendzicha, Director of Corporate Affairs*
1050	*P146/22*	*Health Education England Provider Annual Self-Assessment 2022*	*Enc*	*235*		*Dr Callum Gardner, Executive Medical Director*
		Governance				
1055	*P147/22*	*Corporate Governance Report*	*Enc.*	*279*	*For assurance*	*Angela Wendzicha, Director of Corporate Affairs*
1100	*P148/22*	*Standards of Business Conduct Policy*	*Enc.*	*283*	*For decision*	*Angela Wendzicha, Director of Corporate Affairs*
1105	*P149/22*	*Register of Interest: Bi-annual Review*	*Enc.*	*333*	*For assurance*	*Angela Wendzicha, Director of Corporate Affairs*
1110	*P150/22*	*Escalations to the Trust Board of Directors from the Council of Governors*	*Verbal*	*-*	*For noting*	*Martin Havenhand, Chairman*
		For information				
1115	*P151/22*	*Review of Annual Board Planner*	*To follow*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P152/22	*Any other business*	*-*	*-*	*For noting*	*Martin Havenhand, Chairman*

		Date of next meeting: *04 November 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, 08 JULY 2022

Present:
Mr M Havenhand, Chairman
Miss N Bancroft, Non-Executive Director
Dr J Bibby, Non-Executive Director
Mrs H Craven, Non-Executive Director
Mrs H Dobson, 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
Mrs S Kilgariff, Chief Operating Officer
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:
Mrs S Douglas, Deputy Medical Director
Mr I Hinitt, Director of Estates and Facilities
Mrs S Petty, Head of Midwifery (minute P112/22 only)
Mr J Rawlinson, Director of Health Informatics
Mrs J Roberts, Director of Operations / Deputy Chief Operating Officer
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 K Malik, Non-Executive Director

PROCEDURAL ITEMS

P93/22 CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE

Mr Havenhand welcomed all present with apologies for absence noted.

Specific welcomes were extended to Mrs Kilgariff, attending her first meeting as Chief Operating Officer; Mrs Roberts who had recently joined the Trust as Director of Operations and Mrs Douglas, Deputy Medical Director who would be providing interim cover for the Executive Medical Director during August and will be taking over as interim Medical Director from a date in September.

P94/22 QUORACY CHECK

The meeting was confirmed to be quorate.

P95/22 **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.

Miss Bancroft, Non-Executive Director, declared a conflict of interest with regard to agenda item P120/22 relating to the role of Vice Chair and Senior Independent Director.

Dr Shah, Non-Executive Director declared an interest as the South Yorkshire Integrated Care Board (ICB) Doncaster Place Primary Care Provider Collaborative representative, as a number of reports to be discussed detailed the work of the ICB.

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

P96/22 **MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 06 May 2022 were agreed as a correct record.

P97/22 **MATTERS ARISING FROM THE PREVIOUS MEETING**

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

P98/22 **ACTION LOG**

The Board of Directors reviewed the action log, agreeing that log numbers 6 to 10 would be closed. The one remaining open action (number 41 from 2021 relating to the review of the Trust's governing documents) would be undertaken during quarter 3 and 4. Further supporting information was detailed in the later report to support agenda item P118/22 - Corporate Governance Report.

OVERVIEW AND CONTEXT

P99/22 **REPORT FROM THE CHAIRMAN**

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

Ms Hagger took the opportunity to provide supplementary information relating to a workshop session she had attended at the NHS England / Improvement (NHSE/I) Conference, which had related to health inequalities. The Health Service Journal (HSJ) had also published an article on the same subject from Coventry and Warwickshire. It was pleasing to note that the Trust, as detailed

in a later report, was already moving forward in a number of the areas as outlined at the conference and in the HSJ.

P100/22 **REPORT FROM THE INTERIM CHIEF EXECUTIVE**

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

Dr Jenkins indicated that in relation to COVID, due to a rise in cases of the new variant, the decision had been taken to re-introduce mask wearing for all staff, including non-clinical areas. This replicated the position across other Trusts within the system. The number of COVID positive inpatients on a daily basis averaged circa 30 to 35, with staff sickness absences increasing.

On other matters, all members of the South Yorkshire Integrated Care Board (ICB) were now in post, this included Executive, Non-Executive and Partner Directors. The Chief Executive Officer, and a number of colleagues had visited the Trust, and completed a walkthrough of the patient pathway starting from the Urgent and Emergency Care Centre to the Discharge Lounge. Feedback had been complimentary, particularly in relation to staff and processes.

The Board of Directors noted the report.

CULTURE

P101/22 **ANNUAL RESPONSIBLE OFFICER REPORT**

The Board of Directors received the Responsible Officer's Annual Report (2021/22) and statement of compliance.

Dr Gardner took the opportunity to highlight the key points, confirming that the overall appraisal rate stood at 94% and successful transition to the electronic appraisal system (eAllocate). One added benefit of eAllocate was provision of a summary of every appraisal for review by the Medical Director.

Whilst the requirement to submit the statement of compliance had been suspended during the pandemic, the Trust having continued to progress the requirements had also maintained submission of the statement of compliance.

The Board of Directors noted the continued improvements seen over the last 12 months, and approved the Responsible Officers Annual Report and Statement of Compliance.

P102/22 **MORTALITY AND LEARNING FROM DEATHS ANNUAL REPORT 2021/22**

The Board of Directors received the Mortality and Learning from Deaths Annual Report 2021/22 presented by the Executive Medical Director.

Dr Gardner indicated that the latest Hospital Standardised Mortality Ratio, which included COVID, for the rolling 12-month period stood at 98.3. This placed the Trust within the 'as expected' band and one of the better performing organisations in the region. In terms of Summary Hospital level Mortality

Indicator, the rolling 12-month position was 107.5, which again was in the 'as expected' band. The target remained to reduce this to below 100.

The Trust had joined NHS England & Improvement's Better Tomorrow: Learning from Deaths, Learning for Lives programme, which focused on completion of good quality Structured Judgement Reviews (SJRs), and how they can be used to learn and drive improvement. The data available from utilisation of this programme would support thematic analysis by the Divisions.

In responding to a question from Dr Bibby regarding sustaining improvement, Dr Gardner indicated that the Safe and Sound Mortality Group he chaired would be pivotal in driving and maintaining performance. Key to improvement would be quality SJR discussion from the Divisions, utilising the thematic data.

In highlighting section six of the report and the SJR tables where it was noted that no information had been recorded, Mrs Craven questioned whether this would be addressed in 2022/23. Dr Gardner explained that the previous recording system enabled bypassing this comment field which would not be possible in the new system, and the requirement would be further reinforced as part of the training programme.

Dr Jenkins commented that all clinical interventions, through implementing best practice should make a difference for the patient, which in turn would improve quality of care and mortality rates.

In concluding the discussion, Mr Havenhand thanked colleagues for the focus which had been given to mortality during 2021/22, resulting in the continuing improved position. However, it remained important that implemented systems and processes were embedded to sustain the position.

The Board of Directors noted the Mortality and Learning from Deaths Annual Report for 2021/22.

STRATEGY

P103/22 NATIONAL, INTEGRATED CARE BOARD AND INTEGRATED CARE PARTNERSHIP REPORT

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

Mr Wright explained that the report highlighted the NHS reforms effective from 1 July 2002, which would require local Trusts to increasingly work on a system wide basis.

The Board of Directors noted the report and remained committed to Rotherham being fully engaged in working with the South Yorkshire ICB.

P104/22 **OPERATIONAL OBJECTIVES 2022/23 REVIEW**

The Board of Directors received the month two position against the Operational Objectives 2022/23 presented by the Deputy Chief Executive.

Mr Wright reported ten programmes were individually rated green (on track) and three were rated amber (not on track). The position against each, as detailed within the report had been discussed by the Board Assurance Committees.

The Board of Directors noted the report.

ASSURANCE

P105/22 **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 meetings (25/05/22 and 29/06/22)

Miss Bancroft highlighted a number a key matters. The first related to cyber security, with the Committee having been impressed with progress and engagement in this area.

For the next Committee meeting, feedback from the Executive Directors was anticipated as to "What Good Looks Like", the decision making process and any support required from the ICB in relation to operational performance.

As also detailed in the finance report, the cost improvement programme (CIP) was off plan by £626k. However, a number of transformational schemes were understood to be progressing with the position anticipated to recover in subsequent months. From July financial forecasting, and risks and opportunities to inform decision making, would be presented to the Committee.

Mr Havenhand asked whether the Committee were assured as to CIP delivery, as it was known when agreeing the Financial Plan that it would be challenging, however also pivotal in the delivery of the overall plan. Miss Bancroft confirmed that at this stage of the financial year the Committee were assured of the engagement and commitment to progress the programme, and the actions currently being taken. However, it was too early to state or guarantee that the CIP target would be delivered. Future forecast reports will provide greater transparency and clarity of the position.

As Chair of the CIP (Efficiency) Board, Mr Wright added that he was assured that the required infrastructure was in place to support CIP delivery, with all potential schemes explored. Monthly delivery targets had been established, with future reports anticipated to demonstrate positive progress.

ii. Quality Committee (25/05/2022 meeting)

Dr Shah commented that a number of reports for consideration by the Board comprehensively covered various aspects of the quality agenda and therefore

took the opportunity to highlight a number of matters discussed at the Committee's May meeting.

The Community Division had attended the meeting, with good compliance against the two hour Urgent Response Target having been noted.

The Committee had been assured regarding compliance with body mapping requirements, and the role of both the Safeguarding Operational Group and the Safeguarding Committee in monitoring the position. Mrs Dobson reported that since the May meeting she had been further assured by the findings of the latest body mapping audit which had shown 87% compliance.

In terms of Sepsis management, although the Committee had limited assurance in this area, it was acknowledged that a lot of work had commenced by the task and finish group, with the Committee to continue to monitor the position.

There had been no meeting of the Committee in June, with instead a facilitated development session having taken place as detailed in the Board Assurance Committees Report.

iii. People Committee (24/06/2022)

Ms Hagger highlighted the presentation from the Division of Family Health, and although there were challenges in a number of areas, the Committee had been assured that plans were in place.

Progress had been made against the Operational Plan with a significant development yet to be completed in terms of establishment of a Divisional leadership programme. Another programme was to improve staff facilities and increase the wellbeing support available to our staff. On this matter Dr Shah questioned the ongoing discussions regarding the provision of hot meals out of hours. Dr Jenkins reported that a number of options had been piloted but as yet an appropriate way forward had yet to be agreed by the Executive Team.

Sickness absence for May stood at 6.44%, with Mr Ned explaining that changes to the national COVID-19 workforce guidance would result in a move back to the normal (pre-COVID) contractual arrangements in terms of sickness absence. The potential impact on sickness absence rates following this change would be reflected in future reports. However, the message remained that colleagues should continue to stay away from work if they tested positive for COVID-19.

Good progress continued in development of the new Consultant recruitment pack, the Board Assurance Framework, and the Risk Management process. For the latter, the Committee were seeking revisions to the format of the report.

Mr Ned also took the opportunity to highlight the E-rostering system having received a provisional significant assurance rating following a revisit review from the Internal Auditor. Mr Ned placed on record his appreciation to the teams for the focus given to improve this area.

P106/22 **CARE QUALITY COMMISSION ASSURANCE REPORT**

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

Mrs Dobson took the opportunity to confirm that the Section 31 condition received by the Urgent and Emergency Care Centre (UECC) in 2018 had been lifted, and that the Section 29a Warning Notification issued to UECC in August 2021 had now expired with no further urgent sanctions required. However, the Trust would continue to progress improvements as part of the move to deliver quality improvement rather than the emphasis on delivery of CQC recommendations.

A recent engagement meeting with the CQC had included presentations by a number of clinical teams. These had been well received by the CQC and also afforded the teams to have an appreciation of the CQC process. The Trust had welcomed the CQC suggestion of areas for further focus to support the quality improvement journey.

It was noted that a collaborative approach had been established with Barnsley Hospital NHS Foundation Trust, whereby reciprocal quality assurance visits to clinical services were undertaken. A number had already been completed, with more planned. The approach was well received by both organisations and was already proving beneficial.

The report provided an overview of the CQCs *'A new strategy for the changing world of health and social care'*. However, no further detail had been published by the CQC since its launch.

The Board acknowledged the work which had been undertaken to ensure removal of a number of conditions and warning notifications. It was assured that Divisions were now taking ownership of the requirements, with the shift towards quality improvement which would be further supported by the work described in a later report.

The Board of Directors noted the report.

P107/22 **MONTHLY INTEGRATED PERFORMANCE REPORT**

The Board of Directors received and noted the Integrated Performance Report (IPR), which provided an overview of the organisational position across a number of performance metrics and was to be read in conjunction with other reports presented to the Board.

Dr Bibby commented that the report highlighted areas where positive progress was being seen, but also the areas of continued challenge, such as ambulance handover and patient flow, and questioned the steps being taken to address these particular areas.

In terms of patient flow, Mrs Kilgariff explained that a number of work streams were underway in this area, with progress reflected in the report. Actions were

also being taken across the Rotherham system to tackle delayed discharges and utilisation of community capacity.

The Trust in conjunction with the Yorkshire Ambulance Service had piloted a rapid handover process, which having now been evaluated would be rolled out across the system. However, the actions being taken did not lessen the increased demands on all services.

Mrs Tuckett clarified that the mortality position within the IPR was consistent with that reported to the Quality Committee; however, the most up to date position was as reported by Dr Gardner as part of agenda item P102/22.

The Board of Directors noted the Integrated Performance Report.

P108/22 **RESET AND RECOVERY OPERATIONAL REPORT (INCLUDING COVID-19 UPDATE)**

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

As a number of matters had already been discussed as part of earlier agenda items, Mrs Kilgariff highlighted that the national target that no patient was waiting longer than 104 weeks for treatment by the end of July 2022 continued to be monitored. In terms of referral to treatment times (RTT), it was noted that the Trust was ranked 15th out of 120 trusts, with 1st being the best performer. Additionally, the Trust was in the top ten best performers against the diagnostic standard. However, significant challenges remained across specialities relating to workforce.

As noted earlier, COVID cases were rising, resulting in the requirement once again for face masks to be worn and restrictions on visiting, as such Mr Havenhand sought reassurance that these requirements had been widely publicised to the Rotherham population. Mrs Dobson confirmed that information was available on the Trust website, with social media also having been widely utilised. Whilst there were visiting restrictions, there were exemptions in a number of areas including end of life, patients with learning disabilities, maternity and paediatrics.

The Urgent and Emergency Care Centre (UECC), due to the level of attendance would be challenging in terms of managing segregation of patients, with Dr Shah questioning as to whether appropriate steps were being taken. It was confirmed that in order to avoid delays and overcrowding, maintaining patient flow was important. However, there remained an ability to segregate and socially distance waiting patients. Furthermore, air cleaning technology was being actively considered. All patients admitted from the UECC were tested before being moved to inpatient areas.

The Board of Directors noted the report.

P109/22 **FINANCE REPORT**

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

Firstly, Mr Hackett took the opportunity to confirm receipt of the External Auditors Completion Report with an unqualified opinion without moderation having been issued against the 2021/22 Annual Accounts. Whilst one amendment had been identified to the disclosure notes since they had been reviewed by the Board, this had not resulted in any material change to the annual accounts.

As the Board had previously given delegated authority to the Chair of the Audit Committee and Director of Finance to formally sign off the annual accounts once final feedback had been received from the Auditor, this amendment had been included, with the accounts submitted to the regulator by the deadline.

In terms of the month two financial position, Mr Hackett highlighted the following key matters:

- The 2022/23 Financial Plan was a planned deficit of £2.7m;
- Income and expenditure showed a deficit to plan of £136K in month and £269K year to date;
- Capital expenditure of £329K year to date compared to a budget of £435K which was an under-spend of £106K;
- There had been a decrease in cash of £11,422K, with a closing balance of £21,882K as at 31st May 2022, which was £4,422K lower than plan;
- Challenges continued with regards to pay and locum / agency spend, which was necessary to maintain patient and staff safety;
- The month three position against the cost improvement programme would be reported to the Finance and Performance Committee.

Pending announcement of the national pay awards, Mrs Craven questioned as to how these would be funded if they were above the allocation within the financial plan. Mr Hackett explained the financial plan, as requested, had included a 2% inflationary pay uplift. Any material increase above that level would pose a significant challenge as a 1% difference equated to a £2m cost pressure. No central advice had been made available at this time.

Additionally, Dr Jenkins highlighted that there may also be an increased risk of industrial action and disruption to services, following the announcement from the pay review body. Therefore, it would be prudent for both matters – financial and industrial action – to be added to the Trust's risk register.

ACTION – Director of Finance & Director of Workforce

Other unpredictable inflationary costs included increasing energy costs, and the impact on the capital programme as a result of increased market prices.

The Board of Directors noted the month two finance report and the challenges already been seen in a number of areas.

P110/22 **LEARNING FROM COVID**

The Board of Directors received the report presented by the Director of Strategy, Planning and Performance which summarised the challenges faced by the NHS during the pandemic and how the Trust adapted to different ways of working.

Whilst not exhaustive, the report took the opportunity to highlight a number of key reflections, areas of learning and areas which would continue to be taken forward by the Trust.

In response to a question from Dr Shah, Mrs Tuckett agreed that the pandemic had afforded the opportunity to accelerate implementation of a number of planned initiatives, such as virtual consultations. It was anticipated that these would continue to be enthusiastically taken forward by the clinicians and teams particularly as part of the outpatient transformation programme. Mr Rawlinson added that implementation of digital technologies to support services were now not perceived as being IT projects, but were actively being driven by clinicians.

Mrs Craven commented that the speed of decision making had been crucial during the pandemic, and hoped that in returning to business as usual this would not be lost. However, she questioned the process to revert to pre-pandemic ways of working which may not always be as successful, citing SDEC as an example.

In agreeing that maintaining the pace of change would be important, Mrs Tuckett confirmed that models of care and patient pathways would be determined by the factors at any given time. The SDEC model during the pandemic had addressed the requirements; however, the position was now different hence the current model.

Overall, Mrs Kilgariff considered that one of the significant successes from the pandemic had been the level of engagement with front line staff and operational managers, resulting in a 'can do' attitude, which hopefully would be sustained.

The Board of Directors noted the report, which had comprehensively highlighted the actions taken by the Trust during the pandemic.

P111/22 **QUALITY IMPROVEMENT PLAN**

The Board of Directors received the report presented by the Chief Nurse providing an overview of the Quality Improvement Plan.

Mrs Dobson explained that as part of the Five Year Strategy, there was a specific objective relating to quality improvement, with the report presented to the Board detailing the plan and proposed outputs for the next two years.

As culture and leadership would be critical to successful delivery, it was noted that a business case had been agreed by the Executive Team to appoint a

Head of Quality Improvement, and an Associate Medical Director for Quality Improvement.

Based upon the recommendation of the task and finish group, the Trust would be adopting the NHS England / Improvement Quality Service Improvement and Redesign (QSIR) approach.

The first training cohort had commenced with positive feedback from participants, a second was planned for later in the year and a third in March 2023. It was anticipated that the training would equip colleagues with the necessary skills to become competent internal trainers to further roll out the approach**.** As part of the improvement programme, the Board of Directors would also continue its own development with further sessions planned with NHS England / Improvement.

Mrs Kilgariff commented that although focussed on quality improvement, the programme could also support organisational recovery. Dr Gardner further added that the new speciality doctor leadership programme would include quality improvement, thereby further strengthening medical leadership in terms of quality improvement.

The Board of Directors noted the Quality Improvement Plan Report.

P112/22 **MATERNITY SAFETY INCLUDING OCKENDEN MONTHLY REPORT**

The Board of Directors welcomed Mrs Petty, Head of Midwifery, to the meeting to support discussion on this item.

The Board of Directors noted the monthly update report on maternity safety introduced by the Chief Nurse, which also included the position against the Ockenden requirements.

Mrs Petty informed the Board that the continuity of carer position at the Trust had been reviewed, with the conclusion that there would be no further roll out of provision until staffing levels were stable. A new model, which would see the team increase from 8 to 9, would be piloted from mid-July to ensure sustainable care was provided on the labour ward.

The Clinical Negligence Scheme for Trusts (CNST) had been relaunched in May 2022. Although there were two areas of potential challenge relating to Maternity Service Datasets and Multidisciplinary Training, the Trust remained on trajectory to deliver the standards.

The report also detailed the ambitious maternity digital programme, and provided data from the Divisional Integrated Performance Report.

As the Non-Executive Director Champion for maternity, Ms Hagger confirmed that both she and the Chief Nurse had completed their interviews as part of the Regional Ockenden support visit. The review team had acknowledged the approach being suggested in order to access harder to reach communities, which as further explained by Mrs Dobson would include establishment of a

specific maternity public panel to complement the maternity voices partnership.

In conclusion, Mrs Dobson stated that the Trust was recognised at a national and regional level for its excellent work in relation to maternity services, supported by the results in both patient and staff surveys.

The Board of Directors noted the comprehensive monthly report and were assured of the continued positive progress and plans in place.

P113/22 QUARTERLY MEDICAL WORKFORCE REPORT

The Board of Directors received the report providing an update on job planning and Consultant recruitment presented by the Executive Medical Director.

Dr Gardner reported that progress continued in terms of consultant recruitment, with some previously hard to recruit areas such as in medicine now being filled. However, there remained specialities which continued to be challenged which required long term agency staff to mitigate the position.

The Board of Directors noted the report.

P114/22 DATA SECURITY AND PROTECTION TOOLKIT

The Board of Directors received and noted the report which detailed submission of the Data Security and Protection Toolkit (DSPT) assessment for 2021/22 which had been submitted ahead of the 30 June 2022 deadline.

P115/22 SENIOR INFORMATION RISK OWNER ANNUAL INFORMATION GOVERNANCE REPORT

The Board of Directors received the Annual Information Governance Report from the Senior Information Risk Owner (SIRO).

Mr Wright, in his capacity as SIRO, highlighted a number of areas from the report, these were:

- The annual review by the internal auditor had been completed, with a Substantial Assurance rating;
- The target for 95% compliance against the Information Governance Training had been exceeded.

Dr Gardner, in his role as Caldicott Guardian, also added in order to support the content of the report that robust processes were in place for any requests from Law Enforcement Agencies for personal information.

The Board of Directors noted the annual report from the SIRO.

P116/22 HEALTH INEQUALITIES TASK AND FINISH GROUP UPDATE REPORT

The Board of Directors received the report providing a summary of the work undertaken by the Board Task and Finish Group established to identify and prioritise key actions in order to reduce inequalities in outcomes from care.

Mr Wright reported that the key areas to note from the report were:

- "The full patient-level information of our waiting list was analysed to show where differences in waiting times lie. Our initial analysis showed no significant differences in the average length of wait based on patients' levels of deprivation (drawn from postcode data)."
- "Further work was undertaken to identify whether patients from more deprived areas were disproportionately represented within our long waiters, but again, this analysis demonstrated that there is no significant difference for patients from more deprived areas."
- "The opposite is the case when we look at patients' ability to attend necessary outpatient appointments, with the DNA rate for patients from the most deprived background being almost double that of the patients from the least deprived areas. It is likely that this is due to patients' ability to attend appointments during working hours, the cost of transport to attend appointments and other caring responsibilities which make it difficult for people to travel to the hospital."

The Group had considered the programmes and six key deliverables to be taken forward, having analysed significant levels of data to determine the areas for immediate focus. These areas of future work and learning for partners were outlined within the report. Establishment of the Group had provided Board level input in an important area, and provided a framework which could be utilised in the future to progress emerging key matters.

It was apparent that the demographics for Rotherham were not necessarily the same as in other areas, however it would be important to continue to learn from others through such as peer visits.

In terms of the waiting well programme, the Board considered that there may also be a role for such as the voluntary sector and community and social enterprise.

The Board discussed a number of sections of the report, seeking clarity as to the findings and proposed areas of focus.

In response to a comment from Mr Smith with regard to ensuring the national statistics were relevant to the Rotherham population, Mr Wright indicated that there was a Rotherham wide prevention and health inequalities plan led by Director of Public Health for Rotherham, who had also been a member of the Task and Finish Group, with the Trust heavily involved in this work.

Dr Bibby, as Chair of the Task and Finish Group, concluded that it was evident that there was a strong organisational commitment to progress the health inequalities agenda. She considered that there was a clear plan and objectives to be taken forward by the organisation.

In concluding the discussion Mr Havenhand thanked the Task and Finish Group for their work in this area, which was also a key priority for the Integrated Care Board and the wider system. As such it would be important for this work to be appropriately resourced in order to deliver the plans identified within the report presented to the Board.

Although the Task and Finish Group had finished its work and progress in a number of areas would be reported through the Integrated Performance Report, the Board requested a specific update on health inequalities in a few months. **ACTION – Deputy Chief Executive**

The Board of Directors noted the insightful report outlining the health inequalities programme of work, and further supported the proposed plan as detailed within the report.

REGULATORY COMPLIANCE RISK AND ASSURANCE

P117/22 BOARD ASSURANCE FRAMEWORK

The Board of Directors received the report detailing the 2022/23 Board Assurance Framework (BAF) quarter one position presented by the Director of Corporate Affairs.

Ms Wendzicha confirmed that the position against each BAF risk had been considered by the relevant Board Assurance Committee, with the quarter one position as detailed within the report. Quarter two would see re-commencement of the deep dive process.

The Board noted the BAF position, and agreed the minor rewording of risk D5 as detailed within the report.

BOARD GOVERNANCE

P118/22 CORPORATE GOVERNANCE REPORT

The Board of Directors received for information the Corporate Governance Report from the Director of Corporate Affairs.

Ms Wendzicha outlined that following assent of the Health and Care Act, NHS England had undertaken consultation on a number of revised key governance documents including the Draft Code of Governance for NHS provider Trusts and System working and collaboration: The role of Foundation Trusts Council of Governors. A summary of the proposed amendments were as detailed within the report.

Now that the proposed amendments were known, the process of reviewing the Trust's own governance documents, such as the Constitution, could commence.

The Board of Directors noted the report.

P119/22 BOARD ASSURANCE COMMITTEES

The Board of Directors received the report presented by the Director of Corporate Affairs which outlined a number of proposals with regard to Committees reporting to the Board.

Ms Wendzicha informed the Board that following the annual review of Committee effectiveness, and as a result of forthcoming changes to the Non-

Executive Directors, a number of changes were proposed in relation to Committee membership and streamlining of some of the Committees as detailed within the report.

It was clarified that the Charitable Funds Committee would report into the Board (as Corporate Trustee) from September 2022, therefore negating the need for a separate Corporate Trustee meeting.

The Board of Directors:

- Noted the ongoing development work with the Quality Committee and People Committee;
- Approved the revised Terms of Reference for the Finance and Performance Committee;
- Approved the standing down of the Corporate Trustee meeting and incorporating Charity reporting into the Board business;
- Approved the amalgamation of the Remuneration Committee and Nominations Committee;
- Noted the revised Committee membership which would be effective from 11 July 2022.

P120/22 SENIOR INDEPENDENT DIRECTOR AND VICE CHAIR ROLES

Miss Bancroft's conflict of interest with regard to this agenda item was noted.

The Board of Directors received the report detailing the proposal to appoint Miss Bancroft as Vice Chair from 1 October 2022 to 30 September 2025 and Senior Independent Director from 1 October 2022 to 30 September 2023, subject to annual appraisal.

The proposal was approved by the Board of Directors and would be presented to the Council of Governors at their next meeting.

P121/22 ESCALATION FROM COUNCIL OF GOVERNORS

There were no escalation to the Board of Directors following the Council of Governors meeting held on 18 May 2022.

CLOSING MATTERS

P122/22 ANY OTHER BUSINESS

There were no items of any other business.

P123/22 DATE OF NEXT MEETING

The next meeting of the Board of Directors would be held on Friday, 09 September 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	Meeting action formally closed
		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~~ ~~09/09/22~~ 31/12/22	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. Further information included in agenda item P118/22 (July Board meeting). 02.09.22 - Governance documents to be updated at the end of Q3.	Open	
		2022							
11	08-Jul-22	Finance Report	P109/22	Addition to risk register with regards to impact of pay inflation and potential industrial action	DoF & DoW		Meeting arranged for 20 September with Quality, Governance, Compliance & Risk Manager to disuss the risk.	Recommend to close	
12	08-Jul-22	Health Inequalities task and finish group	P116/22	Further update on position to be provided to Board	DCEO	Jan-23	02.09.2022 - MW confirmed with JB that the next update to Board will be January 2023.	Open	
13									

Open
Recommend to close
Complete

Board of Directors' Meeting
09 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P130/22
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 July 2022 Board meeting: • Joint Chief Executive • Medical Director • Vice Chair and Senior Independent Director • Board Assurance Committees • Strategic Board Meeting 5th August 2022 • South Yorkshire and Bassetlaw Acute Federation
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.
Appendices	Appendix 1 is the detailed membership for each Board Committee.

1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 08 July 2022.

2.0 Joint Chief Executive

2.1 Dr Richard Jenkins has been appointed our substantive Joint Chief Executive along with his role at Barnsley Hospital NHS FT. Richard started his substantive role on 1st September 2022.

3.0 Medical Director

3.1 Dr Callum Gardner, the Trust's Medical Director will be leaving the Trust on 9th September 2022 to take up a Medical Director role in Peterborough. The recruitment process to replace Dr Gardner has commenced, and Ms Susan Douglas (Deputy Medical Director) has been appointed Interim Medical Director until the successful candidate is appointed.

4.0 Vice Chair and Senior Independent Director

4.1 The current Vice Chair and Senior Independent Director Lynn Hagger completes her term of office on 30 September 2022.

4.2 The Board of Directors and the Council of Governors have approved the following:

- Vice Chair: Miss Nicola Bancroft be appointed until 30 September 2025 subject to annual review.
- Senior Independent Director: Miss Nicola Bancroft be appointed for 2022/23.

5.0 Board Assurance Committees

5.1 The Board have approved the Chairs of its Assurance Committees as follows:

- Audit Committee

The current Chair of the Audit Committee, Kamran Malik, Non-Executive Director will remain as Chair until 30 June 2023.

- Quality Committee

The current Chair of the Quality Committee, Rumit Shah, Non-Executive Director will continue as Chair until 30 June 2023.

- Finance and Performance Committee

The current Chair of the Finance and Performance Committee, Nicola Bancroft, Non-Executive Director will continue as Chair until 30 June 2023.

- People Committee

The current Chair of the People Committee, Lynn Hagger, Non-Executive Director completes her term of office at the end of September 2022. Jo Bibby, Non-Executive Director commenced as Chair from 11 July 2022 for a period of two years.

- Charitable Funds Committee

The current Chair of the Charitable Fund Committee, Michael Smith, Non-Executive Director completes his term of office at the end of September 2022. Heather Craven will commence as Chair from 01 October 2022 until 30 June 2023.

5.2 Attached at Appendix 1 is the detailed membership for each Board Committee.

6.0 Strategic Board Meeting 5th August 2022

6.1 The Board of Directors addressed two issues, firstly a session on Assurance, both the role of Non Executive Directors including the Board and Assurance Committees holding Executive Directors to account and the role of Executive Directors holding their colleagues to account. Secondly a session led by Anna Burhouse, Director of Quality Development - RUBIS.Qi at Northumbria Healthcare NHS Foundation Trust. This session addressed what a Learning System is and how it supports continuous Quality Improvement.

7.0 South Yorkshire and Bassetlaw Acute Federation

7.1 The South Yorkshire and Bassetlaw (SYBAF) has produced its Annual Report for 2021/22 and it has been posted on our website.

7.2 The Acute Federation Board has been working with the NHS England and Improvement 'Provider Development Team' to prepare for the new Integrated Care Boards which were established on 1st July under the Health and Social Care Act 2022. Board members of all five acute trusts in South Yorkshire and Bassetlaw met virtually on 16th May to discuss the Acute Federations Purpose Statement, objectives and priorities for the next two years. Another All Board event has been scheduled for later in September.

7.3 A Foundation Trusts Governor Conference is being planned for early October for all governors from both Acute and Mental Health and Community Foundation Trusts. This will include: presentations from Chair/Chief Executive of the ICB; NHS Providers about the Addendum to the Health and Care Act and the role of governors.

Martin Havenhand
Chairman
August 2022

Board Committee Membership with effect from 11 July 2022

Board Committee	Non-Executive Directors								Executive Directors							
	Martin Havenhand	Lynn Hagger	Nicola Bancroft	Heather Craven	Jo Bibby	Kamran Malik	Rumit Shah	Mike Smith	Chief Executive	Deputy Chief Executive	Medical Director	Chief Operating Officer	Chief Nurse	Director of Workforce	Director of Finance	Company Secretary
Audit Committee						Chair	M	VC					M		EL*	Attendee
Finance & Performance Committee		VC	Chair			M				M		M			EL*	Attendee
Quality Committee				M	VC		Chair				M	Attendee	EL*			Attendee
People Committee		M	M		Chair			VC		M			Attendee	EL*		Attendee
Nomination Committee	Chair	M	M	VC	M	M	M	M	M					EL*		Attendee
Charitable Funds Committee		M		VC				Chair		M	M	M	M		EL*	Attendee

Notes:

1. Executive 'attendees' do not count towards the quorum and neither are they voting members. It is not expected that they will provide regular reports to the committee. However, it is envisaged that their attendance will bring greater depth and understanding to support the assurance role of the committee.
3. The Chairman or Chief Executive may attend any committee meeting as an ex officio, non-voting attendee.
4. The Director of Corporate Affairs/Company Secretary may attend any committee meeting as part of their governance role.
5. EL* = non-member, non-voting committee lead Executive.
6. First four committees on the chart = assurance committees

Board of Directors' Meeting
09 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P131/22
Report	**Chief Executive Report**
Executive Lead	Dr Richard Jenkins, Interim Chief Executive
Link with the BAF	The Chief Executive's report reflects various elements of the BAF
How does this paper support Trust Values	The contents of the report have bearing on all three Trust values.
Purpose	**For decision ☐ For assurance ☐ For information ☒**
Executive Summary (including reason for the report, background, key issues and risks)	This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest including: • Covid-19/Recovery • ICS and Rotherham Place • CQC • Staffing The items are not reported in any order of priority.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper reports directly to the Board of Directors.
Board powers to make this decision	No decision is required.
Who, What and When (what action is required, who is the lead and when should it be completed?)	No action is required.
Recommendations	It is recommended that: The Board note the contents of the report.
Appendices	1. Updates from Gavin Boyle, Chief Executive (Designate) SY ICB

1.0 Covid-19

1.1 **Activity:** The number of Covid-19 positive in-patients has been at a steady rate for the majority of the reporting period, however, we are now beginning to see numbers fall slowly. As of the 24th August 2022, since the start of the pandemic, the Trust has seen 5367 cases with sadly 877 deaths. Staff absence is also beginning to recover. About 1 in 40 people locally have Covid-19 currently.

1.2 The Trust continues to undertake a regular review of its restrictions practice and following the last review, it has announced the removal of a requirement for face masks to be worn. Initially, this was agreed in non-clinical areas, however following a decision to extend, this will now include most clinical areas and caring for patients in their own homes.

However, masks should still be worn where colleagues are caring for patients who are Covid-19 positive or have symptoms of Covid-19 and staff have been asked to consider risk assessing mask use when caring for immunosuppressed or vulnerable patients, or in areas where people may have Covid-19. It has been made clear that we will continue to scale our response to Covid-19 up and down in line with community infection rates over the coming months, and therefore mask wearing could be reintroduced.

Routine covid-19 testing of asymptomatic patients and staff has now been discontinued with a few exceptions, for example patients being discharged to a care home or patients who are particularly at risk, such as those with immunocompromised.

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 peak of Covid-19 demand and the resulting bed pressures, as well as increased sickness amongst our own staff. We have had to proactively reduce our theatre timetable given sickness levels amongst our Anaesthetic team, and our Orthopaedic elective ward has been closed for the last four weeks to accommodate non-elective patients. We have continued to experience medical workforce shortages in particular areas, which has exacerbated the demand and capacity challenge we are facing. The size of our overall waiting list has increased in the last two months, and now stands at over 25,000 patients at the end of July, close to a 50% increase compared to April 2021. The number of 26+ week waiters has increased further to just under 3,400, and is almost triple what it was in November 2021. Within these figures, there are a handful of significant pressure points, with 4 specialties accounting for over half of our 18+ week waiters (Trauma & Orthopaedics, Ophthalmology, OMFS and Gynaecology). Recovery plans at specialty level are being finalised, with actions incorporating elements of increasing core capacity, utilising our existing capacity more efficiently and re-designing pathways and ways of working to better manage the increasing demand. The Trust reported a small number of patients waiting over 104 weeks at the end of July which was related to pathway tracking and validation rather than capacity and all those patients have now been treated.

Following some recent investment in additional external capacity in certain specialties (including ENT and Rheumatology), waiting times in these two areas have fallen, and the position is now more positive, albeit it is fragile given the anticipated ongoing workforce challenges in these specialties. Further recovery investment has been agreed in the last two weeks, with ten further schemes agreed for implementation in Q2 and Q3, including insourcing of outpatient, diagnostic and theatre capacity, use of the independent sector within Rotherham and additional weekend clinics. Teams are also taking opportunities to introduce new ways of working in order to better manage the demand and to maximise our capacity, particularly within outpatient settings, given the national programme of work which has been set out. Whilst all Trusts are facing similar elective

care challenges, Rotherham remains in the top twenty acute or combined Trusts in the country for overall Referral to Treatment (RTT) performance in June (latest national data).

1.4 **Urgent and Emergency Care Activity (UECC):** The Trust has seen steady demand for our UECC services throughout the reporting period, albeit with high acuity and sustained pressure across the region resulting in ambulance border deflects at times. The Length of Stay of patients in the Trust has increased and delays in discharge have impacted the operational flow of the trust, which has resulted in additional pressure on our elective capacity due to the need for non-elective beds. Operational plans were put in place for the August bank holiday weekend, with a focus on creating capacity prior to the bank holiday and recovery following the extended weekend.

Work continues with partners in Rotherham and in the SY region to look at discharge pathways to support flow throughout the trust. This includes bed based community provision and home based care, alongside continuing to work with Yorkshire Ambulance Services around admission avoidance and reducing conveyances to hospital.

1.5 **Covid-19 and Flu Vaccination Programme:** The Trust has agreed a proposed model for the delivery of the Autumn Covid-19 Booster and Influenza programme for staff in accordance with NHS England and final Joint Committee on Vaccination and Immunisation (JCVI) advice.

2.0 Integrated Care Board (ICB), Acute Federation and Rotherham Place Development

2.1 The SYB ICB has now commenced formally as of 1st July 2022. Over the past few months partners in South Yorkshire have been working together to build and develop an Integrated Care Board (ICB), an Integrated Care Partnership (ICP), and place based partnerships and provider collaboratives and alliances that are ready for the formal launch date. Please see appendix one further information along with the Chief Executive (Designate) updates for June (and additional one prior to the formal launch date of 1st July, July and August 2022.

2.2 The ICB agreed to take part in a Care Quality Commission (CQC) Test and Learn process as a step in developing future system regulatory processes in a co-creation approach. The South Yorkshire System is one of a handful nationally being involved in this partnership process. The CQC Inspection Team and a number of specialist advisors commenced the review on Monday 8th August 2022, which lasted for 5 days and asked the ICB to involve partners to share their experiences of working within the system. A number of Board colleagues from Rotherham participated.

2.3 The South Yorkshire and Bassetlaw Acute Federation are holding a development session on Monday 19th September 2022. Following the work already undertaken with the NHS England team, to identify its shared purpose and priorities in the context of current system pressures and changes, this session aims to involve a much wider group of senior leaders across organisations, to share progress on collaborative working and to gain views on how colleagues feel the Acute Federation could make the biggest difference. All Board members along with five Clinical Leaders from each organisation have been invited to participate in the session.

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

3.0 Care Quality Commission Update

3.1 Routine engagement meetings continue with the CQC, with the most recent one taking place on 25th August 2022. All actions are being tracked through appropriate committees and the CQC Delivery Group, which meets monthly. Further detail on the work associated with the CQC can be found in the Chief Nurse's report.

4.0 Staffing

4.1 I reported last time, that our Medical Director would be leaving the Trust in the autumn. I can confirm that Dr Gardner's last working day will be Friday 9th September 2022 and interviews to replace him have been scheduled for 13th September 2022. Mrs Susan Douglas has been appointed as Interim Medical Director.

4.2 The National Staff Survey for 2022 will commence in October and the Trust is currently reviewing its processes to ensure maximum participation by staff.

5.0 Miscellaneous

5.1 I am pleased to report that the Trust has been awarded as a National Joint Registry (NJR) Quality Data Provider for 2021/22. The NJR Quality Data Provider scheme was devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory data NJR submission quality audit process and by awarding certificates the scheme rewards those hospitals who have met the targets. To gain Quality Data Provider (QDP) status hospitals were required to meet the targets for best practice; increase engagement and awareness of the importance of quality data collection and embed the ethos that thorough and accurate data ultimately enables the NJR to develop improved patient outcomes.

Dr Richard Jenkins
Chief Executive
September 2022

Update from Gavin Boyle, Chief Executive Designate of South Yorkshire Integrated Care Board

This update goes to the wider partners in health and care in South Yorkshire and Bassetlaw (SYB) to keep everyone informed. To join our distribution list please email: helloworkingtogether@nhs.net

Thursday 30th June 2022

Dear Richard

Today's bulletin is an extraordinary bulletin with a focus on our new organisation, the NHS South Yorkshire Integrated Care Board (ICB) or NHS South Yorkshire, which comes into being this friday (1st July 2022). We hope you find it useful. If you have any queries please email helloworkingtogether@nhs.net

NHS South Yorkshire Integrated Care Board (ICB)

Following several years of locally led development, recommendations from NHS England and NHS Improvement and Royal Assent of the Health and Care Act (2022), in the coming week on 1st July 2022, 42 ICSs will be established across England on a statutory basis, including our own South Yorkshire Integrated Care System.

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

Each ICS includes:

- an Integrated Care Partnership (ICP) – a statutory committee jointly formed between the NHS Integrated Care Board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with

improving the care, health and wellbeing of the population. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

- an Integrated Care Board (ICB) – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. When ICBs are legally established, clinical commissioning groups (CCGs) will be abolished. Our ICB is called NHS South Yorkshire.

- within each ICS, place-based partnerships will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.

- provider collaboratives and alliances will bring providers together to achieve the benefits of working at scale across multiple places and one or more ICSs, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers.

The purpose of ICSs is to bring partner organisations together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Over the past few months partners in South Yorkshire have been working together to build on all the exceptional partnership working that has taken place in our area for many years, and develop an ICB, an ICP, place based partnerships and provider collaboratives and alliances that are ready for 1st July 2022.

I am confident that this work has put us in an excellent position to launch our new organisation and refreshed partnerships and to embark on the start of the next leg of our partnership journey in South Yorkshire.

The first meeting of the Integrated Care Board will take place in public on 1st July 2022 and a recording of the meeting and details of how to view it will also be posted in due course on https://syics.co.uk/about/meetings-and-minutes.

You can find the papers for this meeting and the link for the live stream on the ICS website https://syics.co.uk/about/meetings-and-minutes they have been here from Friday 24th

June.

From 1st July a new ICB website will be launched https://southyorkshire.icb.nhs.uk/. On the website you will find the constitution for the ICB and information about our Executives, Non-Executives and Partner Members, as well as our governance arrangements and mechanisms and our organisational priorities.

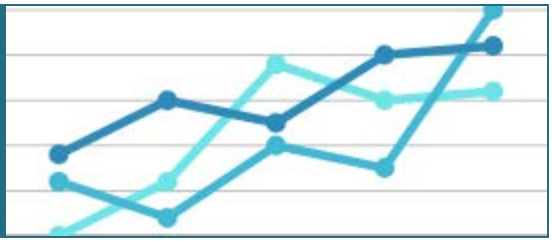
Partners should continue to work with us and our colleagues as they have in recent months, your local place based and system contacts will not be changing at this time.

I would like to thank all the organisations, partners and colleagues who've worked with us to get us to the place where we're all set to take on our legal responsibilities from 1st July 2022, and I look forward to continuing working with you towards our aims of improving outcomes and tackling inequalities for our population.

Thank you

Gavin

COVID-19 data dashboard



The latest Sitrep data for the Yorkshire and Humber region and our five places can be viewed online:

https://coronavirus.data.gov.uk/details/cases

Partners' news

South Yorkshire and regional

Weekly blog, written by the South Yorkshire PCC, Dr Alan Billings:

PCC Blog 107 - South Yorkshire Police and Crime Commissioner (southyorkshire-

pcc.gov.uk)

Fixed Term Post/Secondment Opportunity: SYB Clinical Network Delivery Lead for Cardiac Rehabilitation

The Cardiac Network put in an EOI for some funding from NHSE to decrease inequalities in access to cardiac rehabilitation services in SY.

The Network were successful with the bid and have secured funding for some more in-depth work to look at how we can collaborative enhance cardiac rehab services, ensuring increased access and decrease in health inequalities.

The Network are looking for two people to help with the work:

- Fixed term band 7 project manager
- One day a week of clinical expertise.

Expression of interest form can be found here.

COVID-19 Spring booster vaccination programme

The NHS's top doctor has urged people who still need a spring booster vaccination to come forward as soon as practically possible.

Since March, the NHS has been offering spring booster doses to all people aged 75 years and over, people aged 12 years and over with a weakened immune system, and residents in older adult care homes. See earlier press release here.

The NHS has now invited everyone eligible for this dose (more than 5 million in total), and more than 4 million have already had their jab.

NHS Pride Pack 2022

As part of Pride Week 2022, NHS England have developed a Pride Pack which includes details of events happening across the counrty, NHS Pride resources and information on how you can get involved. You can access the pack here.

Health and care staff honoured in NHS Parliamentary Awards

Nurses, midwives, doctors, vaccination teams and domestic staff are among those celebrated in a prestigious competition to mark the NHS's 74 birthday, as the NHS Parliamentary Awards shortlist is revealed.

A number of trusts in our region have been recognised for their hard work, including:

- Future NHS Award: Cystic Fibrosis HealthHub, Sheffield Teaching Hospitals NHS Foundation Trust

- The COVID Response Award: Barnsley Facilities Management - Hospital Estates Team

Congratulations to everyone shortlisted. The full shortlist can be viewed here.

Leadership for Integrated Care Programme - Cohort 2 Primary Care Networks

The North East and Yorkshire Leadership Academy are delighted to announce that applications for the Leadership for Integrated Care Programme (Cohort 2) are now open.

This programme will be delivered by The Staff College and is designed for clinical and care professional leaders within Primary Care Networks working across North East and Yorkshire. This is a multi-professional leadership programme for leaders who are involved in leading within transformation and change within their system.

The aim is to develop a pipeline of clinical leaders able to lead positive change within the new integrated care architecture.

More information can be found here.

Campaign to address everyday micro-aggressions women face in night time economy - 'No More'

South Yorkshire Police have produced a campaign called ‘No More’ which is focused on the micro-aggressions women experience from a minority of men, particularly within the night time economy. It is bold and courageous and amplifies the women’s voices using the language which they used when sharing it with us. This includes captions such as ‘No more d*ck pics’.

More information and assets to share can be found here:
https://www.nomore-standwithus.com/
https://youtu.be/thtnDlqqsM8

Barnsley

It's been a whole year since the official launch of Barnsley's vision and ambitions for 2030.

Over the last 12 months, the Barnsley 2030 Board, comprised of key stakeholders from across the borough, have been working together to drive the Barnsley 2030 ambition forward.

Watch some of the fantastic stories on the BMBC website from people who share the 2030 vision and their contributions to Barnsley.

You can find out more at Barnsley2030.co.uk.

Doncaster

Understanding people living with a learning disability - a blog by Dr David Crichton, Chief Medical Officer, SY ICB.

Rotherham

Rotherham's Health and Wellbeing Board have agreed plans for Rotherham to work towards a Breastfeeding Friendly Borough status.

The pledge will see Rotherham Council and health partners, along with children's and young people's services, working together to ensure parents make informed and supported choices when it comes to caring for their children. Read more here...

Sheffield

The NHSE Northern Region Community Mental Health team have recently produced a video, made in Sheffield to showcase Primary and Community Mental Health Transformation.

The video is now formally published and is available via the Youtube link here.

Health and care updates from NHS E/I

NHS North East and Yorkshire

Updates up to and including 30th June 2022

Early value assessment: Driving innovation into the hands of health and care professionals

Join NICE for a virtual event to hear about their new approach to providing early value assessments to identify and review the most promising medical technologies that can be used in the NHS.

Discover how this approach will provide quicker assessments, helping NICE to actively draw in digital products, medical devices and diagnostics that address national unmet needs, as set out in the Life Sciences Vision and the NHS Long Term Plan.

Learn how this will help drive innovation into the hands of health and care professionals and give patients faster access to the most promising technologies.

Register for the event now.

Clean Air Day 2022

On Clean Air Day 2022, NHS England has announced that for the first time, every trust in the country now has their own roadmap to tackle climate change and meet the NHS's net zero commitments.

The Sun Who Cares Wins Awards

The Sun's Who Cares Wins awards are back and they need nominations for health heroes across the country. The annual awards, in partnership with NHS Charities Together, honour the extraordinary people that keep our health service running, from cleaners to porters, nurses to doctors and paramedics.

In particular, they are looking for more nominations in the categories below:

- Mental Health Heroes
- 999 Heroes
- Best Nurse

Entries close on July 12. Click here to nominate.

Get in touch at helloworkingtogether@nhs.net or call 0114 305 4487

South Yorkshire Integrated Care System

Update from Gavin Boyle, Chief Executive of South Yorkshire Integrated Care Board

This update goes to the wider partners in health and care in South Yorkshire to keep everyone informed. To join our distribution list please email: helloworkingtogether@nhs.net

Friday 15th July 2022

Dear Mark

Since my last bulletin two weeks ago, I'm delighted that we have now officially and legally become the organisation NHS South Yorkshire Integrated Care Board (ICB). In this week's bulletin you'll hear more about my reflections on this, as well as the increase in Covid infections, the awarding of the George Cross to the NHS and another opportunity to join our behavioural science academy.

NHS South Yorkshire's establishment

July 1st 2022 marked a milestone in NHS history, not so much because of the establishment of the ICBs, but because it marks a significant change in direction. For the last 30 years the NHS has been organised on the principles of competition and the market to raise standards and allocate resources. Today, with the implementation of the Health and Care Act 2022, we see a change in direction towards partnerships, collaboration, and the integration of services. I think most of us working in health and care have always sought to work well with our partners and I think there's a great track record in South Yorkshire of doing just that, however this change puts that spirit of partnership and collaboration on a solid footing.

We had our first Board meeting on the morning of our establishment and as well as taking the necessary decisions to establish the ICB we also considered a fabulous story describing a partnership between people with mental health conditions, NHS colleagues, the charitable and voluntary sector, and the Local Authority to develop a better more integrated model of

service. It was a great example of integrated care where we can use the new ways of working to make this kind of approach not the exception but the rule. You can view our board meeting on our new website .

NHS receives George Cross

Earlier this week NHS England Chief Executive Amanda Pritchard and May Parsons, the nurse who delivered the world's first COVID-19 vaccination outside of a clinical trial, received the George Cross on behalf of the 1.5 million NHS colleagues in England. The George Cross, the highest civilian award for gallantry, recognises the incredible dedication, courage, compassion and skill shown by NHS colleagues over more than seven decades, particularly in the face of the Covid pandemic. This is only the third time the George Cross has been given to a collective body since its introduction in 1940, and it is granted in recognition of "acts of the greatest heroism or of the most courage in circumstances of extreme danger".

In accepting the award Amanda highlighted how she continues to be inspired every day by the ability of NHS colleagues to strive for improvement and to do the very best for our patients. She shared her vision that together, we will continue to innovate, to pioneer new treatments and to make the very best use of technology, with the singular goal of improving the lives of everyone in our society.

I know many NHS colleagues read this bulletin so I'd like to take this opportunity to congratulate you on your role in this achievement, and to thank you for your ongoing commitment and dedication. I hope seeing the George Cross presented to the organisation you work for gave you the sense of pride it should in the fantastic and important work you do.

Increase in Covid cases

Unfortunately, as you will likely have seen in the news, Covid cases are on the increase at the moment, and South Yorkshire is no different in this from the rest of the country. The latest figures from the end of June suggest that over 2 million (one in 25) people in England have the virus. Increasing figures are likely to be caused by Omicron variants BA.4 and BA.5.

It is important that we do everything we can to make sure that everyone continues to feel safe and that we protect ourselves and others. We are anticipating further waves in the autumn and winter and plans continue to be in place to continually monitor, risk assess and adapt the South Yorkshire approach to best support our colleagues and protect our communities.

SYB ICS Behavioural Science Academy

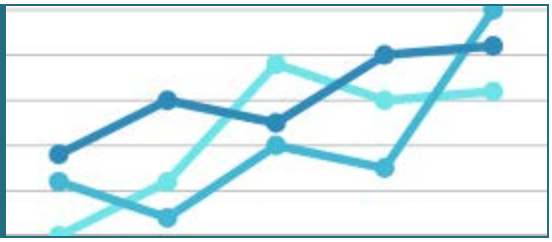
Finally, following a successful first cohort, the South Yorkshire Behavioural Science Academy is now recruiting to the 2nd cohort. The Academy aims to ensure the embedding of Behavioural Science understanding and the development and use of nudge interventions and assets to improve health outcomes is scaled up to make a real difference in SYB. If you

would like to lead the way and become a Behavioural Science Change Facilitator visit https://canceralliancesyb.co.uk/what-we-do/early-diagnosis/behavioural-science-academy or email syicb-sheffield.shefccgbehaviouralscience@nhs.net for more information. Applications close on 25th July.

Thank you

Gavin

COVID-19 data dashboard



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https://coronavirus.data.gov.uk/details/cases

Local news updates

South Yorkshire and regional

Weekly blog, written by the South Yorkshire PCC, Dr Alan Billings:

PCC Blog 109 - South Yorkshire Police and Crime Commissioner (southyorkshire-pcc.gov.uk)

Des Breen, South Yorkshire and Bassetlaw ICS Medical Director

At the end of July we will say farewell to our colleague Des Breen who has been the system Medical Director for 8.5 years, firstly in the Working Together Programme, then New Care Models vanguard and then the ICS. Des has played a key role in the development of the ICS and he has led transformational change in many areas including hospital services, the cancer alliance, health inequalities, harm minimisation and much more. He was the key

clinical figure in SYBs response to the Covid-19 pandemic. He has contributed to many forums regionally on behalf of SYB including the AHSN, Regional Peoples Board, Diagnostic Assurance Board, the Critical Care Advisory Cell and the Transition Oversight Group.

Des has worked nationally bringing his experience as an ICS medical director to the National System Transformation Team. He was key in the development of a variety of national guidance and role profiles. Not least the guidance on clinical and care professional leadership which he led nationally and helped develop this within SYB. He is also helping other integrated care systems as they progress through their development journey. He chairs the national ICS clinical leader's network.

Des has enjoyed the variety of these different roles and being a mentor to his many clinical and non-clinical colleagues. In the future will continue in his national role helping other systems whilst developing a portfolio career. We would like to thank Des for the huge contribution he has made over the years and wish him well in the future.

Be prepared for the hot weather this weekend

With the weather set to reach over 30 degrees across the country this weekend, we would like to share some advice on how to cope in the heatwave. Read more here.

Barnsley

Barnsley Council has launched a new service to help end rough sleeping in our borough.

The council's Housing Led Support Team will work alongside partners to deliver long-term, intensive support, helping people with complex needs who are sleeping rough, facing a housing crisis or have a history of housing instability.

Read more here.

Doncaster

Doncaster has made it to the six-strong shortlist to become the headquarters of Great British Railways. Following strong applications from 42 local authorities across Britain, the city of Doncaster is now one of just a handful remaining before a public vote.

Read more here.

Rotherham

There's additional financial support on its way for families, pensioners and care leavers in Rotherham to help with hardship caused by the cost of living crisis.

Rotherham Council's Cabinet announced initial plans for how it intended to allocate its share of the Household Support Fund in May this year.

Read more here.

Sheffield

Sheffield Children's has welcomed the arrival of the first group of nurses recruited from the region of Kerala in India who will be joining the team over the next few months.

This is part of the Trust's ongoing commitment to recruit as many newly qualified and experienced nurses as it can to offset the local effects of the national nursing shortfall of almost 40,000 nurses.

Read more here.

Health and care updates from NHS E/I

NHS North East and Yorkshire

Updates up to and including 15th July 2022

Advice on staying Covid safe over summer

With summer well underway and social gatherings returning as part of normal life, Covid-19 infections may seem like a distant memory, but with transmission rates rising in the North East and Yorkshire, and England, we must remain cautious.

The region's NHS medical director, Dr Yvette Oade, says there are simple things we can all do to protect ourselves, our families and friends from the risk of serious illness.

Read more here.

Commonwealth Games Time campaign

As part of the Physical Activity & Wellbeing legacy ambition for the Birmingham 2022 Commonwealth Games, which aims to 'accelerate awareness and understanding of mental health and wellbeing issues', DHSC is asking partners to support a Commonwealth Games-inspired campaign to encourage the population to get active as a means of improving their mental wellbeing (as well as their physical health).

The Better Health - Let's do this campaign launched last week and shares hints and tips on how staying active can help your mental health. The aim is to motivate and inspire people to try something new, taking advantage of the Commonwealth Games as a potential moment to improve health and wellbeing.

Thousands of patients to benefit as NHS marks 100th fast-tracked cancer drug

Thousands of people a year with advanced breast cancer will benefit from a life-extending drug that has been fast-tracked onto the frontline of NHS patient care.

The drug, alpelisib, will be used in combination with the hormone therapy, fulvestrant, to target the gene that causes fast-growing tumours.

Up to 3,000 people a year with a certain type of secondary breast cancer will benefit from the treatment, which is the 100th cancer drug being fast-tracked to patients under the NHS Cancer Drugs Fund (CDF), with 80,000 benefitting from a CDF drug in just over five years.

Read more here.

School Aged Immunisation Services survey

School Aged Immunisation Services across the North East and Yorkshire would like feedback from colleagues across the region including from people who work with the service, or have immunisations provided by the service, to help us understand if the service currently meets the needs of all of our population or if any improvements could be made. Click on the following link: School Aged Immunisation Service Survey (office.com)

Get in touch at helloworkingtogether@nhs.net or call 0114 305 4487

NHS
South Yorkshire
Integrated Care Board

Update from Gavin Boyle, Chief Executive of South Yorkshire Integrated Care Board

This update goes to the wider partners in health and care in South Yorkshire to keep everyone informed. To join our distribution list please email: helloworkingtogether@nhs.net

Thursday 18th August 2022

Dear Richard

Welcome the latest edition of our Stakeholder Bulletin where you will find an update from our recent CQC visit, details on this year's HSJ awards and the latest information from across Rotherham, Doncaster, Barnsley and Sheffield.

** Update ** South Yorkshire Integrated Care System (ICS) pilot for of CQC Test and Learn process

As mentioned in my last update, NHS South Yorkshire was approached by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England, to support them in a pilot which will assist in the development of an inspection model for ICBs and ICSs.

The CQC is responsible for ensuring that health and social care services provided are safe, effective, compassionate and of a high quality. Formal inspections of ICBs ICSs will begin in 2023, the model for Local Authorities is also being developed alongside this approach.

Between 8-12 August 2022 we had the pleasure of hosting colleagues from the CQC. Across the 4 days we held a series of interviews and focus groups with our executive members resulting in some great discussions centred around various aspects of our current work and our relationships with our partners.

This pilot is designed to help to test the CQC's approach and enable them to learn from this as they develop their inspection model and the key lines of enquiry that will sit alongside it. It was an honour to be selected to support them in this test and learn phase. We will continue to keep you updated on the results of this pilot over the coming months.

Three South Yorkshire Healthcare Providers Shortlisted in HSJ Awards 2022

NHS South Yorkshire is delighted that three providers from our region have been shortlisted at this year's Health Service Journal Awards (HSJ) Awards, the most prestigious showcase for NHS services. Read more here.

South Yorkshire outperforming other areas in push to improve care

A new report has found that health and care partners in South Yorkshire are outperforming other areas when it comes to joining up services for patients. That's despite higher than average levels of deprivation. Read more here.

Autumn COVID-19 booster and flu vaccine programme

NHS England has now set out plans for the COVID-19 autumn vaccine rollout, beginning in September.

The NHS will become the first healthcare system in the world to use the next generation, bivalent COVID vaccine when it kickstarts the autumn booster rollout in early September. Read more here.

Local NHS staff feature in new campaign to explain support available within GP surgeries

The NHS in North East and Yorkshire have launched a new campaign, "Meet your General Practice Team", to help patients better understand the roles of health professionals working in General Practice who are available to support them with their health care needs. Read more here.

NHS Genomics Healthcare Summit – An Invitation To The Future Now

The inaugural NHS Genomics Healthcare Summit will be held this October. The summit is a chance to explore how genomics is transforming patient care and clinical services today. You'll hear from senior NHS England leaders, visionaries in the field of genomics, from patients and carers, explore the latest advances, and find out about ongoing plans for implementation in the NHS. The summit is free for NHS staff & aimed at:

- NHS staff from across England (national, regional, ICS, ICB)
- Members of Professional Bodies
- NHS Provider organisations
- Academia
- Partner organisations that work with the NHS – NIHR, NICE
- Patient charities and advocacy groups
- Members from the Life Sciences sector

Date: Wed 12 October 2022
Time: 9am - 5.15pm
Place: Grand Connaught Rooms, London, WC2B 5DA

Registration: https://www.pccevents.co.uk/NHSgenomics2022

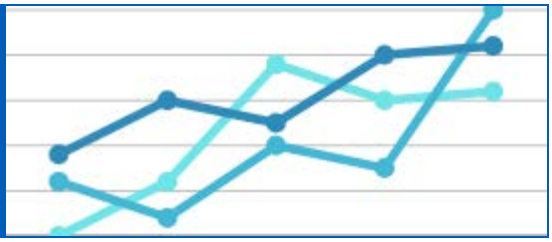
For further information email england.genomics@nhs.net

I hope you find this a useful update and if you do have any feedback about what would make it more useful, or anything about which you would like to hear more, please email helloworkingtogether@nhs.net

Thank you

Gavin

COVID-19 data dashboard



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South Yorkshire and regional

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Barnsley

Cabinet to review annual reports highlighting the great work happening to safeguard adults and children in Barnsley.

Cabinet members will be asked to approve the latest annual reports of the Barnsley Safeguarding Adults Board (BSAB) and Barnsley Safeguarding Children's Partnership (BSCP) when they meet on Wednesday 17 August 2022. Read more here.

Doncaster

Naming of Doncaster as a city.

Doncaster was granted city status as part of this year's Queen's Platinum Jubilee celebrations. Naming a city involves a detailed official process and HM Crown Office will issue the granting documents and scroll that will officially mark it becoming a city from 1 November 2022. Read more here.

Rotherham

Dr Richard Jenkins appointed Chief Executive at The Rotherham NHS Foundation Trust on a substantive basis.

Dr Richard Jenkins has been appointed Chief Executive of The Rotherham NHS Foundation Trust on a substantive basis from 1 September 2022, alongside his existing role at Barnsley Hospital NHS Foundation Trust.

In addition to his role at Barnsley, Richard has been Rotherham's Interim Chief Executive since February 2020 and has helped to lead both Trusts through one of the most difficult periods in the history of the NHS. He is also focussed on working with colleagues to make continual improvements to the care we provide to our patients.

Sheffield

Public Consultation: Proposal to relocate nine GP practices to new health centres in Sheffield.

Sheffield has been given £37m to improve primary care buildings in the city. Most of this money could be used to build new health centres in areas that need them most, bringing together GP and other services all under one roof.

As part of this four new health centres could be built in 2023. If GPs move, their current surgeries will close, so we want to hear from patients and communities about what they think of these plans. Read more here.

Health and care updates from NHS E/I

NHS North East and Yorkshire

Updates up to and including 18th August 2022

NHS slashes longest waits for care despite record numbers of most serious 999 calls

The NHS has made significant progress in reducing waits of more than 18 months since January, while dealing with record numbers of the most serious ambulance call outs in July. Read more here.

Next steps for urgent and emergency care - preparation for winter

NHS E/I has produced a letter which sets out the next steps for planning for winter 2022/23, including a board assurance framework, ensuring there is enough capacity and resilience to meet the pressures of the busy winter period. Read the letter here.

NHS checks for bowel cancer hit record-high thanks to Dame Deborah

Record numbers of people have come forward for bowel cancer checks thanks to lifesaving awareness raising by Dame Deborah James, the NHS has said. Read more here.

Get in touch at helloworkingtogether@nhs.net or call 0114 305 4487

Board of Directors' Meeting
9 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P133/22
Report	**Responsible Officer Report – Quarter 1 2022/23**
Executive Lead	Dr Callum Gardner, Medical Director & Responsible Officer
Link with the BAF	P1; U4
How does this paper support Trust Values	Demonstrates that medical staff are supported and engaged by the Trust to ensure that they have opportunity to reflect on their clinical practice.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to present to the Board details of activity related to Medical Appraisal and Revalidation, as per NHS England and GMC regulations. Key points: • NHS England released guidance on a new appraisal format focusing more on reflection and feedback from colleagues and patients, which is in line with the MAG 2020 form. The Trust uses Allocate for appraisals and is awaiting these changes to be made on the Allocate platform. • As at 31/08/2022, 258 doctors had a Prescribed Connection to The Rotherham NHS Foundation Trust (TRFT). • The majority of appraisals that were delayed in 2021/22 were completed, with a major shift towards the last quarter. This has been looked into and re-aligned. • Patient feedback has continued to be a challenge, especially where telephone consultations are being done more often. Feedback forms are being posted out to increase response rate. • The Responsible Officer has encouraged Doctors to complete up to annual multi-source feedback from patients and colleagues, with the minimum requirement being one cycle every 3 years, which is being actively enforced. • The Trust currently has 22 appraisers, out of a required 26, and will be interviewing for new appraisers. There are 2 colleagues interested. • Training for appraisers continued throughout 2021/22 and further training will be arranged for the new appointees once in post. An Appraiser Refresher course has been booked for September 2022. • The Deputy Appraisal Lead post had been advertised and 2 candidates have applied. • First Quarter 2022/23 appraisal performance: ○ 30 doctors were due their appraisal, 28 of whom have completed their appraisals

	○ The Responsible Officer has spoken to the remaining 2 individuals with appraisals outstanding, 1 of whom is a current cause for concern regarding non-engagement (as is one other individual).
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report will also be discussed at the quarterly Responsible Officer's Advisory Group (ROAG) on 8th September 2022.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	Continued weekly oversight by the Medical Director/Responsible Officer, and quarterly oversight by the Responsible Officer's Advisory Group (ROAG). The Medical Director/Responsible Officer is aware of the two outliers and has commenced appropriate interventions.
Recommendations	It is recommended that the Board notes the quarterly data.
Appendices	1. Medical Appraisal Figures for Q1 2022/23 2. Medical Performance Dashboard – Appraisal, Revalidation & 360MSF

1.0 Introduction

NHS England has continued to focus on appraisals as being supportive and reflective conversations, with less emphasis on written documentation. The new appraisal guide follows on from the 2020 template, incorporating specific additional questions around personal wellbeing and a greater focus on reflections and colleague and patient feedback. This has been included within our appraisal dialogue and the current appraisal document on the Allocate platform is being updated by the provider in line with the latest national guidance, with implementation expected shortly.

2.0 Performance

2.1 The processes of Appraisal and Revalidation are well embedded within the Trust and this is reflected in the final completion figures for 2021/22, which demonstrated continued good engagement of 94%. All appraisals from February 2022 have been completed via the new Allocate eAppraisal system.

2.2 We currently have 22 appraisers, with a target of 26. Further interviews are booked for September, with 2 candidates shortlisted. An Appraiser Refresher course has been booked for September 2022 and an Appraiser forum booked for December 2022.

2.3 A new Deputy Medical Appraisal Lead will be appointed in September 2022 and candidates have been shortlisted.

2.4 Feedback from completed appraisals remains extremely good, particularly with regard to the quality of interaction between the doctor and their appraiser. Of note were the comments about how the doctors felt supported and encouraged.

2.5 Flows of information to doctors regarding complaints, compliments and incidents remains variable and some doctors have highlighted the difficulty in easily accessing this information. However, the Head of Patient Experience has confirmed that all Doctors named in complaints are now notified of the outset, with a record being kept of such notification to enable cross-checking with appraisal reflection. This will continue to be monitored by the Medical Director, supported by his Business Manager, in order to continue to improve flows of information to doctors to support their reflection and learning.

2.6. An updated Appraisal Policy has written and amended following comments from relevant stakeholders. It has now been shared with the Joint Local Negotiating Committee (JLNC) for approval before sending for ratification at the Document Ratification Group (DRG), and is also on the agenda for the Responsible Officer's Advisory Group (ROAG) meeting on the 8th September.

2.7 The Medical Director's Business Manager has composed a new 'Revalidation Checklist' to support the Medical Director in making positive recommendations for revalidation to the GMC as part of his Responsible Officer role. This has been used to good effect. Revalidation recommendations have been reviewed and made up to the end of the year.

2.8 Communication with the GMC regarding concerns has continued throughout this time via the ELA network.

2.9 The Associate Medical Director for Appraisal, Revalidation and Mentorship is working with the Trust's Clinical Director for Dentistry and has introduced a new appraisal document which ensures a supportive focus. Further changes may be made in line with the Trust using the Allocate system.

2.10 A new Responsible Officer's Dashboard is in development (Appendix 2), which will be presented to the quarterly Responsible Officer's Advisory Group (ROAG) meeting moving forward.

2.11 The RO is keen to relaunch/strengthen the Trust's Consultant/SAS new-starter mentorship programme, which he has asked the Associate Medical Director for Appraisal, Revalidation and Mentorship to lead on. A new leadership development programme for all new Consultants and SAS Doctors will also launch in Quarter 3, supported by the Medical Director's Business Manager.

3.0 Conclusion

3.1 Covid continues to disrupt the timing of a small number of appraisals and this is likely to be ongoing.

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

Dr Callum Gardner
Medical Director & Responsible Officer
September 2022

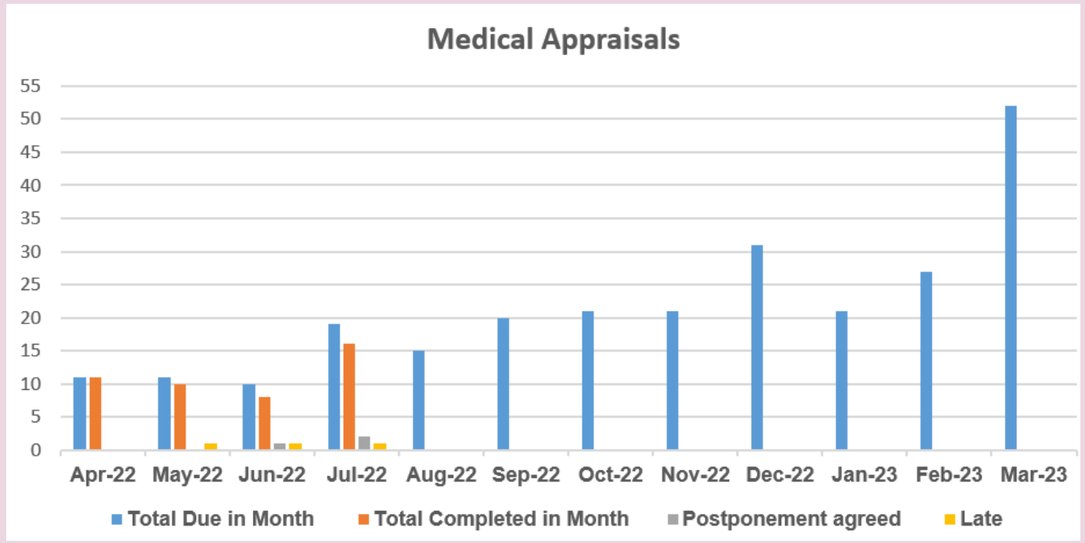
Appendix 1

Indicator		Q1 01/04/2022 – 30/06/2022
1	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	30
1.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period	28
1.2	Number of those within ♯3 above who **did not hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	2
1.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	1
1.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**	1

Medical Performance Dashboard—Appraisal, Revalidation & 360MSF
July 2022

The Rotherham NHS Foundation Trust

Appraisal

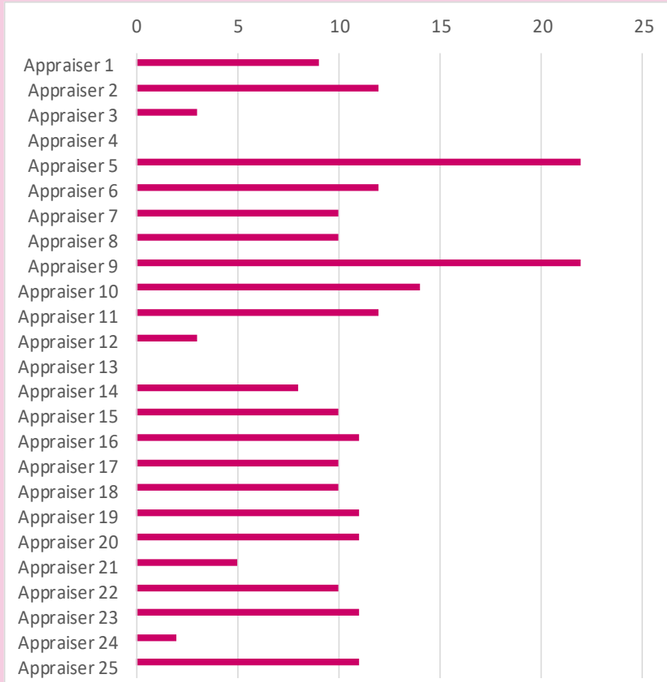


The Trust are seeing continual high rates of medical appraisal. Any appraisal postponements are agreed with the Medical Director prior to their due date. Those individuals engaging 'late' with their appraisal will have a reason recorded and managed in line with policy. The current appraisal rate for the month ending July 22 is 88%.

Workplan updates

Item	Detail	Delivery Date
Appraisal Policy	Re-write of appraisal policy under-way following a switch to a medical e-appraisal system. Sign off due at ROAG and LNC prior to publication	October 2022 **ON TRACK** **OWER: Mario Shekar**
Enhanced Support Policy	Policy expired September 21. rewrite underway. DT to revisit on his return 26th September.	September 2021 **OVERDUE** **OWER: Derek Thomas**
Mentorship	Restarting mentorship programme	October 2022 **ON TRACK** **OWER: Mario Shekar**
Recruitment of Deputy Appraisal Lead	Job Description and advert agreed. Out to interview	October 2022 **ON TRACK** **OWER: Mario Shekar**
Core Standards Quality Assurance	All four core standards monitored through separate action plan. Most actions on track or revised delivery dates have been set in light of revised NHSE timetable	September 2022 **ON TRACK** **OWER: Nikki Boulding**

Appraiser Allocations



Starters

Consultant	1
Speciality Doctor	4
Clinical Fellow	2
GP VTS SR	2
Dental Officer	1

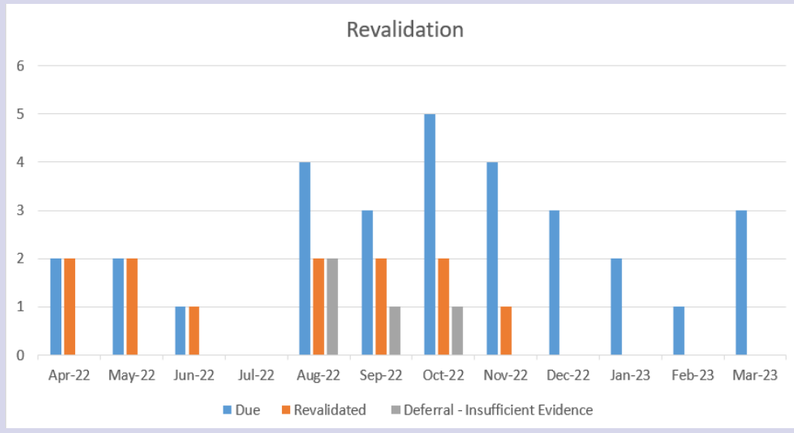
Out of 10 new starters 8 are fixed term either due to short term funding or training contracts. 1 speciality doctor and 1 dental officer occupy permanent posts

Leavers

Consultant	2
Speciality Doctor	3
Clinical Fellow	1
Speciality Reg LAS	1

In relation to consultant posts; one post is flexi-retirement and the other is a locum working timesheet only.

Revalidation



Case Management

Case Opened	ID/Speciality	Detail	Update

360◦ MSF Colleague

Due 22/23	96
In Progress	46
Completed	36
Not Yet Started	14

360◦ MSF Patient

Due 22/23	96
In Progress	46
Completed	36
Not Yet Started	14

360◦ MSF Management

Due 22/23	
In Progress	
Completed	
Not Yet Started	

Medical MAST

April 22	88.60%	Oct 22
May 22	87.13%	Nov 22
Jun 22	88.27%	Dec 22
Jul 22	88.18%	Jan 23
Aug 22		Feb 23
Sep 22		Mar 23

Policies/Audits

Appraisal Policy	Policy in date but subject to rewrite following implementation of new appraisal system. Final sign off due October 22.
Enhanced Support	Policy out of date from Sept 21. work to recommence end of September 22.
Assurance audit on management of cases	Revisit in October 22
Appraiser feedback	Present to ROAG Jan 23

Standards of Business Conduct

84%

GMC Open Cases

5 open cases

0 connected to TRFT

Board of Directors' Meeting
9 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P134/22
Report	**Guardian of Safe Working Report - Q1 2022/23**
Executive Lead	Dr Callum Gardner, Executive Medical Director
Link with the BAF	P1; U4; D5
How does this paper support Trust Values	**Ambitious** - for improvement in working conditions and patient safety. **Caring** - for colleagues and patients. **Together** - solutions are proposed after discussion has identified problems.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	Under the 2016 Junior Doctor Contract, a quarterly report from the Guardian of Safe Working is required to provide assurance to the Board that working in the Trust is safe. The contract specifies maximal shift durations, total hours per week and hours worked without breaks. The number of exception reports is down this quarter, reflecting reduced Covid absences. The intensity of working is consistently high and is sometimes flagged as unsafe by the most junior trainees in Medicine. New rotas are in place from August for the FY1s in Medicine. Overall hours worked are not unsafe.
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 monthly Junior Doctors' Forum (JDF) meetings, the Datix system, personal communication and assorted email correspondence. It has been prepared by the Trust's Guardian for Safe Working and is sponsored by the Medical Director.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	Dealing with the issues raised in the Junior Doctor Forum (JDF), which takes place monthly (JDF attendees include medical staffing, the Medical Director, Director of Medical Education and the Trust's Guardian of Safe Working).
Recommendations	It is recommended that the Board notes this report.
Appendices	None

1.0 Exception Report (ER) Quarterly update

1.1 In the last quarter, as of 8th July 2022, 17 doctors (8 FY1, 2 FY2, 3 CT/ST1, 1 CT3, 1 ST2 and 2 ST6) submitted 82 Exception Reports related to hours worked. There were 4 Exception Reports relating to education and 2 to service support.

1.2 Total overtime hours claimed for were 93.75 for normal time and 4.5 for premium time hours.

1.3 Five Immediate threats to safety were logged - 3 from Cardiology and 2 from Healthcare for Older People (HCOP). Feedback was sought from the trainees concerned and, where appropriate, were highlighted by the Guardian for Safe Working/Director of Medical Education to divisional managers and workforce teams.

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

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

2.0 Exception Report Quarterly details (as of 8/04/22)

Working hours:

(Sub) Specialty	Exceptions	Daytime Hours	Night-time hours
General Medicine (all sub-specialties, except AMU)	39	44	1.25
Acute Medicine (AMU)	26	33.75	0
Medical Division total	65	77.75	1.25
General surgery	10	5.5	2.25
Paediatrics	6	10	1
Obstetrics/Gynaecology	1	0.5	0
Total	**82**	**93.75**	**4.5**

3.0 Qualitative examples from Exception reports

"We were below minimum staffing (4 for the ward) and we had 2 juniors. I was covering patients across four wards…I had 23 patients…….
I felt overwhelmed, …I felt the families were getting a disservice,..I feel uncomfortable working in an environment where I feel patient care is not optimal…"

"Urology shift. Finished jobs on time but stayed late to accompany the reg to see 2 referrals in A&E/ASU."

"+50m"

4.0 Actions to mitigate

4.1 In the example above, help from the surgical FY1s was forthcoming to ease matters.

4.2 The FY1 and StR rotas in Medicine have been re-designed to provide greater weekend twilight cover, albeit at the expense of increasing hours while remaining within contractual maxima. Review will occur after 2 months.

4.3 Recruitment to two Respiratory Consultant positions has occurred and adverts are out for a range of consultant and clinical fellows in medical sub-specialties.

4.4 Medical & Dental Workforce manage rota gaps and source locums to the best of their ability, moving trainee doctors to where need is greatest on a daily basis, factoring in absences and patient numbers. This is challenging, especially as Covid staff absences have been unpredictable.

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

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

4.7 The Director of Medical Education and Foundation Director are also instrumental in raising issues coming to their attention and all have open door availability to trainees for support.

4.8 The Medical Director has monthly diary time set aside to meet with Junior Doctors.

Dr Gerry Lynch
Guardian for Safe Working
August 2022

Board of Directors' Meeting
August 2022

The Rotherham NHS Foundation Trust

Agenda item	P135/22
Report	**Freedom to Speak up Guardian Quarter One update**
Executive Lead	Helen Dobson, Executive Chief Nurse
Link with the BAF	U4: There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.
How does this paper support Trust Values	Promoting a culture of Speaking Up within TRFT supports all three of the Trust values of Ambitious, Caring and Together
Purpose	**For decision** ☐ **For assurance** ☐ **For information** x
Executive Summary (including reason for the report, background, key issues and risks)	To provide the Board with an update of concerns which would be deemed whistleblowing, raised both to the Freedom to Speak Up Guardian (FTSUG) and through other official routes and offer a comparison for TRFT against other local and similar sized organisations To provide an update of how the profile of the Speaking up agenda is being raised and embedded within The Rotherham NHS Foundation Trust. **<u>Summary of Key Points:</u>** The key points arising from the report are • Freedom To Speak Up (FTSU) interviewed during CQC Inspection • Concerns raised by Stroke Unit staff • NGO e-learning packages now fully rolled out & 3 year Mast refresher agreed, Trust Compliance of 97.91% • Regional NGO meeting attended • NGO have published a new policy template • Ockenden report published with reference to speaking up • National speaking up data published • FTSU Lead completed annual refresher training
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	
Board powers to make this decision	N/a

Who, What and When (what action is required, who is the lead and when should it be completed?)	No further action required from the Board
Recommendations	It is recommended that the Board note the Q1 report.
Appendices	None

1. Introduction

The FTSU Guardians initiative was implemented following the Francis report (2015). The aim of Freedom to Speak Up Guardians (FTSUG) 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 during quarter one 2022, highlighting the number of concerns raised, actions taken and resultant learning.

2. Background

This paper provides a review of FTSU concerns raised within the Trust during quarter one 2022/23 and an update following the yearly report in May 2022. 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

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. Within the North East & Yorkshire region the average allocated hours for the FTSU lead is 19.5 hours, this ranges from 0 to 37.5 hours. However there is no direct correlation between increased hours and improved responses to questions relating to speaking up within the national staff survey.

During quarter one, eight concerns have been raised with the FTSU lead, which is a decrease of three from quarter one 2021/22. Five concerns were raised by staff within the Stroke Unit which related to patient safety and culture. These were escalated to the Chief Nurse and Deputy Chief Nurse. These concerns are still open and work is ongoing with the division to bring a satisfactory outcome. The remaining concerns are spread across all divisions and were signposted to HR and Unions as they related to bullying and culture within the divisions.

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

The Trust has an overall compliance rating of 97.91% 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	99.12%

165 Community Services L3	98.57%
165 Corporate Operations L3	96.63%
165 Corporate Services L3	98.16%
165 Emergency Care L3	98.88%
165 Family Health L3	97.24%
165 Medicine L3	96.81%
165 Surgery L3	98.32%

TRFT has become one of the first Trusts in the region to implement FTSU as a MaST topic with a three yearly refresher period. This will be launched during October's FTSU month.

The NGO published the latest national speaking up figures for 2021/22. These showed a total of 20,362 cases had been raised nationally, of which 18% (TRFT 36%) related to Patient Safety and 32.3% (TRFT 44.4%) Bullying & Harassment. The difference in relation to patient safety can be attributed to several concerns being raised from one department during the reporting period.

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.

4.2 National Guardian Office Case Reviews

There have been no case reviews published during quarter one, however the Ockenden report was published which stressed the importance of creating a culture where all staff feel safe and supported to speak up.

5. Conclusion

A relatively consistent number of concerns have been raised during quarter one however benchmarking the Trust against peers remains a challenge due to the nature of the subject.

Our aim is to be a Trust which promotes an equality of access and an ability to speak openly about what happened with a willingness to learn and take accountability with fairness but not removing accountability. FTSU helps foster a learning culture with a balance of fairness, justice, learning and responsibility. It is not about blame, but it is also not about an absence of responsibility and accountability.

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Agenda item	P136/22
Report	**National, Integrated Care Board and Integrated Care Partnership Update**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	R2: There is a risk we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities OP3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of a lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes
How does this paper support Trust Values	Together: this paper demonstrates how the Trust and partners across both Rotherham Place and the wider system work together in providing patient care and also providing mutual support in the continued response to the Covid-19 pandemic and subsequent period of recovery.
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 Integrated Care Board (SYB ICB) and Integrated Care Partnership (Rotherham Place). Key points to note from the report are: • NHS England has set out its next steps to increase 'capacity and operational resilience' in urgent and emergency care services going into winter • The Rotherham Integrated Care Partnership has commenced it's vaccination programme for autumn 2022 • The SY ICB agreed to take part in the Care Quality Commissions Test and Learn process as a step in developing future system regulatory processes in a co-creation approach • The Rotherham Metropolitan Borough Council is currently reviewing the Rotherham Plan, with a series of engagement sessions planned for the month of September

	• The SY ICB has delegated the exercise of some of its functions to a newly established committee of the SY ICB Board in the Rotherham Place (the "SY ICB Place Committee") which will meet in common with the existing Rotherham Place Board.
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 SY ICB level activities in addition to specific papers periodically, as and when required.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Deputy Chief Executive will provide feedback to the Rotherham Place Board following discussions at the Trust Board.
Recommendations	It is recommended that the Board note the content of this paper and take specific actions as follows: • To approve the Terms of reference for the Rotherham Place Board when carrying out Partnership Business. (Appendix 1 part 2). • To note the Terms of reference for the Rotherham Place Board when carrying out ICB Business as a committee of SY ICB (Appendix 1 part 3). • To approve the revised Place Agreement, originally entered into by Partner organisations in Rotherham in 2018 (Appendix 2). • To note the SY ICB and Place Governance Arrangements Diagram (Appendix 3)
Appendices	Appendix 1 - Part 1: Background; Part 2: Terms of reference for the Rotherham Place Board when carrying out Partnership Business; and Part 3: Terms of reference for the Rotherham Place Board when carrying out ICB Business as a committee of NHS South Yorkshire Integrated Care Board. Appendix 2 - The updated the Place Agreement, originally entered into by Partner organisations in Rotherham in 2018. Appendix 3 - SY ICB and Place Governance Arrangements Diagram.

1.0 Introduction

1.1 This report provides an update on national developments and developments across the SY ICB and Integrated Care Partnership (Rotherham Place).

2.0 National Update

2.1 As operational pressures continue across the NHS, NHS England set out its next steps to increase capacity and operational resilience in urgent and emergency care services going into winter. This is based around 8 key objectives / actions backed up by 6 key KPIs which ICBs will monitor. These objectives are:

- Prepare for variants of Covid-19 and respiratory challenges
- Increase capacity outside acute Trusts
- Increase resilience in NHS111 and 999
- Target Cat2 response times and ambulance handover delays
- Reduce crowding in A&Es and target the longest waits
- Reduce hospital occupancy
- Ensure timely discharge
- Provide better support for people at home

The six specific metrics to support these are:

- 111 call abandonment
- Mean 999 call answering times
- Cat2 ambulance response times
- Average hours lost to ambulance handover delays
- Adult general and acute type 1 bed occupancy
- Percentage of beds occupied by patients who no longer meet the right to reside criteria

2.2 The roll out of the Monkey Pox vaccine has been paused due to stock issues. The outbreak has caused an international demand for vaccine with many countries experience supply constraints.

2.3 The UK has become the first country to approve a dual vaccine which tackles both the original and new strain of the Covid-19 virus. This vaccine will be part of the upcoming booster campaign alongside the usual vaccines.

3.0 South Yorkshire Integrated Care Board (SY ICB)

3.1 The SY ICB agreed to take part in the Care Quality Commissions Test and Learn process as a step in developing future system regulatory processes in a co-creation approach. The South Yorkshire System is one of a handful nationally being involved in this partnership process.

3.2 The CQC Test and Learn process commenced on week commencing 8th August 2022 for a duration of 5 days. The CQC Inspection Team and a number of specialist advisors held

face to face and virtual interviews in addition to focus groups. The CQC Planning Team requested that our integrated care partners, including Primary Care Network Directors, were involved in sharing their experience of working within the integrated care system.

4.0 Rotherham Integrated Care Partnership (ICP) update

4.1 The Rotherham ICP has commenced its vaccination programme for autumn 2022. There will be around 144,000 people eligible for vaccinations this autumn with the programme intending to start in September. Delivery will be though primary care and social care staff as well as hubs here at the Trust and at the Rotherham, Doncaster and South Humber Healthcare NHS Foundation Trust.

4.2 The ICP has been part of a 'Place Development Programme'. This is a programme sponsored by NHS England and the Local Government Association. It has been designed to provide Places with bespoke, specialist support to help deliver the best possible population health outcomes in Place. There are three modules looking at primarily; leadership, governance/finance and Population Health Management. The majority of the programme has been focussed on module C, Population Health Management and run through a series of workshop style sessions, which aim to:

- Select a Cohort of the population to focus in on, who experience poorer health outcomes and challenges accessing services.
- Understand that Cohort through data analysis, workshop discussions and engagement.
- Design a Population Health Management Intervention to improve specified outcomes for this population.
- Implement or prepare to implement the Intervention.

The following Cohort has been selected to focus on:

- Working age adults in deprived communities with multi morbidity, including mental health challenges.
- This will include adults with two or more selected Long-Term Conditions where Depression is one of those conditions.
- Focusing on deprived communities covered by the following GP practices / areas:
  - Maltby (Braithwell Road, Blyth Road and Manor Field)
  - South Rotherham (Village and Dinnington)
  - Wath Upon Dearne (Market and Magna)

The next steps include sharing the findings to all modules at a session on 9th September, followed by a final session on 18th October, where partners will discuss how to take forward the learning.

4.3 The Rotherham Metropolitan Borough Council is currently reviewing the Rotherham Plan, with a series of engagement sessions planned for the month of September. Colleagues from the Rotherham Metropolitan Borough Council plan to visit the Trust during September to engage with staff, patients and visitors as part of the consultation process.

5.0 Revised Rotherham Place Governance arrangements

5.1 As referred to in the previous report to Trust Board, on 1st July 2022 the SY ICB was established pursuant to the Health and Care Act 2022, and the statutory functions, staff, assets and liabilities of NHS Rotherham CCG (and the other three CCGs of South Yorkshire) were transferred to the SY ICB. The SY ICB has delegated the exercise of some of its functions to a newly established committee of the SY ICB Board in the Rotherham Place (the "SY ICB Place Committee") which will meet in common with the existing Rotherham Place Board. As a result of these developments, it was necessary to update the existing terms of reference for the Rotherham Place Board to reflect the establishment of the SY ICB Place Committee (see Appendix 1). Appendix 1 is therefore split into three parts as follows:

Part 1: Background;
Part 2: Terms of reference for the Rotherham Place Board when carrying out Partnership Business (defined below); and
Part 3: Terms of reference for the Rotherham Place Board when carrying out ICB Business (defined below) as a committee of NHS South Yorkshire Integrated Care Board.

5.2 Terms of reference for the ICB Place Committee element (set out in Part 3 of the terms of reference at Appendix 1) have been approved by the ICB, including its membership. The members of the ICB Place Committee as at 1 July will be ICB officers only and the ICB Place Committee will be chaired by the Executive Place Director for Rotherham. The remaining members of the Place Board will be Participants (in attendance) at the ICB Place Committee meaning that they will not make decisions or vote on ICB Business but may contribute to discussions. It is expected that the membership of the ICB Place Committee will be reviewed over the next 6-9 months with a view to expanding the membership as appropriate.

5.3 It has also been necessary to update the existing Place Agreement, originally entered into by Partner organisations in Rotherham in 2018 (see Appendix 2). There is also a governance chart provided (see Appendix 3), which illustrates the structures in place across the SY ICB down to place level.

5.4 The key changes to the Rotherham Place Agreement are highlighted below:

- a commencement date of 1 July 2022 – so the SY ICB will be a signatory
- the revised structure of the NHS following the Health & Care Act 2022
- a proposed initial term from 1 July 2022 to 31 March 2024
- the revised governance structure for the Place Partnership
- agreement of the Partners to develop within the next 6 months an updated Place Partnership Development Plan, setting out key areas for further review and development by the partner organisations in the period to April 2023 and beyond
- updating language and terminology to reflect the policy position nationally.

Michael Wright
Deputy Chief Executive
September 2022

1. Structure of these Terms of Reference

These terms of reference are divided into three sections:

Part 1: Background;
Part 2: Terms of reference for the Rotherham Place Board when carrying out Partnership Business (defined below); and
Part 3: Terms of reference for the Rotherham Place Board when carrying out ICB Business (defined below) as a committee of NHS South Yorkshire Integrated Care Board.

PART 1: BACKGROUND

1. The organisations referred to in these terms of reference are Partners in the Rotherham Place Partnership ("**Place Partnership**"). Representatives of the Partners have come together as the Rotherham Place Board ("**Place Board**") to enable the delivery of integrated population health and care services in Rotherham, as set out in more detail below. The Partners have entered into a Place Agreement setting out their commitment to delivery of the Rotherham vision, objectives, and principles (as documented in the Place Agreement).

2. The Place Board in practice carries out two roles:

- Firstly, the Place Board is responsible for aligning decisions on strategic policy matters made by Place Partners that are relevant to the achievement of the Rotherham Place Plan, in accordance with its terms of reference in Part 2. Where applicable, the Place Board may also make recommendations on matters that it has been asked to consider on behalf of a constituent Partner in the Place Partnership. Where the Place Board has been asked to consider matters on behalf of a Partner, the Partner organisation remains responsible for the exercise of its functions and nothing that the Place Board does shall restrict or undermine that responsibility. This work is referred to as "**Partnership Business**".

- Secondly, the Place Board sits as the Rotherham ICB Committee ("**ICB Place Committee**"), which is a committee of the NHS South Yorkshire Integrated Care Board ("**ICB**"). The ICB Place Committee is established as a committee of the ICB Board, in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation & Delegation. When the Place Board sits as the ICB Place Committee it has delegated authority from the ICB Board to make decisions about the use of ICB resources in Rotherham in line with its remit, and otherwise support the ICB as set out in its terms of reference in Part 3 with the membership as set out in paragraph 7 below. The decisions reached by the ICB Place Committee are decisions of the ICB, in line with the ICB's Scheme of Reservation & Delegation **"ICB Business"**. When sitting as the Rotherham ICB Committee, members must comply with ICB policies and procedures.

3. As far as possible, the Partners that are statutory bodies will exercise their respective statutory functions within the Place Board governance structure. This will be enabled:

- For the ICB, through the Place Board sitting as the ICB Place Committee, as outlined above

- For other Partners that are statutory bodies, through those organisations granting delegated authority for decision making to specific individuals (for example a Place Board member) or to specific committees or other structures established by Partner organisations meeting as part of, or in parallel with, the Place Board.

4. For Partners that are not statutory bodies, it is expected that as far as possible the individuals attending meetings of the Place Board will be authorised to take the decisions under consideration on behalf of their organisation.

5. It is expected that in many cases, ICB Business, or any other reserved statutory decisions taken by individuals on behalf of their statutory organisations, will be able to be conducted at meetings of the Place Board, as a result of either individual Partner representatives exercising delegated authority or through the ICB Place Committee making the decision as a committee. Other representatives of

Partner organisations will be attendees at the Place Board at such times subject to the management of any conflicts of interest.

6. Whether decisions are taken under Part 2 and Part 3, or only Part 2 or Part 3 of these terms of reference, the aim will be to ensure that decisions reflect applicable national and local priority objectives and strategies and are taken in accordance with the collaborative principles for the Place Partnership.

7. Membership and attendance at the Place Board differs according to whether or not the Place Board is undertaking Partnership Business or ICB Business in accordance with the relevant terms of reference. The table below sets out the status of individual representatives in each case for ease of reference:

Nominated Representative (Role/Title)	Organisation	Status for Partnership Business	Status for ICB Business
Executive Place Director / Deputy Chief Executive ICB	NHS South Yorkshire Integrated Care Board	Joint Chair	Chair
Chief Executive	Rotherham Metropolitan Borough Council	Joint Chair	Participant
Director of Public Health	Rotherham Metropolitan Borough Council	Member	Participant
Chief Executive	The Rotherham NHS Foundation Trust (TRFT)	Member	Participant
Chief Executive	Voluntary Action Rotherham	Member	Participant
Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)	Member	Participant
[TBC]	Rotherham Primary Care Leadership Group	Member	Participant
Joint Chair	Rotherham Health and Wellbeing Board	Participant	Participant
Joint Chair	Rotherham Health and Wellbeing Board	Participant	Participant
Deputy Place Director, Rotherham Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Chief Nurse, Rotherham Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Deputy Chief Executive	The Rotherham NHS Foundation Trust (TRFT	Participant	Participant
Medical Director, Rotherham Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Chief Finance Officer, Rotherham Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board	Participant	Member

ROTHERHAM PLACE BOARD

PART 2: PLACE BOARD – TERMS OF REFERENCE FOR PARTNERSHIP BUSINESS

1	**Name of committee**	The Rotherham Place Board (the "**Place Board**").
2	**General**	In these terms of reference the following capitalised terms are given the meaning set out in the NHS South Yorkshire Integrated Care Board ("**ICB**") Constitution as updated from time to time, unless the context otherwise requires: Constitution ICB Standing Order or Standing Orders
		Other capitalised terms have the meaning set out below: "Chair" means the chair of the Place Board "Executive Place Director" means that individual appointed by the ICB to oversee and help develop the Place Partnership "ICB Business" has the meaning set out in Part 1 "ICB Place Committee" means the committee of the ICB for the Rotherham Place "ICB Policies" means any policy, process or procedure formally adopted by the ICB "Member" refers to a member of the Place Board as listed in paragraph 6 "Participant" refers to a participant of the Place Board as listed in paragraph 7 "Partner" refers to a partner organisation in the Place Partnership which is also a party to the Place Agreement "Partnership Business" has the meaning set out in Part 1 "Place Agreement" means the Place Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Rotherham "Place Board" means the Place Board as described in the Place Agreement that also sits as the ICB Place Committee as described in the ICB Constitution "Place Partnership" means the partnership of organisations described in the Place Agreement "Terms of Reference for ICB Business" means the terms of reference set out in Part 3 "Working Days" means a weekday that is not a bank holiday in England.

3	**Reports to**	The Place Board reports to the boards of the Partners in relation to Partnership Business. This is done through each Partner representative sitting on the Place Board reporting back to their respective employing/ host organisation.
4	**Purpose**	In relation to Partnership Business, the Place Board provides the strategic and collective leadership for the Place Partnership to deliver the ambitions of the Place Partnership and the Rotherham Place Plan. The Place Board is the forum where all Partners across health and care in Rotherham come together to formulate, agree and implement strategies for implementing the Rotherham Place Plan. The Place Board works across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships between all health and care organisations in the Rotherham health and care community. The Place Board shall operate in accordance with the vision, objectives and principles set out in the Place Agreement for the transformation and better integration of health, care, support and community services for the population of Rotherham.
5	**Remit and responsibilities**	When conducting Partnership Business, the Place Board has responsibility for: • Leading the Rotherham Place Board. • Promoting and encouraging commitment to the Place Plan and "Place Board Principles" set out in the Place Agreement amongst all partner organisations; • Formulating, agreeing and implementing strategies for implementing the Place Plan; • Overseeing the implementation of the Place Agreement and all related contracts in terms of delivering the Rotherham Place Plan in line with the Place Board Principles. • Reviewing performance of the partners against the Rotherham Place Plan and determining strategies to improve performance or rectify poor performance. • Ensuring a proactive approach to establishing the health and social care needs of Rotherham citizens and to react to the changes within the health and social care agenda. • Operating cost of care effectively in the context of the Rotherham health and social care financial circumstances. • Realising cost saving opportunities through system redesign to meet the Rotherham wide efficiency challenge, ensuring impact assessments are completed where appropriate to assess any adverse impact in regard to patient safety and experience. • Providing a forum for parties to resolve disagreement relating to the Rotherham Place Plan. • In undertaking its role, considering recommendations from the Rotherham Place Board Delivery Team in respect of the operation of the Rotherham Place Board and the delivery of the services. • Reporting to the partner organisations and the Health and Wellbeing Board on progress against the Rotherham Place Plan. • Overseeing the development and implementation of the Place Board Development Plan, driving progress in implementation and seeking to overcome any barriers to implementation • Liaising where appropriate with national stakeholders (including NHS England) to communicate the views of the Place Board on matters relating to integrated care in Rotherham. • Operating as the key link between the Place Board and the ICB and work with the ICB to help shape its development, in conjunction with the Place Board's development. This may include nominating Place Board representatives to sit on governance groups at ICB level, as necessary.

6	**Members**	Members contribute to discussion, participate in aligned decision making and are accountable for decisions made. The Members of the Place Board are: NHS South Yorkshire ICB Rotherham Executive Place Director / Deputy Chief Executive ICB (Joint Chair) Rotherham Metropolitan Borough Council (RMBC) Chief Executive (Joint Chair) Director of Public Health The Rotherham NHS Foundation Trust (TRFT) Chief Executive Voluntary Action Rotherham (VAR) Chief Executive Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) Chief Executive Rotherham Primary Care Leadership Group (RPCLG) [Representative TBC] Each Partner will ensure that the Member from their organisation: • Is appointed to attend and represent their organisation on the Place Board with such authority as is agreed to be necessary in order for the Place Board to function effectively in discharging its responsibilities as set out in these terms of reference which is, to the extent necessary, recognised in an organisation's respective scheme of delegation (or similar); • Has equivalent delegated authority to the designated officers of all other member organisations comprising the Place Board (as confirmed in writing and agreed between the Partner organisations); and • Understands the dual role of the Place Board as described in Part 1 of these terms of reference, and the limits of their responsibilities and authority in respect of the Place Board when dealing with Partnership Business and ICB Business (to the extent they are a member of both).
7	**Participants**	The following individuals will be invited to attend each meeting of the Place Board as Participants. Participants attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not participate in decision making. The Participants of the Place Board when discussing Partnership Business are: • Joint Chairs, Rotherham Health and Wellbeing Board • Deputy Place Director, Rotherham Place, ICB (as chair of the Rotherham Place Partnership Delivery Team and Mental Health and Learning Disability Transformation Group Lead) • Strategic Director, Adult Care, Housing and Public Health, RMBC (as joint Urgent and Community Transformation Group Lead) • Deputy Chief Executive, (TRFT) (as joint Urgent and Community Transformation Group Lead) • Director of Children's Services, RMBC (as Children and Young People's Transformation Group Lead) • Head of Communications, Rotherham Place, ICB • Strategy & Delivery Lead, Rotherham Place, ICB • Chief Nurse, Rotherham Place, ICB • Chief Finance Officer, Rotherham Place, ICB • Medical Director, Rotherham Place, ICB • Independent Non-Executive Member, ICB

		The Chair may invite such other Participants to attend any meeting of the Place Board as the Chair considers appropriate.
8	**Deputies**	With the permission of the Chair, Members of the Place Board may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.
9	**Chair**	The meetings will be run alternately by the Joint Chairs of the Place Board (as noted in paragraph 6 above). In the event of both of the Joint Chairs being unable to attend all or part of the meeting, another Member of the Partnership Board shall chair the meeting.
10	**Quoracy**	No Partnership Business shall be transacted unless the following are present as a minimum: a) one Member from each of the ICB and RMBC; and b) two Members from any of the following Partners: TRFT, VAR, RDASH or RPCLG. For the sake of clarity: a) No person can act in more than one capacity when determining the quorum. b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum. Members of the Place Board may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.
11	**Conduct of meetings**	The Place Board is not a separate legal entity or a committee of any of the Partners when considering Partnership Business, therefore it is unable to take decisions separately from its constituent Members or bind any one of them; nor can one Partner organisation 'overrule' another on any matter. The Place Board will operate as a place for discussion of Partnership Business with the aim of reaching consensus to make recommendations and proposals to the boards of Partner organisations, unless the Members have the requisite delegated authority from their Partner organisations to make the relevant decision.
12	**Frequency of meetings**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Place Board determines otherwise and amends these terms of reference accordingly.
13	**Urgent decisions**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Place Board determines otherwise and amends these terms of reference accordingly.
14	**Admission of the press and public**	The Place Board may meet in private to consider Partnership Business. However, if it is also considering ICB Business then press and public will be admitted in accordance with the terms of reference for ICB Business.
15	**Declarations of interest**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Place Board determines otherwise and amends these terms of reference accordingly.
16	**Support to the Place Board**	The arrangements set out in the Terms of Reference for ICB Business shall apply unless the Place Board determines otherwise and amends these terms of reference accordingly.

17	**Authority**	The arrangements set out in the Terms of Reference for ICB Business shall apply in relation to: • investigations • commissioning of reports and surveys • obtaining legal or other independent professional advice unless the Place Board determines otherwise and amends these terms of reference accordingly. In addition, if the Place Board agrees additional requirements regarding the above, those requirements must be complied with. The Place Board has the sub-committees set out in the Terms of Reference for ICB Business. The Place Board is authorised to create and dissolve permanent workstreams and time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, the Place Board must set a clear scope and where appropriate deadline for completion for the workstream or group. Such workstreams or groups shall not be able to take decisions on behalf of the Place Board and shall not be formal sub-committees of the Place Board.
18	**Reporting**	The Place Board shall report to the boards/ senior management of Partner organisations in respect of Partnership Business. It does this through Members reporting back to their organisations. The Place Board shall also report to the Health and Wellbeing Board for Rotherham. The Place Board will receive for information updates on the work of any of its task and finish groups or workstreams.
19	**Conduct of the Place Board**	Members of the Place Board will abide by the 'Principles of Public Life' (The Nolan Principles). The Place Board shall undertake an annual self-assessment of its own performance against these terms of reference. This self-assessment shall form the basis of an annual report from the Place Board to the Rotherham Health and Wellbeing Board.
20	**Amendments**	Any amendment to these terms of reference is Partnership Business. Any changes to these terms of reference must be approved by the Place Board.
21	**Review date**	These terms of reference shall be reviewed annually.

ROTHERHAM PLACE BOARD

PART 3: PLACE BOARD – TERMS OF REFERENCE FOR ICB PLACE COMMITTEE (ICB BUSINESS)

1	**Name of committee**	The Rotherham Place Board (the **Place Board**) is established as and operates as a committee of the NHS South Yorkshire Integrated Care Board ("**ICB**"), in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation when it is considering ICB Business (the "**ICB Place Committee**").
2	**General**	These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership and reporting arrangements of the ICB Place Committee and may only be changed with the approval of the ICB Board. The ICB Place Committee has no executive powers, other than those specifically delegated in these terms of reference. In these Terms of Reference the following capitalised terms are given the meaning set out in the NHS South Yorkshire Integrated Care Board Constitution as updated from time to time, unless the context otherwise requires: • Constitution • ICB • Standing Order or Standing Orders Other capitalised terms have the meaning set out below: "**Chair**" means the chair of the ICB Place Committee "**ICB Business**" matters which are delegated to the ICB Place Committee in line with its purpose at paragraph 4 by the ICB for determination by the ICB Place Committee "**ICB Policies**" means any policy, process or procedure formally adopted by the ICB "**Member**" refers to a member of the ICB Place Committee as listed in paragraph 6 "**Participant**" refers to a participant of the ICB Place Committee as listed in paragraph 7 "**Place Agreement**" means the Rotherham Place Agreement entered into by the Partners (including the ICB) for the transformation and better integration of health and care services for the population of Rotherham "**Place Board**" means the place board as described in the Place Agreement that also sits as the ICB Place Committee when conducting ICB Business "**Working Days**" means a weekday that is not a bank holiday in England The ICB is part of the South Yorkshire Integrated Care System, which has four core purposes: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience and access • enhance productivity and value for money • help the NHS support broader social and economic development.

		The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including: • improving the health of children and young people • supporting people to stay well and independent • acting sooner to help those with preventable conditions • supporting those with long-term conditions or mental health issues • caring for those with multiple needs as populations age • getting the best from collective resources so people get care as quickly as possible.
3	**Reports to**	The ICB Board
4	**Purpose**	The ICB Place Committee will support the ICB in delivering its statutory and/or corporate functions as set out in paragraph 5.
5	**Remit and responsibilities**	The role of the ICB Place Committee will be to actively participate in the Rotherham Place Partnership in accordance with the Place Agreement, and in accordance with the Constitution of the ICB. The ICB Place Committee is responsible for the following: **Regulation and Control** • Establish governance arrangements to support collective accountability between partner organisations for place-based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations. **Strategy and Planning** • Agree a plan to meet the health and healthcare needs of the Rotherham population, having regard to the ICS integrated care strategy and Rotherham health and wellbeing strategies. • Ensure consultation, involvement and engagement on place plans is undertaken where appropriate • Engagement with Health Overview and Scrutiny Committee. • Develop Annual Plan for Delivery of Place Health & Wellbeing Strategy and ICP Strategy • Ensure provision of Health Care Services for Place Population. • Agree Place-based delivery plans. • Allocate resources to deliver the plan in Rotherham, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital). • Approve the operating structure in Rotherham. • Develop joint working arrangements with partners in place that embed collaboration and integration as the basis for delivery within the ICB plan.

		• Arrange for the provision of health services in line with the allocated resources across the ICS through a range of activities including: o convening and supporting providers at Place to lead major service transformation programmes to achieve agreed outcomes. o support the development of primary care networks (PCNs) as the foundations of out-of- hospital care and building blocks of place-based partnerships. Including through investment in PCN management support, data and digital capabilities, workforce development and estates. o working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. • Agree place action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care. • Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability. **Partnership working** • Agree joint working arrangements at Place that embed collaboration and integration as the basis for delivery of the Place plan. **Staffing and human resources** • Delivery of implementation in Rotherham of people priorities. **Risk management** Make arrangements to implement in place ICB risk management arrangements.
6	**Members**	The Members of the ICB Place Committee when undertaking ICB Business are: • Executive Place Director, ICB (Chair) • Chief Nurse, Rotherham Place, ICB • Chief Medical Officer, Rotherham Place, ICB • Chief Finance Officer, Rotherham Place, ICB • NHS South Yorkshire Integrated Care Board (NHS SYICB) - Deputy Place Director, Rotherham Place • Independent Non-Executive Member, ICB The Chair of the ICB must approve the appointment of any Member of the ICB Place Committee and may remove any Member of the ICB Place Committee, acting always in accordance with the ICB Constitution.

7	**Participants**	The following individuals will be invited to attend each meeting of the ICB Place Committee as Participants. Participants attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote. The Participants of the ICB Place Committee when undertaking ICB Business are: • Rotherham Metropolitan Borough Council (RMBC) - Chief Executive • Rotherham Metropolitan Borough Council (RMBC) - Director of Public Health • The Rotherham NHS Foundation Trust (TRFT) - Chief Executive • Voluntary Action Rotherham (VAR) - Chief Executive • Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) - Chief Executive • Rotherham Primary Care Leadership Group (RPCLG) - [TBC] • Rotherham Health and Wellbeing Board (RH&WBB)- Joint Chair • Rotherham Health and Wellbeing Board (RH&WBB)- Joint Chair • Deputy Chief Executive, (TRFT) • The Rotherham NHS Foundation Trust (TRFT) - Deputy Chief Executive ICB officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper. The Chair may invite such other Participants to attend any meeting of the ICB Place Committee as the Chair considers appropriate.
8	**Deputies**	With the permission of the Chair, Members of the ICB Place Committee may nominate a deputy to attend a meeting that they are unable to attend. Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. The deputy may speak on their behalf but may not vote. The decision of the Chair regarding authorisation of nominated deputies is final.
9	**Chair**	The meetings will be run by the Chair of the ICB Place Committee (as noted in paragraph 6 above). If the Chair is absent or is disqualified from participating by a conflict of interest, a member of the ICB shall be chosen by the members present, or by a majority of them, and shall preside. In the event of the Chair being unable to attend all or part of the meeting, another Member of the ICB Place Committee shall chair the meeting.
10	**Quoracy**	No business shall be transacted unless at least 60% of the membership (which equates to 3 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member For the sake of clarity: a) No person can act in more than one capacity when determining the quorum. b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum. Members of the ICB Place Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year

11	**Conduct of meetings**	In line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the ICB Place Committee will have one vote, the process for which is set out below: a. All members of the ICB Place Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, Members of the ICB Place Committee are set out at paragraph 6; Participants and observers do not have voting rights.) b. Absent Members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. c. For the sake of clarity, any additional Participants and Observers (as detailed within Section 5.6. of the Constitution) will not have voting rights. A resolution will be passed if more votes are cast for the resolution than against it. d. If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote. e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.
12	**Frequency of meetings**	The ICB Place Committee will meet monthly in common with the Place Board. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the ICB Place Committee. One third of the members of the ICB Place Committee may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting, If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the ICB Place Committee Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members of the ICB Place Committee specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
13	**Urgent decisions**	In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the ICB Place Committee to meet virtually. Where this is not possible the following will apply: a) The powers which are delegated to the ICB Place Committee may allow for an urgent decision be exercised by the Chair subject to every effort having made to consult to consult with as many members as possible in the given circumstances. b) The exercise of such powers shall be reported to the next formal meeting of the ICB Place Committee for formal ratification, where the Chair will explain the reason for the action taken, and the ICB Audit Committee for oversight.

14	**Admission of the press and public**	In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the ICB at which public functions are exercised will be open to the public. This includes the Place Board where it is discussing ICB Business as the ICB Place Committee. The ICB Place Committee may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. The chair of the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the ICB Place Committee's business shall be conducted without interruption and disruption. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the ICB Place Committee. A public notice of the time and place of the meeting and how to access the meeting shall be given by posting it electronically at least 7 calendar days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. The agenda and papers for meetings will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.
15	**Declarations of interest**	If any Member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	**Support to the ICB Place Committee**	Administrative support will be provided to the ICB Place Committee by officers of the ICB. This will include: • Agreement of the agenda with the Chair, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward; • Maintaining an on-going list of actions, specifying Members responsible, due dates and keeping track of these actions; • Sending out agendas and supporting papers to Members five working days before the meeting. • Drafting minutes for approval by the Chair within five working days of the meeting and then distribute to all attendees following this approval within 10 working days; and • An annual work plan to be updated and maintained on a quarterly basis.

17	**Authority**	The ICB Place Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of the ICB and they are directed to co-operate with any such request made by the ICB Place Committee. The ICB Place Committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations. The ICB Place Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the ICB Place Committee must follow procedures put in place by the ICB for obtaining legal or professional advice. The ICB Place Committee is authorised to create sub-committees or working groups as are necessary to fulfil its responsibilities within its terms of reference. The ICB Place Committee may not delegate powers delegated to it within these terms of reference (unless expressly authorised by the ICB Board) and remains accountable for the work of any such group.
18	**Reporting**	The ICB Place Committee shall submit its minutes to each formal ICB Board meeting. The Chair shall draw to the attention of the ICB Board any significant issues or risks relevant to the ICB. The ICB Place Committee's minutes will be published on the ICB website once ratified. The ICB Place Committee shall submit an annual report to the ICB Audit Committee and the ICB Board. The ICB Place Committee will receive for information the minutes of other meetings which are captured in the ICB Place Committee work plan e.g. sub-committees.
19	**Conduct of the ICB Place Committee**	All Members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures. Members of the ICB Place Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. The Place Board (including the ICB Place Committee) shall agree an annual delivery plan with the ICB Board. The ICB Place Committee shall undertake an annual self-assessment of its own performance against the annual work plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the ICB Place Committee. Any resulting changes to the terms of reference shall be submitted for approval by the ICB Board.
20	**Amendments**	These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership and reporting arrangements of the ICB Place Committee and may only be changed with the approval of the ICB Board.
21	**Review date**	These terms of reference shall be reviewed annually.

[DATED [INSERT] 2022]

1. NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD

2. CONNECT HEALTHCARE ROTHERHAM CIC

3. ROTHERHAM METROPOLITAN BOROUGH COUNCIL

4. ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

4. THE ROTHERHAM NHS FOUNDATION TRUST

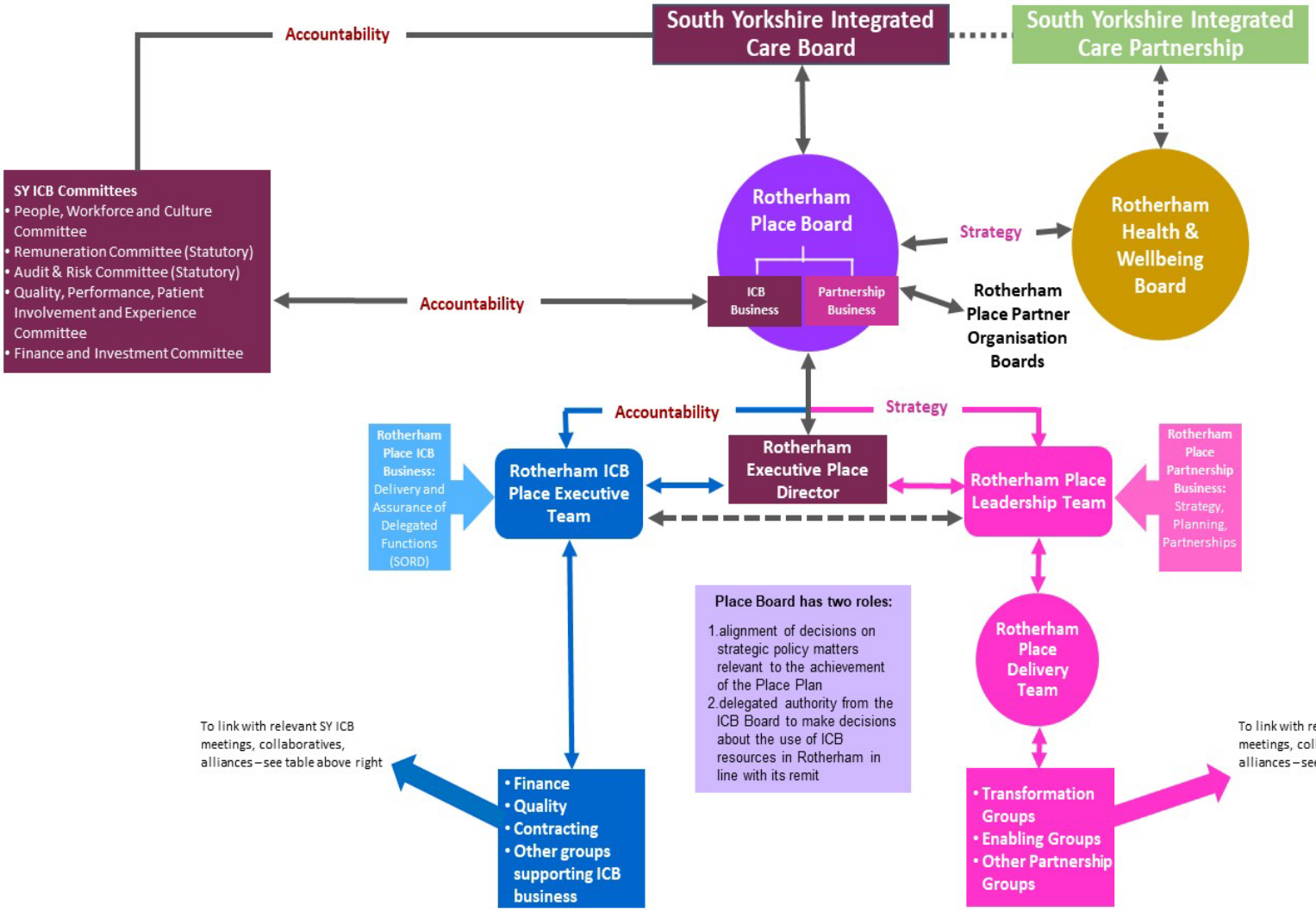
5. VOLUNTARY ACTION ROTHERHAM LIMITED

OVERARCHING PLACE PARTNERSHIP AGREEMENT FOR THE TRANSFORMATION AND BETTER INTEGRATION OF HEALTH, CARE, SUPPORT AND COMMUNITY SERVICES FOR THE POPULATION OF ROTHERHAM

No	Date	Version Number	Author
3-1	300421	1	EV
3-2	290621	2	EV
3-3	140721	3	EV
4	240622	4	EV
5	060722	5	EV

Contents

Figure 1: Rotherham Place Partnership governance structure



DATE: **2022**

This Place Agreement (the **Agreement**) is made between:

1. **NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD** of 722 Prince of Wales Road, Sheffield S9 4EU (the "**ICB**");
2. **CONNECT HEALTHCARE ROTHERHAM CIC** (Company number 10648960) whose registered office is Clifton Medical Centre, Doncaster Gate, Rotherham S65 1DA ("**Connect**");
3. **ROTHERHAM METROPOLITAN BOROUGH COUNCIL** of Riverside House, Main Street, Rotherham S60 1AE (the "**Council**");
4. **ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST** of Woodfield House, Tickhill Road Site, Weston Rd, Doncaster DN4 8QN ("**RDASH**");
5. **THE ROTHERHAM NHS FOUNDATION TRUST** of Rotherham Hospital, Moorgate Road, Rotherham S60 2UD ("**TRFT**"); and
6. **VOLUNTARY ACTION ROTHERHAM LIMITED** a registered charity (Registered Charity Number 1075995) and a company limited by guarantee (Registered Company number 02222190) whose registered office is The Spectrum, Coke Hill, Rotherham S60 2HX ("**VAR**"),

together referred to in this Agreement as the "**Partners**".

The ICB and the Council (in its role as commissioner of social care and public health services) are together referred to in this Agreement as the "**Commissioners**".
Connect, TRFT, RDASH, VAR and the Council (in its role as a provider of social care services, whether directly or through contracting arrangements with third party providers) are together referred to in this Agreement as the "**Providers**".

BACKGROUND

a) The Partners have been working collaboratively across Rotherham to integrate services and provide care closer to home for local people for some time, under a collaborative agreement signed in 2018. This updated Agreement sets out the values, principles and shared ambition of the Partners in supporting continued work to further develop place-based health and care provision for the Rotherham population using a population health management approach and building on the progress achieved by the Partners to date.

b) Rotherham's Integrated Health & Social Care Place Plan (the **"Place Plan"**) detailed the Partners' joined up approach to delivering five key initiatives that will help achieve the Health and Wellbeing Strategic Aims. The Place Partnership governance framework set out in this Agreement will enable the Providers to collaborate in order to identify opportunities for service improvement or redesign in line with the vision and objectives in the Place Plan.

c) Pursuant to the Health and Care Act 2022, on the Commencement Date the ICB was

established as a statutory body and NHS Rotherham Clinical Commissioning Group was dissolved and its functions transferred to the ICB. In line with the principle of subsidiarity, the ICB has delegated certain of its functions to be exercised on its behalf by the Place Partnership through the governance arrangements set out in this Agreement.

d) In light of the Health and Care Act 2022, the Partners recognise that from the Commencement Date they will need to undertake a programme of work through the governance arrangements set out in this Agreement to further develop their place arrangements to become a thriving Place Partnership ready to manage Rotherham resources together for the benefit of the Rotherham population. This programme of work will be set out in a Place Partnership Development Plan to be agreed between the Partners. The Partners will review the operation and contents of this Agreement regularly during 2022/23 as the Place Partnership arrangements evolve.

e) The Partners acknowledge that the Council has a dual role within the Rotherham health and care system as both a commissioner of social care and public health services but also as a provider of social care and public health services either through direct delivery or through various contracts. In its role as commissioner of social care and public health services the Council shall work in conjunction with the ICB and in its role as a provider of social care services the Council shall work in conjunction with the other Providers. The Council recognises the need to ensure and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified to the other Partners and managed.

f) This Agreement sets out the key terms that the Partners have agreed, including:

- the vision of the Partners, and key objectives for the development and delivery of integrated services in Rotherham;
- the key principles that the Partners will comply with in working together through the Place Partnership; and
- the governance structures underpinning the Place Partnership.

g) This Agreement is intended to work alongside:

- the Place Plan;
- the Contracts between the ICB and the Providers and between the Council and the Providers for the delivery of the Services; and
- the Section 75 Agreement between the Commissioners under which they commission the services listed in the schedules to that agreement.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a "person" includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

1.2.3 a reference to a "Provider", the "Council", the "ICB" or the "Commissioner" or any Partner includes its personal representatives, successors or permitted assigns;

1.2.4 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted; and

1.2.5 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 The Partners have agreed to work together to further develop the Place Partnership in order to develop an improved financial, governance and contractual framework for delivering integrated health, support, and community care for the Rotherham population (covered by the ICB and the Council) and to deliver the Place Plan.

2.2 Notwithstanding the good faith consideration that each Partner has afforded the terms set out in this Agreement, the Partners agree that save as provided in Clause 2.3 below this Agreement shall not be legally binding. The Partners each enter into this Agreement intending to honour all of their respective obligations.

2.3 Clauses 9 (*Transparency*), 16 (*Liability*), 18 (*Confidentiality and FOIA*), 19(*Intellectual Property*), 20.4 (*Counterparts*) and 20.5 (*Governing Law and Jurisdiction*) shall come into force from the date of this Agreement and shall give rise to legally binding commitments between the Providers.

2.4 Each of the Providers has one or more individual Contracts (or where appropriate combined Contracts) with the ICB or Council. This Agreement is not intended to conflict with or take precedence over the terms of the Contracts unless expressly agreed by the Partners in writing.

3. APPROVALS

Each of the Partners acknowledges and confirms that as at the date of this Agreement it has obtained all necessary authorisations to enter into this Agreement and that its own organisational leadership body has approved the terms of this Agreement.

4. DURATION AND REVIEW

4.1 This Agreement shall commence on the Commencement Date (1 July 2022) and will continue in full force and effect and will expire on 31 March 2024 (the "**Initial Term**"), unless and until terminated in accordance with the terms of this Agreement.

4.2 Prior to the expiry of the Initial Term of this Agreement will expire automatically without notice unless, no later than six (6) months before the end of the Initial Term, the Partners agree in writing that the term of the Agreement will be extended for a further term to be agreed between the Partners (the "**Extended Term**").

4.3 The Partners will review progress made against the Place Partnership Development Plan and the terms of this Agreement on a half yearly basis and/or at such intervals thereafter as may be agreed between the Partners, and the Partners may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 17 (*Variation*).

SECTION A: PLACE PLAN VISION, OBJECTIVES AND PRINCIPLES

5. THE PLACE PLAN VISION AND OBJECTIVES

5.1 The Place Plan agreed by the Partners is intended to deliver sustainable, effective, and efficient health and care support and community services with significant improvements underpinned by collaborative working through the development of the Place Partnership. The Partners have agreed to work together in order to achieve the objectives set out in the Place Plan.

5.2 The Partners' shared vision as set out in the Place Plan is:

"Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery"

5.3 The Partners acknowledge that they will have to make decisions together in order for the Place Partnership to work effectively. The Partners agree that they will always look to work together and make decisions on a Best for Rotherham basis in order to achieve the objectives in the Place Plan, save for the Reserved Matters listed at Clause 8.1.

6. THE PRINCIPLES

6.1 These Principles underpin the delivery of the Partners' obligations under this Agreement and set out key factors for a successful relationship between the Partners. The Partners acknowledge and confirm that the successful delivery of the Place Plan

will depend on the Providers' ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the provision of the Services in conjunction with the Commissioners.

6.2 The Principles are that the Partners will work together in good faith and, unless the provisions in this Agreement state otherwise, the Partners will:

6.2.1 focus on people and places rather than organisations, pulling pathways together and integrating them around people's homes and localities; adopt a way of working which promotes continuous engagement with and involvement of local people to inform this;

6.2.2 actively encourage prevention, self-management, and early intervention to promote independence and support recovery, and be fair to ensure that all the people of Rotherham can have timely access to the support they require to retain independence;

6.2.3 design pathways together and collaborate, agreeing how we do pathways once collectively, to make our current and future services work better;

6.2.4 be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in Rotherham in the most cost-effective way;

6.2.5 strive for the best quality services based on the outcomes we want within the resource available;

6.2.6 be financially sustainable and this must be secured through our plans and pathway reform;

6.2.7 align relevant health and social care budgets together so we can buy health, care, and support services once for a place in a joined up way;

6.2.8 work together to reduce health inequalities and tackle the wider determinants of health to ensure that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest; and

6.2.9 promoting and striving to adhere to the Nolan Principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership),

(together these are the "**Principles**").

6.3 In addition to the Principles set out above, the Partners will have regard to the values and principles set out in the South Yorkshire Health and Care Compact.

7. PROBLEM RESOLUTION AND ESCALATION

7.1 The Partners agree to adopt a systematic approach to problem resolution which recognises the objectives in the Place Plan and the Principles and which:

7.1.1 seeks solutions without apportioning blame;

7.1.2 is based on mutually beneficial outcomes;

7.1.3 treats each Partner as an equal party in the dispute resolution process; and

7.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

7.2 If a problem, issue, concern or complaint comes to the attention of a Partner which relates to the Place Plan or the Principles or any matter within the scope of this Agreement and is appropriate for resolution between the Partners such Partner shall notify the other Partners and the Partners each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion and/or negotiation within 20 Operational Days of such matter being notified.

7.3 Any Dispute arising between the Partners which is not resolved under Clause 7.2 above will be resolved in accordance with Schedule 3 (*Dispute Resolution Procedure*).

7.4 If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this Agreement) the receiving Partner will liaise with the Place Partnership Delivery Team as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE PLACE PARTNERSHIP

8. RESERVED MATTERS

8.1 The Partners agree and acknowledge that nothing in this Agreement shall operate as to require them to make any decision or act in anyway which shall place any Partner in breach of:

8.1.1 Law;

8.1.2 any Services Contract or the Section 75 Agreement;

8.1.3 any specific Department of Health and Social Care or NHS England policies;

8.1.4 if applicable its Constitution (including for the ICB and the Council); any terms of its NHS provider licence; its registration with the CQC ; the terms of reference or the Place Board or the ICB Place Committee Terms of Reference; or to breach any legislative requirements including the NHS Act 2006 (as amended); or

8.1.5 any term of a non-NHS party's legal constitution or other legally binding agreement or governance document of which specific written notice has been given to the Partners prior to the date of the Agreement,

and the Place Board will not make a final recommendation which requires any Partner to act as such.

9. TRANSPARENCY

9.1 The Partners will provide to each other all information that is reasonably required in order to achieve the objectives in the Place Plan.

9.2 The Partners have responsibilities to comply with Law (including where applicable Competition Law). The Partners will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, the Place Board and the Delivery Team will each ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

9.2.1 it is essential;

9.2.2 it is not exchanged more widely than necessary;

9.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

9.2.4 it may not be used other than to achieve the aims of this Agreement or the Place Plan in accordance with the Principles.

9.3 Subject to compliance with Clause 9.1 above, the Partners will ensure that they provide the Place Board and Delivery Team with all financial cost resourcing, activity or other information as may be reasonably required so that the Place Board and Delivery Team can be satisfied that the Place Plan objectives are being satisfied.

9.4 The Commissioners will make sure that the Place Board and Delivery Team establish appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the Place Plan and for no other purpose whatsoever so that the Partners do not breach Competition Law.

9.5 It is accepted by the Partners that the involvement of the Providers in the governance arrangements for the Place Partnership is likely to give rise to situations where information will be generated and made available to the Providers, which could potentially give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a

separate provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the ICB and/or the Council (where acting as a commissioner) in relation to any competitive procurements that the information it has acquired as a result of its participation in the Place Partnership, other than as a result of a breach of this Agreement, does not preclude the ICB and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations.

9.6 Notwithstanding Clause 9.5 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law which may include excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

SECTION C: GOVERNANCE ARRANGEMENTS

10. PLACE PARTNERSHIP GOVERNANCE

10.1 In addition to the Partners' own Boards / Cabinet / Governing Body, which shall remain accountable for the exercise of each of the Partners' respective functions, the Partners must communicate with each other in a clear, direct, and timely manner. The governance structure for the Place Partnership will include:

10.1.1 the Health and Wellbeing Board for Rotherham;

10.1.2 the Place Board;

10.1.3 the Place Leadership Team; and

10.1.4 the Place Delivery Team.

10.2 The diagram in Schedule 2 (Governance) sets out the governance structure and the links between the various groups in more detail. In addition to the three groups set out in Clause 10.1, as detailed on the diagram in Schedule 2 the Partners have formed a number of 'Enabling Groups' and 'Transformation Groups' which report into the Delivery Team and focus on the Enablers and Transformation Workstreams respectively.

Rotherham Health and Wellbeing Board

10.3 The Rotherham Health and Wellbeing Board is a committee of the Council, charged with promoting greater health and social care integration in Rotherham. The Health and Wellbeing Board will receive reports from the Place Board as to the development of the ICP arrangements under this Agreement and progress against the Place Plan.

Rotherham Place Board

10.4 The Place Board in practice carries out two roles:

10.4.1 firstly, the Place Board has responsibility for aligning decisions on strategic policy matters made by Partners that are relevant to the Place Partnership. Where applicable, the Place Board may also make recommendations on matters that it has been asked to consider on behalf of a constituent Partner in the Place Partnership. Where the Place Board has been asked to consider matters on behalf of a Partner, the Partner organisation remains responsible for the exercise of its functions and nothing that the Place Board does shall restrict or undermine that responsibility. This work is referred to as "**Partnership Business**"; and

10.4.2 secondly, the Place Board sits as the ICB Place Committee for Rotherham ("**ICB Place Committee**"), which is a formal committee of the ICB. The ICB Place Committee is established as a committee of the ICB Board, in accordance with the ICB's Constitution. The ICB Place Committee has delegated authority from the ICB Board to make decisions about the use of ICB resources in Rotherham in line with its remit, and otherwise support the ICB as set out in its terms of reference of Schedule 2. The decisions reached by the ICB Place Committee are decisions of the ICB, in line with the ICB's Scheme of Reservation and Delegation. This work is referred to as "**ICB Business**". When sitting as the ICB Place Committee, Partners must comply with ICB policies and procedures.

10.5 As far as possible, the Partners that are statutory bodies will exercise their respective statutory functions within the Place Board governance structure to the extent they are within the scope of these arrangements. This will be enabled:

10.5.1 for the ICB, through the Place Board sitting as the ICB Place Committee, as outlined above;

10.5.2 for other Partners that are statutory bodies, through those organisations granting delegated authority for decision making to specific individuals (for example a Place Board member) or to specific committees or other structures established by Partner organisations meeting as part of, or in parallel with, the Place Board; and

10.5.3 for Partners that are not statutory bodies, it is expected that as far as possible the individuals attending meetings of the Place Board will be formally authorised to take the decisions under consideration on behalf of their organisation.

10.6 The terms of reference for Partnership Business in Schedule 3 apply to the Place Board as at the Commencement Date. The terms of reference for ICB Business in Schedule 3 apply to the ICB Place Committee as at the Commencement Date and can be found in the governance handbook issued by the ICB and available on the ICB website. The

terms of reference for all governance groups may be updated by agreement of the Partners during the term or as otherwise stated in their terms.

10.7 Whether decisions are Partnership Business or ICB Business or a combination of the two, the aim will be to ensure that decisions reflect applicable national and local strategies and are taken in accordance with the Vision, Objectives and Principles for the Place Partnership.

10.8 The Place Board is the group responsible for:

10.8.1 leading the Place Partnership,

10.8.2 reporting to Partner organisations and the Health and Wellbeing Board for Rotherham on progress against the Place Plan; and

10.8.3 liaising where appropriate with national stakeholders (including NHS England) to communicate the views of the Place Partnership on matters relating to integrated care in Rotherham.

10.9 The Place Board will act in accordance with the terms of reference set out in Schedule 2 (*Governance*) as applicable.

10.10 The joint commissioning governance arrangements between the ICB and the Council in respect of the Better Care Fund as at the Commencement Date will continue to operate separately from the Place Board. Where agreed by the ICB and the Council the Place Board may meet in common with the BCF joint commissioning governance arrangements between the ICB and the Council.

10.11 The Place Board may refer opportunities to develop specific service improvements / redesign (provided they align sufficiently with the Principles and Objectives) to collaboratives of some or all of the Providers (dependent on the opportunity). Where the Place Board refers such opportunities, the Providers may choose to collaborate through existing governance groups (e.g. the Delivery Team), or set up specific task and finish groups, in either case aligning with the work of the Delivery Team and reporting into the Place Board. The scope and detail of delivery by the Providers of any such opportunities will be agreed by the relevant Partners through the Place Board and appended to this Agreement.

Rotherham Place Leadership Team

10.12 The Leadership Team is the oversight group for the delivery of the Rotherham Place Plan, and in driving forward the Partners' ambition for further delegation at place. It is the forum where all Partners come together to strengthen relationships and provide leadership and ambition for transformation of the Place Partnership. It will support oversight of agendas and papers for the Place Board (Partnership Business) and the

ICB Place Committee (as appropriate) and agree any partnership issues for escalation to the Place Board. The terms of reference for the Leadership Team are set out in [Schedule 2].

Rotherham Place Delivery Team

10.13 The Delivery Team is the group responsible for managing the collaborative operation of the Partners and the delivery of the Place Plan. The Delivery Team will act in accordance with its terms of reference set out in [Schedule 2 (*Governance*)].

10.14 The Partners will communicate with each other clearly, directly and in a timely manner to ensure that the Partners (and their representatives) present at the Place Board and Delivery Team are able to represent their nominating organisations to enable effective and timely decisions to be made for each respective Partner under this Agreement.

10.15 Each Partner must ensure that its appointed members of the Place Board, Leadership Team and Delivery Team (or their appointed deputies/alternatives) attend all meetings of the relevant group and participate fully and exercise their rights on a Best for Rotherham basis and in accordance with Clause 5 (*Place Plan Objectives*) and Clause 6 (*Principles*).

11. CONFLICTS OF INTEREST

11.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality the Partners agree to share all information relevant to the achievement of the Place Plan objectives in an honest, open and timely manner.

11.2 The Partners will:

11.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or operation of the Place Board, Leadership Team or Delivery Team, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of the Services;

11.2.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and

11.2.3 use best endeavours to ensure that their Place Board, Leadership Team and Delivery Team representatives comply with the requirements of this Clause 11 when acting in connection with this Agreement.

SECTION D: FINANCIAL PLANNING

12. PAYMENTS

12.1 The Partners who provide services will continue to be paid in accordance with the mechanism set out in their respective Contracts in respect of Services they deliver.

12.2 The Partners have not agreed as at the Commencement Date to share risk or reward. However, the Partners will work together during the Initial Term to develop system financial principles including the potential development of risk/reward sharing mechanisms with the aim of achieving the Objectives in line with the Place Partnership Development Plan. Any future introduction of such a mechanism would require additional legally binding provisions to be agreed between the Partners and incorporated into this Agreement in accordance with Clause 17.

SECTION E: FUTURE DEVELOPMENT OF THE PLACE PARTNERSHIP

13. PLACE PARTNERSHIP DEVELOPMENT PLAN

13.1 The Partners have agreed to work together in the initial six month period from the Commencement Date to develop a Place Partnership Development Plan which will identify priority areas of focus for 2022/23 in order to ensure that further delegation of functions from the ICB and other Partner organisations is enabled by April 2023. Once developed and agreed, the Partners will keep the Place Partnership Development Plan under review through the governance structures set out in this Agreement and may agree to amend the Place Partnership Development Plan as required during the Initial Term, in line with policy direction and legislative developments.

SECTION F: GENERAL PROVISIONS

14. EXCLUSION AND TERMINATION

14.1 A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus) in the event of:

14.1.1 the termination of their Contract; or

14.1.2 an event of Insolvency affecting them.

14.2 A Partner may withdraw from this Agreement by giving not less than 3 months' written notice to each of the other Partners' representatives on the Place Partnership Board.

14.3 A Partner may be excluded from this Agreement on written notice from all of the remaining Partners in the event of a material or persistent breach of the terms of this Agreement by the relevant Partner which has not been rectified within 30 days of notification issued by the remaining Partners (acting in consensus) or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Partner.

14.4 The Place Board may resolve to terminate this Agreement in whole where:

14.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

14.4.2 where the Partners agree for this Agreement to be replaced by a formal legally binding agreement between them.

14.5 Where a Partner is excluded from this Agreement, or withdraws from it, the Partners recognise that the associated Contract may be terminated and/or varied to reflect how the impacted Services are to be delivered. In addition to any specific obligations under the relevant Contract and to ensure a smooth transfer of Services the Partners agree to work together in good faith to agree the necessary changes so that the Services continue to be provided for the benefit of the Population. The excluded Partner shall procure that all data and other material belonging to any other Partner shall be delivered back to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

14.6 For the avoidance of doubt, individuals sitting as members of the Place Board may be removed and/ or may be prevented from participating in meetings in accordance with the relevant Terms of Reference set out in Schedule 2.

15. INTRODUCING NEW PARTNERS

Additional parties may become parties to this Agreement on such terms as the Partners will jointly agree in writing, acting at all times on a Best for Rotherham basis. Any new Partner will be required to agree in writing to the terms of this Agreement (including the legally binding elements) before admission.

16. LIABILITY

The Partners' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Contracts and not this Agreement.

17. VARIATION

Any amendment to this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Partners, provided always that the ICB will be able to amend the Terms of Reference for the ICB Place Committee and ICB Business set out in Schedule 2 without the need for approval from the other Partners.

18. CONFIDENTIALITY AND FOIA

18.1 Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner. Each Partner shall use

Confidential Information received from another Partner solely for the purpose of delivering the Services and complying with its obligations under this Agreement and for no other purpose.

18.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

18.3 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 18 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns, or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

18.4 Nothing in this Clause 18 (*Confidentiality and FOIA*) will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

18.5 The Partners acknowledge that some of them are subject to the requirements of FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that any Partner which is subject to FOIA is able to comply with their statutory obligations.

19. INTELLECTUAL PROPERTY

19.1 In order to develop and deliver the arrangements under this Agreement in accordance with the Principles each Partner grants each of the other Partners a fully paid up, non-exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Partner's obligations under this Agreement.

19.2 If any Partner creates any new Intellectual Property through the development and delivery of the arrangements under this Agreement, the Partner which creates the new Intellectual Property will grant to the other Partners a fully paid up, non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations for the Services and the development and delivery of the arrangements under this Agreement.

20. GENERAL

20.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner

in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

20.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

20.4 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

20.5 This Agreement, and any Dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

20.6 A person who is not a Partner to this Agreement shall not have any rights under or in connection with it.

This Agreement for a Rotherham Place Partnership has been entered into on the date stated at the beginning of it.

Signed by GAVIN BOYLE

for and on behalf of **NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD**

.....

CHIEF OFFICER

Signed by DR GOKUL MUTHOO

for and on behalf of **CONNECT HEALTHCARE ROTHERHAM CIC**

.....

CHAIR

Signed by KATHRYN SINGH

for and on behalf of **ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST**

.....

CHIEF EXECUTIVE

Signed by RICHARD JENKINS

for and on behalf of **THE ROTHERHAM NHS FOUNDATION TRUST**

.....

CHIEF EXECUTIVE

Signed by SHARON KEMP

for and on behalf of **ROTHERHAM METROPOLITAN BOROUGH COUNCIL**

.....

CHIEF EXECUTIVE

Signed by SHAFIQ HUSSAIN

for and on behalf of **VOLUNTARY ACTION ROTHERHAM LIMITED**

.....

CHIEF EXECUTIVE

SCHEDULE 1

Definitions and Interpretation

1 The following words and phrases have the following meanings:

Agreement or Place Agreement	this agreement incorporating the Schedules
Best for Rotherham	best for the achievement of the Place Plan for the Rotherham population on the basis of the Principles
Commencement Date	1 July 2022
Commercially Sensitive Information	Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss
Competition Law	the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector in accordance with the Health and Care Act 2022
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions
Confidential Information	the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including Commercially Sensitive Information and Competition Sensitive Information
Contract	a contract entered into by one of the ICB or the Council and a Provider for the provision of the Services linked to the agreed Transformation

	Workstreams and references to a Contract include all or any one of those contracts as the context requires
Delivery Team	the Rotherham Delivery Team which oversees the work programmes made up of Partner representatives
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 3 for the resolution of disputes which are not capable of resolution under Clause 7 (*Problem Resolution and Escalation*)
Enablers	the enabling workstreams as set out in the Place Plan
Extended Term	has the meaning set out in Clause 4.2
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Contracts), as appropriate
Initial Term	the period from and including the Commencement Date up to and including 31 March 2024
Insolvency	(as may be applicable to each Partner) a Partner taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, 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

Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code.
Leadership Team	the Rotherham Place Leadership Team as described in clause 10.12
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Place Board	the Rotherham Place Board
Place Partnership Development Plan	the development plan for the Place Partnership to be developed and agreed by the Partners by January 2023
Place Plan	the Rotherham Integrated Health & Social Care Place Plan set out in Schedule 4 of this Agreement
Population	the geographical population group of Rotherham as covered by the ICB and Council
Principles	means the principles set out in Clause 6.2
Reserved Matters	the matters set out in Clause 8.1
Section 75 Agreement	the agreement entered into by the ICB and the Council under section 75 of the National Health Service Act 2006 to commission the services listed in the Schedules to that agreement
Service Users	people within the Rotherham population served by the Commissioners and who are in receipt of the Services
Services	the services provided, or to be provided, by each Provider to Service Users pursuant to its respective Contract as set out in the Place Plan
Transformation Workstreams	the workstreams set out in the Place Plan.

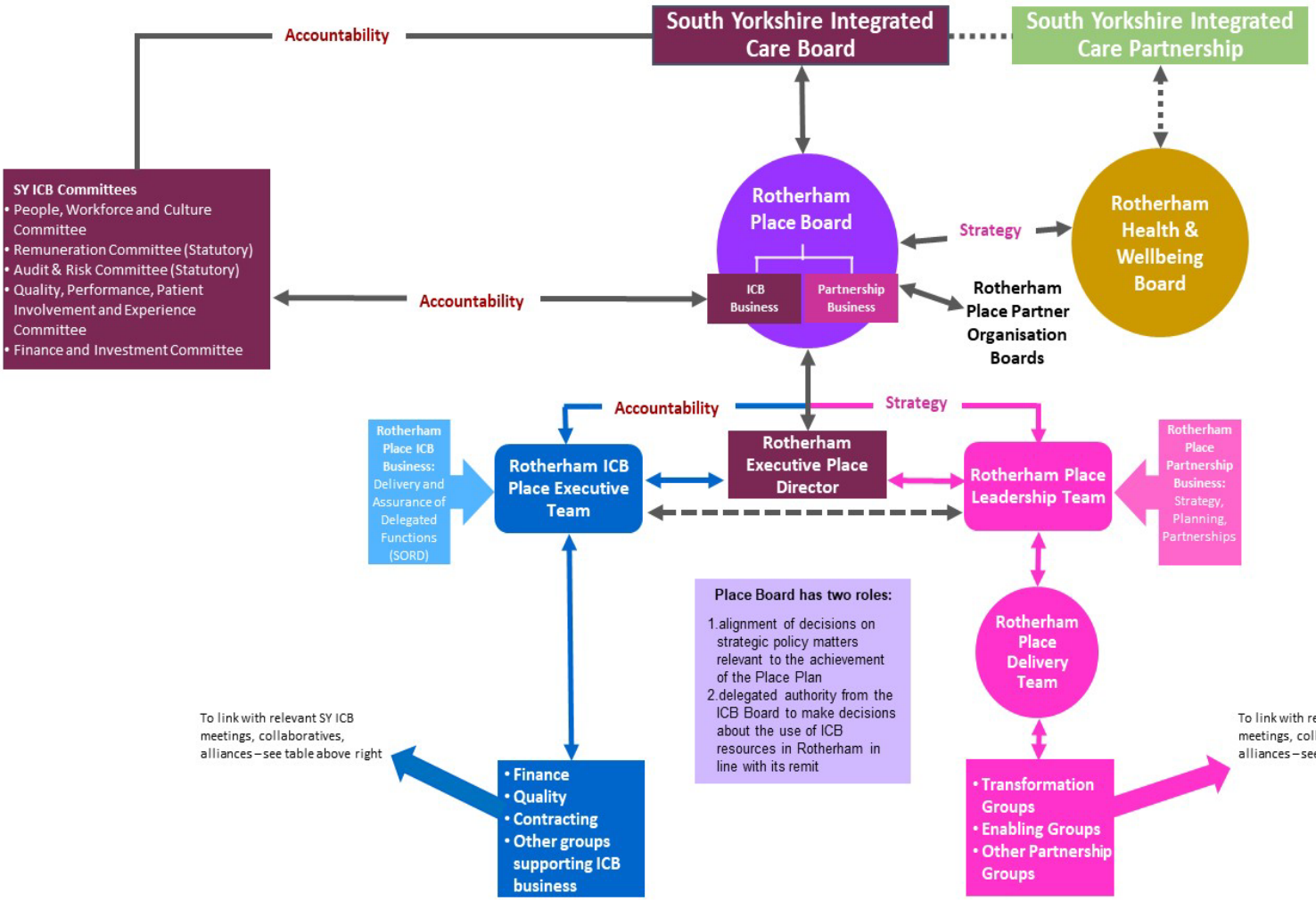
SCHEDULE 2

Governance

1.1 This Schedule 2 sets out the governance arrangements for the Place Partnership under this Agreement.

1.2 The diagram below summarises the governance structure which the Partners have agreed to operate to provide oversight of the development and implementation of the Place Partnership approach and the arrangements under this Agreement.

1.3 This Schedule also contains the terms of reference for the Place Board and the Delivery Team.



Rotherham Place Board Terms of Reference (incorporating the Rotherham ICB Place Committee) [TO BE INSERTED]

Rotherham Place Leadership Team Terms of Reference
[TO BE INSERTED]

Rotherham Place Delivery Team Terms of Reference
[TO BE INSERTED]

SCHEDULE 3

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

1.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 7 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Partners believe that by focusing on the delivery of the Place Plan and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the ICP.

1.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the Place Partnership (each a "**Dispute**") when it arises.

1.4 In the first instance the Delivery Team shall seek to resolve any Dispute to the mutual satisfaction of the Partners. If the Dispute cannot be resolved by the Delivery Team within 10 Operational Days of the Dispute being referred to it, the Dispute shall be referred to the Place Board for resolution.

1.5 The Place Board shall deal proactively with any Dispute on a Best for Rotherham basis in accordance with this Agreement so as to seek to reach a unanimous decision. If the Place Board reaches a consensus that resolves, or otherwise concludes a Dispute, it will advise the Partners of its decision by written notice.

1.6 The Partners agree that the Place Board, on a Best for Rotherham basis, may determine whatever action it believes is necessary including the following:

(a) if the Place Board cannot resolve a Dispute within 20 Operational Days of referral, it may by consensus select an independent facilitator to assist with resolving the Dispute; and

(b) the independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the Place Board to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure and, subject to the terms of this Agreement, the procedure of the Place Board at such discussions;

(iv) determine the number of facilitated discussions, provided that there will be not less than three (3) and not more than six (6) facilitated discussions, which must take place within twenty (20) Operational Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Partners in Dispute equally.

1.7 If the independent facilitator cannot resolve the Dispute within 30 Operational Days of referral of the Dispute by the Place Board, the Dispute must be considered afresh in accordance with this Schedule 3 and only after such further consideration again fails to resolve the Dispute, the Place Board may decide to:

(i) terminate this Agreement in accordance with Clause 15.4.1; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

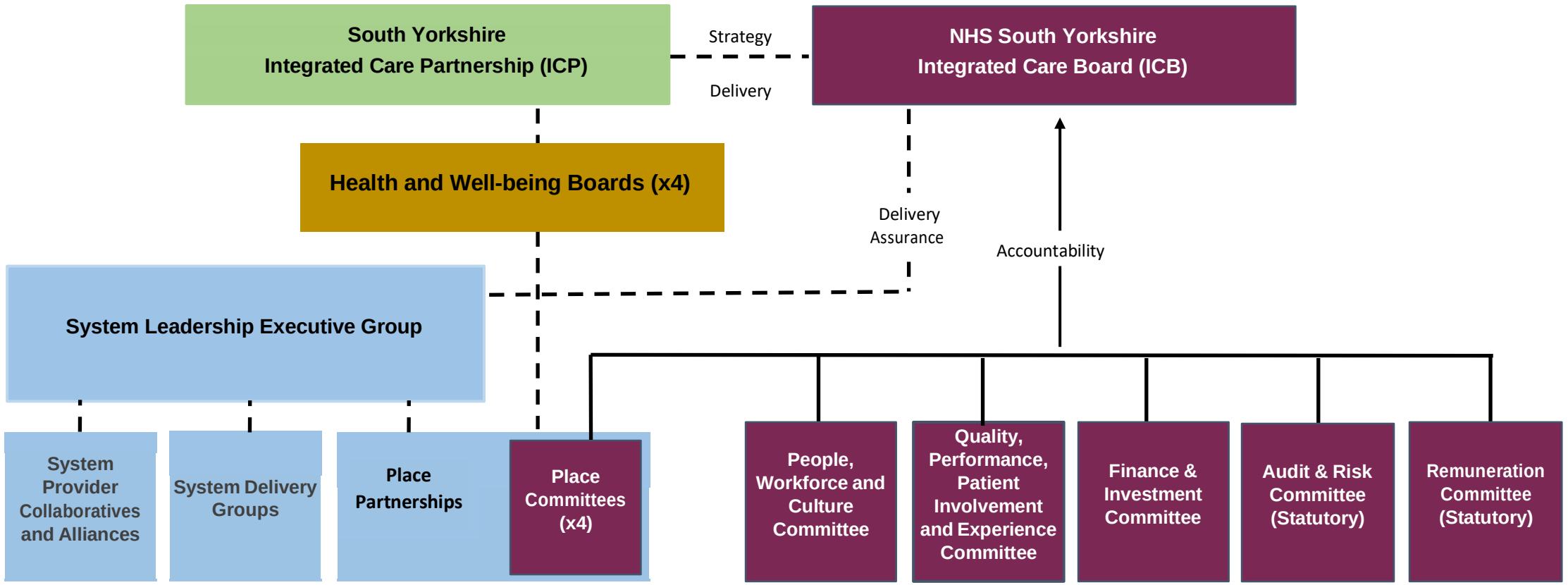
Rotherham Place Plan

ICP Place Plan Final
March 2020.pdf

South Yorkshire Integrated Care Board: Decision Map 1 July 2022

NHS South Yorkshire Integrated Care Board

Summary Functions and Decision Map



Committee or Group	Key
Integrated Care Partnership	
Integrated Care Board and Committees	
External Organisational Governance	
Partnership Forum or Group	
Direct Accountability	
Working relationship and reporting on agreed priorities	

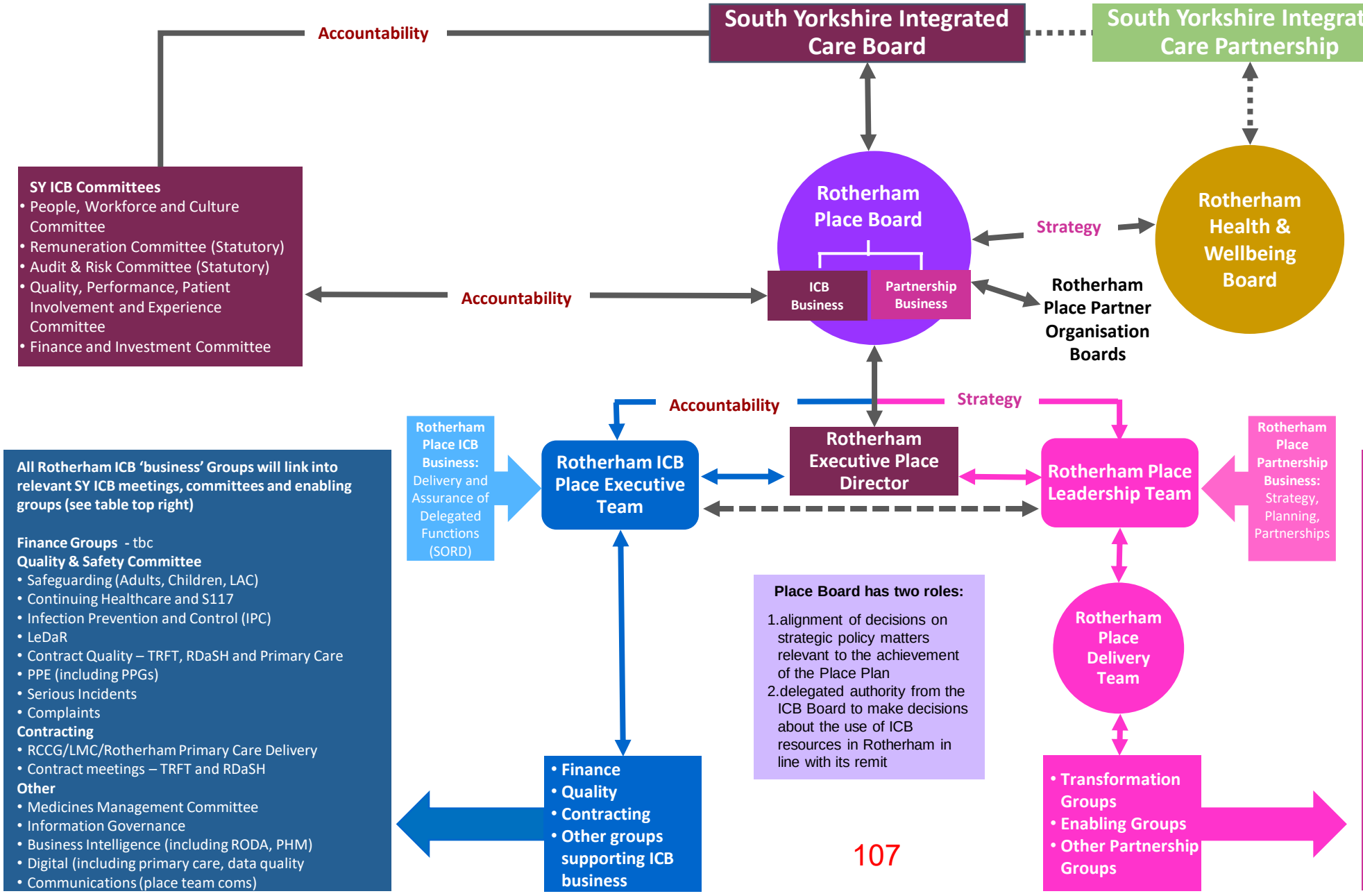
High Level Overview of ICB Committees, Partnerships and Delivery Group

NHS South Yorkshire Integrated Care Board

Committee or Group	Overview
South Yorkshire Integrated Care Partnership	The Integrated Care Partnership is a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. It is a joint statutory committee of the ICB and the 4 local authorities in South Yorkshire. Its main role is developing the Integrated Care Strategy
Health and Wellbeing Boards	Health and Wellbeing Boards are a statutory forum where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and reduce health inequalities. It is responsible producing the Health and Wellbeing Strategy based on the local Joint Strategic Needs assessment of the local population it serves.
South Yorkshire Integrated Care Board	The Integrated Care Board (ICB) is an NHS Statutory Body. It has a Unitary Board with an Independent Chair, Independent non-executive members, a chief executive, executives and statutory partner members who bring the perspective of the various sectors of health and care. The ICB is directly accountable for NHS spend within the ICB area, commissioning of services and arranging healthcare for the population of South Yorkshire, quality and performance within the ICB area. It brings partner organisations together in a new collaborative way with a common purpose and brings the NHS together locally to improve population health and establish shared strategic priorities, connecting to partnership arrangements at system and place. The ICB is accountable to NHS England.
ICB Assurance Committees	The ICB has assurance committees which are chaired by and whose membership is from Independent Non-Executive Members of the Board. They have a critical role in providing assurance to the board on how the ICB is discharging its statutory functions. Assurance Committees are accountable to the Board.
ICB Place Committees	ICB Place committees provide consistency of ICB governance in each place. They provide a mechanism for delegation within the Integrated care Board so that decision on priorities and resources can take place locally in each place with wider health and care partners. ICB Place Committees are one part of the wider set of arrangements in each place to enable integrated working at a local level. Place Committees are accountable to the Board.
Place Partnerships	The Partnership of health and care organisations across each of the Barnsley, Doncaster, Rotherham and Sheffield Places that come together respectively to plan and deliver joined-up services and to improve the health of people who live and work in their respective Places.
System Leadership Executive	An Executive Group to enhance relationships between the leaders across the health and care system and facilitating joint action to improve health and care outcomes and experiences across their populations, by influencing the wider determinants of health, including creating healthier environments and inclusive and sustainable economies. They operate through mutual accountability and consensus and accountability is through members organisations.
System Provider Collaboratives	Provider Collaboratives and Alliances are organisations who provide health and care services working together. This is where something is better done collectively for example a service delivered once to improve access or quality for everyone in South Yorkshire. South Yorkshire has a number of Collaboratives and Alliance any they cover Hospital Trusts, Mental Health Trusts, Primary Care, Children and Young People services, the Voluntary Sector and disease or condition specific Alliances for example Cancer and Maternity. They operate through mutual accountability and consensus and accountability is through members organisations.
System Delivery Groups	System Delivery Group multi-sectoral and multi care and profession groups who collaborate to develop strategies and plans, share good practice and leaning, monitor quality and delivery with a focus on the South Yorkshire population as a whole and each of its place populations. They operate through mutual accountability and consensus and accountability is through members organisations.

ROTHERHAM
ROTHERHAM PLACE PARTNERSHIP I HEALTH AND SOCIAL CARE

Rotherham Place-Partnership: Decision Map/ Governance 1 July 2022 v2.1



South Yorkshire Level

Collaboratives	I. MHLDA II.Acute III.Primary Care
Alliances	a.C&YP b.Cancer c.UECC d.Maternity
Enabling Groups	1.Pop Health 2.Health Inequalities & Inclusion 3.Quality Board 4.Finance, Capital & Estates 5.Digital, Research & Innovation 6.People & Culture 7. Sustainability

High Level Overview of Rotherham Place/ICB Committees and Delivery Groups

Committee or Group	Overview
Rotherham Health and Wellbeing Board	The Health and Wellbeing Board is a statutory forum where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and reduce health inequalities. It is responsible producing the Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment. The Rotherham Health and Wellbeing Board sets the strategic direction for health and social care in Rotherham.
Rotherham Place Partnership Board 'Place Board'	The Rotherham Place Partnership Board (Place Board) has two functions: 1. **As an ICB Place committee** providing a mechanism for delegation within the Integrated care Board so that decision on priorities and resources can take place locally with the wider health and care partners. It is one part of the wider set of arrangements in each place to enable integrated working at a local level enabling delegated authority from the ICB Board to make decisions about the use of ICB resources in Rotherham in line with its remit. The ICB Place Committees is accountable to the ICB Board. 2. **As a Place Partnership** providing a mechanism to deliver on strategic policy matters relevant to the achievement of the Place Plan. All health and care partners across Rotherham work collaboratively to plan and deliver joined-up services and to improve the health of people who live and work in Rotherham. The Place Board will meet monthly and will cover both functions.
Rotherham ICB Place Executive Team	The Rotherham ICB Place Executive Team will be responsible for operational delivery for the Rotherham Place ICB delegated Business. It will support oversight of agendas and papers for the Rotherham Place Board (ICB Business) and the ICB Board (as appropriate), and agree any ICB Committee issues for escalation to the Rotherham Place Board. It will provide oversight of management of Procedural Documents (in line with the ICB Policy); and corporate assurance and risk management for the Rotherham Place (ICB Business). It will ensure progress with the operating plan and ensure effective partner and market relations/management. It will meet weekly.
Rotherham ICB Business Groups (Finance, Quality, Contracting and other groups supporting ICB business)	These are a range of relevant groups delivering on delegated ICB business, reporting into the Rotherham PET and into the relevant SYICB meetings.
Rotherham Place Leadership Team	The Rotherham Place Leadership Team will be the oversight group for the delivery of the Rotherham Place Plan, and in driving forward our ambition for further delegation at place. It will be the forum where all place partners come together to strengthen the excellent relationships already in place and to provide leadership and ambition for place transformation. It will support oversight of agendas and papers for the Rotherham Place Board (partnership business) and the ICB Board (as appropriate) and agree any partnership issues for escalation to the Rotherham Place Board. It will act as the place oversight group for system pressures and place oversight group for major transformation. It will meet weekly except for Place Board dates.
Rotherham Place Delivery Team	Rotherham Place Delivery Team is the operational group for the delivery of the Rotherham Place Plan, reporting to the Rotherham Place Board. All Transformation and Enabling Workstreams report into the Place Delivery Team. Strategic direction will be signed off by the Health and Well-Being Board. It will meet monthly.
Rotherham Place Groups (Transformation, Enabling and other Partnership Groups)	These are a range of relevant groups delivering on the transformation and enabling workstream priorities towards delivery of the Place Plan, reporting into the Rotherham Place Delivery Team and subsequently the Place Board and Health and Wellbeing Board. Transformation and Enabling groups meet monthly.

Board of Directors' Meeting
9th September 2022

The Rotherham NHS Foundation Trust

Agenda item	P137/22
Report	**Operational Objectives 2022/23 Review**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	P1, R2, OP3, U4, D5, D6
How does this paper support Trust Values	Ambitious – The paper provides detail of the delivery of the ambitious operational objectives 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	The purpose of this paper is to present to the Board of Directors a review of progress against the 2022/23 Operational Plan priorities and associated programmes as at Months 3 and 4. At the end of Month 4, nine programmes are individually BRAG rated green (on track) and four are BRAG rated amber (not on track). It has been necessary to move one of the key milestones assigned to Priority 1 – Patients: Empower our teams to deliver improvements in care, namely "Agreed business case for Clinical Governance" from June to August due to the timing delay to present proposals to Executives. This movement does not currently impact on the future milestone relating to the re-distribution of existing clinical governance staff and the completion of recruitment into key posts and as such has not warranted formal escalation to the Executive management team. With reference to Priority 4 – US: Commit to a focus on workplace wellbeing and compassionate leadership, an internal decision has been taken to close the milestone entitled "Inventory of estates locations completed" scheduled for completion at the end of June. This is due to potential cost implications that would have an adverse impact on this year's estates maintenance budget. The expectation is that services which request redecoration of their rest rooms this year, as part of ongoing staff engagement sessions and/or through the Pulse survey, would be re-prioritised into this year's maintenance schedule. A particular risk to overall delivery within Priority 4 relates to the key milestone entitled "Leadership Programme specification signed off" which is now significantly off track, having being originally scheduled for completion in May 2022.

	This delay now presents a considerable risk to delivery of future milestones relating to training sessions earmarked for completion in September, December and March.
Due Diligence	The content of individual monthly highlight reports has been presented to Quality Committee and Finance and Performance Committee meetings held in August 2022. Papers were, however, not called for consideration at the People Committee scheduled to take place in August as the meeting Agenda was formally stood down. The Executive Lead and Senior Responsible Officer have, however, reviewed and signed off the update on Priority 4 (see Appendix 1). The update will be submitted for formal assurance purposes to People Committee in October.
Board powers to make this decision	The principal purpose of the Board is to support the timely delivery of the Trust's strategic objectives / Annual Operational Plan, whilst being assured as to compliance with appropriate statutory and legislative requirements, such as those determined, inter alia, by the Care Quality Commission (CQC).
Who, What and When	Individual Executive Directors act as Executive SROs (Senior Responsible Officers) for each area for ensuring achievement of the Operational Objectives and priorities and are responsible for realising the relevant milestones.
Recommendations	It is recommended that Board consider any actions or additional assurance required as a result of this report.
Appendices	1: Operational Objectives 2022-23 Programme Highlight Reports (June – July 2022)

1.0 Introduction

1.1. The Operational Plan for 2022/23 is built around 5 key priorities aligned to the Trust's strategic PROUD framework:-

- **P1 Patients**: Empower our teams to deliver improvements in care
- **P2 Rotherham**: Ensure equal access to services
- **P3 Our Partners**: Work together to succeed for our communities
- **P4 Us**: Commit to a focus on workplace wellbeing and compassionate Leadership
- **P5 Delivery:** Implement sustainable change to deliver high quality, timely and affordable care

1.2 The priorities are supported by 13 operational programmes that have been set out in formal mandates agreed at the Trust Board meeting held in May 2022.

1.3 The delivery and monitoring of the programmes utilises a standardised Highlight Report (see Appendix 1) so that the Trust can maintain a clear line of sight on progress.

1.4 This paper presents a high level update on progress during Months 3 and 4 against the thirteen programmes of work and reports, by exception, any areas of concern with recommendations for continuance into the next planning cycle.

2.0 Progress against Operational Objectives and Priorities

2.1 Each of the programmes supporting the delivery of the Trust's Operational Objectives and Priorities have been BRAG rated (Blue, Red, Amber, Green) as to their status at the end of July 2022 as illustrated below:

- Completed/Closed
- On track
- Not on track
- Significantly not on track

2.2 The following tables provide the summary position at Months 3 and 4 on each of the programmes of work with their respective BRAG rating. More detailed highlight reports are attached at Appendix 1.

PRIORITY 1 Patients - Empower our teams to deliver improvements in care

Programme	Scope	Summary Position	Status
P1.1 Implement a Quality Improvement Methodology in the Organisation	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.	Cohort 1 Quality and Service Improvement and Re-design (QSIR) trainees (x 20) completed their training in July. Business case approved to appoint a Quality Improvement (QI) Lead and Business Analyst. Job role in development for Associate Medical Director for QI (equivalent to 1 x Programmed Activity). Cohort 2 QSIR trainees have been identified (x 20 delegates) to undertake training in October. A central repository of QI projects is in development. A "buddy" scheme to link Cohort 2 with Cohort 1 trainees is also in development.	GREEN
P1.2 Embed effective quality governance processes and practices across our organisation	Reset our quality governance expectations and embed revised, effective practices and processes across our organization, restructuring relevant teams as appropriate.	Engagement sessions are taking place with Divisions around proposed changes to quality governance. Business case to be presented to Executives in mid-August describes proposals for restructuring current resources and recruitment of two new posts - Head of Clinical Governance role and Data Analyst. Two engagement sessions with Divisional governance leads are scheduled to take place in September.	GREEN
P1.3 Deliver the Trust Quality Priorities	Deliver the 9 Quality Priorities for 2022-23	This sub-programme is out of scope for Operational Plan highlight reporting to Quality Committee therefore BRAG status will be provided for assurance purposes only for the remainder of this year.	GREEN

PRIORITY 2 Rotherham - Ensure Equal Access to Services

Programme	Scope	Summary Position	Status
P2.1 Ensure equal access to services and reduce health inequalities in Rotherham	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 and 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.	Health Inequalities dataset and dashboard has been redesigned with initial deep-dive work undertaken. The report has subsequently been made available and presented to Referral to Treatment / Capacity Planning group, who are to conduct further service deep-dive. Health Informatics have purchased access to an alternative wellbeing dataset provided by CACI – Acorn geodemographic segmentation tool), which is to be used to conduct further health Inequalities analysis on Outpatient services "did not attends" (DNA's). The Waiting Well programme is progressing with an additional Healthy Weight Service pilot (aligned with the QUIT (reduction in tobacco intake programme) to be implemented from August 2022. Communication Station content has been finalised and pilot areas agreed. Translation folders delayed due to contractual issue. Learning disabilities and autism materials nearing completion.	GREEN
P2.2 Implement year one of our Green Plan	Implement the ambitions set out within our Green Plan and move towards delivering on the NHS net Zero Challenge reducing the environmental impact of the Trust	Still awaiting Green Delivery plan from Nifes Consulting, to identify specific carbon reduction opportunities in line with NHS Long Term plan. Also awaiting Carbon Efficiency Fund Validation for schemes implemented in 2021-22. Successful award of Public Sector Decarbonisation Fund (£2.5m conditional on TRFT £500k investment), monies already allocated to install 300 Double Glazed windows (which are already on site) due to commence Aug 2022. Designs progressing to replace "Old" Greenoaks boiler with Air Source Heat Pump.	GREEN

Programme	Scope	Summary Position	Status
P2.3 Enhance our digital services to support patients and their families across Rotherham	Advance our digital offer to patients and their families, and ensure this supports our communities to better manage their interactions with us	Rotherham Health APP utilisation metrics have been identified and will be supplied by Clinical Commissioning Group/Integrated Care Board Patient Hub – Project Manager	**GREEN**

PRIORITY 3 Our Partners - Work Together to Succeed for our Communities

Programme	Scope	Summary Position	Status
P3.1 Deliver the new Urgent Community Response 2 hour standard	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.	Rotherham has achieved Quarter 1 milestones in relation to delivering an 8-8 7 day two hour response service across the Borough and successfully submitting the nationally mandated data set (where some other Place systems are struggling to submit). 7 of the 9 clinical conditions are on-boarded. The remaining 2 pathways are in place but not yet submitting returns. Work continues to improve data quality.	**GREEN**
P3.2 Ensure discharge arrangements are highly effective and sustainable through working with partners in Rotherham	Acute and community discharge pathways, Health and care intermediate care pathways, Commissioned community bed base, therapy provision and Care homes where it is the patients normal place of residence	Initial Integrated Discharge Team Service Improvement plan agreed. Future State Process mapping delayed due to operational pressures, to be rescheduled as soon as possible. Pharmacy Professional Standards "Right First Time" implementation awaiting Medical Director approval and support to commence pilot. Community Right to Reside/Discharge Sitrep submissions have commenced, additional work ongoing to refine and fully automate data provision. Performance Benchmarking and Metrics approved and where metrics are not readily available a request has been submitted to Business Analytics Team with estimated time of arrival September 2022. Achieving Reliable Care (ARC) Pilot – Full implementation delayed due to operational pressures, staff training has commenced on pilot wards and implementation scheduled to commence August/September 2022 Criteria Led Discharge (CLD) – draft standard operating procedure completed and currently under review by medicine. Subject to approval implementation is delayed until August/September 2022.	**AMBER**

PRIORITY 4 Us – Commit to a Focus on Workplace Wellbeing and Compassionate Leadership

Programme	Scope	Summary Position	Status
P4.1 Improve our staff facilities and increase the wellbeing support available to our staff	Design wellbeing facilities available across all areas of work that will enable staff to take a break in an environment that supports their general health and wellbeing.	Staff engagement sessions have taken place across the divisions and are progressing well with initial analysis having now been undertaken. The sessions will continue throughout the year and staff will be sign posted to the relevant service provider for appropriate support as required. The joint clinical psychology service with Barnsley NHS Foundation Trust is now funded and is in the process of being formally established. The business case brief due to be presented to Executives around proposals to establish a Wellbeing Centre on site has not been finalised although meetings are taking place to discuss the outline proposal. It is already envisaged that the cost of establishing a Wellbeing Centre will not be affordable this year and there is no prospect of starting any charity fund raising for such a cause for at least another two years. However, Executive support will be sought in sufficient time to allow a full business case to be developed with a view to phasing the work over one to two years. The cost implications of refurbishing existing rest rooms is already factored into the Estates department's maintenance plans and as such no additional capital expenditure has been earmarked, however, where staff raise concerns about their rest rooms through local	**GREEN**

Programme	Scope	Summary Position	Status
		engagement sessions and/or the Pulse survey, the refurbishment of these areas will be regarded as a priority. A separate inventory for rest room refurbishment will therefore not be undertaken as part of the business case development this year.	
P4.2 Divisional leadership teams will undertake a bespoke leadership development programme	All divisional leadership teams will participate in a programme designed to ensure that they are able 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	Discussions are continuing at Executive level with no decision date confirmed. This is a significant risk to delivery as the original plan was to complete training for the first two cohorts by the end of September.	AMBER

PRIORITY 5 Delivery : Implement Sustainable Change to Deliver High Quality, Timely and Affordable Care

Programme	Scope	Summary Position	Status
P5.1 Shorten elective waiting times for patients, modernise our outpatient services and improve theatre throughput	Restore and improve the efficiency of our theatre pathways, through innovation and improvement including waste reduction where possible and realign our Outpatient (OP) capacity, growing our use of tools such as Advice and Guidance and improve our efficiency	**Outpatients**: 6:4:2 clinic meeting reviews have been implemented with weekly reviews to identify and improve clinic utilisation. Ear, Nose and Throat (ENT) Triage Pilot delayed to September 2022, whilst Data Reporting and Process issues are addressed. ENT have now gone live with Patient Initiated Follow Up (PIFU) appointments, Cardiology & Urology are scheduled to go live with PIFU in the next reporting period. Development timeline for Outpatient Booking Tool "Bookwise" continues to progress with implementation scheduled for September 2022. Contact centre have implemented utilisation of a call-back facility to reduce number of dropped calls and maximise call responses and associated clinic utilisation. Additional Referral to Treatment/Outpatient Datasets currently being investigated to provide further insight in respect of further clinic utilisation opportunities primarily focused on Clinic Cancellations/"did not attend" (DNA's) and Access Policy. **Theatres**: Anaesthetist capacity and workforce challenges currently pose a risk to Elective recovery. Due to workforce challenges, agreement has been reached to proactively take down a proportion of theatre lists over the summer period to reduce the last minute cancellations and reworking of lists that has been consuming significant amounts of resource over the last few months. Following the recommencement of the Theatres Efficiency work stream, work has commenced to identify areas of focus to improve Theatre utilisation and efficiencies. Subsequent improvement plans will be developed from Improvement Academy feedback and Theatre Utilisation analysis when complete.	AMBER
P5.2 Increase the use of same day emergency care and shorten waiting times for patients in UECC	Release pressure on Urgent and Emergency Care services and reducing waiting times for our patients in UECC by ensuring care is provided in the right place, at the right time, including establishing a consistent approach to our same day emergency care pathways.	The final draft of the new Same Day Emergency Care (SDEC) business case has been reviewed by the Chief Executive and other key executives and will be discussed at the Executive Management Team meeting the first week in August, before submission to Finance and Performance Committee. In June, Delivery and Improvement met with the Clinical Lead for the Urgent and Emergency Care Hosted Network and Director of Operations, around SDEC pathways progress and priority pathways identified at the SDEC Integrated Care Board (ICB) meeting. At the July SDEC ICB meeting, clinicians agreed to prioritise low risk chest pain and low risk deep vein thrombosis for regional review/adoption. This will be supported by a Task and Finish Group locally.	GREEN

Programme	Scope	Summary Position	Status
		A visit from the National leads for SDEC and Frailty, and Regional Urgent Care Lead also took place in July and subsequent feedback was shared by the Chief Operating Officer with actions to take forward as a result.	
P5.3 Implement new systems to better understand the costs of our service delivery at patient level	Redesigning our approach to transformational efficiency to deliver financial savings 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.	A number of large scale efficiency schemes are under development and are being taken forward through Efficiency Board to provide assurance / oversight on delivery. They are currently: eRoster, Stock Management, Service Specifications Review, Diagnostic Testing, Pharmacy Invest to Save and Digital Self Check-in. Some broad financial savings have been identified, and some initial developments/improvements are: 42 day approval of Rosters is now at 80%, compared with around 30% this time last year, short notice Bank & Agency costs of £101k (2585 hours) in May reducing to £69k (1881 hours) in June, Pharmacy invest to save business case (c500k saving) approved by the Director of Finance. Service Sustainability Reviews have been refreshed and presented to Finance & Performance Committee. Sustainability reviews will be built into annual business cycle moving forward and incorporate improved financial information following implementation of PLICs (Patient Level Information Costing) - a staffing structure has been agreed with financial approval, and a consultation process is underway to support this. Following a meeting on the 12th August, a project plan will be developed for staffing recruitment and roll-out of PLIC	AMBER

3.0 Conclusions

3.1 The Board Assurance Committees play a key role in ensuring effective oversight and delivery of the Operational Plan. Updates are provided bi-monthly to assurance committees where discussions take place around progress and any specific exceptions to plan that may impact on achievement of objectives and benefits.

3.2 In August the Quality Committee and Finance and Performance Committee considered reports on progress in all of their associated areas and confirmed the following with recommendations for action as deemed applicable.

4.0 Quality Committee

4.1 Due to cancellation of the Quality Committee in June 2022 and there being no key milestones due in the period April to May, the Quality Committee held on 31st August considered highlight reports representing progress made during the four months ending July 2022 in relation to the following areas of work:-

- P1.1 Agree and implement the Trust's agreed approach to Quality Improvement
- P1.2 Reset our quality governance expectations

4.2 The Committee duly noted the reports and progress being made with both programmes BRAG rated green "on track".

4.3 The Executive lead for P1.1 confirmed that a paper will be presented to Quality Committee on a quarterly basis to ensure that members are kept informed of the status and progress of all quality improvement projects and initiatives that are being

implemented through the trust agreed Quality and Service Improvement and Re-design (QSIR) methodology.

4.4 The Committee discussed the approach being undertaken to engage divisional governance leads in the proposal to restructure current resources as outlined in the update relating to P1.2. It was agreed that possible options would be explored in depth with colleagues affected by the proposals and with a view to setting out the pros and cons of each option before reaching a final decision.

4.5 The Committee were **assured** in terms of progress against what has already been planned for delivery up to the end of Quarter 2.

5.0 Finance and Performance Committee

5.1 The Finance and Performance Committee held on 24th August considered the highlight reports for the period June – July 2022 (see Appendix 2) in relation to the following areas of work:-

- P2.1 Ensure equal access to services and reduce health inequalities in Rotherham
- P2.2 Implement year one of our Green Plan
- P 2.3 Enhance our digital services to support patients and their families across Rotherham
- P 3.1 Deliver the new Urgent Community Response 2 hour standard
- P 3.2 Ensure discharge arrangements are highly effective and sustainable through working with partners in Rotherham
- P 5.1 Shorten elective waiting times for patients, modernise our outpatient services and improve theatre throughput
- P 5.2 Increase the use of same day emergency care and shorten waiting times for patients in UECC
- P5.3 Implement new systems to better understand the costs of our service delivery at patient level

5.3 The Committee duly noted the reports and the progress being made with only two of the eight programmes of work BRAG rated amber “not on track”.

5.4 The Committee agreed that it would be beneficial to provide some insight into any themes which could be identified between those programmes ‘doing well’ and those which may be struggling more and how this could help with future learning.

5.5 It was further agreed that operational planning discussions should take place earlier next year in order to focus on specific problems that the trust is trying to solve, identify what our key objectives are and what it is that we must deliver.

5.6 The Committee were **assured** in terms of process against what has already been planned for delivery at this point in the year and noted the importance of keeping on top of the overall risk position which is ultimately affecting rag status of the individual programmes.

6.0 People Committee

6.1 The People Committee meeting scheduled to take place in August was cancelled due to the decision to hold a members' workshop instead of the usual agenda. However the following highlight reports covering the period June to July 2022 (see Appendix 2) were reviewed and signed off by the Executive Lead and Senior Responsible Officer in order to confirm the update on progress to Trust Board and to assign initial BRAG status. The reports will be formally assured at the People Committee meeting scheduled in October.

- P4.1 Improve our staff facilities and increase the wellbeing support available to our staff
- P4.2 Divisional Leadership teams will undertake a bespoke leadership development programme.

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

Michael Wright
Deputy Chief Executive
September 2022

Operational Objectives 2022 - 23

June - July 2022

Appendix 1: Programme Highlight Reports

Board of Directors Meeting

9th September 2022

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: APRIL – JULY 2022

The Rotherham NHS Foundation Trust

Priority:	**P1 Patients : Empower our Teams to Deliver Improvements in Care**
Programme:	**P1.1 Agree and implement the Trust's agreed approach to Quality Improvement** **P1.2 Reset our quality governance expectations** **P1.3 Deliver the 9 Quality Priorities**
Executive Lead:	**Helen Dobson, Chief Nurse**
SRO:	**Victoria Hazeldine, Deputy Chief Nurse/Elaine Jeffers, Deputy Director of Quality Assurance**

RAG STATUS

Programme 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: Standardize our Quality Improvement approach and implement this in order to improve our quality of care for patients: (1) Agree a suitable QI methodology for TRFT, (2) Commence the establishment a QI Faculty for TRFT, (3) Commence the implementation of QI practices and processes across TRFT (using agreed methodology), (4) 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: (1) Review of clinical governance and quality assurance structures across TRFT, (2) 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)
Summary Position:	**Standardise our Quality Improvement approach** : Cohort 1 QSIR trainees have completed training and will commence action learning set phase of the training and to provide continued support from NHSE. Business case approved to appoint the QI Lead and Business Analyst. Job descriptions agreed and recruitment will commence in August. Job role to be defined for Associate Medical Director for QI (equivalent to 1 x Programmed Activity). Cohort 2 QSIR trainees have been identified (x 20 delegates). Training to commence on 19th October 2022. A central repository of QI projects is in development. A "buddy" scheme to link Cohort 2 with Cohort 1 trainees is also in development. **Revise our internal Quality Governance structures and processes :** Engagement sessions are taking place with Divisions around proposed changes to quality governance. A business case has been formulated with a view to presentation to Executives in mid-August which describes proposals for restructuring current resources so that there is clear direction both into and out of corporate. Recruitment of the proposed Head of Clinical Governance role and Data Analyst will commence in September subject to approval from Executives. Two engagement sessions with Divisional governance leads are scheduled to take place on 7th and 14th September. **Deliver our Quality Priorities :** See separate report

PROGRAMME

Activities completed April - July:	• **Standardise our Quality Improvement approach** : QSIR Cohort 1 training completed in July. Business case approved for key posts Head of Quality Improvement and Business Analyst. Cohort 2 trainees identified. • **Revise our internal Quality Governance structures and processes:** Develop the business case proposal around changes to quality governance structures and associated re-distribution of existing resources as well as identifying recruitment needs. • **Deliver our Quality Priorities :** See separate report
Activities planned for August/September:	• **Standardise our Quality Improvement approach :** Confirmation of Cohort 2 QSIR trainees and commencement of recruitment of key posts. Action learning set for Cohort 1 commences. Development of the resource packs and central repository for QI projects commences along with the development of the Cohorts 1 and 2 "buddying" scheme. • **Revise our internal Quality Governance structures and processes:** Finalise the business case proposal and present to Executives. Commence recruitment (in September) for Head of Clinical Governance and Data Analyst. Complete divisional governance leads engagement sessions on 7th and 14th September. • **Deliver our Quality Priorities :** See separate report
Key changes April - July	• **Key Milestone change** – "Agreed business case for Clinical Governance" in Quarter 1 has been moved to August due to a timing delay to present to Executives. This change does not currently impact on the future milestone to re-distribute existing staff and complete recruitment.

Risks:	• Unable to achieve Quality Priorities due to unexpected, external influences beyond our control • Unable to appoint appropriate Head of Quality Improvement	**Issues:**	

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: JUNE - JULY 2022

The Rotherham NHS Foundation Trust

Priority:	**P.2 Ensure Equal Access to Services**
Programme:	**P 2.1 Ensure equal access to services and reduce health inequalities in Rotherham** **P 2.2 Implement year one of our Green Plan** **P 2.3 Enhance our digital services to support patients and their families across Rotherham**
Executive Lead:	**Michael Wright, Deputy Chief Executive**
SRO:	**Louise Tuckett, Director of Strategy, Planning and Performance**

RAG STATUS

Programme 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 well-being. 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 and we advance our digital offer to patients and their families, and ensure this supports our communities to better manage their interactions with us

Summary Position:

Health Inequalities - Health Inequalities Dataset and dashboard has been redesigned with initial Deep-Dive work undertaken. The report has subsequently been made available and presented to RTT / Capacity Planning group, who are to conduct further Service Deep-Dive. Health Informatics have purchased access to an alternative Wellbeing dataset (CACI – Acorn Wellbeing), which is to be used to conduct further Health Inequalities analysis on Outpatient DNA's. Waiting well programme is progressing with additional Healthy Weight Service pilot (aligned with QUIT programme) to be implemented from August 2022. Communication Station content has been finalised and pilot areas agreed. Translation folders delayed due to contractual issue. LD & Autism materials nearing completion.

Green Delivery Plan - Still awaiting Green Delivery plan from Nifes Consulting, to identify specific carbon reduction opportunities in line with NHS Long Term plan. Also awaiting CEF Validation for schemes implemented in 2021-22. Successful award of Public Sector Decarbonisation Fund (£2.5m conditional on TRFT £500k investment), monies already allocated to install 300 Double Glazed windows (which are already on site) due to commence Aug 2022. Designs progressing to replace "Old" Greenoaks boiler with Air Source Heat Pump.

Rotherham Health App – Rotherham Health App utilisation metrics have been identified and will be supplied by CCG/ICB Patient Hub – Project Manager.

PROGRAMMES 2.1, 2.2 & 2.3: Ensure equal access to services and reduce health inequalities in Rotherham, implement Year 1 of our Green Plan, enhance our digital services to support patients and their families across Rotherham

Activities completed in June/July:	• Initial Health Inequalities Data Deep-Dive complete • Rotherham Health App users metric identified via CCG/ICB Patient Hub - Project Manager • Rotherham Health App "Patient Hub" project to be initiated (Health Informatics PMO) to permit delivery of "Maternity Digital Offering" and "Appointment Cancellation and Amendment" functionality required to achieve project milestones
Activities planned for August/ September:	• Services to complete Health Inequalities Deep-Dive at Individual Service level • Launch of Healthy Weight Pilot Scheme • Publication of Green Delivery Plan (Nifes Consulting) • Validation of CEF Year 1 Financial & Carbon Savings
Key changes in June/July:	• None

Risks:	• Availability of accurate up-to-date Deprivation Population data	**Issues:**	• None

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: JUNE - JULY 2022

The Rotherham NHS Foundation Trust

Priority:	**P.3 – Our Partners – Work Together to Succeed for Our Communities**
Programme:	**P3.1 Deliver the new Urgent Community Response 2-hour standard** **P3.2 Ensure discharge arrangements are highly effective and sustainable through working with partners in Rotherham**
Executive Lead:	**Michael Wright, Deputy Chief Executive**
SRO:	**Jodie Roberts, Deputy Chief Operating Officer**

RAG STATUS

Programme Overview:

The Rotherham Urgent and Community Transformation programme is part of the Rotherham Integrated Health and Social Care plan which aims to support 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

Summary Position:

Discharge
Initial IDT Service Improvement plan agreed. Future State Process mapping delayed due to operational pressures, to be rescheduled ASAP. Pharmacy Professional Standards “Right First Time” implementation awaiting Medical Director Approval and support to commence pilot. Community Right to Reside/Discharge Sitrep submissions have commenced, additional work ongoing to refine and fully automate data provision. Performance Benchmarking and Metrics approved and where metrics are not readily available a request has been submitted to Business Analytics Team ETA Sept 22. Achieving Reliable Care (ARC) Pilot – Full implementation delayed due to operational pressures, staff training has commenced on pilot wards and implementation scheduled to commence Aug/Sep 2022
Criteria Led Discharge (CLD) – draft SOP complete, currently under review by medic, subject to SOP approval implementation delayed until Aug/Sep 2022
Two hour urgent response
Rotherham has achieved Q1 milestones in relation to delivering an 8-8 7 day two hour response service across the Borough and successfully submitting the nationally mandated data set (where some other Place systems are struggling to submit). 7 of the 9 clinical conditions are on-boarded. The remaining 2 pathways are in place but not yet submitting returns. Work continues to improve data quality.

PROGRAMMES 3.1 & 3.2 – Deliver the new urgent community response 2 hour standard, ensure discharge arrangements are highly effective and sustainable through working with partners in Rotherham

Activities completed in June/July:

Sustainable discharge

Acute/IDT:
- Self assessment and action plan against nationally mandated 100 day acute discharge challenge

Community:
- Development and embedding of community flow co-ordinator role
- Introduction of community bed MDT huddle to manage effective discharge planning
- Development and go live of community sitrep for Athorpe Lodge
- Drafted options paper for shared care record

Urgent Community Response:
- On going data quality improvement including at elbow support, data cleansing and work to develop consistency of clinical definitions.

Activities planned for August/ September:

Sustainable discharge

Acute/IDT: IDT Future State Process Mapping, Commence all Acute Discharge Project Pilots and 100 day challenge actions

Community:
- On-boarding of intermediate care community bed sit-rep
- Continued development of MDT working to improve discharge planning and reduce length of stay

Urgent Community Response:
- On boarding of outstanding clinical conditions (for completion Q3)
- Further alignment of data set against national requirements and data cleansing
- Recruitment and development of the clinical community hub to support effective triage to right level of care and rapid response

Key changes in June/July:

- Introduction of community bed base huddle to improve discharge planning
- Community service community bed sitrep go live

Risks:

- Insufficient clinical capacity for implementation
- Insufficient BI/ system resource to develop and implement the required changes and reporting needs

Issues:

- System pressures have reduced access to clinical/professional expertise for development and change activity
- Multiple national /ICB requirements are increasing the demands on Place based staff and particularly clinical /professional expertise

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: JUNE - JULY 2022

The Rotherham NHS Foundation Trust

Priority:	**P.4 US - Commit to a focus on workplace wellbeing and compassionate leadership**
Programme:	**P4.1 Improve our staff facilities and increase the wellbeing support available to our staff** **P4.2 Divisional leadership teams will undertake a bespoke leadership development programme**
Executive Lead:	**Steve Ned, Director of Workforce**
SRO:	**Paul Ferrie, Deputy Director of Workforce**

RAG STATUS

Programme 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.

Summary Position:

Workplace Wellbeing – Staff engagement sessions have taken place across the divisions and are progressing well with initial analysis having now been undertaken. The sessions will continue throughout the year and staff will be sign posted to the relevant service provider for appropriate support as required. The joint clinical psychology service with Barnsley NHS FT is now funded and is in the process of being formally established. The business case brief due to be presented to Executives around proposals to establish a Wellbeing Centre on site has not been finalised although meetings are taking place to discuss the outline proposal. It is already envisaged that the cost of establishing a Wellbeing Centre will not be affordable this year and there is no prospect of starting any charity fund raising for such a cause for at least another two years. However, Executive support will be sought in sufficient time to allow a full business case to be developed with a view to phasing the work over one to two years. The cost implications of refurbishing existing rest rooms is already factored into the Estates department's maintenance plans and as such no additional capital expenditure has been earmarked, however, where staff raise concerns about their rest rooms through local engagement sessions and/or the Pulse survey, the refurbishment of these areas will be regarded as a priority. A separate inventory for rest room refurbishment will therefore not be undertaken as part of the business case development this year.

Compassionate leadership - Discussions are continuing at Executive level with no decision date confirmed. This is a significant risk to delivery as the original plan was to complete training for the first two cohorts by the end of September.

PROGRAMME

Activities completed in June/July:	• Sign off new Leadership Programme specification – not completed • Present a business case brief at EMT outlining proposals for a wellbeing centre and the re-decoration of existing staff rest rooms – not completed
Activities planned for August/September:	• Plans to be in place for Autumn Covid and Flu vaccination campaigns (utilising existing space at old Greenoaks) • Business case brief to Executives outlining proposals for a Wellbeing Centre
Key changes in June/July:	• A decision has been taken to close the key milestone entitled “Inventory of estates locations completed” due to the anticipated cost implications that would impact on existing estates maintenance budget. The expectation is that services which request redecoration of their rest rooms as part of ongoing staff engagement sessions and/or through the Pulse survey would be re-prioritised and factored into annual maintenance expenditure. • Due to there being no decision made on the compassionate leadership programme, the milestone entitled “Leadership Programme specification signed off” is now significantly off track (BRAG rated red). Awaiting Executive decision on whether the programme is to go ahead or be deferred (timeline for a decision to be confirmed)

Risks:	• Leadership programme starts later than planned resulting in delayed changes to desired behaviours/compassionate leadership • Delays starting leadership programme impacts on funding availability as budget is re-allocated to other schemes • Preferred option for “wellbeing centre” is deemed too expensive due to cost improvement pressures this year	**Issues:**	

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: JUNE - JULY 2022

The Rotherham NHS Foundation Trust

Priority:	**P5 Delivery – Implement Sustainable Change to Deliver High Quality, Timely and Affordable Care**
Programmes:	**P5.1 Shorten elective waiting times for patients, modernise our outpatient services and improve theatre throughput, P5.2 Increase the use of same day emergency care and shorten waiting times for patients in UECC, P5.3 Implement new systems to better understand the costs of our service delivery at patient level**
Executive Leads:	**P5.1/P5.2 Sally Kilgariff, Chief Operating Officer, P5.3 Steve Hackett, Director of Finance**
SROs:	**P5.1 Louise Tuckett, Director of Strategy, Planning and Performance, P5.2 Jodie Roberts, Deputy Chief Operating Officer, P5.3 Mark Bloy, Deputy Director of Finance**

RAG STATUS

Programme Overview:

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.

Summary Position:

Theatres: Anaesthetist capacity and workforce challenges currently pose a risk to Elective recovery. Due to workforce challenges, agreement has been reached to proactively take down a proportion of theatre lists over the summer period to reduce the last minute cancellations and reworking of lists that has been consuming significant amounts of resource over the last few months. Following the recommencement of the Theatres Efficiency workstream, work has commenced to identify areas of focus on to improve Theatre utilisation and efficiencies. Subsequent improvement plans will be developed from Improvement Academy feedback and Theatre Utilisation analysis when complete.

Outpatients: 6:4:2 clinic meeting reviews have been implemented with weekly reviews to identify and improve clinic utilisation. ENT Triage Pilot delayed to Sept 22, while Data Reporting and Process issues are addressed. ENT have now gone live with PIFU, Cardiology & Urology scheduled to go live with PIFU in the next reporting period. Development timeline for Outpatient Booking Tool “Bookwise” continues to progress with implementation scheduled for Sept’ 22. Contact centre have implemented utilisation of a call-back facility to reduce number of dropped calls and maximise call responses and associated clinic utilisation. Additional RTT/Outpatient Datasets currently being investigated to provide further insight in respect of further clinic utilisation opportunities primarily focused on Clinic Cancellations/DNA’s & Access Policy.

Same Day Emergency Care (SDEC): The final draft of the new SDEC business case has been reviewed by the Chief Executive and other key executives and will be discussed at ETM the first week in August, before submission to FPC. In June, Delivery and Improvement met with the Clinical Lead for UECC Hosted Network (Kay Stenton) and Director of Operations, around SDEC pathways progress and priority pathways identified at SDEC ICB meeting. At the July SDEC ICB meeting, clinicians agreed to prioritise low risk chest pain and low risk DVT for regional review/adoption. This will be supported by a Task and Finish Group locally. A visit from the National leads for SDEC and Frailty, and Regional Urgent Care Lead also took place in July and subsequent feedback was shared by the COO with actions to take forward as a result.

Sustainability: A number of large scale efficiency schemes are under development and are being taken forward through Efficiency Board to provide assurance / oversight on delivery. They are currently: eRoster, Stock Management, Service Specifications Review, Diagnostic Testing, Pharmacy Invest to Save and Digital Self Check-in. Some broad financial savings have been identified, and some initial developments/improvements are: 42 day approval of Rosters is now at 80%, compared with around 30% this time last year, short notice Bank & Agency costs of £101k (2585 hours) in May reducing to £69k (1881 hours) in June, Pharmacy invest to save business case(c500k saving) approved by the Director of Finance. Service Sustainability Reviews have been refreshed and presented to Finance & Performance Committee. Sustainability reviews will be built into annual business cycle moving forward and incorporate improved financial information following implementation of PLICs

PLIC (Patient Level Information Costing) - a staffing structure has been agreed with financial approval, and a consultation process is underway to support this. Following a meeting on the 12th August, a project plan will be developed for staffing recruitment and roll-out of PLIC.

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PROGRAMME 5.1 - Shorten elective waiting times for patients, modernise our outpatient services and improve theatre throughput

Activities completed in June/July:	**Theatres** • Theatres Efficiencies work recommenced • Improvement Academy Work in Theatres complete **Outpatients** • 6:4:2 clinic meeting reviews implemented June • General Surgery & ENT have gone Live with PIFU • Call back facility implemented in Contact Centre
Activities planned for August/ September:	**Theatres** • Complete Theatre Utilisation App review • Relaunch Theatre Utilisation workstream • Complete Theatre Improvement Delivery plan **Outpatients** • ENT triage pilot to go live • Go Live with a further 3 specialties (Gynaecology, Cardiology & Urology) for PIFU • Full Outpatient booking system via “Bookwise” to be implemented
Key changes in June/July:	• None

Risks:	• Lack of Engagement • Lack of required Health Informatics Resource, Significant Operation Pressures • Workforce Issues – Anaesthetic capacity (new)	**Issues:**	• Accessing suitable data for Outpatients Benchmarking and Metrics to be configured

PROGRAMME 5.2 - Increase the use of same day emergency care and shorten waiting times for patients in UECC

Activities completed in June/July:	• Meeting with Clinical Lead for UECC Hosted Network (Kay Stenton) and Director of Ops around SDEC pathways progress and priority pathways identified at SDEC ICB meeting • SDEC ICB meeting agreed clinical pathways to prioritise for regional review/adoption (low risk chest pain and low risk DVT) • National/Regional NHS England Frailty/SDEC visit - feedback shared with actions to take forward • SDEC Business Case reviewed by Chief Executive and other key executives, before submission to ETM early August
Activities planned for Aug/Sept:	• SDEC business case to go to ETM early August • SDEC business case to go to FPC in August • Task and Finish group to be established for streaming/formal direct pathways to SDEC, incorporating SDEC ICB group work • Develop SOP for Same Day Emergency Care provision (across all areas)
Key changes in June/July:	• SDEC ICB meeting agreed clinical pathways to prioritise for regional review/adoption • Decision to establish Task and Finish group for streaming/formal direct pathways to SDEC • Further progressed SDEC Business Case with plan for sign off by Q2

Risks:	• Specialties do not support the pathways/processes that will circumvent UECC	**Issues:**	• Lack of shared ownership of acute pathways • UECC is treated as default location for all urgent care needs

PROGRAMME 5.3 - Implement new systems to better understand the costs of our service delivery at patient level

Activities completed in June/July:	• Paper delivered to the June and July Efficiency Boards on Large Scale Efficiency Schemes progress • Pharmacy invest to save business case approved by the Director of Finance on 22nd July • 'Golden Key' introduced (agency spend approval) 13th June • PLIC staffing structure and Job Descriptions agreed by the Director of Finance • Sustainability reviews discussed with the Executive Team and DRAFT scores completed • Action outlined for '3' and '4' rated services • DRAFT Sustainability report presented to Finance & Performance Committee for assurance.
Activities planned for August/September:	• Paper to be delivered in August and September on Large Scale Efficiency Schemes progress • CSS progressing recruitment for Pharmacy invest to save • Project Plan to be developed for staffing recruitment and roll-out of PLIC • Finalisation of sustainability scores for each service between Executive team and divisions via performance review meetings.
Key changes in June/July	• None

Risks:	• Some saving around large scale efficiency schemes may not deliver in 22/23	**Issues:**	

Subject:	**Finance and Performance Committee July and August 2022 Combined CHAIR'S ASSURANCE LOG – PART 1 AGENDA: Public** **Quorate: Yes**	**Ref:** **P138/22i**	**BoD:09/09/2022**

CHAIR'S LOG: Chair's Key Areas for Assurance/Escalation

Committee / Group: Finance and Performance Committee	**Date:** 27 July, 4 August and 24 August 2022	**Chair:** Nicola Bancroft

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	**Operational Plan Priorities 2022/23**	The Committee received the bi-monthly update on progress against each of the 8 programmes overseen by the Committee All programmes are making good progress towards achieving their objectives, with 3 of the 8 programmes rated amber. A request for underlying performance themes was made to be part of the October update on risk and issue management. The discharge arrangements programme was highlighted as a risk of becoming significantly off track given the highly pressurised service but it was noted that the team was fully engaged on delivering key improvements.	Board of Directors	Assured
2	**Sustainability Reviews**	The Committee received a comprehensive report on the Trust's refreshed approach to the Service Sustainability Reviews. The Committee concluded that it was assured following review of the outcomes including the process whereby actions are required at Divisional Leadership level where the Service Sustainability rating came out at 3 or 4. It was noted that Divisional colleagues would welcome a joint approach next time to ensure consistency of scoring Trust wide.	Board of Directors	Assured

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
3	**Operational Performance**	The Trust is experiencing challenges in both elective and non-elective pathways with deteriorating Referral to Treatment Time and Diagnostic Waiting Time positions. However a Recovery Workshop held in August identified a number of schemes to drive recovery by increasing capacity across a range of areas. A detailed review of recovery plans and the trajectory of "what good looks like' is planned for the September Committee meeting. In terms of the issues around waiting lists, a detailed Standard Operating Procedure has been developed to ensure the Trust has a detailed oversight. The Trust's Internal Auditors are undertaking a review of the current processes relating to waiting lists.	Board of Directors	Limited Assurance
4	**Financial Performance to date and Forecast 2022/23**	The Committee noted a Trust surplus to plan of £297K in month and £100k year to date. The Cost Improvement Plan (CIP) was off plan by £387K (20%) which, albeit an improvement on the previous month, remains a key area of focus. The recurrent full year effect is only 30% of the annual target. The Committee noted slippage on capital expenditure at month 4 and welcomed the actions being taken by the Capital Monitoring Group on phased implementation. The Committee recognised that the £2.7 million income and expenditure agreed deficit financial plan could be delivered but was uncomfortable with the current CIP assumptions, particularly in the light of the impact on future financial years. Following divisional and corporate planned review sessions, a further update is scheduled for the September meeting.	Board of Directors	Assured – subject to further work on the forecast

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
5	**Board Assurance Framework (BAF)**	The two Strategic Board Assurance Risks were discussed and the Committee approved the increase in score of BAF Risk D5 from a score of 9 to a score of 12 given the additional gaps in controls identified. The Committee discussed the dynamics of the Rotherham PLACE and the impact external partners were having on the Trust's ability to deliver which has been included within controls and mitigations under D5. The BAF Risk D6 was discussed and acknowledged that despite the additional controls and mitigations in place, there needed to be a period of monitoring before the risk score could be reduced. The Committee agreed that it was important to understand how the recovery plan, the financial forecast for 2022/23 and the initial 2023/24 financial outlook would impact on the risk target for the end of the financial year.	Board of Directors	Assured

Subject:	Quality Committee July and August 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA: Public Quorate: Yes	Ref: P138/22ii	BoD:09/09/2022

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality Committee	**Date:** 27 July and 31 August 2022	**Chair: Rumit Shah**

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	New Format for the Quality Committee	Following a development session in June 2022, the Quality Committee has now had two meetings using the agreed revised agenda and work plan. The meeting has a refocus on reporting from the six new Committees directly reporting to it in addition to a reduced membership. The strengthened style of reporting lends itself to increased transparency leading to a more robust and detailed discussion. The Committee will review the effectiveness of the changes in December 2022.	Board of Directors	To note.
2	Safeguarding Quarterly Report	Compliance with safeguarding Mandatory training has been discussed and the Committee raised concerns in relation to an apparent disconnect between Divisional reporting and data held within ESR. The Committee referred this matter to the People Committee for further consideration. The Committee was concerned to hear of the gaps in service provision for Psychology support for cancer patients in addition to CAMHS provision for out of hours.	Board of Directors	Limited Assurance

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
3	Patient Experience Committee: Quarterly Report	The Committee acknowledge the amount of improvement that had taken place around patient experience. Further information has been requested for inclusion in the next report around progress made on the patient surveys across both acute and community.	Board of Directors	Assured
4	Resuscitation Training Compliance	The Committee discussed the report noting the low levels of resuscitation training compliance and whilst some improvements had been made more work was required. The Trust does have in place a dedicated resuscitation team responding to cardiac arrests 24 hours per day and noted that front line staff were able to deliver basic life support. As of September 2022 additional training capacity was expected to be available as the resuscitation team would be at funded establishment.	Board of Directors	Limited Assurance
5	Divisional Presentation: UECC	The Committee welcomed the Senior Management Team and whilst it recognised the road map to quality improvement, was assured by the work undertaken to date. Morale within the department was described as 'low' with a high number of nursing staff leaving although recent changes in the Senior Management Team are starting to have a positive impact. Senior leaders were working with the Executive Team to improve staff morale across the whole workforce.	Board of Directors	Assured

Subject:	Audit Committee 29 July 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA Quorate: Yes	Ref: P138/22iii	BoD: 09/09/2022

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Audit Committee	**Date:** 29 July 2022	**Chair: Mike Smith (as vice Chair)**

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 12 approved risks scoring 15 or above at the end of Quarter 1 all of which have now been allocated the appropriate Board Assurance Committee for oversight. The Committee noted the increased engagement in the whole risk management process whilst recognising there is still work to do.	Board of Directors	Assured that plans were in place to address identified gaps and areas for improvement, acknowledging that further work was required
2	Board Assurance Framework	The Committee received the Board Assurance Framework (BAF) report outlining the current position for Quarter 1. The report highlighted the discussion held at each Board Assurance Committee. Internal Audit highlighted that they welcomed the development of the BAF and found the overview report of changes very beneficial.	Board of Directors	Assured on ratings and how assessing BAF positions and supportive of plans going forward.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
3	Board Assurance Committee Annual Reports	The Committee received the Annual Report from each Board Assurance Committee with the respective Chairs in attendance to present the findings and next steps. The Committee was assured around the Annual Reports noting where development had been highlighted.	Board of Directors	Assured
4	Legal Report	Progress against the improvement action plan was highlighted with the Committee noting that systems and processes were now in place within the Legal Department. Internal Audit concurred that with the exception of embedding learning from litigation, all actions had been implemented.	Board of Directors	Assured
5	Progress Report from Internal Auditor	Three reports had been completed and issued (Data Security and Protection Tool (Substantial Assurance), eRostering (Significant Assurance) and Clinical Effectiveness Review (no rating as carried out as an advisory review). The Committee commended the Significant Assurance rating attributed to the eRostering review, acknowledging the significant amount of work undertaken over a period of time to get to this point. The implementation rate for first follow rate was 75% with an overall implementation rate of 88%. The Committee considered and approved changes to the Audit Programme as follows:	Board of Directors	Noted the progress

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• Strategic governance deferred to Quarter 4. • Change in scope to the finance audits to accommodate NHS England's HFMA Financial Sustainability Checklist Audit requirement.		
6	Progress Report from External Auditor	The Committee received assurance on progress for completion of the Value for Money to enable the Audit Completion Certificate to be issued within the deadlines required.	Board of Directors	Assured on the progress to year end completion.
7	Standards of Business Conduct	The Committee reviewed and approved the amendments to the revised Standards of Business Conduct and recommended the Policy to the Board for final approval.	Board of Directors	Recommend to Board for final approval.

Subject:	**People Committee: 22 July 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref P138/22iv	**BoD: 09/09/2022**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: People Committee	**Date:** 22 July 2022	**Chair: Jo Bibby**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Divisional Attendance – Urgent and Emergency Care (UECC)	The Committee welcomed the leadership team from UECC who provided an overview of the Senior Management Team and highlighted the following: • An interim Head of Nursing due to commence August 2022 • Challenges remain with staffing across the department • Staff survey below where it needs to be but work ongoing around culture with increased visibility of the senior leadership team The Committee noted the positive progress already made but recognising the work that still had to be completed in very challenging circumstances.	Board of Directors	Limited Assurance
2	Workforce Report	The Committee received and noted the Workforce report highlighting the following: • Sickness absence for June increased to 6.54% remaining above target. • National rules relating to sickness absence around Covid have been updated with an expectation this will impact on sickness levels.	Board of Directors	Limited Assurance due to the continued sickness absence rates

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee noted that the Proud Awards have taken place which had been a positive celebration for staff.		
3	Messenger Review	The Committee received the Messenger Review which reviewed leadership within the NHS. A number of recommendations came out of the review with clarity required in terms of expectations for implementation.	Board of Directors	Noted
4	E-roster Internal Audit Report	The Committee welcomed the outcome of the Internal Audit Report which concluded there was significant assurance in relation to the governance around E-roster.	Board of Directors	Assured
5	August Committee	The Committee engaged in a development session in place of the scheduled August Committee resulting in a revised work plan and agenda going forward.	Board of Directors	To note

Board of Directors
9 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P139.22
Report	**CQC Assurance Report**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
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)	The paper describes progress to date in response to the Notice of the Decision imposing conditions on the Urgent and Emergency Care Centre UECC), specifically in relation to: • Completion and application of an appropriate Risk Assessment for the most vulnerable patients, including those presenting with a Mental Health need • Ensuring the UECC is clean, free from clutter and staff adhere to infection control standards at all times • Compliance with MAST Training for Hand Hygiene, Safeguarding Adults Level 2 and Safeguarding Children level 3
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 Quality Committee on 31 August
Powers to make this decision	N/A

Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that: The Board of Directors note the content of the Report, in particular the compliance as at 1 September for MAST Training for Hand Hygiene, Safeguarding Adult Level 2 and Safeguarding Children Level 3
Appendices	N/A

1. Background

1.1 The purpose of this paper is to provide a progress update against key improvement areas identified within the conditions imposed by CQC as per the Notice of Decision received in July 2022. The paper address conditions 1, 2 and 3 individually. Conditions 4 and 5 relate only to the reporting timeframe.

1.2 The Trust is required to submit the initial response to the CQC by no later than 12 September 2022, with an update and further evidence required on the first Tuesday of the month thereafter.

2. Condition 1 – Personalised Care: *'The Trust must implement an effective system to ensure service users presenting with risks in relation to their mental health or physical health receive safe care and treatment'.*

2.1 The focus of the Personalised Care workstream is to identify those patients who may be at risk – either from a physical or mental health perspective at the earliest opportunity. Once identified, an appropriate assessment must be made with necessary documentation completed and acted upon in a timely manner.

a) **Mental Health Risk Assessments** - The main Emergency Department SEPIA Dashboard went live on 18 August. This Dashboard provides a real time overview of all patients within the department at any one time. In particular, the Dashboard identifies those patient(s) who require, or have had a Mental Health Risk Assessment completed.

A flag auto-populates at triage for all patients who have presented with deliberate self-harm, an overdose with suicidal tendencies or disclosure of suicidal tendencies, in addition to any general mental health condition. The flag prompts staff to complete a Mental Health Assessment, in particular highlighting the severity of risk to the patient in order to trigger the appropriate response and intervention.

The Dashboard is also visible to senior staff who may not be in the Department at the time, enabling senior oversight for this vulnerable cohort of patients to not only ensure assessments are carried out and may necessitate the movement of staff to provide further support where required.

Since March 2022, the UECC Clinical Governance Lead has reconciled the completion of Mental Health Risk Assessments against the identified cohorts of patients for whom a Mental Health Assessment is mandated. Where an Assessment has not been completed the reconciliation includes a search to ensure a Datix has been completed and necessary actions have been taken.

b) **Pressure Care Risk Assessments** – The Trust uses the Anderson Score – a nationally recognised tool for Emergency Departments.

The Departmental Pressure Area Risk Assessment and repeat skin check documents have been reviewed. Changes have been made to add information about the appropriate selection of dressing, in addition to an improved narrative re the expectation of what is to be documented on the assessment.

If a category 3, 4 or ungradeable (suspected deep tissue injury) pressure ulcer is selected within the Risk Assessment document, the member of staff is automatically directed to a Datix Incident Form, which must be completed and follow the required escalation process.

Repose Cushions are now available within the UECC Waiting Area to support vulnerable patients who have been in the department for an extended length of time and are at risk of pressure damage.

UECC have also updated their section of the Trust 'Guidelines for the Prevention and Treatment of Pressure Ulcers'. The revised guidance is live on the Trust Intranet.

c) **Falls Risk Assessment**

UECC have reviewed the Tendable Audit to identify trends and patterns of unresolved issues, including feedback from staff on ongoing falls issues. They have updated their section of the Trust 'Policy for Slips, Trips and Falls involving patients (including the safe use of bed rails)'. This is due to be ratified at the Patient Safety Committee on 22 September.

In addition, UECC have updated the narrative into the Trust Bed Rail Policy – to specifically encourage staff to consider the capacity of the patient – this is included in the UECC Falls Risk Assessment with an expectation that the rationale for the use of bed rails is documented.

d) **Ligature Risk Assessments**

In addition to the environmental Ligature Risk Assessments completed for all areas across UECC by the Trust Health and Safety Officer, a new Ligature Assessment sheet has been developed and is currently being piloted across the Department.

The information sheet encourages all clinical and non-clinical staff to be aware of the ligature risks within their work area. It provides staff with key information around ligature risks and potential ligature points in their areas.

The form was presented to the Safeguarding Operational Group on 17 August for wider discussion; an outcome of which was to revise the form for general circulation. In the meantime, the form is being piloted across UECC. Feedback from the pilot will be taken to the September Safeguarding Operational Group, following which it is hoped to share the learning and improve Ligature Risk Assessment awareness across the organisation.

2.2 **Intentional Rounding**

a) **Status at a Glance Dashboard (Patient Oversight)**

An additional Dashboard has been built to provide immediate oversight of the clinical status of all patients within UECC. This is currently in the testing phase went live on 31 August. Use of the Dashboard will be evaluated over the coming weeks and updated as required.

The SEPIA Dashboard indicates at a glance, the NEWS Score of the patient, presenting complaint, location and other special indicators – for example dementia, safeguarding, I, P & C, including those patients subject to a Deprivation of Liberty Safeguard (DOLS) or who have a learning disability. The Dashboard will develop further in coming months to include mental health and other vulnerabilities. Figure 1 below is a screen shot of the pilot Dashboard using fictitious patient details.

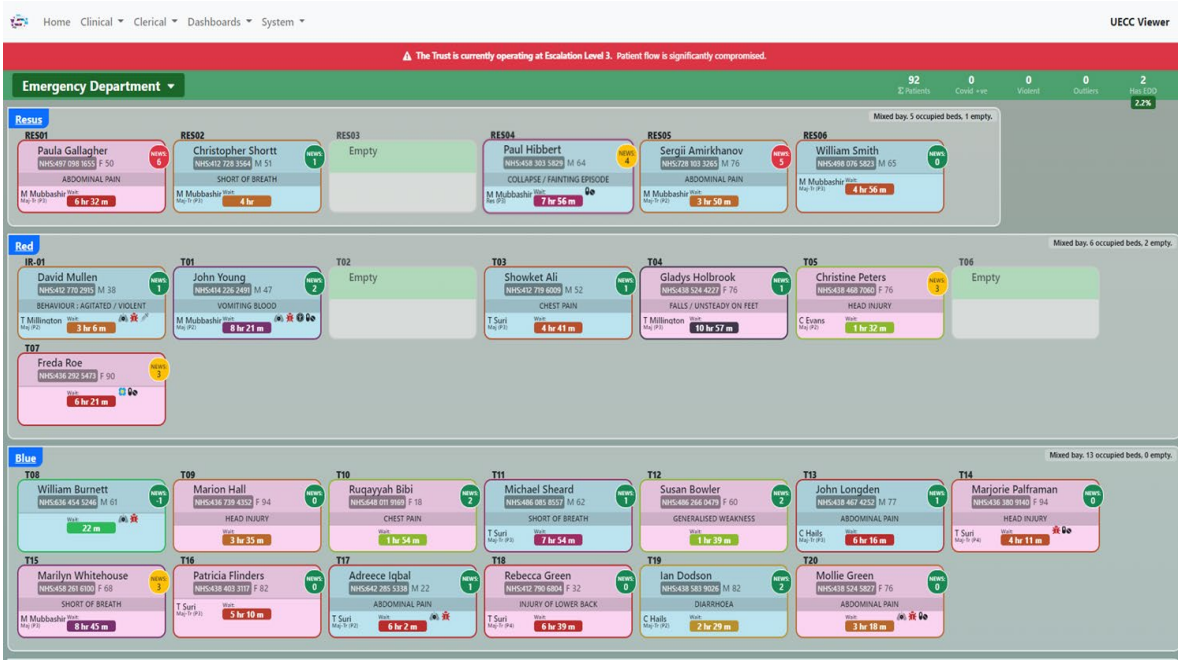


Figure 1

The status at a glance functionality of the SEPIA Dashboard allows staff to see the acuity of patients and respond within the designated timeframes. Senior staff can identify acutely unwell patients and those potentially at risk of deterioration, ensuring that all appropriate actions are being taken.

A coloured spot is to be added to the Patient ID Wrist Bracelet by Reception. The coloured spot corresponds to a specific pathway displayed on the waiting room screen indicating the waiting time for a particular clinical stream. Identifying patients by pathway also enables staff to easily see how many patients are waiting for a specific clinical intervention and respond accordingly. The coloured spots are on order and will be in place early September.

Staff are continually reminded to check that patients have access to a call bell at all times and that staff respond in a timely manner. This issue is included within the routine UECC Tendable Audit and is also a key point of note in the regular Nurse and Consultant in Charge walkabouts.

Patients not having access to a Call Bell has not featured as an 'un-resolved issue (failure)' on the Tendable Audit for the previous three months.

3. **<u>Condition 2 - Environment:</u>** **'***The Trust must implement an effective system to ensure premises and equipment are safe and clean and that the risk of infection is managed appropriately'.*

3.1 Cleaning Schedules

During the CQC visits in both May 2021 and March 2022, the issue of visibility of cleaning schedules was raised. Although CQC acknowledged that the daily cleaning schedules submitted as part of the Notice of Proposal Representations showed good compliance with cleaning requirements, this alone did not provide the assurance that the department was consistently clean and that cleaning schedules were available should the need to check an area arise.

The Head of Facilities has agreed to produce a one page information sheet to be displayed in all staff and patient areas of UECC, confirming the cleaning schedule, location of signed cleaning schedule documentation and the contact information should a member of UECC require an area to be cleaned or any further help from a member of the Facilities team. These will be displayed from the beginning of September.

A message reiterating the responsibility of all staff to ensure the department is clean and free from clutter has been included in the Matron Newsletter in August.

3.2 Cleaning of Equipment

CQC identified that UECC did not have a consistent process in place to visibly identify that equipment had been cleaned between patients or when not in use.

There are already routine I, P & C managed audits in place across the department, the results of which are fed through the UECC Governance meetings; however it has been recognised that the process for ensuring equipment is cleaned appropriately requires strengthening.

The system of attaching a 'green sticker' post equipment cleaning has been sporadic to date but will be mandated through August. This is already in place for items such as commodes. It is recognised this will be a challenge, in particular for equipment that is used frequently and moves from patients to patients. Again, it has been reiterated that ensuring equipment is clean, is the responsibility of all staff, whether they have used the equipment or not.

The presence of a Green Sticker has been added to the daily assurance documentation.

3.3 Appropriate use of Personal Protective Equipment

Through the departmental I, P & C Audits it has been noted that staff do not routinely change gloves and aprons between patient interactions, with many staff wearing gloves even when not indicated.

Appendix 5 of the Trust Decontamination Policy clearly sets out the requirement for the wearing of gloves and aprons and this has been shared across the department with compliance against this section of the Policy now added to the daily assurance checklists.

The importance of appropriately wearing any PPE is reiterated through the departmental safety huddle, Matron's Newsletter, 121 meetings and outcomes of audit.

3.4 Hand Hygiene

The Representations submitted to CQC in June did not provide assurance in relation to Hand Hygiene compliance within UECC. A compliance report is now received every Monday from OD and Workforce to enable senior staff to identify and track compliance on a weekly basis. All non-compliant staff have been contacted and will be individually monitored.

Hand Hygiene compliance as at 22 August 2022 is set out in table 1 below:

Hand Hygiene Compliance 22 August 2022			
Compliance	**No: Required**	**No: Achieved**	**%**
Divisional Grand Total	**189**	**163**	**86%**
Alcohol Service	10	8	80%
Emergency Department Reception	19	13	68%
Emergency Department Emergency Nurse Practitioners (ENPs)	6	3	50%
Emergency Department Medical Staff	17	10	58%
Primary Care Nursing and Midwifery	4	2	50%

Table 1.

The table above indicates the overall compliance for the UECC Division, in addition to the areas where compliance does not meet the required Trust standard of 85%. All staff groups not included are showing as compliant with performance ranging from 86% - 100%.

4. **Condition 3 - Safeguarding:** '*The Trust must implement an effective system to ensure service users are safeguarded from the risk of abuse and improper treatment'.*

4.1 **Safeguarding Mandatory Training**

Progress is being made in increasing compliance with the appropriate levels of Safeguarding Mandatory Training although the pace of this needs to be increased. The two areas CQC have been most concerned relate to Safeguarding Adult Level 2 and Safeguarding Children Level 3.

Through August, there has been a forensic scrutiny of compliance. The Department now receives a bespoke weekly compliance position by Departmental Cost Centre and also by named individual each Monday.

As with the Hand Hygiene compliance, every non-compliant member of staff has been identified and spoken to on an individual basis. The Safeguarding Team are providing additional training sessions and staff are booked on through August and early September.

There have been a number of anomalies to sort out with the accuracy of the data – i.e. staff who are either 'in scope' or 'out of scope' and the mapping of competency requirements against specific Position IDs. Keeping track of compliance is an ongoing task due to the turnover of staff within UECC and the need for regular renewal of competencies.

The GP Lead for the Out of Hours Service continues to work with relevant GP and Practice Manager Colleagues to improve their overall compliance. Tables 2 and 3 below indicate the compliance as at 22 August with Safeguarding Adult Level 2 and Safeguarding Children Level 3 respectively:

Safeguarding Adult Level 2 Compliance 22 August 2022			
Compliance	**No: Required**	**No: Achieved**	**%**
Divisional Grand Total	**153**	**137**	**90%**
Alcohol Service	4	3	75%
Emergency Department Advanced Nurse Practitioners	5	4	80%
Emergency Department Emergency Nurse Practitioners (ENPs)	6	4	67%
Emergency Department Medical Staff	17	13	76%
Primary Care Nursing and Midwifery	4	3	75%
Out of Hours Additional Clinical Services	8	6	75%

Table 2

As with Hand Hygiene compliance, the table above indicates the overall position for the UECC Division, in addition to the areas where performance does not meet the required Trust standard of 85%. All staff groups not included are showing as compliant with performance ranging from 90% - 100%. This is a 2% improvement on the compliance position as reported to the August Board of Directors.

Safeguarding Children Level 3 Compliance 22 August 2022			
Compliance	**No: Required**	**No: Achieved**	**%**
Divisional Grand Total	**151**	**122**	**81%**
Alcohol Service	8	5	62%
Emergency Department Additional Clinical Services	26	21	81%
Emergency Department Advanced Nurse Practitioners	6	3	67%
Emergency Department Emergency Nurse Practitioners (ENPs)	6	3	50%
Emergency Department Paediatric Nursing	4	3	75%
Emergency Department Medical Staff	17	14	82%
Primary Care Medical Staff	8	6	75%
Primary Care Nursing and Midwifery	4	2	50%
Out of Hours Additional Clinical Services	8	3	38%

Table 3

Again, the table above indicates the overall compliance for the UECC Division, in addition to the areas where compliance does not meet the required Trust standard. All staff groups not included are showing as compliant with performance at 100%. This is a 1% improvement on the compliance reported to Board in August.

Achieving compliance for the 29 outstanding staff members is a priority for September. The Safeguarding Children Level 3 is a full day of face to face Think Family training, thus it may be more challenging to release staff when staffing levels are particularly challenged, however, given the importance of achieving this, processes have been identified to release staff for training and provide additional bespoke opportunities.

A further update on the compliance position will be provided verbally within the meeting on 9th September.

4.2 **Safeguarding Audit**

CQC recognised the work that has been undertaken through 2021/22 to improve the recognition and response when a safeguarding concern has been identified. The Safeguarding Team have implemented a number of systems and processes to enable staff to better manage safeguarding referrals and documentation.

A daily Safeguarding Huddle had been implemented in response to previous concerns relating to children's safeguarding within UECC and this has now been extended to include discussion re adult cases. This daily huddle is being further strengthened with a Task and Finish Group led by the Safeguarding Team in place to provide the necessary support, advice and guidance.

Real time feedback is given to UECC staff on all safeguarding referrals within the previous 24-hour period. The Huddle is led by the Safeguarding Team Monday to Friday and continues with UECC senior staff over the weekend.

There have been zero serious incidents declared through 2021/22, where an opportunity to identify a safeguarding concern and take appropriate action has been missed. To ensure this trend continues, the Safeguarding Team have instigated a monthly audit of both adults and children, (the children's audit also identifies adult patients where a safeguarding concern has been raised, but who have dependent children who need to be considered). Both audits have been formally recorded with Clinical Audit and Effectiveness.

The Adult Audit consists of a review of five sets of patient records from a defined cohort of patients where there is a higher risk of a safeguarding concern – i.e. patients presenting with unexplained injury, frail elderly patients and patients with a Learning Disability or Mental Health condition.

A further five sets of patient records are randomly selected from a patient attendance list as a control sample. The output of the audit will be presented through UECC Divisional Governance and to the Safeguarding Operational Group. The outcome from the first report has been received and has not identified any missed opportunities. In fact, the audit has recognised excellent practice and documentation, which has been recognised by the department and shared with the individual staff member.

The Children's Audit also reviewed 10 sets of records, again no missed opportunities were identified; however an issue relating to patients attending UECC from the Ellern Mede Eating Disorder Unit has been identified and is being addressed through the appropriate Divisional Governance route.

5. Conclusion

5.1 As indicated above the first formal response to the Notice of Decision is to be submitted by no later than 12 September. The lessons learned from previous submissions will

ensure there is a greater focus on the impact of the improvements and changes in practice and less description of the process or what is planned to happen.

5.2 There has been an immediate positive benefit to the recent strengthening of the UECC Senior Management Team, and an increased focus on the improvement requirements. Despite the continued operational and staffing challenges, the initiatives that have been identified for a little while are now beginning to come to fruition and it is expected that further rapid improvement will be reported over the coming weeks.

5.3 It is proposed to take the opportunity of showcasing the work being undertaken at each on-site CQC Engagement meeting, with a possibility of this being in September and November. This will add to the monthly submission and hopefully help to provide the assurance required.

6. CQC Engagement

6.1 The CQC Engagement meeting took place on August 25. This was the routine virtual meeting addressing only the standard agenda items.

6.2 The annual CQC Medicines Management call took place on 19 August between the CQC Lead Pharmacist, the Trust Chief Pharmacist and the Deputy Director of Quality Assurance. The key focus of the discussion was to gain assurance around the safe and legal management of controlled drugs, in line with the Trust Controlled Drug Accountable Officer (CDAO) responsibilities and the safe management of patients presenting with Sickle Cell Disease, in particular ensuring timely access to appropriate pain medication.

6.3 In addition, progress against the Medicines Management Delivery Plan, the current staffing and vacancy position and the management of pharmacy risks were key discussion topics. Formal feedback will be provided to both the Trust and to the CQC Relationship team in due course; however no concerns were raised within the meeting.

6.4 As reported previously, CQC are keen to re-commence on-site visits, with a face to face meeting scheduled for 30 September. This will not only provide an opportunity to strengthen the relationship with CQC colleagues and provide an opportunity for them to meet clinical teams across the organisation, but enable the Trust to demonstrate the work being undertaken to meet the requirements of the regulatory conditions in a non-inspectorial environment.

Board of Directors Meeting
09 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P140.22
Report	**Integrated Performance Report – July 2022**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	D5, D6, P1, R2
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 (IPR) is the monthly summary of Trust performance across the four domains of Operational Delivery, Quality, Finance and Workforce. This month's report relates to July 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. The Trust has carried out an assessment of inequalities of access to care, which will be provided within the IPR as a standard report going forward.
Due Diligence	The Finance and Performance, Quality and People 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 – July 2022

Board of Directors

Integrated Performance Report - July 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 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Planned Patient Care												
Waiting List Size	Jul 2022	L	**25,500**		22,244	22,228	23,833	25,304	25,304	19,032		
Referral to Treatment (RTT) Performance	Jul 2022	N	**92%**		73.9%	76.7%	74.0%	72.7%	74.3%	85%		
Number of 52+ Weeks	Jul 2022	L	**180**		73	79	117	151	151	163		
Number of 104+ Weeks	Jul 2022	N	**0**		0	0	0	4	4	0		
Overdue Follow-Ups	Jul 2022	L	-		13,869	14,062	15,411	16,285	16,285	8,637		
First to follow-up ratio	Jul 2022	B	**2.4**		2.26	2.28	2.37	2.31	2.31	3.00		
Day case rate (%)	Jul 2022	B	**80%**		87.2%	86.2%	84.7%	85.9%	86.0%	83%		
Diagnostic Waiting Times (DM01)	Jul 2022	N	**1%**		6.2%	7.3%	8.0%	9.8%	7.8%	24%		
Diagnostic Activity Levels	Jul 2022	L	**9993**		6,895	8,357	8,455	8,260	8,260	7937		
Emergency Performance												
Number of Ambulance Handovers > 60 mins	Jul 2022	N	**0**		201	226	171	186	784	283		
Ambulance Handover Times % > 60 mins	Jul 2022	N	**0%**		10.8%	12.3%	9.9%	10.4%	43.3%	14%		
Number of Ambulance Handovers 30-60 mins	Jul 2022		-		241	267	240	275	1,023	279		
Ambulance Handover Times % 30-60 mins	Jul 2022	L	**5%**		12.9%	14.5%	13.8%	15.3%	56.6%	14%		
Average Time to Initial Assesment in ED (Mins)	Jul 2022	N	**15**		25	27	26	26	26	26		
Proportion of patients spending more than 12 hours in A&E from time of arrival	Jul 2022	L	**2%**		10.0%	9.7%	10.0%	10.2%	10.0%	8%		
Number of 12 hour trolley waits	Jul 2022	N	**0**		0	0	0	0	0	0		
Proportion of same day emergency care	Jul 2022	L	**33%**		38.4%	41.1%	40.1%	41.6%	40.3%	40%		
Cancer Care												
2 Week Wait Cancer Performance	Jun 2022	N	**93%**		90.5%	88.2%	86.8%	72.2%	82.9%	97%		
2 Week Wait Breast Symptoms	Jun 2022	N	**93%**		90.6%	81.3%	90.4%	91.1%	87.8%	95%		
31 day first treatment	Jun 2022	N	**96%**		94.5%	97.7%	97.6%	97.2%	97.5%	93%		
62 Day Performance	Jun 2022	N	**85%**		77.2%	83.8%	69.1%	66.7%	72.0%	72%		
Patients waiting longer than 62 days on the PTL	Jul 2022	L	**65**		73	94	104	115	115	-		
28 day faster diagnosis standard	Jun 2022	N	**75%**		75.6%	73.5%	68.2%	68.9%	70.1%	66%		
Inpatient Care												
Mean Length of Stay - Elective (excluding Day Cases)	Jul 2022				3.08	2.31	2.62	3.06	2.75	3.07		
Mean Length of Stay - Non-Elective	Jul 2022				6.44	5.70	5.63	5.13	5.72	5.29		
Length of Stay > 7 days (Snapshot Numbers)	Jul 2022	L	**142**		178	216	189	235	235	171		
Length of Stay > 21 days (Snapshot Numbers)	Jul 2022	L	**42**		67	80	54	75	75	51		
Right to Reside - % not recorded (Internal Performance from May)	Jul 2022	B	**0%**		3.2%	4.3%	6.2%	6.9%	6.9%	8%		
Discharges before 5pm (inc transfers to Dis Lounge)	Jul 2022	L	**70%**		60.9%	56.4%	56.0%	56.6%	57.4%	57%		
Outpatient Care												
Did Not Attend Rate (OutPatients)	Jul 2022	B	**6.2%**		9.6%	8.4%	8.9%	8.7%	8.9%	8%		
% of all Outpatient activity delivered remotely via telephone or video consultation	Jul 2022	N	**25%**		16.1%	14.6%	15.1%	13.1%	14.7%	19%		
Advice and Guidance - Metric still being worked up												
Number of patient pathways moved or discharged to PIFU, expressed as a proportion of all outpatient activity.	Jul 2022	N	**5%**		0.3%	0.5%	0.4%	0.6%	0.4%			
Community Care												
MusculoSkeletal Physio <4 weeks	Jul 2022	L	**80%**		11.0%	12.7%	18.7%	16.9%	14.9%	20%		
% urgent referrals contacted within 2 working days by specialist nurse (Continence)	Jul 2022	L	**95%**		48.9%	56.0%	42.4%	49.5%	49.5%	51%		
A&E attendances from Care Homes	Jul 2022	L	**144**		86	138	134	126	126	139		
Admissions from Care Homes	Jul 2022	L	**74**		54	90	87	84	84	65		
Patients assessed within 5 working days from referral (Diabetes)	Jul 2022	L	**95%**		75.0%	88.9%	66.7%	84.6%	81.3%	100%		
Urgent 2 Hour Community Response	Jul 2022	L	**70%**		87.5%	87.9%	88.0%	88.1%	88.1%	0%		

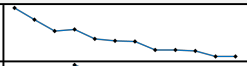
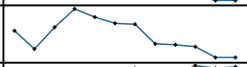
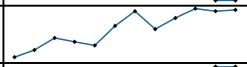
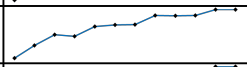
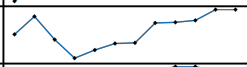
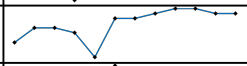
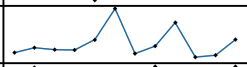
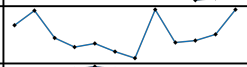
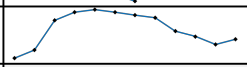
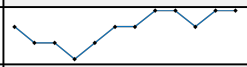
The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Quality

	Reporting Period	Type of Standard	Target 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Mortality												
Mortality index - SHMI	Jan 2022	B	**As Expected**		107.7	107.7	107.3	107.5	--	115.5		
Mortality index - HSMR (Rolling 12 months)	Feb 2022	B	**As Expected**		107.0	102.6	100.1	98.3	--	121.5		
Number of deaths (crude mortality)	Jul 2022		-		102	89	88	85	364	73		
Infection, Prevention and Control												
Clostridium-difficile Infections YTD	Jul 2022		**6**		4	4	7	10	10	2		
Clostridium-difficile Infections (in-month rate)	Jul 2022		-		19	18	18	19	19	17.5		
MRSA Infections (Methicillin-resistant Staphylococcus Aureus)	Jul 2022	L	**0**		0	0	0	0	0	1		
MRSA Infections (Methicillin-resistant Staphylococcus Aureus) (Rate)	Jul 2022		-		0.7	0.7	0.7	0.0	0.0	0.7		
E.coli blood bactertaemica, hospital acquired	Jul 2022		**19**		3	9	13	19	19	1		
CPE Infections, Hospital Provider	Jul 2022		-		0	0	0	0	0	-		
GRE Infections	Jul 2022		-		0	0	0	1	0	0		
Patient Safety												
Incidents - severe or above (one month behind)	Jun 2022	L	**0**		4	2	0	4	6	8		
% Potential of Under Reporting of Pt Safety Incidents	Jul 2022		-		52.60	52.77	52.55	52.68	52.65	50		
Never Events	Jul 2022	L	**0**		0	0	0	0	0	0		
Number of Patient Harms	Jul 2022		-		646	654	663	678	2,641	640		
Number of Patient Harms (Moderate and above)	Jul 2022		-		20	14	28	29	91	23		
Number of Patient Falls	Jul 2022		-		91	92	109	123	415	81		
Number of Pressure Ulcers (G3 and above)	Jul 2022		-		3	1	2	1	7	1		
Medication Incidents	Jul 2022		-		120	147	114	111	492	89		
Readmission Rates (one month behind)	Jun 2022	L	**7.6%**		7.6%	7.8%	7.7%	8.9%	8.1%	8.2%		
Venous Thromboembolism (VTE) Risk Assessment	Jul 2022	N	**95.0%**		97.3%	97.3%	96.4%	95.8%	96.7%	96.7%		
Number of complaints per 10,000 patient contacts	Jul 2022	L	**8**		11.09	9.38	10.39	10.77	10.36	6.74		
Proportion of complaints closed within 30 days	Jul 2022	L	**100.0%**		100.0%	100.0%	100.0%	100.0%	100.0%	95.5%		
Hip Fracture Best Compliance	Jul 2022	L	**65.0%**		59.1%	79.2%	61.5%	47.1%	47.1%	75.0%		
F&F Postive Score - Inpatients & Day Cases	Jul 2022	N	**95.0%**		96.5%	98.8%	97.0%	97.1%	97.5%	96.4%		
F&F Postive Score - Outpatients	Jul 2022	N	**95.0%**		96.8%	97.4%	97.1%	98.0%	97.3%	97.7%		
F&F Postive Score - Maternity	Jul 2022	N	**95.0%**		97.2%	97.9%	99.0%	96.5%	97.7%	98.6%		
Care Hours per Patient Day	Jul 2022	L	**7.3**		6.50	6.50	6.60	6.30	6.30	6.6		
Maternity												
Bookings by 12 Week 6 Days	Jul 2022	N	**90.0%**		91.0%	91.1%	92.2%	92.2%	91.6%	96.4%		
Babies with a first feed of breast milk (percent)	Jul 2022	N	**70.0%**		58.7%	64.8%	59.2%	53.9%	58.9%	62.1%		
Stillbirth Rate per 1000 live births (Rolling 12 months)	Jul 2022	L	**4.66**		2.33	2.72	2.35	1.95	1.95	4.12		
1:1 care in labour	Jul 2022	L	**75.0%**		96.4%	97.5%	97.4%	96.1%	96.8%	95.9%		
Serious Incidents (Maternity)	Jun 2022	L	**0**		1	0	0	0	0	0		
Moderate and above Incidents (Harm Free)	Jun 2022		-		0	0	0	0	0	0		
Cases Referred to HSIB	Jul 2022	L	**5**		0	0	0	0	0	0		
Consultants on labour (Hours on Ward)	Jul 2022		-		62.50	62.50	62.50	62.50	62.50	--		
% women on continuity of care pathway	--											

The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Workforce

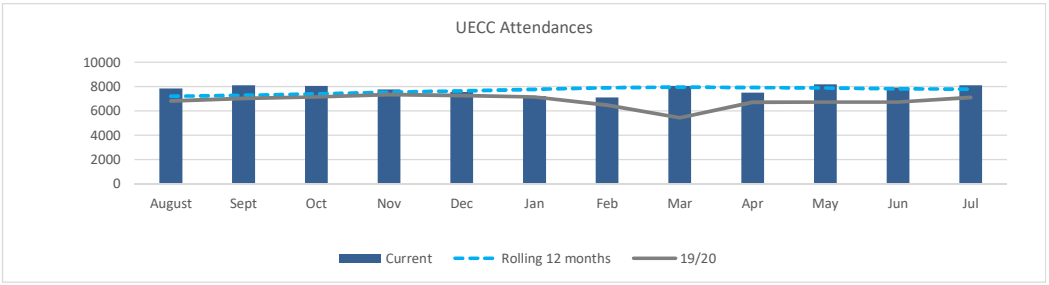
	Reporting Period	Type of Standard	Target 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Workforce												
Whole Time Equivalent against plan - Total	Jul 2022	L			-357	-360	-382	-382	-382	-478		
Whole Time Equivalent plan - Nursing	Jul 2022	L			-54	-56	-65	-65	-65	-76		
Total Headcount	Jul 2022		-		4,942	4,957	4,953	4,955	4,955	4,861		
Vacancy Rate - TOTAL	Jul 2022	L			8.0%	8.1%	8.5%	8.5%	8.5%	4.9%		
Vacancy Rate - Nursing	Jul 2022	L			4.0%	4.1%	4.8%	4.8%	4.8%	5.9%		
Time to Recruit	Jul 2022	L	**34**		35	35	34	34	34	23		
Sickness Rates (%) - inc COVID related	Jul 2022	L	**4.5%**		8.4%	6.4%	6.5%	7.4%	7.0%	6.3%		
Turnover	Jul 2022		**0.7%**		0.8%	0.9%	0.9%	1.2%	1.0%	0.9%		
Appraisals complete (% 12 month rolling)	Jul 2022	L	**90%**		75%	73%	70%	72%	7%	64%		
Appraisals Season Rates (%)	Jul 2022	L	**90%**			18%	35%	50%		-		
MAST (% of staff up to date)	Jul 2022	L	**85%**		91%	90%	91%	91%	91%	91%		
% of jobs advertised as flexible	Jun 2022		-		51%	58%	56%	66%	60%	-		

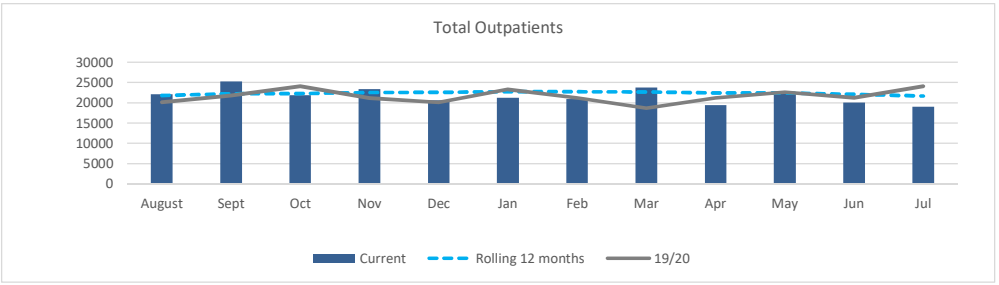
The Rotherham NHS
NHS Foundation Trust

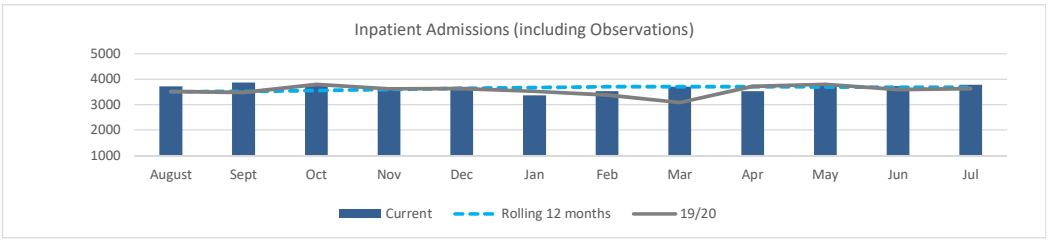
Trust Integrated Performance Dashboard - Finance

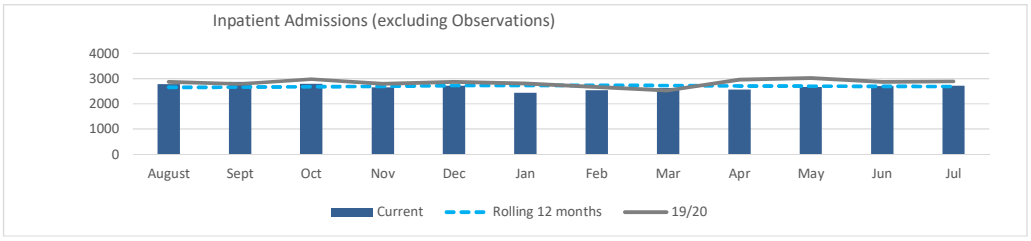
	In Month Plan £000s	In Month Actual £000s		In Month Variance £000s	YTD Plan £000s	YTD Actual £000s		YTD Variance £000s		Forecast V £000s
I&E Performance (Actual)	(242)	55	●	297	607	706	●	100	●	(4,158)
I&E Performance (Control Total)	(386)	(88)	●	297	(652)	(553)	●	100	●	(4,158)
ciency Programme (CIP) - Risk Adjusted	762	1,195	●	433	1,967	1,580	●	(387)	●	(4,124)
Capital Expenditure	619	402	●	217	2,094	771	●	1,323	●	0
Cash Balance	203	3,157	●	2,954	25,096	29,274	●	4,179	●	(2,278)

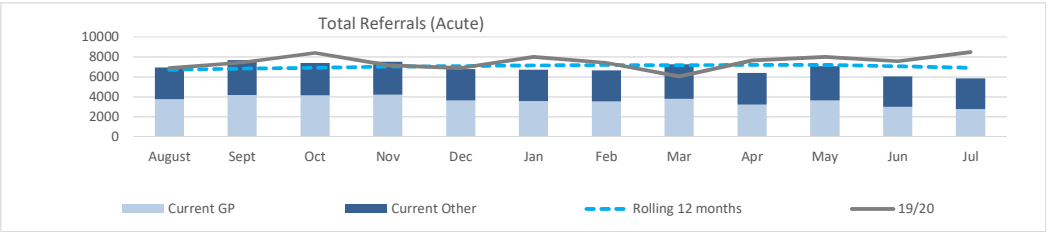
Trust Integrated Performance Dashboard - Activity

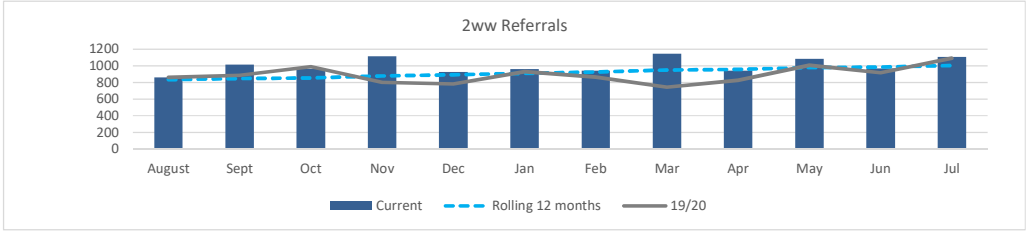












Trust Integrated Performance Dashboard - Activity

ACTIVITY

OUTPATIENTS			
	Activity 22/23	Activity 19/20 (WDA)	As % of 2019/20 WDA
July (provisional)	19,859	19,267	3%
YTD monthly average	20,500	22,775	-10%

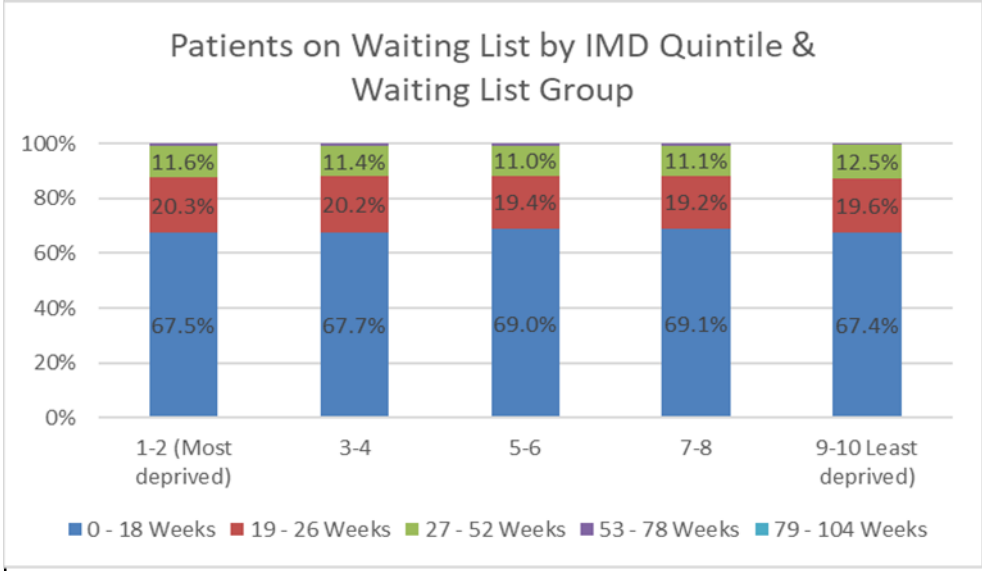
DAYCASES			
	Activity 22/23	Activity 19/20 (WDA)	As % of 2019/20 WDA
July	1,734	2,353	-26%
YTD monthly average	1,709	2,137	-20%

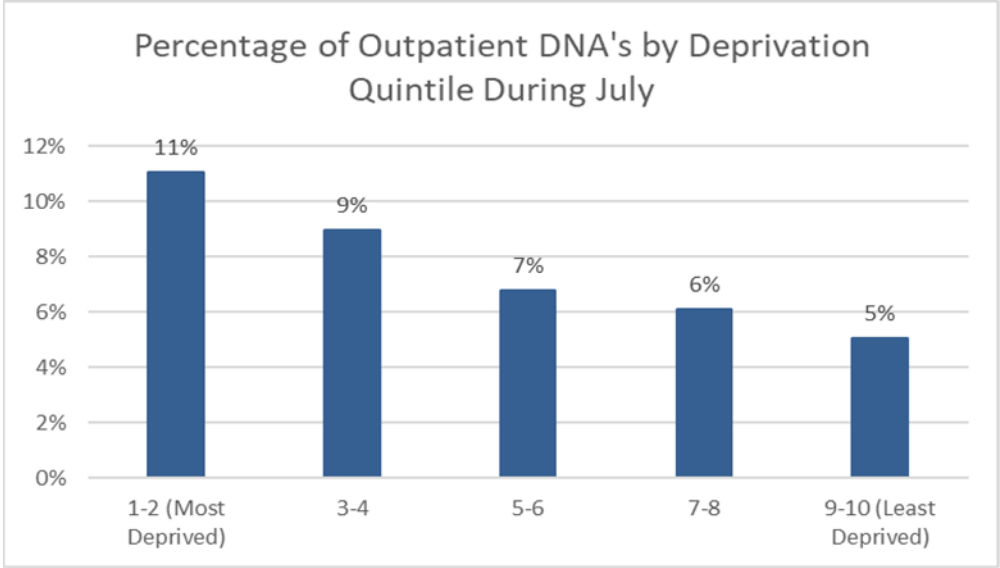
ELECTIVE ACTIVITY			
	Activity 22/23	Activity 19/20 (WDA)	As % of 2019/20 WDA
July	307	409	-25%
YTD monthly average	292	386	-24%

Trust Integrated Performance Dashboard - Health Inequalities

RTT Snapshot 31/07/22

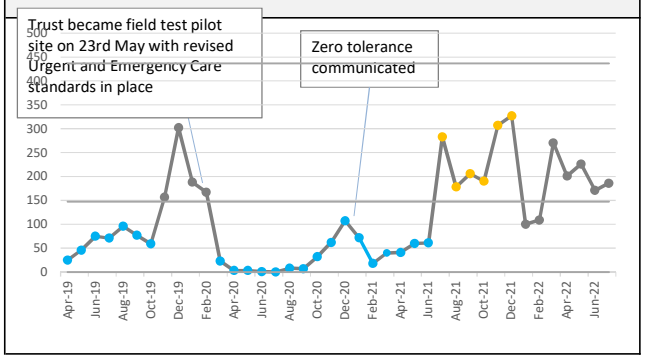
IMD Quintile	Patients on Waiting List	Median Wait (Wks)	% of All RTT Patients	% of Rotherham Poulation	% Proportion Difference to Rotherham Population
1-2	6793	10	33.6%	36.0%	-2.4%
3-4	5006	10	24.8%	23.2%	1.5%
5-6	3251	10	16.2%	15.2%	0.9%
7-8	3751	10	18.6%	19.5%	-1.0%
9-10	1417	10	7.0%	6.0%	1.0%
Total	20210	10	100.0%	100.0%	0.0%



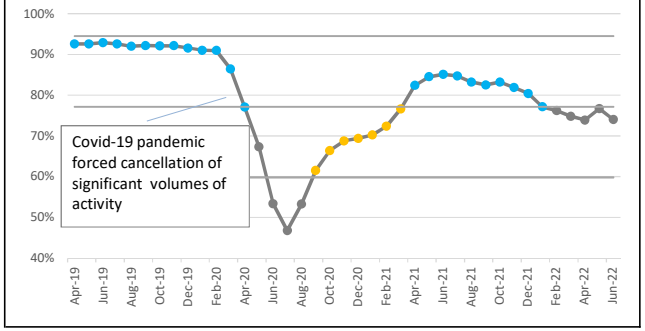


Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (1)

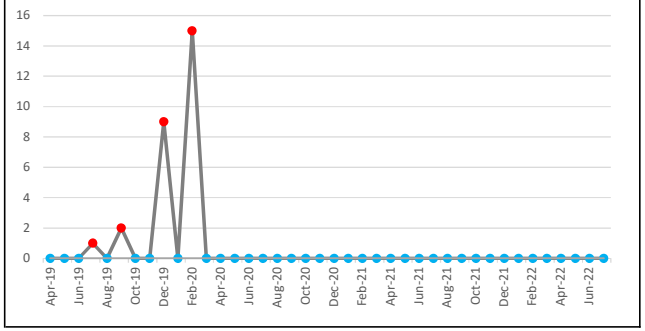
Ambulance Handovers - % of handovers > 60 minutes



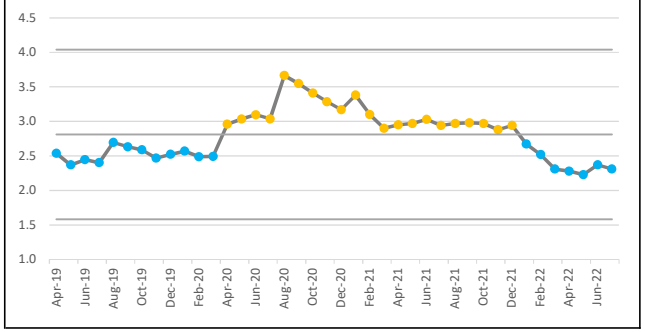
Referral to Treatment - % of patients waiting less than 18 weeks for treatment



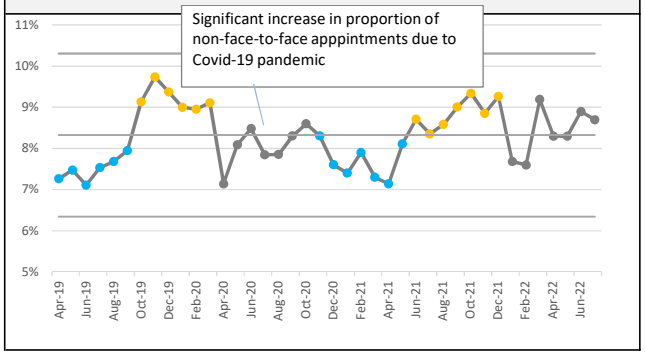
12 hour trolley waits - per month



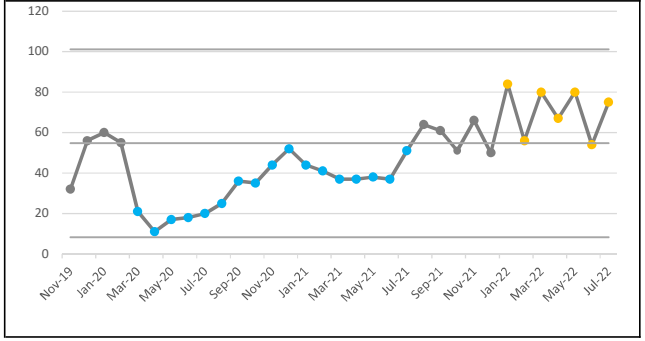
First to Follow-Up Ratio



Did Not Attends (DNAs) % of appointments

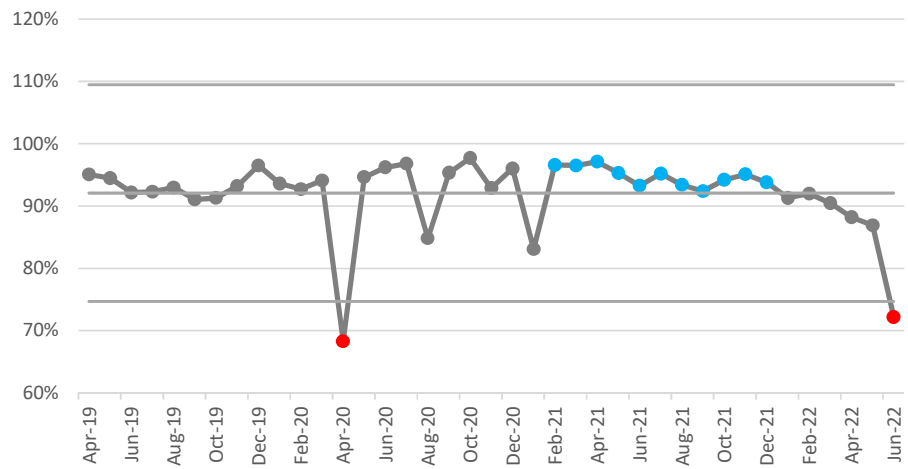


Length of Stay > 21 days (Snapshot Numbers)

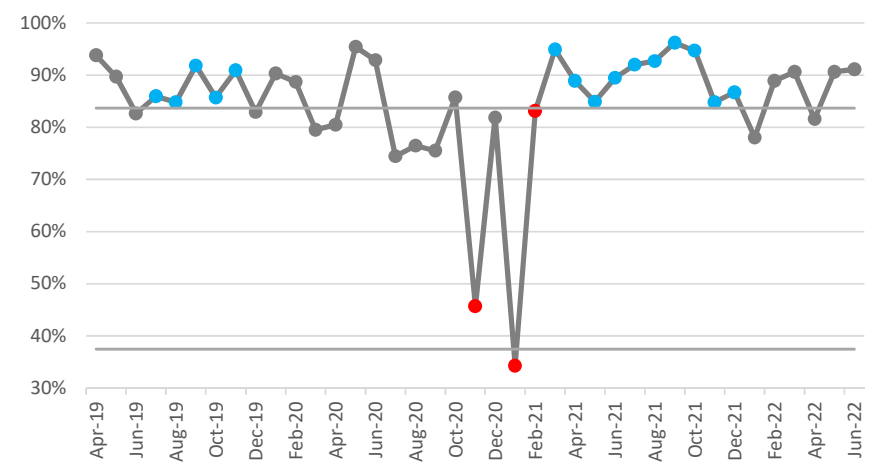


Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (2)

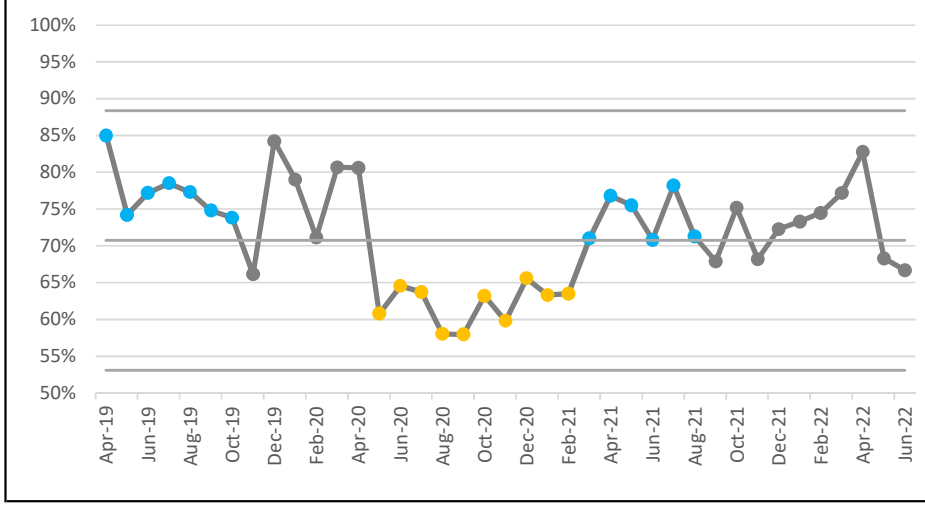
Cancer 2 week wait standard



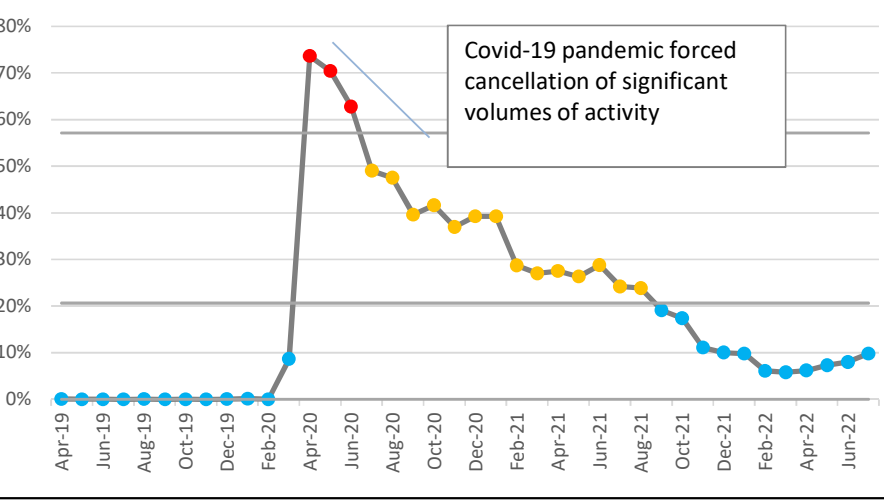
Cancer 2 week wait breast symptoms standard



Cancer 62 day first treatment standard

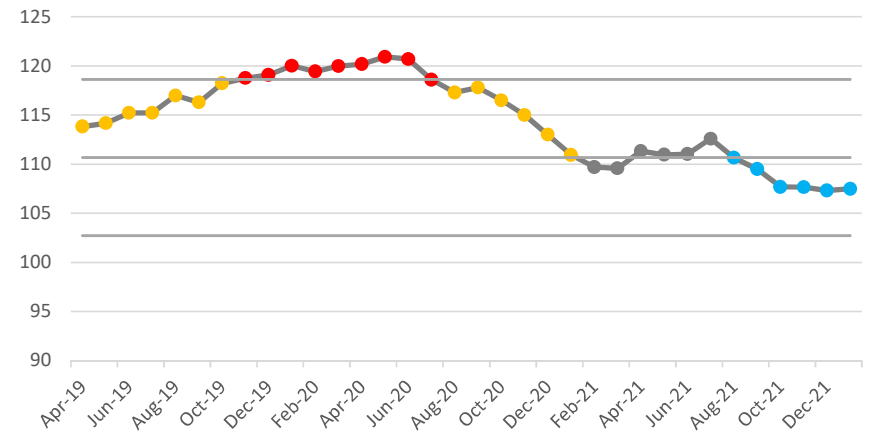


Diagnostics - % of breaches over 6 weeks (DM01)

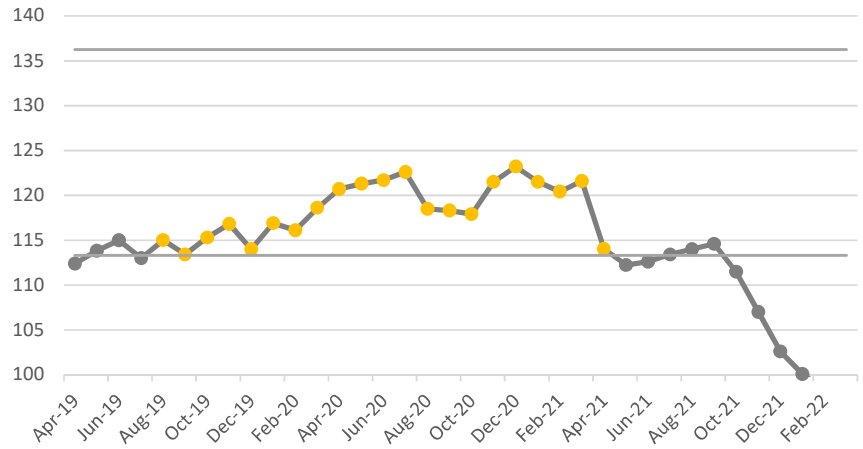


Trust Integrated Performance Dashboard - SPC Charts - Quality (1)

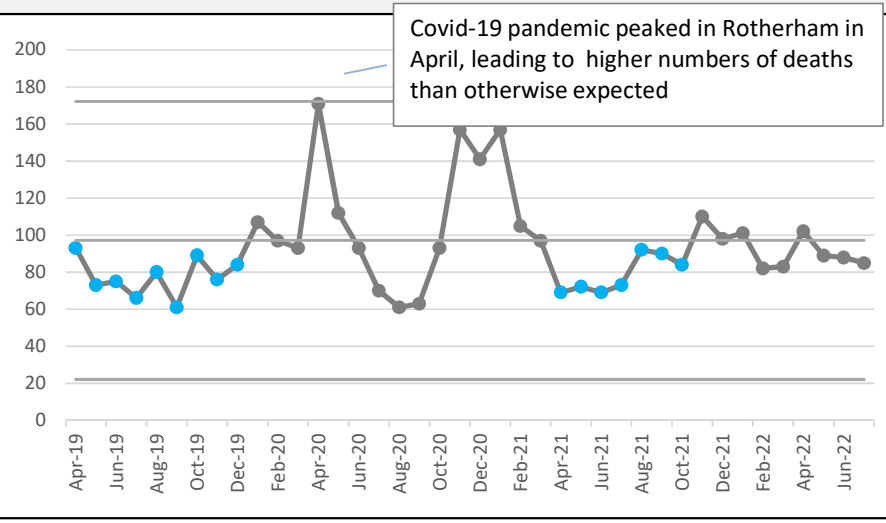
Standardised Hospital Mortality Indicator (SHMI)



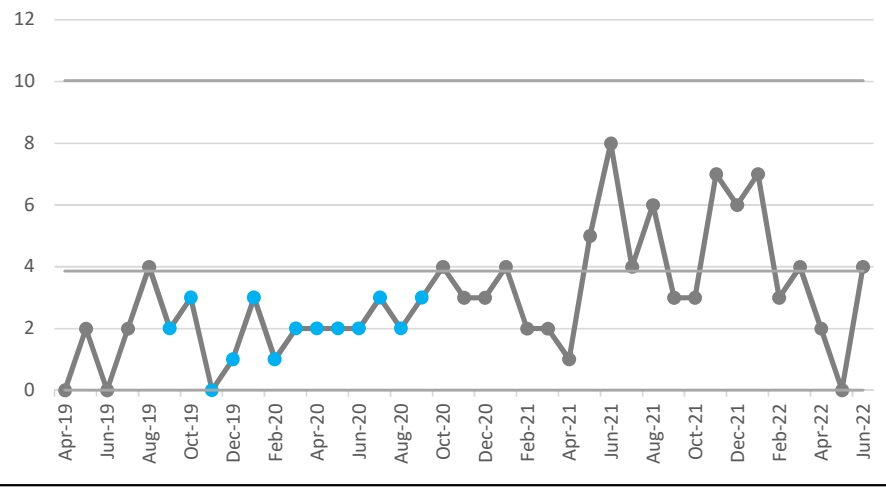
Hospital Standardised Mortality Ratio (HSMR)



Crude Mortality (number of deaths)

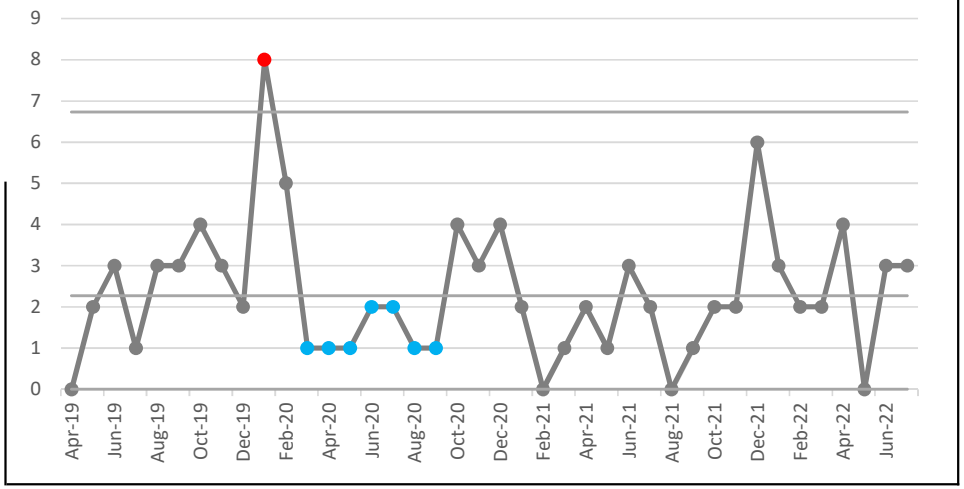


Incidents (severe or above)

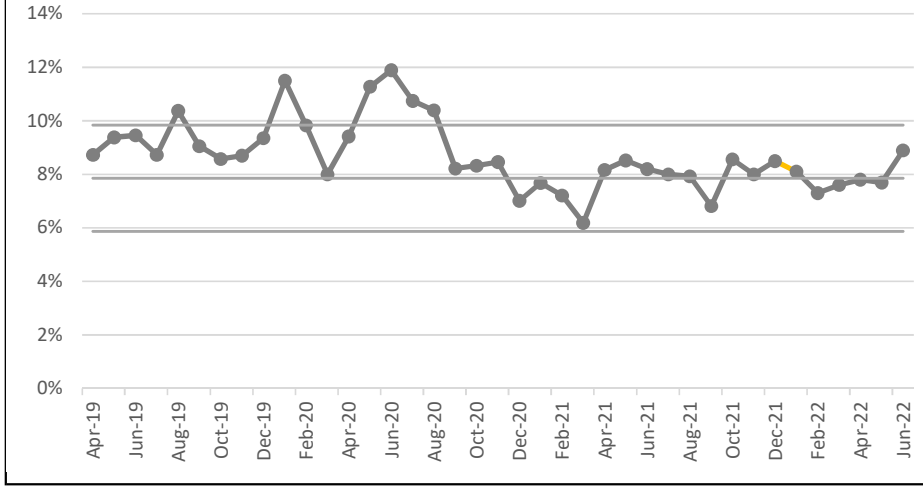


Trust Integrated Performance Dashboard - SPC Charts - Quality (2)

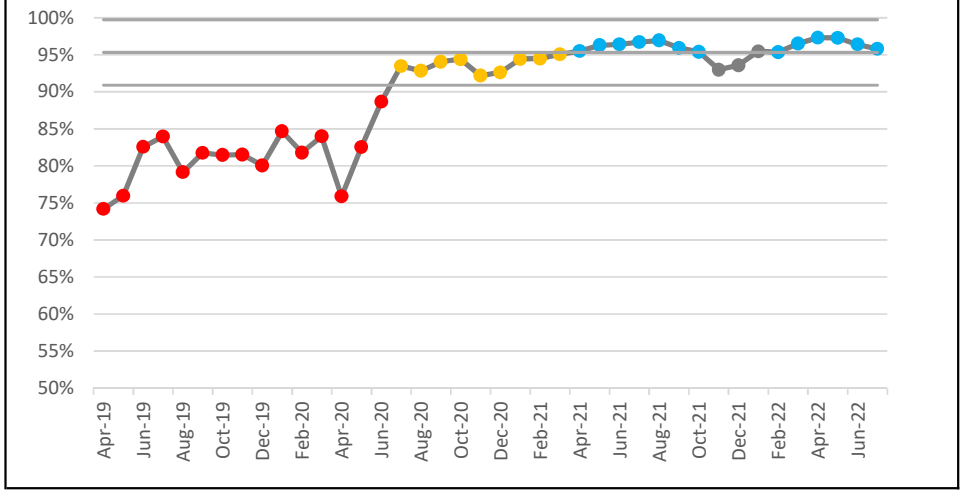
Clostridium difficile infections (number)



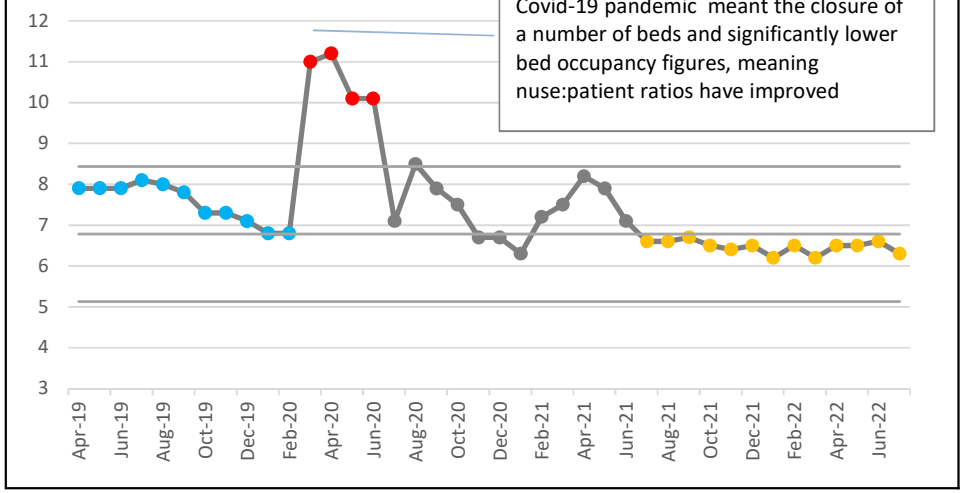
Readmissions (%)



Venous Thrombous Embolism compliance (%)



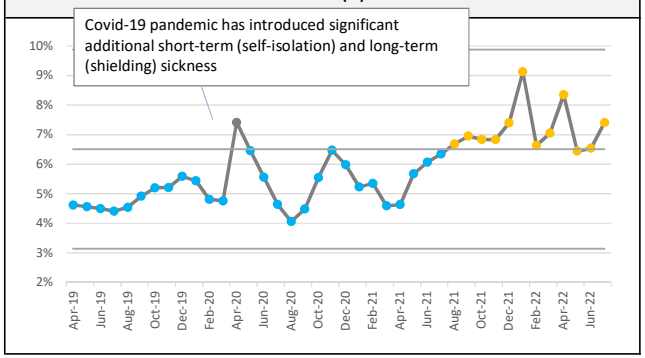
Care Hours per Patient Day



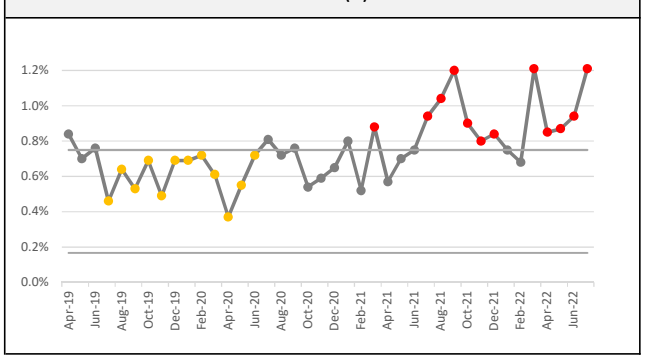
Covid-19 pandemic meant the closure of a number of beds and significantly lower bed occupancy figures, meaning nuse:patient ratios have improved

Trust Integrated Performance Dashboard - SPC Charts - Workforce

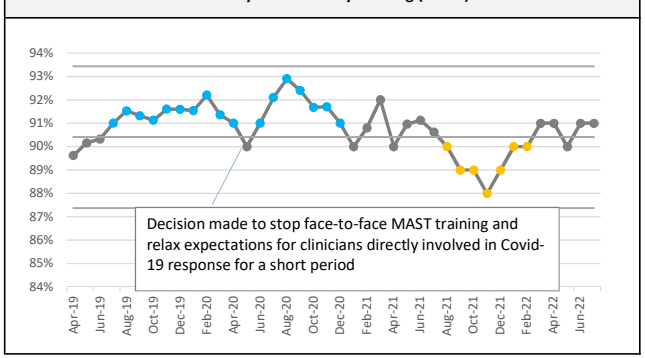
Sickness (%)



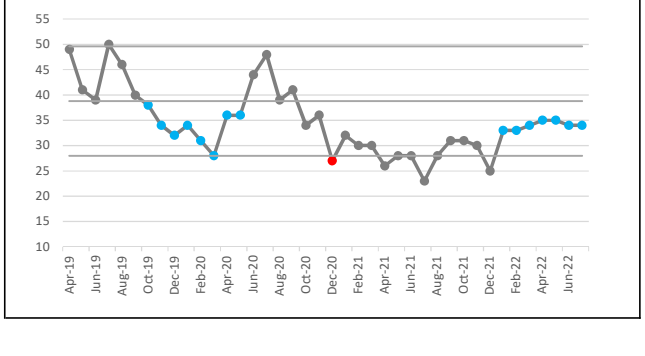
Turnover (%)



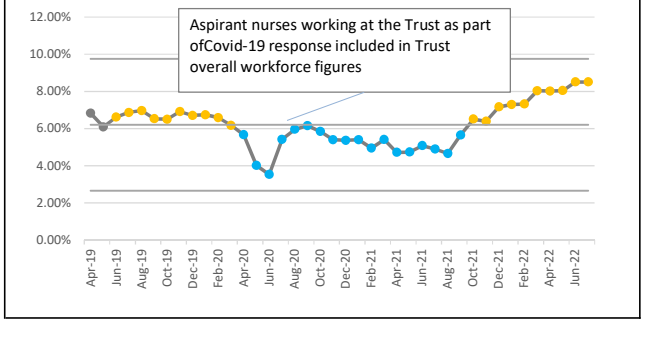
Mandatory and Statutory Training (MAST)



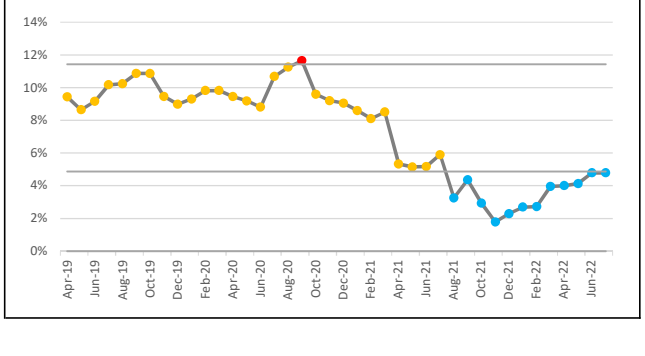
Time to Recruit - days



Vacancy Rate (TOTAL)



Vacancy Rate (Nursing)



Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Daily staffing -actual trained staff v planned (Days)	82.55%	84.17%	87.39%	85.51%	86.74%	89.65%	87.75%	87.62%	86.48%	86.33%	84.11%	83.95%	81.92%
Daily staffing -actual trained staff v planned (Nights)	86.37%	83.00%	83.93%	82.94%	86.32%	87.50%	87.06%	86.41%	84.29%	88.00%	85.52%	86.36%	81.28%
Daily staffing - actual HCA v planned (Days)	104.30%	103.18%	100.43%	99.16%	101.90%	94.90%	90.63%	89.55%	89.47%	96.05%	95.88%	91.45%	80.37%
Daily staffing - actual HCA v planned (Nights)	101.02%	101.69%	98.49%	89.90%	95.29%	90.95%	89.28%	89.06%	92.35%	89.51%	91.18%	94.30%	81.54%
Care Hours per Patient per Day (CHPPD)	6.6	6.6	6.7	6.5	6.4	6.5	6.2	6.5	6.2	6.5	6.5	6.6	6.3

*Figures in July for HCA have been pulled slightly differently so percentages are lower. Deputy Chief Nurse working with services to look at aligning the roster templates with reporting requirements.

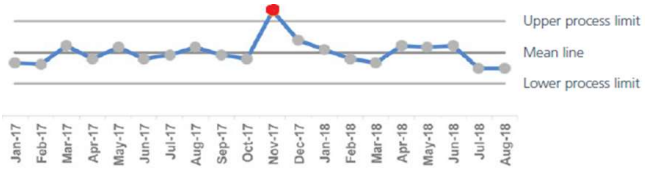
Trust Integrated Performance Dashboard - SPC Methodology

The below summary sets out the proposed methodology and colouring we will use at TRFT, noting the different trends that will be shown as special cause variation or out of control.
We will use the following colours to indicate variation:

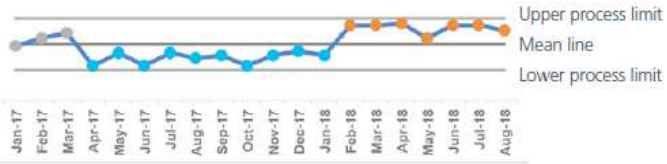
- orange indicates special cause variation of concern and needing action
- blue indicates special cause variation where improvement appears to lie
- grey data indicates no significant variation
- red indicates where the process is out of control (outside control limits)

We will follow the NHS guidance and identify 4 different ways in which a trend will be defined as special cause variation:

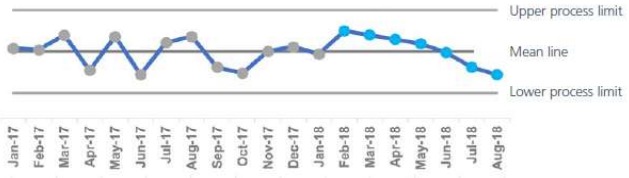
1) A single point outside the control limits



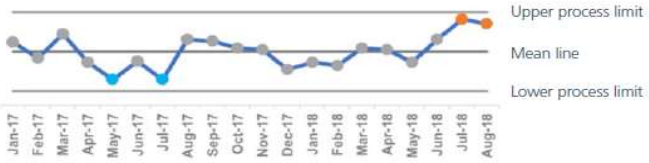
2) A run of at least 6 points above or below the mean line



3) Six consecutive points increasing or decreasing



4) A pattern of 2 out of 3 points within the outer thirds



Ot entified by colour coding within our SPC charts, for ease:

5) 14 consecutive points alternating up and down
6) 15 consecutive points in the central third
7) 8 consecutive points with none in the central third
8) 4 out of 5 consecutive points in the middle third

In addition, we will annotate any reasons for special cause variation which we are aware of.

Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- Site pressures remained high in June and peaked again in July with an increase in numbers of Covid-19 patients occupying acute beds to up to just over 50 at the end of the month. UECC Attendances over the reported two-month period were 7% below 2021 levels, with admissions just slightly below the levels from last year for the same period.
- Related to this, the number of super-stranded patients (21 day+ length of stay) increased in the second half of July to 75 patients, following significant improvements in the position earlier in the period.
- The increased challenges with flow through the organisation led to another difficult two months regarding ambulance handover delays over 60 minutes, with approximately 50 such breaches in most weeks. Handover delays led to just under 450 hours of time lost in each month, and although we benchmark relatively well in SYB (the 2nd best adult acute trust in the system), the SYB system is the poorest performing in NE&Y on this metric, so it is a priority for the ICB. The Trust continues to utilise our Referral Assessment and Triage (RAT) area in UECC to minimise these delays, and has collectively agreed to implementing cohorting where YAS request it, following the pilot earlier in the year. In addition, we have now increased the visibility of theYAS handover screen internally to support escalation and planning, with further access to YAS system being rolled out to the site team and senior colleagues.
- The proportion of patients waiting 12 hours in department was still well above the national targets that have now been set for 2022/23 (2%), with 10% of patients spending at least 12 hours in the UECC in both months. It is worth noting that on occasion these long-wait challenges were due to the Trust accepting diverts from a neighbouring trust, which subsequently led to demand which could not be easily accommodated. In more recent weeks, we have been unable to repatriate these patients to their own areas, which has created further challenges at the back end of the patient pathway.
- These figures demonstrate the intense challenges experienced in the Trust over the last two months, through this combination of high demand and high levels of staff sickness. With the changes in IPC guidance implemented within the Trust in late April, we had expected to see some pressures ease given the reduced need for additional cohorting and therefore reduced ward moves, but in reality, these have not been sufficient enough to change the core performance metrics.

Elective Care

- The size of the waiting list has grown again to over 25,000 patients. This is now almost a 50% increase on the April 2021 figure. There are pressure points in particular within Trauma & Orthopaedics, Dermatology, OMFS and General Surgery. Just under 4,00 of these patients have Decisions to Admit.
- The RTT position has deteriorated again to 72.7%, driven in part by capacity challenges within a few of the larger specialties and the constraints on our elective capacity. Sickness levels and workforce shortages in Anaesthetics and Theatres have led to a need to proactively reduce our theatre lists by 20-25% a day, to minimise the need for last minute cancellations. This deterioration is expected to continue for the next couple of months until we increase our outpatient activity through the additional activities that have been approved through the recovery schemes and until our theatre schedules are back to normal levels.
- With the capacity constraints noted above, we have seen an increase in the number of 52+ week waiters, which has grown to over 150. Teams continue to put plans in place to ensure as many as possible of these long-waiting patients are treated as quickly as possible, including utilising the Independent Sector from September again to free up capacity at the Trust.
- At the very end of July, the Trust identified an issue with how we were capturing Appointment Slot Issue patients who drop off automatically from the national eRS system if not appointed within 180 days. This led to the Trust declaring four 104 week wait patients in the July submission. These breaches were not anticipated and a full internal investigation is underway to ensure we have appropriate controls in place to ensure this will not occur again. All of these patients have now been treated.

Cancer

- The size of the Cancer Patient Tracking List (PTL) increased during June and July, by almost 25%. This has been driven by increases in the Lower GI PTL in particular, with an increase in referrals in July to a record high of almost 300 patient, likely driven by media activity around Dame Deborah James.
- 62-day performance continued to significantly under-deliver against the national constitutional standard and the increasing numbers of patients on the PTL will likely mean the pressure on this metric continues. We continue to see more patients waiting longer for their treatment due to being unfit, or due to poor engagement in their pathway, as well as high numbers of patients now wanting to wait for their appointments or diagnostics due to holidays.
- The Faster Diagnosis Standard (FDS) was not met in June. driven by challenges in Lower GI, Urology and Skin. This will be the primary area of focus for the new Cancer Service Improvement Programme Lead when they are appointed.

QUALITY SUMMARY

Mortality

- The latest Dr Foster data has now been updated to February 2022 for the HSMR and January 2022 for the SHMI. As per the previous position, the HSMR is currently within the 'as expected' category. However, when all Covid-19 activity is excluded from the HSMR, the figure falls to 94.3, well within the 'as expected' category. The in-month HSMR for February 2022 was 81.7, which is statistically within the 'as expected' band. If the regional HSMR values are ranked (lowest to highest) the Trust's HSMR is 5th of 21 acute, non-specialist NHS providers.
- For the 12 month period there were no HSMR diagnosis groups with a relative risk banded as statistically 'higher than expected'. This is the first time this has been the case since the Trust established the Mortality Improvement Group in 2020.
- Crude mortality was 3.4% over the 12-month period, compared to 3.2% regional average (acute, non-specialist Trusts).

Patient Safety

- There were 3 incidents deemed to be severe or above in March and 2 in April, and these have all been investigated at Harm Free Care and Serious Incident (SI) panels as appropriate. Staffing levels continued to be affected due to the Covid-19 pandemic and also annual leave, with a significant reduction in the proportion of trained nursing staff compared to plan overnight in July and also within the HCA workforce both during the day and overnight, such that only 80% of the HCA numbers planned were on shift during the days. Despite this, the numbers of reported harms remained relatively consistent with the prior month, although falls increased slightly. There was an increase in the number of patient harms reported as moderate harm or above in the June and July data, although more than 95% of all harms were considered to cause either low harm or no harm.
- The Trust continued to meet the national Venous Thromboembolism (VTE) assessment target, although for the specialties who are not achieving this performance standard, the Medical Director has raised the issue with the relevant Divisional Directors and Clinical Leads.
- Complaints per 10,000 contacts have remained at a significantly higher level than the prior year, and continue to be above target. However, the absolute number of complaints suggests this is not of significant concern at this stage – with an average monthly number of complaints of 22 last year, compared to

the two latest months of 23 each month. In addition, the Friends and Family Test (FFT) results continued to be positive, with all scores well above the national target.

- Care Hours per Patient Day continues to be well below the benchmark, with a deterioration in trained fill rates within the Safer Staffing data in the most recent two months. The additional nursing recruits expected in September should improve the position. However, following the retirement of the previous postholder responsible for submitting this Safer Staffing and Care Hours per Patient Day data externally, a full review of the collation and calculation process is planned for Q2, to provide assurance that the reported information from previous months was accurate.
- Ockenden – An Ockenden visit took place in late May, with the written report expected imminently. The maternity staff survey results that have been published show TRFT in a very positive comparative light, although the divisional team remain committed to improve staff satisfaction even further.
- CNST – the scheme has relaunched and the maternity team continue to work on the workstreams. There are challenges around the maternity service dataset and carbon monoxide monitoring which are being addressed.

WORKFORCE SUMMARY

Recruitment and Retention

- The number of new starters for July 2022 increased to 55 WTE, which represents a 6 WTE decrease compared with July 2021. The Medicine Division saw the highest number of new starters, with 13 new colleagues. The Trust welcomed 6 qualified Nursing & Midwifery staff and 8 newly qualified staff nurses in July 2022. 21 of the new starters came from another NHS Organisation, 13 of whom came from neighbouring Trusts.
- Overall vacancies for Nursing & Midwifery and support to Nursing & Midwifery was 141 WTE for the month of July. This is reduced to 72 WTE when taking into consideration the 70 candidates going through the external recruitment process. There are currently 35 WTE newly qualified nurses/midwives who are currently awaiting confirmation of registration which have been included in the above figures.
- 12 month rolling turnover (voluntary leavers only) for the Trust was 12.2%, which represents a 3.3% increase compared to July 2021. The Nursing & Midwifery turnover (12 month rolling rate) for the month of May 2022 was 11.2% and represents an increase of 0.7% compared with previous month.
- Of the 58 voluntary leavers for May 2022, 17 had the leaving reason of relocation with a further 17 with the reason work-life balance.
- Promotions, both permanent and temporary taken place over the month of May 2022 equate to 18 WTE, including 5 WTE attributed 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

- Monthly sickness absence rate (inc COVID-19) increased by 0.9% to 7.4%. The decrease in the overall Trust sickness rate was driven by long-term sickness (4.4%), a 0.5% increase compared with previous month. Long-term sickness remains the most significant challenge. The revised national Covid-19 sickness guidance will come into full effect from September.
- 12 month rolling sickness absence for July 2022 was 7% and represents a very small decrease compared to previous month. Compared with the same month the previous year, rolling sickness absence has increased by 1.8%. 12 month rolling sickness absence excluding Covid-19 is 5.4%.

Appraisals and Mandatory Training

- Overall appraisal rolling 12 month compliance rate for the month of July is 72% which is an 8% increase compared to July 2021. The rolling 12 month appraisal rate has increase by 1% compared to previous month. All Divisions remain below the Trust target of 90%.Trust appraisal season compliance rate as at the end of July 2022 was 50% which is a significant (34%) increase when compared to July 2021. Band 7 and above compliance for July 2022 was 68%.
- Core MaST compliance has remained the same and is 6% above the Trust target (85%). Hand Hygiene compliance has increased further (82%), but remains below the Trust target. Information Governance compliance reached 96%, which meets the CQUINN target (95%).
- All Divisions are above the Trust target for both core and job specific combined together, which is a fantastic achievement given the staff sickness challenges and ongoing pressures. Patient Safety and Safeguarding continue to be areas of focus for the Trust, with compliance below expectations.

FINANCE SUMMARY

The Finance summary commentary is included within the separate Finance Report.

Board of Directors Meeting
9 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P142.22
Report	**Operational and Recovery Update**
Executive Lead	Sally Kilgariff, Chief Operating Officer
Link with the BAF	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system D5: we will not deliver safe and excellent performance
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 Trust's performance against key operational performance metrics, along with the recovery actions as of July 2022 • Provides a summary of the Trust's current position in relation to Covid-19 • Describes the activity and actions the Trust is taking to deliver improvements in key operational performance metrics • Updates the Board of Directors on the recovery actions underway The attached report provides a high-level summary of the key operational indicators along with the recovery actions and plans to deliver improvement. A short narrative is provided to summarise the key elements of the position and actions that have been taken to mitigate some of the pressures, followed by slides outlining the Trust's position. The Trust's planning and preparation for winter 2022/23 is underway with the Winter Plan due to be discussed at the Finance and Performance Committee Meeting in September, along with place partners at the new Rotherham Urgent and Emergency Care Group. The Elective Recovery Group continues to meet to discuss and agree recovery actions and has recently agreed the schemes of investment to be funded from the release of £1m to support recovery. Discussions regarding 'what good looks like' for recovery have been taking place, with the Executive Team in agreement that the Trust's ambition should be to go further than the national targets for recovery. Further work is taking place in relation to what this looks like in terms of measurable

	targets, such as the potential and requirements to eliminate 52-week waiters by the end of March 2023. A detailed report around recovery is planned to be discussed at the Finance and Performance Committee Meeting in September, once the detailed specialty-level recovery plans have been finalised.
Due Diligence (include the process the paper has gone to prior to presentation at FPC Meeting)	A more detailed version of the report has been discussed at the Finance and Performance Committee Meetings in July and August, with key escalations covered by the Chair's log.
Board powers to make this decision	The Board has delegated authority to the Finance and Performance Committee to review and feedback to the Board any assurance issues, and breaches in SO, SFIs, scheme of delegation etc.
Who, what and when (what action is required, who is the lead and when should it be completed?)	A monthly report is provided to the Finance and Performance Committee and to the Board of Directors and any actions required are the responsibility of the Chief Operating Officer with support from colleagues.
Recommendations	It is recommended that the Board of Directors note the report.
Appendices	1. Operational and Recovery Update

NHS
The Rotherham
NHS Foundation Trust

Operational Performance and Recovery Update

Board of Directors

September 2022

act

Proud

Summary Narrative

The Rotherham NHS Foundation Trust

- **Operational pressures** intensified again in July, due in part to an increase in the number of Covid-19 patients from the second week of the month to the highest level seen since late April, with the expected simultaneous increase in staff sickness. The number of long length of stay patients rose throughout the month, to the point where the Trust was on Opel Level 4 for over a week. Daily escalation calls were implemented with partners to ensure appropriate Place-level senior engagement on discharge challenges, and a new internal length of stay report was introduced for divisional teams to give them greater visibility over the long length of stay patients whose discharge was within our control to manage.
- These operational pressures led to a need to utilise our **elective orthopaedic ward** for non-elective patients, and cancel routine patients where the beds were required to support emergency demand.
- Given ongoing challenges around **Anaesthetic sickness levels** and consequential high numbers of cancellations of elective patients at the last minute, we made a decision to proactively take down two all-day lists a day from late July until the end of August. This was to minimise the disruption to the operational and clinical teams and our patients from the last minute cancellations of lists we were having to implement. Actions to ensure we can re-ignite our full elective programme from September are in place, as this will not be a capacity reduction we can allow beyond this point given the growing backlog of patients waiting.
- **RTT performance** has declined again to 72.7%, based in part on a couple of larger specialties struggling with growing **capacity and demand** mismatches over the last few months, particularly Ophthalmology and Dermatology. This was a 4 percentage point drop on performance 2 months' ago, and represents an increase in the number of 18 week waiters by just under 1,750 patients. The number of patients waiting 52 weeks or longer for treatment has grown to 151 as of the end of July. This is not expected to decline until at least September, when our normal theatre schedule is re-instated, but given reduced elective capacity, it will likely be Q3 when this number begins to fall. 4 patients were waiting over 104 weeks at the end of July, these have all been seen and treated during August.
- Alongside some of the challenges within RTT performance, we also saw the anticipated deterioration in **Endoscopy performance** (with 269 breaches in month), Echocardiography (130 breaches), with the CT position unchanged (170 breaches).
- **Cancer performance** continues to be below the national standard, with the anticipated challenges in 2ww performance continuing in July and likely to remain until the end of Q2. Work is underway to review the Lower GI pathway through a cross-organisational workshop in late September. Capacity issues within our prostate biopsy service and histopathology have created further delays to pathways which will likely impact on performance throughout Q2.
- A **Recovery workshop** in early August has identified a number of schemes to drive recovery by increasing our capacity across a range of areas, including by insourcing consultants to provide medical workforce capacity, funding additional clinics from our teams, insourcing theatre and anaesthetic teams and utilising the independent sector. These schemes will likely start to impact from the middle of September given the time lags to agree contracts with suppliers.
- Alongside this **recovery investment**, we continue to focus on improving our outpatient pathways and processes through the **Outpatient Transformation Programme**, and have begun the work to improve the throughput within theatres. Similarly, testing approaches such as full referral triage through Consultant Connect have helped identify simple improvements to our services that we can implement to reduce unnecessary demand.
- The performance standards and **recovery requirements for 2022-23** remain incredibly challenging given the wider context we continue to operate in, withincreased sickness levels compared to pre-pandemic. However, we have now identified a number of schemes which should mitigate some of the deterioration in performance we have seen in recent months and ensure we can offer our patients more timely access to care.

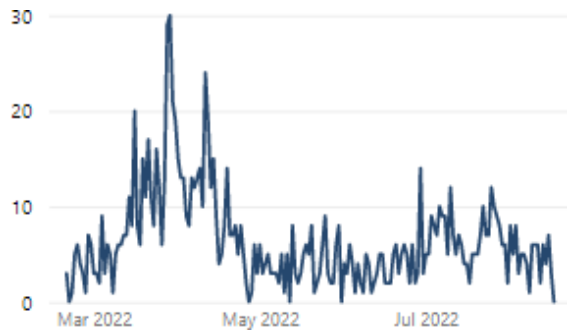
Covid-19 demand

The Rotherham NHS Foundation Trust

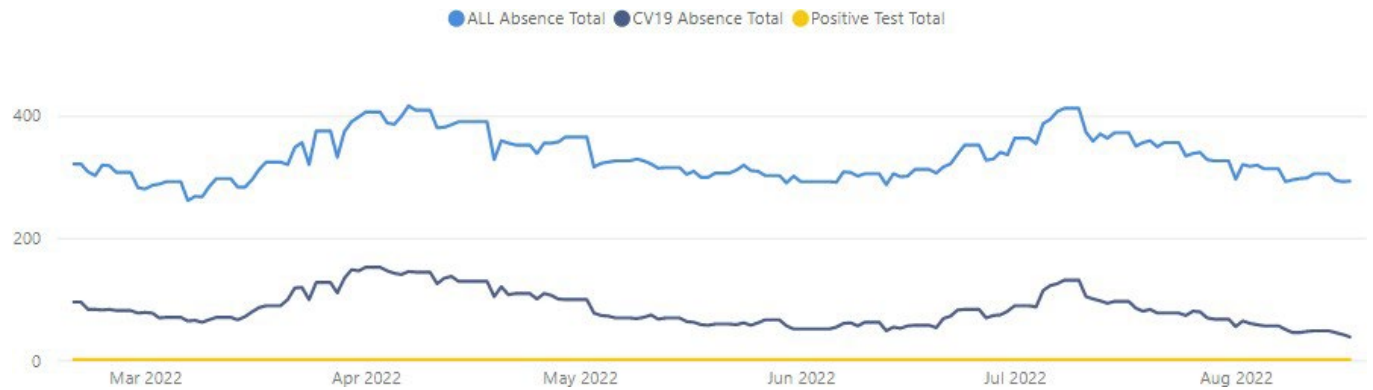
The number of Covid-19 patients in beds increased across July, with staff sickness also seeing a corresponding increase throughout the month

Number of Covid-19 inpatients in beds, Feb – Aug 2022

Covid-19 daily confirmed cases, Feb – Aug 2022



Staff absence by type, Feb – Aug 2022



Covid-19 sickness rules have been updated, and guidance is beginning to flow around the vaccination programme

- As of 7th July, Covid-19 sickness absence will now count towards an employee's sickness absence record
- There will be a transition period for staff already off sick with COVID-19-related illness, but from 1 September, staff who were on COVID-19 sick pay as a result of being unwell prior to 7 July, and continue to be unwell, will revert to their normal contractual sick pay arrangements.
- A flu and Covid-19 vaccination programme for staff is expected to be rolled out in Q3, to support our teams to stay well over the winter period in particular and minimise sickness absence

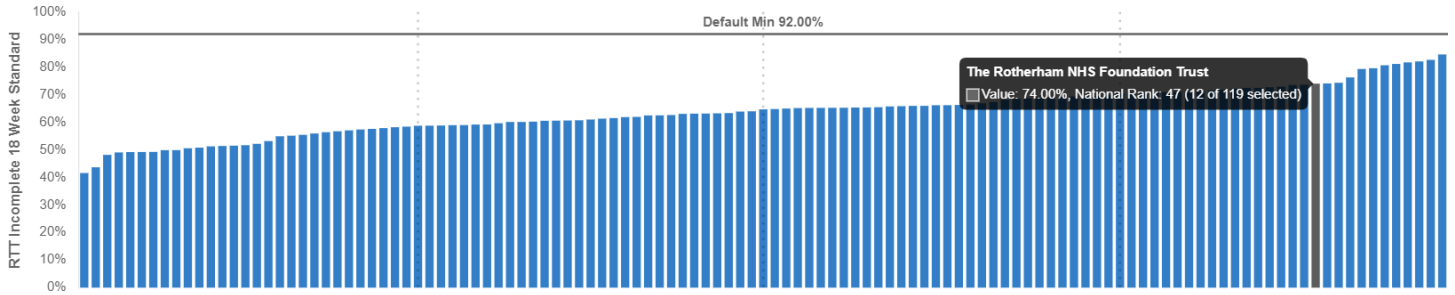
Recovery: RTT performance

Performance against target	
Benchmark performance	
Performance trajectory	

The Rotherham NHS Foundation Trust

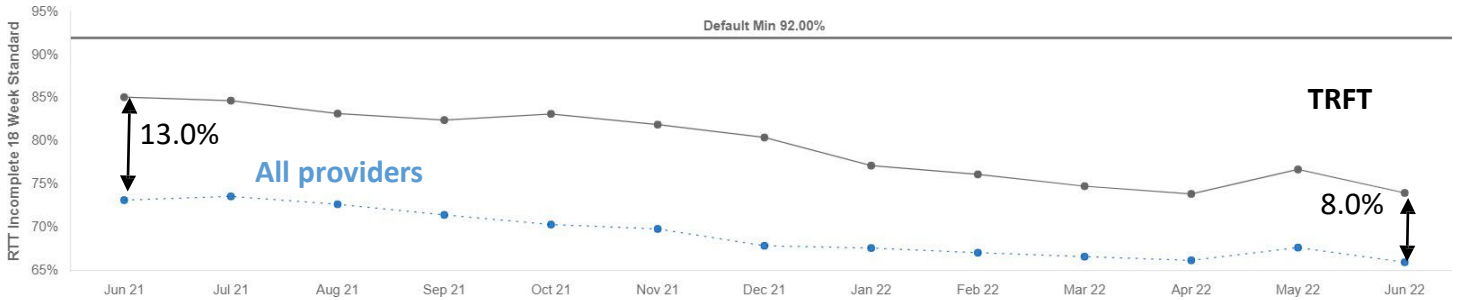
RTT performance in the Trust remains relatively good when compared to other trusts…

RTT Incomplete Standard performance, June 2022 (latest national benchmarking data available)



However, it has deteriorated over the last 12 months, and more substantially than for other providers

RTT Incomplete Standard performance, June 2021 - June 2022



Following agreement to fund £1m of recovery schemes in Q2/Q3 in late July, the below initiatives have been agreed:

- Use of Kinvara Private Hospital for Orthopaedic lists (to free up capacity at TRFT for additional hip and knee lists for more complex patients)
- Insourcing in Gastroenterology, OMFS and ENT (as required)
- Endoscopy insourcing to support increased demand from Gastro insourcing and to reduce existing backlog
- Insourcing of anaesthetist and ODP teams to ensure theatre timetable can return to normal BAU levels
- Additional Ophthalmology cataract lists at weekends
- Additional weekend and evening clinics in Gynae, Cardiology, Ophthalmology, General Surgery (and other specialties based on uptake)
- Locum resource to recover Cardiac CT position

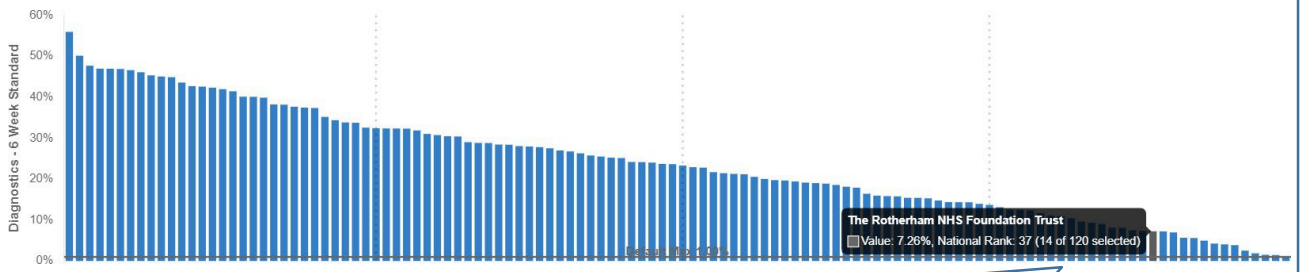
Recovery: DM01

Performance against target	
Benchmark performance	
Performance trajectory	

The Rotherham NHS Foundation Trust

Performance against the diagnostic 6-week standard has improved markedly over the last year with the Trust in the top 20 trusts nationally

DM01 performance compared to all acute and combined trusts, June 2022



The Trust is the 16th best acute or combined Trust on DM01 performance as of the latest national data (June 2022), although we have seen a deterioration in Endoscopy performance in the last 3 months due to a significant increase in the vacancy and sickness rate

The biggest challenges are within Cardiac CT, Endoscopy and Echocardiography

DM01 performance, July 2022

Category	Investigation	<6 weeks	≥ 6 weeks	Performance (% breaches)	Total WL
Imaging	Magnetic Resonance Imaging	351	0	0.0%	351
	Computed Tomography	875	170	16.3%	1,045
	Non-obstetric ultrasound	1,841	0	0.0%	1,841
	DEXA Scan	126	0	0.0%	126
Physiological Measurement	Audiology - Audiology Assessments	427	5	1.2%	432
	Cardiology - echocardiography	571	130	18.5%	701
	Respiratory physiology - sleep studies	248	13	5.0%	261
	Urodynamics - pressures & flows	2	2	50.0%	4
Endoscopy	Colonoscopy	375	116	23.6%	491
	Flexi sigmoidoscopy	90	36	28.6%	126
	Cystoscopy	116	8	6.5%	124
	Gastroscopy	405	109	21.2%	514
	Total	5,427	589	9.8%	6,016

The following actions have been agreed to continue to drive recovery of diagnostic services:

Echocardiography	• Use of InHealth to provide additional capacity. Currently trying to increase number of additional sessions to meet demand
Endoscopy	• Insourcing of for 10 weeks to work through the backlog from the additional Gastroenterology activity (via Consultant Connect referral triage Straight to Test outcomes and insourcing from GutCare)
Cardiac CT	• Additional sessions via our teams and locum cover, with Cardiology input also agreed

Recovery: Cancer 62-day PTL

Performance against target	
Benchmark performance	
Performance trajectory	

The Rotherham NHS Foundation Trust

This year has proved challenging in terms of the number of patients over 62 days on the Cancer PTL, with a doubling in the number since the end of 21/22, driven by Lower GI and Dermatology increases

Number of patients on Cancer PTL over 62 days, GP referrals only

Some of the reasons for the increase are entirely understandable, but there are also clear areas for improvement around clinical engagement and close operational management which need focus over the next few months

It is likely to take a number of months to recover this position, with several actions planned, both at divisional and Trust level

1. Ensuring follow-up appointments are appropriately requested as urgent
2. Running a cross-organisation Lower GI Pathway Review in September
3. Recruiting a further two care navigators to improve patient attendance at appointments
4. Improving clinical engagement around the importance of the national standards and ensuring documentation is completed as appropriate
5. Pre-empting the need for MDT discussion
6. Addressing patient engagement issues quickly and sensitively
7. Building on effective practices already developed to ensure robust PTL processes are embedded across all teams

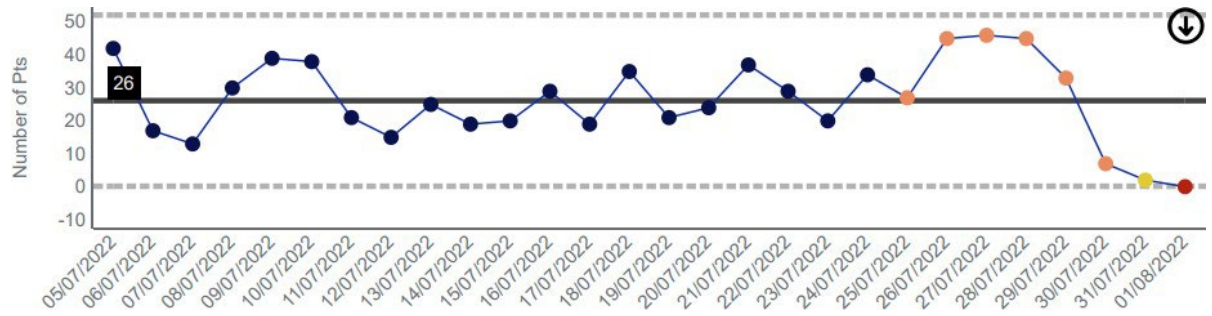
Emergency Performance: UECC 12 hour waits

Performance against target	
Benchmark performance	
Performance trajectory	

The Rotherham NHS Foundation Trust

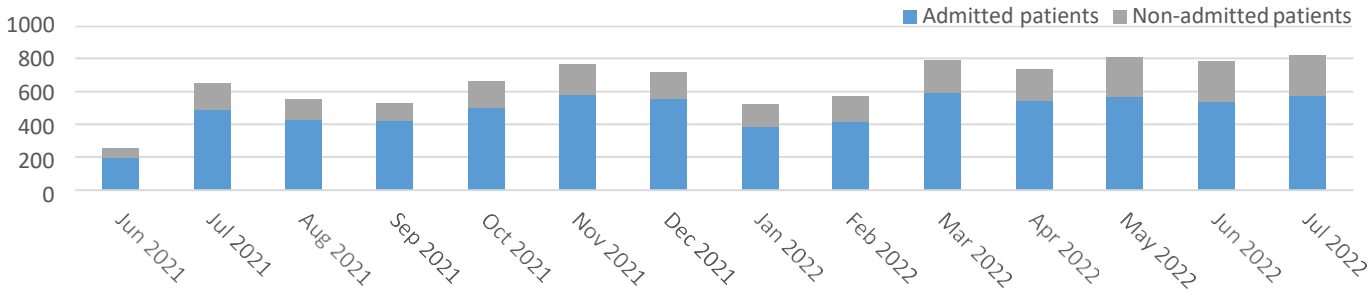
The Trust is still seeing a high number of patients waiting over 12 hours in department, although there was a significant short-term improvement

Number of Patients waiting over 12 hours in the UECC department, July 2022



However, in the last 3 months, approximately 30% of these 12 hour waits have been from patients who were not admitted

12 hour waits in department split by admitted/non-admitted patients, Jun 21 – Jul 2022



This issue has been a challenge since the Trust became part of the new field test standards, so we are implementing new internal measures:

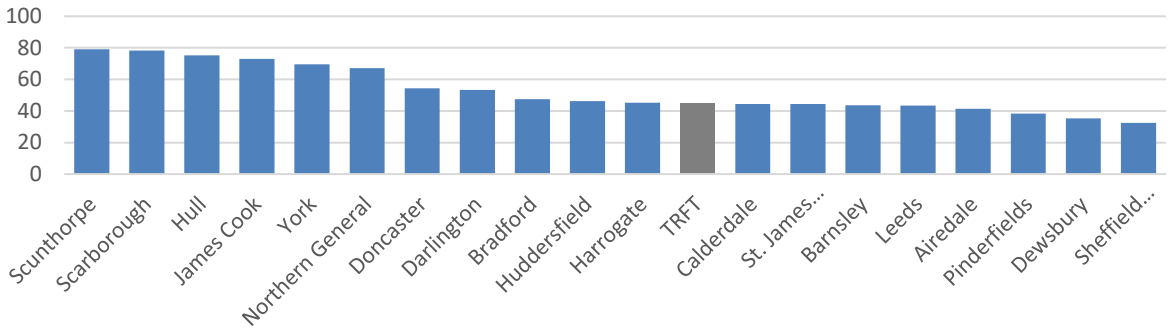
- Introduction of a new escalation policy and recognising 12 hours total time in department as an internal never event
- Review of all patients waiting over 12 hours to take place the following day to ensure lessons are learned and actions taken to improve
- Weekly acute performance meeting established, chaired by Chief Executive, to ensure focus on acute performance and delivery of key actions to improve
- Acute Care Transformation programme continues to drive improvements. Key initiatives include introduction of a Transfer Team to reduce time waiting to transfer to wards
- Maximise patients being streamed to SDEC and ASU facilities. CHAT and Frailty assessments to be undertaken in SDEC.

Emergency Performance: Ambulance handovers

The Rotherham NHS Foundation Trust

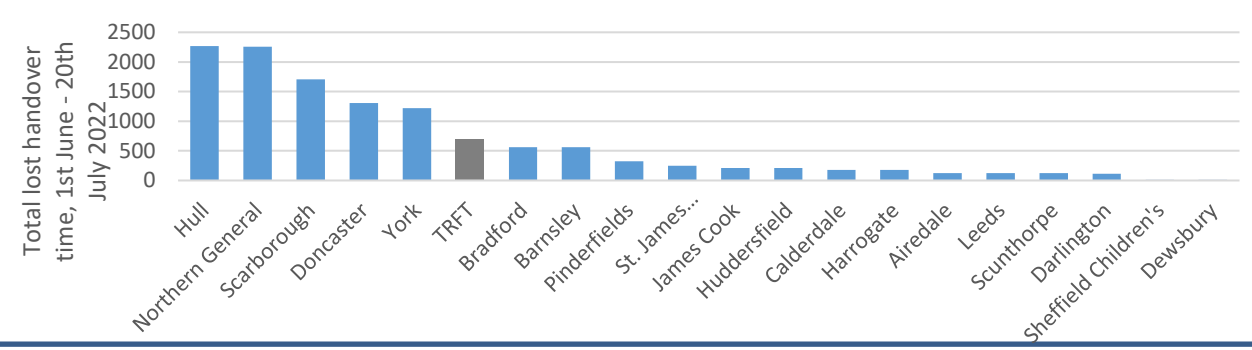
Ambulance handover delays continue to be a national focus, although compared to all NE&Y providers, our average handover time is relatively good

Average handover time by Trust, 1st June – 20th July 2022



However, we still have a relatively high proportion of long handovers, which leads to lost time for YAS teams, and remains a focus

Average handover time by Trust, 1st June – 20th July 2022



Our focus remains on eliminating handovers over an hour long, which requires a number of key actions

- Opening our RAT facility in our UECC to ensure dedicated staff to managing ambulance arrivals
- Implementing cohorting of ambulance patients in our UECC where appropriate, based on the new YAS guidance implemented across South Yorkshire
- Improving flow out of the department, including enacting Full Capacity Protocol when required
- Visibility of YAS handover screen internally to support escalation and planning, further access to YAS system being rolled out to site team and senior colleagues supporting flow and UECC.

Board of Directors' Meeting
09 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P143/22
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D6: We will not be able to deliver our services because we have not delivered on our Financial Plans for 2022/23 in line with national and system requirements leading to financial instability and the need to seek additional support.
How does this paper support Trust Values	This report supports the Trust's vision to always ACT the right way and be PROUD to provide exceptional healthcare to the communities of Rotherham by adhering to the core values – (A)mbitious, (C)aring and (T)ogether and focussing on our strategic ambitions: (a) (P)atients - 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; (b) (R)otherham - We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve; (c) (O)ur partners - We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care; (d) (U)s - We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work; (e) (D)elivery - 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. Exercising strong financial management, control and governance is a key component element in the Trust achieving these ambitions.
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 for April to July 2022: ○ A summary of the key performance metrics linked to income and expenditure (including cost improvement performance), capital expenditure and cash management. • Section 2.1 – Income & Expenditure Account for April to July 2022:

	○ Financial results for the first four months of the financial year 2022/23. - A surplus to plan of £297K in month and £100K year to date; - A similar surplus to the (external) control total in month and year to date. The control total is what the Trust's performance is measured against with NHSE/I, having normally adjusted for depreciation on donated assets. The figures are significantly different this year (year to date) due to non-cash income for the take-on of donated finance leases under IFRS 16 (£685K) as at 1st April 2022 and a contribution to capital expenditure (£758K) for the Public Sector Decarbonisation scheme. • Section 2.2 – Income and Expenditure Account Forecast Out-Turn ○ An initial forecast out-turn up to 31st March 2023 of £4,458K deficit to plan and equally the control total. ○ The Trust only resubmitted its revised plan on 20th June 2022 and hence, at this point it will be reporting externally to the ICB and NHSE/I that it will be delivering that plan. ○ All services must strive to deliver a significant improvement against the Efficiency Programme (CIP) - both in year and full year effect - as this is pivotal to ensuring achievement of the plan and to ensure a robust financial baseline for the 2023/24 financial year. • Section 3 – Capital Expenditure 2022/23 ○ Results for the first four months of the financial year 2022/23 show expenditure of only £771K year to date compared to a budget of £2,094K: an under-spend of £1,323K (63%). ○ The forecast out-turn for the full financial year is indicating expenditure in line with the Trust's CDEL value i.e. £12,733K. • Section 4 – Cash Flow 2022/23 ○ A cash flow graph showing actual and forecast cash movements between April 2021 and March 2023. This includes: - Actual month-end values for April 2021 to July 2022, with a closing cash position of £29,274K as at 31st July 2022 - £4,179K better than plan; - Planned month-end values for August 2022 to March 2023; and - Forecast month-end values for the same period with a forecast closing cash position as at 31st March 2023 of £17,238K, which is £2,278K lower than plan.

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. ○ The overall financial position for I&E has been reviewed collectively by and agreed with the senior Finance Team together with the Director of Finance. ○ CIP performance has been discussed with the CIP (Efficiency) Board chaired by the Deputy Chief Executive. ○ The capital expenditure position has been discussed and reviewed by the Capital Planning & Monitoring Group, chaired by the Director of Finance. ○ More comprehensive and detailed reports of the financial results have been presented to Finance & Performance Committee and the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*
Who, What and When (What action is required, who is the lead and when should it be completed?)	Recovery plans and actions are being developed by services in conjunction with the Director of Finance.
Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	None.

1. Key Financial Headlines

1.1 The key financial metrics for the Trust are shown in the table below. These are:

- Performance against the monthly income and expenditure plan;
- Capital expenditure;
- Cash management.

Key Headlines	Month P £000s	Month A £000s	Month V £000s	YTD P £000s	YTD A £000s	YTD V £000s	Forecast V £000s	Prior Month FV £000s
I&E Performance (Actual)	(242)	55	297	607	706	100	(4,158)	(3,762)
I&E Performance (Control Total)	(386)	(88)	297	(652)	(553)	100	(1,863)	(3,762)
Capital Expenditure	619	402	217	2,094	771	1,323	11,962	(12,364)
Cash Balance	203	3,157	2,954	25,096	29,274	4,179	278,574	(248,427)

1.2 The Trust has under-spent against its I&E plan in July 2022, leading to a marginal under-spend of £100K year to date. The control total is what the Trust's performance is measured against with NHSE/I, having normally adjusted for depreciation on donated assets. The figures are significantly different this year due to non-cash income for the take-on of donated finance leases under IFRS 16 (£685K) as at 1st April 2022 and a contribution to capital expenditure (£568K) for the Public Sector Decarbonisation scheme included in the year to date values.

1.3 The forecast out-turn is showing an initial deficit of £4,158K to plan, which is a deterioration from last month's forecast. The Trust will be reporting delivery of the plan externally, given that it only submitted its revised plan on 20th June 2022. This position will be managed via Reserves in the short-term, with overall expenditure to be reduced in the longer-term to 31st March 2023.

1.5 Capital expenditure is below plan at present by £1,323K, based upon a plan that has been profiled in consultation with individual budget holders. Significant slippage on investment in the hospital estate has so far this year. This will need to be closely monitored going forward by the Capital Planning & Monitoring Group chaired by the Director of Finance.

1.6 The cash position at the end of July 2022 is still very strong, being further above plan in month. This strong position is expected to be maintained throughout the financial year despite forecasting to be below plan at 31st March 2023, which assumes reserves will be used to cover the forecast out-turn deficit on I&E in order to deliver in line with plan.

2. Income & Expenditure Account

2.1 In Month and Year to Date Performance for Month 4 (July 2022)

2.1.1 The table below shows the financial results both in month and year to date. The Trust has delivered a surplus to plan in July 2022 of £297K, giving a year to date surplus to plan of £100K.

Summary Income & Expenditure Position	AP	Month			YTD			2022/2023
		P	A	V	P	A	V	Monthly Trend /
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	Variance
Clinical Income	303,302	25,262	25,291	29	101,413	101,539	125	
Other Operating Income	24,939	2,274	2,287	13	9,073	9,303	230	
Pay	(214,375)	(18,196)	(18,320)	(124)	(72,331)	(72,936)	(605)	
Non Pay	(88,913)	(7,287)	(7,491)	(204)	(28,888)	(29,149)	(261)	
Non Operating Costs	(4,684)	(390)	(375)	15	(1,561)	(1,520)	42	
Reserves	(20,547)	(1,905)	(1,337)	568	(7,099)	(6,530)	568	
Retained Surplus/ (Deficit)	**(278)**	**(242)**	**55**	**297**	**607**	**706**	**100**	
Adjustments	(2,407)	(143)	(143)	(0)	(1,259)	(1,259)	(0)	
Control Total Surplus/ (Deficit)	**(2,685)**	**(386)**	**(88)**	**297**	**(652)**	**(553)**	**100**	

2.1.2 Clinical Income is marginally ahead of plan in month. The over-recovery year to date relates to additional income regarding dental services (£37K), excluded drugs (£60K) and patient charges regarding insurance claims (£23K).

2.1.3 Other Operating Income is similarly marginally ahead of plan in month. Year to date over-performance is being driven by increased income from research, education & training (£93K), staff recharges (£135K) and non-clinical services recharges (£207K) across various services. Some of these will be a direct offset to additional expenditure incurred. This is being offset by reduced income from car parking charges from patients and visitors (£140K), which is currently well below pre-covid levels.

2.1.4 Pay costs are over-spending in month and year to date with a significant under-spend on substantive staff not being offset by external bank and agency costs, but an outstanding CIP target of £837K year to date is the main contributory factor to the cumulative position.

2.1.5 Non Pay costs are over-spending in month and year to date. In month performance is being heavily influenced by an over-spend on depreciation charges now that a substantial CIP saving has been transacted retrospectively in month (with an equal and opposite offset in Reserves) together with undelivered CIPs of £64K. Year to date performance is similarly being influenced by an outstanding CIP target of £220K.

2.1.6 Non-Operating Costs reflect increased interest receivable on cash balances held with Government banking services.

2.1.7 £568K has now been released from Reserves in month to reflect the level of over-delivery on CIPs that is not credited against divisional targets, to maintain consistency with the previous month's reported and forecast positions. Cost containment and CIP delivery will need to be managed proactively across all services if the Trust is to deliver against its overall plan successfully.

2.2 Forecast Out-Turn Performance to 31st March 2023

2.2.1 The table below shows the forecast out-turn for the financial year 2022/23. The Trust is forecasting to deliver £4,258K deficit to plan during the remainder of the financial year to deliver a full year forecast out-turn deficit of £6,843K or £4,158K adverse variance to plan.

Summary Income & Expenditure Position	AP £000s	FO (Full Year) £000s	FV (Full Year) £000s	AV (YTD) £000s	FV £000s	TV £000s	2022/2023 Monthly Trend / Variance
Clinical Income	303,302	303,510	207	125	82	207	
Other Operating Income	24,939	25,721	782	230	552	782	
Pay	(214,375)	(219,400)	(5,025)	(605)	(4,420)	(5,025)	
Non Pay	(88,913)	(90,629)	(1,716)	(261)	(1,455)	(1,716)	
Non Operating Costs	(4,684)	(4,561)	124	42	82	124	
Reserves	(20,547)	(19,078)	1,469	568	901	1,469	
Retained Surplus/ (Deficit)	(278)	(4,436)	(4,158)	100	(4,258)	(4,158)	
Adjustments	(2,407)	(2,407)	(0)	(0)	0	(0)	
Control Total Surplus/ (Deficit)	(2,685)	(6,843)	(4,158)	100	(4,258)	(4,158)	

2.2.2 Clinical Income is forecast to increase above plan from further additional income expected from excluded drugs, dental services and patient charges regarding insurance claims.

2.2.3 Other Operating Income is forecast significant increases in income form staff recharges and both SLA and non-SLA non-clinical income recharges which is being offset by still further reductions in car parking income being below plan for patients and visitors.

2.2.4 Pay is showing a very significant deterioration in performance but this does include, as yet, unidentified CIP budget reductions of £5,257K.

2.2.5 Non Pay costs are similarly showing a significant deterioration in performance, primarily linked to unidentified CIP budget reductions of £1,750K.

2.2.6 Non-Operating Costs reflects increased income from interest receivable on money deposited with Government banking services, that was previously not budgeted for.

2.2.7 Performance on Reserves improves significantly reflecting the full year effect of the over-delivery on CIPs that are not credited against divisional targets.

2.2.8 The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE/I, but assumes appropriate management action and the use of reserves will enable the Trust to deliver its overall plan as a minimum by 31st March 2023 i.e. a year end deficit of £2,685K.

2.2.9 Cost containment and CIP delivery will need to be managed proactively across all services, with clear action plans being developed over the coming weeks, if the Trust is to deliver against its overall plan successfully and hence, recovery plans and actions are being developed by services in conjunction with the Director of Finance.

3. Capital Programme

3.1 During July 2022 the Trust incurred capital expenditure of £402K against a budget of £619K representing an under-spend of £217K, leading to an under-spend year to date of £1,323K as shown in the table below.

Scheme Categories	In Month			YTD			FOT		
	P £000s	A £000s	V £000s	P £000s	A £000s	V £000s	P £000s	A £000s	V £000s
Estates Strategy	466	234	**232**	1,331	257	**1,074**	5,875	5,875	**0**
Estates Maintenance	78	30	**48**	200	169	**31**	1,720	1,720	**0**
Information Technology	68	107	**(39)**	440	242	**198**	1,691	1,691	**0**
Medical & Other Equipment	0	31	**(31)**	97	101	**(4)**	3,419	3,419	**0**
Contingency	7	0	**7**	26	1	**25**	28	28	**0**
Surplus/(Deficit)	**619**	**402**	**217**	**2,094**	**771**	**1,323**	**12,733**	**12,733**	**0**
IFRS16 Adjustment	0	0	**0**	0	16,168	**(16,168)**	0	16,168	**(16,168)**

3.2 From the 1st April 2022, the trust has adopted IFRS16, in line with other NHS organisations. This is a technical accounting standard requiring any assets acquired by the Trust via leasing arrangements to be brought onto the balance sheet (if not already). These assets, totaling £16,168K will need to be accounted for in the capital expenditure position, but will not impact on the Trust's initial overall CDEL position – effectively being managed centrally at a national level.

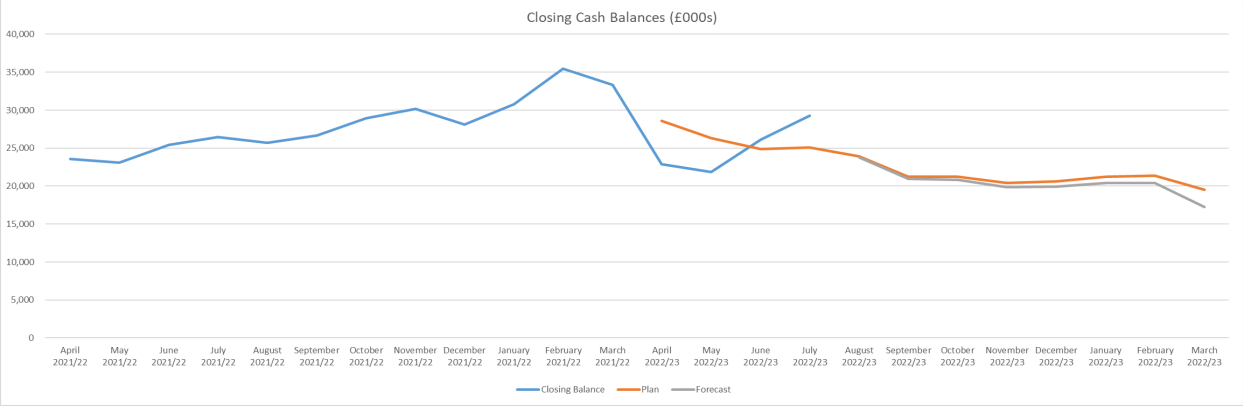
3.3 The table also shows the capital expenditure forecast out-turn for 2022/23 where the Trust is forecasting to use all its CDEL capacity and spend in line with budget on its capital programme, totalling £12,733K.

3.4 Capital Planning & Monitoring Group, chaired by the Director of Finance is responsible for overseeing the capital programme and is already considering what actions could be taken in future months if in year slippage continues or indeed increases towards year-end.

4. Cash Management

4.1 Cash Flow Position 2022/23

4.1 Cash remains buoyant as at 31st July 2022 (£29,274K), which is £4,179K better than plan.



4.2 The forecast suggests a further reduction in cash throughout the year with an overall reduction compared to plan of £2,278K due to reduced depreciation charges and increased stock values, with a forecast closing balance at 31st March 2023 of £17,238K. This assumes that the Trust can successfully deliver an I&E position in line with plan.

Steve Hackett
Director of Finance
16th August 2022

Board of Directors Meeting
9 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P144/22
Report	**Maternity Safety including Ockenden Monthly Report**
Executive Lead	Helen Dobson Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
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)	• It is a national requirement for the Board of Directors to receive a monthly update on Maternity Safety and progress against the actions arising from the Ockenden report. • The Trust has received the final report from The Regional Ockenden Support Visit on 25th May 2022 which is very positive. • The Ockenden 4 pillars have been applied to provide an update on Maternity Safety, including the Quarter 4 and Quarter 1 Perinatal Mortality Review Tool (PMRT) update. • The Division continue to work on the evidence and assurance to achieve the 10 Safety actions for The Maternity Incentive Scheme (MIS) Year 4. • The monthly feedback from Maternity and Neonatal Safety Champions is shared.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper has been prepared by the Head of Midwifery and will be shared through Maternity and Family Health Divisional Governance and the Maternity and Neonatal Safety Champions.
Powers to make this decision	The Trust Board is required to have oversight on the maternity safety work streams. This paper will also feed through to the monthly Trust board.
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 Executive Lead and The Head of Midwifery attends board monthly to discuss the Maternity Safety agenda.
Recommendations	It is recommended that The Trust Board is assured by the progress and compliance to date with the Maternity Safety Work streams
Appendix	1. Ockenden Assurance Visit Report and covering letter 2. Regional Perinatal Oversight Tool

	3. Quarter 1 and Quarter 4 PMRT review (CNST Evidence) – available in reading folder

1. Introduction

1.1 The Trust has received the final report from The Regional Ockenden Support Visit on 25th May 2022 which is very positive. The report and covering letter are attached at Appendix 1. NHSE/I are awaiting the publication of the East Kent Report, which has been delayed, before requesting any further assurance from Trusts on the 15 IEA's in the Final Ockenden Report.

2. Safe Staffing

2.1 The Maternity Service remains challenged with on-going workforce gaps due to maternity leave, long-term and short-term sickness. The table below represents the current Midwifery workforce gaps from July 2022, with a current over establishment of 0.41 as the Division has approved an over-recruitment of 10.00 WTE Midwives to support the ongoing absence. Further roll out of Continuity of Carer teams is currently paused until the staffing shortfalls improve. The trajectory below predicts that this should improve to a gap of 2.76 WTE by October 22.

2.2

Trajectory	Jul	Aug	Sep	Oct
Contracted Vacancies	**-0.41**	**-0.41**	**-0.41**	**-0.41**
Maternity leave	5.92	6.24	5.60	4.80
Long term sickness	3.92	1.92	0.00	0.00
Upcoming Leavers	0.80	1.05	1.05	1.05
New Starters	-0.40	-0.62	-0.80	-0.80
New Starters - students/NQM's	0.00	0.00	0.00	-3.60
Other - see detail	1.72	1.72	1.72	1.72
Total Gaps (not vacancies)	**11.55**	**9.90**	**7.16**	**2.76**
Trajectory - for planning	**11.55**	**9.90**	**7.16**	**2.76**
% Workforce Gaps	**11.8%**	**10.1%**	**7.3%**	**2.8%**

2.3 The recruitment to the 10.00 WTE has been challenging due to the national shortage of Midwives and the Local Maternity System (LMS) system-wide approach to the recruitment of Newly Qualified Midwives (NQM), which prioritised recruitment to Providers with the highest vacancies; Sheffield Teaching Hospitals and Doncaster and Bassetlaw Hospitals. Consequently, TRFT were allocated 3.60 WTE NQM from this process. The Division continues to recruit to the outstanding 5.19 WTE agreed over recruitment.

2.4 The Continuity of Carer (CoC) new model of working commenced in July 2022 to support the staffing shortfalls on labour ward. This involves the midwives on-call for labour ward in the 3 continuity teams working an allocated shift with the potential of caring for women who are not on continuity pathways to support the service at times of high acuity to maintain safe staffing.

2.5 TRFT continue to work with the LMS on developing a more sustainable workforce for Maternity services across South Yorkshire and Bassetlaw.

2.6 Red flag incidents are submitted for the shifts where the Labour Ward Co-Ordinator is not deemed supernumerary. The July Red Flag incidents have been investigated by the Acute Maternity Matron finding that at no time did the Co-Ordinator have a caseload of their own therefore further training has been offered to the Labour Ward Co-Ordinator teams to ensure that they are all aware of this definition when submitting Red Flag data.

2.7 Medical staffing: No Datix reports were submitted in July 2022 to escalate any concerns regarding compliance with mandatory Obstetric escalation, there were no Red Flags reported to escalate the non-compliance with the mandatory twice-daily consultant ward rounds.

3. Workforce Data July 2022

Maternity unit closures	0%	Datix / Birth rate plus
Utilisation of on call midwife to staff labour ward	0%	BirthRate Plus data
1-1 care in labour	100%	Data from BirthRate Plus acuity tool reflects
Continuity team midwife present for continuity birth	95%	Data from BirthRate Plus acuity tool
Supernumerary labour ward co-ordinator	97%	Data from BirthRate Plus acuity tool
Staff absence	7.75%	HR data, short and long term sickness
Obstetric compliance at mandatory consultant escalation	100%	No Datix incidents reported
Compliance with twice daily face to face ward round	100%	Birth rate plus data, no red flags reported

3.1 Obstetric cover gaps: The table below illustrates the locum breakdown:

Grade	No of Shifts	Reason	Internal / External
ST1/2	30	28 x vacancy 2 x VTS mandatory	7 x internal 23 x external
ST3/7	15	6 x sickness 9 x vacancy	13 x internal 2 x external
Consultant	45	23 x vacancy 17 x annual/study leave 5 x additional ANC	45 x internal

4. A Well Trained Workforce:

4.1 Maternity Services have a local training plan in place to meet the core competency framework as outlined in MIS year 4. Training compliance has been a challenge due to the on-going sickness and absence gaps maintaining safe staffing. There is a plan to achieve this target for December 2022. Attendance at training has also been a challenge for Anaesthetic colleagues due to sickness absence; however, there is a recovery plan in place to support this.

5. July Training Data MDT Prompt

Obstetric Consultants	90%	**92%**
Obstetric Registrars	90%	**100%**
Obstetric Trainees	90%	**92%**
Midwives	90%	**81%**
Clinical Support staff	90%	**83%**
Anaesthetists	90%	**73%**

6. Learning From Incidents:

6.1 The regional perinatal oversight tool (Appendix 2) for Quarter 1 (Q1) has been completed and shared through the Maternity, Divisional and Local Maternity system governance meetings.

6.2 The main highlights are that one Serious Incident was declared during this quarter for a difficult 28-week gestation preterm Breach birth. This did not meet the HSIB criteria; therefore has been investigated by the Division with peer review provided by the LMNS.

6.3 The top five themes in incident reporting for Q1 include:

1. Neonatal readmissions for jaundice and weight loss
2. Admissions of term babies to SCBU
3. Staffing (Red flag reporting)
4. Massive Obstetric Haemorrhage
5. Small for Gestational age at birth

6.4 All incidents are investigated by the Lead and Risk midwives and are reported in the weekly Maternity and Gynaecology Multidisciplinary Datix and Avoidable Term Admission into Neonatal Unit (ATAIN) meetings.

6.5 The LMNS data for ATAIN has provided assurance that the ATAIN rates at TRFT have improved to below the 5% trajectory.

6.6 ATAIN Data

Indicator	**2021-22**	**2020-21**	**2019/20**
% OF Term babies admitted to SCBU	3.97%	4.48%	5.64%
Term babies admitted to special care with an avoidable condition as a % of Term admissions (Target reduce % each year)	4.95%	10.9%	16.5%
Term babies admitted to SCBU with an avoidable condition as a % of term births (Target <0.51%	0.21%	0.49%	0.93%

6.7 The MIS Year 4-safety action 1 recommends that Trusts review all eligible perinatal deaths from 22 weeks gestation. The Trust Board is requested to note the quarterly reports for Q4 and Q1 respectively for perinatal mortality reviews from January to March 2022 and April to June 2022.

6.8 The review process is discussed with parents and they are invited to be involved in the review process, sharing their feedback on their care experience and whether they have any questions that they would like the review to address.

6.9 In Quarter 4 there were 4 cases which met the criteria for PMRT (Appendix 3)

Case 1

Neonatal Death – baby born @ 22 weeks gestation.
Investigated as a Datix.

Case 2

Neonatal Death – baby born @ 39+6 weeks gestation. Known mermaid syndrome.
Investigated as a Datix

Case 3

Neonatal Death – baby born @ 22+5 weeks gestation. Known Pre-term rupture of membranes @ 12 weeks gestation.
Investigated as a Datix.

Case 4

Intrapartum Stillbirth @ 28 weeks gestation.
This case has been declared as a Serious Incident and is being investigated as such.

6.10 In Quarter 1 there were 2 cases which met the criteria for PMRT (Appendix 3)

Case 1

Stillbirth @ 35 weeks gestation.
Un-booked pregnancy.
This case is awaiting review at the Perinatal mortality meeting.
Investigated as an after event.

Case 2

Stillbirth @ 36 weeks gestation
This case is awaiting review once all the results are available.
Investigated as a Datix.

6.11 The Maternity Service continues to report a downward trend in stillbirths for July 2022.

Number of stillbirths	0	Dashboard data
Stillbirth rate per 1000 births Rolling 12 months	1.95	Dashboard data

7. Listening to Women

7.1 Following the Ockenden review meeting, the Division has continued to work with the Maternity Voice Partnership (MVP) inviting the Chair and Co-Chair to attend Maternity Governance, monthly Quadumiverate meetings, and Labour Ward Forum to ensure that the service is listening to women and co-producing services.

7.2 In July there were x2 formal complaints regarding communication and postnatal care provision. Complaints in the division are triangulated with outcome data and incidents to monitor themes and trends. Learning is shared with teams through learning points and MAST training on the clinical supervision session.

8. Maternity Incentive Scheme

8.1 The Scheme relaunched on the 6th May 2022, Maternity Services continue to meet twice a month to work through the tracker to review compliance with all safety actions.

8.2 The Trust Board declaration form is required to be submitted to Trust Board with an accompanying presentation by the Head of Midwifery and Divisional Director so that the Trust Board can be satisfied with the evidence provided, giving their permission for the Trust's Chief Executive (CEO) to sign the Board declaration form prior to submission to NHS Resolution. In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for the Integrated Care System is appraised of the MIS safety actions' evidence and declaration form.

8.3 The main areas of challenge include:

Safety Action 2: Maternity Service Datasets:
Teams have been working collaboratively to meet the required standard of at least 9 out of the 11 Clinical Quality Improvement Metrics (CQUIMS) for the July data submission. The indicative data received for July 2022 demonstrates that this should be achieved.

8.4 Safety Action 6 Saving Babies lives care bundle: Achieving the 80% standard for four consecutive months in the reporting period for the smoking data has been a challenge due to the service using x3 different data sources therefore a manual audit has been implemented to support achieving this standard:

Month	Carbon Monoxide Testing undertaken at booking	Carbon Monoxide Testing undertaken at 36 weeks gestation
May 22	82.5%	90.5%
June 22	92.1%	90.5%
July 22	Awaiting data	Awaiting data

8.5 Safety Action 8 Multidisciplinary Training: Training compliance has been a challenge due to sickness and absence rates and maintaining safe staffing levels.

9. Maternity and Neonatal Safety Champions

9.1 There was an informal meeting in July 2022 visiting Greenoaks. The Maternity and Neonatal Safety champions commented on the feedback from staff, noting the improvements that had been made following the Quality improvement work in Antenatal services.

NHS England North East and Yorkshire

August 2022

Re: Ockenden Next Steps Assurance and Support Visit The Rotherham NHS FT on 25th May 2022

Dear Dr Richard Jenkins and Helen Dobson,

We visited your services to assess compliance with the 7 immediate and essential actions from the first Ockenden report published December 2020. The visit was supported by LMS teams, CCG teams and the MVP. This visit was intended to be supportive.

The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were in place and becoming embedded in practice.

Thank you to you and your team for your support and hospitality on the day of the visit, we appreciate the time this took as well as the preparations you made in advance.

We have reviewed both your self-assessment and the evidence you shared with us and together with the information we gathered on the day, we now enclose additional details of our findings to support your continued work towards implementation of the 7 IEA's.

We were extremely grateful to all the individuals who gave up their time to speak to us on the day, an open and honest culture was clearly evident and commitment to high quality compassionate maternity care was positive to see.

With regard to our **findings**, we particularly noted …

- A welcoming environment with information visible in multiple languages
- Good relationships floor to Board
- Cohesive triumvirate and leadership team
- Staff were proud to be part of the organisation and felt valued and supported
- Excellent virtual support which provided a platform for women and families to ask questions to clinical staff - 'Ask Olive'
- Learning Lessons was clearly evident
- Head of Midwifery attends Board monthly to present the maternity Board paper
- Effective leadership observed with a culture of openness and transparency
- Visible governance team with a focus on safety, with adequate time allocated for the roles
- Good support for preceptee midwives
- The MVP feel listened to with good communication from the senior leadership team.
- NED role effective and valued within the service

Details of our findings in relation to each of the 7 immediate and essential actions can be found on the attached document.

Following our visit our **recommendations** for your service would be that you consider how you can:

- Consider increasing women's choice of place of birth for example offering a midwifery led unit (alongside / freestanding)
- Further involve the MVP by inviting them to attend triumvirate, safety champions and governance meetings
- Meet the ask of the RCM leadership manifesto by investing in a DoM and a Consultant Midwife
- Assure compliance with PMRT by considering an audit of required elements
- Consider investment in an end-to-end maternity information system to support quality, safety and assurance as well as improving service user experiences

We hope that you find this feedback supportive and helpful. As a regional maternity team we are keen to support you to bridge any gaps identified in the implementation and embedding of these recommendations. Support is also available from the LMS and your MVP.

A copy of this report will be shared with the regional chief nurse Margaret Kitching and her team, the LMS, MVP, ICB, along with key findings and learning points from the whole region to facilitate shared learning and collaborative working.

Findings will be shared as requested with the national maternity team through national governance architecture.

With best wishes

Tracey

Dr Tracey Cooper MBE, Chief Midwife for North East and Yorkshire

CC - HoM / CD

Trust: Rotherham Hospitals NHS Trust **Site: The Rotherham Hospital**

Date: 25th May 2022

Visiting Team:

Dr Tracey Cooper – Regional Chief Midwife, Claire Keegan – Regional Deputy Chief Midwife, Debi Gibson – Regional Senior Midwife, Anna Temke – Regional Fellowship Midwife, Sarah Wall – Regional Service User Representative,

Cathy Winfield – SYB ICB Chief Nurse, Chris Edwards – SYB LMNS SRO, Tracy Hoggarth – SYB LMNS Midwifery Clinical Lead, Jodie Deadman – SYB LMNS PMO, Jacqui Yeates – SYB LMNS Maternity Transformation Midwife, Sue Cassin CCG representative, Hayley McGovern – Service User Representative - Ellie Gardner - Service User Representative, Michelle Bannon - Service User

Colour key for areas	
Meeting	
Virtual	

IEA Qu	KLOE	Visiting Team Met with	Evidence submitted prior to visit	Triangulation at visit	Self-assessment December 2021 Met Partially Met Not Met	Compliance at visit Met Partially Met Not Met	Comments and observations
Safety Action 1 Enhanced safety							
Q1							
Q1	Are maternity dashboards a formal item on LMNS agendas at least every 3 months?		LMNS Agenda		**Met**	**Met**	Yes
	Are you able to meet as a triumvirate monthly and minute meetings?	Triumvirate	Board minutes	Met to discuss		**Met**	Quadrumvirate well established. Clear evidence of development of action plan as a MDT which is then shared widely within the trust at local, directorate and board level. Key concerns reported were: informed choice and complex pregnancy
	Is there evidence of actions taken, and where is this shared?						
	In relation to the Ockenden action plan, where and how often is this tabled for discussion and what are your concerns?						

	What other concerns are raised on your Ockenden action plan?						
Q2	How is triangulation of incidents/complaints and claims achieved?	Triumvirate	Governance papers	Met to discuss		**Met**	Triangulation of incidents, complaints and claims well narrated, clear process. Openness evident (as a system). The loop is robust. Evidence of learning lessons and feedback to staff across all staff groups. Clear involvement with families
	Is there external clinical specialist opinion from outside the Trust (but from within the region), mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death?		Minutes of PMRT discussions/review	Met to discuss	**Partially Met**	**Met**	Yes
Q3	Are all maternity SI reports (and a summary of the key issues) sent to the Trust Board and the LMNS quarterly?	Triumvirate	Trust Board minutes LMNS Board minutes	Met to discuss	**Met**	**Met**	Process clearly articulated and board papers seen
Q4	Are all PMRT cases reviewed to the required standard?	Triumvirate	Ratified SOP/Guideline Audit timetable and actions Audit with 95% compliance	Met to discuss	**Partially Met**	**Met**	Comprehensive PMRT review report shared and process clearly articulated. Compliance was articulated but audit not demonstrated.
Q5	Are you submitting data to the Maternity Services Dataset to the required standard?	Triumvirate	Confirmation of compliance Action plan if improvements needed	Met to discuss	**Met**	**Met**	Evidence seen. The trust should consider an end to end digital system. The service needs to be assured that any new system will be able to provide the required evidence to meet the national reporting requirements. It should also have the capability to enable service users to interact and input into their personalised care and support plans.
Q6	Have all HSIB cases been reported?	Triumvirate	Audit timetable	Met to discuss	**Met**	**Met**	Yes

			Audit demonstrating 100% compliance				
Q7	Has the Perinatal Clinical Quality Surveillance Model been implemented June 2021?	Triumvirate	Ratified Trust SOP/Guideline Trust Governance structure	Met to discuss	**Partially Met**	**Met**	PQSM well established within the Trust and across the LMNS, but limited MVP involvement in incidents, complaints and claims.
			Ratified LMNS SOP/Guideline Minutes agreed ICS sign off				
Q8	Are all maternity SIs shared with Trust boards at least quarterly and the LMNS?	Triumvirate	Ratified Trust SOP/Guideline of how SI's are shared monthly with Trust Board and LMNS Board Agenda to include SI's as an item Minutes to include, summary, learning and actions		**Met**	**Met**	Process clearly articulated and board papers seen
Q9	What other concerns are raised on your Ockenden action plan?	Triumvirate	Action Plan				See Q1
Safety Action 2 Listening to women & families							
Q 10							

Q 11	Is there an allocated Non-Executive at Board level who works collaboratively with the maternity safety champions?	NED		JD and date appointed Activities Attendance at meetings Recorded output of meetings presented to Board and evidence of action from the interactions	**Partially Met**	**Met**	NED in post, staff spoken to are aware of who the NED is and report regular visiting to the area with examples of actions taken. NED takes a report to Board
				Interactions with staff, services users and MVP			Staff were aware that there is a maternity NED. Report regular visiting to the area with examples of actions taken.
Q 12	Is the PMRT tool used to review perinatal deaths to the standard required including women and families involvement?	Triumvirate	Ratified SOP/Guideline Audit timetable and actions Audit with 95% compliance		**Partially Met**	**Met**	See Q4
Q 13	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		Meeting with Triumvirate and MVP Chair	**Met**	**Met**	The MVP feel listened to with good communication from the senior leadership team. The MVP write the work plan based on views women and families. The trust should consider involving MVPs in quadrumvirate meetings and maternity safety champions meetings MVPs attend LW Forum – consider involvement in governance meetings and staff training

							Consider undertaking 'whose shoes' lead by MVP – demonstrate changes made in feedback The trust should consider how they ensure true coproduction from the start and throughout with guidelines in place
				How is user feedback obtained?			Friends and family tests, 15 steps, Facebook page, CQC maternity survey
				Examples of co-production			Moving of the bereavement suite was based on service user feedback. Support & facilitating families wishes e.g. family & baby visiting the snowdrop memorial garden.
Q 14	Do the Trust safety champions (MW /Obstetrician/Neonatal) meet bimonthly with Board level safety champions and escalate concerns, issues and blockers to improvement work	Safety Champions		Review talk through ratified SOP/Guideline/ TOR	**Partially Met**	**Met**	Yes
				Minutes of meetings Action Log			
				Evidence of action and improvement from the meetings			
Q 15	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		How is user feedback obtained?	**Met**	**Met**	See Q13
				Examples of co-production			
Q 16	Does the non-executive director support the Board level safety Champion who works collaboratively with the maternity safety champions to bring challenge and ensure all voices are heard?	NED Safety Champions		JD and date appointed	**Partially Met**	**Met**	See Q11
				Activities			Attend safety champions meetings, trust board, walkarounds and engagement sessions. Evidence of NED & chief nurse at safety champion meetings.
				Attendance at meetings			
				Interactions with staff, services users and MVP			

				Evidence of check and challenge as a result			
Safety Action 3 Staff training and working together							
Q 17	What MDT training does the maternity service provide?	Triumvirate PDM	Agenda LMNS Board Minutes LMNS Board	Meet PDM: View TNA How is training decided? Ask staff: How effective is the training?	**Partially Met**	**Met**	Comprehensive TNA shared that reflects the core competency framework and is responsive to local learning needs. Good compliance with training evidenced with clear trajectory to ensure >90% compliance across all staff groups. Process for DNA follow up clear. Training compliance is discussed at local governance, directorate reviews and trust board. Live drills evident and take place in a variety of environments. Feedback from staff at the visit was that training was valued and that learning from incidents and national reports was considered and included which made learning meaningful and relevant.
Q 18	Have you implemented a day and night Consultant led MDT ward round on the LW?	Staff		Ask staff what time the MDT ward round is and who attends? Review ward round sign in sheet	**Met**	**Met**	Twice daily ward rounds established and audits in progress.
	Do you have a dedicated obstetric governance lead? Do they have protected PA's?			What difference have you seen in outcomes since the introduction e.g. incident reduction, women's experience Look at Job plans and		**Met**	Visible governance team and focus on safety, with adequate time for the roles

				discuss with General Manager/Consultant clinical director/governance consultant who has oversight			
Q 19	Is all external funding allocated for training ring fenced and confirmation from the Finance Director?	Triumvirate	Ratified SOP/Guideline Invoices Budget spending plans Confirmation from FD Spend reports to LMNS		**Partially Met**	**Met**	Evidence seen
Q 20	Have 90% of each maternity unit staff group attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	PDM		Report of attendance records Trajectory Audit demonstrating 90% of each staff group attendance	**Partially Met**	**Met**	See Q17
Q 21	Is MDT schedule for training in place?	Triumvirate	Agenda LMNS Board Minutes LMNS Board		**Met**	**Met**	See Q17
		PDM Staff		View TNA How is training decided? Ask staff: How effective is the training?			
Q 22	See question 18						

Q 23	See question 19						
Safety Action 4 Managing complex pregnancy							
Q 24	Is there an agreement for the criteria for cases referred to the tertiary level Maternal Medicine Centre?	Consultant Fetal Medicine Lead / AN screening coordinator		Discuss referral pathway	**Not Met**	**Met**	Yes
				Review audit programme Review audit results of compliance and action plans	**Not Met**	**Met**	Referral pathways well narrated Embedded audit – the trust should consider where this is recorded/reported. This could be expanded to include all audit elements of the pathway which would give further assurance. Engaged with LMNS and regional MMN group.
Q 25	Do women with complex pregnancies have a named Consultant lead?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	**Not Met**	**Met**	Referral pathway clearly articulated Embedded audit – the trust should consider where this is recorded/reported. This could be expanded to include all audit elements of the pathway which would give further assurance.
Q 26	Do women with complex pregnancies receive early intervention?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	**Not Met**	**Met**	See Q25
Q 27	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Leads for SBLCBv2		Discuss referral pathway	**Met**	**Met**	Pathways in place and audits in progress.
				Review audit programme Review audit results of compliance and action plans			

Q 28	Do all women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	**Met**	**Met**	Referral pathway clearly articulated, Embedded audit – the trust should consider where this is recorded/reported. This could be expanded to include all audit elements of the pathway which would give further assurance.
Q 29	Do you have agreed maternal medicine specialist centre?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	**Not Met**	**Met**	Plans are in progress within the LMS to fully implement the maternal medicine service. Further work with the LMNS to identify and define how they will work within this pathway is required to give an oversight or how assurance will be gained.
Safety Action 5 Risk assessment throughout pregnancy							
Q 30	Does the AN RA include the ongoing review of place of birth?	Triumvirate		Discuss pathway for out of guidance births Review ratified SOP/Guideline	**Met**	**Met**	This was articulated well as was the pathway for birth choices. Embedded audit – the trust should consider where this is recorded/reported. This could be expanded to include all audit elements of the pathway which would give further assurance.
Q 31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Triumvirate		Discuss pathway for out of guidance births	**Met**	**Met**	See Q30
				Review ratified SOP/Guideline			

				Audit timetable			
				Audit results and action plan			
Q 32	Are you compliant with all 5 elements of SBLCBv2?	Leads for SBLCBv2		Ratified SOP/Guidelines for all 5 elements	**Met**	**Met**	See Q27
				Audit results for all 5 elements (local and regional audit)			
				Review of impact on perinatal mortality Deep dive results			
Q 33	Is a RA review and discussion of place of birth recorded at every contact with a Personalised Care Support Plan	Triumvirate		Discuss pathway for PCSP Review ratified SOP/Guideline Audit timetable Audit results and action plan	**Met**	**Met**	PCSP in place and audit completed
Safety Action 6 Monitoring fetal wellbeing							
Q 34	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.	Lead Midwife and Lead Obstetrician		Rotas/duties	**Partially Met**	**Met**	
				Examples of roles Incident case reviews			Training includes K2, and face to face elements.
Q 35	Do the leads demonstrate sufficient seniority and expertise?	Lead Midwife and Lead Obstetrician	Job Description for both roles and confirmation		**Partially Met**	**Met**	See Q34

			that roles are in post				
Q 36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Leads for SBLCBv2		SOP's Audits for each element Guidelines with evidence for each pathway	**Met**	**Met**	See Q27
Q 37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	PDM		Training compliance	**Met**	**Met**	See Q17
Q 38	Element 4 we are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Lead Midwife and Lead Obstetrician		Lead midwife and obstetrician in place to lead best practice, learning and support Training sessions Reviews		**Met**	See Q34. The trust demonstrated how they had amended the audit tool based on findings from previous audit, this clearly showed understanding and implementation of quality improvement methodology.
Safety Action 7 Informed Consent							
Q 39	Do you have accessible information to enable informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery?	Triumvirate		Demonstration of the information service users can access for mode of birth in all formats Review CS information MVP review of information	**Partially Met**	**Met**	Website reviewed on day of visit, easy to navigate and has a 'read aloud' function and can be translated into different languages and also has a self-referral process. On the day of the visit the maternal choice for caesarean delivery leaflet was not published on the website. This was discussed and the trust were actioning this element.

Q 40	Do you have accessible information to enable accurate evidence based information including all care AN, Intrapartum & PN?	Triumvirate		Demonstration of the information service users can access for evidence based information in all formats	**Partially Met**	**Met**	See Q39
				Review information including all care AN, Intrapartum & PN			
				MVP review of information			
Q 41	Can women participate equally in all decision-making processes and make informed choices about their care?	Triumvirate		Ratified SOP for decision making process and informed choice Review of last CQC maternity survey and action plan Audit timetable	**Met**	**Partially Met**	Professional discussion explored the services understanding of informed choice and sharing of all evidence with women to enable them to make truly informed choices. The service were keen to consider and develop methods of gaining feedback around this element that reflected the lived experience perspective.
				Audit results and action plan			
Q 42	Are women's choices respected following informed discussion and decision made?	Triumvirate		Ratified SOP for decision making process and informed choice and how choices are	**Partially Met**	**Partially Met**	It was clear from discussion that this service is forward thinking in supporting women's choices and use language within guidance which is considered and respectful.

				respected Audit timetable Audit results and action plan			Audit of this needs to be strengthened so that the service can continue with this philosophy.
Q 43	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		How is user feedback obtained? Examples of co-production	**Met**	**Met**	See detail in Q13
Q 44	Are pathways of care clearly described in written information in formats consistent with NHS policy and posted on the trust website.	Triumvirate		Demonstration of the information service users can access for evidence based information in all formats MVP review of information If gaps identified action plan	**Partially Met**	**Met**	See Q39
Workforce Planning/Guidelines							
Q 45	Is the clinical workforce planning to the required standard?	Triumvirate	Review BR+ report how current and accurate is it? Trust Board minutes to fund Six monthly reviews LMNS/ICS workforce plans				Yes

Q 46	Is the midwifery workforce planning to the required standard?	Triumvirate	Review BR+ report how current and accurate is it? Trust Board minutes to fund				Birthrate plus has been completed. It would be helpful if the trust could demonstrate how they plan to meet the ask with the RCM leadership manifesto by sharing their action plan in respect to this.
	Can you describe the pathway for transitional care and how do you audit this?	Triumvirate		Transitional Care Guidelines and Pathways staffing model for transitional care evidence of incident reporting and management of incidents that cross maternity and neonatal care audits of infant outcomes on the transitional care pathways			Pathways in place which are audited quarterly.
Q 47	Is the HOM/DOM responsible/accountable to an executive director?	Triumvirate	Review the JD to ensure accountability is to an executive director Ask how this translates in practice				HoM, accountable to chief nurse.

Q 48	Is the maternity leadership in line with the RCM Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders	Triumvirate	Review the gap analysis				HoM and Deputy HoM in post. Consider further development of the midwifery leadership team. HoM attends board.
			If gaps identified action plan to address				
Q 49	Where non-evidenced based guidelines are utilised, is there a robust assessment process before implementation and ensures that the decision is clinically justified.	Triumvirate	Review ratified SOP Identify if national guidance not followed Evidence of risk assessments if national guidance not followed How many guidelines are out of date				Clear process in place for reviewing and updating guidelines.

NEY Regional Perinatal Quality Oversight Group	System Rating: R/A/G	Reporting Period	Highlight Report
	On Track	Q1 Apr - Jun 22	

South Yorkshire and Bassetlaw
Local Maternity System
Transforming your maternity services together

KPI	Subcategory	Target	Sheffield	Rotherham	Barnsley	Doncaster	Bassetlaw	DBTH Combined	SYB Average: Unweighted
Caesarean Section Rate	Elective	<13%		15.31%					
	Emergency	<17%		16.52%					
Preterm Birth Rate	<26+6 Weeks	<6%		0.34%					
	≤36+6 Weeks	*Annual Rolling Rate*		1.33%					
Massive Obstetric Haemorrhage	≥1.5 Litres	<2.9%		3.44%					
Term Admissions to NICU		<6%		4.94%					
3/4 Degree Tears	SVD / Unassisted	<3.5%		0.86%					
	Instrumental / Assisted	*Overall Rate*		0.68%					
Right Place of Birth		>95%		0.00%					
Smoking at Delivery		<6%		13.10%					
Overall Women on CoC Pathway		>35%		38.73%					
BAME/Deprived on CoC Pathway	BAME	>75%		18.90%					
	Area of Deprivation			35.50%					

Staffing Information	Sheffield	Rotherham	Barnsley	Doncaster	Bassetlaw
MW to Birth Ratio		1:22			
Midwife Vacancy Rate		0			
Labour Ward Co-Ordinator Supernumerary		98%			

Incident Reporting: Quarterly Data	Sheffield	Rotherham	Barnsley	DBTH
Unactioned Datix		9		
Datix Open <30 Days		59		
Maternity Serious Incidents		1	Difficult 28 week breach 14/4/22	
Maternity Never Events		0		
HSIB Cases		0		
Stillbirths: Total		2		
Stillbirths: Term		0		
Stillbirths: Intrapartum		0		
HIE Cases Grade 2 or 3		1	Above SI	
Neonatal Deaths: Early		1		
Neonatal Deaths: Late		0		

Notification to ENS		0		
Maternal Mortality: Direct		0		
Maternal Mortality: Indirect		0		

Ten Steps to Safety	Sheffield	Rotherham	Barnsley	DBTH
Perinatal Review Tool				
MSDS				
ATAIN				
Medical Workforce				
Midwifery Workforce				
Saving Babies Lives Care Bundle V2				
Patient Feedback				
Multi Professional Training				
Safety Champions			Year 3 CNST	
HSIB Early Notification Scheme				

Evidence of Saving Babies Lives Care Bundle Compliance	Sheffield	Rotherham	Barnsley	DBTH
Reducing Smoking		Yes		
Fetal Growth Restriction		Yes		
Reduced Fetal Movement		Yes		
Fetal Monitoring During Labour		Yes		
Reducing Pre Term Birth		Yes		

Audit Tools	Sheffield	Rotherham	Barnsley	DBTH
Audit of 2x Daily Consultant Led Labour Ward Rounds		Yes		
Audit of Named Lead Consultant for Complex Pregnancies		Yes		
Audit of Risk Assessment at each Antenatal Visit		Yes		
Lead CTG Midwife and Obstetrician in Place		Yes		
Exec and Non Exec Director for Perinatal Safety Identified		yes		
MDT Training: Prompt, CTG, Obs Emergencies (Target 90% of Staff)		yes		
Plan in place to meet Birth Rate Plus Standard (Include Target Date)		yes		
Accurate Data Flow to MSDS		Yes		
Maternity SI Shared with Trust Board		3	HSIB case, off pathway NND, LSCS for cephalic baby.	

Other Information	Sheffield	Rotherham	Barnsley	DBTH

Freedom to Speak Up / Whistle Blowing Themes		Nil		
Themes from Datix: Include Top 5 Reported Incident Categories		1. Neonatal readmissions due to jaundice / weight loss. 2. Unplanned term admissions to SCBU. 3. Staffing levels 4. Massive Obstetric Haemorrhage 5. Administration of assessment (SGA) (No longer reporting in Q2 onwards)		
Themes from Maternity Serious Incidents (SIs)		Preterm breech birth		
Themes from Perinatal Mortality Review Tool		Currently no immerging themes for this quarter.		
Themes / Main Areas for Complaints		Top Primary Subjects: 1. Midwifery Care 2. Information		
Listening to Women		MVPs now attend Governance meeting and Labour Ward forum to enable Rotherham to hear women's voices. .		

Evidence of Co-Production		Induction of labour leaflet co-production.		
Listening to Staff		Last Safety Champion walk around in July was undertaken in the Antenatal - staff were happy with moral and transformation plan in ANC. Discussed issues around interpreting service.		
Embedding Learning / Changes Made		New duty of candour electronic record now in use. RFM pathway reinforced. Documentation of triage calls. Increasing midwife to midwife handover for high risk social/safeguarding cases.		

Board of Directors' Meeting
09 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P145/22
Report	**Board Assurance Framework: Quarter 2**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The paper links with the entire Board Assurance Framework
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary	The Board Assurance Committees discussed the Quarter 2 position in relation to the Board Assurance Framework and their respective BAF risks during the meetings scheduled throughout Quarter 2. **People Committee:** Discussed and approved the position in relation to BAF Risk U4. **Finance and Performance Committee:** Discussed and approved the position in relation to BAF Risk D5 and D6. **Quality Committee:** Discussed and approved the position in relation to BAF Risk P1. BAF Risks R2 and OP3 will be discussed at the Board meeting on 9 September 2022. The Board will note the key changes to the Board Assurance Framework as follows:
Due Diligence	The Board Assurance Framework ongoing position for Quarter 2 has been discussed at the relevant Board Committees prior to further scrutiny at the Audit Committee in October 2022.
Board powers to make this decision	In accordance with the approved Matters Reserved to the Board, Internal Controls- the Board is required to ensure the maintenance of a sound system of internal control and risk management, including "*Approval of the Board Assurance Framework".*
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Director of Corporate Affairs continues to work with Executive colleagues in order to develop the revised Board Assurance Framework in order to strengthen the documented levels of assurance and mitigations in addition to the continued identification of any gaps in assurance.
Recommendations	The Board is requested to discuss and approve the position in relation to the Board Assurance Framework for Quarter 2 2022-23.

Appendices	Board Assurance Framework: Quarter 2

1. Introduction

1.1 The Strategic Risks contained within the Board Assurance Framework are allocated to the appropriate Board Assurance Committee and feature as standing agenda items. As such, each Committee has discussed the relevant Board Assurance Risks, the outcome of those discussion detailed within the following report.

2. Review of Strategic Risks

2.1 **P1:** ***There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience.***

2.1.1 The Chief Nurse and the Medical Director are the joint Executive Leads for this risk. During Quarter 2. Following review and discussion at the Quality Committee in July and August 2022, the following additional controls and mitigations have been added:

- **C6 -** An additional control and assurance level has been added due to the commencement of partnership working between the Trust and Barnsley NHS Foundation Trust relating to peer reviews. The first peer review has been completed within Surgery and the next one will be carried out in September within the Medicine Division. Outputs from the peer reviews will be reported through the CQC Delivery Group.
- **C7** – An additional control and assurance level has been added relating to the inclusion of a Quality Improvement and Quality Governance Assurance Priority within the Operational Plan.
- **C8** – The scoping exercise relating to the Serious Incident Investigation process has been completed and therefore moved into a control.

2.1.2 Additional gaps in controls were identified as a result of both the monthly Executive Director reviews and discussions at Quality Committee as follows:

- **G1** – Additional narrative has been added to the gap relating to our lack of quality improvement methodology with actions being identified to enact the approved partial Business Case.
- **G2** – Training has now commenced in relation to Quality Service Implementation and Redesign (QSIR) with Cohort 1 having completed their training. Cohort 2 will commence in October 2022 and the final Cohort in March 2023.
- **G5** – A new gap in control and assurance has been identified relating to lack of oversight of education and training for nurses, midwives, allied health professionals and non-registered workforce. Plans are in place to mitigate by end September 2022. An additional action was added in August to recruit, on a temporary basis additional Clinical Education posts from the existing CPD funding will support closing the gap around lack of oversight and training and education for nurses and midwives.
- **G6** – A new gap (G6) has been added in relation to the lack of a central quality governance department, including actions to mitigate with an overall end date for completion of October 2022.
- **G7** – An additional gap in control was identified at the Quality Committee in July 2022 relating to lack of clarity around resuscitation mandatory training. The Committee requested a deep dive review which was discussed at the August Committee and remains a gap in control.

Review of the Risk Score: BAF Risk P1

2.1.3 The initial score agreed for Quarter 1 was a score of 16 whereby the consequence was graded as a 4 (Major), defined in accordance with the 2008 Risk Matrix for Risk Managers as 'noncompliance with national standards with significant risk to patients if unresolved, low performance rating, critical report'. It is proposed the consequence score remains the same at 4 (Major).

2.1.4 The initial likelihood score agreed for Quarter 1 was 4 (Likely) defined in accordance with the aforementioned matrix as 'will probably happen/recur but is not a persisting issue. It is proposed that likelihood score remains the same at 4 (Likely).

2.1.5 Taking the above into consideration, it is recommended the risk score remains at **16.**

2.2 **R2:** ***There is a risk that we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities.***

2.2.1 The current score for this risk is **12** and it is recommended that remains unchanged for Quarter 2.

2.3 **OP3:** ***There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.***

2.3.1 The current score for this risk is **12** and it is recommended that remains unchanged for Quarter 2.

2.4 **U4:** ***There is a risk we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.***

2.4.1 The Director of Workforce is the Executive Director lead for the current BAF Risk U4. As part of the review process, the Director of Corporate Affairs and the Quality, Compliance and Risk Manager met with the Director of Workforce in early July 2022. Subsequently, the People Committee met in July and approved the following:

- The initial gap in control (G1) relating to the completion of the funding application for NHS Charities Together for psychological support has been completed and there has been moved to a control and mitigation level (C8).

2.4.2 The following additional controls and mitigations have been added to the risk as follows:

- C7 – An amendment from 'ESR' to E-roster has been made in the descriptor and the outcome of the Internal Audit Report has been added to the assurance level.
- C9 – Reciprocal Mentoring has been added as a control.
- C10 – The joint compassionate leadership session facilitated by Professor Michael West has been added.
- C11 – The Executive Team have recently approved funding for protected time for trade unions and this has been added as an additional control and mitigation.

Review of the Risk Score: BAF Risk U4

2.4.3 The BAF Risk U4 was initially graded with a consequence of 4, which in accordance with the aforementioned risk matrix relates to uncertain delivery of key objectives/service due to lack of staff, unsafe staffing levels or competence (>5 days), very low staff morale and no staff attending mandatory/key training. The likelihood was deemed to be a score of 3 which is 'possible, might happen or recur occasionally.'

2.4.4 Consideration has been given to the consequences of the Strategic Risk U4 which will be low morale, lack of staff retention and remains at a score of 4. Given the additional controls and mitigations in place, the likelihood of the risk materialising has been reduced to a score of 2 which is 'unlikely, do not expect it to happen/recur but it is possible it may do so. As such the risk score has been reduced from **12 to 8**.

2.4.5 The People Committee did not meet in August 2022 as the time was utilised as a development session.

2.5 **D5:** ***There is a risk we will not deliver safe and excellent performance because of insufficient resource (financial and human resource0 leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.***

2.5.1 The Director of Finance and the Chief Operating Officer are joint Executive leads for Strategic risk D5 who have discussed the risk on a monthly basis in addition to presentation at the Finance and Performance Committee.

2.5.2 Following review, the additional controls and mitigations have been added as follows:

- C1- Weekly performance reports are presented to the Executive Team Meeting which has recently seen a significant increase in the time patients are waiting within Urgent and Emergency Care in addition to increased waiting times for patients to see a clinician.
- Clarity has been provided to Control C3 in that weekly length of stay reviews take place and a new Discharge Group has been established chaired jointly by the Director of Operations and the Deputy Chief Nurse has been established
- An additional control had been added (C7) relating to the new weekly Acute Performance Meeting chaired by the Interim Chief Executive provides greater weekly oversight of performance.

2.5.3 Additional gaps in controls or assurance have been identified as follows:

- G4: Insufficient oversight of our waiting lists has been added as a gap. The identified mitigation is the establishment of a Patient Tracking List (PTL) Group in order to ensure the Trust maintains a robust targeted waiting list.
- G5: National guidance has not, as yet been received in relation to Urgent Care Metrics and as such, the Trust continues to operate as a Field Test Site.

Review of the Risk Score: BAF Risk D5

2.5.4 The initial score agreed for Quarter 1 was a score of 9 whereby the consequence was graded as a 3 (Moderate) defined, in accordance with the 2008 Risk Matrix for Risk Managers as 'late delivery of key objectives/service due to lack of staff, unsafe staffing levels or competence (>1day); low staff morale; poor staff attendance for mandatory/key training. It is proposed that the consequence remains at 3(Moderate).

2.5.5 The initial likelihood score of 3 (Possible) defined as 'might happen or recur occasionally was agreed during Quarter 1. In light of the increased waiting times within UECC and the gap relating to a robust PTL Group, the likelihood score has been increased to 4 (Likely) in that it will probably happen/recur, but it is not a persisting issue/circumstances.

2.5.5 As a result of the above reviews, the Finance and Performance Committee agreed to the revised risk score for Strategic Risk D5 from **9 to 12.**

2.6 **D6:** ***There is a risk that we will not be able to deliver our services because we have not delivered on our Financial Plans for 2022-23 in line with national and system requirements leading to financial instability and the need to seek additional support to deliver our services.***

2.6.1 The Director of Finance is the Executive Lead of Strategic Risk D6. The risk has been reviewed during July and August in addition to discussions held at the Finance and Performance Committee.

2.6.2 As a result of the aforementioned discussion, the following additional controls and mitigations have been added to the risk:

- C8 - A new control and assurance level has been added given that financial forecasts have been completed for Divisional and Corporate areas which will be monitored via the Finance Reports to Finance and Performance Committee.
- C9 - The Divisional Budgets have now been signed off and therefore this has moved from a gap in controls and assurance (G3) to a new control and assurance (C9).
- C10 - The final CIP plan has been signed off and therefore this has moved from a gap in controls and assurance (G2) to a new control and assurance level (C10)

2.6.3 The following new gap in control and assurance has been identified as follows:

a) G4 - A new gap has been identified and added linked to the Divisional and Corporate financial forecasts insofar as whilst they have been agreed, they have not, as yet come to fruition and will be monitored via the monthly check and challenge meetings with the relevant Divisional and Corporate areas.

Review of Risk Score: BAF Risk D6

2.3.4 The initial score agreed for Quarter 1 was a score of 9 with a consequence score of 3 (Moderate) and an initial likelihood score was 3 (Possible).

2.3.5 Taking the additional gaps in controls and assurance and given that additional monitoring of the progress against the agreed CIP programme and Divisional and Corporate budget monitoring is required it is recommended the risk score remains at **9**.

3. Recommendations

3.1 Taking the above into consideration, it is recommended that the Board:

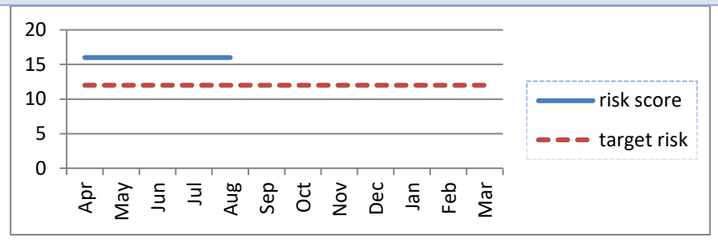
a) Discuss and agree the amendments to the current Board Assurance Framework and identify any additional items to add to the BAF as a result of the discussions and decisions at the Board meeting; and

b) Note the development of the BAF throughout Quarter 2.

Angela Wendzicha
Director of Corporate Affairs
September 2022

Board Assurance Framework Overview for Quarter 2

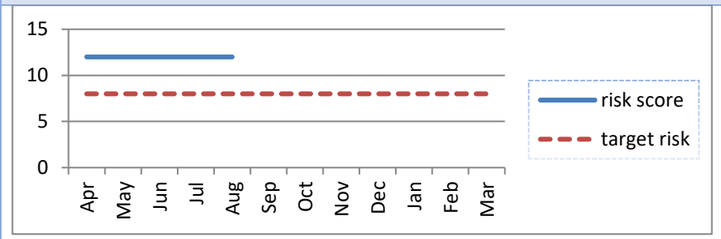
Ambition	Strategic Risk			Original Score LxC	Score Q1	Score Q2	Target Risk Score	Movement	Risk Appetite/ Risk Tolerance
	There is a Risk that….	Because…..	Leading to…..						
Patients: ***We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them.***	**P1: we will not embed quality care within the 5 year plan**	**..of lack of resource, capacity and capability**	**..poor clinical outcomes and patient experience**	4(L)x 4(C)=16	**16**	**16**	3(L)x4(C) =12	⇔	Moderate (12-15)
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**	3(L)x4(C)=12	**12**	**12**	2(L)x4(C) =8	⇔	Moderate (12-15)
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**	3(L)x4(C)=12	**12**	**12**	2(L)x4(C) =8	⇔	Moderate (12-15)
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 the lack of compassionate leadership**	**..an inability to recruit, retain and motivate staff.**	2(L)x4(C)=12	**12**	**8**	2(L)x4(C) =8	⇓	Moderate (12-15)
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 times and potential for patient deterioration and inability to deliver our Operational Plan.**	4 (L)x3(C) = 12	**9**	**12**	2(L)x2(C)=4	⇑	Low (6-10)
	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.**	3(L)x3(C) = 9	**9**	**9**	2(L)x2(C)=4	⇔	Low (6-10)

Strategic Theme: Patients	Risk Scores							
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**		**Board Assurance 2022-23**
Strategic Ambition: **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**	**4(L)x4(C)=16**	**16**	**3(L)x4(C) =12**	**Moderate (12-15)**		**Current**	**Q1** / **Q2**
Link to Operational Plan: ***P1: Empower out teams to deliver improvements in care***							**16**	**16** / **16**
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee & Lead Executive Director**
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.						**~~Risk 5485;~~ Risk 6614; Risk 6545; Risk 6623; Risk 5950; Risk 6075; Risk 6591; Risk 6668; ~~Risk 4897~~; Risk 6142; Risk 6638; Risk 5238; Risk 5761; Risk 6569.**		**Quality Committee Chief Nurse and Medical Director**

	Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***	**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*		
C1	CQC Delivery Group in place with oversight of 'must do and should do' actions from the 2021 CQC Report	Receipt of month assurance reports relating to progress against actions	**July 2022**	Deputy CEO	Level 1		
C2	Established Tendable Audit Programme	Outcome reports received by Quality Committee	**July 2022**	Chief Nurse	Level 1		
C3	Agreed Quality Priorities in place	Progress reports received by Quality Committee quarterly	**May 2022**	Chief Nurse	Level 1		
C4	Implementation of actions following Patient Surveys	Progress reports received by Patient Experience Committee and monitored via Quality Committee	**Aug 2022**		Level 1		
C5	Coordinated approach for learning from deaths	360 Assure Report with Limited Assurance	**July 2022**	Medical Director	Level 3 (negative)		
C6	Partnership working with Barnsley NHSFT	Quarterly peer reviews carried out re Quality Assurance (Q1 – Surgery)	**TBC**	Chief Nurse/Medical Director	Level 3 – Awaiting final outcome report		
C7	Quality Improvement & Quality Governance Assurance Priority within Operational Plan	Bi-monthly updates to Quality Committee		Chief Nurse			
C8	Serious Incident Investigation Scoping exercise completed.			Chief Nurse			

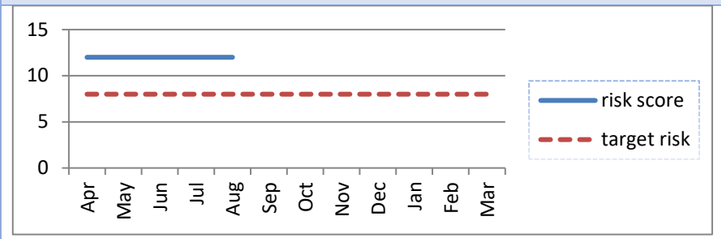
Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**	
G1	Lack of suitable Quality Improvement methodology linked to the Operational Plan	Complete business case for Quality Improvement Faculty	Chief Nurse	June 2022		Business Case Brief discussed at the Executive Team meeting June 2022 Partial Business Case approved at Executive Team Meeting June 2022for recruitment of Head of Quality Improvement and MD (2	
		Complete Job Descriptions for Head of Quality Improvement and MD for Quality Improvement (2 PA's)	Chief Nurse & Medical Director	July 2022	September 2022		

		Review next stage Business Case	Chief Nurse & Medical Director	August 2022	September 2022	PA's) for Quality Improvement – Job descriptions to be completed.	
G2	Lack of Quality Service Implementation and Redesign (QSIR)	QSIR methodology agreed	Chief Nurse & Medical Director	June 2022	June 2023	Cohort 1 completed the training. Cohort 2 to commence in October 2022 and Cohort 3 in March 2023	
G3	Embed strengthened Serious Incident Investigation Process	Complete review of the Serious Incident Investigation Process	Chief Nurse & Medical Director	June 2022	July 2022	Scoping exercise has been completed by external team supporting Quality Improvement work	
		Embed approved SI Process	Chief Nurse & Medical Director		October 2022		
G4	Lack of thematic reviews following Structured Judgement Reviews	Implement actions from 360 Assure Learning from Deaths report	Medical Director		July 2022		
G5	Lack of oversight of education and training for nurses, midwives, Allied Health Professionals and Non-registered workforce	Consultation to restructure existing teams	Deputy Chief Nurse	July 2022	September 2022		
		Establish nursing input in distribution of funds	Deputy Chief Nurse	July 2022	September 2022		
		Development of Trust wide Education Plan for Nurses, Midwives, Allied Health Professionals, and Non-Registered workforce linked to Training Needs Analysis	Deputy Chief Nurse	July 2022	September 2022		
		Additional Clinical Education posts from CPD funding on a temporary basis.	Deputy Chief Nurse	July 2022	November 2022	**Completed**	
G6	Lack of central Quality Governance Department	Task and Finish Group established to identify the structure required.	Chief Nurse	June 2022	August 2022		
		Review of reporting structure for Divisional Governance Leads	Chief Nurse	July 2022	September 2022		
		Recruit into key posts to support the central Governance Team	Chief Nurse	August 2022	October 2022		
G7	Lack of clarity on mandatory training compliance relating to resuscitation training	Quality Committee to receive a deep dive report at the next Committee in August 2022.	Medical Director	July 2022	October 2022	**On the August Committee Agenda**	

Strategic Theme: Patients	Risk Scores							
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23
Strategic Ambition: **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**	**3(L)x4(C)=12**	**12**	**2(L)x4(C) =8**	**Moderate (12-15)**		**Current**	**Q1** / **Q2**
Link to Operational Plan: ***R2: Ensure equal access to services***							**12**	**12** / **12**
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee**
R2: There is a risk that we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities						**Risk**		**Trust Board** **Deputy Chief Executive**

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*		
C1	Trust is a current member at PLACE Board	Trust Board receives reports from PLACE Board	May	Board minutes	Level 1		
C2	Trust is a member of Prevention and Health Inequalities Group		**July**		Level 1		
C3	Trust is a member of the Health and Wellbeing Board		**July**		Level 1		
C4	Deputy Chief Executive attends the Health Select Commission		**July**				
C5							
C6							
C7							

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**	
G1	Trust to be a member of the PLACE Committee of the ICB once established.		Deputy Chief Executive	TBC			
G2	Unknown entity around the ICB governance which is continuing to evolve and mature.		Deputy Chief Executive	TBC		Paper expected for the September Board	
G3	Incomplete data driven identification of Health Inequalities across elective and non-elective pathways.		Deputy Chief Executive		End Quarter 1		

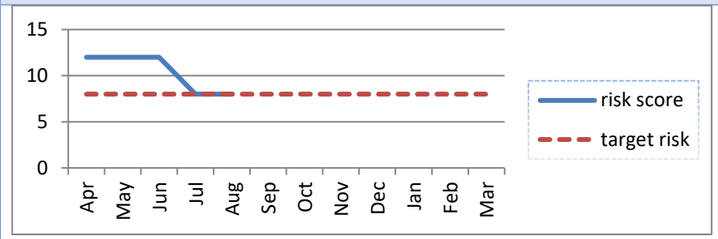
Strategic Theme: Patients	Risk Scores								
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23	
Strategic Ambition: **Our Partners: *We will be proud to collaborate with local organisations to build strong and resilient partnerships* that deliver exceptional, seamless patient care.**	O3	3(L)x4(C)=12	12	2(L)x4(C) =8	Moderate (12-15)		Current	Q1	Q2
Link to Operational Plan: ***P3: Our Partners: Work together to succeed for our communities.***							12	12	12
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee**	
O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.						**Risk**		**Audit Committee and Trust Board Interim Chief Executive & Deputy Chief Executive**	

	Controls and Mitigations *(what have we in place to assist in securing delivery of our ambition)*	Assurance Received *(what evidence have we received to support the control)*	Date Assurance Received	Confirmed By:	Assurance Level *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*		
C1	The Trust is a member of the South Yorkshire & Bassetlaw Acute Federation and Chaired by the Trust Chair	Monthly Reports received by the Trust Board			Level 1		
C2	Shared Chief Executive function between the Trust and Barnsley NHSFT		**01 September 2022 substantive**		Level 1		
C3	Existing collaboration with Barnsley on some clinical services				Level 1		
C4	Existing collaboration with Barnsley around Procurement function				Level 1		
C5							
C6							

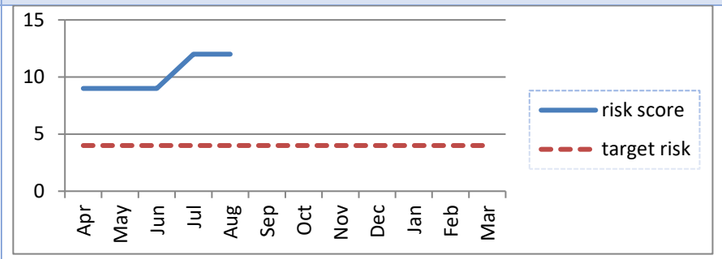
Gaps in Controls or Assurance Quarter 1 2022-23		Actions Required	Action Owner	Date Action Commenced	Date Action Due	Progress Update	
G1	ICB becomes a legal entity on 01 July 2022	Confirmation required of emerging governance arrangements	Deputy CEO		September 2022	Paper to September Board.	
G2							

Board Assurance Framework People Committee: Quarter 2

BAF Risk U4

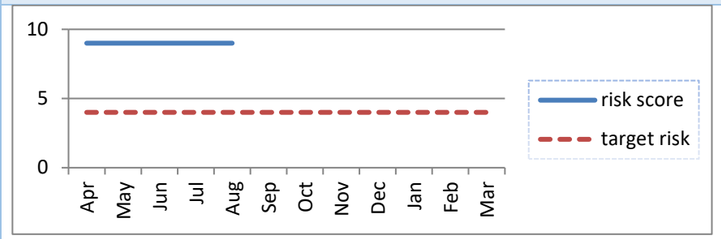
Strategic Theme: Us		Risk Scores								
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23	
Strategic Ambition: **Us:** ***We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.***		U4	3(L)x4(C)=12	2 (L) x 4(C) =8	2(L)x4(C) =8	Moderate (12-15)		Current	Q1	Q2
Link to Operational Plan: ***P4: Commit to a focus on workplace wellbeing and compassionate leadership***									12	8
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee**	
U4: There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.							**Risk 6723, 6668, 6638, 6474**		**People Committee Director of Workforce**	
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*			**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*			
C1	Board Approved People Strategy (2020)	Reports on progress against the People Strategy					Level 1			
C2	Operational Workforce Group in place meeting monthly to support Divisions	Divisional presentations to People Committee on rotation to provide assurance on staff engagement and workforce metrics					Level 1			
C3	Behavioural Framework in place within the Trust	Executive Directors weekly walk rounds					Level 1			
C4	Staff Survey Action Plans including: WDES, and WRES action plans	Progress against action plans monitored via Operational Workforce Group and People Committee					Level 1			
C5	Trust has in place staff Inclusion networks (BAME, LGBT ,Disability)	Various meetings take place on regular basis, reporting into Operational Workforce Group which in turn reports into People Committee			**July 2022**		Level 1			
C6	Establishment Control Panel for recruitment of staff.	Meets on a weekly basis and reports into the Operational Workforce Group					Level 1			
C7	Internal Audit Review of E-Roster	Report from 360 Assurance with Significant Assurance			**July 2022**		Level 3			
C8	Additional staff engagement sessions	Funding secured and sessions confirmed led by Head of Engagement reporting to the Operational Workforce Group			**July 2022**		Level 1			
C9	Reciprocal Mentoring Programme in place	Progress reports to People Committee					Level 1			

C10	Compassionate Leadership Joint session with Barnsley FT led by Professor Michael West.	Report to People Committee in July 2022	**July 2022**		Level 1			
C11	Executive Team approved funding for protected time for Trade Unions				Level 1			
Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**		**Date Action Due**	**Progress Update**	
G1	Additional staff engagement sessions	Funding application for NHS Charities Together for psychological support	Head of Engagement	June 2022		July 2022	Action completed and moved to an Assurance Level in July 2022	
G2	Leadership Programme in place	Identify suitable leadership development programme provider.	Deputy Chief Executive	TBC		TBC	Awaiting final sign off by Deputy CEO.	

Strategic Theme: Delivery		Risk Scores							
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23
Strategic Ambition: ***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**	**3 (L)x3(C)=9**	**4 (L)x3=12**	**2x2=4**	**Low (6-10)**		**Current** **12**	**Q1** **9**	**Q2** **12**
Link to Operational Plan: ***D5: Implement sustainable change to deliver high quality, timely and affordable care***									
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee & Lead Executive Director**
D5: There is a risk we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.							**~~Risk 4897~~; ~~Risk 6469~~; Risk 5761 and Risk 6569**		**Finance and Performance Committee** **Director of Finance & Chief Operating Officer**
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*		**Date Assurance Received**	**Confirmed By:**		**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*		
C1	Monitoring waiting times of patients in UECC	Metric included in the Integrated Performance Report Weekly report to ETM		**August 2022**	**Minutes of F&P**		Level 1		
C2	Divisional Performance meetings chaired by the Deputy CEO.	Monthly reports within IPR to Finance and Performance Committee and Board Divisional Performance meetings with each CSU		**July 2022**	**Chair's Log**		Level 1		
C3	Monitoring right to reside and Length of Stay data	Monthly reports to Finance and Performance Committee and Board Weekly Length of Stay reviews Discharge Group chaired by Director of Operations & Deputy Chief Nurse		**August 2022**	**Minutes of F&P**		Level 1		
C4	Dental and medical workforce vacancy panel chaired by the Medical Director	Additional sessions for dental and medical workforce Additional sessions to address where there is greater need Report through to People Committee		**July 2022**	**Notes of the panel**		Level 1		
C5	Admission avoidance work remains ongoing	Urgent and Community transformation group co-chaired with local authority		**July 2022**			Level 1		
C6	Executive Team oversight	Weekly receipt of Performance Report and Recovery Report		**August 2022**	**ETM minutes**		**Level 1**		
C7	New weekly Acute Performance Meeting chaired by CEO	Weekly oversight		**August 2022**			**Level 1**		

C8	Delays on patient discharge increasing length of stay in hospital and therefore the number of patients with no right to reside due to delays by external partners	Escalation meetings with external partners. Oversight through the new Rotherham Place Urgent and Emergency Care Group (Previously the A&E Delivery Board)	**COO**	**Ongoing**			

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**	
G1	Insufficient acute inpatient beds	Finalise Business Cases and service model for SDEC and AGU	COO	Q1	Q2	No need for business case for AGU; Implementation Plan required for the service model	
G2	National programme around Right to Reside under review	Receipt of National Guidance	COO				
G3	Ring-fence interim frailty assessment beds	ICS SDEC pathways confirmed.	COO			Frailty model and delivery plan required	
G4	Insufficient oversight of waiting lists	Establish PTL Group to develop robust patient targeted list	COO & Director of Operations	Q2	End Q2		
G5	Absence of movement nationally to urgent care metrics	Trust continuing to operate as a Field Test site.	COO	Ongoing	TBC nationally		
	.						

Strategic Theme: Delivery	Risk Scores							
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23
Strategic Ambition: ***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***	**D6**	**3x3=9**	**3x3=9**	**2x2=4**	**Low (6-10)**		**Current**	**Q1** / **Q2**
Link to Operational Plan: ***D5: Implement sustainable change to deliver high quality, timely and affordable care***							**9**	**9** / **9**
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee & Lead Executive Director**
There is a risk we will not be able to deliver our services because we have not delivered on our Financial Plans for 2022-23 in line with national and system requirements						**No Risks on the Risk Register graded 15 and above linked with D6 BAF Risk**		**Finance and Performance Committee: Steve Hackett, Director of Finance**

	Controls and Mitigations *(what have we in place to assist in securing delivery of our ambition)*	Assurance Received *(what evidence have we received to support the control)*	Date Assurance Received	Confirmed By:	Assurance Level *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*		
C1	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	**August 2022**	**Minutes of F&P**	Level 1		
C2	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group	**July 2022**		Level 1		
		Monthly Finance Report to CEO Delivery Group	**July 2022**	**Minutes**	Level 1		
		South Yorkshire Financial Plan Delivery Group			Level 1		
C3	Suitably qualified Finance Team in place	Team in place	**N/A**	**N/A**	Level 1		
C4	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board	**June 2022**	**Board of Directors minute**			
C5	Current Standing Financial Instructions in place	Reviewed and approved by Board	November 2021	**Board of Directors minute**	Level 1		
C6	Internal Audit Reports	Internal Audit Financial Reports	**July 2022**	**Report**	Level 3		
C7	Monthly challenge on performance	Monthly Divisional Assurance meetings	**July 2022**	**Chair's Log to F&P**			
C8	Clarity on Financial Forecast	Financial forecasts completed for Divisional and Corporate areas monitored within Finance Report	**August 2022**	**Minutes of F&P**	**Level 1**		
C9	Divisional Budgets signed off	Monitoring via Finance Reports	**July 2022**	**Reports to F&P**	**Level 1**		Moved from Gap 2 in July 2022
C10	Final CIP Plan signed off	Monitoring via monthly reports	**July 2022**	**Reports to F&P**	**Level 1**		Moved from Gap 3 in July 2022

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**		**Date Action Commenced**	**Date Action Due**	**Progress Update**	
G1	Lack of final sign off for submitted financial plan	Budget sign off required at System level	Director of Finance		Revised financial plan approved at Board in June 2022	June 2022	Signed off and complete	
G2	~~Final CIP required~~	~~Internal CIP requires final sign off~~	~~Director of Finance~~		~~Included within approved financial plan~~	~~June 2022~~	~~Signed off and complete~~ Moved to control C10 July 2022	
G3	~~Divisional Budget sign off~~	~~Complete Divisional Budget sign off~~	~~Director of Finance~~		~~Director of Finance planning to sign off 24/06/2022~~	~~June 2022~~	~~SH awaiting last two budgets~~ Moved to control C9 July 2022.	
G4	Financial forecasts come to fruition	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance		July 2022	March 2023		

Board of Directors' Meeting
9th September 2022

The Rotherham NHS Foundation Trust

Agenda item	P146/22
Report	**Health Education England Provider Self Assessment - 2022**
Executive Lead	Dr Callum Gardner, Medical Director
Link with the BAF	P1; U4
How does this paper support Trust Values	This report demonstrates how we meet our Education Contract standards from Health Education England (HEE) and describes our values, whilst meeting our strategic ambition of working with our Partners and delivering top rate education and training.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The annual HEE Provider Self-Assessment - 2022 is due for submission at the end of September. The final submission is via an online portal; however, HEE have provided a word template to allow for Board sign off. The attached HEE Provider Self-Assessment – 2022 has been collated by Medical Education with support from other areas. However, we did not receive information for all learner groups within the timeframe. The Trust have regular Monitoring the Learning Environment meetings with HEE, so there are no unexpected answers within the report.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Presented at Executive Team Meeting on the 18th August 2022.
Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	Action required is Board sign off to support online submission of the HEE Provider Self-Assessment – 2022 to Health Education England by the 30th September 2022. The Trust's Medical Education Manager will complete the final online submission.
Recommendations	It is recommended that the self-assessment submission report is supported and approved by the Board.
Appendices	1. HEE Provider Self Assessment – 2022

HEE Provider Self-Assessment - 2022

HEE Self-Assessment Tool

HEE Self-Assessment - Introduction
The HEE Self-Assessment (SA) is a process by which providers carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions for providers to provide comments to support their answer, this is optional and not mandatory.

Completing the SA
Some questions within the SA will ask you to provide some further information based on your responses.

Where standards have not been met: In these instances you will be asked to provide some information detailing why the standard has not been met and any work that is underway to ensure it will be met in future.

Where standards have been met: Where you have met the standards, some questions may give you the opportunity to add comments to support your answer.

Responses by Professional Group: In some questions we have asked you to provide a response per professional group. Throughout the SA we have arranged these groups by their regulators. For example, some questions will ask for you to respond for GMC or NMC associated learners or educators.

Further Questions
If you have any queries regarding the completion of the HEE SA, please review the FAQ document. If you still require further information, you can contact your regional HEE Quality Team.

1. Region Selection

Please select your region from the list below:
Health Education Yorkshire and North East

Please select your provider from the list below:
The Rotherham NHS Foundation Trust

2. Please provide details of 3 challenges within education and training that you would like to share with HEE.
(100 word limit on each response)

Example 1	Staffing gaps at all levels and specialties.
Example 2	Release of staff for teaching and training due to work load pressures. Release of educational funding to the correct areas.
Example 3	Increasing demand in clinical areas for student placements across a number of disciplines; the workplaces are becoming saturated.

3. Please provide details of 3 areas of good practice within education and training that you would like to share with HEE.
(100 word limit on each response)

Example 1	Excellent feedback from the Training Tariff Meeting held with the Medical School.
Example 2	We also offer the successful Compass programme which is unique to Rotherham.
Example 3	Development of a multi professional ACP workforce in line with the 2017 HEE multi professional ACP framework.

4. Please tick the box below to confirm that your Self-Assessment response has been signed off at board level before submission back to HEE.

☐ By selecting this box I confirm that the responses in this SA have been signed off at board level

5. Please confirm the date that board level sign off was received:

DD/MM/YYYY

Section 2 - Contracting

6. Do you have board level engagement for education and training?

x Yes
☐ No

If yes, please provide their name and job title; if no, please provide further detail.

Callum Gardner – Medical Director

Helen Dobson – Chief Nurse

Steven Ned – Director of Workforce & Organisational Development

7. Can the provider confirm that the funding provided via the education contract to support and deliver education and training is used for explicitly this purpose?

x Yes
☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Funds received via the LDA are disseminated to support learners across the professions.
No - Please provide further detail	

8. Is an activity in the Education Contract being delivered through a third party provider?

☐ Yes
x No

If yes, please detail who with:

9. Has the provider reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor?

☐ Yes
☐ No
x N/A

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

10. Is the provider able to give assurance that they are compliant with all HEE education and training data requests?

x Yes
☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer

No - Please provide further detail

11. Have there been any health and safety breaches that involve a trainee or learner?

☐ Yes

x No

If yes, please provide detail:

12. Does the provider engage with the ICS for system learning?

☐ Yes

x No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer

No - Please provide further detail

Section 3a - Quality

13. Is the provider aware of the requirements and process for a HEE Quality Intervention, including who is required to attend and how to escalate issues with HEE?

x Yes
☐ No

If no, please provide detail:

14. Have any conditions been imposed on the provider from regulators?

	Yes	No	N/A
GDC	☐	x	☐
GMC	☐	x	☐
GPhC	☐	x	☐
HCPC	☐	x	☐
NMC	☐	x	☐
GOsC	☐	x	☐
Any other learner groups (please define in notes)	x		☐

If yes, please provide further detail:

Outstanding condition from HEE regarding staffing levels on medical wards.

15. Has the provider actively promoted the National Education and Training survey (NETS) to learners?

x Yes
☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to

Information emailed to learners.

support your answer	
No - Please provide further detail	

16. Has the provider reviewed and where appropriate taken action on the basis of the results of the National Education and Training Survey (NETS)

x Yes

☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Associate Medical Director – Medical Education reviews all the data received from HEE for his relevant learners. Feedback given to departments and action plans formulated.
No - Please provide further detail	

17. Does the provider have a Freedom to Speak Up Guardian and do they actively promote the process for raising concerns through them to your learners?

x Yes

☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Mentioned in induction. Posters around the Trust. Information on screensavers.
No - Please provide further detail	

18. Does the provider have a Guardian of Safe Working, and do they actively promote the process for raising concerns through them to their learners?

x Yes

☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Attends Junior Doctor Forum. Is available for trainees to meet with.
No - Please provide further detail	

19. Please confirm whether you have an Equality, Diversity and Inclusion Lead (or equivalent):

x Yes

☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	The Trust employs a Head of Equality, Diversity and Inclusion, and a small EDI team.
No - Please provide further detail	

20. Please confirm that the provider liaises with their Equality, Diversity and Inclusion Lead (or equivalent) to:

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	☐	x
Implement reasonable adjustments for disabled learners?	x	☐
Ensure policies and procedures do not negatively impact learners who may share protected characteristics?	x	☐
Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	☐	x
Ensure International Medical Graduates (IMGs) receive a specific induction in your organisation?	x	☐
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	x	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Where the organisation is aware that a learner has a disability and may require reasonable adjustments, advice is available from the EDI team if required. All Trust policies undergo Equality Impact Assessment. The Trust's Violence Reduction and Prevention Policy sets out the organisation's zero-tolerance approach to discriminatory behaviour by patients. The Head of Security and Head of EDI work closely together to raise awareness of this policy with learners and others, and to support its implementation.
No - Please provide further detail	Reporting mechanisms and analysis of outcome data – at present, reporting mechanisms and data collections, such as WRES, WDES etc are not structured to take learners into account, although those learners employed by the Trust are included. For doctors in training employed by the Trust, information on protected characteristics is often not available, due to this data not transferring across from HEE. This has been raised with HEE. The Trust's Medical Workforce team are (with support from the Head of EDI) currently conducting a gap analysis of the Trust's current induction arrangements for IMGs, in line with the "welcoming and valuing" national guidance. This will be used to inform improvement work.

21. Patient Safety and the promotion of a Patient Safety culture is integral to the HEE Quality Framework. Can you confirm as a provider that you have the following:

	Yes	No
A named Board representative for Patient Safety	☐	x
A named Patient Safety Specialist/s	x	☐
A process to ensure that all staff are made aware of and can access the NHS Patient Safety Syllabus Level 1 training on the e-Learning for Healthcare platform	x	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	NHS Patient Safety Syllabus Level 1 is on ESR. Current compliance 66% June 2022
No - Please provide further detail	Board representation currently, this is being reviewed.

22. Has the provider developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services?

x Yes

☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support	The LKS submitted a QIOF return in 2021. We scored well with scores of 3 for four outcomes (1,2,4 and 5) and scores of 2 for two outcomes (3 and 6). As part of this we have developed a service improvement action plan which we are in the process of implementing.

your answer	
No - Please provide further detail	

23. Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by HEE?

x Yes

☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	We promote BMJ Best Practice on the Library and Knowledge Service (LKS) website and have a pre-authenticated link on the Trust intranet. It is included in the LKS section of the corporate induction handbook. We also include it in our library welcome email to new members and in library inductions and training sessions including those to foundation doctors, medical students, physician associate and midwifery students. In addition, BMJ Best Practice is available through the NHS Knowledge and Library Hub which has been widely promoted by the LKS and is available on the desktop of all TRFT laptops and PCs.
No - Please provide further detail	

Section 3b - HEE Quality Framework Domain 1 - Learning environment and culture

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

24. The learning environment is one in which education and training is valued and championed.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Preceptorship is placed with an identified lead. Supervisor roles within Job Plans. Medical Director attends Junior Doctor Forum and Doctors in Training and Medical Student induction. HCPC staff are given protected time to allow them to focus on a productive learning environment. Advanced though education and training is something championed by the department. In theatres, they have a "Student of the Month" board where staff members can nominate a student who is going above and beyond. There is a mentor WhatsApp group, training boards and student/mentor boards. Podiatry put staff through the NMP course as well as other training.
No - Please provide further detail	

25. The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	X	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Major international recruitment drive within nursing in partnership with HEI. All staff are invited via PDR or other means and are supported in learning. Theatres are planning on training up a BAME lead, LGBTQ+ lead and Disability Lead from different specialties in theatre. There is a large MDT which includes students and staff from many different backgrounds and professional groups.
No - Please provide further detail	

26. The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Trust EDI team work across all staffing groups including learners. A supportive culture is provided by the Trust and departments. Further learning is respected and Core Values of the Trust are followed. Team work is at the heart of that we do. Some departments have posters in their coffee rooms regarding "Psychological safety at work".
No - Please provide further detail	

27. There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	All Trust Grade doctors and ACPs are offered the use of Practitioner's ePortfolio. Feedback is given through teaching sessions and training programmes. Regular performance development reviews take place between staff, students and colleagues. This takes place annually with the main PDR, but also more frequently when additional learning is taking place. Departments have regular audit sessions, where constructive feedback is given. Clinical Educators in place for staff to give CPD and training opportunities. Staff can make suggestions. Comment on PARE from an ODP student, "I received feedback regularly from those I worked with, Both positive and things I could help me improve during my placement."
No - Please provide further detail	

28. Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Trust uses Friend and Family Test for feedback. There is a Patient Experience Team. Services receive good feedback from students and HEIs. A number of students return for a Permanent post. All learners are aware of the importance of the delivery of safe, compassionate and effective care. Teams have regular staff meetings to ensure that Trust visions and objectives are shared. Feedback is given on how to maintain and provide this patient care, based on experiences where Issues may have been encountered. Section leads are involved in a CSU wide quality clinical governance meeting and learning from that is disseminated to the teams. Teams prioritise patient safety by implanting team briefs before patients come down to theatre And the WHO surgical checklist, amongst many other pre and perioperative checks that get carried out. PARE comment from ODP student: "I cannot recall anytime where I felt patient care was lacking in this placement."
No - Please provide further detail	

29. The environment is one that ensures the safety of all staff, including learners on placement.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	All staff and learners receive an induction. All policies are available on the internal HUB. Safety concerns from learners are picked up through PARE, NETS and GMC survey. Clinical Educators have regular check ins with students in order to give them time to reflect or Report anything they feel they need to. Staff are encouraged and know how to file an incident report if needs be. Regular training and checks of MaST/job specific compliance in order to protect staff. Radiology provide a mentoring system to allow those in learning to have someone to be able to call upon and discuss any issues with during the learning. This provides them with a safety net of an individual(s) who are aware of their objectives and will assist them when required. The mentor keeps an overview of the learner, providing them with reassurance.
No - Please provide further detail	

30. All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Identified lead for learners. Freedom to Speak up Guardian and support staff. Datix incident reporting is encouraged. Pastoral support from Medical Education. Engagement with divisional senior management is encouraged.
No - Please	

provide
further
detail

31. The environment is sensitive to both the diversity of learners and the population the organisation serves.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	LINK Lecturers from Sheffield Hallam University. Learning Disability Matron. BAME and LGBTQ+ networks within the Trust. Learners will different issues are provided with specific support. Action plans are set out for students who may need them.
No - Please provide further detail	

32. There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Learners are invited to join Clinical Effectiveness Audit meetings. Learners are encouraged to engage in audits, discuss any QI ideas they may have and departments are willing to assist with any research projects that the learner maybe involved with.
No - Please provide further detail	Due to the length of placements, not all learners are able to participate fully in QI projects.

33. There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Friends and Family Test with the Trust. Learners are always asked to reflect. Action plans can be put in place to support a structured set of goals. Regular audit, presentation and discrepancy meeting are held which are forums for discussion and presentation of positive and negative experiences which may have been had.
No - Please provide further detail	

34. The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail for each facility:

Yes – Optional comments to support your answer	All staff and learners have 24 hour access to the Library & Knowledge Service. This is a location where learners can access such facilities as private learning booths, IT/internet access and educational learning materials. Departments have specific resources available such as drug flash cards, AfPP standards and recommendation books.
No - Please provide further detail	

35. The learning environment promotes multi-professional learning opportunities.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Multi-professional simulation is provided within the Medical Education Centre Including INCASE and CRUMPET. Some learners have specific modules from their HEI about interprofessional working. Most learners will work with a wide variety of staff every day and gain that collaborative working experience. Staff from all groups are willing to engage and support learning opportunities.
No - Please provide further detail	

36. The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Medical Students has access to book on PIE sessions online. Encouraged with Preceptorship. The 24/7 availability of the library learning resources allow any learners to gain access and take control of their own learning. Where possible, placements can be tailored round the individual student needs/interest.
No - Please provide further detail	

Section 3c - HEE Quality Framework Domain 2 - Educational governance and commitment to quality

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

37. There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Learners are supported by the Medical Director, Associate Medical Director – Medical Education, Director of Undergraduate Medical Education, Chief Nurse and Deputy Chief Nurse – Workforce, Development and Education. Those on a learning journey do so with awareness of the relevant area/section Leads. They can Consult the professional lead if required, so they have an overview of the learning which is occurring.
No - Please provide further detail	

38. There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Supported by the Trust's EDI team.
No - Please provide further detail	

39. The governance arrangements promote fairness in education and training and challenge discrimination.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Learners are monitored. International nurses are supported by the Education and Development Team. IMGs are supported by supervisors and Medical Education Team. Availability and access to education and training is available to all. Access to educational funding is often requested via HEE funding to allow progressive education for all staff.

No - Please provide further detail	

40. Education and training issues are fed into, considered and represented at the most senior level of decision making.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Learners are supported by the Medical Director, Associate Medical Director – Medical Education, Director of Undergraduate Medical Education, Chief Nurse and Deputy Chief Nurse – Workforce, Development and Education at various trust meetings. Via the mentoring system, feedback from learners to mentors can be passed on to the section lead For that area, which can be escalated if needs be. The Trust also have access to HEI colleagues to promote discussion.
No - Please provide further detail	

41. The provider can demonstrate how educational resources (including financial) are allocated and used.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	PAs are allocated to doctors to support medical education, both postgraduate and undergraduate. Funding used to support clinical skills and simulation. Staff supported to complete DPS courses such as NMP. In some areas, learners often have scheduled protected time with their mentor.
No - Please provide further detail	

42. Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support	Feedback collected after teaching sessions. Plans to create a destination survey for nursing learners. The Trust has a continuous MaST programme in place, New educational and training opportunities are embraced by the Trust and divisions. Audits are also performed against activity to allow validation of CPD.

your answer

No - Please provide further detail

43. There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GoC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer: Work closely with the relevant HEI and local colleges.
This includes support which includes time, resources and staff input.

No - Please provide further detail

44. Consideration is given to the potential impact on education and training of services changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including HEE and Education Providers).

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	The impact on doctors in training was considered during the service re-design during COVID. Any changes to the provision of service which would impact training and educational time are part of any evaluation into change which would take place. This evaluation would include a range of stakeholders.
No - Please provide further detail	

Section 3d - HEE Quality Framework Domain 3 - Developing and supporting learners

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

45. There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Extra pastoral support is provided. Additional skills sessions or study days can be supported. If possible, the service will offer flexibility in the timing of placements and extra clinical time if required. The Trust provide resources to aid with parity of access to learning. An example is, the use of adjusted input technologies such as voice recognition software.
No - Please provide further detail	

46. The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Extra pastoral support is provided. Additional skills sessions or study days can be supported.
No - Please provide further detail	

47. Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	All Medical Students and Doctors in Training have Named Clinical Supervisors within their department. Practice Supervisors are there to support nursing learners. HCPC students have a Named Clinical Facilitator or Mentor. Regular meetings are held to enable any learning needs to be identified.
No - Please provide further detail	

48. Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Increasing numbers of Professional Nurse Associates to support nursing learners. All Medical Students have Named Clinical Supervisors within their department. Doctors in Training have Named Clinical Supervisors within

	their department and a Named Educational Supervisor. Mentors are experience members of staff who take on board the role aiding the learner.
No - Please provide further detail	

49. Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Doctors in Training have Named Clinical Supervisors within their department and a Named Educational Supervisor. Nursing learners have support from the Practice Learning Facilitator and Placement Expansion Facilitator. Other areas have Mentors or Clinical Educators.
No - Please provide further detail	

50. Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Supported to meet the appropriate curriculum. ePortfolio support is provided for Doctors in Training and Supervisors. Clinical Education Team can support with additional clinical skills and sign offs. Some learners have a logbook from their HEIs to complete. Protected time when required to ensure that the learner has this. Protector time with a Mentor can also be arranged. All learners are supported to ensure that they are able to achieve objective and meet outcomes.
No - Please provide further detail	

51. Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Learners are supported and built in to the make up of the teams. Learners are invited to staff meetings and provided with as much hands on experience As possible.
No - Please provide further detail	

52. Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Doctors in Training and Medical Students received an induction when they start in Post. Some of them are virtual and some are face to face. Employed learners will attend a corporate induction as well as a local induction. They will also have to be MaSt compliant.
No - Please provide further detail	

53. Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Introduced via Induction and supervisor/mentor etc Learners through training and experience will be aware of the role they play, in the pathway of workflows they are involved in.
No - Please provide further detail	

54. Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Doctors in Training are asked to supervise Medical Students and their more junior colleagues. F2 trainees attend a Teach the Teacher courses. Some learners are provided with the experience in appropriate situations to supervise junior staff. This include opportunities to participate on management and leadership courses such as the LEAD course held inhouse. They will always have their mentor or a senior member of staff to relate and liaise with if required.
No - Please provide further detail	

Section 3e - HEE Quality Framework Domain 4 - Developing and supporting supervisors

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

55. Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	X	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	X
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Named Educational and Clinical Supervisors have PAs within their job plan. In other areas, when the requirement for a formal supervisor is required, the appropriate individuals must confirm they have space in their job plan and the willingness to fulfil the post. Such supportive roles and encouraged and supported where possible.
No - Please provide further detail	

56. Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, HEE).

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Individuals in these roles are appropriate qualified and trained. Must be suitable experienced to Fulfil the role. All Named Educational and Clinical Supervisors must complete the HEE Educational Supervisor course. Professional Nurse Associates will have completed Level 7 of their training. Clinical Placement Facilitators attend annual facilitator update sessions.
No - Please provide further detail	

57. Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	x
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Must have attended the HEE Educational Supervisor course. Must be aware of their relevant curriculums and ePortfolios. Clinical Placement Facilitators must attend HEI Facilitator training sessions. Information from relevant HEIs is shared with individuals to allow them to be completely aware of the expected requirements and scope.
No - Please provide further detail	

58. Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of leaners' programmes and career pathways, enhancing their ability to support learners' progression.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	x
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Must have attended the HEE Educational Supervisor course. Must be aware of their relevant curriculums and ePortfolios. Clinical Placement Facilitators must attend HEI Facilitator training sessions. Information from relevant HEIs is shared with individuals to allow them to be completely aware of the expected requirements and scope.
No - Please provide further detail	

59. Clinical supervisors are supported to understand the education, training and any other support needs of their learners.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	☐	☐	x
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Named Clinical Supervisors have PAs within their job plan. HEIs provide courses relevant to their supervisors.
No - Please provide further detail	

60. Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Educational roles are discussed in annual appraisal with the relevant paperwork. Feedback received from HEIs and HEE.
No - Please provide further detail	

Section 3f - HEE Quality Framework Domain 5 - Delivering programmes and curricula

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

61. Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Financial support is available to specialist areas to provide training to learners. Placements at the Trust will include a mixture of clinical time and educational time If required.
No - Please provide further detail	

62. Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Training programmes are reviewed at the end of placements or after survey results are received. Feedback received from HEIs and HEE.
No - Please provide further detail	

63. Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to	The Trust will engage with the education

support your answer	
No - Please provide further detail	

64. Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	☐	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Looking to increase the participation and availability of multi-professional simulation. Currently run an INCASE and CRUMPET course. Some teaching sessions are now run virtually.
No - Please provide further detail	

65. The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	☐	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Patients are invited in to support teaching sessions. They are also used as Knowledge Experts to deliver training.
No - Please provide further detail	

66. Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Teaching sessions are included in the Doctors in Training work schedules. Other learners are scheduled on via E-Roster. Some learners have a required number of clinical hours to complete.
No - Please provide further detail	

Section 3g - HEE Quality Framework Domain 6 - Developing a sustainable workforce

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

67. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Work with local HEIs and HEE. Attend Placement Partnership Meetings.
No - Please provide further detail	

68. Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues

	Yes	No	N/A
GDC Learners	x	☐	☐
GMC Learners	x	☐	☐
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Nursing Learners are supported by the Education and Development Team. Doctors in Training and Medical Students are supported by the Medical Education Team. Both teams can provide advice and also sign post. Mock interviews are provided with feedback.

No - Please provide further detail	

69. The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.

	Yes	No	N/A
GDC Learners	☐	☐	x
GMC Learners	☐	☐	x
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Placement Expansion Facilitator supports this function.
No - Please provide further detail	

70. Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.

	Yes	No	N/A
GDC Learners	☐	☐	x
GMC Learners	☐	☐	x
GPhC Learners	☐	☐	☐
HCPC Learners	x	☐	☐
NMC Learners	x	☐	☐
GOsC Learners	☐	☐	☐
Any other learner groups (please define in notes)	☐	☐	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Clear, defined career path for nursing learners from Domestic to Registered Nurse.
No - Please provide further detail	

Final Submission

Before completing your final submission please ensure you have completed the following:

1. Completed all questions within the Self-Assessment (including the free text sections)
2. You have confirmed that you have received Board level sign off for your submission (Section 1 - Provider)

Confirm Final Submission to HEE *

☐ Complete Submission

Board of Directors' Meeting
09 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P147/22
Report	**Corporate Governance Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with the full BAF
How does this paper support Trust Values	Supports all three Trust values.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The following report highlights a number of developments in the governance arena since the last Board of Directors' meeting: • New Secretary of State for Health & Social Care and Health Ministers appointed • COVID-19 Inquiry commences • CQC launch new regulatory approach • NHS Oversight Framework 2022-23 • Trust Annual Report and Accounts 2021-22
Due Diligence	This paper has not been received elsewhere prior to submission to the Board.
Board powers to make this decision	No decisions required by the Board.
Who, What and When	Any actions generated from further review of the publications will be led by the relevant Executive Director.
Recommendations	It is recommended that the Board note the content of the paper.
Appendices	None

1. Introduction

The following report provides an overview of some regulatory and statutory developments across healthcare.

2. New Ministerial Appointments to the Department of Health and Social Care

2.1 In July 2022 a number of new Ministerial appointments were made at the Department for Health and Social Care.

2.2 Mr Steve Barclay was appointed as the new Secretary of State for Health and Social Care. Mr Barclay was most recently the No 10 Chief of Staff and has also previously served as Secretary of State for Exiting the European Union (2018-2020), Chief Secretary to the Treasury (2020-21) and Minister for Health (in 2018) amongst other roles.

2.3 The following Ministers form part of Mr Barclay's team:

- Gillian Keegan MP, Minister of State for Care and Mental Health
- Maria Caulfield MP, Minister of State
- Maggie Throup MP, Minister for Vaccines and Public Health
- James Morris MP, Minister for Patient Safety and Primary Care
- Lord Kamall, Minister for Technology, Innovation and Life Sciences

3. National COVID-19 Inquiry Begins

3.1 On 21 July 2022 Baroness Hallett officially launched the UK COVID-19 Inquiry and outlined the inquiry's timetable detailing that preliminary hearings would start during 2022 and the first witnesses would be called in spring 2023. Three modules were announced by the Inquiry's chair with further modules to be announced next year.

3.2 Module 1 (launched on 21 July 2022) will examine the preparedness and resilience of the UK for the COVID-19 pandemic. Module 2 will focus on the political and administrative governance and decision-making of the UK government and of the devolved nations. Module 3 will look at the impact of COVID-19, the response of the government and society to it, and its impact on healthcare systems, including patients, hospital and other healthcare workers and staff.

3.3 The Trust has established a COVID-19 Task and Finish Group chaired by the Director of Corporate Affairs ensuring Trust readiness in the event we are called upon to provide evidence to the Inquiry.

4. Care Quality Commission Launches New Regulatory Approach

4.1 Following a year of consultation with key stakeholders, on 12 July 2022 the CQC launched its new single assessment framework covering all types of sectors, service types and levels. The expectation is that this is introduced in a phased way with the aim that from January 2023, the full roll-out of a new way of regulating will commence.

4.2 The framework will keep the rating and five key questions approach (safe, effective, caring, responsive and well-led) in addition to the four-point rating scale of outstanding, good, requires improvement and inadequate.

4.3 Under each key question are a set of quality statements describing what good looks like and link with the relevant Regulations. In addition, six categories of evidence (people's experience of health and care services, feedback from staff and leaders, feedback from partners, observation, processes and outcomes) have been developed to facilitate more structure and consistency in judgements made.

5. NHS Oversight Framework 2022-23

5.1 NHS England published the NHS Oversight Framework (the Framework) for 2022-23 on 27 June 2022. The aforementioned framework describes NHS England's approach to oversight of Integrated Care Boards and Trusts.

5.2 The framework is aligned with the ambitions set out in the NHS Long Term Plan, the 2022-23 NHS operational planning and contracting guidance in addition to reflecting the significant changes enabled by the Heath and Care Act 2022.

5.3 The Framework reinforces system-led delivery of integrated care taking into account of the following:

- The establishment of statutory Integrated Care Boards with commensurate responsibilities;
- NHS England's duty to undertake an annual performance assessment of the aforementioned Integrated Care Boards;
- Early learning from the implementation of the System Oversight Framework; and
- Revised NHS priorities as set out in the 2022-23 planning documentation.

5.4 The Framework is built around national themes reflecting the ambitions of the NHS long Term Plan, apply across both Trusts and Integrated Care Boards as follows:

- Quality of care
- Access and outcomes
- Preventing ill-health and reducing inequalities
- People;
- Finance and the use of resources
- Leadership and capability

5.5 NHS England will monitor and gather insights about performance across each 'theme' which will, in turn be used to support the ongoing monitoring at Integrated care Board and Provider level.

6. Trust Annual Report and Accounts 2021-22

The Annual Report and Accounts for 2021-22 have been provided to Parliament for laying week commencing 5 September 2022 following the return of Parliament after the summer recess.

7. Conclusion

The Board is asked to note the content of the report.

Angela Wendzicha
Director of Corporate Affairs
September 2022

Board of Directors' Meeting
9 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P148.22
Report	**Standards of Business Conduct Policy Review**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with the full Board Assurance Framework
How does this paper support Trust Values	The Standards of Business Conduct are an extension of the Trust's values and reflect our continued commitment to ethical business practices and regulatory compliance
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Standards of Business Conduct Policy has been reviewed and the following amendments were approved by the Audit Committee in July 2022 to bring the Policy in line with the National Model Policy: • Raise the financial limit for gifts, travel, accommodation and sponsorship declarations from £25 to £50; • Require those completing the Gifts, Hospitality or Sponsorship declaration form to declare that they have no interest in the company / individual that has offered them the gift, hospitality or sponsorship; • Ensure all wording contained within NHS England's Conflicts of Interest model policy (March 2017) is included; • Adopt the Trust's policy template; and • Embed the use of a single, electronic system for all colleagues, including members of the Board of Directors, to declare their interests
Due Diligence (include the process the paper has gone through prior to presentation at the meeting)	The revised draft Policy was considered by the Audit Committee at their meeting on 29 July 2022. The Audit Committee approved the amendments and recommended the Board approve the updated Policy.
Board powers to make this decision	The Trust's Matters Reserved state that the Board of Directors: • Has reserved the approval of the Trust's Standards of Business Conduct and Conflicts of Interest policy unto itself. • Will receive *'…declarations of interests from Officers which may conflict with those of the Trust and determining the extent to which such Officers may remain involved with the matter under consideration'.* Constitution: Section 33 details the manner in which conflicts of interests of the Directors should be dealt with.
Who, What and When (what action is required, who is the lead and	The Board of Directors is requested to consider the proposed revisions to the Trust's Standards of Business Conduct and to approve the revised Standards of Business Conduct.

when should it be completed?)	

Recommendations	The Board of Directors is requested to:
	• **Approve the proposed revisions to the Standards:**
	  ○ including the increase in the declaration limit from £25 to £50 for gifts, travel, accommodation and sponsorship;
	  ○ The retention of the £25 limit for meals and refreshments; and
	  ○ the use of the Electronic Staff Record for the declaration of all interests across the Trust
	• **Approve the amended Standards of Business Conduct**

Appendices	1. Revised Standards of Business Conduct

1.0 Introduction

1.1 As part of the three yearly review process, the existing Standards of Business Conduct have been reviewed and a number of revisions are proposed.

2.0 Proposed Revisions

2.1 The following revisions to the Standards are proposed:

2.1.1 That the current financial limit above which declarations are required for the receipt of gifts, travel, accommodation and sponsorship should be increased from the current £25 to £50 in order to align the Standards with NHS England's (NHSE) Conflicts of Interest model policy.

2.1.2 That the declaration limit for meals and refreshments will remain at £25 in accordance with NHS England's guidance.

2.1.3 That an additional declaration is required from all staff completing a declaration form for the receipt of gifts, hospitality and sponsorship confirming that they have no interest in the company / individual offering the gift, hospitality or sponsorship.

2.1.4 The addition of a small amount of wording to the Standards to ensure that all wording in NHSE's Conflicts of Interest model policy is included in the Trust's Standards of Business Conduct.

2.1.5 The adoption of the Trust's policy template.

2.1.6 The addition of the process used to identify 'decision making staff' who are required to make either an annual declaration of interest or a nil return (section 5.2) and how these colleagues are reminded to make their annual returns (section 5.3) utilising compliance reports from the Electronic Staff Record (ESR) system.

2.2 It is also proposed that from the 2022/23 financial year members of the Board of Directors will also make their declarations of interest or nil returns using the ESR system instead of manually completing the 'Register of Directors' Interests Form'. This change will ensure that the Trust has a single, electronic system for all such declarations.

3.0 Recommendation

3.1 The Board of Directors is requested to consider the revision detailed in section 2.2 regarding the introduction of a single, electronic system for the declaration of all interests across the Trust.

3.2 The Audit Committee reviewed the revisions detailed in section 2.1 to the Standards of Business Conduct at their July 2022 meeting and **recommends the amended Standards of Business Conduct for approval** by the Board of Directors.

Lisa Reid
Head of Governance
August 2022

Ref No:

STANDARDS OF BUSINESS CONDUCT
(INCLUDING NHS ENGLAND CONFLICTS OF INTEREST GUIDANCE)

SECTION 1
PROCEDURAL INFORMATION

Version:	11.4
Title of originator / author:	Head of Governance
Title of Responsible committee	Audit Committee
Title of Approving Committee/Group:	Board of Directors
Title of Ratifying Committee:	Board of Directors
Date ratified:	
Date issued:	
Review date:	
Target audience:	All Trust staff (including

Acknowledgements:

NHS England's model policy for Managing Conflicts of Interest in the NHS (March 2017)

Document History Summary

Version	Date	Author	Status	Comment
4	July 2002	Corporate Governance	Final	Incorporated rules for a register of sponsorship, hospitality and gifts Referred staff to Standards of Business Conduct for NHS staff HSG(93)5. District Audit review necessitated revision of the policy and it was agreed in April 2004 that the new post of Secretary to the Board would undertake the review once appointed
5	March 2008	Deputy Trust Secretary	Final	Standards of Conduct were extended significantly to incorporate the Trust's core policies to ensure fit for the future and for the FT environment
6	Novemb er 2011	Deputy Trust Secretary	Draft	Trust's core values; Strengthened employee responsibilities; Revised equality and diversity section; Additional information relating to sponsored study leave for medical staff; Revised information relating to 'blowing the whistle"; New sections added: • IT Security and Acceptable use • Delegated Authority • Outside Interests • Intellectual property
7	March 2012	Head of Governance and Assurance	Ratified	Took into account the recommendations made by both the Assurance Unit's 'Trust Governing Documents' audit (April 2011) and the Bribery Act 'Spot Check' (June 2011)

Version	Date	Author	Status	Comment
8	August 2015	Head of Governance	Ratified	Inclusion of Fit and Proper Person requirement for Directors and Governors; Inclusion of false or misleading information offence under 2014 Care Act; Financial level of declaration reduced from £50 to £25 in line with other organisations; A more comprehensive declaration documentation
9	December 2018	Head of Governance	Ratified	Incorporated NHS England's model Conflicts of Interest policy, April 2017 Includes the legal advice sought following the previous revision to the Standards in 2015. Staff no longer able to take annual leave to work on the Trust's bank where this does not leave them with at least 28 days of annual leave during which they do not work
9 (revised)	May 2019	Head of Governance	Ratified	Document revised to shorten the length of the main document (excluding appendices) from 43 pages to 12
10	August 2020	Head of Governance	Ratified	Minor revisions: To enable the Trust to introduce an electronic process for declarations of interest using the Declarations of Interest Module on the Electronic Staff Record (ESR) Make explicit the fact that 'Decision Making Staff' must make either a nil return or a declaration of interest on an annual basis (as advised by Counter Fraud)

Version	Date	Author	Status	Comment
11.3	July 2022	Head of Governance	Draft	Revised: To ensure all wording within NHS England's model Conflicts of Interest model policy (March 2017) is included To raise the financial level of declarations from £25 to £50 in accordance with NHSE's model policy To require those completing the Gifts, Benefits, Hospitality or Sponsorship declaration form to declare that they have no interest in the company / individual that has offered them the gift, hospitality of sponsorship Formatted as a policy using the Trust's policy template
11.4	September 2022	Head of Governance	Final draft	Version 11.3 approved by Audit Committee in July 2022. Audit Committee recommends the amended Standards of Business Conduct for approval by the Board of Directors in September 2022.

Section 1 Contents

Section 1 Appendices

Section 2 Contents

1. INTRODUCTION

The Rotherham NHS Foundation Trust (the 'organisation'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

2. PURPOSE AND SCOPE

2.1 Purpose

2.1.1 Staff must comply with the national guidance published by NHS England available here: https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf *(see Appendix 4)*

2.1.2 NHS England have published some Frequently Asked Questions to assist staff in understanding their conflicts of interest guidance. These are available here: www.england.nhs.uk/ourwork/coi

2.1.3 In addition managers must comply with the *Code of Conduct for NHS Managers*, October 2002 (*see Appendix 7*). Additional policies have been developed that build upon the core policies referenced herewith.

2.1.4 At The Rotherham NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and include: all salaried employees; all prospective employees – who are part-way through recruitment; contractors and sub-contractors; agency staff; and committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

2.2 Scope

2.2.1 The Rotherham NHS Foundation Trust's Standards of Business Conduct set out the Trust and NHS England's required standards of business practice and regulatory compliance and as such all staff members should adhere to the Standards of Business Conduct at all times. All staff members are expected to familiarise themselves and comply with their professional code of conduct and the seven Nolan Principles for Public Life *(see Appendix 5)*. As members of Trust staff, you also have a responsibility to raise compliance and ethics concerns through our established channels (see *Appendix 3: Dealing with Breaches* for further information about your responsibility to report any breaches of these Standards).

3. ABBREVIATIONS AND DEFINITIONS

3.1 Definitions

3.1.1 Conflicts of Interest

A 'conflict of interest' is: *"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."*[1]

A conflict of interest may be **actual** (there is a material conflict between one or more interests) or **potential** (there is the possibility of a material conflict between one or more interests in the future).

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

3.1.2 Interests

Interests fall into the following categories:

Financial interests: Where an individual may get direct financial benefit[2] from the consequences of a decision they are involved in making.

Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

Indirect interests: Where an individual has a close association[3] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

The *NHS Code of Conduct and Accountability* (third revision, April 2013) very clearly establishes that Boards of Directors must act in a manner which protects the interest of the NHS in the conduct of their business. The values of Accountability, Probity and Openness must underpin the work of each and every NHS Board. All Board members must act impartially and must not be

[1] 'Managing Conflicts of Interest in the NHS: Model policy content for organisations, NHS England, April 2017

[2] This may be a financial gain, or avoidance of a loss.

[3] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

influenced (or be perceived to have been influenced by) business or social interests.

Therefore, all members of the Board of Directors (including Non-Executive Directors) and Governors must declare interests which are '*relevant and material*' and these must be recorded on the Register of Director's interests which is available to the public and in the minutes of the Board meetings. All existing Board Directors should declare relevant and material interests. Any Board Directors or members of the Council of Governors appointed / elected subsequently should do so on appointment or election. If a conflict of interest is established the Board member should withdraw themselves from the discussion and play no part in the decision to be made.

The Health and Social Care Act 2012 states: *'If a director of a public benefit corporation has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the director must declare the nature and extent of that interest to the other directors.'*[4] See the Trust's *'Standing Orders' Section 3* for further information. It is the responsibility of all staff members to avoid conflicts of interest and Directors have a statutory duty to avoid such conflicts of interest enshrined within the Health and Social Care Act 2012[5]. It is important to remember that a member of staff does not need to exploit his or her position to obtain an actual benefit (financial or otherwise) for a conflict of interest to occur.

3.1.3 Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For example, those staff of the Trust who have responsibility for committing resources either directly: by ordering or influencing the ordering of goods and services or by their involvement in the recruitment of new employees; or indirectly: by prescribing or influencing the choice of product or service to be used. For the purposes of this document these people are referred to as 'decision making staff.'

Decision making staff in this organisation are:

- Executive and Non-Executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Those at Agenda for Change band 8D and above and all Consultants
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation

[4] Part 4 – NHS foundation trusts and NHS Trusts, Governance and Management, 152 (3), 18C (1) page 152 of the Health and Social Care Act, Chapter 7.

[5] Part 4 – NHS foundation trusts and NHS Trusts, Governance and Management, 152 (2), 18B (1) (a), page 152 of the Health and Social Care Act, Chapter 7.

- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions

All decision Making staff **must** either **make a declaration of interest annually** or make a **nil return annually** (using the Declarations of Interest module of the Electronic Staff Record (ESR).

3.2 Abbreviations

ESR Electronic Staff Record

SoBC Standards of Business Conduct

4. Roles and Responsibilities

ROLES	RESPONSIBILITIES
Board of Directors	Will ratify the Standards of Business conduct and ensure itself that the Standards are being implemented effectively
Audit Committee	Is responsible for overseeing the implementation of the Standards via the receipt of six-monthly compliance reports; the Standards of Business Conduct Annual Report and considering proposed revisions to the Standards
Chief Executive	The Chief Executive has overall responsibility for: • Ensuring that the processes are in place for the implementation of the Standards • Ensuring that the processes are in place for the monitoring of the Standards • These responsibilities are delegated as described
Executive Lead (Director of Corporate Affairs)	The Executive Lead is accountable to the Board of Directors for ensuring compliance with these standards in all parts of the Trust.
Head of Governance	Operationally leads the implementation of the Standards: • Ensuring the effective dissemination

ROLES	RESPONSIBILITIES
	of the Standards across the Trust • Personally reminding Decision Making Staff who have not completed their annual returns to do so with the support of the appropriate Executive Directors • Ensuring that a six-monthly reports to the Audit Committee are produced identifying Decision Making Staff who have not completed their annual returns in conjunction with the Director of Corporate Affairs • Writing the Standards of Business Conduct Annual Report and ensuring its presentation to the Audit Committee on an annual basis in conjunction with the Director of Corporate Affairs • Proposing revisions to the Standards to the Audit Committee in conjunction with the Director of Corporate Affairs
Decision Making Staff	All decision Making staff **must** either **make a declaration of interest annually** or make a **nil return annually** (using the Declarations of Interest module of the Electronic Staff Record (ESR).
Line Managers	Managers are responsible for ensuring that their staff, including new staff, are aware of and understand the contents of the Standards of Business Conduct and that all conflicts of interest, gifts and hospitality offered and received are submitted to the Head of Governance and are kept up to date.
Trust Staff	All Trust staff are accountable and responsible for understanding and complying with the Standards of Business Conduct, NHS England's guidance on the management of conflicts of interest, applicable laws, regulations, and Trust policies that are related to their jobs. In fulfilling these responsibilities

ROLES	RESPONSIBILITIES
	each member of staff must: • Read, understand, and comply with the Standards of Business Conduct and all Trust policies that are related to his/her job. • Declare any potential material interest • Participate in training and educational programs or events required for his/her job. • Obtain guidance for resolving a business practice or compliance concern if he/she is uncertain about how to proceed in a situation. • Report possible violations of the Standards of Business Conduct, policies, applicable laws, and regulatory requirements. • Cooperate fully in any investigation. • Make a commitment to conduct the Trust's business with integrity and in compliance with applicable laws and regulatory requirements.

We must expect the best from ourselves because who we are as an organisation and as individuals is as important as our ability to deliver the best care and services. How we manage our hospital and community services internally — and how we think about and work with patients, partners, governments, suppliers and communities — impacts upon our productivity and success. It's not enough to just do the right things; we also have to do them in the right way.

These Standards of Business Conduct provide information, education, and resources to help you make good, informed business decisions and to act on them with integrity. In addition, managers should use this resource to foster, manage, and reward a culture of accountability and integrity within their departments. Working together, we can continuously enhance our culture in ways that benefit patients and partners, and that strengthen our interactions with one another.

All staff must declare any potential interest as soon as it arises. Please see Section 5.3 for details of how to identify and declare an interest.

Appendix 2 provides details of how these interests should be managed to avoid a conflict of interest and Appendix 3 describes how the Trust will deal with any breaches of these Standards of Business Conduct.

4.1 Why the Trust has Standards of Business Conduct

This policy will help our staff manage conflicts of interest risks effectively. It introduces consistent principles and rules; provides simple advice about what to do in common situations; and supports good judgement about how to approach and manage interests. This policy should be considered alongside the other organisational policies referenced within it and those detailed in *Appendix 8*.

As responsible public sector healthcare providers, it is not enough to intend to do things right, we must also do them in the right way. That means making business decisions and taking appropriate actions that are ethical and in compliance with applicable legal requirements. As we make these decisions, our values must shine through in all our interactions. The Standards of Business Conduct are an extension of the Trust's values and reflect our continued commitment to ethical business practices and regulatory compliance. In addition, adherence to these Standards will ensure your compliance with NHS England's guidance on the management of conflicts of interest introduced in February 2017.

4.2 How to use the Standards of Business Conduct

The Standards of Business Conduct summarise the regulatory requirements and business practices that guide our decision making and business activities. The Standards contain basic information about our policies as well as information about a particular practice or compliance concern. It is essential that you thoroughly review this publication and make a commitment to uphold its requirements. The Standards of Business Conduct are not intended to cover every issue or situation you may face as a Trust employee. Nor do they replace other more detailed policies. It is your responsibility to be fully aware of these Standards and to adhere to them at all times.

If you need details on a specific policy, you may contact the Director of Corporate Affairs or Head of Governance. If you need guidance regarding a business practice or compliance issue or wish to report a possible violation / breach, talk to your immediate supervisor, manager, another member of management, the Director of Corporate Affairs, Head of Governance, HR team or Local Counter Fraud Specialist. (See *Appendix 3: Dealing with Breaches* for further information). The Trust will handle all inquiries discreetly and make every effort to maintain, within the limits allowed by the law, the confidentiality of anyone requesting guidance or reporting a possible violation / breach.

4.3 Consequences of Not Complying With the Standards of Business Conduct

Failure to comply with the Trust's Standards of Business Conduct may result in disciplinary actions up to and including termination of employment and a referral to the Local Counter Fraud Specialist. See *Appendix 3: Dealing with Breaches* for further information.

Failure to read and/or acknowledge the Standards of Business Conduct does not exempt a staff member from his/her responsibility to comply with the Standards of Business Conduct, NHS England's guidance on the

management of conflicts of interest, applicable laws, regulations, and Trust policies that are related to his/her job.

5. PROCEDURAL INFORMATION

5.1 Step 1: Identification of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

This declaration must include:

- The person's name and their role with the organisation
- A description of the interest declared (reflecting the type of interest they are declaring e.g. financial interest, non-financial interest etc)
- Relevant dates relating to the interest
- Space for comments (e.g. action taken to mitigate conflict)

5.2 Step 2: Identification of decision making staff who must complete an annual declaration or nil return

The Electronic Staff Record (ESR) system automatically identifies the following individuals who are categorised in the NHS England Conflicts of Interests guidance as decision making staff and who therefore must complete an annual declaration or nil return on the ESR system:

- Staff at Agenda for Change bands 8D and above
- Employees holding a job role of Director / Non-Executive Director or Consultant

These staff are categorised as 'national decision maker' in the ESR system.

The Trust has a manual process for the identification of the following decision making staff:

a) Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation

b) Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions

The process involves the regular review of reports extracted from the ESR system detailing new members of staff and staff with changes in employment

status (e.g. promotion / secondment) and the identification of individuals who meet the criteria of groups a) and b) above. These staff are manually categorised in the ESR system as 'decision maker'.

Both of these types of 'decision makers' are included in the annual declaration cohort within the ESR system and receive automated reminders from the ESR system on a quarterly basis to make their annual declaration of interest or nil return.

5.3 Process to ensure decision making staff complete an annual declaration or nil return

The ESR system emails individuals in the annual declaration cohort on a quarterly basis reminding them to declare their interest or make a nil return for the current financial year. Once the individual has made their declaration, the system will not remind them again until the beginning of the next financial year. A member of the Workforce Systems & Compliance team initiates the quarterly reminder email process manually.

The Head of Governance reviews declarations made in year via monthly and quarterly ESR report and will proactively remind decision making staff to complete their annual returns in conjunction with the relevant Executive Director.

Towards the end of the financial year Communications messages are also issued across the Trust (including via Team Brief) to remind decision making staff to complete their declarations by 31 March.

After 31 March, a report is extracted from ESR detailing individuals who have not made an annual return, by staff group and Division. These individuals are contacted directly by either the Head of Governance, Company Secretary or the appropriate Executive Director to request they complete their annual return by 30 April.

Once the revised deadline of 30 April has passed, a full report of all declarations for the financial year is extracted from ESR. This is reviewed to assess how many of the individuals who were reminded to complete their returns have done so. If required, further action is taken by the appropriate Executive Director in relation to individuals who have not completed their annual returns.

5.4 Step 3: Declaration of interests (including gifts and hospitality)

5.4.1 Declarations of Interest

A declaration of interest should be made using the Declarations of Interest module of the Electronic Staff Record (ESR)

Advice as to the materiality of the conflict of interest can be obtained from the Director of Corporate Affairs or the Head of Governance.

After expiry, an interest will remain on the register for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

It is the responsibility of the member of staff to ensure that he/she is not placed in a position which risks, or appears to risk, conflict between his/her private interests and his/her duties and responsibilities on behalf of the Trust.

See the Trust's 'Standing Orders' Section 3 for further information.

It is not possible to list all situations or relationships which may give rise to a conflict of interest, or the appearance of one, so each situation must be evaluated on its individual facts. NHS England have published some Frequently Asked Questions designed to assist in understanding what a conflict of interest is. These are available here: www.england.nhs.uk/ourwork/coi Examples of situations where conflicts of interest may arise, and the principles which should be applied, are given below.

Personal and Business Integrity

Staff members must disclose any material financial interest in any competitor, supplier, customer or other business with which the Trust has significant business dealings. As described earlier for the purposes of this policy 'staff' include:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

These disclosures should be made using the Declarations of Interest module of the Electronic Staff Record (ESR).

Staff may not hold any material financial interest in a supplier, customer or other external business if they have any involvement in the Trust's dealings with that business or supervise anyone with such involvement.

Save as may be expressly permitted in writing, no member of staff may hold a material financial interest in any business the activities of which are:

- In direct competition with the Trust; or
- Otherwise against the interests of the Trust.

The activities of staff members' close relatives can sometimes create conflicts of interest. Staff should disclose any situation where a close relative works or performs services for, or has a material financial interest in, any competitor, supplier, customer or other business with which the Trust has significant business dealings.

These disclosures should be made using the Declarations of Interest module of the Electronic Staff Record (ESR).

No member of staff should have any business involvement with a close relative or with any business for which a close relative works or in which a close relative holds a material financial interest.

No staff member should ever be in a situation where they have the ability to employ, supervise, affect terms and conditions of employment, or influence the management of any close relative. A 'close relative' is someone with whom you have a close family or personal relationship such that it could give rise to a conflict of interest (or the perception of a conflict of interest) in the situations described. It includes any spouse, partner, parent, stepparent, child, step-child, sibling, step-sibling, nephew, niece, aunt, uncle, grandparent, grandchild (and any such relationships arising by marriage). [6]

If you and a close relative both work within Trust you should ensure that you both act in accordance with the Trust's *Policy for Close Personal Relationships at Work.*

5.4.2 Declarations of Gifts, Hospitality and Sponsorship

These should be declared by staff using the declaration form at *Appendix 6* and the advice of the Director of Corporate Affairs or Head of Governance should be sought before such gifts are accepted on behalf of the organisation. See the Gifts and Hospitality Section below for further information

[6] With thanks to the British Marine Standards of Business Conduct, June 2011, source: http://www.britmarine.co.uk/corporate-governance.html, last accessed 26/6/15.

5.4.3 Gifts and Hospitality

Gifts

It is the policy of the Trust to base commercial decisions on commercial criteria. This policy serves the Trust's business interests and fosters constructive relationships with organisations and individuals doing business, or seeking to do business with the Trust. Staff should not accept gifts that may affect, or be seen to affect, their professional judgement or integrity, and to avoid seeking to exert influence to obtain preferential consideration. All such gifts must be returned and hospitality refused.

It is recognised that gifts are commonplace and often deserved, and in some cases can be accepted. However moral judgement should be exercised, especially when dealing with vulnerable people.

Gifts from suppliers or contractors:
Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.

Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):
Gifts of cash and vouchers to individuals should always be declined. Staff should not ask for any gifts. Gifts valued at over £50 should be treated with caution and only be accepted on behalf of The Rotherham NHS Foundation Trust not in a personal capacity. These should be declared by staff using the declaration form at *Appendix 6* and the advice of the Director of Corporate Affairs or Head of Governance should be sought before such gifts are accepted on behalf of the organisation.

Modest gifts accepted under a value of £50 do not need to be declared. A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

Staff must declare, seek approval to accept and register gifts of any kind, from any source (using the form at *Appendix 6*) if they are worth **£50** or more, even where they have been refused / declined. Similarly a declaration (using the form at *Appendix 6*) must be made if several small gifts, benefits, hospitality or sponsorship of any kind are offered totalling over **£50** from the same or a closely related source in a 12-month period. A declaration is required when items have been refused or returned; or approval is required to accept the item(s) being offered.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.

- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Hospitality

Staff should not ask for, or accept, hospitality that may affect, or be seen to affect, their professional judgement. Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:
Under a value of £25 - may be accepted and need not be declared. Of a value between £25 and £75 - may be accepted and must be declared. Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept. A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:
Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared. Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes: offers of business class or first class travel and accommodation (including domestic travel) and offers of foreign travel and accommodation.

A declaration (using the form at *Appendix 6*) must be made for all offers of travel and accommodation with a value of £50 or more. No accommodation or travel should be booked before the declaration has been approved.

What should be declared

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.4.4 Outside Employment

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

Staff should declare any existing outside employment on appointment and any new outside employment when it arises. Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment. The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

What should be declared

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.4.5 Outside Interests

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

All Trust staff (excluding medical staff) are expected to devote the whole of their professional time and ability to deliver the requirements of their post and any other roles and activities, as approved by their line manager, to further the Trust's business. All Trust employees (including medical staff unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed) must notify their line manager if they intend to take up external employment or carry out paid work particularly work which **may conflict with their work for the Trust**. The line manager (with the support of HR Department) will determine whether the interests of the Trust are likely to be harmed in accordance with sections 4 and 20 of these Standards.

Where any such employment or paid activity (e.g. consultancy, speaking at conferences) is intended to take place during the employee's normal contracted hours, line manager approval is required. If the work carried out is part of the employee's normal duties, or could reasonably be regarded as falling within normal duties of the post and is carried out during the normal working hours of that employee, then any fee must be made payable to the Trust.

If the employee wishes to undertake during what would be their normal working hours any paid activity which is personal in nature rather than forming part of the employee's normal duties, they must seek approval to an appropriate period of leave from their normal duties, paid (i.e. annual leave but not study leave) or unpaid, to enable them to undertake the activity. In those circumstances the fee may be retained by the employee.

Any employee who wishes to undertake a 'one off' paid activity entirely in their own time using their own materials and subject matter, that attracts a fee will be able to retain the fee paid, however it would be their responsibility to inform the tax office as appropriate.

Where an employee holds another appointment outside the Trust, including self-employment and is off sick from their Trust post, or on Carers' or Bereavement leave, they should not normally undertake any paid work during the period of sickness and any intention to do so should be agreed with their manager in advance.

Where an employee is found to be working elsewhere, including self-employment, whilst in receipt of contractual sick pay and a GP Fit Note (which stated that the employee could work elsewhere) cannot be provided to confirm their eligibility to work, this may be treated as gross misconduct under the Trust's Disciplinary Procedure and the Trust's Local Counter Fraud Specialist will also be notified, which could result in criminal prosecution. Employees must not take up any paid or unpaid employment during periods of Study Leave during their contracted hours. Such conduct may be treated as gross misconduct under the Trust's Disciplinary Procedure and will be referred to the Trust's Local Counter Fraud Specialist which could result in criminal proceedings.

Employees must not take up any paid or unpaid employment during periods of annual leave where such work would prevent the employee from taking their full annual leave entitlement under the Working Time Regulations (28 days). Employees must not take up any paid employment with the Trust (i.e. any bank shifts or consultancy work) during periods of paid annual leave. In the event that an employee receives payment for a bank shift when they are in a period of paid annual leave from their employment with the Trust, payment for the bank shift must be reimbursed to the Trust.

The Trust may deduct from the salary, or any other sums owed to the employee, any money owed to the Trust under this policy. All staff should not undertake work outside of their contracted hours where such work would be in breach of the Working Time Regulations, although they are entitled to opt out of this if they so wish. This needs to be formally agreed with their manager in writing.

5.4.6 Shareholdings and Other Ownership Issues

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation. Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

What should be declared

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.4.7 Patents

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property. Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

5.4.8 Loyalty Interests

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money for example Integrated Care System (ICS), Acute Federation or Operational Delivery Network (ODN) groups.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.

- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

What should be declared

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.4.9 Donations

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain. Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

Staff who receive a charitable funds donation on behalf of the Trust Charity (The Rotherham Hospital and Community Charity) or affiliated appeals are expected to ensure they act in accordance with the appropriate policy and procedures in place for the receipt of charitable funds. Should staff have any concerns regarding this process they should liaise with their line manager or the Charity Engagement and Development Manager.

Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued. Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared

The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

5.4.10 Sponsored Events

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit

to the organisation and the NHS. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied. At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.

The involvement of a sponsor in an event should always be clearly identified. Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event. Staff arranging sponsored events must declare this to the organisation.

What should be declared

The organisation will maintain records regarding sponsored events in line with the above principles and rules.

5.4.11 Sponsorship for Courses, Conferences, Meetings And Publications

(use the form at Appendix 6 to declare)
Staff may accept commercial sponsorship for courses, conference, meetings and publications if they are reasonably justifiable and in accordance with the principles set out in this policy. In cases of doubt, advice should be sought from your line manager or the Director of Corporate Affairs or Head of Governance. Permission (with details of the proposed sponsorship) must be obtained from the Director of Corporate Affairs or Head of Governance in writing (using the form at *Appendix 6* for course, conferences and meetings or the Declarations of Interest module of the electronic Staff Record (ESR) for publications) in advance of accepting the sponsorship from the company.

Acceptance of commercial sponsorship should not in any way compromise purchasing decisions. Where sponsorship is related to study leave, authorisation should be obtained via the approved system at the time and a copy of the study leave form attached to the declaration form (*Appendix 6*) and forwarded to the Head of Governance for inclusion in the register.

If staff are in any doubt as to when a declaration should be made they should err on the side of caution and are strongly advised to make a declaration. See the Trust's *'Standing Orders';* NHS England's Conflicts of Interest Guidance included at *Appendix 4* and the *Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy)* for further information.

5.4.12 Sponsored Research

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

Funding sources for research purposes must be transparent. Any proposed research must go through the relevant health research authority or other approvals process.

There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service. Staff should declare involvement with sponsored research to the organisation.

What should be declared

The organisation will retain written records of sponsorship of research, in line with the above principles and rules.

- Staff should declare:
- their name and their role with the organisation.
- Nature of their involvement in the sponsored research.
- relevant dates.
- Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.4.13 Sponsored Posts

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

External sponsorship of a post requires prior approval from the organisation. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise. Under no circumstances should staff agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided. Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

Staff should be particularly careful of using, or making public, internal information of a "commercial in confidence" nature, particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition or the viability of the Trust. This principle applies whether private competitors or other NHS providers are concerned and whether or not disclosure is prompted by the expectation of personal gain.

What should be declared

The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.

5.4.14 Clinical Private Practice

(use the Declarations of Interest module of the Electronic Staff Record (ESR)

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[7] including: where they practise (name of private facility); what they practise (specialty, major procedures); and when they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed): seek prior approval of their organisation before taking up private practice; ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS

[7] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

commitments take precedence over private work.[8] Clinical staff should also not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

5.4.16 Wider Transparency Initiatives

The Rotherham NHS Foundation Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These 'transfers of value' include payments relating to: speaking at and chairing meetings; training services; advisory board meetings; fees and expenses paid to healthcare professionals; sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK and donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website: http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

In addition, the 'transfers of value' detailed above should also be declared to the organisation using either the form at *Appendix 6* or the Declarations of Interest module of the electronic Staff Record (ESR) as appropriate.

[8] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

6. REFERENCES

- NHS England Guidance on the Management of Conflicts of Interests, February 2017
- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2021) ABHI Code of Ethical Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- 'Leading Health & Safety at Work - Actions and Good Practice for Board Members', guidance published by the Health and Safety Executive at https://www.hse.gov.uk/leadership/

7. ASSOCIATED DOCUMENTATION

- Counter Fraud, Bribery & Corruption Policy
- Standing Orders
- Standing Financial Instructions
- Policy for Close Personal Relationships at Work.
- Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy)
- Policy for Managing Bullying and Harassment
- Managing Attendance Policy
- Policy and Procedure for Supporting Staff to Raise Concerns at Work (Including Whistleblowing)
- A Colleague's Guide to Raising Concerns (Whistleblowing)
- Risk Management policies
- Policy for Information Technology Acceptable Use

Appendix 1: Guiding Principles and Policy Summary

The Rotherham NHS Foundation Trust is committed to being a high performing Trust. To that end, we must continuously achieve superior safety, and business results while simultaneously adhering to high ethical standards.

The Trust aspires to be at the leading edge of competition within the field of healthcare provision. That requires the Trust's resources – financial, operational, technological, and human – to be employed wisely and evaluated regularly.

While we maintain flexibility to adapt to changing conditions, the nature of our business requires a focused, long-term approach. We will consistently strive to improve efficiency and productivity through learning, sharing and implementing best practices.

We aim to achieve our goals by executing our business plans and by adhering to these guiding principles, our values and the core policies.

The following principles guide our relationships with our service users, staff members, external partners and communities:

Patients – Success depends on our ability to consistently satisfy ever changing patient preferences. We commit to be innovative and responsive in order to provide first class patient care and high quality, safe services. This entails all health professionals keeping up to date with changes in clinical best practice / guidance such as that produced by the National Institute for Health and Care Excellence (NICE), Royal Colleges and other advisory agencies. Health professionals are expected to take such guidance fully into account when exercising their clinical judgment.

Employees – The quality of our workforce provides a valuable competitive edge. To build on this advantage, we will strive to recruit and retain the highest calibre people available and to maximise their opportunities for success through training and development. We are committed to maintaining a safe work environment enriched by diversity and characterised by open communication, trust, and fair treatment.

External Partners – We aim to work with our partners in an open and responsive manner. We will maintain high ethical standards, respect and recognise our partners' expertise and the valid contribution that each can make to the provision of high quality services and an improved patient experience and outcome.

Communities & Social Responsibility – We commit to being a good corporate citizen, maintaining high ethical standards, obeying all applicable laws, rules and regulations, and respecting local cultures and running safe and environmentally responsible services.

Policy Summary

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the NHS England guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • Make a **declaration of interest** or a **nil declaration annually** if you are a **Decision Making Staff member**[9] using the Declarations of Interest module of the Electronic Staff Record (ESR) (see section 5.3 or footnote below for description of who Decision Making Staff are) • **NOT** misuse your position to further your own interests or those close to you • **NOT** be influenced, or give the impression that you have been influenced by outside interests • **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Identify a team or individual with responsibility for: ○ Keeping this policy under review to ensure they are in line with the guidance. ○ Providing advice, training and support for staff on how interests should be managed. ○ Maintaining register(s) of interests. ○ Auditing this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

[9] Executive and Non-Executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money; Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services; Those at Agenda for Change band 8D and above and all Consultants; Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation; Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions

Appendix 2: Management of Interests

General

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and The Rotherham NHS Foundation Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

Common Situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

Strategic decision making groups

In common with other NHS bodies The Rotherham NHS Foundation Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:

- Board of Directors
- Corporate Trustee
- Charitable Funds Committee
- Business Investment Committee
- Medical Devices Management Group
- Rotherham Medicines Optimisation Group

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

In the interest of the Trust, its officers and clinicians, it is important to ensure that contact with commercial representatives is conducted in a satisfactory way.

The Procurement department has adopted the former NHS Supplies/PASA code of conduct to protect staff, its own interests and those of the NHS as a whole. The Code applies to every level of the organisation. Advice may be sought from the Head of Procurement.

See the Trust's *Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy)*

Appendix 3: Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Director of Corporate Affairs, the Head of Governance or the Local Counter Fraud Specialist:

Anna Milanec
Company Secretary
Angela Wendzicha
Director of Corporate Affairs
General Management
Corridor
Level D
Rotherham General Hospital
Moorgate Road
S60 2UD
01709 427021
angela.wendzicha1@nhs.net

Lisa Reid
Head of Governance
General Management
Corridor
Level D
Rotherham General
Hospital
Moorgate Road
S60 2UD
01709 4227747
lisa.reid9@nhs.net

Amanda Smith
Local Counter Fraud
Specialist
Oak House,
Moorhead Way
Bramley
Rotherham
S66 1YY
01709 428701
amanda.smith61@nhs.net

Any suspicions of fraud should only be reported to the Local Counter Fraud Specialist.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the Trust's Policy and Procedure for Supporting Staff to Raise Concerns at Work (Including Whistleblowing).

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation, the Counter Fraud, Bribery and Corruption Policy and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, The NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee at least six monthly.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published within the Standards of Business Conduct Annual Report published on the 'key corporate documents' page of the Trust's website as appropriate, or made available for inspection by the public upon request.

Appendix 4: NHS England Guidance on the Management of Conflicts of Interests

February 2017

Appendix 5: The Seven Principles of Public Life

As recommended by the Committee on Standards in Public Life Committee (Nolan Committee), 1995

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias**.**

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs**.**

These principles apply to all aspects of public life

Source: https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2 last accessed 22/07/22

The Rotherham NHS Foundation Trust

Appendix 6: Standards of Business Conduct Declaration Form for Gifts, Hospitality or Sponsorship

The Standards of Business Conduct require staff to declare gifts and hospitality which are relevant and material to the Trust. All staff are required to comply with all Trust policies and procedures for procurement. ***Please complete the declaration below if your situation meets the following criteria:***

1. Hospitality:

1.1 Meals and refreshments over £25

- Under a value of £25: may be accepted and need not be declared
- Of a value between £25 and £75: may be accepted and must be declared
- Over a value of £75: should be refused unless (in exceptional circumstances) senior approval is given. See notes page for how to seek approval.

1.2 Travel and accommodation

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, See notes page for how to seek approval.
- Prior authorisation must be obtained before acceptance of hospitality over the value of £25. Hospitality cannot be accepted without prior authorisation.

2. Gifts over £50

2.1 Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value. Low cost branded promotional aids may be accepted. See notes page for details.

2.2 From other sources:

- Gifts of cash and vouchers to individuals should always be declined
- Modest gifts accepted under a value of £50 do not need to be declared
- Gifts valued at over £50 should be treated with caution and should not be accepted in a personal capacity. See notes page for how to seek approval to accept such gifts.
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50

3. Sponsorship for Attendance at Courses and Conferences including fees and travel (over the value of £25)

Commercial sponsorship includes NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.

Name of person completing form:						**Date form completed:**
Job Title:						
Ward/Department:						**Date(s) of event / Date of receipt**
Telephone extension and email address:						
Is this a gift / meals & refreshments / travel and accommodation / commercial sponsorship?	**Gift**	**Yes / No**	**Meals & Refreshments**	**Yes / No**	**Travel & Accommodation**	**Yes / No**

A description of the nature and value of the gift / hospitality:								
Location venue, town/city, country								
Source of the gift / hospitality: (e.g. name of company)								
Financial Value of Gift Hospitality or Sponsorship: Indicate whether actual or estimated value	**Total value**	**£**	**Travel**	**£**	**Accommodation**	**£**	**Other**	**£**
Extent of Gift, Hospitality or sponsorship (e.g. train tickets, conference delegate fees, meals, hotel accommodation etc.)								
Is receipt of the benefit to be undertaken in:	**Work time / study leave / personal time / annual leave** (delete as appropriate and append additional information and a copy of study leave form as appropriate)							
Who has approved receipt of the benefit?								
Has the offer of Gift / Hospitality / Benefit / Sponsorship been declined?	**Yes** / **No** If Yes, specify nature of offer:							
Declaration	**I confirm that I have no interests in the individual or the organisation from whom I wish to accept this offer of hospitality, gift or sponsorship.** **I have read and understood The Rotherham NHS Foundation Trust's Standards of Business Conduct as they relate to conflicts of interest, personal activities and hospitality and declare that the information I have provided on this form is correct and complete.** **I understand that if I knowingly provide false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings, including termination of employment.**							
Signature of person completing form								
Email completed form to: Head of Governance at lisa.reid9@nhs.net								
For Office Use Only					**Date form received:**			
Request Approved ☐ **Request Not Approved** ☐ **Reasons:**								
Signature:							**Date:**	
Copy to Central Register ☐ **Copy to Requestor** ☐								

N.B. The details of each declaration will be published in the Standards of Business Conduct Annual Report and this information is available to the public via the Trust's website.

With thanks to Rotherham, Doncaster and South Humber NHS Foundation Trust

NOTES FOR THE COMPLETION OF THE STANDARDS OF BUSINESS CONDUCT DECLARATION FORM FOR GIFTS, HOSPITALITY OR SPONSORSHIP

This declaration form must be completed for offers of gifts, hospitality or sponsorship.

HOSPITALITY

a) Meals and refreshments:

- Under a value of £25: may be accepted and need not be declared
- Of a value between £25 and £75: may be accepted and must be declared
- Over a value of £75: should be refused. In exceptional circumstances approval by an Executive Director is required before meals / refreshments of a value over £75 can be accepted. Staff should complete this form and submit to the Head of Governance for consideration by the Executive Team.

b) Travel and accommodation

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared.
- A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel)
  - offers of foreign travel and accommodation.

Prior authorisation must be obtained before acceptance of hospitality over the value of £25. Hospitality cannot be accepted without prior authorisation.

GIFTS

a) Gifts from suppliers or contractors doing business (or likely to do business) with the organisation:

- Should be declined, whatever their value
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total, and do not need to be declared

b) Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined
- Modest gifts accepted under a value of £50 do not need to be declared
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of The Rotherham NHS Foundation Trust, not in a personal capacity. The advice of the Company Secretary or Head of Governance should be sought before such gifts are accepted on behalf of the organisation through the completion and submission of this declaration form.
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50

- Provide as much detail as possible regarding the event / gift / hospitality for declaration, e.g. dates of travel, method and class of travel, accommodation, food and drinks included etc.
- Provide details of costs and indicate whether actual or estimate.
- Provide the name of the company and/or individual offering the sponsorship/ gift / hospitality.
- Indicate the date and the name of the person referred to for approval.
- Refusal of all offers of gifts, hospitality and sponsorship should be declared.
- This declaration form should be completed as soon as is practicably possible as **no retrospective approval** for gifts, hospitality or sponsorship will be provided.
- If you are unsure what to declare, please discuss with your immediate manager in the first instance. Further advice can be obtained from the Head of Governance, Director of Corporate Affairs, Director of Finance and the Director of Workforce
- Approval for all offers of gifts, hospitality and sponsorship will be via the Trust's Head of Governance or Director of Corporate Affairs.
- The details of each declaration will be published in the Standards of Business Conduct Annual Report and this information is available to the public.

Appendix 7: Code of Conduct for NHS Managers
October 2002

Appendix 8: Bribery, Corruption and Fraud

(see also 6 Gifts and Hospitality)

The Bribery Act 2010, which came into force in July 2011, makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe whether in the UK or abroad. It is also a criminal offence under this Act for any director, manager or officer of the Trust to allow or 'turn a blind eye' to acts of bribery within the organisation. The penalty for bribery can be up to 10 years' imprisonment, with an unlimited fine.

Bribery is defined by the Act as:

> *'…giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.*
>
> *Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.'*[10]

For example, a member of staff who has decision making responsibilities in relation to the award of a contract being offered tickets to an event by a company involved in the procurement process. In the context of the Bribery Act 2010, the offence of bribery refers to **accepting**, as well as **offering,** a bribe.

A new corporate offence was also introduced by the Bribery Act:

- Failure of a commercial organisation to prevent bribery

This means that the Trust can be held responsible if it fails to enact adequate procedures to prevent bribery.

Any member of senior management or any Board member who consents to, or connives in, any active or passive bribery offence will, together with the Trust, be liable for the corporate offence under the Act.

Any individual associated with the Trust who commits acts or omissions forming part of a bribery offence may be liable under the Act. This also applies where an individual is part of a conspiracy to commit the offence with others – including, for example, their employer.

Anyone can report concerns about bribery in the NHS. The Trust's Local Counter Fraud Specialist wants to hear about any suspicions or concerns about bribery. All allegations will be thoroughly and professionally investigated.

Staff should report any suspicions or allegations of bribery immediately to one of the following:

[10] Source: http://www.thebriberyact2010.co.uk/what-is-a-bribe.asp last accessed on 22/7/22.

- The Trust's Local Counter Fraud Specialist (LCFS) to deal with in line with the usual procedures for investigating NHS fraud and corruption

  Amanda Smith

  LCFS

  Oak House

  Moorhead Way

  Bramley

  Rotherham

  S66 1YY

  ☎ 01709 428701

  amanda.smith61@nhs.net

- The Trust's whistleblowing officer. Please see latest version of the Trust's *Policy and Procedure for Supporting Staff to Raise Concerns at Work (Including Whistleblowing)* for contact details

- The NHS Fraud and Corruption Reporting Line (0800 028 40 60) or the online fraud reporting form at www.reportnhsfraud.nhs.uk

All of the above will treat your referral with the utmost discretion and investigate the matter in a professional and impartial manner.

STANDARDS OF BUSINESS CONDUCT
(INCLUDING NHS ENGLAND CONFLICTS OF INTEREST GUIDANCE)

SECTION 2

DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

- Director of Finance
- Audit Committee

9. APPROVAL OF THE DOCUMENT

This document was approved by the Audit Committee

10. RATIFICATION OF THE DOCUMENT

This document was ratified by the Board of Directors.

11. REVIEW AND REVISION ARRANGEMENTS

The Standards will be reviewed in three years' time unless such changes occur as to require an earlier review. This will be led by the Head of Governance.

12. DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
Communication Team	Head of Governance	Email	Within 1 week of ratification	Request that Communication team inform all email users of the location of the document.
All email users	Communication Team	Email	Within 1 week of ratification	Communication team will inform all email users of the policy and provide a link to the policy.
Key individuals Staff with a role/responsibility within the document Heads of Departments / Matrons	Author	Meeting / Email as appropriate	When final version completed	The author must inform staff of their duties in relation to the document.

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

13. IMPLEMENTATION AND TRAINING PLAN

What	How	Associated action	Lead	Timeframe
Awareness raising re: changes to Standards (e.g. financial limit for declarations)	Via Communications messages and training sessions	Training sessions Tailored Communications messages	Head of Governance	Within 3 months of ratification of this policy

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

14.1 Process for Monitoring Compliance and Effectiveness

All declared interests that are material will be promptly transferred to the appropriate register by the Head of Governance or the Corporate Governance Manger.

The organisation will publish the interests declared by decision making staff at bands 8D (or equivalent) and above in the Register of Directors' Interests or the Register of Staff Interests. In addition, those interests declared by staff at lower bands who have given their consent for publication will also be published. This information will be refreshed annually and will be available on the 'key corporate documents' page of the organisation's website

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Head of Governance to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information

may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

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
Decision Making Staff Annual Returns	Compliance reports from ESR system	Head of Governance	Six-monthly	Audit Committee	Audit Committee

14.2 Standards/Key Performance Indicators (KPIs)

100% of Decision Making Staff must make either an declaration of interest or nil return annually on the ESR system

15. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been conducted on this policy. A copy is available on request from rgh-tr.edi@nhs.net

Board of Directors' Meeting
9 September 2022

The Rotherham NHS Foundation Trust

Agenda item	P148/22
Report	**Register of Interest Report: Bi-Annual Review**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with the full Board Assurance Framework
How does this paper support Trust Values	Good governance underpins all Trust values and supports delivery of them
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	In accordance with Section 20(1)(d), Schedule 7, National Health Service Act 2006 (as amended), the Trust, as a public benefit corporation is required to maintain a Register of Interests of Directors (including a nil return) that is available to the public. The Board will note that no new declarations of interest have been made since the last report. Sally Kilgariff has replaced George Briggs as Chief Operating Officer and Jodie Roberts has been added as the new Director of Operations, Future reports will be drawn from the Electronic Staff Register Conflicts of Interest module as part of the move to record the declarations of interests of all staff on one electronic system.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Compliance relating to the Standards of Business Conduct, including declarations of interest continues to be reported to the Audit Committee.
Board powers to make this decision	Standing Orders Section 7 – Declarations of Interest
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Register of Interests is published on the Trust's public facing website and a copy provided to our External Auditors as part of the annual audit requirements.
Recommendations	It is recommended that the Board of Directors note for information the Register of Interest and receive assurance in relation to compliance with Section 20(1)(d), Schedule 7 National Health Service Act 2006 (as amended).
Appendices	1. Register of Interest

The Rotherham NHS Foundation Trust

Register of Interests of the Board of Directors – July 2022

Non-Executive Directors	
Name	**Interests Declared**
Martin Havenhand Chairman	▪ Niece is Associate Operations Director of One Health ▪ Member of Rotherham Together Partnership Board ▪ Chair of Ambition Rotherham Board of Directors ▪ Director of Corporate Trustee
Alphabetical order	
Nicola Bancroft	▪ Business in the Community Member of Finance and Risk Committee ▪ Sister employed by Sheffield Teaching Hospitals NHS Foundation Trust ▪ Director of Corporate Trustee
Joanna Bibby	▪ Director of Health, Health Foundation ▪ Trustee, Centre for Homeless Impact ▪ Director, Business for Health Community Interest Company ▪ Director of Corporate Trustee
Heather Craven	▪ No general interests to declare ▪ Director of Corporate Trustee
Lynn Hagger	▪ Company Secretary, Suburbaret Ltd ▪ Director of Corporate Trustee
Kamran Malik,	▪ No general interests to declare ▪ Director of Corporate Trustee
Dr Rumit Shah	▪ Principal GP in Hatfield, Doncaster ▪ Local Medical Committee Chair, Doncaster ▪ Managing Director Beckingham Medical Services Ltd ▪ Director of Corporate Trustee
Michael John Smith	▪ Non-Executive Director Humber Teaching NHS Foundation Trust ▪ Associate Hospital Manager (under S.23 of Mental Health Act 1983): o Rotherham Doncaster and South Humber NHS Foundation Trust o John Munroe Hospital Group ▪ Owner/Director MJS Business Consultancy Ltd ▪ Trustee, The Rotherham Minster Development Trust ▪ Director/Trustee Magna Science Adventure Centre ▪ Director/Trustee Magna Enterprises Ltd ▪ Director of Corporate Trustee

Executive Directors	
Dr Richard Jenkins, Interim Chief Executive	▪ Chief Executive at Barnsley Hospital NHS Foundation Trust ▪ Director of Corporate Trustee Barnsley Hospital NHS Foundation Trust ▪ Executive Reviewer (Well-led Reviews) for the Care Quality Commission ▪ Fellow of The Royal College of Physicians ▪ Member of the British Humanist Association ▪ Wife employed as a Nurse at York Teaching Hospital NHS Foundation Trust ▪ Director of Corporate Trustee
Alphabetical order	
Helen Dobson, Chief Nurse	▪ Husband is employed at Sheffield Children's NHS Foundation Trust ▪ Director of Corporate Trustee
Dr Callum Gardner, Executive Medical Director	▪ Owner & Director of Innovative Medicine Ltd ▪ Director of Corporate Trustee
Steven Hackett, Director of Finance	▪ No general interests to declare ▪ Director of Corporate Trustee
Sally Kilgariff, Chief Operating Officer	▪ Sister is Group Finance Director at Marks and Spencer ▪ Director of Corporate Trustee
Steven Ned, Director of Workforce	▪ Director of Steven Ned Ltd ▪ Workforce Director at Barnsley NHS Foundation Trust ▪ Director of Corporate Trustee ▪ Niece is a Nurse at The Rotherham NHS Foundation Trust ▪ Trustee of St. Luke's Hospice, Sheffield
Michael Wright, Deputy Chief Executive	▪ No general interests to declare ▪ Director of Corporate Trustee
Non-voting Members	
Angela Wendzicha, Director of Corporate Affairs	▪ No general interests to declare
Ian Hinitt, Directors of Estates and Facilities	▪ Trustee, Director and immediate past President of The Institute of Healthcare Engineering and Estates Management (IHEEM)
James Rawlinson, Director of Health Informatics	▪ Elected member of a UK-wide Chief Information Officer (CIO) Advisory Panel
Jodie Roberts, Director of Operations	▪ No general interests to declare
Louise Tuckett, Director of Strategy, Planning & Performance	▪ Husband is Director of Strategy and Planning at Sheffield Teaching Hospitals NHS Foundation Trust (effective April 2022).
	▪