The Rotherham NHS Foundation Trust

Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 3 November 2023, 9:00 AM — 12:00 PM GMT
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P149/23.	Chairman's welcome and apologies for absence For Information - Presented by Kamran Malik
	P150/23.	Quoracy Check For Assurance - Presented by Kamran Malik
	P151/23.	Declaration of interest For Assurance - Presented by Kamran Malik
	P152/23.	Minutes of the previous meeting held on 08 September 2023 For Decision - Presented by Kamran Malik
	P153/23.	Matters arising from the previous minutes For Assurance
	P154/23.	Action Log For Assurance - Presented by Kamran Malik
9:05 AM	CULTURE	
	P155/23.	Patient Story Presented by Helen Dobson

	P156/23.	Yusuf Nazir Report and Action Plan For Assurance - Presented by Michael Wright
9:25 AM	OVERVIEW AND CONTEXT	
	P157/23.	Report from the Chairman - Verbal For Information - Presented by Kamran Malik
	P158/23.	Report from the Chief Executive For Information - Presented by Richard Jenkins
	P159/23.	Board Assurance Framework For Decision - Presented by Angela Wendzicha
	P160/23.	Corporate Risk Register For Decision - Presented by Angela Wendzicha

P161/23. Board Committees Chairs Reports - Committee Chairs and Lead Executives -

i. Finance & Performance Committee - Chair's Log

ii. Quality Committee - Chair's Log

* Learning from Deaths : Quarterly Report - Jo Beahan presenting

iii. People Committee - Chair's Log

* WRES Annual Report & Action Plan - Daniel Hartley presenting
* WDES Annual Report & Action Plan - Daniel Hartley presenting
* Guardian of Safe Working Quarterly Report - Dr Gerry Lynch presenting
* NHSE Self Assessment - Jo Beahan

iv. Audit & Risk Committee - Chair's Log

* Register of Interests - Angela Wendzicha presenting
* Standing Financial Instructions - Steve Hackett presenting

10:10 AM STRATEGY & PLANNING

P162/23. TRFT Five Year Strategy Six Month Review
For Assurance - Presented by Michael Wright

P163/23. Operational Plan - Six Month Review
For Assurance - Presented by Michael Wright

P164/23. Winter Plan
For Approval - Presented by Sally Kilgariff

10:40 AM SYSTEM WORKING

	P165/23.	SYB ICS and ICP Report For Information - Presented by Michael Wright
	P166/23.	Partnership Working For Information - Presented by Michael Wright
11:10 AM	ASSURANCE	
	P167/23.	Integrated Performance Report For Assurance - Presented by Michael Wright
	P168/23.	Operational Performance Update For Assurance - Presented by Sally Kilgariff
	BREAK	
	P169/23.	Quality Assurance Report For Assurance - Presented by Helen Dobson
	P170/23.	Maternity and Neonatal Safety Report For Assurance - Presented by Helen Dobson
	P171/23.	Finance Report For Assurance - Presented by Steve Hackett
11:50 AM	GOVERNANCE	
	P172/23.	Fit and Proper Person Report - deferred For Assurance - Presented by Angela Wendzicha
	P173/23.	Review of Annual Board Planner For Assurance
	P174/23.	Any Other Business

P175/23. Board Feedback
Presented by Michael Wright

P176/23. Date of next meeting - 5 January 2024

Board held in Public : Action Log								
Log No	Meeting	Report/ Agenda Title	Minute Ref	Agenda item and Action	Lead Officer	Timescale	Comment/ Feedback from the Lead Officer	Open/Close
2	06/10/2023	Governance	2	Governance - Production of a one page guide for new assurance narrative	AW	Dec-23	Process in draft with Assurance Committees in October and will be finalised for November Committee cycle	Open

Open
Recommend to Close
Complete

Public Board of Directors' Meeting

The Rotherham NHS Foundation Trust

Agenda item	P156/23
Report	**Independent Investigation into the Care and Treatment of Yusuf Nazir**
Executive Lead	Dr Jo Beahan, Medical Director and Michael Wright, Deputy Chief Executive
Link with the BAF	**P1; U4**
How does this paper support Trust Values	**Together** – demonstrates that the Trust strives to ensure that quality improvement and the learning from incidents is achieved through a multidisciplinary approach.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	Yusuf was a 5 year old boy who sadly died of respiratory failure on 23rd November in Sheffield Children's NHS Foundation Trust. Following his death, Yusuf's family raised a number of concerns about the care he was provided at The Rotherham NHS Foundation Trust and other NHS providers and an independent investigation was commissioned by NHS South Yorkshire ICB into the care provided by each of the organisations . The investigation was conducted by Niche Health and Social Care Consulting. The Abridged report was publicly released on the 5th October 2023. The report is appended to this paper (see appendix 1). In summary, the report has found that if an admission was necessary at the time of his presentation to The Rotherham NHS Foundation Trust a bed would have been found. The Trusts response to the incident was prompt and its processes were well managed. The report makes recommendations which, while they would not have changed the course of events for Yusuf, should be implemented to ensure there is learning from the case. A meeting was held with Yusuf's mother and uncle with Dr Richard Jenkins, Chief Executive, Dr Jo Beahan, Medical Director and Cindy Storer, Deputy Chief Nurse, on 26th October to discuss the report and the actions being undertaken by the Trust. The recommendation for the Trust and related actions taken or in progress are included with the Trust's Assurance Statement (appendix 2). The actions and ongoing progress will be monitored by the Deputy Chief Executive. Updates will be provided to the Quality Committee.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The abridged report produced by Niche Health and Social Care Consulting has been shared with the Trust Board previously.
Board powers to make this decision	Agreement that the proposed actions are appropriate.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Medical Director will continue to keep the Board appraised of the position.
Recommendations	It is recommended that the Board note and discuss.
Appendices	Appendix 1 Abridged Final Report Appendix 2 The Trust's Assurance Statement

An Independent Investigation into the care and treatment of Yusuf Nazir

Summary findings

The following paragraphs are extracted from the investigation report produced by Niche Health and Social Care Consulting.

Yusuf was a five-year-old boy who died of respiratory failure. The medical cause of death certificate states: 1a) type 1 respiratory failure; 1b) pneumonia; 2) tonsillitis.

This was secondary to an unusually severe inflammatory response which occurred at the end of a 10-day long illness. The illness initially had the features of a fairly benign childhood infection, but it did not respond to the usual treatments of upper and lower respiratory tract conditions. Primary and secondary care reviews were appropriate, with a timely admission to Sheffield Children's Hospital and subsequent extensive investigations and therapeutic attempts. However, these did not stop the progress of the disease. A post-mortem may have helped refine an understanding of Yusuf's underlying pathology, but no post-mortem was carried out.

With hindsight, Yusuf's presentation was not typical of tonsillitis, streptococcal sepsis, asthma or simple community acquired pneumonia. Children do sometimes present atypically and so we have looked critically at his clinical pathway and at whether there were any missed opportunities to stop the course of his disease.

Our investigation shows that if it been considered necessary to admit Yusuf on 15 November, based on his presentation and the observations made, a bed would have been found. On the night of 15 November admissions were being made into the unit despite the UECC, children's assessment unit and ward being very busy.

We have been asked to comment on the actions taken immediately after the incident. We have defined the incident as meaning the complaint made by the family (on 21 November) to Rotherham Hospital sharing their concerns about the failure to admit Yusuf. The Trust responded promptly to this complaint. Details of the complaint procedures were sent to Yusuf's uncle after his initial approach, all interactions were appropriately recorded, as was the wish for the chief executive officer to be made aware of the complaint. The complaint was reviewed by the Incident Review Panel on Friday 25 November. By Monday 28 November the chief executive officer had determined that this case would be declared a serious incident requiring investigation. A 72-hour report was completed, and a serious incident form was logged on 29 November. The chief executive officer met with Yusuf's family on 30 November to apologise. Appropriate duty of candour processes were followed, and his family were informed on 2 December that an independent investigation would be commissioned. The Trust's response was prompt and its processes were well managed.

Investigation Report publication

The NICHE report was published on Thursday 5th October. Communications were disseminated to the Trust's stakeholders, Trust Board, Governors and colleagues. Members of the Executive Team supported staff and teams directly involved in the care of Yusuf. Media briefings were held and opportunities were given for interviews.

A meeting was held with Yusuf's mother and uncle with Dr Richard Jenkins, Chief Executive, Dr Jo Beahan, Medical Director and Cindy Storer, Deputy Chief Nurse, on 26th October to discuss the report and the actions being undertaken by the Trust.

Next Steps

1. The Deputy Chief Executive will work with colleagues to take forward the recommendations. Updates on the associated actions will be tracked through the Quality Committee.
2. Oversight of the implementation of the actions for system partners will be co-ordinated by the ICB.

Dr J Beahan, Medical Director
Michael Wright, Deputy Chief Executive
November 2023

An independent investigation into the care and treatment of Yusuf

York Road Surgery
Yorkshire Ambulance Service NHS Trust
The Rotherham NHS Foundation Trust
Sheffield Children's NHS Foundation Trust

September 2023

FINAL ABRIDGED REPORT (PUBLICATION)

Report Advisory Notice

This report deals with difficult subjects relating to care and treatment of a child. We have made efforts to write our report in a way which is not overly descriptive and limits the use of third-party and non-relevant personal information. However, there are instances where information is necessary, for example, where an opinion has been quoted or a specific act has been documented and this is relevant to the case. We do advise caution in those who may be triggered by reading information which might be sometimes distressing, particularly, that they are helped to read this report in a safe and supported way.

FINAL ABRIDGED REPORT (PUBLICATION)

Final Abridged Report: September 2023

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting healthcare providers with all issues of safety, governance, and quality, including undertaking independent investigations following very serious incidents.

Our Final Report has been written in line with the terms of reference as agreed with NHS England dated 24 January 2023. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This is a confidential report and is for the sole attention of the project sponsor. No other party may place any reliability whatsoever on this report as this report has not been written for their contractual purposes. This report does not contain any legally binding opinion and further advice might be required to establish a legal basis.

This report was commissioned by South Yorkshire Integrated Care Board (supported by NHS England North East and Yorkshire) and cannot be used or published without their permission. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final version of this report should be regarded as definitive.

Niche Health and Social Care Consulting Ltd
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Telephone: 0161 785 1000
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

FINAL ABRIDGED REPORT (PUBLICATION)

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FINAL ABRIDGED REPORT (PUBLICATION)

Part 1 – Summary

Background

1.1 On Wednesday 23 November 2022 Yusuf died at Sheffield Children's Hospital. He had been transferred there from home by Yorkshire Ambulance Service on 18 November.

1.2 On Saturday 12 November 2022 Yusuf developed a temperature during the night and by the morning of Sunday 13 November he was feeling generally unwell. On the evening of Monday 14 November Yusuf began to complain of a sore throat. He was unable to swallow solids and was only drinking sips of water. On Wednesday 23 November 2022 Yusuf died at Sheffield Children's Hospital. He had been transferred there from home by Yorkshire Ambulance Service on 18 November. His mother had taken him to his GP practice on Tuesday 15 November, he was complaining of a sore throat and was prescribed antibiotics by an advanced nurse practitioner. His parents took him to Rotherham Hospital Urgent & Emergency Care Centre (UECC) later that evening. Yusuf was there for six hours and was seen in the early hours of the morning when he was discharged with a diagnosis of severe tonsillitis and an extended prescription of antibiotics. He remained unwell at home over the next two days, developing further breathing and swallowing difficulties and was seen by his GP on the morning of Friday 18 November. Additional antibiotics were prescribed to cover a possible chest infection. Shortly after this his family became so concerned they called an ambulance. Yusuf was taken directly to Sheffield Children's Hospital at the request of his family where he was triaged immediately. After eight hours he was admitted to Ward 4. On Monday 21 November Yusuf's clinical indicators deteriorated markedly and he was admitted to and subsequently intubated on the paediatric intensive care unit (PICU). Despite a wide range of treatments, Yusuf developed multi-organ failure and suffered several cardiac arrests which he did not survive.

1.3 On 21 November Yusuf's uncle made a complaint to The Rotherham NHS Foundation Trust stating that the family believed Yusuf should have been admitted to the hospital earlier in the week and that his deterioration could have been prevented had he been admitted into the children's ward and given intravenous (IV) antibiotics.

1.4 Following a meeting with the family, on 2 December the Trust converted the complaint into a serious incident requiring investigation and South Yorkshire Integrated Care Board commissioned an external independent investigation into the care and treatment that had been given.

Approach to investigation

1.4 The terms of reference for this investigation are set out in Appendix 1. The investigation was led by a partner and director from Niche Consulting and the panel included clinical expertise from a consultant paediatrician with experience in emergency paediatric care, a GP who is a senior partner and primary care board member on an integrated care board, and a consultant paramedic in emergency care. None of the team members had conflicts in this case and all are independent of the services under review.

1.5 The parties involved in the investigation are:

- York Road Surgery (Yusuf's primary care provider)
- Yorkshire Ambulance Service NHS Trust
- The Rotherham NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust

1.6 We requested full and unredacted clinical records, including all blood test results, for Yusuf from his medical history in primary care, prior relevant medical interventions at Rotherham and all records

from 15 to 23 November 2022. We requested incident reports, investigation reports, relevant policies and procedures from all parties.

1.7 We interviewed two primary care staff, six staff from Rotherham Hospital (paediatric UECC and the children's ward) and four PICU consultants from Sheffield Children's Hospital.

1.8 We conducted a site visit on 10 March 2023 at Rotherham Hospital where we saw the UECC and its layout and visited the children's assessment unit and the children's ward. During this site visit we spoke with the security manager who showed us the CCTV footage of the UECC for the night of 15 November. We also met with the deputy divisional lead, staff on the children's ward and staff in the UECC. This gave us the opportunity to view facilities and talk with a wider range of staff about how services are expected to work. The full CCTV footage was provided to us on 17 April 2023. We would like to thank all staff who met with us and provided information.

1.9 We met with Yusuf's family on 13 January 2023 and again on 10 March. They were accompanied by a representative partner from Bindmans legal services. The family provided a chronology of events on 7 March 2023 with photographs and videos of Yusuf's presentation from 15 to 21 November 2022.

1.10 We offer our sincere condolences to his family and thank them for their time and insights.

1.11 A key theme of this case is the experience of Yusuf's family as they sought help from four different NHS services for Yusuf. They have been diligent in describing to us how this felt at each interaction and have provided their perspective on events. We recognise their distress and we do not wish to diminish how this must have felt for them at the time and since in our findings. How his family felt they were treated and spoken with is very real and is an important reflection for everyone involved in this very sad situation. We hope our recommendations in relation to listening to and engaging with worried parents will be addressed by all organisations involved.

Summary findings

1.12 Yusuf was a five-year-old boy who died of respiratory failure. The medical cause of death certificate states: 1a) type 1 respiratory failure; 1b) pneumonia; 2) tonsillitis.

1.13 This was secondary to an unusually severe inflammatory response which occurred at the end of a 10-day long illness. The illness initially had the features of a fairly benign childhood infection, but it did not respond to the usual treatments of upper and lower respiratory tract conditions. Primary and secondary care reviews were appropriate, with a timely admission to Sheffield Children's Hospital and subsequent extensive investigations and therapeutic attempts. However, these did not stop the progress of his illness. The initial observations and blood test results did not suggest serious disease. Yusuf was appropriately treated for possible sepsis, multiple causes of potential pneumonia,[1] asthma and tonsillitis, but the response to all therapies tried was minimal and short-lived. No causative organism has been found on any microbiology, virology or fungal tests. A diagnosis of Lemierre's syndrome[2] would have linked the initial tonsillitis with a later pneumonia, but

[1] Pneumonia is generally defined as an infection that affects one or both lungs. It is a severe inflammation of the lungs in which the alveoli (tiny air sacs) are filled with fluid. This may decrease the amount of oxygen that the blood can absorb from the air breathed into the lung.

[2] Lemierre's syndrome is a severe condition characterised by thrombophlebitis of the internal jugular vein and bacteraemia caused by primarily anaerobic organisms, following a recent oropharyngeal infection. It is a rare and potentially severe complication of bacterial infections that usually affects previously healthy adolescents. It most commonly develops in association with a bacterial throat infection (sometimes in association with the Epstein-Barr virus. The bacteria responsible is usually Fusobacterium necrophorum but other bacteria can be responsible. The initial infection spreads into tissues and deep spaces within the neck, leading to the formation of an infected blood clot (septic thrombophlebitis) in the internal jugular vein. This then circulates into the blood resulting in an infection spreading most commonly to the lungs and other parts of the body e.g. heart and kidneys. This can lead to severe complications such as respiratory distress syndrome due to pulmonary emboli, damage to other organs and/or septic shock (about seven per cent of cases). It can be diagnosed on the basis of signs and symptoms, various blood tests and imaging studies. The mainstay of treatment is antibiotic therapy. A beta-lactamase resistant beta-lactam antibiotic is recommended as an empiric therapy because there have been case reports of treatment failures with penicillin secondary to beta-lactamase producing Fusobacterium necrophorum. Metronidazole, clindamycin and a carbapenem antibiotic (meropenem) were all prescribed

investigations for this did not confirm the diagnosis. A post-mortem may have helped refine an understanding of Yusuf's underlying pathology, but no post-mortem was carried out.

1.14 With hindsight, Yusuf's presentation was not typical of tonsillitis, streptococcal sepsis, asthma or simple community acquired pneumonia. Children do sometimes present atypically and so we have looked critically at his clinical pathway and at whether there were any missed opportunities to stop the course of his disease.

1.15 Yusuf's family is also concerned that a lack of beds at Rotherham Hospital was the reason he was not admitted for IV antibiotics when he visited the UECC on 15 November. They have asked whether he might have survived if he had received IV antibiotics at that time and they are interested in the link between tonsillitis and pneumonia, both of which appear on his death certificate.

1.16 Our investigation shows that if it been considered necessary to admit Yusuf on 15 November, based on his presentation and the clinical observations made, a bed would have been found. We visited the children's ward and interviewed staff and it is clear there are both physical space and procedures in place to admit a child when needed. The commissioned bed numbers are 22 (10 on the assessment unit and 12 on the children's ward). Appendix 2 shows the bed capacity figures for the children's assessment unit (CAU) and the children's ward for 15-18 November. There is an expectation that bed capacity will be flexed[3] beyond this if there is a clinical need because the physical space is available. Should there be capacity problems the escalation flow chart in "*the timely transfer for acute medical patients under the age of 16*" references diverting patients in consultation with the executive team. On the night of 15 November admissions were being made into the unit despite the UECC, children's assessment unit and ward being very busy. Between the hours of 1am and 5am on 16 November, between 17 and 19 bed spaces were occupied on the CAU and the children's ward.

1.17 We explore the link between Yusuf's tonsillitis and his subsequent respiratory failure in detail in this report. Without a post-mortem it is not possible to be conclusive; however, it is evident that Yusuf experienced a highly unusual inflammatory response and the antibiotics and other treatments[4] had no impact. The trajectory of his presentation could not have been predicted and the sudden deterioration in his clinical indicators on 21 November was unexpected. He did not respond to oral antibiotics from 15 to 18 November or IV antibiotics from 18 to 21 November or in the days that

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to Yusuf – metronidazole was the most effective. It is usually required for one to two weeks parenterally (IV) then a further 10 days orally.
Arane, K and Goldman, R (2016) Fusobacterium Infections in Children

[3] The timely transfer for acute medical patients under the age of 16 from UECC Standard Operating Procedure states: *Once the decision to admit has been made and contact is made with the Children's Ward staff by the Paediatric Nurse in Charge in UECC, then the patient should be admitted within 30 minutes of this referral. If due to capacity, there will be challenges in relation to accepting or transferring this admission within 30 minutes of the referral, then this needs to be raised with a planned time frame by which the child can be moved to the ward, including exploring what additional support can be sourced (e.g. Children's ward supporting by collecting the patient if acuity allows). It is essential that both areas take into consideration the acuity and activity in each area ensuring that the safety of the patients for transfer and the safety of patients in other paediatric areas within the Trust are taken into consideration.*
If the ward and CAU are full but there are planned discharges, then the patient must be transferred and the Children's Ward and CAU will need to flex over the defined bed capacity for a short period of time to allow the transfer to take place. This may need some additional nursing resource to support this which can be sought through the Nurse in Charge (NIC), Ward Manager or Matron. If there are no planned discharges and the children's ward or CAU is full then the paediatric registrar needs to be informed and the on-call Consultant will need to be contacted.
If there is high activity or acuity in the Paediatric UECC department or there is a child or young person in the resuscitation area, then support may be required to transfer these patients to the Children's Ward or CAU. This will need to be managed alongside the activity on CAU, the Children's Ward, SCBU, and maternity services. Should there be any delay in this support this needs to be raised as soon as the challenges are identified.
Should there be any challenges following this procedure then the escalation flow chart must be followed ensuring that clear communication is maintained at all-time[s] along with professional courtesy and respectful behaviour. Any delay must be clearly communicated between both areas and the child, young person and family updated on any delay in transfer. Update the site management team so they are aware of any delays from a decision to admit perspective.

[4] Oxygen, anti-viral, anti-inflammatory and anti-fungal medications alongside drugs and nebulisers for asthma and to ease work of breathing e.g. dexamethasone, aminophylline, salbutamol.

followed. After Yusuf's death, the PICU team considered a range of possible causes, but they have all been inconclusive because of conflicting clinical indicators. Whilst on intensive care there were investigations that could not be conducted because of the urgency of the situation, for example, a computerised tomography (CT) scan, a bronchoscopy and biopsy of the lungs, pernasal swab for pertussis (whooping cough), more specific tests for rarer infections and a bone marrow biopsy. These are investigations the PICU team would have wished to conduct had it been possible.

1.18 To consider whether Yusuf had a chest infection that had spread from his tonsillitis a definition of the term 'pneumonia' as used in this case is important. In lay terms it can be seen as a chest infection. However, in this case while the term was appropriately used in discussions with his family, and early indications were that he might have had a chest infection, it was likely that this was not the only factor in this case.

1.19 Pneumonia is generally defined as an infection that affects one or both lungs. It is a severe inflammation of the lungs in which the alveoli (tiny air sacs) are filled with fluid. This may decrease the amount of oxygen that blood can absorb from the air breathed into the lung. In the absence of bacteria having been collected from the lung either by bronchoscopy or in sputum, it is a clinical diagnosis based on the chest X-ray appearances, blood test results and – with hindsight – the response to antibiotics. Yusuf's chest X-ray was consistent with him having pneumonia but the blood tests and lack of response to antibiotics call the diagnosis into question (in terms of an infective cause). Inflammation within the lungs can look like pneumonia on a chest X-ray. Persistent pulmonary infiltrate results when a substance denser than air (e.g. pus, oedema, blood, surfactant, protein or cells) lingers in the lung parenchyma.[5] The leukemoid reaction[6] on 22 November was probably responsible for the chest X-ray findings; his lungs were probably full of white blood cells. The intensivists[7] at Sheffield mentioned "*hepatisation*" of the lung where the organ begins to stiffen. This is seen in a severe inflammatory response, usually secondary to an infection. There is no good evidence that he had a primarily infective type of pneumonia, and he was on treatment for a range of possible bacterial, viral and fungal causes. A post-mortem may have helped refine an understanding further.

1.20 The term sepsis was frequently referred to in the clinical assessments and investigations completed throughout Yusuf's care. Sepsis is an important consideration to keep under constant clinical review. However, there was no evidence of sepsis. Clinical signs that were consistent with sepsis were present when the ambulance crew took him to Sheffield Children's Hospital, but they were not specific and further assessment at Sheffield Children's Hospital and his fairly unremarkable, initial blood tests do not support a diagnosis of sepsis. He was shocked[8] (had an inability to carry sufficient oxygen to the tissues and remove waste from them) towards the end of his life and this was secondary to the severe inflammatory reaction, but it was not necessarily infective.

1.21 We had the benefit of hindsight when reviewing Yusuf's blood results and his presentation in detail. While providing a posthumous diagnosis is not part of the scope or purpose of this investigation, we have considered a range of possible clinical presentations including underlying malignancy (e.g. early leukaemia) and early onset Type 1 diabetes. The available blood results were also shared with an independent haematologist, which meant a wide range of early presenting underlying malignant conditions could be discounted.

1.22 A wide range of non-malignant related conditions involving throat infections were also considered by the investigation and the PICU team and were either discounted as explanations for his presentation or could not be confirmed. These included glandular fever (from the Epstein-Barr (EBV) virus or the cytomegalovirus (CMV)), pertussis (whooping cough), epiglottitis (brought on by

[5] The functional tissues of an organ as distinguished from the connective and supporting tissue.
[6] An increase in the white blood cell count, which can mimic leukaemia.
[7] Intensivists are also known as critical care doctors.
[8] National Center for Biotechnology Information (updated July 25, 2022) National Library of Medicine. StatPearls – Shock

haemophilus influenzae type B or group A streptococcus), an invasive fungal infection, diphtheria and Lemierre's syndrome.

1.23 It is important to note that Yusuf's mother was experienced in the management of his asthma and his repeated respiratory infections, and she said on multiple occasions in UECC and subsequently that she was very concerned about him (and she was supported by her brother in this). An admission to the children's ward at Rotherham Hospital, which, while not clinically indicated, could have been given more consideration and could have been discussed with his family given their concerns. We are of the view that when a parent or relative of a child expresses such concern and distress in the presentation of their sick child, the parental experience should be considered formally. This is a key point of learning for the future assessment of sick children and is included in our national recommendations.

1.24 We have been asked to comment on the actions taken immediately after the incident. We have defined the incident as meaning the complaint made by the family (on 21 November) to Rotherham Hospital sharing their concerns about the failure to admit Yusuf. The Trust responded promptly to this complaint. Details of the complaint procedures were sent to Yusuf's uncle after his initial approach, all interactions were appropriately recorded, as was the wish for the chief executive officer to be made aware of the complaint. The complaint was reviewed by the Incident Review Panel on Friday 25 November. By Monday 28 November the chief executive officer had determined that this case would be declared a serious incident requiring investigation. A 72-hour report was completed, and a serious incident form was logged on 29 November. The chief executive officer met with Yusuf's family on 30 November to apologise. Appropriate duty of candour processes were followed, and his family were informed on 2 December that an independent investigation would be commissioned. The Trust's response was prompt and its processes were well managed.

1.25 The Trust completed the initial 72-hour review and, on the basis of this case, they have begun the recruitment of additional medical staffing for the UECC.

1.26 We have made additional recommendations which, while they would not have changed the course of events for Yusuf, should be implemented to ensure there is learning from this case.

Recommendations

National recommendation:

Recommendation 1: At times there was conflict between relatives, paramedic teams and hospital staff while Yusuf's family attempted to access urgent care.

National research should be commissioned to look into why and when parents raise concerns about their children's acute presentation to health services. There is a need for the development of a mechanism which will objectively measure this, enable empowerment for parents without conflict and be embedded into a system of escalation which enables the safest response. This could build upon the parental concerns work being undertaken by the Great North Children's Hospital (Newcastle Upon Tyne NHS Foundation Trust) and other national and international initiatives. An approach by the SPOT programme to the National Institute for Health and Care Research (NIHR) might help facilitate research funding.

Recommendation 2: Different paediatric observation tools (for example, the Paediatric Observation Priority Score (POPS) and Paediatric Early Warning System (PEWS)) were used by different providers across the care pathway.

We are aware of the efforts of NHS England, the Royal College of Nursing and the Royal College of Paediatrics and Child Health (RCPCH)[9] to agree a national PEWS system[10] through the System-wide Paediatric Observations Tracking (SPOT) programme, We understand there are plans to launch this for paediatric inpatients this year. We would recommend that all Trusts are encouraged to use the national version[11] on its launch and that work continues to align POPS (in use in emergency departments) with the new PEWS tool[12].

Recommendation 3: Parents and relatives raised repeated concerns over time and across providers that his presentation was not his usual self. They took videos and pictures to document his presentation in an attempt to demonstrate their concerns. The history of concerns over the preceding week prior to admission was not clearly apparent in shared records across the system and relied on parents to repeatedly raise them.

- On assessment of the sick child the collation of observations across different providers and locations needs to recognise the history of parental concerns/multiple presentations to different services and inform decision making when determining the need for escalation.
- The SPOT programme should look at ways of embedding patterns of consistent or repeated concerns from parents (and clinicians) into future strategies for assessing the escalation requirements of a sick child.

[9] Paediatric Early Warning System (PEWS) - developing a standardised system for England | RCPCH
[10] https://www.rcpch.ac.uk/resources/paediatric-early-warning-system-pewsystem-developing-standardised-tool-england
[11] There is a paper based version intended for launch in September 2023 (delayed from 23 May 2023) with the digital specification currently being consulted on later in 2023.
[12] We are also aware that work is being conducted at pace to extend the PEWS tool into the emergency department setting. This will be extended into primary care thereafter. This is managed under the SPOT programme.

Primary care recommendations

Recommendation 1: Primary care communication
Yusuf's mother was expecting to see a GP and not a primary care nurse practitioner when she made an appointment for Yusuf.
Patients who make appointments with their GP surgery should be told which healthcare professional they (or their family member) will be seeing, including their name and position.

Recommendation 2: Primary care assessment
The assessments in primary care could have been more comprehensive (although there was no evidence this impacted the outcome).
a. All primary care clinicians who are assessing sick children should have training specific to that assessment, for example, Spotting the Sick Child
b. When assessing sick children, clinicians should be aware of available local and national guidelines, for example:
NICE Guidance: Feverish Children – Risk Assessment
NICE Risk Stratification Tool for Children Under 5 years or UK Sepsis Trust GP Paediatric Sepsis Decision Support Tool for Children Under 5 years
NICE Risk Stratification Tool for Children Aged 5–11 Years or UK Sepsis Trust GP Paediatric Sepsis Decision Support Tool for Children Aged 5–11 Years

Recommendation 3: Primary care equipment
A functional paediatric pulse oximeter[13] was not used when Yusuf attended the GP surgery for his appointment.
All practices should have access to age-appropriate equipment, including pulse oximeters, so clinicians can accurately assess sick children when they present.

Recommendation 4: Onward referral from primary care
There was a lack of clarity in primary care about accessing the opinion of paediatric services at Rotherham Hospital.
To avoid future ambiguity, a written protocol should be produced for the agreed pathway and criteria for referring on for further paediatric assessment from primary care. This should include: the role of the children's assessment unit and the role of the paediatric urgent care centre, how to access an urgent paediatric opinion and clarity on direct access to the children's ward.

Recommendation 5: Patient information
Staff were unaware of the website resource Healthier Together which contains information leaflets and advice (for safety netting).
- Parents should be directed to the Healthier Together website for written patient information.
- Nursing and medical staff working in primary care should be aware of this resource. Leaflets should be printed if parents do not have internet access.

[13] A pulse oximeter is a small device placed on the finger to measure heart rate and oxygen saturations. Paediatric pulse oximeters are smaller than those used for adults.

Yorkshire Ambulance Service NHS Trust recommendations

Recommendation 1: Conflict resolution and listening to family members
Protocols were appropriately considered in transporting Yusuf to Rotherham Hospital, but there were difficult conversations between Yorkshire Ambulance Service staff and the distressed parents as they sought help from the paramedics for their son who was unwell. This added a slight delay to the transfer.

- All clinical teams are to be required to attend the regular conflict resolution training sessions provided by the Trust to support the management of conflict in patient care.
- The training should be extended to include having difficult conversations, working with worried parents and cultural differences in conflict.
- This case should be included as a case study as part of the face-to-face training provided.

Recommendation 2: Clinical assessment
While they did not affect the prompt access to care, the clinical examinations and physiological observations carried out by the paramedics did not fully comply with local or national guidelines.
Essential examinations and physiological observations must be completed and documented in the clinical records in line with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. These must include heart rate, capillary refill time, respiratory examination (including the work of breathing (WOB)[14] and auscultation[15]) and the hydration status for children who present as unwell.

Recommendation 3: Administration of oxygen guidelines
The administration of oxygen was not in line with national guidance although there was evidence that the amount given did have a positive effect on the patient's condition.
For children who have been assessed as hypoxic, oxygen must be administered in line with JRCALC guidelines.

Recommendation 4: Transport protocols
Given the clinical findings, a pre-alert should have been sent to the receiving hospital, but this did not take place.
Pre-alert protocols must be adhered to so that receiving hospitals can prepare for and respond appropriately to the arrival of very sick patients.

[14] The energy expended to inhale and exhale.
[15] Listening to sounds from the heart, lungs or other organs.

The Rotherham NHS Foundation Trust recommendations

Recommendation 1: **Conflict resolution and listening to family members**
Difficult conversations took place between relatives and hospital staff as Yusuf's family attempted to access urgent care.

- All clinical teams are to be encouraged to attend simulation communication training on conflict in patient care.
- It is advised that a reminder be given to staff about responding to parent concerns (as per the amber flag in sepsis guidance). History taking and listening carefully to a concerned parent or relative should be uppermost in the minds of staff presented with a very sick child.

Recommendation 2: Recording systems and paediatric information fields
There were minor recording errors that IT solutions could solve. Namely that the ST6 doctor was still being recorded as a foundation doctor, the child's height was pulled through from SystmOne[16] and the BMI calculations used height/weight (kg), which is more appropriate for adults, when BMI centiles are more appropriate in paediatric care. Accurate weight/height and BMI centiles are essential in paediatric decision-making. The discharge letter appears to use the Early Warning Score (EWS) as the field in the EPR (when POPS is used for children).

- The Trust should examine why there remain problems with changing the grades of staff in the electronic patient record and resolve this for the ST6. They must also establish if it is a wider issue.
- SystmOne should be reviewed with paediatrics in mind. Height and weight recordings should be pulled into records accurately and BMI centiles should be used instead of the adult oriented calculations for BMI. It should also be clear whether POPS or EWS scores have been assessed.

Recommendation 3: Staffing levels in the UECC
Medical staffing levels were below expected levels on the night of 15 November.

- The Trust should assess medical and nursing staffing levels in the paediatric UECC overnight to ensure capacity meets demand. This should include the number of clinicians, their seniority and their level of paediatric experience.
- The Trust should review whether to have paediatricians in the paediatric UECC at all times who can oversee the care of children presenting with medical complaints.
- The Trust should review the feasibility of having a children's assessment unit, ideally co-located with the UECC, open 24 hours a day with medical and nursing staff trained in the care of acutely unwell children.

We understand that these recommendations have already been acted on at Rotherham; a progress report on the changes would be helpful.

Recommendation 4: Patient information
Staff were unaware of the website resource Healthier Together which contains information leaflets and advice (for safety netting).

- Parents should be directed to the Healthier Together website for written patient information.
- Nursing and medical staff working in the paediatric UECC should be aware of this resource. Leaflets should be printed if parents do not have internet access.

[16] The electronic patient record system used at The Rotherham NHS Foundation Trust

Sheffield Children's NHS Foundation Trust recommendations

Recommendation 1: Clinical care
We did not see evidence of cannula patency[17] having been documented and cannot be assured of the quality of cannulation management.
The Trust must ensure that all staff giving antibiotics intravenously check the line is unobstructed before each dose and document regular checks on peripheral IV lines when in situ (visual infusion phlebitis (VIP) score).
We noted time delays between the prescribing of drugs and their administration.
The Trust must ensure that prescribed drugs (in particular antibiotics) are given as soon as possible after prescribing decisions are made. This should be audited in the emergency department (ED), the wards and the PICU.

Recommendation 2: Post-mortems in children who die unexpectedly
Yusuf did not have a post-mortem, which has meant there was a missed opportunity to understand his underlying pathology more definitively.
- The Trust should review its criteria and decision-making in relation to undertaking hospital post-mortems for children who die unexpectedly. This should result in readily available Trust guidelines, considering the values of a multicultural population.
- Support given to clinicians facing conversations with families in difficult situations should be reviewed to ensure it is adequate, in particular the view of PICU staff should be considered.

Recommendation 3: Nutritional assessments
A nutritional risk assessment (STAMP) was not completed. The impact of pre-admission reduced nutritional intake was not assessed.
- The Trust should ensure the STAMP screening is completed accurately on admission as per Trust policy.
- The Trust should review its STAMP guidance to ensure that pre-admission nutritional status is adequately considered in scoring and care planning.

The Trust should make clear what action is expected when a high risk malnutrition score results from STAMP screening with contingencies agreed for out of hours and weekend assessments.

[17] That the line is open and not blocked. A patent IV line is one that is correctly placed, allowing the treatment to flow directly into the patient's vein. A poorly placed IV is not patent and can cause negative side effects.

Part 2 – Chronology of events

This chronology is a high level summary of Yusuf's movements and key contacts with services. Detailed information has been removed to protect confidential information. Our summary, recommendations and analysis in relation to the case can be found in full in the remainder of this report.

Early childhood

2.1 Yusuf was born in August 2017. In the first year of life Yusuf presented with several upper respiratory tract infections. By the age of 15 months Yusuf had a diagnosis of possible asthma with coughing at night. At two years and six months (February 2020) a further admission to hospital required another overnight stay in the children's ward at Rotherham Hospital. The assumption of an asthma diagnosis continued. By September 2020, when Yusuf was three years old, his asthma appeared to be getting worse and a referral was made to the paediatric asthma clinic. As of September 2022 Yusuf continued to present with wheezing symptoms to his GP practice. On 3 October 2022 Yusuf attended the asthma clinic again.

12 to 15 November 2022

Primary care at York Road Surgery

2.2 On Saturday 12 November 2022 Yusuf developed a temperature during the night and by the morning of Sunday 13 November he was feeling generally unwell. On the evening of Monday 14 November Yusuf began to complain of a sore throat.

2.3 On Tuesday 15 November his mother requested an appointment at York Road Surgery. Yusuf was assessed by an advanced nurse practitioner (at 12:36).

Rotherham General Hospital

2.4 Yusuf's mother was concerned about her son's condition. She decided to call NHS 111 for advice.[18] The call was made at 22:46:38. She was advised by NHS 111 at 23:01:42 to take him to the UECC.

2.5 Yusuf arrived at the UECC at approximately 23:15 on 15 November 2022 and he was admitted into the paediatric part of the UECC at 23:21. He was triaged (seen by a nurse for assessment) at 23:28:15. The UECC was busy that night. Yusuf was triaged within seven minutes of arriving in the paediatric UECC. However, it was just over six hours (362 minutes) before he saw a doctor.

2.6 At 01:23:16 Yusuf was transferred to a cubicle. At 01:49 Yusuf was recorded as being comfortable in the side room. Clinical professionals attended the cubicle again at 03:29.

2.7 At 05:17 Yusuf was seen by a doctor. Yusuf left the UECC at 05:35.

16 to 18 November 2022

2.8 By 18 November there had been no improvement in his condition. At 08:37 a face-to-face appointment at 11:30 was arranged by telephone call. Yusuf was seen at 11:22 by a regular locum GP. The GP determined Yusuf still had severe tonsillitis and broadened the spectrum of antibiotics by adding erythromycin 250mg/QDS.

2.9 At 12:35 his uncle made a call to the children's ward at Rotherham General Hospital. At 12:50, having been unable to secure an admission to the ward, Yusuf's family decided that he needed to go to Sheffield Children's Hospital. At 12:53 a friend advised them "*to call 999 and get [him taken] to the children's hospital*".

[18] NHS 111 is run locally by Yorkshire Ambulance Service.

Yorkshire Ambulance Service

2.10 A 999 call to Yorkshire Ambulance Service at 12:59 was made by Yusuf's mother. The call was coded as a category 1,[19] the most life-threatening category, and the call taker stayed on the line and arranged for an ambulance to attend. Six minutes and 16 seconds into the call an ambulance and paramedic crew arrived and by 13:08:48 paramedics were with Yusuf. This was within the national time target of eight minutes.

2.11 At 13:20 the administration of 2 litres (L) of oxygen was started. At 13:30 his uncle rang 999 to ask for Yusuf to be taken to Sheffield Children's Hospital rather than Rotherham Hospital. By 13:48 Yusuf was being taken into the ambulance to go to Sheffield Children's Hospital ED. The ambulance left for the hospital at 14:00.

Sheffield Children's Hospital – ED

18 November 2022

2.12 At 14:34 the ambulance arrived at Sheffield Children's Hospital ED. Yusuf was handed over immediately and triaged by the ED team. At 14:47:01 his observations were recorded. At 15:13 he was seen by a doctor in the Sheffield Children's Hospital ED.

2.13 At 16:40 Yusuf was clerked[20] by the senior house officer. He was reviewed by the ED consultant at 17:10. A chest X-ray was taken at 17:56. At 18:00 he was examined by the paediatric registrar. The chest X-ray was recorded as nothing abnormal detected (NAD) at 18:00. The formal report was provided at 12:57 on 19 November which indicated some lower airways inflammatory/infective change. At 18:30 he was cannulated, and bloods were taken.

2.14 At 19:15 IV benzylpenicillin[21] (790mg QDS[22]) was started and this was given regularly until the early hours of 21 November. At 20:25 the ENT registrar on call recommended a bacterial throat swab, increasing the dexamethasone and IV metronidazole antibiotics[23] (120mg TDS[24]) were to be added to IV benzylpenicillin. The first dose of IV metronidazole was given at 01:00 on 19 November with the IV benzylpenicillin as instructed.

2.15 At 22:27 Yusuf was admitted to Ward 4. He had spent eight hours in the ED. Appendix 4 shows staffing levels across the ED, Ward 4 and PICU from 18 to 23 November.

Sheffield Children's Hospital – Ward 4

2.16 At 23:30 Yusuf was seen by a registrar (ST8) because of stridor[25] and increased WOB. Salbutamol was not having the required effect. Stridor was not observed but he was snoring. He had good bilateral air entry to his lungs, was well perfused and did not have a wheeze. The plan was to continue treatment (IV fluids, IV antibiotics and steroids, repeat bloods/blood gases and blood glucose levels).

19 November

2.17 On the morning of 19 November he was seen at 09:00 by a junior doctor (ST3) from ENT.

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[19] A time critical life-threatening event needing immediate intervention and/or resuscitation.
[20] Clerking is the first and most important contact a medical team has with a patient and involves documentation of a clinical examination.
[21] The IV version of oral Penicillin V.
[22] 50mg/kg based on a body weight of 15.8kg.
[23] Metronidazole works on anaerobic bacteria, benzylpenicillin on aerobic bacteria. Metronidazole was added as the antibiotics for aerobic had not been effective.
[24] 7.5mg/kg body weight.
[25] Stridor breathing is noisy breathing that occurs due to obstructed airflow through a narrowed airway. Stridor breathing is not a diagnosis, but a symptom or a sign that points to a specific airway disorder. It can present as a high-pitched sound made on breathing in.

2.18 Yusuf was seen on the post-take ward round[26] at 12:15 by the on-call consultant paediatrician (diabetes team), and at that time was being given IV metronidazole, IV benzylpenicillin, dexamethasone and had been prescribed Oramorph. He had good bilateral air entry with no added sounds and did have conducted sounds.[27] His urea and electrolyte results were normal (his potassium had normalised again). His CRP, an indicator of inflammation, was noted as 40. The impression was that he was stable. The antibiotics would continue, and he was to be encouraged to drink.

20 November

2.19 On 20 November Yusuf was seen at 10:00 by an ENT registrar. He was maintaining his oxygen saturations on 4L oxygen and did not have a temperature. He had slough on both tonsils and no stridor. The antibiotics were to continue, and he was still to be given dexamethasone TDS. It was hoped his oxygen could be gradually decreased (to levels of 94-98% on air), although his saturations kept dropping on air. A glandular fever screen (for EBV and CMV) was requested as this can present with large, sloughy tonsils and would not be responsive to antibiotics.

2.20 At 12:10 a junior doctor (ST6)[28] saw Yusuf. His bacterial throat swab had come back negative. He had begun to show some mild subcostal recession.[29] The plan for his treatment was to continue his IV antibiotics and wean him off oxygen if possible. His family recall being informed that he had "*a bit of a chest infection now*".

21 November

2.21 Overnight Yusuf had continued breathing difficulties and he began to complain of pain in his abdominal area. According to his family's recollection, he was seen in the early hours of the morning of 21 November 2022 (approx. 02-03.00) by a doctor who listened to his chest.

2.22 Video from his parents shows Yusuf with breathing difficulties at 07:40 and was coughing. At 08:15 he was seen by the night doctor (ST2). A salbutamol/ipratropium nebuliser was given at 08:30.

2.23 At the ENT ward round at 09:00 Yusuf's PEWS was 4+. On examination he had grade 4[30] tonsils still with exudate, multiple raised neck lymph nodes on both sides. The ENT impression was tonsillitis, a lower respiratory tract infection and asthma. By 09:18 his PEWS score had begun to increase in a more sustained manner and was 6+ because of his increased respiratory rate and heart rate. This PEWS score increased to 7+/8+ within the hour.

Sheffield Children's Hospital – PICU

2.24 By 10.00 on 21 November Yusuf had deteriorated significantly. The impression was now of a severe acute asthma exacerbation which was life-threatening and there were concerns about partial airway obstruction, tonsillitis and a lower respiratory tract infection.

2.25 At 10:40 there was no significant improvement and the consultant on call was asked to see him. High dependency unit and consultant ENT reviews were requested.

2.26 At 11:05 a referral to the ICU was made and discussed with the PICU consultant. It was agreed that Yusuf needed ventilation. At 11:45 he was seen by the ENT consultant, the anaesthetic registrar, the PICU team and the consultant paediatrician.

2.27 At 12:00 the medical team wanted to retrieve Yusuf's Covid-19 swab for referral to virology. His throat swab was negative for bacterial infections, so this was to look for any possible viral cause of

[26] Ward round carried out by an on-call consultant to review the previous days admissions.
[27] Noises from the upper airway.
[28] Registrar in their sixth year of training.
[29] The sucking in of the abdomen below the ribs. This is another sign of WOB and it can be a result of a blocked upper airway.
[30] Tonsils are graded on a scale from 0 to 4. Zero means they have been removed up to 4 which means that they are very swollen and lead to a blockage in the airway.

his condition. ENT were also considering a 'hot'[31] tonsillectomy and a nasoendoscopy[32] or microlaryngobronchoscopy[33] to look at the upper airway. His PEWS score was 12/13.

2.28 At 13:30 Yusuf was in PICU. His chest X-ray showed a right lung consolidation.

2.29 At 17:00 his chest X-ray was reported as showing possible Lemierre's syndrome. Ceftriaxone was prescribed and a 24-hourly infusion was begun at 18:00. However, by 19:30 Yusuf had deteriorated again with resistant WOB. He was intubated at 20:00.

22 November

2.30 An ultrasound scan was taken at 11:44 on 22 November to look for cervical lymph nodes to investigate a possible diagnosis of Lemierre's syndrome. This showed results that were not consistent with thrombophlebitis[34] Lemierre's syndrome. A further chest X-ray taken at 13:10 was discussed with Yusuf's parents.

2.31 By 16:30 the PICU team were looking to further interventions including noradrenaline infusions and nitric oxide. Yusuf was in Type 1 (hypoxic) respiratory failure. A further chest X-ray was taken at 16:42 showing ongoing white out/lung collapse.

2.32 Physiotherapy notes suggest he was bleeding when being suctioned – this suggested pulmonary haemorrhage secondary to multi-organ failure and disseminated intravascular coagulation (DIC).[35] This type of bleeding can also be seen in hepatisation syndrome[36] secondary to severe pneumonia.

2.33 At 19:00 on 22 November the PICU team decided to put Yusuf in a prone position.[37] They also tried high-frequency oscillatory ventilation (HFOV).[38] He was being considered for extracorporeal membrane oxygenation (ECMO)[39] if he did not improve with HFOV. The antibiotic clindamycin[40] was added to the spectrum of existing medication. The PICU team also started treatment for potential fungal infections.

2.34 A leukemoid reaction[41] was noted at the same time. This means there was a very high WCC and it may have been an underlying malignancy that was causing this condition. A blood film was appropriately requested to rule out an underlying malignancy (diagnoses like leukaemia). However, Yusuf was recorded as being hypotensive[42] and in stage 3 of acute kidney injury (AKI).[43]

2.35 At 20:40 it was recorded that the PICU team had further discussions with microbiology and chased the blood-borne virus screen, galactomannan test (for aspergillus infections[44]), b-glucan (for invasive fungal infections) and immunoglobin (Ig) levels (for an immunodeficiency). The

[31] An emergency tonsillectomy.
[32] A procedure to look at the inside and back of the throat.
[33] A procedure to look at the larynx, trachea and bronchi (upper lungs).
[34] An inflammatory process that causes a blood clot to form.
[35] DIC is a rare but serious condition that causes abnormal blood clotting throughout the body's blood vessels. DIC may develop if there is an infection or injury that affects the body's normal blood clotting process.
[36] Hepatisation syndrome is the alteration of lung tissue into liver-like tissue.
[37] Proning is a strategy of turning a patient to lie face down for a period of time in order to improve the exchange of oxygen and carbon dioxide in the lungs during mechanical ventilation.
[38] HFOV is a lung protective strategy. Often used as a rescue strategy when conventional mechanical ventilation has failed. It uses rapid ventilation rates with small tidal volumes and reduces ventilator-associated lung injury, especially in the context of acute respiratory distress syndrome and acute lung injury. Acute lung injury means a form of acute respiratory failure, defined by hypoxemia and the presence of bilateral infiltrates on X-ray.
[39] ECMO is similar to a heart–lung bypass machine. It pumps and oxygenates blood outside the body, allowing the heart and lungs to rest.
[40] A strong broad-based antibiotic prescribed to treat severe infections. It has an anaerobic as well as aerobic impact.
[41] An increase in the white blood cell count, which can mimic leukaemia.
[42] Having abnormally low blood pressure.
[43] AKI describes sudden damage to the kidneys that causes them not to work properly. It can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness. Stage 3 is the 'middle' stage and cannot often be cured and can lead to kidney damage that is not normally reversible.
[44] Fungal infections.

microbiologist suggested replacing the ceftriaxone with meropenem[45] [46] along with clindamycin[47] and to start immunoglobulin IV (in case of a staphylococcus infection). They would also liaise with virology to decide if Tamiflu[48] was appropriate. Caspofungin[49] was started at 22:00. Tamiflu was administered at 23:30.

2.36 At 21:30 microbiology also advised clarithromycin[50] as there were some features of atypical mycoplasma pneumonia showing. The first dose was administered at 23:00. A mycoplasma polymerase chain reaction (PCR)[51] test was sent for testing. This test also came back negative.

23 November

2.37 Overnight on 22/23 November Yusuf continued to deteriorate. His right lung showed a complete white out[52] and there was increasing consolidation of his left lung. This suggests that the antibiotic therapy was not working, and his lungs were continuing to deteriorate. He was being treated for possible sepsis with three different antibiotics, for a possible invasive fungal infection and with antivirals (Tamiflu) used to treat and prevent influenza A and influenza B. His WCC (63.55) and CRP (141) were increasing. Late that night, HFOV was being used and cautious hyperhydration to try and thin his blood was discussed with his parents. Other options were also considered including exchange transfusion.[53]

2.38 Yusuf was hyperhydrated for four hours. He continued to deteriorate with a WCC of 68.6 and platelets of 57 dropping to 37. A decision was taken to refer him for ECMO if his oxygenation index worsened.[54] At 08:30 on 23 November 2022 his index was 44 and he was referred for ECMO.

2.39 At 09:15 Yusuf went into cardiac arrest. He passed away at 11:17 on 23 November 2022. A referral was made to the coroner at 16:30 in line with national guidance.

2.40 An initial complaint was raised by Yusuf's uncle with Rotherham Hospital on 21 November 2022. On 25 November the complaint was raised as an incident at the Incident Review Panel and a RED[55] internal investigation was launched. A 72-hour review was completed, and the case was designated a serious incident on 29 November. A decision to request an independent investigation was recorded on 2 December following a meeting with the CEO at The Rotherham NHS Foundation Trust on 30 November.

2.41 A child death review notification was completed on 23 November in line with procedures and a joint agency review (JAR) meeting was held and closed on 29 January 2023.

[45] One dose was given at 22:25. The dose was adjusted for his AKI.
[46] Meropenem is a broad spectrum carbapenem antibiotic used to treat gram-positive and gram-negative bacteria. It is used to treat severe or complicated infections when other antibiotics may not be enough.
[47] Two doses were administered: one at 22:25 on 22 November and one at 04:00 on 23 November.
[48] Tamiflu is used to treat and prevent flu.
[49] Caspofungin is an echinocandin class of medications used to manage and treat several medical conditions. These conditions include febrile neutropenia, candida infections, invasive candidiasis, oesophageal candidiasis and invasive aspergillosis.
[50] Clarithromycin is an antibiotic used to treat chest infections such as pneumonia.
[51] Mycoplasma PCR test is used to test for mycoplasma bacteria which are highly resistant to antibiotics. Mycoplasma pneumonia is spread through contact with droplets from infected people and is thought to require prolonged close contact with an infected person.
[52] Total opacification of one side of the thoracic cavity – likely due to consolidation.
[53] Exchange transfusion is a blood transfusion in which blood or components of blood are exchanged with other blood or blood products. It can be used to counteract the effects of changes in the blood. There is very little research evidence to back such a strategy up in this case.
[54] The oxygenation index helps predict outcomes, especially in paediatric patients and helps determine the need for ECMO. An index over 40 indicates ECMO should be considered.
[55] Grading system used by the Trust for deciding how to investigate based on seriousness of an incident.

Part 3 – Findings by care episode

Preadmission

Commentary on this care episode and points for learning

3.1 Yusuf had a background of what looks to be suboptimally controlled asthma. He had respiratory illnesses from a very young age which were variously diagnosed as bronchiolitis or viral induced wheeze. He was started on asthma preventative therapy (inhaled corticosteroids[56] and montelukast) at a relatively young age and these medications were started and stopped on several occasions. There was a family history of asthma.

3.2 Yusuf did not appear to tolerate montelukast well and struggled with the volumatic spacer for his inhalers at times. In common with many young children, he did not have many exacerbations of wheeze during the pandemic, but his asthma symptoms seemed to have been getting worse during 2022. His mother says though that by September 2022 his asthma was as good as it had ever been. There is some suggestion of faltering growth in the year before his death and his weight gain slowed over the winter period, which correlates with when he had the most episodes of respiratory symptoms.

3.3 Asthma can slow growth and oral steroids can affect height, although that is not usually the case with inhaled steroids. Yusuf was noted to have Harrison sulcus[57] which can be a sign of long-term respiratory issues. One of his last asthma control test (ACT)[58] scores was 16, which suggests that control was suboptimal at times. Yusuf's last recorded ACT was in December 2021. There is no strong suggestion in the way his respiratory problems or his family history are documented to suggest an alternative underlying diagnosis e.g. cystic fibrosis or an immunological problem.

York Road General Practice Surgery

Commentary on this care episode and points for learning

3.4 For the review of primary care we had access to the family timeline, the recordings of the telephone calls between the family of Yusuf and the York Road Surgery on 15 and 18 November 2022, the GP practice clinic records of the consultations on 15 and 18 November 2022 and the full GP clinical record – which included community notes and hospital letters. Interviews were also carried out with the primary care nurse practitioner and the attending locum GP at York Road Surgery.

3.5 There is a broad correlation between the family timeline and the GP records, phone calls and interviews with the clinicians. The only discrepancy was in the family recollection of the GP saying Yusuf needed IV antibiotics when he was seen on 18 November. The family recall antibiotics being recommended at that assessment. The doctor's recollection and recorded notes indicate that he advised UECC attendance if there was no improvement and said that the hospital may consider antibiotics appropriate at that time.

3.6 Yusuf's final illness started around the weekend of 12-13 November 2022. His mother arranged an appointment at the GP surgery on 15 November and they saw a nurse practitioner who prescribed

[56] Corticosteroids are often known as steroids and are anti-inflammatory medicines.
[57] Harrison's sulcus is an indentation on the chest roughly along the sixth rib which is usually bilateral but can also occur unilaterally. The depth of the groove varies but the deepest part always remains over the sixth costal cartilage. It is usually caused by chronic asthma or obstructive respiratory disease. It is also seen in young children/infants with abnormally weak bones e.g. rickets because of defective mineralisation of the bones by calcium necessary to harden them, thus the diaphragm which is always in tension pulls the softened bone inward. Its cause is not fully understood.
[58] ACTs provide a snapshot of how well asthma has been controlled in the preceding few weeks. It is a score out of 25. Symptoms can vary month to month, so scores can change. https://www.asthmacontroltest.com/en-gb/welcome/

Penicillin V for tonsillitis. This was appropriate therapy and the twice a day 250mg dosing option[59] is in line with the BNFC.[60] In the recorded NHS 111 call made by Yusuf's mother on the evening of 15 November 2022, she says that he had been unwell for two days and had been given two doses of antibiotics by then.

3.7 Shortly after both assessments at the practice Yusuf's family sought further urgent medical advice. On 15 November 2022 Yusuf was seen at 12:30 in the practice and at 22:45 in the evening he went to Rotherham UECC. On 18 November 2022 Yusuf was seen at 11:20 in the practice and then at approximately 13:00 the family called 999. At 12:35 on 18 November a call to the children's ward at Rotherham Hospital was made by Yusuf's uncle seeking admission for Yusuf.

3.8 The records of the assessments, the interviews with the clinicians and the family's recollections show that appropriate assessments, treatment plans and safety netting advice were given based on the observations taken and his presentation at the time. Given that on each occasion further urgent medical advice was sought there would not have been an opportunity for primary care to reassess him.

3.9 The following issues that come from reviewing the information would not have altered the outcome for Yusuf but are observations made as part of our review.

3.10 At the time of the family's first call to the practice on 15 November 2022 at 08:23, while the receptionist offered a face-to-face review, it was not made clear to the family which clinician they would see (name or designation of the clinician). Providing that information would have been helpful.

3.11 Reviewing the notes and interviewing the primary care nurse practitioner and the locum GP show that, while their assessments, care plans and safety netting were appropriate, a small number of additional observations could have been carried out in line with best practice guidelines. We are of the view that all primary care clinicians should be encouraged to complete training and regular refresher training in assessing sick children. We have made a recommendation in relation to sharing written/accessible patient information as part of safety netting process and this applies to primary care as well as acute care.

3.12 We identified that whilst paediatric pulse oximeters at the practice might have been available one was not used and we understand one was broken. Measures should be taken to ensure that clinicians have access to age-appropriate equipment for their assessments of children.

3.13 We also identified that practitioners were not able to consistently describe the options for securing an urgent paediatric review from secondary care services. It is clear through interviews that the expectation is that very unwell children who require urgent assessment should attend the UECC, which is the correct pathway, but the primary care staff did not make it clear to Yusuf's mother that the GP could seek a paediatric opinion through this route. The children's assessment unit is for a paediatric opinion (including for GP referrals) and children would normally attend via the UECC for a prearranged meeting with a paediatric doctor. Direct admission to the ward is typically for children who have been discharged in the preceding 48 hours and need to be readmitted. However, we have seen no evidence of a written protocol for accessing advice or an admission to hospital for the general practice for children. Local pathways do not seem to be well understood with respect to seeking a paediatric opinion and admitting unwell children.

3.14 His family seem to have understood that the GP said he was unable to refer to paediatrics at Rotherham. The normal pathway would be that the GP refers to the paediatric registrar at the local hospital who would then agree to see the child in the UECC or paediatric assessment unit. The child then becomes the responsibility of the paediatric team who would treat with IV antibiotics if they felt that was necessary. However, both tonsillitis and pneumonia are usually treated with oral antibiotics unless the child is very unwell or cannot tolerate the oral version.

[59] It is usually given at 125mg four times a day (QDS) but can also be prescribed at 250mg twice a day (BD).
[60] British National Formulary for Children.

3.15 On 18 November 2022, Yusuf's mother was concerned that her son was "*not even 1% better*" (this was recorded in her conversations with the GP practice and then again with the 999 call handler later in the day). Yusuf was given an emergency face-to-face appointment at the GP surgery, and he was prescribed erythromycin to broaden the antibiotic cover because the Penicillin V did not seem to be helping the tonsillitis. Yusuf's heart rate was 122 at that time, which is an amber flag on the NICE sepsis risk stratification chart[61] which means "*moderate to high risk*". As there were no concerns about Yusuf's immunocompetence, it was appropriate to send him home with advice to go to hospital if he was no better later that day.

3.16 However, the absence of a respiratory rate recording, oxygen saturation levels and capillary refill times meant that a sepsis screen could not have been fully completed. The recording of these physiological observations would have been good practice but would not have made a difference to his outcome at this stage because Yusuf's mother sought urgent care within 90 minutes of leaving the GP surgery.

Rotherham NHS Foundation Trust

Commentary on this care episode and points for learning

3.17 Yusuf was appropriately triaged at Rotherham Hospital on 15 November 2022 according to the recorded observations. The POPS was used to assess his acuity which is the agreed protocol in use at the Trust. There is no nationally agreed PEWS in the UK although work is underway in the roll out of a standardised national PEWS.

3.18 The initial triage and nursing input during the night of 15 November was appropriate. However, the department was exceptionally busy and had one junior doctor absent because of sickness, this resulted in long waits. The nursing and medical team we spoke to did not feel that this was a contributory factor in Yusuf's deterioration following his visit. They were reflective but adamant at interview that nothing could have been done differently that night with his care and treatment decisions. On direct questioning, they agreed that having a paediatric registrar on site who is not covering the ward, the labour ward and the neonatal unit at the same time, would be helpful in general but is unlikely to have led to different management decisions in this case. The doctor involved was experienced in paediatric care, possibly more experienced than a junior paediatric registrar. As an advanced paediatric life support instructor, he had a very good understanding of the unwell child and of the importance of listening to parents as their advocates. We consider that on the basis of Yusuf's observations, presentation and diagnosis there was a reasonable expectation that the antibiotics prescribed were appropriate and an admission was not clinically required.

3.19 Yusuf had waited six hours 20 mins before having a medical review which was significantly longer than the average time that evening. (During the period under review, the Trust was one of 14 UK field test sites who were testing proposed new national urgent care standards intended to replace the current four hour A&E target. During this period the Trust was therefore not working to the national four hour standard as they were field testing the proposed new metrics[62]. This commenced 22 May 2019, with a formal Memorandum of Understanding in place between the Trust and NHS England/NHS Improvement) and is due to cease from 15 May 2023. We know from the family's account that they were told that there was only one doctor in the paediatric UECC and that after midnight, that individual was responsible for covering adults and children. The family had concerns about the way they were spoken to overnight, and we wonder if the clinical teams found communication with the family challenging. The doctor who eventually saw Yusuf is an experienced UECC doctor who would not have needed to refer to a paediatrician on the basis of Yusuf's presentation that night and would not have needed to do any further investigations or admit him. If

[61] NICE sepsis risk stratification chart (2017)
[62] Time to Initial Assessment, Time from Arrival to being Seen for Treatment and Mean Time in the Department. These were monitored as Mean Arrival To Initial Assessment (Minutes), Mean Arrival To Seen For Treatment (Minutes), Mean Time In Department (Minutes).

he had seen him earlier, he would have been sent home earlier, he would not have requested an admission.

3.20 Yusuf's mother did have a video of the breathing pattern that concerned them but this was not shared or mentioned in the doctor's notes (despite his mother saying she tried), nor did the doctor document the verbal safety net advice given to the family. We have interviewed that doctor; he did not give the family written safety net advice and was not aware of the Healthier Together site which the Trust told us is the resource in use at Rotherham for written safety net leaflets.

3.21 Yusuf's clinical observations did not warrant an admission to hospital, but his mother was very worried about her child's breathing. She had taken two videos of Yusuf prior to taking him to the UECC. Whilst there is an element of speculation in this regard, videos can prove useful in assessing children and this information might have been helpful. However, his chest was clear at the time and there were no clinical signs of a chest infection or pneumonia. The first chest X-ray taken two days later at Sheffield Children's Hospital was normal and adds credibility to the normal chest assessment at Rotherham in the early hours of 16 November. Had he been admitted, Yusuf would have seen a paediatric consultant on the ward round later that day. We cannot predict if this would have made a difference to the eventual outcome in this case, although treatments were not effective once given at Sheffield.

3.22 The account from the nurse that night suggests that Yusuf's mother was sufficiently empowered to raise concerns with the staff while waiting to see the doctor. His uncle is described as being quite forceful in his request for his nephew to see a doctor and the staff interpreted this as both a concern for his nephew's welfare and frustration at his family members being in the department for so long overnight. There were multiple attempts by Yusuf's mother and uncle to raise their concerns but they felt they were not listened to.

3.23 On 18 November, Yusuf's uncle called the ward to ask if his nephew could be admitted for IV antibiotics after he had been seen by his GP. There was no formal record of the call made which lasted 10 minutes. During the call his uncle states he argued vehemently for an admission but was not listened to. Following discussions with both family and the ward nursing team it is our view that this call failed to successfully communicate to Yusuf's family the rationale for the expected pathway (via the UECC). At this stage his family lacked confidence that Yusuf would get immediate urgent attention at Rotherham Hospital. We understand that new procedures have now been implemented to make a record of telephone calls to the children's ward.

3.24 During our review, we noted a number of recording errors at Rotherham Hospital:

- Yusuf's height was incorrectly recorded and had probably been transferred from the records from a previous asthma clinic. This might make sense for adults but is inappropriate in paediatric care and the IT coding behind this needs to be changed to exclude people under the age of 18. Weight and height recording in children is important as medication doses are often calculated per kg and an accurate recording is essential for accurate medication prescribing.
- BMI calculations used in the asthma clinic are more appropriate for adults; BMI centiles are more appropriate for children.
- In one set of observations Yusuf had "*nasal cannulae*" recorded, which suggests oxygen therapy. The oxygen administration recording was an error but would not have impacted on his care.
- The UECC doctor is a ST6, but his position comes up automatically as "*foundation doctor*" as that is what he was when he originally worked in the Trust (about six years previously). This is an IT error at Rotherham which should be corrected because it can be misleading in a clinical record that is required for investigation and legal purposes.

Yorkshire Ambulance Service NHS Trust

Commentary on this care episode and points for learning

3.25 On 15 November at 22:46:38, Yusuf's mother made a call to the NHS 111 service (hosted by Yorkshire Ambulance Service NHS Trust). Following a description of his condition she was advised to attend Rotherham UECC. Her call was coherent and sensible, and she was patient with the numerous questions that the NHS 111 pathway coordinator had to ask. The call was appropriately managed by the NHS 111 call handler and was appropriately escalated to a clinician. There were no communication issues in this interaction. His family followed the advice to take Yusuf to Rotherham Hospital.

3.26 On 18 November at 12:59, Yusuf's mother called 999 and gave a clear description of a very unwell child with an airway and/or breathing issue. She said her son had been unwell for one week but had only had a "*very little*" runny nose. This made a viral infection less likely. The ambulance arrived at their house six minutes and 20 seconds after the start of her call.

3.27 Yusuf was found to be hypoxic (with oxygen saturations of 91% on air) with a high heart (160 on departure from the house) and high respiratory rate (32 respirations per minute). His GCS score was recorded as 15, but it did not take note that he was only responding to voice. He should have been given a score of 14.

3.28 The outcome of the attendance was Yusuf's appropriate transportation to Sheffield Children's Hospital, although we note that the altercation between the service and family members over the phone in relation to the destination has been subject to a separate complaint investigation. We are of the view that the additional delay caused did not impact Yusuf's eventual care.

3.29 To assess the care and treatment that was given we have referred to guidelines produced by the JRCALC,[63] often referred to as just the 'JRCALC guidelines'. The guidelines are produced for NHS ambulance service paramedics, on behalf of the Association of Ambulance Chief Executives (AACE).

3.30 These guidelines include a number of points that specifically relate to this case and they have been used for this review:

- febrile illness in children
- medical emergencies in children overview
- oxygen

3.31 Yusuf's documented examination indicated that he had no shortness of breath. However, his significant tachypnoea (rapid breathing) of 32 respirations per minute was documented on two occasions – this would indicate difficulty in breathing and/or shortness of breath. This statement therefore contradicts the observations obtained. We would have expected further documented examination specifically around WOB and auscultation (listening to sound in the lungs) to identify a cause for both the increased respiratory rate and the low oxygen saturations. This was important because he had been given antibiotics that day for a possible chest infection. Looking at other potential differential diagnoses such as the exacerbation of his known asthma, a chest infection/pneumonia or consolidation would have been appropriate.

3.32 Yusuf was also recorded as being pale. Pallor is a significant clinical finding in a child, and we would have expected there to have been a documented central capillary refill time which would have given

[63] JRCALC Guidelines Working closely with the National Ambulance Service Medical Directors (NASMeD) who represent all UK ambulance services, JRCALC effectively fulfils the liaison role of its title. The committee is comprised of experts ranging across the whole spectrum of medical disciplines, including paramedics, physicians, midwives, nurses, general practitioners, pharmacists, surgeons, obstetricians, pathologists and others. Members are nominated by their respective organisations /specialities /colleges and formally convene three times a year, with the majority of the guidance review and development happening between meetings.

an overall impression of his perfusion and blood circulation. This would also have been part of an expected sepsis screen, but it was not completed.

3.33 It is documented that Yusuf was not able to eat and drink properly. His mother stated that he last used the toilet that morning to urinate and last opened his bowels two days ago. It is possible that Yusuf could have been dehydrated, and we would also have expected further documented examination to explore this.

3.34 The paramedics put Yusuf on 2L of oxygen at 13:20 as his saturations were at 91% on room air. His readings deteriorated after being taken off oxygen. The paramedics put him back on 1L of oxygen and his saturations increased again to 99%. JRCALC guidelines state that supplementary oxygen should be administered to children with significant illness and/or injury and that all children presenting with this should receive high levels. Given he presented with tachypnoea, tachycardia (rapid heart rate) and low oxygen saturations he should have received high levels of supplementary oxygen.

3.35 In total there were two sets of observations documented, one at 13.18 and one at 14.15. These are incomplete with the first (primary) set omitting to include a heart rate and with both sets missing the blood pressure, capillary refill time, electrocardiogram (ECG) and FeverPAIN score. A blood pressure is difficult to accurately obtain in young children pre-hospital admission and other observations (capillary refill time and colour) would have given a better and earlier overall picture of the child's perfusion status. That said, the observations that were taken were strongly suggestive of Yusuf having a significant respiratory issue.

3.36 While these points did not impact the ultimate decision to transfer him to hospital, the medical emergencies in children guideline states that a full set of observations should be completed. Accurate recordings are critical to decision-making and guidelines should have been adhered to.

3.37 During the documented examination, Yusuf presented with one red flag when assessing paediatric fever (pallor) and five amber flags:

- wakes only with prolonged stimulation
- decreased activity
- oxygen saturation less than 95% in air
- tachycardia more than 140 beats per minute for ages two to five years
- fever for more than five days

3.38 The JRCALC guidelines state that "*for a child with any red flags they must be conveyed to an ED with appropriate paediatric services providing an ATMIST*[64] *pre-alert and conveyed under emergency conditions. They should consider sepsis or meningitis as possible causes and provide care en route*". This guidance is reflected in the Yorkshire Ambulance Service NHS Trust Assessment, Conveyance and Referral of Patients Policy (February 2020).

3.39 Yusuf was showing signs of both breathing and circulatory compromise. He was seriously unwell and had a time critical condition requiring transportation to the nearest suitable receiving hospital without delay and providing a pre-alert. The crew informed Yusuf's mother that he would be taken to the nearest paediatric receiving unit (which was at Rotherham Hospital) given his condition. However, at 13:38 his uncle rang 999 from work to insist that the crew took his nephew to Sheffield Children's Hospital instead. The uncle wanted the call taker to speak to the crew to give them these instructions. The call taker attempted to explain that the crew were best placed to make that decision, but his uncle was insistent that the call taker told them. The call taker put the uncle on hold then came back and said they needed to speak to the crew. It was then established that the uncle was not on scene with either the patient or the crew so the uncle stated he would speak with them.

[64] The ATMIST handover is used by emergency medical services as a rapid, accurate handover tool for a time critical patient.

3.40 The uncle's request (along with his insistence about Yusuf being admitted directly to the ward at Rotherham for IV antibiotics) was understandable given the family's concerns about Yusuf's health (and their impression that there were no beds or doctors at Rotherham) but would have been at odds with national and local guidelines. Yusuf was taken to Sheffield Children's Hospital; the manner in which this request was dealt with by the ambulance crew is subject to a complaint investigation and is not within scope of this investigation.

3.41 We do note, however, that the paramedic crew arrived at Yusuf's house at 13:04 and the time of transfer to the ambulance was 13:48 and the leaving scene time was 14:00. This gives an overall time of 56 minutes on scene. Given his presentation, transportation to hospital without delay should have taken place and an on-scene time of 56 minutes could be considered excessive. However, it is likely that the discussion between the family and paramedics in relation to the proposed destination hospital increased the intervention time.

3.42 The nearest most appropriate hospital with paediatric services was Rotherham Hospital, which from the incident location (Yusuf's home) was 2.7 miles away with an estimated travel time of 10 minutes. The family insisted Yusuf was conveyed to Sheffield Children's Hospital which was 10 miles away with an estimated travel time of 20 minutes.[65]

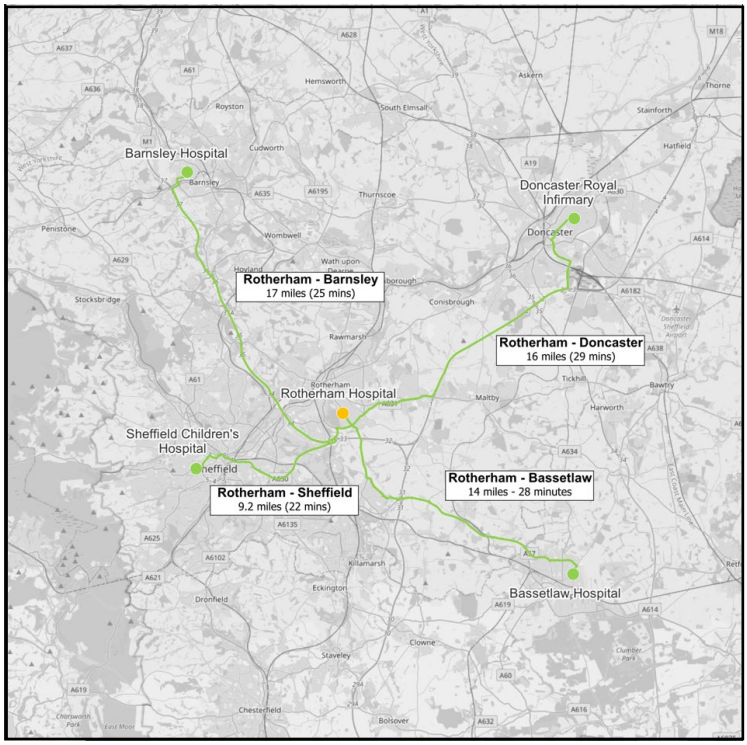


Figure 1: The above map shows distances to local hospitals in relation to Rotherham.

3.43 There was no clinical need for the ambulance to have bypassed Rotherham and this would have been an appropriate hospital for Yusuf to have been taken to with his presentation at that time. JRCALC guidelines support a pre-alert to the receiving hospital, but we can find no record of this happening. However, its absence did not impact Yusuf, who was triaged on arrival at the hospital.

Conclusions/learning

3.44 The paramedic records lack documented essential examinations and physiological observations for Yusuf considering his history and presentation to the ambulance crew. Omissions include: first heart rate, capillary refill time, respiratory examination including WOB and auscultation, and hydration status. They had a working diagnosis of tonsillitis but apart from the history there is no evidence of

[65] Estimates and data from Google Maps.

an examination that would have supported this conclusion. There is no evidence that other potential diagnoses were considered, such as a respiratory cause or dehydration. The transportation of Yusuf to hospital was, however, appropriate. Further examination by the crew would not have altered this decision but may have identified other differential diagnoses needing treatment.

3.45 The administration of oxygen was not in line with national guidance, although there is evidence that the amount given did have a positive effect on the Yusuf's condition.

3.46 The length of time the ambulance spent on scene given Yusuf's presenting condition was longer than expected but some of this time was due to discussions with the family about the hospital destination.

3.47 A pre-alert to the receiving hospital was indicated but did not take place. Yusuf's triage time at the ED was not impacted by the absence of this call.

3.48 Transport to the nearest hospital (Rotherham) under emergency conditions was indicated given the clinical findings but did not take place because of a request by the family for the ambulance to take Yusuf to Sheffield Children's Hospital. This was appropriate in the circumstances described and there is no evidence that this impacted the care that Yusuf received on arrival at the ED.

Sheffield Children's NHS Foundation Trust

Commentary on this care episode and points for learning

3.49 At Sheffield Children's Hospital, Yusuf was seen by three different clinical teams in the ED in an efficient manner. He was described as "*unwell, but not septic*" and the blood test results and observations back up that clinical description. All significant abnormal results were picked up, appropriately escalated and acted on and the decision-making also seems to have been appropriate. He was seen the following morning by the paediatric medical consultant as per national guidelines on admitted children.[66] He appeared to be beginning to get better. The family have a photo during this admission of Yusuf smiling a little while colouring in a book.

3.50 On admission to Ward 4 a nursing assessment was undertaken. This was completed in full, but we note the following in relation to his care:

The assessment noted that Yusuf had "*reduced intake*" but we can see no evidence of this being fully explained in the nursing records (for example, for how long) or of a Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP)[67] being completed. There was also no care plan or food chart to help with monitoring. Yusuf's weight was recorded as 15.8kg but his height was left blank, which would have made it impossible to complete the STAMP or calculate a BMI centile. If the score had been calculated, it is likely that Yusuf would have been classed as high risk of malnutrition due to his presenting condition and recently decreased/poor nutritional intake. As Yusuf's weight was recorded as 16.7kg when he attended Rotherham Hospital there had been a weight loss of 0.9kg in three days. His last recorded weight when he was well was 17.4kg (so there had been a total body weight loss of 9%). The high risk rating should have been responded to (i.e. action should have been taken; a referral made to a dietitian, nutritional support team or consultant; with monitoring as per an agreed care plan). Optimal nutrition was relevant to Yusuf as it is known that malnutrition can make a child more susceptible to infection and can increase fatigue. Conversely, infection also contributes to malnutrition and hence it was important for staff to fully understand his risks so that any deficiencies could be addressed.

3.51 A fluid balance chart was appropriately started; however, this was poorly completed over the period of his stay (some, but not all, of his food intake was also included which was inappropriate for this form). Urine output was recorded as "*passed urine*" rather than including a volume. The volumes of

[66] RCPCH (revised 2015) Facing the Future: Standards for Acute General Paediatric Services
[67] STAMP is a validated nutrition screening tool for use with hospitalised children from 2 weeks to 16 years of age https://www.stampscreeningtool.org/

fluid taken orally included "*sips*". IV fluids were started on admission and stopped at 13:00 on 19 November but restarted at 17:00 on 20 November. Between these times, the fluid intake and output volumes for Yusuf are unclear.

3.52 The fluid balance chart includes a VIP score,[68] which nurses are required to complete when attending to their patients. VIP scores were entered on the morning of the 19 November (as "*0 – IV site healthy*") but there is no recorded entry after this time, despite Yusuf continuing to receive IV antibiotics which were essential to his recovery. This is a concern given that the cannula was bandaged (to keep secure) with commentary in the progress notes at 01:45 and 05:15 on 19 November that it was "*very positional*". This meant its patency was intermittently affected. A change of cannula was required at 13:00 on 20 November and this meant that the administration of his lunchtime dose of antibiotics was delayed because he was not recannulated until 15:00, despite him being unwell at that point ("*very unsettled, coughing lots and a prominent stridor*"). An IV cannula care plan was listed as being required, but we can see no evidence of this being completed. The family have photographic evidence of fluid leakages over the weekend, and it is recorded in the nursing notes that at 06:30 on 21 November, the bandage was covered in blood as the cannula port was loose.

3.53 There were concerns over the weekend that Yusuf might not have got the prescribed antibiotic dose. However, benzylpenicillin was given QDS and it is unlikely that the leaking cannula would have significantly affected the antibiotic efficacy overall[69].

3.54 Throughout the progress notes, there is reference to Yusuf being in pain but with no qualification about where this pain was or how severe it was. Analgesia appears to have been given with good effect, but we have seen no evidence of a care plan or pain assessment tool being used to quantify the pain that was being experienced.

3.55 In Sheffield, one version of the early warning observation scoring is used in the ED (POPS) and a different version (PEWS) is used on the ward. This does not strike us as sensible practice, although we do not believe that this impacted on Yusuf's care.

3.56 Yusuf started to become much more unwell on the morning of Monday 21 November. The observations chart shows a sudden increase in his heart rate at around 09:00 and the clinical notes describe a child with a worsening airway and breathing problem. The family's videos show a child struggling to breathe. This would be unusual for a child who had seemed to be getting better unless he had acute bronchospasm[70] for some reason.

3.57 Yusuf was found to have a "*tight chest*" and was treated with salbutamol – bearing in mind his history of asthma – but with very little positive effect. His tonsils were thought to be obstructing his airway and there was talk of doing a "*hot*" tonsillectomy, which means removing the tonsils while they are still inflamed. His breathing responded temporarily to aminophylline but then deteriorated again. He did not tolerate high-flow oxygen on the PICU and the decision was made to intubate him.

3.58 Intubation was much easier than anyone expected and there was no significant airway obstruction necessitating a hot tonsillectomy. The primary problem was now seen to be in his lungs. The x-ray appearance became worse each day, the increasing consolidation correlating with the difficulty the intensivists were having with oxygenating him. He was on a large amount of oxygen compared to

[68] The VIP score is used for the assessment of the early signs of phlebitis, along with the prompt removal of peripheral IV cannulas.
[69] Antibiotics should ideally be given at regular intervals. In sepsis, the timing of the first dose of antibiotics is important https://ccforum.biomedcentral.com/articles/10.1186/s13054-021-03883-0 and UK national guidance is that they be given in the first hour. However, once started on antibiotics, there is little evidence that missing a dose matters. NHS advice is that, if missed, the dose should be taken as soon as the patient remembers or, if it's almost time for the next dose, skip the missed dose https://www.nhs.uk/conditions/antibiotics/. A 2019 study on missed intravenous antibiotic doses in an intensive care setting in hospital found that only 8% of the patients had all their antibiotic doses given within an hour each side of the prescribed time. Missed doses in this study were associated with an increased length of stay but not with increased mortality.
[70] Bronchospasms are the tightening of the muscles that line the airways in the lungs.

when he was initially intubated and he did not respond definitively to any changes in ventilation or position, any new antibiotics, antifungals, antivirals or any chest physiotherapy.

3.59 Yusuf had a leukemoid reaction, which means the bone marrow pushes out large numbers of white cells as part of a non-cancerous inflammatory reaction, usually an overwhelming infection, massive trauma or a paraneoplastic process.[71]

3.60 There was good engagement by a range of healthcare professionals throughout his case, as shown in the medical notes, with attention paid to possible other causes of his deterioration, including Lemierre's syndrome.

3.61 The hypoxia inevitably led to multi-organ failure and DIC[72] and Yusuf had a cardiac arrest two days after his admission to the PICU. The team discussed in their mortality meeting whether Yusuf should have been referred earlier for ECMO – they concluded that, given the criteria for referral, the team had referred at the earliest opportunity (based on his oxygenation index).

3.62 We interviewed four PICU consultants who had been involved in his care. All had been surprised that he died. The consultants had considered other diagnoses, including diphtheria, pertussis (whooping cough) and haemophilus influenzae B (Yusuf was not immunised against any of these) and had worked hard to try to halt whatever process was leading to his unexpected deterioration. They explained that they had discussed leukapheresis as a management for his extremely high WCC, but mortality from a leukemoid reaction is very high and the evidence behind trying to reduce the white cells by exchange transfusion is not strong. He was being discussed for ECMO when he died and none of the team felt that he could have been referred earlier as the threshold for ECMO had only just been reached on 23 November. They felt that his chest pathology was not typical for an infective pneumonia, and they did not believe that earlier IV antibiotics would have made a difference.

3.63 Until the last few days of his life, there was no significant rise in any of Yusuf's inflammatory markers (CRP, erythrocyte sedimentation rate (ESR)), no rise in lactate and no particularly abnormal vital signs. This was not a usual presentation of sepsis[73] or pneumonia.

3.64 On 21 November a radiologist questioned whether the X-ray findings were consistent with Lemierre's syndrome. This is a rare condition characterised by inflammation and clots in the internal jugular vein and blood infection caused by primarily anaerobic organisms following a recent throat infection. It is usually found in young, previously healthy adults and children. Lemierre's syndrome should be suspected in young healthy patients with prolonged symptoms of pharyngitis[74] followed by symptoms of septicaemia[75] or pneumonia, or an atypical lateral neck pain. Diagnosis requires two out of three of the following:

1) identification of thrombophlebitis of the internal jugular vein by ultrasound scan, or perhaps more reliably, by CT scan

2) growth of *Fusobacterium necrophorum* anaerobic bacteria on a blood culture[76]

3) seeding to the lung causing a pneumonia like picture

3.65 Yusuf was on a considerable amount of treatment that would have treated the bacteria that causes Lemierre's syndrome (*Fusobacterium necrophorum*) as well as the more common streptococcus A.

[71] Symptoms that may develop when substances released by some cancer cells disrupt the normal functioning of surrounding cells and tissues.
[72] DIC is a rare but serious condition that causes abnormal blood clotting throughout the body's blood vessels. DIC may develop if there is an infection or injury that affects the body's normal blood clotting process.
[73] Amarnani, S. and Ranjan, A. (2022) Lemierre's Syndrome: A lethal Complication of Acute Tonsillitis
[74] Inflammation of the pharynx, causing a sore throat.
[75] Blood poisoning, especially that caused by bacteria or their toxins.
[76] Eilbert, W and Singla, N. (2013) Lemierre's Syndrome

3.66 Yusuf's blood cultures were negative but were only aerobic cultures[77] so would not have picked up Fusobacterium necrophorum.[78] The doppler ultrasound scan of his neck on 22 November at 11:44am did not show any inflammation or clot formation consistent with Lemierre's syndrome. An ultrasound of his chest was done at the same time, and it showed "*dense consolidation in the right upper lung*". This may be what his family understand by his neck being "*blocked*". A CT scan would have been helpful in ruling out blood vessel involvement, but he was not stable enough to go to the CT scanner.

3.67 Yusuf did have the third diagnostic feature of a pneumonia like picture. He had low platelets, which is seen in Lemierre's syndrome, but it is also sometimes seen in fungal illnesses. He was on an antifungal. He was on Tamiflu in case the negative influenza swab was a false negative. Numerous samples were sent to the laboratory, including secretions from his endotracheal tube on 21 November, and everything returned normal.

3.68 Yusuf had a blood film sent to the haematology laboratory and it was reported as "*neutrophilia*" and having "*platelets in clumps*". There was no time for investigations such as a CT scan, bronchoscopy or bone marrow biopsy which may have helped with establishing a diagnosis.

3.69 As part of this investigation, Yusuf's blood results and his presentation were discussed with a paediatric haematologist in case this might have been an unrecognised and fast acting leukaemia or one of a range of other neoplastic processes. The haematologist felt it probably was not this. Unfortunately, we are unlikely to definitively ascertain why Yusuf died.

[77] It would be normal not to take anaerobic cultures.
[78] Nygren, D. and Holm, K. (2019) Invasive Infections with Fusobacterium Necrophorum Including Lemierre's Syndrome

Appendix 1 – Terms of reference

Terms of reference for independent investigations in accordance with Appendix 3 of NHS England's Serious Incident Framework 2015

The following terms of reference for an independent review into the care and treatment of Yusuf (2022/25466) have been drafted by NHS England North East and Yorkshire, in consultation with South Yorkshire Integrated Care Board.

The terms of reference will be developed further in collaboration with the appointed investigative supplier, Yusuf's parents and his family.

Purpose and scope of the investigation/commission

To review Yusuf's whole care pathway from his first contact with health services on 15 November 2022 (which includes contact with the general practitioner, Yorkshire Ambulance Service, Rotherham NHS Foundation Trust and Sheffield Children's NHS Foundation Trust), to promptly establish the facts on which clinical decisions were based and determine whether there are any lessons to be learned from the case in relation to the provision of and access to emergency and inpatient paediatric care.

To identify any areas of best practice, opportunities for sustainable system learning and areas where improvements are required.

Family and staff involvement

- Ensure that the family and relevant staff are fully informed of the investigation and the investigative process and they understand how they can contribute to the process.
- Ensure that staff contributing to the investigation process understand how their information will be used and processed and are aware of organisational support.

Terms of reference

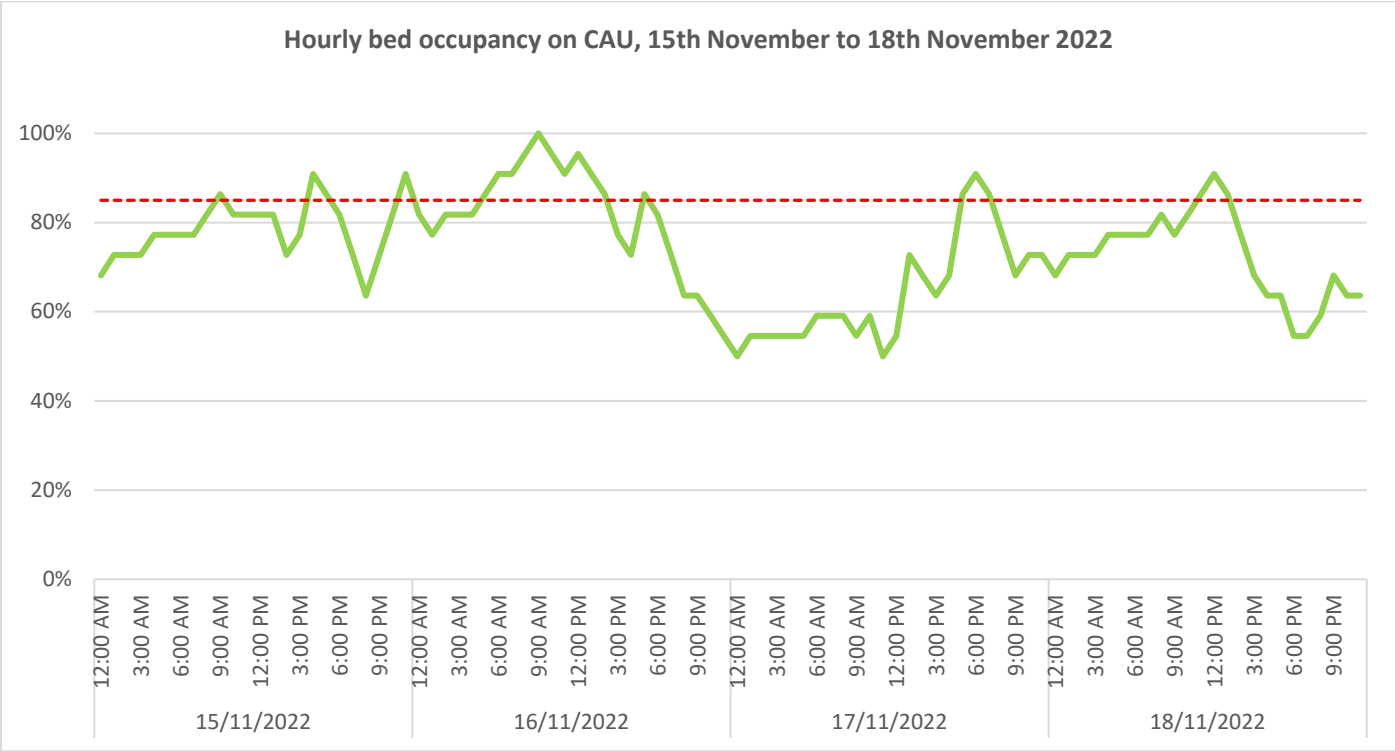
- Building on the rapid review of the case, compile a detailed chronology/timeline leading to hospital admission – mapping key events and decision-making.
- Consider the response immediately following the incident to identify and implement any immediate learning.
- Undertake a desk top review of each contact and consider if the care was appropriate at the time of presentation
- Consider whether any system and/or environmental factors impacted on decision-making across all health contacts, benchmarking against national standards for the care of children in emergency care settings and the use of paediatric early warning tools.
- Were there any points where Yusuf needed an admission paediatric bed? If that was the case, determine the availability of paediatric inpatient beds and access to paediatric expertise (medical and nursing) and the extent to which, if at all, these factors impacted on decisions taken in respect of Yusuf's care.
- Review how paediatric bed capacity is managed in The Rotherham NHS Foundation Trust and how the escalation process works in South Yorkshire should capacity be limited.
- Determine whether the concerns and accounts of Yusuf's family, including his parents and uncle, in respect of his presentation were fully considered as part of care planning.
- Consider whether Yusuf's presentation was fully recognised and understood by healthcare professionals, commenting on whether appropriate care, treatment and support to the family were offered, identifying both areas of good practice and areas of learning.

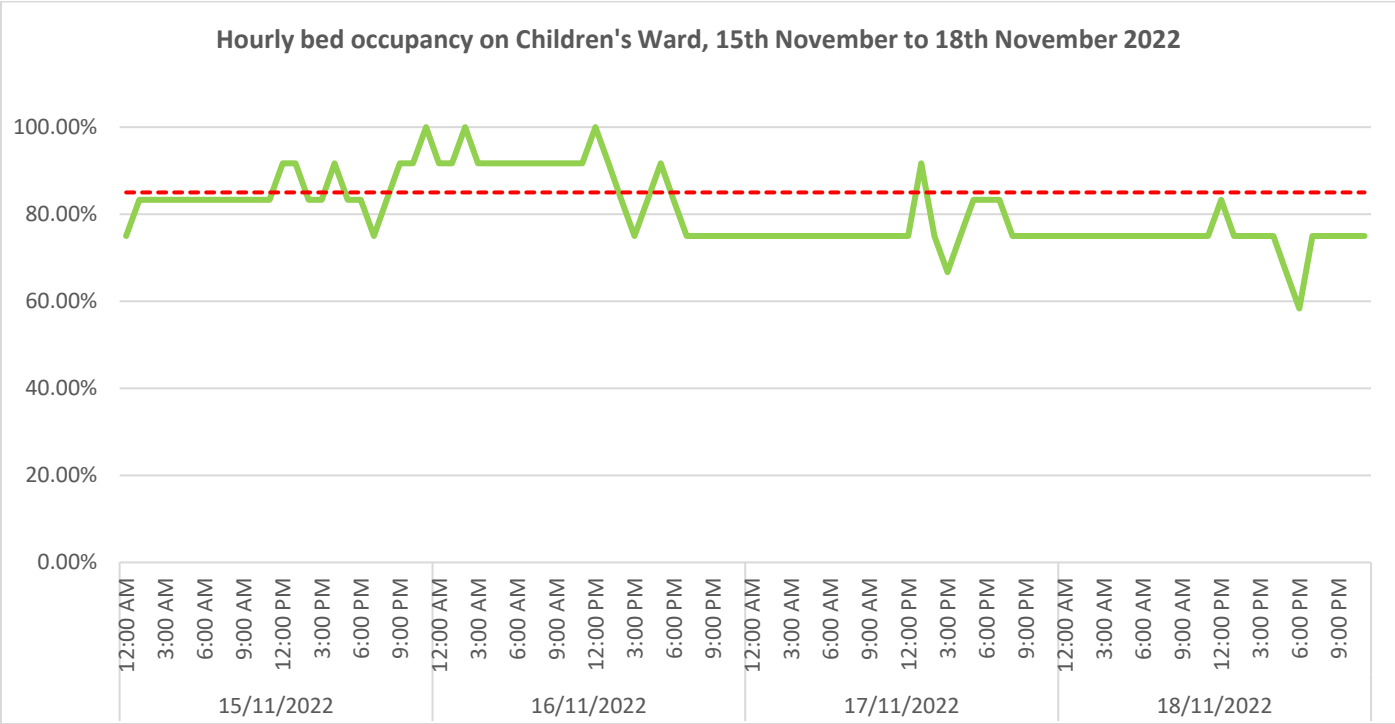
- Identify whether health professionals involved in Yusuf's care had the relevant training or knowledge (e.g. spotting the sick child/PEWS/POPS).
- Determine whether the timeliness and interpretation of diagnostic tests impacted on care and treatment decisions.
- Determine how NHS paediatric services should respond effectively if similar circumstances were to occur.

Deliverables

- To ensure continuous learning, promptly communicate any opportunities for early learning identified throughout investigative activity to the relevant health organisation.
- Provide NHS England with a monthly update on progress (template to be provided by NHS England) detailing actions taken, actions planned, family contact and any barriers/risks to the Review's progress.
- Based on investigative findings, make organisational or service specific, outcome-focused recommendations, with a focus on sustainable system improvement, with a priority rating and expected timescale for completion.
- Provide a final written report and a separate, anonymised and publishable Executive Summary to NHS England (that is easy to read and meets NHS England accessible information standards) within two months of receipt of all clinical records.
- Share the findings of the report in an agreed format, with Yusuf's parents and family, seek their comments and ensure appropriate support is in place for receiving the findings, ahead of publication by NHS England.
- Where recommendations are made, contribute to a stakeholder meeting hosted by NHS England, to provide an opportunity for organisations to explore and fully understand the intention behind all recommendations (to assist effective action planning) and to make any appropriate revisions to the recommendations based upon discussions.

Appendix 2 – Bed capacity on CAU and children's ward (Rotherham) 15-18 November 2022



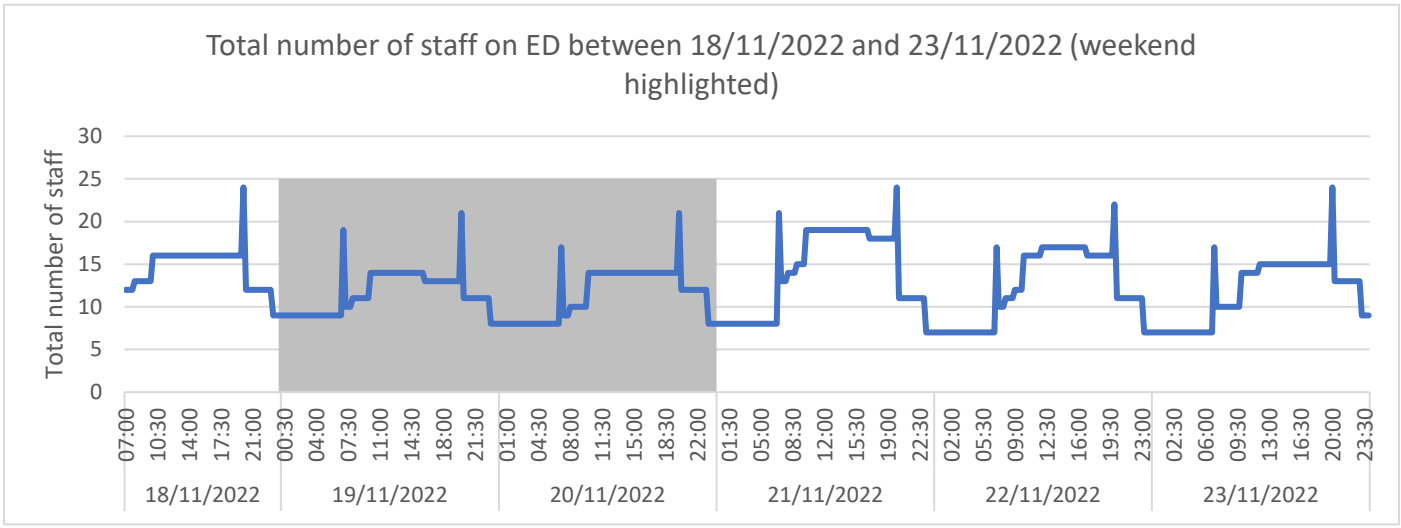


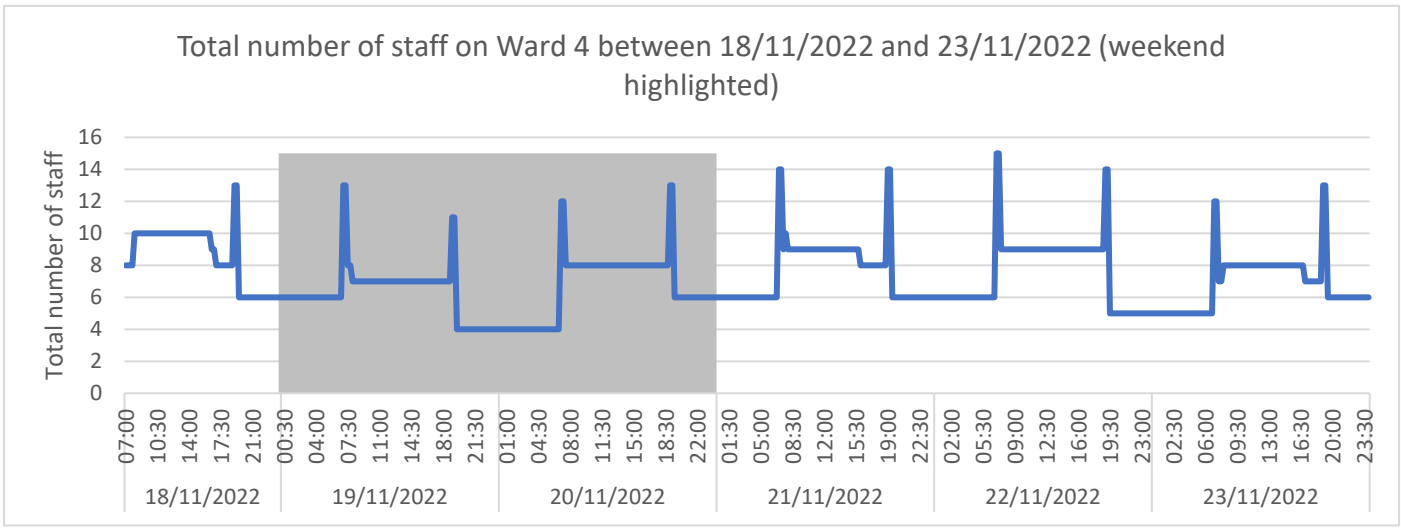
Appendix 3 – Test results 18 to 23 November 2022

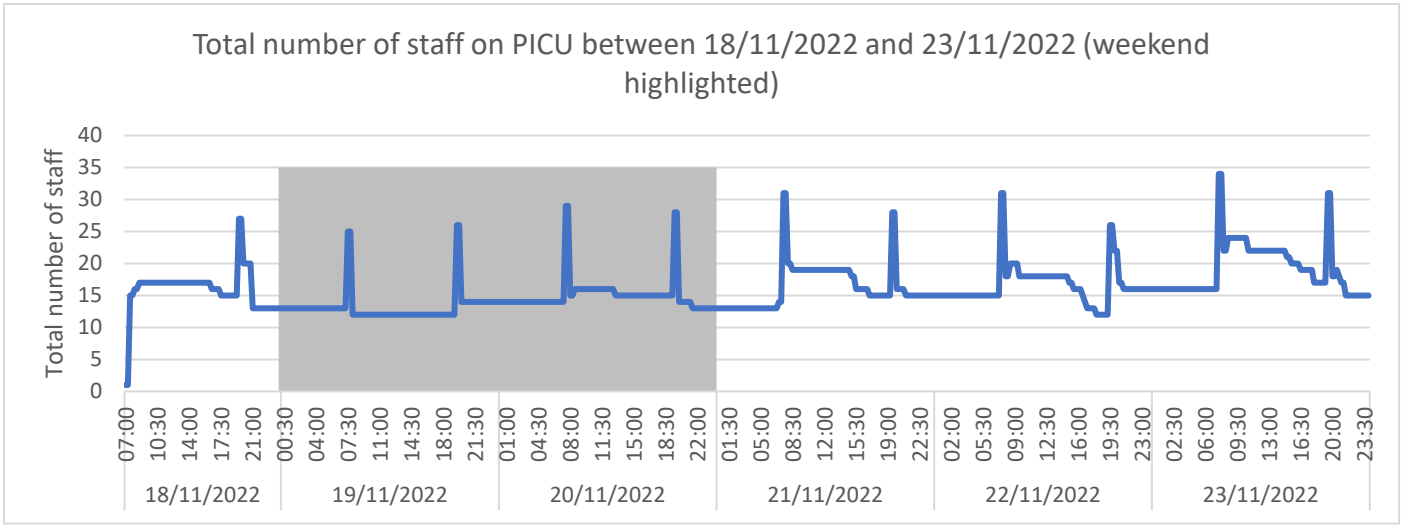
Redacted

Appendix 4 – Ward staffing levels at Sheffield Children's Hospital

We analysed staffing levels at Sheffield Children's in the ED, Ward 4 and on PICU. We did not identify any specific shortfalls. The grey area is the weekend period of 19/20 November 2022.







Appendix 5 – Glossary of terms used

AACE	Association of Ambulance Chief Executives
ACT	asthma control test
AKI	acute kidney injury
BD	twice a day (prescription)
CMV	cytomegalovirus
COPD	chronic obstructive pulmonary disease
CRP	C-reactive protein
CT	computerised tomography
DIC	disseminated intravascular coagulation
EBV	Epstein-Barr virus
ECG	electrocardiogram
ECMO	extracorporeal membrane oxygenation
ED	emergency department
eGFR	estimated glomerular filtration rate
ENT	ear, nose and throat
ESR	erythrocyte sedimentation rate
EWS	Early Warning Score
GCS	Glasgow Coma Scale
Hb	haemoglobin
HFOV	high-frequency oscillatory ventilation
ICU	intensive care unit
Ig	immunoglobin
IV	intravenous
JAR	joint agency review
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
L	litre
NASMeD	National Ambulance Service Medical Directors
PCR	polymerase chain reaction
PEWS	Paediatric Early Warning Scoring
PICU	paediatric intensive care unit
POPS	Paediatric Observation Priority Score
PRN	as required (prescription
QDS	four times a day (prescription)
RCPCH	Royal College of Paediatrics and Child Health
SIRS	systemic inflammatory response syndrome
TDS	three times a day (prescription)
UECC	urgent & emergency care centre
VIP	visual infusion phlebitis
WCC	white cell count
WOB	work of breathing

Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

Read more about us at: **www.nicheconsult.co.uk**

Assurance Statement

Assurance Statement by The Rotherham NHS Foundation Trust (TRFT) in response to an Independent Investigation into the care and treatment of Yusuf.

1. Response to the independent review report

In the first instance, our thoughts are with Yusuf's family at this difficult time and we offer our sincere condolences to them.

We welcome the thorough incident investigation report and note it's finding that the medical care provided to Yusuf in TRFT was appropriate and was not a factor in his sad death. We accept the recommendations and opportunity to improve and set out below the actions we have taken in response to the four recommendations relevant to TRFT.

TRFT's Response to the Recommendations in the Independent Report

Recommendation 1: Conflict resolution and listening to family members
Difficult conversations took place between relatives and hospital staff as Yusuf's family attempted to access urgent care.

- All clinical teams are to be encouraged to attend simulation communication training on conflict in patient care;
- It is advised that a reminder be given to staff about responding to parent concerns (as per the amber flag in sepsis guidance). History taking and listening carefully to a concerned parent or relative should be uppermost in the minds of staff presented with a very sick child.

TRFT Response

We believe it is important that our staff are trained to recognise, manage and resolve conflict situations effectively and so we already include conflict resolution training as part of our mandatory training requirements and this training continues.

In order to complement the existing training, one of our Education Practitioners carries out simulation training that incorporates scenarios where both medical and nursing staff are able to work through how to manage challenging situations and conversations thus further supporting staff to respond with compassion and empathy.

In addition to the above we are reviewing our learning needs analysis for conflict resolution training to ensure we have captured all appropriate staff.

The investigation found that the content of a telephone call made by Yusuf's uncle to the Children's Ward was not recorded. We have introduced a process for recording telephone calls to the Children's Ward and Children's Assessment Unit which is now is fully implemented and embedded within the service.

A Trust wide communication has been circulated to re-iterate the importance of listening and responding to concerns raised by parents or relatives.

Recommendation 2: Recording systems and paediatric information fields.
There were minor recording errors that IT solutions could solve. Namely that the ST6 doctor was still being recorded as a foundation doctor, the child's height was pulled through from SystmOne and the BMI calculations used height/weight, which is more appropriate for adults, when BMI centiles are more appropriate in paediatric care. Accurate weight/height and BMI centiles are essential in paediatric decision making. The discharge letter appears to use the Early Warning Score (EWS) as the filed in the EPR (when POPS is used for children).

- The Trust should examine why there remain problems with changing the grades of staff in the electronic patient record and resolve this for the ST6. They must also establish if it is a wider issue.
- SystmOne should be reviewed with paediatrics in mind. Height and weight recordings should be pulled into records accurately and BMI centiles should be used instead of the adult orientated calculations for BMI. It should also be clear whether POPS or EWS scores have been assessed.

TRFT Response
The Trust accepts that roles within Meditech (our electronic patient record) required updating and when this was brought to our attention during the investigation, a programme of work commenced immediately to do this. The systems of working between the Meditech team and Medical Staffing have been revised to ensure timely updating of staff roles within the system. This programme of work will be completed by December 2023.

Meditech does not automatically 'pull' data from SystmOne rather it recognises the last entry made within Meditech to calculate a patient's BMI score. A communication has been circulated to the relevant staff groups re-iterating that growth charts are held within Meditech and they are to be completed in line with national guidance.

In accordance with national guidance, a range of early warning scores are used within different clinical contexts. In Yusuf's case, the correct POPS tool was used but the way in which this was presented on the screen did not make this clear. We are in the process of amending our system so that alongside each early warning score the name of the tool used is displayed.

Recommendation 3: Staffing levels in the UECC

Medical staffing levels were below expected levels on the night of 15 November.

- The Trust should assess medical and nursing staffing levels in the paediatric UECC overnight to ensure capacity meets demand. This should include the number of clinicians, their seniority and their level of paediatric experience.
- The Trust should review whether to have paediatricians in the paediatric UECC at all times who can oversee the care of children presenting with medical complaints.
- The Trust should review the feasibility of having a children's assessment unit, ideally co-located with the UECC, open 24 hours a day with medical and nursing staff trained in the care of acutely unwell children.

We understand these recommendations have already been acted on at Rotherham; a progress report on the changes would be helpful.

TRFT Response

Significant work has taken place regarding nurse staffing within UECC. With the exception of one part time post, we have now recruited to all posts. Colleagues in the UECC from both adult and paediatric nursing have been working together on competencies to enable adult nurses to work with paediatrics. Paediatric Emergency Nursing level 1 training has commenced for all adult nursing staff in the UECC which provides refresher training for staff on the recognition and management of the sick child in the UECC with a combination of taught sessions, workshops and simulation sessions.

As an immediate action, we added an additional locum Paediatric doctor from 23 November 2022, working out of hours. The Trust has invested further in paediatric medical staffing to support the British Association of Perinatal Medicine medical standards. This provides an additional paediatric doctor on site during nights and weekends with three out of four additional posts now recruited to.

Since the end of 2022, we have recruited four new Consultants to the UECC. In addition, winter funding was provided which enabled an additional doctor to work during times of highest pressure from 12 December 2022. This funding is also available this winter.

There is already a Children's Assessment Unit, co-located with the Children's Ward. The teams have visited local Trusts to see the benefits of a combined emergency department and Children's Assessment Unit and we are considering the merits of this model at TRFT.

Recommendation 4: Patient information
Staff were unaware of the website resource Healthier Together which contains information leaflets and advice (for safety netting).

- Parents should be directed to the Healthier Together website for written patient information.
- Nursing and medical staff working in the paediatric UECC should be aware of this resource. Leaflets should be printed if parents do not have internet access.

TRFT Response
The use of the Healthier Together Online resource is embedded with Paediatric UECC. Posters are visible within the department in addition to business cards with QR Codes being available providing a direct link to the Healthier Together website. In the event families do not have the digital resource to access the website the relevant information is printed for them.

Staff within the paediatric UECC have received e-mail communication raising awareness of the Healthier Together website.

Summary
The Trust recognises this is a difficult time for the family and we reiterate our sincere condolences. The Trust will continue to review the action plan related to the above recommendations with oversight via the Quality Committee and Trust Board.

An abridged report from the Independent Investigation and Trust response can be accessed on our website and has been made available to the Trust Board.

Board of Directors' Meeting
03 November 2023

The Rotherham NHS Foundation Trust

Agenda item	P158/23
Report	**Chief Executive Report**
Executive Lead	Dr Richard Jenkins, 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. 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	None

1.0 Activity

1.1 **Activity:** The elective programme continues to be adversely affected by the different periods of industrial action, as well as challenges with theatre staffing. Late September and early October were particularly challenging due to the consecutive periods of industrial action for both doctors in training and Consultants. A number of outpatient appointments as well as elective lists had to be cancelled to ensure workforce was available to support emergency pathways.

1.2 **Recovery**: The national expectations for elective recovery in 2023/24 require the Trust to treat all patients waiting over 65 weeks for their treatment. Whilst we have relatively low numbers of patients waiting this long for their treatment currently, we do now have two patients waiting over 78 weeks. These patients are both waiting for corneal graft tissue, and we are continuing to work with NHS Blood and Transplant Services to ensure they can receive their treatment as soon as possible. The rapid growth in the number of patients waiting over 52 weeks for their treatment this year is a concern and we now expect the number of patients waiting over 65 weeks to grow and be above our submitted plans until March 2024 when we will ensure all these patients have received treatment. The impact of industrial action in the last two months in particular has been significant, as we have had to cancel much of the planned elective activity within theatres. The Trust's Referral to Treatment (RTT) performance has declined relative to other providers this year, with the Trust now 53rd out of 119 acute or combined Trusts in the latest published national data. We have recently agreed additional funding to support increased activity in the second half of the year, with a particular focus on insourcing into our Anaesthetic and Theatre teams in order to ensure we can run our full planned theatre timetable.

Activity for the first six months of the year has been below 2019/20 levels, in part due to the ongoing gaps within our own teams against 2019/20 availability and a number of periods of industrial action, which impacted heavily on elective capacity and reduced efficiency even outside of these periods. This is particularly noticeable within our day case and inpatient activity, where in the first half of the year we delivered 88% and 84% of 19/20 activity respectively. In the meantime, significant focus on our operational productivity continues, with the Trust's capped theatre utilisation figures now routinely in the top quartile of providers, and outpatient clinic utilisation improving from approximately 85% in 2019/20 to 90% for the first half of this year.

1.3 **Urgent and Emergency Care Activity:** The Trust has seen heightened operational pressures over the last couple of months meaning at times the Trust has operated at OPEL level 3. Work continues to reduce waiting times in our Urgent and Emergency Care Centre and to embed the 4-hour access standard which was reintroduced earlier in the year. There has been continued good performance on eliminating ambulance handover delays, with our trajectory achieved in August and September. The reconfiguration of our acute bed base has now been implemented, with additional capacity opened alongside rightsizing our surgical and medical bed base which will support the Trust ahead of winter.

2.0 Performance

2.1 The Chief Operating Officer and I visited AESSEAL Plc on 14th September 2023 and met with a team involved in the company's achievement of Net Zero carbon emissions. Whilst their business is very different to the NHS, there were many parallels in terms of the approach to staff engagement and development, innovation and a commitment to our wider roles as key partners in Rotherham. A return visit is being arranged to continue our mutual desire to work collaboratively as anchor institutions.

2.2 The Trust experienced, for the first time, both Consultants and Doctors in Training taking Industrial action between 19 and 23 September 2023, which meant an overlap in strike action for one day on 20th September 2023. There was further industrial action from 2nd to 5th October 2023, which this time involved both Consultants and Doctors in Training for the whole period. As mentioned above, the impact has had an effect on activity and staff also.

2.3 The Board will be aware of news reports regarding reinforced autoclaved aerated concrete (RAAC). To confirm, that the Trusts appointed structural engineer has advised that the design intent of the roofs of Rotherham Hospital are of traditional cast concrete structure and not RAAC. We have also received confirmation from the landlords of our community facilities that there is no RAAC present in those buildings.

2.4 The NHS Premises Assurance Model toolkit provides assurance and demonstrates compliance with the statutory requirements and good practice guidelines that inform the delivery of Estates and Facilities services across the required domains. In addition, the tool kit permits the identification and coordination of improvements through a monitored action plan. A report presented to the ETM and accepted on 7th August, enabled the mandatory submission to NHSI on 8th September 2023.

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

3.1 Representatives from the Trust have continued to attend several Place meetings including the Health and Well-Being Board, the Health Select Commission, and the Place Board. A detailed update is provided by the Deputy Chief Executive in his report to the Board of Directors.

3.2 I visited the newly constructed Montagu Elective Orthopaedic Centre for Excellence (MEOC) in October, which is on track to be completed at the end of December, with an expectation that it will welcome its first patients in January 2024. The state-of-the-art facility is impressive and will be a fantastic asset for the people of Rotherham, Barnsley and Doncaster.

3.3 NHS South Yorkshire Integrated Care Board and South Yorkshire Integrated Care System received a Health Service Journal Award for their groundbreaking initiative for staff named ‘Mission menopause – changing culture in South Yorkshire’. The initiative is to raise awareness of menopause and provide support for improving women’s health and well-being during this period in their life. The national award-winning programme has seen 15 partner organisations from South Yorkshire’s local authorities, foundation trusts, primary care, social care, and the voluntary sector come together to share learning and best practice on changing the culture around menopause in the workplace.

4.0 People

4.1 The following Consultants have commenced in post since my last update:

- Dr M Stafford, Emergency Medicine
- Miss M Poothavelil, Obstetrics & Gynaecology

We also have a number of other Consultants that have been offered and accepted posts as part of the formal recruitment process as follows:

- Dr H Hashim, Cardiology

- Miss N Ahmed, Orthodontics

4.2 The monthly staff Excellence Awards winners for the months of August and September 2023 were:

August 2023
Individual Award: Sarah Hawley, ERoster Advisor
Team Award: Neonatal Unit
Public Award: Heather Goldie, Apprentice Physiotherapist

September 2023
Individual Award: Sarah Cooper, Acute Response Team CNS
Individual Award: Mike Smith, Healthy Hospitals Programme Manager
Team Award: Central North District Nursing Team
Public Award: Elvena Guyett, Consultant Obs & Gynae

4.3 The annual NHS Staff Survey has now started and colleagues are being encouraged to take time to complete it by the deadline of 24th November 2023.

4.4 The annual staff vaccination programme – Get Winter Strong (Covid-19 Booster and Flu) has now commenced and eligible colleagues have been invited to book their vaccinations online. Staff will be able to take the flu vaccination at the same time or book separately if not eligible for the Covid-19 booster.

4.5 Our current Director of Estates and Facilities will be leaving the Trust at the end of December 2023 to take on a new role. We have commenced a recruitment process for an Interim Director of Estates and Facilities to provide cover in the period whilst we recruit substantively. I would like to take this opportunity to thank Ian for his work and commitment to the Trust during his time here.

5.0 TV Filming

5.1 I have reported previously that the Trust had agreed to participate in a new Channel Five television programme which would focus on the A & E department at night. Initially, this was for a 12-week period, but this was extended and is due to be completed in the next two weeks. This has enabled the Trust to show the best of what it has to offer and to display some of the great work happening within the department.

6.0 Report into the care of Yusuf Nazir

6.1 The final report on the independent investigation into the death of Yusuf Nazir has now been published. As reported previously, the Trust has been open and transparent with the independent investigators throughout the investigation and whilst the report has not highlighted any issues relating to Yusuf's care that would have changed the outcome, the recommendations made have been accepted and are being implemented. Further detail is available via the Medical Director report. Along with the Medical Director and the Deputy Chief Nurse, I have met with Yusuf's mother and uncle to discuss the report and our actions.

Dr Richard Jenkins
Chief Executive
November 2023

Board of Directors' Meeting
03 November 2023

The Rotherham NHS Foundation Trust

Agenda item	P159/23
Report	**Board Assurance Framework**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The paper relates to all BAF Risks
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and supports all three core values Ambitious, Caring and Together
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	The Board Assurance Framework (BAF) links directly to the Trust's Strategic Ambitions as set out in the 5 Year Strategy (2022-2027) and identifies any strategic risks that could prevent delivery of the Trust's Strategic Ambitions. The following report illustrates the proposed position at the beginning of Quarter 3 2023-24 (Year 2 of the 5 Year Strategy). The BAF Risks have been discussed at the relevant Board Assurance Committees as follows: **People Committee**: Discussed and approved the position in relation to Strategic Risk U4 and D5 where this risk impacts on our People; **Quality Committee**: Discussed and approved the position in relation to Strategic Risk P1; **Finance and Performance Committee:** Discussed and approved the position in relation to Strategic Risk D5 and D7. BAF Risks R2 and O3 have bene reviewed by the Deputy Chief Executive and the Deputy Director of Corporate Affairs in preparation for further discussion at the Board meeting.
Due Diligence	Since presentation at the last Board in early September 2023, the relevant sections of the Board Assurance Framework has been discussed at the relevant Board Committees during September and October 2023
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 the approval of the Board Assurance Framework.

Who, What and When	The Director of Corporate Affairs will continue to work with Executive colleagues in order to review and update the BAF on a monthly basis thus highlighting any risks or issues that have the potential to disrupt achieving our Strategic Ambitions.
Recommendations	It is recommended that the Board: • Discuss and note the progress made in the Board Assurance Framework; • Note and approve the following recommendations; ➢ The score for BAF Risk P1 to remain at 12; ➢ The score for BAF Risk R2 to remain at 8; ➢ The score for BAF Risk O3 to remain at 8; ➢ The score for BAF Risk U4 to remain at 12; ➢ The score for BAF Risk D5 to remain at 20; and ➢ The score for BAF Risk D7 to remain at 15
Appendices	Board Assurance Framework

1. Introduction

1.1 The Board Assurance Framework (BAF) links directly to the Trust's Strategic Ambitions as set out in the 5 Year Strategy (2022-2027) and identifies the strategic risks that could prevent delivery of the Trust's Strategic Ambitions.

1.2 During the financial year 2022-23, the Board provided oversight and approved the positions in relation to an initial total of seven strategic risks on the BAF. The Board will recall that BAF Risk D6 relating to the financial position for the previous financial year has been closed.

1.3 The BAF illustrates the risks to achieving our Strategic Ambitions during the end Quarter 2 and early Quarter 3 of the financial year. Furthermore, the report provides as summary of the discussion and decisions that have taken place at the relevant Board Assurance Committees during September and October 2023. In addition the BAF was presented at the Audit and Risk Committee on 27 October 2023.

1.4 The Board will note that in order to ensure the BAF remains a workable and accessible document, a number of completed gaps in controls have, following agreement at the relevant Assurance Committees moved to archive; these are readily available should there be a need to refer back to them.

1.5 When considering the scoring of each risk, the 2008 Risk Matrix for Risk Managers is used as a reference guide.

Outcome of the September and October 2023 Reviews

2 P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resources, capacity and capability leading to poor clinical outcomes and patient experience.

2.1 Strategic BAF Risk P1 is aligned with the Quality Committee and following review in September and October 2023, additional commentary has been added to the controls and assurance and gaps in assurance sections, highlighted in red for ease of reference.

Controls and assurances

2.2 No additional controls have been added to BAF Risk P1 during this review period.

Gaps in controls

2.3 No significant changes to the gaps in controls for this review period.

2.4 Review of the risk score

The initial score agreed for 2022-23 was **16** whereby the consequence was graded a **4** (Major), defined as noncompliance with national standards with significant risk to patients if unresolved. The initial likelihood score agreed was **4** (Likely) defined as 'will probably happen/recur but is not a persisting issue.'

Following discussion and debate, and taking into consideration the removal of the five Conditions on the Trust's Registration, progress in closing some identified gaps in controls and mitigations, the likelihood was reduced to **3** (Possible) defined as 'might happen or recur occasionally.'

This resulted in the reduction of the overall score to **12.** The Board will note that this is within the target score for the first year of the 5 Year Strategy but remains out with the Boards risk appetite of Very Low pertaining to Quality (score 1-5).

Ongoing progress continues to be made in relation to closing the gaps in controls and as such it is recommended that the risk score remains at **12**.

3 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 health inequalities.

3.1 Strategic BAF Risk R2 has been reviewed by the Deputy Chief Executive and the Deputy Director of Corporate Affairs. The Trust has developed a strong presence at PLACE and therefore, during Quarter 1 that has continued during Quarter 2.

3.2 Following review, it is recommended that the score remains at **8.**

4 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.

4.1 Strategic BAF Risk O3 has been reviewed by the Deputy Chief Executive and Deputy Director of Corporate Affairs. The Trust has continued to develop and strengthen the partnership working with Barnsley Hospitals NHS Foundation Trust with the continuation of the Joint Strategic Partnership which is now supported by a Board approved Memorandum of Understanding.

4.2 There is now in place an agreed Joint Strategic work plan for the remainder of the financial year, the progress of which is monitored through the established Joint Strategic Partnership.

4.3 A joint leadership programme focused on the Triumvirate from the Trust and Barnsley has now been commissioned and the company will commence this important work during October 2023.

4.4 It is recommended that the score remains at **8.**

5 U4: There is a risk that we will not develop and maintain a positive culture because of insufficient financial resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.

5.1 Strategic BAF Risk U4 is aligned to the People Committee and was discussed at the meeting in October 2023. The key developments of note are that strengthened actions plans relating to the WRES and WDES will be presented to the Board for formal approval at the end October 2023.

5.2 Following the outcome of the review at People Committee in October 2023, it is recommended that the score remains at **12.**

6 D5: There is a risk that 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.

6.1 Strategic BAF risk D5 is aligned to the Finance and Performance Committee. Following the monthly review during September and October 2023 it is recommended that the score remains at **20.**

7 D7: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023-24 leading to further financial instability.

7.1 Strategic BAF Risk D7 is aligned to the Finance and Performance Committee. Due to the continuing work around the financial plan it is recommended that the risk score remains at **15** and will be further reviewed when we have further clarity on the system wide financial position.

Gaps in Controls

7.2 G3 Month 6 financial position year to date £1,068,000 adverse variance position with an improvement of £150,000 in month.

Recommendations

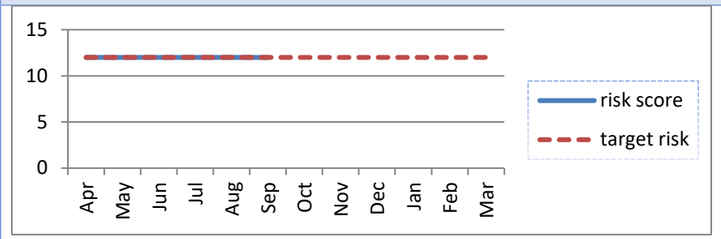
The Board is asked to:

- Discuss and note the current position relating to the Board Assurance Framework;
- Note and approve the recommendations to;
  - The score for BAF Risk P1 to remain at 12;
  - The score for BAF Risk R2 to remain at 8;
  - The score for BAF Risk O3 to remain at 8;
  - Increase the score for BAF Risk D5 to 20;
  - The score for BAF Risk U4 to remain at 12; and
  - The score for BAF Risk D7 to remain at 15.

Angela Wendzicha
Director of Corporate Affairs
27 October 2023

Board Assurance Framework Overview for Quarter 3: 2023-24

Ambition	Strategic Risk			Original Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	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	**12**	**12**	12		3(L)x4(C) =12		Very low (1-5)
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**	2(L)x4(C)=8	**8**	**8**	**8**		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	**8**	**8**	**8**		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.**	3(L)x4(C)=12	**12**	**12**	**12**		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	**12**	**20**	**20**		5(L)x4(C)=20		Low (6-10)
	D7: we will not be able to sustain services in line with national and system requirements	**…of a potential deficit in 2023/24**	**…further financial instability.**	3(L)x 5(C) = 15	**15**	**15**	**15**		3(L)x5(c) =15		Low (6-10)

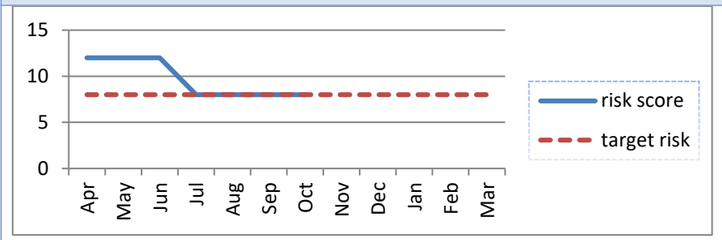
Strategic Theme: Patients		**Risk Scores**									
		BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**			**Board Assurance 2023-24**	
Strategic Ambition: **Patients:** ***We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them***		**P1**	**4(L)x4(C)=16**	**12** **3(L)x4(C)**	**3(L)x4(C) =12**	~~**Moderate (12-15)**~~ **Very Low (1-5)**				**Previous Score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: P1: Empower out teams to deliver improvements in care										**16**	**12**	**12**	**12**	
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks:** **RISK6623, RISK5761, RISK6474, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6623, RISK6886, RISK6414, RISK6284, RISK5238 and RISK6723**				**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.											**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	Quality Delivery Group in place with remit to deliver against CQC standards	Receipt of monthly assurance reports relating to progress against actions Quality Assurance Report to Quality Committee (Quarterly) Monthly reporting to CQC in relation to Conditions on Registration.		July 2023 October 2023 Complete	Deputy CEO Chief Nurse Chief Nurse		Level 1 & Level 3 Level 1& Level 3 Level 1& Level 3						
C2	Established Tendable Audit Programme	Outcome reports received by Quality Committee on a rolling quarterly programme linked to specialist areas Audit reporting programme now included in Committee report to Quality Committee – on a rolling quarterly programme linked to specialist areas – Patient Safety, Safeguarding, Patient Experience, Infection Control as aligns with work plan Monthly Quality Dashboard reported to Divisional Performance Meetings.		 September 2023 September 2023	Chief Nurse Chief Nurse Chief Nurse		Level 1 Level 2 – Medication Safety Audit completed						

		Published Patient Experience Annual Report on Trust website.							
C3	Agreed 2023/24 Quality Priorities in place	Progress reports received by Quality Committee quarterly Monthly metrics dashboard now presented for quantitive data. Clinical Effectiveness is a priority, Clinical Effectiveness Manager now in post.	September 2023	Chief Nurse	Level 1 Progress reports on Quality Priorities presented within each quarter Quarter 1 reports all received by Quality Committee				
C4	Implementation of actions following Patient Surveys	Progress reports received by Patient Experience Committee and monitored via Quality Committee.	August 2023	Chief Nurse	Level 1				Recent inpatient survey results not as expected, an action plan has been developed and is in place
C5	Coordinated approach for learning from deaths	360 Assure Report with Limited Assurance – completed 13 of 15 actions from report. 360 Assure re-audit took place May 2023 – Split opinion with partial assurance. One outstanding action against learning from deaths being disseminated at CSU level. However report did note progress made overall. Learning from Deaths Report to Patient Safety Committee and Quality Committee	May 2023 October 2023	Medical Director	Level 3 Outstanding actions – see G4 below: Learning from deaths at CSU level & Embedding SJR process Learning From Deaths Policy to be completed				
C6	Partnership working with Barnsley NHSFT	Quarterly peer reviews carried out re Quality Assurance (Q1 – Surgery)	Quarter 1	Chief Nurse/Medical Director	Level 1 – Awaiting final outcome report Medicine will be reviewed in December 2022 - revised date Medicine and Outpatients in February 2023, Community in March 2023 (this occurred but was internal only with Barnsley unable to participate), meaning all services will have been reviewed in financial year 2022/23. Reviews now completed External assurance process being reset for 2023/24, will be reviewed in Quarter 2 2023/24. Pharmacy in Barnsley have had a recent CQC report and TRFT are developing a plan to assure Medication Management. A paper will be presented to Quality Committee via the Medication Safety Committee.				
C7	Quality Improvement & Quality Governance Assurance Priority within Operational Plan	Quarterly updates to Quality Committee	October 2023	Chief Nurse	Revised Quality Improvement and Quality Assurance Report with new format from October 2022 incorporating the CQC assurance report. 2022/23 report to be signed off April 2023 and 2023/24 report to go to Quality Committee June 2023.				Presented quarterly.
C8	Implementation of PSIRF	Monthly meetings established	October 2023	Chief Nurse	Fully signed off action plan in place and monthly meetings established. Throughout May 2023 multiple PSIRF plan workshops have been held, Strategic Board session planned for 02/06/2023. Agreed priority themes for Patient Safety related to PSIRF. Quarterly PSIRF update to Quality Committee as part of Patient Safety reporting.				
C9	Implementation of agreed Strategy for Journey to CQC Outstanding rating	Quarterly progress reports to Quality Committee (links with Gap 14), next is July 2023	October 2023	Chief Nurse	**Level 1**				
C10	Implementation of Safeguarding Improvement plan in conjunction with NHSE	Reports to Safeguarding Committee was July 2023	October 2023	Chief Nurse	External review NHSE paediatrics and maternity occurred on 01/06/2023, report due to be sent to TRFT by 30/06/2023, however not received as of 18/07/2023 12-17/07/2023 – Rotherham Adult Safeguarding Peer Review took place				

Gaps in Controls or Assurance Quarter 1 2023-24		Actions Required	Action Owner	Date Action Commenced	Date Action Due			Progress Update	
G1	Lack of suitable Quality Improvement methodology linked to the Operational Plan Developing a sustainable QI faculty and projects with identifiable patient benefits alongside QI methodology.	Review next stage Business Case Submission of next stage business case brief Gained approval at June 23 ETM to proceed to full business case – approved at ETM August 2023 – recruitment to commence Recruit to x2 further roles in QI team	Chief Nurse & Medical Director Chief Nurse & Medical Director Chief Nurse & Medical Director Chief Nurse	August 2022 March 2023 September 2023 Recruitment process commenced	~~September 2022~~ June 2023 ETM 8 June 2023			Recruitment for MD for Quality Improvement (2PA's) to be completed ETM ~~April~~ June 2023	**Out to advert**
G2	**Archived – see version 1.1 2023/24**								
G3	**Archived – see version 1.1 2023/24**								
G4	Lack of thematic reviews following Structured Judgement Reviews	Implement actions from 360 Assure Learning from Deaths report Process to be agreed to ensure learning from deaths is disseminated at CSU level New Learning from Deaths Policy being drafted	Medical Director Medical Director Medical Director		~~July 2022~~ ~~End December 2022~~ March 2024 End Q4 2023/24 End Q4 2023/24			Positive thematic reviews received for Surgery and Paediatrics. Business case to ETM by end of October 2022, draft received at Mortality meeting w/c 03/10/2022. Business case approved at ETM – awaiting recruitment. Completed recruitment of SJR Roles. Completed SJRs (18) are being sent to Divisions Mortality Leads every 4 weeks. Comments from all SJRs are themed and categorised in quarterly Thematic Analysis Reports. A meeting to finalise the Learning from Death policy is being held on 25/08/2023. This is to be approved by the Trust Mortality Group on 05/10/2023, in order to be approved by the Patient Safety Committee on 19/10/2023, before finally being submitted to the Trust's Documentation Ratification Group.	
G5	**Archived – see version 1.1 2023/24**								
G6	Implementing new ways of working for the Quality Governance & Assurance Team.	Recruit into Quality Governance & Assurance 8c Lead Role to support the central Governance Team	Chief Nurse	August 2022	October 2022 ~~Extend to June 2023~~ Extend to October 2023			~~Business case approved Executive Team Meeting 15 September 2022, follow up paper to identify governance structure to ETM 20/10/2022~~. Business case approved in principle Established Quality Governance Assurance Unit and are recruiting to all posts except the lead role	
G7	**Archived – see version 1.1 2023/24**								
G8	**Archived – see version 1.1 2023/24**								
G9	**Archived – see version 1.1 2023/24**								

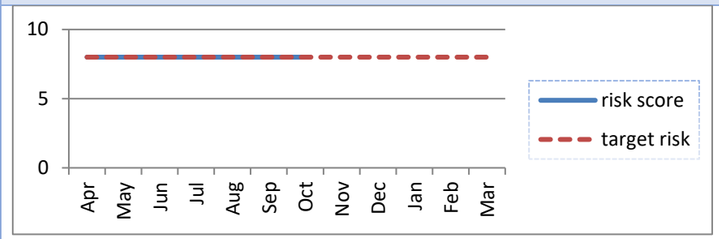
G10	**Archived – see version 1.1 2023/24**								
G11	**Archived – see version 2.2 2023/24 – Superseded by G27**								
G12	**Archived – see version 1.1 2023/24**								
G13	**Archived – see version 1.1 2023/24**								
G14	**Archived – see version 1.1 2023/24**								
G15	**Archived – see version 1.1 2023/24**								
G16	**Archived – see version 1.1 2023/24**								
G17	Increased outbreak of CPE Infection	Managed through the Infection Prevention Control of Decontamination Meeting. UKHSA and ICB have been asked to attend site in May 2023 to undertake an assurance visit	Chief Nurse Chief Nurse	Ongoing May 2023	Ongoing May 2023			Weekly oversight meetings have ceased and moved to Heads of Nursing with oversight at ETM. Deep clean process remains ongoing with Executive oversight. Visit complete, report received and will be presented at IP&C, ETM and in the Clinical Effectiveness quarterly and annual report.	
G18	Lack of assurance regards quality of end of life care	Completion of action plan that has been created in response to 360 assurance report and NACEL 2022 alarm outlier status report Strategy went to May 2023 Quality Committee and Board of Directors September 2023	Medical Director and Chief Nurse	January 2023 September 2023	~~May 2023~~ September 2023 May 2023			Action plan created and shared internally and with external organisations Awaiting completion of NACEL and 360 audit action plan	
G19	Uncertainty regards referral pathway for some tertiary centre cancer services	Regular discussions between MD, COO, CEO. ICB input required.	Medical Director	March 2023	July 2023			Escalated to ETM and Board of Directors Temporary working arrangement agreed for provision of service	
G20	PSIRF preparation to go live in Autumn 2023.	Action plan developed following national guidance Quarterly reporting to Quality Committee and Patient Safety Committee. 360 Assure audit on PSIRF assurance to commence Qtr3.	Medical Director and Chief Nurse Chief Nurse	April 2022 March 2024	March 2024 March 2024			Monthly group meeting established. Patient representative to be agreed. Went live with PSIRF beginning of October – Operational plan and Policy to Patient Safety and then Quality Committee October 2023.	
G21	**Archived – see version 1.1 2023/24**								
G22	**Archived – see version 1.1 2023/24**								
G23	Plan to introduce a Ward accreditation programme	Strategic planning session with Heads of Nursing	Chief Nurse	19/06/2023	December 2023				
G24	As part of the Governance and Assurance Team review, decision required on possible partial centralisation of governance roles.	Paper required for ETM	Chief Nurse	June 2023	On hold pending recruitment of Assurance Lead 8c				

G25	**Archived – see version 2.1 Quarter 2**								
G26	Emerging concern regards National Emergency Laparotomy Audit as trust is an outlier which could be flagged to CQC	Update the Executive Team Identification of resources and Submission of data	Medical Director Clinical Effectiveness Manager	Completed January 2024				Submitting retrospective data, not as much of a risk as initially thought as data is being submitted. Qtr3 will see a 360 Audit of National Audits & NICE Guidelines process.	
G27	Challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4 and D5) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Rates of pay agreed with medical staff to provide cover for junior doctor's strike. Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division. Monitoring of all incidents for possible link to industrial action. Monitoring of cancellation of elective work leading to increased waits for treatment	Divisional Leads & FPC Director of Workforce & FPC Director of Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC Chief Nurse & QC Director of Operations & FPC	Ongoing Completed Commenced Completed June 2023 Ongoing Ongoing	Ongoing Ongoing March 2023			Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. On the July FPC agenda for endorsement in respect of Extra Contractual work. To be reviewed for 2024/25. Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads. Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention. Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM Watchful eye on external factors patient harm being monitored and not believed to be at a level to increase risk rating at this time.	
G28	GAPS in National Audit work	360 Assurance to audit in Qtr3, will also be looking at compliance with NICE Guidelines	Medical Director & QC	January 2024					
Archived Controls within month- Completed									
Archived Gaps within month - Completed									

Strategic Theme: Patients	**Risk Scores**											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**					**Board Assurance 2023-24**	
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~~** **2(L)x4(C)=8**	**~~12~~** **8**	**2(L)x4(C) =8** **Expectation to reduce the likelihood score at the end Q4 thus reaching score.**	**Moderate (12-15)**		**Previous score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**	
Link to Operational Plan: ***R2: Ensure equal access to services***							**12**	**8**	**8**	**8**		
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	~~December~~ September 2023	Board minutes		Level 1					Control remains ongoing	
C2	Trust is a member of Prevention and Health Inequalities Group		**July**			Level 1					**Control remains ongoing**	
C3	Trust is a member of the Health and Wellbeing Board		**July**			Level 1					**Control remains ongoing**	
C4	Deputy Chief Executive attends the Health Select Commission		**July**	**Minutes**		Level 3					**Control remains ongoing**	
C5	Shared Public Health Consultant between RMBC and the Trust commences March 2023	Commenced in post	**March**	**In post**		Level 1					**Completed**	
C6	Meeting with PLACE colleagues to review IDT position.	Meet three times a week to review integrated discharge position.	**October 2023**			Level 1						
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	Ongoing				Awaiting final confirmation from external source	
G2	Unknown entity around the ICB governance		Deputy Chief Executive	Ongoing				Paper expected for the September Board No change to position	

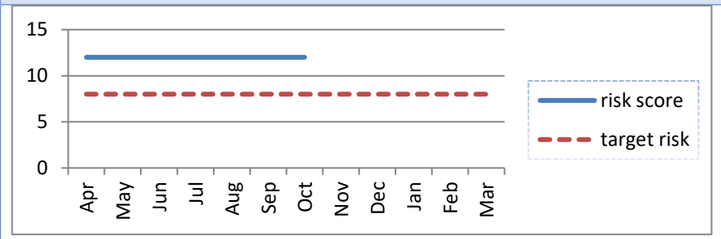
	which is continuing to evolve and mature.								
G3	Incomplete data driven identification of Health Inequalities across elective and non-elective pathways.		Deputy Chief Executive		End Quarter 1			Data relating to access to services available in Trust Integrated Performance Report – suggest close this gap. Gap Closed	

Strategic Theme: Patients	**Risk Scores**										
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2023-24**	
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~~** **2(L)x4(C) = 8**	**8**	**2(L)x4(C) =8**	**Moderate (12-15)**						
Link to Operational Plan: P3: Our Partners: Work together to succeed for our communities.										**Previous score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
										12	**8**	**8**	**8**	
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 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	Completed	**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	In place. Reports to Finance and Performance Committee	**March 2023**		Level 1						
C5	Joint Strategic Partnership and Joint Executive Delivery Group established for oversight and delivery of partnership plan	Meetings of the Strategic Partnership every quarter, Monthly for Delivery Group.		**Reports to Boards on progress**	Level 1						
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.	Completed
G2	Triumvirate Joint Leadership Programme	**Company commissioned to deliver programme**	**Deputy CEO**	**October 2023**	**October 2024**			**Rolled out**	

Board Assurance Framework People Committee: 2023/24 Quarter 3: Version 3.1

BAF Risk U4

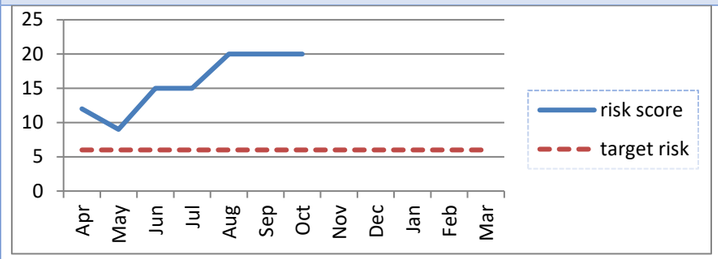
Strategic Theme: Us	**Risk Scores**											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2023-24**		
Strategic Ambition: **Us:** ***We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.***	**U4**	**3(L)x4(C)=12**	**3(L) x 4(C) = 12**	**2(L)x4(C) =8**	**Moderate (12-15)**					**Previous score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***P3: Supporting our People*** ***P2: Improve engagement with our medical colleagues***										**12**	**12**	**12**	**12**	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6474, RISK6801, RISK5238 and RISK6723, RISK 6284**						**Assurance Committee**	
U4: There is a risk that we do not develop and maintain a positive culture because of insufficient financial resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.												**People Committee Director of People**	
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 (2020-23)	Reports on progress against the People Strategy inclusion of BELL Framework	Nov 22	Paper to PC and ETM PC agenda template	Level 1							
C2	Archived – see version 2.1 Quarter 2											
C3	**Archived – see version 2.2 Quarter 2**											
C4	WDES, and WRES action plans	Progress against action plans monitored via Operational Workforce Group and People Committee All Divisions attended Joint Partnership Forum to detail action plans WDES and WRES signed off by Trust Board Revised WRES action plan signed off by the Board of Directors	Agreed at Oct22 Board 21 July 2022 October 2022 January 2023	Reports to People Committee Board minutes Board minutes	Level 1 Level 2 Level 2							**Completed** **Completed** **Completed**

		To submit WRES and WDES action plans to NHSE People Committee Board of Directors	October 2023 November 2023		Level 2					
C5	Archived – see version 2.1 Quarter 2									
C6	Archived – see version 2.1 Quarter 2									
C7	Archived – see version 1.1 2023/24									
C8	Archived – see version 2.1 Quarter 2									
C9	Archived – see version 2.1 Quarter 2									
C10	Archived – see version 1.1 2023/24									
C11	Archived – see version 2.1 Quarter 2									
C12	Archived – see version 1.1 2023/24									
C13	Delivery of the People Promise – staff experience	NHS Staff survey outcomes and scores including Medical engagement Divisional Action Plans to PC on a rolling basis	Q4 2023/4 Q4 2023/4		Level 3 Level 1				**Director of People & Medical Director**	
C14	Delivery of the Nursing and AHP retention and recruitment programme	Reports to People Committee	August 2023	Quarterly report to PC	Level 1				**Chief Nurse**	
C15	**Gap removed as duplicate of G14 above**									
C16	Senior Medical Leadership Development Programme	Reports to People Committee	October 2023	Quarterly report to PC	Level 1				**Director of People & Medical Director**	

Gaps in Controls or Assurance Quarter 1 2022-23	**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	**Archived – see version 1.1 2023/24**							
G2	Leadership Programme in place for Divisional Triumvirate leadership teams	Identify suitable leadership development programme provider.	Deputy Chief Executive & Director of People	Scope to be revised and intensive programme to be agreed.	End November 2022			Tender documentation signed off by Deputy CEO. Procurement exercise scheduled 18/07/23. Delivery partner Value Circle identified and commissioned, beginning engagement work in readiness to launch programme –

								on track – Launch Friday 10th November 2023	
G3	Development of new People Strategy for 2024/2027	Engagement work Research best practice National regional and local context	Director of People	Q2	End March 2024 On track			Early internal engagement underway, People Committee session to be planned Q3 On track – report to PC October 2023, PC Session to be held December 2023	
G4	Development of a workforce plan aligned to clinical, operational, financial plans etc.	Consider scope Priority areas Proposal to take forward Engagement and work	Director of People	To begin Q3	End March 2024 On track			Future dated. On track, work began Q3, discussion at PC	
G5	Challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk D5 and P1)	Divisional Leads & FPC	Ongoing				Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention.	
		Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff.	Director of Workforce & FPC	Completed	Ongoing			Completed On the July FPC agenda for endorsement in respect of Extra Contractual work. To be reviewed for 2024/25.	
		Regular industrial action meetings to mitigate impact.	Director of Operations & FPC	Commenced	Ongoing			Discussion has taken place resulting in the agreement that the Assurance Committees has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads.	
		Clear rates of pay established for strike cover	Director of Workforce & FPC	Completed	March 2023				
		Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	Chief Operating Officer & FPC					Paper sent to September 2023 FPC	
		Financial allocation identified in plan for 2023/24 – risk in allocation of ERF given overall financial position.	FPC	September 2023	September 2023				

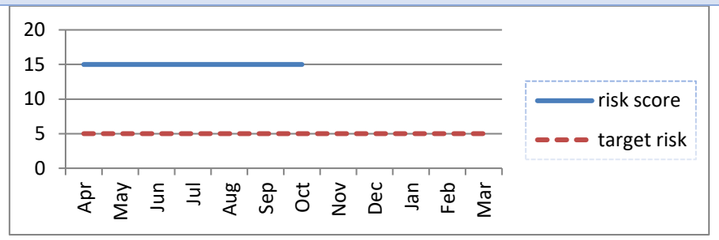
		Impact on staff as a result of industrial action. Support health & Wellbeing of staff. Increased stress leading to increased sickness/absence and burn out.	Director of People & PC	Ongoing	December 2023			Quarterly update on Health & Wellbeing report to PC August 2023 which covered Q4 and Q1. Monthly performance meetings. Support for senior leaders and managers during industrial action. Further support for senior leaders and management being developed Impact on staff and teams, need to support wellbeing of staff dealing with increased stress, sickness absence and impact on team dynamics	
Archived Controls within month - Completed									
Archived Gaps within month - Completed									

Strategic Theme: Delivery	**Risk Scores**										
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2023-24**	
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**	**4(L)x3(C)=12**	**5(L)x~~3~~4=~~15~~20**	**2x3=6**	**Very low (1-5)**		**Previous Score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D5: Implement sustainable change to deliver high quality, timely and affordable care							**6**	**15**	**~~15~~20**	**20**	
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, Risk 6569, RISK6800, RISK6627, RISK6762 RISK6414 and RISK6801**				**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 Daily review of position and weekly through the acute care performance meeting and ETM 4 hour performance has been reintroduced Waiting times have improved in UECC and monitored against trajectory	**October 2023 IPR** **October 2023** **October 2023** **October 2023**	**Minutes of F&P** **ETM minutes** **ETM minutes** **ETM minutes**	Level 1					COO	
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	**October 2023**	**Chair's Log**	Level 1					Deputy CEO	
C3	Monitoring right to reside and Length of Stay data	Monthly reports to Finance and Performance Committee and Board Weekly Length of Stay reviews Improvement with regards to right to reside and IDT caseload Escalation meetings with external partners. Now includes Medical Director	**October 2023** **October 2023** **October 2023**	**Minutes of F&P** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1					COO	

		Oversight through the new Rotherham Place Urgent and Emergency Care Group (Previously the A&E Delivery Board) Number of patients with no right to reside and number on IDT caseload has reduced.							
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	**September 2023** **September 2023**	**Notes of the panel** **Notes of the panel**	Level 1				Deputy CEO to chair
C5	Admission avoidance work remains ongoing	The Rotherham Urgent and Emergency Care Group established from September 2022 (replaced A&E Delivery Board and Urgent and Community Transformation Group). It is chaired by the Deputy Pace Director and deputy chair COO, part 2 focuses on transformation and is led by TRFT Deputy CEO and Director of Adult Social for RMBC. Internal pathway group chaired by medical director focussing on emergency pathways Step up pathways to virtual ward have been implemented, admission avoidance work with YAS direct to Community Urgent Response has also commenced.	**September 2023**	**Minutes of meeting**	Level 1				Rotherham Urgent and Emergency Care Group Chief Operating Officer ACT Steering Group – emergency pathway workstream Medical Director
C6	Executive Team oversight	Weekly receipt of Performance Report and Recovery Report	**September 2023** **September 2023**	**ETM minutes Weekly** **ETM minutes Weekly**	**Level 1**				Weekly Executive Team Meeting Director of Strategy Planning & Performance
C7	Twice per month Acute Performance Meeting chaired by CEO	Weekly oversight	**September 2023**	**Weekly agenda and action log**	**Level 1**				Twice per month Acute Performance Meeting CEO and COO
C8	Archived as amalgamated into C3– see version 1.2 2023/24								
C9	Weekly access meetings with tracker for elective recovery schemes	To include financial allocation from ERF reserve	**September 2023**	**Ongoing**	**Level 1**				Elective Review Meeting COO DoF
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 resulting in high bed occupancy	Additional bed capacity utilising additional national G&A capacity funding. Bed reconfiguration to right size medicine and surgery based on bed modelling.	COO	Q1	Q3			Paper approved at ETM May 2023 supporting investment in additional capacity Sitwell to be opened as additional surge following winter de-escalation Bed reconfiguration to be undertaken in advance of winter. Virtual ward development underway. Paper to ETM re implementing bed reconfiguration in July 2023. Paper approved and consultation commenced and implementation due mid-September 2023. Beds now open w/c 25.09.23 in line with plan.	
G2	Archived – see version 1.1 2023/24								
G3	Ring-fence interim frailty assessment beds	ICS SDEC pathways confirmed.	COO	Q1	Q4			Frailty model introduced with frailty service in reach – not dependent on ring-fenced beds. Assessments undertaken in UECC, 'time-out' session with the team to review further development of the service and model. Bed base for frailty to be identified as part of reconfiguration and then this risk can be closed and archived.	
G4	Review of validation and management of waiting lists	360 Assure audit to validate waiting lists planned	Director of Strategy, Planning and Performance	Q2	Q4			Validation of waiting lists being undertaken, planned review with 360 to be scheduled – to commence September 2023 including data quality audit – met with 360, plan being developed and scope agreed. Text validation and also admin validation.	
	Includes Diagnostic PTL	Weekly position to be included in performance position Information for ETM IPR and development of Diagnostic PTL	Director of Strategy, Planning and Performance	Q1	Q2			Weekly diagnostic information available, forecasting of month end position to be introduced. Weekly data provided to weekly Access meeting	
~~**G5**~~	Archived – see version 1.1 2023/24								
G6	Challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4)	Divisional Leads	Ongoing				Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce.	
		Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff.	Director of Workforce	Commenced	Ongoing			On the July FPC agenda for endorsement in respect of Extra Contractual work. Rates now agreed and implemented. Sessions being undertaken at new rates, risk reduced.	
		Regular industrial action meetings to mitigate impact.	Director of Operations	Commenced	Ongoing			Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads.	

		Rates of pay agreed with medical staff to provide cover for junior doctor's strike. Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	Director of Workforce Chief Operating Officer	Completed June 2023	March 2023			Impact of IA paper to go to ETM and then Confidential Board, as well as FPC, QC and PC. Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention. Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM – time out with team planned and insourcing for the interim term. Further paper to ETM w/c 18.09.23 outlining further work to be undertaken. Good visibility through job plans. Phase 2 of work to be undertaken with external expertise. No further IA dates confirmed as at beginning of October 2023.	
G7	Financial investment/resources to support recovery of waiting lists	Financial allocation identified in plan for 2023/24 – risk in allocation of ERF given overall financial position	Chief Operating Officer					Agreement on schemes to support recovery for next 2-3 months. Currently being costed and implemented. Paper to ETM and July FPC regarding recovery plan. Paper agreed at ETM for July/August, schemes with an outline of schemes to inform allocation for remainder of the year. Plan in place for recovery schemes and investment in line with ERF allocation in 2023/24 plan.	
Archived Controls within month – Completed									
Archived Gaps within month - Completed									

Strategic Theme: Us		Risk Scores										
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2023-24	
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.		**D7**	**3(L)x5(C)=15**	**3 (L) x 5(C) =15**	**1(L)x5(C) =5**	**Low (6-10)**						
Link to Operational Plan: D7: Implement sustainable change to deliver high quality, timely and affordable care												
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks** **RISK6886 and RISK6801**				**Assurance Committee**	
D7: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023/24 leading to further financial instability.							**Risk**				**Finance and Performance Committee** **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	Improvement of clinical productivity to levels experienced in 2019/20 without central funding for outsourcing clinical activities	Monthly Elective Programme Meeting chaired by Chief Operating Officer		**November 2022**			L1					
C2	CIP Track and Challenge in place			**November 2022**	**ETM minutes**		L1					
C3	Contingency of £1.5m in place.				**Trust Board October 2023**		L1					
C4	Winter funding allocated in reserves of £2m.				**Trust Board April 2023**		L1					
C5	Elective recovery fund £5.2m				**Trust Board April 2023**		L1					
C6	TRFT received access to growth money allocated to PLACE.				**Trust Board April 2023**		L1					
C7	Financial plan sign off to NHSE by 04/05/2023	Submitted on time, still awaiting sign off by NHSE			**Trust Board 28 April 2023**							
C8	Service developments held in reserve of £2.5m.				**Trust Board April 2023**							
C9	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee		December 2022	Minutes of F&P		Level 1					
C10	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group		December 2022			Level 1					

Current	Q1	Q2	Q3	Q4
15	15	15	15	

	On plan with mitigations in place to manage winter pressures.	Monthly Finance Report to CEO Delivery Group	December 2022	Minutes	Level 1				
		South Yorkshire Financial Plan Delivery Group			Level 1				
C11	Suitably qualified Finance Team in place	Team in place	N/A	N/A	Level 1				
C12	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board	November 2022	Board of Directors minute					
C13	Current Standing Financial Instructions in place	Reviewed and approved by Board	November 2021	Board of Directors minute	Level 1				
C14	Internal Audit Reports	Internal Audit Financial Reports	**July 2022**	Report	Level 3				
		Review of HFMA Improving NHS Financial Sustainability checklist	**December 2022**	**Report**	Level 3				
		360 Assure Head of Audit opinion presented to Risk and Audit Committee initial indications show Significant Assurance overall	April 2023	Report	Level 3				
C15	Monthly challenge on performance	Monthly Divisional Assurance meetings	November 2022	Chair's Log to F&P					
C16	Clarity on Financial Forecast	Financial forecasts completed for Divisional and Corporate areas monitored within Finance Report. Financial forecast has commenced based on June financial position. Director of Finance in process of agreeing financial recovery plans with each accountable officer – these will be fed into monthly assurance meetings.	July 2023	Minutes of F&P	Level 1				
C17	Regular meetings with ICB on a bi-monthly basis following Single Oversight Framework (SOF) status from 2 to 3.	Awaiting meeting set up Target of SOF status of 2 by Quarter 4.		Director of Finance					

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Unsustainable agency spend (Risk Now)	Weekly Agency Group meets, chaired by Michael Wright	Deputy CEO	Q1	Ongoing				
G2	Recurrently deliver CIP in 2023/24 (Risk Now)	CIP Group Monthly. PMO tracking CIP delivery. CIP report to F&PC monthly.	Deputy CEO	Q1	Ongoing				
G3	Adherence to expenditure Run Rate as per financial plan (Risk Neutral)	Monthly budget reports. Expenditure profile produced monthly throughout year. Reserves Policy in place.	Director of Finance	Q1	Ongoing				

		F&PC oversight. Internal audit systems budgetary control audit. External audit annual accounts. Month 6 financial position year to date £1,068,000 adverse variance position, with improvement of £150,000 in month. With a forecast of £4.3m variance at year end, however it is still believed a break even position can be achieved by management action and the use of reserves.							
G4	Potential reduction of cash balances due to expenditure higher than income which would result in late payments to suppliers. Impact to invest in capital projects. (Future Risk)	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position.	
~~G5~~	**Archived – see version 1.1 2023/24 - Completed**								
G6	Increased cost improvement programme due to national reductions in funding to the South Yorkshire allocation linked to funding formula suggesting South Yorkshire is overfunded. (Future Risk)	Future income risk	Director of Finance						
~~G7~~	**Archived – see version 1.1 2023/24 - Completed**								
G8	Risk that payment by results returns on elective activity with a lack of understanding of the potential impact on elective activity.	Deputy Director of Finance assessing the potential impact in conjunction with the planning guidance expected by the end Quarter 3.	Deputy Director of Finance						
~~G9~~	**Archived – see version 1.1 2023/24 – Completed**								
	Divisional Budgets signed off	Monitoring via Finance Reports	July 2022	Reports to F&P	Level 1				
	Financial forecasts come to fruition (Future Risk)	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance						
G10	Continuing industrial action leading to increased financial outlay in order to cover medical and clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action).	Regular industrial action meetings to mitigate impact. Finance team are currently working on a cost per day figure for future forecasting. Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4)	Director of Finance. Divisional Leads & FPC	Reports to F&P Ongoing				**Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce.** **On the July FPC agenda for endorsement in respect of Extra Contractual work.** To be reviewed for 2024/25.	

		Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Rates of pay agreed with medical staff to provide cover for junior doctor's strike. Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	Director of Workforce & FPC Director of Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC	Commenced Commenced Completed June 2023	Ongoing Ongoing March 2023			**Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads.** **Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO.** **Improvements seen in nursing, support and doctor recruitment and retention.** **Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM**	
G11	National calculation of ERF performance including amendments linked to IA	Letter has been sent to ICB requesting clarification of in-year performance given discrepancies between national calculations and local calculations. Still no national adjustment for IA beyond April 2023, if further losses on elective continue the trust may have to revise its break even projection for year end.	Director of Finance	September 2023 letter sent	Awaiting ICB response				
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Board of Directors' Meeting
03 November 2023

The Rotherham NHS Foundation Trust

Agenda item	P160/23
Report	**Corporate Risk Register Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The following paper links with all BAF Risks
How does this paper support Trust Values	This paper supports the Trust Value of "Use and Evaluate Information to improve". By having up to date information on the Trust's risks we can use and evaluate this information to take actions and decisions that improve both patients' and staff experience.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of the Corporate Risk Register Report is to provide to the Board of Directors an overview of all risks rated at 15 or above across the Trust, all of these risks have been discussed and approved at the trust Risk Management Committee. • Of the 17 approved risks all are within review date. • All of the risks have action plans • Further development of action plans is required for 4 of the risks • Scrutiny of 2 risks that show all actions as complete will follow with the risk owners
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This information has been reviewed through the Risk Management Committee and shared with the Audit & Risk Committee, in a different format, on a quarterly basis.
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?)	Once presented, the Director of Corporate Affairs, as Executive Lead will continue to ensure that risks are appropriately identified, recorded, reviewed and managed.
Recommendations	It is recommended that the Trust Board: • Note the content of the Report

	• Note the progress made in progressing the risk management process.
Appendices	Corporate Risk Register

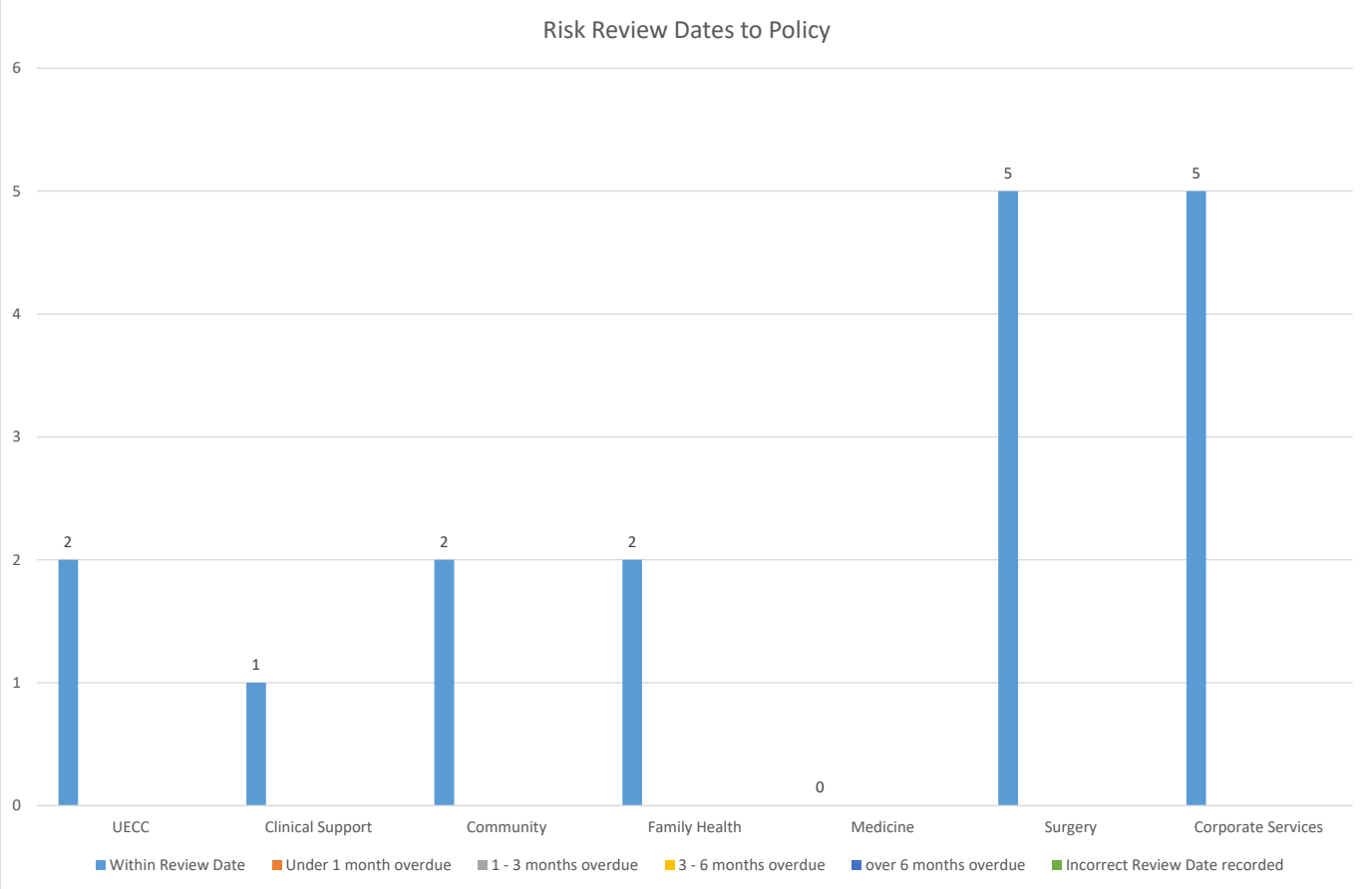
Corporate Risk Register

1. Introduction

1.1 The following report provides an update to the Board of Directors for the review of all risks scoring 15. The risks contained within this report includes all risks rated at 15 or above recorded on Datix on 02/11/2023. Please note that all of these risks have been approved at Divisional level and also approved by the Risk Management Committee. Appendix 1 contains further details of the risks.

2 Risk Review dates

2.2 In terms of compliance with risk review dates, the graph below shows all risks rated at 15 and above for all Divisions. This graph is to provide the Committee with a view regarding the current Trust position for the management and review of these high level risks.



Please note that at time of report publication the Division of Medicine had no risks rated at 15 or above.

3 Risk Action Plans

All risks rated at 15 or above have current action plans, the Corporate Affairs Department are in the process of reviewing these action plans and working with the risk owners where applicable to review the actions. There are currently 4 risks that have action plans logged in Datix with only 1 action, there will be a review of appropriateness and whether there are more actions that should be recorded.

As can be seen in the graph above there are currently 17 risks rated at 15 or above and from these there is a total of 73 individual actions. Of the individual actions 26 are still to be completed, the graph shows that currently all action plans are within target dates.

There are 2 risks that show as all actions have been completed, however the risk owners believe the risks are still valid and open, this will be queried directly with the risk owners and raised at the RMC for discussion.

Following discussion and agreement at the respective Divisional Governance meetings there are 2 risks that are due to have their risk rating reduced with all actions noted as complete. These will be taken to the November 2023 Risk Management Committee for discussion:

- Risk 6724 - DM01 Achievement (Endoscopy) is due to be reduced in rating at the as targets are now being reached.

- 6857 - Risk of Potential Omission of Care Due to Deferral of Planned Community Nursing Visits as capacity improved, vacancies filled, ledgers in use and no reporting visits moved due to lack of capacity than for caseload management purposes.

Alan Wolfe
Deputy Director of Corporate Affairs
November 2023

Corporate Risk Register - Risks Rated 15+ November 2023

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6886	23/03/2023	Hackett, Steve	Corporate Services	Ability to deliver 2023/24 Financial Plan	Non delivery of the financial plan which is currently a £6.0m deficit. Caused by inability to deliver a £12.2m cost improvement programme or under recovery of elective recovery income (current target 103% of 2019/20 activity)or cost pressures exceed amounts set in reserve. Resulting in cash deficiencies limiting ability to pay suppliers and potential regulatory actions for failure to live within financial resources made available.	Extreme Risk 25	Significant 15	Moderate 5	11/10/2023	15/11/2023	[Wallett, Val 11/10/23 10:24:31] M6 financial position is £1.068m which is an improvement in month of £150k. The Trust is still predicting that we will achieve £6m deficit plan at year end. However, lost activity is driving a significant challenge on income. Further review will take place at M7 to assess if the Trust needs to change year end forecast from break even. Agreed with Director of Finance that outstanding actions target dates should be extended due to potential national developments.	Approved Risk	Theatre improvement programme.	23/03/2023	23/02/2024		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	23/02/2024		Kilgariff, Mrs. Sally
													Cost improvement Efficiency Board.	23/03/2023	23/02/2024		Hackett, Steve
													Development of robust capacity plans.	23/03/2023	23/02/2024		Hackett, Steve
													Development of Winter plan.	23/03/2023	23/11/2023		Hackett, Steve
6723	10/06/2022	Vasey, Benjamin	Division of Surgery	Anaesthetic Medical Staffing Availability	Unavailability of Anaesthetists due to long and short term sickness. Caused by long and short term sickness. Resulting in lack of availability of Anaesthetists results: Gaps in the on call rota Loss of operating lists in theatres potential burn out for staff picking up on call shifts.	Significant 12	Extreme Risk 16	Moderate 6	11/10/2023	30/11/2023	[Vasey, Benjamin 11/10/23 13:11:13] Reviewed BV - 11/10/23	Approved Risk	Advertise agency locum at all tiers and recruit as appropriate	01/08/2022	30/09/2022	02/10/2022	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													Reduce elective operating for August - Review for September	01/08/2022	31/08/2022	02/10/2022	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													Full departmental roster review led by SLT	22/09/2022	30/09/2022	23/09/2022	Vasey, Benjamin
													Confirm insourcing arrangement for 6 week period	05/09/2022	05/09/2022	02/10/2022	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													SCH joint recruitment	01/08/2022	31/10/2022	22/06/2023	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													Interview 2x shortlisted consultant candidates	10/01/2023	31/01/2023	16/04/2023	Shuker, Katy
													Agree temporary alignment of additional on call rate with UECC colleagues	01/12/2022	31/01/2023	16/04/2023	Vasey, Benjamin
													Extend use of insourcing support	05/06/2023	29/09/2023	18/07/2023	Thurman (No longer in the Trust), Mr Simon (Inactive
													External review of the Anaesthetic rotas	19/06/2023	31/12/2023		Vasey, Benjamin
													Develop an options appraisal paper for review at ETM.	22/06/2023	31/07/2023	18/07/2023	Vasey, Benjamin

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6421	31/03/2021	Wilman, Mrs. Johanna	Division of Family Health	Backlog of children waiting to be seen for assessment CDC	Delay in assessment and formulation of a care plan for children aged 0-5yrs with additional needs. This will impact on long term outcomes including health and fulfilling educational/developmental potential. Year on year Increase in appropriate referrals due to increased demand, following national trends Covid-19 Pandemic has worsened and continues to worsen the waiting lists	Significant 15	Significant 15	Moderate 6	02/11/2023	01/12/2023	[Wolfe, Alan 18/10/23 14:32:29] Risk approved at rating of 15 at October 2023 Risk Management Committee	Approved Risk	Support without referral Pathway	18/09/2023	30/12/2023		Wilkinson, Jo
													Funding for further staff	18/09/2023	30/11/2023		Wilman, Mrs. Johanna
													Psycology Funding	18/09/2023	30/11/2023		Wilman, Mrs. Johanna
													Joint working with RDASH	18/09/2023	30/11/2023		Wilman, Mrs. Johanna
6623	19/01/2022	Hilton, Mrs. Jenny	Corporate Services	Carbapenemase-producing Enterobacterales (CPE) outbreak	Cross infection with a multi-drug resistant bacteria. Carbapenemase-producing Enterobacterales (CPE) Caused by continued outbreak of an identified strain of CPE. Resulting in infection or colonisation of exposed patients with a multi-drug resistant bacteria.	Significant 15	Significant 15	High Risk 9	31/10/2023	30/11/2023	[Kerrane, Ann Miss 31/10/23 15:30:10] CPE has been included in the National IPC week "bug on a page" information for all of the clinical areas. Confirmation is still awaited regards some of the actions requested. This will be reviewed in a months time and the risk reduced if all actions complete.	Approved Risk	CPE meetings	18/02/2022	18/08/2022	Ongoing	Kerrane, Miss Ann
													Ongoing notification of cases	18/02/2022	18/08/2022	Ongoing	Kerrane, Miss Ann
													meeting with a chemical company	01/04/2022	31/05/2022	30/09/2022	Kerrane, Miss Ann
													meetingwith the meditech team	01/04/2022	31/05/2022	16/06/2023	Kerrane, Miss Ann

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6284	16/09/2020	Broadhurst, Miss Lucy	Division of Clinical Support Services	Cardiac Physiology Staffing Levels	Cardiac Physiology Staffing Levels consistently unable to meet all the needs of the service. This includes performance against waiting list targets, staff wellbeing, training of students and governance responsibilities. The staffing challenges affect all sections of Cardiac Physiology (Echo, Devices, Non-Invasive Cardiology, Reception). The current establishment of the department is 36.17 WTE (June 2023).	Significant 15	Significant 15	Low Risk 3	20/10/2023	19/11/2023	[Gregg, Timothy Mr. 20/10/23 15:35:51] 20/10/2023, TG - Risk assessment updated today. Updates added to the action plans. For further review in 1 month.	Approved Risk	Business case to increase staffing	01/07/2022	20/11/2023		Broadhurst, Miss Lucy
													Maintain grassroots development using external funding schemes	01/09/2022	31/01/2023	20/06/2023	Broadhurst, Miss Lucy
													Maintain efforts to fill staffing vacancies	01/06/2022	31/03/2023	20/06/2023	Broadhurst, Miss Lucy
													Cardiology Staff recruitment	30/01/2023	30/03/2023	20/06/2023	Broadhurst, Miss Lucy
													Echo staffing	06/03/2023	31/03/2023	20/06/2023	Broadhurst, Miss Lucy
													Prioritise training and retention of students/ existing staff	01/03/2023	31/05/2023	01/06/2023	Broadhurst, Miss Lucy
													Use of Echo locums & Elective Services	01/03/2023	31/05/2023	01/06/2023	Broadhurst, Miss Lucy
													Cardiac Physiology Recruitment	20/06/2023	20/11/2023		Broadhurst, Miss Lucy
													Further outsourcing July 2023	17/07/2023	17/09/2023	05/09/2023	Broadhurst, Miss Lucy
													Plan for forthcoming vacancies in Echo team	05/09/2023	07/11/2023		Broadhurst, Miss Lucy
													Proactively address potential burnout in the team	05/09/2023	10/10/2023	05/09/2023	Broadhurst, Miss Lucy
6800	05/10/2022	Kilgariff, Mrs. Sally	Corporate Services	Delays in urgent care pathway due to challenges with patient flow	Patients do not always receive timely access to urgent care due to delays due to challenges with patient flow. Caused by the absence of access to alternative urgent care pathways that avoid patients being seen in UECC and delays in discharge that result in lack of beds for patients to be admitted to. This results in delays to be seen by a clinician in UECC or by a specialty and delays in patients being admitted to a bed in a timely way.	Extreme Risk 20	Extreme Risk 16	High Risk 8	05/10/2023	06/11/2023	[Butler, Helen 05/10/23 13:59:57] Roberts, Jodie Winter Plan approved which will provide additional support to UECC over winter including porter support for timely movement out of UECC. SDEC consultation ongoing which will see medical SDEC opening longer. Senior reviewer now allocated to SDEC 5pm to 10pm. Consultation underway which will see medical SDEC opening longer. Continuing to implement frailty pathway and introduction of virtual wards.	Approved Risk	ACT programme of transformational work	01/01/2022	29/03/2024		Kilgariff, Mrs. Sally
													Improving pathways including expansion of SDECs, implementation of the frailty pathway and introduction of virtual wards	01/01/2022	01/02/2024		Kilgariff, Mrs. Sally
													Improving discharge pathways, particularly ward processes - inlcuding 100 day discharge challenge	01/01/2022	29/03/2024		Storer, Cindy

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6724	10/06/2022	Darrell, Mr Luke	Division of Surgery	DM01 Achievement (Endoscopy)	DM01 is currently not achieving and is not expected to recover during Quarter 2 2022/23. This is caused by Availability of Nurse Endoscopists. Availability of Registered nurses to support lists due to vacancies Increase demand from Gastro backlog reductions. Potential changes to national guidance on overdue surveillance patients. Resulting in Not achieving DM01.	High Risk 8	Significant 15	Moderate 4	02/10/2023	06/11/2023	[Darrell, Luke Mr 02/10/23 20:26:23] Trust remains DM01 non compliant. Ahead of local trajecotry with target of becoming compliant by end of Oct	Approved Risk	Commission Insourcing company to add Capacity	01/12/2022	28/02/2023	14/05/2023	Darrell, Mr Luke
													'Upskilling' endoscopists to ensure JAG booking levels are achieved	01/11/2022	17/02/2023	25/10/2023	Darrell, Mr Luke
													Increase OOH sessions - Specifically Sundays	01/12/2022	31/03/2023	14/05/2023	Darrell, Mr Luke
													Recruit 2x WTE nurse endoscopists	01/11/2022	31/03/2023	18/07/2023	Brammer, Mr John
													Produce business case to staff all available rooms in the dept	14/05/2023	30/06/2023	25/10/2023	Darrell, Mr Luke
													Re-commission insourcing capacity 23/24	16/06/2023	01/07/2023	18/07/2023	Vasey, Benjamin
6718	08/06/2022	Taylor, Ms. Katie	Division of Therapies, Dietetics and Community Care	Hospital heart failure patients not being seen or reviewed by heart failure specialist nurse in a timely manner due to capacity	Delay in patients being reviewed by heart failure specialist Delay in patients being cared for on cardiology wards Longer length of stay due to none or less frequent reviews Poorer clinical outcomes Higher heart failure morbidity Cannot facilitate discharges resulting in patient deterioration when an in patient High staff stress, sickness, burnout and turnover	Significant 15	Significant 15	High Risk 9	12/10/2023	22/11/2023	[Taylor, Katie Ms. 12/10/23 10:49:06] Comments as of 14/9/23 still stand Meeting regarding NHFA arranged for this afternoon	Approved Risk	Review of risk requested by general manager	10/06/2022	17/06/2022	21/06/2022	Fisher, Penny
6801	10/10/2022	Ferrie, Mr. Paul	Corporate Services	Industrial action and effect upon Trust activity	A number of trade unions have recently announced further details on their intention to proceed with statutory ballots These so far include: The Royal College of Nursing (RCN) Royal College of Midwives Junior Doctor Committee of the BMA Chartered Society of Physiotherapists NHS Staff Council trade unions: GMB UNISON Unite This would provide a risk to patient safety due to a lack of suitably qualified staff. There is also the added financial impact on the trust, the net pay costs of each industrial action varies, however we estimate the two instances of junior doctors action has resulted in a £300k cost pressure. A potential risk to patient safety has also been raised in recent months.	Extreme Risk 16	Extreme Risk 16	Moderate 4	12/10/2023	10/11/2023	[Wallett, Val 12/10/23 14:17:19] [Deputy Director of Workforce 12.10.23] - the recent combination of industrial action between consultants and junior doctors has had a significant impact on patients, staff and financial performance which could potentially increase the risk score. However, there are no further industrial action dates confirmed or planned. A review took place on 12th October to assess the latest learning from the junior doctors/consultants strike action (Deputy Medical Director, Deputy Director of HR, Business Manager to the Medical Director, Medical Workforce Manager). Actions were agreed at this meeting and will be shared with divisional colleagues and clinical leads to improve understanding around operational guidance as well as ensuring that appropriate behaviours are demonstrated throughout these difficult times. Further discussions with Executives may be needed to review the risk/BAF score for the organisation.	Approved Risk	Negotiations with local staff side	10/10/2022	29/12/2023		Ferrie, Mr. Paul
													Strategic meeting to be scheduled by the EPRR Team	10/10/2022	30/12/2022	03/07/2023	Patchett, Craig
													Further central government negotiations - monitor and action as and when	10/10/2022	29/12/2023		Ferrie, Mr. Paul

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6762	23/07/2022	Short, Mrs. Sally	Division of Surgery	Inpatient beds in the trolley area ASU	ASU trolley area not operating as surgical SDEC due to unfunded inpatient beds in both bays. Preventing flow from UECC for non ambuatory surgical patients to be managed in ASU. Caused by preventing SDEC operating due to inpatients in 10 non funded beds. Medical and surgical patients in ward surgical beds. Resulting in Increased admissions to hospital due to all patients managed in waiting area sometimes for long periods. Preventing streaming/flow of non ambulatory patients from UECC. Poor patient experience and increased length of stay in department. Preventing good early flow through the unit as previously 10 trollies were available at the start of the day to ensure adequate capacity until patients were discharged from short stay beds.	Moderate 6	Significant 15	Moderate 6	02/11/2023	02/11/2023	[Wolfe, Alan 19/07/23 11:29:00] Risk and actions reviewed by Ben Vasey on 18/07/2023, one action closed.	Approved Risk	Surgica SDEC Task and Finish Group	01/11/2022	01/12/2023		Nield, Tom
													Amend Sepia to reflect 23 IP beds and 10 trollies	14/11/2022	09/12/2022	09/12/2022	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													Complete Trust bed modelling work	01/04/2022	31/03/2023	18/07/2023	Vasey, Benjamin
5238	18/06/2017	Reynard, Jeremy	Division of Emergency Care	Insufficient provision of medical cover within the UECC	Not achieving the new 4 hour target. Delay to be seen by a clinician. Work building up during the day and being done at night.	Significant 15	Extreme Risk 20	High Risk 8	02/11/2023	01/12/2023	[MacCauley, Heather 18:54:51] Risk updated. Risk Reviewed.	Approved Risk	Recruitment process for UECC substantive Consultants	01/01/2021	31/03/2021	08/03/2021	Reynard, Jeremy
													Monitoring of medical staffing levels	07/04/2021	11/05/2021	16/05/2023	Reynard, Jeremy
													Ensure medical staffing levels are improved within UECC	08/06/2021	30/09/2021	16/05/2023	Reynard, Jeremy
													demand and capacity model	10/10/2022	27/02/2023	16/05/2023	Hammond, Lesley
													recruitment of additional consultants	01/05/2023	30/09/2023	02/11/2023	Reynard, Jeremy

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6630	28/01/2022	Windsor, Claire	Division of Surgery	Lack of Critical Care Follow Up Clinic	Critical illness leaves patients at highly significant risk of long term physical, cognitive and psychological problems. This has the potential for considerable residual impact on patients morbidity and longevity. Caused by no Critical Care follow up service. Resulting in failure to provide vital support following discharge resulting in the inability to identify any complications relating to critical illness which require effective management and ongoing treatment or onward referral including significant mental health / psychological sequalae and physical disability. Failure to meet GPIC's V2 standards.	Significant 15	Significant 15	Moderate 6	30/10/2023	30/11/2023	[Windsor, Claire 30/10/23 09:52:06] Still awaiting outcome of changes to Business plan. Email sent to Critical Care Matron, who is awaiting outcome from General Manager.	Approved Risk	Lack of Critical care Follow-Up - Business Case brief for Rehabilitation and Follow-up Service for Critical Care submitted to service manager on the above date.	01/08/2022	31/12/2023		Nield, Tom
6809	20/10/2022	Culham, Helen	Division of Surgery	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	Risk of patient safety incidents and reduced delivery of safe care during invasive procedures.	Significant 15	Significant 15	Moderate 6	02/11/2023	02/12/2023	Ward, Mrs. Sandra 02/11/2023 11:26:09 02/11/2023 - No change to risk at present work ongoing.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	11/12/2023		Nield, Tom
6627	03/01/2022	Kilgariff, Mrs. Sally	Corporate Services	Patients that are Medically Fit for discharge needing Pathway 1-3 have an increased length of stay	Patients that are Medically Fit For Discharge and require Pathway 1-3 face the potential of increased length of stay after being declared Medically Fit For Discharge. There is evidence to suggest that increased length of stay in hospital can be associated with increased risk of infection, low mood and reduced motivation, which can affect a patient's health after they've been discharged and increase their chances of readmission to hospital	Extreme Risk 20	Extreme Risk 16	High Risk 8	05/10/2023	06/11/2023	[Butler, Helen 05/10/23 14:02:11] Roberts, Jodie - Focus on complex discharges and long stay patients to ensure they are reviewed in a timely manner. Community also supporting. Focus on internal delays. ongoing development of care hub will further support discharge to assess model and reduce need for bedded place	Approved Risk	Place to review the potential for Covid Positive Bed Based Capacity across the Place	03/10/2022	30/11/2022	06/10/2022	Kilgariff, Mrs. Sally
													Chief Nurse to review with IPC and Region a review of Covid 19 swabbing guidance in light of increased prevalence	03/10/2022	07/11/2022	06/10/2022	Dobson, Helen
													Daily reporting/dashboard to identify delays and ensure overight	06/10/2022	31/03/2023	21/03/2023	Hepworth, Tracey
													Escalation meetings with place partners and senior executive level support	06/10/2022	31/03/2023	21/03/2023	Kilgariff, Mrs. Sally
													Implement discharge to assess pathways to support assessment of ongoing care in needs in patients own home	06/10/2022	01/02/2024		Fisher, Penny

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6857	24/01/2023	Gibbons, Melanie	Division of Therapies, Dietetics and Community Care	Risk of Potential Omission of Care Due to Deferral of Planned Community Nursing Visits	Omission of patient visits due to lack of capacity and increased demand on resources leading to patients not being seen on allocated days in line with the plan of care. This results in patient visits being moved on to another day either to another planned visit or 'parked' area within Systm One, with no audit trail and no reporting mechanism. This may result in delays to treatment and management and therefore potential worsening of current or development of new health condition. Furthermore this may result in harm to the patient and or significant others both physically and psychologically. A potential outcome may be irreversible harm caused and therefore risk to the organisation including complaints, claims and inquests. This could result in reputational and financial damage.	Extreme Risk 20	Extreme Risk 16	Moderate 4	26/10/2023	22/11/2023	[Hutchinson, Michelle Mrs. 26/10/23 12:59:07] Risk to be Reduced, capacity improved, vacancies filled, ledgers in use. no reporting visits moved due to lack of capacity than for caseload management purposes	Approved Risk	Risk of Potential Omission of Care Due to Deferral of Planned Community Nursing Visits	16/05/2023	26/09/2023	16/05/2023	Gibbons, Melanie
5761	14/12/2018	Reynard, Jeremy	Division of Emergency Care	UECC patient safety due to overcrowding	Overcrowding in the UECC leading to the UECC not being able to function efficiently or effectively.	Extreme Risk 25	Extreme Risk 20	Extreme Risk 16	02/11/2023	02/12/2023	[McAuley, Heather 01/06/23 15:25:18] discussed at divisional governance, still high risk, linking several datix regularly into this . moving to implement 4 hour targets. [Roberts, Jodie 02/11/23] ACT group established and meeting regularly. Increase use of SDEC will support streaming from UECC reducing patients in UECC waiting room.	Approved Risk	Nursing and Medical staffing to be reviewed	31/12/2021	01/04/2022	13/03/2022	Farrow, Lindsay
													Yellow area: Nursing and Medical staffing to be reviewed	31/12/2021	01/04/2022	13/03/2022	Farrow, Lindsay
													new staffing tool to be implemented	13/03/2022	31/12/2023		McAuley, Heather
													transformational work T&F Group	01/01/2022	01/02/2024		Kilgariff, Mrs. Sally
													ACT programme	01/10/2021	03/04/2023	03/07/2023	Hammond, Lesley
													volunteers	04/04/2022	13/10/2022	13/10/2022	Farrow, Lindsay
													intentional rounding	07/03/2022	30/09/2022	30/09/2022	Farrow, Lindsay
6572	15/10/2021	Dean, Kim	Division of Family Health	Special school accommodation	Disruption to current service delivery for children attending Newman special school. There is a risk that services will no longer have access to suitable accommodation within the school in which to work. This issue will potentially affect the following services: speech and language therapy, occupational therapy, physiotherapy, orthotics, community paediatrics, special education nursing	Significant 15	Significant 15	High Risk 9	02/11/2023	01/12/2023	[Dean, Kim 02/11/23 08:43:43] Request made to RMBC for an update on the times scales for the interim plan to be actioned. RMBC are still awaiting on the school to submit the accessibility funding request. RMBC contact Mark Cummins will chase school and support if needed.	Approved Risk	Liaison with RMBC to complete minor works	14/09/2023	02/02/2024		Dean, Kim
													Working with RMBC and school to identify a suitable space	18/09/2023	31/10/2023	27/10/2023	Dean, Kim
													Monthly liaison with RMBC for updates on progress	14/09/2023	02/02/2024		Dean, Kim
													Refurbishment of the 'Bungalow' building	02/11/2023	03/01/2025		Dean, Kim

Subject:	**Finance & Performance Committee CHAIR'S ASSURANCE LOG** **Quorate: Yes**	Ref:	

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

Committee / Group: Finance & Performance Committee	**Date:** 25 October 2023	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Divisional performance: UECC	The Committee noted that whilst the Division faced ongoing challenges, plans were in place to deal with those challenges. However the Committee noted that there remains uncertainty around the year end position.	Board of Directors
2	Operational Plan Priorities Update, Integrated Performance Report and Operational Update	The Committee were assured that threats to performance had been identified and appropriate action plans put in place, however also noted that elective work was still a big issue in an already challenging place with missed trajectories in the 4 hour target. It was noted that the suspension of industrial action had led to a more stable month and that month 7 should see some improvement as a result along with greater clarity regards year end and future elective trajectories.	Board of Directors
3	Cost Improvement Plan Update	The Committee noted that whilst progress overall had been made the Board should be alerted to the fact that recurrent CIPs are at a low level and whilst there has been some progress it does not look like it is enough to achieve our yearend target for recurrent cost improvements.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
4	Integrated Financial Performance Report	The Committee were informed that the Director of Finance and Chair felt assured that the Trust will hit the yearend target figure but are aware of the fragility if things outside of the Trusts control, such as increased industrial action continue.	Board of Directors
5	Data Security and Protection Toolkit Recommendation Report	The Committee commended the work undertaken in order for the Trust to achieve the 95% target for compliance with Information Governance training.	Board of Directors

Subject:	Quality Committee CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	Board of Directors: 3 November 2023

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

Committee / Group: Quality Committee	Date: 25 October 2023	Chair: Ms Julia Burrows

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Divisional Reporting on Quality Compliance - Medicine	The Committee wished to alert the Board that due to operational pressures there is a consistent use of SDEC and Stroke beds which should be ring-fenced.	Board of Directors
2	Integrated Performance Monthly Report	The Committee noted the risks regards coding and the potential impact in SHMI figures and finance, the Board is advised that the Committee has requested that a risk assessment be undertaken in relation to fully understand the issues highlighted by the Medical Director.	Board of Directors
3	Estates Update (including Water Safety, Hand Hygiene training, Food Hygiene training)	The Committee had previously received an escalation from the Infection, Prevention and Control Committee in relation to water safety, hand hygiene, food hygiene and deep cleaning. Following further discussion, the Committee is alerting the Board to the following matters: Water Safety: planned preventative Maintenance records are required for review by the Director of Infection, Prevention and Control as the previous audit was in 2009, to be included on November 2023 agenda.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		Hand Hygiene: concerns raised with accuracy of ESR, to be followed up by Director of Estates. Food Hygiene Training: an electronic training package for staff has been developed but no corresponding Training Needs Analysis has been undertaken, this is to be raised with the Interim Head of Facilities. Ward Deep Cleaning: reported to committee that there is no routine or funded deep cleaning programme in the Trust. The Board had assurance previously of deep cleaning but this cleaning has now stopped. A report by the Head of Estates is to be brought back to November 2023 Committee and then onto Board outlining the decision making process around deep cleaning and the plan to recommence this.	

Board of Directors
03 November 2023

The Rotherham NHS Foundation Trust

Agenda item	P161/23
Report	**Learning From Deaths: Quarterly Report**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	B1 – Standards and quality of care not being met B2 – Demand for care exceeds the resources available B7 – Insufficiently robust quality and clinical governance
How does this paper support Trust Values	**Ambitious** – demonstrates that the Trust strives to deliver the highest standards and quality of care possible. **Caring** – demonstrates that the Trust strives to give outstanding, compassionate care, including around end of life care. **Together** – demonstrates that the Trust strives to ensure that quality improvement and the learning from deaths is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary	**<u>NHS E/I Better Tomorrow LFD SJR Improvement Programme</u>** From 01/04/2023, TRFT's SJRs are being completed by a team of SJR Reviewers who are trained and have dedicated time to complete. This process is designed to significant increase the timeliness, completeness and quality of TRFT's SJRs. The quality, completion rates and timeliness have all significantly increased. However the timeliness target of 90% SJR completions within 60 days of death isn't being met. **<u>360 Assurance LFD Governance Audit Action Plan</u>** The final report for the follow up audit was presented to the Trust on 23/06/2023. Of the 3 High Risk findings identified in the 2021/22 Re-Audit, 2 now have significant assurance. The other has limited assurance and is being worked on. It is expected to be completed well before the 31/03/2024 deadline. It was a positive report overall, with some work still to do. **<u>Mortality Indicators</u>** The latest **HSMR** Score (latest Month Jun 2023) is **92.8**. TRFT are in the 'As Expected' Band. The latest **SHMI** Score (latest Month Apr 2023) is **107.4**. TRFT are in the 'As Expected' Band.

Due Diligence	This report is produced by the Learning from Deaths and Mortality Manager with a final review by the Deputy Medical Director.
Powers to make this decision	N/A
Who, What and When	The Trust is working hard to establish a Learning from Deaths process which provdes intelligence which is used by the Trust to enhance patient care. A major component of the Learning from Deaths process is the case note review of selected deaths. TRFT uses the Structured Judgement Review (SJR) method. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulties in the care process. A new SJR Review Team (6 reviewers), who are trained and have protected time to complete SJRs started in April 2023. This will deliver good quality and timely SJRs. This will provide good intelligence for the Trust, including information from individual reviews and more importantly from the Thematic Analysis of cohorts of SJRs. The Trust's objective is to use this intelligence to drive improvements. This means disseminating the intelligence to Trust Groups/Individuals, who have to expertise to devise and implement changes to care processes and procedures. Learning from Deaths is managed by the Learning from Deaths & Mortality Manager. It is co-ordinated via the Trust Mortality Group, chaired by the Deputy Medical Director, with oversight and assurance through the Trust's Patient Safety Committee and the Quality Committee.
Recommendations	It is recommended that the Board notes the progress on the planned improvements to the Learning from Deaths programme and the latest Mortality Indicator position for the SHMI and HSMR.
Appendices	Learning from Deaths, Thematic Analysis Report 2023/24 Q1 SHMI Report – Latest Month's Data Apr 2023 HSMR Report – Latest Month's Data Jun 2023

1.1 Learning From Deaths Quarterly Report: 2023/24 Q4

	Due Date	SJR Data*	SHMI Latest Month	HSMR Latest Month
This Report	-	2023/24 Q1	01/04/2023	01/06/2023
Next Report	06/12/2023	2023/24 Q2	01/07/2023	01/09/2023

*SJR data is grouped & reported by the date of death

1.0 SJR Completion Figures

Discharge Month	No of Adult TRFT Inpatient & UECC Deaths	SJRs Requested	Completed	Outstanding	% Completed With 60 Days	Overall Care Score < 3	Preventability Score < 4
Apr-23	89	12	10	2	50%	3	2
May-23	77	14	10	4	36%	4	0
Jun-23	81	10	6	4	60%	1	0
2023/24 YTD	247	36	26	10	47%	8	2
2023/24 Q1	247	36	26	10	47%	8	2

Care Score	5 - Excellent	4 - Good	3 - Adequate	2 - Poor	1 - Very Poor

Preventability Score	6 - Definitely not preventable	5 - Slight evidence for preventability	4 - Possibly less than 50-50	3 - Possibly greater than 50-50	2 - Strong evidence for preventability

SJRs completed by the SJR Review Team are of a better standard and with much more free text narrative. However the timeliness and completion rates, whilst an improvement on 2022/23 figures are disappointing. Early technical problems have long since passed and not the cause of this.

The 90% target for completing all SJRs within 60 days isn't being met. 47% represents a significant improvement on the figure for 2022/23 (24%). However, with reviewers being funded, a 100% completion rate, with 90% being within 60 days of death is expected.

The Learning from Deaths process is described as a rapid cycle of learning, where good or poor practice is identified close to the time when care was delivered. Timely SJR is crucial for this

Comments from all SJRs are themed and categorised in quarterly Thematic Analysis Reports

Summary & Distribution 2023/24 Q1 SJR Thematic Analysis

Learning from SJRs comes in the form of free text judgment statements which support the scores given to Phases of Care and to problems identified. These free text comments are allocated to categories based on the element of health care they refer to and whether they are positive, negative or neutral.

The Thematic Analysis reports are distributed to various groups, individuals and teams within the Trust. The purpose is for these groups to review and then to design and implement new/changes to health care processes that will prevent the reoccurrence of these problems or promote good practice.

These two tables detail the categories to which comments are allocated to and the groups/teams which receive the report.

Category of Problem
Medication or Treatment
Assessment/Opinion/Review - Delay/Omission
Tests/Results/Monitoring
Escalation
Communication
End of Life / Palliative Care
Do Not Attempt CPR
Medical History
Location of Care/Bed Avail/Inappr Moves

Group
Deteriorating Patient/Sepsis Group
Medicine Safety Group
Patient Safety Committee
Results Notification
Safeguarding Operational Group
Clinical Governance - Medicine
Clinical Governance - Surgery
End of Life Care

Next Report:

A Thematic Analysis Report will be completed in December for TRFTs 2023/24 Q2 SJRs.

1.1 Learning from Deaths – LeDer, Learning Disabilities & Autism

The LeDer Programme is a Commissioner-led review of deaths for patients with Learning Disabilities and Autism, regardless of the place of death. Provider Trusts are frequency asked to assist with LeDers review when they have been involved in care provision for that patient. TRFT completes SJRs for all Trust deaths for those with Learning Disabilities or Autism.

Deaths for patients are identified by a Learning Disability Flag in MediTech, indicated by the Medical Examiner after a scrutiny, a request from the Matron for Learning Disabilities and Autism, or by a request from the ICB LeDer Team.

LeDer Requests & SJR Figures for Adults with a Learning Disability

Discharge Month	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Avoidability Score < 4
Apr-23	1	1	0	1	0
May-23	1	0	1	0	0
Jun-23	1	1	0	0	0
2023/24 YTD	3	2	1	1	0

Update

TRFT is looking to add an Autism Flag in MediTech, which will be pulled into the Mortality Insights Reports. Work for this is ongoing between, the Health Informatics Team, the MediTech Team and the Matron for Learning Disabilities & Autism.

The trust is also going to add a flag for deaths for patients with a Serious Mental Illness (SMI). This will initially be based on national recognised SMI ICD10 Codes, and was expected to be in place by June 2023. A request to Health Informatics was submitted on 10/01/2023.

1.2 NHSE/I Better Care Tomorrow LFD Improvement Programme (SJR+)

A new process for the completion of SJRs commenced on 01/04/2023. The new process is based on best practice and follows advice from other Trusts and advice from the NHSE/I Better Care Tomorrow Leads.

TRFT now has a small SJR Review Team, who are trained in the Structured Judgment Review method, complete reviews regularly and have protected time. This team are using NHS England/Improvements SJR+ system to record and store its SJRs. This is a national system which is being used by an ever increasing number of Trusts. The SJR form has some enhancements to the form designed in 2017.

This new process contributed to completing some of the Trusts 360 Action points, and is designed to deliver quality complete and timely SJRs.

1.3 360 Assurance Re- Audit May 2023 LFD Governance

The final report for the May 2023 follow up report was presented to the Trust on 23/06/2023. Now 14 of the 15 actions points have been fulfilled

Of the 3 High Risk finding identified in the 2021/22 Re-Audit, 2 now have significant assurance. The other has limited assurance and is being worked on. It is expected to be completed well before the 31/03/2024 deadline. Below is the remaining action point.

We have allocated a limited assurance opinion to the CSU learning (in the Division of Medicine). We did not find evidence that suitable arrangements are consistently in place within CSUs for discussion on the outcomes of mortality reviews/SJRs and that these are shared (and escalated where appropriate) to the Divisional Mortality Sub-group meeting.

Progress

Completed SJRs (18) are being sent to Divisions Mortality Leads every 4 weeks**.** The split is roughly 11 to Medicine, 6 to Surgery and 1 to UECC. The SJRs are grouped according the last treating CSU. Those judged to have had poor care and /or been likely avoidable are highlighted.

The ask for the Divisions Mortality Leads is to complete a brief 1-2 minute review of each SJR and decide which need to be individually disseminated to the CSU and discussed at their Clinical Governance meeting or separate Mortality meeting. All those judged to have had poor care and /or been likely avoidable should automatically be disseminated.

The ask for the CSU Clinical Governance meeting or separate Mortality meeting is to review and discuss these SJRs. Which SJRs have been discussed should be included in the minutes, together which any discussion and resulting actions. These minutes, as evidence, will ultimately complete the outstanding action.

1.4 Learning from Deaths in the Divisions

Monthly Mortality meeting continue to be held in the Divisions of Medicine and Surgery where reviewed deaths are presented and discussed. Deaths are discussed that have been reviewed at Sub Divisional Mortality meetings.

There is an additional Lessons Learnt Section in SJR+, which allows reviewers to indicate which SJRs should be presented at Division and sub divisional level. This pathway will be established over the 1st two quarters of 2023/24.

SJR are being discussed where the Overall Care Score is poor or/and the death is judged to have likely Avoidable. A decision is made as to where a referral to the SI Panel is appropriate and what learning can be taken be from these reviews. The Divisional Mortality Groups continue to present summary reports at the Trust.

Almost remaining quorate the attendance numbers have gone down as a result of Clinical pressures. The Mortality Leads and Divisions remain committed to holding these meetings, and will run whenever possible.

John Taylor
Learning From Deaths & Mortality Manager
Mobile: 07833 634440
Email: john.taylor21@nhs.net

The Rotherham NHS Foundation Trust

31/08/2023

Learning From Deaths
Thematic Analysis SJRs 2023/24 Q1

Content

This report contains the Thematic Analysis of Structured Judgement Reviews (SJRs) completed for deaths in 2023/24 Q1. 23 were completed.

Thematic analysis is a method for analysing and coding qualitative data to determine themes. Thematic analysis of SJRs involves analysing free text comments and assigning these comments to codes.

In this analysis the comments are assigned to a code based on whether they are positive, negative and what factor the positive or negative comment relates to.

Purpose of Thematic Analysis in Learning From Deaths

Grouping comments into categories to highlight recurrent instances/themes will:

:Identify new problems

:Identify the reappearance of problems

:Highlight that some problems thought to be rare are more commonplace

:Provide evidence for problems that are reported anecdotally

:Identify good practice

Reducing Reocccurance Rate of Poor Care for Future Patient & Sharing Good Practice

This is the ultimate objective of the Learning From Deaths Programme.

In order for this report to be affective, it must be read by Trust individuals and groups who can subsequently suggest, design and implement changes that do this.

Content

Thematic Analysis 2022/23 Q3&4: Comments Detailing Poor Care

Thematic Analysis 2022/23 Q3&4: Comments Detailing Good Care

Data Tables

Thematic Analysis 2023/24 Q1: Comments Detailing Poor Care

Delay/Omission/Choice - Medication or Treatment

Consideration as to how we given PRN top up medication to cognitively impaired persons, who can't use PCA or initiate asking for more medications but are in pain when reviewed or directly questioned. Often top up is used to guide the sustained release medication or SC pump. So these patients end up without adequate analgesia.

Continued deterioration of the patient, despite measures taken, was not sufficiently recognised by the parent team. (Inappropriate prescription of sedatives causing unnecessary fall). Lack of clear communication with patient/ family re: expectations, course of disease and plan for managing is obvious.

Investigations of persistent tachycardia in chest trauma should include - repeat ECG, troponin, and consideration for ECHO.

Need for better recording of admission when patient transfer (from NGH)

She received fluid and antibiotics, but the MT sepsis screening was not used

Some drugs were unavailable and prescribed antivirals several days after diagnosis, also although had opinion from Resp team, don't appear to have seen and patient was managed on hi flow O2. Only appears to have been seen by Resp team when he was dying

There was >24hrs delay in obtaining PICC line in a sick patient which is not good care

This is a small area for improvement as she wasn't able due to cognitive impairment to ask for PRN medication so it seems often stayed in pain until she was reviewed rather than asking for pain relief.

Was reviewed and suggested he have Remdesivir, but none available. Was discussed with Resp team, but didn't receive Tocilizumab until 4 days after admission.

Delay/Omission - Escalation

Continued deterioration of the patient, despite measures taken, was not sufficiently recognised by the parent team. (Inappropriate prescription of sedatives causing unnecessary fall). Lack of clear communication with patient/ family re: expectations, course of disease and plan for managing is obvious.

Failure to escalate to critical care in a timely manner when BP low and unresponsive to fluid for several hours

Management on ward was not adequate with inappropriate management of fast AF in the context of worsening sepsis and low platelet count.

Delay/Omission - Assessment/Opinion/Review

Some drugs were unavailable and prescribed antivirals several days after diagnosis, also although had opinion from Resp team, don't appear to have seen and patient was managed on hi flow O2. Only appears to have been seen by Resp team when he was dying

Early use of dietician - There should be some trigger action / point when a patient decreased intake that automatically triggers a referral

He had a flare of his mental health that went unnoticed and had no MH input until his capacity was questioned. It would have been gold standard to have this in tandem with medical treatment.

The Learning Disabilities Team were informed of her stay but were unable to see before she became less responsive

Tandem care for mental health patients who area admitted helps to manage flare ups which are very likely to happen when physically unwell, in an unfamiliar environment as recommended by NICE.

This gentleman would probably have benefitted from input from the Nutritional and Elderly mental health

This patient had significant mental health burden that was not addressed alongside his physical health, this lead to him having several flares and at times the communication with him was impacted significantly by this. Tandem assessment by MH was needed.

Delay/Omission/Interpretation - Tests/Results/Monitoring

Investigations of persistent tachycardia in chest trauma should include - repeat ECG ,troponin, and consideration for ECHO.

significant delay in the reporting of a radiological investigation (ordered as part of the initial admission) and also lack of evidence of the result of the same investigation being chased/ followed by the requesting team,

Location of Care/Bed Availability/Inappropriate Moves

Admission of a patient with a Respect plan to not admit

It is obvious from a few weeks before that this person had significantly worsened and was now bed bound . Needed instigation sooner rather than 2 days from death. Hospital was not the preferred place of death and because lives in Sheffield we were unable to provide and alternative to this .

Should not have been transferred to an IP bed. Died within 24 hours

He was seen initially in good time and was diagnosed with a pneumothorax - delay in chest drain as no theatre space

Medical History

Need for better recording of admission when patient transferred (from NGH)

Need for better documentation of hospital transfer

End of Life/Palliative Care/DNACPR

Admission of a patient with a Respect plan to not admit

Although updates are given to wife, nil discussed about patients wishes or what is in his best interests as he deteriorates.

decision was discussed that no further interventions would be made given her severe frailty, more blood tests were done, which is documented as causing her significant distress

Delay in recognising he was dying

It is obvious from a few weeks before that this person had significantly worsened and was now bed bound . Needed instigation sooner rather than 2 days from death. Hospital was not the preferred place of death and because lives in Sheffield we were unable to provide and alternative to this.

never on EOL care - although opportunities were there when more unwell.

Palliative care were involved towards end of life but patient was already fairly agitated the morning of his death and it may have been appropriate to instigate palliative care earlier on and overnight.

Patient probably should not have been transferred to hospital. As per the Respect form, this was a pre-terminal event in an extremely frail lady from a care setting

Problems with ever considering what may be in her best interests and she spent the last month of her life in hospital

Recognition of last phase of life lacking until last 48 hours there was lots of medically fit for discharge documented and DT taking it off as needed MDT and social support - there should of been an early MDT for him to given him the option of going home

Should not have been transferred to an IP bed. Died within 24 hours

The consultant who reviewed him 5 days prior to this recognised he was likely approaching the end of his life, but didn't action anything so he continued to have acute reviews and NG tube reinsertions until he was cared for on last days of life care plan

Communication

Although updates are given to wife, nil discussed about patients wishes or what is in his best interests as he deteriorates.

This patient had significant mental health burden that was not addressed along side his physical health, this lead to him having several flares and at times the communication with him was impacted significantly by this . Tandem assessment by MH was needed .

Continued deterioration of the patient, despite measures taken, was not sufficiently recognised by the parent team. (Inappropriate prescription of sedatives causing unnecessary fall). Lack of clear communication with patient/ family re: expectations, course of disease and plan for managing is obvious.

Could we finesse the Nil By Mouth decisions.

A gentleman with a failed discharge with advanced dementia and delirium, readmitted shortly after a discharge to step down care should have been some discussion with family in UECC about this mans best interests when in UECC, but nil documented about contact with family

decision making of Chest drain not in the notes

Despite him never having has a MCA, none of the plans of care appear to have been discussed with him, or what he would want given uncertain outcome.

documentation of fluid balance poor overall and difficult to ascertain whether he has received this

he had a NG feeding tube inserted, with no evidence in the notes that this was discussed with him, or is family, this was reinserted several times, including having a bridle placed, again no evidence that any of this was discussed with him or his family.

no recording of discussion with her NOK, or guardians and involving them with her plan of care

Poor documentation of urine out put even when worsening renal function

There is no documentation re: Endoscopy and NJ tube insertion on Meditech

Need for better recording of admission when patient transfer (from NGH)

Need for better documentation of hospital transfer

Thematic Analysis 2023/24 Q1: Comments Detailing Good Care

Delay/Omission/Choice - Medication or Treatment

This ongoing care was excellent - she had regular reviews from both critical care , ART when her NEWS 2 was high as per deteriorating patient guides , regular pain team reviews and changes to medication when she was uble to swallow , regular physio. All best interest decisions and it is obvious that they were patient focussed stopping if causing undue distress

Well managed from start to finish. Injuries sustained following fall but not clearly preventable. Pragmatic approach taken to likely metastatic cancer in a patient with decompensated alcoholic liver disease. Overall well managed.

Delay/Omission - Escalation

This ongoing care was excellent - she had regular reviews from both critical care , ART when her NEWS 2 was high as per deteriorating patient guides , regular pain team reviews and changes to medication when she was uble to swallow , regular physio. All best interest decisions and it is obvious that they were patient focussed stopping if causing undue distress

Delay/Omission - Assessment/Opinion/Review

This ongoing care was excellent - she had regular reviews from both critical care, ART when her NEWS 2 was high as per deteriorating patient guides, regular pain team reviews and changes to medication when she was unable to swallow, regular physio. All best interest decisions and it is obvious that they were patient focussed stopping if causing undue distress

Excellent input from multi-disciplinary teams to facilitate optimal care of all aspects of peri-operative care and recovery.

This was excellent patient centred care and involvement of multiple teams. The documentation of this and shared decision making process is something that should be fed back to the team as excellent care

Clear communications with family documented. Excellent example of shared decision making and patient lead care especially when EOL care was given.

Delay/Omission/Interpretation - Tests/Results/Monitoring

Demonstration of how thorough history taking and history from family members can provide important information regarding recent falls and injuries which helped to identify issues. Good demonstration of looking at bones on chest imaging and identification of fractures.

End of Life/Palliative Care/DNACPR

Clear communications with family documented. Excellent example of shared decision making and patient lead care especially when EOL care was given.

It was quickly identified that the patient was not responding to treatment and was approaching end of life and appropriate end of life care was provided.

Palliative care and parent team involved at all times and good communication noted with family and between teams.

Appropriate communication with family on ITU throughout his ITU stay and when it was clear that the patient was not going to survive he received excellent end of life care

Excellent care by Palliative care team

Good palliative and end of life care

Excellent. Planning to discharge home with end of life care. Had palliative care team involvement and syringe driver in place and was about to be transferred home when she deteriorated further and passed away. Well managed overall.

Recognised dying and started last days of life care plan, good communication with family and referred to palliative care team, who didnt need to intervene, he was kept comfortable and his wife and he were supported well by the team he was familiar with

Communication

Clear communications with family documented. Excellent example of shared decision making and patient lead care especially when EOL care was given.

Appropriate communication with family on ITU throughout his ITU stay and when it was clear that the patient was not going to survive he received excellent end of life care

Excellent input from multi-disciplinary teams to facilitate optimal care of all aspects of peri-operative care and recovery.

This was excellent patient centred care and involvement of multiple teams. The documentation of this and shared decision making process is something that should be fed back to the team as excellent care

Communication between the various teams looking after her was good which enhanced her care, this is also clearly documented

Excellent documentation.

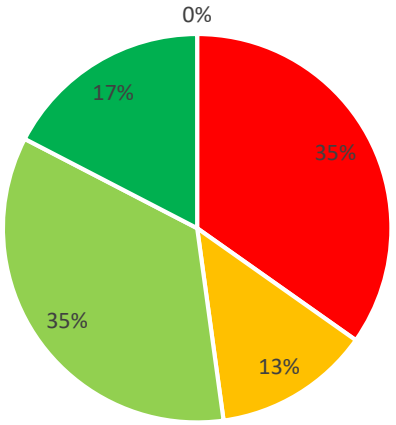
Medical History

Good history taking and identification of acute issues

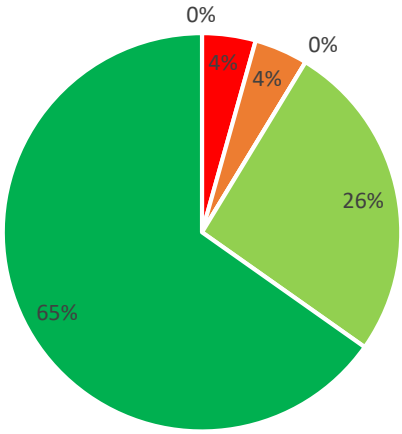
Demonstration of how thorough history taking and history from family members can provide important information regarding recent falls and injuries which helped to identify issues. Good demonstration of looking at bones on chest imaging and identification of fractures.

Data Tables

Overall Care Score	SJRs
1 - Very Poor	0
2 - Poor	8
3 - Adequate	3
4 - Good	8
5 - Excellent	4
Total	23



Avoidability	SJRs
1 - Definitely avoidable	0
2 - Strong evidence of avoidability	1
3 - Probably avoidable (more than 50%)	1
4 - Possibly avoidable (less than 50%)	0
5 - Slight evidence of avoidability	6
6 - Definitely not avoidable	15
Total	23



Comment Relates to	Negative Comments	Positive Comments
Delay/Omission/Choice - Medication or Treatment	9	2
Delay/Omission - Escalation	3	1
Delay/Omission - Assessment/Opinion/Review	7	4
Delay/Omission/Interpretation - Tests/Results/Monitoring	2	1
End of Life/Palliative Care/DNACPR	12	8
Location of Care/Bed Availability/Inappropriate Moves	4	0
Communication	14	6
Medical History	2	2
Total	53	24

Phase of Care	Negative Comments	Positive Comments
Initial 24 hours	9	3
Ongoing Care	9	4
Procedure Care	3	2
EOL	5	3
Overall Care Comments	6	2
Total	32	14

Type	Problems
Problems leading to readmission	4
Problems in assessment	0
Problem with medication	3
Problem with nutrition	4
Problem with infection control	0
Problem related to operation	1
Problem in clinical monitoring	4
Problem in treatment plan	7
Problem in resuscitation	0
Problem in IV fluids	3
Problems in communication	3
Problems in relatives communication	2
Problems in team communication	3
Problem of any other type	3
Total	37

John Taylor
Learning From Deaths & Mortality Manager
Medical Directorate
The Rotherham NHS Foundation Trust

E-mail: john.taylor21@nhs.net
Phone: MS Teams/07833 634440

Latest Publication Date: 14/09/2023
Latest Data Month: Apr-23

TRFT SHMI Report

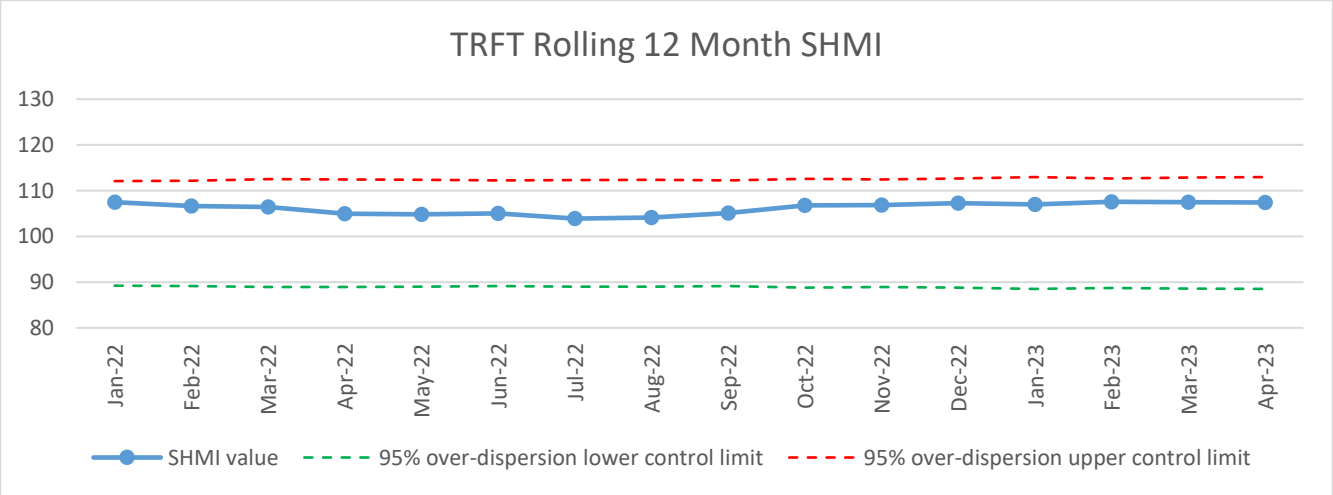
Summary

TRFTs latest Rolling 12 Month SHMI Value is 107.4. TRFT remain in the Band 2 'As Expected' band. The previous value which was 107.5.

2 of the 13 Yorkshire & Humber Non Specialist Trusts are in Band 1 'Higher than Expected'

TRFT has 1 Diagnosis Group in the Higher than Expected Band:

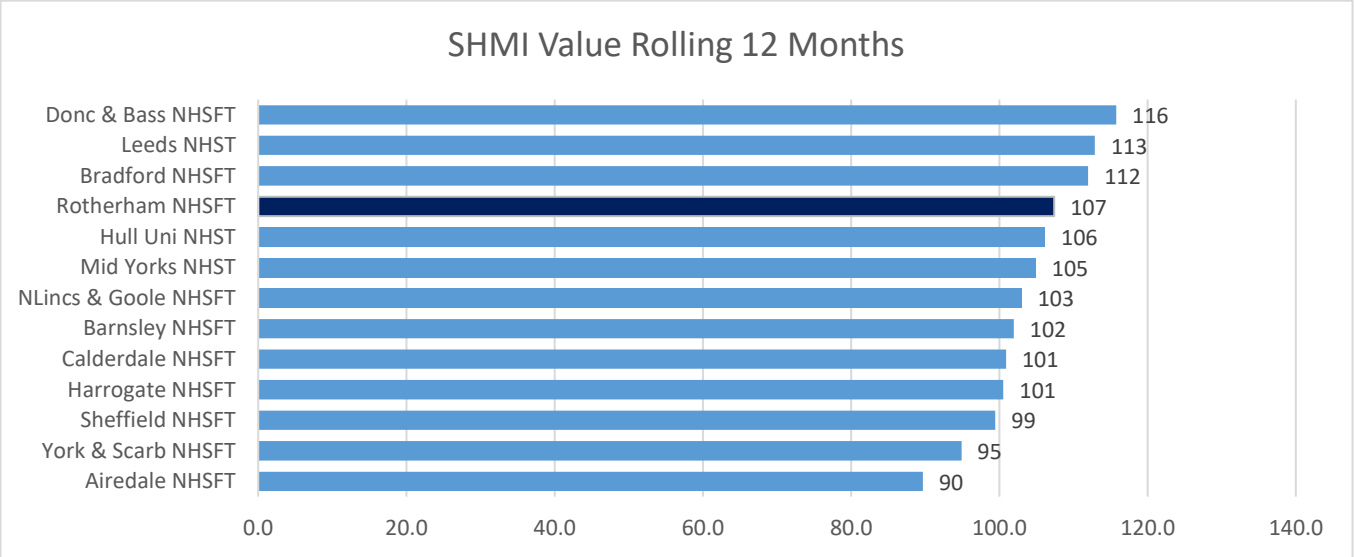
- Pneumonia (excluding TB/STD)



TRFT Latest SHMI Value

End Month	SHMI value	SHMI banding	Number of spells	Observed deaths	Expected deaths
Apr-23	107.4	2	45390	1370	1275

Region Comparator - Yorkshire & Humber Non Specialist Trusts



SHMI Diagnostic Group Breakdown

Diagnosis Group	Number of spells	Observed deaths	Expected deaths	SHMI Value	SHMI banding
Pneumonia (excluding TB/STD)	1405	260	220	120.1	1
Acute bronchitis	990	15	20	88.4	2
Acute myocardial infarction	480	35	35	99.5	2
Cancer of bronchus; lung	45	20	15	111.1	2
Fluid and electrolyte disorders	330	20	20	105.5	2
Fracture of neck of femur (hip)	285	25	20	113.7	2
Gastrointestinal hemorrhage	395	20	20	101.6	2
Secondary malignancies	105	15	20	66.4	2
Septicaemia (except in labour), Shock	560	150	130	115.2	2
Urinary tract infections	890	25	30	84.6	2

Coding Data

TRFT Rank of 13	2nd Highest	2nd Highest	2nd Highest	5th Highest	2nd Highest
Yorks & Humber Region Non Spec Provider Trusts	**% of Spells: Primary Diagnosis is a Sign & Symptom**	**% of Spells: Invalid primary diagnosis code**	**MEAN Secondary Diagnoses per Spell Non Elective**	**% of Spells with palliative care**	**% of deaths with palliative care**
Airedale NHSFT	13.8	0.0	4.4	0.9	21
Barnsley NHSFT	13.3	0.1	6.7	1.4	27
Bradford NHSFT	12.6	0.9	3.8	1.1	34
Calderdale NHSFT	8.2	*	6.2	2.0	38
Donc & Bass NHSFT	10.2	0.0	4.9	2.4	47
Harrogate NHSFT	15.6	0.2	4.3	1.9	41
Hull Uni NHST	11.3	3.6	5.5	2.0	32
Leeds NHST	6.2	*	6.0	1.9	33
Mid Yorks NHST	9.4	0.7	6.2	1.9	37
NLincs & Goole NHSFT	17.6	0.1	4.9	1.3	21
Rotherham NHSFT	17.3	3.0	6.6	1.9	46
Sheffield NHSFT	8.9	0.2	4.7	1.9	37
York & Scarb NHSFT	13.0	0.1	5.2	1.2	27
England	13.3	1.3	5.6	1.9	41

John Taylor
Learning From Deaths & Mortality Manager
Medical Directorate
The Rotherham NHS Foundation Trust

E-mail: john.taylor21@nhs.net
Phone: MS Teams/07833 634440

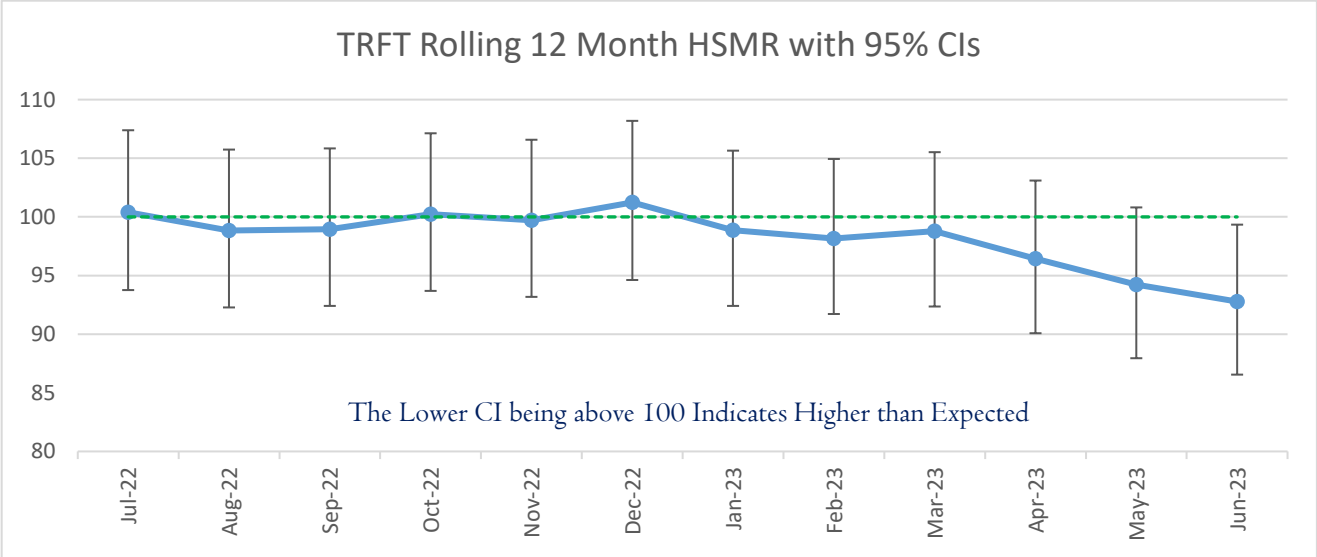
Latest Publication Date: 06/09/2023
Latest Month Data: Jun-23

TRFT HSMR Report

Summary

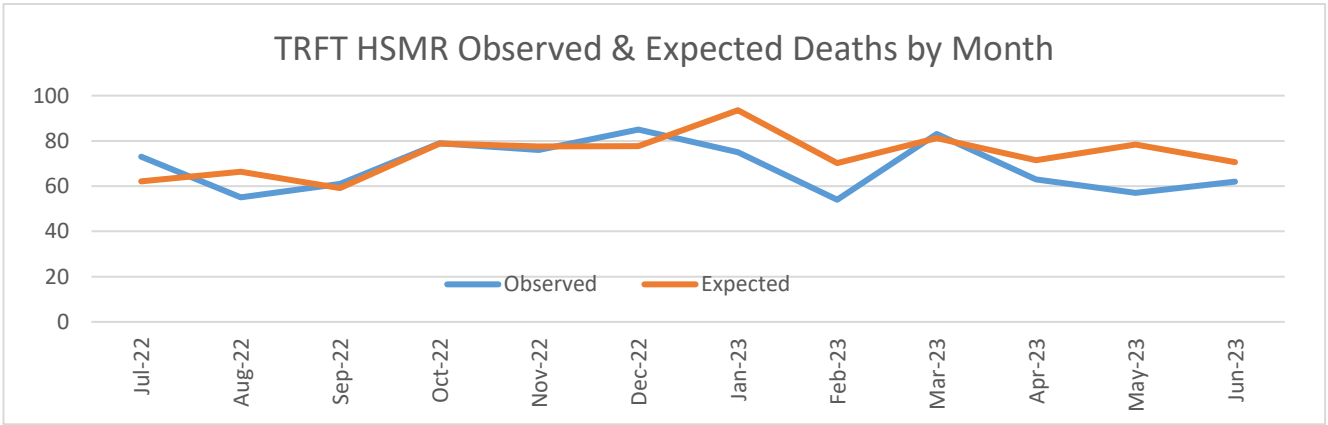
TRFTs latest Rolling 12 Month HSMR Value is 92.8 TRFT are in the 'Lower than Expected' band

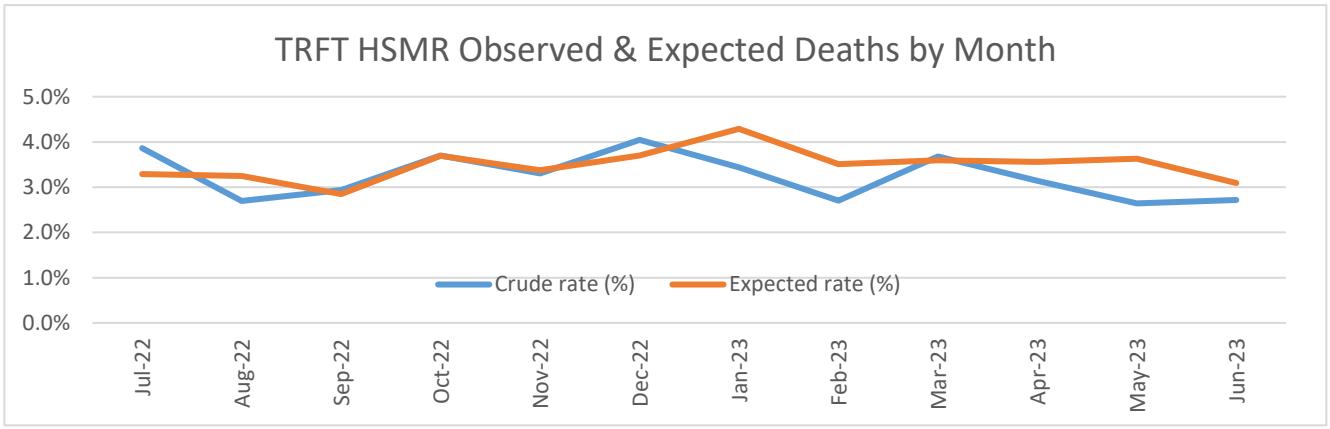
TRFT is in the higher than expected band for this Diagnosis Group:
39 - Leukemias



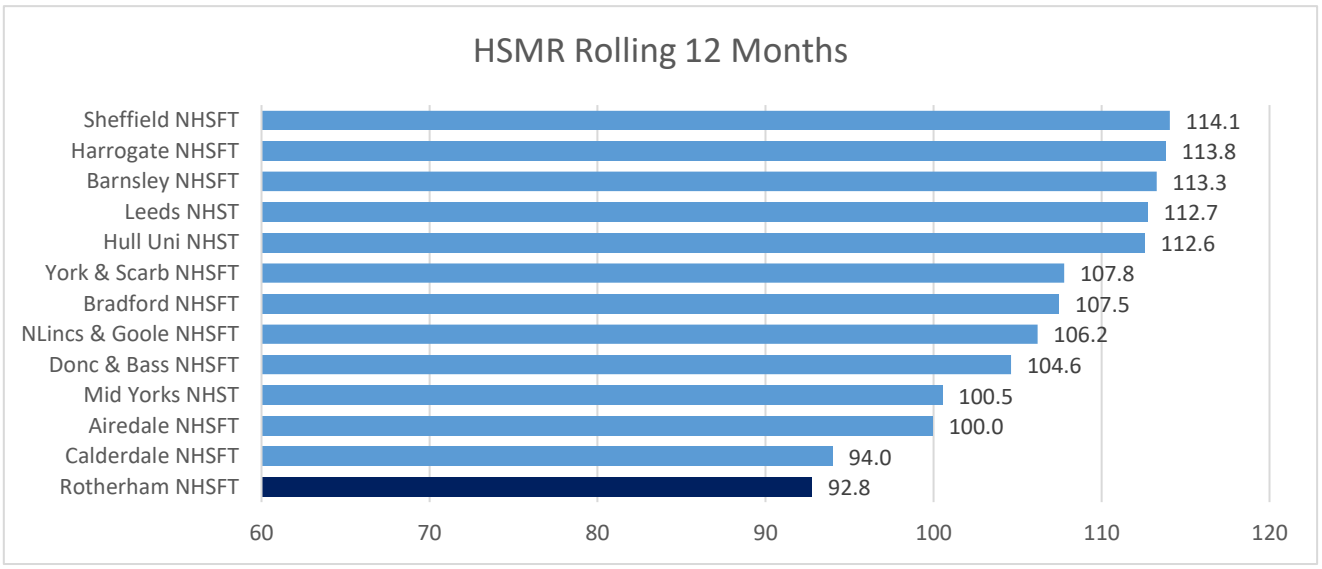
TRFT Latest R12M HSMR Value

End Month	HSMR value	HSMR banding	Number of super spells	Observed deaths	Expected deaths
Jun-23	92.8	lower	25433	823	887





Region Comparator - Yorkshire & Humber Non Specialist Trusts



HSMR Diagnostic Groups Breakdown - Higher Than Expected Groups

Diagnosis group	Superspells	Observed	Expected	Relative risk	95% lower confidence limit
39 - Leukemias	665	7	2.5	283.9	113.8

Subject:	PEOPLE COMMITTEE CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	Board of Directors: 3 November 2023

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

Committee / Group: People Committee	Date: 27th October 2023	Chair: Dr Rumit Shah

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Director of People report key issues	The Committee noted the positive work undertaken to support Black and Minority Ethnic staff including the recent and very successful cultural event held in the main hospital reception.	Board of Directors
2	WRES and WDES Annual Report and Action Plan	The Committee noted and commended the annual report and action plans for both WRES and WDES and recommend approval at Board.	
3	Guardian of Safe Working Quarterly Report	The Committee noted the report and advise that further work is being carried out in triangulation of staffing levels and reported incidents.	Board of Directors
4	Covid and Flu Vaccine Programme	The Committee wished to commend the work undertaken to actively promote the Covid and Flu Vaccination Programme with figures leading to it currently being the best performing trust in South Yorkshire.	Board of Directors
5	NHSE self- assessment 2023	The Committee discussed the self-assessment recommending approval to the Board	Board of Directors

Board of Directors
3rd November 2023

Agenda item	P161/23
Report	Workforce Race Equality Standard (WRES) and Workforce Disability Employment Standard (WDES) and Combined Action Plan 2023
Executive Lead	Daniel Hartley – Executive Director of People
Link with the BAF	D5: Delivery - inability to deliver operational plan resulting in increase in patient waiting times and reduced quality of care U4: Us - 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.
Purpose	Decision ✓ | To Note | For Approval | For Information
Executive Summary (including reason for the report, background, key issues and risks)	The WRES and WDES are annual mandated national reporting schemes first introduced in 2016 and 2019 respectively. Both schemes draw on data from Electronic Staff Record, NHS Jobs and the National Staff Survey. Trusts are required to develop action plans aimed at decreasing the gap in experience between Black and Minority Ethnic staff and White staff, and disabled and non–disabled staff respectively. These reports and action plans need to be considered by the Board and published on the Trust website. The reports set out the progress made and challenges which continue in both areas over the last 12 months. They also provide an update on the actions which TRFT committed to in 2022. Overall in 2023, 14.2% of the workforce is BME (12.7% in 2022). 5% of staff have declared a disability (4.3% in 2022). Whilst progress has been made in some areas, both reports show a continued gap between the experience of working at the Trust for BME and disabled colleagues as compared to White and non-disabled staff. This is therefore a key area of focus to deliver improvements for staff and patients. The combined action plan was developed following extensive internal engagement including staff networks, the Trust's EDI group and senior managers. The action plan represents what will be the Trust's public commitments to its workforce and population on WRES and WDES. Under the themes of Voice, Development and Accountability it also sets out the broader Equality Diversity and Inclusion (EDI) focus that the Board are asked to agree and take forward in 2023/4 and 2024/5. As such this action plan constitutes the EDI programme referred to in the Operational Mandate 3 – Supporting our People. Following approval at Executive Management Team on the 19th October 2023, the reports and

	action plan were endorsed by, and recommended to the Board, by the People Committee on the 27th October 2023.

Recommendations	The Board is asked to
	
	• Approve the WRES and WDES Reports 2023
	• Approve the combined action plan specifically noting
	  ○ the recommendations in the area of voice, development and accountability including actions for the Board over the next year
	  ○ the NHSE requirement to publish the reports and action plan on the TRFT website by the 31st October 2023.

Appendices	WDES Annual Report 2023 WRES Annual Report 2023 WRES and WDES Combined Action Plan 2023

The Rotherham NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD (WRES) ANNUAL REPORT 2023

1. Introduction.

The Workforce Race Equality Standard (WRES) is an annual mandated national reporting scheme first introduced in 2016. It uses defined indicators to measure the experience of Black and Minority Ethnic (BME) staff compared to White staff, drawing on data from Electronic Staff Record (ESR), NHS Jobs and the National Staff Survey. ESR and NHS Jobs data is for the period 1 April 2022 to 31 March 2023, with snapshot data as of 31 March 2023. Staff Survey data is from the 2022 Staff Survey.

Trusts are required by the NHS Standard Contract to use this data to develop action plans aimed at reducing the gap in experience between these two groups, in line with their obligations under the Public Sector Equality Duty. For the purposes of WRES, the BME category does not include staff from White minority groups.

The report covers the statistical measures as per the WRES indicators with relevant commentary and as such is relatively dry in nature. It is important to remember that the numbers contained in the report represent real people and their experiences. Where performance has improved, there is often still a disparity between the workplace experience of BME and white staff and TRFT is committed to making significant progress in this area to ensure the Trust can provide the best possible care for patients.

2. The WRES Indicators

1. Percentage of staff in each of the Agenda for Change (AfC) bands 1 - 9 or medical and dental subgroups and Very Senior Managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.
2. Relative likelihood of white staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.
3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. Relative likelihood of white staff accessing non mandatory training and CPD as compared to BME staff.
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. Percentage believing that trust provides equal opportunities for career progression or promotion.
8. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/ team leader or other colleagues
9. Percentage difference between the organisations' board membership and its overall workforce disaggregated: by voting membership and executive membership of the board.

3. Actions and progress made since WRES report 2022

Action	Progress
Launch & embed the All About Me passport	The Trust launched its All About Me staff passport. This has been designed to support holistic discussions between members of staff and their manager around individual needs, including cultural and religious needs. This launch has been supported by training, and the passport is referenced in the Trust's appraisal template and has been highlighted to managers as part of retention masterclasses.
Complete Reciprocal Mentoring for Inclusion Programme - cohort 1 (and assess feasibility of a further cohort)	Cohort one was completed. All of the programme was designed and delivered in-house; predominately aimed at Board / Executive colleagues partnering with less senior colleagues with protected characteristics. Feedback was very positive from colleagues. The key learning points from the programme were presented and discussed with the Trust's Senior Leaders at their meeting in July 2023. Early discussion is now underway with Place partners regarding the viability of a multi – organisational approach for the next cohort.
Ensure there are specific questions around EDI for interviews for all posts	An EDI question bank was developed and is now included in all interview packs and sent to recruiting managers. Some divisions e.g. Surgery have explored values based recruitment. It is now mandatory for there to be an equality diversity and inclusion question as part of all job interviews at the Trust.
Continue to work with divisions to embed behavioural framework and relevant training	This important work is a key leadership responsibility across the Trust. The behavioural framework is now embedded into the Trust's appraisal process. The People team work with divisional leadership teams to meet the learning needs of the divisions and provide advice to ensure that behaviours are in line with the framework. Specific behavioural charter sessions have taken place and race quality is included in regular training sessions for nursing staff including community district nurses. A number of services and teams have also accessed cultural awareness training from the equality, diversity, and inclusion (EDI) team e.g. Family Health division.
Improve induction and support to our internationally educated staff	Up to 31st March 2023 the Trust had successfully recruited 150 Internationally Educated Nurses (IEN) as part of an ICB approach. The Education and Development team have worked hard to support IENs to pass their OSCE test of competence

	exam (clinical and communication skills), with a 100% pass rate. Significant improvements have been made to induction materials and processes to better support nursing and allied health professionals (AHPs). A new 'what to know about working at TRFT and living in Rotherham' guide has been produced and is shared before new IEN colleagues arrive. 10 nursing and AHP managers have completed a course on cultural competence for managers of internationally educated staff as part of a national pilot. Work is currently underway to embed learning from other professions and national guidance into induction of International Medical Graduates. 9 IENs have been promoted from their original staff nurse post into a variety of more senior roles in the Trust, with 4 colleagues becoming trained Professional Nurse Advocates further supporting IENs to stay and thrive in Rotherham
A new medical leadership programme launched which includes specific EDI modules	A presentation and discussion with new doctors (appointed in last 2 years) around the Trust's behavioural framework and around race equality and anti-racism is included in the Trust's new medical leadership programme, which recently launched at the start of 2023/24 across each division.
Strengthen the BAME Staff Network	Following the establishment of backfill funding arrangements, a chair and vice chair have been recruited for the BAME staff network and are working to grow and develop the network. There has been an increased Executive commitment to working with and attending staff networks, and all three of the Trust's staff networks are represented on the EDI Steering Group and heavily engaged in work to improve policies and processes. Divisions have promoted the networks locally e.g. Surgery promoting the network calendars.
Communicate WRES and WDES action plans to senior leaders within the Trust, ensuring that they are aware of their own responsibilities	WRES and WDES data sets, reports and action plans have been communicated throughout the EDI steering group, and progress updates have been provided regularly to various governance meetings at the Trust e.g., presentation to Senior Leaders Meeting delivered in Q1 2023.
Increase the representation of BME staff within AfC bands 2,3 and 4 towards	Progress has been made at Band 4 with limited or no progress at Bands 2 and 3. More focussed work is required in both clinical and non-clinical areas.

representativeness of the local population	Non clinical (2021; 2022; 2023) = Band 2 (4.3%; 4.3%, 4.3%), Band 3 (2.8%, 2.4%, 2.8%), Band 4 (2.9%, 3.6%, 5.4%) Clinical (2021; 2022; 2023) = Band 2 (4.5%, 5.7%, 6.1%), Band 3 (7.0%, 6.0%, 6.4%), Band 4 (3.0%, 5.0%, 5.8%)

4. WRES assessment against the national indicators

Metric 1: The composition of our workforce

TRFT employed 5021 staff as at the 31st March 2023. Of these, 14.2% (715 people) are BME, 4255 are white, and 51 do not have an ethnicity recorded on ESR. There has been an increase of approximately 1.5 percentage points in the proportion of our workforce who are BME over the last year. Much of this is attributable to planned international recruitment activity. The ethnic diversity of our workforce varies significantly between different departments and staff groups.

(a) Our non-clinical workforce

Band / VSM / NED / Medical and Dental Breakdown	White	BME	Not Stated/ Blank	Total	% BME 2023	2022	2021
Under Band 1	4			4	0.0%		
Bands 1	2	1		3	33.3%		
Bands 2	438	20	3	461	4.3%		
Bands 3	248	7		255	2.8%		
Bands 4	140	8	1	149	5.4%		
Bands 5	84	7	1	92	7.6%		
Bands 6	79	4		83	4.8%		
Bands 7	54	2	1	57	3.5%		
Bands 8a	51			51	0.0%		
Bands 8b	14	1		15	6.7%		
Bands 8c	9		1	10	0.0%		
Bands 8d	8			8	0.0%		
Bands 9	7			7	0.0%		
VSM	9	4		13	30.8%		
Totals	**1147**	**54**	**7**	**1208**	**4.5%**	**4.3%**	**3.9%**

Our non-clinical workforce primarily consists of corporate staff (e.g., Finance, IT, HR), administrative staff and estates and facilities staff. As shown in the table above, there is limited ethnic diversity with a particular lack of BME staff at senior levels (other than VSM or Board level).

(b) Our clinical workforce (excluding medical and dental)

	White	BME	Not Stated/ Blank	Total	% BME	2022	2021
Under Band 1	3	1		4	25.0%		
Bands 2	577	38	4	619	6.1%		
Bands 3	320	22	1	343	6.4%		
Bands 4	195	12		207	5.8%		
Bands 5	508	228	9	745	30.6%		
Bands 6	728	83	8	819	10.1%		
Bands 7	357	21	2	380	5.5%		
Bands 8a	189	13	3	205	6.3%		
Bands 8b	22	6		28	21.4%		
Bands 8c	13	2		15	13.3%		
Bands 8d	8	1		9	11.1%		
Bands 9	1			1	0.0%		
Other	3			3	0.0%		
VSM	1			1	0.0%		
Totals	**2925**	**427**	**22**	**3379**	**12.6%**	**10.8%**	**7.6%**

Our clinical workforce includes nurses and midwives, healthcare support workers, allied health professionals (e.g., physiotherapists, occupational therapists, podiatrists, dietitians, operating department practitioners, orthoptists, osteopaths, physios, radiographers), healthcare scientists and pharmacists. It is the largest part of the workforce, and there is far greater ethnic diversity within our clinical workforce than within our non-clinical workforce. Our clinical workforce is most ethnically diverse at Band 5. Whilst there is good ethnic diversity at and above Band 8B (where there are very few staff overall), BME staff are still under-represented at Bands 6-8a, both in comparison to the clinical workforce and the Trust's overall workforce, however this picture has shown some improvement over the last year. BME staff continue to be underrepresented in bands 2-4.

(c) Our Medical and Dental workforce

	White	BME	Not Stated/ Blank	Total	% BME 2023	2022	2021
Medical & Dental Staff, Consultants	73	99	7	179	55.3%		
Medical & Dental Staff, Medical and dental trainee grades	50	87	5	142	61.3%		
Medical & Dental Staff, Non-Consultants career grade	59	48	8	115	41.7%		
Medical & Dental Senior Manager	1			1	0.0%		
Totals	**183**	**234**	**20**	**437**	**53.6%**	**52.4%**	**46.3%**

(d) Ethnicity by staff group

Staff Group	%BME 2023	2022	2021
Add Prof Scientific and Technic	22.1%	19.7%	20.3%
Additional Clinical Services	7.3%	7.3%	7.0%
Administrative and Clerical	3.8%	3.7%	3.2%
Allied Health Professionals	16.3%	11.0%	9.0%
Estates and Ancillary	4.8%	4.7%	4.6%
Healthcare Scientists	12.3%	13.3%	12.3%
Medical and Dental	53.2%	52.4%	46.5%
Nursing and Midwifery Registered	15.7%	13.0%	6.6%
Grand Total	**14.2%**	**12.7%**	**9.8%**

There is a lack of ethnic diversity amongst our administrative and clerical and estates and ancillary staff. There has been a 5-percentage point increase in the proportion of allied health professional staff recorded as BME since last year. This has been driven by a mixture of planned international recruitment and international candidates applying independently.

The Trust's Nursing and Midwifery workforce has become significantly more diverse, primarily because of planned international recruitment over the last couple of years.

Over half of the Trust's medical and dental workforce is BME. Whilst there has been some specific international recruitment within this staff group, a large proportion of the overall UK medical workforce are BME, and many are UK graduates. Additionally, the medical and dental workforce is a highly mobile one, both nationally and internationally, and changes to the immigration rules since Brexit have made it more straightforward for non-EU candidates to apply for clinical roles within the NHS.

Metric 2: appointment from shortlisting

The relative likelihood of white staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting in 2022/23 was 1.33. This is significantly higher than the figure reported in previous years. This change is likely to be attributable to improvements to reporting facilitated by the new NHS Jobs system. Whilst there is now a greater degree of confidence in this data, it is not directly comparable with data reported in previous years.

This data shows that a white person shortlisted for a post is 1.33 times more likely to be appointed than a BME person shortlisted for the same post. This result is statistically significant, as it is outside the expected range of 0.8-1.2, which would indicate equity.

Metric 3: entry into disciplinary processes

In 2022-23, BME staff were 0.79 times as likely as white staff to enter the formal disciplinary process. This is slightly outside the expected range of 0.8-1.2, however not significantly so, and indicates that BME staff continue to be proportionately slightly less likely to enter the disciplinary process than white staff. Only 17 staff entered the Trust's formal disciplinary process during 2022-23 – this number has been falling for several years as greater emphasis is placed on Restorative Just and Learning Culture and informal resolution of issues.

Metric 4: staff accessing non-mandatory training and CPD

During 2022/23, the relative likelihood of white staff accessing non-mandatory training and CPD as compared to BME staff was 0.94. This is within the expected range of 0.8-1.2, indicating that both groups were roughly equally likely to access non-mandatory training and CPD.

Metric 5: percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

In the 2022 staff survey, 28.6% of BME staff reported that they had experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months, compared to 24% of white staff. This metric has deteriorated slightly compared to last year, and the national benchmark median has also deteriorated slightly. The Trust continues to perform better than the benchmark median.

Metric 6: percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

23.6% of BME staff responding to the 2022 staff survey said that they had experienced harassment, bullying or abuse from staff in the last 12 months, compared to 16.9% of white staff. This metric has deteriorated slightly for BME staff. The Trust continues to perform better than the benchmark median.

Metric 7: percentage believing that trust provides equal opportunities for career progression or promotion

In the 2022 staff survey, 53.8% of BME staff said that they believed the Trust provided equal opportunities for career progression, compared to 62.8% of white staff. This metric has

improved by over 9 percentage points for BME staff, and the Trust is significantly outperforming the benchmark median.

Metric 8: in the last 12 months have you personally experienced discrimination at work from any of the following? Manager/ team leader or other colleagues

In the 2022 staff survey, 14.7% of BME staff reported experiencing discrimination at work from managers, team leaders or other colleagues, compared to 3.8% of white staff. This metric has improved for BME staff from 2021, and the Trust is performing better than the benchmark median.

Metric 9: percentage difference between the organisations' board membership and its overall workforce disaggregated: by voting membership and executive membership of the Board

14.24% of the Trust's overall workforce is BME. As of 31 March 2023, 21.1% of the Board was BME, 28.6% of voting Board members were BME and 9.1% of Executive Board members were BME. It should be noted that WRES data only includes staff on the Trust's payroll, and as of 31st March 2023, TRFT shared two Executive Board members with Barnsley Hospitals NHS FT – the Chief Executive and the Director of Workforce. Of these two, the director of Workforce was on TRFT's payroll, so is included in TRFT's WRES data, whilst the Chief Executive is on Barnsley's payroll, and so is not included in TRFT's WRES data. As of 31st March 2023, 37.45% of the Trust's Non-Executive Directors were BME.

5. Conclusion

BME representation within the Trust's workforce continues to increase, with most progress being made in clinical areas. This increase has been significantly supported by international recruitment and more work is required to address the underrepresentation of the BME population within the Trust's workforce, with a particular focus on diverse local recruitment.

This year has seen some improvements with regard to the experience of BME staff during their employment with the Trust. Whilst the Trust is now performing better than the benchmark median on WRES metrics relating to staff experience, there are still significant opportunities for further improvement. These improvements are essential to deliver on the Trust's ambition for 'Us' – 'we will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work'. Only by achieving that ambition will we be able to provide the best possible care for patients.

6. Next steps

Accompanying this report is the first version of the Trust's intersectional action plan for 23/24 and 24/25 encompassing the WRES and the Workforce Disability Equality Standard (WDES) actions. Engagement on this took place during Q2 of 2023/24 with a number of stakeholder groups and all of the staff networks contributing to the final action plan which will be available on the Trust website following Board sign off. A further report will be published in 2024/25 setting out progress against this action plan.

The Rotherham NHS Foundation Trust

WORKFORCE DISABILITY EQUALITY STANDARD (WDES) ANNUAL REPORT 2023

V Final October 2023

1. Introduction

The Workforce Disability Equality Standard (WDES) is an annual mandated national reporting scheme first introduced in 2019. It uses defined indicators to measure the experience of disabled staff against non-disabled staff, drawing on data from ESR, NHS Jobs and the National Staff Survey. ESR (Electronic Staff Record) and NHS Jobs data is for the period 1 April 2022 to 31 March 2023, with snapshot data as at 31 March 2023. Staff Survey data is from the 2022 Staff Survey. Trusts are required to use this data to develop action plans aimed at decreasing the gap in experience between disabled and non-disabled staff.

Whilst only 4.9% of the Trust's staff have declared a disability on ESR (an increase from 4.3% last year), approximately 20% of staff survey respondents answered "yes" to the question: "Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?" Although the staff survey question is not entirely analogous to the definition of disability, as it does not ask about impact on daily life, the staff survey results are suggestive of continued significant under-reporting of disability via ESR, which is replicated nationally.

2. The WDES Indicators

1. Percentage of staff in each of the AfC bands 1 - 9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.
2. Relative likelihood of non-disabled staff being appointed from shortlisting compared to that of Disabled staff being appointed from shortlisting across all posts
3. Relative likelihood of Disabled staff entering the formal capability process, compared to that of non-disabled staff entering the formal capability process, as measured by entry into a formal capability process
4. a) i) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

   ii) Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months

   iii) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

   b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
5. Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

9. a) The staff engagement score for Disabled staff, compared to non-disabled staff.

   b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

10 Percentage difference between the organisations' board membership and its overall workforce disaggregated: by voting membership and executive membership of the Board.

3. Actions and progress made since WDES report 2022

Action	Progress
Undertake a data cleanse to improve the availability of information regarding the disability status of our staff	All staff Comms from Director of Workforce sent out in December 2022 requesting that staff ensure their data was up to date.
Complete Reciprocal Mentoring For Inclusion Programme cohort 1 and plan cohort 2	Cohort one was completed. All of the programme was designed and delivered in-house; predominately aimed at Board / Executive colleagues partnering with less senior colleagues with protected characteristics. Feedback was very positive from colleagues. The key learning points from the programme were presented and discussed with the Trust's Senior Leaders at their meeting in July 2023. Early discussion is now underway with Place partners regarding the viability of a multi – organisational approach for the next cohort.
Ensure there are specific questions around EDI for interviews for all posts	An EDI question bank was developed and is now included in all interview packs and sent to recruiting managers. Some divisions e.g. Surgery have explored values based recruitment. It is now mandatory for there to be an equality diversity and inclusion question as part of all job interviews at the Trust.
Continue to work with divisions to embed	This important work is a key leadership responsibility across the Trust. The behavioural framework is now embedded into the Trust's appraisal process.

behavioural framework and relevant training	The People team work with divisional leadership teams to meet learning needs of the divisions and provide advice to ensure that behaviours are in line with the framework. Specific behavioural charter sessions have taken place and EDI is included in regular training sessions for nursing staff including community district nurses. A number of services and teams have also accessed diversity and inclusion training from the equality, diversity, and inclusion (EDI) team e.g. Family Health division.
Launch All About Me staff passport and associated training to existing managers, and ensure it is completed by all new managers	The Trust launched its All About Me staff passport. This has been designed to support holistic discussions between members of staff and their manager around individual needs, including health, wellbeing and needs arising from disabilities or long term condition management. This launch has been supported by training, and the passport is referenced in the Trust's appraisal template and has been highlighted to managers as part of retention masterclasses.
Business case for increased disabled parking on main site	An additional 12 disabled car parking bays have been created as part of the public car park, with further spaces being explored.
Business case to centralise reasonable adjustments process	Business case developed however centralised budget not approved and therefore not put in place. Investment made in temporary Workforce Disability Advisor post to support Disabled colleagues across the Trust.
Recruit to Chair and leadership roles within disability staff network and review	All leadership roles recruited to. Currently the network is without a vice-chair but this is expected to be temporary. Staff network inputs quarterly into Equality, Diversity and Inclusion (EDI) steering group.
Ensure voices and needs of disabled staff are included in review of the Managing Attendance Policy	Managing Attendance policy has been reviewed by the Disability Staff Network and feedback has been incorporated into the policy.
Communicate WRES and WDES action plans to senior leaders within the Trust, ensuring that they are aware of their own responsibilities	WRES and WDES data sets, reports and action plans have been communicated throughout the EDI steering group, and progress updates have been provided regularly to various governance meetings at the Trust e.g., presentation to Senior Leaders Meeting delivered in Q1 2023.

4. WDES assessment against national indicators

Metric 1

Percentage of staff in each of the AfC bands 1 - 9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.

Clinical / Non Clinical	Band	Disabled	Non-disabled	Unknown	Total	% 2023 Disabled	% 2022 Disabled
1a) Non Clinical Staff	Under Band 1		4		4	0%	
	Bands 1		3		3	0%	
	Bands 2	25	368	68	461	5%	
	Bands 3	12	219	24	255	5%	
	Bands 4	4	129	16	149	3%	
	Bands 5	10	75	7	92	11%	
	Bands 6	6	68	9	83	7%	
	Bands 7	4	51	2	57	7%	
	Bands 8a	4	45	2	51	8%	
	Bands 8b	1	13	1	15	7%	
	Bands 8c	1	9		10	10%	
	Bands 8d		8		8	0%	
	Bands 9		7		7	0%	
	VSM		9	4	13	0%	
1b) Clinical Staff	Under Band 1		4		4	0%	
	Bands 2	26	535	58	619	4%	
	Bands 3	11	308	24	343	3%	
	Bands 4	7	185	15	207	3%	
	Bands 5	38	667	40	745	5%	
	Bands 6	54	696	69	819	7%	
	Bands 7	18	331	31	380	5%	
	Bands 8a	10	170	25	205	5%	
	Bands 8b	2	25	1	28	7%	
	Bands 8c		13	2	15	0%	
	Bands 8d	2	7		9	22%	
	Bands 9		1		1	0%	
	M&D Staff, Consultants	5	147	27	179	3%	
	M&D Staff, trainee grades	1	128	13	142	1%	
	M&D, career grade	6	95	14	115	5%	
	Other		1	2	3	0%	
	VSM		1	1	2	0%	
Grand Total		**247**	**4322**	**455**	**5024**	**5%**	**4.3%**

Due to the relatively small numbers of staff who have declared a disability, it is useful to analyse this data utilising the banding clusters used within the WDES reporting template, as below.

Staff type	Band / VSM / NED / M&D Breakdown	% Disabled	% Non-Disabled	% Unknown	Total
Non-Clinical	Cluster 1: AfC Bands 2 to 4	4.7%	82.9%	12.4%	872
	Cluster 2: AfC bands 5 to 7	8.6%	83.6%	7.8%	232
	Cluster 3: AfC bands 8a and 8b	7.6%	87.8%	4.6%	66
	Cluster 4: AfC bands 8c to VSM	2.6%	86.8%	10.5%	38
	Total Non-Clinical	**5.6%**	**83.4%**	**11.0%**	**1209**
Clinical	Cluster 1: AfC Bands 2 to 4	3.8%	88.0%	8.3%	1173
	Cluster 2: AfC bands 5 to 7	5.7%	87.1%	7.2%	1944
	Cluster 3: AfC bands 8a and 8b	5.2%	83.7%	11.2%	233
	Cluster 4: AfC bands 8c to VSM	7.4%	81.5%	11.1%	27
	Total Clinical	**5.0%**	**87.2%**	**7.9%**	**3377**
Medical and Dental	M&D- Consultants	2.8%	82.1%	15.1%	179
	M&D- Non-Consultant career grade	5.2%	82.6%	12.2%	115
	M&D- trainee grades	0.7%	90.1%	9.2%	142
	Total Medical and Dental	**2.8%**	**84.9%**	**12.4%**	**436**
Totals	**Number of staff in workforce**	**5.0%**	**86.0%**	**9.0%**	**5024**

With the exception of the most senior levels of the non-clinical workforce, staff who have declared a disability are generally proportionally represented in both the clinical and non-clinical workforce. This has improved over the last year, especially in cluster 2 of the non-clinical workforce. There has been a decrease in the number of “unknown” individuals across all staff groups, reducing from 10.3% to 9.0% over the last year. There has been an increase in disabled staff across both the medical and dental consultant and non-consultant groups, however declared disability rates among medical and dental trainees has declined from 3% to 0.7%. The proportion of disabled staff within the medical and dental workforce remain lower than the rest of the Trust.

The Trust continues to have no Board members with a declared disability.

Metric 2

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

The Trust offers a guaranteed interview scheme and is a Disability Confident Employer. In 2022-23, the Trust shortlisted 150 disabled candidates, and 39 disabled people were appointed to roles within the Trust.

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to that of disabled candidates being appointed from shortlisting was 1.26 – i.e., non-disabled candidates were 1.26 times more likely than disabled candidates to be appointed once shortlisted. This has improved from 1.34 in 2022.

The 39 disabled people appointed to roles within the Trust in 2022-23 represent 4.7% of total new hires.

New hires by disability status

Division	Disabled	Non-disabled	Unknown	% new hires who are disabled
Central Application Process	8	115	4	6.3%
Clinical Support Services	6	107	2	5.2%
Community Services	7	102	3	6.3%
Corporate Operations	4	62	1	5.9%
Corporate Services	3	58	3	4.7%
Emergency Care	2	48		4.0%
Family Health	5	96	1	4.9%
Medicine	2	80		2.4%
Surgery	2	112	2	1.7%
Grand Total	**39**	**780**	**16**	**4.7%**

Metric 3

Relative likelihood of disabled staff entering the formal capability process, compared to that of non-disabled staff entering the formal capability process, as measured by entry into a formal capability process.

Very few formal capability processes are conducted within the Trust. This metric is based on a two-year period. During 2021-2023, 10 staff entered formal capability processes for reasons other than health. Of these, 8 staff members were not disabled, one had not stated whether they had a disability, and one was disabled.

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is calculated at 2.19. – i.e., disabled staff are 2.19 times more likely to enter the formal capability process than non-disabled staff. This metric is static compared to last year, however it should be treated with caution due to the very low numbers involved when calculating this.

Metric 4

Harassment, bullying and abuse.

Data in this section is taken from the Trust's 2022 staff survey results.

(a) (i) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

30.7% of disabled staff reported experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (non-disabled 22.9%). This metric has deteriorated for both disabled (deteriorated by 0.9% compared to 2021) and non-disabled staff (deteriorated by 0.9% compared to 2021).

(ii) Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months

11.8% of disabled staff reported experiencing harassment, bullying or abuse from managers in the last 12 months (non-disabled 5.8%). This metric has deteriorated for disabled staff (deteriorated by 1.2% compared to 2021) and improved slightly for non-disabled staff (improved by 1.3% compared to 2021). The gap in experience between disabled and non-disabled staff has increased to 6%, whilst in 2021 it was 3.5%.

(iii) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

21.7% of disabled staff reported experiencing harassment, bullying or abuse from other colleagues in last 12 months (12.5% non-disabled). This metric has remained roughly stable for both groups.

(b) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

47.2% of disabled staff said that they or a colleague had reported their last experience of harassment, bullying or abuse at work (non-disabled 50.1%). This metric has improved slightly for both disabled colleagues and non-disabled colleagues.

The Trust is performing better than the national benchmark in all of the experience of harassment bullying and abuse WDES metrics, however, it is worse than the benchmark for reporting, for disabled staff (48.4%).

Metric 5

Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.

In the Staff Survey, 63.8% of non-disabled staff felt that the Trust provided equal opportunities for career progression, in comparison to 54.8% of disabled staff. This has increased very slightly, although the gap in experience between the two groups remains constant. Both these figures are above the national benchmark.

Metric 6

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

28.9% of disabled respondents to the staff survey said that they had felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (non-disabled 23.0%). This metric has improved for both groups, but more significantly for disabled staff (by 8.2% compared to 2021).

The Trust's performance on this metric is slightly worse than the national benchmark.

Metric 7

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

35.7% of disabled staff report feeling satisfied or very satisfied with the extent to which the Trust values their work, in comparison to 46.4% of non-disabled staff. This metric has improved for both groups, and the gap between both groups has reduced by two percentage points. Both these figures are slightly above the national average.

Metric 8

Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

80.8% of disabled staff responding to staff survey said that the Trust had made adequate adjustments to enable them to carry out their work, slightly improving from 2021. The Trust remains significantly above the national benchmark.

Metric 9

(a) The staff engagement score for disabled staff, compared to non-disabled staff.

The staff engagement score for disabled staff was 6.3, and the score for non-disabled staff was 6.9. This is a slight deterioration for disabled staff, and a slight improvement for non-disabled staff, which widens the gap in experience between the two slightly. These scores are both equal to the national benchmark.

(b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

Yes. The Trust has a Disability Staff Network, a representative of which sits on the Trust's Equality, Diversity and Inclusion Steering Group. The Staff Network has a defined role and terms of reference. There is a Reciprocal Mentoring for Inclusion programme, allowing disabled staff members to share their experiences and opinions with senior leaders. The CEO has attended the Disability Staff Network to listen to views of disabled colleagues.

Metric 10

Percentage difference between the organisations' board membership and its overall workforce disaggregated: by voting membership and executive membership of the Board.

The Trust has no Board members who have declared that they are disabled, therefore there is a -5% difference between the Trust's Board membership and its overall workforce. This gap has increased since last year.

5 Conclusion

This year's data suggests that there have been some improvements in the experience of disabled staff in the Trust, although there continues to be a significant gap in experience between disabled and non-disabled colleagues. There has been some progress on disabled representation within the workforce however much more work is needed on both this and

ensuring that colleagues feel confident to declare their disability status. These improvements are essential to deliver on the Trust's ambition for 'Us' – 'we will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work'. Only by achieving that ambition will we be able to provide the best possible care for patients.

6 Next Steps

Accompanying this report is the first version of the Trust's intersectional action plan for 23/24 and 24/25 encompassing the WDES and the Workforce Race Equality Standard (WRES) actions. Engagement on this took place during Q2 of 2023/24 with a number of stakeholder groups and all of the staff networks contributing to the final action plan which will be available on the Trust website following Board sign off. A further report will be published in 2024/25 setting out progress against this action plan.

The Rotherham Foundation Trust Combined Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Action Plan October 2023

Action reference number	Theme	Action	Action Owner (role)	Target completion date	WRES Action?	WDES Action?	List any metrics this action links to
2023/01	Voice - staff networks	Ensure that each staff network has an assigned Non Executive and Executive sponsor and that supporting and advocating on behalf of the network forms part of their role	Chair Chief Executive	31/03/2024	Yes	Yes	All metrics
2023/02	Voice - staff networks	Divisions to support and promote attendance to colleagues. To work with staff network chairs to improve active membership and discuss divisional contribution regularly at divisional SLT meetings	Divisional General Managers	31/03/2024	Yes	Yes	All metrics
2023/03	Development - recruitment	Work with EDI group to conduct end-to-end of analysis of candidate journey and organisational policy and practice throughout attraction and recruitment via an inclusion lens and use findings to improve recruitment (Agenda for Change and VSM)	EDI lead Recruitment lead	31/09/2024	Yes	Yes	WRES Metric 1, 2, 7 WDES Metric 1,2,5, 10
2023/04	Development - recruitment	Develop improved information to support disabled candidates and disabled staff	EDI lead	31/12/2023	No	Yes	WDES Metric 1&2
2023/05	Development - recruitment	Work with services to increase the promotion of jobs with local communities at all levels including apprenticeship provision	Recruitment Lead and Learning and Development Lead	30/09/2024	Yes	Yes	WRES Metric 1 WRES Metric 1
2023/06	Development - Staff experience	Develop and standardise induction of International Medical Graduates	Medical Director	31/03/2024	Yes	No	WRES Metric 3
2023/07	Development - Staff experience	Apply for the National Pastoral Care Quality Award. Showcase a cultural celebration event - a chance to network, dance, sing and eat toghether. All Internationally Educated Nurses who have progressed their career at TRFT will be awarded a certificate	Chief Nurse	31/12/2023 31/10/2023	Yes	No	WRES Metrics 1
2023/08	Development - staff experience	Discrimination to be a standing agenda item for violence and aggression group	Deputy Chief Executive	31/12/2023	Yes	Yes	WRES metric 5, WDES metric 4(a)i
2023/09	Development - staff experience	Consider how to bring greater transparency to how the Trust support colleagues requiring reasonable adjustments, including consideration of a single budget for this	Director of People / Director of Finance	31/03/2024	No	Yes	WDES Metric 1
2023/10	Development - learning	Develop an approach to reverse / mutual mentoring based on completion of cohort 1	EDI lead	31/03/2024	Yes	Yes	All metrics
2023/11	Development - learning	EDI team to continue to develop and deliver targeted training, working with divisions and corporate areas to focus on areas and subjects where need is greatest based on WRES and WDES data and insight	EDI Lead	31/03/2025	Yes	Yes	All metrics
2023/12	Development - learning	Embed a learning culture around people management, ensuring that lessons are learned and embedded from external and internal cases and reviews - e.g. Michelle Cox ET case	Director of People	31/03/2024	Yes	Yes	All metrics
2023/13	Accountability	Board of Directors to consider recommendations from new NHSE Equality Diversity and Inclusion plan and recommendations from National NHS Disabled Directors' Network. Refresh and develop this action plan in Q1 2024/25	Chair / Director of People / Director of Corporate Affairs	31/03/2024 30/06/2024	Yes	Yes	All metrics
2023/14	Accountability	Ensure that the Chief Executive and all Non Executive Directors have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and are assessed against these as part of their annual appraisal process	Chair / Director of People / Director of Corporate Affairs	30/06/2024	Yes	Yes	All metrics
2023/15	Accountability	Ensure that all Executive Team members and Divisional leadership teams have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART), related to WRES and WDES metrics and are assessed against these as part of their annual appraisal process	Chief Executive, COO	30/06/2024	Yes	Yes	All metrics

2023/16	Accountability	Work with EDI team to develop and deliver divisional/directorate EDI commitments, taking into account WRES, WDES, staff survey and other relevant data on the refreshed action plan	Directorate/divisional leads	30/06/2024	Yes	Yes	All metrics

Board of Directors
3 November 2023

Agenda item	P161/23
Report	**Guardian of Safe Working report Q2 2023/4**
Executive Lead	Dr Jo Beahan, Executive Medical Director
Link with the BAF	
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. Exception reports in this quarter have ticked upwards. Some consultant absences have had a knock-on effect on trainee hours and intensity. Ward A3 respiratory has been hardest hit in this regard and accounts for roughly one-third of the quarter's total of ER.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	*The Report collates information from the Allocate system for exception reporting, the Junior Doctors' forum monthly meetings, personal communication and assorted email correspondence.* *It has been prepared by Dr G Lynch, RFT Guardian for Safe Working, and sponsored by Dr Jo Beahan, Executive Medical Director.*
Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	*Dealing with the issues raised in Junior Doctor Forum which takes place monthly - JDF attendees including medical staffing, Medical Director, Director of Medical Education and Guardian of Safe Working.*
Recommendations	It is recommended that the Board notes this report.

Appendices

Exception Report (ER) Quarterly updates

In quarter 2, as of 8th October, 37 doctors, (23 FY1, 2 FY2, 2 CT 5ST1,3 ST4, 1 ST5 1 ST6) submitted 154 exception reports related to hours worked. 4 ER related to service support and there were 11 for missed educational opportunities.

Total overtime hours claimed for were 167.59 for normal time and 4.16 for premium time hours.

Six ER cited immediate threats to safety, all from respiratory medicine, mentioning poor staffing, missed breaks and difficulties reviewing all the patients. All immediate issues were responded to by the management team in medicine and the rota coordinators to the best of their ability.

Medical workforce and the GSW have dealt with most ER for payment. The GUM exceptions are planned to be dealt with for time off in lieu (TOIL).

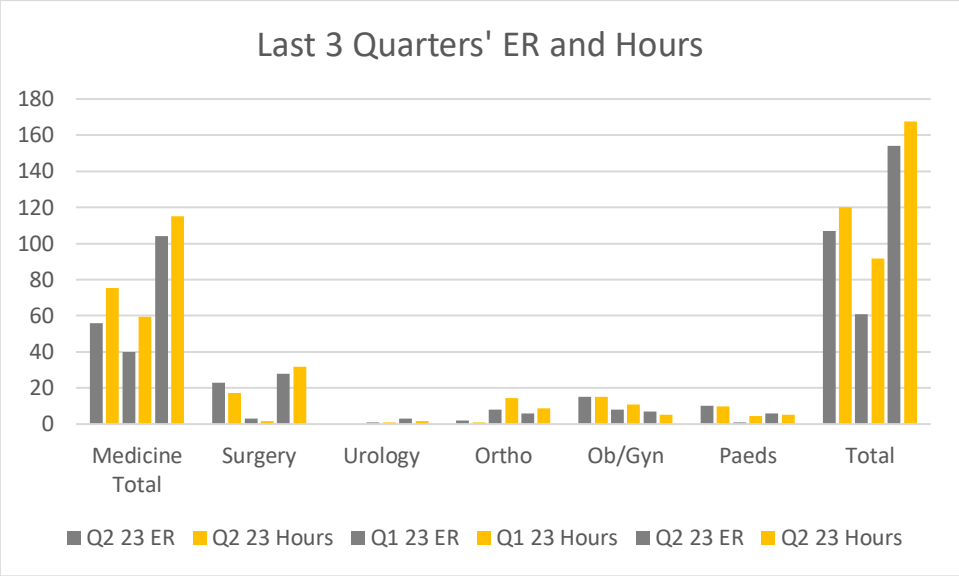
Missed breaks and weekly hours are being closely monitored and it may be that one or more Guardian fines become due for trainee(s) in respiratory medicine on ward A3.

Exception Report quarter 1 Quarterly details (as of 8/10/23)

Working hours:

(Sub) Specialty	Exceptions	Daytime Hours	Nightime hours
Cardiology	19	23.25	
Acute Medicine (AMU)	8	5.5	
Respiratory medicine	55	53.4	0.66
Care of the elderly	16	25.33	
Diabetes	1	2	
GUM	5	5.75	
Medical Division total	104	115.23	
Urology	3	1.5	1
General surgery	28	31.8	2.5
Orthopaedics	6	8.66	
Paediatrics	6	5.32	
Obstetrics/Gynaecology	7	5.08	
Total	154	167.59	4.16

Exceptions and hours by quarter



Qualitative examples from Exception reports

“Raised in JDF that the "minimum staffing" levels in A3 are unsafe and will continue to be so until additional medics added to the rota. We escalated everything we could and handed over all jobs to be chased with the plans etc. We delegated tasks as much as we could and all stayed 1.5 hours late.”

“Stayed half an hour late to hand over.”

“Difficult cases requiring extensive examination, specific needs and emotional needs.”

Actions to mitigate

Medical workforce manage rota gaps to the best of their ability, moving trainee doctors to where need is greatest on a daily basis, factoring in absences and patient numbers.

Particular actions regarding respiratory medicine have included meetings outside the JDF between the affected trainees, the clinical lead for medicine, medical management and the divisional director. Locums are present on the ward and the GSW understands that the return of some consultants to work should help reduce trainee workload.

Regular discussion of all concerns at the Junior doctors’ forum attended by senior representatives from medical workforce, divisions, MD, DME and GSW include missed inductions, availability of IT and printers, patient flow, rotas and staffing.

The GSW is liaising with estates and the CL and deputy general manager regarding finding suitable ward-based workspaces for trainees in medicine.

	The GSW, DME and Foundation director are all instrumental in raising issues coming to their attention and all have open door availability to trainees for support.

Executive Team Meeting
12th October 2023

Agenda item	4249/23
Report	NHSE 2023 Trust Provider Self-Assessment
Executive Lead	Joanne Beahan
Link with the BAF	
Purpose	Decision ☐ To note ☐ Approval X For information ☐ **(Tick only one box)**
Executive Summary (including reason for the report, background, key issues and risks)	The annual NHSE 2023 Trust Provider Self-Assessment is due for submission at the end of November. The final submission is via an online portal however a PDF version has been provided to allow for Board sign off. The attached NHSE 2023 Trust Provider Self-Assessment 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 no unexpected answers within the report.
Recommendations	It is recommended that ETM approve the completed self assessment for before it is presented to Board in November for approval.
Appendices	NHSE 2023 Trust Provider Self-Assessment (PDF version)

NHS England Self-Assessment for Placement Providers 2023

Region Selection

Please do not amend the region you have been allocated to. If you feel this is incorrect please continue to complete the SA and email your regional NHS England WT&E quality team.
North East and Yorkshire

North East and Yorkshire

Please do not amend (NEY Provider)
The Rotherham NHS Foundation Trust

Training profession selection

Please select from the list below those professional groups your organisation currently train, please select all those which apply. Please select only one option for each row.

	Yes we train in this professional group	N/A we do NOT train in this professional group
Dental	X	
Medicine Undergraduate	X	
Nursing	X	
Midwifery	X	
Allied Health Professionals	X	
Pharmacy	X	
Paramedicine		X
Healthcare Science	X	
Psychological Professions		X
Advanced Clinical Practice	X	
Medical Associate Professions	X	
Medicine Postgraduate	X	
Social Care		X

Section 1 - Provider challenges

Example 1: Please choose the most appropriate category for your challenge.

Training space / facilities Geography

Please provide your narrative in the comments box
The is a constant demand for the education rooms within the Trust and with the increase in the size of leaner groups, there is always competition for the larger size rooms.
We are having to look at creative ways of providing education space for all learner within the Trust as well as other pressures on the rooms.

Example 2: Please choose the most appropriate category for your challenge.

Placement management / capacity

Please provide your narrative in the comments box
Increasing demands in clinical areas for student placements across a number of disciplines. The work places are become saturated.
Further learners would affect the qualified staffing ratio required for many areas.

Example 3: Please choose the most appropriate category for your challenge.

Supervisors / Educators (lack of supervisors/educators or time for training)

Please provide your narrative in the comments box
Release of staff to undertake education and training to become supervisors/educators as well as providing protected time away from job duties is difficult due to service pressures.
Allowing supervisors/educators to have time to meet with learners to complete assessments.

Section 2 - Provider achievements and good practice

Example 1: Please choose the most appropriate category for your achievement.

Quality - Improvement Initiatives, response to data, positive feedback

Please provide your narrative in the comments box
Excellent learner feedback received via meetings and surveys i.e Tariff, PARE
Leads are asked to review all feedback and to discuss areas of improvement.
Whilst each training group has their own distinct set up and support structure but all ensure that they foster strong relationships within the Teams including external stakeholders.

Example 2: Please choose the most appropriate category for your achievement.

Collaboration / partnerships

Please provide your narrative in the comments box
The Trust has won a number of awards for its apprenticeships schemes in the past year including:

Provider of the Year - Rotherham & North Nottinghamshire College (RNN)
Rotherham Advertiser Apprentice of the Year
Provider of the Year - Sheffield College

This reflects the hard work our apprenticeship team undertake to quality assure apprenticeships. We have a very good pass rate despite the difficulty of establishing apprenticeship posts against budget constraints.

Example 3: Please choose the most appropriate category for your achievement.

Learner / Trainee Support or Wellbeing

Please provide your narrative in the comments box
Within the Nursing Education structure, every ward has a Learning Environment Manager which the Education Development Team liaise with regularly.
For Medical Undergraduate, there are several clinical leads to support the students and supervisor within the divisions.

Section 3 - Contracting and the NHS Education Contract

Please confirm your compliance with the contractual key performance indicators of the NHS Education Contract.
This should be completed once on behalf of the whole organisation. Please select only one option for each row.

	Yes	No
There is board level engagement for education and training at this organisation.	X	
The funding provided via the education contract to support and deliver education and training is used explicitly for this purpose.	X	
We undertake activity in the Education Contract which is being delivered through a third party provider	X	
We have NOT reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor	X	
We are fully compliant with all education and training data requests	X	
There have been NO health and safety breaches that involve a student, trainee or learner	X	
We continue to engage with the ICS for system learning	X	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
The Trust promotes learning and education for its staff. Such educational activities are made available to allow who qualify and the opportunity is there to apply or to ask to attend.

Funds received via the LDA are disseminated to support learners across professions.

A number of in house teaching sessions are provided both for staff and learner which provides platforms for updating on areas, networking and promoting multi professional learning.

We are support at a Board level by Dr Joanne Beahan - Medical Director and Helen Dobson - Chief Nurse.

Section 4 - Education Quality

Can you confirm as a provider that you...
Please select only one option for each row.

	Yes	No	N/A
Are aware of the requirements and process for an education quality intervention, including who is required to attend and how to escalate issues.	X		
Have 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		
Have a Freedom to Speak Up Guardian and they actively promote the process for raising concerns through them to their learners	X		
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained), and they actively promote the process for raising concerns through them to their learners	X		

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
Within each learner structure, there is regularly communication with teams in the Trust and external stakeholders.
Issues can be escalated accordingly.

The Trust is proud of it's Library & Knowledge Service who received a positive outcome from the LQAF.

We have a Freedom to Speak up team within the Trust. Their details are available on the intranet, screensavers and posters.

The Guardian of Safe Working hours attends the monthly Junior Doctor Forum.

As an organisation, have you been referred to a regulator for education and training concerns in the last 12 months (with or without conditions) (e.g., GMC, GDC, HCPC, NMC, etc)
Note: we are not seeking information about the referral of an individual learner.

We have not been referred to a regulator

Did you actively promote the National Education and Training survey (NETS) to all healthcare learners?

Yes

Please briefly describe your process for encouraging responses; including your organisations response rate (for the 2022 NETS) and your plans to improve this for the next NETS:
Information is emailed to all learners and supervisors as appropriate.
However the response rate can always be improved for further communications will be sent.

Have you reviewed and where appropriate taken action on the outcome of the results of the National Education and Training Survey (NETS)

Yes

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:
Where necessary, areas for improvement have been highlighted and discussed with the relevant lead and departments.

Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:

Name and email address of your Board representative for Patient Safety	Helen Dobson helen.dobson11@nhs.net & Jo Beahan jbeahan@nhs.net
Name and email address of your non executive director representative for Patient Safety	Rumit Shah rumit.shah1@nhs.net
Name and email address of your Patient Safety Specialist/s	Victoria Hazeldine victoria.hazeldine@nhs.net Alison Walker alison.walker32@nhs.net Harjot Khaira harjot.khaira@nhs.net
What percentage of your staff have completed the patient safety training for level 1 within the organisation (%)	Sept 2023 - 95%

Section 5 - Equality, Diversity and Inclusion

Please confirm whether your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):

Yes

If 'yes' please add comments to support your answer sharing details of governance and links with education and training alonside the nominated name of your EDI lead for education and training; if 'no' please provide further detail

Emily Wraw is our Head of Equality Diversity & Inclusion who has a team of people working within Equality Diversity & Inclusion.

The team reports into the People Committee and the EDI Steering Group.

Please confirm that you liaise with your Equality, Diversity and Inclusion Lead (or equivalent) to...
Please select only one option for each row.

	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	
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?		X
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	X	
Ensure a policy is in place to manage Sexual Harassment in the Workplace?	X	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:
Data collections and reports include learners who are on placement with us who are employed by the Trust. However, this does not take in to account learners who are employed elsewhere.

Reasonable adjustments will be provided for all learners if requested; there is a Specialist Workplace Disability Advisor to help with this.

All policies go through an Equality Impact assessment designed to ensure they do not negatively impact any staff including learners, who hold protected characteristics.

International graduate do receive an introduction to the Trust however this is variable between staffing group. The Trust is currently looking at best practice and how this can be rolled out within the Trust.

There are policies in place to report and manage discriminatory behaviour from patients, including a Violence and Aggression group.

Sexual harassment is not permitted in the workplace and is included in the disciplinary policy.

Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share details on EDI initiatives that are specific to or have an impact on education and training in your organisation and the email address for someone we can contact to discuss this further.

The EDI Team manages mandatory EDI training, as well as LGBT awareness training, rave and religion training civility training and any other requested training.

There are three staff network groups with nominated leads - BAME, LGBTQ+ and Disability. These networks regular hold events for staff and learners.

For education and training, what are the main successes for EDI in your organisation?

The EDI regularly attending weekly teaching programme for the learners to provide training and support. They are available for ad hoc requests.

For education and training, what are the main challenges for EDI in your organisation?

Supporting international learners when they join the Trust varies between staffing groups.

Section 6 - Assurance Reporting: learning environment and culture

Thinking about the learning environment and culture of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.
A Radiographer enrolled on an MRI reporting course which will provide them with the skills and knowledge to report certain MRI scans and assist with reducing externally outsourced reports the Trusts sends and reduce the turn around time for these types of reports. Steven Cheung scheung@nhs.net A number of staff have attended the non-medical prescribing course. This has been specifically useful for setting up prescribing to support the Diabetes Podiatry Service patients. This will improv e patient access to antibiotic cover and reduce GP workload. Trevor Pilling trevor.pilling@nhs.net Apprenticeships are encouraged and supported for current staff members. Graham Travis graham.travis1@nhs.net Electronic A-Z for Doctors in Training that is circulated on their first day. Debbie Harrison debbie.harrison10@nhs.net Medical Undergraduate Teaching Champions. Certificate and letter for those who go above and beyond to supports students. Sam Duke sam.duke@nhs.net

Quality Framework Domain 1 - Learning environment and culture
Please select only one option for each row.

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
The learning environment is one in which education and training is valued and championed.	X	
The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	X	
The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.	X	
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	X	
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.	X	
The environment is one that ensures the safety of all staff, including learners on placement.	X	
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	X	
The environment is sensitive to both the diversity of learners and the population the organisation serves.	X	
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.	X	
There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	X	
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.	X	
The learning environment promotes multi-professional learning opportunities.	X	
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	X	

Section 7 - Assurance Reporting: educational governance and commitment to quality

Thinking about the educational governance and commitment to quality of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you to would like share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

The reporting Radiographer team consists of a small group of individuals including two Consultant Radiographers. They activity promote teaching of plain film image reading and hold several educational events each year which are open to all staff, to which a specific topic of plain film reading is discussed to help advance the staff and their knowledge. Steven Cheung scheung@nhs.net

Bi Monthly Medical Education Committee meetings. Chaired by the Associate Medical Director - Medical Education. All TPDs based at TRFT and the Rotherham GP scheme are invited along with Royal College Tutors, Medical Undergraduate, SAS Tutor, Future Leader, Library & Knowledge Service, Educational Pharmacist, Medical Workforce. Debbie Harrison debbie.harrison10@nhs.net

Monthly Learning Environment Manager meetings held by the Education and Development Team. Katie Simpson katie.simpson13@nhs.net

Quality Framework Domain 2 - Educational governance and commitment to quality
Please select only one option for each row.

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
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.	X	
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	X	
The governance arrangements promote fairness in education and training and challenge discrimination.	X	
Education and training issues are fed into, considered and represented at the most senior level of decision making.	X	
The provider can demonstrate how educational resources (including financial) are allocated and used.	X	
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.	X	
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.	X	
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including WT&E and Education Providers).	X	

Section 8 - Assurance Reporting: developing and supporting learners

Thinking about how you develop and support learners within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.
The Trust is keen to ensure the staff based have access to continuing development. An example of this would be the LEAD program, which is run inhouse and provides staff with the theoretical and practical knowledge on how to lead and manage people. The local ICB region also has links with NHSE and has sent staff from South Yorkshire to a national ICB development program, where topics such as developing imaging networks and enhancing imaging network co-operation is discussed. Link Lecturer weekly drop in and WhatsApp group. PATs Tutors Placement Support Officers. Access to the University of Sheffield Gateway Course. Junior Doctors Forum.

Quality Framework Domain 3 - Developing and supporting learners
Please select only one option for each row.

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	X	
The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	X	
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	X	
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.	X	
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.	X	
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.	X	
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	X	
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	X	
Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	X	
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	X	

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

Advanced Clinical Practice

Section 9 - Assurance reporting: developing and supporting supervisors

Thinking about how you develop and support supervisors within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Rotherham has a practice educator who has been recently appointed into post. This is an experienced member of the imaging team who as part of their role will be sharing their knowledge and skills with more junior colleagues, thus promoting their learning and enhancing their skill set.

The Associate Medical Director - Medical Education aims to run two Educational Supervisor Course a year within the Trust. This allows for new supervisors to attend and current supervisors to refresh.
All named clinical and educational supervisors within the Trust must have completed this course. If they have completed the online modules and are awaiting a face to face course. They can start supervising with a mentor.
We actively encourage our SAS doctors to attend the course and become supervisors if appropriate.

Quality Framework Domain 4 - Developing and supporting supervisors
Please select only one option for each row.

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.		X
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, WT&E).	X	
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	X	
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 learners' programmes and career pathways, enhancing their ability to support learners' progression.	X	
Clinical supervisors are supported to understand the education, training and any other support needs of their learners.	X	
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.	X	

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

Advanced Clinical Practice

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Not all educational supervisors have fully recognised supported time within their job plans. The advanced practice lead post has been vacant for 1 year but now recruited to. This exception is recognised and over the next 12 months a job plan review is being undertaken which will support the team sin recognising time spent supervising and ensure this is built in to the job plans. We are setting up and educational supervisor forum to help assess the issues and support new supervisors with training an development. We are also developing ACP educational supervisors to support this within the experienced qualified ACP workforce.

Section 10 - Assurance reporting: delivering programmes and curricula

Thinking about how you deliver programmes and curricula to support training within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Rotherham is part of the student Radiographer training program hosted by Sheffield Hallam University. As part of that, we have a number of clinical liaison officers who are passionate about training and being a mentor for the next generation of Radiography staff.
The team take timeout to explain, teach and provide the students with the skills and experience they require to be able to work in modern healthcare.
The drive, resilience and effort which is put into this program of learning is delivered with care and pride.

Podiatry Service provides the required number of hours required by Huddersfield University on clinical placement . The student keeps and updates a log book from the University during the placement

Regular Practice Partner meetings with the Universities.

Training updates required every two years.

Review feedback both informal and formal from meetings and surveys.

Quality Framework Domain 5 - Delivering programmes and curricula
Please select only one option for each row.

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	X	
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	X	
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.	X	
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	X	
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	X	
Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.	X	

Section 11 - Assurance reporting: developing a sustainable workforce

Thinking about developing a sustainable workforce within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like yo share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

The Trust includes a career conversation for all staff in its non-medical appraisals, as a way of identifying for individual staff how they and their managers work together to increase job satisfaction and encourage them to stay at the Trust. The adoption of this aspect of the appraisal process was developed in 2020/21 as part of an NHS Improvement-supported talent management self-assessment in which the Trust gained access to resources as a talent management ‘early adopter’ Training in these conversations is offered to all non-medical appraisees and appraisers. The focus for appraisals at board level is first and foremost on the quality of conversations between appraisers and appraisees, of which the career conversation is part.

Retained 16 University of Sheffield medical students for the 23/24 F1 cohort.

Education and Development Team attend recruitment events at Sheffield Hallam University. As well as holding Open Days at the Trust.

Quality Framework Domain 6 - Developing a sustainable workforce
Please select only one option for each row.

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	X	
Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues	X	
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.	X	
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.	X	

Subject:	AUDIT & RISK COMMITTEE CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	Board of Directors: 03 November 2023

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

Committee / Group: Audit & Risk Committee	Date: 27 October 2023	Chair: Rumit Shah

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Progress Reporting - Presented by 360 Assurance	The Committee agreed to advise the Board that the first follow up score of 68% was lower than expected with a number of additional actions due for completion in the coming months. The Committee was assured that remedial actions are in place and that the position will be recovered in the coming weeks. It was noted that whilst there should be a level of support in completing actions provided by Corporate Affairs there does need to be more emphasis on the action owners themselves ensuring that target dates are complied with.	Board of Directors
2	Standing Financial Instructions	The Committee approved the amendments to the Standing Financial Instructions.	Board of Directors
3	Register of Interests	The Committee noted the Register of Interests advising that a revised process is in place to ensure all relevant members of staff complete the register in a timely manner.	Board of Directors

Board of Directors Register of Interests as of 20th October 2023

Employee Name	Role	Position Title	Interest Category	Interest Description	Comments	CoI Date From	CoI Date To	Creation Date	Last Updated Date
Roberts, Mrs. Jodie Leigh	Manager	Deputy Chief Operating Officer	I have no interests to declare			05/07/2022		05/07/2022	05/07/2022
Tuckett, Mrs. Louise Elizabeth	Senior Manager	Director of Strategy, Planning & Performance	Non-financial professional interest	I have started a secondment for two days a week to the Department of Health and Social Care as an Expert Adviser on Elective Care.		09/01/2023		09/01/2023	09/01/2023
Tuckett, Mrs. Louise Elizabeth	Senior Manager	Director of Strategy, Planning & Performance	Non-financial personal interests	My husband has taken up a Board role for Sheffield Teaching Hospitals NHS Trust, as Executive Director of Strategy and Planning.		19/04/2022	31/03/2023	02/05/2022	15/07/2022
Tuckett, Mrs. Louise Elizabeth	Senior Manager	Director of Strategy, Planning & Performance	I have no interests to declare			01/04/2021	31/03/2022	15/07/2022	15/07/2022
Hinitt, Mr. Ian	Estates and Facilities Director	Director of Estates & Facilities	I have no interests to declare			29/11/2021		29/11/2021	29/11/2021
Rawlinson, Mr. James	Chief Information Officer	Director of Health Informatics	I have no interests to declare			22/08/2023		22/08/2023	22/08/2023
Rawlinson, Mr. James	Chief Information Officer	Director of Health Informatics	I have no interests to declare			04/09/2020		04/09/2020	04/09/2020
Malik, Mr. Kamran Rashid	Chair	Chairman	I have no interests to declare			10/10/2022	31/03/2023	10/10/2022	10/10/2022
Temple, Mr. Martin John	Non Executive Director	Non Executive Director	I have no interests to declare			29/03/2023		29/03/2023	29/03/2023
Ahmed, Ms. Zlakha	Non Executive Director	Non Executive Director	I have no interests to declare			06/02/2023		06/02/2023	06/02/2023
Ahmed, Ms. Zlakha	Non Executive Director	Non Executive Director	I have no interests to declare			06/02/2023		06/02/2023	06/02/2023
Sissons, Ms. Deirdre (Dee)	Non Executive Director	Non Executive Director	I have no interests to declare			24/01/2023		24/01/2023	24/01/2023
Temple, Mr. Martin John	Non Executive Director	Non Executive Director	Non-financial professional interest	Chair of Council and Pro Chancellor of the University of Sheffield	No obvious conflict , but a Medical School and nursing and medical research. This is ongoing at the time of declaration.	01/08/2022	08/02/2023	08/02/2023	08/02/2023

Employee Name	Role	Position Title	Interest Category	Interest Description	Comments	CoI Date From	CoI Date To	Creation Date	Last Updated Date
Shah, Dr Rumit Zaverchand Lalji	Non Executive Director	Non Executive Director	Non-financial professional interest	Senior Partner General Practice - Hatfield health centre- Doncaster Doncaster LMC chair, Designated Representative Doncaster Primary care collaborative SYB ICB	none of these have changed since I became a NED	04/05/2022	31/03/2023	04/05/2022	07/10/2022
Craven, Mrs. Heather Ann	Non Executive Director	Non Executive Director	I have no interests to declare			01/04/2022	31/03/2023	23/10/2022	23/10/2022
Craven, Mrs. Heather Ann	Non Executive Director	Non Executive Director	I have no interests to declare			17/12/2021	17/12/2021	17/12/2021	17/12/2021
Shah, Dr Rumit Zaverchand Lalji	Non Executive Director	Non Executive Director	Indirect interests	I am a director of Beckingham Medical Services Ltd This is for provision of non NHS related work .	Non has changed since became a NED	01/04/2013	30/06/2024	24/06/2023	24/06/2023
Kilgariff, Mrs. Sally	Chief Operating Officer	Chief Operating Officer	Indirect interests	Sister is Group Finance Director for Marks and Spencer		01/04/2022	31/03/2023	18/09/2020	18/10/2022
Wright, Mr. Michael	Deputy Chief Executive	Deputy Chief Executive	Non-financial professional interest	Trustee of the Rotherham Hospital and Community Charity		01/04/2022	31/03/2023	10/10/2022	10/10/2022
Wright, Mr. Michael	Deputy Chief Executive	Deputy Chief Executive	Non-financial professional interest	TRFT Charity - Corporate Trustee		10/02/2021	19/05/2021	19/05/2021	19/05/2021
Hackett, Mr. Steven Mark (Steve)	Finance Director	Director of Finance	I have no interests to declare			28/03/2023	31/03/2024	28/03/2023	28/03/2023
Hackett, Mr. Steven Mark (Steve)	Finance Director	Director of Finance	I have no interests to declare			10/10/2022		10/10/2022	10/10/2022
Hackett, Mr. Steven Mark (Steve)	Finance Director	Director of Finance	I have no interests to declare			01/04/2022	31/03/2023	10/10/2022	10/10/2022
Wendzicha, Miss Angela	Senior Manager	Director of Corporate Affairs (Company Secretary)	I have no interests to declare			01/09/2021	31/08/2022	15/07/2022	30/03/2023
Beahan, Dr Joanne	Medical Director	Medical Director	Indirect interests	CQC Specialist Advisor for Urgent and Emergency care	attend a monthly meeting and attend inspection visits	28/03/2023	01/04/2024	30/12/2022	28/03/2023

Employee Name	Role	Position Title	Interest Category	Interest Description	Comments	CoI Date From	CoI Date To	Creation Date	Last Updated Date
Beahan, Dr Joanne	Medical Director	Medical Director	Non-financial personal interests	Company Director Ellerthwaite Management Company Limited - holiday accomodation. Owner of a flat in the property. No financial benefits from company		28/03/2023	01/04/2024	30/12/2022	28/03/2023
Beahan, Dr Joanne	Medical Director	Medical Director	Non-financial personal interests	Relationships; Son employed by Barnsley Facilities Services and works at Barnsley Hospital NHS Trust as a porter Daughter registered to work as administrative assistant at Barnsley Hospital NHS Trust through NHSP Husband equity partner / solicitor at Irwin Mitchell Solicitors. Commercial litigation.		28/03/2023	01/04/2024	30/12/2022	28/03/2023
Dobson, Mrs. Helen	Director of Nursing	Chief Nurse	I have no interests to declare			21/07/2022		21/07/2022	21/07/2022
Watson, Ms. Hannah	Non Executive Director	Non Executive Director							
Burrows, Ms. Julia	Non Executive Director	Non Executive Director							
Bibby, Dr Joanna Margaret	Non Executive Director	Non Executive Director	Y - left Trust 30/08/23	Financial interests	Director of Health, Health Foundation		20/01/2023		20/01/2023
Bibby, Dr Joanna Margaret	Non Executive Director	Non Executive Director	Y - left Trust 30/08/24	Non-financial personal interests	Director - SoBow RTM Company		20/01/2023		20/01/2023
Bibby, Dr Joanna Margaret	Non Executive Director	Non Executive Director	Y - left Trust 30/08/25	Non-financial professional interest	Committee member NIHR Public Health Research Prioritisation Committee		20/01/2023		20/01/2023
Bibby, Dr Joanna Margaret	Non Executive Director	Non Executive Director	Y - left Trust 30/08/26	Non-financial professional interest	Honorary member Association of Directors of Public Health		20/01/2023		20/01/2023
Bibby, Dr Joanna Margaret	Non Executive Director	Non Executive Director	Y - left Trust 30/08/27	Non-financial professional interest	Trustee - Centre for Homelessness Impact		20/01/2023		20/01/2023

Employee Name	Role	Position Title	Interest Category	Interest Description	Comments	CoI Date From	CoI Date To	Creation Date	Last Updated Date
Havenhand, Mr. Martin Stephen	Chair	Chairman	Y - left Trust 30/08/28	Non-financial personal interests	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		01/04/2023	31/03/2024	01/12/2022
Havenhand, Mr. Martin Stephen	Chair	Chairman	Y - left Trust 30/08/29	Non-financial professional interest	Chair of Yorkshire Ambulance Service		01/04/2023		18/04/2023

Board of Directors
03 November 2023

Agenda item	P161/23. iv.
Report	**Standing Financial Instructions**
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 2023/24 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	The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) are reviewed annually, to update for changes in guidance, legislation, and for matters of accuracy. In addition to the annual review, updates to SFIs and SoD are recommended to Audit Committee, as and when required, for the Trust to remain compliant with financial governance requirements. The updated SFIs and SoD, as part of the annual review, are included in Appendix 2. Key changes are summarised below:

	• Clarification of financial limits for the procurement of Works. This is not a change in practice but provides clarity in the governing document (paragraph 11.2.6 of the SFIs and Appendix 8). • Updates to Charitable Funds (Funds held on Trust) authorisers and limits (Appendix 10 of the SFIs). This has been considered and supported by Charitable Funds Committee. • Updates to references made to policies, guidance and legislation, and changes in job titles, as applicable (summarised in the main report).
Due Diligence	The existing SFIs and SoD are reviewed annually. There have only been minor changes to reflect references to latest guidance, to regulatory frameworks, to clarify financial limits for procuring Works, and to reflect changes to Charitable Funds (Funds held on trust) authorisation limits.
Board powers to make this decision	SFIs and SoD form part of the statutory regulatory framework for the business conduct of the Trust.
Who, what and when	The SFIs and SoD have been reviewed by the Finance Director and Deputy Director of Finance. Clarification has been sought from colleagues on matters specific to their area of work and responsibilities.
Recommendations	Board of Directors are requested to review the updates to the SFIs and SoD for approval.
Appendices	Standing Financial Instructions – updated October 2023

Annual review of the Standing Financial Instructions and Scheme of Delegation

1. Introduction

1.1 Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) form part of the statutory regulatory framework for the business conduct of the Trust. They have effect as part of the Standing Orders of the Board of the Trust, and detail the financial responsibilities, policies and procedures to be adopted. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and regulators' policies in order to achieve probity, accuracy, economy, efficiency and effectiveness.

1.2 The SFIs and SoD are reviewed annually, to update for changes in guidance, legislation, and for matters of accuracy.

1.3 The SFIs and SoD have been reviewed by the Finance Director and Deputy Director of Finance. Clarification has been sought from colleagues on matters specific to their area of work and responsibilities.

2. Updates to the Standing Financial Instructions and Scheme of Delegation

2.1 The SFIs and SoD (version 5e) approved by the Board on 27 January 2023 have been reviewed, and updates have been reflected in version 5f included at Appendix 2. In paragraph 2.2 below, is a summary of the key changes made between the two versions, and a table is included at Appendix 1 to provide detail of all amendments made.

2.2 Key changes to the SFIs and SoD are:

- Clarification of financial limits for the procurement of Works. This is not a change in practice but provides clarity in the governing document (paragraph 11.2.6 of the SFIs and Appendix 8).
- Updates to Charitable Funds (Funds held on Trust) authorisers and limits (Appendix 10 of the SFIs). This has been considered and supported by Charitable Funds Committee.
- Updates to references made to policies, guidance and legislation, and changes in job titles, as applicable. For example, references to NHS Improvement have been amended to NHS England, and the Director of Workforce has been amended to Director of People.

3. Recommendation

3.1 Board of Directors are requested to review the updates to the SFIs and SoD for approval.

Steve Hackett - Director of Finance
16 October 2023

Appendix 1

Detail of changes to the Standing Financial Instructions and Scheme of Delegation

Version 5e approved January 2023	Version 5f October 2023 – changes for recommendation
Clarification of financial limits for the procurement of Works	
Para 11.2.6 **Quotations – Goods or Services:** A minimum of three written quotations are required where the contract value is expected to be between £10,000 and £35,000 (excluding VAT) unless using an already competitively tendered contract (excluding works). For spend below £10,000 then a value for money check must be completed by the budget holder along with Procurement input. Any contract entered into by the Trust regardless of value must be completed by Procurement and signed as per Paragraph 10.1.7 even those below the thresholds identified in this section.	**Para 11.2.6** **Quotations – Goods, Services and Works:** A minimum of three written quotations are required where the contract value is expected to be between £10,000 and £35,000 (excluding VAT) for goods and services, and between £50,000 and £200,000 (excluding VAT) for works, unless using an already competitively tendered contract (excluding works). For spend below £10,000 for goods and services, and below £50,000 for works, then a value for money check must be completed by the budget holder along with Procurement input. Any contract entered into by the Trust regardless of value must be completed by Procurement and signed as per Paragraph 10.1.7 even those below the thresholds identified in this section.
Appendix 8	**Appendix 8** The extract in 5e for works has been deleted and replaced with the following:

Version 5e approved January 2023

Procedure	Limit (£)[1]
Procure via the use of the Trust's measured term contract or OJEU tender.	Works <£200,000
Formal tendering via the Procurement Department. Advice will be given on the process to be followed.	Works >£200,000

Version 5f October 2023 – changes for recommendation

Works

Limit (Total Contract Value) Works [1]	Procedure
<£50K	No quotation process: • Obtain best value
>£50K-£200K	Informal quotes: • Minimum of 3 informal quotes • Price only or cost/quality/social value evaluation • E-tendering portal not mandatory but can be used • All quotes must be submitted with the requisition • Most advantageous quote will be successful **OR** (up to £100k) Direct appointment via Measured Term Contract (MTC) if appropriate
>£200K – Find a tender (was OJEU[2])	Formal quotes: • Minimum of 3 formal quotes • One local quote where possible[3] • Cost/quality/social value evaluation • E-tendering portal mandatory; advertising optional • Most advantageous quote will be successful
Find a tender (was OJEU[2])	• E-tendering portal mandatory • Advertise on relevant portals • Cost/quality/social value evaluation • Most advantageous tender will be successful

Notes:

1. Excluding VAT.
2. Currently £5,336,937 inclusive of VAT at the prevailing rate.
3. Local to be defined as a base within South Yorkshire & Bassetlaw or with an "S/DN" post code.

Changes to authorisation limits – Charitable Funds

Appendix 10

Authority[1]	Limit (£)[2]
Director of Communications	<£5,000
Chief Nurse/Medical Director/Director of Finance	£5,000 & <£10,000
2 x Executive Directors acting jointly	£10,000 & <£25,000
Charitable Funds Committee	< £25,000
Corporate Trustee	No limit

Appendix 10

Authority[1]	Limit (£)[2]
Head of Fundraising	<£5,000
Any Trustee acting individually	£5,000 & <£10,000
2 x Trustee's acting jointly	£10,000 & <£25,000
Charitable Funds Committee	£25,000 & <£50,000
Corporate Trustee	No limit

Version 5e approved January 2023	Version 5f October 2023 – changes for recommendation
Updates to references to legislation, guidance and job titles within the SFIs and SoD	
	Para 2.2.1 & Appendix 11 – added in a reference to The Health and Care Act 2022
References to NHS Improvement within the document	Amended to read - NHS England
References to Director of Workforce	Amended to read - Director of People
The NHS Foundation Trust Code of Governance	Amended to - Code of governance for NHS provider Trusts
NHS Improvement's Audit Code	Amended to - Code of Audit Practice issued by the National Audit Office
Para 3.4.2 3.4.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice (although this will usually be given unless circumstances warrant otherwise) to require and receive: (a) Access to all records (including patient records), documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature.	Para 3.4.2 3.4.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice (although this will usually be given unless circumstances warrant otherwise) to require and receive: (a) Access to all records (for patient records this will require approval by the Caldicott Guardian), documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature.
Para 9.1.2 (f) Monitor compliance with Intermediaries Legislation (IR35): Countering Avoidance in the Provision of Personal Services for off-payroll arrangements.	Para 9.1.2 (f) Monitor compliance with Off Payroll Working (IR35): Deemed employer responsibilities under off-payroll working rules.

Version 5e approved January 2023	Version 5f October 2023 – changes for recommendation
Paragraph 10.2.6 No order shall be issued for any item or items to any firm that has made an offer of gifts, rewards or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars, or conventional hospitality such as lunches in the course of working visits to suppliers.	Detail deleted as this is in the Code of Business Conduct Paragraph 10.2.6 No order shall be issued for any item or items to any firm that has made an offer of gifts, rewards or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts.
Updates to references to legislation and guidance within the SFIs and SoD	
Para 15.2.1 Losses and special payments are divided into eight categories, as defined below. These categories are: Losses (excluding family practitioner services): 1. Losses of cash. 2. Fruitless payments, including abandoned capital schemes. 3. Bad debts and abandoned claims. 4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use. Special payments (excluding family practitioner services): 5. Compensation payments made under legal obligation. 6. Extra contractual payments to contractors. 7. Ex gratia payments. 8. Extra statutory and extra regulatory payments.	Para 15.2.1 – updated for the latest losses and special payments categories Losses and special payments are divided into categories, as defined below. These categories are: Losses (excluding family practitioner services): 1. Losses of cash. 2. Fruitless payments and constructive losses. 3. Bad debts and abandoned claims. 4. Stores losses and damage to property. Special payments (excluding family practitioner services): 5. Compensation under court order or legally binding arbitration award. 6. Extra-contractual payments. 7. Ex-gratia payments. 8. Special severance payments. 9. Extra statutory and extra regulatory payments.

Version 5e approved January 2023

Appendix 6 – business cases

These limits are then subject to further approval externally as follows:

Where a NHS Foundation Trust is deemed to be in financial distress, as formally determined by NHS Improvement:

Authority	Limit (£)[1,2]
Board	Up to £25,000,000
NHSI Executive Director of Resources/Deputy Chief Executive Officer or NHSI Director of Finance and then the Department of Health & Social Care	£25,000,001 & £30,000,000
NHSI Resources Committee and then the Department of Health & Social Care	£30,000,001 & £50,000,000
NHSI Resources Committee, NHSI Board, Department of Health & Social Care and HM Treasury[3]	Above £50,000,000

1. Figures **include** VAT.
2. Figures apply to capital investment and property transactions, asset disposal and whole-life cost business cases.
3. Business cases subject to whole-life cost rules where the whole-life cost exceeds £50,000,000K will not require NHSI Board approval but will require NHSI Resources Committee approval, unless these cases are specifically referred to the NHSI Board for a decision by the NHSI Resources Committee. NHSI will discuss individual whole-life cost cases that exceed £50,000,000K with the Department of Health & Social Care to confirm whether or not DHSC and HM Treasury approval is required for the business case.
4. In all cases the Trust should follow guidance contained in NHS Improvement's publication "Capital Regime, Investment and Property Business Case Guidance for NHS Trusts and Foundation Trusts" published in November 2016.

Where a NHS Foundation Trust is not deemed to be in financial distress, if a transaction meets any of the criteria below the Trust should report it to NHS Improvement:

In all cases the Trust should follow guidance contained in Monitor's publication "Supporting NHS Providers: Guidance on Transactions for NHS Foundation Trusts" updated in March 2015.

Version 5f October 2023 – changes for recommendation

Appendix 6 – business cases

These limits are then subject to further approval externally as follows:

Where a NHS Foundation Trust is deemed to be in financial distress, as formally determined by NHS England:

Authority	Limit (£)[1,2]
Board	Up to £25,000,000
NHS England and DHSC Joint Investment Sub-Committee (JISC)	£25,000,001 & £30,000,000
NHS England and DHSC Joint Investment Sub-Committee (JISC)	£30,000,001 & £50,000,000
NHS England and DHSC Joint Investment Committee (JIC) and HM Treasury[3]	Above £50,000,000

1. Figures **include** VAT.
2. Figures apply to capital investment and property transactions (non-digital) and digital (self-funded), asset disposal and whole-life cost business cases.
3. Business cases exceeding £50,000,000 either capital cost or whole-life costs, will require approval from NHS England and DHSC Joint Investment Committee and HM Treasury, except for Electronic Patient Records funded by the central frontline digitisation capital.
4. In all cases the Trust should follow guidance contained in NHS England's publication "Capital Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts" published in February 2023.

Version 5e approved January 2023	Version 5f October 2023 – changes for recommendation
Other updates	
	Grammatical updates that do not change the context of the documents. Appendix 11 – List of references – to reflect dates and changes in the titles of the latest guidance/policy.

STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

Version:	Version 5f
Approved by	Board of Directors
Date Approved	To be confirmed
Title of Author:	Deputy Director of Finance
Title of Responsible Committee/Individual:	Audit Committee
Date Issued:	To be confirmed
Review Date:	
Target Audience:	All Colleagues, Contractors, Volunteers

DOCUMENT HISTORY SUMMARY

Version	Date	Author	Status	Comment
1	April 2007	Deputy Director of Finance	New policy	New document to comply with gaining foundation trust status.
1a	April 2010	Deputy Director of Finance		Minor amendments following a planned periodic review.
2	October 2012	Deputy Director of Finance		Major review following serious incident (STEIS 2011/968)
3	September 2014	Interim Director of Finance		Major review following an external financial review of the trust after the departure of the turnaround team.
4	October 2015	Deputy Director of Finance		Significant changes following a planned periodic review.
4a	May 2017	Deputy Director of Finance		Minor amendments following a planned periodic review.
4b	October 2017	Director of Finance & Chief Executive		Minor amendments following discussions at Trust Management Committee.
4c	November 2018	Deputy Director of Finance		Amendments to approval limits and process for business case approval and increasing the quotation threshold for procurement. Other minor changes also incorporated.
4d	December 2018	Director of Finance		Minor amendments following the December Board of Directors.
5	June 2021	Deputy Director of Finance		Amendments to approval limits and process for business case approval. Further review of all sections with the Interim Director of Finance and Chair of Finance & Performance Committee.
5a	July 2021	Deputy Director of Finance		Further amendments to approval limits from the newly appointed substantive Director of Finance.
5b	August 2021	Deputy Director of Finance		Further amendments following discussions at Executive Team and with Divisional Finance Managers.
5c	September 2021	Deputy Director of Finance		Insertion of diagrammatical presentation in Appendices 2, 5 and 6.

5d	July 2022	Deputy Director of Finance		Realignment of procurement thresholds consistent across the Integrated Care System.
5e	January 2023	Deputy Director of Finance		Increase in procurement thresholds consistent across the Integrated Care System; changes to SFI waiver requirements and an increased delegated limit for provider capital investment from £15m to £25m.
5f	October 2023	Deputy Director of Finance		Minor amendments following a planned periodic review. Amendments to Appendix 8 to add clarity to limits for the procurement of Works. Amendments to Appendix 10 authorisation of expenditure from Charitable Funds (funds held on trust).

TABLE OF CONTENTS

1. FOREWORD

1.1 The Board operates within a statutory framework in which it is required to adopt standing orders. The Code of Conduct and Code of Accountability in the NHS requires boards to draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions. The Code also requires boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives.

1.2 Additionally, boards will need locally generated rules and instructions, including financial procedural notes, for use within their organisation. Collectively these must comprehensively cover all aspects of (financial) management and control. In effect, they set the business rules, which all employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

1.3 The purpose of this document is to provide clarity about the financial framework in which the Trust provides patient services. Once these Standing Financial Instructions have been adopted by the Board, they are mandatory for all employees of the Trust and any contractors, consultants or volunteers engaged by the Trust.

2. INTRODUCTION

2.1 General

2.1.1 These Standing Financial Instructions are issued in accordance with financial provisions of The National Health Service Act 2006, and The Health and Social Care Act 2012, as amended by The Health and Care Act 2022 for the regulation of the conduct of foundation trusts in relation to all financial matters. They shall have effect as if incorporated in the Trust's Standing Orders.

2.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Matters Reserved to the Board adopted by the Trust.

2.1.3 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust, including trading units. They do not provide detailed procedural advice. These statements should therefore, be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

2.1.4 Should any difficulties arise regarding the interpretation or application of any of these Standing Financial Instructions, then the advice of the Director of Finance MUST BE SOUGHT BEFORE ACTING. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders and Matters Reserved to the Board.

2.1.5 **FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.**

2.2 Terminology

2.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

(a) "Authorised Signatory" means an employee with delegated authority to commit expenditure on behalf of the Trust/Charity from within approved budgets.

(b) "Board" means the Board of Directors.

(c) "Budget" means a resource, expressed in financial terms, sanctioned by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

(d) "Budget Holder" means an employee with delegated authority to

manage finances (income and expenditure) for a specific area of the Trust with a delegated transactional financial limit of £5,000. Authorised signatories may commit expenditure on behalf of the budget holder for transactions above £5,000.

(e) "Chief Executive" means the chief officer of the Trust who is designated as the Accounting Officer under The NHS Act 2006, as amended.

(f) "Corporate Trustee" means a corporation that has been appointed to act as trustee of a charity. A corporation is a collection of persons, which, in the eyes of the law, has its own legal existence (and rights and duties) separate from those of the persons who form it from time to time. The Board is the corporate trustee for the Rotherham Hospital and Community Charity.

(g) "Delegated Transactional Financial Limit" is the maximum amount of expenditure that any authorised signatory can commit in one transaction. A delegated transactional limit also applies to the Executive Team, Finance & Performance Committee and the Board for approving procurement contracts that can then be ordered against by an authorised signatory (see Appendices 3 and 4).

(h) "Division" refers to a number of service units that are managed and controlled collectively and reported upon as a single entity to the Board. For clarity, the portfolio of each executive director and the Company Secretary is regarded as a separate division. A list of all divisions is included within Appendix 1.

(i) "Funds Held on Trust" refers to those funds that the Trust held as at 1st April 1996 or date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Section 90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

(j) "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

(k) "Management Team" refers to a number of budgets that are managed and controlled collectively and reported upon as a single entity (See Appendix 1).

(l) "NHS England" means the body responsible for overseeing foundation trusts, NHS trusts, independent providers and commissioning organisations.

(m) "Service Unit" refers to a number of budgets that are managed and controlled collectively and reported upon as a single entity (See Appendix 1).

(n) “Trust” means The Rotherham NHS Foundation Trust.

2.2.1 Wherever the title Chief Executive, Director of Finance or other nominated officer is used in these instructions, it shall be deemed to include such other employee who has been duly authorised to represent them.

2.2.2 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2.2.3 All financial values quoted in these Standing Financial Instructions are exclusive of VAT where and when it is applicable.

2.3 Responsibilities and Delegation

2.3.1 The Board exercises financial supervision and control by:

(a) Formulating the financial strategy.

(b) Requiring the submission and approval of budgets.

(c) Defining and approving essential features in respect of procedures and financial systems, including the need to obtain value for money.

(d) Defining specific responsibilities placed on employees as indicated in the Scheme of Delegation (see Appendices 1 to 10).

2.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the “Matters Reserved to the Board” document.

2.3.3 Within these Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as accountable officer to NHS England, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust’s system of internal control.

2.3.4 The general and specific responsibilities of the Chief Executive as the Accounting Officer for the Trust are outlined in more detail in the NHS Foundation Trust Accounting Officer Memorandum published by NHS England.

2.3.5 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.3.6 It is a duty of the Chief Executive to ensure that existing employees and all new appointees are notified of and understand their responsibilities within these Standing Financial Instructions.

2.3.7 The **Director of Finance** is responsible for:

(a) Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies.

(b) Maintaining an effective system of internal financial control including financial procedures, and systems incorporating the principles of separation of duties and internal checks, documenting, maintaining and disseminating procedures to supplement these Standing Financial Instructions. Appropriate registers of these procedures will be maintained.

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

And, without prejudice to any other functions of employees of the Trust, the duties of the Director of Finance include:

(d) The provision of financial advice to the Trust and its employees.

(e) The design, implementation and supervision of systems of internal financial control.

(f) The preparation and maintenance of financial accounts, certificates, estimates, records and reports as the Trust may require for the purposes of carrying out its work, including its statutory duties.

Additionally, the Director of Finance should ensure that all necessary requirements are fulfilled to enable the Trust's external auditors to be able to comply with the Code of Audit Practice published by the National Audit Office, which prescribes the way in which auditors are to carry out their functions as set out in the National Health Service Act 2006, as updated.

2.3.8 **All employees**, severally and collectively, are responsible for:

(a) Security of the property of the Trust in accordance with NHS guidelines.

(b) Avoiding loss.

(c) Exercising economy and efficiency in the use of resources.

(d) Conforming with the requirements of Standing Orders, Standing Financial Instructions, financial procedures, Scheme of Delegation and Matters Reserved to the Board.

(e) Notifying the Director of Finance of any known instances of non-compliance with Standing Financial Instructions.

2.3.9 Under no circumstances should any **contractor or employee of a contractor** be empowered by the Trust to commit it to expenditure or authorised to obtain income on its behalf. This will help ensure compliance with the requirements of Intermediaries Legislation (IR35): Countering Avoidance in the Provision of Personal Services.

2.3.10 For any and all employees who carry out a financial function, the form in which financial records are kept and the manner in which employees discharge their duties must be to the satisfaction of the Director of Finance.

2.4 Escalation Procedures for Non-Compliance

2.4.1 Any instance of non-compliance with Standing Financial Instructions must be notified to the Director of Finance as soon as it has been identified.

2.4.2 The Director of Finance will investigate all significant instances and report the detailed circumstances of each to Audit Committee at its next meeting.

2.4.3 The Director of Finance will determine what disciplinary or other action, if any, is necessary, having sought appropriate advice from the Director of People.

2.4.4 If the Director of Finance is suspected of breaching Standing Financial Instructions, then this should be notified to the Chief Executive who will similarly take action identified above.

2.4.5 Any potential breaches of Standing Financial Instructions by executive directors will be escalated to the Chair of the Audit Committee, who will advise on further actions to be instigated in accordance with the approved Governance and Compliance Framework. Any such breaches not involving the Director of Finance will also be reported to the Director of Finance.

3. AUDIT AND ASSURANCE

3.1 Audit Committee

3.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference, consistent with 'Code of governance for NHS provider Trusts'. Specifically this will include:

(a) Monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained therein.

(b) Ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

(c) Reviewing the internal financial controls.

(d) Reviewing the internal control and risk management systems.

(e) Monitoring and reviewing the effectiveness of the internal audit and counter fraud functions.

(f) Reviewing and monitoring the external auditors' independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

Additionally, the Audit Committee will be responsible for:

(g) Monitoring compliance with Standing Orders and Standing Financial Instructions.

(h) Reviewing the appropriateness of waiving quotation and tender requirements in accordance with Section 11.5 and Appendix 8.

(i) Reviewing schedules of losses and compensations and making recommendations to the Board.

3.1.2 The Audit Committee shall meet at least quarterly and in accordance with its terms of reference.

3.1.3 Where the Audit Committee considers that there is evidence of ultra vires transactions, evidence of improper acts, or other matters to raise, the chairperson of Audit Committee should report them to a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS England (to the Director of Finance in the first instance or the Chief Executive, if the matter involves the Director of Finance).

3.1.4 Similarly, the Audit Committee shall report to the Council of Governors, identifying any matters in respect of which it considers that action or

improvement is needed and making recommendations as to the steps to be taken in accordance with 'Code of governance for NHS provider Trusts'.

3.1.5 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when the internal audit service provider is changed.

3.2 Fraud and Corruption

3.2.1 The Chief Executive and Director of Finance shall monitor and ensure compliance with the Government Functional Standard (GovS 013: Counter Fraud) Management of Counter Fraud, Bribery and Corruption Activity issued by the Counter Fraud Centre of Expertise, part of the Cabinet Office) as well as any other best practice and guidance.

3.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as required by Government Functional Standard (GovS 013: Counter Fraud).

3.2.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with NHS Counter Fraud Authority staff in accordance with the NHS Counter Fraud Manual and in compliance with the Government Functional Standard (GovS 013: Counter Fraud).

3.2.4 The Local Counter Fraud Specialist shall develop a work plan following a comprehensive fraud risk assessment. This work plan shall be agreed with the Audit Committee at the beginning of each financial year, with progress against the plan being reported quarterly.

3.2.5 The Trust must maintain a Counter Fraud, Bribery and Corruption Policy and Response Plan.

3.3 Security Management

3.3.1 The Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State and NHS England on NHS security management.

3.3.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist as specified by the Secretary of State and NHS England in guidance on NHS security management.

3.3.3 The Trust shall nominate a non-executive director to be responsible to the Board for NHS security management.

3.3.4 The Chief Executive has overall responsibility for controlling and co-ordinating security. However, key tasks are delegated to the Security Management Director and the appointed Local Security Management Specialist.

3.4 Director of Finance

3.4.1 The Director of Finance is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function and will normally attend Audit Committee meetings.

(b) Ensuring that the internal audit is adequate and meets the Internal Audit standards.

(c) Deciding at what stage to involve the police in cases of misappropriation, and other irregularities, in conjunction with the Local Counter Fraud Specialist.

(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee, as a minimum covering:

(i) A clear statement on the effectiveness of internal control.

(ii) Major internal financial control weaknesses discovered.

(iii) Progress on the implementation of internal audit recommendations.

(iv) Details of actual performance against plan.

(e) Ensuring that regular and timely reports are prepared for the consideration of the Audit Committee, covering:

(i) Progress against plan over the previous year.

(ii) A detailed plan for the coming year.

3.4.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice (although this will usually be given unless circumstances warrant otherwise) to require and receive:

(a) Access to all records (for patient records this will require approval by the Caldicott Guardian), documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature.

(b) Access at all reasonable times to any land, premises or employee of the Trust.

(c) The production of any cash, stores or other property of the Trust under an employee's control.

(d) Explanations concerning any matter under investigation.

3.5 Role of Internal Audit

3.5.1 Internal audit will review, appraise and report upon:

(a) The extent of compliance with and the financial effect of, relevant established policies, plans and procedures.

(b) The adequacy and application of financial and other related management controls.

(c) The suitability of financial and other related management data.

(d) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) Fraud and other offences.

(ii) Waste, extravagance and inefficient administration.

(iii) Poor value for money or other causes.

3.5.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature (of or pertaining to money), the Director of Finance must be notified immediately.

3.5.3 The Head of Internal Audit shall be accountable to the Director of Finance, where internal audit services are provided internally. Where internal audit services are provided by a third party organisation it will be the responsibility of the Director of Finance to manage the contract between the two organisations and agree a nominated individual to fulfil the role of Head of Internal Audit. At all times the Head of Internal Audit and internal audit services must remain independent and objective and must not be compromised by the role of the Director of Finance.

3.5.4 The Head of Internal Audit will normally attend the Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

3.5.5 The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. This agreement shall be in writing and shall comply with the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every 3 years or whenever a new internal audit provider is appointed.

3.6 External Audit

3.6.1 The external auditor is appointed by the Council of Governors and paid for by the Trust.

3.6.2 In accordance with NHS England's 'Code of governance for NHS provider Trusts':-

(a) The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.

(b) Audit Committee shall:

(i) Make a report to the Council of Governors in relation to the performance of the external auditor, including detail such as the quality and value of the work, and the timeliness of reporting and fees, to enable the Council of Governors to consider whether to re-appoint them.

(ii) Make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

(c) If the Council of Governors does not accept the recommendations from Audit Committee, the Board should include in the annual report a statement from the latter explaining the recommendation and should set out the reasons why the Council of Governors has taken a different position.

3.6.3 The Audit Committee must ensure a cost-efficient service by periodically seeking competitive tenders for the Trust's external audit service. Cost efficiency must not be used as a reason to compromise the quality of the external audit service and compliance with Code of Audit Practice issued by the National Audit Office.

3.6.4 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Audit Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed. The results of the tendering exercise should be reported to the Board.

3.6.5 Should there appear to be a problem with the external audit service being provided, then this should be raised with the external auditor and escalated appropriately within the external audit firm to ensure that the issue is resolved promptly and to the satisfaction of the Audit Committee.

3.6.6 If requested by the external auditor, during part of one Audit Committee meeting each financial year, executive directors and others normally in

attendance will be excluded from the meeting in order to allow private discussions between Audit Committee non-executive members and the external auditor.

3.6.7 The External Audit Engagement Lead and/or the Audit Manager will normally attend Audit Committee meetings.

4. FINANCIAL PLANNING, BUDGETS AND BUDGETARY CONTROL AND MONITORING

4.1 Preparation and Approval of Financial Plan and Budgets

4.1.1 The Chief Executive will compile and submit to the Board an annual financial plan that takes into account financial targets and forecast limits of available resources. The annual financial plan will contain:

(a) A statement of the significant assumptions on which the plan is based.

(b) Details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2 The plan must take into account the views of the Council of Governors in accordance with the Constitution of The Rotherham NHS Foundation Trust and be submitted to NHS England in line with required deadlines.

4.1.3 The local Integrated Care System will be responsible for reviewing the Trust's financial plan as part of its co-ordinating role in compiling a system wide plan for submission to NHS England.

4.1.4 The Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. This will normally happen prior to the start of the financial year or in exceptional circumstances as soon as possible after the start of the financial year, but only in agreement with the Board. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the annual business plan and also meet the necessary requirements within the Trust's terms of authorisation granted by NHS Improvement.

(b) Be consistent, wherever practical and possible, with national guidance and/or instructions.

(c) Accord with workload and workforce plans.

(d) Be produced following discussion with appropriate budget holders.

(e) Be prepared within the limits of available income, unless agreed otherwise by the Board.

(f) Identify potential risks and opportunities.

4.1.5 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board on a monthly basis.

4.1.6 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.1.7 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

4.2 In Year Changes to Budgets

4.2.1 With the exception of budget transfers and virements (see Appendix 6) there will be no changes to budgets in year unless duly authorised via the approval of a business case. Only expenditure that has already been budgeted for can be committed by budget holders and in accordance with their delegated spending limits.

4.2.2 The only corporate bodies with the authority to commit additional (net) expenditure on behalf of the Trust are:

(a) The Executive Team;

(b) Finance & Performance Committee;

and

(c) The Board;

in accordance with limits detailed in Appendix 6.

4.2.3 Where a workforce re-structure is proposed this must follow the establishment change process and only where additional costs are incurred would the above process need to be followed.

4.2.4 Where additional expenditure has already been approved in accordance with either Paragraphs 4.2.2 or 4.2.3 above and there is a likelihood that this resource will be insufficient to fulfil the objectives of the original business case then the budget holder must ensure that:

(a) This is brought to the attention of the Director of Finance as soon as is practicably possible;

(b) No additional expenditure is incurred beyond that already approved in the first instance;

(c) A revised business case is submitted in accordance with limits detailed in Appendix 6 for the additional expenditure to be incurred.

4.2.5 These requirements apply equally to both income and expenditure (see also Paragraph 7.2.4 below) and capital budgets.

4.3 Retrospective Approval for In Year Changes to Budgets

4.3.1 Under normal circumstances, all in year changes to budgets need to be

approved prospectively in accordance with Section 4.2 above before any additional expenditure is committed or incurred.

4.3.2 In exceptional circumstances, approval can be sought and granted retrospectively, but only with the approval of the Director of Finance who will be responsible for ensuring that the necessary governance arrangements are then followed in accordance with the limits detailed in Appendix 6.

4.3.3 Should the Trust come to a view that the expenditure thus committed and or incurred, prior to retrospective approval being granted, cannot be legitimately justified and supported via arrangements contained in Section 4.2 above, then the Director of Finance must:

(a) Consider the necessary actions required to expedite the cancellation of any existing and/or contractual commitments with a view to limiting the amount of any further unapproved expenditure to be incurred in the future;

(b) Escalate the matter in accordance with Section 2.4 above, for non-compliance.

4.3.4 Legitimate justification and support referred to in Paragraph 4.3.3 above, is a matter of subjectivity, but is intended to prevent any authorised signatories making decisions that cannot be substantiated appropriately via consideration of a proper business case.

4.4 Budgetary Delegation

4.4.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation will be in accordance with the financial plan and the Scheme of Delegation (See appendices 1 to 10), both approved by the Board.

4.4.2 The Director of Finance is responsible for maintaining the lists of authorised signatories and their delegated transactional financial limits. Managers are responsible for advising the Director of Finance of all changes in accordance with agreed procedures. An overview of budget delegation within the budgetary control process is diagrammatically presented in Appendix 2.

4.4.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.4.4 The Board, as advised by Finance & Performance Committee, will determine what action is necessary where budgetary totals are being exceeded, if appropriate action has not already been instigated by the Executive Team.

4.4.5 Any budgeted funds not required for their designated purpose(s) must be declared to the Director of Finance who will determine what action, if any is to be taken.

4.4.6 Non-recurring budgets must not be used to finance recurring expenditure.

4.5 Budgetary Control, Forecasting and Reporting

4.5.1 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, containing:

(i) Monthly income and expenditure to date showing trends and, as advised by the Director of Finance and/or requested by Finance & Performance Committee, forecast year-end position.

(ii) Monthly movements in working capital, including cash, where significant.

(iii) Capital scheme spend, commitments and forecast year-end position.

(iv) Explanations of any material variances from plan.

(v) Details of any corrective action where necessary and the Director of Finance's view of whether such actions are sufficient to correct the situation.

(vi) Details of the financial risk ratings and indicators of forward financial risk as set out in NHS England's Risk Assessment Framework.

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible. These will be produced monthly and will be made available to budget holders and authorised signatories in a format agreed by the Director of Finance.

(c) Investigation and reporting of variances from financial, activity and workforce budgets.

(d) Monitoring of management action to correct variances.

(e) Arrangements for the authorisation of budget transfers and virement.

4.5.2 Each budget holder is responsible for ensuring that:

(a) Any likely overspend or reduction of income, which cannot be met by virement, is not incurred without the formal approval of the Board. This will be achieved via the Board's acceptance of the monthly finance report produced by the Director of Finance.

(b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement.

(c) Permanent employees are appointed in accordance with agreed procedures and numbers provided for in the budgeted establishment as approved by the Board. Establishment will be reviewed annually as a minimum.

(d) Their use of temporary staff complies with Trust policies.

4.5.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual financial plan.

4.6 Capital Expenditure

4.6.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in Chapter 13.

4.7 Monitoring Returns

4.7.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS England and any other requisite monitoring organisations. These returns must be accurate and timely and key financial returns will be subject to review by the Director of Finance prior to submission.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Trust, will:

(a) Prepare annual accounts in accordance with International Financial Reporting Standards, as adjusted from time to time with accounting policies and guidance issued by the Department of Health & Social Care in its annually updated Group Accounting Manual, together with the Trust's own accounting policies and generally accepted accounting practice, as appropriate.

(b) Prepare and submit annual financial reports to NHS England certified in accordance with current guidelines.

(c) Submit financial returns to NHS England for each financial year in accordance with the prescribed timetable.

5.2 The annual accounts must be approved by the Board, although this may be delegated to the Audit Committee, which will then make recommendations to the Board, as appropriate.

5.3 The Trust's audited annual accounts must be presented to a public meeting within six months of the end of the financial year to which they relate.

5.4 The Trust will publish an annual report in accordance with its Constitution and in compliance with the NHS England's NHS foundation trust annual reporting manual 2022/23.

5.5 The annual report will be presented to the Council of Governors at a general meeting and similarly presented to the same public meeting as the annual accounts.

6. BANKING AND GOVERNMENT BANKING SERVICES

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by NHS England, which will be consolidated in a Treasury Management Policy.

6.1.2 The Board, via Audit Committee, shall approve the banking arrangements.

6.2 Bank and Government Banking Services Accounts

6.2.1 The Director of Finance is responsible for:

(a) Bank accounts and Government Banking Services accounts.

(b) Establishing separate bank accounts for funds held on trust on behalf of the Corporate Trustee.

(c) Ensuring payments made from bank or Government Banking Services accounts do not exceed the amount credited to the account except where arrangements have been made i.e. accounts should not become overdrawn without explicit prior approval.

(d) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 Banking Procedures

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and Government Banking Services accounts, which must include:

(a) The conditions under which each account is to be operated.

(b) The limit to be applied to any overdraft.

(c) Details of those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated. This will normally be achieved through the list of authorised signatories supplied to the bank.

6.3.3 All funds shall be held in the name of the Trust.

6.3.4 No employee other than the Director of Finance shall open any bank account in the Trust's name. For the Trust's main commercial bank and Government Banking Services, the Director of Finance has discretion to open the number

and type of accounts as necessary to expedite normal day-to-day business activities. For accounts to be used for investment of surplus cash these must be in accordance with the requirements of the Treasury Management Policy.

6.4 Tendering and Review

6.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

6.4.2 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Audit Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed. The results of the tendering exercise should be reported to the Board.

6.5 Electronic Transfer of Funds

6.5.1 All electronic transfers of funds must only be made under secure arrangements approved by the Director of Finance.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Trust shall follow guidance issued by the Department of Health and Social Care for the pricing of its patient related services with commissioners, supplemented by any additional guidance provided by NHS England.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health & Social Care or by statute. This should be incorporated into and documented in the financial planning process to ensure that this happens annually as a minimum.

7.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. This must be via prompt and regular presentation of cash transactions for banking or through the formal debt recovery process for credit income.

7.2.4 The Director of Finance, shall approve business cases for schemes where potential gross income generation exceeds £20,000 per annum (excluding VAT), in order to ensure profitability of such schemes to the Trust overall. Schemes with gross income above £20,000 will need to be approved, similar to business cases, in accordance with the limits referred to in Appendix 6.

7.2.5 The requirements outlined in paragraph 7.2.4 above equally apply to a discontinuation of, or disinvestment in a service or operation.

7.2.6 All contracts and/or service level agreements must be agreed by the Head of Contracts & Business Development who will then sign contracts under £100,000 and pass contracts over £100,000 for signing by the Director of Finance. All such contracts must be retained and stored securely by the Head of Contracts & Business Development.

7.3 Tendering for Services

7.3.1 A decision to submit a bid for services tendered by another organisation must be approved by the Chief Executive in accordance with the formal Business Case Process and Guidance document.

7.3.2 Once a decision has been made to submit a bid for services so tendered, the bid will be co-ordinated, prepared and presented in a form determined by the tender specification and process.

7.3.3 The financial elements of the tender bid must have been agreed by the Director of Finance.

7.3.4 The final tender bid must be approved prospectively in accordance with the financial limits contained in Appendix 6. A register of all submitted tenders will be maintained.

7.4 Debt Recovery

7.4.1 The Director of Finance is responsible for the appropriate recovery action for all outstanding debts. This will include the use of external debt recovery services, where appropriate.

7.4.2 Income not received should be dealt with in accordance with losses procedures described in Section 15.2 and delegated financial limits detailed in Appendix 9.

7.4.3 Overpayments should be detected (or preferably prevented) wherever is reasonably possible and recovery initiated.

7.5 Security of Cash, Cheques and Other Negotiable Instruments

7.5.1 The Director of Finance is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

(b) Ordering and securely controlling any such stationery.

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.5.2 Official Trust monies shall not under any circumstances be used for the encashment of private cheques.

7.5.3 All cheques, postal orders, and cash, shall be banked intact. Disbursements shall not be made from cash received under any circumstances.

7.5.4 The holders of safe keys shall not accept unofficial funds for depositing in their

safes under any circumstances.

7.5.5 The opening of post shall be undertaken by two employees together and all cash, cheques and other forms of payment shall be entered in an approved register before handing to the Director of Finance.

7.5.6 The opening of cash tills, telephones and other coin operated machines and the counting and recording of takings shall be recorded by two officers together. Both shall sign the records and the keys shall be held by a separate nominated officer.

8. CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

8.1 The Chief Executive is responsible for:

(a) Negotiating legal contracts with commissioners for the provision of services to patients in accordance with the financial plan; and for

(b) Establishing the arrangements for providing non-contract activity treatment services in accordance with the guidance contained in 'Who Pays? - Determining which NHS commissioner is responsible for making payment to a provider' published by NHS England and any other best practice guidance.

8.2 In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

(a) Costing and pricing of services.

(b) Payment terms and conditions.

(c) Amendments to contracts.

(d) Non-contract activity arrangements.

(e) Provision of contract data.

(f) Any other financial matters.

8.3 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

8.4 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices shall comply with guidance issued by the Department of Health & Social Care and NHS England.

8.5 The Director of Finance shall produce regular reports detailing actual and forecast contract income linked to patient activity with a detailed assessment of the impact of the variable elements of income. These will be presented monthly for review to Finance & Performance Committee and the Board.

8.6 Any pricing of contracts at marginal cost must be approved by the Director of Finance and reported to the Board if material. Materiality is deemed to be when such contracts have a financial impact in excess of £100,000 (excluding VAT) in this instance.

8.7 The Chief Executive is responsible for ensuring procedures are in place to ensure all patient related activity is recorded appropriately and that flex and freeze dates for agreeing actual levels of activity against contracts are strictly adhered to in order to maximise the level of income received by the Trust.

8.8 Where the Trust wants to procure healthcare services from a third party organisation in order to deliver its contractual obligations with one or more of its commissioners, then this will:

(a) Require a business case to be approved in accordance with Section 4.2 above and financial limits contained in Appendix 6; and
(b) Be undertaken by the Procurement Department, consistent with the requirements contained in Chapter 11.

8.9 Submission of bids for services tendered by another organisation must be undertaken in accordance with the requirements of Section 7.3.

9. TERMS OF SERVICE AND PAYMENT OF ALL STAFF

9.1 Remuneration and Terms of Service

9.1.1 In accordance with Standing Orders, the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Trust's Remuneration Committee will:

(a) Review the ongoing appropriateness and relevance of the Trust's remuneration policy.

(b) Agree the appropriate remuneration and terms of service for the Chief Executive and other executive directors, including:

(i) All aspects of salary (including any performance-related elements/bonuses).

(ii) Provisions for other benefits, including pensions and cars.

(iii) Arrangements for termination of employment and other contractual terms.

(c) Monitor the evaluation of the performance of individual executive directors.

(d) Advise on and oversee appropriate contractual arrangements for executive directors including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

(e) Approve remuneration or other awards made to executive directors outside of contractual obligations only with the approval of HM Treasury, where applicable.

(f) Monitor compliance with Off Payroll Working (IR35): Deemed employer responsibilities under off-payroll working rules.

(g) Monitor redundancy and capitalised pension costs for all staff groups and to approve any such individual arrangements in excess of £100,000.

The Remuneration Committee will take into account the principles contained in NHS England's 'Code of governance for NHS provider Trusts' when exercising its responsibilities.

9.1.3 There shall be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration of individual executive directors. No executive director should be involved in deciding their own remuneration.

9.1.4 Whilst the Board may delegate decision-making about remuneration to the Remuneration Committee, it remains accountable for taking decisions on the remuneration and terms of service of executive directors.

9.1.5 The Trust will remunerate the Chairman and non-executive directors in accordance with instructions issued by the Council of Governors.

9.2 Funded Establishment

9.2.1 The people plans incorporated within the annual business plan and budgets will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive, in accordance with the requirements of establishment control procedures agreed by the Director of People.

9.2.3 Increases to funded establishments can only be approved in accordance with Section 4.2 and financial limits contained in Appendix 6.

9.2.4 The funded establishment of any department may not be exceeded without the prior approval of the Director of Finance and subject to authorised powers of virement contained in Appendix 5.

9.3 Staff Appointments

9.3.1 No employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) Unless authorised to do so by the Chief Executive and in accordance with the requirements of establishment control procedures agreed by the Director of People; and

(b) Within the limit of their approved budget and funded establishment.

9.3.2 The arrangements for securing the services of temporary (agency) staffing must follow establishment control procedures agreed by the Director of People in accordance with :

(a) Master vendor arrangements for all medical staff; and

(b) NHS Professionals for all other staff.

The only exception to this is Board level posts, which will be dealt with as and when required by the Nominations Committee.

9.3.3 The Board will approve procedures presented by the Director of People and Director of Finance for the determination of pay rates and conditions of service, for groups of staff not linked to national terms and conditions whose period of employment has not yet commenced. This relates to the initial establishment of local terms and conditions, which can then be supplemented by the requirements contained in Section 9.4 below.

9.3.4 When appointing staff, authorised signatories must ensure that:

(a) The recruitment, selection and contracting processes are consistent with Trust policies.

(b) Any offer of employment complies with the appropriate terms and conditions of employment for that category of staff.

(c) Appropriate documentation is completed prior to the offer of employment being made and immediately on commencement of duty with the Trust or to a new post within the Trust.

9.3.5 Where a budget holder requires to deviate from national terms and conditions, or locally agreed terms and conditions where these exist, for an individual member of staff, this will need to be prospectively approved jointly by the Director of Finance and the Director of People prior to an offer of employment being made.

9.4 Changes to Rates of Pay

9.4.1 Proposals to pay individual members of existing staff other than in accordance with national terms and conditions, or locally agreed terms and conditions where these exist, will need to be prospectively approved jointly by the Director of Finance and the Director of People.

9.4.2 Proposals to pay groups of existing staff other than in accordance with national terms and conditions, or locally agreed terms and conditions where these exist (for example, changes in rates of pay for bank staff or local on call arrangements) should be approved in the form of a business case and in accordance with the financial limits contained in Appendix 6. There is provision for retrospective approval to support operational and clinical decision making in exceptional circumstances (See Section 4.3 above).

9.4.3 Where proposals outlined in Paragraph 9.4.2 are approved, a post implementation review should be carried out and reported to the Director of Finance and Director of People, with the outcome presented to the Finance & Performance Committee.

9.5 E-Rostering

9.5.1 Staff rosters will be maintained electronically in the E-Allocate system and will be managed and controlled in accordance with procedures agreed by the Director of People.

9.5.2 A separate list of authorised signatories will be maintained by the Director of People in order to ensure compliance with the aforementioned procedures.

9.5.3 An interface will be managed and controlled by the Director of People to ensure appropriate access to e-rosters by NHS professionals in accordance with the aforementioned procedures.

9.6 Processing of Payroll

9.6.1 The Director of People is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications.

(b) The final determination of pay, jointly with the Director of Finance.

(c) Making payment on agreed dates.

(d) Agreeing the method(s) of payment.

9.6.2 The Director of People will issue instructions, having taken appropriate advice from the Director of Finance, regarding:

(a) Verification and documentation of data.

(b) The timetable for receipt and preparation of payroll data and the payment of employees.

(c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay.

(d) Security and confidentiality of payroll information.

(e) Checks to be applied to the completed payroll before and after payment.

(f) Authority to release payroll data under the provisions of the Data Protection Act 2018.

(g) The payment of pay awards and arrears.

(h) Procedures for the change of bank account details by staff.

9.6.3 The Director of Finance will issue instructions regarding:

(a) Methods of payment available to various categories of employee.

(b) Procedures for payment by cheque or bank credits to employees.

(c) Procedures for the recall of cheques and bank credits.

(d) Pay advances and their recovery.

(e) Maintenance of regular and independent reconciliation of pay control accounts.

(f) Separation of duties between the preparation of records and the handling of cash and other types of payment.

(g) A system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

(h) The secure operation of the system for payments by BACS.

9.5.4 Budget holders have delegated responsibility for:

(a) Submitting time records, and other notifications in accordance with agreed timetables.

(b) Completing time records and other notifications in accordance with instructions and in the form prescribed by the Director of People.

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of People must be informed immediately and prompt action taken as necessary to prevent any over-payments arising.

This must be consistent with the requirements of establishment control procedures agreed by the Director of People and transactional financial limits detailed in Appendices 3 and 4, as appropriate.

9.5.5 Regardless of the arrangements for providing the payroll service, the Director of People, having taken appropriate advice from the Director of Finance, shall ensure that payments made by the payroll function are supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures where appropriate.

9.5.6 The Director of Finance will ensure that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.7 Contracts of Employment

9.6.1 All contracts of employment shall be in a format agreed by the Director of People, in conjunction with the Remuneration Committee, as appropriate.

9.6.2 The Board shall delegate responsibility to a budget holder for:

(a) Ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation (see also Paragraphs 9.3.3 and 9.3.4);

and

(b) Dealing with variations to, or termination of, contracts of employment (save for instances arising from clause 9.4); in accordance with the requirements of establishment control procedures agreed by the Director of People.

9.6.3 Where termination of employment involves redundancy (voluntary or compulsory) agreements or any other form of contractual payments, this shall require formal and prospective approval from the Director of Finance or the Remuneration Committee if individually in excess of £100,000 as per Paragraph 9.1.2 (g) above. He or she will seek appropriate advice, as necessary, from the Director of People before making any such decision.

9.6.4 All payments outside contractual obligations (for example, compromise agreements) require formal and prospective approval from the Remuneration Committee to approve a submission to HM Treasury. All payments outside contractual obligations require prospective HM Treasury approval, irrespective of value.

10. NON-PAYROLL EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

10.1.2 No employee shall commit or authorise expenditure unless they have delegated authority to do so.

10.1.3 As part of the approval of annual budgets, as set out in section 4.1, the Board will approve non-pay budgets.

10.1.4 Authorised signatories have delegated authority to commit or authorise non-pay expenditure up to the budget, for the purpose of the budget, subject to the transactional financial limits set out in Appendices 3 and 4.

10.1.5 Virement of budget is permissible within the Trust's approved rules and limits (See Appendix 5).

10.1.6 **Requisitions and Orders:** In line with best practice, most goods or services will be ordered through the Procurement Department (via web-based requisitioning) following a requisition raised by an authorised signatory. A list of goods and services where an official purchase order may not be required will be agreed, maintained and held by the Director of Finance and made available via the intranet.

A single requisition may involve, for example, the requisition of a contract involving a number of annual payments; these payments are added together to determine the transactional financial limit.

Requisitions may not be split or otherwise placed in a manner devised so as to avoid the transactional financial limits.

Requisitions should be placed prior to any goods or services being received and must not be used as a means to retrospectively comply with these instructions.

10.1.7 **Signing of Contracts or Licences:** An order for goods or service may result in a contract or license to be signed by both the Trust and the supplier. All contracts must be agreed by the Head of Procurement who will then sign contracts under £100,000 (excluding VAT) and pass contracts over £100,000 (excluding VAT) for signing by the Director of Finance. All such contracts must be retained and stored securely by the Head of Procurement.

10.1.8 **Authorisation of Invoices:** Most invoices relating to goods requisitioned and purchased via an order issued by the Trust do not require authorisation. The Finance Department will match the Goods Received Note to the invoice and invoice value, and resolve any differences, seeking assistance from

authorised signatories where this is necessary.

Invoices not matched in the way described above, will require authorisation before payment in accordance with delegated transactional financial limits.

10.2 Procedures for Obtaining Goods and Services

10.2.1 In choosing the item to be supplied (or the service to be performed), the advice of the Procurement Department shall be sought in order to obtain value for money and, as far as possible, meet the sustainability obligations of the Trust.

10.2.2 The only exceptions to the above are the Pharmacy Department, which is permitted to procure drugs without seeking the advice of Procurement and patient bespoke Orthotics procurement.

10.2.3 Where the advice of Procurement is not accepted by an authorised signatory, the Director of Finance (and/or the Chief Executive) shall be consulted and may approve procurement contrary to the advice received, as long as the Trust complies with statutory requirements.

10.2.4 Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

10.2.5 The procedure that the Trust shall follow to raise official orders and the authorised signatory's role in this is set out in Chapter 11. All orders must:

(a) Be consecutively numbered in batches, as controlled by the Head of Procurement, unless automatically system generated.

(b) Be in a form approved by the Director of Finance.

(c) State the Trust's terms and conditions of trade.

(d) Only be generated based on the delegated authority of the appropriate signatory as detailed in Appendices 3 and 4.

(e) Be authorised in accordance with procedures determined by the Director of Finance. All orders in excess of £1,000,000 (excluding VAT) must have already been approved in accordance with limits referred to in Appendices 3 and 4.

10.2.6 No order shall be issued for any item or items to any firm that has made an offer of gifts, rewards or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts.

10.2.7 All contracts for example; leases, tenancy agreements and other commitments that may result in a liability shall be notified to the Director of Finance.

10.2.8 These Standing Financial Instructions apply equally to goods and services

relating to funds held on trust, see Appendix 10 for delegated financial limits.

10.2.9 No verbal instructions, without an official order number, are to be given to suppliers of goods and services.

10.2.10 No orders are to be raised after goods and services have already been supplied unless in accordance with agreed procedures approved by the Director of Finance.

10.2.11 No orders to be raised with suppliers of goods and services where the authorised signatory is related to an individual who will directly benefit from that order or, the authorised signatory has a financial interest with that supplier. The Trust's Standards of Business Conduct (including NHS England Conflicts of Interest Guidance) provide further information regarding personal and business integrity and instances where a close family or personal relationship may give rise to a conflict of interest or the perception of such.

10.3 Confirmation of Receipt for Goods and Services

10.3.1 The system for receipt of goods and services shall provide for:

(a) Details of employees authorised to certify invoices (see Paragraph 4.3.2).

(b) Certification that goods have been duly received, examined and are in accordance with specification and the prices are correct.

(c) Certification that work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct.

(d) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined.

(e) Where appropriate, that the expenditure is in accordance with regulations and all necessary authorisation has been obtained.

(f) The account is arithmetically correct.

(g) The account is in order for payment.

(h) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

10.4 Payment for Goods and Services

10.4.1 The Director of Finance is responsible for the prompt payment of accounts and claims, and these shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.4.2 The Director of Finance is responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

10.4.3 The Director of Finance is responsible for designing and maintaining procedures regarding the use and control of purchasing cards.

10.4.4 The Director of Finance is responsible for ensuring that payment for goods and services is only made once the goods and services are received unless in line with contractual terms and conditions imposed by the supplier, subject to the provisions contained in Paragraph 10.4.5.

10.4.5 Pre-payments, other than those specified by contractual terms and conditions imposed by the supplier, are only permitted where exceptional circumstances apply. In all such instances, the advice of both the Director of Finance and the Head of Procurement should be sought before entering into any contractual arrangements. In such instances:

(a) The budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments. Any proposals must be discussed with the Head of Procurement before submitting a request to the Director of Finance.

(b) The Director of Finance may approve the prepayment arrangement to progress if:

(i) The proposed arrangements takes into account the European Union Public Procurement Policy where the contract is above a stipulated financial threshold;

and

(ii) The financial advantage outweighs the disadvantages.

10.4.6 The budget holder is responsible for ensuring that all items due under a pre-payment contract are received and they must immediately advise the appropriate Director or Chief Executive if problems are encountered.

10.5 Petty Cash

10.5.1 Purchases from petty cash are restricted in value and by type of purchase as detailed in Appendix 7 and must be supported by receipt(s) and certified by an authorised signatory within their delegated limit.

10.5.2 The Director of Finance will determine record keeping and other instructions relating to petty cash.

11. TENDERING AND CONTRACTING FOR NON-PAYROLL EXPENDITURE

11.1 Delegated Authority

11.1.1 All tendering and contracting must be carried out by the Procurement Department with the exception of Pharmacy. However, the Procurement Department should still be involved to provide guidance and support, as appropriate, to ensure procurement in this area is undertaken in accordance with the requirements of these Standing Financial Instructions.

11.1.2 No employee is to enter into commercial discussions with potential or actual suppliers without the full agreement and involvement of the Procurement Department.

11.1.3 All contracts will:

(a) Be within the Trust's powers as delegated by the Secretary of State.

(b) Comply with relevant Department of Health & Social Care guidance as advised by the Head of Procurement.

(c) Incorporate the Standard NHS terms and conditions.

(d) Endeavour to obtain best value for money.

(e) Be compliant with the latest government guidance and policy regarding transparency within procurement.

11.1.4 Further details are provided in the Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy) which sets out the framework within which all procurement in the Trust should be undertaken.

11.2 Procedure for Procurement of Non-Payroll Items

11.2.1 Paragraph 10.2.2 provides for the procurement of drugs to be undertaken through the Pharmacy Department, where the Chief Pharmacist will follow similar procurement procedures to those set out below. Relevant paragraphs below equally apply to patient bespoke Orthotics procurement.

11.2.2 Authorised signatories will requisition the required goods or services. All requisitioners will be required to follow the ordering procedures set by the Procurement Department, as referred to in the Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy).

11.2.3 The Procurement Department will follow the processes outlined for the procurement of goods, services, and works in accordance with the financial limits detailed in Appendix 8.

11.2.4 Formal tendering is not required if goods and services are obtained via a framework contract put in place by a recognised body and which is open for

the Trust to utilise. This work will still be undertaken by the Procurement Department.

11.2.5 The Procurement Department will endeavour to obtain best value for money on all of its activity.

11.2.6 **Quotations – Goods, Services and Works:** A minimum of three written quotations are required where the contract value is expected to be between £10,000 and £35,000 (excluding VAT) for goods and services, and between £50,000 and £200,000 (excluding VAT) for works, unless using an already competitively tendered contract (excluding works). For spend below £10,000 for goods and services, and below £50,000 for works, then a value for money check must be completed by the budget holder along with Procurement input. Any contract entered into by the Trust regardless of value must be completed by Procurement and signed as per Paragraph 10.1.7 even those below the thresholds identified in this section. Competitive quotations should be:

(a) Obtained based on specifications or terms of reference prepared by, or on behalf of, the budget holder.

(b) Obtained in writing and published via an e-tendering platform, which includes sending the opportunity through to Contracts Finder for publication.

(c) Treated as confidential and should be retained for inspection.

(d) Evaluated by the Procurement Department in conjunction with the budget holder or delegated officer to select the quotation giving the best value for money. If this is not the lowest quotation, if payment is to be made by the Trust; or the highest, if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record. The Procurement Department will advise on which quotation should be accepted.

11.2.7 **Formal Tendering – Goods or Services and Works:** Where the likely contract value exceeds £35,000 for goods or services, and £200,000 for works, formal tendering will be undertaken.

Where a requirement for goods or services is likely to cost in excess of £35,000 and requisitions for works in excess of £200,000 is known, the budget holder will work with the Procurement Department on a formal tender process unless a framework can be used as referred to in Paragraph 11.2.4 above. The Procurement Department will lead the tendering process in conjunction with the budget holder.

11.2.8 Items estimated to be below the quotation and/or tender limits that subsequently exceed these limits shall be reported to the Director of Finance and Audit Committee along with circumstances where formal procedures have in effect been waived without approval to do so.

11.3 Procedure for Competitive Tendering

11.3.1 Trust standard tendering documentation must be used at all times unless agreed by the Head of Procurement.

11.3.2 The tender specification must be robust and impartial.

11.3.3 Trust tendering procedures must at all times adhere to the transparency agenda set by the European Union and the UK Government. All tenders will be undertaken through the Trust's electronic tendering system. This shall enable suppliers to be alerted that there is a contract opportunity available, in line with the government's transparency agenda.

11.3.4 Tenders will be returned to an 'electronic safe' locked until the due date for the receipt of bids from invited suppliers. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the tenders shall be opened by the Procurement Department.

11.3.5 The Head of Procurement, as guardian for the e-tendering system, is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of the names of all firms or individuals invited to tender, those from which tenders have been received and the date these tenders were opened.

11.3.6 There is generally no discretion to receive tenders after the due date. In exceptional circumstances, the Head of Procurement may approve the inclusion of a late tender. This will only be approved if there is a technical reason why the tender could not be submitted and this reason must be ratified by the e-tendering system supplier.

11.3.7 Acceptance of Tender:

(a) Any clarification questions from the Trust to a tenderer that are deemed necessary to clarify technical aspects of the tender before the award of a contract must be undertaken via the Procurement Department and not directly by the budget holder. All questions must be sent via the e-tendering portal for transparency purposes.

(b) The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.

(c) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive. This will be in accordance with the requirements of Paragraph 4.2 above and financial limits contained in Appendix 6.

(d) The Procurement Department will advise on the award of a contract to a supplier and provide a written de-brief to the unsuccessful bidders. Under no circumstances should an individual outside of the Procurement Department de-brief a supplier.

(e) A duly completed formal contract document (terms and conditions) shall be issued by the Procurement Department for authorisation by the Head of Procurement, or Director of Finance if the contract is related to a private finance initiative/lease agreement or its value is over £100,000.

(f) Following completion of the signed contract, an order should be raised for the goods, services or works.

11.3.8 The Head of Procurement will report to the Board on an exceptional circumstance basis as required by the Chief Executive.

11.3.9 Procurement will ensure that appropriate contract management arrangements are put in place for all accepted tenders in relation to contracts in excess of £500,000 per annum to ensure:

(a) Best value is maintained.

(b) Variations are controlled.

(c) Service continuity is maintained.

(d) Risk is managed.

11.4 Frameworks

11.4.1 The Head of Procurement will ensure the Trust's register of suppliers suitable for the supply of goods or services is kept via the Trust's contracts database. The Head of Procurement will also access such other registers available for use by the NHS.

11.4.2 The Head of Procurement will determine which register (framework agreements) may be used.

11.4.3 The Head of Procurement shall ensure all tenders provide open competition and comply with relevant Department of Health & Social Care guidance.

11.4.4 This does not preclude the assessment at either, or both, pre-qualification questionnaire or evaluation of tender stage, of contractor suitability in for example:

(a) Experience and qualifications.

(b) Understanding of the Trust's needs.

(c) Feasibility and credibility of proposed approach.

(d) Viability to deliver the goods or services.

(e) Health and safety record.

(f) Environmental considerations.

(g) Financial standing - Director of Finance responsibility.

(h) Clinical governance - Medical Director responsibility.

11.5 Waiving of Quotation and Tender Requirements

11.5.1 Quotation and tender limits are detailed in Appendix 8. Consideration of the need for a waiver of quotation/tendering requirements may occur where:

(a) In very exceptional circumstances, formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record.

(b) Specialist expertise or goods and services are required and are available from only one source.

(c) The task is essential to complete the project and arises as an unforeseen consequence of a recently completed assignment and engaging a different supplier for the new task would be inappropriate.

(d) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

(e) Permitted by Department of Health & Social Care guidance; details of which shall be documented in waiving formal tendering.

11.5.2 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

11.5.3 In addition to Paragraph 11.5.1 above, a waiver shall not be required under the following conditions:

(a) Turnkey costs where a tender has been compliantly run for the associated equipment and where a Quantity Surveyor has deemed the turnkey costs to be in line with market value.

(b) The payment is for non-domestic rates.

(c) The payment is for mandatory NHS related fees such as CNST payments, etc.

11.5.4 The goods purchased for equipment specific parts which must, by their nature, be from the original manufacturer and where a cost effectiveness analysis of the current equipment solution has been conducted within the last 12 months to the satisfaction of the Head of Procurement. Where it is decided that competitive tendering is not applicable and therefore, the requirements of Standing Financial Instructions should be waived, the fact of the waiver and the reasons should be documented using the waiver form obtained from the Head of Procurement. Details of both authorised and unauthorised waivers will be reported to the Audit Committee.

11.5.5 All requests to progress with waivers must receive prior approval. All such non-competitive action will require the completion of a waiver form. Waiver forms should be initially sent to the Head of Procurement to review and authorise, if appropriate. Waiver forms require authorisation as set out in accordance with the financial limits detailed in Appendix 8.

11.5.6 It should be noted that European Procurement Law applies at all times and in particular to proposed procurements in excess of the financial thresholds (Official Journal of the European Union limits) appertaining at the time. This cannot be waived and the Procurement Department will advise budget holders as to how compliance can be achieved.

11.5.7 The Audit Committee may, at its discretion, invite regular users of the waiver and non-competitive action procedures, to explain the need and to advise how this action may be avoided.

11.5.8 The Head of Procurement will provide ongoing reports to the Audit Committee detailing the use made of waivers.

11.6 Auctions

11.6.1 Should the Trust choose to access auctions (of any kind) as a process for procurement, this must be done through the Procurement Department and the Director of Finance must be assured the process complies with best practice guidelines.

12. EXTERNAL BORROWING AND INVESTMENTS

12.1 Finance & Performance Committee

12.1.1 The terms of reference for Finance & Performance Committee include overseeing all aspects of cash management as well as external borrowing (including temporary overdraft facilities and Public Dividend Capital) and investments.

12.1.2 The Finance & Performance Committee must operate within its terms of reference established by the Board.

12.1.3 The terms of reference will be reviewed annually.

12.2 Public Dividend Capital

12.2.1 The Trust must always initially seek to maximise sources of funding other than borrowing to fund its capital investment.

12.2.2 Subject to paragraph 12.2.1, the Trust must always seek to maximise the amount of public dividend capital available to it, as appropriate, prior to considering any form of external borrowing (including finance leasing) to fund its capital investment.

12.2.3 The Director of Finance must report to the Board as and when public dividend capital is to be drawn down or repaid.

12.2.4 Repayments of public dividend capital must be approved prospectively by the Board.

12.3 External Borrowing

12.3.1 The Director of Finance will advise the Board, as part of the annual financial planning process, concerning the Trust's ability to pay interest on, and repay the capital element of both public dividend capital and any other borrowing within any limits or restrictions set by NHS England.

12.3.2 All applications concerning external borrowing, either short-term or long-term must be approved prospectively by the Board. In this instance, borrowing excludes finance leases but does include planned temporary overdraft facilities with the Trust's commercial bankers.

12.3.3 All short-term borrowing must be proactively managed as part of a planned approach to monitoring and controlling total working capital with a view to minimising individual and cumulative borrowing applications.

12.3.5 All long-term borrowing must be consistent with the Trust's current financial plan and must not exceed any limits or restrictions set by NHS England.

12.3.4 Under no circumstances must long-term borrowing be used other than to

support capital investment.

12.3.5 The Director of Finance is responsible for reporting periodically, but regularly, to the Board, via Finance & Performance Committee concerning all borrowing, which as a minimum must be annually as referred to in paragraph 12.3.1 above.

12.4 Investments

12.4.1 Temporary cash surpluses must be held in such public or private sector investments in accordance with the Treasury Management Policy approved by the Board.

12.4.2 The Director of Finance is responsible for advising the Board on the investment of surplus cash and will report quarterly, as necessary, to Finance & Performance Committee and annually to the Board concerning the performance of investments held.

12.4.3 The Director of Finance will prepare detailed procedural instructions for the investment of surplus cash and on the records to be maintained.

13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital Investment

13.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

(c) Shall ensure that the capital investment is not undertaken without confirmation of commissioner(s) support, where appropriate, and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every appropriate capital expenditure proposal, the Chief Executive shall ensure that a business case is prepared, in line with the approved Business Case Process and Guidance document.

13.1.3 For capital schemes where the contracts stipulate stage payments, the Director of Finance will ensure that this is reflected appropriately in contractual terms and conditions that are communicated effectively between all parties involved.

13.1.4 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall approve each scheme and issue to the manager responsible :

(a) Specific authority to commit expenditure.

(b) Authority to proceed to tender.

(c) Approval to accept a successful tender, subject to the requirements of Standing Orders

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Health Building Note 00-08 (Parts A and B) guidance and the Trust's Standing Orders.

13.1.6 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.2 Post Project Evaluation

13.2.1 Post project evaluation will be undertaken, as a minimum, on all capital investments where the business case is approved by the Board. The post project evaluation will be reviewed by the Board.

13.2.2 The project evaluation shall be produced in line with the approved Business Case Process and Guidance document.

13.3 Private Finance Initiative and Leasing

13.3.1 The Trust should normally test for private financing or leasing when considering capital procurement. When the Trust proposes to use private financing or leasing (regardless of whether the lease is an operating or finance lease), the following procedures shall apply:

(a) The proposal must obtain approval commensurate with that which is required of assets, goods or services obtained by outright purchase.

(b) The budget holder for the associated private financing/lease cost must authorise that the costs are acceptable within their managed budget.

(c) The Director of Finance shall demonstrate that the financing represents value for money and genuinely provides the desired transfer of risk.

(d) Any finance or lease document must be signed by the Director of Finance (see Paragraph 10.1.7).

(e) The proposal must comply with any guidance issued by NHS England.

13.4 Capital Delegated Limits

13.4.1 All initial allocations for capital schemes within the constraints of the Board approved programme will be set by the Director of Finance.

13.4.2 Following the subsequent tendering/quotation action and the approval of the business case the Director of Finance must give approval before any expenditure is committed in line with procedures contained in the Policy and Guidance for the Procurement of Goods, Services and Works (procurement Policy).

13.4.3 The delegated transactional financial limits detailed in Appendix 4 relate to the subsequent authorisation of all expenditure including staff-related costs, requisitions, orders and invoices. All procurement is subject to the procedures set out in Chapter 11.

13.5 Asset Registers

13.5.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted at least once a year.

13.5.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within this register shall be as determined by the Director of Finance taking account of any guidance issued by the Department of Health & Social Care.

13.5.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties.

(b) Stores, requisitions and payroll records for own materials and labour including appropriate overheads.

(c) Lease agreements in respect of assets held under a finance lease and capitalised.

13.5.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices, where appropriate, and in accordance with procedures approved by the Director of Finance.

13.5.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in the ledger against balances on the fixed asset register.

13.5.6 The value of each asset will be depreciated in accordance with methods and rates determined by the Director of Finance consistent with the requirements of relevant International Financial Reporting Standards, as interpreted by the Department of Health & Social Care within its Group Accounting Manual.

13.5.7 The Director of Finance will calculate capital charges in accordance with:

(a) Useful economic asset lives and the Trust's accounting policies for depreciation; and

(b) In accordance with the Department of Health and Social Care's Group Accounting Manual for public dividend capital dividends payable.

13.6 Security of Assets

13.6.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.6.2 Asset control procedures, including donated assets, must be approved by the Director of Finance. These procedures shall make provision for:

(a) Recording managerial responsibility for each asset.

(b) Identification of additions and disposals.

(c) Identification of all repairs and maintenance expenses.

(d) Physical security of assets in accordance with the Trust's Security Policy.

(e) Periodic verification of the existence of, condition of, and title to, assets recorded.

(f) Identification and reporting of all costs associated with the retention of an asset.

13.6.3 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Director of Finance.

13.6.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of all authorised signatories in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with the Trust's Security Policy.

13.6.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by employees in accordance with the procedure for reporting losses (See Chapter 15 and Appendix 9).

13.6.6 Where practical, assets should be marked as Trust property.

13.6.7 The Chief Executive shall be responsible for establishing and maintaining separate records for equipment on loan from suppliers and items provided through operating lease arrangements (See the Policy and Guidance for the Procurement and Payment of Goods, Services and Works (Procurement Policy)).

14. STORES AND RECEIPT OF GOODS

14.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) Kept to a minimum.

(b) Subjected to annual stock take.

(c) Valued in accordance with the Trust's accounting policies as determined by the Director of Finance taking account of the requirements of International Financial Reporting Standards.

14.2 Subject to the responsibility of the Director of Finance for the systems of control, overall control of stores shall be the responsibility of an officer delegated by the Chief Executive. The day-to-day responsibility may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oils the responsibility of a designated Estates Officer.

14.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the officer delegated by the Chief Executive and agreed with the Director of Finance. Wherever practicable, stocks should be marked as health service property.

14.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores, losses and materials management.

14.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

14.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.7 The designated officer shall be responsible for a system, approved by the Director of Finance, for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also Chapter 15). Procedures for the disposal of obsolete stock shall be determined and agreed by the Director of Finance.

15. DISPOSALS, CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.

(b) Disposed of in accordance with a Board approved policy.

(c) Recorded by the Condemning Officer, who must be an authorised signatory at budget holder level or above, in a form approved by the Director of Finance that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

15.2 Losses and Special Payments

15.2.1 Losses and special payments are divided into categories, as defined below. These categories are:

Losses (excluding family practitioner services):

1. Losses of cash.
2. Fruitless payments and constructive losses.
3. Bad debts and abandoned claims.
4. Stores losses and damage to property.

Special payments (excluding family practitioner services):

5. Compensation under court order or legally binding arbitration award.
6. Extra-contractual payments.
7. Ex-gratia payments.
8. Special severance payments.
9. Extra statutory and extra regulatory payments.

15.2.2 The Director of Finance is responsible for ensuring that suitable procedural instructions are produced for the reporting, recording and accounting of all losses and special payments in accordance with the guidance issued by the Department of Health & Social Care. The Director of Finance must also prepare a Counter Fraud, Bribery and Corruption Policy that sets out the action to be taken in the event of a suspected fraud being detected.

15.2.3 Any employee discovering or suspecting a loss of any kind must notify their line manager immediately, who will ensure the incident is reported in line with the requirements of the Incident and Serious Incident Management Policy. Where a criminal offence is suspected, involving theft or arson, the police will be informed in accordance with the arrangements set down in the Trust's Security Policy. For all suspected losses, actions should be taken without undue delay having regard to the potential seriousness of the loss in each individual case.

15.2.4 The Director of Finance must ensure that all individual losses and special payments above £50 are reported to the Audit Committee and that smaller losses are reported in aggregate. A report of losses apparently caused by theft, arson, neglect of duty or gross carelessness must be made to the Audit Committee as soon as practicable, and must also be similarly reported to the external auditor.

15.2.5 The Board shall approve the writing-off of losses and the making of special payments in accordance with the approved financial limits detailed in Appendix 9.

15.2.6 The Director of Finance shall be authorised to take necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.7 For any loss, the Director of Finance should consider whether any insurance claim can be made or any other action taken to recover some of the loss.

15.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. Details will be entered as they are known. Where an actual value cannot be immediately determined an estimated value should be inserted. The precise format of the register will be determined by the Director of Finance.

15.2.9 Audit Committee will review updates to the Losses and Special Payments Register at each of its scheduled meetings.

16. FINANCIAL SYSTEMS AND DATA

16.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage.

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment.

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews, as he or she may consider necessary, are being carried out.

(e) Ensure, as appropriate, compliance with the requirements of the relevant Data Protection Acts.

(f) Ensure that appropriate data back-up and recovery arrangements are in place.

16.2 The Director of Finance shall satisfy hat new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

16.3 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy that:

(a) Systems acquisition, development and maintenance are in line with

corporate policies.

(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists.

(c) Finance and other appropriate staff have access to such data.

(d) Such computer audit reviews, as are considered necessary, are being carried out.

17. PATIENTS' PROPERTY

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

(a) Notices and information booklets.

(b) Hospital admission documentation and property records.

(c) The verbal advice of administrative and nursing staff responsible for admissions.

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.4 Where Department of Health & Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Where a deceased patient is intestate and there is no lawful next of kin, details of any monies or valuables held should be notified to the Treasury solicitor.

17.7 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of that patient’s monies held by the Trust.

17.8 Staff should be informed, on appointment, by the appropriate manager of their responsibilities and duties for the administration of the property of patients.

17.9 Where patients' property is received for specific purposes and held for

safekeeping the property shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with guidance contained in The Records Management Code of Practice for Health and Social Care 2016 issued by the Information Governance Alliance.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with the above shall only be destroyed at the express instigation of the Chief Executive and records shall be maintained of documents so destroyed.

19. RISK MANAGEMENT & INSURANCE

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which will be approved and monitored by the Board.

19.2 The risk management strategy (see Risk Management Policy) shall, as a minimum, contain the following elements:

(a) The continuous identification and prioritisation of key risks.

(b) A description of actions taken to manage each key risk.

(c) The identification of how risk is measured.

19.3 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities.

(b) Engendering among all levels of staff a positive attitude towards the control of risk.

(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk.

(d) Contingency plans to offset the impact of adverse events.

(e) Audit arrangements including; internal audit, external audit, clinical audit, health and safety review.

(f) Arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make an annual governance statement within the Annual Report and Accounts as referred to in the Department of Health & Social Care's Group Accounting Manual.

19.4 The Director of Finance shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme covering both the Trust and the Charity.

20. FUNDS HELD ON TRUST

20.1 General

20.1.1 All relevant sections of this document equally apply to funds held on trust, which are managed by the Corporate Trustee and registered with the Charity Commission under the charity name of the Rotherham Hospital and Community Charity.

20.1.2 There are, however, certain exceptions and specific requirements that only apply to funds held on trust, which are explained further in this section.

20.1.3 In all aspects of managing funds held on trust, the Corporate Trustee must be mindful of relevant legislation and best practice guidance issued by the Charity Commission.

20.2 External Audit

20.2.1 The external auditor is appointed by the Corporate Trustee and paid for from funds held on trust.

20.2.2 The Corporate Trustee must ensure a cost efficient service by periodically seeking competitive tenders for this service. Cost efficiency must not be used as a reason to compromise the quality of the external audit service.

20.2.3 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Corporate Trustee Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed.

20.2.4 Should there appear to be a problem with the external audit service being provided then this should be raised with the external auditor and escalated appropriately within the external audit firm to ensure that the issue is resolved promptly and to the satisfaction of the Corporate Trustee.

20.3 Budgets, Authorisation of Expenditure and Transactional Financial Limits

20.3.1 No budgets are set for funds held on trust.

20.3.2 All expenditure must be authorised and transacted in accordance with the delegated financial limits detailed in Appendix 10.

20.3.3 The Charity must manage its expenditure within its totality of income overall and commensurate with its policy on reserves.

20.4 Annual Accounts and Reports

20.4.1 The Director of Finance, on behalf of the Corporate Trustee, will:

(a) Prepare annual accounts in accordance with Financial Reporting Standards applicable in the UK, as adjusted from time to time with accounting policies and guidance issued by the Charity Commission, the Charity's own accounting policies and generally accepted accounting practice.

(b) Produce an annual report for funds held on trust, which will comply with the provisions of the latest Statement of Recommended Practice (Charities SORP (FRS102) - Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland)

(c) Prepare and submit financial returns to the Charity Commission for each financial year in accordance with the prescribed timetable.

20.4.2 The formal published annual accounts and report must be received and approved by the Corporate Trustee and cannot be delegated.

20.5 Bank Accounts

20.5.1 All funds shall be held in the name of the Charity.

20.5.2 Only the Director of Finance has the authority to open any bank account in the Charity's name. They have the discretion to open the number and type of bank accounts as necessary to expedite normal day-to-day business, including the investment of surplus cash.

2.5.3 No arrangements shall be made with the Charity's bankers for accounts to be overdrawn. This should not happen and any instances should be reported to the Charitable Funds Committee.

20.6 Income

20.6.1 All gifts, donations and proceeds of fund raising activities that are intended for the Charity's use shall be handed immediately to the Director of Finance to be banked directly.

20.6.2 All gifts and donations shall be received and held in the name of the Charity and administered in accordance with the Charitable Funds Policy, subject to the specific objects for any restricted or designated funds.

20.6.3 Where it becomes necessary for the Charity to obtain a grant of representation in order to obtain a legacy due to the Charity under the terms of a will, the Director of Finance shall be the Trust's nominee for this purpose. Where appropriate, the Director of Finance shall seek legal advice upon the liabilities and other implications for the Charity of obtaining any such grant of representation.

20.6.4 All employees of the Trust who receive enquiries regarding legacies, shall

keep the Director of Finance informed and shall keep an appropriate record. After the death of a benefactor, all correspondence concerning a legacy shall be dealt with by the Director of Finance who will be solely responsible for legally acknowledging receipt of such monies on behalf of the Charity.

20.6.5 The Director of Finance shall advise the Corporate Trustee on the financial implications of any proposal for fund raising activities that the Charity may initiate, sponsor or approve.

20.7 Terms of Service and Payment of Staff

20.7.1 Any staff working directly on behalf of the Charity will not be directly employed by the Charity. They will be employed by the Trust in accordance with the requirements of Chapter 9 above and their pay costs recharged to the Charity.

20.7.2 Any associated non-pay costs associated with their employment with the Trust will be similarly recharged to the Charity.

20.7.3 Any non-recurrent restructuring costs e.g. redundancy costs, etc. incurred by the Trust associated with staff working directly on behalf of the Charity will be similarly recharged.

20.7.4 The Director of Finance will ensure that sufficient funds are available within the Charity to be able to absorb any such costs so recharged.

20.8 Expenditure

20.8.1 All expenditure from funds held on trust, with the exception of legitimate expenses for management and administration, must be in accordance with the specific objects for individual funds, as appropriate.

20.8.2 Expenditure must not result in further commitments and or liabilities for either the Charity or the Trust unless these have been fully identified and adequately funded.

20.9 Investments

20.9.1 In order to discharge its duties as Corporate Trustee the Charity must:

(a) Know and understand its investment powers.

(b) Discharge its duties properly when it takes decisions on investments.

(c) Have proper arrangements in place for holding investments on behalf of the Charity.

(d) Follow legal requirements if it is going to use someone to manage investments on its behalf.

(e) Know what it can and cannot do if it is going to apply an ethical

approach to investments.

(f) Seek professional external advice where appropriate.

20.9.2 These duties should be undertaken in accordance with a clearly defined investment strategy for the Charity, which is kept under regular review.

20.9.3 The Corporate Trustee may choose to adopt one of several approaches to investment management - advisory, discretionary or collective – and seek appropriate advice in arriving at that decision.

20.9.4 All investment decisions must be formally reported to both the Charitable Funds Committee and the Corporate Trustee. For the latter, presentation of the minutes from the previous meeting of the Charitable Funds Committee will be sufficient.

20.10 Capital Expenditure

20.10.1 Other than in exceptional circumstances and agreed by the Corporate Trustee, any capital investment incurred by the Charity will be directly for the benefit of the Trust rather than the Charity itself and hence, will be accounted for as assets on the balance sheet of the Trust and not the Charity.

20.11 Reserves

20.11.1 The Corporate Trustee is responsible for determining a policy on reserves in accordance with Statements of Recommended Practice issued by the Charity Commission.

20.11.2 This requires the Corporate Trustee to include in the Charity's annual report information about its reserves policy and the level of reserves held. In particular, the Corporate Trustee should:

(a) Describe its reserves policy.

(b) Explain why it holds or does not hold reserves.

(c) Quantify and explain the purpose of any material restricted, designated or endowment funds and, where set aside for future expenditure, the likely timing of that expenditure.

(d) Give the level of reserves at the last day of the financial year to which the report relates.

Scheme of Delegation – Appendices 1 to 10

APPENDIX 1: LIST OF DIVISIONS[1]

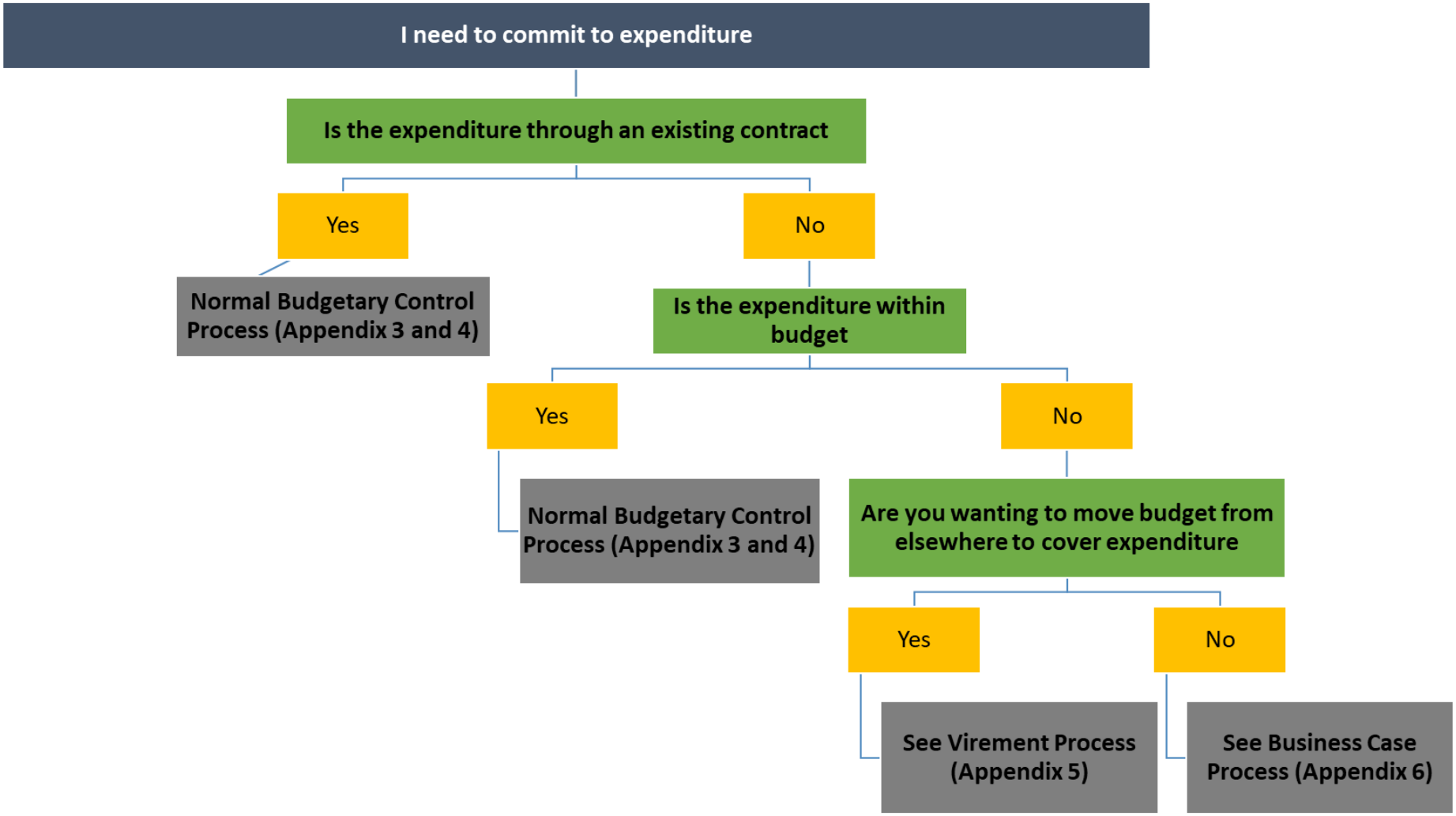
A : Acute Medicine
B : Surgery
C : Family Health
D : Clinical Support
E : Deputy Chief Executive
F : Company Secretary
G : Director of Finance
H : Chief Operating Officer
I : Income[1]
J : Medical Director
K : Chief Nurse
L : Director of People
M : Emergency Care
N : Chief Executive
O : Community Medicine
Z : Central Income & Costs[2]

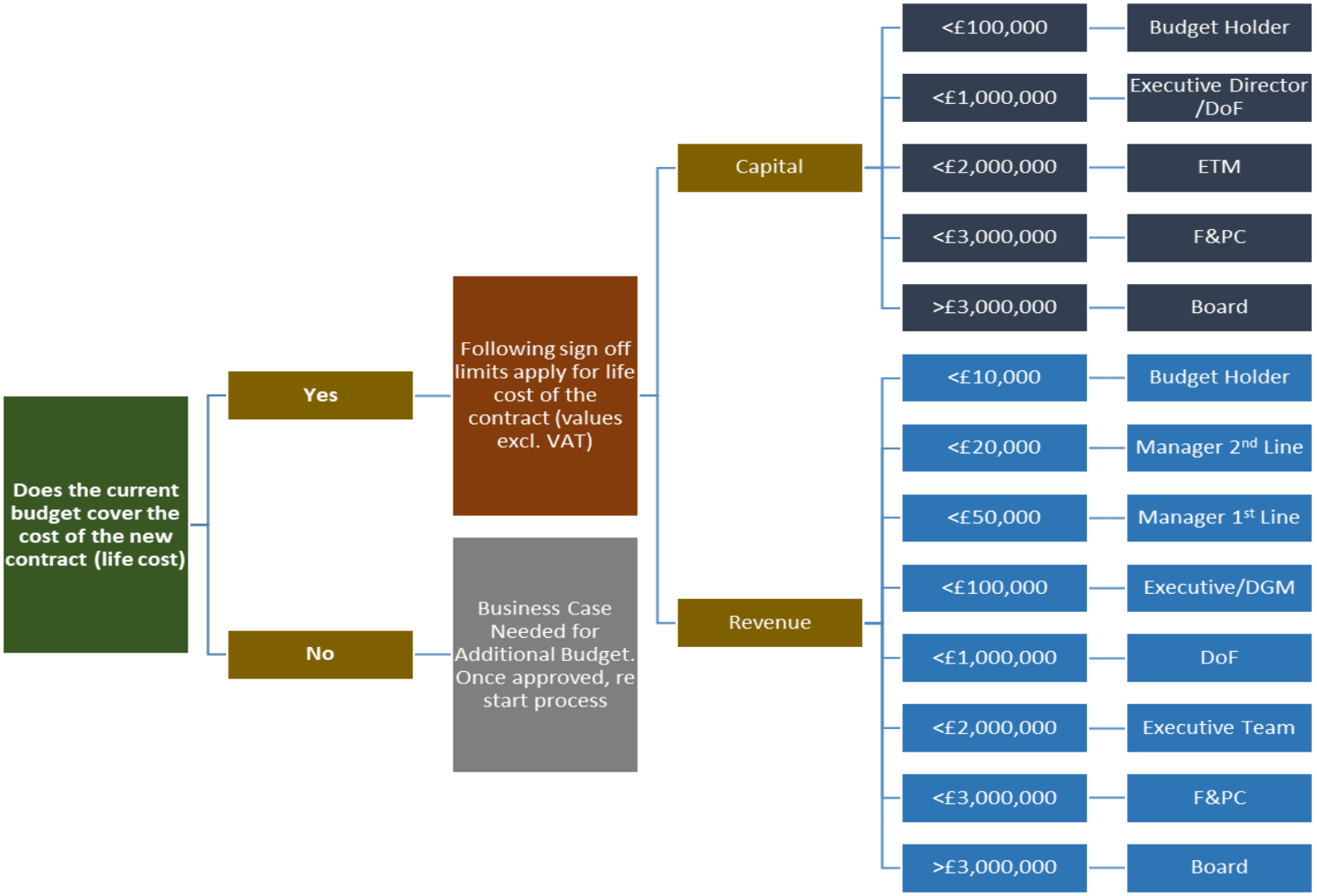
1. A Division will consist of:

   - Several cost centres that constitute a Service Unit;
   - Several service units that constitute a Management Team;
   - Several management teams that constitute a Division.
   - The sum of divisions constitutes the Trust.

2. These are managed by the Director of Finance on behalf of the Board.

APPENDIX 2: OVERVIEW OF BUDGET DELEGATION WITHIN THE BUDGETARY CONTROL PROCESS




Does the current budget cover the cost of the new contract (life cost)
Yes
No
Following sign off limits apply for life cost of the contract (values excl. VAT)
Business Case Needed for Additional Budget. Once approved, re start process
Capital
Revenue
<£100,000
Budget Holder
<£1,000,000
Executive Director /DoF
<£2,000,000
ETM
<£3,000,000
F&PC
>£3,000,000
Board
<£10,000
Budget Holder
<£20,000
Manager 2nd Line
<£50,000
Manager 1st Line
<£100,000
Executive/DGM
<£1,000,000
DoF
<£2,000,000
Executive Team
<£3,000,000
F&PC
>£3,000,000
Board

APPENDIX 3: BUDGET DELEGATION AND FINANCIAL LIMITS FOR AUTHORISED SIGNATORIES - REVENUE FUNDS

Standing Financial Instruction 4.4.1 allows the Chief Executive to delegate management of a budget to permit the performance of a defined range of activities. This appendix details the budgets so delegated on the understanding that the requirements of Standing Financial Instructions 4.4.2, 4.4.3, 4.4.5, 4.4.6, 4 . 5 . 2 , 10.2.1, 10.2.4 and 10.2.7 will be strictly adhered to.

The budgets delegated include generic subjective (income, pay and non-pay) headings referenced to the objective (cost centre) headings identified for each Service Unit and Division. The generic headings are consistent with those contained in the Trust's annual accounts as defined in the Department of Health & Social Care's Group Accounting Manual, whilst the objective headings reflect the Trust's internal management and budgetary reporting structure.

The extent of delegation to budget holders will be reviewed annually by the Chief Executive and approved by the Board.

Within these budgets, the following transactional financial limits apply:

Authorised	Limit (£)[1]
Budget Holder (Maximum of two per cost centre)	£5,000
Manager 2nd in line to an Executive or Divisional General Manager	£20,000
Manager 1st in line to an Executive or Divisional General Manager	£50,000
Executive/Divisional General Manager & Deputy Director of Finance	£100,000
Director of Finance[2,3,4]	£1,000,000
Executive Team[2,3,4]	£2,000,000
Finance & Performance Commitee[2,3,4]	£3,000,000
Board[2,3,4]	No limit

1. Figures exclude VAT.
2. For the approval of procurement contracts before being ordered as in 3 or 4 below.
3. Transactions that need to be physically signed will be done so by the Director of Finance and/or Chief Executive.
4. Transactions that need to be approved electronically will be done so by the Deputy Director of Finance or the Director of Finance.

A detailed organisational structure populated with named authorised signatories is maintained and available on the Trust's intranet.

Some cost centres may have additional requisition points attached to them, which are not shown here. If there is any confusion about cost centres and/or requisition points please contact the Financial Management section of the Finance Department.

Cost centres may be added to the above list during the financial year to which these Standing Financial Instructions and Scheme of Delegation apply. This can only be done with the prior approval of the Director of Finance.

Responsibility for such new cost centres will be delegated to the appropriate budget holder referred to above and will be subject to the same transactional financial limits referred to above and subsequently included on the organisational structure available on the Trust's intranet.

The budget allocated to each cost centre will be consistent with the annual financial plan approved by the Board, updated for any in year changes approved by the Director of Finance, Executive Team or the Board. The total adjusted budget available will be shown in monthly budget statements issued by the Director of Finance and the monthly finance reports to Finance & Performance Committee and the Board.

Initial base budgets produced as part of the annual business plan must be signed-off at divisional or Executive Director level.

APPENDIX 4: BUDGET DELEGATION AND FINANCIAL LIMITS FOR AUTHORISED SIGNATORIES - CAPITAL FUNDS

Standing Financial Instruction 13.1.5 authorises the Chief Executive to issue a scheme of delegation for capital investment management. This appendix details the budgets so delegated on the understanding that the requirements of Standing Financial Instructions 4.4.2, 4.4.3, 4.4.5, 4.4.6, 4.5.2, 10.2.1, 10.2.4 and 10.2.7 will be strictly adhered to.

The budgets delegated include generic subjective (pay and non-pay) headings referenced to the objective (cost centre) headings identified for each Scheme Manager. The generic headings are consistent with those contained in the Trust's annual accounts as defined in the Department of Health & Social Care's Group Accounting Manual, whilst the objective headings reflect the Trust's internal management and budgetary reporting structure.

The extent of delegation to budget holders will be reviewed annually by the Chief Executive and approved by the Board.

Within these budgets, the following transactional financial limits apply:

Authorised	Limit (£)[1]
Budget Holder	£100,000
Project Director/Executive Director	£1,000,000
Director of Finance[2,3,4]	£1,000,000
Executive Team[2,3,4]	£2,000,000
Finance & Performance Committee[2,3,4]	£3,000,000
Board[2,3,4]	No limit

1. Figures exclude VAT.
2. For the approval of procurement contracts before being ordered as in 3 or 4 below.
3. Transactions that need to be physically signed will be done so by the Director of Finance and/or Chief Executive.
4. Transactions that need to be approved electronically will be done so by the Deputy Director of Finance or the Director of Finance.

A detailed organisational structure populated with named authorised signatories is maintained and available on the Trust's intranet.

Cost centres may be added to the above list during the financial year to which these Standing Financial Instructions and Scheme of Delegation apply. This can only be done with the prior approval of the Director of Finance.

Responsibility for such new cost centres will be delegated to the appropriate budget holder referred to above and will be subject to the same transactional financial limits referred to above and subsequently included on the organisational structure available on the Trust's intranet.

The budget allocated to each cost centre will be consistent with the annual business

plan approved by the Board, updated for any in year changes approved by the Director of Finance, the Executive Team or the Board. The total adjusted budget available will be shown in monthly budget statements issued by the Director of Finance and the monthly finance reports to Finance & Performance Committee and Board.

Due to the nature of certain capital schemes that necessarily involve expenditure on building work, engineering work and/or professional fees, the Director of Estates & Facilities is authorised to commit expenditure on behalf of the budget holder.

Additionally, where services are subject to potential VAT recovery, the Director of Finance, via the Head of Financial Services will be necessarily involved in committing professional fees to identify the extent of such VAT.

Any queries regarding the budget available for any particular capital scheme should be addressed to the Deputy Director of Finance or the Head of Financial Services.

APPENDIX 5: VIREMENT RULES AND FINANCIAL LIMITS

This appendix sets down the powers of virement available, both recurrently and non-recurrently, in accordance with Paragraphs 4.2.1 and 4.4.3.

Recurrent Revenue Virement

Budget holders are authorised to vire recurrent savings and under-spends from one budget heading to offset or reduce an existing recurrent overspend on another budget heading. Thus, the impact upon the total budget will be neutral, which will be confirmed by the Director of Finance as part of the monthly budgetary control process.

Recurrent savings and under-spends cannot be utilised to develop new recurrent initiatives.

Recurrent savings or under-spends of a significant nature, as determined by the Director of Finance in discussion with the appropriate Finance Manager, must be identified and transacted as a cost improvement plan or alternatively declared to the Director of Finance for discussion about their potential use.

Non-Recurrent Revenue Virement

Non-recurrent savings or under-spends of a significant nature, as determined by the Director of Finance in discussion with the appropriate Finance Manager, must be declared to the Director of Finance for discussion about their potential use. What this means in reality is that such a saving or under-spend occurring year to date cannot be used to commit unbudgeted expenditure in a future period, unless formally approved by the relevant Executive Director, Divisional General Manager or Deputy Director of Finance (i.e. £100,000 authorised signatory as per Appendix 3). This must be in accordance with an agreed procedure for exceptional spend requests, as approved by the Director of Finance. The maximum value for individual exceptional spend requests must not exceed £5,000 plus VAT, otherwise it will need formal approval of the Executive Team in accordance with the latest Business Case Process and Guidance document.

Non-Recurrent Capital Virement

Capital scheme bids must have robust estimates prepared before funding can be allocated. This must give a clear indication of the split between the cost of works (i.e. building and engineering costs, inclusive of any professional fees) and the cost of equipment. For information technology schemes, this is likely to be split between implementation costs and the cost of equipment and intangible purchases. Any savings or under-spends on either of these two elements within a capital scheme in each case cannot be used for virement between each other unless this is necessary to:

(a) Maintain the overall scheme cost within the total scheme budget allocated;

(b) Maintain the total cost of schemes within a total portfolio budget allocated;

and is

(c) Formally approved in accordance with the limits detailed below.

Otherwise, their impact must be declared as part of year-end out-turn forecasts reported to the Board.

In this instance, a portfolio budget is considered to be the budget allocated across several schemes being managed collectively but individually by the Director of Estates & Facilities and the Director of Health Informatics.

Where a capital scheme is constituted entirely by cost of works or entirely by equipment costs, the budget must be used to fund only those items included within the original estimate. Any savings or under-spends generated from the actual costing of the original specifications cannot be used to enhance the nature of the scheme without prior approval of the Executive Team, Finance & Performance Committee or the Board in accordance with authorisation limits contained in Appendix 6. This equally applies to information technology and any other schemes per se.

Capital virement is subject to the following limits:

(a) Virement of up to 5% of the total scheme costs, up to a maximum of £50,000 is allowed at the discretion of the budget holder without any prior approval.

(b) Virement of between 5% and 10% of the total scheme costs, up to a maximum of £100,000 must be approved by the Director of Finance.

(c) Virement in excess of 10% or £100,000 of the total scheme costs, whichever is the lower must be approved by the Executive Team or the Board in accordance with authorisation limits contained in Appendix 6.

For example:

(a) Scheme Cost £200,000

- Maximum virement approved by the budget holder is 5% i.e. £10,000.
- Maximum virement approved by the Director of Finance is a further 5% i.e. £10,000 giving a total of £20,000.
- Any virement above £20,000 must be approved by the Executive Team in accordance with authorisation limits contained in Appendix 6.

(b) Scheme Cost £1,000,000

- Maximum virement approved by the budget holder is 5% i.e. £50,000.
- Maximum virement approved by the Director of Finance is a further 5% i.e. £50,000 giving a total of £100,000.
- Any virement above £100,000 must be approved by the Executive Team, Finance & Performance Committee or the Board in accordance with authorisation limits contained in Appendix 6.

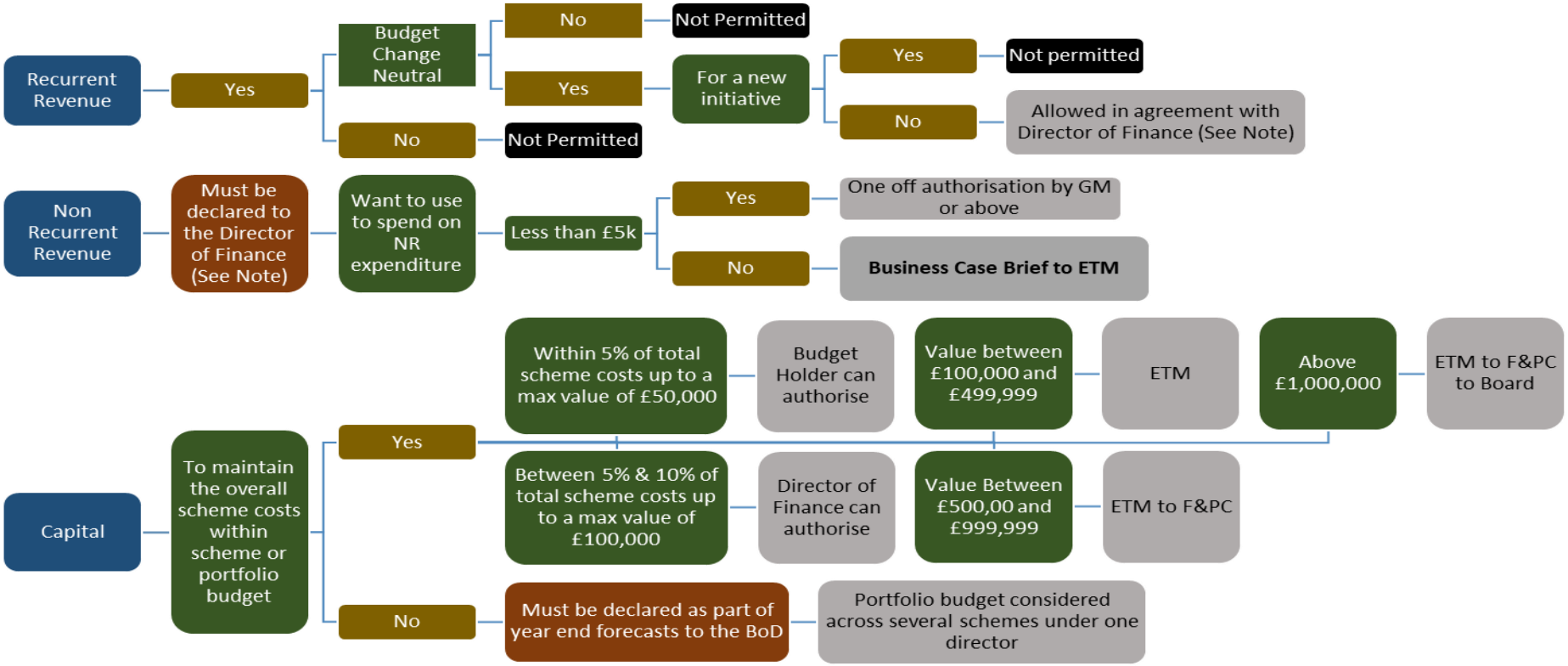
(c) Scheme Cost £2,000,000

- Maximum virement approved by the budget holder is 2.5% i.e. £50,000.
- Maximum virement approved by the Director of Finance is a further 2.5% i.e. £50,000 giving a total of £100,000.
- Any virement above £100,000 must be approved by the Executive Team, Finance & Performance Committee or the Board in accordance with authorisation limits contained in Appendix 6.

Any savings or under-spends on one capital scheme cannot be used for virement to fund additional expenditure on another capital scheme without approval of the Executive Team, Finance & Performance Committee or the Board in accordance with authorisation limits contained in Appendix 6.

Capital virement that does not need formal approval of the Executive Team will be managed and controlled via the Capital Monitoring Group.

OVERVIEW OF VIREMENT RULES AND FINANCIAL LIMITS



Note: Reference to the Director of Finance is implicit rather than explicit, by acceptance/recognition of the monthly out-turn results reported through the budgetary control process.

APPENDIX 6: FINANCIAL LIMITS FOR IN YEAR CHANGES TO BUDGETS

In accordance with paragraph 4.2.1 with the exception of budget transfers and virement (see Appendix 5), there will be no changes to budgets in year unless duly authorised. Only expenditure that has already been budgeted for can be committed by budget holders and in accordance with their delegated spending limits.

The only corporate bodies with the authority to commit additional (net) expenditure on behalf of the Trust and their authorisation limits are detailed below:

Authority	**Limit (£)[1,2,3]**
Director of Finance and Deputy Chief Executive (Via Executive Team)[4]	<£250,000
Chief Executive (Via Executive Team)[4]	£250,000 & <£500,000
Finance & Performance Committee	£500,000 & <£1,000,000
Board	£1,000,000 & above

1. Figures exclude VAT.
2. Figures apply to a mix of annual recurrent and total non-recurrent transactions.
3. Figures are applied gross to income or expenditure, whichever is the greater.
4. By exception and entirely at their discretion, if authority is given in between Executive Team meetings, with such decisions being formally minuted at the next meeting of the Executive Team. Normally authority would be expected to be given following discussion at the appropriate meeting of the Executive Team and formally minuted as part of the record for that meeting.

No other committee or group has authority to commit additional expenditure on behalf of the Trust.

It would normally be expected that any business case would be scrutinised by all levels of authority relative to the financial limit involved. For example:

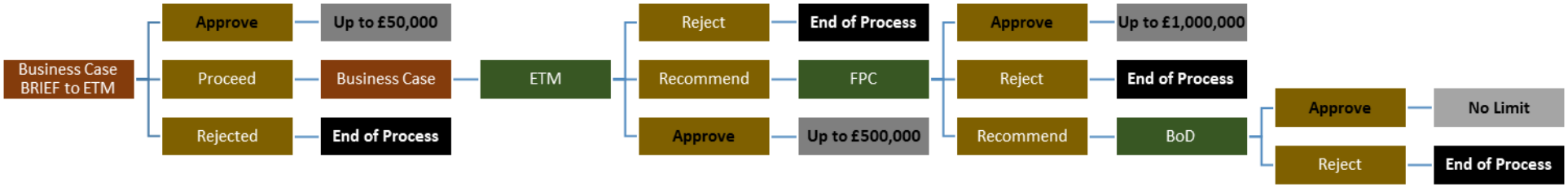
(a) A business case that requires £200,000 recurrent investment can be approved by the Director of Finance or the Deputy Chief Executive following a paper presented to the Executive Team meeting.

(b) A business case that requires £300,000 recurrent investment and £250,000 non-recurrent investment to support its implementation would need to be approved by both the Executive Team and Finance & Performance Committee.

(c) A business case for capital replacement of a significant piece of medical equipment costing £1,200,000 would need to be approved by the Executive Team, Finance & Performance Committee and Board.

These limits equally apply to the virement rules contained in Appendix 5, as appropriate, income generation schemes and discontinuation of, or disinvestment in a service or operation, as referred to in paragraphs 7.2.4 and 7.2.5.

All business cases will need to be produced following the latest Business Case Process and Guidance document.



These limits are then subject to further approval externally as follows:

Where a NHS Foundation Trust is deemed to be in financial distress, as formally determined by NHS England:

Authority	**Limit (£)[1,2]**
Board	Up to £25,000,000
NHS England and DHSC Joint Investment Sub-Committee (JISC)	£25,000,001 & £30,000,000
NHS England and DHSC Joint Investment Sub-Committee (JISC)	£30,000,001 & £50,000,000
NHS England and DHSC Joint Investment Committee (JIC) and HM Treasury[3]	Above £50,000,000

1. Figures **include** VAT.
2. Figures apply to capital investment and property transactions (non-digital) and digital (self-funded), asset disposal and whole-life cost business cases.
3. Business cases exceeding £50,000,000 either capital cost or whole-life costs, will require approval from NHS England and DHSC Joint Investment Committee and HM Treasury, except for Electronic Patient Records funded by the central frontline digitisation capital.
4. In all cases the Trust should follow guidance contained in NHS England's publication "Capital Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts" published in February 2023.

APPENDIX 7: FINANCIAL LIMITS FOR PETTY CASH

In accordance with Paragraph 10.5.1, the delegated transactional financial limits for petty cash are detailed below:

Description	Limit (£)[1]
Return of patients' cash	Up to the amount of cash deposited for safe-keeping
Payment of patients' fares or funeral expenses for which the Trust is liable	Up to the amount of fares paid or funeral expense
All other petty cash payments	£100
1. Figures exclude VAT.	

Petty cash shall not under any circumstances be used for the encashment of private cheques.

APPENDIX 8: PROCUREMENT PROCESS QUOTATION AND TENDER FINANCIAL LIMITS

Goods and Services

Procedure	Limit (£)[1]
Obtain best value.	<£10,000
If no contract exists, obtain a minimum of 3 written quotations.	£10,000 & <£35,000
Formal tendering via the Procurement Department. Advice will be given on the process to be followed.	£35,000 & <OJEU Threshold Limit[2]
Formal tendering complying with OJEU requirements to be undertaken by the Procurement Department. If insufficient tenders are received, a further procurement exercise may be necessary.	>OJEU Threshold Limit
Procure via the use of the Trust's measured term contract or OJEU tender.	Works <£200,000
Formal tendering via the Procurement Department. Advice will be given on the process to be followed.	Works >£200,000

1. Figures exclude VAT.
2. Official Journal of the European Union. Guidance on financial thresholds for different categories of expenditure is available from the Procurement Department.

Works

Limit (Total Contract Value) Works [1]	Procedure
<£50K	No quotation process: • Obtain best value
>£50K-£200K	Informal quotes: • Minimum of 3 informal quotes • Price only or cost/quality/social value evaluation • E-tendering portal not mandatory but can be used • All quotes must be submitted with the requisition • Most advantageous quote will be successful **OR** (up to £100k) Direct appointment via Measured Term Contract (MTC) if appropriate
>£200K – Find a tender (was OJEU[2])	Formal quotes: • Minimum of 3 formal quotes • One local quote where possible[3] • Cost/quality/social value evaluation • E-tendering portal mandatory; advertising optional • Most advantageous quote will be successful

Find a tender (was OJEU[2])	• E-tendering portal mandatory • Advertise on relevant portals • Cost/quality/social value evaluation • Most advantageous tender will be successful

Notes:

1. Excluding VAT.
2. Currently £5,336,937 inclusive of VAT at the prevailing rate.
3. Local to be defined as a base within South Yorkshire & Bassetlaw or with an "S/DN" post code.

Waiving of quotation and tender requirements in accordance with Paragraph 11.5 require authorisation in accordance with the financial limits detailed below:

Authority	**Limit (£)[1]**
Head of Procurement	< £50,000
Director of Finance or Chief Executive	£50,000 & <£100,000
Director of Finance and Chief Executive acting jointly	£100,000 & <£250,000
Chairman/Board	Above £250,0000
1. Figures exclude VAT.	

APPENDIX 9: FINANCIAL LIMITS FOR LOSSES AND SPECIAL PAYMENTS

Authority	Limit (£)[1]
Budget holder	< £250
Director of Finance and Deputy Director of Finance acting jointly	£250 & <£1,000
Audit Committee	£1,000 & <£10,000
Board	Above £10,000
1. Figures exclude VAT.	

These delegated spending limits only apply to the specific circumstances outlined below.

Delegated limits excluding losses and special payments in category 5 (Compensation under court order or legally binding arbitration award) and also payments relating to clinical negligence and personal injury claims within category 7 (Special severance payments).

Budget holders have authority to write-off losses and approve special payments that occur within their area of responsibility, up to a value of £250 per item. These must be approved by an appropriate authorised signatory as designated within the Trust's scheme of delegation and be forwarded to the Director of Finance for action.

All items between £250 and £1,000 will be considered jointly by the Director of Finance and Deputy Director of Finance.

All items with a value in excess of £1,000 must have completed a checklist, as appropriate, in a format prescribed by and prepared by the Director of Finance. To avoid delays in making payments to third parties, approval of losses can be agreed jointly by two executive directors, one of which must be the Director of Finance. All such approvals will be reported through to, and formally ratified by, Audit Committee or the Board at its next available meeting.

Delegated limits and procedures for Category 5 payments and payments in respect of clinical negligence and personal injury claims within Category 7.

Where preliminary analysis concludes that the claim is thought to be valid, approval will be sought to settle. For all claims, including all clinical negligence cases, the Medical Director will notify NHS Resolution in accordance with the Trust's Claims Handling Policy. The Trust will only be liable for any amount up to its agreed level of excess.

APPENDIX 10: AUTHORISATION OF EXPENDITURE AND TRANSACTIONAL FINANCIAL LIMITS - TRUST FUNDS

In accordance with Paragraph 20.3.2 the following financial limits apply for the authorisation of expenditure from funds held on trust.

Authority[1]	Limit (£)[2]
Head of Fundraising	<£5,000
Any Trustee acting individually	£5,000 & <£10,000
2 x Trustee's acting jointly	£10,000 & <£25,000
Charitable Funds Committee	£25,000 & <£50,000
Corporate Trustee	No limit
1. Due to timing issues, if it is not practical to defer a decision until the next meeting of the Charitable Funds Committee, approval can be given as indicated and then reported to the next meeting of the said Committee. 2. Figures exclude VAT.	

Once expenditure has been authorised, official orders can then be raised or invoices approved by any of the following authorised signatories:

Head of Fundraising
Executive Director (Excluding the Director of Finance to maintain separation of duties)
Deputy Director of Finance
Head of Financial Services
Assistant Head of Financial Services

Other expenditure will be necessarily incurred within funds held on trust, whether this is actual cash transactions or non-cash accounting entries.

Cash transactions may include:

(a) Staff and associated non-pay recharges, which will have been previously agreed by the Charitable Funds Committee.

(b) Audit fees, both internal and external, prospectively agreed as necessary by the Corporate Trustee.

(c) Investment brokers fees, as advised by the Charity's appointed investment advisor.

(d) Management costs/overheads, recharged from the Finance Department.

(e) Bank charges.

(f) Realised gains and losses on disposal of investments, as advised by the Charity's appointed investment advisor.

Non-cash transactions may include:

(a) Depreciation on any fixed assets held.

(b) Unrealised gains and losses on disposal of investments, as advised by the Charity's appointed investment advisors.

All such transactions must be authorised and/or actioned by one of the following authorised signatories.

Deputy Director of Finance
Head of Financial Services
Assistant Head of Financial Services

APPENDIX 11: LIST OF REFERENCES

Internal

- Business Case Process and Guidance (August 2022)
- Counter Fraud, Bribery and Corruption Policy (Reference number 588)
- Annual Report and Accounts (Trust-wide document)
- Claims Handling Policy (Reference number 219)
- Constitution of The Rotherham NHS Foundation Trust (Approved by the Council of Governors)
- Governance and Compliance Framework (Finance document)
- Losses and Special Payments Register (Finance document)
- Matters Reserved to the Board (Approved by the Board of Directors in December 2018 - available by contacting the Trust's Company Secretary)
- Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy) (Reference number 370)
- Incident and Serious Incident Management Policy (Reference number 25)
- Risk Management Policy (Reference number 609)
- Scheme of Delegation (Appendices 1 to 10 within Standing Financial Instructions)
- Security Policy (Reference number 27)
- Standards of Business Conduct (including NHS England Conflicts of Interest Guidance) (Version 11 approved by the Board of Directors in November 2021)
- Standing Orders (for the regulation of proceedings and business of the Board of Directors) (Approved by the Board of Directors in November 2021 – available by contacting the Trust's Company Secretary)
- Treasury Management Policy (Reference number 160)

External

- Administration of Estates (Small Payments) Act 1965
- Capital Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts (February 2023 – NHS England)
- Charities SORP (FRS102) - Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland. Code of Audit Practice (April 2020 – National Audit Office)
- Contracts Finder (government web page)
- Data Protection Act 2018
- Directive 2004/18/EC of the European Parliament and of the Council
- Government Functional Standard (GovS 013: Counter Fraud) Management of Counter Fraud, Bribery and Corruption Activity (August 2021– Counter Fraud Centre of Expertise, part of the Cabinet Office)
- NHS England's NHS foundation trust annual reporting manual 2022/23
- Group Accounting Manual (Updated annually - Department of Health & Social Care)

- The Health and Social Care Act 2012, as amended by the Health and Care Act 2022
- Health Building Note 00-08
- Off Payroll Working (IR35): Deemed employer responsibilities under off-payroll working rules
- International Financial Reporting Standards (IFRS)
- NHS Counter Fraud Manual (Available via the NHS Counter Fraud Authority Application Access Portal with appropriate username and password access)
- The National Health Service Act 2006
- NHS Foundation Trust Accounting Officer Memorandum (August 2015 Monitor)
- Code of governance for NHS provider Trusts (Applicable from April 2023 – NHS England)
- NHS Internal Audit Standards (April 2011 – Department of Health & Social Care)
- Official Journal of the European Union (Official gazette of record for the European Union)
- Public Sector Internal Audit Standards (March 2017 – Chartered Institute of Public Finance and Accountancy and the Institute of Internal Auditors)
- The Records Management Code of Practice for Health and Social Care 2021 (updated August 2023) (NHS England)
- Risk Assessment Framework and reporting manual for Independent Sector providers of NHS services (July 2023 – NHS England)
- Assuring and supporting complex change – Statutory transactions, including mergers and requisitions (NHS England)
- Who Pays? Determining which NHS commissioner is responsible for making payment to a provider (June2022 – NHS England)

Executive Team Meeting
3rd November 2023

Agenda item	P162/23
Report	**Strategy Delivery Plan – Year 1 update**
Executive Lead	Louise Tuckett, Director of Strategy, Planning & Performance
Link with the BAF	P1, R2, O3, U4, D5, D6,
How does this paper support Trust Values	This paper sets out the first year of our delivery against the Trust's Strategy, which has at its heart the Trust values of *Ambitious, Caring, Together.*
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	The Trust's Five Year Strategy *'Our New Journey, Together, 2022-2027'* was approved early in 2022, ready for implementation from April 2022. Behind the strategic vision sat a number of clear deliverables within our agreed Strategy Delivery Plan, aligned with our five strategic ambitions and designed to ensure the strategy delivers real change for our organisation. These deliverables were separated into three time horizons – year 1, years 2-3 and years 4-5. This paper provides the Board of Directors with a written update on our progress to deliver the years 2-3 programmes of work for the most recent 6-month period, which is the first six months of that time horizon. Whilst we have not formally published the Strategy Delivery Plan, we are using it at Board level to guide how the strategy needs to feed into our annual planning, and to ensure we are making pragmatic changes to ways of working which ensure implementation of our Trust Strategy. At this stage there are no risks requiring escalation around the implementation of our Delivery Plan, given the recognition that plans across a five-year time horizon will need to be flexible and adaptable to respond to emerging issues and the changing landscape we are operating within.
Due Diligence	The Executive Team have received this written report in advance of the Board of Directors.

Board powers to make this decision	In order to be assured of the delivery of the Trust Strategy, the Board agreed that it was appropriate to receive a bi-annual update on our implementation to date.
Who, What and When	The Director of Strategy, Planning and Performance is responsible for helping to drive the delivery of the strategy throughout the organisation, with the Board of Directors overseeing implementation.
Recommendations	It is recommended that the Board of Directors note the Trust's progress over the last six months to drive forward the Year 2-3 initiatives contained within the Strategy Delivery Plan.
Appendices	

OUR NEW JOURNEY, TOGETHER
STRATEGY DELIVERY PLAN
UPDATE TO BOARD OF DIRECTORS: NOVEMBER 2023

1.0. Background

The Trust launched its new strategy 'Our new journey, together 2022-2027' in early 2022. As part of this launch a delivery plan was produced and presented to the Board of Directors in February 2022. This delivery plan outlined some of the key projects and initiatives that would be delivered to support the implementation of the ambitions outlined within the Strategy. In order for the Board to be assured on delivery against our original plan, it was agreed to provide six-monthly updates to the Board on progress against the delivery plan objectives. Equally, the Board of Directors recognised that there is a need to be flexible and adapt the set of projects over the five year time horizon in order to reflect the changing landscape we are operating in, with these emerging areas of focus being discussed as part of the regular updates.

The first update in November 2022 was delivered via a report and a video which outlined the progress we had been making, with subsequent updates provided in a more traditional format in order to increase the level of assurance being provided. This report provides the board with a update on progress which has been made over the most recent 6 months as we've moved into year 2 of the Strategy delivery plan.

2.0. Progress to date

It is important to note that when it was first developed, the delivery plan was split into three time periods - Year 1, Year 2-3 and Year 4-5. This reflected the increased level of uncertainty as to what initiatives would be our priorities in the later years, as well as reduced confidence over deliverability of some of the longer-term projects in those future time horizons.

This report outlines the progress for the first six months against the initial year 2-3 objectives. As explained above, it is worth noting that some objectives have changed focus which reflects the increased uncertainty when developing a plan two years out, particularly given the rate and level of change (and challenge) the NHS has been managing over the last few years. Equally, some of our strategic activities have been able to move at a faster pace than originally anticipated, and likewise some new initiatives have had to be delivered following changes to national policy or internal developments which weren't envisaged two years ago. Two such examples would be

the upcoming expansion of patient choice requirements and the need for providers to drive this through the Patient-Initiated Digital Mutual Aid System, and also our internal focus on health inequalities and reducing DNA rates of patients from more deprived areas.

The below report is structured into the five strategic ambitions set out in *'Our new journey, together'.* Initiatives have intentionally not been RAG rated at this point to reflect the fact this is an update on the first six months of progress against these two-year deliverables. A more formal assurance rating against each will be provided at the one-year report due in May 2024.

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

Initiative	Progress
Develop a digital tool to allow patients to feed back after every outpatient interaction	The Trust has built a digital feedback tool and is currently trialling it within UECC as part of the Acute Care Transformation programme with initial feedback being positive. Plans to roll out the use of this 'survey tool' into our outpatient settings are now being developed. This work will in part be informed by feedback from several of our recent digital interaction schemes, including the digital validation programme and the upcoming launch of the Patient Initiated Digital Mutual Aid System.
Embed Improvement and Innovation Week to support trialling of new practices	The Trust has appointed to the role of Head of QI and has recently approved an expansion of this QI team. This team will continue to support the organisation in developing innovation and improvement, working with the delivery and improvement team over the next 12-18 months.
Update our patient-facing information about our services	The Trust has updated our website to the consistent NHS format, and within this we have included a number of new sections designed to provide patients with clear information about our services and support available to them, particularly whilst they are waiting

	for elective care. A number of new patient-facing videos have been designed to ensure patients are clear what to expect when they come to hospital for certain procedures. In addition, the developments that we have implemented within Patient Hub and the Rotherham Health App also now give patients direct electronic access to relevant information about their care, and we are hoping to be able to develop this even further to include explanatory videos for patients coming in for particular planned diagnostics and procedures. Earlier in 2023, the Trust invested in a trial of EIDO information (a standardised set of patient-facing clinical information) which is pre-existing and accessible and ensures consistent and appropriate information is being shared with our patients. The Trust has also developed and printed bedside folders on all wards, to bring all patient admission information together in a single place. These are also available in the top 5 local languages and is on our website for easy read.
Implement full remote monitoring of patients where appropriate	Remote monitoring technology is due to be a key part of the wider rollout of our virtual ward model. However, the procurement is being done at ICB level and has been delayed due to a number of factors. This is expected to be resolved during the second half of the year, so increased remote monitoring of patients will be possible during 2024/25. Beyond virtual ward however, there are further opportunities to use remote monitoring of patients which will continue to be explored at service and pathway level.

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.

Initiative	Progress
Install more electric car charging points on the hospital site	An initial set of electric car charging points have been installed on the Trust's main site. The focus is now on the Trust's other sites, with a survey having being undertaken at Woodside and NHS Property Services reviewing the possibility of installing chargers at our community sites including Breathing Space. Further expansion on the main site will form part of the wider discussion on car parking which is one of the key questions needing answering from the recently-approved Estates Strategy.
Sign up to the Social Value Portal	The Trust procurement team is fully engaged with the ICB and Rotherham Place social value work regarding procurement. The Trust are also developing a Social Value Power BI report which shows where we are procuring our services from (i.e. locally, regionally). The Trust is signed up to the Social Value Portal for contracts which it has recently bid for (for example the recent sexual health services tender).
Roll out our QUIT programme to outpatient services	The QUIT programme has been rolled out into Outpatients on an opt-in basis with teams able to refer patients to the QUIT team for smoking cessation support via Meditech. 10 Smoke Free Champions have been confirmed across our Outpatient areas and targeted work is planned with the Stroke Team in November as this is an area of high opportunity given the patient population this team support.

Ensure that relevant jobs are advertised locally and re-instate Trust Open Days	The Trust is now holding Trust-wide Healthcare Support Worker recruitment events every other month in order to generate interest for potential roles within the Trust from our local communities. These roles offer an entry into the organisation for people wishing to find a career in healthcare who aren't keen to pursue formal clinical qualifications before starting work. The recruitment team are also working with Department for Work and Pensions around plans for the team to support Job Seekers in the near future to discuss vacancies and how they can access and use NHS Jobs. The Kickstart Programme - which the Trust participated in in 2021/22 – demonstrated how positive these opportunities can be for offering individuals a route into healthcare where they might otherwise not have found one.
Utilise predictive tools to enhance clinical prioritisation decision-making of patients most likely to come to harm from waiting	The Trust has not yet reviewed the potential for predictive tools to enhance clinical prioritisation decision-making, and this is unlikely to be delivered by year 3. The focus remains on ensuring we are seeing patients for their first appointment more quickly, as that is the most appropriate way for us to identify the clinical prioritisation of their care. In the meantime, we are planning to trial a direct two-way messaging system with certain cohorts of patients waiting for procedures, in order to identify their wider holistic needs and whether these warrant an amendment to the clinical prioritisation. This can include impact on employment potential and social isolation.

OUR PARTNERS

We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care

Initiative	Progress
Identify unsustainable services and agree how we provide these safely, sustainably and at scale through the provider collaborative	The Trust has an established sustainability review process and this is now being refreshed and aligned to the Barnsley Hospital NHS FT process. The work has already led to the development of a Joint Gastro service across the two Trusts and is driving the current work exploring the potential for a Joint Haematology Service. This work will continue through the Barnsley Hospital NHS FT and The Rotherham NHS FT Strategic Partnership, with broader discussions also taking place within the Acute Federation in order to ensure we are structuring our services across the system in the most effective and sustainable way.
Implement staff passports within the ICB	As part of the Acute Federation's draft ten-year vision, a much more mobile workforce model has been identified as one of the key priorities. One element of this will be staff passports, which is an ongoing programme of work across the system. However, in the shorter-term, each of the five providers have agreed to work towards convergence of medical rates of pay over the next few years. This in itself will offer significant benefits to the system from having consistent pay rates at all five providers, and is likely to support broader efforts to increase workforce movements around the system.
Share jointly funded posts across the ICB where appropriate	There have been two key developments over two years which have driven some changes to this original initiative. Firstly, the growth of the Acute Federation has meant that there are now a number of jointly funded posts within this team who work on behalf of all providers for the ICB. This growth in collaboration has been championed by our Chief

	Executive, in particular given his own joint role. Secondly, the development of our strategic partnership with Barnsley Hospital NHS FT, which is precipitating a number of considerations around joint roles where these may support either individual trust or the wider partnership, and where they are appropriate.
Establish shadowing programme with partners for all staff	This initiative has not yet been developed, and will therefore fall into our year 3 programme of work.

US

We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work

Following the appointment of the new Director of People, the focus for 2023/24 is around ensuring the development of a high-quality People Strategy, generated through significant engagement with our workforce. As such, the original initiatives set out in the Delivery Plan will be reviewed following the approval of the new People Strategy, and a refreshed set of deliverables to achieve our strategic ambitions will be incorporated into our annual People Plan.

DELIVERY

We will be proud to deliver our very best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation

Initiative	**Progress**
Undertake a full review of our meeting structures – making sure that waste is eliminated	COVID has a significant impact on the Trust meeting structure and efforts have been made not to automatically reinstate meetings which were stripped out in order to free up people's time to deliver essential activities. More formally, individual Executive Team members have considered the current structure of senior meetings within their portfolios and rationalised these

	(or the attendee requirements) wherever possible. The Chief Operating Officer has established a 'meeting-light' Friday with divisional teams in order to ensure there is one day of the week when teams have more time to get out and about and focus on their own teams.
Explore ways to share and make performance information 'live' and known across the Trust and externally	Over the last 12 months there has been a significant programme of work to transfer all of our information into our Data Warehouse, and use this depository to build live and malleable performance information reports in Microsoft Power BI. This includes our emergency care, elective care and quality information, from which a number of live reports show that significant numbers of colleagues have access to and utilise on a daily basis. Similarly, our Sepia tool has been enhanced to include the operational escalation level 'wheel', and feeds the System Control Centre at the ICB, so they have clear visibility on our operational pressures on a minute-by-minute basis. When compared to other NHS providers, our development in this space is impressive, particularly given it has been led and delivered by our own teams rather than external suppliers (at significant cost). It should enable our decision-making to be based on real-time information and our performance conversations to be more targeted, challenging and action-focussed than otherwise.
Develop a 'Greatix' system for colleagues to regularly report positive behaviours and successes	Initiatives have been launched to allow colleagues to report positive behaviours and success. This includes the use of 'Star Cards' and monthly Excellence Awards which are recognised via Team Brief. The staff Excellence Awards are subsequently recognised at the Trust annual awards. Individual teams have developed unique methods for capturing compliments from patients and staff, and these are being showcased across the Trust to encourage wider roll out.

Launch a ‘Get it Sorted’ programme to fix the little niggles	This work will be developed across the Delivery and Improvement Team and the Quality Improvement team, in order to establish the most effective way to support teams to deliver improvement where they identify opportunities. There is a need to ensure that there isn’t duplication or multiple processes in place which confuse and/or demotivate staff, and following the establishment of our QI function, this particular initiative needs careful thought to ensure it solves the original issue identified.
Build benchmarking into our internal performance reports	The Trust has re-procured the ‘Public View’ system which benchmarks our performance across a broad range of metrics. Executive and Divisional colleagues have been given access to the system, and this comparative information is now used in our performance discussions. The summary benchmarking information is also included within the Trust IPR. Furthermore, a GIRFT Oversight Group has been established to drive forward our review of and response to the clinical benchmarking information flowing from the national GIRFT programme. This is chaired by the Deputy Medical Director, with significant engagement and input from clinical colleagues across the Trust. The Trust is currently considering how tools such as Model Hospital can be brought to the forefront of some of our decision-making, following an exploratory workshop with the Executive Team in October.

3.0. CONCLUSION

Progress continues to be made against the original ambitions of the Strategy Delivery Plan. Over the last two years, there have been emergent issues and further development of priorities that require the Trust to change and adapt its plans in a way that stays true to the delivery of the original strategic ambitions but may require flexibility about the initiatives that need to be delivered within this. This flexible approach will continue to be key for us recognising the extent and breadth of the work we continue to do as a Trust to ensure successful implementation of our Strategy.

Board of Directors' Meeting
3rd November 2023

Agenda item	P163//23
Report	**Operational Objectives 2023/24 for 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 2023/24. 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 2023/24 Operational Plan Priorities and associated programmes during the period April to September 2023. In the first three months of delivery (April to June) the Executive leads concentrated on formalising and embedding the work streams created to deliver the programmes of work and to ensure alignment with operational leads and their key areas of focus. This structured approach has enabled the teams involved to progress the work at pace during quarter two and ensure plans are in place during the next six months to achieve the aims set out in the original mandates approved at trust board in July 2023. A summary of achievements and any specific delays to delivery during Quarter 1 can be found on pages 3 – 5 of this report. The highlight reports at Appendix 1 inform the board of directors of the key achievements and any delays to delivery during the most recent reporting period (Quarter 2). The board is reminded that there will be no overall rag status applied to each separate priority this year as an internal decision was taken to rag rate the milestones and metrics individually as this will provide a more representative view of trends and activity during the reporting period. At the end of Quarter 2, of the nineteen milestones due for completion in accordance with the original mandates, fifteen have remained on track with four others ranked "red" significantly off track. Details on all exceptions and mitigation along with Assurance Committee comments and decisions can be found on pages 6 to 9 of this report.

	At the beginning of Quarter 3, nine out of the twelve risks identified during delivery of the programmes remain open and of the thirteen issues identified, twelve of these also remain open. The risks and issues register at Programme level is updated and monitored through existing assurance channels with documentation and updates monitored by the Delivery and Improvement team. A brief summary of the status of risks and issues assigned to each Priority is detailed on the highlight reports at Appendix 1 and on pages 6 to 9 of this report. So far this year there have been no significant escalations to the Executive Management Team that would warrant a formal request to assurance committees in order to make a fundamental change to the overall aim of any particular priority.
Due Diligence	All highlight reports have been signed off by the Executive Director Leads and have been reviewed and confirmed by the appropriate Assurance Committee.
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 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 2023-24 – Highlight reports for Priorities1 – 6 – July to September 2023

1.0 Introduction

1.1. The Operational Plan for 2023/24 is built around the following 6 key priorities:-

- Focus on the Quality of Care the Trust Provides
- Improve Engagement with our Medical Colleagues
- Supporting our People
- Improve our Emergency Care Pathways to Deliver Faster Access to Care
- Recover Elective Services
- Work in Partnership to Deliver Efficient Services and a Trust that is fit for the Future

1.2 The formal mandates agreed at the Trust Board meeting in July 2023 set out thirty six specific areas of focus that will be delivered through the six key priorities.

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 made during the first six months of delivery and reports by exception any areas of concern with recommendations for continuance into the next planning cycle.

2.0 Conclusion

2.1 The Board Assurance Committees play a key role in ensuring effective oversight and delivery of the Operational Plan. Updates are provided quarterly to assurance committees where discussions take place around progress and any specific exceptions to plan that may impact on achievement of objectives and benefits and where recommendations for corrective actions are decided.

2.2 In July the Board Assurance Committees considered reports on progress made in all of their associated areas during the first three months of the year and confirmed their assurance on progress and delivery as at the end of Quarter 1. A high level summary of achievements made during Quarter 1 is supplied in the tables below.

Priority Title	Achievements Q1 - Summary
Focus on the Quality of Care the Trust Provides	• The Power BI dashboard has been completed and all audit baseline data has been set (milestone achieved) • Establishment of the SJR Learning from Deaths group • AMaT system is now live and will manage trust wide audits (also used for registration and updates on QI projects) • A full Tendable review has been undertaken • Patient Safety Incident Response Framework (PSIRF) Training and Engagement plans in place and awareness session delivered to trust board • Education and Training plan to ensure that PSIRF Standards are met has been agreed ad is now in implementation • 113 staff are now trained practitioners in QSIRP and 19 facilitators in QSIRF. QI Self assessment completed • Requirement confirmed by NHS Impact to undertake their national self assessment when it is launched later this year

Priority Title	Achievements Q1 - Summary
Improve Engagement with our Medical Colleagues	• New Medical Leadership & Development programme commenced on the 28th April 2023 with cohort one concluding on the 22nd September 2023. Cohort two commences in October 23. • Clinical Lead Job Descriptions have been circulated for comment with sign off expected in Q2. • 12 doctors completed the Quality, Service Improvement and Re-design Programme (QSIR) • Specific interventions with key areas identified through pulse surveys, NHS staff survey and the Medical Engagement Scale • Publication of mentoring programme available at the Trust • Appraisal and Revalidation Clinics – all new doctors joining the Trust receive a 1:1 session with the appraisal and revalidation team to support them with completing their appraisal and gathering together all of the required information. This offer is open to existing colleagues at any time. • UECC Medical Away Day – delivering Medical Engagement results and collating ideas for areas of improvement. • "In Your Shoes" - Consultant Shadowing Events – all execs scheduled to undertake shadowing a consultant for the day. These are planned and feedback due in Q2.
Supporting our People	• Initial stakeholder engagement sessions to discuss the refresh of the new People Strategy have been completed • Completed specification and scope for the shared leadership development programme with Barnsley Hospital NHS Foundation Trust (triumvirate level). Tenders received from possible providers to conduct the shared development programme. Formal evaluation process undertaken with representatives from Barnsley • The Retention of Nurses Plan has been developed and includes 7 high impact areas : health and wellbeing, autonomy and shared professional decision making, leadership and teamwork, professional development and careers, pride and meaningful recognition, flexible working, excellence in care. • Nurse Careers Open Days planned (4 events to be held this year) • Pastoral Care Quality Award for Internationally Educated Nurses as well as the ICB membership of Florence Nightingale foundation (15 places confirmed for health care support workers leadership development – celebration event in May) • Launched the RCN Clinical Leadership Programme for band 6 and 7 nurses (May – June) – building understanding of compassionate and inclusive leadership (Michael West) • Joy in work/reconditioning games/hydration and nutrition (nursing/support staff), pride and meaningful work, self rostering initiatives developed, nurse advocates and specific support groups for under represented and/or disadvantaged groups.

Priority Title	Achievements Q1 - Summary
Improve our Emergency Care Pathways to deliver faster access to care	• Completion of scoping of next phase of Digital Patient Flow (including within Command Centre). • The Bed Configuration Plan has been completed • The Direct admission to Medical SDEC Pathway was implemented from 7 June with Yorkshire Ambulance Service taking into consideration the universal exclusion criteria being driven by the ICB. • Work underway to clinically develop staff to help integrate Virtual Wards.Capacity level increased to 30 on Virtual Ward • First draft of Discharge to Assess (D2A) model articulated • Out of area reciprocal assessments draft process and form completed • Community ready unit operational and golden patients identified on Meditech • Get up/get dressed reconditioning games underway – received NHSE award • Board round standards in place • Significant focus at place on supporting complex discharges out of acute Trust has resulted in significant improvement in number of patients on Integrated Discharge Team caseload and a reduction in length of time on caseload.
Recover Elective Services	• **Outpatient Modernisation and Improvement -** A Clinic Utilisation Worskshop was held in April to discuss barriers to improving utilisation. Representatives from the Contact Centre, Outpatients department as well as divisional deputy general managers, service and support managers attended the event. • **Theatres Transformation Programme (TTP) -** 6 key work streams in place. Communication plan in place with two programme launch events held in June. Opportunities to maximize theatre utilisation on the day exist in a number of specialties including Ophthalmology, ENT and Urology • **Cancer Improvement Programme -** Lower GI education session completed as part of the primary care training programme for Rotherham GPs (attended by over 250 delegates).Implemented a revised bowel prep ordering and collection process to reduce time to endoscopy and improve patient experience. Introduced cancer education sessions within the Trust. Completed clinical audit of our transperineal biopsy service (TPB) to minimise delays to patient pathways
Work in Partnership to Deliver Efficient Services and a Trust that is fit for the future	• The Collaborative Delivery Group (with Barnsley Hospital NHS Foundation Trust) has been established and has been renamed the Joint Executive Delivery Group (JEDG) (milestone) • The Joint Haematology Programme Board has been established with the first meeting held in June. A Programme mandate to support delivery of the programme has been developed in draft • Project mandates “To Reduce Unnecessary Diagnostic Testing” and “Effective use of Medical Staffing responsibility payments” developed • The Integrated histology service is in place (milestone completed) • The Efficiency target has been confirmed as £12.1 million for 23-24 • Cross cutting efficiency schemes are in development/progress and are reported through Efficiency Board monthly e.g. e-roster • Agreement of Rotherham Heat Network Options (milestone completed)

2.3 There were minor delays to delivery in Quarter 1 due to a change in NICE Guidelines which affected early progress in Priority 1 relating to the Quality Priority around Sepsis, however, as the changes did not significantly impact on the Quality Priority or the baseline data agreed, it was not considered to be an overall risk to programme delivery and is now back on track.

Slippage was identified in Priority 2 in relation to the planned "In Your Shoes" - Consultant Shadowing Events which were scheduled to start in Quarter 1. However, due to availability and suitable cross matching that would enable Executives to undertake shadowing a consultant for the day, feedback will not be available until October/November onwards.

Delays to delivery in Priority 5 relate to the wider financial challenges that the trust is facing this year and as such, at the start of the year, it was necessary to pause decisions on the elective recovery plan in order to ensure that appropriate risk based decisions could be made. Progress in other areas was delayed due to anaesthetic and theatre staff resourcing challenges. The paper proposing a revised cancer services structure was delayed until July and there had been an unexpected reduction in capacity within the cancer improvement team that impacted on the overall work plan.

The Highlight reports attached at Appendix 2 confirm the status of the six priorities for the three month period ending September 2023. An overview of the exception reports submitted to Board Assurance Committees in October is provided below along with the subsequent confirmation of assurance in terms of process and/or delivery and any agreed recommendations, actions and decisions.

2.4 <u>Quality Committee</u>

The Quality Committee discussed the highlight report in relation to **Priority 1 – Focus on the Quality of Care that the Trust Provides** at their meeting held on 25th October. The report confirmed that all key areas of focus aligned to this priority are in delivery and that significant progress has been made during the period July to September.

The risk relating to insufficient capacity to implement QSIR projects identified through practitioner training has been closed due to confirmation that recruitment for two new roles can now begin. However, the risk concerning the need for appropriate resource to sustain the Patient Safety Incident and Response Framework (PSIRF) beyond the implementation phase remains in place. Discussions are ongoing in order to find an acceptable solution that will cover the Patient Safety Partner role. No new risks or issues have been identified.

The key metrics and milestones earmarked for delivery during Quarter 2 are rag rated green (delivered/achieved).

The Quality Committee therefore recognised and agreed the progress made against the operational plan and were assured by the report.

2.5 People Committee

The People Committee discussed the highlight report in relation to **Priority 2 Improve Engagement with our Medical Colleagues** at their meeting held on 27th October. The report confirmed that significant progress has been made during the period July to September with three key milestones on track for delivery.

Whilst it is accepted that Consultant's Industrial Action would impact on the Medical Leadership Programme sessions scheduled in July, Cohort 1 later completed their course in September as planned. However the Clinical Leads Development Programme (joint with Barnsley) has been delayed from October owing to industrial action.

The postponement of Cohort 2 – Medical Leadership Development Programme due to the expected impact on number of attendees expected and winter pressures, has presented an opportunity, however, to analyse the feedback from the first cohort and assess whether or not any of the content of the 6 workshops will need to be changed.

The risk that the ongoing dispute between the BMA and HM Government remains open due to its probable impact on the trusts ability to sustain high levels of Medical staff engagement during the timeline that the leadership programme is scheduled to run.

The People Committee discussed ways in which the disruption caused by industrial has been mitigated. It was noted that Cohort 1 completed the Clinical Leadership Development programme in September as planned and Clinical Leads are meeting every month and these are well attended by all specialties. The triumvirate leadership programme is also due for launch at the beginning of November.

The People Committee also discussed the highlight report in relation to **Priority 3 Supporting our People** at their meeting held on 27th October which confirmed that all key areas of focus are in delivery and on track with notable achievements such as the Pastoral Care Quality Award for International Educated Nurses and the Interim Quality Mark for Preceptorship both of which were awarded in July.

The RCN Clinical Leadership programme (Band 6 and 7 Registered nurses) has started well with 20 practitioners on board. Likewise 14 healthcare support workers that have completed the prestigious Florence Nightingale Foundation IPC champions training have passed the course and have been recognised by Trust Board.

Further work to enhance nurse retention is being actioned through 7 high impact areas. The work started in September as part of the Retention of Nurses Plan. This work has been shared at internal workshops and with senior leaders as well as externally through safe staffing networks in order to raise awareness and promote the trust as a great place to work.

Team rostering is embedded in the Acute Surgical Unit and is working well. Roll out is now earmarked for seven more areas. There is interest from NHS England to film the teams involved in this development and to promote Rotherham as an exemplar site. Publicity will be through the NHS England website from October.

There is likely to be some risk to delivery in terms of the impact on employee engagement and retention due to the ongoing dispute between the BMA and HM Government and the mixed reaction to the AfC pay award.

One of the milestones for delivery during the period July to September 2023 is reported as Amber due to re-profiling of work on pulse survey review and one Green for EDI programme progress. Other deliverables for 2023/24 are due to start in Q3 with further discussions to take place on the Pulse Survey review as part of the People Strategy work.

For Priority 2 the People Committee were assured that a good deal of progress is being made and further agreed that this will be a 2 – 3 year plan on account of the sizeable cultural shift that is involved.

For Priority 3 the People Committee agreed to the minor changes in the format of the highlight report and were assured on the adjusted delivery plans.

2.6 Finance and Performance Committee

The Finance and Performance Committee discussed the highlight reports in relation to **Priorities 4, 5 and 6** at their meeting held on 25th October. The reports confirmed that all key areas of focus aligned to the three priorities are in delivery and good progress has been made so far this year despite the impact on delivery of the following:-

Priority 4 – Improve our Emergency Care Pathways to Improve Access to Care

Whilst the Trust will achieve the external trajectory agreed with NHSE, it is unlikely that the internal trajectory to achieve the 4 hour standard will be achieved by October 2023. The significant change work that the five work streams within the ACT programme will continue to progress.

In Quarter 3 the Acute Care Transformation (ACT) Steering Group will therefore be focussing on priorities such as operational capacity e.g. full capacity protocol and discharges, bed board accuracy and data as well as improving flow through ward-based processes.

The Urgent and Emergency Care Patient experience scores have, however, improved significantly compared to the same period last year even though some patients are still waiting longer than 4 hours to be seen.

Priority 5 – Recover Elective Services

Staffing issues in both theatres and anaesthetics are making planning and scheduling more difficult due to the inevitability of last minute changes to lists. To mitigate the impact on overall delivery, a new workforce plan (nursing and AHPs) has been developed through the Theatres Transformation programme “Workforce Development” work stream and with support from the work being undertaken through Operational Plan Priority 2 “Medical Engagement” an Anaesthetists Away Day entitled “Personal and Professional Effectiveness – Managing Self and Improving Self Care” has been scheduled to take place on 2nd November. Feedback and actions to be reviewed following evaluation of the event.

Delivery of the Cancer Pathway Improvement Programme has continued to be affected by the depletion in team capacity, however, with the appointment to the Cancer Improvement Programme Manager post due in October further progress will be made. The Programme Manager will commence recruitment to fill the three associated Band 6 Cancer Improvement Officer vacancies after which delivery will be resumed at pace.

There have also been set backs in relation to national data set submissions and the Elective Recovery Funding where issues have been identified between how our information is mapped versus how NHS England are picking the information up in the national data set. Until this matter is resolved there will be no activity percentage available for reporting.

Priority 6 – Work in Partnership to Deliver Efficient Services and a Trust that is fit for the future

Delivery of the Trust Efficiency Target is behind plan. The target of £12.1 million remains a challenge (particularly with regards to the recurrent element). A new risk has been confirmed in relation to our ability to identify deliverable opportunities which could lead to there being not enough schemes and their value being identified. There are continued pressures around excess inflation, increased risk around Elective Recovery Fund, increased Pay Run Rate (mainly due to Agency usage – which included cover for industrial action) and under delivery on Cost improvement plans.

In response to this, Divisional and Corporate areas financial performance is being managed on delivery through regular Performance Meetings, and ad hoc focus meetings. The CIP position continues to improve on a monthly basis and is managed through the monthly Efficiency Board meetings. It is encouraging to note however that the Month 6 CIP positon compares favourably to the M6 position in both 2022/23 and 2021/22. In addition,

The milestone “Proposal developed for Collaborative R&D partnership” is now overdue and is reported as a delay to delivery, however, after initial discussions around capacity to lead the TRFT service, the Medical Lead for Research has been provided with an additional PA to lead on the work. Further Pas have been made available to support Medical colleagues to undertake research as and when required.

During the reporting period, 7 risks to overall delivery remain open across the three Priorities with industrial action impacting high on financial performance and capacity to support delivery. All issues also remain open.

Of the 10 key milestones earmarked for delivery during Quarter 2 across the three Priorities, 8 are rag rated green (on track) and 2 are rag rated red (significantly off track). Planned activity is now in place to recover this position before the end of the year.

The Finance and Performance Committee therefore noted that Priority 4 had been delivered but that Priorities 5 and 6 were becoming more challenged and are starting to go off track. It was acknowledged that a number of trajectories were put into place in March prior to industrial action taking place and due to that some of the trajectories are no longer realistic and as such a set of revised trajectories have been developed going forward.

The Committee agreed that it was assured on the work being done but recognised that there were a number of challenges, in particular elective recovery.

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

Michael Wright
Deputy Chief Executive
November 2023

OPERATIONAL PRIORITIES 2023-24

APPENDIX 1: HIGHLIGHT REPORTS – JULY TO SEPTEMBER 2023

Priority 1: Focus on the Quality of Care the Trust Provides

Priority 2: Improve Engagement with our Medical Colleagues

Priority 3: Supporting our People

Priority 4: Improve our Emergency Care Pathways to Deliver Faster Access to Care

Priority 5: Recover Elective Services

Priority 6: Work in Partnership to Deliver Efficient Services and a Trust that is fit for the Future

PRIORITY 1 FOCUS ON THE QUALITY OF CARE THE TRUST PROVIDES (JULY - SEPTEMBER 2023) – HIGHLIGHT REPORT

Overall aim	In 2023/24 one of the Trust's core priorities is to continually improve the quality of care that it provides to its service users and its local communities. This priority will include all aspects of quality across safety, experience and effectiveness with a focus on key interventions in specific areas as well as the wider cultural and structural changes needed to enable a QI-led organisation.

Executive Lead(s) Assurance Committee	Helen Dobson, Chief Nurse Quality Committee
Operational Lead(s)	Victoria Hazeldine, Deputy Chief Nurse, Beccy Valance, Head of QI, Alison Walker, Quality, Governance & Assurance Matron

Milestones/Metrics : Key
On track/target
Off track/target (to be delivered by year end)
Significantly off track/target

METRIC(S)	BASELINE POSITION	ACTUAL/ TARGET	Quarter 2 2023-24		
			July	Aug	Sept
PSIRF Implementation targets met	100%	Actual	100%	100%	100%
		Target	100%	100%	100%

MILESTONE(S)	July	Aug	Sept
Quality Governance and Assurance Structure Agreed			
Implementation of PSIRF			

New Risks & Issues

QSIR – Risk (CLOSED)
Insufficient resource to support follow up of improvement work carried out through QSIR training

PSIRF - **(1) Risk (open**) if staff are not available to complete training due to capacity constraints. **(2) Risk (open)** Patient safety partner role has not yet been implemented at TRFT this will become part of the NHS Standard contract for 2024-25)

Highlights

What have we achieved?

Quality Priorities:

- 9 quality priorities have been reported through the appropriate committees for Quarter 2
- Quality Governance and Assurance structure agreed (milestone completed ahead of plan) allowing recruitment to commence
- Power BI dashboard continues to be utilized and the measures of success/metrics are all on track
- All audit data continues to be collated
- No significant risks identified

Patient Safety Incident Response Framework (PSIRF):

- PSIRF implementation plans on track to transition to the new framework on 2nd October 2023 and the PSIRF Implementation group is in place to support
- Draft PSIRF plan is completed and progressing through appropriate channels
- PSIRF Policy is completed. The policy will go through Patient Safety Committee on 19th October and Quality Committee 25th October
- Feedback with ideas and suggestions have been collated following an "Identifying PSIR Priorities" session.
- The final Trust PSIRF Patient Safety Priorities have been refined and finalised by the Chief Nurse and Medical Director and include: Patient Safety Incident Type and Issue, Recognition and Escalation of the Deteriorating Patient, Medication (Management of time critical medication - including dispensing, prescribing and administration), Risk Assessments **(**Completion of patient risk assessments and identified actions), Communication (with patients, families and carers)

Quality, Service Improvement and Re-design (QSIR) :

- 136 staff are now trained practitioners in Quality, Service Improvement and Redesign along with 13 QSIR facilitators
- QI Self assessment will be re-done in line with NHS Impact work
- Funding approved for B7 QI practitioner and B5 QI Facilitator

What have been the delays to delivery?

- **None**

Escalations and key decisions required?

- None

P2 IMPROVE ENGAGEMENT WITH OUR MEDICAL COLLEAGUES: - (JULY - SEPTEMBER 2023) – HIGHLIGHT REPORT

Overall aim	In 2023/24 the Trust wants to improve levels of engagement with our medical colleagues. This work is focused on ensuring our medical colleagues feel empowered to provide the best quality care they can, make changes to improve the care they offer and participate in the delivery of the Trust's objectives including its operational performance and financial stability. The Medical Engagement Roadmap will have a direct impact on engagement and in building a future workforce that feels valued.

Executive Lead(s)	**Dr Jo Beahan, Medical Director**
Assurance Committee	**People Committee**
Operational Lead(s)	**Nicola Boulding, Business Manager**

Milestones/Metrics : Key
On track/target
Off track/target (to be delivered by year end)
Significantly off track/target

METRIC	BASELINE POSITION	ACTUAL/ TARGET	Quarter 2 2023-24		
			July	Aug	Sept
No targets due in Q2		Actual	N/A	N/A	N/A
		Target	N/A	N/A	N/A

Milestone	July	Aug	Sept
Job descriptions agreed for Clinical Lead and Divisional Director Roles			
Review induction and development package for international medical graduates			
Embedding of pulse survey to measure improvement			

Risks & Issues

- **Risk** - Performance management process for clinical leads against agreed job role. **(CLOSED)**
- **Issue** - Industrial Action impacting the medical leadership programme as one of the workshops falls on the same day in July **(CLOSED)**
- **Risk** – Funding for mentorship programme **(CLOSED)**
- **Risk** – that the ongoing dispute between the BMA and HM Government and mixed reaction to the AfC pay award impacts TRFT's ability to improve levels of all staff and Medical staff employee engagement **(OPEN)**
- No New Risks and Issues are reported in Q2

Highlights

What have we achieved?

- Key Milestones relating to completion and sign off for the Clinical Lead and Divisional Director role descriptions and the Review of the Induction and Development pack for International Medical Graduates (IMG) have been achieved. For the IMG's an action plan is now in place and a local group has been established, including representation from International Medical Graduates who will feed in their "lived experience". The group is scheduled to meet on a quarterly basis.
- New Medical Leadership & Development Programme - Cohort 1 completed the Programme as planned in September.
- Clinical Lead meetings are now embedded and are well attended by all divisions and specialties.
- A further 2 doctors have commenced Quality, Service Improvement and Redesign (QSIR) practitioner training
- Pre appraisal information packs which include mandatory training, complaints and incidents are in place.
- The General Surgery Cultural Review has been completed and will be reviewed by the Executive Director of People during Q3
- Due to action taken from the National Staff Survey 2022 the decision was taken to hold an Anaesthetics Away Day entitled "Personal and Professional Effectiveness – Managing Self and Improving Self Care". The event is scheduled to take place on 2nd November.
- Funding has been identified to run the Mentorship Programme. Candidates have come forward to undertake the programme due to complete in Q4. Associated Risk has therefore closed.
- All doctors who join the trust now receive an induction for medical appraisal, 360 and revalidation.
- The Medical Matters newsletter is now published monthly with good contributions being made from various departments and specialties from across the trust
- The UECC "Medical Away Day" has been completed and was well received. Results from their Medical Engagement Scores (from 2008 and 2017) and appropriate feedback has also been shared.
- The first round of Consultant Shadow Events with Executives has been completed. The events covered "A Day in the life of…." and included provision of feedback. A paper is in development with a view to presentation to Executives on the medical leadership programme, consultant shadowing and the medical engagement road map which will need to be revised for 2023-24 (calendar year).
- An SAS advocate has been recruited to support the development of the SAS programme
- All new doctors are now meeting with the Medical Director as soon as they join the trust

What have been the delays to delivery?

- The Clinical Leads development programme (joint with Barnsley) has been delayed from 4th October owing to industrial action. The associated Risk due to the likelihood of ongoing dispute between the BMA and the Government will subsequently remain open.
- Medical Leadership Development Programme - Cohort 2 - has been postponed to April 2024 due to the number of attendees expected, also impact of winter pressures. This delay will, however, provide sufficient time to analyse feedback received so far and to assess whether or not any of the content of the 6 Workshops will need to be changed.

Escalations and key decisions required?

None

P3 - SUPPORTING OUR PEOPLE (JULY TO SEPTEMBER 2023) – HIGHLIGHT REPORT

Overall aim	In 2023/24 the Trust will continue to support and develop our people – 'Us' in our PROUD Strategic Ambition. 'Our new journey, together' strategy (2022-2027) sets out that we will be proud to be colleagues in an inclusive, diverse and welcoming organization that is simply a great place to work. It describes the need to ensure we have the right workforce in terms of shape, size and skills to deliver high quality services for our patients. We will develop our approaches to workforce planning and staff experience in pursuit of this ambition.

Executive Lead	**Daniel Hartley, Director of People**
Assurance Committee	**People Committee**
Operational Lead	**Paul Ferrie, Deputy Director of Workforce**

Milestones/Metrics : Key
On track/target
Off track/target (to be delivered by year end)
Significantly off track/target

Metric	Baseline Jan 23	Measure	Q4 Mar 2022/23	Q1 Jun 2023/24	Q2 Sep 2023/24
Turnover rate (rolling 12 m)	12.2%	Actual	11.87%	11.50%	10.66%
		Target	11%		
Vacancy rate	7.34%	Actual	-6.68%	-6.18%	-6.81%
		Target	Validation taking place		
Sickness Absence (rolling 12 m)	6.75%	Actual	6.65%	6.13%	5.97%
		Target	0.75% from baseline		

Milestone	Q1	Q2	Q3	Q4
Development of EDI Programme	n/a			
Pulse Survey Review and Publish Staff Survey results	n/a			
Refreshed People Strategy engaged on and published	n/a	n/a		
Proposal for Workforce Plan agreed and developed	n/a	n/a		

Highlights

What have we achieved?

- The shared development programme with BHFT (triumvirate) contract has been awarded to "Value Circle" and is currently being mobilised with a soft launch scheduled for November.
- The WRES and WDES annual reports and combined action plan has been completed, taking in feedback from a range of internal stakeholders. This includes plans for further Board development and as such completes the EDI programme milestone for 2022/23 once approved by People Committee and Board.
- A paper outlining the design plan for creating the new People Strategy has been developed for presentation at ETM on 5th October. A multi professional steering group and project group has been established to drive this work.
- The Retention of Nurses Plan, is working well and actions in each of the 7 high impact areas:- health and wellbeing, autonomy and shared professional decision making, leadership and teamwork, professional development and careers, pride and meaningful recognition, flexible working and excellence in care are being delivered. This work has been shared internally with senior leaders and externally across the ICB and Region.
- The Pastoral Care Quality Award for International Educated Nurses and the Interim Quality Mark for Preceptorship was achieved in July 2023. The RCN Clinical leadership programme has started for 20 B6/7 Registered Nurses
- Team rostering has been deployed on the Acute Surgical unit and a further 7 areas are now adopting. Interest is being shown by NHS England who want to promote Rotherham as an exemplar site and share best practice

What have been the delays to delivery?

- The work to review TRFT's use of the National Pulse survey will now be included in the People Strategy design work during Q3 and 4, as opposed to Q 2,3,4.

Escalations and key decisions required?

- None

Risks & Issues

RISK – that the ongoing dispute between the BMA and HM Government and mixed reaction to the AfC pay award impacts TRFT's ability to improve levels of all staff and Medical staff employee engagement (OPEN)
RISK – that impact of the dispute and operational pressures increases stress on both managers and staff impacting; turnover, vacancy rate, sickness absence and levels of employee engagement (OPEN)
NEW RISK – that increased turnover and sickness absence at a senior level in the People team reduces ability to deliver work programme (OPEN)

P4 IMPROVE OUR EMERGENCY CARE PATHWAYS TO DELIVER FASTER ACCESS TO CARE
JULY – SEPTEMBER 2023 - HIGHLIGHT REPORT

Overall aim

In 2023/24 Trust will continue to develop and improve its urgent care pathways, processes and performance. This priority will cover all elements of urgent care across community, acute and partner services. A key element within this priority will be the delivery of the 4-hr national standard and the focus of work will be on key drivers and enablers of this.

Executive Lead	Sally Kilgariff, Chief Operating Officer
Assurance Committee	Finance and Performance Committee

Milestones/Metrics : Key

- On track/target
- Off track/target (to be delivered by year end)
- Significantly off track/target

METRIC	BASELINE POSITION	ACTUAL/ TARGET	Quarter 2 2023-24 July	Aug	Sept
Trust 4hr performance	22/23 Q4 44.02%	Actual	64%	57%	61%
		Target 76% by Oct 23 Trajectory	60%	65%	70%
Urgent Community Response % achieved within 2 hours	End of April 2023 85.7%	Actual	74%		
		Target > 70%	>70%	>70%	>70%
Adult G&A Bed Occupancy	April 23 90%	Actual	90%	91%	89%
		Target < 92%	<92%	<92%	<92%
Patients with no right to reside	April - 53	Actual	47	62	44
		<54 by March 24 Trajectory	60	52	56
Average daily throughput Medical SDEC	2022/23 Q4 (inc clinics): 19 incl. weekends & bank holidays	Actual	25	21	24
		30 by March 24	30 by Mar 24	30 by Mar 24	30 by Mar 24
Patients cared for on virtual ward	March 23 15	Actual	31	36	25
		Trajectory	24	32	40

Milestone	July	Aug	Sept
Relocation of SDEC full business case			
Direct admission to SDEC Pathway tranche 1 go live **Q2**			

New Risks & Issues

Risk: Operational pressures (i.e. Industrial Action) **(OPEN)**
Risk: Lack of funding to support estates plans **(OPEN)**
Issue: SDECs used for beds during escalation periods **(OPEN)**
Issue: Lack of availability of Surgical SDEC trollies **(OPEN)**
Issue: UECC is used as a default location for all urgent care needs **(OPEN)**
Issue: Delays to technology support now in the "standstill" period of the procurement phase until end October **(NEW)**
Issue: safe governance to ensure visibility of all patients on virtual ward **(NEW)**

Highlights

What have we achieved?

Acute Care Transformation Programme (ACT) achievements:

- Bed reconfiguration is now completed (B5 transferred to Medicine as a 24 bedded unit, Stroke Unit has reduced to 24 beds, B10 is to remain open with 22 beds, Sitwell is to re-open as a 14 bedded surgical ward. The associated reset week started on 25th September.
- Acute Care Standards were relaunched on 25th September
- E-guidance tool for GPs is now in place to support appropriate utilisation of diagnostics
- New streamlined process for UECC triage/assessment started on 25 September
- SDEC/UECC/Primary Care have agreed that all areas will adopt the new Yorkshire Ambulance Service SDEC exclusion criteria for referrals/streaming
- Completed a review of Urgent Primary Care location (for winter) and ways of working for Out of Hours service to provide 24hr Primary Care across UECC. Confirmed there are no plans to move Primary Care in winter 2023-24
- Triage Nurse referral processes have moved to an Out of Hours Dispatcher in order to add patients to the Primary Care work list after 10pm
- A new Workforce mandate has been developed with 5 key areas of focus identified and milestones required for delivery in Q3-4
- UECC administration service review has been signed off by the UECC senior leadership team
- Recruitment and retention process is now embedded in UECC
- Emergency Care Data Set (ECDS) requirements have been segregated into 4 key areas of focus (Snomed/Data warehouse changes, version 4 in ED, Type 5s (SDEC) and Type 6s. Progress will be monitored through a new, overarching ECDS group lead by Health Informatics due to the nature of the work and the impact on EPR.

Community Services (Community Hub, UCR, Virtual Ward) achievements:
Virtual Ward

- Feedback from a national NHSE virtual ward event validated Rotherham's approach with the majority of examples of best practice being in place. Noted that remote tech has been a national challenge, with few having successfully implemented. Interoperability remains a challenge.
- Remote tech preferred provider expected w/c 2 Oct
- Following an increase in discharge referrals August has seen an increase in step up (avoidance referrals).
- The majority of patients remain at home following discharge from the virtual ward.
- Development of heart failure pathway is progressing.

Urgent Community Response

- UCR has seen a record number of referrals (620 in July) and continues to perform above the requirement of 70% of referrals to be responded in 2 hours
- Recording of Diabetes and Urgent Catheter Care services now on board

Improving discharge processes (internally and externally) achievements:

- Transfer of Care Hub (TOCH) to be launched 09 / 10 / 23. Phase 1 brings together the health Care Co-ordination Centre and Urgent Community Response with the Integrated Discharge Team to support admission avoidance and discharge.
- Procurement is progressing well regarding the Home from Hospital service (home care to support hospital discharge when re-ablement resource not initially available). Evaluation of bids is underway and mobilisation is on-track for mid-November.
- Out of area trusted assessment pilot with Sheffield planned for October.
- Positive feedback on Care Home Trusted Assessor role. Job role drafted.
- Soft launch of therapy D2A assessments starting in May has resulted in 118 assessments in the community.
- 300 patients have been supported by community in reach for admission avoidance and early discharge home since April.

What have been the delays to delivery?

- Delays to the technology to support - this is now in the 'standstill' period of the procurement phase until the end of October when discussions will commence with the preferred bidder
- Work to ensure safe governance of the ward is being undertaken to ensure visibility of all patients on Virtual Ward by moving the different unplanned units on to one SystemOne unit
- ACT Programme - Completion of the standard operating procedures and Data Dictionary is delayed 2 months to October
- ACT Programme - Following a review of internal dash boards and reports an Independent 360 review has been confirmed for completion in November
- Ongoing periods of industrial action is impacting on operational teams capacity to undertake transformation work

Escalations and key decisions required?

None

P5 RECOVER ELECTIVE SERVICES JULY - SEPTEMBER 2023 – HIGHLIGHT REPORT

Overall aim	In 2023/24 the Trust need to recover its elective position so that it can provide timely care to its patients. This priority will include all elective care pathways including cancer, outpatients and theatres. The work will be primarily focused on the recovery of pre-covid activity and the reduction in waiting times for our elective patients.

Executive Lead(s)	Sally Kilgariff, Chief Operating Officer (overall) Louise Tuckett, Director of Strategy, Planning & Performance (Theatres), Jodie Roberts, Director of Operations (Outpatients)
Assurance Committee	Finance and Performance Committee

Milestones/Metrics : Key
On track/target
Off track/target (to be delivered by year end)
Significantly off track/target

METRIC	BASELINE POSITION	ACTUAL/ TARGET	Quarter 2 2023-24		
			July	Aug	Sept
Activity % of 19/20	Target 101%	Actual	TBC	TBC	TBC
		Target	103%	103%	103%
Over 65 week waiters	35	Actual	24	40	58
		Target	60	60	50
OP Clinic Utilisation	80%	Actual	82.3%	82.4%	82.9%
		Target	90%	90%	90%
Theatre Capped utilisation (internal data)	75%	Actual	85%	78%	-
		Target	85%	85%	85%
Cancer faster diagnosis performance	65%	Actual	80.3%	77.6%	-
		Target	75%	75%	75%

Milestone	July	Aug	Sept
Cancer - Uology pathway review workshop delivered			
Cancer - Cancer Services structure in place			
TTP - Theatre Assistant Booking Tool in development/ready for testing			
TTP – Workforce model agreed			
TTP – Patient Sending SOP drafted for testing			
Outpatients - process map sessions with Outpatients department staff to understand issues, develop and priorities action plan			
Outpatients – review referral processes across specialties			

Risks & Issues

- Issue - Data quality (Outpatients & Theatres) **(OPEN)**
- Issue - Outpatient Clinic Capacity for triage and outpatients **(OPEN)**
- Issue - Clinical Engagement (Outpatients & Theatres) **(OPEN)**
- Issue - Staff Capacity/ Time (Outpatients & Theatres) **(OPEN)**
- Issue - National Vacancy/skill shortages/retirements and Anaesthetics and Operating Department nursing (Theatres) **(OPEN)**
- Issue - Theatre stores processes/paper based, storage space, procurement inventory and materials management **(OPEN)**
- Issue - Industrial action - activity levels/elective recovery funding **(OPEN)**
- Issue – how our information is mapping ERF vs NHS/SUS national data set, unable to confirm ERF income values **(NEW – OPEN)**

Highlights

What have we achieved?

Outpatient Modernisation and Improvement

- **Clinic Utilisation** – Services have conducted 'house keeping' of their clinics, removing those which are no longer in use and contributing to lower utilisation scores.
- **Referral Optimisation** – Referrals can now be processed in Meditech in 6 specialties. Referral document created to support clinicians to process and triage referrals in Meditech. Review of referral process across different specialties completed. Highlighted variation in process and also potential of CNS's triaging referrals. This will be explored in other workstreams.
- **Reducing Referrals –** Much of this work is being overseen within the GIRFT meetings in terms of reducing follow-ups by 25%. The workstream is concentrating on expanding PIFU further and increasing the use of PIFU as an option.
- **Outpatients Flow** –Agreement made with domestic services and nursing staff to ensure doors can open earlier for patients who arrive early for the first appointments. Agreed plan to provide ECG training to nursing staff to be able to take ECG readings for ad-hoc requests to reduce wait for patients. More efficient process agreed with Pharmacy for nursing staff to collect patient prescriptions.
- **Internal Processes –** Monthly Outpatients forum meeting now in place and well attended by Service Managers, Support Service Managers, Deputy General Managers and Contact Centre to discuss Outpatient issues and priorities. Working closely with Contact Centre to improve working relationships and communication between services and the Contact Centre. Weekly drop-in session to start for Services to communicate any upcoming issues and priorities for Contact Centre to focus.

Theatres Transformation Programme (TTP)

- **Optimising Theatre Lists –** Information from process mapping has informed the Principles of Scheduling and Validation. A 12 week "visual" of scheduling process has been developed and will be part of the new Scheduling Guidelines. Orthopaedics, Ophthalmology and General Surgery have started testing the Theatres Booking Assistant (Power BI tool) to ensure the information within the tool is correct prior to wider consultation and roll out. A Focus Week is planned for 30th October to pilot some of the changes that have been recommended by the team
- **Preparing patients for surgery** – Text message reminders now in place. Funding and Business Case approved to use Netcall for Electronic Pre-op Triage.
- **Maximising Utilisation on the Day** – The Command centre approach has started with the installation of a wall mounted TV screen displaying an overview of Theatres utilization that day. A draft Sending SOP is in development following engagement sessions with ENT, Ophthalmology and Urology. The SOP which is intended to rebalance session start and finish times and will be piloted during a re-set week in October.
- **Workforce Development** - The new Workforce plan has been completed. The plan will support the changes required in e-roster that will bring improvements in expenditure control linked to new cost centres assigned to specific teams e.g ODPs, scrubs and recovery.
- **Patient Safety & Clinical Governance** - Electronic team brief, (using i-pads) is being trialed in Theatre 3 and 11 and the electronic de-brief is also being explored. These will improve reporting and escalation of issues. Emergency Quick Reference Guide (Anaesthetists) has been published. A User Group has been established to develop an Emergency Theatres booking SOP. A Patient Safety event has been scheduled for 14th November.
- **Equipment & the Environment** - Inventory management system business case agreed for external funding with the key area of focus to be theatres. A joint Project team with NHS Supply chain is in place and their first meeting was held on 7th September. Decluttering theatre street and corridors is progressing well with a number of bulky items earmarked for auction/return to supplier for parts/waste segregation.

Cancer Improvement Programme

- Successful recruitment of Cancer Improvement Programme lead to drive the programme forward. Recruitment of three Band 6 Improvement Officers underway
- Cancer services centralisation has been approved at ETM and will be implemented once the Associate Director of Operations to commences in post - due to start in post at end of October.
- Delivery of the existing programme continues through Cancer Alliance funding

What have been the delays to delivery?

- Staffing issues in both theatres and anaesthetics are making planning and scheduling more difficult due to the inevitability of last minute changes and issues.
- Internal data analytics has taken time to develop meaningful insight (from scratch)
- Work stream leads capacity to support programmes of work
- Industrial action particulary in outpatients
- Due to recent issues identified between how our information was mapping ERF versus how NHSE are picking it up from SUS in the national data set, we are unable to confirm the ERF income values at this time

Escalations and key decisions required?

- Trust Board self assessment return confirmed that the trust does not have to plan to achieve 25% reduction in follow ups

P6 WORK IN PARTNERSHIP TO DELIVER EFFICIENT SERVICES AND A TRUST THAT IS FIT FOR THE FUTURE JULY - SEPTEMBER 2023 – HIGHLIGHT REPORT

Overall aim	In 2023/24 the Trust needs to ensure that both the organisation as a whole and its services are fit for the future. This priority includes the development of our relationship with Barnsley NHS FT to develop ways of working in order to deliver excellence, enhancement of resources (human and physical) and operating efficiencies. The clinical and operational work will mainly focus on the longer-term, while financially the focus will be more short term.

Executive Lead(s)	Michael Wright, Deputy Chief Executive, Steve Hackett, Director of Finance
Assurance Committee	Finance and Performance Committee

Milestones/Metrics : Key
On track/target
Off track/target (to be delivered by year end)
Significantly off track/target

METRIC(S)	BASELINE POSITION	ACTUAL / TARGET	Quarter 2 2023-24		
			July	Aug	Sept
Delivery of the Efficiency Target	N/A	Actual (£)	1,191,610	1,669,560	2,187,640
		Target (£)	3,216,056	4,146,460	5,076,874
Variance from Financial Plan	N/A	Actual (£)	-1,320k	-1,218k	-1,068k
		Target (£)	-2,516	-3,082	-3,665

Milestone	July	Aug	Sept
Proposal Developed for Collaborative R & D Partnership			

Risks & Issues

- Issue - Lack of clinical / divisional engagement to make efficiency savings and service change **(OPEN)**
- Risk – the ability to identify deliverable opportunities for CIP remains a challenge across the Trust and could lead to not enough schemes and value being identified **(NEW)**
- Risk – Ongoing challenges around cost improvement delivery linked to increased costs in pay and the challenges particularly with regards to the recurrent element. Impact of junior doctors industrial action is having an adverse impact on financial performance. **(OPEN)**
- Risk – ongoing risk around cost pressures and under delivery of CIP on the financial position (**OPEN**)

Highlights

What have we achieved?

- **Service development with BHFT** - JEDG continues to provide monthly oversight and direction of the Haematology Programme, and also BAU aspects of the Gastroenterology Redesign Programme
- **Haematology Programme** - Monthly Haematology Programme Board meetings are progressing. A Haematology Engagement Event was held on 13th Sept with Haematology staff from TRFT and BHFT in attendance. Feedback from this event will help shape the scope and the objectives of the Haematology Programme
- **Reduction in unnecessary diagnostic testing** – CT data has been benchmarked against BHFT, DBHFT and STH. CT data gathering and analysis continues in order to shape the project scope and objectives
- **Medical staffing responsibility payments** - The Draft Job Planning policy is being presented to the LNC in October for support following wider consultation and engagement. This will include the creation of a Job Planning Assurance Group (JPAG) which will be responsible for the consistency and review of ANR payments.
- **Trust wide Efficiency Programme** – The 2023/24 target is £12.176m at M6 the FOT is £9.601m which is 78.85% of target (71.88% risk adjusted) and the FYE Recurrent is £6.882m which is 56.52% of target (52.23% risk adjusted). A number of cross-cutting efficiency schemes are being developed to support delivery of the 2023/24 CIP, and possibly beyond (e.g. e-Roster and stock Management). It is anticipated that saving opportunities should become evident as the scoping of these schemes continues to develop.
- Divisions have been tasked with developing a long term Forward CIP Plan (to cover the 2024/25, 2025/26 and 2026/27 financial years) by the November Efficiency Board.

What have been the delays to delivery?

- **Collaborative R&D partnership** - The milestone "Proposal developed for Collaborative R&D partnership" is now overdue, however, after initial discussions around capacity to lead the TRFT service, the Medical Lead for Research has been provided with an additional PA to lead on the work. Further PA have been made available to support Medical colleagues to undertake research as and when required.

Escalations and key decisions required?

- The Trust is off-plan with the Financial Plan. There are continued pressures around excess inflation, increased risk around ERF, increased Pay Run Rate (mainly due to Agency usage – which included cover for industrial action) and under delivery on CIP.
- The Trust Efficiency Target is behind plan. The target of £12.1 million remains a challenge (particularly with regards to the recurrent element). In response to this, Divisional and Corporate areas financial performance is being managed on delivery through regular Performance Meetings, and ad hoc focus meetings. The CIP position continues to improve on a monthly basis and is managed through the monthly Efficiency Board meetings. It is encouraging to note however that the Month 6 CIP positon compares favourably to the M6 position in both 2022/23 and 2021/22. In addition,

Board of Directors
3rd November 2023

The Rotherham NHS Foundation Trust

Agenda item	**P/164/23**
Report	**Winter Plan 23/24**
Executive Lead	Jodie Roberts, Director of Operations
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 provided to the Board of Directors for assurance around the planning that has taken place in preparation for Winter. This includes a joint planning session with Barnsley, evaluation of Winter 2022/23, fortnightly meetings of the Winter planning group and a robust confirm and challenge session with the General managers to manage proposed schemes and associated finances. In addition the Trust has received a letter from NHS England outlining the national approach to 2023/34 winter planning. This focuses on 4 key areas for winter: 1. Continue to deliver on Urgent Emergency Care (UEC) recovery plan by ensuring high impact interventions are in place 2. Completing operational and surge planning 3. Integrated Care Boards (ICB) to ensure effective system working across all parts of the system 4. Supporting our workforce These requirements have been taken into account as part of the development of the Trust's winter plan. A presentation has been included as part of the papers in order to identify the key actions the Trust will take as part of Winter this year. This also includes working closely with ICB and Place partners to support flow and capacity. The first and final drafts have been to the Executive team and Finance and Performance committee. The likely spend on costed schemes is currently £1,296,858 which leaves a deficit of £541,121. This is however supported by savings on later starts of recurrently funded schemes for Winter and additional bed capacity for

	2023/24. Winter 2024/25 will have less funds available to support through Winter. This will however be supported by recurrently funded schemes in place all year which provide flexibility and consistency. The delivery of transformation work including Same Day Emergency Care (SDEC), virtual ward and discharge work in the community will mitigate against winter in 2024/25.
Due Diligence (include the process the paper has gone to prior to presentation at FPC Meeting)	A number of meetings have taken place with Divisions to ensure that the right support has been identified throughout Winter. This has also been presented at Executive Team meeting and Finance and Performance Committee.
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?)	Board of Directors are asked to note the contents of the report, including the levels of finances that are available to support the Trust during Winter 23/24
Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	1. Winter Planning 2023 / 24

Winter Plan 2023 / 24

Preparations for Winter 2023/24

- Reflections on last winter
- Planning for Winter 2023/24
- TRFT winter plan
- Bed Capacity
- Winter workshop with Barnsley
- PLACE winter planning
- National planning guidance for Winter- **Delivering operational resilience across the NHS this winter**

Last Winter

- Evaluation of last winter
- Debrief sessions - structured post winter and mid term
- Tracking of spend
- Flexibility to manage pressures and adapt to changes
- National asks

Last Winter

In order to manage the pressures expected over the winter period NHSE called a summit of all providers in November to manage 6 key aims of which TRFT had 3 to meet:

- 111 call abandonment.
- Mean 999 call answering times.
- Category 2 ambulance response times.
- Average hours lost to ambulance handover delays per day.
- Adult general and acute type 1 bed occupancy (adjusted for void beds).
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

Performance against National Targets 2022/23

	Trajectory for Daily Average Hours Lost from Ambulance Handovers						
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trajectory	18.0	15.0	15.0	13.0	13.0	10.8	10.8
Actual	24.0	20.7	24.5	40.3	11.8	16.4	8.0

	General & Acute (G&A) Bed Occupancy						
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trajectory	95.6%	95.0%	93.2%	93.2%	94.0%	93.2%	92.6%
Actual	92.6%	92.2%	91.6%	92.5%	91.3%	90.3%	90.3%

	Number of Patients with No Right to Reside						
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trajectory	65	65	65	62	59	56	53
Actual	56	57	52	68	44	52	37

Last Winter

Elective Admissions

	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	2661	3120	2993	2427	2792	2596	2756
2019/20	2736	2966	2656	2478	2665	2560	2120
2020/21	2088	2117	2156	2088	1947	2096	2452
2021/22	2534	2318	2311	2081	1915	2102	2390
2022/23	2395	2449	2775	2222	2639	2718	2896

NEL admissions

	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1820	1916	1892	1936	2068	1887	2048
2019/20	1851	1935	1826	1920	1958	1727	1683
2020/21	1930	1872	1784	1714	1753	1715	1939
2021/22	1916	1814	1778	1838	1718	1736	1756
2022/23	1659	1803	1815	1833	1873	1735	1962

Attendances

	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5849	6110	6111	6214	6811	6016	6575
2019/20	6977	7123	7303	7225	7112	6452	5413
2020/21	7206	6607	6130	6215	5675	5635	7343
2021/22	8100	8043	7766	7542	7204	7094	8066
2022/23	7350	7818	8010	8117	7207	6840	7802

Last winter

What went well

- Additional senior support on site
- Additional support for paediatric UECC
- POCT testing in ED
- Additional support in medicine and UECC
- Extended opening hours for the discharge lounge
- Additional transport
- Transfer team
- Surge capacity for paediatrics
- Protecting elective orthopaedic ward
- Escalation wheel and Command Centre
- Extended opening hours for pharmacy
- Medical and pharmacy input into community ready unit

What we learnt

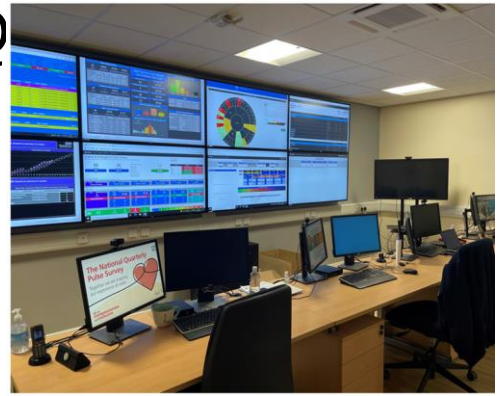
- Temporary posts are not able to be filled
- Additional COVID and FLU testing kits to be ordered
- Winter came earlier than anticipated
- Bed capacity was a challenge
- SDECs used for inpatients
- Early booking of temporary medical staff
- Consistency of schemes e.g if hours are extended they need to be all the time rather than changing

Winter planning in August

- Winter letter & national call last week
- Fortnightly winter planning meetings since June
- Joint workshop with Barnsley
- Strategic Board session
- Draft plan FPC August
- September Board
- Industrial Action

TRFT Winter Plan

- Allocation for winter in our 23/24 financial plan £2 million
- Bed reconfiguration – increased G&A capacity national funding £1.2 million (725k used recurrently from £2 million allocation for Winter to support)
- Recurrently funded schemes discharge coordinators x3, increase in opening hours for community ready unit and additional support for IDT/community nursing
- Transformation work - SDEC, virtual ward, YAS push model, Q Discharge work
- Planning for ongoing Industrial Action
- Escalation plan - internal, place and region- SCC



Bed capacity

- Review demand and capacity in operational plan submission
- Bed reconfiguration – increase capacity (sitwell) and rightsize medicine (ward B5)
- Extra beds (escalation) winter - bay in surgery (6) and medicine (9)
- B6 vacant ward once SCBU scheme is complete (additional surge capacity)
- Protect SDECs and community ready unit
- Protecting electives
- Orthopaedic ring-fenced ward
- Spot purchase in community with support from community teams

TRFT Winter Schemes

Winter	2023-24
Winter Spend Plan - 2023-24 opening balance	1,274,455
Apr-May	518,718
Amount available	755,737
Current winter plans - based on likely spend	1,296,858
Deficit	-541,121
Non Recurrent Savings from UEC	598,209
Net Across Winter/UEC	57,087

TRFT Winter Schemes

- Increase in medical cover for medicine and SDEC (consultants, middle grade and junior)- £265,608
- Escalation beds on B5- £235,200
- Additional capacity in IRR, RR and CHAT- £200,000
- Additional medical workforce in UECC-£176,764
- Additional pedantic nursing support to manage surge in RSV- £55,508
- Support out of hours for POCT testing in ED (In hours support required from other areas)- £94,640
- Escalation beds Rockingham- £104,000
- Extended opening hours of surgical SDEC- £ 73,020
- Additional portering to support UECC overnight-£17,280
- Transport- £30,000
- Smaller schemes- Vaccination tracker, flu tests and additional ward clerk cover- £80,000

Recurrent Schemes

- Increase in G and A bed capacity
- Discharge coordinators
- IDT/ community nursing
- Increase in opening hours for the community ready unit (CRU)

Finance

- The schemes identified fall within the £1.3 million allocated for Winter 2023/24 (inclusive of under spend on additional bed capacity)
- Winter 2024/25 will however have £1 million in reserves for Winter and will require transformation schemes such as SDEC, Virtual ward, discharge to assess and increased bed capacity to support any additional pressures during Winter.

Place winter plan

- Allocations
  - £500K winter funding
  - Discharge funding supporting social care schemes
- Social care – reablement and additional homecare
- Trusted assessor, bridging model
- Voluntary sector – transfer of care hub, social prescriber, Age UK
- Out of area trusted assessment pilot with Sheffield
- Mental Health – increase in workforce
- Place escalation wheel

Delivering operational resilience across the NHS this winter

- National approach to 2023/34 winter planning
- Focuses on delivering of UEC Recovery Plan
- No additional national funding
- Incentive scheme
- Public scrutiny run up to next general election
- Session for ICB and Trust chairs in September

4 key areas of focus:

1. Continue to deliver on UEC recovery plan by ensuring **high impact interventions** are in place
2. Completing **operational and surge planning**
3. ICBs to **ensure effective system working** across all parts of the system
4. Supporting our **workforce**

Winter preparedness – key national metrics

Needs to support **two key ambitions** for UEC Recovery:

- 76% of ED patients admitted, transferred or discharged within 4 hours by March 24
- On average Cat 2 ambulance response incidents reduced to 30% 2023-4, with further improvement 2024-5

Incentive Scheme: Access to share of £150M capital fund 2024-5

- Achieve an average of 80% 4 hour performance over Q4 2023-4
- Complete at least 90% of ambulance handovers within 30 minutes during Q3 and 4 2023-4

1. High impact interventions

- Maturity assessments undertaken
- Universal improvement offer
- Systems will received dedicated support
- Four areas to focus improvement for winter

1. High impact interventions

Ref No	Area	Assess Score
1	**Same Day Emergency Care**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.	2
2	**Frailty**: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.	5
3	**Inpatient flow and length of stay (acute)**: Reducing variation in inpatient care and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.	4
4	**Community bed productivity and flow**: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.	3
5	**Care Transfer Hubs**: Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.	4
6	**Intermediate care demand and capacity**: Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.	5
7	**Virtual wards**: Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.	6
8	**Urgent Community Response**: Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.	6
9	**Single point of access** *(overlaps with our TOCH model but needs to link in with other pathways eg Mental Health)* Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.	7
10	**Acute Respiratory Infection Hubs**: Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.	5

Lead on delivery of high impact interventions 1-4

- **SDEC** 12 hours a day, 7 days, reduce variation
- **Frailty** Reduce variation/admission& improve recognition of cases that would benefit
- **Inpatient flow and LOS**
  - Reduce variation in inpatient care & LOS for urgent & emergency pathways/conditions & cohorts through efficiencies & bringing forward discharge planning incl
  - Improvements in ambulance handover
  - Documented prof standards for rapid speciality in-reach to ED.
- **Community bed productivity and flow** *(this is mostly focussed on acute, but we also need to review community).*
- Reduce variation in inpatient care & LOS, max therapeutic interventions, reduce deconditioning and bring forward discharge planning
  - Availability of G&A incl run up to Christmas, escalate number of beds needed
  - Focus on improving the 4 hour performance target of 76%
  - Focus on 12 hour waits
  - Ensure clear arrangements in place for those likely to require step down support with early referral to transfer of care hub. SOPs in place to minimise variation, discharge delays and max rehab & reablement
  - Optimise 7 day working
  - Timely data
  - Ensure sufficient capacity in place for elective pathway, with triggers to open additional non elective capacity
  - Improved primary/secondary care interface with system wide understanding of pressures
  - Ensure robust workforce plans for increased demand incl Christmas, planning for staff sickness related to flu/covid and IA
  - Flexible mechanisms for pooling/utilising resources across organisations incl staff banks & mutual aid & digital solutions
  - Vaccination plans for staff, patients & volunteers

ICB & Community

- Lead on delivery of high-impact interventions 5-10
- **Care transfer hubs** implement a standard operating procedure to reduce variation, maximise community rehab & reablement incl over winter holiday period
- **Intermediate care demand & capacity** with LA commission sufficient capacity for step down care including home and bed based utilising BCF & discharge monies incl packages of care where needed. Ensure resource gaps escalated & data returns submitted. Ensure data sharing arrangements in place for care plans & streamline pathways. Monitor the impact of IC on peoples functional outcomes & long term care needs
- **Virtual ward** be accountable for the delivery of vw capacity, max use ensuring 80% occupancy. Provide step up/down capacity at scale for frailty, respiratory and **heart failure** tightly aligned to:
  - Accepting referrals from care homes, 999, primary care, ucr with agreed processes
  - UCR going **beyond** the 9 clinical conditions and including cat 3 & 4
  - Advanced clinical support for care homes outside of UCR hours to facilitate care within the care home where appropriate
  - Single point of access to drive standardisation of urgent care co-ordination including number /breadth of services profiled in the DOS /999, maximising uptake

ICB & Community

- Helping people to stay well at home, avoid hospital admissions where possible, provide fast & responsive urgent and emergency care for those who need it and ensuring people admitted to hospital can return home as soon as possible when they are well enough
- Strategy - help people stay at home, avoid admission, prompt discharge

2. Operational and surge planning

- Review operational plans – demand and capacity, winter surge
- Winter scenarios – covid, ongoing IA
- Table top exercises/testing
  - TRFT
  - Place
  - Working closely with public health in response to surges in infection

3. Effective system working

- Winter roles and responsibilities
- DHSC – winter letter re adult social care priority actions for winter
- NHSE- Winter letter
- Updated specification for System Co-ordination Centres (SCC)
- New Operational Escalation (OPEL) framework

4. Supporting our workforce

- Protect and improve the wellbeing of the workforce
- People Promise
- Vaccination
- Areas for breaks
- Consistent offer of food and drink
- Priority of supporting teams to have breaks and finish on time
- Rest periods
- Developing leadership support
- Robust on call system

Board of Directors' Meeting
08 September 2023

The Rotherham NHS Foundation Trust

Agenda item	P165/23
Report	**National, Integrated Care Board and Rotherham Place 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 robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of a of 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 Board of Directors with an update on national developments, developments across the South Yorkshire Integrated Care Board (SYB ICB) and Rotherham Place. Key points to note from the report are: • A total of 42 hospital buildings have so far been identified as containing reinforced autoclaved aerated concrete (RAAC). 7 of the affected hospitals are due to be replaced by 2030. • The ICBs Children and Young People's Alliance ran an online event in October to bring people together to talk about health equity for children and young people (C&YP) and to hear from young people about what matters most to them in the places and spaces where they live, learn, work and access health services. • The 2nd cohort of the Inclusive Cultures Partnership Programme: Reciprocal Mentoring commenced in October. The programme is aimed at helping to create a more diverse leadership across the ICB. • Recommended Summary Plan for Emergency Care Treatment (ReSPECT) went live in Rotherham on the 1 October 2023. ReSPECT creates personalised recommendations for a

	person's clinical care and treatment in a future emergency in which they are unable to make or express choices. • A new section of support has been added to RotherHive, Life Stages. This will continue to be developed into 2024. This section has been created to support adults in Rotherham and the people they care about. • The Rotherham Place System Winter Plan has been developed and agreed by all partners via the Rotherham Urgent and Emergency Care (UEC) Group.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Executive Team receives a weekly verbal update covering key Place and 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?)	*N/A*
Recommendations	It is recommended that the Board note the content of this paper.
Appendices	Appendix 1 Rotherham Place Partnership Update September and October 2023

1.0 Introduction

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

2.0 National Update

2.1 On the 6th October, NHS England published data reported by NHS Trusts on industrial action taken by junior doctors and consultants from the British Medical Association, junior doctors from the Hospital Consultants and Specialists Association, and consultants and dental trainees from the British Dental Association. The period covered by the data was from 0700 on Monday 2nd October until 0700 on Thursday 5th October. In addition, the data included members of the Society of Radiographers who took industrial action for 24 hours from 0800 on Tuesday 3rd October to 0800 on Wednesday 4th October. It should be noted that the data is provisional, as not all Trusts were able to supply data on workforce, or acute, community mental health and learning disability rescheduled activity.

2.2 The table below provides a (provisional) summary of the number of colleagues in England taking industrial action on the dates referred to above:

Region	Total number of staff absent from work as a result of IA (headcount) for the period of action 07:00 2 October 2023 to 06:59 3 October 2023	Total number of staff absent from work as a result of IA (headcount) for the period of action 07:00 3 October 2023 to 06:59 4 October 2023	Total number of staff absent from work as a result of IA (headcount) for the period of action 07:00 4 October 2023 to 06:59 5 October 2023
England	**24,663**	**27,137**	**25,605**
East of England	2,415	2,598	2,567
London	3,757	4,207	3,591
Midlands	4,974	5,209	5,306
North East & Yorkshire	4,262	4,642	4,653
North West	4,251	4,744	4,380
South East	3,092	3,488	3,147
South West	1,912	2,249	1,961

2.3 A total of 42 hospital buildings have so far been identified as containing reinforced autoclaved aerated concrete (RAAC). 7 of the affected hospitals are due to be replaced by 2030.

3.0 South Yorkshire Integrated Care Board (SYICB)

3.1 The 2nd cohort of the Inclusive Cultures Partnership Programme: Reciprocal Mentoring commenced in October. The programme is aimed at helping to create a more diverse leadership across the ICB. This is done though bringing together in a learning partnership, Black, Asian and Minority Ethnic leaders aspiring to work in more senior roles. Representation from organisations across the ICB, including the Trust, are part of the c40 people involved.

3.2 The ICBs Children and Young People's Alliance ran an online event in October to bring people together to talk about health equity for children and young people (C&YP) and to hear from young people about what matters most to them in the places and spaces where they live, learn, work and access health services.

The ambition is to be able to identify the social determinants likely to have the biggest impacts on health for C&YP in the short and long term and subsequently who is most likely to be impacted by them.

4.0 Rotherham Place

4.1 Following an update at September Place Board, public health colleagues produced an update on support available to residents with regard to the cost-of-living crisis. This includes:

- Awareness training to support money matters by RMBC
- Rotherhive – the mental health and wellbeing resources across Rotherham
- NHS Low Income Scheme

They also pointed to support available from utility providers.

4.2 ReSPECT went live in Rotherham on the 1 October 2023. ReSPECT creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.

4.3 Place Board received an update from the Place Digital Workstream in September. There are currently 36 live projects, between May 2022 and September 2023, 31 projects have been completed.

4.4 A new section of support has been added to RotherHive, Life Stages. This will continue to be developed into 2024. This section has been created to support adults in Rotherham and the people they care about. Mental health is important at any stage in life, from adolescence through to an adult and into your older years. This section provides a wealth of information to support an individual and the people they care about with different events and stages in life. Life stages is a useful resource for everyone in our communities. In this section you will find information, support, and advice on areas such as Marriage, Relationship Breakdowns, Parenting, Menopause, Going to University and Aging and Later Life.

4.5 Place Board received an update from the Maternity/Children and Young Peoples Workstream. The key areas covered include:

- Priorities, milestones, and metrics are agreed, priorities align to the Health and Wellbeing Strategy Aim 1 and the ICP Bold Ambitions
- Children and Young People's Partnership Board re-developed. The Board provides excellent opportunity for voice and influence
- Child and Adolescent Mental Health Service Looked After Children pathway in place
- Launch of Accessibility strategy and first round of funding applications being considered
- Start for life pack including robust digital offer in development

Next Steps are to:

- Embed the Breastfeeding friendly Borough Declaration

- Review the Child Development Centre
- Re-develop, implement, and embed a tiered sleep pathway
- Actively engage in recruitment activity to increase the number of foster carers
- Ensure children and young people with special educational needs and disabilities and their families can access accurate and relevant information on the Local Offer
- Produce a mental health transition pathway to support effective transition for looked after children and care leavers with social, emotional and mental health needs
- Maximise the use of the Rotherham Health Record to provide a 'health passport' to support transition from paediatric to adult services
- Implement and embed preparation for adulthood guidance

4.6 The Community Occupational Therapy (COT) Service is provided by The Rotherham NHS Foundation Trust but is funded between the South Yorkshire Integrated Care Board and Rotherham Metropolitan Borough Council.

Due to several factors including being unable to recruit to vacancies and the impacts of the pandemic, the COT Service came to the position of having 1,077 people waiting for an assessment and a wait time of 48 weeks in June 2022. An action plan was developed to bring down the waiting times for people needing OT intervention. As at the beginning of October 2023, the waiting numbers have now decreased to 260 people waiting for an assessment and the longest wait for allocation is 11 weeks. Work is ongoing with the team to ensure this waiting time continues to decrease.

4.7 The Rotherham Place System Winter Plan has been developed and agreed by all partners via the Rotherham UEC Group. It was approved by the Rotherham Place Board and will be received by the Health and Wellbeing Board and Health Scrutiny in November. Further information covering the key highlights of the plan are provided in Appendix 1, together with updates on all recent Rotherham Place activity.

4.8 The Health Select Commission met on the 28 September. The Deputy Chief Executive attended. The key areas of focus included Suicide Prevention and Adult Social Care preparedness for CQC inspections.

4.9 The Health and Wellbeing Board met on the 27th September 2023. The key areas of discussion included an update on the Loneliness Action Plan, an update on the NHSE funded pilot to support frequent attenders to ED with complex Alcohol and Mental Health needs. This initiative is led by the Trust.

4.10 The Consultant in Public Health, employed jointly by the Trust and the local authority has been in post for seven months. He is leading a programme of work to manage population health within Rotherham, based on tackling health inequalities and developing preventative interventions. Work currently underway includes:

- Development of a community engagement project in Maltby and Dinnington to explore the needs of members of the community who are living with multiple

long-term health conditions, with a longer term view to develop targeted, evidence based and effective interventions.

- Undertaking an evaluation of the equalities impacts of the Mexborough Elective Orthopaedic Centre, working alongside colleagues from Barnsley and Doncaster.
- Developing an understanding of the wider impacts of outreach interventions in the alcohol liaison team.
- Building a programme of health coaching training for staff across the trust and wider system, building on the MECC programme and working with local authority and ICB colleagues.
- Exploring opportunities to embed exercise referrals into our clinical pathways.
- Examining the inequalities experienced in the diabetic pathway for those already referred to the Trust's services (e.g. access to insulin pump technology); and also in the wider system, leading the work stream on prevention of type 2 diabetes within the system transformation programme.
- Responding to health protection matters, such as our procedures for engaging with Environmental Health teams in the case of allergic response to food or other stimuli; looking at the epidemiological data around a hypothesised rise in necrotising fasciitis across Yorkshire, for example.

Michael Wright
Deputy Chief Executive
November 2023

Rotherham Place Partnership Update: September / October 2023

The Cost of Living Crisis – following a discussion at September Place Board, Public Health colleagues produced an update on what support is available and where it can be found. The update covers:

- ***Awareness training to support money matters*** Money matters – Rotherham Metropolitan Borough Council
- ***Rotherhive*** RotherHive – The wellbeing and mental health resource for Rotherham
- ***NHS Low Income Scheme***: https://www.nhsbsa.nhs.uk/nhs-low-income-scheme
- ***Utility Priority Customer Scheme***
- ***Gas & Electric*** - Get help from your supplier - Priority Services Register | Ofgem
- ***Water*** - Yorkshire Water - Priority services register

Work is being led by RMBC's Humanitarian Group and anyone wishing to join from Place partner organisations can e-mail: katie.norcliffe@rotherham.gov.uk.

The **Rotherham Place Medicines Optimisation Team** with support from our **Mental health Commissioner** were awarded **silver** for our **Antidepressant Review Project** (missing out on Gold by 2 votes!)

The Rotherham Neurorehabilitation service supports people recovering from stroke, road traffic accidents, serious falls and other conditions or events that require intensive therapeutic, medical, and nursing care to help them regain their optimum level of physical, cognitive, communicative, social behavioural function.

From 1 August 2023, Rotherham, Doncaster and South Humber NHS Foundation Trust became the new provider and employer of staff working within the service (formerly The NHS Rotherham Foundation Trust).

Five community beds are provided in Magnolia Lodge in Doncaster. Community neuro nurses will continue to visit people in Rotherham, in their own homes or other settings and the therapy elements will continue the Park Rehabilitation in Rotherham.

ReSPECT creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment. **ReSPECT went live in Rotherham on 1 October 2023.**

Place Board received an update from the **Place Digital Workstream** in September. There are currently 36 live projects, between May 2022 – September 2023 31 projects have been completed, over a range of partners such as TRFT, VAR, CCG (as was) and RDASH.

What's Working Well

01 Rotherham Heath Record (RHR)
- New platform rolled out to all practices
- Increased usage across primary and social care staff
- Data sharing model agreed to onboard care home users
- Children's services dataset received

02 Rotherham Health App
- 22.4% of Rotherham population with logins to RHA
- Push notifications launched
- Appointments are now live at PCN level, offering patients appointments with a social prescribing link worker

03 RDaSH EPR Procurement
- The full tender documentation, including Output Based Specification, was issued to market on the 14th August,

04 TRFT Patient Hub & Wayfinder Programme
- Number of future appointments enabled for notification in Patient Hub has been extended from 64% to 76%
- NHS Wayfinder Programme phase II live
- 1167 notifications delivered via the NHS app

05 Yorkshire and Humber Care Record (YHCR)
- TRFT data consumer pilot now live
- Rotherham Hospital provider data maturity scoping document approved
- GP Consumer Pilot to go live

06 Rotherham IT Services Review
- GovRoam testing details have now been shared with all partners.
- Consolidation of Place and TRFT data centres in planning
- Shared site network under consideration at Riverside

07 Digital Inclusion (DI)
- DI Strategy, Action Plan and Comms Plan completed and approved
- Recruitment for Digital Support Officers ongoing
- Databank Pilot successful
- Website ready for launch

08 RODA
- Profiling focused geographies to inform the development of population health interventions
- Early work on the environmental benefits of delivering appointments virtually
- Exploratory analysis of customer insights data

Key work over the next period includes developments for the Rotherham Health App, Digital Inclusion and Rotherham Health Record.

Medical Director Update

I've been asked to update on what I've been doing so things of interest (hopefully) over the last 3 months are:

- Covid and Flu immunisations: Jo Martin has done fantastic work in moving forward plans to implement Covid and Flu jabs. To date Rotherham is sitting on top of the SY league table for Covid jab percentage given with 38.8%. I sit on the SY meeting, but Jo does all the work!
- Another highlight has been the work on anti-depressant de-prescribing for which Stuart Lakin's Rotherham Medicines Management team has won a PrescQIPP national award. This uses the specialist pharmacy team to help patients who have been taking anti-depressants for a long time to gradually reduce and stop them, something which is both very difficult and time consuming.
- I've very much enjoyed and embraced my QSIR (Quality Service Improvement and Redesign) training and am looking forward to embedding the learning and working with colleagues using the methods.
- I've continued to work on the Health and Wellbeing Board where I am Vice-Chair and a co-sponsor for Aim 1, best start in life. I've also attended a couple of partnership meetings and continue to represent Rotherham at the ICP (Integrated Care Partnership) meetings, the last of which discussed employment and Health
- I have monthly meetings with the other Medical Directors where we are working on ways to work better together between places and solve issues
- In the area of cancer, I've particularly been involved with Grail, a new blood test that may be used by the NHS starting next year, which can detect early cancer. We have been making plans for how to organise that if we are given the go-ahead. I also have the pleasure of chairing the primary care clinical delivery group in the absence of the usual chair Dr Steph Edgar. We discussed some issue regarding thyroid cancer and issues regarding screening. In my "other" role I continue to work on Targeted Lung Health Checks
- Within primary care I continue to chair a monthly collaboration board which includes General Practice, but also invites pharmacy and optometry colleagues. We also invite medical leaders from TRFT, RDASH and public health to update on local news and issues and discuss problems.
- In primary care we hosted an access event, attended by the majority of Rotherham practices, where good practice regarding access to primary care was discussed, and practices were supported to make action plans going forward for a contractual requirement on their part. Organised by Rachel Garrison and team, this was the first time that this method of delivery has been used and may be taken forward as best practice by NHSE
- In other areas I've attended a meeting on oral health, looking at the possibility of fluoridating the water, and care closer to home where we discuss local paediatric pathways
- Finally, I continue to organise Rotherham Protected Learning Time and Commissioning events (PLTC), but am taking a break from this as the next one is being organised by the Rotherham GP Federation

Dr Jason Page, MBBS BSc
General Practitioner / Rotherham Place Medical Director within NHS South Yorkshire / Rotherham Macmillan GP

RotherHive

ROTHERHIVE is an online platform which was developed (originally by NHS Rotherham CCG) to provide a range of verified practical advice and accurate contact details for local, national, and online mental health and wellbeing services for adults in Rotherham.

Wellbeing is a state of being happy and healthy in our bodies (physically) and in our minds (mentally). Mental Health is defined as a state of wellbeing in which an individual can cope with the normal stresses of life and can work productively.

Following several initiatives, conversations in the community and feedback, it became clear that people in Rotherham needed a reliable online platform where they could go to get trusted and verified information. The platform has been developed and designed to make it as easy as possible for the adults of Rotherham, whether they are in need themselves or for someone who is concerned about someone else, to engage with the online platform enabling them to find the right and most relevant information they need all in one place, as quickly as possible.

ROTHERHIVE Life Stages - is a new section which will continue to be developed as we move into 2024. This section has been created to support adults in Rotherham and the people they care about. Mental health is important at any stage in life, from adolescence through to an adult and into your older years. This section provides a wealth of information to support an individual and the people they care about with different events and stages in life. Life stages is a useful resource for everyone in our communities. https://rotherhive.co.uk/life-stages/ In this section you will find information, support, and advice on:

- Marriage
- Major life events
- Relationship breakdowns
- Pregnancy
- Parenting
- Going to university
- Child to adult
- Menopause
- Ageing and later life

Rotherhive can be accessed at https://rotherhive.co.uk/
Where you will also find a short animation that shows users how to navigate the site.

Place Board received an update from the **Maternity/Children and Young Peoples** Workstream, key highlights were:

- Priorities, milestones, and metrics are agreed, priorities align to the Health and Wellbeing Strategy Aim 1 and the ICP Bold Ambitions
- Children and Young People's Partnership Board re-developed. The Board provides excellent opportunity for voice and influence
- Child and Adolescent Mental Health Service Looked After Children pathway in place
- Launch of Accessibility strategy and first round of funding applications being considered
- Start for life pack including robust digital offer in development

Next Steps are to:

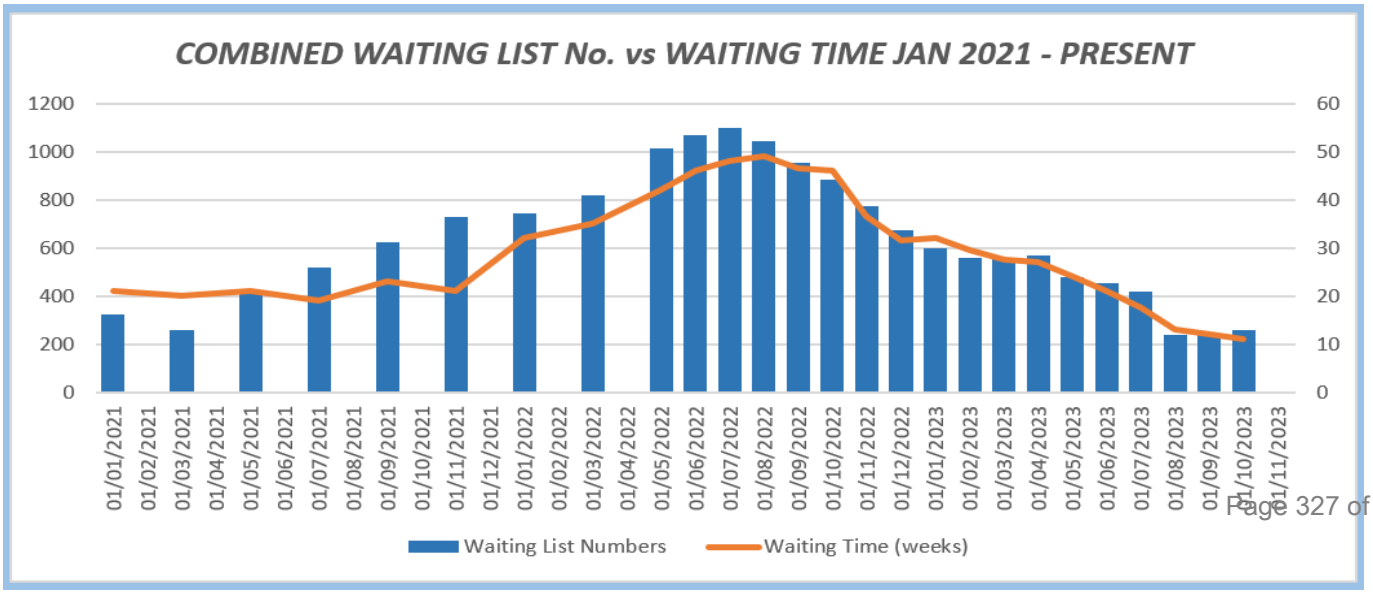
- Embed the Breastfeeding friendly Borough Declaration
- Review the Child Development Centre
- Re-develop, implement, and embed a tiered sleep pathway
- Actively engage in recruitment activity to increase the number of foster carers
- Ensure children and young people with SEND and their families can access accurate and relevant information on the Local Offer
- Produce a mental health transition pathway to support effective transition for looked after children and care leavers with SEMH needs
- Maximise the use of the Rotherham Health Record to provide a 'health passport' to support transition from paediatric to adult services
- Implement and embed preparation for adulthood guidance

The Community Occupational Therapy (COT) Service is provided by The Rotherham NHS Trust but is funded between the South Yorkshire Integrated Care Board and Rotherham Metropolitan Borough Council. The funding for the COT service is from Better Care Fund (BCF) funding under a Section 75 agreement between ICB and RMBC, with the ICB as lead commissioners.

Due to several factors including being unable to recruit to vacancies and the effects of the pandemic the COT Service came to the position of having 1,077 people waiting for an assessment and a wait time of 48 weeks in June 2022. With Commissioners and the COT Service an action plan was developed to bring down the waiting times for people needing OT intervention. The less complex requests being received were analysed and alternative pathways investigated. Training was given to OTs working in other Services in Rotherham to allow them to directly access simple adaptations for the people they were working with, which eradicated the person's wait for a second unnecessary assessment by the COT Service. Working closely with the RMBC Adaptations Team around early financial assessments to allow people to make decisions earlier about how they wished to progress the work needed, and around assessment for some simple adaptations in Council properties.

We reviewed the Royal College of Occupational Therapy guidance 'Adaptations without Delay', which challenged the Service to look at what grades of staff should be undertaking what complexity of assessments and interventions, and this led to our Support Worker workforce taking on more complex cases, with support when needed. As the situation improved, despite the shortage of Occupational Therapists nationally, we were able to recruit to the vacant OT posts. We also gained support to increase our admin support hours to ensure the clinicians are freed to have a more clinical focus going forward. Funding was also given to work with a private provider to undertake 160 cases on our behalf and this is currently ongoing.

As of the beginning of October 2023 the waiting numbers have now decreased to 260 people waiting for an assessment and the longest wait for allocation is 11 weeks. Work is ongoing with the team to ensure this waiting time continues to decrease.



The **Rotherham Place System Winter Plan** has been developed and agreed by all partners via the Rotherham UEC Group. It was approved by the Rotherham Place Board and will be received by the Health and Wellbeing Board and Health Scrutiny in November.

What worked well

- Rotherham Place Winter Plan developed in collaboration with all partners, aligned to Urgent and Emergency Care priorities
- Strong relationships with agreed escalation to executive level for assurance
- More integrated multi-disciplinary working to manage flow
- Additional senior support on site
- Point of care testing in the emergency department
- Extended hours e.g., discharge lounge, transport, pharmacy
- Surge capacity for paediatrics
- Acute escalation wheel and command centre

What we Learned

Learning Point	Mitigation for 2023-4
Seasonal pressures came earlier than anticipated with worst impact prior to Christmas	National scenario plans including projections from the Southern Hemisphere have informed planning processes
Difficult to recruit to temporary roles	TRFT have recruited to year round posts where proven. Some roles substantively recruited to at risk, otherwise flexible options used such as additional hours
Bed capacity was a challenge	Virtual ward beds opened, additional general, and acute/surge beds planned as well as community residential surge/spot purchase beds
Bedded use of assessment units	Plans in place to protect these areas
Consistency of Schemes	Joint planning to ensure schemes work together, e.g., where one service has extended hours, this needs to be aligned with other services and communicated. Joint health and social care information pack being developed

What's different in brief 2023-24

Health and Social Care in the acute hospital

- Re-introduction of the 4 hour standard
- Ambulance hand over delays improvement plan
- Additional social workers to support the front door for admission avoidance and discharge
- Additional General & Acute beds and additional surge beds phased implementation
- Additional patient transport crew Mon to Fri, 2–10 pm Nov – March
- Protect Same Day Emergency Services, electives, and orthopaedic pathways
- Senior role to support electives and cancer pathways
- New MRI scanner in place for cancer patients, reducing waiting times
- Breast pain cancer pathway in place to filter to correct clinic and reduce two week waits

Health and Social Care in the Community

- Introduction of the virtual ward (5 beds Dec 22) capacity for 60 from October 23
- Development of the Urgent Community Response offer
- Development of the PUSH model with Yorkshire Ambulance Service to avoid unnecessary conveyances including a Rothercare enabler and additional transport
- Temporary resource for community nurse to support in-reach, therapy locum and additional support worker hours
- Implementation of the Integrated Transfer of Care Hub
- Additional reablement hours
- Hospital at home service commissioned
- Trusted assessor pilots to support out of area discharges and timely discharges to care homes
- Continuation of 15 residential surge beds at Lord Hardy Court, with spot purchase beds to better meet individual needs/complexity

Primary Care

- Primary care will run at full core capacity, with primary care hub for additional appointments, freeing up PCNs to support more complex cases (Dec 23 – Feb 24)
- Flu and Covid vaccinations for patients delivered as a system using PCN/place footprint for delivery
- Enhanced access to primary care including increase reception capacity and cloud telephony
- Early additional recruitment taking place for additional seasonal staffing.
- Use of NHS professionals to support staff sickness

Children and Young People

- Multi-agency silver working group meeting weekly to monitor key pressures
- CYPs Crisis & Intensive Community Support Team will engage to provide risk assessment/care/treatment to avoid re-presentation at UECC
- Self-help support and wider public health information will be promoted
- The Me in Mind Teams will work intensely with schools to support resilience and provide early intervention where children and young people are showing the early sign of emotional distress.

Mental Health

- Support for crisis beds
- Improved access to support including for those who have attempted suicide
- Expansion of safe space crisis drop in
- Roll out of mental health awareness training
- Focus on patient flow with new mental health escalation framework

Voluntary and Community Sector

- Continuation of Voluntary Action Rotherham Urgent and Emergency social prescriber pilot for admission avoidance and discharge
- Continuation of You Ask We Respond personal health budget pilot to support timely discharge
- Re-prioritisation of Age UK hospital aftercare service including non-personal care and access to low level equipment

System

- Community escalation wheel to enable whole system view of system pressures
- Agreed approach to winter and system exceptionality meetings
- Communications plan across Place including support for cost of living crisis

What are the key challenges

- Impact of industrial action including mitigation planning / recovery
- System challenges – capacity to focus on developing and embedding new ways of working
- Cost of living pressures
- Demand, complexity of patients and delayed discharges impacting on performance at times of pressure
- Risk of Covid surges potentially impacting on bed base / staff availability

Board of Directors Meeting
3rd November 2023

Agenda item	P166/23
Report	**Joint Strategic Partnership Update**
Executive Lead	Dr Richard Jenkins, Chief Executive Michael Wright, Deputy Chief Executive
Link with the BAF	OP3: There is a risk robust service configuration across the system will not progress and deliver seamless end-to-end patient care across the system because of a of lack of appetite for developing strong working relationships and mature governance processes leading to poorer patient outcomes.
How does this paper support Trust Values	Together: the paper demonstrates how The Rotherham NHS FT and Barnsley Hospital NHS FT have been working together in partnership with the ambition of improving the quality and sustainability of services.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary	The Rotherham NHS FT and Barnsley Hospital NHS FT appointed a Joint Chief Executive and agreed to develop a Joint Work Programme in 2022. A governance structure has been put in place to support the delivery and oversight of the partnership programme across both organisations, including at Executive and non-Executive level. This paper revisits the information provided at the July meeting of the Trust Board and also provides an update on the initiatives within the partnership work plan. The specific areas covered include: 1. Governance arrangements including an update of how the arrangements are progressing 2. A recap on the significant programmes of work and information around progress to date 3. An update on planned next steps for the programme
Due Diligence	Elements of this report have been presented to both Boards of Directors at TRFT and BHFT.
Board powers to make this decision	N/A
Who, What and When	N/A

Recommendations	The Board of Directors is asked to note the progress on the work programme and also note that the governance arrangements are starting to embed.
Appendices	

1.0 Background

1.1 The Rotherham NHS Foundation Trust (TRFT) and Barnsley Hospital NHS Foundation Trust (BHNFT) agreed to a strategic partnership in 2022, facilitated by the appointment of a Joint Chief Executive.

1.2 The Trusts created a Joint Strategic Partnership Group (JSPG), comprising both Chairs, a Non-Executive Director from each Trust, both Managing Directors and the Joint Chief Executive. This group meets quarterly and works on behalf of both Trust Boards to have oversight on the development and delivery of a joint partnership programme.

1.3 The Trusts also agreed to bring together a few members of each Executive Team to form a Joint Executive Delivery Group (JEDG), responsible for driving the delivery of the joint work programme on an ongoing basis. This included the triumvirates of both trusts, plus the Managing Directors/Deputy Chief Executives, the Joint Director of Corporate Governance, the Director of Strategy, Planning & Performance from TRFT and the Assistant Directors of Strategy, Planning and Delivery from the two trusts. This group meets monthly to review the progress against the planned programme.

1.4. The two trusts have been working closely together in an informal manner since the appointment of the interim Joint Chief Executive in 2020. Until the agreement around a more formal strategic partnership in 2022, this has taken the form of each organisation learning from the other, proactively sharing best practice and exploring opportunities for collaboration. Equally, over this time we have had a Joint Director of Workforce and interim Joint Director of Communications, so discussions between Executive Team peers have taken place as a natural consequence of the informal relationship we've had for the last four years.

1.5 Since the appointment of the Joint Chief Executive in 2022, the partnership has strengthened, both in terms of the formal governance structure which has been put in place in order to ensure delivery of the partnership programme, and subsequently the collaboration that has taken place between the two organisations. Over the last six months the joint programme has delivered some tangible and significant benefits to both trusts, which are summarised in the below report.

2.0 Development and Delivery of the Joint Work Programme

2.1 The Partnership Work Programme (Appendix 1) was produced through a structured engagement approach involving both Executive Teams and the wider Senior Leaders groups.

2.2 As shared previously at each Trust Board, in this inaugural year of partnership, the various individual pieces of work have been grouped into three major themes:

- Governance
- Major programmes
- Smaller projects

2.3 Updates on these areas of work are provided below.

3.0 Theme 1: Governance

3.1 This theme covers the governance and formal structures necessary to ensure delivery of the programme. It includes the minimum necessary governance for the programme and underpins the delivery of the full programme of work. In addition to the governance structures, the Director of Strategy, Planning and Performance at The Rotherham NHS FT has recently agreed to support the Partnership approximately two days a week, in order to provide Executive Team leadership to the programme of work. A full role description is in development, but the primary focus will be two-fold – firstly, ensuring delivery of the existing Partnership programme and development of the longer-term programme, and secondly, representing the Parntership on behalf of the Joint Chief Executive at relevant forums as required. This will also strengthen the link between the two organisations and the Acute Federation, supporting the desire for the Partnership to have an appropriate voice at System level.

3.2 The governance structure which was established earlier in 2023 continues, with the monthly **Joint Executive Delivery Group (JEDG)** focussing on the oversight of delivery of the new programme. This supports the **Joint Strategic Partnership Group (JSPG)** which ensures Board-level assurance on the impact of the partnership across both trusts.

3.3 On a quarterly basis, a **Joint Executive Team Meeting,** with membership consisting of both Trust Executive Teams, now takes place quarterly to facilitate ongoing relationship-building and shared approaches. The meeting encourages sharing of best practice in order to facilitate learning between the two trusts, as well as collaborative discussion about the trusts' approaches to different local and national issues. For example, in the most recent meeting, both Trusts presented their draft responses to the national elective care requirements letter, with an early thought-paper on potential future EPR convergence presented by the Directors of Health Informatics and a proposal around return to financial balance shared by the Directors of Finance. This collaborative discussion and debate has facilitated a number of further conversations between teams to support each organisation's deliverables.

3.4 The inaugural **Joint Senior Leaders** meeting took place in April 2023 as noted in the previous update, with a focus on cross-organisational divisional collaboration and opportunities. Outside of this forum, divisional and Clinical Business Unit (CBU) teams have continued to engage with each other over potential mutual support, building on the initial discussions held earlier in the year. The next Joint Senior Leaders meeting is planned for November 2023, with Sir Jim Mackey agreeing to speak to colleagues and offer his perspectives on the current challenges and opportunities within the NHS. These sessions will take place three times a year.

4.0 Theme 2: Major programmes

4.1 Three major programmes of work have been identified to be taken forward in 2023/24 initially – a Clinical Services Review, a Joint Leadership Development Programme and Commercial Opportunities.

4.1.1 Clinical Services Review: This programme of work entails a systematic review of clinical services in both Trusts using a shared methodology that has previously been developed and used at different times by the two Trusts. The outputs of this iterative piece of work will used to drive strategic thinking and decisions for teams to develop, deliver and maintain high quality, safe and sustainable services. The reviews were completed at both Trusts in Q1 and shared at the Joint Executive

Delivery Group for discussion in order to identify specific learnings, shared challenges and potential opportunities to collaborate and support each other. There was some further work requested for a future, more detailed review of outputs and opportunities in Q4, to align with the completion of the next iteration of sustainability reviews at that point.

Related to this, having successfully delivered the **Joint Gastroenterology Service** and embedded this into business as usual service delivery, the joint scoping of further potential opportunities to directly collaborate within services took place in Q1. Following this, the two Trusts have begun work at pace around a potential future **Joint Haematology Service**, with a clinical summit taking place in mid-October to agree the future vision for such a service. This has established a three-pronged vision for such a service, which mitigates the significant workforce challenges at Barnsley NHS FT in the short-term, and also builds towards a joint inpatient service offering in the future. It is anticipated that further services will be identified for similar exploration early in 2024/25, with clinical colleagues from both trusts leading discussions around any such development opportunities.

Whilst these joint approaches may appear an obvious solution to particular service challenges at one or other trust, this level of collaboration embodies the way in which both trusts are considering the benefits across the whole partnership of such options. It is often the case that whilst the most challenged trust will benefit significantly from increased joint working, the second trust may have to manage a drop in performance due to the bringing together of teams and services.

4.1.2 **Joint Leadership Development**: Both Trusts recognise that effective, empowered and valued leadership is the key to this partnership succeeding, as well as to both Trusts delivering on their own objectives and ambitions. Following the competitive tender exercise which closed in the summer, Value Circle have been selected as our chosen provider to deliver a comprehensive and broad leadership development programme for our Divisional and CBU leadership teams, which is due to be launched in early November 2023 and be a 12-month engagement. The programme will be focused on developing the leadership behaviours and skills needed to thrive within the partnership environment the trusts are building, and will also enable development of the more conventional internal management and leadership skills required to deliver outstanding results within teams. It should therefore support both each individual trust's delivery potential, but will also enhance our potential to maximise the opportunities from the partnership.

As well as the divisional and CBU leadership development programme, going forward the Trusts will collaborate on scoping approaches to leadership development for defined key groups, for example Ward Managers, Clinical Leads and Service Managers. The critical mass and shared learning approaches that a joint initiative would bring is expected to be advantageous to both Trusts in recruiting, retaining and developing a pipeline of high quality individuals. Given the increasing challenges within the NHS at the moment, that will become ever more important in the coming years.

Taking this further and to take a more direct approach to a shared learning ethos, both Trusts are also keen to consider innovative rotational posts for management colleagues, analogous to the rotational approaches traditionally used for medical staff. This would expose managers to different approaches and experiences in two Trusts and in different services over a number of years, and should provide a broad

basis for developing towards higher roles.

4.1.3 Commercial: With an increasing move towards system working across the NHS, more contracts are being procured at system-level, with convergence around suppliers considered a positive outcome. Within the partnership, there are further opportunities to work together on upcoming sizeable procurements, with the Joint Head of Procurement role lending itself well to this collaborative approach. Both trusts will continue to ensure consideration is given to whether joint procurement offers quality and financial benefits to the partnership.

5.0 Theme 3: Project work

5.1 This area of focus captures our smaller, more discrete opportunities which nevertheless, in the aggregate, will provide considerable benefits to both organisations. These pieces of work are owned and delivered by the relevant corporate or operational teams. They include the ongoing maturing of existing approaches as well as new areas for exploration. The following paragraphs provide an update on the specific areas which have progressed since the update to the Board of Directors a few months ago.

5.1.1 Joint roles: One notable benefit of the partnership is the enablement of potential joint roles across the two organisations, where it can support sustainability of our small teams and where increased collaboration brings benefits to both trusts. The two trusts already share a Joint Head of Procurement post, as well as the Joint Chief Executive. Over the last few months, the Joint Director of Corporate Affairs post has been appointed to, and a Joint Director of Communications role is also being explored. In addition, the Chief Pharmacist at TRFT has been supporting Barnsley on an interim and short-term basis for the last few months given a critical gap, and this has been extended for a further six months to provide continuity whilst permanent recruitment options are finalised.

Whilst there is no intention of joint roles becoming the default, these positive examples of how the two organisations can work together to manage critical workforce gaps demonstrate the significant benefit to be gained from consideration of these arrangements (even on a short-term basis) where these opportunities arise. This is particularly the case within small teams within the trusts, where resilience can be a significant challenge within smaller providers such as each of ours. As such, a review of the structures and make-up of our corporate teams will take place over Q3 and Q4, in order to establish if there are areas where further joint working may support improved outcomes for either or both teams.

5.1.2 NHS Graduate Scheme – earlier in 2023, the two trusts submitted a joint bid to NHS England to host up to 5 NHS Graduate Scheme individuals over 23/24 and 24/25, with the intention of rotating any successful candidates across the two organisations over the placement period. The bid was successful, with TRFT and BHFT attracting 4 out of the total of 37 candidates who were offered placements across the entire North East and Yorkshire region, significantly more than would be expected given the size of our two trusts. These colleagues started in post in September, and after a month's intense induction programme, two colleagues are now working in each organisation for the next 12 months before they move to the other Trust for the second half of their two-year placement. Being able to offer the NHS Graduate Scheme trainees this mixed experience within two providers was seen as a unique and highly positive element of our bid, which demonstrates the

increasing value the NHS is placing on proactive partnership working.

5.1.3 Website development: Both Trusts have now launched their revised websites following the joint procurement exercise. This ensures both Trusts have a consistent and standardised public-facing website. The next step is to carry out significant development work on the internal websites of both organisations.

6.0 Next Steps

6.1 With the increased resource now allocated to the partnership programme at Executive level, it is anticipated that further momentum will build around the partnership in the second half of the year. Similarly, the leadership development programme for divisional and CBU leadership teams that is due to run through Q3 and Q4 will naturally lead to further identification of opportunities for collaboration, and bring a further injection of energy to the work that has already begun at pace.

6.2 A key element of work required in Q3 and Q4 will be generation of the future partnership workplan for 2024/25. Equally, further focus is expected on sharing the opportunities and benefits of the partnership more broadly both internally within our two organisations and externally with the wider NHS.

7.0 Conclusions

7.1 Since the formal strategic partnership was agreed, the two Trusts have stepped up the level of partnership working between the two organisations and increased the level of resource allocated to delivery. The agreed work programme is intended to systematically and formally build on those good foundations through a diverse set of workstreams focussed on supporting each organisation to progress important areas around quality of services for patients, becoming better employers in a supply-limited NHS workforce environment, supporting delivery of operational standards and contributing to more effective use of public money. The programme runs through to the end of the 2023-24 year, at which point a further set of proposals for subsequent years will be developed. This will be based on an objective assessment of the learning identified from our first full year of partnership working.

8.0 Recommendations

8.1 The Board of Directors is asked to note the progress on the partnership and support the future development planned around the programme.

Dr Richard Jenkins
Chief Executive
October 2023

Board of Directors Meeting
3rd November 2023

Agenda item	P167/23
Report	**Integrated Performance Report – September 2023**
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 2023 data wherever it is available. It highlights performance against agreed national, local or benchmarked targets. The regular assessment of inequalities of access to care within our elective care portfolio is provided within this report. There are a number of Statistical Process Control (SPC) charts included at the end of this report. A brief explanation of the key elements of the SPC charts is included at the back for reference.
Due Diligence	The Finance and Performance, Quality Committee 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 – September 2023

Board of Directors

Integrated Performance Report - September 2023

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 - KPI DQ KEY

Data Quality Key for DQ Icons and Scoring.

S - Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?
T - Timely & Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data. Are all the elements of information needed present in the designated data source and no elements of needed information are missing?
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)?
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

Trust Integrated Performance Dashboard - Operations

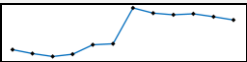
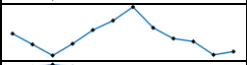
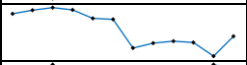
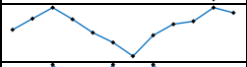
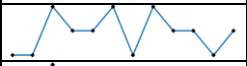
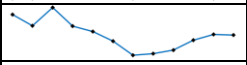
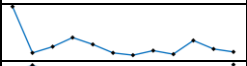
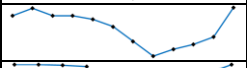
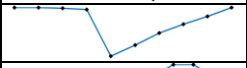
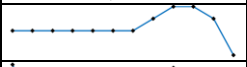
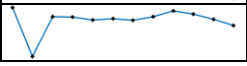
KPI	Reporting Period	Type of Standard	Target 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Planned Patient Care												
Waiting List Size	Sep 2023	L	**27,500**		30,032	31,507	32,544	33,235	33,235	25,733		
Referral to Treatment (RTT) Performance	Sep 2023	N	**92%**		64.1%	62.1%	59.5%	59.5%	62.9%	67%		
Number of 52+ Weeks	Sep 2023	L	**350**		363	477	601	706	706	217		
Number of 78+ Weeks	Sep 2023	L	**0**		0	0	3	2	2	9		
Number of 65+ Weeks	Sep 2023	L	**50**		28	24	40	58	58	0		
Overdue Follow-Ups	Sep 2023	L	-		14,997	15,874	16,004	15,827	15,827	16,433		
First to follow-up ratio	Sep 2023	B	**2.4**		2.56	2.59	2.69	2.59	2.63	2.36		
Day case rate (%)	Sep 2023	B	**85%**		84.4%	85.1%	86.1%	84.2%	84.7%	85%		
Diagnostic Waiting Times (DM01)	Sep 2023	N	**1%**		5.7%	5.6%	6.9%	4.8%	5.7%	12%		
Diagnostic Activity Levels - for Key Modalities (from Apr 2023)	Sep 2023	L	**7774**		8,378	8,020	7,558	8,066	8,066	8906		
Capped Theatre Utilisation	Aug 2023	L	**85%**		77.7%	75.2%	79.6%	77.2%	77.2%			
Emergency Performance												
Number of Ambulance Handovers > 60 mins	Sep 2023	N	**0**		88	54	114	28	420	314		
Ambulance Handover Times % > 60 mins	Sep 2023	N	**0%**		4.6%	2.8%	5.8%	1.4%	3.6%	19%		
Number of Ambulance Handovers 30+ mins	Sep 2023		-		231	169	270	152	1,228	565		
Ambulance Handover Times % 30+ mins	Sep 2023	L	**10%**		12.0%	8.7%	13.7%	7.7%	10.5%	34%		
Average Time to Initial Assesment in ED (Mins)	Aug 2023	N	**15**		23	25	23	26	27	25		
4hr Performance in Dept	Sep 2023	N	**70%**		58%	64%	56.5%	61.4%	59.1%			
Proportion of patients spending more than 12 hours in A&E from time of arrival	Sep 2023	L	**2%**		4.9%	3.2%	7.2%	4.2%	4.7%	14%		
Number of 12 hour trolley waits	Sep 2023	N	**0**		0	0	0	0	0	10		
Proportion of same day emergency care	Sep 2023	L	**33%**		43.9%	44.1%	40.0%	41.7%	43.1%	43%		
Cancer Care												
2 Week Wait Cancer Performance	Aug 2023	N	**93%**		71.3%	81.4%	86.5%	71.8%	81.8%	97%		
2 Week Wait Breast Symptoms	Aug 2023	N	**93%**		40.7%	95.7%	82.5%	84.4%	91.1%	95%		
31 day first treatment	Aug 2023	N	**96%**		90.3%	97.4%	98.2%	91.4%	97.7%	93%		
62 Day Performance	Aug 2023	N	**85%**		56.2%	65.9%	74.5%	68.5%	69.1%	72%		
The number of cancer 62-day pathways waiting 63 days or more after an urgent suspected cancer referral	Aug 2023	L	**64**		67	52	41	46	46	-		
28 day faster diagnosis standard	Aug 2023	N	**75%**		74.6%	72.1%	80.3%	77.6%	70.0%	66%		
Inpatient Care												
Mean Length of Stay - Elective (excluding Day Cases)	Sep 2023				2.68	2.63	3.21	2.98	2.86	2.74		
Mean Length of Stay - Non-Elective	Sep 2023				5.20	4.90	5.73	5.15	5.33	6.23		
Length of Stay > 7 days (Snapshot Numbers)	Sep 2023	L	**142**		162	176	162	155	155	218		
Length of Stay > 21 days (Snapshot Numbers)	Sep 2023	L	**62**		43	69	43	46	46	80		
Right to Reside - % not recorded (Internal Performance from May)	Sep 2023	B	**0%**		6.7%	8.0%	8.4%	9.6%	9.6%	7%		
Discharges before 5pm (inc transfers to Dis Lounge)	Sep 2023	L	**70%**		62.7%	61.3%	62.4%	62.1%	61.5%	59%		
Outpatient Care												
Did Not Attend Rate (OutPatients)	Sep 2023	B	**6.2%**		8.3%	7.6%	7.4%	7.6%	8.1%	9%		
% of all Outpatient activity delivered remotely via telephone or video consultation	Sep 2023	N	**25%**		11.4%	11.8%	12.7%	13.4%	12.1%	16%		
Number of patient pathways moved or discharged to PIFU, expressed as a proportion of all outpatient activity.	Sep 2023	N	**5%**		1.9%	2.2%	1.9%	2.0%	2.1%			
LUNA Data Quality Score	Sep 2023	N	**99%**				99.1%	99.3%	99.3%			
% of RTT PTL Reported as Validated	Sep 2023	N	**60%**				21%	78%	78%			
Community Care												
MusculoSkeletal Physio <4 weeks	Sep 2023	L	**80%**		29.1%	23.3%	28.1%	28.9%	26.0%	13%		
A&E attendances from Care Homes	Sep 2023	L	**144**		156	154	169	144	144	137		
Admissions from Care Homes	Sep 2023	L	**74**		101	112	128	111	111	86		
Urgent 2 Hour Community Response (one month behind)	Jul 2023	L	**75%**		85.8%	82.9%	82.9%	73.9%	80.3%	89%		
Numbers of pts on virtual ward	Sep 2023	L	**40**		23	31	36	25	25	0		
Number of patients in month accepted onto virtual ward (Total)	Sep 2023				68	120	108	130	130	0		

The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Quality

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
Mortality												
Mortality index - SHMI (Rolling 12 months)	Jun 2023	B	**As Expected**		107.79	106.75	105.00	102.90	--	105.02		
Mortality index - HSMR (Rolling 12 months)	Jul 2023	B	**As Expected**		96.49	93.95	92.78	89.74	--	101.6		
Number of deaths (crude mortality)	Sep 2023		-		75	45	73	74	417	78		
Infection, Prevention and Control												
Clostridioides-difficile Infections	Sep 2023	L	**2**		4	2	1	2	18	5		
Clostridioides-difficile Infections (rate)	Sep 2023		-		30.0	29.3	30.0	28.1	28.1	21.5		
E.coli blood bactertaemica, hospital acquired	Sep 2023	L	**4**		3	3	5	2	23	4		
P. Aeruginosa (Number)	Sep 2023	L	**1**		0	0	0	0	0	0		
Klebsiella (Number)	Sep 2023	L	**1**		1	0	2	4	11	0		
Patient Safety												
Serious Incidents - one month behind	Aug 2023	L	**0**		2	4	4	3	14	5		
Number of Patient Incidents (including no-harm)	Sep 2023		-		979	949	1,019	958	5,684	0		
Number of Patient Falls (moderate and above)	Sep 2023		-		2	3	2	0	7	0		
Number of Pressure Ulcers (G3 and above) - one month behind	Aug 2023		-		0	1	1	0	2	1		
Medication Incidents	Sep 2023		-		100	96	89	98	587	98		
Readmission Rates (one month behind) - NE - excluding D/Cs	Aug 2023		-		10.9%	11.2%	10.5%	9.2%	10.6%	12.1%		
Venous Thromboembolism (VTE) Risk Assessment	Sep 2023	N	**95.0%**		94.7%	94.9%	95.3%	95.6%	95.1%	96.4%		
Hip Fracture Best Compliance	Sep 2023	L	**65.0%**		58.6%	76.0%	69.2%	71.9%	71.9%	75.0%		
Patient Experience												
Number of complaints per 10,000 patient contacts	Sep 2023	L	**8**		10.49	6.34	8.41	11.82	9.41	11.00		
F&F Postive Score - Inpatients & Day Cases	Sep 2023	N	**95.0%**		97.7%	98.6%	94.2%	97.2%	97.3%	96.7%		
F&F Postive Score - Outpatients	Sep 2023	N	**95.0%**		98.1%	98.5%	97.2%	96.7%	97.5%	97.8%		
F&F Postive Score - Maternity	Sep 2023	N	**95.0%**		100.0%	96.6%	100.0%	97.1%	99.2%	96.5%		
Care Hours per Patient Day	Sep 2023	L	**7.3**		7.40	7.30	7.00	7.00	7.00	6.3		
Maternity												
Bookings by 12 Week 6 Days	Sep 2023	N	**90.0%**		93.2%	92.5%	96.4%	92.3%	92.8%	92.6%		
Babies with a first feed of breast milk (percent)	Sep 2023	N	**70.0%**		60.6%	63.6%	58.5%	59.2%	60.2%	56.2%		
Stillbirth Rate per 1000 live births (Rolling 12 months)	Sep 2023	L	**4.66**		2.71	2.72	2.75	2.77	2.77	2.32		
1:1 care in labour - One month behind	Aug 2023	L	**75.0%**		99.6%	99.1%	100.0%	100.0%	99.7%	97.6%		
Serious Incidents (Maternity) - One month behind	Aug 2023	L	**0**		0	0	0	0	0	0		
Moderate and above Incidents (Harm Free) - One month behind	Aug 2023		-		0	0	0	0	0	0		
Consultants on labour (Hours on Ward)	Sep 2023		-		62.50	62.50	62.50	62.50	62.50	--		

Trust Integrated Performance Dashboard - Workforce

	Reporting Period	Type of Standard	Target	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	Sep 2023	L	-		-247	-240	-257	-275	-275	-435		
Whole Time Equivalent plan - Nursing	Sep 2023	L	-		-82	-84	-95	-93	-93	-81		
Vacancy Rate - TOTAL	Sep 2023	L	-		6.18%	6.02%	4.30%	6.81%	6.81%	9.66%		
Vacancy Rate - Nursing	Sep 2023	L	-		6.02%	6.19%	7.03%	6.72%	6.72%	5.95%		
Time to Recruit	Sep 2023	L	**34**		36	36	35	36	36	36		
Sickness Rates (%) - inc COVID related	Sep 2023	L	**4.50%**		5.09%	5.71%	6.07%	6.03%	5.97%	6.67%		
Short-term Sickness Rate (%)	Sep 2023	L			1.2%	1.4%	1.5%	2.1%		2.1%		
Long-term Sickness Rate (%)	Sep 2023	L			3.9%	4.4%	4.6%	4.0%		4.4%		
Turnover (12 month rolling)	Sep 2023	L	**11.00%**		11.5%	10.9%	11.1%	10.7%	10.7%	11.90%		
Appraisals complete (% 12 month rolling)	Sep 2023	L	**90.00%**		75%	76%	78%	86%	86%	79.00%		
Appraisals Season Rates (%)	Sep 2023	L	**90.00%**		44%	58%	70%	84%	84%	74.00%		
MAST (% of staff up to date)	Sep 2023	L	**85.00%**		94%	94%	93%	90%	90%	92.00%		
% of jobs advertised as flexible	Sep 2023		-		81.16%	75.68%	66.15%	55.22%	69.05%	89.80%		

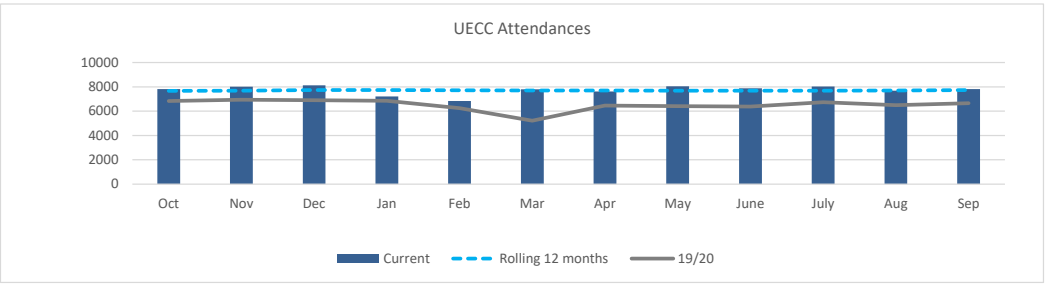
The Rotherham NHS
NHS Foundation Trust

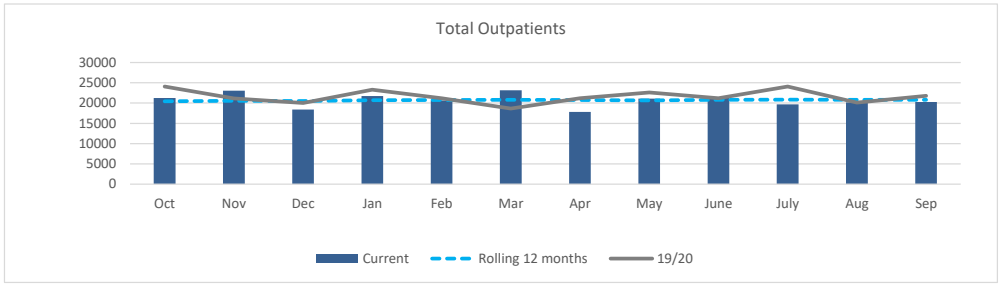
Trust Integrated Performance Dashboard - Finance

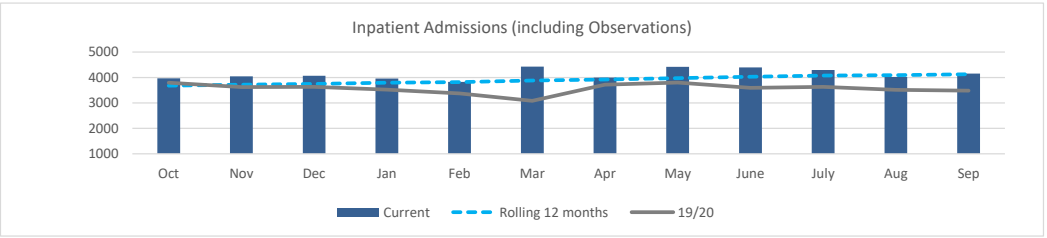
Apr 23 - Aug 23

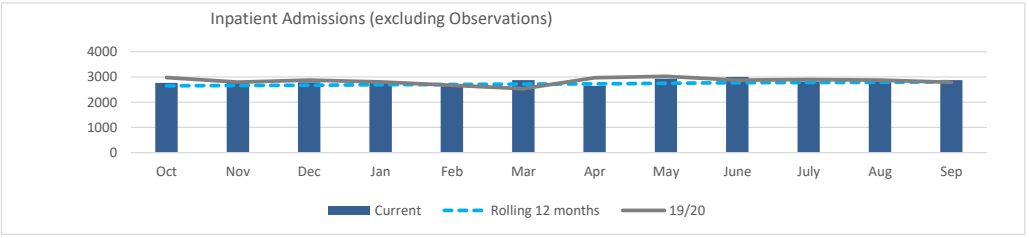
	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast V £000s
I&E Performance (Actual)	(646)	(496)	150	(4,040)	(5,108)	(1,068)	(4,316)
I&E Performance (Control Total)	(584)	(433)	150	(3,665)	(4,733)	(1,068)	(4,316)
iciency Programme (CIP) - Risk Adjusted	930	588	(343)	5,077	2,258	(2,819)	(3,397)
Capital Expenditure	701	584	117	4,622	1,795	2,827	0
Cash Balance	(155)	(2,601)	(2,446)	18,769	16,379	(2,390)	(256)

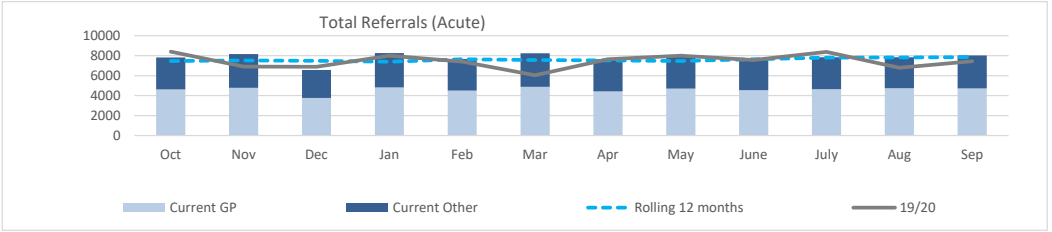
Trust Integrated Performance Dashboard - Activity

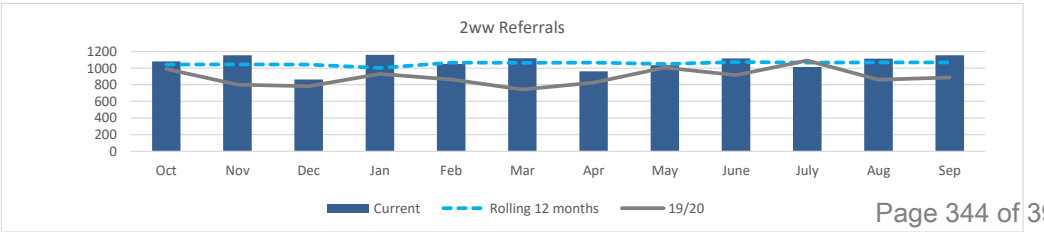












Trust Integrated Performance Dashboard - Activity

ACTIVITY

OUTPATIENTS			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
September	20,442	20,359	**100%**
YTD monthly average	20,653	20,034	**99%**

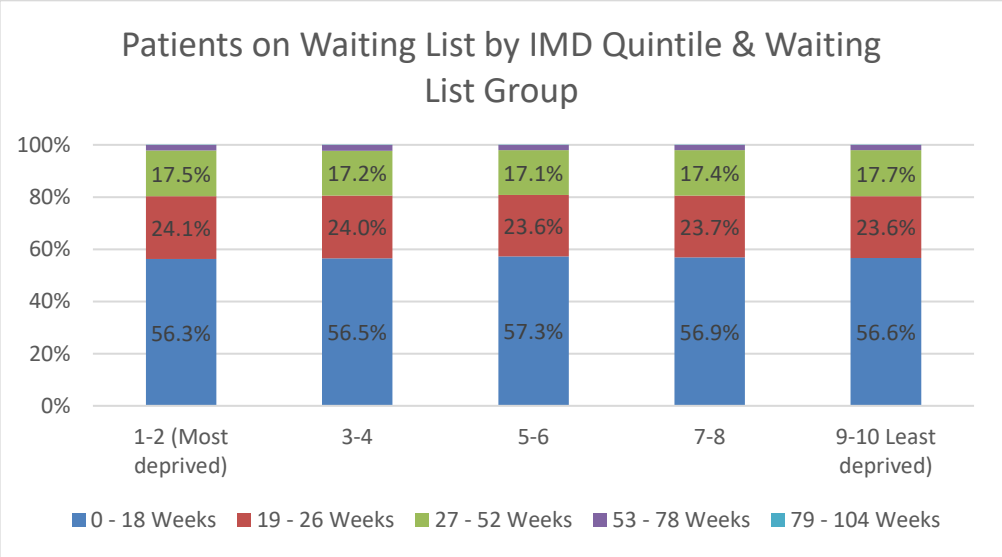
DAYCASES			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
September	2,260	1,938	**86%**
YTD monthly average	2,202	1,931	**89%**

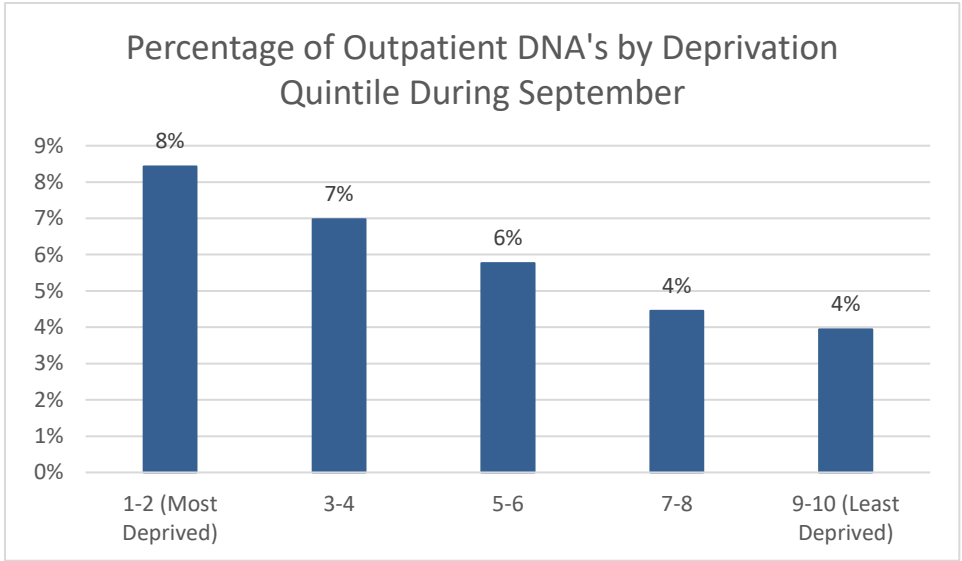
ELECTIVE ACTIVITY			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
September	401	339	**85%**
YTD monthly average	410	340	**84%**

Trust Integrated Performance Dashboard - Health Inequalities

RTT Snapshot 24/09/23

IMD Quintile	Patients on Waiting List	Median Wait (Wks)	% of All RTT Patients	% of Rotherham Poulation	% Proportion Difference to Rotherham Population
1-2	9,969	14	37.2%	36.0%	1.2%
3-4	6,199	14	23.1%	23.2%	-0.1%
5-6	4,208	14	15.7%	15.2%	0.5%
7-8	4,924	14	18.4%	19.5%	-1.1%
9-10	1,542	14	5.8%	6.0%	-0.2%
Total	**26,808**	**14**	**100.0%**	**100.0%**	**0.0%**





Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 21/22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Daily staffing -actual trained staff v planned (Days)	82.43%	83.69%	84.87%	87.47%	82.86%	84.14%	84.80%	88.00%	91.00%	90.00%	89.00%	86.00%	86.00%
Daily staffing -actual trained staff v planned (Nights)	90.41%	86.89%	83.94%	84.53%	84.97%	88.28%	90.92%	94.00%	98.00%	95.00%	92.00%	90.00%	88.00%
Daily staffing - actual HCA v planned (Days)	83.46%	86.96%	82.06%	81.44%	84.32%	81.81%	80.00%	85.00%	90.00%	89.00%	90.00%	90.00%	89.00%
Daily staffing - actual HCA v planned (Nights)	89.86%	93.64%	90.73%	85.46%	94.75%	92.02%	90.00%	94.00%	97.00%	102.00%	102.00%	100.00%	93.00%
Care Hours per Patient per Day (CHPPD)	6.3	6.2	6.3	6.4	6.4	6.4	6.5	7.1	8.0	7.4	7.3	7.0	7.0

Key: < 85% 85-89% >=90%

Statistical Process Control Charts
Fact Sheet

The Rotherham
NHS Foundation Trust

Perform	Assure	Description
H	F	Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or deteriorating performance. This system is not capable. It will **FAIL** the target without system change.
H	P	Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or worse performance. However despite deterioration the system is capable and will consistently **PASS** the target.
H	?	Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or worse performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
L	F	Special cause of a concerning nature where the measure is significantly **LOWER**. This occurs where there is deteriorating performance. This system is not capable. It will **FAIL** the target without system change.
L	P	Special cause of a concerning nature where the measure is significantly **LOWER**. This occurs where there is deteriorating performance. However the system is capable and will consistently **PASS** the target.
L	?	Special cause of a concerning nature where the measure is significantly **LOWER**. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
	F	Common cause variation, no significant change. This system is not reliably capable. It will **FAIL** to consistently meet target without system change.
	P	Common cause variation, no significant change. The system is capable and will consistently **PASS** the target.
	?	Common cause variation, no significant change. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
H	F	Special cause of an improving nature where the measure is significantly **HIGHER**. This occurs where there improving performance. However the system is still not capable. It will **FAIL** the target without system change.
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Arrows show direction of travel. Up is Good, Down is Good

SPC Rules

A single point outside the control limits

Whenever a data point falls outside a process limit (upper or lower) something unexpected has happened because we know that 99% of data should fall within the process limits.

Consecutive points above or below the mean line

A run of values above or below the average (mean) line represents a trend that should not result from natural variation into the system

Consecutive points increasing or decreasing

A run of values showing continuous increase or decrease is a sign that something unusual is happening in the system.

Two out of three points close to the process limits

A pattern of two points in any three consecutive points close (in the outer third to the process limits.

Statistical Process Control Charts
Fact Sheet

The Rotherham
NHS Foundation Trust

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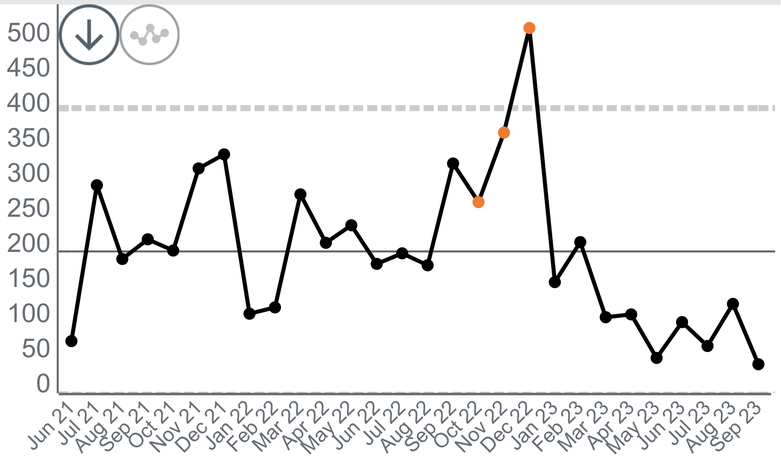
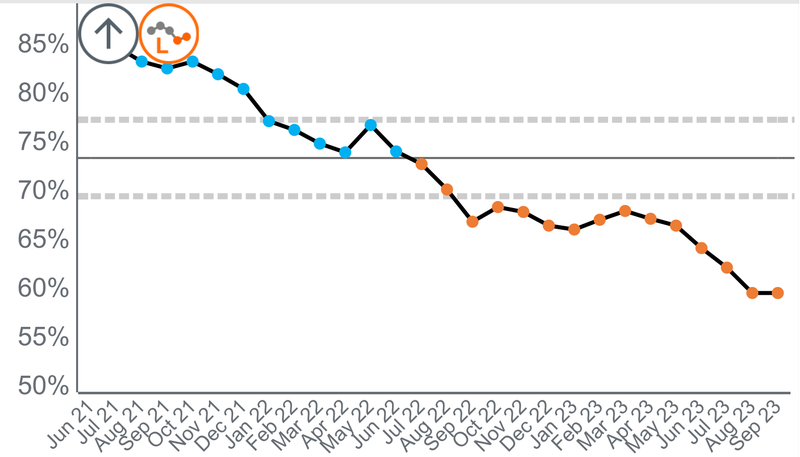
Statistical Process Control Charts
Operational Performance Page 1

The Rotherham
NHS Foundation Trust

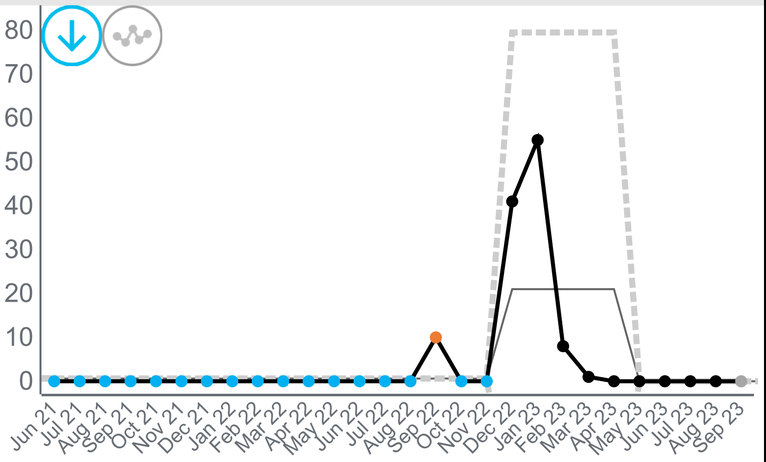
Ambulance Handovers by Date



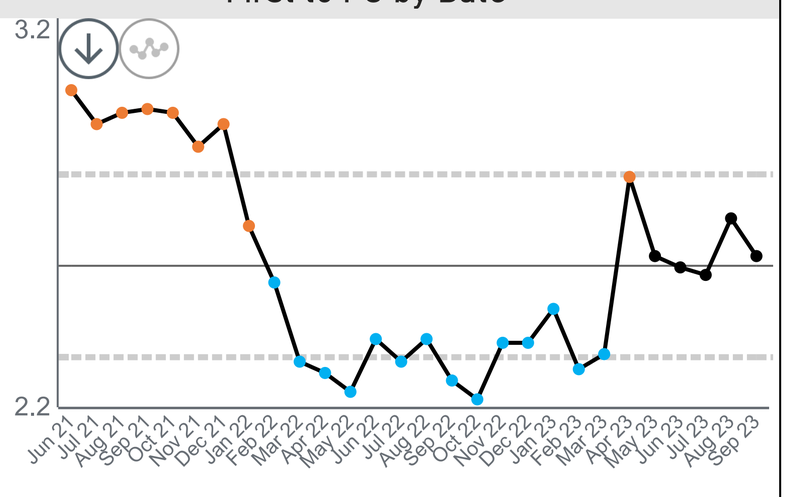
RTT by Date



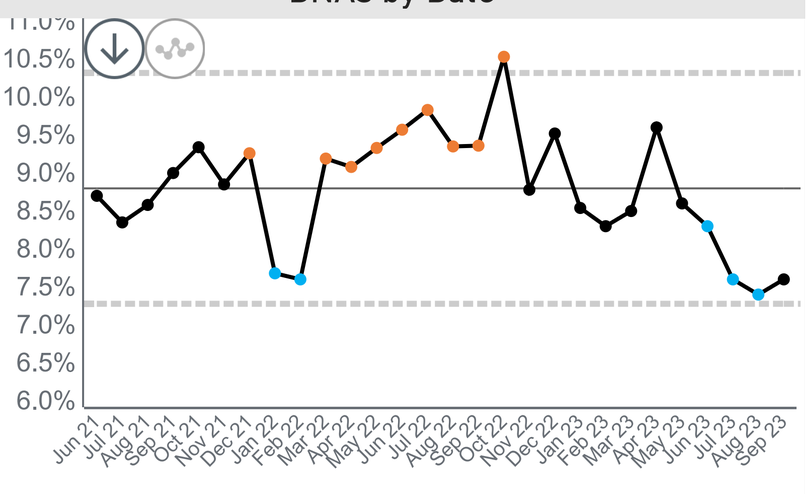
12hr Trolley Waits by Date



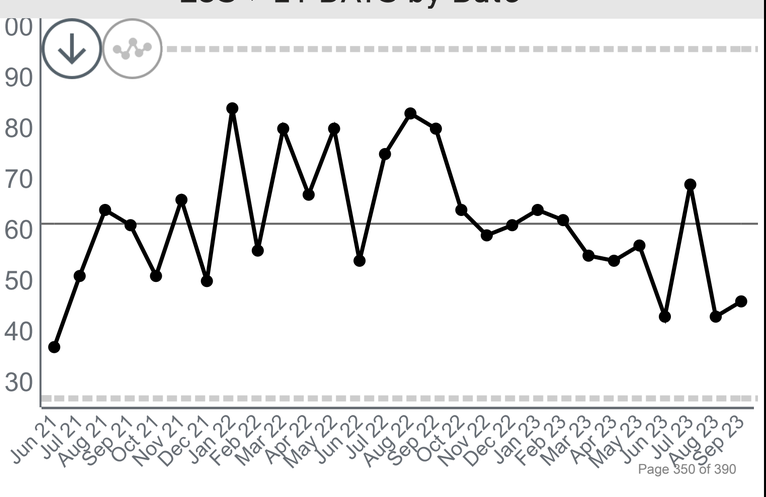
First to FU by Date



DNAs by Date



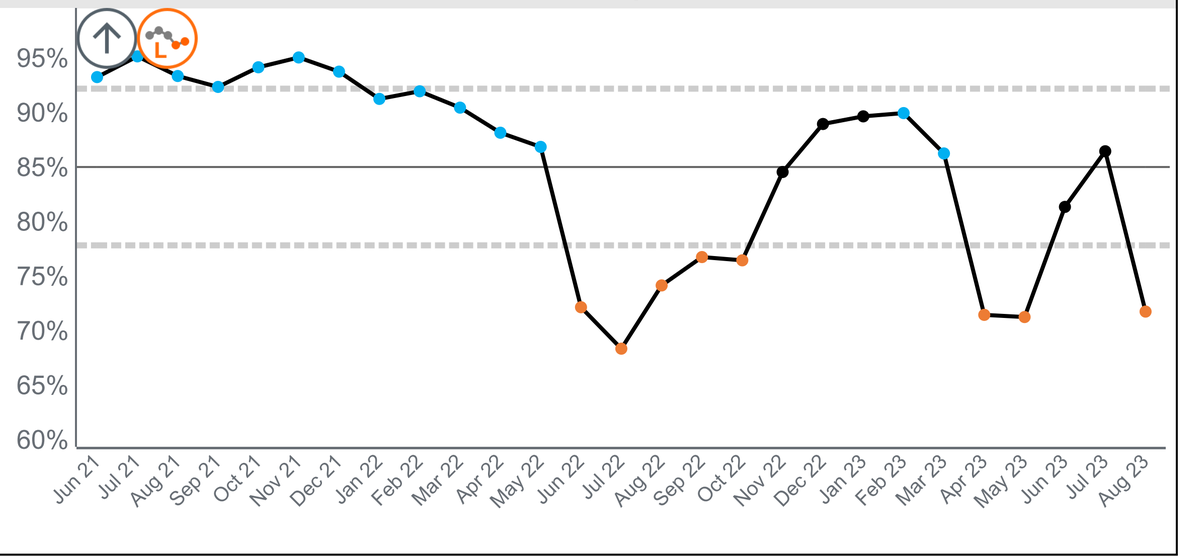
LOS > 21 DAYS by Date



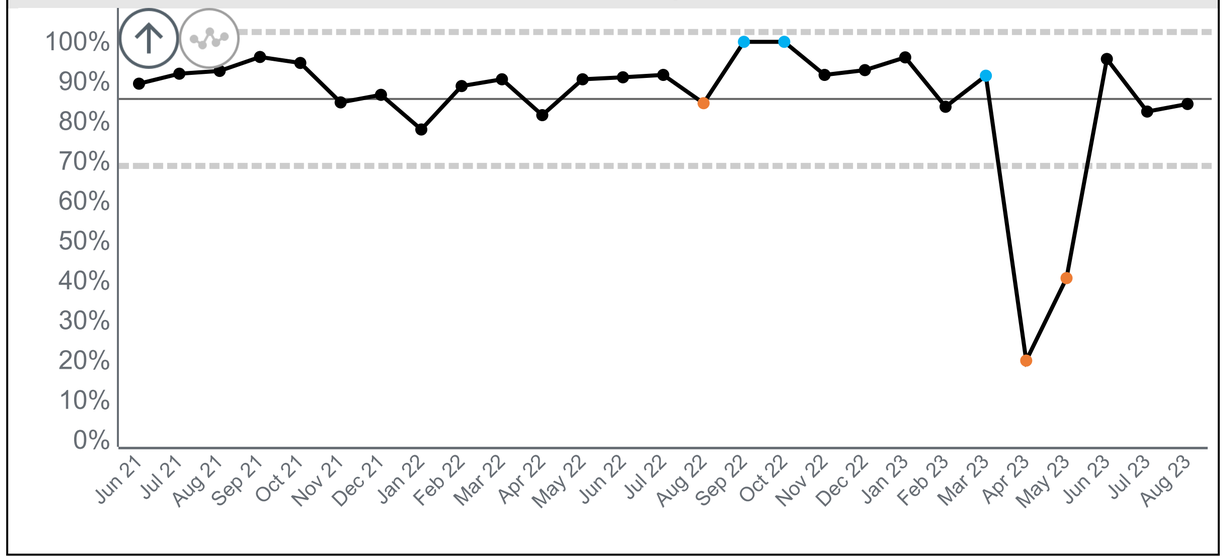
Statistical Process Control Charts
Operational Performance Page 2

The Rotherham NHS Foundation Trust

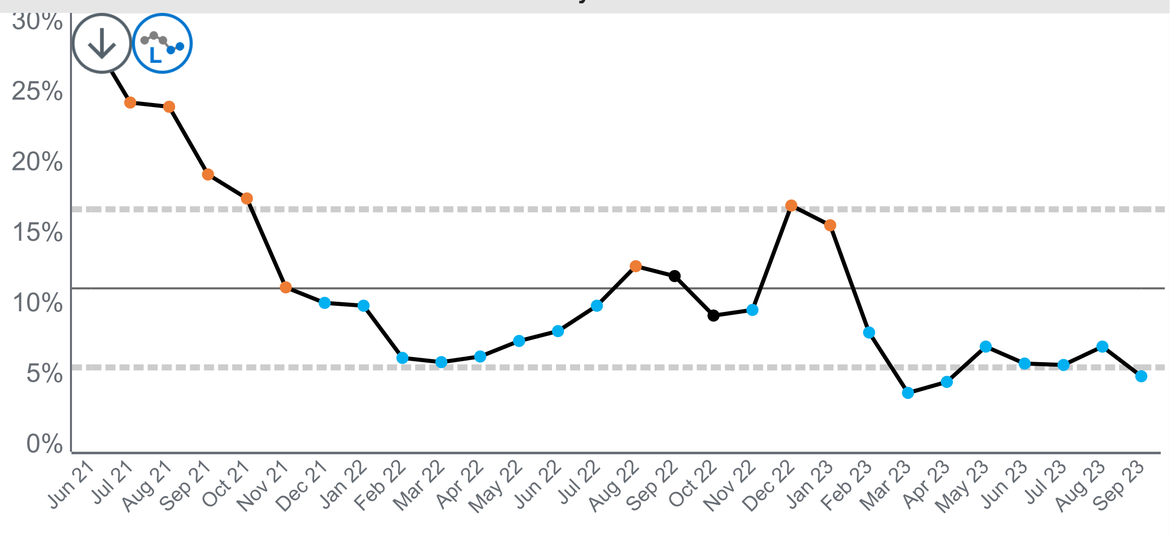
Cancer 2ww by Date



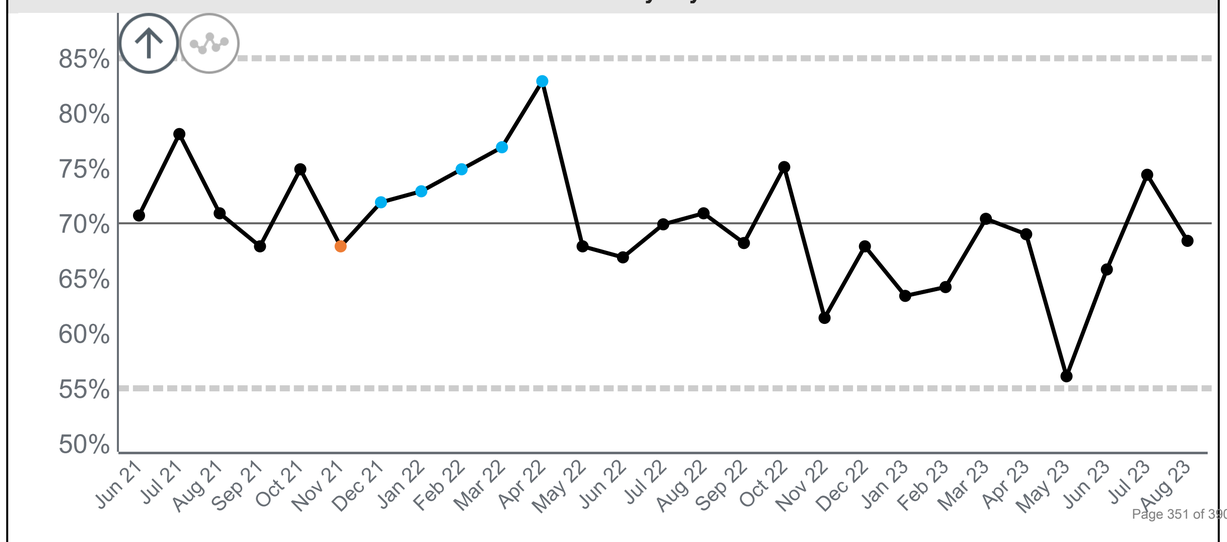
Breast 2ww by Date



DM01 by Date



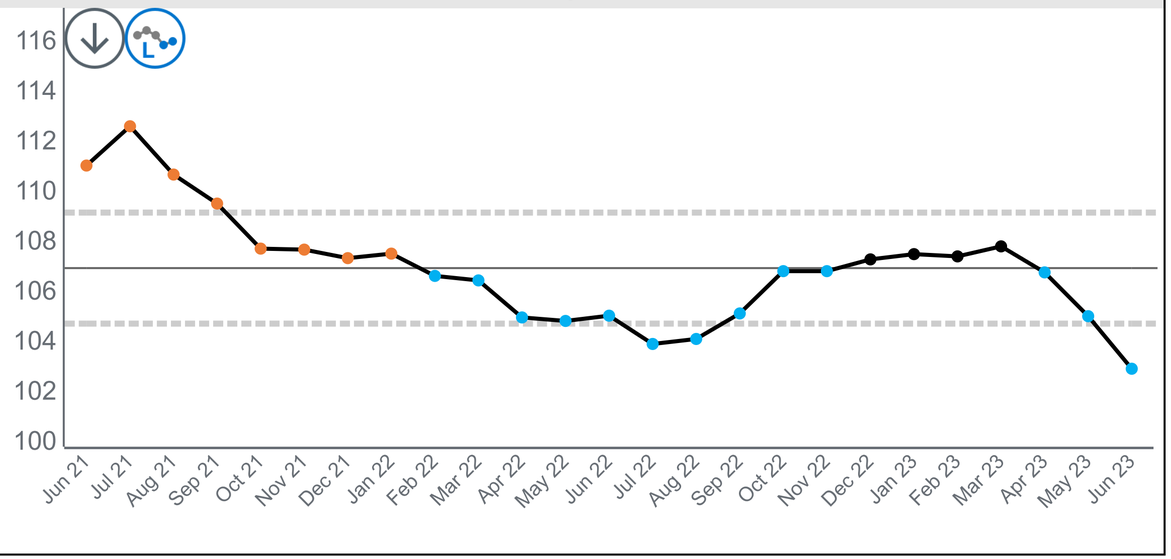
Cancer 62 day by Date



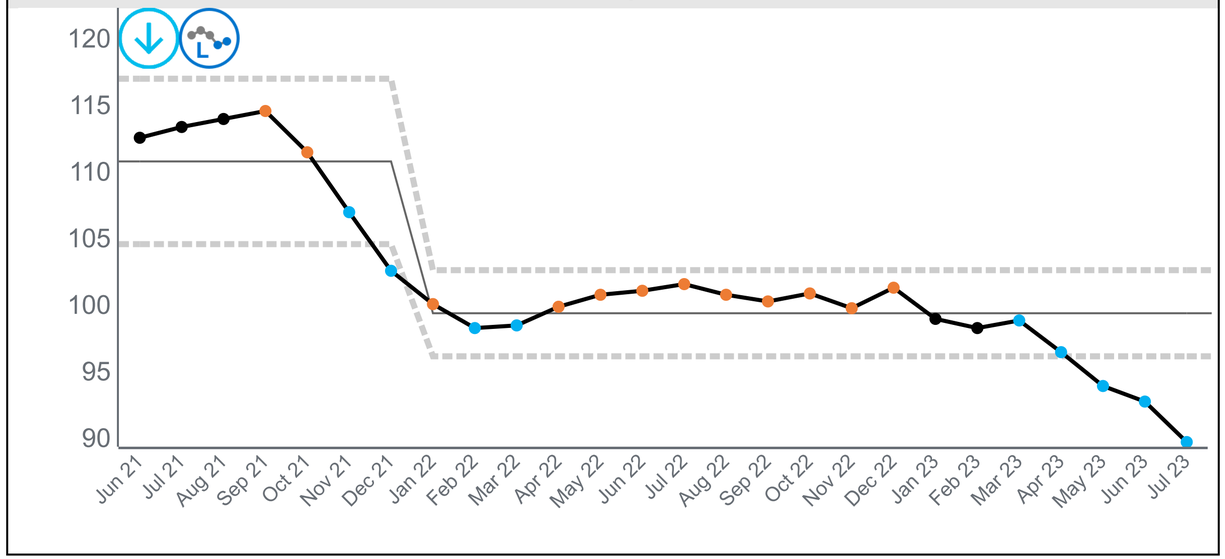
Statistical Process Control Charts
Quality Performance Page 1

The Rotherham NHS Foundation Trust

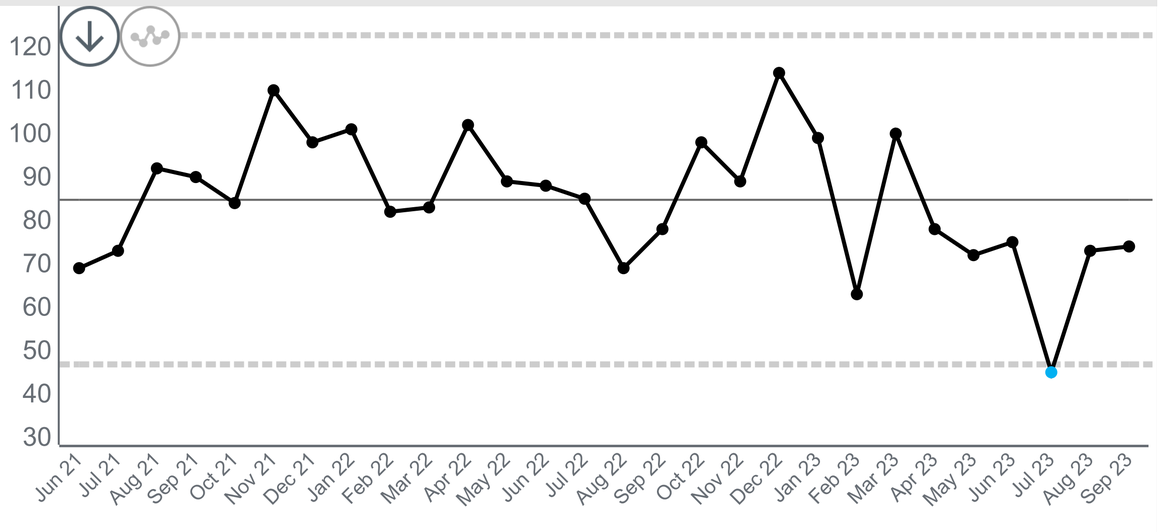
SHMI by Date



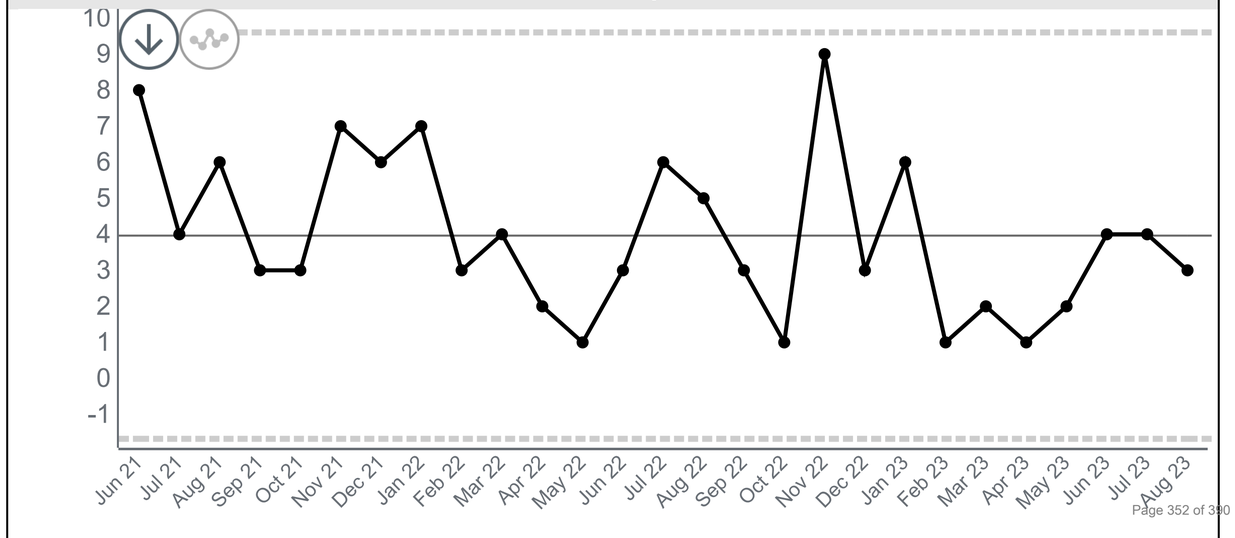
HSMR by Date



Crude Mortality by Date



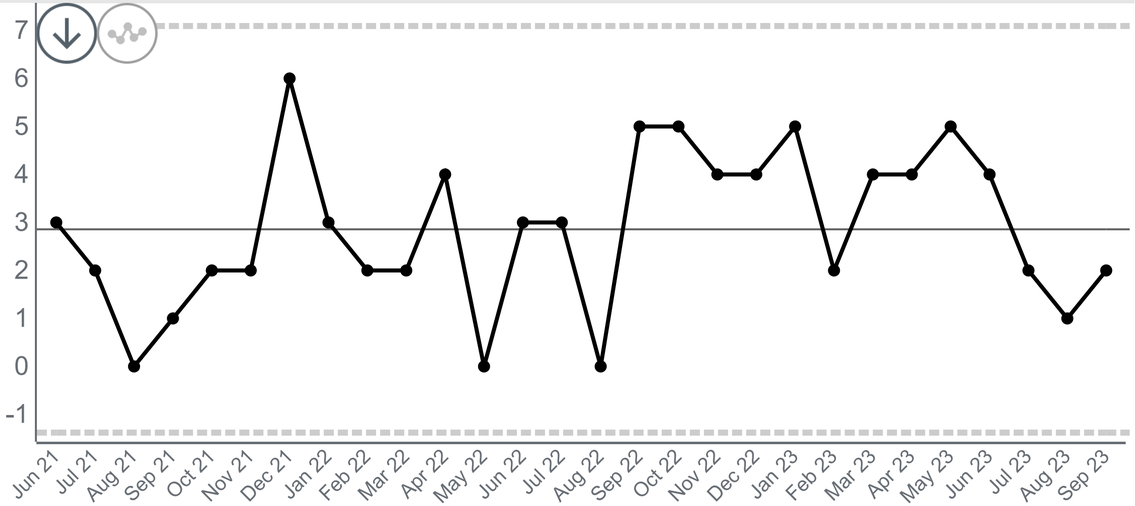
Incidents by Date



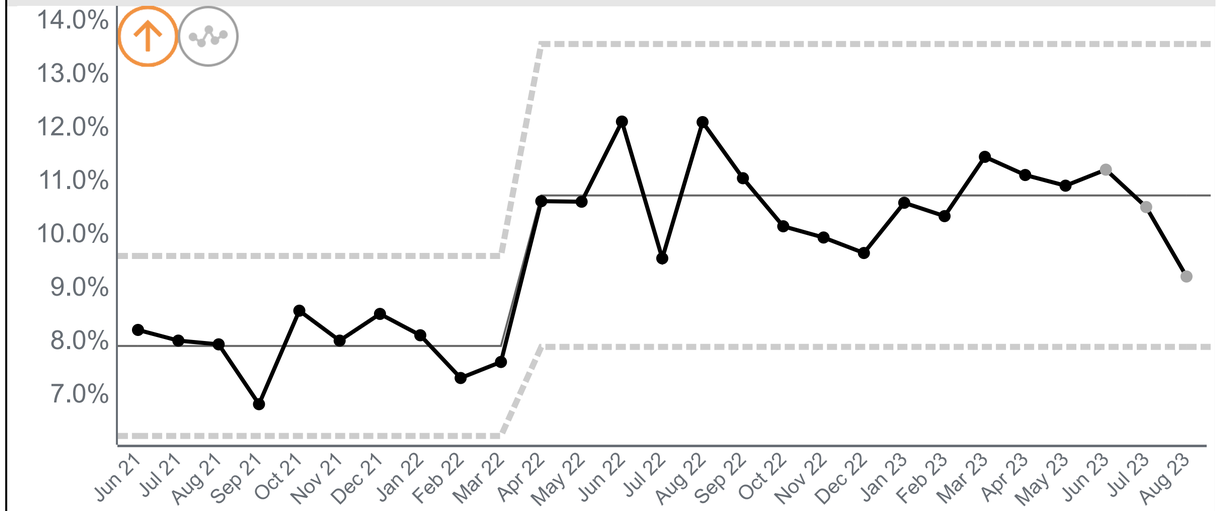
Statistical Process Control Charts
Quality Performance Page 2

The Rotherham NHS Foundation Trust

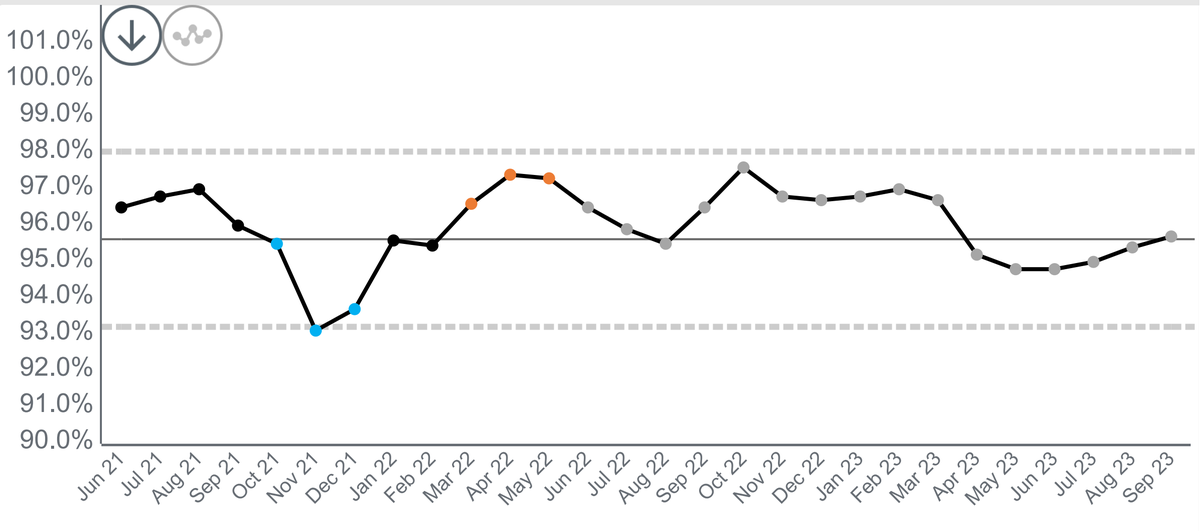
Clostridium-difficile Infections by Date



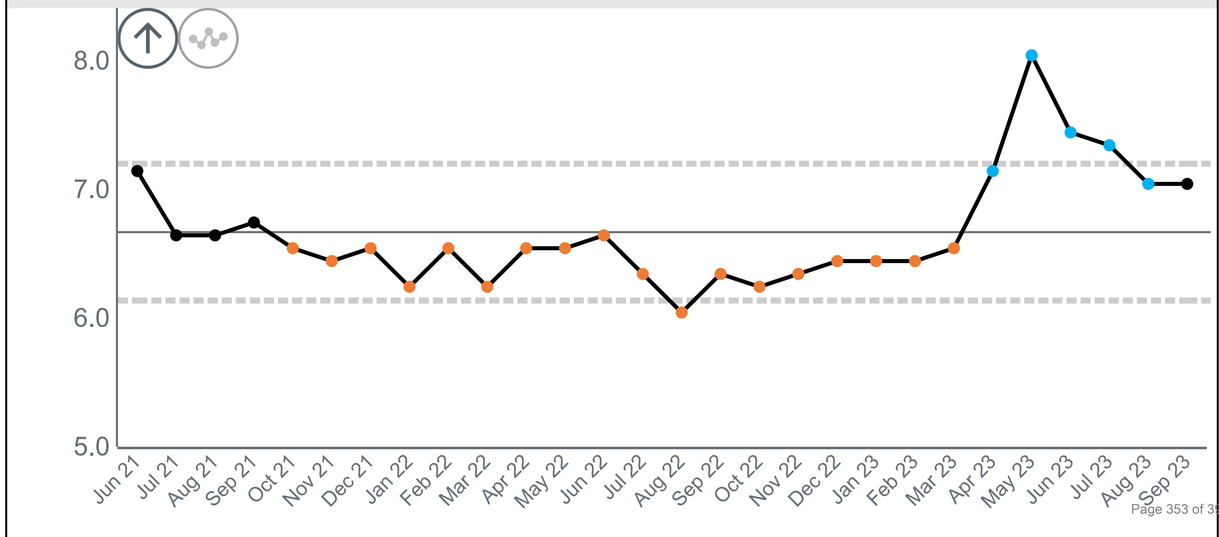
Readmissions by Date



VTE and First VTE Target by Date



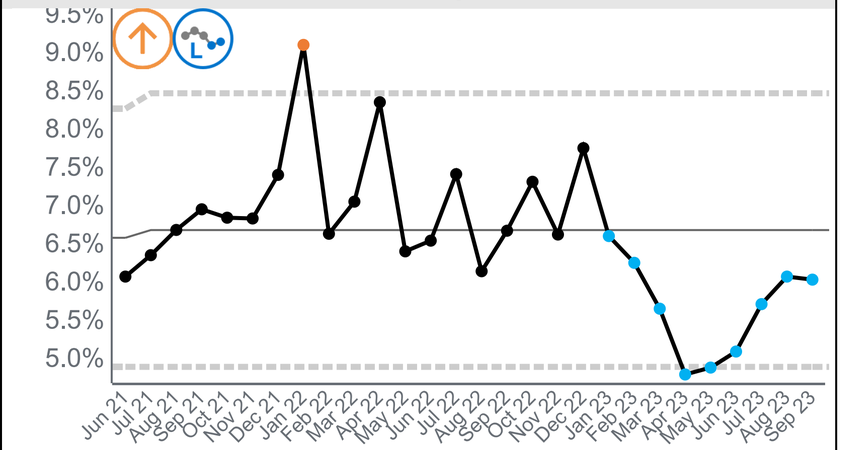
Care hours per patient day by Date



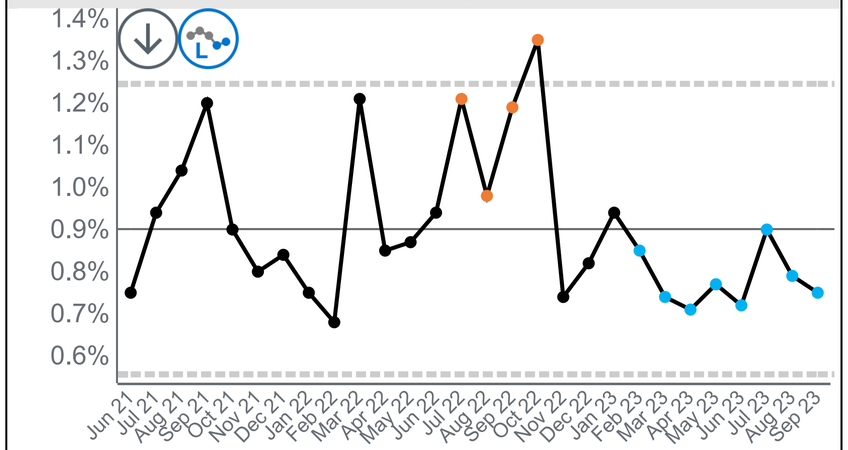
Statistical Process Control Charts
Workforce Performance Page 1

The Rotherham NHS Foundation Trust

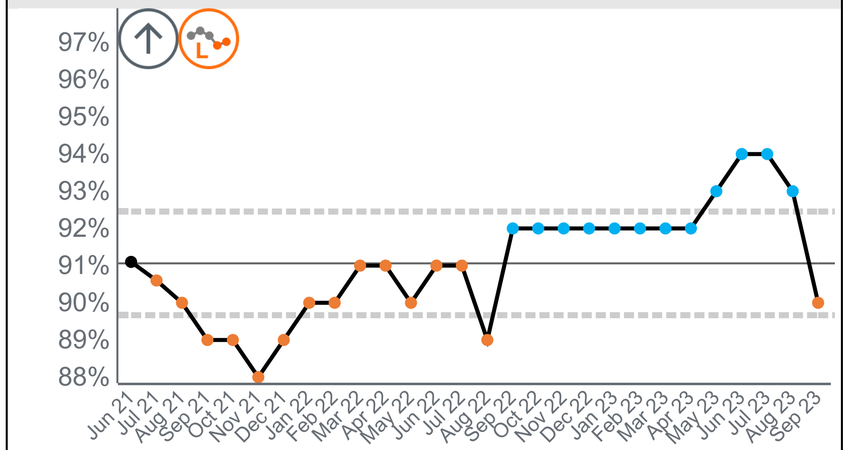
Sickness by Date



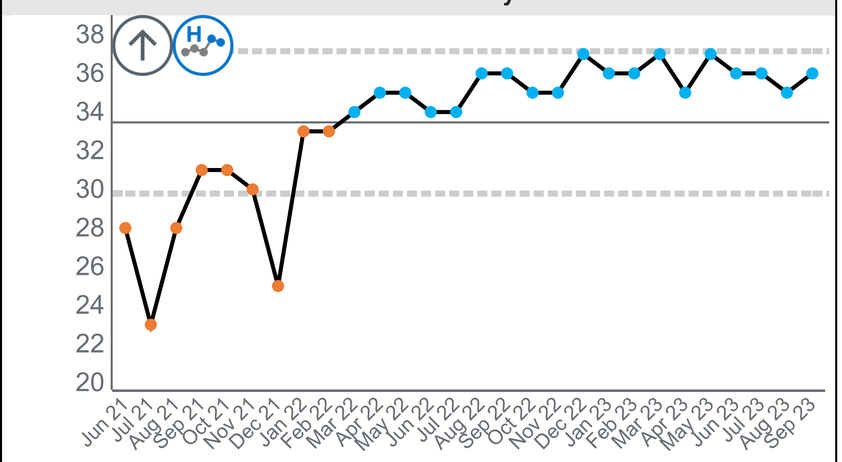
Turnover by Date



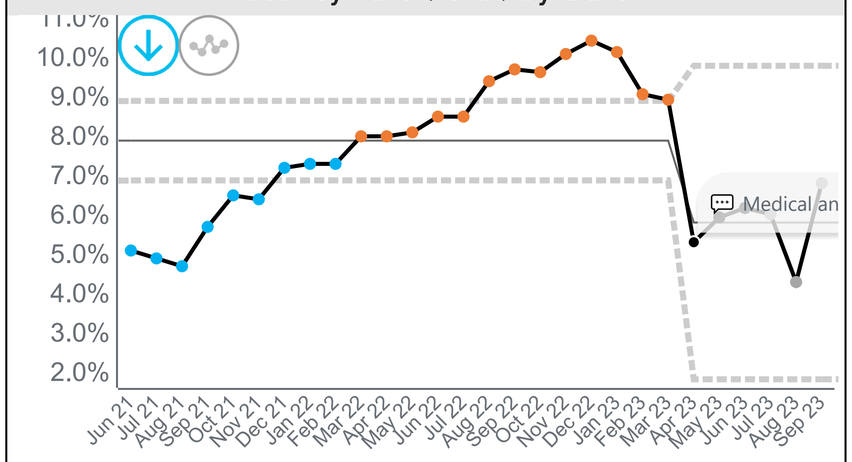
MAST by Date



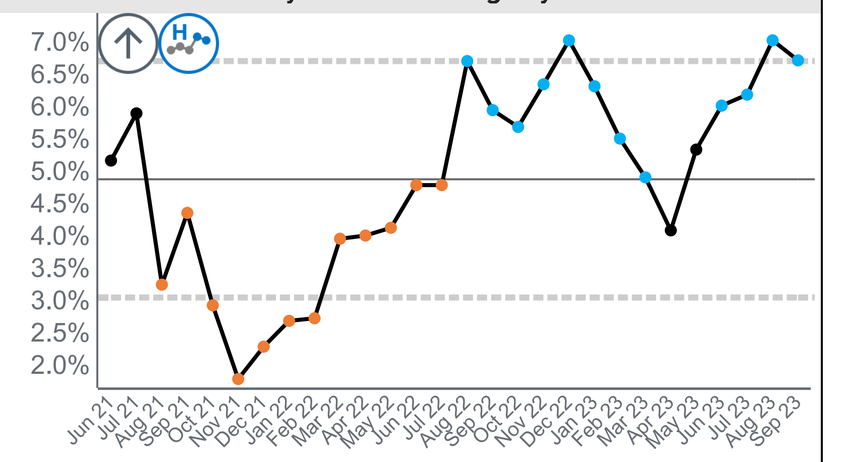
Time to Recruit by Date



Vacancy rate (total) by Date



Vacancy rate (nursing) by Date



Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- Long length-of-stay (21+ day) patients have fallen to a more manageable level, although there are still opportunities to deliver more effective discharge through improved internal processes. Meetings with system partners continue to take place to allow the escalation of problems and co-ordinate targeted action to address any issues.
- The number of ambulances exceeding a one-hour handover fell to below 30 in month, the lowest volume since February 2021, which is a significant achievement. Ambulance handover performance improved across the board but there is still further work to do to embed the improved ways of working to ensure consistency.
- The proportion of patients waiting over 12 hours in A&E fell back slightly to just over 4% but this is still double the national ambition of 2%. The Trust is continuing to work toward this eventuality being all-but-eliminated in 2023/24 with the reintroduction of the 4-hour standard.
- This performance continues to reflect the slight reduction in non-elective pressure experienced in the Trust in the most recent month of activity, which is due to ongoing work supporting improved flow through the Trust and through improved front-door pathways. The SDEC model has played a key role in streaming patients to an appropriate setting within the Trust or elsewhere and improved our ability to effectively manage the significant demands on our services. There continues to be higher numbers of patients with increased acuity who require additional support.

Elective Care

- The waiting list has continued to grow and is now just under 30% higher than the same month last year. There continues to be sustained pressure from high levels of referrals which has contributed to this increase in the waiting list. In addition, the ongoing constraints on theatre capacity alongside medical workforce gaps in some of our large volume specialties have amplified the demand and capacity mis-match we are seeing.
- As such, activity continues to run below the 103% target, achieving 100% of 19/20 for Outpatients, 86% of 19/20 for Daycases and 84% for Inpatients in the

latest month. However, given there was a period of Consultant and Junior Doctor Industrial action in September, the effective working days for elective activity in theatres in particular fell to 19 compared to the 21 in 2019/20 due to all non-urgent General Anaesthetic activity being cancelled other than lists we were able to run via insourcing. This level of performance therefore demonstrates the gradual improvement being made to deliver increased levels of activity relative to pre-pandemic.

- Industrial action has been managed with the main aim being to reduce its impact on our patients, and to ensure patient safety throughout. However, the most recent three periods of Industrial Action, which included Consultant action, have impacted significantly on our elective capacity, and therefore on the length of waits for our patients.
- A continuing decline in the RTT position is sitting alongside a growing waiting list, with challenges in increasing capacity to meet this demand leaving the RTT position now at its lowest point since September 2020. This has also shifted the Trust's relative performance when benchmarked nationally, with the Trust falling to 53rd out of 119 acute or community providers in the latest data, compared to 17th at the start of the year.
- These challenges have contributed to a significant increase in 52+ week waiters, with the growth in 65+ week waiters now tipping us above the trajectories set at the start of the year (before the ongoing industrial action could be anticipated). The Trust continues to collaborate across the region to ensure delivery of the national expectation around long-waiters 2023/24, but expects to under-deliver against our 65ww trajectory now until March 2024.

Cancer

- After several challenging months, performance in cancer has shown some signs of recovery, although in many areas it continues to under-deliver against the national constitutional standards. NHS England announced a number of changes to the expectations around national constitutional standards in August 2023, which reduced the core standards from 10 to 3, as detailed in the Operational Performance Report.
- Performance against the Faster Diagnosis Standard (FDS) has improved recently, with two consecutive months of achievement for the first time since the standard was introduced. However, this improved performance is not yet embedded within tumour sites, and further work is needed to ensure consistent achievement of the standard. The most challenged tumour sites are Colorectal, Upper GI, Skin and Urology (Prostate), with a variety of reasons for this including significant demand increases (Skin), medical workforce challenges (Skin and Upper GI) and pathway inefficiencies (Colorectal and Prostate). A new Cancer Improvement Programme Lead has been appointed to lead our pathway improvement work, and will begin in post in January 2024.

QUALITY SUMMARY

Mortality

- The latest mortality data has now been updated to June and July 2023 for the SHMI and the HSMR respectively. As per the previous position, the HSMR is currently within the 'as expected' category and has improved in-month to the best reported mortality score for a number of years.
- The HSMR value provided within the IPR this month is now aligned with the reporting period for SHMI as the Trust has now moved to a new mortality benchmarking provider – HED.
- The SHMI has fallen to 102.9 (data for June 2023). The coding team continue to improve the accuracy of the coding but we have seen a drop-off in depth of coding since September 2022 when we were no longer able to code previously-coded co-morbidities and therefore had to cease use of a supporting tool by 3M. Further work is underway to better understand where the most significant changes have occurred, and engagement with clinicians continues to identify opportunities to improve our depth of coding.

Patient Safety

- There were 3 Serious Incidents in September, which is a similar level to previous months. However, there are no themes of concern within the recent figures. All SIs are investigated via the Harm Free Care Panel, with actions implemented to ensure appropriate learning is shared and mitigating actions put in place.
  The complaint level has increased in the last two months, some of which can likely be attributed to two periods of consultant and junior doctor industrial action, which led to high numbers of patients cancellations and Christmas Day cover across a number of days. That said, there is ongoing fluctuations in the number of complaints per month due to the low absolute volumes.
  Care Hours Per Patient Day is unchanged from last month. Whilst the CHpPD figure is still above levels seen earlier in the calendar year, it remains below other providers and in the bottom quartile in the latest benchmarking data. However, the CHpPD figures for registered nurses is a relatively good position and in the 3rd quartile, with the % of the CHpPD in the top third of providers. This indicates it is lower levels of non-qualified staff which is affecting our relative performance on CHpPD. Increased sickness levels have been a factor driving this over the last two months. The latest Safer Staffing data continues to show huge improvements in all areas of nurse staffing compared to earlier in the calendar year. The impact of recent recruitment is anticipated to lead to an improvement next month.

WORKFORCE SUMMARY

Retention and Recruitment

- The Trust welcomed 75 new starters for the month of September 2023. 13 were qualified nursing & midwifery staff and 11 were Nursing Support.
- Surgery division had the highest amount of leavers for the month of September, with 15 colleagues moving onto new opportunities. Staff groups with the highest amount of leavers (excluding medic rotation) were Additional Clinical Services (11) followed by Nursing (7).
- Analysis shows that of the 41 voluntary leavers for September 2023, 16 had less than 1 years' service with TRFT, which contributes to just under half of the total amount of leavers. The top 3 leaving reasons for September were: To undertake further education or training; Promotion; Relocation.

Attendance

- Monthly sickness absence rate for the month of September 2023 decreased by 0.04%. The decrease in the overall sickness rate was driven by long term sickness (3.96%), a 0.37% improvement when compared with previous month (4.26%)
- Sickness absence at the Trust continues to be relatively high, being in the bottom quartile of trusts.
- Medicine continues to have the highest sickness absence for the 8th consecutive month (7.68%). Corporate Services division has seen the largest increase in sickness absence, a 0.18% increase on previous month
- 12 month rolling sickness absence for September 2023 was 5.97%

Appraisals and Mandatory Training

- Overall appraisal (rolling 12 months) compliance for the month of September 2023 was 86% which is a 7% increase when compared to September 2022.
- All divisions have seen an increase in compliance for both appraisal season and 12 month rolling. Surgery (95%) and Medicine (91%) are the two divisions above the 90% target.

FINANCE SUMMARY

The Finance summary commentary is included within the separate Finance Report.

Board of Directors
03 November 2023

The Rotherham NHS Foundation Trust

Agenda item	**P168/23**
Report	**Operational 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 at the end of September 2023. The attached summary shows the position against each of the key operational indicators which NHS England and the ICB are using to monitor the performance of the Trust as part of their Board Assurance Framework. The Finance and Performance committee have received a more detailed update on each of these, along with the actions we are taking to improve our performance and ensure delivery of the year-end targets. The main headlines: • The Trust operated at OPEL level 2/3 throughout the month of September 2023. • Performance against the 4hour standard was 61% against an internal trajectory of 70% and agreed trajectory with NHSE of 55%. • The Trust did not achieve the trajectory for 65 week waiters, with 58 patients waiting against a trajectory of 50. • Doctors in Training and Consultants took strike action from the 19 to 22 September 2023 and from 02 to 05 October 2023. • A Reset week took place during 25 September 2023. • Update on patients awaiting Corneal Grafts. • Mexborough Elective Orthopaedic Centre (MEOC) update. • An update on EPRR Activities has been included.
Due Diligence (include the process the paper has gone to prior to presentation at FPC Meeting)	This report is a high level of summary of the more detailed operational update that has been discussed at The Finance and Performance Committee in October, 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 Update Report 2. Performance against National Key Metrics

Operational Update Report – September 2023

1.0 Operational Pressures Escalation Level (OPEL) & Urgent Care

The Trust saw more heightened operational pressures throughout the month of September, predominately operating at OPEL Level 2 but at times the Trust did reach OPEL Level 3. There were spikes in demand which saw periods of inpatients being supported in the medical Same Day Emergency Care area (SDEC), which at times had some impact on flow.

Work continues with divisions to implement their plans to achieve the 4-hour performance target of 76% by October, focusing on flow and the use of the different SDEC areas. The overall performance for the month was 61%, which was ahead of the target agreed with NHSE, however, this was behind the internal target of 70%.

Recognising the current challenges in embedding this work given current challenges, including Industrial Action, an additional role is being put in place for a period of 6 months. The post will provide clinical input to support embedding the Acute Care Standards with a focus on ensuring the Trust is achieving and maintaining four-hour care standards.

2.0 Elective and Cancer Care

The operational teams continue to focus on elective recovery and prioritise long waiting patients being seen, however, the elective programme continues to be adversely affected by the different periods of industrial action.

Late September and early October were particularly challenging due to the consecutive periods of industrial action for both doctors in training and consultants. A number of outpatient appointments had to be cancelled to ensure workforce was available to support emergency pathways. Minimal cancellations were made to elective lists due to doctors in training taking industrial action, however, significant cancellations have been made in response to each period of consultant industrial action.

This impacted particularly on the number of patients waiting over 65 weeks, with the Trust not achieving the trajectory of 50 patients waiting over 65 weeks. The number of patients waiting at the end of September 2023 was 58. With the consecutive period of industrial action in early October, it is expected that the Trust will also not meet the trajectory for October 2023.

Further additional activity and recovery schemes from the Elective Recovery funding have been identified and agreed for delivery in the second half of the year within the financial plan. Revised trajectories have been agreed with divisions, outlining delivery of the 65 week wait target by March based on activity continuing in line with plans and no further periods of industrial action.

The national Patient Initiated Digital Mutual Aid System (PIDMAS) is due to launch at the end of October, whereby patients are offered a potential alternative choice of where to have their treatment. The Trust has plans in place with the operational teams to implement this. This may mean some longer-waiting patients choose to be treated elsewhere.

3.0 Corneal Grafts

Of the long waiting patients, a number are awaiting corneal grafts, with 3 patients waiting over 65 weeks at the end of September. The Trust is receiving support from Sheffield Teaching Hospitals for patients requiring this procedure as tissue becomes available. These patients are awaiting tissue from NHS Blood and Transplant Authority, with tissue only being allocated nationally to the longest waiting patients.

4.0 Industrial Action

The Trust saw Consultants and Doctors in Training take industrial action between the 19 to 23 September 2023, which for the first time saw both Doctors in Training and Consultants overlapping in strike action on the 20th September. Strike action also took place on the 02 to 05 October 2023, again with both Consultants and Doctors in Training taking strike action together.

As with previous periods of industrial action, significant planning and preparation took place to mitigate the impact to patient care as much as possible. During the industrial action, command and control continued to be in place with twice daily tactical and strategic meetings taking place.

It continues to be evident that the ongoing nature of the industrial action, is impacting on our clinical and operational teams, not just during the period of action, but in the planning and recovery period, as well as on their ability to undertake other work.

5.0 Reset Week

During week commencing 25 September 2023, a 'Rotherham Reset' week commenced. The reset week enabled the Trust to relaunch the Acute Care Standards, open beds on Sitwell and realign medical and surgical beds as part of the bed reconfiguration. Paediatrics implemented different ways of working on their assessment unit, moving away from a bed-based model to a chair based model and reallocating the advanced nurse practitioner workforce to enable greater efficiency through available capacity. The Site Team also implemented some new ways of working which focussed on supporting delivery of the 4-hour standard and timely discharge. A review of patients with a long length of stay was completed and focus will remain on this in order to expedite discharges.

6.0 Mexborough Elective Orthopaedic Centre (MEOC)

Mexborough Elective Orthopaedic Centre (MEOC) has taken a significant step forward as much of the facility was installed in late September 2023. The service will open its doors in early 2024, and will feature two state-of-the-art theatre units, two anaesthetic rooms and a recovery suite, in addition to 12 inpatient beds.

The MEOC project team are asking for local people's views on the new service, and what things need to be considered to ensure patients receive the very best care, treatment, and experience. Recruitment is current being undertaken, led by the project team at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. Discussions are taking place with Chief Operating Officers and the Programme Director for MEOC around staffing of the centre, including contingencies if there were any delays to recruitment.

7.0 Emergency Preparedness Resilience Response (EPRR) Update

The EPRR team have submitted initial evidence against the EPRR core standards to the ICB and regional NHSE EPRR teams for peer review. Feedback has been provided and the team are currently analysing the report, identifying any supplementary evidence to inform the final assessment and compliance rating.

The EPRR team supported the Director of Operations coordinating the annual service of the onsite Battery Energy Storage System (BESS). Working closely with Estates and the Divisions of Surgery and Clinical Support Services, a service schedule was implemented resulting in no disruption to critical services.

A structured debrief was held following the BMA industrial action during August where a number of recommendations were identified and included into the planning process for September's industrial action.

The EPRR team and Director of Operations participated in an ICB led workshop to consider plans for the receipt of patients should they need to be evacuated from Doncaster Royal Infirmary given the challenges with the estate. Further workshops will be scheduled alongside an exercise to test plans.

Planning has also taken place in preparation for the annual Cyber security exercise, scheduled for October to test the Trust response in respect of a threat to data security, a key component of the Trust's EPRR preparedness and included in the annual Data Security Protection Toolkit self-assessment against the national data Guardian's security standards.

The EPRR Team supported the Division of Family Health in facilitating an exercise to test the response to a fire incident evacuation within the Special care Baby Unit

Incidents
The EPRR team supported the coordination of the BMA junior doctors and consultants' joint industrial action when the full incident command and control structure was activated. A debrief has been scheduled to capture both good practice and learning to take forward into future planning.

Sally Kilgariff
Chief Operating Officer
October 2023

Appendix 2: National Key Metrics – Performance Against Trajectories

Performance was above target across six of the eight nationally submitted metrics, with both of the areas of challenge likely to continue to under-deliver for a few months against the original trajectory

G&A Bed occupancy – based on KH03 submission						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Actual	90.0%	89.0%	90.6%	90.0%	91.3%	88.7%

Patients with No Right to Reside						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	58	58	58	60	62	56
Actual	53	61	40	47	58	44

Daily Average Hours Lost from Ambulance handovers						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	10.8	10.8	10.8	10.8	10.8	10.8
Actual	8.1	4.4	7.3	5.1	8.7	4.2

Urgent Community Response Standard						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	70%	70%	70%	70%	70%	70%%
Actual	86%	83%	83%	74%*		

Number of Referral to Treatment 65 week waiters						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	40	50	60	60	60	50
Actual	27	30	28	24	40	58

Cancer patients waiting over 62 days following a GP referral						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	60	60	60	64	64	64
Actual	59	67	52	41	46	62

4-hour Urgent and Emergency Care Performance						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Internal plan	45%	50%	55%	60%	65%	70%
National Submission	45%	45%	50%	50%	55%	55%
Actual	55%	60%	58%	64%	57%	61%

Number of Patients on Virtual Ward						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	12	16	24	24	32	40
Actual	14	15	23	31	36	25

Board of Directors' Meeting
3 November 2023

The Rotherham NHS Foundation Trust

Agenda item	P169/23
Report	**Quality Assurance Report (including Care Quality Commission)**
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 purpose of the Quality Assurance Report is to provide an overview of all quality activity across the Trust, with a focus on Care Quality Commission requirements and to identify progress against the Quality Assurance Framework, to support our delivery of outstanding care. There are four key elements that collectively describe how the Trust will move forward on its 'Journey to Outstanding'. • Quality Assurance • Quality Governance • Quality Improvement • CQC Relationship/ future inspection methodology All actions within the Quality Improvement Plan (derived from previous CQC inspections) are now complete with the majority being embedded. All divisions have participated in comprehensive self-assessments that are driving their quality improvement agendas. The Trust will be working towards the new self-assessment framework in Q3 and Q4. We maintain a positive and open relationship with the engagement team and have responded positively to all enquiries and requests to support other Trusts.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This information has been reviewed through the CQC Delivery Group and shared with Quality Committee, in a different format, on a quarterly basis.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Trust Board: • Note the content of the Report • Note the progress made in progressing the Quality Assurance Programme
Appendices	None

1. Quality Assurance

1.1 The Quality Assurance programme continues to be delivered and is monitored through the CQC Quality Delivery Group and Quality Committee. All Core Services across both Acute and Community sites underwent a review in quarter four against the relevant CQC Inspection framework and have built upon this in the current year.

1.2 Although self-assessment has continued in Quarter 2, it is to be noted that the new CQC self-assessment framework has now been published. Therefore, the framework will need to be adjusted and this will then be utilised during Q3 and Q4.

1.3 Peer review activity is currently paused whilst the transition to the new self-assessment framework in completed. There will be a programme of work identified for the 2024/2025 year.

1.4 Quality Delivery groups have continued to be held monthly with the exception of August and remain quorate. The performance against the Quality Improvement Plan has further improved, driven by a significant number of actions in UECC becoming embedded. There are no amber actions remaining and there continues to be an increase in the number of embedded actions completed. In October, there was a review of all Green actions presented, 32 in total. The Divisions have been requested to focus on providing sufficient evidence for the embedding of these actions.

	RAG Definitions
	Has failed to deliver by target date/Off track and now unlikely to deliver by target date
	Off track but recovery action planned to bring back on line to deliver by target date
	Completed / On track to deliver by target date
	Delivered and embedded so that it is now business as usual and the expected outcome is being routinely achieved. This has to be supported by appropriate and approved evidence.
	Subject to external input to fully achieve

Core Service	Red	Amber	Green	Blue	Grey
Trustwide	0	0	2	2	0
UECC	0	0	16	18	1
Medicine	0	0	8	17	0
Maternity	0	0	2	4	0
Children and Young People	0	0	4	18	2
Total	0	0	32	59	3
Percentage	**0%**	**0%**	**34%**	**63%**	**3%**

Table 1.

1.5 The Trust is now in a position to move away from a retrospective, reactive approach, to one of continuous quality improvement. The Improvement Plan needs to align to other quality and safety initiatives – for example, the Quality Priorities and PSIRF, where collectively, change is supported by evidence and intelligence based information that will ultimately deliver the overall Trust Strategy and drive forward the Journey to Outstanding.

2. Quality Governance / CQC Relationship

2.1 Although we have not recently received any external scrutiny from the CQC, we maintain a positive approach to engagement. The engagement meetings have restarted in September. It was discussed within that meeting the changes occurring within the CQC and the transition of relationship leads. We have received three enquiries and these have all been responded to promptly with no escalations required.

2.2 The CQC have communicated the roll out programme of the new self-assessment framework. There will be opportunities for the Trust to learn from pilot sites during this time.

2.3 The transition of the CQC relationship team will occur over the next two months. It was acknowledged the positive support that has been provided during the current tenure.

3. Quality Improvement

3.1 Quality Improvement is now well established within the organisation. Quality Service Improvement and Redesign (QSIR) training is available in two tiers, QSIR P (Practitioner 5 day course) – up to end October 2023 116 practitioners, with four cohorts planned for 2024. QSIR F (Fundamentals 1 day course) 19 attendees over 2 courses to end July 2023, with 3 more courses of up to 20 attendees per course for the remainder of 2023. This is against the original plan of training 50 people per annum. There are 4 cohorts planned for 2024.

All newly qualified nurses, midwives and therapists will receive Qi training as part of their preceptorship programme to QSIR Fundamentals level from November 2023, with the expectation they will present a project back at the end of the programme.

3.2 As the organisation matures in its QI journey, colleagues attending training will be able to bring projects ideas identified by divisions which may include patient safety work. Currently these are some of the projects relating to patient safety:

- Reducing time to referral of deteriorating patients
- Early interventions for mobility with therapists
- Improve rate of admissions to virtual ward
- Improve confidence for paediatric nurses care for the jaundiced neonate
- Improve clinical medication reviews to improve medication safety
- Introduction of Achieving Reliable Care for Safety
- Outlier identification
- Reconditioning awards

3.3 A recognised constraint on the Qi programme to date has been the inability to provide full follow up support to projects such as those listed above. This has meant that benefits to patients and any cost improvements resulting from changes are not being appropriately recorded. The follow up business case was therefore approved in July which supports recruitment of 1.0 Band 7 and 1.0 Band 5 practitioners to join this team which will significantly strengthen governance, monitoring, reporting and benefits realisation.

3.4 AMAT registration is now built into day 3 of the QSIR Practitioner programme from October 2023 cohort. Currently 33 projects are registered and regular action learning sets are also starting to support staff undertaking Qi work or registering on the system.
Medical trainees are currently proactively registering their QI projects, Qi and Clinical Effectiveness are working together to provide guidance on these projects and how to define clinical audit, research and Qi.

4. Future Inspection Methodology

4.1 CQC have announced that they will start to use the new Regulatory Single Assessment Framework in the South of England from November 2023. They will still schedule assessments by considering the level of risk, so not all providers will have an immediate assessment. Other regions, including ourselves, will remain on the current assessment framework for now with an expected roll out to other areas by the end of March 2024.

5. Conclusion

5.1 Although we have not had any external scrutiny, all divisions have been actively assessing their position against CQC requirements and taking action where necessary. The process has moved away from a reactive approach to CQC findings and is now an embedded quality improvement approach driven by peer and self-assessments, PSIRF and feedback from service users.

5.2 The Trust will be working towards preparedness for the new self-assessment framework in Q3 and Q4.

5.3 During the next quarter, it is hoped to recruit to the Qi posts and strengthen the oversight and output of Qi initiatives.

Victoria Hazeldine
Deputy Chief Nurse
October 2023

Board of Directors' Meeting
3 November 2023

The Rotherham NHS Foundation Trust

Agenda item	P170/23
Report	**Maternity and Neonatal Safety inc Ockenden 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	• It is a national requirement for The Board of Directors to receive a monthly update on Maternity Safety, which goes through Quality Committee. • The LMNS undertook a deep dive into the Saving Babies Lives Version 3 implementation tool on the 25th of September 2023. A revised work plan has now been agreed between the Service and the LMNS to support full implementation by March 2024. A further assurance visit took place by the LMNS on the 6th of October 2023 which focused on the current position for achieving all 10 standards of CNST. • Theme 1: The Maternity Service has completed the benchmarking exercise for the 3 year delivery and the paper shares some examples of actions required. • Theme 2: 16 Early Career Midwives have started in post at TRFT. The Qualified in Speciality (QIS) Register Nurse staffing is included this month for the Neonatal Unit. • Theme 3: Training compliance has been impacted by the new rotation of Doctors, industrial action and safe staffing. Extra sessions have been scheduled to support the trust achieving the requirement for 90% compliance by December 2023. The service has received positive feedback regarding Midwifery students at Sheffield Hallam University. No Serious Incidents were declared in September. • Theme 4: The rolling stillbirth rate is 2.36 per 1000, the Attain KPI has been met in September at 3.6%
Due Diligence	This paper has been prepared by the Head of Midwifery and shared through Maternity and Family Health Divisional Business and Governance, the Maternity and Neonatal Safety Champions and Quality Committee

Board powers to make this decision	The Trust Board and Quality Committee are required to have oversight on the maternity safety work streams.
Who, What and When	Helen Dobson, Chief Nurse, is the Board Executive Lead. The Head of Midwifery attends Trust Board monthly to discuss the Maternity Safety agenda.
Recommendations	It is recommended that the Board of Directors are assured by the progress and compliance demonstrated in paper to date with the Maternity Safety Work streams.
Appendices	1. CNST Monthly update 2. Benchmarking against the 3 year delivery plan 3. Birth rate plus August data **All appendices are available in the Convene Reading Room**

Maternity Safety

Introduction

1.1 The LMNS undertook the first of a number of planned check and challenge meetings on the 25th of September 2023. Benchmarking of the six elements of SBLV3 using the implementation tool and the associated evidence was reviewed by external peers from the LMNS and Rotherham Place. The tool demonstrates Rotherham's current self-assessment as of Q4 2022/23 (Table 1.1) which has been validated by the LMNS. An action plan is in place and been jointly agreed with the LMNS, this will facilitate the unit to achieve the required 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element in order to achieve CNST year 5 standards by February 2024. Full compliance of all 6 elements is to be achieved by March 2024.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	30%	Partially implemented	20%
Element 2	Fetal growth restriction	Partially implemented	25%	Partially implemented	20%
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%
Element 4	Fetal monitoring in labour	Partially implemented	40%	Partially implemented	40%
Element 5	Preterm birth	Partially implemented	56%	Partially implemented	26%
Element 6	Diabetes	Not implemented	0%	Partially implemented	33%
All Elements	TOTAL	Partially implemented	37%	Partially implemented	26%

Table 1.1

It is expected that the total compliance rates for each element will significantly increase over the coming months. This will be due to the collection of evidence in the form of audits and the updating of guidelines which will rapidly bring us in line with much of the updated SBLV3 care bundle. Other, more challenging areas which have been identified to achieve include; data extraction from the current multiple EPR systems and the lack of a Diabetic Nurse available to pregnant women in the antenatal clinic are key obstacles to overcome. Work continues with IT and the wider Trust diabetes work stream to engage the required resources to achieve compliance.

1.2 On the 6th of October 2023 a CNST 'deep dive' took place by the LMNS to consider Rotherham's current position against the CNST year 5 standards. Achievements and challenges were discussed and a review of the current level of evidence took place. The LMNS oversite also ensures that all Trusts within the SYB region are consistent with the evidence submitted to Boards. 8 out of the 10 standards are on track to be achieved by the deadline of February 2024. The remaining 2 standards which are outstanding are Standard 8, in which a 90% attendance at MDT training must be met prior to December 2023. Whilst it was anticipated that this would be achieved, staffing challenges and strike action over the summer months has impacted on staff attendance at planned training events. Secondly, Standard 6, to implement SBLV3 has been discussed in 1.1. Appendix 1 demonstrates current compliance for each of the CNST Standards.

2. Theme 1: Listening to and working with women and families with compassion Key commitments

2.1 A first draft of the benchmarking against the 3 Year Delivery Plan has been completed and shared with the LMNS (Appendix 2). This plan clearly sets out a path towards fully achieving the vision of a safe and responsive service and clearly demonstrates how we will continue to strive to listen to women and their families. A sample of actions include;

- Birthrights UK training to all levels of the MDT, focusing on the theme of informed consent.
- Introducing an hour long community home visit at 34 week gestation to have a birth planning discussion.
- Auditing the quality of the Personalised Care Plans and Co-produce a new version with the MNVPs to improve use by women and staff.
- A Task and Finish group has been established and a further investment of Midwife hours within the Infant Feeding Team will be provided to achieve a Baby Friendly Accreditation by March 2027.
- Investment in equipment to improve access to interpreting services in all areas.
- Improve data collection of deprivation scores and ethnicity to focus resources where needed the most.

2.2 Findings from the recent Picker survey have been further scrutinised, whilst there is an improvement on the 2022 scores generally, it is reassuring that 19% of the respondents were from women who were non-white or of non-British origin (Table 2.1). The current percentage of non-white/British service users is 19.47%, this data has been taken from the Antenatal booking report. This information will positively influence service development.

Comparator (Organisation Overall)	White	Mixed/ Multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other ethnic groups	I would prefer not to say
n = 148	n = 118	n = 9	n = 8	n = 9	n = 1	n = 1

Table 2.1

2.3 Safety action 7 of the CNST standards, requires evidence of co-production with the MNVPs. Evidence has been collected and achievement of this standard has been agreed with the LMNS. This has been possible due the numerous and varied projects that have and are currently being worked on. Projects include work streams around informed consent, privacy and dignity and improving the woman's journey through the induction of labour process as a mode of birth. The 2022 CQC Picker survey action plan was co-produced and moving forwards, the 2023 results will also be reviewed and an action plan will be co-produced again. This will ensure that the woman's voice is present in all service improvement ideas. The MNVP current work plan also incorporates how they can assist Rotherham maternity services in prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation.

2.4 The neonatal unit have also introduced engagement sessions with the MNVP to support their user and parent engagement further. Plans are in place to celebrate and raise awareness for the World Prematurity Day on the 17th November 2023.

3. Theme 2: Grow, Retain and support the workforce

3.1 The Midwifery incentive continued in September to support safe staffing in Maternity services. Appendix 3 shares the acuity data report highlighting that staffing met the acuity for 87% of the care episodes reported. Table 3.1 represents the current workforce gaps which will remain the same until the 16 early career midwives (who have commenced in post this month) have completed their supernumerary period. The early indications of the recent Birthrate+ review of the current establishment, suggests that a further 5 WTE bands 3-7 would be require to meet the current needs and acuity of the service.

Maternity Staffing live nominal roll as at : 30/09/2023	2023/24											
Trajectory	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Contracted Vacancies	**2.53**	**0.44**	**1.40**	**-0.15**	**2.15**	**1.72**	**1.72**	**1.72**	**1.72**	**1.72**	**1.72**	**1.72**
Maternity leave	1.23	2.03	3.99	4.95	5.59	6.59	6.59	6.59	6.16	6.80	4.04	4.68
Long term sickness	4.12	5.12	4.88	4.88	5.99	2.07	0.64	0.00	0.00	0.00	0.00	0.00
Upcoming Leavers	0.20	0.00	0.81	1.76	0.00	1.64	1.64	1.64	4.64	4.96	4.96	4.96
Other - see detail	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60
Total Gaps	**9.68**	**9.19**	**12.68**	**13.04**	**15.33**	**13.62**	**12.19**	**11.55**	**14.12**	**15.08**	**12.32**	**12.96**
New Starters (reducing gaps)	-2.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	-13.84	-13.84	-13.84	-13.84	-13.84	-13.84
Trajectory - for planning	**7.28**	**9.19**	**12.68**	**13.04**	**15.33**	**13.62**	**-1.65**	**-2.29**	**0.28**	**1.24**	**-1.52**	**-0.88**
% Workforce Gaps	**7.4%**	**9.3%**	**12.9%**	**13.3%**	**15.6%**	**13.8%**	**-1.7%**	**-2.3%**	**0.3%**	**1.3%**	**-1.5%**	**-0.9%**

Table 3.1

3.2 Table 3.2 represents the Qualified in speciality (QIS) Registered Nurse Competency in the neonatal unit demonstrating that the Division meets the BAPM requirement of 70%.

	In Post- October 2023	**WTE Direct Care in Unit**	**WTE with NOT included**
Total Establishment	34.42	30.32	31.52
Total RNs	30.42	27.32	28.52
QIS	24.38	21.28	22.48
QIS %	**80%**	**78%**	**79%**
QIS and/or Pre QIS Foundation Competency	27.26	24.16	25.36
QIS and/or Pre QIS Foundation Competency %	90%	88%	89%

Table 3.2

3.3 Table 3.2 below represents September 2023 workforce data; Sickness rates have shown a more positive picture with a slight decrease following the previous few months which demonstrated a gradual incline. There are no themes identified and sickness and absence is supported in line with the Trust policy.

Workforce Data – September 2023:

Maternity unit closures	0	Datix / Birth-rate Plus®
Utilisation of on call midwife to staff labour ward (Night Duty)	1	Birth-rate Plus® data/ Datix

1-1 care in labour	100%	Data from Birth-rate Plus® acuity tool / Maternity Dashboard
Redeploy staff internally	27	Birth rate plus Acuity (Occasions)
Redeploy staff from Community	5	Birth rate plus Acuity (Occasions)
Matron Working Clinically	4	Birth rate plus Acuity
Delay in Induction of Labour	13	Birth rate plus Data and Datix
Supernumerary labour ward co-ordinator	100%	Data from Birth-rate Plus® acuity tool/Maternity Dashboard/Datix
Staff absence	5.74%	August data HR systems long term 3.93%% short term 1.34%%
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

Table 3.2

3.4 **Obstetric cover gaps**: The table below (Table 3.3) illustrates the locum breakdown for September 2023. Both new Obstetrics and Gynaecology newly appointed consultants have now commenced in post. Each new consultant has taken specialist areas which have begun to improve the care offered with the ANC and increased the clinic capacity.
Nenonates: Interviews are planned in October to support the outstanding Medical workforce vacancy to meet BAPM requirements of agreed 3.7 WTE.

Grade	No of Shifts	Reason	Internal / External
ST1/2	6	1 x Sickness 2 x Vacancy 3 strike cover	6 x Internal
ST3/7	21	5 x Sickness 1 x Induction 3 x entrustability 3 x strike 9 x Vacancy	17 x Internal 4 x external
CONSULTANT	40	4 x Vacancy 4 x Annual/Study Leave 11 x Additional clinics 1 x Additional theatres 15 x entrustability 1 x sickness 4 x induction MP	41 x Internal

Table 3.3

4. Theme 3: Developing and sustaining a culture of safety, learning and support

4.1 Despite staffing challenges and industrial action, efforts to achieve the year 5 CNST training requirements continues. The requirement is for 90% attendance of the relevant staff groups for the Core Competency Framework Version 2 (CCF V2). The reporting period for this was changed by the Maternity incentive scheme (MIS) in July 2023 to 12 consecutive months from 1st December 2022 to 1st December 2023. Historically, the curriculum for TRFT ran from September to July so this has now been changed to meet this requirements. Table 4.1 demonstrates our current position. New Obstetric Registrars and ST1-2's are included within the data having commenced in Aug/Sept 23 and this has reduced the compliance of these staff groups.

Due to strike action x2 obstetric registrars and x1 obstetric ST1-2 did not attend maternity MAST in September either due to involvement in industrial action or supporting staffing/rostering needs as a result of the industrial action. Extra sessions have been organised to support the achievement of the 90% compliance of all staff groups before December 2023. We are currently awaiting further guidance on this from MIS on this as this is currently a challenge for most organisations.

Month	July 23	Sept 23
Obstetric Consultants	**95.5%**	**75%**
Obstetric Registrars	**96%**	**50%**
Obstetric Trainees	**95.5%**	**54%**
Midwives	**87.5%**	**72%**
Clinical Support staff	**95.5%**	**83%**
Anaesthetists	**90%**	**71%**

Table 4.1

4.2 Sheffield Hallam University shared feedback in the month of September 2023 of students who had undertaken placements within the maternity services (Table 4.2). All areas had positive scores of over 95%, with the average positive score for the whole unit being 96.7%. The feedback has been shared with all teams and has offered assurance to the senior team of a positive learning culture.

Wharncliffe	Number of Reviews	1 of 10
	Average (%)	96.7% positive
	Additional Comments	None
Greenoaks	Number of Reviews	1 of 10
	Average (%)	96.7% positive
	Additional Comments	None
Community	Number of Reviews	4 of 10
	Average (%)	98.3% positive
	Additional Comments	"amazing" "friendly" "welcoming" "supportive" "encouraging" "staff listen to each other"
Labour Ward	Number of Reviews	4 of 10
	Average (%)	95.4% positive
	Additional Comments	"amazing"

		"welcoming" "kind" "team work in the best ways" "supportive in emergencies"

Table 4.2

Learning from Incidents:

4.3 Find attached the Obstetric incidents summary for September 2023.

During September 2023, there were 118 incidents reported on Datix for Obstetrics, of which 20 were graded as moderate harm at the time of the incident. All cased have had an MDT review and have later been downgraded to low or no harm as it was noted that appropriate care management was given. No Serious incidents were declared in September Table 4.4 provides further data for the moderate incidents from September on the deprivation scores and ethnicity so that we can analyse the data further for themes and trends.

	April 23	May 23	June 23	July 23	Aug 23	Sept 23
Stillbirth	0	0	1	0	1	1
Late Fetal loss	0	0	0	0	1	0
Neonatal death	0	0	0	0	1	0
Pre-eclampsia	0	0	0	1	0	1
3rd degree tear	5	2	2	3	2	8
PPH >1500	5	4	12	5	10	9
Shoulder dystocia	1	3	3	5	1	1
Unintended injury or clinical task	1	0	0	0	0	0
Low cord gases	1	3	4	1	5	0
Low apgars	0	2	1	1	1	1
Total:	13	14	23	16	22	20

Table 4.3

Incident	Sep-23	Ethnicity	Deprivation Score
Stillbirth	1	Not stated	7
Late Fetal loss	0		
Neonatal death	0		
Pre-eclampsia	1	White British	1
3rd degree tear	8	x1 Not stated x1 Not collected x1 Pakistani x4 White British White British x1 Any Other Ethnic Group	1 (x2) 3 4 (x2) 6 (x2) 7

PPH >1500	9	x7 White British x2 Not stated	1 3 5 (x2) 6 (x2) 7 8 (x2)
Shoulder dystocia	1	White British	1
Unintended injury or clinical task	0		
Low cord gases	0		
Low apgars	1	Not stated	6
Total:	20		

Tables 4.4

There has been a rise in the number of 3rd degree tears that occurred in the month of September 2023. The team will continue to monitor this type of injury over the coming months, identifying any themes and trends.

Listening to issues raised by staff or service users

4.4 In September 2023 x 2 formal complaint was logged regarding Maternity care. One complaint was due to the woman feeling unsupported in labour and the second was due to the woman feeling unsupported with her birth choices.

5. Theme 4: Standards and structures that underpin safer, more personalised and more equitable care:

In the month of September 2023 the perinatal deaths included:

X 1 Stillbirth @ 38/40 (RIP). Met criteria for PMRT
X 1 Neonatal death @ 16/40 – did not meet criteria for PMRT and not included in adjusted figures due to gestation

5.1 Rolling 12 months October 2022 – September 2023
Number of births - 2524
Number of Stillbirths in Sept 2023 (adjusted) – 1
Number of neonatal deaths in Sept 2023 (adjusted) - 0

Perinatal mortality All deaths (including congenital anomalies)

5.2

Type of death	Number	Rate per 1000 births
Stillbirth	6	2.37
Neonatal death	7	2.75

Table 5.1

Post Code	Deprivation Score (lower number = higher deprivation)	Ethnicity
S60 5**	6	White British
S61 4**	1	White British
S9 1**	2	South Asian
S65 2**	1	White British
NND		
S9 I**	Not found	South Asian
S61 I**	Not found	Other White Background
S60 2**	2	South Asian

Tables 5.2

Total perinatal 5.16/1000 births

5.3 Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP)

Type of death	Number	Rate per 1000 births
Stillbirth	6	2.37
Neonatal death	1	0.39

Table 5.3

Adjusted Total Perinatal (stillbirths and neonatal deaths) 2.76/1000 births

Avoidable Term Admissions into the Neonatal unit (ATAIN)

5.4 Table 9 shares the ATAIN data for September which demonstrates that the admission rate has decreased from the previous month with 7 term admissions in the month of September 2023. All cases are reviewed at the weekly MDT ATAIN meeting. 1 cases was found to be avoidable. This case involved a mother who was admitted with a consealed pregnancy in which she birthed her baby but then required HDU care following a Covid diagnosis. The baby was cared for on the NNU until the mother was well enough to be re-united with its mother.

Number of admissions to Neonatal Unit:	**18**
Number of Transitional Care babies on LW/WHC:	(HRG-04) 5
	(BAPM) 27
Number of Term Admissions:	**7**

Term Admissions as a Percentage of all Live Births:	**3.6%**
Avoidable Admissions:	**2**
Unavoidable Admissions:	**5**
Excluded from ATAIN Review:	**0**

Table 5.4

Sarah Petty
Head of Nursing and Midwifery
Family Health Division

Board of Directors' Meeting
3 November 2023

Agenda item	P171/23
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 2023/24 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 September 2023 (Month 6 2023/24): ○ A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management. • Section 2 – Income & Expenditure Account for September 2023 (Month 6 2023/24):

	○ Financial results to September 2023. - A surplus to plan of £150K in month and a deficit to plan of £1,068K year to date; - The same surplus to the (external) control total of £150K in month and a deficit of £1,068K year to date. The Trust's performance is measured against the control total with NHS England, having adjusted for depreciation on donated and right of use assets (£374K year to date). • Section 3 – Income and Expenditure Account Forecast Out-Turn ○ An initial forecast out-turn up to 31st March 2024 of £4,316K deficit to plan and equally the control total. ○ The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE but assumes appropriate management action and the use of reserves will enable the Trust to deliver its overall plan by 31st March 2024, a year end deficit of £5,977K. • Section 4 – Capital Expenditure for September 2023 (Month 6 2023/24) ○ Expenditure for the six month period ending September 2023 is £1,795K against a budget of £4,622K: an under-spend of £2,827K (61%). ○ The capital programme is being reviewed and monitored at the Capital Monitoring Group, chaired by the Director of Finance. Capital expenditure is expected to fully deliver against plan. • Section 5 – Cash Flow 2023/24 ○ A cash flow graph showing actual cash movements between April 2022 and September 2023. A month-end cash value as at 30 September 2023 of £16,379K, which is £2,390K worse than plan due to slippage on income receipts and increased creditor payments in month.
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 NHS England. ○ 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 Efficiency Board chaired by the Deputy Chief Executive.

	○ The capital expenditure position has been discussed and reviewed by the Capital 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?)	• Overall financial performance was discussed at the monthly performance meeting on 31 October 2023. • CIP performance was discussed at the Efficiency Board meeting held on 18 October 2023. • Capital expenditure was reviewed at the Capital Monitoring Group held on 16 October 2023. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 25 October 2023, including feedback from all of the above. Any issues for escalation from the Committee will be reported at the meeting of the Board.
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)	(646)	(496)	150	(4,040)	(5,108)	(1,068)	(4,316)	(5,625)
I&E Performance (Control Total)	(584)	(433)	150	(3,665)	(4,733)	(1,068)	(4,316)	(5,625)
Capital Expenditure	701	584	117	4,622	1,795	2,827	0	0
Cash Balance	(155)	(2,601)	(2,446)	18,769	16,379	(2,390)	(256)	(248)

1.2 The Trust has under-spent against its I&E plan in September 2023 but cumulatively there remains an overspend of £1,068k year to date. The Trust's performance is measured against its control total with NHS England, which is after adjusting for depreciation on donated and right of use assets, this is showing the same adverse variance. These figures do not include any adjustment for under or over-performance on elective recovery activity, which is assumed to be covered within the current level of reserves. The cost pressure resulting from pay awards are now within the position.

1.3 Capital expenditure is behind plan in month and year to date, with cumulative spend of £1,795k against a budget of £4,622k. Capital spend is forecast to fully deliver against plan.

1.4 The cash position at the end of September 2023 is £16,379K. Despite being below plan by £2,390K, this remains a strong cash balance. The reduction against plan is due to slippage on income receipts and timing of creditor payments.

2. Income & Expenditure Account for September 2023 (Month 6 2023/24)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a surplus to plan in September 2023 of £150K and a year to date deficit to plan of £1,068K.

Summary Income & Expenditure Position	AP £000s	Month P £000s	Month A £000s	Month V £000s	YTD P £000s	YTD A £000s	YTD V £000s	2023/2024 Monthly Trend / Variance
Clinical Income	324,214	28,266	27,787	(479)	162,604	159,954	(2,650)	
Other Operating Income	24,548	2,160	2,403	243	12,645	13,222	576	
Pay	(235,304)	(21,061)	(21,468)	(407)	(117,919)	(121,099)	(3,180)	
Non Pay	(92,473)	(8,523)	(8,776)	(252)	(49,939)	(51,547)	(1,608)	
Non Operating Costs	(3,969)	(331)	(295)	36	(1,985)	(1,779)	206	
Reserves	(23,741)	(1,157)	(148)	1,009	(9,445)	(3,858)	5,588	
Retained Surplus/(Deficit)	(6,726)	(646)	(496)	150	(4,040)	(5,108)	(1,068)	
Adjustments	748	62	62	(0)	374	374	(0)	
Control Total Surplus/(Deficit)	(5,977)	(584)	(433)	150	(3,665)	(4,733)	(1,068)	

2.2 Clinical Income is behind plan in month and year to date mostly due to under performance on elective recovery activity. ERF divisional targets are included in budgets. This

underperformance is currently offset in reserves as the performance against NHSE's target, and updates for new tariff prices are being validated.

2.3 Other Operating Income is ahead of plan in month and year to date with increased income from staff recharges (£178K), which will be an offset to the pay over-spend, increased research, development and education income (£206K), and other non-clinical income (£298K), which will have non-pay spend against it.

2.4 Pay costs are over-spending by £407K (2%) in month. The main contributory factors in month are industrial action and £322K under-delivery of cost improvement targets. The year to date performance is also being influenced by undelivered cost improvement targets of £2,523K.

2.5 Non Pay costs are over-spending by £252K in month and by £1,608K year to date. The main categories of overspends are on drugs £643K, premises £917K and under-delivery of cost improvement targets of £297K.

2.6 The positive performance in Non Operating Costs is due interest receivable and financing costs being better than plan.

2.7 £5,588K has already been released from Reserves year to date, this is specifically to cover the underperformance against ERF and under delivery of CIP.

3 Forecast Out-Turn Performance to 31st March 2024

3.1 The table below shows the forecast out-turn position for the financial year 2023/24. The Trust is forecasting to deliver a £4,316K deficit to plan.

Summary Income & Expenditure Position	AP £000s	FO (Full Year) £000s	AV (YTD) £000s	FV £000s	TV £000s	2023/2024 Monthly Trend / Variance
Clinical Income	324,214	322,125	(2,650)	561	(2,089)	
Other Operating Income	24,548	26,466	576	1,342	1,919	
Pay	(235,304)	(242,684)	(3,180)	(4,200)	(7,380)	
Non Pay	(92,473)	(95,235)	(1,608)	(1,154)	(2,762)	
Non Operating Costs	(3,969)	(3,559)	206	205	411	
Reserves	(23,741)	(18,155)	5,588	(2)	5,586	
Retained Surplus/ (Deficit)	(6,726)	(11,041)	(1,068)	(3,248)	(4,316)	
Adjustments	748	748	(0)	(0)	(0)	
Control Total Surplus/ (Deficit)	(5,977)	(10,293)	(1,068)	(3,248)	(4,316)	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected. This underperformance is currently offset in reserves awaiting validation of the performance against target from NHSE. No further under-delivery of ERF is forecast at this stage. Additional income is forecast from other variable activities.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£1,228K) and staff recharges (£520K). This additional income will equally be offset by further increases in pay and non-pay expenditure.

3.4 Pay is showing a significant deterioration in performance this is mostly due to undelivered annual CIP budget reductions £5,803K.

3.5 Non Pay costs are similarly showing a significant deterioration in performance linked to continued increasing costs, most notably within premises £1,693K and undelivered CIPs £1,100K.

3.6 Non Operating Costs reflect increased income from interest receivable on money deposited with Government banking services that continues to increase due to continued cash balances and increased interest rates.

3.7 The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE but assumes appropriate management action and the use of reserves will enable the Trust to deliver its overall plan by 31st March 2024, a year end deficit of £5,977K.

3.8 Cost reduction and CIP delivery will need to be managed proactively across all services, with clear action plans being implemented, if the Trust is to deliver against its overall plan. With the continuation of industrial actions, the risk of being able to deliver this financial plan is increasing. The financial impact of industrial actions is being assessed at a national level but as yet no confirmation has been received on allowances beyond April industrial action.

4. Capital Programme

4.1 As at September 2023 the Trust has incurred capital expenditure of £1,795K against a budget of £4,622K representing an under-spend of £2,827K (61%).

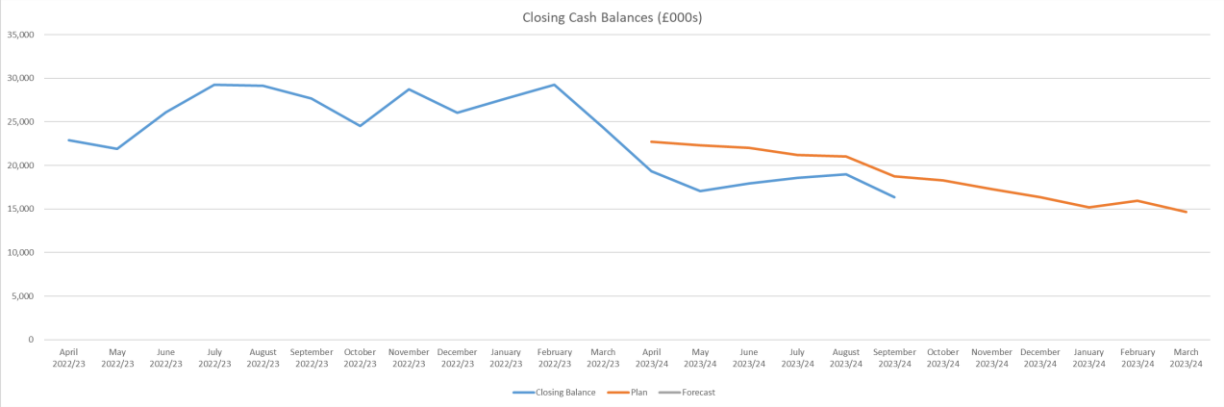
Capital Expenditure	Month			YTD			Forecast	Prior Month
	P	A	V	P	A	V	V	FV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Estates Strategy	737	150	587	1,429	354	1,074	0	0
Estates Maintenance	337	197	140	563	407	156	0	0
Information Technology	316	94	222	1,082	738	345	0	0
Medical & Other Equipment	266	142	124	682	296	386	0	0
Other	(956)	0	(956)	866	0	866	0	0
TOTAL	701	584	117	4,622	1,795	2,827	**0**	**0**

4.2 'Other' is the re-profiling of the internal budget against the capital plan submitted to NHSE. Against the re-profiled internal plan the under-spend is £1,961K (52%).

4.3 The capital programme is monitored at the Capital Monitoring Group, chaired by the Director of Finance. Capital expenditure is expected to fully deliver against plan of £10,355K.

5. Cash Management

5.1 Compared to plan, there is an adverse variance in-month of £2,446K and year to date variance of £2,390K. Cash remains strong with a closing cash balance of £16,379K as at 30 September 2023 as shown in the graph below. This is due to slippage on income receipts and increased creditor payments.



5.2 This has allowed the Trust to earn interest on its daily cash balances of £100K in-month (£595K year to date), which will help contribute towards the Trust's cost improvement target for 2023/24.

5.3 The recent rise in interest rate will further increase interest receivable income throughout the year, albeit it will only be marginal.

Steve Hackett
Director of Finance
16th October 2023

Board Planner

Action tracker log no.	Event/Issue		2022		2023								2024	
	TRUST BOARD MEETINGS		Sept	Nov	Jan	Mar		May	June	July	Sept	Nov	Jan	March
				4	9	3		5	20	7	8	3		
			M6	M8	M10	M12		M2		M4	M6	M8	M10	M12
		Lead												
	PROCEDURAL ITEMS													
	Welcome and Apologies	Chair	•	•	•	•		•		•	•	•	•	•
	Quoracy Check	Chair	•	•	•	•		•		•	•	•	•	•
	Declaration of Conflicts of Interest	Chair	•	•	•	•		•		•	•	•	•	•
	Minutes of the previous Meeting	Chair	•	•	•	•		•		•	•	•	•	•
	Action Log	Chair	•	•	•	•		•		•	•	•	•	•
	Matters arising (not covered elsewhere on the agenda)	Chair	•	•	•	•		•		•	•	•	•	•
	Chairman's Report (part 1 and part 2)	Chair	•	•	•	•		•		•	•	•	•	•
	Chief Executive's Report (part 1 and part 2)	CEO	•	•	•	•		•		•	•	•	•	•
	STRATEGY & PLANNING													
	TRFT Five Year Strategy 6 month Review	CEO		•				•				•		
	Operational Plan: 6 Month Review	DCEO		•				•				•		
	Annual Operational Planning Guidance	DoF			•								•	
	Winter Plan	COO		•								•		
	Digital Strategy	CEO			•dfd	•dfd				•dfd	•dfd	•		
	Estates Strategy	DoF			•dfd	•dfd				•			•	
	People Strategy	DoW												•
	Quality Improvement Strategy.	CN										•		
	Public and Patient Involvement Strategy	CN												•
	SYSTEM WORKING													
	SYB ICS and ICP report	DCEO	•	•	•	•		•		•	•	•	•	•
	SYB ICS CEO Report (included as part of CEO report)	CEO		•	•	•		•		•	•	•	•	•
	Partnership Working	NED			•			•				•		•
	CULTURE													
	Patient Story	CN		•		•				•		•		•
	Staff Story	DoW			•			•			•		•	
	Annual Staff Survey	DoW				•		•						
	Staff Survey Action Plans	DoW												
	Freedom to Speak Up Quarterly Report	ChN	•		•			•			•		•	
	Gender Pay Gap Report and Action Plan	DoW				•								•
	Workforce Race Equality Standards (WRES)	DoW									• dfd	•		
	Workforce Disability Equality Standard Report (DES)	DoW									• dfd	•		
	Public Sector Equality Duty Report	DoW												•
	Medical Engagement	MD						•						
	Patient Experience Annual Report	CN								•				
	ASSURANCE													
	Integrated Performance Report:	COO	•	•	•	•		•		•	•	•	•	•
	Quarterly Medical Workforce Data	MD												
	Maternity and Neonatal Safety Report	CN	•	•	•	•		•		•	•	•	•	•
	Safe Staffing & Establishment Nurse review (6 monthly)	CN			•					•			•	
	Reports from Board Assurance Committees	NEDs	•	•	•	•		•		•	•	•	•	•
	Finance Report	DoF		•	•	•		•		•	•	•	•	•
	Operational Update, Including Recovery and Winter Update	COO			•	•		•		•	•	•	•	•
	ASSURANCE FRAMEWORK													
	Governance Report	DoCA		•	•	•		•		•	•	•	•	•
	Board Assurance Framework	DoCA	•	•	•	•		•		•	•	•	•	•
	Quarterly Risk Management Report	DoCA			•			•		•		•		•
	Annual Review of risk appetite	DoCA										•		

Action tracker log no.	Event/Issue		2022		2023								2024	
	TRUST BOARD MEETINGS		Sept	Nov	Jan	Mar		Ma	June	July	Sept	Nov	Jan	March
				4	9	3		5	20	7	8	3		
			M6	M8	M10	M12		M2		M4	M6	M8	M10	M12
	Assurance Board Committee ToRs	DoCA												
	Health and Safety Annual Report	DoE								•				
	Quality Assurance Report (1/4)including Care Quality Commission update	CN	•	•		•		•			•	•		•
	Annual Report from SIRO	DCEO								•				
	Safeguarding Annual Report	CN			•								•	

	EPRR Annual Statement of Compliance	SK											•	
	Health Inequalities	DCEO								•				
	POLICIES													
	Health and Safety Policy (review date Oct 2023)	DoE									•dfd	•		
	Freedom to Speak Up Policy (Updated when National Policy available)	CN												
	Management of Complaints and Concerns Policy (review due 2025)	CN												
	Procurement Policy (due for renewal March 2023)	DoF				•								
	Risk Management Policy	DoCA			•dfd	•								
	REGULATORY AND STATUTORY REPORTING													
	Annual Report and Audited Accounts	DoF							•					
	Audit Committee Annual Report	Com Chair							•					
	People Committee Annual Report	Com Chair							•					
	Finance and Performance Committee Annual Report	Com Chair							•					
	Quality Committee Annual Report	Com Chair							•					
	Nomination and Remuneration Committee Annual Report	Com Chair							•					
	Annual Quality Account (approval)	CN							•					
	Data Security and Protection Toolkit Recommendation Report	SIRO								•dfd		•		
	NHSI: Licence Condition G6(3) certification	DoCA							•					
	NHSI: Licence Condition FT4(8) certification (duty to comply with governance arrangements)	DoCA							•					
	NHSI: Licence Condition re compliance with Training of Governors	DoCA							•					
	Quarterly Report from the Responsible Officer Report (Validation)	MD			•			•			•		•	
	ANNUAL Responsible Officer report (Validation)	MD						•dfd		•				
	Quarterly Report from the Guardian of Safe Working	MD			Q4 •			Q1 •		Q2 •		Q3 •		
	ANNUAL Report from the Guardian of Safe Working	MD						•					•	
	Quarterly 'how we learn from deaths' report	MD			•			•				•		•
	ANNUAL 'how we learn from deaths' report	MD								•				
	Emergency preparedness, resilience and response (EPRR) assurance process sign off	COO									•			
	Regulatory/Statutory Positions (annual)	DoCA				•		dfd						•
	Serious Incidents and Legal Report	CN / DoCA				•		•			•	•		•
	Controlled Drugs Annual Report	MD												•
	BOARD GOVERNANCE													
	Executive Team Meetings report	CEO		•	•			•		•	•	•	•	•
	Assurance Committee Chairs Logs	NEDs		•	•	•		•		•	•	•	•	•
	Register of Sealing (bi-annual review)	DoCA			•dfd	•				•				
	Register of Interests (bi-annual review)	DoCA	•			•dfd		•df d		•	•dfd	•		•
	Register of use of electronic signature (bi-annual review)	DoCA								•				

Action tracker log no.	Event/Issue		2022		2023								2024	
	TRUST BOARD MEETINGS		**Sept**	**Nov**	**Jan**	**Mar**		**May**	**June**	**July**	**Sept**	**Nov**	**Jan**	**March**
				4	**9**	**3**		**5**	**20**	**7**	**8**	**3**		
			M6	**M8**	**M10**	**M12**		**M2**		**M4**	**M6**	**M8**	**M10**	**M12**
	Review of Board Feedback	DoCA				•								
	Review of Board Assurance Terms of Reference	DoCA			•									
	Review of Standing Financial Instructions	DoF			•dfd	•dfd		•dfd		•				
	Review of Scheme of Delegation	DoF			•dfd	•dfd		•dfd		•				
	Review of Standing Orders	DoCA			•dfd	•dfd		•dfd		•				
	Review of Matters Reserved to the Board	DoCA			•dfd	•								
	Constitution	DoCA								•				
	Annual (re)appointment of Senior Independent Director (requires Governor input) included in Chairs Report	Chair								•				
	Annual (re)appointment of Board Vice Chair (part of Chair's report)	Chair		•						•				
	Annual Board Meeting dates - approval	DoCA								•				
	Fit and Proper	DoCA									•			
	Escalations from Governors	Chair			•	•				•		•		
	Remuneration Committee Chair Assurance Report	Chair										•		

	Nomination Committee Chair Assurance Report	Chair												
	Review of Board Planner	Chair	•	•	•	•		•		•	•	•	•	•
	Annual Refresh of Committee membership (part of Chairs Report)	Chair	•					•						
	Audit Committee minutes	Chair			•			•		•			•	
	Quality Committee minutes	Chair		•	•	•		•		•	•	•	•	•
	People Committee	Chair		•	•	•		•		•	•	•	•	•
	Finance and Performance Committee minutes	Chair		•	•	•		•		•	•	•	•	•
	Nomination Committee minutes (ad hoc)	Chair		•	•			•		•	•	•		
	Remuneration Committee Annual Report	Chair			•									
	Remuneration Committee minutes (ad hoc)	Chair		•	•					•		•		
	Business Cases for consideration by Board value in excess of £1m													
	Award Supply Contract: orthopaedic Hips and Knees Prosthesis			•										
	Orthopaedic Centre				•									
	LIMS				•									
	Board feedback				NB	SK		DS		JBe	MT	MW	RS	SH
	NED Review of complaints files (Quarterly)				MT			HC		DS		RS	KM	

Event/Issue

			2022	2023						2024
	STRATEGIC BOARD FORUM		Dec	Feb	April	June	Aug	Oct	Dec	Feb
			9	3	14	2	4	6	8	
			Forum	Forum	Forum	Forum	Forum	Forum	Forum	Forum
			M9	M11	M1	M3	M5	M7	M9	M11
		Lead								
	Matters for discussion									
	Digital Strategy	CEO	•							
	Estates Strategy (may now be at Jan Board)	DoF		•						
	Quality Improvement Strategy.	CN			•					
	Revised Integrated Performance Report:	COO		•						
	Corporate Trustee Training	DoCA		•						
	Annual Operational Planning Guidance	DoF		•?						
	CQC Inspection Process	CN			•					
	Annual Review of risk appetite	DoCA					•			
	Patient Safety Training	CN			•					
	Annual Review of risk appetite	AW							•	