Board of Directors (Public)
The Rotherham NHS Foundation Trust

Schedule	Friday 3 May 2024, 9:00 AM — 12:30 PM BST
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P61/24.	Chairman's welcome and apologies for absence For Information
	P62/24.	Quoracy Check For Assurance
	P63/24.	Declaration of interest For Assurance
	P64/24.	Minutes of the previous meeting held on 8th March 2024 For Approval
	P65/24.	Matters arising from the previous minutes For Assurance
	P66/24.	Action Log For Decision
9:15 AM	OVERVIEW AND CONTEXT	

	P67/24.	Staff Story - Florence Nightingale leadership development and QI - Ghulam Farooque, Hannah Peart, Rachel Watson attending For Information - Presented by Daniel Hartley and Helen Dobson
	P68/24.	Report from the Chairman - Verbal For Information - Presented by Mike Richmond
	P69/24.	Report from the Chief Executive For Information - Presented by Richard Jenkins
	P70/24.	Board Committees Chairs Reports - Committee Chairs i. Quality Committee - Chair's Log - Julia Burrows ii. People & Culture Committee - Chair's Log - Martin Temple iii. Finance & Performance Committee - Chair's Log - Martin Temple For Information
10:00 AM	STRATEGY AND PLANNING	
	P71/24.	Five Year Strategy Refresh For Decision - Presented by Michael Wright
	P72/24.	People and Culture Strategy For Approval - Presented by Daniel Hartley
	P73/24.	Fire Safety Strategy For Decision - Presented by Linda Martin and Steve Hackett
	P74/24.	Organisational Priorities 2023/24 - End of Year Report For Assurance - Presented by Michael Wright

	P75/24.	Organisational Priorities 2024/25 For Decision - Presented by Michael Wright and Louise Tuckett
10:45 AM	BREAK	
10:55 AM	SYSTEM WORKING	
	P76/24.	National, Integrated Care Board and Rotherham Place Update For Information - Presented by Michael Wright
	P77/24.	Partnership Working - Joint Strategic Partnership Update For Assurance - Presented by Martin Temple
11:10 AM	CULTURE	
	P78/24.	Freedom to Speak up Guardian Quarter 3 & 4 Report For Information - Presented by Helen Dobson
11:15 AM	ASSURANCE	
	P79/24.	Integrated Performance Report For Assurance - Presented by Michael Wright
	P80/24.	Maternity and Neonatal Safety Report, presented by Sarah Petty For Assurance - Presented by Helen Dobson
	P81/24.	Paediatric Audiology CQC Response For Decision - Presented by Jo Beahan
	P82/24.	Finance Report For Assurance - Presented by Steve Hackett

P83/24. Operational Update Report - End of Year Review
For Assurance - Presented by Sally Kilgariff

11:45 AM ASSURANCE FRAMEWORK

P84/24. Board Assurance Framework
For Decision - Presented by Angela Wendzicha

P85/24. Corporate Risk Register Report
For Assurance - Presented by Angela Wendzicha

P86/24. Quality Assurance Report
For Assurance - Presented by Helen Dobson

12:05 PM REGULATORY AND STATUTORY REPORTING

P87/24. Responsible Officer Report Quarter 3
For Assurance - Presented by Jo Beahan

P88/24. Guardian of Safe Working Annual Report, presented by Gerry Lynch
For Information - Presented by Jo Beahan

P89/24. Learning from Deaths Quarterly Report
For Assurance - Presented by Jo Beahan

12:20 PM BOARD GOVERNANCE

P90/24. Register of Interests Bi Annual Review
For Assurance - Presented by Angela Wendzicha

P91/24. Any Other Business
For Discussion

P92/24. Annual Work Plan 2024-25
For Information

P93/24. Questions from Members of the Public on the Business of the Meeting
For Discussion

P94/24. Date of next meeting - 5 July 2024

Draft until approved at the 3rd May 2024 meeting

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 08 March 2024, 1.30 – 3.00 pm
Boardroom

Present: Mr M Richmond, Chairman
Mrs H Craven, Non-Executive Director
Mrs H Dobson, Chief Nurse
Dr J Beahan, Medical Director
Mr S Hackett, Director of Finance
Dr R Jenkins, Chief Executive
Mrs S Kilgariff, Chief Operating Officer
Mr M Temple, Non-Executive Director
Mr D Hartley, Director of People
Mr M Wright, Deputy Chief Executive
Dr R Shah, Non-Executive Director
Ms J Burrows, Non-Executive Director
Ms H Watson, Non-Executive Director

In attendance: Mrs L Martin, Director of Estates and Facilities
Mrs L Tuckett, Director of Strategy Planning and Performance
Ms A Wendzicha, Director of Corporate Affairs
Mr G Rimmer, Lead Governor
Mr Alan Wolfe, Deputy Director of Corporate Affairs (minutes)
Mr Henry Hall, Patient - for item P35/24
Mr P Stewart, General Manager Medicine Division - for item P35/24
Dr Joe Joseph, Consultant Haematologist - for item P35/24
Mr A Turvey, Consultant in Public Health - for item P41/24
Ms S Petty, Head of Midwifery - for item P45/24

Apologies: Mrs Z Ahmed, Associate Non-Executive Director
Mrs D Sissons, Non-Executive Director
Mr J Rawlinson, Director of Health Informatics
Mr K Malik, Non-Executive Director
Mrs J Roberts, Director of Operations/Deputy COO

Item	Procedural Items	Action
P29/24	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE**	
P30/24	**QUORACY CHECK** The meeting was confirmed to be quorate.	
P31/24	**DECLARATIONS OF INTEREST**	

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	Dr Jenkins' interest in terms of his joint role as Chief Executive of both the Trust and Barnsley Hospital NHS Foundation Trust was noted. Ms Wendzicha's interest in terms of her role as Director of Corporate Affairs of the Trust and Director of Corporate Affairs at Barnsley Hospital NHS Foundation Trust was noted.	
P32/24	**MINUTES OF PREVIOUS MEETING** Page 4 of 13: "The Guardian has now been amended to be a full time role" should read "The hours of the Guardian have been increased". Page 12 of 13: - EPRR "there was a 2 year period to be compliant" should read "the Chief Operating Officer expects the Trust to be in position to achieve compliance in a timeframe of the next 2 years". The minutes were approved as an accurate record of the Board of Directors held on 12th January 2024.	
P33/24	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items.	
P34/24	**ACTION LOG** The actions indicated to close this month were approved for closure.	
	CULTURE	
P35/24	**Patient Story** The Board of Directors welcomed Dr Joe Joseph, Consultant Haematologist, and one of his patients Mr Henry Hall, an 86 year old male who has been receiving treatment as part of the Home Chemotherapy Service. This service pilot started in March 2023 following a year and a half in planning. The service has two chemotherapy trained nurses to provide home treatment and now treat acute myeloid leukaemia as well, seven days a month over the full twelve months a year. This service leads to less travel for patients, and there were 40 patients treated during the first year pilot. The team are keen to continue the service beyond the pilot stage and have secured funding, as it makes a massive difference to the cancer patients lives. TRFT currently is the only trust in the region with such a service. Mr Hall informed the Board that he had asked for the treatment himself, he has been quite healthy through his lifetime, until last year when he suffered a minor back injury in his garden. A few weeks later he attended UECC and saw a GP who referred him for physiotherapy; due to his pain becoming severe he again attended UECC and underwent blood tests, with these indicating cancerous blood issue, myeloma. Mr Hall was then brought into TRFT for 11 days to start his chemotherapy treatment, he stated that it went well for him in hospital and he also attended Sheffield	

	Teaching Hospitals for radiology treatment. Following this he was discharged home. Mr Hall then continued to travel to the hospital to continue treatment, he declared that he found car parking to be a constant issue, before the nurse service then started in his home setting. He felt that the first 3 months of his treatment was the worst part, as he was still dealing with back pain and the chemotherapy starting to make itself known with lots of side effects. He also reported problems mobilising upstairs and having to sleep in a reclining chair which was once used by his late wife. He found it very helpful to have the same nurse every week, Hannah, helping him to establish a relationship where she could also act as a conduit with the hospital rather than having to deal with everything himself on top of treatment. Hannah was able to alert Dr Joseph and discuss any issues with dual treatments for bone and leukaemia, and also stepped in when Mr Hall lost his appetite contacting the dietitians. She also noted issues with an appointment confirmation for blood tests and was again able to help and take stress off both Mr Hill and ultimately the Trust. Mr Hill says that he now reached a good place, his blood is back to normal and his back ache is a lot easier, with him declaring himself in the last week or so relatively pain free. Overall he found the service to be extremely good, with a good service from the hospital, Hannah and Dr Joseph himself. The Board of Directors thanked Mr Hill for bringing to life the impact the new service has had on our patients. They agreed that there were lessons to be learned for all Trust patients, which the Trust needs to review and act on, including car parking, settling patients into their own home during and following treatment. When Mr Hill as asked if there was one thing he would change what would it be? He clearly stated the car park.	
P36/24	**<u>Gender Pay Gap Report and Action Plan</u>** Mr Hartley announced that the day of the Board meeting was International Women's day and that the Trust had planned trust wide communications later in the day. He believed that it was apt that on this day this report should be presented, it summarises broadly the wider position and the history of pay differences. There has been an improvement at TRFT with the Trust's Gender Pay Gap (mean and median) as of 31st March 2023 it is 27.72% & 17.24%, this has improved since last year when it stood at 30.30% and 25.73% respectively. There is an ambition that within the range of district general hospitals TRFT wants to become an exemplar on this subject with equal pay bands, training and also removing barriers to future staff appointments. There is a range of approaches needed to deliver these outcomes, with specific actions being developed as part of the wider Equality Delivery System programme.	

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	Mrs Craven requested confirmation of how the data was collected, Mr Hartley confirmed that the data collection followed national NHS and Government standards and guidance with 2 genders recorded on ESR, male and female only. It was agreed that the Trust still needed better overall gender balance in specific jobs, historical issues had caused gender imbalance but since Covid there had been more equal distribution as well as upcoming retirement of longer serving male consultants, which will also help with more gender balance. The Board requested assurance that males and females doing same job for the Trust were paid the same wage, and Mr Hartley was able to assure them of that as legally the Trust is obliged to have a joint job validation process. The Board agreed it was helpful to have broader picture of Trust staff as per the report.	
	STAFF SURVEY Mr Hartley confirmed that the survey results had been embargoed until the morning of Thursday 7th March 2024; however they were now fully published and showed strong progress against all areas of the survey, with TRFT being the second most improved trust to work at in England; this had also been published in the previous day's Health Service Journal. There are 7 areas of the Trust's People Promise and we are building on an already strong position over the last 3 to 4 years, in fact 2 areas of the People Promise are already in the top decile against all 122 acute trusts in the country. Mr Hartley added that it was interesting to see how these results are mirrored in the everyday business of the Trust where we are seeing improved retention rates of staff up 9%, which in real terms makes a direct difference to the patient experience as outlined in the Patient Story earlier in the agenda where continuity of care was highlighted by Mr Hill as a positive of his experience. Mr Hartley explained that the immediate plan was to look at two specific aspects of the strategy to improve on and to focus on a small number of cross organisation actions relating to the topics of Violence & Aggression and Staff Appraisals. He added that it was also important to be clear that all Divisions and Directors are responsible for the "we said, we did" initiative. Dr Jenkins was asked whether or not the results were as he expected them to be, he felt that this year it had been hard to tell due to external factors such as the industrial action, so he was thrilled to see how much the Trust has improved and this improvement and positivity needed to be used wider by the Trust, for example using it in all marketing for employment opportunities. Dr Jenkins also reminded the Board that whilst this year sees the Trust in the top ten of Trusts nationwide it can still improve, the pursuit of excellence is our ambition and this will come through the new People Strategy. He looks forward to next year's survey, the need to maximise all areas of improvement and to get the positive message out wider.	

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	OVERVIEW AND CONTEXT	
P37/24	**Report from the Chairman** Mr Richmond started his section by confirming that the Non-Executive colleague Mrs Sissons had stood down as a NED and he wished to register the thanks of the Trust and the Board for all her hard work undertaken whilst in her post. Mr Richmond had attended a national meeting the previous week in London designed specifically for NHS Provider and Commissioning Chairs. He reported that there had been a lot of talk of austerity going forward, as well as balancing the budget and challenges ahead, an example of the challenge being population growth with 15% growth in the population of England in the last 5 years alone. Mr Richmond reiterated the Trust Emergency Department target ask of 76% going forward and that as a Trust this needed to be not only achieved but surpassed with the need to go further, stretching back to targets of a decade ago and aiming for 95%. He stated that he wanted to be clear that the declared budget target had to be met, even with the financial envelope being exceedingly tight. He understands that whilst there was an increase in investment in the Trust workforce there has been no corresponding increase in productivity and whilst this had to be improved, it is one consequence of overstretch post Covid and needed to be understood and included in thought processes at the highest level of government. Mr Richmond concluded by bringing the Board's attention to the fact that every NHS Trust who are rated as outstanding by the CQC has in place a systematic approach to quality improvement; this needs to be the case also at TRFT and it is up to Board to set the bar and goals, with additional Board focus going forward.	
P38/24	**Report from the Chief Executive** Dr Jenkins reported that as this was the last month of the financial year there was a lot of focus on delivery. With regards to the 4 hours target the Trust has been running below target level, however it is noted that a lot of other Trusts collect and report their data differently which can boost their figures and TRFT can rely on the accuracy of its data.The Trust has seen increased attendances with winter viruses and there had been a lot of infection control issues during the last few weeks largely in part due to norovirus, however there has been improvements more recently. With regards to the financial plan for 2024/25, Dr Jenkins confirmed that the full planning guidance was expected next week. The Board should expect the 4 hour target to remain at 76% but the Trust should be aiming higher. He added that an interim plan had been released and he expected the non-financial elements of the final plan to be same as the interim plan. There was a planned initial submission to NHS England and the ICB prior to deadline on Thursday 14th March 2024 and a further submission by Thursday 21st March 2024. In order to discuss and approve the initial	

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	submission there would be an extraordinary Board held on before the 14th March deadline. The industrial action by Junior Doctors and Consultants has paused for now and regards the pay offer made to the Consultant body, Dr Jenkins is - cautiously optimistic. Mrs Watson raised the issue of the Mexborough Elective Orthopaedic Centre of Excellence (MEOC) and how use of it could be maximised following an initial slow start. Dr Jenkins feels that the Trust needs to drive productivity and use it to the maximum output as the centre frees up resource on main site hospital. The Trust is in a partnership with Doncaster NHSFT and there have been some operational challenges as the Doncaster team run the day to day operation of the centre, although these are being worked out as time goes by, with TRFT teams now scheduling patients; there was always going to be a few start up issues with three separate organisations using one facility. Mrs Craven also added that it was important that TRFT ensured that it got its part of the operation right in order to hold the other organisations to account when required. Mr Hackett added that MEOC will have to perform better than the main site in order to attract patients to travel there in order to use the facility.	
P39/24	**<u>Board Committees Chairs Reports</u>** i. Quality Committee Ms Burrows highlighted the excellent work done by the UECC who are building on their staff survey results and now have a waiting list of nurses waiting to join the team. With regards to the Quality Priorities, these require a rescheduling of the time line for next year, as targets were not met this year with 2 targets not likely to become green before the end of the financial year, the committee would like to hit ground running on 1st April 2024. ii. People Committee Dr Shah outlined the consultation taking place regards 'Divisional Care Groups'. There had been significant improvements in terms of the participation in and response to the Staff Survey, which should be reflected in Trust job adverts in order to attract a high calibre of staff who want to work at a progressive Trust. There is an ongoing deep dive into sickness absence, which appears to not be out of synch with other Trusts, and finally that the Trust is working to improve the provision with its current occupational health provider. iii. Finance & Performance Committee That the Committee continues to monitor targets was confirmed by Mr Temple, this includes costs such as agency staff. The CIPs for the year failed to achieve targets, however the final figures were well beyond where	

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	the Trust expected to be, especially with external pressures such as the ongoing industrial action. The big take away message for the Board is that financially cash is running out and next year if the Trust doesn't perform it will be required to turn to external borrowings with all of the complications and cost that involves. iv. Audit & Risk Committee Mr Malik highlighted the 360 Assurance progress with the PSIRF audit providing moderate assurance; Patient Experience had also developed positively with lots of good progress made, and a significant number of actions being completed and closed off since the Board paper was produced and published.	
	SYSTEM WORKING	
P40/24	**SYB ICS and ICP Report** Mr Wright reported that his paper looked at the work being undertaken by the Trust with the Health Select Commission and local councils, and the generally positive feedback since the ICB was established in July 2022. His paper looked at the Place Terms of Reference and Place Partnership which came into effect at establishment in July 2022 and were now due for review. Mrs Craven questioned what the outcomes of Place were, as Rotherham is one of the most deprived areas of country, Mr Wright highlighted the work of the alcohol outreach team which has recently secured further funding for an extra 6 months, and there is also the work on health inequalities. Mrs Craven acknowledged that a lot of the work is long term and it was hard to see short term results but outcome data would be helpful for assurance. Dr Shah added that it was hard to see progress as a lot of the work is around personal lifestyle choices and improving health, Dr Jenkins noted that the Trust cannot single handled improve outcomes for the individuals of Rotherham, however we can all work out were the Trust can make a difference. Areas to look at include smoking cessation which is estimated to save 70 lives every year, also weight checks of children alongside follow up appointments help, as well as work around activity and unpaid carers with the need for a strategy on how to support them. Mr Richmond agreed that the hospital can help; it can argue for the right things for the people of Rotherham, it can encourage and establish educational work to increase working on alcohol, with work on reducing drinking and consumption. Dr Beahan also added that the Quality Priorities include work on reducing weight pre-surgery. The issue of how the Trust influences at Place remains however, with the example of what are the council doing about health eating and allowing fast food outlets to be established next to schools. Mrs Watson did add that she felt underwhelmed by the language used and she could not see any ambition in the wording of the document, Mr Wright agreed to feed this back to the ICS and ICP.	***Mr Wright***

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P41/24	**SYB ICS - Wider Needs of Rotherham Community** Mr Turvey, the Consultant in Public Health advised the Board that he had now been in post for 1 year. He highlighted the immediate priorities following the Board ask for him to provide an update of work undertaken so far. Mr Turvey outlined that the Rotherham area had an aging population, with greater levels of deprivation than the rest of England generally, alongside increased long term conditions, increased levels of burden to health care and also increased levels of non-communicable disease. To some extent all of these issues have a preventable element and his role, which is a joint one between the Trust and the wider system is to tackle health inequalities whilst making sure TRFT is tailoring its offer to the need of the local population. Where the Trust can make a difference was listed in Mr Turvey's presentation and he focused briefly on a number of the key points. He was trying to dig into areas of inequality with a local viewpoint as it is not the same as rest of country, an example being that 25% of the population do not know their ethnicity and the Trust and partners need this data in order to help. He is looking at DNA rates by drilling down to identify trends, so he can then look to address and improve performance and attendance. So far he admits that it has been a lot of the usual elements such as travel costs, appointment times during work time and child care issues. The Board queried whether once a patient had DNA'd were they lost to system, Mr Turvey confirmed that this was not always the case with many making another appointment, although there are a number who are lost and also some will end up moving from being elective to being on a non-elective or emergency pathway which increases the burden on the Trust, the job is to identify ways of avoiding that. With regards to cancer services Mrs Kilgariff admitted that some work needs to be linked into work at the Place level, as currently there is no specific group at Place and this would be a good opportunity to look wider, it was agreed that Mrs Kilgariff and Mr Wright would raise this with Place colleagues. Dr Shah commented on the lack of ethnicity data being recording saying that it could be a case of individuals being fearful of how the data could be used, for example raising issues related to an individuals or families immigration status. He asked if there was another way of collecting the data and looking at the data. Mr Turvey explained that this was not just a local problem and gaps might also be likely to staff not recording the data correctly. A final mention was for Schools and obesity levels, Mr Turvey confirmed that the Children's Partnership have picked up as a key priority, looking at the behaviours of children and parents.	***Mrs Kilgariff / Mr Wright***
P42/24	**Committees in Common** Dr Jenkins outlined that the premise of Committees in Common had been introduced a number of years ago, and Ms Wendzicha would provide an update. She explained that in 2016/17 work had been undertaken and the	

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	initiative launched, however it had not gained much in the way of traction prior to Covid and the Acute Federation Board has recently looked to relaunch it. As such they had asked that all Trust Boards reaffirm the partnership agreement which had now been updated to reflect modern NHS terminology. TRFT is the last board in the region to consider this reaffirmation and approve the Terms of Reference and partnership. Mrs Craven challenged the paper which stated that decisions delegated to the Committees in Common would consist of just the Trust Chair and Trust CEO, and should it not be a board decision rather than only two Board members. Dr Jenkins confirmed that the Trust CEO and Trust Chair have certain delegated powers and these would cover this item, this was a governance model used widely and there were no additional powers as a result, but in any case he confirmed that they would in best practice look for board support for such decisions. The reaffirmation of the partnership agreement was approved.	
	<u>ASSURANCE</u>	
P43/24	**<u>Integrated Performance Report</u>** Mr Wright's headline messages was that mortality continues to be positive with both HMSR and SMHI where they are expected to be, these are-usually a good indicator of reliable care. Mr Richmond noted that a lot of the indices were red, Mr Wright clarified that this was mainly due to a lack of capacity due to patient flow, with length of stay a national concern but one that needs to be a local focus which will in turn improve the data. The current sickness absence levels have increased, especially in the Medicine Division and these are being monitored at the monthly performance meetings. Ms Burrows felt it was helpful to see additional comments contained within the report following the SPC charts, however these could do with a bit more explanation of when data shifts that it confirms that a new target has been set, Mrs Tuckett and Mr Wright agreed to reflect on this for future reporting. Mr Richmond noted the number of admissions through emergency pathways was high, keeping the Trust under constant pressure and that this needs looking at with external partners.	***Mrs Tuckett / Mr Wright***
P44/24	**<u>Operational Performance Report</u>** Mrs Kilgariff highlighted the incredibly challenging period the Trust has recently been through, however in context a lot has been achieved during the period, a period including 46 days of industrial action, since April 2023, which equates to 14% of staff time taken away from operational work. She admitted that with the background of the operational pressures, the Trust often working at OPEL Level 3 more frequently the 4 Hours target of 76% will not be achieved, although some improvements will be made and the target will be hit in some specific areas such as minor injuries. The Trust will hit the 65 weeks target with the exception of corneal grafts, with this being due to a national shortage of tissue, this locally effects a	

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	total of 13 Rotherham patients. Focus is on ensuring patients exceeding 65 weeks are seen by the end of March 2024. DN01 will be also be a success, with the Trust in the top ten nationally for compliance with the constitutional standard by the end of March 2024. Mrs Craven queried the flow and use of SDEC, seeking confirmation of the plan and whether or not it was working. Mrs Kilgariff confirmed that it was being used for inpatients, and that work was ongoing with Place partners in order to expedite discharge. There is also the plan to relocate SDEC so it can't be used for inpatients in the future. Mrs Craven sought a permanent solution, which the Executives agreed with, and also confirmed that whilst not ideal and used because of operational pressures the Trust has also managed to keep medical and surgical SDEC provision going, despite those pressures.	
P45/24	**<u>Maternity and Neonatal Safety Report</u>** Mrs Dobson introduced the paper, outlining that the format had changed since its last presentation to the Board as there is now a national template that includes more information and a suite of SPC charts. The intention is for this template to allow better access to data which can then be used to compare with other Trusts. Going forward this report will come bi-monthly to the Board following it being presented to the Quality Committee (QC), the QC will also receive a smaller exception report in the months this full report is not presented. Mrs Dobson highlighted table 2.2 which contained 4 years' worth of data and illustrated a significant reduction in perinatal mortality, the best in the region. There had unfortunately been 1 neonatal death in 2023. The Picker CQC Maternity inpatient survey has also been published with very positive results for the service, a total of 8 areas being better than most other Trusts. The Staff Survey results also showed improved ratings for the advocacy questions which were a very positive 77% recommending the Trust as a place to work and 78% as a place to receive treatment. Mrs Dobson advised that a query from Mr Richmond regarding the Maternity Dashboard and two different groups smoking at booking and smoking at birth, needs to be looked in 9 months in order to review the hopeful improvement along the timeline of the maternal event.	
P46/24	**<u>Safe Staffing and Establishment Nurse Review</u>** Mrs Dobson confirmed that the paper had been updated since presentation at the previous Board, with data that had previously been confusing removed. She confirmed that the correct data collection tool, the validated Safer Nurse Care Tool (SNCT), had been used. There is a Whole Time Equivalent (WTE) figure of 835 in the funding establishment, with the validated tool suggesting an over-establishment of 16 WTE across the Trust. This very close figure can be explained by slight discrepancies in numbers between Surgery and Medicine cover across trust and different bed	

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	numbers on different wards; with a certain amount of professional judgment being required during analysis of the data. As such the recommendation of the Chief Nurse and Deputy Chief Nurse is that the funding establishment is appropriate with those minor caveats. This data is to be reviewed every 6 months and will be discussed further at the June 2024 Strategic Board.	
P47/24	**Finance Report** Mr Hackett went through the key items contained within his paper up to the end of January 2024 the position had improved by £70k against delivering its planned deficit at 31st March 2024 of £5,977k. The challenges of covering the additional costs and loss of revenue relating to the industrial action had been estimated at £1.2m and he had received some positive news in an email the same morning, with confirmation that the ICB will contribute £1.5m towards funding against costs incurred from the industrial action. This offset expenditure will allow the Trust to hit its £4.7m target, as long as impact of activity in March 2024 hits plan, with the current figures being positive and the 76% target doesn't encroach into surgical capacity and elective activity remains on track with a positive trajectory. There had been an amount of national late allocation funding for capital projects that brought a short turnaround time as the funding had to be spent by the end of March 2024, including time for the initial application identifying appropriate projects. There was a total of £250k for internal works and improvements to the Trust environment, including investment in the Trust car parks. Mr Hackett reported that Cash Management was behind target with an adverse variance in-month of £646k and a year to date variance of £1,927k. Mr Richmond queried whether there was a pre-prepared of potential capital projects, Mr Hackett confirmed that the Estates Team holds a list of low value multiple jobs on an active spreadsheet and that it did not contain any medical items it was impossible to get funding spent on medical ideas due to the short turnaround time involved. Mrs Craven added that a more detailed estates shortlist was also required, and it had been agreed in principle for this to be included in the Estates Strategy. Mrs Martin pointed out that the strategy was a multi layered document requiring a full update survey of the estate and a 5 to 10 year plan to be updated. There was also the need for it to contain a full refurbishment plan so it will take some time to produce.	
	ASSURANCE FRAMEWORK	
P48/24	**Board Assurance Framework** The paper was introduced by Ms Wendzicha who confirmed that due to the recent high level of operational and financial pressures the BAF risks D5 and D7 maintain the risk rating of 20. Dr Shah questioned BAF risk O3 and its current rating of 8, he appreciated the Trust's relationship with Barnsley was good, however in terms of the wider system working was 8 an appropriate rating when we are offering a lot of collaborative working but don't see a lot	

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	of collaboration from other organisations. Dr Jenkins confirmed that there is a lot of partnership work ongoing, such as Mexborough Elective Orthopaedic Centre of Excellence (MEOC) and work with Sheffield, however it is the end of the financial year and it was time to review the BAF statements and articulation of the individual risks; Ms Wendzicha confirmed that it was appropriate and timely to refresh the strategy which are linked to operational objectives. The Board agreed with the risk ratings.	
P49/24	**Corporate Risk Register** Ms Wendzicha provided details in relation to the Trust' high level risks rated at 15 and above, she confirmed that these were discussed in detail at the various divisional Governance meetings on a monthly basis before presentation to the Risk Management Committee for additional scrutiny and challenge and then the Executive Team Meeting. She also highlighted the inclusion in the paper of the Issues Register, this was still in development and is a sign of how much the risk management processes are maturing within the Trust. Dr Shah raised the risk regarding cyber security and whether that should be included on the Issues Register, Ms Wendzicha stated that it would be picked up and monitored through the Risk Management Committee process. With regards to the risk relating to the shortage of consultant anaesthetists, Mr Richmond queried the recent employment of new anaesthetists and whether that should be reflected in a reduced risk rating, Dr Beahan confirmed that at the moment the rating should remain as the new staff are yet to actually commence in post and with one of them that might be a while off due to planned maternity leave. Mitigations to be taken in the short term included review of working patterns, additional organisation of workforce to cover rotas and additional expertise sought to review the rotas.	
P50/24	**Quality Assurance Report** The report was introduced by Mrs Dobson who outlined that this paper was intended to provide the Board with a flavour of the template to be used and it will be followed up by session at the Strategic Board in April 2024.A new quality dashboard to go live April 2024 with 6 different pages to each dashboard relating to the following domains of Well Led, Safety, Staffing, Experience, Infection and Tenderable. This will be a trust wide dashboard once fully developed, currently it is only at ward level. The Exemplar Accreditation programme will also go live in April and again the domains will tie in with the CQC domains plus a QI element also, this will be rolled out to 4 wards going live in April 2024 with a further roll out following that. Whilst Qi is well established in the Trust capacity to provide full follow up has been an issue, new medical staff have now appointed to support ongoing and new QI work with more detail around outputs to follow. An issue that has been dealt with was the unavailability of QSIR due to cost implications and the development of an in-house training model being led by	

	the Trust alongside Barnsley NHSFT, with delivery planned across the South Yorkshire region. The Trust met with the CQC team recently to look at future methodology and the CQC confirmed quarterly meetings would take place going forward, however they have indicated that acute Trusts were currently not a CQC priority and they are also now looking at primary. Mrs Dobson confirmed that no CQC issues have been raised since the last quarterly report. Mr Richmond stated that he believed the new exemplar accreditation programme had huge potential and wondered how could the Trust catalyse it as quickly as possible to maximise its impact. Mrs Dobson warned that it would probably not be suitable for acceleration at this time as collecting the data packs is largely reliant on the Health Informatics Team. She did agree that once up and running it would be assessed again to see if it could be done quicker, she also confirmed that the teams were still to build models for certain areas and specialities including Community.	
	REGULATORY AND STATUTORY REPORTING	
P51/24	**Learning from Deaths Quarterly Report** Dr Beahan confirmed that the latest Trust Summary Hospital-level Mortality Indicator (SHMI) was in the expected band at 102.4, with no conditions that are cause for concern. The position regards Structured Judgement Reviews (SJRs) is that 70% of the SJRs were completed within the 60 day target, this follows the establishment of the team one year ago, Dr Beahan confirmed that there had been an improvement in the quality of the final reports over that time also. This is in contrast to April 2023 when only 48% were completed according to target. She reported that approximately 20% of deaths are subjected to an SJR and this often follows concerns raised by the families or staff involved. There is to be an alert flag on Power BI to indicate mental health patients who are all subject to a SJR.	
P52/24	**PSIRF Operational Plan** Mrs Dobson confirmed that the PSIRF Plan had already been presented to the Quality Committee and the ICB. The Plan sets out the profile of incidents, the range of tools to be used and the various pathways of investigation dependent upon the severity of the incident. Mrs Dobson reminded the Board that going forward the term Serious Incident (SI) would be replaced by the term Patient Safety Incident Investigation (PSII) and that the Plan will be on the Trust website as has to be accessible to public.	
P53/24	**2023/2024 Annual Accounts: Going Concern** Mr Hackett introduced the report and advised that this and the following two agenda items, P54/24, 2023/2024 Annual Accounts: Operating Segments and P55/24, Accounts: Accounting Policies, were presented to the Board for approval.	

	The Board of Directors approved all three reports.	
P54/24	**2023/2024 Annual Accounts: Operating Segments** Approved, see P53/24 above.	
P55/24	**2023/2024 Accounts: Accounting Policies** Approved, see P53/24 above.	
	BOARD GOVERNANCE	
P56/24	**Terms of Reference:** Ms Wendzicha advised that the Terms of Reference had been subject to the annual review and presented for approval at each of the Assurance Committees, they had been brought to the Board for the final approval stage: i. Quality Committee - approved ii. People & Culture Committee - approved iii. Finance & Performance Committee - approved iv. Audit & Risk Committee - approved	
P57/24	**Any other business** The only other business raised was by Mr Hackett who informed the Board that the previous week the Council of Governors had formally approved the appointment of the Trust's external auditors, following the correct tendering process this was to continue to be Mazars.	
P58/24	**Annual work plan** Ms Wendzicha requested that any comments from Board members should be sent to her directly.	
P59/24	**Questions from Members of the Public** No questions were received from the public.	
	Date of next meeting Date of extraordinary board: 13 March 2024	

Chair

Date:

Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
2023								
3	04-Aug-23	Maternity Safety	C158/23	Maternity services to be a future topic for a patient story for Board	CN	~~Nov.23~~ Mar-24	Timings to be agreed for the Board Planner. Alternative patient story identified for November 2023. Next patient story - March 2024. March patient story - Home Chemotherapy Service. HD to speak to ZA to determine if the patient still wishes to come to Board. The conclusion is that this particular patient will not attend Board.	Recommend to close
4	03/11/2023	Board Committees Chairs Reports	161/23	Register of Interests	AMW	May-24	Corporate Affairs to assist with Register of Interest declarations. Next report due to Audit and Risk Committee in April then Board in May 2024. Report on agenda for both ARC and Board.	Recommend to close
6	03/11/2023	Assurance	169/23	Quality Assurance Report	HD	Apr-24	CQC preparation to be added to a Strategic Session in April 2024. Presented at Strategic Board in April.	Recommend to close
2024								
4	08/03/2024	SYB ICS and ICP Report	40/24	Mr Wright to feedback comments received on the language used and the lack of ambition in the wording of the document to the ICS and ICP	MW	Apr-24	Comments had been fed back	Recommend to close
5	08/03/2024	SYB ICS - Wider Needs of Rotherham Community	41/24	The need to link in cancer services work to work at the Place level would be raised with Place colleagues	SK/MW	Apr-24	MW discussed with South Yorkshire ICB (Rotherham Place) and agreed to look at this in more detail and agree actions to take forward.	Recommend to close
6	08/03/2024	Integrated Performance Rep	43/24	The report to be reviewed to ensure additional information is included on when data shifts and confirms a new target has been set	LT/MW	Apr-24	Explanatory commentary now included within SPC charts. New IPR also addresses issue	Recommend to close

Key
Open
Recommend to Close
Complete

Board of Directors' Meeting
3 May 2024

Agenda item	P69/24
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. It focuses on the following key areas: • Operational Matters • Performance • Integrated Care Board (ICB), Acute Federation and Rotherham Place Development and Partnership Working • People
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	No action is required.
Recommendations	It is recommended that the Board note the contents of the report.
Appendices	1. Chief Executive of NHS South Yorkshire update report

1.0 Operational Matters

1.1 The final two months of the year remained positive from an elective recovery perspective, as the Trust pushed to deliver the national expectations for the end of the year. There was no industrial action in March, although the 15% increase in UECC attendances presented bed challenges throughout the month which led to some cancellations of elective activity. However, the additional capacity provided by insourcing within theatres and anaesthetics enabled us to continue with regular weekend theatre lists within the most pressured specialties, and we also continued outpatient insourcing within Ophthalmology and Dermatology, in order to reduce waiting times for patients waiting for their first appointment. Provisional figures suggest that the Trust's overall activity levels compared to 2019-20 rose to the highest level of the year in March, following significant improvement throughout the second half of the year with this additional investment in capacity. The waiting list has remained relatively stable over the last several months as a consequence of this extra activity in some of these high-volume specialties, although this is a very mixed picture at specialty level and will need intense focus in 2024-25. The absence of industrial action in March allowed a more 'business as usual' approach to operational delivery.

1.2 The national expectations for elective recovery in 2023-24 required the Trust to treat all patients waiting over 65 weeks by the end of March 2024, which the Trust committed to delivering on the assumption that there was no further industrial action after the early January period. Unfortunately, further action did take place in late February and at the end of March, there were 22 patients waiting over 65 weeks with 4 of these waiting over 78 weeks. A number of these patients are awaiting corneal grafts, with these procedures reliant on tissue from NHS Blood and Transplant which was not available before the end of the year. Efforts are now focussed on ensuring these patients and all other long waiters receive treatment as early as possible in 2024-25. The number of patients waiting over 52 weeks for their treatment has stabilised but remains well above where we want it to be for our patients, with ENT and OMFS additional areas of significant challenge as we head into next year. The Trust has set a number of very ambitious targets for elective care delivery in 2024-25 in order to ensure we deliver significant reductions in waiting times for our patients.

1.3 **Urgent and Emergency Care Activity:** The Trust saw a significant increase in demand for UECC services during March 2023. With just under 9000 patients attending the department in March, this was a 15% increase compared to March 2023. Work continues to improve the Trust's four-hour standard and, whilst the target of 76% was not achieved, improvements have been made, ending the year in March 2024 at 62.9%. On-going improvement work delivered in March 2024 will continue and further transformation will be delivered via the Acute Care Transformation programme.

2.0 Performance

2.1 The NHS Planning Guidance for 2024/25 has now been published and as reported previously, the Trust is aware of the key requirements and had already started to plan prior to the publication. The Trust was required to submit revised activity plans by Friday 19th April 2024.

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

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

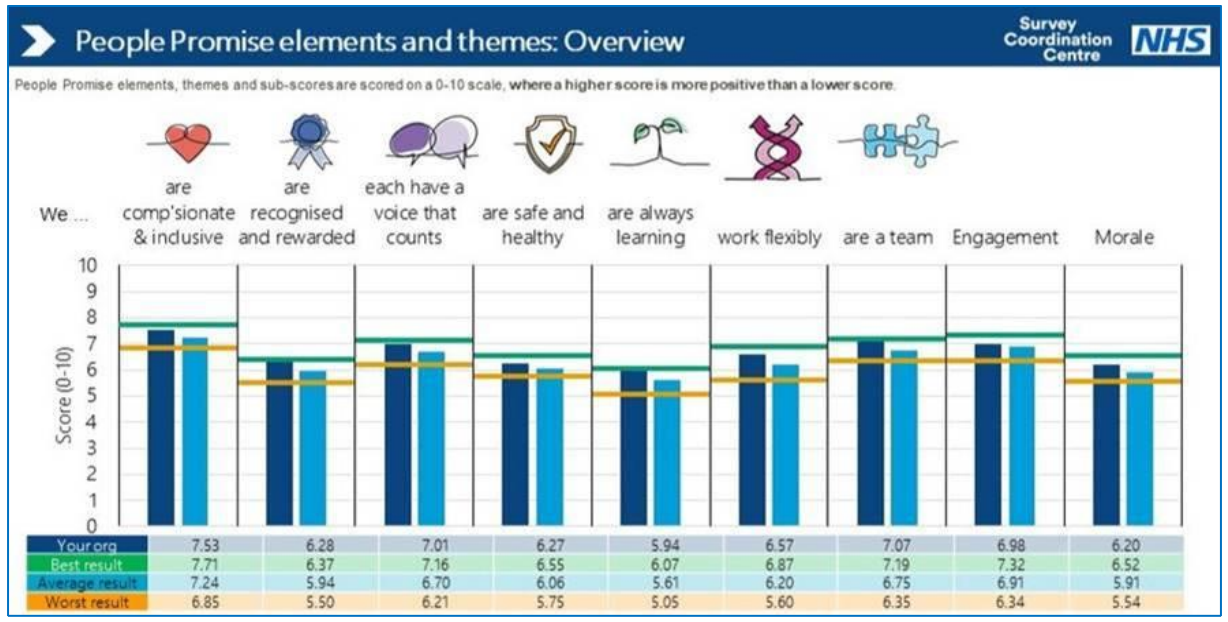
Place Board. A further update is provided by the Deputy Chief Executive in his report to the Board of Directors.

3.2 I attach (appendix 1) the March 2024 update report from the Chief Executive of NHS South Yorkshire, which highlights the work of the ICB and system partners for January and February 2024.

3.3 The Barnsley and Rotherham partnership continues to flourish with a number of events taking place to provide an opportunity for colleagues to make connections, focus on shared learning, support and best practice. As part of this, I attended a Strategic Leadership session in May for the Senior Leadership Teams at both Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust. This event had a strong focus on people and the NHS People Promise with each organisation sharing respective results of the NHS Staff Survey.

4.0 People

4.1 The 2023 NHS National Staff Survey results were published in March this year. Overall, our results were excellent with the Trust seeing significant improvements across all domains (see below). The Trust saw the second biggest increase in England for the question 'If a friend or relative needed treatment, I would be happy with the standard of care provided by the organisation'. The Trust is immensely proud of the progress made and teams are clear on the further improvements they would like to make based on staff feedback.



4.2 I am delighted to report that our Chief Nurse has been shortlisted for the William Rathbone X Award – The Queen's Nursing Institute, which recognises Executive Nurse Leadership. Helen was nominated by colleagues and evidence was submitted of her contribution to the national agenda, her achievements in the delivery of excellent nursing services in the organisation as well as any other achievements. Those nominated have been invited to an event in London which will take place on 10th May 2024. I am sure you will all want to wish Helen good luck.

4.3 The annual PROUD Awards event will return on 14th June 2024 and recognises the amazing dedication and excellence of colleagues across the Trust and community. The Trust received over 750 nominations in total, which is the most ever received. Congratulations to all our shortlisted finalists and good luck on the night.

4.4 The monthly staff Excellence Awards winners for the months of February and March 2024 are as follows:

February 2024
Individual Award: Abigail Starr, Speech and Language Therapy, Bob Lundy, Estates and Facilities
Team Award: Education & Development Team, Wentworth South Community Nursing Team (North Locality)
Public Award: Day Surgery and Anaesthetics, Mr Alex Anderson, Orthopaedics

March 2024
Individual Award: Amanda Hobson, Fracture Clinic, Jeff Menday, Fracture Clinic
Team Award: Employee Relations Team, Community Ready Unit
Public Award: Ward A1

4.5 I am pleased to announce that Emma Parkes has commenced in her new role as Joint Director of Communications for Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust as at 1st April 2024. Her Deputy, Liz Close has also commenced in post this week and will support Emma across both Trusts.

4.6 Louise Tuckett (Director of Strategy, Planning and Performance) leaves the Trust in May for a national role. Louise has made an enormous contribution to the leadership of the Trust over the last 6 years and leaves with our thanks and best wishes for her next challenge.

Dr Richard Jenkins
Chief Executive
May 2024

Enclosure 7

Chief Executive Report

Integrated Care Board Meeting

6 March 2024

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive

Purpose of Paper

The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.

Key Issues / Points to Note

Key issues to note are contained within the attached report from the Chief Executive.

Is your report for Approval / Consideration / Noting

To note.

Recommendations / Action Required by the Board

The Board is asked to note the content of the report.

Board Assurance Framework

This report provides assurance against the following corporate priorities on the Board Assurance Framework (place ✓ beside all that apply):

Priority 1 - Improving outcomes in population health and health care.	✓	Priority 2 - Tackling inequalities in outcomes, experience, and access.	✓
Priority 3 - Enhancing productivity and value for money.	✓	Priority 4 - Helping the NHS to support broader social and economic development.	✓

In addition, this report also provides evidence against the following corporate goals (place ✓ beside all that apply):

Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference.	✓
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	✓
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	✓
Are there any Resource Implications (including Financial, Staffing etc)?	
No	
Have you carried out an Equality Impact Assessment and is it attached?	
No	
Have *you involved patients, carers and the public in the preparation of the report?*	
No	

Chief Executive Report

Integrated Care Board Meeting

6 March 2024

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for January and February 2024.

2. Integrated Care System Update

2.1 Integrated Care Partnership Board meeting.

The January 2024 Integrated Care Partnership meeting again focussed on employment and the relationship between work and health. We heard about a programme called Employment is for Everyone, which aims to improve employment opportunities for autistic people and people with a learning disability. At the meeting, colleagues described how only 5% of South Yorkshire's learning disability community of working age are in employment, for people with autism its about 25% however for the rest of the population this is well over 70%. The aim is to work with public and private employers to close this gap. This will require around 5,000 people with learning disability or autism to be supported into work over the next five years and the programme aims to achieve this.

In addition, at a previous ICP Board meeting colleagues at Barnsley MBC presented their Pathways to Work Commission. This aims to support people who are economically inactive back into work, particularly those with health conditions themselves or with caring responsibilities. There was an opportunity for NHS and other health partners to contribute to this through a special Health session at the beginning of February 2024, led by the Rt. Hon. Alan Milburn and Dame Carol Black. There was a discussion about areas of national policy that could help support this aim and what can be achieved locally in South Yorkshire. We now await the outcome of the Commission and how this can be used across South Yorkshire to increase economic participation and the benefits to the health and care system, as well as the health and wellbeing of our communities.

2.2 Financial position

Despite the challenging financial environment this year the position of the NHS in South Yorkshire has stabilised over the last couple of months. The system is currently £42.9m overspent against its plan and is forecasting a year end deficit of £48.6m. This is a marginal improvement against the plan re-submitted in November which forecast a year end deficit of £54.5m against our total annual expenditure of £3.1bn. The ICB is continuing to work with local NHS organisations to improve this position if possible. In addition, the ICB is developing the 2024/25 financial plan with NHS provider organisations, our place partnerships and cross-South Yorkshire provider collaboratives and alliances.

2.3 Industrial action

Junior Doctors have not agreed a settlement with the Government and at the time of writing their mandate for further action is due to end at the end of February 2024, the BMA intends to ask members to extend the mandate for a further six months. The most recent action ran for five days between Saturday 24 February and Thursday 29 February 2024 and was supported by doctors in training who are members of the British Medical Association (BMA) and members of the Hospital Consultants and Specialists Association (HCSA).

Consultant members of the BMA narrowly rejected the Government pay offer. However, the BMA has called for the reopening of talks, given the closeness of the vote it's hoped that there is still potential to reach an agreement.

The NHS in South Yorkshire has continued to maintain urgent and emergency care, as well as some planned treatment and appointments where possible during industrial action. The South Yorkshire ICB has continued to provide support through its Incident Co-ordination Centre, which has operated at all times during industrial action in line with our Category 1 responder status.

2.4 Director of Performance and Delivery

NHS South Yorkshire has appointed Sarah Perkins as its new Director of Performance and Delivery following a competitive process. Sarah will lead the new Performance and Delivery function within the ICB following the transfer of the former Locality Team from NHS England in December. Sarah is currently Interim Chief Executive of Wythenshawe, Trafford, Withington, and Altrincham (WTWA) for Manchester University Foundation Trust. During her five years at Manchester University Foundation Trust Sarah has made a significant contribution to the Trust and has worked hard to improve services for patients.

2.5 Mexborough Elective Orthopaedic Centre

The first patients have now been treated at the Mexborough Elective Orthopaedic Centre. The orthopaedic centre specialises in hip and knee replacement and other operations, including hand and foot, and knee and elbow procedures, for residents within Barnsley, Doncaster and Rotherham areas. It comprises two state-of-the-art theatre units, two anaesthetic rooms and a recovery suite, in addition to 12 inpatient beds.

The centre will treat 40 patients per week until mid-2024, when this is expanded to 64 patients a week across six days. In the first year of operation it is anticipated the centre will undertake around 2,200 orthopaedic procedures, equating to about 40% of the current orthopaedic waiting list. The collaboration between the three hospital trusts in Barnsley, Doncaster and Rotherham, is already starting to receive national recognition with NHS leaders keen to see how the facility works.

3. NHS South Yorkshire

3.1 NHS England ICB Running Costs Allowance (RCA)

The Integrated Care Board is concluding a restructuring programme in response to a nationally mandated 30% reduction of its running costs allowance. A limited voluntary redundancy scheme has seen 11 staff leave the ICB and we are currently supporting a number of colleagues at risk of redundancy in applying for existing vacancies. This process will conclude by the end of the financial year. In addition, whilst we are retaining a base in Barnsley, Doncaster, Rotherham and Sheffield reflecting the importance of local relationships, we are planning to reduce our estates

costs by co-locating with public sector partners in some of our Places which will make a significant financial saving and has helped to minimise staffing reductions.

3.2 Pharmacy First

NHS South Yorkshire has welcomed the national launch of the Pharmacy First service. The service means patients can now receive direct treatment for seven common conditions directly at participating pharmacies, including the prescription of medicines without visiting a GP. Pharmacists have always been able to give advice and signpost to the best place to access care, but Pharmacy First means they give treatment themselves. In South Yorkshire over 95% of pharmacies have signed up to be part of the new service. The expectation is that it will help to make it easier for people to get the care they need and free up GP appointments for others.

3.3 NHS Dental Recovery Plan

The NHS Dental Recovery Plan was announced on 7 February 2024 with a key focus on improving access to NHS dentistry for local people. The ICB took delegated responsibility for commissioning dental services in July 2023 had have already engaged closely with local practices. We welcome this national plan which provides a framework for further improvement and will provide a full update on our response at today's public Board meeting.

3.4 Measles

Parents and carers in South Yorkshire are being urged to book their children in for their missed measles, mumps, and rubella (MMR) vaccine as part of a new drive to protect children from becoming seriously unwell, as measles cases rise across the country. The NHS campaign will see all parents of children aged from six to 11 years contacted encouraging them to make an appointment with their child's GP practice for their missed MMR vaccine. Last year the NHS sent texts, emails and letters to parents and carers of 1-5-year-olds who were unvaccinated and thanks to those efforts, around 10% of those children received an MMR vaccine.

Measles is not just a childhood disease and can be serious at any age. If caught during pregnancy it can be very serious causing stillbirth, miscarriage and low birth weight and NHS bosses are urging young adults to catch up on any missed doses before thinking about starting a family. Two doses of the safe and effective MMR vaccine are needed for maximum life-long protection, with the first dose given around the child's first birthday, and the second dose given at around three years and four months old.

3.5 Start with People Strategy

NHS South Yorkshire is encouraging partners and our wider communities to help refresh our 'Start with People: South Yorkshire' strategy, which was launched in July 2022 when NHS South Yorkshire was created. The strategy outlines how we listen to our communities and involve them in the way we provide NHS and care services.

Since 2022 when the initial strategy was launched a lot has changed in health and care. We have since engaged on the Integrated Care Partnership strategy and the Five-Year Joint Forward Plan. From those involvement exercises our communities told us that the three most important area to focus on were:

- Awareness – the need for more information about health prevention and availability of different health and social care services.
- Access – making it easy for people to access health and social care services and removing barriers
- Agency – enabling people to have the information, tools and capacity to make informed decisions and be in control of their lives

The ‘Start with People: South Yorkshire’ strategy is being developed through until March 2024.

3.6 National GP Leadership Event

I’m delighted that Dr Andy Hilton Chair of the SY Primary Care Alliance attended the first national GP leadership in London on 31 January 2024 on behalf SY ICB Primary Care Provider Alliance. The meeting brought together GP leaders from each of the 42 systems representing general practice as a provider. There will be subsequent leadership events for dentists, pharmacists, nurse and ARRS roles with regional events in the Summer bringing the collective primary care leaders together. The event was opened by NHSE Chair Richard Meddings, with keynote from Navina Evans, Chief Workforce Officer, NHSE on the long-term workforce plan. The group will reconvene in person in the autumn but will have subsequent virtual sessions in the interim potentially discussing primary care provider collaboration, continuity of care, leadership development.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

Sheffield held its first Inclusion Health Summit in January attended by nearly 50 people, spanning a range of strategic and operational services, with expertise, knowledge and lived experience. Dr Bola Owolabi, Director of Health Inequalities at NHS England, was the guest speaker and set the scene on why Inclusion Health matters and its importance across health and care. A further two summits are being planned in Sheffield in February and March, at the end of which a long-term action plan will be agreed for the city.

4.2 Doncaster

A major investment in robotic surgery has been announced at Doncaster and Bassetlaw Teaching Hospitals. The Trust’s charity will fund a £3.6 million Intuitive Da Vinci Xi surgical robot to deliver cancer surgery. The state-of-the-art surgical robot will transform the way DBTH performs cancer surgery for colorectal cancer patients. The surgeon operated camera and robotic arms are controlled from a console using an advanced set of instruments for a minimally invasive surgery. This procedure allows for greater precision than traditional laparoscopic (also known as ‘keyhole’) or open surgery. One surgeon is already fully trained and a further three are due to begin training next month, with all four colorectal surgeons able to operate independently on the machine within six months.

4.3 Rotherham

The Rotherham NHS Foundation Trust have reopened the hospital's refurbished neonatal unit. Launched in September 2023, the Tiny Toes appeal aimed to raise £150,000 for a comprehensive redevelopment of the neonatal unit, ensuring that the facilities align with the exceptional care provided by hospital staff. The unit refurbishment includes enhanced heating, lighting, and accessibility accommodation for up to 16 babies at a time.

4.4 Barnsley

Barnsley Council have launched a new breastfeeding campaign so that parents feel like they can breastfeed anytime, anywhere. Data relating to breastfeeding rates in Barnsley from 2022/23 show that by 6-8 weeks, only 33% of mums are continuing to breastfeed, a 28% decrease from the 61% that initially started. The most common factors cited in stopping breastfeeding include feelings of nervousness and anxiety around breastfeeding in public. South Yorkshire has a wider focus through its Maternity Services Five Year Plan, which aims to support the 16,000 babies born in the area each year.

5. General Updates

5.1 Smoking consultation

In South Yorkshire there are at least 16,000 hospital admissions due to smoking each year, and smoking takes the lives of 5,900 people every year from our communities. In addition, Smokers are 2.5 times more likely to need social care and on average will need care 10 years earlier than non-smokers. There are also estimates that suggest there are around 11,000 people out of work due to smoking in South Yorkshire.

The Government consultation aimed at creating a smoke-free generation was announced in October 2024 and since then more than 28,000 responses were submitted, including from NHS South Yorkshire and many of its partners. The government will now bring forward legislation at the earliest opportunity that will take measures to:

- change the age of sale for all tobacco products, cigarette papers and herbal smoking products whereby anyone born on or after 1 January 2009 will never legally be sold tobacco products alongside prohibiting proxy sales, and change warning notices
- introduce regulation making powers to restrict flavours, point of sale and packaging for vaping products (nicotine and non-nicotine) as well as other consumer nicotine products
- introduce new FPNs for England and Wales with a penalty of £100 where it is believed an offence has been committed in relation to age of sale and free distribution legislation for tobacco and vapes (nicotine and non-nicotine) and regulate to extend these provisions to other consumer nicotine products

NHS SY has written to elected representatives to ask them to support the measures and will continue to demonstrate our support for this important legislation.

5.2 South Yorkshire Digital Health Hub

Google has announced investment in ground-breaking research, apprenticeships and digital skills training through the South Yorkshire Digital Health Hub to help address health inequalities and drive economic growth across the region. The £4m South Yorkshire Digital Health Hub, which Sheffield Teaching Hospitals is a lead partner in with University of Sheffield and Sheffield Hallam University aims to improve peoples' health and quality of life by creating innovative digital technologies to improve the way diseases are diagnosed and treated.

As part of this, the South Yorkshire Digital Health Hub will work with Google on a series of pioneering research opportunities. The first in a series of pioneering studies will assess if smartphone sensors could aid the detection and prevention of illnesses. Professor Chico, Honorary Consultant Cardiologist, says the research could improve health outcomes and look at how technology can be harnessed to support information gathering.

Google has also announced a three-year partnership with the South Yorkshire Mayoral Combined Authority to fund 30 digital apprenticeships for small businesses in South Yorkshire.

5.3 Race Equality #CallMyNameRight

Staff across the NHS and care in South Yorkshire are encouraging colleagues to "call my name right". Nearly 14% of NHS staff are non-UK nationals and many will have their name mispronounced on a daily basis or feel pressure to adopt an anglicized version. This represents more than 10,000 people working in health and care in South Yorkshire, as well as many other British colleagues whose names are regularly pronounced incorrectly. Using the correct pronunciation not only improves the working lives of valued colleagues, it can also prevent confusion between colleagues and even potentially reduce mistakes and errors. The campaign was launched as part of Race Equality Week, which ran from 5-11 February 2024, and was supported by Dr Rajeev Gupta, the Consultant Paediatrician who started the campaign, and Vivienne Williams, Chair of the ICB Race Network.

5.4 LGBT+ History month

Staff from across the Integrated Care System has been supporting LGBT+ History Month throughout February 2024. The month-long annual celebration is celebrated in February each year to coincide with the 2003 abolition of Section 28. Events to mark the celebration included history and literature sessions in Sheffield Central Library as well as performances, walking tours and discussion events across South Yorkshire.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 6 March 2024

Subject:	Quality Committee CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	QC

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

Committee / Group: Quality Committee	**Date: 27 March 2024 and 24 April 2024**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Quality Priorities for 2024/25	The Committee received the final proposal for the Quality Priorities 2024/25 and there was agreement and support on the decision to reduce from nine priorities to three, to allow for in-depth focus in these areas. The short timescale to launch was noted with regret and concern was expressed about the limited scope of the priorities as described in the report, particularly the one on diabetes. However, the committee was informed there was triangulation with PLACE priorities in the discussions which provided further breadth for the priorities, including around prevention and health improvement. The committee was also informed that a broader and more ambitious scope would be worked up in the quality priority working group and presented to the Quality Committee, starting with the diabetes priority for the April meeting. Subject to this, the committee approved the Quality Priorities for 2024/25.	Board of Directors
2	Divisional Reporting on Quality Compliance: Surgery Division	The divisional presentation raised questions on the guidance given by the committee to divisions for their attendance and presentation. It was agreed to develop a template with input from the Quality Committee sub-operational groups to provide a clear structure to ensure quality focused and contextual information and assurance is provided by divisions.	Board of Directors
3	Organisational Priorities	This item was deferred this month due to the delay in national guidance for the performance element. The Chief Nurse suggested that the quality aspect is circulated outside the meeting, to allow for adequate time for members to comment prior to presentation at April Quality Committee.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
4	Risk Register	The Committee alert the Board to the lack of movement for some specific risks rated at 15 or above. One such risk is Risk 6324 – Delays to 18 week wait and 52 week breaches (Gynaecology) which has been on the risk register since 23/11/2020 rated at 15 with no change to the rating in four years and the continued adverse effect upon patient experience. The Committee has requested a report to be provided by the Risk Owner to be brought to the May 2024 meeting for discussion, this report should be produced in conjunction with input from the Chief Operating Officer.	Board of Directors

Subject:	**PEOPLE AND CULTURE COMMITTEE CHAIR'S ASSURANCE LOG** **Quorate: Yes**	Ref:	**Board of Directors**

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

Committee / Group: People and Culture Committee	**Date: 19th April 2024**	**Chair: Dr Rumit Shah**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Pastoral Care Quality Award	The committee received information on the Trust's success in the Pastoral Care Quality Award, which is a scheme that supports NHS Trusts to provide high-quality pastoral care to internationally educated nurses and midwives. The subsequent positive retention statistics for the Trust (141 out of 161 nurses that have arrived since 2020) further signals the high-quality pastoral care provided to the international nurses.	Board of Directors
2	Director of People Report	The Executive Director of People's report highlighted the proposed changes to the Board Assurance Framework (BAF) wording for U4, which is aligned to the committee. Although supportive of the changes to align with the new People and Culture Strategy, concern was raised over the risk relating to resource and how there will be continued oversight moving forwards. It was agreed to **advise** the Board for further discussions surrounding this risk and the BAF refresh for 2024/25.	Board of Directors
3	People and Culture Strategy 2024-2027	The strategy was presented to the committee highlighting the engagement, the reference to the previous strategy and the proposed measurements, alongside a presentation showcasing the branding for the strategy. The committee discussed that this has been an excellently researched piece of work with exemplar levels of engagement and **approved** the strategy for	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		recommendation to Board, pending minor amendments discussed in the meeting.	
4	Engagement and Health and Wellbeing Report	The committee received information on the health & wellbeing programmes and initiatives to support staff at the Trust, including the vaccination programme, staff survey engagement, face to face counselling, menopause groups and advocates, and Vivup (the employee assistance programme). The Deputy Director of People highlighted the work done for Menopause, the external accreditation and awards recognition that the Trust has received; and the triangulation of this work with the ICB 3 year health & wellbeing road map.	Board of Directors
5	Organisational Priorities	The Operational Plan Q4 report detailed continuing medical engagement work for which the 2024/25 road map will be triangulated with the staff survey result. It also presented positive trends in turnover rates and discussions were had on the target rate and target brackets for 2024/25 to ensure a healthy range for the organisation, noting that 0% would be counterproductive as some turnover is a positive. The committee also received the draft organisational priorities 2024/25, which align with the new People and Culture strategy and signal the ambitions for the year.	Board of Directors
6	Job Planning	The committee received the report and were assured by ongoing work, the new job planning policy in place, increased engagement and visibility through divisional performance meetings and the committee noted the progress in yearend position; 68% in 2023/24 compared to 28% in 2022/23. The expectation is that the outstanding 32% for 2023/24 will be complete in 2 months.	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 27 March 2024 & 24 April 2024	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Divisional Presentation UECC Medicine	The committee received the divisional presentation from UECC and would **advise** the Board on the sheer scale of the challenge and the work that has been undertaken, whilst recognising that there are more challenges ahead. The committee would also like to highlight the increased attendance rates in UECC and the continued prevalence of mental health patients. Challenges during the last financial year and the good work that has been done. The Committee wanted to **advise** the Board of the progress made within Medicine, the challenges the division had faced and the opportunity from coming together with UECC in the new care in a radical way and the positive feedback received from the team on working together.	Board of Directors
2	Integrated Performance Report	The Integrated Performance report highlighted that productivity is a concern for the Trust and it was discussed that there is interest SYICB-wide on productivity rates. The Board is **advised** of the issue of productivity and that the 76% 4 hour target will not be met.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
3	Year End Operational Report	It was recognised that a lot of good work had taken place in the last year, despite all the challenges including 33 days being lost due to industrial action and the Board should be **advised** accordingly.	
4	Integrated Financial Performance Report	The committee agreed that it was important to **assure** the Board that the Trust has delivered against all the business critical activities and has performed as it set out to do at the beginning of the year. The Board should be **alerted** to the difficulties faced in putting a financial plan together without the appropriate information being made available to the Trust from external organisations.	Board of Directors
5	Board Assurance Framework (BAF)	The Board is to be **advised** that wider discussion on the BAF and Risk Appetite will occur at the next Strategic Board and as such the recommendation to decrease the BAF risk ratings of D5 and D7 to 12 was not approved at this point.	

Board of Directors Meeting
3rd May 2024

Agenda item	P71/24
Report	**Five Year Strategy Refresh**
Executive Lead	Michael Wright – Managing Director
How does this paper support Trust Values	The Trust's strategy defines our three Trust values, and as such as the key document which sets out how we will deliver these within our work.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	This paper summarises the discussions at the Board seminar in April 2024, whereby Board members participated in a workshop around a potential review and restatement of our five-year strategy, as we near the halfway point of the current strategy. The paper proposes a way forward following these discussions, which centres around development of an addendum to the existing strategy (widely considered still appropriate and relevant). This addendum would set out a number of strategic objectives for the next three years, which have been drafted based on our discussions to date. However, some light-touch engagement is proposed in order to test these with relevant colleagues and stakeholders. As such, the existing strategy document would remain as our current strategy, with a halfway reset included as an addendum. To date, 7 strategic objectives have been identified for further exploration internally, noting that these are likely to change as conversations take place and these are more fully developed. If the Board of Directors approves the next steps set out in this paper, a development paper will be discussed at the Board Strategic Forum in August following some light-touch internal engagement via the Executive Team and Senior Leaders forums.
Due Diligence	This report has been developed at pace following the Board of Directors Strategic Forum in April. It is being discussed at ETM on 2nd May, with any feedback to be provided verbally to the Board of Directors on 3rd May 2024.
Board powers to make this decision	The Board of Directors is responsible for setting the strategic direction of the organisation.
Who, What and When	N/A
Recommendations	The Board of Directors is asked to approve the proposal around the next steps for the strategic review and restatement as set out in this

	paper.
Appendices	Strategic Review and Restatement Proposal

THE ROTHERHAM NHS FOUNDATION TRUST

Trust Strategy: Our New Journey Together 2022 -2027

Mid Stage Review and Restatement

1.0. OVERVIEW

The Trust developed a new strategy in late 2021. The new strategy was delivered at a time when the Trust had been through a significant amount of change, from within the Trust, within the broader NHS and across the wider population.

In developing the new strategy, the Trust committed to and undertook a significant amount of engagement across the Trust workforce, the Trust's partners, and the patients – with over 500 engagements recorded. This engagement had a real and tangible impact on the strategy and what the organisation set out as its strategic ambitions over the subsequent five years.

However, the Trust also recognise that while it is proud of our strategy, its vision, values and the ambition within it, the organisation have been through another period of significant change over the subsequent two years and as such, it is right that the Board take some time to reflect on progress, both good and bad, re-assess the local and national context and consider if the strategic ambition is still right.

Therefore, the Board of Directors and the Executive Team have committed to undertaking a Mid Stage Review and Restatement of our strategy. This paper sets out the proposed approach to undertake this work.

2.0. RATIONALE FOR THIS WORK

There is a case for undertaking a review of our current strategy at this halfway point, in order to understand if the ambition and direction of travel within it is still reflective of our intended goals for the next three years. This is for two main reasons; firstly, that the Trust has achieved a substantial amount over the first half of the strategy, and in some cases potentially exceeded the original ambition within the strategy and secondly, that the last two years have continued to be a time of very tangible change for the Trust, the NHS and the wider environment. As such, it is right that we confirm that the strategy is still appropriately supporting us and underpinning our long-term goals.

2.1. WHAT THE TRUST HAS ACHIEVED SO FAR

As stated within the current strategy, the Trust had already delivered significant improvement in the previous 18 months prior to its launch, particularly in relation to the staff survey results, being awarded Digital Aspirant Funding, making strong progress on elective recovery and the removal of some of the regulatory support regarding our

financial position. However, the document is also clear that this progress was just the start and, as an organisation, the Trust wanted to push on from this stronger position.

Over the subsequent 2 years the Trust has continued this progress with real and tangible improvements made across a range of areas. Highlights of this include, but are not limited to:

- Removal of the section 29a on UECC by the CQC, which has led to a step change in the Trust's relationship with the regulator. UECC have also seen the number of complaints reduce by 75%
- Staff survey results have continued to improve with the latest results demonstrating performance in the upper quartile (or often decile) across 7 out of the 8 ranked 'People Promise' themes and the Trust's improvement noted as the second most improved in the country within the Health Service Journal
- Improvement in the Trust's headline mortality indicator (HMSR) from 120+ to 90 in late 2023, moving from 'above expected' to 'below expected' and becoming the best performing Trust in the North East and Yorkshire
- The implementation of a QI methodology across the Trust with over 130 practitioners trained and an increasing socialisation of the methodology and approach across the Trust.
- Delivery of over £20,000,000 of cost improvements over the two years of 2022/23 and 2023/24, helping to stabilise the Trust's financial position and ensure delivery of the agreed financial plan for the last 3 years
- Operational Delivery – one of the first trusts to deliver the DM01 constitutional standard in March 2024 and top quartile performance on the number of year-long waiters as of February 2024.

These achievements should not be underestimated and represent the hard work and dedication of countless numbers of our staff.

2.2. WHAT HAS CHANGED

Alongside these wide-ranging achievements for the Trust, there have also been some significant changes in the local and national environment in which the Trust operates, which we need to respond to. Some of these include:

- A very stark and clear change in the public perception of the NHS, with only 24% of the public now 'satisfied' with the NHS compared to 60% pre-pandemic
- The relationship between the government and the NHS workforce which resulted in the largest strikes in the NHS history in 2023-24.
- The continued economic challenges within the country and clear expectation that the NHS will not receive significant additional funding for the foreseeable future.

- The formal launch of the South Yorkshire ICB and its recognition within the formal regulatory regime within the NHS
- The continued development of the Acute Federation, including the appointment of a permanent Managing Director
- The approval of the Pathology Target Operating Model with Sheffield Teaching Hospitals NHS FT as the single employer across the region
- The growth and maturity of our collaboration with Barnsley Hospital NHS FT
- The appointment of a new Chair, Medical Director, Chief Operating Officer, Chief Nurse, Director of People all within the first two years of the Strategy, with the Joint Chief Executive moving from an interim role to substantive

3.0. PROPOSED WAY FORWARD

The Board of Directors held a discovery and exploratory session at the Board Seminar session in April. This was structured around an analysis of the environment that the Trust operated in (via a Political, Economic, Social and Technological assessment), an analysis of the Trust itself (via a Strengths, Weaknesses, Opportunities and Threats assessment) followed by an open session exploring the ambition the Trust can show over the next five years.

Though review of the outputs and the general narrative and additional comments made at the time, the following key messages were taken away.

- There was minimal / no desire to produce a 'new' strategy as this is neither needed nor would it be a priority for the Trust over the next 6 months.
- The current strategy is generally still appropriate. The Vision, Values and Strategic Ambitions continue to be relevant and give us the right strategic direction.
- The Trust, while operating in a very difficult environment currently, could be more ambitious in some areas given the improvements and achievements made over the last two years.
- However, while there was a desire to be ambitious, there was also a continued need to ensure that the basics – and the building blocks to which that ambition could be delivered – were right

Given the above, the following approach is proposed across key areas:

3.1. The Strategy document

It is not proposed to make significant changes to the strategy document. This is generally seen as still relevant and appropriate. However, as stated above, there is a want to set some stretch areas of ambition in some areas. Therefore, it is proposed that an addendum / additional section is included within the document. This will ensure

that the Trust still has a single strategy document, but that we are able to include a welcome from our new Chair and CEO, explain the review process we have been through and set out our new strategic objectives. These objectives will be more tangible and delivery focused.

It is not proposed that the remaining document is fully updated, even for areas which may be considered out of date. The rationale for this is that any update to the current document outside of the addendum would also mean that any other section which is not amended is in effect updated by exception. It is significantly cleaner to leave the current document untouched with the addendum forming a new section.

3.2. Engagement

The Trust has recently engaged with its staff around a number of areas – initially through the staff survey and then the People and Culture strategy and may do again in the near future when a Clinical Strategy is developed. There is therefore a reluctance to do another round of full engagement, as it may disengage staff who will want to see the Board of Directors' activities reflecting the biggest priorities for the Trust.

However, there is a compelling story to tell in our related communication with staff, which would recognise a period of significant achievement for the organisation (above and beyond where we expected by this point), whilst also being clear that the Trust still has much bigger and bolder ambitions it wants to fulfil in the next three years. This story could form the basis of some light-touch engagement with teams.

3.3. Updated Ambitions

Based on engagement from the Board of Directors strategic forum in April, it is proposed that the updated ambitions are set out across a number of themes. These represent some of the discussion that took place at the workshop. These would set out the enhanced ambition for the Trust over the next 2-3 years and would form a key part of our work profile.

A draft set of these is set out below. These can be mapped across the original PROUD strategic ambitions. Please note that these themes will be engaged on further and so are likely to be subject to change.

- The Partnership with BHFT (Our Partners)

The partnership with BHFT has developed at pace over the last two years, moving from an area of exploration into a genuine partnership which is working to deliver both large scale programmes of work (such as our Joint Gastroenterology and Haematology services) and enabling teams to work together and share learning as standard.

- Income Generation (Delivery)

The financial position of the Trust is challenged, and the Trust could be ambitious in diversifying its income outside of its normal commissioners. This could put the Trust on a more sustainable financial footing, as well as opening up exciting and innovative opportunities for our colleagues.

- System Provider (Our Partners)

The reconfiguration of pathology services into Sheffield Teaching Hospitals NHS FT is unlikely to be the last service which is moved towards a more centralised model. The Trust is keen to be on the front foot with an ambition to be the hub for at least one of these services. This would be based around areas where the Trust considers itself an exemplar within the system, for example in radiology.

- Brand / Reputation / Public Relationship (Rotherham)

The Trust can make progress on its reputation within the NHS, but importantly across Rotherham. The recent improvements made in the Trust are not yet reflected in the public's perception, but it is important we change this through some focussed work to build our brand.

- One Team, One Culture (US)

Building on the new People and Culture strategy, the Trust could set more ambition around the development of a One Team, One Culture philosophy and how the Trust becomes the organisation that everyone wants to join and progress their career with.

- AI / Digitisation (Patients)

The development of AI over the last 6-12 months has opened up a range of possibilities within healthcare. Given our early adoption of many digital technologies to date and the impressive capabilities we have in this area, the Trust has an opportunity to embrace this and be at the forefront of some of these changes.

- Integration (Rotherham)

The Trust can explore how it can provide a greater range of services across our patients needs. This may include the Trust providing services traditionally provided by other organisations, for example care homes and primary care services.

3.4. Next Steps

If the Board of Directors are in general agreement with the proposed way forward then a timeline for delivery will be developed.

This will include further engagement with the Board, Executive Team and Senior Leadership team of the Trust, both on the ambitions themselves and the specific deliverables within each theme where appropriate. It will also include light-touch engagement with the Trust's staff. This engagement will be based around the good news story of the last two years, alongside a narrative that the Trust wants to go further and to stretch itself to provide its overarching Vision.

Board of Directors
3rd May 2024

Agenda item	P72/24
Report	‘Us’ – TRFT People and Culture Strategy 2024-2027
Executive Lead	Daniel Hartley – Director of People
Link with the BAF	The People and Culture Strategy influences all the BAF risks across Patients, Rotherham, Our Partners, Us and Delivery (P1, R2, OP3, U4, D5, D7).
Purpose	Decision [ ] To Note [ ] For Approval [✓] For Information [ ]
Executive Summary	The current Trust People Strategy ‘Our People Strategy: The Rotherham Way,’ has recently expired. A diverse steering group has overseen work to develop a new strategy since December 2023. This new strategy ‘Us’ - The Rotherham NHS FT People and Culture Strategy 2024 -2027 is presented here for Board approval. The purpose of the strategy is to enable ‘Us’ to deliver excellent healthcare through our people. Rooted in our values of ambitious, caring and together, the strategy is our blueprint for approaches to people and culture between now and 2027. It is organised in three themes and sets out how we will; retain and recruit; develop and lead inclusively and create high levels of engagement and improvement – all for the benefit of our people and patients. It builds on the strong progress the Trust has made over recent years evidenced for example by significant improvement in staff survey results and reduced turnover. Given the importance of culture to organisational success this strategy supports and enables all aspects of PROUD and directly contributes to our ability to deliver quality care, operational targets and financial sustainability as well as specific people and culture goals. We have engaged widely to develop the strategy, with over 250 colleagues contributing directly through a variety of channels. We have reviewed existing feedback from our people and patients and researched the evidence base on links between effective approaches to people and culture and staff and patient outcomes. The Trust’s People and Culture Committee endorsed this strategy at its April meeting and, subject to Board approval, it will be launched in May 2024. Measure of success are set out and key organisational people and culture priorities and targets will flow from this strategy each year.

Recommendations	The Board of Directors are asked to; 1. note the engagement and research that has been undertaken to develop this strategy overseen by a diverse steering group 2. approve ‘Us’ - People and Culture Strategy 2024-2027 and note plans for launch during May.
Appendices	1 Equality Impact Assessment screening tool 2 TRFT People and Culture Strategy 2024-2027

1.0 Introduction

1.1 The current Trust People Strategy 'Our People Strategy: The Rotherham Way,' has recently expired. A diverse steering group has overseen work to develop a new strategy since December 2023. This new strategy 'Us' - The Rotherham NHS FT People and Culture Strategy 2024 -2027 is presented here for Board approval.

2.0 Key issues

2.1 The purpose of the strategy is to enable 'Us' to deliver excellent healthcare through our people. Rooted in our values of ambitious, caring and together, the strategy is our blueprint for approaches to people and culture between now and 2027.

2.2 As a people and culture strategy it relates not just to the 'Us' in PROUD but to all aspects of our strategic ambitions as a Trust. Our culture influences how we work to deliver quality care for patients, our success in achieving operational targets as well as how we can best deliver financial sustainability. The strategy articulates key people and culture measures and areas of focus for the Trust.

2.3 It is organised in three themes and sets out how we will; retain and recruit; develop and lead inclusively and create high levels of engagement and improvement. It is designed to improve the experience of our people and the quality of care we can provide for our patients. It builds on the strong progress the Trust has made over recent years evidenced for example by significant improvement in staff survey results and reduced turnover. It is research and engagement based drawing on the evidence base for engagement and organisational success as well as healthcare specific research.

2.4 The development of this strategy was overseen by a diverse steering group made up of colleagues from across the Trust. This multi-professional group included clinicians, managers, team members and the chairs of our three staff networks and Trade Union colleagues. It was supported by a project team and has met regularly over the past five months. The group set itself a goal of creating a strategy it was proud of and achieved this goal with the final draft, after it had gone through several iterations aimed at continuously improving the draft strategy based on feedback.

3 Engagement

3.1 We have engaged widely to develop the strategy, with over 250 colleagues contributing directly to this work. This was primarily through the completion of a survey either in person at a 'pop up' stall in the staff café, or via QR code online. This engagement activity had the benefit of explaining the links between high levels of engagement and staff and patient outcomes as well as asking a series of questions on what matters most to staff. Questions were posed based on the Engage for Success engagement model referenced in the strategy as well as on the NHS People Promise and Quality Improvement. The results of the engagement have informed the development of this strategy.

3.2 Our people told us a number of things, the importance of behaviours to them and the need for us to do more to amplify the voices of our staff. 'we are a team' was judged the most important element of the NHS People Promise with 'reward and 'recognition the area needing most work. Given the national pay disputes between the government and Trade Unions this last point is perhaps unsurprising. The importance of right staffing

levels, patient centered care and more manageable workloads also came through strongly in the feedback. We also received encouraging feedback about the spread of knowledge and adoption of quality improvement approaches from those surveyed.

3.3 In addition to this primary research we reviewed existing feedback from our people and patients. This covered a number of groups of people and provided us with rich insight. Specifically we reviewed feedback from; all staff through the NHS staff survey results and free text comments, medical and nursing students, apprentices and new starters to the organisation. We also looked at what our volunteer survey and community engagement told us and examined multiple types of patient feedback including compliments, complaints and concerns. Both staff and patient feedback are key measures proposed by the strategy.

3.4 In developing this strategy the People and Culture Committee received presentations and discussed the strategy in December and February before endorsing the final version at the April committee. In addition, as it relates to the whole of PROUD the engagement pack was presented and discussions held at Quality Committee and Finance and Performance Committee in Q4 of 2023/4.

3.5 In addition a presentation was made to the Council of Governors and this was followed up with a further presentation at a Governors development session. Specific points of feedback were taken on board from each of these discussions which along with other feedback have strengthened the strategy.

4 Key features of the strategy

4.1 Given the progress made by the Trust during the life of the last People Strategy this new People and Culture strategy represents both continuity and change. Continuity in respect of many of the aspects of the Trust approach to valuing people, mixed with a new strategy model and emphasis on the methods of delivery of the strategy. This is articulated as being underpinned by a Trust wide Equality Diversity and Inclusion plan and then through local and trust wide 'We said we did' and workforce plans with clear accountabilities for each.

4.2 The strategy is aligned to the national NHS People Promise and reflects the changing nature of work as well as the increasing importance of partnership to the Trusts deliver. Specific collaboration is called out across the Integrated Care System on staff Health and Wellbeing.

4.3 The strategy model sets out the three themes introduced earlier and for each of these a page of the strategy sets out the key areas of focus under each. These areas of focus will form the Trust people and culture work programme over the next three years, whilst retaining the flexibility for us to adapt to changing circumstances and opportunities.

4.4 The strategy promotes our staff networks and the importance of the Trust's Freedom to Speak Up (FTSU) arrangements. It also restates our commitment to partnership working with Trade Union colleagues as an important part of our delivery in the People and Culture arena.

4.5 The metrics set out cover a range of quantitative and qualitative measures and each will be benchmarked where possible to do so. Where measurements do not exist these will be developed. The measures give prominence to the importance of our work to benefit the town and people of Rotherham and this strategy includes relevant measures via

patient experience and engagement feedback that we need to support and challenge our people to act upon.

5 Finalisation and launch

5.1 The strategy presented for approval is the 'full length version' and the main audiences for the full strategy are the Board, Executive team, senior leaders and managers across the Trust as well as relevant external organisations e.g. Care Quality Commission. It will be launched to all staff however the main content is being made into a 'short version,' specifically designed to be more accessible for all staff.

5.2 Video content has been used throughout the strategy to bring it to life and these videos will be used as part of the launch with a dedicated Hub page created. Subject to Board approval this strategy will be launched in early May 2024.

6 Implementation and delivery

6.1 There are two aspects to implementing this strategy, rooted in the fact that people and culture is both everyone's responsibility (senior leaders, managers, and all staff in terms of behaviours) and an area that requires professional leadership from the People team and many other teams contributing to this agenda across the Trust.

6.2 In terms of staff experience, service led and Trust wide 'We said, we did' plans will drive much of the improvements in the experience for our people. These are being led and managed locally with senior leaders and managers involving staff in creating these plans, working on the issues that matter most to specific teams. As set out in the strategy these are being complemented by a Trust wide 'we said, we did' plan covering areas that require Trust wide leadership and focus to make improvements. The Trust wide we said we did plan will be launched as a follow up to the launch of this strategy with the priorities for 2024/25 being appraisal, car parking, disability adjustments, sexual safety and violence and aggression.

6.3 The creation of workforce plans for service areas and Trust wide is the other key development which will enable the delivery of this strategy. Work has been underway to create a specific workforce plan for Urgent and Emergency Care and a Trust wide workforce plan will be the subject of a future Board presentation in 2024/25.

6.4 In terms of implementation of the work that requires the professional leadership by the People team and key internal partners, the next step is to produce a roadmap covering the next three years. This will be presented to the People and Culture Committee who will also receive formal 6 monthly reports on progress in implementing this strategy.

6.5 Measure of success are set out in page 19 of the strategy showing the areas that we will pay particular attention to under retain and recruit, develop and lead inclusively and engagement and improvement. We will measure excellence through benchmarking with appropriate comparator organisations and we intend for the achievements of the Trust to be recognised externally. Key headline people and culture priorities and targets will flow from this strategy each year as part of organisational priority setting and these will be reported to Board.

7 Conclusion

7.1 The purpose of our People and Culture strategy is to enable us to deliver excellent healthcare to our patients through our people. It sets out three key themes - retain and recruit, develop and lead inclusively and engagement and improvement with clear methods of implementation and measurement.

7.2 This report, like the strategy, concludes with me putting on record thanks to colleagues from across the Trust who have contributed to the creation of this strategy and for everything our brilliant people do every day for patients.

8 Recommendation

8.1 The Board of Directors are asked to;

1. note the engagement and research that has been undertaken to develop this strategy overseen by a diverse steering group
2. approve 'Us' - People and Culture Strategy 2024-2027 and note plans for launch during May.

Daniel Hartley
Director of People
April 2024

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name: Us – TRFT People & Culture Strategy | Date/Period of Document: 2024- 2027

Lead Officer: Daniel Hartley | Job title: Director of People

☐ Function	☐ Policy	☐ Procedure	☒ Strategy	☐ Other:________________________________
Describe the main aim, objectives and intended outcomes of the above: The purpose of the strategy is to enable 'Us' to deliver excellent healthcare through our people. Rooted in our values of ambitious, caring and together, the strategy is our blueprint for approaches to people and culture between now and 2027. It is organised in three themes and sets out how we will; retain and recruit; develop and lead inclusively and create high levels of engagement and improvement – all for the benefit of our people and patients.				

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

You need to ask yourself:

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

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

2.	**Positive impact:**			
Could the policy have a **significant** positive impact on equality by reducing inequalities that already exist? Explain how will it meet our duty to:		**Response**		**If yes, please state why and the evidence used in your assessment**
		Yes	**No**	
1	Eliminate discrimination, harassment and / or victimisation	x		Equality, Diversity and Inclusion is a key priority area for the strategy, and this strategy commits the Trust to developing a new Trust wide EDI plan to underpin all the actions in the Strategy. This will build on our current published action plan at [Equality, Diversity and Inclusion | The Rotherham NHS Foundation Trust (therotherhamft.nhs.uk)]().
2	Advance the equality of opportunity of different groups	x		
3	Foster good relationships between different groups	x		

3. Summary

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

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

Date assessment completed: 12th April 2024	Is a full equality impact assessment required?	☒ No

Junction 3
Junction 2
Clinical Engineering Dept
Toilets
The first step
to managing
is knowing
to find
NHS
The Rotherham
NHS Foundation Trust
The Rotherham NHS Foundation Trust
Us
People and Culture Strategy
2024 - 2027
Ambitious
Caring
Together

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Look out for the icon below featuring video links by members of the Trust providing additional information

Welcome

to The Rotherham NHS Foundation Trust's People and Culture Strategy 2024 - 2027

The purpose of this strategy is to enable 'Us' to deliver excellent healthcare to our patients through our people.

Dr Richard Jenkins
Chief Executive

WATCH NOW

Welcome to our new People and Culture Strategy. As a Trust we are on a journey to excellence and our people and culture are at the heart of everything we do for patients.

The last few years have proved to be very challenging for our people and the wider population of Rotherham. The impact and consequences of the pandemic mean that people are waiting longer for elective healthcare and we have also seen unprecedented demand for diagnostic testing, community services and urgent and emergency care.

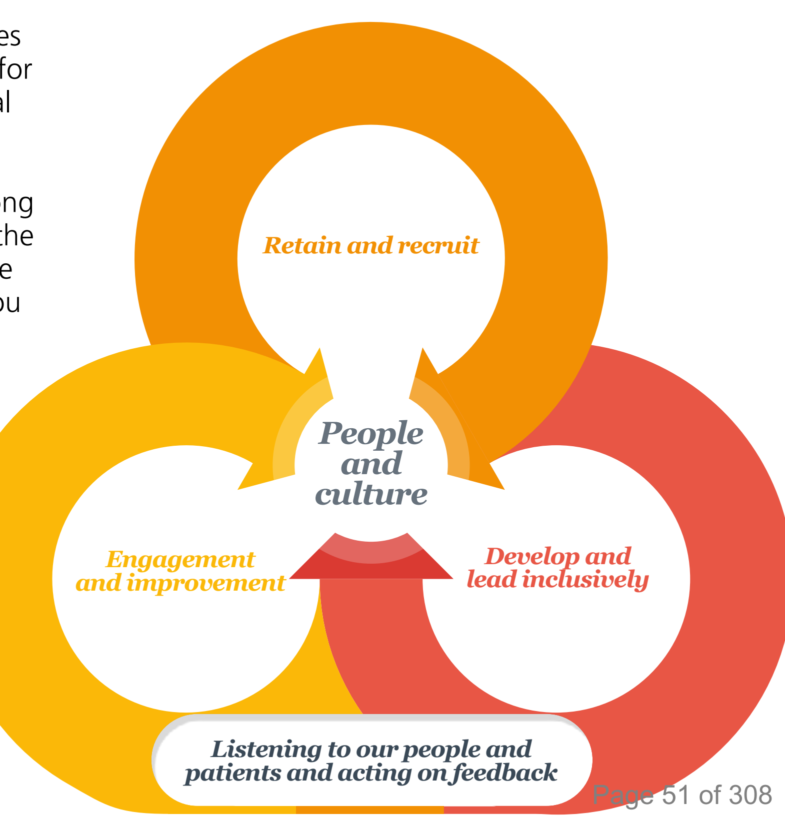
Despite these significant challenges, our people continue to work exceptionally hard and in a values based way to deliver the best possible healthcare for patients. We make a difference to the lives of local people every day.

In terms of people and culture we have made strong progress over recent years. We are very proud of the fact that in the 2023 NHS staff survey we were the 2nd most improved Trust in England on 'would you recommend TRFT as a place to work?'

We have engaged widely to develop this strategy which will see us focus on retaining and recruiting, developing and leading inclusively and creating the conditions for engagement and improvement. This is set out in the following model which will guide our approach;

By doing these things whilst listening to patients and acting on their feedback I am confident we will make even more progress. Over the next three years we will continue to listen to our people and will measure this progress in a number of ways. We will also celebrate and recognise the achievements of our people along the way.

Thank you to everyone who has contributed to the development of this strategy.



Our strategic approach

Our Vision

We will always ACT the right way and be PROUD to provide healthcare to the people of Rotherham

Our Values

Our Strategic Ambitions (PROUD)

To implement this strategy care groups and services will involve team members in developing and delivering **'we said, we did'** plans based on staff survey feedback. These will be complemented by a Trust wide **'we said, we did'** plan covering the areas that need a whole organisation focus.

Our People and Culture Strategy is rooted in our values and relates to the 'Us' in PROUD. It also influences all of our strategic ambitions as our culture sets the tone for how we make our vision a reality through our people. We want all our people to be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare for patients.

This strategy aligns to our overall Trust strategy and complements other Trust wide strategies. Each year we will set out our specific objectives as part of annual priority setting.

We will develop workforce plans for service areas and the whole Trust and underpin all our work with an **equality, diversity and inclusion (EDI) plan**. Our EDI plan will be designed to make sure we take effective action so that all our people have a great experience of work and can fulfil their potential.

Trust wide

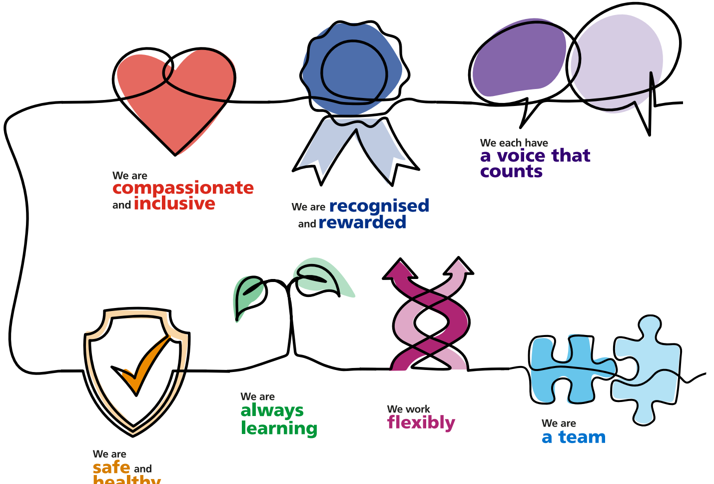
Service specific and Trust wide

National and local context

In developing this strategy we have reviewed best practice and evidence as well as the national aspirations for people and culture in the NHS. We have considered how the world of work is changing and the increasing importance of partnerships to deliver for patients.

NHS People Promise

The NHS People Promise sets out what people in the NHS can expect and is aligned to the NHS Staff survey, the key way in which we measure progress on people and culture. The People Promise covers the overall measures of Engagement and Morale as well as seven themes as follows;



NHS Long Term Workforce Plan

The NHS Long Term Workforce plan is intended to put the NHS workforce on a sustainable footing and set out aspirations in relation to training, retention and reform. This will inform the specific workforce plans we develop for the Trust and individual services over the next three years.

The world of work

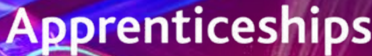
The world of work is also changing with four generations now working alongside each other, changing expectations of flexibility and an improved recognition of individual differences in the workplace. Technology continues to augment work and offers new opportunities to improve staff experience and patient care. Lastly, national disputes over pay have led to unprecedented levels of industrial action which have impacted on all our people in multiple ways. This is the context as we begin 2024/25.

Partnerships

We work with partners across Rotherham and South Yorkshire where doing so brings benefits to our patients. We are proud to be involved in a number of partnerships for example across Rotherham place, between The Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust, across South Yorkshire Acute Federation, and across the South Yorkshire Integrated Care System with the Integrated Care Board.

Celebrating and recognising our people

It is really important to us that we celebrate and recognise the achievements of our people. We have a number of ways of doing this some of which are shown here. We also showcase some of the external recognition our people have received because of their work in the Trust.



WATCH NOW

Cindy Storer
Deputy Chief Nurse

Profile of our people

Headcount by Staff Group - Feb 2024 data

Staff group	Headcount
Professional Scientific and Technical	99
Clinical Services	1115
Administrative and Clerical	984
Allied Health Professionals	511
Estates and Ancillary	338
Healthcare Scientists	124
Medical and Dental	448
Registered Nursing and Midwifery	1502
Grand total	**5121**

Number of different nationalities of our people

Grand total	68

Our progress and challenges

Our People Strategy 2020/2023 set out a number of ambitions around 4 themes; Build, Engage, Lead and Learn.

Over this period we have made considerable progress in a number of areas. A few highlights of this are as follow;

- Staff turnover reduced from over 11% to under 9%
- Workforce growth 9% or over 360 people
- Development of TRFT behavioural framework
- Supporting all our people through Covid pandemic
- Appraisal and Mandatory and Statutory Training completion rates over 85%
- Staff survey response rates 48% to 67%
- Engagement measure in NHS staff survey 6.6 to 7.0
- Improvements in a number of aspects of WRES and WDES and Gender Pay

As a Trust we have more work to do to make sure we are fully inclusive so that all our people have a great experience of work and can fulfil their potential. We also have more work to do to make sure we better represent the diversity of the population of Rotherham. We are still challenged by the level of our sickness absence and our use of agency workers given labour market shortages in some areas. We are committed to making a difference in these areas and will measure and report progress between now and 2027.

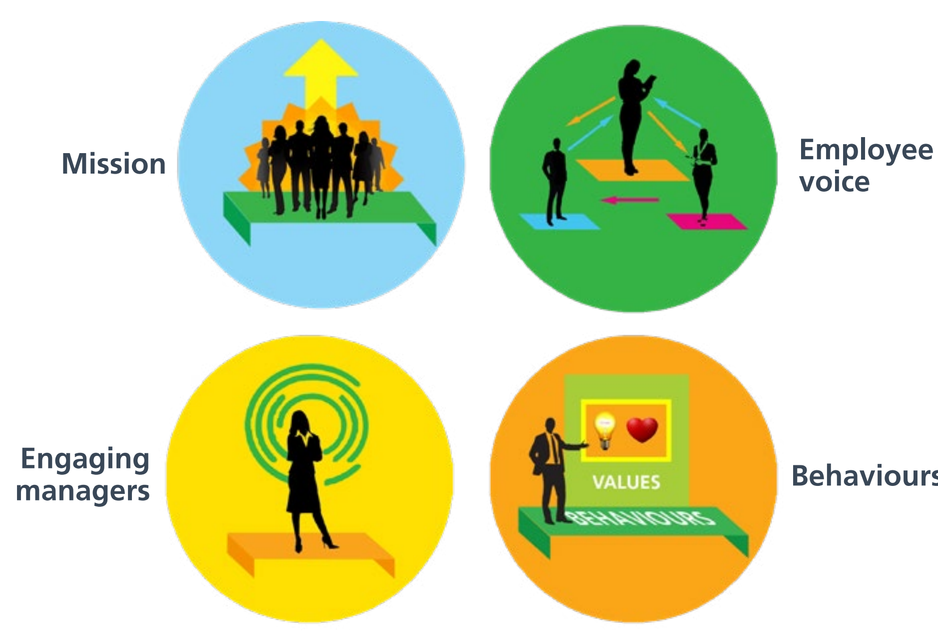
Why is engagement important?

We know that if we look after our people, our people will be able to look after our patients. In developing this strategy we found strong evidence that demonstrates the links between a positive culture and improved outcomes for people and patients.

A key feature of a positive culture is high levels of staff engagement. So what does the evidence say about the links between high levels of engagement and outcomes? The Engage for Success movement in alliance with the Chartered Institute of Personnel and Development (CIPD) found through research that 'there is a high correlation between employee engagement and high performance across all sectors of the economy.' (Engage for success 2012).

Adapted from West and Dawson, King's Fund 2012 and Wake and Green, BMJ 2019

NHS specific research has also found strong links between whether or not people would recommend the Trust as a place to work and receive treatment, engagement levels and patient outcomes. West and Dawson (2012) found a number of significant associations between high levels of engagement and positive staff and patient outcomes.



Adapted from Engage for success 2012

The research points to some of the benefits being high rates of staff satisfaction and retention, health, safety, wellbeing and attendance, innovation and improved patient experience. Creating the conditions for high levels of engagement is good for our people and good for our patients. As we do this consistently we build trust over time. Engage for Success have identified 4 key drivers of engagement and we used these concepts along with staff survey results to help us develop this strategy.

How we created this strategy

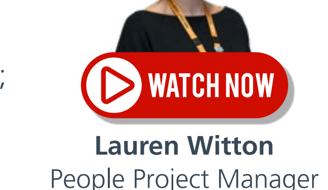
A diverse steering group and project team oversaw and delivered the work to engage with people across the Trust to develop this strategy.

This consisted of two main approaches. Firstly, we produced an engagement pack and a survey which people could complete online or via hardcopy. We visited a number of team events and used a 'pop up' stall to engage with colleagues. Secondly we reviewed existing feedback from our people, patients, students, apprentices, volunteers, and engaged with specific groups e.g. senior leaders, staff networks, new starters, Trust Governors.

We asked people their views on the 4 drivers of engagement, what matters most to them and what needs the biggest improvement. We also asked a number of questions about what makes TRFT a great place to work and what needs to improve to make it better. In combination with the staff survey we have used this to inform the key areas of action for the organisation set out later in this strategy.

From over 250 responses from people across a number of roles and areas;

Behaviours, Employee Voice, Engaging managers and **Mission** were seen as most important to people, in that order.
Employee Voice, Behaviours, Engaging managers and **Mission** were seen as the priority order for improvement.



Lauren Witton
People Project Manager

The main ways this strategy addresses this feedback is through;

- 'We said, we did' plans (Employee voice)
- Refreshing the TRFT Behavioural framework (Behaviours)
- People Manager development (Engaging managers)
- Focus on the role of senior leaders and managers in communicating mission, milestones and achievements (Mission)

Thank you to everyone who contributed to developing this strategy.

Our People and culture strategy

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Together

Retain and recruit

Retain and recruit people with the right skills, values and behaviours

People and culture

Engagement and improvement

Create a compassionate culture and high levels of engagement and improvement

Develop and lead inclusively

Develop, lead and manage our people inclusively so that everyone is valued and can fulfil their potential

Listening to our people and patients and acting on feedback

Daniel Hartley
Director of People

Retain and recruit

Key areas of focus 2024-2027

Health, wellbeing and attendance – use the NHS Health and Wellbeing Framework and our 'prevent, protect and promote, support model' to support the health and wellbeing of our people. Focus on meeting the core needs of our people and together reduce the number of days lost to sickness absence

Safe staffing and availability – deliver safe staffing levels to make sure we have the right people with the right skills in the right place at the right time and optimise the availability of our people across all service areas

Flexibility – deploy more team based rostering, increase the flexibility of work and careers including sideways transfer and partial retirement options, review relevant policies and processes to support flexibility

Role and Career support – further develop our current approaches to support people in roles e.g. buddying, professional advocacy, career coaching, mentoring

Recognition – review existing recognition approaches both internally and externally, further develop the PROUD awards and develop a greater profile of the achievements of our people

Workforce planning – develop Trust wide and individual service plans to promote clinical and service sustainability, retention and recruitment, cost-effectiveness and quality

Attraction and recruitment – modernise our approaches to enable us to both compete and collaborate successfully

Bank and agency – further improve our bank experience and effectiveness and reduce agency expenditure

Rotherham – deliver on the People commitment in our Rotherham Anchor Charter. Supporting local people to fulfil their potential, working with schools and colleges to inspire the next generation and contributing to reducing health inequalities

Working in partnership where doing so brings benefit for our patients.

Develop and lead inclusively

Key areas of focus 2024-2027

Behaviours – Support and challenge everyone to role model leadership by living the values every day across the Trust. Engage on and update our behavioural framework

Inclusion – develop and deliver an integrated Equality Diversity and Inclusion plan including (but not limited) to Workforce Race Equality standards, Workforce Disability Equality standards and Gender pay gap reporting actions

Senior leaders – Support senior leaders to lead well based on the principles of the NHS Leadership Way – compassion, curiosity and collaboration. Communicate mission, milestones and achievements as a strategic narrative internally and externally

Leadership and Management – review approach to leadership development across the Trust with recommendations for improvement. Develop people managers based on the NHS expectations of people managers so managers consistently support their people to fulfil their potential

Education and learning offer – develop a governance framework around Mandatory, Statutory, Role specific training and professional development. Review associated policies, processes and evaluation to improve effectiveness and impact. Build on and expand current approach to Apprenticeships

Appraisals – continuously improve our approach to improve the quality of conversations and effectiveness of appraisal. Consider use of NHS Scope for growth tool

Digital skills and technology - review our digital skill needs and the impact and opportunities of Artificial intelligence, machine learning and other technologies for our people and work

Working in partnership where doing so brings benefit for our patients.

Engagement and improvement

Key areas of focus 2024-2027

Staff experience – Co-create and deliver 'we said, we did' plans with teams to improve the voice of our people and improve levels of engagement and experience. Achieve high response rates to NHS staff survey. Consider complementary engagement/sentiment feedback including use of digital channels

Improvement – Seek continuous improvement of work and services on our journey to excellence. Support our people trained in quality improvement to showcase their work and develop greater impact of this work across the Trust. Scale improvement learning as part of our education and learning offer

Patient feedback – strengthen the line of sight to our people on how we can improve our communication and behaviours for patients. Listen to patients and further develop patient centered care approaches

Freedom to Speak Up – further develop FTSU arrangements to support our people to speak up and address issues raised

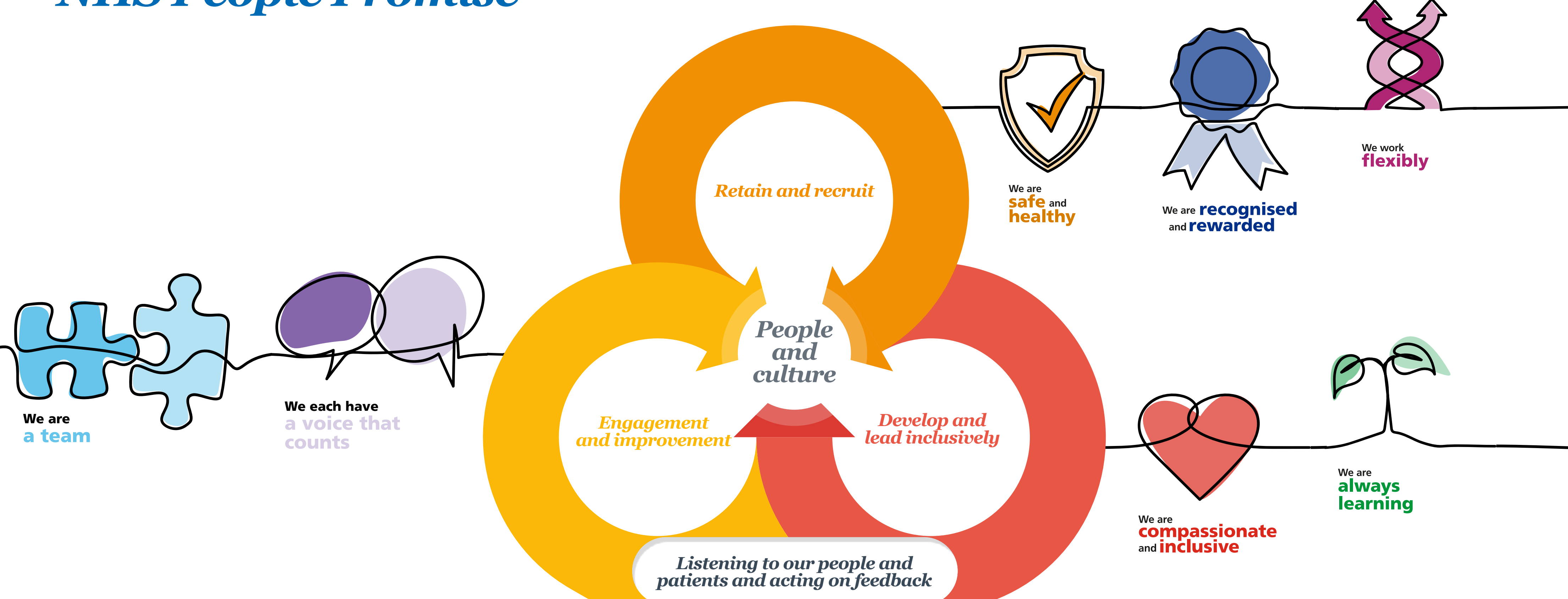
Engagement with key people partners – support staff networks to flourish (BAME, LGBTQ+, Disability) and develop champions across the organisation for key areas of support to people e.g. menopause champions. Build on strong relationships with local and regional Trade Union colleagues

Data, insight and intelligence – refresh people and culture performance reporting and improve integration with other sources of insight to support team Exemplar Accreditation. Prepare for ESR II implementation

People services – develop our people services with a new mandate, mission and model to support the delivery of this strategy. Review customer channels, policies and processes to support senior leaders, managers and all our people to deliver excellence

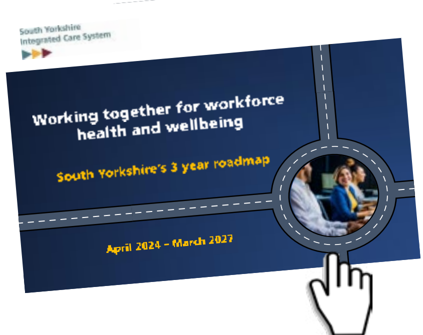
Working in partnership where doing so brings benefit for our patients.

People and Culture strategy and the NHS People Promise

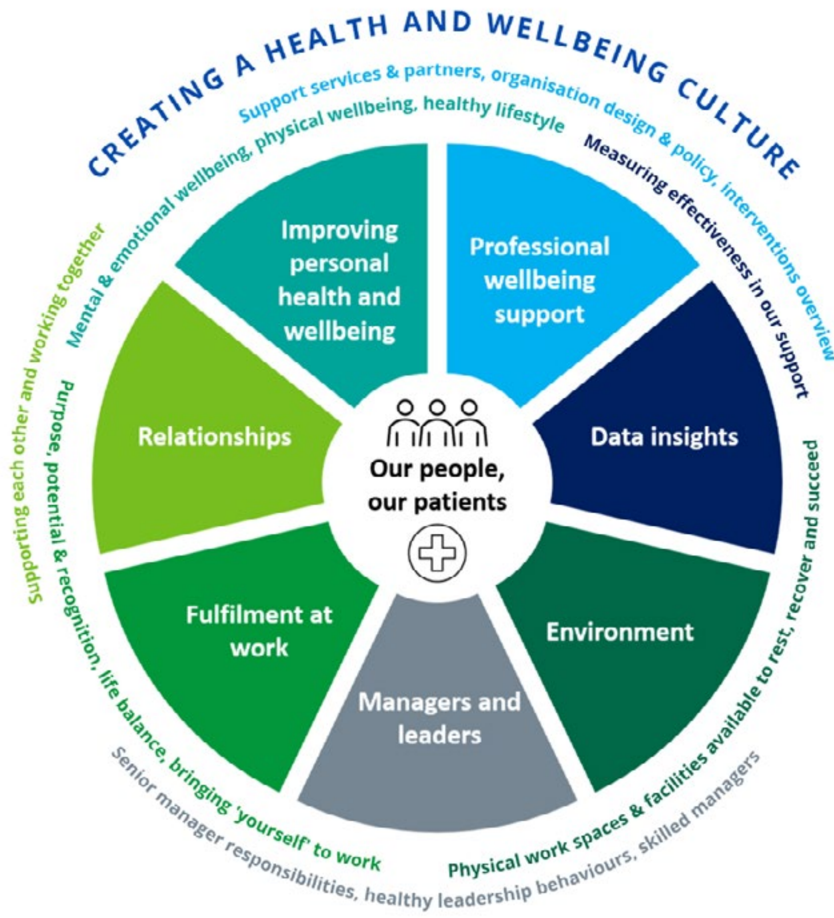


Health, Wellbeing and Attendance

A key area to support our people is our work on Health, Wellbeing and Attendance. We will use the NHS Health and Wellbeing Framework to guide our approach. In addition we have curated guidance and standards from the World Health Organisation (WHO), National Institute for Clinical Excellence (NICE) and International Organisation for Standardisation (ISO) to help ensure the psychological health & safety and mental wellbeing of our people. In keeping with these, we will implement actions that will: 'Prevent' exposure to psychosocial risks / risks to mental health at work; 'Protect & Promote' mental health and well-being at work; and provide 'Support' for staff when they need it.



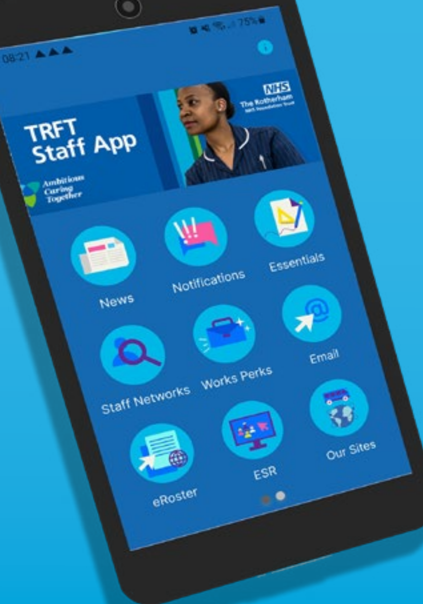
We are also proud to be part of the work across South Yorkshire *'Working together for workforce health and wellbeing - 3 year roadmap 2024-2027'*



NHS HWB Framework, NHS England

Graphic adapted by Carl Barnes, Occupational Psychologist, People Team, TRFT

Important aspects of our culture



The needs of our people

Achieve potential

- I can achieve my potential
- I inspire and support others
- I deliver excellent services and quality patient care

Esteem

- I do a great job
- I am recognised and valued
- I make improvement happen

Belonging

- I belong to an inclusive team
- I can develop and learn
- I am treated fairly as a unique individual

Safety and security

- I know my shifts at least 6 weeks in advance
- I have any reasonable adjustments in place and my wellbeing is supported
- I have the tools to do my job
- I know there is zero tolerance of bullying, violence, discrimination and harassment

Core needs

- I have access to; parking / transport options, lockers, toilets, decent food, water and wifi
- I know there are enough people on the shift, the temperature is ok, there are decent rest areas and I can take my break

Adapted from Dr Catherine Anderson, 2024

One of our new colleagues Dr Catherine Anderson has updated Maslow's hierarchy of needs for the 21st Century for TRFT. The idea behind the model is that as humans we have different types of need that we wish to have fulfilled - the headings in the model. The higher needs and outcomes begin to emerge when people feel the previous needs have been satisfied. For us all to achieve our potential we need to make sure that the needs of each level are met.

We have developed this further based on feedback from our people when creating this strategy and from the staff survey free text comments. We will use it to continue to improve our approaches to meeting the needs of our people across the Trust.

Delivery and Governance

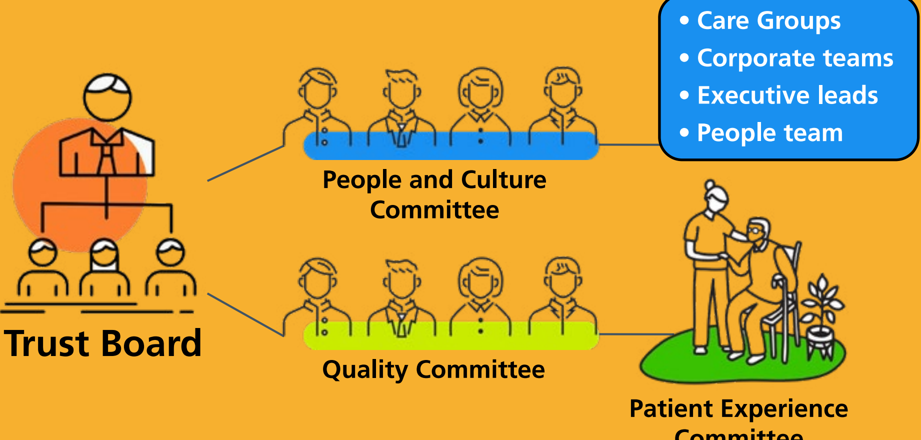
This strategy is designed to be delivered by senior leaders, people managers and all staff across the Trust, supported by the People team.

The main Trust governance oversight will be via the Trust People and Culture Committee, and the Board of Directors. The People and Culture committee will receive quarterly reports on the delivery of each year's o People and Culture priorities and 6 monthly reports on the overall delivery of our People and Culture strategy.

Care groups and corporate teams will present to the Committee at regular intervals in order to receive challenge and support to the achievement of their people and culture objectives including 'We said we did' plans.

Internal forums to support the delivery of this strategy will be reviewed and refreshed as necessary. Partnership working with Trade Union colleagues will continue to be a key feature of delivery across the Trust.

Retain and recruit, develop and lead inclusively, engagement and improvement will form the framework for delivery, encompassing all elements of the People Promise, morale and engagement.



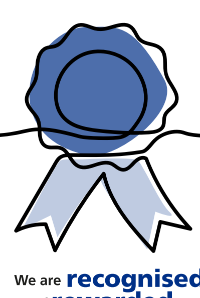
WATCH NOW

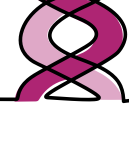
Dr Rumit Shah
Chair of People and Culture Committee

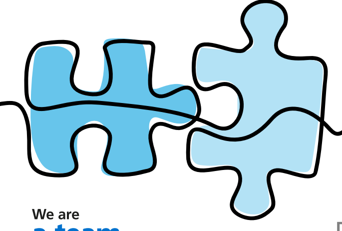
Implementing our strategy and measuring success

This strategy sets out a journey to excellence and we will report on and develop key metrics to measure our progress. We will measure excellence through benchmarking with appropriate comparator organisations and we intend for the achievements of the Trust to be recognised externally. Annual people and culture objectives and targets will be set as part of organisational priority setting. We will pay attention to the measures below covering key areas under retain and recruit, develop and lead inclusively and create engagement and improvement and our national/statutory reporting requirements.

Retain and recruit	*Develop and lead inclusively*	*Engagement and improvement*
Health, Wellbeing and Attendance	**Equality, Diversity and Inclusion**	**NHS Staff Survey**
1. Wellbeing themes from Model Health system based on staff survey and FTSU measures; Psychological safety, demands and resources, healthy working environment, stress and burnout, positive engagement 2. Attendance and sickness absence by type, duration and cost 3. Progress against HWB Framework measures 4. Take up of and effectiveness of health and wellbeing support	1. Workforce Race Equality standard, Workforce Disability Equality standard, Gender Pay Gap measures 2. Participation in staff networks and involvement of network in people and culture developments 3. Staff survey question relating to whether staff think the Trust respects individual differences	1. Overall staff engagement measure 2. Results for recommend the Trust as a place to work and receive treatment 3. Results for National Training Survey run by the General Medical Council
Key People Performance Indicators	**Developing our role as an Anchor organisation in Rotherham**	**Patient Experience and Engagement**
1. Overall MAST, Appraisal and Job Planning completion rates and effectiveness indicators 2. Retention and recruitment metrics including bank and agency utilisation 3. Flexibility metrics re rostering and role flexibility	1. Inspiring the next generation through work with schools and colleges and Skills Street 2. Providing opportunities for local people to fulfil their potential	1. Friends and family test recommendation score 2. Compliments and complaints relating to communication, attitudes and behaviours in line with Trust values 3. Relevant measures from patient experience improvement plan taken from patient surveys







Thank you

Thank you to everyone who contributed to the development of our People and Culture Strategy. From the project team and steering group that oversaw this work to everyone who engaged with it. To the Communications team for the photo and video work and graphic design.

On behalf of the Executive Team, thank you to our brilliant people for everything you do for patients in Rotherham.

Daniel Hartley
Director of People
March 2024

Public Board of Directors' Meeting

Agenda item	P73/24
Report	**FIRE SAFETY STRATEGY- 2024**
Executive Lead	Linda Martin/ Steve Hackett
Link with the BAF	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* 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.*
How does this paper support Trust Values	
Purpose	For decision X For assurance ☐ For information ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this document is to set down the strategy for fire safety within TRFT and how objectives for life safety and property protection are delivered at The Rotherham NHS Foundation Trust.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Authorised by the Health and Safety Committee and Trust Executive Committee
Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	This document will provide a high-level overview of the fire safety aspects of the fire engineering design that were and are incorporated into the buildings in its original and subsequent construction phases and the management fire safety procedures implemented with the day to day operation of the Trust.
Recommendations	It is recommended that the Board approve the enclosed strategy.
Appendices	Fire safety Strategy

THE ROTHERHAM NHS FOUNDATION TRUST

FIRE SAFETY STRATEGY

2024

Version:	3
Ratified by:	Health & Safety Committee
Date ratified	6 December 2023
Title/Name of Sponsor	Director of Estates and Facilities
Title/Name of originator/author	Fire Safety Advisor
Date issued	TBD
Review date	TBD
Target Audience	Trust Wide

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Document History Summary

Version	Date	Author	Status	Comment
1a	Oct 17	Trust Fire Safety Advisor	Initial Draft	
1	Feb 18	Trust Fire Safety Advisor	Final	
2a	Mar 20	Trust Fire Safety Advisor	Draft	Forwarded to Topic Lead for Triennial Review
2b	Oct 20	Trust Fire Safety Advisor	Draft	Document circulated for Health & Safety Committee review
2	Oct 20	Trust Fire Safety Advisor	Final	Document approved by Health & Safety Committee
3a	Jul 23	Trust Fire Safety Advisor	Draft	Forwarded to Topic Lead for Triennial Review
3b	Oct 23	Trust Fire Safety Advisor	Draft	Document circulated for Health & Safety Committee review
3	Nov 23	Trust Fire Safety Advisor	Approved	Document approved by Health & Safety Committee
3		Trust Fire Safety Advisor		Document submitted to the Executive Team Meeting for review.

1. INTRODUCTION

1.1 Purpose Statement

The purpose of this document is to set down the fire safety objectives and how these objectives for life safety and property protection are delivered at The Rotherham NHS Foundation Trust. A fire safety approach has been adopted in developing this fire strategy recognising the inter-relationship between treatment and non-treatment facilities, retail units, customer cafe area, and support services.

This document will provide a high-level overview of the fire safety aspects of the fire engineering design that were and are incorporated into the buildings in its original and subsequent construction phases and the management fire safety procedures implemented with the day to day operation of the Trust.

It is recognised that fire safety plays an important role in influencing building design. The development of fire safety objectives at an early stage of the design process and progressing throughout the project phases is to ensure the continuity of cohesion of fire safety design.

The fire safety strategy and design of The Rotherham NHS Foundation Trust reflects a multi-occupancy scenario. This document should be read in conjunction with the latest Fire Risk Assessments issued to all departments.

1.2 Description of Buildings

The Rotherham NHS Foundation Trust was originally constructed in 1977, the site consists of:

1.2.1 The Main Hospital

The Main Hospital phase 1, 2, 3 & 3b. This is a concrete framed building with concrete beam floors consisting of 5 levels with a central corridor on Levels A, B, C, and D the wards and departments lead off this central corridor. There are 4 junctions along the corridor Junction numbers 2 and 4 house the main lifts for the premises. Phase 1 of the building incorporates the main part of the Trust including outpatients and a large amount of the wards, phase 2 has more wards located with phase 3 having maternity, endoscopy and dermatology located within it. Phase 3b is a further extension which has wards and the urology outpatients located within it. The 5 levels are broken down as follows with departments and wards entrances at one of 4 junctions along the main corridor.

Level A

Junction 1: Wards A1, 2, 3, 4, Angiography & Cardiac Suites, Coronary Care & Clinical Engineering.

Junction 2: Sterile Services, Pharmacy Manufacturing, Pathology Clinical Chemistry, Medical Physics, Stores, Portering, Linen, Rooftop Restaurant. & Cardiac Device Suite.

Junction 3: Ward A5, A6 & A7, Photopheresis, Haematology & Immunology. Nutrition & Dietetics.

Junction 4: Children's Wards 1, 2 & 3, High Dependency Unit (Paediatrics) Children's Assessment Unit.

Level B

Junction 1: Urgent & Emergency Care Centre, Fracture Clinic, Orthopaedic, Clinical Decision Unit, Medical Admissions Ward B1, 2, & 3, Clinical Radiology, (X-Ray, Ultrasound, CT & MRI), AMU, ASU & SDEC.

Junction 2: Theatre Admissions Unit, Intensive Care Unit (ICU), High Dependency Unit (HDU) & Theatre Treatment Suite

Junction 3: Wards 4 5 & 6 Short Stay Unit, Surgical Assessment Unit, Delivery Suite, Operating Theatres.

Junction 4: Alternative Level of Care Wharncliffe Ward, Sitwell Ward, Ward B10 &11, Gynaecology, Pregnancy Advisory Service, Early Pregnancy Advisory Unit (EPAU), Special Care Baby Unit (SCBU).

Level C

Junction 1: Main Entrance, Main Outpatients, Pre-admission Centre, Orthodontic, Whiston Suite.

Junction 2: Medical Illustration, Breast Screening & Assessment Unit, Chatham Suite & Oral Maxillofacial Department.

Junction 3: Earl of Scarborough, Macmillan Suite, Physiotherapy, Occupational Therapy, Orthotics, Pharmacy Dispensary, Chaplain's Office, Chapel, Prayer Room, Sexual Health Services.

Junction 4: Endoscopy, Colposcopy, Fitzwilliam Ward, Children's Clinic & Day Surgery, Dermatology, Early Pregnancy Assessment Unit.

Level D

Junction 1: Medical Secretaries, Education Centre, Library & Diabetes Education and Resource Centre.

Junction 2: Volunteer Office, Cancer Services Dept., Community Ready Unit (Discharge lounge).

Junction 3: Earl of Scarborough Suite MDT Room, General Management, NHS Professionals, Estates & Facilities Department & Clinical Operations Hub.

Junction 4: Administration offices, Medical Secretaries, Darshane Unit Urology Outpatients, Mortuary, Stroke Unit & Moorgate Wing.

Level E

Administration offices

The main Hospital is served by 4 internal core escape staircases, one at junctions 1, 2, 3 and 4 with a further number of external escape staircases all of which are suitably protected, all staircases are numbered. The main use of the building is primarily for healthcare as defined within HTM 05-03 Part K, however there are also support services and offices within the building, these other occupancies also include, a retail outlet and cafe, a public and staff restaurant.

1.2.2 Well Being & Integrated Neurological Conditions Unit

This is a single storey building, brick built with a traditional tiled roof. It has a fire alarm system fitted which is part of the main Hospital system. This unit operates Monday to Friday 08:00 – 16:00. The fire alarm system is part of the Hospital main system.

1.2.3 New Greenoaks

A single storey brick built building with internal breeze blockwork and concrete floor with a traditional tiled roof. The use of this building is the Antenatal/Gynaecology Clinic. It is a day unit and operates between the hours of 08:00 – 18:00 Monday to Sunday. The fire alarm system is part of the Hospital main system.

1.2.4 Diaverum Renal Dialysis Unit

This is a single storey building constructed of brickwork with exterior grain effect insulated cladding & sloped insulated roof. It is a day unit that operates between 07:30 – 17:30 Monday to Friday. The fire alarm system is part of the main Hospital system.

1.2.5 Computer Centre

This is a single storey brick building with a tiled ridged roof. It is staffed 24 hours, seven days a week, 365 days a year for the provision of the hospital IT functions and equipment.

1.2.6 The Lodge

This is a two-storey building that is stone built with a traditional tiled roof. It houses the Security Department and has a stand-alone fire alarm system fitted. The building is manned 24 hours, seven days a week.

1.2.7 Residential Accommodation.

These are three separate residential blocks built in the 1970s consisting of three floors with a small basement plant room where the gas heating boilers are located – Derwent Court (56 flats), Loxley Court (41 flats) & Swale Court (50 flats).

Each building is constructed of external brickwork with internal blockwork and concrete floor separation with timber supported apex tiled roofs.

The fire alarm systems have recently been upgraded to comply with the current BS 5839 standards and have been connected to the main Hospital system.

1.3 Design Parameters

The fire safety provisions incorporated into the design are in accordance with the Building Regulations Requirements, Health Technical Memorandums and relevant British Standards as approved at each construction phase of the works. Any modifications that have been made to the property have continued to have these standards implemented as an integral part of the design specification requirements and statutory approval.

The fire safety of the complex is based on Fire Engineering principles and due to the size of the building some are unique to this facility. It is for this reason that plans for alterations or modifications are strictly controlled to ensure design principles are not breached.

2. COMPARTMENTATION & INTERNAL FIRE SPREAD

2.1 Compartmentation Strategy

The Health Technical Memorandum recommends that a building of this type and size needs to be compartmented using fire resisting construction to floors and walls.

The objectives of this are to:

- Prevent rapid fire spread which could trap occupants
- Reduce the chances of a fire becoming large
- Large fires represent a greater hazard to building occupants
- Reduce the fire threat to fire fighters and other persons in the immediate vicinity. To ensure that life safety and assets can be protected fire compartments have been constructed to limit the spread of fire within the building to separate the higher occupancy risk areas from the lower risks and contain any potential high fire loads. The compartmentation is designed to allow people to stay within the building should a fire break out by providing adequate fire separation between each designated area which will always have a safe route away from the fire and terminate to a place of ultimate safety.

2.2 Methods of Fire Rating

The fire resistance periods for compartmentation are based on complying with the requirements of the Health Technical Memorandums and Building Regulations as appropriate at each construction phase and subsequently other newer versions of the regulations have and are being applied where modifications have been made to the structure in recent times. Compliance with the recommendations of British Standards relating to structural fire precautions and fire safety installations are also applied. The compartment strategy is made up of two key elements: passive and active fire protection measures implemented by passive means of firewalls, fire doors, fire shutters, fire stopping, fire dampers and active by suppression systems, as follows:

- An in-situ concrete floor slab at floor levels with fire stopping at wall junctions.
- Fire resisting block work and stud partitions enclosing the wards and Hospital streets and sub-dividing it internally when required.
- Fire resisting timber doors in the compartment walls, fitted with either closers or electromagnetic hold-open devices as appropriate.
- Fire stopping is provided to all compartment wall junctions with external walls compartment floors, and also at opening reveals in fire-resisting partitions.
- Fire dampers are provided in ventilation ducts, where penetrations occur through fire rated partitions.

Minimum ratings for structure and fire doors to key areas are:

Area	Time (minutes)
Hospital Streets	60
Plant Areas	60
Electrical Rooms	60
Electrical Cupboards	30
Compartment Floors	60
Compartment Doors	60
Kitchens	30
Fire Fighting Shafts	60
Fire Fighting Stairs	60
Fire Doors Protected Lobby	30
Fire Doors Corridors	30
Glazing in fire structure	30/60

2.3 Internal Spread of Fire Linings

The interior wall and ceiling surfaces in a building can have a major influence on how fast a fire may develop. The restrictions contained in Health Technical Memorandums and Building Regulations are intended to prevent the spread of fire across such internal surfaces. It is recommended that where combustible wall and ceiling linings are proposed they satisfy the following classifications given in the relevant Health Technical Memorandum and Building Regulations, rooms - Class 1 Circulation spaces - Class 0. It is considered good fire safety practice to ensure that, where ever possible, all furniture, fixtures and fittings have low ignitability, are of limited combustibility, and do not give off noxious fumes if ignited. This is particularly applicable to circulation areas/spaces of the building.

3. STRUCTURAL FIRE PROTECTION

3.1 Statutory Requirements

The Trust is subject to control under the Regulatory Reform (Fire Safety) Order 2005 with the Chief Executive Officer for the Trust having the ultimate responsibility for compliance.

3.2 Fire Safety Design

The principle design is to protect the life risk within the building fire safety design which is organised around the fire growth and its resulting products of combustion, for example flame/heat and smoke/gas. The ease of generation and movement of these products is influenced by the counter-measures provided by the building structure. The effectiveness of the building fire safety systems determines the speed, quality, and paths of movement of those products of combustion.

3.3 Fire Growth

The simplest description of the fire growth process is to divide it into three fire regimes:

- pre-combustion
- smouldering combustion
- flaming combustion

Pre-combustion is considered the process of heating fuels to their ignition point, during which time vapours and particulates are released from the fuel.

Smouldering combustion is defined as glowing on the fuel surface and may or may not be related to the oxygen content in the vicinity of the smouldering process.

Flaming combustion is almost self-explanatory, in that the production of sufficient energy and fuel vapours in the combustible range is the condition that underlines and supports the presence of flame.

3.4 Fire Safety Objectives

The fire safety objectives are to determine the degree to which the property and its associated facilities protect the occupants, the structure, contents, continuity of operations and impact on the community. It is impossible to completely prevent the ignition of a fire in a building, therefore, the overall fire safety objective is when a building is designed to a standard it needs to be maintained to that benchmark, and any subsequent alterations, modifications or refurbishments are approved in a similar manner.

Structural fire protection measures to the Trust have been designed in accordance with the relevant Health Technical Memorandums and Building Regulations B1. This includes both passive and active fire protection measures. The building has been provided with the relevant level of fire rating to the structure during its construction and fit out phases. More detailed information can be obtained by referring to building plans and operating and maintenance manuals.

4. FIRE SAFETY SYSTEMS

4.1 Fire Alarm

FIRE ALARM SYSTEM (L1)

All of the Trust buildings have an automatic fire alarm system, smoke and heat detectors as required, with a series of break glass call points. The system is a Gent Vigilon analogue addressable with 17 main panels situated within the building. There are repeater panels and links from other fire alarm systems attached to the system also situated within the building. The repeater panels are only for information and the system cannot be silenced or reset from these panels. An actuation of the fire alarm system will also activate some of the smoke dampers within the affected zones in Phases 1, 2 & 3 along with shutting down relevant plant and air handling units as laid down within the Hospital's cause and effect fire alarm strategy. All external buildings apart from the Security Lodge are interfaced to the Trust fire alarm system, when these systems are operated it activates the panels within the Trust and also a red indication light within the switchboard department. There are Vigilon panels in both 4 loop and 6 loop versions. The 4 loop Vigilon has a self-contained power supply and battery standby for at least 24 hours and the 6 loop with external batteries will support a system for 72 hours in the event of mains and stand by generator power failure. The fire alarm when in "operational" mode is currently two stage alarm fire alarm system. The two stage alarm principle is approved by South Yorkshire Fire & Rescue Service and complies with Article 14 of the Regulatory Reform (Fire Safety) Order 2005.

Operation of the Fire Alarm System

The fire alarm system provided in the Trust will operate upon the actuation of a single automatic fire detector or upon the operation of a break glass call point device. The fire alarm will sound a continuous alarm within the zone where a device has activated and sound intermittently within all other areas within the main building to facilitate the phased evacuation procedure.

When the system is activated by either a heat, smoke or manual call point the message is shown on all the panels within the Trust including the repeater panels. On this activation the Switchboard team send a message out on the emergency bleep system to inform the Fire Response Team the location of the call. The subsequent activation of an automatic fire detector or manual call point within the building will result in the fire alarm returning to full fire mode. The fire alarm system can be reset when the stand down has been given by the Fire Safety Advisor or Clinical Site Manager (221 bleep) who is in charge of the Fire Response Team.

Example
A fire detector actuates on Level B within the x-ray department of the Trust. The fire alarm system operates immediately sounding continually within this department and intermittently in the remainder of the Trust. The occupants of the x-ray department first look for the fire, or if need be, begin to evacuate the department. All other departments send a member of staff to their nearest fire alarm panel then the panel closest to the incident send 4 members of staff to assist the department that has the continual alarm.

The fire alarm system is tested weekly, every Thursday morning 08:00 – 12:00 with the results of the test recorded within the Estates Department. The fire alarm contractor, Professional Fire Systems, carry out maintenance, repairs, commissioning and annual testing which is completed every week on a Wednesday between 08:00 – 16:30. Annual certificates are kept with the Estates Department.

4.2 Automatic Smoke Detection

The vast majority of the property is protected by an automatic fire detection system. All the devices are constantly monitored by the main fire alarm panel. The system is designed currently to operate the evacuation process and alert all Trust staff, patients and visitors that there is a possible fire within the building. The system is not connected to a call centre as there is 24-hour cover from the Fire Response Team and the Switchboard staff. Designers need to be aware that it is important to achieve an L1 standard as outlined in BS5839 on building design and refurbishment projects.

4.3 Automatic Suppression Systems

The main concourse area and all commercial premises on Level C are covered by a sprinkler deluge system, with associated tanks and pumps located off corridor at rear of commercial premises.

There are automatic FM200 fire suppression systems within the Computer Centre located near the staff car park, D Level Computer Server Room and the Telecommunication Switch Room within Switchboard. Access to these areas is controlled by the I.T. and Estates Departments.

4.4 Dry Risers and Wet Risers

There are dry and wet risers fitted within the Hospital at strategic areas in compliance with BS5306, the locations of the risers can be found on the fire strategy drawing.

4.5 Hose Reels

First aid fire-fighting hose reels throughout the Trust and any of the Trust premises have been removed. This is due to the legionella risk, and a view has been taken that the members of staff are not sufficiently trained or adequately equipped to use a hose reel as it is considered that this type of equipment should be used by fully trained fire fighters and not Trust staff. It is recommended by most UK fire services to remove hose reels and provide sufficient portable fire-fighting appliances.

4.6 First Aid Hand Operated Portable Fire Equipment

The majority of hand operated portable fire equipment provided are made up of water/ foam or CO_2, there should be no dry powder extinguishers within the main parts of the Trust or ancillary buildings other than plant room and workshop areas.

4.7 Smoke Control and Ventilation

Smoke control within the building is achieved by the means of fitting smoke seals to all fire doors which will also be an aid for fire-fighting activities; this will maintain clear smoke free zones outside of the area that is affected by fire. The primary objective of smoke control is to preserve the continuity of treatment and delay final evacuation, whilst providing an aid to Fire Service personnel in their fire-fighting activities. Controlled Fire Growth – each fire compartment is kept within the limits of those stated within the Health Technical Memorandum. Throughout all phases of the Trust there are some automatic smoke dampers within the air handling units. There are different types of dampers including fusible link and automatic ones that are connected to the fire alarm system. The fire alarm strategy incorporates the shutdown of some of the air supply systems for each area in the event of the fire alarm being activated. Details of all the damper systems and air handling units can be found within the Estates Department on Level B. Smoke Ventilation – smoke ventilation can only be achieved by means of natural ventilation. It should be noted that all of the staircases are provided with manually operated vents.

4.8 Lifts

There are a number of lifts in the Trust which are for patients, visitors and staff, these are not fire lifts. When the fire alarm operates in the lift junction areas all lifts stop on Level C. They are reset by the fire alarm being reset. There are also a number of goods lifts which are used for equipment, these lifts are not fire lifts.

5. MEANS OF ESCAPE

5.1 General Principles

A concrete framed building with fire doors protecting the escape routes and providing compartmentation as required within the Health Technical Memorandums.

5.2 Evacuation Strategy

There has been little change made to the fire escape strategy since it was constructed. However, as each new development has taken place the evacuation strategy for life safety has been key part of the approvals process.

5.3 Full Building Evacuation

In the unlikely event that the building requires a full evacuation this will be covered within the Rotherham NHS Foundation Trust Major Incident Procedures facilitated by a joint collaboration of all the emergency services and senior Trust officials.

5.4 Emergency Power Supplies

Primary and secondary power supplies are installed to serve life safety systems within the building. Secondary power for the Trust will emanate from backup generators located around the Trust in electrical sub-stations.

The locations for the electrical sub-stations and backup generators are as follows:

- Electrical sub-station A, opposite Moorgate entrance.
- Electrical sub-station B, next to Swale Court.
- Electrical sub-station C, near RDASH Woodlands.
- Electrical sub-station D and G, Estates yard B Level and staff red car park.
- Electrical sub-station E, main public car park.

The secondary power supply is tested and maintained on a regular basis by the Estates Department.

5.5 Emergency Lighting

The emergency lighting currently conforms to British Standard 5266 Part 1 and is currently under review with new emergency lights being fitted under a rolling programme carried out by the Estates Department. Whilst there are backup generators that will provide power to the lighting circuits should the primary power source fail, it should be understood that should the distribution panel fail or the electrical wiring fail then a battery backup system is essential to provide adequate lighting for the purposes of means of escape. The emergency lighting circuits should have a suitable means for testing as per British Standard 5266 Part 1 2005 paragraph 9.3.3. This is currently undertaken by the Estates Department who are adapting certificate type paperwork along with the testing. Also the Trust is placing self-testing

emergency lighting systems in departments which are linked to the building maintenance system.

5.6 Escape Route Signage

Fire exit signage is provided throughout the Trust showing the escape routes and fire exits. These are mounted over doors, ceilings and hung at strategic positions within the building and other escape routes from various locations within the Trust. Signage has generally been sized according to the predicted viewing distance and sited conspicuously in accordance with the Health Technical Memorandum recommendations. All signs meet the recommendations of BS 5499-4 Safety Signs.

5.7 Fire Doors Emergency Exits

Manually operated fire exit doors are either provided with break-glass emergency release devices, push pads, or crash bars. Some doors are also integrated with the Trust security systems which are designed to fail safe, where necessary, on the actuation of the fire alarm systems. Green emergency door release boxes are also fitted where required to enable the doors to be opened in the event of any technical failure of the systems.

5.8 Persons with disabilities/additional needs

Whilst the building is fully compliant for the evacuation of persons with additional needs, it should be noted that trained personnel are available to assist with their safe evacuation from the building. Where new developments are being carried out suitable safety features and systems are being adopted in line with BS 5588: Part 8, Equality Act 2010 and Building Regulations requirements. This is completed through the capital team within the Estates Department.

6. MANAGEMENT ROLES AND FIRE SAFETY PLAN

6.1 Duty of Care Responsibilities

The Trust has appointed responsible persons (Board of Directors and Chief Executive, supported by the Chief Operations Officer) to take control of such fire precautions and to ensure, as far as is reasonably practicable, the safety of any of their employees; and in relation to relevant persons who are not their employees, take such general fire precautions as may be reasonably required in the circumstances of the case to ensure the premises are safe. The responsible person as designated within the Trust's fire policy will make and give effect to such arrangements as are appropriate, having regards to the size of their undertaking and the nature of their activities, for the effective planning, organisation, control monitoring and review of the preventive and protective measures for life safety, property protection and duty of care that needs to be delivered for a safe and secure operation.

6.2 Responsible Persons (Board of Directors and Chief Executive)

The Responsible Person means a person who has control of the premises (as occupier or otherwise) in connection with the carrying on by their trade, business or other undertaking (for profit or not). This control may be delegated to the Fire Safety Manager (Director of Estates and Facilities).

The Fire Safety Manager and wider Estates team are responsible for the following:

- Obtain expert advice on fire legislation;
- An awareness of all fire safety features in their buildings;
- Obtain expert technical advice;
- Fire safety risks particular to the organisation;
- Requirements for mobility impaired patients, staff and visitors with regard fire procedures;
- Compliance with legislation, taking into account advice from the Fire Safety
- Advisor or instruction from the Fire Authority;
- Co-operation between employers where two or more share the premises;
- Monitoring and the mitigation of unwanted fire incidents;
- Liaison with enforcing authorities;
- Liaison with other managers and provide a link to Trust committees;
- Monitoring the inspection and maintenance of fire safety systems and equipment to ensure it is compliant;
- Review of identified risks in fire risk assessments and if necessary place on the Trust risk register;
- Ensure the day to day implementation of the fire safety policy;
- Provide support for the Fire Safety advisor.

6.3 Competent Person (Fire Safety Advisor)

The Responsible Person has appointed a Competent Person/s to assist them in undertaking the preventive and protective measures for the Trust. The competent person appointed is to comply with Article 18 of the Regulatory (Fire Safety) Order 2005. "This is a person deemed to be competent where having regard to the task they are required to perform and taking into account of the size of the hazards if the undertaking or establishment in which they undertake the work, possess sufficient training, experience and knowledge appropriate to the work undertaken".

6.4 Fire Risk Assessment

It is a requirement under Article 9 of the Regulatory Reform (Fire Safety) Order 2005 that the Trust carries out a Fire Risk Assessment of the premise and record any significant findings. The process of risk assessment is an on-going task that is constantly monitored and reviewed. This process is carried out by the Trust Fire Safety Advisor who works with all the department managers. The overall fire risk is covered within the Trust's Fire Policy and this document. Each individual area/department has a fire risk assessment carried out by the Fire Safety Advisor which is passed over to each manager. This is an on-going process which is monitored and audited by the Trust's Fire Safety Advisor.

6.5 Management Fire Safety Policy

The Fire Safety Policy sets out the approach to life safety and property fire protection and incident management planning within The Rotherham NHS Foundation Trust and has been prepared in accordance with the guidelines of the Regulatory Reform (Fire Safety) Order 2005 and the Health Technical Memorandums. The Trust presents many special problems in respect of life safety because of the large numbers of patients with various levels of ability and consciousness in a single building and the critical need to protect the operational function of the building against possible disruption. The primary purpose of the policy is the protection of life safety and also to protect the Trust and its contents against fire, to ensure compliance with all relevant statutory controls, and establish effective liaison with the local Fire and Rescue Service. To ensure that measures provided for fire safety are compatible with the operational needs of The Rotherham NHS Foundation Trust, so far as is practicable to make all staff aware of the importance of fire safety and ensure that they receive appropriate training at different levels, along with their duties, so that they can discharge their responsibilities effectively. To ensure that the required standards of fire safety in the buildings are regularly audited and inspected in line with the Fire Safety Policy so that it can be effectively managed to reduce the danger from fire to be as low as is reasonably practicable.

6.6 Maintenance of Fire Safety Equipment and Provisions

Estates and Procurement in conjunction with the Fire Safety Advisor via their preferred Service Partners have in place a planned inspection, maintenance and testing programme to ensure all fire protection systems are fit for service

and can operate effectively when required in an emergency situation. Arrangements and contracts are in place for competent staff and specialist contractors for maintenance to be carried out on all life safety and fire protection systems with records retained on site with the Estates Department.

6.7 Contractors and Service Partners on the Premises and Hot Works

Specialist contractors and service partners can present additional fire risk, as they may be unfamiliar with the premises and with the associated fire risks and fire precautions to be observed. This risk can be increased when they are carrying out hazardous tasks such as hot works and using substances that give off flammable vapours. The Estates Officers based on Level B have a process in place for the control of this function with a Permit to Work and hazardous risk assessment plan in place to safely control the operation. This comes in different types of Permits to Work including the Hot Works Permit. At times the Security Department will inspect areas which are being worked on out of normal hours or when a 7-day permit is issued. The Health & Safety Advisor and/or Estates & Facilities Health & Safety Co-ordinator audit these permits to ensure the standards are being followed.

6.8 Training

Staff are an integral part of the fire risk management process and the Trust has an excellent fire-training package in place for the training of all staff. This training is delivered by trainers who are employed by the Trust working for Estates and Facilities. The trainers make it clear at the start of every presentation that they are not fire safety advisors and cannot answer any technical questions regarding fire safety. Any questions are passed to the Fire Safety Advisor who returns the answer to the staff member who asked it. Training sessions are arranged by the trainers who carry out mandatory fire training to all staff twice a month and departments as and when required. The Fire Safety Advisor carries out training with Main Theatres, Intensive Care and High Dependency Units. All members of staff sign in on attendance and this paper work is sent to the Learning and Development Department. They place the information on to the ESR system and keep the training records up to date. Fire training is given to all members of staff on an annual basis.

6.9 Statutory Records

One of the essential elements that the Estates management need to be in control of is the holding of statutory records, keeping them up to date, (can be in manual or electronic form) and having them preferably readily available to any of the statutory enforcing bodies on request. These records should include:

- Fire Alarm System
- Automatic Detection
- Wet and Dry Risers
- Fire Fighting Equipment
- Emergency Lighting

- Emergency Generators
- Smoke Control Systems
- Fire Suppression Systems

Where changes are made to the building as a result of refurbishment or new projects floor plans will be reviewed and updated by the Estates Capital team.

6.10 Control of Substances Hazardous to Health (COSHH)

Substances hazardous to health have become a major importance to emergency response teams and need to be carefully controlled and managed to mitigate the risk to patients, visitors, employees, and Fire Service personnel who may have to deal with such an incident. Regardless of its size or nature, each COSHH incident can present a potential hostile environment. All COSHH substances are readily identified within the area stored and are satisfactorily controlled. Copies of the COSHH registers are held within the department and electronically – centrally on Alcumus SypoCMS which can be made quickly available to the Fire Service when they have to deal with an incident.

7. ACCESS AND FACILITIES FOR THE FIRE SERVICE

7.1 General

In a building of such size and complexity it is essential that means are provided and maintained to ensure the safe and unimpeded access for the Fire Service personnel at all levels with the building. In general, access facilities for the fire service are as recommended in HTM 05-02 Chapter 7.

7.2 Access

There are 6 main entrances to the Trust and each level has an exit to ground floor. These are:

- Level A – Entrance leading onto Oakwood Hall Drive.
- Level B – A&E
- Level C – Main Entrance & Maternity Entrance
- Level D – PGME & at Management/Executive Entrance
- Level E – Entrance to the Moorgate Wing

There are also a number of fire escape stairwells that can be used for access via the Security Department. These also house the dry risers that are located around the Trust. Upon arrival of the Fire Service, information relating to the fire location will be passed on initially by the Security team who will take the Fire Service Commander to the department that has the incident. On their arrival at the department a more detailed brief will be carried out by the Clinical Site Manager (221 Bleep) who is the responsible person for the incident. An assessment will then be made by the Fire Service Commander of the most suitable method of dealing with the incident. The corridors and staircases are fully fire protected in accordance with HTM 05-02.

7.3 Water Supplies

There is a 155mm main situated within the service roadways and strategically around the site. The meter point is near the bus stop on Baker Street. The main is a ring main with spurs coming off at points around the Trust. There are 31 dedicated hydrants around the site which are tested by the fire extinguisher contractor.

7.4 Fire Service Predetermined – Attendance

On receipt of an emergency call from the Hospital, the Fire Service have an agreed predetermined attendance to this Hospital which has been given a Class 'A' Category. The number of fire appliances to respond is 3 Fire Appliance Pumps.

8. COMMAND AND CONTROL

8.1 Contingency Planning

Contingency plans need to include preparation and response to a wide range of unusual events. This can include possible emergencies and incidents that include fire, communications, water, power supplies, weather, time of day, time of week, time of year, traffic issues and other unexpected/unplanned events. It is essential that when management prepare their contingency plans that these key elements are discussed and incorporated into the final plans as necessary. For this to be successful this needs buy in from service partners and concessionaires and they need to be kept up to date on each review of the plan and if any table top exercises are performed they need to be involved. This will be carried out in conjunction with the Emergency Planning & Business Resilience Manager for the Trust.

8.2 Incident Management Systems Operations

The Incident Management System Operations should be considered as the basic command control process to be used to deal with any size or kind of incident that may occur at the Trust. This process is covered in the Trust Major Incident Plan which members of the Trust Silver Command team operate from the Incident Control Centre within PGME. The Executive team would operate from the Board room (assuming neither of those locations were affected by the incident).

8.3 Command Organisation

For this management to be successful it is important to appoint a senior position from the management team as the Emergency Co-ordinator to set up Command and Control and liaise with the Fire Service. This person should report to the Senior Management Team. Ensure the Control Centre is available to the Emergency Services and is properly briefed and trained and coordinates the activities of the company and it service partners.

8.4 Fire Response Team

The building is served by a 24 hour, 7 day a week Fire Response Team; consisting of porters, Estates engineer, Security staff and a Clinical Site Manager (221 Bleep) who are all involved within the evacuation procedure should an actuation of the fire alarm take place, this is detailed within the Trust's Fire Safety Policy.

8.5 Re-entry into the Rotherham NHS Foundation Trust

Once the incident has been professionally acted upon and closed and the life safety and fire protection systems have been restored to their operational status, the Fire Response Team will stand down the incident and get people back to normality and into the building when designated safe by the Fire Service.

Board of Directors' Meeting
3rd May 2024

Agenda item	P74/24
Report	**Organisational Priorities 2023/24 – End of Year Report**
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 October 2023 to March 2024, namely: P1 Focus on the Quality of Care the Trust Provides P2 Improve Engagement with our Medical Colleagues P3 Supporting our People P4 Improve our Emergency Care Pathways to Deliver Faster Access to Care P5 Recover Elective Services P6 Work in Partnership to Deliver Efficient Services and a Trust that is fit for the Future 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 4). 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 the year, of the 30 key milestones due for completion across all six priorities and in accordance with the original mandates, 24 have delivered in full with 4 ranked as "red" significantly off track and 2 ranked as "amber" off track.

	The milestones RAG-rated red relate to Priority 4 - Achievement of the 76% national four hour standard and P6 - The proposal to develop a Research and Development partnership arrangement with Barnsley; the completion of the review into small corporate teams and the completion of the full EPR business case. Details relating to the delays in completion by the end of March are reported in Appendix 1. The milestones RAG-rated amber relate to P1 - Delivery of the Quality Improvement Plan and P3 - The Refreshed People Strategy. Both documents were completed on time, however an internal decision was taken in favour of joint publication in the new financial year and as such is not regarded as significantly off track. Details on all exceptions and mitigation along with Assurance Committee comments and decisions can be found on pages 8 to 15 of this report. At the end of March 2024, out of the 30 risks and issues identified during delivery of the programmes, 13 of these 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 in the highlight reports at Appendix 1 and in the body of this report. During the six months ending March 2024 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 or delivery plans 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 – January to March 2024

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 six months ending March 2024 and reports by exception any areas of concern.

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 April 2024 the Board Assurance Committees considered reports on progress made in all of their associated areas during the final three months of the year ending March 2024 and confirmed their assurance on progress and delivery. A high level summary of achievements made during Quarter 3 and Quarter 4 is supplied in the tables below.

Priority Title	Achievements Q3 – Q4 - Summary
Focus on the Quality of Care the Trust Provides	**Quality Priorities** • All quality priorities aligned to patient safety have delivered within agreed timescales. The sepsis work will continue into 2024/25 along with a planned audit programme that will be implemented in conjunction with the clinical effectiveness team • The Trust position (through patient audits e.g. tendable has maintained greater than 90% across all elements showing improvements in care • Quality Governance and Assurance structure agreed (milestone completed ahead of plan)

Priority Title	Achievements Q3 – Q4 - Summary
	Patient Safety Incident Response Framework (PSIRF): • PSIRF (Patient Safety Incident Response Framework) is fully implemented across the trust • Level 1 is greater than 90% compliant. Level 2 has been published by NHS England and has been implemented into job profiles in staff records **Quality, Service Improvement and Re-design (QSIR)** • Band 5 Quality Improvement Facilitator and Band 7 Quality Improvement Practitioner appointed • Quality Improvement Strategy has been completed with a plan to launch with the People Strategy (early 2024) • Improvement Learning South Yorkshire will be launched as of 1st April 2024 • 100+ QSIR practitioners have completed training since the programme began in 2022-23 • Health Foundation and NHS Impact self assessments completed. The gap analysis has formed the basis of the QI strategy and plan.
Improve Engagement with our Medical Colleagues	• Medical Engagement Road Map implemented • First cohort for the new Consultants and SAS Doctors development programme completed in September and was evaluated in October 2023 • New medical leadership appointments include a new SAS (specialty and specialist doctors) Advocate, CESR (Certificate of Eligibility for Specialist Registration) lead and SAS tutors. The doctors in these new roles will support the wider development needs of our SAS doctors along with a new SAS Forum. • The International Medical Graduates (IMG) Working Group is in place to support retention of junior doctors from overseas • Successful and well attended Joint clinical leads event held with Barnsley in February • Job Planning Policy developed • Autonomous Practice Policy developed • National Staff Survey Results indicate an improvement in both measures of success assigned to the priority relating to staff perception that care is the trusts number 1 priority and that friends and relatives would be happy with the standard of care provided by the trust.

Priority Title	Achievements Q3 – Q4 - Summary
Supporting our People	• The response to the national staff survey 2023 is 67%. This is significant and the highest ever for the trust. It is also well above the national average of 46%. Also noted is the improved performance across the "advocacy and engagement" questions. Rotherham has been identified as one of the most improved organisations in England on a number of measures. Divisional action plans are in place and will follow a "We said, We did" format. • Following staff experience feedback last year a new Staff App was launched at the beginning of December to provide colleagues with useful information and updates at their finger tips • The joint leadership programme with Barnsley launched on 10th November. The joint clinical leads development programme, also with Barnsley, launched on 6th February. • Workforce plans have been developed for UECC, Medical SDEC and Theatres utilizing a new, standard template which will be rolled out across the trust • Turnover, sickness absence and vacancy rates have achieved year end targets despite the risks identified in the Risks and Issues log relating to the impact of industrial action. Albeit sickness absence remains higher than pre-pandemic levels which were below 5% • 20 Matrons started their Matron Development Course (as commissioned through Florence Nightingale resources) • Cohort 2 of Band 6 and Band 7 nurses started their Clinical Leadership Programme (10 nurses) • 12 Healthcare Support workers have completed their Florence Nightingale training • Over 40 new graduates started on the new preceptorship programme • 8 new areas have commenced team e-rostering • A Cultural celebration event was held in October which was very well attended • 50% reduction in nursing and support staff leaver rates sustained over a 12 month period (bands 2 – 8d) • Shortlisted for Nursing Times Award in November
Improve our Emergency Care Pathways to deliver faster access to care	• The Full Capacity Protocol, Escalation Policy and On Call handbook has been reviewed and amended. Key changes are around use of the community ready unit and the use of areas on appropriate wards. Changes have also been made to the escalation policy and on call handbook for escalation. • New OPEL(Operational Pressures Escalation Levels) framework is live and reporting SCC (system control centres). • Acute Care Standards completed along with Who goes Where • Directory of Services completed for Medicine, Surgery and Family Health urgent care services • A new "White Clinic" has been introduced to support the surgery same day emergency care pathway work in relation to orthopaedics and fracture clinic. • An acute respiratory hub delivered through the GP federation went live in December. The community virtual ward team are working with the community specialist respiratory teams to develop the ARI (Acute Respiratory Infection) virtual ward pathway. This work mirrors the national predictions for covid/flu. • Medical SDEC (same day emergency care) extended hours consultation has ended with a twilight shift being put into place starting at 5pm. • Transfer of Care Hub launched in October • RMBC commissioned Home from Hospital service (home care to support hospital discharge when re-ablement resource not initially

Priority Title	Achievements Q3 – Q4 - Summary
	available) launched 16th November and is well utilised, supporting earlier discharge. • More than 400 patients have been supported by community in reach for admission avoidance and early discharge home since April. • 236 patient assessments in the community supported by therapy D2A since launch in May • Place wheel live testing completed, ready to roll out for further testing with stakeholder. • UECC - good response rates to Friends and Family Test questionnaires with an average 87.4% positive responses. The service also regularly receives cards/letters/emails from patients that describe the service as “wonderful, supportive, professional and friendly and communication with patients is excellent”. • Heart failure, hypertension and headache pathways now in place. • Workforce plans completed for UEC and Medical SDEC utilising the new trust template • Continuing to see good response rates to the Friends and Family Test questionnaires with an average 87.4% positive result. The service also received 16 cards/letters/emails from patients that described the service as “wonderful, supportive, professional and friendly and communication with patients is excellent”. • Rotherham Place Partnership plans developed for Ambulatory Emergency Care and Frailty pathways as well as Respiratory and Diabetes. Executive leads and SRO’s assigned.
Recover Elective Services	**Outpatient Modernisation and Improvement** • Text message functionality in place to fill short notice clinic cancellations • Patient Initiated Follow ups (PIFU) assigned to Dermatology, Gastroenterology, Diabetes, Endocrine and HCOP • ECG staff nurse training in place. Room allocated to provide better space to take measurements and privacy for patients who may wish to discuss safeguarding or other private matters. Patients transferred to Community Ready Hub after their ECG. • Improvements in data is providing a breakdown of clinic utilisation by capacity type which gives services better insight into utilisation losses and where clinics could be converted to support elective recovery • Process for letters to be generated by the Contact Centre based on information provided by the consultant at triage is progressing well. Once the process is widely established, consultants will no longer need to dictate a letter back to the GP when a referral is declined. • Divisional PTL meetings have been implemented to support operational management of waiting lists, which feed into the newly established Trust Wide Access Meeting to provide oversight and assurance. **Theatres Transformation Programme (TTP)** • Process map and SOP developed for electronic triage (pre-operative). • Booking tool for theatre lists developed and signed-off by governance • Scheduling and validating guidelines developed.. • Theatre Flow SOP developed and Theatre Flow Co-ordinator role recruited – due to start June 2024 • E-Roster go live in February for nursing, support staff and Allied Health Professionals

Priority Title	Achievements Q3 – Q4 - Summary
	• Electronic team brief to support patient safety and clinical governance in place • Decluttering theatre street and corridor areas resulted in 38 obsolete pieces of equipment being sent to auction in February. • Successful bid secured by Procurement for external funding to support a new Inventory Management System which will prioritise theatres for implementation. **Cancer Improvement Programme** • Cancer Improvement programme manager and cancer improvement officer both recruited and will be in post by January 2024. Recruitment in progress for two further cancer improvement officers. • Bid for GRAIL (NHS Galeri trial) funding submitted and awaiting outcome from national team. (Galeri – revolutionary blood test to detect early stages of cancer). • Cancer services has been centralized, reporting to the Associate Director of Operations • Cancer Strategy in development and new Cancer Governance and Business Meetings in place to strengthen quality and performance • Engagement sessions and improvement workshops held with Urology and Lung services. Target opportunities identified in Lower Gastro-intestinal (LGI), Urology and Skin Cancer Pathways • Cancer PTL meetings have been implemented to support operational management of waiting lists, which feed into the newly established Trust Wide Access Meeting to provide oversight and assurance.
Work in Partnership to Deliver Efficient Services and a Trust that is fit for the future	**Haematology Programme** • A Combined Inpatient Model (with Barnsley) proposal has been developed and is supported by the Joint Executive Team. The proposal is subject to guidance around any public consultation requirements being clarified and then managed. **Medical staffing responsibility payments:** • New job planning policy in place along with an agreed Job Planning Framework. Job Planning Assurance Groups are also scheduled throughout the year to act as a consistency check and ensure job plans are equitable. • The job planning year ending 31st March 2024 stands at 68% which is a significant increase on the previous year of 28%. The focus will now be on initiating the 2024/25 job planning round and ensuring that we get to 90% or above in terms of sign off. **Trust wide Efficiency Programme** • The 2023/24 target was £12.176m at M9 (December) the FOT was £10,573k, which was 86.83% of target (81.67% risk adjusted) and the FYE Recurrent is £7,871k, which was 64.65% of target (60.36% risk adjusted). At M12 (March) / year-end the Final Outturn was £11,018k, which is 90.49% of target and the FYE Recurrent was £7,532k, which is 61.86% of target, and also represents 68.36% of the total CIP (cost improvement plan) delivered

2.3 The Highlight reports attached at Appendix 1 confirm the status of the six priorities for the three month period ending March 2024. An overview of the exception reports submitted to Board Assurance Committees in April is provided below, along with the subsequent confirmation of assurance in terms of process and/or delivery and any agreed recommendations, actions and decisions.

3.0 Quality Committee

3.1 All key areas of focus aligned to this priority made significant progress during the period January to March 2024 with all nine Quality Priorities completed in accordance with plan.

3.2 Delays due to limited capacity to support delivery of Quality and Service Improvement/Re-design projects this year has made it difficult to measure the effectiveness of local improvements and the impact that these are having on patient care. As a result of this the associated metric relating to "impact on patients based on QSIR projects" will be monitored into 2024-25 by the QI team now that the team structure is confirmed and new roles at Band 7 and Band 5 have been appointed.

3.3 Pulse survey results have not been published at the end of Q4 therefore the associated metric is not available. The results reported through the national staff survey (2023) have, however improved in the same or similar domains relating to advocacy, involvement and engagement, namely:-

- Opportunities to show initiative in my role
- Able to make improvements happen in my work
- Felt my role makes a difference to patients
- Care of patients/service users is the organisation's top priority

These results are a clear indication that staff are keen to get more involved in quality improvement initiatives and this is further confirmed by the number of participants that have already completed QSIR practitioner training this year.

3.4 The decision was taken to align the implementation of the QI Plan with the launch of the People Strategy 2024/25 therefore this is the only milestone assigned to the priority that has not fully completed by the end of March, however, the QI plan itself is ready for launch.

3.5 All risks and issues to delivery assigned to this priority have been closed.

3.6 This final highlight report for 2023-24 (Appendix 1) confirms that the objectives set out in the original mandate have been met and as such the trust is taking significant steps towards it becoming a QI led organisation.

3.7 The Quality Committee discussed the Quarter 4 highlight report in relation to **Priority 1 – Focus on the Quality of Care that the Trust Provides** at their meeting held on 24th April 2024 and whilst the Committee was assured on the report, it was confirmed that there will be a formal round up of the 2023-24 Quality Priorities at the Quality Committee meeting in May 2024.

4.0 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 19th April 2024. The report confirmed that significant progress has been made during the period January to March 2024.

4.1 P2 Improve Engagement with our Medical Colleagues

Of particular note regarding this project is the work that has been completed during the period January to March to consolidate engagement activity relating to SAS (specialty and specialist) doctors which has culminated in the establishment of the SAS Forum, chaired by the trust's SAS Advocate. The Autonomous Practice Policy has also been developed, and, building on the success of last year's SAS development Day the trust is now looking to host a regional development day in 2024 which is highly commendable.

The Medical Engagement Road Map for 2024-25 will focus on the results of the 2023 national staff survey which has already published improvements in the two key areas aligned to this work which are advocacy and engagement. The results of the local Pulse survey are not available at the end of March, therefore the associated metric referenced in the original mandate has been closed.

The Medical Engagement Road Map for 2024-25 is now in development and is due to be presented at the Executive Team meeting by the end of May 2024.

Areas of concern to delivery of the overall aims of this priority at the end of 2023-24 related to the following:-

After delays caused by industrial action earlier in the year, the joint Clinical Leads event with Barnsley went ahead in February as planned and was a resounding success. The threat of industrial action will however remain in place for the foreseeable future as junior doctors now have a renewed mandate for strike action in place for the next six months. The associated risk relating to industrial action is therefore closed for the purpose of this project as it has not significantly impacted on overall milestone delivery.

4.2 P2 Supporting our People

The People and Culture Strategy was prepared and ready for presentation and approval for People Committee in April and Trust Board of Directors in May in line with the delivery plan agreed at Executive Team meeting in November to enable sufficient engagement to take place over Winter.

Areas of concern to delivery of the overall aims of this priority at the end of 2023-24 related to the following:-

Due to capacity constraints and site pressures it became necessary to put specific arrangements into place in order to complete the Workforce Plans for UECC and Medical SDEC by the end of March.
The Workforce Development focus group, aligned to the Acute Care Transformation Programme 2023-24, was tasked with initiating and then supporting the planning

process utilising a newly developed workforce planning template. The template has proven to be effective and will form the basis of future workforce planning work.

Results relating to sickness absence and turnover have ended in a positive position at the end of the year despite the risk that industrial action would otherwise impact on staff engagement and retention as well as staff health and wellbeing, particularly due to stress.

4.3 For both Priority 2 and Priority 3 the People Committee were assured at their meeting on 19th April by the work completed to date.

5.0 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 24th April 2024.

All key areas of focus aligned to the three priorities have made good progress in the final three months of the financial year ending March 2024 despite relentless operational pressures as well as from the impact of industrial action, particularly on delivery of the 4 hour standard.

Areas of concern to delivery of the overall aims of each of the three programmes at the end of 2023-24 related to the following:-

5.1 Priority 4 – Improve our Emergency Care Pathways to deliver faster access to Care

Industrial action and prolonged site pressures have impacted on capacity to drive transformational change and progress has therefore slowed down in some areas particularly around clinical pathway reviews, digital patient flow/live bed status and the finalisation of workforce plans for UEC and Medical SDEC. Working groups have been set up to support the work streams and learning from these and the ACT Steering Group meetings which have been held monthly will help inform 2024/25 programmes of work.

There have been further demands placed on the trust to achieve 76% 4 hour performance in March. The weekly 4 hour Performance meetings have therefore continued with regular updates to the national team on a daily basis as required. The gravity of this task has asserted greater pressure on services that are striving to progress changes that will provide better care for our patients. Constraints relating to the estate still exist, particularly in relation to provision of ring-fenced SDEC capacity.

In the community setting, discharging and patient flow has seen delays due to concerns around safe staffing levels and infection control which has deflected resource away from planned changes and reduced support capacity. This resulted in contingency plans being activated for pathway 2 community beds.

However, the Transfer of Care Hub has now been established with pathway 1 and 2 community partners joining discharge board rounds to identify capacity and allocate discharges earlier in the day. An MDT is held daily for complex cases and a daily review of pathways zero “no criteria to reside” patients is now in place.

A community-led long length of stay meeting is also up and running and held twice weekly to support improvements in flow.

At the start of the year, six work streams were developed as part of the Acute Care Transformation Programme (ACT - 4 hour standard). Delivery of the work streams was assigned to the Acute Care Transformation Steering Group. The work streams included:- 1. Operational capacity and escalation, 2. Urgent Care Pathways, 3. UEC Ways of Working, 4. Workforce Development, 5. Re-introduction of the 4 hour standard, 6. Patient Experience.

In November the ACT Steering Group approved closure due to completion of work stream 5 Re-introduction of the 4 hour standard as its primary purpose was to ensure that essential reporting mechanisms were in place, including a newly developed dashboard, and to make preparations for the introduction of the new (ECDS) Emergency Care Data Set version 4. ECDS version 4 is now progressing through a new work stream 7. Digital, introduced in January 2024 which also incorporates activity around "digital patient experience" and progressing improvements in technology, systems and processes in UEC.

At the end of February 2024 the ACT Steering Group considered work stream closure requests for three further work streams to be stepped down by the end of March, namely Operational capacity and Escalation, Ways of Working and Patient Experience. All associated milestones and key tasks have been completed and consideration has been given to the movement of any remaining tasks and activities into the 2024/25 ACT Programme or to be transitioned to business as usual status.

Of the seven risks to delivery identified against this programme at the start of 2023-24, four remain in place at the end of March and will transition into plans for ACT 2024/25, namely:-

- Operational pressures including industrial action
- Medical Same Day Emergency Care (SDEC) is used for beds during escalation periods
- Lack of availability of Surgical SDEC trollies
- UECC is used as a default location for all urgent care needs

With the exception of three key tasks relating to the Workforce Development work stream and the remaining milestone (2023-24) assigned to the new Digital work stream, all other milestones have been completed.

5.2 Priority 5 – Recover Elective Services

Theatres

The Theatres Transformation Steering Group meets every month to progress the six work streams which form part of the 2023-24 Theatres Transformation Programme (TTP), namely, 1. Preparing Patients for Surgery, 2. Optimising Theatre Lists through Planning, 3. Maximising Utilisation on the Day, 4. Workforce Development, 5. Patient Safety & Clinical Governance, 6. Managing Equipment & the Environment.

There have been ongoing concerns around delays in commencing electronic triage (pre-operative stage) and the development and implementation of the new patient booking tool (optimising theatre lists). Actions are in place to progress the initiatives but as staffing issues persist and competing demands within scheduling teams appear to be ongoing, this work will continue into 2024-25.

A new Theatre Flow standard operating procedure has been developed to ensure that sessions start on time (theatre optimisation), however, the procedure has not yet been fully signed off. The Theatres and Anaesthetics teams are working through the various issues highlighted through staff feedback and a new Patient Flow Co-ordinator role has been appointed to join the team in June 2024 to support the new processes and new ways of working.

Following the roll out of e-roster for nursing and allied health professionals (workforce development) in February, work is now being carried out to iron out initial snags that have been identified. The number of vacancies within the allied health professionals and nursing team remains an ongoing challenge, largely due to a national shortage of qualified practitioners. A workforce plan is being developed to continue the work into 2024-25.

Due diligence processes are now in place to ensure that obsolete equipment that has typically cluttered the theatre environment is disposed of safely and with potential to obtain revenue from sale at auction. There is more work to do in 2024-25 to create more space and declutter the area in the advent of the new Inventory Management System installation which will require dedicated space to centralise storage of theatre consumables. An operational partnership group has been set up to progress the implementation of the system in Theatres by August 2024 with end user training and engagement pre-requisite to successful roll out and positive user experience.

Of the thirty-six risks to delivery identified against this programme at the start of 2023-24, five remain in place at the end of March. These will transition into plans for 2024/25, namely:-

- Staffing levels – allied health professionals and nursing
- Activity levels restricting release of staff for training
- Staff eligible for retirement
- National vacancy and skill shortage around allied health professionals and nursing staff
- Stores processes reliant on individual local knowledge

With regards to the status of the milestone delivery plan for this programme it is noted that of the original fifty key tasks identified, seven have ended the year off track from their original timeline but are expected to complete within Q1 of 2024-25. Five key tasks have ended the year significantly off track and will transition into plans for 2024-25 with renewed timescales.

A programme of work is in development for 2024-25 that will encompass the NHS Further Faster guidance that has been published to support trusts in their elective recovery work and ensure efficient pathways are in place. Further Faster checklists have been completed to support the work.

Outpatients

Outpatient clinic utilisation performance has been significantly off track during the three months ending March 2024 despite a number of improvement initiatives being put into place this year to improve performance.

Insight into clinic utilisation losses and where clinics could be converted to support elective recovery is, however, improving as services now receive a breakdown of clinic utilisation and capacity to inform decision making. Medicine have started weekly drop in sessions to discuss priorities for the week ahead and work is ongoing to reduce the time taken for consultants to dictate GP letters and with support from the Contact Centre, letters are being generated on information provided by the consultant at triage. These initiatives will free up time for consultants to optimise their time with patients.

Seven risks and issues were identified against this programme at the start of 2023-24, two remain outstanding at the end of March. These will transition into plans for elective recovery 2024/25 as appropriate:-

- Power BI outpatients App – requires health informatics capacity to progress
- Outpatient Clinic Capacity – can only run if physical space and staff available

With regards to the status of the milestone delivery plan for this programme it is noted that of the original forty-seven key tasks identified, ten have ended the year off track from their original timeline and one has ended the year significantly off track. Outstanding tasks will therefore transition into plans for 2024-25 with a renewed timescale.

As in Theatres, a programme of work is in development for 2024-25 for Outpatients that will encompass the NHS Further Faster guidance that has been published to support trusts in their elective recovery work and ensure efficient pathways are in place. Further Faster checklists have been completed to support the work.

Cancer

The delay reported in delivering the Cancer Urology pathway workshop due to awaiting recruitment of the cancer service improvement team, has not prevented the delivery of targeted pieces of work around re-engagement across the cancer pathways including a Urology and Lung improvement workshop being delivered. Nine cancer pathways have also been reviewed in accordance with Best Practice timed pathways as well as Good News Clinics being introduced to support patients being informed of non-cancer diagnosis.

Cancer Services team staffing issues resulting in tracking delays is now being mitigated via a restructure and cancer improvement work will continue at pace into 2024-25, pending the commencement of a second Cancer Improvement Officer in April 2024.

5.3 **Priority 6** : **Work in Partnership to deliver efficient services and a trust that is Fit for the future**

This priority has focussed on clinical, operational and financial objectives as well as the development of the trusts relationship with Barnsley.

Of the six key milestones assigned to this priority, two have not been delivered in accordance with timelines agreed in the original mandate. Details provided below.

At the start of the year an opportunity to form a collaborative R&D partnership had been presented and discussions have taken place during the year to progress the initiative, however, due to more pressing priorities elsewhere in the Medical Director's portfolio which also require joint working the decision was taken not to proceed. The milestone assigned to this activity is therefore closed.

The opportunity to deliver operational efficiencies within corporate teams started with an initial deep dive and high level comparison of structures across Rotherham and Barnsley trusts. Whilst the review has completed the milestone assigned to this piece of work in relation to a joint review, discussions will continue into 2024-25 in order to allow Executive Directors from both trusts to agree on next steps and learn from each other around ways of working to generate efficiencies.

There has been a delay in delivering the milestone assigned to completion of the full EPR business case due to the ICS request to review the risks and benefits to a system-wide EPR implementation and have subsequently commissioned a more detailed cost analysis. The Acute Federation Chief Executives and CIOs will continue to meet monthly during 2024-25 to progress proposed convergence plans.

The trust financial position which is reported separately to Efficiency Board and Finance and Performance Committee can also be found on Appendix 1 in the Priority 6 Highlight Report noting that the efficiency target is significantly off track at the end of March 2024. The variance from financial plan has recovered in March due to the ICB reimbursement of expenditure incurred on account of industrial action earlier in the year.

The risks and issues assigned to this priority relate to ongoing challenges around cost improvement delivery some of which are linked to increased costs in pay and the impact that industrial action has had on financial performance. It was acknowledged that by Month 10 cost improvement opportunities to increase the forecast outturn were limited but the risk to identified schemes not delivering cost savings was low.

Plans are in development to pursue specific, high impact cost saving and income generative schemes in 2024-25 through a new two-year "Back to Balance" programme which will further develop joint operational efficiencies and partnership working as well as achieve productivity and activity (financial targets).

At their meeting on 24th April 2024, the Finance and Performance Committee discussed the quarter 4 updates on Priorities 4, 5 and 6.

Their discussion also focussed on what had been learned during the last twelve months and in particular what has been done to support Theatres in 2024-25. Reference was made to there being two big pieces of work that would have high impact if implemented properly, namely e-rostering and the new booking tool.

The Finance and Performance Committee were assured by the update.

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

Michael Wright
Deputy Chief Executive
April 2024

OPERATIONAL PRIORITIES 2023-24

APPENDIX 1: HIGHLIGHT REPORTS – JANUARY TO MARCH 2024

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

P1 - FOCUS ON THE QUALITY OF CARE THE TRUST PROVIDES (JANUARY – MARCH 2024) – 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, Jo Beahan, Medical Director 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 4 2023-24		
			Jan	Feb	Mar
PSIRF Implementation targets met	100%	Actual	100%	100%	100%
		Target	100%	100%	100%
Quality Priorities Metrics met	100%	Actual	100%	100%	100%
		Target	100%	100%	100%
Positive impact on patients based on QSIR projects completed – Year end metric					
Pulse survey results (advocacy/motivation/involvement/engagement) Year end metric					
Trust wide average scores are greater than 90% for each Tendable audit (showing improvements in care) Year end metric			>90%	>90%	>90%

MILESTONE(S)	Jan	Feb	Mar
Delivery of the QI plan			

New Risks & Issues

None

Highlights

What have we achieved?

Quality Priorities:

- All quality priorities aligned to patient safety have delivered within agreed timescales. The sepsis work will continue into 2024/25 along with a planned audit programme that will be implemented in conjunction with the clinical effectiveness team
- We are continuing the use of tendable for monitoring assurance, however, audit collection and data is now encouraged via the AMAT system. The Trust position has maintained greater than 90% across all elements showing improvements in care

Patient Safety Incident Response Framework (PSIRF):

- Milestone achieved - PSIRF framework is fully implemented across the organization
- 360 assurance has also been completed alongside the implementation of PSIRF and all actions delivered. One risk to delivery remains, however, around the patient safety partner role however this is reflected throughout the NHS and is identified on the local risk register

Quality, Service Improvement and Re-design (QSIR) :

- Successfully recruited Band 7 Quality Improvement Practitioner and Band 5 QI Facilitator
- As of 1st April Improvement Learning South Yorkshire will be launched. This is a collaborative development between 5 organisations across South Yorkshire, including the ICS, that will provide standard quality improvement training across the region. This is offered in the form of a one day foundation course and a three day practitioner programme. To date around 100 QSIR practitioners have completed training since the programme began in 2022-23
- Milestone achieved - Health Foundation and NHS Impact self assessments completed. The gap analysis has formed the basis of the QI strategy and plan.

What have been the delays to delivery?

- Limited capacity to support delivery of QSIR projects this year has made it difficult to focus on measuring the effectiveness of local improvements and the impact these have had on patients therefore the associated metric relating to "impact on patients based on QSIR projects" will be monitored into 2024-25 and reported to Quality Committee accordingly. The positive impact metric aligned to this work has therefore not commenced as originally planned. Changes have however been made to the QI team structure which will support specific areas next year and enable progress towards achieving QI-led organization status as set out in the original mandate.
- Pulse survey results have not been made available at the end of Q4 therefore the associated metric can not be published. The results reported through the national staff survey (2023) have, however, are improved in the same/similar domains (advocacy, involvement and engagement)
- The milestone relating to the delivery of the QI plan has not completed as envisaged due to the decision taken to align its implementation with the People Strategy in 2024-25.

Escalations and key decisions required?

- None

P2 IMPROVE ENGAGEMENT WITH OUR MEDICAL COLLEAGUES: - (JANUARY TO MARCH 2024) – 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, Associate Director**

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 3 2023-24		
			Oct	Nov	Dec
Increased National staff survey Q23a (staff perceive care to be Trust's No.1 priority)	69%	Actual	N/A	N/A	74%
		Target	N/A	N/A	72.5%
National staff survey Q23d (friends/relatives happy with standard of care provided) 5% higher than 2022	50%	Actual			58%
		Target			52.2%
"Pulse Surveys (Medical & Dental): (1) Advocacy, (2) Motivation, (3) Involvement, (4) Engagement "	(1) 4.95 (2) 6.00 (3) 4.90 (4) 5.14	Pulse Survey Results not available at end March			

Milestone	Oct	Nov	Dec
All key milestones for 2023-24 plans delivered			

Risks & Issues

- None

Highlights

What have we achieved?

- SAS development – as a result of the SAS survey a work programme has been developed. This includes a dedicated SAS Forum open to all SAS doctors at the trust, chaired by our SAS advocate. The SAS forum will be instrumental in looking at innovative ways of utilizing the external professional development fund. The programme also includes a dedicated project looking at those doctors who wish to CESR (certificate eligibility for specialist registration). The Autonomous Practice Policy has been developed and awaiting ratification. All SAS doctors are now in receipt of 1.5 SPA regardless of whether they are less than full time. This has been applied across the board. The SAS Week 2024 Programme has been developed and for the first time, building on the success of last year, we are looking to host a regional SAS development day. We have also completed an exercise to establish which specialty doctors across the trust who are eligible to apply for a Specialist role.
- The joint clinical leads event with Barnsley in February was a huge success. The event evaluated well with goods levels of participation from all delegates. The second joint clinical leads event is scheduled for September 2024. Agenda with relevant speakers are being explored.
- Medical engagement roadmap for 2024-25 is in development and due to be presented at Executive team by end May 2024. The road map for 2024-25 will focus on the results of the staff survey, medical leadership programmes, SAS development and a dedicated "Later Careers" project which is specifically looking at how we support doctors in their senior years.
- Job Planning Assurance groups (JPAG) are scheduled to take place from May 2024. Individual specialties will present their job plans to panel for them to undergo a consistency check. The panel will also make sure that plans are equitable across the board.
- Engagement work with the Anaesthetics team is continuing and general surgery will be a focus for 2024-25
- National Staff Survey Results indicate an improvement in both measures of success assigned to the priority relating to staff perception that care is the trusts number 1 priority and that friends and relatives would be happy with the standard of care provided by the trust.

What have been the delays to delivery?

- The threat of industrial action has remained in place for the duration of this project with junior doctors now have a renewed mandate for strike action in place for the next 6 months. Consultants have agreed the pay deal . There has been no agreement on the SAS doctors.
- The Pulse survey results are not available at the end of March (metric not completed) however the 2023 national staff survey results indicate an improvement in the same/similar areas relating to advocacy and engagement

Escalations and key decisions required?

- None

P3 - SUPPORTING OUR PEOPLE (JANUARY – MARCH 2024) – 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 People**

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	Q3 Dec 2023/24	Q4 Mar 2023/24
Turnover rate (rolling 12 m)	12.2%	Actual	11.87%	11.50%	10.66%	9.49%	8.94%
		Target	11%				
Vacancy rate	7.34%	Actual	-6.68%	-6.18%	-6.81%	-6.67%	-5.98%
		Target	-8.5%				
Sickness Absence (rolling 12 m)	6.75%	Actual	6.6%	6.1%	6.0%	5.8%	5.8%
		Target	0.75% from baseline				
National staff survey results			Above national average scores for all staff survey domains. Engagement measure 2nd quartile.				

Milestone	Q1	Q2	Q3	Q4
Refreshed People Strategy engaged on and presented for approval	n/a	n/a		

Risks & Issues

None

Highlights

What have we achieved?

- Milestone – Refreshed People and Culture Strategy engaged on and scheduled for Board sign off in May 2024 in line with Executive Team agreed schedule from November 2023 (noting not fully signed off as at 31/03/24 hence Amber in metric)
- Milestone – National staff survey (2023) results published with divisional plans now in place to progress local actions/improvements arising from the survey in a "We said, We did" format
- Workforce plans have been developed for UECC, Medical SDEC and Theatres utilizing a new, standard template
- The joint Triumverate development programme (with Barnsley) was launched in February as planned
- Turnover, sickness absence and vacancy rates have achieved year end targets despite the risks identified in the Risks and Issues log relating to the impact of industrial action. Albeit sickness absence remains higher than pre-pandemic levels which were below 5%
- National staff survey results highlighted improved performance across the advocacy and engagement questions. Rotherham has been identified as one of the most improved organisations in England on a number of measures

What have been the delays to delivery?

- EDI plan published Q3 by integrating WRES and WDES action plans. EDI plan to be developed in Q1 and Q2 2024/25 to support new People and Culture Strategy.

Escalations and key decisions required?

- Note progress and close down 2023/24 reporting period, with Operational Priorities 24/25 to supercede this reporting.

P4 - IMPROVE OUR EMERGENCY CARE PATHWAYS TO DELIVER FASTER ACCESS TO CARE
JANUARY TO MARCH 2024 - 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 4 2023-24 Jan	Feb	Mar
Trust 4hr performance	22/23 Q4 44.02%	Actual	55.38%	57.24%	62.91%
		Target 76% by Oct 23 Trajectory	60%	65%	70%
Urgent Community Response % achieved within 2 hours	End of April 2023 85.7%	Actual	70% +	70% +	70% +
		Target > 70%	>70%	>70%	>70%
Adult G&A Bed Occupancy	April 23 90%	Actual	93%	91%	91%
		Target < 92%	<92%	<92%	<92%
Patients with no right to reside	April - 53	Actual	94	87	47
		<54 by March 24 Trajectory	62	50	54
Average daily throughput Medical SDEC	2022/23 Q4 (inc clinics): 19 incl. weekends & bank holidays	Actual	19	26	27
		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	67	44	76
		Trajectory	80	80	80

Milestone	Jan	Feb	Mar
Achievement of 4 hour target			
Workforce plans UEC, MSDEC completed			
Real time bed update modelling shared			

New Risks & Issues

- None

Highlights

What have we achieved?

Acute Care Transformation Programme (ACT) achievements:

- Heart failure and headache pathways now in place. Early pregnancy and Cauda Equine Syndrome (CES) pathways in development. 7 Frailty workshops held at place level to map the current state and identify next steps
- Additional nurse and ANP assigned to support a new initiative in fracture clinic. The trial which started on 20th March will operate between 5pm and midnight Monday to Friday and 8 am to midnight on Saturday. The objective of the initiative is to free up capacity in yellow area for majors patients.
- The "Who Goes Where" that supports the new Acute Care Standards completed. Urgent care/direct access directories completed.
- Workforce plans completed for UEC and Medical SDEC utilising the new trust template
- Continuing to see good response rates to the Friends and Family Test questionnaires with an average 87.4% positive result. The service also received 16 cards/letters/emails from patients that described the service as "wonderful, supportive, professional and friendly and communication with patients is excellent".
- New Digital Work stream mandate developed. This work stream will deliver improvements in IT systems, data and processes in UEC. The work stream is also leading on delivery of the Emergency Care Data Set (ECDS) version 4 which is due to go live on 1st July 2024.
- Rotherham Place Partnership plans developed for Ambulatory Emergency Care and Frailty pathways as well as Respiratory and Diabetes.. Executive leads and SRO's assigned.

Virtual Ward (VW)

- Current capacity target is 80 VW beds (as of February) of a total of 100 VW beds. Occupancy rates remain challenged.
- Admitted 1,761 patients since its opening in December 2022.
- Proactively in reaching into UECC and has broadened the scope for discharge.
- Remote tech: contract, IT gateway and SOP have been completed. Go live dependent on hazard log, meetings underway to progress.
- Work continuing with YAS to grow the PUSH model. Community team developing respiratory and community nursing pathways and reviewing 999 calls from care homes.
- Heart failure pathway development underway.

Urgent Community Response

- Successful in consistently achieving the national target of 70% each month. However, there's a downwards trend in the percentage of referrals meeting the 2 hour standard, from mid-80% to mid-70%.
- Work has been done to integrate the urgent, unplanned teams into a single team to enable the flexible allocation of resource across admission avoidance and discharge pathways according to demand/individual need. This will be underpinned by a single SystmOne unit to enable greater governance and transparency of capacity.

Improving discharge processes (internally and externally) achievements:

- The Transfer of Care Hub has been established with pathway 1 and 2 community partners now joining discharge board rounds to identify capacity and allocate discharges earlier in the day. An MDT is held daily for complex cases.A daily review of pathway 0 no criteria to reside patients is now in place. The community escalation / long length of stay meeting is now community led and held twice weekly to improve flow
- Place Community Escalation Wheel live and validated by stakeholders, now providing a whole system view of system flow and Opel escalation levels with agreed action cards for each escalation level. Stakeholders include TRFT, the Integrated Discharge Team, the Council's reablement and home care provision, commissioned community bed base, commissioned VCS urgent response services and the GP Fed. There are separate reports for YAS and primary care.
- A new electronic discharge referral form is being implemented providing a more coherent and comprehensive summary of individual need which can be used for all discharge pathways. This will reduce the need for multiple referral forms requiring manual data and speed up decision making.
- Streamlined communication routes agreed with Sheffield to facilitate out of area transfers.
- Care home trusted assessor, full time role recruited to, checks being finalised. Interviews planed for fractional role to provide 7 day cover.
- Enhanced understanding and collaboration between discharge pathways for home and bed based reablement and therapy, including acute and community therapy to therapy discussions to facilitate right level of care

What have been the delays to delivery?

- Industrial action and winter system pressures have impacted on capacity, slowing the pace of change. Learning will help inform next steps
- TOCH Operational Dashboard feasibility outcome delayed.
- There has been a significant increase in out of area discharges, particularly with Sheffield. We are working on a trusted assessor pilot with Sheffield, but this has been delayed at their request whilst they implement their transfer of care hub.
- Contingency plans activated for pathway 2 community beds due to closures resulting from safe staffing levels and infection control. This deflected resource away from planned change and diluted support.
- Direct admission to surgical SDEC via YAS is compromised due to lack of space for additional trollies. The Surgical SDEC SOP includes admission criteria, exclusion criteria and can differentiate between what the service can and cannot do with trollies. Surgical SDEC offers a service by which GP's can directly speak to the senior surgical assessor for advice without going through transfer of care hub or UEC.

Escalations and key decisions required?

- None

P5 - RECOVER ELECTIVE SERVICES JANUARY - MARCH 2024 – 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 4 2023-24		
			Jan	Feb	Mar
Activity % of 19/20	Target 101%	Actual	TBC	TBC	TBC
		Target	101%	101%	101%
Over 65 week waiters	35	Actual	95	75	14
		Target	106	37	0
OP Clinic Utilisation	80%	Actual	67.1%	67.2%	64.8%
		Target	90%	90%	90%
Theatre Capped utilisation	75%	Actual	76.4%	79.5%	75.2%
		Target	85%	85%	85%
Cancer faster diagnosis performance	65%	Actual	70%	78%	79%
		Target	75%	75%	75%

Milestone	Jan	Feb	Mar
Cancer – Recruitment to Cancer Improvement Team positions			
Cancer – Strategy planning away day delivered			
TTP - Theatre Assistant Booking Tool developed and training taking place with relevant teams.			
TTP – Process map reviewing paediatric referrals to declaring patients are fit for surgery/understand issues			
TTP – Scheduling and Validation guidelines developed and rolled-out.			
Outpatients - Scope ECG training for staff.			
Outpatients – Engage with medical staff re Outpatient flow			

Risks & Issues

- **Issue** - Outpatient Clinic Capacity for triage and outpatients **(OPEN)**
- **Issue** - Clinical Engagement (Outpatients) **(OPEN)**
- **Issue** - Staff Capacity/ Time (Outpatients) **(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)**

Highlights

What have we achieved?

Outpatient Modernisation and Improvement Programme

- **Clinic Utilisation** – Breakdown of clinic utilisation by capacity type is providing services with more insight into utilisation losses and where clinics could be converted to support elective recovery.
- **Referral Optimisation –** Process for letter to be generated by the Contact Centre based on information provided by the consultant at triage is progressing well. Once in place, consultants will no longer need to dictate a letter back to the GP when a referral is declined.
- **Reducing follow-ups –** Patient Initiated Follow Ups (PIFU) continue to be developed within specialties, with Diabetes and Endrocrine, and HCOP now set up.
- **Outpatients Flow** – Training package being developed to support booking bloods with the aim to ensure the correct booking processes are used. This will reduce delays in clinic and improve the patient experience.
- **Internal Processes –**Weekly drop-in sessions have started with Medicine to pick up weekly issues and discuss priorities for the week ahead. Booking rules templates developed for majority of clinics to support Contact Centre when clinics can be converted.
- Divisional PTL meetings have been implemented to support operational management of waiting lists, which feed into the newly established Trust Wide Access Meeting to provide oversight and assurance.
- Further Faster Checklists and Action plans have been completed and will inform the Outpatients Transformation programme going into 2024/ 2025.

Theatres Transformation Programme (TTP)

- **Preparing patients for surgery** – Electronic Triage is now in place. Management Intent and Anaesthetic Type are now mandatory fields on an Amb Order.
- **Optimising Theatre Lists –** A scheduler engagement session took place to discuss the Scheduling and Validating guidelines. Challenges around scheduling and pre-assessment were discussed and actions fed back to appropriate workstreams. Validation in Microsoft Teams has been tested in Orthopaedics however roll-out delayed until booking tool in use and lists are booked further in advance.
- **Maximising Utilisation on the Day** –. Sending SOP developed however following positive engagement across Theatre Teams, it has been redrafted and named Theatre Flow SOP to aligned more closely with the full content and purpose of the SOP. Theatre Flow Coordinator has been appointed with a start date in June.
- **Workforce Development** - Activity roster built in Theatres with staff training completed in time for go live on 26 February. Work continuing to build nursing/AHP competency profiles in ESR.
- **Patient Safety & Clinical Governance** – Electronic patient safety checks are being developed to improve documentation. Team Brief continues to be integrated across Theatres. Patient Safety continues to be a focus during audit training days.
- **Equipment & the Environment** – Decluttering theatre street and corridor areas resulted in 38 obsolete pieces of equipment being sent to auction in February. Work is continuing to rationalize sterile instrument packs and streamline consumable storage in time for the new (IMS) inventory management system (Ingenica) go live. Estates work to improve storage space in main theatre stores completed 8th March. An IMS project kick off meeting with presentation to staff was held on 21st March. System "super users/change champions" have been identified. Operational Partnership Agreement in place and first steering group meeting held on 25th March.
- Further Faster Checklists and Action plans have been completed and will inform the Theatre Transformation programme going into 2024/ 2025.

Cancer Improvement Programme

- Cancer Improvement Programme Manager and Improvement Officer in post, 1 x additional Improvement Officer due April 2024
- Endoscopy utilisation PowerBI dashboard development commenced
- Positive re-engagement across Cancer pathways, Urology and Lung Improvement Workshop to be delivered in Q1
- Cancer Services Away Day 5 March 2024 to support development of the Cancer Strategy, positively attended and received
- Good News Clinics introduced within Cancer pathways to expedite patients being informed of non-cancer diagnosis
- 9 Cancer pathways reviewed in accordance with Best Practice Timed Pathways
- Targeted improvement work within high opportunity LGI, Urology and Skin Cancer pathways
- Restructure of the Cancer Services Team to strengthen resilience and improve focus on productivity and performance.
- Cancer PTL meetings have been implemented to support operational management of waiting lists, which feed into the newly established Trust Wide Access Meeting to provide oversight and assurance.
- Cancer Transformation Programme in development for 2024/25 to progress the positive work already commenced as described above.

What have been the delays to delivery?

- Theatres - Staffing issues in scheduling teams as well as in theatres and anaesthetics are making planning and scheduling more difficult due to the inevitability of last-minute changes and issues.
- Theatres – Go live date for new Inventory Management system pushed back from May to August
- Outpatients - Industrial action affecting activity levels, particularly in Outpatients, however Further Faster work will provide new focus on elective recovery programme.
- Cancer Urology pathway review workshop delayed awaiting recruitment to Cancer Service Improvement Team
- Cancer Improvement Team recruitment, 2 x WTE in post, 1 x WTE pending start (April 2024), 1 x WTE vacancy
- Cancer Services Team staffing issues resulting in tracking delays, which is now being mitigated via restructure.

Escalations and key decisions required?

- None

P6 - WORK IN PARTNERSHIP TO DELIVER EFFICIENT SERVICES AND A TRUST THAT IS FIT FOR THE FUTURE
JANUARY – MARCH 2024 – 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 4 2023 - 24		
			Jan	Feb	Mar
Delivery of the Efficiency Target	N/A	Actual (£,000)	6,725	7,743	11,018
		Target (£,000)	9,631	10,909	12,176
Variance from Financial Plan	N/A	Actual (£,000)	6,930	6,740	4,715
		Target (£,000)	5,350	5,664	5,977

Milestone – Quarter 4 2023-24	Jan	Feb	Mar
Proposal Developed for Collaborative R & D Partnership (Q2 milestone)			
Completion of review into small corporate teams & Services review (Q3 milestone)			
EPR – Full Business Case (Q3 milestone)			

Risks & Issues

- **Issue** - Lack of clinical / divisional engagement to make efficiency savings and service change **(OPEN)**
- **Issue** – the ability to identify deliverable opportunities for CIP remained a challenge across the Trust and led to not enough schemes and value being identified **(OPEN)**
- **Issue** – 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 service development with BHFT, including the Haematology Programme that is currently in progress.

Haematology Programme – Monthly Haematology Programme Board meetings are progressing. The Haematology Programme consists of 3 x Projects: 1) Nursing Workforce Project 2) Combined In-Patient Facility Project 3) Consultant Workforce Project. A Combined Inpatient Model proposal was supported at the Joint Executive Team Meeting on 6th March subject and at both Trusts Board of Directors, subject to guidance around any public consultation requirements being clarified and then managed.

Reduction in unnecessary diagnostic testing – Due to the wide scope of this work, the initial area of focus is CT scanning within Radiology, and more specifically CT referrals through UECC. The Deputy CEO is in discussion with the Medical Director around the future direction of this work.

Medical staffing responsibility payments:

- JLNC has signed off the Trust updated job planning policy. This will not be ratified at DRG and then published. This is a significant step forward for the Trust as an agreed policy has not been in place for some time. The job planning policy has now been ratified by the Document Ratification Group (DRG) and published to the intranet. This document is now readily available for doctors to review and will assist in managing the next round of job planning. The job planning year ending 31st March 2024 stands at 68% which is a significant increase on the previous year of 28%. The focus will now be on initiating the 2024/25 job planning round and ensuring that we get to 90% or above in terms of sign off.
- JLNC have also agreed the Job Planning Framework and also to the creation of the JPAG including its TOR. These panels will now be scheduled throughout the year which will act as a consistency check to ensure job plans are equitable across the board. Job Planning Assurance Group (JPAG) commence for the first time in May 2024. This group will act as a consistency check across all specialities to ensure that job plans are equitable across the board. As specialities reach first sign off they will then be presented to the JPAG for assurance before proceeding to second and final sign off

Trust wide Efficiency Programme – The 2023/24 target is £12.176m at M12 / year-end the Final Outturn is £11,018k, which is 90.49% of target and the FYE Recurrent is £7,532k, which is 61.86% of target, and also represents 68.36% of the total CIP delivered. A number of cross-cutting efficiency schemes are in development to support delivery of the Trusts CIP (e.g. e-Roster and Inventory Management System) and whilst progress is being seen, the identification and realisation of financial efficiencies remains a challenge. As the challenge of delivering CIP intensifies, alongside the Trusts ambition of delivering a financial balance of £0 within the next 2 financial years, delivery of 'big' cross-cutting schemes will become increasingly important. Divisions and Corporate areas have been tasked with developing a long term Forward CIP Plan (to cover the 2024/25, 2025/26 and 2026/27 financial years) and the development of those plans are being reported through Efficiency Board. We do not currently have assurance around the value of those schemes; however, the next Efficiency Board meeting will focus on confirming a more assured set of numbers.

Financial Plan – Whilst indicators were 'red' in January and February, this was due to industrial action costs (£1.5m) which were received in March.

What have been the delays to delivery?

Collaborative R&D partnership - Given recent discussions with both Trust Medical Directors and a review of this proposed objective, it has been agreed to not proceed further at this stage given a change in the expected opportunity, as well as more pressing priorities elsewhere in the Medical Director portfolios which require joint working

Completion of review into small corporate teams:

- Team level data has now been retrieved from both organisations, which has enabled a high-level comparison of structures across the two Trusts for most areas of our work. This has been shared with Executive Directors and a discussion around the outputs and next steps was held at the Joint Executive Team Meeting with Barnsley Hospital NHS FT on 6th March.
- Following this initial discussion, both Executive Teams agreed to hold paired Executive Director discussions in April and May in order to identify tangible areas for closer joint working, either through greater collaboration or more structural changes such as joint roles and joint teams. These discussions will also seek to identify potential opportunities to collaborate on and learn from each other around ways of working in order to generate efficiencies.

EPR Full Business Case - Draft OBC has been produced and its presentation is predicated on DBTH decision making around EPR within the ICS. ICS have concluded a review of risks and benefits to System wide EPR implementation, and are now commissioning more detailed cost analysis. Acute Fed chief executives and CIOs continue to meet on a monthly basis to progress EPR convergence.

Escalations and key decisions required?

- None

Board of Directors Meeting
3rd May 2024

Agenda item	P75/24
Report	**Organisational Priorities 2024/25**
Executive Lead	Michael Wright – Managing Director Louise Tuckett – Director of Strategy, Planning & Performance
How does this paper support Trust Values	The Organisational Priorities are grounded in our three Trust values, with a real ambition shown within each of the 4 domain objectives, as well as a focus on the impact on the care we provide and
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	Following initial review at the Board seminars in February 2024 and April 2024, the attached Trust Organisational Priorities are presented to Board today for approval. These priorities have been reviewed at the three relevant Assurance Committees, following feedback at the two strategic Board seminar sessions, namely: • Quality of Care – Quality Committee • People & Culture – People Committee • Operational Delivery – Finance & Performance Committee • Financial Sustainability – Finance & Performance Committee The People Committee and Finance & Performance Committee approved the organisational priorities, subject to minor amendments which have now been incorporated. The Quality Committee required more specificity around one of their two objectives, which has been added following a discussion with the Chief Nurse around appropriate levels of ambition and stretch. The proposed organisational priorities focus heavily on identifying what we are aiming to deliver as a Trust, as well as the programmes we will use to achieve our ambitions. It is worth noting that there is a significant amount of challenge and stretch included within these priorities, in line with our Trust values. The Board is asked to note the level of ambition which has been set within the objectives, and recognise that delivery of all of these will require significant effort within the Trust and across our Place and system partners, as well as no unplanned disruption through industrial action. Following approval of the Organisational Priorities for 24/25, a visual poster will be developed for wider sharing within the organisation so that these objectives can be cascaded throughout the organisation via relevant channels. Assurance Committees will receive a quarterly update on progress against each of their domains, with the Board of

	Directors receiving a bi-annual update on delivery. This will focus heavily on delivery of the metrics we have committed to achieving.
Appendices	1 – Draft Organisational Priorities 2024-25

QUALITY OF CARE

Focus on providing high quality care & improving the experience of our patients

Objective 1 — **Deliver care that is consistent with CQC 'Good' by the end of 2024/25**

Providing high quality, safe and effective care is our core business and as such we need to ensure that we deliver consistently good care across all of our services

Objective 2 — **Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys**

The experience our patients have while under our care is important. Recent performance has been disappointing and focused work is needed to make a step change.

PEOPLE & CULTURE

Focus on engaging with our people & improving the organisational culture

Objective 1 — **Achieve a top quartile engagement measure in the 2024/25 staff survey**

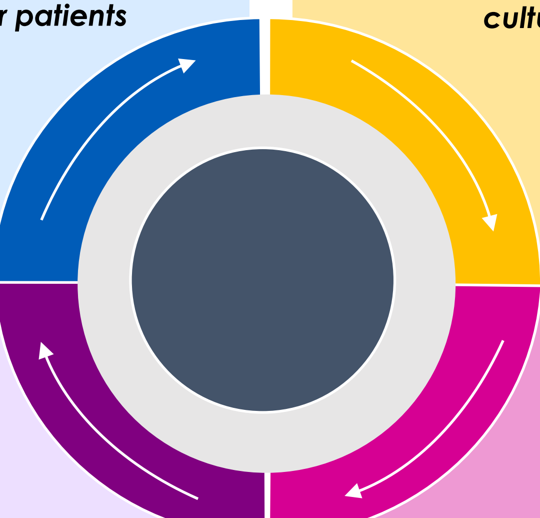
There are significant links between high levels of engagement and a number of positive staff and patient outcomes.

Objective 2 — **Improve attendance by reducing sickness absence by 1%**

Supporting better health and wellbeing will benefit our people, reduce sickness absence and improve attendance.

Objective 3 — **Retain our people by achieving a healthy turnover rate in the range of 8-9.5%**

Retaining our staff is the best way of making sure we have highly skilled, experienced teams with the right values.



OPERATIONAL DELIVERY

Focus on our operational delivery and improving access to care

Objective 1 — **Deliver 4 hour performance of 80% before March 2025**

An effective, high performing emergency care system within the Trust will improve outcomes and experience for patients and reduce the impacts on other parts of the Trust

Objective 2 — **Go beyond the national ambition on long-waiters and RTT performance**

The focus on long waiters is a national priority given the experience these patients will have whilst on the waiting list. We need to make progress towards returning elective waits to pre-pandemic levels.

Objective 3 — **Consistently deliver the Cancer Faster Diagnosis Standard by Q4**

The ability to quickly diagnose or rule out cancer is a critical part of the national drive to improve cancer performance and outcomes, and is key to patient experience.

FINANCIAL SUSTAINABILITY

Focus on becoming a financially sustainable & productive organisation

Objective 1 — **Deliver the financial plan for 2024/25 and deliver year 1 of the plan to return the Trust to a break-even position for 2026/27**

The Trust must live within its means and ensure that it is financially sustainable. It also needs to provide financial headroom to make appropriate investments into services.

Objective 2 — **Ensure significant improvement across the full range of system productivity metrics**

The Trust needs to deliver its services efficiently to provide the best possible care for the money available to us.

EPR TRANSITION

The organisation will need to focus on the transition to a new EPR system before our current system requires changing in 2026

ORGANISATIONAL PRIORITY:	**QUALITY OF CARE :** *Focus on providing high quality care & improving the experience of our patients*
EXECUTIVE LEAD(S):	**HELEN DOBSON & JO BEAHAN**
ASSURANCE COMMITTEE:	**QUALITY COMMITTEE**

OBJECTIVES	Deliver care that is consistent with CQC 'Good' by the end of 2024/25	Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys
Why is this important	Providing high quality, safe and effective care is our number one priority and as such we need to ensure that we deliver consistently good care across all services	Patient experience is a key part of quality of care. Our inpatient and UECC survey results were disappointing last year, and we need to focus on making step change improvements over the coming year
How will we measure if we have achieved this objective	• We cannot predict if the CQC will inspect the Trust over the time frame outlined for this objective. • Therefore, the Trust will invite an external peer review (likely to be part of an Acute Federation programme), with the results of this peer review as well as our own self-assessment taken as performance on this measure and delivered in line with a CQC inspection.	• The measure for this objective will be the national IP and UECC CQC surveys. The results, when published will allow the Trust to benchmark itself against other Acute and Community providers. • The target is to be at least in the 3rd quartile in both surveys, with a stretch target of achieving the 2nd quartile (currently both are in the 4th quartile)
Baseline Position	• The Trust is currently rated as 'Requires Improvement' by the CQC when last inspected in June 2021	The Trust benchmarked as the 3rd worst performer in the country in the 2022 National Inpatient Survey. The overall UECC patient experience was reported as 'somewhat worse than expected' compared to peers.
When do we aim to deliver this objective	• Peer Review Inspection: Q4 2024/25 • Results: Q4 2024/25	• We will deliver this objective for patients who are under our care in 2024. • These results will be reported in Summer and Autumn 2025
What are the main change actions will we take to deliver this objective(s)	**Trust Quality Priorities:** The Trust Quality Priorities will support high impact areas for the Trust, improving our overall level of care, supporting both the experience of patients and the journey to Good **Exemplar Accreditation Programme:** The Trust is launching an exemplar accreditation programme to provide consistent, insightful information into the quality of care our services provide. In 2024/25 baseline positions will be established for all wards. **Patient Experience Improvement Plan:** The Trust has in place a patient experience improvement plan with work being considered against 6 domains. This plan has been audited by 360 assurance but will be refreshed at regular intervals (including in Autumn 2024) to reflect the most recent survey results.	
What are the measures of delivery	• Quality Priority Metrics for delivery in 2024/25 • Friends and Family Test results for UECC and inpatients (as reported in IPR) • Peer inspection outcome overall equivalent of CQC 'good' with no areas assessed as 'inadequate' • Exemplar Accreditation Trajectories: Expectation at least 75% improve their scores against baseline by March 2026 • National Inpatient and UECC CQC Patient Experience Survey results	

ORGANISATIONAL PRIORITY:	**PEOPLE AND CULTURE** *Focus on improving the experience of our people and developing our culture*
EXECUTIVE LEAD(S):	**DANIEL HARTLEY**
ASSURANCE COMMITTEE:	**PEOPLE AND CULTURE COMMITTEE**

OBJECTIVES	Achieve a top quartile engagement measure in the 2024/25 staff survey	Improve attendance by reducing sickness absence by 1%	Retain our people by achieving a healthy turnover rate of between 8-9.5%
Why is this important	Evidence shows that there are significant links between high levels of engagement and a number of positive staff and patient outcomes. We want to improve the overall level of engagement across the Trust, as well as improving it for everyone.	Supporting better health and wellbeing will benefit our people and improve attendance. High levels of attendance contribute to us being productive and delivering high quality care for patients.	Retaining our staff is the best way of making sure we have highly skilled, experienced teams with the right values.
How will we measure if we have achieved this objective	The national staff survey position will be benchmarked nationally against the 'staff engagement' question. We will also focus on the results by protected characteristics as our goal is to reduce unequal experiences of work whilst improving levels of engagement for everyone.	Sickness absence rate compared to 2023/24. We will achieve this target if the Trust's rolling sickness absence rate is 4.8% or less.	Staff turnover rate compared to 2023/24 (voluntary leavers, rolling measure)
Baseline Position	The Trust was 71st (3rd quartile) in 22/23, 37th (2nd quartile) in 23/24 when benchmarked nationally.	March 2024: Sickness absence rate was 5.79%.	March 2024; Turnover rate was 8.94%
When do we aim to deliver this objective	Staff survey in 2024/25, reported in Q4 2024/25.	March 2025	March 2025
What are the main change actions will we take to deliver this objective(s)	**People and Culture Strategy:** The Trust will launch a new People and Culture strategy in Q1 24/25 to set our approach to delivering our vision through our people and culture. This will cover our approach to; retain and recruit; develop and lead inclusively; creating engagement and improvement. **Integrated EDI Plan:** Building on our existing approaches the Trust will develop an integrated Equality, Diversity and Inclusion plan in Q2 and Q3 24/25 which will set out specific actions to improve inclusion across the Trust. **'We said, we did' plans :** Building on the 23/24 staff survey results, all services (care groups and corporate teams) have been asked to develop and deliver 'we said, we did' plans to address key issues for staff in their areas. In addition to this a number of organisation wide actions will make up our Trust wide We said we did plan - violence and aggression, disability adjustments, appraisals, sexual safety and car parking. **Attendance and sickness absence**: The Trust will carry out a deep dive into attendance and sickness absence in Q1 and Q2 based on the National Health and Wellbeing Framework and our local prevent; protect and promote and support model.		
What are the measures of delivery	Staff engagement score.	Sickness absence rate (rolling 12 months).	Turnover rate (rolling 12 months).

ORGANISATIONAL PRIORITY:	**OPERATIONAL DELIVERY** *Focus on our operational delivery and improving access to care*
EXECUTIVE LEAD(S):	**SALLY KILGARIFF & JODIE ROBERTS**
ASSURANCE COMMITTEE:	**FINANCE AND PERFORMANCE COMMITTEE**

OBJECTIVES	Deliver 4 hour performance of 80% before March 2025	Go beyond the national ambition on long-waiters and RTT performance	Consistently deliver the Faster Diagnosis Standard by Q4
Why is this important	An effective, high performing emergency care system within the Trust will improve outcomes and experience for patients and reduce the impacts on other part of the Trust.	The focus on long waiters is a national priority given the experience these patients have while waiting. Equally, we need to make progress towards returning elective waits to pre-pandemic levels. The Trust has the ambition to go beyond the national ask in order to provide our patients with more timely access to elective care.	The Trust's ability to diagnose, and subsequently start treatment for patients with cancer is a critical part of the national drive to improve cancer outcomes. Within the Trust we want to ensure that we deliver this standard.
How will we measure if we have achieved this objective	Trust 4hr performance. The aim is to deliver 80% performance before the national requirement for delivery (of 78%) in March 2025.	The Trust will eliminate 65 week waiters by June 2024, in advance of the national expectation of September 24 and will also go beyond this by reducing the number of patients waiting over a year by 50% by March 2025. The Trust will ensure 8 specialties deliver the NHS Constitutional RTT standard by year-end.	Faster Diagnosis Standard across all tumour groups as reported in the IPR. Delivery of the 77% standard at Trust level consistently in Q4 2024/25.
Baseline Position	Performance for March 2024 was 63%.	As at end of February 2024 the Trust had 678 patients over 52 weeks. 2 out of 17 specialties are delivering the 92% standard.	FDS performance was 70.3% in January 2024.
When do we aim to deliver this objective	We aim to improve our performance in the first half of the year so we are delivering 80% in October 2024. It is anticipated that there will be a decline in performance over winter before return to 80% in March 2025.	Eliminate 65 week waiters by July 2024. 50% reduction in 52 week waiters by end of March 25 (and 0 in all medical specialties) Ensure at least 8 specialties achieve RTT standard by March 2025.	For all of Q4: January - March 2025
What are the main change actions will we take to deliver this objective(s)	**ACT Programme:** The Trust will continue its Acute Care Transformation programme in 2024/25. The programme has made progress in a number of areas and will continue to focus on actions to deliver the 4hr standard. Focus in 24/25 will be on ambulatory and frailty pathways, in line with the wider Rotherham Place priorities, as well as discharge pathway efficiency. **Theatre Transformation Programme:** The Trust will continue TTP and focus on Theatre productivity, including improving utilisation and throughput such that we deliver increased activity. **Outpatient Programme**: The Trust will continue its OP programme, focussing on the delivery of the Further Faster programme as well as the changes needed as part of our Back to Balance programme, such as increased utilisation. **Cancer and Endoscopy Improvement:** Significant work within our Cancer Improvement programme is focused on Endoscopy. This work will be formalised within 2024/25, with support provided by our Cancer Improvement team to support all patients through Endoscopy.		
What are the measures of delivery	• 4 hour performance • SDEC patients per day • Delayed Discharges • Patients on Virtual Ward • Urgent Community Response Performance	• Elective Activity (compared to 19/20) • Capped Theatre Utilisation Rate • Clinic Utilisation • New: FU ratio	• Faster Diagnosis Standard by tumour site • Endoscopy DM01 performance

ORGANISATIONAL PRIORITY:	**FINANCIAL SUSTAINABILITY:** *Focus on becoming a financially sustainable and productive organisation*
EXECUTIVE LEAD(S):	**STEVE HACKETT & MICHAEL WRIGHT**
ASSURANCE COMMITTEE:	**FINANCE AND PERFORMANCE COMMITTEE**

OBJECTIVES	Deliver the financial plan for 2024/25 and deliver year 1 of the plan to return the Trust to a break-even position for the 2026/27 financial year	Ensure significant improvement across the full range of system productivity metrics
Why is this important	The Trust must be financially viable so that it can continue to provide services to our local communities, invest in improving services and support and develop our staff.	The Trust must make best use of the resources it is allocated, providing the highest levels of activity for these resources.
How will we measure if we have achieved this objective	• The Trust's financial position is a standard reporting function within the Trust. • The target will be to have a recurrent break-even position for M12 2025/26	• Full range of Acute Federation productivity metrics to be agreed in April 2024, with national productivity metrics due to be published in summer 2024 • Trust will deliver agreed improvements across all metrics
Baseline Position	The Trust is expecting to have an underlying recurrent deficit of £17m at the end of 2024/25	TBC in Q1 – dependent on Acute Federation (Q1) and national publication (Q2) as mentioned above.
When do we aim to deliver this objective	• 2025/26 M12 (to enable a 2026/27 plan for break-even financial position)	• Q4 2024/25
What are the main change actions will we take to deliver this objective(s)	**Trust Efficiency Programme:** The Trust will continue to run its usual efficiency programme with targets given to all Care Groups and Corporate Areas and progress reported through the usual report to FPC. **Back to Balance Programme:** The Trust is developing a Back to Balance (B2B) programme. The programme contains a number of workstreams focused on delivering step change financial performance and improving the productivity of the organisation. **Financial Benchmarking:** The Trust will continue to work towards the implementation of a PLICs/Costing system which enables improved financial data and information across the Trust, enabling services to understand (and improve) their financial contribution.	
What are the measures of delivery	• Efficiency Programme Performance • B2B programme metrics (TBC) • Elective Activity (compared to 19/20)	

Board of Directors' Meeting
3 May 2024

Agenda item	P76/24
Report	**National, Integrated Care Board and Rotherham Place Update**
Executive Lead	Michael Wright, Managing Director
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 providing mutual support.
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: • The NHS is set to roll out the first ever targeted treatment for brain tumours in Children and Young People in England, which can be taken at home and has been shown to significantly slow the progression of the disease, allowing a better quality of life for longer. • The NHS Digital Weight Management Programme is helping patients referred to the service to lose weight. • Cancer patients in the South Yorkshire area are set to benefit from innovative new treatments thanks to the opening of a new state-of-the-art £4m nuclear medicine and molecular radiotherapy suite at Weston Park Cancer Centre. • Rotherham was successful in getting additional funding from the Government to support work with children and families. Family Hubs operate in Rotherham Children's Centres and Early Help buildings. Local families can visit with their children and receive information, advice and support for all things related to raising a family. From a Trust perspective, it is evident that there are a number of benefits, with a key area being the work to support breastfeeding across Rotherham Borough. A strategic breastfeeding lead has been funded to lead on the implementation and management of the UNICEF Baby

	Friendly Initiative standards across the Rotherham Borough. The post holder is working closely with colleagues at the Trust and wider agencies to ensure practices align. The aim is to improve initiation and sustainment rates across the Rotherham area. • The Baby packs' initiative that supports new parents - In February, Rotherham Cabinet approved the Council's 2024/25 Budget including provisions to undertake a full procurement to provide Baby Packs for Rotherham new born babies. On average, there are 2,740 babies born each year in Rotherham who will benefit from this investment proposal, ensuring that every new child's family has access to essential items right from the beginning of the child's life. Again, from a Trust perspective, the baby pack scheme is seen as critical for Rotherham's commitment to providing all children with the best possible start in life. Colleagues at the Trust see that being part of this initiative ensures that all items in the packs are safe and in alignment with the key public health messages that midwives and health visitors deliver as part of their roles • Rotherham MBC continues to lead work on suicide prevention with a number of targeted actions. A key outcome to note is that the suicide rate in Rotherham per 100,000 of population for 2020-2022 has fallen to 12.4 from 13.1 in 2019-2021. • Rotherham Place celebrated the 2023 Staff Survey achievements at the Trust.
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 South Yorkshire Integrated Care Board (SYICB) 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 and provide feedback/comments on the Place Board Terms of Reference and the Place Partnership Agreement.
Appendices	1. Rotherham Place Partnership Update March and April 2024.

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 The NHS is set to roll out the first ever targeted treatment for brain tumours in Children and Young People in England, which can be taken at home and has been shown to significantly slow the progression of the disease, allowing a better quality of life for longer.

2.2 Dabrafenib with trametinib (types of cancer growth blockers) has been found to stop the disease progressing for more than three times as long as standard chemotherapy for children with low-grade gliomas that have a specific genetic mutation, while helping many be spared the harsh side effects that can come with chemotherapy. The treatment will be available on the NHS in the coming months for young people aged 1-17 with low-grade or high-grade gliomas that have a specific mutation, following a green light from the National Institute for Health and Care Excellence (NICE) on 24th April.

2.3 The NHS Digital Weight Management Programme is helping patients referred to the service to lose over eight pounds. A new peer reviewed paper, published in The Obesity Journal, shows that 63,937 people were referred to the scheme in its first year with 50% taking up the offer and enrolling onto the service. A total of 14,268 of those then went on to complete the programme (April 2021 to March 2022), with people who completed it losing 3.9kg or 8.59lbs over 12 weeks. Of the 31,718 people who started the initiative, including those who did not complete, the average weight loss was still 2.2kg or 4.85lbs.

2.4 Members of the British Medical Association (BMA), which represents NHS consultants, voted by 83% to accept the government's new pay offer, which also included changes to the review body on doctors' and dentists' remuneration.

2.5 The BMA have announced that Junior Doctors have voted to extend the mandate for Industrial Action following the results of its latest re-ballot.

3.0 South Yorkshire Integrated Care Board (SYCIB)

3.1 Cancer patients in the South Yorkshire area are set to benefit from innovative new treatments thanks to the opening of a new state-of-the-art £4m nuclear medicine and molecular radiotherapy suite at Weston Park Cancer Centre. The brand-new facility which boasts high-precision technologies which can detect, image and treat tumours and visualise organ systems in real time, will play a key role in enabling the specialist cancer hospital to deliver a wave of newly targeted treatments that are set to come on board in the next few years.

3.2 The SYICB has ongoing work across South Yorkshire in dentistry. The ICB has a responsibility for the improvement of dental services and inherited real challenges when the responsibility for dentistry was transferred from NHS England. Access to routine and urgent care is a key issue for patients and families and therefore can impact negatively on other primary care services and patient pathways for other dental and secondary care services.

There continues to be a backlog of dental care with demand for NHS care being significantly higher than pre-pandemic levels at all practices. While the number of available appointments for regular and routine treatment are increasing, and access figures are gradually improving, dental practices continue to balance the challenge of clearing any

backlog with managing new patient demand. Whilst restoration of dental activity continues, it is encouraging that the latest figures for access to 30th June 2023 show that access levels in South Yorkshire amongst adults and children shows an improving picture across all four places. There is significantly better access in South Yorkshire than in England overall. The ICB are currently progressing a number of initiatives to further improve the position.

4.0 Rotherham Place

4.1 Rotherham was successful in getting additional funding from the Government to support work with children and families. Family Hubs operate in Rotherham Children's Centres and Early Help buildings. Local families can visit with their children and receive information, advice and support for all things related to raising a family. Family Hubs bring many services together, to work with families from pregnancy and through childhood to the teenage years and up to twenty-five with special educational needs and disabilities.

Rotherham has embedded the Family Hubs programme within all Children's Centres and further sites are being identified, facilitated by Voluntary Action Rotherham. Within the three main hubs, the following services are co-located:

- Early Help, Infant feeding specialist,
- Nursery Nurses,
- 0 to 19 Service,
- Substance Misuse workers,
- Midwifery,
- Perinatal Mental Health,
- MESMAC,
- Children Social Care,
- Employment Support Advisers,
- Digital Inclusion Team, Rotherham Rise,
- Holiday Activity Fund,
- Home Learning Workers,
- Intrahealth, Youth Justice Services and Voluntary Action Rotherham.

From a Trust perspective, it is evident that there are a number of benefits, with a key area being the work to support breastfeeding across Rotherham Borough. A strategic breastfeeding lead has been funded to lead on the implementation and management of the UNICEF Baby Friendly Initiative Standards across the Rotherham Borough. The post holder is working closely with colleagues at the Trust and wider agencies to ensure practices align. The aim is to improve initiation and sustainment rates across the Rotherham area.

4.2 Rotherham Place have developed a Workforce and Organisational Development Plan. Previously, Rotherham Place delivered joint recruitment events that resulted in local people being recruited into health and social care careers. However, there continues to be competitive workforce recruitment in South Yorkshire and as a result, Rotherham Place are keen to improve recruitment to key posts and develop skills from young ages. Specific objectives include:

- Develop a Place Employer's Brand
- Building Effective Partnerships
- Skills Pipeline and Employability

- Embedding Equality and Diversity

Colleagues from the Trust are involved, and updates and outcomes will be provided at future Trust Board meetings. Linked to this and in relation to an initiative previously supported at Trust Board, the Skills Street development at Gulliver's has moved at pace. As a registered Community Interest Company, Skills Street's primary aim is giving back to South Yorkshire, with schools and members of the public utilising the venue from across Rotherham, Barnsley, Doncaster and Sheffield. Skills Street is due to open in September and the Trust and partners, supported by the Rotherham Place Workforce team are currently planning how to best use the space for health and social care with a view to showcasing the different NHS Professions to attract the future workforce.

4.3 Rotherham Place Board met in March and April 2024, receiving updates on a number of initiatives as well as a detailed review of the Rotherham Place Operational Performance Report. Place Board received an update on the 'Baby packs' initiative that supports new parents. In February, Rotherham Cabinet approved the Council's 2024/25 Budget including provisions to undertake a full procurement to provide Baby Packs for Rotherham new-born's.

On average, there are 2,740 babies born each year in Rotherham who will benefit from this investment proposal, ensuring that every new child's family has access to essential items right from the beginning of the child's life. The packs will include high quality items that promote positive parent and child interaction and safety improving outcomes for the child. Registering for the packs will also help parents to access a range of support and advice services provided through Rotherham's Family Hubs including by maternity, 0-19 and Early Help services.

The Baby Pack scheme will be universally available for all babies and new parents. It aims to promote a fair and equal start for all children and to aid in achieving the best possible outcomes for all Rotherham's children. From a Trust perspective, the baby pack scheme is seen as critical for Rotherham's commitment to providing all children with the best possible start in life. Colleagues at the Trust see that being part of this initiative, ensures that all items in the packs are safe and in alignment with the key public health messages that midwives and health visitors deliver as part of their roles. The intended benefits include:

- Reducing socio-economic inequalities by encouraging registration with family hubs enabling information sharing to promote targeted engagement when families may benefit from help and support.
- Informing parental behaviours that will positively impact on outcomes for the child, including chid development, safe sleeping practices, attachment, and parent-child interaction.

4.4 The Health and Wellbeing Board met in March and received a number of updates including:

- Physical activity

Rotherham was chosen for the Sport England Place Expansion Programme. Physically active people have better health and wellbeing outcomes. Inactivity is distributed unequally with higher rates of inactivity in areas of deprivation, across certain

demographic groups and in those with long-term health conditions. Inactivity in Rotherham is greater than the national average, with almost 1 in 3 inactive.

An increased focus on wider physical activity in Rotherham began with the Local Authority Healthy Weight Declaration, which was signed in January 2020. A strategic review of physical activity then took place in July 2021 with a broad range of stakeholders involved in visioning and developing a plan of action. This culminated in a final Big Active Conversation workshop in January 2023. From this approach, an action plan was shared with Health and Wellbeing Board in March last year. The over-arching actions identified through this work are overseen by the Moving Rotherham Board, under which sits a Wider Physical Activity and Health Subgroup and a separate set of working groups under the theme of Sports, Facilities and Events.

There are a number of key areas of success since March 2023, which include:

- The Women's Euro legacy programme has provided events across Rotherham with 368 hours of volunteer time contributed.
- Training has been provided to social prescribers/link workers to increase awareness of benefits of physical activity and confidence to signpost and support patients into opportunities.
- Specific new social prescribing offers, which include physical activity, have been commissioned, including for carers and those with mental health conditions.
- The Rotherham 10K fun run took place from Clifton Park in May with the biggest ever involvement of children and young people with over five hundred taking part.
- Training has been delivered to care home activity coordinators around embedding physical activity opportunities for residents and staff.

4.5 Rotherham MBC continues to lead work on suicide prevention with a number of targeted actions. Recent actions include:

- Continued promotion of the Place Guidance document for staff and volunteers on responding to people at risk of suicide.
- Bespoke training for voluntary sector organisations.
- Chronic pain workshop held with Partners in February 2024, with a follow-up session for clinicians planned for early Summer. Plans for establishing a multidisciplinary 'pain hub' in Rotherham are being explored.
- Suicide awareness training running for staff across Place from January to March 2024.
- RotherHive promoting additional topics like pain management & mental health over the life course.
- Suicide Awareness session in Safeguarding Awareness week, November 2023.

A key outcome to note is that the suicide rate in Rotherham per 100,000 of population for 2020-2022 has fallen to 12.4 from 13.1 in 2019-2021.

4.6 The Health and Wellbeing Board also received an update on the work of the combatting drugs partnership. The Rotherham Combatting Drugs Partnership was established in September 2022. The partnership aims to work together across the system to deliver the aims of the National 10 Year Drug Strategy:

- From Harm to Hope, at a local level

- Break drug supply chains
- Deliver a world class treatment system
- Achieve a shift in the demand for drugs.

A number of actions have been taken including a new substance misuse early help team in the family hubs began taking referrals in August enhancing early identification and access to specialist services for parents. Work has continued to implement the revised pathway for access into detoxification and rehabilitation, enabling more individuals to benefit and increase successful treatment outcomes. New posts are now in place in the sexual health service, working with the drugs and alcohol service to identify new clients and enhance the service offer in both services. Drinkcoach was procured and went live in April 2023. This is an online commissioned service that allows people to assess their drinking and receive personalised advice and support online including free coaching sessions.

The South Yorkshire Police Drug and Alcohol Related Death Prevention Coordinator Role was successfully recruited to and is now supporting work improving local intelligence systems to reduce harms from drugs. In addition, Drug expert witnesses are now in place to support the investigation of drug offences with appropriate knowledge, skills and experience. To ensure effective intelligence management additional South Yorkshire Police Threat and Harm meetings are now chaired by the force drug lead. Operation GROW, a partnership approach to cannabis, continues to be successful. A new Serious and Organised Crime Tasking Group to discuss intelligence relating to organised crime group members is now in place.

The Trust is currently assessing the level of clinical activity associated with substance misuse to establish if the work being undertaken has resulted in a shift in the number of patients attending Urgent and Emergency Care. Specific work has already been undertaken in relation to the work of the Trust's Alcohol Care Team, which does clearly indicate that interventions do avoid hospital admissions.

4.7 The Trust's Consultant in Public Health, employed jointly by the Trust and the Local Authority has been in post for one year. They are leading a programme of work to manage population health within Rotherham, based on tackling health inequalities and developing preventative interventions. The Rotherham Population Health Management Operational Group continues to develop population-focussed initiatives and interventions across the Place. Current work includes:

- Developing actionable insight from the Maltby and Dinnington engagement work, incorporating further qualitative population engagement and feeding in to work streams such as physical exercise, chronic pain, mental health transformation, access to services and addressing the wider determinants of health.
- Producing population insight to address the four key transformation areas of the ICB's 2024 plans: Frailty, Ambulatory Care, Diabetes and Respiratory pathways.
- Working with partners to establish better data sharing platforms and to develop better population insight tools.
- Supporting and developing the Rotherham prevention pathway, looking at opportunities for early identification and intervention of preventable health conditions

The Trust's own health inequalities programme is undertaking a number of initiatives, organised across six domains: understanding patient needs; providing patient-centred care; supporting staff to live healthy lives; ensuring equity of access; building prevention

into our pathways and improving the lives of our communities. A review of Trust activities to promote health equality includes:

- Establishment of the Armed Forces Welfare Officer post in March this year. The postholder has already made contact with 35 patients and has provided bespoke support to veterans and their families.
- The digital weight management pilot is continuing in the five key surgical pathways selected nationally, with the potential to expand into other pathways currently under discussion. Over 60% of patients we have contacted in this way have engaged with the process, and around half have a recorded start date.
- The Making Every Contact Count enhanced training has been piloted with health care assistants, and will be the subject of a lunchtime lecture this Summer. We are working with clinicians, the HR team and local partners to ensure we have a package of training which can help all staff have confident, health-promoting, coaching style conversations with patients, visitors and other staff members.
- Development of cancer care initiatives such as personalised care and support planning through holistic needs assessment and creation of better cancer information and signposting, supported by care navigators and a cancer app. A steering group has been set up to monitor and target resources to support high-quality care for patients and families.
- Bespoke work to improve our intelligence and develop actionable insight within the Trust. For example, identifying areas to target for improved recording of patient demographic information
- Analysis and development of a toolkit to understand the circumstances of patients who have missed appointments, including an interactive dashboard and a pilot, scalable approach to undertaking health equity audit work, which can be applied to a wide range of observed inequalities going forward.

4.8 The Trust continues to work with South Yorkshire Police to tackle violent and aggressive behaviour against colleagues working on the front line at the Trust. There have been a number of prosecutions of patients following recent instances of violence and further work is ongoing with the aim of reducing violent and aggressive behaviour towards Trust staff.

4.9 Finally, as can be seen at Appendix A (Rotherham Place Partnership Update March and April 2024) Rotherham Place celebrated the 2023 Staff Survey achievements at the Trust.

Michael Wright
Managing Director
May 2024

Rotherham Place Partnership Update: March and April 2024

Action on Prevention and Health Inequalities

Respiratory Transformation Group Driving Action - Respiratory has been selected as one of Rotherham's four high impact areas, and work has started to bring partners together to transform the current pathway. An initial workshop took place in March, which had good representation across primary care, secondary care, commissioners, public health, and social care to identify priority areas of focus for the transformation.

Building on this workshop, a partnership group has been established, which is already making progress to transform respiratory services. This has included pursuing a pilot of exercise classes to support pulmonary rehab within leisure centres and developing an alternative pathway to reduce admission to hospital, with Yorkshire Ambulance Service making direct referrals to the community respiratory team. The group will oversee a wide range of priorities relating to respiratory with a whole pathway approach and will build on the foundation of positive partnership working.

Moving Rotherham Partnership recognised by Sports England - Sports England has recognised the Moving Rotherham partnership and has chosen Rotherham as a partner for the Sport England Place Expansion Programme. This is a national programme which will direct £190m of investment to 80-100 places across the country.

In selecting Rotherham as a partner, Sports England acknowledged the progress of the partnership, strength of relationships, strategic recognition of the importance of physical activity and its inclusion in a range of key strategies. The Moving Rotherham Partnership has made significant progress over the past year, which has included delivering the Women's Euro Legacy programme, training social prescribers and link workers, overseeing festivals and events (such as Uplift Festival and Rotherham 10k), awarding small grants to community groups, promoting active travel, and expanding RotherHive to include a section on Moving More.

Engaging Local People Living with Long-term Conditions - 1,221 people in Maltby and Dinnington have had their say on their experience of living with a long-term condition.

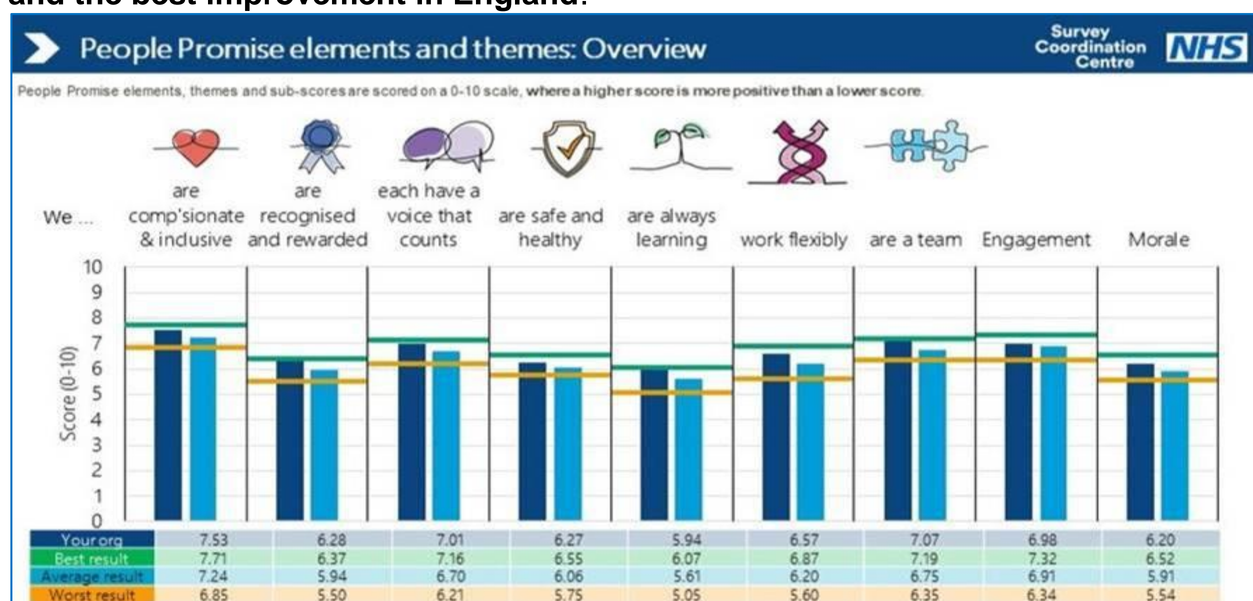
This has been a collaborative project between Primary Care Networks (PCNs), Public Health, The Rotherham NHS Foundation Trust, the South Yorkshire Integrated Care Board (Rotherham Place) and the Council's Neighbourhoods Team, and has built on Rotherham's participation in the national Place Development Programme. Maltby and Dinnington were identified as priority areas of interest in terms of multi-morbidity and opportunities for learning.

Through PCNs, a survey went out to all patients with some of the most common long-term conditions in Rotherham, and the response rate was over 50%, which has provided extremely rich data and insights. Some of the high-level findings have included that almost every respondent was living with more than one long-term condition, 32.4% had experienced poor mental health or emotional wellbeing and 24.8% reported living with some form of pain. Analysis is ongoing, but the early insights are already feeding into work programmes and helping to drive action.
More than half of those surveyed confirmed that they would be happy to be involved in further work, which offers a significant opportunity to build on these insights through further engagement events and focus groups. Planning for this next step is underway.

2023 NHS Staff Survey: Celebrating Progress

The Rotherham NHS Foundation Trust have made strong improvements in the 2023 NHS Staff survey across a range of areas and themes. The trust is immensely proud of the progress made and clear on the further improvements they want to make based on staff feedback.

In the questions about 'advocacy,' and recommending the Trust they achieved the **3rd best, 2nd best and the best improvement in England**.



	We are comp'sionate & inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Engagement	Morale
Your org	7.53	6.28	7.01	6.27	5.94	6.57	7.07	6.98	6.20
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54

TRFT results are the dark blue column, the average from all of the Trusts in England is shown by the light blue column. The green line is England's best result, the yellow line is England's worst result.

All Age Autism Strategy – received at Place Board in March, builds on the progress made in the delivery of the 2020 23 strategy and sets the strategic direction and priorities for the next three years. It has been informed by co-production work undertaken with people with lived experience, including workshops with representatives from a wide range of professionals, people with autism, parents, families, carers, and local businesses. The workshops gathered rich information and

Rotherham 5-19 Neurodevelopmental pathway update

During the last 12 months the Service have worked to screen all 900 children waiting (9 month wait), meaning all children referred into the 5-19 neurodevelopmental pathway are screened within 4 weeks. Therefore, children and families know within 4 weeks if they have been accepted for assessment and receive advice, guidance, and signposting to available support whilst they are waiting (this is provided regardless to whether they are accepted for assessment).

Targeted work with education has resulted in significant improvements to the quality of referrals, this has reduced the time taken for clinicians to gather information for assessment and frees them up to spend more time with children and families, it has also reduced the length of assessments increasing the number that clinicians can complete. The referral pathway ensures implementation of the Special Educational Needs and Disability (SEND) graduated response so that we are assured children and families have access to support whilst they are waiting.

Although the number of referrals has increased over the last few years, we are making progress to reduce the waiting list and have seen both the length of time children wait for assessment and the number of children waiting reduce. Referrals are allocated based on complexity of need therefore allocations are not always taken from the longest waits. When children are taken off the waiting list and are re-referred, they are added to the waiting list with the date of their first referral, so not all children have been on the waiting list for all of the time they have been waiting. 40 children have waited longer than 156 weeks (3 years).

Rotherham Town Centre SEND Hub

A new centre for children and young people with Special Educational Needs and Disabilities (SEND) and neurodiverse adults will be located in the Rotherham Town Centre.

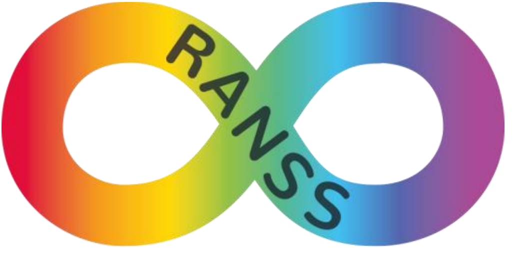
This is part of a project between Rotherham Parent Forum Ltd (RPFL) and Rotherham Council. RPFL is made up of RPCF (Rotherham Parent Carers Forum) for families of children and young people with additional needs 0-25 years, and RANSS (Rotherham Adult Neurodiverse Support Service) for Neurodivergent Adults in Rotherham aged 18+.

The SEND Hub will be based in the Eric Manns building and will offer a range of activities, training, support, and partnership with services for the people who access, with inclusive amenities throughout to reflect the needs of the whole SEND community. RPCF and RANSS are planning to develop a timetable of daily activities, inviting organisations to deliver specific sessions based on their areas of expertise.

The timetable will be developed in coproduction with the SEND community to ensure that it provides a wide and varied offer to meet their interests and needs. The activity within the SEND Hub will all be focused on developing inclusion in a safe and familiar environment, thereby reducing social isolation, and improving wellbeing.

Work is currently taking place to develop a design specification for the SEND Hub.

Rotherham Parent Forum Ltd are a registered charity run by and for families of children and young people (aged 0 to 25) who have SEND. For more information visit: https://www.rpcf.co.uk/ . Further information about available support can be found on the Rotherham SEND Local Offer website at: https://www.rotherhamsendlocaloffer.org.uk/



Rotherham Adult Neurodiversity Support Service

The extension and redevelopment of the Broom Lane practice, which was funded through the £57.5m South Yorkshire Primary Care Capital Programme, has now been completed.

Good Governance – at the February Confidential Place Board members reviewed the Place Board Terms of Reference and updated Rotherham Place Agreement. During February and March, the documents were considered by partners through their own governance arrangements ahead of the Place Board approving them at the April public meeting. The Terms of Reference for the Place Board when carrying out ICB Business (acting as the Rotherham ICB Committee) have also been updated in line with the South Yorkshire ICB requirements and will go for approval to the July ICB Board.

A Year of Success for the Virtual Ward

In December 2022, The Rotherham NHS Foundation Trust (TRFT) opened the virtual ward to patients. The purpose of the ward is to support people at home who would otherwise be in hospital. Since opening the virtual ward team have supported around **1,760 patients** to receive hospital-standard acute care at home.

Virtual wards provide an alternative to hospital admission, or a patient staying in hospital longer than they need to. It aims to keep patients at home or in their usual place of residence, supporting patients with the acute care, treatment, and remote monitoring they need, and includes comprehensive medical assessments and access to community services. This benefits patient experience and health services by reducing pressure on hospital beds, which in turn enables those attending the Urgent and Emergency Centre to be seen quicker.

Helen Dobson, Chief Nurse at TRFT, said '*We know that patients can recover quicker in their own home, where they can try and keep as much of their normal routine as possible. We have some exceptional colleagues working in our community services with a wide range of skills that enable us to run a service like the virtual ward. The ward frees up hospital beds for those who are most in need of treatment and monitoring in a hospital environment*'

Patients can be referred up to 14 days at a time, and for the treatment and management of a variety of conditions, including heart failure, delirium, acute kidney injuries and acute respiratory conditions. The ward currently looks after patients on frailty and respiratory pathways.

Virtual Ward current capacity target is 80% beds as of February (total of 100 beds) with an average length of stay of 7 days.

Goodbye - We Will Miss You!

Rotherham Place said goodbye this week to two people who have played an important role in the development and success of the Rotherham Place Partnership. **Sue Cassin**, Chief Nurse in Rotherham, retired in January after a 48 year career in the NHS. And **Cllr David Roche** retires in the near future, and this week attended his last Place Board.

And not forgetting **Oak House** which has been the home for many Rotherham NHS staff for 20 years, as PCT, CCG and now as the Rotherham ICB Place Team – many happy memories!

Board of Directors Meeting
3rd May 2024

Agenda item	P77/24
Report	**Joint Strategic Partnership Update**
Executive Lead	Dr Richard Jenkins, Chief Executive Michael Wright, Deputy Chief Executive Martin Temple – Non Executive Director
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 Joint Strategic Partnership has continued to develop over the last 6 months. The key points to note include the following: **Clinical Services Review:** The work to develop and deliver a joint Haematology Service has continued at pace. The project has a formal governance structure including engagement from our clinical teams. **Service Sustainability Reviews:** The two trusts have continued to collaborate and align their processes around Service Sustainability Reviews with them being completed and shared in Q4 2024. **Joint Leadership Development**: The programme continues and will run through to quarter 3. Initial feedback from participants has been positive. **Joint Roles:** The Trusts continue to explore the possibilities of joint roles across teams and have recently appointed a Joint Director and a Joint Deputy Director of Communication which has strengthened and added resilience to both organisations' teams. **Joint Clinical Leaders:** The first Joint Clinical Leads session was held in February, bringing together over 60 leaders from both Trusts. With positive feedback received, further sessions are being planned in 2024. **NHS Graduate Trainees**: Following on from the successful bid to host trainees commencing in September 2023 the collaborative has again bid to host trainees from the next cohort. The Trusts were successful in their bid and are likely to be allocated trainees to commence in September 2024. In line with the approach undertaken in 2023/24, a structured work programme has been developed (Appendix 1). This is based on engagement across both organisations and consideration of the ongoing programme of work already in place
Due Diligence	Elements of this report have been presented to both Boards of Directors at TRFT and BHFT through the Joint Strategic Partnership Group.
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
Appendices	Partnership Plan on a Page 2024-25

1.0 Background

2.1 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.

2.2 The Trusts created a Joint Strategic Partnership Group (JSPG), comprising both Chairs, a Non-Executive Director from each Trust, both Managing Directors, the Joint Director of Corporate Governance 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.

2.3 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 Joint Chief Executive plus the Managing Directors/Deputy Chief Executives, Medical Directors, Chief Operating Officers, Director of Strategy, Planning & Performance (TRFT), Joint Director of Corporate Governance 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.

2.4 The two trusts have been working closely together since the appointment of the interim Joint Chief Executive at TRFT in 2020. However, the arrangement progressed to a more formal strategic partnership in 2022, with the interim Joint Chief Executive arrangement being formalised into a substantive joint role.

2.5 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. This partnership has taken the form of each organisation learning from the other, proactively sharing best practice and exploring opportunities for collaboration.

2.6 A formal programme of work was developed for delivery in 2023/24 based around three themes. These were:

- Theme 1: Governance
- Theme 2: Major Programmes
- Theme 3: Project Work

3.0 Delivery against this plan

3.1 The collaborative has made good progress against the original ambitions with a number of areas successfully delivered, or in progress. These include:

3.1.1 **Clinical Services Review:** The work to develop and deliver a joint Haematology Service has continued at pace. The project has a formal governance structure including engagement from our clinical teams. The development of an assessment matrix has allowed the decision regarding a single inpatient unit to be clinically led and support any

public engagement which will be required. It is also evident that this programme will continue for a significant period of time and as such it is unlikely that another service collaboration on this scale will be commenced in 2024/25.

3.1.2 **Service Sustainability Reviews:** The Two trusts continued to collaborate and align their processes around Service Sustainability Reviews with them being completed in Q4 2024. The information was reviewed and shared at the Joint Executive Meeting in February 2024. The methodology developed by TRFT and BHFT has since been adopted by the Acute Federation and is being rolled out across other providers.

3.1.3 **Joint Leadership Development**: The programme continues and will run through to quarter 3. Initial feedback from participants has been positive.

3.1.4 **Joint Roles:** The Trust continues to explore the possibilities of joint roles across teams and have recently appointed a Joint Director and a Joint Deputy Director of Communications, strengthening, and adding resilience to both organisations' teams. Further work is now taking place with Executive Leads to look at their functions and the opportunities for further collaboration including where it is possible, and beneficial to have joint roles.

3.1.5 **Joint Clinical Leaders:** The first Joint Clinical Leads session was held in February, bringing together over 60 leaders from both Trusts. With positive feedback received, further sessions are being planned in 2024.

3.1.6 **NHS Graduate Trainees**: Following on from our successful bid to host trainees commencing in September 2023 the collaborative has bid again to host trainees from the next cohort. The Trusts were successful in their bid and are likely to be allocated trainees to start in September 2024. The feedback from our current trainees has been positive regarding their experiences and the level of support and guidance they have received. Additionally, their placement managers who manage them on a day-to-day basis have been really positive around the tangible contribution they are already making to their teams.

3.1.7 **Performance Dashboard**: The Trusts have developed a joint performance dashboard, highlighting key metrics across both organisations enabling variations in performance to be identified. This work is being finalised with the intention that it is used to guide conversations and identify areas where there is an opportunity for learning, or joint development.

Development of the Work Programme into 2024/25

3.2 In line with the approach undertaken in 2023/24, a structured work programme has been developed (Appendix 1). This is based on engagement across both oragnisations and consideration of the ongoing programme of work already in place.

3.3 The programme of work is again structured around three main themes.

- Defined Programmes of Work
- Collective Influence and Mutal Support
- Moving to Business as Usual

3.4 These themes have been updated reflecting the growing maturity and goals of the partnership.

4.0 Programmes of Work

4.1 Four programmes of work have been developed for 2024/25. Two of these programmes are the continuation of work commenced in 2023/24 – Joint Clinical Services focused on the Haematology services and the Senior Leadership Development Programme, with the completions and evaluation of that programme planned for quarter 3/4. Two new programmes are being developed – Clinical Services Learning Programme and Corporate Team Opportunities.

4.1.1 **Clinical Services Learning Opportunities:** Building on the successes of the Haematology engagement event and the Joint Clinical Leads session, a programme of work will be developed to bring together clinical teams from services across both organisations. The aim will be to enable the teams to collaborate independently of any formal programme – such as in Haematology – and support and learn from each other on an ongoing basis.

4.1.2 **Corporate Team Opportunities:** To complement the work on clinical services we have also begun some focused work on our corporate services structures and processes, exploring where collaboration may help us improve and/or be more efficient. There are no set expectations on how teams should collaborate, and this could range from shared learning towards joint teams and leadership where appropriate and beneficial.

4.2 **Collective Influence and Support:** Over 2023/24 the Trusts have been able to support each other and provide a collective voice (when appropriate) into our regional and national systems. We want to continue this into 2024/25 with a focus on two specific areas:

4.2.1 **Financial Recovery:** Both organisations have a challenging financial recovery plan to deliver over the next 2 years. The drivers and solutions to these challenges will have some similarities, but also be different in both organisations. The ability to share insight, ideas and approaches across the Trusts will be invaluable in supporting the individual organisations to deliver the ambition.

4.2.2 **System and Acute Federation Delivery:** The two Trusts can have greater influence when they act together. As a collaborative, the ability to engage on key System and Acute Federation programmes to support delivery – and delivery in a way which supports the Trusts – is key. This will include areas such as the development and continued implementation of MEOC and the implementation and realisation of benefits from the networked pathology service.

4.3 **Moving to Business as Usual**

4.4 The maturing nature of the partnership has been positive over the last few years. Individuals, teams and services have begun to proactively engage with each other as a route to support, learning and improvement. The collaborative wants to continue to foster this culture, providing the opportunity, and importantly the permission for teams to look to collaborate by default. Initially this work will be focused on communication across both Trusts supported by the new Joint leadership in our communications functions.

5.0 Conclusions

5.1 The two Trusts continue to make progress in partnership working which is having a tangible impact at both organisations. The programme of work agreed for 2023/24 has delivered key interventions and put in place appropriate governance arrangements. The programme agreed for 2024/25 continues this ambition with a focus on enabling teams to work together, either through structured programmes of work or through a culture of collaboration, to deliver improvements for patients, to services and our staff.

6.0 Recommendations

6.1 The Board of Directors is asked to note the progress on the partnership and support the future development planned around the programme.

BHFT & TRFT Partnership Programme 2024-25

DEFINED PROGRAMMES OF WORK

Programme	Objective	Q1	Q2	Q3	Q4
Joint Clinical Services	Continue to develop and deliver the Haematology collaboration and undertake a review and learning from the Gastroenterology programme	• Agree the Haematology IP model across both organisations • Undertake a review of the Gastroenterology programme with a focus on the financial benefits	• Continued delivery and implementation of the Haematology collaboration		
Senior Leadership Development Programme	Complete the Senior Leadership Development Programme, ensuring that have developed and raised expectations of our leaders	• Undertake the final sessions of the leadership development programme		• Undertake a review of the effectiveness of the programme and opportunities for further cohorts	
Clinical Service Learning Programme	Introduce a programme of clinical service learning between the two Trusts, offering teams the opportunity to come together to share learning and opportunities	• Agree programme / session approach • Agree prioritisation of initial y1 services • Undertake and evaluate the approach with one service	• Finalise the programme following review of single service • Roll out on a monthly basis to other services	• Rolling programme to deliver session for 10 teams across 24/25	
Corporate Team Opportunities	Complete a full review of corporate team structures and agree (and implement) appropriate changes to ways of working and structures to improve effectiveness and efficiency	• Complete corporate area reviews with each Executive Director pairing • Share initial findings and opportunities at Joint ETM	• Confirm proposed changes to roles/structures via appropriate mechanisms • Agree areas of focus for ways of working collaboration and development • Develop corporate team collaboration session outline to enable each team to identify potential joint working opportunities and roll out across teams		

COLLECTIVE INFLUENCE AND MUTUAL SUPPORT

Programme	Objective	Q1	Q2	Q3	Q4
Financial Recovery and Back to Balance	Collaborate on programme of work to deliver financial balance in both organisations by the end of 25/26, maximising opportunities to work together in order to reduce costs and increase income	• Finalise each internal Trust 'Back to Balance' plan based on final financial plan submissions	• Adopt Acute Federation Productivity Metrics within Partnership Dashboard • Share learning and opportunities	• Share learning from opportunities and challenges identified from productivity metric comparison on ongoing basis	
System and Acute Federation Delivery	Engage collaboratively on key System and Acute Federation programmes to ensure successful delivery and appropriate engagement from our teams	• Ensure MEOC delivery improves in order to meet national expectations • Proactively support new Pathology service go-live in April	• Engage with Acute Federation Service Sustainability Reviews and ensure appropriate input from our two trusts		

MOVING TO BUSINESS AS USUAL

Programme	Objective	Q1	Q2	Q3	Q4
Promotion and enabling of the collaboration	Continue to provide the opportunities, culture and permission for teams to actively seek out the collaborative as a place of support, development and opportunity	• Develop a communication plan for the collaborative across both organisations that gives staff and teams insight into what the collaborative offers	• Implement the communication plan and part of BAU comms		

Board of Directors' Meeting
3 May 2024

Agenda item	P/78/24
Report	**Freedom to Speak up Guardian Quarter 3/4 Update**
Executive Lead	Helen Dobson, Executive Chief Nurse
Link with the BAF	U4: There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.
How does this paper support Trust Values	Promoting a culture of Speaking up within TRFT supports all three of the Trust values of ambitious, Caring and Together
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒ x
Executive Summary (including reason for the report, background, key issues and risks)	This paper provides the Board of Directors with an update of concerns which would be deemed whistleblowing, raised both to the Freedom To Speak Up Guardian and through other official routes and offer a comparison for TRFT against other local and similar sized organisations. There is an update of how the profile of the Speaking up agenda is being raised and embedded within The Rotherham NHS Foundation Trust. **<u>Summary of Key Points:</u>** The key points arising from the report are • Staff survey results very positive • Reduction in number of staff raising concerns • New lead Guardian appointed & in post • New policy drafted on new NGO template and to be submitted for ratification • FTSU sessions held with nurse preceptorship
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was presented to the People Committee in April 2024.
Board powers to make this decision	N/a

Who, What and When (what action is required, who is the lead and when should it be completed?)	No further action required from the Board.
Recommendations	It is recommended that the Board note the Q3& 4 report.
Appendices	None

1. Introduction

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

1.2 The Trust introduced FTSU Guardians (FTSUG) in 2015, with a FTSUG lead appointed in October 2016.

2. Background

2.1 The report aims to provide the Peoples Committee with a high-level overview of the activity undertaken by the FTSUG during quarter three and four 2023-24, highlighting the number of concerns raised, actions taken and resultant learning.

3. Reporting and Governance

3.1 Since the last report in December 2023 the FTSUG lead has remained the responsibility of the Chief Nurse. The lead role has since been filled and the successful candidate appointed to the role on an increased 0.6 WTE.

3.2 During this reporting period only one concern has been raised that related to bullying & harassment/attitudes and behaviours. Due to the low numbers of concerns raised there are no trends across departments, divisions or staff groups.

3.3 The concern was escalated to line managers/HR and is now closed and the individual who raised the concern informed of the outcome.

3.4 The FTSUG lead meets regularly with the Chief Executive, Chief Nurse and Director of People, which provides an opportunity for discussion regarding issues raised, and potential learning opportunities. The FTSUG lead has also had regular support from the Senior Independent Director regarding issues and themes.

3.5 The Trust has an overall compliance rating of 93.51% for FTSU Mast e-learning training with every division being above the target of 85%.

Division	Conflict Resolution
Clinical Support Services	95.67%
Community Services	96.42%
Corporate Operations	87.07%
Corporate Services	89.77%
Emergency Care	92.35%
Family Health	93.55%
Medicine	92.44%
Surgery	95.67%
Grand Total	93.51%

3.6 In addition to the lead guardian, there are 8 Freedom to Speak Up Ambassadors within the Trust, one of which has also attended the National Guardians training session. A further review of the FTSU structure will take place now that the new lead is in post.

4. Summary of FTSU Concerns for TRFT

4.1 There is no pattern due to the small number of concerns raised during quarter three and four.

5. Feedback following Raising a FTSU concern

5.1 It remains difficult to get feedback from staff who have raised concerns via the questionnaires, as there is a reluctance to respond once the concerns have been addressed.

6. Raising the Profile of FTSU within TRFT

6.1 Work has continued to increase the visibility of FTSU within the Trust. This has included development of promotional information on the role of the guardians.

6.2 The FTSU Ambassadors' have highlighted the role and associated agenda through various forms. The FTSUG lead is continuing to work with the equality and diversity lead to increase awareness amongst all staff groups.

7. National Guardian Office Data

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

8. TRFT Comparison with National Data

8.1 The value of comparison between Trusts is difficult to determine as a high or low number of concerns does not necessarily provide assurance regarding the speaking up culture of the Trust. The NGO remains keen for Trusts to avoid comparison.
The staff survey results remains the best indicator of staff confidence in speaking up, the data for the recent staff survey (Nov 2023) shows significant increase in staff confidence. The full breakdown will be included in a future report.

8.2 The key performance indicator for organisation is that the NGO receive a data return each quarter.

9. National Guardian Office Case Reviews

9.1 There have been no case reviews published during quarter three or four.

10. Conclusion

10.1 There has been a large decrease in the number of concerns that have been raised during the final two quarters of 2023/24. The responses to the staff survey are extremely encouraging and the guardians will continue to promote a positive speaking-up culture, to prevent harm and improve outcomes for both colleagues and patients.

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

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

Board of Directors Meeting
3rd May 2024

Agenda item	P79/24
Report	**Integrated Performance Report – March 2024**
Executive Lead	Michael Wright, Managing Director
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 March 2024 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 and our safer staffing levels are provided separately 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. Work continues on the development of a new IPR in time for 2024/25 reporting for April data. The most recent Board seminar in April provided a clear agreement around the direction of travel, with work now focussed on confirming the details of the information to be provided across all domains.
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 Managing Director is the Lead Executive for reporting on the performance of the organisation through the Integrated Performance Report on a monthly basis.

Recommendations	It is recommended that the Board of Directors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.
Appendices	Integrated Performance Report – March 2024

Board of Directors

Integrated Performance Report - March 2024

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			
Patient Safety	Cancer Care			
Maternity	Inpatient Care			
Patient Experience	Community Care			

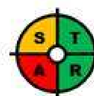
CQC DOMAINS

Responsive	Effective	Safe	Caring	Well Led
Planned Patient Care	Mortality	Infection Prevention & Control	Patient Experience	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 23/24	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	Mar 2024	L	**27,000**		30,647	29,954	30,402	30,814	30,814	26,434		
Referral to Treatment (RTT) Performance	Mar 2024	N	**92%**		60.4%	60.1%	60.4%	59.8%	61.7%	68%		
Number of RTT patients waiting 52+ Weeks	Mar 2024	L	**150**		713	697	678	679	679	315		
Number of RTT patients waiting 78+ Weeks	Mar 2024	L	**0**		3	6	5	4	4	0		
Number of RTT patients waiting 65+ Weeks	Mar 2024	L	**0**		90	95	74	22	22	0		
Overdue Follow-Ups	Mar 2024	L	**-**		13,881	13,063	14,041	15,347	15,347	14,809		
First to follow-up ratio	Mar 2024	B	**2.4**		2.32	2.28	2.50	2.54	2.47	2.33		
Day case rate (%)	Mar 2024	B	**85%**		84.4%	88.2%	85.5%	84.2%	85%	85%		
Day case rate (%) - Model Hospital	Dec 2023	B	**85%**		83.9%	84.9%	84.8%	83.8%	--	78%		
Diagnostic Waiting Times (DM01)	Mar 2024	N	**1%**		2.8%	2.0%	1.3%	0.2%	3.9%	4%		
Diagnostic Activity Levels - for Key Modalities (from Apr 2023)	Mar 2024	L	**8669**		7,826	9,049	8,435	8,615	8,615	9730		
Capped Theatre Utilisation *(internal data)*	Mar 2024	L	**85%**		77.5%	76.4%	79.5%	75.2%	75.2%			
Emergency Performance												
Number of Ambulance Handovers > 60 mins	Mar 2024	N	**0**		144	348	236	166	1,442	95		
Ambulance Handover Times % > 60 mins	Mar 2024	N	**0%**		6.4%	15.9%	11.3%	7.1%	5.8%	5%		
Number of Ambulance Handovers 30+ mins	Mar 2024		**-**		424	692	538	502	3,883	288		
Ambulance Handover Times % 30+ mins	Mar 2024	L	**10%**		18.7%	31.6%	25.8%	21.6%	15.6%	15%		
Average Time to Initial Assesment in ED (mins)	Mar 2024	N	**15**		26	32	29	24	27	26		
4hr Performance in Dept - against internal target	Mar 2024	N	**76%**		59%	55%	57.2%	62.9%	59.2%			
4hr Performance in Dept - against external target	Mar 2024	N	**70%**		59%	55%	57.2%	62.9%	59.2%			
Proportion of patients spending more than 12 hours in A&E from time of arrival	Mar 2024	L	**2%**		5.1%	8.7%	8.0%	5.8%	5.4%	7%		
Number of 12 hour trolley waits	Mar 2024	N	**0**		7	30	4	7	49	1		
Proportion of same day emergency care	Mar 2024	L	**33%**		38.5%	34.1%	38.2%	40.2%	41.1%	44%		
Cancer Care												
31 Day Treatment General Standard *(new standard from Oct 23)*	Feb 2024	N	**96%**		99.0%	94.8%	95.2%	95.1%	96.3%	93%		
62 Day Treatment General Standard *(new standard from Oct 23)*	Feb 2024	N	**85%**		78.7%	74.9%	73.3%	72.1%	75.9%	72%		
The number of cancer patients waiting 63 days or more after a GP 2ww referral	Mar 2024	L	**54**		54	59	51	44	44	-		
28 day faster diagnosis standard	Feb 2024	N	**75%**		73.8%	78.5%	70.1%	77.9%	70.0%	66%		
Inpatient Care												
Mean Length of Stay - Elective (excluding Day Cases)	Mar 2024				2.95	2.31	2.19	2.66	2.67	2.38		
Mean Length of Stay - Non-Elective	Mar 2024				5.01	5.35	5.38	5.19	5.29	5.66		
Length of Stay > 7 days (Snapshot Numbers)	Mar 2024	L	**142**		174	201	187	195	195	187		
Length of Stay > 21 days (Snapshot Numbers)	Mar 2024	L	**60**		46	56	61	54	54	55		
Right to Reside - % not recorded *(internal data)*	Mar 2024	B	**0%**		9.9%	14.2%	12.2%	14.9%	14.9%	7%		
% of patients where date of discharge is same as Discharge Ready Date	Feb 2024				84%	82%	80%	83%	--	-		
Discharges before 5pm (inc transfers to Community Ready Unit)	Mar 2024	L	**70%**		62.1%	63.9%	63.6%	63.3%	61.9%	59%		
Outpatient Care												
Did Not Attend rate (outpatients)	Mar 2024	B	**6.2%**		9.2%	8.3%	7.7%	8.0%	8.8%	9%		
% of all outpatient activity delivered remotely (via telephone or video)	Mar 2024	N	**25%**		13.7%	11.8%	12.6%	13.7%	12.5%	12%		
Proportion of all outpatient appointments with patients discharged to PIFU	Mar 2024	N	**5%**		2.8%	3.0%	3.5%	2.9%	2.4%			
LUNA Data Quality Score	Mar 2024	N	**99%**		99.2%	99.0%	99.0%	99.0%	--			
% of RTT PTL reported as validated	Mar 2024	N	**90%**		84.2%	91.67%	90.63%	87.20%	87.20%			
Community Care												
MusculoSkeletal Physio <4 weeks	Mar 2024	L	**80%**		26.2%	19.4%	24.7%	24.7%	26.0%	18%		
A&E attendances from care homes	Mar 2024	L	**144**		162	148	149	164	164	141		
Admissions from care homes	Mar 2024	L	**74**		114	117	109	135	135	102		
Urgent 2 hour Community Response	Feb 2024	L	**70%**		73%	73%	71%	69%	76%	82%		
Numbers of pts on virtual ward	Mar 2024	L	**80**		53	67	44	76	76	0		
Number of patients in month accepted onto virtual ward (Total)	Mar 2024				327	279	213	242	242	0		

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)	Dec 2023	B	**As Expected**		100.8	100.7	100.6	98.7	--	107.3		
Mortality index - HSMR (Rolling 12 months)	Jan 2024	B	**As Expected**		90.1	89.8	90.2	92.1	--	99.0		
Number of deaths (crude mortality)	Mar 2024		-		99	104	81	101	964	100		
Infection, Prevention and Control												
C. difficile Infections	Mar 2024	L	**2**		4	0	4	7	45	4		
C. difficile Infections (rate)	Mar 2024		-		29.9	26.5	27.6	29.7	29.7	25.9		
E.coli blood bactertaemica, hospital acquired	Mar 2024	L	**4**		3	2	2	8	47	2		
P. Aeruginosa (Number)	Mar 2024	L	**0**		2	0	0	0	4	0		
Klebsiella (Number)	Mar 2024	L	**0**		0	0	0	0	14	0		
Patient Safety												
Serious Incidents - one month behind (PSII process from 20th Nov 24)	Feb 2024	L	**0**		3	4	2	3	34	1		
Number of Patient Incidents (including no-harm)	Mar 2024		-		895	1,087	904	990	11,392	-		
Number of Patient Falls (moderate and above)	Mar 2024		-		1	4	2	1	18	2		
Number of Pressure Ulcers (G3 and above) - one month behind	Feb 2024		-		0	2	0	2	8	0		
Medication Incidents	Mar 2024		-		84	99	104	94	1177	91		
Readmission Rates (one month behind) - NE - excluding D/Cs	Feb 2024		-		9.2%	8.7%	9.5%	8.0%	9.7%	10.4%		
Venous Thromboembolism (VTE) Risk Assessment	Mar 2024	N	**95.0%**		96.7%	96.8%	97.1%	96.2%	95.9%	96.6%		
Hip Fracture Best Practice Tariff Compliance	Feb 2024	L	**65.0%**		76.0%	62.0%	74.0%	82.0%	82.0%	81.5%		
Patient Experience												
Number of complaints per 10,000 patient contacts	Mar 2024	L	**8**		7.11	9.01	11.14	8.96	9.76	7.78		
F&F Postive Score - Inpatients & Day Cases	Mar 2024	N	**95.0%**		97.8%	97.7%	98.1%	97.8%	97.3%	99.2%		
F&F Postive Score - Outpatients	Mar 2024	N	**95.0%**		95.8%	95.1%	95.9%	96.6%	97.2%	98.4%		
F&F Postive Score - Maternity	Mar 2024	N	**95.0%**		100.0%	95.2%	97.4%	95.1%	97.9%	100.0%		
Care Hours per Patient Day	Mar 2024	L	**7.3**		6.90	7.10	6.80	6.70	6.70	6.5		
Maternity												
Bookings by 12 Week 6 Days	Mar 2024	N	**90.0%**		93.1%	91.9%	91.7%	90.9%	92.6%	94.9%		
Babies with a first feed of breast milk (percent)	Mar 2024	N	**70.0%**		55.1%	53.7%	58.3%	62.2%	59.5%	63.7%		
Stillbirth Rate per 1000 live births (Rolling 12 months)	Mar 2024	L	**4.66**		2.72	2.34	2.31	2.31	2.31	2.78		
1:1 care in labour - One month behind	Feb 2024	L	**75.0%**		100.0%	100.0%	100.0%	100.0%	99.7%	100.0%		
Serious Incidents (Maternity) - One month behind	Feb 2024	L	**0**		0	0	0	0	0	1		
Moderate and above Incidents (Harm Free) - One month behind	Feb 2024		-		0	0	0	0	0	0		
Consultants on labour (Hours on Ward)	Mar 2024		-		62.50	62.50	62.50	62.50	62.50	--		

Trust Integrated Performance Dashboard - Workforce

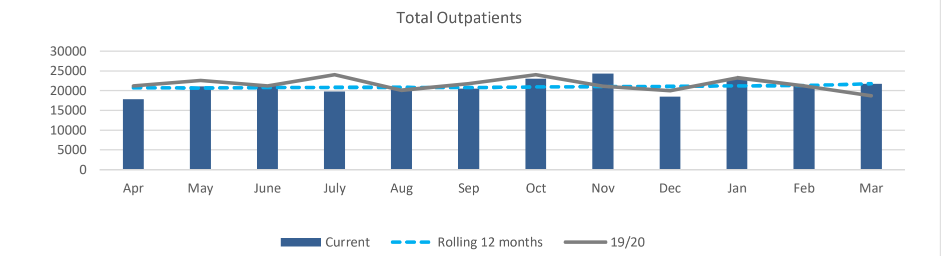
	Reporting Period	Type of Standard	Target	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Workforce												
Number of WTE vacancies - Total	Mar 2024	L	**285**		251	225	226	237	237	404		
Number of WTE vacancies - Nursing and Midwifery	Mar 2024	L	**98**		71	65	77	86	86	66		
Vacancy Rate - TOTAL	Mar 2024	L	**6.4%**		6.2%	5.6%	5.6%	6.0%	6.0%	8.93%		
Vacancy Rate - Nursing	Mar 2024	L	**7.3%**		5.1%	4.7%	5.5%	6.1%	6.1%	4.91%		
Time to Recruit	Mar 2024	L	**34**		37	34	34	38	38	37		
Sickness Rates (%) - inc COVID related	Mar 2024	L	**4.5%**		6.2%	6.7%	6.2%	5.3%	5.8%	5.65%		
Short-term Sickness Rate (%)	Mar 2024				2.3%	2.8%	2.3%	2.0%	-	-		
Long-term Sickness Rate (%)	Mar 2024				3.9%	3.9%	3.9%	3.3%	-	-		
Turnover (12 month rolling)	Mar 2024		**11%**		9.6%	9.3%	8.8%	8.9%	8.9%	-		
Appraisals complete (% 12 month rolling)	Mar 2024	L	**90%**		86%	84%	84%	82%	82%	81.00%		
Appraisals Season Rates (%)	Mar 2024	L	**90%**		85%	84%	84%	82%	82%	81.00%		
MAST (% of staff up to date)	Mar 2024	L	**85%**		91%	91%	91%	90%	90%	92.00%		
% of jobs advertised as flexible	Mar 2024		-		41.1%	32.4%	37.5%	63.6%	58.6%	67.4%		

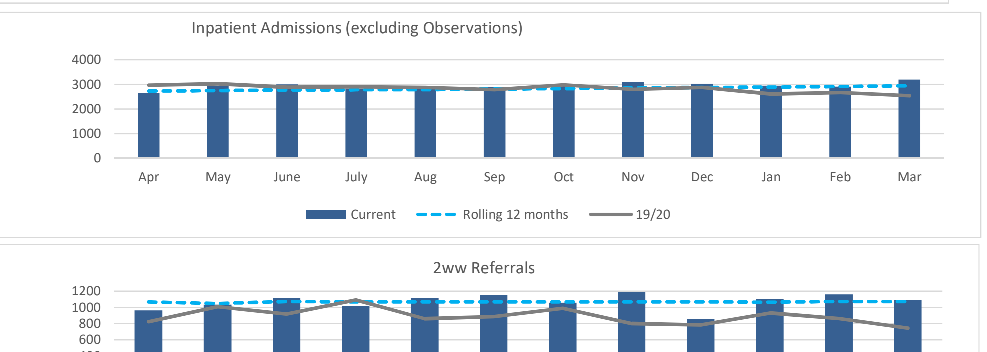
Trust Integrated Performance Dashboard - Finance

Apr 23 - Jan-24

	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)	(377)	(601)	(224)	(6,725)	(8,666)	(1,941)	(2,092)
I&E Performance (Control Total)	(316)	2,025	2,341	(5,977)	(4,715)	1,262	(1,427)
Efficiency Programme (CIP) - Risk Adjusted	1,267	3,277	2,009	12,176	11,018	(1,158)	(1,507)
Capital Expenditure	665	4,676	(4,011)	12,285	12,287	(2)	0
Cash Balance	(1,334)	(5,865)	(4,531)	14,638	12,116	(2,522)	(4,248)

Trust Integrated Performance Dashboard - Activity





Trust Integrated Performance Dashboard - Activity

Please note: March 2020 was the month that the Covid-19 pandemic affected NHS services nationwide, with significant amounts of non-urgent and non-life-saving care cancelled. Therefore, activity comparisons to March 2020 need to be treated with caution.

ACTIVITY

OUTPATIENTS			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
March	17,158	21,515	**138%**
YTD monthly average	20,289	20,355	**102%**

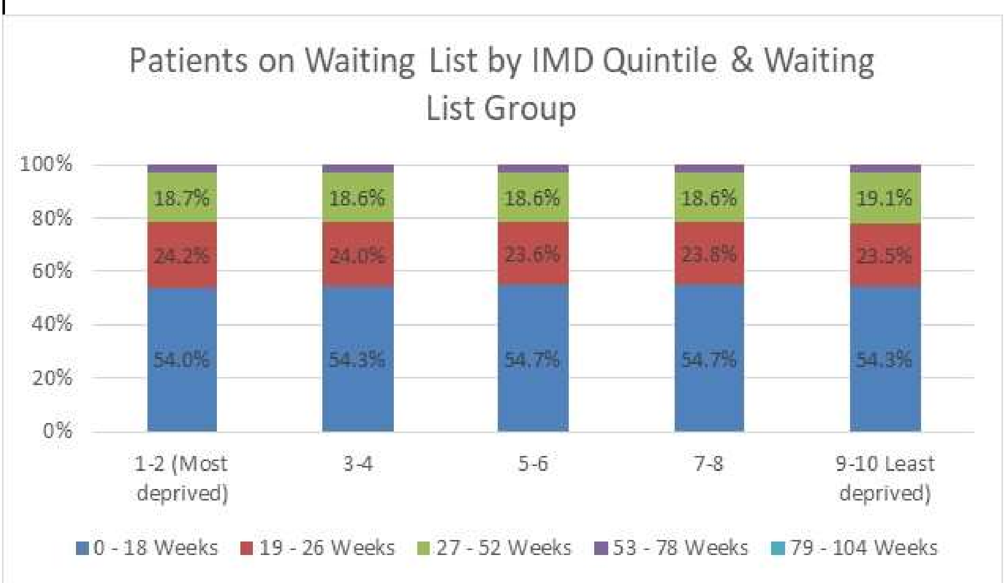
DAYCASES			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
March	1,739	2,140	**135%**
YTD monthly average	2,160	2,021	**95%**

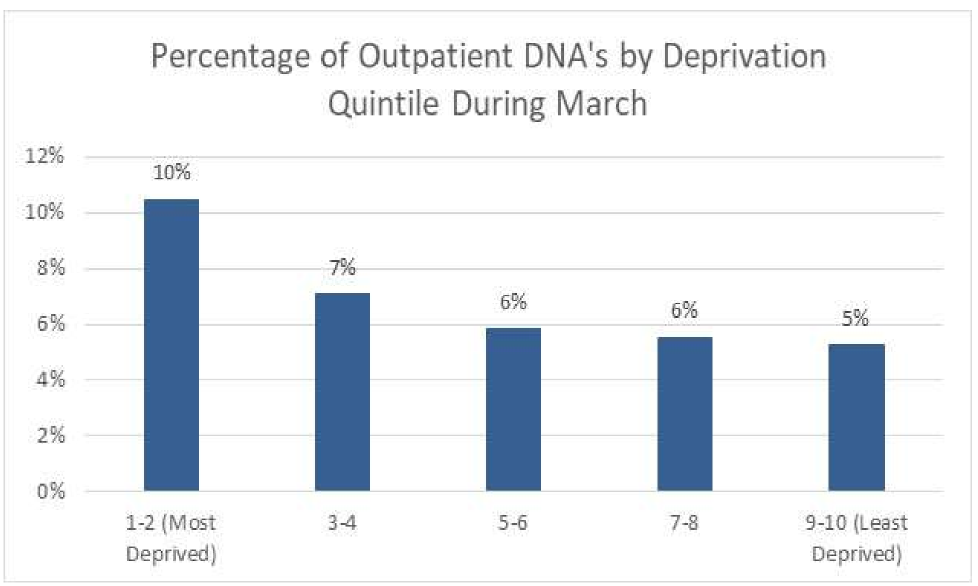
ELECTIVE ACTIVITY			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
March	356	390	**121%**
YTD monthly average	403	341	**86%**

Trust Integrated Performance Dashboard - Health Inequalities

RTT Snapshot 31/03/24

IMD Quintile	Patients on Waiting List	Median Wait (Wks)	% of All RTT Patients	% of Rotherham Population	% Proportion Difference to Rotherham Population
1-2	10,495	14	37.9%	36.0%	1.9%
3-4	6,605	14	23.9%	23.2%	0.6%
5-6	4,128	13	14.9%	15.2%	-0.3%
7-8	5,015	14	18.1%	19.5%	-1.4%
9-10	1,469	14	5.3%	6.0%	-0.7%
Total	**27,692**	**14**	**100.0%**	**100.0%**	**0.0%**





Safer Staffing

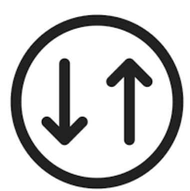
Trust Wide Scorecard Rolling 12 Months & Year End position 21/22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Daily staffing -actual trained staff v planned (Days)	84.8%	88.0%	91.0%	90.0%	89.0%	86.0%	86.0%	87.0%	90.0%	92.0%	91.0%	90.0%	88.0%
Daily staffing -actual trained staff v planned (Nights)	90.9%	94.0%	98.0%	95.0%	92.0%	90.0%	88.0%	90.0%	92.0%	92.0%	92.0%	95.0%	96.0%
Daily staffing - actual HCA v planned (Days)	80.0%	85.0%	90.0%	89.0%	90.0%	90.0%	89.0%	91.0%	91.0%	91.0%	92.0%	96.0%	96.0%
Daily staffing - actual HCA v planned (Nights)	90.0%	94.0%	97.0%	102.0%	102.0%	100.0%	93.0%	102.0%	103.0%	101.0%	94.0%	112.0%	109.0%
Care Hours per Patient per Day (CHPPD)	6.5	7.1	8.0	7.4	7.3	7.0	7.0	6.8	6.9	6.9	7.1	6.8	6.7

Key: < 85% 85-89% >=90%

Statistical Process Control Charts

Fact Sheet

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.
H	P	Special cause of an improving nature where the measure is significantly **HIGHER**. This occurs where there is improving performance. The system is capable and will consistently **PASS** the target.
H	?	Special cause of an improving nature where the measure is significantly **HIGHER**. This occurs where there improving performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
L	F	Special cause of an improving nature where the measure is significantly **LOWER** This occurs where there improving performance. However the system is still not capable. It will **FAIL** the target without system change.
L	P	Special cause of an improving nature where the measure is significantly **LOWER**. This occurs where there is improving performance. The system is capable and will consistently **PASS** the target.
L	?	Special cause of an improving nature where the measure is significantly **LOWER**. This occurs where there improving performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).



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

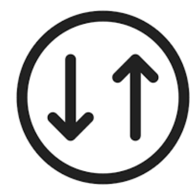
A run of values showing continuous increase or decrease is a sign that something unusual is happening in the system.

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

Perform	Assure	Description
H	F	Special cause of a concerning nature where the measure is significantly **H**IGHER. This occurs where there is higher pressure in the system or deteriorating performance. This system is not capable. It will **F**AIL the target without system change.
H	P	Special cause of a concerning nature where the measure is significantly **H**IGHER. This occurs where there is higher pressure in the system or worse performance. However despite deterioration the system is capable and will consistently **P**ASS the target.
H	?	Special cause of a concerning nature where the measure is significantly **H**IGHER. 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 **L**OWER. This occurs where there is deteriorating performance. This system is not capable. It will **F**AIL the target without system change.
L	P	Special cause of a concerning nature where the measure is significantly **L**OWER. This occurs where there is deteriorating performance. However the system is capable and will consistently **P**ASS the target.
L	?	Special cause of a concerning nature where the measure is significantly **L**OWER. 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 **F**AIL to consistently meet target without system change.
	P	Common cause variation, no significant change. The system is capable and will consistently **P**ASS 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 **H**IGHER. This occurs where there improving performance. However the system is still not capable. It will **F**AIL the target without system change.
H	P	Special cause of an improving nature where the measure is significantly **H**IGHER. This occurs where there is improving performance. The system is capable and will consistently **P**ASS the target.
H	?	Special cause of an improving nature where the measure is significantly **H**IGHER. This occurs where there improving performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
L	F	Special cause of an improving nature where the measure is significantly **L**OWER This occurs where there improving performance. However the system is still not capable. It will **F**AIL the target without system change.
L	P	Special cause of an improving nature where the measure is significantly **L**OWER. This occurs where there is improving performance. The system is capable and will consistently **P**ASS the target.
L	?	Special cause of an improving nature where the measure is significantly **L**OWER. This occurs where there improving performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).



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

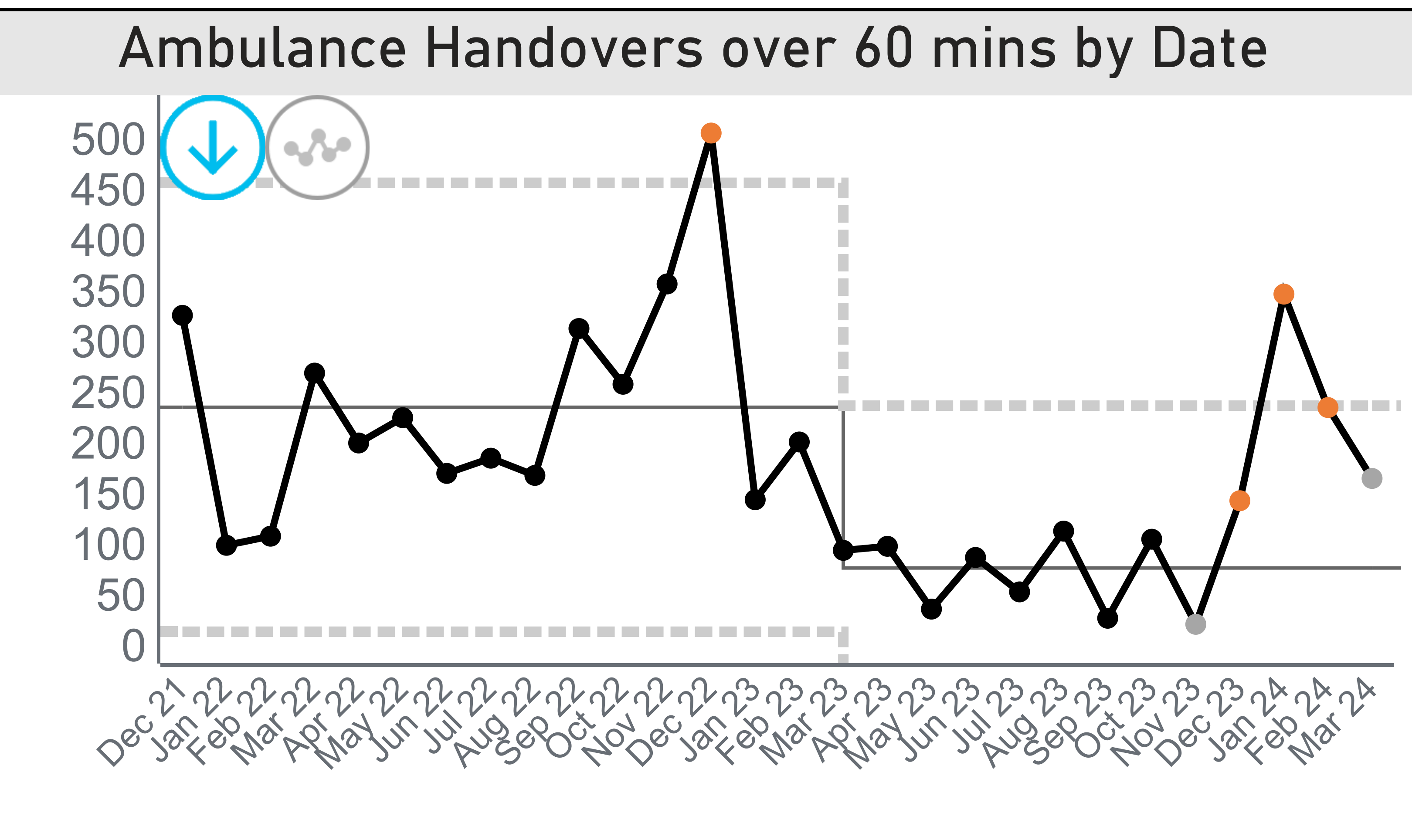
Consecutive points increasing or decreasing

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
Operational Performance Page 1

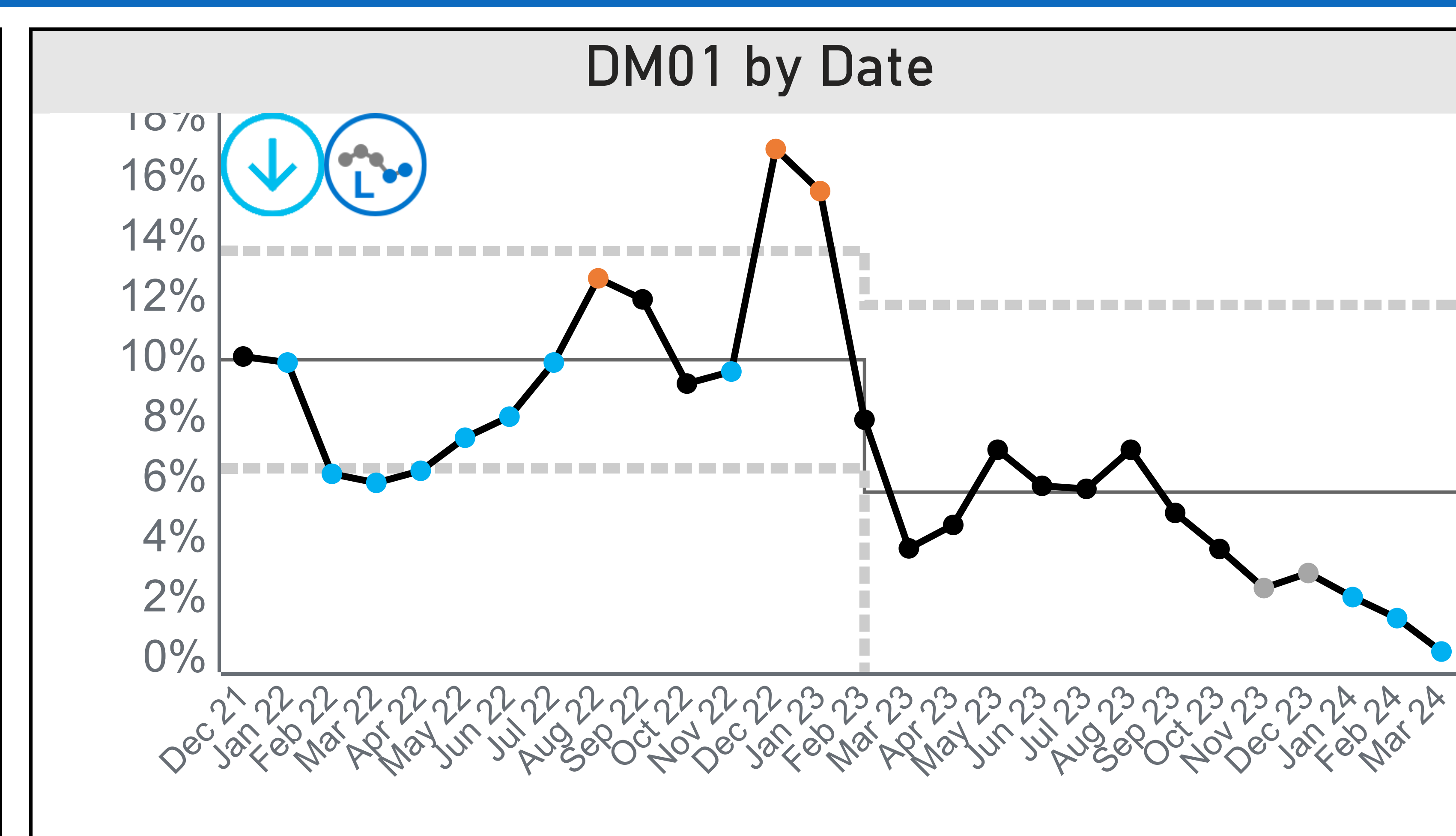


Improvement noted from Mar 23 of an average of 250 Handovers to 75 Handovers. Special cause noted in January with the increase to 348 decreasing to 236 in February and 166 in March.

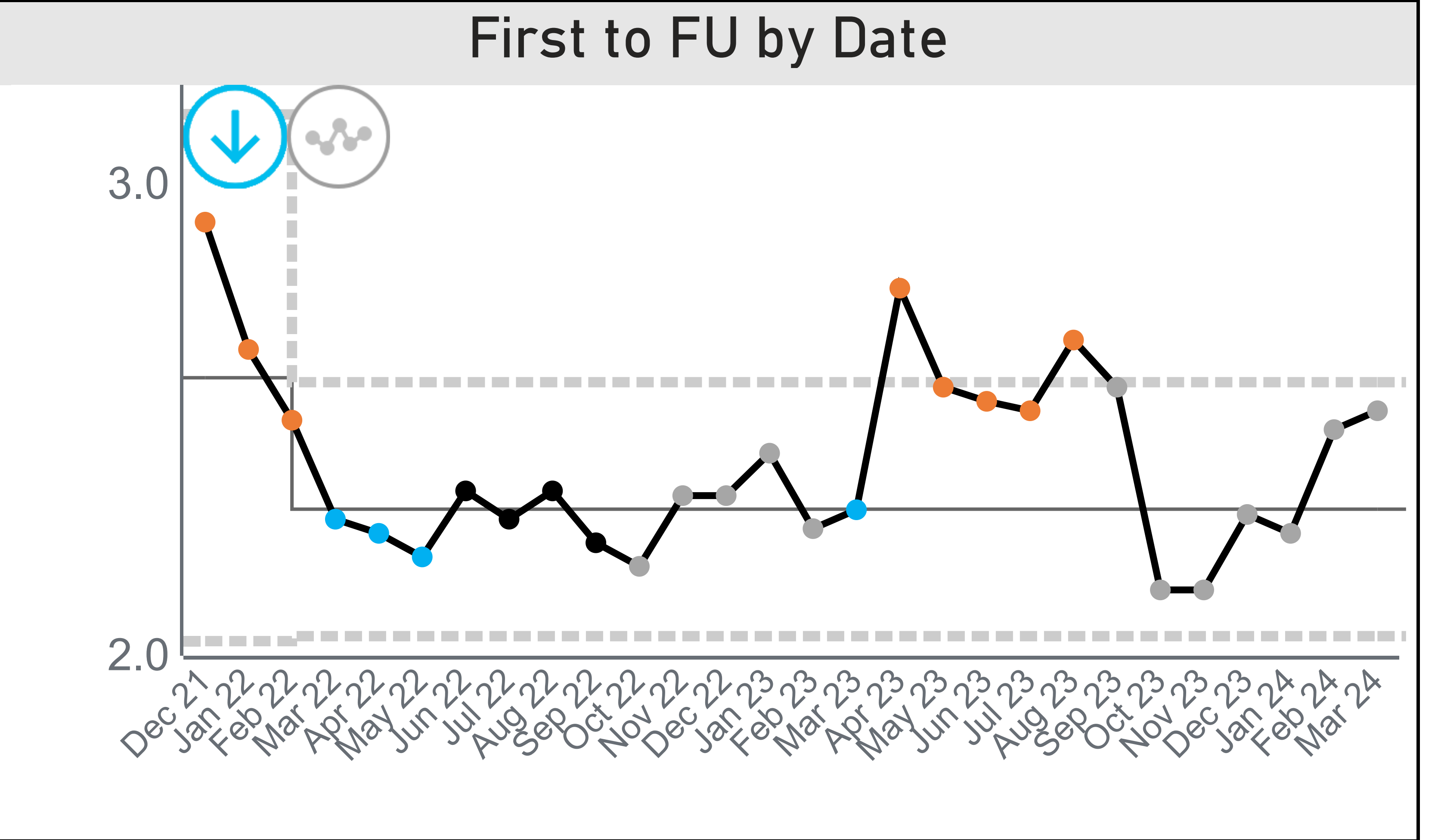
RTT by Date

80%
75%
70%
65%
60%
55%
50%
Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 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 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24

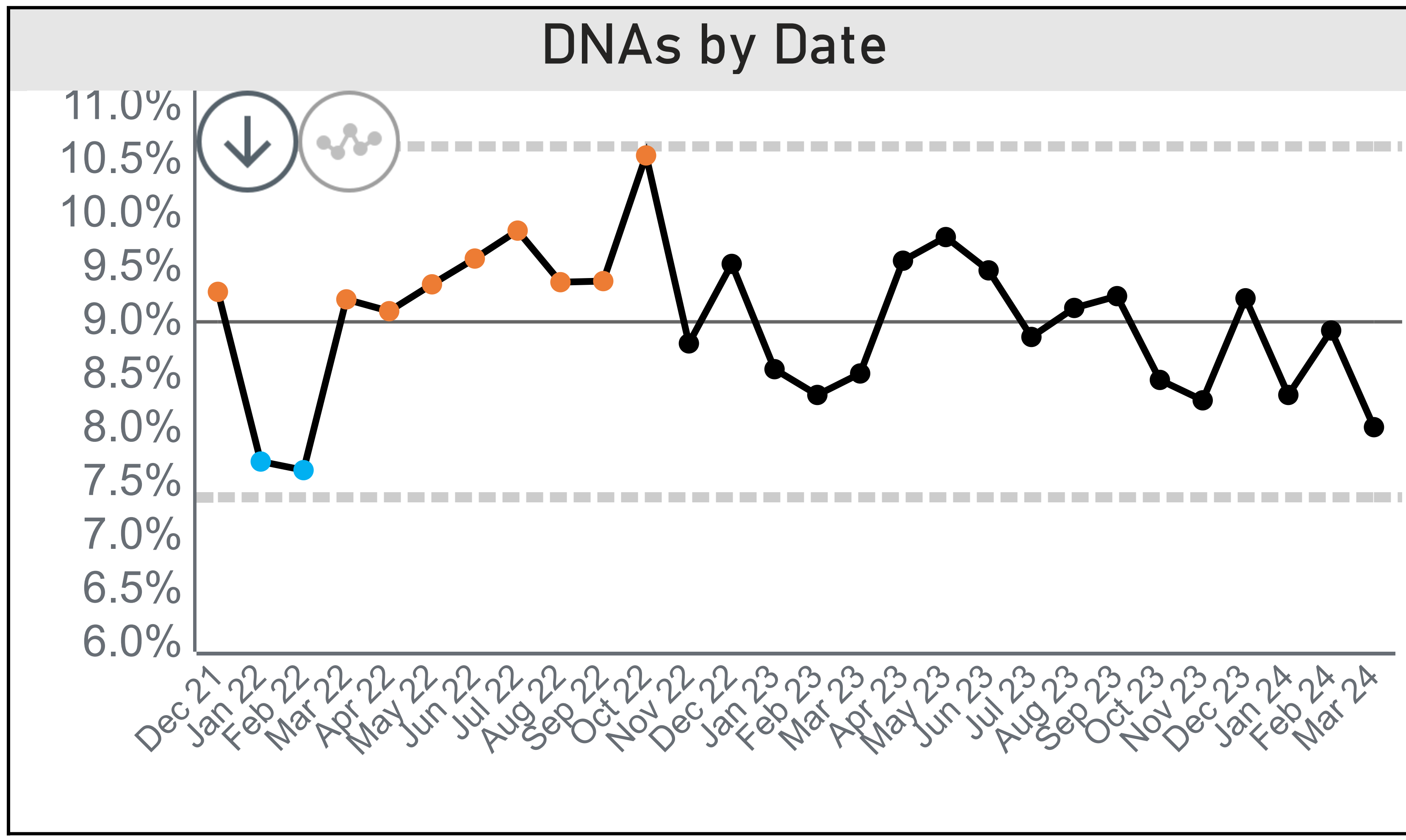
Continuous deterioration from 80% in Oct 21 to 60% in Jan 24, stabilising slightly from Aug 22 - Mar 23.



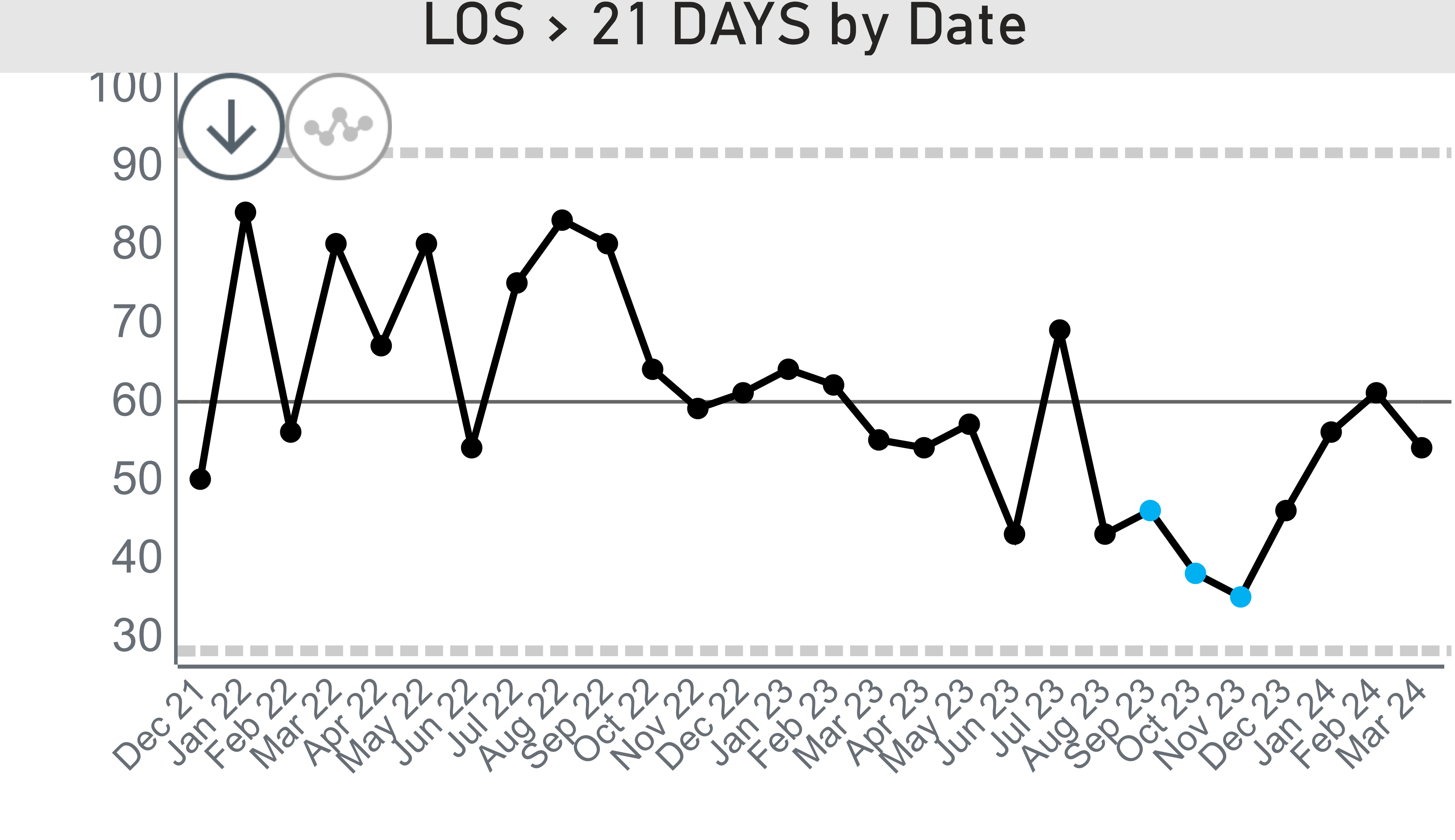
Significant improvement seen from an average of 10% to 6%. Meeting the target in March at 0.19%.



Common cause variation seen at an average of 2.2.

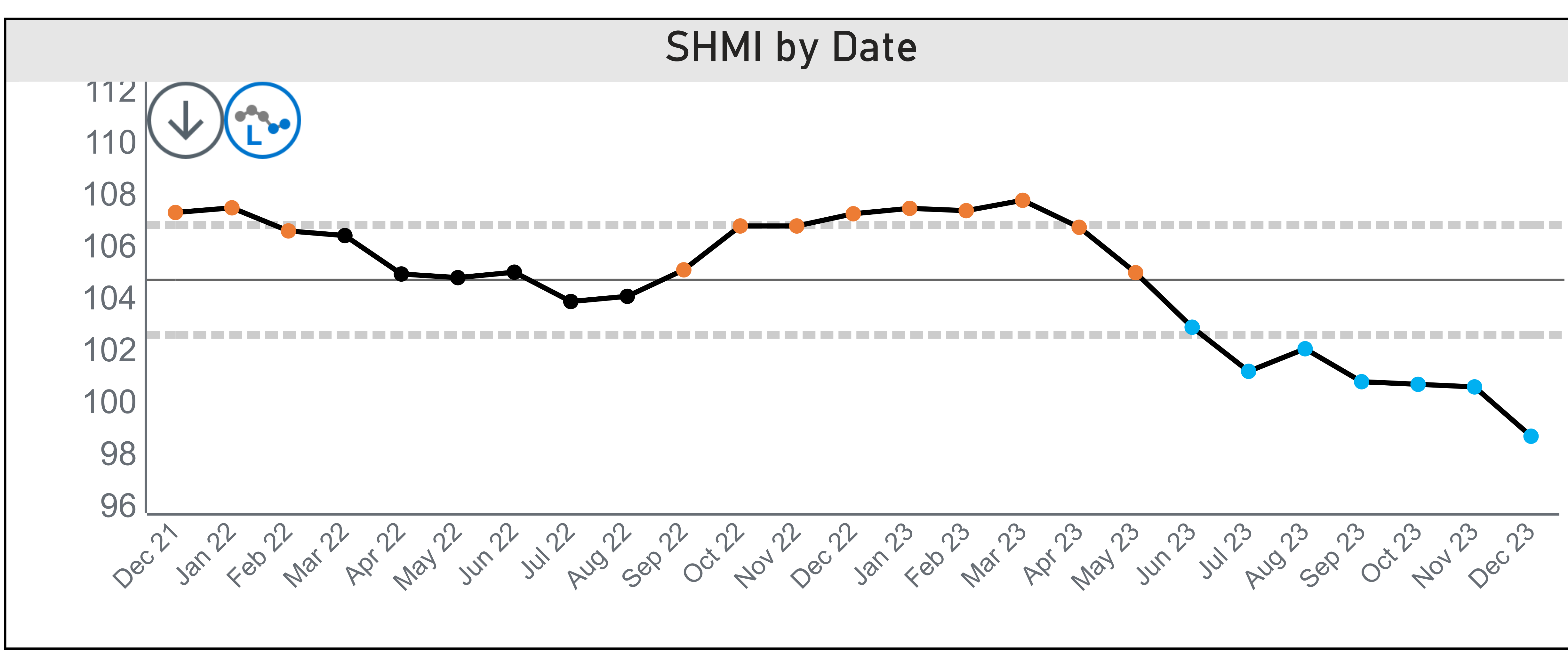


An average of 9% throughout the last 3 years. No significant variations noted.

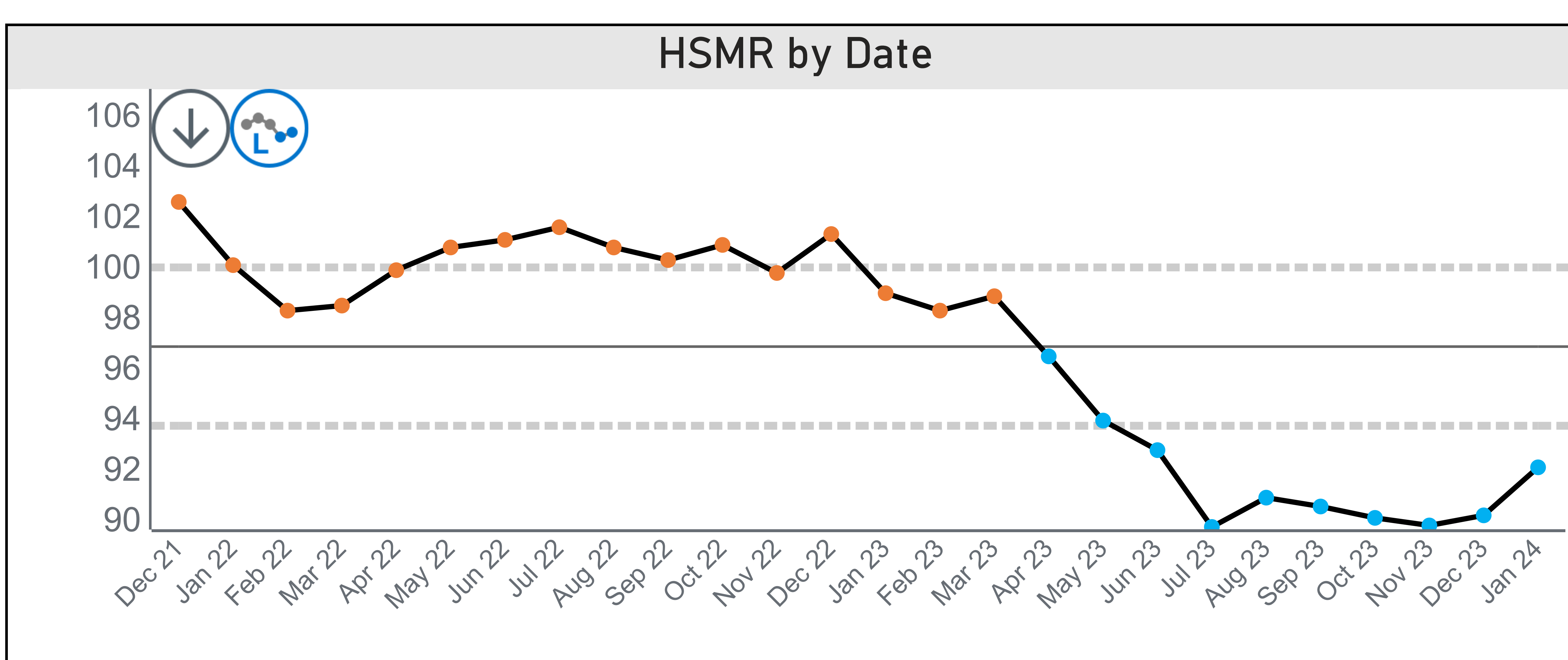


An average of 60 patients throughout the last 3 years. No significant variations noted.

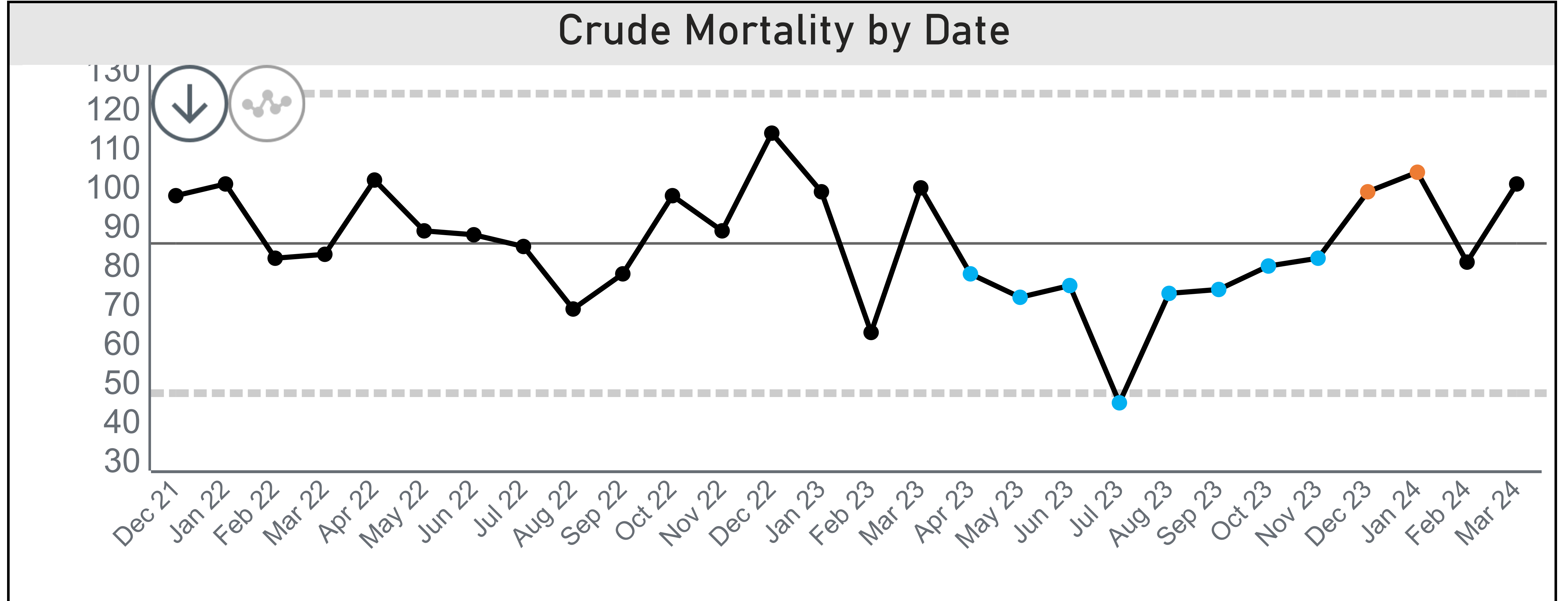
Statistical Process Control Charts
Quality Performance Page 1



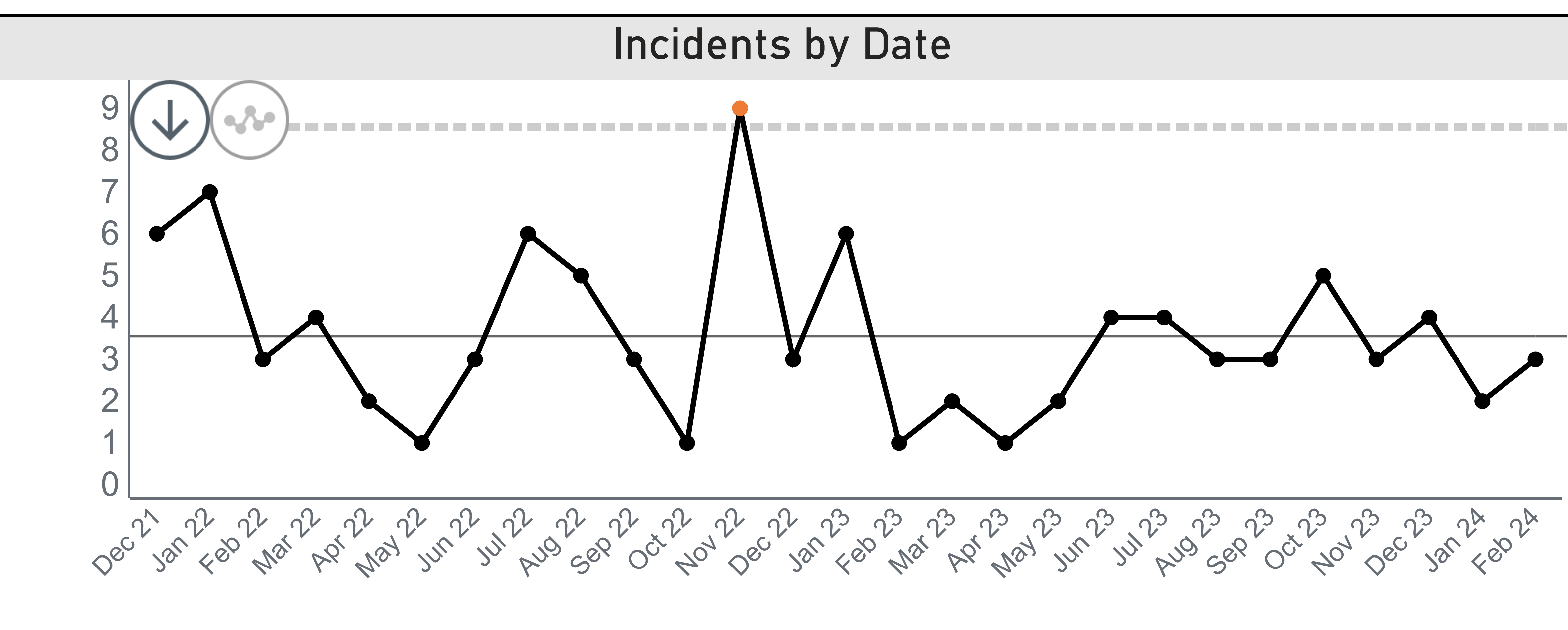
Significant improvement seen. Averaging at 105 over the last 3 years reducing to around 103 from June 23 and again to 96 in Dec 23.



Significant improvement seen from Oct 21 to Nov 23 with a slight deterioration in Dec 23 - Jan 24.

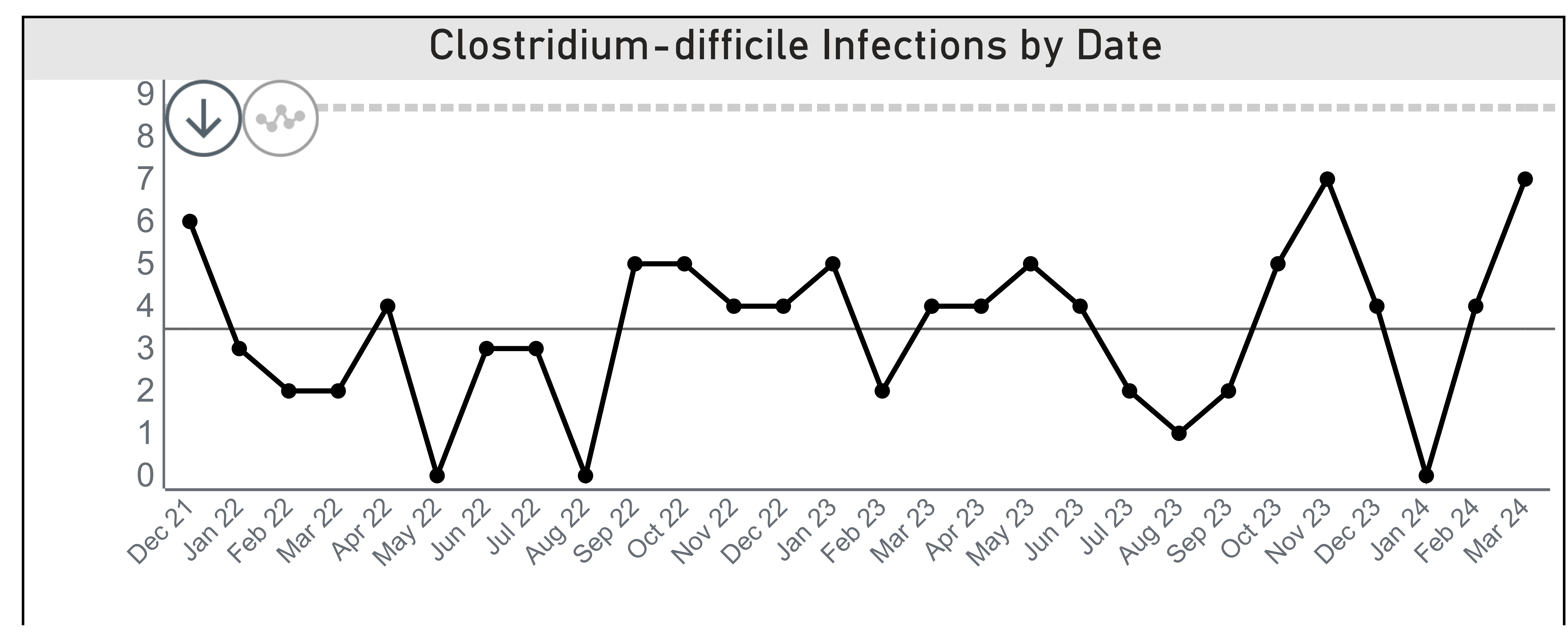


Averaging at 88 cases per month, no significant change.

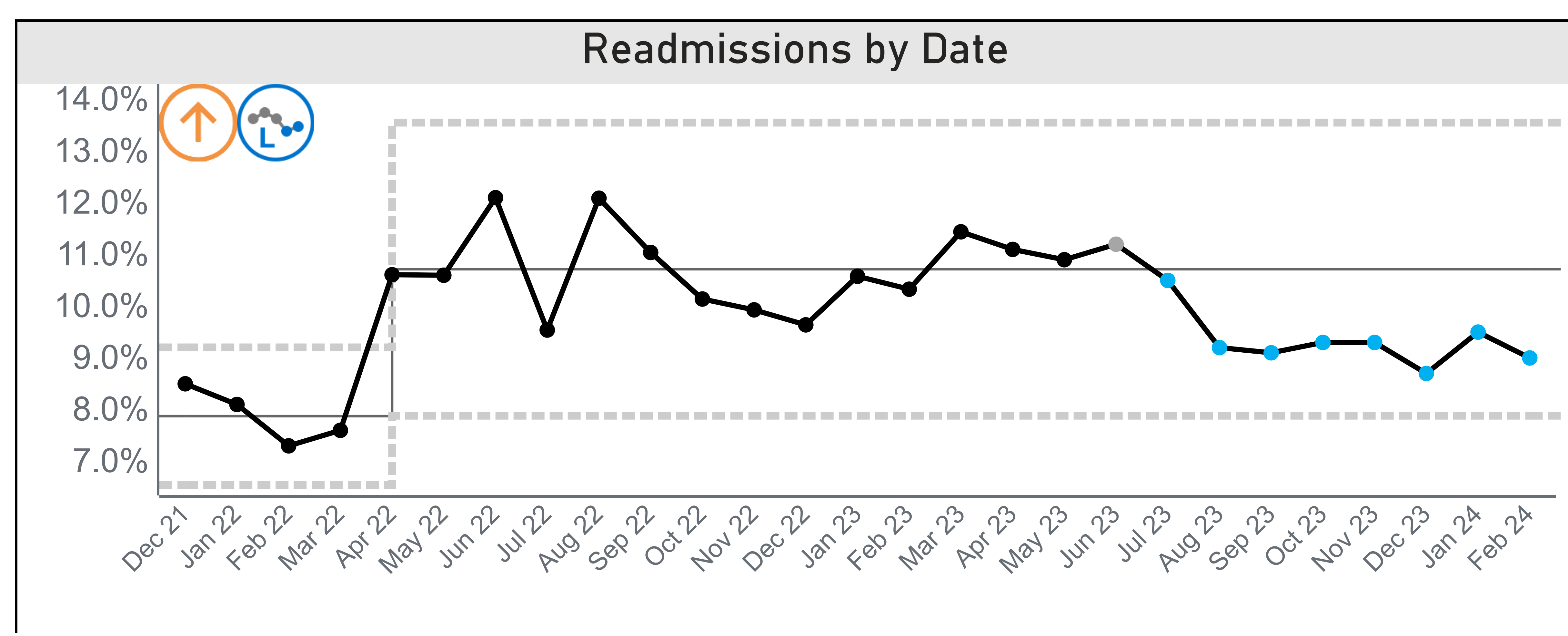


Averaging at 4 incidents a month, no significant change.

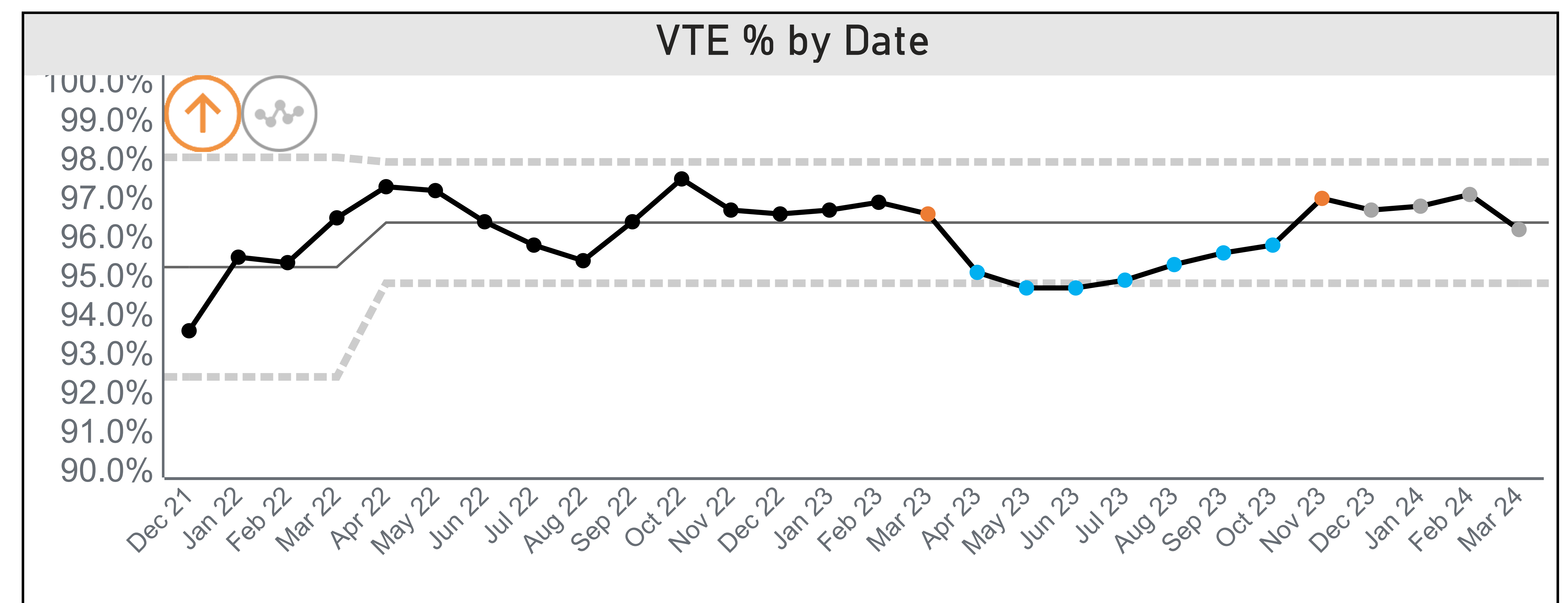
Statistical Process Control Charts
Quality Performance Page 2



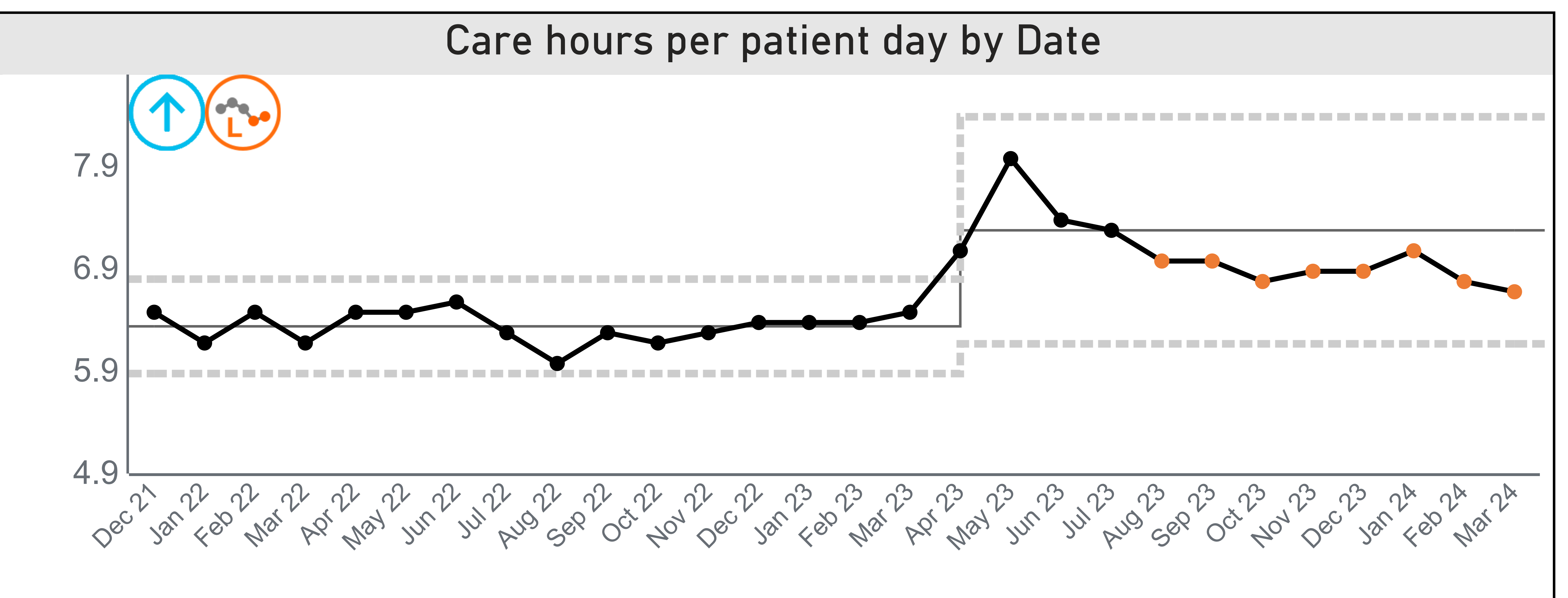
No significant change - averaging at 3 cases per month.



There was a measurement change in April 22 as per guidance. Improvement seen within the measurement change from Aug 23.

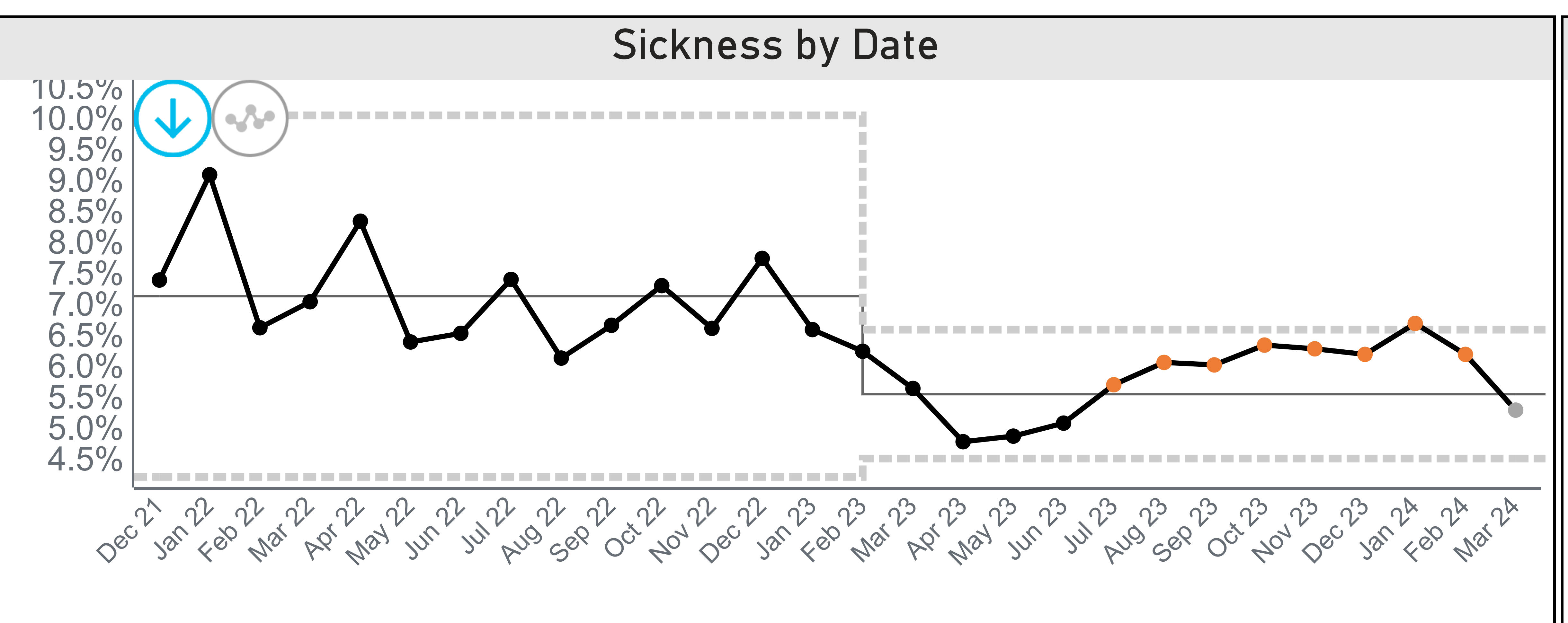


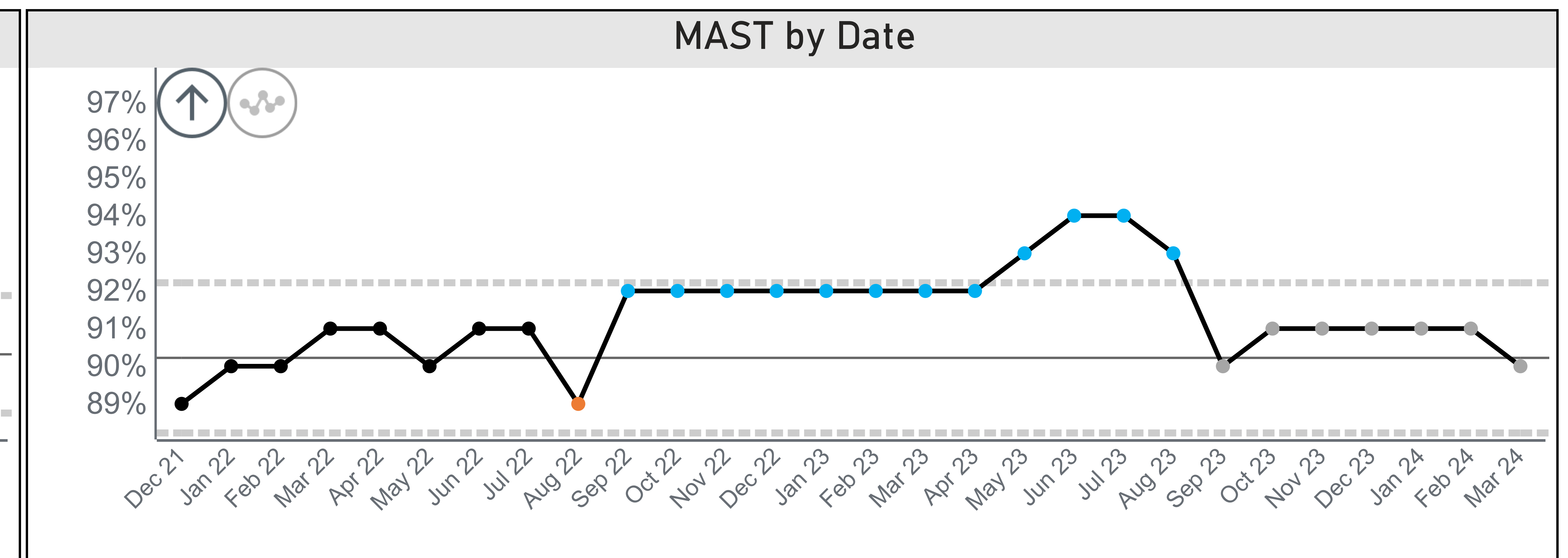
A slight improvement noted from an Average of 95% around Oct 21 - Mar 22, improving to 96.5% between Apr 22 - Mar 24.



A significant improvement from an average of 6 within Oct 21 - Mar 23 to 7.1 from Apr 23.

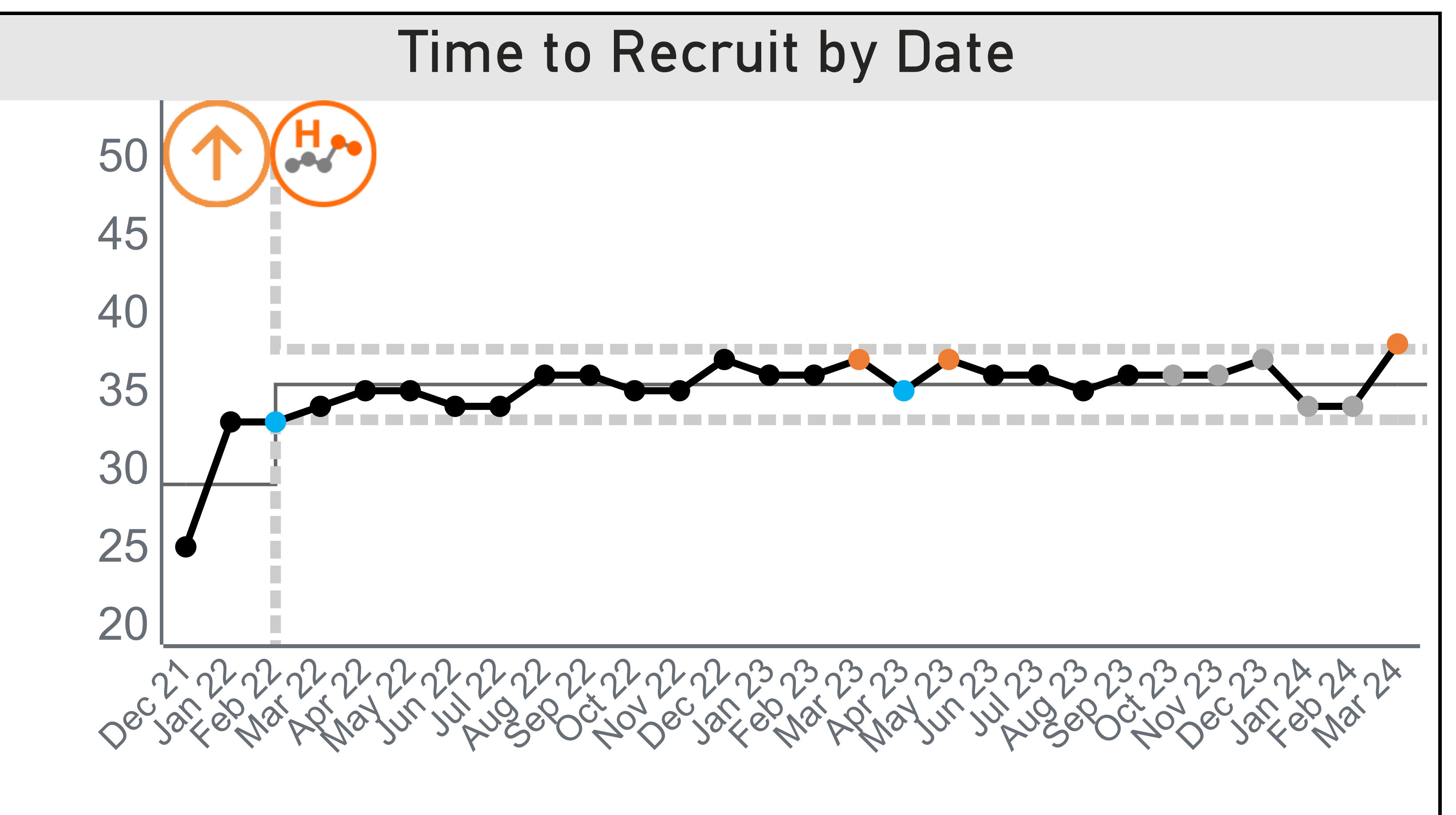
Statistical Process Control Charts
Workforce Performance Page 1

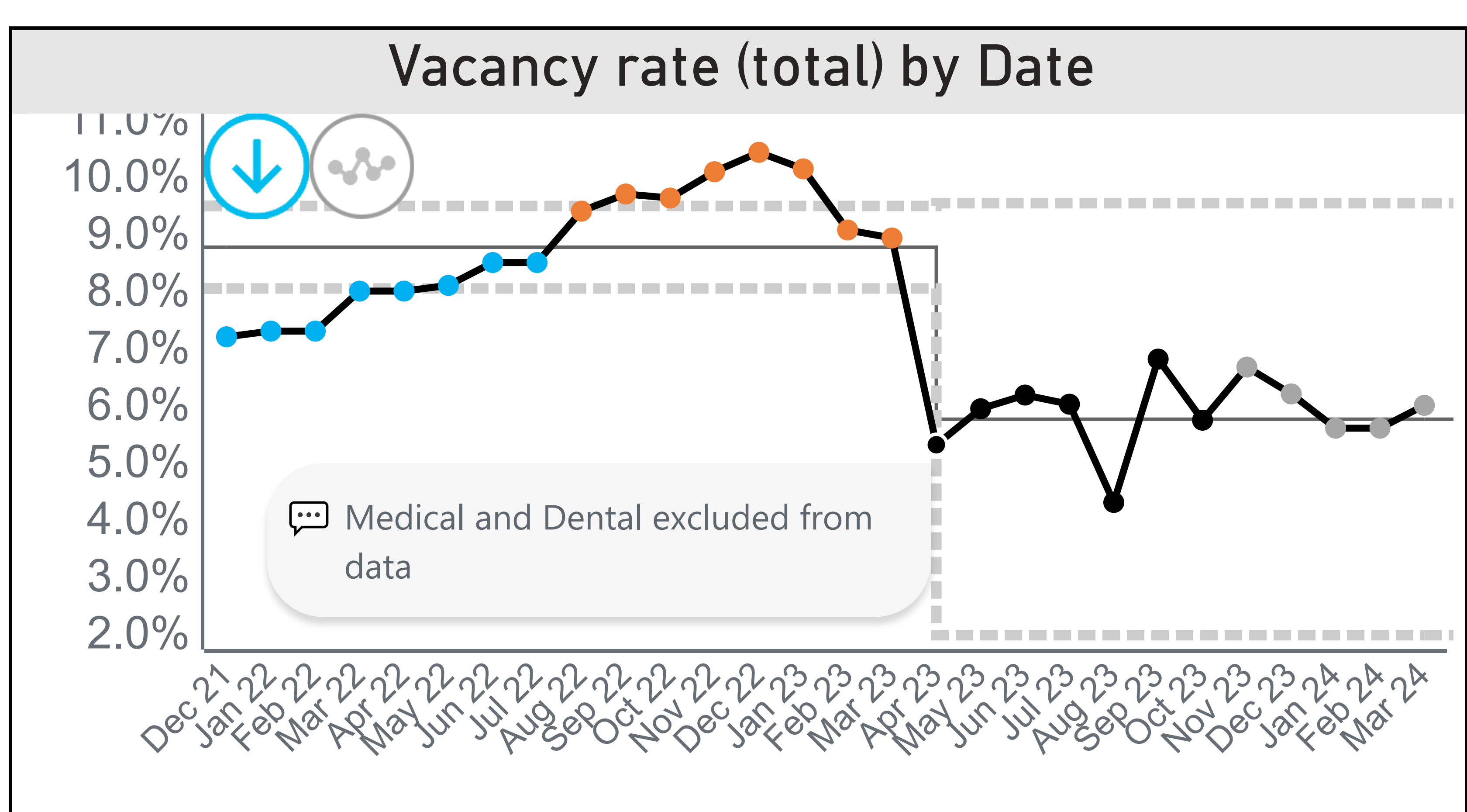


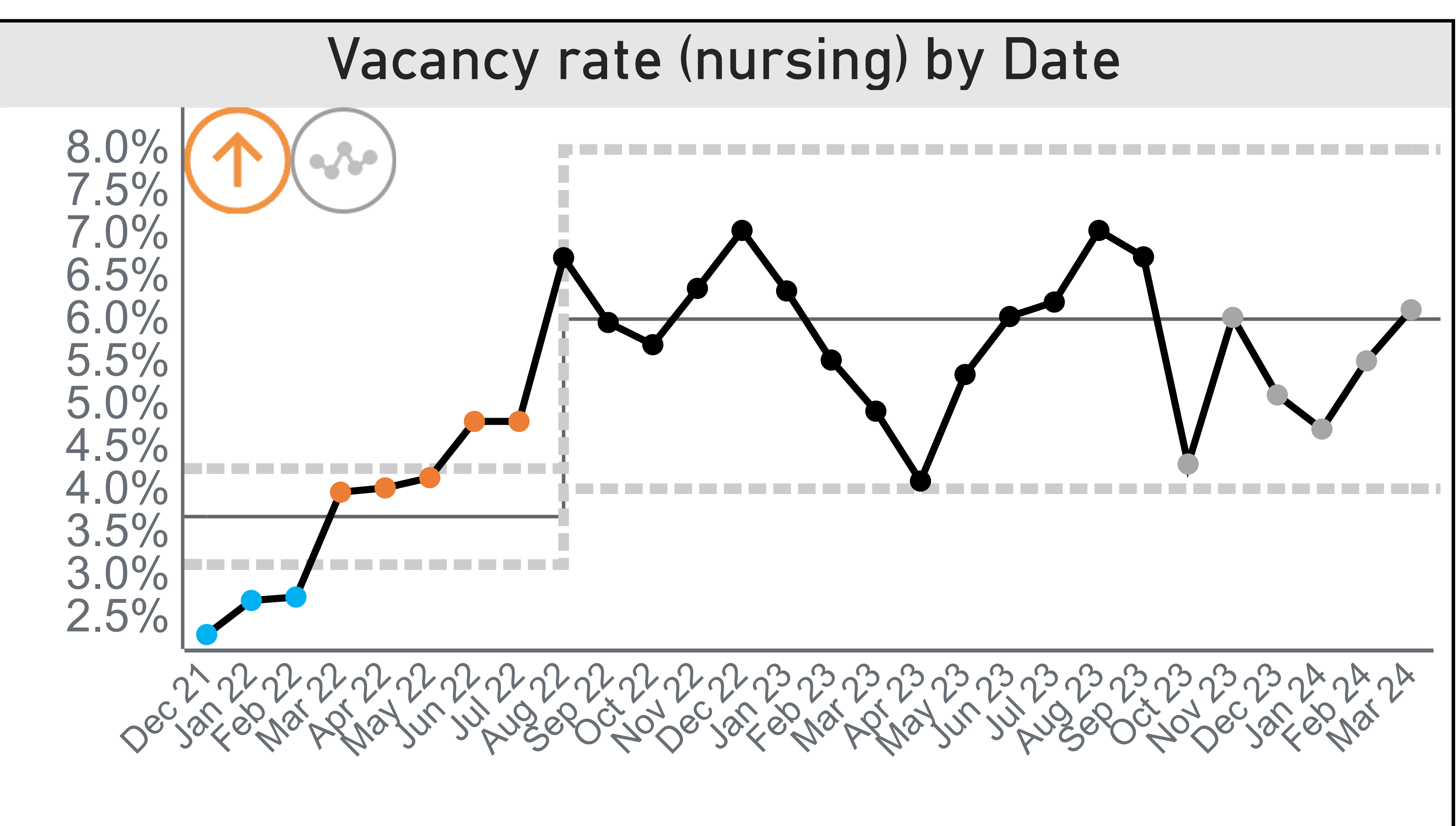


A significant improvement in sickness seen from an average of 7.2% to 5.5% although performance beginning to deteriorate showing a special cause variation.

MAST is Averaging at 90%







A significant deterioration seen from an average of 30 days at the end of Feb 22 to an average of 35 days throughout the remainder of 2022 and 2023.

A significant improvement seen although a measure change was implemented in Apr 23 when medical and dental were excluded from the data. Average of 6% seen throughout 23/24.

A deterioration is noted from an average of 3.5% to 6% where performance has remained since Aug 22.

Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- There was a significant national focus on 4 hour delivery in March 2024, which led to the re-introduction of a command and control structure within the trust to manage the day-to-day position in UECC. This appeared to deliver a noticeable improvement in a number of metrics, especially when the demand pressures are taken into account.
- The proportion of ambulances with long handover times has decreased despite the high levels of attendances in March (12% above March 2023 levels), with just over 7% of ambulance handovers waiting more than 60 minutes compared to almost 16% in previous months. This is reflected in national data with the Trust performing relatively well in the second-best quartile for handover delays >30 minutes.
- This improved level of delivery in the month is reflected in other metrics around emergency care, with a reduction in the number of patients waiting more than 12 hours in A&E, and a significant reduction in patients experiencing a 12 hour+ trolley wait.
- Increasing numbers of patients are being treated through SDEC with just over 40% of patients being streamed there, putting the trust in the second-best quartile for this metric.
- The volume of patients with a long length of stay (both 7+ and 21+ days) has stabilised following a period of growth reflecting the impact of efforts to manage this, with regular meetings with system partners to allow collaborative resolution of issues.

Elective Care

- The waiting list has experienced a period of stability, fluctuating around 30,000 waiters for several months now, ands down from a peak of 32,774 in October 2023. While the waiting list isn't yet reducing, this is still a positive as it is a significant change from several months ago where the waiting list was growing rapidly. However, there are signs of significant pressures in a few particular specialties (including Trauma & Orthopaedics, OMFS and ENT) which are being masked by reductions elsewhere (particularly in Ophthalmology). As these improved specialties stabilise, we will need to focus on reducing the waiting lists in those areas which are seeing sustained growth.

- The RTT position continues to be stable at around 60%, reflecting the influence the waiting list has on this metric to some extent. Progress has been made on eliminating the longest waits, with both 65+ and 78+ week waiters reducing towards 0. However, there remains a sizeable number of 52+ week waiters where the Trust plans to go beyond the national ambition and deliver a 50% reduction in these long waits by the end of 2024/25.
- Elective activity was strong in March, although the comparisons to 2019/20 volumes are to some extent irrelevant given it was the first month of the COVID pandemic in the UK, with the majority of non-urgent activity cancelled in the last 10 days of March 2020. As such, the comparison to YTD is more valuable, which demonstrates a positive improvement in March compared to the prior 11 months across all points of delivery, with Outpatients and Daycases up 6% on average monthly activity for the year and Inpatient activity 14% above the average monthly level for the year. This is a very positive trend as we move into 2024/25, needing to deliver 103% of our 19/20 value-weighted activity for the full-year.

Cancer

- Performance on the 31 Day Treatment Standard has fluctuated around 95% for several months, just below the target of 96%, although the YTD position is above the 96% standard.
- This contrasts with the 62 Day Treatment Standard where the trust is at 72%, which is 13% below the national standard of 85% but above the national expectation of 70%. Additional focus is now being placed on performance against this new standard since its introduction in October 2023.
- There has been variability in performance against the Faster Diagnosis Standard (FDS) which has moved between 78% and 70% over the past few months. However, recent improved performance in Skin pathways bodes well for future delivery of the FDS standard, as this is one of the highest volume specialties and where the national ambition is to deliver 85% FDS in order to compensate for likely lower performance in some of the more complex pathways.

QUALITY SUMMARY

Mortality

- Both the SHMI and the HSMR continue to be as “as expected” with performance generally stable over the period after several months of improvement.

Patient Safety

- There were 3 incidents deemed to be severe or above in March, which is line with performance over the past several months. 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.
- Patient complaints in February increased to 11.14 per 10,000 patient contacts, significantly over other months in this period.
- F&F Positive Score continues to be strong with all domains except UECC exceeding their target of 95%.
- Care Hours per Patient Day has been below target for all months in this period and improving performance on this metric continues to be a priority. This month’s figure was affected by the additional beds that were open in March, which meant our staffing levels were spread across more thinly than would otherwise have been the case. Work continues on unpicking our CHpPD performance, with a comparison to the performance at Barnsley Hospital NHS FT taking place during May in order to identify any noticeable areas of difference and learning going forward.

Infection, Prevention & Control

- There has been an increase in hospital acquired infections in the last month, notably C difficile. This has been a trend we’ve seen over the last year, with our performance deteriorating from 2nd quartile performance a year ago to bottom quartile in the most recent benchmarked data. Actions are in place in terms of cleaning and leadership in the most affected areas.

WORKFORCE SUMMARY

Retention and Recruitment

- The Trust welcomed 43 new starters for the month of March 2024. 7 were qualified nursing & midwifery staff and 10 were Nursing Support colleagues.
- Clinical Support Services had the highest number of leavers for the month of March 2024 with 108 colleagues officially leaving the Trust. However, this was due to the TUPE transfer of Laboratory Services to Sheffield Teaching Hospital NHS FT. Community Services were the other division with a highest number of leavers, with 16 colleagues leaving the trust.
- Staff groups with the highest number of leavers (excluding TUPE) were Additional Clinical Services, 17, followed by Admin & Clerical, 10.
- We are still finding it challenging to encourage staff leaving the Trust to complete exit questionnaires, with fewer than 1 in 7 staff opting to do this.

Attendance

- Monthly sickness absence rate for the month of March 2024 decreased by 0.91%. The reduction in the overall 12-month rolling sickness rate exceeded our in-year ambition of 0.75%, which is a significant achievement given the ongoing pressures for colleagues.
- The decrease in the overall sickness rate in March was driven by long term sickness with almost all divisions seeing a decrease. Divisions continue to focus on ensuring staff are appropriately supported when they are off work and the sickness absence policy is followed.
- Medicine remain the Division with the highest sickness absence rate (6.96%). Surgery have had the highest decrease (1.72%) when compared to other divisions against February 2024. Emergency Care have seen the largest increase when compared to last month with an increase of 0.56%.
- December 2023 is the most up to date national benchmarking data on sickness absence and for that month the Trust was in the second worst quartile.

Appraisals and Mandatory Training

- Overall appraisal compliance (rolling 12 months) for the month of March 2024 was 82.3% which is a 1.1% increase when compared to March 2023.
- Clinical Support Services have seen an increase when compared with last month whilst all other Divisions have seen a decrease, with a 1.6% decrease showing at Trust level.

Board of Directors' Meeting
3 May 2024

Agenda item	P/80/24
Report	**Maternity and Neonatal Safety**
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 Perinatal oversight maternity dashboard data is represented below in the Safety Statistical Process Control charts (SPC). There are no themes to highlight. • The perinatal summary for March 2024 is highlighted in the SPC charts. The total perinatal data for April 2023- March 2024 is 4.62 per 1000, the adjusted rate excluding deaths due to congenital abnormalities and medical terminations of pregnancy (MTOP) is 2.7 per 1000. Learning and findings from the Perinatal Mortality Review Tool process is shared within the report. • There are currently no Maternity and Neonatal Safety investigations ongoing (MNSI). There are currently 2 ongoing patient safety investigation incidents (PSII) X1 for maternity and x1 for neonates. • Multidisciplinary training data is shared and there has been a decline in training compliance for trainee doctors due to the new rotation in February. • 20 incidents were graded as moderate in March 2024. None of the incidents required escalation to harm free following investigation by the Division. • An update is provided in the report on the recent Local Maternity and Neonatal System (LMNS) assurance visit and the Saving Babies Lives (SBL) assurance visit, highlighting that the service is making good progress. • The Avoidable Term Admission to the Neonatal (ATAIN) data is reported at 5.7% for March 2024.
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 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 bi-monthly to discuss the Maternity and Neonatal Safety agenda.
Recommendations	It is recommended that the Trust Board are assured by the perinatal Quality report for March 2024.
Appendices	1. Perinatal Mortality Review Tool report 2. Birth rate plus March data 3. South Yorkshire Local Maternity System LMNS assurance visit All appendices can be found in the Reading Room on Convene

Maternity Safety Statistical Process Control charts (SPC)

Total births

300 250 200 150 100 50 0

Apr 23 Jun 23 Aug 23 Oct 23 Dec 23 Feb 24

Term stillbirths

10 9 8 7 6 5 4 3 2 1 0

01/04/23 01/05/23 01/06/23 01/07/23 01/08/23 01/09/23 01/10/23 01/11/23 01/12/23 01/01/24 01/02/24 01/03/24

HIE

10 9 8 7 6 5 4 3 2 1 0

01/04/23 01/05/23 01/06/23 01/07/23 01/08/23 01/09/23 01/10/23 01/11/23 01/12/23 01/01/24 01/02/24 01/03/24

Terms babies to NNU

25 20 15 10 5 0

01/04/23 01/05/23 01/06/23 01/07/23 01/08/23 01/09/23 01/10/23 01/11/23 01/12/23 01/01/24 01/02/24 01/03/24

Early neonatal deaths

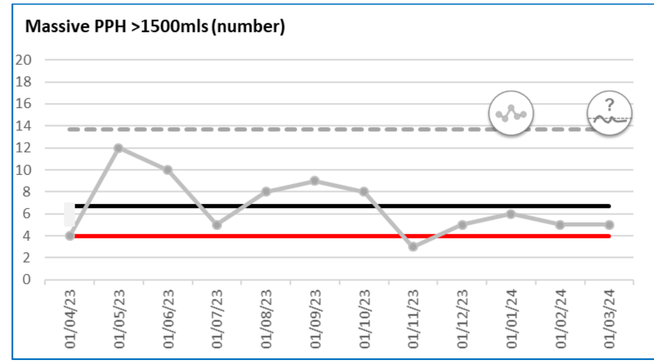
10 9 8 7 6 5 4 3 2 1 0

01/04/23 01/05/23 01/06/23 01/07/23 01/08/23 01/09/23 01/10/23 01/11/23 01/12/23 01/01/24 01/02/24 01/03/24

Number of 3rd/4th degree tears

20 18 16 14 12 10 8 6 4 2 0

01/04/23 01/05/23 01/06/23 01/07/23 01/08/23 01/09/23 01/10/23 01/11/23 01/12/23 01/01/24 01/02/24 01/03/24



Tables 2.1

TRFT Maternity Dashboard: General

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at booking %	Feb 24	10.4%	-			11.3%	5.7%	16.9%
Smoking at birth %	Feb 24	10.6%	-			11.3%	6.8%	15.7%
Number of bookings	Mar 24	241	-			248	181	314
Booking < 13 weeks	Mar 24	89.2%	90.0%			89.7%	84.7%	94.6%
Booking < 10 weeks	Mar 24	72.6%	90.0%			72.0%	63.3%	80.7%
Personalised Care Plan	Mar 24	99.6%	95.0%			97.8%	94.4%	101.1%
Total Induction rate	Mar 24	33.6%	32.8%			33.5%	25.5%	41.5%
Augmentation IOL	Mar 24	38	-			42	21	63
Augmentation 1st Stage	Mar 24	13	-			14	-2	29
Augmentation 2nd stage	Mar 24	1	-			3	-1	7
Shoulder dystocia	Mar 24	5	2			3	-4	9
Massive PPH >1500mls (number)	Mar 24	5	4			7	0	14
Massive PPH >1500mls (%)	Mar 24	2.6%	2.0%			3.1%	-0.1%	6.3%
Number of 3rd/4th degree tears	Mar 24	6	8			4	-1	8
3rd/4th degree tears in normal birth	Mar 24	6	-			3	-2	7
3rd/4th degree tears in normal birth (%)	Mar 24	5.6%	-			2.1%	-2.2%	6.5%
3rd/4th degree tears assisted birth	Mar 24	0	-			1	-2	4
3rd/4th degree tears assisted birth (%)	Mar 24	0.0%	-			5.5%	-15.9%	26.9%
Number of eclamptic fits	Mar 24	0	-			0	0	0
Pressure ulcers	Mar 24	0	-			0	-1	1
Optimal Cord Clamping	Feb 24	95.0%	-			90.0%	82.7%	97.3%
APGARS 0-6 @ 1 minute	Mar 24	14	-			11	-4	26
APGARS 7-10 @ 1 minute	Mar 24	178	-			205	167	242
Skin to skin	Mar 24	81.7%	80.0%			81.7%	70.1%	93.3%
Breastfeeding	Feb 24	58.2%	-			59.3%	49.7%	69.0%

DATA MEASURES – REVISED PERINATAL QUALITY SURVEILLANCE TOOL

Trust:

CQC Maternity Ratings	**Overall**	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Select Rating: Good	Select Rating: Good	Select Rating: Good	Select Rating: Good	Select Rating: Good	Select Rating: Good

Maternity Safety Support Programme	Select	No

	2024											
	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	No immediate learning identified at the January 2024 perinatal Meeting. Cases to be closed still.	Questions raised at the review meeting, the cases are to be presented again for further discussion and review.	No perinatal mortality meeting held March 2024									
2. Findings of review of all cases eligible for referral to HSIB	1 case in progress. Draft report received with no safety recommendations	1 case completed. Final report shared with staff involved. Tripartite meeting to be held with family in April. No safety recommendations	No cases reported to MNSI in March									
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	16 recorded as moderate harm. Following MDT review 0 remained moderate harm	15 recorded as moderate harm. Following MDT review 0 remained at moderate harm	20 recorded as moderate harm. Following MDT review 0 remained at moderate harm									
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	All staff groups are over the required 90% compliance range. See point 7.0 in report.	Training compliance of Obstetric trainees has declined to below 90% due to new rotation of trainees. Training for all other disciplines is >90%	See section 12.2									

2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	See point 12 within this report for a full break down.	No issues for escalation	See section 19									
3.Service User Voice Feedback	NHS CQC Maternity Survey 2024 Result, see point 5.1 within this report.	MNVP role to change over to the MNVP engagement officer from April 2024.	MNVP 15 Steps NNU									
4.Staff feedback from frontline champion and walk-abouts	Walk-about and meeting feedback, see point 13 within this report.	Visit to NNU to support the team. No escalations.	No walk around meeting in March 2024									
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil	Nil	Nil									
6.Coroner Reg 28 made directly to Trust	0	0	0									
7.Progress in achievement of CNST 10	Achieved	Achieved	Achieved									

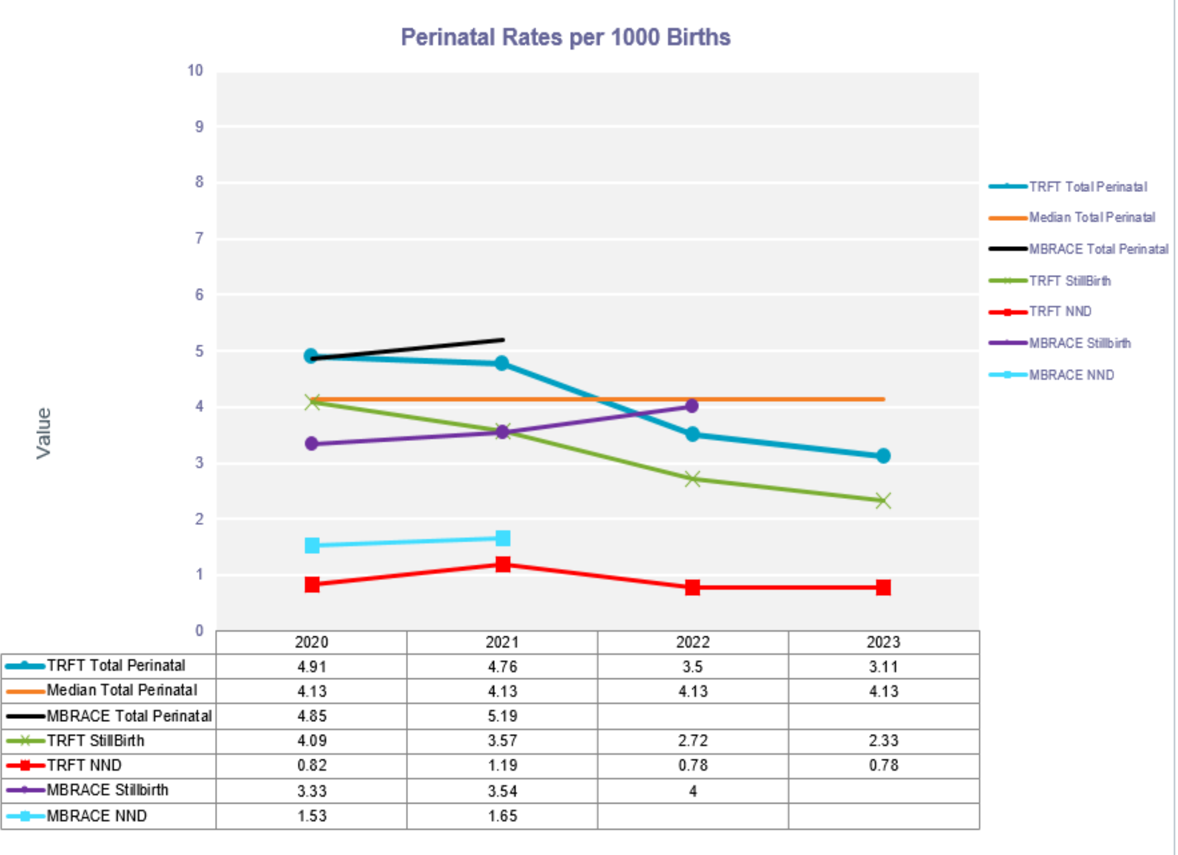
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	2023 results 77%
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	2023 results 91%

1 Report Overview

1.1 This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and Neonatal services team. The information within the report reflects actions in line with the Three Year Delivery Plan for Maternity and Neonatal services. The report will also provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the clinical quality group.

2 Perinatal Mortality Rate

2.1 The Statistical Process Control charts (SPC) (Table 2.1 above), demonstrate how Rotherham Foundation Trust is performing against the ambition to half the rates of perinatal mortality from 2010 to 2025. Nationally, there is more to do to achieve this target and all maternity services are currently working towards the full implementation of Saving Babies Lives Care Bundle Version 3. Table 2.2 represents the current total perinatal mortality rate for The Rotherham Foundation Trust (TRFT). It can be noted from the tables that there has been a significant reduction in the Trusts total perinatal death rates since 2020. MBRRACE data is only available up until 2021.



	2020	2021	2022	2023
TRFT Total Perinatal	4.91	4.76	3.5	3.11
Median Total Perinatal	4.13	4.13	4.13	4.13
MBRACE Total Perinatal	4.85	5.19		
TRFT StillBirth	4.09	3.57	2.72	2.33
TRFT NND	0.82	1.19	0.78	0.78
MBRACE Stillbirth	3.33	3.54	4	
MBRACE NND	1.53	1.65		

Table 2.2 Total perinatal deaths

2.2 A sample of quality improvement work which has taken place since 2020 to reduce the number of stillbirths includes the following initiatives;

- Full implementation of Saving Babies Lives Version 3. Currently working towards full implementation of version 3 of the revised safety bundle.
- Full compliance with all 10 CNST safety standards for MIS, (Maternity Incentive Scheme) in years 2022/23 and more recently 2023/24.
- Robust reviews are undertaken using external peer support to review all stillbirths and neonatal deaths that meet the PMRT criteria. Parents experience also informs the learning and to make positive service changes.
- TRFT Charities have supported the Maternity service to implement the use of the Mama Academy wellbeing wallets from 2021. The wallets provide secure protection for handheld records and scan documents, with useful safety netting advice when to call the Maternity unit, including concerns regarding reduced fetal movements, pain and feeling unwell. A further order of the wallets has been placed to cover 18 months of bookings. We are currently exploring funding support for the wallets in the top five languages for TRFT.

2.3 Work to reduce the number of stillbirths and neonatal deaths due to abnormalities has taken the form of consanguinity clinics across the region to support families to make informed choices and offer genetic counselling. TRFT have links into the Sheffield Teaching Hospital clinics to refer where required. RFT also now has a local Fetal-medicine unit consultant in place

3 Perinatal Mortality Summary for month of March 2024

3.1 Two women chose to have a termination of pregnancy due to fetal abnormalities in March 2024 at TRFT. 1 case was below 22 weeks gestation therefore did not meet the criteria for PMRT. 1 case was @ 22 weeks gestation and met the criteria for notification only. 1 woman sadly had a neonatal death which was expected due to the known congenital anomaly. 1 woman had a fetal loss @ 19 weeks gestation and 1 woman had a loss of 1 twin following laser for Twin to Twin Transfusion Syndrome (TTS). Table 3.1 reports perinatal data from March 2024 in comparison to the last two years data as a rolling tracker.

	2022 Total:	2023 Total:	01/01/2024 – 29/02/2024	In Month: March 2024	Information
Total Stillbirths (All)	7	6	-	-	
Stillbirths >37 weeks	1	1	-	-	
Stillbirths 24 - 36+6 weeks	6	5	-	-	
Intrapartum Stillbirths	1	-	-	-	
MTOP Anomaly >24 weeks	0	2	-	-	
Adjusted Stillbirths	7	6	0	0	
Total Neo-Natal Deaths (NND)	8	4	1	1	See 1 below
ENND >24 weeks up to 7 days of life	7	2	-	-	
LNND 7-28 days	1	1	-	-	
Adjusted Neonatal Deaths – All gestation (EXCL MTOP)	2	2	0	0	

Total Adjusted Perinatal (24 wk – 28 days)	**9**	**8**	**0**	**0**	
MTOP ENND	**1**	**-**	**-**	**-**	
Stillbirth Elsewhere	**0**	**-**	**-**	**-**	
Neo-Natal Deaths Elsewhere (outside of TRFT)	**2**	**2**	**-**	**-**	
Maternal Deaths	**0**	**1**	**-**	**-**	
NVF <24 weeks	**12**	**10**	**2**	**4**	**See 2 below**
NPMRT entered	**12**	**10**	**1**	**1**	
NPMRT Closed	**14**	**10**	**2**	**-**	

Table 3.1

3.2 The rolling figure of stillbirths and neonatal deaths from April 2023 to March 2024 are as follows;

Perinatal mortality All deaths (including congenital anomalies) Total perinatal **4.62/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	6 (incl MTOP)	2.31
Neonatal death	6	2.31

Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) Adjusted Total Perinatal **2.7/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	5	1.93
Neonatal Death	2	0.77

4 PMRT real time data monitoring tool

4.1 The full PMRT report for 2023 can be viewed in appendix 1. In Jan 2024 – March 2024, 4 new PMRT cases were closed and the reports published.

4.2 Other summary findings of note were;

- All pregnancies identified as being intrauterine growth restricted (IUGR) in this period were managed appropriately prenatally.
- Parental perspective of care were sought and considered in the review process in 100% of cases.

5 Learning from PMRT reviews

5.1 Following the last 12 months review, issues identified have included one woman who was not booked for maternity care prior to attending the unit and being diagnosed with an intrauterine death and a further case which could have had more detailed discussions around post-mortem options. However, the panel felt that neither of the learning points would have made a difference to the outcomes of the cases.

6 **Maternity and Newborn Safety Investigation (MNSI)** formally known as Healthcare Safety Investigation Branch (HSIB) **and Maternity Serious Incidents (SI's)**

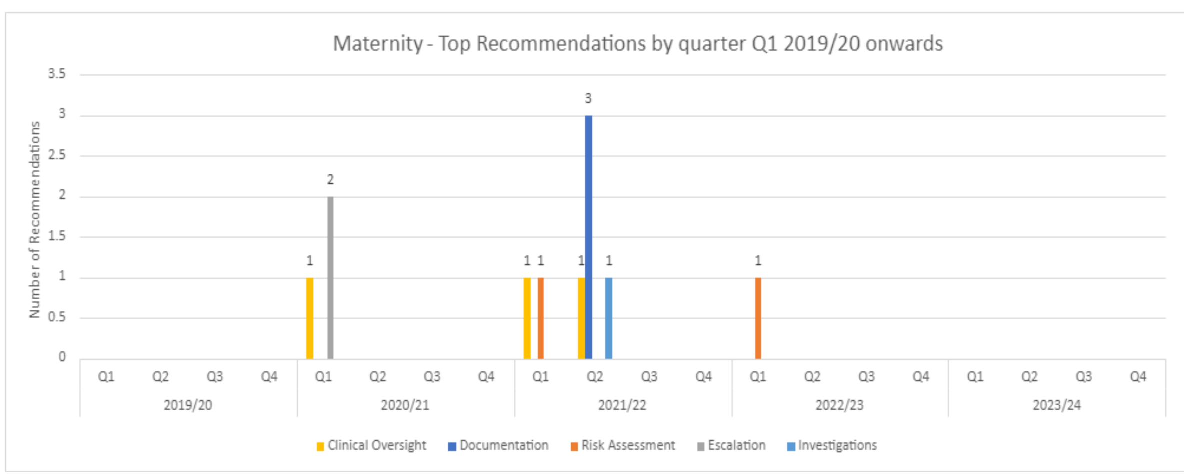
6.1 Since the commencement of HSIB maternity investigations in 2018, TRFT have report 20 cases for external review. Of the 20 cases, 8 were rejected, leaving 12 cases progressing to a full external investigation. 12 cases have been completed to date with one completed this month.

6.2 In Table 6.1 a breakdown of all cases that have been finalised can been see, along with any safety recommendations suggested by HSIB/MNSI.

Case No		Category	Date completed	Comments
1901	319	HIE/Cooling	22/12/2019	2 safety recommendations
1902	430	HIE/Cooling	13/03/2020	No safety recommendations
1903	555	Maternal Death	03/02/2020	No safety recommendations
1909	1185	HIE/Cooling	30/06/2020	2 safety recommendations
1912	1509	HIE/Cooling	18/08/2020	4 safety recommendations
2007	2295	HIE/Cooling	18/01/2021	No safety recommendations
2009	2470	Neonatal Death	01/04/2021	3 safety recommendations
2101	2893	HIE/Cooling	20/07/2021	6 safety recommendation
MI-003385		HIE/Cooling	18/10/2021	No safety recommendations
MI-003662		Neonatal Death	22/11/2021	No safety recommendations
MI-005238		Stillbirth	24/05/2022	1 safety recommendation
MI-028038		HIE	22/02/2024	No safety recommendations

Table 6.1

6.3 Of the recommendations from completed report, Table 3.2 shows the type of recommendations made to TRFT. All action plans following recommendations are completed and have been approved through governance processes. Following finalisation of our most recent investigation, no safety recommendations have been suggested. An action plan has been generated based on learning identified within the completed investigation.



7 MNSI and Current Patient Safety Investigation progress update (Table 7.1)

Ref	MNSI Reference	Confirmed level of investigation	Date confirmed Investigation	Incident overview	Progress
2023/16751	N/A	PSII	04/09/2023	Missed third degree tear following instrumental birth	Presented to sign off panel 10/04/2024
164265	N/A	PSII	08/01/2024	28+5 day neonatal death.	Draft shared with staff and family.

Table 7.2.

8 Coroner Reg 28 made directly to Trust

8.1 TRFT Maternity have no Coroner Regulation 28 orders.

9 Maternity Patient Safety Investigations and After Action Reviews

9.1 During the month of March there was no maternity patient safety investigations declared.

9.2 After Action Reviews which have taken place in the month of March 2024 include a cord prolapse which resulted in a category 1 caesarean section. The caesarean was performed under a general anaesthetic where an anaesthetic emergency occurred for a difficult intubation. The baby was born in poor condition and required resuscitation. The After Action Review identified there were areas to help improve communication between teams during emergency situations, including consideration of a rapid team brief document, emergency call flow chart readily displayed to aid correct emergency calls being placed depending on the situation. This harm was not graded as a moderate as there was no harm to the mother and baby however, it was felt that a review was needed to highlight learning and good practice.

10 Midwifery Continuity of Care (MCOC)

10.1 Background: Work continues to collect demographic and outcome data, linking this to deprivation scores. By collecting this information, enhanced continuity of Midwifery can be designed around the woman who have the most need and who will benefit from this enhanced pathway of care. Prior to commencing an enhanced midwifery service for our most vulnerable service users, staffing levels are required to be optimum to give resilience to the project. See section 12.0 for safe staffing information.

10.2 Other initiatives within TRFT Maternity is the implementation of the 3 Year Delivery Plan. This has 4 themes with a number of objectives which have been developed by women for women who use maternity services. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

11 Three year delivery plan for maternity and neonatal services

Below is an update on the 3 Year Delivery plan for Maternity and Neonatal services for March 2024. The Division has received feedback from the LMNS assurance visit from the 23rd January 2024 the full report is available in Appendix 3 The overall reflections and observations included:

- The visiting team were keen to hear how the Listening to Learn templates were helping to influence practice and services
- The visiting team would be keen to hear more about, and share learning from, the health equity audit that is underway
- The Trust team demonstrated a clear understanding of the local population and focus on Core20PLUS5
- Positive feedback about the leadership team was received from several staff members
- The maternity information system was noted to be challenging.

11.1 Listening to women

- TRFT are currently awaiting the appointment of the MNVP engagement lead, which will be an employed role supported by the LMNS. In the Meantime, the service user lead for the LMNS will continue to support TRFT.
- Friends and Family feedback has been analysed from December – February 2024 and overall the feedback is positive demonstrating high levels of satisfaction with the service. QR codes and forms are printed in the top five service user languages to ensure that we aim to get representative feedback from the local community.
- A 15 steps visit was completed on the Neonatal Unit in February 2024 by the MNVP. The report highlighted that the visit was very positive and that new environment was welcomed by the parents who felt that it was a calm and welcoming space, a few minor recommendations were made for improvements including, swipe access for parents and hand washing / storage for outdoor coats for parents.

11.2 Developing our workforce

- The Maternity service is working with the LMNS on a system wide approach to Early Career midwife recruitment. A recruitment event was hosted by TRFT in March 2024 and a large number of students requested TRFT to be their first choice for employment.
- The Division is currently exploring a further over recruitment of 4 WTE to support the increased training in Maternity services as the current head room of 21% does not meet this requirement. Headroom is in line with the trust policy of 21% however, in 2022, the final Ockenden report recommended a headroom which is calculated using the last 3 years for annual leave, sickness, and training requirements. Using this methodology this calculates to 30%. The Division proposes that this proposal is reconsidered by the Trust Board, recommending that an uplift of 25% would contribute to supporting the additional training requirements required in maternity services which is 5 days annually per midwife. This would also align TRFT with other providers in the LMNS where the uplift ranges between 24.5-25%.

11.3 Developing a safety Culture

- The Divisional Leadership Team have attended Perinatal Quadrumvirate Culture and Leadership Development Programme. The team are currently working on the action plan following listening events and feedback sessions with staff groups. The high level feedback is highlighted in the data below:

5

Notable Insights by Percentile and Key SCORE Items

99 respondents in 6 Work Settings at The Rotherham NHS Foundation Trust

Cultural Strengths

%ile	
81st	It is easy for personnel here to ask questions when there is something that they do not understand.
80th	I have a chance to use my strengths every day at work.
79th	In this work setting, the learning environment allows us to gain important insights into what we do well.

Engagement Strengths

%ile	
80th	With respect to the participation in decision making that I experience here, the decision making process is clear to me.
77th	With respect to the participation in decision making that I experience here, I can participate in decisions about the nature of my work.
74th	With respect to the participation in decision making that I experience here, I have a direct influence on my organizations decisions.

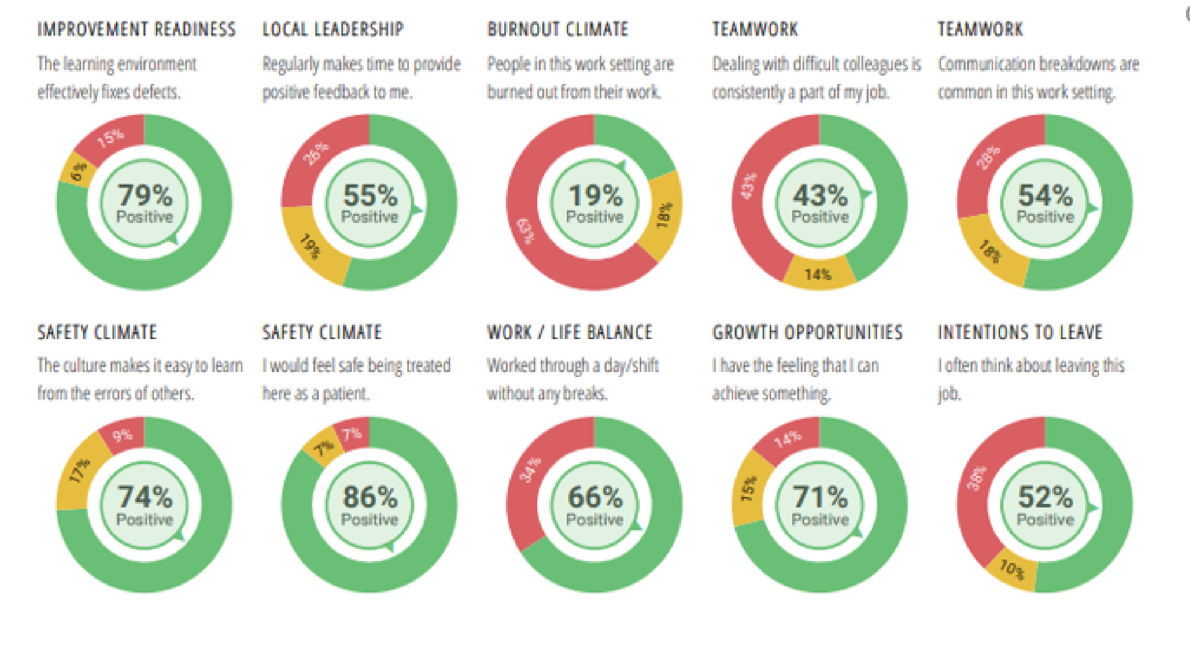
Cultural Opportunities

%ile	
29th	In the past work week felt frustrated by technology.
32nd	My mood reliably recovers after frustrations and setbacks.
40th	I can always regain a positive outlook despite what happens.

Engagement Opportunities

%ile	
38th	With respect to the growth opportunities in this work setting, I have enough variety in my work.
49th	With respect to my intentions to leave this organization, I have plans to leave this job within the next year.
50th	With respect to job-related uncertainty about the future in this work setting, I feel certain that I will keep my current job in the next year.

Key Drivers of Culture & Engagement (Green is good)



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Safe & Reliable

Table 11.3

11.4 Developing standard structures for safe, equitable and effective care

11.5 Maternity Digital is going through many changes at the moment. A large piece of work has taken place following the National Safety Patient Alert regarding the Maternity electronic patient record Euroking in December 2023. Consequently, several actions required to be completed by all Trusts prior to June 2024 to ensure information was not being back or forward filled into subsequent patient's records. The actions for TRFT included identifying potential risks of what we call 'Patient Queries' that auto-populate across different patient visits and could subsequently pull incorrect information into the patient record on Meditech. We added this to the Maternity Risk Register. With the help of the application specialist team we isolated 1619 'Patient Queries' across maternity and neonates. The Digital Midwife then mapped these 1619 questions to the document or assessment they belonged to, to give them context. These were then individually risk assessed through low, medium or high risk and the decision made which ones posed a risk to forward filling into patient records and should be changed from a 'Patient Query'. These have now all been amended and next steps include testing for assurance that amended fields no longer auto-populate. Work is on track to be completed mid to end of May 2024 in time for the June deadline.

11.6 Additionally, the maternity team supported by the Digital team have benchmarked both Meditech and SystmOne against the Digital Capabilities Framework and a work plan have been developed to ensure that we meet the core capabilities.

11.7 Following several meetings and liaison with the Digital Transformation Committee it has been agreed that Meditech does not have the functionality as the single Maternity EPR. The project to move Community Midwifery to Meditech has been paused while the Trust decide on their overall EPR over the next two years. It was deemed to be safer to remain on two systems for the interim period. This has been added to the risk register to monitor the situation closely. The main risks identified included a lack of case loading management and case loading overview for the Community Leads and concerns around safeguarding. In addition, there was no adequate solution to collating a single Pregnancy ID which is a recommendation of NHS England.

11.8 Further work involves computerised CTG, following a recommendation from the second Ockenden report for CTG overview systems. Network points have been installed in April in all labour rooms ready to roll-out the project.

12 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

12.1 The Division continues to work towards the three year core curriculum local training plan, which has had input from service users (MNVP), and has been informed through learning from themes and trends from incidents and investigations. Year Six Maternity incentive scheme guidance published on 2nd April 2024 requires 90% attendance of the relevant staff groups at:

1. Fetal Monitoring training
2. Multiprofessional Maternity emergencies
3. Neonatal life support training

12.2 Table 12.2 represents the current training compliance for March 2024, the reason for compliance been low for trainees and anaesthetists has been due to the new rotation. NHSP midwives and support staff are all scheduled to attend training.

	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	Midwives (All bands)	NHSP Midwives	Clinical Support staff	Anaesthetists
PROMT	92%	100%	44%	95%	100%	87%	78%
Core Competency Day (Modules 1/4/5/6)	92%	100%	44%	95%	100%	84%	N/A
Fetal Monitoring	92%	90%	100% - (Career SHO only)	96%	78%	N/A	N/A
Newborn life support Ob's and Maternity	92%	100%	44%	96%	100%	84%	N/A
Newborn life support Paeds and nurses.	Paediatric consultants 91%	N/A	N/A	Neonatal Nurses 97.5%	N/A	N/A	N/A

Table 12.2

13 Safety Champions meetings

13.1 The required standard for Maternity incentive scheme for safety action 9 have been updated to include:

13.2 Discussions regarding safety intelligence must take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management in their organisation.

- Discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan using the Patient Safety Incident Response Framework (PSIRF).
- Removed requirement within MIS for Non-Executive Directors and Board Safety Champions to be registered with the dedicated Future NHS workspace

13.3 In March 2024 there was a formal Safety champion meeting, the only escalation was an update on the appointment of a new Non Executive Safety Champion. The Maternity and Neonatal matrix was discussed, including off pathway births, compliance with Preterm birth pathway and digital update included in the Maternity and Neonatal Board paper.

14 Concerns raised by service users

14.1 MNVP attended the meeting virtually and raised that there were some aspects of their work plan which had not been achieved due to capacity. An updated

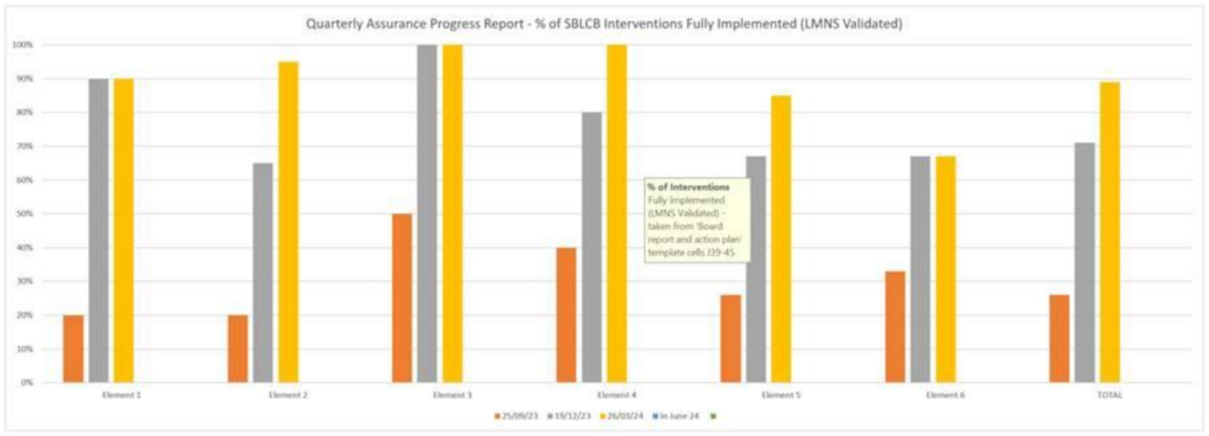
that both chairs would be standing down from their roles on the 31st March 2024.

15 Culture/SCORE survey findings

15.1 Please refer to section 11.3

16 Saving Babies Lives V3

16.1 In March 2024, the LMNS undertook a further assurance review of Rotherham maternity services to assess our progression towards fully implanting the Saving Babies Lives Version 3 care bundle. At the last visit, we were assessed as being 71% compliant. In the more recent visit, our implementation was evidenced as being 89% compliant. The 2024 year 6 CNST requirements now stipulate that Trusts must clearly show progression at each LMNS visit. This can be seen in the below table.



Work still to be completed to demonstrate 100% compliance includes;

- **Smoking element 1**: Training for all staff undertaking the VBA e-learning.
- **FGR: Element 2:** Further audit data for the new guideline for uterine artery Doppler.
- **Pre-term birth, Element 5**: Job plans and JD's for all pre-term leads still required.
- Pre-term remains above 6%:
- 70% of babies born before 34 weeks to have all optimisations interventions. Diabetes, Element 6: DNS – LMNS pleased with progress but to keep partially compliant until job recruited to. Will reassess in Q4.

17 NHS Resolution Maternity Incentive Scheme (MIS) update in month

17.1 TRFT have received confirmation that the validation checks have been completed by MIS and the Division has successfully achieved all 10 safety actions for year 5. Year 6 MIS guidance was published on the 2nd April and the Division continues to work on these safety standards with monthly meetings to update progress and discuss any challenges. The board declaration is to be submitted to NHS resolution by the 3rd March 2025 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.

- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

18 The number of incidents logged graded as moderate or above and what actions are being taken

18.1 The tables below highlight the number of women who suffered a moderate harm in the month of March 2024. Table 11.1 shows that in March there were 20 incidents that were recorded as a moderate harm and the categories. All cases have been examined at the Maternity Weekly Datix meeting by a senior MDT. Following review all 20 were downgraded as care was found to have be appropriate. Regardless of the outcomes from the MDT reviews, deprivation scores have been collected for this group (Table 11.2) and show that for March, the worst outcomes were sustained by the women who live in the poorest areas of Rotherham. In Table 11.3, the cumulative data collected since October 2023, this same theme of high deprivation and an increased level of harm can be identified.

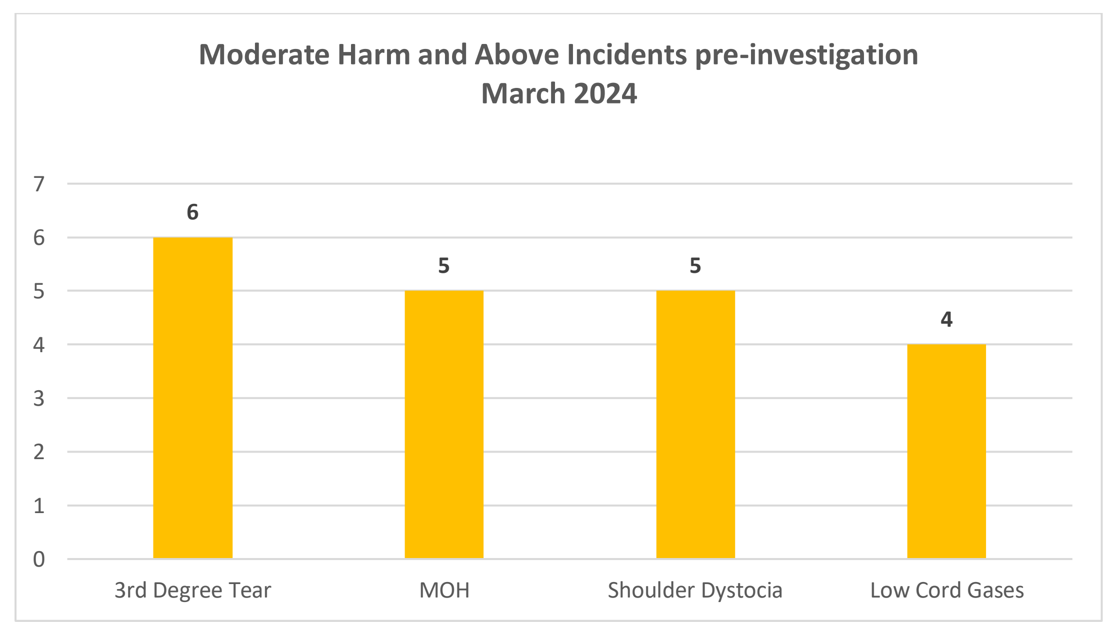


Table 11.1

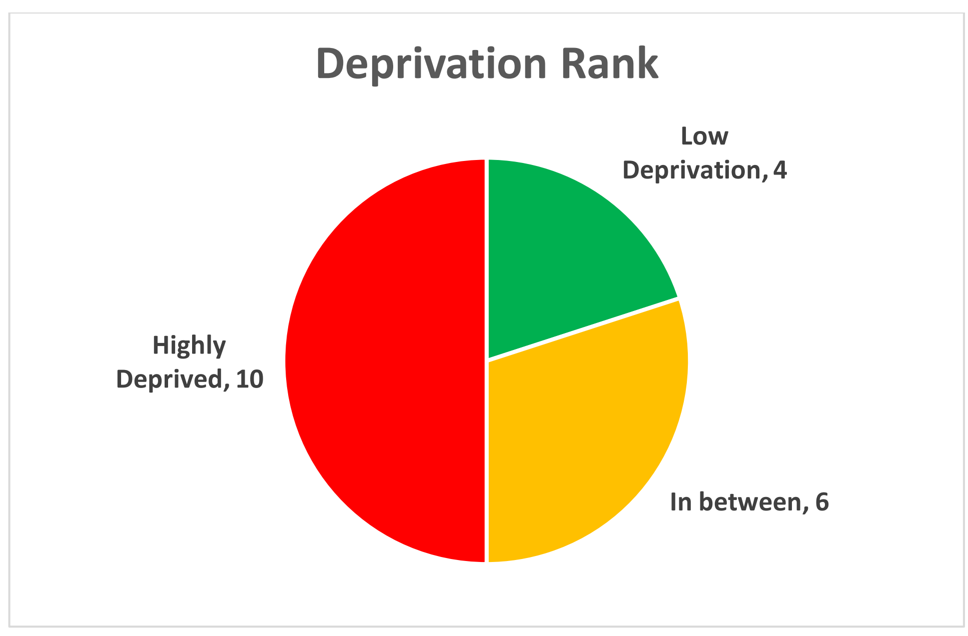


Table 11.2

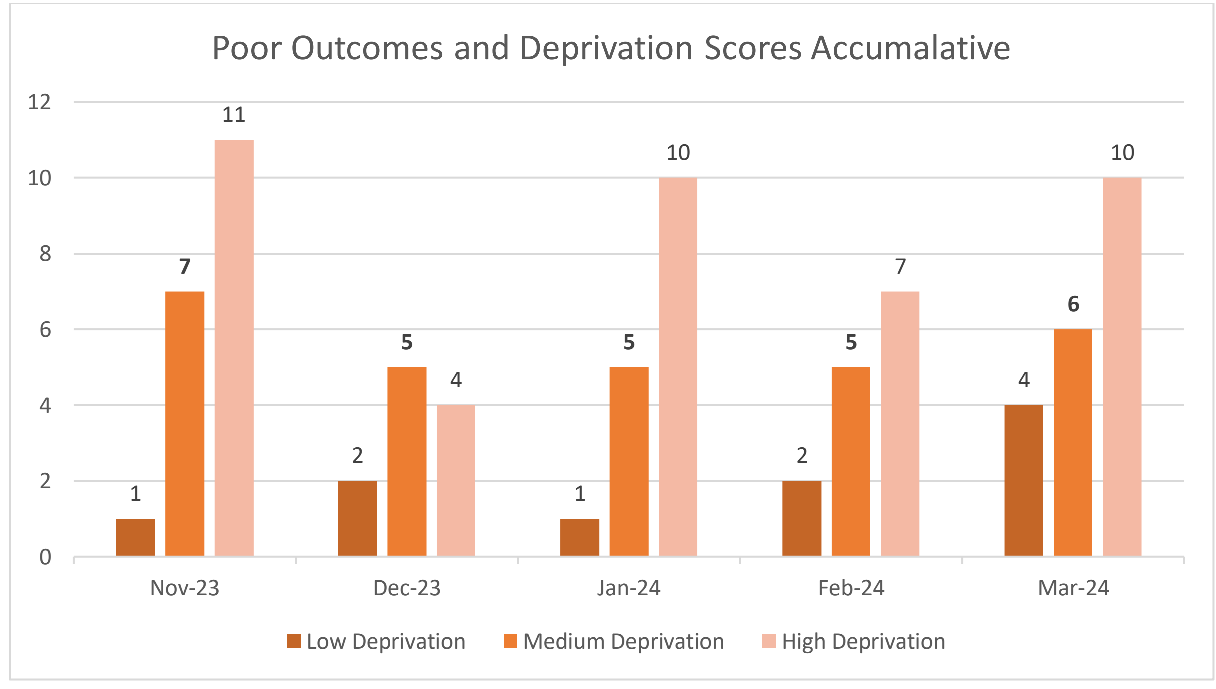


Table 11.3

19 Safe Maternity Staffing

19.1 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings. Maternity and midwifery staffing is reported separately to the Family Health Division and Trust Board biannually to meet the requirements for the maternity incentive scheme. Below is the monthly position of midwifery and maternity staffing.

20 Midwifery Staffing

31/03/2024							
	2023/24						
Trajectory	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Contracted Vacancies	-5.20	-7.70	-7.95	-7.61	-3.66	-6.58	-6.58
Maternity leave	6.59	6.59	6.59	7.23	6.80	7.44	7.28
Long term sickness	1.07	3.63	5.59	4.56	4.56	1.64	0.00
Upcoming Leavers	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other - see detail	1.60	1.60	1.60	1.60	1.60	1.60	1.60
Total Gaps	**4.06**	**4.12**	**5.83**	**5.78**	**9.30**	**4.10**	**2.30**
New Starters (reducing gaps)	0.00	0.00	0.00	0.00	0.00	0.00	-0.16
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trajectory - for planning	**4.06**	**4.12**	**5.83**	**5.78**	**9.30**	**4.10**	**2.14**
% Workforce Gaps	**4.1%**	**4.2%**	**5.9%**	**5.8%**	**9.4%**	**4.1%**	**2.2%**

Table 12.1

20.1 The current position for midwifery workforce and gap can be seen in Table 12.1 and shows that there has been a reduction since last month to 2.2%. The funded establishment remains over recruited to support the gaps made up from maternity leave.

20.2 Appendix 2 shows the acuity data for labour ward for March 2024 and demonstrates that midwifery staffing met acuity 93% of the time, with 7% showing that the unit was short by up to 2 Midwives, actions taken to reduce the acuity gaps included, lead midwives and specialist midwives being re-deployed to assist and maintain safety and one to one care for the mothers in labour.

20.3 Table 12.2 below represents March workforce data. Sickness rates have remained very similar to last month. No themes or trends have been identified.

Maternity unit closures	0	Datix / Birth-rate Plus®
Utilisation of on call midwife to staff labour ward (Night Duty)	0	Birth-rate Plus® data/ Datix
1-1 care in labour	100%	Data from Birth-rate Plus® acuity tool / Maternity Dashboard
Redeploy staff internally	6	Birth rate plus Acuity (Occasions)
Redeploy staff from Community	0	Birth rate plus Acuity (Occasions)
Matron Working Clinically	0	Birth rate plus Acuity
Delay in Induction of Labour	1	Birth rate plus Data and Datix
Supernumerary labour ward co-ordinator	100%	Data from Birth-rate Plus® acuity tool/Maternity Dashboard/Datix

Staff absence 1	5.34%	March 24 data, 2.04% short term 3.30% long term
Obstetric compliance at mandatory consultant escalation	100%	No Datix incidents reported
Compliance with twice daily face to face ward round	100%	Datix

Table 12.2

21 Obstetric staffing

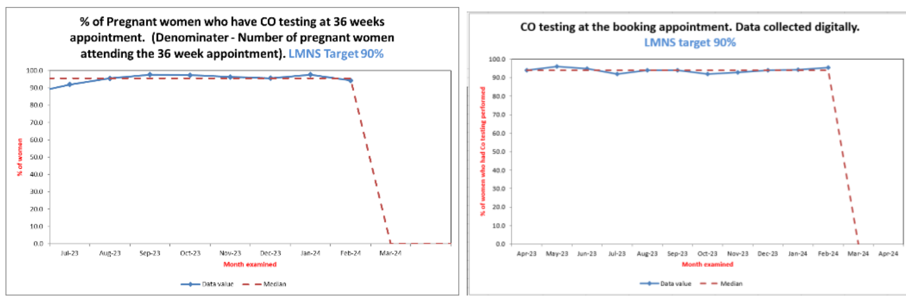
21.1 The following outlines Obstetric cover on the delivery suite and gaps in the rota.

Grade	No of Shifts	Reason	Internal / External
ST1/2	11	3 x Sickness 3 x Reduced Duties 5 x Vacancy	9 x internal 2 x external
ST3/7	33	2 x Vacancy 20 x Additional weekend theatres 1 x Additional clinic 9 x Reduced Duties 1 x Sickness absence	27 x Internal 6 x external
CONSULTANT	8	6 x Additional weekend theatre 1 x Back up consultant 1 x Additional Section List	8 x Internal

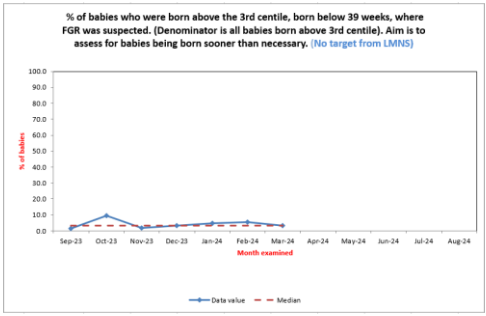
22 Quality Improvement projects / progress

22.1 Below is a sample of quality improvement projects that are currently being undertaken within maternity service. Most have been registered on AMAT with others to be registered soon by the leads and findings to be added from PDSA and audit.

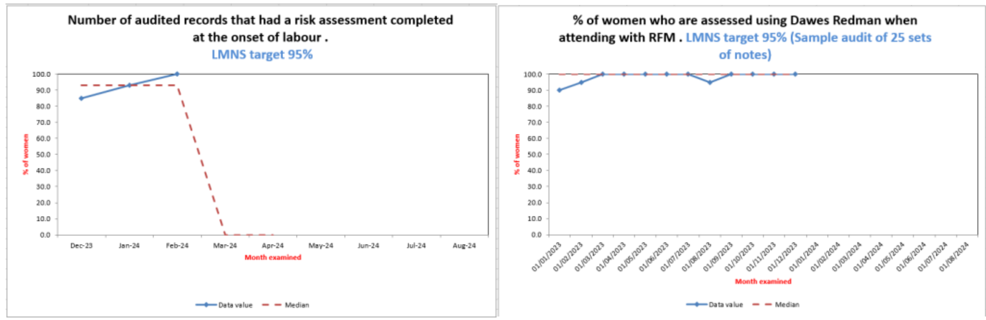
- Reducing smoking in pregnancy (SBLV3, Element 1). PDSA cycles and audit have shown that the work of the community midwives have consistently met the target of offering CO testing to over 90% of women at the booking appointment and at the 36 week appointment.



- Increasing surveillance of small babies in the antenatal period and reducing inappropriate births of suspected small babies. (SBLV3 Element 2).



- Improving surveillance and awareness of reduced fetal movements (SBLV3 Element 3) and Effective fetal monitoring (SBLV3 Element 4).



23 Implementation of the A EQUIP model

23.1 The Professional Midwifery Advocate (PMA) team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement) which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation. Our PMAs have supported colleagues following two clinical incidents that required After Action Reviews which was valued by those colleagues involved. PMA activity for the month is detailed below in Table 15.1.

March 2024	
Number of PMAs (headcount)	10
Restorative Supervision Sessions held	0
Career Conversations held	1
Improvement Projects supported by PMA	4

Table 15.1

24 Avoidable Admission into the Neonatal Unit (ATAIN)

24.1 The National Ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. The national ambition for term admissions is below 6%, however TRFT strives to be as low as possible.

This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, team work and improvement capability within maternity units.

24.2 Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

24.3 The number of term babies admitted to the Neonatal Unit (NNU) in March 2024 was 11. This as a percentage of all live births is 5.7% (local ambition is below 5%, national ambition is below 6%). Weekly multidisciplinary reviews of all term admissions to NNU are undertaken using a LMNS standardised approach. There were no avoidable admissions in March 2024. The ATAIN figures for Q4 will be submitted to the LMNS in April along with the completed rolling action plan for Avoidable Term Admissions to NNU for the year 2023-24. This body of work ensures that we remain compliant for CNST Safety Action 3.

25 Unanticipated Term Admissions to NNU as a Percentage of All Live Births (Table 16.1)

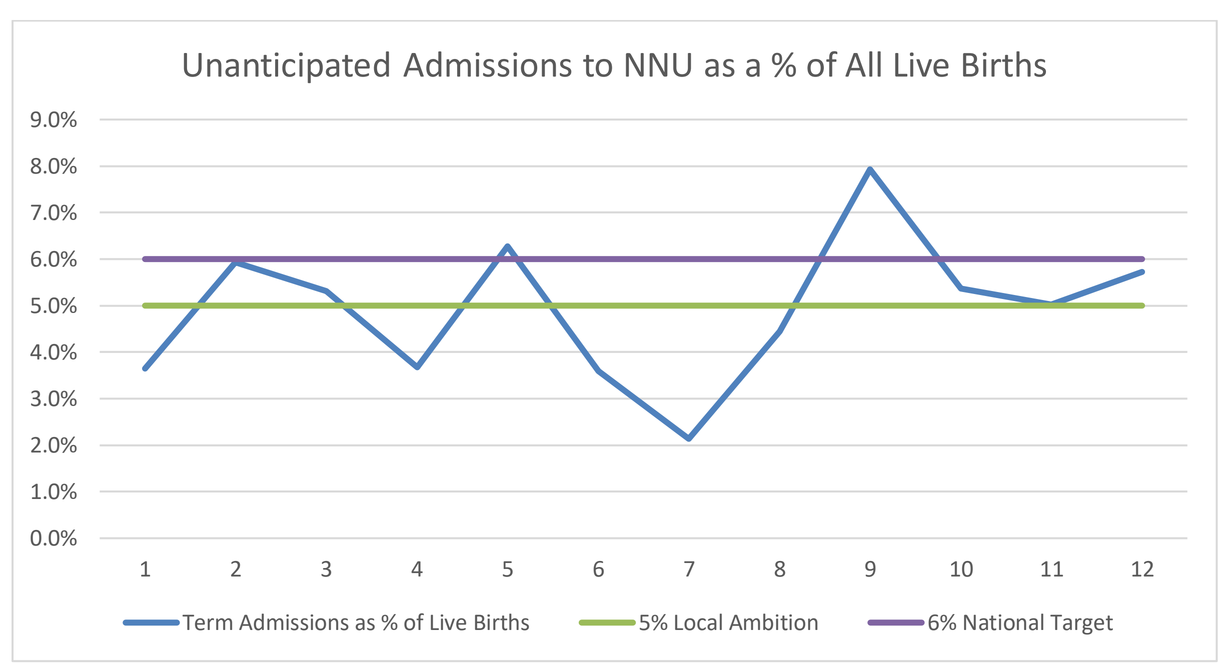


Table 16.1

26 Staff Survey

Annually	Report on: Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)
Update: 2023 survey results The most available data is for "*I would recommend my organisation as a place to work*" – 77% (Trust average 63%) This is an increase from the 2022 staff survey results which were 59%) "*I would recommend my organisation for care/treatment* "-. 78% (Trust average 58%) This is an increase from 66% from the 2022 result.	

Annually	Report on: Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)
Update: 91.67% of trainees surveyed felt that the support they received out of hours was good or excellent.	

27 Red Risks/Risk register highlights

27.1 The highest risk currently on the Obstetric dashboard is the use of poor quality plastic wallets, the Division is hoping that the new care group structure will bring an opportunity to resolve this issue. An interim measure of some more robust plastic wallets is on order and are expected to be in use by the end of April.

ID	Title	Risk level (current)	Review date	Approval status
6873	Risk of losing patient paper medical records due to the introduction of plastic wallets and the removal of stronger card folders	Extreme Risk 16	24/02/2024	Approved Risk

28 Recommendation

28.1 The Quality Committee/Board of Directors are asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme. It is recommended that the Quality Committee are assured by the progress and compliance demonstrated in paper to date with the Maternity Safety Work streams.

Public Board of Directors' Meeting
3 May 2024

Agenda item	P81/24
Report	**Paediatric Audiology CQC Response**
Executive Lead	Joanne Beahan Medical Director
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	A review of paediatric audiology nationally has identified systemic failings in hearing services with some patients experiencing significant delays in formal diagnosis and therapeutic management of hearing loss. A regional peer review has rated the service at TRFT as amber and an improvement plan has been developed. A South Yorkshire Quality Improvement group has oversight at ICB level. The Trust has submitted a remedial action plan for review and has a quality improvement plan (appendix 1) Appendix 2 shows the South Yorkshire Outcomes by trust with the overall rating for TRFT at 83% - regional average 70%. A letter from the CQC (appendix 3) was received by the Trust on the 8th April and was discussed at ETM. Trust boards are asked to consider the assurance that they have about the safety, quality and accessibility of children's hearing services and submit a report to the CQC. To consider; - IQUIPS accreditation (improving quality in physiological services) - Board level assurance about paediatric audiology using IQIPS standards as a guide - Number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support At ETM the following actions were agreed; - Updating the Trust risk register

	- Identification of incidents of harm - Consideration of IQUIPS accreditation A follow up paper will be discussed at ETM, Quality Committee and Board in July. Board is asked to discuss and consider submission of a response to the CQC by 30th June.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Discussed at ETM
Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	30th June 2024
Recommendations	It is recommended that the Board is asked to discuss and consider submission of a response to the CQC by 30th June.
Appendices	1. Paediatric Audiology ICB Action Plan 2. South Yorkshire Outcomes 3. CQC Letter

ACTION PLAN – Paediatric Audiology ICB Action review

Description of the issue / Objective State the individual Issue / Objective	**Action Number**	**Action required** What action is to be taken? How will it be achieved? Is this for groups or individuals? Any other measures?	**Action Owner - Job Role**	**Target Action Completion Date** **DD/MM/YYYY**	**Actual Action Completion Date** **DD/MM/YYYY**	**Action Complete Yes/No**	**Periodic Review Required: (state if** Not Applicable, Monthly, Quarterly, Annually)	**Evidence of Completion** What records are there of the actions taken? (This must be concrete evidence that gives assurance and is auditable)	**Action to be added to the Audit Plan?**
Calibration recording of before and after adjustment values, uncertainty of measurement and appropriate stimuli included	**1**	Escalate to BAA professional body to engage calibration providers to improve/recognise responsibilities in provision of certification to services	**Audiology Lead**	**31.01.2024**	**3.1.24**	**YES**	**BAA board confirmed by email calibration meeting arranged with manufacturers 30th Jan**	**Email response**	
	1	Request calibration certification be provided when next annual calibration due.	**Audiology Lead**	**01.06/2024**					
	1	Contact alternative calibration to request annual quote and include certification requirements within request	**Maintenance contracting Team / Audiology Clinical Lead**	**01/06/2024**					**No**

ABR Testing overlay of responses	**2**	In house training with ABR staff to discuss overlay and use of grouping	**Audiology lead**	**1.2.24**					
	2	**Peer review system across SY+B to review protocol for case review.**	**Regional ABR colleagues**	**1.2.24**	**04.10.23**	**YES**		**SY+B ABR Peer review group agreed to submit all ABR cases for review and collate all submissions and comments.**	
	2	**Development request to be submitted to software provider regarding alterations to software given difficulties grouping curves**	**Audiology lead**	**1.3.24**					
	2	**Engage with new regional ABR peer review processes from Jan 24**	**Audiology Lead**	**14.1.24**	**10.1.24**	**YES**		**New regional ABR Peer review process being proposed by Regional scientific lead.**	

								Regional Meet planned 5/2/24 and 5/3/24.	
	2	**Submit funding request to CPD funding and SLT for both staff undertaking ABR to carry out additional training as per national recommendations**	**Audiology lead**	**31.3.24**				**On back of paediatric Quality Review new training courses being developed for practitioners. Red sights offered first places so anticipated Sept 2023.**	
Audit BAA Quality Standards not mentioned within Audit plan	**3**	Rating for this domain is a based upon 3 questions. One being is the BAA Quality Standards mentioned within audit plan	**Audiology Lead**				**Yes added to agenda for departmental governance group and added to TDCC governance group template for service.**	2 sites out of 22 were green within the ICB review. All other sites were red. We had 2/3 questions covered and the 3rd Question about our Audit plan. We have an audit plan and it mis-refers to the Paediatric	**Yes**

								Quality Standards rather than BAA Quality Standards. We currently have a action plan to the BAA quality standards which has been discussed within TDCC Governance.	
Staffing	**4**	Not all staff in the service are registered	**Audiology Lead**					**Despite being part of ICB review staff registration is not mandatory to practice as NHS audiologist. Thresholds within the ICB audit were 90% plus. We had 80 % registered and are now at 91% as one new starter has registered.**	

	4	**Discuss professional registration within clinical meeting**	**Principal Audiologist**	**17.1.24**				**Discuss within audiology clinical meet importance of CPD and professional registration**	
Documentation	**5**	**Local deviations from national standards described. Review of peer documents and update local guidance as required.**	**Audiology Lead**	**1.6.24**					

Click a site name to go to its detail

Domain	Barnsley	Doncaster and Bassetlaw	Sheffield Childrens	Sheffield Teaching	South West Yorkshire Partner	Rotherham	Include in rating?	Average score by metric
Calibration	D	D	B	D	C	D	Y	78%
Documentation	A	B	C	B	D	B	Y	62%
VRA Rooms		B	A		A	A	Y	72%
Audit	D	D	D	D	D	D	Y	45%
Incident/Risks	B	D	A	B	D	A	Y	65%
Staffing	A	A	A	A	A	B	Y	96%
ABR	B	D	C	B	B	A	N	66%
Overall rating (for selected metrics included in rating)	75%	45%	87%	85%	58%	83%		70%
	C	D	B	B	D	B		Serious Risk

- Barnsley Hospital:- Rated as Amber requires quality improvement plan.
- Doncaster & Bassetlaw Hospitals:- Rated as red and requires a full incident management response
- Sheffield Childrens:- Rated as Amber requires quality improvement plan
- Sheffield Teaching Hospitals:- Rated as Amber requires quality improvement plan. Score is low and is related to the services delivered. The trust were seen as a excellent service and will be approached to support regional peer reviews in the future
- South West Yorkshire Partnership :- Rated as red and requires a full incident management response
- Rotherham Foundation Trust:- Rated as Amber requires quality improvement plan

From: Care Quality Commission <CQC@public.govdelivery.com>
Sent: Monday, April 8, 2024 12:10 PM
To: JENKINS, Richard (BARNSLEY HOSPITAL NHS FOUNDATION TRUST) <richard.jenkins4@nhs.net>
Subject: Action required: Paediatric audiology services

You don't often get email from cqc@public.govdelivery.com. Learn why this is important

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The independent regulator of health and social care in England

8 April 2024

Dear colleague,

Re: Paediatric audiology services

As you may be aware, an expert review undertaken by NHS Lothian in Scotland found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.

These findings led to a review of the service provided by 4 NHS trusts in England which found similar failing. A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and integrated care boards (ICBs) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

Childhood deafness is a significant health and developmental risk. A National Deaf Children's Society survey in 2023 showed that:

- 527,898 children are known to the hearing services.
- In 2022 there were an estimated 8,405 children not supported by a hearing service.
- Ninety-four percent of children referred to ear nose and throat (ENT) services were

missing the six-week initial appointment target, with an average waiting time of 141 days.
- More than half of respondents (52%) reported that their trusts were missing the 126-day target for grommets surgery. This was a rise of 23% since 2019. The average waiting time was now 178 days, with a maximum wait of 540 days.
- Most paediatric audiology services (79%) did not offer wax removal, and most of them referred children to ear nose and throat (ENT) services for this, leading to lengthy delays.
- Thirty-nine percent of services failed to meet the 42-day waiting list target for an initial hearing assessment for babies and children who were not referred via newborn hearing screening.
- Only 26 services (23%) reported that they were currently accredited by Improving Quality in Physiological Services (IQIPs).

The main themes identified by providers in the same survey were long waiting lists, staffing issues, increasing demands on services, barriers to gaining Improving Quality in Physiological Services (IQIPs) accreditation and other resource or funding issues.

The total number of children with permanent deafness reported to be on services' caseloads has decreased by more than 7% since 2019. The incidence of permanent deafness generally remains stable, so this may suggest that some children have not yet been identified.

CQC are working closely with NHS England to help understand the current situation across the country regarding the level of assurance boards have about the quality of hearing services for children that they commission or provide.

The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC, we strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS. Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care. ICB's should ensure there are plans in place so that trusts can implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems.

Services that are not IQIPs accredited should formally register this as a quality risk in their quality reporting system.

Please can I ask that at the next full board meeting, the board considers the assurance that they have about the safety, quality, and accessibility of your children's hearing services. Following that consideration, the board should submit a report to CQC that makes clear:

- Whether you have achieved IQUIPS accreditation, including whether there were any improvement recommendations made.
- Whether you are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

NHS England have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.

Boards may be aware that UKAS have a benchmarking tool for provider of audiology services considering accreditation to help them understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it.

We are keen to understand the progress made towards accreditation and how the service across the county is improving over time. We would therefore ask that further to your initial

report to CQC (as outlined above), an additional review of assurance is conducted at a subsequent board meeting and a further follow up report on progress is provided to us.

The intent of this letter is information gathering and to gain a picture of service provision and the speed with which improvements are being made across the country. We are wanting to collaborate with other stakeholders to do our part in bringing about improvements in the care and treatment of this cohort of children.

Information returns from providers will be shared with operational colleagues to add to the wider information held about providers. It may be used to assist in the determination of risk levels within services for children and young people, but at this point it is not the intent to undertake stand-alone site visits based on what we are told about the service in your trust. That does not mean we will not conduct a thematic review or bespoke assessment process in the future, but rather to reiterate that we want to focus on getting a clear picture about what is happening at provider level now.

For clarity, we require consideration by the full board at the next meeting. An initial response should be sent to CQC no later than 30 June 2024. A subsequent response should follow after the next full board meeting. If there is any reason this cannot be achieved, please do come back to us with the reasons and when you consider you might be able to tell us about your service.

Please send your responses to Terri Salt, the lead senior specialist for this work, by email to terri.salt@cqc.org.uk. Terri can also be contacted if you have any questions or queries about this letter.

Yours sincerely,

Prem Premachandran MBE
Medical Director
Care Quality Commission

This email was sent to richard.jenkins4@nhs.net using GovDelivery Communications Cloud on behalf of: Care Quality Commission · Citygate · Newcastle · NE1 4PA

Board of Directors' Meeting
3 May 2024

Agenda item	P82/24
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 March 2024 (Month 12 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 March 2024 (Month 12 2023/24):
	
	    ○ Financial results to March 2024.

	- The Trust out-turned with a control total deficit of £4,715k, this is an improvement of £1,262k against its original planned deficit of £5,977k. - The Trust's performance is measured against its control total with NHS England having adjusted for depreciation on donated assets, PFI transitional costs and impairments, these are £3,951K year to date. Excluding these the deficit is £8,666K. - In delivering a control total deficit of £4,715K, the Trust has also met its target improvement reported in November 2023. • Section 3 – Capital Expenditure for March 2024 (Month 12 2023/24) o Expenditure for the twelve month period ending March 2024 is £12,287K against a budget of £12,285K and has fully delivered against its plan. Additional funding has been received in-year increasing the capital programme from £10,355K to £12,285K. o The capital programme has been reviewed and monitored at the Capital Monitoring Group, chaired by the Director of Finance. • Section 4 – Cash Flow 2023/24 o A cash flow graph showing actual cash movements between April 2022 and March 2024. A month-end cash value as at 31st March 2024 of £12,116K, which is £2,522K worse than plan. o Performance against the Better Payment Practice Code in March 2024 is 94.9% by number of invoices and 90.3% by value of invoices against the 95% target.
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. o 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. o CIP performance has been discussed with the Efficiency Board chaired by the Deputy Chief Executive. o The capital expenditure position has been discussed and reviewed by the Capital Monitoring Group, chaired by the Director of Finance. o 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 meetings. • CIP performance was discussed at the Efficiency Board meeting held on 17 April 2024. • Capital expenditure was reviewed by the Capital Monitoring Group on 15 April 2024. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 24 April 2024, 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 Plan £000s	Month Actual £000s	Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Prior Month Forecast variance £000s
I&E Performance (Actual)	(377)	(601)	(224)	(6,725)	(8,666)	(1,941)	(2,092)
I&E Performance (Control Total)	(316)	2,025	2,341	(5,977)	(4,715)	1,262	(1,427)
Capital Expenditure	665	4,676	(4,011)	12,285	12,287	(2)	0
Cash Balance	(1,334)	(5,865)	(4,531)	14,638	12,116	(2,522)	(4,248)

1.2 The Trust outturned with a control total deficit of £4,715k, this is an improvement of £1,262k against its original planned deficit of £5,977k.

1.3 The control total is the I&E performance that the Trust is measured against by NHSE. In delivering a control total deficit of £4,715K the Trust has also met its target improvement reported in November 2023.

1.4 The control total is after adjusting for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 - Leases. The impact of these, is an overall net cost pressure of £3,951K, which is included in the I&E performance but is allowed and added back in the control total. The impact of the year end revaluation adjustments are included in March 2024.

1.5 The Trust received £1.5m of funding in March 2024 from SY ICB for periods of Industrial Actions, from December 2023 to March 2024, which together with the use of reserves has enabled the Trust to deliver the £4,715k control total deficit.

1.6 Divisional performance and financial recovery plans have been monitored throughout the year by Executive Directors.

1.7 The SY ICB and regional NHSE team have held bi-monthly review meetings with the Trust.

1.8 Capital expenditure was ahead of plan in month and outturned on plan, with cumulative spend of £12,287k against a budget of £12,285k. Expenditure has been monitored by the Capital Monitoring Group chaired by the Director of Finance throughout the financial year.

1.9 The cash position at the end of March 2024 is £12,116K. This is a strong cash balance which is slightly worse than plan but better than last month's forecast due to the timing of payment runs.

2. Income & Expenditure Account for March 2024 (Month 12 2023/24)

2.1 The table below shows the financial results subjectively (by type of expenditure). In March 2024, the Trust delivered an adverse retained deficit variance of £225K and a favourable variance of £2,338K against the control total deficit.

Summary Income & Expenditure Position	Annual plan	Month			YTD			2023/2024
	£000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Monthly Trend / Variance
Clinical Income	327,766	29,705	40,897	11,192	327,766	335,563	7,797	
Other Operating Income	27,573	3,936	4,831	895	27,573	30,328	2,755	
Pay	(242,476)	(22,403)	(32,119)	(9,716)	(242,476)	(257,413)	(14,937)	
Non Pay	(103,418)	(11,351)	(15,858)	(4,507)	(103,418)	(112,894)	(9,476)	
Non Operating Costs	(3,969)	(331)	(323)	8	(3,969)	(4,250)	(281)	
Reserves	(12,201)	68	1,971	1,903	(12,201)	0	12,201	
Retained Surplus/(Deficit)	**(6,726)**	**(376)**	**(601)**	**(225)**	**(6,726)**	**(8,666)**	**(1,940)**	
Adjustments	748	62	2,626	2,564	748	3,951	3,203	
Control Total Surplus/(Deficit)	**(5,977)**	**(313)**	**2,025**	**2,338**	**(5,977)**	**(4,715)**	**1,262**	

2.2 The year to date deficit to plan is £1,940K, and £1,262K favourable to the plan control total. The difference of £3,203K is due to the impact of accounting for Private Finance Initiatives (PFI) under IFRS 16 – Leases, and impairments relating to the year end valuation of assets. The Trust's Carbon Energy Scheme liability is accounted for as a PFI.

2.3 Clinical Income is ahead of plan in-month and year to date due to a year end disclosure relating to pension payments of £9,499K. These are paid centrally by NHSE during the year and disclosed in provider accounts in income and pay at year end, the overall impact is net neutral. Excluding this, the year to date position would be an under performance of £1,702K, an adverse variance on elective recovery activity of £5,022K which is offset by over performance on other categories of clinical income of £3,320K, which includes the £1.5m of income received for Industrial Actions in the last quarter of the financial year.

2.4 Other Operating Income was ahead of plan in month and year to date with increased income from staff recharges (£449K), which will be an offset to the pay over-spend, increased research, development and education income (£1,676K), other non-clinical income (£259K) and clinical services SLA (£437K).

2.5 Pay costs were over-spent in month by £9,716K and the year to date performance was adverse to plan by £14,937K. The impact of the pension payment disclosure referred to in clinical income above of £9,499k explains most of these variances. The year to date is further impacted by undelivered cost improvement targets, Industrial Action and premium rates for agency staff.

2.6 Non Pay costs are over-spending by £4,507K in-month and by £9,476K year to date. The main categories of overspends are on impairments of assets relating to year end revaluations of £2,606K, drugs £1,869K, premises £2,218K, clinical supplies £1,803K, general supplies and services £454K and legal fees of £404K.

2.7 The adverse performance in Non-Operating Costs is due to the impact of accounting for the Carbon Energy Scheme under IFRS 16, which is allowed in the control total and included in Adjustments. Interest receivable and other finance costs remain better than plan by £384K.

2.8 £12,201K has been released from Reserves year to date, this is mostly to cover the underperformance against ERF, premium rates for agency staff and non-pay costs referred to above.

4. Capital Programme

4.1 As at March 2024 the Trust has incurred capital expenditure of £12,287K against a budget of £12,285K representing an over-spend of £2K allowable within the SY system.

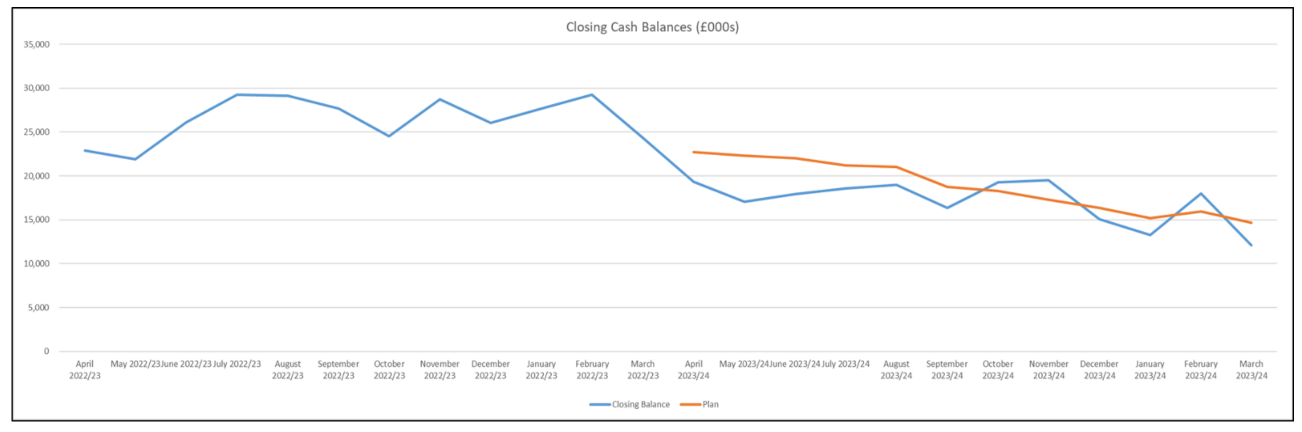
Capital Expenditure	Month			YTD				
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	In-year funding and PDC £'000s	Total funding £'000	Actual £000s	Variance £000s
Estates Strategy	254	901	(647)	4,316	(192)	4,124	4,014	110
Estates Maintenance	16	1,271	(1,255)	1,713	651	2,364	2,489	(125)
Information Technology	137	1,106	(969)	1,925	612	2,537	2,559	(22)
Medical & Other Equipment	517	1,366	(849)	2,755	473	3,228	3,193	35
Other	(259)	32	(291)	(354)	386	32	32	0
TOTAL	665	4,676	(4,011)	10,355	1,930	12,285	12,287	(2)

4.2 In-year the Trust has received additional funding of £1,930K. Public Dividend Capital of £1,461K was received for specific schemes, additional capital allocations made available from SY ICS underspends of £455K, and internal plan changes of £14K.

4.3 The capital programme has been monitored at the Capital Monitoring Group, chaired by the Director of Finance and has fully delivered against its plan.

5. Cash Management

5.1 Compared to plan, there is an adverse variance in-month of £4,531K and year to date variance of £2,522K. Cash remains strong with a closing cash balance of £12,116K as at 31 March 2024.



5.2 This has allowed the Trust to earn interest on its daily cash balances of £89K in-month (£1,169k year to date), which has helped to contribute towards the Trust's cost improvement target for 2023/24.

Steve Hackett
Director of Finance
21 April 2024

Board of Directors
03 May 2024

Agenda item	P83/24
Report	**Operational Update Report - End of Year Review**
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 (including reason for the report, background, key issues and risks)	This report is presented to Board of Directors for information regarding the Trust's performance against key operational performance metrics over the last financial year. 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 returned to the national access standard of 4 hours in year with a year-end target of 76% of all patients with seen, admitted or discharged within 4 hours of arrival to the UECC. Whilst the ambition of 76% was not achieved, improvements have been made along the way starting April 2023 at 54.8% and ending the year in March at 62.9%. • UECC has seen an increase in year on year attendances and a year on year increase in admissions which has seen additional pressures on UECC and the bed base in the Trust. • Virtual ward has been a significant development in year with more acutely unwell patents being managed at home within reach support from the virtual ward teams. At its peak the virtual ward had 76 patients on. The virtual ward is supporting discharge from hospital but is also supporting the admission avoidance agenda.

	• Criteria to Reside has continued to reduce and by year end achieved the target. The ongoing work to support patients who no longer need to be in hospital will continue over the next year focusing on internal delays and early supported discharge via the virtual ward. • The Trusts has remained focused on eliminating patients waiting over 65 weeks for treatment. At year end the Trust had only 22 patients waiting over 65 weeks, with 4 over 78 weeks. • The Trust achieved its Cancer 62-day target by year end with a target of 54 and achieving 44. • Significant work has been carried out in diagnostics over the year with the Trust finishing the year on 0.19% succeeding in becoming compliant with the constitutional standard of 1%. • The Trust has throughout the last year had 12 periods of industrial action involving junior doctors and or consultants. One period being concurrently run and another at the same time. The industrial action has accounted for 14.5% of lost working days throughout the year. • Progress against the EPRR action plan has resulted in five previously rated partially compliant core standards now self-assessed as fully compliant and the one non-compliant standard now self-assessed as partially compliant. This increases compliance by 35% in the 23/24 self-assessment to current position of 42%. • From the 1st April, we will be making some changes to the way we structure our services, moving away from our present structure of six clinical divisions. Moving forward our services will be organised into four Care Groups.
Due Diligence (include the process the paper has gone through prior to presentation at the 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 April, 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 End of year review

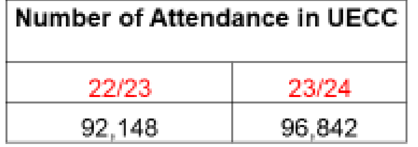
1.0 Urgent Care

The Trust returned to the national access standard of 4 hours in year with a year-end target of 76% of all patients to be seen, admitted or discharged within 4 hours of arrival to the UECC. Whilst the ambition of 76% was not achieved, improvements have been made along the way starting April 2023 at 54.8% and ending the year in March at 62.9%.

This has been in the context of significantly increased demand, with UECC seeing an increase in year on year attendances and a year on year increase in admissions. This has resulted in additional pressures on UECC and the bed base in the Trust, with the Trust operating at increased levels of operational pressures (OPEL 3 and above). A winter debrief has taken place where all schemes have been evaluated and planning has already begun for next year's winter.

The ACT programme for 2024/25 will continue to focus on the delivery of 4 hours focussing particularly on urgent care pathways and alternatives to UECC.

UECC Performance

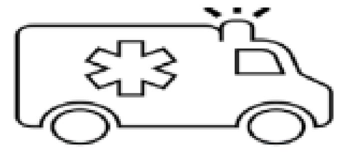


Number of Attendance in UECC	
22/23	23/24
92,148	96,842

Up by 4694 attendance this financial year that's a 5% increase overall this year.

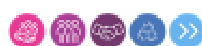
Number of 4-hour breaches in UECC	
22/23	23/24
50,651	39,506

The number of 4-hour breaches has reduced by 11,145 as the trust implements the 4 hour access standard



Number of Ambulance Handovers - Over 30 Mins	
22/23	23/24
5748	3880

Despite the increase in attendances our Ambulance Handovers within 30 mins has improved



2.0 Discharge

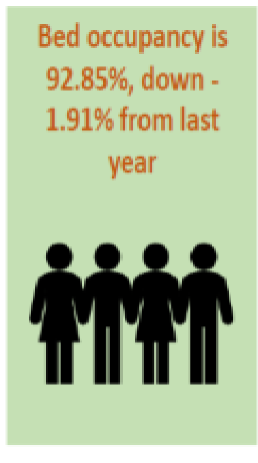
The regional discharge team visited and reviewed our discharge processes, where as a PLACE and as a Trust we received good feedback regarding these along with potential ways of going further to support discharge from hospital.

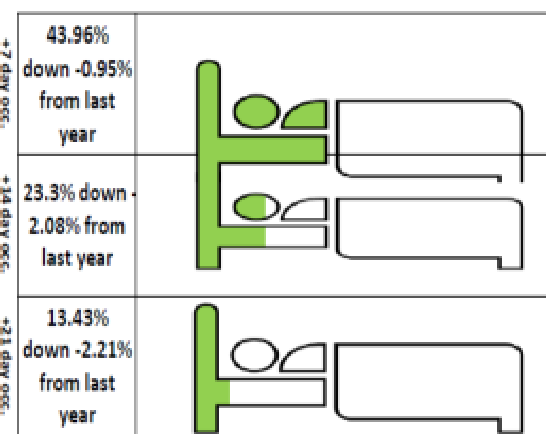
The use of the virtual ward has been a significant development in year with more acutely unwell patents being managed at home with in-reach support from the virtual ward teams. At its peak the virtual ward had 76 patients on. The virtual ward is supporting discharge from hospital but is also supporting the admission avoidance agenda.

Criteria to Reside has continued to reduce and by year end achieved the target. The ongoing work to support patients who no longer need to be in hospital will continue over the next year focusing on internal delays and early supported discharge via the virtual ward.

Alongside the work that has taken place on discharge there has been a huge amount of transformation work in admission avoidance with our community teams supporting UECC, in reaching into acute ward areas and working closely with the Yorkshire ambulance service to reduce conveyance to hospital. This collaborative work has had a significant impact on keeping people in their own homes and supporting flow through the system. The benefit of being an integrated Trust has allowed us to use our services where they are needed at times of surge and significant pressure.

Bed Occupancy





- Additional bed capacity in the trust
- Bed modelling needs to be redone to acknowledge increase in admissions
- Continued efforts on Long Length of Stay and Criteria to Reside has resulted in improvement in LOS
- Increased focus on discharge across the trust and at PLACE will further support bed occupancy

3.0 Elective and Cancer Care

The national expectation is now to eliminate patients waiting over 65 weeks for treatment by the end of September 25. Despite this and the challenges of industrial action, the Trust has remained focused on its ambition to eliminate waits over 65 weeks and at the year end the Trust had only 22 patients waiting over 65 weeks, with 4 of those over 78 weeks. The longest waiting patients were mainly due to the complexity of care they required, including 5 patients awaiting a corneal transplant (these are awaiting tissue to be allocated from NHSBT given national challenges with tissue availability).

This is a great achievement for our teams who dedicated the last quarter of the year to ensuring that the times our patients were waiting for treatment were reduced (overall waiting list) but the focus on those patients waiting the longest has significantly improved. Looking ahead to the next year the transformation programmes will continue with an aim for us to go “further, faster” in line with the Getting it Right First Time (GIRFT) programme.

The Trust achieved its Cancer trajectory for patients waiting over 62-days, with a target of 54 and achieving 44. The cancer services team were centralised in year bringing together the teams to really focus on the pathways for our cancer patients. Ongoing transformation work will continue into the next financial year with a dedicated transformation programme for Cancer, in a similar way to ACT, Theatre transformation and Outpatients.

4.0 Diagnostics (DM01)

The constitutional standard is that all patients should be seen within 6 weeks across a range of modalities. As part of the recovery agenda, Trusts are being asked to return to less than 5% waiting over 6 weeks by March 2025. Significant work has been carried out to recover our diagnostic waiting times, resulting in the Trust finishing the year on 0.19%. This is a significant achievement in ensuring our patients receive early diagnostics as part of their overall pathway, with the Trust benchmarking in the top decile nationally and being one of the first Trust's to recover compliance.

5.0 Industrial action

The Trust has throughout the last year had 12 periods of industrial action involving junior doctors and/or consultants. One period being concurrently run with another at the same time. The industrial action has accounted for 14.5% of lost working days throughout the year. This does not take into account any of the planning for or post recovery from industrial action. The industrial action has had a significant impact on elective waiting lists, including out patients, flow and normal business as usual. Clinicians and operational teams have worked closely to ensure that services could be maintained whilst also supporting people to take industrial action. The consultants have been advised by their union to accept the pay offer and at present the junior doctors have voted in favour of further industrial action into the next financial year.

6.0 EPRR Update

In January 2024, the Board of Directors approved the statement of compliance with the EPRR Core Standards along with an accompanying improvement plan. In April, the Finance and Performance Committee have received an update on the action plan for assurance as a sub-committee of the Board.

Work has been ongoing to address the actions with five partially compliant core standards now self-assessed as fully compliant and the one non-compliant standard now being partially compliant. This increases compliance from 35% in the 23/24 self-assessment to a current position of 42%. Progress on some areas has been impacted by the team supporting the planning and incident management associated with industrial action and significant operational pressures throughout winter.

7.0 Divisional Management Structure

From the 1st April, we will be making some changes to the way we structure our services, moving away from our present structure of six clinical divisions. Moving forward our services will be organised into four Care Groups. The services within the Clinical Support Services Division will be realigned to the Family Health and Community Divisions, with pathology services transferring to the new South Yorkshire Pathology Network model. In addition, Medicine and UECC will be merging into one Care Group.

Whilst there is still further work to do in recovering our waiting times and improve our performance, I would like to acknowledge the improvements our teams have made throughout 2023/24. I would like to take the opportunity to express my thanks to all colleagues that have delivered these improvements in what has been a particularly challenging year, both in terms of increased demand on services and ongoing periods of industrial action.

Sally Kilgariff
Chief Operating Officer
April 2024

National Key Metrics - Performance Against Trajectories

Adult G&A bed Occupancy - based on KH03 Submission												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Actual	90%	89%	91%	90%	91%	89%	90%	89%	89%	93%	91%	91%

Data run monthly from Live Bed State and based on Adult G&A only (predicted position for KH03)

Patients with no R2R												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	58	58	58	60	62	56	56	56	62	62	60	54
Actual	53	61	40	47	58	44	66	51	46	94	87	47

Total number of patients with no R2R as at the last day of the month (reporting day after month end for completeness)

Daily Average Hours lost from Ambulance Handovers												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8
Actual	8.1	4.4	7.3	5.13	8.71	4.3	9.6	6.7	12.0	24.4	20.1	14.2

Data taken from YAS report - total number of Hours lost divided by number of days in the month for the average.

Urgent Community Response Standard												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Actual	86%	83%	83%	74%	75%	76%	73%	73%	73%	71%		

Number of RTT 65 Week waiters												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	40	50	60	60	60	50	78	146	148	106	37	0
Actual	27	30	28	24	40	58	77	76	89	95	74	22

Data taken from Monthly RTT Submission

Cancer Patients waiting over 62 days following a GP Referral												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	60	60	60	64	64	64	60	60	64	64	60	54
Actual	59	67	52	41	46	62	44	58	54	59	51	44

Data taken as at the last day of the month.

4-hour UECC performance												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Internal Plan	45%	50%	55%	60%	65%	70%	76%	76%	76%	76%	76%	76%
National Submission	45%	45%	50%	50%	55%	55%	60%	60%	65%	65%	70%	76%
Actual	55.0%	60.0%	58.0%	63.8%	56.5%	61.4%	58.3%	62.8%	58.7%	55.38%	57.24%	62.91%

Data taken from Monthly Submission - subject to change following further validation but unlikely)

Number of Patients on Virtual Ward												
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	12	16	24	24	32	40	56	64	72	80	80	80
Actual	14	14	23	31	36	25	36	76	53	67	44	76

Board of Directors Meeting
03 May 2024

Agenda item	P/84/24
Report	**Board Assurance Framework**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with 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 therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	The development of the new Board Assurance Framework has continued on a monthly basis. The People Committee, Quality Committee and Finance and Performance Committee have each reviewed the Strategic Board Assurance Risks aligned to them as follows: **People Committee:** Discussed and approved the position in relation to Strategic Risk U4 and recommend that the risk score remains at 12. **Finance and Performance Committee:** Discussed and approved the position in relation Strategic Risk D5 and D7 relating to future financial risk. The Committee discussed the feasibility of reducing both scores to 12, the outcome being the scores remain at 20. **Quality Committee:** Discussed and approved the position in relation to Strategic Risk P1 recommending the score remains at 12 The Board will continue to review and approve the recommended scores for Strategic Risks R2 and OP3. The attached report illustrates the position in relation to the Board Assurance Framework for the end of Quarter 4 2023/24 and the beginning of Quarter 1 2024/25.
Due Diligence	Since presentation at the last Board in early March 2024, the relevant sections of the Board Assurance Framework have been discussed at the relevant Board Committees during March and April 2024.
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. In addition, following approval of the Trust Objectives for 2024-25, the BAF and Risk Appetite will be reviewed at updated to reflect any changes.
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 rating for BAF Risk P1 to remain at 12; ➢ The rating for BAF Risk R2 to remain at 8; ➢ The rating for BAF Risk O3 to remain at 8; ➢ The rating for BAF Risk U4 to remain at 12; ➢ The rating for BAF Risk D5 to remain at 20; and ➢ The rating for BAF Risk D7 to remain at 20
Appendices	Board Assurance Framework for the beginning Quarter 1 2024/25

1. Introduction

1.1 The development of the new Board Assurance Framework (BAF) to align with the 5 Year Strategy was commenced during Quarter 1 2022/23 when the Board approved a total of five Strategic Board Assurance Risks that would be monitored via the relevant Board Assurance Committees on the monthly basis with final approval by Trust Board on a quarterly basis.

1.2 The BAF is now entering its third year in 2024/25 and continues to be monitored on a monthly basis at the Assurance Committees and quarterly at Board.

1.3 The following report illustrates the discussion and decisions taken by the relevant Board Assurance Committees and the Executives during the period end of Quarter 4 2023/24 and the beginning of Quarter 1 2024/25.

2. Outcome of the Reviews carried out in Quarter 4 and Quarter 1.

P1: There is a risk 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.

Risk aligned to the Quality Committee

2.1 The Chief Nurse and the Medical Director are the Executive Director leads for Strategic Risk P1. As part of the continuing review of the BAF, monthly discussions take place with the Chief Nurse, Medical Director and Deputy Director of Corporate Affairs. There is also linkage with the BAF and the current Risk Register.

Updates to the Controls and Mitigations

2.2 Controls C1, C3, C4 and C5 have been updated with date of latest assurance received and additional forms of assurance confirmation.

2.3 C2: A new control for 2024/25 will relate to Quality Dashboard on Power BI with Tenable one element of the tool.

2.4 C3: Final selection of 3 quality priorities agreed. Details of the metrics to be finalised - to April 2024 Quality Committee

2.5 C4: Inpatient embargoed results expected May 2024 for publication in August 2024

2.6 C5: Internal Audit Learning from Deaths signed off. 2024/25 focus moving away from HMSR to SHMI. New Patient Safety Associate Medical Director to concentrate on learning from Deaths. A total of 15 of 15 actions now completed.

2.7 C6: Self-assessment approach Q1-Q3

2.8 C7: Signed off as complete - to go to April 2024 Quality Committee

2.8 C8: Completed

2.10 C9: Session held at April 2024 Strategic Board Session. Will become more embedded in Operational Plan 2024/25. Well Led Peer review planned 2024/25.

2.9 C11: Focus groups commencing May 2024

Updates to the Gaps in Controls and Mitigations

2.11 **G1:** Recruitment for MD for Quality Improvement (2PA's) completed AMD for Patient Safety & QI Lead in post. Band 7 now in post, Band 5 is ongoing. ETM supported option to bring QI training in-house, this is a regional approach. MD, Band 5 and Band 7 posts now filled and employment commenced. Improvement Learning South Yorkshire (ILSY) now in place and regional training live from April 2024. All actions now completed

2.12 **G4**: Actions from 360 report now completed awaiting 360 audit sign off April 2024.

2.13 **G17:** Aim to respond to UKSHA in April 2024

2.14 **G18**: NACEL to change to a rolling programme of audit. All actions Completed.

2.15 **G20**: Operational plan presented at Board March 2024. All actions Completed

2.16 **G23:** Programme gone live and on track, this will now be an ongoing process across trust with inpatient adult wards completed. Criteria to be agreed for other departments and teams, Children's and Maternity in October 2024 and UECC in April 2025.

2.17 **G24:** Completed.

2.18 **G26**: 360 in process of completing for quarter 1 2024/25 Submitting data now, awaiting results.

2.19 **G27:** Consultants have reached agreement. Potential for Junior Doctors and GP's ongoing action remains.

2.20 **G28**: 360 audit now signed off, significant assurance, audit plan update to April 2024 Audit & Risk Committee.

2.21 **G29:** Completed.

3. Review of the Risk Score relating to P1

3.1 The initial score agreed for Quarter 1 2022-23 was a score of 16 whereby the consequence was graded as a 4 (Major), defined in accordance with the 2008 Risk Matrix for Risk Managers as 'noncompliance with national standards with significant risk to patients if unresolved, low performance rating, critical report'. It is proposed the consequence score remains the same at 4 (Major).

3.2 The initial likelihood score agreed for Quarter 1 was 4 (Likely) defined in accordance with the aforementioned matrix as 'will probably happen/recur but is not a persisting issue. It is proposed that likelihood score remains the same at 4 (Likely). During Quarter 1 2023-24, the likelihood score was reduced to 3.

3.4 Taking the above into consideration, it was recommended the risk score remains at **12** at the beginning of Quarter 1**.**

4. Risk aligned to the Board

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 health inequalities.

Updates to the Controls and Mitigations

4.1 **C5:** A shared Public Health Consultant between RMBC and the Trust commenced in post - completed

4.2 **C6:** Meetings three times a week have been instigated by the Trust to review the Integrated Discharge position.

Updates to the Gaps in Controls and Mitigations

4.3 **G1:** Trust to be a member of the PLACE Committee of the ICB once established - TRFT attend, contribute and comment but are not members.

4.4 **G2:** Unknown entity around the ICB governance which is continuing to evolve and mature. ICB Governance Terms of Reference now agreed and signed off.

4.5 **G3:** Incomplete data driven identification of Health Inequalities across elective and non-elective pathways. Public Health Consultant: The Trust has reviewed elective waiting lists split by indices of multiple deprivation and found little variation between broad groups in terms of wait times, although further work is planned to dig deeper and to set up a regular reporting framework on waiting list inequalities more broadly.

Review of the Risk Score relating to R2

5. It is recommended that the score remains at **8** which the Board will note is currently the target score.

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.

Update to the Controls and Mitigations

6.1 **C1:** Shared Chief Executive, Governance function and Director of Communications between the Trust and Barnsley NHSFT - completed

6.2 **C4:** Existing collaboration with Barnsley around Procurement function in place. Reports to Finance and Performance Committee

7 Updates to the Gaps in Controls and Mitigations

7.1 **G3:** New Pathology Partnership model with new governance arrangements following TUPE. New arrangements will need to embed with assurance provided to TRFT, Identified colleague to lead on target operational model for TRFT, Managing Director to attend Governance meetings

Review of the Risk Score relating to O3

7.2 It is recommended that the score remains at **8** which the Board will note is at target score.

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

Risk aligned to People Committee

8.1 The Director of People is the Executive Director lead for the current BAF Risk U4. As part of the review process, the Deputy Director of Corporate Affairs met with the Director of People throughout Quarter 4 and Quarter 1 on a monthly basis with the last review being in April 2024.

Update to the Controls and Mitigations

8.2 **C4** WRES and WDES actions will contribute towards trust wide EDI plan quarter 2 2024/25

8.3 **C13** NHS Staff survey outcomes and scores including Medical engagement to be presented at People Committee and then the March 2024 Board of Directors. Staff Survey next steps' to go to April 2024 People Committee

Updates to Gaps in Assurances

8.4 **G3** Development of new People Strategy for 2024/2027; information was shared at Strategic Board January 2024, the Strategy then went to go to the February 2024 People Committee and then final version went to April 2024 People Committee for sign off before presentation at the May 2024 Board of Directors.

8.5 **G4** Update to be provided at April 2024 People Committee via the Directors Report and then to be closed off.

8.6 **G5** Deep dive into sickness absence taking place quarter 1 and 2 - attendance management audit currently underway and plan of work for 2024/25 to be presented to PC in April 2024.

Review of the Risk Score relating to U4

8.7 The BAF Risk U4 was initially graded with a consequence of 4, which in accordance with the aforementioned risk matrix relates to uncertain delivery of key objectives/service due to lack of staff, unsafe staffing levels or competence (>5 days), very low staff morale and no staff attending mandatory/key training. The likelihood was deemed to be a score of 3 which is 'possible, might happen or recur occasionally.'

8.8 Consideration has been given to the consequences of the Strategic Risk U4 which will be low morale, lack of staff retention and remains at a score of 4. Given the additional controls and mitigations in place, the likelihood of the risk materialising had previously been reduced to a score of 2 which is 'unlikely, do not expect it to happen/recur but it is possible it may do so.

8.9 Following further discussions at the People Committee in February 2024 and April 2024 it is recommended that BAF Risk U4 remains at **12.**

8.10 The Board will note that despite the risk score, the risk remains within the current approved risk appetite with a continuing acceptance of a greater degree of inherent risk in pursuing workforce innovation with the caveat that we could potentially improve the skills and capabilities of our workforce.

8.11 The April People and Culture Committee discussed the need to amend how the risk is articulated to align with the revised organisational priorities. The Board will further consider this at the next Strategic Board session.

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.

Risk aligned to Finance and Performance Committee

9 The Director of Finance and the Chief Operating Officer are the Executive Director leads for Strategic Risk D5. As part of the deep dive review process, the Deputy Director of Corporate Affairs met with the Director of Finance and Chief Operating Officer monthly during Quarter 4 and Quarter 1 resulting in the following amendments:

Update to the Controls and Mitigations

9.1 Controls **C1, C2, C3, C4, C5, C6, C7** and **C9** have been updated with date of latest assurance received and additional forms of assurance confirmation.

Updates to Gaps in Assurances

9.2 **G1** – Pressures are bed capacity due to high attendance and admissions.

9.3 **G4** - 1st Draft 360 Assurance report received and actions identified to be included in response. Final report received and recommendations implemented. Access Policy implemented.

9.3 **G6** - Consultants agreed pay deal. Junior doctors re-balloted for further industrial action, no dates yet announced. Recovery schemes continuing into month 1 of 2024/25

Review of the Risk Score relating to D5

9.4 The risk had been graded initially at **15** and following further discussion at December 2023 Board it was agreed that the rating should be increased to 20 due to the ongoing pressures of industrial action.

9.5 The risk was reviewed in April 2024 by the Director of Finance, Chief Operating Officer and the Deputy Director of Corporate Affairs in April 2024. Based on account of the Trust having no signed off financial plan for 2024/25, there was a proposal for an estimated risk rating of 12 for both D7 and D5. It was acknowledged that this would likely deteriorate once the full details of the plan had been finalised, however currently on the belief that it will be deliverable, based on 103% elective activity and no further industrial action, that the consequence was 4 with a current likelihood of 3. This reduction of the risk rating was taken to the April 2024 Finance & Performance Committee for discussion and approval. Following the discussion it was agreed that the risk rating should remain at 20, the risk will continue to be reviewed on a monthly basis.

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.

10 BAF Risk D7 looks ahead to the potential future financial situation for the Trust.

Update to the Controls and Mitigations

10.1 Controls **C3, C4, C5, C6, C7** and **C8** have been updated with date of latest assurance received and additional forms of assurance confirmation.

Updates to Gaps in Assurances

10.2 **G3** - End of financial year £4.7m deficit, which was £1.2m better than plan. The main risk that remains is the potential cost of back Pay of B2 and B3 posts.

10.3 **G10** - Consultants agreed pay deal. Junior doctors re-balloted for further industrial action, no dates yet announced. Recovery schemes continuing into month 1 of 2024/25.

Review of the Risk Score relating to D7

10.4 The risk had been graded initially at **15** and following further discussion at December 2023 Board it was agreed that the rating should be increased to 20 due to the ongoing pressures of industrial action. The risk was reviewed in April 2024 by the Director of Finance, Chief Operating Officer and the Deputy Director of Corporate Affairs in April 2024.

10.5 As set out in section 9.5 above, following robust discussion at the Finance and Performance Committee in April the recommendation is for the risk to remain at 20 with continuing monthly review.

Recommendations

The Committee is asked to:

- Discuss and note the progress made in the development of the Board Assurance Framework during the last financial year;
- Note the recommendations from the Board Committees in relation to the risk scores for the end of Quarter 4 2023/24 and beginning of Quarter 1 2024/25.

Alan Wolfe
Deputy Director of Corporate Affairs
25 April 2024

Ambition	Strategic Risk			Original Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	Target Risk Score	Movement	Risk Appetite
	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	2022/23 4(L)x 4(C)=16 2023/24 Quarter 4 3(L) X 4) = 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				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	2022/23 3(L)x4(C)=12 2023/24 Quarter 4 2(L) X 4(C) = 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				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	2022/23 4 (L)x3(C) =12 2023/24 Quarter 4 5(L) X 4(C) = 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.	2022/23 3(L)x 5(C) =15 2023/24 Quarter 4 5(L) X 4(C) = 20	20				4(L)x5(c) =20		Low (6-10)

BAF Risk P1 – Version 1.1 Quarter 1: 2024-25

Strategic Theme: Patients	Risk Scores										
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2024-25**	
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	Very Low (1-5)	15 10 5 0 / Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar / risk score / target risk	**Previous Score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: P1: Empower out teams to deliver improvements in care							**12**	**12**			

BAF Risk Description	**Linked Risks on the Risk Register & BAF Risks:**	**Assurance Committee & Lead Executive Director**
	RISK6623, RISK5761, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6886, RISK6284, RISK5238, RISK6723, RISK6958, RISK6857, RISK6801, RISK6888, RISK6718 and RISK6421	
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	December 2023	Deputy CEO	Level 1 & Level 3	Future of Group to be reviewed by Managing Director, Chief Nurse and Medical Director
		Quality Assurance Report to Quality Committee (Quarterly)	April 2024	Chief Nurse	Level 1& Level 3	
		Monthly reporting to CQC in relation to Conditions on Registration.	Complete	Chief Nurse	Level 1& Level 3	
C2	Established Tendable Audit Programme	Outcome reports received by Quality Committee on a rolling quarterly programme linked to specialist areas		Chief Nurse	Level 1	A new control for 2024/25 will relate to Quality Dashboard on Power BI with Tenable one element of the tool.
		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	January 2024	Chief Nurse	Level 2 – Medication Safety Audit completed	
		Monthly Quality Dashboard reported to Divisional Performance Meetings.	Feb 2024	Chief Nurse		

		Published Patient Experience Annual Report on Trust website.							Transition to Power BI dashboard underway with fully functional for April 2024
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.	April 2024	Chief Nurse	Level 1 Progress reports on Quality Priorities presented within each quarter Quarter 2 reports all received by Quality Committee				Work has commenced to produce the draft Quality Priorities for 2024/25 with the draft to go to Quality Committee in January 2024. Final selection to go in March 2024 Final selection of 3 priorities agreed, metrics details to be finalised - to April 2024 QC
C4	Implementation of actions following Patient Surveys	Progress reports received by Patient Experience Committee and monitored via Quality Committee.	To go to QC February 2024	Chief Nurse	Level 1 Level 3				Recent inpatient survey results not as expected, an action plan has been developed and is in place. Maternity survey results published by CQC in Feb 24 showing positive outcome. Inpatient embargoed results expected May 2024 for publication in August 2024
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 and Board in November 2023. HSMR continuing to track downwards	May 2023 January 2024	Medical Director	Level 3 Outstanding actions – see G4 below: Learning from deaths at CSU level & Embedding SJR process Learning From Deaths Policy to be signed off by the Medical Director - Policy gone through Document Ratification Group and published on 24th November 2023. Last 6 months HSMR showing downward trend and now lowest in Y&H region				Learning from Deaths signed off. 2024/25 focus moving away from HMSR to SHMI. New Patient Safety Associate Medical Director to concentrate on learning from Deaths. 15 of 15 actions now 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.				Process currently paused whilst we transition to new CQC assessment framework from February 2024. Self-assessment approach Q1-Q3
C7	Quality Improvement & Quality Governance Assurance Priority within Operational Plan	Quarterly updates to Quality Committee	January 2024	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 October 2023.				Presented quarterly. Next April 2024. Signed off as complete - to go to April 2024 QC

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. PSIRF plan approved at Quality Committee and by ICB at Contract Quality Meeting It was reported at the Audit & Risk Committee that 360 Assurance had undertaken review of PSIRF implementation, report received and gave Moderate Assurance for PSIRF and the lack of an oversight group for learning actions. There was a significant opinion for patient experience work stream.				**Completed** Plan to go to Board March 24 and will be published on Trust website
C9	Implementation of agreed Strategy for Journey to CQC Outstanding rating	Quarterly progress reports to Quality Committee (links with Gap 14), next was October 2023 Meeting with CQC to discuss expectations 25/01/24 has been cancelled by CQC - next meeting scheduled 29/02/2024. Session held at April 2024 Strategic Board Session	October 2023	Chief Nurse	**Level 1**				Will become more embedded in Operational Plan 2024/25 Well Led Peer review planned 2024/25
C10	Implementation of Safeguarding Improvement plan in conjunction with NHSE	Reports to Safeguarding Committee was July 2023	To go to QC Feb24	Chief Nurse	External review NHSE paediatrics and maternity occurred on 01/06/2023, report sent to TRFT August 2023 with positive assurance 12-17/07/2023 – Rotherham Adult Safeguarding Peer Review took place Adult plan with NHSE has been delayed until April 2024 due to internal capacity issues, NHS team attending Strategic Board February 2024.				Focus groups commencing May 2024
C11	Creation of a Quality Metrics Dashboard (including outcome of Tendable Audits) for all ward areas on Power BI platform.	Dashboard created and in use on specific wards.	To go live April 2024	Chief Nurse	Level 1				

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	Review next stage Business Case	Chief Nurse & Medical Director	August 2022	~~September 2022~~ June 2023			Recruitment for MD for Quality Improvement (2PA's) completed AMD for Patient Safety & QI Lead in post Band 7 now in post, Band 5 is ongoing. MD, Band 5 and Band 7 posts now filled and employment commenced	
		Submission of next stage business case brief	Chief Nurse & Medical Director	March 2023	ETM 8 June 2023			QI Medical Lead recruitment process underway. Appointment now made - all posts now filled	
	Developing a sustainable QI faculty and projects with identifiable patient benefits alongside QI methodology.	Gained approval at June 23 ETM to proceed to full business case – approved at ETM August 2023 – recruitment to commence	Chief Nurse & Medical Director	September 2023				ETM ~~April~~ June 2023	
		Recruit to x2 further roles in QI team	Chief Nurse	Recruitment process commenced					
		Trust have received notice from NHSE that QSIR provision has been outsourced to company called AQuA with cost implications, paper has been submitted to ETM to explore other options	Chief Nurse	January 2024	April 2024			ETM supported option to bring QI training in-house, this is a regional approach	

								Improvement Learning South Yorkshire (ILSY) now in place and regional training live from April 2024 **All actions now completed**	
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 going through final sign off	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. Development of lessons learned resource to be undertaken 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. Learning from Deaths Policy now fully signed off. One outstanding action from 360 - Division of Medicine now using process for SJR review at CSU level and the evidence from this will be used for 360 sign off in March 2024. Completed awaiting 360 audit sign off April 2024. **Audit signed off - all actions Completed**	
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~~ ~~Extend to March 2024~~ Extend to July 2024			~~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	Potential 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	April 2024 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. Aim respond to UKSHA in April 2024 To respond to UKSHA by May 2024	
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. NACEL to be four times per annum from 2024 NACEL 2024 has commenced, new Lead Nurse for End of Life now in post Paper to ETM regards restructure of team approved and End of Life will now sit Corporately - December 2023 NACEL to change to a rolling programme of audit **All actions Completed**	
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 November – Operational plan and Policy to Patient Safety, then Quality Committee October 2023 and by ICB at Contract Quality Meeting. 360audit report to Audit & Risk Committee January 2024 Gone live - Operational plan presented at Board March 2024. **All actions Completed**	
G21	**Archived – see version 1.1 2023/24**								
G22	**Archived – see version 1.1 2023/24**								
G23	Plan to introduce an exemplar accreditation programme	Strategic planning session with Heads of Nursing	Chief Nurse	19/06/2023	December 2023			To go live from April 2024, with raising awareness sessions to be held January to March 2024. Lead wards in three divisions identified. Initial planning sessions have taken place with ward managers from A7, A5, B10 and Rockingham. Programme gone live and on track, this will now be an ongoing process across trust with inpatient adult wards completed. Criteria to be agreed for other departments and teams, Children's and Maternity in October 2024 and UECC in April 2025.	
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			**Completed**	
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. Position for NELA now better, however other National Audits are challenged. 360 in process of completing for quarter 1 2024/25 Submitting data now, awaiting results	
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.	Divisional Leads & FPC Director of Workforce & FPC	Ongoing Completed	 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.	

		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	Director of Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC Chief Nurse & QC Director of Operations & FPC	Commenced Completed June 2023 Ongoing 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 Watchful eye on external factors patient harm being monitored and not believed to be at a level to increase risk rating at this time. Next round of junior doctor IA commenced over Christmas and New Year period Further industrial action confirmed for 24th to 29th February 2024. No further dates confirmed. Consultants have reached agreement. Potential for Junior Doctors and GP's ongoing action remains.	
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				Position for NELA now better, however other National Audits are challenged. 360 audit now signed off, significant assurance, audit plan update to April 2024 Audit & Risk Committee	
G29	Quality Metrics Dashboard created	Training is ongoing with all divisions and to be fully live from April 2024	Chief Nurse	Apiril 2024				Completed - live	
Archived Controls within month- Completed									
Archived Gaps within month - Completed									

BAF Risk R2 – Version 1.1 Quarter 1: 2024-25

Strategic Theme: Patients	**Risk Scores**						**Board Assurance 2024-25**				
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**	**Previous score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
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.*** ***Link to Operational Plan: R2: Ensure equal access to services***	R2	2(L)x4(C)=8	8	2(L)x4(C) =8	Moderate (12-15)	10, 5, 0; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; risk score; target risk	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 PLACE reports summarized by MW and report to Trust Board every two months	~~December~~ September 2023	Board minutes	Level 1	Control remains ongoing
C2	Trust is a member of Prevention and Health Inequalities Group	Public Health Consultant also now attends Group Public Health Consultant is 50/50 split with RMBC	**March 24**		Level 1	**Control remains ongoing**
C3	Trust is a member of the Health and Wellbeing Board		**July 23**		Level 1	**Control remains ongoing**
C4	Deputy Chief Executive attends the Health Select Commission	Ran Workshop for Commission December 2023	**July 23**	**Minutes**	Level 3	**Control remains ongoing**
C5	Shared Public Health Consultant between RMBC and the Trust commences March 2023	Commenced in post Public Health Consultant developing a work programme to go to Trust Board	**March 23** **March 24**	**In post**	Level 1	**Completed**
C6	Meeting with PLACE colleagues to review IDT position.	Meet at least three times a week to review integrated discharge position.	**March 24**		Level 1	
C7	PLACE Leadership Team meeting every Wednesday morning	Deputy Chief Executive attends along with other Rotherham PLACE members	**Weekly**		Level 1	

	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	TRFT attend, contribute and comment but are not members	Managing Director	Ongoing		Awaiting final confirmation from external source.

	of the ICB once established.							TRFT has not been made a member, this is a decision made across all South Yorkshire ICB	
G2	Unknown entity around the ICB governance which is continuing to evolve and mature.	ICB Governance Terms of Reference now agreed and signed off	Managing Director	March 24				Paper expected for the September Board No change to position	
G3	Incomplete data driven identification of Health Inequalities across elective and non-elective pathways.	Public Health Consultant: The Trust has reviewed elective waiting lists split by indices of multiple deprivation and found little variation between broad groups in terms of wait times, although further work is planned to dig deeper and to set up a regular reporting framework on waiting list inequalities more broadly.	Managing Director		End Quarter 1			Data relating to access to services available in Trust Integrated Performance Report – suggest close this gap and archive. Gap Closed	
G4	Ethnicity details not on all electronic systems	Public Health Consultant identifying and working on solution.	Managing Director	Ongoing	End of Quarter 1				
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 2024-25				
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.** ***Link to Operational Plan: P3: Our Partners: Work together to succeed for our communities.***	O3	2(L)x4(C) = 8	8	2(L)x4(C) =8	Moderate (12-15)	10 / 5 / 0; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; risk score; target risk	Previous score Q4 2023-24: 8	Q1: 8	Q2	Q3	Q4
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	Reports received by the Trust Board every two months from Chief Executive Report	March 24		Level 1
C2	Shared Chief Executive, Director of Corporate Affairs and Director of Communications between the Trust and Barnsley NHSFT	Completed	Sept 2022 substantive March 24		Level 1
C3	Existing collaboration with Barnsley on some clinical services	Gastro service up and running, Haematology service in progress MEOC now opened.	January 24		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.	January 24	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	Managing Director		September 2022			Paper to September Board.	Completed - to be archived
G2	Triumvirate Joint Leadership Programme	Company commissioned to deliver programme Commencement of programme	Managing Director	October 2023 November 2023	October 2024			Rolled out	
G3	New Pathology Partnership model with new governance arrangements following TUPE. New arrangements will need to embed with assurance provided to TRFT	Identified colleague to lead on target operational model for TRFT, Managing Director to attend Governance meetings	Managing Director	Started 01/04/2024	End of Quarter 1 Head of Nursing (Governance & Quality) to be embedded in role and start receiving assurance from governance at Pathology Partnership				
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Board Assurance Framework People Committee: 2024/25 Quarter 1: Version 1.1
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 2024-25		
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)	15 10 5 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; risk score; target risk	**Previous score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***P3: Supporting our People*** ***P2: Improve engagement with our medical colleagues***							**12**	**12** ⟺			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **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*	Board Assurance 2024-25
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	WRES and WDES action plans submitted to NHSE and People Committee	October 2023	Board minutes	Level 2	**Completed**
		WRES and WDES action plans submitted to Board of Directors	November 2023	Board minutes		
		Progress against action plans monitored via Operational Workforce Group a	Agreed and signed off at Nov23 Board	Reports to People Committee	Level 1	**Ongoing**
		Actions will contribute towards trustwide EDI plan quarter 2 2024/25		Board minutes	Level 2	**Completed**
		All Divisions attended Joint Partnership Forum to detail action plans	21 July 2022			

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 to be presented at People Committee and then the March 2024 Board of Directors “We said, we did” Action Plans to PC on a rolling basis - ‘Staff Survey next steps’ to go to April 2024 PC.	Q4 2023/4 March 2024 Q4 2023/4	Completed On track	Level 3 Level 1				**Director of People & Medical Director**
C14	Delivery of the Nursing and AHP retention and recruitment programme	Reports to People Committee	~~October 2023~~ Q3/Q4	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 Ongoing quarterly report**
C17	Leadership Programme in place for Divisional Triumvirate leadership teams	Identify suitable leadership development programme provider. Tender documentation signed off by Deputy CEO. Procurement exercise scheduled 18/07/23. Scope to be revised and intensive programme to be agreed. Delivery partner Value Circle identified and commissioned, began engagement work and launched programme Friday 10th November 2023. Delivery in train	November 2023		Level 1				**Deputy Chief Executive & Director of People**

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**~~	**Gap moved to control (C17) - See version 3.2 2023/24**							

G3	Development of new People & Culture 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 ETM agreed scope Nov'23 Internal steering group now leading work. Information shared at Strategic Board January 2024, to go to February 24 People Committee and then final version to April 24 PC for sign off and then May 24 Board. On track.	
G4	Development of a workforce plan aligned to ~~clinical, operational, financial plans etc.~~ Acute Care Transformation (ACT) programme & Theatres Transformation Programme (ETM agreed scope)	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 ETM agreed scope Nov'23 Work in train, update to be presented to Feb24 PC Update to be provided at April 2024 PC via the Directors Report and then to be closed off.	
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 &	Completed	March 2023				

			FPC						
		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					Papers sent to FPC Impact of Industrial Action paper sent to September FPC Phase 1 deep dive undertaken. Phase 2 has commenced which involves an independent review.	
		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 & presented at December'23 PC. (update now due at February'24 committee) Impact on staff and teams, need to support wellbeing of staff dealing with increased stress, sickness absence and impact on team dynamics Deep dive into sickness absence taking place quarter 1 and 2 - attendance management audit currently underway and plan of work for 2024/25 to be presented to PC in April 2024.	
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 2024-25**				
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 ***Link to Operational Plan: D5: Implement sustainable change to deliver high quality, timely and affordable care***	D5	4(L)x3(C)=12	5(L)x34=1520	2x3=6	Very low (1-5)	25, 20, 15, 10, 5, 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar risk score target risk	**Previous Score Q4 2023-24** **20**	**Q1** **20**	**Q2**	**Q3**	**Q4**
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 5761,~~ ~~Risk 6569~~, RISK6800, RISK6627, RISK6762 ~~RISK6414~~, RISK6755, RISK6638, RISK6718, RISK6723, RISK6958, RISK6888, RISK6598 , 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	**April 2024 IPR** **April 2024 IPR** **April 2024 IPR** **April 2024 IPR**	**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	**April 2024 IPR**	**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 Oversight through the new Rotherham Place Urgent and Emergency Care Group (Previously the A&E Delivery Board)	**April 2024 IPR** **April 2024 IPR** **April 2024 IPR**	**Minutes of F&P** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1	COO

		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	**April 2024 IPR** **April 2024 IPR**	**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.	**April 2024 IPR**	**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	**April 2024 IPR** **April 2024 IPR**	**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	**April 2024 IPR**	**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. New weekly PTL for Elective and Cancer week commenced 27/11/2023	**April 2024 IPR**	**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. Bed modelling rerun. Bed base right, bed occupancy improved to below 92% standard. Challenges due to winter pressures and IA in proximity to Christmas and New ear period and subsequent impact on bed capacity due to high acuity, above plan on A&E attendances and admissions.	
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 underway, awaiting outcome. Validation of waiting list over 90% requirement. Awaiting formal report and verbal feedback provided	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 1st Draft 360 Assurance report received and actions identified included in response sent to 360. Final report received and recommendations implemented. Access Policy implemented.	
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 - plans agreed. No further dates confirmed. Consultants agreed pay deal. Junior doctors re-balloted for further industrial action, no dates yet announced. Recovery schemes continuing into month 1 of 2024/25	
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 - now being implemented. Positive impact on both activity and waiting times.	
Archived Controls within month – Completed									
Archived Gaps within month - Completed									

BAF Risk D7: Version 1.1 Quarter 1 2024-25

Strategic Theme: Us	Risk Scores								
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2024-25		
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) X 4(C)=12	3(L) X 4(C)=12	1(L)x4(C) =4	Low (6-10)		Previous Score Q4 2023-24	Q1	Q2 / Q3 / Q4
Link to Operational Plan: D7: Implement sustainable change to deliver high quality, timely and affordable care							20	20	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks** **RISK6886, RISK6755 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**		

Risk Movement chart: y-axis 0, 5, 10, 15, 20, 25; x-axis Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar; legend: risk score, target risk.

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 March 2024**	L1
C4	Winter funding allocated in reserves of £2m.			**Trust Board March 2024**	L1
C5	Elective recovery fund £5.2m			**Trust Board March 2024**	L1
C6	TRFT received access to growth money allocated to PLACE.			**Trust Board March 2024**	L1
C7	Financial plan sign off to NHSE by 04/05/2023	Submitted on time, still awaiting sign off by NHSE		**Trust Board March 2024**	
C8	Service developments held in reserve of £2.5m.			**Trust Board March 2024**	
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
	On plan with mitigations in place to	Monthly Finance Report to CEO Delivery Group	December 2022	Minutes	Level 1

	manage winter pressures.	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	**Trust Board November 2023**	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	**Trust Board October 2023**	**Report**	Level 3				
		360 Assure Head of Audit opinion presented to Risk and Audit Committee initial indications show Significant Assurance overall	October 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. Met three times, twice as RTFT and then once alongside Doncaster and Barnsley. Initial conversation about return to financial balance within 2 years.		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	Monthly budget reports. Expenditure profile produced monthly throughout year.	Director of Finance	Q1	Ongoing			**End of financial year £4.7m deficit, which was £1.2m better than plan.**	

	as per financial plan (Risk Neutral)	Reserves Policy in place. F&PC oversight. Internal audit systems budgetary control audit. External audit annual accounts.						**The main risk that remains is the potential cost of back Pay of B2 and B3 posts.**	
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. The Trust will run out of cash at some point during the second half of the financial year 2024/25.	
~~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. Anticipated loss based on month 1 to month 6 achieving £3.5m ICB notified. Financial Plan predicted on no further loss.	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) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff.	Director of Finance. Divisional Leads & FPC Director of Workforce & FPC	Reports to F&P Ongoing Commenced	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. 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.	

		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 Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC	Commenced Completed June 2023	Ongoing March 2023			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 Industrial action for junior doctors occurred over Christmas and New Year period. No further dates confirmed.	
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. Trust has received a further £511,000 reduction to the ERF target. However ICB have requested the Trust to improve its financial plan by the same amount. No further funding for costs of Industrial Action will be given to the Trust.	Director of Finance	September 2023 letter sent	Awaiting ICB response				
G12	Revised Financial Plan is now £4.47m deficit which is an adjustment of £1.26m	Board approved revised Financial Plan with 3 actions on 20/11/2023	Director of Finance	November 2023	Monthly reviews to 31/03/2024				
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Board of Directors' Meeting
3rd May 2024

Agenda item	P85/24
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 25 approved risks, 1 is not within review date. • All risks have action plans in place, however, further development of action plans is required to ensure completion dates are monitored and updated.
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	Appendix 1 Corporate Risk Register

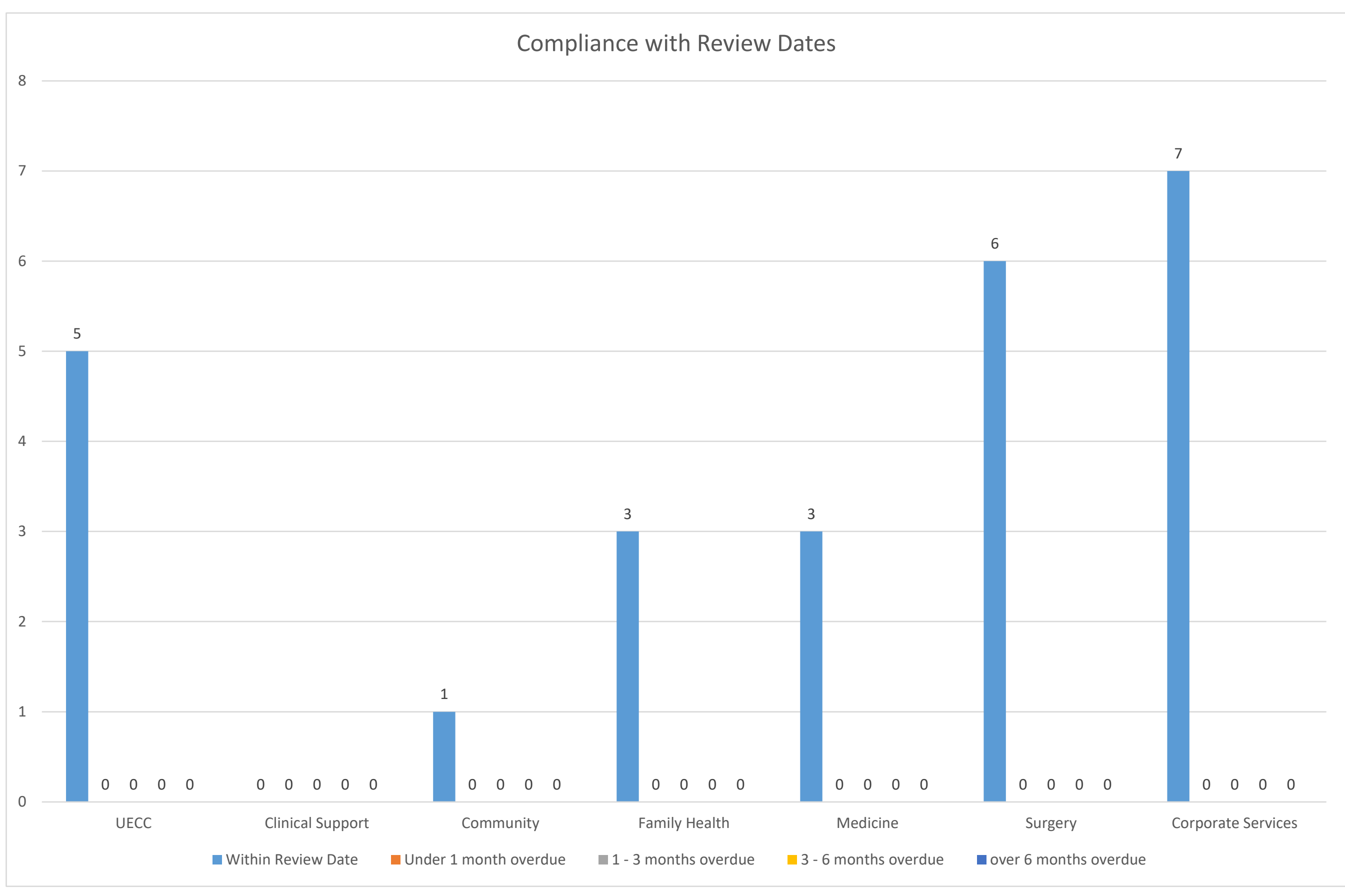
Corporate Risk Register

1. Introduction

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 24/04/2024. 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

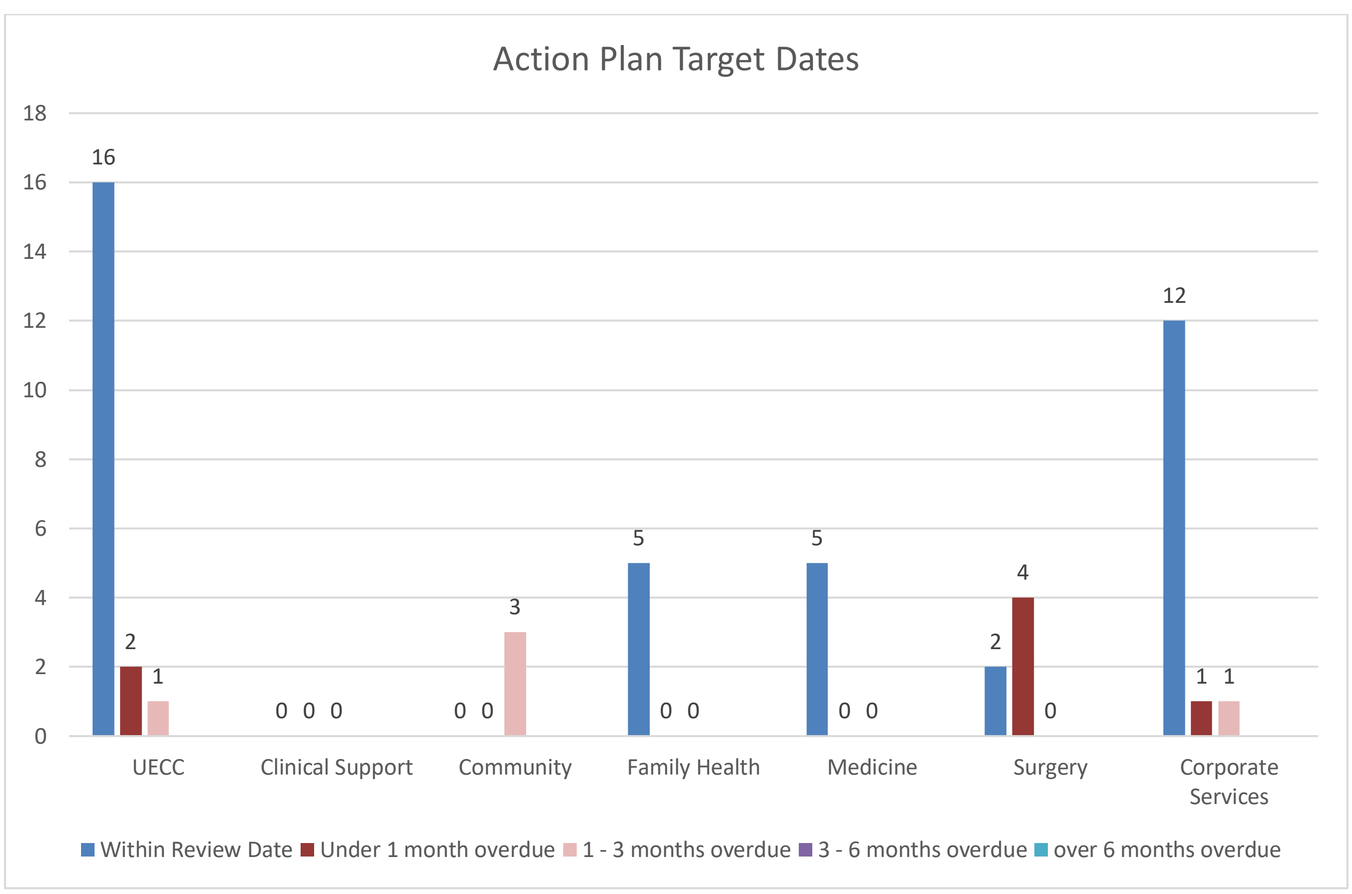
In terms of compliance with risk review dates, the graph below shows all risks rated at 15 and above for all Divisions. This graph is to provide the Board of Directors with a view regarding the current Trust position for the management and review of these high level risks.



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

3 Risk Action Plans

All risks rated at 15 or above have current action plans in place. The Corporate Affairs Department are in the process of reviewing these action plans and working with the risk owners where applicable to ensure good practice of this aspect of risk management.



There are currently 25 risks rated at 15 or above and from these there is a total of 94 individual actions inputted on Datix. Of these actions 52 are still to be completed and the graph above shows that all action plans are within target date, less than 1 month overdue or 1-3 months overdue. It was reiterated at April Risk Management Committee the requirement to review action plan dates and progress, as part of the monthly review for each risk.

Family Health and Medicine have achieved full compliance in this aspect, and UECC has seen a significant increase in active actions (7 in March to 19 in April) signalling the recent work to reassess and improve their risk management function.

There were 3 risks approved at the March 2024 RMC for rating of 15 or above:

- Risk 7010 – Delay in heart failure patients reviews - rated at 20
- Risk 7052 – Medicine Division ability to achieve Financial Control - rated at 20

- Risk 6638 - The Division’s ability to ensure sufficient numbers of suitably qualified, competent and experienced registered nurses

There were 5 risks approved at the April 2024 RMC for rating of 15 or above, details of these risks are to be presented to the next Executive Team Meeting on 02nd May 2024 for discussion and will be included in the next Board Corporate Risk Report.

4 Emerging Risks

The Trust now attempts to identify emerging risks to the Trust. These are seen as risks that are not already recorded on Datix and could arise due to potential changes in service delivery, funding or national changes in regulations or NHSE/CQC initiatives.

The following have been identified by the divisional representatives at the Risk Management Committee, who monitor the risks monthly, and were noted by the January 2024 Audit & Risk Committee and put forward to the May 2024 Committee:

• Second Medical Opinion (Martha’s Rule): a National and local approach to this is underway.
• Surgical misogyny: a Sexual Safety Executive Lead has been nominated.
• Significant fall of training nurses and AHPs (Allied Health Practitioner) at Sheffield Hallam University resulting in a substantial shortfall in staff coming through in 2-3 years’ time.

This is not a limited or completed list and the Divisions are asked to discuss and submit further examples with the Divisional Governance Leads and the Corporate Affairs Department, either directly or in the RMC.

Alan Wolfe
Deputy Director of Corporate Affairs
April 2024

Corporate Risk Register 15+

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.	HIgh 25	High 20	Low 5	17/04/2024	17/05/2024	[Wallett, Val 17/04/24 10:55:32] [Steve Hackett - 17.04.24] The draft annual accounts have been prepared which demonstrate a year end control total deficit of £4.7m which is consistent with the agreed improvement to the Trust's £6m deficit plan. However, the Trust underachieved against its £12m CIP by c. £1.m and will have a recurrent carry forward into 2024/25 of c. £4.5m. This has been factored into the 2024/25 financial plan. The Trust also utilised all capital resource limit in 2023/24 and ended the year with a slightly better cash balance and forecast.	Approved Risk	Theatre improvement programme.	23/03/2023	31/05/2024		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	31/05/2024		Kilgariff, Mrs. Sally
													Cost improvement Efficiency Board.	23/03/2023	29/03/2024	20/03/2024	Hackett, Steve
													Development of robust capacity plans.	23/03/2023	31/05/2024		Kilgariff, Mrs. Sally
													Development of Winter plan.	23/03/2023	23/11/2023	03/11/2023	Hackett, Steve
6166	26/05/2020	Ramsden, Daniel	Corporate Services	Absence of a Isolated Power Supply (IPS) within All Theatres	Lack of protection to vulnerable patients in Group 2 medical locations, from the risks associated with electrical leakage currents. It is also a requirement of the standards that Group 2 Medical Locations shall have an automatic electrical supply available within 15 seconds in the event of power failure. Consequently it is usual for an IPS unit to be backed-up by an on-line UPS (uninterruptible power supply) as this will provide a 'no-break' supply source.	HIgh 16	HIgh 16	Low 4	17/04/2024	17/05/2024	[Ramsden, Daniel 12/04/24 12:12:19] No further progress on theatre access for the works	Approved Risk	Theatres require UPS/IPS systems installing.	06/09/2023	03/06/2024		Ramsden, Daniel
													Theatres require UPS/IPS systems installing.	06/09/2023	01/11/2024		Ramsden, Daniel
6723	10/06/2022	Agger, Joanne	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.	Moderate 12	HIgh 15	Low 6	08/04/2024	08/05/2024	[Rimmer, Claire 09/04/24 15:07:43] 08.04.24 - Update from Action 'Phase Two' (Joanne Agger): Insourcing remains in place to support gaps due to vacancy and sickness. Staff have been appointed to existing consultant vacancies. Advert also to go out for a 12 month locum. 19.03.24 - This risk was discussed at March RMC. It was reported that there had been a recent round of consultant recruitment but it had not been possible to recruit to all the available posts. The Anaesthetic Department was looking to adjust the establishment overall to attract people into non-consultant posts. Work had been done with the Assistant Director for Strategy, Planning & Integration and KS to look at what is in place at the moment and then compare that with staffing in similar organisations. AMW requested that the actions for phase 2 were broken down into more actions to enable them to be monitored effectively.	Approved Risk	Advertise agency locum at all tiers and recruit as appropriate	01/08/2022	30/09/2022	02/10/2022	Agger, Joanne
													Reduce elective operating for August - Review for September	01/08/2022	31/08/2022	02/10/2022	Agger, Joanne
													Full departmental roster review led by SLT	22/09/2022	30/09/2022	23/09/2022	Marsden, Gillian
													Confirm insourcing arrangement for 6 week period	05/09/2022	05/09/2022	02/10/2022	Marsden, Gillian
													SCH joint recruitment	01/08/2022	31/10/2022	22/06/2023	Marsden, Gillian
													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	Marsden, Gillian
													Extend use of insourcing support	05/06/2023	29/09/2023	18/07/2023	Marsden, Gillian
													External review of the Anaesthetic rotas	19/06/2023	31/12/2023	08/01/2024	Marsden, Gillian
													Develop an options appraisal paper for review at ETM.	22/06/2023	31/07/2023	18/07/2023	Marsden, Gillian
													Phase two	08/01/2024	30/06/2024		Agger, Joanne
6421	31/03/2021	Wilman, Mrs. Johanna	Division of Family Health	Backlog of children waiting to be seen for assessment Child Development Centre (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	HIgh 15	HIgh 15	Low 6	24/04/2024	31/05/2024	[Wilman, Johanna Mrs. 24/04/24 09:47:52] Progress has been more structured and a detailed action plan has been created by Vicky Whitfield, myself and Alison Cowie. The following has been agreed 1. CDC process planning day arranged with all staff, stakeholders and service users for 21st May 2024. 2. New referral process is up and running staff are working collaboratively to ensure consistency and continuity in health and education triage processes. 3. New nurse clinics have been concentrating on children aged under three and this has reduced this cohort of children waits down considerably. We had 117 waiting in March we now have 62 with the longest wait for these children being in the region of 7 months. 4. A new streamlined pathway has been developed and discussed at CDC Forum meeting. All staff can see the benefits of this new process and it will cut down appointments in the long term for children newly referred to the service. It wont however impact on the backlog. 5. We have had a couple of setback this week with the newly appointed band 4 fixed term Nursery Nurse resigning and another senior member of the team has approached advising she does not know if she can continue working. Both have significant family	Approved Risk	Support without referral Pathway	18/09/2023	31/05/2024		Wilkinson, Jo
													Funding for further staff	18/09/2023	30/11/2023	02/01/2024	Wilman, Mrs. Johanna
													Psycology Funding	18/09/2023	28/06/2024		Wilman, Mrs. Johanna
													Joint working with RDASH	18/09/2023	30/06/2024		Wilman, Mrs. Johanna

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											issues, both will impact on our waiting times. 6 Work is ongoing with collating the information for the possible CAMHS transfer. The number of children is much less now than initially thought and the amount of work that has been undertaken to get to this point has been immense and feels almost pointless.						
7069	14/02/2024	Storer, Cindy	Corporate Services	Band 2/3 Healthcare Support Worker job descriptions and re-banding following changes to the National job profiles in 2021	1a - There is a risk that the consultation process is not managed affectively and line with Trust policy. 2a - There is a risk that agreements with staff side on backpay go back to 2021 as stated which increases the financial risk significantly. 3a – There is a risk, new job descriptions and associated clinical skills frameworks are not followed and implemented in line with Trust policy. 4a – There is a risk that the organisation consultation is delayed resulting in increased backpay and responsibility payments. 5a – There is a risk of trade union action. 6a – There is a risk of local and National media attention if the process is not managed effectively. 7a – There is a risk of organisational unrest and indirect impact on clinical care due to ongoing consultation process affecting workforce and morale.	High 25	High 20	Moderate 10	15/04/2024	15/05/2024	[Storer, Cindy 15/04/24 09:11:03] The paper on progress of the consultation and financial costs were approved at the Board of Directors 12 April 2024. The risks to the organisation remains unchanged and the staff consultation process commences week commencing 15 April	Approved Risk	Organisational change process to be followed	27/02/2024	03/05/2024		Storer, Cindy
													Implement operational and strategic groups with key stakeholders	15/01/2024	17/05/2024		Storer, Cindy
													Additional senior nurse and HR support needed	01/01/2024	31/05/2024		Storer, Cindy
													Updated paper to executive team colleagues on progress and revised financial impact	11/03/2024	13/05/2024		Dobson, Helen
7010	26/10/2023	Lunn, Mrs. Clare	Division of Integrated Medicine	Delay in heart failure patient reviews	delay in patients being reviewed by heart failure nurse spacialist Delay in patient being cared for on all wards including cardiology Longer length of stay due to none or less frequent reviews Poor clinical outcomes Higher heart failure morbidity cannot facilitate dischargesresulting in patient deterioation when an in-patient High staff stress and potential for sickness and burnout.	HIgh 15	HIgh 15	Low 6	12/04/2024	13/05/2024	[Lunn, Clare Mrs. 12/04/24 12:24:13] reviewed post inquest re-heart failure patient now x 4 patients known with no referral into service therefore risk remians at 15 meeting for business case next week. CL	Approved Risk	data collection of referrals into the system	30/10/2023	11/12/2023	28/12/2023	Lunn, Mrs. Clare
													to discuss the data with SLT in division	13/11/2023	30/11/2023	14/02/2024	Lunn, Mrs. Clare
													data analysis of patient reviews	20/11/2023	29/02/2024	14/02/2024	Lunn, Mrs. Clare
													to complete a short business case	14/02/2024	13/06/2024		Lunn, Mrs. Clare
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.	High 20	HIgh 16	Moderate 8	09/04/2024	09/05/2024	[Butler, Helen 09/04/24 15:18:26] High Occupancy bed and high virtual ward occupancy. Work ongoing to support services and achieve 4 hour access standard	Approved Risk	ACT programme of transformational work	01/01/2022	01/05/2024		Kilgariff, Mrs. Sally
													Improving pathways including expansion of SDECs, implementation of the frailty pathway and introduction of virtual wards	01/01/2022	01/05/2024		Kilgariff, Mrs. Sally
													Improving discharge pathways, particularly ward processes - inlcuding 100 day discharge challenge	01/01/2022	29/03/2024		Storer, Cindy
7052	19/01/2024	Stewart, Paul	Division of Integrated Medicine	Division of Medicine risk to meeting financial control total	There is a risk of the Division of Medicine being unable to meet the financial control total in place at the start of the 2023/24 financial year.	HIgh 15	High 20	Moderate 12	19/04/2024	20/05/2024	[Carney, Louise 19/04/24 11:02:31] Risk level increased to 20.	Approved Risk	Financial Recovery Plan	03/04/2023	08/07/2024		Stewart, Paul
6691	28/04/2022	Reynard, Jeremy	Division of Emergency Care	Effect of un-embedded 4 hour and Acute Care Standards	The lack of ACS compliance across the trust has a detrimental effect on 1. Overcrowding in the UECC 2. Medical capacity in the UECC 3. Nursing capacity in the UECC Overcrowding in the UECC leading to the UECC not being able to function efficiently or effectively. 1. Unable to see patients. 2. Unable to offload ambulances 3. Dangerous overcrowding in the Main Waiting Room. 4. Delay to time critical treatment 5. Delay to time critical medication.	High 20	High 20	Moderate 12	23/04/2024	28/05/2024	[McAuley, Heather 25/04/24 14:45:15] slight change to title to show risk due to 4 hr standards not being embedded by Trust	Approved Risk	Work with Executive team on embedding the standards and engagement with the Trust	01/11/2023	05/02/2024		Reynard, Jeremy
													Transformational work, Task and finish group	01/02/2024	08/04/2024		Kilgariff, Mrs. Sally
													New staffing tool to be implemented	05/06/2023	15/07/2024		Maton, Lynsey
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	HIgh 15	HIgh 15	Moderate 9	24/04/2024	22/05/2024	[Bell, Beky Miss 25/04/24 11:40:46] Reviewed at HOS Governance Meeting, KT to provide PF with more details following discussion with Acute Heart Failure Specialist Nurse	Approved Risk	Review of risk requested by general manager	10/06/2022	29/02/2024		Fisher, Penny
													Meet with business managers from Community and Medicine to review business case	04/01/2024	29/02/2024		Fisher, Penny
										Page 2 of 5			Meeting	01/02/2024	15/02/2024		Hitchman, Mr James

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7001	12/10/2023	Reynard, Jeremy	Division of Emergency Care	In ability to get patients to CT in a timely manner	Delay to CT for patients in the UECC. 30% of majors and resus patients undergo a CT from the UECC, half of which are subsequently discharged. Only 50% of patients get a CT result within 2 hours of request. At 3hours 25% of patients who are discharged are still waiting for a result.	High 20	High 15	Low 4	23/04/2024	28/05/2024	[McAuley, Heather 25/04/24 14:50:38] discussed at divisional governance meeting, agreed level of risk remains.	Approved Risk	QI Project	16/11/2023	30/04/2024		Staunton, Eamon
													Portering.	01/10/2023	31/01/2024	20/12/2023	Maton, Lynsey
													2nd CT scanner for Trust	01/11/2023	30/08/2024		Reynard, Jeremy
													Transfer team and transfer policy	01/11/2023	30/09/2024		Maton, Lynsey
													discussions across divisions.	16/11/2023	14/06/2024		Stephenson, Daniel
													Safer care nursing tool	01/01/2023	30/04/2024		Maton, Lynsey
7027	29/11/2023	Reynard, Jeremy	Division of Emergency Care	Inability to provide analgesia and other time critical medications in UECC in a timely manner	Delays to pain relief, less appropriate pain relief been given. Delay to review. Delay to antibiotics. Delay to other time critical medications. Delay to ADREQ and therefore transfer and the 4 hour target.	High 15	High 15	Moderate 8	26/03/2024	23/04/2024	[Wallett, Val 22/04/24 11:35:32] Risk rating of 15 approved at Risk Management Committee - 16.04.24	Approved Risk	review available PGDs	20/12/2023	24/06/2024		Maton, Lynsey
													Improve access to other services	01/02/2024	30/04/2024		Maton, Lynsey
													Improve flow	01/02/2024	30/08/2024		Hammond, Lesley
													Nursing capacity to meet demand	01/02/2024	30/08/2024		Maton, Lynsey
													explore Sepia function to show patients who require time critical medicines	22/04/2024	24/06/2024		Farrow, Lindsay
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.	High 16	High 20	Low 4	17/04/2024	17/05/2024	[Wallett, Val 17/04/24 11:42:18] [Deputy Director of Workforce 17.04.24] No change in relation to current risk score status. Following extensive negotiations a new pay offer from government for consultants in England was proposed and accepted by the union membership. Following the recent ballot, the junior doctors voted to extend their mandate for industrial action to include action short of strike (ASOS) an additional form of industrial action to effectively sustain pressure. The new mandate period covers from 3 April 2024 to 19 September 2024; there are currently no plans for industrial action.	Approved Risk	Negotiations with local staff side	10/10/2022	03/06/2024		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	03/06/2024		Ferrie, Mr. Paul
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.	Low 6	High 15	Low 6	08/04/2024	09/05/2024	[Timms, Deborah Mrs. 08/04/24 15:07:11] 8 April 2024 - Risk updated above with more detail as requested at RMC. Information added: It's a risk because it limits the treatment that can be delivered on SSDEC essentially meaning that you cannot run an SSDEC model. We are unable to give IV fluids, IV antibiotics, oxygen etc. This means that you are less likely to be able to deliver same day emergency care and get patients home again thus increasing the pressure on ED and the organisation as a whole. For example of a pathway that you would be able to run if you had an SSDEC would be the 4 hour tonsillitis bundle – IV fluids, steroids and antibiotics with a view to getting a significant proportion of selected patients back home again the same day. We are unable to do this as we don't have trolleys. We only have a waiting room.	Approved Risk	Surgical SDEC Task and Finish Group	01/11/2022	31/03/2024		Timms, Mrs. Deborah
													Amend Sepia to reflect 23 IP beds and 10 trollies	14/11/2022	09/12/2022	09/12/2022	Marsden, Gillian
													Complete Trust bed modelling work	01/04/2022	31/03/2023	18/07/2023	Marsden, Gillian
5967	27/10/2019	Hammond, Lesley	Division of Emergency Care	Insufficient provision of medical cover within the UECC and GP out of hours service	Updated 11.03.24 to link with Risk 6131 and 5238. Lack of staffing in the GP Out of Hours Service. Unable to fill the MG rota, especially at night (within UECC). Not achieving the new 4 hour target. Delay to be seen by a clinician.	High 15	High 15	Moderate 9	23/04/2024	28/05/2024	[McAuley, Heather 25/04/24 14:52:14] discussed in divisional governance and risk level agreed.	Approved Risk	ACT programme	04/04/2022	03/04/2024		Hammond, Lesley
													Recruitment	04/04/2022	03/04/2023	18/05/2023	Hammond, Lesley
													Winter plan	01/11/2023	31/03/2024	25/04/2024	Reynard, Jeremy
													Review of rota	01/02/2023	30/04/2024		Reynard, Jeremy
													Workforce plan from ACT work	01/02/2023	03/08/2024		Reynard, Jeremy
													Senior clinical fellows	04/12/2023	30/08/2024		Reynard, Jeremy

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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')
6969	18/08/2023	Staunton, Eamon	Division of Emergency Care	Issues with joined up IT services and lack of procedures/protocols	Key Issue 1: When additional bloods are added on to an existing request by UECC these could be missed as these are completed on paper. Key Issue 2: Imaging, not been seen or delay to be seen by correct speciality /consultant. Significant increased work to sort imaging and redirect Imaging to correct Consultant and speciality. With subsequent SI and incidents arising from specialities not seeing own imaging. 2 PAs of EM Consultant time a week sorting this, and 2 hrs a day of secretarial time used. Key Cause 3: lack of electronic speciality referrals	High 20	High 20	Low 6	26/03/2024	23/04/2024	[Wallett, Val 22/04/24 11:41:57] Risk approved at Risk Management Committee - 16.04.24	Approved Risk	escalate to deputy medical director	05/09/2023	05/09/2023	05/09/2023	Staunton, Eamon
													Results Acknowledgement Group	02/02/2024	02/07/2024		Reynard, Jeremy
													Consultant Awareness of Issue	02/02/2024	05/07/2024		Reynard, Jeremy
6888	23/03/2023	Fletcher, Michelle	Corporate Services	Lack of clinical psychology support for risk reducing surgery patients.	Treatment delays for patients who are gene positive requiring breast surgery.	HIgh 15	HIgh 15	Moderate 9	19/02/2024	20/05/2024	[Short, Sally Mrs. 17/04/24 08:06:58] No change. Sat with Corporate as below	Approved Risk	Lack of Psychological support for the breast cancer patients	31/08/2023	28/12/2023	31/08/2023	Timms, Mrs. Deborah
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.	HIgh 15	HIgh 15	Low 6	11/04/2024	13/05/2024	[Windsor, Claire 11/04/24 15:41:57] Awaiting outcome of business case following changes.	Approved Risk	Lack of Critical care Follow-Up	01/08/2022	28/06/2024		Timms, Mrs. Deborah
6809	20/10/2022	Oliver, Lauren	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.	HIgh 15	HIgh 15	Low 6	14/03/2024	30/04/2024	[Oliver, Lauren 08/04/24 16:42:43] Risk reviewed on the 08/04/24 - no change and work remains ongoing. Digital Sister's secondment extended which will help to implement.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	29/03/2024		Timms, Mrs. Deborah
6958	02/08/2023	Agger, Joanne	Division of Surgery	Lack of Rheumatology Consultants to meet service need	Failure to provide a consultant led Rheumatology Service	HIgh 15	HIgh 15	Moderate 9	19/03/2024	13/05/2024	[Rimmer, Claire 09/04/24 14:32:09] Update from 19th March RMC - KS reported that the Trust had recently appointed to a post so by September/October there should be one colleague back from maternity leave and two new consultants in post which should significantly mitigate the risk. It was suggested that the risk score remain the same until the new staff had commenced and then review the score. The recruitment action on the action was asked to remain open until consultant in post.	Approved Risk	consultant recruitment	02/01/2023	31/10/2024		Agger, Joanne
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	High 20	High 16	Moderate 8	09/04/2024	09/05/2024	[Butler, Helen 09/04/24 15:21:15] Plan for B5 for all complex discharges and IDT to be based on same ward	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
6873	20/12/2022	Stables, Sarah	Division of Family Health	Risk of losing patient paper medical records due to the introduction of plastic wallets and the removal of stronger	Maternity patient paper records are required to be safely stored for 25 years in case of any legal request from the families we care for. The risk is that CTG's and paper records may be lost leaving the Trust compromised at a later point in time.	HIgh 16	HIgh 16	Low 4	16/04/2024	16/05/2024	[Dodd, Jamie Mr. 16/04/24 10:01:39] 16/04/2024: A Ford update: "I have just received some of the order from NHS Supply Chain, on the advice note it says the plastic wallets will be here on the 18/04/2024." Advice note attached.	Approved Risk	In talks with the patient records department to attempt to find a solution	23/02/2023	11/05/2024	10/01/2024	Stables, Sarah
													Meeting with Deputy Head of Midwifery, Carol O'Neill and Angela Ford to discuss ongoing issues. Records department				

Corporate Risk Register 15+

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')
				card folders									agreed to reinstate card files until process of scanning documents is fully in place. Will be monitored through Governance.	10/01/2024	01/06/2024		Stables, Sarah
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	High 15	High 15	Moderate 9	04/04/2024	30/04/2024	[Dean, Kim 04/04/24 11:19:12] Update from Newman school. 2 larger classrooms have had works completed now. The small room to be used as a space for Dr's medicals still needs works to remove old sink.	Approved Risk	Liaison with RMBC to complete minor works	14/09/2023	30/04/2024		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	05/04/2024	Dean, Kim
													Refurbishment of the 'Bungalow' building	02/11/2023	03/01/2025	05/04/2024	Dean, Kim
6638	07/02/2022	Smith, Mrs. Gail	Division of Integrated Medicine	The division's ability to ensure sufficient numbers of suitably qualified, competent and experienced RN	The Division of Medicines ability to recruit to all Registered Nurse vacancies and to ensure there are sufficient numbers of suitable qualified, competent and experienced Registered Nurses and HCSWs The risk assessment covers; Acute Medical Unit, Short Stay Unit, A1,A2,A3,A4,A5,A6,A7,Coronary Care Unit, Stroke and Neuro-rehabilitation The division's ability to provide safe and effective staffing with the right numbers of Registered Nurses with the right skills in the right place at the right time, which has the potential risk of; • Potential failure to protect patients and colleagues from harm • Potential increase in `care left undone / missed care` For example the ability to provide timely administration of medication, ability to provide effective pain management, ability to provide the required frequency to change a patients position to maintain safety, comfort and effective skin care, ability to undertake timely patient assessments and timely interventions for patients • Ability to provide timely patient observations in line with the assessed frequency of NEWS 2 in line with trust policy • Ability to provide the appropriate level of care for patient as assessed by the `supportive observation of care tool` • Ability of Registered Nurses to provide contemporaneous documentation as outlined in the Nursing and Midwifery Code Professional standards of practice and behaviour for nurses, midwives and nursing associates • Ability of Ward Managers to maintain their supervisory role • Ability of colleagues to have the time, space and opportunities to share learning, sustain and embed learning in clinical practice • Potential material breach of Care Quality Commission condition of registration • Potential increase in colleague's sickness and absence • Potential increase in colleagues leaving the division and or trust • Potential for the division to be non-complaint with MAST Training and Appraisals • The increase in the use of bank and agency colleagues, this has the potential to affect the financial stability of the Division and the organisation, has the ability if fill rates are low to affect the Care Hours Per Patient Day across the ward areas	High 25	High 20	Low 6	19/04/2024	20/05/2024	[Stewart, Paul 19/03/24 11:46:13] Reviewed at Risk Management Committee 19/03/2024. It was agreed that this risk, whilst the additional beds are the responsibility of the Division of Medicine to manage, that the associated actions cannot all sit with the Division due to the lack of control in decisions affecting whether we open the beds or otherwise. Linked to Risk 7084 regarding operational pressures and additional beds.	Approved Risk	Continue to Actively recruit to all RN and HCA Vacancies	08/07/2022	08/09/2022	08/09/2022	Smith, Mrs. Gail
													Recruit HCA through the Monthly HCA Recruitment Programme	03/09/2022	03/07/2023	26/02/2024	Smith, Mrs. Gail
													Review Internationally Educated Nurse recruitment	30/09/2022	06/10/2022	06/10/2022	Smith, Mrs. Gail
													Maintain active rolling advertisement for Band 5 Registered Nurses across the division	06/10/2022	06/07/2023	26/02/2024	Smith, Mrs. Gail
													Review AOA Allocations for the Division of Medicine	01/09/2022	30/09/2022	30/09/2022	Smith, Mrs. Gail
													HRBP and HON to review Long Term Sickness Cases across the Division	30/01/2023	27/03/2023	26/03/2023	Smith, Mrs. Gail
													HRBP to work with Ward Managers and Deputy Ward Managers to provide refresher training in relation to sickness and absence management	06/02/2023	28/04/2023	17/04/2023	Smith, Mrs. Gail
													Introduction of Roster review meetings	08/02/2023	29/05/2023	08/06/2023	Smith, Mrs. Gail
													Bespoke recruitment event for RNs across medicine	01/03/2024	30/04/2024		Smith, Mrs. Gail
													review of staffing - provision of safe staffing	26/02/2024	26/08/2024		Benton, Jennifer
													Sickness absence monitoring	26/02/2024	27/05/2024		Smith, Mrs. Gail
6755	20/07/2022	Marsden, Gillian	Division of Surgery	Ability to Achieve Financial Control Total	There is a risk of the Division not achieving it's agreed financial control total for the financial year 23/24	Moderate 12	High 20	Low 4	24/04/2024	24/05/2024	Colley, Nicola 24/04/2024 21:51 Whilst budgets have not been confirmed I am not expecting significant change. CIPs 80.35% was identified, but only 39.45% was recurrent, means £1,364,000 will be transferred and added to 2024-25 target	Approved Risk	FOT Recovery Plan	27/09/2022	31/03/2023	16/04/2023	Marsden, Gillian
													CIP Delivery Plan	01/04/2023	31/03/2024		Marsden, Gillian

Board of Directors' Meeting
3 May 2024

Agenda item	P86/24
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. All actions within the Quality Improvement Plan (derived from previous CQC inspections) are now complete with the majority being embedded. There have been no enquiries or concerns raised by the CQC. A CQC self-assessment tool has been developed internally and Divisions will be supported to complete this new format throughout Q1 and Q2. A live quality dashboard is now available for adult in patient wards and progress has commenced to include additional areas. Evidence from this tool will support the Exemplar Accreditation programme that commenced in April 2024 with four wards completing the accreditation process in the first month. The Quality Improvement programme continues with the move to a local South Yorkshire delivery model for training commencing. We are commencing the process of developing a new Clinical Quality Strategy to underpin our quality plan, improvement and assurance.

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 Quality 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 • Support the proposal to develop a Clinical Quality Strategy
Appendices	None

1. Quality Assurance

1.1 The Quality Assurance programme continues to be delivered and is monitored through the Quality Delivery Group and Quality Committee.

1.2 Although self-assessment continued in Quarter 4, this is now completed under the new CQC self-assessment framework. Whilst the CQC domains remain the same, the key lines of enquiry (KLOE's) have now been replaced with Quality Statements. There are 34 quality statements in total across the 5 key questions of safe, effective, caring, responsive and well-led.

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. Previously this has been in conjunction with Barnsley NHSFT which will continue but there are also discussions about widening this to include all of the South Yorkshire Acute Federation and those Trusts outside of the ICS who have either commenced the self-assessment process or demonstrate areas of excellence.

1.4 Quality Delivery groups have continued to be held monthly with the exception of January and remain quorate. The performance against the Quality Improvement Plan has further improved, with only 3 actions remaining which are all green. There will be a discussion in relation to how those actions may now be tracked through the appropriate groups or committees and whether they have now reached a point where they can now be closed.

	RAG Definitions
(Red)	Has failed to deliver by target date/Off track and now unlikely to deliver by target date
(Amber)	Off track but recovery action planned to bring back on line to deliver by target date
(Green)	Completed / On track to deliver by target date
(Blue)	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.
(Grey)	Subject to external input to fully achieve

Core Service	Red	Amber	Green	Blue	Grey
Trustwide	0	0	0	4	0
UECC	0	0	0	34	1
Medicine	0	0	1	24	0
Maternity	0	0	0	5	1
Children and Young People	0	0	2	20	2
Total	0	0	3 (16 last quarter)	87 (75 last quarter)	4
Percentage	**0%**	**0%**	**3% (17% last quarter)**	**93% (80% last quarter)**	**4%**

Table 1.

1.5 The improvement plan above linked to the last official CQC inspection and can now be considered closed with all actions complete – although evidence is still being monitored for the remaining 3 green actions to demonstrate embeddedness. Since that time we have undertaken peer assessments for the main bed holding areas and self-assessments within a number of lesser inspected areas.

1.6 As self-assessments, these cannot be taken to be a definitive position but they form a useful measure to help focus attention as we transition towards the new CQC assessment framework.

1.7 The Trust has developed further relationships with the Medical Director for the CQC and will continue to gain invaluable insight into the new self-assessment framework and work in collaboration to develop the well-led questions.

2. Quality Governance

2.1 Over the past year, Divisions have developed quality dashboards to provide assurance on performance and assist with identifying where additional support is required. Although these have been extremely useful, the variation between formats has prevented easy comparison between different divisions. This has also been a time consuming exercise for clinical teams with a focus on collating data rather than using it to drive improvement. Health Informatics have now created a standardised quality dashboard within Power BI.

2.2 The new dashboard draws from metrics already available in a range of other systems to triangulate this information. Sources include Datix, E-roster, Tendable and ESR. The data is therefore presented to the clinical area allowing teams to focus on what the data is telling them and develop and deliver appropriate action plans. All in patient wards are now live on this system with plans to add department and community areas later this year. At present, data is only available at individual ward level but the process to amalgamate this to give divisional and Trust wide level reports is currently underway. Once Trust wide information is available, this will form part of the quality metrics presented to Quality Committee each month as part of the Performance Report. Individual department and divisional data will continue to be assessed through the monthly performance meetings with Divisions.

2.3 Although the Power BI system will provide valuable data, a more sophisticated approach is needed to give assurance that improvements are being made and sustained as a consequence. To enable this, the Trust has developed an internal accreditation system, which we have called **Exemplar Accreditation**. This has involved the creation of a set of standards so that areas for improvement can be identified and areas of excellence celebrated. It is a comprehensive assessment on the quality of care at ward, unit and department levels; bringing key measures together into a single overarching framework.

2.4 All areas will be assessed annually as part of this process. The first 4 areas have now been accredited, which were B10, A5, A7 and Rockingham.

2.5 A5 were placed within the white category which is demonstrated as learning and improving. Rockingham and A7 were placed in the working towards accreditation element and B10 were successful of achieving full accreditation at Bronze level.

Rating	Descriptors	Accredited	Scrutiny (Reassessment and Review)	Next Steps
GOLD Exemplar area	Significantly exceeds the Trust standard expectation	Yes	Must Have: • No white standards. • 60% or more of the standard are gold. • Must have achieved gold standards for Safeguarding, Infection Control, Falls, Incidents of HAPU and Appraisals* • Must have evidence of action planning and reassessment*	Improvement plan required for Bronze measures as appropriate. Bi-annual monitoring
SILVER Excellent Care	Greatly exceeds the Trust standard expectation. Some measures require improvement	Yes	Must Have: • 20% or less white standards. • 50% or more of the standard are gold. • Must have evidence of action planning and reassessment*	Improvement plan required for white measures. Bi-annual monitoring
BRONZE Highly Commended- Aspiring and Improving	Exceeds the satisfactory Trust standard expectation. Some measures require improvement	Yes	Must Have: • 20% or less white standards. • Must have evidence of action planning and reassessment*	Improvement plan required for white measures. Bi-annual monitoring
WORKING TOWARDS ACCREDITATION Efficient and safe- On the pathway to excellence	Minimum standard expected at the Trust. Measures require improvement	No	Must Have: • 30% or less white standards.	Improvement plan required for white measures. Bi-annual monitoring
Learning and Improving	Below the minimum standard expected at the Trust. Measures require improvement and regular monitoring	No	Must Have: • More than 30% of the standards are white.	Improvement plan required for white measures. Regular support by Accreditation team. Quarterley monitoring

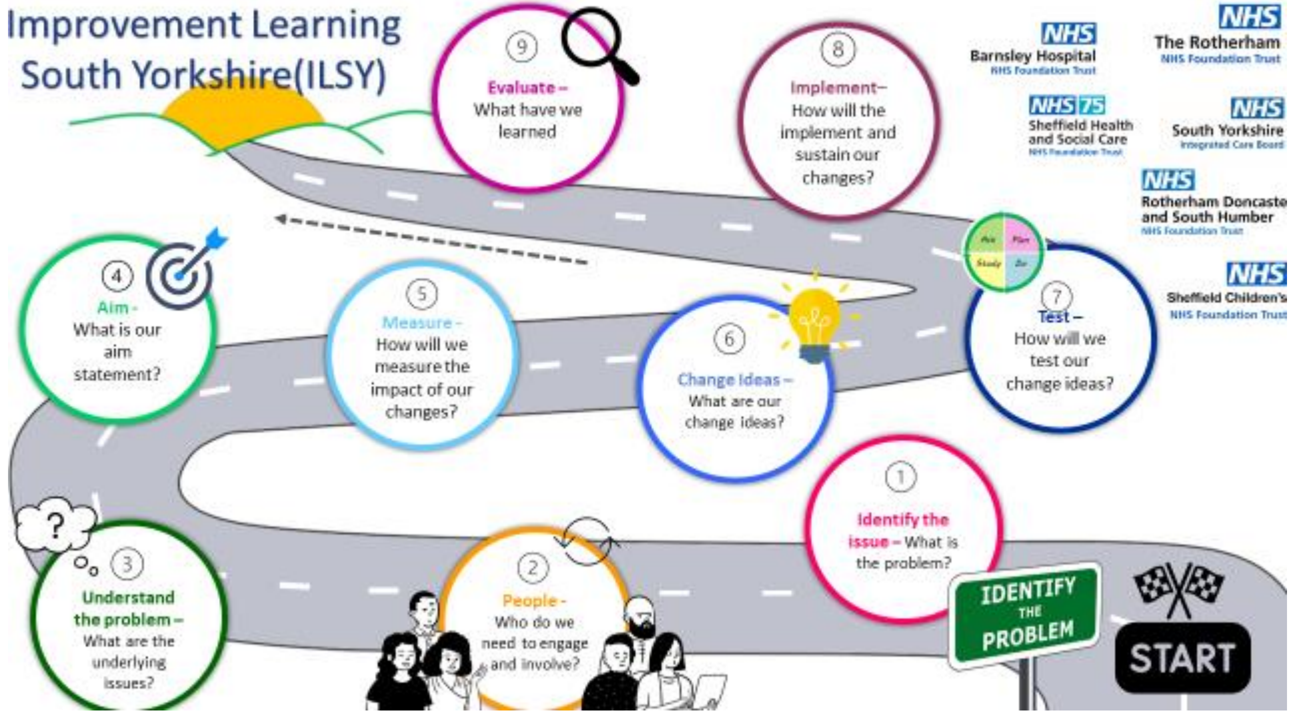
3. Quality Improvement

3.1 Quality Improvement is now well established within the organisation. A recognised constraint on the Qi programme to date has been the inability to provide full follow up support to registered improvement projects. This has meant that benefits to patients and any cost improvements resulting from changes have not being appropriately recorded. The new Practitioner and Facilitator post holders have now commenced. We have also successfully recruited two consultants to Associate Medical Director roles, both of which include an element of Qi support. These posts will strengthen the Qi functionality going forward allowing greater benefits to be realised.

3.2 In total 93 projects are registered on AMaT from across the Trust. 112 QSIR Practitioners have been trained and part of the work of the new Qi team members will be to encourage registration of work done as part of this course.

3.3 The expansion of the Qi team will now provide resource to be able to review the impact of quality improvement throughout the Trust. 2024/25 plans will include a look back of projects and what measurable improvements we have identified. This information will be delivered within future reports.

3.4 From the May 2024 cohort the Practitioner training will be “Improvement Learning South Yorkshire” (ILSY) which will include a one day Foundation course from June 2024. This has been co-designed between 5 organisations across South Yorkshire; ourselves, Barnsley, RDaSH, The ICB, and Sheffield Health and Social Care. The new 3 day programme is based on the 9 step roadmap for Qi below.



3.5 The Qi team are currently working directly with the Quality Governance team on the first quarterly Trust wide shared learning event in April 2024. This will also aim to identify key Qi initiatives under the PSIRF lens for the next cohorts of ILSY.

3.6 The accreditation programme has a specific pillar dedicated to Quality Improvement. There will be a number of criteria which areas will be required to demonstrate how they have used Qi methodology to improve patient care and experience. This will be marked against a set of descriptors. The accreditation programme will require the ongoing support from the Qi team throughout the year, not only in the accreditation phases, but then the ongoing support to enable the areas to improve for next years process.

4. Care Quality Commission Future Inspection Methodology and Engagement

4.1 CQC have now commenced using the new Regulatory Single Assessment Framework although we are not yet aware of any acute NHS Trust's that have been assessed or inspected. During an engagement meeting with the Trust on 29th February, the new relationship team described the new process and confirmed that they will prioritise onsite inspections to those organisations with a higher risk profile at this stage. CQC have requested we reduce engagement meetings from monthly to quarterly whilst they adapt to the new process. The Trust have invited the team for an onsite visit for the next meeting which they have accepted with a request to visit the new Neonatal Unit noted.

4.2 There have been no enquiries for information or concerns raised by the CQC since the last quarterly report.

4.3 There are a number of CQC support tools and videos that the Trust has engaged with in preparation for single assessment. Meetings are being held with Divisions to aid an understanding of how this self-assessment will be completed throughout the year. The supporting documentation pack will be rolled out through Q1 and Q2 to initial areas.

4.4 There will be a commissioned well-led review for the Board of Directors in the upcoming months. The caveat of which is that this will potentially be conducted under the previous CQC inspection framework questions.

5. Conclusion

5.1 Although we have not had any external scrutiny, all divisions have continued to monitor their position against CQC requirements. The self-assessment process has paused whilst we transition to the new system but templates have been created to allow this to restart from April. 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 Members of the Executive Team have now met our new CQC engagement team and hope to cultivate as productive a relationship with them as we have had with the previous team.

5.3 Exemplar accreditation has now commenced, with 4 adult inpatient wards completing their assessment in April and B10 achieving Bronze Accreditation. The Exemplar Accreditation for adult inpatient wards will have completed in October 2024.

5.4 Quality Improvement methodology has now transitioned to be "Improvement Learning South Yorkshire" (ILSY) which will include a one day Foundation course from June 2024. This has been co-designed between 5 organisations across South Yorkshire; ourselves, Barnsley, RDaSH, The ICB, and Sheffield Health and Social Care.

5.5 During Quarter 1 of 2024/5, we will begin the process of developing a new Clinical Quality Strategy to underpin our quality plan, improvement and assurance.

Victoria Hazeldine
Deputy Chief Nurse
April 2024

Board of Directors' Meeting
3rd May 2024

Agenda item	P87/24
Report	**Responsible Officer Report – Q3 2023/24**
Executive Lead	Dr Jo Beahan, Medical Director & Responsible Officer
Link with the BAF	P1; U4
How does this paper support Trust Values	Demonstrates that medical staff are supported and engaged by the Trust to ensure that they have opportunity to reflect on clinical practice.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to present to the Board details of activity related to Medical Appraisal and Revalidation, as per NHS England and GMC regulations. Key points: • NHS England and GMC have set out how the new Good Medical Practice should be used when it comes to force on 31st January 2024. • Appraisal has to be changed to the new system by 2025. • The evaluation of appraisal platforms took place in October 2023. The team unanimously felt that L2P as a provider suited what we as a Trust require for our Medical Staff. • Third quarter (Oct – December) 2023/24 appraisal performance: ◦ 76 doctors were due their appraisal. 73 held their meeting within this reporting period, and the others have booked appointments outside of the reporting period, reasons for which were understood and accepted.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Not applicable - presented to the Board on a quarterly basis, but no other Committee. However, this report will be presented to the quarterly Responsible Officer's Advisory Group (ROAG) moving forward and has been discussed and approved.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	
Recommendations	It is recommended that the Board notes the quarterly data.
Appendices	1. Medical Appraisal Figures for Q3 2023/24

1.0 Introduction

NHS England is currently providing guidance of how to implement the new Good Medical Practice guidance for appraisals. This needs to be embedded by April 2025. Junior Doctor strikes have affected completion of some appraisals. The appraisal team is looking to recruit more appraisers to help reduce the burden on existing colleagues and reduce the requirement for external appraisers.

2.0 Performance

2.1 The processes of Appraisal and Revalidation is continuing to support colleagues effectively and has had good feedback in the recent trust survey.

2.2 We currently have 23 appraisers and 2 appointed recently who are yet to train with a target of 28.

2.3 Appraiser refresher course online has been procured for all appraisers and will take place later this year once the changes have been made to the appraisal forms under the guidance from NHS England.

2.4 We are starting to receive information from the Divisional Directors regarding complaints relating to colleague behavioural issues from other colleagues.
Reflections on these are taking place in appraisals.

2.5. Mentorship course has been well advertised and received a lot of interest. It will now take place on the 14th March 2024 to support the Trust policy of offering all new permanent doctors appointed to the trust an opportunity to have a mentor.

2.6 The NHS England revalidation checklist is populated by the appraisal Support Managers, checked by the Associate Medical Director for Appraisals and then forwarded to the Responsible Officer for approval. Once a revalidation decision is made, the recommendation is sent to GMC and the document is filed for future reference. Recommendations have been made up till and including end of April 2024.

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

2.10 The General Dental Council does not require dentists to have an appraisal separate from job planning but the Trust's Dental Clinical Director has agreed to use a supportive appraisal document for the TRFT community dentists and send a copy to the appraisal office to be filed. This had not happened recently as the Clinical Director being off on maternity leave. This has been discussed again and has now resumed.

3.0 Conclusion

3.1 Appraisal figures for this quarter are at a good rate considering the challenges our doctors have faced with the industrial strikes.

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

Dr Jo Beahan
Medical Director & Responsible Officer
April 2024

Appendix 1

	Indicator	**Q3 01/10/2023 – 31/12/2023**
1	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	76
1.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period	73
1.2	Number of those within ♯3 above who **did not hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	3
1.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO/ Appraisal lead**	3
1.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**	

Board of Directors' Meeting
3rd May 2024

Agenda item	P88/24
Report	**Guardian of Safe Working Annual report 2023/4 including Q4 data**
Executive Lead	Dr Jo Beahan, 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 and annual report from the Guardian of Safe Working (GSW) 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. A dispute over national pay and conditions for Junior Doctors remains unresolved into a second year, with 33 days of Industrial Action so far in 2023/24, and more possible this year. The number of exception reports and additional hours worked is similar to last year's, making a relative increase allowing for strike days. Junior Doctors in Medicine account for the largest proportion. Overall hours worked are not unsafe. The intensity of working is always high in Medicine and workload and staffing are sometimes flagged as unsafe; especially by the most junior trainees. Senior trainees in Orthopaedics are in grievance procedures with the Trust over an issue of rostered versus actual hours and backpay arising. This is currently being resolved and adjustments made to the rota. There has been a reduction in exception reports from A3 following changes to Junior Doctor staffing and Consultant working patterns. From August, there will be an expansion in HST (Higher Specialist Trainee) numbers by 6 which are part funded by HEE. There will also be an increase in Foundation Doctor numbers. This may impact favourably on Junior Doctors. Adjustments have been made to the medicine rota to reduce hours. Trainee Doctors are encouraged to report missed educational opportunities although numbers remain low. A monthly forum is held to allow trainees to raise concerns and suggest improvements to working conditions.

	The recent NETS (National Education Training Survey) has shown an improvement of trainee experience in Anaesthetics, Emergency Medicine, Paediatrics and Obstetrics and Gynaecology. The experience of Foundation Trainees in Medicine has significantly improved including workload. Overall, the Trust rated as the 2nd highest acute provider in Yorkshire and Humber. Trainee experience in surgery does not benchmark well and has deteriorated across a number of domains. Bespoke intervention is planned for this trainee group.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The report collates information from the Allocate system for exception reporting, the Junior Doctors' Forum (JDF) monthly meetings, the Datix system, personal communication and assorted email correspondence. It has been prepared by Dr Gerry Lynch, Rotherham NHS Foundation Trust's (TRFT) Guardian for Safe Working, and sponsored by Dr Jo Beahan, 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 include medical staffing, Medical Director, Director of Medical Education and Guardian for Safe Working.
Recommendations	The Board is asked to continue its support for safe working for the Trust's trainees by continuing a recruitment strategy for doctors and allied professionals in medicine; and supporting the Division of Medicine to explore mitigation of short term sickness on nights and weekends which can impact quality of care for patients and cause excessive workload for Junior Doctors.
Appendices	

Gerry Lynch
Guardian for Safe Working
April 2024

Exception Report 4th Quarter details (as of 28/3/24) by ward/specialty

Working hours:

(Sub) Specialty	Exceptions	Daytime Hours	Nightime hours
A1 Cardiology	9	9.25	
A1 HCOP	11	13.833	
A2 HCOP	2	1.5	
A4 HCOP	2	2.5	
A3 Respiratory	14	13.17	
A5 Diabetes	3	1.92	
A5 Gastro	1	0	
AMU	22	16.42	
B5 Gen med	1	0.5	
Medical Division total	65	59.1	
General surgery ASU	5	4.85	0.5
General Surgery B10	5	6.75	
Paediatrics	1	0	0.5
Total	76	70.7	1

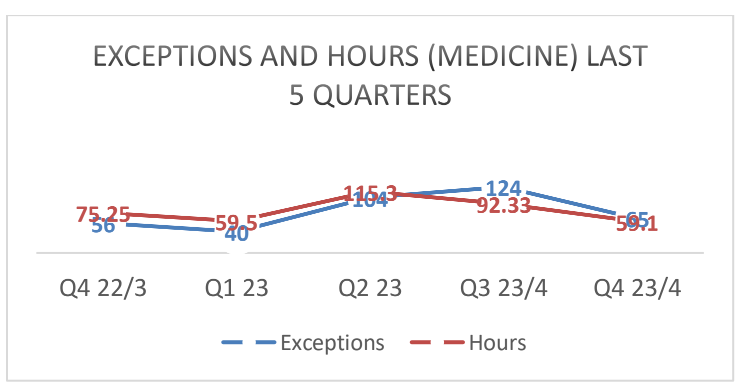
Exception report annual details 2023/24

Working hours:

(Sub) Specialty	Exceptions	Daytime Hours	Nightime hours
Medical Division total	333	326.16	2.16
General surgery	73	66.73	13.33
Orthopaedics	14	23.16	
Paediatrics	9	12.32	0.5
Obstetrics/Gynaecology	15	15.88	
Urology	4	2.5	1
ED	1	1	
Total	449	448.05	16.99

Exception reports for missed educational opportunities

There were 23 exception reports for missed educational opportunities in 23-24 these are dealt with by the Director of medical education.



Immediate safety concerns

Excluding 2 done in error, there were 10 immediate safety concerns throughout the year. All were dealt with by either the ES or GSW and escalated when appropriate to the divisional leadership.

Triangulation with Datix system

Search of Datix system revealed 7 incidents in the past year where lack of trainee staff are mentioned - 5 from Medicine, 1 from Obstetrics and Gynaecology and 1 from the Acute Response Team. 6 of these have been graded as no-harm incidents. The most recent, from Medicine on 30th April 2024 has been graded initially as moderate harm. At review, there was no evidence of harm and the division is meeting to learn from the 30th April incident.

Guardian fines

Guardian fines totalling £217.79 total to two doctors and £626.69 to the GSW Cost Centre have been levied on the medical division. The Cost Centre funds to be used for benefit of the trainee doctors' cohort.

Qualitative examples from Exception reports

"*Unable to safely handover until 1800 due to understaffing"*

"Immense ward commitment, with 10+referrals daily. Not helped by the fact that we have 2 new SHOs who are quite new to the system and ward."

"We had no registrar or consultant due to illness, and 21 patients compared to the usual 16"

Actions to mitigate issues

Due to employment of a floating doctor and improved consultant rostering, the number of exception reports from Ward A3 has fallen from 56 in Q3 to 14 in Q4.

From April, a modified FY2 - CT2 rota with 46 basic hours as opposed to 47.25 should reduce the chances of fines falling due to trainees exceeding the average 48 hour week.

A new orthopaedic registrar rota is being designed around the needs of the service and backpay is being negotiated to affected trainees.

Job adverts are currently out for consultants in HCOP and acute medicine as well as a Specialty Doctor in Acute Medicine.

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

The GSW, Director of Medical Education and Foundation Director have raised any serious problems highlighted in exception reports to the divisional leadership in Medicine, as well as to Medical Workforce where appropriate. In particular, any which might pose genuine immediate threats to safety.

Regular discussion of all concerns at the Junior Doctors Forum attended by representatives from Medical Workforce, Divisions, Medical Director, Director of Medical Education and Guardian for Safe Working. Concerns addressed include rotas and staffing, missed educational opportunities, IT/ Meditech and equipment issues consultant supervision, lack of WOWs, label printers, issues with lack of bleeps and DECT phones and the new wifi phone system, locum induction and Meditech access.

The Divisional Director has arranged meetings to address concerns arising from the most recent Datix in Medicine.

Board of Directors
3rd May 2024

Agenda item	P89/24
Report	**Learning From Deaths - Quarterly Report**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	**P1:** There is a risk that we will not embed quality care within the 5 year plan. **OP3**: There is a risk that robust service configuration across the system will not progress and deliver seamless end-to-end patient care across the system. **D5:** There is a risk that we will not deliver safe and excellent performance.
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 Better Tomorrow LFD SJR Improvement Programme**</u> A team of trained reviewers are now in place with time allocated to complete Structured Judgement Reviews. In December 2023 77% were completed within 60 days and overall completion of 92 % for Quarter 3 23/24. 10 reviews had a care score of less than 3 with 1 deemed as avoidable. 14 reviews were completed as required by LeDeR with 4 having a care score of less than 3 with none deemed as avoidable. A new flag is in place for patients with Serious Mental Illness (SMI) which will enable SJRs to be completed for this group. SJRs with an overall poor care score or avoidability are now submitted to the DATIX system and discussed at panel when required. This will ensure appropriate learning from deaths in these categories and enables triangulation with PSIRF themes. Thematic analysis is circulated to relevant groups. The relevant groups are being asked to report / feedback how this information has changed practice.

	The thematic analysis for end of life care will be a key focus for improvement during this year. SJR+ has previously been supplied from NHSE. This has now moved to AQUA who have introduced a charge for this. We are currently reviewing this and exploring alternatives. **360 Assurance LFD Governance Audit Action Plan** The outstanding action from the 360 audit relating to learning from deaths at divisional level specifically medicine has now been completed. All actions from 360 learning from deaths are now closed. **Mortality Indicators** The latest **SHMI** Score (latest Month Oct 2023) is **101.9**. TRFT are in the 'As Expected' Band. The latest **HSMR** Score (latest Month Jan 2024) is **92.1**. TRFT are in the 'Lower than Expected' Band. A paper discussing the rationale to stop reporting on HSMR is attached to this paper. This was discussed at Quality Committee in April and QC were in agreement with the recommendation. The board is asked to approve this decision. The two conditions with the highest SHMI are fracture neck of femur and fluid and electrolyte disorders. Each of these will be having increased scrutiny to enable understanding and improvement work undertaken. **AMD Posts** There are now 2 Consultants in post as Associate Medical Directors for Patient Safety and Quality Improvement. They will provide additional support for Learning From Deaths and PSIRF implementation as initial priorities.
Due Diligence	This report is produced by the Learning from Deaths and Mortality Manager with a final review by the 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 provides intelligence which is used by the Trust to enhance care for present and future patients. 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 (7 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 the 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	1. Learning from Deaths, Thematic Analysis Report 2023/24 Q3 2. SHMI Report – Latest Month's Data Oct 2023 3. HSMR Report – Latest Month's Data Jan 2024

1.0 Learning from Deaths Quarterly Report: 2023/24 Q2

	Due Date	SJR Data*	SHMI Latest Month	HSMR Latest Month
This Report	-	2023/24 Q3	01/10/2023	01/01/2024
Next Report	07/06/2024	2023/24 Q4	01/01/2024	01/03/2024

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

SJR Completion Figures

Month of Discharge	Adult Inpatient & UECC Deaths	SJR Requested	Completed	Out-standing	% Completed	Overall Care Score < 3	Preventa-bility Score < 4
Apr-23	89	13	13	0	100%	3	2
May-23	77	15	15	0	100%	4	0
Jun-23	81	13	13	0	100%	2	0
Jul-23	52	14	13	1	93%	5	0
Aug-23	79	13	13	0	100%	2	0
Sep-23	83	21	21	0	100%	4	0
Oct-23	88	15	15	0	100%	5	0
Nov-23	87	18	17	1	94%	2	1
Dec-23	111	30	26	4	87%	3	0
2023/24 YTD	747	152	146	6	96%	30	3
2023/24 Q1	247	41	41	0	100%	9	2
2023/24 Q2	214	48	47	1	98%	11	0
2023/24 Q3	286	63	58	5	92%	10	1

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

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

SJR Timeliness Figures

Month of Discharge	% Completed < 60 Days
Apr-23	46%
May-23	33%
Jun-23	46%
Jul-23	36%
Aug-23	38%
Sep-23	67%
Oct-23	67%
Nov-23	72%
Dec-23	77%
2023/24 YTD	57%
2023/24 Q1	41%
2023/24 Q2	50%
2023/24 Q3	73%

2022/23 Year end Figures

SJRs Completed	45%
Completed <60 Days of Death	24%

SJRs completed by the SJR Review Team are of a much better quality with more free text narrative. However timeliness figures whilst an improvement on 2022/23 figures require further improvement.

The 90% target for completing all SJRs within 60 days isn't being met. 57% 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 completion and intelligence dissemination is crucial for this.

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

2.0 Summary & Distribution 2023/24 Q3 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 or negative.

The Thematic Analysis reports are distributed to various groups, individuals and teams within the Trust. The purpose is for these groups to review the reports 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 who receive the report.

Category of Problem
Medication or Treatment
Escalation
Assessment/Opinion/Review
Tests/Results/Monitoring
Location of Care/Bed Availability/Inappr
End of Life/Palliative Care/DNACPR
Communication

Groups Distributed to
Deteriorating Patient Group
Medicine Safety Committee
Patient Safety Committee
Results Flagging & Notification
Safeguarding Operational Group
Clinical Governance - Medicine & its CSUs
Clinical Governance - Surgery & its CSUs
End of Life Group
Sepsis QI Group
Parenteral Nutrition & NG Feed T&F
Quality Governance & Assurance Group
Divisional Mortality Meeting - Medicine
Divisional Mortality Meeting - Surgery
Trust Mortality Group

3.0 Next Report:

The next Thematic Analysis Report will be completed in June 2024 for 2023/24 Q4 SJRs.

4.0 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 LeDer reviews when they have been involved in the care provision for that patient. TRFT completes SJRs for all Trust deaths for those with Learning Disabilities or Autism.

Deaths for these patients are identified by a Learning Disability Flag and an Autism Flag in the Trust's Mortality Insights Power BI Reports, indicated by the Medical Examiner after a scrutiny, a request from the Matron for Learning Disabilities and Autism, or by a request from a ICB LeDer Team.

Completed SJRs are distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding and to the requesting 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	Preventability Score < 4
Apr-23	1	1	0	1	0
May-23	1	1	0	0	0
Jun-23	1	1	0	0	0
Jul-23	0	0	0	0	0
Aug-23	2	2	0	1	0
Sep-23	2	2	0	0	0
Oct-23	1	1	0	1	0
Nov-23	2	2	0	1	0
Dec-23	4	4	0	0	0
2023/24 YTD	14	14	0	4	0

Update

The Trust now (since Feb 2024) has a flag in its Mortality Insights Power BI Report which highlights deaths for patients with a Serious Mental Illness (SMI). The flag uses national recognised SMI ICD10 Codes coded during the patient's last admission. This means that the Trust process for identifying these patients for SJR is now more robust and doesn't solely rely on them being identified during a Medical Examiner Scrutiny.

SJRs have been requested for all 2023/24 SMI deaths identified using this flag.

5.0 NHS 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 in SJR+ 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.

6.0 360 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. 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.

7.0 Plan to fulfil the remaining action point

Completed SJRs (c21) are being sent to Division's Mortality Leads every 4 weeks**.** The split is roughly 13 to Medicine, 6 to Surgery and 2 to UECC. The SJRs are grouped according the last treating CSU. Those judged to have had poor care and /or been likely preventable are highlighted.

The ask for the Division's 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 separately held Mortality meeting. SJRs should be selected if they have learning points related to both good and poor care. All those judged to have had poor care and /or been likely preventable 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.

8.0 Progress

In December 2023 a small SJR Review Group has been formed in the Division of Medicine. This multi-disciplinary group meets monthly and will assist the Division's Mortality Lead in selecting individual SJRs for dissemination to the CSUs. In addition a template has been sent out to the CSUs, to be included in their Governance minutes, which details SJR/Mortality discussions and any actions.

Minutes from the CSU meetings will be reviewed by the Learning from Death and Mortality Manager during January and February, in order to produce an evidenced report for the April 2024 360 Re-Audit.

9.0 Learning from Deaths in the Divisions

Monthly Mortality meetings are held in the Divisions of Medicine, Surgery and by the Urgent & Emergency Care Team. Reviewed deaths are presented and discussed. These can be a SJR, a local review or both.

Mortality is also discussed at CSU meetings, either as agenda item in the CSU Governance meeting or a separately held CSU Mortality meeting.

Every 4 weeks completed SJRs (c21) are distributed to the Medicine, Surgery and UECC Mortality leads. The ask is for a brief review to be undertaken in order to select a small cohort of SJRs with learning points (both positive and negative). These SJRs in addition to those where the Overall Care Score is poor or judged to have been more than likely preventable are disseminated to the CSUs for discussion at their Governance or separately held Mortality meeting.

All SJRs where the Overall Care Score is poor or the death is judged to have likely preventable are entered as an incident on Datix. These SJRs and the reasons for their poor care score or preventability are then reviewed following the governance process. These cases can be referred to panel where a Serious Incident can be declared, a Patient Safety Incident Investigation undertaken, resulting in an After Action Review.

Update

Clinical and administrative pressures in the Division of Surgery have seen some of their Divisional Mortality meeting cancelled over the Autumn/Winter.

John Taylor
Learning from Deaths & Mortality Manager
April 2024

John Taylor
Learning From Deaths & Mortality Manager
Mobile: 07833 634440
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12/03/2024

Appendix 1

Learning From Deaths
Thematic Analysis SJRs 2023/24 Q3

Content

This report contains the Thematic Analysis of Structured Judgement Reviews (SJRs) completed for deaths in 2023/24 Q3. 51 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 Reocccurances 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

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

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Delay/Omission/Choice - Medication or Treatment

2 doses of antibiotics(not first) were missed because the patient was confused(known dementia) and unable to take oral medications.This could have been switched to an IV preparation to ensure the medication could be administered.

I would have expected this patient to have adjunct treament for Covid. It is not clear why not.

discussions had with neurosurgery regarding safety of starting prophylactic tinzaparin with the history of previous sub arachnoid haemorrhage should have happened sooner and she should have commenced tinzaparin sooner in the stay.

11 hours within the UECC prolonged wait for bed with no documentation of food or drink offered during this time

high sodium due to dehydration it is unclear why given iv dextrose

No further dose of antibiotics administered after initial loading dose of antibiotics; for a period from 13-18 of November 2023.
Explanation given: medicine not available.
However there seems to have been no acknowledgement of the above fact and/ or exploring the option for a suitable alternative. This is despite documentation from the pharmacy team w.r.t this being an active problem on 13/11/2023.

missed opportunity in UECC for pain relief and delay in investigations lead to long stay in department although difficult in the agitated patient .

Agitated patients should be considered for analgesia as they cannot express pain especially if underlaying cognitive impairment

Decision to offer emergency high risk surgery, that could potentially have been predicted, and not discuss this when decision made not to have planned elective procedure

another example of the recurring theme of unsatisfactory antibiotic treatment. Despite appropriate/ provisional diagnosis and initial administration of antibiotics, continuing doses of antibiotics were not prescribed after stat dose in A&E.
This could have been based on the inflammatory markers; but it's difficult to understand the rationale of not continuing antibiotics with a working diagnosis of UTI and AKI.

Delay/Omission - Assessment/Opinion/Review

discussions had with neurosurgery regarding safety of starting prophylactic tinzaparin with the history of previous sub arachnoid haemorrhage should have happened sooner and she should have commenced tinzaparin sooner in the stay.

The patient was under specialist respiratory care at STH, but there was no Respiratory input to their care.
Given the PMH of the patient, the Differential diagnosis of Cardiac failure only comes in on the 2nd.
The patient was not reviewed over the weekend.

Require weekend reviews for unwell patients

Patient was admitted to ward and treated for LRTI 8 days ago and planned for virtual ward follow up but no evidence this occured. Patient was then brought in state of arrest 8 days later.

There was some delay to being seen by a clinician in Resus

She was seen early on the 28th with Delirium there is no review to assertain the cause of this.

Advice sort from gastro specialist would of benefited from regular ward round by them to complement ITU care but this did not adversely affect her out come

Difficulty in contacting Cardiology

Dementia screen should have been done on admission due to poor history ,was missed.

This is clearly a complex medical patient who was very frail. However, incomplete initial assessment meant that important information about the patient's recent imaging was missed. This may have contributed to delays in accessing specialty opinions. Reproducing assessments with 'cut and paste' function meant that there were delays in acknowledging important information in past medical history.

A poorer aspect of care seems to be the multiple referrals made from surgery to get medicine to take her care over contrary to the rib injury pathway this portrays an attitude of not wanting her under surgical care rather than patient centered care. This was not detrimental to her given the Palliative care were involved early in this ladies case .

Delay/Omission/Interpretation - Tests/Results/Monitoring

Delay in formal echo due to staffing.

Only criticism would be lack of urine culture

There was a delay in recognising the high sodium on the Sunday 8th

End of Life/Palliative Care/DNACPR

Decision to offer emergency high risk surgery, that could potentially have been predicted, and not discuss this when decision made not to have planned elective procedure

No communication from the Care Home.
Should this patient be nursed in the NH, rather than transferred to the ED

Moved to Last Days of Life care on admission.
Should this patient have been transferred to the trust.
Should they have ben seen in the Care Home and the LDL plan made there.

Ideally should not have been admitted and received palliative care at home.

Documented by Palliative care team that there were difficulties in knowing if anything had been but in place as unable to see documentation from a different local Trust Palliative Care team.

No consideration of care planning, despite 3 admissions with similar issues in the months prior to her death, she should have had the opportunity to have more choice in her care at the end of her life. When family expressed that she wouldnt have wanted ongoing treatment, treating team didnt respond to this and they didnt discuss this with the patient.

She had a DNACPR and would never have benefitted from CPR, but unfortunately we carried out CPR. as the DNACPR was not available.

End of Life Care should have been considered earlier

The only question is given she has a Respect form not for admission why did the nurse (community) going out (pts home) not explore other options rather than emergency admission to meet this family and patients care needs

Lack of escalation plan or treatment limits despite acknowledgement of advanced frailty, significant co-morbidities and prolonged stay in the hospital.

noted that he has not eat or drank for more than 5 days by dietician and that he is end stage at this point last days of life care should of been discussed with family

the team recognised futility of treatment but continued to give iv medications. and multiple attempts at cannulation and investigations this is documented to have caused distress and should have been considered for stopping sooner

opportunities missed to discuss with her that she was likely approaching the end of her life, this discussion was only had with her and family shortly before her death

This lady was recorded as extremely frail on admission, was under care of virtual ward prior to admission, could have involved some advance care planning before admission, to prevent this lady who was recorded as extremely frail dying in hospital

Earlier recognition that she was dying would have resulted in a more dignified death

Need to advance care plan PRIOR to admission and to take notice of frailty scores in planning ongoing care. If we record that we think someone is dying, we should consider how the last weeks of someones life is best spent

She was over investigated and remained under care of surgeons inappropriately and had ongoing referrals to people who couldnt help her.
Earlier recognition that she was dying would have resulted in a more dignified death

Due to some confusion regarding the validity of the patients RESPECT form, a photocopy of which was in the notes, upon suffering a cardiac arrest she received brief CPR and adrenaline. CPR attempts were discontinued relatively quickly and she passed away. Her RESPECT form was clearly mentioned in her initial clerking and was known about and in addition she now had an unsurvivable metastatic cancer. The validity of her RESPECT form should have been ensured.

May have been better managed in the community rather than have been readmitted for EoL care

Location of Care/Bed Availability/Inappropriate Moves

No communication from the Care Home.
Should this patient be nursed in the NH, rather than transferred to the ED

Moved to Last Days of Life care on admission.
Should this patient have been transferred to the trust.
Should they have ben seen in the Care Home and the LDL plan made there.

Ideally should not have been admitted and received palliative care at home.

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May have been netter managed in the community rather than have been readmitted for EoL care

missed opportunity in UECC for pain relief and delay in investigations lead to long stay in department although difficult in the agitated patient .

Plan was for ERCP at STH - delay in transferring due to bed pressures and some issues with communication to bed manager at STH.

placing an elderly patient for a prolonged period of time on AMU is not best practice and we should be aiming for them to be under frailty /HCOP

She continued to be nursed in surgical bed, despite being taken over by medics shortly after admission. Referred to palliative care team 3 days later, remained under care of surgeons which was not appropriate and HCOP only took over care when she was clearly dying. No communication

Communication

No communication from the Care Home.
Should this patient be nursed in the NH, rather than transferred to the ED

Plan was for ERCP at STH - delay in transferring due to bed pressures and some issues with communication to bed manager at STH.

Documented by Palliative care team that there were difficulties in knowing if anything had been but in place as unable to see documentation from a different local Trust Palliative Care team.

Difficulty in contacting Cardiology

This is clearly a complex medical patient who was very frail. However, incomplete initial assessment meant that important information about the patient's recent imaging was missed. This may have contributed to delays in accessing specialty opinions. Reproducing assessments with 'cut and paste' function meant that there were delays in acknowledging important information in past medical history.

11 hours within the UECC prolonged wait for bed with
no documentation of food or drink offered during this time

No further dose of antibiotics administered after initial loading dose of antibiotics; for a period from 13-18 of November 2023.
Explanation given: medicine not available.
However there seems to have been no acknowledgement of the above fact and/ or exploring the option for a suitable alternative. This is despite documentation from the pharmacy team w.r.t this being an active problem on 13/11/2023.

PTWR review 18:20, unclear which Consultant

when telling relatives of the Medically fit for discharge status it is important to communicate when this position changes to avoid confusion .

Ideally admission could have avoided admission and been cared for in community

Term 'acopia' used by admitting doctor. Not a term that demonstrates compassion and empathy and should be discouraged

No real discussions on admission about patients wishes, or expectations

Delay/Omission/Choice - Medication or Treatment

Good involvement from microbiology to guide antibiotic decisions.

excellent initial care following GI haemorrhage guidance and massive transfusion guide.

nursing aspects of care excellent

This is an excellent example of early decision making and clear communication with the family with a patients centred approach

A good example of decision making for delivering holistic care in a patient who lacks capacity to make decisions w.r.t his own treatment.
Early involvement of specialty teams and wider MDT to make treatment decisions in the patient's best interest.

Delay/Omission - Assessment/Opinion/Review

Good involvement from microbiology to guide antibiotic decisions.

A good example of decision making for delivering holistic care in a patient who lacks capacity to make decisions w.r.t his own treatment.
Early involvement of specialty teams and wider MDT to make treatment decisions in the patient's best interest.

Good input from the LD team and ART team. Prompt gastro response to referral

Many examples of good practice and excellent documentation /communication- referral to dietetic services, Urology, Orthopedics/ Palliative care

Overall good care. Good MDT working, good communication with patient and relatives. Good EoL care.

Clear reviews of her condition and response to changing condition and concerns from family

Continuing MDT involvement in delivery of care and good communication between specialist teams and family. Excellent documentation from MDT team contribution w.r.t rehabilitation, capacity assessment and communication with family.

End of Life/Palliative Care/DNACPR

Overall good care. Good MDT working, good communication with patient and relatives. Good EoL care.

Excellent palliative care and documentation from the palliative care team and consultant during the last week of life

Patient received excellent palliative care from the palliative care team.

Excellent EOL care on ITU with good communication.

Palliative care was excellent both in this admission and the last and the standard of documentation excellent by all involved in her care .

Good example of communication with patient in deciding treatment escalation plan and ascertaining patient's wishes.

Excellent documentation from parent team and palliative care team w.r.t decision making process and balancing benefit/ risk of active treatment against palliative care.

Excellent communication with family and delivery of EOLC.

excellent palliative care

excellent communication by EOL team

Early referral to palliative care team, while still receiving active treatment, care, smoothly changed to last days of life care plan and nursed in side ward for privacy. Good ongoing communication from all professionals

Excellent effort to contact/ communicate with family members on the other hemisphere and appropriate timing and EOL with clear documentation of timeline and reasons for decision making.

HF nurse ref to palliative care as this lady was considered palliative in community as per EPRF which is excellent practice

excellent care by the palliative care team and symptomatic treatment with the wishes of the patient taken into account .

Communication

Overall good care. Good MDT working, good communication with patient and relatives. Good EoL care.

Excellent EOL care on ITU with good communication.

Good example of communication with patient in deciding treatment escalation plan and ascertaining patient's wishes.

Excellent communication with family and delivery of EOLC.

Early referral to palliative care team, while still receiving active treatment, care, smoothly changed to last days of life care plan and nursed in side ward for privacy. Good ongoing communication from all professionals

Excellent effort to contact/ communicate with family members on the other hemisphere and appropriate timing and EOL with clear documentation of timeline and reasons for decision making.

Many examples of good practice and excellent documentation /communication-referral to dietetic services, Urology, Orthopedics/ Palliative care

Clear reviews of her condition and response to changing condition and concerns from family

Continuing MDT involvement in delivery of care and good communication between specialist teams and family. Excellent documentation from MDT team contribution w.r.t rehabilitation, capacity assessment and communication with family.

This is an excellent example of early decision making and clear communication with the family with a patients centred approach

Initial assessment is excellent with initial medical clerking excellently documented , clear in ceilings of care and addressing family concerns as well as considering the patients wishes as expressed on previous admission .

ITU excellent documentation and care , communications with family

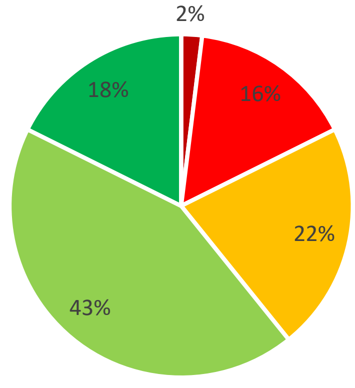
excellent initiation of care and timely clerking
really excellent discussion by consultant with the family - clear limits of care and if hospital is preferred place

Delay/Omission/Interpretation - Tests/Results/Monitoring

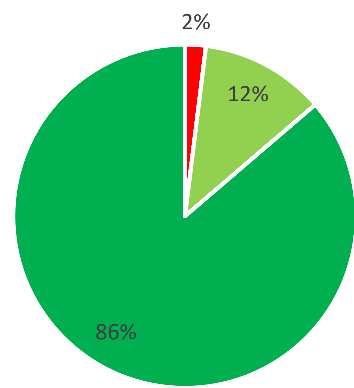
importance of blood cultures in guiding antibiotics treatment. Impressive provision of diagnostics overall

Data Tables

Overall Care Score	SJRs
1 - Very Poor	1
2 - Poor	8
3 - Adequate	11
4 - Good	22
5 - Excellent	9
Not Recorded	0
Total	51



Preventability	SJRs
1 - Definitely Preventable	0
2 - Strong evidence for Preventability	1
3 - Possibly Preventable (more than 50%)	0
4 - Possibly Preventable (less than 50%)	0
5 - Slight evidence for Preventability	6
6 - Definitely not Preventable	44
Not Recorded	0
Total	51



Comment Relates to	Negative Comments	Positive Comments
Delay/Omission/Choice - Medication or Treatment	10	5
Delay/Omission - Escalation	0	0
Delay/Omission - Assessment/Opinion/Review	11	7
Delay/Omission/Interpretation - Tests/Results/Monitoring	3	1
End of Life/Palliative Care/DNACPR	19	14
Location of Care/Bed Availability/Inappropriate Moves	10	0
Communication	12	13
Total	65	40

Type	Problems
Problems leading to readmission	6
Problems in assessment	2
Problem with medication	5
Problem with nutrition	1
Problem with infection control	1
Problem related to operation	1
Problem in clinical monitoring	2
Problem in treatment plan	9
Problem in resuscitation	2
Problem in IV fluids	3
Problems in communication	7
Problems in relatives communication	5
Problems in team communication	8
Problem of any other type	2
Total	54

John Taylor
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Latest Publication Date: 14/03/2024
Latest Data Month: Oct-23

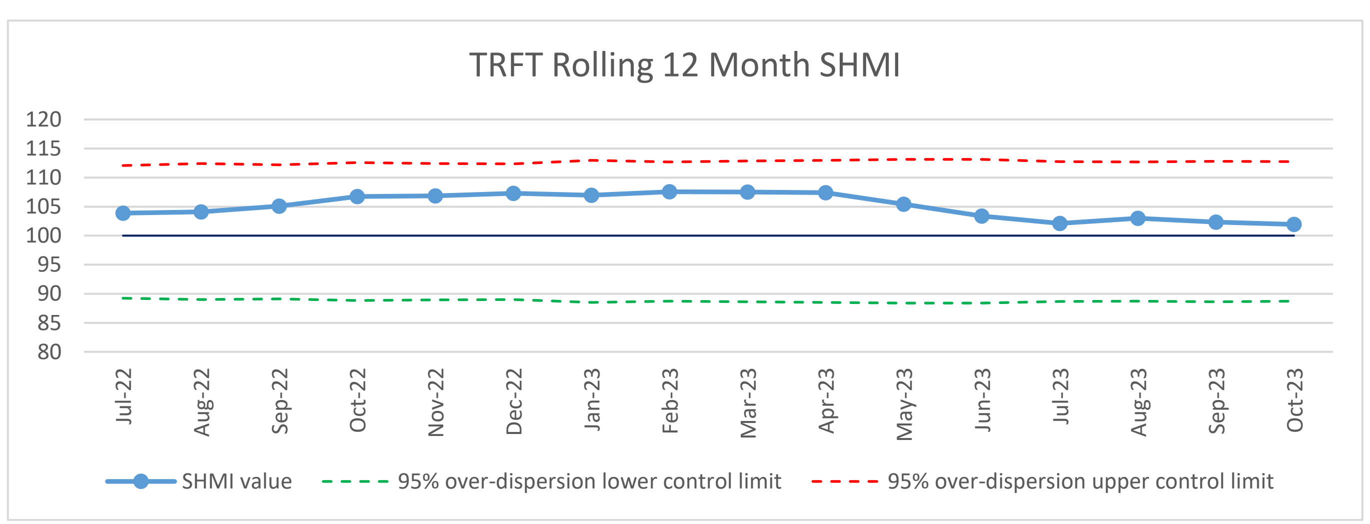
Appendix 2

TRFT SHMI Report

Summary

TRFTs latest Rolling 12 Month SHMI Value is 101.9. TRFT remain in the Band 2 'As Expected' band. The previous value was 102.4.

TRFT has 0 Diagnosis Groups in the Higher than Expected Band.

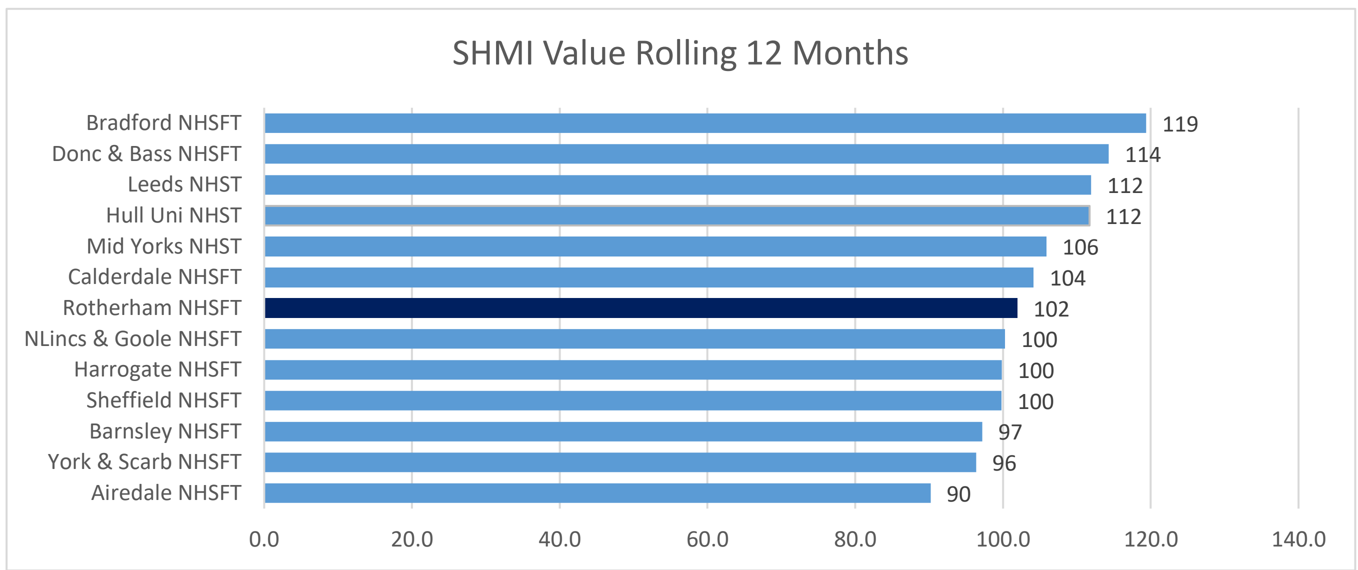


TRFT Latest SHMI Value

End Month	SHMI value	SHMI banding	Number of spells*	Observed deaths	Expected deaths
Oct-23	101.9	2	48815	1360	1335

* Excluded Day Cases and Regular Attendances

Region Comparator - Yorkshire & Humber Non Specialist Trusts



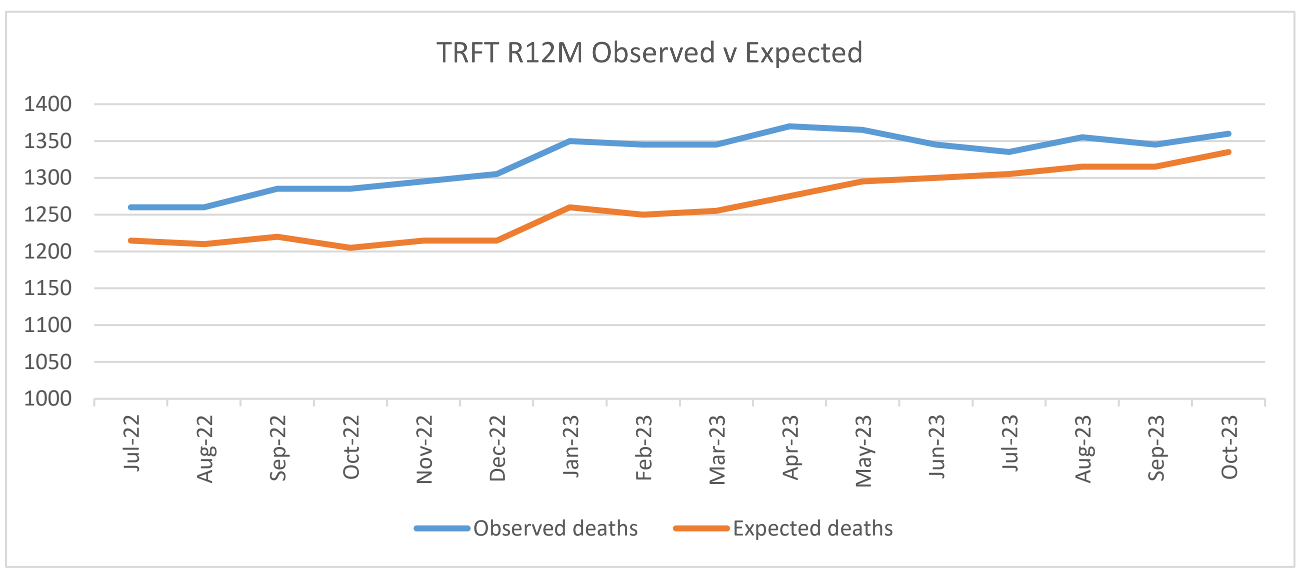
SHMI Diagnostic Group Breakdown

Diagnosis Group	Number of spells	Observed deaths	Expected deaths	SHMI Value	SHMI banding
Acute bronchitis	1105	15	20	64.4	2
Acute myocardial infarction	435	30	30	93.1	2
Cancer of bronchus; lung	55	20	20	93.6	2
Fluid and electrolyte disorders	355	25	20	122.0	2
Fracture of neck of femur (hip)	315	30	20	138.1	2
Gastrointestinal hemorrhage	390	10	15	77.2	2
Pneumonia (excluding TB/STD)	1505	240	220	109.9	2
Secondary malignancies	120	20	25	78.2	2
Septicaemia (except in labour), Shock	625	165	140	117.3	2
Urinary tract infections	985	25	30	72.0	2

Coding Data

TRFT Rank of 13	2nd Highest	3rd Highest	2nd Highest	6th 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**
Rotherham NHSFT	17.2	2.6	6.5	1.8	50
Airedale NHSFT	14.2	0.0	4.5	1.0	24
Barnsley NHSFT	14.1	0.1	7.1	1.9	33
Bradford NHSFT	14.5	3.2	3.6	1.1	35
Calderdale NHSFT	8.3	0.0	6.2	2.0	40
Donc & Bass NHSFT	11.4	0.1	4.8	2.4	53
Harrogate NHSFT	17.0	1.3	4.5	1.8	41
Hull Uni NHST	12.8	6.2	5.4	2.0	33
Leeds NHST	5.9	*	6.1	1.8	31
Mid Yorks NHST	9.4	0.6	6.5	2.0	38
NLincs & Goole NHSFT	17.7	0.1	4.8	1.2	22
Sheffield NHSFT	9.6	0.2	4.7	1.8	37
York & Scarb NHSFT	13.5	0.0	5.5	1.2	27
England	14.0	1.8	5.7	2.0	42

Comparison of the SHMI Observed and Expected Deaths



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Latest Publication Date: 05/04/2024
Latest Month Data: Jan-24

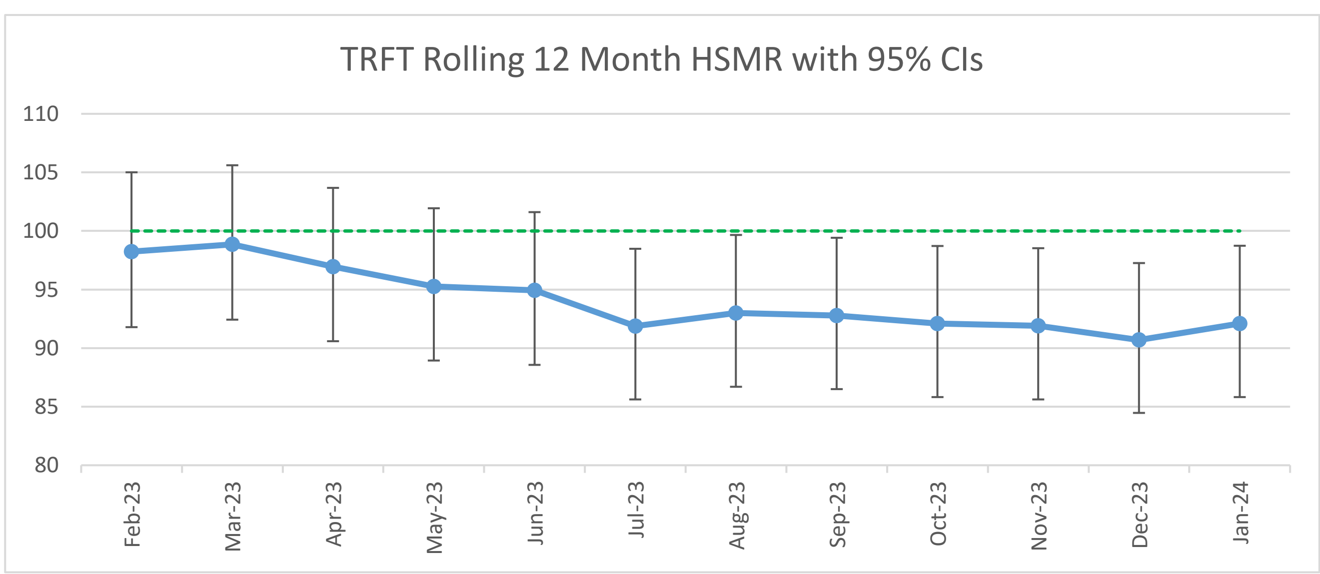
Appendix 3

TRFT HSMR Report

Summary

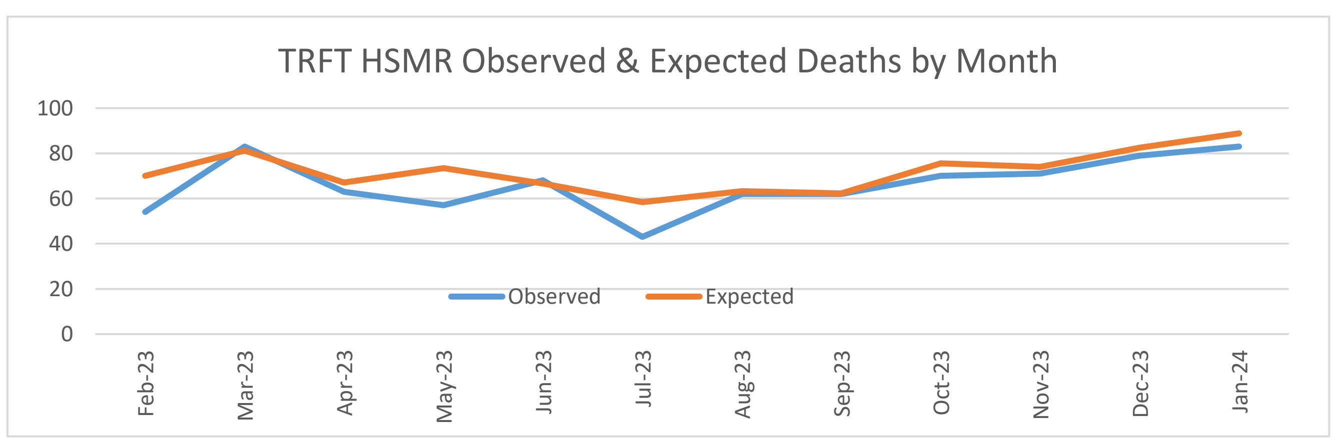
TRFTs latest Rolling 12 Month HSMR Value is 92.1 TRFT are in the 'Lower than Expected' band

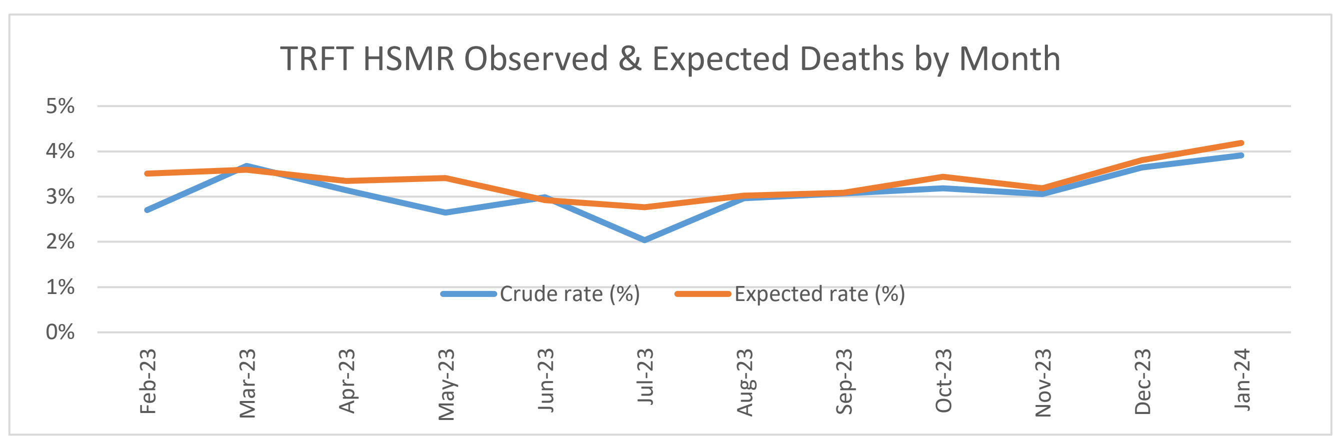
TRFT is in the higher than expected band for no Diagnosis Groups:



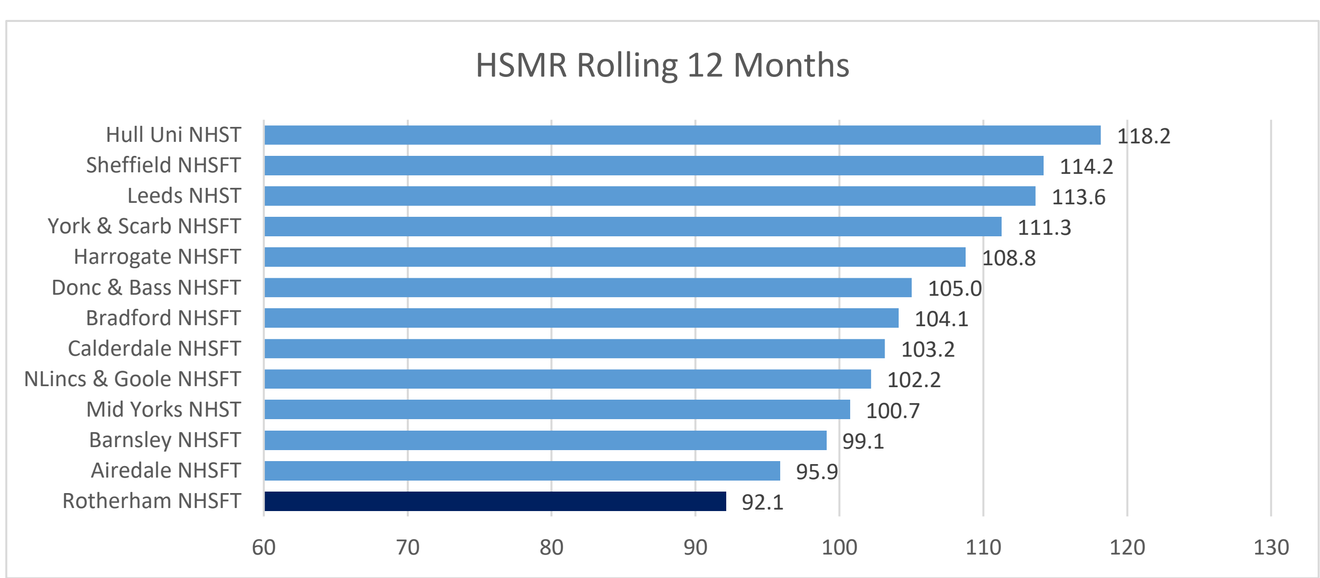
TRFT Latest R12M HSMR Value

End Month	HSMR value	HSMR banding	Number of super spells	Observed deaths	Expected deaths
Jan-24	90.2	lower	25802	787	873





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

Quality Committee Meeting
24TH April 2024

Agenda item	QC/94/24
Report	**Proposal to Cease Reporting of the HSMR Mortality Metric**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	**D5:** we will not deliver safe and excellent performance
How does this paper support Trust Values	This proposal will ensure that TRFT has robust processes for monitoring quality and safety, and is responsibly using its resources for this.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	In 2022, NHS England announced it was decommissioning the reporting of the Hospital Standardised Mortality Indicator (HSMR). The NHS produced its own mortality indicator, the Summary Hospital Level Mortality Indicator (SHMI), in order to have one robust mortality indicator for adoption across the NHS. NHSE have concluded that monitoring the HSMR has no benefits over solely monitoring the SHMI.
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	The proposal has been discussed at the Trust Mortality Group and has support from the Medical Director, the Deputy Director for Data & Insights and the Learning for Deaths & Mortality Manager.
Powers to make this decision	Quality Committee to accept or reject the proposal.
Who, What and When	This proposal is required to be agreed by the Quality Committee. If agreed, reporting changes will be made by the Learning from Deaths & Mortality Manager and the Health Informatics Team.
Recommendations	It is recommended that TRFT cease monitoring & reporting of the HSMR.
Appendices	HSMR – Cease Reporting Proposal

John Taylor
Learning from Deaths & Mortality Manager
March 2024

John Taylor
Learning From Deaths & Mortality Manager
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Proposal to Stop Routine Reporting of the Hospital Standardised Mortality Ratio (HSMR), from 01/04/2024

Following the recommendations from the national review of the HSMR in 2010, the Department of Health and Social Care commissioned NHS Digital to produce and publish the Summary Hospital-Level Mortality Indicator (SHMI). See appendix 1.

The initial review, reviewed the HSMR and other Mortality metrics and decided that it would be beneficial to have a **single methodology for a mortality indicator for adoption across the NHS**.

The SHMI has several differences from the HSMR, which are designed to gives a more complete picture of mortality associated with hospitalisation. The SHMI methodology aims to reduce or eliminate the effects of by variations in clinical coding practice, discharges processes and palliative care provision in the community.

Main Differences between the SHMI & HSMR

Attribute	SHMI	HSMR	Rationale for Change
Deaths Included	All Deaths	83% Deaths	Gives a more complete picture of mortality associated with hospitalisation
Deaths 30 days post discharge	Included	Not Included	Gives a more complete picture of mortality associated with hospitalisation & reduces the effects of differences in discharge processes and palliative care provision (hospice) in the community
Palliative Care Coding	no adjustment	adjusts	Variation in coding practice & over-adjustment concerns
Diagnosis Group, Accumulate Risk Monitoring & Banding	10 Diagnosis Groups	56 Diagnosis Groups	Groups with high numbers of deaths and statistical models that are considered to have sufficiently explained the expected variation in outcomes due to the case-mix adjustment.

SHMI Publication

The SHMI began producing quarterly publications in 2011, which has since moved to monthly.

Data is available at Trust level and broken down by diagnosis group. Banding and accumulated risk charts (VLAD) are produced for 10 large volume (deaths) diagnosis groups.

Metrics are also produced for several factors that can affect the SHMI, including data quality, palliative coding and coding depth metrics.

Patient level identifiable data is available to the Trust, for investigation.

Monitoring & Reporting Since 2011

The purpose of the SHMI was to have one robust mortality indicator for adoption across the NHS in order to reduce duplication which causes confusion for both the public and NHS colleagues. However since 2011 most Trusts have continued to report on both the SHMI and HSMR.

Monitoring and reporting of the HSMR might have persisted because NHS England/Improvement (NHSE/I) and the Care Quality Commission (CQC) continued to do this, until their announcement in 2022 informing that they would be ceasing to do this. See appendix 2.

Since then an increasing number of Trusts* are no longer reporting on the HSMR. This is in part due to NHSE/I's announcement and also due to their own conclusions that monitoring the HSMR provides no benefits over monitoring the SHMI alone, and indeed has costs and downsides for the Trust. **The Rotherham NHS FT believes this to be the case.**

*being report at the Better Care Tomorrow Learning from Deaths National Workshop and at Regional Mortality Group Meetings

Proposal

- To cease reporting on the HSMR from 01/04/2024
- To continue the close monthly monitoring & reporting of the SHMI
- To only monitor the monthly HSMR Trust value
- To consider more in-depth monitoring if the Trust HSMR is in or heading to being in the higher than expected band, and not accompanied by a similar rise in the SHMI

Benefits

- Reduced confusion for the public and TRFT colleagues.
- Every minute investigating the HSMR or its discussion in Mortality Group and wider Trust meetings is a minute taken away from discussions on the SHMI, the Learning from Deaths Programme and any other quality improvement programmes.
- Less time for clinical coding and clinical investigations into alerts for low volume HSMR Groups. These investigations require resources and have provided little or no benefit to the TRFT over the years.
- Following recommendation by NHS E/I Mortality Metric experts

Costs/Risks

There is strong recommendation from NHS England that reporting on the HSMR ‘offers little or no value over SHMI data’’.

NHS England and or CQC return to HSMR monitoring (de-skilling/knowledge loss)

A return is unlikely, however the skills required of analysts and other NHS colleagues to monitor, analyse and report on the HSMR are the same required for the SHMI, which will be ongoing.

Missed Opportunities for Investigation

Investigations into small volume (deaths) diagnosis groups for the HSMR has demonstrated little or no benefit for the Trust. The larger volume groups are banded by the SHMI, which also produces VLAD charts (accumulated risk), for these groups.

If the Trust HSMR diverges in a negative way from the SHMI by heading towards or into the higher than expected band, HSMR monitoring can be quickly stepped up.

Appendix

1.

National Review of HSMR, 2010

HSMR_2011Review3.pdf

National Review of HSMR Consensus Statement 2011

HSMR_2011Review2.pdf

2.

NHS England/Improvement Announcement – Cessation of HSMR Monitoring

Please Note

As a result of the continuous rationalisation of the work we undertake on behalf of the NHS, and an internal consultation with experts on mortality datasets that we report through our analytical products, it has been decided that NHSEI will decommission the reporting of **Hospital Standard Mortality Ratio** (**HSMR**) data with immediate effect.

Summary Hospital-level Mortality Indicator (**SHMI**) was commissioned to be the official NHS hospital-wide mortality indicator for acute trusts back in 2011 and it is considered that although HSMR data have been reported for many years this offers little or no value over SHMI data. Any reporting done using this data going forward will need to be amended and replaced with SHMI data. Work is ongoing to make sure that SHMI continues to provide the most useful hospital mortality data analysis as the patterns of delivery of care changes over time.

Whilst HSMR data may be available to individual NHS Acute Trusts via commercial providers, it is for those trusts to consider whether HSMR data adds value to their organisations in addition to other mortality indicators available to them.

For more information regarding SHMI data please follow this link.
If you have any queries about this change, please contact
england.patquality@nhs.net

Board of Directors
3 May 2024

Agenda item	P90/24
Report	**Register of Interests Bi Annual Review**
Executive Lead	Angela Wendzicha
Link with the BAF	**Links with all BAF risks**
How does this paper support Trust Values	The Standards of Business Conduct are an extension of the Trust's values and reflect our continued commitment to ethical business practices and regulatory compliance
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	In accordance with Section 20(1) (e), Schedule 7 of the National Health Service Act 2006 (as amended), the Trust, as a public benefit corporation is required to maintain a Register of Interests of Directors that is available to the public. This includes where there is a nil return. The attached report illustrates the Board of Directors Register of Interests for 2024. The Board should note there are no declarations of interest noted that may compromise the business of the organisation.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Register of Interest has been presented to the Audit and Risk Committee.
Board powers to make this decision	Constitution: Section 33 refers to the manner in which conflicts of interests of the Board members should be dealt with.
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 all declarations of interest are kept up to date, recorded, reviewed and accurate.
Recommendations	It is recommended that the Audit & Risk Committee: • Note the content of the Report
Appendices	Register of Interests

Board Conflict of Interest Declarations Held in ESR as at - 31 March 2024

Employee Name	Service Department	Cost Centre Department	Role	Position Title	Interest Category	Interest Description	Comments	CoI Date From	CoI Date To
Rawlinson, Mr. James	165 Health Informatics L5	165 Director of Health Informatics	Chief Information Officer	Director of Health Informatics	I have no interests to declare			22/08/2023	
Rawlinson, Mr. James	165 Health Informatics L5	165 Director of Health Informatics	Chief Information Officer	Director of Health Informatics	I have no interests to declare			04/09/2020	
Kilgariff, Mrs. Sally	165 Company Secretary L5	165 Chief Executive	Chief Operating Officer	Chief Operating Officer	Indirect interests	Sister is Finance Director for Marks and Spencer		01/04/2022	31/03/2025
Craven, Mrs. Heather Ann	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	I have no interests to declare			31/03/2023	31/03/2024
Craven, Mrs. Heather Ann	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	I have no interests to declare			01/04/2022	31/03/2023
Craven, Mrs. Heather Ann	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	I have no interests to declare			17/12/2021	17/12/2021
Shah, Dr Rumit Zaverchand Lalji	165 Company Secretary L5	165 Board of Directors	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
Shah, Dr Rumit Zaverchand Lalji	165 Company Secretary L5	165 Board of Directors	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
Wright, Mr. Michael	165 Company Secretary L5	165 Chief Executive	Deputy Chief Executive	Deputy Chief Executive	Non-financial professional interest	Trustee of the Rotherham Hospital and Community Charity		01/04/2023	31/03/2024
Wright, Mr. Michael	165 Company Secretary L5	165 Chief Executive	Deputy Chief Executive	Deputy Chief Executive	Non-financial professional interest	TRFT Charity - Corporate Trustee		10/02/2021	19/05/2021
Hackett, Mr. Steven Mark (Steve)	165 Company Secretary L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare			28/03/2024	31/03/2025
Hackett, Mr. Steven Mark (Steve)	165 Company Secretary L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare		I have no declarations to make	21/02/2024	31/03/2024
Hackett, Mr. Steven Mark (Steve)	165 Company Secretary L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare			28/03/2023	31/03/2024
Hackett, Mr. Steven Mark (Steve)	165 Company Secretary L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare			10/10/2022	
Hackett, Mr. Steven Mark (Steve)	165 Company Secretary L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare			01/04/2022	31/03/2023
Malik, Mr. Kamran Rashid	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	Financial interests	Director of Red Button Consulting Ltd	Offering Coaching and Consulting Services	01/02/2023	05/02/2024
Malik, Mr. Kamran Rashid	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	I have no interests to declare			10/10/2022	31/03/2023
Wendzicha, Miss Angela	165 Company Secretary L5	165 Chief Executive	Senior Manager	Director of Corporate Affairs (Company Secretary)	Non-financial professional interest	Outside employment	I have a Joint role as Director of Corporate Affairs with Barnsley Hospital NHS Foundation Trust	01/02/2023	
Dobson, Mrs. Helen	165 Company Secretary L5	165 Chief Executive	Director of Nursing	Chief Nurse	I have no interests to declare			21/07/2022	21/12/2024
Roberts, Mrs. Jodie Leigh	165 Chief Operating Officer L5	165 Chief of Hospital	Manager	Deputy Chief Operating Officer	I have no interests to declare			05/07/2022	
Beahan, Dr Joanne	165 Company Secretary L5	165 Chief Executive	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
Beahan, Dr Joanne	165 Company Secretary L5	165 Chief Executive	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
Beahan, Dr Joanne	165 Company Secretary L5	165 Chief Executive	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
Temple, Mr. Martin John	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	I have no interests to declare			29/03/2023	
Temple, Mr. Martin John	165 Company Secretary L5	165 Board of Directors	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
Ahmed, Ms. Zlakha	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	I have no interests to declare			06/02/2023	
Ahmed, Ms. Zlakha	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	I have no interests to declare			06/02/2023	
Hartley, Mr. Daniel	165 Company Secretary L5	165 Chief Executive	Chief People Officer	Director of People	I have no interests to declare			01/03/2024	
Watson, Mrs. Hannah Elizabeth	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	Non-financial professional interest	Permanent employment as HRD Director, Department for Transport		01/12/2023	
Watson, Mrs. Hannah Elizabeth	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	Non-financial professional interest	Permanent employment as Director of Learning and Talent Aquisition, HMRC		17/08/2023	30/11/2023
Burrows, Ms. Julia Margaret	165 Company Secretary L5	165 Board of Directors	Non Executive Director	Non Executive Director	Non-financial professional interest	Honorary Professor Sheffield Hallam University Honorary Senior Lecturer University of Sheffield	Both are unpaid honorary appointments	09/11/2023	06/11/2026
Richmond, Dr Michael Nicol	166 Company Secretary L5	166 Board of Directors	Chair	Chair	I have no interests to declare			25/04/2024	31/03/2025

Employee Name	Service Department	Cost Centre Department	Role	Position Title	Interest Category	Interest Description	Comments	CoI Date From	CoI Date To
Jenkins, Mr. Richard	167 Company Secretary L5	165 Chief Executive	Chief Executive	Chief Executive	Outside Employment	Joint CEO	The Rotherham NHS FT	15/12/2021	2019/20,2020/21,2021/22,2022/23
Jenkins, Mr. Richard	168 Company Secretary L5	166 Chief Executive	Chief Executive	Chief Executive	Loyalty Interests	My wife works as a Band 5 Community Nurse for the York and Scarborough Hospitals NHS FT. There is no known actual conflict.	Melanie Jenkins	15/12/2021	2015/16 & before,2016/17,2017/18,2018/19,2019/20,2020/21,2021/22,2022/23
Jenkins, Mr. Richard	169 Company Secretary L5	167 Chief Executive	Chief Executive	Chief Executive	Nil Declaration			21/12/2021	2022/21
Jenkins, Mr. Richard	170 Company Secretary L5	168 Chief Executive	Chief Executive	Chief Executive	Nil Declaration			18/02/2022	2021/22
Jenkins, Mr. Richard	171 Company Secretary L5	169 Chief Executive	Chief Executive	Chief Executive	No Change to existing declarations			31/03/2022	2021/22
Jenkins, Mr. Richard	172 Company Secretary L5	170 Chief Executive	Chief Executive	Chief Executive	No Change to existing declarations			13/06/2022	2022/23
Jenkins, Mr. Richard	173 Company Secretary L5	171 Chief Executive	Chief Executive	Chief Executive	Loyalty Interests	Member of the labour party since November 2022	Labour Party	31/03/2023	2022/23
Jenkins, Mr. Richard	174 Company Secretary L5	172 Chief Executive	Chief Executive	Chief Executive	Outside Employment	I occasionally undertake CQC inspections of NHS Trusts as a Well Led Advisor. This is not remunerated although accommodation and expenses are covered.	Care Quality Commission	16/02/2024	2023/24
Martin,Mrs. Linda	165 Estates Mgt & Admin L5	165 Estates & Facilities L4	Interim Director of Estates and Facilities	Interim Director of Estates and Facilities	Nil Declaration				
Tuckett, Mrs. Louise Elizabeth	165 Strategy & Transformation L5	165 Programme Management Office	Senior Manager	Director of Strategy, Planning & Performance	I have no interests to declare			01/10/2023	31/03/2024
Tuckett, Mrs. Louise Elizabeth	165 Strategy & Transformation L5	165 Programme Management Office	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	30/09/2023
Tuckett, Mrs. Louise Elizabeth	165 Strategy & Transformation L5	165 Programme Management Office	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
Parks, Mrs. Emma			Senior Manager	Director of Communications	Nil Declaration				

Board Planner

Action	Event/Issue	Lead	2024							2025	
	TRUST BOARD MEETINGS		**Jan**	**March**	**May**	**June**	**July**	**Sept**	**Nov**	**Jan**	**March**
			12	**8**	**3**	**11**	**7**	**8**	**3**		
			M10	**M12**	**M2**		**M4**	**M6**	**M8**	**M10**	**M12**
	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	COO								•	
	Winter Plan	COO							•		
	Digital Strategy	CEO					•		•		
	Estates Strategy	DoF	•				•			•	
	People and Culture Strategy	DoW			•						
	Quality Improvement Strategy.	CN							•		
	Fire Safety Strategy (via ETM)	DOE			•						
	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			•			•			
	SYB ICS - Wider Needs of Rotherham Community	Public Health		•				•			
	CULTURE										
	Patient Story	CN		•			•		•		•
	Staff Story	DoW	•		•			•		•	
	Annual Staff Survey	DoW		•							
	Staff Survey Action Plans	DoW									
	Freedom to Speak Up Quarterly Report	CN	•		•			•		•	
	Gender Pay Gap Report and Action Plan	DoW		•							•
	Workforce Race Equality Standards (WRES)	DoW						•			
	Workforce Disability Equality Standard Report (DES)	DoW						•			
	Public Sector Equality Duty Report	DoW							•		
	Patient Experience and Inclusion Annual Report	CN					•				
	ASSURANCE										
	Integrated Performance Report:	COO	•	•	•		•	•	•	•	•
	Maternity including Ockenden	CN	•	•	•		•	•	•	•	•
	Safe Staffing & Establishment Nurse review (6 monthly)	CN	•				•			•	
	Safe Staffing & Establishment Nurse review	CN		•							
	Reports from Board Assurance Committees	NEDs	•	•	•		•	•	•	•	•
	Finance Report	DoF	•	•	•		•	•	•	•	•
	Operational Update, Including Recovery and Winter Update	COO	•	•	•		•	•	•	•	•
	Car Parking Review (via ETM)	DOE			•						
	Summary of review on Laboratory safety prior to TUPE of staff	MD		•							
	ASSURANCE FRAMEWORK										
	Governance Report	DoCA	•	•	•		•	•	•	•	•
	Board Assurance Framework	DoCA	•	•	•		•	•	•	•	•
	Quarterly Risk Management Report	DoCA		•	•		•		•		•
	Corporate Risk Register	DoCA	•	•	•		•	•	•	•	•
	Annual Review of risk appetite	DoCA					•				
	Assurance Board Committee ToRs - Audit & Risk Committee	DoCA					•				
	Assurance Board Committee ToRs - FPC, QC, PC	DoCA		•							
	Health and Safety Annual Report	DoE						•			

	Quality Assurance Quarterly Report	CN		•		•			•	•		•
	SIRO Annual Report	DCEO						•				
	Safeguarding Annual Report	CN							•			
	Organ Donation Annual Report	HC						•				
	POLICIES											
	Health and Safety Policy (review date August 2026)	DoE							•			
	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 February 2026)	DoF										
	Risk Management Policy (due April 2026)	DoCA										
	REGULATORY AND STATUTORY REPORTING											
	Annual Report and Audited Accounts	DoF					•					
	Audit & Risk Committee Annual Report	Com Chair					•					
	People & Culture 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						•				
	Quarterly Report from the Responsible Officer Report (Validation)	MD	•			•			•		•	
	ANNUAL Responsible Officer report (Validation)	MD				•						
	Quarterly Report from the Guardian of Safe Working	MD	Q4 •			•		Q2 •		Q3 •		
	ANNUAL Report from the Guardian of Safe Working	MD				•					•	
	Learning from Deaths Quarterly Report	MD		•		•				•		•
	Learning from Deaths Annual Report	MD						•				
	Emergency preparedness, resilience and response (EPRR) assurance process sign off	COO						•				
	Legal Report	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						•			•	
	Register of Interests (bi-annual review)	DoCA				•				•		
	Register of use of electronic signature (bi-annual review)	DoCA						•			•	
	Review of Board Feedback	DoCA						•				
	Review of Board Assurance Terms of Reference	DoCA										
	Review of Standing Financial Instructions	DoF								•		
	Review of Scheme of Delegation	DoF								•		
	Review of Standing Orders	DoCA								•		
	Review of Matters Reserved to the Board (ad hoc)	DoCA										
	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 Person	DoCA						•				
	Escalations from Governors	Chair						•	•	•	•	•
	Remuneration Committee Chair Assurance Report	Chair								•		
	Nomination Committee Chair Assurance Report	Chair								•		
	Annual Planner	Chair	•	•		•		•	•	•	•	•
	Annual Refresh of Committee membership (part of Chairs Report)	Chair				•						
	Audit & Risk Committee minutes	Chair	•			•		•			•	
	Quality Committee minutes	Chair	•	•		•		•	•	•	•	•
	People & Culture Committee	Chair	•	•		•		•	•	•	•	•
	Finance & Performance Committee minutes	Chair	•	•		•		•	•	•	•	•
	Nomination Committee minutes (ad hoc)	Chair				•		•	•	•		
	Remuneration Committee Annual Report	Chair						•				
	Remuneration Committee minutes (ad hoc)	Chair						•		•		
	Going Concern	DoF		•								•

	Segmental Reporting	DoF		•								•
	Accounting Policies	DoF		•								•
	Ad Hoc Business Cases for consideration by Board value in excess of £1m											
	Out-patient Pharmaceutical Dispensing Services	COO				•						
	Board feedback		RS	SH		HW		JBe	MT	MW	RS	SH
	NED Review of complaints files (Quarterly)		KM			HC		JB		RS	KM	

	STRATEGIC BOARD FORUM										
			Dec	**Feb**	**April**	**June**	**Aug**	**Oct**	**Dec**	**Feb**
			8	**2**	**12**	**2**	**9**	**4**	**6**	
			Forum	**Forum**	**Forum**	**Forum**	**Forum**	**Forum**	**Forum**	**Forum**
			M9	**M11**	**M1**	**M3**	**M5**	**M7**	**M9**	**M11**
		Lead								
	Matters for discussion									
2023	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			•					
2024	People and Culture	DoP	•							
	People Strategy	DoP	•							
	Quality, Service Improvement & Redeisgn (QSIR)	CN	•							
	Planning 2024/25	DCEO		•						
	IPR	DoSPP		•						
	Staff Survey 2023	DoP		•						
	People and Culture Strategy 2024	DoP		•						
	2024/25 Strategy Refresh	Ch			•					
	IPR	DoSPP			•					
	Operational Objectives	DoSPP			•					
	Quality Assurance	CN			•					
	New CQC Process	CN			•					
	CQC: Trust Preparedness	CN			•					
	BAF Review and Decision	DoCA				•				
	Risk Appetite	DoCA				•				